State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

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

Quarterly Report for the period
January 1, 2020 – March 31, 2020

Submitted Via PMDA Portal on June 30, 2020

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I. Background and Introduction

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

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

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

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

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

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

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

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

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

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

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

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the first quarterly report for waiver year 65, covering the period from January 1, 2020 through March 31, 2020 (QE032020).***

II. Outreach/Innovative Activities

i. Member and Provider Services

Key updates from QE032020:

- Provider Member Relations and Coordination of Benefits units merged effective March 2, 2020.
- COVID-19 pandemic creates substantial increase in telemedicine services.
- Provider Management Module (PMM) receives CMS certification retroactive to May 1, 2019.

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

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

<u>Provider Member Relations and Coordination of Benefits Units Merge</u>

As of March 2, 2020 The Coordination of Benefits unit and Provider Members Relations unit at the Department of Vermont Health Access (DVHA) combined to become the Member and Provider Services Unit. The combination of these two units allows for uniformity while working with Medicaid members and enrolled providers. The new 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 unit also works diligently to recover funds from third parties where Medicaid should not have been solely responsible. Those efforts include estate recovery, absent parent medical support recovery, casualty recovery, patient liability recovery, Medicare recovery, Medicare prescription recovery, special needs recovery, and trust recovery.

Additionally, the unit also ensures members have access to appropriate healthcare for their medical, dental, and mental health needs. The unit monitors the adequacy of the Green Mountain Care (GMC) network of providers and ensures that members are served in accordance with managed care requirements. The unit oversees Non-Emergency Medical Transportation (NEMT) for covered service for members enrolled in Medicaid.

COVID-19 Response

The national emergency declaration enabled CMS to grant state and territorial Medicaid agencies a wider range of flexibilities under section 1135 waivers for Provider Enrollment. The State of Vermont has implemented the following in the wake of 2019 Novel Coronavirus Disease (COVID-19):

1. Temporarily waive provider enrollment requirements to ensure a sufficient number of providers are available to serve Medicaid enrollees. Such requirements include the payment of application fees, criminal background checks, or site visits.
2. Temporarily cease the revalidation of providers who are located in-state or otherwise directly impacted by a disaster.
3. Temporarily waive requirements that physicians and other health care professionals be licensed in the state or territory in which they are providing services, so long as they have equivalent licensing in another state.

Increases in provider enrollment attributable to any of the above flexibilities allows for increased access for our members.

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

Provider Management Module (PMM) CMS Certification

Vermont has implemented Provider Management with DXC Technologies. In response to the state's request for CMS certification, the CMS certification team reviewed the Provider Management system and relevant artifacts/materials during a certification review conducted in Waterbury, Vermont, on November 21, 2019.

CMS approved the request for certification for Vermont's Provider Management system. This was based upon CMS's comprehensive review of Vermont's Provider Management system, including all documentation provided by Vermont, discussions with Vermont and vendor staff, and observations prior to, during, and after the CMS review.

Based on this review, CMS approved the state's request for certification retroactive to the implementation date of May 1, 2019. As a result, the state is eligible to request 75 percent Federal Financial Participation (FFP) retroactive to the Provider Management system implementation date of May 1, 2019.

III. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE032020:

- The Customer Support Center received more than 102,602 calls in QE0320, down 4% from QE0319. Additionally, 9,392 calls were separately received from the payment line. This was a reduction from the QE0319 incoming call amount of 10,226.
- As of May 2020, DVHA is currently supported by 110 Assisters (104 Certified Application Counselors, 2 Navigators, and 4 Brokers), with 4 Assisters in training, working in 49 organizations including hospitals, clinics, and community-based organizations.
- Increasing numbers of customers are using self-service functions. Self-serve applications comprised nearly half (46%) of all applications in QE0320. This is a slight increase from QE0319. In addition, 59% of customers made recurring payments in QE0320. This was a slight growth of 6% compared to the previous year's first quarter.

Enrollment

As of QE0320, more than 199,461 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 123,898 in Medicaid for Children and Adults (MCA) and 75,563 in Qualified Health Plans (QHPs), with the latter divided between 25,796 enrolled with VHC, 7,671 direct-enrolled with their insurance carrier as individuals, and 42,096 enrolled with their small business employer.

Medicaid Renewals

The effect of the COVID-19 emergency on redeterminations for Medicaid for Children and Adults (MCA) processes was felt in the final month of the quarter. The passive renewal success rate for the quarter averaged 48%, slightly higher than the monthly averages over the last year.

Pre-populated renewal applications were sent to the remainder of the population, requiring an active response. Due to the public health emergency, coverage for people enrolled as of March 18th could not end or see a decrease in benefit per CMS guidance on enhanced FMAP funding. Therefore, households that did not respond were not closed, and applications that would have resulted in closures or benefit

changes were not processed to completion. Cases that did not go ex-parte or that could not be renewed into the same coverage had coverage extended to be redetermined in a later month.

1095 Tax Forms

DVHA-HAEEU mailed two versions of IRS Form 1095 during QE0320. 1095A serves as proof of coverage and subsidy for QHP members to use when filing taxes. Nearly 25,000 initial forms were mailed to QHP members in January. Corrected forms are sent throughout the winter and spring due to reconciliation efforts or when members pay overdue 2019 bills. 1095-related service requests decreased by 16% from QE0319 and DVHA-HAEEU successfully handled the incoming volume.

1095B is an informational form that shows months of coverage for Medicaid members. Just over 109,000 were mailed in January in advance of the deadline. For tax year 2019, the federal deadline was March.

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 102,602 calls in QE0320. January 2020 was especially busy, with follow up open enrollment and 1095 form calls. As of the end of QE0320, Maximus had 83 customer service representatives, down nearly 14% from the 96 on staff at the end of QE0319. Maximus answered 53% of calls within 24 seconds in January 2020, 67% in February 2020, and 69% in March 2020. All three months were shy of the 75% target.

Maximus is 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 an increase in the volume of calls and a slight increase in the proportion of calls that were escalated. 11% of QE0320 calls were transferred to DVHA-HAEEU staff, up from 7.92% in QE0319. Just as importantly, DVHA strived to answer all calls that were transferred; 77% of transferred calls were answered in five minutes in QE0320, compared to 93% in QE0319.

Timely Processing of Member Requests

In the spring of 2016, DVHA-HAEEU set a goal of completing 75% of member requests within ten business days by October 2016 and 85% by June 2017. In QE0316, fewer than 60% of VHC requests were completed within ten days. In QE0317, more than 90% of requests were completed within ten days. In QE0318 and again in QE0319, more than 95% of VHC requests were completed within ten days. QE0320 reached 96%.

System Performance

Throughout most of QE0320, the system continued to operate as expected. The system had 100% availability in the quarter. The average page load time for the quarter was less than two seconds (1.43)

in each of the three months – which is within the two-second target.

In-Person Assistance

As of May 2020, DVHA is currently supported by 110 Assisters (104 Certified Application Counselors, 2 Navigators, and 4 Brokers), with 4 Assisters in training, working in 49 organizations including hospitals, clinics, and community-based organizations. Assister support is available in all of Vermont's 14 counties to help Vermonters enroll in health coverage through Vermont's health insurance marketplace. DVHA continues to strategically adapt and evolve the program and has realized improvements in training and communication methods as well as significant improvements to process consistency and data quality.

The program saw an expected temporary reduction in the total number of Assisters, specifically Brokers due to the shift in strategy to heavily target CACs for renewal into the program. Further, the program now encourages higher levels of engagement and proficiency from Assisters. Despite the targeted renewal effort, and elimination of less active roles, the programs Assister count has already begun to trend upwards onboarding an average of over four new Assisters per month in the 2020 calendar year thus far.

Outreach

DVHA used advisory meetings media inquiries, social media, and other collaborative engagements with partners and stakeholders to notify Vermonters about programmatic changes related to the COVID-19 pandemic.

The Plan Comparison Tool, which helps customers estimate total costs of coverage based on family members' age, health, and income, was used in more than 10,700 sessions during the quarter, which is a slight decrease over QE0319.

Self-Service

During QE0320, DVHA-HAEEU continued to promote self-service options for customers to pay their bills, report changes, and access tax documents and other forms. Self-service leads to an improved customer experience as Vermonters can log in at their convenience. It also has the benefit of using automation to reduce staffing expenses. Year-over-year comparisons show that more customers are using self-service functions, including both online accounts for health coverage applications and reported changes as well as the options of paying premiums through monthly recurring payments rather than one-time payments. Automatic recurring payments ensure that members' premiums are paid on time, helping them to avoid going into a grace period – and ultimately losing coverage – due to late payments.

Self-serve applications comprised nearly half (49%) of all applications in QE0320. Additionally, more than 7,100 recurring payments were made per month. This is up just over ~1000 per month compared to QE0319. Just under 60% of all electronic payments were recurring payments (59%).

ii. Choices for Care and Traumatic Brain Injury Programs

Key updates from QE032020:

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

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

Nursing Homes use CMP Funds to purchase technology

33 Nursing Homes in Vermont applied for and received grants of up to $3000 to purchase technology to facilitate both social visits and telemedicine visits for residents mpacted by the State of Vemont Stay Home/Stay Safe order.

Choices for Care Regulations

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

Adult Day Services

Adult Day Centers were required to close on March 17, 2020 as a result of the State of Vermont declaration of emergency and Stay Home/Stay Safe order. DAIL continues to support providers and participants whose services have been disrupted.

Money Follows the Person (MFP)

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

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

Wait Lists

- There is currently no wait list for the High Needs Group.
- There continues to be provider wait lists for Moderate Needs Group, estimated at almost 675 people statewide. Because the eligibility criteria for Moderate Needs services is so broad, Vermont does not expect to eliminate the wait list in the near future. However, the state in the process of revising the wait list procedures from chronological to priority-based in order to serve applicants with the greatest needs first.
- There is currently no wait list for the TBI program.

iii. Developmental Disabilities Services Division

Key updates from QE032020:

- HCBS Site Visits Completed
- Conflict Free Case Management System Evaluation in full swing

New Payment Model in Development

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

DVHA has engaged a Medicaid reimbursement consultant firm to assist the State in completing a provider rate study. The rate study has collected detailed information from providers regarding actual costs to deliver the defined categories of service under HCBS. The rate study is complete and new rates for services have been proposed. The information gathered will be utilized initially in developing the new payment model. It will later be decided whether these new rates can be adopted in the program. In addition to the provider rate study, the project is examining alternative assessment tools, resource allocation methods and options for more efficiently capturing encounter data for these services. A new methodology has been established for providers to report encounter data regarding services being delivered to participants. Provider agencies are currently adapting their electronic health records and business processes to prepare to report the data using the new method that will lead to increased transparency and accountability in the use of funds. The State is also in the process of developing an RFP for a contractor to conduct needs assessments using a standardized assessment tool, the Supports Intensity Scale. Design of the new payment model is continuing. Ongoing work will be required, including seeking any needed CMS approval.

Work on payment reform continued in the first quarter until it was put on hold in mid-March due to the COVID state of emergency. The state will decide when it can resume payment reform activities.

HCBS Rules Implementation

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

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

Wait List

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

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

There were no individuals who met a HCBS funding priority who were waiting for services that helps address the need related to the funding priority. As of 6/30/19, there were 276 people who requested HCBS services but were denied because they did not meet a funding priority. 23 people were waiting for FMR and 13 were waiting for FFF. There was no one waiting for TCM or PSEI. The waiting list is monitored by providers to determine if people have a change in circumstance that makes them eligible to receive HCBS. The waiting list is also reviewed when additional funds become available for other programs.

iv. Global Commitment Register

Key updates from QE032020:

- 15 policies were posted to the GCR in Q1 2020.
- Since the Global Commitment Register (GCR) launched in November 2015, 210 final GCR policies have been publicly posted.

The GCR is a database of policy changes to and clarifications of existing Medicaid policy under Vermont's 1115 Global Commitment to Health waiver. It is based on the Federal Register and can be used as both a public notice and documentation tool for Medicaid policy. Like the Federal Register, the GCR can be used to publish proposed policy, including information on public comment submissions, final policy, notices, and policy clarifications. The GCR is available on the DVHA website to ensure that policy changes are transparent to Vermonters and to provide a forum for public comments.

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

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

A combined total of 15 policies were posted to the GCR this past quarter. This includes 6 proposed changes, 6 final changes, and 3 clarifications. Changes include updates to rates and/or rate methodologies, clinical coverage changes, administrative rulemaking notices, an approved waiver amendment notice, and policy changes stemming from the public health emergency and the COVID-19 pandemic.

The GCR can be found here: http://dvha.vermont.gov/global-commitment-to-health/global-commitment-register.

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

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

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

Key updates for QE032020:

- Reporting on metrics will not be available until the third quarter report of 2020 (QE0920).
- 10 hospitals are participating in the Recovery Coaches in the Emergency Room Program.
- The Substance Use Disorder Treatment Standards and Compliance Assessment Tool were updated and reissued for a January 1, 2020 effective date.
- VT Helplink launched for public use in March 2020.

2. Executive Summary

During the first quarter of 2020 the State of Vermont continued to have all ASAM levels of care available and no ongoing waitlist to access to Medication Assisted Treatment. Many treatment providers have shifted to telemedicine, while others have adjusted daily census and implemented social distancing and other strategies to continue serving patients during the COVID-19 pandemic.

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

ADAP continued to adapt the value-based payment model for residential programs, to align with its All Payer Model Agreement with CMS. The utilization and reimbursement data were reviewed last quarter and as a result of the review the rates for the episodic payments were adjusted for a January 1, 2020 effective date. ADAP has been monitoring the impact of the rate adjustment and continued to elicit feedback from the residential providers on the design of the quality withhold and the performance measures under consideration.

ADAP's centralized intake and resource center, "VT Helplink: Alcohol and Drug Support Center" launched for public use in March 2020. Major components include: 1) a call center staffed by certified

Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self-screen tool, and 3) an appointment board to connect callers in need of treatment with appointments to ADAP's Preferred Provider Network. ADAP is working to onboard SUD treatment providers into the provider portal.

The Substance Misuse Prevention Oversight and Advisory Council (SMPC) was established within the Vermont Department of Health and encompasses all substances of misuse including alcohol; cannabis; controlled substances such as opioids, cocaine and methamphetamines; and tobacco products, tobacco substitutes and substances containing nicotine.

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

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

Assessment of Need and Qualification for SUD Services

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Implementation Update			
Compared to the demonstration design details outlined in the STCs and implementation plan, have there been any changes or does the state expect to make any changes to: A) the target population(s) of			There are no planned changes to the target population or clinical criteria.

the demonstration? B) the clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration?			
Are there any other anticipated program changes that may impact metrics related to assessment of need and qualification for SUD services? If so, please describe these changes.			There are no anticipated program changes.
☒ The state has no implementation update to report for this reporting topic.			

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

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

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

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

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

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

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

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

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

Summary:

The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 27 substance use disorder treatment provider locations. The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were revised for a January 1, 2020 effective date.

Milestone 2 - Table 1

Action	Revised Completion Date	Responsible	Status
Finalize Substance Use Disorder Treatment Standards	August 1, 2018	Director of Quality Management and Compliance	Completed
Update Compliance Assessment Tool with revised Substance Use Disorder Treatment Standards and all	August 15, 2018	Director of Quality Management and Compliance	Completed

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

Vermont continues to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS. The value-based portion of the new model is anticipated to be implemented in 2020, however this may need to be re-evaluated depending on the impact of the COVID-19 pandemic. The utilization and reimbursement data were reviewed. As a result of the review the rates for the episodic payments were adjusted effective January 1, 2020. ADAP continued to elicit feedback from the residential providers on the design of the quality withhold and the performance measures under consideration.

Milestone 2 – Table 2

Action	Date	Responsible
Develop the criteria for the differential case rate	Completed	ADAP Director of Clinical Services

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

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

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

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

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

Prompts	Demonstration Year (DY) and	Related metric (if any)	Summary

	quarter first reported		
Milestone 3 Metric Trends			
☒ The state is not reporting any metrics related to this reporting topic.			
Milestone 3 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards? b. State review process for residential treatment providers' compliance with qualifications standards? c. Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site? **Summary**: The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 27 substance use disorder treatment provider locations. The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were revised for a January 1, 2020 effective date.			
Are there any other anticipated program changes that may impact metrics related to the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities (if the state is reporting such metrics)? If so, please describe these changes.			
☐ The state has no implementation update to report for this reporting topic.			

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 4 Metric Trends			

Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 4 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care? **Summary**: Vermont continues to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS. The value-based portion of the new model is anticipated to be implemented in 2020, however this may need to be re-evaluated depending on the impact of the COVID-19 pandemic. The utilization and reimbursement data were reviewed. As a result of the review the rates for the episodic payments were adjusted effective January 1, 2020. ADAP continued to elicit feedback from the residential providers on the design of the quality withhold and the performance measures under consideration. ADAP's centralized intake and resource center "VT Helplink: Alcohol and Drug Support Center" launched for public use March 2020. Major components include: 1) a call center staffed by certified Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self-screen tool, and 3) an appointment board to connect callers in need of treatment with appointments to ADAP's Preferred Provider Network. ADAP is working to onboard SUD treatment providers into the provider portal.			
Are there any other anticipated program changes that may impact metrics related to provider capacity at critical levels of care, including for medication assisted treatment (MAT) for OUD? If so, please describe these changes.			
☐ The state has no implementation update to report for this reporting topic.			

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

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

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

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

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

Prompts	Demonstration Year (DY) and	Related metric (if any)	Summary

	quarter first reported		
Milestone 6 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 6 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports? **Summary**: Vermont launched the Recovery Coaches in the Emergency Department Program on July 1, 2018. 10 hospitals are participating in the program.			
Are there any other anticipated program changes that may impact metrics related to care coordination and transitions between levels of care? If so, please describe these changes.			
☐ The state has no implementation update to report for this reporting topic.			

SUD Health Information Technology (Health IT)

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

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

assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			

☒ The state has no metrics trends to report for this reporting topic.

Implementation Update

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

a. How health IT is being used to slow down the rate of growth of individuals identified with SUD?
b. How health IT is being used to treat effectively individuals identified with SUD?
c. How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD?
d. Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels?
e. Other aspects of the state's health IT implementation milestones?
f. The timeline for achieving health IT implementation milestones?
g. Planned activities to increase use and functionality of the state's prescription drug monitoring program?

