State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 18
(7/1/2022 – 12/31/2022)

Quarterly Report for the period
July 1, 2022 – September 30, 2022

Resubmitted Via PMDA Portal on December 21, 2022

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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 the 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.

2022: On June 28, 2022, Vermont received approval for a five-and-a-half-year extension of the Global Commitment to Health 1115 waiver, effective July 1, 2022, through December 31, 2027. This extension will

enable the state to continue to test, monitor, and evaluate a managed care-like delivery system, home and community-based services, and novel pilot programs, as well as pursue innovations to maintain high-quality services and programs that are cost-effective. Overall, the demonstration extension will continue to promote health equity by expanding coverage and access to services.

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is a quarterly report for waiver year 18, covering the period from July 1, 2022, through September 30, 2022 (QE092022).***

II. Outreach/Innovative Activities

i. Member and Provider Services

Key updates from QE092022:

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

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

<u>NEMT Update</u>

Third quarter calendar year 2022 trip numbers for transportation-eligible VT Medicaid members through DVHA's non-emergency medical transportation contractor appear to have somewhat leveled off compared to the same period last calendar year, although the impact of Covid still has kept the number of ride requests lower than

pre-Covid times. In this three-month period last year, the contractor provided only 2,000 fewer trips than in this same quarter this year. The number of program-related complaints stayed fairly constant during the same period last year, with overall complaint numbers remaining well below the contracted performance standard of 5% of all rides provided (maintaining a rate of less than 1%).

Coordination of Benefit Activity

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

Areas of activities:

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

Coordination of Benefit Collection Table:

MPS - Coordination Recovery Activities "Q2"	
Casualty	$502,260.07
Estate	$205,382.18
Third-Party & Court-Ordered Medical	$228,857.10
Medicare Prescription Drug Premium/Claims	$113,243.47
Over Resource/Hospice/Patient Share/Credit Balance	$177,117.12
Annuity/Trust/Waiver	$37,086.22
Lamp/Map, Medicare Claim Recoupment	$352,692.99
Third-Party Claim Recoupment	$51,107.59
Total	**$1,667,746.74**

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

Coordination of Benefit-Cost Avoidance Table:

Cost Avoidance "Q2"	
Third-Party Liability	$21,344,297.88
Medicare	$115,324,798.03
Total	**$136,669,095.91**

CMS Interoperability and Patient Access-Daily Transmission of MMA and Buy-in files

The MMIS Project to implement multiple CMS requirements specified in the Interoperability and Patient Access final rule (CMS-9115-F) to improve patient access to their health information will have a phased rollout in preparation for the complete solution implementation by January 1st, 2023.

- This effort will enable Vermont Medicaid members to use a smartphone, tablet, or personal computer to access their health data. This data will be viewed via a third-party app on a smart device of the members' choice. The data will include Patient Health Data (Claims, Clinical (available 2023), and Pharmacy), Preferred Drug List data, and Provider Directory data.

- The implementation of the Application Programming Interface (API) has been executed with a successful go-live and notification to third-party apps. The phased roll-out of two pilots has begun to gain user experience downloading the apps and to measure the accuracy of claims and pharmacy data. Pilot #1 commenced in September 2022 and remains in progress. The second pilot will commence in November 2022 with additional members to gain user experience downloading the apps and additionally gain user expectations.
- The implementation of clinical data is underway with the testing of files. The full public roll-out will occur once the clinical transfer of data and an additional user pilot are complete.

The Daily Transmission of the MMA and Buy-In files project was divided into three phases: migration to the use of Globalscape to send and receive files to CMS, requirements, system design and implementation of Buy-in file daily exchange, and lastly; requirements, system design and implementation of MMA file daily exchange.

- All phases of this project have been completed, including the successful implementation of the Daily Buy-in Files and the Daily MMA file exchanges with CMS. The Daily Buy-In File(s) exchanges were implemented on 2/1/22, before the deadline, and without incident. The Daily MMA File Exchange was implemented timely on 4/1/22. The Daily File Exchange part of the Interoperability was completed early/on time and within budget.

Payer Initiated Eligibility

Payer Initiated Eligibility (PIE) is data-matching with health entities to recover Medicaid monies. Medicaid can recover monies paid that should have been paid by another insurer or liable party for three years from the claim date of service. Currently, the PIE process/data-matching is a very manual process the MPS unit of DVHA manages and measures performance.

The Payer Initiated Eligibility (PIE) project restarted, completing requirements such as Globalscape event

configuration and ACCESS system designs. Gainwell Technologies is working on the file matching and sorting algorithm. MPS staff have been performing quality control reviews of the algorithm and algorithm updates, allowing the algorithm creation process to continue.

