OPEN MINDS

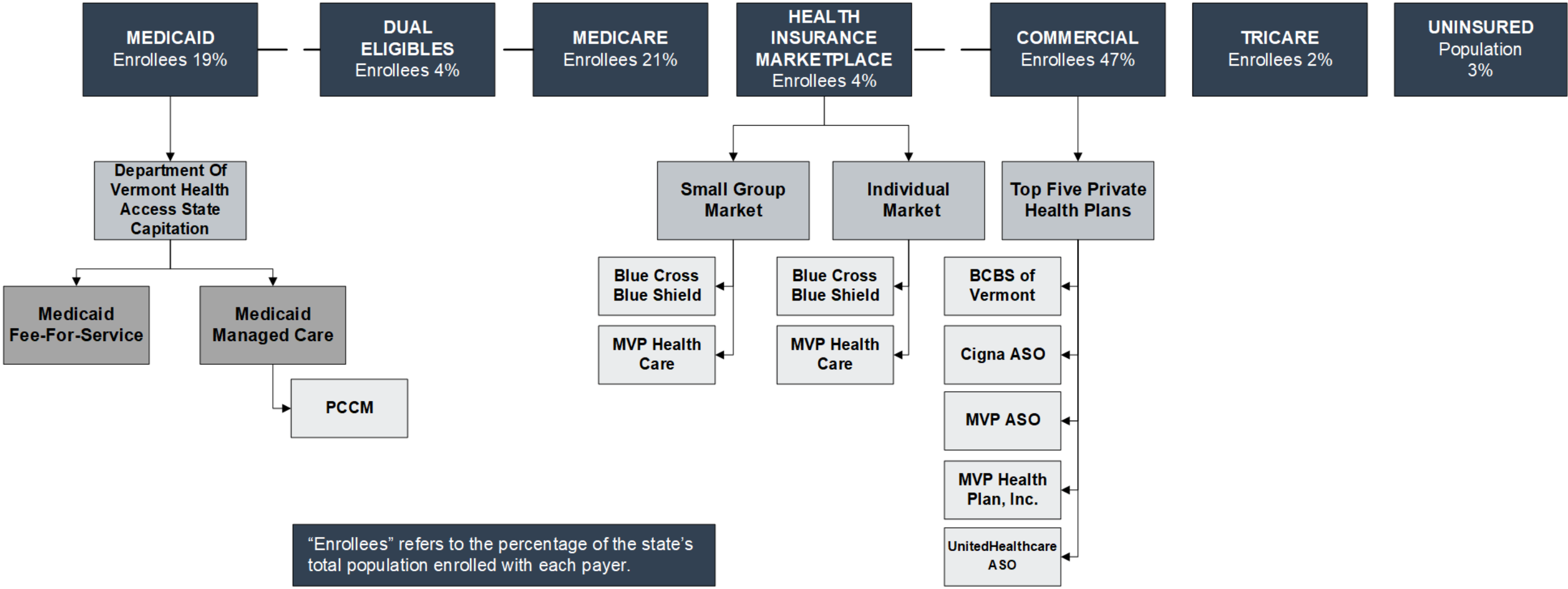
Vermont Health & Human Services State Profile

Health & Human Services System Market Profile Overview

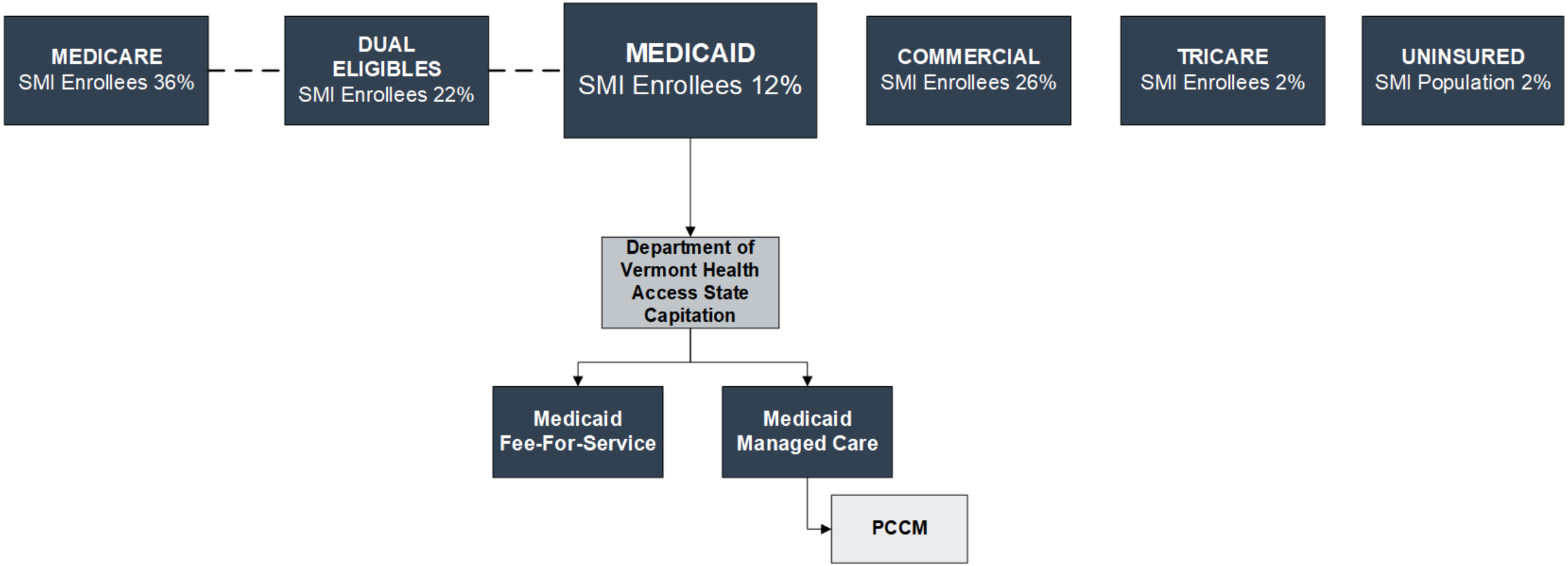
A. Executive Summary

A.1. Vermont Physical Health Care Coverage by Payer

Total Vermont Population- 645,570
Estimated SMI Population- 31,633



A.1. Vermont Behavioral Health Care Coverage by Payer



"Enrollees" refers to the percentage of the state's total SMI population enrolled with each payer.

A.2. Medicaid Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	**Active Program**	**Description**
Managed Care Health Plan		The Department of Vermont Health Access serves as the managed care entity for the Agency of Human Services; however, the Department is not at-risk for services.
Primary Care Case Management (PCCM)	✓	The state has a PCCM program called PC Plus.
Accountable Care Organization (ACO) Program	✓	Medicaid participates in the state's all-payer ACO model.
Affordable Care Act (ACA) Model Health Home	✓	The state has a health home program for persons with opioid addiction who are receiving medication assisted treatment.
Patient-Centered Medical Home (PCMH)	✓	Medicaid is a participating payer in the state's PCMH initiative.
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)		None
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	The state has one CCBHC
Other Care Coordination Initiative		None

A.3. Health Care Safety-Net Delivery System

State Agencies Responsible For Uninsured Citizens & Delivery System Model

Physical Health Services

- The Department of Health, Office of Rural Health and Primary Care within the Vermont Agency of Human Services provides physical health services to the uninsured population through 12 local health offices.

Mental Health Services

- The Department of Mental Health within the Vermont Agency of Human Services contracts with 16 Designated Agencies to provide mental health treatment services to the uninsured population.

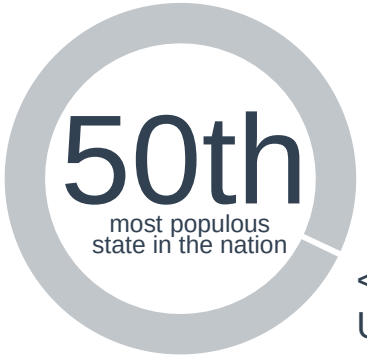
Addiction Treatment Services

- The Department of Health, Division of Alcohol and Drug Abuse Programs within the Vermont Agency of Human Services delivers addiction disorder treatment services to the uninsured population through a network of provider organizations.

