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 April 1, 2024 – June 30, 2024

Submitted Via PMDA Portal on August 29, 2024

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I. Background and Introduction

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

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

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

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

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

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

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

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

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

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

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

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the second quarterly report for waiver year 20, covering the period from April 1, 2024, through June 30, 2024 (QE062024).***

II. Outreach/Innovative Activities

Member and Provider Services

Key updates from QE062024:

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

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

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

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

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

NEMT Update

For each month in the second quarter of 2024, VPTA (DVHA's non-emergency medical transportation contractor) supplied a steady number of rides, to a consistent number of VT Medicaid members. In April, 23,858 rides were provided to 6,629 members. In May, it was 25,323 rides to 6,657 members; in June, there were 22,235 rides provided to 6,643 members. Over this period, the complaints and member no shows stayed consistent with those from the previous calendar quarter.

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 "Q3"	
Casualty	$331,982.52
Estate	$208,598.36
Third-Party & Court-Ordered Medical	$109,102.01
Medicare Prescription Drug Premium/Claims	$64,394.66
Over Resource/Hospice/Patient Share/Credit Balance	$637,349.55
Annuity/Trust/Waiver	$29,310.81
Lamp/Map, Medicare Claim Recoupment	$146,827.01
Third-Party Claim Recoupment	$9,289.66
Total	**$1,536,854,58**

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 "Q3"	
Third-Party Liability	$11,667,007.62
Medicare	$182,134,355.03
Total	**$193,801,362.65**

III. Operational/Policy Developments/Issues

Key updates from QE062024:

- The Customer Support Center received 58,588 calls in QE0624, up 2% from the previous year.
- DVHA is supported by 121 Assisters (111 Certified Application Counselors, 4 Navigators, and 6 Brokers). Working in 83 locations including hospitals, clinics, and community-based organizations.
- 21 New Assisters applied during this quarter (application dates from April 1, 2024, thru June 30, 2024). There are currently 36 Assisters still in training (this number includes any Assister who applied in 2024 but has not completed training).
- Increasing numbers of customers are using self-service functions. Self-serve applications comprised over half (54%) of all applications in QE0624.

Vermont Health Connect

Enrollment

As of QE0624, more than 198,725 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 127,249 in Medicaid for Children and Adults (MCA) and 71,476 in Qualified Health Plans (QHPs), with the latter divided between 30,196 enrolled with VHC, 4,339 direct enrolled with their insurance carrier as individuals, and 36,941 enrolled with their small business employer.

Medicaid Renewals

Second round renewals post-Unwind were initiated this quarter. People coming up for renewal starting in this quarter have had an Unwind renewal. Ex-parte success rate on a household level was 73% for the quarter. Ex parte success rate was higher due both to continued permission to use unwind waivers and likely ineligibles having been removed from enrollment during the Unwind.

The mitigation strategy for Individual Ex-parte continued this quarter in advance of the system updates that will allow VHC to do ex parte on an individual level automatically. The system was updated in June with the updated functionality and will run for the first time in July.

1095 Tax Forms

Tax year 2023 1095-B corrections began generation February 2024.
337 corrections for the period 4/1-6/30/24 were generated but not sent out unless member requested.

Customer Support Center

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

The Customer Support Center received 58,588 calls in QE0624, up 2% from the previous year. Maximus answered 98% of calls within 24 seconds in April 2024, 94% in May 2024, and 95% in June 2024.

Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to DVHA-HAEEU for resolution and log service requests, which are escalated to the appropriate resolver group. This year has seen a slight increase in the volume of calls with a slight increase in the proportion of calls that were escalated. 8% of QE0624 calls were transferred to DVHA-HAEEU staff, up from 6% in QE0623. Just as importantly, DVHA strived to answer all calls that were transferred; 95% of transferred calls were answered in five minutes in QE0624, compared to 97% in QE0623.

Timely Processing of Member Requests

In the spring of 2016, DVHA-HAEEU set a goal of completing 75% of member requests within ten business days. In QE0624, more than 99% of the VHC requests were completed within the same ten-day time frame.

In-Person Assistance

DVHA is supported by 121 Assisters (111 Certified Application Counselors, 4 Navigators, and 6 Brokers). Working in 83 locations including hospitals, clinics, and community-based organizations.

21 New Assisters applied during this quarter (application dates from April 1, 2024, thru June 30, 2024). There are currently 36 Assisters still in training (this number includes any Assister who applied in 2024 but has not completed training).
Assister education is ongoing with bi-weekly webinars, a bi-weekly newsletter, and re-certification upcoming in the next quarter.

Outreach

With the year-long Medicaid Renewal Restart process ending this quarter, DVHA to time to reflect on outreach operations. Information about Medicaid renewals and related notices have been repurposed and integrated into messaging on the website, social media accounts and direct customer outreach via email and texting. DVHA continues to consider and develop new ways to enhance community engagement efforts – be that though other State of Vermont partners, new partner organizations, provider offices. DVHA is looking how to outreach to other persons and/or group to reach marginal communities.

The Plan Comparison Tool is a key educational tool. It is used by Vermonters to find a health plan that best fits their needs and budget. It is a core piece of DVHA's educational tools. The Tool was used in over 13,000 sessions during the quarter.

Self-Service

During QE0624, DVHA-HAEEU continued to promote self-service options for customers to report changes, and access tax documents and other forms. Self-service leads to an improved customer experience as Vermonters can log in at their convenience. It also has the benefit of using automation to reduce staffing expenses. Year-over-year comparisons show that more customers are using self-service functions, including both online accounts for health coverage applications and reported changes as well as the options of paying premiums through monthly recurring payments rather than one-time payments.

Choices for Care and Traumatic Brain Injury Program

DAIL

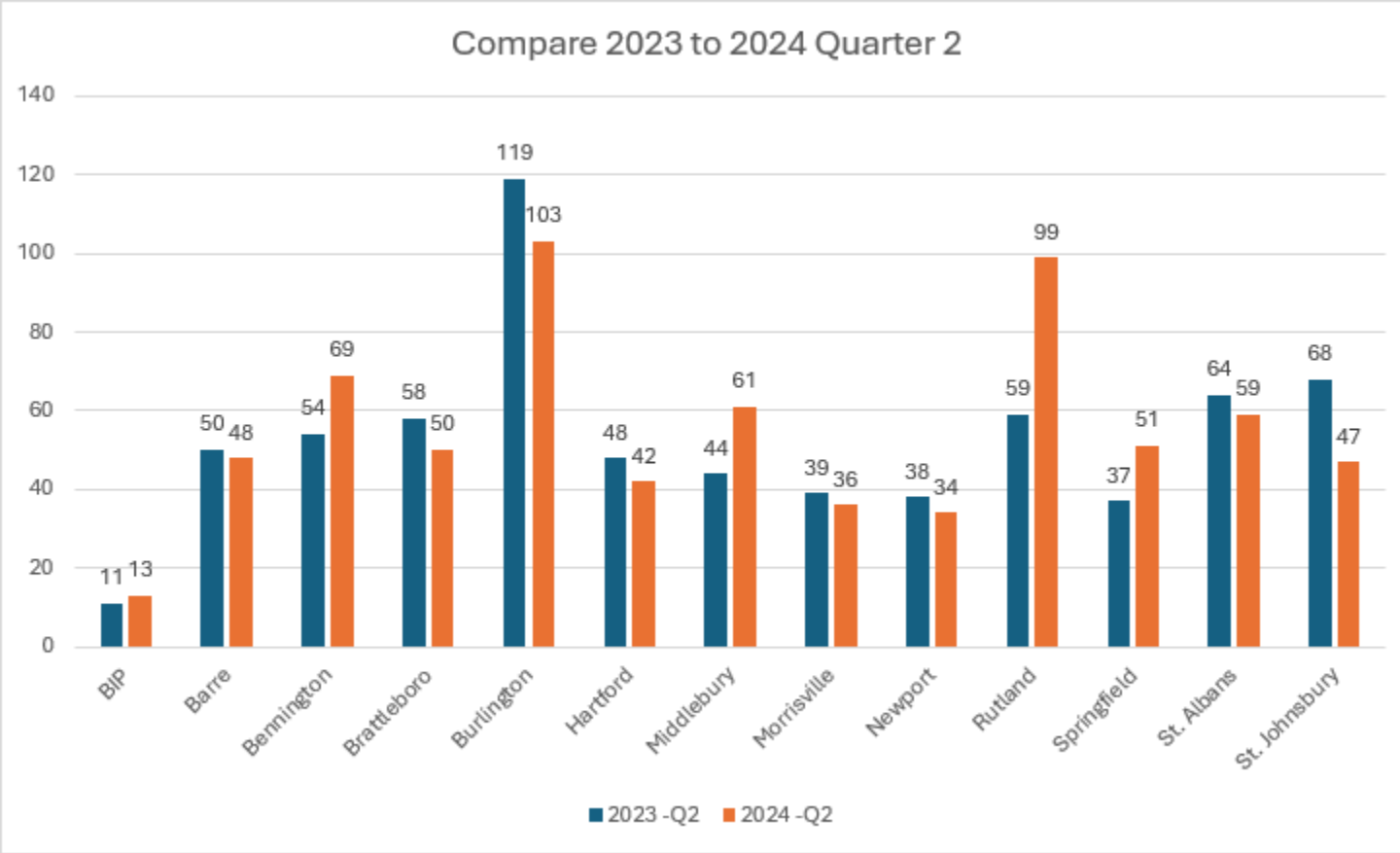
Choices for Care

At the end of Q2, CFC enrollment included:

NH – 1855 participants
ERC – 545 participants
Home Based – 2374participants.
Moderate Needs –704participants

ASD had a 3% increase in applications in Q2 2024 vs Q2 2023

Q2 2023 = 689 Applications
Q2 2024 = 712 Applications



Choices for Care Providers

In Q2, ASD met with all Choices for Care case management providers at the regional level to prepare for the transition of case management to the Area Agencies on Aging. ASD met with regional partners to provide education and support for the transition of clients currently served through home health agencies. More information can be found here: [Project Overview – Vermont HCBS]

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

Enhanced FMAP spending plan:

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

Money Follows the Person (MFP)

The MFP grant has been re-authorized through (CY) 2028. The VT Department of Aging and Independent Living (DAIL) Adult Services Division has been awarded funds for CY2021,CY2022 and CY2023 operations and received budget approval for CY 2024 in March.

MFP goal for the CY2024 award is to fund transitions for fifty-eight (58) Choices for Care participants to a home-based setting.

MFP Progress as of Q2 2024:

9 participants graduated from the program,

25 transitions have been supported,

38 active participants moving towards graduation,

27 participants moving towards transition.

As part of the grant re-authorization, CMS has also relaxed the eligibility rules for the MFP program. We will be seeking permission from CMS to increase our service population to include individuals with I/DD and to provide supplemental funds for food for our participants as part of the Demonstration project. These changes will occur when CMS requests an updated operations protocol from MFP later this year.

In 2021, DAIL was awarded a $5M MFP Capacity Building Grant. These dollars are being used to strengthen the systems serving Money Follows the Person and Choices for Care participants by increasing the number of direct service workers, increasing support for unpaid caregivers, and piloting new HCBS services to meet unmet care needs. The Capacity Building Grant Funding is being used for the following approved initiatives, spread across 11 contracts:

1. Direct service workforce development and retention
2. Falls prevention and mobility.
3. Use of assistive technology
4. Expansion of volunteer programs
5. Holistic social and mental health supports
6. Brain injury Neuroresource facilitation
7. Independent living and home modifications
8. Development of Complex Care Discharge Planning models

<u>Brain Injury Program</u>

Current enrollment = 84 individuals, 3 individuals graduated from the BIP, The BIP received 14 applications, 6 were eligible for a higher level of care, 2 were voluntary withdrawal/options counseling was provided, and 6 met clinical eligibility for BIP; 3 of them were accepted into services by a provider and 3 were added to the waitlist

ASD program staff met with VCIL and the Brain Injury Association of Vermont to coordinate efforts to support individuals who either are not eligible for or are who are waiting for BIP services.

Wait Lists

- There is no wait list for the High Needs Group.
- There continues to be provider wait lists for Moderate Needs Group, homemaker providers report a waitlist of approx. 500 individuals, Adult Day providers report a waitlist of 18 individuals. Because the eligibility criteria for Moderate Needs services are so broad, Vermont does not expect to eliminate the

wait list. ASD is exploring changes to the MNG allocation process to address the waitlist.

- ASD established a waitlist for individuals waiting for services in the BIP. While funding is available for individuals who have been approved for enrollment, providers are unable to accept new participants due to workforce capacity. The State has clinically approved 18 individuals for services who are currently waiting for services due to provider workforce capacity challenges. While waiting for a provider, individuals are referred to the Brain Injury Alliance for neuro-resource facilitation services. DAIL released an RFI in 5/2024 in preparation for an RFP that will be released in September 2024 to award a statewide case management entity for the Brain Injury Program. ASD anticipates that implementing the contract will significantly decrease or eliminate the BIP waitlist.

Developmental Disabilities Services Division (DDSD)

Payment and Delivery System Reform Update:

As the Developmental Disabilities Services Division continues its work related to Payment Reform, DDSD provided opportunities for stakeholder education and feedback. These sessions are instrumental in engaging key partners in policy development for this initiative. The Payment Reform Advisory Committee has been leveraged to determine appropriate supplemental questions to include on the Supports Intensity Scale-Adult (SIS-A) assessment, to ensure the tool is directly asking about all appropriate areas to assist with person-centered planning and service authorization in Vermont. An Advisory Subcommittee also developed a "Context Assessment". The Supplemental Questions and Context document will be used in conjunction with the standard SIS-A to inform the best set of services through person-centered planning. The current Context document is still in draft form; the Advisory Subcommittee continues to seek input regarding the topic areas and specific questions asked to refine the proposed tool. Additionally, work continues to determine "model service mixes" related to the Six Level Framework that the State has adopted, development of proposed rates for the future state and a proposed model to share with partners. It is expected that more information on these topics will be available in Quarter Three.

Please see prior report submissions for previous highlights.

Proposed Policy for Payment for Legally Responsible Individuals Update:

Building off the work through the State System of Care Plan for Developmental Disabilities—SFY2023-SFY2025, input from key partners and nationwide research, DDSD crafted a proposed policy for Payment to Legally Responsible Individuals. The Division worked in partnership with the Department Vermont Health Access (DVHA) Policy Unit to ensure consistency with other Vermont AHS program which were implementing similar policies. Through technical assistance and feedback, DDSD received initial approval of the proposal policy from CMS. Next steps in Quarter Three include operationalization of the policy with Direct Service Providers and the State's Fiscal/Employer Agent, updating State regulation to include this policy, and create "Guidelines Implementing the Paying Legally Responsible Individuals Policy".

Please see prior report submissions for previous highlights.

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.

IV. Expenditure Containment Initiatives

Vermont Chronic Care Initiative (VCCI)

Key updates from Q2 2024:

- Overview
- VTeam Based Care Learning Collaborative
- Care Coordination Housing Resource Team
- Public Safety Enhancement Teams
- Performance Improvement Project
- Metrics

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

The work of the Vermont Team Based Care Initiative is active across the State. Each region of

the state is working on identifying their regional goals for the learning collaboratives. They have been meeting with community partners to discuss how team-based care works in the community now and what some areas for improvement and/or enhancements are. The initiative is being led by the Blueprint Program Managers, Field Directors and experts from the Camden Coalition. Simultaneously, the work group on developing the online self-paced Team Based Care trainings has met several times to begin the work of developing the trainings. VCCI has been designated as a "Team based care Specialist" program, and two nurses from VCCI are part of the Training Curriculum workgroup We have also begun a manual as a guide for communities on best practices of team-based care implementation.

Housing is healthcare and VCCI works with many people who are experiencing homelessness. VCCI serves many Vermonters experiencing homelessness. Nurse case managers continue to work closely with Field Directors and Coordinated Entry agencies to help identify those that would benefit and who want the services that VCCI offers. VCCI is now a member of the Balance of State Continuum of Care and a referral partner for Coordinated Entry across the State.

There are four regions of the State that have hosted public safety summits for providers, educators, advocates and state and municipal leaders to look at the public safety and public data for their regions and develop plans and strategies in attempt to turn the curve. VCCI is a key partner in these initiatives and has been at the table in Rutland, Bennington, Springfield and Brattleboro as a resource around complex care management and outreach efforts to people who have had difficulty engaging in our systems of care. When people's health and social needs are being met, we know that this collectively has a positive impact on public safety and public health.

VCCI is working with DVHA on a performance improvement project looking at all processes related to New to Medicaid outreach. The project will integrate the new AHS Health Related Social Needs Screening Tool into the New to Medicaid screening process. The tool was developed as part of a pilot and is essentially the CMS Health Related Social Needs tool with a few extra questions added around physical health needs. The project will also look at creating efficiency measures within the operations of the program.

VCCI continues to work with Acentra for export of health-related screenings/surveys into the VHIE via VITL with anticipated completion next quarter.

