State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 20
(1/1/2024 – 12/31/2024)

Quarterly Report for the period October 1, 2024 – December 31, 2024

Submitted Via PMDA Portal on March 31, 2025

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I. Background and Introduction

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

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

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

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

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

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

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

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

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

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

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

2024: On July 2, 2024, Vermont received approval to amends the Global Commitment to Health Waiver to provide Medicaid coverage for individuals transitioning out of incarceration. As outlined in the federal waiver, sentenced incarcerated individuals will become eligible for Medicaid 90 days before their release.

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the fourth quarterly report for waiver year 20, covering the period from October 1, 2024, through December 31, 2024 (QE122024).***

II. Outreach/Innovative Activities

Member and Provider Services

Key updates from QE122024:

- Non-Emergency Medical Transportation (NEMT) Updates.
- Coordination of Benefit Activity

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

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

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

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

NEMT Update

In the fourth quarter of calendar year 2024, DVHA's non-emergency medical transportation (NEMT) program showed that the numbers from previous quarters were indicative of the average utilization of the program, as the numbers over time remained steady, with a few minor ups and downs. Program complaint numbers continued to run well below the contracted standard, maintaining a monthly rate of less than 1%. Rides scheduled/provided and incoming call volume for the contractor also maintained a steady trend, with only minor fluctuations month to month.

Overall utilization numbers have never fully rebounded to pre-Covid levels. The average rides-per-month-per-member has continued to moderately rise since pre-Covid, as lower monthly member counts have outpaced the lower trips provided counts, driving up the cost-per-member ratio for DVHA's contractor, VPTA.

Coordination of Benefit Activity

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

Areas of activities:

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

recovery of Medicaid funds for physicians' services, durable medical equipment, home health care, or skilled nursing facility care.

- **Third-Party Recoupment:** Seek recovery from providers when Medicaid paid for services as primary and the primary payer requires additional information for recovery.

Coordination of Benefit Collection Table:

MPS – Coordination Recovery Activities "Q4"	
Casualty	$572,332.69
Estate	$367,235. 12
Third-Party & Court-Ordered Medical	$166,677.59
Medicare Prescription Drug Premium/Claims	$96,258.01
Over Resource/Hospice/Patient Share/Credit Balance	$269,212.19
Annuity/Trust/Waiver	$33,696.46
Lamp/Map, Medicare Claim Recoupment	$47,189.22
Third-Party Claim Recoupment	$32,918.97
Total	**$1,585,520.25**

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

Coordination of Benefit-Cost Avoidance Table:

Cost Avoidance "Q4"	
Third-Party Liability	**$12,917,504.37**
Medicare	**$179,930,475.64**
Total	**$192,847,980.01**

III. Operational/Policy Developments/Issues

Key updates from QE122024:

- The Customer Support Center received 54,815 calls in QE0924, down 19% from the previous year.
- During this period, DVHA has done significant work to create clear external messaging about the changes for this Open Enrollment. This has included developing accessible information and collaborating with key external partners to algin messaging and message timing.
- Increasing numbers of customers are using self-service functions. Self-serve applications comprised slightly under half (47%) of all applications in QE0924.

Vermont Health Connect

Enrollment

By the end of 2024, more than 196,639 Vermonters were enrolled in Vermont Health

Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 125,880 in Medicaid for Children and Adults (MCA) and 70,759 in Qualified Health Plans (QHPs), with the latter divided between 29,959 enrolled with VHC, 4,141 direct enrolled with their insurance carrier as individuals, and 36,659 enrolled with their small business employer.

Vermont Health Connect's eleventh open enrollment period launched successfully on November 1, 2024. In October 2024, 99.94% of eligible QHP renewals were handled through a single, clean automated process.

Vermonters visited the online Plan Comparison Tool 101,847 times between January 1, 2024, and December 31, 2024. This accounts for a 203% increase over the prior year.

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Medicaid Renewals

The first round of unwind renewals were largely initiated by April and second round renewals commenced thereafter. System upgrades to handle ex parte on an individual, rather than household, level were implemented and took effect for renewals initiated in July. For the last two months of '24 cases in need of manual renewals were bumped out to mid-'25 in order to catch up on renewal and verification backlogs. Ex parte renewals for those months were completed. Unwind flexibilities and waivers implemented in '23 remained in effect. Many of those will be made permanent features of renewals in '25. The ex parte success rate for the year was 71%.

QHP Renewals

DVHA kicked off a series of meetings with its internal stakeholders and Maintenance and Operations vendor in mid-summer 2024 to prepare for the upcoming Open Enrollment. These meetings focused on testing, notices, business, and transactional planning activities. A new initiative was brought for 2025 Open Enrollment, 'targeted Gold mapping' where we would auto map selected Silver enrollees into a Gold plan as it was more cost effective and a better plan to have.

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 2024, this step was operated with a single, clean, automated run that took care of 99.94% of eligible cases. The 0.06% 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 2025 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 fourth year in which QHP premiums are no longer being handled by our previous premium processor, WEX Health. In November 2024, 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 2025 QHP renewal experience a success.

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Applying Online

The percentage of Vermonters applying for coverage online has more than tripled over the last nine years, increasing from 16% of VHC applications in June 2016 to 51% in December 2024. 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.

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 2024, 97% 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 two months in 2024. 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.

DVHA also executed monthly reconciliation of the marketplace's enrollment systems in 2024. 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 2024, DVHA met the goal every month with Blue Cross Blue Shield of Vermont (BCBSVT) and Northeast Delta Dental (NEDD). By May 2024, Vermont successfully initiated almost all Medicaid renewals. The renewals, verifications, terminations, and other related activities were executed according to each individual's Medicaid batch. Despite this achievement, there remain several backlogged categories, including applications, verifications, and return mail, due to the substantial increase in the Medicaid population undergoing renewal. Throughout the calendar year 2024, Vermont Health Connect (VHC) effectively initiated 12 Medicaid batches.

DVHA also honed its Medicaid reconciliation process in 2024. 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 2024. The percentage of phone calls answered within 24 seconds averaged 82%. Well above the 75% goal.

The overall inbound call volume in 2024 almost mirrored 2023. 2024 call volumes increased by 0.5%.
Additionally, there was a slight increase in the percentage of calls that Maximus needed to escalate to DVHA in 2024. In 2024, 7.8% 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 2024. In 2017 DVHA set a goal of answering 90% of calls within five minutes. In 2024 they met that goal by 5%. In 2024, 95% of all calls transferred to DVHA were answered within five minutes.

In-person Assisters

2024 saw a significant increase in the number of active Assisters. The Assister Program went from 94 Assisters in 2023 to 130 Assisters at the end of 2024. This came from an increase in Certified Application Counselors from 85 to 121.

Additionally, the program has 86 participating organizations with coverage in all 14 Vermont counties.

Going forward in 2025, the Assister Program will focus on improving support for new and certified Assisters. Recruiting efforts will focus on connecting the Assister Program with existing State of Vermont programs that serve Vermonter's without health insurance or who may want to change their coverage.

Outreach & Education

During 2024, DVHA built on the experience garnered from activities of previous public information campaigns. First was the continuation of the monthly Medicaid renewal process. While many customers had Medicaid benefits renewed automatically, DVHA made efforts to ensure other customers continued to have access to health coverage. The direct outreach mediums included notices, text messages and emails. The indirect outreach mediums included social media and e-newsletters to partners. Second was a campaign before and during Open Enrollment to inform customers and potential customers about the greater affordability of marketplace health plans. A more direct message focused on "selling" Gold Plans which, with financial help, gave customers lower monthly premiums costs for a better coverage.

To better promote access to health care, DVHA deepened its partnership with the Vermont

Department of Labor (DOL). DOL is the first point of contact when businesses downsize or close. They host Rapid Response events to counsel about state resources such as filing for unemployment and resources for re-employment, while DVHA presents on access to health care after loss of minimal essential coverage. This partnership is beginning to further DVHA's outreach to businesses.

The Plan Comparison Tool continues to play its important dual role. First, it is the primary tool to help Vermonters find a health plan that best fits their needs and budget. Second, it is an educational tool to help customers and potential customers assess their choices for coverage.

The Plan Comparison tool was visited over 49,000 times in 2024. The Tool was visited over 24,000 times. This final period included the run-up to and most of the annual Open Enrollment period.

DVHA also promoted an Affordable Employer Coverage Tool. This online tool helps a potential customer determine if their Employer Sponsored Insurance is affordable for themselves and/or their household. If not, they could apply for financial help with marketplace coverage.

Future Development

To allow an additional modality for Vermonters to renew their Medicaid for the Aged, Blind and Disabled (MABD), a self-service version of the application went live in Summer 2024. This online application allows a Vermonter to renew their 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.

Global Commitment Register

The Global Commitment Register (GCR) is a database of policy changes to and clarifications of existing Medicaid policy under Vermont's 1115 Global Commitment to Health waiver. Created in November 2015, it is based on the Federal Register and can be used as both a public notice and documentation tool for Medicaid policy. Like the Federal Register, the GCR can be used to publish a proposed policy, including information on public comment submissions, final policy, notices, and policy clarifications. The GCR is available on the Agency of Human Services website to ensure that policy changes are transparent to Vermonters and to provide a forum for public comments.

The GCR listserv is a group of hundreds of interested parties who have elected to receive periodic key updates about Vermont health care programs, which includes policy changes to all Medicaid programs as well as policy changes to Vermont's Health Benefit Exchange. Policy changes posted to the GCR include changes made under the authority of the 1115 waiver, proposed waiver amendments or extensions, administrative rule changes, changes to rate methodologies, and State Plan Amendments. 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.

Policy or Administrative Difficulties

These topics are raised and addressed during monthly wavier monitoring calls with CMS.

Key Operational and Other Challenges

These topics are raised and addressed during monthly wavier monitoring calls with CMS.

State Legislative Developments

There were no state legislative developments that impacted the demonstration during this reporting period.

Marketplace Subsidy Program

Number of individuals served – 14,876 in SFY 2025
Size of the subsidies - $1,616,987 year to date actuals through 9/30/2024

IV. Financial/Budget Neutrality Development/Issues

As is the monthly process, AHS paid DVHA 1/12th of the legislative budget for Global Commitment on the first business day of each month during the October – December 2024 quarter. This payment served as the proxy by which to draw down federal funds for Global Commitment (GC).

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

This quarter represents the fourth quarter of DY20 of the GC Waiver. Vermont calculates $1.69B for without waiver expenditures and reported $1.61B with waiver expenditures, leaving a savings subtotal of $80.8M. There are also 12 Hypothetical Tests for various demonstration groups. The hypothetical tests for New Adult, SMI IMD, Maternal Health & Treatment Services, CRT, Moderates and Reentry Non-Services reflect a surplus. Whereas the test for SUD IMD, Global Rx, and Marketplace Subsidies shows a moderate deficit. The total of the deficit is $6.1M, the

cumulative Waiver savings is $336M . There is nothing to report for the Housing Pilot, SUD CIT, Reentry Services, HRSN Services and HRSN Infrastructure because those programs have not yet been operationalized. Lastly, for Investments, Vermont reported $38.4M in expenditures for the quarter, which leaves $46.5M at the end of DY20.

We note the Budget Neutrality was impacted by pmpm updated provider rate increases that were implemented beginning 7/1/2022.

Vermont continues to implement HCBS programs using the Reinvestment funds under the American Rescue Plan of 2021. For QE01224, Vermont reported $540K in Program expenses, $2.9M in Investments, and $2.2M in Admin expenses.

V. Member Month Reporting

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

The table below contains Member Month Reporting for DY19 and DY20 and includes the unduplicated count of member months for SUD IMD and SMI IMD stays.

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

Medicaid Eligibility Group	Total DY 2018	Total DY 2019	Total DY 2020
ABD - Non-Dual - Adult	**38,226**	**88,762**	**89,704**
ABD - Non-Dual - Child	**8,739**	**22,381**	**23,262**
ABD - Duals	**136,650**	**275,676**	**265,560**
Non - ABD Adult	**112,369**	**205,008**	**143,063**
Non - ABD Child	**378,139**	**733,460**	**675,580**
Hypothetical Groups			
New Adult	**454,502**	**874,138**	**725,971**
SUD - IMD ABD	**51**	**142**	**106**
SUD - IMD ABD Dual	**70**	**156**	**112**
SUD - IMD Non ABD	**121**	**430**	**152**
SUD - IMD New Adult	**623**	**1,299**	**1,299**
SMI - IMD ABD	**55**	**127**	**169**
SMI - IMD ABD Dual	**10**	**28**	**35**
SMI - IMD Non ABD	**20**	**173**	**53**
SMI - IMD New Adult	**174**	**350**	**351**
Housing Pilot	**0**	**0**	**0**
Maternal Health and Treatment Services	**114**	**343**	**232**
CRT	**1,213**	**2,437**	**3,074**
SUD CIT	**0**	**0**	**0**

VT Global RX	**55,178**	**108,758**	**109,817**
Moderate Needs Group	**731**	**1,367**	**1,219**
Marketplace Subsidy	**60,841**	**139,440**	**173,911**
Reentry Services	**0**	**0**	**0**
Reentry Non-Services	**0**	**0**	**0**

Yearly unduplicated enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement.

