State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Annual Report
For Demonstration Year 19
January 1, 2023, to December 31, 2023

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I. Background and Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit an annual report. This is the report for the nineteenth waiver year, which ended on December 31, 2023. This report also encompasses fourth-quarter updates for this demonstration year (10/1/22 - 12/31/23).

II. Highlights and Accomplishments

- By the end of 2023, more than 208,062 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 138,684 in Medicaid for Children and Adults (MCA) and 69,378 in Qualified Health Plans (QHPs), with the latter divided between 26,908 enrolled with VHC, 4,529 direct enrolled with their insurance carrier as individuals, and 37,941 enrolled with their small business employer.

- DVHA received a compliance score of 98.3% during this year's External Quality Review Organization (EQRO)Review of Compliance with Medicaid Managed Care Standards Audit.

- DVHA's *Managing Hypertension* PIP received a score of 96 percent for all applicable evaluation elements scored as *Met*, a score of 100 percent for critical evaluation elements scored as *Met*, and an overall validation status of *Met*.

- During CY 2023, VCCI maintained an average case load of roughly 208 people served per month.

- The majority of Vermont's primary care practices are Blueprint-participating Patient-Centered Medical Homes, as 131 of Vermont's estimated 168 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 2023-Q4, the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs was 3,649.

- Act 78 of 2023 provided two years of funding for a pilot project targeted at enhancing health services related to mental health and substance use in Vermont through expansion of the Blueprint for Health's CHTs, including Developmental Understanding and Legal Collaboration for Everyone (DULCE) family specialist program. The final quarter of 2023 saw a large increase in staffing for these new CHT positions. At the end of Q4 CY2023 there were 26.6 FTE hired of a total of 82 FTE funded for the two-year pilot.

- In CY 2023, the Pharmacy Cost Management (PCM) program enrolled an additional 541 members for a total of 3,723 members on 188 covered medications throughout the program.

- DAIL implemented the CBA minimum wage increase, as well as an 8% rate increase for HCBS services, impacting all consumer surrogate self-directed programs.

- Implemented a Global Payment Program (GPP) pilot as a complementary payment model to the Vermont Medicaid Next Generation (VMNG) program.

- In FFY2023, Global Commitment, Medicaid, paid for 13,154 inpatient stays and 358,232 outpatient visits for Vermonters. The total number of inpatient stays was similar from FFY22 to FFY23. Outpatient visits decreased by about 9% during the same period.

III. Project Status

i. Enrollment Information and Member Month Reporting

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

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

Table 1. Member Month Reporting – Demonstration Year 19 (January – December 2023), *subject to revision*

Medicaid Eligibility Group	Total DY 2019	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
ABD - Non-Medicare - Adult	88,873	6,402	6,616	7,273	7,649	7,711	7,708	7,649	7,661	7,610	7,552	7,532	7,510
ABD - Non-Medicare - Child	22,314	1,461	1,545	1,813	1,955	1,998	1,969	1,939	1,943	1,944	1,939	1,914	1,894
ABD - Dual	274,281	22,865	22,902	23,056	23,074	23,120	23,193	23,115	23,096	22,968	22,524	22,296	22,072
Non ABD - Non-Medicare - Adult	204,771	18,676	18,686	18,596	18,712	18,789	17,349	16,057	16,236	15,820	15,483	15,456	14,911
Non ABD - Non-Medicare - Child	732,572	63,228	63,137	62,859	62,717	62,620	61,457	60,598	60,621	59,923	58,937	58,571	57,904
Hypothetical Groups													
New Adult	873,307	77,729	78,090	77,655	77,522	77,651	74,674	72,286	72,038	69,711	66,644	64,971	64,336
SUD - IMD ABD	136	18	9	9	9	12	9	12	8	12	15	15	8
SUD - IMD ABD Dual	146	32	17	14	14	7	11	9	7	7	11	7	10
SUD - IMD Non ABD	190	39	14	19	13	8	6	20	18	9	17	12	15
SUD - IMD New Adult	1,555	326	115	133	111	102	74	122	116	91	132	106	127
SMI - IMD ABD	127	3	3	3	13	20	15	11	11	14	8	11	15
SMI - IMD ABD Dual	28	1	1	1	1	1	1	3	2	11	2	3	1
SMI - IMD Non ABD	173	4	3	4	42	42	46	8	8	4	4	2	6
SMI - IMD New Adult	350	20	23	32	45	31	26	25	28	35	21	28	36
Housing Pilot	0							-	-	-	-	-	-
Maternal Health and Treatment Services	343	19	33	23	27	30	26	25	25	51	28	24	32
CRT	2,437	188	186	186	184	185	185	201	195	213	226	232	256
SUD CIT	0												
VT Global RX	108,990	9,040	8,994	8,940	8,908	8,869	8,918	9,031	9,141	9,245	9,289	9,307	9,308
Moderate Needs Group	1,391	111	114	114	114	115	113	113	112	114	120	122	129
Marketplace Subsidy	143,113	11,424	11,716	11,704	11,355	11,339	11,540	11,918	12,124	12,319	12,520	12,627	12,527

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ii. Global Commitment to Health Post Award Forum

A post award forum for the latest Global Commitment to Health 1115 waiver renewal was held on Monday, April 24, 2023. This forum was conducted following Special Terms & Condition 44 of the Global Commitment to Health 1115 Demonstration waiver. Public comments were solicited and accepted at this forum and public notice of the forum was posted to the Global Commitment Register on March 2nd, 2023.

iii. Vermont Health Connect

By the end of 2023, more than 208,062 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 138,684 in Medicaid for Children and Adults (MCA) and 69,378 in Qualified Health Plans (QHPs), with the latter divided between 26,908 enrolled with VHC, 4,529 direct enrolled with their insurance carrier as individuals, and 37,941 enrolled with their small business employer.

Vermont Health Connect's eleventh open enrollment period launched successfully on November 1, 2023. In October 2023, 99.8% of eligible QHP renewals were handled through a single, clean automated process. Vermonters visited the online Plan Comparison Tool 33,518 times between January 1, 2023, and December 31, 2023. This accounts for a 35% decrease over the prior year.

Medicaid Renewals

The unwind from the Covid public health emergency (PHE) began in April. For the first time since early 2020, all enrollees were scheduled for a renewal in order to determine continuing eligibility. DVHA initiated a number of flexibilities to facilitate handling the volume of renewals, expanding the population who could renew automatically and offering more verification options. Those no longer eligible for MCA were screened for a QHP with assistance, or Medicaid programs for the aged and disabled.

For renewals initiated during the first nine months of the unwind, 28,131 cases, or 49%, went ex parte.

QHP Renewals

DVHA kicked off a series of meetings with its internal stakeholders and Maintenance and Operations vendor in mid-summer 2023 to prepare for the upcoming Open Enrollment. These meetings focused on testing, notices, business, and transactional planning activities.

The first step in the renewal effort involves determining eligibility for the coming year's state and federal subsidies and enrolling beneficiaries in new comparable versions of their health and/or dental plans. In October 2023, this step was operated with a single, clean, automated run that took care of 99.8% of eligible cases. The 0.2% failure rate meant that only a small number of cases needed to be renewed by staff the following day, allowing all beneficiaries to have updated accounts and 2024 information before the start of Open Enrollment.

This meant that they could log onto their online accounts on the first day of Open Enrollment, see their benefits and net premiums for the coming year, and select a new plan if they wanted to do so. Beneficiaries also had the option to call the Customer Support Center or meet with an In-Person Assister and go through the same steps if they did not want or were unable to use the online option.

The second step involves sending these files to the insurance carriers to ensure appropriate billing and effectuation. This is the third year in which QHP premiums are no longer being handled by our previous premium processor, WEX Health. In November 2023, this initial integration run was completed with 99.1% accuracy for the insurance carriers. DVHA and its partners collaborated to clean up and re-send the remaining cases well in advance of the new year. The third step consists of a year-end business process that allows changes to be made on cases if the beneficiary reports changes in household or income information.

Altogether, performance on these three steps made the 2024 QHP renewal experience a success.

Applying Online

Five years ago, DVHA set a goal for a continual 10% year-over-year increase in the adoption of self-service functionalities. Since that time, the actual growth in online applications has far exceeded the goal. The percentage of Vermonters applying for coverage online has more than tripled over the last five years, increasing from 16% of VHC applications in June 2016 to 62% in December 2023. The online option has the potential for improved customer experience as Vermonters can log in at their convenience. The increased automation can also allow state staff to spend less time processing applications and more time delivering on other priorities for Vermonters.

Change Requests

During the first few years of Vermont's health insurance marketplace, many beneficiary change requests took several weeks or months to complete. For 2018, DVHA set a target to complete 95% of requests within ten days and met this goal for beneficiaries managed in the Vermont Health Connect system. In the last quarter of 2023, 98% of requests were completed within ten days – exceeding this goal.

Integration and Reconciliation

DVHA set a goal of integrating enrollment files across its insurance carrier partners' systems with no more than a 0.79% error rate and achieved this goal for all but one month in 2023. DVHA and its partners also acted quickly to resolve errors that did arise. DVHA's goal was to ensure that no more than one-twentieth of one percent of cases sat in error status for more than ten days. That equates to an inventory of 11 or fewer errors open more than ten days.

DVHA also executed monthly reconciliation of the marketplace's enrollment systems in 2023. Multiple enrollment systems (Vermont Health Connect, payment processing vendor WEX, and the three insurance carriers) create the risk of discrepancies for Medicaid and QHP members across systems. In 2019, DVHA set a target of addressing 100% of potential discrepancies each month. In 2023, DVHA met the goal every month with Blue Cross Blue Shield of Vermont (BCBSVT) and Northeast Delta Dental (NEDD). During April 2023 Medicaid Unwind was initiated that allowed VHC to start following old procedures. Renewals, verifications, terminations, and more were initiated based on an individual's Medicaid batch. Many Medicaid buckets were still put on hold, due to the public health emergency as individuals had not been up for their renewal. Overall, during calendar year 2023 VHC successfully initiated 9 Medicaid batches.
DVHA also honed its Medicaid reconciliation process in 2023. As previously mentioned, the public health emergency limited certain actions.

Customer Support Center

Callers to VHC's contracted Customer Support Center experienced prompt service during the first half of 2023. During the months of June through December, the percentage of phone calls answered within 24 seconds averaged 35% and 40% less than the 75% goal respectively. The staffing issues that plagued the nation were felt at our call center as well. The overall inbound call volume in 2023 was lower (49%) than the corresponding months in 2022.
Additionally, there was a decrease in the percentage of calls that Maximus needed to escalate to DVHA in 2023. In 2022, 7.9% of all calls were transferred to DVHA compared to 6.5% being transferred in 2023.
DVHA's Tier 2 call center maintained prompt service on escalated calls through 2023. In 2017 DVHA set a goal of answering 90% of calls within five minutes. In 2023 they met that goal by 6%. In 2023, 96% of all calls transferred to DVHA were answered within five minutes.

In-person Assisters

DVHA is currently supported by 100 assisters: 91 Certified Application Counselors, 4 Navigators, and 5 Brokers). There are 26 individuals in training to be certified as a CAC.

The program has 79 participating organizations with coverage in all 14 Vermont counties.

Through the utilization of technology, the program has improved data management and online educational resources for our Assisters. Going forward, this year, our focus shifts to ongoing organizational recruitments to further promote equitable access to Assister organizations.

Outreach & Education

During 2023, DVHA ran two information campaigns simultaneously – the Medicaid Renewal process and Open Enrollment. This entailed a fair amount of planning to ensure that the public and key partners were educated and engaged. DVHA continued to use the historical channels of its websites, social media, virtual events, e-newsletters, and advisory committee meetings. Additionally, DVHA integrated the use of director customer outreach via notices and postcards, as well as text messaging and emails, to remind customers to open and respond to mailings.

DVHA also used grant money to help create and implement a "Refresh. Review. Reply." campaign for the Medicaid renewal process. The unifying message connected products across the communication mediums – website, social media, direct customer outreach, partner and provider newsletters. The grant also included paid digital and radio marketing to promote important messaging.

To better engage community partners, DVHA sent out partner newsletters which are designed to disseminate important information. This effort was of particular importance due to the two campaigns and the response to the flood-affected communities. The department continues to recruit and grow the list of partner organizations to more effectively reach a great number of Vermonters.

The Plan Comparison Tool continues to play its important dual role. First, as the primary tool to help Vermonters find a health plan that best fits their needs and budget. Second, as an educational tool to help customers and potential customers assess their choices for coverage. DVHA promoted use of the Plan Comparison tool as a straightforward aid for the Medicaid Unwind and Open Enrollment

DVHA also launched a new, more user-friendly version of the on-line tool during 2023. It provided the same information but in a clearer and easier way to help navigate through plans and options.
The Plan Comparison tool was visited over 44,000 times in 2023. During the year's final quarter, which included most of the annual Open Enrollment period, the Tool was visited over 20,000 times.

Future Development

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

IV. Findings

i. External Quality Review

Key updates:

- DVHA received a compliance score of 98.3 % during this year's EQRO Audit.
- DVHA received an overall PIP validation score of Met – with 100% of all applicable evaluation elements receiving a score of Met.
- All DVHA performance measures reported to AHS were determined to be reliable and valid.

During this year, the state spent time preparing subject matter experts for the 2023 EQRO compliance audit. This included an orientation to the audit standards and the audit timeline. In addition, the EQRO, HSAG, performed a fully remote version of their annual review of compliance with standards. Activities included a desk review of documents and conducting virtual interviews with key staff members. These annual audits follow a three-year cycle of standards. During this year's review, HSAG evaluated the degree to which DVHA complied with federal Medicaid managed care regulations and the associated AHS intergovernmental agreement (IGA) in eight performance categories (i.e., standards). The eight standards included requirements associated with federal Medicaid managed care standards found at 42 CFR §438.10, 438.12, 438.100, and 438.214–230.

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

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

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

EQRO Audit Results:

During Q4 2023, the state supported their External Quality Review Organization (EQRO), HSAG, as they prepared this year's set of reports for each of the mandatory EQR activities listed below.

Validation of the PIP

During this year, HSAG continued to validate DVHA's PIP, Managing Hypertension. The PIP topic addresses the management and control of hypertension and is based on the HEDIS 2022 Controlling High Blood Pressure (CBP) measure and technical specifications. HSAG used CMS' PIP validation protocol as the methodology to validate the PIP. HSAG's validation evaluated the data analysis of results and QI strategies of the PIP (i.e., the Implementation stage). This year, DVHA reported its first remeasurement rate and the QI activities conducted. The MCE updated its causal/barrier analysis and continued and/or revised the interventions based on intervention evaluation data results.

DVHA's *Managing Hypertension* PIP received a score of 96 percent for all applicable evaluation elements scored as *Met*, a score of 100 percent for critical evaluation elements scored as *Met*, and an overall validation status of *Met*. The validation findings suggest that DVHA continued with a methodologically sound PIP and met all validation criteria except for achieving statistically significant improvement in the performance indicator. The MCE performed appropriate data analysis and made data-driven, informed decisions related to QI processes and continuing interventions. The improvement achieved at the first remeasurement was not statistically significant. DVHA is hopeful that changes made to interventions and continued monitoring will result in greater improvement in the next remeasurement.

Validation of Performance Measures

HSAG validated rates for a set of performance measures selected by AHS for 2023 reporting. The validation also determined the extent to which the Medicaid-specific performance measures calculated by DVHA followed the HEDIS 2023 specifications. AHS identified the measurement period for all measures as calendar year (CY) 2022. AHS required that the measures be calculated according to the National Committee for Quality Assurance's (NCQA's) *Healthcare Effectiveness Data and Information Set (HEDIS®) 20, Volume 2, Technical Specifications for Health Plans*. Although most measures were reported using administrative data, DVHA was required to report three measures using both administrative and medical record data, known as the hybrid methodology, to ensure that the rates more accurately reflected the services provided to beneficiaries. The validation findings confirmed that all rates were reportable.

Monitoring Compliance with Standards

AHS requested that HSAG continue to review one of the three sets of federal Medicaid managed care standards during each EQR contract year. During this year's review, HSAG evaluated the degree to which DVHA complied with federal Medicaid managed care regulations and the associated AHS intergovernmental agreement (IGA) in eight performance categories (i.e., standards). The eight standards included requirements associated with federal Medicaid managed care standards found at 42 CFR §438.10, 438.12, 438.100, and 438.214–230.

HSAG conducted the review consistent with CMS *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. HSAG reviewed DVHA**'s** written operating policies and procedures, program plans, meeting minutes, numerous written reports, and other data and documentation related to DVHA**'s** performance during the review period. Reviewers also conducted staff interviews related to each of the eight standards to allow DVHA staff members to elaborate on the written information HSAG reviewed, assess the consistency of staff responses given during the interviews against the written documentation, and clarify any questions reviewers had following the document review.

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

HSAG reviewed DVHA's performance related to 546 elements across the eight standards. Of the 546 applicable elements, DVHA obtained a score of *Met* for 532 elements, *Partially Met* for nine elements, and *Not Met* for five elements. As a result, DVHA obtained a total percentage of compliance score across the 546 requirements of 98.3 percent.

Preparation of the External Quality Review Annual Technical Report

During Q4, 2023, the state supported HSAG as they compiled and analyzed all data from its 2023 EQR activities to develop the Annual Technical Report. This report summarizes findings on access to and quality of care including a description of how the data from all activities conducted per the Medicaid Managed Care regulations were aggregated and analyzed, and conclusions were drawn asto the quality and timeliness of, and access to the care furnished to its Medicaid beneficiaries.

SUD Monitoring Protocol

During 2022, the state submitted and received CMS approval for an updated Monitoring Protocol for the SUD programs authorized by the Global Commitment to Health demonstration. The Monitoring Protocol Template was developed in cooperation with CMS and subject to CMS approval. Components of the Monitoring Protocol included: a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 9.2 and reporting relevant information to the state's Health IT plan described in STC 9.6; b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section 12 of the demonstration; and c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines were informed by state data, and targets benchmarked against performance in best practice settings. Progress on the performance measures identified in the Monitoring Protocol were reported via the quarterly and annual monitoring reports.

SUD Mid-Point Assessment

The state must conduct an independent mid-point assessment by June 30, 2025. In the design, planning and conduction of the mid-point assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: SMI/SED and/or SUD treatment providers, beneficiaries, and other key partners. The state must require that the assessor provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than 60 days after June 30, 2025. The state must brief CMS on the report. During this year, the state contracted with an independent evaluator to assess their 1115 waiver/demonstration. The SUD mid-point assessment requirement was included as a deliverable in the evaluation contract.

SMI/SED Monitoring Protocol

Last year, the state submitted and received approval for an updated SMI/SED Monitoring Protocol for the SMI/SED program authorized by the Global Commitment to Health demonstration that reflected the changes to the SMI/SED Monitoring Protocol required by STC 10.2(c). The SMI/SED Monitoring Protocol Template was developed in cooperation with CMS and subject to CMS approval. Progress on the performance measures identified in the Monitoring Protocol were reported via the quarterly and annual monitoring reports. Components of the Monitoring Protocol included: a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 10.2 and STC 10.4, reporting relevant information to the state's SMI/SED Financing Plan described in Attachment L, and reporting relevant information to the state's Health IT plans described in STC 10.3; b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section 12 of the demonstration; and c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines were informed by state data, and targets benchmarked against performance in best practice settings.

SMI/SED Mid-Point Assessment

As per the demonstration/waiver STCs, the state must conduct an independent mid-point assessment by June 30, 2024.

In the design, planning and conducting of the mid-point assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: SMI/SED providers, beneficiaries, and other key partners. The state must require that the assessor provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The

state must provide a copy of the report to CMS no later than 60 days after June 30, 2024. The state must brief CMS on the report.

During this year, the state contracted with an independent evaluator to assess their 1115 waiver/demonstration. The SMI mid-point assessment requirement was included as a deliverable in the evaluation contract. During Q4, the state worked with the independent evaluator to develop a design to guide the assessment. The state will continue to work with the evaluator to plan the assessment over the next quarter.

ii. Quality Assurance and Performance Improvement Activities

Key updates from QE122023/Annual:

- Through the efforts of DVHA's formal PIP, the Vermont Medicaid Program began covering automatic blood pressure monitors through its pharmacy benefit.
- Achieved a 97.4% fully Met score on the annual Compliance EQR.
- Collaborated with AHS on revision of network adequacy standards.

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

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

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

PIHP Quality Committee

The Quality Committee remained active throughout 2023 and consists of representatives from all departments within AHS that serve the Medicaid population. The committee continues to structure itswork around the federal managed care quality program guidelines. During this period, the Quality Committee reviewed our performance for the measures within *DVHA's Global Commitment to Health* Core Measure Set. These measures are chosen to represent the breadth of services provided to Vermont Medicaid members and to act as an indicator of our overall Medicaid members' health. Most of these measures are validated each year by an external quality review (EQR) organization. As a result of the Quality Committee's review, a short list of potential quality improvement topics is identified.

Additionally, the committee followed our work plan throughout the year and reviewed quality measure reporting for various special health care needs populations, the annual Child andAdult CAHPS surveys, a grievance and appeals summary and confidentiality procedures, including HIPAAbreach tracking.

Home and Community Based Services (HCBS) Work Group –

The HCBS Work Group started at the end of 2023 and is made up of Quality and Policy representatives from the Agency of Human Services, as well as Quality representatives from DVHA, DAIL and DMH. This group is responsible for direction setting, data collection and analysis of the HCBS Assurance Measure Set.

Formal CMS Performance Improvement Project (PIP)

DVHA's formal PIP topic is the management of hypertension. This project was implemented with the goal to expand access to blood pressure monitors for Vermont Medicaid members. Those with high blood pressure are more likely to get their pressures under control if they record the values at home and share the results with providers (self-monitored blood pressure). Close monitoring of a member's blood pressure will allow faster medical intervention and may reduce medications utilized and doctor or emergency department visits.

The Vermont Medicaid Pharmacy program began covering blood pressure monitors obtained through pharmacy providers, effective 09/22/2023. Pharmacists will be able to order and dispense blood pressure monitors to Medicaid members, when medically necessary.

Other Collaborative Quality Improvement Projects

The Quality Improvement team continued to work with the following groups on collaborative QI projects during 2023:

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

- The Department of Children and Families (DCF), the Vermont Department of Health (VDH), and the Vermont Child Health Improvement Program (VCHIP) wrapped up a CMS-sponsored learning collaborative to improve the timeliness of comprehensive health visits for children and adolescents entering foster care. We decided to continue meeting as a team and extend the work we had started into 2024.

Quality Measure Reporting

- CMS Medicaid Quality Core Measure Sets –
    - The Quality Unit and the Data Unit prepared and submitted the Adult and ChildQuality Core Set rates for MY 2022 into the CMS reporting platform.

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - the DVHA Quality Unit's Director of Quality Management coordinated the 2023 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Children's and Adults Medicaid 5.1H survey. DVHA continued to include the AHRQ supplement questions regarding access to mental health care services. The contracted vendor, DataStat, Inc., distributed and collated the surveys according to AHRQ and NCQA

protocols in the fall of2023. The results of the surveys were delivered to DVHA in February 2024 and will be presented by the Director of Quality Management to the PIHP Quality Committee in March 2024.

- HEDIS measure production – In addition to producing administrative (claims-based) measures, the Quality Improvement and Data teams worked with our quality measures vendor to produce hybrid measures in 2023. DVHA performs internal training and record abstraction for two of those hybrid measures, while our vendor produces the remaining two. DVHA's administrative and hybrid measure rates were validated by our EQRO. Individual measure results were confirmed, and areas of strength were highlighted, as were opportunities for improvement.

Results Based Accountability (RBA)/Process Improvement

Results Based Accountability (RBA) scorecards are developed at DVHA for both internal and external performance management purposes. The use of this performance management framework and corresponding presentation tool has been spearheaded by the Agency's Central Office QI staff. The DVHA Quality Unit staff received training and has used this tool to create a *Global Commitment to Health* Core Measure scorecard, Experience of Care, and other performance budgeting scorecards. DVHA's largest scorecard, named the Performance Accountability Scorecard includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services. Scorecards that were newly developed or actively maintained during 2023 include the following initiatives: Adult Core Set of Health Care Quality Measures, Child Core Set of Health Care Quality Measures, the DVHA Dental Program and the Applied Behavior Analysis (ABA) Program.

COVID-19 Dashboard

The Quality Improvement Team was tasked with creating and maintaining a COVID-19 dashboard at the end of March 2020 to monitor the response to the pandemic: both the impact it had on operations and the activities staff engaged in. An internal evaluation tool, the dashboard was updated monthlyand made available to all DVHA staff via our intranet. DVHA's Management Team highlighted certainmetrics within the dashboard at its regular meetings. This work was maintained throughout 2022. Measures were reviewed in 2023 and either retired or shifted to DVHA's larger Performance Accountability Scorecard.

Vermont Next Generation Medicaid ACO

In 2023 DVHA's Director of Quality Management received, reviewed and approved the quarterly VMNG ACO quality management reports. Quality and Clinical staff from both organizations met quarterly with a focus on quality measurement and ongoing QI efforts. A representative from the VMNG ACO is a standing member of DVHA's formal PIP, the topic ofwhich is managing hypertension.

Comprehensive Risk Assessment

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

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

The assessment entails collaboration with other Agency departments and informed updates to DVHA's Inter-Governmental Agreement (IGA) with AHS.

During 2023, the risk assessment team:

- lead the annual Compliance EQR audit, on which DVHA achieved a 97.4% fully Met score.
- Submitted the Annual Report on PI Monitoring Activities to AHS
- Collaborated with AHS on revision of network adequacy standards.

Global Commitment (GC) Investment Review

AHS Departments are required to monitor and evaluate the performance of their investments on an ongoing basis and subject them to formal review according to a periodic schedule. Performance monitoring is accomplished via a quarterly and annual review of performance information contained in a web browser-based software application (Clear Impact Scorecard). The scorecard includes the following data elements: investment description (i.e., the goal of the investment, the activities being supported, and information on how they are provided), performance measures (i.e., the data being collected and analyzed to determine if the investment is achieving its desired goal), results (performance measure rates for the most recent reporting period), and an interpretation of the results (i.e., comparing actual to expected rates using performance targets and/or benchmarks and to characterize trends or patterns in the data). During this year, VDH, DCF, DMH, DOC, and DAIL highlighted the performance of a subset of their investments using the scorecard in one of the quarterly reports to CMS. During this most recent quarter, The AHS highlighted the performance of its Blueprint program. The Clear Impact Scorecard for this investment is included in this report as Attachment 6.

Payment Models & Performance Monitoring

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

The scorecard includes the following data elements: payment model description (i.e., the goal of the payment model, the activities being supported, and information on how they are provided), performance measures (i.e., the data being collected and analyzed to determine if the payment model is achieving its desired goal), results (performance measure rates for the most recent reporting period), and an interpretation of the results (i.e., comparing actual to expected rates using performance targets and/or benchmarks and to characterize trends or patterns in the data). During this year, scorecards for the following payment models were published: ACO, Dental, CIS, Blueprint, and DMH. The Integrating Family Services (IFS) payment model scorecard is normally shared during the Q4/Annual report. During 2023, the IFS payment model was folded into the mental health case rate model so there is no longer a separate IFS payment model. As a result, the state will no longer be reporting an IFS scorecard with the Q4/Annual report. Going forward, this report will include the Blueprint payment model Clear Impact Scorecard. It is attached to this report as Attachment 7. During the next quarter, the state will adjust the payment model reporting schedule to accommodate these changes.

