State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 16
(1/1/2021 – 12/31/2021)

Quarterly Report for the period
January 1, 2021 – March 30, 2021

Submitted Via PMDA Portal on May 28, 2021

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I. Background and Introduction

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

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 eligiblefor 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 determinedpresumptively 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 authority for Vermont to receive federal Medicaid funding for Substance Use Disorder treatment services provided to Medicaid enrollees in Institutions for Mental Disease (IMDs).

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

As Vermont's Medicaid Single State Agency and under the Terms and Conditions of the Global Commitment to Health Waiver, AHS has entered into an Inter-Governmental Agreement (IGA) with the Department of Vermont Health Access (DVHA). The AHS/DVHA IGA functions similarly to a Medicaid Managed Care contract in that it delineates program requirements and responsibilities between AHS and DVHA and according to federal Medicaid Managed Care requirements found at 42 CFR §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 first quarterly report for waiver year 16, covering the period from January 1, 2021 through March 31, 2021 (QE032021).***

II. Outreach/Innovative Activities

i. Member and Provider Services

Key updates from QE032021:

- Non-Emergency Medical Transportation (NEMT) Updates.

The Member and Provider Services (MPS) Unit ensures members have access to appropriate health care 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 implementation of the enrollment, screening, and revalidation of providers in accordance with Title 42 Code of Federal Regulations (CFR) §455.410 and §455.450 requiring that all participating providers be screened upon initial enrollment and revalidation of enrollment.

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

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

member issues and needs.

NEMT Update

While NEMT-related numbers have not totally rebounded to match the pre-COVID levels of first quarter 2020, they have begun to steadily climb in the first quarter of 2021. Rides provided have reached a high of almost 19,000 per month in March (18,000 in February), as compared to 31,000 in March of 2020 (43,000 in February). As the number of rides has increased, so has the number of calls, DMV checks, and address checks sent to DVHA staff. The number of referrals received and processed by DVHA was much less than that of the same period in 2020, as the new contractual obligation of the Vermont Public Transportation Association (VPTA) handling all referrals up to 100 miles away from a member's home went into effect in January (the old mileage limit was 60 miles, resulting in more work for DVHA staff).

III. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE032021:

- The Customer Support Center received more than 59,862 calls in QE0321, down 41% from the previous year. Additionally, 6,448 calls were separately received from the payment line. This was a reduction of 32% from the QE0320 incoming call amount of 9,392.
- As of April 16, 2021, DVHA is currently supported by 107 Assisters (96 Certified Application Counselors, 7 Navigators, and 4 Brokers), with 5 Assisters in training, working in 50 organizations including hospitals, clinics, and community-based organizations.
- Increasing numbers of customers are using self-service functions. Self-serve applications comprised over half (53%) of all applications in QE0321. This is a 7% increase from QE0320. In addition, 42% of customers made recurring payments in QE0321. This is an increase of 6% from QE0320. Please note that the percent of recurring payments was previously reported as 59% for QE0320. Reevaluation of this figure found that 36% of customers made recurring payments in QE0320.

Enrollment

As of QE0321, more than 216,014 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 144,296 in Medicaid for Children and Adults (MCA) and 71,718 in Qualified Health Plans (QHPs), with the latter divided between 23,634 enrolled with VHC, 7,467 direct enrolled with their insurance carrier as individuals, and 40,617 enrolled with their small business employer.

Medicaid Renewals

For each month of the first quarter, and for the duration of the public health emergency, MCA redeterminations are processed only for cases that can be renewed ex parte. Cases that require an application have coverage extended; renewals will be rescheduled once the end date of the PHE is

known. The passive renewal success rate for the quarter averaged 51%.

1095 Tax Forms

1095B is an informational form that shows months of coverage for Medicaid members. 109,842 initial 1095B's were mailed to customers in January in advance of the deadline. For tax year 2020, the federal deadline was March. 1095B corrections began mailing on February 8, 2021. As of mid-April2021, 757 corrections have been sent.

Customer Support Center

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

The Customer Support Center received more than 59,862 calls in QE0321. January 2021 was especially busy, with follow up open enrollment and 1095 form calls. As of the end of QE0321, Maximus had 47 customer service representatives, down 43% from the 83 on staff at the end of QE0320. Maximus answered 92% of calls within 24 seconds in January 2021, 94% in February 2021, and 88% in March 2021. All three months exceeded the target of 75%.

Maximus is the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to DVHA-HAEEU for resolution and log service requests, which are escalated to the appropriate resolver group. This year has seen a decrease in the volume of calls and a slight decrease in the proportion of calls that were escalated. 9% of QE0321 calls were transferred to DVHA-HAEEU staff, down from 11% in QE0320. Just as importantly, DVHA strived to answer all calls that were transferred; 97% of transferred calls were answered in five minutes in QE0321, compared to 77% in QE0320.

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 by October 2016 and 85% by June 2017. In QE0316, fewer than 60% of VHC requests were completed within ten days. In QE0317, more than 90% of requests were completed within ten days. In QE0318 and again in QE0319, more than 95% of VHC requests were completed within ten days. QE0320 reached 96% and QE0321 was 91%.

System Performance

Throughout most of QE0321, the system continued to operate as expected. The system had 100% availability in the quarter. The average page load time for the quarter was less than two seconds (1.46) in each of the three months – which is within the two-second target.

In-Person Assistance

As of April 16, 2021, DVHA is currently supported by 107 Assisters (96 Certified Application Counselors, 7 Navigators, and 4 Brokers), with 5 Assisters in training, working in50 organizations including hospitals, clinics, and community-based organizations. Assister support is available in all of

Vermont's 14 counties to help Vermonters enroll in health coverage through Vermont's health insurance marketplace.

The program has seen increased Assister engagement in training participation. As Assisters return to more in-person work and with the addition of ARPA related changes, it is expected that the number of total Assisters will climb.

Outreach

DVHA continued to use advisory meetings media inquiries, social media, and other collaborative engagements with partners and stakeholders to notify Vermonters about the continued timeline of the programmatic changes related to the COVID-19 pandemic.

The Plan Comparison Tool, which helps customers estimate total costs of coverage based on family members' age, health, and income, was used in more than 11,870 sessions during the quarter, which isa slight increase from QE0320.

Self-Service

During QE0321, DVHA-HAEEU continued to promote self-service options for customers to pay their bills, report changes, and access tax documents and other forms. Self-service leads to an improved customer experience as Vermonters can log in at their convenience. It also has the benefit of using automation to reduce staffing expenses. Year-over-year comparisons show that more customers are using self-service functions, including both online accounts for health coverage applications and reported changes as well as the options of paying premiums through monthly recurring payments rather than one-time payments.

Self-serve applications comprised over half (53%) of all applications in QE0321. Additionally, more than 6,900 recurring payments were made per month. This is down 200per month compared to QE0320. Just over 63% of all electronic payments were recurring payments. This is a 4% increase from QE0320.

ii. Choices for Care and Traumatic Brain Injury Programs

DAIL

Choices for Care

DAIL has responded to the COVID-19 pandemic by continuing to support flexibility in the established Waiver. DAIL COVID-19 resources can be found online here: https://dail.vermont.gov/novel- coronavirus-information

Long Term Care Providers

DAIL continued to support Long Term Care providers during Q1by updating and providing access to the Guidance for Operations During COVID-19 Health Emergency. Resources for LTC providers can also be found here: https://dail.vermont.gov/novel-coronavirus-information/information-long-term-care-providers

Electronic Visit Verification (EVV) was implemented 1/1/2021.

Adult Day Services: Adult Day Centers were required to close on March 17, 2020 as a result of the State of Vermont declaration of emergency and Stay Home/Stay Safe order. DAIL continued to support providers and participants whose services have been disrupted. Adult Day Providers have submitted reopening plans with target dates in May and June.

Money Follows the Person (MFP)

The MFP grant has been re-authorized through (CY) 2024. We have been awarded funds forCY2021 operations. This award is funded to help transition fifty-three (53) Choices for Care participants from a SNF toa home-based setting. As part of the grant re-authorization, CMS has always relaxed the eligibility rules for the MFP program. A math model that we created for CMS projects that Vermont should be able to serve 50% more participants. We are currently negotiating for additional funds to cover the additional transitions. We expect to receive funding authorization for CY2022 to CY2024 as part of the CY2022 budget process. DAIL is completing the application process for a $5M Supplemental Grant Award. The purpose of the grant to build capacity and infrastructure for out LTSS system. Application is expected to be submitted by April 30,2021 and approval within 4 to 6 weeks.

Brain Injury Program: Current enrollment = 79 individuals, 4 individuals are in the process of enrolling.

Wait Lists

- There is currently no wait list for the High Needs Group.
- There continues to be provider wait lists for Moderate Needs Group, estimated at almost 700 people statewide. Because the eligibility criteria for Moderate Needs services is so broad, Vermont does not expect to eliminate the wait list. However, the state is piloting two separate acuity-based models for revising the wait list procedures from chronological to priority-based to serve applicants with the greatest needs first.
- There is currently no wait list for the TBI program.

iii. Developmental Disabilities Services Division

Key updates from QE032021:

- Coronavirus 19 Response
- Payment Reform Activities
- HCBS Rules Implementation

Coronavirus 19 Response

The quarter ending 03/2021 continued to require response to the coronavirus pandemic. The Developmental Disabilities Services Division (DDSD) took continuing steps to protect the health and safety of developmental services recipients. New guidance in QE032021 included:

1. Extension of grants made through the final allotment of coronavirus relief funds to

support Difficulty of Care stipends for unpaid family caregivers.
2. Extension of authority for Difficulty of Care stipends for unpaid family caregivers who were providing care in lieu of typically available supports.
3. Extension of authority for Difficult of Care stipends for shared living providers who were providing additional care in lieu of typically available supports.

Actions taken throughout CY2020 include:

1. Creation of tools to support the resumption of some community activities and employment supports after meeting with the person and their team to conduct a person-centered assessment of risk.
2. Changes to service delivery requirements supporting health and safety, including but not limited to; personal protective equipment requirements, allowances for telehealth services, transportation guidelines, home-visiting requirements, signature requirements, and redeployment of support staff.
3. Weekly provider video calls and monthly advocacy and stakeholder video town-halls.
4. Difficulty of Care stipends for unpaid family caregivers who were providing care in lieu of typically available supports.
5. Difficult of Care stipends for shared living providers who were providing additional care in lieu of typically available supports.

Payment and Delivery System Reform

The Developmental Disabilities Services Division (DDSD) and DVHA have initiated a project to explore a new payment model for Developmental Disabilities home and community-based services (HCBS). This project was put on hold during the quarter ending 06/2020 due to the coronavirus pandemic.

The DD HCBS program has grown significantly over the years from several hundred to several thousand participants. This has provided the impetus for modernization to allow for more efficient oversight of the program. Overall, the goal of this payment reform project is to create a transparent, effective, and administrable payment model for Developmental Disabilities Services that aligns with the broader payment reform and health care reform goals of AHS. The State has engaged stakeholders including recipients, families, advocacy organizations, and providers to participate in workgroups for the development and implementation of the new payment model.

DVHA previously engaged a Medicaid reimbursement consultant firm to assist the State in completing a provider rate study. The rate study collected detailed information from providers regarding actual costs to deliver the defined categories of service under HCBS. The rate study was completed and new rates for services were proposed. The information gathered will be utilized initially in developing the future payment model. It will later be decided whether these new rates can be adopted in the program. In addition to the provider rate study, the project has examined alternative assessment tools, resource allocation methods and options for more efficiently capturing encounter data for these services. A new methodology was established for providers to report encounter data regarding services being delivered to participants. Provider agencies are

still adapting their electronic health records and business processes to prepare to report the data using the new method that will lead to increased transparency and accountability in the use of funds.

The State has resumed work on preparing providers to report encounter date in the first quarter of CY2021. Agencies began reporting encounter data to the MMIS on 3/1/21. The State developed an RFP for a contractor to conduct needs assessments using a standardized assessment tool, the Supports Intensity Scale. However, this RFP was interrupted due to the pandemic. The RFP was reposted in September and the State has selected Public Consulting Group (PCG) and finalized the contract in April. The State is working with PCG to prepare for the start of assessments, tentatively scheduled for July, with a training period for assessors starting in May. . Design of the new payment model will be continuing as the tempo of state response to the pandemic abates. Ongoing work will be required, including seeking any needed CMS approval.

HCBS Rules Implementation

HCBS Settings Requirements - Work on HCBS rules implementation was paused in CY2020 due to additional workload and pressures of the coronavirus pandemic. DDSD plans to resume work on implementing the HCBS rules to ensure compliance with all requirements by 2022.

Summary of work to date- the Division completed site visits to validate survey information submitted by providers in September 2019. Providers are mostly in compliance with the setting requirements with minor changes being required. It is anticipated that all providers will be able to comply with the setting requirements and none will need to transition recipients to other settings. This information was included in the Vermont's State Transition Plan in February 2020. In addition, DDSD has been developing policy guidance for providers to ensure compliance with the rules. The DDSD Quality Management Unit has incorporated oversight of HCBS rule requirements into their overall quality review process to ensure ongoing compliance with the rules. With the completion of the site visits and information incorporated in the Vermont STP, the DDSD Quality Management Unit is preparingand sending reports to each provider agency requiring a plan of correction to addressthe areas of non- compliance by the 2022 deadline.

Conflict of Interest in Case Management- In QE 032021, the State met with CMS in order to provide information regarding the draft "Choice" model for case management that was developed in response to extended stakeholder engagement efforts made in 2019. DDSD continued to participate in conversations with DVHA and other AHS departments about ways to improve safeguards and mitigation strategies that would reduce potential conflict.

A key component of Vermont's mitigation strategies includes reissuing the RFP for an independent developmental service needs assessor, also described in the section above regarding payment reform. As of the QE 032021 the Division was still in contract negotiations with the apparently successful bidder. The Division continues to work with the Department of Vermont Health Access and other AHS Departments on a plan for inclusion in the next Global Commitment to Health waiver renewal application.

Wait List

DDSD collects information from service providers on individuals who request funding for Home and Community-Based Services (HCBS) and other services including Targeted Case Management (TCM), Family Managed Respite (FMR), Flexible Family Funding (FFF) or Post-Secondary Education Initiative (PSEI). The information is gathered by the State from providers to determine individuals with developmental disabilities (DD) who are waiting for DD services but are not currently eligible. HCBS funding priorities are the method by which Vermont prioritizes who will receive caseload funding allocated annually by the legislature. Individuals are placed on the waiting list if they meet the following criteria:

1. HCBS Applicants: Individuals with DD who are clinically and financially eligible but who do not meet a funding priority for HCBS and have been denied services in whole or in part.
2. Individuals who are clinically and financially eligible for TCM, FMR, FFF or PSEI, but for whom there are insufficient funds.

There were no individuals who met a HCBS funding priority who were waiting for services that helps address the need related to the funding priority. As of 6/30/20, there were 243 people who requested HCBS services but were denied because they did not meet a funding priority. 7 people were waiting for FMR and 5 were waiting for FFF. There was no one waiting for TCM or PSEI. The waiting list is monitored by providers to determine if people have a change in circumstance that makes them eligible to receive HCBS. The waiting list is also reviewed when additional funds become available for other programs.

iv. Global Commitment Register

Key updates from QE032021:

- 23 policies were posted to the GCR in Q1 2021.
- Since the Global Commitment Register (GCR) launched in November 2015, 240 final GCR policies have been publicly posted.

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

The GCR listserv is a group of about 370 interested parties who have elected to receive periodic key updates about Vermont health care programs, which includes policy changes to all Medicaid programs as well as policy changes to Vermont's Health Benefit Exchange. A policy change in the GCR could be a change made under

the authority of the waiver, a proposed waiver amendment or extension, an administrative rule change or a State Plan Amendment. The GCR also contains policy clarifications for when an issue is identified that is not clearly answered in current policy.

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

A public health emergency (PHE) was declared in March 2020 due to the COVID-19 pandemic. The PHE continues to impact the state budget and Medicaid operations, which is reflected in the number and type of policies being posted to the GCR. There were 5 proposed policies and one policy clarification posted in QE032021. A total of 17 final policies were posted in QE032021. Changes included updates to rates and/or rate methodologies, clinical coverage changes, and administrative rulemaking notices. Policy changes stemming from the public health emergency and the COVID-19 pandemic included a change to vaccine administration reimbursement.

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

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

1. Title Page for Vermont's SUD Components of the Global Commitment to Health Demonstration

State	Vermont
Demonstration Name	Global Commitment to Health 1115 Demonstration
Approval Date	July 1, 2018
Approval Period	July 1, 2018 – December 31, 2021
SUD (or if broader demonstration, then SUD Related) Demonstration Goals and Objectives	*Enter summary of the SUD (or if broader demonstration, then SUD related) demonstration goals and objectives as summarized in the STCs and/or demonstration fact sheet.*

Key updates for QE032021:

- 12 hospitals are participating in the Recovery Coaches in the Emergency Room Program.
- VT Helplink received over 470 calls and 19,700 website visits.

2. Executive Summary

During the first quarter of 2020 the State of Vermont continued to have all ASAM levels of care available and no ongoing waitlist to access to Medication Assisted Treatment. Treatment providers continue to utilize telemedicine and other strategies to continue serving patients during the COVID-19 pandemic.

Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were revised for a January 1, 2020 effective date. ADAP continued to adapt the value-based payment model for residential programs, to align with its All-Payer Model Agreement with CMS. ADAP has been monitoring the impact of the rate adjustment and has made recommendations for an additional rebase to be effective next quarter.

ADAP's centralized intake and resource center, "VT Helplink: Alcohol and Drug Support Center" has been operational for over a year. In the first quarter of 2021, VT Helplink received over 470 calls and 19,700 website visits. Major components include: 1) a call center staffed by certified Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self-screen tool, and 3) an appointment board to connect callers in need of treatment with appointments to ADAP's Preferred Provider Network. ADAP is working to onboard SUD treatment providers into the provider portal.

The Substance Misuse Prevention Oversight and Advisory Council (SMPC) was established within the Vermont Department of Health and encompasses all substances of misuse including alcohol; cannabis; controlled substances such as opioids, cocaine and methamphetamines; and tobacco products, tobacco substitutes and substances containing nicotine. The SMPC provided written testimony to the Vermont House Government Operations Committee on bill S. 25 (an act relating to miscellaneous cannabis regulation procedures). The testimony focused on previously drafted cannabis regulations.

Vermont launched the Recovery Coaches in the Emergency Department Program on July 1, 2018. 12 hospitals are participating in the program.

Assessment of Need and Qualification for SUD Services

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Implementation Update			
Compared to the demonstration design details outlined in the STCs and implementation plan, have there been any changes or does the state expect to make any changes			There are no planned changes to the target population or clinical criteria.
to: A) the target population(s) of the demonstration? B) the clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration?			
Are there any other anticipated program changes that may impact metrics related to assessment of need			There are no anticipated program changes.

and qualification for SUD services? If so, please describe these changes.			
☒ The state has no implementation update to report for this reporting topic.			

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 1 Implementation Update			
Summary: There are no planned changes to access SUD treatment or the SUD benefit coverage.			
Are there any other anticipated program changes that may impact metrics related to access to critical levels of care for OUD and other SUDs? If so, please describe these changes.			There are no anticipated program changes.
☒ The state has no implementation update to report for this reporting topic.			

Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria

This reporting topic focuses on use of evidence-based, SUD-specific patient placement criteria to assess the state's progress towards meeting Milestone 2.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary

Milestone 2 Metric Trends

☒ The state is not reporting any metrics related to this reporting topic.

Milestone 2 Implementation Update

Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to:

a. Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria?
b. Implementation of a utilization management approach to ensure:
    i. Beneficiaries have access to SUD services at the appropriate level of care?
    ii. Interventions are appropriate for the diagnosis and level of care?
    iii. Use of independent process for reviewing placement in residential treatment settings?

Summary:

The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 28 substance use disorder treatment provider locations. The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were revised for a January 1, 2020 effective date.

Milestone 2 - Table 1

Action	Revised Completion Date	Responsible	Status
Finalize Substance Use Disorder Treatment Standards	August 1, 2018	Director of Quality Management and Compliance	Completed
Update Compliance Assessment Tool with revised Substance Use Disorder Treatment Standards and all residential ASAM criteria	August 15, 2018	Director of Quality Management and Compliance	Completed
Updated online recertification survey to reflect new revision of	October 31, 2018	Director of Quality Management and Compliance	Completed

Substance Use Disorder Treatment Standards			
Use the Compliance Assessment Tool to certify ASAM Level 3.5 Level of Care provider (Valley Vista Vergennes)	December 31, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Use the Compliance Assessment Tool to certify ASAM Level 3.5 Level of Care provider (Valley Vista Bradford)	December 31, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Implement the Compliance Assessment Tool	October 3, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Use of the Compliance Assessment Tool to certify ASAM Level 3.3 Level of Care Provider (Recovery House)	March 31, 2019	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Use of the Compliance Assessment Tool to certify ASAM Level 3.2-WM Level of Care Provider (Act 1/Bridge)	March 31, 2019	Director of Clinical Services; Director of Quality Management and Compliance	Completed

ADAP continued to adapt the value-based payment model for residential programs, to align with its All-Payer Model Agreement with CMS. ADAP has been monitoring the impact of the rate adjustment and has made recommendations for an additional rebase to be effective next quarter.

Milestone 2 – Table 2

Action	Date	Responsible
Develop the criteria for the differential case rate	Completed	ADAP Director of Clinical Services
Model the methodology using the identified criteria for the Vermont teamto review	Completed	Payment Reform Team
Work with financial colleagues to finalize budget and rate decisions for the model	Completed	Payment Reform Team, ADAP Director of Clinical Services, VDH Business Office
Residential providers toprovide feedback	Completed	ADAP Director of Clinical Services
Work with the Medicaid fiscal agent to identify and complete the necessary system's changes required for the Medicaid billing system	Completed	ADAP Director of Clinical Services, Payment Reform Team, DXC (Fiscal Agent)

Work with the residential providers to provide technical assistance and education around the necessary	Completed	ADAP Clinical Team

billing changes			
Regional Managers will partner with the compliance andquality team to determine the appropriate frequency with which the Regional Managers will perform the between audit chart reviews	Completed	ADAP Clinical Team and ADAP Quality Team	
Are there any other anticipated program changes that may impact metrics related to the use of evidence-based, SUD-specific patient placement criteria (if the state is reporting such metrics)? If so, please describe these changes.			

Milestone 3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

This reporting topic focuses on the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities to assess the state'sprogress towards meeting Milestone 3.

Milestone 3 Metric Trends
☒ The state is not reporting any metrics related to this reporting topic.
Milestone 3 Implementation Update

Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to:

a. Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards?
b. State review process for residential treatment providers' compliance with qualifications standards?
c. Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site?

Summary:

The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 28 substance use disorder treatment provider locations.
The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were revised for a January 1, 2020 effective date.

Are there any other anticipated program changes that may impact metrics related to the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities (if the state is reporting such metrics)? If so, please describe these changes.			

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

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

This reporting topic focuses on provider capacity at critical levels of care including for medication assisted treatment (MAT) for OUD to assess the state's progress towards meetingMilestone 4.

Milestone 4 Metric Trends

Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			

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

Milestone 4 Implementation Update

Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care?

Summary:

ADAP continued to adapt the value-based payment model for residential programs, to align with its All-Payer Model Agreement with CMS. ADAP has been monitoring the impact of the rate adjustment and has made recommendations for an additional rebase to be effective next quarter. ADAP's centralized intake and resource center "VT Helplink: Alcohol and Drug Support Center" has been operational for over a year. In the first quarter of 2021, VT Helplink received over 470 calls and 19,700 website visits. Major components include:

1) a call center staffed by certified Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self-screen tool, and 3) an appointment board to connect callers in need of treatment with appointments to ADAP's Preferred Provider Network. ADAP is working to onboard SUD treatment providers into the provider portal.

Are there any other anticipated program changes that may impact metrics related to provider capacity acritical levels of care, including for medication assisted treatment (MAT) for OUD? If so, please describe these changes.			

Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

This reporting topic focuses on the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD to assess the state's progress towards meeting Milestone5.

Milestone 5 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 5 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD? b. Expansion of coverage for and access to naloxone? **Summary**: There are no planned changes to the prescribing guidelines and other interventions.			
Are there any other anticipated program changes that may impact metrics related to the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD? If so,please describe these changes.			
☒ The state has no implementation update to report for this reporting topic.			

Milestone 6: Improved Care Coordination and Transitions between Levels of Care
This reporting topic focuses on care coordination and transitions between levels of care to assess the state's progress towards meeting Milestone 6.

Milestone 6 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Milestone 6 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community- based services and supports? **Summary**: Vermont launched the Recovery Coaches in the Emergency Department Program on July 1,2018. 12 hospitals are participating in the program.			
Are there any other anticipated program changes that may impact metrics related to care coordination and transitions between levels of care? If so, please describe these changes.			
☐ The state has no implementation update to report for this reporting topic.			

SUD Health Information Technology (Health IT)

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

Metric Trends			
Discuss any relevant trends that the data shows related to			
assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Implementation Update			

Prompts: Compared to the demonstration design and operational details outlined in STCs and implementation plan, have there been any changes or does the state expect to make any changes to:

a. How health IT is being used to slow down the rate of growth of individuals identified with SUD?
b. How health IT is being used to treat effectively individuals identified with SUD?
c. How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD?
d. Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels?
e. Other aspects of the state's health IT implementation milestones?
f. The timeline for achieving health IT implementation milestones?
g. Planned activities to increase use and functionality of the state's prescription drug monitoring program?

Summary:

- Vermont has a requirement and funding in the current contract with Appriss to connect VPMS to RxCheck for interstate data sharing. RxCheck is developing functionality for direct integration with EHRs and other health systems. Appriss has provided a change order to connect to RxCheck.
- Funding through the Center for Disease Control and Prevention, and the Bureau for Justice Administration requires the connection to RxCheck. The MOU has been signed and is in place with IJIS, the contractor who manages the operation of RxCheck.
- The current contract for the VPMS was put out to bid in 2019. The request for proposal (RFP) included priorities such as improved access and support for providers, integration and data management, and increased reporting functionality. The independent review of the selected vendor was accepted. Due to COVID-19 delays, negotiation for the contract is ongoing. In order to ensure continued access, an amendment with Appriss was signed through the end of November 2020.
- VPMS, Dr. First and Appriss are in the process of testing and verifying Appriss's

Gateway integration tool to enable direct population of VPMS data into Dr. First's prescription ordering section, eliminating the need for providers to navigate between systems.

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

The scope of the providers receiving reports have been expanded and will now include those who have prescribed controlled substances other than opioids as well. • VDH conducted an impact evaluation of the 7/1/17 pain prescribing rule change to assess the impact of the new prescribing rules on prescribing patterns, determine if the new prescribing rules affect awareness/usage of VPMS and evaluate the impact of stricter prescribing rules on future prescription opioid misuse. This evaluation is available here: https://www.healthvermont.gov/sites/default/files/documents/pdf/Pain_Rules_Eval_FINAL%20.pdf and details that opioid prescribing to treat pain has decreased since the implementation of the Rule for the Prescribing of Opioids for Pain in July 2017. More prescribers are actively engaged with VPMS. Fewer Vermonters, including those 17 and under, are receiving prescriptions, and the prescriptions that are dispensed are in lower amounts. VT Helplink: Alcohol & Drug Support Center, encompasses a call center, public-facing informational website, and a web-based appointment. board. VT Helplink was launched in March 2020 and continues to be fully operational. In the first quarter of 2021, VT Helplink received over 470 calls and 19,700 website visits.			
Are there any other anticipated program changes that may impact metrics related to SUD Health IT (if the state is reporting such metrics)? If so, please describe these changes.			
☐ The state has no implementation update to report for this reporting topic.			

Other SUD-Related Metrics

9.2 Other SUD-Related Metrics
9.2.1 Metric Trends

Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be			
described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
9.2.2 Implementation Update			
Are there any other anticipated program changes that may impact the other SUD-			
related metrics? If so, please describe these changes.			
☒ The state has no implementation updates to report for this reporting topic.			

Budget Neutrality

10.2 Budget Neutrality
10.2.1 Current status and analysis

Discuss the current status of budget neutrality and provide an analysis of the budget neutrality to date. If the SUD component is part of a comprehensive demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality as a whole.			Updates on Budget Neutrality can be found in Section V. *Financial/Budget Neutrality Development/Issues* of this report.
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
10.2.2 Implementation Update			

Are there any anticipated program changes that may impact budget neutrality? If so, please describe these changes.			
[Add rows as needed]			
☒ The state has no implementation updates to report for this reporting topic.			

SUD-Related Demonstration Operations and Policy

11.1 SUD-Related Demonstration Operations and Policy
11.1.1 Considerations

Highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.			
[Add rows as needed]			
☒ The state has no related considerations to report for this reporting topic.			
11.1.2 Implementation Update			

Compared to the demonstration design and operational details outlined in STCs and the implementation plan, have there been any changes or does the state expect to make any changes to: a. How the delivery system operates under the demonstration (e.g., Through the managed care system or fee for service)? b. Delivery models affecting			
demonstration participants (e.g., Accountable Care Organizations, Patient Centered Medical Homes)? c. Partners involved inservice delivery?			

Has the state experienced any significant challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers)? Has the state noted any performance issues with contracted entities?			
What other initiatives is the state working on related to SUD or OUD? How do these initiatives relate to the SUD demonstration? How are they similar toor different from the SUD demonstration?			
[Add rows as needed]			
☒ The state has no implementation updates to report for this reporting topic.			

SUD Demonstration Evaluation Update

12.1 SUD Demonstration Evaluation Update			
12.1.1 Narrative Information			
Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the			Updates on the SUD evaluation work, deliverables, and timeline can be found in Sections VIII. *Quality Improvement* and IX. *Demonstration Evaluation* of this report.

demonstration. See report template instructions for moredetails.			
Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.			
List anticipated evaluation-related deliverables related to this demonstration and their due dates.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
12.1.2 Implementation Update			
Are there any anticipated program changes that may impact budget neutrality? If so, please describe these changes.			
[Add rows as needed]			
☐ The state has no SUD demonstration evaluation update to report for this reporting topic.			

Other Demonstration Reporting

13.1 Other Demonstration Reporting
13.1.1 General Reporting Requirements

Have there been any changes in the state's implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol?			
Does the state foresee the need to make future			
changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation changes?			
Compared to the details outlined in the STCs and the monitoring protocol, has the state formally requested any changes or does the state expect to formally request any changes to: a. The schedule for completing and submitting monitoring reports? b. The content or completeness of submitted reports? Future reports?			Updates on the Monitoring Protocol work, deliverables, and timeline can be found in Section X. *Compliance* of this report.

Has the state identified any real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation?			
[Add rows as needed]			
☒ The state has no updates on general reporting requirements to report for this reporting topic.			
13.1.2 Post Award Public Forum			
If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which theforum was held and in the annual report.			
[Add rows as needed]			

Ⅳ. Expenditure Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE032021:

- COVID-19 Response
- Alignment of VCCI with state health care reform and ACO
- Working on bidirectional interface with VITL

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

During QE 032021, VCCI continued to be a resource in the state's response to the public health crisis with both licensed (10) and non-licensed (3) staff available for COVID-vaccination in roles of either vaccinator or intake/exit worker. Staff schedule availability has been shared and the team are eager to help Vermont with its vaccination efforts. As Vermont continued to increase vaccination access to more of our neighbors, VCCI was asked to support the state's efforts with those with eligible conditions. For residents, whose condition status was not clear, VCCI nurses validated the presence of an eligible condition, through outreach and screening. This was a short- term project that lasted four weeks. The pandemic has certainly highlighted telehealth services as an important tool for both patients and healthcare providers, but lack of technology access can be a barrier for some. With goal of increasing beneficiary access to telehealth services/providers, as well as to their VCCI case manager, VCCI procured technology through a federal grant. VCCI received 2 distributions of technology (November and December) and the team started to distribute both iPads and/or Wi-Fi extenders to beneficiaries with identified need and with the ability to navigate use of the technology. At end of this first quarter, VCCI has been able to
distribute technology to 53 unique beneficiaries and plans to continue to distribute supplies through 2021.