Summary:

- Vermont has a requirement and funding in the current contract with Appriss to connect VPMS to RxCheck for interstate data sharing. RxCheck is developing functionality for direct integration with EHRs and other health systems. Appriss has provided a change order to connect to RxCheck.
- Funding through the Center for Disease Control and Prevention, and the Bureau for Justice Administration requires the connection to RxCheck. The MOU has been signed and is in place with IJIS, the contractor who manages the operation of RxCheck.
- The current contract for the VPMS was put out to bid in 2019. The request for proposal (RFP) included priorities such as improved access and support for providers, integration and data management, and increased reporting functionality. The independent review of the selected vendor was accepted. Due to COVID-19 delays, negotiation for the contract is ogoing. In order to ensure continued access, an amendment with Appriss was signed through the end of November, 2020.
- VPMS, Dr. First and Appriss are in the process of testing and verifying Appriss's Gateway integration tool to enable direct population of VPMS data into Dr. First's prescription ordering section, eliminating the need for providers to navigate between systems.
- VPMS staff are engaged with the NESCSO State HIT Learning Community. This group works to create a shared understanding of Federal legislation, the current state of PDMP activities, and identifies opportunities for multi-state alignment.
- VPMS staff participated in interviews for the development of statewide data integration opportunities. These interviews were with the contractor tasked with developing the health IT infrastructure plans for the HIE Steering Committee and were combined with other data systems needs and requirements for integration.
- VDH promoted the availability of technical assistance at the prescriber level. Promotion was integrated into the implementation of prescriber insight reports. Insight reports include metrics for providers about the prescriptions dispensed that they prescribed and comparisons with other providers within their specialty. Vermont continues to offer prescriber reports on a quarterly basis. New enhancements to the report include metrics on stimulants and sedatives in addition to opioids.

The scope of the providers receiving reports have been expanded and will now include those who have prescribed controlled substances other than opioids as well. • VDH conducted an impact evaluation of the 7/1/17 pain prescribing rule change to assess the impact of the new prescribing rules on prescribing patterns, determine if the new prescribing rules affect awareness/usage of VPMS and evaluate the impact of stricter prescribing rules on future prescription opioid misuse. This evaluation is available here: https://www.healthvermont.gov/sites/default/files/documents/pdf/Pain_Rules_Eval_FINAL%20.pdf and details that opioid prescribing to treat pain has decreased since the implementation of the Rule for the Prescribing of Opioids for Pain in July 2017. More prescribers are actively engaged with VPMS. Fewer Vermonters, including those 17 and under, are receiving prescriptions, and the prescriptions that are dispensed are in lower amounts. The centralized intake and resource Center, branded as VT Helplink: Alcohol & Drug Support Center, encompasses a call center, public-facing informational website, and a web-based appointment board. VT Helplink was launched to the public in March 2020.			
Are there any other anticipated program changes that may impact metrics related to SUD Health IT (if the state is reporting such metrics)? If so, please describe these changes.			
☐ The state has no implementation update to report for this reporting topic.			

Other SUD-Related Metrics

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
9.2 Other SUD-Related Metrics			
9.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
9.2.2 Implementation Update			
Are there any other anticipated program changes that may impact the other SUD-			

related metrics? If so, please describe these changes.			
☒ The state has no implementation updates to report for this reporting topic.			

Budget Neutrality

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

SUD-Related Demonstration Operations and Policy

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
11.1 SUD-Related Demonstration Operations and Policy			
11.1.1 Considerations			

Highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.			
[Add rows as needed]			
☒ The state has no related considerations to report for this reporting topic.			
11.1.2 Implementation Update			
Compared to the demonstration design and operational details outlined in STCs and the implementation plan, have there been any changes or does the state expect to make any changes to: a. How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service)? b. Delivery models affecting			

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

SUD Demonstration Evaluation Update

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
12.1 SUD Demonstration Evaluation Update			
12.1.1 Narrative Information			
Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See			Updates on the SUD evaluation work, deliverables, and timeline can be found in Sections VIII. *Quality Improvement* and IX. *Demonstration Evaluation* of this report.

report template instructions for more details.			
Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.			
List anticipated evaluation-related deliverables related to this demonstration and their due dates.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
12.1.2 Implementation Update			
Are there any anticipated program changes that may impact budget neutrality? If so, please describe these changes.			
[Add rows as needed]			
☐ The state has no SUD demonstration evaluation update to report for this reporting topic.			

Other Demonstration Reporting

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
13.1 Other Demonstration Reporting			
13.1.1 General Reporting Requirements			
Have there been any changes in the state's implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol?			
Does the state foresee the need to make future			

changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes?			
Compared to the details outlined in the STCs and the monitoring protocol, has the state formally requested any changes or does the state expect to formally request any changes to: a. The schedule for completing and submitting monitoring reports? b. The content or completeness of submitted reports? Future reports?			Updates on the Monitoring Protocol work, deliverables, and timeline can be found in Section X. *Compliance* of this report.
Has the state identified any real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation?			
[Add rows as needed]			
☒ The state has no updates on general reporting requirements to report for this reporting topic.			
13.1.2 Post Award Public Forum			
If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual report.			
[Add rows as needed]			

☒ There was not a post-award public forum held during this reporting period and this is not an annual report, so the state has no post award public forum update to report for this reporting topic.

Notable State Achievements and/or Innovations

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
14.1 Notable State Achievements and/or Innovations			
14.1 Narrative Information			
Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.			
[Add rows as needed]			
☒ The state has no notable achievements or innovations to report for this reporting topic.			

IV. Expenditure Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE032020:

- Alignment of VCCI with state health care reform and ACO
- Enhanced VCCI Population
- Working on bidirectional interface with VITL of 2020

The VCCI provides case management services to Medicaid beneficiaries throughout Vermont. The VCCI team is comprised of licensed, field-based case managers who provide clinical case management services to the complex beneficiaries within the communities they serve. Two non-licensed professional staff complement the team, with their primary role as outreach to those members new to the health plan. In QE032020, VCCI continued efforts toward improved alignment with health care reform and the system of care; formalizing its shift from historically serving only those who were predicted to be high cost/high risk to needs based eligibility and outreach. The VCCI team delivers short term, intensive case management to beneficiaries with complex health needs. In alignment with the ACO model, the VCCI implements the complex care model, utilizing patient engagement tools, pulling together care teams and helping beneficiary in the identification of a long-term lead care coordinator. In addition to the beneficiary, potential care team members may include primary care providers, hospital case managers, community and designated mental health agency providers, AHS partners such as Economic Services Division and Employment Specialists. Lead Care Coordinators help to support the member in goal setting and in the development of the shared care plan. With goal of further alignment, the full VCCI staff expects to train in Care Navigator (CN), OCV's communication platform, in March 2020. The CN platform will enable VCCI to share information and update care plans with community care teams on complex members.

Another population the VCCI team has supported this past year are beneficiaries new to Medicaid. Case managers use a screening tool that assesses access to primary care, health conditions and risky behaviors, and social determinants of health. The goal is to orient the beneficiary to the system of care, including navigating services for health and health-related needs such as facilitating access to primary and dental care, to housing/food security resources, to tobacco cessation services, and facilitating connections to local domestic violence resources. Beneficiaries' responses to screening questions coupled with the clinical judgment of VCCI case managers allows stratification into 1 of 4 risk levels – mirroring the ACO's framework. If a member is stratified as Risk 3 or higher, the beneficiary is offered VCCI case management services for the short-term, community-based case management services described above, for the initial stabilization and implementation of the complex care model.

Figure 1. Percent of Members Age 18+ Screened by VCCI Within 2 Months of Enrollment

% of members ages 18+ enrolled in Medicaid during the month who are screened by VCCI within 2 months														
										SFY20				
	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
	X	X	X	X	X	X	X	X	10/15/19	11/15/19	12/15/19	01/15/20	02/15/20	03/15/20
# of new to Medicaid members	404	567	551	356	276	428	309	307	321	419	432	360	364	547
# of new to Medicaid members reached	103	230	310	175	99	168	117	129	125	180	165	91	83	101
# of new to Medicaid members screened	84	204	260	141	97	156	103	110	75	147	142	115	117	164
% of new to Medicaid members screened	20.8%	36.0%	47.2%	39.6%	35.1%	36.4%	33.3%	35.8%	23.4%	35.1%	32.9%	31.9%	32.1%	29.98

In QE032020, VCCI continued to PDSA outreach to those < 18 years of age that are new to the health plan. Collaboration with the Vermont Department of Health yielded an edited version of the screening tool for adults and an opportunity to coach this population on EPSDT preventive services and benefits. Goals of outreach to our pediatric population new to the health plan are education, facilitation to PCP and dental care, and referral to other case management services available.

In the Spring of 2019, the VCCI team supported the St. Johnsbury community in an expanded ACO attribution pilot with goal of ensuring the care is the same for the entire population. The beneficiary cohort the VCCI local team outreached had been on the health plan, but without any evidence of claims. The St. Johnsbury VCCI team utilized the screening used on the outreach to those new to the health plan; with same goal of facilitating access to primary care and dental, along with other health and health related services the beneficiary identified as a need. During this first quarter of CY 2020, VCCI continued to meet with DVHA Payment Reform, the St. Johnsbury community, and OneCare Vermont to continue to plan workflows for implementation of statewide attribution. Input and experience from VCCI was incorporated into an Expanded Attribution Guide/Report highlighting the experience in the St Johnsbury community. VCCI is prepared to continue outreach on its identified cohort utilizing existing screening tools, and the skills of our licensed field team.

Over this upcoming year, VCCI will continue to work and coach community partners to transfer knowledge of services available and provide support as needed so that navigational assistance for beneficiaries is seamless.

The eQHealth care management system utilized by VCCI for daily operations and programmatic reports is now CMS certified – making eQHealth the only CMS certified case management system.

This past year marks the 4th year that the VCCI team has been functional in the eQHealth care management system. eQHealth supported the VCCI's program evolution and population enhancement by way of:

- Interface for the VITL data
- ADT messaging through VITL

Data from the Health Information Exchange is now part of the beneficiary record in eQ. This data includes ADT messages, lab data, vaccination data and care documents for those facilities that are sending the data through the VHIE interface. This data allows for more comprehensive, medically focused care management.

ii. Blueprint for Health

Key updates from QE032020:

- The majority of Vermont's primary care practices are now Blueprint-participating Patient-Centered Medical Homes, as evidenced by 136 of Vermont's primary care practices are Blueprint-participating practices. The estimated total number of primary care practices operating in the state is 169, of which an estimated 148 employ more than one provider.
- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid use disorder. As of March 2020, the number of clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) was 3,504, and the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs increased to 3,472.

Patient Centered Medical Home Program

The Blueprint uses national standards to drive improvements in primary care delivery and payment. The program helps primary care providers transform their practices into National Committee for Quality Assurance (NCQA)-certified Patient-Centered Medical Homes. Patient-Centered Medical Home model supports care that is patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety. The model also promotes care that is provided when and where the patient needs it, and in a way that the patient understands it. Patient-Centered Medical Homes in Vermont are supported by multi-disciplinary teams of dedicated health professionals in each of the state's health service areas. These teams provide supplemental services that allow Blueprint-participating primary care practices to focus on promoting prevention, wellness, and coordinated care. The Community Health Team support primary care providers in identifying root causes of health problems, including mental health and screening for social determinants of health. They also connect patients with effective interventions, manage chronic conditions, or provide additional opportunities to support improved well-being.

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

condition management, and ongoing practice transformation in alignment with State-led health care reform priorities. These include:

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

Blueprint-participating Patient-Centered Medical Homes currently serve 285,404 insurer-attributed patients, of which 96,447 are Medicaid enrollees. Attribution to a practice is determined by the practice at which the patient has received the majority of their primary care within the 24 months prior to the date the attribution process is conducted. These practices and patients are supported by 170 full-time equivalents of Community Health Team staff.

Quarterly Highlights

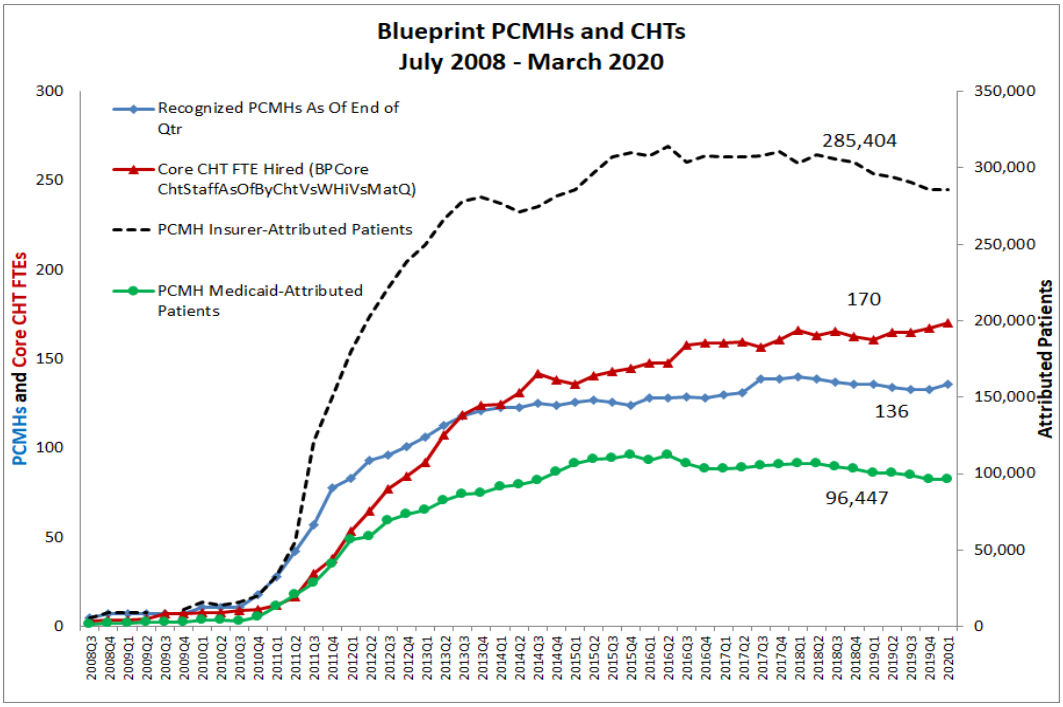
In Quarter 1 Jan- March 2020, 136 Vermont practices were operating as Patient-Centered Medical Homes, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of practices participating in the Blueprint for Health program is a key performance measure; the Blueprint estimates that there are about 169 total primary care practices operating in the state, of which an estimated 148 employ more than one provider.

During this quarter, 5 practices renewed according to the 2017 NCQA Patient-Centered Medical Home recognition standards. This new recognition process has been greatly streamlined and is composed of three tracks based on a practice's history as a Patient-Centered Medical Home.

The Blueprint Women's Health Initiative expanded in Q3 and added Planned Parenthood of Northern New England 12 sites. In Q4 they successfully hired a Director of Behavioral Health Services and are actively looking to hire and staff those sites.

As of March 13th, Governor Phil Scott declared a "Stay Home, Stay Safe" state of emergency in Vermont. Our patient centered medical homes, specialty practices, and spokes acted quickly in order to provide continuity of care while still following the governor's orders. Most practices were able to provide most staff with laptops and rapidly purchased technology platforms if they did not currently have one to provide telehealth services. The Blueprint approved use of funding to purchase additional licenses for online platform. It is anticipated that there will be an extensive update and changes in the field as Quarter 2 progresses.

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



Practice Health Profiles and Community Health Profiles

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

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

i. 01/2013 - 12/2013
ii. 07/2013 - 06/2014
iii. 01/2014 - 12/2014

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

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

Hub & Spoke Program

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

Many of these outcomes were supported by the recent evaluation of Vermont's Hub & Spoke system. The State Plan Amendment for the Vermont Medicaid Program, approved by the Centers for Medicare and Medicaid Services, established a Health Home for Vermonters with opioid use disorder. As of July 1, 2013, Medicaid beneficiaries receiving medication-assisted treatment for opioid use disorder in a Hub or Spoke setting were eligible to receive enhanced services, such as comprehensive care management, care coordination, comprehensive transitional care, health promotion, individual and family support, and referral to community and social support services. The Health Home functions to enhance Hub programming and embeds essential support staff (1 registered nurse and 1 licensed mental health clinician per every 100 Medicaid patients receiving medication-assisted treatment) into Spoke practices for a patient-centered, team- and evidenced-based approach to the treatment of opioid use disorder and the provision of Health Home services. Based upon the "significant impact" demonstrated by the Hub and Spoke system, Vermont is working towards gaining All Payer participation in the Opioid Use Disorder Health Home model.

The Blueprint, in partnership with the Division of Alcohol and Drug Abuse Programs (Department of Health), continues to offer learning sessions with expert-led, and peer-supported, training in best practices for providing team- and evidence-based medication-assisted treatment for opioid use disorder. For many physicians, nurse practitioners, and physician assistants, access to specialized

staffing and ongoing training opportunities provide the support and confidence the providers need to accept the challenge of treating opioid use disorder in community-based medical practice settings (Spokes). For patients, the Spoke staff become a critical part of their care team, working together week-by-week and month-by-month towards long-term recovery and improved health and well-being. At the end of the 1st quarter of 2020, capacity for receiving medication-assisted treatment in Spoke settings continued to increase, as evidenced by 3,472 Vermonters with Medicaid insurance receiving medication-assisted treatment for opioid use disorder from 270 prescribers and 72.65 full-time equivalent Spoke staff, working as teams, across more than114[1] different Spoke settings (as of March 2020).

Quarterly Highlights

- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid use disorder, as evidenced by the 3,503 clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) as of March 2020 and the monthly average of 3,472 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs as of March 2020.

- Medication-assisted treatment for opioid use disorder is being offered across the State of Vermont by more than 114 different Spoke settings and by 270 medical doctors, nurse practitioners and physician assistants who work with 72.65 FTE licensed, registered nurses and licensed, Master's-prepared, mental health / substance use disorder clinicians as a team to offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder (as of March 2020).

- Toward the end of Q1 2020, all Spoke sites began transitioning to remote and telehealth services in response to Vermont's "Stay Home, Stay Safe" emergency order that went into effect on March 13, 2020.

- As of November 1, 2019, the Blueprint has a contract with Dartmouth College for the 2019-2020 MAT Learning Collaborative. The 2019-2020 MAT Learning Collaborative will include a series of five webinars, six regional in-person training sessions, and one statewide conference. For the 1st quarter of 2020, the Learning Collaborative events orchestrated by Dartmouth College, in conjunction with Blueprint for Health and Vermont Department of Health's Division of Alcohol and Drug Abuse Programs, consisted of one webinar and two regional in-person training sessions. In response to the COVID-19 pandemic and Vermont's "Stay Home, Stay Safe" emergency declaration, Dartmouth College is working to restructure the remainder of the Learning Collaborative to accommodate entirely virtual sessions as of March 2020.

iii. Behavioral Health

Key updates from QE032020:
- Team Care program revisions
- Applied Behavior Analysis

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

The Behavioral Health Team is responsible for concurrent review and authorization of inpatient psychiatric and detoxification services for Medicaid primary beneficiaries. Team members work closely with discharge planners at inpatient facilities to ensure timely and appropriate discharge plans. DVHA collaborates with other departments to support coordination of care. The team refers members to VCCI services and helps ensure continuity of care for beneficiaries already enrolled with VCCI admitted to inpatient or residential care facilities. In recognition of the inherent challenges in providing strong clinical documentation to justify admission and continued stay within 24 hours of admission, over the past two years DVHA has engaged in a pilot project in which there is automatic initial authorization of 5 days for all beneficiaries meeting the acute level of care criteria at the Brattleboro Retreat. This practice allows time for the assessment and formulation of an individualized plan of care and discharge plan for each beneficiary admitted. The team has engaged in quarterly reviews of admissions of 5 days or less to determine whether authorization would have been given without the pilot. For each quarter greater than 90% of the admissions and stays would have been authorized with strict adherence to the criteria. The COVID-19 pandemic resulted in an increase in length of stay for Vermont Medicaid inpatient psychiatric placements. Almost all OOS programs had a hold on admissions and the ICPC process was temporarily shut down. Residential Programs in Vermont for children and adolescents overall reduced capacity. The pandemic also impacted community and residential treatment program placements for adults. Due to the lack of placements, DVHAs authorization decisions were affected and additional authorization was required in order to keep our members safe and stable during this time.