Figure 1 below shows that in the first quarter of the year the number of newly enrolled members decreased steadily since April, however the total number of open cases has remained relatively constant. This is likely due to longer lengths of stay in the program. The length of time and regularity of visits are dependent on the complexity and severity of the needs of the beneficiaries. In addition, capacity for care in the community has also played a role in the length of time people remain in the program. VCCI case managers work with beneficiaries until the goals of their care plans are met or they are connected to needed services in the community with a lead care coordinator assigned. (See Figure 1 below). Face to face visits remain relatively constant with an average of 65% of all VCCI services being in person versus telephonic or virtual.

Figure 1. Beneficiary Enrollment and Face to Face Visits

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Measure	2/15/2024	3/15/2024	4/15/2024	5/15/2024	6/15/2024	7/15/2024
# new VCCI eligible members enrolled monthly in care management	45	34	29	53	43	29
Total Open Cases (including newly enrolled - above)	220	224	235	274	287	276
% of VCCI enrolled members with a face to face visit during the month	65.45%	66.25%	63.40%	60.22%	68.99%	65.22%

VCCI continued the work started in 2019, of telephonic outreach and health related social needs screening to beneficiaries new to the health plan. The Medicaid screening tool poses questions related to access to health care and health care-related issues including primary care, dental, housing, transportation, and food, with direct facilitation to those services desired by the beneficiary. The numbers of people new to Medicaid plan were at the highest in the month of December 2023 at 659 and lowest in February 2024 at 415. The number of members who respond to screening has had a slight increase going from 39% to 43% of all adults New to Medicaid receiving Health Related Social Needs screening. Most of the screenings are done via phone with a few and n via mail. There are challenges of connecting to people due to disconnected phone numbers or mail failure to deliver notices. The VCCI New to Medicaid team also aids those that need and want help finding a primary care provider.

Figure 2. Number of New to Medicaid Beneficiaries Screened

Updated Dates - month reported	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Updated Dates - due date	1/15/2024	2/15/2024	3/15/2024	4/15/2024	5/15/2024	6/15/2024	7/15/2024
# of new to Medicaid members (Adults 18+)	511	456	495	659	502	415	437
# of new to Medicaid members reached	139	141	130	153	110	87	189
# of new to Medicaid members outreach screening attempted	449	444	405	543	426	334	357
# of new to Medicaid members successfully screened	191	196	191	235	201	145	160

Blueprint for Health

Key Updates from QE062024

- The majority of Vermont's primary care practices are Blueprint Patient-Centered Medical Homes, with 129 of Vermont's estimated 165 primary care practices participating. The number of multi-provider practices is estimated at 148, further making the proportion of Blueprint practices higher among larger practices.
- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid-use disorder. As of 2024-Q2, the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs was 3,428
- Blueprint received funding through legislative appropriation for a pilot expansion program in 2023.

Vermont continues to provide access to enhanced preventive health, psychosocial screening and comprehensive family planning serves as evidenced by the commitment of 40 practices, including 7 Planned Parenthood sites, to

participate in the Pregnancy Intention Initiative as of June 2024.

Blueprint Expansion

Act 167 requires that the "Director of Health Care Reform shall recommend the amounts by which health insurers and Vermont Medicaid increase the per-person, per-month payments toward Blueprint for Health Community Health Teams and providing quality facilitation…in furtherance of the goal of providing additional resources necessary for delivery of comprehensive primary care services to Vermonters and to sustain access to primary care services in Vermont." The Blueprint received funding for this proposal and was able to provide this funding to 13 Health Service Areas beginning in August. The proposal recommended piloting increased investments in expanded Community Health Team capacity for Mental Health and Substance Use Disorder treatment and investing in Hubs for co-occurring mental health and poly-substance use disorder for two years using Medicaid funds. Continuing Investment in Blueprint for Health and Increasing Access to Mental Health and Substance Use Disorder Services through Integration with Primary Care will:

- Strengthen prevention, reduce practice variation, increase coordination oversight, and direct workflow through Quality Improvement Facilitation and analytics;
- Expand capacity to address mental health and substance use disorders through Community Health Team staffing to include Community Health Workers, Social Workers, Family Specialists, and Counselors who will screen for, and in some cases treat, MH, SUD and social determinants of health; and
- Promote the healthy development of infants and young children and supporting their parents, as related to mental health, substance use disorder, and/or social determinants of health.

<u>Patient-Centered Medical Home Program</u>

The Blueprint uses national standards to drive improvements in primary care delivery and payment. The program helps primary care providers transform their practices into National Committee for Quality Assurance (NCQA)-certified Patient-Centered Medical Homes. Vermont's Patient-Centered Medical Home (PCMH) model supports care for all patients that are patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety, regardless of insurance type. The model is based on the NCQA criteria, which are required for Blueprint participation and have been met by almost all of Vermont's primary care practices. The model also promotes care that is provided when and where the patient needs it, and in a way that the patient understands. Patient-Centered Medical Homes in Vermont are supported by multi-disciplinary teams of dedicated health professionals that provide supplemental services that allow Blueprint-participating primary care practices to focus on promoting prevention, wellness, and coordinated care. These Community Health Teams (CHTs) support primary care providers and their patients with case management, care coordination, and screening for mental health needs, substance use, and social determinants of health (SDOH). They discuss and support patient-centered goals while addressing whole-person health with effective interventions that support mental and chronic conditions.

Blueprint Program Managers provide leadership in each community to coordinate healthcare delivery system improvement efforts and set up the systems through which integrated services can be delivered in the community. While they are employed by the hospital or FQHC in the HSA, they help organize, lead, and staff collaborative initiatives with the ACO, local human service agencies, health departments, specialty care providers, mental health providers, and primary care providers to facilitate the integration of services. They are responsible for contacting all primary care practices within their HSA to encourage, engage, and support practice participation in the Blueprint and other health system reform activities. Additionally,

Program Managers are responsible for administering funds and staffing plans for the local CHTs on behalf of all participating payers, including core CHT, Spoke staff, and WHI staff. In addition to Program Managers, the Blueprint supports participating practices with a quality improvement coach, called a Quality Improvement (QI) Facilitator. QI Facilitators support practices with data on practice performance and their training and expertise in process improvement methodologies (such as Clinical Microsystems, Model for Improvement, and Lean process improvement). Quality Improvement Facilitators initially help primary care practices to secure National Committee for Quality Assurance (NCQA) PCMH recognition. After the recognition is achieved, the facilitators regularly return to help with quality improvement efforts related to panel management and outreach, care coordination, promotion of individual health and wellness, chronic condition management, and ongoing practice transformation in alignment with State-led health care reform priorities. These priorities include:

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

Selected QI Projects

QI facilitators worked with practices and community collaboratives across their assigned geographic areas to support quality improvement initiatives relevant to population needs and priorities. Some examples of projects led and supported by QI facilitators in Q2 are included below:

- Addressing no-show appointment rates through making office environments more inclusive for individuals of diverse sexual orientations and gender identities.
- Implementing serious illness conversation initiation in pilot sites
- Improving counselling referrals for tobacco cessation
- Implementing EMR related Diabetic Eye Exam improvements
- Immunization workflow improvement, in partnership with the department of health, utilizing CDC strategies

CHT Expansion

QI facilitators provided participating practices with support for integrating newly hired Community Health Team staff, practices related to Social Determinant of Health, Mental Health, and Substance use screening, and enhancing team-based care and community referral pathways. QI facilitators assisted all participating practices to complete a gap analysis of current screening protocols and subsequently prioritize implementation domains.

The Blueprint for Health hosted a Community Health Team Learning Collaborative. The Health Service Areas of Newport, St. Johnsbury, and Morrisville completed a pilot learning collaborative on Community Health Team structures and functions. This community of practice focused on peer-to-peer learning and sharing of promising practices related to recruitment, hiring, orientation/training/supervision, internal and external referral management, caseload management (including discharge), assessment and outcome documentation, tracking and reporting, and pass-through funding administration. Each community ended with developing HSA specific priorities and SMART goals to work on within the next 6 months and decided upon a shared goal to streamline and simplify MOU and invoicing

procedures related to the shared FQHC through this region: Northern Counties Health Care.

Patient-Centered Medical Home (PCMH) Recognition

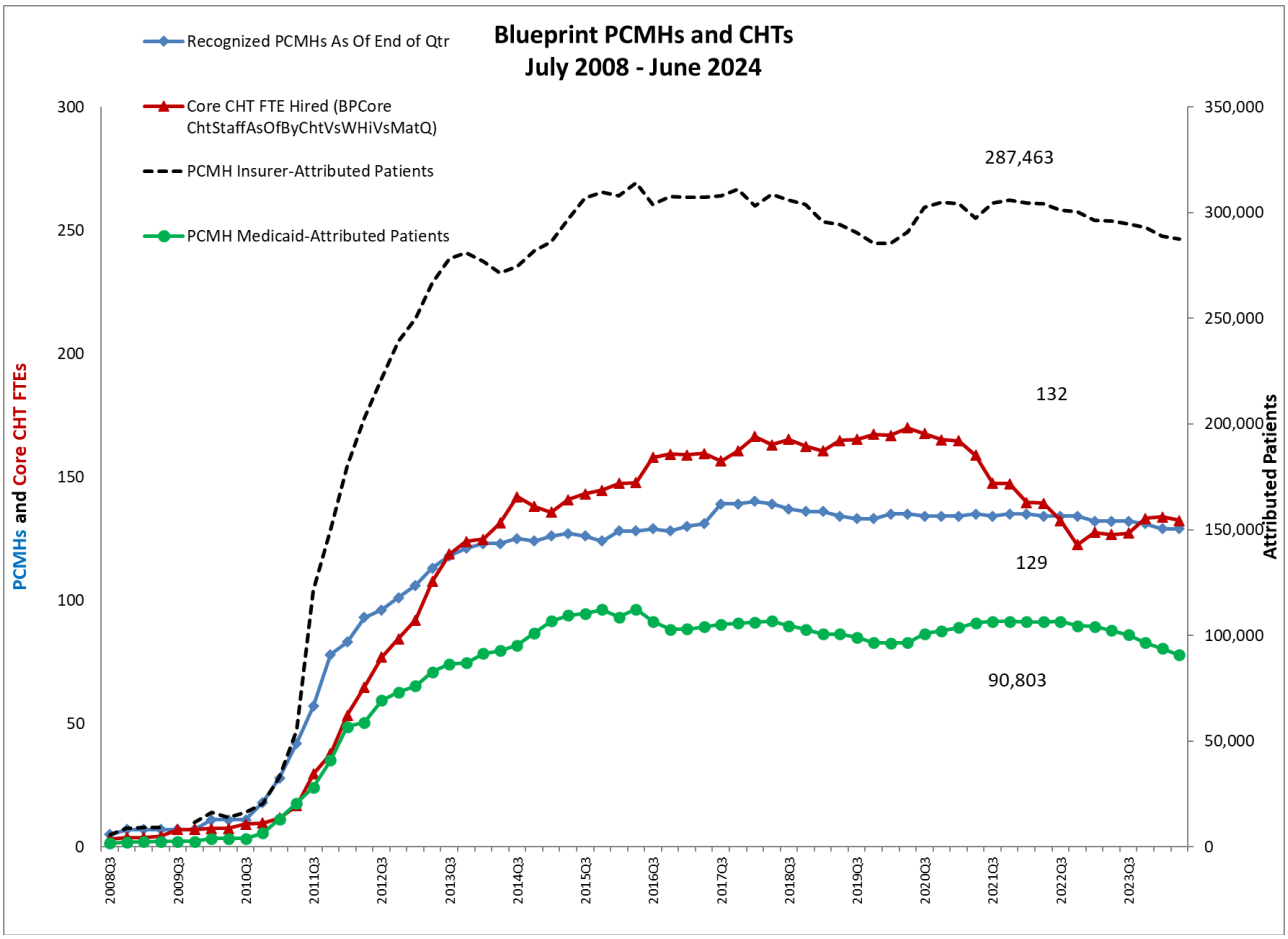
Thirty-six Vermont primary care practices achieved National Committee for Quality Assurance Patient-Centered Medical Home recognition (through annual reporting) during the second quarter of 2024. This quarter has far more practices moving through the annual reporting process based on an extension that was granted by NCQA in 2023 for practices participating in the Blueprint for Health wanting to use results from the Consumer Assessment of Health Care Programs and Services (CAHPS) Patient Experience Survey.

Two practices from the St. Albans and the Rutland Health Service Areas were randomly selected by NCQA for an audit during their PCMH Annual Reporting Submission. NCQA and the practice went through a comprehensive review of organizational standards, policies, and practices related to Individual Patient Care meetings, Diversity, Comprehensive Health Assessments, Patient Visits, Care Management, Care Planning, Referral Management/Sharing Clinical Information, and Quality Improvement related to resource stewardship, patient experience, and performance reporting.

Blueprint-participating Patient-Centered Medical Homes currently serve 287,463 insurer- attributed patients, of which 90,803 are Medicaid enrollees. Attribution to a practice is determined by the practice at which the patient has received most of their primary care within the 24 months before the date the attribution process is conducted. These practices and patients are supported by 132 full-time equivalents of Community Health Team staff.

In Quarter 2 129 Vermont practices were operating as Patient-Centered Medical Homes, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of practices participating in the Blueprint for Health program is a key performance measure; the Blueprint estimates that there are about 165 total primary care practices operating in the state.

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



Community Health Profiles

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

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

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

Hub & Spoke Program

Medication for opioid use disorder (MOUD) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole patient" approach to the treatment of opioid use disorder. The Hub and Spoke system of care in Vermont provides MOUD in two settings – regional, specialty Opioid Treatment Programs (OTPs,

Hubs), which provide higher intensity treatment, and office-based opioid treatment (OBOT, Spokes) in community-based medical practice settings. The Blueprint administers the Spoke part of the Hub & Spoke system of care. Peer-reviewed literature has established that MOUD (also known previously as medication-assisted treatment) is an evidence-based, effective approach to the treatment of opioid use disorder, based upon notable, published outcomes such as decreased opioid use, decreased opioid-related overdose deaths, decreased criminal activity, decreased infectious disease transmission, and increased social functioning and retention in treatment.

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

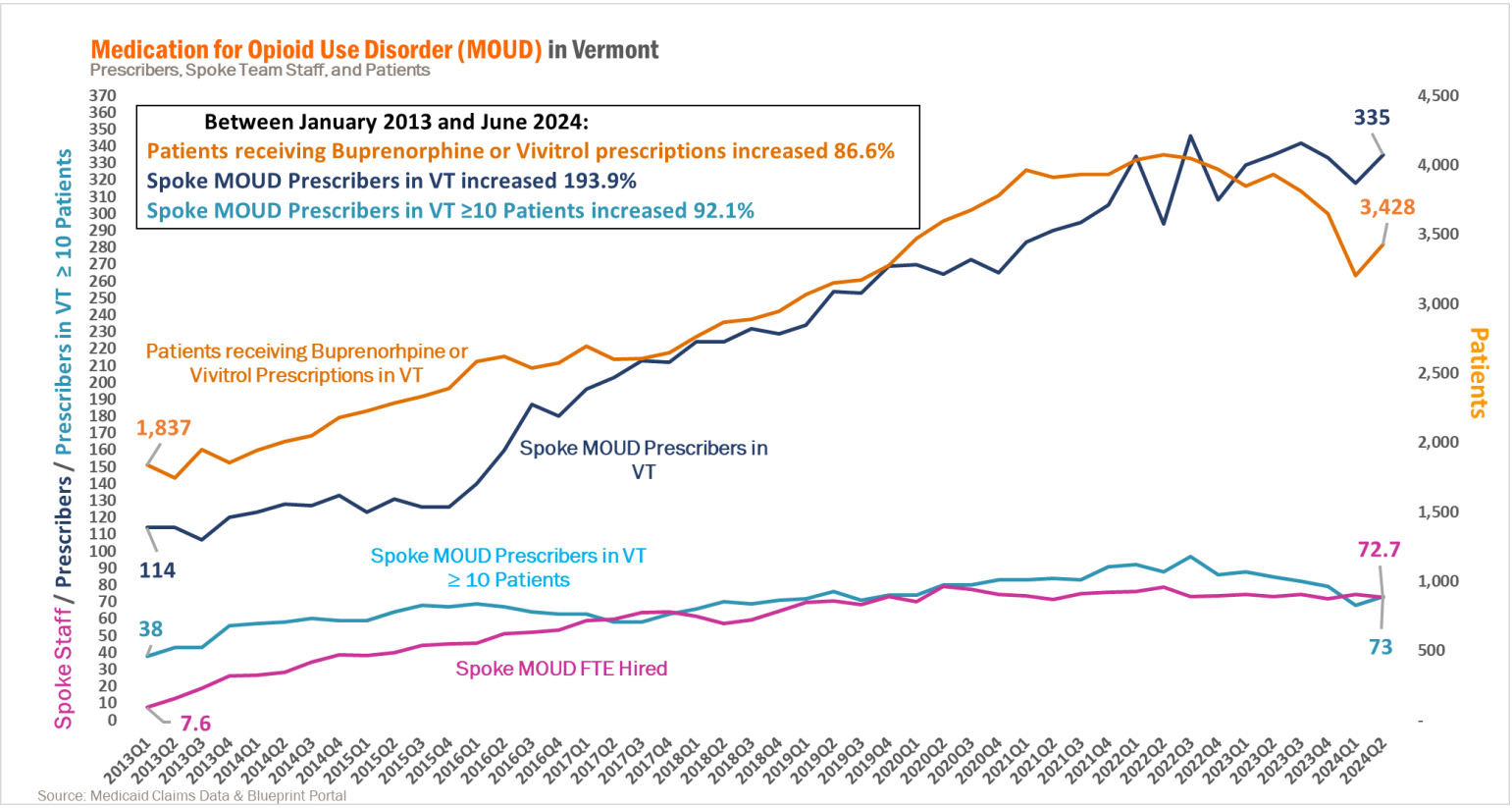
April - June 2024 Highlights

The Blueprint, in partnership with the Division of substance use prevention, in conjunction with a contract with Dartmouth, who was our successful bidder this quarter and will allow us to continue to offer learning sessions with expert- led, and peer-supported, training in best practices for providing team-and evidence-based medication- for opioid use disorder for the next two years. Sessions alternated between didactic and webinars this quarter and that will be the ongoing plan. We have changed the name of our services to CARE which stands for **C**ollaborative to **A**dvance Mental Health Treatment & Substance Use **R**ecovery for **E**veryone. This quarter was our annual conference at the Lake Morey Inn on June 14, 2024. We had 179 participants which included nurses, social workers, therapists, primary care providers and substance use disorder clinicians. Frances Jensen, the plenary speaker spoke on Substance Use in the Adolescent Brain: What Neuroscience Can Tell Us. We had speakers discussing social drivers of health, supporting pregnant and parenting folks, trauma informed care. We had positive feedback on this conference, respondents indicated that learning objectives for each session were very effectively addressed. We had peers on our panels and that was noted to be very helpful to understand a lived experience.