VCCI continued efforts toward improved alignment with health care reform and the system of care; formalizing its shift from historically serving only those who were predicted to be high cost/high risk to needs based eligibility and outreach. VCCI is working with the ACO on two main areas for alignment: formal adoption of the complex care model with utilization of common tools and expanded attribution. In alignment with the ACO model, the VCCI implements the complex care model, utilizing patient engagement tools, pulling together care teams and helping beneficiary in the identification of a long-term lead care coordinator. In addition to the beneficiary, potential care team members may include primary care providers, hospital case managers, community and designated mental health agency providers, AHS partners such as Economic Services Division and Employment Specialists. Lead Care Coordinators help to support the member in goal setting and in the development of the shared care plan. There remains varying community implementation of this service delivery: lead care coordinator may be identified but has not yet engaged with the beneficiary; an identified care team of one provider. Information is intended to be shared within OCV communication platform of Care Navigator, but this can be challenging. The system often feels like another health record to manage; not all partners on a beneficiary care team may have access to Care Navigator; and 2021 attribution will not be loaded into Care Navigator until late Spring. All VCCI field-based staff have been trained in using Care Navigator. There remains variance with communityknowledge and scope of understanding of the expanded attribution and development of community workflows to help manage this population. VCCI has assessed how we could improve our role in supporting the ACO and communities; and have coordinated with colleagues at DVHA. VCCI and

Blueprint for Health have just begun to meet with managers from OCV, with the objectives of ensuring consistent communication and messaging, ensuring communities have the knowledge and tools, and review of data.

Our team continues to receive referrals, from ACO providers, on ACO attributed beneficiaries, presenting with complex health (including SUD and MH conditions) and social needs; and continues to provide clinical case management services. Reasons cited for referral to VCCI versus referral to in-house care coordinator is due to the 1) members complexity requiring intensive case management.
2) beneficiary is not established at the attributed practice 3) primary care office does not have the staffing resources to manage beneficiaries with complex needs 4)) Practice focus on high and very high risk members, and member being referred does not meet that criteria. VCCI works to stabilize members while building long term community care team. 5) when VCCI is in the field, VCCI ability to meet with members in-person, where member may physically be whether a motel, shelter, apartment, etc.

During this first quarter, VCCI has worked with partners at Department of Corrections (DOC) and the selected Healthcare Vendor to refine workflow for transitions of care for those being released from/or entering incarceration, into the community. Planning has involved assessment of necessary and appropriate health and safety information, leveraging the systems and assessments that both DOC and the Healthcare Vendor have already incorporated into their current systems and workflow. Mutual goals are to support and facilitate beneficiaries' integration back into the community, and access to both health and health related services, for improved quality of life and decreasing chance of recidivism.

VCCI continues to serve beneficiaries who are at risk or high risk - discharged from an inpatient stay without an established primary care, and to a homelessness status; with a cognitive impairment trying to manage their uncontrolled diabetes; those with uncontrolled chronic conditions who utilize the ED. Our population served are often referenced to as the 'hidden population' or 'those who fall through the cracks.With established workflows, utilization of evidenced based assessments with subsequent plan of care development and beneficiary centered approach, VCCI case managers provide consistent, frequent intervention to help beneficiaries meet their health and health related goals.

Another area that VCCI is working on with our partners at VITL and the Blueprint is to have the data related to social determinants of health that VCCI collects on beneficiaries through our comprehensive surveys to be part of the member's record in the VHIE. This will assist the ACO with a more accurate way of predicting riskfor members and being able to intervene on those members with issues earlier, so they do not become part of that very high-risk group.

The clinical documentation system that VCCI utilizes through eQ Health is CMS certified and VCCI has exercised the option to extend the contract with the Vendor for the two additional years.The system contains clinical information via an interface with Vermont's HIE vendor, VITL to enhance case managers' ability to formulate and put into motion a true patient centered, clinicallyfocused plan of care.

VCCI is looking ahead to the next quarter with goals to include resumption of in-person, field-based beneficiary visits; assist with standardizing the tools of the complex care model delivery statewide; the implementation of workstream with our colleagues at the Department of Corrections on transitions of care with beneficiaries released from/entering incarceration; and collaboration with our Agency of Human Services on procurement of safe housing for high-risk, housing unstable members. The above goals are appropriate with consideration of the VCCI role in the All-Payer Model reboot and move to the AHS

Secretary's Office.

ii. Blueprint for Health

Patient-Centered Medical Home Program

The Blueprint uses national standards to drive improvements in primary care delivery and payment. The program helps primary care providers transform their practices into National Committee for Quality Assurance (NCQA)-certified Patient-Centered Medical Homes. The Patient-Centered Medical Home model supports care that is patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety. The model also promotes care that is provided when and where the patient needs it, and in a way that the patient understands it. Patient-Centered Medical Homes in Vermont are supported by multi-disciplinary teams of dedicated health professionals in each of the state's health service areas. These teams provide supplemental services that allow Blueprint- participating primary care practices to focus on promoting prevention, wellness, and coordinated care. The Community Health Teams support primary care providers in identifying root causes ofhealth problems, including mental health and screening for social determinants of health.
They also connect patients with effective interventions, manage chronic conditions, or provide additional opportunities to support improved well-being.

Patient Centered Medical Home Program

Blueprint Program Managers, who are local leaders in each community, are responsible for contacting all primary care practices within their health service area to encourage, engage, and support practice participation in the Blueprint for Health and learning health system activities. Annually, Program Managers report on the remaining primary care practices in each region that have not begun the process of transforming their practice into Patient-Centered Medical Homes and indicate the rationale provided by each practice contact. Importantly, Blueprint Program Managers report very few practices in each health service area remaining who are not currently engaged with the Blueprint for Health program. In addition to Program Managers, the Blueprint supports participating practices with a quality improvement coach, called a Quality Improvement Facilitator. Quality Improvement Facilitators use their own training and expertise in process improvement methodologies (such as Clinical Microsystems, Model for Improvement, and Lean process improvement) and data interpretation for when they review the practice's data or data provided by the Blueprint for Health. Quality Improvement Facilitators initially help launch patient-centered practices and secure NCQA Patient-Centered Medical Home recognition. After 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 include:

- focusing quality improvement activities on All-Payer Model and Accountable Care Organization quality measures;
- team-based care;

- implementation of new initiatives (e.g., Spoke program, Women's Health Initiative, improving opioid prescribing patterns);
- prevention and management of chronic conditions (e.g., for diabetes and hypertension through connections with learning collaboratives, self-management programs, health coaches, registered dieticians, and care management).

Blueprint-participating Patient-Centered Medical Homes currently serve 306,061 insurer-attributed patients, of which 103,696 are Medicaid enrollees. Attribution to a practice is determined by the practice at which the patient has received the majority of their primary care within the 24 months prior to the date the attribution process is conducted. These practices and patients are supported by 165 full- time equivalents of Community Health Team staff.

Quarterly Highlights

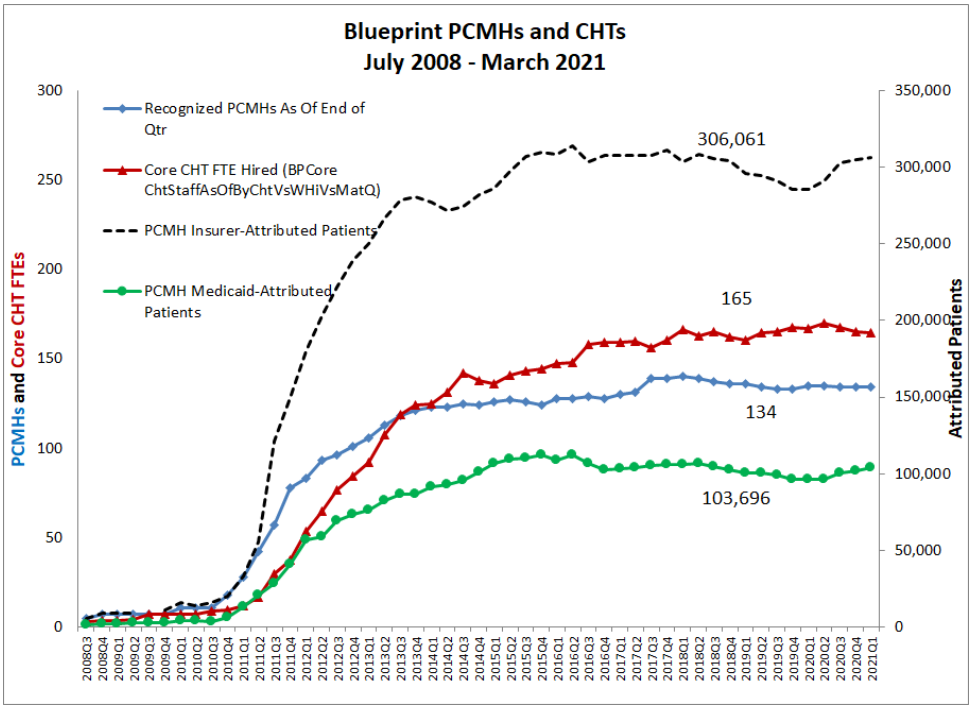
In Quarter 1 (January- March 2021), 134 Vermont practices were operating as Patient-Centered Medical Homes, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of practices participating in the Blueprint for Health program is a key performance measure; the Blueprint estimates that there are about 169 total primary care practices operating in the state, of which an estimated 148 employ more than one provider.

In collaboration with the Blueprint for Health, NCQA has extended the Recognition status of PCMH practices with Annual Reporting deadlines between March and December 2020. The adjusted deadlines now reflect an Annual Reporting date of December 1, 2020, and a Recognition End date of December 31, 2020.

Since Governor Phil Scott has declared a state of emergency in Vermont, which has continued this quarter, Patient-Centered Medical Homes, specialty practices, and Spokes have acted quickly to provide continuity of care. Most of the network used their electronic health records to run various reports based on a few factors of risk: age greater than 60 withchronic conditions, John Hopkins ACG scale, potential for fragmented care, mental health and substance use diagnosis, and high healthcare resource usage. They also cross-referenced patients who missed appointments and who needed follow up as soon as possible. The Community Health Teams reached out to the patients who met these criteria. On these calls, they would also inquire about other social determinants of health, such as access to food and medicine. While in-person

visits have increased, telehealth continues to be an option for primary care appointments and screenings. The network continues to work diligently to ensure excellent patient care and care coordination for the best health outcomes. We are finding that behavioral health and dieticiansare returning to the office and providing in person care with proper safety precautions in place.

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



Practice Health Profiles and Community Health Profiles

In the past, 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 health service area and patients in each Patient-Centered Medical Home. Unfortunately, due to budget constraints, these profiles were not produced this year. Previous publications covered the following data time periods:

01/2013 – 12/2013
07/2013 - 06/2014
01/2014 - 12/2014
07/2014 - 06/2015
01/2015 – 12/2015
07/2015 – 06/2016
01/2016 – 12/2016
07/2016 – 06/2017
01/2017 – 12/2017
01/2018 – 12/2018

Profiles are posted at http://blueprintforhealth.vermont.gov/community-health-profiles. Most recently, the Blueprint for Health published its 2020 Annual Report. This report reviews more in depth how the Program Managers, Quality Improvement Facilitators, Patient-Centered Medical Homes, Community Health Teams interact to provide services, coordinate care across communities, and work with the state's accountable care organization. The report is available at:
https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/BlueprintforHealthAnnualRep

ortCY2020.pdf.

Hub & Spoke Program

Medication-assisted treatment for opioid use disorder is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole patient" approach to the treatment of opioid use disorder. The Hub and Spoke system of care in Vermont provides medication- assisted treatment for opioid use disorder in two settings – regional, specialty Opioid Treatment Programs (OTPs, Hubs), which provide higher intensitytreatment and office-based opioid treatment (OBOT, Spokes) in community-based medical practice settings. The Blueprint administers the Spoke part of the Hub & Spoke system of care. Peer-reviewed literature has established medication-assisted treatment as an evidence- based, effective approach to the treatment of opioid use disorder, based upon notable, published outcomes such as decreased opioid use, decreased opioid-related overdose deaths,decreased criminal activity, decreased infectious disease transmission, and increased social functioning and retention in treatment.

Many of these outcomes were supported by the recent evaluation of Vermont's Hub & Spoke system. The State Plan Amendment for the Vermont Medicaid Program, approved by the Centers for Medicare and Medicaid Services, established a Health Home for Vermonterswith opioid use disorder. As of July 1, 2013, Medicaid beneficiaries receiving medication- assisted treatment for opioid use disorder in a Hub or Spoke setting were eligible to receive enhanced services, such as comprehensive care management, care coordination, comprehensive transitional care, health promotion, individual and family support, and referral to community and social support services. The Health Home functions to enhance Hub programming and embeds essential support staff (1 registered nurse and 1 licensed mental health clinician per every 100 Medicaid patients receiving medication-assisted treatment) into Spoke practices for a patient-centered, team- and evidenced- based approachto 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.

The Blueprint, in partnership with the Division of Alcohol and Drug Abuse Programs (Department of Health), continues to offer learning sessions with expert-led, and peer-supported, training in best practices for providing team- and evidence-based medication-assisted treatment for opioid use disorder. For many physicians, nurse practitioners, and physician assistants, access to specialized staffing and ongoing training opportunities providethe support and confidence the providers need to accept the challenge of treating opioid use disorder in community-based medical practice settings (Spokes). For patients, the Spoke staff become a critical part of their care team, working together week-by-week and month- by-month towards long-term recovery and improved health and well-being. At the end of the 1st quarter of 2021, capacity for receiving medication-assisted treatment in Spoke settings continued to increase, as evidenced by 3,933 Vermonters with Medicaid insurance receiving medication-assisted treatment for opioid use disorder from 283 prescribers and 73.54 full-time equivalent Spoke staff, working as teams, across more than 90[1] different Spoke settings (as of March 2021).

Quarterly Highlights

Vermont continues to demonstrate substantial access to medication-assisted treatment for Vermonters with opioid use disorder. As of March 2021, a monthly average of 3,933 Medicaid beneficiaries were served by Office-Based Opioid Treatment (OBOT/Spoke) programs. As of 2020-Q4, 3,259 Vermont residents aged 18-64 received treatment in a Hub (source: ADAP Hub and Spoke Quarterly Report for 2020-Q4).

Medication-assisted treatment for opioid use disorder is being offered across the State of Vermont by more than 90 different Spoke settings and by 283 medical doctors, nurse practitioners and physician assistants who work with 73.54 FTE licensed, registered nurses and licensed, Master's-prepared, mental health / substance use disorder clinicians as a teamto offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder (as of March 2021).

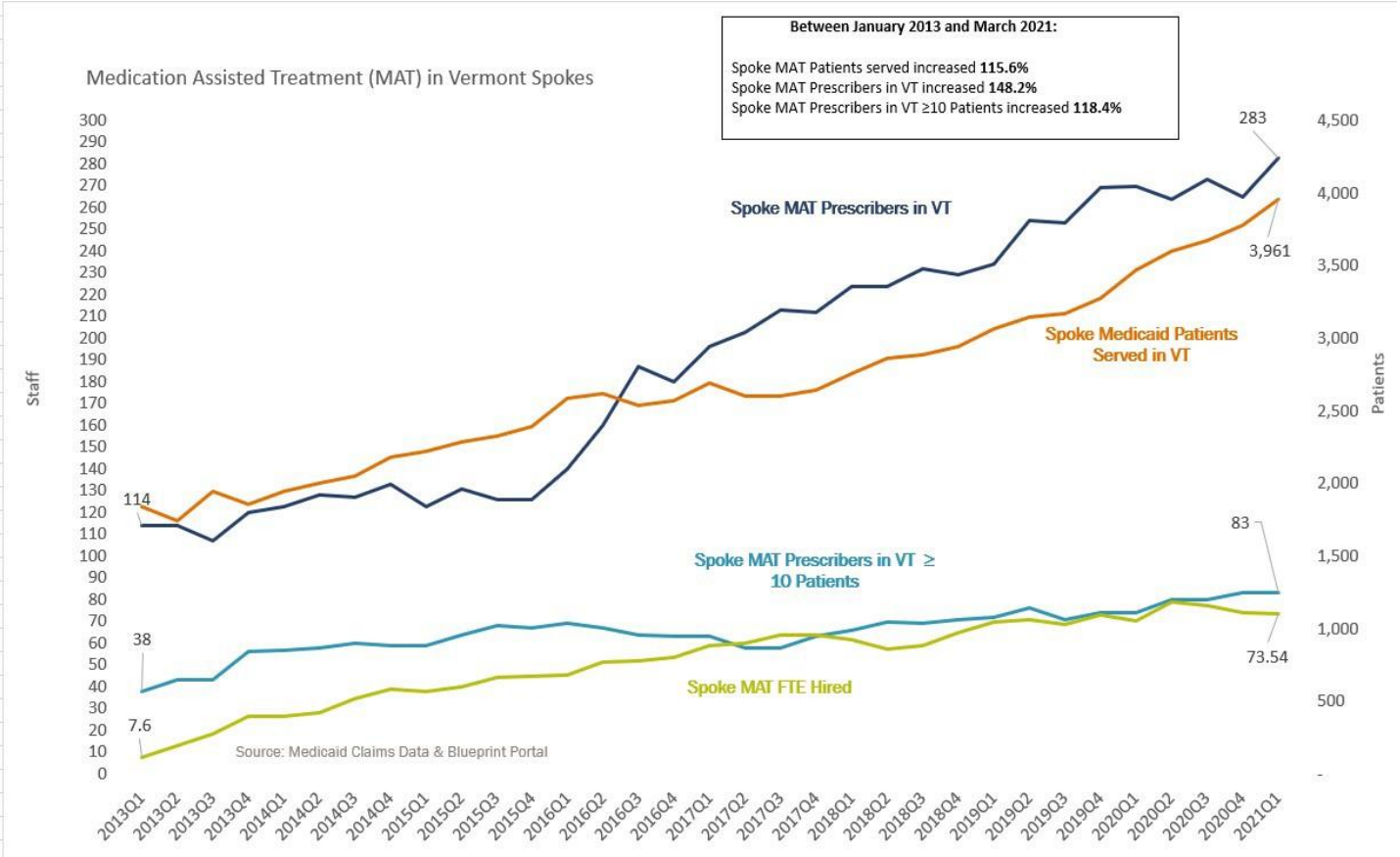
Toward the end of Q1 2020, all Spoke sites began transitioning to remote and telehealth services in response to Vermont's "Stay Home, Stay Safe" emergency order that went into effect on March 13, 2020. At the end of Q1 2021, many Spoke nurses were providing care in both telehealth and in-person visits, and the Spoke counselors were continuing to deliver care remotely. Dependent on COVID-19 case rates throughout the state, in Q1 of 2021 Spoke nurses fluctuated their frequency of in-person care. For example, in areas of the statewhere case rates increased, Spoke nurses reduced the amount of in-person visits they had based on patient risk stratification as evaluated by the provider and care team. Patients whowere determined to be stable were more likely to have telehealth-only visits from both the Spoke nurse and the Spoke counselor at the end of Q1 2021.

Since November 1, 2019, the Blueprint has had a contract with Dartmouth College for the 2019-2020 MAT Learning Collaborative. The 2019-2020 MAT Learning Collaborative included a series of five webinars, six training sessions, and one statewide conference. In response to the COVID-19 pandemic and Vermont's "Stay Home, Stay Safe" emergency declaration, Dartmouth College restructured the remainder of the Learning Collaborative to accommodate entirely virtual sessions as of June 2020. For the 4th quarter of 2020, the 2019-2020 Learning Collaborative event orchestrated by Dartmouth College, in conjunction with Blueprint for Health and Vermont Department of Health's Division of Alcohol and Drug Abuse Programs, consisted of a two-day statewide virtual conference. The 2019-2020 Learning Collaborative cycle concluded in October2020.

As of November 1, 2020, the Blueprint extended their contract with Dartmouth College through June 2021, in alignment with the end of the Sate fiscal year. The remainder of Q4 in2020 consisted of curriculum planning for six virtual learning sessions hosted monthly fromJanuary –June 2021. The key themes for this set of learning sessions will involve the intersection of Alcohol Use Disorder (AUD) with MAT, long-term MAT care, and the intersection of mental illness with MAT. During Q1 2021, Dartmouth hosted two webinars, one virtual training session, and began conference planning for Q3 2021, to be hosted by Dartmouth in the next contract extension.

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

Figure 3. MAT-SPOKE Implementation Jan 2013 – March 2021



Women's Health Initiative

The Women's Health Initiative (WHI) began as a state initiative to support pregnancy intention. The WHI program continues to evolve and strives to support Vermont women in their efforts to experience healthy pregnancies, avoid unintended pregnancies, and build thriving families. The Blueprint partners with women's specialty health providers and primary care practices, providing additional resources to support of the women they serve. These resources include payments for participating in the WHI and Community Health Team staff. In return, practices attest that they provide enhanced screenings, brief interventions andreferrals to treatment, initiate referral agreements with key community-based organizations in their HSA, conduct comprehensive family planning counseling, and provide patients with access to same day long- acting reversible contraception (LARC).

At a minimum, WHI providers engage with patients at new patient and annual visits to screen for social determinants of health needs including food and housing insecurity and interpersonal violence, as well as depression, anxiety, harm to self or others, and substance use disorders. They also discuss pregnancy intention for the coming year using the One Key Question® 12, which asks if, when, and under what circumstances a woman would like to become pregnant. Women with a desire to become pregnant receive services to support a healthy pregnancy. If the woman would like to prevent pregnancy, contraception methods are discussed and timely access to

LARC is offered on site for the same day, if clinically indicated.

Like the core CHT and Spoke programs, the WHI provides increased mental health and social service staffing at specialty practices and utilizes the CHT at Blueprint PCMH practices. If a patient identifies as

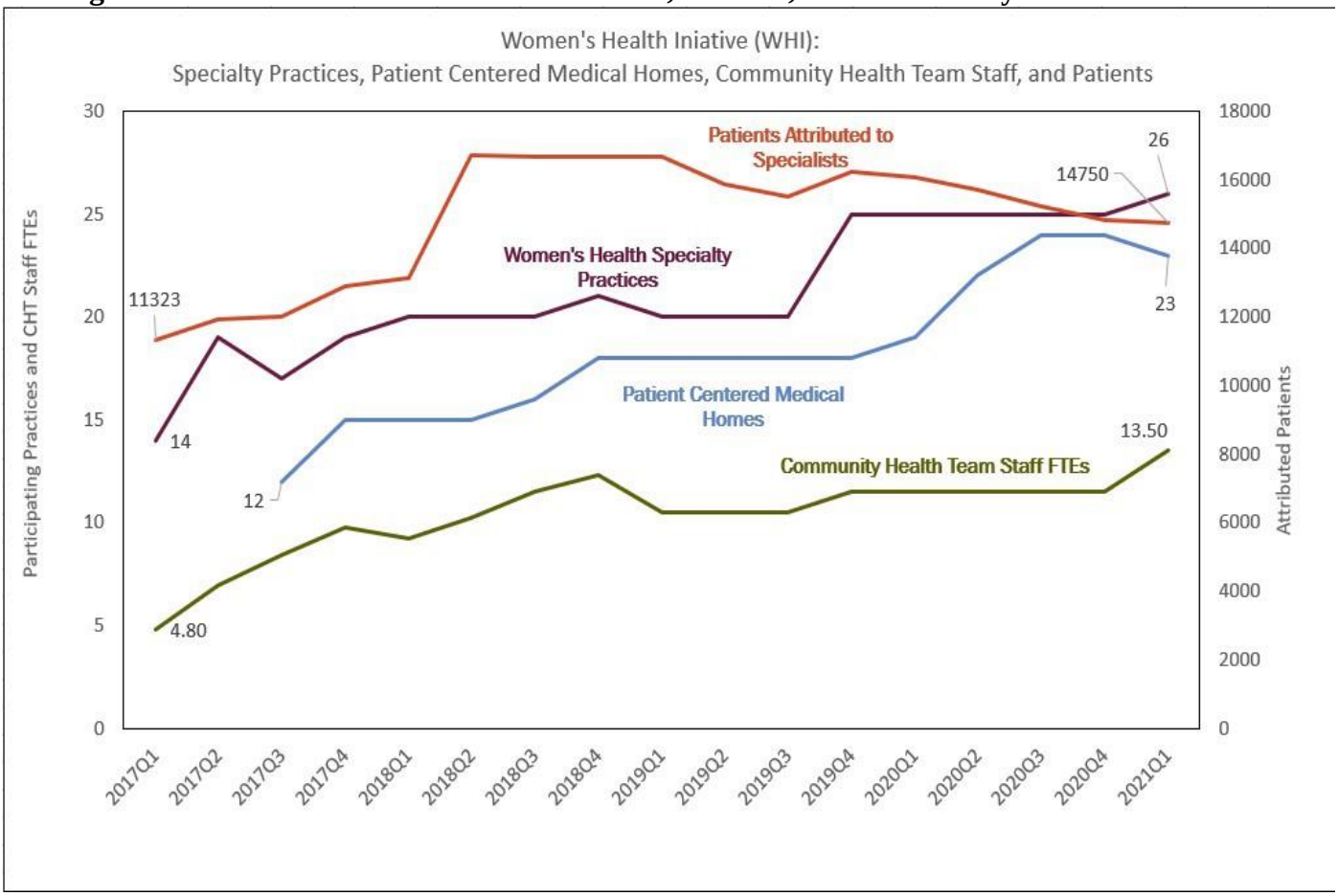
at-risk, they have immediate access to a WHI social worker for brief interventions, counseling, and navigation to community-based services and treatment as needed. WHI clinicians work closely with community partners and develop mutual referral agreements and establish meaningful relationships withthose partners to support patients.

Quarterly Highlights

- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 49 practices (26 women's health and 23 primary care) to participate in the Women's Health Initiative as of 4/1/2021.
- We have successfully reengaged the Newport Health Service area. Their Ob/gyn practice has rejoined as of4/1/2021.
- Practices are working hard to engage community partners in referral agreements. These agreements enhance relationships and pathways to care. Practices are updating policy/practices documents regarding SDOH and LARC insertion
- We have committed to present a WHI data dashboard quarterly to the field in our monthly call. The field has shared that this has been extremely helpful in understanding LARC insertion. We have also been able to see practices that are not engaged in WHI program. We will then follow up to see if there is interest in this program.
- Dr. Lauren MacAfee from the UVM network is scheduled for upcoming trainings in the next quarter for lunch-and-learns and a LARC insertion training. We have a good number of folks signed up, supported by our field.
- The Community Quality Improvement Facilitator and Assistant Director meet with each Health Service Area practice leads and quality improvement facilitators to engage in continuous quality improvement projects related to the attestation elements. Program Managers reported that these were helpful to continue keeping a focus on this program.

We hope to engage the last HSA in discussion about WHI in the upcoming months which is our Windsor health service area. Our data shows the FQHC is engaging in LARC insertion and we would like to share information about our program.

Figure 4. Women's Health Initiative: Practices, Patients, and Community



Health Team (CHT) Staffing Figure 5. Women's Health Implementation by Region

Health Service Area / Team	WHI Specialist Practices as of 4/1/2021	WHI PCMH Practices as of 4/1/2021	WHI CHT Staff FTE Hired as of 4/1/2021	WHI Specialist Quarterly Attributed** Medicaid Beneficiaries as of 4/1/2021	WHI PCMH Quarterly Attributed** Medicaid Beneficiaries as of 4/1/2021
Barre	1	1	1.00	682	233
Bennington	1	2	0.50	928	264
Brattleboro	1	0	1.00	884	0
Burlington	3	8	3.00	2575	4609
Middlebury	2	0	0.75	655	0
Morrisville	1	4	0.50	413	1217
Newport	1	0	0.00	862	0
Randolph	2	0	0.50	526	0
Rutland	2	0	1.50	1654	0
Springfield	1	5	1.00	0	1779
St. Albans	1	0	0.00	1034	0
St. Johnsbury	1	2	0.75	867	781
Windsor*	0	0	0.00	0	0
Planned Parenthood (Statewide)	12	0	3	3670	0
Total	**25**	**23**	**13.5**	**14,750**	**8,883**

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

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

iii. Behavioral Health

Key updates from QE032021:

- Alternative payment model for Brattleboro Retreat
- Applied Behavior Analysis

The Behavioral Health Team is responsible for concurrent review and authorization of inpatient psychiatric and detoxification services for Medicaid primary beneficiaries. Team members work closely with discharge planners at inpatient facilities to ensure timely and appropriate discharge plans. DVHA collaborates with other departments to support coordination of care. The team refers members to VCCI services and helps ensure continuity of care for beneficiaries already enrolled with VCCI admitted to inpatient or residential care facilities. The COVID-19 pandemic resulted in an increase in length of stay for Vermont Medicaid inpatient psychiatric placements. Almost all OOS programs had a hold on admissions and the Interstate Compact on the Placement of Children (ICPC) process was temporarily shut down. Residential Programs in Vermont for children and adolescents overall reduced capacity. The pandemic also impacted community and residential treatment program placements for adults. Due to the lack of placements, DVHAs authorization decisions were affected, and additional authorization was required to keep our members safe and stable during this time. In June 2020, both out of state and in state programs slowly began to lift the hold on admissions and the ICPC process.
Utilization management staff have continued to issue administrative authorization decisions to support continued inpatient stays when necessary. There has been a significant reduction in the number of days necessary to ensure safety and stability through extended stays. This reduction is likely attributable to the reopening of programs providing lower levels of care.

As of March 1, 2021, Vermont Medicaid modified reimbursement methodology for inpatient services delivered by the Brattleboro Retreat (the Retreat). Prior to implementation Department of Vermont Health Access & Department of Mental Health reimbursed the Retreat for services using different methodologies on a fee-for-service, per claim basis. The new model allows for a prospective payment informed by a number of factors:

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

DVHA, DMH and the Retreat have agreed upon performance measures and a monitoring platform for the model is being built by the Quality and Clinical Integrity team at DVHA
The Behavioral Health Team also manages the Team Care program. Team Care can be a

useful tool for members who may need additional support getting the most appropriate healthcare available to meet their needs. All available data is reviewed to determine whether enrollees need to remain in the program. Standards for inclusion and removal have been operationalized by the team. A screening tool, manual, and inclusion procedure have been developed. The unit conducts quarterly 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 enrollment of potential new members. Team Care program members are also referred to VCCI when appropriate.
Outreach with providers and pharmacies is ongoing. An outward facing brochure for Providers has been created and an internal and outward facing educational campaign on the Team Care program has been developed. There have been minimal external referrals to the program. The lack of referrals may demonstrate success of the VermontPrescription Monitoring System (VPMS) and new opiate rules associated with VPMS.

Team members participate in the SFI Interagency Team and the Youth Service System Enhancement Council (a collaborative with ADAP, DMH, VCRIP, Vocation Rehabilitation, DCF, and more). Team members are active in ensuring that beneficiaries with multi- department involvement are getting appropriate services delivered in the most efficient manner. This is accomplished through participation in state interagency team meetings, the Mobile Crisis Response Initiative, by attending monthly CRC meetings, participating in weekly case review, and development of protocols for cross departmental service delivery. Our unit worked with other departments on developing a system to notify DVHA regarding all children with Medicaid that are awaiting placement in Emergency Departments for DVHA to assist with placements when needed.

