State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 19
(1/1/2023 – 12/31/2023)

Quarterly Report for the period
April 1, 2023 – June 30, 2023

Submitted Via PMDA Portal on August 29, 2023

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I. Background and Introduction

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

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

2007: a component of the Catamount Health program was added, enabling the state to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the federal poverty level (FPL), and who do not have access to cost-effective employer-sponsored insurance, as determined by the State.

2009: the state extended Catamount Health coverage to Vermonters at or below 300 percent of the FPL.

2011: inclusion of a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life-limiting illnesses that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training, and respite for caregivers.

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

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

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

2016: On October 24, 2016, Vermont received approval for a five-year extension of the Global Commitment to Health 1115 waiver, effective from January 1, 2017, through December 31, 2021. 2018: As of July 1, 2018, the Global Commitment to Health demonstration was amended to include the authority for Vermont to receive federal Medicaid funding for substance use disorder treatment services provided to Medicaid enrollees in Institutions for Mental Diseases (IMDs).

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

2022: 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.

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the second quarterly report for waiver year 19, covering the period from April 1, 2023, through June 30, 2023 (QE062023).***

II. Outreach/Innovative Activities

i. Member and Provider Services

Key updates from QE062023:

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

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

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

recovery, Medicare recovery, Medicare prescription recovery, special needs recovery, and trust recovery.

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

NEMT Update

In the second quarter of calendar year 2023, non-emergency medical transportation trip numbers for eligible VT Medicaid members remained steady, with a slight jump in May, only to be followed by a minor dip in June. The month's numbers have averaged around 26,000 rides, with continued minor week to week fluctuations. Historically, warmer weather numbers tend to trend a bit lower than in the colder months in general. Overall program complaint numbers continue to run well below the contracted performance standard of 5% of all rides provided, maintaining a monthly rate of less than 1%.

Overall, trip numbers remain only 50-60% of what they were pre-Covid.

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.

Coordination of Benefit Collection Table:

MPS - Coordination Recovery Activities "Q2"	
Casualty	$268,673.91
Estate	$429,826.94
Third-Party & Court-Ordered Medical	$296,344.79
Medicare Prescription Drug Premium/Claims	$198,250.27
Over Resource/Hospice/Patient Share/Credit Balance	$689,416.51
Annuity/Trust/Waiver	$380,948.43
Lamp/Map, Medicare Claim Recoupment	$89,814.90
Third-Party Claim Recoupment	$173,819.60
Total	**$2,527,095.35**

Reports denied claims when a client has known Third Party Liability (TPL) or Medicare coverage. The claim(s) would not have indicated A Third-Party Liability (TPL) or Medicare primary payment or has a payment indicated as partially paid.

Coordination of Benefit-Cost Avoidance Table:

Cost Avoidance "Q2"	
Third-Party Liability	$86,311,265.99
Medicare	$155,524,285.64
Total	**$241,835,551.63**

III. Operational/Policy Developments/Issues

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i. Vermont Health Connect

Key updates from QE062023:

- The Customer Support Center received 57,631 calls in QE0623, up 40% from the previous year.
- The Medicaid Renewal process starting in April 2023 resulted in DVHA implementing the next phase of their multi-modal communication campaign. This campaign is designed to engage customers in the renewal process through both direct and indirect messaging.
- Increasing numbers of customers are using self-service functions. Self-serve applications comprised over half (59%) of all applications in QE0623.

Enrollment

As of QE0623, more than 221,246 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 153,458 in Medicaid for Children and Adults (MCA) and 67,788 in Qualified Health Plans (QHPs), with the latter divided between 25,062 enrolled with VHC, 4,794 direct enrolled with their insurance carrier as individuals, and 37,932 enrolled with their small business employer.

Medicaid Renewals

The Medicaid Unwind started, and we resumed sending out manual renewals to people who did not renew ex parte. Several waivers were implemented to increase the number of people who could passively renew, which were offset by scheduling ineligible enrollees for the first two months of the Unwind. June's renewal batch was the first to have a passive success rate of over 50% in years. The passive renewal success rate for the quarter averaged 39%.

1095 Tax Forms

Tax year 2022 1095b corrections began generation on March 10, 2023. 642 corrections for the period 4/1-6/30/22 were generated but not sent out unless member requested.

Customer Support Center

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

The Customer Support Center received more than 51,631 calls in QE0623, up 40% from the previous year. Maximus answered 97% of calls within 24 seconds in April 2023, 94% in May 2023, and 46% in June 2023. With increased staffing and lower call volumes, Maximus met the target in QE0623.

Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to DVHA-HAEEU for resolution and log service requests, which are escalated to the appropriate resolver group. This year has seen a decrease in the volume of calls with a slight increase in the proportion of calls that were escalated. 6% of QE0623 calls were transferred to DVHA-HAEEU staff, down from 7% in QE0622. Just as importantly, DVHA strived to answer all calls that were transferred; 97% of transferred calls were answered in five minutes in QE0623, compared to 99% in QE0622.

Timely Processing of Member Requests

In the spring of 2016, DVHA-HAEEU set a goal of completing 75% of member requests within ten business days. In QE0622, more than 98% of the VHC requests were completed within the same ten-day time frame and 99% in QE0622.

System Performance

The system continued to operate as expected throughout QE0623, achieving 100% availability outside of scheduled maintenance in each of the three months. The average page load time for the quarter was 0.1 seconds – which is well under the two-second target.

In-Person Assistance

As of July 31, 2023, DVHA is supported by 112 Assisters (103 Certified Application Counselors, 4 Navigators, and 5 Brokers). 30 Assisters are in training (whose application date is April 1, 2023, or later). Working in 55 organizations, including hospitals, clinics, and

community-based organizations. Assister support is available in all of Vermont's 14 counties.

Outreach

The Medicaid Renewal process starting in April 2023 resulted in DVHA implementing the next phase of their multi-modal communication campaign. This campaign is designed to engage customers in the renewal process through both direct and indirect messaging.
Related communications include but are not limited to noticing, text messaging, emails, social media posts, website updates, paid media, Assister training, and stakeholder newsletters.

The Plan Comparison Tool continues to be a primary tool to help Vermonters' search for health plans that could fit their budget. It is a core piece of DVHA's educational tools, helping customers assess their choice for coverage, whether during Open Enrollment or the start of the Medicaid Renewal period and. It was used in over 13,400 sessions during the quarter.

Self-Service

During QE0623, DVHA-HAEEU continued to promote self-service options for customers to report changes, and access tax documents and other forms. Self-service leads to an improved customer experience as Vermonters can log in at their convenience. It also has the benefit of using automation to reduce staffing expenses. Year-over-year comparisons show that more customers are using self-service functions, including both online accounts for health coverage applications and reported changes as well as the options of paying premiums through monthly recurring payments rather than one-time payments.

ii. Choices for Care and Traumatic Brain Injury Program

DAIL

Choices for Care

Electronic Visit Verification:

DAIL Adult Services Division (ASD), in partnership with DVHA and VDH, continues to work with homecare agencies and individuals who self-direct their personal care services to provide access to educational materials to support the adoption of EVV throughout the state. Information on EVV can be found HERE. Beginning July 1, 2022, ARIS Solutions, Vermont's contracted fiscal agent, implemented the policy that Medicaid program funds cannot be used to pay for services if EVV is not used to record in-home personal care services. Extensive communication was provided before implementation and is outlined here. As of May 2023, there is a 100% adoption rate for EVV usage for required services.

Choices for Care Providers

In Q2, Choices for Care and Brain Injury Program providers continued to report challenges with hiring and retaining staff. This workforce challenge is reported across the full range of providers including case management, personal care attendants, adult day providers, Nursing Homes, and Enhanced Residential Care Providers.

Enhanced FMAP spending plan:

The Initial Spending Plan Narrative was submitted in June 2021. ASD is now implementing activities as outlined in the plan. More information is available HERE

Adult Day

Adult Day Agencies continue to report that difficulty hiring staff has been a limiting factor in increasing attendance. However, attendance is slowly increasing in 2023. During Q2, DAIL's Quality Management Unit completed site visits for the recertification of Adult Day providers.

At the end of Q2, CFC enrollment included:

NH – 2652 participants
ERC – 547 participants
Home Based – 2231 participants
Moderate Needs – 949 participants

Money Follows the Person (MFP)

The MFP grant has been re-authorized through (CY) 2027. The VT Department of Aging and Independent Living (DAIL) Adult Services Division has been awarded funds for both CY2021 and CY2022 operations and received budget approval for CY 2023 in May.

This award for CY 2023 will fund transitions for sixty-two (62) Choices for Care participants from a SNF to a home-based setting. As part of the grant re-authorization, CMS has also relaxed the eligibility rules for the MFP program. We will be seeking permission from CMS to increase our service population to include individuals with I/DD and to provide supplemental funds for food for our participants as part of the Demonstration project. These changes will occur when CMS requests an updated operations protocol from MFP later this year.

DAIL has been awarded a $5M MFP Supplemental Grant. These dollars will be used to strengthen the systems serving Money Follows the Person and Choices for Care participants by increasing the number of direct service workers, increasing support for unpaid caregivers, and piloting new HCBS services to meet unmet care needs. The Supplemental Grant Funding will be used for the following seven approved initiatives:

1. Direct service workforce development and retention
2. Falls prevention and mobility
3. Use of assistive technology
4. Expansion of volunteer programs
5. Holistic social and mental health supports
6. Brain injury supports
7. Independent living and home modifications

In CY 2023 Q2 an additional initiative was added to support discharge planning for complex care individuals at acute care facilities

In the second quarter of CY 2023, MFP has transitioned an additional 12 individuals (for a total of 23 in CY 2023 so far) with 11 more in the pre-transition category.

Brain Injury Program

Current enrollment = 89 individuals, 16 individuals are in the process of enrolling/pending service provider capacity, and 2 new Applicants are pending clinical assessment.

Wait Lists

- There is no wait list for the High Needs Group.
- There continue to be provider wait lists for Moderate Needs Group, estimated at 600-700 people statewide. Because the eligibility criteria for Moderate Needs services are so broad, Vermont does not expect to eliminate the wait list.
- There is currently no wait list for the Brain Injury program as there is funding to serve all those approved. The State has clinically approved 14 individuals for services who are currently waiting for services due to provider workforce capacity challenges. While waiting for a provider, individuals are referred to the Brain Injury Alliance for neuro-resource facilitation services.

iii. Developmental Disabilities Services Division (DDSD)

Payment and Delivery System Reform Update:

Through comprehensive stakeholder input, DAIL/DDSD determined that a 6-level framework would best meet Vermont's needs to use the Supports Intensity Scale-Adult (SIS-A) assessment as it continues work. Additionally, work is required to determine the preferred language to use in referring to the levels of support.

Last quarter, the American Association on Intellectual and Developmental Disabilities released the second edition of the SIS-A. Vermont is an early adopter of this edition. Based on internal discussions and input from stakeholders, we will analyze results once a critical number of second edition assessments have been completed to confirm that changes to the new edition do not result in significant changes to scores. This analysis is underway.

Looking to the future, DAIL/DDSD will engage in a validation study of the SIS-A within the Vermont DDS population, led by Vermont's contractor Burns and Associates. By looking at results from the SIS-A with previously performed Vermont-developed Needs Assessment and records, the Vermont team will test the validity of the SIS-A for Vermont's DDS HCBS recipients. This will be done through a representative sample of 150 individuals receiving supports, across the spectrum of needs.
Please see prior report submissions for previous highlights.

DDS System of Care Plan Renewal

At the beginning of the year, DAIL/DDSD renewed the State System of Care Plan for Developmental Disabilities. This Plan included several special initiatives as Division priorities and has begun work to achieve these goals.

Using ARPA/enhanced FMAP funding, in a joint effort through the Vermont State Legislature, the Division has crafted a request for proposals for pilot planning grants for housing innovation within the DDS system. Using what is learned through this process—which has included a stakeholder Steering Committee, DAIL/DDSD will have building blocks to work with community partners to explore new options throughout the State.

The Division has established a workgroup to focus on achieving goals related to strengthening the direct support professional workforce—both for agency-directed staff as well as self- and surrogate-

directed staff. To implement a permanent option which would allow parents to be paid to provide services to their adult children through DS HCBS dollars, Vermont will need to seek approval through Agency of Human Services leadership, gain CMS approval and undertake administrative rule making. To move this initiative forward, DAIL/DDSD is working with key stakeholders for input on design and implementation options to ensure appropriate rights and protections of the individuals, administrative feasibility, and quality assurance.

Please see prior report submissions for previous highlights.

iv. Global Commitment Register

The GCR is a database of policy changes to and clarifications of existing Medicaid policy under Vermont's 1115 Global Commitment to Health waiver. It is based on the Federal Register and can be used as both a public notice and documentation tool for Medicaid policy. Like the Federal Register, the GCR can be used to publish 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 hundreds of 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.

There were 27 proposed policies posted in QE0623. A total of 11 final policies were posted in QE06323.Changes included updates to rates and/or rate methodologies (including appropriations from the Vermont legislature), administrative rulemaking notices, and Medicaid State Plan amendments.

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

IV. Expenditure Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE062023:

- Beneficiary Enrollment
- New To Medicaid Screenings
- Team-based Care Initiative Updates
- SDOH Screening Update
- Staffing Update

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 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, and local care management teams and assist a member in navigating the system of health and health-related care.

In the second quarter of 2023, VCCI has seen a decline in the number of new referrals. This is likely due to the decrease in contract staffing over the past few months and the re-deployment of VCCI nurses. Looking into the third quarter, we should see an improvement in this value. Our goal of increasing the percentage of face-to-face visits remains relatively steady around 66% of visits being in person. Most members request multi-modal interventions. Most prefer a hybrid model with some home visits mixed in with virtual or telephonic visits. We have also been in the process of updating our home visit safety protocols.

As seen below, VCCI maintained an average case load of 200 people served per month over the second quarter. The length of time and regularity of visits are dependent on the complexity and severity of the needs of the beneficiaries. VCCI case managers work with beneficiaries until the goals of their care plans are met or they are connected to needed services in the community with a lead care coordinator assigned. (See **Figure 1).**

Figure 1. Beneficiary Enrollment and Face to Face Visits

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Measure	2/15/2023	3/15/2023	4/15/2023	5/15/2023	6/15/2023	7/15/2023
# new VCCI eligible members enrolled monthly in care management	49	44	40	27	37	29
Total Open Cases (including newly enrolled - above)	232	241	235	198	207	197

% of VCCI enrolled members with a face-to-face visit during the month	61.21%	61.00%	69.36%	63.13%	67.15%	66.50%
	61.21%	61.00%	69.36%	63.13%	67.15%	66.50%

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 health care-related issues including Primary Care, Dental, housing, transportation, and food, with direct facilitation to those services desired by the beneficiary. The numbers new to Medicaid plan decreased in February and March of 2023 (**Figure 2).**

Figure 2. Number of New to Medicaid Beneficiaries Screened

Updated Dates - month reported	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
received from data unit	10/15/2022	11/15/2022	12/15/2022	1/15/2023	2/15/2023	3/15/2023	4/15/2023
Updated Dates - due date	1/15/2023	2/15/2023	3/15/2023	4/15/2023	5/15/2023	6/15/2023	7/15/2023
# of new to Medicaid members (Adults 18+)	439	376	486	547	405	290	365
# of new to Medicaid members reached	85	77	91	127	84	53	82
# of new to Medicaid members screened	187	161	208	248	189	130	159

VCCI leadership in partnership with Healthcare Reform has developed a project committee for our Team-based Care Initiative with representation from all departments within the Agency of Human Services. We have contracted with the Camden Coalition for technical assistance in reinvigorating our Team-based Care process across departments. The Camden Coalition has been working with stakeholders across the State to determine their experiences and needs with complex care. Camden is working on synthesizing the information they captured during interviews and will then put

together recommendations for the Agency.

Vermont Chronic Care Initiative is working with Agency of Human Services Field Services and the Blueprint Program to launch a Team-Based Care trainings/learning collaboratives by region to identify regional cultures of care and train health and social health care providers on the complex care model and tools of engagement. The multi-agency team working on the Social Determinants of Health screening elements have created those elements adapted from the CMS tool. The tool is being put into a system called CommCare that Agency of Human Services staff will be able to access to screen people using their services for other needs and make appropriate referrals to other department services or for team-based care services. In the past quarter, our team has been busy working on recruitment for our vacant positions including traveling nurse positions. We have had two new nurses begin in Barre and Bennington. We currently have three full-time vacancies, one in each of the following locations: Burlington, Brattleboro and St. Johnsbury.

ii. Blueprint for Health

Key Updates from QE062023

- Many Vermont's primary care practices are Blueprint Patient-Centered Medical Homes, with 132 of Vermont's estimated 182 primary care practices participating. The number of multi-provider practices is estimated at 148, further, making the proportion of Blueprint practices higher among larger practices.
- As of 2023-Q2, the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) program is 3,934.

Vermont continues to provide access to enhanced preventive health, psychosocial screening and comprehensive family planning serves as evidenced by the commitment of 41 practices and 7 Planned Parenthood sites to participate in the Women's Health Initiative as of June 2023.

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 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 that provide supplemental services that allow Blueprint-participating primary care practices to focus on promoting prevention, wellness, and coordinated care. These Community Health Teams (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 chronic conditions.

Blueprint Program Managers provide leadership in each community to coordinate healthcare delivery system improvement efforts and set up the systems through which integrated services can be delivered in the community. While they are employed by the hospital or FQHC in the

HSA, they help organize, lead, and staff collaborative initiatives with the ACO, local human service agencies, health departments, specialty care providers, mental health providers, and primary care providers to facilitate the integration of services. They are responsible for contacting all primary care practices within their HSA to encourage, engage, and support practice participation in the Blueprint and other health system reform activities. Additionally, Program Managers are responsible for administering funds and staffing plans for the local CHTs on behalf of all participating payers, including core CHT, Spoke staff, and WHI staff.

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 data on practice performance and their training and expertise in process improvement methodologies (such as Clinical Microsystems, Model for Improvement, and Lean process improvement). Quality Improvement Facilitators initially help primary care practices to secure National Committee for Quality Assurance (NCQA) PCMH recognition. After the recognition is achieved, the facilitators regularly return to help with quality improvement efforts related to panel management and outreach, care coordination, promotion of individual health and wellness, chronic condition management, and ongoing practice transformation in alignment with State-led health care reform priorities. These priorities include:

- focusing quality improvement activities on All-Payer ACO Model and ACO quality measures
- promoting team-based care
- implementation of Blueprint and other health care reform initiatives (e.g., Spoke program, Women's Health Initiative)
- 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).

Q2Highlights

April - June 2023

Many of Vermont's Patient-Centered Medical Homes opted to extend their annual recognition date with the National Committee for Quality Assurance until this quarter to fully utilize results from the State of Vermont Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey. As a result, forty-eight (48) 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. Three practices which subside in large Vermont organizations were randomly audited as part of their annual submission process. This year's audit focused practices on core functions of the medical home, and assessed each audited practice on their performance of the following:

- completing and documenting a comprehensive health assessment (which includes considerations for advance care planning, developmental screening, mental health status, substance use history, and social determinant of health screening)
- maintaining up to date medication lists
- holding care team meetings
- maintaining a directory of community resources
- providing timely advice by telephone

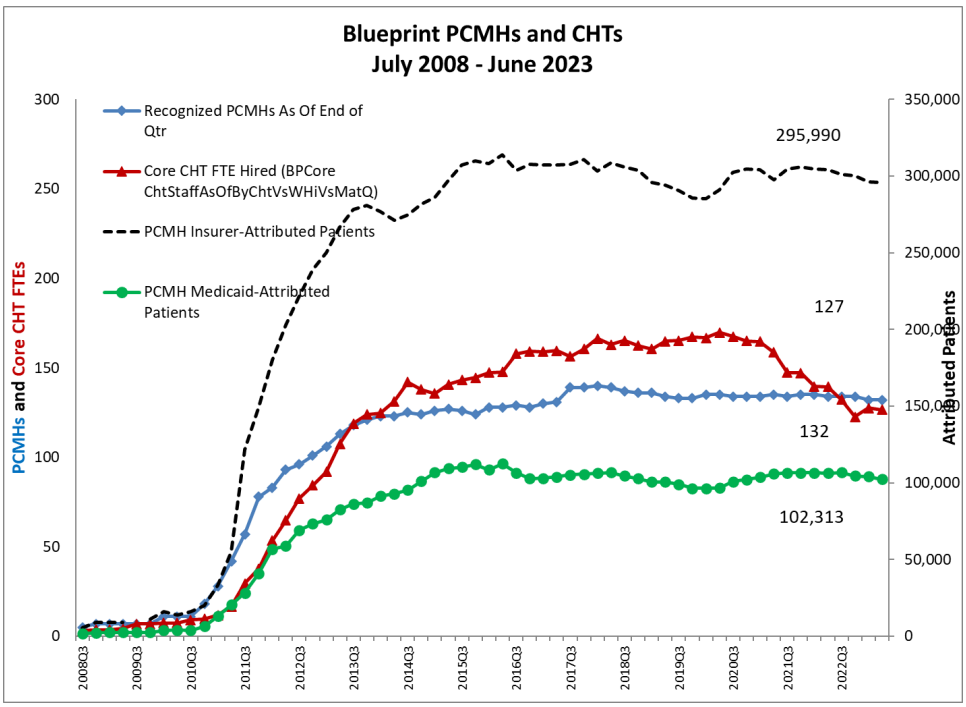
- monitoring patients for care management needs
- person centered care planning
- referral management
- sharing of patient information, and
- quality efforts related to resource utilization and patient/family experience of care

During this quarter, the Blueprint for Health quality improvement network partnered with the Area Health Education Center and Vermont Department of Health to review and work in partnership with Physician Academic Detailers and Quality Professionals about the updated recommendations from CDC related to Opioid Prescribing and pending updates to the Vermont Prescription Monitoring System. The network of quality improvement facilitators also reviewed the Community Health Profiles and Performance Payment criteria for communication with practices.

Blueprint-participating Patient-Centered Medical Homes currently serve 295,990 insurer- attributed patients, of which 102,313 are Medicaid enrollees. Attribution to a practice is determined by the practice at which the patient has received most 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.

In Quarter 2(April – June 2023), 132 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.

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, and 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 for opioid use disorder (MOUD) 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 MOUD 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 that MOUD (also known previously as medication-assisted treatment) is an evidence-based, effective approach to the treatment of opioid use disorder, based upon notable, published outcomes such as decreased opioid use, decreased opioid-related overdose deaths, decreased criminal activity, decreased infectious disease transmission, and increased social functioning and retention in treatment.

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 MOUD 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 MOUD) 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.

