State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 17
(1/1/2022 – 12/31/2022)

Quarterly Report for the period
April 1, 2022 – June 30, 2022

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Table of Contents

I. Background and Introduction 3
II. Outreach/Innovative Activities 4
III. Operational/Policy Developments/Issues 7
IV. Expenditure Containment Initiatives 47
V. Financial/Budget Neutrality Development/Issues 83
VI Member Month Reporting 83
VII. Consumer Issues 85
VIII. Quality Improvement 86
IX. Demonstration Evaluation Activities 90
X. Compliance 90
XI. Reported Purposes for Capitate Revenue Expenditures 91
XII. State Contact(s) 92
XIII. Attachments 92

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 the 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 42CFR §438. DVHA also has sub-agreements with the other State entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, and specialized child and family services).

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the second quarterly report for waiver year 17, covering the period from April 1, 2022, through June 30, 2022 (QE062022).***

II. Outreach/Innovative Activities

i. Member and Provider Services

Key updates from QE062022:

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

The Member and Provider Services (MPS) Unit ensures members have access to appropriate healthcare for their medical, dental, and mental health needs. The MPS Unit monitors the adequacy of the Green Mountain Care (GMC) network of providers and is responsible for the implementation of the enrollment, screening, and revalidation of providers 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 revalidation of enrollment.

Additionally, the unit works to coordinate benefit and collection practices with providers, members, and other insurance companies to ensure that Medicaid is the payer of last resort. The

unit is also responsible for Medicare Part D casework including claims processing assistance, coverage verification, and issue resolution. The MPS Unit works diligently to recover funds from third parties where Medicaid should not have been solely responsible. Those efforts include estate recovery, absent parent medical support recovery, casualty recovery, patient liability recovery, Medicare recovery, Medicare prescription recovery, special needs recovery,and trust recovery.

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

NEMT Update

In the second quarter of the calendar year 2022, trips provided to transportation-eligible VT Medicaid members by DVHA's non-emergency medical transportation contractor continued to rebound from the Covid-related low utilization of a year ago. In this quarter last year, the contractor provided 16,000 less trips than the same time period this year. The number of program-related complaints stayed fairly constant with the same period last year, with overall complaint numbers remaining well below the contracted performance standard of 5% of all rides provided (maintaining a rate of less than 1%).

Coordination of Benefit Activity

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

Areas of activities:

- **Casualty:** Seek reimbursement when a third-party liability or medical insurance exists during an accident and Medicaid has paid for medical services**.**
- **Estate:** Seek adjustment or recovery from estates of individuals who received long–term care services paid for by the Medicaid program**.**
- **Third Party/Court Ordered Medical: Seek reimbursement** from insurance carriers for Medicaid claims paid as primary.
- **Medicare Prescription Drug Premium/Claims:** - Seek adjustment or recovery when members have Medicare part D plan premium cost and rebilling of Medicare part D pharmacy claims.
- **Over Resource/Hospice/Pt. Share/Credit Balance:** Seek collections that had been determined to be owed for program eligibility.
- **Annuity/Trust/Waiver:** When someone VT Medicaid it is sometimes determined by the eligibility unit to make DVHA the beneficiary of an annuity policy for that person to be eligible for and remain on Medicaid- trust. A Special Needs Trust (SNT)/Pooled Trust is a legal document in which any disabled person can transfer their assistance which is managed and administered by the Trustee for the benefit of the individual. When the assets are placed into the SNT, the beneficiary is still eligible to receive Medicaid benefits.
- **Medicare Recoupment:** Automated recovery process to see collection from providers when Medicare paid for services primary to Medicare, instructing provider to bill primary Medicare.

- **Lamp/Map:** LAMP (Legal Assistance to Medicare Patients)/MAP (Medicare Advocacy Program - Members who were wrongfully denied Medicare coverage, the decision was overturned and the recovery of Medicaid funds for physicians' services, durable medical equipment, home health care, or skilled nursing facility care.
- **Third Party Recoupment:** Seek recovery from providers when Medicaid paid for services as primary and the primary payer requires additional information for recovery.

Coordination of Benefit Collection Table:

MPS - Coordination Recovery Activities "Q2"	
Casualty	$268,673.14
Estate	$397,205.62
Third-Party & Court-Ordered Medical	$435,492.89
Medicare Prescription Drug Premium/Claims	$92,424.21
Over Resource/Hospice/Patient Share/Credit Balance	$426,355.08
Annuity/Trust/Waiver	$15,344.08
Lamp/Map, Medicare Claim Recoupment	$330,766.77
Third-Party Claim Recoupment	$256,1748.64
Total	**$4,528,010.43**

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

Coordination of Benefit-Cost Avoidance Table:

Cost Avoidance "Q2"	
Third-Party Liability	$21,436,060.68
Medicare	$126,926,929.33
Total	**$148,362,990.01**

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

The MMIS Project to implement multiple CMS requirements specified in the Interoperability and Patient Access final rule (CMS-9115-F) to improve patient access to their health information will have a phased rollout in preparation for the January 1st, 2023 due date.

- This effort will enable Vermont Medicaid members to use a smartphone, tablet, or personal computer to access their health data. This data will be viewed via a third-party app on a smart device of the members' choice. The data will include Patient Health Data (Claims, Clinical (available 2023), and Pharmacy),

Preferred Drug List data, and Provider Directory data.

- The implementation will be a phased roll-out of two pilots to gain user experience downloading the apps and the accuracy of health data. Pilot #1 will commence in August 2022. The second pilot will commence in November 2022 with additional members to gain user experience downloading the apps and additionally gain user expectations.

The Daily Transmission of the MMA and Buy-In files project was divided into three phases: migration to the use of Globalscape to send and receive files to CMS, requirements, system design and implementation of Buy-in file daily exchange, and lastly; requirements, system design and implementation of MMA file daily exchange.

- All phases of this project have been completed; including the successful implementation of the Daily Buy-in Files and the Daily MMA file exchanges with CMS. The Daily Buy-In File(s) exchanges were implemented on 2/1/22, before the deadline, and without incident. The Daily MMA File Exchange was implemented timely on 4/1/22. The Daily File Exchange part of the Interoperability was completed early/on time and within budget.

III. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE062022:

- The Customer Support Center received 41,277 calls in QE0622, down 30% from the previous year.
- As of July 18, 2022, DVHA is supported by 112 Assisters (103 Certified Application Counselors, 5 Navigators, and 4 Brokers). 14 Assisters are in training (whose application date is January 1, 2022, or later). Working in 62 organizations including hospitals, clinics, and community-based organizations.
- Increasing numbers of customers are using self-service functions. Self-serve applications comprised over half (54%) of all applications in QE0622.

Enrollment

As of QE0622, more than 227,516 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 156,655 in Medicaid for Children and Adults (MCA) and 70,861 in Qualified Health Plans (QHPs), with the latter divided between 25,077 enrolled with VHC, 5,362 direct enrolled with their insurance carrier as individuals, and 40,422 enrolled with their small business employer.

Medicaid Renewals

For each month of the second quarter, and for the duration of the public health emergency, MCA

redeterminations are processed only for cases that can be renewed ex parte. Cases that require an application have coverage extended; renewals will be rescheduled once the end date of the PHE is known. The passive renewal success rate for the quarter averaged 40%.

1095 Tax Forms

Tax year 2021 1095B corrections began mailing out to customers on February 8, 2022. 170 corrections for the period of 4/1-6/30/22 have been sent out.

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 41,277 calls in QE0622, down 30% from the previous year. Maximus answered 89% of calls within 24 seconds in April 2022, 85% in May 2022, and 83% in June 2022. With increased staffing and lower call volumes, Maximus met the target in QE0622.

Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to DVHA-HAEEU for resolution and log service requests, which are escalated to the appropriate resolver group. This year has seen a decrease in the volume of calls with a slight increase in the proportion of calls that were escalated. 7% of QE0622 calls were transferred to DVHA-HAEEU staff, down from 10% in QE0621. Just as importantly, DVHA strived to answer all calls that were transferred; 99% of transferred calls were answered in five minutes in QE0622, compared to 98% in QE0621.

Timely Processing of Member Requests

In the spring of 2016, DVHA-HAEEU set a goal of completing 75% of member requests within ten business days. In QE0621, more than 98% of the VHC requests were completed within the same ten-day time frame, and 98% in QE0622.

System Performance

The system continued to operate as expected throughout QE0622, achieving 100% availability outside of scheduled maintenance in each of the three months. The average page load time for the quarter was 1.4 seconds – which is under the two-second target.

In-Person Assistance

As of July 18, 2022, DVHA is supported by 112 Assisters (103 Certified Application Counselors, 5 Navigators, and 4 Brokers). 14 Assisters are in training (whose application date is

January 1, 2022, or later). Working in 62 organizations including hospitals, clinics, and community-based organizations. Assister support is available in all of Vermont's 14 counties. The program continues to focus on recruitment, shown by an increase of ~7% increase of Assisters from last quarter. The program also continues to emphasize Assister education through multiple mediums.

Outreach

DVHA continued to use advisory meetings and other collaborative engagements with partners and stakeholders to notify Vermonters about the continued timeline of the programmatic changes related to the COVID-19 pandemic. DVHA has developed and will soon implement a webpage specific to information related to the PHE unwind and subsequent implications and information.

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 9,831 sessions during the quarter.

Self-Service

During QE0622, DVHA-HAEEU continued to promote self-service options for customers to report changes, and access tax documents and other forms. Self-service leads to an improved customer experience as Vermonters can log in at their convenience. It also has the benefit of using automation to reduce staffing expenses. Year-over-year comparisons show that more customers are using self-service functions, including both online accounts for health coverage applications and reported changes as well as the options of paying premiums through monthly recurring payments rather than one-time payments. Self-serve applications comprised over half (54%) of all applications in QE0622.

ii. Choices for Care and Traumatic Brain Injury Program

DAIL

Choices for Care

Electronic Visit Verification:

DAIL Adult Services Division, in partnership with DVHA and DPH, continues to work with homecare agencies and individuals who self-direct their personal care services to provide access to educational materials to support the adoption of EVV throughout the state. Information on EVV can be found HERE

Choices for Care Providers – In quarter 2, providers continued to report challenges with hiring and retaining staff. This workforce challenge is reported across the full range of providers including case management, personal care attendants, adult day providers, Nursing Homes, and Enhanced Residential Care Providers

Minimum Wage and 8% Medicaid rate increases were implemented: In July, DAIL implemented a new minimum wage for independent direct support providers according to the Collective Bargaining Agreement. This raised the minimum wage to $13.44/hour. Additionally, HCBS service rates were increased by 8%. The 8% increase was implemented for both agency-directed services and consumer/surrogate-directed budgets.

Enhanced FMAP spending plan:

The Initial Spending Plan Narrative was submitted in June 2021. During the reporting Q3 reporting period, The Adult Services Division engaged with stakeholders for input on the set of activities included in the Home and Community-Based Services (HCBS) Initial Spending Plan. Written comments informed the mid-October quarterly update of the Initial Spending Plan. This is an extension of the initial due date for comments that were posted on June 18th. More information is available HERE

Adult Day

Adult Day Agencies continue to report that difficulty hiring staff has been a limiting factor in increasing enrollment. Ten out of eleven providers require that participants be fully vaccinated, and all require individuals to be able to wear a mask. In quarter 2, Adult Day providers continue to report challenges with staffing, including a lack of drivers to provide transportation to/from the Adult Day Centers. DAIL, in partnership with community stakeholders, is working in communities that do not have access to Adult Day Services to explore opportunities for reestablishing AD services in those areas.

At the end of Q2, CFC enrollment included:

NH – 2290 participants

ERC – 551 participants

Home Based – 2204 participants

Moderate Needs – 1035 participants

Money Follows the Person (MFP)

The MFP grant has been re-authorized through (CY) 2024. The VT Department of Aging and Independent Living (DAIL) Adult Services Division has been awarded funds for CY2021 and CY2022 operations.

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

DAIL has been awarded a $5M MFP Supplemental Grant. These dollars will be used to strengthen the systems serving Money Follows the Person and Choices for Care participants by

increasing the number of direct service workers, increasing support for unpaid caregivers, and by piloting new HCBS services to meet unmet care needs. The Supplemental Grant Funding will be used for the following seven approved initiatives:

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

CY2022 transitions – through quarter 2, 49 individuals were transitioned with 23 additional individuals in the pre-transition category

Brain Injury Program: Current enrollment = 94 individuals, 15 individuals are in the process of enrolling/pending service provider capacity, and 1 new Applicant is pending clinical assessment.

Wait Lists

- There is no wait list for the High Needs Group.
- There continue to be provider wait lists for Moderate Needs Group, estimated at almost 550 people statewide. Because the eligibility criteria for Moderate Needs services are so broad, Vermont does not expect to eliminate the wait list. Agencies are currently using different methods to address priority/acuity – we plan to transition to a statewide method. The state is currently piloting two separate acuity-based models for revising the wait list procedures. The goal of this work is to identify/implement a state-wide standardized approach to the priority scale.
- There is currently no wait list for the Brain Injury program.

iii. Developmental Disabilities Services Division (DDSD)

Key updates from QE062022:
- Payment Reform Activities

Payment and Delivery System Reform Update:

DAIL/DDSD, through its independent assessor (PCG), continues to perform the newly implemented assessment to amass a statewide sample of 500 statewide. Using this sample, the results will be analyzed to determine if, and how, the SIS-A can be used as part of Vermont's payment redesign.

To support the assessment efforts, DAIL and PCG scheduled engagement sessions with the

provider network. These sessions allowed parties to come together, ask questions, provide feedback, and learn from one another. DAIL and PCG will offer these sessions to other stakeholders in the future.

Please see prior report submissions for previous highlights.

DDS System of Care Plan Renewal

Stakeholder input is key to the renewal of the DDS System of Care Plan renewal. To solicit input, the Division will engage in targeted input sessions related to the three identified areas of focus:

- Housing Options/Alternatives
- Paying Parents with Medicaid Funds to Provide Care to Their Child(ren)
- Support Services Specific to the Needs of Adults with Autism

To ensure opportunities for engaging in input across the entire System of Care, DDSD will schedule general input sessions. Initially targeted stakeholder sessions—on the topic of housing options/alternatives were held to build off of the momentum of a Legislative initiative that afforded funding for housing pilot projects.

Related to this effort, DAIL/DDSD extended Continuing Conversion of Unused HCBS Funds for FY 2022 for Shared Living Providers and Unpaid Family Caregivers to provide an option to guard against health and safety risks and mitigate the workforce crisis the system faces. The Division will review the ongoing appropriateness to continue this payment flexibility as DAIL/DDSD considers including an option to pay parents with DDS HCBS funds to provide support to their child as part of the System of Care renewal process and how to operationalize such an option if applicable.

Please see prior report submissions for previous highlights.

Clinical/Crisis Continuum of Care Expansion

Related to the increased mental needs of individuals with I/DD, the capacity of Vermont's developmental disabilities system's clinical and crisis resources has been severely stretched. While Vermont has the Vermont Crisis Intervention Network (VCIN), DAIL/DDSD has found that this resource was not enough to meet the needs of Vermonters with I/DD.

In October 2022, DAIL/DDSD worked with VCIN to expand the crisis bed capacity from 2 beds to 3, however with the public health emergency and significant workforce crisis, the demand has outstripped the resource.

Additionally, DAIL/DDSD is working with provider agencies to implement Intensive Transition Support (ITS) beds. These supports will be a complement to the VCIN crisis beds, but unlike the

crisis beds which are intended to be a short-term support (14-21 days), ITS supports are designed as a longer-term stabilization resource (approximately 6 months). DAIL/DDSD is developing 4 ITS beds in 2022-2023. The first ITS bed is expected to be operational in the Summer of 2022.

DAIL/DDSD is in negotiation regarding a contract for psychiatric/medical consultation. This would provide DDSD staff direct support for individuals when admitted or at an emergency department without a clear discharge plan or prognosis. The consultant will also be available to provide peer-to-peer communications with medical professionals as discharge planning occurs.

iv. Global Commitment Register

Key updates from QE062022:

- 22 policies were posted to the GCR in QE062022.
- Since the Global Commitment Register (GCR) launched in November 2015, 322 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 a proposed policy, including information on public comment submissions, final policy, notices, and policy clarifications. The GCR is available on the AHS website to ensure that policy changes are transparent to Vermonters and to provide a forum for public comments.

The GCR listserv is a group of about 400 interested parties who have elected to receive periodic key updates about Vermont health care programs, which includes policy changes to all Medicaid programs as well as policy changes to Vermont's Health Benefit Exchange. A policy change in the GCR could be a change made under the authority of the waiver, a proposed waiver amendment or extension, an administrative rule change, or a State Plan Amendment. The GCR also contains policy clarifications for when an issue is identified that is not answered in the current policy.

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

A public health emergency (PHE) was declared in March 2020 due to the COVID-19 pandemic. The PHE continues to impact the state budget and Medicaid operations, which is reflected in the number and type of policies being posted to the GCR. There were 16 proposed policies posted in QE0622. A total of 3 final policies were posted in QE0622. Three policy clarifications were posted to the GCR in QE0622. Changes included updates to rates and/or rate methodologies (including appropriations from the Vermont legislature), clinical coverage changes, administrative rulemaking notices, and changes stemming from the public health emergency and the COVID-19 pandemic.

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

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

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 andObjectives	1. Increased rates of identification initiation, and engagement in treatment; 2. Increase adherence to and retention in treatment; 3. Reductions in overdose deaths, particularly those due to opioids; 4. Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services; 5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and 6. Improved access to care for physical health conditions among beneficiaries.

Key updates for QE062022:

- Name Change: Division of Alcohol and Drug Abuse Programs changed to Division of Substance Use Programs
- VT Helplink received 305 calls and 12,272 website visits.

Executive Summary

The Governor approved bill H. 462 (Act 115) on May 16, 2022. This Act includes multiple amendments including changing the name of the Division of Alcohol and Drug Abuse Programs (ADAP) to the Division of Substance Use Programs (DSU). Use of the "Division of Alcohol and Drug Abuse Programs" or "ADAP" will no longer be used in this report and will be replaced with "Division of Substance Use Programs" or "DSU".

The State of Vermont continued to have all ASAM levels of care available and no ongoing waitlist to access Medications for Opioid Use Disorders. Treatment providers continued to provide telemedicine, where appropriate, while others adjusted daily census as needed to mitigate fluctuating risk from COVID-19 and continued strategies to continue serving patients requiring in-person services during fluctuating COVID-19 levels in their communities.

Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were effective January 1, 2020, and continue to be used consistently with site visits. DSU met with the DVHA Payment Reform team and plans to explore the value-based payment model for residential programs, to align with its All-Payer Model Agreement with CMS, as a part of larger discussions around the SUD system of care reform in the next quarter.

DSU's centralized intake and resource center, "VT Helplink: Alcohol and Drug Support Center" was launched for public use in March 2020. From April 1 to June 30, 2022, VT Helplink received 305 calls and 12,272 website visits. During that time, web visitors searched for services online over 850 times. A new marketing campaign promoting VT Helplink services launched this quarter. Major components of VT Helplink 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 treatmentwith appointments to DSU's Preferred Provider Network.

The Substance Misuse Prevention Oversight and Advisory Council (SMPC) was established within the Vermont Department of Health and encompass all substances of misuse including alcohol; cannabis; controlled substances such as opioids, cocaine, and methamphetamines; and tobacco products, tobacco substitutes, and substances containing nicotine. The SMPC met seven times as a full Council with each of the four subcommittees meeting an additional three times over the calendar year 2021. The SMPC has three goals of the SMPC are the following:

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

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

During this last quarter, the SMPC focused its attention on the Vermont Legislative session to provide information or support to ensure prevention was a focus of all substance-related policy decision-making.

Vermont launched the Recovery Coaches in the Emergency Department Program on July 1, 2018. 13 Hospitals are participating in the program with the final hospital coming on board by July 1, 2022.

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 the assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.	DY2 Q2	Medicaid Beneficiaries with SUD Diagnosis (monthly) Medicaid Beneficiaries with SUD Diagnosis (annually) Medicaid Beneficiaries Treated in an IMD for SUD	During the COVID pandemic, Vermont experienced a decrease in the number of Medicaid beneficiaries identified with SUD diagnoses as well as decreases in people receiving SUD services other than medications for opioid use disorders. People were not seeking care across the healthcare system during the pandemic, which would account for the decrease and ongoing concerns about COVID and the variants have continued to impact people seeking healthcare services. DSU has worked with VT Helplink and SUD treatment providers to market and educate Vermonters that treatment services are available and that it is safe to seek treatment. Providers have continued to utilize telemedicine as allowable and clinically appropriate to increase options for individuals to seek treatment and to maximize the stressed clinical workforce.
[Add rows as needed]			
The state has no metrics trends to report for this reporting topic.			
Implementation Update			
			There are no planned changes.

Compared to the demonstration design details outlined in the STCs and implementation plan, have there been any changes or does the state expect to make any changes to: A) the target population(s) of the demonstration ? B) the clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration ?			

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any	Summary
Milestone 1 Metric Trends			

Discuss any relevant trend that the data shows related to the assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.	DY2 Q2	6 Any SUD Treatment	
		7 Early Intervention	Services coded as early intervention have been consistently low (averaging one beneficiary per month) as most intervention services in Vermont are provided through other mechanisms or funding. .
		8 Outpatient Service	Outpatient services decreased due to COVID and peoples' concerns about seeking healthcare services. Providers ramped up capacity to provide services through telemedicine and are currently able to provide services through telemedicine and in-person, giving more options to those

			seeking services. Telemedicine services have
			been impacted by a lack of access to adequate internet services in some rural areas as well the cost/data limits. All healthcare services in Vermont have been impacted by Vermont's pre-COVID workforce shortage across licensed professionals (nursing, clinicians) and allied staff, which was exacerbated during the pandemic.
		9 Intensive Outpatient and Partial Hospitalization Services	IOP services remain low due to the difficulty of providing group-based services during The pandemic. Some services are being provided via telemedicine. Telemedicine services are impacted by the rural nature of the state, lack of adequate internet in some areas as well as the impact of limited data/usage for some individuals. Anecdotal reports from the substance use disorder treatment field also indicate fatigue within their patient populations with virtual healthcare.
		10 Residential and Inpatient	Residential providers have continued to experience varying reductions in available COVID-19 outbreaks as well as safety precautions to reduce the potential for outbreaks in their facilities. Additionally, challenges with ensuring all clients are tested for COVID-

		Services	19 immediately before admission or can access a single, isolation room has impacted the pacing of admission. Additionally, residential providers are feeling the pressures of Vermont's workforce crisis, from clinical to milieu staff, which is at times also impacting census capacity and admissions pacing.
		11 Withdrawal Management	This has been trending downward with some month-to-month variation
		12 Medication Assisted Treatment	The number of beneficiaries receiving medications for opioid use disorder has

			continued to increase quarter by quarter.
		36 Average Length of Stay in IMDs	CY2020 LOS is 13.66 days
[Add rows as needed]			

The state has no metrics trends to report for this reporting topic.
Milestone 1 Implementation Update
Prompts: Compared to the demonstration design and operational details outlined in theimplementation 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 is no anticipated program

☒ 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 in the implementation plan, have there been any changes, or does the state expect to make any changes to:
Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria?
Implementation of a utilization management approach to ensure:
Beneficiaries have access to SUD services at the appropriate level of care.
Interventions are appropriate for the diagnosis and level of care?
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 33 substance use disorder treatment provider locations. The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were effective January 1, 2020. Due to the COVID pandemic, provider site reviews were put on hold until July 2021 when they resumed in a virtual environment. ADAP has completed three remote site visits utilizing the tool this quarter.

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	August 15, 2018	Director of Quality	Completed	

Assessment Tool with revised Substance Use Disorder Treatment Standards and all residential ASAM criteria		Management and Compliance	
Updated online	October 31, 2018	Director of Quality	Completed
recertification survey		Management and	
to reflect a new revision		Compliance	
of Substance Use			
Disorder Treatment Standards			
Use the Compliance	December 31, 2018	Director of Clinical	Completed
Assessment Tool to		Services; Director of	
certify ASAM Level 3.5 Level of Care provider (Valley Vista Vergennes)		Quality Management and Compliance	
Use the Compliance	December 31, 2018	Director of Clinical	Completed
Assessment Tool to		Services; Director of	
certify ASAM Level		Quality Management	
3.5 Level of Care provider (Valley Vista Bradford)		and Compliance	
Implement the Compliance Assessment Tool	October 3, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed

Use of the Compliance	March 31, 2019	Director of Clinical	Completed
Assessment Tool to		Services; Director of	
certify ASAM Level 3.3 Level of Care Provider (Recovery House)		Quality Management and Compliance	
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

DSU has met with the DVHA Payment Reform team regarding plans to develop a value-based payment model for residential programs to align with its All-Payer Model Agreement with CMS. The value-based payment component of the residential payment model is still in consideration for inclusion in the larger system reform.