The Behavioral Health Team also manages the Team Care program. Team Care can be a useful tool for members who may need additional support getting the most appropriate healthcare available to meet their needs. Clinical review of all available data supports continued review of current enrollees' need to remain in the program. Standards for inclusion and removal have been operationalized by the team. A procedure for inclusion, screening tool, and a manual have been developed. The unit conducts quarterly reviews of claims data, including pharmacy and emergency department visits, to identify members who may benefit from the support of the Team Care program. Clinicians review this data and determine enrollment of potential new members. Team Care program members are also referred to VCCI when appropriate. Outreach with providers and pharmacies is ongoing, an outward facing brochure for Providers has been created and an internal and outward facing educational campaign on the Team Care program has been developed. There have been minimal external referrals to the program. The lack of referrals may demonstrate success of the Vermont Prescription Monitoring System (VPMS) and new opiate rules associated with VPMS.

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

The Applied Behavior Analysis case rate payment methodology became effective on 07/01/2019. The goal of this payment reform project was to increase utilization and access to services. Since the

initiation of the case rate, we have seen an increase in new members that have begun receiving ABA services. There has been an increase in enrollment with Vermont Medicaid of new agencies that provide ABA services. The QICI, Payment Reform, Policy, and the Business Unit are currently working to finalize reconciliation for dates of service July 1, 2019 through December 31, 2019.

The DVHA ABA Team has been actively communicating with ABA providers regarding the COVID-19 pandemic, specifically regarding concerns of their abilities to continue to serve members during this time. The ABA Team reviewed the ABA CPT Codes and made recommendations to the DVHA commissioners' team regarding expanding the use of telehealth (visual and audio) specific to ABA services. Several ABA providers communicated that they were attempting to provide ABA services through a telehealth platform but were finding that families were having a difficult time assisting with this process. Since the end of May, ABA providers have begun to slowly resume ABA services in clinics as well as in home settings.

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

Prior to the COVID-19 pandemic, the Quality team partnered with VCCI to assist in conducting 'Initial Screening Birth to 18 Years' survey. The unit attended a training with VCCI in early 2020 and began surveying members/guardians, and planned to conduct this work through 2020. The Quality Unit will resume assisting VCCI once there is more clarity regarding how the pandemic is impacting this project.

iv. Mental Health System of Care

Key updates from QE032020:

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

System Overview

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

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

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

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

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

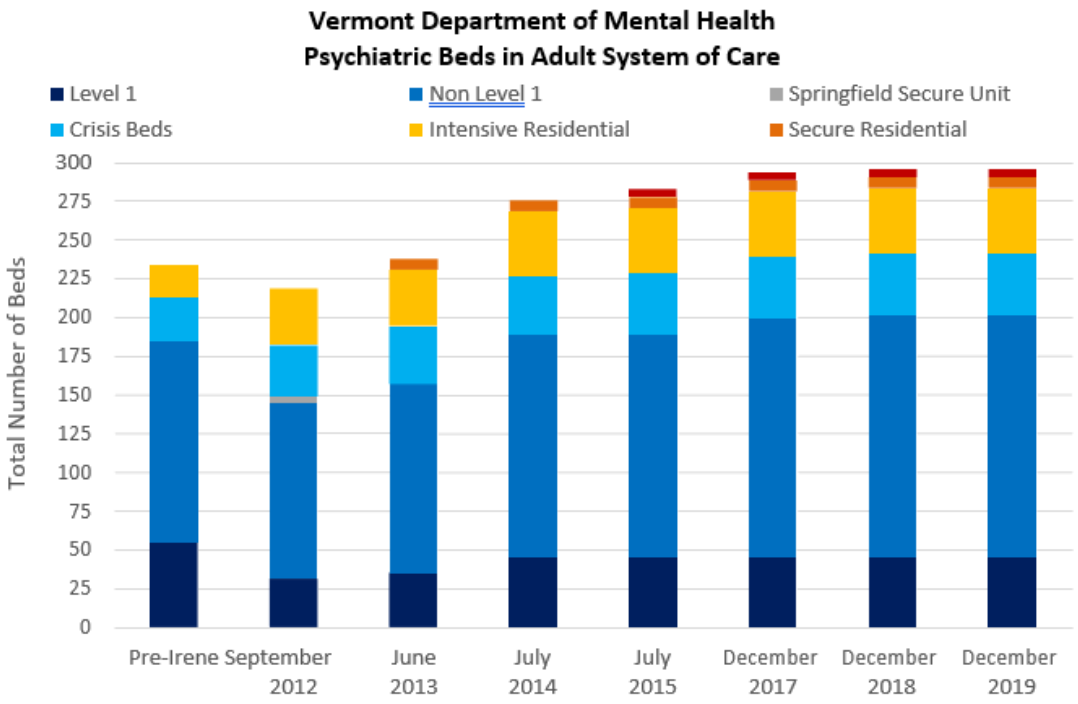
There are a number of policy and programmatic updates below related to the COVID pandemic. The Governor of Vermont, Phil Scott, declared a state of emergency on March 13, 2020 that has recently been extended to July 15, 2020. As well, on March 24, 2020 Governor Scott issued a "Stay Home, Stay Safe" order that ordered Vermonters to restrict and minimize activities outside of the home and directed non-essential businesses and non—profits to cease in person operations. These orders have had a tremendous impact on the service delivery of mental health services throughout Vermont in all community-based settings and inpatient facilities.

Enhancements of the Mental Health System of Care through DMH:

<u>Hospital Services</u>

- There are 45 Level 1 beds and a total of 199 adult psychiatric inpatient beds across the system of care. During the COVID pandemic, a number of beds closed due to low staffing and a decrease in individuals presenting with a need for a higher level of care. Vermont anticipates staffing levels and beds that were needed prior to the pandemic will become a necessity again.
- Act 190 (2018) provided $5.5 million dollars for the development of 12 inpatient Level I beds at the Brattleboro Retreat. This work is continuing but has been delayed due to the COVID-19 pandemic.
- With the COVID-19 pandemic creating pressure on different parts of the adult system of care, a new partnership has been established and a contract has been signed with the Windham Center, located next to the Springfield Hospital in Southern Vermont. The Windham Center is developing 10 adult beds that will be available this summer should there be a need for a COVID-19 positive inpatient, psychiatric care treatment wing.

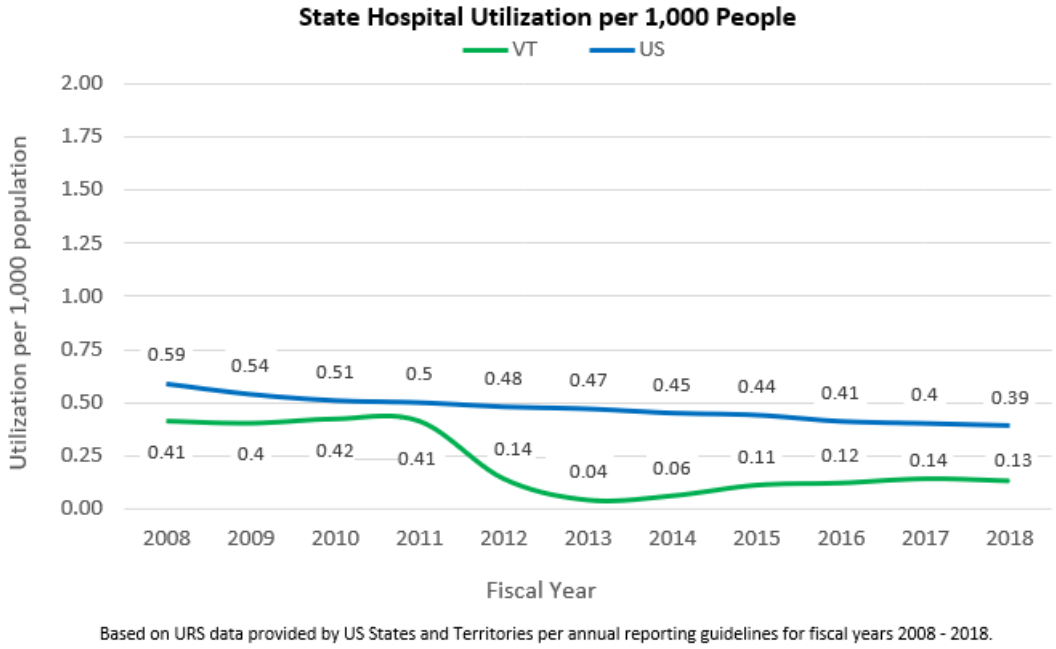
Figure 3. Vermont DMH Psychiatric Beds in Adult System of Care



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

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

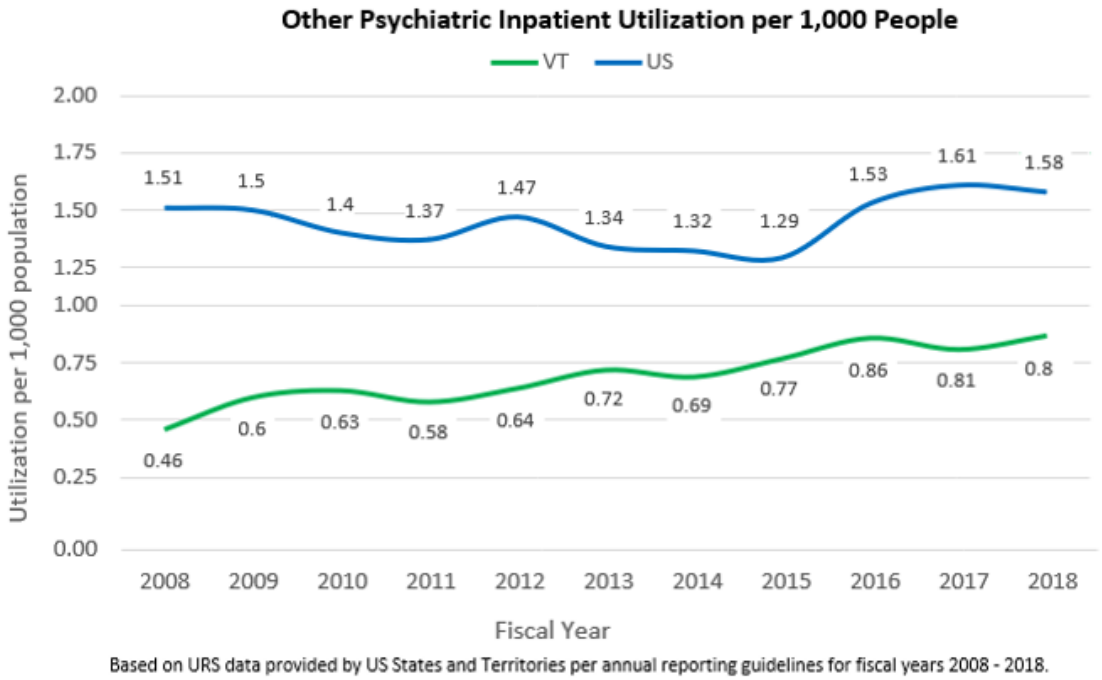
Figure 4. State Hospital Utilization per 1,000 people (in Vermont and the United States)



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

The national rate of state hospital utilization continues to decline year-over-year. Vermont Psychiatric Care Hospital opened in FY 2015 with 25 beds and Vermont's rate of inpatient utilization continues to be lower than the national average in the United States. The significant decrease from FY 2011 to FY 2012 represents the closure of Vermont State Hospital due to flooding from Tropical Storm Irene in August 2011. The Vermont hospital utilization data is showing a slowly progressing upward trend since 2012. Vermont is one of a handful of states that only has one state hospital. Nationally, the number of state hospital beds and residents at the end of the year has been steadily decreasing. DMH will be paying close attention to these rates as there is anticipation and evidence already that this pandemic and the social isolation that has occurred because of it will increase the needs for mental health treatment and support.

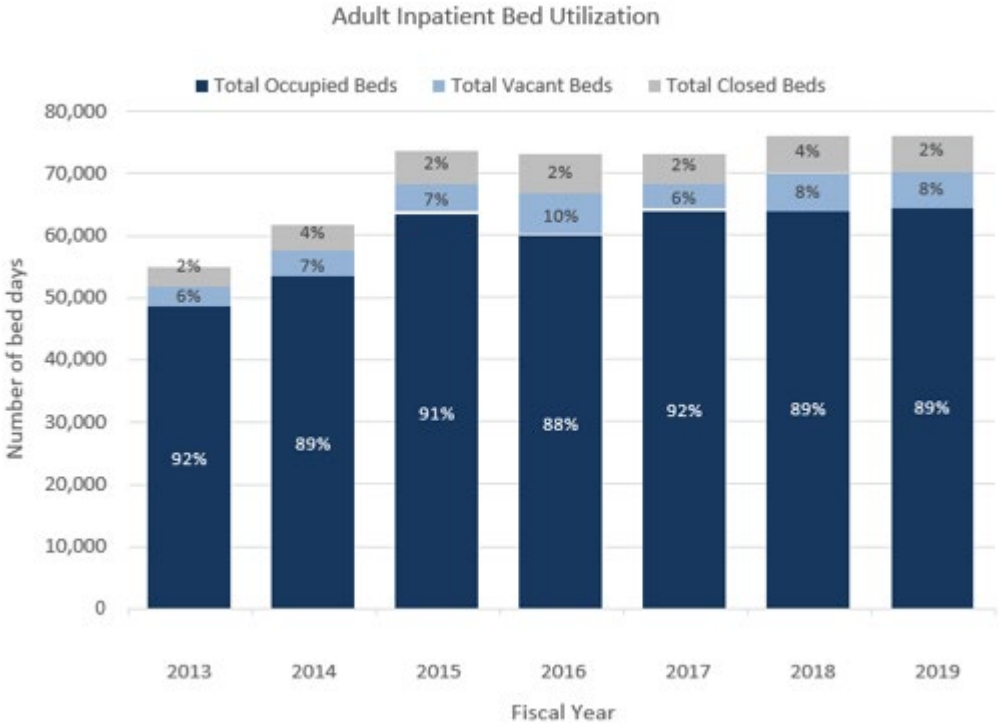
Figure 5. Other Psychiatric Hospital Utilization per 1,000 people (in Vermont and the United States)



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

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

Figure 6. Adult Inpatient Utilization and Bed Closures



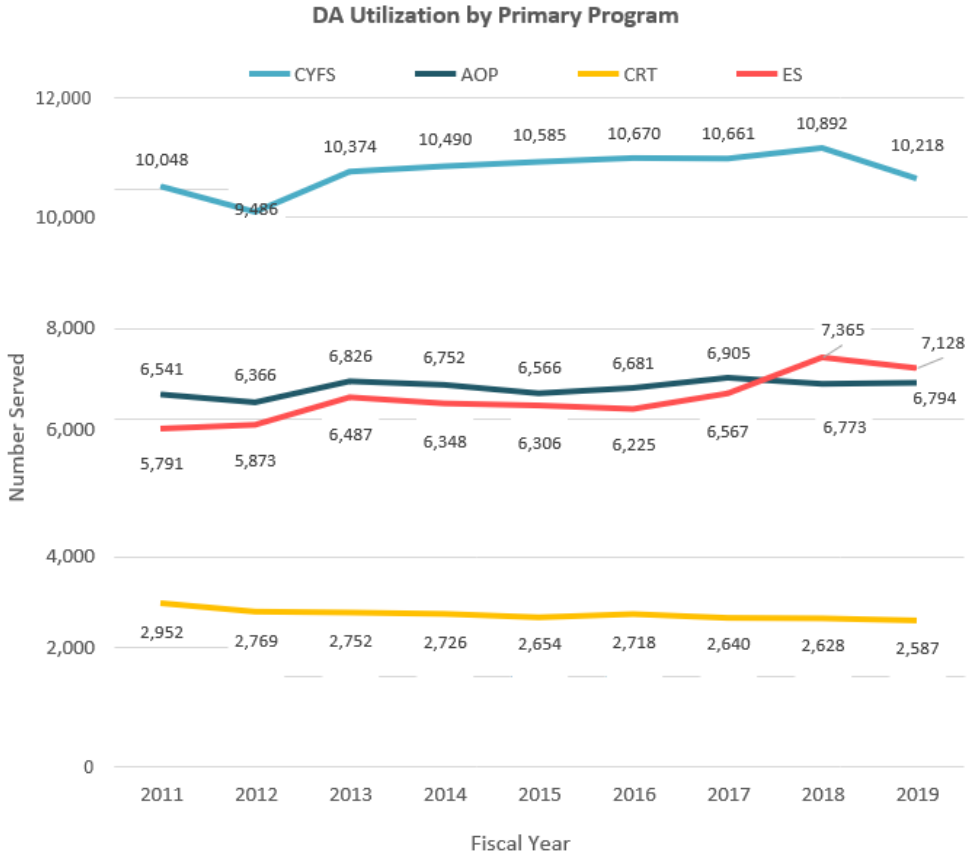
This chart depicts the total bed day capacity across the Vermont Designated Hospital system through FY 2019. The total bed day availability across the system has remained relatively constant in 2018 and 2019 with new bed capacity coming online in 2020. In 2019, bed closures represented 2% of adult inpatient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

<u>Community Services</u>

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

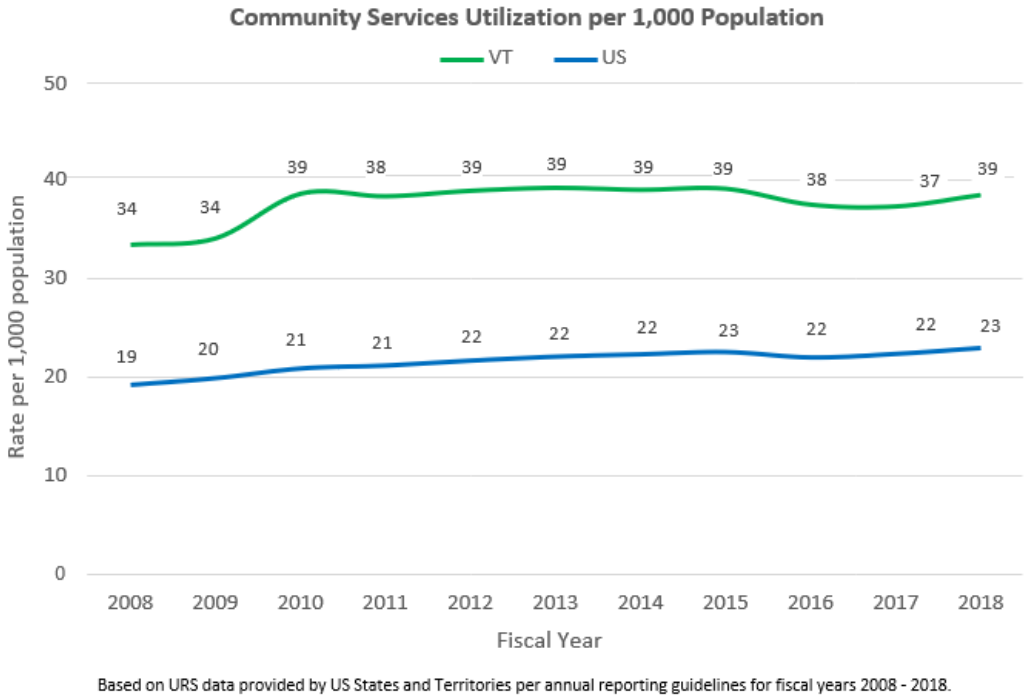
Enhanced community services funding provided by the legislature through increased appropriations to key mental health programs in the community over the last several years has helped, but staff recruitment and retention necessary to meet and expand these service capacities continues to be a struggle.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