VI. Consumer Issues

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

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

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

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

Public Forums

The Medicaid and Exchange Advisory Committee is a federally required committee with the opportunity to participate in Medicaid policy development and program administration. The Medicaid and Exchange Advisory Committee meets 10 times per calendar year, taking a recess in August and December, on the 4th Monday of each month unless otherwise noticed. Meetings are held from 10AM – 12PM and are open to the public. Meeting minutes for each meeting are publicly posted here: https://dvha.vermont.gov/advisory-boards/medicaid-and-exchange-advisory-committee.

Additionally, public forums are occasionally held for administrative rule making or when the 1115 waiver is being amended or renewed. In such instances, information about each forum is publicly posted on Vermont's Global Commitment Register. Forums of this nature will be reported in the Global Commitment Register section of this report.

VII. Quality Improvement

Quality Assurance and Performance Improvement Activities

Key updates from QE0122024:

- DVHA administered both the Health Plan and HCBS CAHPS surveys.
- DVHA submitted its 2024 Network Adequacy ratios. DVHA Quality and Data staff participated in quality measure workflow development as part of the MDWAS initiative.

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

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

PIHP Quality Committee

The Quality Committee remained active during QE1224 and consists of representatives from all departments within AHS that serve the Medicaid population. The committee continues to structure its work around the federal managed care quality program guidelines. Topics addressed this quarter included an annual review of grievance and appeals trends, utilization management activities and applied behavior analysis (ABA) program quality metrics.

Home and Community-Based Services (HCBS) Quality Subcommittee

The HCBS Quality subcommittee is coordinated by DVHA and includes representatives from DAIL and DMH, the departments that are delegated service delivery to Vermont Medicaid's HCBS special health care needs populations. During this reporting period, the committee reviewed each HCBS program's structure and activities and provided information for compliance EQR follow-up. The HCBS CAHPS survey was also administered by a contracted vendor during QE1224.

Formal CMS Performance Improvement Project (PIP)

DVHA's formal PIP topic is focused on new-to-Medicaid (NTM) members receiving an initial screening within 90 days of their enrollment. Regulatory review identified this as an area for improvement. During this reporting period, a cross-Agency team completed a cause and effect diagram and identified possible change ideas.

Quality Measure Reporting

- HEDIS measure production –In addition to producing and reporting on administrative (claims-based) measures annually, the Quality Improvement, Clinical and Data teams work with our quality measures vendor to produce hybrid measures. These teams are engaged in DVHA's MDWAS initiative and are helping to design future workflows.
  CAHPS Experience of Care measures – The 2024Health Plan CAHPS surveys for Adults and Children. were administered during QE1224. Results will be available in QE0325 and reviewed by the Quality Committee.

Vermont Next Generation Medicaid ACO

During QE01224, DVHA's Director of Quality Management received, reviewed, and approved the quarterly VMNG ACO quality management reports. Quality and Clinical staff from DVHA and the VMNG ACO also meet quarterly with a focus on quality measurement and ongoing QI efforts.

Comprehensive Risk Assessment

Staff from DVHA's Quality, Oversight & Monitoring, and Compliance units maintain a comprehensive risk assessment program for Vermont's Medicaid program. The purposes of this joint effort 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 informs updates to inter-agency partner agreements.

During QE0122024, the risk assessment team coordinated the compilation of network adequacy ratios, established a workgroup to assess compliance with returned member mail and began preparing for the 2025 compliance EQR.

Global Commitment (GC) Investment review.

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

During this most recent quarter, the state highlighted the performance of a subset of their Blueprint investments. The Clear Impact Scorecards for these investments are included in this report as Attachment 6.

Payment Models & Performance Monitoring

AHS Departments are required to monitor and evaluate the performance of their payment models on an ongoing basis and subject them to formal review according to a periodic schedule.
Performance monitoring is accomplished via a quarterly and annual review of performance information contained in a web browser-based software application (Clear Impact Scorecard). The scorecard includes the following data elements: investment description (i.e., the goal of the investment, the activities being supported, and information on how they are provided), performance measures (i.e., the data being collected and analyzed to determine if the investment is achieving its desired goal), results (performance measure rates for the most recent

reporting period), and an interpretation of the results (i.e., comparing actual to expected rates using performance targets and/or benchmarks and to characterize trends or patterns in the data). During this most recent quarter, the state reported the performance of their Blueprint payment model. The Clear Impact Scorecard for this payment model is included in this report as Attachment 7.

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

The quality strategy is intended to serve as a blueprint or road map for states and their contracted health plans in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. In the Special Terms and Conditions (STCs) of the State's recent waiver extension, CMS has included prescriptive 1915(c) HCBS quality requirements for the State's 5 HCBS programs (CFC, DS, BIP, CRT, MH Under 22). As a result, the State is required to extend its existing quality strategy to include HCBS. During this quarter, the State continued to identify the HCBS Quality Improvement Strategy (QIS) guidance as they update their broader waiver Quality Strategy. The QIS for VT HCBS is a part of the state's overall 1115/Medicaid Quality Strategy and as such the HCBS specific QIS may be imbedded within this larger approach. The state continues to review and revise their overall approach and will be updating the sections related to HCBS to reflect the use of the new HCBS measure set that the state is piloting with CMS as well as the new Access and Medicaid Managed Care Rule requirements.

SUD Monitoring Protocol and Reports

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

SUD Midpoint Assessment

As per STC 9.4 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 SUD treatment providers, beneficiaries, and other key partners. During Q4, the state continued to work with the evaluator to develop the assessment. Specifically, the state worked to help define the sample frame for survey participants (i.e., SUD stakeholders). It is anticipated that the survey will be distributed during the next quarter. AHS will continue to work with the evaluator to complete the midpoint assessment.

SMI Monitoring Protocol and Reports

The SMI Monitoring Protocol specifies the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements of the demonstration. During this quarter, the state submitted quarterly narrative and data monitoring reports for the serious mental illness (SMI) component of the Global Commitment to Health demonstration, to the Centers for Medicare & Medicaid Services (CMS), as required by the state's special terms and conditions (STC).

SMI Midpoint Assessment

As per STC 10.8 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. During Q2, the mid-point assessment was completed by an independent evaluator and submitted to CMS. The state is currently awaiting CMS feedback.

VIII. Demonstration Evaluation Activities

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

Overall Waiver

During the quarter, the state continued to work with an independent evaluator to assess access to data sources and the availability of metrics to support the overall waiver. The Medicaid Management Information System (MMIS) has been identified as a critical data source. The state plans to use Globalscape EFT as their managed file transfer solution. Globalscape accounts were approved and created for the independent evaluator. It is anticipated that these accounts will be tested and operational by next quarter.

Innovative Assessment Evaluation

The state plans to evaluate all investments authorized under the demonstration in accordance with STC 15.3. Hypotheses for investments will reflect appropriate goals for each area of investment as described in STC 11.1 and broadly assess whether they collectively contribute to the goals of the demonstration, such as the reduction of disparities in health outcomes. During this quarter, the state worked with the vendor on a contract amendment to adjust the approach used to assess managed care investments as well as the output delivered to the state upon completion. The new approach would require the evaluator to "screen" half of the remaining investments for evaluability and provide that state with a recommendation re: an appropriate evaluation methodology. This will allow the evaluator to provide key findings for various types of investments. The state will continue to work with the evaluator to ensure the contract is in place by next quarter.

Summative Evaluation Report

The draft Summative Evaluation Report covers the 2022–2027 demonstration period. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals. During this quarter, the state continued to work with the independent evaluator to plan for the summative evaluation report.

PHE Flexibilities

There was no evaluation activity associated with the COVID-19 public health emergency (PHE) during this quarter.

Waiver Performance Evaluation

During Q4 2024 the state continued to work with the University of Massachusetts to identify metrics, gaps in metrics, as well as potential data sources needed to produce metrics designed to enhance the state's ability to assess the performance of their Medicaid managed care model. In addition, the state began to engage the evaluator in developing an agreement designed to support a research partnership between the state and the UMASS/UVM evaluation team. Initial discussions have centered around what type of agreement would be most appliable as well as defining relationships and responsibilities for all involved parties. The state will continue to work with the evaluator to update these deliverables over the course of the next quarter.

IX. Compliance

Key updates from QE122024:

- EQRO Review Activities – supported the development of the EQR Technical Report
- SIU Activities are included in this section.

External Quality Review

During Q4, 2024, the state supported HSAG as they compiled and analyzed all data from its 2024 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 as to the quality and timeliness of, and access to the care furnished to its Medicaid beneficiaries.

Lawsuits or Legal Actions

During the last quarter, no audits, investigations, or lawsuits occurred that impacted the demonstration.

Intra-Governmental Agreement (IGA) between AHS and DVHA

The AHS/DVHA IGA documents the Global Commitment to Health demonstration requirements between AHS and DVHA. As per the Special Terms and Conditions (STCs) of the waiver, this agreement must be reviewed and approved annually by CMS. During this quarter, the state submitted the CY2025 agreement and Rate Certification to CMS for review/approval.

Special Investigations Unit (SIU)

CMS has requested that the state provide them with quarterly reports detailing 1) the number of provider investigations conducted by the SIU as well as 2) the number of suspected fraud referrals provided to the state Medicaid agency by the SIU. This information for the current quarter is included in the table below.

Table 1. SIU Activity Q4 2024

REPORTING ELEMENT	#
The number of provider investigations conducted by the PIHP	32

The number of suspected fraud referrals provided to the state Medicaid agency by the PIHP	1
The number of Personal Care Assistant related suspected fraud referrals provided to the state Medicaid agency by the PIHP	1
Number of Provider Preventable Conditions identified by the SIU in the fourth quarter of CY2024	0
The number of hospital acquired condition cases identified by DVHA SIU in the fourth quarter of CY 2024.	24

X. Reported Purposes for Capitate Revenue Expenditures

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

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

XI. State Contact(s)

Fiscal	Richard Donahey, CFO VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	802-241-0442 (P) richard.donahey@vermont.gov
Medicaid Director	Monica Ogelby Vermont Medicaid Director Agency of Human Services 280 State Drive Waterbury, VT 05671-100	802-338-6643 Monica.ogelby@vermont.gov
Policy/Program	Ashley Berliner, Director of HealthCare Policy & Planning VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	802-578-9305 (P) 802-241-0958 (F) ashley.berliner@vermont.gov
Managed Care Entity	DeShawn Groves, Commissioner of the Department of Vermont Health Access 280 State Drive Waterbury, VT 05671-1000	802-798-4982 (P) 802-879-5962 (F) DaShawn.Groves@vermont.gov