Milestone 2 – Table 2

Action	**Date**	**Responsible**
Develop the criteria for the differential case rate	Completed	DSU 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 forthe model	Completed	Payment Reform Team, DSU Director of Clinical Services, VDH Business Office
Residential providers to provide feedback	Completed	DSU Director of Clinical Services
Work with the Medicaid fiscal agent to identify and complete the necessary system changes required for the Medicaid billing system	Completed	DSU 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	DSU 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	DSU Clinical Team and DSU 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 quarter first reported	Related metric (if any)	Summary
Milestone 3 Metric Trends			
☒ The state is not reporting any metrics related to this reporting topic.			
Milestone 3 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined in the implementation plan, have there been any changes, or does the state expect to make any changes to: **Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards?** **The state review process for residential treatment providers' compliance with qualifications standards?**			

Availability of medication-assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off-site? **Summary:** The current version of the Substance Use Disorder Treatment Standards is beingused. The Compliance Assessment Tool has been utilized with 33 substance use disorder treatment provider locations. The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were effective January 1, 2020. Due to the COVID pandemic, provider site reviews were put on hold until July 2021 when they resumed in a virtual environment. DSU has completed three remote site visits utilizing the tool thisquarter.			
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 the assessment of need and qualification for SUD services. At a minimum, changes (+or -) greater than two percent should be described.		SUD Provider Availability SUD Provider Availability – MAT	
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 4 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined in the implementation plan, have there been any changes, or does the state expect to make anychanges to planned activities to assess the availability of providers enrolled in Medicaidand accepting new patients across the continuum of SUD care? **Summary**: DSU met with the DVHA Payment Reform team regarding the value-based payment model for residential programs to align with its All-Payer Model Agreement with CMS. Vermont anticipates resuming work on the model as a part of thework around the entire system of care throughout the fall/winter of 2022. DSU's centralized intake and resource center "VT Helplink: Alcohol and Drug Support Center" was launched for public use in March 2020. From April 1 to June 30, 2022, VT Helplink received 305 calls and 12,272 website visits. During that time, web visitors searched for services online over 850 times. A new marketing campaign promoting VT Helplink services launched this quarter. Major components of VT Helplink 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 DSU's Preferred Provider Network.			
Are there any other anticipated program changes that may impact metrics relatedto 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 Milestone5.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 5 Metric Trends			
Discuss any relevant trends that the data shows related to the assessment of needand qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.		15 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment 18 Use of Opioids at High Dosage in Persons Without Cancer 21 Concurrent Use of Opioids	The percentage of adults in continuous pharmacotherapy for OUD has decreased which may be an unintended consequence of Vermont's robust access to Medications for opioid use disorders. Individuals who may be ambivalent about treatment may be less concerned about leaving treatment since they know there will be no wait to get back in; also, there are several cash-only and other Spoke options available which may lead to moremovement in and out of treatment. Additionally, anecdotal information from our Corrections partners as well as the treatment field has indicated more patients seeking pathways for recovery that do not include medications, which may be impacting pharmacology numbers.
		Benzodiazepines 22 Continuity of Pharmacotherapy for Opioid Use Disorder	
[Add rows as needed]			

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

Milestone 5 Implementation Update

Prompts: Compared to the demonstration design and operational details outlined in theimplementation plan, have there been any changes, or does the state expect to make any changes to: Implementation of opioid prescribing guidelines and other interventions related to the prevention of OUD? 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 toaddress 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 quarter first reported	Related metric (if any)	Summary
Milestone 6 Metric Trends			
Discuss any relevant		17 Follow-Up	Recovery Coaches are dispatched to 13

trends that the data		After Emergency	emergency departments to support
shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.		Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	individuals who present with a SUD at the ED including providing linkages to follow-up visits upon discharge.

☒ 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. 13 hospitals are participating in the program. Virtual recovery services have been implemented.

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

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) Greater than two percent should be described.		Q1 PDMP Users/ Checks Q2 PDMP Linkages	
		Q3 HIT/HIE Plan	
[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: How health IT is being used to slow down the rate of growth of individuals identified with SUD? How health IT is being used to treat effectively individuals identified with SUD? How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD?			

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?
Other aspects of the state's health IT implementation milestones?
The timeline for achieving health IT implementation milestones.
Planned activities to increase use and functionality of the state's prescription drugmonitoring program?

Summary:

As of May 2021, Vermont has connected to both the RxCheck and PMPi hubs for interstate data sharing. RxCheck is developing functionality for direct integration with EHRs and other health systems, and PMPi employs the Gateway product for health system integrations. In April of 2022, VPMS went live with RxCheck v3.0. The VPMS Program Manager attended the biannual RxCheck Governing Board meeting in May 2022.

VPMS, Dr. First, and Bamboo Health (formerly Appriss) are in the process of testing and verifying the Gateway integration tool to enable a direct population of VPMS datainto Dr. First's prescription ordering section, eliminating the need for providers to navigate between systems. However, the deployment of VPMS staff for COVID-19 response has delayed the start of this initiative.

In June 2022, three pilot locations were selected to begin the process for integration. Two are smaller hospitals and one is a small family practice. The locations were selected due to their vendors stated readiness to integrate using the Gateway product and the inclusion of integration in their existing vendor contracts. Once legal approvals are in place, these locations will provide the opportunity to ensure a smooth process by giving real-time oversight to the integration implementation and initial maintenance.

VPMS currently is integrated through Gateway with the Veteran's Affairs health system as required by the Mission Act. This allows VA providers to query the prescription history of their Vermont patients, regardless of if they have a Vermont license. Previously, VA providers were not allowed direct access to the prescription monitoring program without a VT license. As VA providers are not required to have a license within the state that they are working, this created a gap for those providers working in, but not licensed in, Vermont.

VPMS staff are engaged with the NESCSO State HIT Learning Community. This groupworks to create a shared understanding of Federal legislation, the current state of PDMP activities, and identifies opportunities for multi-state alignment.

Vermont continues to offer prescriber reports on a quarterly basis. These reports provide in-depth snapshots of prescriptions dispensed from those prescribers of opioids, sedatives, benzodiazepines and stimulants.

In March 2022, VPMS resumed its regular prescriber compliance after pausing it during the COVID response. Prescribers who had prescribed within a quarter and did not have an active account were notified of the requirement to re-activate or register for a PDMP account. This resulted in large number of new prescribers and prescribers updating their account information.

VPMS initiated conversations with the State Medicaid office to ensure that reporting for the prescriber compliance reporting in Section 5042 of the Support Act will proceed smoothly once it is required in October of 2022.

Are there any other anticipated program changes that may impactmetrics 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	DemonstrationYear (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		Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries Inpatient stays for SUD per 1,000 Medicaid beneficiaries.	Overdose deaths are variable. Vermont has seen a significant increase in fentanyl involvement in opioid overdose fatalities. Fentanyl is 50-100 times stronger than heroin and the amount in the drug supply often isn't known to users until itis used. Fentanyl is currently the most prevalent substance involved in opioid-related deaths)
qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be			

described.		Beneficiaries Readmissions Among Beneficiaries with SUD Overdose Deaths (count) Overdose Deaths (rate) 32 Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD	of opioid-related fatalities has increased each year since 2011 (9%). Of note, deaths involving fentanyl can include prescription and/or illicit fentanyl and fentanyl analogs. We are increasingly seeing xylazine involvement which is concerning because it exacerbates opioid-related decreases in respiration and is not responsive to naloxone. Vermont has been working to decrease drug overdoses and in 2020 and 2021 published a social autopsyshowing places where individuals who died of a drug overdose interacted with a variety of Vermont programs. Fatal overdoses increased in 2020 and 2021 after a decrease in 2019. This is likely due to the stress, social isolation, and disruptions in services and drug supply associated with COVID-19 and a changing drug supply. Community support systems such as recovery groups were moved to a remote format, a method not accessible or accepted by everyone accessing these services. COVID-related social isolation may have resulted in more people using alone and

			anecdotal information suggests that the stimulus payments allowed for larger drug purchases. Medication-assisted treatment provision increased in 2020 but residential and intensive outpatient care was less available due to the group nature of these services, and outpatient care was provided remotely. Provision of harm reduction services, which includes information about safer use and referrals to treatment as well as distribution of naloxone and clean syringes were less able to be provided, in person. There was a 38% reduction in people visiting sites where naloxone is distributed and a 20% decrease in naloxone kits distributed in 2020 compared to 2019.
[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.			As a result of COVID-19, the Vermont Department of Health Division of Substance Use Programs (DSU) is taking the following actions to address the increase in drug overdoses. Naloxone – The Department continues to provide naloxone and training through collaborations with community-based organizations, including getting naloxone to the motels where the state is housing people experiencing homelessness. VT Helplink is a free and confidential referral service available to connect people to resources and treatment (802-565- LINK or VTHelplink.org) Recovery Centers are conducting outreach to reduce relapse and prevent overdoses (e.g. Harm Reduction Pack distribution, peer support specialists, Recovery Coaching referrals, etc.) Providers are increasing outreach to patients and are continually re-evaluating patients' stability to triage for in-person supports, decreased take-homes, etc. DSU has regular calls with Preferred Providers. The clinical team at DSU receives critical incidents of overdoses from the preferred providers for people currently in treatment. Overdoses were reported by providers to include people in longer-term recovery and people who had left treatment before COVID. The Department is working with partners to continue to disseminate key harm reduction messaging on the increased risks

			associated with overdose and using alone.
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 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 moredetail.			
[Add rows as needed]			
☒ The state has no related considerations to report for this reporting topic.			
11.1.2 Implementation Update			
Compared to the demonstration design and operational details outlined in STCs and the implementation plan, have there been any changes, or does the state expect to make any changes to: a. How the delivery system operates under the			
demonstration (e.g., through the managed care system or fee for service)? Delivery models affecting demonstration participants (e.g., Accountable Care Organizations, Patient-Centered Medical Homes)? Partners involved in service delivery?			

Has the state experienced any significant challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers)? Has the state noted any performance issues with contracted entities?			
What other initiatives is the state working on related to SUD or OUD? How do these initiatives relate to the SUD demonstration? How are they similar to or different from the SUD demonstration?			
☒ 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			
Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template			Updates on the SUD evaluation work, deliverables and timeline can be found in Sections VIII. *Quality Improvement* and IX. *Demonstration Evaluation* of this report.

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 to achieving the goals and timeframes agreed to in the STCs.			
List anticipated evaluation-related deliverables related to this demonstration and their due dates.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
12.1.2 Implementation Update			
Are there any anticipated program changes that may impact budget neutrality? If so, please describe these changes.			
[Add rows as needed]			
The state has no SUD demonstration evaluation update to report for this reporting topic.			

Other Demonstration Reporting

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

Does the state foresee the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation? changes?			
Compared to the details outlined in the STCs and the monitoring protocol, has the state formally requested any changes, or does the state expect to formally request any changes to The schedule for completing and submitting monitoring reports? 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 plan for remediation?			
[Add rows as needed]			
☒ The state has no updates on the general reporting requirements to report for thisreporting topic.			
13.1.2 Post Award Public Forum			
If applicable within the timing of the demonstration, provide æsummary of the annualpost-award public forum held according to42 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., the 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 QE062022:

Resume in person visits

- VCCI Utilization
- New to Medicaid Screening Data
- Collaboration with Healthcare Reform team on Complex Care Model
- Staff training initiatives
- Workforce updates

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

the system of health and health-related care.

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In the first quarter of 2022, VCCI has focused on updating in-person visit guidance to ensure safe visiting during the pandemic for both staff and members. Prioritization criteria were established so the most vulnerable members resumed home visits first. Most members request multi-modal interventions. Most prefer a hybrid model with some home visits mixed in with virtual or telephonic visits.

The percentage of home-based visits has been slowly yet steadily increasing during the first and second quarters. The percentages of visits seem to correlate with the prevalence of COVID in communities at the time.

As seen below, VCCI provided care management services to 289 unique individuals in Q22022 The length of time and regularity of visits are dependent on the complexity and severity of the needs of the beneficiaries. VCCI case managers work with beneficiaries until the goals of their care plans are met.

(See **Figure 1).**

Figure 1. Beneficiary Enrollment and Face To Face Visits

	SFY22					
	Jan-22	**Feb-22**	**Mar-22**	**Apr-22**	**May-22**	**Jun-22**
Measure	2/15/2022	3/15/2022	4/15/2022	5/15/2022	6/15/2022	7/15/2022
# new VCCI eligible members enrolled monthly in care management	33	33	46	24	30	21
Total Open Cases (including newly enrolled - above)	276	280	273	238	245	210
% of VCCI enrolled members with a face-to-face visit during the month	17.03%	17.86%	25.64%	29.83%	34.29%	41.90%

VCCI continued work started in 2019, of telephonic outreach and screening to beneficiaries new to the health plan. The new Medicaid screening tool poses questions related to access to health care and health care-related issues including Primary Care, Dental, housing, transportation, and food, with direct facilitation to those services desired by the beneficiary. The numbers new to the health plan have declined somewhat from the first quarter. (**Figure 2).** Timely access to some services desired by beneficiaries continued to present as a challenge this past quarter. Wait times for the establishment of primary care are longer in many areas of the state. -

Figure 2. Number of New to Medicaid Beneficiaries Screened April 1 – June 30,

# New to Medicaid members	**327**

# of those members reached	**72**
# of new members screened	**105**

Successful facilitation of access to PCP appointments to establish new patient care continues to be a challenge, with barriers including long wait times for new patient appointments, the requirement for former health records, and practices closed to new patients. These factors may have impacted the low data point for successful care establishment (**Figure 3).** Wait times for new patient appointments varied throughout the state; one practice was citing a 7-12 month wait time. Several practices require former health records before even scheduling a new patient appointment. Work is anticipated with state colleagues and VITL to provide reinforcement and training on Vermont's information exchange as an initial mechanism to obtain health history and medication list while awaiting a more comprehensive health record set. Dental practices accepting new patients with Medicaid are also sparse statewide. Access to dental care continues to be a challenge for Vermonters with Medicaid.

% of New to Medicaid members who accepted help with PCP establishment and who successfully established care with practice/medical home

Measure	Q3	Q4
# of "New to Medicaid" members who already had a PCP they saw regularly (of those screened)	4/15/2022	7/15/2022
# who didn't have a PCP and declined help	483	361
# who didn't have a PCP and accepted help	13	6
# of members who successfully established care	155	87
% of members who successfully established care	8	2
	5.16%	2.30%

VCCI leadership is working with the Healthcare Reform team on re-evaluating our complex care model and how it is implemented statewide. Due to workforce turnover in direct care organizations statewide, much of the training the state provided on the complex care model has not been carried on. Our team is looking at ways to provide ongoing training on the model in a way that is sustainable.

VCCI has been working with VITL doing some testing with their updated platform and the new single sign-on button that is integrated within our eQ Health Care Management system. Our team worked with VITL to test their new platform and made recommendations for improvements for ease of use within the field.

Over the last quarter, we have focused on staff training initiatives for our statewide team. We have worked with our medical director and pharmacy team to implement a medication reconciliation process/protocol for all RN case managers to do with every beneficiary served. Our team is working with people to gather all

information on prescribed medications and is communicating that to all providers and prescribers. They have also been helping beneficiaries appropriately dispose of unused medications. This is initiative is aimed at improving the health and safety of beneficiaries.

The VCCI team met in person for the first time since the pandemic began during the last quarter for a day-long training event. Our two senior nurses provided an overview of our case management system and process to enhance consistency in our practices statewide. For many new staff, it was their first time meeting their team in person.

Another training and overview we initiated for the team was an overview of the Department of Mental Health system in Vermont. Many of the beneficiaries served in VCCI have co-occurring mental health conditions. Many nurse case managers have struggled to find mental health programs in communities that can serve new patients. Many patients need both counseling services and psychiatric services since many primary care physicians are not comfortable prescribing psychotropics, however, we have scares resources statewide for both services. The Vermont Department of Mental Health provided a comprehensive overview of the continuum of mental health care in Vermont.

VCCI continues to face workforce challenges. Over the past quarter, three staff have transitioned either into new jobs or into retirement. VCCI has six RN case manager vacancies and one Outreach Coordinator position. The program is actively recruiting and is focused on identifying retention strategies for current program staff.

In the past quarter, our team has been busy working on recruitment for our seven vacant positions. Six of the positions are nurse case management positions and one was an Outreach Coordinator position. At the end of June 2022, we were close to filling three of the positions, however, we also received notification of one staff person planning to retire at the end of August. Recruitment and retention continue to be a challenge in our program. Our current staff has been working very hard to be responsive to meet the needs of beneficiaries despite our vacancies.

. **Goals CY 2022**:

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

ii. Blueprint for Health

Key updates from QE 062022:

- The majority of Vermont's primary care practices are now Blueprint-participating Patient-Centered Medical Homes, as 134 of Vermont's estimated 169 primary care practices are Blueprint-participating practices (and an estimated 148 employ more than one provider).
- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid-use disorder. As of 2022-Q2, the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke)

programs is 3,725.

- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 44 practices and 6Planned Parenthood sites to participate in the Women's Health Initiative as of June 2022

Patient-Centered Medical Home Program

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

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

Blueprint Program Managers provide leadership in each community to coordinate healthcare delivery system improvement efforts. While they are employed by the hospital or FQHC in the HSA, they help organize, lead, and staff collaborative initiatives with the ACO, local human service agencies, health departments, specialty

care providers, mental health providers, and primary care providers to facilitate the integration of services. They are responsible for contacting all primary care practices within their HSA to encourage, engage, and support practice participation in the Blueprint and other health system reform activities. Additionally, Program Managers are responsible for administering funds and staffing plans for the local CHTs on behalf of all participating payers, including core CHT, Spoke staff, and WHI staff.
Program Managers set up the systems through which integrated services can be delivered in the community.

In addition to Program Managers, the Blueprint supports participating practices with a quality improvement coach, called a Quality Improvement (QI) Facilitator. QI Facilitators support practices with Blueprint-generated all-payer data on practice performance and their training

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

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

Q2Highlights

With the impact of the pandemic at this phase presenting as increased, but manageable clinical demand, many Blueprint for Health practices and other stakeholder groups have signaled readiness to refocus efforts on quality improvement opportunities. In response to either newly-identified community needs or performance quality measures, structured QI activities and resources have re-emerged that are designed to improve the health of the population, assist providers to address their patients' needs, and adapt to the value/quality-based payment environment.

There has been a considerable effort this quarter to re-establish collaborative relationships with the various organizations offering quality improvement resources and activities to practices, including the Quality Innovation Network-Quality Improvement Organization, OneCare Vermont, Bi-State Primary Care Association, and the Vermont Child Health Improvement Program. For example, the QI facilitation network has been working in partnership with these organizations to assist with practice recruitment for learning sessions, provider resource dissemination, collaborative/pilot recruitment, and direct QI support for important topics such as youth vaping, sepsis management, and chronic disease/diabetes prevention and management.

As part of the ongoing work of patient-centered medical homes, thirty-nine (39) practices across the State completed their National Committee for Quality Assurance annual recognition process in this period, demonstrating their ongoing commitment to the model and continuous quality improvement. Three of these practices were randomly selected for audit (NCQA randomly audits at least 10% of participating practices nationally); this is the first time Vermont practices have been selected since the transition to the sustaining recognition process in 2017. Practices were required to share additional evidence within ten (10) business days to demonstrate how they, for example, assess diversity, complete medication reconciliation, update care plans, identify patients with unplanned hospital admissions and emergency department visits, and share important clinical and performance information for continuity of care and quality improvement.

Public Health Emergency

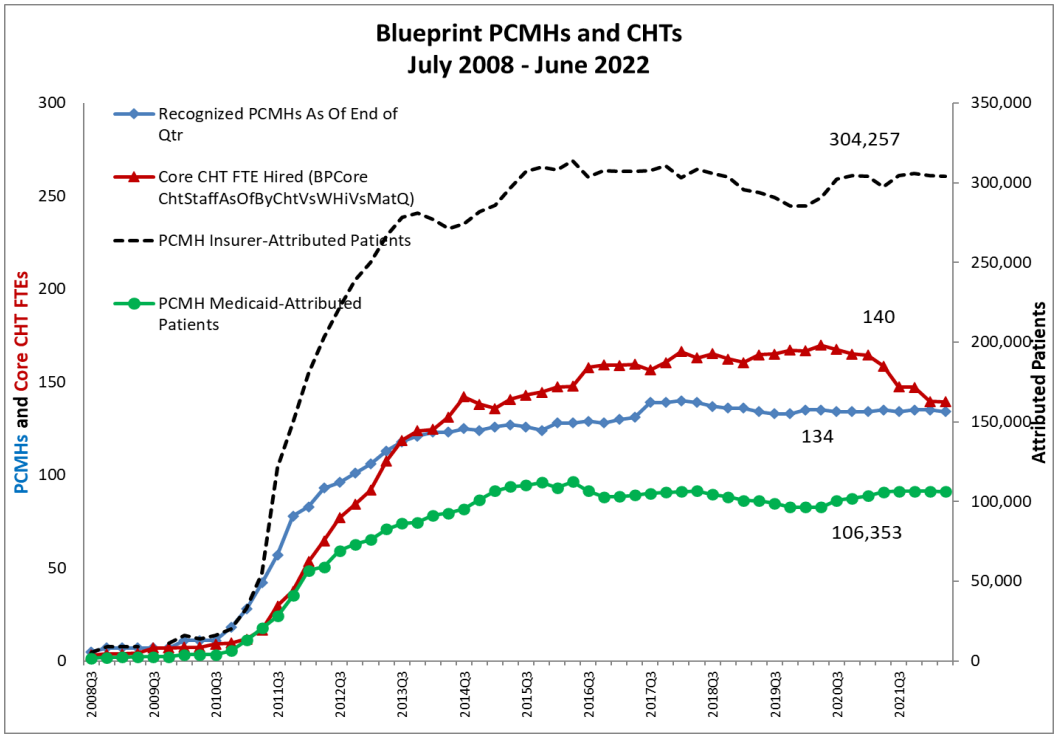
The Blueprint network focused on adaptability, resilience, patience, and continued persistence. We have seen an increase in response within primary care offices for testing,

vaccines, and overall care for patients with Covid. We continue to work with VDH to inform our network and keep us up to date on any current information on Covid cases, vaccine clinics, and booster availability. . We will also continue to monitor the impact of monkeypox/hMPXv and other public health emergencies.

Blueprint-participating Patient-Centered Medical Homes currently serve 304,257 insurer-attributed patients, of which 106,353 are Medicaid enrollees. Attribution to a practice is determined by the practice at which the patient has received the majority of their primary care within the 24 months before the date the attribution process is conducted. These practices and patients are supported by 140 full-time equivalents of Community Health Team staff.

In Quarter 2 (April - June 2022), 134 Vermont practices were operating as Patient-Centered Medical Homes, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of practices participating in the Blueprint for Health program is a key performance measure; the Blueprint estimates that there are about 169 total primary care practices operating in the state.

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



Community Health Profiles

Since 2013, the Blueprint for Health has supported data-driven population health improvement by producing profiles that describe the health status, health care utilization, expenditures, and outcomes of populations in each hospital service area and, until 2019, patients in each Patient-Centered Medical Home. Unfortunately, due to budget constraints, practice-level profiles have been suspended since 2019

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

The Blueprint Annual Report to the Vermont Legislature reviews more in-depth how the Program Managers, Quality Improvement Facilitators, Patient-Centered Medical Homes, and Community Health Teams interact to provide services, coordinate care across communities, and work with the state's accountable care organization. The latest report is available at:

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

Hub & Spoke Program

Medication-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.

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.

