# *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
## July 1, 2021 – September 30, 2021

**Submitted Via PMDA Portal on December 10, 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 eligible for Marketplace coverage beginning January 1, 2014. The renewal also added the New Adult Group to the demonstration effective January 1, 2014. Finally, the renewal also included premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL.

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

2016: On October 24, 2016, Vermont received approval for a five-year extension of the Global Commitment to Health 1115 waiver, effective from January 1, 2017, through December 31, 2021. 2018: As of July 1, 2018, the Global Commitment to Health demonstration was amended to include 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 third quarterly report for waiver year 16, covering the period from July 1, 2021, through September 30, 2021 (QE092021).***

## II. Outreach/Innovative Activities

### i. Member and Provider Services

**Key updates from QE092021:**

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

The Member and Provider Services (MPS) Unit ensures members have access to appropriate healthcare for their medical, dental, and mental health needs. The MPS Unit monitors the adequacy of the Green Mountain Care (GMC) network of providers and is responsible for 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 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

During the last quarter of FY21 and first few months of FY22, DVHA's NEMT numbers and work volume continued the slow rebound from the drastic drop off at the beginning of the pandemic. All indicators (referrals, exemptions, incoming calls, and ride requests/provided) steadily increased over this period. Requests for out of state trips jumped markedly, reflecting the opening of more options for VT Medicaid members to care not available in the state.

| | SFY21 | | | | | | | | | | | | SFY22 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **20-Jul** | **20-Aug** | **20-Sep** | **20-Oct** | **20-Nov** | **20-Dec** | **21-Jan** | **21-Feb** | **21-Mar** | **21-Apr** | **21-May** | **21-Jun** | **21-Jul** | **21-Aug** |
| **# member rides** | 17,590 | 17,819 | 18,162 | 19,932 | 18,466 | 17,904 | 17,836 | 17,751 | 20,756 | 19,675 | 19,946 | 21,905 | 23,080 | 24,415 |
| **# member rides on time** | 17,456 | 17,710 | 18,068 | 19,509 | 18,312 | 17,748 | 17,654 | 17,673 | 20,546 | 19,482 | 19,751 | 21,550 | 22,731 | 24,146 |
| **% member rides on time** | **99.20%** | **99.40%** | **99.50%** | **97.90%** | **99.20%** | **99.10%** | **99.00%** | **99.60%** | **99.00%** | **99.00%** | **99.00%** | **98.40%** | **98.50%** | **98.90%** |

Coordination of Benefit Activity

Coordination of Benefits (COB) refers to the activities involved in determining Medicaid benefits when anenrollee has coverage through an individual, entity, insurance, or program that is liable to pay for health care services. Individuals eligible for Medicaid assign their rights to third party payments to the State Medicaid Agency.

Medicaid beneficiaries may have one or more additional sources of coverage for health care services. Third Party Liability (TPL) refers to the legal obligation of third parties (for example,

certain individuals, entities, insurers, or programs) to pay part or all the expenditures for medical assistance furnished under a Medicaid.By law, all other available third-party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. DVHA is required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services that are available under the Medicaid state plan.

| **Cost Avoidance "Q3"** | |
|---|---|
| Third Party Liability | $ 6,063915.16 |
| Medicare | $ 127,207,596.82 |
| **Total** | **$133,271,511.98** |

**Coordination of Benefit Cost Avoidance Table:**

| **Coordination Recovery Activities "Q3"** | |
|---|---|
| Casualty | $324,406.26 |
| Estate | $197,771.38 |
| Third Party & Court Ordered Medical | $180,350.95 |
| Medicare Prescription Drug Premium/Claims | $170,199.84 |
| Over Resource/Hospice/Patient Share/Credit Balance | $321,127.33 |
| Annuity/Trust/Waiver | $64,802.78 |
| Medicare Claim Recoupment (Retro Billing) | $26,939.15 |
| Third Party Claim Recoupment | $126,390.80 |
| Home Health/Nursing Home | $58,192.02 |
| **Total** | **$1,470,180.51** |

## III. Operational/Policy Developments/Issues

### i. Vermont Health Connect

**Key updates from QE0921:**

- The Customer Support Center received more than 58,500 calls in QE0921. Call volume is down 9% in QE0921 as compared to QE0920.
- DVHA is currently supported by 108 Assisters (98 Certified Application Counselors, 7 Navigators, and 3 Brokers), with 5 Assisters in training, working in 53 organizations including hospitals, clinics, and community-based organizations.
- Increasing numbers of customers are using self-service functions, especially recurring payments. An average of 68% of customers made recurring payments in QE0921. This is a 3% growth from the prior year.

Enrollment

As of QE0921, more than 221,960 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 150,907 in Medicaid for Children and Adults (MCA) and 71,053 in Qualified Health Plans (QHPs), with the latter divided between 24,398 enrolled with VHC, 6,268 direct enrolled with their insurance carrier as individuals, and 40,387 enrolled with their small business employer.

Medicaid Renewals

For each month of the third quarter, and for the duration of the public health emergency, MCA redeterminations are processed only for cases that can be renewed ex part. 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

The last corrections run for 2020 1095B was June 28, 2021. Preparations are currently underway for EOY 2021 generation which will begin in December.

Customer Support Center

DVHA continues to contract with Maximus to staff and manage the VHC Customer Support 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 just over 58,500 calls in QE0921. Call volume is down 9% in QE0921. Maximus answered 81% of calls within 24 seconds in July 2021, 83% in August

2021, and 98% in September 2021. Maximus exceeded the target of 75% of calls answered within 24 seconds for QE0921.

Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to DVHA-HAEEU for resolution and log service requests, which are escalated to the appropriate resolver group. In July of QE0921, the transfer rate was 9.2%, in August the transfer rate was 8.9%, and in September the transfer rate went down to 8.4%. In QE0921, DVHA-HAEEU answered 99% of all transferred calls within five minutes compared to 91% in QE0920.

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 this past quarter, 99% of the VHC requests were completed within the same ten-day time period.

System Performance

The system continued to operate as expected throughout QE0921, achieving 100% availability outside of scheduled maintenance. The average page load time for the quarter was 1.38 seconds – well within the two-second target.

In-Person Assistance

DVHA is currently supported by 108 Assisters (98 Certified Application Counselors, 7 Navigators, and 3 Brokers), with 5 Assisters in training, working in 53 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.

Outreach

Vermont Health Connects website continued to be a key source of information for current and prospective customers alike, receiving more than 78,049 visits in the quarter – a 0.14% decrease from the previous quarter while a 25% increase from last year's same quarter. The increase could be subject to the many communications alerting customers to our website for more information on ARPA.

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 10,204 sessions during the quarter.

Vermont Health Connect has launched several digital stakeholder toolkits to promote a variety of initiatives including increased opportunities for financial assistance due to ARPA, the transition of premium payments from VHC to the carriers, and promotion of 2022 Open Enrollment. The

department also conducted a series of six, virtual health insurance town halls, open to the public to discuss ARPA and answer related questions.

Self-Service

During QE0921, 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. Automatic recurring payments ensure that members' premiums are paid on time, helping them to avoid going into a grace period – and ultimately losing coverage – due to late payments.

Self-serve applications comprised over half (62%) of all applications in QE0921, up slightly from QE0920 (56%). More than 7,400 customers made recurring payments per month in QE0921. Overall, 48% of all payments made per month are recurring payments and 68% of all electronic payments in QE0921 were recurring payments.

ii. Choices for Care and Traumatic Brain Injury Programs

DAIL

Choices for Care

**Electronic Visit Verification**:

DAIL Adult Services Division, in partnership with DVHA and DPH, continues to work with homecare agencies and individuals who self-direct their personal care services to provide access to educational materials to support the adoption of EVV throughout the state. Information on EVV can be found HERE

**Enhanced FMAP spending plan**:

The Initial Spending Plan Narrative was submitted in June 2021. During the reporting Q3 reporting period, The Adult Services Division engaged with stakeholders for input on the set of activities included in the Home and Community-Based Services (HCBS) Initial Spending Plan. Written comments informed the mid-October quarterly update of the Initial Spending Plan. This is an extension of the initial due date for comments that was posted on June 18th. More information is available HERE

**Adult Day** 11 Adult Day service providers reported that they have reopened. Average enrollment is 44% of pre-pandemic census. Providers report that difficulty hiring staff has been a limiting factor in increasing enrollment. Ten out of eleven providers require that participants be fully vaccinated, and all require individuals to be able to wear a mask.

DAIL continues to support Long Term Care providers during Q3 by updating and providing access to the Guidance for Operations During COVID-19 Health Emergency. Resources for LTC providers can also be found here: https://www.healthvermont.gov/covid-19/health-care-professionals/long-term-care-and-group-living-settings

Money Follows the Person (MFP)

The MFP grant has been re-authorized through (CY) 2024. The VT Department of Aging and Independent Living (DAIL) Adult Services Division has been awarded funds for CY2021 operations. This award is funded to help transition fifty-three (53) Choices for Care participants from a SNF to a home-based setting. As part of the grant re-authorization, CMS has also 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 has been awarded a $5M MFP Supplemental Grant. These dollars will be used to strengthen the systems serving Money Follows the Person and Choices for Care participants by increasing the number of direct service workers, increasing supports for unpaid caregivers and by piloting new HCBS services to meet unmet care needs. The Supplemental Grant Funding will be used for the following seven approved initiatives:

1. Direct service workforce development and retention
2. Falls prevention and mobility
3. Use of assistive technology
4. Expansion of volunteer programs
5. Holistic social and mental health supports
6. Brain injury supports
7. Independent living and home modifications

CY2021 transitions = 64 participants and there are currently 17 participants in the process of transitioning.

Brain Injury Program: Current enrollment = 80 individuals, 12 individuals are in the process of enrolling. 12 New Applicants pending clinical assessment.

Wait Lists

- There is no wait list for the High Needs Group.
- There continues to be provider wait lists for Moderate Needs Group, estimated at almost 550 people statewide. Because the eligibility criteria for Moderate Needs services is so broad, Vermont does not expect to eliminate the wait list. Agencies are currently using different methods to address priority/acuity – we plan to transition to a statewide method. The state is currently piloting two separate acuity-based models for revising the wait list procedures. The goal of this work is to identify/implement a state-wide standardized approach to the priority scale.
- There is currently no wait list for the Brain Injury program.

iii. Developmental Disabilities Services Division

**Key updates from QE09021:**

- We continue to recruit for the DDSD Director position, which has been vacant since 6/22/2021.
- Coronavirus 19 Response
- Payment Reform Activities
- HCBS Rules Implementation

Coronavirus 19 Response

The quarter ending 09/2021 continued to require response to the coronavirus pandemic. New guidance in QE092021 included:

Continuing Conversion of Unused HCBS Funds for FY 2022 for Shared Living Providers and Unpaid Family Caregivers issued on 9/30/2021

Please see prior report submissions for previous highlights.

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. PCG began conducting assessments in July 2021. Design of the new payment model will be continuing as the tempo of state response to the pandemic abates. We have heard support for this work from self-advocates and the Developmental Disabilities Council, and opposition to this work based on significant workforce shortages from the provider community and are working to identify a path forward that recognizes all input received.

DDSD held two Encounter Data Workgroup Meetings during QE062021:
DDSD_Payment_Reform-Encounter_Data_Meeting_Schedule.pdf (vermont.gov)

Ongoing work will be required, including seeking any needed CMS approval.

HCBS Rules Implementation

HCBS Settings Requirements - Work on HCBS rules implementation was paused inCY2020 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 preparing and sending reports to each provider agency requiring a plan of correction to address the areas of non- compliance by the 2022 deadline.

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. DDSD continues to work with the Department of Vermont Health Access and other AHS Departments on a plan for submission to CMS by December 17, 2021.

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 0902021 the vendor, Public Consulting Group, has been selected and has begun their needs assessment work.

iv. Global Commitment Register

**Key updates from QE092021:**

- Policies were posted to the GCR in Q3 2021.
- Since the Global Commitment Register (GCR) launched in November 2015 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 Agency of Human Services' website to ensure that policy changes are transparent to Vermonters and to provide a forum for public comments.

The GCR listserv is a group of about 394 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, and 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 4 proposed policies and 18 final policies posted in QE092021. No policy clarifications were posted this quarter. Changes included updates to rates and/or rate methodologies and clinical coverage changes.

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)

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 | 1. Increased rates of identification initiation, and engagement in treatment;<br>2. Increase adherence to and retention in treatment;<br>3. Reductions in overdose deaths, particularly those due to opioids;<br>4. Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;<br>5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and<br>6. Improved access to care for physical health conditions among beneficiaries. |

**Key updates for QE092021:**

- From July 1 to September 20, 2021, VT Helplink received over 390 calls and 10,900 website visits. Web visitors have searched for services online over 1,000 times.
- 12 hospitals are participating in the Recovery Coaches in the Emergency Department Program.
- The Compliance Assessment Tool has been utilized with 33 substance use disordertreatment provider locations.

Executive Summary

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 continued to provide telemedicine, where appropriate, while others adjusted daily census as needed to mitigate fluctuating risk from COVID-19 and continued social distancing, masking and other strategies to continue serving patients requiring in person services during the COVID-19 pandemic.

Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were effective January 1, 2020. ADAP continues to suspend plans to develop the value-based

payment model for residentialprograms, to align with itsAll-Payer Model Agreement with CMS, due to the COVID-19 pandemic. ADAP has been meeting with residential treatment providers regarding COVID-19 pandemic related issues and related impacts to services. ADAP continued to collect, compile and review stakeholder feedback, including information gathered in a Requestfor Information (RFI) related to the overallSUD treatment system. The value-based payment component of the residential payment model is still in consideration for inclusion in the larger system reform.

ADAP's centralized intake and resource center, "VT Helplink: Alcohol and Drug Support Center" launched for public use in March 2020. From July 1 to September 20, 2021, VT Helplink received over 390 calls and 10,900 website visits. Web visitors have searched for services online over 1,000 times. 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 oftreatment with appointments to ADAP's Preferred Provider Network. Some residential treatment programs have started reporting capacity/bed availability through VT Helplink's provider portal, and work continues to engage providers and expand the database of SUD resources available to consumers.

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 has met ten times between October 2019 to October 2020. The SMPC has three goals of the SMPC are the following:

- Increase protective factors and build resilience and feelings of connectedness in Vermont communities, across all ages, cultures, and socioeconomic conditions.
- Decrease risk factors for substance use in Vermont for individuals of all ages, cultures, and socioeconomic conditions.
- Increase efficiency and collaboration on prevention efforts across all state, public, and private entities, through a consolidated and holistic approach to prevention that is sustainable, scalable,and equitable.

Information on the SMPC can be found here: www.healthvermont.gov/SMPC

During this last quarter, the SMPC worked on finalizing their report to the Vermont General Assembly for the 2022 legislative session. The SMPC focused their review and recommendations on the following four categories: Prevention Services Policy Equity and Health Disparities Substance Use Prevention and Health Promotion Communication Efforts

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 (ifany) | 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. | DY2 Q2 | Medicaid Beneficiaries with SUD Diagnosis (monthly)<br><br>Medicaid Beneficiaries with SUD Diagnosis (annually)<br><br>Medicaid Beneficiaries Treated in an IMD for SUD | Vermont experienced a decrease in the number of Medicaid beneficiaries identifiedwith SUD diagnoses leading to decreases in people receiving SUD services other than medication assisted treatment for opioid use disorder. These changes in provision of treatment coincide with the COVID-19 pandemic which first peaked in Vermont in April and then again in November/December2020. People were not seeking care across the healthcare system during the pandemic, which would account for the decrease and ongoing concerns about COVID and the variants have continued to impact people seeking healthcare services. ADAP has worked with VT Helplink and SUD treatment providers to market and educate Vermonters that treatmentservices are available, and it is safe to seek treatment. |
| *[Add rows as needed]* | | | |
| The state has no metrics trends to report for this reporting topic. | | | |
| **Implementation Update** | | | |
| | | | There are no planned changes to the target population or clinical criteria |

| | | | |
|---|---|---|---|
| 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 to: A) the target population(s) of the demonstration ? B) the clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration ? | | | |

**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 trend 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. | DY2 Q2 | 6 Any SUD Treatment | Vermont experienced a decrease in people receiving SUD treatment. People were not seeking care across the healthcare system during the pandemic, which would account for the decrease. ADAP has worked with VT Helplink and SUD treatment providers to market and educate Vermonters that treatment services are available, and it is safe to seek treatment. However, it is likely that ongoing concerns about the pandemic and the COVID variants continues to impact peoples' comfort in seeking out healthcare services. |
| | | 7 Early Intervention | Services coded as early intervention have been consistently low (averaging one beneficiary per month) as most intervention services inVermont are provided through other mechanisms or funding. . |
| | | 8 Outpatient Service | Outpatient services decreased due to COVID and peoples' concerns about seeking healthcare services. Providers ramped up capacity to provide services through telemedicine while the stay-at-home order was in place and are currently able to provide services through telemedicine and in person, giving more options for those seeking services. Telemedicine services have |

| | | | |
|---|---|---|---|
| | | | been impacted by lack of access to adequate internet services in some rural areas as well the cost/data limits. |
| | | 9 Intensive Outpatient and Partial Hospitalization Services | IOP services remain low due to the difficulty of providing group-based services during the pandemic. Some services are being provided via telemedicine. Telemedicine services are impacted by the rural nature of the state, lack of adequate internet in some areas as well as the impact of limited data/usage for some individuals. |
| | | 10 Residential and Inpatient Services | One residential treatment provider experienced a COVID-19 outbreak among clients and were required to hold admissions while the provider and Health Department |
| | | | staff worked to contain the outbreak through isolation and quarantine protocols. The provider was successful in containing the outbreak to a small number of clients and admissions were able to resume. Residential providers have continued to experience a reduction in available capacity due to COVID-19 safety precautions to reduce the potential for outbreaks in their facilities. Additionally, challenges with ensuring all clients are tested for COVID-19 immediately prior to admission has impacted |

| | | | |
|---|---|---|---|
| | | | pacing of admissions. |
| | | 11 Withdrawal Management | This has been trending downward with some month-to- month variation |
| | | 12 Medication Assisted Treatment | The number of beneficiaries receiving MAT has continued to increase quarter by quarter. |
| | | 36 Average Length of Stay in IMDs | 2020 data not yet available |
| [Add rows as needed] | | | |

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

**Milestone 1 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 access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g. outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management)?

SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication assisted treatmentservices provided to individuals in IMDs?

**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 is no anticipated program |

☒ 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:<br>Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria?<br>Implementation of a utilization management approach to ensure:<br>Beneficiaries have access to SUD services at the appropriate level of care.<br>Interventions are appropriate for the diagnosis and level of care?<br>Use of independent process for reviewing placement in residential treatment settings?<br><br>**Summary:**<br>The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 33 substance use disorder treatment provider locations. The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were effective January 1, 2020. Due to the COVID pandemic, provider site reviews were put on hold until July 2021 when they resumed in a virtual environment. ADAP has completed nine remote site visits utilizing the tool this quarter. | | | |

**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 | August 15, 2018 | Director of Quality | Completed |

| | | | |
|---|---|---|---|
| Assessment Tool with revised Substance Use Disorder Treatment Standards and all residential ASAM criteria | | Management and Compliance | |
| Updated online | October 31, 2018 | Director of Quality | Completed |
| recertification survey | | Management and | |
| to reflect new revision | | Compliance | |
| of Substance Use | | | |
| Disorder Treatment Standards | | | |
| Use the Compliance | December 31, 2018 | Director of Clinical | Completed |
| Assessment Tool to | | Services; Director of | |
| certify ASAM Level 3.5 Level of Care provider (Valley Vista Vergennes) | | Quality Management and Compliance | |
| Use the Compliance | December 31, 2018 | Director of Clinical | Completed |
| Assessment Tool to | | Services; Director of | |
| certify ASAM Level | | Quality Management | |
| 3.5 Level of Care provider (Valley Vista Bradford) | | and Compliance | |
| 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 |

Vermont continues to suspend plans to develop a value-based payment model for residential programs to align with its All-Payer Model Agreement with CMS due to the impact of the COVID-19 pandemic. ADAP has continued to collect stakeholder feedback, including information gathered in a Request for Information (RFI) related to the overall SUD treatment system. The value-based payment component of the residential payment model is still in consideration for inclusion in the larger system reform.

**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 team to 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 to provide 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 billing changes | Completed | ADAP Clinical Team | |
| Regional Managers will partner with the compliance and quality 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. | | | |
| The state has no implementation update to report for this reporting topic. | | | |

**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's progress towards meeting Milestone 3.*

| Prompts | Demonstration Year (DY) and quarter first reported | Related metric (if any) | Summary |
|---|---|---|---|
| **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:**<br>**Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards?**<br>**State review process for residential treatment providers' compliance with qualifications standards?** | | | |

| | | | |
|---|---|---|---|
| **Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site?**<br><br>**Summary:**<br><br>**The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 33 substance use disorder treatment provider locations.**<br>**The Substance Use Disorder Treatment Standards and corresponding compliance assessment**<br>**tool was effective January 1, 2020. Due to the COVID pandemic, provider site reviews were put on hold until July 2021 when they resumed in a virtual environment. ADAP has completed nine remote site visits utilizing the tool this quarter.** | | | |
| 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,<br>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 meeting Milestone 4.*

| Prompts | Demonstration Year (DY) and quarter first reported | Related metric(if any) | Summary |
|---|---|---|---|
| **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. | | SUD Provider Availability<br><br>SUD Provider Availability – MAT | The number of providers who were enrolled in Medicaid and qualified to deliver SUD services, including those who meet the standards to provide buprenorphine/methadone as part of MAT, has increased. |
| *[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**:
Vermont continues to suspend plans to develop a value-based payment model for residential programs to align with its All-Payer Model Agreement with CMS due to the COVID-19 pandemic. Vermont anticipates resuming work on the model as a part of the work around the entire system of care throughout the fall/winter of 2021/2022.

ADAP's centralized intake and resource center "VT Helplink: Alcohol and Drug Support Center" launched for public use March 2020. From July 1-September 20, 2021, VT Helplink received over 390 calls and 10,900 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. Some residential treatment programs have started reporting capacity/bed availability through VT Helplink's provider portal, and work continues to engage providers and expand the database of SUD resources available to consumers.

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

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

**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 toaddress opioid abuse and OUD to assess the state's progress towards meeting Milestone5.*

| Prompts | Demonstration Year (DY) and quarter first reported | Related metric (ifany) | Summary |
|---|---|---|---|
| **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. | | 15 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment<br>18 Use of Opioids at High Dosage in Persons Without Cancer<br>21 Concurrent Use of Opioids<br><br>Benzodiazepines<br>22 Continuity of Pharmacotherapy for Opioid Use Disorder | The percentage of adults in continuous pharmacotherapy for OUD has decreased which may be an unintended consequence of Vermont's robust access to MAT. Individuals who may be ambivalent about treatment may be less concerned about leaving treatment since they know there will be no wait to get back in; also, there are a number of cash only and other Spoke options available which may lead to more movement in and out of treatment. |
| *[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:<br>Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD?<br>Expansion of coverage for and access to naloxone?<br><br>**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.

| Prompts | Demonstration Year (DY) and quarter first reported | Related metric (if any) | Summary |
|---|---|---|---|
| **Milestone 6 Metric Trends** | | | |
| Discuss any relevant | | 17 Follow-Up | Recovery Coaches are dispatched to 12 |

| | | | |
|---|---|---|---|
| trends that the data<br><br><br><br><br>shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described. | | After Emergency<br><br><br><br>Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence | emergency departments to support<br><br><br><br>individuals who present with a SUD at the ED including providing linkages to follow-up visits upondischarge. |
| ☒ 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?<br><br>**Summary**:<br>Vermont launched the Recovery Coaches in the Emergency Department Program on July 1,2018. 12 hospitals are participating in the program. Virtual recovery services have been implemented. | | | |
| 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 | | | |
| 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.

| 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. | | Q1 PDMP Users/ Checks<br><br>Q2 PDMP Linkages | |
| | | Q3 HIT/HIE Plan | |
| *[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:<br>How health IT is being used to slow down the rate of growth of individuals identified with SUD?<br>How health IT is being used to treat effectively individuals identified with SUD?<br>How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD? | | | |

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?
Other aspects of the state's health IT implementation milestones?
The timeline for achieving health IT implementation milestones.
Planned activities to increase use and functionality of the state's prescription drug monitoring program?

**Summary**:

As of May 2021, Vermont has connected to both the RxCheck and PMPi hubs for interstate data sharing. RxCheck is developing functionality for direct integration with EHRs and other health systems, and PMPi employs the Gateway product for health system integrations.

VPMS, Dr. First and Bamboo Health (formerly Appriss) are in the process of testing and verifying the 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. However, deployment of VPMS staff for COVID-19 response has delayed the start of this initiative.

VPMS currently is integrated through Gateway with the Veteran's Affairs health system as required by the Mission Act. This allows VA providers to query the prescription history of their Vermont patients, regardless of if they have a Vermont license. Previously, VA providers were not allowed direct access to the prescription monitoring program without a VT license. As VA providers are not required to have a license within the state that they are working, this created a gap for those providers working in, but not licensed in, Vermont.

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.

Vermont continues to offer prescriber reports on a quarterly basis. These reports provide in-depth snapshots of prescriptions dispensed from those prescribers of opioids, sedatives, benzodiazepines and stimulants.

| | | | |
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| 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

| Prompts | Demonstration Year (DY) and quarter first reported | Related metric (if any) | Summary |
|---|---|---|---|
| **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 | | Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries<br>Inpatient stays for SUD per 1,000 Medicaid beneficiaries. | Overdose deaths are variable. Vermont has seen a significant increase in fentanyl involvement in opioid overdose fatalities. Fentanyl is 50-100 times stronger than heroin and the amount in the drug supply often isn't known to users until it is used. Fentanyl is currently the most prevalent substance involved in opioid- related deaths) |
| qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be | | | |

| | | | |
|---|---|---|---|
| described. | | Beneficiaries Readmissions Among Beneficiaries with SUD<br><br>Overdose Deaths (count)<br><br>Overdose Deaths (rate)<br><br>32 Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD | of opioid-related fatalities and has increased each year since 2011 (9%). Of note, deaths involving fentanyl can include prescription and/or illicit fentanyl and fentanyl analogues.<br><br>Vermont has been working to decrease drug overdoses and in 2020, published a social autopsy showing places where individuals who died of a drug overdose interacted with a variety of Vermont programs.<br><br>Fatal overdoses have increased in 2020 after a decrease in 2019. This is likely due to the stress, social isolation, and disruptions in services and drug supply associated with COVID-19. Community support systems such as recovery groups were moved to a remote format, a method not accessible or accepted by everyone accessing these services. COVID-related social isolation may have resulted in more people using alone and |

| | | | |
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| [Add rows as needed] | | | anecdotal information suggests that the stimulant payments allowed for larger drug purchases. Medication assisted treatment provision increased in 2020 but residential and intensive outpatient care were less available due to the group nature of these services, and outpatient care was provided remotely. Provision of harm reduction services, which includes information about safer use and referrals to treatment as well as distribution of naloxone and clean syringes were less able to be provided in- person. There was a 40% reduction in people visiting sites where naloxone is distributed and a 24% decrease in naloxone kits distributed in the first six month of 2020 compared to first six months of 2019. |
| ☒ 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. | | | As a result of COVID-19, the Vermont Department of Health Division of Alcohol and Drug Abuse (ADAP) is taking the following actions to address the increase in drug overdoses.<br>Naloxone – The Department continues to provide naloxone and training through collaborations with community-based organizations, including getting naloxone to the motels where the state is housing people experiencing homelessness.<br>VT Helplink is a free and confidential referral service available to connect people to resources and treatment (802-565- LINK or VTHelplink.org)<br>Recovery Centers are conducting outreach to reduce relapse and prevent overdoses (e.g. Harm Reduction Pack distribution, peer support specialists, Recovery Coaching referrals, etc.)<br>Providers are increasing outreach to patients and are continually re-evaluating patients' stability to triage for in-person supports, decreased take-homes, etc.<br>ADAP has regular calls with Preferred Providers.<br>The clinical team at ADAP receives critical incidents for overdoses from the preferred providers for people currently in treatment.<br>Overdoses were reported by providers to include people in longer-term recovery and people who had left treatment prior to COVID.<br>The Department is working with partners to continue to disseminate key harm reduction messaging on the increased risks |

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| | | | associated with overdose and using alone.<br>ADAP continues to collaborate with communities to enhance Rapid Access to Medication Assisted |
| | | | Treatment (RAM). The statewide expansion includes 13 hospital emergency departments with at least one waivered practitioner in their Emergency Department (ED). |
| The state has no implementation updates to report for this reporting topic. | | | |

Budget Neutrality

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

| Prompts | Demonstration Year (DY) and quarter first reported | Related metric (if any) | Summary |
|---|---|---|---|
| **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.<br>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:<br>a. How the delivery system operates under the | | | |
| demonstration (e.g., through the managed care system or fee for service)?<br>Delivery models affecting demonstration participants (e.g., Accountable Care Organizations,Patient Centered Medical Homes)?<br>Partners involved in service 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?<br>How are they similar to or different from the SUD demonstration? | | | |
| ☒ The state has no implementation updates to report for this reporting topic. | | | |

SUD Demonstration Evaluation Update

| Prompts | Demonstration Year (DY) and quarter first reported | Related metric (if any) | Summary |
|---|---|---|---|
| **12.1 SUD Demonstration Evaluation Update** | | | |
| 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 demonstration. See report template | | | Updates on the SUD evaluation work, deliverables, and timeline can be found in Sections VIII. *Quality Improvement* and IX. *Demonstration Evaluation* of this report. |

| | | | |
|---|---|---|---|
| instructions for more details. | | | |
| 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

| Prompts | Demonstration Year (DY) and quarter first reported | Related metric (if any) | Summary |
|---|---|---|---|
| **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:<br>The schedule for completing and submitting monitoring reports?<br>The content or completeness of submitted reports?<br>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 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 summary of the annual post-award public forum held pursuant to 42 CFR<br>§ 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 the forum was held and in the annual report. | | | |
| [Add rows as needed] | | | |
| ☒ There was not a post-award public forum held during this reporting period and this is not an annual report, so the state has no post award public forum update to report for this reporting topic. | | | |

Notable State Achievements and/or Innovations

| Prompts | Demonstration Year (DY) and quarter first reported | Related metric (if any) | Summary |
|---|---|---|---|
| **14.1 Notable State Achievements and/or Innovations** | | | |
| **14.1 Narrative Information** | | | |

| | | | |
|---|---|---|---|
| Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries. | | | |
| *[Add rows as needed]* | | | |
| ☒ The state has no notable achievements or innovations to report for this reporting topic. | | | |

## IV. Expenditure Containment Initiatives

### i. Vermont Chronic Care Initiative (VCCI)

**Key updates from QE092021:**

- Working with AHS on improving transitions in care and implementing complex care model with population involved with Department of Corrections
- PCP Access - data collection
- Resumption of in person visits with beneficiaries
- Alignment of VCCI with state health care reform and ACO

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 seven 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. Primary mode of intervention is through in-person visits with beneficiaries, meeting them in their homes, at motels, shelters, at homeless camps and at co visits with providers. 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 identified through our care management predictive modeling methodology. VCCI case managers and outreach coordinators are also welcoming those new to Medicaid (NTM), and completing screening, and identifying and prioritizing needs. Our screening tool asks questions about access to care (including medical and dental homes), the presence and status of health conditions, and about other needs that would assist them in maintaining +/or improving their health by stabilizing social determinants such as housing, food and safety. The VCCI team works to facilitate direct connections with medical homes, community-based self-management programs, local care management teams and assist beneficiary in navigating the system of health and health related care.