Q2 Highlights

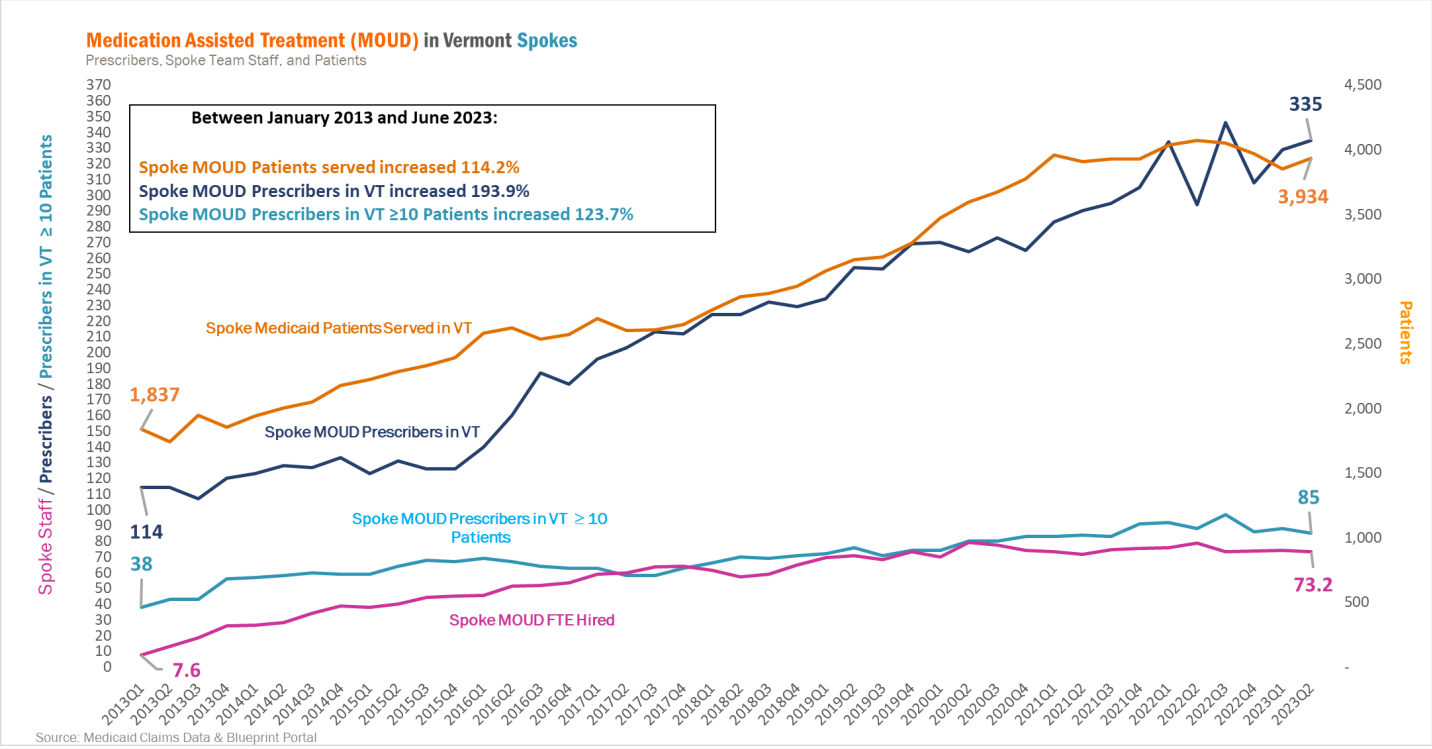
The Blueprint, in partnership with the Division of substance use prevention, in conjunction with a contract with Dartmouth allows us to continue to offer learning sessions with expert- led, and peer-supported, training in best practices for providing team-and evidence-based medication- for opioid use disorder. Sessions alternated between didactic and webinars this quarter. Supporting families with SUD has a robust turn out. Holistic treatment for folks with polysubstance was another topic presented. We continue to receive positive feedback on these sessions. Our contract with Dartmouth expired this month. We had a request for proposal posted and Dartmouth was the successful bidder again. We will be looking at new agenda topics and ensuring we are addressing

the connection of mental health and substance use for a whole health perspective. The field continues to have some challenges with work force as many do in hiring nurses and clinicians and the network continues to be creative to recruit.

Vermont continues to demonstrate substantial access to MOUD for Vermonters with opioid use disorder. MOUD is being offered across the State of Vermont by more than 87 different Spoke settings as of June 2023.) The monthly average of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs increased from 3850 in Q1 of 2023 to 3,934 in Q2 of 2023. There are 335 medical doctors, nurse practitioners, and physician assistants who prescribe Buprenorphine or Vivitrol in Vermont. There are 73.2 FTE of licensed, registered nurses, and licensed, Master's-prepared, mental health/substance use disorder clinicians who work as a team to offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder.

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

Figure 2. MOUD-SPOKE Implementation Jan 2013 – June 2023



Women's Health Initiative

The Women's Health Initiative (WHI) began as a state initiative to support pregnancy intention. The Women's Health Initiative (WHI) strives to support any persons who can become pregnant in their efforts to experience healthy pregnancies, avoid unintended pregnancies, and build thriving families.

The WHI provides increased mental health and social service staffing at specialty practices and utilizes the existing CHT at Blueprint PCMH practices. If a patient identifies as at-risk, they have immediate access to a WHI mental health clinician for brief interventions, counseling, and navigation to community-based services and treatment as needed.

The Blueprint partners with participating specialty providers and PCMH primary care practices to support patients ages 15-44. WHI providers engage with patients at the 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.

People who can become pregnant with a desire to become pregnant receive services to support a healthy pregnancy. If the individual 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 meet with community partners to educate and establish meaningful relationships to support patients and to support community partners in supporting community members.

Q2 2023 Highlights

WHI Program Lead meets regularly with representatives from all WHI practices to identify process improvement opportunities, ensure the program elements are in place, and support improved patient experience of care.

We have continued to outreach to practices to share the mission of the WHI program and assess interest in incorporating this into their practice and we hope to have some new practices engage in our Franklin County area.

Practices are working hard to engage community partners in education and understanding the WHI program. These partnerships and education around the mission of the program enhance relationships and pathways to care. We have presented a WHI data dashboard to the field in our monthly call every quarter.

We have received feedback on being more inclusive in the name of our program. We have consulted Boston Medical Center which has done some work with the state of Massachusetts to work with primary /specialty care practices to promote equity and inclusiveness. We have surveyed the field and have had focus groups to gather input on name change. The expected change is to occur in Sept 2023 with the proposed name being Pregnancy Intention Program. We provided the field with a Long-Acting Reversible Contraceptive Training in June that was attended by 15 providers which is the maximum number. Dr. Lauren MacAfee through UVM is an amazing teacher and the field truly appreciates being able to learn this skill.

Our AHEC/UVM Project Echo is coming to an end in June. The faculty provided a 1-hour training monthly for 6 months for providers to increase knowledge and comfortability in transgender care. We have received positive feedback that providers appreciate having experts to support learning and expanding their knowledge base on transgender care.

Figure 3 below shows WHI enrollment and staffing over time. In Q2 2023, the number of WHI practices enrolled is 41. 18 women's specialty health care sites and 23 PCMH participated in the Women's Health Initiative as of June 2023.

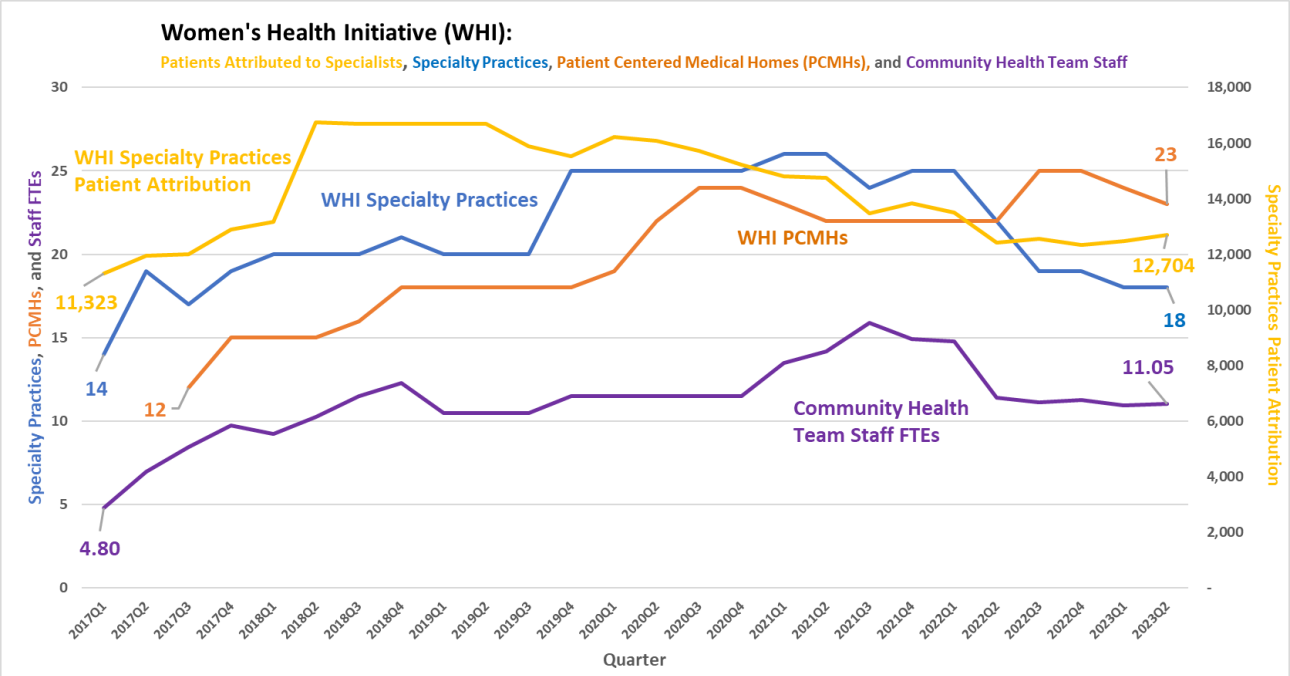

Women's Health Initiative (WHI):
Patients Attributed to Specialists, Specialty Practices, Patient Centered Medical Homes (PCMHs), and Community Health Team Staff
WHI Specialty Practices Patient Attribution
WHI Specialty Practices
WHI PCMHs
Community Health Team Staff FTEs
11,323
14
12
4.80
23
12,704
18
11.05
Specialty Practices, PCMHs, and Staff FTEs
Specialty Practices Patient Attribution
Quarter

Table 4. Women's Health Implementation by Region

Health Service Area	WHI Specialist Practices as of June 2023	WHI PCMH Practices as of June 2023	WHI CHT Staff FTE Hired as of June 2023	WHI Specialist Quarterly Attributed* Medicaid Beneficiaries as of June 2023	WHI PCMH Quarterly Attributed* Medicaid Beneficiaries as of June 2023
Barre	1	0	0.75	655	0
Bennington	1	2	1.1	936	224
Brattleboro	1	0	0.5	966	0
Burlington	2	8	1.2	2382	4699
Middlebury	1	0	0.75	849	0
Morrisville	1	3	0.5	336	1288
Newport	1	0	1	980	0
Randolph	1	0	0.5	159	0
Rutland	1	0	1	1289	0
Springfield	0	5	0	0	1713
St. Albans	0	0	0	0	0
St. Johnsbury	1	2	0.75	931	622
Windsor	0	3	0	0	97
Planned Parenthood (Statewide)	7	0	3	3486	0
Total	18	23	11.05	12969	8643

*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.

iii. Mental Health, Substance Use Disorder, and Behavioral Health

Key updates from QE062023:

- Per Diem Rate for Mental Health Extended Stays in Emergency Departments
- Team Care Program
- Applied Behavior Analysis (ABA)

The Clinical Integrity Unit (CIU) at DVHA is responsible for the concurrent review and authorization of inpatient psychiatric and detoxification services for members with Medicaid as a primary insurer. The CIU works closely with providers at inpatient facilities to ensure timely and appropriate discharge plans. DVHA collaborates with other departments to support the coordination of care. The CIU refers members to VCCI services and helps ensure continuity of care.

As of March 1, 2021, Vermont Medicaid modified the reimbursement methodology for inpatient services delivered by one of Vermont's largest psychiatric facilities. Before the implementation of this payment reform project, the DVHA & Department of Mental Health (DMH)reimbursed this 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

The DVHA, DMH, and the psychiatric facility have agreed upon performance measures and a monitoring platform for this payment model. Year two reconciliation has been completed and the model is now in year 3.

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 a 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.

The CIU manages the Team Care program. Team Care is a care management program and is a federally mandated prescription lock-in program 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 are ongoing. There have been minimal 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.

CIU team members participate in the 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, participating in weekly case reviews and developing 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 manages the Applied Behavior Analysis (ABA) benefit. In 2021, DVHA changed the timing of the ABA tier submission and payment from prospective to post-service delivery 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. Data for these measures show 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 after 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 (VBP) project. Beginning Calendar Year 2023, DVHA's ABA Tiered Payment Model will incorporate provider results on three performance measures into the reconciliation process and calculations. This VBP 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 the calendar year 2023 and a withhold thereafter). The measures include the amount of service provided in member months, the 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 which required a public comment period before implementation in CY '23. The Senior Autism Specialist is currently working with the Payment Reform Unit to develop and disseminate VBP letters outlining each provider's overall VBP score, and the resulting amount earned. The plan is for each VBP letter to be disseminated at the same time as each provider's 2022 Reconciliation Letter.

The DVHA Senior Autism Specialist conducts biennial clinical documentation reviews with Vermont Medicaid enrolled ABA providers who provide services to Vermont Medicaid members. The purpose of these reviews is to ensure that members are receiving quality care, that providers are accurately reimbursed for provided services, verify that required documentation is included in members' charts and that clinical documentation follows ABA Policy and Clinical Guideline standards. Five clinical documentation reviews have been completed thus far in calendar year 2023.

iv. Mental Health System of Care

Key updates from QE062023:
- Leadership and Reporting updates

System Overview

The Department of Mental Health (DMH) 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). The Vermont Agency of Human Services (AHS) provides funding through Provider Grant Agreements to ten (10) Designated Agencies (DAs) and two (2) Specialized Service Agencies (SSAs). These agencies are located across Vermont for the provision of:

- **Community Rehabilitation and Treatment (CRT)** services for adults with SMI
- **Adult Outpatient Therapy** for adults who are experiencing mental health 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 (SED) and their families.

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

Inpatient care is provided through a decentralized system that includes one state-run psychiatric care hospital, Vermont Psychiatric Care Hospital (VPCH), and six (6) Designated Hospitals (DHs) located across the state.

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

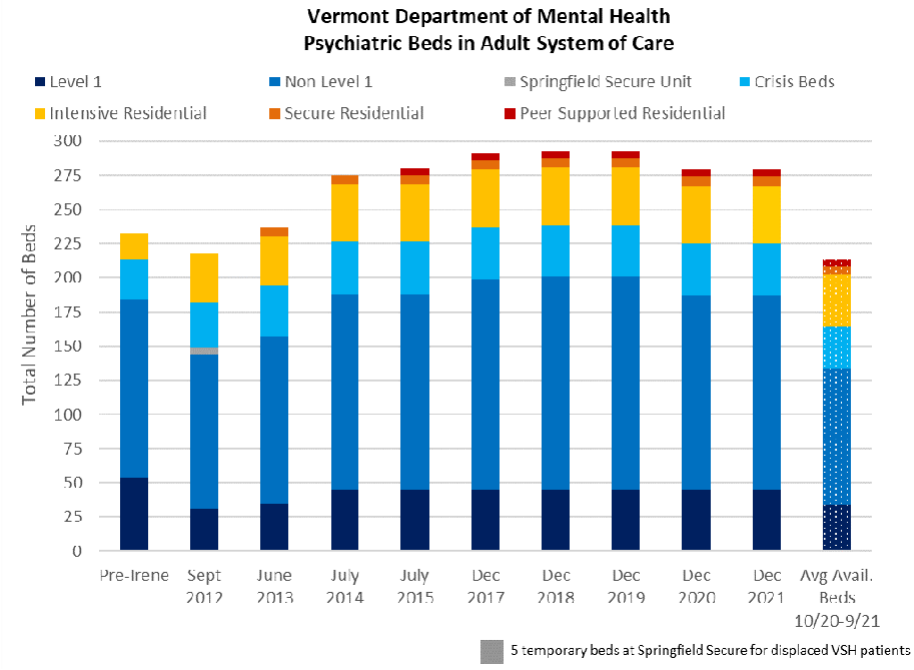
Throughout 2021 and continuing to the present, the Coronavirus Disease 2019 (COVID-19) pandemic has continued to challenge the mental health system of care in Vermont, primarily through statewide staffing shortages and inpatient bed closures.

Updates on the Mental Health System of Care

A. Hospital and Inpatient Care

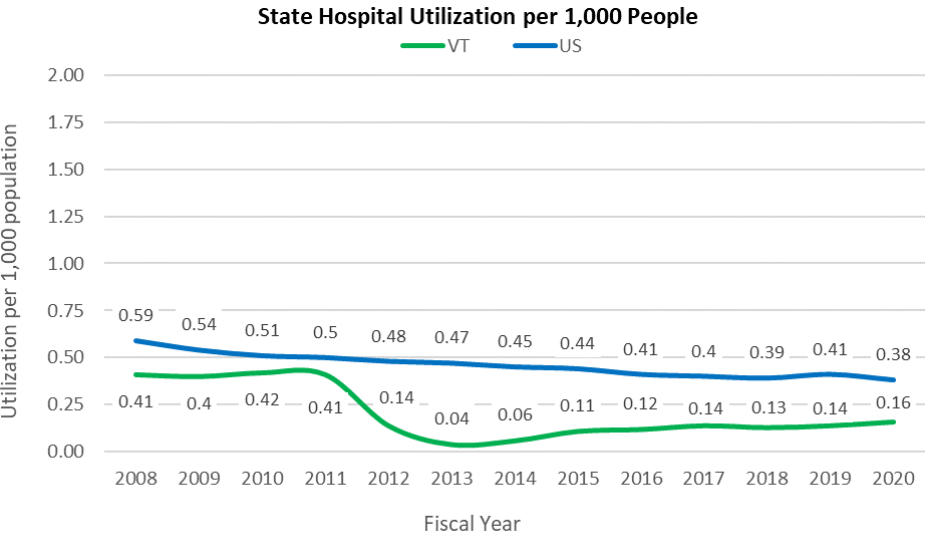
Vermont has 45 Level 1 beds and 159 adult psychiatric inpatient beds across the system of care. During the COVID-19 pandemic, several beds closed due to staffing, construction, patient acuity, and public health safety protocols, as well as an initial decrease in individuals presenting with a need for a higher level of care. The primary reason for bed closures as of October (2021) is a severe workforce shortage across the mental health system. In a state with approximately 3,300 staff across ten designated agencies that provide mental health care, there are more than 550 vacant positions as of this writing.

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's utilization compared to national benchmarks. Data from these two charts are calculated by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Uniform Reporting System (URS), which generates the National Outcomes Measures (NOMs). Updated bed data will be presented in the next quarterly report.

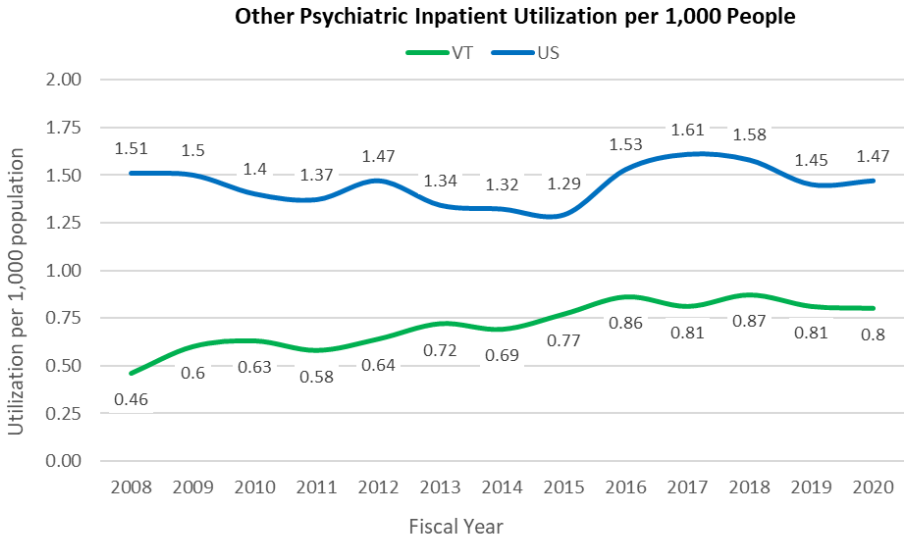
Figure 4. State Hospital Utilization per 1,000 people (in Vermont and the United States)



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

The national rate of state hospital utilization continues to decline year over year. VPCH opened in fiscal year (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 shows a slowly progressing upward trend since 2012. Vermont is one of a handful of states that only has one state-run psychiatric hospital. The pandemic has significantly increased the need for mental health treatment and support.

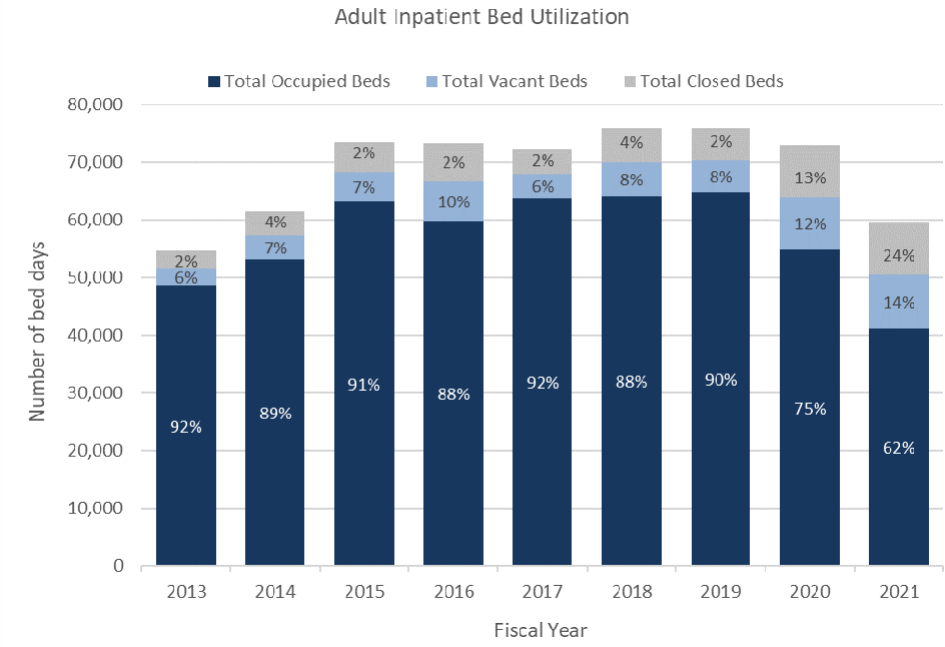
Figure 5. Other Psychiatric Hospital Utilization per 1,000 people (in Vermont and the United States)



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

Other Involuntary Psychiatric Hospital Utilization unit admissions, such as those at DHs, are included in Figure 5. The national rate of psychiatric hospital utilization since 2008 has generally held steady through 2020, while Vermont's rate of utilization continued to increase. 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 6. Adult Inpatient Utilization and Bed Closures



The Adult Inpatient Utilization and Bed Closures chart depicts the total bed day capacity across the Vermont DH system through FY 2021. The total bed-day availability across the system remained relatively constant in 2018 and 2019, with bed-day utilization decreasing by 15% in 2020 and 13% in 2021. The impact of the COVID-19 pandemic has contributed to the 2% increase in bed vacancies and the 11% increase in beds closed for FY 2020 through FY 2021. Over nine years, 2021 saw the lowest level of adult inpatient bed utilization. Data from 2022 will be illustrated in the upcoming quarterly report.

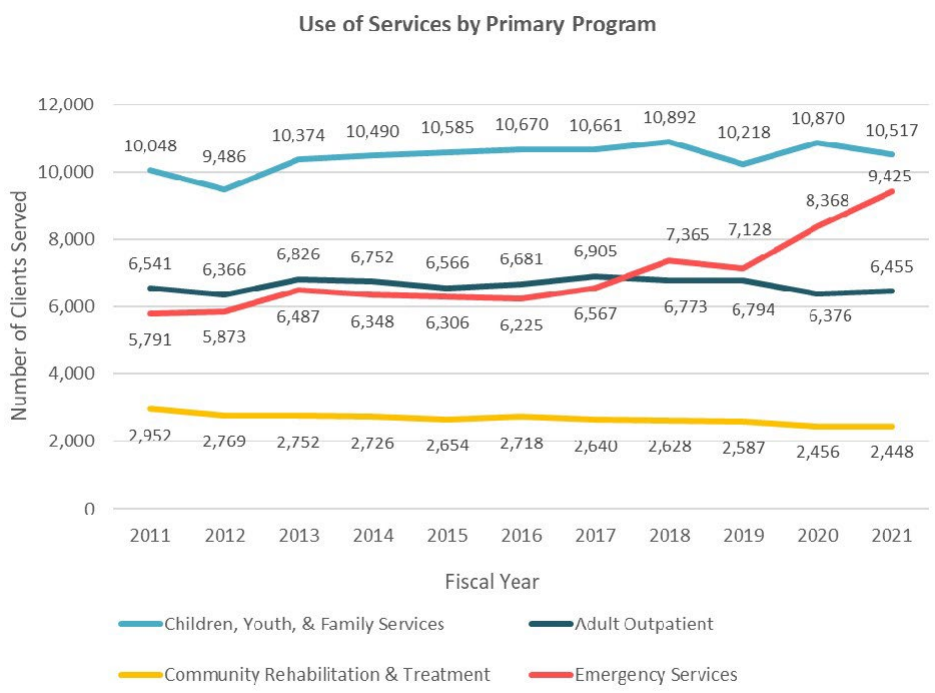
B. Community-based and Outpatient Services

Enhanced community services funding provided by the Vermont legislature through increased appropriations to critical 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 continue to be a struggle. Additionally, the payment reform initiative that was implemented on January 1, 2019, has been integral to stabilizing the mental health system of care at the DAs. The initiative has reduced barriers to access to care and promoted a more responsive and "needs" driven service delivery 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.