Figure 7. Designated Agency Volume by Program



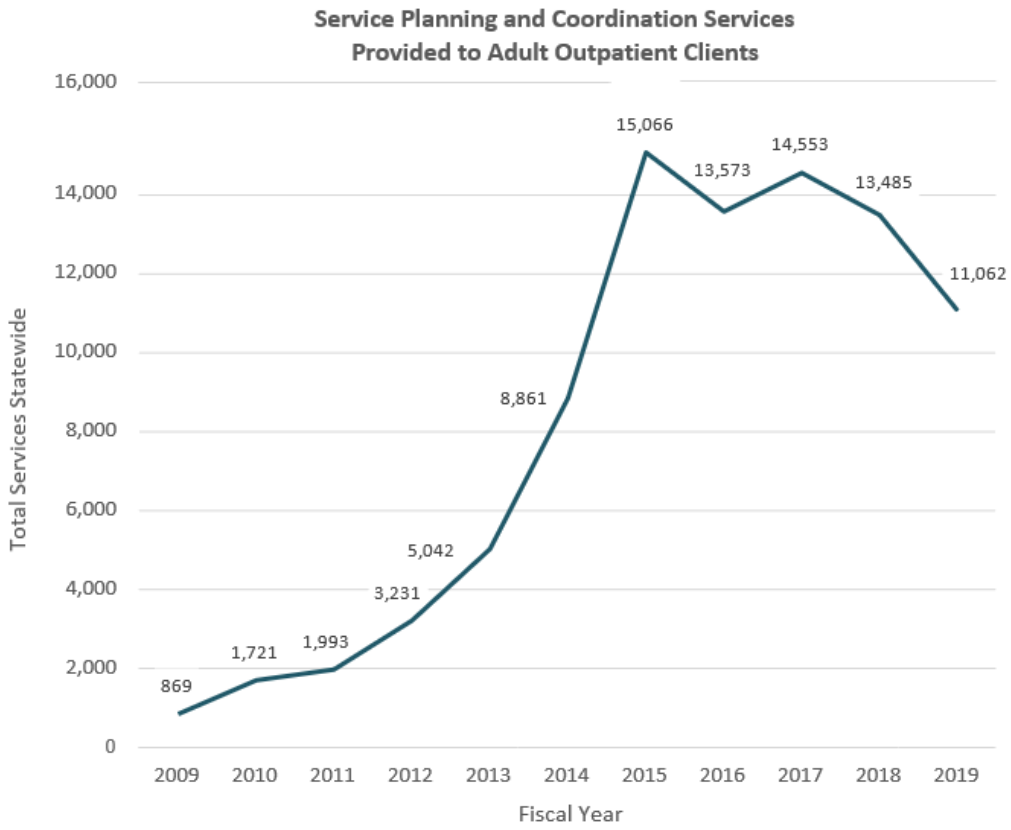
The highest number of persons served by programs offered by the Designated Agencies (DAs) continues to be in services for children, youth, and families. This program has until FY 2019 shown a slow upward trend for a seven-year period with FY 2019 showing a nearly 6% decrease in numbers serve. The Emergency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

Figure 8. Community Utilization per 1,000 Populations



The Vermont community mental health system serves nearly 40 out of every 1,000 Vermonters, which is substantially higher than the national figure. The most recent national data available through 2018 shows that Vermont has a strong and fairly consistent record of service delivery in community-based programs. While the progress appears to be static, data shown in Figure 8 below, indicates that significantly higher rates of service are being provided to fewer numbers of clients who may otherwise have needed hospital levels of care. This number however is also showing a downward trend since 2015.

Figure 9. Service Delivery: Planning and Coordination

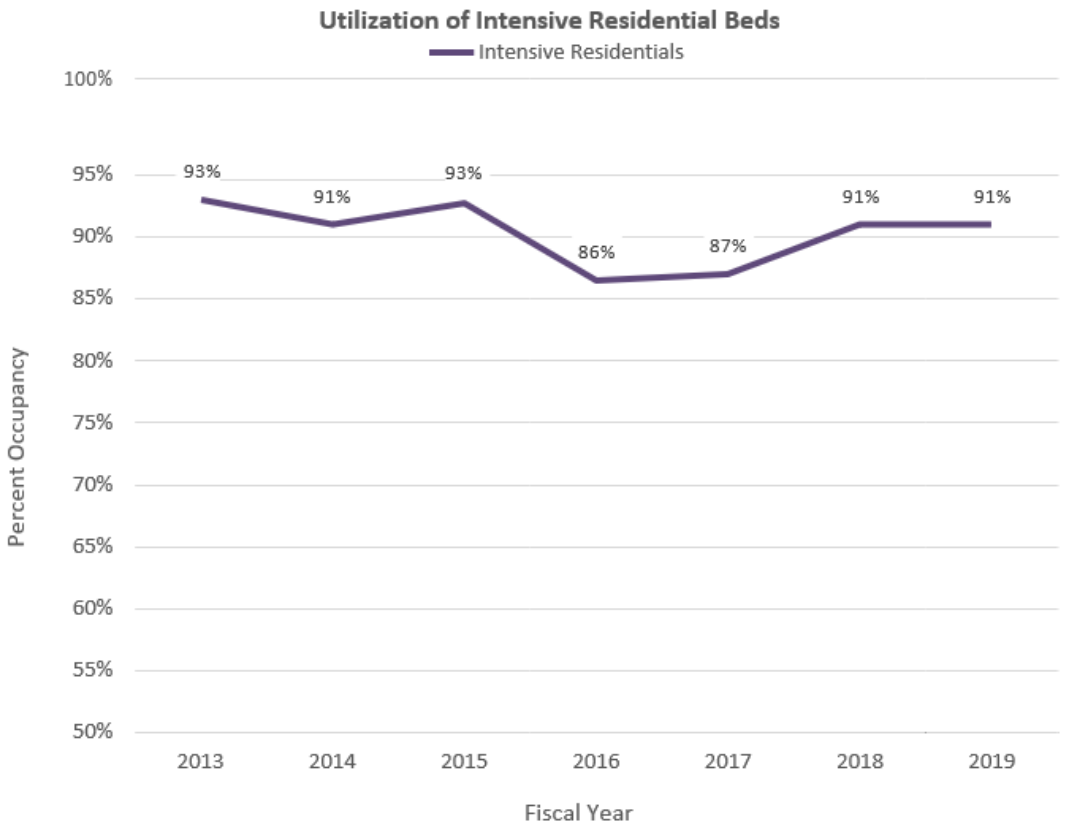


The support of non-categorical case management led to a steady increase in the number of services provided to adult outpatient clients allowing additional support to those in need but ineligible for case management through Community Rehabilitation and Treatment services through FY 2015. Levels remain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

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

Residential and Transitional Services

Figure 10. Intensive Residential Bed Utilization



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

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

<u>Performance and Reporting</u>

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

    - Creation of a "Vermont Psychiatric Care Hospital Outcomes" scorecard to meet legislative reporting requirements
    - Migration of the "DMH Snapshot" and the "DMH continued reporting" report to the RBA scorecard reporting tool
- Exploration of visualization tools to create more responsive reporting
- Participation in development of the Agency of Human Services Community profiles
- DMH has several RBA scorecards containing data and performance measures related to the system of care.

Regulation and Guidance

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

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

Payment Reform

DMH continues to work on payment reform, building off the Medicaid Pathways work and aligning necessary changes in the provider system with the All-Payer Model. The Department is working toward having several—if not all—children's mental health programs in a model similar to Integrating Family Services. Work is underway on a similar initiative for adult mental health services. The goal of this work is to move toward a simple, but accountable system that reduces the complexities of payment and shifts the focus of the providers and the department on outcomes and quality. DMH is committed to reforming the system to better serve Vermont's population and continue to move towards full integration.

Integrating Family Services

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

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

Both IFS regions continue to utilize the Child and Adolescent Needs and Strengths (CANS) to look at

the needs and strengths of children they are serving. The agencies are using this progress monitoring tool to track progress over time. They are showing that through supports and services children/youth are increasing in their strengths and decreasing needs. The caveat to this is that for children involved in the child welfare system it is taking longer to see positive results; not surprising given the fact that these children experience high levels of trauma, exposure to substances, and/or abuse and neglect—this data also follows national trends in data analysis for this subset of the population.

Vision 2030

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

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

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

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

v. Pharmacy Program

Key updates from QE032020:

- The Drug Utilization Review Board (DURB) held one meeting this quarter.
- Bulletins and Advisories

Pharmacy Benefit Management Program

The DVHA's Pharmacy Unit manages the pharmacy benefits for all of Vermont's publicly-funded pharmacy benefit programs. The Pharmacy Unit's goal is to provide the highest quality prescription

drug benefits in the most cost-effective manner possible. This is accomplished by providing broad coverage of prescription and over-the-counter pharmaceuticals, controlling pharmacy expenditures through managing cost, brand and generic utilization, and reducing state administrative costs. The State of Vermont utilizes the pharmacy benefit management company, Change Healthcare (CHC), to provide an array of operational, clinical, and programmatic support in addition to managing a call center in South Burlington, Vermont, for pharmacies and prescribers. The Pharmacy Unit is also responsible for overseeing the contract with CHC. The Pharmacy Unit manages over $185 million in gross drug spend, and routinely analyzes national and DVHA drug trends, reviews drug utilization, and seeks innovative solutions to delivering high-quality customer service, assuring optimal drug therapy for DVHA members while managing drug utilization and cost.

Pharmacy Operations

- Pharmacy claims processing - enforcing coverage rules for various program.
- Pharmacy provider assistance - DVHA, Change Healthcare Technical and Clinical Call Centers.
- Liaison to Coordination of Benefits Unit/Part D Plan Team/Eligibility/Maximus to resolve issues. Vermont Department of Health (VDH)-Vaccine Program, Substance Abuse Program, Department of Mental Health (DMH) management of antipsychotics.
- Works with Vermont Medication Assistance Program (VMAP)and Children with Special Health Needs (CSHN) to assist in the management of the programs.

Clinical

- Manages drug utilization and cost
    - Federal, State, Supplemental rebate programs
    - Preferred Drug list
    - Drug Utilization Review/Pharmaceutical & Therapeutics Board activities
        - therapeutic class reviews, prior authorization criteria reviews and step-therapy protocols
        - Specialty Pharmacy
- Manages exception requests, second reconsiderations, appeals and fair hearings with the Policy Unit
- Works with Program Integrity Unit on drug utilization issues

Bulletins and Advisories/Communications

The following communications were sent to pharmacies and providers:

****Attention Pharmacies and Prescribers****
Important Pharmacy Information in Response to COVID-19

In response to COVID-19 concerns and to ensure that Medicaid members have access to the medications they need, the Department of Vermont Health Access (DVHA) is implementing the following changes to its prescription drug benefits programs, **effective 3/18/2020**:

1. **Members may request early refills of medication up to a 90-day supply as needed.**

- Pharmacies will be able to override the early refill edit by using the NCPDP Submission Clarification Code=13 for the adjudication of pharmacy claims. This code is utilized by the dispensing pharmacist when processing an early refill for the patient and indicates than an override is needed based on an emergency/disaster situation recognized by the payer. The use of SCC 13 will override a Reject 79 (Refill too soon) and applies to all drugs including controlled substances for which refills are allowed. It will NOT override either Reject 75 (prior authorization required) or Reject 76 (plan limits exceeded). DVHA will monitor claims using this submission clarification code to ensure it is used only when medically necessary. Improper use of SCC13 will subject the claim to recoupment.

2. **The day supply limit for Suboxone Film has been extended up to 30-days.** Non-preferred buprenorphine formulations are also extended up to 30-days but will require the pharmacist to call the Help Desk for an override. The prescriber may need to be contacted for an adjustment to the quantity written on the prescription.
3. **Co-pays are being waived for medications that may be used to treat the symptoms of COVID-19.**
    - This includes antihistamines, cough suppressants, anti-febrile/analgesic medications, cough & cold combination products, inhalers, and leukotriene receptor antagonists.
4. **The 90-day supply requirement for select medications can be overridden to allow pharmacies to better manage their inventory and avoid any drug shortages.** Pharmacies must call the Help Desk for an override at this time.

Drug Utilization Review Board

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

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

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

Drug Utilization Review Board meetings occur seven times per year. In QE0320, the DURB held one meeting. The DURB is scheduled to hold three meetings next quarter. Information on the DURB and its activities in 2020 is available at this link: https://dvha.vermont.gov/advisory-boards/drug-utilization-review-board

Drug Utilization Review Board Meetings

Ten new drugs and no therapeutic drug classes were reviewed at the DURB meeting held this quarter; two RetroDur reviews and one safety alert was also presented.

vi. All Payer Model: Vermont Medicaid Next Generation Program

Key updates from QE032020:

- Executed a contract extension with OneCare for a 2020 performance year of the program.
- Began conducting financial reconciliation activities for the 2019 performance year, in order to determine financial and quality performance. Results will be available in early Q3 2020.
- Consider programmatic adjustments to address impacts of COVID-19 on contractual obligations and OneCare provider network.
- Continue to support Vermont's broader efforts to develop an integrated health care delivery system under an All Payer Model through future program planning and implementation.

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

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

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

DVHA and OneCare executed a contract amendment to extend the VMNG program into a 2020 performance year in Q4. The most notable programmatic change was the development of a more inclusive attribution methodology that is a modified version of the 2019 geographic attribution pilot in one participating Health Service Area. This resulted in an expanded attribution methodology that was

conducted in addition to the traditional attribution methodology that has been used since the 2017 performance year. Because the expanded attribution methodology represented a significant programmatic change, other adjustments were minimal. This ensures continued alignment across payer programs as part of the Vermont All Payer ACO Model, while allowing the VMNG program the opportunity to test an adjusted attribution methodology with the potential to scale to other payers in future performance years.

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

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

DVHA and OneCare began exploring options for flexibility in the VMNG program to hold providers harmless for negative impacts related to the COVID-19 pandemic and State of Emergency. Discussion will continue into Q2 and additional quarters of 2020, though the end of the State of Emergency and extent of the pandemic's impact on Vermont's health system are not known as this time.

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

V. Financial/Budget Neutrality Development/Issues

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

As is the process after each quarterly submission of the CMS-64, AHS reconciled the quarterly amount claimed on the CMS-64 with the monthly payments made to DVHA. The State prepared the CMS-64 based upon actual allowable Medicaid expenditures (program, investments and administration) for the given quarter. AHS submitted and certified the CMS64 report for QE0320 on May 30, 2020, as is normal.

Overall, the budget neutrality exercise indicates that for March 2020 quarter, the State's total "With Waiver" expenditures were 2.3% ($8,312,351) lower than the total "Without Waiver" amount (caseloads multiplied by the Budget Neutrality PMPMs).

For the supplemental budget neutrality tests, only one category is showing a deficit: AHS has observed that the New Adult category is exceeding its budget neutrality PMPM by $7,346,817, or 7.58%. AHS

will research this variance and continue to monitor this category to determine if this is a part of normal quarterly fluctuations.

AHS continues to actively monitor Investment spending. The total Investment spending for QE0320 was $41,594,792. There was $831,250 erroneously reported for Delivery System Reform Investments; this will be rectified in QE0620. (Note: CY2020 marks the second year in which room and board and physician training program investments must be phased down by 33%.) The HIT and non-State plan related Education fund Investments have already been fully phased down.

COVID's effect on budget neutrality will become clearer during the quarter ending September 30, 2020. Governor Scott declared a State of Emergency on March 13, 2020, which included postponing all non-essential medical procedures. The state is expecting significant decreased utilization during the QE 0620. In addition, while of minimal impact, the state has ceased some copayments for the duration of the public health emergency.

Another impact of COVID has been the State's ongoing work to implement the reporting requirements required for federal financial participation for Institution for Mental Diseases (IMD) services provided to Vermont Medicaid members with Severe Mental Illness (SMI). This was approved by CMS in December 2019. SMI reporting was intended to go into effect for QE0320, but due to resource challenges the State was unable to report any SMI expenses. The State will report prior quarter adjustments retro to 1/1/20 when the reporting mechanisms go live in QE0920.

VI. Member Month Reporting

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

The table below contains Member Month Reporting for QE0320 of CY2020, and includes the unduplicated count of member months for SUD IMD stays. CY2019 and CY 2018 member months are also reported in the tables below.

Impact of COVID: Due to the public health emergency, the State is expecting to report increased enrollment during the QE 0620.

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

Demonstration Population	Medicaid Eligibility Group	Total CY 2020, QE 0320	Total CY 2019	Total CY 2018
1, 4*, 5*	ABD - Non-Medicare - Adult	20,021	81,339	83,071
	SUD - IMD - ABD	47	149	78
	SMI - IMD - ABD	0		
1	ABD - Non-Medicare - Child	5,055	23,844	25,577
1, 4*, 5*	ABD – Dual	63,685	257,606	257,263
	SUD - IMD - ABD Dual	64	158	78
	SMI - IMD - ABD Dual	0		
2	Non-ABD, Non-Medicare - Adult	23,070	104,011	143,377
	SUD - IMD - Non-ABD	77	222	187
	SMI - IMD - Non-ABD	0		
2	Non-ABD, Non-Medicare - Child	172,555	703,792	723,120
	Medicaid Expansion			
7	Global RX	19,097	77,516	79,488
8	Global RX	10,338	44,175	46,792
6	Moderate Needs	553	2,219	2,319
	New Adults			
3	New Adult without child	102,548	423,191	471,886
	SUD - IMD New Adult w/o child	486	1,352	791
	SMI - IMD New Adult w/o child	0		
3	New Adult with child	59,848	233,171	223,882
	SUD - IMD New Adult with child	87	259	114
	SMI - IMD New Adult with child	0		
	Total	477,531	1,953,004	2,058,023
* Long Term Care Group Subset				
4 only	ABD Long Term Care Highest Need	8,691	35,369	34,856
5 only	ABD Long Term Care High Need	4,033	15,462	14,055

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

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

Table 3. Medicaid Non-BN Rates Effective CY 2020

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

VII. Consumer Issues

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

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

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

VIII. Quality Improvement

Key updates from QE032020:

- The Clinical Services Team continued to lead a formal CMS PIP project focused on improving substance use disorder treatment through the promotion of telehealth services.
- DHVA's Quality Committee modified the Medicaid Program's *Global Commitment to Health* Core Performance Measure Set.