We continue to meet with the managers across our health service to offer support and hear ways to engage folks and community partners.

Vermont continues to demonstrate substantial access to MOUD for Vermonters with opioid use disorder. MOUD is being offered across the State of Vermont by more than 78 different Spoke settings as of June 2024. The monthly average of Medicaid beneficiaries receiving Buprenorphine or Vivitrol prescriptions was 3,428 in Q2 of 2024. There were 335 providers who prescribed Buprenorphine or Vivitrol in Vermont. There are 72.7 FTE of registered nurses and mental health/substance use disorder clinicians who work as a team to offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder.

Figure 2. MOUD-SPOKE Implementation January 2013 - June 2024*



*Q1-2024 patient and prescriber data is incomplete due to missing prescription claims as a result of the Change Healthcare Cyberattack.

Pregnancy Intention Initiative

The Women's Health Initiative (WHI) began as a state initiative to support pregnancy intention. The Women's Health Initiative (WHI) strives to support any persons who can become pregnant in their efforts to experience healthy pregnancies, avoid unintended pregnancies, and build thriving families. We have changed the name of this program with further description below and will begin using this ongoing in reference to the program.

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

The Blueprint partners with participating specialty providers and PCMH primary care practices to support patients ages 15-44. Providers engage with patients at the new patient and annual visits to screen for mental health needs, substance use, and SDOH. They ask about pregnancy intention for the coming year using the One Key Question®, which asks if, when, and under what circumstances a woman would like to become pregnant.

People who can become pregnant with a desire to become pregnant receive services to support a healthy pregnancy. If the individual would like to prevent pregnancy, providers conduct comprehensive family planning counseling and provide patients with options for most and moderately effective contraception, which could include access to same-day long-acting reversible contraceptives (LARC) if clinically indicated.

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

Q2 2024 Highlights

The Women's Health Initiative program has changed its name. We have received feedback on being more inclusive in the name of our program. We have consulted Boston Medical Center which has done some work with the state of Massachusetts to work with primary /specialty care practices to promote equity and inclusiveness. When talking about reproduction, reproductive rights, and gynecological health, transgender and non-binary patients deserve the same inclusive and affirming care as cisgender folks. That starts with changing the language around transgender pregnancy. We have surveyed the field and have had focus groups to gather input on name change. The name change occurred Sept 2023. Our new name is Pregnancy Intention Program and communication to the field was sent out about this change. Documentation was updated to reflect new name.

Pregnancy Intention Initiative (PII) Program Lead meets regularly with representatives from practices to identify process improvement opportunities, ensure the program elements are in place, and support improved patient experience of care. We would like all practices who have signed on to expansion to begin engaging ages15-44 with One Key Question or age-appropriate question regarding interest in contraception and education around sexual health.

With the closures of PPNNE in recent years we are still seeing some access concerns across certain rural health service areas for in person appointments. We have continued to outreach to practices sharing the mission of the PII program and assess interest in incorporating this into their practice.

Practices are working hard to engage community partners in education and understanding the PII program. These partnerships and education around the mission of the program enhance relationships and pathways to care. We have present a PII data dashboard to the field in our monthly call every quarter to discuss trends in usage of most and moderately effective contraception in our health service areas.

We provided the field with a Long-Acting Reversible Contraceptive Training June 2024 that was attended by 13 providers which is the maximum amount for Nexplanon certification. Dr. Lauren MacAfee through UVM is an amazing teacher and the field truly appreciates the training. We are working with Family Child Health to discuss a training on inter partner violence and new recommendations and other clinical considerations on contraceptive counseling and the new O pill that is available over the counter as examples of questions and needs the field has expressed.

Figure 3 below shows PII enrollment and staffing over time. In Q2 2024, the number of PII practices enrolled is 40. 18 women's specialty health care sites and 22 PCMH participated in the Pregnancy Intention Initiative as of June 2024.

Figure 3. Pregnancy Intention Initiative Implementation by Region

Health Service Area	PII Specialist Practices as of Q1 2024	PII PCMH Practices as of Q1 2024	PII CHT Staff FTE Hired as of Q1 2024	PII Specialist Quarterly Attributed* Medicaid Beneficiaries as of Q1 2024	PII Quarterly Attributed* Medicaid Beneficiaries as of Q1 2024
Barre	1	0	0.75	609	0
Bennington	1	0	1	988	0
Brattleboro	1	0	.5	807	0
Burlington	2	9	1.2	2,115	4144
Middlebury	1	0	0.75	786	0
Morrisville	1	3	0.50	329	1129
Newport	1	0	1	885	0
Randolph	1	0	0.50	121	0
Rutland	1	0	1	1,027	0
Springfield	0	5	0.00	0	1474
St. Albans	0	0	0.00	0	0
St. Johnsbury	1	2	0.75	847	516
Windsor	0	3	0.00	0	79
Planned Parenthood (Statewide)	7	0	2.8	2,653	0
Total	18	22	10.75	11,167	7342

*Quarterly attributed patient counts at the HSA level have a small amount of overlap due to patients moving across HSAs in different months. The statewide quarterly total is deduplicated.

Mental Health, Substance Use Disorder, and Behavioral Health

Key updates from QE062024:

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

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

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

facility for services using different methodologies on a fee-for-service, per-claim basis. The new model allows for a prospective payment informed by several factors:

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

The DVHA, DMH, and the psychiatric facility have agreed upon performance measures and a monitoring platform for this payment model. Year three reconciliation has been completed and the model is now in year 4.

The CIU is also responsible for the concurrent review and authorization of inpatient and residential eating disorder treatment services for members with Medicaid as a primary insurer. Over the past few years, DVHA has worked to enhance the availability of these services to members. This has included removing prior authorization and expanding coverage of residential eating disorder treatment services for adults 21 years and older when deemed medically necessary.

Effective 07/01/2022, the DVHA began reimbursement for extended Emergency Department (ED) stays in which a Vermont Medicaid member was meeting clinical criteria for inpatient psychiatric level of care (LOC) AND there were no inpatient beds available for placement. Requesting hospitals may submit a request after a Vermont Medicaid member meeting inpatient psychiatric LOC has had an initial 24-hour stay in an ED. The CIU is reviewing and making authorization determinations for these requests. We are entering year three of the benefit and utilization has been consistent.

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

CIU team members participate in the Interagency Team and the Youth Service System Enhancement Council (a collaborative with ADAP, DMH, VCRIP, Vocation Rehabilitation, DCF, and more). Team members are active in ensuring that members with multi- department involvement are getting appropriate services delivered most efficiently. This is accomplished through participation in state interagency team meetings, a biweekly Shared Response to Emergency Placements meeting and participating in weekly case reviews and developing protocols for cross-departmental service delivery. The CIU worked with other departments on developing a system to notify DVHA regarding all children with Medicaid that are awaiting placement in Emergency Departments for DVHA to assist with placements when needed.

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

The DVHA ABA team is working with the Payment Reform Unit on a valued based payment (VBP) project. Beginning Calendar Year 2023, DVHA's ABA Tiered Payment Model will incorporate provider results on three performance measures into the reconciliation process and calculations. This VBP proposal will allow providers to earn up to 10 points and up to 1% of their total earned service level tier payments (the 1% is anticipated to be an added payment for services provided in the calendar year 2023 and a withhold thereafter). The measures include the amount of service provided in member months, the percentage of total billed hours that are direct therapeutic service hours, and timely claims submissions. The Senior Autism Specialist worked with the payment reform and policy teams on provider outreach to ensure information was thoroughly and accurately discussed. The Policy Unit posted a GCR which required a public comment period before implementation in CY '23. In July of CY2024, the DVHA will be finalizing CY2023 data to determine how much of the proposed 1% of total earned service level tiered payments each provider will receive.

The DVHA Senior Autism Specialist conducts biennial clinical documentation reviews with Vermont Medicaid enrolled ABA providers who provide services to Vermont Medicaid members. The purpose of these reviews is to ensure that members are receiving quality care, that providers are accurately reimbursed for provided services, verify that required documentation is included in member's charts and that clinical documentation follows ABA Policy and Clinical Guideline standards. Five clinical documentation reviews have been completed thus far in calendar year 2024.

Pharmacy Program

Pharmacy Benefit Management Program

The DVHA's Pharmacy Unit oversees the pharmacy benefit implementation for all of Vermont's publicly funded pharmacy benefit programs. The Pharmacy Unit's goal is to provide the highest quality prescription drug benefits in the most cost-effective manner. This is accomplished by providing broad coverage of prescription and over-the-counter pharmaceuticals, while controlling pharmacy expenditures through both utilization and cost management strategies. DVHA utilizes the Pharmacy Benefit Management Change Healthcare (CHC) now Optum Rx, to administrator the program. The partnership provides a full complement of operational, clinical, and programmatic support in addition to managing a call center for pharmacies and prescribers. The Pharmacy Unit is also responsible for overseeing the contractual agreement with CHC/Optum Rx manages and reports approximately $299 million in gross drug spend annually (SFY2023), analyzes national and Vermont Medicaid drug trends, and reviews drug utilization. A primary goal of the Pharmacy Unit is to seek innovative solutions to deliver high-quality customer service, while assuring optimal drug therapy for Vermont Medicaid members and managing drug utilization and cost.

Pharmacy Operations

- Pharmacy claims processing – Assuring that members have access to medically-necessary medications within the coverage rules for DVHA's various pharmacy benefit plans.
- Pharmacy provider assistance – Assisting pharmacies and prescribers with various issues related to claims processing, prior authorizations, and other operational and clinical issues.
- Coordination of multiple benefits programs – The Pharmacy Unit interfaces with the Coordination of Benefits Unit, The Medicare Part D team, the Eligibility Unit, and the Member Call Center. These interactions lead to increased member assistance and resolution of member issues.
- The Pharmacy Unit serves as a liaison to Vermont Department of Health (VDH) in multiple clinical areas including vaccines, asthma and smoking cessation, In-addition, there is communication with the Division of Substance Use Program, and the Department of Mental Health (DMH) related to the management of psychotherapeutic drug use in children. The Pharmacy Unit also works with the Vermont Medication Assistance Program (VMAP) and Children with Special Health Needs (CSHN) program to assist in with drug and rebate management of these programs.
- Managing various clinical activities including drug utilization and cost:
  - Federal, state, and supplemental rebate programs
  - Preferred Drug List management.
  - Prior authorization and utilization management programs
  - Drug Utilization Review Board activities; therapeutic class reviews, new drug reviews, prior authorization criteria review, and step-therapy protocols
  - Specialty pharmacy management, including enrollment and monitoring.
  - Physician-administered drug management
- Manages exception requests, the Early and Periodic Screening, Diagnostic and Treatment EPSDT benefit requests, appeals, and fair hearings with the Policy Unit.
- Works with Special Investigations Unit (SIU) on drug utilization issues related to fraud, waste, and abuse.

Operational Activity Reports

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

	No PA	Automated Edits						
Period	**Claims Paid w/o PA**	**Claims Paid w/Auto PA**	**Claims Paid with Auto Edit**	**Claims Paid w/Online Override**	**Claims Paid w/Emergency PA**	**Claims Paid due to Grandfathering**	**Claims Paid w/Clinic al PA**	**Total Claim Count**
Quarter 2	**!! Department of Vermont Health Access (DVHA), Pharmacy Benefit Manager, Change Healthcare/Optum Rx which operates Vermont's Medicaid pharmacy claims system, experienced a significant cyber security issue on February 1, 2024. We currently do not have data to share for this quarter.**							

- The total claim count does not include compounded drugs.

Paid Claims and Drug Spend

MEDICAID

Period	# Claims	# Of Members	State Paid Amounts
2Q2024	**!! Department of Vermont Health Access (DVHA), Pharmacy Benefit Manager, Change Healthcare/Optum Rx which operates Vermont's Medicaid pharmacy claims system, experienced a significant cyber security issue on February 1, 2024. We currently do not have data to share for this quarter.**		

VPHARM

Period	# Claims	# Of Members	State Paid Amounts
2Q2024	**!! Department of Vermont Health Access (DVHA), Pharmacy Benefit Manager, Change Healthcare/Optum Rx which operates Vermont's Medicaid pharmacy claims system, experienced a significant cyber security issue on February 1, 2024. We currently do not have data to share for this quarter.**		

- The total claim count does not include compounded drugs.

Provider Communications

*For full communication please go to Pharmacy Programs Bulletins and Advisories | Department of Vermont Health Access

Point of Sale (POS) Patching	6/12/24 - Due to the need to perform system maintenance, the DVHA POS system will be unavailable for approximately 5 minutes starting at 9:00PM on Friday, June 14,2024. Pharmacy claims will not be adjudicated during this time.
Drug File Updates	6/10/24 - Restoration of pharmacy services (Drug Pricing Updates, New Drug Products and NDC updates, SMAC disputes, and Rejected Claim Issues) will be implemented in the Vermont Medicaid system, effective June 8, 2024.
Temporary Dispensing Fee Increase	5/31/24 - Vermont Medicaid will provide an enhanced Professional Dispensing Fee for prescribed drugs to account for the manual and time-consuming procedures pharmacies had to perform due to the Change Healthcare outage. The Professional Dispensing Fee for pharmacy claims of $11.13 will increase by $3.26 per claim to $14.39, from June 3, 2024, to June 30, 2024. This change will be automatically implemented for pharmacy claims, excluding specialty

	drug and 340B drug claims.
Preferred Drug List	5/7/24 - As a friendly reminder, although pharmacy prior authorizations are not back to full functionality, providers are reminded to refer to the Preferred Drug List, https://dvha.vermont.gov/providers/pharmacy/preferred-drug-list-pdl-clinical-criteria to review clinical criteria.
Opioid Safety Checklist for MME	4/12/24 - On 4/15/2024, the cumulative Morphine Milligram Equivalent (MME) edit will be applied on claims for new members with a cumulative daily MME > 90 per day, or > 120 MME per day for existing members (applies to any combination of short and/or long-acting opiates). Claims exceeding this limit without a prior authorization on file will receive rejection- 922 MORPHINE MILLIGRAM EQUIVALENCY (MME) EXCEEDS LIMITS. This rejection will not apply to members with a current prior authorization on file to exceed MME limits.
Gainwell Provider Email Advance	4/2/24 - Reminder to include current process for submitting Medicaid claims and provide update on your organization restoration status and anticipated timeline for full restoration. This is to allow providers to receive advance payment due to the Cyber activity.

Clinical Activities

The Department of Vermont Health Access (DVHA) continues a phased recovery following the outage that occurred in February 2024, due to the national cyber security issue affecting Optum (formally Change Healthcare).
On March 18, 2024, pharmacy claims began processing again.

Vermont Medicaid removed copay requirements for all members for the duration of the outage. A $0.00 copay was applied on claims processed for dates of service throughout the outage (February 21 – March 18, 2024).

To reduce pharmacy burden, when claims processing resumed, DVHA was bypassing condition codes: Reject Code 75 – PA Required, Reject Code 76 – Plan Limitations Exceeded, Reject Code 79 – Refill Too Soon.

On 04/02/2024, Reject-79 Refill Too Soon and Reject-79 Refill Too Soon Carryover returned to normal function.

While prior authorization was not available, pharmacies and prescribers are expected to follow Vermont Medicaid's Preferred Drug List requirements for non-preferred medications. The Department is genuinely appreciative of the patience and understanding of members, pharmacies, and providers during this time. DVHA remains committed to transparency, and we will continue to provide updates and issue instructions for Medicaid members and prescribers.