Key Efforts Include:

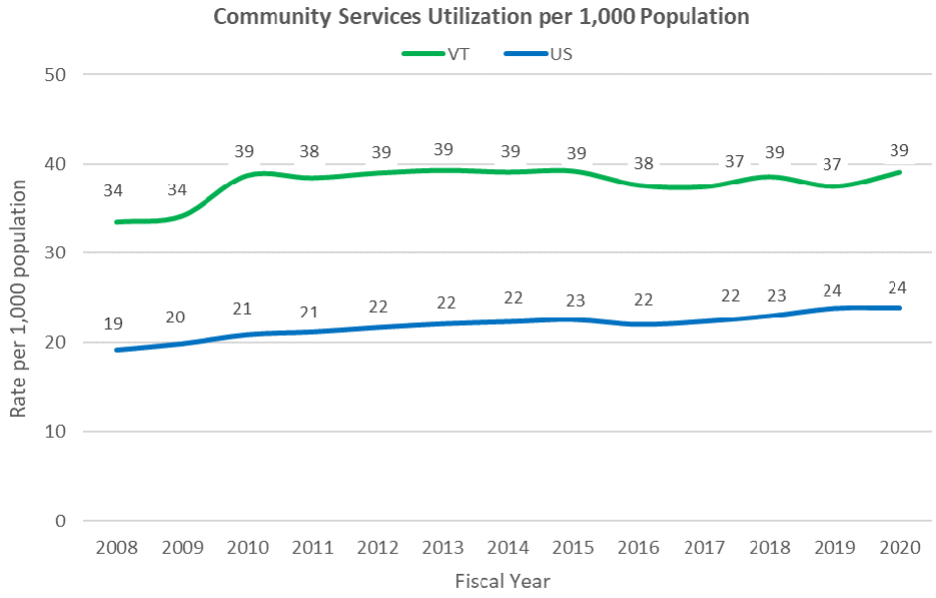
- Established a Workforce Task Group to explore recruitment and retention strategies
- Increased capacity within Community Rehabilitation and Treatment and peer programs to provide community support, outreach, and crisis response continues to develop Broad utilization of non-categorical case management services for Adult Outpatient and Emergency Services programs

Figure 7. Use of Services by Primary Program



The highest number of persons served by programs offered by the DAs continues to be in children, youth, and family services (CYFS), as indicated in Figure 7. The 3% decrease from FY 2020 to FY 2021 may be related to the COVID-19 pandemic, but generally, the use of CYFS services has remained relatively stable during the past 10 years. The Emergency Services (ES) programs had a 32% increase from FY 2019 to FY 2021, which may reflect the ongoing, increased support needs associated with the impacts of COVID-19. The Adult Outpatient Programs (AOP) saw a slight increase in utilization, while the Community Rehabilitation and Treatment (CRT) programs saw a slight decrease from FY 2020 to FY 2021. Both adult programs have seen relatively slow trend changes over the ten years reflected. FY 2021 reflects more of the pandemic's impact on system services with ES showing the largest increase in services provided.

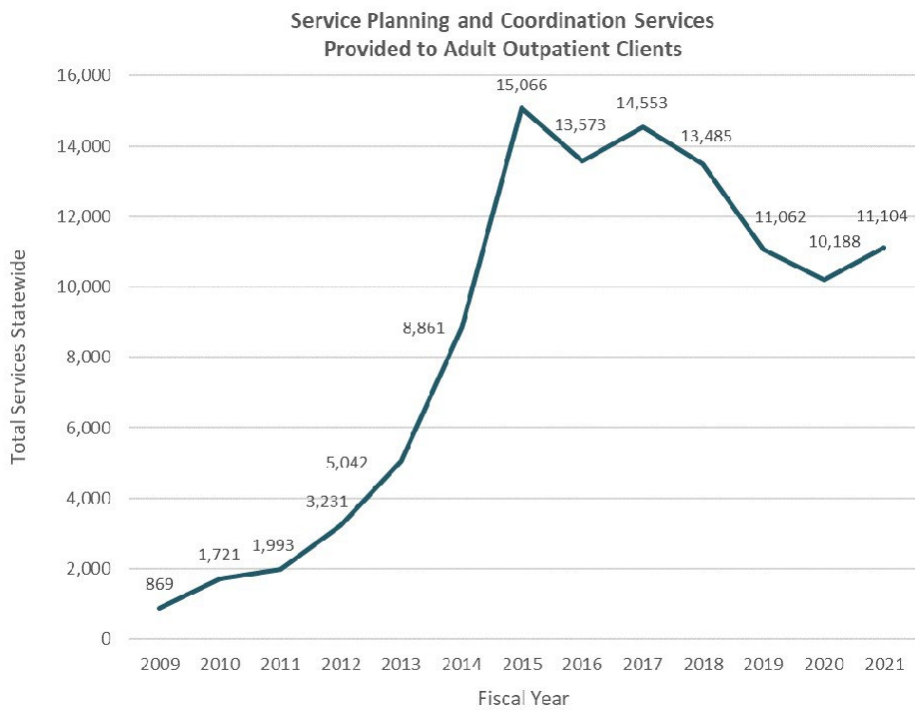
Figure 8. Community Services Utilization per 1,000 Populations



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

The Vermont community mental health system serves nearly 40 out of every 1,000 Vermonters, which is substantially higher than the national utilization rate. The most recent national data available through 2020 continues to highlight that Vermont consistently demonstrates a strong record of service delivery in community-based programs. The system of care is established on the principle that the intensity of services that an individual requires will change over time, specifically that individuals will receive community-based treatment appropriate to their needs and move to higher or lower levels of care only as necessary to support them. For many who have a chronic illness, this is more challenging, as they continuously require a higher level of service needs within the system. Others enter and exit intermittently depending on their individual needs. The payment reform transition away from a fee-for-service model to both an adult and children's case rate with a value-based payment component has provided ongoing flexibility to meet the needs of the individuals.

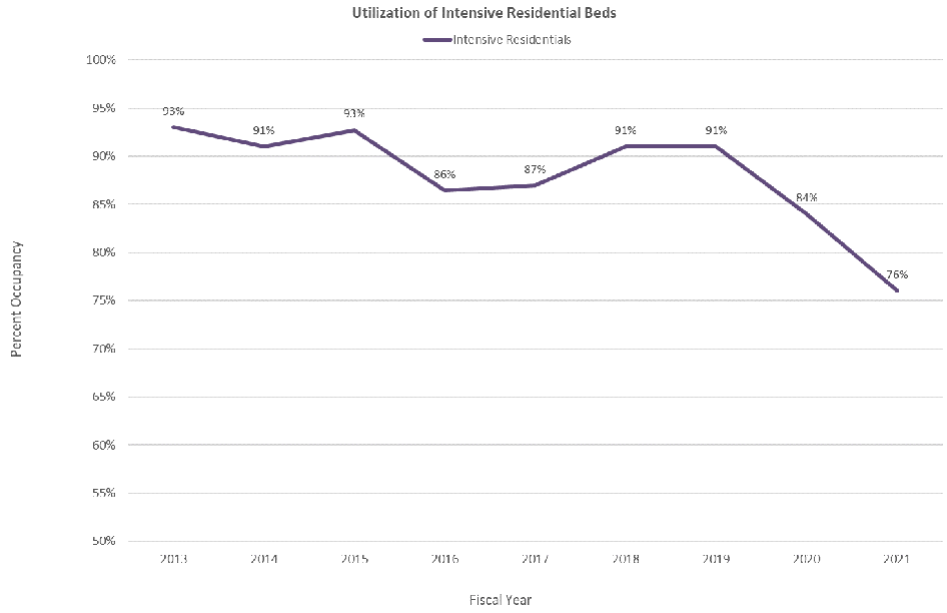
Figure 9. Service Planning and Coordination Services



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 remained elevated for this population from FY 2016 to FY 2017 with an approximately 30% decline from FY 2017 to FY 2020. Interestingly, there has been a 9% reported in the past fiscal year. This is a noteworthy increase in service planning and coordination to meet this population health-level need for adult case management services. DMH's payment reform initiative launched in January 2019 continues to support flexible service delivery including case management services when needed.

Residential and Transitional Services

Figure 10. Utilization of Intensive Residential Beds



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

FY 2020 and 2021 showed a 15% total decrease in utilization over the nine years to 76%. The impact of the pandemic during these fiscal years and the changing capacities of programs to safely transfer and introduce new residents into programs have 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. Continued reporting and data visualizations via the RBA framework are:

- Implementation of value-based payment measures that allow DAs to earn an additional allocation based on the performance of agreed-upon quality metrics.
- Mental Health Payment Reform utilization scorecard, monitoring caseload, and utilization for all services within the mental health case rate to monitor the impact of the payment model.
- Creation of a "Vermont Psychiatric Care Hospital Outcomes" scorecard to meet legislative reporting requirements.
- Migration of the "DMH Snapshot" and "DMH continued reporting" to the RBA scorecard reporting tool
- Exploration of visualization tools to create more responsive reporting.
- Participation in the development of the AHS Community profiles.

Mental Health Payment Reform

In 2019 DMH implemented an alternative Medicaid payment model for the DAs for mental health services. Most notably, the payment model for children's and adult services transitioned from traditional reimbursement mechanisms (a combination of program-specific budgets and fee-for-service payments) to a monthly case rate model. The mental health case rate model is one of the more mature alternative Medicaid payment models implemented by AHS, completing the third performance year on December 31, 2021. The foundational goals and principles driving mental health payment reform have remained unchanged throughout the life of this program. Those goals include:

- Encouraging flexibility in service delivery that supports comprehensive, coordinated care;
- Standardizing the approach to tracking population indicators, progress, and outcomes;
- Simplifying payment structures and improving the predictability of provider payments;
- Improving accountability, equity, and transparency; and
- Shifting to value-based payment models that reward outcomes and incentivize best practices.

An important program accomplishment from payment reform is that providers are now successfully submitting encounter claims to the Medicaid Management Information System (MMIS), which allows the State to monitor service delivery and other aspects of performance. Additionally, the introduction of value-based payments supports quality improvement and accountability for outcomes. During each measurement year, DMH withholds a percentage of each agency's approved adult and child case rate allocations for these payments.

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 through a singular AHS Master Grant agreement. The State created an annual aggregate spending cap for two providers in Addison County (the local Designated Agency and the Parent-Child Center) and one in Franklin/Grand Isle Counties (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, youth, and families.

On January 1, 2019, the IFS sites became aligned with larger payment reform efforts occurring across AHS, including having value-based measures in alignment with statewide implementation. At the same time, IFS regions have additional requirements for the measurement of performance improvement following the broader scope of services included in those regions. Vermont submitted a multi-year payment model for consideration to CMS in September 2018 and received approval in late December that goes through 2022.

Both IFS regions continue to utilize the Child and Adolescent Needs and Strengths (CANS) tool to holistically assess both the needs and strengths of the children that they are serving. These agencies are using this monitoring tool to track progress over time. Data are showing that through support and services, children and youth are increasing their strengths and decreasing their needs. The regions are also working to implement the Adult Needs and Strengths Assessment (ANSA).

In late June, the IFS grantee, Northwestern Counseling and Support Services (NCSS), which serves

Franklin and Grand Isle Counties, had their bi-annual integrated chart review, which included all AHS departments reviewing charts for minimum standards across the various funding streams that create the integrated case rate. The results from the review indicated a few areas for improvement which NCSS adequately addressed.

Vision 2030

Through the summer, fall, and early winter of 2019, DMH engaged in a public planning and development process that involved soliciting stakeholder participation and feedback as an integral part of this process. The plan, known as "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 and between providers, community organizations, and DAs. The workforce must use the best technologies, as well as evidence-based practices and tools, for making data-informed decisions, supporting systems learning, and producing measurable outcomes. Links to materials generated throughout this process are posted at this link: https://mentalhealth.vermont.gov/about- us/department- initiatives/10-year-planning-process-mental- health-think-tank

Following the plan submitted to the legislature in January 2020, DMH was anticipating convening a Mental Health Integration Council in the fall of 2020, to begin the work of implementation. The demands of the COVID-19 pandemic on Vermont's health systems, however, delayed that work. The Mental Health Integration Council kicked off on July 13th, 2021, and the Council has since met twice with subgroups convening on specific topics in between meetings.

Leadership and Reporting Updates

DMH has a new Director of Operations, Planning, and Development, Lee Dorf, as well as a new Medical Director, Dr. Kelley Klein. Both these members of the leadership team have oriented quickly to their respective roles and provided guidance and expertise related to DMH's work.

Additionally, DMH has begun to transition to writing shorter reports and increasing the use of RBA Scorecards to provide more real-time based on timeframes (e.g., monthly, quarterly, bi-annual, annual), brief reporting via both quantitative and qualitative data.

v. Pharmacy 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 spend and routinely analyzes national and DVHA drug trends reviews drug utilization, and seeks innovative solutions to delivering high-quality customer service, assuring optimal drug therapy or 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, the Division of Substance Use Program, 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, and 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 Unit on drug utilization issues related to fraud, waste, and abuse.

Operational Activity Reports

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

	No PA	Automated Edits						
Period	**Claims Paid w/o PA**	**Claims Paid w/Auto PA**	****Claims Paid with Auto Edit**	**Claims Paid w/Online Override**	**Claims Paid w/Emergency PA**	**Claims Paid due to Grandfathering**	**Claims Paid w/Clinical PA**	**Total Claim Count**
Quarter 2	504,934	76	20,752	209	111	6,753	16,241	549,076
	92%	<1%	4%	<1%	<1%	1%	3%	100%
Quarter 1	510,392	90	21,366	245	106	7,724	16,171	556,094
	92%	<1%	4%	<1%	<1%	1%	3%	100%

- The total claim count does not include compounded drugs.

Paid Claims and Drug Spend

MEDICAID

Period	# Claims	# Of Members	State Paid Amounts
2Q2023	497,307	86,682	$77,657,154.77
1Q2023	502,093	86,585	$75,372,873.84

VPHARM

Period	# Claims	# Of Members	State Paid Amounts
2Q2023	66,327	6,724	$1,363,657.54
1Q2023	68,177	6,853	$1,957,846.70

- The total claim count does not include compounded drugs.

Provider Communications

Important Vermont Medicaid Fraud, Waste, and Abuse (FWA)	The Special Investigations Unit (SIU) is committed to fighting Fraud, Waste & Abuse within Vermont's Medicaid program. The SIU has recently been made aware of members who have been prescribed controlled substances from prescribers who are not enrolled in Vermont Medicaid, sometimes this could be an out-of-state provider. If a prescriber is not enrolled, and a claim is submitted, DVHA will not be able to cover the cost of the prescription and in some instances the member may request to pay out of pocket (cash). There are concerns about quality, safety, and appropriateness of the care being provided in these scenarios as well as considerations around Fraud, Waste & Abuse. We encourage pharmacists and pharmacy staff to be aware of members paying cash for controlled substances from prescribers who choose not to enroll in Vermont Medicaid or any other concerns about controlled substances and Medicaid members.
Prescription Signature Requirements	In response to the COVID-19 Public Health Emergency (PHE), the Department of Vermont Health Access (DVHA) temporarily waived signature requirements for receipt or delivery of prescriptions. In line with the end of the PHE, signature requirements will resume on May 11, 2023. Documentation of the offer to counsel and proof of delivery will be required for every prescription, effective 5/11/2023.
Over the Counter (OTC) Coverage Changes	Effective August 1, 2023, The Department of Vermont Health Access (DVHA) is discontinuing coverage for over-the-counter melatonin, vitamin D, and antihistamine products. The change to coverage is a result of changes to the State Fisal Year 2024 Medicaid budget. Coverage will remain in place as medically necessary for Vermont Medicaid members under the age of 21 according to Health Care Administration Rule 4.106 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services.

Clinical Activities

Hypertension Promoting Interoperability Program (PIP)

The Department of Vermont Health Access (DVHA) is required to run a program of formal and informal performance improvement projects (PIPs). The goal of these PIPs is to make improvements over time on a chosen topic. DVHA chose to focus on hypertension and created a Hypertension PIP program. The goal of this program is to implement increased monitoring and reductions in blood pressure values among members.

One of the goals for this program is to expand access to blood pressure monitors for Vermont Medicaid members. Those with high blood pressure are more likely to get their pressures under control if they record the values at home and sharing the results with providers. Close monitoring of a member's blood pressure will allow faster medical intervention and may reduce medications utilized and doctor or emergency department visits.

Currently, members obtain blood pressure monitors from enrolled DME providers, which are limited in number, and this could present a barrier to access. This program has a goal to expand access to prescribed blood pressure monitors from enrolled Medicaid pharmacies, allowing members to have access to this service from the multiple pharmacies in Vermont. This goal has an expected start date of

09/01/2023.

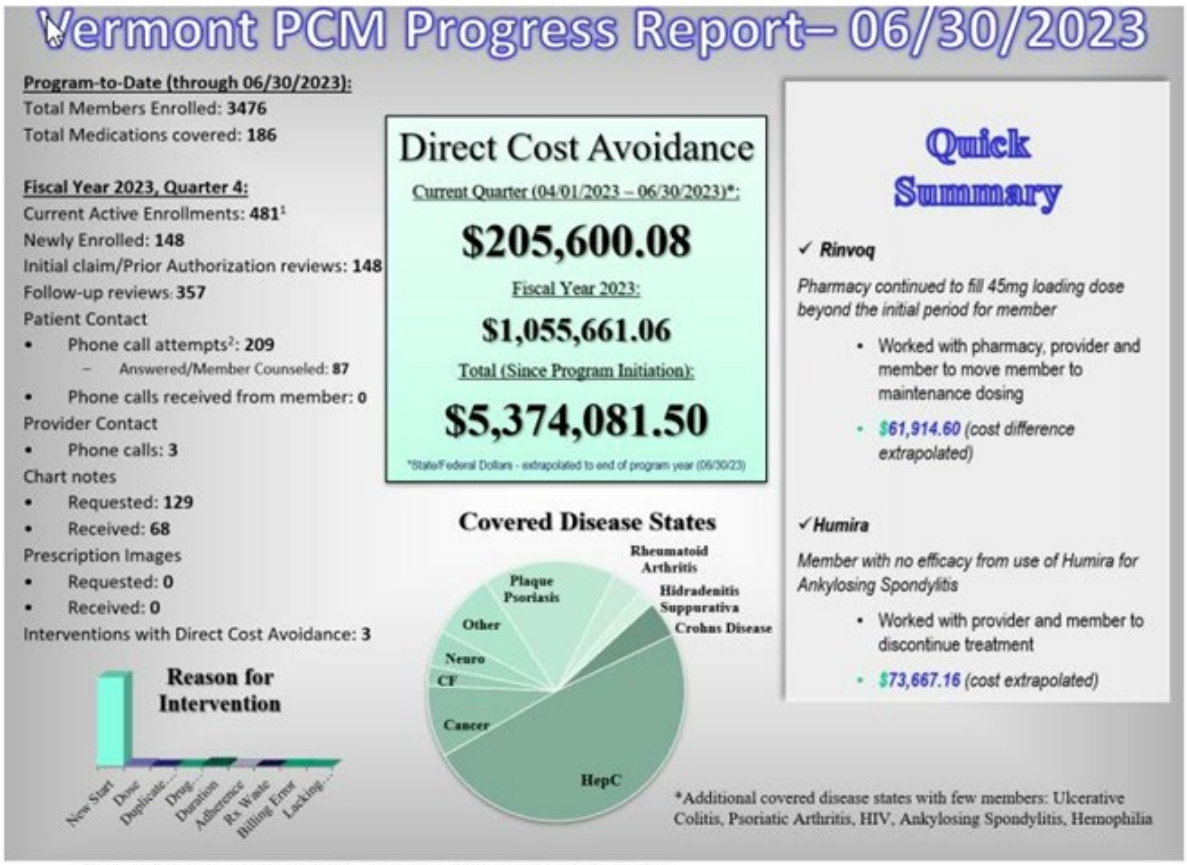
Pharmacy Cost Management (PCM) Program

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 the full value of these medications in improving patient outcomes. 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 the 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.

Change Healthcare (April 1, 2023, through June 30, 2023). Change Healthcare Pharmacy Management Reporting Suite is a collection of reports recording the process and progress of PCM.

In the second quarter of 2023, the PCM program enrolled an additional 148 members for a total of 3,476 members on 186 unique medications. The program is actively monitoring 481 enrollees. A total of 209 outgoing telephone calls were placed to members, 87 of which resulted in member counseling. During this quarter of the Vermont PCM program, four interventions led to direct and measurable cost avoidance. Furthermore, interventions that do not bring about direct cost avoidance are in place to encourage adherence and thus improve member outcomes and avoid unnecessary medical costs. Through interventions in the PCM program, unnecessary drug spends of $205,600.08 avoided in the second quarter of the state fiscal year 2023. More than $5.3 million in unnecessary drug spend has been avoided throughout the program.



vi. All-Payer Model: Vermont Medicaid Next Generation Program

Key updates from QE062023:

- Executed a contract amendment with OneCare for a 2023 performance year of the program.
- Continued conducting financial reconciliation activities for the 2022 performance year, in order to determine financial and quality performance. Results will be available in late Q3 or early Q4 2023.
- Entered into contract amendment negotiations with OneCare for a 2023 performance year.
- Continue to support Vermont's broader efforts to develop an integrated health.

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. Since 2017, the number of risk-bearing hospital communities participating in the VMNG model has grown from 4 to 14 and it is now considered a statewide program in terms of provider participation and member attribution.

DVHA and OneCare entered into a subsequent agreement for the 2022 performance year after an RFP was released in mid-2021 for ACO services and OneCare was selected as the successful bidder. The agreement terms are for one year with three possible one-year extensions to the program.

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 many programmatic areas ensures program stability and continued alignment across payer programs as part of the Vermont All-Payer ACO Model.

DVHA began financial reconciliation activities for its 2022 performance year in Q1 2023. Reconciliation activities will determine the ACO's spend as compared to their financial target and quality performance for the 2022 performance year. Reconciliation activities will continue into Q3 2022, and the final results will be available in Q3 or Q4 2022.

DVHA entered into contract negotiations with OneCare for the 2024 performance year in late-Q2 of 2023. Potential changes to the program for the 2024 performance year include minor modifications to the quality component of the program and the inclusion of a pilot

payment model for hospitals participating in the VMNG program. Other anticipated programmatic changes are minor. Negotiations are expected to continue into Q3 and Q4 of 2023.

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

V. Financial/Budget Neutrality Development/Issues

As is the monthly process, AHS paid DVHA 1/12th of the legislative budget for Global Commitment on the first business day of each month during the January - March 2023 quarter. This payment served as the proxy by which to draw down Federal funds for Global Commitment (GC).