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

PIHP Quality Committee

The Quality Committee remained active during QE0320 and consists of representatives from all departments within AHS that serve the Medicaid population. The committee continues to structure its work around the federal managed care quality program guidelines and the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of health care. During this reporting period, the Quality Committee modified the *Global Commitment to Health* (GC) Core Measure Set. Based on the committee's annual performance measure evaluation

and changes to national quality measure sets, the decision was made to retire a few measures and add a few new measures that will fill some gaps and better align with other measure sets currently used in the State.

Additionally during the QE0320, the committee reviewed the annual Child and Adult CAHPS survey results and confidentiality procedures, including HIPAA breach tracking.

Formal CMS Performance Improvement Project (PIP)

The Director of Quality Management continued to coordinate VT Medicaid's formal CMS Performance Improvement Project (PIP) during the QE0320 – the topic of which is substance use disorder treatment. The cross-departmental PIP team is focused on a multi-pronged telehealth-related intervention. Targeted communications about telehealth were dispersed via provider banners and newsletter articles during 2019.

Interim indicator data on telehealth use is collected to monitor progress. Data points include: number of telehealth episodes of care, number of unduplicated providers billing for telehealth and number of unduplicated members receiving telehealth services. There was an increase in all metrics from the baseline of Q2 SFY 18. Data continued to show that SUD treatment providers were using telehealth in comparatively small numbers and continued focus here could be meaningful.

PIP team representatives spearheaded a state-wide stakeholder group with a partner organization, the Vermont Program for Quality in Health Care (VPQHC). The purpose of this group was to explore the expansion of telemedicine across the state, including the provision of technical assistance with telehealth platform implementation. The telemedicine stakeholder group met for the first time in late 2019. During the QE0320, a sub-group met to plan an in-person Telehealth 101 training curriculum, with the goal of offering and recording this meeting to interested providers, with targeted outreach to SUD treatment providers, in the late spring/early summer of 2020. However, during QE0320 the COVID-19 virus spread, a state of emergency was declared and all plans for an in-person training were put on hold. The pre-existence of the telemedicine stakeholder group allowed key players in Vermont (policymakers, providers, payers, subject matter experts and educators) to quickly pivot their efforts starting mid-late March 2020 to an accelerated series of educational offerings. Twice weekly "office hours" webinars started in late March. Topics have focused primarily on technical assistance with implementing telemedicine platforms, but also have included billing and reimbursement, gaining client consent and telemedicine visit workflow.

Other Collaborative Quality Improvement Projects

The Quality Unit staff completed two informal quality improvement projects during 2019. The topics were chlamydia screening (CHL) and adults' access to ambulatory/preventive services (AAP). The Quality Improvement & Clinical Integrity Unit merged with two other units (Clinical Operations and Pharmacy) during the QE0320. The new combined group is called the Clinical Services Team. Goals of this new team include realizing efficiencies, aligning priorities and reducing redundancies. During the QE0320 the Clinical Services Team's Directors and CMO began assessing clinical priorities as the groundwork for a new collaboration (this was slowed a bit as staff time was diverted to COVID-19 response). As the year progresses, focus areas will be chosen and QI tools and methodology will be incorporated into these efforts.

Quality Measure Reporting

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

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - the DVHA Quality Unit's QI Administrator coordinated the 2019 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Children's and Adults Medicaid 5.0H survey. The contracted vendor, DataStat, Inc., distributed and collated the surveys according to AHRQ and NCQA protocols in the fall of 2019. The results of the surveys were delivered to the DVHA in February 2020 and were presented to the PIHP Quality Committee in March 2020.

- HEDIS measure production – The Clinical Services Team launched the HEDIS 2020 season by requesting that our contractor perform medical record retrieval for five hybrid measures and abstraction for one of those measures. DVHA staff prepared abstraction training, tools and materials during QE0320 and began abstracting the other four measures at the end of March 2020.

- Clinical Services Team staff continued conversations with staff from Vermont Information Technology Leaders (VITL) to explore using the data stored in the Vermont Health Information Exchange (VHIE) for hybrid measure production in the future. Initial system testing will be performed later in CY 2020.

- The Director of Quality Management formed an RFP team for the HEDIS/Quality Measures contract during the QE0320. The team began modifying the scope within this contract, with the goal of posting the RFP and selecting a vendor during QE0920.

Results Based Accountability (RBA)/Process Improvement

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

The Clinical Services Team also maintained their Green Belt status during QE0320 by submitting and updating personal development plans and attending additional courses. Green Belt is the highest level of internal training offered through the State based on LEAN/RBA principles. The trainings are centered around process improvement and contribute to the Governor's initiative called PIVOT, or Program to Improve Vermont Outcomes Together.

COVID-19 Dashboard

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

Vermont Next Generation Medicaid ACO

During the QE0320 the DVHA's Director of Quality Management received, reviewed and approved the quarterly VMNG ACO quality management reports. Quality and Clinical staff from DVHA and the VMNG ACO typically meet quarterly with a focus on quality measurement and ongoing QI efforts, but the March 2020 meeting was canceled due to the onset of the COVID-19 emergency.

AHS Performance Accountability Committee

During this quarter, the AHS Performance Accountability Committee (PAC) did not meet. Instead, the state took the time to review the meeting cadence of the group. Getting the meeting cadence right makes a huge difference in how well the team performs. The following factors are being reviewed: urgency and importance of goals, tenure of participants, relevancy of topics, and interdependence. The goal is to have regularly scheduled meetings maintain work momentum and strengthen the relationships between team members.

Global Commitment (GC) Investment Review

AHS Departments are required to monitor and evaluate the performance of their investments on an ongoing basis and subject them to formal review according to a periodic schedule. Performance monitoring is accomplished via a quarterly and annual review of performance information contained in a web browser-based software application (Clear Impact Scorecard). The scorecard includes the following data elements: investment description (i.e., the goal of the investment, the activities being supported, and information on how they are provided), performance measures (i.e., the data being collected and analyzed to determine if the investment is achieving its desired goal), results (performance measure rates for most recent reporting period), and an interpretation of the results (i.e., comparing actual to expected rates using performance targets and/or benchmarks and to characterize trends or patterns in the data). During this most recent quarter, DMH and DVHA highlighted the performance of a subset of their investments. The Clear Impact Scorecards for these investments is included in this report as Attachment 7.

Payment Models & Performance Monitoring

AHS Departments are required to monitor and evaluate the performance of their payment models on an ongoing basis and subject them to formal review according to a periodic schedule. Performance monitoring is accomplished via a quarterly and annual review of performance information contained in a web browser-based software application (Clear Impact Scorecard).

During this most recent quarter, DVHA highlighted the performance of its Dental Incentive Program payment model. In addition, DCF highlighted the performance of its Children's Integrated Services payment model. Both Clear Impact Scorecards for these payment models are included in this report as Attachment 8.

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

During this quarter, the CQS/STP was posted for public comment. The public comment period started on February 19, 2020 – and originally ran through March 20, 2020. The document was posted on the AHS website and the notice was distributed to subscribers using the Global Commitment Register (GCR). A link to the CQS/STP was also included in the body of the notice. The updated version of the strategy/plan includes content that addresses the following milestones:

- completion of site-specific assessment & validation activities (VT-5.0),
- an updated chart of the number of sites falling into categories of compliance (VT-5.1),
- incorporate results of settings analysis into final version of the STP and releasing for public comment (VT-6.0),
- identification of settings that overcome the presumption and will be submitted for heightened scrutiny and notification to provider (VT-17.0),
- complete gathering information and evidence on settings requiring heightened scrutiny that it will present to CMS (VT-18.0), and
- incorporate list of settings requiring heightened scrutiny and information and evidence (VT-19.0).

Due to the COVID-19 pandemic, the comment period was extended from 30 to 60 days. The comment period is scheduled to end during the next quarter.

SUD Monitoring Protocol

The SUD Monitoring Protocol specifies the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 49 of the demonstration. These metrics consist of (1) established quality measures endorsed by NQF or included in other Medicaid Quality Measures measure sets, (2) CMS-constructed implementation performance metrics and (3) state-defined Health Information Technology (HIT) metrics. For each performance measure, the SUD Monitoring Protocol identifies a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points. During this quarter, the state continues to support the calculation of the monitoring metrics identified in the monitoring protocol. In addition to reviewing the technical specifications manual, the state considered which monitoring metrics may be useful to include in the formal waiver evaluation.

SMI Monitoring Protocol

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

Components of the Monitoring Protocol must include the following: 1) an assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 103(c) and STC 104(c), reporting relevant information to the state's SMI/SED financing

plan described in Attachment C, and reporting relevant information to the state's Health IT plans described in STC 104(d); 2) a description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section IX of the demonstration; and 3) a description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings. The state plans to submit the SMI Monitoring Protocol during the next quarter.

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

During this quarter, the existing Global Commitment to Health demonstration evaluation contract with Pacific Health Policy Group, PHPG, was revised to add deliverables and dollars to accommodate the evaluation requirements of the recently approved Serious Mental Illness (SMI) amendment. During the quarter, the state worked with their independent evaluator to incorporate the Serious Mental Illness (SMI) amendment provisions. Specifically, the document was revised to meet the requirements specified by the demonstration's Special Terms and Conditions (STCs), include CMS SMI monitoring and evaluation tools, and align with CMS SMI evaluation design guidance. The revised draft evaluation design is due to CMS during the next quarter.

Also, during this quarter, the state continued to work with the evaluator to implement Substance Use Disorder (SUD) evaluation activities. Time was spent identifying preferred providers that would be surveyed during the second round of inquiry. The state also continued to work with the evaluator to identify additional data element requirements associated with performance measures used to support evaluation related research questions and hypotheses. Once the additional data elements were identified – a standardized instrument to collect the information was developed. State staff responsible for calculating the rates associated with the measures are required to submit the completed tool to the evaluator during the next quarter.

X. Compliance

Key updates from QE032020:

- DVHA is preparing subject matter experts for this year's EQRO Audit.
- AHS and DVHA are developing new structures to manage compliance activities.
- Compliance Committee review is underway.
- All DVHA performance measures reported to AHS were determined to be reliable and valid.

The state worked with the External Quality Review Organization (EQRO) to develop the material necessary for each of the required annual external quality review activities (i.e., performance improvement project validation, performance measure validation, and compliance review). Performance Improvement Project (PIP) validation items included the PIP validation timeline, review templates and report outline. Performance Measure Validation itemed the PMV timeline, a document request letter, a rate reporting template, and HEDIS roadmap. Review of Compliance with Standards items included a document request letter as well as desk and documentation review forms. All timelines included the following elements: start date, completion date, task, and responsible party. All letters and materials are expected to be sent to DVHA during the next quarter.

Monitoring Compliance with Standards

DVHA began preparing subject matter experts for the 2020 EQRO compliance audit. This included an orientation to the audit standards and the audit timeline. For this year's compliance review, the auditors will focus on the following standards:

- Provider Selection
- Credentialing and re-credentialing
- Beneficiary rights
- Benificiary communications
- Confidentiality
- Grievances, appeals and fair hearings
- Subcontractual delegations

Updates to Agency Approach to Medicaid Compliance

DVHA and AHS held a series of meetings to develop updates to the processes and communications channels used to manage Medicaid compliance in the agency. These updates include better lines of communication, clearer reporting and accountability requirements, updates to the Compliance Committee and better coordination of efforts across the agency.

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Compliance Committee

During this quarter, the committee did not meet. Instead, the state took the time to review and assess the adequacy of the committee's charter. One of the elements considered this quarter was the meeting cadence of the group. Getting the meeting cadence right makes a huge difference in how well the team performs. Other factors to be looked at include, but are not limited to the following: goals, participants, topics, and interdependence with other existing state committees. The goal is to identify improvements to the charter that allow the group to maintain work momentum and strengthen their relationships with existing structures/processes.

XI. Reported Purposes for Capitated Revenue Expenditures

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

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

Attachment 6 is a summary of Investments, with applicable category identified, for QE032020.

XII. Enclosures/Attachments

Attachment 1: Budget Neutrality Workbook
Attachment 2: Enrollment and Expenditures Report
Attachment 3: Complaints Received by Health Access Member Services
Attachment 4: Medicaid Grievance and Appeal Reports
Attachment 5: Office of the Health Care Advocate Report
Attachment 6: QE032020 Investments
Attachment 7: Investment Scorecard: Department of Mental Health
Attachment 8a: Payment Model Scorecard: DVHA Dental Incentive Program
Attachment 8b: Payment Model Scorecard: Children's Integrated Services

XIII. State Contact(s)

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

Date Submitted to CMS: June 30, 2020

ATTACHMENTS

Attachment 1 - Budget Neutrality

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
April 30, 2020

ELIGIBILITY GROUP	DY 12 JAN - DEC 2017	DY 13 JAN - DEC 2018	DY 14 JAN - DEC 2019	DY 15 JAN - DEC 2020	DY 16 JAN - DEC 2021	Total
Without Waiver (Caseload x pmpms)						
ABD - Non-Medicare - Adult	$ 142,860,455	$ 130,050,973	$ 132,051,426	$ 33,706,154	$ -	$ 438,669,009
ABD - Non-Medicare - Child	$ 85,359,001	$ 78,434,428	$ 75,825,351	$ 16,669,975	$ -	$ 256,288,754
ABD - Dual	$ 664,153,383	$ 693,539,886	$ 720,158,181	$ 184,624,089	$ -	$ 2,262,475,539
Non ABD - Non-Medicare - Adult	$ 101,757,250	$ 96,887,008	$ 73,729,237	$ 17,154,852	$ -	$ 289,528,347
Non ABD - Non-Medicare - Child	$ 392,665,288	$ 406,444,058	$ 413,780,431	$ 106,116,148	$ -	$ 1,319,005,926
Total Expenditures Without Waiver	**$ 1,386,795,376**	**$ 1,405,356,354**	**$ 1,415,544,626**	**$ 358,271,218**	**$ -**	**$ 4,565,967,574**
With Waiver						
ABD Non Medicare Adult	$ 162,602,154	$ 162,728,372	$ 168,382,861	$ 48,602,532	$ -	$ 542,315,918
ABD - Non-Medicare - Child	$ 66,593,208	$ 60,077,015	$ 58,176,676	$ 16,366,145	$ -	$ 201,213,043
ABD - Dual	$ 445,847,909	$ 461,739,496	$ 484,543,363	$ 121,252,354	$ -	$ 1,513,383,122
Non ABD - Non-Medicare - Adult	$ 84,040,228	$ 84,275,155	$ 67,221,781	$ 18,556,447	$ -	$ 254,093,610
Non ABD - Non-Medicare - Child	$ 305,543,574	$ 335,706,591	$ 350,804,595	$ 100,354,462	$ -	$ 1,092,409,223
Premium Offsets	$ (655,991)	$ (772,935)	$ (774,152)	$ (143,692)	$ -	$ (2,346,769)
Moderate Needs Group	$ 1,488,408	$ 1,378,915	$ 1,429,868	$ 8,378	$ -	$ 4,305,569
Marketplace Subsidy	$ 6,355,286	$ 6,242,717	$ 5,915,336	$ 1,568,747	$ -	$ 20,082,087
VT Global Rx	$ 13,824,166	$ 15,300,919	$ 10,692,124	$ 251,163	$ -	$ 40,068,372
VT Global Expansion VHAP	$ 414,824	$ (0)	$ 0	$ -	$ -	$ 414,824
CRT DSHP	$ 10,331,787	$ 9,240,772	$ 6,787,058	$ 1,547,549	$ -	$ 27,907,166
Investments	$ 142,332,671	$ 148,500,000	$ 119,133,232	$ 41,594,792	$ -	$ 451,560,695
Total Expenditures With Waiver	**$ 1,238,718,223**	**$ 1,284,417,019**	**$ 1,272,312,741**	**$ 349,958,877**	**$ -**	**$ 4,145,406,860**
Supplemental Test: New Adult (Gross)						
Limit New Adult	$ 370,689,611	$ 375,735,593	$ 369,341,461	$ 95,219,271	$ -	$ 1,210,985,936
Without Waiver SUD - IMD New Adult Expenditures		$ 2,704,249	$ 4,842,747	$ 1,732,804	$ -	$ 9,279,799
Without Waiver SMI - IMD New Adult Expenditures				$ -	$ -	$ -
With Waiver New Adult Expenditures	$ 295,620,340	$ 312,104,578	$ 315,241,704	$ 102,902,443	$ -	$ 1,025,869,064
With Waiver SUD - IMD New Adult Expenditures		$ 2,826,119	$ 5,869,169	$ 1,396,448	$ -	$ 10,091,736
With Waiver SMI - IMD New Adult Expenditures				$ -	$ -	$ -
Surplus (Deficit)	*$ 75,069,271*	*$ 63,509,145*	*$ 53,073,335*	*$ (7,346,817)*	*$ -*	$ 184,304,934
Supplemental Test: IMD SUD (Gross)						
SUD - IMD ABD - Non-Medicare - Adult		$ 268,039	$ 529,433	$ 172,680	$ -	$ 970,152
SUD - IMD ABD - Dual		$ 214,495	$ 442,312	$ 182,389	$ -	$ 839,196
SUD - IMD Non ABD - Non-Medicare - Adult		$ 533,391	$ 633,224	$ 219,632	$ -	$ 1,386,247
Limit SUD IMD Without Waiver		**$ 1,015,926**	**$ 1,604,968**	**$ 574,701**	**$ -**	**$ 3,195,595**
SUD - IMD ABD Non Medicare Adult		$ 249,820	$ 646,440	$ 169,698	$ -	$ 1,065,959
SUD - IMD ABD - Dual		$ 199,224	$ 545,837	$ 106,654	$ -	$ 851,715
SUD - IMD Non ABD - Non-Medicare - Adult		$ 540,841	$ 803,762	$ 188,953	$ -	$ 1,533,557
Limit SUD IMD With Waiver		**$ 989,886**	**$ 1,996,039**	**$ 465,305**	**$ -**	**$ 3,451,230**
Surplus (Deficit)		*$ 26,040*	*$ (391,071)*	*$ 109,396*	*$ -*	$ (255,635)
Supplemental Test: IMD SMI (Gross)						
SMI - IMD ABD - Non-Medicare - Adult				$ -	$ -	$ -
SMI - IMD ABD - Dual				$ -	$ -	$ -
SMI - IMD Non ABD - Non-Medicare - Adult				$ -	$ -	$ -
Limit SMI IMD Without Waiver		**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
SMI - IMD ABD Non Medicare Adult				$ -	$ -	$ -
SMI - IMD ABD - Dual				$ -	$ -	$ -
SMI - IMD Non ABD - Non-Medicare - Adult				$ -	$ -	$ -
Limit SMI IMD With Waiver		**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Surplus (Deficit)		*$ -*	*$ -*	*$ -*	*$ -*	$ -
Waiver Savings Summary						
Annual Savings	$ 148,077,153	$ 120,939,335	$ 143,231,886	$ 8,312,341	$ -	$ 420,560,715
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	$ 44,423,146	$ 30,234,834	$ 35,807,971	$ 2,078,085	$ -	$ 112,544,036
Total Savings	$ 44,423,146	$ 30,234,834	$ 35,807,971	$ 2,078,085	$ -	$ 112,544,036
Cumulative Savings	***$ 44,423,146***	***$ 74,657,980***	***$ 110,465,951***	***$ 112,544,036***	***$ 112,544,036***	***$ 112,544,036***
	11%	9%	10%	2%		