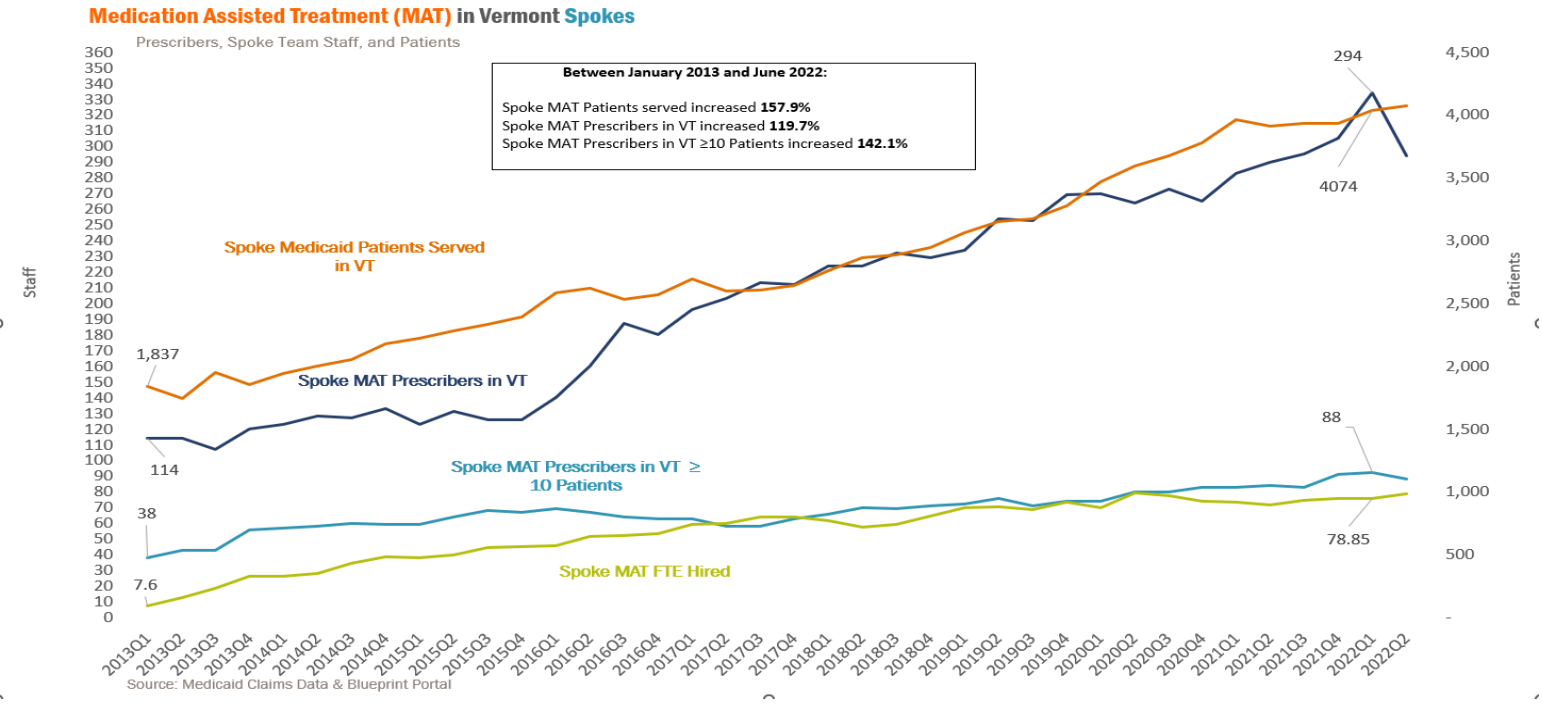
Q2 Highlights

The Blueprint, in partnership with the Division of substance use prevention, in conjunction with a contract with Dartmouth allows us to continue to offer learning sessions with expert-led, and peer-supported, training in best practices for providing team-and evidence-based medication-assisted treatment for opioid use disorder. Sessions alternated between didactic and webinars this quarter. We have been actively planning for our two-day hub/spoke conference on integration of care that will take place in Oct 2022

Vermont continues to demonstrate substantial access to medication-assisted treatment for Vermonters with opioid use disorder. Medication-assisted treatment is being offered across the State of Vermont by more than 75 different Spoke settings as of June 2022.) The capacity to serve Vermonters continued to increase, as evidenced by a monthly average of 4074 Medicaid beneficiaries were served by Office-Based Opioid Treatment (OBOT/Spoke) programs.) There are 294 medical doctors, nurse practitioners, and physician assistants who work with 78.85 FTE licensed, registered nurses, and licensed, Master's-prepared, mental health/substance use disorder clinicians as a team to offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder (as of full-time equivalent Spoke staff working as teams.

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

Figure 2. MAT-SPOKE Implementation Jan 2013 – March 2022



Women's Health Initiative

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

The Women's Health Initiative (WHI) strives to support any persons who can become pregnant in their efforts to experience healthy pregnancies, avoid unintended pregnancies, and build thriving families. The WHI provides increased mental health and social service staffing

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

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

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

Q2 2022 Highlights

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

We have continued to outreach to practices to share the mission of the WHI program and assess interest in incorporating this into their practice.

Practices are working hard to engage community partners in referral agreements. These agreements enhance relationships and pathways to care. We have presented a WHI data dashboard to the field in our monthly call every quarter. We received feedback on what would be useful data for the field from claims and will continue to support the field with this information. We have received feedback on being more inclusive in the name of our program and we will assess this in future quarters. The field has asked to be more inclusive of pregnant persons and increase asking all Vermonters about pregnancy intention with partners.

This quarter was significant for our WHI program in that PPNNE closed four offices. They shared that because of limited resources and the national crisis for reproductive health access, they need to reallocate resources. This includes adding more days per week to other health centers and continuing to offer. Before office closing fact sheets were shared on the closest sites that are taking new patients. PPNNE shared they have a robust telehealth program for All birth control methods except LARC (we have a birth control by mail program for pills, rings, and Depo too)

- Emergency contraception pills
- HIV prevention (PrEP)
- Gender-affirming hormone therapy

- STI screening and treatment (we have a mail-in testing program now)
- Preventive care up to age 24
- Uncomplicated UTI care
- Care for people with uncomplicated depression and anxiety

Concerns that were discussed with our health service area field managers were concerns of access generally. We discussed specific topics of accessing pregnancy termination services. Availability of care for uninsured/underinsured/young folks not wanting to be on parents' insurance and ensuring the privacy of these protected services.
Alternative sites experiencing an increase in bad debt due to the sliding scale of PPNNE for services. Availability of transportation to other catchment areas
Gender affirming (available telehealth) but several specialty/PCMH aren't comfortable with this. The Blueprint is looking into further training and support for providers who want to increase comfortability and knowledge in transgender care.

A Nexplanon training was provided by Dr. Macafee from UVM medical center. The providers were very thankful to learn and meet in person again. We will be scheduling a full-day LARC training in the fall.

Figure 3 below shows WHI enrollment and staffing over time. In 2022, the number of PCMHs enrolled are 44. 22 women's specialty health care sites and 22 PCMH to participate in the Women's Health Initiative as of June 2022. 52

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

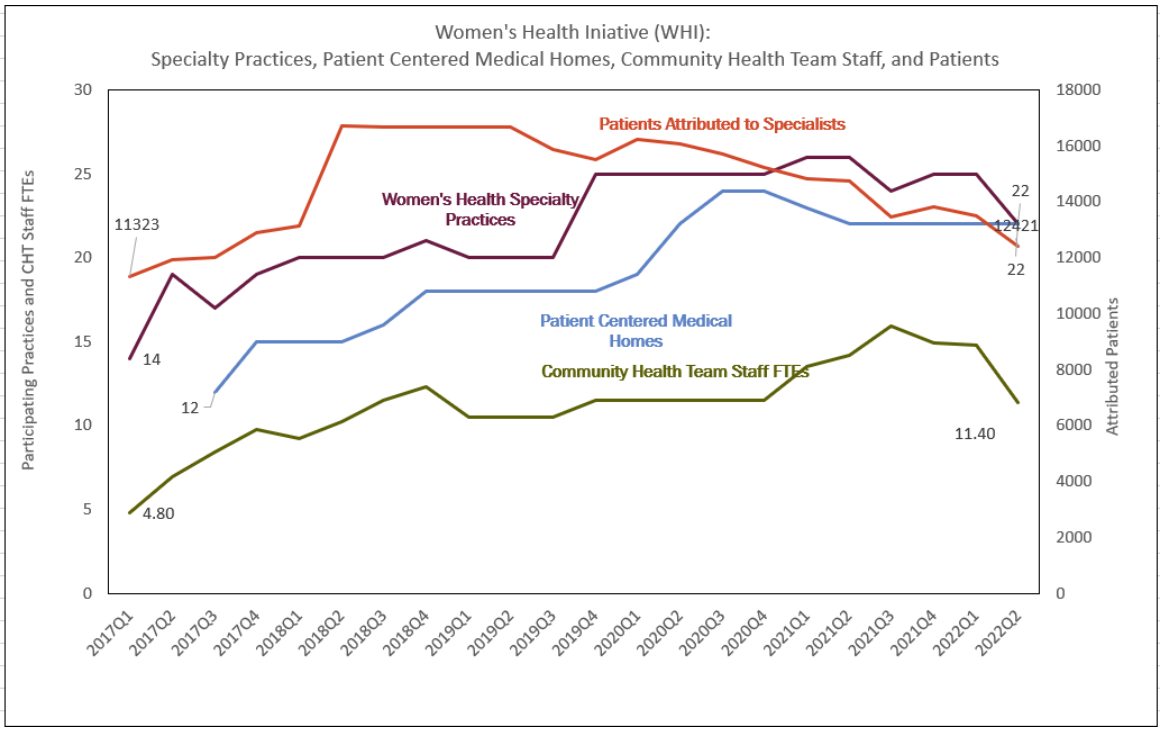


Table 4. Women's Health Implementation by Region

Health ServiceArea / Team	WHI Specialist Practices as of June 2022	WHI PCMH Practices as of June 2022	WHI CHT Staff FTE Hired as of June 2022	WHI Specialist Quarterly Attributed** Medicaid Beneficiaries as of June 2022	WHI PCMH Quarterly Attributed** Medicaid Beneficiaries a June 2022
Barre	1	1	1.5	531	334
Bennington	1	2	0.50	834	258
Brattleboro	1	0	.6	899	0
Burlington	2	9	2	1930	4770
Middlebury	1	0	0.75	625	0
Morrisville	1	3	0.50	282	1200
Newport	1	0	1	917	0
Randolph	2	0	0.0	282	0
Rutland	2	0	1.5	1730	0
Springfield	0	5	0	0	1547
St. Albans	0	0	0.0	0	0
St. Johnsbury	1	2	0.75	815	704
Windsor*	0	0	0.00	0	0
Planned Parenthood (Statewide)	11	0	3.2	3576	0
Total	25	22	11.4	12421	8812

*The Windsor Health Service Area does not have women's health specialty practices.
**Quarterly attributed patient counts at the HSA level have a small amount of overlap due to patients moving across HSAs in different months. The statewide quarterly total is deduplicated.
***The PPNNE practice in Rutland is included in both the WHI Specialist field for those Rutland and in the PPNNE statewide field. Patients are allocated to the Rutland HSA. Total WHI Specialist practice count is deduplicated.

iii. Mental Health, Substance Use Disorder and Behavioral Health

Key updates QE062022:
- Alternative payment model
- Team Care
- Applied Behavior Analysis

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

As of March 1, 2021, Vermont Medicaid modified the reimbursement methodology for inpatient services delivered by a psychiatric facility. Before implementation Department of Vermont Health, Access & Department of Mental Health reimbursed the facility for services using different methodologies on a fee-for-service, per claim basis. The newmodel allows for a prospective payment informed by several factors:

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

DVHA, DMH, and the facility have agreed upon performance measures and a monitoring plat form for the model is being built by the Quality and Clinical Integrity team at DVHA. Year one reconciliation was completed on 5/31/22.

The CIU also manages the Team Care program which is a care management program and a federally mandated prescription lock-in program to prevent misuse, abuse, and diversion of medications on the FDA Controlled Substance Schedule such as opioid pain medications and sedatives. Team Care can be a useful tool for members who may need additional support getting the most appropriate healthcare available to meet their needs. A clinical review of all available data supports the continued review of current enrollees' need to remain in the program. The unit conducts bi-annual reviews of claims data, including pharmacy and emergency department visits, to identify members who may benefit from the support of theTeam Care program. Clinicians review this data and determine the enrollment of potential new members. Team Care program members are also referred to VCCI when appropriate.

Outreach with providers and pharmacies is ongoing. The unit has attended staff meetings of various departments/units and posted advisories for providers. There is also an outward-facing brochure available for Providers. There have been minimal referrals to the program. The lack of referrals may demonstrate the success of the Vermont Prescription Monitoring System (VPMS) and new opioid

prescribing standards and practices associated with VPMS.

CIU team members participate in the 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 members with multi- department involvement are getting appropriate services delivered most efficiently. This is accomplished through participation in state interagency team meetings, the Mobile Crisis Response Initiative, participating in weekly case reviews, and developing protocols for cross-departmental service delivery. Our unit worked with other departments on developing a system to notify DVHA regarding all children with Medicaid that are awaiting placement in Emergency Departments for DVHA to assist with placements when needed.

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

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

The DVHA Senior Autism Specialist conducts annual site visits/audits with Vermont Medicaid enrolled ABA providers who provide services to Vermont Medicaid members. The purpose of these visits/audits is to ensure that members were receiving quality care, that providers are accurately reimbursed for provided services, to verify that required documentation is included in members' charts and that clinical documentation followsABA Policy and Clinical Guideline standards.

Site visits/audits are completed in a virtual format. The process includes a virtual tour of the provider's Electronic Health Records system, and the provider electronically submits clinical documentation to be reviewed independently by the DVHA Senior Autism Specialist or designee. Nine virtual site visits/audits have been completed so far this year with the goal to visit all 18 ABA

providers by December 2022.

iv. Mental Health System of Care

Key updates from QE062022:
- Leadership and Reporting updates

System Overview

The Department of Mental Health (DMH) is responsible for mental health services provided under state funding to special-needs populations, including children with serious emotional disturbances (SED) and adults with severe mental illnesses (SMI). The Vermont Agency of Human Services (AHS) provides funding through Provider Grant Agreements to ten (10) Designated Agencies (DAs) and two (2) Specialized Service Agencies (SSAs). These agencies are located across Vermont for the provision of:

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

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

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

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

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

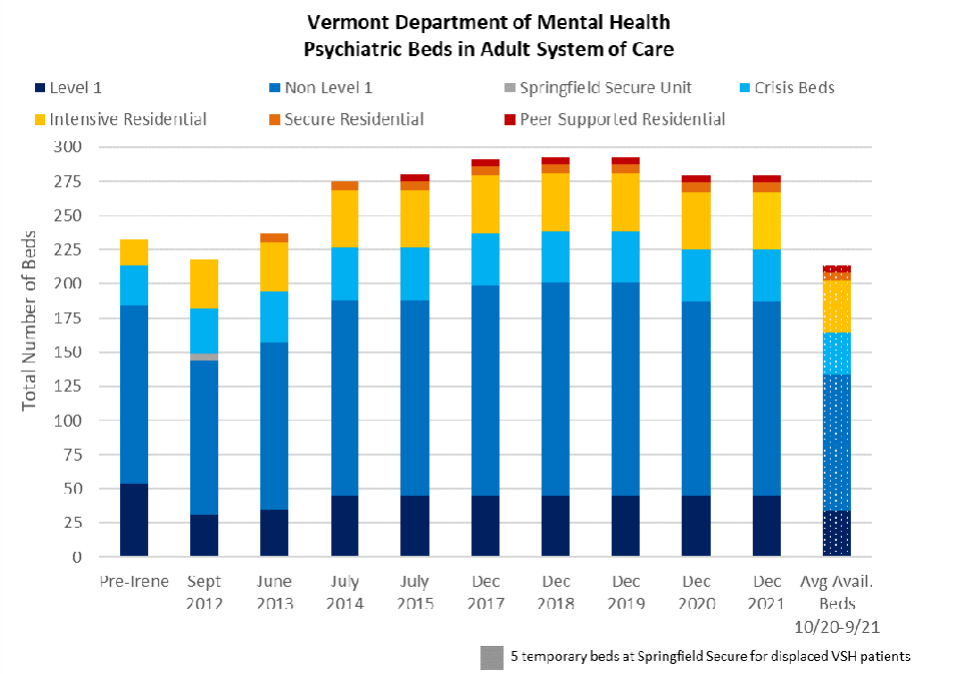
Updates on the Mental Health System of Care

A. Hospital and Inpatient Care

Vermont has 45 Level 1 beds and 159 adult psychiatric inpatient beds across the system of care. During the COVID-19 pandemic, several beds closed due to staffing, construction,

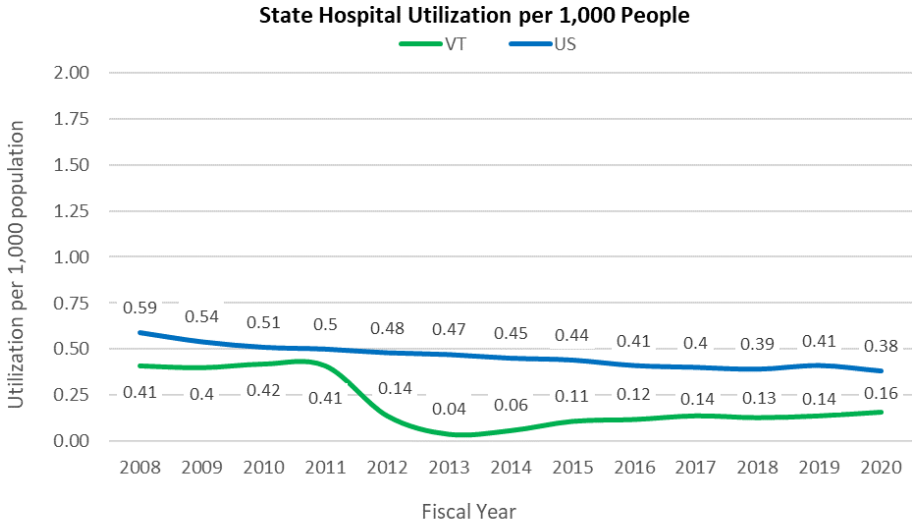
patient acuity, and public health safety protocols, as well as an initial decrease in individuals presenting with a need for a higher level of care. The primary reason for bed closures as of October (2021) is a severe workforce shortage across the mental health system. In a state with approximately 3,300 staff across ten designated agencies that provide mental health care, there are more than 550 vacant positions as of this writing.

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



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

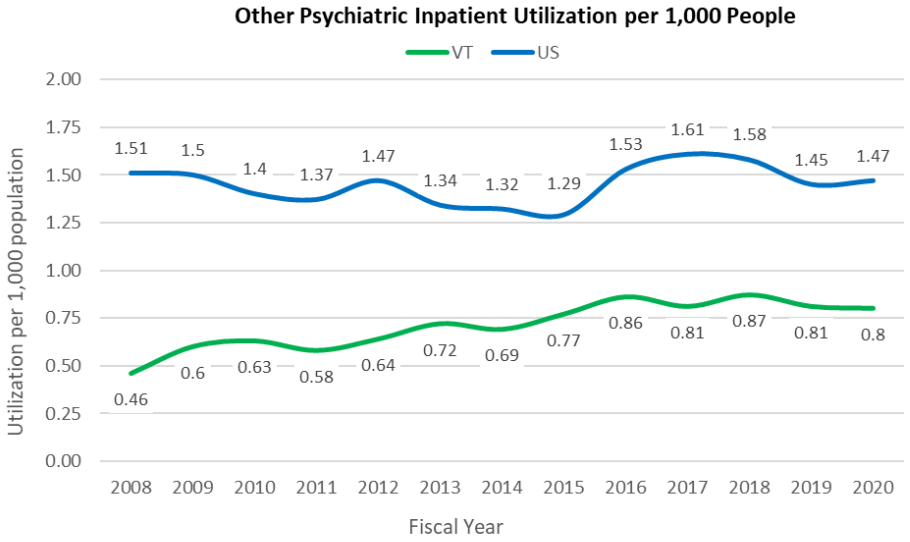
Figure 4. State Hospital Utilization per 1,000 people (in Vermont and the United States)



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

The national rate of state hospital utilization continues to decline year over year. VPCH opened in fiscal year (FY) 2015 with 25 beds, and Vermont's rate of inpatient utilization continues to be lower than the national average in the United States. The significant decrease from FY 2011 to FY 2012 represents the closure of Vermont State Hospital due to flooding from Tropical Storm Irene in August 2011. The Vermont hospital utilization data shows a slowly progressing upward trend since 2012. Vermont is one of a handful of states that only has one state-run psychiatric hospital. The pandemic has significantly increased the need for mental health treatment and support.

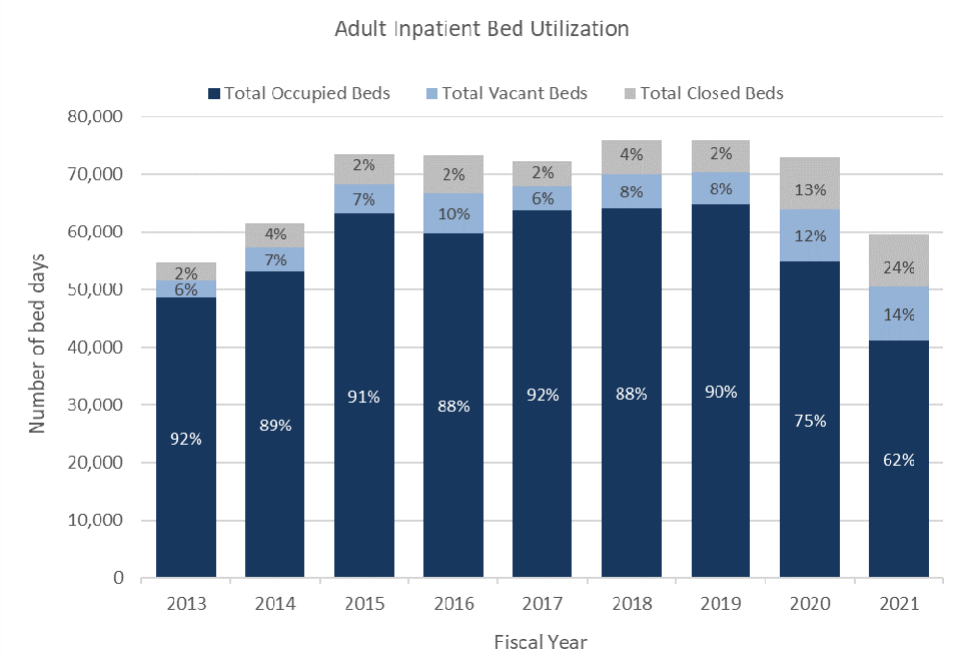
Figure 5. Other Psychiatric Hospital Utilization per 1,000 people (in Vermont and the United States)



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

Other Involuntary Psychiatric Hospital Utilization unit admissions, such as those at DHs, are included in Figure 5. The national rate of psychiatric hospital utilization since 2008 has generally held steady through 2020, while Vermont's rate of utilization continued to increase. Inpatient utilization is still below the national average, while rates of community services utilization in Vermont continue to be markedly higher than national averages (Community Utilization per 1,000 Populations).

Figure 6. Adult Inpatient Utilization and Bed Closures



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

B. Community-based and Outpatient Services

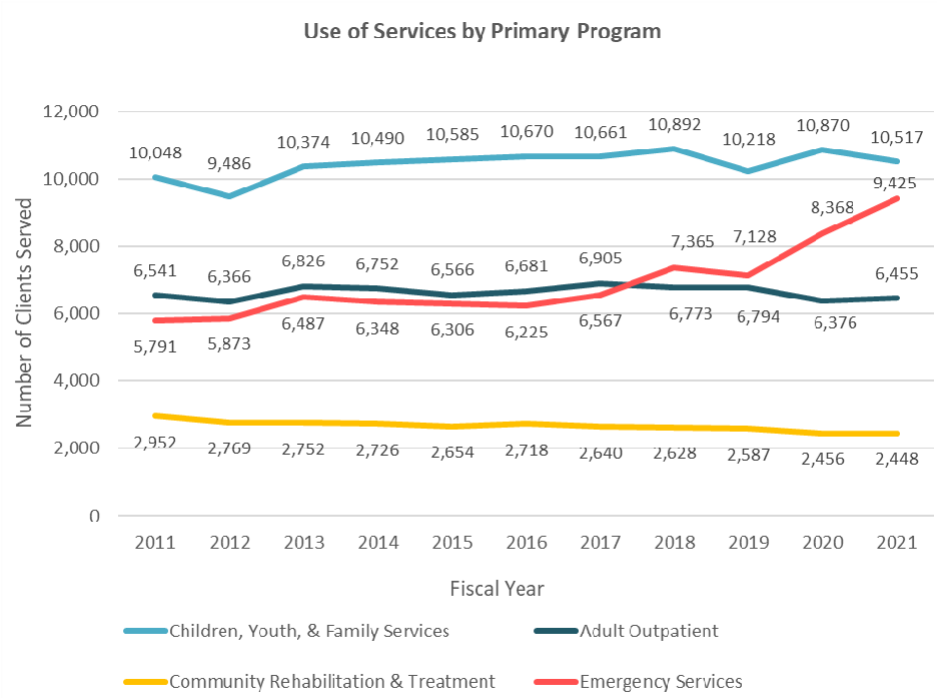
Enhanced community services funding provided by the Vermont legislature through increased appropriations to critical mental health programs in the community over the last several years has helped, but staff recruitment and retention necessary to meet and expand these service capacities continue to be a struggle. Additionally, the payment reform initiative that was implemented on January 1, 2019, has been integral to stabilizing the mental health system of care at the DAs. The initiative has reduced barriers to access to care and promoted a more responsive and "needs" driven service delivery to individuals seeking mental health services. The new payment reform methodology, more flexible service delivery, and value-based incentive payment framework focused on quality and outcomes support a more streamlined approach to adult program access and the service capacity available in each DA catchment area.