This quarter, VCCI continued to engage with the Agency of Human Services and Department of Corrections; VCCI's role is to support the Department of Corrections (DOC) with learning and implementation of the complex care model with a population with complex health and social needs. This quarter, VCCI and one Probation and Parole office implemented referral process, with DOC referring beneficiaries to VCCI for screening, stratification, and risk level-based intervention, including providing case management through the complex care model for those stratified at a high-risk level. VCCI met with 2 additional Probation and Parole district office this quarter and will begin to implement same workflow. In addition, VCCI continues to work with DOC and the health care vendor with goal of supporting successful transitions of care - from facility to community, with facility staff sending referrals to VCCI for community-based case management. 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.

Since 2018, the VCCI has been engaged in outreach to those new to our health plan - outreach, screening, stratification, and provision of appropriate intervention. As members identify a readiness to establish primary care, our staff facilitate 3-way phone calls with beneficiaries, to a medical home of their choice. The experience has yielded variance in medical home readiness to accept new patients; to include a record requirement of former health records before providing a new patient appointment, long wait times for new patient appointments, or closed to new patients. This past quarter, we began to formally collect the data on the status and will continue to work with data analyst for comparative analysis so to give timely updates on the challenges with access to primary care. There are larger issues of primary care provider retirement/shortage. However, on the issue of former record requirements in place, the VCCI hopes to work with our state colleagues and with VITL to assess health record on the HIE, as proxy for more comprehensive record set.

Good to share that VCCI continues to meet with beneficiaries in person, having resumed in June of this year. VCCI continues to work with our medical provider and follow public health guidance to ensure current recommendations are being followed. At this time, those at highest risk will be seen in person; those just released from an inpatient stay, with cognitive or intellectual impairment, with poor phone/internet connection, and when professional judgment yields that an in person visit needs to be made. One thing the pandemic has taught us, is that the use of virtual platforms is a viable option for how we connect with others and will remain in our toolkit as a medium for serving and communicating with beneficiaries.

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 the 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; the attribution information may not reflect current utilization; and 2021 attribution was not loaded into Care Navigator until late Spring. All VCCI field-based staff have been trained in using Care Navigator. There remains variance with community knowledge 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) primarycare 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 criterion. VCCI works to stabilize members while building long term community care team. 5) VCCI ability to meet with members in-person, where member may physically be whether a motel, shelter, apartment, etc.

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, utilizing the complex care model.

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 both our initial screening and comprehensive surveys to be part of their record in the VHIE. This will assist the ACO with a more accurate way of predicting risk and being able to intervene on those beneficiaries with issues earlier, so they do not become part of that very high-risk group. VCCI expects to receive report analysis from the ACO in early Fall of 2021.

The clinical documentation system that VCCI utilizes through eQ Health is CMS certified and DVHA has exercised the option to extend the contract with the Vendor for one year with option to extend one additional year x 2. 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, clinically focused plan of care.

VCCI is looking ahead to the next quarter with goals to include continued in-person, field-based beneficiary visits; assist with standardizing the tools of the complex care model delivery statewide; continued process improvement with collaboration with DOC probation and parole; continued 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 broadening VCCI's integration with other AHS Departments. 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

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

The Blueprint uses national standards to drive improvements in primary care delivery and payment. The program helps primary care providers transform their practices into National Committee for Quality Assurance (NCQA)-certified Patient-Centered Medical Homes. 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 of health 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 their 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 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, prevention, and management of chronic conditions

During the past quarter, the Blueprint worked with the Vermont Department of Health to transition the day-to-day administration of the Self-Management Programs that have historically been administered by the Blueprint. Planning for this transition included work with the Regional Coordinators, Department of Health staff, and other stakeholders. The Blueprint executed a Memorandum of Understanding with the Department of Health, outlining the expectations of both organizations for the programming, how the Blueprint funding of the programming will flow to the Department of Health, and how the HSAs will be engaged. This move further reinforces the key role that the Department of Health has provided in the supporting the programs through content management, communications platforms, reporting requirements for the Centers for Disease Control, and other evaluations.

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.

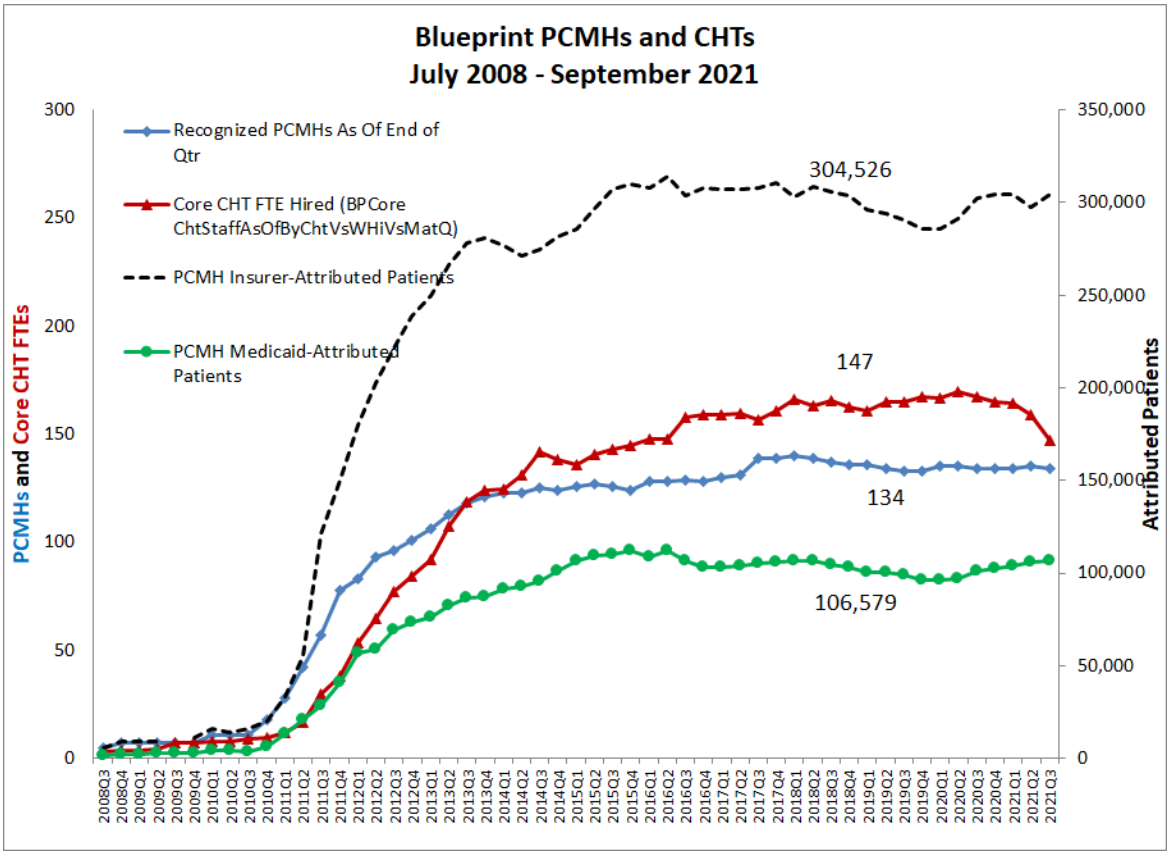
Quarterly Highlights

In Quarter 3 (July- September 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.

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 with chronic conditions, John Hopkins ACG scale, potential for fragmented care, mental health and substance use diagnosis, and high health care 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 dieticians are returning to the office and providing in person care with proper safety precautions in place.

As Vermont continues to have very high vaccination rates. The Blueprint team has been working closely on various committees and with VDH to understand the planning for transition of Covid 19 vaccine to the PCMH as large vaccination hubs are closing. We have asked our QI network to make this transition a priority in support to practice workflows.

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/BlueprintforHealthAnnualReportCY2020.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 intensity treatment and office-based opioid treatment (OBOT, Spokes) in community-based medical practice settings. The Blueprint administers the Spoke part of the Hub & Spoke system of care. Peer-reviewed literature has established 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 Vermonters

with opioid use disorder. As of July 1, 2013, Medicaid beneficiaries receiving medication-assisted treatment for opioid use disorder in a Hub or Spoke setting were eligible to receive enhanced services, such as comprehensive care management, care coordination, comprehensive transitional care, health promotion, individual and family support, and referral to community and social support services. The Health Home functions to enhance Hub programming and embeds essential support staff (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 approach to the treatment of opioid use disorder and the provision of Health Home services. Based upon the "significant impact" demonstrated by the Hub and Spoke system, Vermont is working towards gaining All Payer participation in the Opioid Use Disorder Health Home model.

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 provide the 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 Quarter 3 of 2021, capacity for receiving medication-assisted treatment in Spoke settings continued to increase, as evidenced by 3630 Vermonters with Medicaid insurance receiving medication-assisted treatment for opioid use disorder from 295 prescribers and 74.67 full-time equivalent Spoke staff, working as teams, across more than 100[1] different Spoke settings (as of September 2021).

Quarterly Highlights

- Vermont continues to demonstrate substantial access to medication-assisted treatment for Vermonters with opioid use disorder. As of Sept 2021, Q 3 a monthly average of 3,930 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).

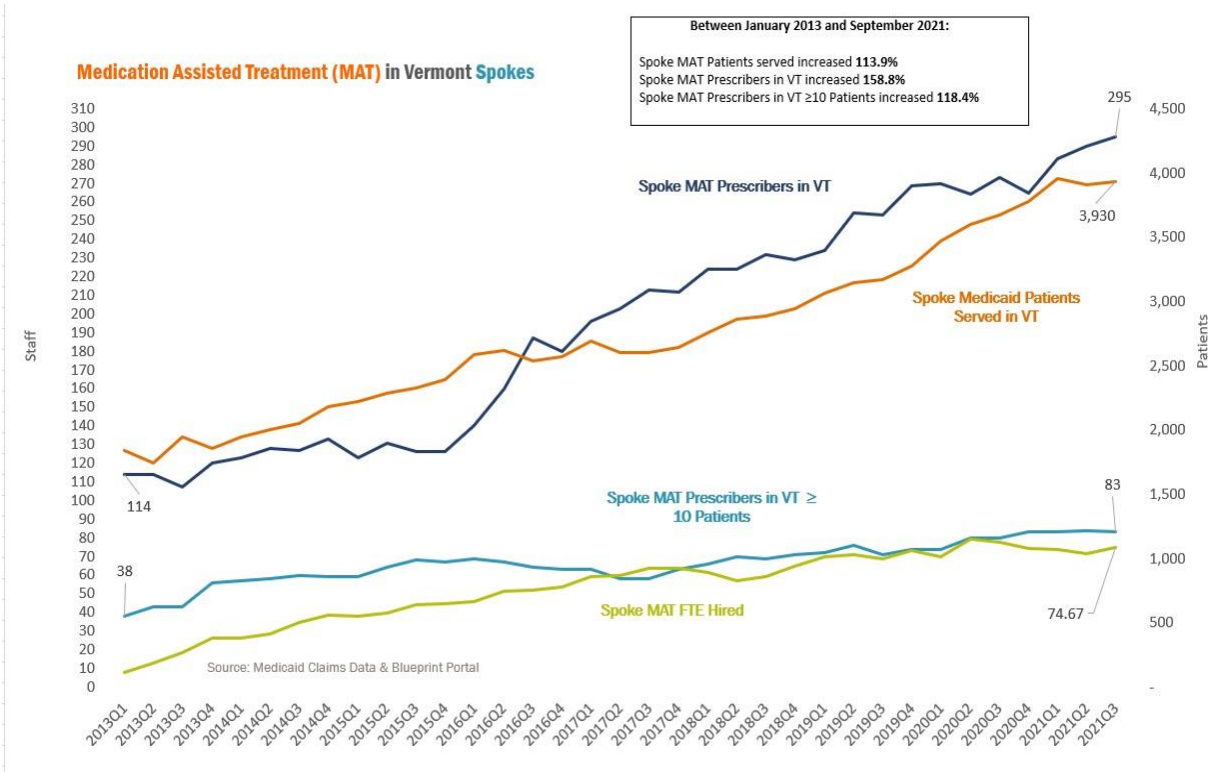
- Medication-assisted treatment for opioid use disorder is being offered across the State of Vermont by more than 100 different Spoke settings and by 295 medical doctors, nurse practitioners and physician assistants who work with 74.67 FTE licensed, registered nurses andlicensed, Master's-prepared, mental health / substance use disorder clinicians as a team to offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder (as of September 2021).

- The Departments of Health and Health Access and the Blueprint for Health have been longstanding partners in working to improve the services for and health of

Vermonters withsubstance use disorders. As we continue to assess the pandemic-related personal stressors clients struggled with and which increased treatment complexity. Spoke providers changedthe way they provide care in response to the risks posed by COVID-19. To decrease in-person contact, our federal partners temporarily allowed physicians to do physical exams viatelemedicine instead of the previously required in-person physicals for people being treated with buprenorphine. They also expanded the allowance of exceptions for take-home doses of medications in Hubs as clinically appropriate to reduce the risk of COVID exposures and infections as well as the risks of overdose, continued substance use and diversion of medications in our communities. The Department of Vermont Health Access increased the allowable buprenorphine supply from 14 days to 30 days for Vermont Medicaid members, reducing the number of times people had to be seen in person in our Spoke providers.

- Throughout the pandemic, Vermont's Hub and Spoke providers were able to maintain access to life saving treatment at all times. We continue to observe that patients are returning to in person services. The Blueprint has maintained a contract with Dartmouth College to Provide Organization, Coordination, Facilitation, and Delivery of the Blueprint- Sponsored Medication Assisted Treatment Program Learning Session since 2019. The Blueprint has continued to feel positive about collaboration and extended their contract through June 30, 2022. Some key themes for this set of learning sessions are, practice workflows, quality improvement, motivational engagement for harm reduction & promotingrecovery and team behavioral management. We have finalized the agenda and speakers for atwo day Statewide Opioid Treatment Conference (virtual) in the Fall of 2021. We will be focusing on many topics, but we are specifically looking forward to health care equity in Vermont. As well as discussing patient interviews and patient perspectives in care.

- Lastly, we met with our Blueprint Program managers to discuss the use of VT Helplink which isa free and confidential referral service available to connect people to resources and treatment to ensure that was shared community wide.




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 and referrals 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® 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 most and moderately effective contraception such as LARC is offered. We strive for same day access if clinically indicated. The WHI program provides increased mental health staffing at specialty practices and utilizes the CHT at Blueprint PCMH practices for services If a patient identifies as at-risk, they have immediate access to a

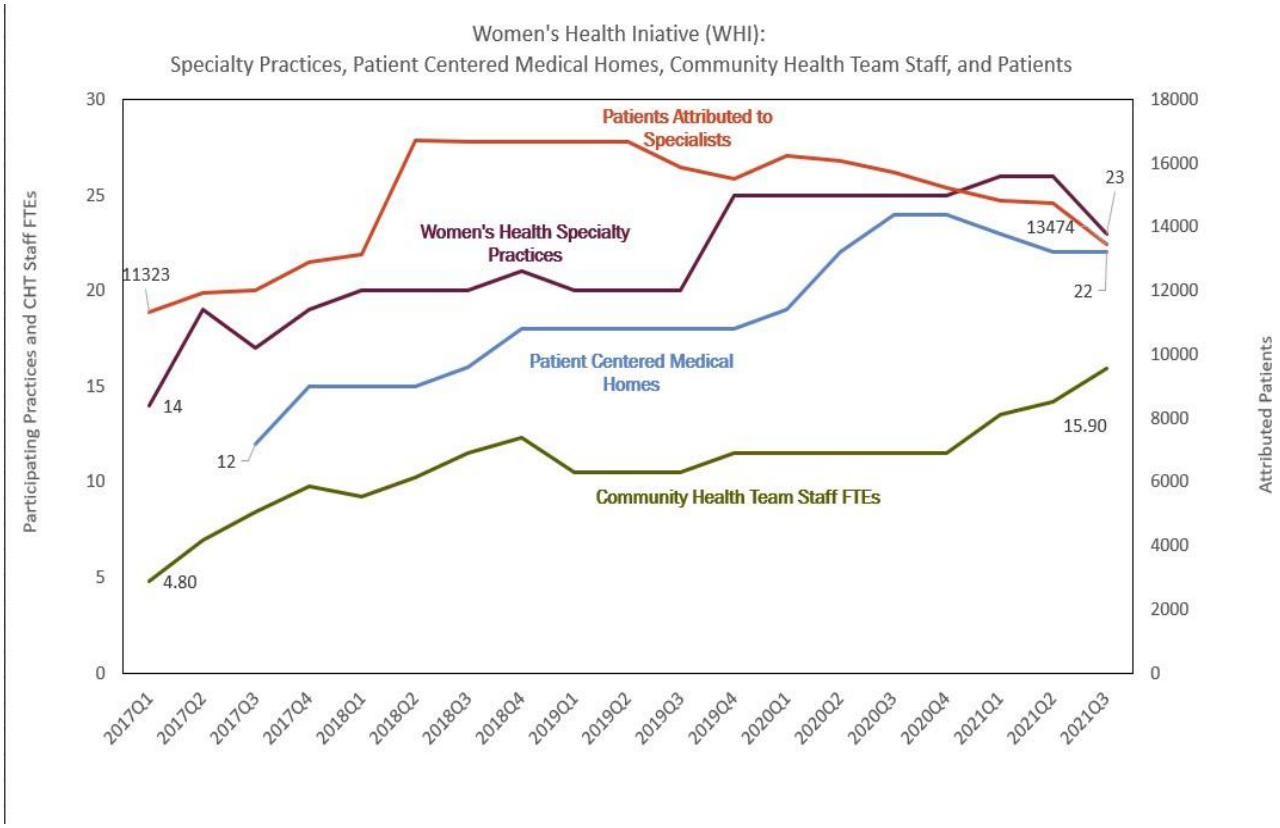
WHI social worker for brief interventions, counseling, and navigation to community-based services and treatment as needed. WHI clinicians work closely with community partners and develop mutual referral agreements and establish meaningful relationships with those partners to support patients.

Quarterly Highlights

- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of48 practices (23 women's health and 22 primary care) to participate in the Women's Health Initiative. We have also seen an increase in embedding the SDOH questions in practices electronic health record. This will assist the practice in having a greater understanding of challenges that patients are experiencing.
- We have had increased interest in expanding WHI within the St. Albans services area which includes a FQHC as well as independent practices. We continue to have our CHT team 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 been presenting the 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 and use of most and moderately effective contraception. PPNNE presented a 10 Best Practices of Contraceptive Counseling. We had a wonderful turn out for this training and asalways, the field is thankful for educational opportunities. Dr. Lauren MacAfee will be presenting another lunch and learn in the next quarter and is always a resource to the WHI program. We and the field are very thankful to have this resource.
- 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 quarterly.

Program Managers reported that these were helpful to continue keeping a focus on this 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 10/1/2021 | WHI PCMH Practices as of 10/1/2021 | WHI CHT Staff FTE Hired as of 10/1/2021 | WHI Specialist Quarterly Attributed** Medicaid Beneficiaries as of 10/1/2021 | WHI PCMH Quarterly Attributed** Medicaid Beneficiaries as of 10/1/2021 |
|---|---|---|---|---|---|
| Barre | 1 | 1 | 1.5 | 636 | 204 |
| Bennington | 1 | 2 | 0.50 | 933 | 268 |
| Brattleboro | 1 | 0 | 0.6 | 899 | 0 |
| Burlington | 2 | 9 | 2 | 2580 | 4864 |
| Middlebury | 2 | 0 | 0.75 | 646 | 0 |
| Morrisville | 1 | 3 | 0.50 | 325 | 1401 |
| Newport | 1 | 0 | 1 | 903 | 0 |
| Randolph | 2 | 0 | 0.5 | 484 | 0 |
| Rutland | 2 | 0 | 3 | 1395 | 0 |
| Springfield | 0 | 5 | 0 | 0 | 1744 |
| St. Albans | 0 | 0 | 0.00 | 0 | 0 |
| St. Johnsbury | 1 | 2 | 0.75 | 873 | 829 |
| Windsor* | 0 | 0 | 0.00 | 0 | 0 |
| Planned Parenthood (Statewi | 12 | 0 | 4.8 | 4157 | 0 |
| Total | 23 | 22 | 15.9 | 13,831.00 | 9,310.00 |

*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.
***The PPNNE practice in Rutland is included in both the WHI Specialist field for Rutland and in the PPNNE statewide field. Patients are allocated to the Rutland HSA. 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 QE092021:**
- Alternative payment model for Brattleboro Retreat
- Team Care
- Applied Behavior Analysis

The Behavioral Health Team is responsible for concurrent review and authorization of inpatient psychiatric and detoxification services for Medicaid primary members. The Behavioral Health

team works 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 members already enrolled with VCCI admitted to inpatient or residential care facilities.

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. The unit has created an outreach plan for the next year, which includes attending staff meetings of various departments/units and posting advisories for providers. 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. In May a targeted mailing was sent to enrolled Primary Care providers. The mailing included a letter describing the program, copies of the Team Care brochure and the referral form, as well as links to the DVHA Team Care webpage. With the assistance of the DVHA Pharmacy Unit, a targeted email was sent to enrolled Pharmacists and Pharmacies in July. As the result of the mailing and email, there have been three referrals to the program. Lack of referrals may demonstrate success of the Vermont Prescription Monitoring System (VPMS) and new opioid prescribing standards and practices 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 members 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 enrollmentof 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 ofprospectively determining treatment hours for the subsequent month. Provider concerns included 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 decided that effective July 1, 2021, DVHA would change the timing of ABA case ratetier submissions and payments from a prospective payment to a post-service delivery payment. Providers received their first post- service delivery ABA payment in August for services rendered in July. The ABA team will review data after a few months to determine if the change in timing of payment has impacted theaccuracy of claims submissions and services provided. The ABA team is actively working to finalize reconciliation for dates of service January 1, 2020,through December 31, 2020. There are three providers who are still working to finalize claims submissions. The team is in the process of reviewing claims data from the first half of reconciliation for dates of service January 1, 2021, through June 30, 2021, with the plan to sharethis preliminary half year data with providers. This will allow providers to review the services provided against claims submitted and will remind them to submit claims within the required six-month timeframe.

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. Thirteen 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 QE092021:**
- Leadership and Reporting updates

System Overview

The Department of Mental Health (DMH) 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 (DAs) and two Specialized Service Agencies (SSAs). 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.

DMH 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 DAs in their catchment area. Peer- and family-run organizations also help educate individuals and families to advocate for their needs within the DAs and across multiple service provider organizations.

Inpatient care is provided through a decentralized system which includes one state-run psychiatric care hospital, Vermont Psychiatric Care Hospital (VPCH), and five Designated Hospitals (DHs) 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 Coronavirus Disease 2019 (COVID-19) pandemic. This public health emergency had a tremendous impact on the delivery of mental health services throughout Vermont in all community-based

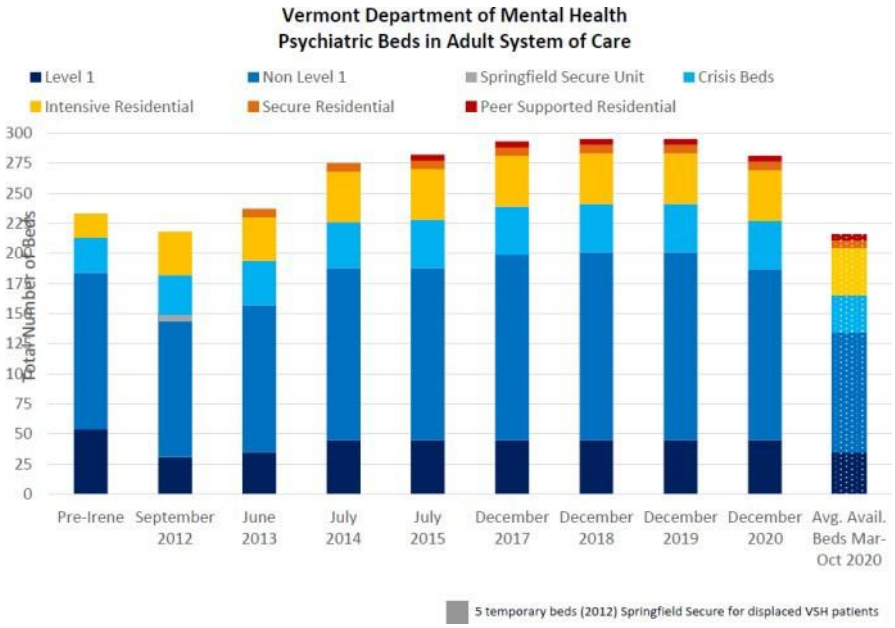
settings and inpatient facilities. Vermont's state of emergency officially ended by executive order on June 15, 2021 due to Vermont's high vaccination rate (over 80% of eligible Vermonters) and recovery efforts. However, the executive order also states interagency collaborations, food programs, and housing arrangements shall continue to be in place and arranged by the AHS "to respond to the conditions created or caused by COVID-19 in order to alleviate hardship and suffering of citizens and communities".

Updates on the Mental Health System of Care

Hospital and Inpatient Care

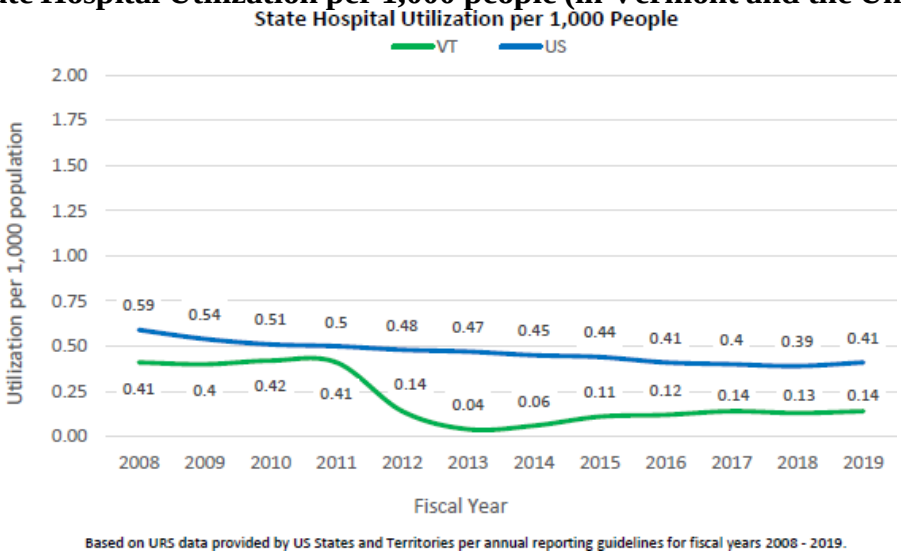
There are 45 Level 1 beds and a total of 159 adult psychiatric inpatient beds across the system of care. During the COVID-19 pandemic, a number of beds closed due to staffing, construction, patient acuity, and public health safety protocols, as well as an initial decrease in individuals presenting with a need for a higher level of care. The primary reason for bed closures as of October (2021) is a severe shortage of workforce across the mental health system. In a state with approximately 3,300 staff across ten designated agencies who provide mental health care, there are more than 550 vacant positions as of this writing.