Pharmacy Cost Management (PCM) Program

! Department of Vermont Health Access (DVHA), Pharmacy Benefit Manager, Change Healthcare/Optum Rx which operates Vermont's Medicaid pharmacy claims system, experienced a significant cyber security issue on February 1,

2024. We currently do not have data to share for this quarter.

All-Payer Model: Vermont Medicaid Next Generation Program

Key updates from QE062024:

- Executed a contract extension with OneCare Vermont for a 2024 performance year of the program.
- Implemented a Global Payment Program (GPP) pilot as a complementary payment model to the VMNG program.
- Began reconciliation (financial and quality) for the 2023 performance year.
- Continue to support Vermont's broader efforts to develop an integrated healthcare delivery system under an All-Payer Model through incremental programmatic improvements, iteration, and evolution.

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

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

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

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

DVHA began financial reconciliation activities for its 2023 performance year in Q1 2024.Reconciliation activities will determine the ACO's spend as compared to their financial target and quality performance for the 2023 performance year. Final reconciliation results will be available in early Q4 2024.

DVHA and OneCare executed a contract amendment for a 2024 performance year of the VMNG program in Q4 of 2023. This amendment included a new, voluntary, complementary payment model (the Global Payment Program, or GPP) to issue separate "global" monthly prospective payments to current hospital and independent primary care participants in the VMNG ACO program. These prospective payments are for Vermont Medicaid members who are not attributed to the VMNG ACO program for Total Cost of Care-related services at participating hospital and independent physician practice participants, and this payment model is reconciled to actual fee-for-service experience separately and distinctly from the prospective payments issued to OneCare Vermont for VMNG ACO-attributed members. Independent physician practices began participating in the GPP at the beginning of Q1 2024, and it is anticipated that hospitals who opt into the program will begin participating at the beginning of Q3 2024. This approach begins to separate the provider payment methodology from an attribution methodology and is an incremental step toward a more global, budget-based payment model, as Vermont looks forward to the next iteration of an All-Payer Model agreement through potential future participation in the federal AHEAD model. Other programmatic changes to the model were minor, to ensure program stability and. continued alignment across payer programs as part of the Vermont All-Payer ACO Model. Changes included increasing the risk corridor to $\pm$3% and combining the traditional and expanded attribution cohorts for the purposes of financial reconciliation.

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

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

V. Financial/Budget Neutrality Development/Issues

As is the monthly process, AHS paid DVHA 1/12th of the legislative budget for Global Commitment on the first business day of each month during the April – June 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 second quarter of DY20 of the GC Waiver. Vermont calculates $740M for without waiver expenditures and reported $794M with waiver expenditures, leaving a deficit subtotal of $54.8M. There are also 10 Hypothetical Tests for various demonstration groups. The hypothetical tests for New Adult, SMI IMD, Maternal Health & Treatment Services, CRT and Moderates reflect a surplus. Whereas the test for SUD IMD, Global Rx, and Marketplace Subsidies shows a moderate deficit. The total of the deficit is $3.3M, which reduces the cumulative Waiver savings to $28.7M deficit. There is nothing to report for the Housing Pilot or SUD CIT because those programs have not yet been operationalized. Lastly, for Investments, Vermont reported $56.7M in expenditures for the quarter which leaves $119.9M available for the remainder of DY20.

We note the Budget Neutrality deficit, and this will be mitigated through the proposed pmpm updated rates that account for 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 QE0624, Vermont reported $1.2M in Program expenses, $3.7M in Investments, and $1.5M in Admin expenses.

VI. Member Month Reporting

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

The table below contains Member Month Reporting for DY18, 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	88,821	44,912
ABD - Non-Dual - Child	8,739	22,343	11,531
ABD - Duals	136,650	275,379	132,538
Non - ABD Adult	112,369	204,897	74,601
Non - ABD Child	378,139	733,379	341,565
Hypothetical Groups			
New Adult	454,502	874,071	375,469
SUD - IMD ABD	51	142	59
SUD - IMD ABD Dual	70	156	59
SUD - IMD Non ABD	121	430	78
SUD - IMD New Adult	623	1,299	631
SMI - IMD ABD	55	127	90
SMI - IMD ABD Dual	10	28	15
SMI - IMD Non ABD	20	173	31

SMI - IMD New Adult	174	350	206
Housing Pilot	0	0	0
Maternal Health and Treatment Services	114	343	155
CRT	1,213	2,437	1,530
SUD CIT	0	0	0
VT Global RX	55,178	108,797	55,208
Moderate Needs Group	731	1,377	715
Marketplace Subsidy	60,841	139,440	85,224

VII. Consumer Issues

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

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

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

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

VIII. Quality Improvement

Quality Assurance and Performance Improvement Activities

Key updates from QE062024:

- DVHA initiated a new formal PIP focused on new-to-Medicaid (NTM) screening.

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 QE0624 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 annual review of experience of care survey results, performance improvement project reporting, as well as Home and Community-Based Quality Subcommittee activity updates.

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 focused on collecting and aggregating data for CMS' HCBS Compliance Measure Set.

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 and baseline data were developed. DVHA also submitted its annual PIP summary for external quality review. DVHA's submission received a Met score of 100%.

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. The Medical Record Review (MRR) process, including chart retrieval and abstraction, was completed during QE0624 for four hybrid measures.

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CAHPS Experience of Care measures – The Quality Unit received the 2023 Health Plan CAHPS survey result summaries for Adults and Children from our contracted vendor during Q1 2024. The Children with Chronic Conditions question set was added to the survey; thus, a new scorecard tool was created by the Quality Unit to better incorporate these results. This reporting was delivered to the Quality Committee during QE0624.

Vermont Next Generation Medicaid ACO

During QE0624, 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 QE062024, the risk assessment team coordinated preparation for 2024 EQR audits, including Managed Care Compliance, Performance Measure Validation (PMV) and a new Network Adequacy Validation (NAV).

Global Commitment (GC) Investment review.

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

During this most recent quarter, DOC and DCF highlighted the performance of a subset of their investments. The Clear Impact Scorecards for these investments is included in this report as Attachment 6.

Payment Models & Performance Monitoring

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

During this most recent quarter, DVHA highlighted the performance of its Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO) payment model. The Clear Impact Scorecard for this payment model is included in this report as Attachment 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 Q2, the state continued to work with the evaluator to develop the assessment. Specifically, the state worked to help identify quantitative monitoring data and potential stakeholders for qualitative data collection. AHS will continue to work with the evaluator to develop a timeline and workplan for midpoint assessment completion.

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.

IX. Demonstration Evaluation Activities

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

Overall Waiver

During the quarter, the state worked with an independent evaluator to address the CMS feedback they received last quarter on their draft evaluation design for the overall waiver. Key areas addressed included the following: elaborate on key details of the evaluation design and comparison group selection; clarify time periods for all quantitative outcome measures; avoid causal language when using

descriptive or pre-post analyses; provide more details in quantitative analysis plans; include further detail on investment assessments; and include additional detail on primary data collection plans. The modified design was submitted to CMS at the end of the 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 investments 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 continued to work with an independent evaluator on the assessment of the Year 1 investments. The state will continue to support the evaluator as they begin to assess the first set of priority investments.

Summative Evaluation Report

During this quarter, the state worked with the independent evaluator that produced the summative evaluation to modify the report to address CMS feedback received last quarter. The draft Summative Evaluation Report covers the 2017–2021 demonstration period. Specific areas addressed include the following: ensure consistency in the reported hypotheses and measures and include a description of the status of all measures listed in the Evaluation Design; conduct tests of statistical significance for all quantitative measures and add results to summary tables or provide a rationale for not feasible; revise language to clarify key concepts in the evaluation; define acronyms and terms used, particularly in the Executive Summary; present uncertainty around estimates; and clarify the multiple testing approach. The revised Summative Evaluation Report was submitted to CMS during this quarter.

PHE Flexibilities

In response to the COVID-19 public health emergency (PHE), Vermont applied for a new section 1115(a) demonstration flexibility requesting CMS approval for waiver and expenditure authorities to facilitate the delivery of effective care and to allow the state to focus operations on addressing the PHE. Specifically, the state requested to waive the requirement 42 CFR 438.406(b)(4) Handling of Grievances and Appeals, that allows beneficiaries to provide evidence and testimony “in person” to appeal an adverse benefit determination during the PHE. This application was approved by CMS on December 3, 2020. During this quarter, the state worked with the independent evaluator to produce/submit the final evaluation report associated with this waiver.

Waiver Performance Evaluation

During Q2 2024 the state continued to work with their new evaluator, University of Massachusetts, to conduct evaluation activities associated with Vermont’s Global Commitment to Health 1115 research and demonstration waiver. The overall responsibilities of the contractor are to enhance the state’s ability to assess the performance of their Medicaid managed care model as well as to support the future development of partnerships with appropriate research partners. Specific activities included the following: establishing a connection between UMASS staff and MDWAS project staff/contractors, understanding MDWAS Data Lake data sources, identifying data needed to assess performance, as well as beginning identify gaps in data sources and elements. The state anticipates initial deliverables next quarter.

X. Compliance

Key updates from QE062024:

- EQRO Review Activities – Planning for all 2024 activities continue. Final review material sent to DVHA.
- SIU Activities are included in this section.

External Quality Review

During the last quarter, the state worked with the External Quality Review Organization (EQRO) to finalize the material necessary for each of the required annual external quality review activities (i.e., performance improvement project validation, performance measure validation, compliance review, and network adequacy validation). By the end of the quarter, letters and materials for all EQRO-related activities were sent to DVHA.

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. There was no IGA activity this quarter.

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 Q2 2024

REPORTING ELEMENT	#
The number of provider investigations conducted by the PIHP	22
The number of suspected fraud referrals provided to the state Medicaid agency by the PIHP	2
The number of Personal Care Assistant related suspected fraud referrals provided to the state Medicaid agency by the PIHP	0
Number of Provider Preventable Conditions Identified by the SIU in the second quarter of CY2024	0

XI. Reported Purposes for Capitate Revenue Expenditures

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

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

system and promote the transformation to value-based and integrated models of care.

XII. State Contact(s)

Fiscal	Richard Donahey, CFO VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	802-241-0442 (P) richard.donahey@vermont.gov
Medicaid Director	Monica Ogelby Vermont Medicaid Director Agency of Human Services 280 State Drive Waterbury, VT 05671-100	802-338-6643 Monica.ogelby@vermont.gov
Policy/Program	Ashley Berliner, Director of HealthCare Policy & Planning VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	802-578-9305 (P) 802-241-0958 (F) ashley.berliner@vermont.gov
Managed Care Entity	Adaline Strumolo, Acting Commissioner of the Department of Vermont Health Access 280 State Drive Waterbury, VT 05671-1000	802-241-0147 (P) 802-879-5962 (F) adaline.strumolo@vermont.gov

XIII. Attachments

Attachment 1	Budget Neutrality Workbook
Attachment 2	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	QE062024 Investments (GC Investments)
Attachment 6	Investment Scorecard(s)
Attachment 7	Payment Model Scorecard(s)

Date Submitted to CMS: May 29, 2024

Attachment 1

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
QE 0624

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	$ 91,924,294	$ 220,989,204	$ 117,041,677
ABD - Non-Medicare - Child	$ 23,320,945	$ 60,947,723	$ 32,300,798
ABD - Dual	$ 289,588,696	$ 600,451,945	$ 299,666,408
Non ABD - Non-Medicare - Adult	$ 88,456,625	$ 168,898,333	$ 65,352,425
Non ABD - Non-Medicare - Child	$ 226,334,361	$ 457,999,046	$ 225,643,226
Total Expenditures Without Waiver	**$ 719,624,921**	**$ 1,509,286,251**	**$ 740,004,534**
With Waiver			
ABD - Non-Medicare - Adult	$ 95,250,705	$ 217,911,333	$ 119,278,153
ABD - Non-Medicare - Child	$ 20,360,439	$ 61,080,929	$ 36,430,219
ABD - Dual	$ 283,809,254	$ 616,434,108	$ 333,634,706
Non ABD - Non-Medicare - Adult	$ 56,470,924	$ 100,095,762	$ 41,774,182
Non ABD - Non-Medicare - Child	$ 173,656,454	$ 385,793,986	$ 206,412,977
Individual Cost Effective	$ -	$ -	$ -
Community Transition Services	$ -	$ -	$ -
MDAAP	$ -	$ 582,000	$ 54,000
Investments	$ 73,392,050	$ 110,768,382	$ 56,719,293
Total Expenditures With Waiver	**$ 702,939,826**	**$ 1,492,666,500**	**$ 794,303,530**
Waiver Savings Summary			
Subtotal Annual Savings	$ 16,685,095	$ 16,619,750	$ (54,298,996)
Hypothetical Test Deficits	$ (1,204,077)	$ (3,198,525)	$ (3,308,369)
Cumulative Savings	$ 15,481,018	$ 28,902,243	$ (28,705,121)
HYPOTHETICAL TESTS			
Hypothetical Test 1: New Adult			
Limit New Adult PMPM*MM	$ 261,350,820	$ 523,985,586	$ 237,899,419
New Adult Total Expenditures	$ 222,857,284	$ 445,820,821	$ 211,677,527
Surplus (Deficit)	$ 38,493,536	$ 78,164,765	$ 26,221,892
Hypothetical Test 2: SUD IMD			
SUD - IMD ABD - Non-Medicare - Adult	$ 156,312	$ 449,184	$ 194,658
SUD - IMD ABD - Dual	$ 129,959	$ 298,269	$ 117,319
SUD - IMD Non ABD - Non-Medicare - Adult	$ 342,876	$ 1,259,382	$ 238,726
SUD - IMD New Adult	$ 1,941,629	$ 4,220,302	$ 2,166,899
Limit SUD IMD PMPM*MM	**$ 2,570,776**	**$ 6,227,137**	**$ 2,717,602**
SUD - IMD ABD Non Medicare Adult	$ 156,753	$ 455,254	$ 301,337
SUD - IMD ABD - Dual	$ 236,032	$ 503,170	$ 321,257
SUD - IMD Non ABD - Non-Medicare - Adult	$ 380,721	$ 671,824	$ 420,995
SUD - IMD New Adult	$ 2,146,823	$ 4,876,050	$ 3,191,079
SUD IMD Total Expenditures	**$ 2,920,329**	**$ 6,506,298**	**$ 4,234,668**
Surplus (Deficit)	$ (349,553)	$ (279,161)	$ (1,517,066)
Hypothetical Test 3: SMI IMD			
SMI - IMD ABD - Non-Medicare - Adult	$ 3,070,568	$ 7,317,673	$ 5,408,740
SMI - IMD ABD - Dual	$ 357,432	$ 1,030,686	$ 574,239
SMI - IMD Non ABD - Non-Medicare - Adult	$ 726,715	$ 6,497,072	$ 1,216,605
SMI - IMD New Adult	$ 7,128,451	$ 14,947,557	$ 9,299,174
Limit SMI IMD PMPM*MM	**$ 11,283,167**	**$ 29,792,988**	**$ 16,498,758**
SMI - IMD ABD Non Medicare Adult	$ 1,622,662	$ 5,221,278	$ 2,698,586
SMI - IMD ABD - Dual	$ 525,975	$ 1,186,763	$ 560,718
SMI - IMD Non ABD - Non-Medicare - Adult	$ 700,985	$ 1,575,936	$ 725,368
SMI - IMD New Adult	$ 5,491,100	$ 13,081,690	$ 6,767,163
SMI IMD Total Expenditures	**$ 8,340,722**	**$ 21,065,667**	**$ 10,751,835**
Surplus (Deficit)	$ 2,942,445	$ 8,727,321	$ 5,746,923
Hypothetical Test 4: Housing Pilot			
Limit Housing Pilot PMPM*MM	$ -	$ -	$ -
Housing Pilot Total Expenditures	$ -	$ -	$ -
Surplus (Deficit)	$ -	$ -	$ -
Hypothetical Test 5: Maternal Health and Treatment Services			
Limit Maternal Health and Treatment Services PMPM*MM	$ 1,105,887	$ 3,361,989	$ 1,540,384
Maternal Health and Treatment Services Total Expenditures	$ 1,179,899	$ 3,212,211	$ 961,609
Surplus (Deficit)	$ (74,012)	$ 149,778	$ 578,775
Hypothetical Test 6: CRT			
Limit CRT PMPM*MM	$ 6,149,760	$ 12,788,302	$ 8,406,118
CRT Total Expenditures	$ 4,735,011	$ 11,488,848	$ 6,612,945
Surplus (Deficit)	$ 1,414,749	$ 1,299,454	$ 1,793,173
Hypothetical Test 7: SUD CIT			
Limit SUD CIT PMPM*MM	$ -	$ -	$ -
SUD CIT Total Expenditures	$ -	$ -	$ -
Surplus (Deficit)	$ -	$ -	$ -
Hypothetical Test 8: Global Rx			
Limit Global Rx PMPM*MM	$ 4,928,451	$ 9,714,705	$ 4,931,130
Global Rx Total Expenditures	$ 5,708,962	$ 12,634,069	$ 6,570,559
Surplus (Deficit)	$ (780,511)	$ (2,919,364)	$ (1,639,429)
Hypothetical Test 9: Moderates			
Limit Moderates PMPM*MM	$ 609,493	$ 1,179,722	$ 646,047
Moderates Total Expenditures	$ 445,520	$ 879,923	$ 622,509
Surplus (Deficit)	$ 163,973	$ 299,799	$ 23,538
Hypothetical Test 10: Marketplace Subsidy			
Limit Marketplace Subsidy PMPM*MM	$ 2,027,688	$ 4,782,013	$ 3,036,291
Marketplace Subsidy Total Expenditures	$ 1,955,249	$ 4,623,575	$ 3,188,165
Surplus (Deficit)	$ 72,439	$ 158,438	$ (151,874)

Attachment 2

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

State of Vermont
Department of Vermont Health Access
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Waterbury, VT 05671-1010

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Questions, Complaints and Concerns Received by Health Access Member Services
April 1, 2024 – June 30, 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.