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

During this year, the state worked with its independent evaluator Pacific Health Policy Group, PHPG, to perform the evaluation activities outlined in the CMS-approved evaluation design. Activities included identifying additional data element requirements associated with performance measures used to support

evaluation-related research questions and hypotheses and supporting the calculation of the rates associated with the measures submitted to the evaluator. During the first quarter of the year, the state worked with the evaluator to finalize the summative evaluation report. The Summative Evaluation Report included the information in the approved Evaluation Design and was developed in accordance with CMS Guidance: *Preparing the Interim and Summative Evaluation Reports*. During the second quarter, the state submitted the summative evaluation report to CMS for review/approval. Upon receipt of CMS feedback, the state will have 60 days from the date of the feedback to review/resubmit the report.

GC Draft Evaluation Design

During this year, the state worked with their new independent evaluator to develop the draft evaluation design. The state submitted, for CMS comment and approval, the draft Evaluation Design during the year. The draft Evaluation Design was developed in accordance with the following CMS guidance (including but not limited to): (1) Attachment A (Preparing the Evaluation Design) of these STCs, and all applicable technical assistance on applying robust evaluation approaches, including using comparison groups and beneficiary surveys to develop a draft Evaluation Design; and (2) All applicable evaluation design guidance, including guidance about substance use disorder, serious mental illness, premiums, and overall demonstration sustainability. The Evaluation Design is the state's plan for how it will accomplish the evaluation of their 1115 wavier. Specifically, the design identifies the state's hypotheses, evaluation questions, associated measures, and analytic methods. The state is awaiting CMS feedback. Once feedback is received, the state will submit a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments.

Intra-Governmental Agreement (IGA) between AHS and DVHA

During this year, the AHS QIM submitted the 2024 Agency of Human Services (AHS) and the Department of Vermont Health Access (DVHA) IGA to CMS for approval. In addition to the IGA, the state submitted (1) the actuarial certification and workbook of the capitation rates for Vermont's Global Commitment to Health for the contract period 1/1/24-12/31/24 and (2) the CMS provided Contract and Rate Submission Cover Sheet (Appendix A). The state expects CMS feedback on their 2024 IGA during the first two quarters of next year.

iii. Provider and Member Relations (PMR)

Key updates from QE122023:

- 2023 Summary
- Quarter 4 Updates

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

Quarter 4 Updates and 2023 Summary

Non-Emergency Medical Transportation (NEMT)

In the fourth quarter of calendar year 2023, non-emergency medical transportation utilization remained fairly steady, with a small decline in trips provided compared to the same period last year. Staffing issues at the subcontractor level had an obvious impact, with both the call wait times and call abandonment rate showing increases over the previous calendar year fourth quarter. Program complaint numbers also continue to run well below the contracted performance standard of 5% of all rides provided, still maintaining a monthly rate of less than 1%.

Since utilization numbers continue to remain below pre-Covid levels, the consistent lower numbers appear to be hinting that this may be the new normal. The difference now is that the average rides-per-month-per-member has risen since pre-Covid, as lower monthly member counts have outpaced the lower trips provided counts.

Coordination of Benefit Activity

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

Areas of activities:

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

Member and Provider Services Coordination of Benefit Collection Table:

MPS - Coordination Recovery Activities "Q4"	
Casualty	$320,428.41
Estate	$657,805.69
Third-Party & Court-Ordered Medical	$120,278.81
Medicare Prescription Drug Premium/Claims	$23,267.32
Over Resource/Hospice/Patient Share/Credit Balance	$604,904.79
Annuity/Trust/Waiver	$14,403.55
Lamp/Map, Medicare Claim Recoupment	$275,633.36
Third-Party Claim Recoupment	$51,465.35
Total	**$2,068,187.28**

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

Coordination of Benefit-Cost Avoidance Table:

Cost Avoidance "Q4"	
Third-Party Liability	$35,651,700.32
Medicare	$207,267,342.99
Total	**$242,919,043.31**

Coordination of Benefits activities: The unit coordinates benefit and collection processes with providers, members, other state departments, third party contractors, and other insurance companies to ensure Medicaid is the payor of last resort. Responsibilities include Medicare Part D case work, claims processing assistance, coverage verification and access to care issue resolution. The Member and Provider Services unit works diligently to recover funds from third parties which include estate recovery, absent parent medical support recovery, casualty recovery, patient liability recovery, Medicare and Medicare Part D prescription recovery, special needs recovery, and trust recovery.

In the year 2023 the Coordination of Benefit collections and cost avoidance has remained steady with little monthly increases.

COB OnDemand: The Department of Vermont Health Access (DVHA) is in the process of implementing the National Eligibility Data Base (NEDB) process to capture commercial insurance coverage from multiple health insurance carriers. DVHA is contracted with Gainwell Technologies to assist with performing daily third-party liability identification and deployment of a newly developed Transactional Matching and Verification (TMV) technology that is powered by Gainwell's proprietary NEDB. Gainwell has invested in this technology to rebuild our data matching and verification processes, which have many benefits such as reducing improper primary payments made by Medicaid, the number of denied claims, and rebilling of claims. This process maximizes services through commercial insurances when reducing the number of claim resubmission, while increasing, correcting, and limiting the mismatching of billing. This new process is expected to go live at the beginning of June of 2024. The implementation of COB OnDemand is expected to increase the State of Vermont's cost avoidance by 40%.

Healthcare referrals: Coordination of Benefits handles multiple daily inquiries from numerous other Vermont departments, providers, and third-party contractors. Inquiries include verifying, adding, or updating commercial and Medicare coverage to Vermont's ACCESS system. This process requires research and collaboration with insurance companies, providers, third party contractors and members. Verifying and updating insurance on a member's account on the ACCESS system requires verifying of a member's healthcare eligibility and the rules and policies of their Vermont program. This knowledge is crucial when handling an access to care live billing issue and to ensure that the correct resolution is presented, and that Medicaid is the always the payor of last resort. In the year 2023 the Coordination of Benefits assisted with over 6,000 referrals to ensure that members could access their primary benefits along with various publicly funded programs.

Beginning in middle of 2023, the State of Vermont started the unwind of the public health emergency (PHE) that was initiated in 2020 with the start of COVID-19. During this time, the eligibility team has been reviewing members' cases since they were not allowed to be reviewed or changed during the PHE, meaning many members' Vermont programs changing or more verification of primary insurance was needed. Since the unwind of the PHE, Coordination of Benefits has received an increased amount in referrals to assist and resolve, including verifying primary commercial or Medicare insurance/Medicare Part D plans.

Health Insurance Premium Program (HIPP): Vermont's Health Insurance Premium Program (HIPP) pays for Medicaid eligible members and their families to receive assistance with a portion or all of their health insurance plan through their employer or COBRA. This program is designed to save money for Medicaid members with high healthcare costs by reimbursing all or a portion of the cost of their health insurance premium. In 2023 we implemented Questions and Answers on various HIPP questions, as well as an online application to make applying for the HIPP program very easy for the member. Since implementation of the online application, we have received 24 new cases which has brought Coordination of Benefits a 25% increase in HIPP cases since the deployment of the online application.

V. Cost Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE122023:

- Overview
- Team Based Care 2.0 Updates
- Care Coordination Housing Resource Teams
- CMS Care Management Platform
- CMS Metrics

The Vermont Chronic Care Initiative (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 members who experience complex health and social needs. 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 the 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.

Vermont Chronic Care Initiative has been a key partner working with the Camden Coalition and other programs in the State to review and plan ways to further expand and improve upon our Team Based Care services and system in Vermont. The Camden Coalition has produced a report outlining their recommendations for enhancements for our Team Based Care Model. Vermont Chronic Care Initiative is helping to move this work forward into the implementation phase and is working collaboratively with Field Services, the Blueprint Program and One Care to begin Learning Collaboratives across the State to help regions enhance their Team Based Care processes and services. Vermont Chronic Care Initiative is one of the few Team Based Care Specialist programs in Vermont and are seen as leaders in the Team Based Care statewide.

Over the last calendar year, Vermont Chronic Care Initiative staff have been instrumental in providing services and consultation for the State's Care Coordination Housing Resource Teams (CCHRT.) These teams were developed to provide outreach, social determinants of health screening and care coordination to people experiencing homelessness in our hotel programs. VCCI leadership helped to develop and launch the program in October 2022. Most of the households in the cohort also experience high health and social needs. The VCCI team has provided direct case management services to many in the program and has been steadfast in providing services on-site at hotel locations throughout the State. The team has also provided training and consultation to other state professionals offering services to the population.

The Vermont Chronic Care Initiative has been a key contributor of Social Determinants of Health Screening Pilot for the Agency of Human Services. The team has been having various programs pilot the CMS Social Determinant of Health Screening tool as part of their program's intake process. VCCI piloted the common screening tool by integrating within their existing outreach/screening of Vermonters new to Medicaid. The New to Medicaid Program that is embedded in VCCI has also been piloting the questions. Utilizing the same standardized screening tool across the agency has many advantages, especially in matching people to the right services based upon their needs and goals.

Over the past year, the Vermont Chronic Care Initiative has developed and tested new data elements with VITL, and the CMS care management platform used to export data collected through screening and assessment stored in VITL into the Health Information Exchange. The program was interviewed by VITL and was highlighted in VITL's annual report as a program that uses VITL data.

In the fourth quarter of 2023, VCCI saw increases in the number of referrals in October and November, and a decline in December. The average number of referrals per month for calendar year 2023 was 35. VCCI served 420 unique individuals over 2023. The goal of increasing the percentage of face-to-face visits remains relatively steady at around 65% of visits being in person. Most members request multi-modal interventions. Most prefer a hybrid model with some home visits mixed in with office, virtual or telephonic visits. Home visit safety protocols have been updated and implemented. In general, staff report feeling safe and comfortable when meeting members in their homes with the new safety protocols in place.

As seen below, VCCI maintained an average case load of roughly 208 people served per month over the calendar year. The length of time and regularity of visits are dependent on the complexity and severity of the needs of the beneficiaries. VCCI case managers work with beneficiaries until the goals of their care plans are met or they are connected to needed services in the community with a lead care coordinator assigned. (See Figure 1 below).

Figure 1. Beneficiary Enrollment and Face to Face Visits

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Measure	2/15/2023	3/15/2023	4/15/2023	5/15/2023	6/15/2023	7/15/2023	8/15/2023	9/15/2023	10/15/2023	11/15/2023	12/15/2023	1/15/2024
# new VCCI eligible members enrolled monthly in care management	49	44	40	27	37	29	31	29	27	41	39	23
Total Open Cases (including newly enrolled - above)	232	241	235	198	207	197	185	177	185	210	219	217
% of VCCI enrolled members with a face to face visit during the month	61.00%	69.36%	63.13%	67.15%	66.50%	67.57%	71.75%	69.75%	69.73%	76.19%	66.21%	58.06%

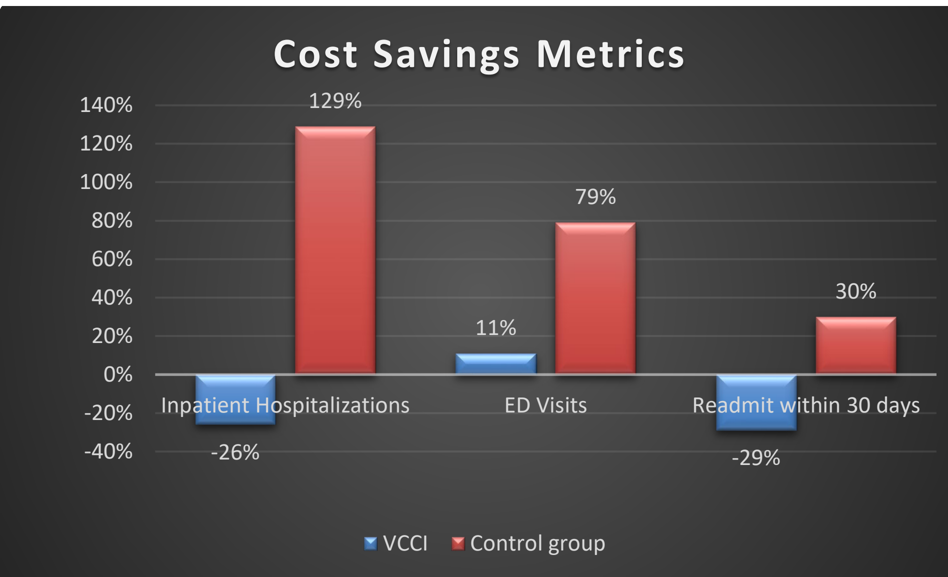
VCCI continued the work started in 2019, of telephonic outreach and social determinants of health screening to beneficiaries new to the health plan. The Medicaid screening tool poses questions related to access to health care and health care-related issues including primary care, dental, housing, transportation, and food, with direct facilitation to those services desired by the beneficiary. The numbers of people new to Medicaid plan were at the highest in the month of August at 517 and lowest in May at 248. constant since January with the lowest (**Figure 2).** The number of members who respond to screening is relatively constant with approximately 45% of all adults New to Medicaid receiving screening.

Figure 2. Number of New to Medicaid Beneficiaries Screened

Updated Dates - month reported	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
received from data unit	2/15/2023	3/15/2023	4/15/2023	5/15/2023	6/15/2023	7/15/2023	8/15/2023	9/15/2023	10/15/2023
Updated Dates - due date	5/15/2023	6/15/2023	7/15/2023	8/15/2023	9/15/2023	10/15/2023	11/15/2023	12/15/2023	1/15/2024
# of new to Medicaid members (Adults 18+)	405	290	365	284	248	315	517	366	511
# of new to Medicaid members reached	84	53	82	60	57	70	112	87	139
# of new to Medicaid members outreach screening attempted				274	236	303	428	328	449
# of new to Medicaid members successfully screened	189	130	159	120	114	146	180	128	191
% of new to Medicaid members screened	46.67%	44.83%	43.56%	42.25%	45.97%	46.35%	34.82%	34.97%	37.38%

Figure 3 displays findings from a cost savings study during the calendar year of 2022. The study compared the number of visits for inpatient admissions, emergency department visits, and hospital readmissions within 30 between those members enrolled in VCCI and a control group of those NOT enrolled in VCCI. The graph below shows that those receiving VCCI services had a decline in inpatient admissions while the control group had a 129% increase in inpatient admissions. Only 11% of VCCI members utilized the emergency room while 79% of control group had emergency room visits in the same time period. Members in the VCCI programs had reductions in readmissions to hospital within 30 days while the control group had a 30% increase. The data speaks to the cost savings when people with complex health and social needs receive intensive case management services from the VCCI team.

Figure 3. Cost Savings Metrics CY22



ii. Mental Health, Substance Use Disorder and Behavioral Health

Key updates from QE122023:

- Inpatient psychiatric placements
- Applied Behavior Analysis

The Clinical Integrity Unit (CIU) is responsible for concurrent review and authorization of inpatient psychiatric and detoxification services for members with Medicaid as a primary insurer. The CIU works closely with inpatient facilities to ensure timely and appropriate discharge plans. The Department of Vermont Health Access (DVHA) collaborates with Agency partners to support the coordination of care. The CIU refers members to VCCI services and helps ensure continuity of care for members already enrolled with VCCI. As of March 1, 2021, Vermont Medicaid modified the reimbursement methodology for inpatient services delivered by a psychiatric facility. Before implementation DVHA & Department of Mental Health (DMH) reimbursed the facility for services using a fee-for-service, per claim basis payment approach. The new model allows for a prospective payment informed by several factors:

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

DVHA, DMH and the facility have agreed upon performance measures and a monitoring platform for the model was built by the DVHA Quality and Clinical Integrity units. Year two reconciliation is projected was completed in April 2023.

The CIU manages the Team Care program. Team Care is a care management program and a federally mandated prescription lock-in program. The program is to prevent misuse, abuse and diversion of medications on the FDA Controlled Substance Schedule such as opioid pain medications and sedatives. Team Care can be a useful tool for members who may need additional support getting the most appropriate healthcare available to meet their needs. A clinical review of all available data supports the continued review of current enrollees' need to remain in the program on an annual basis. The unit conducts annual reviews of claims data, including pharmacy and emergency department visits, to identify members who may benefit from the support of the Team Care program. Clinicians review this data and determine the enrollment of potential new members. Outreach and education with providers and pharmacies is ongoing. There have been minimal external referrals to the program. The lack of referrals may demonstrate the success of the Vermont Prescription Monitoring System (VPMS) and new opioid prescribing standards and practices associated with VPMS.

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

CIU team members participate in the State Interagency Team and the Youth Service System Enhancement Council (a collaborative with ADAP, DMH, VCRIP, Vocation Rehabilitation, DCF, and more). CIU 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 the development of protocols for cross-departmental service delivery. The CIU 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. Additionally, the CIU works within the larger DVHA Clinical Services Team (CST) to develop clinical practice guidelines which are guidance documents to support best practice. There was the development of Depression clinical practice guidelines in 2023.

The CIU manages the Applied Behavior Analysis (ABA) benefit. In 2021, DVHA changed the timing of the ABA tier submissions and payments from prospective submissions and payments to post-service delivery submissions and payments after receiving feedback from providers regarding the difficulty of prospectively determining treatment hours for the subsequent month. An important goal of this program is to increase access to direct services for Medicaid members by giving providers the flexibility to innovate and utilize 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 . The average monthly census has increased since the implementation of the payment model and has held steady during the past four 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 CIU is working with the Payment Reform Unit on a valued based payment project. Beginning with Calendar Year 2023, DVHA's ABA Tiered Payment Model will incorporate provider results on three performance measures into the reconciliation process and calculations. This value-based payment proposal will allow providers to earn up to 10 points and up to 1% of their total earned service level tier payments (the 1% is anticipated to be an added payment for services provided in calendar year 2023 and a withhold thereafter). The measures include, amount of service provided in member months, percentage of total billed hours that are

direct therapeutic service hours and timely claims submissions.

The CIU 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 are receiving quality care, that providers are accurately reimbursed for provided services, to verify that required documentation is included in members' charts and that clinical documentation follows ABA Policy and Clinical Guideline standards.

Clinical documentation reviews 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 . Eighteen site visits were completed in 2023 reviewing the CY22 clinical data.

iii. *Blueprint for Health*

Key updates from QE 12/2023:

- The majority of Vermont's primary care practices are Blueprint-participating Patient-Centered Medical Homes, as 131 of Vermont's estimated 168 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 2023-Q4, the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs was 3,649.
- Vermont continues to provide access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 40 practices and all 7 Planned Parenthood sites to participate in the Women's Health Initiative as of February 2024.
- Act 78 of 2023 provided two years of funding for a pilot project targeted at enhancing health services related to mental health and substance use in Vermont through expansion of the Blueprint for Health's CHTs, including Developmental Understanding and Legal Collaboration for Everyone (DULCE) family specialist program. The final quarter of 2023 saw a large increase in staffing for these new CHT positions. At the end of Q4 CY2023 there were 26.6 FTE hired of a total of 82 FTE funded for the two-year pilot.

Patient-Centered Medical Home Program

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

Patient-Centered Medical Homes in Vermont are supported by multi-disciplinary teams

of dedicated health professionals in each of the state's Health Service Areas (HSAs). These teams, called Community Health Teams (CHTs), provide supplemental services that allow Blueprint-participating primary care practices to focus on promoting prevention, wellness, and coordinated care The CHTs support primary care providers and their patients with case management, care coordination, and screening for mental health needs, substance use, and social determinants of health (SDOH). They discuss and support patient-centered goals while addressing whole-person health with effective interventions that support mental and physical wellbeing. They also provide additional opportunities to support improving chronic conditions.
Blueprint Program Managers provide leadership in each community to coordinate healthcare delivery system improvement efforts. While they are employed by the hospital or FQHC in the Health Service Area, they help organize, lead, and staff collaborative initiatives with the ACO, local human service agencies, health departments, specialty care providers, mental health providers, and primary care providers to facilitate the integration of services. They are responsible for contacting all primary care practices within their HSA to encourage, engage, and support practice participation in the Blueprint and other health system reform activities. Additionally, Program Managers are responsible for administering funds and staffing plans for the local CHTs on behalf of all participating payers, including core CHT, Spoke staff, and WHI staff. Program Managers set up the systems through which integrated services can be delivered in the community.

In addition to Program Managers, the Blueprint supports participating practices with a quality improvement coach, called a Quality Improvement (QI) Facilitator. QI Facilitators support practices with Blueprint-generated all-payer data on practice performance and their own training and expertise in process improvement methodologies. Quality Improvement Facilitators initially help primary care practices to secure National Committee for Quality Assurance (NCQA) PCMH recognition. After the recognition is achieved, the facilitators regularly return to help with quality improvement efforts related to panel management and outreach, care coordination, promotion of individual health and wellness, chronic condition management, and ongoing practice transformation in alignment with State-led health care reform priorities. These priorities include:

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

CY2023 Highlights

Quality Improvement

2023 Patient Experience - Consumer Assessment of Healthcare Providers and Services (CAHPS)

A total of 123 Patient-Centered Medical Homes chose to participate in the Statewide Patient Experience Survey in 2023. Quality Improvement Facilitators supported practices through all stages of this process, from integrating the 2022 survey results into ongoing quality improvement projects related to patient and family experience of care, to providing

valuable feedback from participating practices in previous years, to supporting practices with submission of required files. QI feedback led to Central Office creation of promotional posters for use in patient waiting and exam rooms, social media posts, and newsletter templates into Spanish and French for use at the practices. Facilitators also supported some practices to resolve HIPPA related issues and help to identify how to put systems and processes in place for future prevention of any issues.

Patient-Centered Medical Home (PCMH) Recognition
Quality Improvement Facilitators offer practice facilitation support to all practices participating in the PCMH Blueprint for Health Initiative, ranging from coaching and consultation to PCMH content expertise, to in depth QI assistance with establishing requirements and providing evidence to the National Committee on Quality Assurance (NCQA). Facilitators worked with each practice for the 6-12+ months prior to their PCMH Recognition deadline to prepare for transformation or annual reporting as a PCMH. In 2023, considerable focus was given to preparing practices to meet the mandatory EMR requirement, to prepare for the 2024 requirement for submission of standardized measure reporting, to understand and integrate the updated standards related to collection of demographic information and care planning requirements, to complete a comprehensive gap analysis of all core standards, and/or prepare for annual reporting submission.

By the numbers:
- 1 Vermont practice was newly engaged, but not yet recognized, from Vermont between Jan 1 – December 31, 2023
- 3 Vermont practices completed a (new/accelerated/corporate credit) transformation between Jan 1 – December 31, 2023
- 128 Vermont practices sustained their PCMH recognition in 2023.
- 5 Vermont practices lost their PCMH recognition in 2023 due to acquisition, merger, closure, or failure to submit annual reporting requirements in 2023.
- 5 Vermont practices were selected for audit by NCQA in 2023

Community Health Team (CHT) Expansion

Quality Improvement Facilitators supported the Community Health Team Expansion Pilot by:
- Providing valuable input into program design and evaluation and measurement activities, specifically providing insight into the PCMH standards, practice landscape, and other overlapping quality initiatives and programs.
- Assisting with dissemination of information and educating practices about the CHT expansion pilot.
- Assisting practices with self-assessment of needs and readiness
- Assisted with implementation planning.
- Completed chart review with practices for pilot evaluation and data to support QI/implementation areas of focus.
- Met with participating pilot practices on at least a monthly basis to establish and work towards 1-2 implementation and or quality improvement goals.

Practice Continuous Quality Improvement Support

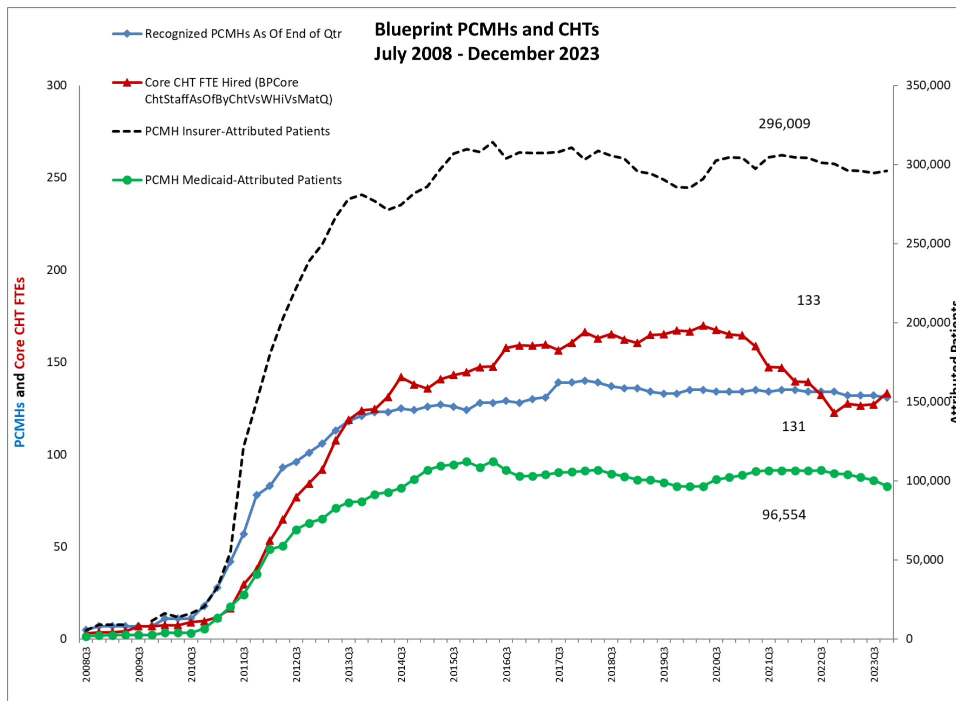
Blueprint for Health Quality improvement facilitators provided varying levels of continuous quality improvement support to the practices in their assigned geographic areas, dependent on the needs of the organization and the various quality initiatives and programs in which they participated in 2023. QI support focused on increasing practice capacity (e.g., Creating infrastructure for continuous improvement, building skills in leadership and QI teams that support continuous improvement), direct support (e.g. Quality meeting facilitation, managing quality improvement/change projects, organizational assessment, optimizing health IT for performance monitoring and population management), coordinating quality opportunities (e.g. ACO, suicide grants, Immunization QI projects, VCHIP Champ projects), and

supporting implementation of targeted changes and improvements by identifying and sharing exemplary practices.

Community Quality Improvement Projects

Quality Improvement Facilitators worked with community groups, in much the same way that they have traditionally worked with practices. The quality improvement processes and tools are the same, but the objective is community-wide improvement on priorities the community has identified through its Community Health Needs Assessment process or that are All-Payer Model or ACO objectives. Rather than practice teams, Facilitators work with area Community Collaboratives/Accountable Communities for Health or their workgroups, to realize community-wide improvements. Focus areas varied across the state, reflective of the needs identified as part of the Community Health Needs Assessment and other means of prioritizing the health and social needs of a local population. Projects supported by QI facilitators ranged from follow-after hospitalization to referral pathways for early intervention, to chronic condition management, to support for housing needs, to addressing substance use and overdose deaths.