The informal testing or quality control efforts of MPS have resulted in a continually improving process. Informal Globalscape testing and ACCESS system uploading has been done resulting in the identification and resolution of system bugs. System integration testing and user acceptance testing are expected to occur soon the project is on track to implement in early 2023.

III. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE092022:

- The Customer Support Center received 39,801 calls in QE0922, down 31% from the previous year.
- As of November 16, 2022, DVHA is supported by 118 Assisters (110 Certified Application Counselors, 4 Navigators, and 4 Brokers). 70 Assisters are in training (whose application date is January 1, 2022, or later). Working in 63 organizations including hospitals, clinics, and community-based organizations.
- Increasing numbers of customers are using self-service functions. Self-serve applications comprised over half (59%) of all applications in QE0922.

Enrollment

As of QE0922, more than 231,643 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 158,847 in Medicaid for Children and Adults (MCA) and 72,796 in Qualified Health Plans (QHPs), with the latter divided between 24,187 enrolled with VHC, 5,310 direct enrolled with their insurance carrier as individuals, and 43,299 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 parte. Cases that require an application have coverage extended; renewals will be rescheduled once the end date of the PHE is known. The passive renewal success rate for the quarter averaged 43%.

1095 Tax Forms

The last corrections run for TY 2021 1095B was June 28, 2022. Preparations are currently underway for TY 2022 generation which began in November.

Customer Support Center

Maximus continues to manage the VHC Customer Support Center (call center). The Customer Support Center serves Vermonters enrolled in both public and private health insurance coverage

by providing support with phone applications, payment, basic coverage questions, and change of circumstance requests.

The Customer Support Center received more than 39,801 calls in QE0922, down 31% from the previous year. During the last quarter, Maximus answered 87% of calls within 24 seconds. With increased staffing and lower call volumes, Maximus met the target in QE0922.

Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to DVHA-HAEEU for resolution and log service requests, which are escalated to the appropriate resolver group. This year has seen a decrease in the volume of calls with a slight increase in the proportion of calls that were escalated. 8% of QE0922 calls were transferred to DVHA-HAEEU staff, down from 1% in QE0921. Just as importantly, DVHA strived to answer all calls that were transferred; 99% of transferred calls were answered in five minutes in QE0922.

Timely Processing of Member Requests

In the spring of 2016, DVHA-HAEEU set a goal of completing 75% of member requests within ten business days. In QE0921, more than 86% of the VHC requests were completed within the same ten-day time frame, and 99% in QE0922.

System Performance

The system continued to operate as expected throughout QE0922, achieving 100% availability outside of scheduled maintenance in each of the three months. The average page load time for the quarter was 2.03 seconds – which is slightly over the two-second target.

In-Person Assistance

As of November 16, 2022, DVHA is supported by 118 Assisters (118 Certified Application Counselors, 4 Navigators, and 4 Brokers). 70 Assisters are in training (whose application date is January 1, 2022, or later). Working in 63 organizations including hospitals, clinics, and community-based organizations. Assister support is available in all of Vermont's 14 counties. The program continues to focus on recruitment, shown by an increase of ~5% increase of Assisters from last quarter. The program is focusing on program strategy and continues to emphasize Assister education through multiple mediums.

Outreach

DVHA continued to use advisory meetings and other collaborative engagements with partners and stakeholders to notify Vermonters about the continued timeline of the programmatic changes related to the COVID-19 pandemic. DVHA has implemented a webpage specific to information related to the PHE unwind and subsequent implications and information. The Vermont Health Connect website also continues to undergo enhancements to improve accessibility and ease of navigation. DVHA has also launched a series of public and partner town halls to inform Vermonters about Open Enrollment.
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 9,460 sessions during the quarter.

Self-Service

During QE0922, DVHA-HAEEU continued to promote self-service options for customers to report changes, and access tax documents and other forms. Self-service leads to an improved customer experience as Vermonters can log in at their convenience. It also has the benefit of using automation to reduce staffing expenses. Year-over-year comparisons show that more customers are using self-service functions, including both online accounts for health coverage applications and reported changes as well as the options of paying premiums through. Self-serve applications comprised over half (59%) of all applications in QE0922.

ii. Choices for Care and Traumatic Brain Injury Program

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. Beginning July 1, 2022, ARIS Solutions, Vermont's contracted fiscal agent, implemented the policy that Medicaid program funds cannot be used to pay for services if EVV is not used to record in-home personal care services. Extensive communication was provided prior to implementation and is outlined here.