B. Vermont Health Financing System Overview

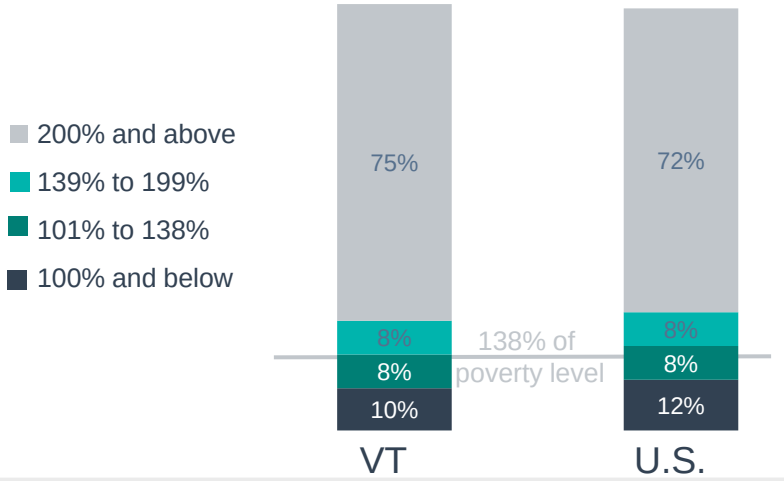
B.1. Population Demographics

Total Vermont Population- 645,570
Estimated SMI Population- 31,633



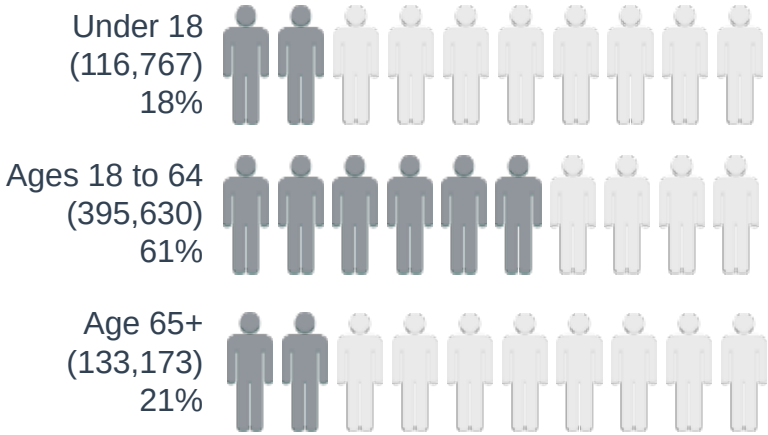
<1% of the
U.S. population

Population Distribution By Income To Poverty Threshold Ratio

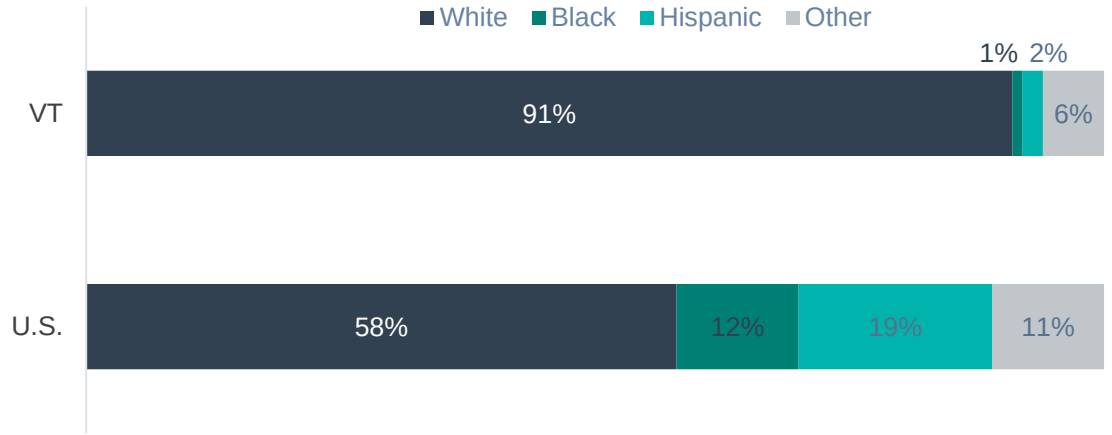


Median Household Income
Vermont $72,431
U.S. $69,717

Population Distribution By Age

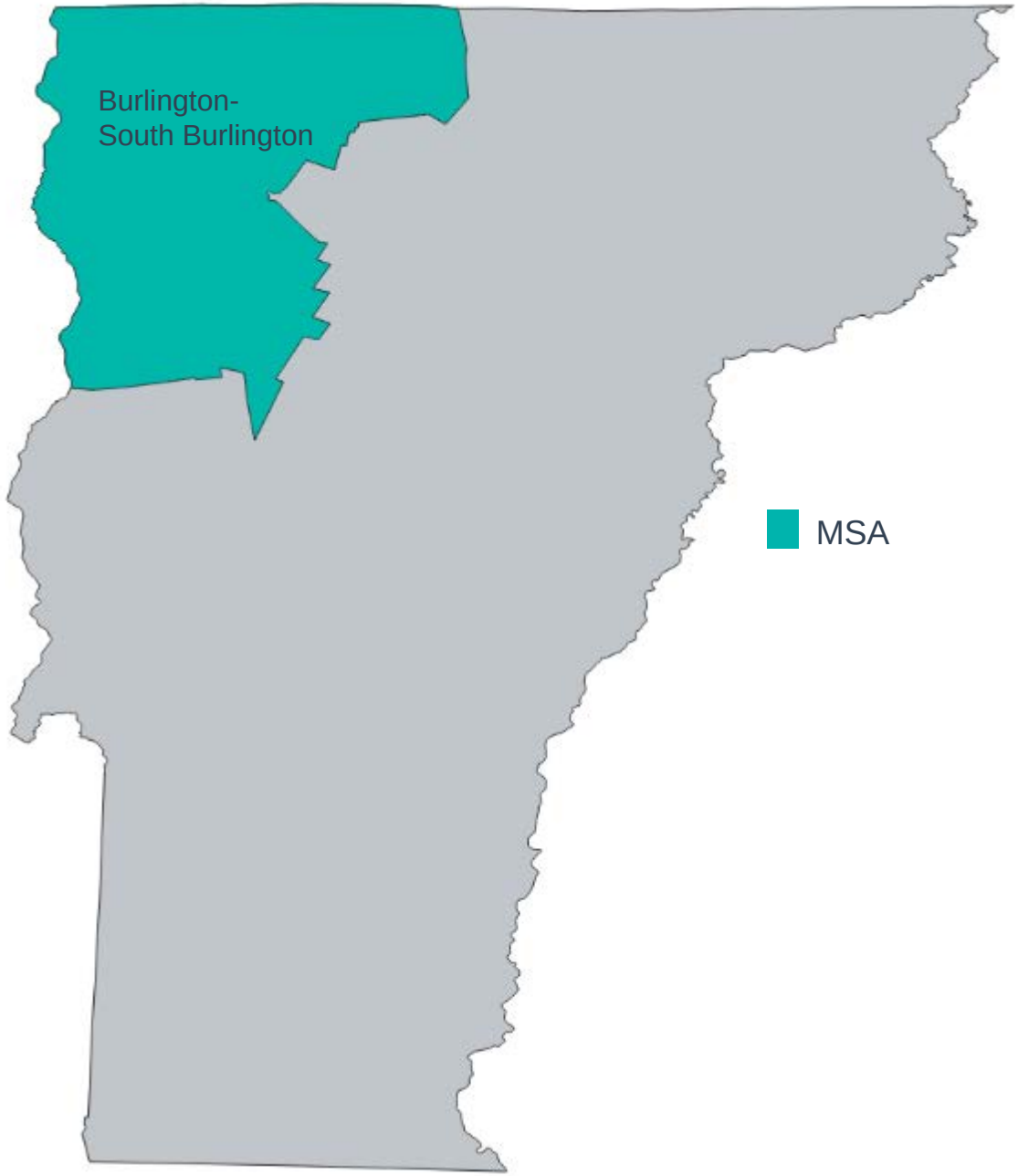


Vermont & U.S. Racial Composition

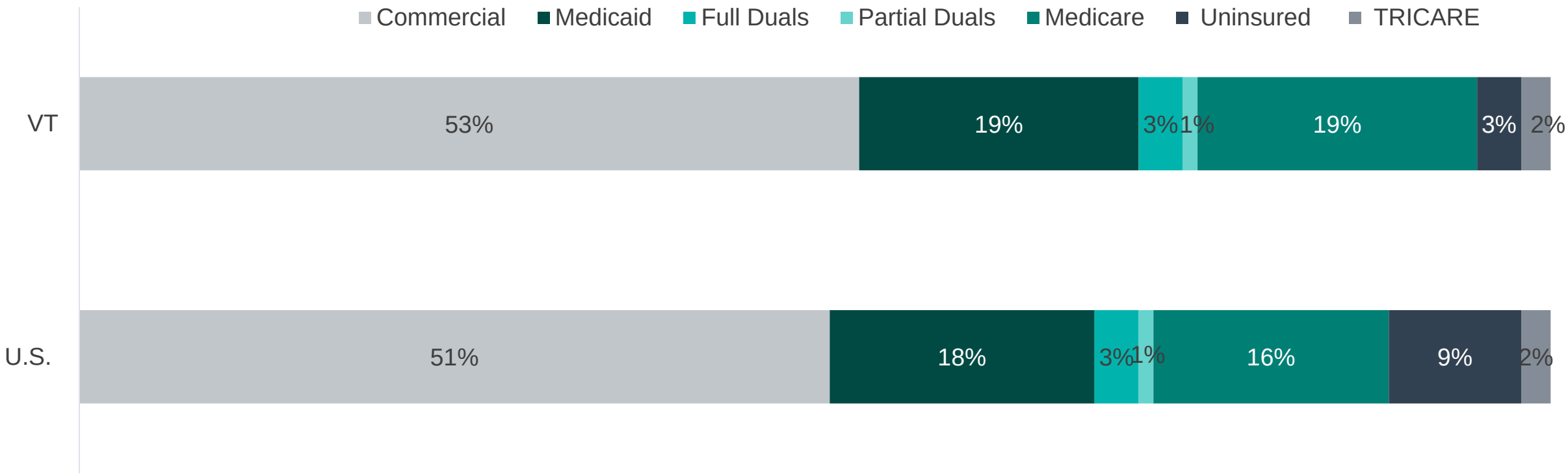


B.2. Population Centers

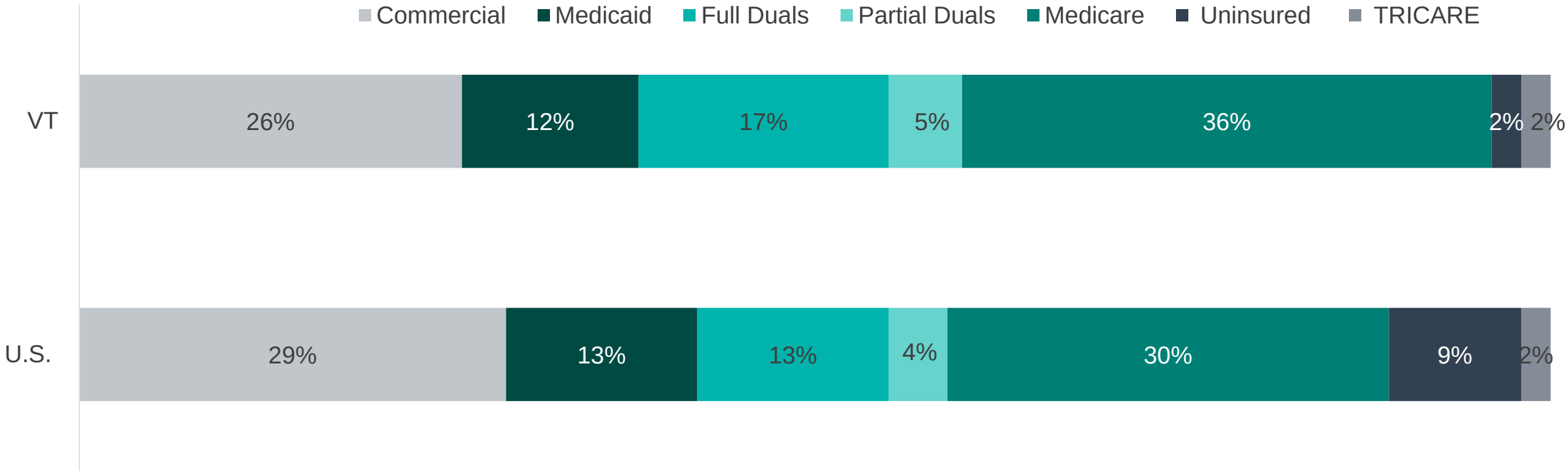
Metropolitan Statistical Areas (MSAs)		
MSA	**MSA Residents**	**Percent Of Population**
Total MSA Population	**226,715**	**35%**
Burlington-South Burlington, VT	226,715	35%



B.3. Population Distribution By Payer: National vs. State



B.3. SMI Population Distribution By Payer: National vs. State



B.4. Largest Vermont Payers By Enrollment

Plan Name	Plan Type	Enrollment*
Medicaid fee-for-service (FFS)	Medicaid	205,072
Blue Cross Blue Shield of Vermont	Commercial	172,084
Medicare FFS	Medicare	124,679
MVP Health Plan	Commercial	37,316
Cigna ASO	Commercial administrative services only (ASO)	36,637
MVP ASO	Commercial ASO	31,864
UnitedHealthcare ASO	Commercial ASO	14,593
TRICARE	Other public	13,154
AARP MedicareComplete	Medicare Advantage	9,211
Care Improvement Plus	Medicare Advantage	5,635

* Medicaid enrollment as of December 2021; TRICARE as of July 2020; Commercial as of December 2021; Medicare enrollment as of December 2021

B.4. Largest Vermont Payers By Estimated SMI Enrollment

Plan Name	Plan Type	Enrollment*	Estimated SMI Enrollment
Medicaid fee-for-service (FFS)	Medicaid	205,072	10,049
Blue Cross Blue Shield of Vermont	Commercial	172,084	8,432
Medicare FFS	Medicare	124,679	6,109
MVP Health Plan	Commercial	37,316	1,828
Cigna ASO	Commercial administrative services only (ASO)	36,637	1,795
MVP ASO	Commercial ASO	31,864	1,561
UnitedHealthcare ASO	Commercial ASO	14,593	715
TRICARE	Other public	13,154	645
AARP MedicareComplete	Medicare Advantage	9,211	451
Care Improvement Plus	Medicare Advantage	5,635	276

* Medicaid enrollment as of December 2021; TRICARE as of July 2020; Commercial as of December 2021; Medicare enrollment as of December 2021

B.5. Health Insurance Marketplace

Health Insurance Marketplace	
Health Plan Marketplace Percentage	5%
Type of Marketplace	State-based
Individual Enrollment Contact	https://portal.healthconnect.vermont.gov/VTHBELand/welcome.action
	1-855-899-9600
Small Business Enrollment Contact	http://info.healthconnect.vermont.gov/SB
	1-855-499-9800

2022 Individual Market Health Plans
1. Blue Cross Blue Shield 2. MVP Health Care

2022 Small Group Market Health Plans
1. Blue Cross Blue Shield 2. MVP Health Care

B.6. Accountable Care Organization (ACOs)

Commercial	
ACO	**Commercial Insurer**
Vermont Collaborative Physicians	Blue Cross Blue Shield Vermont

Next Generation Model ACOs
OneCare Vermont Accountable Care Organization

Medicare Shared Savings ACOs
NH Value Care ACO LLC

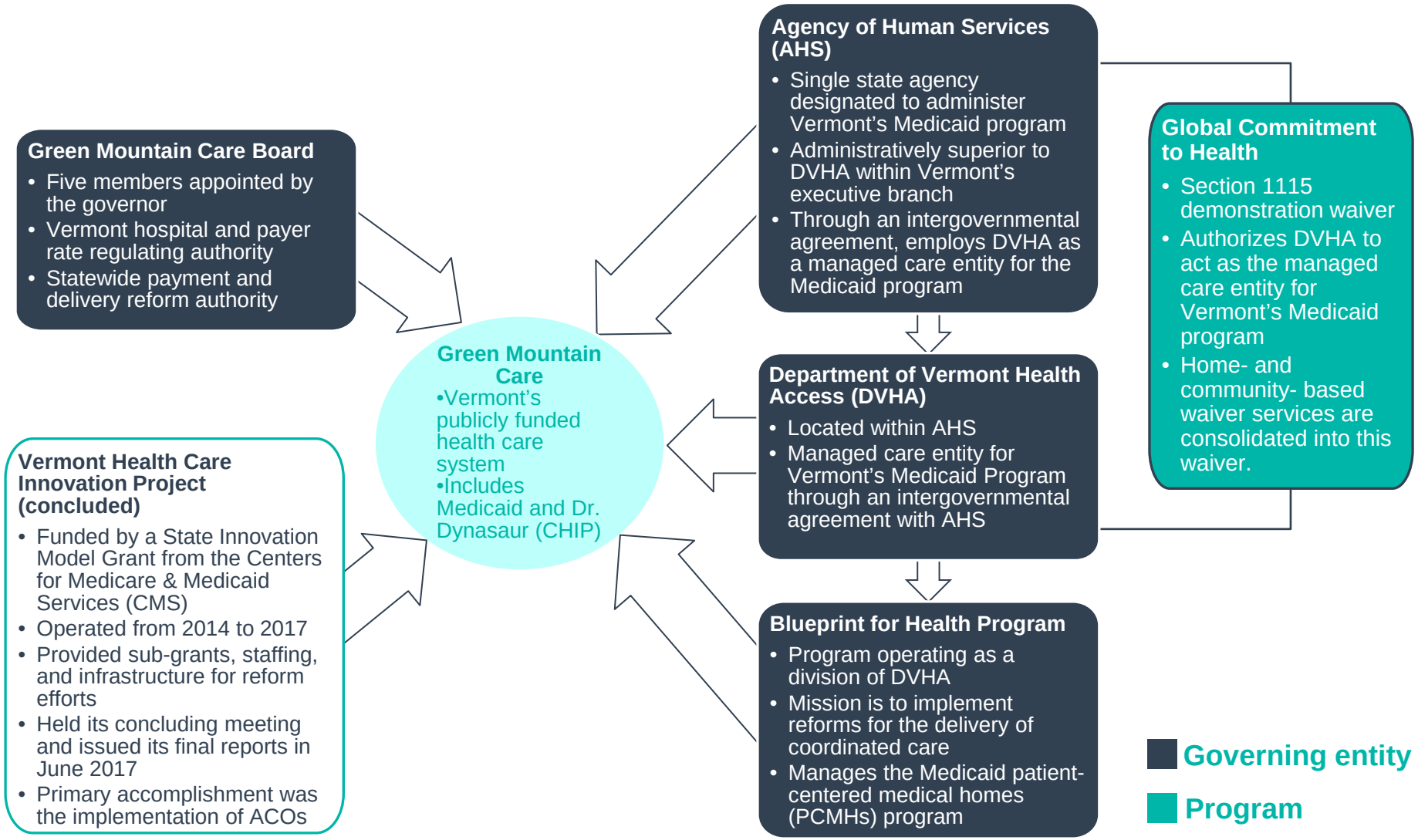
*Note: OneCare Vermont is the state's all-payer accountable care organization