XII. Attachments

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

Date Submitted to CMS: March 31, 2025

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
QE 1224

ELIGIBILITY GROUP	DY 18 Jul 2022 - Dec 2022	DY 19 Jan 2023 - Dec 2023	DY 20 Jan 2024 - Dec 2024
Without Waiver (Caseload x pmpms)			
ABD - Non-Medicare - Adult	$ 92,436,584	$ 233,077,473	$ 251,612,544
ABD - Non-Medicare - Child	$ 25,702,360	$ 69,519,415	$ 76,574,084
ABD - Dual	$ 329,382,527	$ 727,150,585	$ 753,207,828
Non ABD - Non-Medicare - Adult	$ 90,632,341	$ 177,875,191	$ 133,486,363
Non ABD - Non-Medicare - Child	$ 231,995,839	$ 482,147,266	$ 477,587,769
Total Expenditures Without Waiver	**$ 770,149,651**	**$ 1,689,769,930**	**$ 1,692,468,588**
With Waiver			
ABD - Non-Medicare - Adult	$ 95,250,705	$ 217,911,333	$ 241,487,416
ABD - Non-Medicare - Child	$ 20,360,439	$ 61,080,929	$ 69,065,112
ABD - Dual	$ 283,809,254	$ 616,434,108	$ 683,740,909
Non ABD - Non-Medicare - Adult	$ 56,470,924	$ 100,095,762	$ 86,654,175
Non ABD - Non-Medicare - Child	$ 173,656,454	$ 385,793,986	$ 409,497,482
Individual Cost Effective	$ -	$ -	$ -
MDAAP	$ -	$ 582,000	$ 638,500
Investments	$ 73,392,050	$ 110,768,382	$ 120,511,391
Total Expenditures With Waiver	**$ 702,939,826**	**$ 1,492,666,500**	**$ 1,611,594,985**
Waiver Savings Summary			
Subtotal Annual Savings	$ 67,209,825	$ 197,103,429	$ 80,873,603
Hypothetical Test Deficits	$ (848,008)	$ (2,132,397)	$ (6,111,992)
Cumulative Savings	$ 66,361,817	$ 261,332,849	$ 336,094,460
HYPOTHETICAL TESTS			
Hypothetical Test 1: New Adult			
Limit New Adult PMPM*MM	$ 270,115,084	$ 554,229,716	$ 492,803,634
New Adult Total Expenditures	$ 222,857,284	$ 445,820,821	$ 440,532,291
Surplus (Deficit)	$ 47,257,800	$ 108,408,895	$ 52,271,343
Hypothetical Test 2: SUD IMD			
SUD - IMD ABD - Non-Medicare - Adult	$ 186,101	$ 681,556	$ 598,190
SUD - IMD ABD - Dual	$ 165,345	$ 452,169	$ 360,529
SUD - IMD Non ABD - Non-Medicare - Adult	$ 385,707	$ 1,849,370	$ 786,933
SUD - IMD New Adult	$ 2,055,009	$ 5,063,996	$ 5,708,092
Limit SUD IMD PMPM*MM	**$ 2,792,162**	**$ 8,047,091**	**$ 7,453,744**
SUD - IMD ABD Non Medicare Adult	$ 156,753	$ 455,254	$ 574,110
SUD - IMD ABD - Dual	$ 236,032	$ 503,170	$ 621,909
SUD - IMD Non ABD - Non-Medicare - Adult	$ 380,721	$ 671,824	$ 826,209
SUD - IMD New Adult	$ 2,146,823	$ 4,876,050	$ 6,713,110
SUD IMD Total Expenditures	**$ 2,920,329**	**$ 6,506,298**	**$ 8,735,338**
Surplus (Deficit)	$ (128,167)	$ 1,540,793	$ (1,281,594)

ELIGIBILITY GROUP	DY 18 Jul 2022 - Dec 2022	DY 19 Jan 2023 - Dec 2023	DY 20 Jan 2024 - Dec 2024
Hypothetical Test 3: SMI IMD			
SMI - IMD ABD - Non-Medicare - Adult	$ 2,713,093	$ 9,092,862	$ 15,896,924
SMI - IMD ABD - Dual	$ 339,708	$ 1,268,692	$ 1,970,454
SMI - IMD Non ABD - Non-Medicare - Adult	$ 635,268	$ 8,192,796	$ 3,360,705
SMI - IMD New Adult	$ 6,175,185	$ 17,170,206	$ 22,184,762
Limit SMI IMD PMPM*MM	**$ 9,863,254**	**$ 35,724,555**	**$ 43,412,845**
SMI - IMD ABD Non Medicare Adult	$ 1,622,662	$ 5,221,278	$ 5,410,061
SMI - IMD ABD - Dual	$ 525,975	$ 1,186,763	$ 1,111,185
SMI - IMD Non ABD - Non-Medicare - Adult	$ 700,985	$ 1,575,936	$ 1,496,868
SMI - IMD New Adult	$ 5,491,100	$ 13,081,690	$ 14,066,751
SMI IMD Total Expenditures	**$ 8,340,722**	**$ 21,065,667**	**$ 22,084,865**
Surplus (Deficit)	$ 1,522,532	$ 14,658,888	$ 21,327,980
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	$ 1,105,887	$ 3,361,990	$ 2,305,607
Maternal Health and Treatment Services Total Expenditures	$ 1,179,899	$ 3,212,211	$ 1,111,339
Surplus (Deficit)	$ (74,012)	$ 149,779	$ 1,194,268
Hypothetical Test 6: CRT			
Limit CRT PMPM*MM	$ 6,347,496	$ 13,362,242	$ 17,819,087
CRT Total Expenditures	$ 4,735,011	$ 11,488,848	$ 13,475,185
Surplus (Deficit)	$ 1,612,485	$ 1,873,394	$ 4,343,902
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	$ 5,063,133	$ 10,501,672	$ 10,872,981
Global Rx Total Expenditures	$ 5,708,962	$ 12,634,069	$ 15,621,864
Surplus (Deficit)	$ (645,829)	$ (2,132,397)	$ (4,748,883)
Hypothetical Test 9: Moderates			
Limit Moderates PMPM*MM	$ 632,827	$ 1,292,567	$ 1,223,852
Moderates Total Expenditures	$ 445,520	$ 879,923	$ 1,201,999
Surplus (Deficit)	$ 187,307	$ 412,644	$ 21,853
Hypothetical Test 10: Marketplace Subsidy			
Limit Marketplace Subsidy PMPM*MM	$ 2,027,831	$ 4,781,398	$ 6,196,449
Marketplace Subsidy Total Expenditures	$ 1,955,249	$ 4,623,575	$ 6,277,964
Surplus (Deficit)	$ 72,582	$ 157,823	$ (81,515)

ELIGIBILITY GROUP	DY 18 Jul 2022 - Dec 2022	DY 19 Jan 2023 - Dec 2023	DY 20 Jan 2024 - Dec 2024
Hypothetical Test 11: Reentry Services			
Re Entry Services Limit (PMPMxMM)	$ -	$ -	$ -
Re Entry Services	$ -	$ -	$ -
Surplus (Deficit)	$ -	$ -	$ -
Re Entry Non-Services Limit (AGG)	$ -	$ -	$ 750,539
Re Entry Non-Services	$ -	$ -	$ -
Surplus (Deficit)	$ -	$ -	$ 750,539
Hypothetical Test 12: HRSN			
HRSN Services Limit (AGG)	$ -	$ -	$ -
HRSN Services	$ -	$ -	$ -
Surplus (Deficit)	$ -	$ -	$ -
HRSN Infrastructure Limit (AGG)	$ -	$ -	$ -
HRSN Infrastructure	$ -	$ -	$ -
Surplus (Deficit)	$ -	$ -	$ -

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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

Agency of Human Services
[Phone] 802-879-5900
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Questions, Complaints and Concerns Received by Health Access Member Services
January 1, 2024 – December 31, 2024

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 2024:

- **Provider Complaint –** Member requested to document feedback as he feels that there are not enough Dental specialists that accept VT Medicaid as insurance. He feels that there should be a reimbursement program for customers that have to pay out of pocket for a non Medicaid provider. The agent apologized for the inconvenience and documented the feedback.

February 2024:

- **System Efficiency –** Member states that he received a recording upon his first attempt to contact GMC that indicated that his phone number was not recognized and member's call was disconnected. Member would like to share this information with SOV as he states he's concerned that his area code could of caused this as his area code is not a Vermont area code. Member is concerned that he may not be the only one who has experienced it and wants this issue investigated. The agent apologized for the inconvenience and documented the customers feedback.

March 2024:

- **Provider Complaint -** Member is calling in to document feedback about the Pharmacy outage. He states due to the outage his wife was unable to get her prescriptions. He states the provider services number that the pharmacy told him to contact for verification is unreliable. The agent apologized for the inconvenience and did explain the PBM process as well as documented the feedback.
- **Other Resources -** Member feels that XXXXX XXXXX company drivers discriminated against him due to his hearing disability. He also feels violated that the driver refused to drive him any further after finding out member submitted a complaint on him previously. He says he feels it is unfair for driver to not want to drive him anymore just because he complained. He also states an additional driver treated him in the same manner because he stated that he would be complaining about him as well. The agent apologized for the inconvenience and documented the feedback. They also offered to file a Formal Grievance.

April 2024

- **Provider Complaint:** Caller requested to document feedback for the eye doctors office XXXX XXXXXXX, due to poor services. He states they did not complete his comprehensive eye exam nor did they write him a prescription but they still are trying to bill him for complete services. He states he does not feel as if he should be billed because they did not properly assist him. He is currently searching for a different eye doctor to obtain his services the correct way and to the necessary prescriptions. The agent apologized for the inconvenience and documented their feedback and offered to mail them the Provider Complaint form.
- **Other Resources:** Member called to provide feedback towards XXXXX. She stated "I had an apt today XXXXX was suppose to pick me up at 12:30 PM and drop me off at 2:15 PM. The guy showed up at 11:47 AM, with all scams I don't answer number I do not know. Apparently he called and didn't leave a message, I called XXXX and they didn't have anyone to come back and get me. It's a very important doctor appointment, this is not the first time I've had to cancel my appointments because of XXXXX". The agent offered her the VPTA number to submit a complaint, she did not have a pen on her so the agent offered to document the feedback.

May 2024:

- **Other Resources:** Member called in to document feedback regarding the VTMedicaid.com website. When searching for a Provider, she feels that it should show providers near her location and not have to look them up by city. The agent apologized for the inconvenience, documented the feedback, and tried to assist the customer with looking for a provider. They did not have the patience to wait.
- **Covered Services:** Member called to document feedback that the Pharmacy told her that Medicaid will only allow a month's supply of medication when it used to be the 3 month supply. The Customer wants to report that Medicaid shouldn't be controlling the amount of medication she receives. The agent apologized for the inconvenience, documented the feedback.

June 2024:

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
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- **Provider Complaint:** Member is calling in regards to his insurance coverage, he stated he was poorly treated and he has to go to other places for his treatments. Member stated that he received a bill from the doctor's office for his Radiography, and Medicaid is not processing the claim. They are also doing everything they can to not process the claim. The agent apologized for the inconvenience, documented the feedback and provided information based on covered services for MRI's and went over the claims in Gainwell.
- **Other Resources:** Member called in to let us know that the VT Medicaid website is not user friendly. When searching for a provider she thinks that it should show providers near a location and not have to look up city by city. I tried to help her by looking up Otolaryngologists but she said she has no time for me to do that and wanted me to call her back with a list of names. Told her I wouldn't be able to do so that she needed to stay on the line. The agent apologized for the inconvenience, documented the feedback and tried to assist the customer by providing names of providers through VTMedicaid.com

July 2024:

- **No issues reported**

August 2024:

- **Potential Scam:** Member called to report that she received a call from what she considers to be a scammer. She states the caller knew that she recently enrolled on a GMC program and called to do a survey asking about her recent enrollment asking for personal information, in which the member did not provide. Member states the caller/scammer already had her name and phone number. Member is concerned that information for new enrollments are somehow being accessed by scammers and would like to share her concerns with the state. The agent apologized for the inconvenience, reassured her that call was not from VHC/GMC and documented the feedback.
- **Potential Scam:** Rehabilitation counselor called to report that he is receiving what he suspects to be scam calls from individuals claiming to be Medicaid/Medicare providers trying to get information on behalf of patients and or himself such as Medicaid/Medicare member ID numbers. The agent apologized for the inconvenience, reassured them that call was not from VHC/GMC and documented the feedback.
- **Provider Complaint:** Member is concerned about not being able to get prescriptions from the pharmacy in a timely manner. Member feels as though it's not fair that XXXXXX pharmacy will not fill her prescription due to it being a high-cost medication. Member says she receives many excuses from the pharmacy when it's time to refill her prescriptions. The pharmacy stated she will need to take her 2 expensive medications to another pharmacy to be filled. The agent apologized for the inconvenience and documented the feedback.