The Applied Behavior Analysis case rate payment methodology became effective on 07/01/2019. The goal of this payment reform project was to increase utilization and access to services. Since the initiation of the case rate, we have seen an increase in new members that have been receiving ABA services. There has been an increase in Vermont Medicaid enrollment of new agencies that provide ABA services. Although there have been positive outcomes with the implementation of the case rate methodology, multiple ABA providers have provided feedback regarding the difficulty of prospectively determining treatment hours for the next month. Provider concerns include end of year payment reconciliation. The ABA team includes the QICI, Payment Reform, Policy and Business units. The team explored alternatives and posted a Global Commitment Register (GCR) on May 5th which proposed a change in the timing of the payment to a post-delivery payment. Providers would not be required to prospectively set payment tiers. After posting the proposal for public comment and reviewing and considering responses, the team has decided that effective July 1, 2021, DVHA is changing the timing of ABA case rate tier submissions and payments from a prospective payment to a post-service delivery payment.

Prior to the COVID-19 pandemic, the DVHA ABA team was conducting site visits/audits with ABA providers. The purpose of these visits/audits was to ensure that members were receiving quality care, that providers are accurately reimbursed for provided services, to verify that required documentation is included in members charts, and that clinical documentation follows ABA Policy and Clinical Guideline standards.

Site visits/audits have resumed as of January 2021 and are completed in a virtual format due to social distancing restrictions. This includes a virtual tour of the providers Electronic Health Records system. Additionally, the provider electronically submits clinical documentation to be reviewed by the Autism Specialist or designee. Six virtual site visits/audits have been successfully completed with the goal to visit every ABA provider by December 2021.

iv. Mental Health System of Care

Key updates from QE032021:

- Activities related to the COVID-19 pandemic.
- Integrating Family Services Activity
- Implementation of DMH 10-Year Plan

System Overview

The Department of Mental Health is responsible for mental health services provided under state funding to special-needs populations including children with serious emotional disturbances (SED) and adults with severe and persistent mental illnesses (SPMI). Funding is provided through the Vermont Agency of Human Services (AHS) Master Grants to ten Designated Agencies and two Specialized Service Agencies. These agencies are located across the state of Vermont for the provision of:

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

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

Inpatient care is provided through a decentralized system which includes one state-run psychiatriccare hospital and five Designated Hospitals located across the state.

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

There are a number of policy and programmatic updates below related to the COVID pandemic. The Governor of Vermont, Phil Scott, declared a state of emergency on March 13, 2020 and on

March 24, 2020 Governor Scott issued a "Stay Home, Stay Safe" order that ordered Vermonters to restrict and minimize activities outside of the home and directed non-essential businesses and non—profits to cease in person operations. These orders have had a tremendous impact on the service delivery of mental health services throughout Vermont in all community-based settings and inpatient facilities.

Enhancements of the Mental Health System of Care through DMH:

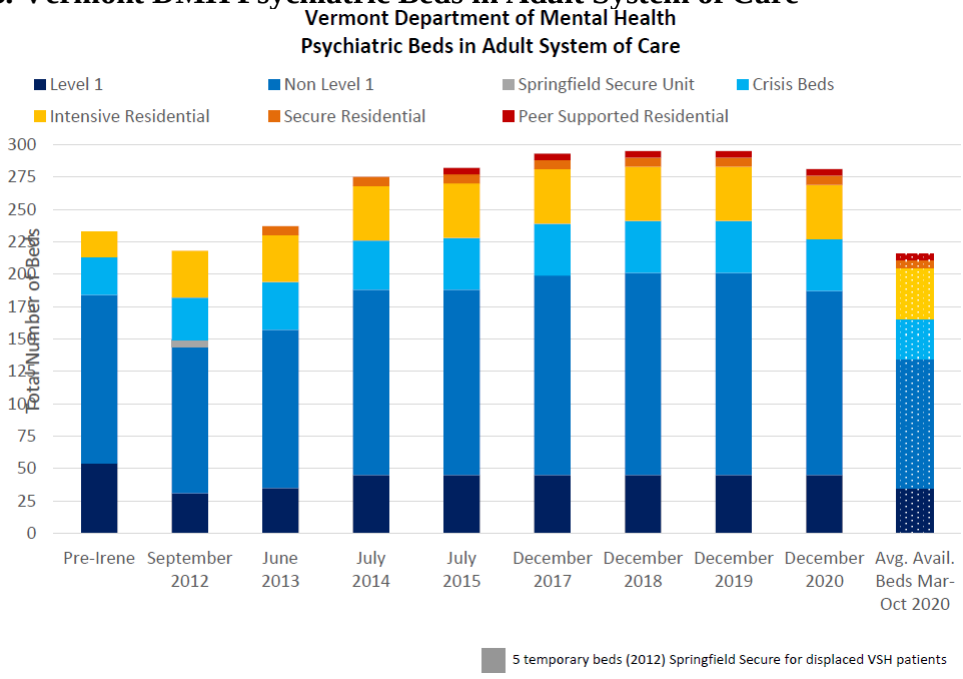
Hospital Services

There are 45 level 1 beds and a total of 159 adult psychiatric inpatient beds across the system of care. During the Covid-19 pandemic, a number of beds closed due to low staffing and a decrease in individuals presenting with a need for a higher level of care. The planned 12 inpatient Level I beds at the Brattleboro Retreat have opened, improving our system capacity.

The temporary loss of 14 adult beds in response to public health and environmental safety guidance for both inpatients and staff until renovations are completed and effects of the Covid-19 pandemic mitigated. This temporary bed loss is identified in the chart below.

In addition to this temporary loss of adult beds, the COVID-19 pandemic had a ripple effect across the adult inpatient system of care during this same period. In the below table, a bar illustrating Average Available Beds March – October 2020 reflects a system-wide impact across inpatient and community-based crisis beds and residential programs.

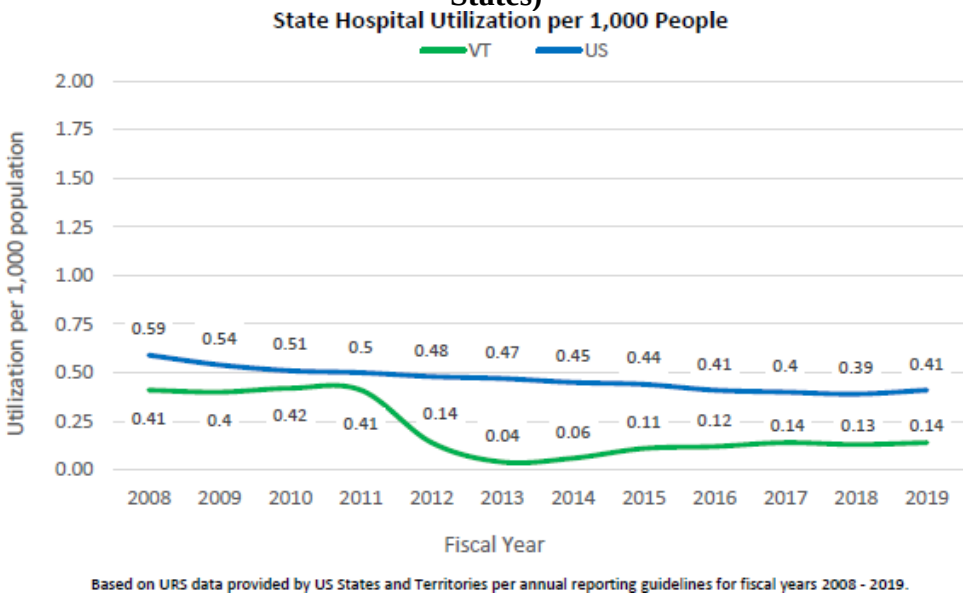
Figure 3. Vermont DMH Psychiatric Beds in Adult System of Care



DMH compares the utilization of its system of care to national benchmarks. The following two charts provide information on Vermont utilization as compared to national benchmarks. Data from these two charts are calculated by the Substance Abuse and Mental Health Services Administration's (SAMSHA) Uniform ReportingSystem (URS), which generates the National Outcomes Measures (NOMs). FY 2019 is the most

recent data available.

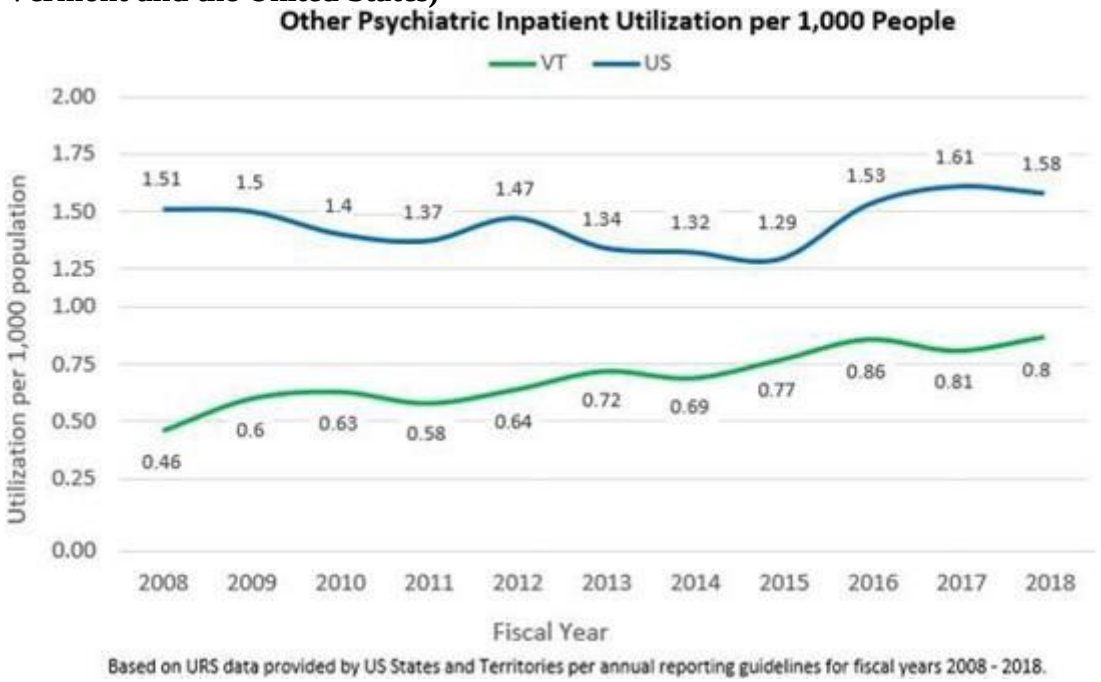
Figure 4. State Hospital Utilization per 1,000 people (in Vermont and the United States)



Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2019.

The national rate of state hospital utilization continues to decline year-over-year. Vermont Psychiatric Care Hospital opened in FY 2015 with 25 beds and Vermont's rate of inpatient utilization continues to be lower than the national average in the United States. The significant decrease from FY 2011 to FY 2012 represents the closure of Vermont State Hospital due to flooding from Tropical Storm Irene in August 2011. The Vermont hospital utilization data is showing a slowly progressing upward trend since 2012. Vermont is one of a handful of states that only has one state hospital. Nationally, the number of state hospital beds and residents at the end of the year has been steadily decreasing. MH will be paying close attention to these rates as there is anticipation and evidence already that this pandemic and the social isolation that has occurred because of it will increase the needs for mental health treatment and support.

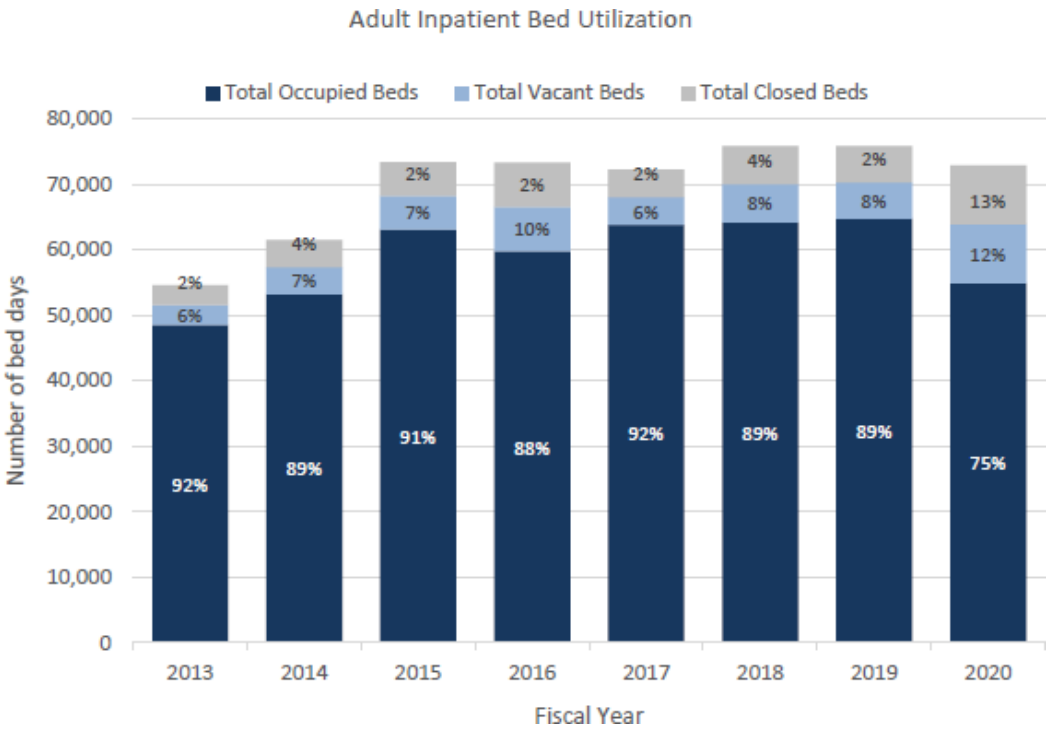
Figure 5. Other Psychiatric Hospital Utilization per 1,000 people (in Vermont and the United States)



Other involuntary psychiatric hospital unit admissions, such as those at Designated Hospitals, are included in the Other Psychiatric Hospital Utilization chart. The national rate of psychiatric hospital utilization since 2008 has generally declined year-over year through 2016 while Vermont's rate of utilization has increased. However, in both 2017 and 2018 there have been substantial increases in national utilization of psychiatric hospital beds.

Vermont experienced a slight decline in 2017. Inpatient utilization is still below the national averages while rates of community services utilization in Vermont continues to be markedly higher than national averages (Community Utilization per 1,000 Populations).

Figure 6. Adult Inpatient Utilization and Bed Closures



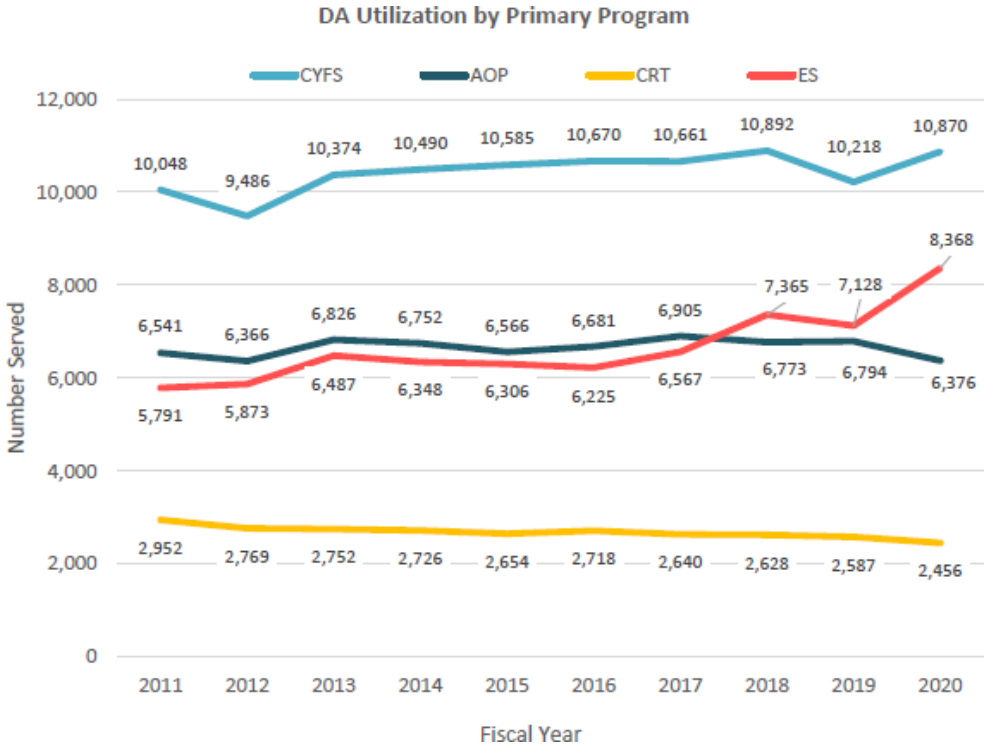
The Adult Inpatient Utilization and Bed Closures chart depicts the total bed day capacity across the Vermont Designated Hospital system through FY 2020. The total bed day availability across the system has remained relatively constant in 2018 and 2019 with bed day utilization decreasing 14%in 2020. The impact of the COVID-19 pandemic has contributed to the 4% increase in bed vacancies and the 11% increase in beds closed for much of 2020. Over this eight-year period, 2020 has seen thelowest level of adult inpatient bed utilization.

Community Services

- Establish Community Outreach Team in Washington County (Collaboration with Public Safety)
- Increased capacity within Community Rehabilitation and Treatment and peer programs to provide community support, outreach, and crisis response continues to develop
- Broad utilization of non-categorical case management services for Adult Outpatient and Emergency Services programs
- Increased capacity to provide mobile crisis responses to those needing screening and intervention in the community
- Increased and additional training for Team Two collaboration between law enforcement and mental health responders
- Additional availability of soft-restraints for law enforcement transports for involuntary mental health hospitalizations
- Resources to assist individuals in finding and keeping stable housing
- Expansion of peer-supported warmline hours

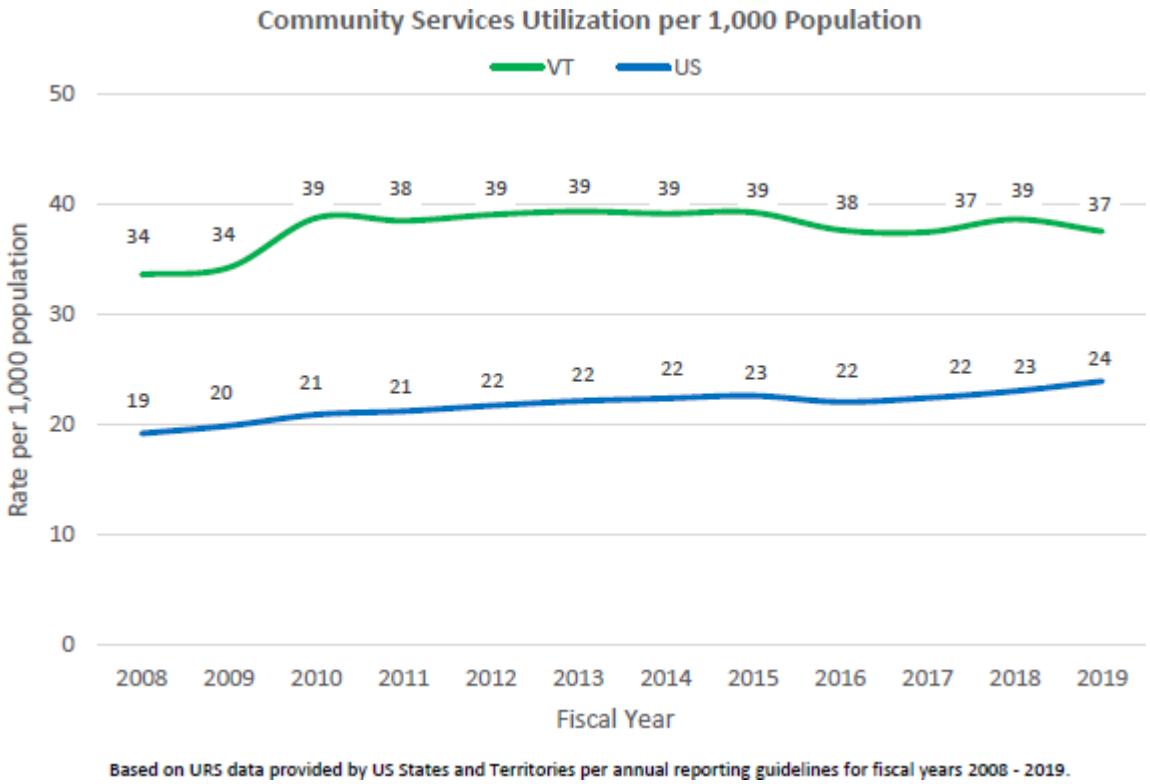
Enhanced community services funding provided by the legislature through increased appropriations to key mental health programs in the community over the last several years has helped, but staff recruitment and retention necessary to meet and expand these service capacities continues to be a struggle. The payment reform initiative beginning 1/1/2019 has also been an effort to reduce barriers to access and promote more "needs" driven service delivery that can be more responsive to individuals seeking mental health services. The new payment reform methodology, more flexible service delivery, and value-based incentive payment framework focused on quality and outcomes supports a more streamlined approach to adult program access and the service capacity available in each DA catchment area.

Figure 7. Designated Agency Volume by Program



The highest number of persons served by programs offered by the Designated Agencies (DAs) continues to be in services for children, youth, and families. The 6% decrease noted in 2019 appears to have self- corrected and closely approximates utilization in 2018. Similarly, the Emergency Services programs also had an upward trend overall in 2020 which may reflect the increased support needs associated with the impacts of Covid-19. The Adult Outpatient programs saw a 6% decline in utilization while the Community Rehabilitation and Treatment (CRT) programs saw 4% decline. Both of these adult programs have seen flat or slow trend changes over the nine-year period reflected. As FY2020 all programs utilization essentially reflects only one quarter of potential impact from the COVID-19 pandemic, FY 2021 will be more reflective of the virus' impact to system services and capacities to meet the needs of individuals served in Calendar Year 2020.

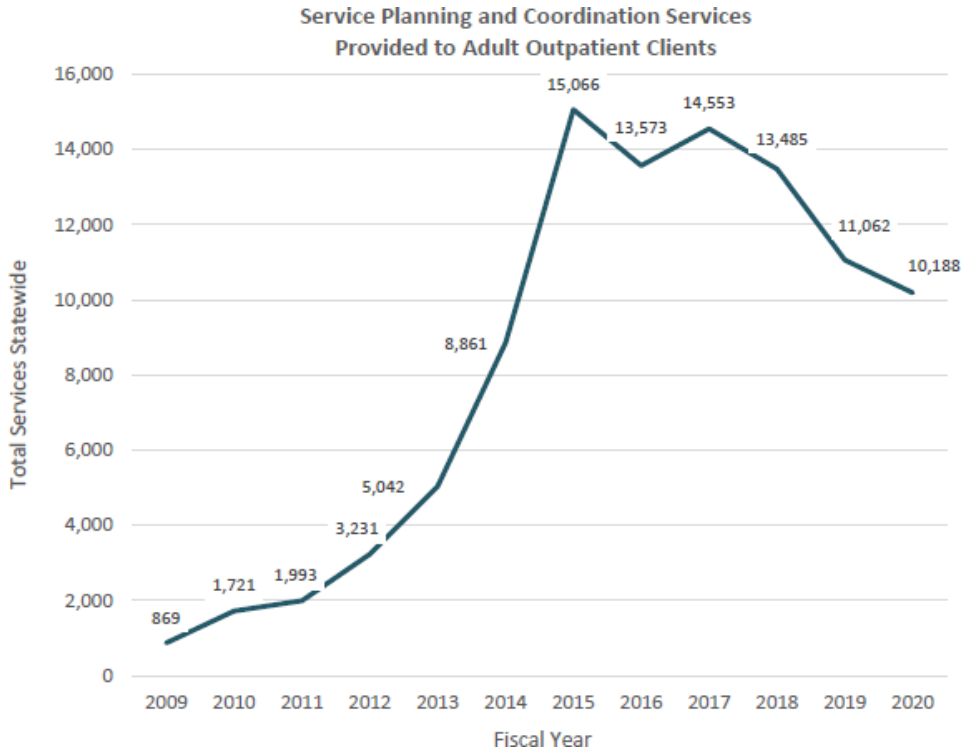
Figure 8. Community Utilization per 1,000 Populations



Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2019.

The Vermont community mental health system serves nearly 40 out of every 1,000 Vermonters, which is substantially higher than the national utilization rate. The most recent national data available through 2018 shows that Vermont has a strong and fairly consistent record of service delivery in community-based programs. The system of care is established on the principle that the intensity of services an individual requires will change over time. Individuals receive community-based treatment appropriate to their needs and move to higher or lower levels of care only as necessary to support them. For many who have a chronic illness this is more challenging, as they continuously require higher level of service needs within the system.For others, they enter and exit intermittently depending on their individual needs. The case rate payment reforms provide the ongoing flexibility to meet the needs of the individuals and provide the necessary services.

Figure 9. Service Delivery: Planning and Coordination

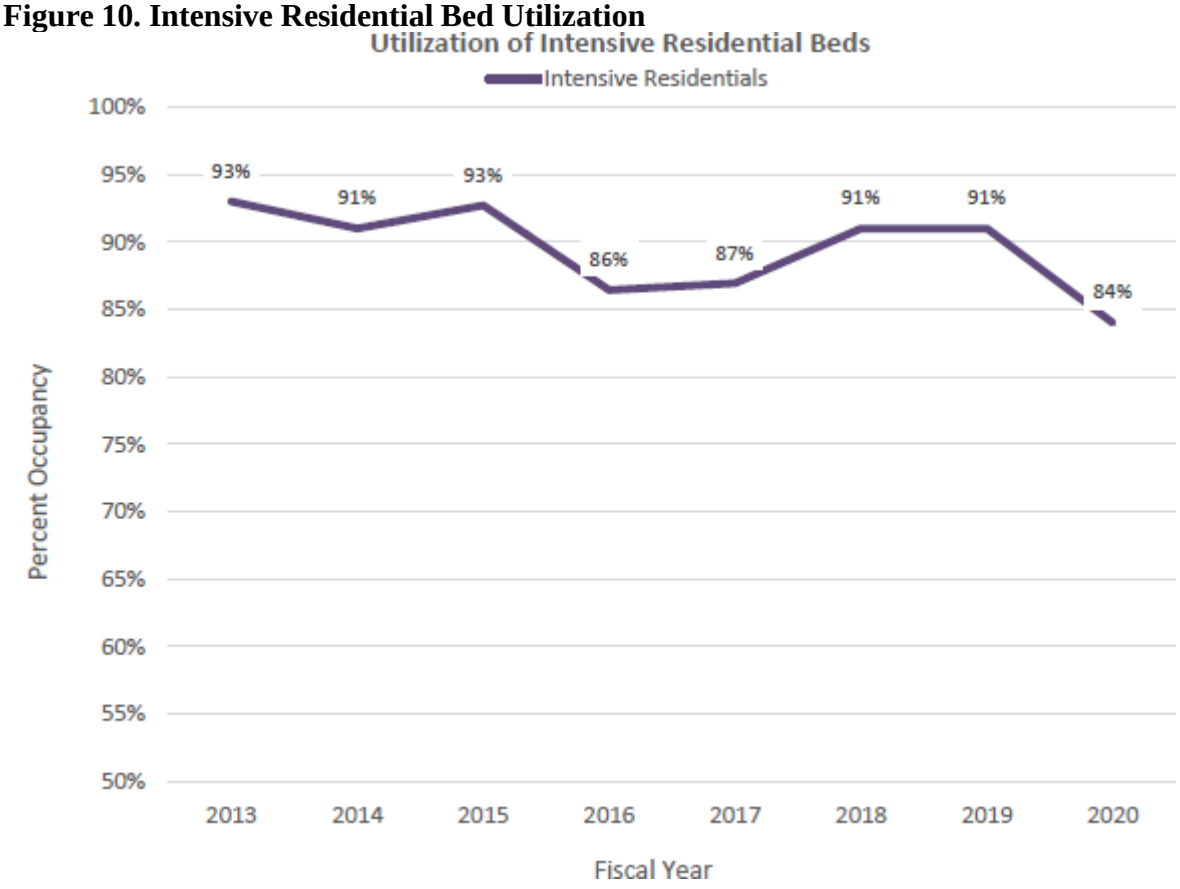


The support of non-categorical case management led to a steady increase in the number of services provided to adult outpatient clients allowing additional support to those in need but ineligible for case management through Community Rehabilitation and Treatment services through FY 2015. Levels remain elevated for this population FY 2016 through FY 2018, but the data shows a decline in recent years. It is still worth noting that the expansion of services provided for service planning and coordination has met a population need for this level of case management services for adults. The Department's payment reform launched in January 2019 continues to support flexible service delivery including case management services when needed.

The system of care is established on the principle that the intensity of services an individual requires will change over time. Individuals receive community-based treatment appropriate to their needs and move to higher or lower levels of care only as necessary to support them. For many who have a chronic illness this is more challenging, as they continuously require higher level of service needs within the system. For others, they enter and exit intermittently depending on their individual needs. The system must have the flexibility to meet the needs of the individuals and provide the necessary services.

Residential and Transitional Services

Figure 10. Intensive Residential Bed Utilization



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

2019. 2020 saw the greatest decrease in utilization over the eight-year period to 84%. The influence of the pandemic through much of 2020 and the changing capacities of programs to safely transfer and introduce new residents into programs likely contributed to this drop. Effects of the virus on 2020 data appears evident throughout this reporting period.

Performance and Reporting

- Along with AHS, DMH has adopted the Results-Based Accountability (RBA) framework for assessing performance of providers via grants and contracts.
  - Creation of a "Vermont Psychiatric Care Hospital Outcomes" scorecard to meet legislative reporting requirements.
  - Migration of the "DMH Snapshot" and the "DMH continued reporting" report to the RBA scorecard reporting tool
- Exploration of visualization tools to create more responsive reporting.
- Participation in development of the Agency of Human Services Community profiles
- DMH has several RBA scorecards containing data and performance measures related to the system of care.

Regulation and Guidance

To align with federal policy shifts brought on by the COVID-19 pandemic, DMH issued new guidanceto providers this past year on:

- COVID-19 Hospital Discharge Guidance
- General Guidance to Designated Agencies
- Critical Incident Reporting Requirements
- Medical Clearance Guidance
- The use of telehealth and HIPAA requirements
  - Recommended precautions for

Caregivers Payment Reform

DMH continues to work on payment reform, building off the Medicaid Pathways work and aligning necessary changes in the provider system with the All-Payer Model. The Department has created a case rate for children/youth mental health services, and a case rate for adult mental health services. The goal of this work is to move toward a simple, but accountable system that reduces the complexities of payment and shifts the focus of the providers and the department on outcomes and quality. DMH is committed to reforming the system to better serve Vermont's population and continue to move towards full integration.

Integrating Family Services

The initial IFS implementation site in Addison County began on July 1, 2012, and the second pilot region in Franklin/Grand Isle counties began on April 1, 2014. These pilots included consolidation ofover 30 state and federal funding streams into one unified whole through one AHS Master Grant agreement. The State created an annual aggregate spending cap for two providers in Addison County (the Designated Agency and the Parent Child Center) and one in Franklin/Grand Isle (this provider isboth the Designated Agency and Parent Child Center). This has created a seamless system of care toensure no duplication of services for children and families.