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



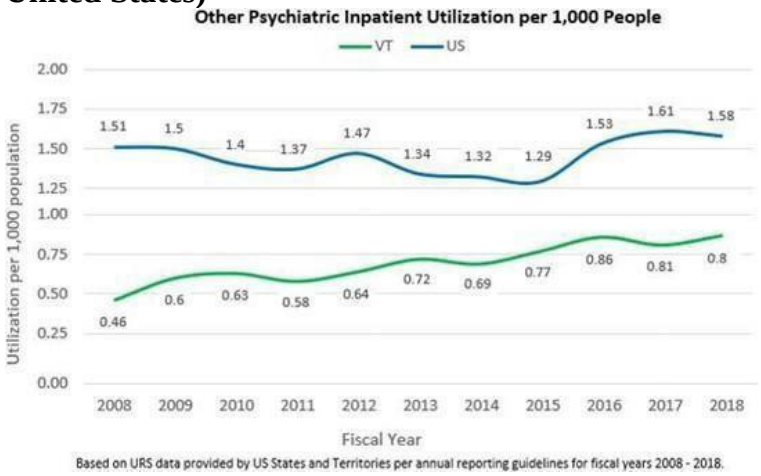

DMH compares the utilization of its system of care to national benchmarks. The following two charts provide information on Vermont's utilization as compared to national benchmarks. Data from these two charts are calculated by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Uniform Reporting System (URS), which generates the National Outcomes Measures (NOMs). Updated bed data will be presented in the next quarterly report.

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



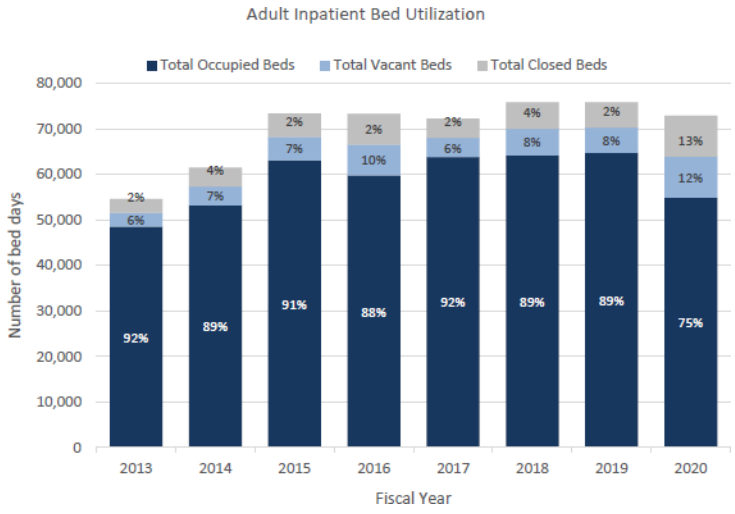

The national rate of state hospital utilization continues to decline year-over-year. VPCH opened in fiscal year (FY) 2015 with 25 beds and Vermont's rate of inpatient utilization continues to be lower than the national average in the United States. The significant decrease from FY 2011 to FY 2012 represents 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-run psychiatric hospital. Nationally, the number of state hospital beds and residents at the end of the year has been steadily decreasing. DMH will be paying close attention to these rates as there is anticipation and existing evidence that this pandemic and the subsequent social isolation that has accompanied it will significantly 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 Utilization unit admissions, such as those at DHs, are included in Figure 5. The national rate of psychiatric hospital utilization since 2008 generally declined year-over-year through 2016 while Vermont's rate of utilization increased. However, in both 2017 and 2018 (most recent data available), 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 continue 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 DH system through FY 2020. The total bed day availability across the system 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 an eight-year period, 2020 saw the lowest level of adult inpatient bed utilization. Data from 2021 will be illustrated in the upcoming quarterly report.

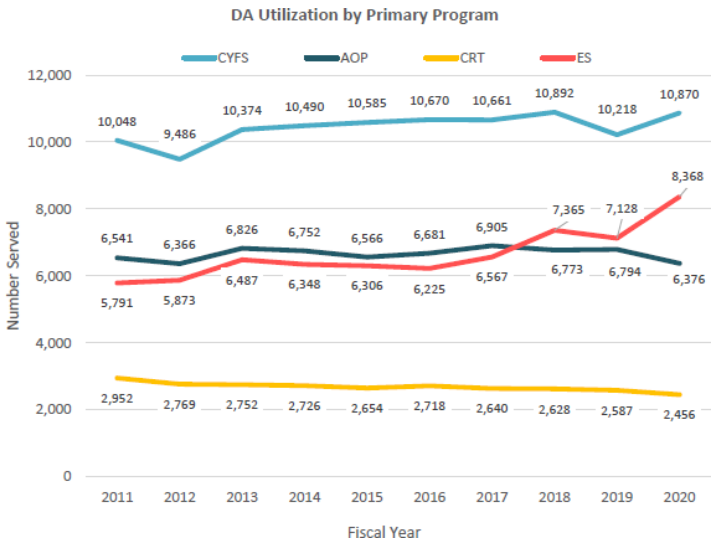
Community-based and Outpatient Services

Enhanced community services funding provided by the Vermont 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 in January of 2019 has also been integral 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.

Key Efforts Include:

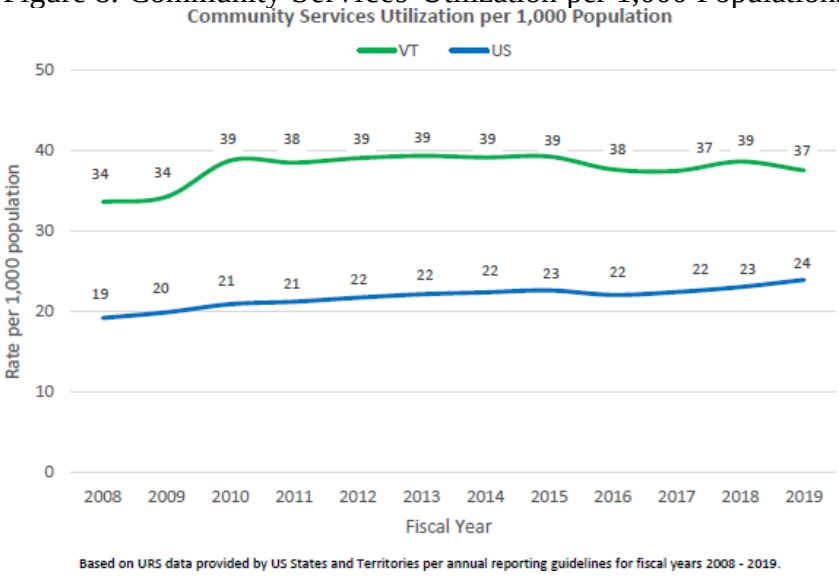
- Established Workforce Task Group to explore recruitment and retention strategies
- Increased capacity within Community Rehabilitation and Treatment and peer programs to provide community support, outreach, and crisis response continues to develop
- Broad utilization of non-categorical case management services for Adult Outpatient and Emergency Services programs

Figure 7. Designated Agency Utilization by Primary Program



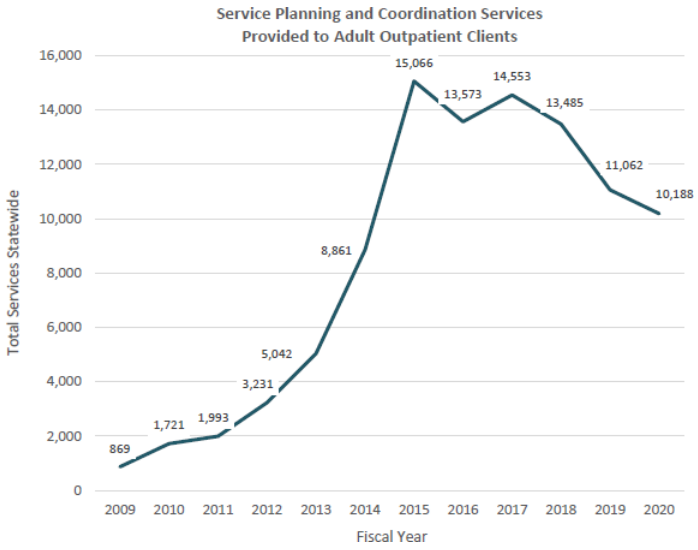

The highest number of persons served by programs offered by the DAs continues to be in children, youth, and families services (CYFS), as indicated in Figure 7. The 6% decrease noted in 2019 appears to have self-corrected and closely approximates utilization in 2018. Similarly, the Emergency Services (ES) programs also had an overall upward trend in 2020, which may reflect the increased support needs associated with the impacts of COVID-19.The Adult Outpatient Programs (AOP) 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. Given that FY 2020 utilization essentially reflects only one quarter of potential impact from the COVID-19 pandemic, FY 2021 will be more reflective of the virus's impact to system services and capacities and that data is currently being analyzed for presenting in the upcoming quarterly report.

Figure 8. Community Services Utilization per 1,000 Populations




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 consistent record of service delivery in community-based programs. The system of care is established on the principle that the intensity of services that 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 payment reform transition away from a fee for service model to a case rate with a value-based payment component has provided ongoing flexibility to meet the needs of the individuals and provide the necessary services.

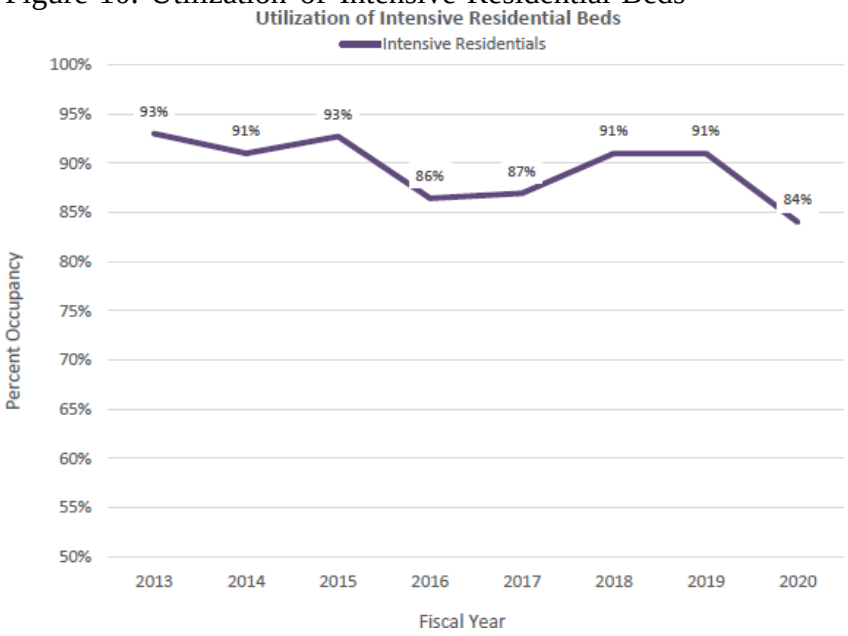
Figure 9. Service Planning and Coordination Services




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 CRT services through FY 2015. Levels remained elevated for this population from 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 health-level need for adult case management services. DMH's payment reform initiative launched in January 2019 continues to support flexible service delivery including case management services when needed.

Residential and Transitional Services

Figure 10. Utilization of Intensive Residential Beds




The Intensive Residential Recovery (IRR) programs 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 aggregated utilization of beds in these programs. FY 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-to18-month time frame for residents.

FY 2020 saw the greatest decrease in utilization over the eight-year period to 84%. The influence of the pandemic in the fiscal year and the changing capacities of programs to safely transfer and introduce new residents into programs likely contributed to this drop. Effects of the pandemic on these data appear evident throughout this reporting period., DMH expects the data from FY 2021 will tell a more complete story around the impact of the pandemic on care delivery.

Performance and Reporting

Along with AHS, DMH has adopted the Results-Based Accountability (RBA) framework for assessing performance of providers via grants and contracts. Recent additions to our RBA framework are:

- Implementation of value-based payment measures that allow DAs to earn an additional allocation based on performance of agreed upon quality metrics.
- Mental Health Payment Reform utilization scorecard, monitoring caseload, and

utilization for all services within the mental health case rate to monitor the impact of the payment model.
- Creation of a "Vermont Psychiatric Care Hospital Outcomes" scorecard to meet legislative reporting requirements.
- Migration of the "DMH Snapshot" and "DMH continued reporting" report to the RBA scorecard reporting tool
- Exploration of visualization tools to create more responsive reporting.
- Participation in development of the AHS Community profiles.

Mental Health 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 Vermont All-Payer Model. The Department created a case rate for CYFS mental health services, as well as a case rate for adult mental health services. The goal of this work is to move toward a simplified, system with accountability based on defined quality metrics that both reduces the complexities of payment and shifts the focus of the providers and the department to clinical outcomes and quality of care. DMH is committed to reforming the system to better serve Vermont's population and continue moving towards full integration of mental health and physical health care.

Integrating Family Services (IFS)

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 of over 30 state and federal funding streams into one, unified whole through a singular AHS Master Grant agreement. The State created an annual aggregate spending cap for two providers in Addison County (the local Designated Agency and the Parent Child Center) and one in Franklin/Grand Isle Counties (this provider is both the Designated Agency and Parent Child Center). This has created a seamless system of care to ensure no duplication of services for children, youth, 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 measurement of performance improvement 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) tool to holistically assess both the needs and strengths of children that they are serving. These agencies are using this monitoring tool to track progress over time. Data are showing that through supports and services, children and youth are increasing in their strengths and decreasing needs. The caveat to this information is that, for children involved in the childwelfare system, it is taking longer to see positive results. This finding is not surprising given that these children experience high levels of trauma, exposure to substances, and/or abuse and neglect, which also follows national trends for this population.

In late June, the IFS grantee, Northwestern Counseling and Support Services (NCSS), which serves Franklin and Grand Isle Counties, had their bi-annual integrated chart review, which included all AHS departments reviewing charts for minimum standards across the various funding streams that create the integrated case rate. The results from the review indicated a few areas for improvement which NCSS which they have already addressed.

Vision 2030

Through summer, fall, and early winter of 2019, DMH engaged in a public planning and development process that involved soliciting stakeholder participation and feedback as an integral part of this process. The plan, known as "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 acrossevery Vermont community. This requires improved coordination across sectors and between providers, community organizations, and DAs. The workforce must use the best technologies, as well as evidence-based practices and tools, 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, delayed that work. The Mental Health Integration Council kicked off on July 13th, 2021, and the Council has since met twice with subgroups convening on specific topics in between meetings.

Leadership and Reporting Updates

DMH has a new Commissioner, Emily Hawes, and Deputy Commissioner, Alison Krompf, who was previously in the role of Director of Quality and Accountability. A new Director of Quality and Accountability, Stephen DeVoe, joined the Department in mid-October and is orienting to this role, which oversees research and statistics, as well as quality of care through ongoing monitoring and of data to support the system of care and ensure accountability, as needed. He will be leading data collection and analyses, drafting and updating reports, and assisting with

departmental initiatives, such as the Serious Mental Illness Monitoring Workbook that will be included in the upcoming quarterly operational report.

v. Pharmacy Program

**Key updates from QE092021:**

- 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
    - PREP Medication Copay Waiver

**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 criteria review 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 3** | 460,502 | 123 | 45,924 | 422 | 84 | 7,922 | 19,381 | 534,358 |
| | 86% | <1% | 9% | <1% | <1% | 1% | 4% | 100% |
| **Quarter 2** | 471,000 | 108 | 42,925 | 388 | 110 | 8,529 | 19,152 | 545,312 |
| | 86% | <1% | 8% | <1% | <1% | 2% | 4% | 100% |
| **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 |
|---|---|---|---|
| 3Q2021 | 469,012 | 80,502 | $63,165,489 |
| 2Q2021 | 444,037 | 74,168 | $58,138,668 |
| 1Q2021 | 476,386 | 81,314 | $62,102,891 |

**VPHARM**

| Period | # Claims | # of Members | State Paid Amounts |
|---|---|---|---|
| 3Q2021 | 67,294 | 7,201 | $1,209,326.22 |
| 2Q2021 | 70,811 | 7,339 | $1,337,018.07 |
| 1Q2021 | 72,027 | 7,834 | $1,873,161.14 |

**Provider Communications Issued**

| | |
|---|---|
| Changes to Coverage for Continuous Glucose Monitoring (CGM) Systems and Supplies | As of 10/1/2021, continuous Glucose Monitoring (CGM) systems and supplies will be available ONLY through pharmacy channels and will no longer be accepted via DME provider channels. Prior authorization requirements that had been waived temporally because of COIVD-19 Public Health Emergency will be reinstated. Prescribers may send prescriptions electronically to the pharmacy or and write prescriptions for patients. Claims will adjudicate in "real tine" through the Pharmacy Point of Sale (POS). |
| COVID-19 Vaccine Booster Billing | Effective 9/09/2021, pharmacies can submit claims for reimbursement for administration of the 3rd dose ("Booster") of the Moderna or Pfizer-BioNTech COVID-19 vaccine retroactive to dates of service on or after August 12, 2021. |
| Influenza (Flu) 2021/2022 Season | Communication around the Influenza (Flu) vaccines 2021/2022 season for enrolled Medicaid providers on guidance and reimbursement. |
| Synagis Atypical 2021 Summer Season | RSV is on the rise and in response to this atypical inter-seasonal change in RSV activity, the American Academy of Pediatrics (AAP) issued "Interim Guidance" supporting the use of Synagis® in patients who qualify for coverage per current clinical guidelines during periods when RSV |

| | |
|---|---|
| | incidence is epidemic in the area. DVHA will continue to monitor RSV activity and may end the atypical Synagis® "season" when the percent positives on antigen tests is ≤ 10% for 2 weeks or the percent positives on PCR tests is ≤ 3% for 2 consecutive weeks |
| Updated Age Edits for Codeine Pain and Cough Medication | The DUR Board reviewed pharmacy dispensing data from 2019-2020 and identified that codeine pain and cough mediations continue to be prescribed in small but significant percentage of patients 12 and under. As a result of the analysis, the Board recommended additional edits be placed on the use of codeine in children 12 and under. Effective July 30th, 2021, prior authorizations requirement of the use of codeine in anyone 12 and under was implemented. |
| Team Care Program | The Team Care Program is a federally mandated prescription lock-in program to prevent misuse, abuse, and diversion of medications on the FDA Controlled Substance Schedule. The program is intended to identify and help address un-met healthcare and/or addiction treatment needs. A communication was sent to pharmacies and pharmacists that included links to the Team Care new brochure, referral form and additional links for more information regarding the Team Care Program. |
| Pharmacist-Provided Tobacco Cessation Services | Effective July 1, 2021, the Vermont Medicaid program allows reimbursement for pharmacists providing tobacco cessation counseling. The change was made to support the provisions of Act 178 of the 2020 legislative session. |

## 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 Q3 CY2021, we enrolled 4 pharmacists for an overall total of 318 enrolled pharmacist at the end of the quarter.

**Drug Utilization Review Board (DURB)**

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.

**Drug Utilization Review Board (DURB) Meetings**

Drug Utilization Review Board meetings occur seven times per year and always have a robust agenda. During Q3 CY2021, DVHA held 1 DURB meetings.

The chart below lists CYQ3 2021 activities of the Drug Utilization Review Board.

| Review Topic | CYQ3 2021 Total |
|---|---|
| Therapeutic Drug Classes: Periodic Review | 8 |
| Full New Drug Reviews | 8 |
| FDA Safety Alerts | 1 |
| New/Updated Clinical Guidelines | 1 |
| RetroDUR/ProDUR reviews | 3 |
| New Managed Therapeutic Drug Classes | 0 |
| BioSimilar Drug Reviews | 0 |

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 agenda typically follows this sample format.

VERMONT

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

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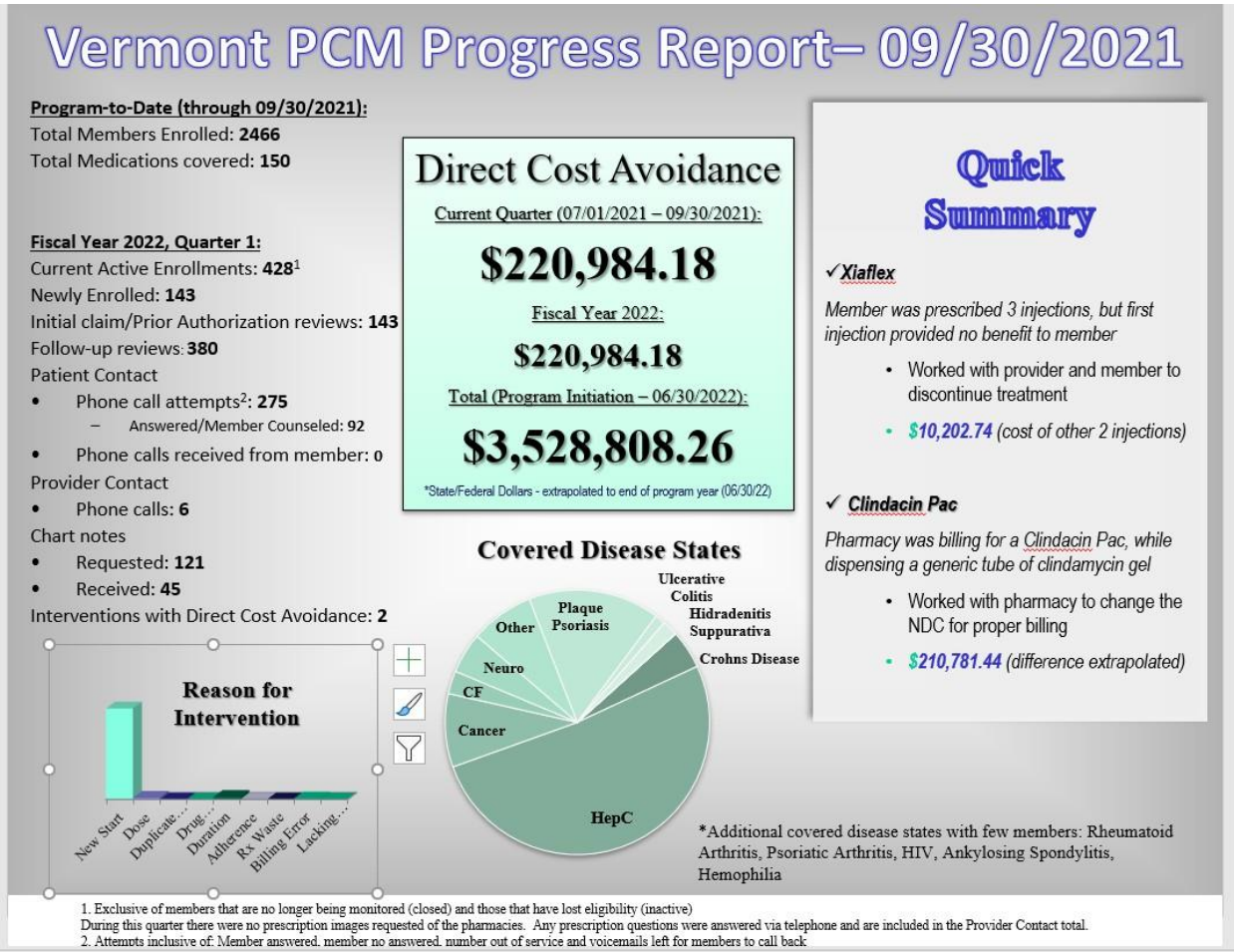
- **Executive Session** **6:00 - 6:30**
- **Introductions and Approval of DUR Board Minutes** **6:30 - 6:35**
  (Public Comment Prior to Board Action**)**
- **DVHA Pharmacy Administration Updates** **6:40 - 6:45**
- **Medical Director Update** **6:45 - 6:50**
- **Follow-up Items from Previous Meetings** **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**

**<u>Pharmacy Cost Management (PCM) Program</u>**

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 (July 1, 2021, through September 30, 2021). Change Healthcare Pharmacy Management Reporting Suite by a collection of reports recording the process and progress of PCM.

The program is actively monitoring 428 enrollees. A total of 275 outgoing telephone calls were placed to members, 92 of which resulted in member counseling. During this quarter of the Vermont PCM program, two 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 CYQ3 2021, the Vermont Medicaid Pharmacy Cost Management (PCM) program enrolled 143 new members, and continued management of an additional 380 patients, resulting in improved pharmaceutical care and a savings of nearly $220,984 and lifetime savings attributable to the PCM program total more than $3.5 million.

**Pharmacy Changes related to Federal/State Legislation:**

**PrEP Medication Copay Waiver**-Effective October 1, 2021, a copay does not apply to Pre-Exposure Prophylaxis (PrEP). PrEP is a once daily antiretroviral medication taken to prevent HIV. The US Preventive Services Task Force (USPSTF) has given PrEP an "A" rating as a recommended preventive service. PrEP has a high certainty of substantial benefit to reduce the risk of HIV infection in persons at high risk of HIV infection.

The Affordable Care Act requires all covered US Preventive Services Task Force (USPSTF) Services Rated "A" or "B" to not incur a copayment. A copayment will not be deducted from claims for PrEP and pharmacists shall not require a copayment from a Medicaid member.

vi. All Payer Model: Vermont Medicaid Next Generation Program

**Key updates from QE092021:**

- Continued conducting financial reconciliation activities for the 2020 performance year, in order to determine financial and quality performance. Results will be available in Q4 2021.
- Entered into contract negotiations with the Apparently Successful Bidder for ACO services in the VMNG program for a 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

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 continued conducting financial reconciliation activities for its 2020 performance yearin Q3 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 Q3 2021, and final results will be available in Q4 2021.

DVHA issued 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, and received one bid.In Q2, DVHA selected and entered contract negotiations with an apparently successful bidder, OneCare Vermont. DVHA continued contract negotiations into Q3 and anticipate execution of the contract at the end of Q4 2021. DVHA anticipates the elements of its VMNG model will remain like its current iteration.

## 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 September 2021 quarter (July through September 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 QE0921 on October 30, 2021, as is normal.

Vermont has received partial approval for the temporary 10% FMAP increase for qualifying HCBS services under the American Rescue Plan Act of 2021 (ARP), beginning April 1, 2021, through March 31,2022. The MBES system was not updated to reflect this FMAP opportunity until the QE0921 CMS-64 filing, at which time a prior quarter adjustment (PQA) for the QE0621

was also submitted. Vermont also submitted HCBC reinvestment expenditures, which also receive the enhanced FMAP. Total HCBS expenditures for were $180,842,778 for QE0621 and $161,768,622 for QE0921, resulting in an increased FMAP of approximately $33 million combined for the two quarters. Vermont expects to engage CMS for technical assistance relating to how HCBS affects Budget Neutrality.

Overall, the budget neutrality exercise indicates that for September 2021 quarter, the State's total "With Waiver" expenditures were $95,493,180 (24%) lower than the total "Without Waiver" amount (caseloads multiplied by the Budget Neutrality PMPMs), indicating a quarterly surplus. This compares to a surplus of $73,890,874 reported for QE0621, and a total CY2021 surplus to date of $272,910,596.

For the supplemental budget neutrality tests, the New Adult test is showing a surplus of $31,107,984 for QE0921. This compares to a surplus of $24,116,802 reported for QE0621 and a total CY2021 surplus to date of $87,250,912.

For QE0921, the SMI IMD test is showing a deficit of $2,958,489 compared to a deficit of $5,552,508 (revised from previous report) for QE0621. CY2021 to date, the deficit for SMI IMD is $7,751,103.

The SUD IMD test is showing a deficit of $141,081 for QE0921, compared to a surplus of $801,074 reported for QE0621. CY2021 to date, there is a surplus of $534,485.

Deficits in SMI IMD and SUD IMD are applied to the overall budget neutrality test. Currently, there is ample room in the overall budget neutrality test to accommodate SUD IMD and SMI IMD deficits.

Please note, the above-mentioned budget neutrality calculations are based on Vermont's interpretation of how Budget Neutrality should be calculated. Vermont uploaded the PMDA Budget Neutrality template for DY15 which has different calculations. Vermont is not in agreement with those calculations and looks forward to finding resolution with CMS on these discrepancies.