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



Community Health Profiles

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

Hospital Service Area (HSA) community profiles are posted at. http://blueprintforhealth.vermont.gov/community-health-profiles.
The Blueprint Annual Report to the Vermont Legislature reviews more in-depth how the Program Managers, Quality Improvement Facilitators, Patient Centered Medical Homes,

Community Health Teams interact to provide services, coordinate care across communities, and work with the state's accountable care organization. The latest report is available at: https://blueprintforhealth.vermont.gov/annual-reports

Hub & Spoke Program

Hub & Spoke is Vermont's system of medication for opioid use disorder (MOUD) supporting people in recovery from opioid use disorder (OUD). The Department of Health and the Blueprint for Health have been longstanding partners to support Vermont's Hub and Spoke providers, partners, and provider leaders together to share expertise and continue to improve the quality of care in the system. The State Plan Amendment for the Vermont Medicaid Program, approved by the Centers for Medicare and Medicaid Services, established a Health Home for Vermonters with opioid use disorder. As of July 1, 2013, Medicaid beneficiaries receiving medication-assisted treatment for opioid use disorder in a Hub or Spoke setting were eligible to receive enhanced services, such as comprehensive care management, care coordination, comprehensive transitional care, health promotion, individual and family support, and referral to community and social support services. The Health Home functions to enhance Hub programming and embeds essential support staff.

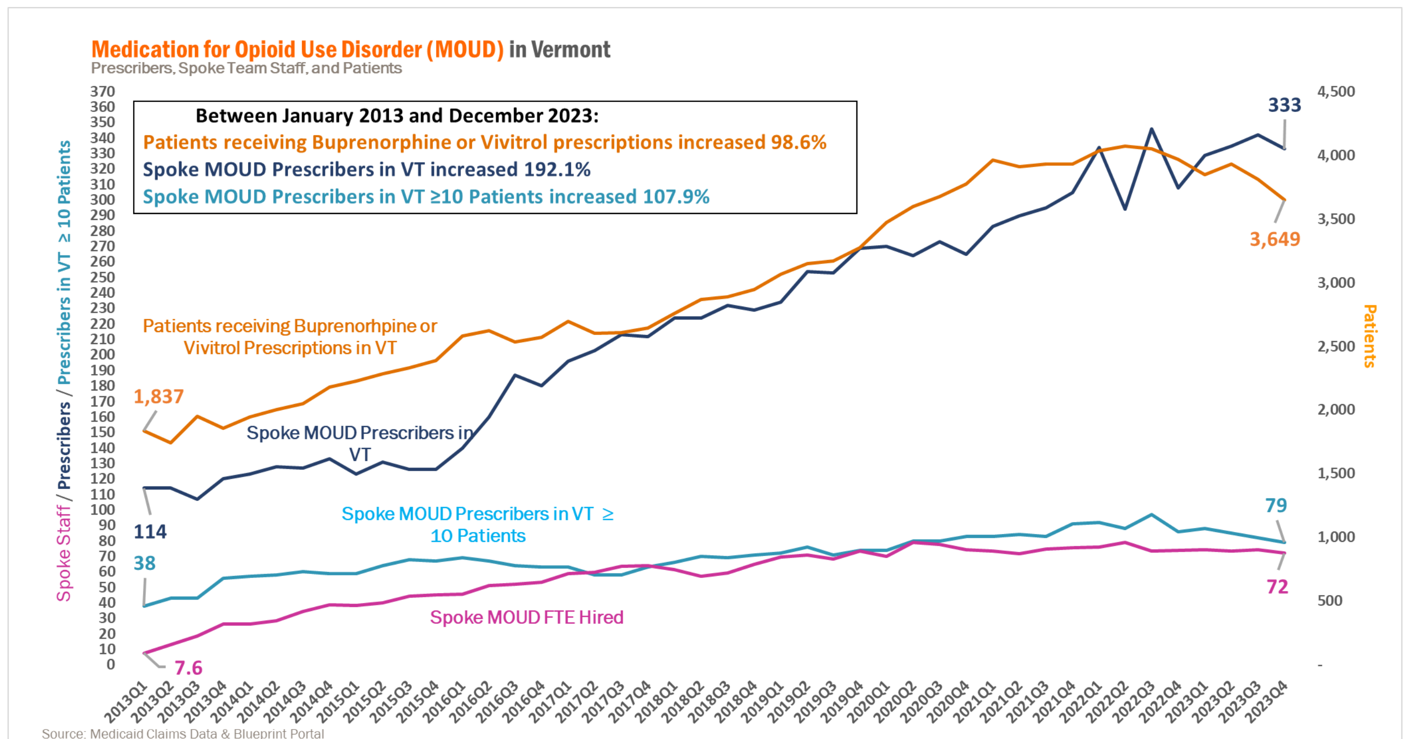
The Blueprint administers the Spoke part of the Hub & Spoke system of care, while the Department of Health administers the Hubs. For every 100 Medicaid patients that are prescribed buprenorphine or vivitrol, the Blueprint supports communities to hire a full-time nurse and mental health clinician to embed in the practices and support Vermonters. Vermont continues to demonstrate substantial access to MOUD by funding registered nurses and licensed, Master's-prepared, mental health/substance use disorder clinicians as a team. These Spoke teams offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder. The Blueprint continues to encourage the use of VT Help link, a free and confidential referral service available to connect people to resources and treatment (802-565-LINK or Vermont Help Link).

The Blueprint contracted with the Center for Technology and Behavioral Health at Dartmouth College for Medication Assisted Treatment Learning Collaboratives provided to the Hub & Spoke Opioid Use Disorder care network. The curriculum, delivered from January through June 2023, included six virtual monthly events. Three webinars featured national presenters and three virtual workshops featured Vermont-based content experts and sessions alternated between didactic care management webinars and multidisciplinary care management workshops. An average of 49 OUD care specialist nurses or mental health clinicians attended each event.

Q4 Highlights

Vermont continues to demonstrate substantial access to MOUD and health home services for Vermonters with OUD. MOUD is being offered across the State of Vermont by more than 78 different Spoke settings (as of December 2023). The capacity to serve Vermonters is evidenced by a monthly average of 3,649 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs. There are 333 medical doctors, nurse practitioners, and physician assistants who work with 72 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 .

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



<u>Women's Health Initiative</u>

The Women's Health Initiative (WHI) has strived to support people who can become pregnant in their efforts to experience healthy pregnancies, avoid unintended pregnancies, and build thriving families. This year the Women's Health Initiative program changed its name to the Pregnancy Intention Initiative (PII) to focus on being more inclusive for transgender and non-binary patients. The Blueprint surveyed the field and held focus groups to gather input on the name change.

The PII provides mental health staffing at specialty practices and utilizes the existing CHT at participating Blueprint PCMH practices. Practices attest to support the goals of PII. People with a desire to become pregnant or prevent pregnancy can receive services to support decision making. If an individual would like to prevent pregnancy, providers conduct comprehensive family planning counseling and provide patients with options for most and moderately effective contraception, which could include access to same-day long-acting reversible contraceptives (LARC) if clinically indicated. If a person would like to become pregnant, they receive support for a healthy pregnancy. The practice screens for social determinants of health such as food security, housing security, interpersonal violence, depression, anxiety, harm to self or others, mental health issues, and substance use. Positive screens are addressed with brief interventions and treatment by the embedded PII mental health clinician if indicated. These clinicians also communicate programmatic information to community partners to build meaningful relationships, support patients more closely, and create seamless transitions of care when referral is necessary.

In 2023, the Blueprint reinstated quarterly in-person hands-on trainings to support the PII network of providers in contraceptive care. In collaboration with the University of Vermont, Dr. Lauren MacAfee trained more than 50 providers this year from Blueprint PII sites in LARC insertion and best practices around patient choice of contraception in the past year. The community providers requested further training and support for individuals who want to increase comfortability and knowledge in gender-affirming care. In January, the Area Health Education Centers and University of Vermont Project Echo began supporting the network and provided six monthly training courses for clinicians in

gender-affirming care.

Q4 Highlights

Figure 3 below shows PII enrollment and staffing over time. By the end of 2023, the number of practices enrolled was 40, comprising of 18 women's specialty health care sites and 22 PCMHs.

Figure 3. Pregnancy Intention Initiative: Practices, Patients, and Community Health Team (CHT) Staffing

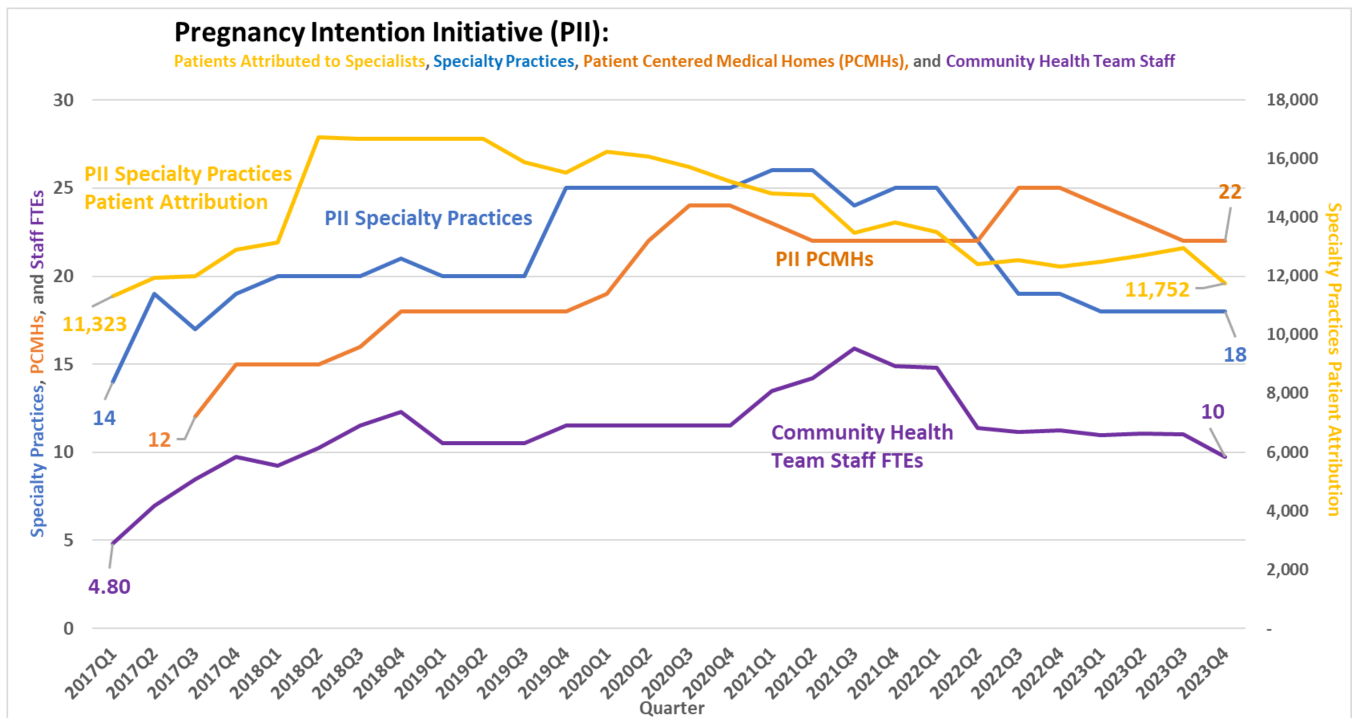


Table 4. Pregnancy Intention Initiative by Region

Health Service Area / Team	PII Specialist Practices as of Q4 2023	PII PCMH Practices as of Q4 2023	PII CHT Staff FTE Hired as of Q4 2023	PII Specialist Quarterly Attributed* Medicaid Beneficiaries as of Q4 2023	WHI PCMH Quarterly Attributed* Medicaid Beneficiaries as of Q4 2023
Barre	1	0	0.75	634	0
Bennington	1	0	1	974	0
Brattleboro	1	0	.5	875	0
Burlington	2	9	1.2	2,266	4383
Middlebury	1	0	0.75	819	0
Morrisville	1	3	0.50	337	1196
Newport	1	0	1	949	0
Randolph	1	0	0.50	143	0
Rutland	1	0	1	1,104	0
Springfield	0	5	0	0	1555
St. Albans	0	0	0.00	0	0
St. Johnsbury	1	2	0.75	881	569
Windsor	0	3	0.00	0	90
Planned Parenthood (Statewide)	7	0	1.8	2,770	0
Total	18	22	9.75	11,752	7793

*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.

iv. Pharmacy Program

Key updates from CY2023

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

- Clinical Activities
  1. Management of Biosimilar Drugs
  2. Hepatitis C Prior Authorization Form/Criteria Updates
  3. Prior Authorization Removal and Updates to Medications for Opioid Use Disorder
  4. Hypertension Performance Improvement Project (PIP)
  5. High-Cost Drugs
  6. Pharmacy Cost Management (PCM) Program

Pharmacy Benefit Management Program

The DVHA's Pharmacy Unit oversees the pharmacy benefit implementation 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. 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. DVHA utilizes the Pharmacy Benefit Management company, Change Healthcare (CHC), to administer the program. This partnership provides a full complement of operational, clinical, and programmatic support in addition to managing a call center for pharmacies and prescribers. The Pharmacy Unit is also responsible for overseeing the contractual agreement with CHC, manages and reports on approximately $299 million in gross drug spend annually (SFY2023), analyzes national and Vermont Medicaid drug trends, and reviews drug utilization. A primary goal of the Pharmacy Unit is to seek innovative solutions to deliver high-quality customer service, while assuring optimal drug therapy for Vermont Medicaid members and 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.
- ☐ Coordination of multiple benefit programs – The Pharmacy Unit interfaces with the Coordination of Benefits Unit, the Medicare Part D Plan Team, the Eligibility Unit, and the Member Call Center. These interactions lead to increased member assistance and resolution for member problems.
- ☐ The Pharmacy Unit serves as a liaison to Vermont Department of Health (VDH) in multiple clinical areas including; vaccines, asthma, and smoking cessation. In addition, there is communication with the Division of Substance Use Program and the Department of Mental Health (DMH) related to the management of psychotherapeutic drug use in children. The Pharmacy Unit also works with Vermont Medication Assistance Program (VMAP) and

Children with Special Health Needs (CSHN) program to assist in the drug and rebate management of the programs.

- □ Managing various clinical activities including drug utilization and cost:
  - o Federal, State, Supplemental rebate programs
  - o Preferred Drug List management
  - o Prior authorization and utilization management programs
  - o Drug Utilization Review Board activities: therapeutic class reviews, new drug reviews, prior authorization criteria review, and step-therapy protocols.
  - o Specialty pharmacy management, including enrollment and monitoring.
  - o Physician-administered drug management
- □ Manages exception requests, Early and Periodic Screening, Diagnostic and Treatment EPSDT benefit requests, appeals, and fair hearings with the Policy Unit.
- □ Works with Special Investigation Unit (SIU)on drug utilization issues related to fraud, waste, and abuse.

Operational Activity Reports

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

	No PA	Automated Edits						
Period	**Claims Paid w/o PA**	**Claims Paid w/Auto PA**	****Claims Paid with Auto Edit**	**Claims Paid w/Online Override**	**Claims Paid w/Emergency PA**	**Claims Paid due to Grandfathering**	**Claims Paid w/Clinical PA**	**Total Claim Count**
Quarter 4	443,607	64	19,995	164	17	5,388	9,044	478,279
	93%	<1%	4%	<1%	<1%	1%	2%	100%
Quarter 3	454,918	67	19,787	201	87	6,242	15,519	496,821
	92%	<1%	4%	<1%	<1%	1%	3%	100%
Quarter 2	504,934	76	20,752	209	111	6,753	16,241	549,076
	92%	<1%	4%	<1%	<1%	1%	3%	100%
Quarter 1	510,392	90	21,366	245	106	7,724	16,171	556,094
	92%	<1%	4%	<1%	<1%	1%	3%	100%

- Total claim count does not include compounded drugs.

Paid Claims and Drug Spend

MEDICAID

	#Claims	# Of Members	State Paid Amounts
4Q2023	445,069	74,129	$69,274,916.86
3Q2023	449,572	78,868	$72,943,219.31
2Q2023	497,307	86,682	$77,657,154.77
1Q2023	502,093	86,585	$75,372,873.84

VPHARM

	#Claims	# Of Members	State Paid Amounts
4Q2023	57,108	6,325	$1,136,219.68
3Q2023	60,278	6,587	$1,225,510.29
2Q2023	66,327	6,724	$1,363,657.54
1Q2023	68,177	6,853	$1,957,846.70

Provider Communication

CYQ4 Communications	
POS System Outage Resolved	Change Healthcare POS system outage has been resolved. Pharmacy claims may be re-processed. We apologize for any inconvenience this has caused.
Important Notice: Point of Sale (POS) Temporary Outage	Change Healthcare is currently experiencing an unplanned POS system outage. Pharmacy claims will not be adjudicated during this time.
Preferred Drug List (PDL) Changes	Changes to the PDL, effective January 1, 2024, were sent out to providers in December 2023.
Reminder: Vermont Medicaid Billing with Primary Commercial Insurance	Pharmacies are required to bill and follow the primary insurance coverage rules before billing Vermont Medicaid as the secondary payer.
Important Coverage Changes to Prescription Biosimilar Drugs	Effective 1/1/24, Vermont Medicaid made changes to the physician fee schedule and Hospital Based Outpatient Services (OPPS) fee schedule. Rituximab: Riabni™ (rituximab-arrx) Q5123 will be moving to non-preferred. Ruxience® (rituximab-pvvr) Q5119 and Truxima® (rituximab-abbs) Q5115 will remain preferred with no prior authorization required. Trastuzumab: Herceptin® (trastuzumab) J9355, Ontruzant® (trastuzumab-dttb) Q5112, and Ogivri® (trastuzumab-dkst) Q5114 will be moving to non-preferred. Herzuma® (trastuzumab-pkrb) Q5113 will be preferred. Kanjinti® (trastuzumab-anns) Q5117 and Trazimera™ (trastuzumab-qyyp) Q5116 will remain preferred with no prior authorization required.
COVID-19 Vaccine Coverage for Members Ages 3 and Older	Effective November 10, 2023, The Department of Vermont Health Access will reimburse pharmacies for the cost of the COVID-19 vaccine and its administration in accordance with the Public Readiness and Emergency Preparedness Act (PREP Act). The PREP Act authorizes pharmacists, pharmacy interns, and pharmacy technicians to administer COVID-19 vaccinations to children ages 3 years and older. COVID-19

	vaccines are available for Medicaid members under the age of 19 through the Vaccines for Children Program (VFC).
Changes to Coverage for Flovent® HFA and Flovent Diskus®	Change Healthcare was notified by GlaxoSmithKline that Flovent® Diskus (fluticasone propionate powder) and Flovent® HFA (fluticasone propionate inhalation aerosol) will be discontinued, effective 12/31/23. The following are preferred alternatives for Vermont Medicaid, available without prior authorization: • ARNUITYTM ELLIPTA® (fluticasone furoate) • ASMANEX® (mometasone furoate) • PULMICORT FLEXHALER® (budesonide) • QVAR REDIHALER® (beclomethasone dipropionate)
Changes to Coverage for Ciprodex® Otic Suspension	Change Healthcare was notified by Novartis that brand Ciprodex® Otic suspension (ciprofloxacin 0.3%/dexamethasone 0.1%) has been removed from the market. Pharmacies may continue to dispense until the available supply has been exhausted. The following are preferred alternatives for Vermont Medicaid, available without prior authorization: • Ofloxacin 0.3% Otic Solution • Neomycin/Polymixin B Sulfate/Hydrocortisone Solution • Neomycin/Polymixin B Sulfate/Hydrocortisone Suspension
Covid-19 Communications	Effective 10/5/23, The Department of Vermont Health Access (DVHA) is updating the administration fee for the 2023-2024 commercial COVID-19 vaccines to $40.00, to align with Medicare reimbursement. This change will be retroactive to 9/11/2023.
CYQ1-CYQ3 **Communications**	• Updates to Buprenorphine Prior Authorization Requirements - 09.21.23 • Covid-19 Vaccinations 2023/2024 Season for Adults and Children - 9.22.23 • Covid-19 Vaccinations 2023/2024 Season for Adults 9.21.23 • Reminder: Vermont Medicaid Billing with Primary Commercial Insurance 9.18.23 • Auto Refill Language added to Pharmacy Provider Manual - 9.18.23 • Pharmacy Billing for Blood Pressure Monitors - 9.18.23 • Influenza (Flu) 2023_2024 Season - 8.18.23 • Pharmacy Newsletter - 8.9.23 • SCC13 Extension Due to Flooding - 8.9.23 • Changes to Incontinence Supplies for Medicaid - Effective 8.15.23 • Changes to Administration Fee for Vaccines - 7.28.23 • Important information for Medicaid Beneficiaries Extension - 7.25.23 • Important Information for Medicaid Beneficiaries - 7.14.23 • Over the Counter (OTC) Coverage Changes - Effective 8.1.23 • Important Vermont Medicaid Fraud, Waste, and Abuse (FWA) - 5.26.23 • Prescription Signature Requirements - 04.11.23 • Early Refill Overrides with Submission Clarification Code (SCC) 13 - Effective 4.3.23 • Point of Sale (POS) Blackout Period Wednesday 3/29/23 - 3.21.23 • Pharmacy Newsletter March 2023 • 5% Copay Cap - Effective 4.1.23

	• 5% Copay Cap PowerPoint and GCR Proposed Policy: Limitations on Cost-Sharing for Vermont Medicaid Members • Important Changes to Administration Fee for Vaccines - Effective 3.15.23 • Pharmacy Benefit Provider Satisfactory Survey for Prescribers and Pharmacies - 02.27.23 • Updates to Buprenorphine Prior Authorization Form - 2.14.23 • Update on Synagis® (palivizumab) Dispensing - 2.13.23 • Preferred Albuterol Sulfate Inhaler Availability - 1.27.23 • Differin Coverage Changes - Effective 1.1.23 • Change to Medicaid Copay - Effective 2.1.23 • Important Information on Reimbursement for High-Investment Carve-Out Drugs 01.05.23

Clinical Activities

Management of Biosimilar Drugs: The Pharmacy Unit continually monitors and adjusts utilization controls on biosimilar drugs that are reimbursed in the pharmacy and medical benefit billing programs. With an increase in biosimilar drug production, the appropriate management of these products can result in reduced costs to the Vermont Medicaid program. Any changes implemented to biosimilar drugs are reported on Vermont's Preferred Drug List or posted fee schedules, with proper notification and outreach to providers well beforehand.

Hepatitis C Prior Authorization Form/Criteria Updates: The Pharmacy Unit implemented a full therapeutic review, complimented by provider and professional organization interviews, related to available treatments for hepatitis C and utilization management controls. After meeting with local providers, the prior authorization form for these treatments was updated to reflect guideline updates, with a focus on reduced provider burden. At the end of 2023, an updated form was created that guides providers to simplified treatment algorithms and allows for attestation of most prerequisite laboratory values.

Prior Authorization Removal and Updates to Medications for Opioid Use Disorder: Effective 10/06/2023, the maximum daily dose for buprenorphine/naloxone tablets and Suboxone® (buprenorphine/naloxone) films were changed from 16 mg to 24 mg per day. Quantity limits were modified accordingly. The Division of Substance Use at the Vermont Department of Health continues to support the focus on safety when prescribing buprenorphine. Both ASAM and DVHA Guidelines recommend monitoring for medication diversion and the appropriateness of continued treatment. Effective 10/6/23, DVHA made changes to both extended-release injectable formulations of buprenorphine, making them more accessible to providers and patients. These products are associated with a lower diversion risk. Sublocade was moved to preferred and Brixadi was added as a preferred agent. Sublocade will be limited to 1 injection per 28 days. Brixadi, weekly formulation, will be limited to 1 injection per week (max of 4 injections per 28 days) and Brixandi, monthly formulation, will be limited to 1 injection per 28 days.

Hypertension Performance Improvement Project (PIP): This project was implemented with the goal to expand access to blood pressure monitors for Vermont Medicaid members. Those with high blood pressure are more likely to get their pressures under control if they record the values at home and share the results with providers (self-monitored blood pressure). Close monitoring of a member's blood pressure will allow faster

medical intervention and may reduce medications utilized and doctor or emergency department visits.

The Vermont Medicaid Pharmacy program began covering blood pressure monitors obtained through pharmacy providers, effective 09/22/2023. Pharmacists will be able to order and dispense blood pressure monitors to Medicaid members, when medically necessary.

High-Cost Drugs: The Department of Vermont Health Access (DVHA) changed how it pays for certain high-cost carve-out inpatient drugs, in accordance to the proposed Global Commitment Register GCR 22-002. This change was made to ensure that providers are being paid their actual cost for the drug and to allow the State to take advantage of available federal rebates.

As of January 1, 2023, hospitals are required to separate a high-cost drug from the inpatient claim. The inpatient claim will pay using the standard Diagnosis-Related Group (DRG) methodology minus the carved out high-cost drug. Prior Authorization will be required for the drug and inpatient stay. Along with billing the high-cost drug on CMS 1500 claim form, the provider will be required to submit the invoice for the drug. Along with billing these drugs cannot be acquired through the 340B program and reimbursement will be paid at the actual acquisition cost.

Pharmacy Cost Management (PCM) Program:

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

The PCM pharmacist provides direct outreach to prescribers and pharmacies to discuss the goals of therapy as well as the appropriateness of the drug, dose, and duration of therapy, and follow-up. The pharmacist works directly with prescribers to choose the most cost-effective treatment regimens for each patient with consideration of age, gender, co-morbidities, and when pertinent, biological, and genetic markers. In addition, they communicate directly with pharmacies to ensure that the medications are dispensed to the patients at the correct times and are billed appropriately. Prescribers are notified when a patient demonstrates poor adherence.

In CY 2023, the PCM program enrolled an additional 541 members for a total of 3,723 members on 188 covered medications throughout the program. A total of 763 outgoing telephone calls were placed to members, 315 of which resulted in member counseling. During this CY of the Vermont PCM program, sixteen interventions led to direct and measurable cost avoidance. Furthermore, interventions that do not bring about direct cost avoidance are in place to encourage adherence and thus improve member outcomes and avoid unnecessary medical costs. Through interventions in the PCM program, unnecessary drug spends of $979,364avoided in CY2023. More than $5.9 million in unnecessary drug spend has been avoided throughout the program.

v. Choices for Care and Traumatic Brain Injury Programs

Key updates from YE122023:

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

Summary of Individuals served through CFC and BIP in SFY2023:

Choices for Care (CFC)	**SFY 2023**
Unique People Served by CFC	**6674**
High/Highest	**5715**
Moderate Needs	**1095**
Money Follows the Person	**50**
HCBS High/Highest	
Total Unique People Served	**2883**
Percentage of High/Highest CFC	**50%**
ERC	
Total Unique People Served	**762**
Percentage of High/Highest CFC	**18%**
Nursing Facility High/Highest	
Total Unique People	**2694**
Percentage of High/Highest CFC	**37%**
Brain Injury Program (BIP)	**SFY 2022**
Total Unique People Served	**89**

Brain Injury Program:

On 12/31/2023 there were 42 individuals enrolled in the Long-Term Program had 42 individuals enrolled in the Rehab Program

DAIL administered a survey of providers and participants to determine if BIP participants have access to employment or volunteer supports. Results indicate that employment services and support available to all participants who have identified employment goals as part of their person-centered care plan.