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

This quarter represents the second quarter of DY19 of the GC Waiver. Vermont calculates $762.8M for Without Waiver expenditures, and reported $721.5M in With Waiver expenditures, leaving a savings subtotal of $41.3M. There are also 10 Hypothetical Tests for various demonstration groups. The hypothetical tests for New Adult, SUD IMD, SMI IMD, Maternal Health & Treatment Services, CRT, Moderates, and Marketplace Subsidies reflect a surplus, whereas the test for Global Rx shows a moderate deficit. The total of the deficit is $678k which reduces the cumulative Waiver savings to $40.7M. There is nothing to report for the Housing Pilot or SUD CIT because those programs have not yet been operationalized. Lastly, for Investments, Vermont reported $15.9M in expenditures for the quarter which leaves $137.7M available for the remainder of DY19.

Vermont continues to implement HCBS programs using the Reinvestment funds under the American Rescue Plan of 2021. For QE0623, Vermont reported $4.7M in Program expenses, $540k in Investments, and $743k in Admin expenses.

VI. 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 a twelve-month period due to a beneficiary's change in enrollment status.

The table below contains Member Month Reporting for DY18 and DY19 and includes the unduplicated count of member months for SUD IMD and SMI IMD stays.

Table 1. Member Month Reporting – ***subject to revision due to retroactive enrollment***

Medicaid Eligibility Group	Total DY 2018
ABD - Non-Medicare - Adult	38,264
ABD - Non-Medicare - Child	8,735
ABD - Dual	136,570
Non ABD - Non-Medicare - Adult	112,461
Non ABD - Non-Medicare - Child	378,126
Hypothetical Groups	
New Adult	454,355
SUD - IMD ABD	51
SUD - IMD ABD Dual	70
SUD - IMD Non ABD	121
SUD - IMD New Adult	624
SMI - IMD ABD	55
SMI - IMD ABD Dual	10
SMI - IMD Non ABD	20
SMI - IMD New Adult	156
Housing Pilot	0
Maternal Health and Treatment Services	114
CRT	1,213
SUD CIT	0
VT Global RX	55,197
Moderate Needs Group	731
Marketplace Subsidy	60,841

Medicaid Eligibility Group	Total DY 2019
ABD - Non-Medicare - Adult	43,510
ABD - Non-Medicare - Child	10,714
ABD - Dual	137,539
Non ABD - Non-Medicare - Adult	110,828
Non ABD - Non-Medicare - Child	375,313
Hypothetical Groups	
New Adult	462,830
SUD - IMD ABD	66
SUD - IMD ABD Dual	95
SUD - IMD Non ABD	99
SUD - IMD New Adult	861
SMI - IMD ABD	57
SMI - IMD ABD Dual	6
SMI - IMD Non ABD	141
SMI - IMD New Adult	177
Housing Pilot	0
Maternal Health and Treatment Services	158
CRT	1,114
SUD CIT	0
VT Global RX	53,829

Moderate Needs Group	**689**
Marketplace Subsidy	**69,078**

VII. Consumer Issues

AHS and DVHA have several mechanisms whereby consumer issues are tracked and summarized. The first is through Health Access Member Services. This is a contracted function for providing information on healthcare programs, assisting with the eligibility process, and helping beneficiaries to understand the benefits and responsibilities of their particular program.

The complaints received by Member Services are reported to DVHA (see Attachment 3). Member Services works to resolve the issues raised by beneficiaries, and the reports are seen by several management staff at DVHA.

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

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

VIII. **Quality Improvement**

Quality Assurance and Performance Improvement Activities

Key updates from QE062023:

- Presented CAPHS results to the Quality Committee.
- Launched the annual medical record review (MRR) process.
- Continued coordination of DVHA's comprehensive risk assessment project.

The QI unit partners with the Compliance and Oversight & Monitoring units as part of a larger Risk & Quality Management (RQM) Team. The over-arching goals of this team include:

- Create a culture of proactive regulatory compliance and continuous quality improvement;
- 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 identify ways to improve the services we deliver to Vermonters;
- coordinate the production and/or analysis of standard performance measures about all Medicaid enrollees, including the special health care needs populations (service provision delegated to IGA partners).

PIHP Quality Committee

The Quality Committee remained active during QE0623 and consists of representatives from all departments within AHS that serve the Medicaid population. The committee continues to structure its work around the federal managed care quality program guidelines and the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of healthcare. Topics addressed this quarter included annual quality improvement project and risk assessment updates, and quality measure reporting for various special health care needs populations.

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 QE0623. Project work focuses on activities related to improving members' access to blood pressure monitors, which supports work being done in other parts of the Agency that focuses on provider and patient education and connecting to community resources. DVHA submitted an annual PIP Summary to our EQR during this reporting period. The project's study measure improved slightly during measurement year 2022.

Other Collaborative Quality Improvement Projects

The Quality Improvement team continued to work with the following groups on collaborative QI projects during QE0623:

- 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 continues 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) are on a learning collaborative to improve the timeliness of comprehensive health visits for children and adolescents entering foster care. During this reporting period, we collected data on our test of change, worked on expanding that test to other areas within the state, and participated in all CMS-led learning collaborative meetings.

Quality Measure Reporting

HEDIS measure production –In addition to producing and reporting on administrative (claims-based) measures annually, the Quality Improvement and Data teams work with our quality measures vendor to produce hybrid measures. During this reporting period, the hybrid measure production process was completed for five (5) hybrid measures. DVHA's certified HEDIS vendor performed medical record retrieval (MRR) for all five hybrid measures and abstracted records for three of those measures. DVHA clinicians abstracted the other two measures.

CAHPS Experience of Care measures - during QE0623 DVHA's Director of Quality Management met with the CAHPS vendor to discuss addition of the Children with Chronic Conditions (CCC) supplemental question set to the annual Child Health Plan 5.1 survey starting in the fall of 2023.

Results Based Accountability (RBA)/Process Improvement

Results Based Accountability (RBA) scorecards are developed at DVHA for both internal and external performance management purposes. DVHA Quality Unit staff use this tool to create a *Global Commitment to Health* Core Measure scorecard, Experience of Care, and other performance budgeting scorecards. DVHA's largest scorecard, named the Performance Accountability Scorecard includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services. Scorecards that were newly developed or actively maintained during QE0623 include the following: Dental Benefit, Applied Behavior Analysis and Payment Models.

COVID-19 Dashboard

The Quality Team was tasked with creating and maintaining a COVID-19 dashboard at the end of March 2020 to monitor the response to the pandemic: both the impact it has had on operations and the activities staff have engaged in. As an internal evaluation tool, the dashboard is updated monthly and made available to all DVHA staff via our intranet. QE0323 was the last reporting period during which the Dashboard was actively maintained in its entirety. Some Dashboard measures were moved to the ongoing DVHA Performance Accountability Scorecard during this most recent reporting period.

Vermont Next Generation Medicaid ACO

During QE0623, DVHA's Director of Quality Management received, reviewed, and approved the quarterly VMNG ACO quality management reports. Quality and Clinical staff from DVHA and the VMNG ACO also meet quarterly with a focus on quality measurement and ongoing QI efforts. A representative from the VMNG ACO is also a standing member of DVHA's formal PIP, the topic of which is managing hypertension.

Comprehensive Risk Assessment

Staff from DVHA's Quality, Oversight & Monitoring, and Compliance units developed a comprehensive risk assessment program for Vermont's Medicaid program at the end of 2021. This work is ongoing. 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 and informed updates to DVHA's Inter-Governmental Agreement (IGA) with AHS.

In addition to researching managed care standards, the risk assessment team prepared for the annual Compliance EQR audit during QE0623.

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 most recent quarter, DCF and DOC highlighted the performance of a subset of their 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: 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 most recent quarter, the Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) highlighted the performance of their payment model. The Clear Impact Scorecard for this payment model is included in this report as Attachment 7.

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

This quality strategy is intended to serve as a blueprint or road map for states and their contracted health plans in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. In the Special Terms and Conditions (STCs) of the State's recent waiver extension, CMS has included prescriptive 1915(c) HCBS quality requirements for the State's 5 HCBS programs (CFC, DS, BIP, CRT, MH Under 22). As a result, the State is required to extend its existing quality strategy to include HCBS. During this quarter, the State continues to identify the resource lift necessary to address gaps and implement CMS' HCBS quality requirements. Also, during this quarter, CMS provided AHS feedback on their 2021 Quality Strategy. While CMS does not approve state managed care quality strategies, they do review them to assure they are complete and in alignment with Medicaid and Children's Health Insurance Program (CHIP) elements detailed at 42 CFR 438.340 and 457.1240(e). Feedback was focused on the following aspects of the strategy: quality and appropriateness of care & monitoring and compliance. The state will review the feedback and during the next quarter, let CMS know if they agree with their assessment or if they believe any component of the assessment is inaccurate.

SUD Monitoring Protocol and Reports

The SUD Monitoring Protocol specifies the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements of the demonstration. During this quarter, the state submitted quarterly narrative and data monitoring reports for the substance use disorder (SUD) component of the Global Commitment to Health demonstration, to the Centers for Medicare & Medicaid Services (CMS), as required by the state's special terms and conditions (STC). Also, during this quarter, the state received CMS feedback on their previously

submitted Monitoring Reports. Feedback was received for both Part A (data) and Part B (narrative) of the report. During the quarter, AHS has worked with colleagues at DSU and DVHA to review and respond to feedback. In addition, at the request of the state, CMS provided technical assistance to the state SUD data team re: their report feedback. During a TA call, CMS reviewed recent feedback on narrative and data reports and responded to state questions/comments. The state agreed to edit previous reports and adjust current and future reports to align with the guidance. It was also agreed that the state would submit the Q1 SUD monitoring report with the Q2 report due to CMS next quarter.

SMI Monitoring Protocol and Reports

The SMI Monitoring Protocol specifies the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements of the demonstration. During this quarter, the state submitted quarterly narrative and data monitoring reports for the serious mental illness (SMI) component of the Global Commitment to Health demonstration, to the Centers for Medicare & Medicaid Services (CMS), as required by the state's special terms and conditions (STC). Also, during this quarter, the state received CMS feedback on their previously submitted Monitoring Reports. Like the SUD monitoring reports above, the state requested technical assistance from CMS to review their feedback. A meeting was scheduled during the next quarter for CMS to provide technical assistance to the state SMI/SED data team. It was also agreed that the state would submit the Q1 SMI/SED monitoring report with the Q2 report due to CMS next quarter.

IX. Demonstration Evaluation Activities

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

During the quarter, the state reviewed responses to the waiver evaluation RFP and selected a vendor. By the end of the quarter, a contract was drafted/executed. The state will work with the new vendor during the next quarter to develop a draft evaluation design for the overall waiver as well as one for the Public Health Emergency (PHE) Reasonable Opportunity Period (ROP) extension. In addition, the state submitted the draft Summative Evaluation Report to CMS via the PMDA. The report includes the information in the CMS-approved Evaluation Design for the previous waiver. The state anticipates receiving feedback on the draft report during the next quarter.

X. Compliance

Key updates from QE062023:

- EQRO Document Preparation

External Quality Review

During the last quarter, the state continued to work with the External Quality Review Organization (EQRO) to develop the material necessary for each of the required annual external quality review activities (i.e., performance improvement

project validation, performance measure validation, and compliance review). Performance Improvement Project (PIP) validation items included the PIP validation timeline, review templates, and report outlines. Performance Measure Validation items included the PMV timeline, a document request letter, a rate reporting template, and a HEDIS roadmap. Review of Compliance with Standards items included a document request letter as well as desk and documentation review forms. All letters and materials are expected to be sent to DVHA during the next quarter.

Intra-Governmental Agreement (IGA) between AHS and DVHA

During this quarter, there was no activity associated with the AHS / DVHA IGA. The CY2024 IGA is due to CMS on October 3, 2023.

XI. Reported Purposes for Capitate Revenue Expenditures

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

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

XII. State Contact(s)

Fiscal	Richard Donahey, CFO VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	802-241-0442 (P) richard.donahey@vermont.gov
Medicaid Director	Monica Ogelby Vermont Medicaid Director Agency of Human Services 280 State Drive Waterbury, VT 05671-100	802-338-6643 Monica.ogelby@vermont.gov
Policy/Program	Ashley Berliner, Director of HealthCare Policy & Planning VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	802-578-9305 (P) 802-241-0958 (F) ashley.berliner@vermont.gov

Managed Care Entity	Andrea DeLaBruere, Commissioner of the Department of Vermont Health Access 280 State Drive Waterbury, VT 05671-1000	802-585-5356 (P) Andrea.delabruere@vermont.gov

XIII. Attachments

Attachment 1	Budget Neutrality Workbook
Attachment 2	Complaints Received by Health Access Member Services
Attachment 3	Medicaid Grievance and Appeal Reports
Attachment 4	Office of the Health Care Advocate Report
Attachment 5	QE062020 Investments (GC Investments)
Attachment 6	Investment Scorecard(s)
Attachment 7	Payment Model Scorecard(s)

Date Submitted to CMS: August 29, 2023

Attachment 1

Budget Neutrality (BN) Workbook

The DY19 Q2 BN reporting deadline was extended from 8/29 to 9/22 to allow CMS an opportunity to investigate an issue with the reporting template. During this quarter, it was noticed that there were some expenditures in the C report sheet that were not appearing in the C Report Grouper and Summary TC sheets. CMS plans to connect with the PMDA Help Desk to see if they need to make any updates to the template.

Attachment 2

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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

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

Questions, Complaints and Concerns Received by Health Access Member Services
April 1, 2023 – June 30, 2023

The following information represents the monthly documentation of Green Mountain Care Member Questions, Complaints, and Concerns as reported to Green Mountain Care Member Services (1-800-250-8427) per quarter. Calls are addressed per guidelines (policy, scripts, multi-tier resolver groups) developed by the Department of Vermont Health Access and in collaboration with Maximus. The nature of each call is assessed by the customer service representative (CSR) and the appropriate action (appeal rights, fair hearings, policy explanation, etc.) is then applied. If the call requires an action or advice that is beyond the scope of information available to the CSR, the member is then afforded a warm transfer to the appropriate subject matter expert within DVHA (e.g. Member and Provider Services, Health Access Eligibility & Enrollment Unit, etc.). Each documented question, complaint, or concern is captured in order to ensure that the member's needs are met and that proper resolution is guaranteed.

April 2023:

- **Provider Complaint -** Caller requested to submit feedback as she was referred to a Dentist at xxxxx which she went for a cleaning and the Dentist started doing work without telling her exactly what she was doing. This resulted in her having more issues and more pain. She then had to go to another Dentist to get the previous work fixed. She is now stuck with paying for the service. The Agent apologized for the inconvenience, documented the feedback, mailed a Provider Complaint Form and offered to file a Formal Grievance for the customer.
- **Provider Complaint -** Caller wanted to file negative feedback as he states xxxxxx did not give him the full prescription that his Doctor prescribed her. He usually gets 28 and the Pharmacy only gave him 23. The Agent apologized for the inconvenience, documented the feedback, referred the customer to have the doctor contact Provider Services and also offered to mail out a Provider Complaint Form.
- **Provider Complaint -** Caller wanted to document that she is unable to find a Dentist that is accepting new Medicaid patients. She states she has called all over Vermont and each place is not accepting new patients and tell her they will not anytime soon. The Agent apologized for the inconvenience, documented the feedback and offered to help her search through the VT Medicaid Portal.

- **Provider Complaint -** Caller called to document that he is unable to find a Dentist that accepts VT Medicaid as insurance. He states this is a serious problem, as no offices are accepting new patients. The Agent apologized for the inconvenience, documented the feedback and offered to help him search through the VT Medicaid Portal.
- **Covered Services -** Caller's daughters provider told her that we would not cover it "she doesn't meet the criteria, pretty much nobody does". She doesn't think this is fair as a lot of kids need braces. The dentist will not submit the PA to be denied due to already know it doesn't meet the criteria. Due to the PA not being submitted caller is unable to file a Fair Hearing/Appeal. The Agent apologized for the inconvenience and explained to the customer they could document their feedback. They also advised to talk to the dentist to see if they can submit the PA in case she needs to appeal the decision.

May 2023:

- **Provider Complaint -** Caller states that he has been looking for a Dentist that accepts VT Medicaid for the past four days and is unable to find one that is accepting new patients. He even has an ESD Dental Voucher and still cannot get seen. He thinks this is a major problem as everyone needs Dental care. The Agent apologized for the inconvenience, documented the feedback and assisted the customer with searching on VTMedicaid.com for a Dentist that is accepting new patients in the area.
- **Provider Complaint –** Caller states that he has called so many Dentists throughout the past two years and no one is accepting new patients. He is very upset as he could not go for his check up and get the dental care that he needs. The Agent apologized for the inconvenience, documented the feedback and assisted the customer with searching on VTMedicaid.com for a Dentist that is accepting new patients in the area.
- **Provider Complaint -** Caller requested to document that xxxxxx is over charging her for co-pays and refilling her prescriptions without her permission. She has filed a complaint with Customer Service but no one has responded to her complaint. The Agent apologized for the inconvenience, documented the feedback and advised the customer to make sure they are billing her PDP first then Vpharm.
- **Provider Complaint -** Caller called to submit a complaint regarding the Pharmacy and trying to refill her daughters prescription early. She was told by the Pharmacist that the refill is too soon and that her daughter may be taken more of the medication than what she was prescribed if she is out already. The Agent apologized for the inconvenience, documented the feedback and offered to file a Formal Grievance.
- **Covered Services -** Caller called to document feedback on Transportation services. She states “xxxxxxx could not get me a ride because I was told that a 24/48 hour call ahead is needed. I am 75 year lady old who is under critical care and it is hard for me to do so. I need to make it to my appointments. If I need to get a lawyer/attorney I will again. I have no car or other way to get there. Why can't people drive down my street? Why is it needed to have a notice of 24 to 48 hrs? Its your guy's rule note Medicaid. You are trying to dictate my office visits, I call and tell you that I have an appointment on Wednesday and Monday is the only availability, how does that make sense on me getting to my appointments?" The Agent apologized for the inconvenience, documented the feedback and referred the customer to VPTA to file a complaint.
- **Provider Complaint -** Shawn requested to document feedback as he has called over 10 Offices and no one is accepting new medicaid patients. He does not think it is fair that

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Agency of Human Services
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offices tell him they have openings and then when they find out he has Medicaid they say their quota for Medicaid patients is filled and they refuse to schedule him an appointment. Shawn states he lives in Hardwick and even though it would be expensive to drive to Burlington he could not find a dentist there either. Shawn would like to know what good the insurance is if he cannot use it and feels lack of dental care can affect his overall health. The Agent apologized for the inconvenience, documented the feedback and assisted the customer with searching on VTMedicaid.com for a Dentist that is accepting new patients in the area. Also provided the customer with the phone number to VT Legal Aid.

June 2023:

- **Provider Complaint** - Ernest requested to file feedback about a Provider that he saw. Ernest states that he had begged the doctor to find out why he had swelling in his legs. In spite of multiple requests the doctor did not order any tests for him and the only thing he would do is give him bandages and left him with bleeding toes. He would only prescribe refills without any help. Ernest feels that he was not given proper treatment. The agent apologized for the inconvenience and documented the feedback.
- **Covered Services** - Caller would like to submit feedback due to having to wait to speak with someone after speaking with Transportation contractor then being forwarded to VT Medicaid and then to VPTA to request exception. She states "I have never asked for help and asking for transportation assistance and have been denied due to have a vehicle at home". The agent apologized for the inconvenience and documented the feedback and provided the number to VPTA to request the Exception form.

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
April 1, 2023 – June 30, 2023

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data from the centralized database that were filed from April 1, 2023, through June 30, 2023.

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 twenty grievances filed and seven 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 receipt of a grievance must be sent within five days; the average was three days. Of the grievances filed, 80% were filed by the beneficiary, and 20% were filed by a representative. DMH had 90%, DAIL had 5%, and VDH had 5% of the grievances filed.

Grievances were filed for service categories mental health, case management, community social supports, employment services, developmental services and outpatient services.

There were no Grievance Reviews filed this quarter.

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

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

During this quarter, there were fifty-five appeals filed. Of these fifty-five appeals, forty-one were resolved (75%), four were untimely (7%), nine were withdrawn (16%), and one (2%) was still pending.

Of the twenty-four appeals that were resolved this quarter, 98% were resolved within the statutory time frame of 30 days. The average number of days it took to resolve these cases was twenty days. Acknowledgement letters of receipt of an appeal must be sent within five days; the average was two days.

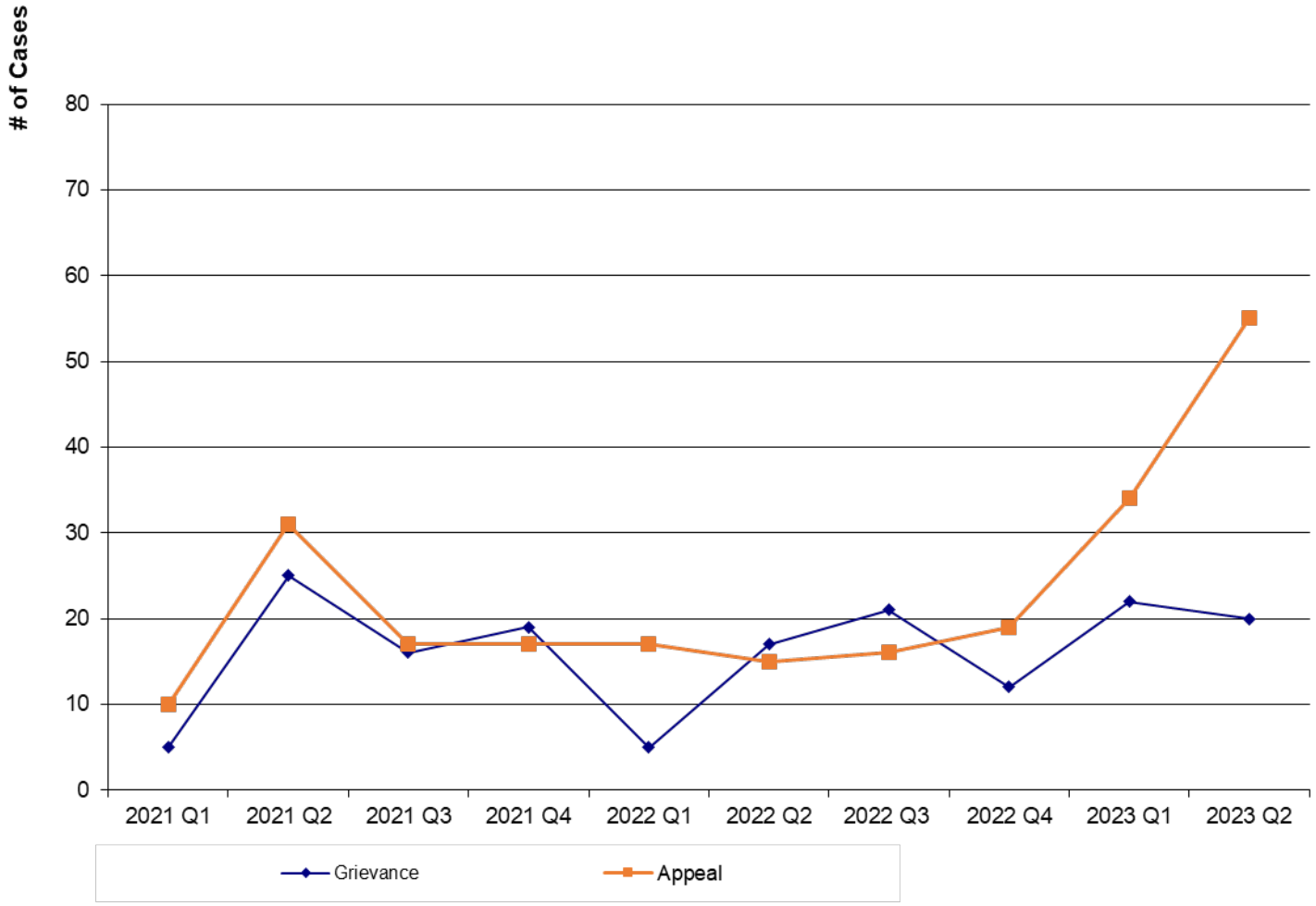
Of the fifty-five appeals filed, DVHA had 54 appeals filed (98%), and VDH had 1 (2%). There were no appeals filed for DAIL, DCF or DMH this quarter.