On January 1, 2019, the IFS sites became aligned with larger payment reform efforts occurring across AHS including having value-based measures in alignment with statewide implementation. At the same time, IFS regions have additional requirements for performance measurement in accordance with the broader scope of services included in those regions. Vermont submitted a multiyear payment model for consideration to CMS in September 2018 and received approval in late December that goes through 2022.

Both IFS regions continue to utilize the Child and Adolescent Needs and Strengths (CANS) to look at the needs and strengths of children they are serving. The agencies are using this progress monitoring tool to track progress over time. They are showing that through supports and services children/youth are increasing in their strengths and decreasing needs. The caveat to this is that for children involved in the child welfare system it is taking longer to see positive results; not surprising given the fact that these children experience high levels of trauma, exposure to substances, and/or abuse and neglect— this data also follows national trends in data analysis for this subset of the population.

This summer, the IFS grantee in Franklin/Grand Isle will have their bi-annual integrated chart review which includes all AHS departments reviewing charts for minimum standards across the various fundingstreams that create the integrated case rate.

Vision 2030

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

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

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

Following the plan submission to the legislature in January 2020, DMH was anticipating convening a Mental Health Integration Council in the fall of 2020, to begin the work of implementation. The demands of the COVID-19 pandemic on Vermont's health systems, however, has delayed that work. Work that was called for in the plan, however, has in many instances been advanced in direct response to the pandemic. Telehealth options, for example, are now available for anyone seeking mental health care, and are fully reimbursable.
Much work has been undertaken to ensure children's mental health services are available even if children are not in a physical school building. DMH is creating an inventory of work that is moving ahead and continues its support in that work within the department staff capacity available. DMH has continued planning for the Council and looks forward to convening this work as soon as circumstances allow.

v. Pharmacy Program

Key updates from QE032021

- Operational Activities
    - Prior Authorization (PA) Data
    - Paid Claims and Drug Spend
    - Provider Communications
- Clinical Activities
    - Pharmacist enrollment
    - Drug Utilization Review Board (DURB)/Preferred Drug List
    - Pharmacy Cost Management (PCM) Program
- Pharmacy Changes related to Federal/State Legislation
    - Tobacco Cessation
    - Morphine Milligram Equivalents (MME)

Pharmacy Benefit Management Program

The DVHA's Pharmacy Unit manages the pharmacy benefits for all of Vermont's publicly funded pharmacy benefit programs. The Pharmacy Unit's goal is to provide the highest quality prescription drug benefits in the most cost-effective manner possible. This is accomplished by providing broad coverage of prescription and over-the-counter pharmaceuticals, while controlling pharmacy expenditures through both utilization and cost management strategies. The DVHA utilizes the pharmacy benefit management company, Change Healthcare (CHC), to provide a full complement of operational, clinical, and programmatic supports in addition to managing a call center in South Burlington for pharmacies and prescribers. The Pharmacy Unit is also responsible for overseeing the contract with CHC. The Pharmacy Unit manages approximately $200 million in gross drug spend, and routinely analyzes national and DVHA drug trends, reviews drug utilization, and seeks innovative solutions to delivering high-quality customer service, assuring optimal drug therapy for DVHA members while managing drug utilization and cost.

Pharmacy Operations

- Pharmacy claims processing – Assuring that members have access to medically-necessary medications within the coverage rules for DVHA's various pharmacy benefits.
- Pharmacy provider assistance – Assisting pharmacies and prescribers with various issues related to claims processing, prior authorizations, and other operational and clinical issues.
- Pharmacy Interface to Coordination of Benefits Unit/Part D Plan Team/Eligibility/Member Call Center to coordinate benefits and resolve member issues.
- Liaison to Vermont Department of Health (VDH) in multiple clinical areas-Vaccines including COVID vaccines, Alcohol & Drug Abuse Programs (ADAP), Asthma, Smoking Cessation, and Department of Mental Health (DMH) related to management of psychotherapeutic drug use in children. The Pharmacy Team also works with Vermont Medication Assistance Program (VMAP) and Children with Special Health Needs (CSHN) to assist in the drug and rebate management of the programs.
- Clinical Activities include managing drug utilization and cost.
    - Federal, State, 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 criteriareview and step-therapy protocols.
- Specialty pharmacy management
- Physician-administered drug management

- Manages exception requests, EPSDT requests, appeals and fair hearings with Policy Unit.
- Works with Program Integrity Unit on drug utilization issues related to fraud, waste, and abuse.

Operational Activity Reports

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

	No PA	Automated Edits						
Period	**Claims Paid w/o PA**	**Claims Paid w/Auto PA**	**Claims Paid with Auto Edit**	**Claims Paid w/Online Override**	**Claims Paid w/Emergency PA**	**Claims Paid due to Grandfathering**	**Claims Paid w/Clinical PA**	**Total Claim Count**
Quarter 1	438,915	92	46,264	249	104	9,093	19,441	514,158
	85%	<1%	9%	<1%	<1%	2%	4%	100%

- Total claim count does not include compounded drugs.

Paid Claims and Drug Spend

MEDICAID

Period	# Claims	# of Members	State Paid Amounts
1Q2021	444,632	74,351	$58,370,599.25

VPHARM

Period	# Claims	# of Members	State Paid Amounts
1Q2021	72,027	7,834	$1,873,161.14

Provider Communications Issued

Important Update on Early Refill Overrides with Submission Clarification Code (SCC)=13 for 90-Day Maintenance Medications	Effective 2/19/2021, DVHA will no longer the automatic on-line override of the 90-day maintenance rule, and pharmacies must call the Help Desk for an override. A prior authorization must be submitted to continue dispensing less than a 90-day supply of maintenance medications. This is due to the fact that most drug shortages related to the PHE have been resolved.
Update on Synagis (palivizumab) Dispensing	No further orders of Synagis® for Respiratory Syncytial Virus (RSV) prophylaxis will be authorized after 3/4/2021 since the positivity rate on PCR and Antigen tests for RSV remains below 2% for over 2 consecutive weeks. This is most likely due to social distancing and emergency guidelines put into place related to the PHE.
New Coverage of Omnipod DASH Insulin Pump	Coverage of Omnipod® DASH products have been added to the pharmacy benefit effective 4/1/21. The manufacturer is making it available through the pharmacy channel, not through DME. This will not require prior authorization.
Pharmacy Newsletter	A pharmacy newsletter went out in January 2021 giving updates on Pharmacist Enrollment for billing and reimbursement of COVID-19 vaccine administration, How to bill for COVID-19 vaccine administration, Prior Authorizations Extensions related to the PHE, Changes to Preferred Albuterol Inhalers, Coverage changes for Taltz, Preferred Drug List (PDL) 2021 Changes, and Drug Utilization Review Board (DURB) 2021 Meeting Schedules

Clinical Activities

Pharmacist Enrollment

Effective September 1, 2020, under the guidance of the federal PREP Act and Vermont Board of Pharmacy Emergency Guidance pharmacists, pharmacy technicians, and pharmacy interns under the supervision of a licensed pharmacist were able to enroll in the Vermont Medicaid program as licensed providers to provide Medicaid services in accordance with their scope of practice, and state and federal law allowing them to administer COVID-19 Vaccines to Vermont Medicaid members.

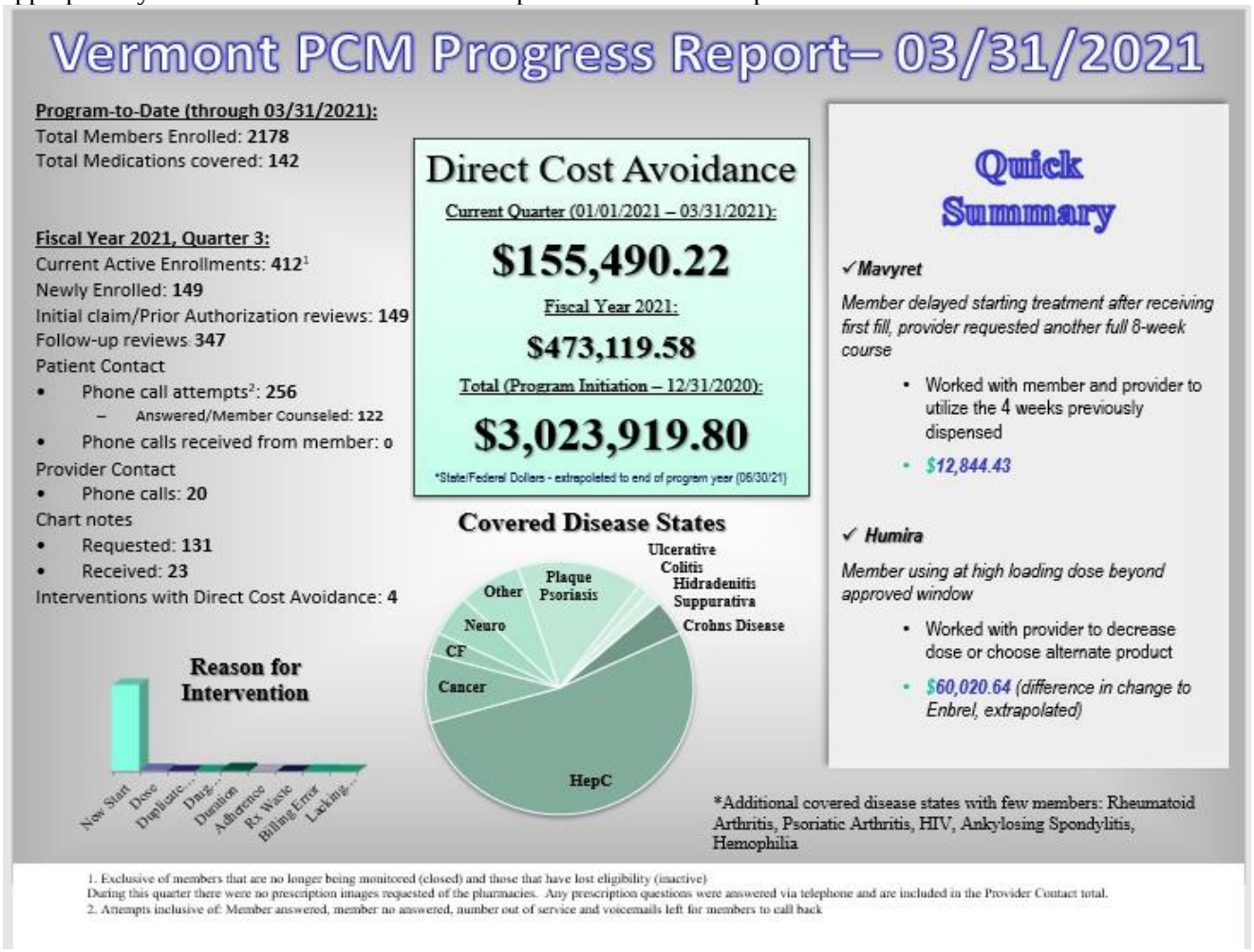
During Q1 CY2021, we enrolled 192 pharmacists for an overall total of 251 enrolled pharmacist at the end of the quarter.

Pharmacy Cost Management (PCM) Program

In late SFY 2017, DVHA, in collaboration with Change Healthcare, implemented the Pharmacy Cost Management (PCM) Program. The goal of the program is to mitigate the impact of high-cost specialty drugs on pharmaceutical expenditures while ensuring that the full value of these medications in improving patient outcomes and reducing medical expenditures can be realized. Achieving this goal requires focused and attentive oversight and

management of both the drugs and the patients receiving them to ensure that patients are not only prescribed the optimal drug for their specific condition, but that they are taking the drug as prescribed and are receiving the appropriate monitoring, testing and follow-up care.

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



Change Healthcare (January 1, 2021 through March 31, 2021). Change Healthcare Pharmacy Management Reporting Suite by a collection of reports recording the process and progress of PCM.

The program is actively monitoring 412 enrollees. A total of 256 outgoing telephone calls were placed to members, 122 of which resulted in member counseling. During this quarter of the Vermont PCM program, four interventions led to direct and measurable cost avoidance. Furthermore, interventions that do not bring about direct cost avoidance are in place to encourage adherence and thus improve member outcomes and avoid unnecessary medical costs. In CY2021, the Vermont Medicaid Pharmacy Cost Management (PCM) program enrolled 149 new members, and continued management of an additional 347 patients, resulting in improved pharmaceutical care and a savings of nearly $155,500, and lifetime savings attributable to the PCM program total more than $3 million.

Pharmacy Changes related to Federal/State Legislation:

Tobacco Cessation

Per Act 178 of the 2020 legislative session pharmacists may prescribe both prescription and over-the-counter tobacco cessation products. Provision of this service must be done in accordance with a protocol approved by the Commissioner of Health after consultation with the Director of Professional Regulation and the Board of Pharmacy. The Vermont Medicaid program will reimburse pharmacists for providing tobacco cessation counseling. Pharmacists will be paid according to the Resource-Based Relative Value Scale (RBRVS) fee schedule. Coverage will continue to be limited to 16 visits per year for Medicaid members, which can be exceeded with prior authorization. This expansion to cover tobacco cessation services provided by pharmacists is expected to increase utilization of this benefit and improve the quit rate among Vermont Medicaid members. This change will be implemented on July 1, 2021.

Morphine Milligram Equivalent (MME)

Pursuant to the Medicaid Drug Utilization (DUR) provisions that were included in Section 1004 of the "Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment of Patients and Communities Act", also referred to as the SUPPORT Act, the Department of Vermont Health Access (DVHA) implemented prescription limits for opioids used in treating chronic pain. These standards are focused on preventing harm by minimizing opportunities for misuse, abuse, and diversion, and to optimize prevention of addition and overdose. The amount of daily morphine milligram equivalents (MMEs) is frequently used as a risk factor to evaluate potential opioid related harms. DVHA uses the MME conversion factors provided by the Centers for Disease Control (CDC). More detailed information can be found on their website at https://www.cdc.gov/drugoverdose/prescribing/guideline.html. Effective May 1, 2021, additional edits apply that include any combination of short and long-acting opioids and members on chronic therapy for non-cancer pain. Members new to opioid therapy with a daily MME greater than 90 per day will require the completion of an opioid safety checklist as a prior authorization. Members with existing claims history in the past 90 days for opioids (not new to therapy) will require a safety checklist if the daily MME exceeds 120 per day.

Drug Utilization Review Board

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

1) Review and approve drug use criteria and standards for both retrospective and prospective drug use reviews.
2) Apply these criteria and standards in the application of DURB activities.
3) Review and report the results of DUR programs; and
4) Recommend and evaluate educational intervention programs.

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

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

The chart below lists CYQ1 2021 activities of the Drug Utilization Review Board.

Review Topic	CYQ1 2021 Total
Therapeutic Drug Classes: Periodic Review	9
Full New Drug Reviews	12
FDA Safety Alerts	0
New/Updated Clinical Guidelines	0
RetroDUR/ProDUR reviews	2
New Managed Therapeutic Drug Classes	1
BioSimilar Drug Reviews	1

Drug Utilization Review Board Meetings

Drug Utilization Review Board meetings occur seven times per year and always have a robust agenda. Information on the DURB and its activities in 2021 is available at this link: https://dvha.vermont.gov/advisory-boards/drug- utilization-review-board

The sample agenda typically follows this format.

VERMONT

Department of Vermont Health Access
Pharmacy Benefits Management Program
DUR Board Meeting Agenda

- **Executive Session** **6:00 - 6:30**
- **Introductions and Approval of DUR Board Minutes** **6:30 - 6:35**
  (Public Comment Prior to Board Action**)**
- **DVHA Pharmacy Administration Updates** **6:40 - 6:45**
- **Medical Director Update** **6:45 - 6:50**
- **Follow-up Items from Previous Meetings** **6:50 - 6:50**
- **RetroDUR/ProDUR** **6:50- 7:10**
- Introduce:
- Data presentation:
- **Clinical Update: Drug Reviews** **7:10-7:45**
  (Public comment prior to Board action)
  Biosimilar Drug Reviews
- **Full New Drug Reviews**
  (Any new drug reviews that also fall within the Therapeutic Class Review (TCR) will be discussed during the Therapeutic Class Review)
- **New Managed Therapeutic Drug Classes** **7:45 -7:45**
  (Public comment prior to Board action)
- **Therapeutic Drug Classes – Periodic Review** **7:45 - 8:30**

(Public comment prior to Board action)

- **Review of Newly Developed/Revised Criteria** **8:30 - 8:30**
  (Public comment prior to Board action)
- **General Announcements** **8:30 – 8:30**
- **Adjourn** **8:30**

vi. All Payer Model: Vermont Medicaid Next Generation Program

Key updates from QE032021:

- Executed a contract extension with OneCare for a 2020 performance year of the program.
- Began conducting financial reconciliation activities for the 2020 performance year, in order to determine financial and quality performance. Results will be available in early Q3 2021.
- Drafted and released RFP for ACO services through the VMNG program for 2022 contract start date.
- Continue to support Vermont's broader efforts to develop an integrated health care delivery system under an All-Payer Model through future program planning and implementation.

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

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

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

DVHA began conducting financial reconciliation activities for its 2020 performance year in Q1 2021. Reconciliation activities will determine the ACO's spend as compared to their financial target and quality performance for the 2020 performance year. Reconciliation activities will continue through Q22021,and final

results will be available by the end of Q3 2021.

DVHA drafted and released a Request for Proposals (RFP) for ACO services through the Vermont Medicaid Next Generation ACO Program for a contract start date of January 1, 2022. DVHA anticipatesthe elements of its VMNG model will remain similar to its current iteration. DVHA will select apparently successful bidder(s) in late Q2 or early Q3 of the program and anticipates entering into contract negotiations with those bidders in Q3 and Q4 of 2021.

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 March 2021 quarter (January through March 2021). This payment served as the proxy by which to draw down Federal funds for Global Commitment (GC).

As is the process after each quarterly submission of the CMS-64, AHS reconciled the quarterly amount claimed on the CMS-64 with the monthly payments made to DVHA. The State prepared the CMS-64 based upon actual allowable Medicaid expenditures (program, investments, and administration) for the given quarter. AHS submitted and certified the CMS64 report for QE0321 on April 30, 2021, as is normal.

Overall, the budget neutrality exercise indicates that for March 2021 quarter, the State's total "With Waiver" expenditures were $103,526,841(26%) lower than the total "Without Waiver" amount (caseloads multiplied by the Budget Neutrality PMPMs).

For the supplemental budget neutrality tests, the New Adult test is showing a surplus of $32,054,230. The SMI IMD test is showing a deficit of 1,468,888 and the SUD IMD test is showing a deficit of $125,509. The deficits in SMI IMD and SUD IMD are applied to the overall budget neutrality test. There is ample room in the overall budget neutrality test to accommodate these deficits.

AHS continues to actively monitor Investment spending. The total Investment spending for QE0321 was $22,664,232. The total CY2021 Budget Neutrality Investment Limit is $136,500,000.

VI. Member Month Reporting

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

The table below contains Member Month Reporting for QE0321 of CY2021 and includes the unduplicated count of member months for SUD IMD and SMI IMD stays. CY2020 and CY 2019 member months are also reported in the tables below.

Table 1. Member Month Reporting – Calendar Year 2021 (QE0321), *subject to revision*, with CY2020 and CY2019.

Demonstration Population	Medicaid Eligibility Group	CY2021 (Quarter Ending 03/21)	Total CY2020	Total CY2019
1, 4*, 5*	ABD - Non-Medicare - Adult	20,023	79,917	81,293
	SUD - IMD - ABD	11	106	149
	SMI - IMD – ABD	14	68	
1	ABD - Non-Medicare - Child	4,805	20,010	23,855
1, 4*, 5*	ABD – Dual	65,591	260,336	257,866
	SUD - IMD - ABD Dual	19	136	158
	SMI - IMD - ABD Dual	7	8	
2	Non ABD - Non-Medicare - Adult	34,493	112,494	104,150
	SUD - IMD - Non ABD	31	161	222
	SMI - IMD - Non ABD	6	24	
2	Non ABD - Non-Medicare - Child	184,904	714,020	703,957
	Medicaid Expansion			
7	Global RX	19,656	78,078	77,498
8	Global RX	10,290	41,565	44,169
6	Moderate Needs	444	1,962	2,208
	New Adults:			
3	New Adult without Child	129,659	453,605	423,150
	SUD - IMD New Adult w/o Child	203	1,157	1,352
	SMI - IMD New Adult w/o Child	60	210	
3	New Adult with Child	75,413	267,085	233,294
	SUD - IMD New Adult with Child	38	209	259
	SMI - IMD New Adult with Child	12	43	
	Total	545,679	2,031,194	1,953,580

Table 2. GC Budget Neutrality PMPM Rates, CY 2021 (January 1, 2021 – December 31, 2021)

STC PMPM Budget Neutrality	
Medicaid Eligibility Group	**DY 16 PMPM CY2021**
ABD - Non-Medicare - Adult	$1,745.83
SUD - IMD ABD	$ 3,798.97
SMI - IMD ABD	$ 16,054.00
ABD - Non-Medicare - Child	$3,419.74
ABD - Dual	$3,006.28
SUD - IMD ABD Dual	$ 2,901.13
SMI - IMD ABD Dual	$ 19,633.00
Non ABD - Non-Medicare - Adult	$780.03
SUD - IMD Non ABD	$ 2,852.36
SMI - IMD Non ABD	$ 10,448.00
Non ABD - Non-Medicare - Child	$643.26
New Adult Group	$ 610.97
SUD - IMD - New Adult	$ 3,042.23
SMI - IMD - New Adult	$ 12,182.00

Table 3. Actuarially Certified PMPM Rates, CY 2021 (January 1, 2021 – December 31, 2021)

Effective 1/1/21 - 12/31/21	CY 2021
ABD Adult	$2,245.83
ABD Child	2,937.38
ABD Dual	2,364.58
Global Rx	107.97
Moderate Needs	669.53
New Adult	436.24
Non-ABD Adult	584.09
Non-ABD Child	494.25

VII. Consumer Issues

AHS and DVHA have several mechanisms whereby consumer issues are tracked and summarized. The first is through Health Access Member Services. This is a contracted function for providing information on health care programs, assisting with the eligibility process, and helping beneficiaries to understand the benefits and responsibilities of their particular program. The complaints received by Member Services are reported to DVHA (see Attachment 3). Member Services works to resolve the issues raised by beneficiaries, and the reports are seen by several management staff at DVHA.

The second mechanism to assess trends in beneficiary issues is the Managed Care Grievance and Appeal report. This report is based on data entered by grievance and appeal coordinators in various locations across the MCE. The database into which they enter information helps them track the

timeframes for responding to the grievances and appeals, as well as assists DVHA and AHS in monitoring compliance and assessing if there are trends that may benefit from a performance improvement project.

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

VIII. Quality Assurance and Performance Improvement Activities

Key updates from QE032021:

- Intervention planning began for DVHA's new formal PIP topic, management of hypertension. 3 focused sub-groups were created to work on activities related to: policy/reimbursement, provider and patient education and community resources.
- DVHA's Quality Team worked on multiple other collaborative QI projects, all with a focus on realizing efficiencies, aligning priorities and reducing redundancies.

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

PIHP Quality Committee

The Quality Committee remained active during QE0321and consists of representatives from all departments within AHS that serve the Medicaid population. The committee continues to structure its work around the federal managed care quality program guidelines and the triple aims of health care:

improving the patient experience, improving the health of populations, and reducing the per capita cost of health care. During this time period, the Quality Committee reviewed our performance for the measures within *DVHA's Global Commitment to Health* Core Measure Set and based on those results recommended a new formal PIP topic focused on managing hypertension (see next item).

The committee followed our work plan and reviewed the annual Child and Adult CAHPS surveys, as well as confidentiality procedures and HIPAA breach tracking.

Formal CMS Performance Improvement Project (PIP)

During QE0920, DVHA followed our standard operating procedure (SOP) for selection of a new formal CMS PIP topic. Through that process, managing hypertension was chosen as our recommended study topic. The

project team was assembled during QE1220 and performed a root cause analysis exercise. During QE0321, barriers were reviewed and prioritized by the project team. Intervention activities were chosen and 3 focused sub-groups were created to work on activities related to: policy/reimbursement, provider and patient education and community resources.

Other Collaborative Quality Improvement Projects

DVHA's Clinical Services Team strives to realize efficiencies, align priorities and reduce redundancies. With these overarching goals in mind, the Quality team worked with the following groups on collaborative QI projects during QE0321:

- DVHA's Long Term Care unit in relation to a data collection process improvement that will allow that unit to present sought-after metrics on the effects of COVID-19 on our long-term care application processing. DVHA'sClinical Operations unit to address a legislative directive. DVHA is exploring prior authorization requirementswith a lens toward recommending modifications to current practice.
- The Department of Mental Health on an Agency-wide alternative payment model (APM) for inpatient services delivered by a regional psychiatric and detoxification facility. The purpose of the APM is to add administrative simplicity in claims processing and a predictable cash flow for inpatient stays that are primarily the responsibility of Vermont Medicaid. The Clinical Services Team lead the work group that established quality of care measures to ensure that cost and quality incentives are aligned in the APM.

Quality Measure Reporting

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - the DVHA Quality Unit's Director of Quality Management coordinated the 2020 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Children's and Adults Medicaid 5.0H survey. The contracted vendor, DataStat, Inc., distributed and collated the surveys according to AHRQ and NCQA protocols in the fall of2020. The results of the surveys were delivered to DVHA during this reporting period and were presented by the Director of Quality Management to the PIHP Quality Committee and to DVHA's Management Team in March 2021.

- HEDIS measure production – In 2020 and into QE0321, the Quality Unit staff worked with DVHA's Business Office, Payment Reform Unit and Data Unit to re-negotiate the HEDIS measure production vendor contract. In addition to producing administrative (claims based) measures, the Quality Unit began preparing for the HEDIS2021season by requested that our selected vendor, Cotiviti, perform medical record retrieval for four hybrid measures and abstraction for two of those measures. DVHA clinicians will abstract the other two measures. DVHA's Quality Assurance Manager prepared abstraction training, tools and materials during QE0321.

- Leaders (VITL) in 2019 to explore using the data stored in the Vermont Health Information Exchange (VHIE)for hybrid measure production in the future. Initial system testing was performed in CY 2020 and indicated a need for further analysis. This work was slowed due to the COVID-19 pandemic but will continue into CY 2021 as we discuss with VITL the best approach to the data comparisons we need to make.

Results Based Accountability (RBA)/Process Improvement

Results Based Accountability (RBA) scorecards are developed at DVHA for both internal and external performance management purposes. The use of this performance management framework and corresponding presentation tool has been spearheaded by the Agency's Central Office QI staff. The DVHA Quality Unit staff use this tool to create a *Global Commitment to Health* Core Measure scorecard, Experience of Care, and other performance budgeting scorecards. The largest scorecard effort during 2020 was made to the DVHA

Performance Accountability Scorecard - which includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services. Scorecards that were newly developed or actively maintained during QE0321 include the following initiatives: Applied Behavior Analysis (ABA) Program, DVHA Dental Program and Payment Reform Models.

The Quality Improvement Team also maintained their Green Belt status during QE0321 by updating and submitting personal development plans. Green Belt is the highest level of internal training offered through the State based on LEAN/RBA principles. The trainings are centered around process improvement and contribute to the Governor's initiative called PIVOT, or Program to Improve Vermont Outcomes Together.

COVID-19 Dashboard

The Quality Team was tasked with creating and maintaining a COVID-19 dashboard at the end of March 2020 to monitor the response to the pandemic: both the impact it has had on operations and the activities staff have engaged in. As an internal evaluation tool, the dashboard is updated weekly and made available to all DVHA staff via our intranet. DVHA's Management Team highlights certain metrics within the dashboard at its regular meetings. This work was maintained throughout 2020 and continues into 2021. Additional measures are added to the dashboard as appropriate.

Vermont Next Generation Medicaid ACO

During QE0321, 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 typically meet quarterly with a focus on quality measurement and ongoing QI efforts. Although temporarily paused during CY 2020 due primarily to the pandemic, these quarterly meeting have been re-established and will carry forward starting in QE0621.A representative from the VMNG ACO is a standing member on DVHA's new formal PIP, the topic of which is managing hypertension.

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 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, DMH and DVHA highlighted the performance of a subset of their investments. The Clear Impact Scorecards for these investments is included in this report as Attachment 7.

Payment Models & Performance Monitoring

AHS Departments are required to monitor and evaluate the performance of their payment models on an ongoing basis and subject them to formal review according to a periodic schedule. Performance monitoring is accomplished via a quarterly and annual review of performance information contained in a web browser-based software application (Clear Impact Scorecard). The scorecard includes the following data elements: payment model description (i.e., the goal of the payment model, the activities being supported, and information on how they are provided), performance measures (i.e., the data being collected and analyzed to determine if the payment model is achieving its desired goal), results (performance measure rates for 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 Dental Incentive Program payment model. In addition, DCF highlighted the performance of its Children's Integrated Services payment model. Both Clear Impact Scorecards for these payment models are included in this report as Attachment 8.

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

During this year, the CQS/STP was posted for public comment. The public comment period started on February 19,2020 – and originally ran through March 20, 2020. The document was posted on the AHS website and the notice was distributed to subscribers using the Global Commitment Register (GCR). A link to the CQS/STP was also included in the body of the notice. The updated version of the strategy/plan included content that addresses the following milestones:

- completion of site-specific assessment & validation activities (VT-5.0),
- an updated chart of the number of sites falling into categories of compliance (VT-5.1),
- incorporate results of settings analysis into final version of the STP and releasing for public comment (VT-6.0),
- identification of settings that overcome the presumption and will be submitted for heightened scrutiny and notification to provider (VT-17.0),
- complete gathering information and evidence on settings requiring heightened scrutiny that it will present to CMS (VT-18.0), and
- incorporate list of settings requiring heightened scrutiny and information and evidence (VT- 19.0).

Due to the COVID-19 pandemic, the comment period was extended from 30 to 60 days. During the extended STP public comment period, the state received feedback from one stakeholder, the Vermont Developmental Disabilities Council (VTDDC). The main theme of the VTDDC feedback was concern regarding the plan's failure to address and ensure ongoing compliance with conflict of interest in the delivery of case management services in Vermont's HCBS programs. Vermont has been directed by CMS that the correct avenue for managing Conflict Free Case Management requirements is through its upcoming waiver renewal. Given this guidance, no modifications were made to the STP based on the feedback. Vermont continues to work with CMS and stakeholders, including the VTDDC, on the correct approach to these requirements for each of its home and community-based services programs outside of the Statewide Transition Plan, which is specific to CMS requirements regarding HCBS settings. A copy of Vermont's current STP was posted on the CMS HCBS STP website.

During this year, the state received feedback from CMS re: their recently submitted CQS/STP. The feedback focused on the following aspects of the plan: site-specific settings assessment, validation of the HCBS settings, remediation strategies, ongoing monitoring of settings, and heightened scrutiny. The state's response to the COVID-19 public health emergency has limited in- person, on-site visits which as caused a delay in confirming the implementation of assessment and validation generated corrective actions. The state continues to address those action items that can be resolved remotely and will reevaluate its progress during the year to come.

SUD Monitoring Protocol

The SUD Monitoring Protocol specifies the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 49 of the demonstration. The protocol consists of two parts: a set of narrative sections and a metrics workbook. These metrics consist of (1) established quality measures endorsed by NQF or included in other Medicaid Quality Measures measure sets, (2) CMS-constructed implementation performance metrics and (3) state-defined Health Information

Technology (HIT) metrics. For each performance measure, the SUD Monitoring Protocol identifies a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points. During this quarter, there was no reporting – but the state continues to support the calculation of the monitoring metrics according to the timeline outlined in Table A of Appendix A of the Monitoring Protocol Alignment Form.