C. Medicaid Administration, Governance & Operations

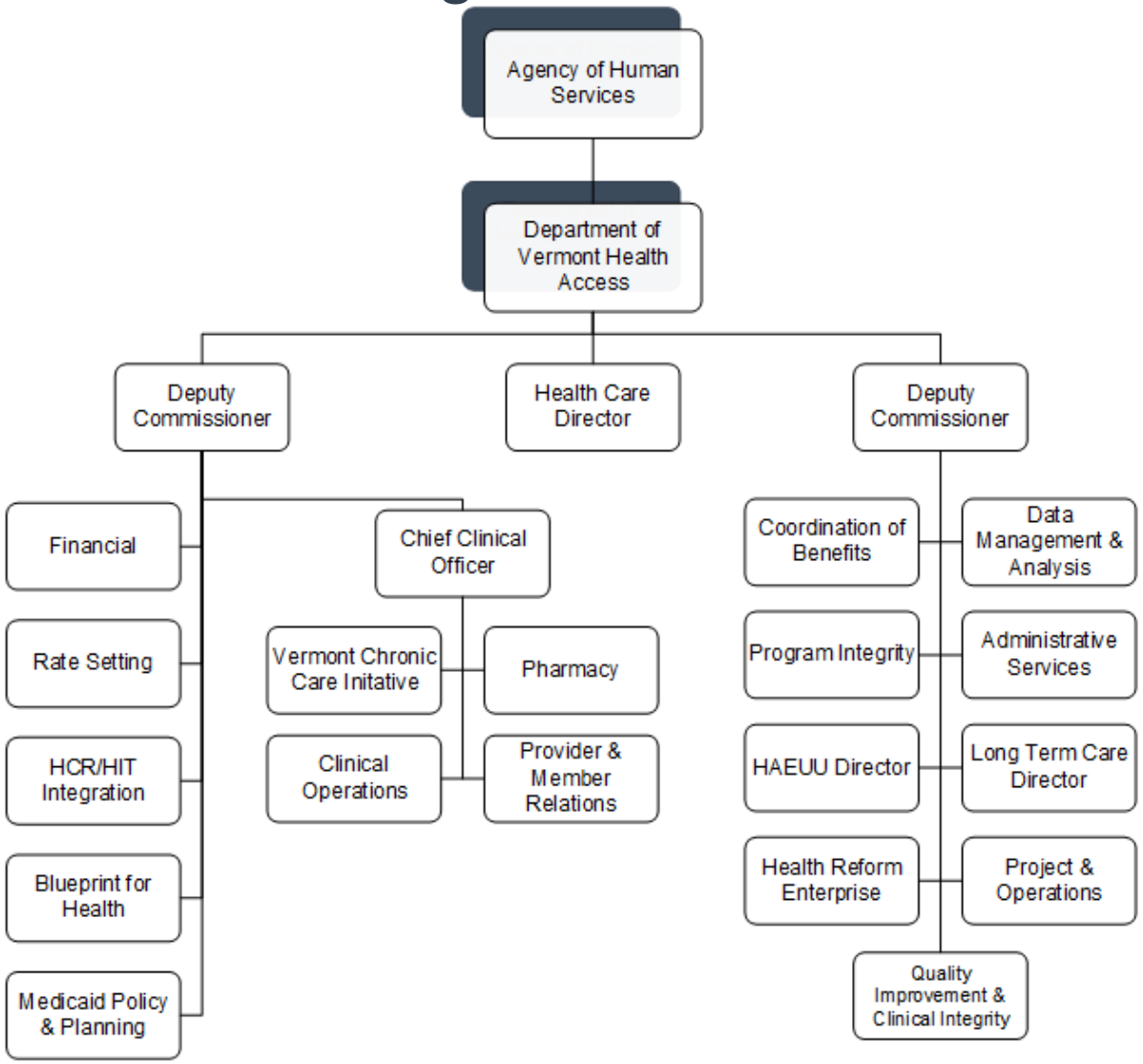
C.1. Medicaid Governance: Related Programs & Partners

- Vermont's publicly funded health insurance programs are called Green Mountain Care and include:
  - Medicaid
  - Dr. Dynasaur (the state's CHIP program)
- Green Mountain Care is separate from the Green Mountain Care Board (GMCB).
  - GMCB was created in 2011 by Act 48, the legislation that outlined a single-payer health care system for Vermont.
  - In 2014, Governor Pete Shumlin announced that the costs of a single-payer system were too high to proceed with implementation.
  - Had it been implemented, the single-payer program would also have fallen under the Green Mountain Care umbrella.
- The GMCB remains a five-member committee—each appointed by the governor—with three main functions:
  - Regulate all hospital budgets and all payer rates
  - Test new innovations in health care delivery
  - Implement payment and delivery reforms

C.1. Medicaid Governance: Related Programs & Partners



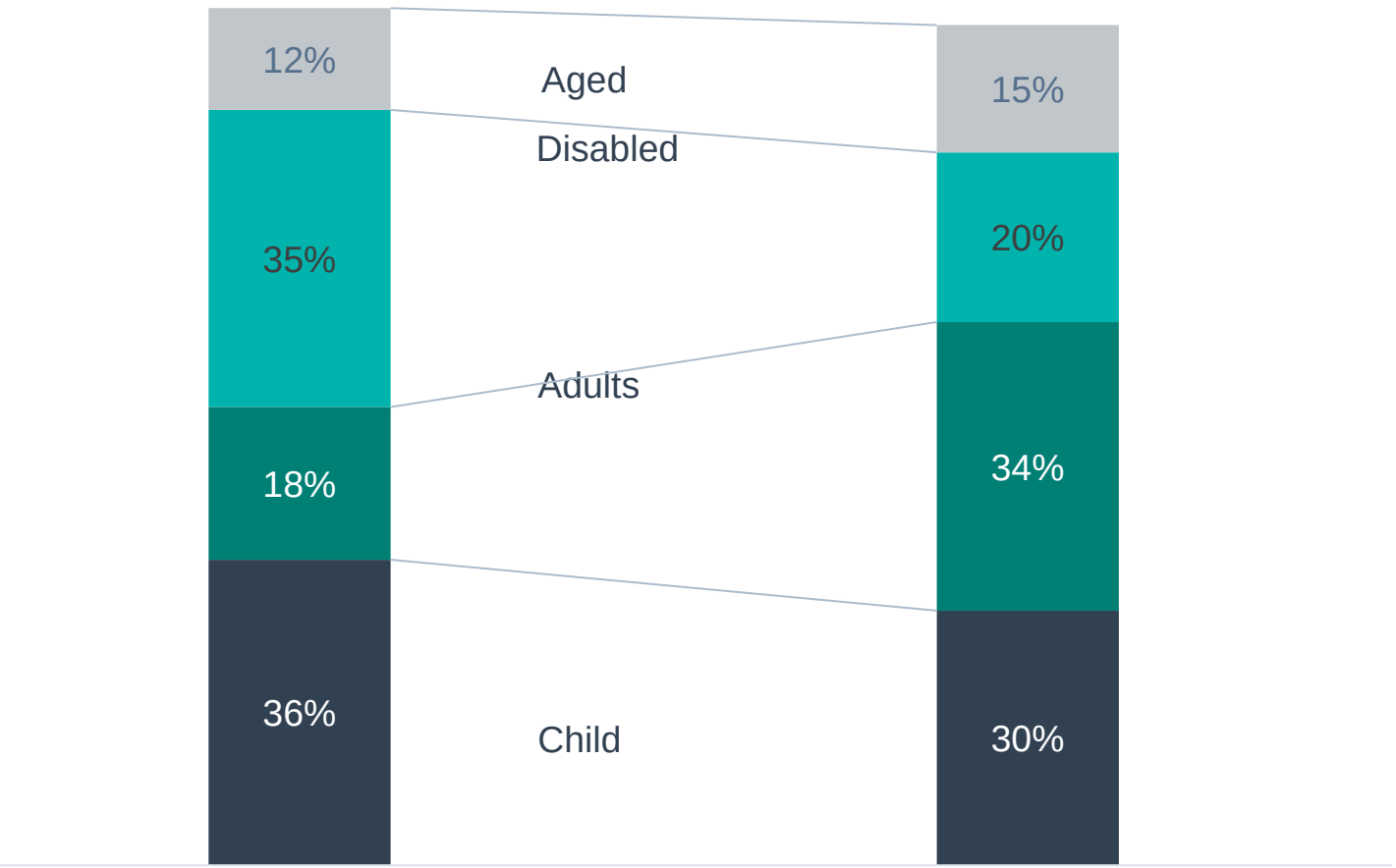
C.1. Medicaid Governance: Organization Chart



C.1. Medicaid Governance: Key Leadership

Name	Position	Department	Email
Jenney Samuelson	Secretary	Agency of Human Services	jenney.samuelson@vermont.gov
Todd Daloz	Deputy Secretary	Agency of Human Services	todd.daloz@vermont.gov
Andrea De La Bruere	Commissioner, Medicaid Director	Department of Vermont Health Care Access	andrea.delabruere@vermont.gov
Adaline Strumolo	Deputy Commissioner, Health Services and Managed Care	Department of Vermont Health Care Access	adaline.strumolo@vermont.gov
Lori Collins	Deputy Commissioner, Policy, Fiscal, and Support Services	Department of Vermont Health Care Access	lori.collins@vermont.gov
John Saroyan	Director, Blueprint for Health	Department of Vermont Health Care Access	john.m.saroyan@vermont.gov

C.2. Medicaid Program Spending By Eligibility Group



Based on FY 2020 data

Medicaid Spending Per Enrollee, FY 2020	U.S.	VT*
All populations	$8,718	$6,945
Children	$3,495	$3,327
Adults	$5,461	$2,198
Expansion adults	$7,227	$N/A
Disabled	$23,123	$31,390
Aged	$18,552	$25,604

*VT spending based on FY 2019

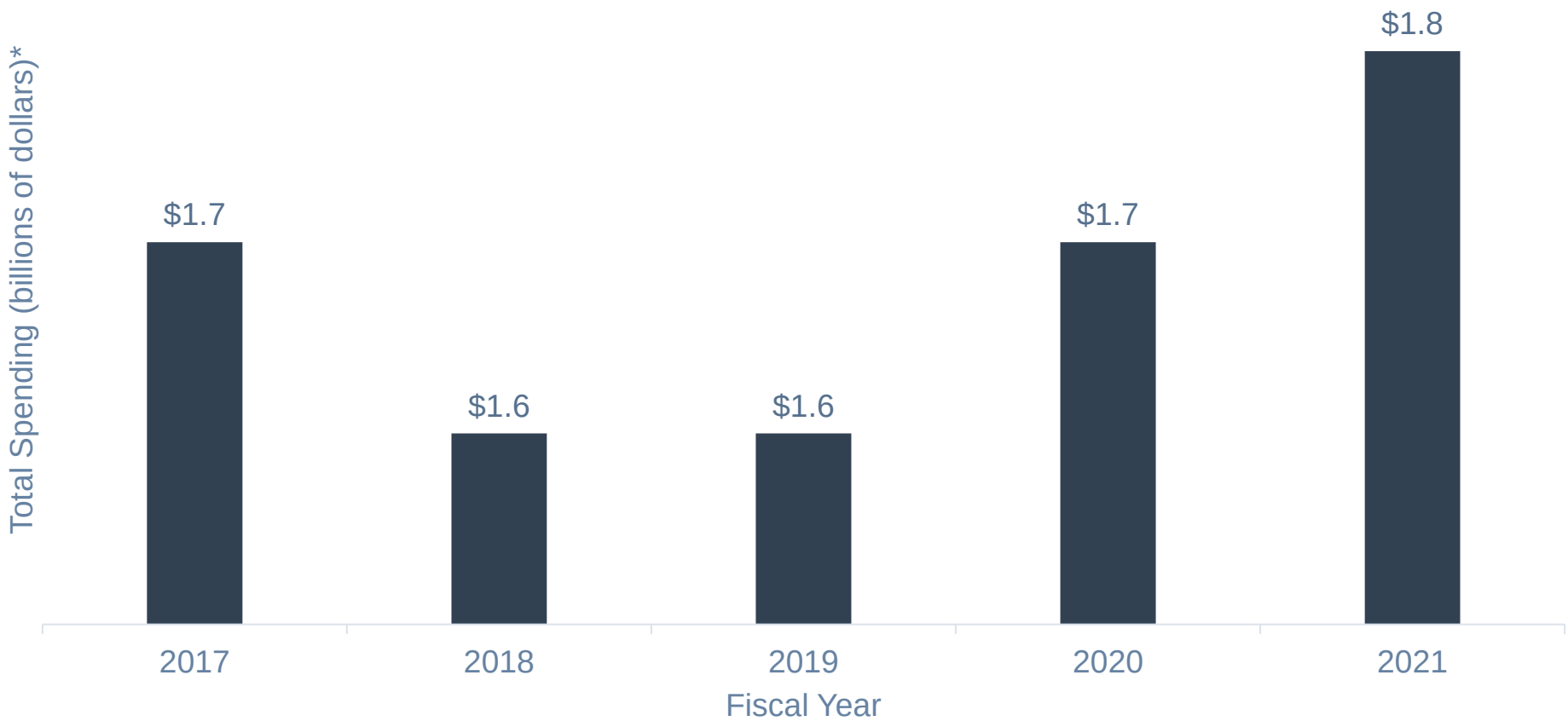
C.2. Medicaid Program Spending: Budget

Budget Item	SFY 21Est Spending	Percent Of Budget*
Other acute	$1,417,000,000	78%
Home- and community-based LTSS	$241,000,000	13%
Institutional LTSS	$131,000,000	7%
Hospital	$23,000,000	1%
Medicare premiums and coinsurance	$5,000,000	<1%
Budget Total: $1,817,000,000		