Key Efforts Include:

- Established Workforce Task Group to explore recruitment and retention strategies
- Increased capacity within Community Rehabilitation and Treatment and peer programs to provide community support, outreach, and crisis response continues to develop

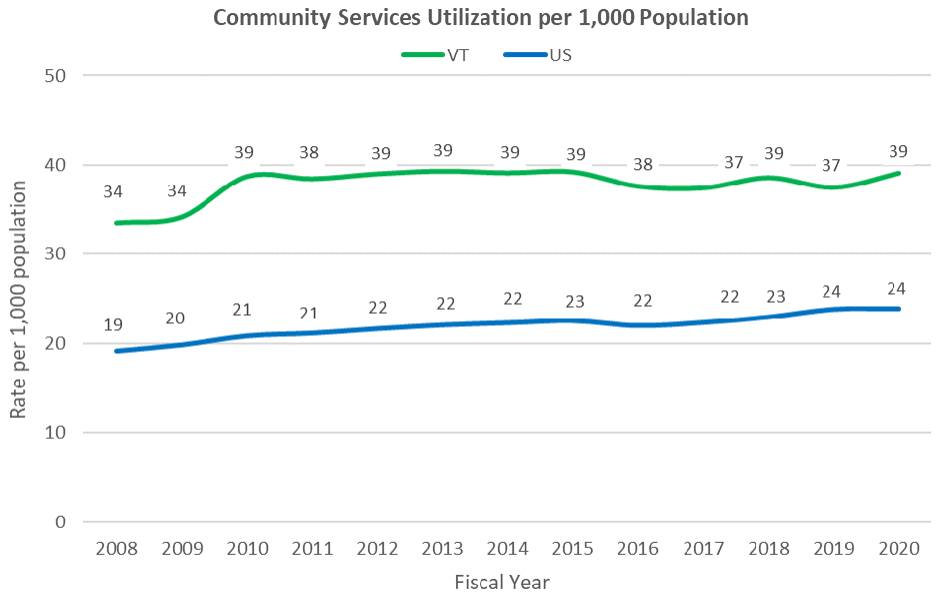
Broad utilization of non-categorical case management services for Adult Outpatient and Emergency Services programs

Figure 7. Use of Services by Primary Program



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

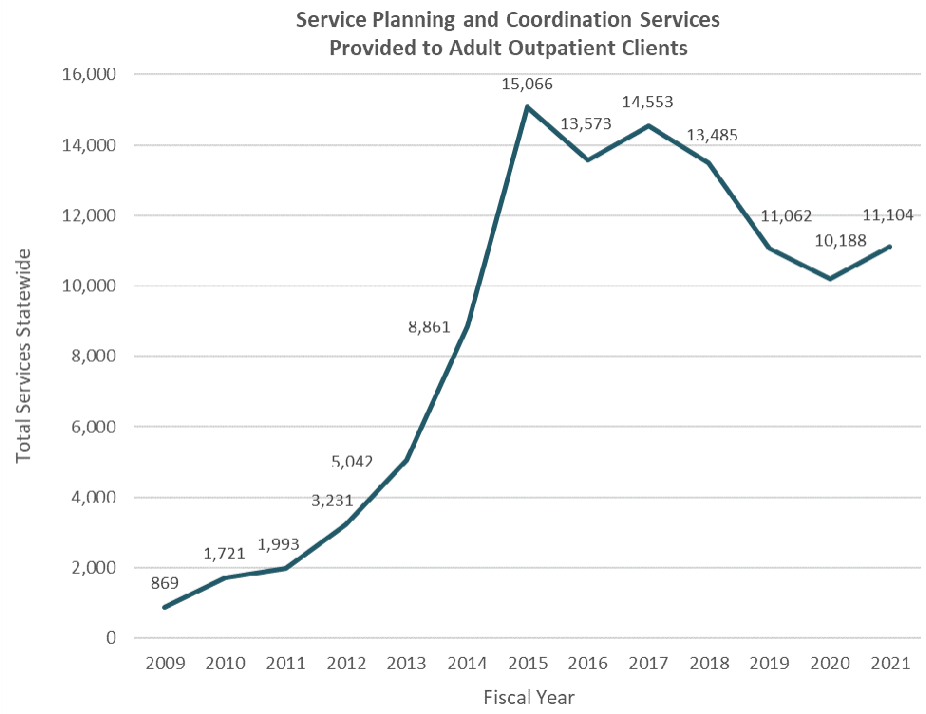
Figure 8. Community Services Utilization per 1,000 Populations



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

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

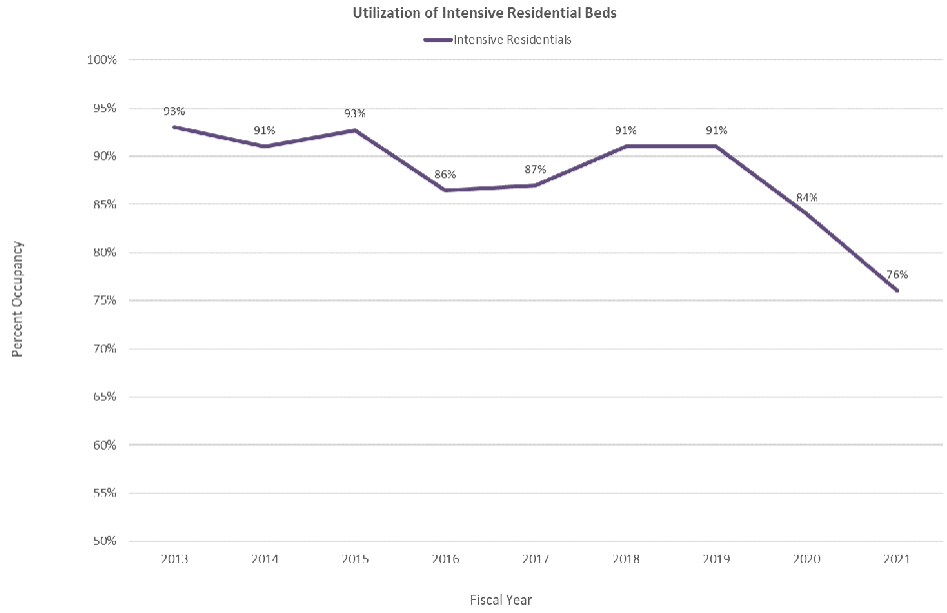
Figure 9. Service Planning and Coordination Services



The support of non-categorical case management led to a steady increase in the number of services provided to adult outpatient clients allowing additional support to those in need but ineligible for case management through CRT services through FY 2015. Levels remained elevated for this population from FY 2016 to FY 2017 with an approximately 30% decline from FY 2017 to FY 2020. Interestingly, there has been a 9% reported in the past fiscal year. This is a noteworthy increase in service planning and coordination to meet this population health-level need for adult case management services. DMH's payment reform initiative launched in January 2019 continues to support flexible service delivery including case management services when needed.

Residential and Transitional Services

Figure 10. Utilization of Intensive Residential Beds



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

FY 2020 and 2021 showed a 15% total decrease in utilization over the nine years to 76%. The impact of the pandemic during these fiscal years and the changing capacities of programs to safely transfer and introduce new residents into programs have likely contributed to this drop.

Performance and Reporting

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

- Implementation of value-based payment measures that allow DAs to earn an additional allocation based on the performance of agreed-upon quality metrics.
- Mental Health Payment Reform utilization scorecard, monitoring caseload, and

utilization for all services within the mental health case rate to monitor the impact of the payment model.
- Creation of a "Vermont Psychiatric Care Hospital Outcomes" scorecard to meet legislative reporting requirements.
- Migration of the "DMH Snapshot" and "DMH continued reporting" to the RBA scorecard reporting tool
- Exploration of visualization tools to create more responsive reporting.
- Participation in the development of the AHS Community profiles.

Mental Health Payment Reform

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

• Encouraging flexibility in service delivery that supports comprehensive, coordinated care;

• Standardizing the approach to tracking population indicators, progress, and outcomes;

• Simplifying payment structures and improving the predictability of provider payments;

• Improving accountability, equity, and transparency; and

• Shifting to value-based payment models that reward outcomes and incentivize best practices.

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

Integrating Family Services (IFS)

The initial IFS implementation site in Addison County began on July 1, 2012, and the second pilot region in Franklin/Grand Isle Counties began on April 1, 2014. These pilots included the consolidation of over 30 state and federal funding streams into one, unified whole through a singular AHS Master Grant agreement. The State created an annual aggregate spending cap for two providers in Addison County (the local Designated Agency and the Parent-Child Center) and one in Franklin/Grand Isle Counties (this provider is both the Designated Agency and

Parent-Child Center). This has created a seamless system of care to ensure no duplication of services for children, youth, and families.

On January 1, 2019, the IFS sites became aligned with larger payment reform efforts occurring across AHS, including having value-based measures in alignment with statewide implementation. At the same time, IFS regions have additional requirements for the measurement of performance improvement in accordance with the broader scope of services included in those regions. Vermont submitted a multi-year payment model for consideration to CMS in September 2018 and received approval in late December that goes through 2022. Both IFS regions continue to utilize the Child and Adolescent Needs and Strengths (CANS) tool to holistically assess both the needs and strengths of the children that they are serving. These agencies are using this monitoring tool to track progress over time. Data are showing that through support and services, children and youth are increasing in their strengths and decreasing needs. The regions are also working to implement the Adult Needs and Strengths Assessment (ANSA).

In late June, the IFS grantee, Northwestern Counseling and Support Services (NCSS), which serves Franklin and Grand Isle Counties, had their bi-annual integrated chart review, which included all AHS departments reviewing charts for minimum standards across the various funding streams that create the integrated case rate. The results from the review indicated a few areas for improvement which NCSS adequately addressed.

Vision 2030

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

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

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

Following the plan submitted to the legislature in January 2020, DMH was anticipating convening a Mental Health Integration Council in the fall of 2020, to begin the work of implementation. The demands of the COVID-19 pandemic on Vermont's health systems, however, delayed that work. The Mental Health Integration Council kicked off on July 13th,

2021, and the Council has since met twice with subgroups convening on specific topics in between meetings.

Leadership and Reporting Updates

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

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

v. Pharmacy Program

Key updates from QE062022

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

Pharmacy Benefit Management Program

The DVHA's Pharmacy Unit manages the pharmacy benefits for all of Vermont's publicly funded pharmacy benefit programs. The Pharmacy Unit's goal is to provide the highest quality prescription drug benefits in the most cost-effective manner possible. This is accomplished by providing broad coverage of prescription and over-the-counter pharmaceuticals while controlling pharmacy expenditures through both utilization and cost management strategies. The DVHA utilizes the pharmacy benefit management company, Change Healthcare (CHC), to provide a full complement of operational, clinical, and programmatic support in addition to managing a call center in South Burlington for pharmacies and prescribers. The Pharmacy Unit is also responsible for overseeing the contract with CHC. The Pharmacy Unit manages approximately $231 million in gross drug spending and routinely analyzes national and DVHA drug trends reviews drug utilization, and seeks innovative solutions to delivering high-quality customer service, assuring optimal drug therapy for DVHA members while managing drug utilization and cost.

Pharmacy Operations

- □ Pharmacy claims processing – Assuring that members have access to medically-necessary medications within the coverage rules for DVHA's various pharmacy benefits.
- □ Pharmacy provider assistance – Assisting pharmacies and prescribers with various issues related to claims processing, prior authorizations, and other operational and clinical issues.
- □ Pharmacy Interface to Coordination of Benefits Unit/Part D Plan Team/Eligibility/Member Call Center to coordinate benefits and resolve member issues.
- □ Liaison to Vermont Department of Health (VDH) in multiple clinical areas-Vaccines including COVID

vaccines, Alcohol& Drug Abuse Programs (ADAP), Asthma, Smoking Cessation, and the Department of Mental Health (DMH) related to the management of psychotherapeutic drug use in children. The Pharmacy Team also works with Vermont Medication Assistance Program (VMAP) and Children with Special Health Needs (CSHN) to assist in the drug and rebate management of the programs.

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

Operational Activity Reports

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

	No PA	Automated Edits						
Period	**Claims Paid w/o PA**	**Claims Paid w/Auto PA**	****Claims Paid with Auto Edit**	**Claims Paid w/Online Override**	**Claims Paid w/Emergency PA**	**Claims Paid due to Grandfathering**	**Claims Paid w/Clinical PA**	**Total Claim Count**
Quarter 2	508,626	93	10,228	243	94	6,872	16,651	542,807
	94%	<1%	2%	<1%	<1%	1%	3%	100%
Quarter 1	488,631	92	19,851	190	98	7,260	15,777	531,899
	92%	<1%	4%	<1%	<1%	1%	3%	100%

- The total claim count does not include compounded drugs.

Paid Claims and Drug Spend

MEDICAID

Period	**# Claims**	**# Of Members**	**State Paid Amounts**
2Q2022	**484,772**	**87,713**	**$68,602,012.81**
1Q2022	471,462	80,819	$65,686,210.08

VPHARM

Period	**# Claims**	**# Of Members**	**State Paid Amounts**

2Q2022	**66,979**	**7,031**	**$1.390.713.66**
1Q2022	67,154	7,157	$2,038,496.04

Provider Communications

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

Changes to Administration Fees for Vaccines	Effective 1/1/2022, the pharmacy administration fee for vaccines will be changing from $13.97 to $13.87. This does not apply to COVID-19 vaccination administration rates. This adjustment is being made to align with changes to the physician fee schedule (CPT code 90471) for adult vaccinations by primary care practitioners. DVHA-enrolled pharmacies may be reimbursed for vaccinations administered by pharmacists to adults 19 years and older who are enrolled in Vermont's publicly funded programs. Pharmacists must be compliant with all Vermont laws governing vaccine administration. Failure to comply with all Vermont immunization regulations will subject these claims to recoupment.

Clinical Activities

Hypertension Management Initiative

Pharmacy recently began a collaboration with the Hypertension Performance Improvement Project to improve the Scorecard Measure Controlling High Blood Pressure. You can view the currently targeted measure here https://app.resultsscorecard.com/Measure/Embed/100093207.

One of the first activities the Pharmacy Unit supported was to improve access to blood pressure cuffs. This included communicating with pharmacies on how to bill a prescription for a digital blood pressure monitor as a DME claim.

DVHA currently allows the purchase of automatic blood pressure (BP) monitors for the following additional diagnoses: essential hypertension, benign hypertension, nonspecific hypertension, elevated blood pressure without the diagnosis of hypertension, hypertensive heart disease without heart failure, and pregnancy-related hypertension diagnoses. A prescription for the digital BP monitor, along with a diagnosis is needed and claims are processed as a DME claim.

We are continuing to ask pharmacies to consider stocking blood pressure monitors to fulfill the potential demand that may be generated by this program.

The manual sphygmomanometer/blood pressure apparatus with cuff and stethoscope will no longer be allowed for purchase. The criteria for coverage can be found on the Department of Vermont Access (DVHA) website at https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/durable-medical-equipment

Pharmacy Cost Management (PCM) Program

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

Vermont PCM Progress Report– 06/30/2022

Program-to-Date (through 06/30/2022):
Total Members Enrolled: **2866**
Total Medications covered: **163**

Fiscal Year 2022, Quarter 4:
Current Active Enrollments: **436**[1]
Newly Enrolled: **128**
Initial claim/Prior Authorization reviews: **128**
Follow-up reviews: **402**
Patient Contact
- Phone call attempts[2]: **187**
  - Answered/Member Counseled: **77**
- Phone calls received from member: **0**

Provider Contact
- Phone calls: **3**

Chart notes
- Requested: **95**
- Received: **70**

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

Interventions with Direct Cost Avoidance: **4**

Direct Cost Avoidance

Current Quarter (04/01/2022 – 06/30/2022)*:

$250,914.48

Fiscal Year 2022:

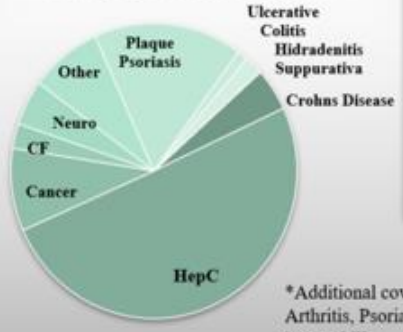
$1,016,596.36

Total (Since Program Initiation):

$4,318,420.44

*State/Federal Dollars - extrapolated to end of program year (06/30/22)

Covered Disease States



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

Quick Summary

✓ ***Cosentyx***

Provider increased member to 450mg monthly, which is above the FDA approved dosage

- Worked with provider, member and pharmacy to decrease dosage within limits
- ***$74,169.24*** *(cost extrapolated)*

✓ ***Humira***

Provider was trialing doubling the dose of Humira, and using beyond FDA approved dosing

- Worked with provider and member to increase use of topical to ease symptoms
- ***$74,932.68*** *(cost extrapolated)*

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

Change Healthcare (April 1, 2022, through June 30, 2022). Change Healthcare Pharmacy Management Reporting Suite is a collection of reports recording the process and progress of PCM.

In the second quarter of 2022, the PCM program enrolled an additional 128 members for a total of 2,866 members on 163 unique medications. The program is actively monitoring 436 enrollees. A total of 187 outgoing telephone calls were placed to members, 77 of which resulted in member counseling. During this quarter of the Vermont PCM program, four interventions led to direct and measurable cost avoidance. Furthermore, interventions that do not bring about direct cost avoidance are in place to encourage adherence and thus improve member outcomes and avoid unnecessary medical costs. Through interventions in the PCM program, unnecessary drug spending of nearly $250,914was avoided in the second quarter of the state fiscal year 2022. More than $4.32 million in unnecessary drug spend has been avoided throughout the program.

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

Key updates from QE062022:

- Executed a new contract with OneCare for a 2022 performance year of the program.
- Continued conducting financial reconciliation activities for the 2021 performance year, in order to determine financial and quality performance. Results will be available in late Q3 or early Q4 2022.
- Entered into contract amendment negotiations with OneCare for a 2023 performance year.
- Continue to support Vermont's broader efforts to develop an integrated health

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

DVHA and OneCare entered into an agreement for the 2017 performance year as a pilot year with four possible one-year extensions to the program. Four risk-bearing hospital communities participated in the *Vermont MedicaidNext Generation* (VMNG) model for the pilot year: the University of Vermont Medicaid Center, Central VermontMedical Center, Northwestern Medical Center, and Porter Hospital, with additional participation from FQHCs, independent practices, home health providers, Designated Agencies, and skilled nursing agencies in the four communities. Since 2017, the number of risk-bearing hospital communities participating in the VMNG model has grown from 4 to 14 and it is now considered a statewide program in terms of provider participation and member attribution.

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

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

DVHA began conducting preliminary financial reconciliation activities for its 2021 performance year in Q1 2022. Reconciliation activities will determine the ACO's spend as compared to their financial target and quality performance for the 2021 performance year. Reconciliation activities will continue into early Q4 2022, and the final results will be available in Q4 2022.

DVHA entered into contract negotiations with OneCare for the 2023 performance year in late Q2 of 2022. Potential changes to the program for the 2023 performance year could include modifications to the quality component of the program, changes in the rate development methodology, and the inclusion of a pilot payment model for hospitals participating in the VMNG program. Other anticipated programmatic changes are minor. Negotiations are expected to continue into Q3 and Q4 of 2022.

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

V. Financial/Budget Neutrality Development/Issues

As is the monthly process, AHS paid DVHA 1/12th of the legislative budget for Global Commitment on the first business day of each month during the June 2022 quarter (April through June 2022).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 QE622 on August 30, 2022, as is normal.

Because the GC Waiver was being renegotiated, the original termination date of the waiver was extended for an additional two quarters: QE 0322 and QE0622. Beginning with the QE0922, the Budget Neutrality report will reflect the renegotiated waiver.

QE0322 was the final of four quarters that received a temporary 10% FMAP increase for qualifying HCBS services under the American Rescue Plan Act of 2021. The State processed a PQA in QE0622 for an additional $5.9 million in qualifying HCBS Services eligible in the Apr2021-Mar2022 time period. Cumulatively, Vermont has earned over $69.3 million in additional FMAP for the four applicable quarters. These additional matching funds must be used to supplement and not supplant existing state Medicaid HCBS services in effect as of April 1, 2021. Vermont intends to reinvest the 10% FMAP funds while also drawing down Medicaid federal financial participation as outlined in the approved HCBS spending plan. To date, Vermont has expended $13.5 million through QE0622 in the HCBS spending plan.

Overall, the budget neutrality exercise indicates that for the June 2022 quarter, the State's total "With Waiver" expenditures were $69,743,665(17%) lower than the total "Without Waiver" amount (caseloads multiplied by the Budget Neutrality PMPMs), indicating a quarterly surplus. The QE0622 surplus of 17% is consistent with QE0322's surplus of 16%.

The QE0622 supplemental budget neutrality tests results are as follows:

- The New Adult test resulted in a surplus of $20,702,045. This represents a 52% increase compared to the New Adult surplus of QE0322, which was $13,588,281.
- The SMI IMD test resulted in a deficit of $5,993,770. This represents a 149% increase from QE0322, which had a deficit of $2,403,256.
- The SUD IMD test resulted in a surplus of $766,828. This represents a significant improvement over QE0322, when the SUD IMD test resulted in a $98,544 deficit.

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

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

AHS continues to actively monitor Investment spending. The total Investment spending for QE0622 was $ 24,540,752, compared to QE0322, when the investment spending was $27,843,705. Combined, QE0322 and QE0622 total investment spending is $52,384,457. The total CY2022 Budget Neutrality Investment Limit is $68,250,000 (for QE0322 and QE0622), indicating an Investment surplus of $15,865,543.

VI Member Month Reporting

The State of Vermont certifies the accuracy of the member month reporting. The enrollment report is produced on the 15th of every month. The member months are subject to revision 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 CY2022 and includes theunduplicated count of member months for SUD IMD and SMI IMD stays. CY2021 and CY 2020 member months are also reported in the tables below.

Table 1. Member Month Reporting – Calendar Year 2022 (QE0322-QE1222), *subject to revision*, with CY2021 and CY2020.

Demonstration Population	Medicaid Eligibility Group	Total CY 2022 (JAN - JUN)	Total CY 2021	Total CY 2020
1, 4*, 5*	ABD - Non-Medicare - Adult	39,101	79,549	79,846
	SUD - IMD - ABD	48	71	106
	SMI - IMD - ABD	76	66	71
1	ABD - Non-Medicare - Child	9,026	19,083	20,060
1, 4*, 5*	ABD - Dual	133,548	266,292	260,532
	SUD - IMD - ABD Dual	69	121	136
	SMI - IMD - ABD Dual	30	26	12
2	Non ABD - Non-Medicare - Adult	101,522	165,250	112,654
	SUD - IMD - Non ABD	171	145	161
	SMI - IMD - Non ABD	34	24	26
2	Non ABD - Non-Medicare - Child	375,258	745,148	713,979
	Medicaid Expansion			
7	Global RX	38,169	77,493	78,064
8	Global RX	19,008	40,108	41,565
6	Moderate Needs	852	1,700	1,963
	New Adults			
3	New Adult without Child	291,717	544,209	453,635
	SUD - IMD New Adult w/o Child	585	971	1,157
	SMI - IMD New Adult w/o Child	178	203	211
3	New Adult with Child	151,615	300,757	267,004
	SUD - IMD New Adult with Child	106	220	209
	SMI - IMD New Adult with Child	36	53	44
	Total	**1,161,149**	**2,241,489**	**2,031,435**

Table 2. GC Budget Neutrality PMPM Rates, CY 2022 (January 1, 2022 - June 2022)

STC PMPM Budget Neutrality	
Medicaid Eligibility Group	**DY 17 PMPM CY2022**
ABD - Non-Medicare - Adult	$1,745.83
SUD - IMD ABD	$3,798.97
SMI - IMD ABD	$16,054.00
ABD - Non-Medicare - Child	$3,419.74
ABD - Dual	$3,006.28
SUD - IMD ABD Dual	$2,901.13
SMI - IMD ABD Dual	$19,633.00
Non-ABD - Non-Medicare - Adult	$780.03
SUD - IMD Non-ABD	$2,852.36
SMI - IMD Non-ABD	$10,448.00
Non-ABD - Non-Medicare - Child	$643.26
New Adult Group	$610.97
SUD - IMD - New Adult	$ 3,042.23
SMI - IMD - New Adult	$ 12,182.00

Table 3. PMPM Rates Approval by CMS, CY 2022 (January 1, 2022 – December 31, 2022)

Medicaid Eligibility Group (MEG)	Capitation Rates PMPM	
ABD Dual	$	2,105.97
ABD Non-Dual Adult	$	2,763.84
ABD Non-Dual Child	$	3,330.95
Non - ABD Adult	$	800.57
Non - ABD Child	$	604.59
Moderate Needs Group	$	844.48
New Adult	$	600.96
Global Rx	$	135.26
Total	$	863.83

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.

VII. **Quality Improvement**

Quality Assurance and Performance Improvement Activities

Key updates from QE062022:

- Submitted DVHA's annual formal PIP summary for scoring by our EQRO.
- Continued participation in CMS' Foster Care Learning Collaborative.
- Continued coordination of DVHA's comprehensive risk assessment project.