September 2024:

- **Provider Complaint:** Member wanted Feedback submitted to express his frustration about having to keep calling the doctor's office to call Provider Services about facilitating the Prior Authorization. Member believes that Provider Services is not processing the Prior Authorization in a timely manner. His son is unable to pick up this prescription without the PA approved first. The supervisor apologized for the inconvenience and documented the feedback.
- **Covered Services:** Caller called because she wanted to let Medicaid know that the coverage is worthless. She explained that she knows many people who get claims denied and it is all Medicaid's fault. Specifically, her daughter isn't having her chiropractor visits covered. She went on to explain the provider has spent countless hours on the phone with provider services and got nowhere. She states he is no longer accepting Medicaid due to this. She also explained she knows dentists aren't accepting Medicaid anymore because all their claims get denied. She wanted the feedback documented as she believes it is criminal and wants someone to fix Medicaid. She also explained that we need to actively find more providers. The supervisor apologized for the inconvenience and documented the feedback.
- **Provider Complaint:** Member called to submit negative feedback regarding XXXXXX. She said that they keep billing her for services that Medicaid paid and they bill her additional amounts and she does not believe that is right as they are a Medicaid dental provider. The agent documented the feedback and referred her to her Provider to contact Provider Services.
- **Provider Complaint:** Member called in to report that XXXXXXX is refusing to assist with filling prescription. They denied to contact GOOLD services / VHC customer serviced for a manual override or to verify coverage. The agent documented the feedback and referred her to her Provider to contact Provider Services.
- **Other Resources:** Member wanted to pass along a complaint about having a PA denied for a medication her son needs to have prior to treatment for a severe allergy. She did not understand why all of a sudden the medication needs a PA when she has never had to have one prior to this round of injections. She was frustrated that we did not have the answers and referred the provider to provider services to get any kind of form they need. She thinks we should be able to get any necessary forms and not bother the doctors and nurses with this type of necessary paperwork. The agent apologized for the inconvenience, documented the feedback and provided the customer with the information that we do have.

October 2024

- **Provider Complaint:** Caller wanted to document that the XXXXX XXXXX has treated him unfairly as he was recently asked if he was distributing illegal substances and was kicked out. He states the provider referred him to get inpatient treatment at a rehab facility. The agent apologized for the inconvenience, mailed out the Provider Complaint form and documented the customers feedback.
- **DVHA Feedback:** Caller requested to document feedback as the phone number of 800-250-8427 is not listed on DVHA's website. The CSR Lead explained the website states to call 855-899-9600, 800-250-8427 is just another line within the call center as some agents are trained on different systems. The agent apologized for the inconvenience and documented the customers feedback.

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November 2024

- **Provider Complaint:** Caller requested to document feedback, she states "XXXXX stated patient XXXXXX is getting her RX in XXXXX located in XXXXXX illegally, without seeing the Doctor for over a year. She also stated her PCP is refilling the Rx for XXXXXX without her. The agent apologized for the inconvenience and documented the customers feedback. They also offered to send out the Provider Complaint Form.
- **Covered Services:** Member called in and requested to document feedback about his Vpharm 2 coverage. He states the coverage is pointless and does not provide any useful benefits to him. He doesn't understand why we would provide a program that doesn't benefit anyone. The agent documented the feedback and tried to explain the benefits that Vpharm provides to customers.

December 2024

- **Provider Complaint:** Caller is requesting to submit negative feedback regarding the online list of providers at VTMedicaid.com. He states that he believes that the online list should only display data for primary care providers that is pulled directly from the internal database used by GMC to update Medicaid cases so that he does not have to make more than one phone call when updating his PCP if the provider he chooses from the online list is not registered as a PCP. The agent apologized for the inconvenience and documented the feedback.

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Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
October 1, 2024 – December 31, 2024

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, 2024, through December 31, 2024.

Grievances: 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 thirty-one grievances filed and seven were addressed. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of receipt of a grievance must be sent within five days; the average was three days. DMH had 81%, and DAIL had 19%, of the grievances filed.

Grievances were filed for service categories case management, mental health, counseling, LTC, provider issues, inpatient hospital and prescription.

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 forty-two appeals filed. Of these forty-two appeals, thirty-two were resolved, seven were still pending, two were untimely, and one was withdrawn.

Of the thirty-two appeals that were resolved this quarter, 93% were resolved within the statutory time frame of 30 days. The average number of days it took to resolve these cases was twenty-three days. Acknowledgement letters of receipt of an appeal must be sent within five days; the average was three days.

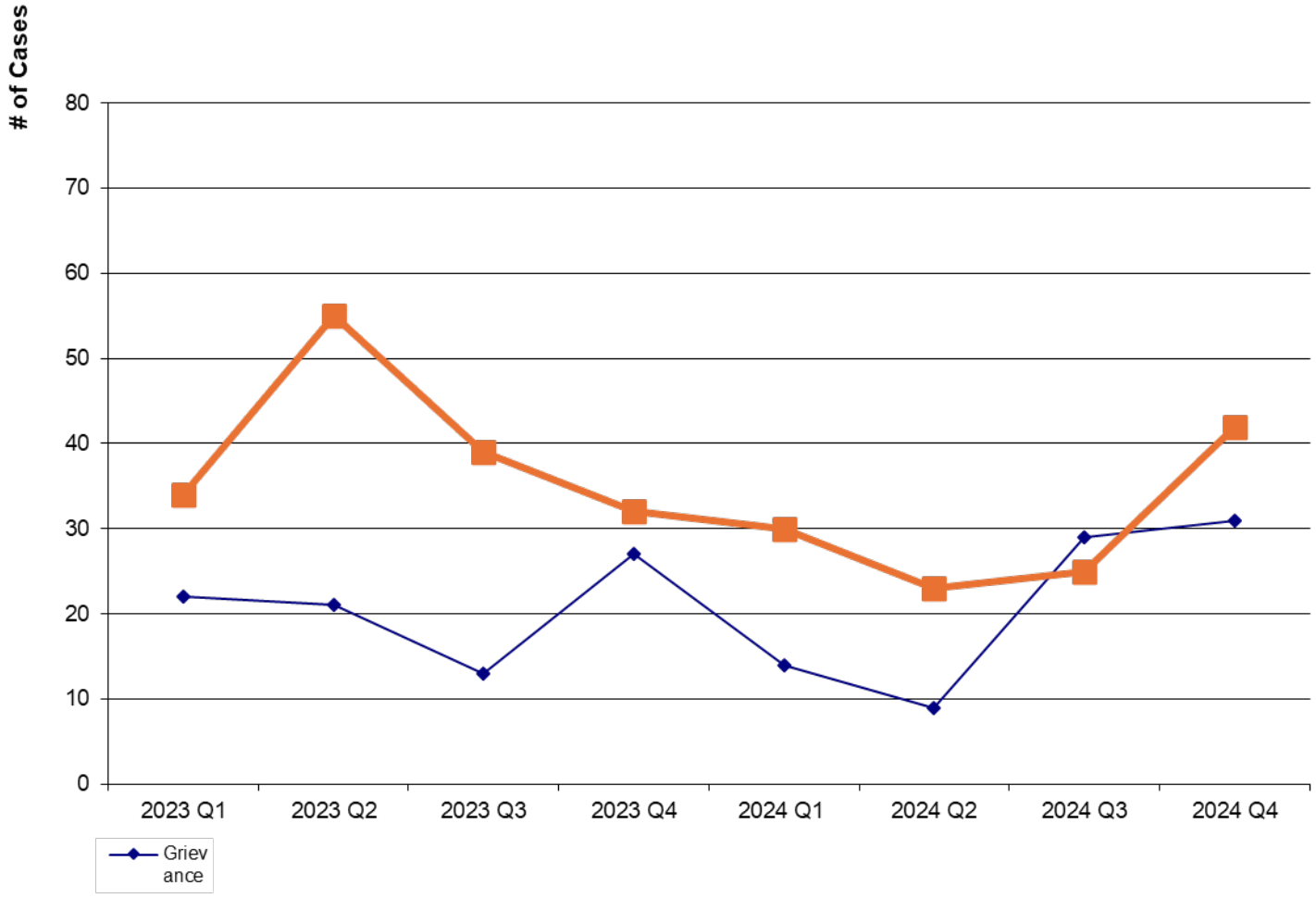
Of the forty-two appeals filed, DVHA had thirty-five appeals filed (83%), VDH had six (14%) and DMH has one (3%).

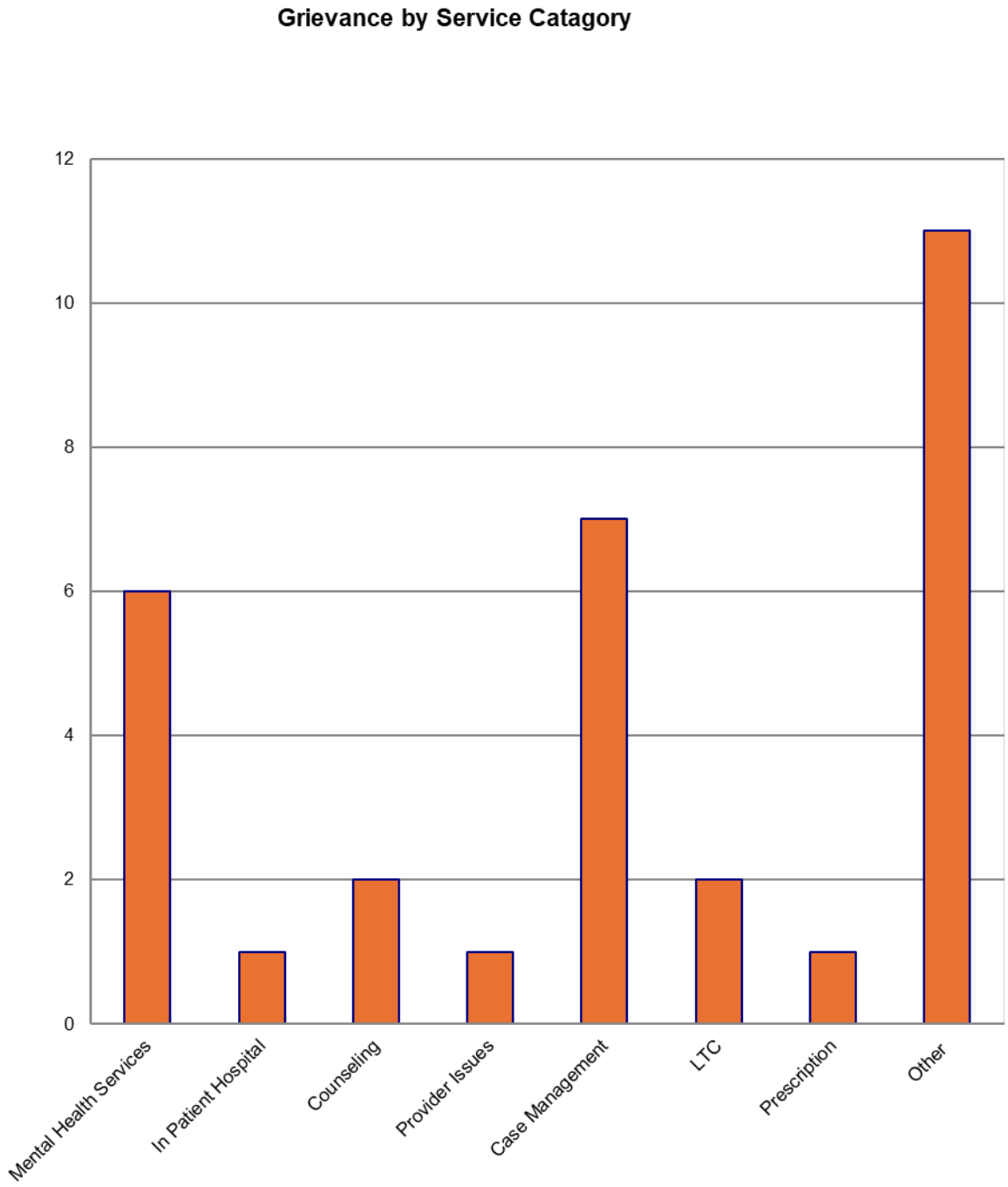
The appeals filed were for service categories dental, occupational therapy, prescription drugs, chiropractic, transportation, outpatient hospital, and personal care.