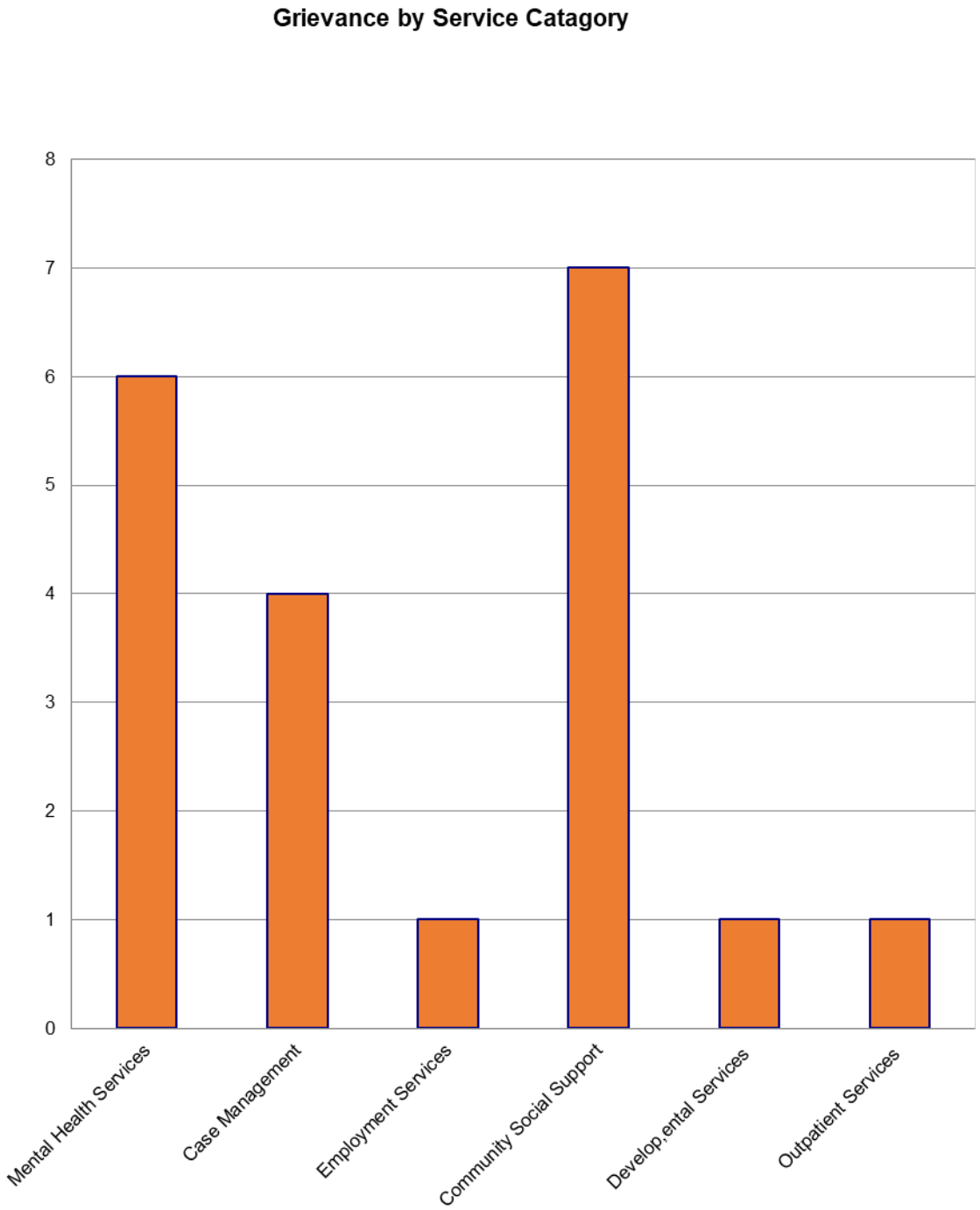
The appeals filed were for service categories dental, outpatient hospital, personal care, prescription, surgical and transportation.

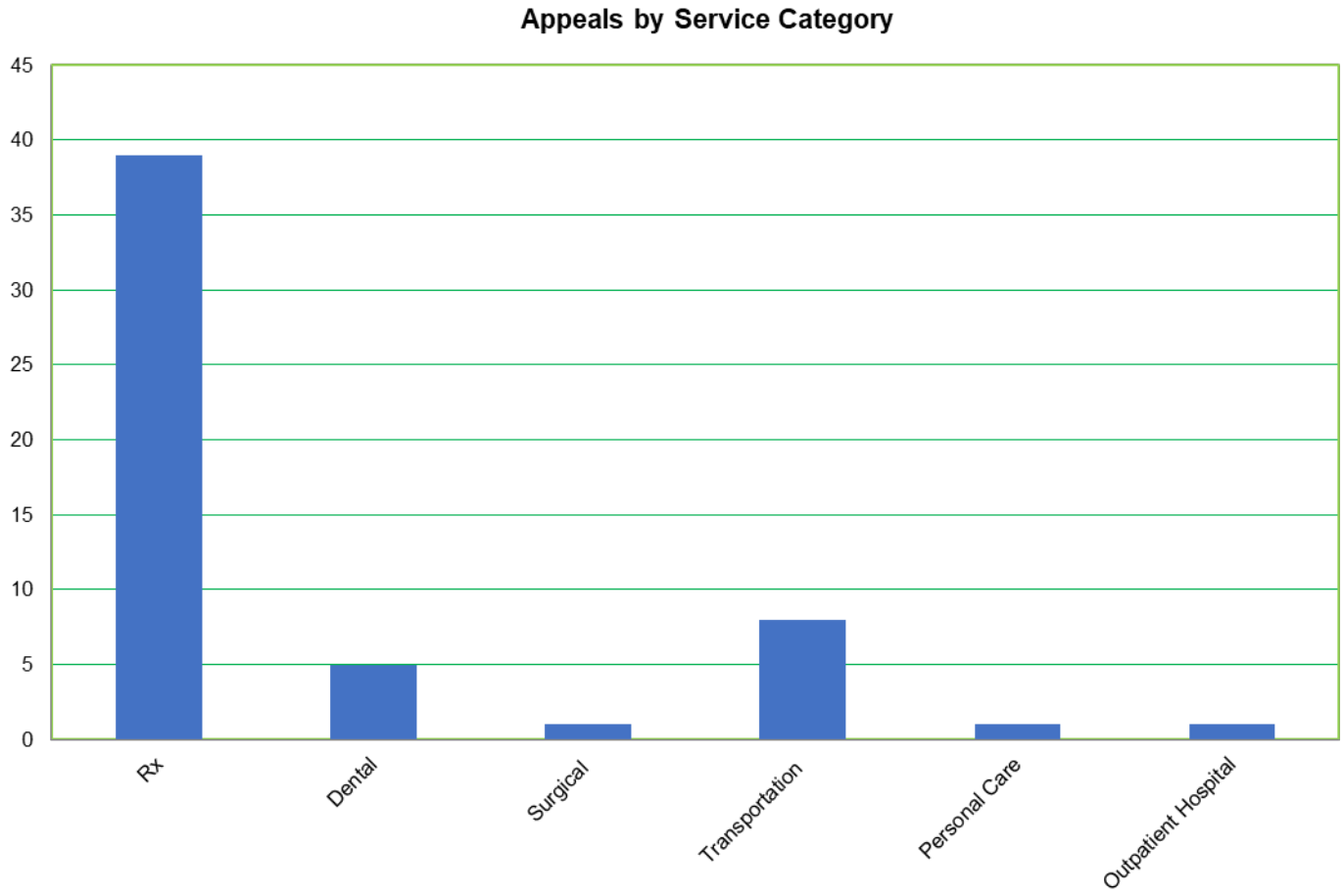
Beneficiaries must exhaust the internal appeal process before they can file a fair hearing if their appeal is not decided in their favor. There were two fair hearings filed this quarter.

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

Grievances and Appeals
January 1, 2021 thru June 30, 2023




Grievance by Service Catagory
8
7
6
5
4
3
2
1
0
Mental Health Services
Case Management
Employment Services
Community Social Support
Develop.ental Services
Outpatient Services


Appeals by Service Category
45
40
35
30
25
20
15
10
5
0
Rx
Dental
Surgical
Transportation
Personal Care
Outpatient Hospital

Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

April 1-June 30, 2023

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

July 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. The HCA Helpline now has eight advocates working to resolve issues and answer questions.

The HCA opened 859 cases this quarter (897, the previous quarter). In this past quarter, Vermont Health Connect (VHC) re-started its Medicaid eligibility reviews. Reviews and closures for Medicaid and other state health care programs had been paused for three years during the COVID public health emergency. This quarter, the HCA focused on increasing public awareness and understanding about the review process. We want to help consumers understand their health care options and prevent the loss of health care coverage. For enrollees new to Medicaid in the last three years, the review process will be unfamiliar.

When doing our Medicaid renewal outreach, the HCA worked to increase language access. The HCA partnered with the Vermont Language Justice Project to produce a short video titled "Open the Envelope," which discussed Medicaid renewal notices. These videos were translated into 17 different languages, and they have been collectively viewed over 1,236 times on YouTube and Facebook.

The HCA has also worked to keep its own website updated with renewal information. This past quarter—we had 1305 page views of our webpage on Medicaid limits, and 593 pageviews of the webpage about VHC, Medicaid and Dr. Dynasuar. Our news item titled "Medicaid renewals Re-started" had 500 pageviews. In addition to calling, Vermonters can contact the Helpline on our website, and this past quarter we had 131 online help requests.

During the quarter, more consumers started to call with questions about their health care options, and what they should do if they were found ineligible for Medicaid. The HCA Helpline provided consumer education about the renewal process, and we saw an uptick in calls on VHC renewals, Medicaid renewals, eligibility for Special Enrollment Periods, and Eligibility for Premium Tax Credit. We expect to see increased eligibility calls in the coming quarters. We also spoke to another 158 households about all types of Medicaid eligibility and applying for DVHA programs. The HCA advocates also participated in multiple outreach events. In addition, the HCA did a training

Theo called the HCA because he missed his enrollment period for his employer insurance. His employer was telling him that he would have to wait until the next year to enroll. Theo had a chronic medical condition that requires multiple prescriptions, so he could not wait almost a year to get onto coverage. The HCA advocate explained that Vermont Health Connect (VHC) has a new special enrollment period (SEP) that allows you to enroll outside of the open enrollment period if you are under 200 percent of the federal poverty level (FPL). Theo was under the 200 FPL income limit, so he could use the SEP to enroll. However, because he had an offer of employer insurance, he was not eligible for subsidies to help for his premiums. Even though he had not actually signed up for the employer plan, the offer made him ineligible for subsidies. He could not afford the premiums without a subsidy. But the HCA advocate also found that Theo's income was not that far above the Medicaid limit. She advised him that he could lower his monthly income by opening a traditional IRA account. By contributing to the IRA, his income was lowered, and he would be Medicaid eligible. Theo opened the account, and was able to get onto Medicaid, allowing him to get his prescriptions.

about the end of the public health emergency and the Medicaid review process, for the rest of Vermont Legal Aid and Legal Services Vermont.

The HCA is also doing focused consumer education for Medicare eligible Vermonters. During the PHE, many Vermonters who became Medicare eligible stayed on Medicaid for Children and Adults. Normally, once you become Medicare eligible, you lose eligibility for Medicaid for Children and Adults and need to transition to a different type of Medicaid, Medicaid for the Aged Blind and Disabled (MABD). MABD has lower income requirement and resource rules, and so many people who are eligible for Medicaid for Children and Adults, will be over-income for MABD. During the PHE, because VHC was not reviewing or closing Medicaid, many Medicare eligible Vermonters stayed on MCA. Some Medicare eligible Vermonters also did not sign up for Medicare Part B when they became eligible because they were still on Medicaid for Children and Adults. This year, there are new special enrollment periods for exceptional circumstances for Part B enrollment, including one that gives you an SEP after you lose Medicaid coverage. See SSA - POMS: HI 00805.385 - Exceptional Conditions Special Enrollment Period (SEP) for Termination of Medicaid Eligibility - 12/20/2022

This new SEP will help Vermonters who did not enroll on Part B because they were still on Medicaid due to the PHE. The HCA is also working with community partners to assist Vermonters as they transition to new coverage. The new Medicare SEP will also mean people can enroll without a gap in their health coverage, and that they will not have late enrollment penalty.

The HCA is continuing its work to increase Medicare affordability for all Vermonters. We continue to advocate for increasing the income limits for Medicare Savings Programs (MSPs). The MSPs pay for Medicare Part B premiums, and in some cases pay Medicare cost-sharing. By increasing the income limits, more Vermonters would be able to access the medical care they need. Last quarter, we spoke to 175 households about Medicare eligibility, affordability, enrollment, and consumer education questions. The HCA is laying the foundation for a focused outreach to Vermonters who are on Medicare to gather their stories and understand how affordability impacts their access to care.

The HCA policy team also spent time this quarter preparing for the insurance rate review process. The HCA will be working to make sure the voices of individual Vermonters are heard in the process. We are working to engage more individuals and small business owners. The HCA will again focus on affordability, and how the rate of annual increases is not sustainable for individuals or small businesses in Vermont.

Case Stories:

Ava's Story:

Ava called the HCA because she was having trouble getting healthcare in Vermont. She moved to Vermont from another state, where she had coverage on a plan from the state marketplace for herself and her kids. But, she was having trouble applying on VHC, and one of her kids had high health needs. She was so frustrated that she was thinking of leaving the state. The HCA advocate investigated and found that the application had been denied. VHC had denied the application because of lack of income verification. The HCA advocate discovered that Ava did not have any countable income. One of the children received SSI, but that does not count as income for Medicaid. Ava also received child support, but that is also not considered countable income for MCA and Dr. Dynasauar. Ava was eligible for Medicaid and the kids for Dr. D. If you have no income, you can attest to that with VHC, and the HCA advocate helped Ava to attest that the household did not have income. The application was processed, and the whole family was able to get on coverage.

Vera's Story:

Vera called the HCA because VHC was telling her that she did not have a special enrollment period to enroll on a VHC plan. Without a special enrollment, Vera would be without coverage for the rest of the year. The HCA advocate investigated Vera's situation. Earlier in the year, Vera left her job, and enrolled on COBRA. COBRA allowed her to have a continuation of her employer health insurance after she left her job. Her employer had agreed to subsidize the COBRA coverage for several months. Typically, COBRA is very expensive, and Vera could not afford it without help from her former employer When the employer subsidy ended, she applied on VHC and was denied the SEP. The HCA advocate explained to Vera that this was an error. There is a special enrollment period for Vera's situation, when someone loses assistance paying for COBRA. The HCA advocate pointed out the error to VHC, and it agreed to reverse its decision and allow Vera to enroll on a plan. This meant Vera was able to get onto a VHC plan, and she would not have a gap in her insurance coverage.

Hayden's Story

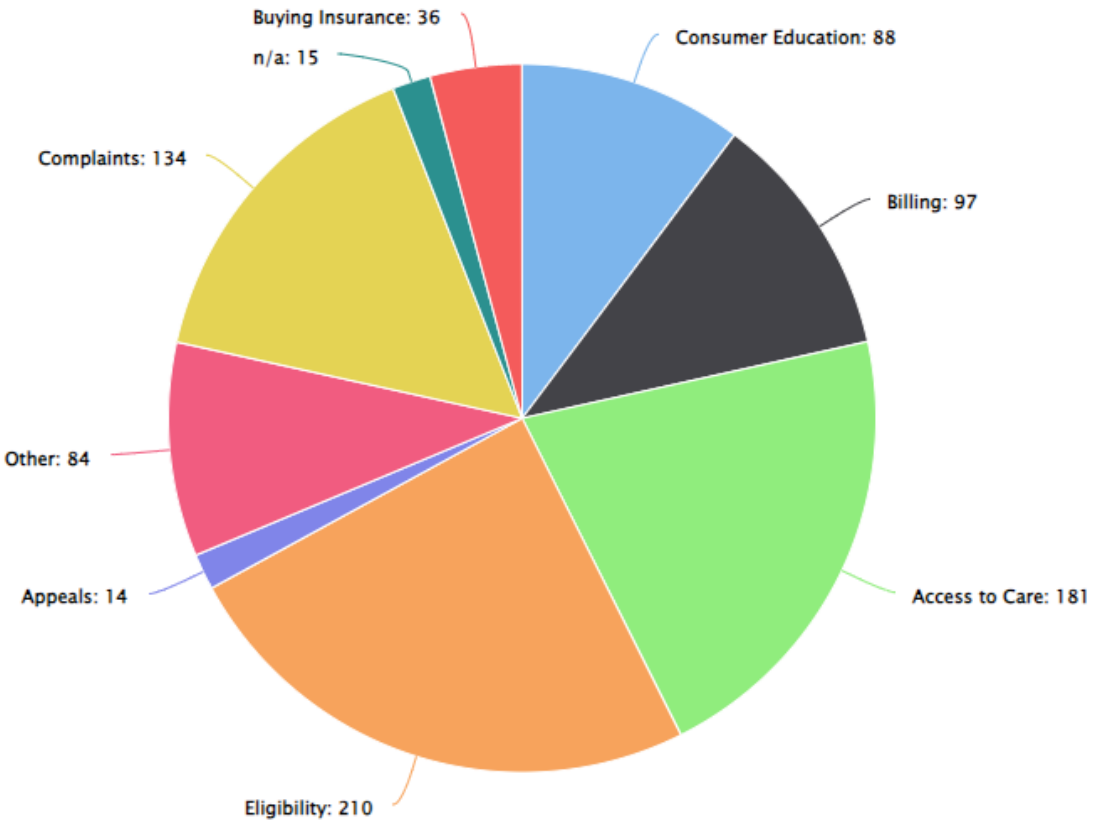
Hayden called because he received a notice from VHC about his Medicaid coverage. This quarter, VHC re-started Medicaid reviews, after a three-year pause due to the COVID Public Health Emergency (PHE). Hayden was on Medicaid for Children and Adults during the COVID PHE. During the PHE, he also turned 65 and enrolled on Medicare. Normally, when you become eligible for Medicare, you lose your eligibility for Medicaid for Children and Adults. The type of Medicaid that works with Medicare is called Medicaid for Aged, Blind and Disabled (MABD). MABD has much lower income limits, and it also has resource limits. Often people who are eligible for Medicaid for Children and Adults find out that they are over-income or over-resourced for MABD. Once the reviews re-started, Hayden's MCA coverage was going to end. The HCA advocate guided Hayden through the renewal process, and explored with him the programs that he would be eligible for. Hayden was going to be over-income for MABD, but she explained how he could apply for a Medicare Savings Program to help pay for Medicare Part B premiums. During the PHE, Hayden also had not signed up for a Medicare Part D plan. The HCA advocate explained that the closure of his Medicaid would mean that he would have a special enrollment period for a Part D plan. He was also going to be eligible for VPharm, which would help pay for his Part D premiums.

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 859 calls this quarter. We assign cases a primary issue, depending on the nature of the legal issue. Normally, we have more Eligibility and Access to Care cases than the other issues, and that was true this quarter. Callers' primary issue category were as follows:

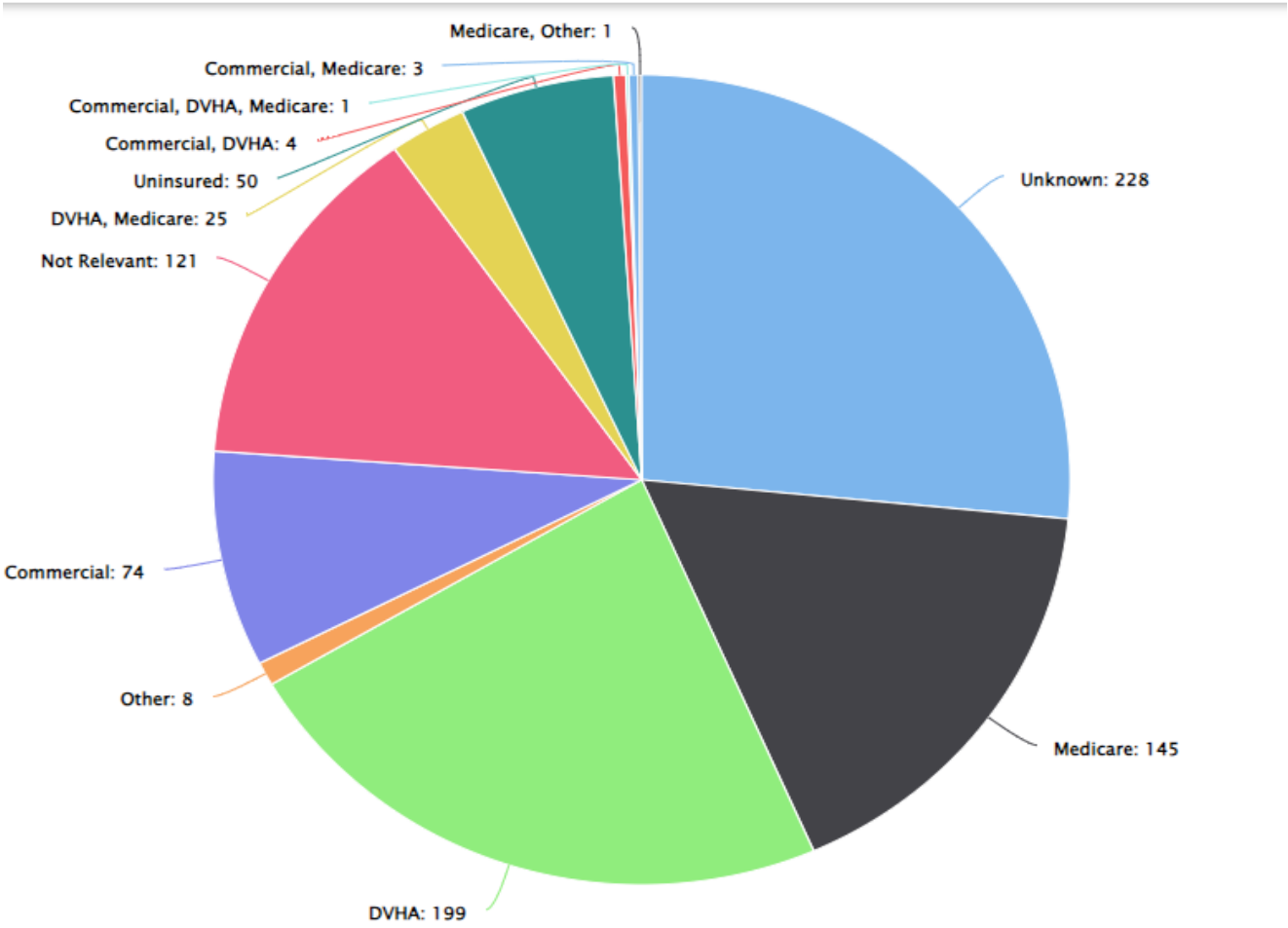
Chart: Q2 FY2023 Caller Primary Issue Category



** The "Other" primary issue category 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 HCA also tracks its callers by insurance category. We don't collect insurance information for every case, because sometimes it is not always relevant to the caller's issue.

Table: Insurance Coverage for Q2 FY2023 Callers for whom Insurance Coverage



The top issues Q2 FY2023 callers had were:

Table: Top Ten Primary Issues of Q2 FY2023

1. **Complaints-Provider 83**
2. **Eligibility for Medicaid-MAGI 79**
3. **Access to Care -Dental & Dentures 37**
4. **Access to Care -Prescription Drugs 31**
5. **Complaints-Hospital 30**
6. **Eligibility Medicaid-Non-MAGI 24**
7. **Consumer Education-Medicare 20**
8. **Consumer Education-Info/Applying for DVHA Programs 19**
9. **Billing-Hospital Billing/Financial Assistance 19**
10. **Buying Insurance-VHC-17**
11. **Consumer Education-General Questions about Insurance-17**

Overall Cases Resolution Q2SFY2023

HCA tracks how it resolves its cases. A complex intervention means that the Advocate spent more than two hours on the case. A direct intervention means that the HCA Advocate made at least one call on behalf of the client.