- 30% of the consumers are currently employed.
- 86% of the consumers report their agency supports them in finding employment.
- 100% of providers reported that employment services are available to BIP participants.
- The survey of both providers and consumers confirmed that participants in the Brain Injury Program have access to

employment and volunteer support services.

The BIP program had 26 applications, 2 graduations, 1 transfer to CFC.

18 individuals were clinically approved, but not served by an agency due to workforce capacity. DAIL has established a waitlist process for the Brain Injury Program and works closely with the Brain Injury Alliance of Vermont Neuro Resource Facilitation staff to connect individuals on the waitlist to other available programs and services.

Choices for Care:

Money follows the Person Grant:

In 2023 the Money Follows the Person Grant

Transitioned 50 participants.

For CY2023 Vermont requested funds to support approximately 62 Choices for Care (CFC) participants transitioning from a skilled nursing facility.

In August 2021, MFP received notice of the award of a $5million Capacity Building Supplemental Grant. The money was awarded to support the following CMS-approved demonstration activities in 2023, MFP managed contracts for the following:

- Increased mental health support for CFC participants and their family caregivers.
- Scholarship mentorship support to Direct Services Workers
- Increasing volunteer capacity and training for Area Agencies on Aging
- Piloting the use of Neuro Resource Facilitation to better identify CFC and MFP participants with brain injury.
- Expanding funding for home modifications to support individuals seeking to remain in community settings of their choice.
- Piloting the CAPABLE program for falls prevention
- Increasing the use of AT to promote independence for CFC and MFP participants.
- The supplemental grant runs through September 2025
- 2 Contracts were implemented with hospitals to improve hospital discharge planning protocols and processes for discharging individuals will complex care needs who have been unable to discharge despite no longer needing acute care. This initiative will begin in May 2023.

Choices for Care Regulations

In 2023, DAIL continues to engage with stakeholders to pilot an acuity-based screening tool for use when a waitlist is required for the Moderate Need Program. Piloting of the screening tool was initiated on 11/2020, with statewide implementation delayed until 2025.

Adult Day Services

Adult Day Centers provided services to 325 individuals, which is 38% below pre-pandemic rates. Several centers have not reopened. DAIL continues to work with community partners in underserved areas to develop new Adult Day Programs. DAIL implemented an increased rate for Adult Day Services in July 2023. Adult Day Providers continue to express that the barriers to full census include workforce shortage and challenges with transportation of participants to and from the centers.

Quality Management Unit

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

Wait Lists

There is currently no wait list for the High Needs Group. There continues to be provider wait lists for Moderate Needs Group, estimated at over 700 people statewide. Workforce shortage continues to be the main driver for the waitlist. The Brain Injury Program had a waitlist of 19 individuals. Provider capacity to enroll new BIP participants is main driver of the waitlist.

vii. Developmental Disabilities Services Division (DDSD)

Conflict of Interest and Payment Reform: Developmental Disabilities Home and Community Services (DD HCBS)

DDSD continues its work with the Department of Vermont Health Access (DVHA) to meet compliance regarding the State's Conflict of Interest Corrective Action Plan. Through this partnership, a recommendation to separate case management functions from the DD HCBS Agencies (Designated Agencies and Specialized Service Agencies) and solicit statewide contracts for Case Management Entities through the State of Vermont procurement process (Request for Proposal/RFP) was made DDSD continues to refine roles and responsibilities in the future state for the Division, the Case Manager/Case Manager Entity and the DD HCBS Agency.

In conjunction with the work being done around Conflict of Interest, DDSD continues its Payment Reform initiative. *Please see previous report submission for prior highlights regarding DDS Payment Reform.* Based on analysis performed on completed Supports Intensity Scale-Adult (SIS-A) assessments, the Division has developed a 6-level framework to determine needs once the full transition to the SIS-A is complete. This framework has been validated against the needs assessed by the Vermont's Developmental Disabilities Services Needs Assessment and the framework was found to be comparable. This knowledge allows DDSD to move to the next phase of Payment Reform, assigning budgets to the 6-Level Framework.

An additional piece necessary to move forward with Payment Reform is a Provider Rate Study. This work, which involves gathering significant information from Designated Agencies and Specialized Service Agencies regarding the rates currently used related to services provided will help to inform appropriate rate setting moving forward in a standardized approach. The data will be collected by the end of Calendar Year 2023 and the information will be analyzed in early 2024.

Proposed Caregiver Protocol: Payment for Services for Legally Responsible Individuals

Following the Appendix K authorities, which allowed DDSD a temporary measure to provide Legally Responsible Individuals payment, the Division has undertaken work to draft a caregiver protocol for a permanent policy. This work has included significant stakeholder input—engagement sessions with self-advocates, parents, and direct service providers. The draft policy was submitted to CMS at the end of Calendar Year 2023 for initial feedback. The Division is hopeful to have a subsequent draft of this policy available effective by Spring 2024.

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

Key updates from QE122023:

- Executed a contract extension with OneCare Vermont for a 2024 performance year of the program.
- Implemented a Global Payment Program (GPP) pilot as a complementary payment model to the VMNG program.
- Continue to support Vermont's broader efforts to develop an integrated healthcare delivery system under an All-Payer Model through future program planning and implementation.

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

DVHA and OneCare entered into an agreement for the 2017 performance year as a pilot year with four possible one-year extensions to the program. Four risk-bearing hospital communities participated in the *Vermont Medicaid Next Generation* (VMNG) model for the pilot year: the University of Vermont Medicaid Center, Central Vermont Medical Center, Northwestern Medical Center, and Porter Hospital, with additional participation from FQHCs, independent practices, home health providers, Designated Agencies, and skilled nursing agencies in the four communities. 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 issues a prospective Per-Member-Per-Month (PMPM) payment to the ACO; the ACO distributes payments to providers participating in the program per contractual arrangements between the ACO and providers. The ACO is paid for each attributed beneficiary according to their Medicaid Eligibility Group, and the ACO is accountable for the cost and quality of care of each attributed beneficiary. Payments for services not included in the ACO contract continue to be paid fee-for-service, as are payments made to Medicaid providers not participating in the ACO's network.

DVHA and OneCare executed a contract amendment for a 2024 performance year of the VMNG program in Q4 of 2023. This amendment included a new, voluntary, complementary payment model (the Global Payment Program, or GPP) to issue separate "global" monthly prospective payments to current hospital and independent primary care participants in the VMNG ACO program. These prospective payments are for Vermont Medicaid members who are not attributed to the VMNG ACO program for Total Cost of Care-related services at participating hospital and independent physician practice participants, and this payment model is reconciled to actual fee-for-service experience separately and distinctly from the prospective payments issued to OneCare Vermont for VMNG ACO-attributed members. Independent physician practices began participating in the GPP at the beginning of Q1 2024, and it is anticipated that

hospitals who opt into the program will begin participating at the beginning of Q3 2024. This approach begins to separate the provider payment methodology from an attribution methodology and is an incremental step toward a more global, budget-based payment model, as Vermont looks forward to the next iteration of an All-Payer Model agreement through potential future participation in the federal AHEAD model. Other programmatic changes to the model were minor, to ensure program stability and. continued alignment across payer programs as part of the Vermont All-Payer ACO Model. Changes included increasing the risk corridor to ±3% and combining the traditional and expanded attribution cohorts for the purposes of financial reconciliation.

The VMNG program saw provider participation remain consistent between the 2023 and 2024 performance years, which indicates that the program may have reached scale in the state. The number of risk-bearing hospital communities remained constant at fourteen for the 2024 performance year. The number of attributed lives for the 2024 performance year decreased from 142,101 (105,101 through the traditional attribution methodology and 37,000 through the expanded attribution methodology) to 116,088 across both cohorts, partially driven by the resumption of redetermination activities in 2023 and a decrease in the total number of eligible Medicaid members in the state overall.

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

vii. *Global Commitment Register*

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

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

Health care policy stakeholders are notified via email every time a proposed or final policy is posted to the GCR; an email is also sent when policy clarifications are posted. Stakeholders have an opportunity to provide comments on proposed GCR policies before the policies are made final.

Comments received are posted in the GCR online. The GCR emails are also distributed to members of the Medicaid and Exchange Advisory Committee.

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

VI. Utilization Management

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

i. Clinical Utilization Review Board

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

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

The CURB has the following duties and responsibilities:

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

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

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

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

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

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

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

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

Telemedicine and Remote Patient Monitoring

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

Telemedicine Utilization

Data show that telemedicine utilization peaked in April 2020. Since then, telemedicine utilization has decreased, and in-person visits have increased (Appendix II). This includes telemedicine provided via audio and visual connection as well as audio-only telemedicine. The Board reviewed data and offered the following:

- Recommended empowering providers to use clinical judgement to determine best use of audio-only telemedicine services;
- Encouraged the Department to develop exclusionary (versus inclusionary) guidelines for audio-only services; and
- Endorsed audio-only monitoring for chronic conditions.

ii. Drug Utilization Review Board

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

- review and approve drug use criteria and standards for both retrospective and prospective drug use reviews.
- apply these criteria and standards in the application of DURB activities.
- review and report the results of DUR programs; and
- recommend and evaluate educational intervention programs.

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

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

The chart below lists some of the state fiscal year 2023 activities of the Drug Utilization Review Board.

Drug Utilization Review Board Activities in 2023

Review Topic	SFY2023 Total
Therapeutic Drug Classes: Periodic Review	49
Full New Drug Reviews	45
FDA Safety Alerts	3
New/Updated Clinical Guidelines	26
RetroDUR/ ProDUR reviews	6
New Managed Therapeutic Drug Classes	1
BioSimilar Drug Reviews	2

Drug Utilization Review Board (DURB) Meetings

Drug Utilization Review Board meetings occur seven times per year and always have a robust agenda. Information on the DURB and its activities in 2022/2023 is available at this link: https://dvha.vermont.gov/advisory-boards/drug- utilization-review-board

The sample agenda typically follows this format.

.DURB Board Meeting Agenda

- Executive Session
- Introductions and Approval of DUR Board Minutes (Public Comment Prior to Board Action)
- Chief Medical Officer Updates
- Follow-up Items from Previous Meetings RetroDUR/ProDUR
- Clinical Update: Drug Reviews 7:10-7:45 (Public comment prior to Board action)
- Biosimilar Drug Reviews
- Full New Drug Reviews
- (Any new drug reviews that also fall within the Therapeutic Class Review (TCR) will be discussed during the Therapeutic Class Review)
- New Managed Therapeutic Drug Classes (Public comment prior to Board action)
- Therapeutic Drug Classes – Periodic Review (Public comment prior to Board action)
- Review of Newly Developed/Revised Criteria (Public comment prior to Board action)
- General Announcements

iii. Appropriateness of Services

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

iv. Vermont Integrity Program

Special Investigations Unit

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

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

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

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

SIU works to establish and maintain the integrity of the Medicaid program by engaging in activities to prevent, detect and investigate Medicaid provider fraud, waste, and abuse. SIU receives referrals from a variety of sources and uses data mining and analytics to investigate allegations of fraud, waste, and abuse. SIU works with Vermont Medicaid providers and partners to identify payment integrity issues and will provide education to providers when deficiencies and incorrect billing practices are identified. SIU works with providers to develop the appropriate resolution and recovers overpayments. Cases with credible allegations of fraud are referred to the Medicaid Fraud Residential Abuse Unit (MFRAU). In addition, SIU assists other Medicaid program units to facilitate changes in policies, procedures, and program logic to ensure the integrity of the programs.

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

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

Outcomes

SIU takes pride in ensuring the appropriate use and spending of Medicaid federal and state dollars while promoting high quality patient care, which diverts dollars that could otherwise be spent to safeguard the health and welfare of Medicaid recipients.

Below are the fourth quarter 2023 figures for the Special Investigations Unit:

- The number of provider investigations conducted by the PIHP: 37
- The number of suspected fraud referrals provided to the state Medicaid agency by the PIHP: 2
- The number of Personal Care Assistant related suspected fraud referrals provided to the state Medicaid agency by the PIHP: 5
- Number of Provider Preventable Conditions Identified by the SIU in the fourth quarter of CY2023: 0

In 2023, the SIU reviewed approximately 179 cases related to potential provider fraud, waste, and abuse allegations. In total, SIU successfully settled and cost-avoided a collective $3,686,496.

Oversight & Monitoring Unit

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

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

Effective oversight & monitoring ensures:

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

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

Oversight & Monitoring (O&M)

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

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

Outcomes

In the calendar year 2023 the O&M unit continued its work in coordinating DVHA participation in State, Federal, and independent audits and examinations, seeking to ensure that information shared is consistent, accurate, and timely. In general, the public health emergency resulted in somewhat reduced external audit activity this year. In 2023 O&M:

- Facilitated five state and federal audits of DVHA programs.
- Monitored five state and federal audits of DVHA programs.
- Provided ongoing tracking and monitoring and follow-up of Corrective Action Plans.
- Supported AHS and DVHA staff with documentation standards for better Standard Operating Procedures and policies. Thirty SOPs were created and approved in 2023.

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

Payment Error Rate Measurement (PERM)

The Payment Error Rate Measurement (PERM) audit, required by CMS to review for improper payments in Medicaid or CHIP programs, runs on a three-year cycle and looks at the full scope of a paid claim including beneficiary eligibility determinations, healthcare provider enrollment, and the medical records to substantiate the claim.
The RY2023 PERM audit cycle ended as of April 14, 2023. Sampled claims with dates of service between 7/1/21 – 6/30/22 were reviewed remotely by CMS Contractors.

Outcomes

PERM audit error finding results:

Out of 547 data processing reviews, only 3 claims were found in error.

Out of 417 medical record reviews, only 16 claims were found in error.

Out of 373 eligibility reviews, only 2 were found in error.

OMU is working with DVHA, sister department units and the state's fiscal agent Gainwell to create corrective action plans to address the error findings. OMU will work with units regarding implementation and monitoring of CAPs to minimize repeat findings and meet the good faith effort required to not face PERM monetary disallowances.

Healthcare Quality Control Unit (HCQC)

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

Outcomes

RY2023 MEQC & Internal: 1,103 cases reviewed.

- MEQC Audit: 948 cases (Medicaid, CHIP)
    - Audit period: Jan 1-Dec 31, 2023
    - Plan Proposal was submitted and accepted 10/28/2022.
    - Case level details and CAPS due 8/1/2024
    - Full review of 800 minimum cases
- Internal Audit: 155 cases (VPharm, IHIP)
    - Audit Period: Jan 1-Dec 31, 2023

Promoting Interoperability & Medicaid Data Aggregation and Access Program (HIT Auditor)

- The Promoting Interoperability Program (PIP), formerly known as the EHR Incentive Program (EHRIP), was established by the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act of the American Recovery & Reinvestment Act (ARRA). The program was designed to support providers during the period of health information technology transition and includes the requirement that States develop financial oversight and monitoring of expenditures for the Medicaid PIP/EHRIP. The Program has ended.

- The HIT Auditor has been participating in the development of the Medicaid Data Aggregation and Access Program, which creates a new incentive-based program to provide health information technology infrastructure support to Medicaid home and community-based service providers, working in conjunction with HIE program on project planning, development of request for proposals for consultative services to support the project and for an attestation system, defining eligible provider types, engagement with the HIE Steering Committee, development of MDAAP program rules and audit functions, and facilitating collaborative meetings with other

states.

Outcomes

- HIT Promoting Interoperability Program audits for program year 2021 were completed under version 9.1 of the CMS approved Audit Plan, including addressing a patient volume check that was not fully completed prepayment during program years 2019-2021. All audits were reported to CMS.

v. Inpatient, Outpatient, and Emergency Department Utilization

Methods

Utilization statistics for inpatient, outpatient, and emergency department services provided under Global Commitment during FFY 2021-23 were compiled by DVHA's Data Unit in February 2024 using paid claims data. The scope of analysis included institutional services provided under the Medicaid program between 10/1/2020 and 9/30/2023, excluding crossover claims.[1] The following areas of utilization were the focus of this analysis:

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

Total Outpatient Utilization
- Emergency Department Utilization

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

Findings

The following table (**Table 5**) presents discharge counts and average length-of-stay by age for inpatient services provided in FFY 2021-23.

Table 5. Inpatient Utilization by Fiscal Year and Age Group

Total Inpatient:	Sum LOS Days			Discharges			Average LOS Days		
Age	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**
<1	9,534	10,063	8,913	2,467	2,426	2,285	3.9	4.2	3.9
1-9	1,721	2,225	2,800	365	477	503	4.7	4.7	5.6
10-19	9,675	7,985	10,220	984	914	994	9.8	8.7	10.3
20-44	27,513	30,399	32,767	5,421	5,464	5,543	5.9	5.6	5.9
45-64	27,037	25,784	26,840	3,726	3,652	3,683	7.3	7.0	7.3
65+	2,306	1,652	2,016	117	121	146	19.7	13.7	13.8
Overall	**77,786**	**78,108**	**83,556**	**13,080**	**13,054**	**13,154**	**5.9**	**6.0**	**6.4**

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

The table below is a continuation of **Table 5** above and presents classifications of inpatient stays counts and average length-of-stay by age for the same time period

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

Age	Sum LOS Days 2021	Sum LOS Days 2022	Sum LOS Days 2023	Discharges 2021	Discharges 2022	Discharges 2023	Average LOS Days 2021	Average LOS Days 2022	Average LOS Days 2023
<1	9,195	9,979	8,840	2,431	2,409	2,266	3.8	4.1	3.9
1-9	1,394	1,948	2,470	295	416	426	4.7	4.7	5.8
10-19	9,130	7,245	9,595	859	797	882	10.6	9.1	10.9
20-44	20,810	22,481	25,554	4,253	4,295	4,410	4.9	5.2	5.8
45-64	19,671	18,285	19,073	2,754	2,753	2,788	7.14	6.6	6.8
65+	2,060	1,447	1,842	90	102	128	22.9	14.2	14.4
Overall	**62,260**	**61,385**	**67,374**	**10,682**	**10,772**	**10,900**	**5.8**	**5.7**	**6.2**

A1) Alcohol/Substance Inpatient Medical:

Age	Sum LOS Days 2021	Sum LOS Days 2022	Sum LOS Days 2023	Discharges 2021	Discharges 2022	Discharges 2023	Average LOS Days 2021	Average LOS Days 2022	Average LOS Days 2023
<1	-	-	-	-	-	-	-	-	-
1-9	-	-	8	-	-	1	-	-	8.0
10-19	14	44	64	6	6	4	2.3	7.3	16.0
20-44	1,049	1,158	1,195	326	332	339	3.2	3.5	3.5
45-64	893	973	937	216	242	241	4.1	4.0	3.9
65+	4.00	104	9	1	5	2	4.0	20.8	4.5
Overall	**1,960**	**2,279**	**2,213**	**549**	**585**	**587**	**3.6**	**3.9**	**3.8**

A2) Mental Health Inpatient Medical:

Age	Sum LOS Days 2021	Sum LOS Days 2022	Sum LOS Days 2023	Discharges 2021	Discharges 2022	Discharges 2023	Average LOS Days 2021	Average LOS Days 2022	Average LOS Days 2023
<1	5	-	-	1	-	-	5.0	-	-
1-9	427	424	897	34	37	45	12.6	11.5	19.9
10-19	7,575	5,465	8,190	446	366	527	17.0	14.9	15.5
20-44	9,726	11,299	12,698	810	908	992	12.0	12.4	12.8
45-64	6,643	4,494	5,156	302	311	375	22.0	14.5	13.8
65+	1,384	504	401	8	11	16	173.0	45.8	25.1
Overall	**25,760**	**22,186**	**27,342**	**1,601**	**1,633**	**1,955**	**16.1**	**13.6**	**14.0**

A3) Other Inpatient Medical:

Age	Sum LOS Days 2021	Sum LOS Days 2022	Sum LOS Days 2023	Discharges 2021	Discharges 2022	Discharges 2023	Average LOS Days 2021	Average LOS Days 2022	Average LOS Days 2023
<1	9,190	9,979	8840	2,430	2,409	2,266	3.8	4.1	3.9
1-9	967	1,524	1565	261	379	380	3.7	4.0	4.1
10-19	1,541	1,736	1341	407	425	351	3.8	4.1	3.8
20-44	10,035	10,024	11,661	3,117	3,055	3,079	3.2	3.3	3.8
45-64	12,135	12,818	12,980	2,236	2,200	2,172	5.4	5.8	6.0
65+	672	839	1,432	81	86	110	8.3	9.8	13.0
Overall	**34,540**	**36,920**	**37,819**	**8,532**	**8,554**	**8,358**	**4.0**	**4.3**	**4.5**

B) Inpatient Surgery:									
	Sum LOS Days			**Discharges**			**Average LOS Days**		
Age	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**	**2021**	**2022**	**2023**
<1	338	81	43	35	15	16	9.7	5.4	2.7
1-9	314	267	301	64	57	62	4.9	4.7	4.9
10-19	531	728	609	118	111	108	4.5	6.6	5.6
20-44	6,658	7,868	7,157	1,161	1,158	1,122	5.7	6.8	6.4
45-64	7,296	7,396	7,751	962	884	888	7.6	8.4	8.7
65+	239	204	163	26	18	17	9.2	11.3	9.6
Overall	**15,376**	**16,544**	**16,024**	**2,366**	**2,243**	**2,213**	**6.5**	**7.4**	**7.2**

The following table (**Table 6**) presents visit counts by age for outpatient services provided in FFY2021-23; first emergency department services, next other outpatient services, and then the combination of ED and other outpatient services.

FFY21	**Age**	**Emergency Department**		**Other Outpatient**		**Total**
		N	%Total	N	%Total	N
	<1	1,368	26%	3,934	74%	5,302
	1-9	8,132	20%	33,237	80%	41,369
	10-19	11,836	22%	42,165	78%	54,001
	20-44	32,318	22%	116,196	78%	148,514
	45-64	14,038	13%	96,031	87%	110,069
	65+	207	11%	1,612	89%	1,819
	Overall	67,899	19%	293,175	81%	361,074

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

FFY23	**Age**	**Emergency Department**		**Other Outpatient**		**Total**
		N	%Total	N	%Total	N
	<1	2,412	43%	3,260	57%	5,672
	1-9	13,562	37%	23,013	63%	36,575
	10-19	15,627	31%	35,176	69%	50,803
	20-44	38,089	26%	110,694	74%	148,783
	45-64	16,564	15%	97,319	85%	113,883
	65+	287	11%	2,229	89%	2,516
	Overall	86,541	24%	271,691	76%	358,232

Discussion

In FFY2023, Global Commitment, Medicaid, paid for 13,154 inpatient stays and 358,232 outpatient visits for Vermonters. The total number of inpatient stays was similar from FFY22 to FFY23. Outpatient visits decreased by about 9% during the same period.

Alcohol/substance-abuse inpatient stays were somewhat shorter in duration, inpatient surgeries were moderately longer, and psychiatric stays were much longer than other inpatient medical stays. Psychiatric inpatient medical services constituted 15% of the total inpatient stays and 33% of inpatient days. Average length of stay for all types of visits was similar (within 0.5 days) between FFY22 and FFY23. Average length of stay across alcohol/substance-abuse, psychiatric, and other (non-surgical) inpatient stays was longest for the 65+ age group at about 14 days, followed by the 10-19 age group at about 11 days. Averages of stays across these categories for all other age groups were under 7 days.

Among outpatient visits, emergency department visits constituted 20% of outpatient visits during FFY22 and 24% of outpatient visits during FFY23.

VII. Policy and Administrative Difficulties

Fiscal & Operational Management:

DY18 included the renewal of the Global Commitment to Health Waiver. Due to the timing of the renewal negotiations, DY 18 represents only a six-month period (July 2022 - December 2022). DY 19 represents the full calendar year (January 2023 - December 2023) During the demonstration years, AHS paid DVHA 1/12 of the legislative budget for Global Commitment on the first business day of every month. This payment served as the proxy by which to draw down federal funds for Global Commitment. Each quarter the State prepared the CMS-64 based upon actual allowable Medicaid expenditures (program, investments and administrative). Administrative costs are claimed outside of GC budget neutrality. After each quarterly submission, AHS reconciled what was claimed on the CMS-64 versus the monthly payments made to DVHA.

Vermont reported on all applicable category of service rows on the CMS-64 report. In the past Vermont used an internal report received from the MMIS fiscal agent, Gainwell, to assist with claiming on all applicable rows, but it was a very manual, labor-intensive process. Vermont has worked with Gainwell to develop an automated CMS-64 report that aligns all categories of service reporting lines.

The Budget Neutrality construct is a combination of Without Waiver vs With Waiver expenditures, as well as 10 Hypothetical Tests. The Investments are included in the With Waiver expenditures. As of the end of DY19, Vermont calculates $29.8M in Waiver Savings. However, there were two Hypothetical tests (SUD IMD and Global Rx) in a deficit position which reduced the Waiver savings by $4.3M, to $25.5M. Upon further guidance from CMS, Vermont fully intends to recalculate Budget Neutrality pmpms given the recent CMS policy update and Vermont's STCs. Vermont anticipates the carry-forward savings from the previous demonstration (DY12-18) to be slightly over $1B which will be used towards the current demonstration's activities.

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

- Expenditures for HCBS Investment of $108K was not accounted for correctly internally and will be corrected.

- Vermont exceeded the IMD Investments cap and will be making an adjustment to reduce the claim as a prior quarter adjustment next quarter. The adjustment will reduce the IMD Investment by $225,083 to the cap of $24,324,818.

Vermont claimed a prior quarter adjustment for the temporary 10% FMAP increase for qualifying HCBS services under the American Rescue Plan of 2021 (ARPA). The total amount for the 10% FMAP drawn continues to be $71.8M which will be re-invested as match into $161.6M of total spending on new and approved HCBS spending plan activities. To date, Vermont has spent $70.8M (~44%) of its HCBS spending plan.

VIII. Capitated Rate Setting

The PMPM rates as set for 1/1/23-12/31/23 are listed below. AHS submitted the calendar year 2023 PMPM Medicaid rates to CMS in January 2023.