Choices for Care Providers – In quarter 3, Choices for Care and Brain Injury program providers continued to report challenges with hiring and retaining staff. This workforce challenge is reported across the full range of providers including case management, personal care attendants, adult day providers, Nursing Homes, and Enhanced Residential Care Providers. In July, DAIL implemented a new minimum wage for independent direct support providers according to the Collective Bargaining Agreement. This raised the minimum wage to $13.44/hour. Additionally, HCBS service rates were increased by 8%. The 8% increase was implemented for both agency-directed services and consumer/surrogate-directed budgets.

Enhanced FMAP spending plan:

The Initial Spending Plan Narrative was submitted in June 2021. During the reporting 2021Q3 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. ASD is now implementing activities as outlined in the plan More information is available HERE

Adult Day

Adult Day Agencies continue to 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. In quarter 3, Adult Day providers continue to report challenges with staffing, including a lack of drivers to provide transportation to/from the Adult Day Centers. DAIL, in partnership with community stakeholders, will meet with targeted communities that do not have access to Adult Day Services to explore

opportunities for reestablishing AD services in those areas. Stakeholder meetings are scheduled for October 2022. During Q3 and Q4, Vermont's Quality Management Unit is scheduled to complete site visits for the recertification of Adult Day providers.

At the end of Q2, CFC enrollment included:

NH – 2328 participants
ERC – 555 participants
Home Based – 2192 participants
Moderate Needs – 1009
participants

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 and CY2022 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. MFP received funding authorization for CY2022 and expects to receive funding in CY's 2023 and 2024. We will be seeking permission from CMS to increase our service population to include individuals with I/DD and to provide supplemental funds for food for our participants as part of the Demonstration project.

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 support for unpaid caregivers, and 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

CY2023 transitions – through quarter 3, 54 individuals were transitioned with 23 additional individuals in the pre-transition category

Brain Injury Program

Current enrollment = 85 individuals, 14 individuals are in the process of enrolling/pending service provider capacity, and 6 new Applicants are pending clinical assessment.

Wait Lists

- There is no wait list for the High Needs Group.
- There continue to be provider wait lists for Moderate Needs Group, estimated at almost 700 people statewide. Because the eligibility criteria for Moderate Needs services are 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 (DDSD)

Payment and Delivery System Reform Update:

DAIL/DDSD, through its independent assessor (PCG), continues to perform the newly implemented assessment completing a statewide sample of 500 statewide. Using this sample, the results will be analyzed to determine if, and how, the SIS-A can be used as part of Vermont's payment redesign. DAIL/DDSD consulted stakeholders to develop a process related to scheduling assessments, marking the beginning of the 3-year cycle of independently administered assessments.

In preparation for the release of the SIS-A Second Edition, the DAIL team consulted contractors, stakeholders, and staff about how to address upcoming changes to the tool.

Please see prior report submissions for previous highlights.

DDS System of Care Plan Renewal

Stakeholder input is key to the renewal of the DDS System of Care Plan renewal. To solicit input, the Division will engage in targeted input sessions related to the three identified areas of focus:

- Housing Options/Alternatives
- Paying Parents with Medicaid Funds to Provide Care to Their Child(ren)
- Support Services Specific to the Needs of Adults with Autism

DAIL/DDSD scheduled a total of 17 general and targeting input sessions, and input sessions related to the above priority areas and crafted an online survey which was completed by approximately 275 stakeholders.
Please see prior report submissions for previous highlights.

Clinical/Crisis Continuum of Care Expansion

Related to the increased mental health needs of individuals with I/DD, the capacity of Vermont's developmental disabilities system's clinical and crisis resources has been severely stretched.

While Vermont has the Vermont Crisis Intervention Network (VCIN), DAIL/DDSD has found that this resource was not enough to meet the needs of Vermonters with I/DD. DAIL/DDSD has worked with a local community provider to develop additional Collaborative Crisis Capacity to expand

statewide resources. This capacity includes a crisis bed, intended to provide short-term crisis stabilization, support measured in two to three weeks, as well as a longer-term transition bed that can provide support for a longer period. These supports mirror the other statewide crisis resources and were developed in close consultation with the VCIN clinical team.

DAIL/DDSD executed a contract for psychiatric/medical consultation. This provides DDSD staff direct support for individuals when admitted or at an emergency department without a clear discharge plan or prognosis. The consultant is available to provide peer-to-peer communications with medical professionals as discharge planning occurs.

Please see prior report submissions for previous highlights

iv. Global Commitment Register

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 a proposed policy, including information on public comment submissions, final policy, notices, and policy clarifications. The GCR is available on the AHS website to ensure that policy changes are transparent to Vermonters and to provide a forum for public comments.