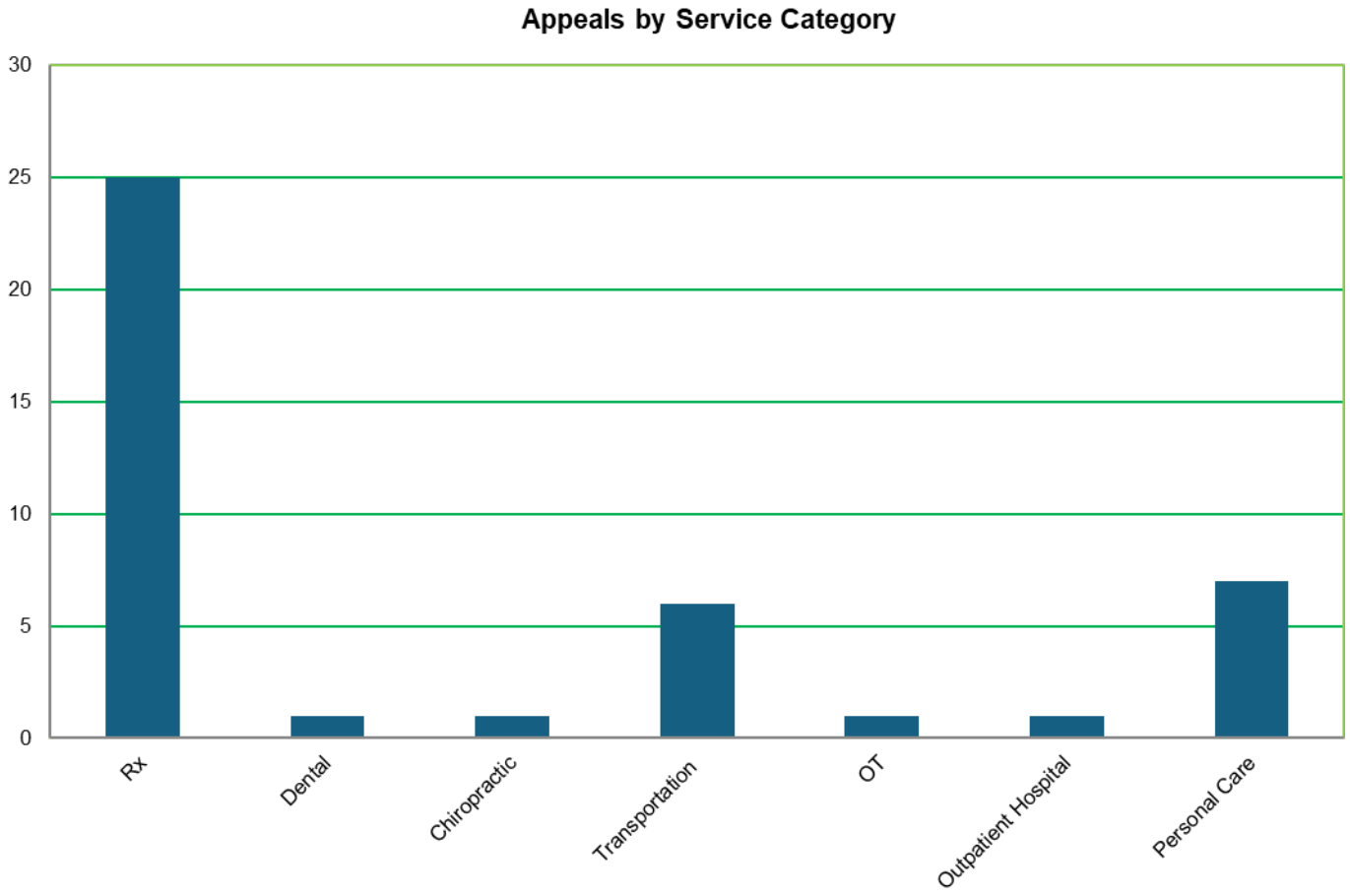
Beneficiaries must exhaust the internal appeal process before they can file a fair hearing if their appeal is not decided in their favor. There was one fair hearing filed this quarter.

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

Grievances and Appeals
January 1, 2023 thru December 31, 2024




Grievance by Service Catagory
12
10
8
6
4
2
0
Mental Health Services
In Patient Hospital
Counseling
Provider Issues
Case Management
LTC
Prescription
Other


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

Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

October 1-December 31, 2024

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

January 21, 2025

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 940 cases this quarter (717, the previous quarter). The increase in calls was due to both Vermont Health Connect Open Enrollment (November 1 to January 15) and Medicare Open Enrollment (October 15 to December 7.) During the Medicare Open Enrollment, enrollees have the chance to change their Part D plans or switch to Part C coverage, or switch back to Original Medicare. During the quarter, Medicaid eligibility was again the top issue (126 calls). We also had 80 calls about buying a QHP on VHC. We saw an increase in calls about Medicare Supplemental Insurance (19 calls). Several Part C plans left the state this year, and consumers called the HCA to discuss their options, whether they should get supplemental coverage or enroll in a different Part C plan. Overall, we talked to 50 households Medicare consumer education, and 43 households about eligibility for Medicare Savings Programs to help pay for cost-sharing.

The HCA focused on helping consumers navigate the changed landscape and take advantage of new opportunities this Vermont Health Connect Open Enrollment. Our news item: "Vermont Health Connect Enrollment Through Jan. 15: Learn About Lower Premiums and Costs!" had 641 views. In 2025, APTC eligible consumers had increased buying power for gold and platinum plans on VHC. For the first time, gold plans were also less expensive than silver plans, and HCA advocates spent significant time explaining this new dynamic to consumers. We talked to 29 households about eligibility for Premium Tax Credit. We also talked to 5 households about Special Enrollment Periods.

During Open Enrollment, we worked particularly hard to reach BC/BS enrollees on Silver 87 and Silver 94 enhanced plans. This year the two insurance carriers on VHC had significantly different premium rate increases. The different premium increases and silver alignment particularly impacted enrollees on BC/BS Silver 94 and Silver 87 Enhanced plans. Enhanced silver plans offer lower out of pocket costs to income eligible Vermonters. To be on a Silver 87 or Silver 94 you must be at or below 200 FPL. These enrollees were not mapped to gold plans, because the Silver 87 and 94 are more generous than gold plans.

Mila's Story:

Mila urgently called the HCA because she was due to give birth in the next couple of weeks, and she had no insurance coverage. She lost her employer coverage when she left her job. She had applied for Dr. Dynasuar for pregnancy, and been denied and she did not understand why, because she no current income. Mila was now unclear if there would be time to establish coverage before the birth of the baby because she had been told she would need to wait an entire month before applying again. First, the HCA advocate explained that Medicaid eligibility is based currently monthly income, and Mila did not need to wait another month to re-apply. The HCA advocate, however, did not think that Mila needed to re-apply because an error had been made with her application. The advocate discovered that when Mila's application had been processed her income from her former job had been mistakenly counted as current income. That made it look like Mila was over-income for the program. The advocate was able to update the income that day, and Mila was found eligible for coverage the same day, which was a huge relief. Dr.D for pregnancy coverage will be in place for her pregnancy and for 12-month post-partum period after the birth of the baby.

However, the BC/BS enrollees had significant premium increases. To save money and keep the same level of cost-sharing benefits, they needed to switch to an MVP Enhanced Silver Plan. The HCA worked very closely with VHC on outreaching this group. It sent two rounds of postcards to these enrollees, explaining that they had the opportunity to save money this year. The HCA received calls from consumers who received the postcards and wanted to discuss their insurance choices further. We responded to those calls by helping Vermonters pick the best plans for their families. One consumer told the HCA advocate that it was the postcard that prompted them to look at their insurance rates again this year, and they ended up changing plans for 2025 and saving significant money. Another Vermonter told the HCA that their costs had doubled, and the HCA postcard helped alert them to their options this year. They were also able to change plans and pay much less for their monthly premiums. Although the numbers are not final yet because Open Enrollment does not end until January 15th, at least 204 enrollees from this group switched from BC/BS Silver 87/94 to MVP Silver 87/94 plans.

This postcard was sent to 3040 BC/BS 87/94 enrollees in December:


TAKE ACTION
SHOP FOR HEALTH INSURANCE WITH VERMONT HEALTH CONNECT FROM NOVEMBER 1ST - JANUARY 15TH. VISIT HEALTHCONNECT.VERMONT.GOV.
SHOP & SAVE
MVP COSTS LESS THAN BCBSVT IN 2025 AND OFFERS SIMILAR COVERAGE.
GET HELP
CALL THE OFFICE OF THE HEALTH CARE ADVOCATE (HCA) FOR FREE AND CONFIDENTIAL HELP.
THE HCA IS A PART OF VERMONT LEGAL AID. CONTACT THE HCA AT 1-800-917-7787 OR VISIT VTLAWHELP.ORG/HEALTH.

Case Stories:

Oakley's Story:

Oakley called the Health Care Advocate (HCA) because he had recently moved to Vermont. However, when he applied through Vermont Health Connect (VHC) to sign up for a Qualified Health Plan, Oakley was shown as ineligible for a Special Enrollment Period (SEP). Oakley moved to Vermont during the annual Open Enrollment Period (OEP), but if he enrolled through the OEP, his coverage would not start until January 1. Oakley needed coverage sooner. Under the rules for this SEP, his coverage could start the first day of the month after he moved to Vermont. The HCA advocate investigated and discovered that when Oakley first created his VHC account, he had mistakenly entered an earlier move date, making it appear that their 60-day SEP had already expired. Oakley was able to correct the date, and the system then reflected the actual date he moved to Vermont. He was eligible for an SEP and could sign for coverage that would start the first of the next month. The HCA advocate also provided guidance on the VHC plans and the subsidies. Oakley qualified for subsidies and was able to enroll on an affordable VHC plan.

Kimi's Story

Kimi called the HCA with an eligibility question. He had recently turned sixty-five and was no longer eligible for Medicaid for Children and Adults. The HCA advocate explained that to qualify for the type of Medicaid that works with Medicare, he needed to meet an income and resource test. Kimi owned a piece of property in addition to his house. The property was in a different location from his house, and it was not producing any income Under the Medicaid resource rules, Kimi's house was not counted as a resource, but the other property would be counted as a resource and it put him over the resource limit for Medicaid for Aged Blind and Disabled. This was true even though that property was not very valuable. The resource limit for MABD is very low, only $2000 for an individual and $3000 for a couple. The HCA advocate explained that although Kimi was not eligible for MABD, he was eligible for both a Medicare Savings Program (MSP) and VPharm, because they are based on monthly income limits, and do not have resource tests. Kimi was eligible for an MSP called QMB that will cover his Medicare Part B premium and cost-sharing and VPharm will help with his Part D prescription costs.