Medicaid Eligibility Category (MEG)	Original CY23 PMPM	Revised CY23 PMPM	Rate Change
ABD Dual	$2,222.01	$2,247.25	1.1%
ABD Non-Dual Adult	$2,901.13	$2,837.64	-2.2%
ABD Non-Dual Child	$2,984.95	$2,942.54	-1.4%
Non – ABD Adult	$656.08	$638.55	-2.7%
Non – ABD Child	$533.12	$514.24	-3.5%
Moderate Needs Group	$617.62	$613.41	-0.7%
New Adult	$580.56	$574.27	-1.1%
Global Rx	$169.23	$160.44	-5.2%
Composite	$860.01	$849.84	-1.2%

Attachments

Attachment 1

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
QE 0923

ELIGIBILITY GROUP	DY 18 Jul 2022 - Dec 2022	DY 19 Jan 2023 - Dec 2023
Without Waiver (Caseload x pmpms)		
ABD - Non-Medicare - Adult	$ 91,924,294	$ 165,361,703
ABD - Non-Medicare - Child	$ 23,320,945	$ 45,033,035
ABD - Dual	$ 289,588,696	$ 450,120,530
Non ABD - Non-Medicare - Adult	$ 88,456,625	$ 130,789,960
Non ABD - Non-Medicare - Child	$ 226,334,361	$ 346,483,607
Total Expenditures Without Waiver	**$ 719,624,921**	**$ 1,137,788,834**
With Waiver		
ABD - Non-Medicare - Adult	$ 95,250,705	$ 163,085,730
ABD - Non-Medicare - Child	$ 20,360,439	$ 43,548,395
ABD - Dual	$ 283,809,254	$ 453,698,859
Non ABD - Non-Medicare - Adult	$ 56,470,924	$ 78,674,610
Non ABD - Non-Medicare - Child	$ 173,656,454	$ 288,249,222
Individual Cost Effective	$ -	$ -
Community Transition Services	$ -	$ -
HIE	$ -	$ -
Investments	$ 73,392,050	$ 74,786,308
Total Expenditures With Waiver	**$ 702,939,826**	**$ 1,102,043,124**
Waiver Savings Summary		
Subtotal Annual Savings	$ 16,685,095	$ 35,745,710
Hypothetical Test Deficits	$ (1,204,077)	$ (2,209,068)
Cumulative Savings	$ 15,481,018	$ 49,017,660
HYPOTHETICAL TESTS		
Hypothetical Test 1: New Adult		
Limit New Adult PMPM*MM	$ 261,350,820	$ 405,431,126
New Adult Total Expenditures	$ 222,857,284	$ 352,321,361
Surplus (Deficit)	$ 38,493,536	$ 53,109,765
Hypothetical Test 2: SUD IMD		
SUD - IMD ABD - Non-Medicare - Adult	$ 156,312	$ 310,000
SUD - IMD ABD - Dual	$ 129,959	$ 225,614
SUD - IMD Non ABD - Non-Medicare - Adult	$ 342,876	$ 427,604
SUD - IMD New Adult	$ 1,941,629	$ 3,866,173
Limit SUD IMD PMPM*MM	**$ 2,570,776**	**$ 4,829,391**
SUD - IMD ABD Non Medicare Adult	$ 156,753	$ 307,970
SUD - IMD ABD - Dual	$ 236,032	$ 376,693
SUD - IMD Non ABD - Non-Medicare - Adult	$ 380,721	$ 479,933
SUD - IMD New Adult	$ 2,146,823	$ 3,498,849
SUD IMD Total Expenditures	**$ 2,920,329**	**$ 4,663,445**
Surplus (Deficit)	$ (349,553)	$ 165,946
Hypothetical Test 3: SMI IMD		
SMI - IMD ABD - Non-Medicare - Adult	$ 3,070,568	$ 5,358,611
SMI - IMD ABD - Dual	$ 357,432	$ 809,825
SMI - IMD Non ABD - Non-Medicare - Adult	$ 726,715	$ 6,046,408
SMI - IMD New Adult	$ 7,128,451	$ 11,317,436
Limit SMI IMD PMPM*MM	**$ 11,283,167**	**$ 23,532,280**
SMI - IMD ABD Non Medicare Adult	$ 1,622,662	$ 3,878,099
SMI - IMD ABD - Dual	$ 525,975	$ 826,125
SMI - IMD Non ABD - Non-Medicare - Adult	$ 700,985	$ 1,246,201
SMI - IMD New Adult	$ 5,491,100	$ 9,932,357
SMI IMD Total Expenditures	**$ 8,340,722**	**$ 15,882,782**
Surplus (Deficit)	$ 2,942,445	$ 7,649,498
Hypothetical Test 4: Housing Pilot		
Limit Housing Pilot PMPM*MM	$ -	$ -
Housing Pilot Total Expenditures	$ -	$ -
Surplus (Deficit)	$ -	$ -
Hypothetical Test 5: Maternal Health and Treatment Services		
Limit Maternal Health and Treatment Services PMPM*MM	$ 1,105,887	$ 2,538,645
Maternal Health and Treatment Services Total Expenditures	$ 1,179,899	$ 2,376,555
Surplus (Deficit)	$ (74,012)	$ 162,090
Hypothetical Test 6: CRT		
Limit CRT PMPM*MM	$ 6,149,760	$ 9,041,545
CRT Total Expenditures	$ 4,735,011	$ 8,367,695
Surplus (Deficit)	$ 1,414,749	$ 673,850
Hypothetical Test 7: SUD CIT		
Limit SUD CIT PMPM*MM	$ -	$ -
SUD CIT Total Expenditures	$ -	$ -
Surplus (Deficit)	$ -	$ -
Hypothetical Test 8: Global Rx		
Limit Global Rx PMPM*MM	$ 4,928,451	$ 7,256,196
Global Rx Total Expenditures	$ 5,708,962	$ 9,465,264
Surplus (Deficit)	$ (780,511)	$ (2,209,068)
Hypothetical Test 9: Moderates		
Limit Moderates PMPM*MM	$ 609,493	$ 894,069
Moderates Total Expenditures	$ 445,520	$ 632,780
Surplus (Deficit)	$ 163,973	$ 261,289
Hypothetical Test 10: Marketplace Subsidy		
Limit Marketplace Subsidy PMPM*MM	$ 2,027,688	$ 3,615,968
Marketplace Subsidy Total Expenditures	$ 1,955,249	$ 3,346,558
Surplus (Deficit)	$ 72,439	$ 269,410

Attachment 2

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

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

Questions, Complaints and Concerns Received by Health Access Member Services
January 1, 2023 – December 31, 2023

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

January 2023:

- **Provider Complaint** – Caller wanted to document that dentist enrollment should not be done with a dentist that does not accept GMC as insurance. XXXXXX XXXXX was assigned as the caller's dentist, but when they called to set up an appointment, the office indicates that they do not accept GMC as insurance. The Agent apologized for the inconvenience, documented the feedback, and assisted the customer with finding another Dentist in the area.
- **Provider Complaint** - Caller has extreme difficulty finding a PCP and would like to give feedback that this situation is very difficult even for someone who is knowledgeable about health care systems. Caller is concerned that their insurance will not work without a PCP for referrals, PA's and Medical Care. They have called customer service and many MD offices to resolve finding a PCP without success. The PCP they want to use is XXXX XXXXX, at XXX XXXXXX but this MD is not listed as PCP in Maxstar, ACCESS or VTMedicaid Portal. The only PCP that is listed in Maxstar XXXX is XXXXXXX XXXX. Caller was assigned to XXXX XXXXXX, when they call this office they say XXXX XXXXX is not PCP there and that they are sure XXXX XXXXXXX is PCP with VT Medicaid. The Agent apologized for the inconvenience, documented the feedback and ensured the customer the feedback will be passed on.

- **Covered Services** - Caller is requesting to submit negative feedback regarding Medicaid's limitation on dental coverage. Caller feels that the $1000 per calendar year limit is too prohibitive and does not provide enough coverage for even basic dental work for an adult in a single year. Caller also claims that the limit is discriminatory against low income people, because many dentists choose to not accept Medicaid because of the lower reimbursement they receive. The Agent apologized for the inconvenience and documented the feedback. They also explained the Dental Voucher through DCF.
- **Provider Complaint** - Caller spoke with a supervisor and is frustrated that they ran out of their RX and the pharmacist won't refill until next week. The RX is also over the counter so on occasion they have had to pay out of pocket, however member is unable to afford to do so this month. Caller advised the bottle says "Take 2 tablets by mouth twice a day or as directed". Caller has been taking 3 tablets instead of 2 and has discussed this with their provider, because the language on her bottle says "or as directed" they are confused as to why they can't refill her RX today instead of next week. The Supervisor referred the caller to their provider and recommend they discuss the prescription with them if an adjustment is needed. I offered Ombuds number as well, however caller declined due to needing this RX ASAP.
- **Payment Issue** - Caller requested to document negative feedback as they want to be able to pay the Vpharm coverage by phone. Caller believes this option should be available to all customers and not just VHC customers. The Agent documented the feedback and explained the payment options that we have available for Vpharm.

February 2023:

- **Provider Complaint** - Caller called to state the Providers that are listed on the VTMedicaid.com website are not up to date, most that they had called are not accepting Medicaid or are only accepting Children up to a specific age. The Agent apologized for the inconvenience, documented the feedback and assisted the customer with finding more Providers that accept Medicaid in the area.
- **Provider Complaint** - Caller can not find a dentist that will except the VT Medicaid as insurance. Caller says that there are no dentist in their area which is Brattleboro that takes Medicaid. Caller states they will take you if you pay cash but not Medicaid. This a health concern and they have missed work due to not being able to locate a Dentist that will except Medicaid. The Agent apologized for the inconvenience, documented the feedback and assisted the customer with finding more Providers that accept Medicaid in the area.
- **Provider Complaint** - Caller wanted to express how hard it is to locate a Dental Surgeon that's willing to accept VT Medicaid. They state they had called all over the state of VT and heard the same thing from most VT Dentist/Dental Surgeons. Medicaid had been amazing for most things, right now caller's child has to have their wisdom teeth out due to being in pain. The soonest we could schedule an appointment is in June. Caller can't even get in with their Dentist to try and be referred somewhere sooner. Most providers say they stopped accepting Medicaid patients due to how little they get paid for their services. They cant afford to take anymore patients. Also caller had been dropped by their PCP out of nowhere just for having VT Medicaid as insurance. Caller would like to see the rate VT Dentist are paid increased to allow them to take on more patients easier. The Supervisor apologized for the inconvenience, documented the feedback and assisted the customer with finding more Providers that accept Medicaid in the area.

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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

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

March 2023:

- **Provider Complaint** - Caller requested to file negative feedback. Caller states the Provider list on VTMedicaid.com is not accepting new patients. Caller states every place that they have called is not accepting new patients. Caller feels this is unfair as they are trying to seek healthcare needs. The Agent apologized for the inconvenience, documented the feedback and assisted the customer with finding more Providers that accept Medicaid in the area.
- **Covered Services** - Caller feels that the State of Vermont is paying more for prescriptions than their primary PDP Atena is. Caller states that they have been on Medicare for two months now and Atena has only paid 49 cents for a $203.00 medication and Vpharm picked up the rest. Caller feels this is unfair as their medications get denied if Vpharm will not pay. The Agent apologized for the inconvenience and referred the customer to Vermont Legal Aid for further research.
- **Provider Complaint** - Caller requested to document that they are not satisfied with the fact that VTMedicaid.com provider lookup list is not up to date. When searching for a provider on the site they have encountered the wrong number for a provider and then learned the provider is now retired. Caller would like to see us update the list more often so it can be of more assistance. The Agent apologized for the inconvenience, documented the feedback and assisted the customer with finding more Providers that accept Medicaid in the area.
- **Covered Services** - Caller called in regards to a procedure not being covered. Caller had gender reassignment surgery but has had complications such as, breast implant causing signification issues and facial feminization surgery. Caller is trying to get the repairs to the implants and have the initial facial feminization surgery covered. Caller has been told by their provider that Medicaid will not cover the facial feminization surgery and is now currently seeking psychology help in trying to manage their anxiety, depression and suicidal ideations to exist as a transwoman in the current political society. The Agent apologized for the inconvenience as well as documented the customers feedback. The Agent reviewed GAC options and referred the customer to Vermont Legal Aid for further research.
- **Provider Complaint** - Caller requested to document negative feedback regarding finding a Dentist that accepts VT Medicaid as insurance. Caller feels that Dentists no longer are accepting Medicaid because of how little the SOV will pay for services. Caller states this is an issue throughout Vermont. People with Medicaid need to be able to get assistance with their Oral Health needs. Caller feels it is not fair that people with low income have to suffer to be able to get the care that they need because of the insurance carrier they have.

The Agent apologized for the inconvenience, documented the feedback and assisted the customer with finding more Providers that accept Medicaid in the area.

- **Provider Complaint** - Caller requested to document feedback as none of the Dentists in the Bennington area are accepting new patients as the VTMedicaid.com portal shows. Caller also stated that some of the offices that are listed on the Medicaid Portal are no longer accepting Medicaid insurance as payment. The Agent apologized for the inconvenience, documented the feedback and assisted the customer with finding more Providers that accept Medicaid in the area.
- **Covered Services** - Caller would like to submit negative feedback regarding Transportation benefits being denied. Caller is highly upset due to her being Disabled. They cannot move on their own and is unable to drive, walk and hardly stand. Caller is very dissatisfied with this decision. The Agent apologized for the inconvenience, documented feedback and offered the customer a Fair Hearing/Appeal.

April 2023:

- **Provider Complaint -** Caller requested to submit feedback as she was referred to a Dentist at xxxxx which she went for a cleaning and the Dentist started doing work without telling her exactly what she was doing. This resulted in her having more issues and more pain. She then had to go to another Dentist to get the previous work fixed. She is now stuck with paying for the service. The Agent apologized for the inconvenience, documented the feedback, mailed a Provider Complaint Form and offered to file a Formal Grievance for the customer.
- **Provider Complaint -** Caller wanted to file negative feedback as he states xxxxxx did not give him the full prescription that his Doctor prescribed her. He usually gets 28 and the Pharmacy only gave him 23. The Agent apologized for the inconvenience, documented the feedback, referred the customer to have the doctor contact Provider Services and also offered to mail out a Provider Complaint Form.
- **Provider Complaint -** Caller wanted to document that she is unable to find a Dentist that is accepting new Medicaid patients. She states she has called all over Vermont and each place is not accepting new patients and tell her they will not anytime soon. The Agent apologized for the inconvenience, documented the feedback and offered to help her search through the VT Medicaid Portal.
- **Provider Complaint -** Caller called to document that he is unable to find a Dentist that accepts VT Medicaid as insurance. He states this is a serious problem, as no offices are accepting new patients. The Agent apologized for the inconvenience, documented the feedback and offered to help him search through the VT Medicaid Portal.
- **Covered Services -** Caller's daughters provider told her that we would not cover it "she doesn't meet the criteria, pretty much nobody does". She doesn't think this is fair as a lot of kids need braces. The dentist will not submit the PA to be denied due to already know it doesn't meet the criteria. Due to the PA not being submitted caller is unable to file a Fair Hearing/Appeal. The Agent apologized for the inconvenience and explained to the customer they could document their feedback. They also advised to talk to the dentist to see if they can submit the PA in case she needs to appeal the decision.

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

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

May 2023:

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

Shawn states he lives in Hardwick and even though it would be expensive to drive to Burlington he could not find a dentist there either. Shawn would like to know what good the insurance is if he cannot use it and feels lack of dental care can affect his overall health. The Agent apologized for the inconvenience, documented the feedback and assisted the customer with searching on VTMedicaid.com for a Dentist that is accepting new patients in the area. Also provided the customer with the phone number to VT Legal Aid.

June 2023:

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

July 2023:

- **Provider Complaint -** Member requested to document that they cannot find a Dentist in the area that will take new VT Medicaid Patients. Caller states that they had to pay out of pocket to be able to see a Dentist as they would not accept the GMC Insurance. Member is wanting to be reimbursed for the cost as there are no Dentists that are willing to accept new VT Medicaid patients. The Agent apologized for the inconvenience and documented the feedback and assisted with finding a Dentist in the area.
- **Covered Services -** Member received a text message directing them to DVHA website for the following message that is very concerning. The statement" Beginning August 1, 2023, the Vermont Medicaid program will discontinue coverage for over-the-counter melatonin, vitamin D, and antihistamine products for Medicaid members ages 21 and older. This coverage change is a result of changes to the State Fiscal Year 2024 Medicaid budget. These items are available for purchase in grocery stores and pharmacies without a prescription. This change also applies to Medicare members enrolled in VPharm." Member is on MABD and is very concerned they won't be able to afford his antihistamines and Vitamin D . Caller believes these medicines will cost them 40 dollars a month. Caller thinks this isn't fair because there was no notice and that they are still recovering from the flood incident. Caller says they will call the Governor's office as well. The Agent apologized for the inconvenience and documented the feedback.
- **Covered Services –** Caller, on behalf of their son, (listed as a part of HH in CRM) called as they got a letter stating that as of 08/15/23 they would have to contact XXXXXX as they are going to be the new, sole vendor for incontinence supplies. Caller finds it easier to order diapers for their son from another vendor as they have been getting the right order always and on time. Caller states it would not make things easier for them as they do not even know

if XXXXX has the diapers that their son uses and also it took them a while to find the right diapers. The Agent apologized for the inconvenience and documented the feedback.
- **Covered Services -** Caller stated they got a letter that their incontinence supplies should be ordered from XXXXXX. Caller said that the style and brand they need is not available with them. Caller wished to submit negative feedback as their autistic grandson would have trouble using the brand and style available through the new supplier. Initially it had taken lot a time to adjust to the style he has been using now. Caller said that it would be difficult for them to get him use to the new style again. The Agent apologized for the inconvenience and documented the feedback.

August 2023:

- **Provider Complaint -** Member requested to document feedback as they cannot find a dentist in Rutland that accepts Medicaid. Member also does not have transportation to be able to travel to another town. Caller feels that there should be more dentists that take new patients and accept Medicaid. The agent apologized for the inconvenience and documented the customers feedback.
- **Covered Services -** Member called because they received a letter from DVHA dated 7/24/2023 informing them that they must order incontinence supplies from vendor XXXXXX as of 8/15/2023. Caller says that they have dealt with them in the past and they are very difficult to deal with. Caller states the supplies are of inferior quality and the products have actually "given bloody cuts and rashes". Caller says they only sell their own brands and they are unable to order any other brand through XXXXXX. Caller thinks this is unfair because they are now unable to receive the products that work for them and won't cause them harm. The agent apologized for the inconvenience and documented the customer's feedback. They also mailed the customer a Medical Exception Form.
- **Covered Services -** Member requested to document feedback as they are concerned with the lack of benefits provided by VT MCA for addicts to receive rehab. Caller states that it is a disease just like cancer, and for VT to serve as one of the highest statics in death amongst addicts in the Nation; the 2 week program set in place on MCA is not realistic.Caller says that most rehabs are $1000.00 per day and this is why so many of their friends have lost their children. Caller says they just want to save their son's life and needs some help. Please do more. Caller also wants to state that NH & MA has much extensive MCA coverage for addicts offering as little as a year to assist in the recovery of. The agent apologized for the inconvenience and documented the customers feedback. They also mailed the customer a Medical Exception Form.

- **Provider Complaint -** Member requested to submit negative feedback against the provider XXXXXX. Caller has been going to XXXXXX for 20 years. They were prescribed ten Valium a month, on 02/27/23 their horse died. Their horse died of severe Colic and is now disabled with PTSD. Caller needs Valium when upset. XXXXXX refused the prescription. Caller had documentation in hand approving the need for the prescription. Caller was forced to leave the practice. Caller states that made the trauma much worse. Caller is upset XXXXXX sent her prescription to XXXXXXX and they were ones who approved the prescription. Caller started with another provider 04/17 and requested all medical records be transferred. Caller no longer goes to the XXXXXXXX practice and does not want to deal with them. Caller states it's retraumatizing. The agent apologized for the inconvenience and documented the customers feedback.
- **Covered Services -** Member is calling to document Feedback regarding the new DME supplier XXXXXXX. Caller states that the products received were not up to standards, compared to the old supplier. Caller states they would have to use multiple products at once to fulfill one task. The agent apologized for the inconvenience, documented the feedback and offered to mail the customer a Complaint Form.
- **Provider Complaint -** Member requested to file negative feedback ast hey feel their doctor is not being responsive to their needs. Caller believes that they are not being responsive to their needs as their health is going downhill and they haven't done anything to make them get better. Caller seems to believe they have some sort of lime disease. The agent apologized for the inconvenience, documented the feedback and referred the customer to Legal Aid as well as advised they can switch doctors at any time.

September 2023:

- **Provider Complaint** - Member wanted to submit negative feedback as they hoped it would help to get the word out that there are no dentists available in the area. Caller states they have called over 40 different dental offices attempting to get in and none are accepting new VT Medicaid patients. The agent apologized for the inconvenience, documented the feedback.
- **Provider Complaint** - Member called to document negative feedback, as they tried calling many Dentists in VT but they are not accepting new patients. Caller would like to submit this as feedback as it is very hard to find the Dentists. Caller also mentioned the system is not updated and the Doctors who shows they accept new patient in the system, when she calls they are not accepting any new patients. The agent apologized for the inconvenience, documented the feedback. The agent also provided some dentists that are a little further out from their area.
- **Provider Complaint** - Member called to request to speak with a supervisor. Caller wanted to document another negative feedback SR as she had to pay out of pocket for Dental services, due to all the dentists in her area not accepting Medicaid. Caller states they want to know what is being done by the SOV to improve access to Dental care for people on Medicaid. The supervisor apologized for the inconvenience, documented the feedback. They also provided the customer with Community Resources information and VLA's phone number.
- **Covered Services** - Member called to document negative feedback. Their son is running out of pull-ups and the vendor XXXXXXX states they have no idea when his size will be back in stock. XXXXXXXX sent another sample size that do not fit him. When he spoke

with XXXXXXX management they told him this issue has been going on for a few months, and that other sizes are also on back order. He asked if he could pay out of pocket and be reimbursed which we are unable to reimburse individuals. He asked to change vendors which is also not possible. He says it's not fair that SOV changed vendors that can't fulfil the order and that he has to pay out of pocket several hundred dollars a month XXXXXX to get his son the necessary products. The agent apologized for the inconvenience, documented the feedback and offered to mail out a Medical Exception Form.

October 2023:

- **Covered Services -** Member requested to document feedback as Melatonin is no longer covered over the counter. Member states they do not think it's fair that low class families are now being punished. Vermont is singling out low class families that are living off of the state. The higher ups are going against them with not giving them medications that they need to survive. The agent apologized for the inconvenience, documented feedback and offered to mail an Exception Form.
- **Covered Services -** Member is calling to document that they cannot take the Medicaid Bus due to preexisting conditions and has sent in the Medical Exception Forms that document this and has not received a response back yet. Member also states that they are being refused individual rides and is being forced to take the Bus. The agent apologized for the inconvenience, documented the feedback and referred the member to VPTA.
- **Provider Complaint** – Member feels the VT Medicaid website should be updated. Member states having called multiple places and been told they no longer accept Medicaid or have a waiting list that is longer than 6 months. The agent apologized for the inconvenience, documented the feedback and provided the member with more contacts that accept VT Medicaid.

November 2023:

- **Lack of Notice -** Member wanted to report negative feedback about V-Pharm invoices. Member states they do not want to call every time they fail to receive an invoice. Member has not received their invoice this month and they have been late other months. The agent documented the feedback and gave an address to mail their check to and her UID number.
- **Provider Complaint –** Member wants to let us know that if our program connected them to an office and not just an individual PCP it would be easier because they have had to call multiple times to change their PCP because the Doctors office and our database never match. The agent documented the feedback and advised the member that we only need to list someone at that office and they can see whichever Doctor they prefer.

December 2023:

- **Provider Complaint** - Member requested to document feedback and states "I believe that the State of Vermont should build in more incentives for providers to provide Medicaid so that more Provider's will accept Vermont Medicaid and provide more services to Vermonters. I feel that if Medicaid isn't paying Providers enough money to see poor people they will only accept rich payments and the Providers that do accept VT Medicaid may be lower quality and unable to get the higher paying clients. I feel we have a right to have Providers that will serve us as well." The CSR apologized for the inconvenience and documented the feedback.

Attachment 3

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
October 1, 2023 – December 31, 2023

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data from the centralized database that were filed from October 1, 2023, through December 31, 2023.

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

During this quarter, there were twenty-seven grievances filed and fourteen were addressed. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of receipt of a grievance must be sent within five days; the average was three days. Of the grievances filed, 81% were filed by the beneficiary, and 19% were filed by a representative. DMH had 81%, and DAIL had 19% of the grievances filed.

Grievances were filed for service categories mental health, case management, community social support, Long Term Care, counseling, psychiatric and staff contractor issues.

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 thirty-two appeals filed. Of these thirty-two appeals, twenty-nine were resolved (91%), one was untimely (3%), two were withdrawn (6%), and one (3%) was still pending.

Of the twenty-nine appeals that were resolved this quarter, 97% were resolved within the statutory time frame of 30 days. The average number of days it took to resolve these cases was twenty days. Acknowledgement letters of receipt of an appeal must be sent within five days; the average was two days.

Of the thirty-two appeals filed, DVHA had thirty appeals filed (94%), and VDH had 2 (6%).

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

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

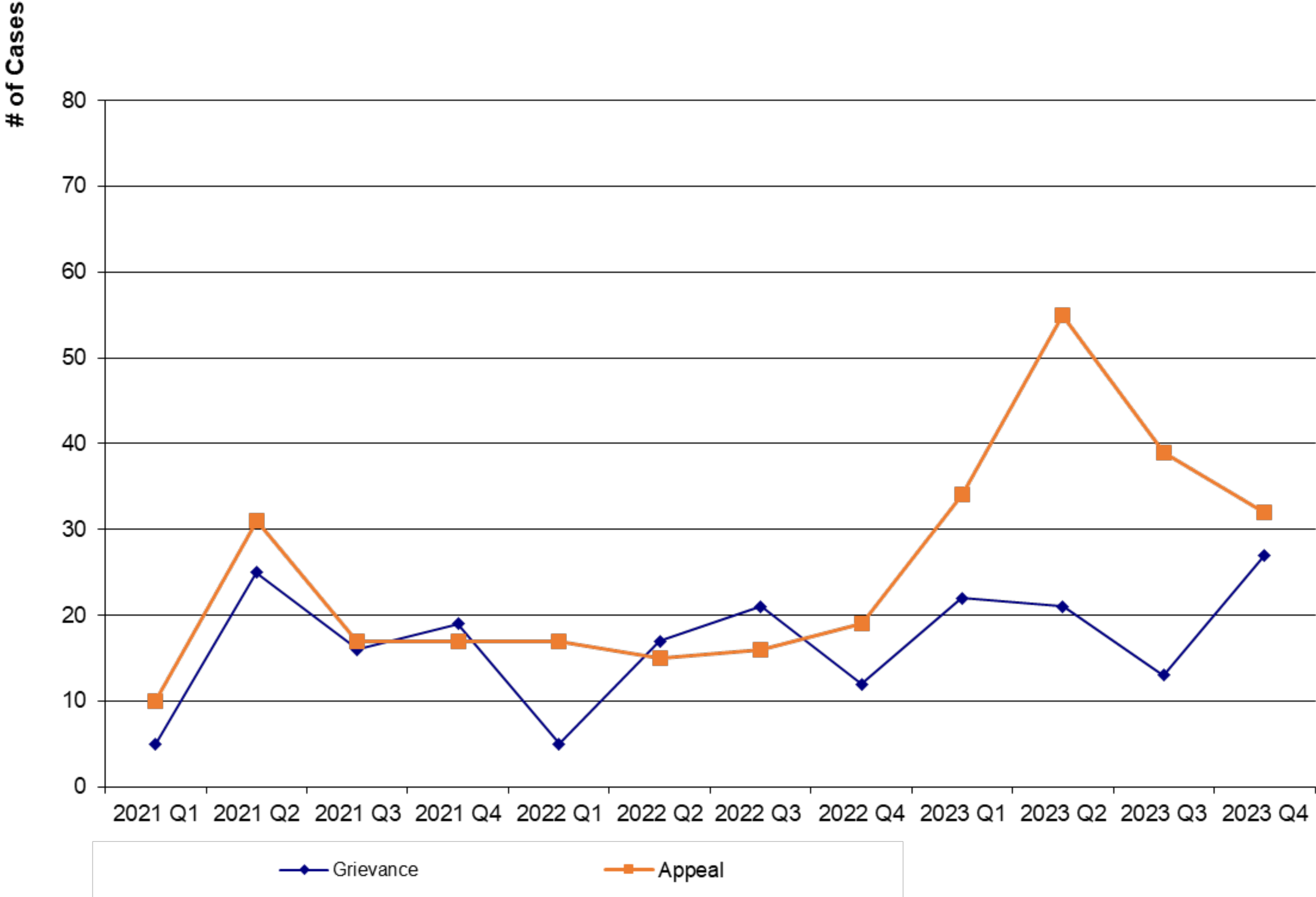
Enrollees may participate in appeals, by written testimony, telephonically, and by video or virtual communication.