Federal & County Financial Participation	
FY 2022 Federal Medical Assistance Percentage (FMAP)	62.67%
CY 2022 Newly Eligible FMAP (expansion population)	88%
Counties contribute to state Medicaid share	Yes

*Percent of budget is calculated with the totals the state provided

C.2. Medicaid Program Spending: Change Over Time



C.3. Medicaid Expansion Status

	Medicaid Expansion
Participating In Expansion	Yes
Date Of Expansion	January 2014
Medicaid Eligibility Income Limit For Able-Bodied Adults	133% of Federal poverty level (FPL) Note: The Patient Protection and Affordable Care Act (PPACA) requires that 5% of income be disregarded when determining eligibility
Legislation Used To Expand Medicaid	None
Number Of Individuals Enrolled In The Expansion Group (March 2022)	72,118
Number Of Enrollees Newly Eligible Due To Expansion	N/A
Benefits Plan For Expansion Population	The alternative benefit plan is identical to the state plan.

C.4. Medicaid Program Benefits

Federally Mandated Services

1. Inpatient hospital services other than services in an institution for mental disease (IMD)
2. Outpatient hospital services
3. Rural Health Clinic services
4. Federally Qualified Health Center (FQHC) services
5. Laboratory and x-ray services
6. Nursing facilities for individuals 21 and over
7. Early and Periodic Screening and Diagnosis and Treatment (EPSDT)
8. Family planning services and supplies
9. Free standing birth centers
10. Pregnancy-related and postpartum services
11. Nurse midwife services
12. Tobacco cessation programs for pregnant women
13. Physician services
14. Medical and surgical services of a dentist
15. Home health services
16. Nurse practitioner services
17. Non-emergency transportation to medical care

Vermont's Optional Services

1. Podiatrists' services
2. Optometrists' services
3. Chiropractors' services
4. Other practitioner services
5. Private duty nursing
6. Clinic services
7. Dental services (excluding orthodontics)
8. Physical, occupational, and speech/language therapy
9. Prescribed drugs
10. Prosthetic devices
11. Diagnostic, screening, and preventive services
12. Rehabilitative services
13. Inpatient and intermediate care facility services in IMDs for those 65 years and older
14. Intermediate care facility services
15. Inpatient psychiatric facility services for those under age 22
16. Hospice care
17. Case management
18. Respiratory care
19. Nursing facility services for patients under 21
20. Personal care services
21. Medication Assisted Treatment (MAT)

D. Medicaid Financing & Service Delivery System

D.1. Medicaid Financing & Service Delivery System

Medicaid System Characteristics		
	Green Mountain Care*	
Characteristics	**Medicaid Fee-For-Service (FFS)**	**Medicaid Primary Care Case Management (PCCM)**
Enrollment (June 2022)	22,599	199,497
SMI Enrollment	• Vermont does not specifically preclude individuals with SMI from enrolling in its PCCM, but dual eligibles are excluded. Therefore, the SMI population is split between FFS and the PCCM. • Estimated 11% of SMI population in FFS, 89% in PCCM	
Management	Department of Vermont Health Access (DVHA)	DVHA
Payment Model	Non-risk capitated rate (state receives a per member per month capitation for enrollees that is reconciled quarterly)	• Non-risk capitated rate (state receives a per member per month capitation for enrollees that is reconciled quarterly) • PCPs receive a per member per month fee based on health care utilization
Geographic Service Area	Statewide	Statewide

Total Medicaid: 213,096 | Total Medicaid With SMI: 10,441

* Vermont considers its entire Medicaid system to be managed care and provides Medicaid services to FFS and PCCM members under a non-risk capitated rate through the Department of Vermont Health Access.

D.1. Medicaid System Overview

Medicaid Financial Delivery System Enrollment	
Total Medicaid population distribution	100% in state-operated, non-risk managed care, within that system: • Estimated 11% in FFS, 89% in PCCM
SMI population inclusion in managed care	• Vermont does not specifically preclude individuals with SMI from enrolling in its PCCM, but dual eligibles are excluded. Therefore, the SMI population is split between FFS and the PCCM. • Estimated 11% of population in FFS, 89% in PCCM
Dual eligible population inclusion in managed care	• Dual eligibles are excluded from the state's PCCM program. • Estimated 100% of population in FFS

Medicaid Financing & Risk Arrangements: Behavioral Health		
Service Type	**FFS Population**	**PCCM Population**
Traditional behavioral health	Covered FFS by the state within the state capitated system (non-risk)	Covered FFS by the state within the state capitated system (non-risk)
Specialty behavioral health	Covered FFS by the state within the state capitated system (non-risk)	Covered FFS by the state within the state capitated system (non-risk)
Pharmaceuticals	Covered FFS by the state within the state capitated system (non-risk)	Covered FFS by the state within the state capitated system (non-risk)
Long-term services and supports (LTSS)	Covered FFS by the state within the state capitated system (non-risk)	Covered FFS by the state within the state capitated system (non-risk)

D.1. Medicaid Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	**Active Program**	**Description**
Managed Care Health Plan		The Department of Vermont Health Access serves as the managed care entity for the Agency of Human Services; however, the Department is not at-risk for services.
Primary Care Case Management (PCCM)	✓	The state has a PCCM program called PC Plus.
Accountable Care Organization (ACO) Program	✓	Medicaid participates in the state's all-payer ACO model.
Affordable Care Act (ACA) Model Health Home	✓	The state has a health home program for persons with opioid addiction who are receiving medication assisted treatment.
Patient-Centered Medical Home (PCMH)	✓	Medicaid is a participating payer in the state's PCMH initiative.
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)		None
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	The state has one CCBHC
Other Care Coordination Initiative		None

D.1. Medicaid Financing & Service Delivery System: Overview

- Green Mountain Care is Vermont's unique Medicaid financing and service delivery system, structured to support the state's goal of implementing a single-payer health care delivery system.
- The Department of Vermont Health Access (DVHA) acts as a managed care entity for the Vermont Agency of Human Services through an intergovernmental agreement authorized by the 1115 Global Commitment to Health Demonstration waiver.
- DVHA is considered similar to a non-risk prepaid inpatient health plan, setting payment schedules and adhering to federal regulations—such as maintaining an adequate provider network and complying with audit requirements.
  - DVHA receives a per member per month capitation rate for each Medicaid enrollee from the Vermont Agency of Human Services. Because capitation rates are reconciled to actual expenses quarterly, DVHA takes on no actual risk.
  - DHVA is subject to medical loss ratio (MLR) of 85%. If the MLR is not met, the capitation rate must be reduced until it is met.
- DVHA delivers care to the Medicaid population through two systems, FFS and PCCM.
- Although Vermont considers Green Mountain Care to be a managed care system, the Centers for Medicare & Medicaid Services (CMS) does not.

D.1. Medicaid Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or PCCM	Mandatory PCCM Enrollment
Parents and caretakers			X
Children			X
Blind and disabled individuals			X
Aged individuals			X
Dual eligibles	X		
Medicaid expansion			X
Individuals residing in nursing homes	X		
Individuals residing in ICF/IDD	X		
Individuals in foster care			X
Other populations	• Individuals with private insurance • Individuals receiving home- and community-based services	• Less than two choices for primary care physician in a designated area	

D.2. Medicaid FFS Program: Overview

- Although most services are provided by DVHA on an FFS basis, Vermont considers its entire Medicaid system to be managed care.

D.3. Medicaid Managed Care Program: Overview

- Total Medicaid enrollment as of June 2022 was 213,096.
- Although most services are provided by DVHA on an FFS basis, Vermont considers its entire Medicaid system to be managed care.
  - The state Medicaid agency, DVHA, acts like a non-risk prepaid inpatient health plan setting payment schedules and adhering to federal regulations, such as maintaining an adequate provider network and complying with audit requirements.
- The state operates two delivery systems under DVHA:
  - Traditional FFS: Dual eligibles and individuals receiving long-term services and supports (LTSS) are served under the FFS system. DHVA has the authority to negotiate rates with these provider organizations.
  - Primary Care Plus (PC Plus): Children, parents/caretaker relatives, the Medicaid expansion population, and the aged, blind, and disabled population are served by the state's primary care case management (PCCM) program.
- *OPEN MINDS* estimates that 22,599 individuals receive services through the FFS system, and 199,497 receive services through PC Plus as of June 2022.

D.3. Medicaid Managed Care Program: Behavioral Health Benefits

Behavioral health and pharmacy benefits are covered FFS by the state.

Managed Care Mental Health Benefits
1. Inpatient services
2. Diagnosis, assessment, and evaluation
3. Emergency care
4. Crisis intervention
5. Individual, family, and group psychotherapy
6. Specialized rehabilitation services
7. Day hospital
8. Community Rehabilitation and Treatment waiver program

Managed Care Addiction Treatment Benefits
1. Inpatient services
2. Residential treatment
3. Partial hospitalization and psychosocial rehabilitation
4. Screening, Brief Intervention and Referral for Treatment (SBIRT)
5. Outpatient services
6. Intensive outpatient services
7. Opioid treatment program
8. Withdrawal management
9. Medication assisted treatment (MAT)
10. Addiction assessment
11. Detoxification services
12. Medication Therapy Management

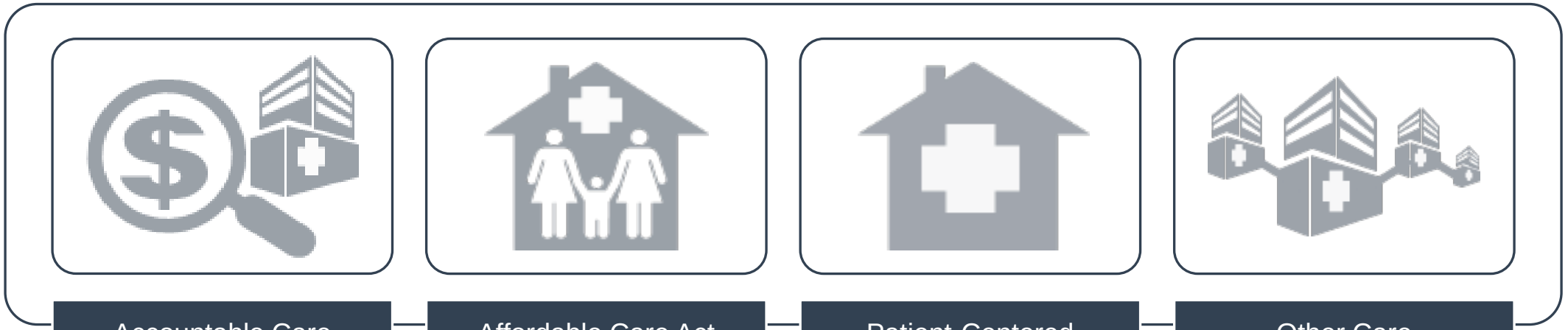
D.3. Medicaid Managed Care Program: SMI Population

- Vermont does not specifically preclude individuals with SMI from enrolling in its PCCM, but dual eligibles are excluded. Therefore, the SMI population is split between FFS and the PCCM.
- As of June 2022, *OPEN MINDS* estimates that 11% of the SMI population is enrolled in FFS, and 89% is enrolled in the state's PCCM.
- Individuals with SMI are eligible to receive Community Rehabilitation and Treatment waiver program services.