SUD Mid-Point Assessment

The assessment includes an examination of progress toward meeting each milestone and timeframe approved in theSUD Implementation Protocol, and toward closing the gap between baseline and target each year in performance measures as approved in the SUD Monitoring Protocol. The assessment also includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations, and any recommendations. In addition, the assessment includes a determination of factors that affected achievement on themilestones and performance measure gap closure percentage points to date, and a determination of selected factorslikely to affect future performance in meeting milestones and targets not yet met and about the risk of possibly missing those milestones and performance targets. For each milestone or measure target at medium to high risk ofnot being met, the assessor will provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The state's SUD Mid-Point Assessment was submitted to CMS during Q4 2020.

SMI Monitoring Protocol

The state's special terms and conditions (STCs) for its current five-year demonstration period (July 1,2017–June 30, 2021) were amended in December 2019 to include a Serious Mental Illness (SMI) component. As per the new STCs, the state is required to submit a SMI Monitoring Protocol to CMS within 150 calendar days after approval of SMI implementation plan. The Monitoring Protocol Template must be developed in cooperation with CMS and is subject to CMS approval.

The SMI Monitoring Protocol describes the state's monitoring plans for their SMI demonstration. Components of the Monitoring Protocol must include the following: 1) an assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 103(c) and STC 104(c), reporting relevant information to the state's SMI/SED financing plan described in Attachment C, and reporting relevant information to the state's Health IT plans described in STC 104(d); 2) a description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section IX of the demonstration; and 3) a description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

During Q1 2021, the state received feedback on their updated version of the protocol – including metrics workbook. The state responded to the feedback and resubmitted a final version of the protocol. This version of the workbook incorporates the feedback discussed during the state's February 25, 2021 call with CMS. Specifically, the state added the following language to the narrative description found on the Protocol – SMI & SED definitions tab of the workbook (Cells 14B and 14C): "…during the measurement period or 11 months prior." By making these changes, CMS granted verbal approval of Vermont's SMI Monitoring Protocol – with the official notice being delayed due to the transition in administration.

SMI/SED Mid-Point Assessment

The state also continued to work with the evaluator on the SMI Mid-Point Assessment. During this year, a design

and discussion meeting was held with DMH as well as a follow-up meeting which included DMH, DVHA and IT staff. Finally, the state worked with departments to ensure evaluation data is submitted to an independent evaluator according to the established schedule. Response to the COVID-19 public health emergency has slowed progress – but the current timeline remains applicable. The state will continue to regularly monitor the availability of data to support the evaluation report and assess its ability to maintain the current timeline.

IX. Demonstration Evaluation Activities (*including SUD and SMI/SED*)

GC Final Evaluation Design

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 analyzing 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 their 1115 wavier. Specifically, the design identifies the state's hypotheses, evaluation questions, associated measures, and analytic methods.

The GC Final Evaluation Design is the state's plan for how it will accomplish the evaluation of their 1115 wavier. Specifically, the design identifies the state's hypotheses, evaluation questions, associated measures, and analytic methods.

During last quarter, the state submitted a final version of the GC Evaluation Design to CMS for review/approval. This version incorporated the CMS feedback that was received on October 20, 2020. During a subsequent phone conversation, CMS indicated that the state's design was "for all intent and purposes" approved – but due to the administration transition – a formal approval letter would be delayed.

PHE Evaluation Design

In an effort to address the COVID-19 public health emergency, the State of Vermont applied for and was approved for a new section 1115(a) demonstration opportunity available to states under title XIX (Medicaid) of the Social Security Act. Under this demonstration opportunity, the state of Vermont requested CMS to waive the requirement, at 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.

During last quarter, the state submitted an evaluation design for the COVID-19 section 1115 demonstration. The design provided a background description of the policies and objectives of the state's demonstration, a general overview of the research questions the state will examine in the final report, an outline of data sources the state feels may be useful to both contextualize and respond to these questions, and any anticipated limitations to these monitoring and evaluation plans. During this quarter, CMS indicated during a phone conversation that the state's design was "for all intent and purposes" approved – but due to the administration transition – a formal approval letter would be delayed.

GC Interim Evaluation Report

The state's GC Interim Evaluation Report (IER) was submitted to CMS during Q4 2020. The report was produced by an independent evaluator using CMS tools and guidance to ensure alignment with the state's special terms and conditions and CMS expectations. Specifically, the draft interim evaluation report discusses evaluation progress

and presents findings to date using hypotheses, evaluation questions, and measures identified in the CMS approved evaluation design. During this quarter, the state worked with the independent evaluator to modify the IER to respond to the CMS feedback. It is anticipated that a final version of the IER will be submitted to CMS during the next quarter.

X. Compliance

Key updates from QE032021:

- The 2021 EQRO Preparation
- Compliance Committee progress
- DVHA is preparing subject matter experts for this year's EQRO Audit.
- AHS and DVHA continue to develop new structures to manage compliance activities.
- Compliance Committee monitoring and oversight is underway.

During this quarter, the state worked with the External Quality Review Organization (EQRO) to develop the material necessary for each of the required annual external quality review activities (i.e., performance improvement project validation, performance measure validation, and compliance review). Performance Improvement Project (PIP) validation items included the PIP validation timeline, review templates and report outline. Performance Measure Validation items included the PMV timeline, a document request letter, a rate reporting template, and HEDIS roadmap. Review of Compliance with Standards items included a document request letter as well as desk and documentation review forms. All timelines included the following elements: start date, completion date, task, and responsible party. All letters and materials are expected to be sent to DVHA during the next quarter.

Monitoring Compliance with Standards

During this quarter, DVHA began preparing subject matter experts for the 2021 EQRO compliance audit. This included an orientation to the audit standards and the audit timeline. For this year's compliance review, the auditors will focus on the following standards:

- Practice Guidelines
- Quality Assessment and Performance Improvement Program
- Health Information Systems

Compliance Committee

During this quarter, the committee reviewed and provided feedback to the new committee SharePoint site. The site was updated to include contact information for committee members, a task list, and document folders for agendas, meeting notes, and reference documents. Also, during this quarter, the committee reviewed the annual workplan which will be used to guide the committee's activities during the year. The workplan will be finalized during the next quarter, and monitoring activities will commence.

Intra-Governmental Agreement (IGA) between AHS and DVHA

During this quarter, the state responded to a request from CMS to resend the signature page of the CY2021 AHS DVHA IGA. In addition, CMS asked the state to review the implementation of risk mitigation strategies, including risk corridors – and share how they might apply to the state's managed care model. The state provided the signature page and offered the position that a risk mitigation strategy does not apply to the AHS-DVHA IGA because DVHA is considered a non-risk based PHIP. The state expects to receive CMS approval of the CY2021

AHS DVHA IGA during the next quarter.

XI. Reported Purposes for Capitated 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:

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

Attachment 6 is a summary of Investments, with applicable category identified, for QE032021.

XII. Enclosures/Attachments

Attachment 1: Budget Neutrality Workbook
Attachment 2: Enrollment and Expenditures Report
Attachment 3: Complaints Received by Health Access Members Services
Attachment 4: Medicaid Grievance and Appeal Reports
Attachment 5: Office of the Health Care Advocate Report
Attachment 6: QE032021 Investments
Attachment 7: Investment Scorecard
Attachment 8: Payment Model Scorecard

XIII. State Contact(s)

Fiscal:	Sarah Clark, CFO VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	 802-505-0285 (P) 802-241-0450 (F) sarah.clark@vermont.gov
Policy/Program:	Ashley Berliner, Director of Health Care Policy & Planning VT Agency of Human Services 280 State Drive, Center Building Waterbury, VT 05671-1000	 802-578-9305 (P) 802-241-0958 (F) ashley.berliner@vermont.gov
Managed Care Entity:	Cory Gustafson, Commissioner Department of VT Health Access 280 State Drive, NOB 1 South Waterbury, VT 05671-1010	 802-241-0147 (P) 802-879-5962 (F) cory.gustafson@vermont.gov

Date Submitted to CMS: **May 28, 2021**

ATTACHMENTS

Attachment 1

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
May 5, 2021

ELIGIBILITY GROUP	DY 12 JAN - DEC 2017	DY 13 JAN - DEC 2018	DY 14 JAN - DEC 2019	DY 15 JAN - DEC 2020	DY 16 JAN - DEC 2021	Total
Without Waiver (Caseload x pmpms)						
ABD - Non-Medicare - Adult	$ 142,860,455	$ 130,050,973	$ 131,976,747	$ 134,543,466	$ 34,956,754	$ 574,388,395
ABD - Non-Medicare - Child	$ 85,359,001	$ 78,434,428	$ 75,860,331	$ 65,987,377	$ 16,431,851	$ 322,072,988
ABD - Dual	$ 664,153,383	$ 693,539,886	$ 720,885,032	$ 754,719,271	$ 197,184,911	$ 3,030,482,483
Non ABD - Non-Medicare - Adult	$ 101,757,250	$ 96,887,008	$ 73,827,769	$ 83,650,538	$ 26,905,575	$ 383,028,139
Non ABD - Non-Medicare - Child	$ 392,665,288	$ 406,444,058	$ 413,877,439	$ 439,100,879	$ 118,941,347	$ 1,771,029,012
Total Expenditures Without Waiver	**$ 1,386,795,376**	**$ 1,405,356,354**	**$ 1,416,427,318**	**$ 1,478,001,532**	**$ 394,420,438**	**$ 6,081,001,018**
With Waiver						
ABD Non Medicare Adult	$ 162,602,152	$ 162,728,372	$ 168,382,861	$ 177,858,509	$ 42,067,863	$ 713,639,757
ABD - Non-Medicare - Child	$ 66,593,208	$ 60,077,015	$ 58,176,676	$ 55,369,700	$ 11,450,062	$ 251,666,660
ABD - Dual	$ 445,847,909	$ 461,739,496	$ 484,543,363	$ 476,164,427	$ 107,771,356	$ 1,976,066,551
Non ABD - Non-Medicare - Adult	$ 84,040,229	$ 84,275,155	$ 67,221,781	$ 69,967,054	$ 19,202,180	$ 324,706,398
Non ABD - Non-Medicare - Child	$ 305,543,574	$ 335,706,591	$ 350,805,773	$ 334,351,461	$ 83,662,690	$ 1,410,070,090
Premium Offsets	$ (655,991)	$ (772,935)	$ (774,152)	$ (413,790)	$ (59,488)	$ (2,676,355)
Moderate Needs Group	$ 1,488,408	$ 1,378,915	$ 1,429,868	$ 703,701	$ 97,441	$ 5,098,333
Marketplace Subsidy	$ 6,355,286	$ 6,242,717	$ 5,915,336	$ 5,862,966	$ 1,501,797	$ 25,878,103
VT Global Rx	$ 13,824,167	$ 15,300,919	$ 10,692,124	$ 3,494,233	$ 1,339,241	$ 44,650,684
VT Global Expansion VHAP	$ 414,825	$ (0)	$ 0	$ -	$ -	$ 414,825
CRT DSHP	$ 10,331,787	$ 9,240,772	$ 6,787,058	$ 5,604,875	$ 1,136,735	$ 33,101,227
Investments	$ 142,332,671	$ 148,500,000	$ 119,133,231	$ 114,806,088	$ 22,664,232	$ 547,436,222
Total Expenditures With Waiver	**$ 1,239,374,215**	**$ 1,285,189,954**	**$ 1,273,088,069**	**$ 1,244,183,015**	**$ 290,893,597**	**$ 5,332,728,849**
Hypothetical Test 1: New Adult						
Limit New Adult PMPM*Mem-Mon	$ 370,689,611	$ 375,735,593	$ 369,387,603	$ 422,569,375	$ 125,292,840	$1,663,675,022
With Waiver New Adult Total Expenditures	$ 295,620,338	$ 312,104,578	$ 315,240,526	$ 368,166,529	$ 93,238,610	$1,384,370,580
Surplus (Deficit)	*$ 75,069,273*	*$ 63,631,015*	*$ 54,147,078*	*$ 54,402,846*	*$ 32,054,230*	$ 279,304,442
Hypothetical Test 2: SUD IMD						
SUD - IMD ABD - Non-Medicare - Adult		$ 268,039	$ 529,433	$ 389,449	$ 41,789	$ 1,228,710
SUD - IMD ABD - Dual		$ 214,495	$ 442,312	$ 387,577	$ 55,121	$ 1,099,505
SUD - IMD Non ABD - Non-Medicare - Adult		$ 533,391	$ 633,224	$ 459,230	$ 88,423	$ 1,714,268
SUD - IMD New Adult		$ 2,704,249	$ 4,842,747	$ 4,130,907	$ 733,177	$ 12,411,080
Limit SUD IMD Without Waiver PMPM*Mem-Mon	**$ -**	**$ 3,720,174**	**$ 6,447,715**	**$ 5,367,163**	**$ 918,511**	**$ 16,453,563**
SUD - IMD ABD Non Medicare Adult		$ 249,820	$ 646,440	$ 411,251	$ 48,699	$ 1,356,211
SUD - IMD ABD - Dual		$ 199,224	$ 545,837	$ 342,450	$ 59,370	$ 1,146,881
SUD - IMD Non ABD - Non-Medicare - Adult		$ 540,841	$ 803,762	$ 516,507	$ 94,328	$ 1,955,439
SUD - IMD New Adult		$ 2,826,119	$ 5,869,169	$ 4,250,210	$ 841,623	$ 13,787,121
Limit SUD IMD With Waiver (Total Expenditures)	**$ -**	**$ 3,816,005**	**$ 7,865,208**	**$ 5,520,418**	**$ 1,044,020**	**$ 18,245,651**
Surplus (Deficit)	*$ -*	*$ (95,830)*	*$ (1,417,494)*	*$ (153,255)*	*$ (125,509)*	$ (1,792,088)
Hypothetical Test 3: SMI IMD						
SMI - IMD ABD - Non-Medicare - Adult				$ 1,059,916	$ 224,756	$ 1,284,672
SMI - IMD ABD - Dual				$ 151,168	$ 137,431	$ 288,599
SMI - IMD Non ABD - Non-Medicare - Adult				$ 241,344	$ 62,688	$ 304,032
SMI - IMD New Adult				$ 2,952,257	$ 877,104	$ 3,829,361
Limit SMI IMD Without Waiver PMPM*Mem-Mon	**$ -**	**$ -**	**$ -**	**$ 4,404,685**	**$ 1,301,979**	**$ 5,706,664**
SMI - IMD ABD Non Medicare Adult				$ 1,726,684	$ 489,758	$ 2,216,442
SMI - IMD ABD - Dual				$ 188,470	$ 177,312	$ 365,782
SMI - IMD Non ABD - Non-Medicare - Adult				$ 727,204	$ 194,563	$ 921,767
SMI - IMD New Adult				$ 5,348,474	$ 1,909,234	$ 7,257,708
Limit SMI IMD With Waiver (Total Expenditures)	**$ -**	**$ -**	**$ -**	**$ 7,990,832**	**$ 2,770,867**	**$ 10,761,699**
Surplus (Deficit)		*$ -*	*$ -*	*$ (3,586,147)*	*$ (1,468,888)*	$ (5,055,035)
Waiver Savings Summary						
Annual Savings	**$ 147,421,162**	**$ 120,166,400**	**$ 143,339,249**	**$ 233,818,517**	**$ 103,526,841**	**$ 748,272,169**
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	*$ 44,226,348*	*$ 30,041,600*	*$ 35,834,812*	*$ 58,454,629*	*$ 25,881,710*	*$ 194,439,100*
Hypothetical Test 2 & 3 adjustment	**$ -**	***$ (95,830)***	***$ (1,417,494)***	***$ (3,739,402)***	***$ (1,594,397)***	***$ (6,847,123)***
Total Cumulative Savings		**$ 74,172,118**	**$ 108,589,437**	**$ 163,304,664**	**$ 187,591,977**	**$ 187,591,977**

New Adult Waiver Savings Not Included in Waiver Savings Summary
See Budget Neutrality New Adult tab (STC#64)
See CY2021 Investments tab
See EG MM CY 2021 Tab for Member Month Reporting

Budget Neutrality New Adult

New Adult (w/ and w/o Child) Medical Costs Only	**DY 14 – PMPM**				**DY 15 – PMPM**				**DY 16 – PMPM**			
	QE 0319	**QE 0619**	**QE 0919**	**QE 1219**	**QE 0320**	**QE 0620**	**QE 0920**	**QE 1220**	**QE 0321**	**QE 0621**	**QE 0921**	**QE 1221**
(A) New Adult Group PMPM Projection	$562.71	$562.71	$562.71	$562.71	$586.34	$586.34	$586.34	$586.34	$610.97			
(B-1) eligible member months w/ Child	57,969	58,516	58,610	58,199	60,037	65,214	66,464	67,879	75,413			
(B-2) eligible member months w/o Child	110,736	106,927	103,710	101,777	102,648	110,982	116,871	118,700	129,659			
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	$ 32,619,735.99	$ 32,927,538.36	$ 32,980,433.10	$ 32,749,159.29	$ 35,202,094.58	$ 38,237,576.76	$ 38,970,501.76	$ 39,800,172.86	$ 46,075,080.61			
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	$ 62,312,254.56	$ 60,168,892.17	$ 58,358,654.10	$ 57,270,935.67	$ 60,186,628.32	$ 65,073,185.88	$ 68,526,142.14	$ 69,598,558.00	$ 79,217,759.23			
(D-1) New Adult FMAP w/ Child	53.89%	53.89%	53.89%	53.86%	60.06%	60.06%	60.06%	60.77%	60.77%			
(D-2) New Adult FMAP w/o Child	93.00%	93.00%	93.00%	93.00%	90%	90%	90%	90%	90%			
(E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child	$ 17,578,775.73	$ 17,744,650.42	$ 17,773,155.40	$ 17,638,697.19	$ 21,142,378.00	$ 22,965,488.60	$ 23,405,683.36	$ 24,186,565.05	$ 27,999,826.49			
(E-2 = C2 x D-2) Federal Share of Supplemental Cap 1 w/o Child	$ 57,950,396.74	$ 55,957,069.72	$ 54,273,548.31	$ 53,261,970.17	$ 54,167,965.49	$ 58,565,867.29	$ 61,673,527.93	$ 62,638,702.20	$ 71,295,983.31			
Subtotal Federal Share Supplemental Cap 1	$ 75,529,172.47	$ 73,701,720.14	$ 72,046,703.71	$ 70,900,667.37	$ 75,310,343.49	$ 81,531,355.89	$ 85,079,211.28	$ 86,825,267.25	$ 99,295,809.79			
Total FFP reported for New Adult Group	$ 67,854,834.87	$ 68,588,592.26	$ 63,276,555.83	$ 54,245,264.74	$ 82,218,290.81	$ 68,092,015.38	$ 69,686,466.57	$ 73,806,046.32	$ 74,243,005.17			
Supplemental Budget Neutrality Test 1 over/(under) - report any negative # under main GC budget neutrality	$ 7,674,337.60	$ 5,113,127.88	$ 8,770,147.88	$ 16,655,402.63	$ (6,907,947.32)	$ 13,439,340.51	$ 15,392,744.72	$ 13,019,220.93	$ 25,052,804.62			

Report to
The Vermont Legislature

Medicaid Program Enrollment and Expenditures Quarterly Report

In Accordance with 33 V.S.A. § 1901f

Submitted to: The General Assembly

Submitted by: Mike Smith, Secretary
Agency of Human Services

Prepared by: Sarah Clark, Chief Financial Officer
Agency of Human Services

Report Date: March 4, 2021

VERMONT
AGENCY OF HUMAN SERVICES

TABLE OF CONTENTS

BACKGROUND

In accordance with 33 V.S.A. § 1901f, a quarterly report on enrollment and total expenditures by Medicaid eligibility group for all programs paid for by the Department of Vermont Health Access shall be submitted to the General Assembly by March 1, June 1, September 1, and December 1 of each year. To the extent such information is available, total expenditures for Medicaid-related programs paid for by other departments within the Agency of Human Services shall be included.

KEY TERMS

Caseload: Average monthly member enrollment

PMPM: Per Member Per Month

MEG: Medicaid Eligibility Group

ABD Adult: Beneficiaries age 19 or older; categorized as aged, blind, disabled, and/or medically needy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Agency of Human Services
Caseload and Expenditure Report

DVHA Only YTD SFY'21

Medicaid Eligibility Group	SFY'21 Restatement As Passed Caseload	Budget	PMPM	SFY'21 Actuals Thru December 31, 2020 Caseload	Expenses	PMPM	% of Expenses to Budget Line Item	Ending Enrollment as of December
ABD Adult	6,475	$ 61,811,034	$ 795.51	6,248	$ 27,162,157	$ 724.52	43.94%	6,244
ABD Dual	17,439	$ 57,644,404	$ 275.46	17,722	$ 22,348,615	$ 210.18	38.77%	17,767
General Adult	8,114	$ 50,275,041	$ 516.34	10,174	$ 26,649,151	$ 436.54	53.01%	10,653
New Adult Childless	35,000	$ 187,427,978	$ 446.26	39,916	$ 103,929,550	$ 433.95	55.45%	41,247
New Adult w/Child	19,988	$ 94,734,165	$ 394.96	23,639	$ 53,710,739	$ 378.68	56.70%	24,438
BD Child	1,604	$ 20,361,380	$ 1,057.84	1,642	$ 12,471,047	$ 1,265.97	61.25%	1,622
General Child	57,698	$ 164,653,910	$ 237.81	59,946	$ 73,545,813	$ 204.48	44.67%	60,243
Underinsured Child	509	$ 431,984	$ 70.72	562	$ 211,406	$ 62.71	48.94%	568
CHIP	4,450	$ 8,934,633	$ 167.32	4,307	$ 3,810,942	$ 147.49	42.65%	4,293
Vermont Premium Assistance	16,515	$ 5,819,526	$ 29.36	15,543	$ 2,841,347	$ 30.47	48.82%	14,944
Vermont Cost Sharing	*3,481*	$ 1,216,331	$ 29.12	*3,184*	$ 680,417	$ 35.62	55.94%	3,106
Pharmacy Only	9,664	$ 7,577,935	$ 65.35	10,054	$ 1,413,216	$ 23.43	18.65%	10,078
Choices for Care - Traditional	-	$ -	$ -	-	$ -	$ -	0.00%	-
Choices for Care - Acute	4,329	$ 36,642,934	$ 705.38	4,485	$ 22,233,904	$ 826.29	60.68%	4,404
Total Medicaid	181,785	$ 697,531,255	$ 319.76	194,237	$ 351,008,303	$ 301.19	50.32%	196,501

All AHS YTD SFY'21

Medicaid Eligibility Group	SFY'21 Restatement As Passed Caseload	Budget	PMPM	SFY'21 Actuals Thru December 31, 2020 Caseload	Expenses	PMPM	% of Expenses to Budget Line Item	Ending Enrollment as of December
ABD Adult	6,475	$ 151,121,555	$ 1,944.94	6,248	$ 68,701,238	$ 1,832.52	45.46%	6,244
ABD Dual	17,439	$ 236,468,790	$ 1,129.98	17,722	$ 104,746,094	$ 985.09	44.30%	17,767
General Adult	8,114	$ 63,603,893	$ 653.23	10,174	$ 33,455,007	$ 548.03	52.60%	10,653
New Adult Childless	35,000	$ 222,379,565	$ 529.48	39,916	$ 121,840,041	$ 508.73	54.79%	41,247
New Adult w/Child	19,988	$ 107,785,455	$ 449.38	23,639	$ 61,238,852	$ 431.76	56.82%	24,438
BD Child	1,604	$ 42,707,863	$ 2,218.82	1,642	$ 21,493,341	$ 2,181.84	50.33%	1,622
General Child	57,698	$ 314,954,688	$ 454.89	59,946	$ 136,273,152	$ 378.88	43.27%	60,243
Underinsured Child	509	$ 891,605	$ 145.97	562	$ 441,561	$ 130.99	49.52%	568
CHIP	4,450	$ 11,871,861	$ 222.32	4,307	$ 4,899,446	$ 189.61	41.27%	4,293
Vermont Premium Assistance	16,515	$ 5,819,526	$ 29.36	15,543	$ 2,841,347	$ 30.47	48.82%	14,944
Vermont Cost Sharing	*3,481*	$ 1,216,331	$ 29.12	*3,184*	$ 680,417	$ 35.62	55.94%	3,106
Pharmacy Only	9,664	$ 7,577,935	$ 65.35	10,054	$ 1,413,216	$ 23.43	18.65%	10,078
Choices for Care - Traditional	4,457	$ 232,658,547	$ 4,350.06	4,642	$ 107,732,604	$ 3,868.18	46.31%	4,558
Choices for Care - Acute	*4,329*	$ 41,611,012	$ 801.01	*4,485*	$ 24,479,328	$ 909.74	58.83%	4,404
Total Medicaid	181,913	$ 1,440,668,626	$ 659.96	194,395	$ 690,235,644	$ 591.78	47.91%	196,655

VERMONT
AGENCY OF HUMAN SERVICES

All AHS and AOE YTD SFY'21

Medicaid Eligibility Group	SFY'21 Restatement As Passed Caseload	Budget	PMPM	SFY'21 Actuals Thru December 31, 2020 Caseload	Expenses	PMPM	% of Expenses to Budget Line Item	Ending Enrollment as of December
ABD Adult	6,475	$ 152,344,291	$ 1,960.67	6,248	$ 68,948,591	$ 1,839.12	45.26%	6,244
ABD Dual	17,439	$ 236,613,121	$ 1,130.67	17,722	$ 104,760,142	$ 985.23	44.27%	17,767
General Adult	8,114	$ 63,818,217	$ 655.43	10,174	$ 33,495,802	$ 548.70	52.49%	10,653
New Adult Childless	35,000	$ 222,481,367	$ 529.72	39,916	$ 121,852,188	$ 508.78	54.77%	41,247
New Adult w/Child	19,988	$ 107,788,739	$ 449.39	23,639	$ 61,243,843	$ 431.79	56.82%	24,438
BD Child	1,604	$ 55,465,796	$ 2,881.64	1,642	$ 23,582,891	$ 2,393.96	42.52%	1,622
General Child	57,698	$ 350,980,456	$ 506.92	59,946	$ 145,033,497	$ 403.23	41.32%	60,243
Underinsured Child	509	$ 1,150,685	$ 188.39	562	$ 500,847	$ 148.58	43.53%	568
CHIP	4,450	$ 13,400,423	$ 250.94	4,307	$ 5,313,870	$ 205.65	39.65%	4,293
Vermont Premium Assistance	16,515	$ 5,819,526	$ 29.36	15,543	$ 2,841,347	$ 30.47	48.82%	14,944
Vermont Cost Sharing	*3,481*	$ 1,216,331	$ 29.12	*3,184*	$ 680,417	$ 35.62	55.94%	3,106
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Choices for Care - Acute	*4,329*	$ 41,641,756	$ 801.60	*4,485*	$ 24,481,817	$ 909.83	58.79%	4,404
Total Medicaid	181,913	$ 1,492,957,188	$ 683.92	194,395	$ 701,881,071	$ 601.77	47.01%	196,655

The Vermont Cost Sharing Reduction (VCSR) population are also eligible for Vermont Premium Assistance (VPA) and the caseload counts are included in the VPA caseload counts and are not duplicated in the total. The budget and expenses are specificto each program.

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

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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

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

Questions, Complaints and Concerns Received by Health Access Member Services
January 1, 2021 – March 31, 2021

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

January 2021:

- Caller is calling with feedback on the Transportation program for Southern VT. Organizing transportation and routes are still taking too long to line up through Shared Transportation based in Brattleboro. There is a lack of consistency in drivers and knowledge of routes. Caller has back issues and accommodations for van or car ride is necessary. The process takes too long, and doctors are not filling out applications in a timely manner. Caller must wait for VPTA to follow up and it can take weeks before an appointment is made and confirmed. CSR apologized for his frustrations, advised he should contact VPTA, but also offered to document his feedback. DVHA's Member and Provider Relations NEMT staff followed up with VPTA and the caller.

February 2021:

- No issues to report

March 2021:

- Caller states that she should not have to call her provider and have them call Provider Services about a certain prescription. Caller feels that if she is the one receiving coverage and should have access to all of that information without going through her provider. Caller

states it is very inconvenient to have to contact their provider so much to get this information. CSR apologized for the inconvenience, documented their feedback, and provided the caller with the phone number to Vermont Legal Aid as requested.

- Caller wished to submit negative feedback on Durable Medical Equipment, specifically braces. Caller believes that replacements should be allowed more than once every 5 years as the braces do not seem to last more than 2 years. CSR apologized for the inconvenience and documented the feedback.

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
January 1, 2021 – March 31, 2021

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 January 1, 2021 through March 31, 2021.

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 10 grievances filed; three were addressed. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was three days. Of the grievances filed, 80% were filed by the beneficiary, and 20% were filed by a representative. DMH had 80%, DAIL had 20%, and DVHA had 10% of the grievances filed. There were no grievances filed for DCF or VDH during this quarter.

Grievances were filed for service categories case management, program/policy concerns, community social supports, and mental health services.

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 5 appeals filed. Of these 5 appeals, 4 were resolved (90%).