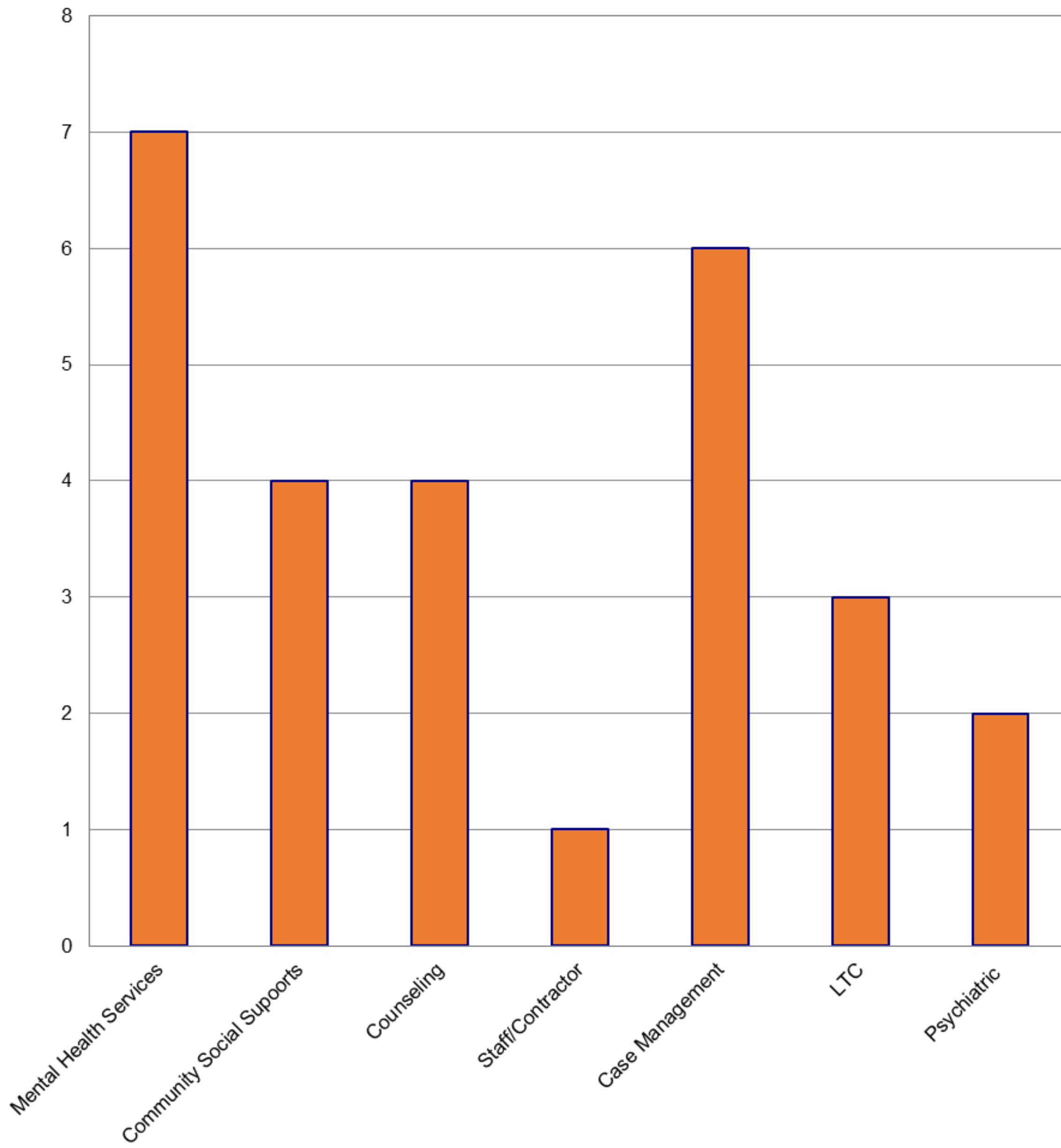
2023 Yearly Summary

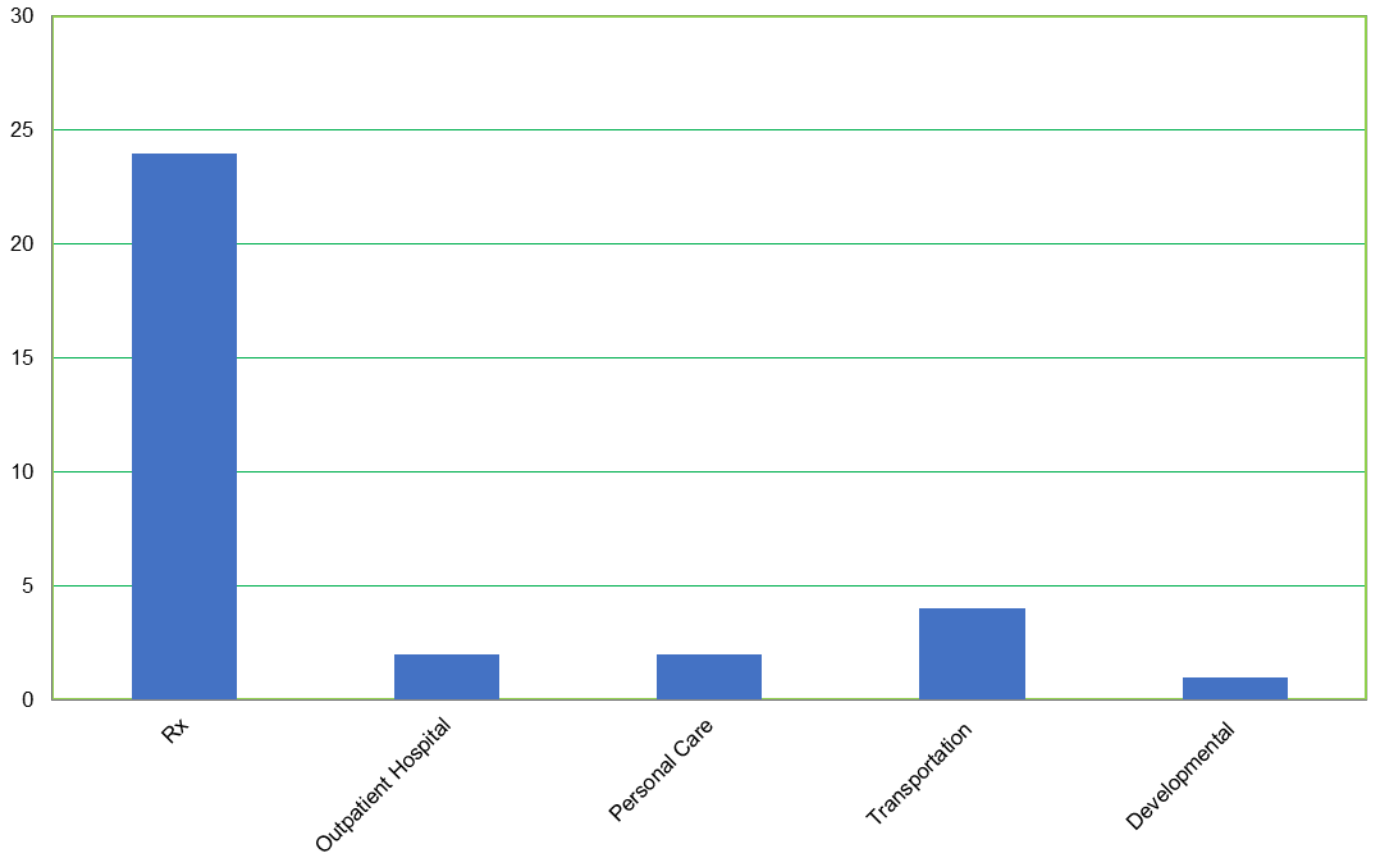
Grievances: There were 84 Grievances filed in 2023. Of those 84 grievances filed, DAIL had 12%, DMH had 82%, DVHA had 4%, DCF had 1% and VDH had 1%. The top service categories for grievances filed were for mental health, community/social support, and case management.

Appeals: There were 160 appeals filed in 2022. Of those appeals filed, DAIL had 4%, DMH had 3%, DVHA had 87%, and VDH had 6%. The top reasons for appeal were prescriptions, transportation services, and personal care services.

Grievances and Appeals
January 1, 2021 thru December 31, 2023




Grievance by Service Catagory
8
7
6
5
4
3
2
1
0
Mental Health Services
Community Social Supoorts
Counseling
Staff/Contractor
Case Management
LTC
Psychiatric


Appeals by Service Category
30
25
20
15
10
5
0
Rx
Outpatient Hospital
Personal Care
Transportation
Developmental

Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

October 1 – December 31, 2023

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

January 21, 2024

Summary and Update

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

The HCA opened 882 cases this quarter (856, the previous quarter). In this quarter, both Vermont Health Connect and Medicare started their annual open enrollment periods. Medicare enrollees can sign up and or change their Part D or Part C plans. The helpline saw significant numbers of calls about Medicare; over a third of our callers were Medicare enrollees. (318/882) We also talked to 42 households about eligibility for Medicaid for the Aged, Blind, and Disabled (MABD), the type of Medicaid that works with Medicare. MABD has resource limits on how much money you can save in your bank or retirement accounts. Our webpages on resource limits had 458 visits. We also talked to another 25 households about Medicare Savings Programs, which help pay for Medicare premiums and cost-sharing. Our webpages on Medicare Savings Programs had over 600 visits. We gave consumer education on Medicare enrollment and coverage to 28 households.

The HCA continues its work to expand Medicare Savings Programs. Our calls consistently reflect a high need for help with both the premium costs and cost-sharing. Our calls also reflect that Vermonters are struggling with prescription costs. Our webpages on buying prescriptions had 500 visits. We talked to 26 households about access to prescription medication. Expanding access to Medicare Savings programs will improve prescription coverage. Anyone who is eligible for a Medicare Savings Program, is automatically eligible for "Extra Help," a federal program that helps pay for Medicare Part D premiums and reduces copayments.

The HCA launched its Medicare webpage, which features the stories of Vermonters who are struggling with the costs: Medicare Stories | Vermont Legal Aid (vtlegalaid.org) Expanding the limits to Medicare Savings Program will make a significant and immediate financial impact on many Vermont seniors and disabled Vermonters. It will help them afford the health care they need, and it will be a step towards creating a more equitable system for seniors and disabled Vermonters. The Affordable Care Act expanded coverage for those under 65, and expanding Medicare Savings Programs will be a similar step for Vermonters on Medicare.

Nicola's Story

When Nicola went to the pharmacy to pick up her prescription, she was told that she had no coverage. She was confused because she had just received her Medicaid card, and when she called VHC she was told she had active coverage. She called the HCA because she needed to pick up a prescription after a medical procedure. She could not afford to pay for it out-of-pocket, and her provider told her she needed to take the medication soon after the procedure. The HCA advocate called VHC to investigate, and she found out that Nicola's pharmacy was trying to submit a claim, and it kept being denied. It was denied because it was showing that Nicola had other insurance coverage, so the system was thinking that coverage should pay for the prescription. Medicaid is always the payer of last resort, which means if there is another type of coverage, it will pay first before Medicaid pays a claim. Nicola, however, did not have any other coverage. The HCA made an expedited request to get the other insurance removed from the system, and VHC was able to do it the same day. That meant that Nicola's prescription was approved, and she was able to pick it up that same day.

VHC also started its annual open enrollment this quarter, and we saw significant calls about VHC issues. We talked to many consumers about buying insurance or switching to a new VHC plan. Additionally, VHC continued the "unwinding" process from the Public Health Emergency (PHE), so consumers were also doing Medicaid reviews. Eligibility for MAGI Medicaid was again the top issue getting calls on the helpline. We talked to 62 households about MAGI Medicaid eligibility and 36 about buying a VHC plan. We continue to work with VHC to reduce the number of Vermonters who lose their Medicare coverage during the review process. Our website also had heavy traffic on its Medicaid pages. We had over 1,400 page views on the Medicaid page. We had over 400 page views on our pages on Medicaid and VHC, and over 300 on our pages on Dr. Dynasaur.

We are also working closely with community partners to assist Vermonters applying for coverage with the Immigration Health Insurance Plan (IHIP). We are intervening in cases where consumers are having issues navigating the application process, and we continue to work to make systemic changes to improve the entire application process. We worked on 11 IHIP cases this quarter. Of those cases, 10 were eligibility cases where there was a problem with the application, and 1 was a billing case. The cases also required significant time, 8 out 11 were complex interventions, which meant that they required two or more hours work by the advocate.

This quarter, the HCA also participated with other stakeholders on the plan design for the 2025 VHC plans. This is an annual process, and the HCA works with other stakeholders to limit the impact of cost-sharing and premium increases on consumers as much as possible with the goal of ensuring that consumers have a range of affordable options that meet their health care needs.

In preparation for the implementation of the new Financial Assistance Policy statute (Act 119), the HCA continued its work on developing educational tools for hospitals and consumers. We talked to 13 households about hospital bills and patient financial assistance. The HCA plans on working with hospitals to help ensure that the patient financial assistance policies are updated and reflect the changes in the statute. We are also planning consumer outreach. This work will continue all year. The HCA plans to do major consumer education to make Vermonters know about the changes to policies.

Case Stories:

Nina's Story:

Nina called the HCA because she was having trouble signing up for a new Vermont Health Connect (VHC) plan for 2024. She had been on a VHC plan all year and was receiving Advance Premium Tax Credit (APTC) to help pay for it. During the Open Enrollment period, she wanted to switch to another VHC plan. But when she tried to switch, she was told she was not eligible for any subsidies. Nina could not afford a plan without subsidies. When the HCA advocate investigated, she found that Nina had been found eligible for Medicaid. Under the eligibility rules, you cannot be eligible for Medicaid and receive APTC at the same time. But when the HCA advocate studied what VHC in its system for Nina's income, she found that VHC had entered that Nina had no income. Because of this error, it looked like Nina was eligible for Medicaid. It was not clear how this error occurred because Nina had not reported any income changes to VHC. Once her income was corrected, VHC showed her eligible for significant APTC. With the APTC, Nina was able to enroll in a plan that suited her health care needs for 2024.

Jackson's Story:

Jackson called the HCA because he had lost his Medicaid coverage. He had been on Dr. Dynasaur coverage, but he had aged off the program. Dr. Dynasaur provides health care coverage for kids up to 19 and pregnancy. He was without any coverage for over a month, despite trying to apply with VHC multiple times. Before exploring the problems that Jackson was having with his VHC application, the HCA advocate found out Jackson's income. He was employed with a job that offered health insurance. His employment income put him above the income limit for Medicaid for Children and Adults (MCA). This is the type of Medicaid that works for adults, and it has lower income limits than Dr. Dynasaur. The HCA advocate next explored whether Jackson could get a VHC plan with subsidies. If you have an offer of what is considered affordable and adequate "minimum essential coverage" (MEC), you are not eligible for subsidies to help pay for a VHC plan. It would still be possible to enroll in a VHC plan even with the offer of employer insurance, but for most people a full cost plan is not affordable. It is also possible to be on both Medicaid and your employer insurance at the same time, but Jackson was above the Medicaid limit. Based on its cost and coverage, Jackson's employer insurance met the definition of affordable and adequate. That meant that he could either enroll in his employer insurance or on a full cost plan with VHC. With this information, Jackson decided against enrolling on a full cost VHC plan, and instead enrolled on his employer plan.

Nora's Story:

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Overview

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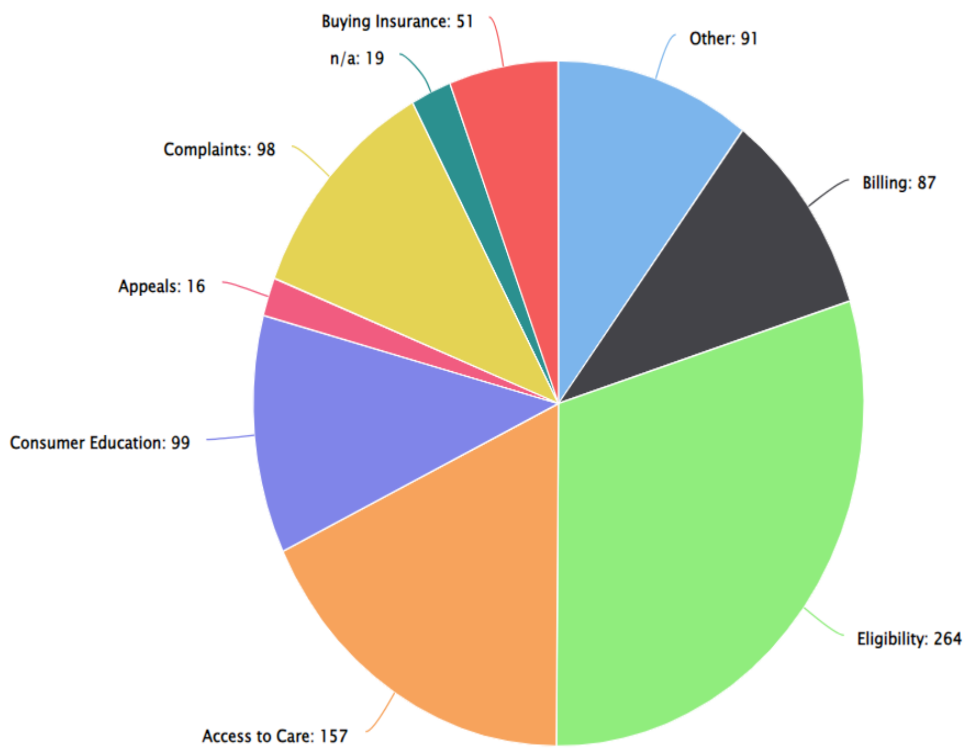
Number of Cases by Primary Issue: October 1-December 31, 2023



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The HCA also tracks its callers by insurance category. We don't collect insurance information for every case, because sometimes it is not always relevant to the caller's issue. This quarter DVHA and Medicare cases made up 520 out of the 882cases.

Chart: Q4

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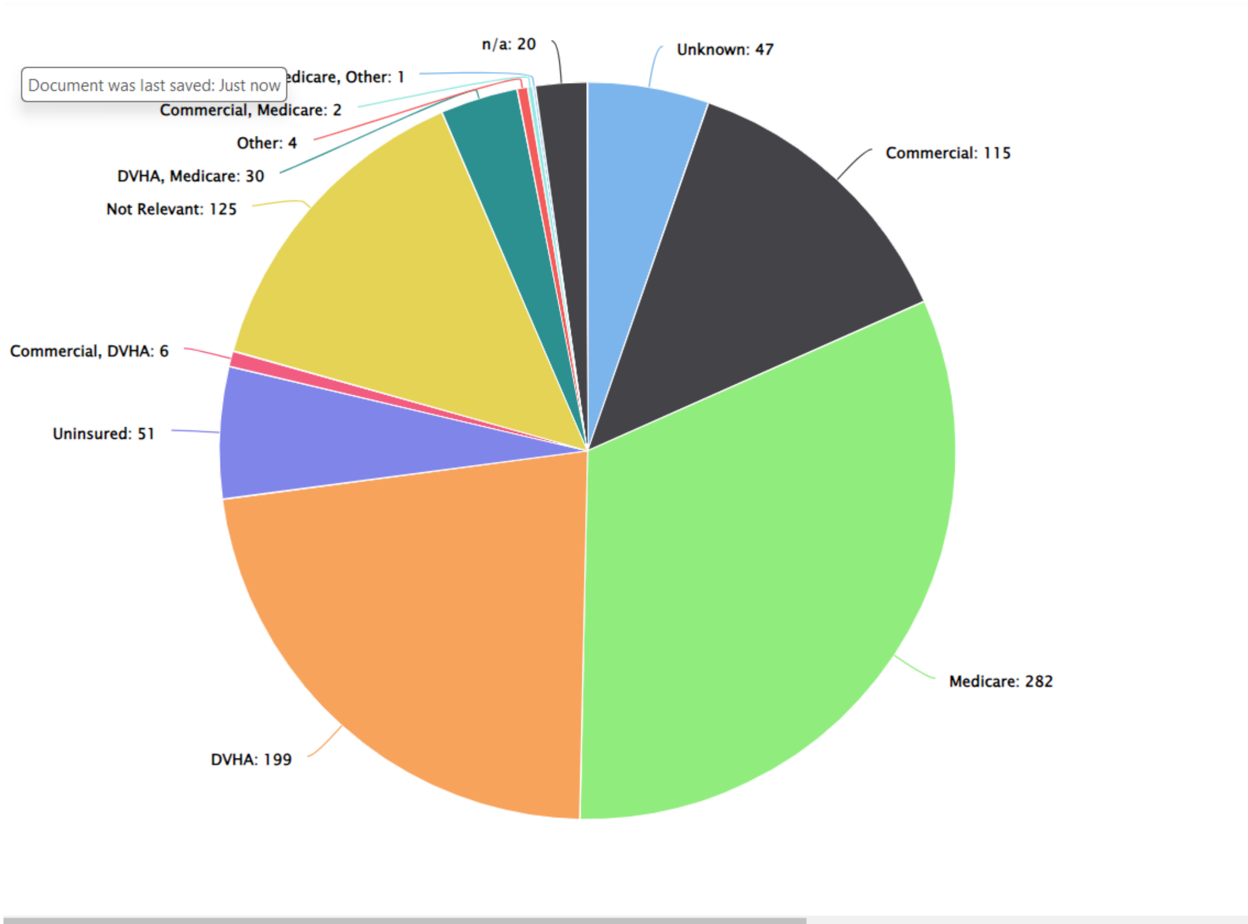

Table: Top Ten Primary Issues: October 1-December 31, 2023.

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DVHA Cases: total of 236 of 882 total cases

Top Five Primary Issues

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2. **Access to Prescription Drugs 11**
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Top Three Primary Issues

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- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Health Connect
- Vermont Health Care for All
- Vermont Interfaith Action (VIA)Vermont Language Justice Project
- Vermont Medical Society
- Vermont – NEA
- Vermont Professionals of Color Network
- Vermont Public Interest Research Group (VPIRG)
- Vermont Workers' Center
- You First

Increasing Reach and Education Through the Website

VTLawHelp.org is a statewide website maintained by Vermont Legal Aid and Legal Services Vermont. The site includes a substantial Health section (*https://vtlawhelp.org/health*) with more than 170 pages of consumer-focused health information maintained by the HCA.

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

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

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

1. Health - section home page – 1,742 pageviews
2. Dental Services – 1,577
3. Income Limits - Medicaid – 1,418
4. Medicare Savings Programs – 613
5. Buying Prescription Drugs – 500 *
6. Resource Limits - Medicaid – 458
7. Medicaid – 457
8. Medicaid, Dr. Dynasaur & Vermont Health Connect – 429
9. Long-Term Care – 418
10. Medical Decisions: Advance Directives – 348
11. Dr. Dynasaur – 342
12. Prescription Assistance State Programs – 324*
13. HCA Help Request Form – 320 pageviews and 111 online help requests
14. Vermont Health Connect – 301
15. Choices for Care Giving Away Property or Resources – 259
16. Services Covered – Medicaid – 256
17. Medicaid and Medicare (Dual Eligible) – 237
18. Choices for Care Income Limits – 235
19. Advance Directive forms – 218
20. Choice for Care Resource Limits – 208*
21. Medical Debt – 201

This quarter we had these additional news items:

- Medicaid Renewal Starts Again – 73 pageviews
- It's Open Enrollment Time for Health Care Plans – 63
- People Impacted by Flood Can Sign Up for Health Coverage. Those Who Lost Medicaid Can, Too – 52

Outreach and Education

The Office of the Health Care Advocates (HCA) engaged in both in-person and virtual outreach activities this quarter to raise awareness about our offices' services and provide accessible information about health insurance options in Vermont.

Our messaging continued to prioritize providing accurate and accessible information on the Medicaid renewal process. Additionally, our communications efforts focused on sharing content about the Medicare and Vermont Health Connect Open Enrollment Periods.

We strive to break down the barriers that Vermonters face in understanding and utilizing insurance. This goal is especially important now as many members of our community are evaluating their health insurance options for 2024 this quarter. We use a hybrid outreach model to advance this goal. We feel that both in-person and virtual resources make our services more accessible to those who face challenges utilizing traditional intake systems such as seniors, people with disabilities, and those with language needs.

We partnered with 11 organizations and participated in 8 outreach presentations this quarter. Our partnerships included work with the **Family Room, Bridges to Health, and the Howard Center**.

The HCA utilized Facebook, Instagram, and Youtube to connect with community members, legislators, and partner organizations. We used these platforms to share important updates pertaining to Medicaid renewals and the Vermont Health Connect Open Enrollment Period. We continued to circulate educational videos on common health insurance terms and plan selection for Qualified Health Plans. These videos have received over 450 views this past quarter. We also utilized Facebook and Instagram to share updates related to the Medicare Open Enrollment Period and Special Enrollment Periods through Vermont Health Connect. This content was shared by 8 organizations across Vermont.

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 two clinics where community members connected with legal advocates to get free and confidential advice. Childcare and in-person interpretation were available to support people seeking our assistance. These clinics are primarily designed to connect seniors and those with language needs with legal support.

Office of the Health Care Advocate

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

https://vtlawhelp.org/health

Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report
October 1 – December 31, 2023
to the
Agency of Administration
submitted by

Michael Fisher, Chief Health Care Advocate
Office of the Health Care Advocate

January 21, 2024

Summary and Update

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

The HCA opened 882 cases this quarter (856, the previous quarter). In this quarter, both Vermont Health Connect and Medicare started their annual open enrollment periods. Medicare enrollees can sign up and or change their Part D or Part C plans. The helpline saw significant numbers of calls about Medicare; over a third of our callers were Medicare enrollees. (318/882) We also talked to 42 households about eligibility for Medicaid for the Aged, Blind, and Disabled (MABD), the type of Medicaid that works with Medicare. MABD has resource limits on how much money you can save in your bank or retirement accounts. Our webpages on resource limits had 458 visits. We also talked to another 25 households about Medicare Savings Programs, which help pay for Medicare premiums and cost-sharing. Our webpages on Medicare Savings Programs had over 600 visits. We gave consumer education on Medicare enrollment and coverage to 28 households.