Cooper's Story

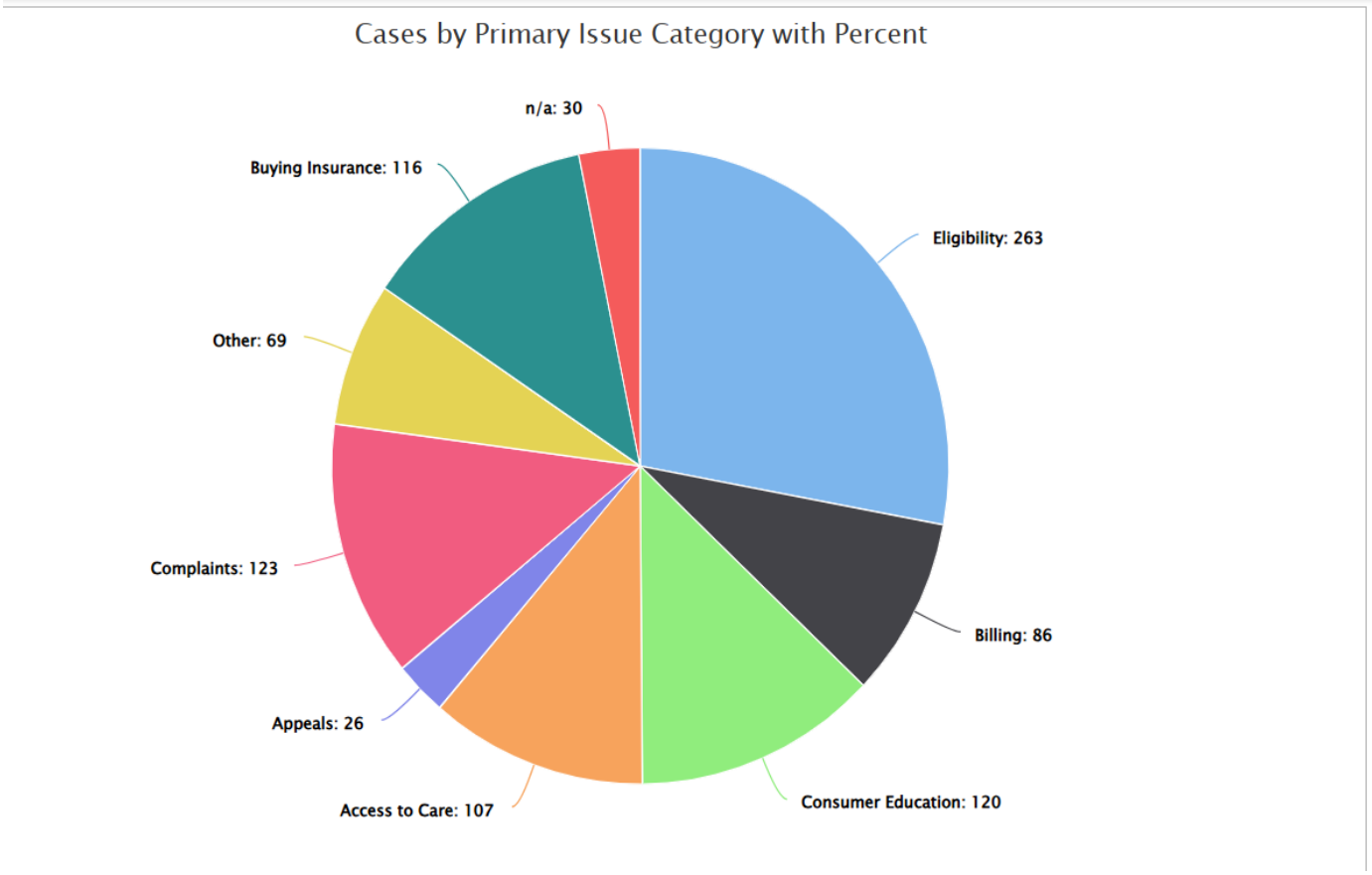
Cooper called the HCA after hitting a roadblock on the VHC website. He was trying to enroll in a plan, but when he applied, it showed him as being ineligible for any subsidies. Cooper had run into problems the year before with his VHC enrollment and had accidentally enrolled in a catastrophic plan. That plan had not worked well for him. You cannot get subsidies to help pay for catastrophic plans, and they have high cost-sharing. For 2025, he wanted to make sure that he enrolled on a bronze plan with a low monthly premium. When the HCA advocate spoke to Cooper, she quickly determined that based on Cooper's income, he was eligible for over $900 of subsides per month. When the HCA advocate called VHC, she discovered that there was an error, showing that Cooper had an offer of employer insurance. This was why it was saying Cooper was not eligible for subsidies. If you have an offer of affordable employer insurance, you are not eligible for subsidies. Cooper, however, did not have an offer of employer insurance. VHC was able to correct that and update his income. With the corrected subsidies, Cooper was able to enroll in bronze plan for just dollars a month. His plan also covered three visits with a provider before he met his deductible.

Overview

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

Primary Issue

The HCA received 940 calls this quarter. We assign cases a primary issue, depending on the nature of the legal issue. Normally, we have more Eligibility and Access to Care cases than the other issues. However, because Medicare Open Enrollment and VHC Open Enrollment both occurred in this quarter, we have slightly more Buying Insurance cases and Consumer Education cases than Access to Care cases. We also had a considerable number of complaints. The "Other" primary issue category includes communication problems with health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues Callers' primary issue category.



Insurance Type:

The HCA also tracks its callers by insurance category. We do not 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 over half of all cases (497 of 940 cases).

Number of Cases by Insurance: October 1 to December 31, 2024

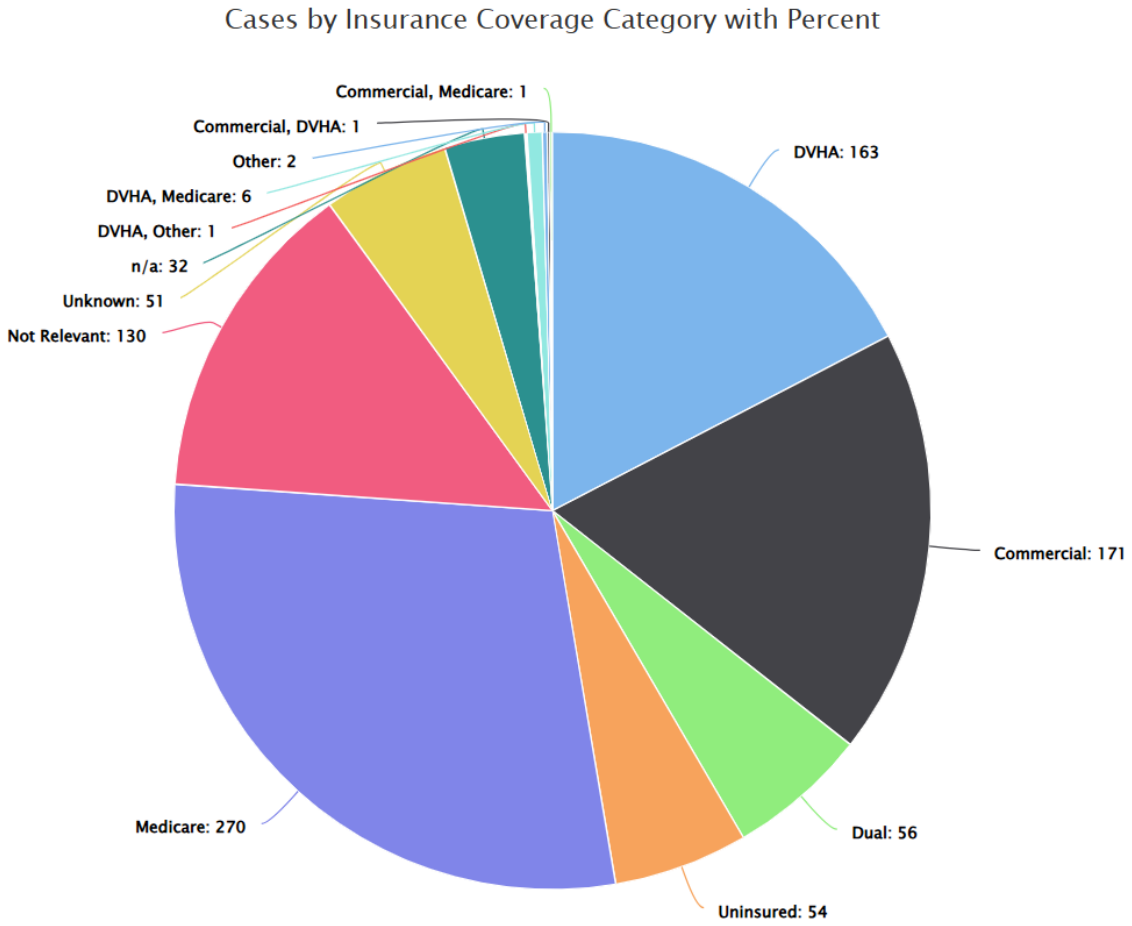


Table: Top Ten Primary Issues: October 1 to December 31, 2024

All Cases: 940

All Cases: Top Ten Primary Issues

1. Buying Insurance: QHP-VHC 80
2. Eligibility for MAGI Medicaid 79
3. Provider Complaints 68
4. Consumer Education Medicare 50
5. Eligibility Medicare Savings Programs 43
6. Eligibility Non-MAGI Medicaid 32
7. Complaints Hospitals 31
8. Eligibility Premium Tax Credit 29
9. Access to Care Prescription Drugs 22
10. Buying Insurance: Medicare Supplemental Insurance 19

DVHA Cases: total of 171 of 940 total cases

Top Five Primary Issues

1. Eligibility for MAGI Medicaid 42
2. Provider Complaints 121
3. Access to Care Prescription Drugs 8
4. Buying Insurance: QHP-VHC 8
5. Eligibility Non-MAGI Medicaid 6

Uninsured Cases: total 54 out of 940 cases

Top Three Primary Issues

1. Eligibility for MAGI Medicaid 16
2. Buying Insurance: QHP-VHC 10
3. Eligibility for Premium Tax Credit 8

Commercial Cases: total of 173 out of 940 cases

Top Three Primary Issues

1. Buying Insurance QHP-VHC 60
2. Eligibility Premium Tax Credit 18
3. Eligibility for MAGI Medicaid 11

Overall Cases Resolution

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

Case Outcomes Sept 1 to December 31, 2024

Brief Analysis and or Advice	505
Direct Intervention	78
Complex Intervention	46
Brief Analysis and Referral	242
Inquiry Answered During Initial Call	0
Duplicate Case	18
Other	2
Client Withdrew	0

Highlights of HCA

During this quarter, we provided 679 households with consumer education. We helped 65 households estimate their eligibility for insurance or get onto coverage. We assisted ten households with their health insurance applications. We helped with eight applications for the Immigration Health Insurance Plan and Emergency Medicaid. We saved consumers $202,781 this quarter.

Consumer Protection Activities

Rate Review

The HCA reviews and analyzes all commercial insurance carrier requests to the Green Mountain Care Board (Board) to change premium prices. The Board decided two premium price change requests during the quarter from October 1, 2024 through December 31, 2024. No premium price change requests were pending at the close of the quarter.

MVP submitted one of the premium price change requests decided by the Board this quarter: 2025 MVP Large Group HMO Rate filing. MVP requested an 11.1% annual manual rate increase that would affect approximately 1589 Vermonters. The HCA has appeared on behalf of Vermonters in this matter and reviewed all aspects of the filing.

Cigna Health and Life Insurance Company (CHLIC) submitted the other premium price change request decided by the Board this quarter: the CHLIC 2025 Large Group filing. In that matter, CHLIC requested an increase of 11.5% to the manual rate. The proposed increase would impact roughly 3,151 Vermonters.

The HCA appeared on behalf of Vermonters in this matter, reviewed all aspects of the filing, and submitted memorandums in lieu of hearing.

The Board approved, but modified, both premium price change requests.

Hospital Budgets

The HCA continues to advocate that the Board exercise its provider rate setting to address Vermont's affordability crisis. The HCA continues to actively provide feedback to legislators, the Board, AHS, and other stakeholders inform state-wide discussions focused on hospital sustainability and transformation as a part of Act 167. The HCA also continues to advocate for hospitals to fully comply with Act 119 – which standardized patient financial assistance policies.

Certificate of Need Review Process

The HCA has statutory authority to assert interested party status in certificate of need (CON) proceedings before the GMCB. The HCA will participate in the CON hearing for Southwestern Vermont Medical Center, Development of Adolescent Inpatient Medical Health Unit (GMCB-014-23con) through asking questions focused on health equity for patients seeking care at this facility We actively monitor certificate of need applications as they are submitted and assert party status when the interests of Vermonters are clearly impacted.

Oversight of Accountable Care Organizations

The HCA provided written comments to the GMCB regarding OneCare Vermont's (OCV) FY25 budget, which recommended that the Board reduce their administrative costs given their announcement to sunset their operation in FY26.

Additional Green Mountain Care Board and other agency workgroups

The HCA attended the GMCB's weekly board meetings, monthly Data Governance meetings and several other legislatively established workgroups focused on affordability and access.

The Medicaid and Exchange Advisory Committee

The Advisory Committee met two times this quarter. The content of this quarter's meetings included a focus on the Plans for Open Enrollment, The AHEAD and CCBHC models, discussion about the Marketplace Affordability Report, electing new committee leadership, and updating the committees by-laws.

Collaboration with Other Organizations

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

- AARP Vermont
- American Civil Liberties Union of Vermont

- All Copays Count Coalition
- Bi-State Primary Care Association
- Blue Cross Blue Shield of Vermont
- Department of Financial Regulation
- Disability Rights Vermont
- Families USA
- The Family Room
- The Howard Center
- IRS Taxpayer Advocate Service
- League of Women Voters of Vermont
- Let's Grow Kids
- Migrant Justice
- MVP Health Care
- National Academy for State Health Policy
- NHeLP, National Health Law Program
- New American Clinic/Family Room
- OneCare Vermont
- Open Door Clinic
- Planned Parenthood of Northern New England
- Rights and Democracy (RAD)
- Rural Vermont
- South Royalton Legal Clinic
- SHIP, State Health Insurance Assistance Program
- University of Vermont Medical Center
- University of Vermont Migrant Health, Bridges to Health
- Vermont Alzheimer's Association
- Vermont Association of Hospitals and Health Systems
- Vermont Association of Area Agencies on Aging
- Vermont Businesses for Social Responsibility (VBSR)
- Vermont Commission on Women
- 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 – National Education Association (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 to provide the latest and most accurate information to Vermont consumers.