D.3. Medicaid Managed Care Program: Pharmacy Benefit

Vermont Managed Care Program Pharmacy Benefit & Utilization Restrictions	
State Uses Pharmacy Benefit Manager	Yes, Change Healthcare
Responsible For Financing General Pharmacy Benefit	Medicaid FFS
Responsible For Financing Mental Health Pharmacy Benefit	Medicaid FFS
State Uses A Preferred Drug List (PDL) For General Pharmacy	Yes
State Uses A PDL For Mental Health Drugs	Yes, anxiolytics, anticonvulsants, antidepressants, mood stabilizers, and antipsychotics are included in the general pharmacy PDL.
State Uses A PDL For Addiction Treatment Drugs	Yes, smoking cessation and opiate cessation drugs are included in the general pharmacy PDL.
Coverage Of Antipsychotic Injectable Medications	Antipsychotic injectable medications are covered as a pharmacy benefit.
Utilization Restrictions For Mental Health Or Addiction Treatment Drugs	• Mental health and addiction treatment drugs are subject to diagnostic criteria, age restrictions, quantity limits, daily dosage limits, and medication duration limits. • Prior authorization is required for all non-preferred drugs. • Individuals must have a documented side effect, allergy, or treatment failure of two or more preferred mental health drugs before a non-preferred drug will be administered.
State Has A Pharmacy Lock-In Program Or Other Restriction Program	The state operates the Team Care program to prevent fraud, waste, or misuse of medical services. Individuals enrolled in the Team Care Program are restricted to one PCP and one pharmacy.

D.4. Medicaid Program: Care Coordination Initiatives



Accountable Care Organization (ACO) Program	Affordable Care Act Health Home	Patient-Centered Medical Home (PCMH)	Other Care Coordination Initiative
The state Medicaid program participates in the Vermont all-payer ACO program.	The state has health homes for individuals with opioid use related addiction disorder.	The state has a multi-payer PCMH program through the Blueprint for Health program.	None

D.4. Medicaid Program: All-Payer ACO Model

- The 2017 extension of the state's section 1115 Global Commitment to Health demonstration waiver includes authorization for the Medicaid program to enter into ACO arrangements that align with the Vermont all-payer ACO model.
  - The Vermont all-payer ACO model stems from an agreement between the state and the federal government to limit the rate of growth for per capita health care spending to 3.5% in the state.
  - The state aims to have 70% of the state population attributed to an ACO by 2022. The state estimates that 42% of the state's population was attributed to an ACO during Performance Year 3 (2020).
- The baseline year of the model was 2017, and the first performance period began in January 2018 and will run for five years.
- One ACO—OneCare Vermont—participates in the all-payer model.
  - The OneCare ACO contract was awarded a one year term, with the potential for four one-year extensions. The state and OneCare filed one-year extension for 2019, and are in the process of negotiating a third one-year extension for 2020. In 2021, OneCare Vermont began negotiations for a five year extension.
- In Performance period 0 the ACO had approximately 29,000 attributed members, in performance year 1 the ACO had approximately 113,000 attributed members and Performance year 3 attributed members are projected to be 188,000.
  - In November 2021, the state reported nearly 288,000 total members.
- The Medicaid component of the all-payer model is The Vermont Medicaid Next Generation ACO (VMNG), which is aligned with the CMS Medicare Next Generation ACO program. The model has both upside and downside risk for the ACO, and part of the payment is based on quality.
  - One commercial payer, Blue Cross Blue Shield of Vermont, and one self-insured plan, University of Vermont Medical Center participate in the all-payer model.
- The program initially had an end date planned for December 31, 2022, but it has been extended through the end of 2023. It is likely to continue through 2024, with plans for a new model to start in 2025.

D.4. Medicaid Program: All-Payer ACO Model

All Payer ACO Model Overview			
	Medicaid	**Medicare**	**Commercial**
Attributed Members (PY4 - 2021)	111,335	62,392	68,834
Eligible Populations	All Vermont Medicaid enrollees except: • Dual eligibles • Enrollees with limited benefits • Enrollees with evidence of third party coverage	All Vermont Medicare FFS enrollees	• Fully insured beneficiaries • Members of self-insured health plans • Medicare Advantage plans Excludes: • Federal employee and military plans • Members of health plans without a Certificate of Authority from Vermont's Department of Financial Regulation
Progress Towards Achieving Attributed Member Scale Targets	N/A	Target: 75%	Target: 50%
	N/A	Actual: 47%	Actual: 30%
	N/A	Difference: (-28%)	Difference: (-20%)
Payment Mechanism from Payer to ACO	All-inclusive population-based payment (AIPBP) for eligible participants – such as hospitals – and FFS for non-eligible participants	AIPBP for eligible participants – such as hospitals – and FFS for non-eligible participants	BlueCross BlueShield of Vermont delivers services FFS
Risk Arrangement	Two-sided risk arrangement, no minimum savings or loss. 100% share with 3% Total Cost of Care (TCOC) risk corridor. No truncation, no payer-provided reinsurance, and no risk adjustments.	Two-sided risk arrangement, no minimum savings or loss. 80% share with 5% TCOC risk corridor. No payer provided reinsurance and no risk-adjustments.	Two-sided risk arrangement, no minimum savings or loss rate. 50% share with 6% TCOC risk corridor. No payer-provided reinsurance and no risk-adjustment.

D.4. Medicaid Program: Medicaid Next Generation ACO

Vermont Medicaid Next Generation ACO Program Characteristics	
Eligible Population	• All full-benefit, non-dual eligible Medicaid beneficiaries who are without other health insurance and who had at least one month of Medicaid enrollment in either of the two preceding fiscal years • As of June 2020, there were approximately 103,548 attributed individuals
Attribution Model	Prospectively attributed based on the physician practice from which the member received the preponderance of qualified services during the two-year attribution period
Geographic Service Area	13 communities.
Care Delivery Model	• OneCare Vermont is the participating ACO, with its network of four hospital systems and other provider organizations, including FQHCs, independent practices, and designated agencies

Payment Model	• Actuarially determined PMPM fee based on Medicaid eligibility group
	  • Two-thirds of the PMPM fee is a fixed prospective payment that the ACO pays to hospitals and hospital-owned practices; The remaining third of the PMPM fee is for estimated FFS payments made by the ACO to other provider organizations.
	• Additional PMPMs
	  • $6.50 PMPM administration fee that the ACO retains
	  • $2.50 PMPM care management fee that the ACO passes through to provider organizations
	• The ACO is at-risk for costs up to 3% above the expected total cost of care (TCOC). The ACO retains savings up to 3% below the expected TCOC.

Practice Performance & Improvement	• There is a quality withhold of 1.5% that OneCare can pay out to its members if it meets quality thresholds

D.4. Medicaid Program: Medicaid Next Generation ACO

Services Included In ACO Total Cost Of Care
1. Inpatient and outpatient services
2. Specialty and primary care physician services
3. Nurse practitioner services
4. Skilled nursing services
5. Ambulatory surgical center services
6. FQHC and Rural Health Clinic services
7. Home health services
8. Hospice services
9. Physical, occupational, and speech therapy
10. Midwife services
11. Chiropractic services, audiology, and podiatry
12. Optometrist and optician services
13. Independent laboratory services
14. Ambulance transport
15. Durable medical equipment, medical supplies, prosthetics, and orthotics
16. Dialysis facility services

Services Excluded From ACO Total Cost Of Care
1. Pharmacy
2. Nursing facility*
3. Dental care
4. Non-emergency transportation
5. Mental health and substance abuse services provided by Department of Mental Health Designated Agencies and Specialized Service Agencies
6. Home- and community-based services
7. Enhanced residential care
8. Personal care services
9. Targeted case management
10. State psychiatric hospital services
11. Involuntary inpatient psychiatric stays
12. Services administered and paid for by the Department of Disabilities, Aging, and Independent living
13. Smoking cessation services

D.4. Medicaid Program: Medicaid Next Generation ACO Locations & Quality Measures

ACO Quality Measures	
1.	Follow up after emergency department discharge for addiction disorder and/or mental health treatment
2.	30-day follow up after emergency department discharge for addiction disorder and/or mental health treatment
3.	Child and Adolescent Well-Care Visits
4.	Developmental Screening in the first three years of life.
5.	All-cause unplanned admission for individuals with multiple chronic conditions
6.	Tobacco use assessment and cessation
7.	Diabetes blood sugar control
8.	Hypertension control
9.	Initiation and engagement of addiction disorder treatment
10.	Screening for clinical depression and follow-up plan
11.	Seven-day follow up after hospitalization for mental illness
12.	CAHPS Patient Experience

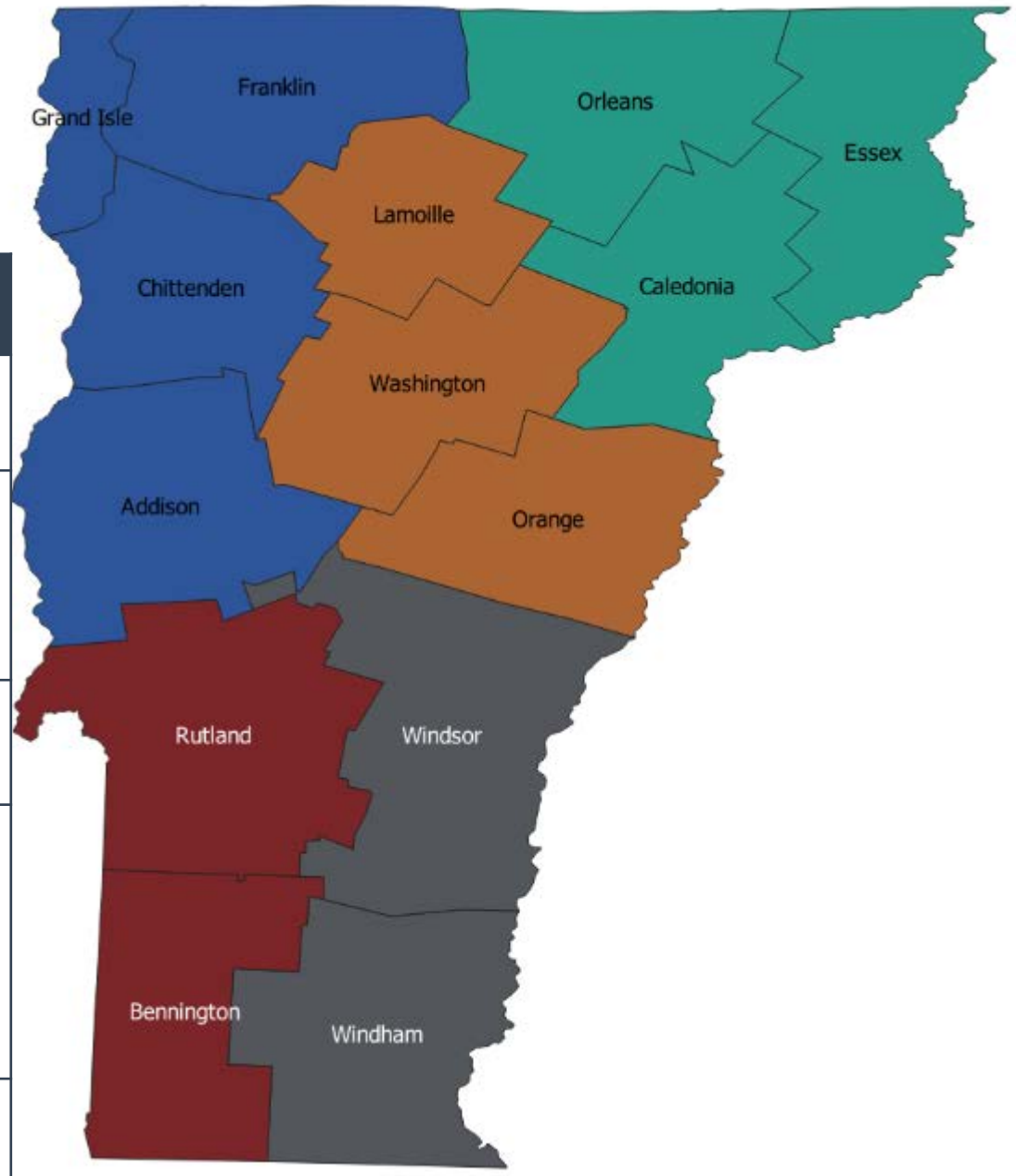
ACO Service Areas	
1.	Bennington
2.	Berlin
3.	Brattleboro
4.	Burlington
5.	Lebanon
6.	Middlebury
7.	Newport
8.	Randolph
9.	Rutland
10.	Springfield
11.	St. Albans
12.	St. Johnsbury
13.	Windsor

D.4. Medicaid Program: Opioid Health Homes

VT Health Homes For Beneficiaries Receiving Medication Assisted Therapy For Opioid Addiction	
Target Population	• Individuals receiving medication assisted therapy (MAT) for the chronic condition of opioid addiction
Enrollment Model	Individuals are automatically enrolled, but may opt-out
Geographic Service Area	Statewide, with at least one hub facility and a network of spoke facilities in each of six service areas
Care Delivery Model	• Provide the six core health home functions and medication administration through a “hub and spoke” system • Hub facilities provide methadone and buprenorphine for clinically complex health care consumers and are available to provide consultation to the spoke facilities. • Spoke facilities provide buprenorphine to less clinically complex health care consumers. • Each health care consumer undergoing MAT has a clinical professional-led medical home and Community Health Team, a single MAT prescriber, a pharmacy home, and access to hub or spoke health home nurses and clinical professionals.
Payment Model	• Hub payment: DVHA pays monthly $493 bundled rate for both MAT and health home services for individuals who receive at least one treatment service and one health home service in that month. • Spoke payment: DVHA pays $163.75 per consumer per month based on the average monthly number of unique health care consumers for which Medicaid paid a buprenorphine pharmacy claim for during the most recent 3-month period.
Practice Performance & Improvement	• Hospital admissions and discharges, emergency room visits, skilled nursing home admissions, advanced imaging, adult BMI, and screenings for clinical depression, tobacco use, and cervical cancer • Cost comparison using pre- and post-implementation data for the target population, case load growth, Medicaid enrollment, and medication assisted treatment.