The HCA continues its work to expand Medicare Savings Programs. Our calls consistently reflect a high need for help with both the premium costs and cost-sharing. Our calls also reflect that Vermonters are struggling with prescription costs. Our webpages on buying prescriptions had 500 visits. We talked to 26 households about access to prescription medication. Expanding access to Medicare Savings programs will improve prescription coverage. Anyone who is eligible for a Medicare Savings Program, is automatically eligible for "Extra Help," a federal program that helps pay for Medicare Part D premiums and reduces copayments.

The HCA launched its Medicare webpage, which features the stories of Vermonters who are struggling with the costs: Medicare Stories | Vermont Legal Aid (vtlegalaid.org) Expanding the limits to Medicare Savings Program will make a significant and immediate financial impact on many Vermont seniors and disabled Vermonters. It will help them afford the health care they need, and it will be a step towards creating a more equitable system for seniors and disabled Vermonters. The Affordable Care Act expanded coverage for those under 65, and expanding Medicare Savings Programs will be a similar step for Vermonters on Medicare.

Nicola's Story

When Nicola went to the pharmacy to pick up her prescription, she was told that she had no coverage. She was confused because she had just received her Medicaid card, and when she called VHC she was told she had active coverage. She called the HCA because she needed to pick up a prescription after a medical procedure. She could not afford to pay for it out-of-pocket, and her provider told her she needed to take the medication soon after the procedure. The HCA advocate called VHC to investigate, and she found out that Nicola's pharmacy was trying to submit a claim, and it kept being denied. It was denied because it was showing that Nicola had other insurance coverage, so the system was thinking that coverage should pay for the prescription. Medicaid is always the payer of last resort, which means if there is another type of coverage, it will pay first before Medicaid pays a claim. Nicola, however, did not have any other coverage. The HCA made an expedited request to get the other insurance removed from the system, and VHC was able to do it the same day. That meant that Nicola's prescription was approved, and she was able to pick it up that same day.

VHC also started its annual open enrollment this quarter, and we saw significant calls about VHC issues. We talked to many consumers about buying insurance or switching to a new VHC plan. Additionally, VHC continued the "unwinding" process from the Public Health Emergency (PHE), so consumers were also doing Medicaid reviews. Eligibility for MAGI Medicaid was again the top issue getting calls on the helpline. We talked to 62 households about MAGI Medicaid eligibility and 36 about buying a VHC plan. We continue to work with VHC to reduce the number of Vermonters who lose their Medicare coverage during the review process. Our website also had heavy traffic on its Medicaid pages. We had over 1,400 page views on the Medicaid page. We had over 400 page views on our pages on Medicaid and VHC, and over 300 on our pages on Dr. Dynasaur.

We are also working closely with community partners to assist Vermonters applying for coverage with the Immigration Health Insurance Plan (IHIP). We are intervening in cases where consumers are having issues navigating the application process, and we continue to work to make systemic changes to improve the entire application process. We worked on 11 IHIP cases this quarter. Of those cases, 10 were eligibility cases where there was a problem with the application, and 1 was a billing case. The cases also required significant time, 8 out 11 were complex interventions, which meant that they required two or more hours work by the advocate.

This quarter, the HCA also participated with other stakeholders on the plan design for the 2025 VHC plans. This is an annual process, and the HCA works with other stakeholders to limit the impact of cost-sharing and premium increases on consumers as much as possible with the goal of ensuring that consumers have a range of affordable options that meet their health care needs.

In preparation for the implementation of the new Financial Assistance Policy statute (Act 119), the HCA continued its work on developing educational tools for hospitals and consumers. We talked to 13 households about hospital bills and patient financial assistance. The HCA plans on working with hospitals to help ensure that the patient financial assistance policies are updated and reflect the changes in the statute. We are also planning consumer outreach. This work will continue all year. The HCA plans to do major consumer education to make Vermonters know about the changes to policies.

Case Stories:

Nina's Story:

Nina called the HCA because she was having trouble signing up for a new Vermont Health Connect (VHC) plan for 2024. She had been on a VHC plan all year and was receiving Advance Premium Tax Credit (APTC) to help pay for it. During the Open Enrollment period, she wanted to switch to another VHC plan. But when she tried to switch, she was told she was not eligible for any subsidies. Nina could not afford a plan without subsidies. When the HCA advocate investigated, she found that Nina had been found eligible for Medicaid. Under the eligibility rules, you cannot be eligible for Medicaid and receive APTC at the same time. But when the HCA advocate studied what VHC in its system for Nina's income, she found that VHC had entered that Nina had no income. Because of this error, it looked like Nina was eligible for Medicaid. It was not clear how this error occurred because Nina had not reported any income changes to VHC. Once her income was corrected, VHC showed her eligible for significant APTC. With the APTC, Nina was able to enroll in a plan that suited her health care needs for 2024.

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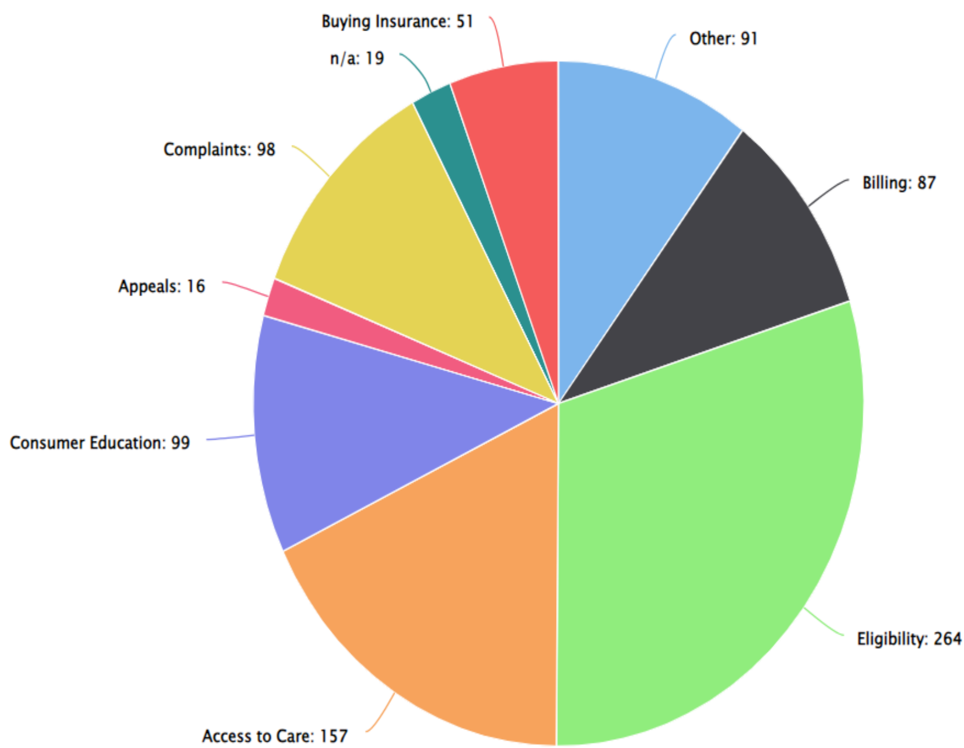

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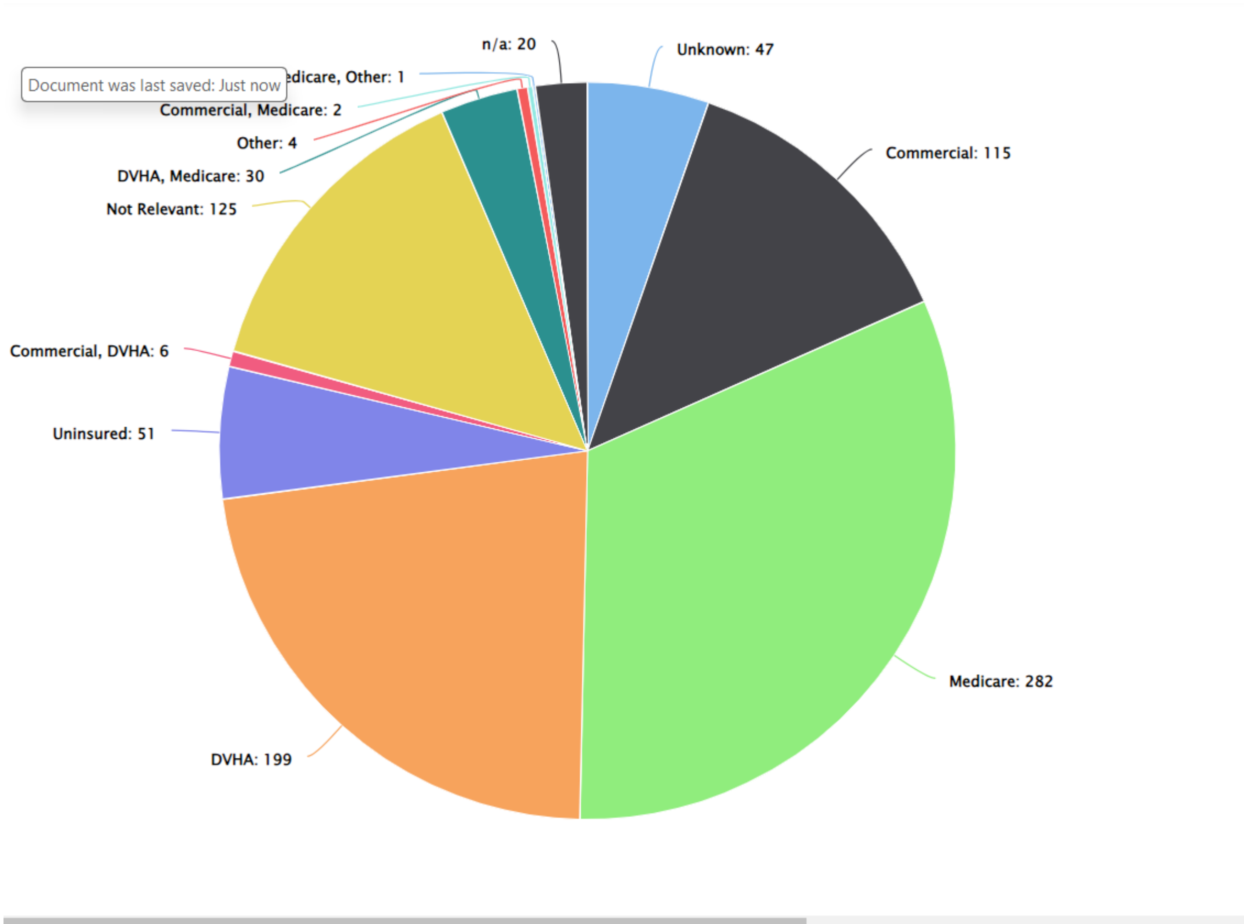

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- Vermont Medical Society
- Vermont – NEA
- Vermont Professionals of Color Network
- Vermont Public Interest Research Group (VPIRG)
- Vermont Workers' Center
- You First

Increasing Reach and Education Through the Website

VTLawHelp.org is a statewide website maintained by Vermont Legal Aid and Legal Services Vermont. The site includes a substantial Health section (*https://vtlawhelp.org/health*) with more than 170 pages of consumer-focused health information maintained by the HCA.

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

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

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

1. Health - section home page – 1,742 pageviews
2. Dental Services – 1,577
3. Income Limits - Medicaid – 1,418
4. Medicare Savings Programs – 613
5. Buying Prescription Drugs – 500 *
6. Resource Limits - Medicaid – 458
7. Medicaid – 457
8. Medicaid, Dr. Dynasaur & Vermont Health Connect – 429
9. Long-Term Care – 418
10. Medical Decisions: Advance Directives – 348
11. Dr. Dynasaur – 342
12. Prescription Assistance State Programs – 324*
13. HCA Help Request Form – 320 pageviews and 111 online help requests
14. Vermont Health Connect – 301
15. Choices for Care Giving Away Property or Resources – 259
16. Services Covered – Medicaid – 256
17. Medicaid and Medicare (Dual Eligible) – 237
18. Choices for Care Income Limits – 235
19. Advance Directive forms – 218
20. Choice for Care Resource Limits – 208*
21. Medical Debt – 201

This quarter we had these additional news items:

- Medicaid Renewal Starts Again – 73 pageviews
- It’s Open Enrollment Time for Health Care Plans – 63
- People Impacted by Flood Can Sign Up for Health Coverage. Those Who Lost Medicaid Can, Too – 52

Outreach and Education

The Office of the Health Care Advocates (HCA) engaged in both in-person and virtual outreach activities this quarter to raise awareness about our offices' services and provide accessible information about health insurance options in Vermont.

Our messaging continued to prioritize providing accurate and accessible information on the Medicaid renewal process. Additionally, our communications efforts focused on sharing content about the Medicare and Vermont Health Connect Open Enrollment Periods.

We strive to break down the barriers that Vermonters face in understanding and utilizing insurance. This goal is especially important now as many members of our community are evaluating their health insurance options for 2024 this quarter. We use a hybrid outreach model to advance this goal. We feel that both in-person and virtual resources make our services more accessible to those who face challenges utilizing traditional intake systems such as seniors, people with disabilities, and those with language needs.

We partnered with 11 organizations and participated in 8 outreach presentations this quarter. Our partnerships included work with the **Family Room, Bridges to Health, and the Howard Center**.

The HCA utilized Facebook, Instagram, and Youtube to connect with community members, legislators, and partner organizations. We used these platforms to share important updates pertaining to Medicaid renewals and the Vermont Health Connect Open Enrollment Period. We continued to circulate educational videos on common health insurance terms and plan selection for Qualified Health Plans. These videos have received over 450 views this past quarter. We also utilized Facebook and Instagram to share updates related to the Medicare Open Enrollment Period and Special Enrollment Periods through Vermont Health Connect. This content was shared by 8 organizations across Vermont.

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 two clinics where community members connected with legal advocates to get free and confidential advice. Childcare and in-person interpretation were available to support people seeking our assistance. These clinics are primarily designed to connect seniors and those with language needs with legal support.

Office of the Health Care Advocate

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

https://vtlawhelp.org/health

Attachment 5

DY19 Investment Expenditures

Department	Final Receiver Suffix	Investment Description	QE 0323	QE 0623	QE 0923	QE 1223	DY19 Total
AHSCO	9090	Designated Agency Underinsured Services	1,778,704	1,852,759	1,778,704	4,498,901	**9,909,068**
AHSCO	9421	HCBS Investment - Workforce Recruitment & Retention Program	3,365,373	393,700	1,374,236	1,505,870	**6,639,179**
AHSCO	9421	HCBS Investment - Innovative Solutions to Enhance and Strengthen HCBS	-	74,565	-	-	**74,565**
AOE	n/a	Non-state plan Related Education Fund Investments	-	-	-	-	**-**
DCF	9400	Investments - Balance and Restorative Justice	-	245,675	284,133	175,242	**705,050**
DCF	9402	Medical Services	51,809	21,535	52,328	10,775	**136,447**
DCF	9403	Residential Care for Youth/Substitute Care (1)	-	-	-	(263)	**(263)**
DCF	9405	Aid to the Aged, Blind and Disabled CCL Level III	1,194,513	970,142	1,252,224	936,958	**4,353,837**
DCF	9406	Aid to the Aged, Blind and Disabled Res Care Level III	32,943	26,578	34,563	25,507	**119,591**
DCF	9407	Aid to the Aged, Blind and Disabled Res Care Level IV	70,334	56,189	72,238	53,354	**252,115**
DCF	9408	Essential Person Program	193,603	199,732	207,776	204,114	**805,225**
DCF	9409	GA Medical Expenses	32,345	43,787	19,473	40,936	**136,541**
DCF	9411	Therapeutic Child Care	325,485	276,560	323,014	340,078	**1,265,137**
DCF	9412	Lund Home	-	-	-	-	**-**
DCF	9413	Prevent Child Abuse Vermont: Shaken Baby	-	-	-	-	**-**
DCF	9414	Prevent Child Abuse Vermont: Nurturing Parent	20,163	34,334	22,334	10,617	**87,448**
DCF	9415	Challenges for Change: DCF	38,787	96,291	38,924	52,165	**226,167**
DCF	9416	Strengthening Families	243,244	450,628	-	230,840	**924,712**
DCF	9417	Lamoille Valley Community Justice Project	-	-	-	-	**-**
DCF	9418	Building Bright Futures	114,319	70,876	24,798	104,111	**314,104**
DCF	9419	United Ways 2-1-1	113,200	113,200	222,754	3,646	**452,800**
DCF	9421	Lund Substance Abuse Screening & Referral	-	-	85,249	(85,249)	**-**
DCF	9425	Lund Substance Abuse Screening & Referral	-	-	-	340,997	**340,997**
DAIL	9421	HCBS Investment	-	(2,394)	1,759,360	-	**1,756,966**
DAIL	9602	Mobility Training/Other Svcs.-Elderly Visually Impaired	92,642	93,253	89,317	97,299	**372,511**
DAIL	9603	DS Special Payments for Medical Services	619,132	937,839	637,930	723,491	**2,918,392**
DAIL	9604	Flexible Family/Respite Funding	368,699	308,238	-	609,964	**1,286,901**
DAIL	9606	Support and Services at Home (SASH)	245,011	245,349	244,852	245,364	**980,576**
DAIL	9607	HomeSharing	69,427	69,522	73,403	-	**212,352**
DAIL	9608	Self-Neglect Initiative	130,158	-	136,392	-	**266,550**
DMH	9421	HCBS Investment	-	(551)	-	-	**(551)**
DMH	9501	Special Payments for Treatment Plan Services	12,761	-	10,311	44,585	**67,657**
DMH	9502	Mental Health Outpatient Services for Adults	1,070,339	-	415,569	1,953,942	**3,439,850**
DMH	9504	Mental Health Consumer Support Programs	104,739	-	139,256	151,266	**395,261**
DMH	9505	Mental Health CRT Community Support Services	13,104	-	-	-	**13,104**
DMH	9506	Mental Health Children's Community Services	337,504	-	111,400	1,194,006	**1,642,910**
DMH	9507	Emergency Mental Health for Children and Adults	-	-	-	1,102,674	**1,102,674**
DMH	9508	Respite Services for Youth with SED and their Families	311,344	-	22,798	932,513	**1,266,655**
DMH	9511	Institution for Mental Disease Services: DMH - VPCH	8,472,209	-	8,105,690	7,491,425	**24,069,324**
DMH	9512	Institution for Mental Disease Services: DMH - BR	-	-	-	-	**-**
DMH	9514	Seriously Functionally Impaired: DMH	13,178	-	-	-	**13,178**
DMH	9516	Acute Psychiatric Inpatient Services	1,550,673	(405,757)	91,932	1,410,952	**2,647,800**
DMH	9521	Suicide Prevention	-	-	-	56,633	**56,633**
DMH	9914	Investments (STC-79) - CRT Global Commitment	-	-	306,652	-	**306,652**
DOC	n/a	Return House	49,807	57,311	36,532	-	**143,650**
DOC	n/a	Northern Lights	-	-	-	-	**-**
DOC	n/a	Pathways to Housing - Transitional Housing	374,723	412,945	531,858	-	**1,319,526**
DOC	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)	76,432	70,680	72,549	447,990	**667,651**
DOC	n/a	Northeast Kingdom Community Action	29,245	12,093	28,033	70,995	**140,366**
DOC	n/a	Intensive Substance Abuse Program (ISAP)	-	-	-	56,405	**56,405**
DOC	n/a	Intensive Domestic Violence Program	-	-	-	-	**-**
DOC	n/a	Community Rehabilitative Care	1,810,081	82,054	851,961	-	**2,744,096**
DOC	n/a	Intensive Sexual Abuse Program	-	-	-	973,678	**973,678**
DOC	n/a	Elevate Youth	-	-	-	-	**-**
DOC	n/a	Vermont Achievment Center	-	-	-	9,814	**9,814**
DVHA	9421	HCBS Investment	-	(258)	-	-	**(258)**
DVHA	9102	Vermont Blueprint for Health	914,380	525,984	746,788	1,194,961	**3,382,113**
DVHA	9103	Buy-In	1,319	1,154	1,319	11,286	**15,078**
DVHA	9104	HIV Drug Coverage	20	-	-	-	**20**
DVHA	9106	Patient Safety Net Services	35,538	174,875	755,188	189,809	**1,155,410**
DVHA	9107	Institution for Mental Disease Services: DVHA	-	-	-	-	**-**
DVHA	9108	Family Supports	-	-	-	-	**-**
DVHA	9109	One Care VT ACO Quality & Health Management	-	-	-	-	**-**
DVHA	9110	One Care VT ACO Advanced Community Care Coordination	-	-	-	-	**-**
DVHA	9111	One Care VT ACO Primary Prevention Development	-	-	-	-	**-**
DVHA	9113	Investments Blueprint Expansion and Dulce	-	-	-	1,123,190	**1,123,190**
DVHA	9209	Investments (STC-79) - Family Planning	-	-	36,199	62,127	**98,326**
VDH	9201	Emergency Medical Services	252,798	207,803	25,108	182,230	**667,939**
VDH	9203	TB Medical Services	-	-	318,472	-	**318,472**
VDH	9204	Epidemiology	238,553	269,566	307,528	393,351	**1,208,998**
VDH	9205	Health Research and Statistics	310,605	314,423	749,893	458,166	**1,833,087**
VDH	9206	Health Laboratory	816,411	1,244,441	333,248	904,577	**3,298,677**
VDH	9207	Tobacco Cessation: Community Coalitions	526,666	252,004	-	347,851	**1,126,521**
VDH	9209	Family Planning	266,059	253,421	2,615,620	75,219	**3,210,319**
VDH	9210	Physician/Dentist Loan Repayment Program	908,466	-	-	1,071,154	**1,979,620**
VDH	9213	WIC Coverage	1,025,841	1,675,190	450,179	1,427,552	**4,578,762**
VDH	9214	Area Health Education Centers (AHEC)	174,030	-	20,891	-	**194,921**
VDH	9217	Patient Safety - Adverse Events	11,726	38,406	203,352	8,943	**262,427**
VDH	9219	Substance Use Disorder Treatment	880,802	2,270,356	197,005	773,189	**4,121,352**
VDH	9220	Recovery Centers	661,381	632,061	70,852	817,830	**2,182,124**
VDH	9221	Enhanced Immunization	72,609	384,433	19,503	117,113	**593,658**
VDH	9222	Poison Control	38,822	39,355	142,210	10,612	**230,999**
VDH	9223	Public Inebriate Services, C for C	567,220	283,431	15,548	33,002	**899,201**
VDH	9224	Fluoride Treatment	18,319	26,694	-	20,480	**65,493**
VDH	9226	Healthy Homes and Lead Poisoning Prevention Program	53,208	49,345	356,498	54,637	**513,688**
VDH	9228	VT Blueprint for Health	463,589	405,802	8,432	458,076	**1,335,899**
VDH	9421	HCBS Investment - Pediatric Pallative Care Program Supply Carts	49	4,377	-	-	**4,426**
VDH	9421	HCBS Investment - Expand VTHelplink	-	51,320	-	225,124	**276,444**
VSC	n/a	Health Professional Training	-	-	-	-	**-**

Attachment 6

Blueprint All-Payer PCMH

Blueprint PCMH

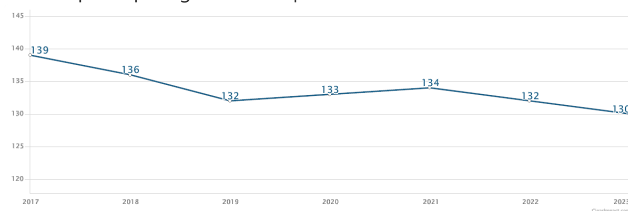
What We Do

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

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

Measures

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



Most Recent Period	Current Actual Value	Current Target Value	Current Trend
2023	130	–	↘ 2
2022	132	–	↘ 1
2021	134	–	↗ 2
2020	133	–	↗ 1
2019	132	–	↘ 2
2018	136	–	↘ 1
2017	139	–	↗ 2
2016	129	–	↗ 1
2015	124	–	↘ 1

Story Behind the Curve

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

The Blueprint has approached a saturation point where the program has recruited most of the available primary care

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

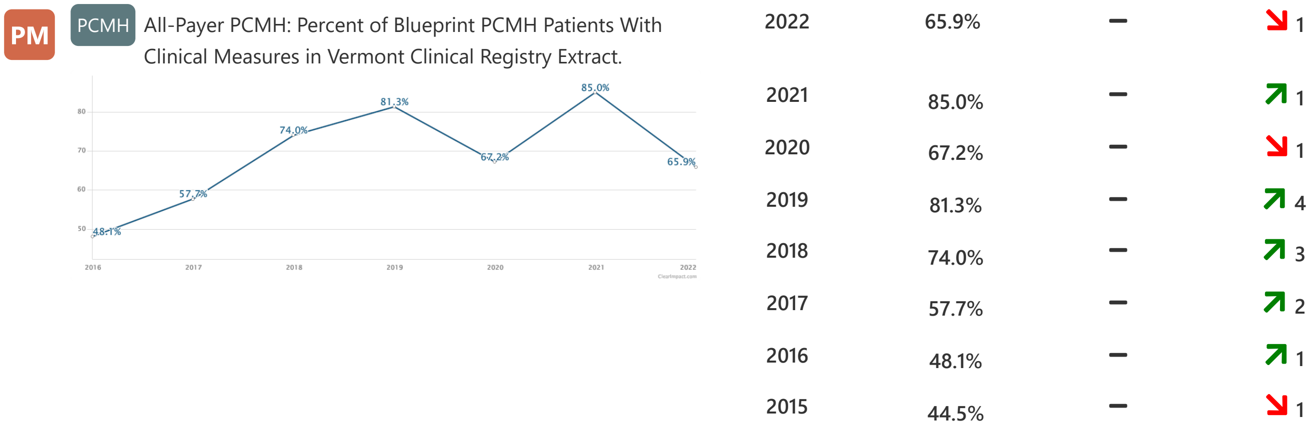
Partners

The Local Blueprint Transformation Network, which includes:

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

Notes on Methodology

The number of participating practices per quarter is generated from data stored in the Blueprint portal. The Blueprint Data Analyst manages information stored in the Blueprint portal.