A decision to more closely align compliance with quality improvement workflows led to recent restructuring within DVHA. The QI unit now partners with the Compliance and Oversight & Monitoring units as part of a larger Risk & Quality Management (RQM) Team. The over-arching goals of this team include:

- Create a culture of pro-active regulatory compliance and continuous quality improvement;
- identify, analyze, prioritize and correct compliance risks across all departments and programs responsible for Medicaid service delivery;
- take advantage of opportunities to move beyond compliance and identify ways to improve the services we deliver to Vermonters;
- coordinate the production and/or analysis of standard performance measures pertaining to all Medicaid enrollees, including the special health care needs populations (service provision delegated to IGA partners).

PIHP Quality Committee

The Quality Committee remained active during QE0622 and consists of representatives from all departments within AHS that serve the Medicaid population. The committee continues to structure its work around the federal managed care quality program guidelines and the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of healthcare. During this time, the committee followed our work plan and reviewed progress updates from quality improvement and risk management project leads.

Formal CMS Performance Improvement Project (PIP)

DVHA's formal PIP topic is the management of hypertension. Intervention strategies have been chosen and continued to be implemented and changes tracked during QE0622. Sub-group work focuses on activities related to access to blood pressure monitors, provider and patient education, and connecting to community resources. The PIP annual summary report was also submitted to DVHA's EQRO for scoring during QE0622.

Other Collaborative Quality Improvement Projects

The Quality Improvement team continued to work with the following groups on collaborative QI projects during QE0622:

- The Department of Mental Health on an Agency-wide alternative payment model (APM) for inpatient services delivered by a regional inpatient psychiatric hospital. The purpose of the APM is to add administrative simplicity in claims processing and a predictable cashflow for inpatient stays that are primarily the responsibility of Vermont Medicaid. QI staff continue to contribute quality of care measures and analysis to ensure that cost and quality incentives are aligned in the APM.

- The Department of Children and Families (DCF), the Vermont Department of Health (VDH), and the Vermont Child Health Improvement Program (VCHIP) are on a learning collaborative to improve the timeliness of comprehensive health visits for children and adolescents entering foster care. During this reporting period, we established a partnership with a district office, provided project background, and planned a series of process mapping meetings.

Quality Measure Reporting

HEDIS measure production –In addition to producing administrative (claims-based) measures, the Clinical Services Team produced four (4) HEDIS hybrid measures again in 2022. DVHA's certified HEDIS vendor performed medical record retrieval (MRR) for all four hybrid measures and abstracted records for two of those measures. DVHA clinicians abstracted the other two measures. DVHA's Quality Assurance Manager prepared abstraction training, tools, and materials during QE0322. She oversaw the MRR process during QE0622 and will submit the validation sample to our performance measure EQRO during QE0922.

The Director of Quality Management represents Vermont Medicaid in the New England Quality Consortium, which provides CMS with input annually on proposed changes to the Quality Core Performance Measure Sets.

Results Based Accountability (RBA)/Process Improvement

Results Based Accountability (RBA) scorecards are developed at DVHA for both internal and external performance management purposes. The use of this performance management framework and corresponding presentation tool has been spearheaded by the Agency's Central Office QI staff. The DVHA Quality Unit staff use this tool to create a *Global Commitment to Health* Core Measure scorecard, Experience of Care, and other performance budgeting scorecards. DVHA's largest scorecard, named the Performance Accountability Scorecard includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services. Scorecards that were newly developed or actively maintained during QE0622 include the following programs: Applied Behavior Analysis (ABA) and Dental.

The Quality Improvement Team also maintained its "Green Belt" status during QE0622 by participating in quality improvement activities and Green Belt meetings. Green Belt is the highest level of internal training offered through the State based on LEAN/RBA principles. The training is centeredaround process improvement and contributes to the Governor's initiative called PIVOT, or Program to Improve Vermont Outcomes Together.

COVID-19 Dashboard

The Quality Team was tasked with creating and maintaining a COVID-19 dashboard at the endof March 2020 to monitor the response to the pandemic: both the impact it has had on operations and the activities staff have engaged in. As an internal evaluation tool, the dashboardis updated monthly and made available to all DVHA staff via our intranet. This work continues into 2022 and will while the PHE is in effect. Measures are retired and additional measures are added to the dashboard as appropriate.

Vermont Next Generation Medicaid ACO

During QE0622, DVHA's Director of Quality Management received, reviewed, and approved the quarterly VMNG ACO quality management reports. Quality and Clinical staff from DVHA and the VMNG ACO also meet quarterly with a focus on quality measurement and ongoing QI efforts. A representative from the VMNG ACO is also a standing member of DVHA's formal PIP, the topic of which is managing hypertension.

Comprehensive Risk Assessment

Staff from DVHA's Quality, Oversight & Monitoring, and Compliance units began developing a comprehensive risk assessment program for Vermont's Medicaid program at the end of 2021. This work will continue throughout 2022. The purposes of the project are to:

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

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

Global Commitment (GC) Investment review

AHS Departments are required to monitor and evaluate the performance of their investments on

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

During this most recent quarter, DOC highlighted the performance of a subset of their investments. The Clear Impact Scorecard for this investment 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). The scorecard includes the following data elements: investment description (i.e., the goal of the investment, the activities being supported, and information on how they are provided), performance measures (i.e., the data being collected and analyzed to determine if the investment is achieving its desired goal), results (performance measure rates for the most recent reporting period), and an interpretation of the results (i.e., comparing actual to expected rates using performance targets and/or benchmarks and to characterize trends or patterns in the data). During this most recent quarter, DVHA highlighted the performance of its Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) payment model. The Clear Impact Scorecard for this payment model is included in this report as Attachment 8.

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

During this quarter, the state received feedback on its CQS/STP from the Vermont Developmental Disabilities Council (VT DDC). The state accepted comments as timely filed, retained them, and will make them available to CMS for review. The state will continue to involve stakeholders in discussions regarding the assurance of ongoing compliance with the regulations.

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. During this quarter, the state submitted quarterly monitoring reports for the substance use disorder (SUD) component of the Global Commitment to Health demonstration, to the Centers for Medicare & Medicaid Services (CMS), as required by the state's special terms and conditions (STC). The state awaits CMS feedback to ensure that these monitoring reports provide all the information requested by the templates.

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. COVID response has delayed the production and submission of the SMI Monitoring Protocol reports. During this quarter, the state submitted its first SMI/SED monitoring report via the CMS PMDA and expects to receive feedback during the next quarter.

IX. Demonstration Evaluation Activities

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

During the quarter, the state continued to work with its independent evaluator, PHPG, to collect the necessary data to support the development of the Summative Evaluation Report. The report includes the information in the CMS-approved Evaluation Design. The state will continue to regularly monitor the availability of data to support the evaluation report and assess its ability to maintain the current timeline.

X. Compliance

Key updates from QE062022:

- EQRO RFP
- AHS/DVHA IGA
- DVHA is preparing subject matter experts for this year's EQRO Audit.

External Quality Review Request for Proposal

The state's external quality review contract expired during QE032022. During this quarter, the state developed a new EQR contract and worked with the vendor to plan for CY2022 review activities.

External Quality Review

During the last quarter, the state worked with the External Quality Review Organization (EQRO) to develop the material necessary for each of the required annual external quality review activities (i.e., performance improvement project validation, performance measure validation, and compliance review). Performance Improvement Project (PIP) validation items included the PIP validation timeline, review templates, and report outlines. Performance Measure Validation items included the PMV timeline, a document request letter, a rate reporting template, and HEDIS roadmap. Review of Compliance with Standards items included a document request letter as well as desk and documentation review forms. All letters and materials were sent to DVHA during this quarter. Due to the ongoing COVID-19 pandemic, both on-site reviews (i.e., review of compliance with standards & performance measure validation) will be conducted remotely.

Intra-Governmental Agreement (IGA) between AHS and DVHA

The CY2022 Agency of Human Services (AHS) and the Department of Vermont Health Access

(DVHA) IGA was submitted to CMS for review/approval and the state is currently awaiting CMS feedback.

XI. Reported Purposes for Capitate Revenue Expenditures

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

- Reduce the rate of uninsured and/or underinsured in Vermont.
- Increase the access 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 healthcare delivery system and promote the transformation to value-based and integrated models of care.

XII. State Contact(s)

Fiscal	Richard Donahey, CFO VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	802-241-0442 (P) richard.donahey@vermont.gov
Policy/Program	Ashley Berliner, Director of HealthCare Policy & Planning VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	802-578-9305 (P) 802-241-0958 (F) ashley.berliner@vermont.gov
Managed Care Entity	Adaline Strumolo, Acting Commissioner of Department of Vermont Health Access 280 State Drive Waterbury, VT 05671-1000	802-241-0147 (P) 802-879-5962 (F) adaline.strumolo@vermont.gov

XIII. 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 (GC Investments)
Attachment 7	Investment Scorecard(s)
Attachment 8	Payment Model Scorecard(s)

Date Submitted to CMS: September 9, 2022

Attachment 1: Budget Neutrality Workbook

Budget Neutrality New Adult		
New Adult (w/ and w/o Child) Medical Costs Only	**DY 17 – PMPM**	
	QE 0322	**QE 0622**
(A) New Adult Group PMPM Projection	$610.97	$610.97
(B-1) eligible member months w/ Child	75,622	75,993
(B-2) eligible member months w/o Child	145,265	146,452
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	$ 46,202,773.34	$ 46,429,443.21
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	$ 88,752,557.05	$ 89,477,778.44
(D-1) New Adult FMAP w/ Child	62.67%	62.67%
(D-2) New Adult FMAP w/o Child	90%	90%
(E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child	$ 28,955,278.05	$ 29,097,332.06
(E-2 = C2 x D-2) Federal Share of Supplemental Cap 1 w/o Child	$ 79,877,301.35	$ 80,530,000.60
Subtotal Federal Share Supplemental Cap 1	$ 108,832,579.40	$ 109,627,332.66
Total FFP reported for New Adult Group	$ 101,387,387.08	$ 90,991,140.32

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
August 30, 2022

ELIGIBILITY GROUP	DY 12 JAN - DEC 2017	DY 13 JAN - DEC 2018	DY 14 JAN - DEC 2019	DY 15 JAN - DEC 2020	DY 16 JAN - Dec 2021	DY 17 JAN - JUNE 2022	Total
Without Waiver (Caseload x pmpms)							
ABD - Non-Medicare - Adult	$ 142,860,455	$ 130,050,973	$ 131,976,747	$ 134,423,935	$ 138,879,031	$ 68,263,699	$ 746,454,839
ABD - Non-Medicare - Child	$ 85,359,001	$ 78,434,428	$ 75,860,331	$ 66,152,263	$ 65,258,898	$ 30,866,573	$ 401,931,495
ABD - Dual	$ 664,153,383	$ 693,539,886	$ 720,885,032	$ 755,287,479	$ 800,548,314	$ 401,482,681	$ 4,035,896,775
Non ABD - Non-Medicare - Adult	$ 101,757,250	$ 96,887,008	$ 73,827,769	$ 83,769,514	$ 128,899,958	$ 79,190,206	$ 564,331,704
Non ABD - Non-Medicare - Child	$ 392,665,288	$ 406,444,058	$ 413,877,439	$ 439,075,666	$ 479,323,902	$ 241,388,461	$ 2,372,774,815
Total Expenditures Without Waiver	**$ 1,386,795,376**	**$ 1,405,356,354**	**$ 1,416,427,318**	**$ 1,478,708,857**	**$ 1,612,910,103**	**$ 821,191,620**	**$ 8,121,389,628**
With Waiver							
ABD Non Medicare Adult	$ 162,602,152	$ 162,728,372	$ 168,382,861	$ 177,858,509	$ 173,807,393	$ 94,778,048	$ 940,157,335
ABD - Non-Medicare - Child	$ 66,593,208	$ 60,077,015	$ 58,176,676	$ 55,369,700	$ 46,735,126	$ 26,482,078	$ 313,433,803
ABD - Dual	$ 445,847,909	$ 461,739,496	$ 484,543,363	$ 476,164,427	$ 473,478,125	$ 254,458,473	$ 2,596,231,793
Non ABD - Non-Medicare - Adult	$ 84,040,229	$ 84,275,155	$ 67,221,781	$ 69,967,054	$ 82,724,813	$ 48,168,532	$ 436,397,564
Non ABD - Non-Medicare - Child	$ 305,543,574	$ 335,706,591	$ 350,805,773	$ 334,351,461	$ 346,363,466	$ 205,061,572	$ 1,877,832,438
Premium Offsets	$ (655,991)	$ (772,935)	$ (774,152)	$ (413,790)	$ (333,330)	$ (110,118)	$ (3,060,315)
Moderate Needs Group	$ 1,488,408	$ 1,378,915	$ 1,429,868	$ 703,701	$ 528,428	$ 352,365	$ 5,881,684
Marketplace Subsidy	$ 6,355,286	$ 6,242,717	$ 5,915,336	$ 5,862,966	$ 5,315,462	$ 2,101,786	$ 31,793,553
VT Global Rx	$ 13,824,167	$ 15,300,919	$ 10,692,124	$ 3,494,233	$ 5,311,566	$ 2,603,943	$ 51,226,952
VT Global Expansion VHAP	$ 414,825	$ (0)	$ 0	$ -	$ -	$ -	$ 414,825
CRT DSHP	$ 10,331,787	$ 9,240,772	$ 6,787,058	$ 5,604,875	$ 4,317,023	$ 2,189,244	$ 38,470,759
Investments	$ 142,332,671	$ 148,500,000	$ 119,133,231	$ 114,795,890	$ 104,848,491	$ 52,384,458	$ 681,994,741
Total Expenditures With Waiver	**$ 1,239,374,215**	**$ 1,285,189,954**	**$ 1,273,088,069**	**$ 1,244,172,817**	**$ 1,243,429,893**	**$ 688,580,499**	**$ 6,973,835,446**
Hypothetical Test 1: New Adult							
Limit New Adult PMPM*Mem-Mon	$ 370,689,611	$ 375,735,593	$ 369,387,603	$ 422,539,471	$ 516,248,877	$ 270,862,552	$ 2,325,463,708
With Waiver New Adult Total Expenditures	$ 295,620,338	$ 312,104,578	$ 315,240,526	$ 368,166,529	$ 394,240,162	$ 236,572,226	$ 1,921,944,358
Surplus (Deficit)	*$ 75,069,273*	*$ 63,631,015*	*$ 54,147,078*	*$ 54,372,942*	*$ 122,008,715*	*$ 34,290,326*	*$ 403,519,349*
Hypothetical Test 2: SUD IMD							
SUD - IMD ABD - Non-Medicare - Adult		$ 268,039	$ 529,433	$ 389,449	$ 269,727	$ 182,351	$ 1,638,999
SUD - IMD ABD - Dual		$ 214,495	$ 442,312	$ 387,577	$ 351,037	$ 200,178	$ 1,595,598
SUD - IMD Non ABD - Non-Medicare - Adult		$ 533,391	$ 633,224	$ 459,230	$ 413,592	$ 487,754	$ 2,527,191
SUD - IMD New Adult		$ 2,704,249	$ 4,842,747	$ 4,130,907	$ 3,623,296	$ 2,102,181	$ 17,403,379
Limit SUD IMD Without Waiver PMPM*Mem-Mon	**$ -**	**$ 3,720,174**	**$ 6,447,715**	**$ 5,367,163**	**$ 4,657,652**	**$ 2,972,463**	**$ 23,165,167**
SUD - IMD ABD Non Medicare Adult		$ 249,820	$ 646,440	$ 411,251	$ 206,455	$ 120,945	$ 1,634,912
SUD - IMD ABD - Dual		$ 199,224	$ 545,837	$ 342,450	$ 213,896	$ 160,581	$ 1,461,987
SUD - IMD Non ABD - Non-Medicare - Adult		$ 540,841	$ 803,762	$ 516,507	$ 388,888	$ 308,994	$ 2,558,993
SUD - IMD New Adult		$ 2,826,119	$ 5,869,169	$ 4,250,210	$ 3,463,348	$ 1,713,659	$ 18,122,505
Limit SUD IMD With Waiver (Total Expenditures)	**$ -**	**$ 3,816,005**	**$ 7,865,208**	**$ 5,520,418**	**$ 4,272,587**	**$ 2,304,180**	**$ 23,778,398**
Surplus (Deficit)	*$ -*	*$ (95,830)*	*$ (1,417,494)*	*$ (153,255)*	*$ 385,065*	*$ 668,283*	*$ (1,281,514)*
Hypothetical Test 3: SMI IMD							
SMI - IMD ABD - Non-Medicare - Adult				$ 1,106,677	$ 1,059,564	$ 1,220,104	$ 3,386,345
SMI - IMD ABD - Dual				$ 226,752	$ 510,458	$ 588,990	$ 1,326,200
SMI - IMD Non ABD - Non-Medicare - Adult				$ 261,456	$ 250,752	$ 355,232	$ 867,440
SMI - IMD New Adult				$ 2,975,595	$ 3,118,592	$ 2,606,948	$ 8,701,135
Limit SMI IMD Without Waiver PMPM*Mem-Mon	**$ -**	**$ -**	**$ -**	**$ 4,570,480**	**$ 4,939,366**	**$ 4,771,274**	**$ 14,281,120**
SMI - IMD ABD Non Medicare Adult				$ 1,726,684	$ 3,495,784	$ 2,963,163	$ 8,185,631
SMI - IMD ABD - Dual				$ 188,470	$ 884,861	$ 618,976	$ 1,692,307
SMI - IMD Non ABD - Non-Medicare - Adult				$ 727,204	$ 825,373	$ 977,165	$ 2,529,742
SMI - IMD New Adult				$ 5,348,474	$ 9,785,706	$ 8,608,996	$ 23,743,176
Limit SMI IMD With Waiver (Total Expenditures)	**$ -**	**$ -**	**$ -**	**$ 7,990,832**	**$ 14,991,724**	**$ 13,168,300**	**$ 36,150,856**
Surplus (Deficit)		*$ -*	*$ -*	*$ (3,420,352)*	*$ (10,052,358)*	*$ (8,397,026)*	*$ (21,869,736)*
Waiver Savings Summary							
Annual Savings	**$ 147,421,162**	**$ 120,166,400**	**$ 143,339,249**	**$ 234,536,040**	**$ 369,480,210**	**$ 132,611,121**	**$ 1,147,554,182**
Shared Savings Percentage	30%	25%	25%	25%	25%	25%	
Shared Annual Savings	$ 44,226,348	$ 30,041,600	$ 35,834,812	$ 58,634,010	$ 92,370,053	$ 33,152,780	$ 294,259,603
Hypothetical Test 2 & 3 adjustment	***$ -***	***$ (95,830)***	***$ (1,417,494)***	***$ (3,573,607)***	***$ (10,052,358)***	***$ (8,397,026)***	***$ (23,536,315)***
Total Cumulative Savings		**$ 74,172,118**	**$ 108,589,437**	**$ 163,649,840**	**$ 245,967,535**	**$ 270,723,289**	**$ 270,723,289**

NewAdult Waiver Savings Not Included in Waiver Savings Summary
See Budget Neutrality NewAdult tab (STC#64)
See CY2022 Investments tab
See EG MM CY 2022 Tab for Member Month Reporting

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: Jenney Samuelson, Secretary
Agency of Human Services

Prepared by: Richard Donahey, Chief Financial Officer
Agency of Human Services

Report Date: September 1, 2022

VERMONT
AGENCY OF HUMAN SERVICES

TABLE OF CONTENTS

BACKGROUND 2

KEY TERMS 2

MEDICAID PROGRAM ENROLLMENT AND EXPENDITURES 4

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 aged 19 or older; categorized as aged, blind, disabled, and/or medically needy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEDICAID PROGRAM ENROLLMENT AND EXPENDITURES

Agency of Human Services
Caseload and Expenditure Report

DVHA Only YTD SFY'22

	SFY'22 BAA			SFY'22 Actuals Thru June 30, 2022				
Medicaid Eligibility Group	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	% of Expenses to Budget Line Item	Ending Enrollment as of June 2022
ABD Adult	6,227	$ 52,893,284	$ 707.85	6,117	$ 61,100,684	$ 832.45	115.52%	6,047
ABD Dual	18,233	$ 46,112,790	$ 210.76	18,307	$ 51,195,208	$ 233.05	111.02%	18,334
General Adult	14,291	$ 77,289,940	$ 450.69	16,159	$ 70,203,809	$ 362.05	90.83%	17,340
New Adult Childless	49,215	$ 265,873,087	$ 450.19	47,805	$ 253,540,691	$ 441.97	95.36%	49,015
New Adult w/Child	26,643	$ 129,622,440	$ 405.43	25,109	$ 131,731,050	$ 437.20	101.63%	25,476
Dr. D Expansion - State Only*	22	$ 216,354	$ 819.52					
BD Child	1,553	$ 19,254,300	$ 1,033.18	1,535	$ 18,708,639	$ 1,015.84	97.17%	1,479
General Child	61,573	$ 164,468,531	$ 222.59	61,833	$ 187,229,516	$ 252.33	113.84%	61,730
Underinsured Child	548	$ 557,147	$ 84.72	616	$ 505,917	$ 68.41	90.80%	647
CHIP	4,535	$ 10,097,335	$ 185.54	4,707	$ 9,920,819	$ 175.64	98.25%	4,791
Dr. D Expansion - State Only*	100	$ 983,646	$ 819.70					
Vermont Premium Assistance	15,937	$ 5,615,851	$ 29.36	12,471	$ 4,524,778	$ 30.23	80.57%	11,132
Vermont Cost Sharing	*3,236*	*$ 1,130,724*	*$ 29.12*	*3,041*	*$ 985,102*	*$ 26.99*	*87.12%*	*3,203*
Pharmacy Only	9,853	$ 5,042,856	$ 42.65	9,616	$ 6,392,816	$ 55.40	126.77%	9,533
Choices for Care - Traditional								-
Choices for Care - Acute	*4,366*	*$ 41,297,576*	*$ 788.24*	*4,448*	*$ 37,926,790*	*$ 710.49*	*91.84%*	*4,344*
Total Medicaid	213,096	$ 820,455,861	$ 320.85	208,721	$ 833,965,820	$ 332.97	101.65%	209,868
**New for SFY22, no expenditures reported as of QE0622.*								

All AHS YTD SFY'22

	SFY'22 BAA			SFY'22 Actuals Thru June 30, 2022				
Medicaid Eligibility Group	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	% of Expenses to Budget Line Item	Ending Enrollment as of June 2022
ABD Adult	6,227	$ 153,567,299	$ 2,055.13	6,117	$ 153,597,144	$ 2,092.63	100.02%	6,047
ABD Dual	18,233	$ 253,104,325	$ 1,156.81	18,307	$ 241,373,224	$ 1,098.76	95.37%	18,334
General Adult	14,291	$ 95,626,957	$ 557.62	16,159	$ 87,397,793	$ 450.72	91.39%	17,340
New Adult Childless	49,215	$ 265,873,087	$ 450.19	47,805	$ 290,497,057	$ 506.39	109.26%	49,015
New Adult w/Child	26,643	$ 146,757,103	$ 459.02	25,109	$ 147,473,898	$ 489.45	100.49%	25,476
Dr. D Expansion - State Only*	22	$ 216,354	$ 819.52					
BD Child	1,553	$ 40,649,435	$ 2,181.23	1,535	$ 38,365,888	$ 2,083.18	94.38%	1,479
General Child	61,573	$ 315,808,081	$ 427.42	61,833	$ 326,276,049	$ 439.73	103.31%	61,730
Underinsured Child	548	$ 1,045,003	$ 158.91	616	$ 954,145	$ 129.03	91.31%	647
CHIP	4,535	$ 13,396,698	$ 246.17	4,707	$ 13,220,181	$ 234.05	98.68%	4,791
Dr. D Expansion - State Only*	100	$ 983,646	$ 819.70					
Vermont Premium Assistance	15,937	$ 5,615,851	$ 29.36	12,471	$ 4,524,778	$ 30.23	80.57%	11,132
Vermont Cost Sharing	*3,236*	*$ 1,130,724*	*$ 29.12*	*3,041*	*$ 985,102*	*$ 26.99*	*87.12%*	*3,203*
Pharmacy Only	9,853	$ 5,042,856	$ 42.65	9,616	$ 6,392,816	$ 55.40	126.77%	9,533
Choices for Care - Traditional	4,494	$ 249,895,952	$ 4,633.88	4,589	$ 229,352,558	$ 4,164.52	91.78%	4,486
Choices for Care - Acute	*4,366*	*$ 46,078,958*	*$ 879.50*	*4,448*	*$ 42,564,623*	*$ 797.37*	*92.37%*	*4,344*
Total Medicaid	213,224	$ 1,594,792,327	$ 623.29	208,862	$ 1,582,975,256	$ 631.59	99.26%	210,010
**New for SFY22, no expenditures reported as of QE0622.*								

VERMONT
AGENCY OF HUMAN SERVICES

All AHS and AOE YTD SFY'22

	SFY'22 BAA			SFY'22 Actuals Thru June 30, 2022				
Medicaid Eligibility Group	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	% of Expenses to Budget Line Item	Ending Enrollment as of June 2022
ABD Adult	6,227	$ 154,765,334	$ 2,071.16	6,117	$ 154,699,543	$ 2,107.65	99.96%	6,047
ABD Dual	18,233	$ 253,206,809	$ 1,157.27	18,307	$ 241,467,527	$ 1,099.19	95.36%	18,334
General Adult	14,291	$ 96,095,086	$ 560.35	16,159	$ 87,828,552	$ 452.94	91.40%	17,340
New Adult Childless	49,215	$ 265,873,087	$ 450.19	47,805	$ 290,568,965	$ 506.52	109.29%	49,015
New Adult w/Child	26,643	$ 146,765,684	$ 459.05	25,109	$ 147,481,793	$ 489.48	100.49%	25,476
Dr. D Expansion - State Only*	22	$ 216,354	$ 819.52					
BD Child	1,553	$ 51,250,352	$ 2,750.07	1,535	$ 48,120,559	$ 2,612.83	93.89%	1,479
General Child	61,573	$ 353,899,197	$ 478.97	61,833	$ 361,326,444	$ 486.97	102.10%	61,730
Underinsured Child	548	$ 1,333,204	$ 202.74	616	$ 1,219,340	$ 164.89	91.46%	647
CHIP	4,535	$ 14,772,517	$ 271.45	4,707	$ 14,596,000	$ 258.41	98.81%	4,791
Dr. D Expansion - State Only*	100	$ 983,646	$ 819.70					
Vermont Premium Assistance	15,937	$ 5,615,851	$ 29.36	12,471	$ 4,524,778	$ 30.23	80.57%	11,132
Vermont Cost Sharing	*3,236*	*$ 1,130,724*	*$ 29.12*	*3,041*	*$ 985,102*	*$ 26.99*	*87.12%*	*3,203*
Pharmacy Only	9,853	$ 5,042,856	$ 42.65	9,616	$ 6,392,816	$ 55.40	126.77%	9,533
Choices for Care - Traditional	4,494	$ 249,895,952	$ 4,633.88	4,589	$ 229,352,558	$ 4,164.52	91.78%	4,486
Choices for Care - Acute	*4,366*	*$ 46,081,496*	*$ 879.55*	*4,448*	*$ 42,566,958*	*$ 797.42*	*92.37%*	*4,344*
Total Medicaid	213,224	$ 1,646,928,146	$ 643.66	208,862	$ 1,631,130,936	$ 650.80	99.04%	210,010
**New for SFY22, no expenditures reported as of QE0622.*								

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

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

Questions, Complaints and Concerns Received by Health Access Member Services
April 1, 2022 – June 30, 2022

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

April 2022:

- Provider Complaint - Customer called to express concern that Medicaid Providers are not providing the Explanation of Benefits to Customers. Customer feels it is the customers responsibility to make sure Providers are not committing fraud by sending in claims for services that the customer did not receive. The Agent documented the callers feedback, and also explained how they could obtain a History of Claims by requesting Proof in Writing.