AHS continues to actively monitor Investment spending. The total Investment spending for QE0921 was $27,376,164 (compared with $24,613,969 for QE0621). The total CY2021 investment expenditures for all three quarters total $74,654,365. 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 15$^{th}$ 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 QE0921 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 throughQE0921), *subject to revision*, with CY2020 and CY2019.**

| Demonstration Population | Medicaid Eligibility Group | Total CY 2021 (JAN-SEPT) | Total CY 2020 | Total CY 2019 |
|---|---|---|---|---|
| 1, 4*, 5* | ABD - Non-Medicare - Adult | 59,878 | 79,846 | 81,293 |
| | SUD - IMD - ABD | 62 | 106 | 149 |
| | SMI - IMD - ABD | 43 | 71 | |
| 1 | ABD - Non-Medicare - Child | 14,353 | 20,060 | 23,855 |
| 1, 4*, 5* | ABD - Dual | 198,828 | 260,532 | 257,866 |
| | SUD - IMD - ABD Dual | 94 | 136 | 158 |
| | SMI - IMD - ABD Dual | 18 | 12 | |
| 2 | Non ABD - Non-Medicare - Adult | 111,499 | 112,654 | 104,150 |
| | SUD - IMD - Non ABD | 118 | 161 | 222 |
| | SMI - IMD - Non ABD | 16 | 26 | |
| 2 | Non ABD - Non-Medicare - Child | 557,520 | 713,979 | 703,957 |
| | Medicaid Expansion | | | |
| 7 | Global RX | 58,377 | 78,064 | 77,498 |
| 8 | Global RX | 30,412 | 41,565 | 44,169 |
| 6 | Moderate Needs | 1,301 | 1,963 | 2,208 |
| | New Adults | | | |
| 3 | New Adult without Child | 402,959 | 453,635 | 423,150 |
| | SUD - IMD New Adult w/o Child | 770 | 1,157 | 1,352 |
| | SMI - IMD New Adult w/o Child | 160 | 211 | |
| 3 | New Adult with Child | 230,849 | 267,004 | 233,294 |
| | SUD - IMD New Adult with Child | 177 | 209 | 259 |
| | SMI - IMD New Adult with Child | 42 | 44 | |
| | **Total** | **1,667,476** | **2,031,435** | **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 Improvement

Quality Assurance and Performance Improvement Activities

**Key updates from QE092021:**

- Intervention planning and implementation continued for DVHA's formal PIP topic, management of hypertension. 3 focused sub-groups are working on activities related to: policy/reimbursement, provider and patient education and community resources.
- DHVA's Quality Team worked with our vendor to prepare the 2021 Adult and Children's CAHPS Medicaid 5.0H survey tools.
- DVHA's Quality Team is leading an internal team through CMS/Mathematica's sponsored Foster Care Learning Collaborative. We created a team charter as well as an AIM statement and began gathering baseline data.

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 QE0921 and consists of representatives from all departments within AHS that serve the Medicaid population. The committee continues to structureits 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 healthcare. During this time period, the committee followed our work plan and reviewed DVHA's Global Commitment Core Performance Measure Set. These measures are chosen to represent the breadth of services provided to Vermont Medicaid members, and to act as an indicator of our overall Medicaid members' health. Most of these measures are validated each year by an external quality review (EQR) organization. As a result of the Quality Committee's review, a short list ofpotential quality improvement topics is identified.

Formal CMS Performance Improvement Project (PIP)

During QE0920, DVHA followed our standard operating procedure (SOP) for selection of a newformal CMSPIP 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. Sub-group intervention planning and implementation continued during QE0921.

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 continued to work with the following groups on collaborative QI projects during QE0921:

- DVHA's Clinical Operations unit to address a legislative directive. DVHA is exploring prior authorization requirements with 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 inpatient psychiatric hospital. The purpose of the APM is to add administrative simplicity in claims processing and a predictable cash flow for inpatient stays that are primarily the responsibility of Vermont Medicaid. The Clinical Services Team lead the work group that established quality of care measures to ensure that cost and quality incentivesare aligned in the APM.

Additionally, during QE0921, DVHA's Quality team continued to lead an internal work group that is participating in the CMS/Mathematica sponsored learning collaborative focused on youth in foster care. We are partnering with colleagues from the Department of Children and Families (DCF), the Vermont Department of Health (VDH) and the Vermont Child Health Improvement Program (VCHIP) on thiseffort. During this reporting period we created a team charter and an AIM statement and began gathering baseline data.

Quality Measure Reporting

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - the DVHA Quality Unit's Director of Quality Management prepared the 2021 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Children's and Adults Medicaid 5.0H survey tools during QE0921. Of note this year, DVHA included the new AHRQ supplement questions regarding access to mental health care services. DVHA works with a contracted vendor, DatStat, Inc., to distribute and collate the surveys according to AHRQ and NCQA protocols. Surveys will be distributed to members during QE1221.

HEDIS measure production –In addition to producing administrative (claims based) measures, the Clinical Services Team produced four (4) HEDIS hybrid measures in 2021. Training and record abstraction were performed earlier in the year. DVHA's administrative and hybrid measure rates were then validated by our EQRO during QE0921. Individual measure results were confirmed, and areas of strength were highlighted, as were opportunities for improvement.

Quality Unit staff originally spearheaded conversations with staff from Vermont Information Technology 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 testingwas performed in CY 2020 and indicated a need for further analysis. This work was slowed due to the COVID-19 pandemic but will resume as resources allow.

Results Based Accountability (RBA)/Process Improvement

Results Based Accountability (RBA) scorecards are developed at DVHA for both internal and externalperformance 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. DVHA's largest scorecard, named the Performance Accountability Scorecard includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services. Scorecards that were newly developed or actively maintained during QE0921 include the following initiatives: Adult Core Set of Health Care Quality Measures, Child Core Set of Health Care Quality Measures and the DVHA Programmatic Performance Budget.

The Quality Improvement Team also maintained their "Green Belt" status during QE0921 by participating in quality improvement activities. 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 VermontOutcomes 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 monthly 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 QE0921, DVHA's Director of Quality Management received, reviewed and approved the quarterly VMNG ACO quality management reports. Quality and Clinical staff from DVHA and the VMNG ACO also meet quarterly with a focus on quality measurement and ongoing QI efforts Topics discussed during our 09/21 meeting included measurement year (MY) 2020 quality measure results, preparing to use Vermont's clinical registry for measure production and QI project updates. A representative from the VMNG ACO is also a standing member on DVHA's formal PIP, the topic of which is managing hypertension.

AHS Performance Accountability Committee

COVID-19 response has continued to delay the restart of the Performance Accountability Committee. A revisioning session has been re-scheduled for next quarter. Agenda items include but are not limited to the following: performance accountability system building/sustaining, Medicaid program quality assessment and performance improvement requirements, and alignment with health care reform efforts.

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, VDH and DAIL 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: 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, Blueprint for Health and DMH highlighted the performance of their payment models. The 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 quarter, the state continued to modify the CQS/STP using feedback received from CMS during the second quarter. The feedback focused on the following aspects of the plan: incorporating individuals' private homes, accounting for 100% of residential settings, adjusting the number of TBI settings, and accounting for TBI residential settings. In addition, CMS requested that the state add a link to the STP Elements section for the public comment received and state response as well as to review and edit the document verb tense to reflect current status. The state expects to make the requested edits and submit an updated version of the CQS/STP during the next quarter.

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. During the previous quarter, the state submitted quarterly monitoring reports for the substance use disorder (SUD) component of the Global Commitment to Health demonstration, to the Centers for Medicare & Medicaid Services (CMS), as required by the state's special terms and conditions (STC). These monitoring reports are Vermont's first submissions of monitoring metrics using the CMS-provided SUD demonstration monitoring report tools following approval of its SUD monitoring protocol. Later in the quarter, CMS provided more detailed feedback to the state in order to ensure that these monitoring reports provide all the information requested by the templates and assist the state in using these tools for future monitoring report submissions. The feedback included the following: clarifying specification version, revising measurement period, including subpopulation data, as well as guidance for future monitoring report. The state anticipates responding to the feedback and posting a modified spreadsheet that responds to the feedback during the next quarter.

SUD Mid-Point Assessment

The assessment includes an examination of progress toward meeting each milestone and

timeframe approved in the SUD 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 the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely 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 of not 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. COVID response has delayed production and submission of the SMI Monitoring Protocol reports. The state will continue to work with CMS to identify a reasonable timeline for the delivery of this deliverable.

## IX. Demonstration Evaluation Activities

During the quarter, the state continued to work with their independent evaluator, PHPG, to collect the necessary data to support the development of the Summative Evaluation Report. The report includes the information in the CMS-approved Evaluation Design. Most data submissions are due next quarter. 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. The state will reach out to those supplying data for the evaluation during the next quarter.

## X. Compliance

**Key updates from QE092021:**

- The 2021 EQRO report was received
- Medicaid Risk Assessment Progress

Monitoring Compliance with Standards

During this quarter, the state's EQRO, HSAG, performed a fully remote version of their annual review of compliance with standards. Activities included a desk review of documents and conducting virtual interviews with key staff members. These annual audits follow a three-year cycle of standards. During this year's review, HSAG evaluated the degree to which DVHA complied with federal Medicaid managed care regulations and the associated AHS intergovernmental agreement (IGA) in three performance categories (i.e., standards). The three standards included requirements associated with the federal Medicaid managed care Quality Assessment and Performance Improvement standards found at CFR §438.236, §438.242, and

§438.330. The standards included requirements related to the following:

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

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

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

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

Medicaid Risk Assessment

A project was initiated to conduct a comprehensive risk assessment for all Global Commitment programs. Project staff include the Compliance Officer, Quality Improvement Administrator, Oversight and Monitoring Director and the Quality Assurance Manager.

This assessment will start with a review of the Quality Assurance and Performance Improvement work performed by programs across AHS. We selected this topic because of the recent EQRO compliance audit recommendations. Once this topic is complete, we will continue the review focusing on other compliance requirements. The overall goal of this project is to proactively find and correct any compliance deficiencies identified by project staff. To do this, we will interview subject matter experts across AHS and document our findings and corrective actions.

Compliance Committee

During this quarter, the compliance committee met and discussed the following: departmental representation, work plan development, EQRO preparation. Specific topics addressed included the following: program integrity, quality assessment/performance improvement program, and care coordination.

Intra-Governmental Agreement (IGA) between AHS and DVHA

During this quarter, the state began to draft the CY2022 Agency of Human Services (AHS) and the Department of Vermont Health Access (DVHA) IGA. In addition, the PMPM rate was requested. The final version of the document is expected to be submitted to CMS by the end of the fourth quarter.

## XI. Reported Purposes for Capitate Revenue Expenditures

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

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

## XII. State Contact(s)

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

## XIII. Attachments

| | |
|---|---|
| Attachment 1 | Budget Neutrality Workbook |
| Attachment 2 | Enrollment and Expenditures Report |
| Attachment 3 | Complaints Received by Health Access Member Services |
| Attachment 4 | Medicaid Grievance and Appeal Reports |
| Attachment 5 | Office of the Health Care Advocate Report |
| Attachment 6 | QE032020 Investments (GC Investments) |
| Attachment 7 | Investment Scorecard(s) |
| Attachment 8 | Payment Model Scorecard(s) |

**Date Submitted to CMS: December 10, 2021**

**Attachment 1**

**State of Vermont Global Commitment to Health**
**Budget Neutrality PMPM Projection vs 64 Actuals Summary**
**November 23, 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 - Sept 2021 | Total |
|---|---|---|---|---|---|---|
| **Without Waiver (Caseload x pmpms)** | | | | | | |
| ABD - Non-Medicare - Adult | $ 142,860,455 | $ 130,050,973 | $ 131,976,747 | $ 134,423,935 | $ 104,536,809 | $ 643,848,919 |
| ABD - Non-Medicare - Child | $ 85,359,001 | $ 78,434,428 | $ 75,860,331 | $ 66,152,263 | $ 49,083,528 | $ 354,889,552 |
| ABD - Dual | $ 664,153,383 | $ 693,539,886 | $ 720,885,032 | $ 755,287,479 | $ 597,732,640 | $ 3,431,598,419 |
| Non ABD - Non-Medicare - Adult | $ 101,757,250 | $ 96,887,008 | $ 73,827,769 | $ 83,769,514 | $ 86,972,565 | $ 443,214,106 |
| Non ABD - Non-Medicare - Child | $ 392,665,288 | $ 406,444,058 | $ 413,877,439 | $ 439,075,666 | $ 358,630,315 | $ 2,010,692,767 |
| **Total Expenditures Without Waiver** | **$ 1,386,795,376** | **$ 1,405,356,354** | **$ 1,416,427,318** | **$ 1,478,708,857** | **$ 1,196,955,857** | **$ 6,884,243,762** |
| **With Waiver** | | | | | | |
| ABD Non Medicare Adult | $ 162,602,152 | $ 162,728,372 | $ 168,382,861 | $ 177,858,509 | $ 130,207,266 | $ 801,779,160 |
| ABD - Non-Medicare - Child | $ 66,593,208 | $ 60,077,015 | $ 58,176,676 | $ 55,369,700 | $ 34,421,408 | $ 274,638,006 |
| ABD - Dual | $ 445,847,909 | $ 461,739,496 | $ 484,543,363 | $ 476,164,427 | $ 350,868,410 | $ 2,219,163,604 |
| Non ABD - Non-Medicare - Adult | $ 84,040,229 | $ 84,275,155 | $ 67,221,781 | $ 69,967,054 | $ 62,984,199 | $ 368,488,417 |
| Non ABD - Non-Medicare - Child | $ 305,543,574 | $ 335,706,591 | $ 350,805,773 | $ 334,351,461 | $ 259,232,341 | $ 1,585,639,741 |
| 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 | $ 368,604 | $ 5,369,496 |
| Marketplace Subsidy | $ 6,355,286 | $ 6,242,717 | $ 5,915,336 | $ 5,862,966 | $ 4,168,551 | $ 28,544,857 |
| VT Global Rx | $ 13,824,167 | $ 15,300,919 | $ 10,692,124 | $ 3,494,233 | $ 3,818,756 | $ 47,130,199 |
| VT Global Expansion VHAP | $ 414,825 | $ (0) | $ 0 | $ - | $ - | $ 414,825 |
| CRT DSHP | $ 10,331,787 | $ 9,240,772 | $ 6,787,058 | $ 5,604,875 | $ 3,321,361 | $ 35,285,853 |
| Investments | $ 142,332,671 | $ 148,500,000 | $ 119,133,231 | $ 114,806,088 | $ 74,654,365 | $ 599,426,356 |
| **Total Expenditures With Waiver** | **$ 1,239,374,215** | **$ 1,285,189,954** | **$ 1,273,088,069** | **$ 1,244,183,015** | **$ 924,045,261** | **$ 5,965,880,514** |
| ***Hypothetical Test 1: New Adult*** | | | | | | |
| Limit New Adult PMPM*Mem-Mon | $ 370,689,611 | $ 375,735,593 | $ 369,387,603 | $ 422,539,471 | $ 387,237,674 | $1,925,589,952 |
| With Waiver New Adult Total Expenditures | $ 295,620,338 | $ 312,104,578 | $ 315,240,526 | $ 368,166,529 | $ 299,986,762 | $1,591,118,732 |
| *Surplus (Deficit)* | *$ 75,069,273* | *$ 63,631,015* | *$ 54,147,078* | *$ 54,372,942* | *$ 87,250,912* | *$ 334,471,220* |
| ***Hypothetical Test 2: SUD IMD*** | | | | | | |
| SUD - IMD ABD - Non-Medicare - Adult | | $ 268,039 | $ 529,433 | $ 389,449 | $ 235,536 | $ 1,422,457 |
| SUD - IMD ABD - Dual | | $ 214,495 | $ 442,312 | $ 387,577 | $ 272,706 | $ 1,317,090 |
| SUD - IMD Non ABD - Non-Medicare - Adult | | $ 533,391 | $ 633,224 | $ 459,230 | $ 336,578 | $ 1,962,424 |
| SUD - IMD New Adult | | $ 2,704,249 | $ 4,842,747 | $ 4,130,907 | $ 2,880,992 | $ 14,558,894 |
| **Limit SUD IMD Without Waiver PMPM*Mem-Mon** | **$ -** | **$ 3,720,174** | **$ 6,447,715** | **$ 5,367,163** | **$ 3,725,813** | **$ 19,260,865** |
| SUD - IMD ABD Non Medicare Adult | | $ 249,820 | $ 646,440 | $ 411,251 | $ 172,403 | $ 1,479,915 |
| SUD - IMD ABD - Dual | | $ 199,224 | $ 545,837 | $ 342,450 | $ 110,952 | $ 1,198,463 |
| SUD - IMD Non ABD - Non-Medicare - Adult | | $ 540,841 | $ 803,762 | $ 516,507 | $ 291,867 | $ 2,152,978 |
| SUD - IMD New Adult | | $ 2,826,119 | $ 5,869,169 | $ 4,250,210 | $ 2,616,106 | $ 15,561,604 |
| **Limit SUD IMD With Waiver (Total Expenditures)** | **$ -** | **$ 3,816,005** | **$ 7,865,208** | **$ 5,520,418** | **$ 3,191,328** | **$ 20,392,959** |
| *Surplus (Deficit)* | *$ -* | *$ (95,830)* | *$ (1,417,494)* | *$ (153,255)* | *$ 534,485* | *$ (1,132,094)* |
| ***Hypothetical Test 3: SMI IMD*** | | | | | | |
| SMI - IMD ABD - Non-Medicare - Adult | | | | $ 1,106,677 | $ 690,322 | $ 1,796,999 |
| SMI - IMD ABD - Dual | | | | $ 226,752 | $ 353,394 | $ 580,146 |
| SMI - IMD Non ABD - Non-Medicare - Adult | | | | $ 261,456 | $ 167,168 | $ 428,624 |
| SMI - IMD New Adult | | | | $ 2,975,595 | $ 2,460,764 | $ 5,436,359 |
| **Limit SMI IMD Without Waiver PMPM*Mem-Mon** | **$ -** | **$ -** | **$ -** | **$ 4,570,480** | **$ 3,671,648** | **$ 8,242,128** |
| SMI - IMD ABD Non Medicare Adult | | | | $ 1,726,684 | $ 2,735,031 | $ 4,461,715 |
| SMI - IMD ABD - Dual | | | | $ 188,470 | $ 623,209 | $ 811,679 |
| SMI - IMD Non ABD - Non-Medicare - Adult | | | | $ 727,204 | $ 518,049 | $ 1,245,253 |
| SMI - IMD New Adult | | | | $ 5,348,474 | $ 7,546,462 | $ 12,894,936 |
| **Limit SMI IMD With Waiver (Total Expenditures)** | **$ -** | **$ -** | **$ -** | **$ 7,990,832** | **$ 11,422,751** | **$ 19,413,583** |
| *Surplus (Deficit)* | | *$ -* | *$ -* | *$ (3,420,352)* | *$ (7,751,103)* | *$ (11,171,455)* |
| **Waiver Savings Summary** | | | | | | |
| Annual Savings | **$ 147,421,162** | **$ 120,166,400** | **$ 143,339,249** | **$ 234,525,842** | **$ 272,910,596** | **$ 918,363,248** |
| Shared Savings Percentage | 30% | 25% | 25% | 25% | 25% | |
| Shared Annual Savings | $ 44,226,348 | $ 30,041,600 | $ 35,834,812 | $ 58,631,460 | $ 68,227,649 | $ 236,961,870 |
| Hypothetical Test 2 & 3 adjustment | ***$ -*** | ***$ (95,830)*** | ***$ (1,417,494)*** | ***$ (3,573,607)*** | ***$ (7,751,103)*** | ***$ (12,838,034)*** |
| ***Total Cumulative Savings*** | | **$ 74,172,118** | **$ 108,589,437** | **$ 163,647,290** | **$ 224,123,836** | **$ 224,123,836** |

*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 | $610.97 | 610.97 | |
| (B-1) eligible member months w/ Child | 57,969 | 58,516 | 58,610 | 58,199 | 60,037 | 65,214 | 66,459 | 67,867 | 75,413 | 76,970 | 78,582 | |
| (B-2) eligible member months w/o Child | 110,736 | 106,927 | 103,710 | 101,777 | 102,648 | 110,982 | 116,879 | 118,708 | 129,659 | 134,102 | 139,208 | |
| (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 | $ 38,967,570.06 | $ 39,793,136.78 | $ 46,075,080.61 | $ 47,026,360.90 | $ 48,011,244.54 | |
| (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 | $ 68,530,832.86 | $ 69,603,248.72 | $ 79,217,759.23 | $ 81,932,298.94 | $ 85,051,911.76 | |
| (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% | 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% | 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 | $ 23,403,922.58 | $ 24,182,289.22 | $ 27,999,826.49 | $ 28,577,919.52 | $ 29,176,433.31 | |
| (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 | $ 61,677,749.57 | $ 62,642,923.85 | $ 71,295,983.31 | $ 73,739,069.05 | $ 76,546,720.58 | |
| 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 | $ 85,081,672.15 | $ 86,825,213.07 | $ 99,295,809.79 | $ 102,316,988.56 | $ 105,723,153.89 | |
| 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 | $ 83,784,434.33 | $ 83,439,260.42 | |
| 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 | $ 15,395,205.59 | $ 13,019,166.75 | $ 25,052,804.62 | $ 18,532,554.24 | $ 22,283,893.47 | |

Attachment 2

# 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:** September 1, 2021

VERMONT
AGENCY OF HUMAN SERVICES

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## 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

# MEDICAID PROGRAM ENROLLMENT AND EXPENDITURES

## Agency of Human Services
## Caseload and Expenditure Report

### DVHA Only YTD SFY'21

| Medicaid Eligibility Group | SFY'21 BAA Caseload | SFY'21 BAA Budget | SFY'21 BAA PMPM | SFY'21 Actuals Thru June 30, 2021 Caseload | SFY'21 Actuals Thru June 30, 2021 Expenses | SFY'21 Actuals Thru June 30, 2021 PMPM | % of Expenses to Budget Line Item | Ending Enrollment as of June 2021 |
|---|---|---|---|---|---|---|---|---|
| ABD Adult | 6,475 | $ 59,467,740 | $ 765.35 | 6,241 | $ 55,539,766 | $ 741.62 | 93.39% | 6,236 |
| ABD Dual | 17,678 | $ 48,359,639 | $ 227.97 | 17,921 | $ 45,495,222 | $ 211.56 | 94.08% | 18,070 |
| General Adult | 10,043 | $ 60,812,047 | $ 504.60 | 11,121 | $ 58,810,030 | $ 440.67 | 96.71% | 12,511 |
| New Adult Childless | 37,550 | $ 204,362,854 | $ 453.53 | 42,029 | $ 219,469,261 | $ 435.16 | 107.39% | 44,803 |
| New Adult w/Child | 22,473 | $ 102,062,482 | $ 378.46 | 24,521 | $ 114,487,987 | $ 389.08 | 112.17% | 25,714 |
| BD Child | 1,634 | $ 21,562,729 | $ 1,099.69 | 1,624 | $ 19,998,435 | $ 1,025.98 | 92.75% | 1,578 |
| General Child | 59,540 | $ 146,388,328 | $ 204.89 | 60,630 | $ 155,451,561 | $ 213.66 | 106.19% | 61,087 |
| Underinsured Child | 549 | $ 527,572 | $ 80.08 | 558 | $ 542,218 | $ 81.01 | 102.78% | 537 |
| CHIP | 4,450 | $ 8,852,317 | $ 165.77 | 4,338 | $ 9,417,889 | $ 180.93 | 106.39% | 4,320 |
| Vermont Premium Assistance | 15,935 | $ 5,625,792 | $ 29.42 | 15,187 | $ 5,591,697 | $ 30.68 | 99.39% | 14,646 |
| *Vermont Cost Sharing* | *3,235* | $ 1,076,393 | $ 27.73 | *3,044* | $ 1,176,262 | $ 32.20 | 109.28% | 2,924 |
| Pharmacy Only | 9,889 | $ 5,630,360 | $ 47.45 | 9,980 | $ 4,892,710 | $ 40.85 | 86.90% | 9,899 |
| Choices for Care - Traditional | - | $ - | $ - | - | $ - | $ - | 0.00% | - |
| *Choices for Care - Acute* | 4,477 | $ 46,175,225 | $ 859.49 | *4,440* | $ 41,518,289 | $ 779.32 | 89.91% | 4,325 |
| Total Medicaid | 190,693 | $ 710,903,477 | $ 310.67 | 198,589 | $ 732,391,326 | $ 307.33 | 103.02% | 203,726 |

### All AHS YTD SFY'21

| Medicaid Eligibility Group | SFY'21 BAA Caseload | SFY'21 BAA Budget | SFY'21 BAA PMPM | SFY'21 Actuals Thru June 30, 2021 Caseload | SFY'21 Actuals Thru June 30, 2021 Expenses | SFY'21 Actuals Thru June 30, 2021 PMPM | % of Expenses to Budget Line Item | Ending Enrollment as of June 2021 |
|---|---|---|---|---|---|---|---|---|
| ABD Adult | 6,475 | $ 149,134,880 | $ 1,919.37 | 6,241 | $ 141,631,362 | $ 1,891.19 | 94.97% | 6,236 |
| ABD Dual | 17,678 | $ 227,898,074 | $ 1,074.30 | 17,921 | $ 215,994,082 | $ 1,004.40 | 94.78% | 18,070 |
| General Adult | 10,043 | $ 74,194,121 | $ 615.64 | 11,121 | $ 73,272,422 | $ 549.04 | 98.76% | 12,511 |
| New Adult Childless | 37,550 | $ 239,454,004 | $ 531.41 | 42,029 | $ 256,028,579 | $ 507.65 | 106.92% | 44,803 |
| New Adult w/Child | 22,473 | $ 115,165,886 | $ 427.05 | 24,521 | $ 129,675,883 | $ 440.70 | 112.60% | 25,714 |
| BD Child | 1,634 | $ 43,998,441 | $ 2,243.90 | 1,624 | $ 39,347,380 | $ 2,018.64 | 89.43% | 1,578 |
| General Child | 59,540 | $ 297,289,260 | $ 416.09 | 60,630 | $ 292,350,543 | $ 401.82 | 98.34% | 61,087 |
| Underinsured Child | 549 | $ 989,028 | $ 150.13 | 558 | $ 1,073,305 | $ 160.36 | 108.52% | 537 |
| CHIP | 4,450 | $ 11,789,545 | $ 220.78 | 4,338 | $ 11,900,937 | $ 228.63 | 100.94% | 4,320 |
| Vermont Premium Assistance | 15,935 | $ 5,625,792 | $ 29.42 | 15,187 | $ 5,591,697 | $ 30.68 | 99.39% | 14,646 |
| *Vermont Cost Sharing* | *3,235* | $ 1,076,393 | $ 27.73 | *3,044* | $ 1,176,262 | $ 32.20 | 109.28% | 2,924 |
| Pharmacy Only | 9,889 | $ 5,630,360 | $ 47.45 | 9,980 | $ 4,892,710 | $ 40.85 | 86.90% | 9,899 |
| Choices for Care - Traditional | 4,605 | $ 233,587,557 | $ 4,227.06 | 4,590 | $ 208,116,863 | $ 3,778.17 | 89.10% | 4,477 |
| *Choices for Care - Acute* | *4,477* | $ 51,163,140 | $ 952.33 | *4,440* | $ 46,091,384 | $ 865.16 | 90.09% | 4,325 |
| Total Medicaid | 190,821 | $ 1,456,996,483 | $ 636.28 | 198,740 | $ 1,427,143,410 | $ 598.41 | 97.95% | 203,878 |



VERMONT
AGENCY OF HUMAN SERVICES

## All AHS and AOE YTD SFY'21

| Medicaid Eligibility Group | SFY'21 BAA Caseload | SFY'21 BAA Budget | SFY'21 BAA PMPM | SFY'21 Actuals Thru June 30, 2021 Caseload | SFY'21 Actuals Thru June 30, 2021 Expenses | SFY'21 Actuals Thru June 30, 2021 PMPM | % of Expenses to Budget Line Item | Ending Enrollment as of June 2021 |
|---|---|---|---|---|---|---|---|---|
| ABD Adult | 6,475 | $ 150,320,795 | $ 1,934.63 | 6,241 | $ 142,468,791 | $ 1,902.37 | 94.78% | 6,236 |
| ABD Dual | 17,678 | $ 228,038,059 | $ 1,074.96 | 17,921 | $ 216,054,903 | $ 1,004.69 | 94.75% | 18,070 |
| General Adult | 10,043 | $ 74,401,992 | $ 617.36 | 11,121 | $ 73,446,714 | $ 550.34 | 98.72% | 12,511 |
| New Adult Childless | 37,550 | $ 239,552,739 | $ 531.63 | 42,029 | $ 256,099,243 | $ 507.79 | 106.91% | 44,803 |
| New Adult w/Child | 22,473 | $ 115,169,071 | $ 427.06 | 24,521 | $ 129,686,660 | $ 440.73 | 112.61% | 25,714 |
| BD Child | 1,634 | $ 56,372,188 | $ 2,874.96 | 1,624 | $ 46,700,267 | $ 2,395.87 | 82.84% | 1,578 |
| General Child | 59,540 | $ 332,230,166 | $ 465.00 | 60,630 | $ 320,232,936 | $ 440.15 | 96.39% | 61,087 |
| Underinsured Child | 549 | $ 1,240,306 | $ 188.27 | 558 | $ 1,296,652 | $ 193.73 | 104.54% | 537 |
| CHIP | 4,450 | $ 13,318,106 | $ 249.40 | 4,338 | $ 13,125,827 | $ 252.16 | 98.56% | 4,320 |
| Vermont Premium Assistance | 15,935 | $ 5,625,792 | $ 29.42 | 15,187 | $ 5,591,697 | $ 30.68 | 99.39% | 14,646 |
| *Vermont Cost Sharing* | *3,235* | $ 1,076,393 | $ 27.73 | *3,044* | $ 1,176,262 | $ 32.20 | 109.28% | 2,924 |
| Pharmacy Only | 9,889 | $ 5,630,360 | $ 47.45 | 9,980 | $ 4,892,710 | $ 40.85 | 86.90% | 9,899 |
| Choices for Care - Traditional | 4,605 | $ 233,587,557 | $ 4,227.06 | 4,590 | $ 208,116,863 | $ 3,778.17 | 89.10% | 4,477 |
| *Choices for Care - Acute* | *4,477* | $ 51,192,959 | $ 952.89 | *4,440* | $ 46,103,720 | $ 865.39 | 90.06% | 4,325 |
| Total Medicaid | 190,821 | $ 1,507,756,483 | $ 658.45 | 198,740 | $ 1,464,993,245 | $ 614.28 | 97.16% | 203,878 |

The Vermont Cost Sharing Reduction (VCSR) population are also eligble for Vermont Premium Assistance (VPA) and the caseload counts are included in the VPA caseload counts and are not duplicatively reflected in the total. The budget and expenses are specific to 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.