D.4. Medicaid Program: Opioid Health Homes Service Areas

Map Key	Hub Facility	Counties Served
	BAART Behavioral Health Services, Northeast Kingdom Human Services	Caledonia, Orleans, Essex
	Central Vermont Addiction Medicine, Lamoille Health Partners, Treatment Associates, Inc, Clara Martin Center, Valley Vista, BAART Programs , Central Vermont Substance Abuse Services, Washington County Youth Services Bureau	Lamoille, Orange, Washington
	Brattleboro Retreat, CTC Programs, Health Care & Rehabilitation Services of Vermont, Clara Martin Center	Windham and Windsor
	Howard Center, BAART Behavioral Health Services, Counseling Service of Addison County, Valley Vista – Women's Program, Centerpoint Adolescent Treatment Services, Lund, Riverstone Counseling, UVMMC Day One, Northwestern Counseling & Support Services	Addison, Chittenden, Franklin, Grand Isle
	West Ridge Center for Addiction Recovery, United Counseling Service, Evergreen Substance Abuse Services, Recovery House	Rutland, Bennington



D.4. Medicaid Program: Patient-Centered Medical Home

Blueprint For Health Patient-Centered Medical Homes (PCMH) Characteristics	
Target Population	• All Medicaid beneficiaries
Enrollment Model	Individuals are attributed to the primary care practice with which they have had the majority of their primary care visits in the preceding 24 months
Geographic Service Area	Statewide
Care Delivery Model	• Primary care providers (PCPs) recognized as PCMHs by the National Committee for Quality Assurance (NCQA) • Provide team-based care, population health management, care management and support, and care coordination and transitions • PCPs are supported by local Community Health Teams (CHT) that provide supplemental social, economic, and medical services. • There are 137 participating practices
Payment Model	• PCPs receive a $3.00 per member per month (PMPM) base payment for maintaining NCQA accreditation and participating in the Unified Community Collaborative for strengthening community health infrastructure. • PCPs may also receive performance-based payments of up to $0.25 PMPM for utilization value performance, and up to $0.25 PMPM for quality performance. • These payments are in addition to any PCCM payments that a provider organization may receive. • CHTs are funded by participating payer organizations based on market share of claims-attributed health care consumers.
Practice Performance & Improvement	• Quality measures include adolescent well-care visits, development screening in the first three years of life, diabetes control, and rate of hospitalization for ambulatory care sensitive conditions • The Total Resource Utilization Index (TRUI) is the utilization performance measure

D.5. Medicaid Program: Demonstration & Care Management Waivers

Waiver Title	Waiver Type	Enrollment Cap	Effective Date	Expiration Date
Vermont Global Commitment to Health	1115	None	10/01/2005	12/31/2028

- The Global Commitment to Health section 1115 demonstration waiver designates the Department of Vermont Health Access (DVHA) as the managed care entity for the Vermont Medicaid program.
- Savings generated through the waiver can be invested to expand eligibility, to fund public health programs, and to enter into joint public-private health care initiative programs.
- LTSS and home- and community-based services (HCBS) are included in the Global Commitment to Health waiver.
  - HCBS and LTSS are delivered FFS.
  - The state breaks HCBS service delivery into four programs. See the next slide.
  - At this time, Vermont Medicaid does not utilize a waitlist for individuals with high level of needs. For individuals in the Choices for Care program with a moderate level of need, the state may place individuals on the waitlist if the state follows the special provision to ensuring these individuals receive care.
- The waiver was most recently approved for a five-year period beginning in January 2017 and ending in December 2021. This approval included a new authorization to enter into ACO arrangements that align in design with those of other health care payers in the Vermont all-payer ACO Model
  - A September 2019 amendment allows the state to provide residential treatment for addiction disorder treatment in an IMD.
  - A December 2019 detailed the state's SMI/SED Demonstration Implementation Plan.
  - A June 2021 waiver renewal requested the approval to include: coverage for incarcerated individuals, SUD benefits for low- and moderate-income individuals, residential mental health coverage, a permanent supportive housing pilot, workforce development, participation in the health information exchange, and deployment of an electronic patient engagement platform. This was approved in October 2022.

D.5. Medicaid Program Demonstration & Care Management Waivers: Global Commitment To Health HCBS Programs

Global Commitment To Health HCBS Programs	
Program name	**Services**
Choices for Care	Provides long-term care and HCBS to persons age 65 and over and persons with physical disabilities age 18 and over.
Community Rehabilitation and Treatment (CRT)	Provides clinical interventions and HCBS to individuals over age 18 diagnosed with a severe, persistent mental illness that has not responded to less intensive treatment and has resulted in significant functional disability.
Enhanced Family Treatment (EFT) (Also known as the Children's Mental Health Waiver and Mental Health Under 22)	Provides HCBS to persons under age 22 who have a primary diagnosis of mental illness (other than autism or conduct disorder) and would otherwise require treatment in an inpatient psychiatric facility.
Traumatic Brain Injury (TBI)	Provides HCBS to individuals age 16 and older diagnosed with a recent moderate to severe brain injury who demonstrate a potential for independent living and vocational activities.

D.5. Medicaid Program Demonstration & Care Management Waivers: Community Rehabilitation & Treatment Program

	Community Rehabilitation & Treatment Program Model Characteristics
Target Population	• Eligible Medicaid beneficiaries over age 18 who have been diagnosed with a severe, persistent mental illness, have a demonstrated need for substantial inpatient or residential treatment supports, and have a documented significant functional disability as a result of mental illness. • The waiver authorizes CRT services for persons not otherwise eligible for Medicaid with incomes between 133% and 185% of the FPL.
Enrollment Model	• Individuals opt-in to the CRT program and may disenroll at any time. • After referred persons are evaluated by a clinical professional for diagnosis of an SMI, their enrollment is determined by a DA screening committee and program director
Geographic Service Area	Statewide
Care Delivery Model	• The CRT program is managed by the Vermont Department of Mental Health (DMH) and its Designated Agencies (DA). For more information on Vermont's DAs, see Section F.4. • Vermont has also designated Pathways Vermont in Burlington as a Specialized Service Agency (SSA) for the CRT program. CRT program services are generally provided by DAs or the SSA, but may be subcontracted if clinically necessary and unavailable at the DA/SSA. • Services include clinical interventions, medication management, crisis services, community supports, service coordination, individualized plans of care, psychoeducation, employment services, housing supports, and recovery education.
Payment Model	• DMH acts as a PIHP and receives monthly capitation payments from DVHA • The DAs receive a monthly case rate from DMH based on a six-month look back and specialized payments for high need individuals. • Clinical services are paid to provider organizations by DMH on an FFS basis. • State general funds are allocated monthly to the DAs to finance services for participants not covered under the waiver, as well as services not billable to Medicaid.

D.5. Medicaid Program: Demonstration & Care Management Waivers: SUD Demonstration and SMI/SED Demonstration

- Vermont has had long-standing authority under the Global Commitment to Health waiver to provide mental health and addiction treatment services in institutions for mental disease.
  - In 2016 CMS required that the state to develop a phase-out plan of their current IMD use starting in 2021 or transition to the same criteria used by other states to allow services in IMDs.
- To allow the state to continue the use of IMDs for addiction disorder, CMS approved Vermont's substance use disorder amendment with an effective date of July 1, 2018. Under the amendment Vermont will also:
  - Develop a case rate rather a per day per diem for residential services
  - Certify residential treatment facilities using the ASAM levels of care
  - Develop a centralized triage, intake, and call center for persons seeking OUD/SUD services
  - Improve discharge planning and transitions between care settings
- Based on new guidance issued by CMS in November 2018, Vermont requested an amendment to the Global Commitment to Health Waiver to allow the state to provide care for mental health in IMDs.
  - Under the guidance released by CMS, states must keep the statewide average length of stay to 30 days or less. Vermont is requesting a statewide average length of stay that is much longer.
- In December 2019, CMS approved an amendment to begin the early stages of a SMI/SED Demonstration. The state's current milestones are listed on the next slide.

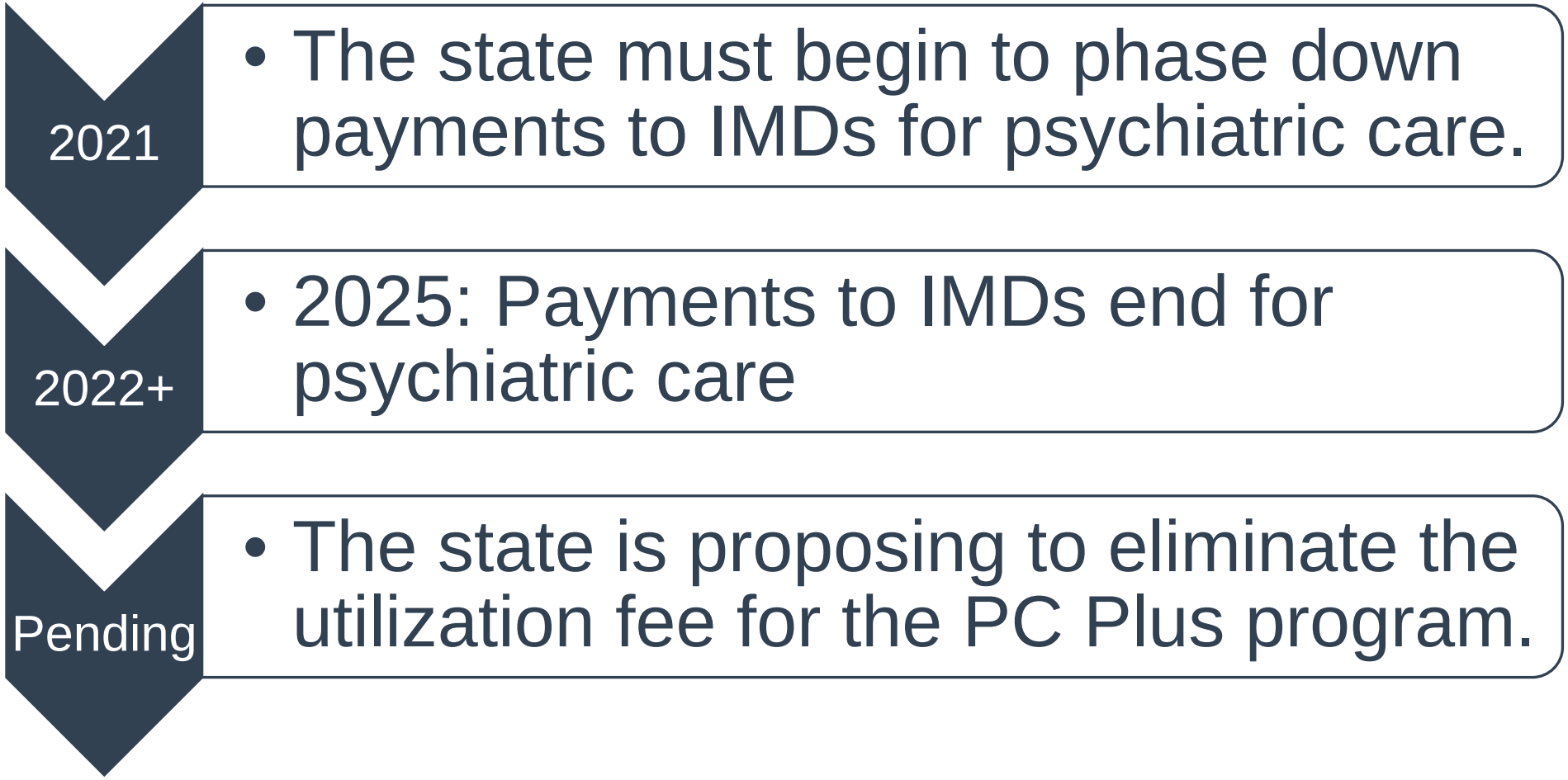
D.5. Medicaid Program Demonstration & Care Management Waivers: SMI/SED Demonstration Implementation Plan

SMI/SED Demonstration Implementation Plan Milestones	
Milestone	**Description**
Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.	Ensures that beneficiaries receive high quality care in hospitals and residential settings.
Improving Care Coordination and Transitioning to Community-Based care.	Ensures the services needed to transition to and be successful in community-based mental health care partnerships with hospitals, residential providers, and community-based providers.
Increasing Access to Continuum of Care, including Crisis Stabilization Services.	Ensures Individuals with SMI and SED will have access to a continuum of care.
Earlier Identification and Engagement in Treatment, Including through Increased Integration	Ensures earlier identification of mental health conditions and focused efforts to engage individuals into treatment sooner.
Financing Plan	State Efforts to increase access to community-based mental health providers statewide.
Health IT Plans	The state must submit a plan that describes the states ability to leverage health, IT and advanced health information exchanges in support of the demonstration.