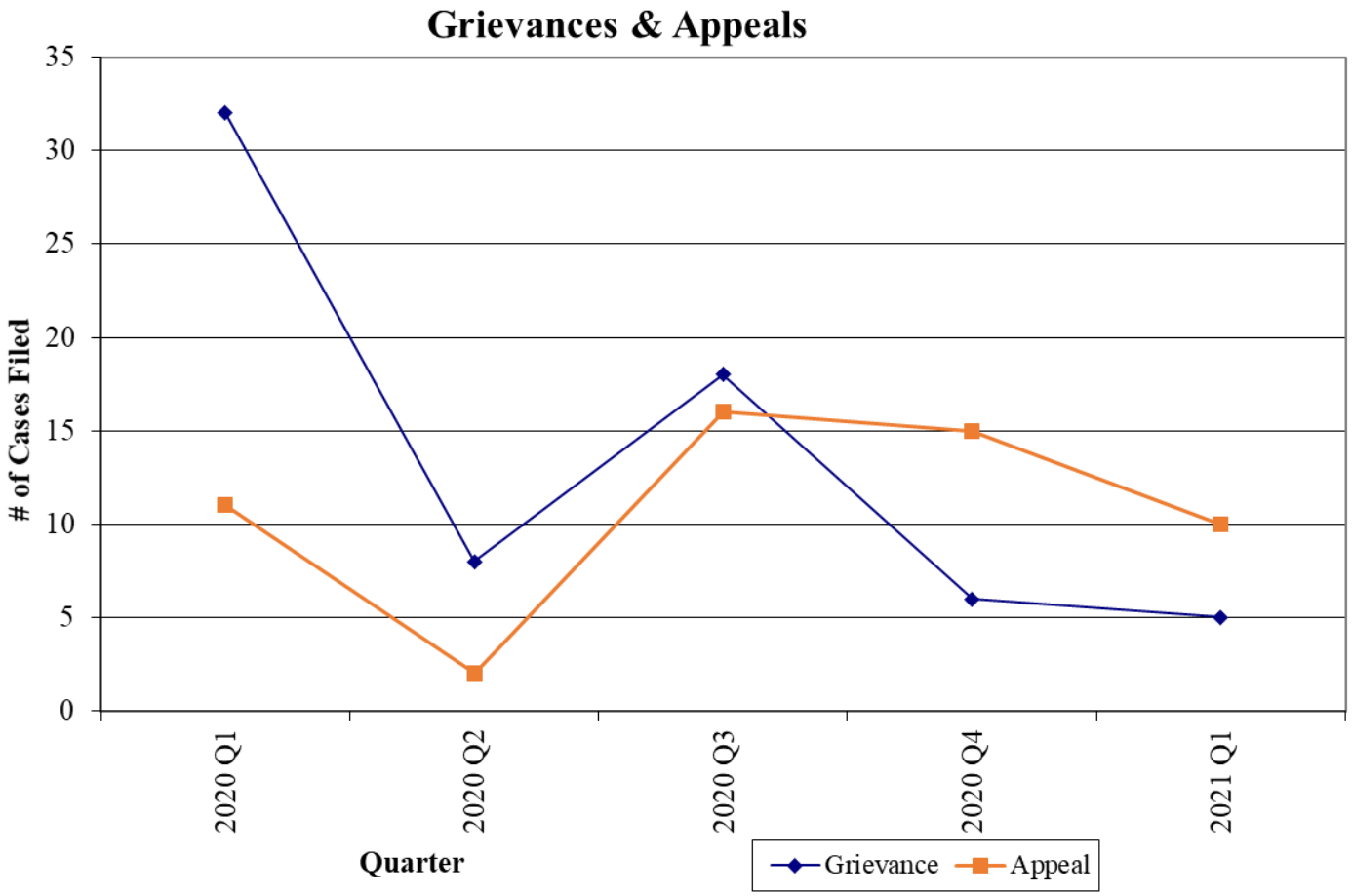
Of the 4 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 30 days. The average number of days it took to resolve these cases was 20 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

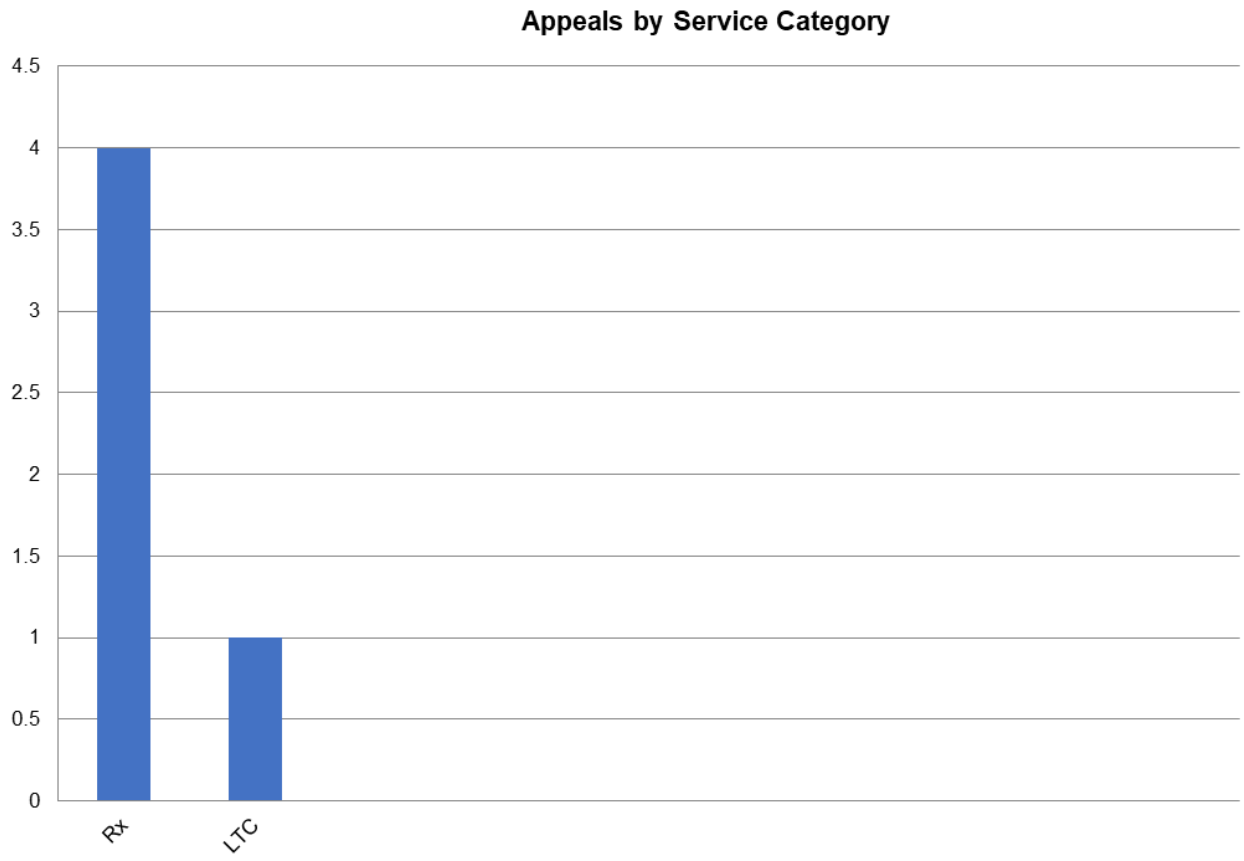
Of the 5 appeals filed, DVHA had 4 appeals filed (90%) and DAIL had 1 (10%).

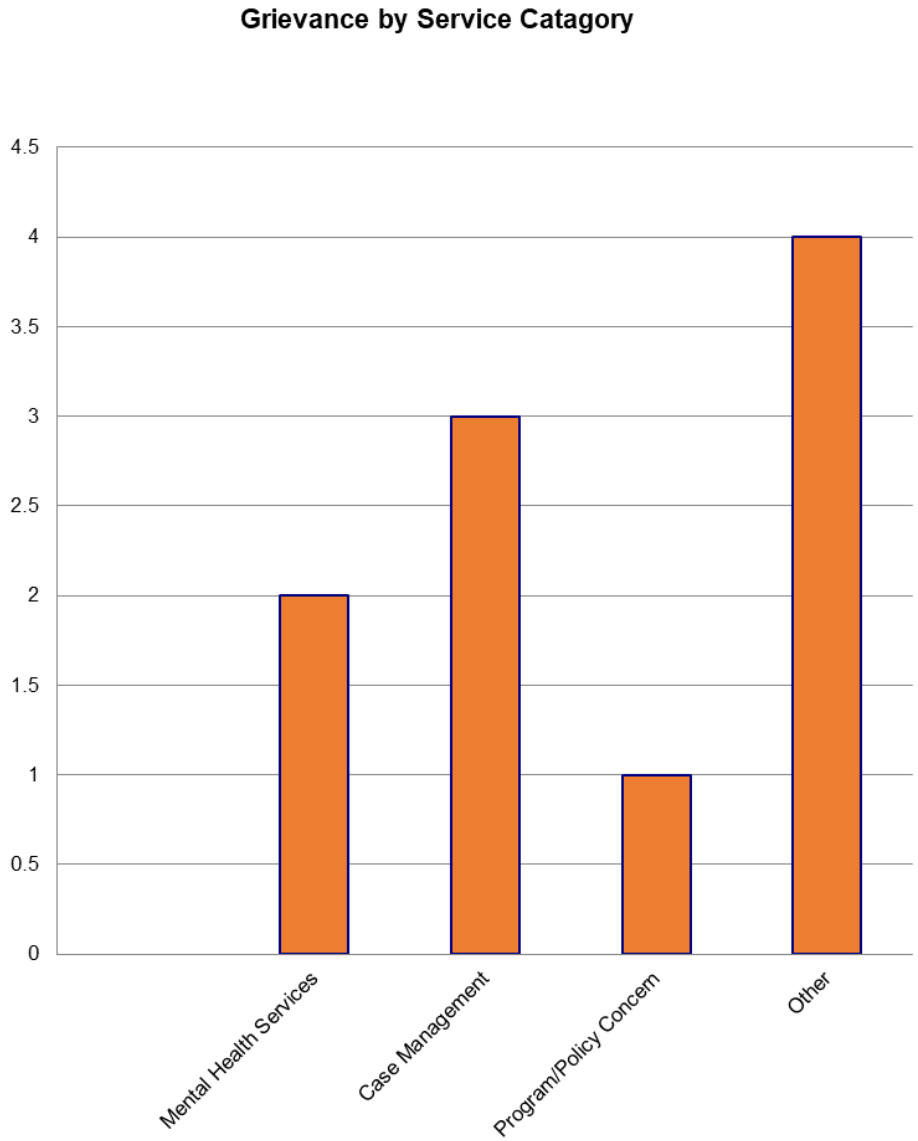
The appeals filed were for service categories prescriptions, and Long Term Care.

Beneficiaries must exhaust the internal appeal process before they can file a fair hearing if their appeal is not decided in their favor. There was no fair hearing filed this quarter.

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


Grievances & Appeals
35
30
25
20
15
10
5
0
# of Cases Filed
2020 Q1
2020 Q2
2020 Q3
2020 Q4
2021 Q1
Quarter
Grievance
Appeal


Appeals by Service Category
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Rx
LTC


Grievance by Service Catagory
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Mental Health Services
Case Management
Program/Policy Concern
Other

Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

January 1, 2021 - March 31, 2021

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

April 16, 2021

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, state agencies, and the state legislature.

Since Governor Scott's "stay at home" order on March 24, 2020, the HCA has been operating remotely and it anticipates operating remotely through the early summer of 2021, at least. The HCA helpline now has eight advocates working to resolve issues during this crisis. During this quarter, we saw a high number of cases involving access to care for dental care (42) and prescription drugs (43). The advocates also are also getting calls about COVID testing and treatment (13) and COVID vaccines (9). Medicaid eligibility remained our top issue, accounting for 19% of all HCA cases this quarter (148).

The passage of the American Rescue Plan Act will have a direct impact on many Vermonters. It will increase the amount of Advance Premium Tax Credit (APTC) most households are eligible for. It will also make some households newly eligible for APTC, by removing the eligibility cut off for APTC. It also waived repayment of excess APTC for 2020 and waived $10,200 of unemployment income for 2020. We had 35 calls about repayment of APTC to the IRS, and 48 calls this quarter from Vermonters with questions and issues related to unemployment and health care coverage. The HCA is planning on doing significant outreach and consumer education on ARPA in the next quarter.

The HCA helpline had 768 calls this quarter. During the COVID-19 crisis, the State of Vermont has not been conducting Medicaid reviews or closing state health care programs. Medicaid eligibility is typically a top issue for the HCA, and we had over 2,000 pageviews on our website about Medicaid eligibility this quarter. As the state of Vermont starts processing some changes in the next quarter, we expect to see an increase in calls about this issue.

The HCA helpline continues collaborating with other parts of Vermont Legal Aid to make sure the community understands the impact on health care programs of both new unemployment programs, hazard pay, and the stimulus checks created by the CARES ACT, and the American Rescue Plan Act. We are continually working on updating our website so consumers can access the latest information on how these programs will impact their Medicaid and other public benefits. The HCA is participating with the Disability Law Project at Vermont Legal Aid on a workgroup to try to ensure that Vermonters on Medicaid for the Working Disabled can maintain their coverage.

Bradley's Story

Bradley had been injured in an accident and had gone to Urgent Care. But he found that he did not have any coverage, even though he was unemployed and had applied for Medicaid. When the HCA advocate investigated, she found that he had applied for Medicaid early in the winter when he lost his job. The application had not been completed, because Bradley did not have his former spouse's tax or income information. Their divorce was not final, but they lived separately and did not file taxes together. VHC did not screen Bradley for Medicaid at that time, even though he should have been screened as a household of 1 and would have been eligible. The HCA advocate was able to get Medicaid reinstated back to the month Bradley first applied, and his bills from the Urgent Care visit were covered by Medicaid.

The HCA has been active this quarter in Legislative considerations on various topics including expanding coverage for children and pregnant individuals without regard to immigration status, and considerations about our health insurance marketplace organization. The HCA advocated for the use of one-time Federal funds to improve access to dental care and dentures for lower income Vermonters. We continue to participate on the Vaccine Implementation Advisory Committee convened by the Vermont Department of Health as well as various other boards and work groups.

As vaccine availability increases, we are hopeful that COVID infection rates will start to wind down. We know, though, that Vermonters will continue to grapple with the impact of this disease for years to come. The HCA will consider the lessons learned during this public health emergency and will advocate for accessible and affordable coverage that recognizes the needs of all Vermonters.

Glenn's' Story

When Glenn filed his federal taxes, he discovered that he owed over $3000 in re-payment for Advance Premium Tax Credit (APTC). APTC helps reduce monthly premiums. The amount of APTC you receive during the year is based on your projected income. In 2020, Glenn's income ended up higher than he was expecting because he had been assigned some extra shifts in the final months of the year due to the COVID pandemic. This resulted in too much APTC during the year, and thus he was going to have to repay all of it. Fortunately for Glenn, the American Rescue Plan Act (ARPA) had been passed, and it included a provision about waiving APTC overpayment for 2020. The HCA advocate explained that for 2020 only, people did not have to re-pay excess amount of APTC. This meant that Glenn would save the $3,000. The HCA advocate also worked with Glenn to update his income for 2021, so he would receive the correct amount of APTC.

Camden's Story:

Camden called the HCA because he had lost his job and was without any coverage. He had missed his special enrollment period to sign up on Vermont Health Connect (VHC). If you lose employer coverage, you have a 60- day special enrollment period to enroll on a VHC plan, but you can apply for Medicaid at any time. Camden was over the income limit for Medicaid eligibility. VHC, however, has a new, temporary, special enrollment period for uninsured Vermonters that allows them to enroll outside of the Open Enrollment period. The HCA advocate advised Camden that he would be able to apply and enroll in a VHC plan. Camden was found eligible for Advance Premium Tax Credit (APTC) to help pay for the monthly premium. He enrolled in a bronze plan, so he could have coverage while he continued to look for a new job.

Phoebe's Story:

Phoebe called the HCA when she received a much higher premium bill than she was expecting. Phoebe expected the premium to be about $100 a month, and instead her bill was for more than $400. When she called VHC about it, it discovered the problem but told her it could not be changed for at least two months. She called the HCA because she could not afford the higher price in the meantime. The HCA advocate investigated and found that Phoebe had called VHC to report a drop in her income at the end of 2020. With the change in her income, her premium should have decreased but the change was never applied, which explained why Phoebe got the incorrect premium bill. The HCA advocate was able to get the premium fixed back to January, which meant that Phoebe did not have to wait and could afford to pay the premium.

Overview

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

The HCA received 768 calls[1] this quarter. We divided these calls into broad categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category, based on the caller's primary issue, were as follows:

- **28.61%** about **Access to Care**
- **15.71%** about **Billing/Coverage**
- **2.43%** about **Buying Insurance**
- **14.05%** about **Complaints**
- **8.68%** about **Consumer Education**
- **20.82%** about **Eligibility** for state and federal programs
- **7.94**% were categorized as **Other**, which includes Medicare Part D, communication problems with providers or health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

We have a customized case management system that allows us to track more than one issue per case. This enables us to see the total number of calls that involved multiple issues. For example, although 163 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, an additional 253 cases had eligibility listed as a secondary concern.

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

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

The full quarterly report for January-March 2021, includes:

- This narrative
- Seven data reports, including three based on the caller's insurance status:
  - **All Calls/All Coverages**: 768
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 252

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

- **Commercial Plan Beneficiaries**: 145
- **Uninsured Vermonters**: 44
- **Vermont Health Connect (VHC)**: 150
- **Reportable Activities (Summary & Detail)**: 36 activities and 2 documents

The Top Issues Generating Calls

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

All Calls 468 (vs. 819 last quarter)

1. Complaints about Providers 109 (vs. 88 last quarter)
2. MAGI Medicaid Eligibility 78 (117)
3. Information/applying for DVHA programs 64 (95)
4. Medicare Consumer Education 52 (82)
5. Premium Tax Credit Eligibility 50 (92)
6. Buying QHPs through VHC 47 (55)
7. Complaints about Hospitals 46 (42)
8. Access to Prescription Drugs/Pharmacy 43 (63)
9. Billing Premiums 43 (25)
10. Access to Dental Care 42 (33)
11. Hospital Billing & Financial Assistance 42 (29)
12. Medicaid eligibility (non-MAGI) 41 (73)
13. Eligibility for Special Enrollment Periods 40 (59)
14. Buy-in programs/Medicare Savings Programs 37 (60)
15. Access to Nursing Home & Home Health 35 (26)
16. IRS Reconciliation Education 35 (32)

Vermont Health Connect Calls 150 (182)

1. Premium Tax Credit eligibility 47 (87)
2. MAGI Medicaid Eligibility 46 (76)
3. Buying QHPs through VHC 43 (54)
4. IRS Reconciliation Education 31 (32)
5. ACA Tax issues 28 (38)
6. Eligibility for Special Enrollment Periods 27 (38)
7. Information about DVHA 22 (42)
8. Premiums Billing 21 (7)
9. Information about ACA 21 (33)
10. Termination of Insurance 20 (27)

DVHA Beneficiary Calls 252 (vs. 277 last quarter)

1. MAGI Medicaid Eligibility 48 (53)
2. Information about DVHA 32 (43)

3. Complaints about Providers 28 (25)
4. Access to Dental Care 19 (17)
5. Medicaid Eligibility (non-MAGI) 19 (40)
6. Access to Prescription Drugs/Pharmacy 17 (33)
7. Balance Billing 15 (13)
8. Eligibility for MSPs/Buy-In Programs 15 (22)
9. Prior Authorization Criteria for Healthcare Access 14 (11)
10. Access to Transportation 13 (14)
11. Coordination of Benefits for Billing 13 (10)

Commercial Plan Beneficiary Calls 145 (vs. 173 last quarter)

1. Premium Tax Credit Eligibility 32 (49)
2. Buying QHPs through VHC 29 (27)
3. IRS Reconciliation Education 24 (20)
4. Special Enrollment Period Eligibility 24 (26)
5. ACA Tax issues 22 (19)
6. Medicare Consumer Education 24 (10)
7. Premiums Billing 18 (14)
8. Termination of Insurance 18 (18)
9. Coverage & Contract Questions 16 (16)
10. VHC – Maximus Complaints 13 (9)

The HCA received **768** total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as "dual eligible"): 33% (252 calls)
- **Medicare**[2] **beneficiaries (**Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as "dual eligible," Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 24% (181 calls)
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans 19% (145 calls)
- **Uninsured:** 8% (44 calls)

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

Dispositions of Closed Cases

All Calls: We closed 763 cases this quarter. Overall, 275 were resolved by brief analysis and advice. Another 266 were resolved by brief analysis and referral. There were 111 complex interventions involving complex analysis and more than two hours of an advocate's time, and 39 cases that involved at least one direct intervention on behalf of a consumer. The HCA provided consumer education to more than half of all the cases (435). We also estimated eligibility for insurance coverage and helped enroll people onto coverage in 72 cases. We saved consumers $68,814.12 this quarter.

Consumer Protection Activities

Hospital Budget Review

The HCA participates in the Board's annual hospital budget review process, which runs from July to September each year. During the last quarter, as usual, we provided feedback to the Board on its draft hospital budge guidance for the upcoming hospital budget submissions. The HCA also submitted a list of our own questions for the hospitals to answer with their hospital budget submissions.

Certificate of Need Review Process

In the last quarter, the HCA entered an appearance in two Certificate of Need matters in order to monitor them for consumer protection issues. The first application was submitted by an out-of-state entity proposing to purchase and operate a Vermont ambulance company. The second application was submitted by the Vermont Department of Mental Health proposing to develop a secure residential mental health treatment program in Essex, Vermont. These applications are pending.

Oversight of Accountable Care Organizations

The HCA participates in the Board's annual ACO budget review process. This quarter, the HCA reviewed the Board's proposed changes to its rule governing the ACO certification and budget review processes. We provided written feedback on the draft rule and met with the Board to discuss our comments. Our concerns mainly revolved around consumer representation, clarity, transparency, and meaningful process.

Other Green Mountain Care Board and other agency workgroups

Over the last quarter, the HCA attended the Board's weekly board meetings, monthly Data Governance meetings, bi-weekly Prescription Drug Technical Advisory Group meetings, and the Board's General Advisory Committee meeting. In the Data Governance meetings, the HCA was an active participant in the development of rules regarding access to VHCURES (Vermont's All-Payer Claims Database) and VHUDDS (Vermont Hospital Unified Discharge Data Set.)

Vaccine Implementation Advisory Committee

The COVID-19 Vaccine Implementation Advisory Committee serves in an advisory role to the Commissioner of Health. It was given the charge of assisting with four primary activities including identify and reach critical populations, promote COVID-19 vaccination, develop crisis and risk communication messaging, and to carry out the vaccine implementation plan.

We continue to advocate for a prioritization of populations in correctional facilities and other congregate living environments where people cannot isolate from each other. The HCA joined with others in this Advisory Committee in pushing for a policy statement calling for all inmates in Vermont Correctional facilities to be offered a Covid Vaccine during the phase of distribution at that time. The Advisory Committee agreed with this position and forwarded the recommendation to the Commissioner of Health.

The HCA is supportive of the Administration's move to offer Covid Vaccines to Vermont's BIPOC communities who are at increased risk due to a long history of systemic racism that has resulted in unequal access to our health care system and other social determinants that increase their risks.

The Medicaid and Exchange Advisory Committee

The HCA participated in three meetings this quarter. These meetings focused on Open Enrollment, APTC tax risk issues, Electronic Visit Verification, integrated Enrollment and Eligibility, and the Medicaid Budget.

The HCA presented to the Advisory Committee this quarter about H. 430. This is a proposal brought to the Legislature this year by the HCA that would expand benefits to pregnant individuals and children who are not eligible for Medicaid due to their immigration status. The Advisory Committee took the active step of voting in favor of this policy proposal.

Legislative Advocacy

Advocating in a fully-remote Legislative session has its challenges. While it is easier to track the work of committees, being a resource to members and to committees is made more difficult because it is so much harder to engage in the informal work that takes place in the Vermont State House. The HCA has attempted to continue the practice of maintaining a presence to support legislators in their policy considerations and to help them understand some of the important complexities of our health care and health finance systems.

The HCA worked on two bills this year before they were introduced. Growing out of our long-term efforts to reduce medical debt and improve hospital financial assistance policies, we worked on the creation of what became H.287, an act relating to patient financial assistance policies and medical debt protection. Due to this year's public health emergency, we asked that legislators not bring this bill up for discussion this year. We are hopeful that the Legislative health care committees will pay attention to these issues in the next legislative year. The HCA also put considerable effort into H.353, an act relating to pharmacy benefit management. We are also hopeful that this bill will be given ample time for consideration next year.

This year, during the budget consideration process, the HCA put a proposal on the table in House Health care to expand Dr Dynasaur coverage for children and pregnant individuals who are not eligible for coverage due to their immigration status. We pulled together a coalition of supporters who did a tremendous job of convincing the committee that this bill was advisable and that it should move forward. The bill, H.430, an act relating to expanding eligibility for Dr. Dynasaur to all income-eligible children and pregnant individuals, regardless of immigration status, passed out of house health care on a unanimous vote. It worked its way through the House Appropriations Committee and through all stages of passage on the house floor. As of the end of this quarter H.430 is in Senate Health and Welfare committee.

As the details of the new Premium Tax Credit rules in the American Rescue Plan Act became apparent, the HCA policy team revisited the old question of whether Vermont's merged market for the small and individual groups continued to make sense. By dividing this market, small group rates could be reduced, and increased federal tax credits due to ARPA would largely shield individuals from the increase in the individual market. After much discussion and consideration, we decided that this question was important enough to warrant a call-to-action letter to key health care focused legislators. The Senate Finance Committee moved quickly with S. 135, an act relating to separating the individual and small group health insurance markets for plan year 2022. The issuers, the Scott Administration, and the business community joined in support of this bill. At the time of this writing, it appears that the language of S.135 will be attached to another bill, S.88. It is looking promising that it will become law.

Collaboration with Other Organizations

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

- American Civil Liberties Union of Vermont
- Bi-State Primary Care
- Blue Cross Blue Shield of Vermont
- Department of Financial Regulation
- Economic Equity Fund Group/Vermont Community Foundation
- Families USA
- Georgetown University Health Policy Institute
- IRS Taxpayer Advocate Service
- Migrant Justice
- Milk with Dignity
- MVP Health Care
- NHeLP, National Health Law Program
- OneCare Vermont
- Open Door Clinic
- Pine Tree Legal Services
- Planned Parenthood of Northern New England
- RISPnet Group
- Rural Vermont
- South Royalton Legal Clinic
- Spectrum Youth and Family Services
- SHIP, State Health Insurance Assistance Program
- United States of Care
- University of Vermont Medical Center
- University of Vermont Migrant Health, Bridges to Health
- USCRI
- Vermont Association of Hospitals and Health Systems
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Health Connect
- Vermont Medical Society
- 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 180 pages of consumer-focused health information maintained by the HCA.

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

Popular Web Pages

* means the page moved into the top 20 this quarter

The top-20 health pages on our website this quarter — which was during the COVID-19 emergency:

1. *Income Limits - Medicaid* – 2,002 pageviews
2. *Health* - section home page – 1,792
3. *Dental Services* – 852
4. *Services Covered – Medicaid – 419*
5. *Medicare Savings Programs* – 397
6. *Long-Term Care* – 368
7. *Medicaid* – 350
8. *News: Coronavirus and Long-Term Care* – 351
9. *HCA Help Request Form* – 325 pageviews and 118 online help requests
10. *Medicaid, Dr. Dynasaur & Vermont Health Connect* – 322
11. *Resource Limits - Medicaid* – 321
12. *Advance Directive forms* – 297
13. *Choices for Care* – 272
14. *Medical Decisions: Advance Directives* – 266
15. *Medicaid and Medicare Dual Eligible* – 227
16. *Choices for Care Income Limits* – 198 *
17. *Vermont Long-Term Care Ombudsman Project* – 177 *
18. *Vermont Health Connect* – 173
19. *Federally Qualified Health Centers – 172 **
20. *Dr. Dynasaur* – 167

We also had this timely news item: *News: Coronavirus SEP for Vermont Health Connect* – 97

The top-10 health pages during last week of the quarter:

1. *Health* - section home page – 123
2. *Income Limits - Medicaid* – 106
3. *Dental Services* – 61
4. *Services Covered - Medicaid – 27*
5. *News: You May Be Eligible for New Financial Help for Health Insurance (ARPA)* – 26
6. *Long-term Care* – 24
7. *Medicaid* – 23
8. *HCA Help Request Form* – 23 pageviews and 15 online help requests
9. *Medicaid, Dr. Dynasaur & Vermont Health Connect* – 22
10. *Medicare Savings Programs* – 19

Outreach and Education

The HCA's ability to conduct in-person outreach activities was again limited because of the COVID-19 pandemic. To better meet the needs of Vermonters during this time, our office used virtual platforms to connect with partner organizations and give presentations and establish relationships to build our referral network.

We partnered with **16 organizations and participated in 11 outreach presentation** as a means of providing Vermonters with accurate and accessible information on insurance eligibility health care policy.

On January 13th, Mike Fisher, the Chief Health Care Advocate, gave a presentation to the Vermont Legislature's Social Equity Caucus. He provided the audience, which consisted of 38 attendees, with topical information about the Office of the HCA's individual advocacy policy work as a means of building our referral network.

From February 5th - March 15th, the HCA connected with 8 organizations from across Vermont that provide direct service to immigrants and refugees to disseminate information about the free assistance our office can offer. We dedicated more outreach capacity to this group because health insurance eligibility rules can be complicated for these populations. The HCA's Communications Coordinator, Alicia Roderigue, partnered with organizations such as Pine Tree Legal Services, the South Royalton Legal Clinic, Milk with Dignity, Migrant Justices, the University of Vermont's Bridges to Health Program, and Vermont USCRI, to deliver legal education about immigration status and health insurance eligibility and distribute translated outreach material in Spanish.

On March 25th, we also partnered with the Open Door Clinic to provide legal education to staff members on immigrant eligibility for Advanced Premium Tax Credit. The Open Door Clinic is a free health clinic for uninsured and under-insured adults in Addison County, Vermont. It primarily serves undocumented Vermonters or international workers that hold an H2A status This presentation was specifically tailored to address questions about Advanced Premium Tax Credit eligibility and for H2A workers. We also developed and distributed an educational flyer on this topic.

The HCA continued to develop its referral relationship with Planned Parenthood of Norther New England, Vermont Access to Reproductive Freedom, and Rural Vermont by taking part in topical check-ins and policy proposal conversations. This collaboration has helped our office connect with an array of Vermonters who often have urgent access to care questions.