Year	Value		Trend
2022	65.9%	–	↘ 1
2021	85.0%	–	↗ 1
2020	67.2%	–	↘ 1
2019	81.3%	–	↗ 4
2018	74.0%	–	↗ 3
2017	57.7%	–	↗ 2
2016	48.1%	–	↗ 1
2015	44.5%	–	↘ 1

Story Behind the Curve

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

Partners

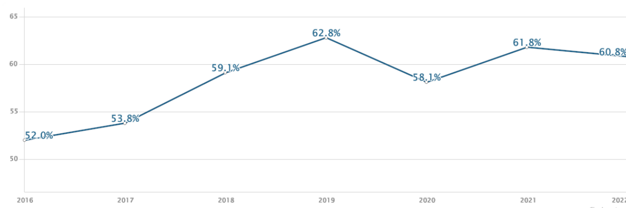
- Vermont Information Technology Leaders (VITL)
- Capitol Health Associates (until 12/31/2019)
- Electronic Health Record (EHR) vendors

- Patient-Centered Medical Homes (PCMHs)
- DVHA HIE/HIT Unit

Notes on Methodology

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

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



Year	Value		Trend
2022	60.8%	–	↘ 1
2021	61.8%	–	↗ 1
2020	58.1%	–	↘ 1
2019	62.8%	–	↗ 4
2018	59.1%	–	↗ 3
2017	53.8%	–	↗ 2
2016	52.0%	–	↗ 1
2015	49.0%	–	→ 1

Story Behind the Curve

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

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

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

Partners

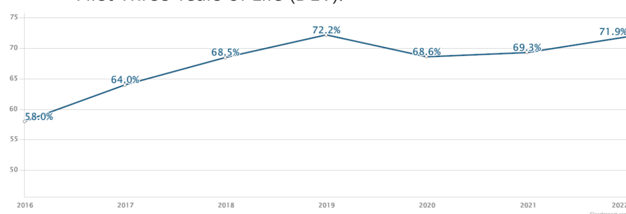
- The local Blueprint Transformation Network, which includes: QI Facilitators, Community Health Team leaders, and Project Managers

- Staff at Blueprint Patient-Centered Medical Homes

Notes on Methodology

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

PCMH All-Payer PCMH: NQF1448 Developmental Screening in the First Three Years of Life (DEV).



Year	Value		Trend
2022	71.9%	–	↗ 2
2021	69.3%	–	↗ 1
2020	68.6%	–	↘ 1
2019	72.2%	–	↗ 5
2018	68.5%	–	↗ 4
2017	64.0%	–	↗ 3
2016	58.0%	–	↗ 2
2015	50.0%	–	↗ 1

Story Behind the Curve

The Developmental Screening measure was chosen for its potential to positively impact young children at a developmentally critical time. The screenings provide opportunities for early identification and interventions that support improved development and health. Statewide organizations such as the Vermont Department of Health, the Vermont Child Health Improvement Program (VCHIP), OneCare Vermont, and the Blueprint for Health have supported efforts to use data for quality improvement initiatives and increase communication and coordination around child well-being. Currently, patient-centered medical homes receive Blueprint for Health performance payments based on this measure in the practice's hospital service area. The goal is for a region to perform better than the statewide average and demonstrate improvement between measurement periods or have outcomes in the 90th percentile relative to other regions. HEDIS does not benchmark this measure.

Partners

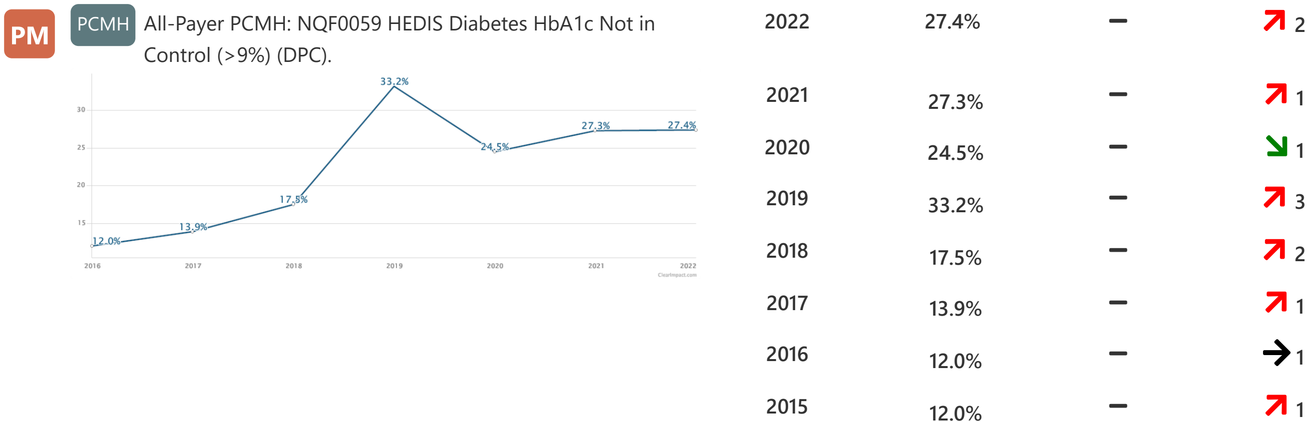
- The local Blueprint Transformation Network, which includes: QI Facilitators, Community Health Team leaders, and Project Managers
- Staff at Blueprint Patient-Centered Medical Homes (PCMHs)
- Vermont Department of Health

- Vermont Child Health Improvement Program

Notes on Methodology

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

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



2022	27.4%	–	↗ 2
2021	27.3%	–	↗ 1
2020	24.5%	–	↘ 1
2019	33.2%	–	↗ 3
2018	17.5%	–	↗ 2
2017	13.9%	–	↗ 1
2016	12.0%	–	→ 1
2015	12.0%	–	↗ 1

Story Behind the Curve

Diabetes affects over 6% of the Vermont population and is a leading cause of death due to chronic conditions. Additionally, those with diabetes or pre-diabetes often go undiagnosed. However, guideline-based early detection, treatment, and self-management can help individuals with diabetes improve control of the disease and improve long-term health outcomes and quality of life.

The goal is for a region to perform better than the statewide average and demonstrate improvement between measurement periods or have outcomes in the 90th percentile relative to other regions.

Partners

- Patient-Centered Medical Homes
- Community Health Teams
- Vermont Department of Health
- OneCareVermont

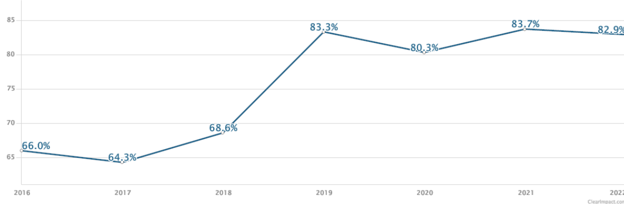
Notes on Methodology

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

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

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

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



Year	Value		Trend
2022	82.9%	–	↘ 1
2021	83.7%	–	↗ 1
2020	80.3%	–	↘ 1
2019	83.3%	–	↗ 2
2018	68.6%	–	↗ 1
2017	64.3%	–	↘ 3
2016	66.0%	–	↘ 2
2015	68.0%	–	↘ 1

Story Behind the Curve

The Blood Pressure in Control measure is the fourth of 4 key indicators of quality health care. This measure assesses the percentage of continuously enrolled members with hypertension, ages 18-85 years, whose last recorded systolic blood pressure was less than 140 mm/Hg and whose last recorded diastolic blood pressure was less than 90 mm/Hg. Hypertension is a risk factor for much morbidity, including heart disease and stroke, which are leading causes of death in the United States.

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

The goal is for a region to outperform the statewide average and demonstrate improvement between measurement periods or have outcomes in the 90th percentile relative to other regions.

Partners

• The local Blueprint Transformation Network, which includes: QI Facilitators, Community Health Team

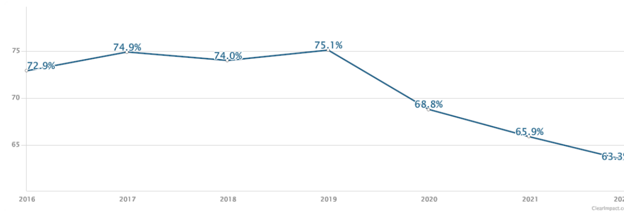
leaders, and Program Managers
• Staff at Blueprint Patient-Centered Medical Homes
• Vermont Department of Health
• OneCare Vermont
• Support and Services at Home (SASH)
• New England Quality Innovation Network-Quality Improvement Organization
• Vermont Program for Quality in Health Care, Inc.

Notes on Methodology

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

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

PCMH All-Payer PCMH: Percent of Primary Care Patients Attributed to PCMHs.



2022	63.3%	–	↘ 3
2021	65.9%	–	↘ 2
2020	68.8%	–	↘ 1
2019	75.1%	–	↗ 1
2018	74.0%	–	↘ 1
2017	74.9%	–	↗ 1
2016	72.9%	–	↘ 2
2015	73.2%	–	↘ 1

Story Behind the Curve

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

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

Partners

- The local Blueprint Transformation Network, which includes: QI Facilitators, Community Health Team leaders, and Project Managers

- Staff at Blueprint Patient-Centered Medical Homes (PCMHs)

Notes on Methodology

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

Attachment 7

P **Blueprint GC PCMH**

Blueprint PCMH

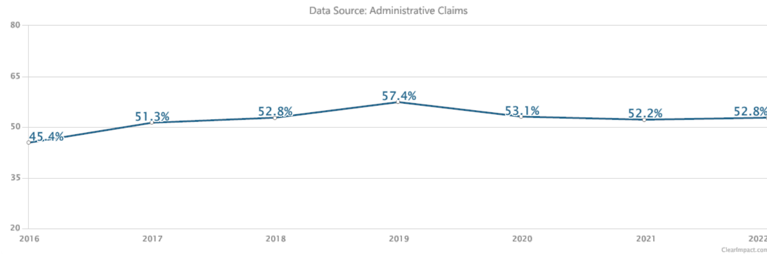
What We Do

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

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

Measures

PM PCMH Medicaid: NQF1448 Developmental Screening in the First Three Years of Life (DEV)



Most Recent Period	Current Actual Value	Current Target Value	Current Trend
2022	52.8%	–	↗ 1
2021	52.2%	–	↘ 2
2020	53.1%	–	↘ 1
2019	57.4%	–	↗ 5
2018	52.8%	–	↗ 4
2017	51.3%	–	↗ 3
2016	45.4%	–	↗ 2
2015	43.1%	–	↗ 1

Story Behind the Curve

The Developmental Screening measure was chosen for its potential to positively impact young children at a developmentally critical time. The screenings provide opportunities for early identification and interventions that support improved development and health. Statewide organizations such as the Vermont Department of Health, the Vermont Child Health Improvement Program (VCHIP), OneCare Vermont, and the Blueprint for Health have supported efforts to use data for quality improvement initiatives and increase communication and coordination around child well-being. Currently, patient-centered medical homes receive Blueprint for Health performance payments based in part on risk-adjusted results (not displayed here) for all-payer, PCMH-attributed patients on this measure in the practice's hospital service area. The goal is for a region to perform the statewide average and demonstrate improvement between measurement periods or have outcomes in the 90th percentile relative to other regions. HEDIS does not benchmark this measure.

While this payment model supports all patients in the medical home, regardless of payer, the data show the statewide average for Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes. Historically, one factor that could have affected outcomes was the reinstatement of eligibility redetermination after 2016, which led to the removal of a number of individuals (often healthier and younger) from the Medicaid rolls, thereby changing the composition of the Medicaid population.

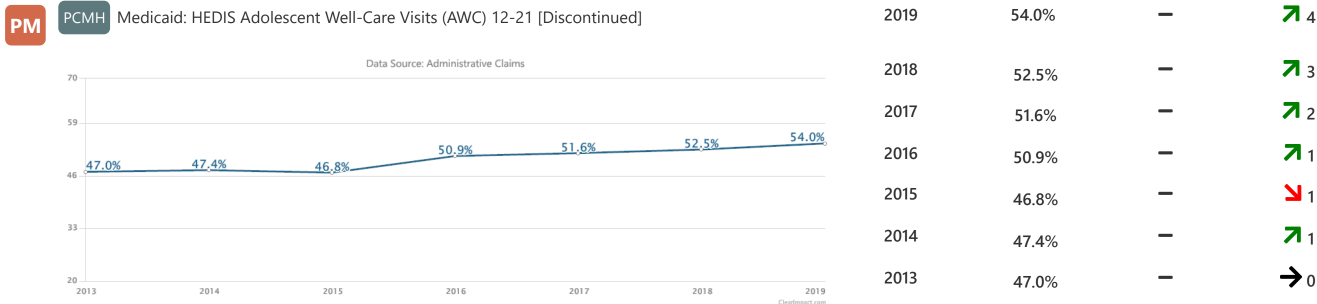
Partners

1. Patient Centered Medical Homes

2. Community Health Teams
3. Vermont Department of Health
4. Vermont Child Health Improvement Program
5. Early education and child care professionals

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes. This is a claim-based HEDIS measure that calculates the number of children who turned 1, 2, or 3 years of age in the measurement period who were screened for the risk of developmental, behavioral, and social delays using a standardized screening tool. (NQF #1448)



Year	Value		Trend
2019	54.0%	–	↗ 4
2018	52.5%	–	↗ 3
2017	51.6%	–	↗ 2
2016	50.9%	–	↗ 1
2015	46.8%	–	↘ 1
2014	47.4%	–	↗ 1
2013	47.0%	–	→ 0

Story Behind the Curve

Adolescent well-care visits provide an important opportunity to establish lifelong healthy behaviors, identify risk factors (e.g., sexual activity, substance use, depression, etc.), and intervene at an early stage if concerns are raised. However, the percent of adolescents who receive this care frequently drops off except for students participating in sports. While this payment model supports all patients in the medical home, regardless of payer, this measure shows the statewide average for Medicaid-primary members, of whom a majority are attributed to a patient-centered medical home. Practices and communities continue their efforts to improve further upon this measure.

Blueprint perfomance payments incentivize PCMHs in a region to perform the all-payer statewide average and to demonstrate improvement between measurement periods or have outcomes in the HEDIS 90th Percentile. Historically, one factor that could have affected outcomes was the reinstatement of eligibility redetermination after 2016, which led to a number of individuals (often healthier and younger) removed from the Medicaid rolls, thereby changing the composition of the Medicaid population. This measure was discontinued after Report Year 2020 / Measurement Year 2019.

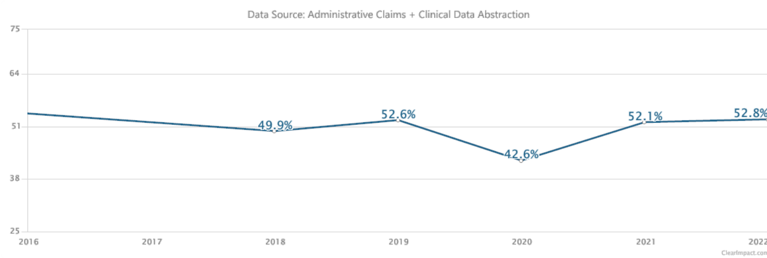
Partners

1. Patient Centered Medical Homes
2. Community Health Teams
3. Vermont Child Health Improvement Program
4. OneCare Vermont
5. School nurses

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes. This is a claim-based HEDIS measure that calculates adolescents and young adults 12-21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. This measure was discontinued after Report Year 2020 / Measurement Year 2019.

Year	Value		Trend
2022	52.8%	–	↗ 2



2021	52.1%	–	↗ 1
2020	42.6%	–	↘ 1
2019	52.6%	–	↗ 1
2018	49.9%	–	↘ 1
2015	56.4%	–	↗ 1
2014	48.2%	–	↘ 1
2013	53.3%	–	→ 0

Story Behind the Curve

Hypertension is a risk factor for much morbidity, including heart disease and stroke, which are leading causes of death in the United States. Guideline-based medical treatment and increases in healthy behaviors can improve the management of this condition.

While these types of interventions and this payment model support all patients in the medical home, this measure show the statewide average for all Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes (PCMHs). Historically, one factor that could have affected outcomes was the reinstatement of eligibility redetermination after 2016, which led to a number of individuals (often healthier and younger) removed from the Medicaid rolls, thereby changing the composition of the Medicaid population.

The goal is for a region to perform the statewide average and demonstrate improvement between measurement periods or have outcomes in the 90th percentile relative to other regions.

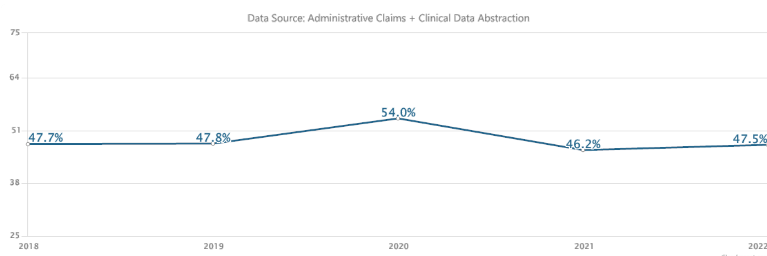
Partners

1. VT Department of Health
2. OneCare Vermont
3. SASH
4. New England QIN-QIO
5. Vermont Program for Quality in Health Care

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes. This is a hybrid claims/clinical HEDIS measure. The measure includes members age 18-85 years, who were identified in claims as having hypertension and for whom we had valid blood pressure readings. Those members whose blood pressure was less than 140/90 mmHG were considered to have their hypertension in control. (NQF #0018)

PCMH Medicaid: NQF0059 HEDIS Diabetes HbA1c Not in Control (>9%) (DPC)



2022	47.5%	–	↗ 1
2021	46.2%	–	↘ 1
2020	54.0%	–	↗ 2
2019	47.8%	–	↗ 1
2018	47.7%	–	→ 0

Story Behind the Curve

Diabetes affects over 6% of the Vermont population and is a leading cause of death due to chronic conditions. Additionally, those with diabetes or pre-diabetes often go undiagnosed. However, guideline-based early detection, treatment, and self-management can help individuals with diabetes improve control of the disease and improve long-term health outcomes and quality of life.

The data show the statewide rate for Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes (PCMHs). For this measure, lower rates are better. Efforts to improve care management continue.

The goal is for a region to perform better than the statewide average and demonstrate improvement between measurement

periods or have outcomes in the 90th percentile relative to other regions.

Partners

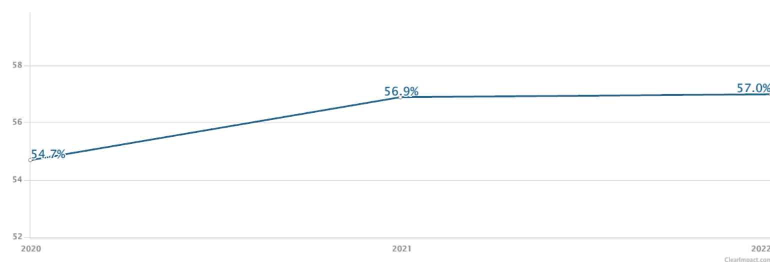
1. Patient-Centered Medical Homes
2. Community Health Teams
3. Vermont Department of Health
4. OneCareVermont

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes. This is a hybrid claims/clinical HEDIS measure. The measure includes members age 18 to 75 years identified in claims as having diabetes and for whom we obtained valid HbA1c measurement data. If the HbA1c glycosylation was greater than nine percent, that member was considered "in poor control". (NQF #0059)

PCMH Medicaid: HEDIS Child and Adolescent Well-Care Visits (WCV) 3-21

2022	57.0%	–	↗ 2
2021	56.9%	–	↗ 1
2020	54.7%	–	→ 0



Story Behind the Curve

Child and adolescent well-care visits provide an important opportunity to establish lifelong healthy behaviors, identify risk factors (e.g., sexual activity, substance use, depression, etc.), and intervene at an early stage if concerns are raised. However, the percent of adolescents who receive this care frequently drops off except for students participating in sports. While this payment model supports all patients in the medical home, regardless of payer, this measure show the statewide average for Medicaid-primary members, of whom a majority are attributed to a patient-centered medical home. Practices and communities continue their efforts to improve further upon this measure.

Blueprint perfomance payments incentivize PCMHs in a region to perform the all-payer statewide average and to demonstrate improvement between measurement periods or have outcomes in the HEDIS 90th Percentile for adolescents 12-21.

Partners

1. Patient Centered Medical Homes
2. Community Health Teams
3. Vermont Child Health Improvement Program
4. OneCare Vermont
5. School nurses

Notes on Methodology

New measure, beginning with Measurement Year 2020. The population sample for this measure consists of Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes. This is a claim-based HEDIS measure that calculates the proportion of children and adolescents 3-21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.

P **Blueprint GC PII**

Blueprint WHI

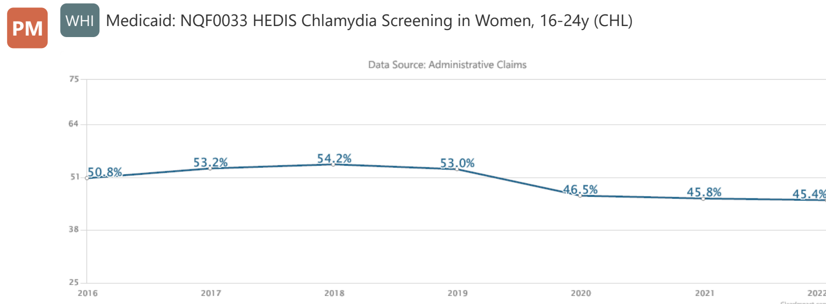
What We Do

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

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

Measures

PM WHI Medicaid: NQF0033 HEDIS Chlamydia Screening in Women, 16-24y (CHL)



Most Recent Period	Current Actual Value	Current Target Value	Current Trend
2022	45.4%	–	↘ 4
2021	45.8%	–	↘ 3
2020	46.5%	–	↘ 2
2019	53.0%	–	↘ 1
2018	54.2%	–	↗ 2
2017	53.2%	–	↗ 1
2016	50.8%	–	↘ 1
2015	52.5%	–	↗ 1
2014	49.8%	–	↘ 1

Story Behind the Curve

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

Partners

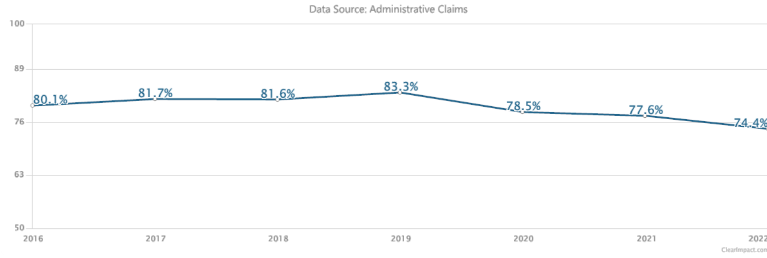
1. DVHA Quality Unit
2. VT Department of Health
3. Planned Parenthood of Northern New England

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, of whom a majority are attributed to patient-

centered medical homes. This measure shows the percentage of female members, ages 16 to 24, identified as sexually active and who had at least one test for chlamydia in the measurement year. This measure is derived from claims data.

WHI Medicaid: HEDIS Adults' Access to Preventive/Ambulatory Health Services (AAP)



Year	Value		Trend
2022	74.4%	–	↘ 3
2021	77.6%	–	↘ 2
2020	78.5%	–	↘ 1
2019	83.3%	–	↗ 1
2018	81.6%	–	↘ 1
2017	81.7%	–	↗ 2
2016	80.1%	–	↗ 1
2015	75.8%	–	↘ 2
2014	79.7%	–	↘ 1

Story Behind the Curve

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

Partners

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

Notes on Methodology

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

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

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

P **Blueprint GC CHT**

Blueprint CHT

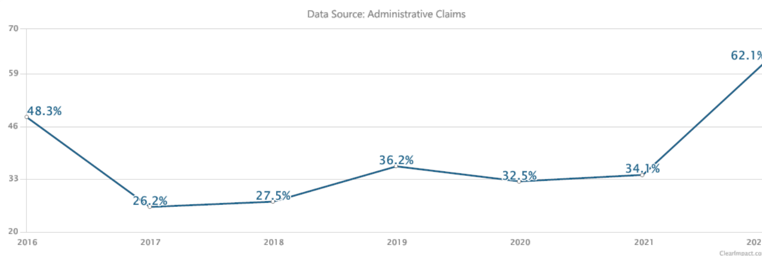
What We Do

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

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

Measures

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



Most Recent Period	Current Actual Value	Current Target Value	Current Trend
2022	62.1%	–	↗ 2
2021	34.1%	–	↗ 1
2020	32.5%	–	↘ 1
2019	36.2%	–	↗ 2
2018	27.5%	–	↗ 1
2017	26.2%	–	↘ 1
2016	48.3%	–	→ 0

Story Behind the Curve

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

Partners

1. Patient-Centered Medical Homes
2. Community Health Teams
3. Vermont Department of Health

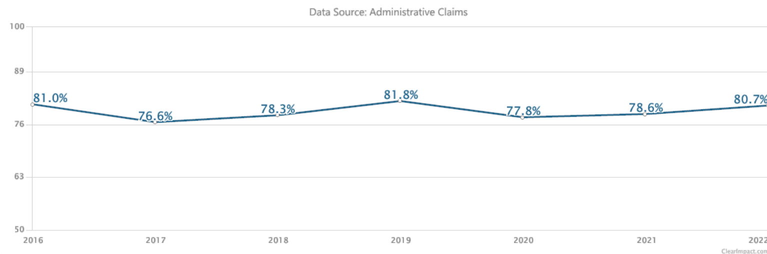
4. Green Mountain Care Board
5. OneCareVermont

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes, and therefore have access to Community Health Teams.

This HEDIS measure shows the percent of emergency department (ED) visits for members, age 13 years and older, with a principal diagnosis of substance use disorder who had a follow-up visit for substance use disorder within 30 days of the ED visit. (NQF #3488)

PM CHT Medicaid: NQF3489 HEDIS Emergency Dept Visits for Mental Illness, 30-Day % With Follow-Up (FUM)



Year	Value		Trend
2022	80.7%	–	↗ 2
2021	78.6%	–	↗ 1
2020	77.8%	–	↘ 1
2019	81.8%	–	↗ 2
2018	78.3%	–	↗ 1
2017	76.6%	–	↘ 1
2016	81.0%	–	→ 0

Story Behind the Curve

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

Partners

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

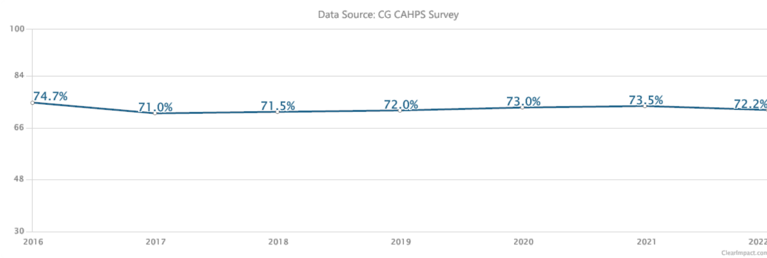
Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes, and who therefore have access to Community Health Teams.

This measure shows the percent of emergency department (ED) visits for members, age 6 years and older, with a principal diagnosis of mental illness who had a follow-up visit for mental health within 30 days of the ED visit. (NQF #3489)

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

Year	Value		Trend
2022	72.2%	–	↘ 1



2021	73.5%	–	↗ 4
2020	73.0%	–	↗ 3
2019	72.0%	–	↗ 2
2018	71.5%	–	↗ 1
2017	71.0%	–	↘ 2
2016	74.7%	–	↘ 1
2015	76.6%	–	↗ 1

Story Behind the Curve

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

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

Partners

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

Notes on Methodology

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