Attachment 3

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**
**July 1, 2021 – September 30, 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.

**July 2021:**

- Member is calling to complain about their dentist's office. I have mailed them a complaint form and they may additionally call Legal aid. Member requested to submit negative feedback with xxx xxxxxxxx. Member has been seen 3 times, all by different dentists, two of whom have left the practice and the next did not seem to know anything about their case. Member says they have not done anything for them and do not have an actual plan on how to resolve their dental issues. All dentists have suggested different things and apparently not advised other dentist what they were planning. Member feels they may be taking advantage of Medicaid by changing plans and trying to charge for different procedures as different dentists see them. Member feels that this office has too much turnover in dentists to be effective. Member feels that the dental office was not fair to them when they asked about their dental plans and suggested they go see a different dentist. CSR apologized for the inconvenience, documented her feedback, provided member with the phone number to VT Legal Aid and mailed them a Provider Complaint form.
- Member requested to submit negative feedback. Michael called about having issues with the hospital at xxxxx xxxxxx about getting the correct prescription that they need. Member states no one is helping them. Member states they are being delayed in getting effective healthcare. Member states they have xxxxxx xxxxxx issue and needs the medicine for the

xxxxxxx. Member states they just want the prescription. CSR apologized for the inconvenience and documented their feedback and offered to send out a Provider Complaint Form.

**August 2021:**

- Member wanted to submit feedback regarding Out of State Services. Member states that Medicaid's Out of State Services are negligent and should be covered. CSR documented their feedback and reviewed the Out of State Covered Services.
- Member requested to submit negative feedback about a prescription they need for their son. The Prior Authorization required for them to try other options before they would approve the one the doctor was requested. CSR apologized for the inconvenience and offered to document her feedback.

**September 2021:**

- Member wanted to document negative feedback on the rate the Medicaid pays for Dental services. Member stated, "Because the rate is so low, Dentists are now dropping patients who only have Medicaid coverage". CSR apologized for the inconvenience, documented feedback, and offered to find the member another dentist that accepts Medicaid.

Attachment 4

# Grievance and Appeal Quarterly Report
# Medicaid Managed Care Model
# All Departments Combined Data
# August 1, 2021 – October 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 August 1, 2021, through October 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 16 grievances filed; one was 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, 69% were filed by the beneficiary, 25% were filed by a representative, and 6% were filed by other. DMH had 24%, DAIL had 38%, and DVHA had 38% of the grievances filed. There were no grievances filed for DCF 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 17 appeals filed. Of these 17 appeals, 7 were resolved (41%).

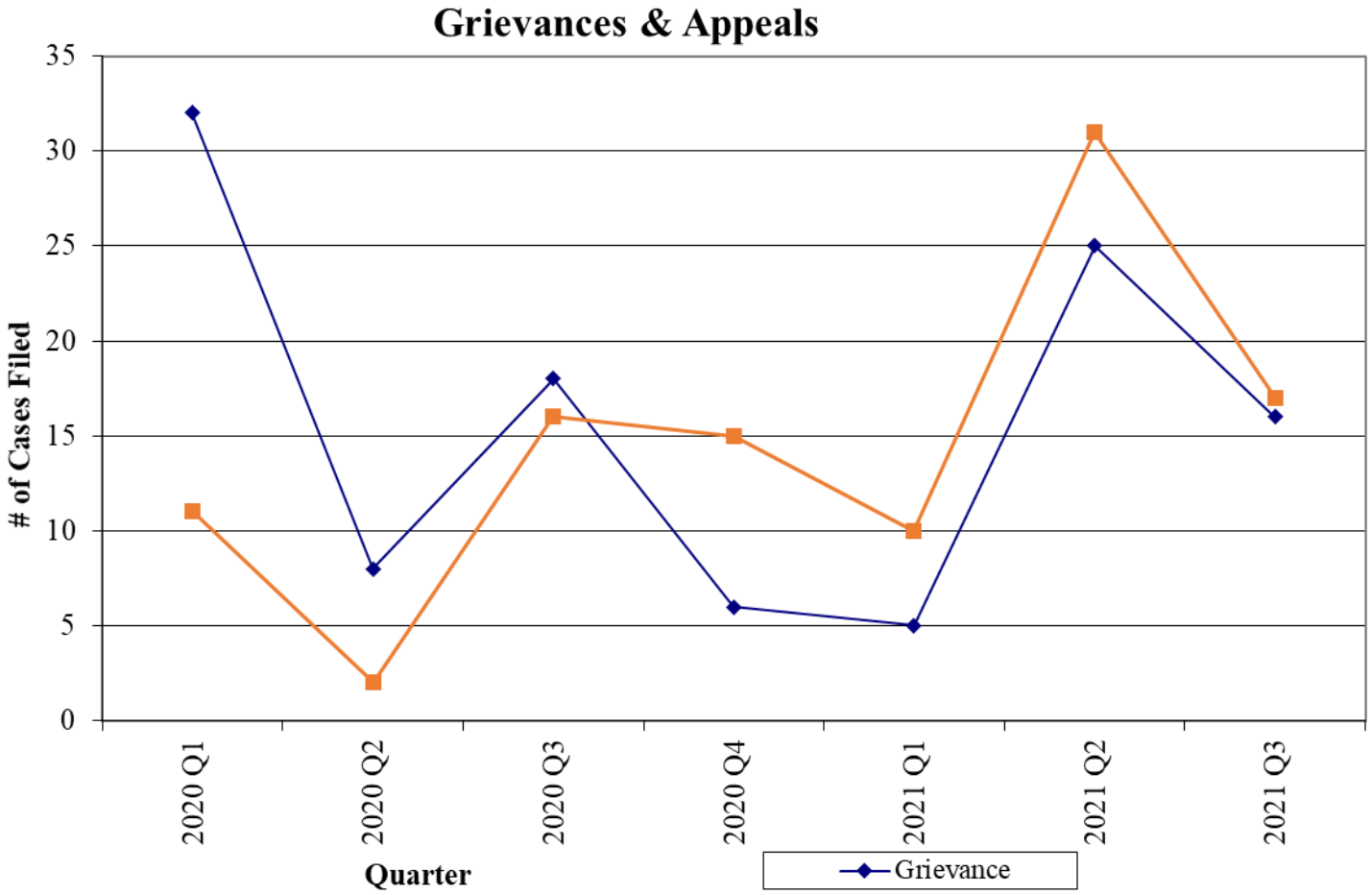
Of the 7 appeals that were resolved this quarter, 86% were resolved within the statutory time frame of 30 days. The average number of days it took to resolve these cases was 22 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

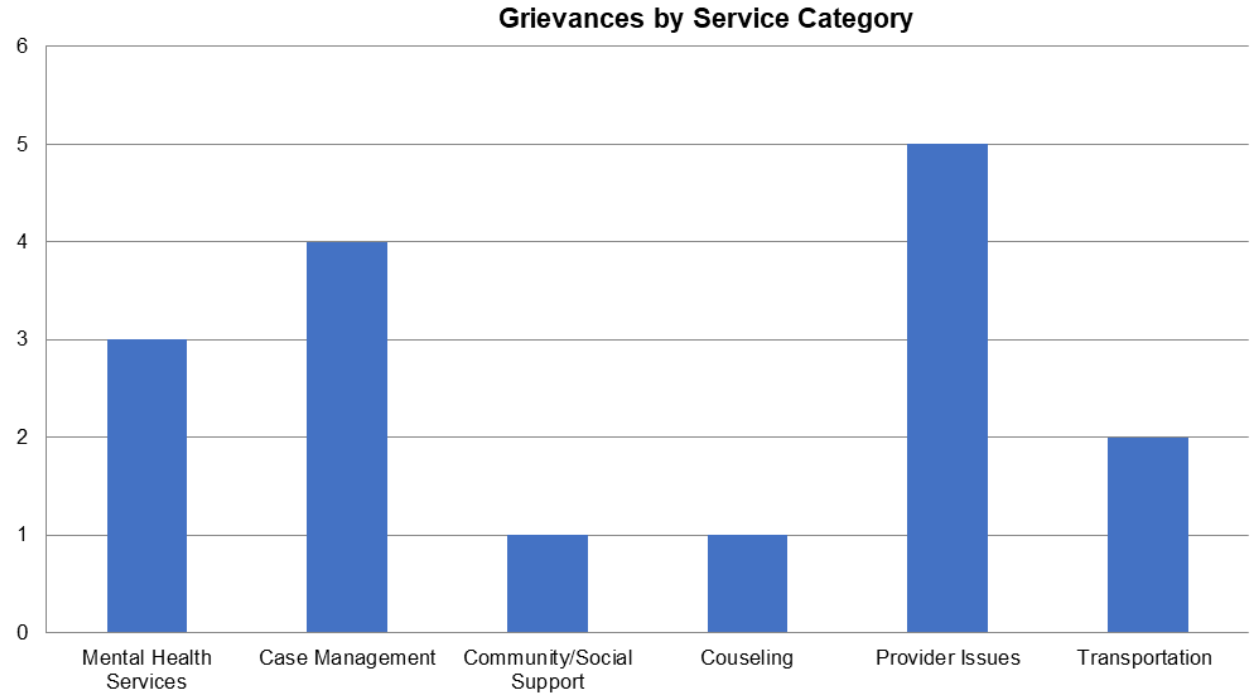
Of the 17 appeals filed, DVHA had 6 appeals filed (35%), DAIL had 7 (41%), DMH had 3 (18%) and VDH had 1 (6%).

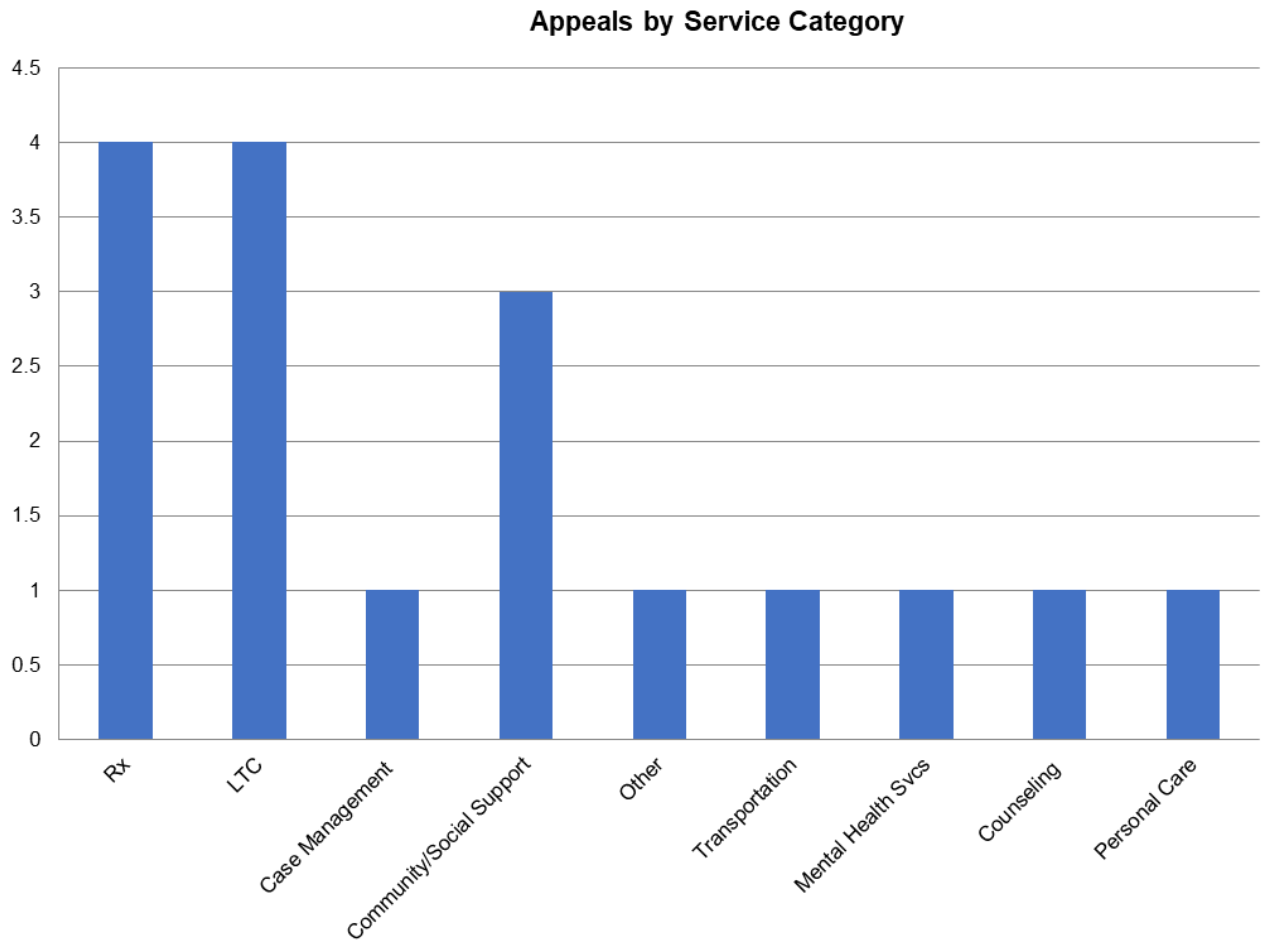
The appeals filed were for service categories, community/social supports, transportation, prescriptions, case management, counseling, metal health services, personal care services and Long-Term Care.

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 one 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
2021 Q2
2021 Q3
Quarter
Grievance


Grievances by Service Category
6
5
4
3
2
1
0
Mental Health Services
Case Management
Community/Social Support
Couseling
Provider Issues
Transportation


Appeals by Service Category
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Rx
LTC
Case Management
Community/Social Support
Other
Transportation
Mental Health Svcs
Counseling
Personal Care

**Attachment 5**

Vermont Legal Aid

# Office of the Health Care Advocate

Quarterly Report

July 1, 2021 - September 30, 2021

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

October 21, 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 until the spring of 2022. The HCA Helpline now has seven advocates working to resolve issues.

The HCA has focused on medical debt for years, and this quarter we launched a medical debt story telling project to gain a deeper understanding of how medical debt impacts Vermonters. Hundreds of Vermonters responded and shared often difficult stories of how medical debt often impacts their ability to get timely care. Many consumers told us that they have delayed or skipped medical care because of their fear of medical debt. Many of these consumers had insurance at the time they went into debt. The HCA will continue its work on this project by bringing these Vermont voices to the policy table in the State House this year. There are reasonable steps the Legislature can take to reduce the burden of medical debt on Vermont families.

During this quarter, we again saw a significant number of cases related to the American Rescue Plan Act (ARPA). ARPA increases the amount of Advance Premium Tax Credit (APTC) most Vermont households are eligible for, which makes Vermont Health Connect (VHC) plans more affordable. It also removes the income eligibility cut-off for APTC, which makes some households newly eligible for APTC. Additionally, it paid for COBRA subsidies for eligible employees, from April to September 2021. The HCA gave consumer education about ARPA to 30 households. We commented on one notice that VHC sent consumers about ARPA subsidies. In addition, we spoke to 13 households about the Special Enrollment Period (SEP) for uninsured Vermonters. We also had 194 pageviews on our website about that SEP.

The HCA is also working with VHC and other stakeholders to prepare for the premium payment transition. Starting in 2022, VHC enrollees will start to pay their premiums directly to the insurance carrier, instead of to VHC. The HCA has been working with VHC on consumer education and outreach about the transition. We plan to cover the topic on our website and in our townhalls. We also started our preparation for Open Enrollment and submitted comments on three Open Enrollment notices that VHC plans on sending to consumers.

**Roger's Story**

After Roger lost his job, he had signed up for a plan that he found advertised online. Roger believed he was buying full coverage insurance. But when he went to the doctor's office and tried to use it, the doctor could not bill it. He called the HCA because he needed medical care and could not afford it without insurance. The HCA advocate investigated and found that Roger had not really signed up for an insurance plan at all. The "plan" that he purchased had practically no coverage at all. This meant Roger was uninsured. Because VHC has had a special enrollment period for uninsured Vermonters this quarter, the HCA advocate helped Roger sign up for a plan. With the increased American Rescue Plan Act subsidies, Roger was able to find an affordable plan that would help cover his medical care.

The HCA helpline had 737 calls this quarter. Medicaid eligibility remains the top issue. We had 182 calls about all types of Medicaid eligibility. We had 2,253 pageview on our website on Medicaid eligibility. Advocates also helped Vermonters with 10 cases involving a VHC eligibility error.

The HCA is also working with other stakeholders to consider changes to the Vermont Essential Health Benchmark plan on Vermont Health Connect. The group is considering whether the plan can be updated and expanded within the regulatory framework to cover items such as dental care for adults, fertility services, or hearing aids. During this quarter, we met and heard from stakeholders and advocates about possible changes.

The HCA helpline continues collaborating with other projects within 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 will again advocate for the use of one-time Federal funds to improve access to dental care and dentures for lower income Vermonters and plans to continue to advocate for increased dental access in the coming year 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 the COVID-19 pandemic stretches on, we know that Vermonters are still confronting the economic and health impacts of the pandemic. The HCA will continue to work to make health care more accessible for all Vermonters, and to make the system more equitable, responsive, and affordable.

**Anel's Story**

Anel called the HCA after he tried to pick up a 90-day supply of a prescription at the pharmacy. He could not afford the cost. When the HCA advocate spoke with him, she discovered that Anel was on Medicare, but he was not enrolled on a Part D prescription plan. He was past the enrollment period for Part D, and because he had not enrolled when he was first eligible, he would also have a late enrollment penalty. For the immediate prescription, the HCA advocate directed Anel to the Health Assistance Program at UVMMC to get assistance paying for that prescription. The HCA advocate then investigated and found that Anel was eligible for a Medicare Savings Program called Q1-1. This program would pay for his Part B premiums. In 2021, Part B costs $148.50 per month. It covers outpatient medical services. Being on a Medicare Savings Program also meant that Anel would be deemed eligible for a program called Extra Help (also called Low Income Subsidy). Extra Help pays for the Part D premium and keeps copayments low. By being deemed eligible, he would be enrolled in a Part D plan, outside of the open enrollment period. This also waived his Part D late enrollment penalty. The HCA advocate helped Anel complete the application, and he was found eligible for Q1-1 and deemed eligible for Extra Help. This meant he would be able to afford his prescriptions going forward and have help paying the Part B premium.

**Liam's Story**

Liam needed help from the HCA because he was trying to report an income change to VHC, but each time he put his new income into the online portal, he would get an error message. Liam's income had dropped significantly, and he was having trouble making his monthly premium payments. After the HCA advocate learned that his income had dropped, she explained that he would be eligible for more Premium Tax Credit (PTC) to help pay his premium. The amount of PTC you are eligible for is based on your household size and income. Also, under the American Rescue Plan Act (ARPA), many Vermont households are eligible for increased PTC. When the HCA advocate reported the change, she was able to get a new eligibility determination that reflected Liam's new income and the more-generous ARPA subsidies. VHC was also able to figure out why Liam could not report changes to his portal, and they fixed the issue so he could use it to report any future changes. When VHC was able to update his income information, Liam's monthly premium dropped from over $300 per month to less than $50.

**Marcene's Story**

Marcene called the HCA because she did not have any prescription coverage. She was on Medicare but had not been able to pay for her Medicare Part D prescription plan. Her plan was terminated for non-payment at the start of the year, and now she needed to fill a prescription. Each year, Part D has an annual open enrollment in the fall when you can sign up or change plans. You need a special enrollment period to sign up outside the annual enrollment period. After talking to Marcene, the HCA advocate discovered that she would be eligible for VPharm. VPharm is the state program that helps pay Part D premiums and reduces copayments. Being enrolled in a state pharmacy assistance program also gives you a special enrollment period to change or enroll onto a Part D plan. However, one barrier for Marcene was that to be eligible for VPharm you need to be enrolled in a Part D plan. The HCA advocate explained that Marcene should still apply and get a letter of "conditional eligibility," which would state that she would be eligible for VPharm if she were on a Part D plan. She could then use that notice to enroll on a Part D plan, and finally enroll in VPharm to get assistance with the premium and copayments.

# 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 737 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:

- **31.09%** about **Access to Care**
- **10.67%** about **Billing/Coverage**
- **2.24%** about **Buying Insurance**
- **13.97%** about **Complaints**
- **8.17%** about **Consumer Education**
- **17.79%** about **Eligibility** for state and federal programs
- **13.57**% were categorized as **Other**, which includes communication problems with health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

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 135 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, an additional 296 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 July – September 2021 includes:

- This narrative
- Seven data reports, including three based on the caller's insurance status:
  - **All Calls/All Coverages**: 737
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 258

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

- **Commercial Plan Beneficiaries**: 107
- **Uninsured Vermonters**: 36
- **Vermont Health Connect (VHC)**: 109

## 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 737 (vs. 747 last quarter)**

1. Complaints about Providers 101 (87)
2. MAGI Medicaid Eligibility 90 (98)
3. Medicaid eligibility (non-MAGI) 54 (48)
4. Medicare Consumer Education 54 (52)
5. Buy-in programs/Medicare Savings Programs 52 (42)
6. Information/Applying for DVHA programs 50 (64)
7. Access to Prescription Drugs/Pharmacy 48 (39)
8. Access to Nursing Home & Home Health 38 (43)
9. Other issues (Not Health-related) 36 (33)
10. Other Issues (Health-related) 35 (30)
11. Access to Dental Care 33 (27)
12. Premium Tax Credit Eligibility 33 (56)
13. Hospital Financial Assistance 27 (34)
14. Special Enrollment Period 26 (37)
15. Access to Specialty Care 24 (30)
16. Information about HCA 24 (23)

**Vermont Health Connect Calls 109 (125)**

1. MAGI Medicaid Eligibility 43 (51)
2. Premium Tax Credit eligibility 31 (53)
3. Buying QHPs through VHC 23 (33)
4. ARPA (American Rescue Plan Act) Consumer Education 16 (40)
5. Information about DVHA 16 (25)
6. ARPA Eligibility 14 (30)
7. Eligibility for Special Enrollment Periods 14 (22)
8. Eligibility for COVID-19 Special Enrollment Period 13 (9)
9. Termination of Insurance 13 (24)
10. Eligibility for Fair Hearing Appeals 12 (6)
11. IRS Reconciliation Education 12 (27)

**DVHA Beneficiary Calls 258 (vs. 230 last quarter)**

1. MAGI Medicaid Eligibility 50 (48)
2. Complaints about Providers 38 (9)
3. Medicaid Eligibility (non-MAGI) 38 (26)
4. Information about DVHA 28 (28)
5. Information about Medicare 26 (12)
6. Eligibility for MSPs/Buy-In Programs 26 (19)
7. Access to Prescription Drugs/Pharmacy 18 (16)
8. Access to Dental Care 15 (15)
9. Access to Transportation 15 (15)
10. Access to Nursing Home & Home Health 14 (6)

**Commercial Plan Beneficiary Calls 107 (vs. 132 last quarter)**

1. Premium Tax Credit Eligibility 20 (32)
2. Eligibility for MAGI Medicaid 16 (17)
3. Premiums Billing 14 (16)
4. Buying QHPs through VHC 14 (21)
5. ARPA Consumer Education 12 (32)
6. ARPA Eligibility 12 (24)
7. Hospital Financial Assistance 11 (11)
8. Access to Prescription Drugs 10 (4)
9. Special Enrollment Period Eligibility 10 (22)
10. Termination of Insurance 10 (23)

The HCA received **737** 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"): 35% (258 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): 25.6% (189 calls)
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans) 14.5% (107 calls)
- **Uninsured:** 4.9 % (36 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 760 cases this quarter. Overall, 319 were resolved by brief analysis and advice. Another 297 were resolved by brief analysis and referral. There were 68 complex interventions involving complex analysis and more than two hours of an advocate's time, and 36 cases that involved at least one direct intervention on behalf of a consumer. The HCA provided consumer education in 504 cases. We also estimated eligibility for insurance coverage and helped enroll people onto coverage in 62 cases. We saved consumers $12,477.11 this quarter.

# Consumer Protection Activities

**Health Insurance Rate Review**

The HCA reviews and analyzes all commercial insurance carrier requests to the Green Mountain Care Board (Board) to change premium prices.

The Board decided four premium price change requests during the quarter from July 1, 2021, through September 1, 2021. Additionally, there is one premium price change request pending as of the end of this quarter. The four matters decided all relate to changes to the premium of plans sold on Vermont Health Connect (VHC). There are four filings, as opposed to two, due to legislative action that split the individual and small group market in 2022.

MVP submitted two premium price change requests decided by the Board this quarter: the 2022 MVP Small Group filing and the 2022 MVP Individual filing. Both filings relate to plans sold on VHC or directly by the carrier. The MVP Small Group filing impacts roughly 21,850 Vermonters. MVP requested an average premium price increase of 5%. The MVP Individual filing impacts roughly 15,350 Vermonters. MVP requested an average premium price increase of 17%. On August 5, 2021, the Board issued a decision in these two filings. The Board approved a premium price increase of 12.7% for the 2022 MVP Individual filing and 0.8% for the 2022 MVP Small Group filing. The HCA appeared on behalf of Vermonters in these matters and filed various motions, questions, and memoranda. Additionally, the HCA appeared at the public hearing on these two matters.

BCBSVT submitted two premium price change requests decided by the Board this quarter: the BCBSVT Small Group filing and the 2022 BCBSVT Individual filing. Both filings relate to plans sold on VHC or directly by the carrier. The BCBSVT Small Group filing impacts roughly 18,750 Vermonters. BCBSVT requested an average premium price change of -7.8%. The BCBSVT Individual filing impacts roughly 15,800 Vermonters. BCBSVT requested an average premium price increase of 7.9%. On August 5, 2021, the Board approved an average premium price change of -6.7% for the 2022 BCBSVT Small Group filing and 4.7% for the 2022 BCBSVT Individual filing. The HCA appeared on behalf of Vermonters in these matters. The HCA appeared on behalf of Vermonters in this matter and filed various motions, questions, and memoranda. Additionally, the HCA appeared at the public hearing on these matters

There is one premium price change request pending at the end of this quarter: the 2022 MVP Large Group HMO. This filing impacts roughly 2,100 Vermonters. MVP has proposed an increase to the manual rate for this book of business by approximately 8.5%. The HCA appeared on behalf of Vermonters in this

matter and will file all appropriate motions, questions, and memoranda to represent the interests of Vermonters.

Lastly, Blue Cross Blue Shield of Vermont (BCBSVT), appealed the Board's orders in both filings decided this quarter to the Supreme Court of Vermont. The HCA is a party to the ongoing litigation related to BCBSVT's appeal.

**Hospital Budgets (SP)**

The HCA reviews and analyzes all hospital budget submissions to the Green Mountain Care Board (GMCB), prepares questions for the hospital budget hearings, and submits a post-hearing memo with recommendations to the Board. This years' memo focused on issues of affordability, access, and health equity for Vermonters. The HCA consulted with community stakeholders and advocated for race equity to be prioritized by the Board and the hospitals, and pushed for increased budgetary commitments and institutional attention to diversity, equity, and inclusion (DEI) efforts both during and after the budgetary hearings.

**Certificate of Need Review Process (SP)**

In the last quarter, the HCA entered an appearance in a Certificate of Need for a new collaborative surgery center to be housed in Colchester.

**Oversight of Accountable Care Organizations (SP)**

The HCA participates in the Board's annual ACO budget review process. We will be meeting with the GMCB Staff on the ACO Team to discuss the budget for OneCare Vermont (OCV) in the coming weeks. Our team will focus on issues of affordability and access.

The HCA also worked with GMCB Board Staff to finalize budgetary guidance for Medicare-only ACOs. This guidance was presented at the GMCB meeting on October 13th and will likely be voted on by the GMCB likely later this month. Our additions to the budgetary guidance included requests for theory-of-change research, information on how ACO's approach addresses racial disparities in health, disclosures of potential conflicts of interests, and detailed information regarding ACO member attribution in their business models.

**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, and weekly Prescription Drug Technical Advisory subgroup meetings (which includes the Out-of-Pocket Costs and Pharmacy Benefit Manager subgroups).