Case Outcomes Q2FY2023

Brief Analysis and or Advice	383
Direct Intervention	44
Complex Intervention	56
Brief Analysis and or Referral	280
Case Still Open by the End of the Quarter	49
Duplicate Case	26
Other	12
Client Withdrew	4
Test Case	1

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 on one premium price change request during the quarter from April 1, 2023, through June 31, 2023. Six premium price change requests were pending at the close of the quarter.

On May 11, 2023, the Board issued a Decision and Order related to the 2024 Blue Cross and Blue Shield of Vermont (BCBSVT) Large Group Filing. BCBSVT requested a price increase of 10.8% for this block of business. The Board approved a 9.8% price increase. The HCA appeared on behalf of Vermonters in this matter and took all appropriate actions to represent the best interests of Vermonters in this matter.

There were six premium price change requests pending at the close of this quarter. Four of these pending filings are the 2024 Vermont Health Connect (VHC) filings: the 2024 BCBSVT Small Group VHC filing (BCBSVT Small Group); the 2024 BCBSVT Individual Group VHC filing (BCBSVT Individual); the 2024 MVP Small Group VHC filing (MVP Small Group); and the 2024 MVP Individual Group VHC filing (MVP Individual). For 2024, as was the case in 2022 and 2023, there are four filings instead of two, because the legislature opted to keep the individual and small group markets unmerged for another year.

The BCBSVT Small Group filing impacts roughly 21,943 Vermonters and BCBSVT is requesting an average premium price increase of 14.5% for this book of business. The BCBSVT Individual filing impacts roughly 18,517 Vermonters and BCBSVT is requesting an average premium increase of 15.5% for this book of business. The MVP Small Group filing impacts roughly 16,262 Vermonters and MVP is requesting an average premium increase of 12.5% for this book of business. The MVP Individual filing affects roughly 11,602 Vermonters and MVP is requesting an average premium price increase of 12.8% for this book of business. The HCA has appeared on behalf of Vermonters in all four of these matters. Further, the HCA will file all appropriate memoranda and other documents. In addition, the HCA will appear at the hearings on these matters to question the carriers' witnesses and provide affirmative testimony in its role representing the interests of Vermonters in proceedings before the Board.

The two other premium price change requests pending at of the close of the quarter are the BCBSVT Association Health Plan filing and the BCBSVT Large Group Unit Cost Trend filing. The HCA has appeared in both matters and will continue to take all appropriate actions to represent the best interests of Vermonters in the matters.

Hospital Budgets

The HCA Is currently reviewing FY24 hospital budget submissions in preparation for annual hearings conducted by the GMCB in August. Given the high charge requests again this year, the HCA plans to raise concerns rooted in lack of affordability for Vermonters and Vermont families.

Certificate of Need Review Process

The HCA has statutory authority to assert interested party status in certificate of need (CON) proceedings before the GMCB. The HCA continues to advise the GMCB as they review a CON application by University of Vermont Medical Center (UVMMC) to build a new Outpatient Surgery Center (MCB-004-

23con). We continue to actively monitor certificate of need applications as they are submitted and assert party status when the interests of Vermonters are clearly impacted.

Oversight of Accountable Care Organizations

The HCA continues to provide both written and oral comments as a part of the FY23 OneCare Vermont (OCV) budget hearing process, the FY24 budget guidance process for OneCare Vermont, and the FY24 Medicare-Only ACO budget guidance. 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.

Global Budget Technical Advisory Group

The HCA is a member of the Global Budget Technical Advisory group convened by both the GMCB and the Agency of Human Services. This group met four times this quarter exploring the technical options that may be available to Vermont. This discussion hinges significantly on decisions at CMS and whether there are options for a Vermont agreement with CMS that will work for our state.

The Medicaid and Exchange Advisory Committee

The Advisory Committee met three times this quarter. The content of this quarter's meetings included a focus on messaging and planning for the PHE Unwind, The Vermont 1115 Global Commitment Waiver, CAHPS Survey, Durable Medical Equipment access, The Camden Coalition work in Vermont and the Health Benefits Eligibility and Enrollment HBEE Rule Revisions.

Legislative Advocacy

This quarter included the conclusion of the first year of the Legislative Biennium. The Chief Advocate spent considerable time this quarter engaging with new and incumbent legislators to make sure they are aware of the HCA as a resource for their constituents, as well as promoting an agenda that continues to focus on key improvements to our health care system. Our primary focus on Medicare Savings Plan eligibility as well as Immigrant Health Insurance coverage resulted in the introduction of bills in the house and senate on both topics. We remain hopeful that next year the Legislature will devote some of its precious time on these policy areas.

The HCA participated in several legislative discussions on the following bills.

H.494 An act relating to making appropriations for the support of government. The HCA actively advocated for an increase in the Medicaid dental cap as well as funding for the Bridges to Health program in addition to stated support for numerous other parts of the bill. The bill passed the House and Senate, was vetoed by the Governor and the legislature overrode the Veto.

S.54 An act relating to individual and small group insurance markets. The HCA supported this bill which extends the current practice of rating the individual and small groups separately for 2024 and 2025. The bill has passed both the House and the Senate and was delivered to the Governor on April 12th.

S.36 An act relating to permitting an arrest without a warrant for assaults and threats against health care workers and disorderly conduct at health care facilities. The HCA supported a balanced approach to this bill that recognized the stated needs of the workers in Emergency Departments and first responders and recognized the risks of bringing more law enforcement into the health care setting. We supported a narrowing of the disorderly conduct in this bill as well a significant narrowing of the health care facilities where warrantless arrests could be called for. The bill has passed the Senate and House and was signed by the Governor.

S.9 An act relating to the authority of the State Auditor to examine the books and records of State contractors. The HCA supported this bill in the Senate recognizing the importance of an independent auditor's ability to safeguard taxpayer dollars even when those monies flow through independent contractors. The bill passed the Senate and remained in House Government Operations at the end of the session.

S.37 An act relating to access to legally protected health care activity and regulation of health care providers. The HCA supported this bill. The bill passed the senate and the House and was signed by the Governor.

S.65 An act relating to commercial insurance coverage of epinephrine auto-injectors. The HCA supported this bill once it was fashioned to comply with high deductible health plans. The bill passed the Senate and remained in House Health Care at the end of the session.

S.79 An act relating to limitations on hospital liens. The HCA Supported this bill and joined with a small group of advocates to find a compromise. The HCA had fought for protections for patients who are eligible for a hospital's free care policy from Hospital Liens, but compromised as the bill is a step in the right direction. The bill passed the Senate Judiciary Committee after crossover and is currently in Senate Rules. The language of S.79 was attached to H.206 in the Senate and passed through all stages with that bill.

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 recently worked with the following organizations:

- American Civil Liberties Union of Vermont
- All Copays Count Coalition
- Bi-State Primary Care
- Blue Cross Blue Shield of Vermont
- Committee on Vermont Elders
- Department of Financial Regulation
- Families USA
- The Family Room
- The Howard Center
- 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
- Parent University
- 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 Cheese Council
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Health Connect
- Vermont Health Care for All
- Vermont Interfaith Action (VIA)Vermont Language Justice Project
- Vermont Medical Society
- Vermont – NEA
- Vermont Professionals of Color Network
- 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. *Health* - section home page – 1,666
2. *Dental Services* – 1,529
3. *Income Limits - Medicaid* – 1,305 pageviews
4. *Medicaid, Dr. Dynasaur & Vermont Health Connect* – 593
5. *Medicare Savings Programs* – 467
6. *Long-Term Care* – 429
7. *Dr. Dynasaur* – 386
8. *Medicaid* – 385
9. *Medical Decisions: Advance Directives* – 385
10. Resource Limits - Medicaid – 382
11. Services Covered – Medicaid – 377
12. *HCA Help Request Form* – 346 pageviews and 131 online help requests
13. *Advance Directive forms* – 345
14. Federally Qualified Health Centers – 222
15. Choices for Care Income Limits – 221
16. Medicaid and Medicare (Dual Eligible) – 219 *
17. Vermont Health Connect – 219
18. Choices for Care Giving Away Property or Resources – 214
19. Complaints About Doctors and Other Providers – 214 *
20. *Choices for Care* – 194

This quarter we had these additional news items:

- Medicaid Renewal Process Starts Again in April – 500 pageviews
- Your Benefits and the Public Charge Rule for Immigration – 26

Outreach and Education

The Office of the Health Care Advocates (HCA) engaged in both in-person and virtual outreach activities this quarter. The HCA engages with Vermonters via social media, partnering with community organizations to develop referral relationships, outreach presentations, the circulation of virtual education videos, and legal clinics. Our office prioritized raising the visibility of our Helpline through a variety of different platforms to ensure that we are reaching Vermont residents from different geographic, language, and age demographics.

From April to June of 2023, we partnered with 22 organizations and participated in 16 outreach presentations as a means of providing accurate and accessible information on insurance eligibility and health care policy. Some of these organizations included the:

- Vermont Worker's Center
- Parent University
- The Family Room
- The Vermont Cheese Council
- The Howard Center
- Vermont Language Justice Project
- Vermont Professionals of Color Network

Much of our outreach efforts this quarter were focused on spreading accurate and accessible information related to the Medicaid renewal process. Our approach to this work included the delivery of outreach presentations, the development of streamlined referral systems, and the distribution of messaging toolkits.

Our office continued to use virtual platforms such as Facebook, Instagram, Zoom, and YouTube to connect with partner organizations and deliver legal education presentations. We used Facebook and Instagram to share important updates on a variety of health care related topics. Our messaging primarily highlighted new special enrollment periods for Qualified Health Plans, expanded Dr. Dynasaur postpartum coverage, and Medicaid dental access.

To prioritize language access in our Medicaid renewal outreach, we partnered with the Vermont Language Justice Project to produce a short video titled "Open the Envelope," which discussed Medicaid renewal notices. These videos were translated into 17 different languages, and they have been collectively viewed over 1,236 times on YouTube and Facebook.

The HCA also provided in-person case support through a legal help clinic. These clinics were developed in collaboration with Vermont Legal Aid and the Old North End Community Center. The Old North End Community Center houses organizations such as AALV, the Family Room, the New American Clinic, and the Champlain Senior Center. The HCA organized two clinics where community members connected with legal advocates to get free and confidential advice. Childcare and in-person interpretation were available to support people seeking our assistance.

Additionally, the HCA participated in tabling events in Chittenden and Washington County to expand our office's name recognition through in-person connections. On April 29th, members of our Advocacy Team participated in the spring Mexican Consulate event in Montpelier. This event enabled us to make

connections with Vermont residents who immigrated from Mexico. We were able to provide this population with information about our office's services and consumer education on insurance eligibility and patient financial assistance. On May 25th, we participated in a community resource series in collaboration with Parent University, the Burlington Electric Department, and Energy Efficiency Vermont. The primary audience of this series were Burlington residents with language needs. This outreach event enabled us to connect with these individuals so they could become familiar with their services.

Office of the Health Care Advocate

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

https://vtlawhelp.org/health

Attachment 5

DY18 Investment Expenditures

Department	Final Receiver Suffix	Investment Description	QE 0922	QE 1222	DY18 Total	
AHSCO	9090	Designated Agency Underinsured Services	1,704,648	1,778,704	**3,483,352**	
AHSCO	9421	HCBS Investment - Workforce Recruitment & Retention Program	9,928,667	6,891,941	**16,820,608**	NEW - HCBS Investment
DCF	9402	Medical Services	107,476	49,373	**156,849**	
DCF	9405	Aid to the Aged, Blind and Disabled CCL Level III	973,859	990,538	**1,964,397**	
DCF	9406	Aid to the Aged, Blind and Disabled Res Care Level III	26,515	27,151	**53,666**	
DCF	9407	Aid to the Aged, Blind and Disabled Res Care Level IV	59,070	59,160	**118,230**	
DCF	9408	Essential Person Program	190,058	179,739	**369,797**	
DCF	9409	GA Medical Expenses	32,349	43,450	**75,799**	
DCF	9411	Therapeutic Child Care	322,904	431,552	**754,456**	
DCF	9414	Prevent Child Abuse Vermont: Nurturing Parent	18,091	25,752	**43,843**	
DCF	9415	Challenges for Change: DCF	31,537	45,188	**76,725**	
DCF	9416	Strengthening Families	225,190	59,615	**284,805**	
DCF	9417	Lamoille Valley Community Justice Project	45,903	-	**45,903**	
DCF	9418	Building Bright Futures	58,585	88,263	**146,848**	
DCF	9419	United Ways 2-1-1	113,235	113,183	**226,418**	
DAIL	9421	HCBS Investment - Bonus Payment to HCBS Providers	2,859,351		**2,859,351**	NEW - HCBS Investment
DAIL	9602	Mobility Training/Other Svcs.-Elderly Visually Impaired	89,128	101,820	**190,948**	
DAIL	9603	DS Special Payments for Medical Services	71,918	731,030	**802,948**	
DAIL	9604	Flexible Family/Respite Funding		484,634	**484,634**	
DAIL	9606	Support and Services at Home (SASH)		492,401	**492,401**	
DAIL	9607	HomeSharing	73,451	69,764	**143,215**	
DAIL	9608	Self-Neglect Initiative	126,099	-	**126,099**	
DMH	9501	Special Payments for Treatment Plan Services	22,221	14,856	**37,077**	
DMH	9502	Mental Health Outpatient Services for Adults	27,083	1,389,189	**1,416,272**	
DMH	9504	Mental Health Consumer Support Programs	55,948	165,987	**221,935**	
DMH	9505	Mental Health CRT Community Support Services		13,114	**13,114**	
DMH	9506	Mental Health Children's Community Services	66,669	1,083,216	**1,149,885**	
DMH	9507	Emergency Mental Health for Children and Adults		4,586,400	**4,586,400**	
DMH	9508	Respite Services for Youth with SED and their Families		631,554	**631,554**	
DMH	9511	Institution for Mental Disease Services: DMH - VPCH	7,467,669	9,108,662	**16,576,331**	
DMH	9512	Institution for Mental Disease Services: DMH - BR	(4,316)	(34,446)	**(38,762)**	
DMH	9514	Seriously Functionally Impaired: DMH	9,405	(1,182)	**8,223**	
DMH	9516	Acute Psychiatric Inpatient Services	217,650	249,796	**467,446**	
DOC	n/a	Return House	107,075	43,564	**150,639**	
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	Community Rehabilitative Care	854,120	-	**854,120**	
DVHA	9102	Vermont Blueprint for Health	644,937	945,505	**1,590,442**	
DVHA	9103	Buy-In	1,021	1,691	**2,712**	
DVHA	9104	HIV Drug Coverage		-	**-**	
DVHA	9106	Patient Safety Net Services	181	29,622	**29,803**	
DVHA	9107	Institution for Mental Disease Services: DVHA	1,301,961	2,100,135	**3,402,096**	
DVHA	9110	One Care VT ACO Advanced Community Care Coordination		(165,521)	**(165,521)**	
VDH	9201	Emergency Medical Services	168,200	221,033	**389,233**	
VDH	9203	TB Medical Services	501	-	**501**	
VDH	9204	Epidemiology	243,388	285,870	**529,258**	
VDH	9205	Health Research and Statistics	312,978	370,397	**683,375**	*Admin Investment
VDH	9206	Health Laboratory	867,223	1,055,555	**1,922,778**	
VDH	9207	Tobacco Cessation: Community Coalitions	335,124	461,330	**796,454**	
VDH	9209	Family Planning	259,050	182,769	**441,819**	
VDH	9210	Physician/Dentist Loan Repayment Program	353,500	1,867,253	**2,220,753**	
VDH	9213	WIC Coverage	315,422	999,512	**1,314,934**	
VDH	9214	Area Health Education Centers (AHEC)	355,239	-	**355,239**	
VDH	9217	Patient Safety - Adverse Events	22,559	11,033	**33,592**	*Admin Investment
VDH	9219	Substance Use Disorder Treatment	549,503	176,012	**725,515**	
VDH	9220	Recovery Centers	436,133	516,534	**952,667**	
VDH	9221	Enhanced Immunization	85,875	79,405	**165,280**	
VDH	9222	Poison Control		34,834	**34,834**	
VDH	9223	Public Inebriate Services, C for C	258,998	76,196	**335,194**	
VDH	9224	Fluoride Treatment	17,480	25,132	**42,612**	
VDH	9226	Healthy Homes and Lead Poisoning Prevention Program	47,416	56,301	**103,717**	
VDH	9228	VT Blueprint for Health	190,201	305,466	**495,667**	
VDH	9421	HCBS Investment - Pediatric Pallative Care Program Supply Carts	333	-	**333**	NEW - HCBS Investment
VSC	n/a	Health Professional Training	409,461		**409,461**	
			33,327,722	**40,064,329**	**73,392,051**	
			33,327,722	40,064,329	101,775,000	DY18 limit
					28,382,949	remaining

DY19 Investment Expenditures

Department	Final Receiver Suffix	Investment Description	QE 0323	QE 0623	DY19 Total	
AHSCO	9090	Designated Agency Underinsured Services	1,778,704	1,852,759	**3,631,463**	
AHSCO	9421	HCBS Investment - Workforce Recruitment & Retention Program	3,365,373	393,700	**3,759,073**	NEW - HCBS Investment
AHSCO	9421	HCBS Investment - Innovative Solutions to Enhance and Strengthen HCBS	-	74,565	**74,565**	NEW - HCBS Investment
DCF	9400	Investments - Balance and Restorative Justice	-	245,675	**245,675**	NEW
DCF	9402	Medical Services	51,809	21,535	**73,344**	
DCF	9405	Aid to the Aged, Blind and Disabled CCL Level III	1,194,513	970,142	**2,164,655**	
DCF	9406	Aid to the Aged, Blind and Disabled Res Care Level III	32,943	26,578	**59,521**	
DCF	9407	Aid to the Aged, Blind and Disabled Res Care Level IV	70,334	56,189	**126,523**	
DCF	9408	Essential Person Program	193,603	199,732	**393,335**	
DCF	9409	GA Medical Expenses	32,345	43,787	**76,132**	
DCF	9411	Therapeutic Child Care	325,485	276,560	**602,045**	
DCF	9414	Prevent Child Abuse Vermont: Nurturing Parent	20,163	34,334	**54,497**	
DCF	9415	Challenges for Change: DCF	38,787	96,291	**135,078**	
DCF	9416	Strengthening Families	243,244	450,628	**693,872**	
DCF	9417	Lamoille Valley Community Justice Project	-	-	**-**	
DCF	9418	Building Bright Futures	114,319	70,876	**185,195**	
DCF	9419	United Ways 2-1-1	113,200	113,200	**226,400**	
DAIL	9421	HCBS Investment	-	(2,394)	**(2,394)**	NEW - HCBS Investment
DAIL	9602	Mobility Training/Other Svcs.-Elderly Visually Impaired	92,642	93,253	**185,895**	
DAIL	9603	DS Special Payments for Medical Services	619,132	937,839	**1,556,971**	
DAIL	9604	Flexible Family/Respite Funding	368,699	308,238	**676,937**	
DAIL	9606	Support and Services at Home (SASH)	245,011	245,349	**490,360**	
DAIL	9607	HomeSharing	69,427	69,522	**138,949**	
DAIL	9608	Self-Neglect Initiative	130,158	-	**130,158**	
DMH	9421	HCBS Investment	-	(551)	**(551)**	NEW - HCBS Investment
DMH	9501	Special Payments for Treatment Plan Services	12,761	-	**12,761**	
DMH	9502	Mental Health Outpatient Services for Adults	1,070,339	-	**1,070,339**	
DMH	9504	Mental Health Consumer Support Programs	104,739	-	**104,739**	
DMH	9505	Mental Health CRT Community Support Services	13,104	-	**13,104**	
DMH	9506	Mental Health Children's Community Services	337,504	-	**337,504**	
DMH	9507	Emergency Mental Health for Children and Adults	-	-	**-**	
DMH	9508	Respite Services for Youth with SED and their Families	311,344	-	**311,344**	
DMH	9511	Institution for Mental Disease Services: DMH - VPCH	8,472,209	-	**8,472,209**	
DMH	9512	Institution for Mental Disease Services: DMH - BR	-	-	**-**	
DMH	9514	Seriously Functionally Impaired: DMH	13,178	-	**13,178**	
DMH	9516	Acute Psychiatric Inpatient Services	1,550,673	(405,757)	**1,144,916**	
DOC	n/a	Return House	49,807	57,311	**107,118**	
DOC	n/a	Pathways to Housing - Transitional Housing	374,723	412,945	**787,668**	
DOC	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)	76,432	70,680	**147,112**	
DOC	n/a	Northeast Kingdom Community Action	29,245	12,093	**41,338**	
DOC	n/a	Community Rehabilitative Care	1,810,081	82,054	**1,892,135**	
DVHA	9421	HCBS Investment	-	(258)	**(258)**	
DVHA	9102	Vermont Blueprint for Health	914,380	525,984	**1,440,364**	
DVHA	9103	Buy-In	1,319	1,154	**2,473**	
DVHA	9104	HIV Drug Coverage	20	-	**20**	
DVHA	9106	Patient Safety Net Services	35,538	174,875	**210,413**	
DVHA	9107	Institution for Mental Disease Services: DVHA	-	-	**-**	RETIRED
VDH	9201	Emergency Medical Services	252,798	207,803	**460,601**	
VDH	9204	Epidemiology	238,553	269,566	**508,119**	
VDH	9205	Health Research and Statistics	310,605	314,423	**625,028**	*Admin Investment
VDH	9206	Health Laboratory	816,411	1,244,441	**2,060,852**	
VDH	9207	Tobacco Cessation: Community Coalitions	526,666	252,004	**778,670**	
VDH	9209	Family Planning	266,059	253,421	**519,480**	
VDH	9210	Physician/Dentist Loan Repayment Program	908,466	-	**908,466**	
VDH	9213	WIC Coverage	1,025,841	1,675,190	**2,701,031**	
VDH	9214	Area Health Education Centers (AHEC)	174,030	-	**174,030**	
VDH	9217	Patient Safety - Adverse Events	11,726	38,406	**50,132**	*Admin Investment
VDH	9219	Substance Use Disorder Treatment	880,802	2,270,356	**3,151,158**	
VDH	9220	Recovery Centers	661,381	632,061	**1,293,442**	
VDH	9221	Enhanced Immunization	72,609	384,433	**457,042**	
VDH	9222	Poison Control	38,822	39,355	**78,177**	
VDH	9223	Public Inebriate Services, C for C	567,220	283,431	**850,651**	
VDH	9224	Fluoride Treatment	18,319	26,694	**45,013**	
VDH	9226	Healthy Homes and Lead Poisoning Prevention Program	53,208	49,345	**102,553**	
VDH	9228	VT Blueprint for Health	463,589	405,802	**869,391**	
VDH	9421	HCBS Investment - Pediatric Pallative Care Program Supply Carts	49	4,377	**4,426**	NEW - HCBS Investment
VDH	9421	HCBS Investment - Expand VTHelplink	-	51,320	**51,320**	NEW - HCBS Investment
VSC	n/a	Health Professional Training	-	-	**-**	
			31,564,441	**15,911,316**	**47,475,757**	
			31,564,441	15,911,316	185,127,500	DY19 limit
					137,651,743	remaining

Transitional Housing

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

Most Recent Period | Current Actual Value

Why Is This Important?