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:

- **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

Attachment 3

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
April 1, 2024 – June 30, 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 April 1, 2024, through June 30, 2024.

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

During this quarter, there were twenty-three grievances filed and eight were addressed. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of receipt of a grievance must be sent within five days; the average was three days. DMH had 83%, and DAIL had 17% of the grievances filed.

Grievances were filed for service categories case management, counseling, mental health, CRT community services, emergency and outpatient.

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 nine appeals filed. Of these nine appeals, seven were resolved (78%), and two were still pending.

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

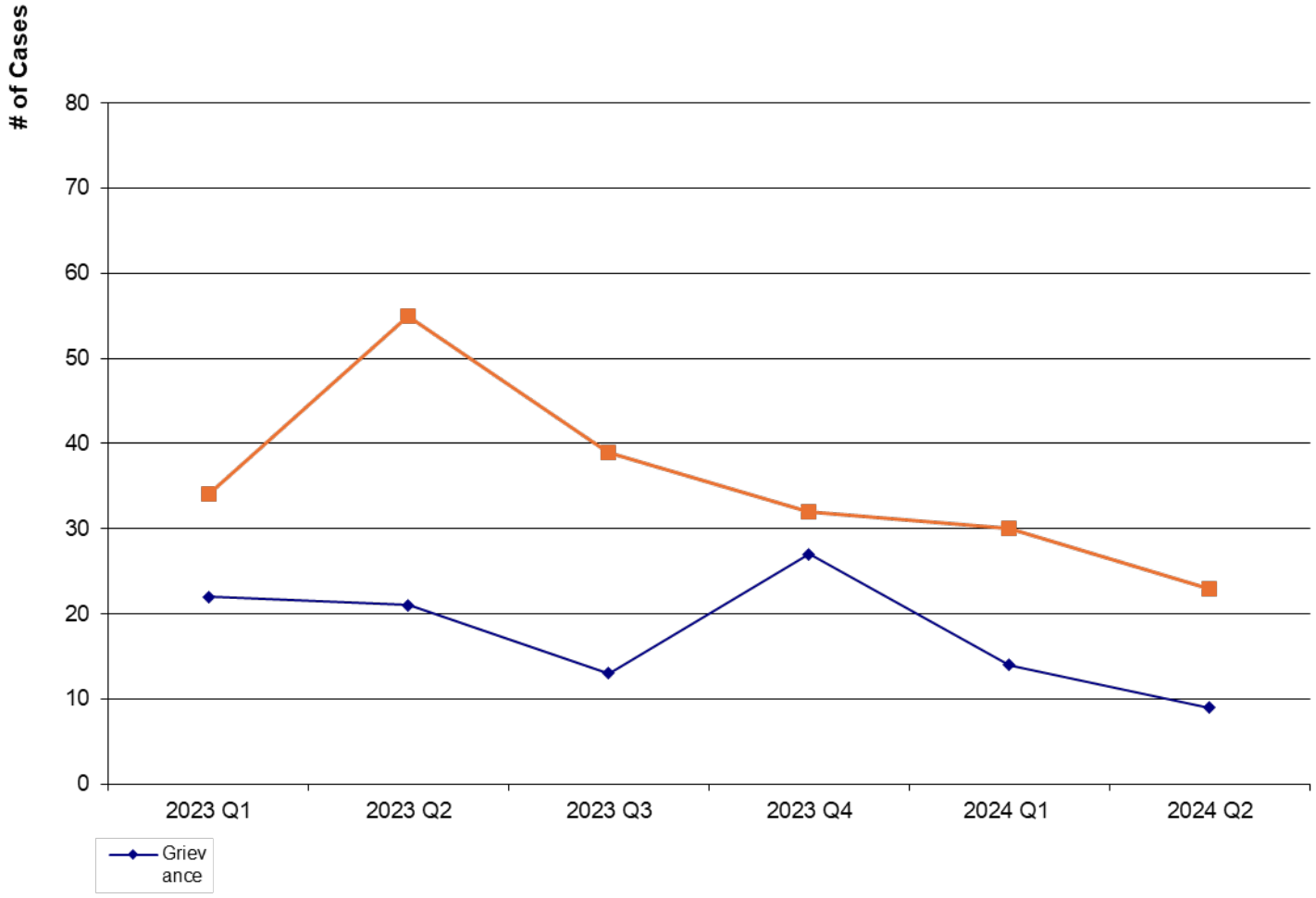
Of the nine appeals filed, DVHA had five appeals filed (56%), VDH had 3 (33%) and DAIL had one (11%).

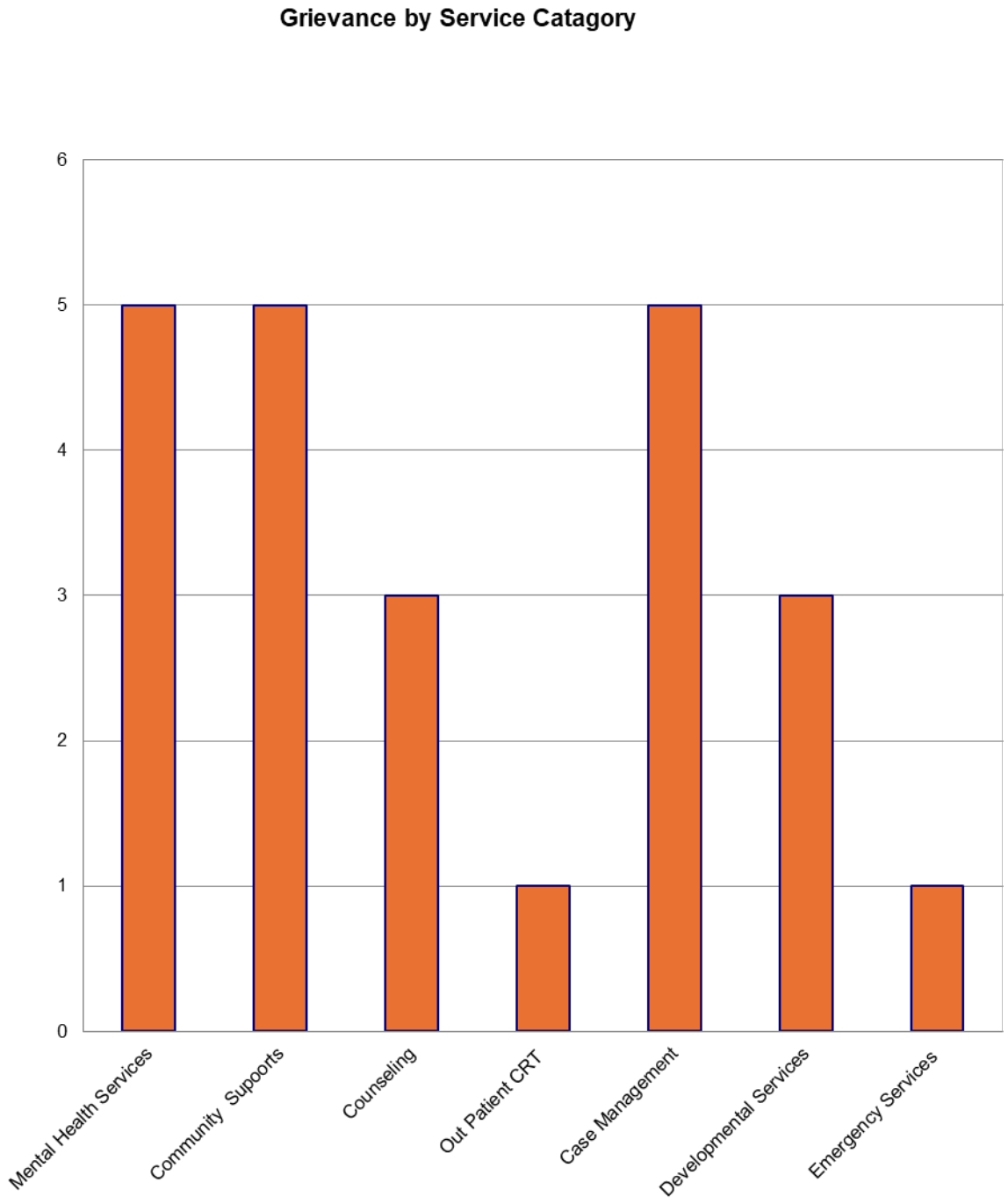
The appeals filed were for service categories outpatient hospital, prescription, personal care, long term care, and transportation.

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

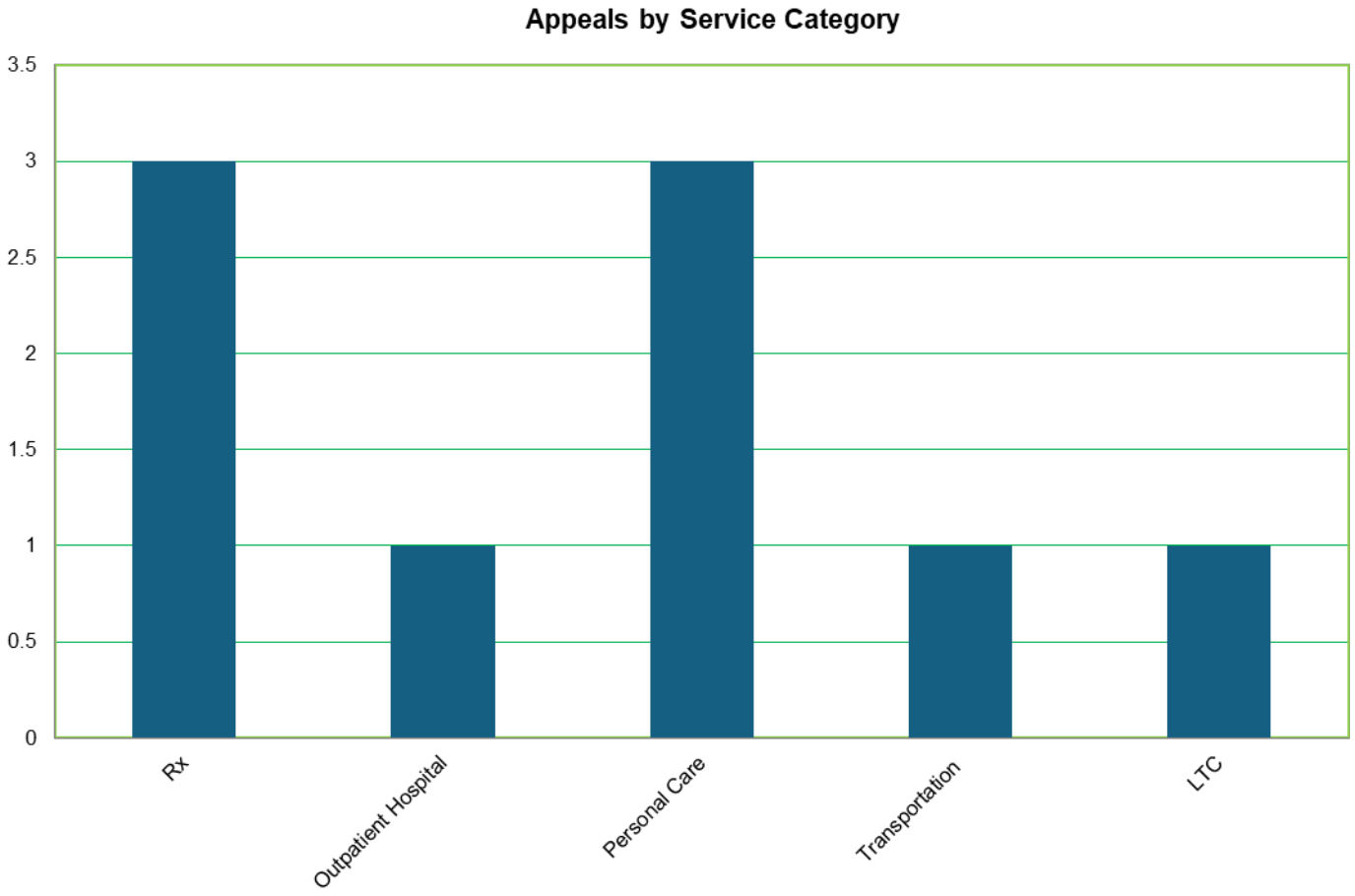
Enrollees may participate in appeals, by written testimony, telephonically, and by video or virtual communication.

Grievances and Appeals
January 1, 2023 thru June 30, 2024




Grievance by Service Catagory
6
5
4
3
2
1
0
Mental Health Services
Community Supports
Counseling
Out Patient CRT
Case Management
Developmental Services
Emergency Services

Att


Appeals by Service Category
3.5
3
2.5
2
1.5
1
0.5
0
Rx
Outpatient Hospital
Personal Care
Transportation
LTC

Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

April 1-June 30, , 2024

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

July 21, 2024

Summary and Update

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

Ruby's Story

Ruby called the HCA because she had not gotten her insurance cards in the mail. She had recently left her job where she had employer insurance and had signed up for a VHC plan. But when the HCA advocate researched the missing cards, she found that Ruby had not actually enrolled on an individual plan with VHC. She had accidently purchased a "scam" plan, which made itself look like health insurance but was not. To enroll on an individual plan in Vermont, you can enroll through VHC or through the two carriers, BC/BS or MVP. Ruby had enrolled on plan that was making itself look like an individual plan and had already paid one premium. It would not have covered Ruby's medical costs. Thankfully, this was discovered before Ruby needed medical care. The HCA advocate explained that leaving her employer insurance created a special enrollment period on VHC. The HCA advocate helped her apply on VHC. She was found eligible for subsidies to help with the premiums and was able to get on an actual individual plan. The HCA also helped Ruby report the scam insurance with hopes of protecting other Vermonters.

The HCA opened 778 cases this quarter (901, the previous quarter). During the quarter, Medicaid eligibility was again the top issue (103 calls), and our website had 1352 pagviews to our Medicaid eligibility page. We also advised 13 households on eligibility appeals regarding Medicaid and other state health care programs. In the appeal cases, the consumer's health coverage has been closed or reduced, or they have been found ineligible for a program. We give advice on the eligibility rules and the appeals process. We also received a considerable number of calls from Vermonters having issues getting prescription medication (37), and from those who had complaints about their medical providers (61). The complaints about providers covered a wide range of issues including the provider not being responsive or not adequately addressing the patient's medical issues.

This past biennium, the HCA's main legislative priority was to increase the eligibility for a Medicaid funded program that wraps around Medicare for lower income Vermonters called the Medicare Savings Program (MSP). After a year of educating legislators, a storytelling effort in the fall to amplify the voices of Vermonters and an active 2024 session, we were successful in pushing the Legislature and State Government to take an especially important step to expand the MSP. As early as January 1, 2026, Vermont will extend eligibility for its Medicare Savings Program (MSP) to an estimated additional **11,863 Vermonters at an estimated annual savings & benefits of $48.1 Million for these Vermonters.** This benefit should extend to individuals with income up to $29,367 and married couples with income up to $39,874 per year.

The MSP provides a crucial lifeline for older adults and people living with a disability, allowing them to afford health care and keep more of their hard-earned Social Security income to spend on basic needs like housing, food, and medicine. We spoke to 244 households on Medicare this quarter. We provided consumer education on enrolling on Medicare to over twenty of those household, and we advised over sixty of the households on programs that can reduce Medicare costs such Medicare Savings Programs, Medicaid for Aged, Blind and Disabled, VPharm and Low-Income Subsidy. We also had 564 pageviews of our pages on Medicare Savings Programs.

The HCA continued its work on developing educational tools for hospitals and consumers in preparation for the implementation of the new Financial Assistance Policy statute (Act 119). The changes include new definitions of residency and income. Under the law, people who have incomes under 250% of the Federal Poverty level will get a 100% discount from charges, and people with income between 250% FPL and 400% FPL will have a minimum of a 40% discount from charges. The HCA has been hard at work over the last year attempting to assist hospitals in complying with the new law. The HCA advocates completed an internal training on Act 119, so they will be prepared to help Vermonters access help under the new law. We talked to ten households about patient financial assistance and another eight about hospital billing, and our webpage on Financial Assistance had 281 views, and moved into the top twenty webpages this quarter.