May 2022:

- Policy – Customer requested to speak with a Supervisor regarding Transportation needs. Customer is in between homes right now and needs a ride three times a week. Customer was inquiring about having two different addresses on file, so they don't have to call every other day to change it. The Supervisor apologized for the inconvenient, documented the feedback and advised that we can only have one Residential Address on file at a time. We are able to update it whenever he needs it to be changed.
- Provider Complaint - Customer wanted to document Negative Feedback regarding the lack of Medicaid Providers in the area. Customer states that there are not enough Medicaid Therapists and Dentists. Customer states that none are available in their area, which is very inconvenient. The Agent apologized for the inconvenience, documented the Feedback and assisted the Customer with finding a Provider through VTMedicaid.com.
- Customer states that they are very upset with the way that Transportation Provider has been handling their scheduled pick-ups for her appointments. Caller states that they received a Robo call with a specific pick-up time and then the driver is way later than what was stated. This has caused to have to cancel the appointment and reschedule. This has now happened on two occasions and thinks that the transportation should be picking up and dropping off at the correct times as these appointments are extremely important. The Agent apologized for the inconvenience, documented the feedback and provided the phone number to the Vermont Public Transportation Association to submit a complaint.
- Customer reports that they booked a ride through Transportation Provider and they never provided the ride for their appointment. Customer is worried that if they have an urgent appointment, they will have no transportation to get to and from the appointment. The Agent apologized for the inconvenience, documented the feedback and provided the phone number to the Vermont Public Transportation Association to submit a complaint.

June 2022:

- Provider Complaint - Customer wished to submit negative feedback regarding XXXXXXX Health Center. Customer states that they are making them go to many office visits even though they have already figured

out the problem. Customer wants an ultrasound appointment, but their provider will not provide them with a referral without going to the office visit first. Customer feels that they do not need to go in for another visit as they already had many. Customer feels the provider should just submit the referral. The Agent apologized for the inconvenience, documented the feedback and offered the customer a Provider Complaint Form.

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
April 1, 2022 – June 30, 2022

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data from the centralized database that were filed from April 1, 2022, through June 30, 2022.

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

During this quarter, there were 17 grievances filed; eight 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, 82% were filed by the beneficiary, and 18% were filed by a representative. DMH had 70%, DAIL had 18%, and VDH had 12% of the grievances filed.

Grievances were filed for service categories case management and community social supports

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 15 appeals filed. Of these 15 appeals, 14 were resolved (93%).

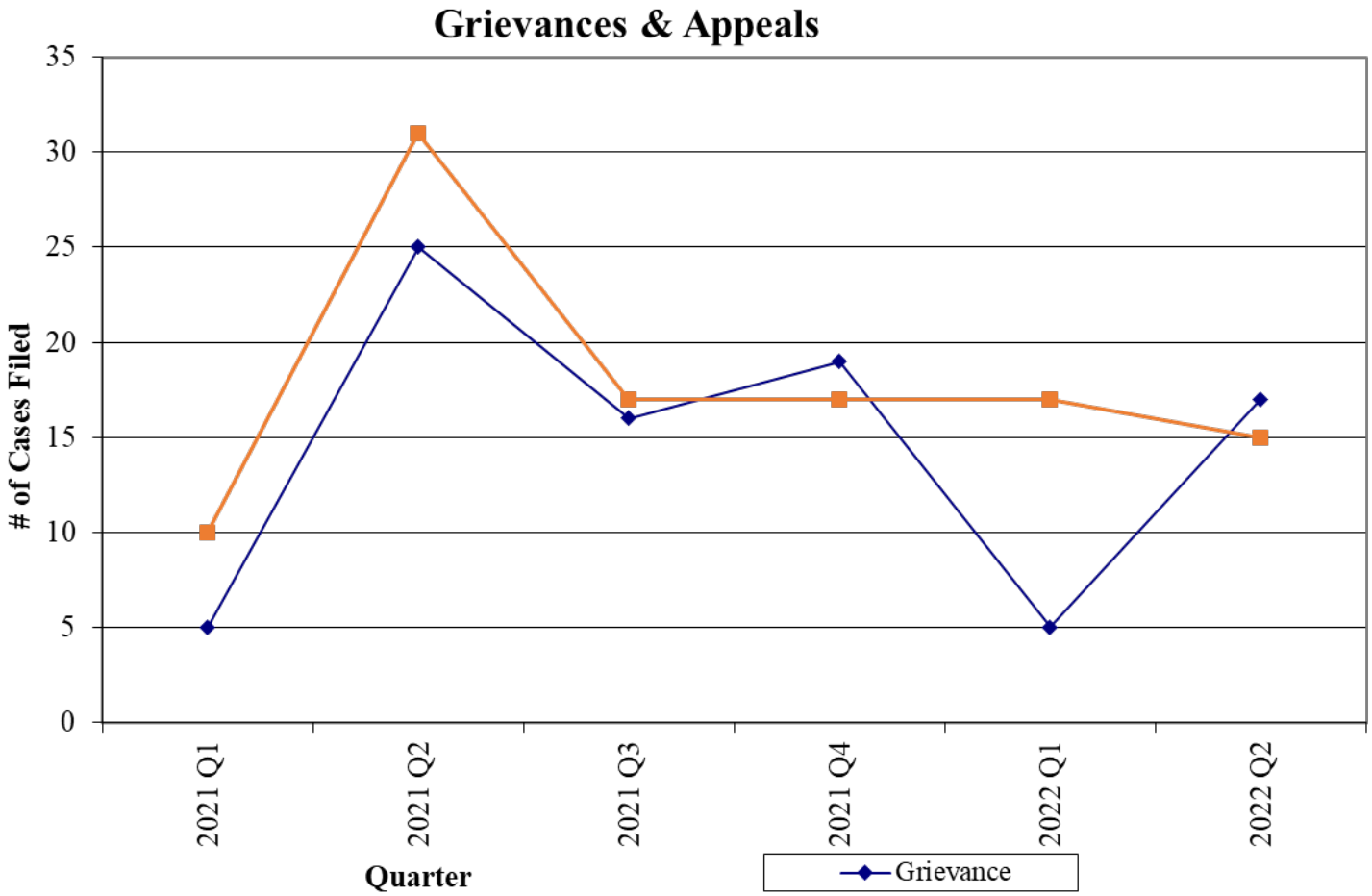
Of the 14 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 30 days. The average number of days it took to resolve these cases was 14 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was three days.

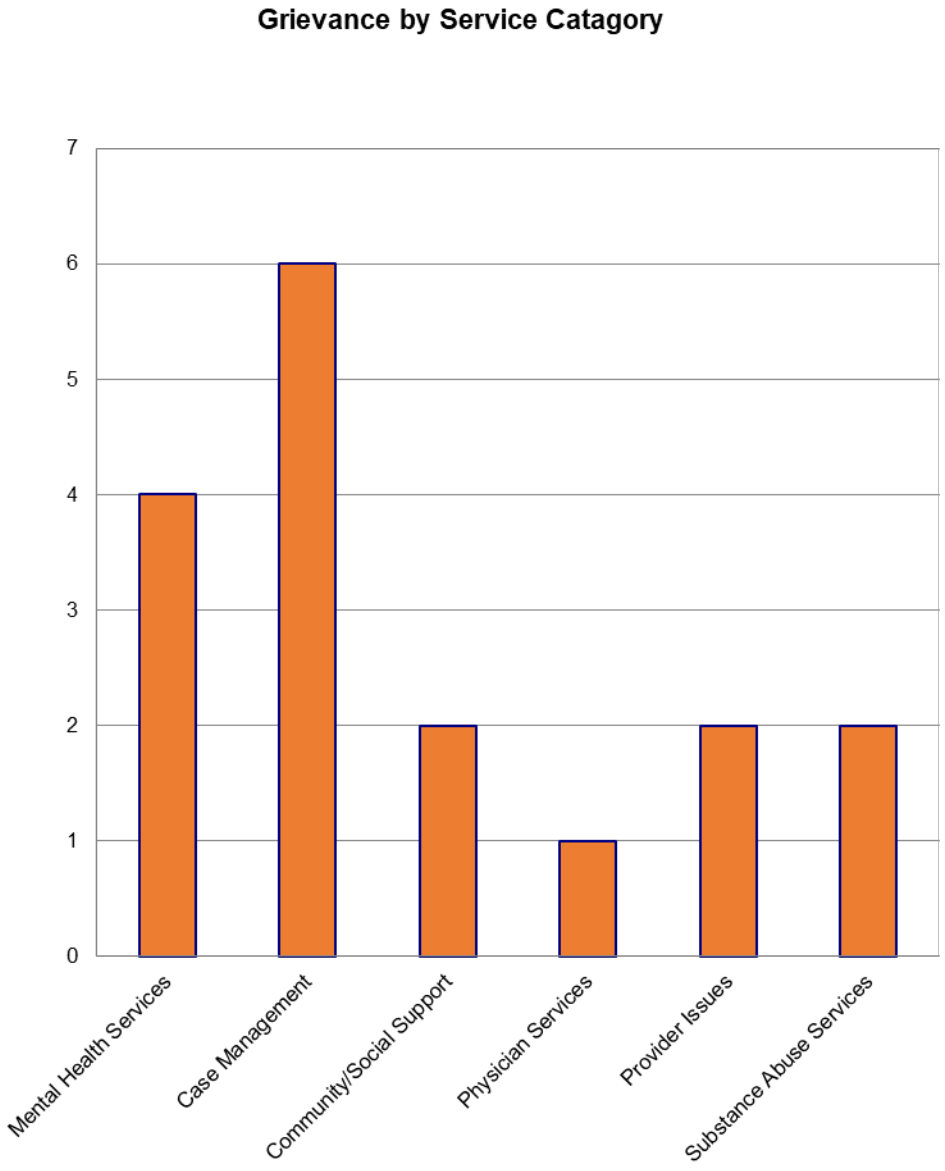
Of the 15 appeals filed, DVHA had 11 appeals filed (73%), DAIL had 1 (7%), VDH had 2 (13%) and DMH had 1 (7%).

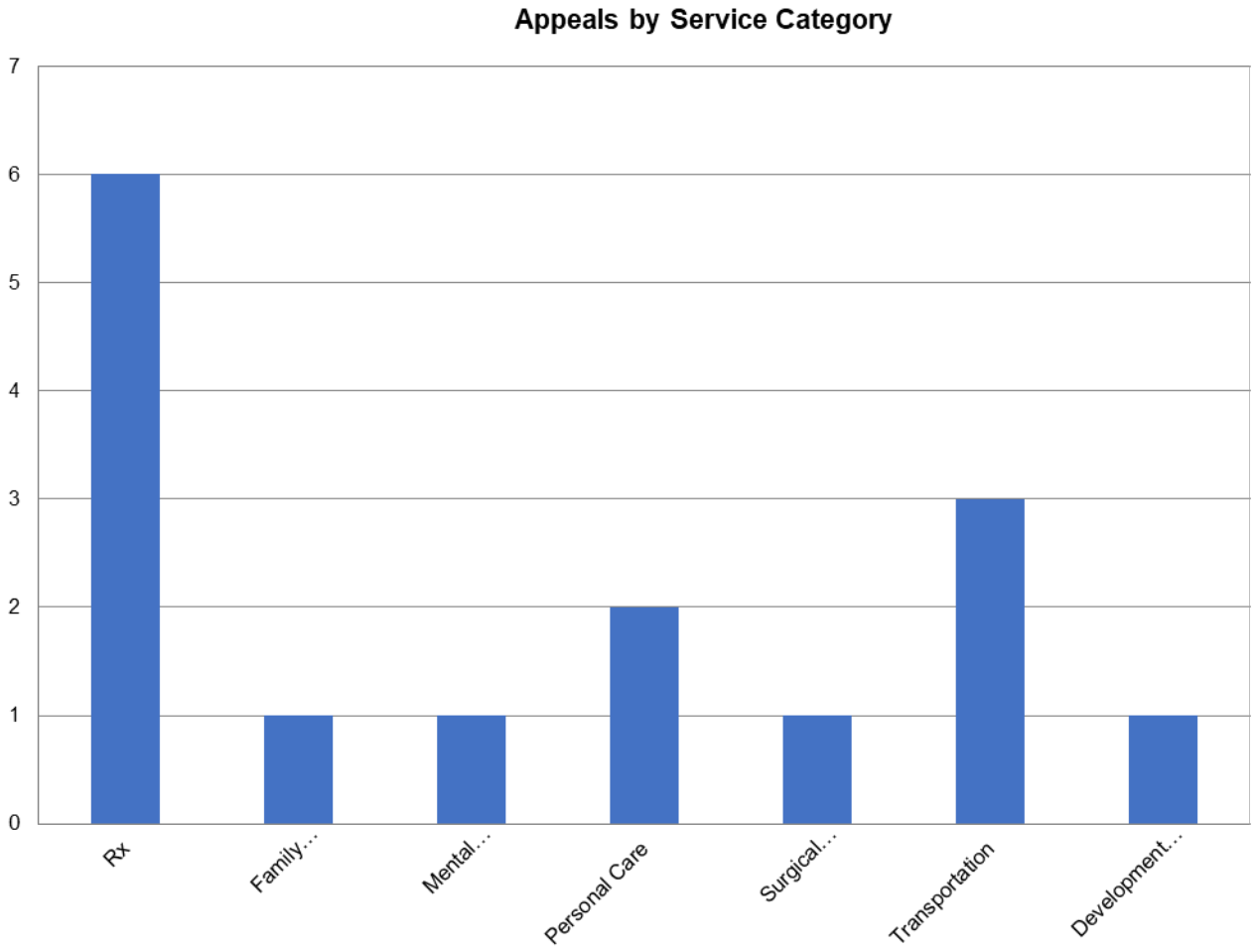
The appeals filed were for service categories, Personal care, family planning, mental health, prescriptions, surgical, developmental, and transportation.

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

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


Grievances & Appeals
35
30
25
20
15
10
5
0
# of Cases Filed
2021 Q1
2021 Q2
2021 Q3
2021 Q4
2022 Q1
2022 Q2
Quarter
Grievance


Grievance by Service Catagory
7
6
5
4
3
2
1
0
Mental Health Services
Case Management
Community/Social Support
Physician Services
Provider Issues
Substance Abuse Services


Appeals by Service Category
7
6
5
4
3
2
1
0
Rx
Family…
Mental…
Personal Care
Surgical…
Transportation
Development…

Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

January 1, 2022 - March 31, 2022

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

July 21, 2022

Summary and Update

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

The HCA Helpline now has eight advocates working to resolve issues. The Helpline advocates are working on a hybrid schedule now.

This quarter, the HCA started to participate on a workgroup focusing on Medicare costs, specifically supplemental coverage and enrollment, and Medicare Part C. The HCA gets a significant number of calls from consumers who can't afford Medicare costs. We spoke to 60 households about Medicare Savings Programs, which help with Medicare premium costs. We also spoke to another 14 households about purchasing Medicare supplemental coverage. We advised another 13 households about their eligibility for VPharm, the state's pharmacy program that helps with Part D premiums and copayments, and 10 households about the Low-Income Subsidy, which is the federal program that helps reduce Part D costs. We also gave 73 households consumer education about Medicare.

We also spoke to 197 households about all types of Medicaid eligibility. We also continued to get a significant number of calls about provider complaints (100 calls), and from consumers who faced delays getting care (19 calls). On the website, the Medicaid eligibility page had 2,257 page views. Overall, the HCA helpline had 794 calls this quarter.

The HCA has also been working closely with DVHA to prepare for the launch of the Immigrant Health Insurance Plan. The HCA reviewed the application for the program and four other notices and met with community stakeholders to help develop outreach plans. The HCA also developed its own outreach materials to share with consumers and community stakeholders. HCA plans on doing multiple outreach events and trainings for the new program.

Vermont's health care system is still under a great deal of stress. During the coming months, the Green Mountain Care Board will make decisions about how much to raise insurance rates, and how much hospitals can raise their commercial rates. The proposed rate increases if approved will price more and more Vermonters out of the care they need. Vermonters are still having trouble accessing the care they need. Many must wait months for a medical or dental appointment. We had 34 calls from households having trouble accessing dental care, 23 about primary care, and 23 having trouble finding a specialist. Our webpage on dental services had over 1000

Allie's Story

Allie was leaving her job, so she could go back to school and pursue a degree that would increase her employment prospects. But leaving her job, meant that she was going to lose her employer-based insurance. Her school required that she have proof of health insurance coverage, and she needed to show proof of coverage before she could start classes. Allie could not afford the school insurance coverage. She was going to need to take out additional student loans to pay for the insurance costs. When the HCA advocate spoke with Allie, she explained that eligibility for Medicaid for Children and Adults (MCA) was based on current monthly income. Because Allie no longer had the income from her job, she would be eligible. The HCA advocate helped Allie apply and expedite the application. This meant that Allie had proof of insurance by her school's deadline, and she would save thousands of dollars in insurance premiums while she was in school.

pageviews. Consumers must also contend with increasing costs of gas, food, housing, and find a way to pay for their medical care The HCA will continue to work to make healthcare more accessible for all Vermonters, and to advocate for a system that is more equitable, responsive, and affordable.

Oran's Story:

Oran called the HCA because he could no longer get Medicaid transportation to his long-time provider. He had been seeing this provider for years, and he did not want to change to a brand-new provider who did not understand his complex medical history. Many providers in his area also were not even accepting new patients. Since Oran did not have access to a car or live near the bus line, Medicaid had been transporting him to the appointments. It had already transported him to multiple appointments this year, but then suddenly he got a notice saying he needed to find the closest provider within his county. The notice said he was no longer eligible to get rides to his current provider. The HCA advocate reviewed the rules and found that the wrong rule had been applied. Under Medicaid transportation rules, you must show that your appointments are medically necessary. But also, that you were seeing an available primary care provider within a 30-mile radius. Oran's provider was in a different county, but under the 30-mile radius. The HCA advocate argued that Oran had already submitted all the necessary proof of medical necessity, and his rides had been denied in error. The HCA advocate reached out to the state's general transportation contractor. The transportation contractor agreed, and the rides were reinstated.

Jake's Story:

Jake needed his rescue inhaler for his asthma. He had applied to Medicaid when he recently moved to Vermont, but the inhaler was still being denied. He could not afford to pay out-of-pocket. Medicaid has $1 or $2 co-payments for prescriptions, but without coverage, the inhaler would cost nearly $40. He needed to have the rescue inhaler in case he had a sudden attack. When the HCA advocate investigated, she found that Medicaid had the incorrect date of birth for Jake, and that was causing the prescriptions to be denied. When his Medicaid application was submitted, it had listed an incorrect date of birth. The HCA advocate was able to get the date of birth corrected. The system updated that day, and Jake was able to pick up his inhaler.

Ava's Story:

Ava called the HCA because she was pregnant and did not have any insurance coverage. The HCA advocate explained that Vermont Health Connect (VHC) has a special enrollment period (SEP) for pregnancy. The SEP allows new enrollees who are pregnant to apply and enroll on a VHC plan at any time during the year. After reviewing Ava's household income, however, the advocate found that she was very close to the Dr. Dynasaur limit. Dr. Dynasuar covers children up to age 19 and pregnant people, and it has no monthly premiums or copayments for pregnancy coverage. Also, once you are Dr. D coverage for pregnancy, you stay on it for your entire pregnancy and post-partum period, even if your income increases. Dr. Dynsaur eligibility is based on your taxable income. Ava had been planning on contributing to a traditional IRA (individual retirement account) already. Contribution to traditional IRAs reduce taxable income. The HCA advocate advised Ava to slightly increase that contribution. The increased contribution lowered her taxable income for the month and made her eligible for Dr. Dynasaur. The HCA advocate assisted with the application, and Ava was found eligible for Dr. Dynasaur for her pregnancy and post-partum period.

Overview

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

The HCA received 794 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:

- **33.50%** about **Access to Care**
- **10.33%** about **Billing/Coverage**
- **2.27 %** about **Buying Insurance**
- **12.97%** about **Complaints**
- **10.58%** about **Consumer Education**
- **18.26%** about **Eligibility** for state and federal programs
- **10.20%** were categorized as **Other**, which includes communication problems with health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

We have a customized case management system that allows us to track more than one issue per case. This enables us to see the total number of calls that involved multiple issues. For example, although 145 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, an additional 363 cases had eligibility listed as a secondary concern.