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

P GCI Transitional Housing Services

Most Recent Period | Current Actual Value

What We Do

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

Who We Serve

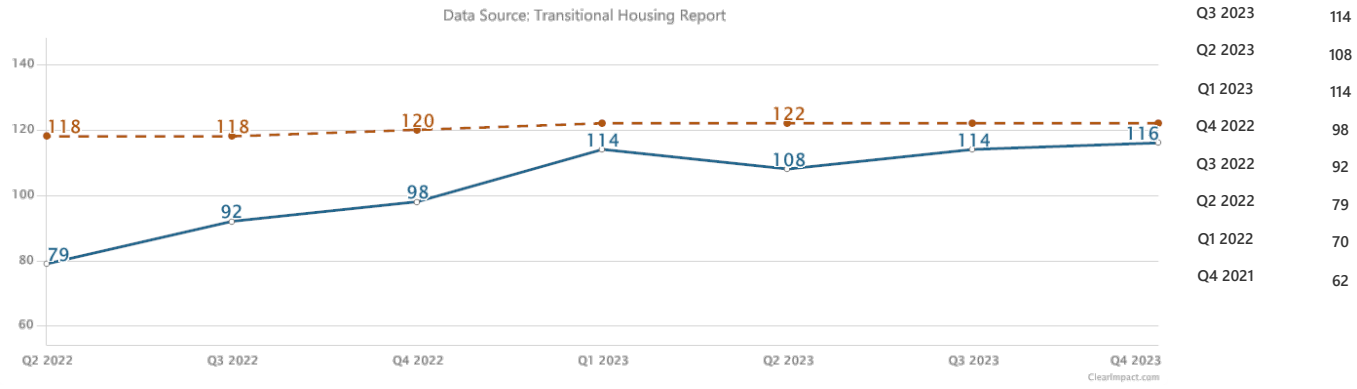
Reintegrative housing funded by the Department of Corrections is targeted to support those with complex needs to rejoin their community safely. The individuals we serve have conditions (including, but not limited to) mental health challenges, substance misuse, developmental disabilities, severe functional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

How We Impact

Our program activities are designed to facilitate our targeted outcomes:

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

PM GCI Number of Individuals Served



Q4 2023	116
Q3 2023	114
Q2 2023	108
Q1 2023	114
Q4 2022	98
Q3 2022	92
Q2 2022	79
Q1 2022	70
Q4 2021	62

Story Behind the Curve

The number of individuals served can fluctuate over time depending on the circumstance of people in the program and the circumstance of people scheduled for release. The quarterly target (FY23) for number of people served was 122 for each quarter. The actual number of people served in FY23 averaged 93% of the target.

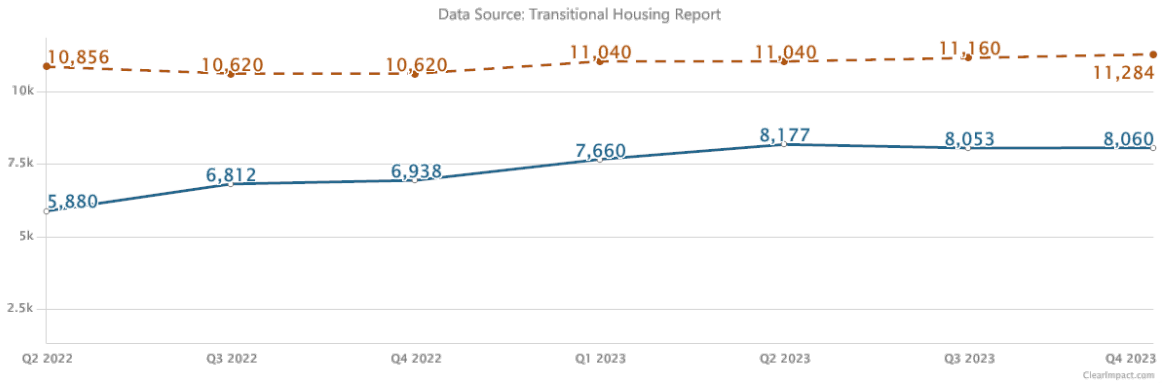
FY22 was the first year of a new grant cycle after a significant shift in the housing model DOC supports, away from congregate sober housing to more independent apartments with wraparound services. Given that Vermont has a severe lack of affordable housing, it mook most of the year for programs to add new apartments to their portfolio.

Partners

What Works

Action Plan

PM HW Bed Days Utilized



Q4 2023	8,060
Q3 2023	8,053
Q2 2023	8,177
Q1 2023	7,660
Q4 2022	6,938
Q3 2022	6,812
Q2 2022	5,880
Q1 2022	4,610
Q4 2021	1,389

Story Behind the Curve

Bed utilization fluctuates each quarter because of the variability in individuals' circumstances. The bed days for FY23 totaled 31,950 which was 72% of our annual target (44,524). The quarterly target for FY23 ranged from 11,040 to 11,284 as more beds were added to programs. While we are below our annual targets, we are meeting at minimum 69% of our target bed days utilized.

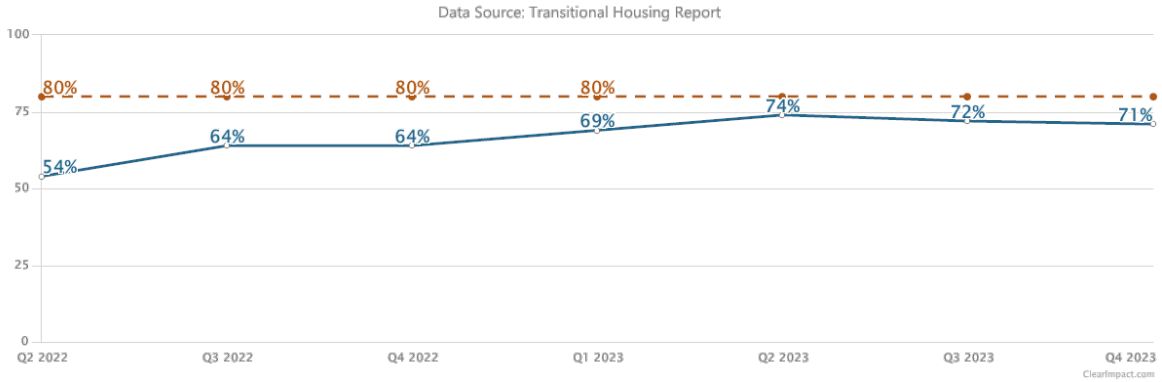
The target represents 100% utilization, 365 days a year. Our metric goal is 80% utilization.

Partners

What Works

Action Plan

PM HW Percent of Beds Utilized



Q4 2023	71%
Q3 2023	72%
Q2 2023	74%
Q1 2023	69%
Q4 2022	64%
Q3 2022	64%
Q2 2022	54%
Q1 2022	42%
Q4 2021	59%

Story Behind the Curve

Overall utilization for FY23 was 72%, which was a 16% increase from FY22. The target for FY23 was 80%; thus, we were below the target percent of beds utilized by an average of only 8% for FY23.

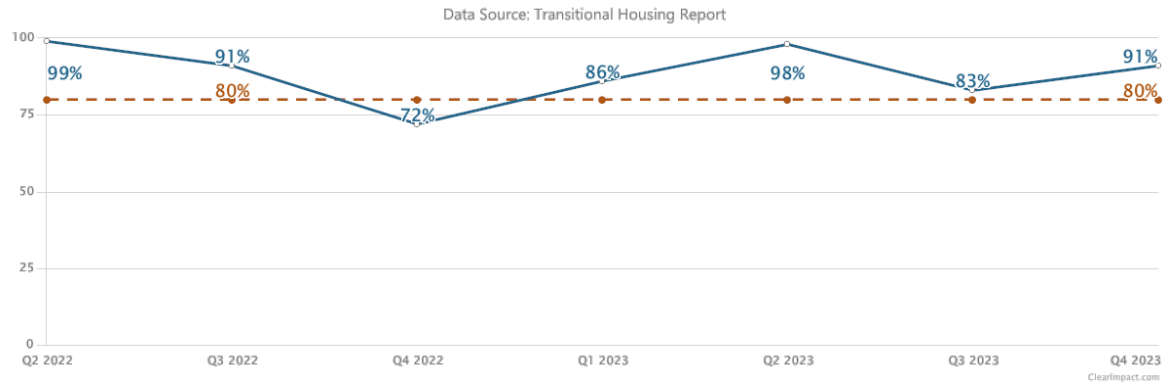
Utilization has steadily improved as we have brought new apartments into the program and are transitioning out of the COVID-19 pandemic.

Partners

What Works

Action Plan

PM HW Percent of Referrals Accepted



Q4 2023	91%
Q3 2023	83%
Q2 2023	98%
Q1 2023	86%
Q4 2022	72%
Q3 2022	91%
Q2 2022	99%
Q1 2022	94%
Q4 2021	90%

Story Behind the Curve

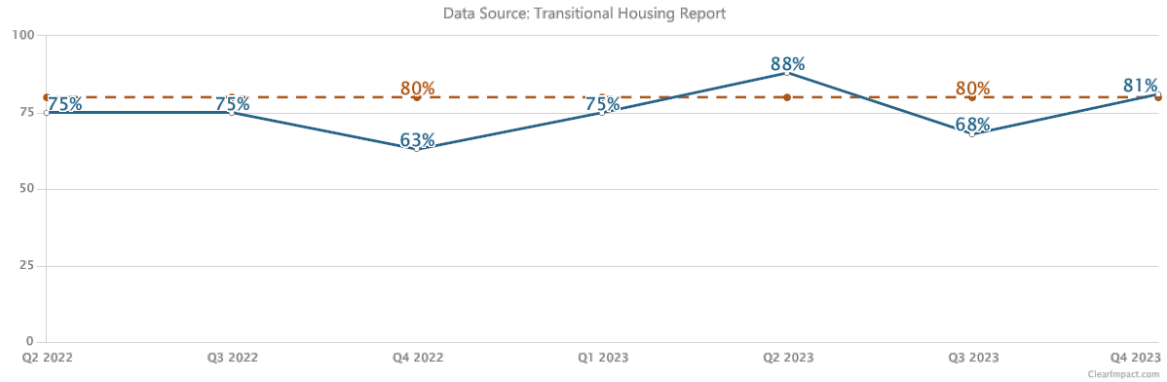
In FY23, we were consistently above the target of 80% referrals accepted with an average of 90%. In Q2 of FY23, we were above our quarterly target for percent of referrals accepted by 18% with 98% of referrals accepted.

Partners

What Works

Action Plan

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



Q4 2023	81%
Q3 2023	68%
Q2 2023	88%
Q1 2023	75%
Q4 2022	63%
Q3 2022	75%
Q2 2022	75%
Q1 2022	57%
Q4 2021	40%

Story Behind the Curve

Overall, the percent of participants employed, enrolled in an educational/training program, or receiving benefits at exit for FY23 was 77%, which is only 3% below our annual target of 80%. The continuously higher percentage demonstrated in FY22-23 compared to FY21 is because employers are more willing to hire people with criminal records due to a workforce shortage. This measure only captures a participants' status upon exit from the program which may have happened over the course of the program.

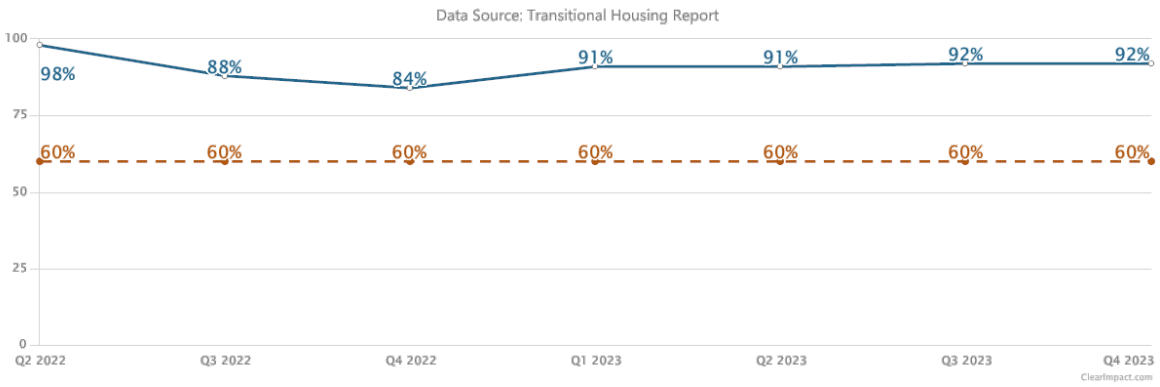
Partners

What Works

Action Plan

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

Q4 2023	92%



Q3 2023	92%
Q2 2023	91%
Q1 2023	91%
Q4 2022	84%
Q3 2022	88%
Q2 2022	98%
Q1 2022	97%
Q4 2021	99%

Story Behind the Curve

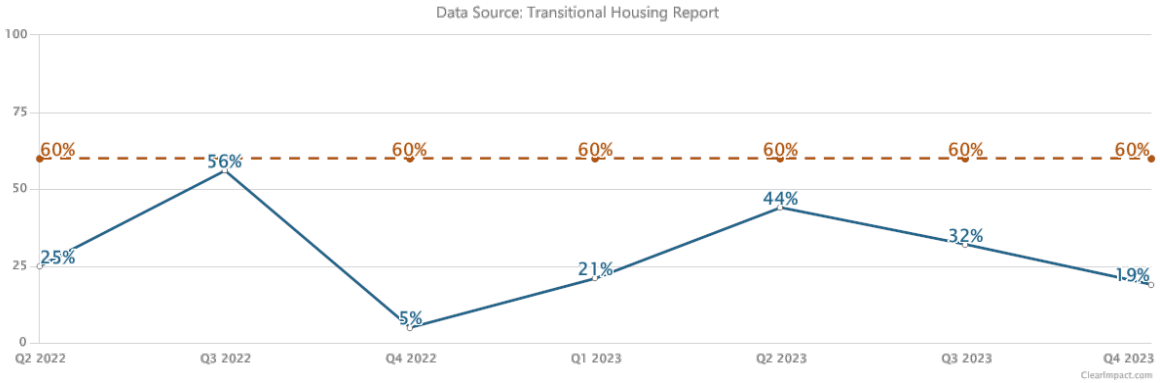
Remaining crime free is significantly associated with successful reentry. In FY23, an average of 93% of program participants remained crime free while in the program (well above our 60% annual target). We have been consistently above our FY23 quarterly target (60%), with a high of 99% of program participants remaining crime free while in the program.

Partners

What Works

Action Plan

PM BO Percent of Participants Exiting to Permanent Housing



Q4 2023	19%
Q3 2023	32%
Q2 2023	44%
Q1 2023	21%
Q4 2022	5%
Q3 2022	56%
Q2 2022	25%
Q1 2022	29%
Q4 2021	20%

Story Behind the Curve

The percentage of people who exit transitional housing to permanent housing varies across time due to the high variable nature of individuals' circumstances. In FY23, and a total of 27% of program participants exited the program to permanent housing, which is 33% below our 60% annual target.

There is a severe affordable housing shortage in Vermont, which was exacerbated by the far-reaching impacts of the global COVID-19 pandemic, along with inflation and substantial rent increases. Landlords are hesitant to rent to individuals with complex needs and the market is so competitive that it is very difficult to locate permanent housing. We are also seeing an increase in the severity of substance misuse and mental health challenges among supervised individuals, which makes the transition to permanent housing even more challenging.

Partners

What Works

Action Plan

Strengthening Families Child Care Program

Promotes high quality comprehensive early care and education and afterschool programs for at-risk children and families.

P DCF **Strengthening Families Child Care**

Most Recent Period | Current Actual Value | Current Trend | Baseline % Change

What We Do

Strengthening Families Child Care provides grants to 28 community child care programs throughout Vermont to ensure affordable access to high quality comprehensive early care and education and afterschool programs for children and families challenged by economic instability and other environmental risk factors.

Who We Serve

These grants serve:

- Children/families eligible for and participating in the CDD Child Care Financial Assistance Program (at least 25% of enrolled children).
- Children/families who are receiving specialized child care services: including children with an open case with the Family Services Division of the Department for Children and Families (including foster children), children in families participating in Reach Up, refugee children and teen parents.

How We Impact

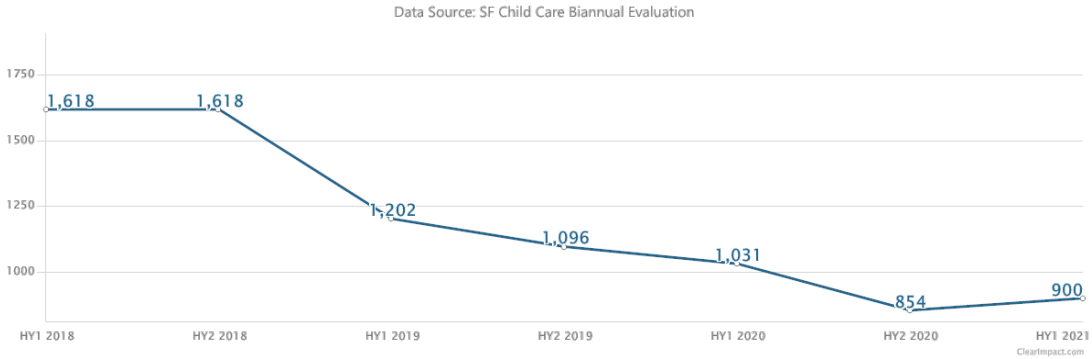
The following impacts on intended by these grants:

- Documented use of the Center for Social Policy Strengthening Families Program Assessment tool through submission of outcomes and related program plan.
- Continuity of care improves as measured by attendance records and compared to participants in CCFAP including specialized care in other non Strengthening Families programs.
- 70% of parents report positive family experiences (protective factors) as part of their overall experience of having an enrolled child in the program.

Budget Information

Strengthening Families Child Care	FY22 Actual	FY23 Projected	FY24 Governor Recommended
Program Budget	$1,024,282	$1,050,000	$1,110,000 (not final)

PM CDD # of children enrolled

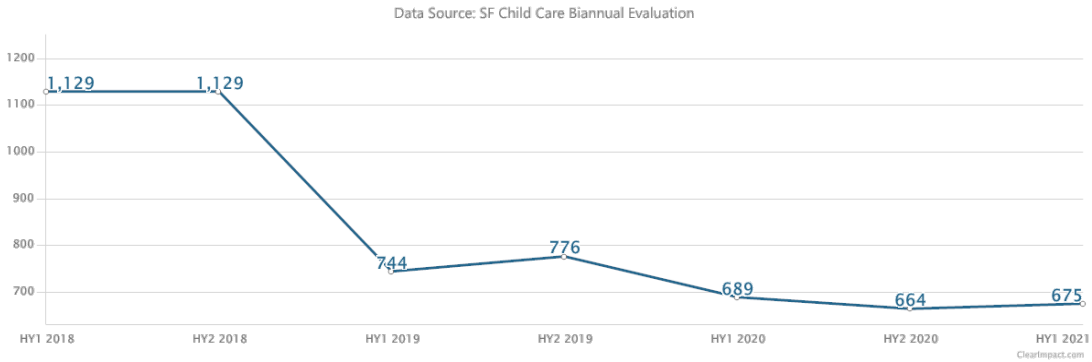


HY1 2021	900	↗ 1	-48% ↘
HY2 2020	854	↘ 4	-50% ↘
HY1 2020	1,031	↘ 3	-40% ↘
HY2 2019	1,096	↘ 2	-36% ↘
HY1 2019	1,202	↘ 1	-30% ↘
HY2 2018	1,618	→ 1	-6% ↘
HY1 2018	1,618	↘ 3	-6% ↘
HY2 2017	1,672	↘ 2	-3% ↘
HY1 2017	1,681	↘ 1	-2% ↘

Story Behind the Curve

Over the past 3 years some programs that were participating in Strengthening Families chose to no longer participate. They found they could support families in the same way by fully utilizing the Child Care Financial Assistance Program (CCFAP). In addition, one program closed. As the number of programs decreased the number of children in all of Strengthening Families decreased. In July 2018, a new round of Strengthening Families grants were put into place, with 24 grantees. This is a smaller number of grantees than in the past, which is one of the factors of why fewer children were served in FY19. In March 2020 Vermont experienced a child care closure due to COVID-19. Since the closure the number of families using any child care in the state has decreased, including the enrollment at Strengthening Families grantee programs.

PM CDD # of CCFAP participants enrolled



HY1 2021	675	↗ 1	-39% ↘
HY2 2020	664	↘ 2	-40% ↘
HY1 2020	689	↘ 1	-37% ↘
HY2 2019	776	↗ 1	-29% ↘
HY1 2019	744	↘ 1	-32% ↘
HY2 2018	1,129	→ 1	3% ↗
HY1 2018	1,129	↗ 2	3% ↗
HY2 2017	920	↗ 1	-16% ↘
HY1 2017	904	↘ 1	-18% ↘

Story Behind the Curve

In 2017 two programs participating in Strengthening Families chose to no longer participate and receive grant funds, as they found they could support families in the same way by fully utilizing the Child Care Financial Assistance Program (CCFAP). In addition, one program closed. As the number of programs decreased the number of children in all of Strengthening Families decreased. In July 2018, a new round of Strengthening Families grants were put into place, with 24 grantees. This is a smaller number of grantees than in the past, which is one of the factors of why fewer children were served in FY19. In 2020, as a result of the COVID-19 pandemic families are not utilizing any child care in the numbers they were in the past, as a result the number of CCFAP eligible children is lower in all child care programs in the state.

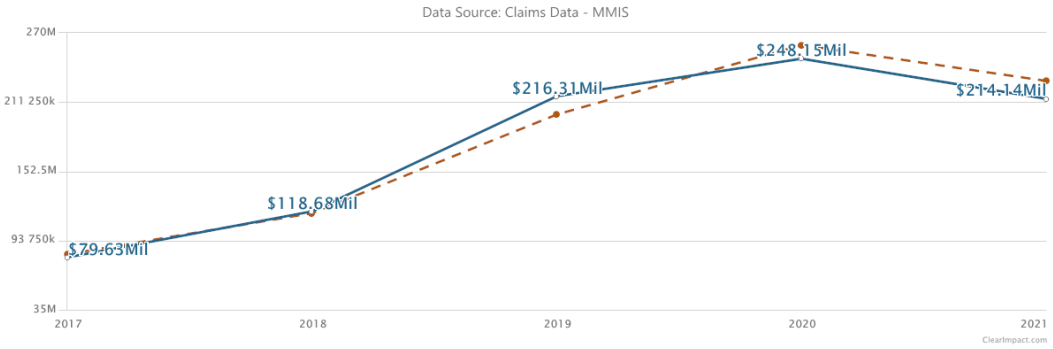
DVHA Payment Model Scorecard

The DVHA Payment Model Scorecard provides a description of the payment reform models managed by the Department, as well as the key measures used to monitor each model's performance. This scorecard is used in part for regular progress reporting to CMS.

O DVHA All Vermonters Are Healthy

	Most Recent Period	Current Actual Value	Current Trend

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



2021	$214.14Mil	1
2020	$248.15Mil	3
2019	$216.31Mil	2
2018	$118.68Mil	1
2017	$79.63Mil	0

Notes on Methodology

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

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

[Please note that final 2021 financial data is currently undergoing internal evaluation and is not publicly available at this time. It is Vermont's intent to report on this data in Q4 2022.]

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

ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible). In order to make year-over-year comparisons for the VMNG program, the expanded attribution population is not included in this measure.

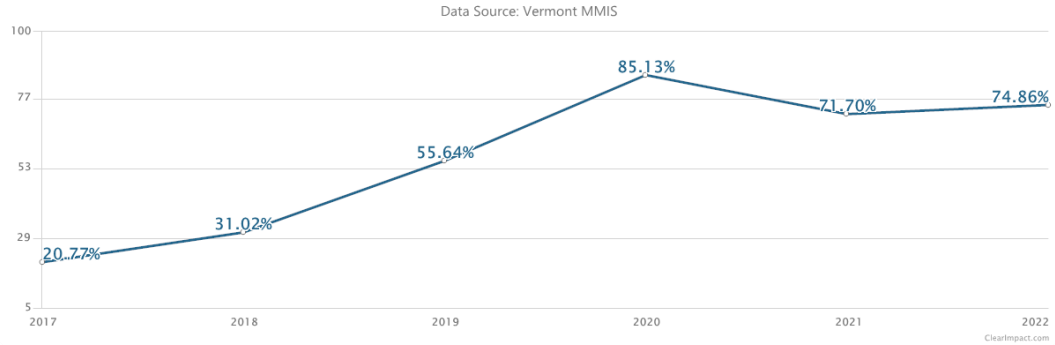
Story Behind the Curve

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

Modifications were made in 2020 and 2021 to the ACO's risk corridor to hold providers harmless for the effects of the COVID-19 pandemic and associated Public Health Emergency (PHE). The VMNG program mirrored modifications at the federal level and reduced the downside risk corridor to be proportionate to the number of months of the program year in which there was an active PHE. For both 2020 and 2021, this reduced the downside risk corridor to 0%.