This quarter HCA also continued its work on Silver alignment for Open Enrollment 2025. Silver alignment is a change to how Silver plans on VHC are valued. For APTC eligible consumers, the net result from this change will mean they will be eligible for more APTC and have increased buying power for gold and platinum plans on VHC. The gold and platinum plans have lower deductibles and cost-sharing. It is estimated that the improvement could be worth as much as **$40 million of increased subsidies and increased buying power** for Vermonters. With the increased APTC many households could even move to premium free gold plans. The HCA has started meeting with VHC and other stakeholders to develop a plan to educate consumers about the impact of these changes. During this quarter, we had meetings with DVHA and other stakeholders, to specifically develop a communication plan. The HCA also provided feedback for some consumer notices. The HCA also advocated for mapping some VHC consumers on silver plans, to higher value gold plans. Because of the change this year, the gold plans will be less expensive than the silver ones. By mapping some of the consumers, it will ensure that they can take advantage of increased APTC this year.

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Case Stories:

Taylor's Story:

Taylor called the HCA because her Social Security check was suddenly smaller. She had discovered that her Medicare Part B premium payment ($174.70) was being deducted from her check. She had been on a Medicare Savings Program that had been paying for the Part B premium every month but had no idea why the program had ended. Medicare Savings Programs help with Medicare costs by paying for premiums and in some cases, cost-sharing. The HCA advocate started to investigate why Taylor's MSP had been closed. Taylor had been on the MSP that paid for both the Medicare Part B premium and cost-sharing, and her income had not changed. After doing some research, she found that Taylor's MSP had been closed in error. Taylor had completed an eligibility review earlier in the year, but the review paperwork had arrived slightly after the deadline. This meant that her coverage had closed, but VHC had attempted to reinstate the MSP a couple days later when it received the review paperwork. However, Taylor's MSP had not been fully reinstated because of a glitch in the system. The HCA advocate was able to get the MSP reinstated. She also explained to Taylor that she would be refunded the Part B premiums that were taken out of her Social Security when she should have been on the MSP.

Lorenzo's Story:

Lorenzo called the HCA because his Medicaid had closed, and he was not sure what to do next. The HCA advocate discovered that Lorenzo was slightly above the Medicaid limit. He also had an offer of employer sponsored insurance. But Lorenzo could not afford to pay the insurance premiums and afford to pay his rent and other bills. Because he had an affordable offer of employer insurance, he was not eligible to get a VHC plan with subsidies. If you have an offer of affordable health insurance, you are ineligible to get subsidies. Whether a plan is considered affordable or not depends on the costs of the premiums and your household income. Even though the plan was "affordable" under the law, Lorenzo could not afford it. Lorenzo was considering going without insurance coverage. But the HCA advocate looked at his income again. She found that he could lower his countable income for Medicaid by making a small monthly contribution to his (401) (K) plan at work. The contribution was less than the monthly premium for his employer insurance. Medicaid eligibility is based on your taxable income, and Lorenzo could reduce the income that Medicaid counted each month, and also, he increased his retirement savings. By making these contributions, Lorenzo was able to apply to Medicaid and was found eligible again.

Novak's Story:

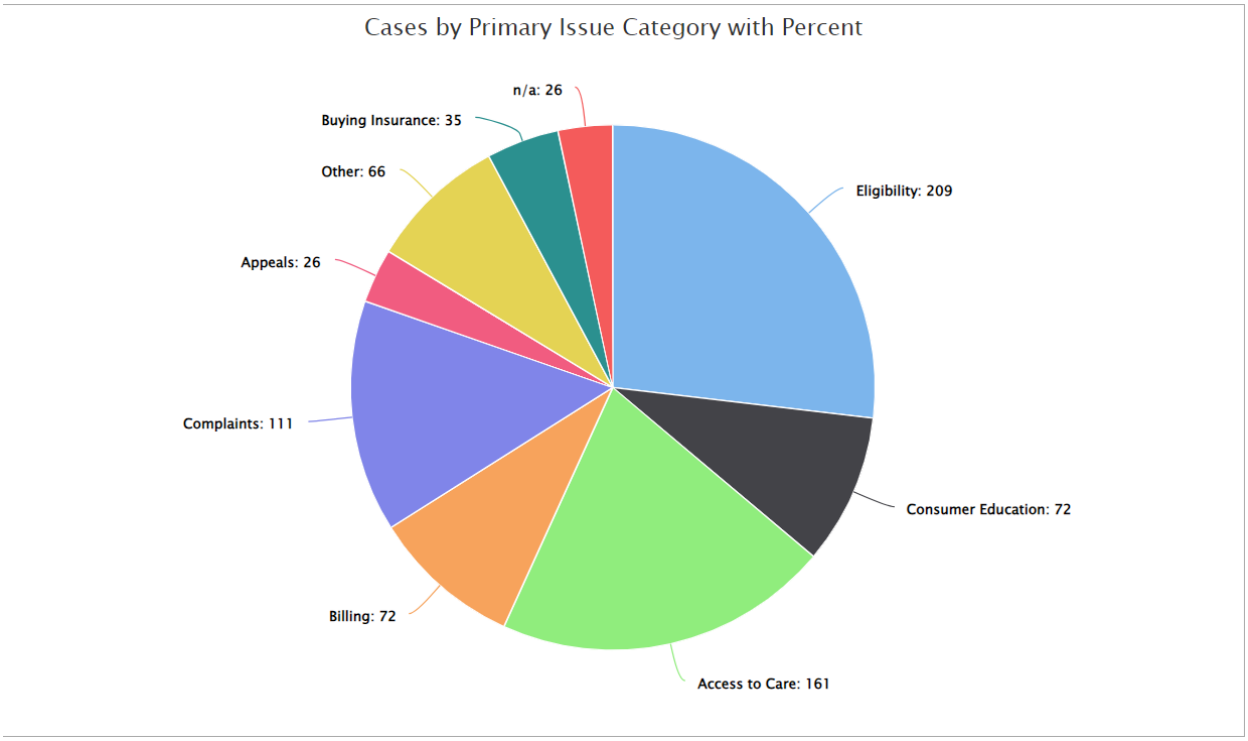
Novak called because he wanted to reduce his hours at work, but he was worried about the impact on his insurance coverage. Novak was working full-time and on employer sponsored insurance (ESI), but he was hoping to reduce his hours to three days a week. This reduction would mean he no longer qualified for his employer coverage. The HCA advocate explained that when Novak's employer coverage ended, he would have a special enrollment period to get on a VHC plan. He would have 60 days to enroll, and he would be able enroll so he would not have a gap in coverage between his ESI and VHC plans. She then reviewed Novak's eligibility for subsidies based on his reduced income. Novak was eligible for substantial APTC and planned to use the APTC to enroll on a gold VHC plan. VHC plans have metal levels from bronze to platinum. The gold and platinum plans have lower cost-sharing costs. After learning of his eligibility for a special enrollment plan and APTC, Novak felt confident in going forward with his plan to reduce his work hours.

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 778 calls this quarter. We assign cases a primary issue, depending on the nature of the legal issue. Normally, we have more Eligibility and Access to Care cases than the other issues, and that was true this quarter, with those two areas making up nearly half of all HCA calls. 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 the cases. (444 of 788 cases).

Number of Cases by Insurance: April 1 to June 30, 2024.

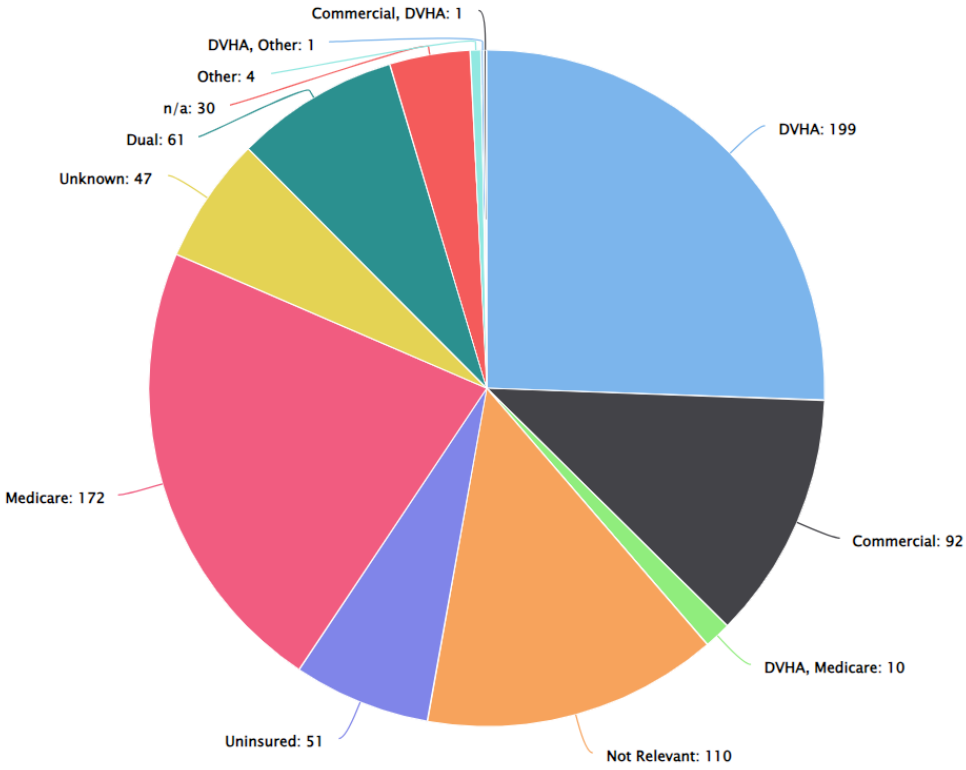


Table: Top Ten Primary Issues: April 1 to June 30, 2024

All Cases: 778

All Cases: Top Ten Primary Issues

1. **Eligibility for MAGI Medicaid 68**
2. **Provider Complaints 61**
3. **Access to Care Prescription Drugs 37**
4. **Eligibility for non-MAGI Medicaid 35**
5. **Hospital Complaints-30**
6. **Access to Dental Care-30**
7. **Buying Insurance 22**
8. **Consumer Education Medicare 19**
9. **Consumer Education Applying for DVHA programs 17**
10. **Appeals Fair Hearings Covered Services 13**

DVHA Cases: total of 211 of 788 total cases

Top Five Primary Issues

1. **Eligibility for MAGI Medicaid 41**
2. **Provider Complaints 16**
3. **Access to Prescription Drugs 11**
4. **Access to Dental 11**
5. **Complaints Hospital 9**

Uninsured Cases: total 51 out of 788 cases

1. **To Eligibility for MAGI 15**
2. **Buying Insurance 11**
3. **Eligibility for Special Enrollment Period 3**

Commercial Cases: total of 93 out of 788 cases

Top Three Primary Issues

4. **Eligibility Premium Tax Credit 7**
5. **Buying Insurance 6**
6. **Eligibility for MAGI Medicaid 5**

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 April1 to June 30, 2024

Brief Analysis and or Advice	391
Direct Intervention	58
Complex Intervention	55
Brief Analysis and or Referral	212
Inquiry Answered During Initial Call	1
Duplicate Case	13
Other	7
Client Withdrew	0

Highlights of HCA

During this quarter, we provided 544 households with consumer education. We helped 39 households estimate their eligibility for insurance or get onto coverage. We assisted 12 households with their health care applications. We helped with 9 applications for the Immigration Health Insurance Plan. We saved consumers $161,168 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 on two premium price change requests during the quarter from April 1, 2024, through June 30, 2024. Six premium price change requests were pending at the close of the quarter.

On May 9, 2024, the Board issued a Decision and Order related to the 2024 Blue Cross and Blue Shield of Vermont (BCBSVT) Large Group Filing. BCBSVT requested a price increase of 8.4% for this block of business, which the Board approved without modification. On May 29, 2024, the Board issued a Decision and Order related to the 2024 CIGNA Health and Life Insurance Company Large Group filing. CIGNA requested a 9.6% premium price increase for this book of business. The Board approved a 5.3% increase. The HCA appeared on behalf of Vermonters in these matters and took all appropriate actions to represent the best interests of Vermonters.

There were six premium price change requests pending at the close of this quarter. Four of these pending filings are the 2025 Vermont Health Connect (VHC) filings: the 2025 BCBSVT Small Group VHC filing (BCBSVT Small Group); the 2025 BCBSVT Individual Group VHC filing (BCBSVT Individual); the 2025 MVP Small Group VHC filing (MVP Small Group); and the 2025 MVP Individual Group VHC filing (MVP Individual). The BCBSVT Small Group filing impacts roughly 22,018 Vermonters and BCBSVT is requesting an average premium price increase of 22.2% for this book of business. The BCBSVT Individual filing impacts roughly 23,164 Vermonters and BCBSVT is requesting an average premium increase of 19.3% for this book of business. The MVP Small Group filing impacts roughly 15,027 Vermonters and MVP is requesting an average premium increase of 11.2% for this book of business. The MVP Individual filing affects roughly 10,616 Vermonters and MVP is requesting an average premium price increase of 12.6% for this book of business. The HCA has appeared on behalf of Vermonters in all four of these matters and will file all appropriate memoranda and other documents. In addition, the HCA will appear at the hearings on these matters to question the carriers' witnesses and provide affirmative testimony in its role representing the interests of Vermonters in proceedings before the Board.

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

Hospital Budgets

The HCA is preparing to review hospital budget submissions for the FY25 year once they are submitted on July 8th. The HCA is also participating in state-wide discussions focused on hospital sustainability and transformation as a part of Act 167.

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 submitted a written public comment in support of UVM Medical Center's Outpatient Surgery Center (MCB-004-23con) pursuant to conditions focused on ensuring affordability and access The HCA also submitted questions as a interested party in the CON application for Southwestern Vermont Medical Center, Development of Adolescent Inpatient Medical Health Unit (GMCB-014-23con). We continue to actively monitor certificate of need applications as they are submitted and assert party status when the interests of Vermonters are clearly impacted.

Oversight of Accountable Care Organizations

The HCA is currently reviewing, preparing questions and feedback for the GMCB as we begin reviewing the FU25 budgets for Medicare-only ACOs operating in Vermont or that plan to operate in Vermont in the upcoming fiscal year.

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.

Global Budget Technical Advisory Group

The HCA is a member of the Global Budget Technical Advisory Group convened by the GMCB and the Agency of Human Services. This group met three times this quarter exploring the technical aspects of global budgets and numerous decisions that Vermont must make if it is to pursue this option with CMS. We learned officially this quarter that CMS is particularly interested in building on Vermont's existing payment reform model.

The Medicaid and Exchange Advisory Committee

The Advisory Committee met three times this quarter. The content of this quarter's meetings included an ongoing focus on the Medicaid redetermination process, presentations and discussions on the Global Commitment Waiver, weight loss drug coverage, Advisory Committee Budget recommendations, the Health Benefit Eligibility and Enrollment rules revisions and Silver Boosting.

Legislative Advocacy

Medicare Savings Program (MSP)

This past biennium, the HCA's main legislative priority was to increase the eligibility for a Medicaid funded program that wraps around Medicare for lower income Vermonters called the Medicare Savings Program (MSP). After a year of educating legislators, a storytelling effort in the fall to amplify the voices of Vermonters and an active 2024 session, we were successful in pushing the Legislature and State Government to take a very important step to expand the MSP. As early as January 1, 2026, Vermont will extend eligibility for its Medicare Savings Program (MSP) to an estimated additional **11,863 Vermonters at an estimated annual savings & benefits of $48.1 Million for these Vermonters.** This benefit should extend to individuals with income up to $29,367 and married couples with income up to $39,874 per year.

The MSP provides a crucial lifeline for older adults and people living with a disability, allowing them to afford health care and keep more of their hard-earned Social Security income to spend on basic needs like housing, food, and medicine.

This is a phenomenal victory for Vermonters who are enrolled in Medicare who have long been subject to the lowest level of financial support of any population when accessing health care. The estimated savings to Vermonters are significant!

11,863 Vermonters will get to keep $2,096 in their pockets each year.
Annual savings for Vermonters: $24.9 Million

Eligible Vermonters will have larger Social Security checks because the MSP will pay the Part B premium ($174.70/month) This is an **economic stimulus** for older adults and people with disabilities – it will increase household income by $2,096 if single or $4,192 if married and both spouses have Medicare.

9,419 Vermonters will pay $0 at the doctor and hospital.
Annual savings to Vermont hospitals and patients: $3.2 Million

The best MSP level covers deductibles and cost-sharing for Medicare Part A (hospital) and Part B (medical) services. It ensures that these Vermonters can get the health care they need, when they need it, and that providers are compensated for this care.

3,769 Vermonters will receive financial help with prescriptions for the 1st time.
Annual Value of new Rx benefit for Vermonters: $20 Million

Being enrolled in an MSP qualifies you for the free and 100% federally funded Low Income Subsidy (LIS). The LIS program will pay eligible Vermonters' Medicare Part D (prescription drug) premiums & deductibles, and significantly lower their co-pays.

Pharmacy Benefit Manager (PBM) Regulation and Copay Accumulator Protection

Act 127 (H.233) - An act relating to licensure and regulation of pharmacy benefit managers. The HCA worked on this bill with the bill sponsor and a small group of stakeholders from its inception through the entire legislative process. This is an important bill that tasks the Department of Financial Regulation with regulating the conduct of Pharmacy Benefit Managers (PBMs) with respect to health plan sponsors, pharmacists, and Vermont consumers. The bill adds greater transparency to drug pricing by banning spread pricing, where PBMs charge consumers and plan sponsors more for drugs than they reimburse pharmacies. This bill will also directly help Vermonters struggling with high drug prices by requiring pharmacy benefit managers to count drug manufacturer copay assistance toward a covered person's deductibles and out-of-pocket maximums. Vermont is the 21st state to pass this protection.