Popular Web Pages

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

1. Health - section home page – 2,173 pageviews
2. Dental Services – 1,726
3. Income Limits - Medicaid – 1,033
4. Medicare Savings Programs – 560
5. Patient Financial Assist. & Affordable Medical Care – 438
6. Medicaid, Dr. Dynasaur & Vermont Health Connect – 361
7. Vermont Health Connect – 357
8. HCA Help Request Form – 339 pageviews and 134 online help requests
9. Medical Decisions: Advance Directives – 322
10. Long-Term Care – 310
11. Medicaid – 293
12. Dr. Dynasaur – 284
13. Resource Limits - Medicaid – 277
14. Medicaid and Medicare Dual Eligible – 276*
15. Vision – 263
16. Choices for Care Income Limits – 215
17. Prescription Help – State Pharmacy Programs – 197*
18. Choices for Care Giving Away Property or Resources – 189
19. Advance Directive forms – 187
20. Services Covered by Medicaid – 167*

This quarter we had these additional news items:

- Vermont Health Connect Enrollment Through Jan. 15: Learn About Lower Premiums and Costs! – 641 pageviews*
- New Patient Financial Assistance Law Goes Into Effect – 157
- Medicaid Renewal Started Again – 13
- People Impacted by Flood Can Sign Up for Health Coverage. Those Who Lost Medicaid Can, Too – 11

* signifies that this page moved into the top 20 this quarter

Outreach and Education

The Office of the Health Care Advocates (HCA) engaged in both in-person and virtual outreach activities during the fourth quarter of 2024 to raise awareness about our services and provide accessible information on health insurance options available to Vermonters. We focused our efforts on supporting

individuals through the Vermont Health Connect Open Enrollment Period (OEP) and the Medicare Open Enrollment period. Our outreach aimed to ensure Vermonters have the information they need to make informed decisions regarding their health insurance coverage for 2025.

Medicare Outreach: We prioritized outreach to older and disabled Vermonters during the Medicare Annual Open Enrollment.(10/15/2024 – 12/7/2024). Our outreach model included both in-person and virtual activities that helped us reach individuals in diverse geographic locations as they evaluated their health insurance options. Our outreach and education efforts primarily focused on recent changes to Medicare Advantage plans and switching to Original Medicare, as well as changes to Part D plans and coverage in 2025.

- We hosted **four legal clinics** in accessible community spaces, including a senior center-adjacent community center.
- Outreach materials were distributed to **10 libraries** across Vermont, ensuring wide access to information.
- We implemented **two social media campaigns** on Front Porch Forum and Facebook to alert Vermonters to recent changes and promote our free and confidential services.

Vermont Health Connect Open Enrollment Period (OEP) Outreach: The Vermont Health Connect OEP (11/1/2024 – 1/15/2025) provided an important opportunity for Vermonters purchasing insurance through the individual market to review their coverage and take action to change their insurance plans for 2025. Policy changes related to insurance rate increases and silver alignment made it vital for enrollees to compare their options for their upcoming year. Significant HCA outreach activities included:

- Participating in **stakeholder meetings** with the Vermont Department of Health Access (DVHA), BCBS, and MVP to coordinate outreach efforts, including consumer engagement on automapping.
- Through a partnership with DVHA, we connected with **3,040 Silver 94 and 87 enrollees**, sending targeted communications to help them compare plans across carriers for 2025.
- **Twelve organizations** helped us reach a diverse array of Vermonters. Our partners included the Vermont Professionals of Color Network, AALV, ECDC, Outright VT, and the Root Social Justice Center, with whom we co-hosted **seven outreach presentations**.
- **Social media campaigns** on Facebook, Instagram, and Reddit helped us connect with a broader audience. Our posts included important updates about the OEP deadline and insurance affordability changes.
- Our **Vermont Law Help webpage** for the Vermont Health Connect OEP was viewed more than **6,000 times**, providing invaluable resources for those seeking guidance during the enrollment period.

Collaborations and Partnerships:
The HCA continued our legal help partnership with Vermont Legal Aid, the Family Room, and Bridges to Health. We hosted three events where community members connected with legal advocates to learn more about emerging legal needs and connect with resources. Childcare and in-person interpretation were available to support people seeking our assistance. These events primarily served seniors and those with language needs. Members of our advocacy team have also started to attend “paperwork

nights" at the Old North End Community Center to be to answer health insurance related questions and raise awareness about our office.

With the continued support of our community partners, we were able to provide Vermonters with accurate and accessible information to make informed decisions about their health insurance. Looking ahead, the HCA remains committed to reducing barriers to health insurance access and ensuring all Vermonters have the tools and support they need to navigate their options successfully.

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

DY20 Investment Expenditures

Department	Final Receiver Suffix	Investment Description	QE 0324	QE 0624	QE 0924	QE 1224	DY20 Total
AHSCO	9090	Designated Agency Underinsured Services	1,821,625	1,821,623	1,809,523	5,529,994	**10,982,765**
AHSCO	9093	Health Care Reform	-	1,460,558	781,700	700,337	**2,942,595**
AHSCO	9421	HCBS Investment - Workforce Recruitment & Retention Program	-	-	-	-	**-**
AHSCO	9421	HCBS Investment - Innovative Solutions to Enhance and Strengthen HCBS	288,126	1,068,556	1,313,991	1,211,284	**3,881,957**
AOE	n/a	Non-state plan Related Education Fund Investments	-	-	-	-	**-**
DCF	9400	Investments - Balance and Restorative Justice	606,298	557,153	726,297	480,218	**2,369,966**
DCF	9402	Medical Services	45,716	18,050	15,865	14,975	**94,606**
DCF	9403	Residential Care for Youth/Substitute Care (1)	-	-	-	-	**-**
DCF	9405	Aid to the Aged, Blind and Disabled CCL Level III	1,094,376	1,011,117	975,655	994,613	**4,075,761**
DCF	9406	Aid to the Aged, Blind and Disabled Res Care Level III	13,740	26,438	25,321	26,085	**91,584**
DCF	9407	Aid to the Aged, Blind and Disabled Res Care Level IV	29,478	58,158	52,535	50,222	**190,393**
DCF	9408	Essential Person Program	215,927	225,551	225,109	214,496	**881,083**
DCF	9409	GA Medical Expenses	46,231	36,203	18,999	47,428	**148,861**
DCF	9411	Therapeutic Child Care	453,327	496,554	497,266	444,725	**1,891,872**
DCF	9412	Lund Home	-	-	-	-	**-**
DCF	9413	Prevent Child Abuse Vermont: Shaken Baby	-	-	-	-	**-**
DCF	9414	Prevent Child Abuse Vermont: Nurturing Parent	38,535	36,790	16,817	22,437	**114,579**
DCF	9415	Challenges for Change: DCF	54,609	40,997	55,297	50,791	**201,694**
DCF	9416	Strengthening Families	172,705	241,232	319,027	316,841	**1,049,805**
DCF	9417	Lamoille Valley Community Justice Project	-	-	-	-	**-**
DCF	9418	Building Bright Futures	122,813	126,981	203,147	-	**452,941**
DCF	9419	United Ways 2-1-1	-	396,221	205,672	125,537	**727,430**
DCF	9421	HCBS Investment	-	-	-	-	**-**
DCF	9425	Lund Substance Abuse Screening & Referral	170,498	340,997	258,214	350,864	**1,120,573**
DAIL	9421	HCBS Investment - Independent Direct Support Providers	699,646	111,728	163,359	254,447	**1,229,180**
DAIL	9602	Mobility Training/Other Svcs.-Elderly Visually Impaired	94,970	124,761	70,650	90,990	**381,371**
DAIL	9603	DS Special Payments for Medical Services	518,557	1,192,395	212,230	730,615	**2,653,797**
DAIL	9604	Flexible Family/Respite Funding	304,933	305,066	(32,094)	628,508	**1,206,413**
DAIL	9605	Quality Review of Home Health Agencies	-	-	-	-	**-**
DAIL	9606	Support and Services at Home (SASH)	245,205	245,271	122,703	122,594	**735,773**
DAIL	9607	HomeSharing	36,251	118,855	126,983	-	**282,089**
DAIL	9608	Self-Neglect Initiative	126,009	-	127,265	-	**253,274**
DAIL	9609	Seriously Functionally Impaired: DAIL	-	-	-	-	**-**
DAIL	9610	Nutritious Meals for Older Adults in Need	-	-	-	86,753	**86,753**
DMH	9501	Special Payments for Treatment Plan Services	7,047	33,543	2,824	9,231	**52,645**
DMH	9502	Mental Health Outpatient Services for Adults	447,321	256,908	111,824	824,213	**1,640,266**
DMH	9504	Mental Health Consumer Support Programs	108,677	97,949	50,579	96,525	**353,730**
DMH	9505	Mental Health CRT Community Support Services	-	-	-	-	**-**
DMH	9506	Mental Health Children's Community Services	434,058	591,808	270,421	585,535	**1,881,822**
DMH	9507	Emergency Mental Health for Children and Adults	510,054	582,177	85,172	870,138	**2,047,541**
DMH	9508	Respite Services for Youth with SED and their Families	317,509	305,963	22,940	492,324	**1,138,736**
DMH	9510	Emergency Support Fund	-	-	-	-	**-**
DMH	9511	Institution for Mental Disease Services: DMH - VPCH	5,067,670	5,694,070	4,441,270	5,067,670	**20,270,680**
DMH	9512	Institution for Mental Disease Services: DMH - BR	-	-	-	-	**-**
DMH	9514	Seriously Functionally Impaired: DMH	-	-	-	-	**-**
DMH	9516	Acute Psychiatric Inpatient Services	(536,563)	446,987	198,674	195,487	**304,585**
DMH	9519	Mobile Crisis Uninsured/Underinsured	-	-	-	384,627	**384,627**
DMH	9521	Suicide Prevention	270,368	363,761	270,342	176,874	**1,081,345**
DMH	9522	Alternatives to Emergency Room MH Crisis Care	-	71,295	-	258,620	**329,915**
DMH	9523	MH Peer and Consumer Supports	-	893,278	423,395	815,551	**2,132,224**
DMH	9914	CRT Global Commitment	-	-	-	-	**-**
DMH	9421	HCBS Investment	108,035	1,271,410	147,094	1,297,259	**2,823,798**
DMH	n/a	QE 202403 64.9 Waiv Line 69 reporting; PQA to be submitted QE 202406	(626,400)	-	626,400	-	**-**
DOC	n/a	Elevate Youth (formerly Return House)	17,597	-	-	27,865	**45,462**
DOC	n/a	Northern Lights	-	-	-	-	**-**
DOC	n/a	Pathways to Housing - Transitional Housing	326,055	-	594,746	368,950	**1,289,751**
DOC	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges	38,836	-	71,345	60,459	**170,640**
DOC	n/a	Northeast Kingdom Community Action	32,815	(630)	36,574	30,535	**99,294**
DOC	n/a	Intensive Substance Abuse Program (ISAP)	-	-	-	-	**-**
DOC	n/a	Intensive Domestic Violence Program	-	-	-	-	**-**
DOC	n/a	Community Rehabilitative Care	829,791	90,825	-	617,393	**1,538,009**
DOC	n/a	Intensive Sexual Abuse Program	-	-	-	-	**-**
DOC	n/a	Vermont Achievment Center	-	-	-	-	**-**
DVHA	9421	HCBS Investment	41,642	-	211,002	101,972	**354,616**
DVHA	9423	HCBS Spend Plan Investment GC CNOM	-	-	-	-	**-**
DVHA	9101	Vermont Information Technology Leaders/HIT/HIE/HCR	-	-	-	-	**-**
DVHA	9102	Vermont Blueprint for Health	838,774	1,100,188	780,727	1,146,659	**3,866,348**
DVHA	9103	Buy-In	(8,025)	1,398	1,572	2,138	**(2,917)**
DVHA	9104	HIV Drug Coverage	-	-	-	-	**-**
DVHA	9106	Patient Safety Net Services	174,037	154,390	30,679	22,337	**381,443**
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	Blueprint Expansion and Dulce	1,046,511	1,083,501	1,232,066	1,178,162	**4,540,240**
DVHA	9114	Blueprint for Health Spoke	-	-	1,257,010	1,242,152	**2,499,162**
DVHA	9115	Pregnancy Intention Initiative	-	-	25,258	23,406	**48,664**
DVHA	9209	Family Planning	55,866	105,810	53,273	82,995	**297,944**
VDH	9201	Emergency Medical Services	177,558	205,085	108,368	159,096	**650,107**
VDH	9203	TB Medical Services	6,040	-	23,163	-	**29,203**
VDH	9204	Epidemiology	343,844	68,580	129,000	146,473	**687,897**
VDH	9205	Health Research and Statistics	318,545	422,660	348,714	464,608	**1,554,527**
VDH	9206	Health Laboratory	805,457	1,004,911	863,970	981,098	**3,655,436**
VDH	9207	Tobacco Cessation: Community Coalitions	316,372	467,308	222,771	423,271	**1,429,722**
VDH	9208	Statewide Tobacco Cessation	-	-	-	-	**-**
VDH	9209	Family Planning	150,438	75,219	75,219	-	**300,876**
VDH	9210	Physician/Dentist Loan Repayment Program	264,171	(2,640)	256,471	4,066,025	**4,584,027**
VDH	9211	Renal Disease	-	-	-	-	**-**
VDH	9213	WIC Coverage	1,215,588	2,175,282	56,599	1,453,533	**4,901,002**
VDH	9214	Area Health Education Centers (AHEC)	167,011	(31,000)	-	261,399	**397,410**
VDH	9217	Patient Safety - Adverse Events	19,147	11,529	14,516	13,834	**59,026**
VDH	9219	Substance Use Disorder Treatment	1,337,456	1,249,158	64,518	371,316	**3,022,448**
VDH	9220	Recovery Centers	894,619	1,790,421	975,894	837,641	**4,498,575**
VDH	9221	Enhanced Immunization	69,844	141,624	69,061	100,388	**380,917**
VDH	9222	Poison Control	-	102,607	-	12,644	**115,251**
VDH	9223	Public Inebriate Services, C for C	225,478	635,305	303,666	-	**1,164,449**
VDH	9224	Fluoride Treatment	30,628	27,570	18,709	24,577	**101,484**
VDH	9225	Medicaid Vaccines	-	-	-	-	**-**
VDH	9226	Healthy Homes and Lead Poisoning Prevention Program	59,141	69,429	55,622	67,232	**251,424**
VDH	9228	VT Blueprint for Health	461,965	530,028	391,370	489,934	**1,873,297**
VDH	9421	HCBS Investment - Pediatric Pallative Care Program Supply Carts	-	-	-	-	**-**
VDH	9421	HCBS Investment - Expand VTHelplink	222,906	308,706	29,962	84,515	**646,089**
VSC	n/a	Health Professional Training	474,166	-	2,116,373	-	**2,590,539**
VVH	n/a	Vermont Veterans Home	-	-	-	-	**-**