**Act 140 Workgroups**

The HCA participates in two workgroups convened as part of Act No. 140 (H.960) – An act relating to miscellaneous health care provisions. These workgroups are led by the Green Mountain Care Board and the Department of Financial Regulation. We have been particularly involved in the prior authorization component of the legislation. The HCA discussed the impact that prior authorization procedures often have on Vermonters' ability to access the right care at the right time, highlighting that delayed or denied

care ultimately makes future treatment more difficult and expensive. We encouraged stakeholders to build on the shared goal of simplifying and streamlining the PA process, and to start by focusing on PA approvals for medications and procedures for common, routine chronic medical conditions.

**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 to identify and reach critical populations, promote COVID-19 vaccination, develop crisis and risk communication messaging, and to carry out the vaccine implementation plan. The Advisory committee did not meet this quarter but will continue to meet from time to time as there are needs to discuss vaccine rollouts to new populations.

**The Medicaid and Exchange Advisory Committee**

The Advisory Committee met two times this quarter. The content of this quarter's meetings included ongoing discussions about the impacts of the American Rescue Plan Act on Vermont's Medicaid and Exchange programs, the implementation of H.430 (Act48) of 2021 which expanded health coverage to children and pregnant women who are not eligible for Medicaid due to their immigration status, and an update on the Federal Medical Assistance Percentage (FMAP) 10% increase opportunity for Home and Community Based Services. In addition the Advisory Committee discussed its budget priorities for the upcoming budget year.

**Mental Health Integration Council**

The HCA is a member of this newly formed council. The council met two times this quarter focusing on its initial organization, defining its purpose and goals, and the creation of subgroups to look at the challenges and success of true integration in different parts of the health care landscape.

**EHB Benchmark Plan Workgroup** July 16th, July 30th

The HCA participated in two meetings of the Essential Health Benefits Plan Workgroup. During this quarter we defined the service areas that should be costed out in consideration of updating our EHB. The workgroup also started to take testimony from stakeholders and advocates about these service areas.

**Legislative Advocacy**

During the summer months of this quarter, the HCA met with various legislators in response to their requests for information and started the process of legislative outreach for the coming legislative year. The HCA also testified before the Legislative Task Force on Affordable, Accessible Health Care about the early findings of the medical debt story telling project.

**Medical Debt Story Telling Project**

The HCA has long recognized the impact of medical debt on Vermonters. This year, in addition to the ongoing casework and the regulatory work, we engaged in a proactive outreach project with specific goals in mind.

First, we want to help diminish the stigma that people experience when they owe medical debts beyond their ability to pay. Vermonters and their policymakers must understand that these debts are related to structural problems in our health care system. Many families, even those with insurance, are exposed to unreasonable medical charges for preventive, routine, and emergency medical care, given their income.

Second, the HCA wanted to learn more about how medical debt impacts Vermonters. We heard directly from Vermont families whose medical debt prevents them from seeking medical care.

This quarter's activities included a significant amount of outreach to Vermonters through paid media, social media, community organizations, and legislators. We engaged Vermonters first through a simple survey. The main goal of this survey tool was to engage a broader set of Vermonters and to hear directly from them in their own words.

This project will continue with additional phases of more in-depth discussions with a smaller set of people to help us deepen our understanding of how Vermont households experience medical debt. We plan to share our findings publicly with Vermonters and the Legislature, as well as other major stakeholders in the health policy arena.

# 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
- AFL-CIO
- Bi-State Primary Care
- Bridges to Health
- Blue Cross Blue Shield of Vermont
- Department of Financial Regulation
- Families USA
- IRS Taxpayer Advocate Service
- Migrant Justice
- MVP Health Care
- National Academy for State Health Policy
- NHeLP, National Health Law Program
- New American Clinic/Family Room
- OneCare Vermont
- Open Door Clinic
- Planned Parenthood of Northern New England
- Rights and Democracy (RAD)
- RISPnet Group
- Rural Vermont
- South Royalton Legal Clinic
- Spectrum Youth and Family Services
- SHIP, State Health Insurance Assistance Program
- University of Vermont Medical Center
- University of Vermont Migrant Health, Bridges to Health Vermont Association of Hospitals and Health Systems
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Health Connect
- Vermont Health Care for All
- Vermont Interfaith Action (VIA)
- Vermont Medical Society
- Vermont - NEA
- Vermont Workers' Center
- VPIRG
- 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:

1. *Income Limits - Medicaid* – 2,253 pageviews
2. *Health* - section home page – 1,572
3. *Dental Services* – 680
4. *Services Covered – Medicaid – 467*
5. *Medicaid* – 465
6. *Long-Term Care* – 425
7. *HCA Help Request Form* – 332 pageviews and 120 online help requests
8. *Medicare Savings Programs* – 332
9. *Resource Limits - Medicaid* – 299
10. *Medical Decisions: Advance Directives* – 282 (up 44% from the last quarter)
11. *News: Coronavirus and Long-Term Care* – 269
12. *Medicaid, Dr. Dinosaur & Vermont Health Connect* – 268
13. *Choices for Care* – 258
14. *Transportation for Health Care* – 224
15. *Vermont Health Connect* – 211
16. *Choices for Care Income Limits* – 207
17. *Advance Directive forms* – 202
18. *Dr. Dynasaur* – 190
19. *Prescription Help – State Pharmacy Programs* – 179 (up 50% from the last quarter) *
20. *Vermont Long-Term Care Ombudsman Project* – 170

This quarter we had these additional news items:

- *News item 1: You May Be Eligible for New Financial Help for Health Insurance (ARPA)* – 199
- *News item 2: Coronavirus SEP for Vermont Health Connect* – 194
- *News item 3: Vermont Health Connect Has a Special Enrollment Period* – 130

# Outreach and Education

The Office of the Health Care Advocate's (HCA) ability to conduct in-person outreach activities was limited this quarter because of the COVID-19 pandemic. To better meet the needs of Vermonters during this time, our office used virtual platforms to connect community members, with accurate and accessible information about health insurance eligibility and health care policy.

Many of the HCA's outreach activities this quarter focused on educating Vermonters on the impacts of American Rescue Plan Act (ARPA.) ARPA made many Vermont households eligible for more financial help to pay their premiums.

We collaborated with **18 organizations and participated in 8 outreach presentations** to provide Vermonters and direct service providers with accurate and accessible information on insurance eligibility health care policy.

The HCA utilized social media platforms such as Facebook and YouTube to produce interactive educational resources to inform Vermonters about the increased financial assistance that is available through Vermont Health Connect.

On **July 1**, the HCA hosted a **Town Hall event on Facebook Live**. Attendees learned about the benefits that ARPA had increased for many Vermonters households. They also learned about the Special Enrollment Period that was available to uninsured Vermonters, and the special rules related to Medicaid and the Public Health Emergency. This live event was attended by **seventeen** Vermonters. The audience was able to ask questions during the town hall. This video has subsequently been viewed 210 times. The HCA also produced a short education video on this subject matter that was published on YouTube.

In addition to hosting live Town Hall events and producing digital educational resources, the HCA also co-hosted education events in collaboration with partner organizations.

On **July 20th** our office partnered with UVM Medical Center's Clinical Social Work Team to host an educational event about the services that the HCA can provide to Vermonters in addition to the increased financial assistance and special enrollment period that was available through Vermont Health Connect.

The HCA's Communication Coordinator hosted **seven** more presentations on these subjects during this quarter in collaboration with the Refugee and Immigrant Service Provider Network, Spectrum, the Planned Parenthood Action Fund, the Vermont Association for the Education of Young Children, Pathways, and Outright Vermont. These education presentations were attended by **58 direct service providers**. These collaborations have led to referrals that have helped our office connect with an array of Vermonters who often have urgent access-to-care questions.

In an effort to connect with college age Vermonters, the HCA's Communications Coordinator participated in tabling events at the **University of Vermont, Champlain College, and the**

**Community College of Vermont**. Many students face complicated choices related to their health insurance options, so we made an effort to proactively inform this demographic of the HCA's services. We connected with over **151 students** at these events.

Additionally, we collaborated with six other non-profit organizations to host an event called Community Partners in the Park. We connected with **45 Burlington community members** who were invited to join us in a local park to engage in wellness activities and learn about resources that are available to them.

The HCA also developed digital outreach materials that were distributed on Facebook and Front Porch Forum. These materials provided Vermonters with information on increased financial assistance that is available through Vermont Health Connect for those who received unemployment in 2021 in addition to other increased benefits that are now available for Vermont Health Connect enrollees. We used targeted ads through Facebook to connect over **900 Vermonters** with this information.

### 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**:**

- **October Open Enrollment Stuffer**
- **Open Enrollment Notice: RE002**
- **Open Enrollment Notice: Re005**
- **ARPA Notice: Unemployment Insurance**

**Office of the Health Care Advocate**

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

https://vtlawhelp.org/health

## CY 2021 Investment Expenditures

| Department | Final 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 | 10,235 | 140,765 | | **264,250** |
| AHSCO | 9090 | Investments (STC-79) - Designated Agency Underinsured Services (54) | 1,575,984 | 1,575,984 | 1,575,984 | | **4,727,952** |
| AOE | n/a | Non-state plan Related Education Fund Investments | | | | | **-** |
| DCF | 9402 | Investments (STC-79) - Medical Services (55) | 41,263 | 14,021 | 48,271 | | **103,555** |
| 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 | 1,021,040 | 1,010,121 | | **3,041,911** |
| DCF | 9406 | Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57) | 26,243 | 26,431 | 26,538 | | **79,212** |
| DCF | 9407 | Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58) | 61,115 | 58,539 | 56,817 | | **176,471** |
| DCF | 9408 | Investments (STC-79) - Essential Person Program (59) | 191,025 | 184,639 | 186,115 | | **561,779** |
| DCF | 9409 | Investments (STC-79) - GA Medical Expenses (60) | 42,555 | 20,511 | 49,202 | | **112,268** |
| DCF | 9411 | Investments (STC-79) - Therapeutic Child Care (61) | 287,305 | 279,190 | 311,274 | | **877,770** |
| DCF | 9412 | Investments (STC-79) - Lund Home (2) | 693,053 | 720,143 | 612,428 | | **2,025,623** |
| 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 | 18,270 | 17,665 | | **68,250** |
| DCF | 9415 | Investments (STC-79) - Challenges for Change: DCF (9) | 36,083 | 23,333 | 23,157 | | **82,573** |
| DCF | 9416 | Investments (STC-79) - Strengthening Families (26) | 198,336 | 304,099 | 202,563 | | **704,999** |
| DCF | 9417 | Investments (STC-79) - Lamoille Valley Community Justice Project (62) | 54,594 | 58,253 | 56,430 | | **169,277** |
| DCF | 9418 | Investments (STC-79) - Building Bright Futures (35) | 129,876 | 112,290 | 99,002 | | **341,167** |
| DCF | 9419 | Investments (STC-79) - United Ways 2-1-1 (41) | | | 75,475 | | **75,475** |
| DDAIL | 9602 | Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63) | 148,054 | 90,774 | 87,554 | | **326,382** |
| DDAIL | 9603 | Investments (STC-79) - DS Special Payments for Medical Services (64) | 1,119,839 | 374,476 | 940,239 | | **2,434,555** |
| DDAIL | 9604 | Investments (STC-79) - Flexible Family/Respite Funding (27) | 289,286 | 267,578 | 570,909 | | **1,127,772** |
| 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 | 245,124 | 245,009 | | **736,004** |
| DDAIL | 9607 | Investments (STC-79) - HomeSharing (77) | 69,670 | 69,459 | 73,451 | | **212,579** |
| DDAIL | 9608 | Investments (STC-79) - Self-Neglect Initiative (78) | 130,202 | | 135,411 | | **265,613** |
| DDAIL | 9609 | Investments (STC-79) - Seriously Functionally Impaired: DAIL (65) | | 29,990 | | | **29,990** |
| DMH | 9501 | Investments (STC-79) - Special Payments for Treatment Plan Services (28) | 23,353 | 39,545 | 26,789 | | **89,688** |
| DMH | 9502 | Investments (STC-79) - MH Outpatient Services for Adults (66) | 827,220 | 774,685 | 804,889 | | **2,406,794** |
| DMH | 9504 | Investments (STC-79) - Mental Health Consumer Support Programs (79) | 98,319 | 113,715 | 147,083 | | **359,117** |
| DMH | 9505 | Investments (STC-79) - Mental Health CRT Community Support Services (16) | (697,469) | 1,436,960 | 2,026,730 | | **2,766,221** |
| DMH | 9506 | Investments (STC-79) - Mental Health Children's Community Services (12) | 597,557 | 559,399 | 799,397 | | **1,956,353** |
| DMH | 9507 | Investments (STC-79) - Emergency Mental Health for Children and Adults (29) | 2,332,038 | 2,304,917 | 3,141,077 | | **7,778,031** |
| DMH | 9508 | Investments (STC-79) - Respite Services for Youth with SED and their Families (67) | 311,549 | 267,100 | 465,994 | | **1,044,643** |
| DMH | 9510 | Investments (STC-79) - Emergency Support Fund (22) | 131,863 | 105,167 | 263,468 | | **500,499** |
| DMH | 9511 | Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - VPCH | 3,154,313 | 3,069,979 | 5,232,837 | | **11,457,129** |
| DMH | 9512 | Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - BR | 2,607,983 | 2,161,055 | 495,118 | | **5,264,156** |
| DMH | 9514 | Investments (STC-79) - Seriously Functionally Impaired: DMH (68) | 28,956 | 27,630 | 44,177 | | **100,763** |
| DMH | 9516 | Investments (STC-79) - Acute Psychiatric Inpatient Services (13) | 156,906 | 194,642 | 425,526 | | **777,075** |
| DOC | n/a | Return House | 74,551 | 187,218 | 48,853 | | **310,622** |
| DOC | n/a | Northern Lights | 79,633 | 152,252 | | | **231,885** |
| DOC | n/a | Pathways to Housing - Transitional Housing | 176,666 | 159,478 | 181,700 | | **517,844** |
| DOC | n/a | St. Albans and United Counseling Service Transitional Housing (Challenges for Change) | 68,677 | 125,682 | - | | **194,359** |
| 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 | 1,371,534 | - | | **2,171,744** |
| 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 | 659,434 | 687,057 | | **2,049,273** |
| DVHA | 9103 | Investments (STC-79) - Buy-In (52) | 15,276 | 10,701 | 891 | | **26,868** |
| DVHA | 9104 | Investments (STC-79) - HIV Drug Coverage (53) | 1,438 | | 605 | | **2,043** |
| DVHA | 9106 | Investments (STC-79) - Patient Safety Net Services (18) | | | | | **-** |
| DVHA | 9107 | Investments (STC-79) - Institution for Mental Disease Services: DVHA (7) | 426,792 | 1,591,171 | 1,175,335 | | **3,193,299** |
| 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 | 143,874 | 105,463 | | **333,760** |
| VDH | 9203 | Investments (STC-79) - TB Medical Services (74) | 487 | 309 | 1,695 | | **2,491** |
| VDH | 9204 | Investments (STC-79) - Epidemiology (40) | 27,503 | 27,340 | 57,856 | | **112,699** |
| VDH | 9205 | Investments (STC-79) - Health Research and Statistics (39) | 140,741 | 207,756 | 276,900 | | **625,397** |
| VDH | 9206 | Investments (STC-79) - Health Laboratory (31) | 454,147 | 584,377 | 702,215 | | **1,740,739** |
| VDH | 9207 | Investments (STC-79) - Tobacco Cessation: Community Coalitions (50) | 582,170 | 588,892 | 392,920 | | **1,563,981** |
| VDH | 9208 | Investments (STC-79) - Statewide Tobacco Cessation (76) | | | | | **-** |
| VDH | 9209 | Investments (STC-79) - Family Planning (75) | 296,039 | 274,108 | 165,257 | | **735,404** |
| VDH | 9210 | Investments (STC-79) - Physician/Dentist Loan Repayment Program (25) | 144,000 | 455,000 | 504,000 | | **1,103,000** |
| VDH | 9211 | Investments (STC-79) - Renal Disease (73) | | | | | **-** |
| VDH | 9213 | Investments (STC-79) - WIC Coverage (37) | | 1,983 | | | **1,983** |
| VDH | 9214 | Investments (STC-79) - Area Health Education Centers (AHEC) (21) | 166,717 | | 393,568 | | **560,285** |
| VDH | 9217 | Investments (STC-79) - Patient Safety - Adverse Events (47) | 8,582 | 10,082 | 547 | | **19,212** |
| VDH | 9219 | Investments (STC-79) - Substance Use Disorder Treatment (30) | 1,009,910 | 623,086 | 974,923 | | **2,607,919** |
| VDH | 9220 | Investments (STC-79) - Recovery Centers (17) | 478,134 | 313,439 | 359,915 | | **1,151,488** |
| VDH | 9221 | Investments (STC-79) - Enhanced Immunization (46) | 17,426 | 22,648 | 17,238 | | **57,312** |
| VDH | 9222 | Investments (STC-79) - Poison Control (48) | 37,010 | 31,765 | 32,316 | | **101,091** |
| VDH | 9223 | Investments (STC-79) - Public Inebriate Services, C for C (23) | 561,415 | 421,582 | 269,348 | | **1,252,345** |
| VDH | 9224 | Investments (STC-79) - Fluoride Treatment (38) | 6,196 | 5,179 | 8,162 | | **19,537** |
| VDH | 9225 | Investments (STC-79) - Medicaid Vaccines (24) | | | | | **-** |
| VDH | 9226 | Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49) | 15,804 | 19,072 | 20,937 | | **55,813** |
| VDH | 9228 | Investments (STC-79) - VT Blueprint for Health (44) | 110,032 | 66,834 | 171,539 | | **348,405** |
| VSC | n/a | Health Professional Training | - | | 409,461 | | **409,461** |
| VVH | n/a | Vermont Veterans Home | | | | | **-** |
| | | | **22,664,232** | **24,613,969** | **27,376,164** | **-** | **74,654,365** |

# Public Health Statistics (formerly Health Research and Statistics)

## What We Do

The Public Health Statistics program collects, manages, analyzes, and reports information about health status, health resources, and health care utilization in Vermont. Public Health Statistics is also a responsive program that is on call for providing other services as requested. These requests can be for new analyses of existing data, for analysis or evaluation of data for a program, for the modification and/or expansion of an existing data system, or for the development of a new data system. As priorities and resources change the program must respond to the changing needs of the department.

## Who We Serve

This is a public health program that benefits the entire population by providing data for health planning and evaluation.

Research and statistics data is requested by, and disseminated to, a variety of users including programs within the Department of Health, other agencies and departments within state government, hospitals and health care providers, and community level organizations.

## How We Impact

Investment objective:

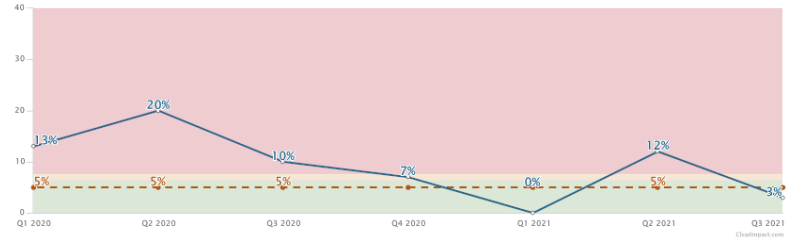
Provide public health approaches and other innovative programs to improve the health outcomes, health status, and quality of life for uninsured, underinsured, and Medicaid-eligible individuals in Vermont

## Performance Monitoring Plan

The Vermont Department of Health will monitor this plan in two ways:

1. The Performance Management Committee will review all investment programs and associated performance measures annually.
2. Commissioners and Division Directors will review selected measures at bi-weekly leadership meetings.

## Measures




| Time Period | Current Actual Value | Current Target Value | Current Trend |
|---|---|---|---|
| Q3 2021 | 3% | 5% | 1 |
| Q2 2021 | 12% | 5% | 1 |
| Q1 2021 | 0% | 5% | 3 |
| Q4 2020 | 7% | 5% | 2 |
| Q3 2020 | 10% | 5% | 1 |
| Q2 2020 | 20% | 5% | 3 |
| Q1 2020 | 13% | 5% | 2 |
| Q4 2019 | 3% | 5% | 1 |
| Q3 2019 | | 5% | 1 |

Story Behind the Curve

Last Updated: November 2021

Author: Vital Records, Vermont Department of Health

Federal and state agencies rely on birth certificates for identity, proof of age, proof of citizenship, employment identification, benefit eligibility, and document origination (e.g. driver's licenses, Social Security cards, and passports). Many of those agencies use the Electronic Verification of Vital Events (EVVE) system maintained by NAPHSIS (National Association for Public Health Statistics and Information Systems) to either verify the contents of a paper birth certificate or to request an electronic certification instead of the paper birth certificate. The Department of Health contracted Ancestry.com in 2007 to enter data for approximately a quarter million birth records going back to 1909 and authorized EVVE users to send an electronic query through EVVE to verify or deny the match with the official record in the Vermont database.

Non-matches are reviewed by vital statistics staff and while most are generally due to EVVE user errors occasionally there are errors in the Vermont database. We are continuously reviewing and correcting records with the goal of a less than 5% error rate.

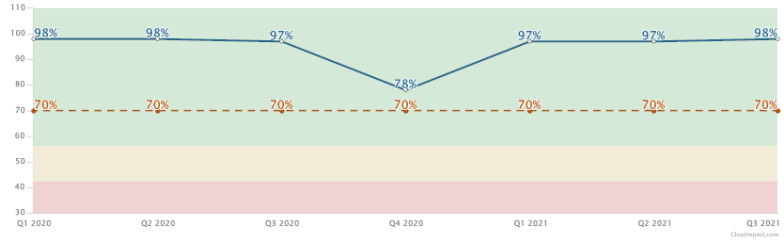
Partners

The Social Security Administration, Department of State – Passport Services, Office of Personnel Management and Vermont Department of Motor Vehicles are just some of the federal and state agencies who use Electronic Verification of Vital Events to improve business operations and customer service, and to protect against fraudulent activities.

Notes on Methodology

Birth queries/matches began in late 2014, but performance data collection began in summer 2015.

| | | | |
|---|---|---|---|
| % of births submitted to the Health Department within 5 business days of the birth | Q3 2021 | 70% | 1 |




| | | | |
|---|---|---|---|
| Q2 2021 | 97% | 70% | 1 |
| Q1 2021 | 97% | 70% | 1 |
| Q4 2020 | 78% | 70% | 2 |
| Q3 2020 | 97% | 70% | 1 |
| Q2 2020 | 98% | 70% | 1 |
| Q1 2020 | 98% | 70% | 1 |
| Q4 2019 | | 70% | 1 |
| Q3 2019 | | 70% | 1 |

Story Behind the Curve

Last Updated: November 2021

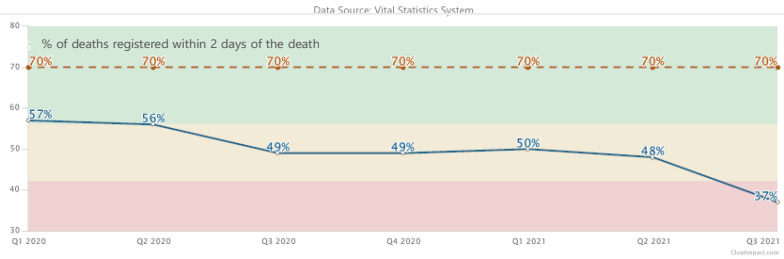
Author: Vital Records, Vermont Department of Health

Per Vermont statute, birth records shall be submitted to the Department of Health within 5 business days of the birth. Once submitted a birth record is registered in the statewide registration system and the birth certificate is immediately available for issuance at the town and state level. Birth certificates are required in order to obtain insurance and social security cards and sometimes for travel so it is imperative that birth records be submitted in a timely manner.

The decrease in timeliness in Q4 2020 was a result of the cyber attack on the University of Vermont Medical Center Health Network. Users of the Department's Electronic Birth Registration System at the University of Vermont Medical Center, Porter Medical Center, and Central Vermont Medical Center were unable to submit birth records for several weeks.

Partners

Vermont hospitals enter birth record information directly into the Health Department's Electronic Birth Registration System (EBRS). Licensed midwives who attend home births fax completed birth worksheets to the Vital Records Office where staff enter the data into the EBRS. When an unattended home birth occurs, a nurse from the Department of Health local health office helps the parents complete the birth worksheet and submits to the Vital Records Office for entry into EBRS.




| | | | |
|---|---|---|---|
| Q3 2021 | 37% | 70% | 2 |
| Q2 2021 | 48% | 70% | 1 |
| Q1 2021 | 50% | 70% | 1 |
| Q4 2020 | 49% | 70% | 1 |
| Q3 2020 | 49% | 70% | 2 |
| Q2 2020 | 56% | 70% | 1 |
| Q1 2020 | 57% | 70% | 1 |
| Q4 2019 | 49% | 70% | 1 |
| Q3 2019 | 53% | 70% | 1 |

Story Behind the Curve

Last Updated: November 2021

Author: Vital Records, Vermont Department of Health

The death certificate is a permanent legal record of the fact of death of a person and is needed by family members to obtain insurance and Social Security benefits, settle pension claims, and transfer of title of property. It is important that death certificates be available in a timely manner.

Under Vermont law, within 24 hours after a person dies the licensed health care professional who last attended that person shall certify the cause of death and communicate with the funeral director or family member handling disposition. All Vermont deaths are entered into the Department's Electronic Death Registration System (EDRS). Once the licensed health care professional certifies the cause of death and the funeral director signs the demographic section of the record in the EDRS, it is registered and the death certificate is available for issuance at the state and local (town clerk) level. The Vital Records Office runs a daily report of incomplete records and reminds funeral directors and certifiers to finish records.

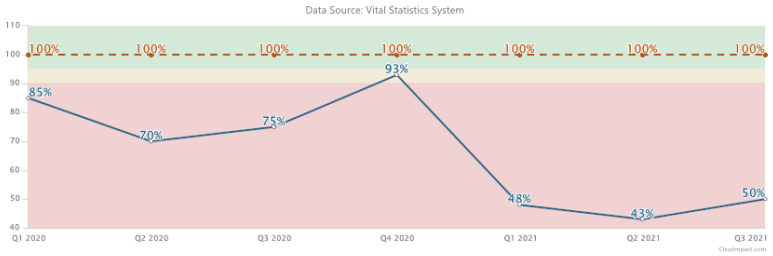
Partners

Funeral homes, physicians, physician assistants and advance practice registered nurses and staff from the Office of the Chief Medical Examiner submit death records via the Department's Electronic Death Registration System.

Notes on Methodology

Deaths in Vermont with known date of death.

| | | | |
|---|---|---|---|
| % of court orders processed within 5 business days of receipt | Q3 2021 | 100% | 1 |




| | | | |
|---|---|---|---|
| Q2 2021 | 43% | 100% | 2 |
| Q1 2021 | 48% | 100% | 1 |
| Q4 2020 | 93% | 100% | 2 |
| Q3 2020 | 75% | 100% | 1 |
| Q2 2020 | 70% | 100% | 1 |
| Q1 2020 | 85% | 100% | 2 |
| Q4 2019 | 78% | 100% | 1 |
| Q3 2019 | 72% | 100% | 2 |

Notes on Methodology

Birth corrections and name change orders for births that occurred July 1, 2005 and later.

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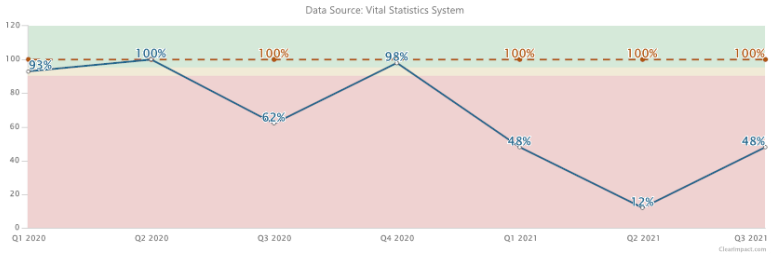
PM PHS % of adoptions processed within 5 business days of receipt




| | | | |
|---|---|---|---|
| Q3 2021 | 48% | 100% | 1 |
| Q2 2021 | 12% | 100% | 2 |
| Q1 2021 | 48% | 100% | 1 |
| Q4 2020 | 98% | 100% | 1 |
| Q3 2020 | 62% | 100% | 1 |
| Q2 2020 | 100% | 100% | 2 |
| Q1 2020 | 93% | 100% | 1 |
| Q4 2019 | 40% | 100% | 3 |
| Q3 2019 | 56% | 100% | 2 |

Story Behind the Curve

Last Updated: November 2021

Author: Vital Records, Vermont Department of Health

Within 30 days after a decree of adoption becomes final, the probate court should send a report of adoption to Vital Records which includes information to identify the adoptee's birth certificate, and information necessary to create a new birth certificate. The Vital Records Office processes the adoption in the statewide registration system and sends letters of instructions requesting copies of the original birth certificate to the town of birth, town of residence, and the Vermont State Archives and Records Administration, if relevant. The volume of adoptions received from the courts ebbs and flows weekly and processing times may vary depending on other priorities in the Vital Records Office and available staff.

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Partners

Vermont Probate Courts, Lund Home, Vermont City and Town Clerks.

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Notes on Methodology

Adoptions processed on births that occurred July 1, 2005 and later.