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.

<u>Popular Web Pages</u>

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

1. *Health* - section home page – 1,810 pageviews
2. *Dental Services* – 1,678
3. *Income Limits - Medicaid* – 1,352

4. *Medicare Savings Programs* – 564
5. *Buying Prescription Drugs* – 499
6. *Long-Term Care* – 450
7. *HCA Help Request Form* – 372 pageviews and 117 online help requests
8. *Resource Limits - Medicaid* – 364
9. *Medicaid, Dr. Dynasaur & Vermont Health Connect* – 360
10. *Medical Decisions: Advance Directives* – 326
11. *Medicaid* – 323
12. *Vision* – 303 *
13. *Choices for Care Giving Away Property or Resources* – 293
14. *Patient Financial Assist. & Affordable Medical Care* – 281 *
15. *Choices for Care Income Limits* – 270
16. *Choice for Care Resource Limits* – 251
17. *Medical debt* – 234 *
18. *Dr. Dynasaur* – 232
19. *Prescription Assistance State Programs* – 230
20. *Advance Directive forms* – 208

This quarter we had these additional news items:

- *Some Problems with Medicaid Prescriptions* – 58 pageviews
- *Medicaid Renewal Starts Again* – 26
- *People Impacted by Flood Can Sign Up for Health Coverage. Those Who Lost Medicaid Can, Too* – 20

* 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 this quarter to raise awareness about our offices' services and provide accessible information about health insurance options in Vermont. Our messaging prioritized providing accurate and accessible information on the health insurance access for non-citizens, Vermont Health Connect Special Enrollment Periods (SEP), and Medicare Savings Programs. We hosted three legal clinics, facilitated seven trainings, and rolled out two social media campaigns to connect Vermonters with our services and proactively provide consumer education on health insurance and health law topics.

We strive to break down the barriers that Vermonters face in understanding and utilizing insurance. This goal is especially important now as many members of our community are evaluating their health insurance options as Vermonters lose Medicaid coverage due to the unwind and others transition to Medicare. We use a hybrid outreach model to advance this goal. We feel that both in-person and virtual resources make our services more accessible to those who face challenges utilizing our telephonic and online intake systems. We strive to meet the needs of seniors, people with disabilities, and those with language needs by hosting in-person clinics in community spaces virtual trainings in partnership with local non-profits and community centers.

We partnered with 17 organizations and participated in seven outreach presentations this quarter. Some of our partnerships included work with the Family Room, the Community Asylum Seekers Project, the Vermont Asylum Assistance Project, the IRS Taxpayer Advocate, Transitions II, and the Vermont Association of Area Agencies on Aging. We lead training on eligibility for health insurance for non-citizens at the Welcoming New Americans Symposium at Vermont Law School in June. This symposium was attended by over 300 virtual and in-person attendees.

The HCA utilized Facebook, Instagram, YouTube, and Reddit to connect with community members, legislators, and partner organizations. We used these platforms to share important updates pertaining to the new under 200 % FPL and loss of Medicaid Vermont Health Connect Special Enrollment Periods and health insurance options for older and disabled Vermonters. We circulated virtual advertisements through social media on the benefits of and eligibility for Medicare Savings Programs and Medicaid for the Working Disabled.

The HCA also continued our legal help partnership with Vermont Legal Aid and the Old North End Community Center. The HCA organized three clinics where community members connected with legal advocates to get free and confidential advice. In April we collaborated on a new clinic model in partnership with the Family Room and UVM Medical school in which participants would have access to health care services and other community resources on a walk-in basis. Childcare and in-person interpretation were available to support people seeking our assistance. These clinics are primarily designed to connect seniors and those with language needs with legal support.

Office of the Health Care Advocate

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

https://vtlawhelp.org/health

Attachment 5

DY20 Investment Expenditures

Department	Final Receiver	Investment Description	QE 0324	QE 0624	QE 0924	QE 1224	DY20 Total
AHSCO	9090	Designated Agency Underinsured Services	1,821,625	1,821,623	-	-	**3,643,248**
AHSCO	9093	Health Care Reform	-	1,460,558	-	-	**1,460,558**
AHSCO	9421	HCBS Investment - Workforce Recruitment & Retention Program	-	-	-	-	**-**
AHSCO	9421	HCBS Investment - Innovative Solutions to Enhance and Strengthen HCBS	288,126	1,068,556	-	-	**1,356,682**
AOE	n/a	Non-state plan Related Education Fund Investments	474,166	-	-	-	**474,166**
DCF	9400	Investments - Balance and Restorative Justice	606,298	557,153	-	-	**1,163,451**
DCF	9402	Medical Services	45,716	18,050	-	-	**63,766**
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	-	-	**2,105,493**
DCF	9406	Aid to the Aged, Blind and Disabled Res Care Level III	13,740	26,438	-	-	**40,178**
DCF	9407	Aid to the Aged, Blind and Disabled Res Care Level IV	29,478	58,158	-	-	**87,636**
DCF	9408	Essential Person Program	215,927	225,551	-	-	**441,478**
DCF	9409	GA Medical Expenses	46,231	36,203	-	-	**82,434**
DCF	9411	Therapeutic Child Care	453,327	496,554	-	-	**949,881**
DCF	9412	Lund Home	-	-	-	-	**-**
DCF	9413	Prevent Child Abuse Vermont: Shaken Baby	-	-	-	-	**-**
DCF	9414	Prevent Child Abuse Vermont: Nurturing Parent	38,535	36,790	-	-	**75,325**
DCF	9415	Challenges for Change: DCF	54,609	40,997	-	-	**95,606**
DCF	9416	Strengthening Families	172,705	241,232	-	-	**413,937**
DCF	9417	Lamoille Valley Community Justice Project	-	-	-	-	**-**
DCF	9418	Building Bright Futures	122,813	126,981	-	-	**249,794**
DCF	9419	United Ways 2-1-1	-	396,221	-	-	**396,221**
DCF	9421	Lund Substance Abuse Screening & Referral	-	-	-	-	**-**
DCF	9425	Lund Substance Abuse Screening & Referral	170,498	340,997	-	-	**511,495**
DAIL	9421	HCBS Investment - Independent Direct Support Providers	699,646	111,728	-	-	**811,374**
DAIL	9421	HCBS Investment - Independent Direct Support Providers	-	-	-	-	**-**
DAIL	9602	Mobility Training/Other Svcs.-Elderly Visually Impaired	94,970	124,761	-	-	**219,731**
DAIL	9603	DS Special Payments for Medical Services	518,557	1,192,395	-	-	**1,710,952**
DAIL	9604	Flexible Family/Respite Funding	304,933	305,066	-	-	**609,999**
DAIL	9605	Quality Review of Home Health Agencies	-	-	-	-	**-**
DAIL	9606	Support and Services at Home (SASH)	245,205	245,271	-	-	**490,476**
DAIL	9607	HomeSharing	36,251	118,855	-	-	**155,106**
DAIL	9608	Self-Neglect Initiative	126,009	-	-	-	**126,009**
DMH	9421	HCBS Investment	-	-	-	-	**-**
DMH	9501	Special Payments for Treatment Plan Services	7,047	33,543	-	-	**40,590**
DMH	9502	Mental Health Outpatient Services for Adults	447,321	256,908	-	-	**704,229**
DMH	9504	Mental Health Consumer Support Programs	108,677	97,949	-	-	**206,626**
DMH	9505	Mental Health CRT Community Support Services	-	-	-	-	**-**
DMH	9506	Mental Health Children's Community Services	434,058	591,808	-	-	**1,025,866**
DMH	9507	Emergency Mental Health for Children and Adults	510,054	582,177	-	-	**1,092,231**
DMH	9508	Respite Services for Youth with SED and their Families	317,509	305,963	-	-	**623,472**
DMH	9510	Emergency Support Fund	-	-	-	-	**-**
DMH	9511	Institution for Mental Disease Services: DMH - VPCH	5,067,670	5,694,070	-	-	**10,761,740**
DMH	9512	Institution for Mental Disease Services: DMH - BR	-	-	-	-	**-**
DMH	9514	Seriously Functionally Impaired: DMH	-	-	-	-	**-**
DMH	9515	Mobile Crisis Uninsured/Underinsured	-	-	-	-	**-**
DMH	9516	Acute Psychiatric Inpatient Services	(536,563)	446,987	-	-	**(89,576)**
DMH	9521	Suicide Prevention	270,368	363,761	-	-	**634,129**
DMH	9522	Alternatives to Emergency Room MH Crisis Care	-	71,295	-	-	**71,295**
DMH	9523	MH Peer and Consumer Supports	-	893,278	-	-	**893,278**
DMH	9914	CRT Global Commitment	-	-	-	-	**-**
DMH	9421	HCBS Investment - Lund Substance Abuse Screening & Referral	108,035	1,271,410	-	-	**1,379,445**
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	-	-	-	**17,597**
DOC	n/a	Northern Lights	-	-	-	-	**-**
DOC	n/a	Pathways to Housing - Transitional Housing	326,055	-	-	-	**326,055**
DOC	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges	38,836	-	-	-	**38,836**
DOC	n/a	Northeast Kingdom Community Action	32,815	(630)	-	-	**32,185**
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	-	-	**920,616**
DOC	n/a	Intensive Sexual Abuse Program	-	-	-	-	**-**
DOC	n/a	Vermont Achievment Center	-	-	-	-	**-**
DVHA	9421	HCBS Investment	41,642	-	-	-	**41,642**
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	-	-	**1,938,962**
DVHA	9103	Buy-In	(8,025)	1,398	-	-	**(6,627)**
DVHA	9104	HIV Drug Coverage	-	-	-	-	**-**
DVHA	9106	Patient Safety Net Services	174,037	154,390	-	-	**328,427**
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	-	-	**2,130,012**
DVHA	9209	Family Planning	55,866	105,810	-	-	**161,676**
VDH	9201	Emergency Medical Services	177,558	205,085	-	-	**382,643**
VDH	9203	TB Medical Services	6,040	-	-	-	**6,040**
VDH	9204	Epidemiology	343,844	68,580	-	-	**412,424**
VDH	9205	Health Research and Statistics	318,545	422,660	-	-	**741,205**
VDH	9206	Health Laboratory	805,457	1,004,911	-	-	**1,810,368**
VDH	9207	Tobacco Cessation: Community Coalitions	316,372	467,308	-	-	**783,680**
VDH	9209	Family Planning	150,438	75,219	-	-	**225,657**
VDH	9210	Physician/Dentist Loan Repayment Program	264,171	(2,640)	-	-	**261,531**
VDH	9211	Renal Disease	-	-	-	-	**-**
VDH	9213	WIC Coverage	1,215,588	2,175,282	-	-	**3,390,870**
VDH	9214	Area Health Education Centers (AHEC)	167,011	(31,000)	-	-	**136,011**
VDH	9217	Patient Safety - Adverse Events	19,147	11,529	-	-	**30,676**
VDH	9219	Substance Use Disorder Treatment	1,337,456	1,249,158	-	-	**2,586,614**
VDH	9220	Recovery Centers	894,619	1,790,421	-	-	**2,685,040**
VDH	9221	Enhanced Immunization	69,844	141,624	-	-	**211,468**
VDH	9222	Poison Control	-	102,607	-	-	**102,607**
VDH	9223	Public Inebriate Services, C for C	225,478	635,305	-	-	**860,783**
VDH	9224	Fluoride Treatment	30,628	27,570	-	-	**58,198**
VDH	9226	Healthy Homes and Lead Poisoning Prevention Program	59,141	69,429	-	-	**128,570**
VDH	9228	VT Blueprint for Health	461,965	530,028	-	-	**991,993**
VDH	9421	HCBS Investment - Pediatric Pallative Care Program Supply Carts	-	-	-	-	**-**
VDH	9421	HCBS Investment - Expand VTHelplink	222,906	308,706	-	-	**531,612**
VSC	n/a	Health Professional Training	-	-	-	-	**-**
VVH	n/a	Vermont Veterans Home	-	-	-	-	**-**
			-	-	-	-	**-**

P Transitional Housing Services

GCI

What We Do

Transitional housing programs often play an integral role in the reintegration of formerly incarcerated individuals. The goal of these programs is for participants who have been recently released from incarceration to progress into permanent living situations within 1-2 years. As part of their transitional housing programs, participants engage in clinical reentry and recovery services that support their physical and behavioral health, and promote long-term stability. In this way, the supportive services delivered through transitional housing programs diminish reliance on carceral systems of care.

Who We Serve

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

How We Impact

Our program activities are designed to facilitate our targeted outcomes:
- Participants will have priority access to supportive clinical services
- Participants will have access to transitional housing
- Reincarceration will be reduced
- Personal and family relationships will improve
- Employment opportunities will be explored
- Quality of life for participants will improve

Measures

Measures	Most Recent Period	Current Actual Value	Current Target Value	True	Current Trend	Baseline % Change
PM GCI Number of Individuals Served	Q4 2024	108	126	–	↘ 4	-23% ↘
	Q3 2024	110	126		↘ 3	-22% ↘
	Q2 2024	112	126		↘ 2	-21% ↘

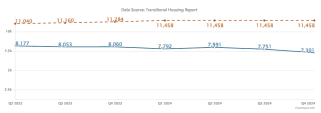
Q1 2024	113	126		↘ 1	-20% ↘
Q4 2023	116	122		↗ 2	-18% ↘
Q3 2023	114	122		↗ 1	-19% ↘
Q2 2023	108	122		↘ 1	-23% ↘
Q1 2023	114	122		↗ 5	-19% ↘
Q4 2022	98	120		↗ 4	-30% ↘

Story Behind the Curve

The number of individuals served can fluctuate over time depending on the circumstance of people in the program and the circumstance of people scheduled for release. The quarterly target (FY24) for number of people served was 126 for each quarter. The actual number of people served in FY24 averaged 88% of the target.

FY24 saw both new and recurring challenges impacting program participant counts. The unprecedented flooding the State experienced resulted in multiple apartments being damaged to the extent that they were uninhabitable. Consistent with previous years, lack of affordable housing remained a barrier. Additionally, in FY24, DOC decreased the number of funded beds in the community.

PM HW Bed Days Utilized



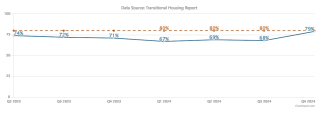
Q4 2024	7,301	11,458	–	↘ 2	304% ↗
Q3 2024	7,751	11,458		↘ 1	328% ↗
Q2 2024	7,991	11,458		↗ 1	342% ↗
Q1 2024	7,792	11,458		↘ 1	331% ↗
Q4 2023	8,060	11,284		↗ 1	346% ↗
Q3 2023	8,053	11,160		↘ 1	345% ↗
Q2 2023	8,177	11,040		↗ 6	352% ↗
Q1 2023	7,660	11,040		↗ 5	323% ↗
Q4 2022	6,938	10,620		↗ 4	284% ↗

Story Behind the Curve

Bed utilization fluctuates each quarter because of the variability in individuals' circumstances. The bed days utilized for FY24 totaled 30,835 out of an annual target of 45,833. We were below our original target of 80% annual utilization, with 67% of our bed days utilized.

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

PM HW Percent of Beds Utilized



Q4 2024	79%	80%	–	↗ 1	16% ↗
Q3 2024	68%	80%		↘ 1	0% →
Q2 2024	69%	80%		↗ 1	1% ↗
Q1 2024	67%	80%		↘ 3	-1% ↘
Q4 2023	71%	80%		↘ 2	4% ↗
Q3 2023	72%	80%		↘ 1	6% ↗
Q2 2023	74%	80%		↗ 2	9% ↗

Q1 2023	69%	80%		↗ 1	1% ↗
Q4 2022	64%	80%		→ 1	-6% ↘

Story Behind the Curve

Overall utilization for FY24 was 71%, which was a 1% decrease from FY23. The target for FY24 was 80%; thus, we were below the target percent of beds utilized by an average of only 9% for FY24.

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

PM HW Percent of Referrals Accepted

Q4 2024	75%	80%	–	↗ 2	-16% ↘
Q3 2024	71%	80%		↗ 1	-20% ↘
Q2 2024	49%	80%		↘ 2	-45% ↘
Q1 2024	58%	80%		↘ 1	-35% ↘
Q4 2023	91%	80%		↗ 1	2% ↗
Q3 2023	83%	80%		↘ 1	-7% ↘
Q2 2023	98%	80%		↗ 2	10% ↗
Q1 2023	86%	80%		↗ 1	-3% ↘
Q4 2022	72%	80%		↘ 2	-19% ↘

Story Behind the Curve

In FY24, 63% of statewide referrals to Transitional Housing programs were accepted, whereas the target acceptance rate was 80%. Those applying/reapplying to transitional housing programs have increasingly presented with higher levels of need than can be met by these programs, leading to application denials. For applicants who are applying after having been in the program previously, denials can result due to past actions that presented a threat to the staff or the program as a whole. Since programs often master lease, rather than own the transitional housing stock, landlords also deny certain applicants, which, in turn, forces programs to not accept individuals.