P Blueprint Hub and Spoke (Health Homes) Hub and Spoke

What We Do

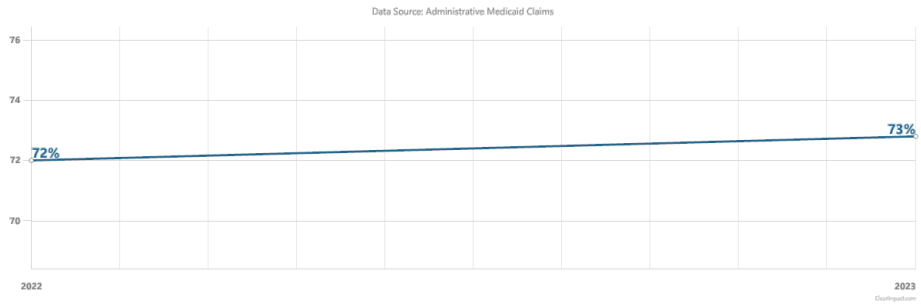
The Vermont Blueprint for Health is a nationally recognized initiative that designs community-led strategies for improving health and well-being. The Blueprint invests in and supports Patient-Centered Medical Homes, Community Health Teams, the Pregnancy Intention Initiative, Accountable Communities for 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.

This Hub and Spoke system builds on existing Medication for Opioid Use Disorder (MOUD) resources and the Blueprint's primary care infrastructure of Patient-Centered Medical Homes (PCMH) and multidisciplinary Community Health Teams (CHT) to provide enhanced services for the Medicaid population receiving treatment for Opioid Use Disorder (OUD). Currently, most MOUD patients are prescribed buprenorphine in Office-Based Opioid Treatment (OBOT) settings by licensed physicians, osteopaths, nurse practitioners, or physician assistants with limited access to mental health and use disorder services. These OBOT settings are referred to as Spokes and are supported by a Nurse and Mental Health Clinician funded by a per member per month payment based on buprenorphine prescriptions. A smaller number of patients receive methadone treatment in highly regulated Opioid Treatment Programs (OTPs), referred to as Hubs, with associated health and mental health care integration.

The Hub and Spoke system is also referred to as Health Homes in federal reporting.

Measures

	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
PM Hub and Spoke Medicaid Health Home: Engagement for Treatment of Opioid Use Disorder (IET)	2023	73%		↗ 1
	2022	72%	–	→ 0



Story Behind the Curve

The percentage of new Opioid Use Disorder episodes that have evidence of treatment engagement within 34 days of initiation, for ages 18 to 64.

This data only includes Medicaid members who are receiving buprenorphine prescriptions or methadone for the treatment of Opioid Use Disorder, of whom a majority are treated within the Hub and Spoke system. This measurement is a good indicator of whether or not patients with new episodes of OUD are receiving treatment within the Hub and Spoke System.

One factor that could be affecting outcomes is the reinstatement of eligibility redetermination starting in 2023, which has led to a number of individuals being removed from the Medicaid rolls, thereby changing the composition of the Medicaid Health Home population.

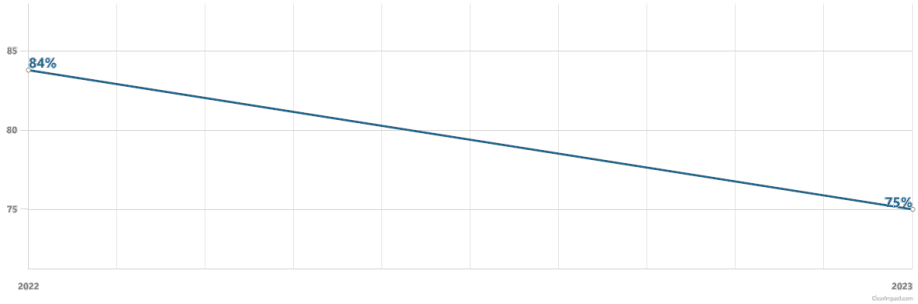
Partners

- Vermont Department of Health
- Center for Technology and Behavioral Health at Dartmouth College

PM Hub and Spoke

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

2023	75%		↘ 1
2022	84%	—	→ 0



Story Behind the Curve

The percentage of emergency department (ED) visits for members 18 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was a follow-up.

This data only includes Medicaid members who are receiving buprenorphine prescriptions or methadone for the treatment of Opioid Use Disorder, of whom a majority are treated within the Hub and Spoke system. Therefore, it functions well as an indicator of whether or not Hub and Spoke patients that have an Emergency Department visit due to substance use are being engaged post-visit in follow-up treatment.

One factor that could be affecting outcomes is the reinstatement of eligibility redetermination starting in 2023, which has led to a number of individuals being removed from the Medicaid rolls, thereby changing the composition of the Medicaid Health Home population.

Partners

- Vermont Department of Health
- Center for Technology and Behavioral Health at Dartmouth College

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Blueprint GC PCMH Blueprint

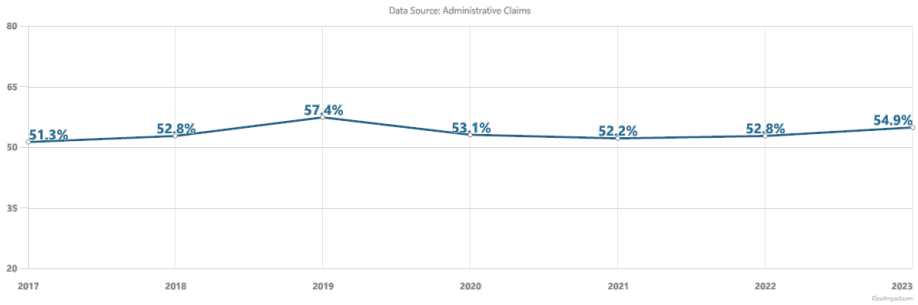
What We Do

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
2023	54.9%		↗ 2
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 shows the statewide average for Medicaid-primary members, of whom a majority are attributed to patient-centered medical homes. One factor that could be affecting outcomes is the reinstatement of eligibility redetermination in 2023, which has led to the removal of a number of individuals 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

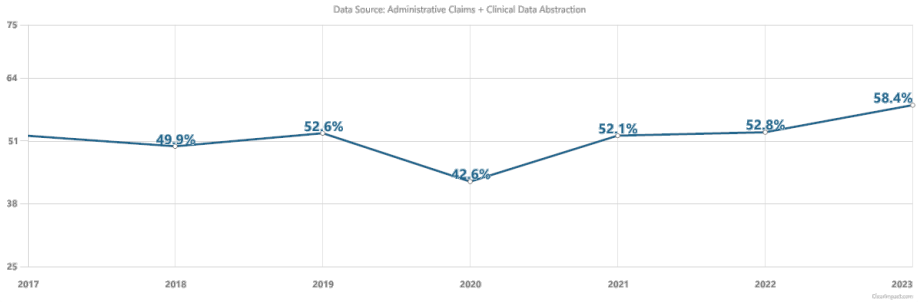
Notes on Methodology

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)

PM PCMH Medicaid: HEDIS Adolescent Well-Care Visits (AWC) 12-21 [Discontinued]

2019	54.0%		↗4

PM PCMH Medicaid: NQF0018 HEDIS Hypertension With Blood Pressure in Control (<140/90 mmHg) (CBP)



2023	58.4%		↗3
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

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 be affecting outcomes was the reinstatement of eligibility redetermination in 2023, which has led to a number of individuals being 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.

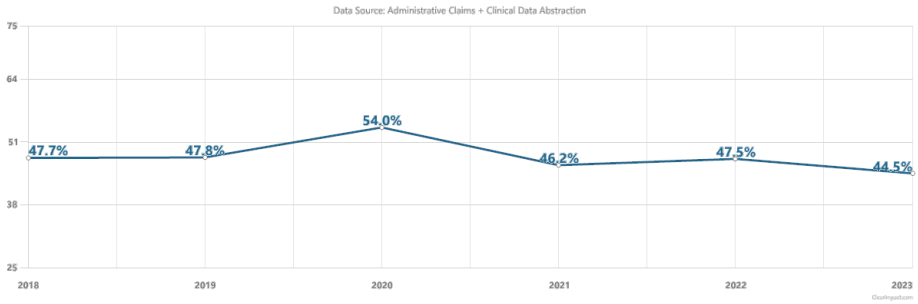
Partners

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)

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



2023	44.5%		↘ 1
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.

One factor that could be affecting outcomes was the reinstatement of eligibility redetermination in 2023 following the Pandemic Health Emergency, which has led to a number of individuals being removed from the Medicaid rolls, thereby changing the composition of the Medicaid population.

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

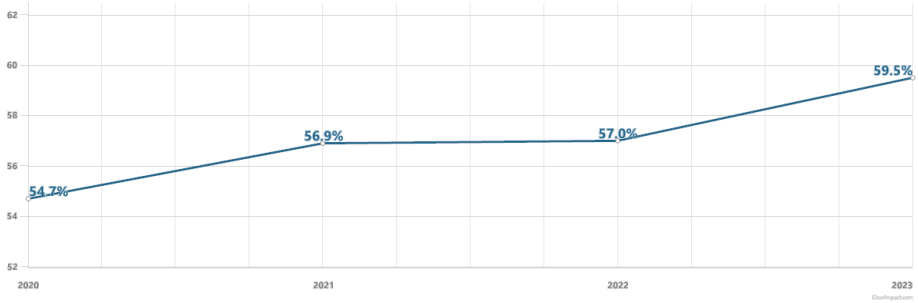
1. Patient-Centered Medical Homes
2. Community Health Teams
3. Vermont Department of Health
4. OneCareVermont

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)

In MY22, the Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD) measure was modified by the measure steward into a combined measure that has two rates: HbA1C Control (<8%) and HbA1C Poor Control (>9%). The combined measure is called Hemoglobin A1c Control for Patients With Diabetes (HBD-AD).

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



2023	59.5%		↗ 3
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.

One factor that could be affecting outcomes was the reinstatement of eligibility redetermination in 2023 following the Pandemic Health Emergency, which has led to a number of individuals being removed from the Medicaid rolls, thereby changing the composition of the Medicaid population.

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.

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