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# HomeShare Vermont

DAIL | Older Adults | Disabilities | GCI | homeshare

## Budget information

HomeShare VT grants:

| SFY2021 | SFY2020 | SFY2019 | SFY2018 | SFY2017 | SFY2016 |
|---|---|---|---|---|---|
| $280,000 | $279,163 | $179,940 | $179,940 | $179,940 | $179,940 |

MCO Investment Expenditures for homesharing programs: includes indirect allocations to GC MCO (per DAIL business office):

| SFY2022 plan | SFY2021 | SFY2020 | SFY2019 | SFY2018 | SFY2017 | SFY2016 |
|---|---|---|---|---|---|---|
| $342,000 | $290,034 | $308,442 | $300,494 | $345,105 | $340,882 | $339,966 |

## What We Do

HomeShare Vermont provides screening, matching and ongoing support services for older Vermonters and Vermonters with disabilities who wish to continue living in their own homes (hosts), pairing them with others (guests) who are looking for affordable housing. These matches allow people to remain at home and to receive help with yard work, light chores, homemaking services, transportation, or companionship in exchange for reduced rent from the guest.

## Who We Serve

HomeShare Vermont serves Vermonters who are looking to share housing for mutual benefit. Most people sharing their homes (hosts) are older Vermonters or Vermonters with disabilities. People looking for housing (guests) are financially challenged by market rents or are in housing transitions. HomeShare Vermont serves Chittenden, Addison, Franklin, Grand Isle, Washington, Orange, and Lamoille Counties.

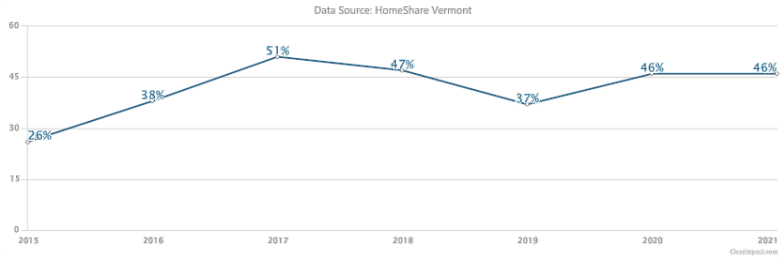
## How We Impact

HomeShare Vermont:

- Helps make housing more affordable for Vermonters
- Helps older Vermonters and Vermonters with disabilities live in their own homes
- Helps improve the quality of life for homesharing participants, who report that they feel safer, less lonely, eat better, and feel healthier

## Measures

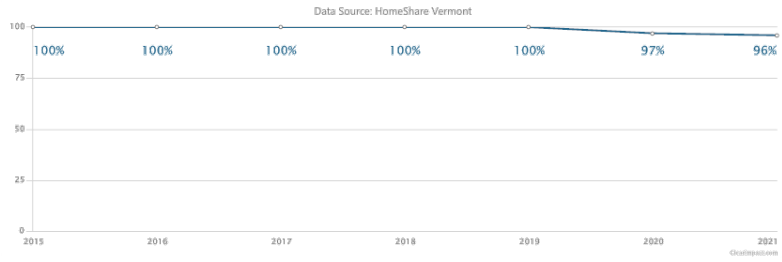
PM | DAIL | HomeShare Vermont: Percent of People who report they are able to stay safely at home because of a match




| Most Recent Period | Current Actual Value | Current Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|
| 2021 | 46% | – | → 1 | 77% ↑ |
| 2020 | 46% | – | ↗ 1 | 77% ↑ |
| 2019 | 37% | – | ↘ 2 | 42% ↑ |
| 2018 | 47% | – | ↘ 1 | 81% ↑ |
| 2017 | 51% | – | ↗ 2 | 96% ↑ |
| 2016 | 38% | – | ↗ 1 | 46% ↑ |
| 2015 | 26% | – | → 0 | 0% → |

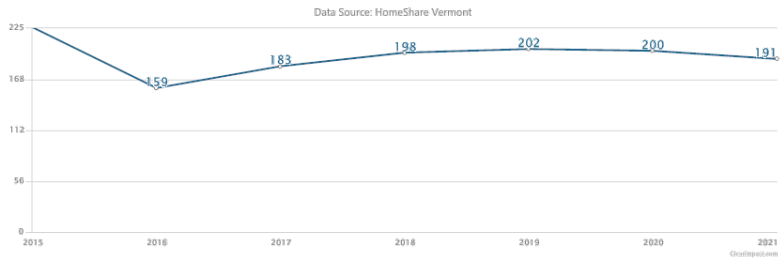
PM | DAIL | HomeShare Vermont: Percent of People who report they have improved quality of life

| | | | | |
|---|---|---|---|---|
| 2021 | 96% | – | ↘ 2 | -4% ↓ |




| | | | | |
|---|---|---|---|---|
| 2020 | 97% | – | ↘ 1 | -3% ↓ |
| 2019 | 100% | – | → 4 | 0% → |
| 2018 | 100% | – | → 3 | 0% → |
| 2017 | 100% | – | → 2 | 0% → |
| 2016 | 100% | – | → 1 | 0% → |
| 2015 | 100% | – | → 0 | 0% → |

PM DAIL HomeShare Vermont: Total Unduplicated Number of People in a Match




| | | | | |
|---|---|---|---|---|
| 2021 | 191 | – | ↘ 2 | -15% ↓ |
| 2020 | 200 | – | ↘ 1 | -12% ↓ |
| 2019 | 202 | – | ↗ 3 | -11% ↓ |
| 2018 | 198 | – | ↗ 2 | -12% ↓ |
| 2017 | 183 | – | ↗ 1 | -19% ↓ |
| 2016 | 159 | – | ↘ 1 | -30% ↓ |
| 2015 | 226 | – | → 0 | 0% → |

## Actions

| Name | Assigned To | Status | Due Date | Progress |
|---|---|---|---|---|

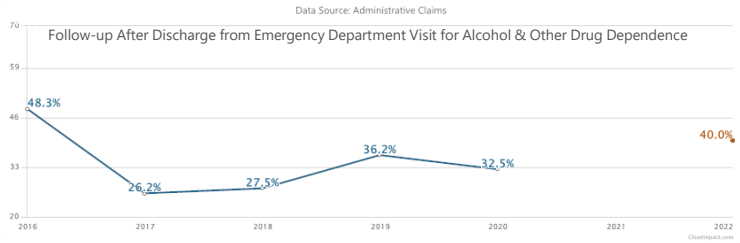
# Blueprint for Health - Community Health Teams (CHTs)

## What We Do

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

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

## Measures




| Time Period | Current Actual Value | Current Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|
| 2020 | 32.5% | | 1 | -33% |
| 2019 | 36.2% | | 2 | -25% |
| 2018 | 27.5% | | 1 | -43% |
| 2017 | 26.2% | | 1 | -46% |
| 2016 | 48.3% | | 0 | 0% |

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes, and who therefore have access to Community Health Teams. The red dot on the graph represents the target value the State aims to achieve by the year 2022 for this measure as outlined in the Vermont All-Payer ACO model Agreement. The solid blue trend line represents the actual data values for Medicaid-primary members.

This HEDIS measure shows the percent of emergency department (ED) visits for members, age 18 years and older, with a principal diagnosis of substance use disorder who had a follow-up visit for substance use disorder within 30 days of the ED visit. (NQF #2605)

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Partners

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

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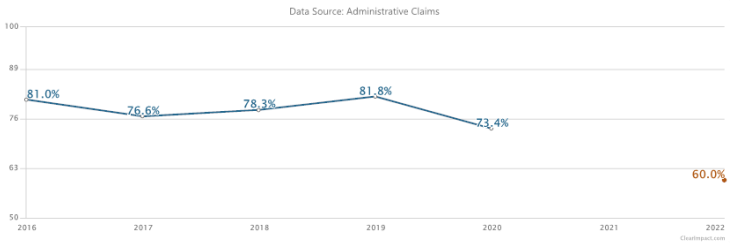
Story Behind the Curve

In support of people with substance use disorders, Vermont has committed to expanding access to treatment and services that can address factors contributing to these disorders, in much the same way that other chronic conditions are managed. This effort requires coordination and partnership among social, medical, and mental health providers. Community Health Teams play a critical role in this coordination and navigating individuals to the most appropriate level of treatment and support services. Following up with individuals who have an Emergency Department visit due to substance use is an important point of contact and an opportunity to engage a person in treatment if needed. Measuring whether this contact is made is one way to monitor the Community Health Team's engagement in the health care system. The population for this measure consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes, and who therefore have access to Community Health Teams. One factor that could have affected the outcomes was the reinstatement of eligibility redetermination after 2016, which led to a number of individuals (often healthier and younger) removed from the Medicaid rolls, thereby changing the composition of the Medicaid population. Community Health Teams, in collaboration with practices, OneCare Vermont, and community-based services, continue to work on strategies to address improving these rates.

P CH Follow-up After Discharge from Emergency Department for Mental Health




| | | | | |
|---|---|---|---|---|
| 2020 | 73.4% | | 1 | -9% |
| 2019 | 81.8% | | 2 | 1% |
| 2018 | 78.3% | | 1 | -3% |
| 2017 | 76.6% | | 1 | -5% |
| 2016 | 81.0% | | 0 | 0% |

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes, and who therefore have access to Community Health Teams. The red dot on the graph represents the target value the State aims to achieve by the year 2022 for this measure as outlined in the Vermont All-Payer ACO model Agreement. The solid blue trend line represents the State's actual values for Medicaid-primary members.

This measure shows the percent of emergency department (ED) visits for members, age 18 years and older, with a principal diagnosis of mental illness who had a follow-up visit for mental health within 30 days of the ED visit. (NQF #2605)

---

Partners

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

---

Story Behind the Curve

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

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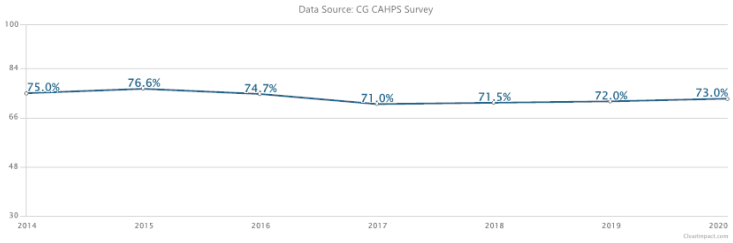
PM CHT % of Patients who Responded Yes or Always to Coordinated Care Composite, CG CAHPS Survey




| | | | | |
|---|---|---|---|---|
| 2020 | 73.0% | | 3 | -3% |
| 2019 | 72.0% | | 2 | -4% |
| 2018 | 71.5% | | 1 | -5% |
| 2017 | 71.0% | | 2 | -5% |
| 2016 | 74.7% | | 1 | 0% |
| 2015 | 76.6% | | 1 | 2% |
| 2014 | 75.0% | | 0 | 0% |

Notes on Methodology

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

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Partners

1. Patients
2. Patient-Centered Medical Homes
3. DVHA Payment Reform Unit

4. Green Mountain Care Board
5. OneCare Vermont

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Story Behind the Curve

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

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

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# Blueprint for Health - Patient Centered Medical Homes (PCMHs)

## What We Do

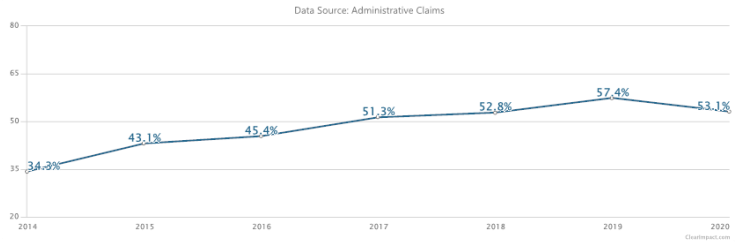
The Vermont Blueprint for Health is a nationally recognized initiative that designs community-led strategies for improving health and well-being. The Blueprint invests in and supports Patient-Centered Medical Homes, Community Health Teams, the Women's Health Initiative, Accountable Communities for Health,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

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

## Measures

PCM

### Developmental Screening in the First Three Years of Life




| Time Period | Current Actual Value | Current Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|
| 2020 | 53.1% | | 1 | 55% |
| 2019 | 57.4% | | 5 | 67% |
| 2018 | 52.8% | | 4 | 54% |
| 2017 | 51.3% | | 3 | 50% |
| 2016 | 45.4% | | 2 | 32% |
| 2015 | 43.1% | | 1 | 26% |
| 2014 | 34.3% | | 0 | 0% |

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes. This is a claim-based HEDIS measure that calculates the number of children who turned 1, 2, or 3 years of age in the measurement period who were screened for the risk of developmental, behavioral, and social delays using a standardized screening tool. (NQF #1448)

Partners

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

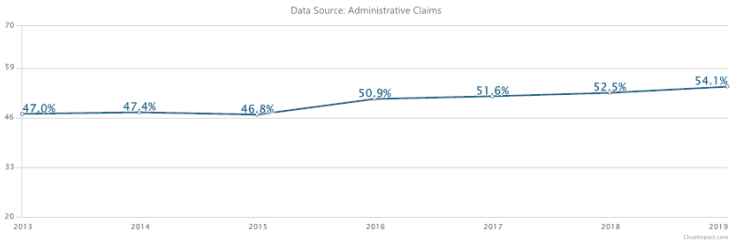
Story Behind the Curve

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

While this payment model supports all patients in the medical home, regardless of payer, the data show the statewide average for Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes. Historically, one factor that could have affected outcomes was the reinstatement of eligibility redetermination after 2016, which led to the removal of a number of individuals (often healthier and younger) from the Medicaid rolls, thereby changing the composition of the Medicaid population.

### Adolescent Well Care Visits

| Time Period | Current Actual Value | Current Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|
| 2019 | 54.1% | | 4 | 15% |




| | | | | |
|---|---|---|---|---|
| 2018 | 52.5% | | 3 | 12% |
| 2017 | 51.6% | | 2 | 10% |
| 2016 | 50.9% | | 1 | 8% |
| 2015 | 46.8% | | 1 | 0% |
| 2014 | 47.4% | | 1 | 1% |
| 2013 | 47.0% | | 0 | 0% |

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes. This is a claim-based HEDIS measure that calculates adolescents and young adults 12-21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. This measure was discontinued after Report Year 2020 / Measurement Year 2019.

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Partners

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

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Story Behind the Curve

Adolescent well-care visits provide an important opportunity to establish lifelong healthy behaviors, identify risk factors (e.g., sexual activity, substance use, depression, etc.), and intervene at an early stage if concerns are raised. However, the percent of adolescents who receive this care frequently drops off except for students participating in sports. While this payment model supports all patients in the medical home, regardless of payer, this measure shows the statewide average for Medicaid-primary members, over 70% of whom are attributed to a patient-centered medical home. Practices and communities continue their efforts to improve further upon this measure.

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

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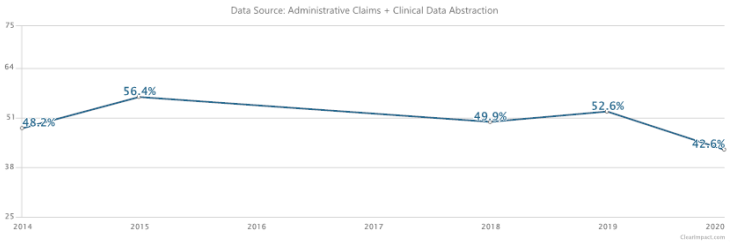
PCM Controlling High Blood Pressure




| | | | | |
|---|---|---|---|---|
| 2020 | 42.6% | | 1 | -20% |
| 2019 | 52.6% | | 1 | -1% |
| 2018 | 49.9% | | 1 | -6% |
| 2015 | 56.4% | | 1 | 6% |
| 2014 | 48.2% | | 1 | -10% |
| 2013 | 53.3% | | 0 | 0% |

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes. This is a hybrid claims/clinical HEDIS measure. The measure includes members age 18-85 years, who were identified in claims as having hypertension and for whom we had valid blood pressure readings. Those members whose blood pressure was less than 140/90 mmHG were considered to have their hypertension in control. (NQF #0018)

---

Partners

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

---

Story Behind the Curve

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

While these types of interventions and this payment model support all patients in the medical home, this measure show the statewide average for all Medicaid-primary members, of whom more than 70 % are attributed to patient-centered medical homes (PCMHs). Historically, one factor that could have affected outcomes was the reinstatement of eligibility redetermination after 2016, which led to a number of individuals (often healthier and younger) removed from the Medicaid rolls, thereby changing the composition of the Medicaid population.

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

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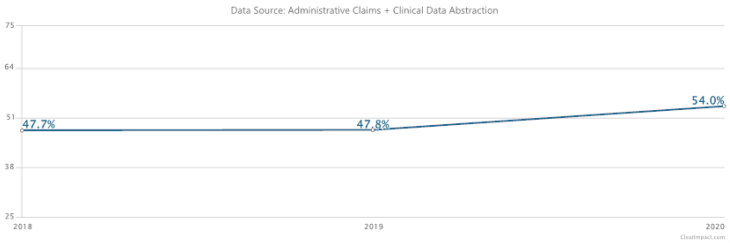
PM PCMH Diabetes in Poor Control




| | | | | |
|---|---|---|---|---|
| 2020 | 54.0% | | 2 | 13% |
| 2019 | 47.8% | | 1 | 0% |
| 2018 | 47.7% | | 0 | 0% |

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes. This is a hybrid claims/clinical HEDIS measure. The measure includes members age 18 to 75 years identified in claims as having diabetes and for whom we obtained valid HbA1c measurement data. If the HbA1c glycosylation was greater than nine percent, that member was considered "in poor control". Increasing rates indicate that the population with diabetes needs additional interventions or is in worse health. (NQF #0059)

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Partners

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

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Story Behind the Curve

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

The data show the statewide rate for Medicaid-primary members, of whom more than 70% are attributed to patient-centered medical homes (PCMHs). For this measure, lower rates are better. Efforts to improve care management continue.

The goal is for a region to perform better than the statewide average and demonstrate improvement between measurement periods or have outcomes in the 90th percentile relative to other regions. HEDIS does not benchmark this measure.

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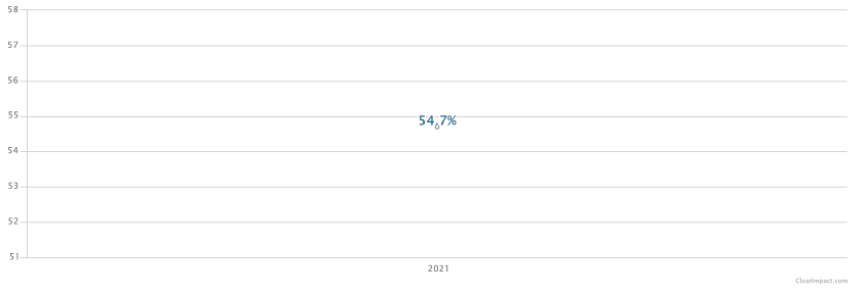
PM PCMH Child and Adolescent Well-Care Visits (WCV) (HEDIS) 3-21




| | | | | |
|---|---|---|---|---|
| 2021 | 54.7% | | 0 | 0% |

Notes on Methodology

New measure, beginning with Report Year 2021. The population sample for this measure consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes. This is a claim-based HEDIS measure that calculates the proportion of children and adolescents 3-21 years of age who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.

Partners

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

Story Behind the Curve

Child and adolescent well-care visits provide an important opportunity to establish lifelong healthy behaviors, identify risk factors (e.g., sexual activity, substance use, depression, etc.), and intervene at an early stage if concerns are raised. However, the percent of adolescents who receive this care frequently drops off except for students participating in sports. While this payment model supports all patients in the medical home, regardless of payer, this measure show the statewide average for Medicaid-primary members, over 70% of whom are attributed to a patient-centered medical home. Practices and communities continue their efforts to improve further upon this measure.

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

# Blueprint for Health - Women's Health Initiative

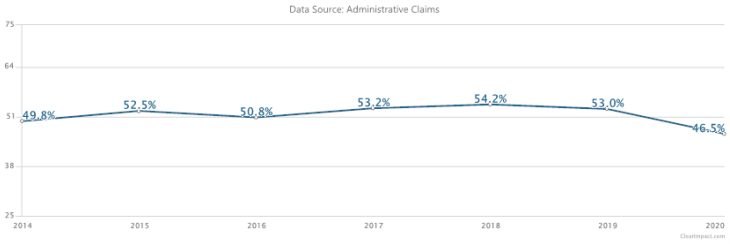
## What We Do

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

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

## Measures

### % of Chlamydia Screening in Women




| Time Period | Current Actual Value | Current Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|
| 2020 | 46.5% | | 2 | -8% |
| 2019 | 53.0% | | 1 | 5% |
| 2018 | 54.2% | | 2 | 7% |
| 2017 | 53.2% | | 1 | 5% |
| 2016 | 50.8% | | 1 | 0% |
| 2015 | 52.5% | | 1 | 4% |
| 2014 | 49.8% | | 1 | -2% |
| 2013 | 50.6% | | 0 | 0% |

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes. This measure shows the percentage of female members, ages 16 to 24, identified as sexually active and who had at least one test for chlamydia in the measurement year. This measure is derived from claims data.

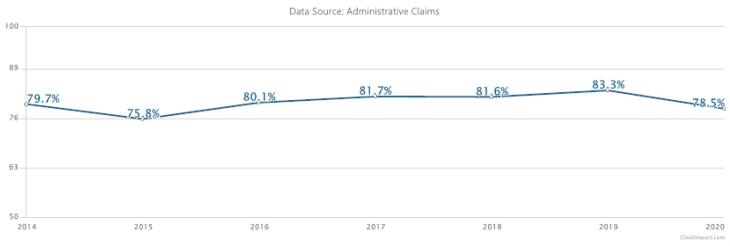
Partners

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

Story Behind the Curve

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

### Adults' Access to Preventive/Ambulatory Health Services




| Time Period | Current Actual Value | Current Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|
| 2020 | 78.5% | | 1 | -10% |
| 2019 | 83.3% | | 1 | -5% |
| 2018 | 81.6% | | 1 | -7% |
| 2017 | 81.7% | | 2 | -6% |
| 2016 | 80.1% | | 1 | -8% |
| 2015 | 75.8% | | 2 | -13% |
| 2014 | 79.7% | | 1 | -9% |
| 2013 | 87.3% | | 0 | 0% |

Notes on Methodology

The population sample for this measure consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes. This measure shows the percentage of Medicaid-primary members 20 years and older who had an ambulatory or preventive care visit during the measurement year.

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

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

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Partners

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

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Story Behind the Curve

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

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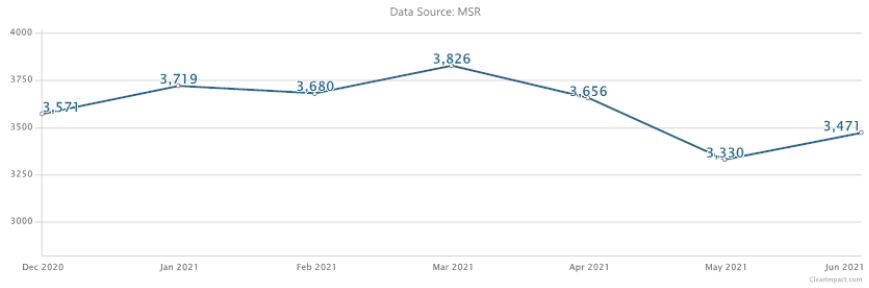
# DMH Value Based Payment Measures

## How_Much VBP: Number of Individuals Served

How_Much Number of children/youth (0-17) served




| Most Recent Period | Current Actual Value | Current Target Value | Current Trend |
|---|---|---|---|
| Jun 2021 | 3,471 | | |
| May 2021 | 3,330 | | |
| Apr 2021 | 3,656 | | |
| Mar 2021 | 3,826 | | |
| Feb 2021 | 3,680 | | |
| Jan 2021 | 3,719 | | |
| Dec 2020 | 3,571 | | |
| Nov 2020 | 3,478 | | |
| Oct 2020 | 3,132 | | |
| Sep 2020 | 2,971 | | |
| Aug 2020 | 3,615 | | |
| Jul 2020 | 3,052 | | |
| Jun 2020 | 3,278 | | |
| May 2020 | 3,165 | | |
| Apr 2020 | 3,219 | | |
| Mar 2020 | 3,575 | | |
| Feb 2020 | 3,534 | | |
| Jan 2020 | 3,602 | | |
| Dec 2019 | 3,478 | | |
| Nov 2019 | 3,503 | | |
| Oct 2019 | 3,556 | | |
| Sep 2019 | 3,166 | | |
| Aug 2019 | 3,113 | | |
| Jul 2019 | 3,200 | | |
| Jun 2019 | 3,185 | | |
| May 2019 | 3,270 | | |
| Apr 2019 | 3,317 | | |
| Mar 2019 | 3,268 | | |
| Feb 2019 | 3,092 | | |
| Jan 2019 | 3,218 | | |

Story Behind the Curve

The Department of Mental Health monitors the number of children and youth served under payment reform but does not set a target for growth. The goal of payment reform is not necessarily to serve more clients, as the payment model does not come with additional resources. However, DMH is interested in whether the new payment model has an impact on access to care and the ability to serve more Vermonters.

Although the numbers served experienced a decrease due to COVID-19, overall, the payment model was seen as integral to the stabilization of our community mental health services. The prospective payments provided fiscal stability while the agencies utilized flexibilities to serve clients via telehealth or outdoors per safety guidelines. The agencies were able to weather the core of the impact from April - September and climb back up to their previous baseline. Additionally, DMH and DVHA supported agencies with federal COVID Relief funds to maintain access with clients through technology and with appropriate PPE, contributing to their ability to serve individuals safely.

## Partners

The ten Designated Agencies providing services to children and families, as well as their umbrella agency Vermont Care Partners.

## What Works

## Strategy

## Notes on Methodology

The total non-duplicated number of children/youth (0-17) served by Designated Agencies regardless of payer.

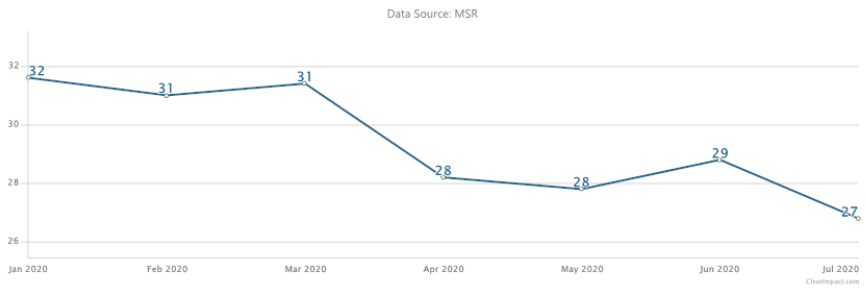
Data analyzed from Monthly Service Reporting system. Clients counted if they received one qualifying service within the month. Qualifying services are those that count a person toward the caseload and allow the agency to earn the full PMPM for that client.

For any given year of service (Jan - Dec):

- Pull MSR services
- Calculate age of client from the midpoint of the service year (June 30, XXXX)
- Select clients who are aged 0-17
- Aggregate to clinic client level, with flag for total services during fiscal year
- Select clients who have a least 1 unit (as defined in the *Provider Manual*)

Report figure on a designated agency level basis

How_Much Number of eligible children/youth (0-17) served [per 1,000 children residents]




| | |
|---|---|
| Jul 2020 | 27 |
| Jun 2020 | 29 |
| May 2020 | 28 |
| Apr 2020 | 28 |
| Mar 2020 | 31 |
| Feb 2020 | 31 |
| Jan 2020 | 32 |
| Dec 2019 | 31 |
| Nov 2019 | 31 |
| Oct 2019 | 31 |
| Sep 2019 | 28 |
| Aug 2019 | 27 |
| Jul 2019 | 28 |

| | |
|---|---|
| Jun 2019 | 28 |
| May 2019 | 29 |
| Apr 2019 | 29 |
| Mar 2019 | 29 |
| Feb 2019 | 27 |
| Jan 2019 | 28 |

## Story Behind the Curve

This measure is used to monitor the penetration rate of a catchment area for an age-specific population, and to provide information about the population health.

**updates for this measure are pending information from the American Community Survey, which has been delayed due to COVID-19.*

Services provided to children and families in the community mental health system have historically been seasonally affected, and we expect to see the regular ups and downs continue. Additionally, it should be noted we expect a decrease in volume of service provided due to the COVID 19 pandemic. DMH and DVHA have supported the agencies with COVID Relief funds to maintain access with clients through technology and with appropriate PPE. We do not expect to see the number of clients served to decrease as much as the overall volume due to COVID, given most agencies are able to serve all clients at least once in the month.

## Partners

The ten Designated Agencies providing services to children and families, as well as their umbrella agency Vermont Care Partners.