Promoting Plain Language in Health Communications

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

- **Adverse Action Rule Change Blurb**

- **IFC draft**
- **VHC webpages: Small business credit, Public charge, Notices FAQ, Migrant workers, Medicaid Spenddowns, Income Reporting, Health Insurance basics, Grace period without APTC, Grace Period with APTC, Full Cost Direct Enroll, Financial Help FAQ, Filing Taxes, Exemptions, Cost-sharing reductions, APTC, Appeals, and Affordability.**

Office of the Health Care Advocate

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

https://vtlawhelp.org/health

Attachment 6

CY 2021 Investment Expenditures

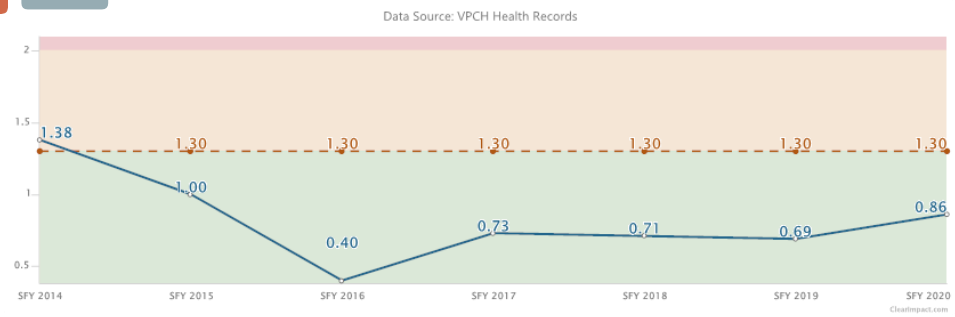
Department	Receiver Suffix	Investment Description	QE 0321	QE 0621	QE 0921	QE 1221	CY 2021 Total
AHSCO	9091	Investments (STC-79) - 2-1-1 Grant (41)	113,250				**113,250**
AHSCO	9090	Investments (STC-79) - Designated Agency Underinsured Services (54)	1,575,984				**1,575,984**
AOE	n/a	Non-state plan Related Education Fund Investments					**-**
DCF	9402	Investments (STC-79) - Medical Services (55)	41,263				**41,263**
DCF	9403	Investments (STC-79) - Residential Care for Youth/Substitute Care (1)					**-**
DCF	9405	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56)	1,010,750				**1,010,750**
DCF	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	26,243				**26,243**
DCF	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	61,115				**61,115**
DCF	9408	Investments (STC-79) - Essential Person Program (59)	191,025				**191,025**
DCF	9409	Investments (STC-79) - GA Medical Expenses (60)	42,555				**42,555**
DCF	9411	Investments (STC-79) - Therapeutic Child Care (61)	287,305				**287,305**
DCF	9412	Investments (STC-79) - Lund Home (2)	693,053				**693,053**
DCF	9413	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)					**-**
DCF	9414	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34)	32,315				**32,315**
DCF	9415	Investments (STC-79) - Challenges for Change: DCF (9)	36,083				**36,083**
DCF	9416	Investments (STC-79) - Strengthening Families (26)	198,336				**198,336**
DCF	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	54,594				**54,594**
DCF	9418	Investments (STC-79) - Building Bright Futures (35)	129,876				**129,876**
DDAIL	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	148,054				**148,054**
DDAIL	9603	Investments (STC-79) - DS Special Payments for Medical Services (64)	1,119,839				**1,119,839**
DDAIL	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)	289,286				**289,286**
DDAIL	9605	Investments (STC-79) - Quality Review of Home Health Agencies (42)					**-**
DDAIL	9606	Investments (STC-79) - Support and Services at Home (SASH) (43)	245,870				**245,870**
DDAIL	9607	Investments (STC-79) - HomeSharing (77)	69,670				**69,670**
DDAIL	9608	Investments (STC-79) - Self-Neglect Initiative (78)	130,202				**130,202**
DDAIL	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)					**-**
DMH	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	23,353				**23,353**
DMH	9502	Investments (STC-79) - MH Outpatient Services for Adults (66)	827,220				**827,220**
DMH	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79)	98,319				**98,319**
DMH	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16)	(697,469)				**(697,469)**
DMH	9506	Investments (STC-79) - Mental Health Children's Community Services (12)	597,557				**597,557**
DMH	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)	2,332,038				**2,332,038**
DMH	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)	311,549				**311,549**
DMH	9510	Investments (STC-79) - Emergency Support Fund (22)	131,863				**131,863**
DMH	9511	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - VPCH	3,154,313				**3,154,313**
DMH	9512	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - BR	2,607,983				**2,607,983**
DMH	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	28,956				**28,956**
DMH	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	156,906				**156,906**
DOC	n/a	Return House	74,551				**74,551**
DOC	n/a	Northern Lights	79,633				**79,633**
DOC	n/a	Pathways to Housing - Transitional Housing	176,666				**176,666**
DOC	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)	68,677				**68,677**
DOC	n/a	Northeast Kingdom Community Action					**-**
DOC	n/a	Intensive Substance Abuse Program (ISAP)					**-**
DOC	n/a	Intensive Domestic Violence Program					**-**
DOC	n/a	Community Rehabilitative Care	800,210				**800,210**
DOC	n/a	Intensive Sexual Abuse Program					**-**
DOC	n/a	Vermont Achievment Center					**-**
DVHA	9101	Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8)					**-**
DVHA	9102	Investments (STC-79) - Vermont Blueprint for Health (51)	702,782				**702,782**
DVHA	9103	Investments (STC-79) - Buy-In (52)	15,276				**15,276**
DVHA	9104	Investments (STC-79) - HIV Drug Coverage (53)	1,438				**1,438**
DVHA	9106	Investments (STC-79) - Patient Safety Net Services (18)					**-**
DVHA	9107	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	426,792				**426,792**
DVHA	9108	Investments (STC-79) - Family Supports (72)					**-**
DVHA	9109	DSR Investment (STC-83) – One Care VT ACO Quality & Health Management (81)					**-**
DVHA	9110	DSR Investment (STC-83) – One Care VT ACO Advanced Community Care Coordination (82)					**-**
DVHA	9111	DSR Investment (STC-83) - One Care VT ACO Primary Prevention Development (83)					**-**
GMCB	n/a	Green Mountain Care Board					**-**
UVM	n/a	Vermont Physician Training	108,212				**108,212**
VAAFM	n/a	Agriculture Public Health Initiatives					**-**
VDH	9201	Investments (STC-79) - Emergency Medical Services (19)	84,423				**84,423**
VDH	9203	Investments (STC-79) - TB Medical Services (74)	487				**487**
VDH	9204	Investments (STC-79) - Epidemiology (40)	27,503				**27,503**
VDH	9205	Investments (STC-79) - Health Research and Statistics (39)	140,741				**140,741**
VDH	9206	Investments (STC-79) - Health Laboratory (31)	454,147				**454,147**
VDH	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	582,170				**582,170**
VDH	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)					**-**
VDH	9209	Investments (STC-79) - Family Planning (75)	296,039				**296,039**
VDH	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)	144,000				**144,000**
VDH	9211	Investments (STC-79) - Renal Disease (73)					**-**
VDH	9213	Investments (STC-79) - WIC Coverage (37)					**-**
VDH	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	166,717				**166,717**
VDH	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	8,582				**8,582**
VDH	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)	1,009,910				**1,009,910**
VDH	9220	Investments (STC-79) - Recovery Centers (17)	478,134				**478,134**
VDH	9221	Investments (STC-79) - Enhanced Immunization (46)	17,426				**17,426**
VDH	9222	Investments (STC-79) - Poison Control (48)	37,010				**37,010**
VDH	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	561,415				**561,415**
VDH	9224	Investments (STC-79) - Fluoride Treatment (38)	6,196				**6,196**
VDH	9225	Investments (STC-79) - Medicaid Vaccines (24)					**-**
VDH	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)	15,804				**15,804**
VDH	9228	Investments (STC-79) - VT Blueprint for Health (44)	110,032				**110,032**
VSC	n/a	Health Professional Training	-				**-**
VVH	n/a	Vermont Veterans Home					**-**
			22,664,232	**-**	**-**	**-**	**22,664,232**

GC Investments - Department of Mental Health

GC_Investment: Increase the access of quality healthcare to the uninsured, underinsured, and Medicaid beneficiaries

Institution for Mental Disease (IMD) Services: DMH (3) - Vermont Psychiatric Care Hospital

	Most Recent Period Most	Current Actual Value Current	Current Trend Current



SFY 2019	0.69	2
SFY 2018	0.71	1
SFY 2017	0.73	1
SFY 2016	0.40	2
SFY 2015	1.00	1
SFY 2014	1.38	0

Story Behind the Curve

We want the # of hours of seclusion and restraint to go down.

Providing patient care in an environment that is safe and supportive is important for recovery. VPCH, through its work with the SAMHSA Six Core Strategies for Reducing seclusion and restraint has lowered its rate of seclusion and restraint to approximately one half-hour per 1,000 patient hours, which is almost an hour less than the established target.

Updated February 2018

Partners

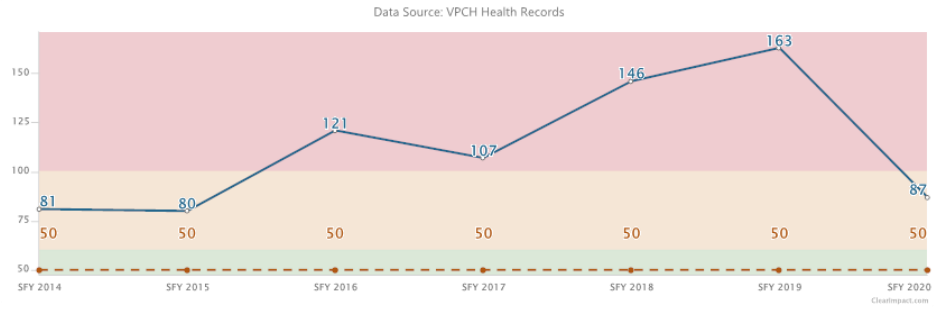
Strategy

Notes on Methodology

Data is calculated using reports of emergency involuntary procedures (EIPs) and total patient hours captured by VPCH's electronic medical record. The rate is calculated by dividing the total hours of seclusion and restraint divided by the total patient hours and multiplied by 1,000. This rate is the nationally established metric for reporting EIPs.

PM Average length of stay in days for discharged patients

SFY 2020	87	1



SFY 2019	163	2
SFY 2018	146	1
SFY 2017	107	1
SFY 2016	121	1
SFY 2015	80	1
SFY 2014	81	0

Story Behind the Curve

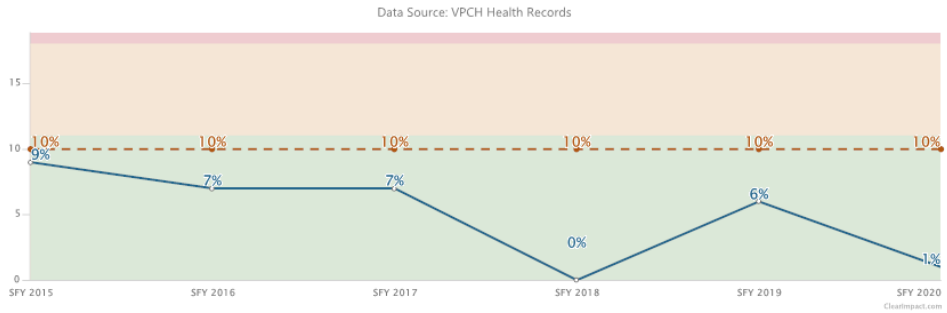
While the average length of stay at VPCH is higher than the target rate, the length of stay has decreased over the past year by 2 weeks. VPCH has also been accepting more acute patients resulting in longer stays, thereby creating a slight drop in the inpatient census over the year.

Partners

Strategy

Notes on Methodology

How_W % of discharges readmitted involuntarily within 30 days of discharge



SFY 2020	1%	1
SFY 2019	6%	1
SFY 2018	0%	1
SFY 2017	7%	1
SFY 2016	7%	1
SFY 2015		0

Story Behind the Curve

In 2017, VPCH maintained its target of 10% of patients' that were discharged were readmitted involuntarily within 30 days. VPCH exceeded this expectation for 2018, with 0% of patients who were discharged were readmitted involuntarily within 30 days.

Partners

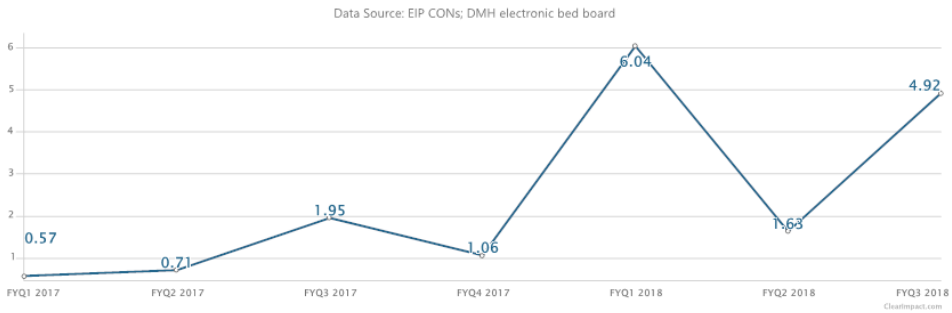
Strategy

Notes on Methodology

GC_Investment Institution for Mental Disease (IMD) Services: DMH (3) - Brattleboro Retreat

How_Well # hours of seclusion and restraint per 1,000 patient hours (BR - Level 1)

Most Recent	Current Actual	Current Trend
FYQ3 2018	4.92	1



FYQ2 2018	1.63	1
FYQ1 2018	6.04	1
FYQ4 2017	1.06	1
FYQ3 2017	1.95	3
FYQ2 2017	0.71	2
FYQ1 2017	0.57	1
FYQ4 2016	0.49	3
FYQ3 2016	0.63	2

Story Behind the Curve

We want the # of hours of seclusion and restraint to go down.

Providing patient care in an environment that is safe and supportive is important for recovery.

Updated February 2018

Partners

What Works

Action Plan

Notes on Methodology

Based on data submitted by Designated Hospitals to the Department in compliance with department requests for submittal of Certificates of Need (CON) following emergency involuntary procedures for patients located on Level 1 Units and electronic bed board data submitted to the Department for Level 1 Units. Procedures for seclusion, restraint, and emergency medication meet criteria defined by the Centers for Medicare and Medicaid Services for clients involuntarily admitted to Vermont Designated Hospitals.

Ratio calculation:

Numerator: Total number of hours that psychiatric patients were in seclusion or restraint (restraint includes all manual and mechanical)

Denominator: Total patient hours on Level 1 units divided by 1,000 patient hours

PM How_Well Length of stay (mean) for discharged Level 1 patients (BR - Level 1)

Story Behind the Curve

Partners

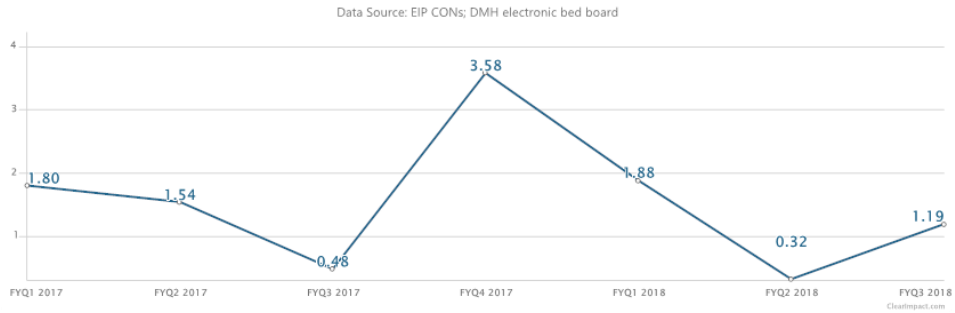
What Works

Action Plan

Notes on Methodology

P GC_Investment Acute Psychiatric Inpatient Services (13) Rutland Regional Medical Center

PM How_Well # hours of seclusion and restraint per 1,000 patient hours on RRMC Level 1 Unit



	Most Recent	Current Actual	Current Trend
FYQ3 2018	1.19		1
FYQ2 2018	0.32		2
FYQ1 2018	1.88		1
FYQ4 2017	3.58		1
FYQ3 2017	0.48		2
FYQ2 2017	1.54		1
FYQ1 2017	1.80		1
FYQ4 2016	0.83		1
FYQ3 2016	4.02		2

Story Behind the Curve

Partners

What Works

Action Plan

Notes on Methodology

Based on data submitted by Designated Hospitals to the Department in compliance with department requests for submittal of Certificates of Need (CON) following emergency involuntary procedures for patients located on Level 1 Units and electronic bed board data submitted to the Department for Level 1 Units. Procedures for seclusion, restraint, and emergency medication meet criteria defined by the Centers for Medicare and Medicaid Services for clients involuntarily admitted to Vermont Designated Hospitals.

Ratio calculation:

Numerator: Total number of hours that psychiatric patients were in seclusion or restraint (restraint includes all manual and mechanical)

Denominator: Total patient hours on Level 1 units divided by 1,000 patient hours

PM How_Well Length of stay (mean) for discharged Level 1 patients (RRMC - Level 1)

Story Behind the Curve

Partners

What Works

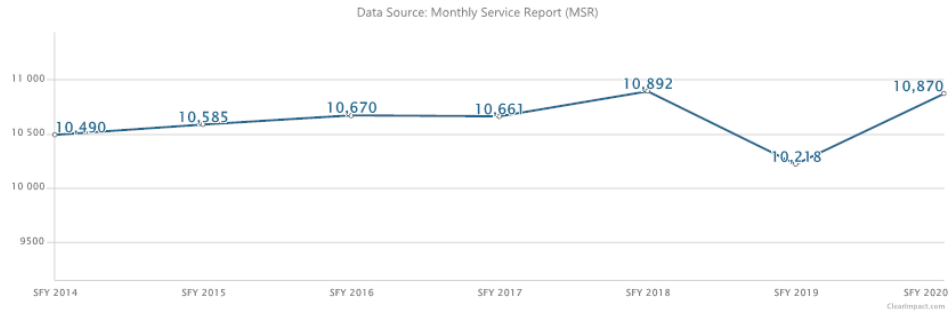
Action Plan

Notes on Methodology

P GC_Investment Mental Health Children's Community Services (12)

PM How_Much # of children and youth served by C&F

Data Source: Monthly Service Report (MSR)



	Most Recent	Current Actual	Current Trend
	SFY 2020	10,87 0	1
	SFY 2019	10,218	1
	SFY 2018	10,892	1
	SFY 2017	10,661	1
	SFY 2016	10,670	4
	SFY 2015	10,585	3
	SFY 2014	10,490	2
	SFY 2013	10,374	1
	SFY 2012	9,783	2

Story Behind the Curve

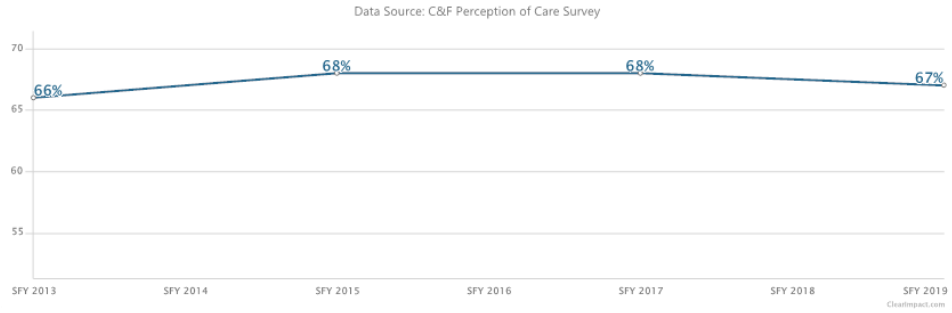
Partners

What Works

Action Plan

Notes on Methodology

Better_ % of adolescents reporting positive outcomes



SFY 2019	67%	1
SFY 2017	68%	1
SFY 2015	68%	2
SFY 2013	66%	1
SFY 2011	65%	1
SFY 2009	65%	2
SFY 2007	63%	1
SFY 2003	54%	1

Story Behind the Curve

Partners

What Works

Action Plan

Notes on Methodology

Report based on the Children and Family Perception of Care Survey, administered bi-annually by the Department of Mental Health to adolescents age 13-17 receiving services from Designated Agencies who are Medicaid enrolled.

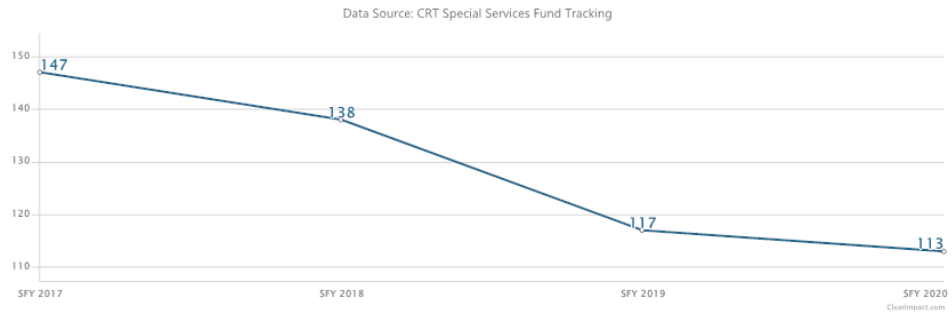
P GC_Investment (WIP) Emergency Support Fund (22)

Most Recent Period	Current Actual Value	Current Trend

P GC_Investment Special Payments for Treatment Plan Services (28)

How_Much # of CRT clients served with special services funding

Most Recent Period	Current Actual Value	Current Trend
SFY 2020	113	3



SFY 2019	117	2
SFY 2018	138	1
SFY 2017	147	0

Story Behind the Curve

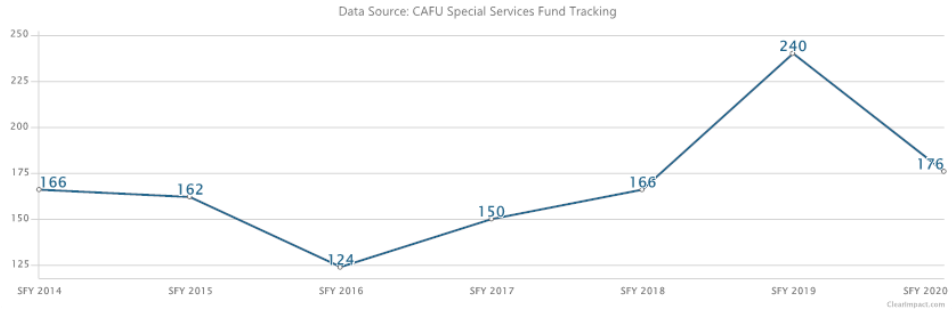
Partners

What Works

Action Plan

Notes on Methodology

How_W # of youth served with special services funding



SFY 2020	176	1
SFY 2019	240	3
SFY 2018	166	2
SFY 2017	150	1
SFY 2016	124	2
SFY 2015	162	1
SFY 2014	166	0

Story Behind the Curve

Partners

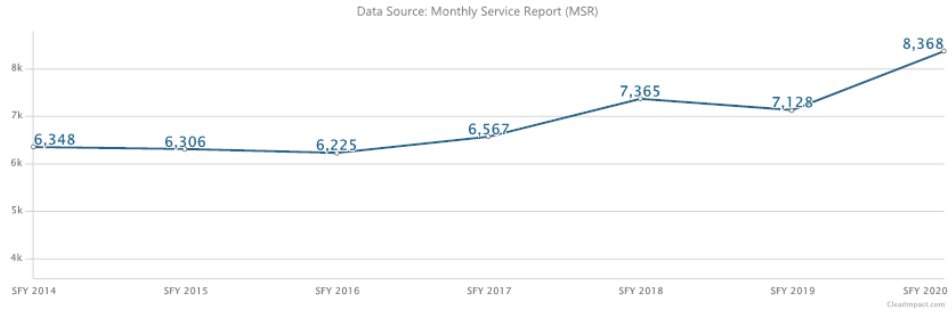
What Works

Action Plan

Notes on Methodology

P GC_Investment Emergency Mental Health for Children and Adults (29)

How_Much # served by ES



	Most Recent	Current Actual	Current Trend
SFY 2020	8,368	8,368	1
SFY 2019	7,128		1
SFY 2018	7,365		2
SFY 2017	6,567		1
SFY 2016	6,225		3
SFY 2015	6,306		2
SFY 2014	6,348		1
SFY 2013	6,487		4
SFY 2012	5,876		3

Story Behind the Curve

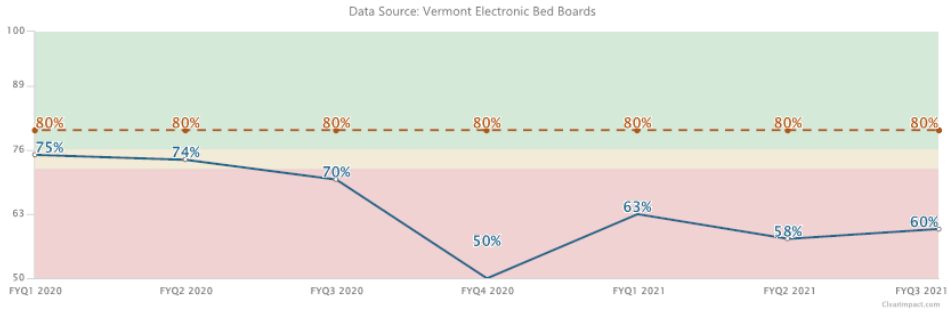
Partners

What Works

Action Plan

Notes on Methodology

How_Mu % occupancy of Designated Agency adult crisis bed programs



FYQ3 2021	60%	1
FYQ2 2021	58%	1
FYQ1 2021		1
FYQ4 2020		5
FYQ3 2020		4
FYQ2 2020	74%	3
FYQ1 2020	75%	2
FYQ4 2019		1
FYQ3 2019		1

Story Behind the Curve

Partners

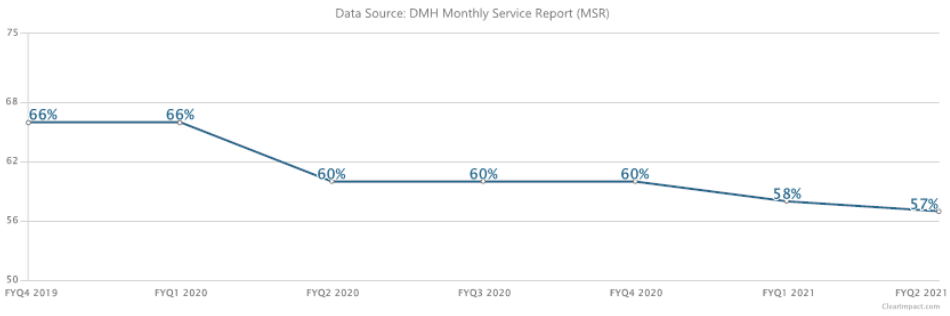
What Works

Action Plan

Notes on Methodology

Based on data reported daily to the DMH electronic bed board for adult crisis bed programs. Percent occupancy is calculated using the maximum beds occupied per program per day divided by the maximum beds available per program per day.

% of people receiving non-emergency services within 7 days of emergency services



FYQ2 2021	57%	2
FYQ1 2021	58%	1
FYQ4 2020	60%	2
FYQ3 2020	60%	1
FYQ2 2020	60%	1
FYQ1 2020	66%	2
FYQ4 2019	66%	1
FYQ3 2019	66%	2
FYQ2 2019	64%	1

Story Behind the Curve

Partners

Strategy

Notes on Methodology

Based on Monthly Service Report (MSR) data submitted by Designated Agencies for mental health programs to the State of Vermont Department of Mental Health. Emergency services are operationally defined as emergency/crisis assessment, support and referral under any program of service or assignment (service code "G01" in the MSR). Non-emergency services are operationally defined as services other than emergency/crisis or assessment, support and referral under crisis bed services for any program of service or assignment. Time is calculated from the last emergency service at a DA during the quarter to the first non-emergency service across the DA system.

PM How_Well % of total served in ES who are seen in the community (in development)

Story Behind the Curve

Partners

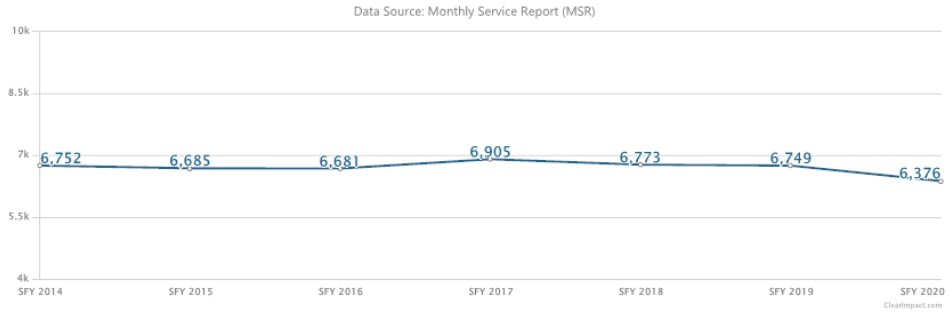
What Works

Action Plan

Notes on Methodology

P PM GC_Investment How_Much Mental Health Outpatient Services for Adults (66) # of people served in AOP

Most Recent	Current Actual	Current Trend
SFY 2020	6,376	3



SFY 2019	6,749	2
SFY 2018	6,773	1
SFY 2017	6,905	1
SFY 2016	6,681	3
SFY 2015	6,685	2
SFY 2014	6,752	1
SFY 2013	6,826	1
SFY 2012	6,366	2

Story Behind the Curve

We want to monitor the number of people served in adult outpatient services (AOP) at the Designated Agencies and Specialized Service Agencies. AOP provides services for adults who do not have prolonged serious disabilities but who are experiencing emotional, behavioral, or adjustment problems severe enough to warrant professional attention. Numbers served in AOP have remained stable year over year.

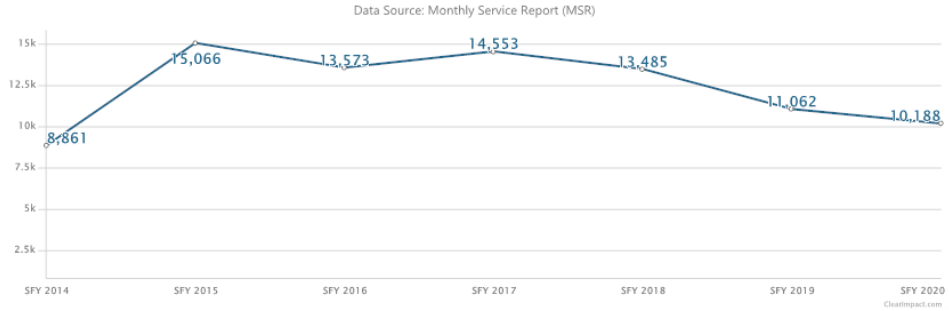
Partners

What Works

Action Plan

Notes on Methodology

How_Mu # of non-categorical case management services



SFY 2020	10,188	3
SFY 2019	11,062	2
SFY 2018	13,485	1
SFY 2017	14,553	1
SFY 2016	13,573	1
SFY 2015	15,066	6
SFY 2014	8,861	5
SFY 2013	5,042	4
SFY 2012	3,231	3

Story Behind the Curve

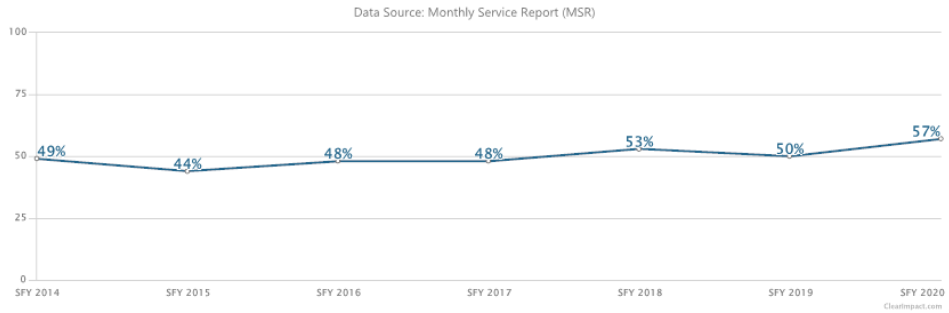
Partners

What Works

Action Plan

Notes on Methodology

PM Better Off % improved upon discharge from AOP



SFY 2020	57%	1
SFY 2019	50%	1
SFY 2018	53%	1
SFY 2017	48%	1
SFY 2016	48%	1
SFY 2015	44%	2
SFY 2014	49%	1
SFY 2013	51%	1
SFY 2012	48%	2

Story Behind the Curve

Designated Agencies continue to report greater percentages of discharge information with each fiscal year (toggle comparison). As greater percentages of clients are reported, the percent with positive outcomes appears to decline, which may be due to greater percentages of clients with ongoing difficulties being reported. For example, SFY 2008 appears to be markedly higher than subsequent years in positive outcomes, but it also has the lowest percentage of clients reported in that year.

Partners

Vermont Designated Agencies

What Works

Action Plan

Notes on Methodology

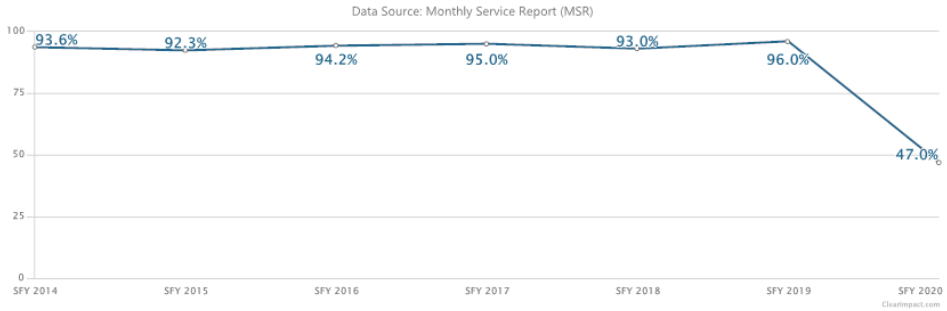
Based on Monthly Service Report (MSR) data submitted to the Department of Mental Health by Designated Agencies. Clinical staff are asked to rate as "improved," "unchanged," or "worse" the condition of each client whose case is closed. These ratings represent the professional opinion of the clinicians. Discharge rates reported for designated agency clients may underestimate the actual rates. This occurs because it was not possible to identify clients who were discharged during a quarter in which they received services and their condition on termination had not yet been rated. Clients who died while they were on the rolls of the community program or institutions are counted as discharged clients and are included in the discharge rate.