New Adult Waiver Savings Not Included in Waiver Savings Summary
See Budget Neutrality New Adult tab (STC#64)
See CY2020 Investments tab
See EG MM CY 2020 Tab for Member Month Reporting

Budget Neutrality New Adult

New Adult (w/ and w/o Child) Medical Costs Only	**DY 12 – PMPM**				**DY 13 – PMPM**				**DY 14 – PMPM**				**DY 15 – PMPM**			
	QE 0317	**QE 0617**	**QE 0917**	**QE 1217**	**QE 0318**	**QE 0618**	**QE 0918**	**QE 1218**	**QE 0319**	**QE 0619**	**QE 0919**	**QE 1219**	**QE 0320**	**QE 0620**	**QE 0920**	**QE 1220**
(A) New Adult Group PMPM Projection	$518.26	$518.26	$518.26	$518.26	$540.03	$540.03	$540.03	$540.03	$562.71	$562.71	$562.71	$562.71	$586.34	$586.34	$586.34	$586.34
(B-1) eligible member months w/ Child	55,223	57,077	56,789	55,632	55,583	55,408	55,889	57,002	57,969	58,504	58,565	58,133	59,848			
(B-2) eligible member months w/o Child	124,999	124,981	121,338	119,219	120,870	119,755	116,895	114,366	110,736	106,935	103,737	101,783	102,548			
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	$ 28,619,871.98	$ 29,580,726.02	$ 29,431,467.14	$ 28,831,840.32	$ 30,016,487.49	$ 29,921,982.24	$ 30,181,736.67	$ 30,782,790.06	$ 32,619,735.99	$ 32,920,785.84	$ 32,955,111.15	$ 32,712,020.43	$ 35,091,276.32			
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	$ 64,781,981.74	$ 64,772,653.06	$ 62,884,631.88	$ 61,786,438.94	$ 65,273,426.10	$ 64,671,292.65	$ 63,126,806.85	$ 61,761,070.98	$ 62,312,254.56	$ 60,173,393.85	$ 58,373,847.27	$ 57,274,311.93	$ 60,127,994.32			
(D-1) New Adult FMAP w/ Child	54.46%	54.46%	54.46%	53.47%	53.47%	53.47%	53.47%	53.89%	53.89%	53.89%	53.89%	53.86%	60.06%			
(D-2) New Adult FMAP w/o Child	86.89%	86.89%	86.89%	86.69%	89.95%	89.95%	89.95%	89.99%	93.00%	93.00%	93.00%	93.00%	90%			
(E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child	$ 15,586,382.28	$ 16,109,663.39	$ 16,028,377.00	$ 15,416,385.02	$ 16,049,815.86	$ 15,999,283.90	$ 16,138,174.60	$ 16,588,845.56	$ 17,578,775.73	$ 17,741,011.49	$ 17,759,509.40	$ 17,618,694.20	$ 21,075,820.56			
(E-2 = C2 x D-2) Federal Share of Supplemental Cap 1 w/o Child	$ 56,289,063.93	$ 56,280,958.24	$ 54,640,456.64	$ 53,562,663.92	$ 58,713,446.78	$ 58,171,827.74	$ 56,782,562.76	$ 55,578,787.77	$ 57,950,396.74	$ 55,961,256.28	$ 54,287,677.96	$ 53,265,110.09	$ 54,115,194.89			
Subtotal Federal Share Supplemental Cap 1	$ 71,875,446.21	$ 72,390,621.63	$ 70,668,833.64	$ 68,979,048.94	$ 74,763,262.64	$ 74,171,111.64	$ 72,920,737.36	$ 72,167,633.34	$ 75,529,172.47	$ 73,702,267.77	$ 72,047,187.36	$ 70,883,804.30	$ 75,191,015.45			
Total FFP reported for New Adult Group	$ 62,816,665.28	$ 61,830,391.33	$ 54,643,069.28	$ 51,158,852.52	$ 62,183,045.44	$ 63,756,150.76	$ 62,666,336.47	$ 61,269,677.13	$ 67,854,834.87	$ 68,588,592.26	$ 63,276,555.83	$ 54,245,264.74	$ 82,218,290.81			
Supplemental Budget Neutrality Test 1 over/(under) - report any negative # under main GC budget neutrality	$ 9,058,780.94	$ 10,560,230.30	$ 16,025,764.37	$ 17,820,196.41	$ 12,580,217.20	$ 10,414,960.88	$ 10,254,400.88	$ 10,897,956.21	$ 7,674,337.60	$ 5,113,675.51	$ 8,770,631.53	$16,638,539.56	$ (7,027,275.36)			

Report to
The Vermont Legislature

Medicaid Program Enrollment and Expenditures Quarterly Report

In Accordance with 33 V.S.A. § 1901f

Submitted to: The General Assembly

Submitted by: Mike Smith, Secretary
Agency of Human Services

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

Report Date: June 1st, 2020

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BACKGROUND

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

KEY TERMS

Caseload: Average monthly member enrollment

PMPM: Per Member Per Month

MEG: Medicaid Eligibility Group

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICAID PROGRAM ENROLLMENT AND EXPENDITURES

The Department of Vermont Health Access

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

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

The Department of Vermont Health Access

Caseload and Expenditure Report
All AHS YTD SFY'20

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

The Department of Vermont Health Access

Caseload and Expenditure Report

DVHA Only YTD SFY'20

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

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

Questions, Complaints and Concerns Received by Health Access Member Services
January 1, 2020 – March 31, 2020

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

January 2020:

- Caller stated that the Vermont Medicaid Portal Provider Look Up Tool is not user friendly. They feel that there should be more options or for it to be easier for their customers to look up providers. CSR apologized for their frustrations, helped them look up providers, and offered to document their feedback.
- Caller stated they feel that a dental practice in Rutland was trying to bill Medicaid incorrectly and would not address the problem. CSR apologized for caller's frustration and offered to document their feedback. Member and Provider Services contacted the provider to address the issue.

February 2020:

- Caller wanted to relay negative feedback on behalf of all Dr. D recipients in Rutland. The caller's children need glasses and there is only one provider in Rutland that accepts Medicaid and she only sees patients between 10:30-11:30 on Wednesdays. The caller feels this is ridiculous due to children having to be removed from school and most parents not being able to take off this time from work. The caller thinks provider should have open availability and wonders how many children are without glasses. The caller feels there needs to be more options for people who are on Medicaid/Dr. D. CSR apologized for caller's frustration and offered to assist in finding another doctor. Member and Provider Services followed up with the member and the provider.

March 2020:

- No issues to report.

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
January 1, 2020 – March 31, 2020

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data compiled on June 24, 2020 from the centralized database that were filed from January 1, 2020 through March 31, 2020.

Grievances: A grievance is an expression of dissatisfaction about any matter that is not an action taken by the Medicaid Managed Care Model.

During this quarter, there were 11 grievances filed; six were addressed. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was three days. Of the grievances filed, 90% were filed by the beneficiary, and 10% were filed by the beneficiary's representative. Of the 11 grievances filed, DMH had 73%, and DAIL had 27%. There were no grievances filed for DVHA, DCF or VDH during this quarter.

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

There were no Grievance Reviews filed this quarter.

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

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

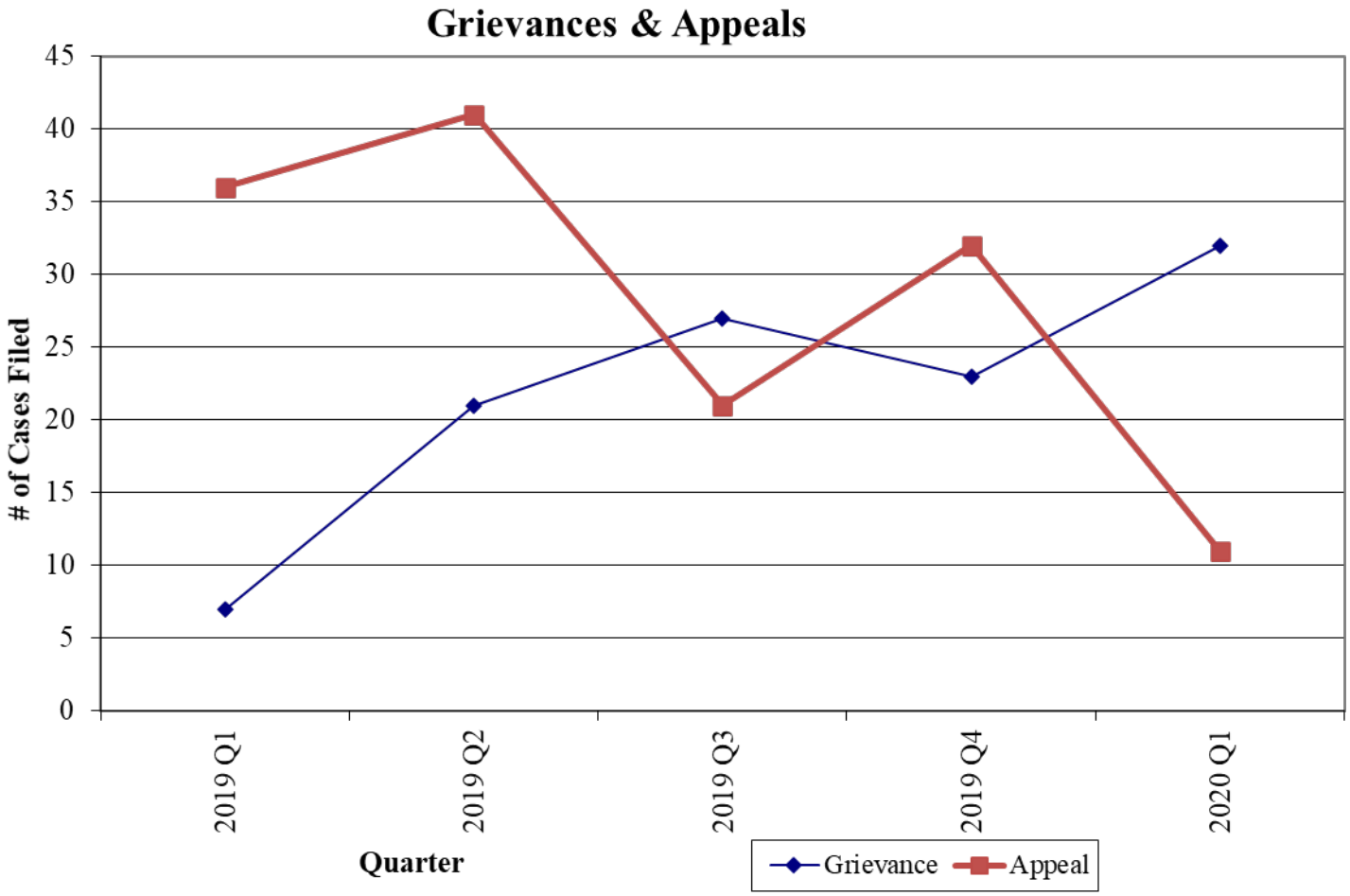
During this quarter, there were 32 appeals filed. Of these 32 appeals, 17 were resolved (53%).

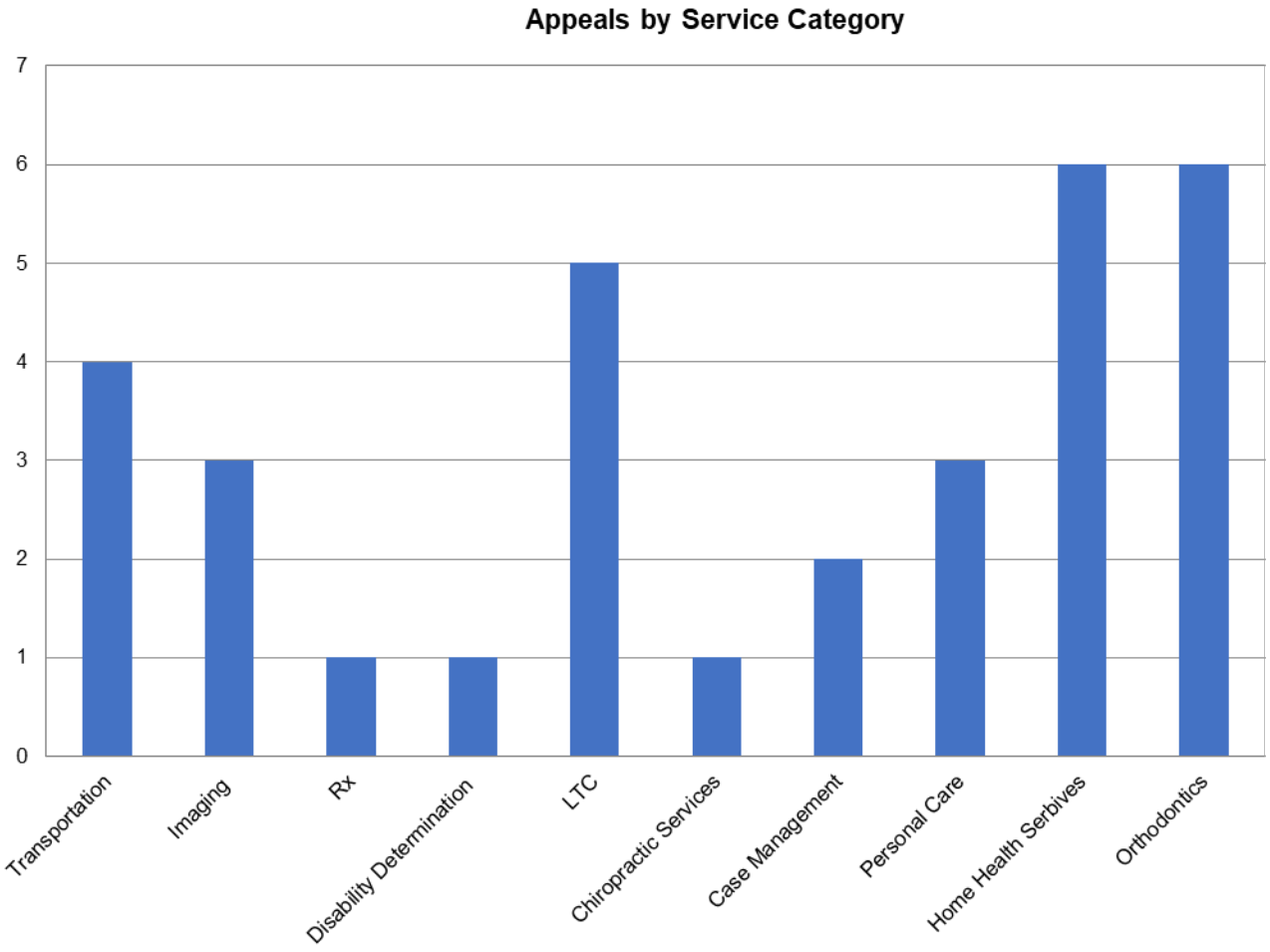
Of the 17 appeals that were resolved this quarter, 94% were resolved within the statutory time frame of 30 days. One appeal was resolved after the 30-day timeframe, the average number of days it took to resolve these cases was 26 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

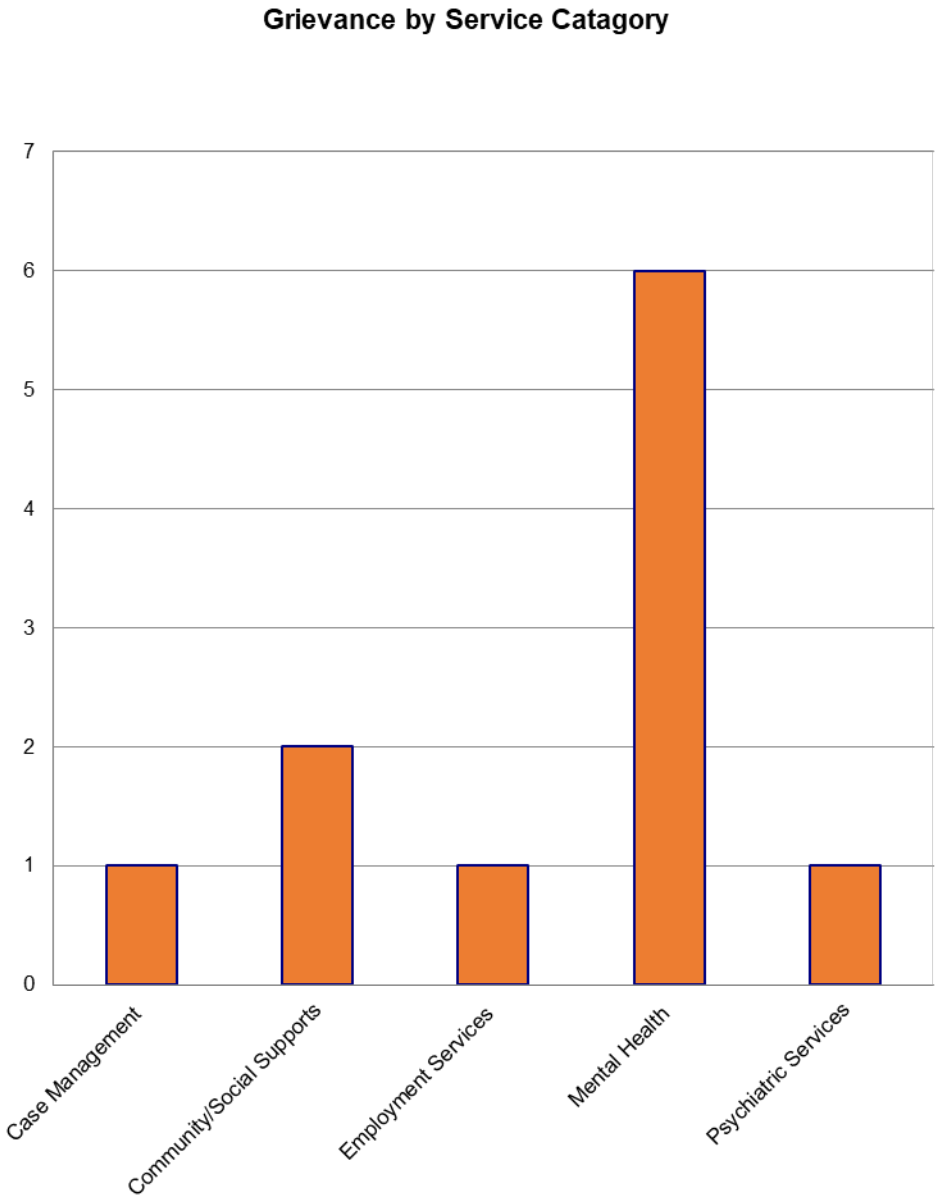
Of the 32 appeals filed, DVHA had 15 appeals filed (47%), DAIL had 12 (38%), VDH had 3 (9%) and DMH had 2 (6%).