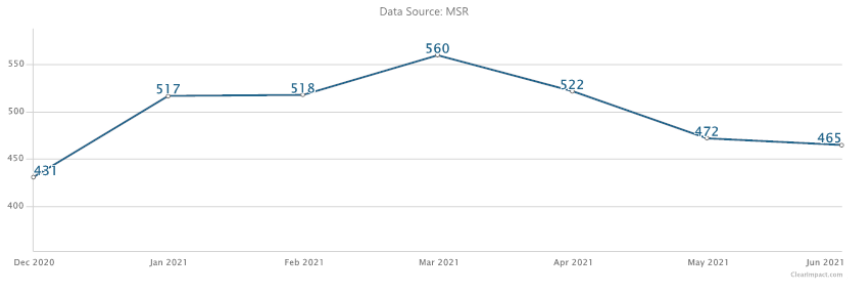
## What Works

## Strategy

## Notes on Methodology

Data for this measure is unable to be updated. This data is built using information from the American Community Survey (ACS). For 2020, the collection and analysis was impacted by COVID-19. An experimental estimate is expected on 11/30. For more information, visit this page: https://www.census.gov/programs-surveys/acs/data/experimental-data.html

Number of young adults (18-21) served




| | |
|---|---|
| Jun 2021 | 465 |
| May 2021 | 472 |
| Apr 2021 | 522 |
| Mar 2021 | 560 |
| Feb 2021 | 518 |
| Jan 2021 | 517 |
| Dec 2020 | 431 |
| Nov 2020 | 408 |
| Oct 2020 | 409 |
| Sep 2020 | 393 |
| Aug 2020 | 451 |
| Jul 2020 | 409 |
| Jun 2020 | 449 |
| May 2020 | 437 |

| | | | |
|---|---|---|---|
| Apr 2020 | 463 | | |
| Mar 2020 | 495 | | |
| Feb 2020 | 516 | | |
| Jan 2020 | 514 | | |
| Dec 2019 | 371 | | |
| Nov 2019 | 379 | | |
| Oct 2019 | 416 | | |
| Sep 2019 | 382 | | |
| Aug 2019 | 395 | | |
| Jul 2019 | 396 | | |
| Jun 2019 | 444 | | |
| May 2019 | 456 | | |
| Apr 2019 | 485 | | |
| Mar 2019 | 492 | | |
| Feb 2019 | 483 | | |
| Jan 2019 | 522 | | |

## Story Behind the Curve

This measure is used to monitor the total number of transition aged youth served by the Designated Agencies to further the State's understanding of this age group. DMH has identified a need for better coordination and a smoother transition from child and adolescent services into adult services. By acting as the denominator in other measures, this helps the State to assess the breadth of impact of other work performed by the Designated Agencies.

Numbers served appear to cycle through the calendar year, with increases at the beginning of the year and then decreasing over time. DMH will be reviewing this data with the designated agencies to better understand what appears to be a 12 month cycle for changes in numbers served.

## Partners

The ten Designated Agencies providing services to children and families, as well as their umbrella agency Vermont Care Partners.

## What Works

## Strategy

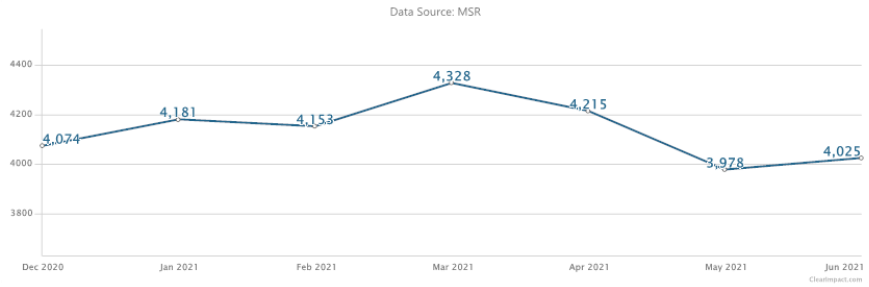
## Notes on Methodology

For any given year of service (Jan - Dec):

- Pull MSR services
- Calculate age of client from the midpoint of the service year (June 30, XXXX)
- Select clients who are aged 18-21
- Aggregate to clinic client level, with flag for total services during fiscal year
- Select clients who have a least 1 unit (as defined in the *Provider Manual*)

Report figure on a designated agency level basis
The age of the individual served is captured as "point in time" and thus an individual may be served by more than one age-specific program in the calendar year, but they will only be captured in one. These counts are designed to help us understand the total number of clients each program served and are not used to inform the case rates.

How_Much Number of Adults served




| | |
|---|---|
| Jun 2021 | 4,025 |
| May 2021 | 3,978 |
| Apr 2021 | 4,215 |
| Mar 2021 | 4,328 |
| Feb 2021 | 4,153 |
| Jan 2021 | 4,181 |
| Dec 2020 | 4,074 |
| Nov 2020 | 4,128 |
| Oct 2020 | 4,031 |
| Sep 2020 | 3,887 |
| Aug 2020 | 4,324 |
| Jul 2020 | 3,851 |
| Jun 2020 | 3,945 |
| May 2020 | 3,834 |
| Apr 2020 | 3,948 |
| Mar 2020 | 4,017 |
| Feb 2020 | 3,901 |
| Jan 2020 | 4,023 |
| Dec 2019 | 3,821 |
| Nov 2019 | 3,879 |
| Oct 2019 | 4,007 |
| Sep 2019 | 4,102 |
| Aug 2019 | 4,168 |
| Jul 2019 | 4,151 |
| Jun 2019 | 4,112 |
| May 2019 | 4,114 |
| Apr 2019 | 4,261 |
| Mar 2019 | 4,214 |
| Feb 2019 | 4,121 |
| Jan 2019 | 4,200 |

## Story Behind the Curve

The Department of Mental Health monitors the number of children and youth served under payment reform but does not set a target for growth. The goal of payment reform is not necessarily to serve more clients, as the payment model does not come with additional resources. However, DMH is interested in whether the new payment model has an impact on access to care and the ability to serve more Vermonters. This measure is used to monitor the total number of clients served by the Designated Agency, and to further the State's understanding of changes and/or variations in the mental health needs of the catchment area. By acting as the denominator in other measures, this helps the State to assess the breadth of impact of other work performed by the Designated Agencies.

The number of adults served appeared to decrease at the end of 2019, however it has maintained a fairly steady increase since that time. Despite the impact of the COVID-19 pandemic, overall, the payment model is seen as integral to the stabilization of our community mental health services. The prospective payments provided fiscal stability while the agencies utilized flexibilities to serve clients via telehealth or outdoors per safety guidelines. The agencies were able to weather the core of the impact from April - September and climb back up to their previous baseline. Additionally, DMH and DVHA supported agencies with federal COVID Relief funds to maintain access with clients through technology and with appropriate PPE, contributing to their ability to serve individuals safely.

## Partners

The ten Designated Agencies providing services to children and families, as well as their umbrella agency Vermont Care Partners.

## What Works

## Strategy

## Notes on Methodology

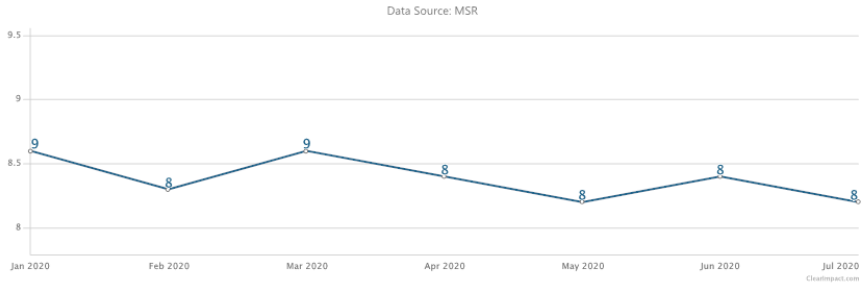
For any given year of service (Jan - Dec):

- Pull MSR services
- Calculate age of client from the midpoint of the service year (June 30, XXXX)
- Select clients who are aged 18 or older
- Aggregate to clinic client level, with flag for total services during fiscal year
- Select clients who have a least 1 unit (as defined in the *Provider Manual*)

Report figure on a designated agency level basis

The age of the individual served is captured as “point in time” and thus an individual may be served by more than one age-specific program in the calendar year, but they will only be captured in one. These counts are designed to help us understand the total number of clients each program served and are not used to inform the case rates.

I How_Much Number of adults served [per 1,000 residents]




| | | | |
|---|---|---|---|
| Jul 2020 | 8 | | |
| Jun 2020 | 8 | | |
| May 2020 | 8 | | |
| Apr 2020 | 8 | | |
| Mar 2020 | 9 | | |
| Feb 2020 | 8 | | |
| Jan 2020 | 9 | | |
| Dec 2019 | 8 | | |
| Nov 2019 | 8 | | |
| Oct 2019 | 9 | | |
| Sep 2019 | 9 | | |
| Aug 2019 | 9 | | |
| Jul 2019 | 9 | | |
| Jun 2019 | 9 | | |
| May 2019 | 9 | | |
| Apr 2019 | 9 | | |
| Mar 2019 | 9 | | |
| Feb 2019 | 9 | | |
| Jan 2019 | 9 | | |

## Story Behind the Curve

This measure is used to monitor the penetration rate of a catchment area for an age-specific population, and to provide information about the population health.

Numbers served appeared to decrease at the end of 2019. DMH is currently reviewing whether data reporting was inaccurate during that time. Some of our network agencies went through a difficult electronic record transition in the fall of 2019 that may have suppressed service reporting.

## Partners

The ten Designated Agencies providing services to children and families, as well as their umbrella agency Vermont Care Partners.

## What Works

## Strategy

## Notes on Methodology

Data for this measure is unable to be updated. This data is built using information from the American Community Survey (ACS). For 2020, the collection and analysis was impacted by COVID-19. An experimental estimate is expected on 11/30. For more information, visit this page: https://www.census.gov/programs-surveys/acs/data/experimental-data.html

For any given year of service (Jan - Dec):

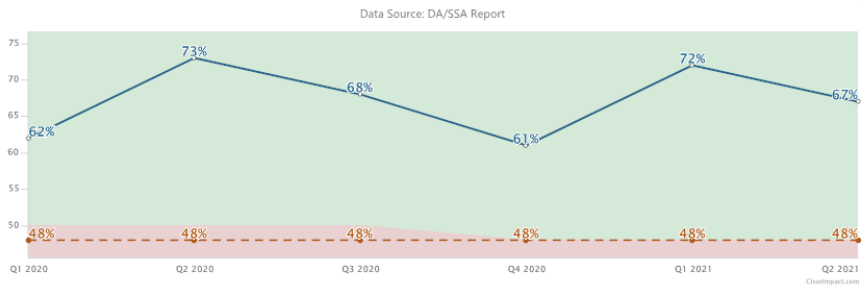
- Follow steps for measure 8(Number of Adults (18+) served)
- Request most recent demographic data from VDH on a catchment level basis
- Calculate per capita rate based on formula below

> The rates of clients served per 1,000 population are presented as a comparable standardized measure of the proportion of the residents of specified geographical regions who are served by specified programs. This utilization rate is computed according to the formula:
>
> R = 1,000 C / P

where R is the rate of clients served per 1,000 population, C is the number of clients served, and P is the age-specific population of the geographic area in question.

Report figure on a designated agency level basis.

How Well VBP: How Well Individuals Were Served




| | Most Recent Period | Current Actual Value | Current Target Value | Current Trend |
|---|---|---|---|---|
| Q1 2021 | | 72% | 48% | 1 |
| Q4 2020 | | 61% | 48% | 2 |
| Q3 2020 | | 68% | 48% | 1 |
| Q2 2020 | | 73% | 48% | 1 |
| Q1 2020 | | 62% | 48% | 0 |

## Story Behind the Curve

Data from Calendar Year 2020 was analyzed to set a target for 2021. Although as a system, the mean is well above the target, there are 2 out of 10 agencies who have yet to meet this performance measure target, indicating the target remains attainable yet motivating. When faced with the COVID-19 pandemic, the Department of Mental Health formally adjusted the definition of "face to face" to include telehealth visits.

A few agencies have adjusted their intake process to allow for same day appointments in an effort to improve upon this measure. This is an indication that the measure is changing behavior in the community mental health system due to the close monitoring of this data and the incentive to improve.

## Partners

All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

## What Works

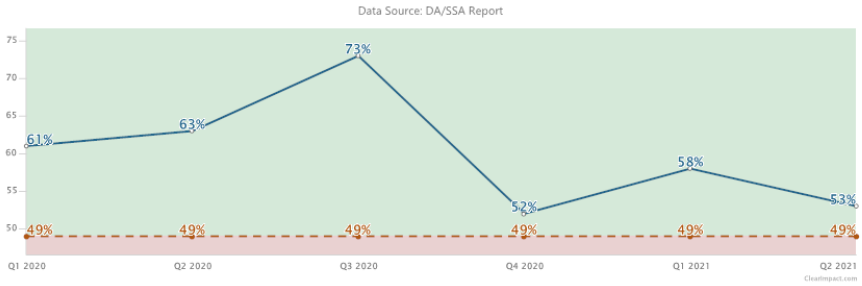
## Strategy

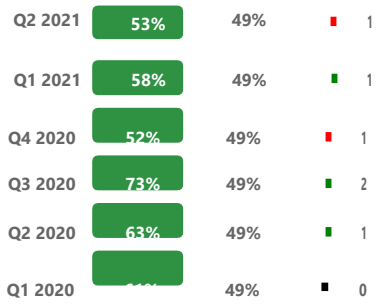
## Notes on Methodology

Calculate each person's wait between when the person called, and the first appointment offered:

- Numerator = # of inactive clients offered a face to face (or telehealth) appointment within five calendar days
- Denominator = Total # of inactive clients calling saying they need help.

How_Wel Percentage of clients seen for treatment within 14 calendar days of assessment




## Story Behind the Curve

The Department of Mental Health adopted this measure because clients who receive continuous care are more likely to remain engaged in care. The target was set based on an analysis of calendar year 2020 data. This measure has been impacted by the COVID-10 pandemic. Although many agencies were able to continue to offer timely initial intake appointments, often through telehealth, the percentage of clients seen for follow up treatment within 14 days experienced a decrease. The rationale for this is extensive disruptions in staff and client's lives, such as illness, quarantine, and child care issues, making follow through on scheduled visits more difficult. The Department will continue to monitor performance as these disruptions become less intense to determine whether an adjustment in target is necessary.

## Partners

All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

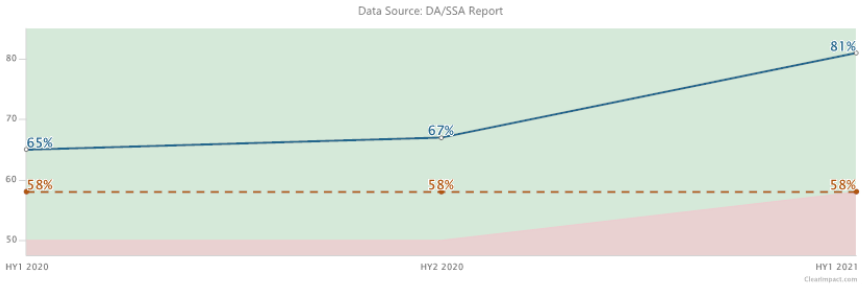
## What Works

## Strategy

## Notes on Methodology

- Numerator = # of clients seen face to face (or telehealth) for any clinically indicated service within 14 days after intake assessment (psychosocial assessment)
- Denominator = Total # of previously inactive clients with an intake who have a face to face (or telehealth) follow-up service in the calendar year

How_Well Percentage of clients with a CANS update recorded within the last 6 months.




| | | | |
|---|---|---|---|
| HY1 2021 | 81% | 58% | 2 |
| HY2 2020 | 67% | 58% | 1 |
| HY1 2020 | | 58% | 0 |

## Story Behind the Curve

The Child and Adolescent Needs and Strengths assessment (CANS) was implemented January 1, 2020. Providers are to administer the tool prior to developing the treatment plan, and then again every six months for progress monitoring. This metric illustrates a moderately successful first year of implementation, for which the target was based on, followed by a large increase in implementation in 2021. The significant improvement in adoption of the CANS, up to 81% is very encouraging. The implementation has been supported with a very committed statewide CANS implementation team, which includes providers and supervisors as well as state leaders. Barriers to implementation are discussed and problems and solutions are shared across agencies. The Department of Mental Health will continue to evaluate the performance on this measure and determine whether the target should be adjusted for future years.

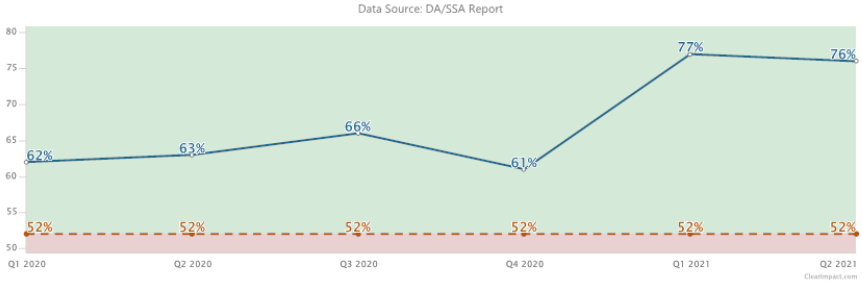
## Partners

## What Works

## Strategy

## Notes on Methodology

Percentage of adult clients screened for substance use.




| | | | |
|---|---|---|---|
| Q2 2021 | | 52% | 1 |
| Q1 2021 | 77% | 52% | 1 |
| Q4 2020 | 61% | 52% | 1 |
| Q3 2020 | 66% | 52% | 2 |
| Q2 2020 | 63% | 52% | 1 |
| Q1 2020 | | 52% | 0 |

## Story Behind the Curve

The Department of Mental Health utilized calendar year 2020 data to determine the target for CY21 for the percentage of clients screened for substance use with the CAGE-AID. There was some initial concern that providers would be less able to ensure adherence to screening workflows due to the COVID-19 pandemic and ensuing remote work increases. However, federal funding to support remote technology and a strong commitment from the community mental health agencies to continue quality care resulted in an increase in CY21 on the utilization of the CAGE-AID screening tool. DMH will continue to monitor performance over the coming year to determine if future targets need to be adjusted.

## Partners

All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric

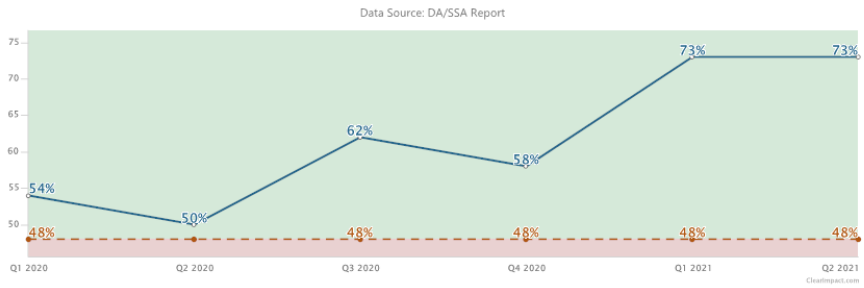
## What Works

## Strategy

## Notes on Methodology

- Numerator = # of adult clients with a new episode of care screened for substance use using the CAGE-AID
- Denominator = Total # of adult clients with a new episode of care in the time frame with an initial assessment

How_We Percentage of clients screened for psychological trauma history




| | | | |
|---|---|---|---|
| Q2 2021 | 73% | 48% | 1 |
| Q1 2021 | 73% | 48% | 1 |
| Q4 2020 | 58% | 48% | 1 |
| Q3 2020 | 62% | 48% | 1 |
| Q2 2020 | 50% | 48% | 1 |
| Q1 2020 | | 48% | 0 |

## Story Behind the Curve

The Department of Mental Health utilized calendar year 2020 data to determine the target for CY21 for the percentage of clients screened for psychological trauma using the PC-PTSD-5. There was some initial concern that providers would be less able to ensure adherence to screening workflows due to the COVID-19 pandemic and ensuing remote work increases. However, federal funding to support remote technology and a strong commitment from the community mental health agencies to continue quality care resulted in an increase in CY21 on the utilization of the PC-PTSD-5 screening tool. DMH will continue to monitor performance over the coming year to determine if future targets need to be adjusted.

## Partners

All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

## What Works

## Strategy

## Notes on Methodology

- Numerator = # of adult clients with a new episode of care screened for psychological trauma history using the PC-PTSD-5
- Denominator = Total # of adult clients with a new episode of care in the time frame with an initial assessment

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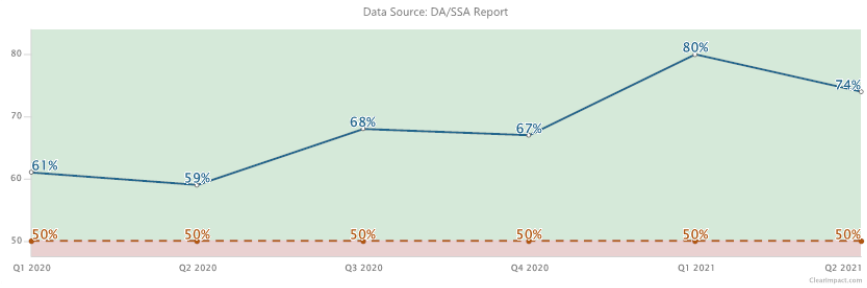
How_We Percentage of clients screened for depression




| | | | |
|---|---|---|---|
| Q2 2021 | 74% | 50% | 1 |
| Q1 2021 | 80% | 50% | 1 |
| Q4 2020 | 67% | 50% | 1 |
| Q3 2020 | 68% | 50% | 1 |
| Q2 2020 | 59% | 50% | 1 |
| Q1 2020 | [illegible] | 50% | 0 |

## Story Behind the Curve

The Department of Mental Health utilized calendar year 2020 data to determine the target for CY21 for the percentage of clients screened for depression using the PhQ2/9. There was some initial concern that providers would be less able to ensure adherence to screening workflows due to the COVID-19 pandemic and ensuing remote work increases. However, federal funding to support remote technology and a strong commitment from the community mental health agencies to continue quality care resulted in an increase in CY21 on the utilization of the PhQ2/9 screening tool. DMH will continue to monitor performance over the coming year to determine if future targets need to be adjusted.

## Partners

All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

## What Works

## Strategy

## Notes on Methodology

- Numerator = # of adult clients with a new episode of care screened for depression using the PHQ-9
- Denominator = Total # of adult clients with a new episode of care in the time frame with an initial assessment

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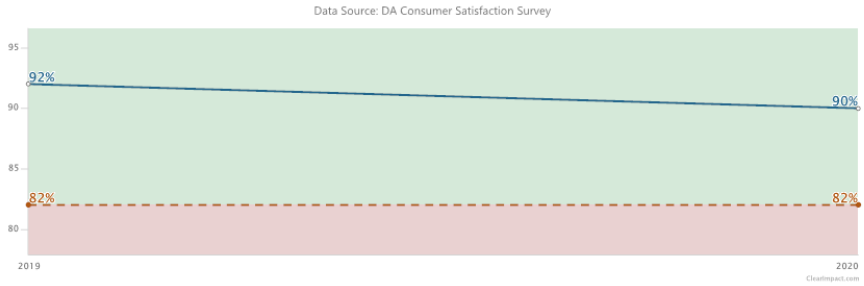
O How_Well VBP: Survey Measures

How_Well Percentage of clients indicate services were "right" for them

| Most Recent | Current Actual Value | Current Target | Current Trend |
|---|---|---|---|
| 2020 | [illegible] | 82% | 1 |




| | | | |
|---|---|---|---|
| 2019 | | 82% | 0 |

## Story Behind the Curve

This measure provides agency with client feedback about their perception of whether services were the “best fit” for their needs. When interpreted alongside the other Universal Consumer Satisfaction Survey (UCSS) questions, provides information about the agency’s ability to meet the client’s needs. Agencies performed well above target on aggregate for this measure but experienced a slight decrease in performance from the previous year. It is important to note that this survey was conducted prior to the COVID-19 pandemic. All survey data reported for value-based payment will be reflecting services from the year prior. Agencies are concerned the surveys they sent out in 2020 to be analyzed next year may reflect lower scores due to impacts of the pandemic, however they are on track for conducting that survey as planned.

## Partners

All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

## What Works

## Strategy

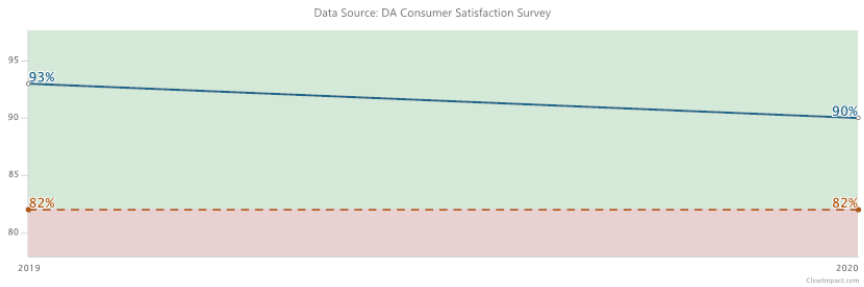
## Notes on Methodology

Annual.  At the time of review, agencies are required to submit their most recent, complete survey results.

- Numerator = # of responses endorsing the 2 positive Likert options (4 or 5 on the survey)
- Denominator = Total # of responses

I How_Well Percentage of clients indicate they received the services they “needed”

| | | | |
|---|---|---|---|
| 2020 | 90% | 82% | 1 |
| 2019 | 93% | 82% | 0 |



## Story Behind the Curve

Provides agency with client feedback about their perception of whether services were the “best fit” for their needs. When interpreted alongside the other Universal Consumer Satisfaction Survey (UCSS) questions, provides information about the agency’s ability to meet the client’s needs. The agencies performed well above target on aggregate for this survey item but experienced a slight decrease compared to the previous year. It is important to note that this survey was conducted prior to the COVID-19 pandemic. All survey data reported for value-based payment will be reflecting services from the year prior. Agencies are concerned the surveys they sent out in 2020 to be analyzed next year may reflect lower scores due to impacts of the pandemic, however they are on track for conducting that survey as planned.

## Partners

All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

## What Works

## Strategy

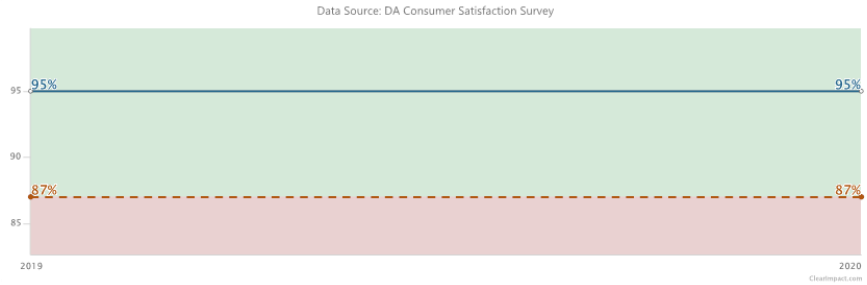
## Notes on Methodology

Annual.  At the time of review, agencies are required to submit their most recent, complete survey results.

- Numerator = # of responses endorsing the 2 positive Likert options (4 or 5 on the survey)
- Denominator = Total # of responses

How_We | Percentage of clients indicate they were treated with respect

| | | | |
|---|---|---|---|
| 2020 | 95% | 87% | 1 |
| 2019 | 95% | 87% | 0 |




## Story Behind the Curve

Provides agency with client feedback about their perception of whether staff were respectful. When interpreted alongside the other Universal Consumer Satisfaction Survey (UCSS) questions, provides information about the agency’s ability to meet the client’s needs. The agencies performed well above target on aggregate for this survey item.  It is important to note that this survey was conducted prior to the COVID-19 pandemic. All survey data reported for value-based payment will be reflecting services from the year prior. Agencies are concerned the surveys they sent out in 2020 to be analyzed next year may reflect lower scores due to impacts of the pandemic, however they are on track for conducting that survey as planned.

## Partners

All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

## What Works

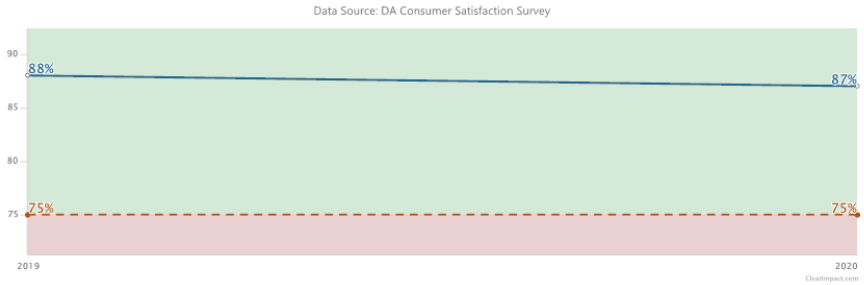
## Strategy

## Notes on Methodology

Annual.  At the time of review, agencies are required to submit their most recent, complete survey results.

- Numerator = # of responses endorsing the 2 positive Likert options (4 or 5 on the survey)
- Denominator = Total # of responses

I Better_Off Percentage of clients indicate services made a difference




| | | | |
|---|---|---|---|
| 2020 | | 75% | 1 |
| 2019 | | 75% | 0 |

## Story Behind the Curve

Provides agency with client feedback about their perception of whether services made an impact on their wellbeing. When interpreted alongside the other Universal Consumer Satisfaction Survey (UCSS) questions, provides information about the agency's ability to meet the client's needs. The agencies performed well above target on aggregate for this survey item, with a slight decrease of 1% point from the previous year.  It is important to note that this survey was conducted prior to the COVID-19 pandemic. All survey data reported for value-based payment will be reflecting services from the year prior. Agencies are concerned the surveys they sent out in 2020 to be analyzed next year may reflect lower scores due to impacts of the pandemic, however they are on track for conducting that survey as planned.

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## What Works

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