PM DVHA Percent of Medicaid enrollees aligned with ACO

2022	74.86%	1



2021	71.70%	1
2020	85.13%	3
2019	55.64%	2
2018	31.02%	1
2017	20.77%	0

Notes on Methodology

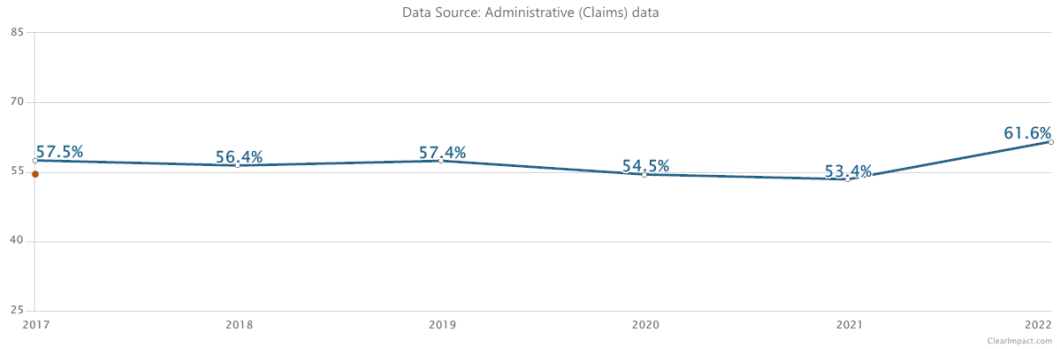
Attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible). In order to make year-over-year comparisons for the VMNG program, the expanded attribution population is not included in the numerator for this measure.

Story Behind the Curve

This measure demonstrates the percentage of the attributable Medicaid population that has been assigned to the VMNG program on an annual basis. Attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible). In order to make year-over-year comparisons for the VMNG program, the expanded attribution population is not included in the numerator for this measure.

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

PM Adolescent Well Care Visits (HEDIS® AWC)



2022	61.6%	1
2021	53.4%	2
2020	54.5%	1
2019	57.4%	1
2018	56.4%	1
2017	57.5%	0

Notes on Methodology

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

ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible). In order to make year-over-year comparisons for the VMNG program, the expanded attribution population is not included in the numerator for this measure.

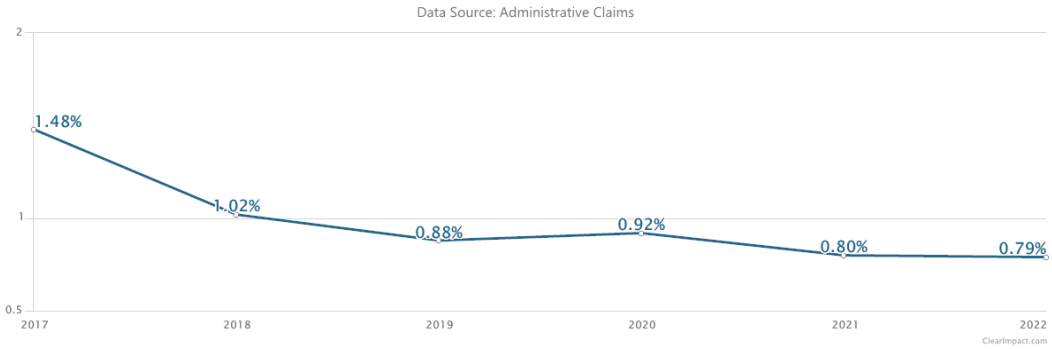
Story Behind the Curve

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

Caution should be exercised when drawing conclusions from the 2020, 2021, and 2022 data. Due to the COVID-19 pandemic and associated Public Health

Emergency (PHE), the utilization of services in 2020, 2021, and 2022 was significantly curtailed or otherwise affected for the entirety of the Medicaid population (including the ACO-attributed population). Further, the increased Medicaid enrollment and lack of redetermination activity during the PHE may also have impacted the quality performance data for those years.

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



2022	0.79%	2
2021	0.80%	1
2020	0.92%	1
2019	0.88%	2
2018	1.02%	1
2017	1.48%	0

Notes on Methodology

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

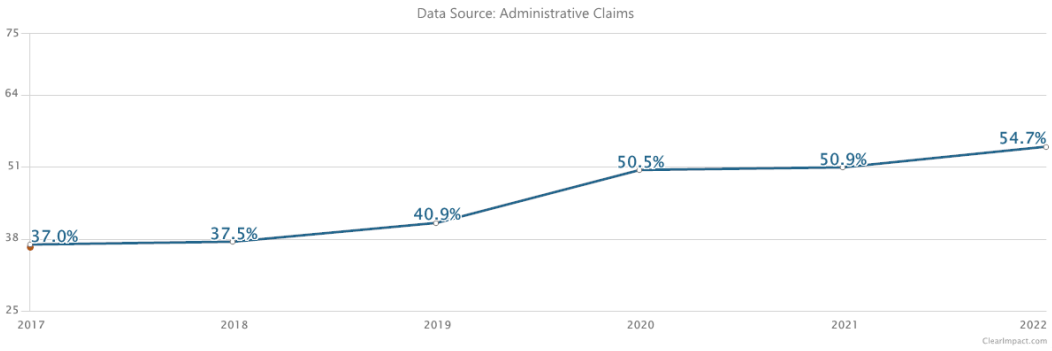
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible). In order to make year-over-year comparisons for the VMNG program, the expanded attribution population is not included in the numerator for this measure.

Story Behind the Curve

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

Caution should be exercised when drawing conclusions from the 2020, 2021, and 2022 data. Due to the COVID-19 pandemic and associated Public Health Emergency (PHE), the utilization of services in 2020, 2021, and 2022 was significantly curtailed or otherwise affected for the entirety of the Medicaid population (including the ACO-attributed population). Further, the increased Medicaid enrollment and lack of redetermination activity during the PHE may also have impacted the quality performance data for those years.

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



2022	54.7%	5
2021	50.9%	4
2020	50.5%	3
2019	40.9%	2
2018	37.5%	1
2017	37.0%	0

Notes on Methodology

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

ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible). In order to make year-over-year comparisons for the VMNG program, the expanded attribution population is not included in the numerator for this measure.

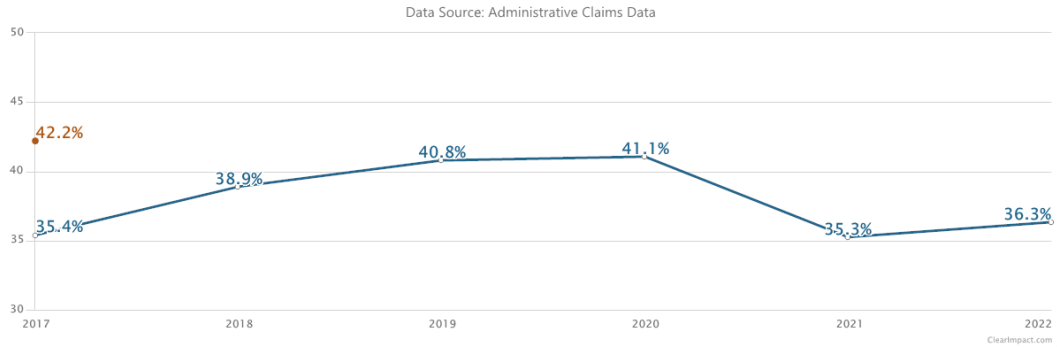
Story Behind the Curve

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

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

Caution should be exercised when drawing conclusions from the 2020, 2021, and 2022 data. Due to the COVID-19 pandemic and associated Public Health Emergency (PHE), the utilization of services in 2020, 2021, and 2022 was significantly curtailed or otherwise affected for the entirety of the Medicaid population (including the ACO-attributed population). Further, the increased Medicaid enrollment and lack of redetermination activity during the PHE may also have impacted the quality performance data for those years.

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



2022	36.3%	1
2021	35.3%	1
2020	41.1%	3
2019	40.8%	2
2018	38.9%	1
2017	35.4%	0

Notes on Methodology

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

ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible). In order to make year-over-year comparisons for the VMNG program, the expanded attribution population is not included in the numerator for this measure.

Story Behind the Curve

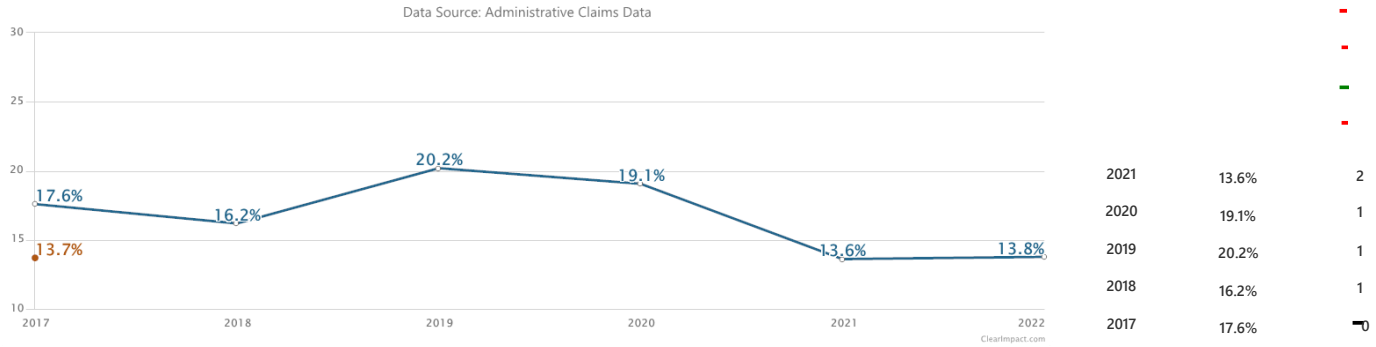
This measure assesses the percentage of ACO-attributed Medicaid beneficiaries 13 years of age and older who are diagnosed with alcohol and other drug dependence (AOD) and who start treatment through an inpatient AOD admission or an outpatient service for AOD within 14 days.

Caution should be exercised when drawing conclusions from the 2020, 2021, and 2022 data. Due to the COVID-19 pandemic and associated Public Health Emergency (PHE), the utilization of services in 2020, 2021, and 2022 was significantly curtailed or otherwise affected for the entirety of the Medicaid population (including the ACO-attributed population). Further, the increased Medicaid enrollment and lack of redetermination activity during the PHE may also have impacted the quality performance data for those years.

Action Plan

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

2022	13.8%	1



Notes on Methodology

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

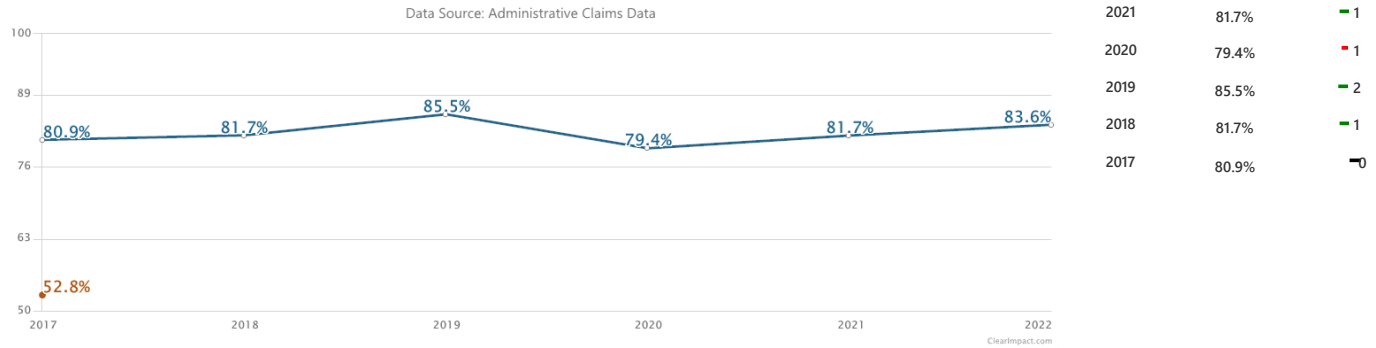
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible). In order to make year-over-year comparisons for the VMNG program, the expanded attribution population is not included in the numerator for this measure.

Story Behind the Curve

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

Caution should be exercised when drawing conclusions from the 2020, 2021, and 2022 data. Due to the COVID-19 pandemic and associated Public Health Emergency (PHE), the utilization of services in 2020, 2021, and 2022 was significantly curtailed or otherwise affected for the entirety of the Medicaid population (including the ACO-attributed population). Further, the increased Medicaid enrollment and lack of redetermination activity during the PHE may also have impacted the quality performance data for those years.

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



Notes on Methodology

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

ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible). In order to make year-over-year comparisons for the VMNG program, the expanded attribution population is not included in the numerator for this measure.

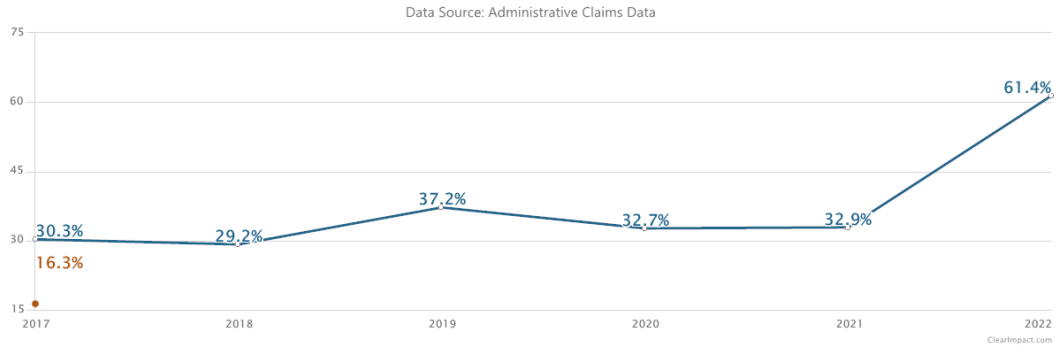
Story Behind the Curve

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

Caution should be exercised when drawing conclusions from the 2020, 2021, and 2022 data. Due to the COVID-19 pandemic and associated Public Health Emergency (PHE), the utilization of services in 2020, 2021, and 2022 was significantly curtailed or otherwise affected for the entirety of the Medicaid population (including the ACO-attributed population). Further, the increased Medicaid enrollment and lack of redetermination activity during the PHE may also have

impacted the quality performance data for those years.

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



2022	61.4%	2
2021	32.9%	1
2020	32.7%	1
2019	37.2%	1
2018	29.2%	1
2017	30.3%	0

Notes on Methodology

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

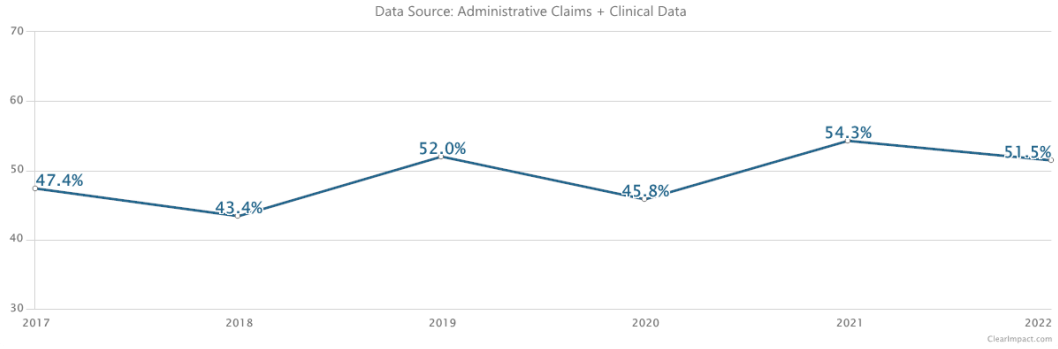
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible). In order to make year-over-year comparisons for the VMNG program, the expanded attribution population is not included in the numerator for this measure.

Story Behind the Curve

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

Caution should be exercised when drawing conclusions from the 2020, 2021, and 2022 data. Due to the COVID-19 pandemic and associated Public Health Emergency (PHE), the utilization of services in 2020, 2021, and 2022 was significantly curtailed or otherwise affected for the entirety of the Medicaid population (including the ACO-attributed population). Further, the increased Medicaid enrollment and lack of redetermination activity during the PHE may also have impacted the quality performance data for those years.

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



2022	51.5%	1
2021	54.3%	1
2020	45.8%	1
2019	52.0%	1
2018	43.4%	1
2017	47.4%	0

Notes on Methodology

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

ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible). In order to make year-over-year comparisons for the VMNG program, the expanded attribution population is not included in the numerator for this measure.

Story Behind the Curve

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

Caution should be exercised when drawing conclusions from the 2020, 2021, and 2022 data. Due to the COVID-19 pandemic and associated Public Health

Emergency (PHE), the utilization of services in 2020, 2021, and 2022 was significantly curtailed or otherwise affected for the entirety of the Medicaid population (including the ACO-attributed population). Further, the increased Medicaid enrollment and lack of redetermination activity during the PHE may also have impacted the quality performance data for those years.

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

2022	56.7%	1
2021	56.1%	2
2020	58.7%	1
2019	62.1%	1
2018	59.3%	1
2017	59.8%	0

Notes on Methodology

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

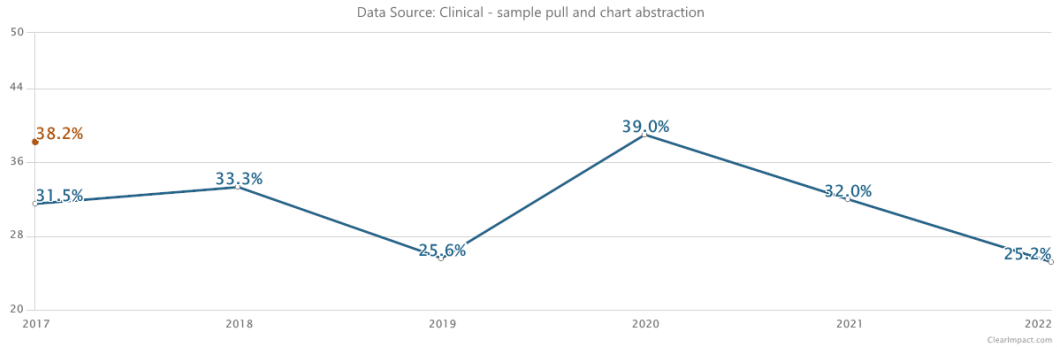
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible). In order to make year-over-year comparisons for the VMNG program, the expanded attribution population is not included in the numerator for this measure.

Story Behind the Curve

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

Caution should be exercised when drawing conclusions from the 2020, 2021, and 2022 data. Due to the COVID-19 pandemic and associated Public Health Emergency (PHE), the utilization of services in 2020, 2021, and 2022 was significantly curtailed or otherwise affected for the entirety of the Medicaid population (including the ACO-attributed population). Further, the increased Medicaid enrollment and lack of redetermination activity during the PHE may also have impacted the quality performance data for those years.

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



2022	25.2%	2
2021	32.0%	1
2020	39.0%	1
2019	25.6%	1
2018	33.3%	1
2017	31.5%	0

Notes on Methodology

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

ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible). In order to make year-over-year comparisons for the VMNG program, the expanded attribution population is not included in the numerator for this measure.

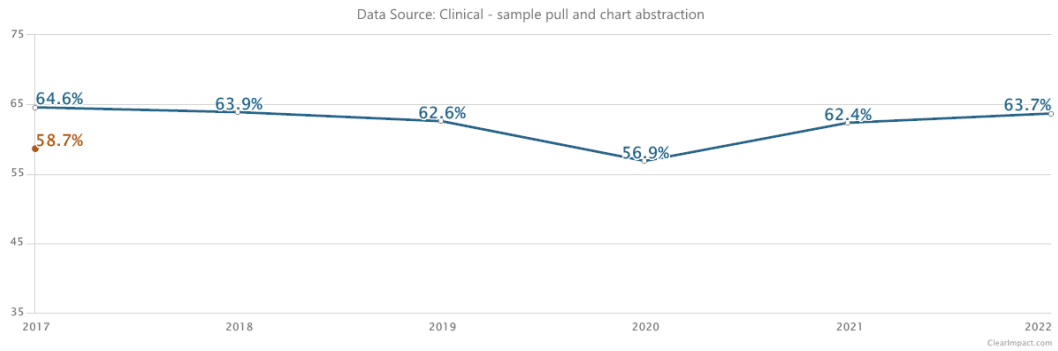
Story Behind the Curve

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

Caution should be exercised when drawing conclusions from the 2020, 2021, and 2022 data. Due to the COVID-19 pandemic and associated Public Health Emergency (PHE), the utilization of services in 2020, 2021, and 2022 was significantly curtailed or otherwise affected for the entirety of the Medicaid population

(including the ACO-attributed population). Further, the increased Medicaid enrollment and lack of redetermination activity during the PHE may also have impacted the quality performance data for those years.

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



2022	63.7%	2
2021	62.4%	1
2020	56.9%	3
2019	62.6%	2
2018	63.9%	1
2017	64.6%	0

Notes on Methodology

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

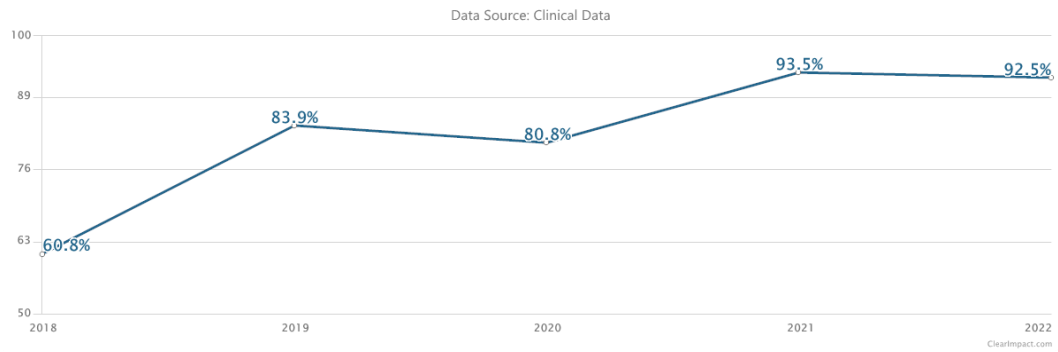
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible). In order to make year-over-year comparisons for the VMNG program, the expanded attribution population is not included in the numerator for this measure.

Story Behind the Curve

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

Caution should be exercised when drawing conclusions from the 2020, 2021, and 2022 data. Due to the COVID-19 pandemic and associated Public Health Emergency (PHE), the utilization of services in 2020, 2021, and 2022 was significantly curtailed or otherwise affected for the entirety of the Medicaid population (including the ACO-attributed population). Further, the increased Medicaid enrollment and lack of redetermination activity during the PHE may also have impacted the quality performance data for those years.

PM DVHA Tobacco Use Assessment and Tobacco Cessation Intervention



2022	92.5%	1
2021	93.5%	1
2020	80.8%	1
2019	83.9%	1
2018	60.8%	0

Notes on Methodology

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

ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible). In order to make year-over-year comparisons for the VMNG program, the expanded attribution population is not included in the numerator for this measure.

Story Behind the Curve

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

Caution should be exercised when drawing conclusions from the 2020, 2021, and 2022 data. Due to the COVID-19 pandemic and associated Public Health Emergency (PHE), the utilization of services in 2020, 2021, and 2022 was significantly curtailed or otherwise affected for the entirety of the Medicaid population (including the ACO-attributed population). Further, the increased Medicaid enrollment and lack of redetermination activity during the PHE may also have impacted the quality performance data for those years.