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

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

The full quarterly report for April– June 2022 includes:

- This narrative
- Five data reports, including three based on the caller's insurance status:
  - **All Calls/All Coverages**: 794
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 249

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

- **Commercial Plan Beneficiaries**: 119
- **Uninsured Vermonters**: 54
- **Vermont Health Connect (VHC)**: 83

The Top Issues Generating Calls

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

All Calls 794 (vs. 819 last quarter)

1. Complaints about Providers 100 (103)
2. MAGI Medicaid Eligibility 84 (82)
3. Medicare Consumer Education 73 (92)
4. Medicaid Eligibility (non-MAGI) 64 (57)
5. Buy-in Programs/Medicare Savings Programs 60 (52)
6. Information/Applying for DVHA Programs 53 (70)
7. Access to Prescription Drugs/Pharmacy 49 (61)
8. Access to Nursing Home & Home Health 48 (43)
9. Other Issues (Not Health-related) 45 (58)
10. Part D Plan Eligibility 42 (24)
11. Special Enrollment Period Eligibility 42 (46)
12. Complaints about Hospital 40 (38)
13. Medicare Eligibility 39 (34)
14. Termination of Insurance 34 (21)
15. Access to Dental Care 34 (31)

Vermont Health Connect Calls 83 (vs. 118 last quarter)

1. Medicaid Eligibility – MAGI 43 (48)
2. Special Enrollment Period Eligibility 28 (27)
3. Premium Tax Credit Eligibility 26 (45)
4. Buying QHPs through VHC 20 (28)
5. Termination of Insurance 17 (16)
6. Information about DVHA 14 (20)
7. Nonfinancial Eligibility Requirements 9 (8)
8. IRS Reconciliation Education 8 (16)
9. Information about ACA 7 (10)
10. Information about Medicare 6 (9)
11. Employer Sponsored Insurance 6 (4)

DVHA Beneficiary Calls 249 (vs. 86 last quarter)

1. Non-MAGI Medicaid Eligibility 33 (12)
2. Information about Medicare 32 (13)
3. Information about DVHA 30 (5)
4. Medicaid – MAGI Eligibility 28 (6)
5. Eligibility for MSPs/Buy-In Programs 24 (7)
6. Complaints about Providers 23 (8)
7. Part D Plan Eligibility 21 (7)
8. Access to Dental 19 (3)
9. Medicare Eligibility 18 (2)
10. Access to Prescription Drugs 16 (6)

Commercial Plan Beneficiary Calls 119 (vs. 160 last quarter)

1. Eligibility for MAGI Medicaid 24 (16)
2. Premium Tax Credit Eligibility 16 (27)
3. Eligibility for Special Enrollment Period 15 (15)
4. Termination of Insurance 13 (11)
5. Buying QHPs through VHC 13 (20)
6. Billing – Hospital Billing & Financial Assistance 12 (15)
7. Information about DHVA 9 (10)
8. Private Insurance – Covered Service Appeals 7 (5)
9. IRS Reconciliation Consumer Education 7 (12)
10. Medicare Consumer Education 7 (12)

The HCA received **794** total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as "dual eligible"): 31.36% (249 calls)
- **Medicare**[2] **beneficiaries (**Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as "dual eligible," Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 25.69% (204 calls)
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans) 12.5% (100 calls)
- **Uninsured:** 6.80 % (54 calls)

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

Dispositions of Closed Cases & Money Saved

All Calls: We closed 826 cases this quarter. Overall, 387 were resolved by brief analysis and advice. Another 291 were resolved by brief analysis and referral. There were 104 complex interventions involving complex analysis and more than two hours of an advocate's time, and 30 cases that involved at least one direct intervention on behalf of a consumer. The HCA provided consumer education in 557 cases. We also estimated eligibility for insurance coverage and helped enroll people onto coverage in 55 cases. We saved consumers $186,069.91 this quarter.

Consumer Protection Activities

Rate Review

The HCA reviews and analyzes all commercial insurance carrier requests to the Green Mountain Care Board (Board) to change premium prices. The Board decided two premium price change requests during the quarter from April 1, 2022, through June 30, 2022. Additionally, there are six premium price change requests pending at the close of the quarter.

The Vermont Health Plan (TVHP) submitted a premium price change request decided by the Board this quarter: the TVHP Large Group filing. The overall price change requested was +7.9%. This premium price change request was consolidated with Blue Cross Blue Shield of Vermont's (BCBSVT) Large Group premium price change request. On May 18, 2022, the Board approved an average premium price change of +7.6% for the consolidated filings. The HCA appeared on behalf of Vermonters in this matter.

BCBSVT submitted one premium price change request decided by the Board this quarter: the BCBSVT Large Group filing. As noted above, the BCBSVT Large Group filing was consolidated with the TVHP Large Group filing. As also noted above, overall premium price change requested was 7.9%. On May 18, 2022, the Board approved an average premium price change of +7.6%. The HCA appeared on behalf of Vermonters in this matter.

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

The BCBSVT Small Group filing impacts roughly 19,851 Vermonters. BCBSVT is requesting an average premium price increase of +12.5%. The BCBSVT Individual filing impacts roughly 16,556 Vermonters. BCBSVT is requesting an average premium increase of +12.3%. The MVP Small Group filing impacts roughly 20,900 Vermonters. MVP is requesting an average premium increase of +16.6%. The MVP Individual filing affects roughly 15,026 Vermonters. MVP is requesting an average premium price increase of +17.4%. The HCA has appeared on behalf of Vermonters in all four of these matters. Further, the HCA will file all appropriate memoranda and other documents. In addition, the HCA will appear at the hearings on these matters to question the carriers' witnesses and provide affirmative testimony in its role representing the interests of Vermonters in proceedings before the Board.

The two other premium price change requests pending as of the close of this quarter are BCBSVT's and TVHP's Large Group Unit Cost Trend Filing Q4. These two premium price change requests have been

consolidated into a single matter by the Board. The HCA appeared on behalf of Vermonters in these matters.

Hospital Budgets

The HCA is engaged in preparatory review, analysis, and research work for the upcoming FY23 hospital budget hearings in August. As a part of this process, we submitted written questions to all the hospitals and have provided feedback, recommendations, and questions to the GMCB hospital budget team to assist their review and analysis. We are currently reviewing all the hospital budget submissions and focusing on hospitals' commitment to health equity, financial transparency, and consumer affordability and access. The HCA looks forward to participating in the hospital budget hearings in mid-August and engaging on these important consumer-focused areas.

Certificate of Need Review Process

In the last quarter, the HCA monitored several ongoing and new applications. We worked directly with Nick Kahm of the Kahm Clinic (GMCB-009-21con: The Kahm Clinic – New Eating Disorder Treatment Program) as well as the Board to advocate that the clinic accepts Medicaid as a payer. The Board ultimately approved the CON with specific reference to the importance of ensuring access for individuals and families on Medicaid to eating disorder treatment, and the Kahm Clinic reached an agreement to accept Medicaid as a payer. We participated in preliminary conversations with CON applicants as needed to advocate for requiring DEI and trauma-informed training for all staff and leadership. Specifically, we met with senior leadership of Northwestern Medical Center to provide feedback regarding the renovation of their emergency room and mental health patient suite in collaboration with community mental health advocates and psychiatric survivors. We will continue to actively monitor certificate of need applications as they are submitted.

Oversight of Accountable Care Organizations

The HCA provided written questions, edits and general recommendations that were incorporated in both the FY23 Medicare-Only Budget Guidance and FY23 ACO Budget Guidance as issued by the GMCB ACO Budget team. Our comments focused on the importance of establishing clear methods of quantitative and qualitative evaluation of ACO performance, financial transparency, and the prioritization of population health programs rooted in a social determinants of health approach. After the conclusion of the FY23 hospital budget process, the HCA will meet with the GMCB ACO Budget team to discuss how to evaluate the FY23 budget for OneCare Vermont (OCV).

Additional Green Mountain Care Board and other agency workgroups

Over the last quarter, the HCA attended the Board's weekly board meetings, monthly Data Governance meetings, and monthly Prescription Drug Technical Advisory subgroup meetings (which includes the Out-of-Pocket Costs and Pharmacy Benefit Manager subgroups). The HCA also participated in a workgroup focused on identifying metrics for evaluating wait times at Vermont hospitals in collaboration with the GMCB and the Vermont Association of Hospitals and Health Systems (VAHHS). These metrics were ultimately incorporated into the FY23 Hospital Budget Guidance.

Vermont Hospital Quality Framework Workgroup

The HCA continues to participate in the Vermont Hospital Quality Framework Workgroup – whose charge is to "design a framework of meaningful metrics that provides relevant information and accurately reflects the hospital system's quality of care within the healthcare reform environment in Vermont." The HCA presented to the workgroup about the importance of inclusion of non-clinical quality measures.

The Medicaid and Exchange Advisory Committee

The Advisory Committee met three times this quarter. The content of this quarter's meetings included a focus on the Global Commitment negotiations, Advisory committee membership, PHE Unwind Communications Plan, Immigrant Health Insurance (IHIP) Implementation Plan.

Mental Health Integration Council

The HCA is a member of the Mental Health Integration Council. The Chief Advocate participated in meetings of the full council as well as the Pediatric integration subgroup during this quarter. The council continued its work in understanding the efforts already underway and defining potential ways to improve on those efforts.

Legislative Advocacy

The Vermont Legislature came to a close for the biennium during this quarter. Given this, we will highlight the more significant efforts and outcomes of the policy areas that the HCA engaged in. The Chief Advocate spent considerable time in the State House both advocating for changes to Vermont laws, as well as being responsive to legislators and legislative committees. The following bills represent most of our advocacy this year:

H. 353 (Act 131): The HCA worked with stakeholders on House Bill H. 353 – which establishes a framework for regulating pharmacy benefit managers (PBMs) and improving transparency. The bill successfully passed the House and after considerable negotiation a compromise was struck between the House and the Senate. We worked with the Department of Financial Regulation regarding specific provisions contained in the bill related to fiduciary responsibilities being considered in the pending legislation. The bill was signed by the governor.

H.287 *(Act 116):* An act relating to patient financial assistance policies and medical debt protection. Passage of H.287 has been a significant priority for the HCA this biennium. The bill addresses some of the challenges that Vermonters face when seeking patient financial assistance, and that we hear about from consumers who call the HCA helpline. We worked in collaboration with the Vermont Association of Hospitals and Health Systems to find common ground that we presented to the House Health Care Committee. Both the House and the Senate moved the bill with very few changes from the negotiated agreement between the HCA and VAHHS. The bill was signed by the Governor.

S.239 (Act 99): An act relating to enrollment in Medicare supplemental insurance policies. This bill as introduced would have created an annual open enrollment period for Medigap plans and created a study group to look at insurance coverage issues impacting Vermonters on Medicare. The HCA has been promoting this bill over the last two biennium. This year, the bill was first taken up by Senate Health and Welfare who passed the bill with only small adjustments to section two of the bill. The bill then moved to Senate Finance where the carriers opposed the bill due to their concern that the creation of an

annual open enrollment period would lead to higher rates. The Senate Finance Committee removed the annual open enrollment period and forwarded the study sections of the bill. The House Health Care Committee moved the bill as passed by the Senate with the inclusion of a study group question about the advisability of updating Vermont's Medicare Savings Plan eligibility standards. The bill was signed by the Governor.

S.285(Act 167): An act relating to health care reform initiatives, data collection, and access to home- and community-based services. This bill started in Senate Health and Welfare, motivated significantly by the Green Mountain Care Board's interest in moving forward on a plan to address hospital sustainability. The bill costs $5 million. The HCA supported the bill due to its promise of public engagement and honest conversations with Vermont communities about the financial and workforce challenges facing Vermont hospitals. The House and the Senate moved on a compromised version of the bill that balanced the perspectives of the administration and the GMCB. The bill was signed by the Governor.

H.489 (Act 137): An act relating to miscellaneous provisions affecting health insurance regulation. This bill started as a largely uncontroversial bill from the Department of Financial regulation. The HCA supported it in the House with minor edits that were agreed to. On the Senate side, in the Senate Finance Committee, Blue Cross and Blue Shield proposed permanently unmerging the individual and small group QHP marketplace, whether or not Congress extends the ARPA Premium Tax Credits. The HCA opposed unmerging the market as long as there is no system and funding to support the individual market from the significant rate increases that would result. The House agreed to the Senate changes and the bill was signed by the Governor.

Medical Debt Story Telling Project

The HCA has long recognized the impact of medical debt on Vermonters and health care access issues related to the cost of services. This quarter, in addition to ongoing casework and the regulatory work, we continued to work on a medical debt project to highlight the experiences of Vermonters with these issues.

Our Medical Debt Story Telling Project was an integral part of our legislative strategy to pass H.287 that created a statewide minimum standard for hospital free care policies. This quarter, with our focus on the run up to insurance rate review and hospital budget review, this project was put on standby. People can interact with a web map to view stories by county in addition to being able to filter stories by topic and/or geography. The web application is available at *www.vtmedicaldebt.org*. The stories were drawn from responses to a survey on medical debt that we fielded in 2021.

One of the key takeaways from the stories that came to us, was the number of Vermonters who are on Medicare who struggle with medical debt. We see this project as a way to raise awareness of that dynamic in the future.

Collaboration with Other Organizations

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

- American Civil Liberties Union of Vermont
- Bi-State Primary Care
- Bridges to Health
- Blue Cross Blue Shield of Vermont
- Burlington Brigade of Code for America
- Burlington Code Academy
- Department of Financial Regulation
- Families USA
- IRS Taxpayer Advocate Service
- Let's Grow Kids
- Mexican Consulate
- Migrant Justice
- MVP Health Care
- National Academy for State Health Policy
- NHeLP, National Health Law Program
- New American Clinic/Family Room
- OneCare Vermont
- Open Door Clinic
- Planned Parenthood of Northern New England
- Rights and Democracy (RAD)
- Rural Vermont
- South Royalton Legal Clinic
- SHIP, State Health Insurance Assistance Program
- U.S. Based Committee for Refugees and Immigrants Vermont
- University of Vermont Medical Center
- University of Vermont Migrant Health, Bridges to Health Vermont Association of Hospitals and Health Systems
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Health Connect
- Vermont Health Care for All
- Vermont Interfaith Action (VIA)
- Vermont Medical Society
- Vermont - NEA
- Vermont Workers' Center
- VPIRG
- You First

Increasing Reach and Education Through the Website

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

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

Popular Web Pages
* Means the page moved into the top 20 this quarter

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

1. *Income Limits - Medicaid* – 2,257 pageviews
2. *Health* - section home page – 1,579
3. *Dental Services* – 1,055
4. *Medicaid, Dr. Dynasaur & Vermont Health Connect* – 776
5. *Medicaid* – 579
6. *Services Covered – Medicaid* – 541
7. *Long-Term Care* – 522
8. *Medicare Savings Programs* – 413
9. *HCA Help Request Form* – 358 pageviews and 115 online help requests
10. *Resource Limits - Medicaid* – 354
11. *Medical Decisions: Advance Directives* – 307
12. *Dr. Dynasaur* – 282
13. *Choices for Care Income Limits* – 276
14. *Prescription Help – State Pharmacy Programs* – 271
15. *Choices for Care* – 254
16. *Federally Qualified Health Centers* – 253 *
17. *Advance Directive forms* – 250
18. *Choices for Care Giving Away Property or Resources* – 232
19. *Transportation for Health Care* – 228 *
20. *Vermont Health Connect* – 224

This quarter we had these additional news items:

- *Your Benefits and the Public Charge Rule for Immigration* – 110 pageviews
- *Coronavirus and Long-Term Care* – 25
- *You May Be Eligible for New Financial Help for Health Insurance (ARPA)* – 20
- *More Financial Help Available for Vermont Health Connect Plans for 2022* – 9
- *Sessions Gather Stories of Long Wait Times for Health Services* – 3

Outreach and Education

The Office of the Health Care Advocates (HCA) engaged in both in-person and virtual outreach this quarter. This hybrid model has made our services more accessible to community members who are seniors or have limited English proficiency. We engaged with Vermonters via social media. We also partnered with community organizations to develop referral relationships and deliver outreach presentations. The HCA also created and circulated virtual education videos and hosted legal clinics.

We partnered with 21 organizations and participated in 16 outreach presentations to provide accurate and accessible information on insurance eligibility health care policy. These organizations included United Way of Northwestern Vermont, the Vermont Language Justice Project, the Vermont Workers Center, Rural Vermont, the New Leaders Council, Migrant Justice, and the Vermont Professionals of Color Network - just to name a few. These partnerships included the delivery of outreach presentations, the development of streamlined referral systems, and coordinated messaging on important health law topics such as the COVID-19 Public Health Emergency, insurance rate review, and the Immigrant Health Insurance Plan.

Our office continued to use virtual platforms such as Facebook, Zoom, and YouTube to connect with partner organizations and deliver legal education presentations. We used our Facebook page to deliver messaging on a variety of health care related topics, but most notably, we produced and distributed an outreach video that discussed Medicaid and the COVID-19 Public Health Emergency. This video has been viewed 556 times. Additionally, we circulated educational material on transgender and non-binary access to gender affirming care, access to reproductive planning resources in Vermont, and health care affordability.

From April 5th to June 15th the HCA connected with six organizations from across Vermont that provide direct service to migrant workers, asylum seekers, and other categories of immigrants who traditionally struggle to access healthcare because of their Immigration status. We provided consumer education about our office and its free services by conducting outreach and intake at the Mexican Consulate events in Montpelier, Middlebury, and during a Wellness Collective event on Winooski. We dedicated more outreach capacity to this group in preparation for the implementation of the Immigrant Health Insurance Plan. Additionally, health insurance eligibility rules for those with different lawful immigration statuses can be complicated, so our office continues to prioritize engaging with these populations to advance health equity.

We partnered with organizations such as the AALV, the Family Room, the University of Vermont's Bridges to Health Program, the Open Door Clinic, the Immigrant Assistance Project, and the Community Asylum Seekers Network to deliver education and assistance about immigration status and health insurance eligibility.

The HCA also continued in-person outreach and service delivery through a legal help partnership with Vermont Legal Aid and the Old North End Community Center. The Old North End Community Center hosts organizations such as AALV, the Family Room, the New American Clinic, and the Champlain Senior Center. The HCA organized three clinics where community members connected with legal advocates to get free and confidential advice. Childcare and in-person interpretation were available to support people seeking our assistance.

Promoting Plain Language in Health Communications

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

Immigrant Health Insurance Plan Application

Immigrant Health Insurance Plan Review Notice

Immigrant Health Insurance Plan Verification Macros

Immigrant Health Insurance Plan Notice of Decision

Welcome to the Immigrant Health Insurance Plan Flyer

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: QE032020 Investments (GC Investments)

CY 2022 Investment Expenditures					
Department	Final Receiver Suffix	Investment Description	QE 0322	QE 0622	CY 2022 Total
AHSCO	9090	Investments (STC-79) - Designated Agency Underinsured Services (54)		3,137,836	**3,137,836**
AOE	n/a	Non-state plan Related Education Fund Investments			**-**
DCF	9402	Investments (STC-79) - Medical Services (55)	29,886	63,416	**93,302**
DCF	9403	Investments (STC-79) - Residential Care for Youth/Substitute Care (1)			**-**
DCF	9405	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56)	1,015,016	984,159	**1,999,175**
DCF	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	27,165	26,980	**54,145**
DCF	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	60,495	59,887	**120,382**
DCF	9408	Investments (STC-79) - Essential Person Program (59)	199,586	186,923	**386,509**
DCF	9409	Investments (STC-79) - GA Medical Expenses (60)	37,180	51,743	**88,923**
DCF	9411	Investments (STC-79) - Therapeutic Child Care (61)	291,853	352,186	**644,039**
DCF	9412	Investments (STC-79) - Lund Home (2)	1,018,417	708,387	**1,726,804**
DCF	9413	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)			**-**
DCF	9414	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34)	36,225	18,112	**54,337**
DCF	9415	Investments (STC-79) - Challenges for Change: DCF (9)	54,412	35,689	**90,101**
DCF	9416	Investments (STC-79) - Strengthening Families (26)	259,426	258,385	**517,811**
DCF	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	113,155	59,941	**173,097**
DCF	9418	Investments (STC-79) - Building Bright Futures (35)	116,423	89,375	**205,798**
DCF	9419	Investments (STC-79) - United Ways 2-1-1 (41)	113,203	150,937	**264,139**
DDAIL	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	142,394	98,295	**240,688**
DDAIL	9603	Investments (STC-79) - DS Special Payments for Medical Services (64)	437,186	995,656	**1,432,842**
DDAIL	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)	288,412	293,984	**582,396**
DDAIL	9605	Investments (STC-79) - Quality Review of Home Health Agencies (42)			**-**
DDAIL	9606	Investments (STC-79) - Support and Services at Home (SASH) (43)	245,165	245,813	**490,978**
DDAIL	9607	Investments (STC-79) - HomeSharing (77)	69,470	69,654	**139,124**
DDAIL	9608	Investments (STC-79) - Self-Neglect Initiative (78)	140,627		**140,627**
DDAIL	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)			**-**
DMH	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	15,618	35,544	**51,162**
DMH	9502	Investments (STC-79) - MH Outpatient Services for Adults (66)	613,644	28,738	**642,382**
DMH	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79)	110,675	86,018	**196,693**
DMH	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16)	1,421,292	(283,000)	**1,138,291**
DMH	9506	Investments (STC-79) - Mental Health Children's Community Services (12)	569,189	258,586	**827,775**
DMH	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)	2,324,813	1,563,523	**3,888,336**
DMH	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)	310,397	168,666	**479,062**
DMH	9510	Investments (STC-79) - Emergency Support Fund (22)	93,455	(98,070)	**(4,615)**
DMH	9511	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - VPCH	7,505,908	577,898	**8,083,805**
DMH	9512	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - BR	615,596	746,760	**1,362,356**
DMH	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	26,486	29,137	**55,623**
DMH	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	106,888	(70,141)	**36,748**
DOC	n/a	Return House	105,347	(100,401)	**4,946**
DOC	n/a	Pathways to Housing - Transitional Housing	482,456	469,011	**951,467**
DOC	n/a	St Albans and United Counseling Service Transitional Housing (Challenges for Change)	63,660	124,653	**188,313**
DOC	n/a	Northeast Kingdom Community Action	-	47,763	**47,763**
DOC	n/a	Community Rehabilitative Care	1,686,841	929,131	**2,615,972**
DVHA	9102	Investments (STC-79) - Vermont Blueprint for Health (51)	587,252	828,418	**1,415,669**
DVHA	9103	Investments (STC-79) - Buy-In (52)	3,358	1,021	**4,379**
DVHA	9106	Investments (STC-79) - Patient Safety Net Services (18)		14,886	**14,886**
DVHA	9107	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	1,433,991	1,152,500	**2,586,491**
VDH	9201	Investments (STC-79) - Emergency Medical Services (19)	188,129	247,196	**435,326**
VDH	9203	Investments (STC-79) - TB Medical Services (74)	741	3,961	**4,701**
VDH	9204	Investments (STC-79) - Epidemiology (40)	112,702	2,536,865	**2,649,567**
VDH	9205	Investments (STC-79) - Health Research and Statistics (39)	309,495	379,019	**688,515**
VDH	9206	Investments (STC-79) - Health Laboratory (31)	945,283	1,217,349	**2,162,633**
VDH	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	608,501	331,526	**940,027**
VDH	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)			**-**
VDH	9209	Investments (STC-79) - Family Planning (75)	248,354	327,955	**576,308**
VDH	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)	48,000	308,011	**356,011**
VDH	9211	Investments (STC-79) - Renal Disease (73)			**-**
VDH	9213	Investments (STC-79) - WIC Coverage (37)	491,701	1,172,490	**1,664,191**
VDH	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	(12,000)	120,555	**108,555**
VDH	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	7,674	26,597	**34,271**
VDH	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)	1,069,403	1,044,075	**2,113,479**
VDH	9220	Investments (STC-79) - Recovery Centers (17)	451,852	582,120	**1,033,972**
VDH	9221	Investments (STC-79) - Enhanced Immunization (46)	69,322	63,342	**132,664**
VDH	9222	Investments (STC-79) - Poison Control (48)	15,354	39,165	**54,518**
VDH	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	304,575	267,167	**571,742**
VDH	9224	Investments (STC-79) - Fluoride Treatment (38)	21,825	32,475	**54,299**
VDH	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)	18,272	61,134	**79,406**
VDH	9228	Investments (STC-79) - VT Blueprint for Health (44)	171,960	358,420	**530,381**
AHSCO	9421	Direct to HCBS Spend Plan Investment		1,023,333	**1,023,333**
			27,843,705	**24,540,752**	**52,384,457**

Transitional Housing

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

Most Recent Period | Current Actual Value

P GCI Transitional Housing Services

Most Recent Period | Current Actual Value

What We Do

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

Who We Serve

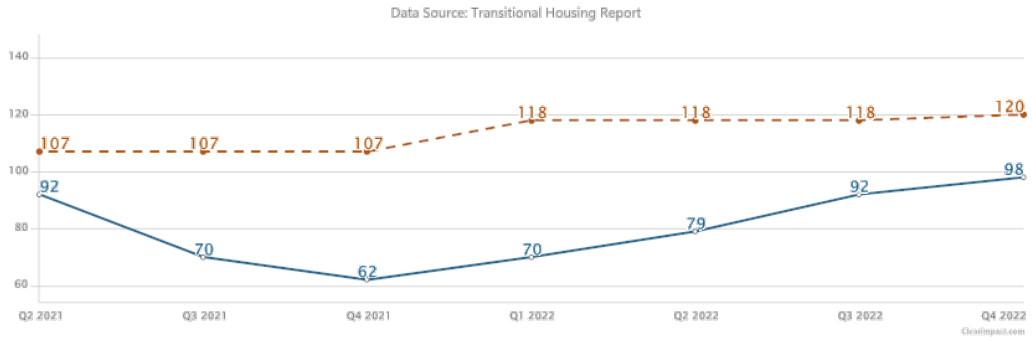
Reintegrative housing funded by the Department of Corrections is targeted to support those with complex needs to rejoin their community safely. The individuals we serve have conditions (including, but not limited to) mental health challenges, substance misuse, developmental disabilities, severe functional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

How We Impact

Our program activities are designed to facilitate our targeted outcomes:

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

PM GCI Number of Individuals Served | **Q4 2022** | **98**



Q3 2022	92
Q2 2022	79
Q1 2022	70
Q4 2021	62
Q3 2021	70
Q2 2021	92
Q1 2021	99
Q4 2020	73

Story Behind the Curve

The number of individuals served can fluctuate over time depending on the circumstance of people in the program and the circumstance of people scheduled for release. The quarterly target (FY22) for number of people served was 118 for Q1-Q3 and 120 for Q4; the actual number of people served in FY22 was consistently below this target, although the number of individuals served consistently rose each quarter in FY22.