D.5. Medicaid Program: Section 1915 (c) HCBS Waivers

- The state does not have any 1915 (c) HCBS waivers. All HCBS is provided through the state's 1115 waiver, Global Commitment to Health.

D.6. Medicaid Program New Initiatives: Timeline



E. Dual Eligible Financing & Service Delivery System

E.1. Dual Eligible Medicaid Financing & Service Delivery System

Dual Eligible* Medicaid System Characteristics	
Characteristics	**Medicaid Fee-For-Service (FFS)**
Enrollment (June 2022)	22,599
Estimated SMI Enrollment	7,2321
Management	Department of Vermont Health Access (DVHA)
Payment Model	Non-risk capitated rate (state receives a per member per month capitation for enrollees that is reconciled quarterly)
Geographic Service Area	Statewide

Total Dual Eligible Enrollment: 22,599 | Total Dual Eligible Enrollment With SMI: 7,231

*Unless otherwise noted, the term *dual eligibles* in this section refers to Medicare enrollees with full Medicaid benefits.

E.2. Largest Dual Eligible Health Plans By Estimated SMI Enrollment

- Vermont does not have any PACE or Medicare Advantage D-SNP plans. All individuals receive services through the Medicare FFS delivery system.

E.3. Dual Eligible Medicaid Financing & Delivery System: Overview

- Dual eligible enrollment as of June 2022 was 22,599.
- Medicare covers most acute services (which may include psychiatric care), while Medicaid, the payer of last resort, covers LTSS and non-physician behavioral health services.
- Since dual eligible beneficiaries are excluded from enrolling in primary care case management (PCCM), dual eligible beneficiaries receive Medicaid services through the FFS system.

E.4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives

- Vermont does not have a dual eligible demonstration with the Centers for Medicare and Medicaid Services (CMS).

F. Long-Term Services & Supports Financing & Service Delivery System

F.1. LTSS Financing & Service Delivery System

Vermont does not currently operate a MLTSS program, instead all beneficiaries receive care through the FFS or PCCM program.

LTSS Medicaid System Characteristics	
Characteristics	**Medicaid Managed Care**
Enrollment (December 2021)	N/A
Estimated SMI Enrollment	N/A
Management	N/A
Payment Model	N/A
Geographic Service Area	N/A

Total LTSS Enrollment: N/A| Total LTSS Enrollment With SMI: N/A

F.1. Medicaid LTSS Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or Managed Care	Mandatory PCCM Enrollment
Disabled adults			X
Disabled children			X
Blind individuals			X
Aged individuals			X
Dual eligibles	X		
Individuals with I/DD	X		
Individuals residing in nursing homes	X		
Individuals residing in ICF/IDD	X		
Other HCBS Recipients	X		
Other populations	• Individuals enrolled in home- and community-based services waivers • Subsidized adoption children		

F.2. LTSS Medicaid Financing & Delivery System: Overview

- Vermont does not currently operate a MLTSS program, instead all beneficiaries receive care through the FFS or PCCM program.

F.3. Medicaid LTSS Program: Health Benefits

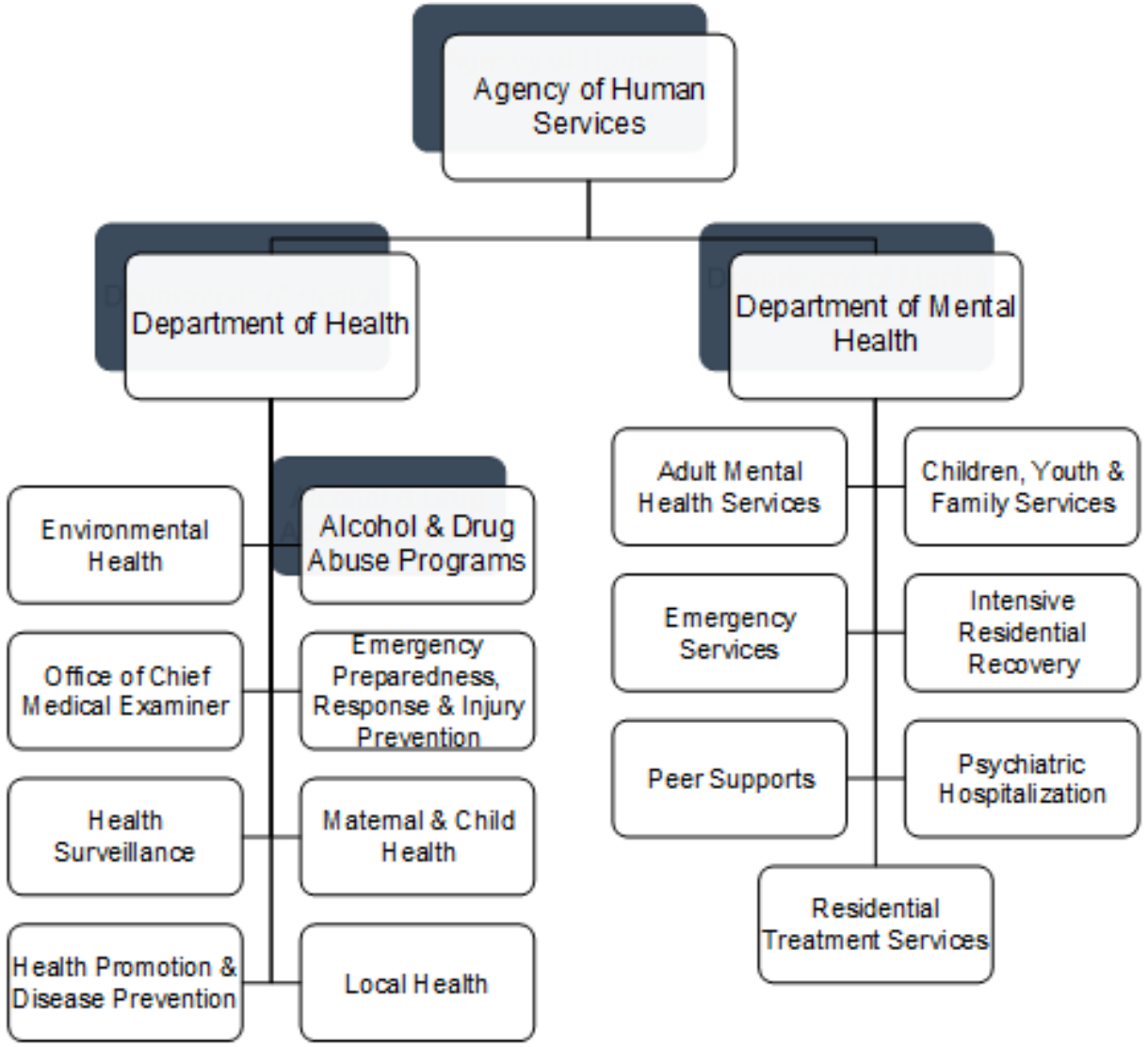
- Vermont does not currently operate a MLTSS program, instead all beneficiaries receive care through the FFS or PCCM program.

F.4. LTSS Medicaid Financing & Delivery System: New Initiatives

- Vermont has no pending initiatives that will influence the finance or delivery systems of the LTSS population.

G. State Behavioral Health Administration & Finance System

G.1. Agency Of Human Services: Organization Chart



G.1. Agency Of Human Services: Key Leadership

Name	Position	Department	Email
Jenney Samuelson	Secretary	Agency of Human Services	Jenny.samuelson@vermont.gov
Mark Levine, M.D.	Commissioner	Department of Health	mark.levine@vermont.gov
Emily Hawes	Commissioner	Department of Mental Health (DMH)	emily.hawes@vermont.gov
Frank Reed	Director of Mental Health Services	DMH	frank.reed@vermont.gov.
Patricia Singer	Director	DMH Adult Services Utilization	patricia.singer@vermont.gov
Kelly Dougherty	Deputy Health Commissioner	Department of Health	kelly.dougherty@vermont.gov
Alison Krompf	Deputy Commissioner	Department of Mental Health	alison.krompf@vermont.gov

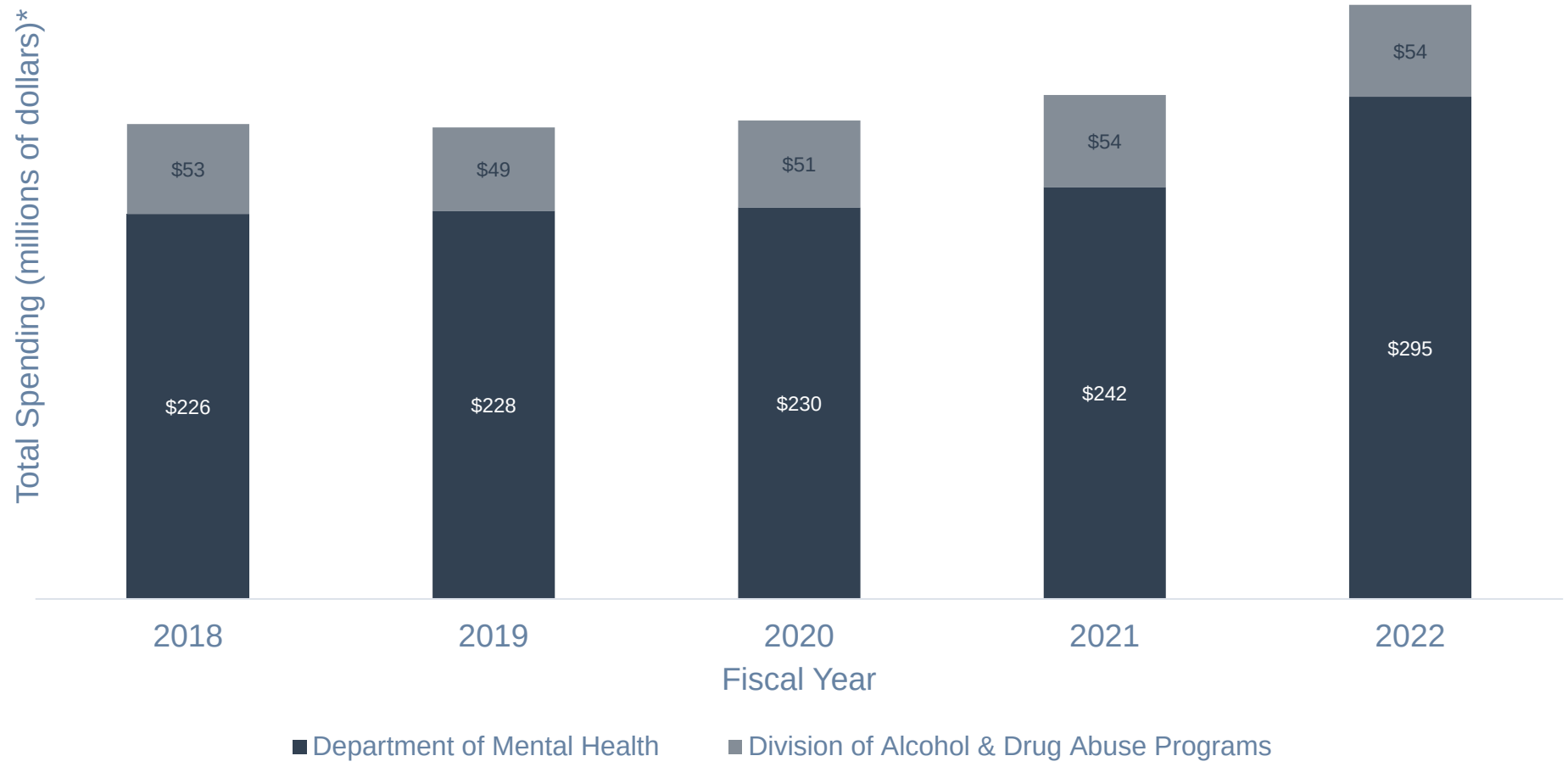
G.2. Department Of Mental Health: Spending

Budget Item	SFY 2022 Requested Budget	Percent Of Budget
Children's Programs	$115,404,565	39%
Community Rehabilitation and Treatment	$69,999,174	24%
Other Services	$38,496,856	13%
Vermont Psychiatric Care Hospital	$23,587,252	8%
Inpatient Mental Health	$18,929,423	6%
Crisis/Emergency services	$12,874,656	4%
Outpatient Services	$9,051,728	3%
Consumer Support Program	$3,233,521	1%
Homeless services	$1,748,324	1%
Respite Care	$1,601,005	1%
Budget Total: $294,926,504		

G.2. Division Of Alcohol & Drug Abuse: Spending

Budget Item	SFY 2022 Budget Request	Percent Of Budget
Alcohol and Drug Abuse Program	$54,392,705	100%
Budget Total: $54,392,705		

G.2. Agency Of Human Services: Spending Over Time



*All years budget requested.