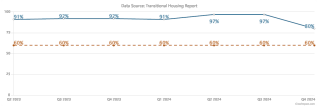
PM BO Percent of Participants Employed/Enrolled in an Educational/Training Program or Receiving Benefits at Exit

Q4 2024	68%	80%	–	↘ 1	-23% ↘
Q3 2024	88%	80%		↗ 4	0% →
Q2 2024	85%	80%		↗ 3	-3% ↘
Q1 2024	83%	80%		↗ 2	-6% ↘
Q4 2023	81%	80%		↗ 1	-8% ↘
Q3 2023	68%	80%		↘ 1	-23% ↘
Q2 2023	88%	80%		↗ 2	0% →
Q1 2023	75%	80%		↗ 1	-15% ↘
Q4 2022	63%	80%		↘ 1	-28% ↘

Story Behind the Curve

Overall, the percent of participants employed, enrolled in an educational/training program, or receiving benefits at exit for FY24 was 79%, which is only 1% below our annual target of 80%. The continuously higher percentage demonstrated in FY22-23-24 compared to FY21 is because employers are more willing to hire people with criminal records due to a workforce shortage. This measure only captures a participants' status upon exit from the program which may be artificially low since it does not include benefits or employment that may have happened over the course of the program.

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

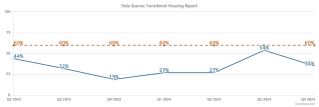


Q4 2024	80%	60%	–	↘ 1	-17% ↘
Q3 2024	97%	60%	→ 1	1% ↗	
Q2 2024	97%	60%	↗ 1	1% ↗	
Q1 2024	91%	60%	↘ 1	-5% ↘	
Q4 2023	92%	60%	→ 1	-4% ↘	
Q3 2023	92%	60%	↗ 1	-4% ↘	
Q2 2023	91%	60%	→ 1	-5% ↘	
Q1 2023	91%	60%	↗ 1	-5% ↘	
Q4 2022	84%	60%	↘ 2	-13% ↘	

Story Behind the Curve

Remaining crime free is significantly associated with successful reentry. In FY24, an average of 91% of program participants remained crime free while in the program (well above our 60% annual target). We have been consistently above our FY24 quarterly target (60%), with a high of 97% of program participants remaining crime free while in the program.

PM BO Percent of Participants Exiting to Permanent Housing



Q4 2024	35%	60%	–	↘ 1	17% ↗
Q3 2024	54%	60%	↗ 1	80% ↗	
Q2 2024	27%	60%	→ 1	-10% ↘	
Q1 2024	27%	60%	↗ 1	-10% ↘	
Q4 2023	19%	60%	↘ 2	-37% ↘	
Q3 2023	32%	60%	↘ 1	7% ↗	
Q2 2023	44%	60%	↗ 2	47% ↗	
Q1 2023	21%	60%	↗ 1	-30% ↘	
Q4 2022	5%	60%	↘ 1	-83% ↘	

Story Behind the Curve

The percentage of people who exit transitional housing to permanent housing varies across time due to the high variable nature of individuals' circumstances. In FY24, and a total of 35% of program participants exited the program to permanent housing, which is 25% below our 60% annual target.

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

Strengthening Families Child Care

What We Do

The Strengthening Families grant program provides support to community childcare programs across Vermont to ensure affordable access to high quality comprehensive early care and education services for children and families challenged by economic instability and other environmental risk factors with the overall purpose to support children's school readiness and assist families in providing stable and supported households for their child(ren).

Who We Serve

These grants serve:

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

How We Impact

The following impact is intended by these grants:

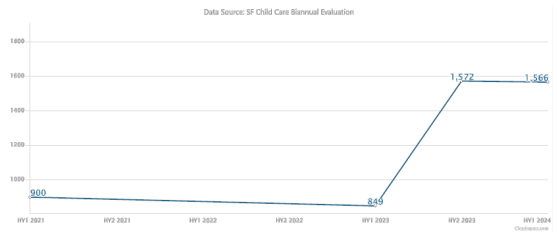
- Documented use of the Center for Social Policy Strengthening Families Program Assessment tool through submission of outcomes and related program plan.
- Continuity of care improves as measured by attendance records and compared to participants in CCFAP including specialized care in other non-Strengthening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

Budget Information

Strengthening Families Child Care	SFY23 Actual	SFY24 Actual	SFY25 Actual
Program Budget	$978,676	$1,100,000	$1,110,000

Measures

CDD # of children enrolled



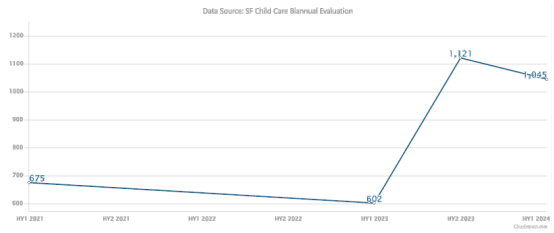
Time Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
HY1 2024	1,566	–	↘ 1	-9% ↘
HY2 2023	1,572	–	↗ 1	-8% ↘
HY1 2023	849	–	↘ 1	-50% ↘
HY1 2021	900	–	↗ 1	-48% ↘
HY2 2020	854	–	↘ 4	-50% ↘
HY1 2020	1,031	–	↘ 3	-40% ↘
HY2 2019	1,096	–	↘ 2	-36% ↘
HY1 2019	1,202	–	↘ 1	-30% ↘

HY2 2018	1,618	–	→ 1	-6% ↘

Story Behind the Curve

CDD has supported the implementation of the Center for Social Policy's Strengthening Families Approach in community childcare programs across Vermont through a competitive grant process since 2010. In June 2023, a new cohort of Strengthening Families grantees was awarded funding expanding the number of grantees to 27 programs, some of which had received funding previously, and others, this was a new funding award. Since a larger number of grantees were awarded support than in previous years, more children are being served. Continued funding for the current cohort of grantees is being supported through Fall 2025.

CDD # of CCFAP participants enrolled



HY1 2024	1,045	–	↘ 1	-5% ↘
HY2 2023	1,121	–	↗ 1	2% ↗
HY1 2023	602	–	↘ 1	-45% ↘
HY1 2021	675	–	↗ 1	-39% ↘
HY2 2020	664	–	↘ 2	-40% ↘
HY1 2020	689	–	↘ 1	-37% ↘
HY2 2019	776	–	↗ 1	-29% ↘
HY1 2019	744	–	↘ 1	-32% ↘
HY2 2018	1,129	–	→ 1	3% ↗

Story Behind the Curve

The number of children participating in the Child Care Financial Assistance Program (CCFAP) with a Strengthening Families provider increased since early 2023, partially due to the increase in the number of grantees and the total number of children being served. Additionally, CCFAP utilization rates have increased overall since July 2023 due to the implementation of Act 76, an act related to child care and early childhood education. The law makes major investments in Vermont's child care system, including an increase in the income guidelines for CCFAP so more families are eligible for assistance.

P

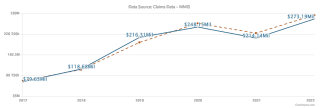
Vermont Medicaid Next Generation (VMNG) Accountable Care Organization (ACO)

DVHA ACO

What We Do

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

Measures

Measures	Most Recent Period	Current Actual Value	Current Target Value	True	Current Trend	Baseline % Change
PM DVHA Expected and Actual Total Cost of Care for Medicaid enrollees aligned with an ACO	2022	$273.19Mil	$285.23Mil	–	↗ 1	243% ↗
	2021	$214.14Mil	$229.31Mil		↘ 1	169% ↗
	2020	$248.15Mil	$259.79Mil		↗ 3	212% ↗
	2019	$216.31Mil	$200.81Mil		↗ 2	172% ↗
	2018	$118.68Mil	$117.14Mil		↗ 1	49% ↗
	2017	$79.63Mil	$82.32Mil		→ 0	0% →

Notes on Methodology

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

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

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

- The dotted red line above shows the ETCOC

- The solid blue line above shows the ATCOC

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

Story Behind the Curve

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

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

PM DVHA Percent of Medicaid enrollees aligned with ACO

2023	81.96%	–	–	↗ 2	295% ↗
2022	74.86%	–		↗ 1	260% ↗
2021	71.70%	–		↘ 1	245% ↗
2020	85.13%	–		↗ 3	310% ↗
2019	55.64%	–		↗ 2	168% ↗
2018	31.02%	–		↗ 1	49% ↗
2017	20.77%	–		→ 0	0% →

Notes on Methodology

Attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline

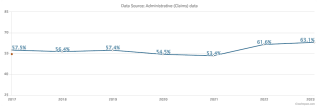
period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms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

Story Behind the Curve

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

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

PM DVHA Adolescent Well Care Visits (HEDIS® AWC)



2023	63.1%	–	–	↗ 2	10% ↗
2022	61.6%	–		↗ 1	7% ↗
2021	53.4%	–		↘ 2	-7% ↘
2020	54.5%	–		↘ 1	-5% ↘
2019	57.4%	–		↗ 1	0% →
2018	56.4%	–		↘ 1	-2% ↘
2017	57.5%	54.6%		→ 0	0% →

Notes on Methodology

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

ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population and attributes members based on their Medicaid eligibility at the beginning of the performance year,

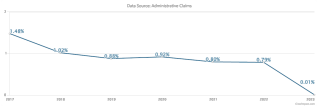
the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible). In order to make year-over-year comparisons for the VMNG program, the expanded attribution population is not included in the numerator for this measure.

Story Behind the Curve

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

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

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



2023	0.01%	–	–	↘ 3	-99% ↘
2022	0.79%	–		↘ 2	-47% ↘
2021	0.80%	–		↘ 1	-46% ↘
2020	0.92%	–		↗ 1	-38% ↘
2019	0.88%	–		↘ 2	-41% ↘
2018	1.02%	–		↘ 1	-31% ↘
2017	1.48%	–		→ 0	0% →

Notes on Methodology

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

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

Story Behind the Curve

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

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

The measure specifications were revised significantly for the 2023 performance year, and caution should be exercised when comparing 2023 to past years' performance on this measure.

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

2023	50.1%	–	–	↘ 1	35% ↗
2022	54.7%	–		↗ 5	48% ↗
2021	50.9%	–		↗ 4	38% ↗
2020	50.5%	–		↗ 3	36% ↗
2019	40.9%	–		↗ 2	11% ↗
2018	37.5%	–		↗ 1	1% ↗
2017	37.0%	36.5%		→ 0	0% →

Notes on Methodology

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

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

Story Behind the Curve

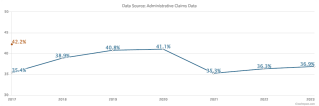
This measure looks at continuity of care for mental illness. It measures the percentage of Medicaid

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

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

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

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



2023	36.9%	–	–	↗ 2	4% ↗
2022	36.3%	–		↗ 1	3% ↗
2021	35.3%	–		↘ 1	0% →
2020	41.1%	–		↗ 3	16% ↗
2019	40.8%	–		↗ 2	15% ↗
2018	38.9%	–		↗ 1	10% ↗
2017	35.4%	42.2%		→ 0	0% →

Notes on Methodology

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

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

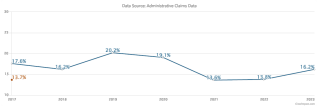
Story Behind the Curve

This measure assesses the percentage of ACO-attributed Medicaid beneficiaries 13 years of age and

older who are diagnosed with alcohol and other drug dependence (AOD) and who start treatment through an inpatient AOD admission or an outpatient service for AOD within 14 days.

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

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



2023	16.2%	–	–	↗ 2	-8% ↘
2022	13.8%	–		↗ 1	-22% ↘
2021	13.6%	–		↘ 2	-23% ↘
2020	19.1%	–		↘ 1	8% ↗
2019	20.2%	–		↗ 1	15% ↗
2018	16.2%	–		↘ 1	-8% ↘
2017	17.6%	13.7%		→ 0	0% →

Notes on Methodology

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

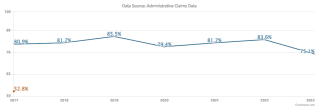
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline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

Story Behind the Curve

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

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

lack of redetermination activity during the PHE may also have impacted the quality performance data for those years.

PM	DVHA	Follow Up After ED Visit for Mental Illness - within 30 days (HEDIS® FUM)	2023	75.1%	–	–	↘ 1	-7% ↘
			2022	83.6%	–		↗ 2	3% ↗
			2021	81.7%	–		↗ 1	1% ↗
			2020	79.4%	–		↘ 1	-2% ↘
			2019	85.5%	–		↗ 2	6% ↗
			2018	81.7%	–		↗ 1	1% ↗
			2017	80.9%	52.8%		→ 0	0% →

Notes on Methodology

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

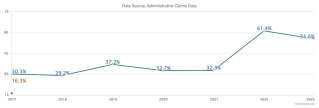
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline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

Story Behind the Curve

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

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

PM	DVHA	Follow Up After ED Visit for Alcohol or Other Drug Dependence - within 30 days (HEDIS® FUA)	2023	55.6%	–	–	↘ 1	83% ↗



2022	61.4%	–		↗ 2	103% ↗
2021	32.9%	–		↗ 1	9% ↗
2020	32.7%	–		↘ 1	8% ↗
2019	37.2%	–		↗ 1	23% ↗
2018	29.2%	–		↘ 1	-4% ↘
2017	30.3%	16.3%		→ 0	0% →

Notes on Methodology

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

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

Story Behind the Curve

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

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

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

2023	56.1%	–	–	↗ 1	18% ↗
2022	51.5%	–		↘ 1	9% ↗
2021	54.3%	–		↗ 1	15% ↗
2020	45.8%	–		↘ 1	-3% ↘
2019	52.0%	–		↗ 1	10% ↗
2018	43.4%	–		↘ 1	-8% ↘
2017	47.4%	–		→ 0	0% →

Notes on Methodology

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

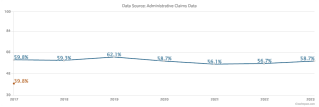
ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline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

Story Behind the Curve

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

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

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



2023	58.7%	–	–	↗ 2	-2% ↘
2022	56.7%	–		↗ 1	-5% ↘
2021	56.1%	–		↘ 2	-6% ↘
2020	58.7%	–		↘ 1	-2% ↘
2019	62.1%	–		↗ 1	4% ↗
2018	59.3%	–		↘ 1	-1% ↘
2017	59.8%	39.8%		→ 0	0% →

Notes on Methodology

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

ACO attribution is prospective and set at the beginning of a performance year. Beginning in 2020, attribution is conducted in two steps. The first, or traditional methodology, is based on a member's relationship with a primary care provider in the ACO's network and qualifying utilization in a baseline period. The second, or expanded methodology, examines the remainder of the Medicaid population

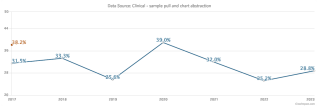
and attributes members based on their Medicaid eligibility at the beginning of the performance year, the absence of a primary care relationship with a non-ACO-participating provider, and a lack of other forms of insurance coverage (i.e., the member must be in an aid category that receives the full Medicaid benefit in order to be attribution-eligible). In order to make year-over-year comparisons for the VMNG program, the expanded attribution population is not included in the numerator for this measure.

Story Behind the Curve

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

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

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



2023	28.8%	–	–	↗ 1	-9% ↘
2022	25.2%	–		↘ 2	-20% ↘
2021	32.0%	–		↘ 1	2% ↗
2020	39.0%	–		↗ 1	24% ↗
2019	25.6%	–		↘ 1	-19% ↘
2018	33.3%	–		↗ 1	6% ↗
2017	31.5%	38.2%		→ 0	0% →

Notes on Methodology

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

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

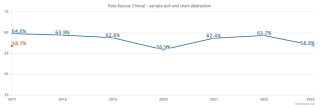
measure.

Story Behind the Curve

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

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

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



2023	58.8%	–	–	↘ 1	-9% ↘
2022	63.7%	–		↗ 2	-1% ↘
2021	62.4%	–		↗ 1	-3% ↘
2020	56.9%	–		↘ 3	-12% ↘
2019	62.6%	–		↘ 2	-3% ↘
2018	63.9%	–		↘ 1	-1% ↘
2017	64.6%	58.7%		→ 0	0% →

Notes on Methodology

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

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

Story Behind the Curve

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

Caution should be exercised when drawing conclusions from the 2020, 2021, and 2022 data. Due to the COVID-19 pandemic and associated Public Health Emergency (PHE), the utilization of services in 2020,

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

PM	DVHA	Tobacco Use Assessment and Tobacco Cessation Intervention	2023	93.1%	–	–	↗ 1	53% ↗
			2022	92.5%	–		↘ 1	52% ↗
			2021	93.5%	–		↗ 1	54% ↗
			2020	80.8%	–		↘ 1	33% ↗
			2019	83.9%	–		↗ 1	38% ↗
			2018	60.8%	–		→ 0	0% →

Notes on Methodology

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

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

Story Behind the Curve

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

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