FY22 was the first year of a new grant cycle after a significant shift in the housing model DOC supports, away from congregate sober housing to more independent apartments with wrap around services. Given that Vermont has a severe lack of affordable housing, it took most of the year for programs to add new apartments to their portfolio. Also, the DOC exited many incarcerated individuals to a variety of housing options during the COVID-19 pandemic, and there were fewer referrals to our transitional housing partners in FY22.

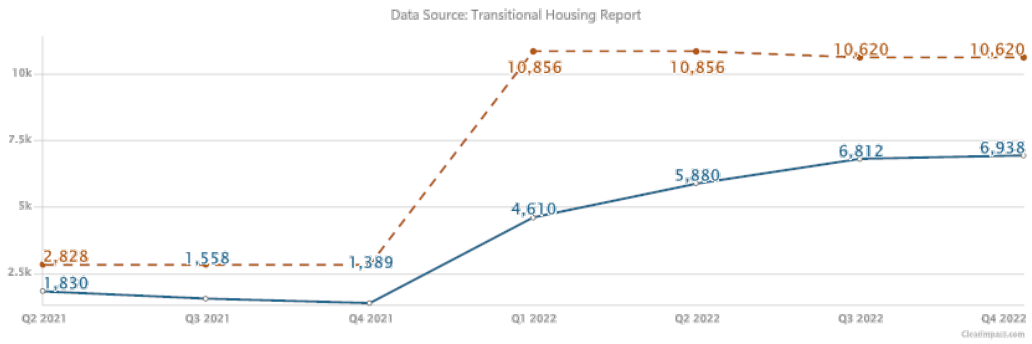
Two programs who received MCO funding in FY20 and FY21 phased out of operation and different programs were funded with MCO in FY22.

Partners

What Works

Action Plan

PM HW Bed Days Utilized



Q4 2022	6,938
Q3 2022	6,812
Q2 2022	5,880
Q1 2022	4,610
Q4 2021	1,389
Q3 2021	1,558
Q2 2021	1,830
Q1 2021	2,625
Q4 2020	2,635

Story Behind the Curve

Bed utilization fluctuates each quarter because of the variability in individuals' circumstances. The bed days for FY22 totaled 24,240 which was 56% of our annual target (43,252). The quarterly target for FY22 was 10,856/10,620. While we are below our annual targets, with the exception of Q2 we are meeting at minimum 64% of our target bed days utilized.

The target number of bed days utilized substantially increased in FY22 because new programs were funded with MCO investment. Also, our largest provider shifted their program structure and greatly expanded services in FY22. The gradually increasing bed days utilized in FY22 reflects the acquisition and occupancy of many new individual apartments throughout the year.

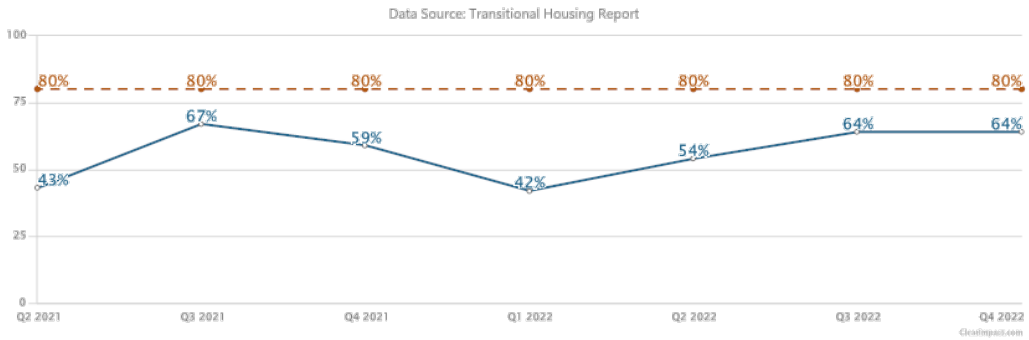
Two programs who received MCO funding in FY20 and FY21 phased out of operation as part of a shift in DOC transitional housing investments.

Partners

What Works

Action Plan

PM HW Percent of Beds Utilized



Q4 2022	64%
Q3 2022	64%
Q2 2022	54%
Q1 2022	42%
Q4 2021	59%
Q3 2021	67%
Q2 2021	43%
Q1 2021	62%
Q4 2020	63%

Story Behind the Curve

Overall utilization for FY22 was 56%. The target for FY22 was 80%; thus, we were below the target percent of beds utilized by an average of 24% for FY22.

The percent of beds utilized substantially increased in FY22 because new programs were funded with MCO investment. Also, our largest provider shifted their program structure and greatly expanded services in FY22. The gradually increasing percent of beds utilized in FY22 reflects the acquisition and occupancy of many new individual apartments throughout the year.

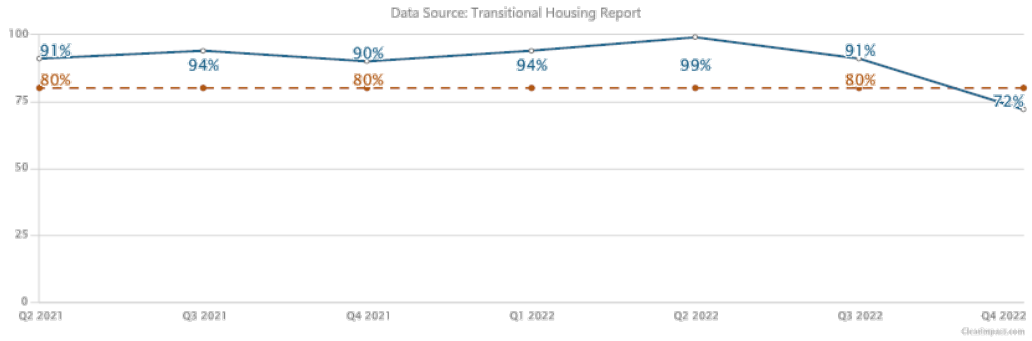
Two programs who received MCO funding in FY20 and FY21 phased out of operation as part of a shift in DOC transitional housing investments.

Partners

What Works

Action Plan

PM HW Percent of Referrals Accepted



Q4 2022	72%
Q3 2022	91%
Q2 2022	99%
Q1 2022	94%
Q4 2021	90%
Q3 2021	94%
Q2 2021	91%
Q1 2021	95%
Q4 2020	87%

Story Behind the Curve

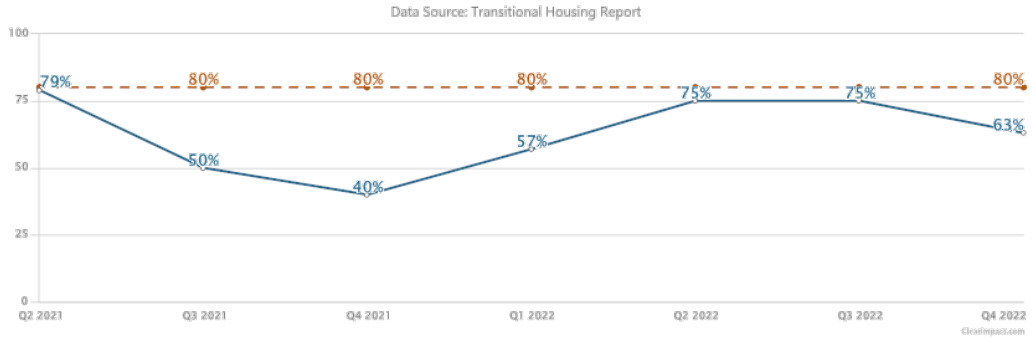
Despite being under the goal in Q4 for percent of referrals accepted, overall in FY22, we were above target at an average of 89%. In Q1 of FY22, we were above our quarterly target for percent of referrals accepted by 19% with 99% of referrals accepted.

Partners

What Works

Action Plan

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



Q4 2022	63%
Q3 2022	75%
Q2 2022	75%
Q1 2022	57%
Q4 2021	40%
Q3 2021	50%
Q2 2021	79%
Q1 2021	59%
Q4 2020	65%

Story Behind the Curve

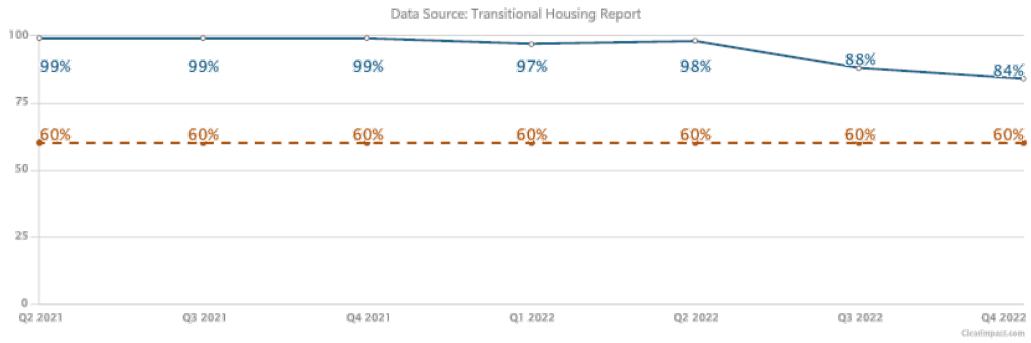
Overall the percent of participants employed, enrolled in an educational/training program, or receiving benefits at exit for FY22 was 67%, which is 13% below our annual target of 80%. The percentage increase of this metric in FY22 over FY21 is because employers are more willing to hire people with criminal records due to a workforce shortage. This measure only captures a participants' status upon exit from the program which may be artificially low since it does not include benefits or employment that may have happened over the course of the program.

Partners

What Works

Action Plan

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



Q4 2022	84%
Q3 2022	88%
Q2 2022	98%
Q1 2022	97%
Q4 2021	99%
Q3 2021	99%
Q2 2021	99%
Q1 2021	97%
Q4 2020	100%

Story Behind the Curve

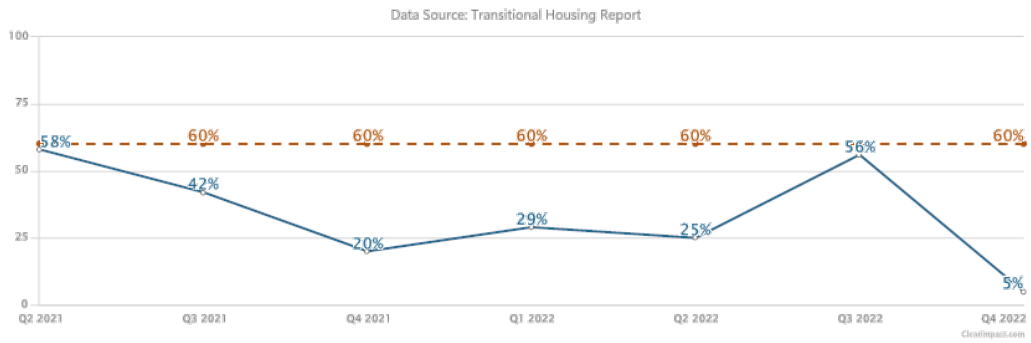
Remaining crime free is significantly associated with successful reentry. In FY22, a total of 89% of program participants remained crime free while in the program (well above our 60% annual target). We have been consistently above our FY22 quarterly target (60%), with a high of 98% of program participants remaining crime free while in the program.

Partners

What Works

Action Plan

PM BO Percent of Participants Exiting to Permanent Housing



Q4 2022	5%
Q3 2022	56%
Q2 2022	25%
Q1 2022	29%
Q4 2021	20%
Q3 2021	42%
Q2 2021	58%
Q1 2021	27%
Q4 2020	45%

Story Behind the Curve

The percentage of people who exit transitional housing to permanent housing varies across time due to the high variable nature of individuals' circumstances. In FY22, an a total of 28% of program participants exited the program to permanent housing, which is 32% below our 60% annual target.

There is a severe affordable housing shortage in VT, which was exacerbated by the far-reaching impacts of the global COVID-19 pandemic. Although there may be vouchers available, there are very few apartments to be found. Landlords were prevented from evicting tenants during the pandemic and now are hesitant to rent to individuals with complex needs. We are also seeing an increase in the severity of substance misuse and mental health challenges among supervised individuals, which makes the transition to permanency even more challenging.

Partners

What Works

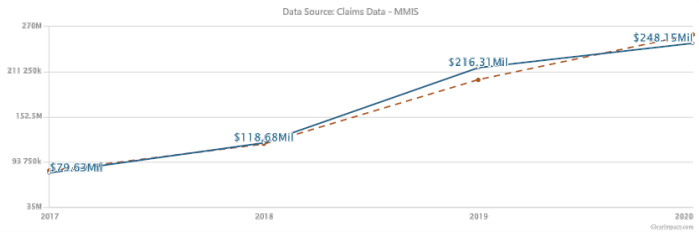
Action Plan

What We Do

The Vermont Medicaid Next Generation (VMNG) ACO program is a pilot program for a risk-bearing ACO to receive prospective payment and assume accountability for the costs and quality of care for prospectively-attributed Medicaid members. The VMNG model is structured similarly to the Medicare Next Generation ACO Model, but has been modified to address the needs of the Medicaid population in Vermont. Medicaid issues a prospective All-Inclusive Population Based Payment (AIPBP) to the ACO on a Per-Member-Per-Month basis according to a member's Medicaid Eligibility Group. Performance monitoring on the ACO's defined measure set occurs at least annually.

Measures

Measures	Most Recent Period	Current Actual Value	Current Target Value	True	Current Trend	Baseline % Change
PM DVHA Expected and Actual Total Cost of Care for Medicaid enrollees aligned with an ACO	2020	$248.15Mil	$259.79Mil		3	212%
	2019	$216.31Mil	$200.81Mil		2	172%
	2018	$118.68Mil	$117.14Mil		1	49%
	2017	$79.63Mil	$82.32Mil		0	0%



Notes on Methodology

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

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

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

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

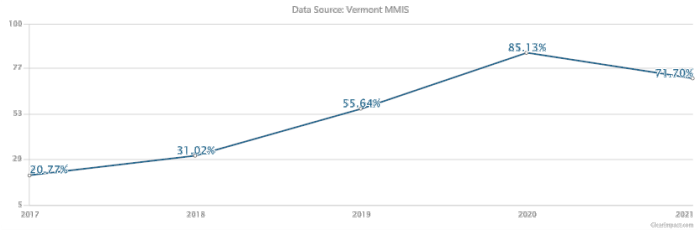
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline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

Story Behind the Curve

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

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

PM DVHA Percent of Medicaid enrollees aligned with ACO



2021	71.70%	1	245%
2020	85.13%	3	310%
2019	55.64%	2	168%
2018	31.02%	1	49%
2017	20.77%	0	0%

Notes on Methodology

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

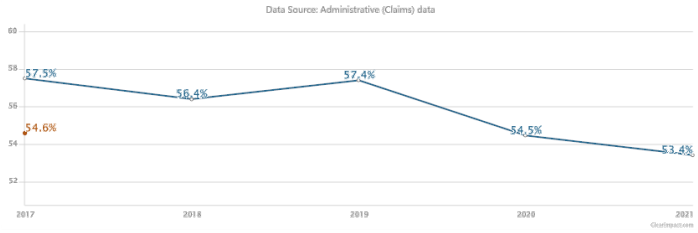
Story Behind the Curve

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

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

PM DVHA Adolescent Well Care Visits (HEDIS® AWC)

2021	53.4%	2	-7%



2020	54.5%		1	-5%
2019	57.4%		1	0%
2018	56.4%		1	-2%
2017	57.5%	54.6%	0	0%

Notes on Methodology

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

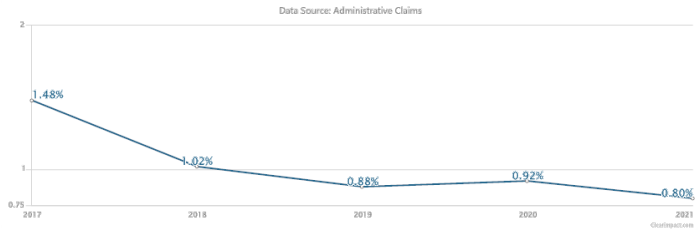
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline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

Story Behind the Curve

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

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

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



2021	0.80%		1	-46%
2020	0.92%		1	-38%
2019	0.88%		2	-41%
2018	1.02%		1	-31%
2017	1.48%		0	0%

Notes on Methodology

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

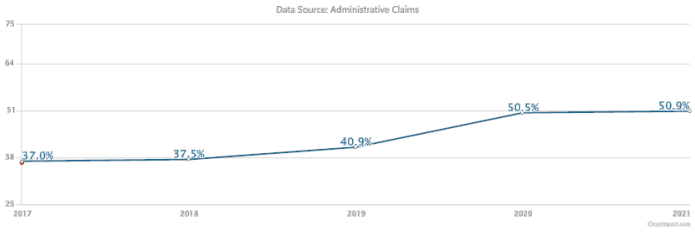
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline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

Story Behind the Curve

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

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

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



2021	50.9%		4	38%
2020	50.5%		3	36%
2019	40.9%		2	11%
2018	37.5%		1	1%
2017	37.0%	36.5%	0	0%

Notes on Methodology

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

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

Story Behind the Curve

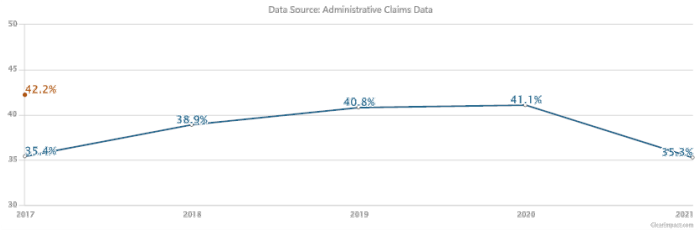
This measure looks at continuity of care for mental illness. It measures the percentage of Medicaid beneficiaries 6 years of age and older who are attributed to the ACO and who were hospitalized for selected mental disorders and then seen on an outpatient basis by a mental health provider within 7 days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

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

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

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

2021	35.3%		1	0%



2020	41.1%		3	16%
2019	40.8%		2	15%
2018	38.9%		1	10%
2017	35.4%	42.2%	0	0%

Notes on Methodology

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

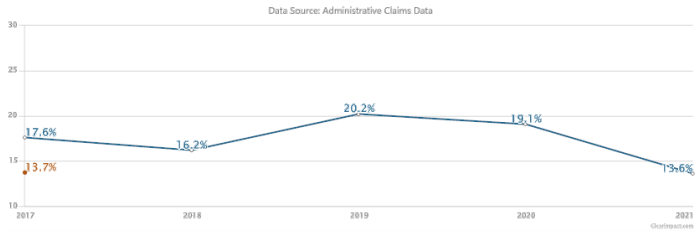
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline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

Story Behind the Curve

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

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

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



2021	13.6%		2	-23%
2020	19.1%		1	8%
2019	20.2%		1	15%
2018	16.2%		1	-8%
2017	17.6%	13.7%	0	0%

Notes on Methodology

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

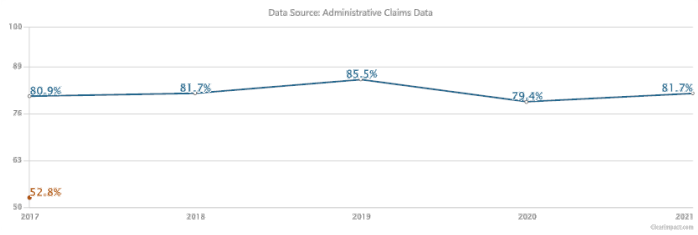
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline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

Story Behind the Curve

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

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

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



2021	81.7%		1	1%
2020	79.4%		1	-2%
2019	85.5%		2	6%
2018	81.7%		1	1%
2017	80.9%	52.8%	0	0%

Notes on Methodology

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

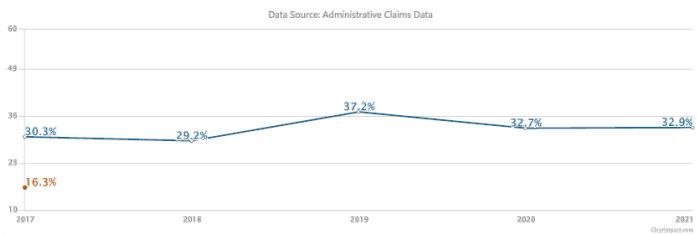
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline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

Story Behind the Curve

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

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

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



2021	32.9%		1	9%
2020	32.7%		1	8%
2019	37.2%		1	23%
2018	29.2%		1	-4%
2017	30.3%	16.3%	0	0%

Notes on Methodology

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

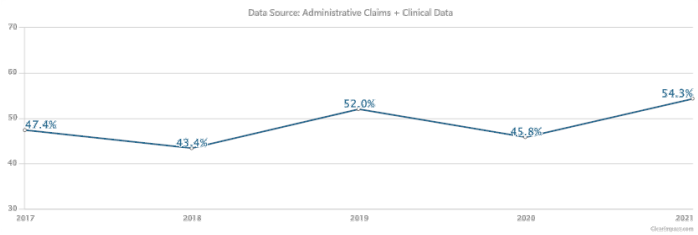
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline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

Story Behind the Curve

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

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

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



2021	54.3%	1	15%
2020	45.8%	1	-3%
2019	52.0%	1	10%
2018	43.4%	1	-8%
2017	47.4%	0	0%

Notes on Methodology

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

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

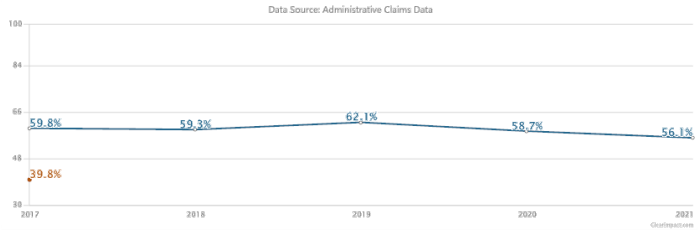
Story Behind the Curve

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

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

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

2021	56.1%	2	-6%



2020	58.7%		1	-2%
2019	62.1%		1	4%
2018	59.3%		1	-1%
2017	59.8%	39.8%	0	0%

Notes on Methodology

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

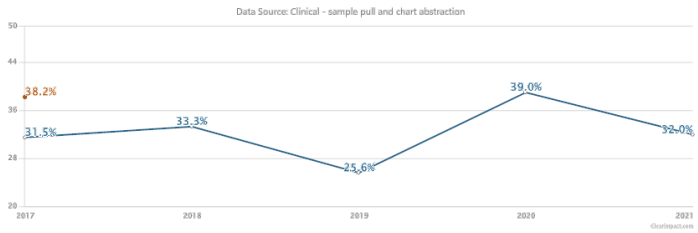
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline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

Story Behind the Curve

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

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

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



2021	32.0%		1	2%
2020	39.0%		1	24%
2019	25.6%		1	-19%
2018	33.3%		1	6%
2017	31.5%	38.2%	0	0%

Notes on Methodology

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

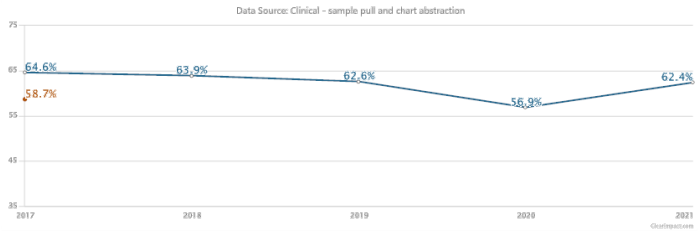
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline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

Story Behind the Curve

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

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

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



2021	62.4%		1	-3%
2020	56.9%		3	-12%
2019	62.6%		2	-3%
2018	63.9%		1	-1%
2017	64.6%	58.7%	0	0%

Notes on Methodology

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

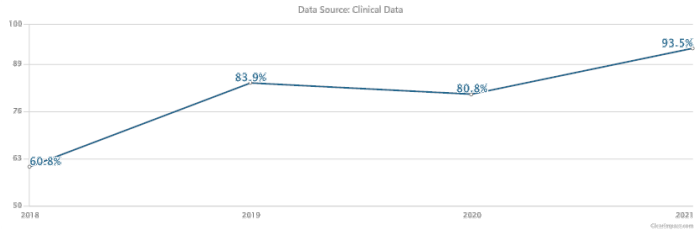
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline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

Story Behind the Curve

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

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

PM DVHA Tobacco Use Assessment and Tobacco Cessation Intervention



2021	93.5%		1	54%
2020	80.8%		1	33%
2019	83.9%		1	38%
2018	60.8%		0	0%

Notes on Methodology

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

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

Story Behind the Curve

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

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

Actions

Name	Assigned To	Status	Due Date	Progress