G.3. State Psychiatric Institutions

State Psychiatric Institutions		
Institution	**Location**	**Beds**
Vermont Psychiatric Care Hospital	Berlin	25

G.4. Behavioral Health Safety-Net Delivery System

- The Department of Mental Health (DMH) contracts with one private, non-profit provider organization—called a Designated Agency—in each the state's 10 geographic regions to provide mental health services to the uninsured population.
- The Department of Mental Health also designates two organizations as Specialized Service Agencies (SSAs) to serve distinctive populations in more than one area of the state.
  - The Northeastern Family Institute provides specialized services to children, youth, and families.
  - Pathways Vermont provides adult outpatient and community rehabilitation and treatment services.
- Revenue streams for the Designated Agencies and SSAs include federal and state funding, private pay, public and third-party insurance, and charitable donations.
- Services available through the Designated Agencies and SSAs include adult outpatient services, community rehabilitation and treatment, children and families services, emergency services, and advocacy and peer services.
- Individuals with SMI who have income between 133% and 185% of the FPL may qualify for services through the Community Rehabilitation and Treatment program.
- The Division of Alcohol and Drug Abuse Programs contracts with a network of provider organizations called Preferred Provider Organizations (PPOs) to deliver addiction disorder treatment services to the uninsured population throughout the state.
- Seven of the Designated Agencies are also PPOs. Designated Agency service areas can be found on the following slide.

G.4. Behavioral Health Safety-Net Delivery System: Designated Agencies

Map Key	Designated Agency	Counties Served
	Clara Martin Center*	Orange
	Counseling Service of Addison County*	Addison
	Healthcare and Rehabilitation Services of Southeastern Vermont*	Windham and Windsor
	Howard Center*	Chittenden
	Lamoille County Mental Health	Lamoille
	Northeast Kingdom Human Services*	Caledonia, Essex, and Orleans
	Northwestern Counseling and Support Services*	Franklin and Grand Isle
	Rutland Mental Health Services, Inc.	Rutland
	United Counseling Service, Inc.*	Bennington
	Washington County Mental Health Services, Inc.	Washington

* Indicates that the agency is also a Preferred Provider Organization for addiction treatment services.

H. Appendices

H.1. *OPEN MINDS* Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Commercial	3.6% of the commercially insured population over age 18	Substance Abuse and Mental Health Services Administration. (2022, January). Results from the 2020 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved October 2022 from https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip
Medicaid	35.9% of adults age 18 to 64, not dually eligible for Medicare, who qualify for Medicaid based on a disability	Medicaid and CHIP Payment and Access Commission. (2022, June). Report to Congress on Medicaid and Chip. Retrieved October 2022 from https://www.macpac.gov/publication/june-2022-report-to-congress-on-medicaid-and-chip/
	8.1% of persons in the Medicaid expansion population	Substance Abuse and Mental Health Services Administration. (2022, January). Results from the 2020 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved October 2022 from https://www.samhsa.gov/data/sites/default/files/reports/rpt35323/NSDUHDetailedTabs2020v25/NSDUHDetailedTabs2020v25/2020NSDUHDetTabs01112022.zip
Medicare	16% of persons in the Medicare population, not dually eligible for Medicaid	Centers for Medicare and Medicaid Services. (2021). Medicare-Medicaid Coordination Office Report to Congress. Retrieved October 2022 from https://www.cms.gov/files/document/reporttocongressmmco.pdf

H.1. *OPEN MINDS* Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Medicare-Medicaid Dual Eligibility	25% of persons in the Medicare population dually eligible for partial Medicaid benefits	Congressional Budget Office. (2013, June). Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spends, and Evolving Policies. Retrieved October 2022 from https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44308_DualEligibles2.pdf
	32% of persons in the Medicare population dually eligible for full Medicaid benefits	U.S. Department of Health and Human Services. (2019, May 9). Analysis of Pathways to Dual Eligible Status: Final Report. Retrieved October 2022 from https://aspe.hhs.gov/basic-report/analysis-pathways-dual-eligible-status-final-report
Other Public	8.3% of persons served by the Veterans Administration health care system or the TRICARE military health system	Military Health Systems. (2020, August 7). Examination of Mental Health Accession Screening: Predictive Value of Current Measures and Report Processes. Retrieved October 2022 from https://www.health.mil/Reference-Center/Presentations/2019/11/04/Examination-of-Mental-Health-Accession-Screening-Update
No Health Care Insurance	6.2% of uninsured persons over age 18	Substance Abuse and Mental Health Services Administration. (2019, August). Results from the 2018 National Survey on Drug Use and Health: Mental Health Detailed Tables. Retrieved December 16, 2019 from https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2018R2/NSDUHDetailedTabs2018.pdf

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Alternative Benefit Plan	ABP	State designed benefit package for the Medicaid expansion population (childless adults with income below 138% of the FPL). The benefit package must include the ten essential benefits as laid out in the PPACA. The Medicaid expansion population deemed medically frail (including those with SMI) are exempt from receiving benefits through the ABP.
Accountable Care Organizations	ACO	ACOs are groups of provider organizations—such as physicians and hospital systems—that form an agreement to coordinate care for a set group of individuals. If the ACO delivers high quality care—measured through performance metrics—and lowers the cost of providing care against a baseline, then the organization receives a portion of the savings generated. ACOs can exist alongside all payment structures (fee-for-service and managed care delivery systems) and payers (Medicare, Medicaid, commercial).
Administrative Services Organization	ASO	An arrangement in which an organization hires a third party to deliver administrative services to the organization, such as claims processing and billing. The ASO is not at-risk.
Capitation		A set amount of money paid per enrollee per month to a health care entity to cover the cost of health care services. Capitation can cover the cost of all health care services or subset of services, such as care coordination or home- and community-based services.
Carve-out		A carve-out is a Medicaid managed care financing model where some portion of Medicaid benefits—dental services, pharmacy services, behavioral health services, etc.—are separately managed and/or financed. Carve-out services can be financed on an at-risk basis by another organization or retained by the state Medicaid agency on a fee-for-service basis.
Certified Community Behavioral Health Clinic	CCBHC	Behavioral health clinics specially certified in a demonstration established by section 223 of the Protecting Access to Medicare Act of 2014. The clinics are designed to provide community-based mental health and addiction treatment services, to advance the integration of behavioral health with physical health care, and to provide care coordination across the full spectrum of health services.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Community Mental Health Center	CMHC	An organization that can demonstrate that it is actively providing all services in section 1913(c)(I) of the Public Health Services Act, including a.) Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC's mental health service area who have been discharged from inpatient treatment at a mental health facility; b.) 24 hour-a-day emergency care services; c.) Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and d.) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission. Additionally, the organization must meet the specifications for the state where it provides services.
Dual Eligible		An individual who is eligible for Medicare (Part A and B) and Medicaid. Medicare serves as the individual's primary insurance, and Medicaid acts as a supplement. Dual eligibles are sometimes referred to as Medicare-Medicaid enrollees (MMEs).
Federal Poverty Level	FPL	The U.S. Department of Health and Human Services sets a standard level of income that is used to determine eligibility for services and benefits, including Medicaid. In 2022, the FPL is $13,590 for an individual and $27,750 for a family of four.
Fee-For-Service	FFS	A system where the payer, in this case Medicaid, contracts directly with provider organizations and pays for providing care on a unit by unit basis. Health plans may also reimburse provider organizations on a FFS basis meaning they pay for each unit of care or test.
Health Home		A "whole person" care coordination model that specifically targets populations with chronic conditions including those with SMI. Health homes provide six essential functions: 1.) Comprehensive care management; 2.) Care coordination and health promotion; 3.) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; 4.) Individual and family support; 5.) Referral to community and social support services; 6.) Use of health information technology to link services. Health homes were originally developed as a Medicaid program, but have been adopted by other payers. For a state to have an official health home program they must have an approved state plan amendment.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Health Insurance Marketplace	HIM	Created by the PPACA, the health insurance marketplace is an online platform where individuals and small businesses can purchase health insurance. The federal government subsidizes coverage purchased on the marketplace through premium tax credits for individuals with income up to 400% of the FPL.
Home- & Community-Based Services	HCBS	Long-term services and supports provided in the home or community in order to avoid institutionalization. Traditionally provided through 1915(c) waivers, HCBS services are usually limited to specific populations and a specific number of people. HCBS services include skilled nursing care, personnel care services, assistance with activities of daily living, and custodial care.
Institutions For Mental Disease	IMD	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including addiction. Federal financial participation is available for Medicaid IMD services for individuals under the age of 21 and age 65 and over. In recent years, CMS has relaxed the rules prohibiting payments in IMDs for individuals age 21-64. Medicaid health plans may provide up to 15 days of IMD services per month in lieu of state plan services if medically appropriate, cost effective, and consented to by the individual. Additionally, states may be granted a 1115 waiver authority to allow individuals to receive addiction and mental health treatment in IMDs.
Long-Term Services & Supports	LTSS	Services provided in the home, community, or institutional setting to those who experience difficulty living independently and completing activities of daily living as a result of cognitive disabilities, physical impairments, disabling chronic conditions, and/or age.
Managed Care		A health care delivery and financing system designed to manage cost, utilization, and quality. In Medicaid, states generally implement managed care through contracts with health plans, which provide a limited set of benefits to enrollees through a capitated or per person per month (PMPM) rate. The health plans generally assumes full-risk for the cost of treatment, and therefore contracts with a network of provider organizations to provide care at the most efficient rate possible while still maintaining member health.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicaid		Medicaid is a joint federal-state program that provides health coverage to economically disadvantaged populations, such as low-income adults, children, and aged, blind, and disabled (ABD) individuals. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines. Financing is a shared responsibility of the federal government and the states.
Medicaid Waiver		Granted by CMS, waivers allow states to make temporary changes to their Medicaid program in order to test out new ways to deliver health coverage.
Medicaid Waiver Section 1115	1115 waiver	Known as research and demonstration waivers, states can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
Medicaid Waiver Section 1915(b)	1915(b) waiver	States can apply for waivers to provide services through managed care delivery systems, or otherwise limit an individual's choice of health plan or provider organization.
Medicaid Waiver Section 1915(c)	1915(c) waiver	States can apply for waivers to provide long-term care services in home- and community-based settings, rather than institutional settings.
Medical Home		A medical home is not a physical place, but a model for care coordination. Medical homes provide primary care services, care coordination, enhanced access to care, and care that is culturally and linguistically appropriate. Medical homes exist across multiple payers.
Medicare		Federal health insurance for individuals over the age of 65, individuals with certain disabilities, and individuals with end stage renal disease. Medicare covers most acute care services (which may include psychiatric care), but does not cover LTSS or non-physician behavioral health services.
Medicare Advantage	MA	Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicare Advantage Special Needs Plan	SNP	A special type of Medicare Advantage plan that is designed to provide targeted coordinated care to individuals who are a) institutionalized; b) dual eligible; and/or c) meet the severe chronic disabled conditions set forth by CMS. Plans emphasize improved care primarily through continuity of care and care coordination.
Medicare Part A		Hospital Insurance: Covers hospital, skilled nursing care, hospice, and home health care for most eligible individuals at no cost. Financed through payroll tax and deductibles, copayments are only charged if a stay becomes long-term.
Medicare Part B		Supplementary Medical Insurance: Covers most outpatient services, and consumers pay a premium based on income level.
Medicare Part C		Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.
Medicare Part D		Outpatient Prescription Drug Benefit: Private plans contract with Medicare to provide coverage for prescription drugs. Most consumers pay premiums based on their income.
Metropolitan Statistical Area	MSA	An urbanized area with a population of at least 50,000 plus adjacent territory that has a high degree of social and economic integration as measured by commuting ties.
Patient-Centered Medical Home	PCMH	See Medical Home.
Patient Protection & Affordable Care Act	PPACA or ACA	U.S. health care reform signed into law in 2010. The legislation regulates certain aspects of private and public health insurance programs and authorizes an individual mandate to secure essential health coverage, premium tax credits for the purchase of private health insurance, and increased insurance coverage of preexisting conditions. In 2012 the Supreme Court ruled that state participation is optional for provisions of the law expanding Medicaid coverage to adults ages 18 to 64 with incomes under 138% of the FPL. In 2017, Congress repealed the tax penalties associated with the individual mandate essentially ending the mandate.

H.2. Glossary Of Terms

Word	Abbreviation	Definition
Primary Care Case Management	PCCM	A health care delivery system model with limited utilization and cost control. Under the PCCM model, Medicaid enrollees choose a primary care physician who acts as a gatekeeper for more intensive services. The primary care physician generally receives a per person per month (PMPM) fee for care coordination, and is reimbursed fee-for-service for all medical services provided.
Program Of All Inclusive Care For The Elderly	PACE	PACE serves populations over the age of 55 who are eligible for skilled nursing home care by utilizing a comprehensive delivery system of social, medical, and long-term care services to keep enrollees in the community for as long as possible. PACE is an optional state Medicaid program, and may only be available in certain states, or regions within states.
Serious Mental Illness	SMI	A mental, behavioral, or emotional disorder that lasts for a sufficient duration of time and causes impairment of major life activities. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.
Supported Employment		Provides services and supports to help individuals with disabilities become employed in an integrated or competitive work environment, and retain that employment.
Supported Housing		Housing provided for as long as needed at little or no cost to individuals with mental illness, or other vulnerable populations who are homeless or at-risk for homelessness. Mental health and social services are offered to participants, but are not a condition for participation in the program. The goal is to allow individuals to live as self-sufficient, independent lives as possible.
Value-Based Reimbursement	VBR	Reimbursement model in which payers financially reward or penalize health care provider organizations for performance on quality and cost of care. VBR payment mechanisms include P4P; capitation; shared savings models; shared risk models; and payments based on clinically-defined episodes, called episodes of care or bundled payments.

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