The appeals filed were for service categories; program eligibility, orthodontics, personal care, chiropractic, transportation, long term care, community supports, prescriptions, community/social supports, home health services, imaging, prescriptions, and case management.

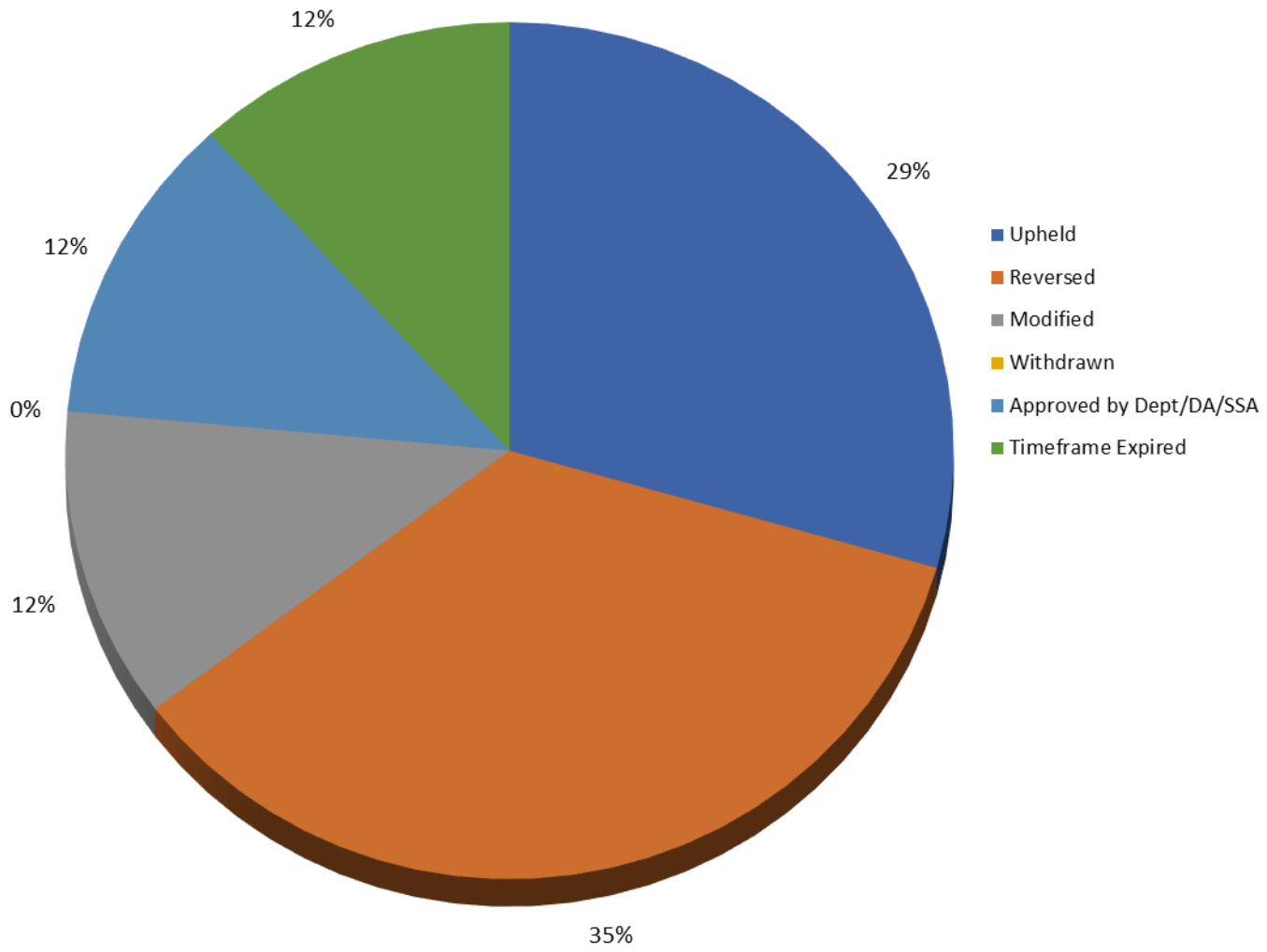
Beneficiaries must exhaust the internal appeal process before they can file a fair hearing if their appeal is not decided in their favor. There was one fair hearing filed this quarter.


Grievances & Appeals
45
40
35
30
25
20
15
10
5
0
# of Cases Filed
2019 Q1
2019 Q2
2019 Q3
2019 Q4
2020 Q1
Quarter
Grievance
Appeal


Appeals by Service Category
7
6
5
4
3
2
1
0
Transportation
Imaging
Rx
Disability Determination
LTC
Chiropractic Services
Case Management
Personal Care
Home Health Serbives
Orthodontics


Grievance by Service Catagory
7
6
5
4
3
2
1
0
Case Management
Community/Social Supports
Employment Services
Mental Health
Psychiatric Services

Appeal Resolutions
1/1/2020 thru 3/31/2020



Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

January 1, 2020 - March 31, 2020

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

April 17, 2020

Summary and Update

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

All Vermonters are struggling with the impact of the COVID-19 crisis. The pandemic is having serious impacts on every part of our healthcare system, the finances of many families, and much of State Government.

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

Since Governor Scott's stay at home order on March 24, 2020, the HCA has been operating remotely. The HCA helpline continues to advocate and resolve issues during this crisis. All of the HCA advocates are helping Vermonters obtain and maintain health insurance during this pandemic. We have put a special emphasis on doing outreach about VHC's special enrollment period for the uninsured as well as outreach to help Vermonters who have experienced loss of jobs and income during the crisis. We have done outreach on social media, updated our website, and contacted former clients who could be eligible for the SEP. In March 2020, we had 968 page views on the special enrollment period. We also had over 2,500 pages views for our page on Medicaid limits. The HCA is working to keep our website updated with the latest information about the COVID-19 crisis.

The HCA helpline is talking to many Vermonters who have lost their jobs and their insurance because of the pandemic. We are doing consumer education on Medicaid eligibility and special enrollments periods. We are also collaborating with other parts of Vermont Legal Aid to make sure the community understands the impact on health care programs of both new unemployment programs and the stimulus check created in the CARES ACT. The HCA policy team has advocated to make COVID-19 testing and treatment more accessible for all Vermonters.

We will be advocating for Vermonters both during and in the aftermath of this crisis.

Overview

The HCA provides assistance to consumers through our statewide helpline (**1-800-917-7787**) and through the Online Help Request feature on our website, Vermont Law Help (*https://vtlawhelp.org/health)*. We have a team of advocates located in Vermont Legal Aid's Burlington office that provides this help to any Vermont resident free of charge, regardless of income.

The HCA received 933 calls[1] this quarter. We divided these calls into broad categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category, based on the caller's primary issue, were as follows:

- **24.44%** (228) about **Access to Care**
- **9.11%** (85) about **Billing/Coverage**
- **2.36%** (22) about **Buying Insurance**
- **9.22%** (86) about **Complaints**
- **12.86 %** (120) about **Consumer Education**
- **30.33%** (283) about **Eligibility** for state and federal programs
- **9.54%** (89) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

We have a customized case management system that allows us to track more than one issue per case. This enables us to see the total number of calls that involved a particular issue. For example, although 283 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, an additional 491 cases had eligibility listed as a secondary concern.

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

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

The full quarterly report for January-March 2020, includes:

- This narrative
- Seven data reports, including three based on the caller's insurance status:
  - **All Calls/All Coverages**: 933 calls (compared to 921 calls last quarter)

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

- **Department of Vermont Health Access (DVHA) beneficiaries**: 273 calls (314 calls last quarter)
- **Commercial Plan Beneficiaries**: 175 calls (184 calls last quarter)
- **Uninsured Vermonters**: 129 calls (73 calls last quarter)
- **Vermont Health Connect (VHC)**: 258 calls (204 calls last quarter)
- **Reportable Activities (Summary & Detail)**: 91 activities and 2 documents (34 activities, 4 documents)

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

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

1. *Income Limits – Medicaid* – 2,613 pageviews
2. *Health – section home page* – 1,697
3. *News: Coronavirus SEP for Vermont Health Connect* – 1,366
4. *Medicaid* – 852
5. *Dental Services* – 615
6. *Services Covered by Medicaid* – 563
7. *Resource Limits – Medicaid* – 440
8. *Long-term Care* – 405
9. *Medicaid, Dr. Dynasaur & Vermont Health Connect* – 403
10. *Supplemental Plans Medicare* – 382
11. *HCA Help Request Form* – 369 pageviews and 113 online help requests
12. *Prescription Help – State Pharmacy Programs* – 358
13. *Choices for Care* – 325
14. *News: More Medicaid dental coverage* – 311
15. *Advance Directive forms* – 291
16. *Dr. Dynasaur* – 290
17. *Medical Decisions: Advance Directives* – 237
18. *Vermont Health Connect - main page* – 230
19. *Medicaid and Medicare Dual Eligible* – 222
20. *Choices for Care income limits* – 213

The **top-10 health pages** in the last week of March, during COVID-19 emergency:

1. *News: Coronavirus SEP for Vermont Health Connect* – 968 pageviews
2. *Health – section home page* – 294
3. *Income Limits – Medicaid* – 162
4. *Services Covered by Medicaid* – 71
5. *HCA Help Request Form* – 53 pageviews and 12 online help requests
6. *Medicaid, Dr. Dynasaur & Vermont Health Connect* – 38
7. *Medical Decisions: Advance Directives* – 35
8. *Vermont Health Connect - main page* – 31
9. *Choices for Care* – 30
10. *News: Coronavirus and long-term care* – 30

Office of the Health Care Advocate

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

https://vtlawhelp.org/health

Attachment 6 - GC Investments

CY 2020 Investment Expenditures

Department	STC #	Receiver Suffix	Investment Description	QE 0320	QE 0620	QE 0920	QE 1220	CY 2020 Total
AHSCO	41	9091	Investments (STC-79) - 2-1-1 Grant (41)	113,118				**113,118**
AHSCO	54	9090	Investments (STC-79) - Designated Agency Underinsured Services (54)	1,654,744				**1,654,744**
AOE	11	n/a	Non-state plan Related Education Fund Investments					**-**
DCF	55	9402	Investments (STC-79) - Medical Services (55)	19,357				**19,357**
DCF	1	9403	Investments (STC-79) - Residential Care for Youth/Substitute Care (1)	1,912,130				**1,912,130**
DCF	56	9405	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56)	1,044,408				**1,044,408**
DCF	57	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	29,590				**29,590**
DCF	58	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	64,468				**64,468**
DCF	59	9408	Investments (STC-79) - Essential Person Program (59)	219,628				**219,628**
DCF	60	9409	Investments (STC-79) - GA Medical Expenses (60)	51,744				**51,744**
DCF	61	9411	Investments (STC-79) - Therapeutic Child Care (61)	376,070				**376,070**
DCF	2	9412	Investments (STC-79) - Lund Home (2)	736,919				**736,919**
DCF	33	9413	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)					**-**
DCF	34	9414	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34)	60,572				**60,572**
DCF	9	9415	Investments (STC-79) - Challenges for Change: DCF (9)	53,402				**53,402**
DCF	26	9416	Investments (STC-79) - Strengthening Families (26)	273,766				**273,766**
DCF	62	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	39,744				**39,744**
DCF	35	9418	Investments (STC-79) - Building Bright Futures (35)	67,756				**67,756**
DDAIL	63	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	91,642				**91,642**
DDAIL	64	9603	Investments (STC-79) - DS Special Payments for Medical Services (64)	1,857,013				**1,857,013**
DDAIL	27	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)	983,521				**983,521**
DDAIL	42	9605	Investments (STC-79) - Quality Review of Home Health Agencies (42)					**-**
DDAIL	43	9606	Investments (STC-79) - Support and Services at Home (SASH) (43)	204,345				**204,345**
DDAIL	77	9607	Investments (STC-79) - HomeSharing (77)	77,635				**77,635**
DDAIL	78	9608	Investments (STC-79) - Self-Neglect Initiative (78)	75,990				**75,990**
DDAIL	65	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)	12,503				**12,503**
DMH	28	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	35,672				**35,672**
DMH	66	9502	Investments (STC-79) - MH Outpatient Services for Adults (66)	1,610,793				**1,610,793**
DMH	79	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79)	166,746				**166,746**
DMH	16	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16)	1,118,798				**1,118,798**
DMH	12	9506	Investments (STC-79) - Mental Health Children's Community Services (12)	1,375,069				**1,375,069**
DMH	29	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)	6,186,457				**6,186,457**
DMH	67	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)	813,840				**813,840**
DMH	22	9510	Investments (STC-79) - Emergency Support Fund (22)	376,000				**376,000**
DMH	3	9511	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - VPCH	5,575,018				**5,575,018**
DMH	3	9512	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - BR	2,555,765				**2,555,765**
DMH	68	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	18,855				**18,855**
DMH	13	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	788,263				**788,263**
DOC	4	n/a	Return House	138,725				**138,725**
DOC	5	n/a	Northern Lights	98,438				**98,438**
DOC	6	n/a	Pathways to Housing - Transitional Housing	254,634				**254,634**
DOC	14	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)	67,477				**67,477**
DOC	15	n/a	Northeast Kingdom Community Action					**-**
DOC	69	n/a	Intensive Substance Abuse Program (ISAP)					**-**
DOC	70	n/a	Intensive Domestic Violence Program					**-**
DOC	71	n/a	Community Rehabilitative Care					**-**
DOC	80	n/a	Intensive Sexual Abuse Program					**-**
DVHA	8	9101	Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8)					**-**
DVHA	51	9102	Investments (STC-79) - Vermont Blueprint for Health (51)	791,428				**791,428**
DVHA	52	9103	Investments (STC-79) - Buy-In (52)	11,704				**11,704**
DVHA	53	9104	Investments (STC-79) - HIV Drug Coverage (53)	682				**682**
DVHA	18	9106	Investments (STC-79) - Patient Safety Net Services (18)	(2,817)				**(2,817)**
DVHA	7	9107	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	2,104,330				**2,104,330**
DVHA	72	9108	Investments (STC-79) - Family Supports (72)					**-**
DVHA	81	9109	DSR Investment (STC-83) – One Care VT ACO Quality & Health Management (81)					**-**
DVHA	82	9110	DSR Investment (STC-83) – One Care VT ACO Advanced Community Care Coordination	281,250				**281,250**
DVHA	83	9111	DSR Investment (STC-83) - One Care VT ACO Primary Prevention Development (83)	550,000				**550,000**
GMCB	45	n/a	Green Mountain Care Board					**-**
UVM	10	n/a	Vermont Physician Training	505,932				**505,932**
VAAFM	36	n/a	Agriculture Public Health Initiatives					**-**
VDH	19	9201	Investments (STC-79) - Emergency Medical Services (19)	156,190				**156,190**
VDH	74	9203	Investments (STC-79) - TB Medical Services (74)	670				**670**
VDH	40	9204	Investments (STC-79) - Epidemiology (40)	283,856				**283,856**
VDH	39	9205	Investments (STC-79) - Health Research and Statistics (39)	341,770				**341,770**
VDH	31	9206	Investments (STC-79) - Health Laboratory (31)	812,356				**812,356**
VDH	50	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	329,282				**329,282**
VDH	76	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)					**-**
VDH	75	9209	Investments (STC-79) - Family Planning (75)	394,479				**394,479**
VDH	25	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)					**-**
VDH	73	9211	Investments (STC-79) - Renal Disease (73)					**-**
VDH	37	9213	Investments (STC-79) - WIC Coverage (37)	949,286				**949,286**
VDH	21	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	108,295				**108,295**
VDH	47	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	12,770				**12,770**
VDH	30	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)	1,230,889				**1,230,889**
VDH	17	9220	Investments (STC-79) - Recovery Centers (17)	427,012				**427,012**
VDH	46	9221	Investments (STC-79) - Enhanced Immunization (46)	99,642				**99,642**
VDH	48	9222	Investments (STC-79) - Poison Control (48)					**-**
VDH	23	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	475,043				**475,043**
VDH	38	9224	Investments (STC-79) - Fluoride Treatment (38)	8,505				**8,505**
VDH	24	9225	Investments (STC-79) - Medicaid Vaccines (24)					**-**
VDH	49	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)	47,836				**47,836**
VDH	44	9228	Investments (STC-79) - VT Blueprint for Health (44)	269,056				**269,056**
VSC	32	n/a	Health Professional Training	204,730				**204,730**
VVH	20	n/a	Vermont Veterans Home					**-**
				41,594,792	**-**	**-**	**-**	**41,594,792**

P

Institution for Mental Disease (IMD) Services: DMH (3) - Vermont Psychiatric Care Hospital

DMH GC Investment

Attachment 7 - Investment Scorecard: Department of Mental Health

What We Do

Description/Objective:

This investment pays for direct care costs (i.e. psychiatric care, medication therapy, counseling, activities of daily living, etc.) at Vermont Psychiatric Care Hospital (VPCH). VPCH is a 25-bed, acute care hospital located in Berlin, Vermont that offers patient areas designed for care, comfort, and safety. Patients are encouraged to engage in all aspects of prescribed treatment and participate in activities that will facilitate recovery. The investment funds staff time and patient care at VPCH.

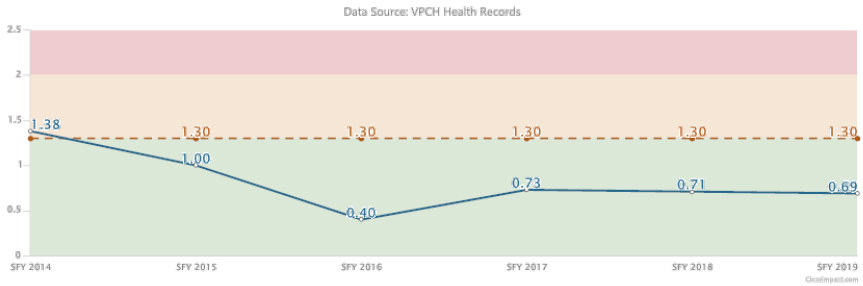
Interpretation of Results

Since its opening in FY 2015, VPCH has been committed to several initiatives related to patient care and patient satisfaction with services.

Seclusions and restraints have been below established targets for 3 of the last 4 years of reporting, due to VPCH's participation in SAMHSA's Six Core Strategies for reducing seclusion and
restraint. As VPCH has been accepting more acute inpatient stays across the system of care, it has still been able to decrease average length of stay for discharged patients and involuntary readmissions have remained stable over the past year. In 2016 VPCH met its target of lowering readmission rates.

Measures

PM How_Well # hours of seclusion and restraint per 1,000 patient hours



	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
	SFY 2019	0.69	1.30	↘ 2
	SFY 2018	0.71	1.30	↘ 1
	SFY 2017	0.73	1.30	↗ 1
	SFY 2016	0.40	1.30	↘ 2
	SFY 2015	1.00	1.30	↘ 1
	SFY 2014	1.38	1.30	→ 0

Story Behind the Curve

We want the # of hours of seclusion and restraint to go down.