P PM GC_Investment Better_Off

Respite Services for Youth with SED and their Families (67)

% of children and youth receiving respite services who remain in their homes

Most Recent	Current Year Actual	Current Trend
SFY 2020	47.0%	1



SFY 2019	96.0%	1
SFY 2018	93.0%	1
SFY 2017	95.0%	2
SFY 2016	94.2%	1
SFY 2015	92.3%	1
SFY 2014	93.6%	1
SFY 2013	92.0%	1

Story Behind the Curve

Partners

What Works

Action Plan

Notes on Methodology

Based on data reported the Department of Mental Health by Designated Agencies via the monthly service report (MSR) for children and adolescents receiving services. "Children and youth receiving respite services who remain in their homes" is defined as those receiving respite services who are currently living in a desirable residential arrangement and a desirable living arrangement at the end of the fiscal year.

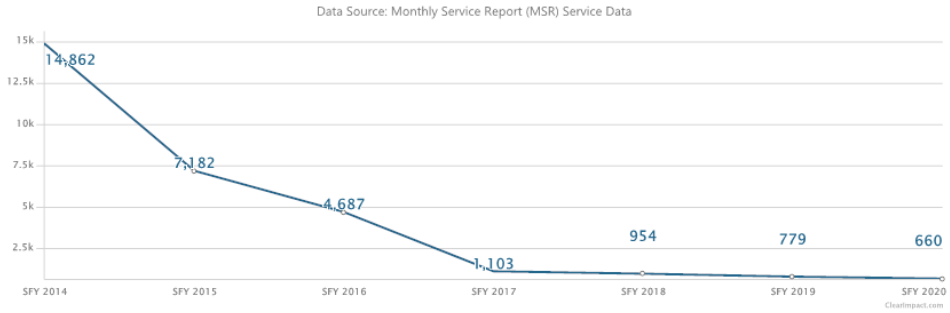
Desirable residential arrangements include an owned home, Section 8 housing, or other type of rental. Desirable living arrangements include residing with a spouse, child, relatives, or alone.

P PM GC_Investment MCO_Investment

Seriously Functionally Impaired: DMH (68)

Units of service funded by SFI

Most Recent	Current Year Actual	Current Trend
SFY 2020	660	6



SFY 2019	779	5
SFY 2018	954	4
SFY 2017	1,103	3
SFY 2016	4,687	2
SFY 2015	7,182	1
SFY 2014	14,862	3
SFY 2013	4,013	2
SFY 2012	1,445	1

Story Behind the Curve

Partners

What Works

Action Plan

Notes on Methodology

P GC_Investment (WIP) Mental Health Consumer Support Programs (79)

Most Recent Period	Current Actual Value	Current Trend

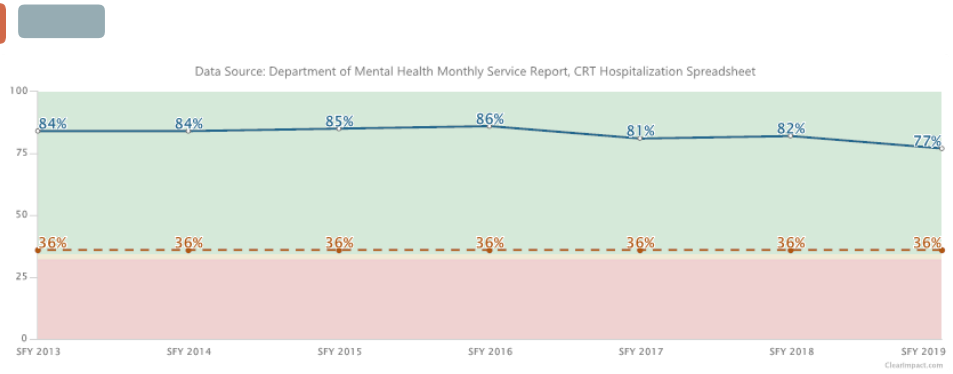
O GC_Investment Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system

Most Recent Period	Current Actual Value	Current Trend

P PM How Well GC_Investment Mental Health CRT Community Support Services (16)

% of CRT clients receiving follow up services within 7 days of psychiatric hospitalization discharge

Most Recent Period	Current Actual Value	Current Trend
SFY 2019		1



SFY 2018	82%	1
SFY 2017	81%	1
SFY 2016	86%	2
SFY 2015	85%	1
SFY 2014	84%	1
SFY 2013	84%	1
SFY 2012		1

Story Behind the Curve

Community Rehabilitation & Treatment (CRT) program provides treatment and support to individuals living in the community as well as those discharged from a psychiatric hospitalization. Outpatient follow-up care is a critical component of post discharge planning for patients hospitalized (*Follow-Up After Hospitalization for Mental Illness, NCQA).*

Proper follow up care is associated with lower rates of readmission and with a greater likelihood that gains made during hospitalization are retained. The period immediately following discharge from inpatient care is recognized as a time of increased vulnerability. The first appointment within 7 days of discharge is intended to be the bridge between intense care and support in the hospital and the transition to recovery in the community. This table shows that CRT programs consistently have a high percentage of contact following the discharge which correlates to the low hospitalization rate of those enrolled in the CRT program. This support offers a route for the clients' success and stability in their community.

Partners

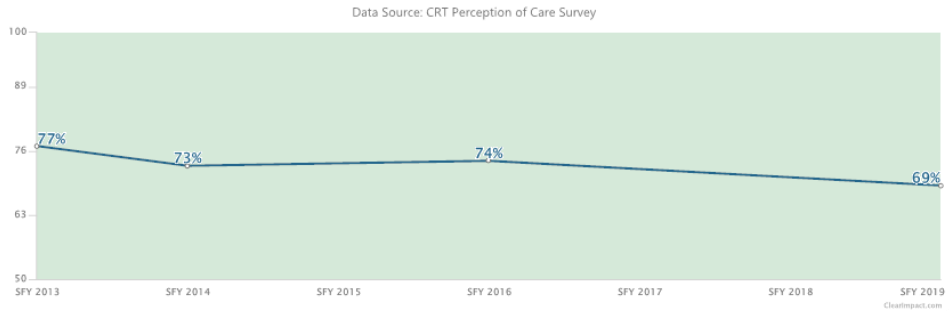
The CRT system of care includes CRT services at each of the Designated Agencies which includes psychiatry services. Many of the Designated Agencies have Intensive Residential Recovery, Group Homes, Crisis Beds, Community Cadre, and Employment Services. CRT programs partner with local Medical Providers, Home Health Agencies, Offices of Economic Opportunity, Vocational Rehabilitation, and Housing Trust agencies.

Strategy

The strategy for continued success is for the client, the client's treatment team, and support system to develop a treatment plan that will assist the client to be successful living in the community. Evidence has shown that the relationship between the client and the treatment team is extremely important to decrease any stigma associated with mental illness as well as as identify any warning signs that the client may be decompensating. Designated Agencies use evidence-based practices to help increase positive outcomes.

Notes on Methodology

PM Better_Off % of CRT clients reporting positive outcomes



SFY 2019	69%	1
SFY 2016	74%	1
SFY 2014	73%	1
SFY 2013	77%	1
SFY 2012	71%	1
SFY 2011	71%	1
SFY 2010	74%	2
SFY 2009	72%	1

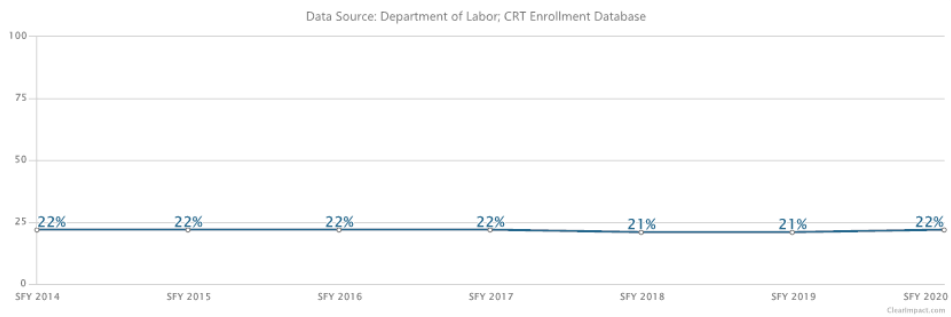
Story Behind the Curve

Positive rehabilitative outcomes are associated with clients reporting positive outcomes.

Partners

Strategy

Notes on Methodology



SFY 2019	21%	1
SFY 2018	21%	1
SFY 2017	22%	3
SFY 2016	22%	2
SFY 2015	22%	1
SFY 2014	22%	2
SFY 2013	20%	1
SFY 2012	19%	1

Story Behind the Curve

Successful employment is the most powerful catalyst for recovery and change, especially for individuals living with a mental illness.[1] Working helps further recovery more than any other single intervention – more than therapy, case management or medication alone. Research also demonstrates that unemployment is extremely bad for one's overall health.[2] However, returning to work after unemployment improves health by as much as unemployment damages it.[3]

People do want to work; 60-70% of individuals receiving public mental health services nationwide desire competitive employment, yet only 10-15% find employment.[4] [5] Extensive and rigorous research (25 randomized controlled trials) demonstrates that the Individual Placement and Support (IPS) practice is the most effective approach for helping people with mental illness obtain competitive employment of their choice.[6] When offered with high-fidelity, IPS supported employment services help 50-60% of job seekers achieve employment, higher wages, and job longevity.

Nationally, less than 2 percent of adults living with mental illness receive access to IPS supported employment services.[7] Vermont currently provides IPS services to 15% of CRT enrollees and of those individuals, 52% find and/or successfully maintain employment.

Vermont was the first state to implement IPS statewide and witnessed its access to IPS supported employment increase from 0% in FY1999 to 24% in 2005. At that time, Vermont stood out for its high employment rate. Due to the commitment of Vocational Rehabilitation and DMH leadership to increase

the focus on supported employment statewide, Vermont witnessed close to a 200% increase in CRT employment rates (from 16% in FY1999 to 30% in FY2001). Vermont maintained these higher rates until 2005 when a slow, gradual decline began. The recession in 2008 exacerbated the decline. Since FY12 the employment rate has remained steady at 22%. The access rate to supported employment services also remained steady until FY2015 when it began to decline to 15% in FY17.

Part of the reason for the decline in access to supported employment services is the decrease in supported employment staff at the community mental health centers. In FY2015, Vocational Rehabilitation ended its 30+ years of supported employment grant-funding to the CRT programs due to federal funding cuts. CRT programs came to rely on VR funding to hire supported employment staff.

How has the CRT employment rate remained the same over the last several years despite a decrease in access to IPS supported employment services? One reason is the IPS services have increased in quality; of those with access to IPS services the employment success rate has increased from 47% in FY14 to 52% in FY17. People are maintaining their jobs longer and/or developing careers with support. The community mental health centers have remained committed to providing IPS services with its existing flexible case rate funding. Lastly, some mental health centers have begun to hire more staff with lived experience of mental health challenges to work as peer support staff or in other agency positions.

One potential reason for the decreased employment rate from 30% to the current 22% over the years is that several individuals who were working experienced an increased level of independence and recovery and no longer chose to receive CRT services. A reduced target rate may be another reason. The employment target rate was set at 35% in FY2012 based on past performance history. In FY2015, the state reduced the target rate to "maintain or improve current employment rate" due to providers' requests as part of Master Grant negotiations.

Measuring access to supported employment, monitoring fidelity to the IPS practice, and tracking the employment rate of people enrolled in CRT all contribute to Vermont's knowledge of who is better off.

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[1] IPS Employment Center: Evidence for IPS (2018). Retrieved on 5/30/18 from https://ipsworks.org/index.php/evidence-for-ips/

[2] Mathers, C. and Schofield, D. (1998). The health consequences of unemployment: The evidence. *Medical Journal of Australia*, 168 (4) 178–82.

Libby, A. M., V. Ghushchyan, et al. (2010). Economic Grand Rounds: Psychological Distress and Depression Associated with Job Loss and Gain; the Social Costs of Job Instability. *Psychiatric Services* 61(12): 1178-1180.

Dance, A. (2011). The unemployment crisis. *American Psychological Association Monitor*, 42(3).

Warr, P. (1987). *Work, unemployment, and mental health*. Oxford: Oxford University Press.

[3] Schuring, M., Mackenback, J., Voorham, T., Burdorf, A. (2011). The effect of re-employment on perceived health. *Journal of Epidemiology and Community Health*, 65(7), 639-644.

Waddell, G. & Burton, K. (2006). Is work good for your health and wellbeing? *The Stationary Office*, Norwich, England.

[4] McQuilken, M., Zahniser, J.H., Novak, J., Starks, R.D., Olmos, A., & Bond, G.R. (2003). The Work Project Survey: Consumer perspectives on work. *Journal of Vocational Rehabilitation*, 18(1), 59-68.

[5] Mental Illness: NAMI Report Deplores 80 Percent Unemployment Rate (2014). Retrieved on 5/30/18 from https://www.nami.org/Press-Media/Press-Releases/2014/Mental-Illness-NAMI-Report-Deplores-80-Percent-Une

[6] Marshall, T., Goldberg, R.W., Braude, L., Dougherty, R.H., Daniels, A.S., Ghose, S.S., et al. (2014). Supported employment: Assessing the evidence. *Psychiatric Services*, 65, 16-23.

[7] Bruns, E.J., Kerns, S.E., Pullmann, M.D., Hensley, S.W., Lutterman, T., & Hoagwood, K.E., (2016). Research, data, and evidence-based treatment use in state behavioral health systems, 2001-2012. *Psychiatric Services*, 67(5), 496-503.

Partners

DMH partners with the Community Rehabilitation and Treatment (CRT) programs and Pathways-Vermont, Vocational Rehabilitation (VR), VCPI, NAMI-VT, and the IPS International Learning Collaborative to achieve higher employment rates. DMH expects each CRT program to offer IPS supported employment services and offers free fidelity monitoring and technical assistance to achieve good fidelity to the practice. As part of good fidelity, each CRT program should have at least two full-time employment specialists focused entirely on IPS services. (Currently, each program has at least one employment specialist on its treatment team and four programs have at least two employment specialists.) Collaboration with VR is a core element of IPS services. Most CRT programs engage in coordinated supports with the local VR office to benefit the job seeker while DMH and VR collaborate at the state level. Six of the ten CRT programs submit quarterly employment data to the IPS International Learning Collaborative and DMH works closely with the IPS collaborative to increase its expertise around technical assistance.

What Works

Research indicates that programs with high adherence, or fidelity, to the evidence-based practice of IPS have higher employment rates [1]. DMH provides technical assistance, training, and program fidelity monitoring to help improve fidelity to the practice. The partnerships with the CRT programs, state and local stakeholders, and continuous quality improvement activities lead to more people achieving employment.

[1] Kim, S.J., Bond, G.R., Becker, D.R., Swanson, S.J., & Langfitt-Reese, S. (2015) Predictive validity of the Individual Placement and Support fidelity scale (IPS-25): A replication study. *Journal of Vocational Rehabilitation* 43, 209–216.

Action Plan

DMH will continue to work closely with the CRT programs and their employment specialists to provide technical assistance, training, and oversight as needed and/or as requested. DMH will continue to conduct fidelity reviews biennially at each designated agency. DMH will continue to meet bi-monthly with Vocational Rehabilitation and monthly with the International IPS Learning Collaborative. Data will be collected for each agency and reviewed regularly on fidelity ratings, access to supported employment services, and employment rates for both the CRT program level and the employment program level. DMH will examine existing policies to determine if any need to be addressed to improve the quantity and quality of employment services.

Notes on Methodology

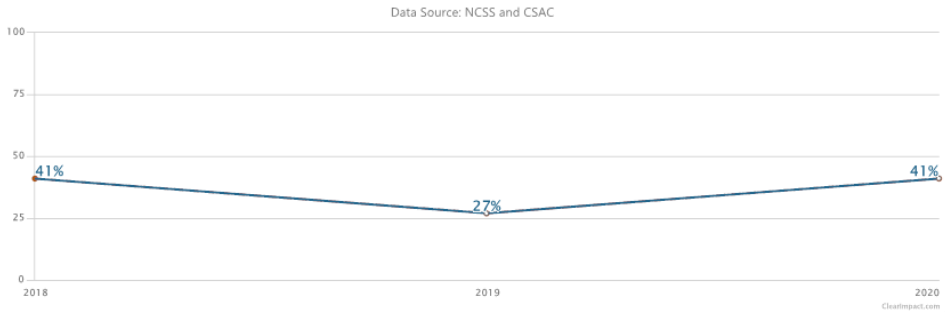
This report is based on record linkage of the Vermont Department of Mental Health (DMH) and Department of Labor (DOL) databases. DMH client data are submitted by Community Programs in conformance with contractual requirements. DOL data are submitted by employers in conformance with state and federal laws. Workers who are excluded from DOL reporting are the self-employed, firm owners not incorporated and the following employee groups: elected officials, employees of nonprofit religious, charitable and educational organizations, unpaid family members, farm workers (with some exceptions), railroad employees, and individuals employed in neighboring states.

Numbers include Community Rehabilitation and Treatment (CRT) clients aged 18 - 64 who were active during each reporting year and includes all employment reported for each year.

IFS Payment Model

P CMS Integrating Family Services

PM CMS % of clients seen within 5 days of their first call requesting services.



	Most Recent	Current Actual	Current Trend
	2020	41%	1
	2019	27%	1
	2018	41%	0

Story Behind the Curve

This measure is used to monitor from an access perspective. When a family calls requesting services, IFS regions are looking to provide them supports and services as quickly as possible. Important to note is that while we are looking for quick access, families are also being asked when they would like services which may impact the timeline for services beginning.

At NCSS, IFS is a program within Children and Youth Services, so they have a centralized intake and do not track this for individual programs but as a children's system of care within the Designated Agency system. The data for IFS specifically must be pulled manually and continues to be a training issue because of the way the centralized workflow is set up.

- 17% seen within 5 calendar days
- 42% were offered an appointment within 5 calendar days

Another important factor to consider with this performance measure is that the majority of services provided to families are home and community-based (at NCSS that accounts for 92% of their services) which can also impact how quickly clients are seen upon their first call. Families are often provided support by phone and that does not get counted in this measure.

For both of these agencies, as is true for the entire mental health system in Vermont and nationwide the COVID pandemic has put tremendous stress on the system. Due to that fact, DMH is not surprised by fluctuations in data which is being experienced in all agencies.

Target: IFS grantees will demonstrate a 2% decrease in the average wait time (in days) between first call requesting services and first appointment offered.

The definition of first call is when contact with the client/family themselves has been made and they have stated they would like or need services

Partners

NCSS and CSAC

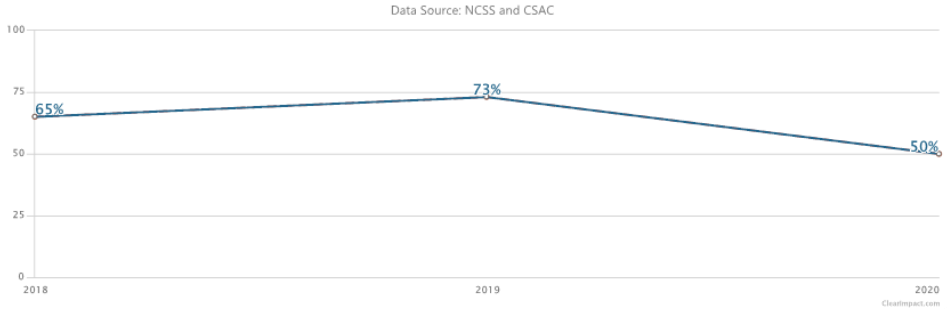
What Works

Notes on Methodology

Numerator: Time in days between first call requesting services and appointment offered.

Denominator: Total number of inactive clients requesting services.

PM CM2 % of eligible clients with a CANS administered



2020	50%		1
2019	73%		1
2018	65%		0

Story Behind the Curve

The CANS is a comprehensive tool that integrates client-level data in one place, while revealing areas that need intense or immediate action, moderate action, or watchful waiting. The simple scoring and clear visual representations help to inform treatment plans and services, by allowing children and caregivers to identify and envision their needs and strengths and communicate them easily to multiple providers. One unique feature of the CANS is that it also focuses on the strengths of children and their caregivers; this positive lens can prove instrumental in a personalized treatment plan.

Vermont began implementation of the CANS in 2015 with the IFS regions being early adopters. This meant the regions have had to invest time and resources in training their staff in the CANS, tracking data and embedding the CANS information in their EHR systems. These regions have begun utilizing the data to track individual's progress over time and to look at program data to assess if children are better off as a result of interventions provided by their interdisciplinary teams.

For both of these agencies, as is true for the entire mental health system in Vermont and nationwide the COVID pandemic has put tremendous stress on the system. Due to that fact, DMH is not surprised by fluctuations in data which is being experienced in all mental health agencies across the state.

Target: IFS grantees will demonstrate a 2% increase of children who have the CANS administered per the eligibility guidelines in the IFS Procedures Manual

Partners

NCSS and CSAC.

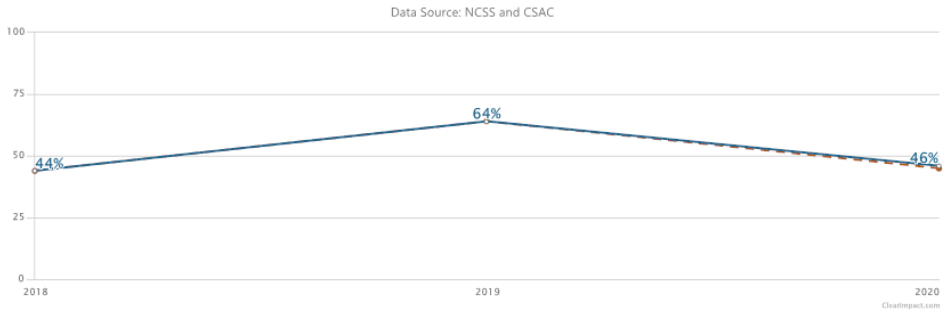
What Works

Notes on Methodology

Numerator: All children with a first CANS administered

Denominator: All children eligible for a CANS receiving services

PM CM % of clients who have a plan of care completed within 45 days of referral



2020	46%	1
2019	64%	1
2018	44%	0

Story Behind the Curve

This measurement is a Medicaid standard which indicates access to care.

Access to care data is being focused on across all the designated agency systems and having operationalized definitions of referral date is being worked on. The definition clarity will be established for 2020. Through the process of payment reform, it became clear that across the system this was an area to work on and the engagement from both the state and DA system has been strong.

We suspect there are clients in the denominator who did not follow through with care which could explain why this percentage is so low. We will continue to monitor this data point closely. As well, with the implementation at one IFS site of a new EMR staff are getting used to a new system and paperwork which could also account for some of the decrease.

For both of these agencies, as is true for the entire mental health system in Vermont and nationwide the COVID pandemic has put tremendous stress on the system. Due to that fact, DMH is not surprised by fluctuations in data which is being experienced in all mental health agencies in Vermont.

Target: IFS grantees will demonstrate a 2% increase in the percent of clients that have a plan completed within 45 days of referral during the measurement period.

Partners

NCSS and CSAC

What Works

Notes on Methodology

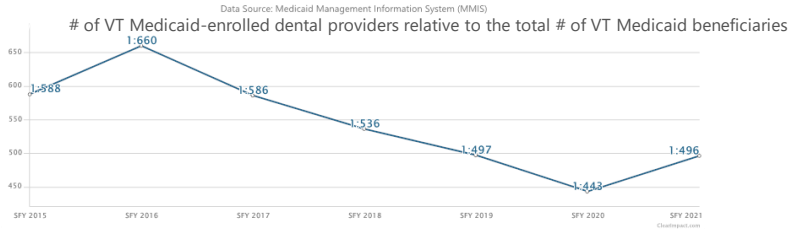
Numerator: All children who have a plan of care completed within 45 days

Denominator: All children eligible for a plan of care

What We Do

The Dental Incentive Program was created to recognize and reward dentists who serve Medicaid beneficiaries and to improve access to dental care. Twice a year, an incentive payment is given to dental practices who, over the last 6-month period, provided more than $50,000 in services.

This scorecard is updated every six months and tracks a) the total number of providers eligible for the incentive payment and b) the number of dental providers in Vermont relative to the total Medicaid population.

Measures	Most Recent Period	Current Actual Value	Current Target Value	True	Current Trend	Baseline % Change
	SFY 2021	1:496			1	-16%
	SFY 2020	1:443			4	-25%
	SFY 2019	1:497			3	-15%
	SFY 2018	1:536			2	-9%
	SFY 2017	1:586			1	0%
	SFY 2016	1:660			1	12%
	SFY 2015	1:588			0	0%

Notes on Methodology

- The data value used for beneficiary enrollment is the number of full-benefit Vermont Medicaid enrollees on active status as of January 1 each year.
- The data value used for dentists is the number of dentists enrolled in Vermont Medicaid on active status with an address in Vermont as of January 1 each year. This includes individual provider organizations and hygienists who bill separately.

Partners

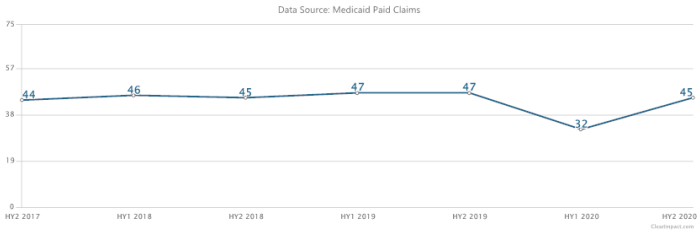
- Department of Vermont Health Access (DVHA): Clinical Operations (Dental staff), Provider & Member Relations, Data, Policy and Quality Units
- Vermont Department of Health's Oral Health Program
- Vermont Dentists
- Vermont State Dental Society (VSDS)

Story Behind the Curve

This measure shows the number of Vermont Medicaid enrolled dentists relative to the number of VT Medicaid beneficiaries. For this measure, a lower ratio is better. The baseline for this measure is SFY 2015 to align with Medicaid Expansion which led to an increase in the number of adults eligible for the Medicaid dental benefit.

The trend line above shows that the ratio of dentists to the Medicaid population was lower in SFY 2020 when the pre-Covid-19 enrollment counts were at a five-year low. In SFY 2021, the slightly higher number is the result of an increased supply of dentists, but also an increase in Medicaid enrollment. It is nearly identical to the ratio found in SFY2019.

# of dental practices eligible for dental incentive payment (total Medicaid paid claims of $50k or more)	HY2 2020	45			1	36%



HY1 2020	32
HY2 2019	47
HY1 2019	47
HY2 2018	45
HY1 2018	46
HY2 2017	44
HY1 2017	50
HY2 2016	43

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within the historically normal range.

Actions

Name	Assigned To	Status	Due Date	Progress

CDD, Children's Integrated Services

CDD CIS

What We Do

The Child Development Division (CDD), Children's Integrated Services is a unique model for integrating early childhood health, mental health, evidence based home visiting, early intervention and specialized child care services for pregnant and postpartum women and children birth to age six.

Who We Serve

CDD, Children's Integrated Services (CIS) has four core services:

- Early Intervention: Services for children from birth up to age 3 with or at risk of a developmental delay or disability.
- Strong Families VT Home Visiting: Services delivered in the home for pregnant and postpartum parents and young children who have concerns about factors that impact healthy family development.
- Early Childhood and Family Mental Health: Services to promote healthy social-emotional development for children and their families from birth to age 6 who may have mental health concerns.
- Specialized Child Care: Services to help children with high needs connect to and experience success in high quality child care settings.

How We Impact

The model is designed to improve child and family outcomes by providing family-centric holistic services, effective service coordination, and flexible funding to address prevention, early intervention, health promotion, and accountability.

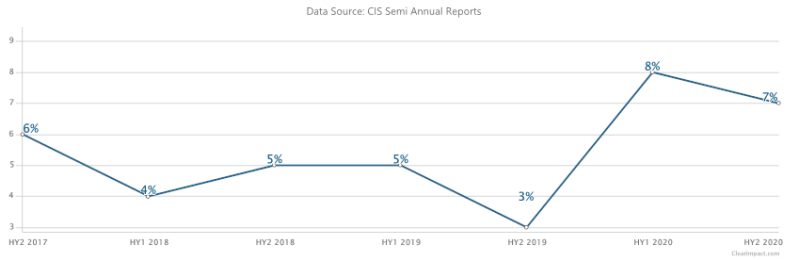
CIS Clients Lost to Follow Up: When a CIS client discontinues services without notice and does not respond to repeated attempts at contact, they are considered "lost to follow up." CIS teams attempt to decrease this outcome through strong family engagement and effective outreach, so a decrease in this measure indicates an improvement in practice.

Referrals Triaged by CIS Coordinator: A goal is to increase community awareness that CIS is a comprehensive source for early childhood services. Over time this performance measure has stayed between 78% - 83% of referrals made directly to the CIS coordinator, which indicates a high community awareness.

Clients with One Plan Completed within 45 Days: A key step in engaging families and beginning timely service delivery is the completion of a One Plan, the individualized service plan used in CIS. Starting services in a timely manner ensures that every client has the best opportunity to maximize their growth and development while accessing CIS services. An increase over the base in clients with completion of a One Plan within 45 Days is the target.

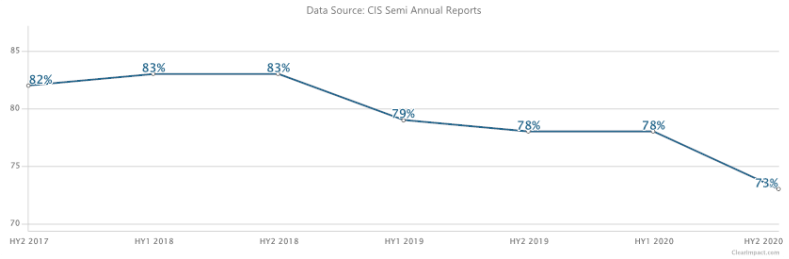
Measures

PM CDD % CIS Clients Lost to Follow Up



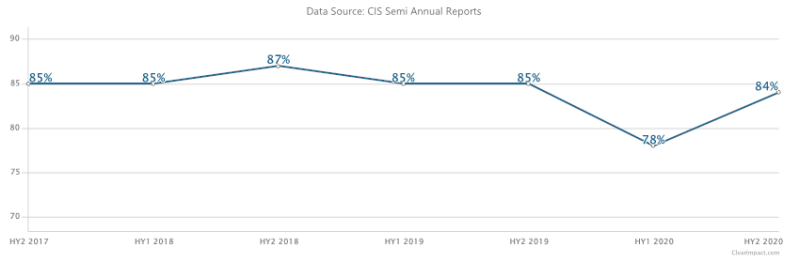
Most Recent	Current Actual	Current Target	Current Trend	Baseline % Change
HY2 2020	7%		1	-22%
HY1 2020	8%		1	-11%
HY2 2019	3%		1	-67%
HY1 2019	5%		1	-44%
HY2 2018	5%		1	-44%
HY1 2018	4%		2	-56%
HY2 2017	6%		1	-33%
HY1 2017	7%		1	-22%
HY2 2016	7%		1	-22%

PM CDD % of Referrals Triaged by CIS Coordinator



HY2 2020	73%	1	-5%
HY1 2020	78%	1	1%
HY2 2019	78%	2	1%
HY1 2019	79%	1	3%
HY2 2018	83%	1	8%
HY1 2018	83%	2	8%
HY2 2017	82%	1	6%
HY1 2017	78%	1	1%
HY2 2016	80%	1	4%

PM CDD % of Clients with One Plan Completed withing 45 days



HY2 2020	84%	1	8%
HY1 2020	78%	1	0%
HY2 2019	85%	1	9%
HY1 2019	85%	1	9%
HY2 2018	87%	1	12%
HY1 2018	85%	1	9%
HY2 2017	85%	3	9%
HY1 2017	83%	2	6%
HY2 2016	79%	1	1%

Actions

Name	Assigned To	Status	Due Date	Progress