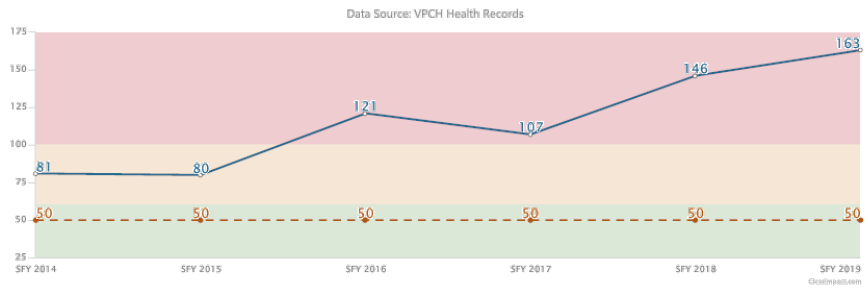
Providing patient care in an environment that is safe and supportive is important for recovery. VPCH, through its work with the SAMHSA Six Core Strategies for Reducing seclusion and restraint has lowered its rate of seclusion and restraint to approximately one half-hour per 1,000 patient hours, which is almost an hour less than the established target.

Updated February 2018

Notes on Methodology

Data is calculated using reports of emergency involuntary procedures (EIPs) and total patient hours captured by VPCH's electronic medical record. The rate is calculated by dividing the total hours of seclusion and restraint divided by the total patient hours and multiplied by 1,000. This rate is the nationally established metric for reporting EIPs.

PM VPCH Average length of stay in days for discharged patients

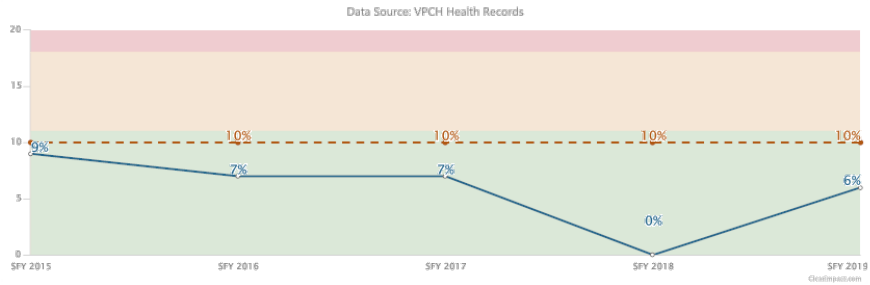


SFY 2019	163	50	↗ 2
SFY 2018	146	50	↗ 1
SFY 2017	107	50	↘ 1
SFY 2016	121	50	↗ 1
SFY 2015	80	50	↘ 1
SFY 2014	81	50	→ 0

Story Behind the Curve

While the average length of stay at VPCH is higher than the target rate, the length of stay has decreased over the past year by 2 weeks. VPCH has also been accepting more acute patients resulting in longer stays, thereby creating a slight drop in the inpatient census over the year.

PM How_Well % of discharges readmitted involuntarily within 30 days of discharge



SFY 2019	6%	10%	↗ 1
SFY 2018	0%	10%	↘ 1
SFY 2017	7%	10%	→ 1
SFY 2016	7%	10%	↘ 1
SFY 2015	9%	10%	→ 0

Story Behind the Curve

In 2017, VPCH maintained its target of 10% of patients' that were discharged were readmitted involuntarily within 30 days. VPCH exceeded this expectation for 2018, with 0% of patients who were discharged were readmitted involuntarily within 30 days.

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Attachment 8 - Payment Model Scorecard: DVHA Dental Incentive Program

P **DVHA Dental Incentive Program**

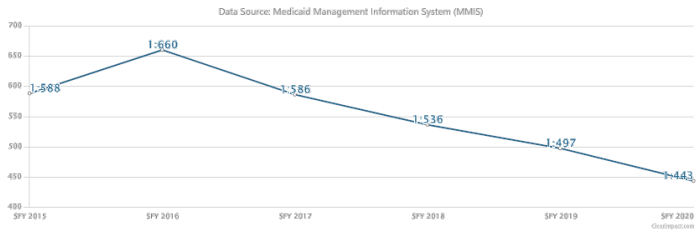
DVHA Dental

What We Do

The Dental Incentive Program was created to recognize and reward dentists who serve Medicaid beneficiaries and to improve access to dental care. Twice a year, an incentive payment is given to dental practices who, over the last 6-month period, provided more than $50,000 in services.

This scorecard is updated every six months and tracks a) the total number of providers eligible for the incentive payment and b) the number of dental providers in Vermont relative to the total Medicaid population.

Measures	Most Recent Period	Current Actual Value	Current Target Value	True	Current Trend	Baseline % Change
PM DVHA # of VT Medicaid-enrolled dental providers relative to the total # of VT Medicaid beneficiaries	SFY 2020	1:443	–	–	↘ 4	-25% ↓
	SFY 2019	1:497	–		↘ 3	-15% ↓
	SFY 2018	1:536	–		↘ 2	-9% ↓
	SFY 2017	1:586	–		↘ 1	0% →
	SFY 2016	1:660	–		↗ 1	12% ↑
	SFY 2015	1:588	–		→ 0	0% →



Notes on Methodology

- The data value used for beneficiary enrollment is the number of full-benefit Vermont Medicaid enrollees on active status as of January 1 each year.
- The data value used for dentists is the number of dentists enrolled in Vermont Medicaid on active status with an address in Vermont as of January 1 each year. This includes individual provider organizations and hygienists who bill separately.

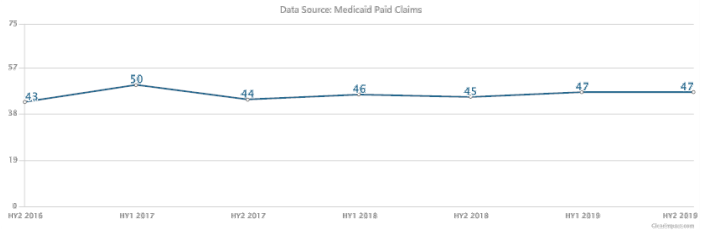
Partners

- Department of Vermont Health Access (DVHA): Clinical Operations (Dental staff), Provider & Member Relations, Data, Policy and Quality Units
- Vermont Department of Health's Oral Health Program
- Vermont Dentists
- Vermont State Dental Society (VSDS)

Story Behind the Curve

This measure shows the number of Vermont Medicaid enrolled dentists relative to the number of VT Medicaid beneficiaries. For this measure, a lower ratio is better. The baseline for this measure is SFY 2015 to align with Medicaid Expansion which led to an increase in the number of adults eligible for the Medicaid dental benefit.
The data trend indicates that the number of enrolled dentists has increased while the number of eligible beneficiaries has decreased. Also, Vermont began enrolling independently practicing dental hygienists in July 2016.

PM DVHA # of dental practices eligible for dental incentive payment (total Medicaid paid claims of $50k or more)



HY2 2019	47	–	–	→	1	42% ↑
HY1 2019	47	–		↗	1	42% ↑
HY2 2018	45	–		↘	1	36% ↑
HY1 2018	46	–		↗	1	39% ↑
HY2 2017	44	–		↘	1	33% ↑
HY1 2017	50	–		↗	1	52% ↑
HY2 2016	43	–		↘	1	30% ↑
HY1 2016	48	–		↗	5	45% ↑
HY2 2015	47	–		↗	4	42% ↑

Notes on Methodology

This measure is calculated on the half calendar year (CY). Payments are made in the fall for services provided January - June of each year (HY1), and then again in the spring for services provided July - December of each year (HY2). The delay in payment is due to claims run out.

Partners

- Department of Vermont Health Access (DVHA): Clinical Operations (Dental staff), Provider & Member Relations, Data, Policy and Quality Units
- Vermont Department of Health's Oral Health Program
- Vermont Dentists
- Vermont State Dental Society (VSDS)

Story Behind the Curve

For SFY 2008 and beyond, the Vermont Legislature authorized DVHA to begin distributing $292,836 annually to support the program. The DVHA and the VSDS agreed that the funds would be distributed bi-annually; distributions of $146,418 are made in the spring and fall, for an annual total of $292,836. Each dental practice that receives $50,000 or more biannually in Medicaid paid claims is eligible for the payment. The amount paid is calculated as a percentage of the Medicaid claims paid. Historically, 36-50 dentists have qualified for semi-annual payouts and a share of the $146,418 available.

Action Plan

The Dental Incentive program data is reviewed two times per year. In addition, the Agency collects and analyzes additional dental measures in order to make system improvements.

Attachment 8b - Payment Model Scorecard: Children's Integrated Services

What We Do

Children's Integrated Services is a unique model for integrating early childhood health, mental health, evidence based home visiting, early intervention and specialized child care services for pregnant and postpatum women and children birth to age six.

Who We Serve

Children's Integrated Services (CIS) has four core services:

- Early Intervention: Services for children from birth up to age 3 with or at risk of a developmental delay or disability.
- Strong Families VT Home Visiting: Services delivered in the home for pregnant and postpartum parents and young children who have concerns about factors that impact healthy family development.
- Early Childhood and Family Mental Health: Services to promote healthy social-emotional development for children and their families from birth to age 6 who may have mental health concerns.
- Specialized Child Care: Services to help children with high needs connect to and experience success in high quality child care settings.

How We Impact

The model is designed to improve child and family outcomes by providing family-centric holistic services, effective service coordination, and flexible funding to address prevention, early intervention, health promotion, and accountability.

CIS Clients Lost to Follow Up: When a CIS client discontinues services without notice and does not respond to repeated attempts at contact, they are considered "lost to follow up." CIS teams attempt to decrease this outcome through strong family engagement and effective outreach, so a decrease in this measure indicates an improvement in practice.

Referrals Triaged by CIS Coordinator: A goal is to increase community awareness that CIS is a comprehensive source for early childhood services. Over time this performance measure has stayed between 78% - 83% of referrals made directly to the CIS coordinator, which indicates a high community awareness.

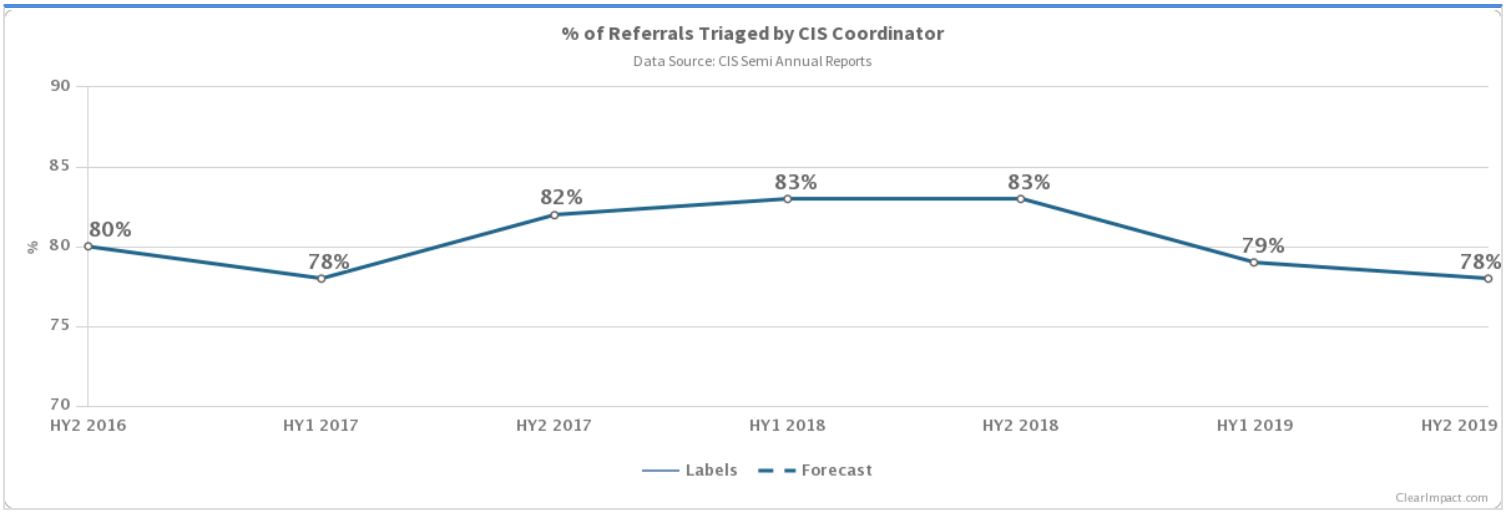
Clients with One Plan Completed within 45 Days: A key step in engaging families and beginning timely service delivery is the completion of a One Plan, the individualized service plan used in CIS. Starting services in a timely manner ensures that every client has the best opportunity to maximize their growth and development while accessing CIS services. An increase over the base in clients with completion of a One Plan within 45 Days is the target.

Measures	Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
PM CDD % CIS Clients Lost to Follow Up	HY2 2019	3%	–	↘ 1	-67% ↓
PM CDD % of Referrals Triaged by CIS Coordinator	HY2 2019	78%	–	↘ 2	1% ↑
PM CDD % of Clients with One Plan Completed withing 45 days	HY2 2019	85%	–	→ 1	9% ↑

PM

% of Referrals Triaged by CIS Coordinator

CDD CIS Half Year | Higher is Better | Not Calculated



Story Behind the Curve

An increase in referrals made directly to the CIS coordinator, rather than directly to individual service providers, indicates growing community awareness that CIS is a comprehensive source for early childhood services.

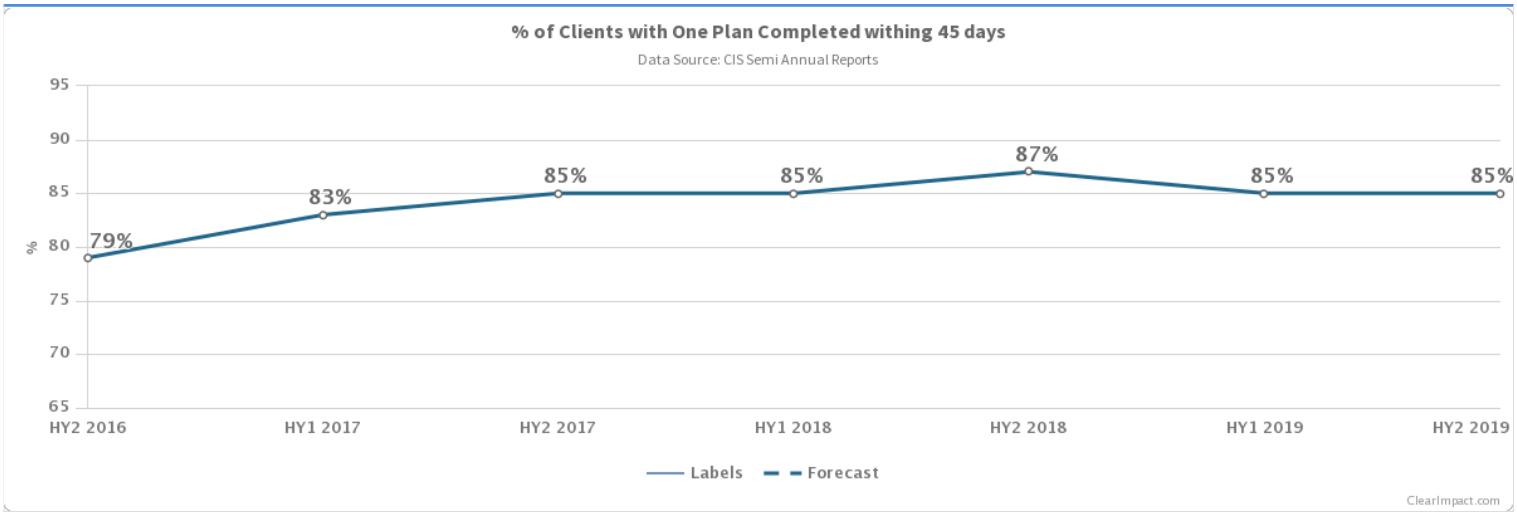
Partners

Children's Integrated Services (CIS) partners with local agencies to provide services to families. A list of partners is available on the Department for Children and Families website here https://dcf.vermont.gov/partners/cis

PM

% of Clients with One Plan Completed withing 45 days

CDD CIS Half Year | Higher is Better | Not Calculated



Story Behind the Curve

A key step in engaging families and beginning timely service delivery is the completion of a One Plan, the individualized service plan used in CIS. Starting services in a timely manner ensures that every client has the best opportunity to maximize their growth and development while accessing CIS services.

Partners

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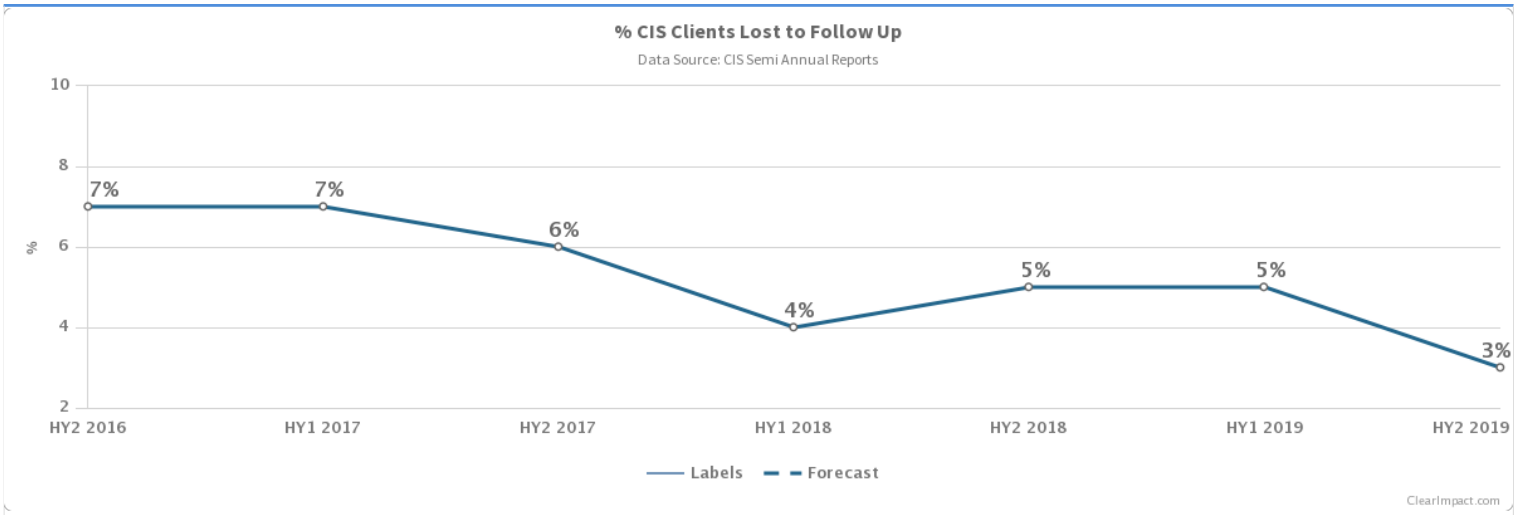
PM

% CIS Clients Lost to Follow Up

CDD CIS Half Year | Lower is Better | Not Calculated



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