The GCR listserv is a group of about 400 interested parties who have elected to receive periodic key updates about Vermont health care programs, which includes policy changes to all Medicaid programs as well as policy changes to Vermont's Health Benefit Exchange. A policy change in the GCR could be a change made under the authority of the waiver, a proposed waiver amendment or extension, an administrative rule change, or a State Plan Amendment. The GCR also contains policy clarifications for when an issue is identified that is not answered in the current policy.

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

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 16 proposed policies posted in QE0622. A total of 3 final policies were posted in QE0622.
Three policy clarifications were posted to the GCR in QE0622. Changes included updates to rates and/or rate methodologies (including appropriations from the Vermont legislature), clinical coverage changes, administrative rulemaking notices, and changes stemming from the public health emergency and the COVID-19 pandemic.

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

IV. Expenditure Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE092022:

Resume in person visits

- VCCI Utilization
- New to Medicaid Screening Data
- Collaboration with Healthcare Reform team on Complex Care Model
- Staff training initiatives
- Workforce updates

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

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In the third quarter of 2022, VCCI has focused on updating in-person visit guidance to ensure safe visiting during the pandemic for both staff and members. Prioritization criteria were established so the most vulnerable members resumed home visits first. Most members request multi-modal interventions. Most prefer a hybrid model with some home visits mixed in with virtual or telephonic visits. We have also been in the process of updating our home visit safety protocols.

The percentage of home-based visits has been slowly yet steadily increasing during the first and second quarters. The percentages of visits seem to correlate with the prevalence of COVID in communities at the time.

As seen below, VCCI provided care management services to 221 unique individuals in Q32022 The length of time and regularity of visits are dependent on the complexity and severity of the needs of the beneficiaries. VCCI case managers work with beneficiaries until the goals of their care plans are met. (See **Figure 1).**

Figure 1. Beneficiary Enrollment and Face to Face Visits

	Mar-22	Jun-22	Sep-22
Measure	4/15/2022	7/15/2022	10/15/2022
# new VCCI eligible members enrolled monthly in care management	46	21	31
Total Open Cases (including newly enrolled - above)	273	210	221
% of VCCI enrolled members with a face-to-face visit during the month	25.64%	41.90%	46.10%

VCCI continued work started in 2019, of telephonic outreach and screening to beneficiaries new to the health plan. The new Medicaid screening tool poses questions related to access to health care and health care-related

issues including Primary Care, Dental, housing, transportation, and food, with direct facilitation to those services desired by the beneficiary. The numbers new to the health plan have declined somewhat from the first quarter. (**Figure 2).** Timely access to some services desired by beneficiaries continued to present as a challenge this past quarter. Wait times for the establishment of primary care are longer in many areas of the state.

Figure 2. Number of New to Medicaid Beneficiaries Screened July 1 – Sept 30, 2022

Updated Dates - month reported	Dec-21	Mar-22	Jun-22
received from the data unit	1/15/2022	4/15/2022	7/15/2022
Updated Dates - due date	4/15/2022	7/15/2022	10/15/2022
# of new to Medicaid members (Adults 18+)	469	327	423
# of new to Medicaid members reached	153	72	101
# of new to Medicaid members screened	171	105	158
% of new to Medicaid members screened	36.46%	32.11%	37.35%

Successful facilitation of access to PCP appointments to establish new patient care continues to be a challenge, with barriers including long wait times for new patient appointments, the requirement for former health records, and practices closed to new patients. These factors may have impacted the low data point for successful care establishment (**Figure 3).** Wait times for new patient appointments varied throughout the state; one practice was citing a 7-12 month wait time. Several practices require former health records before even scheduling a new patient appointment. Work is anticipated with state colleagues and VITL to provide reinforcement and training on Vermont's information exchange as an initial mechanism to obtain health history and medication list while awaiting a more comprehensive health record set. Dental practices accepting new patients with Medicaid are also sparse statewide. Access to dental care continues to be a challenge for Vermonters with Medicaid.

VCCI leadership is working with the Healthcare Reform team on re-evaluating our complex care model and how it is implemented statewide. Due to workforce turnover in direct care organizations statewide, much of the training the state provided on the complex care model has not been carried on. Our team is looking at ways to provide ongoing training on the model in a way that is sustainable.

VCCI has been working with VITL doing some testing with their updated platform and the new single sign-on button that is integrated within our eQ Health Care Management system. Our team worked with VITL to test their new platform and made recommendations for improvements for ease of use within the field.

Over the second quarter, we have focused on staff training initiatives for our statewide team. We have worked with our medical director and pharmacy team to implement a medication reconciliation process/protocol for all RN case managers to do with every beneficiary served. Our team is working with people to gather all information on prescribed medications and is communicating that to all providers and prescribers. They have also been helping beneficiaries appropriately dispose of unused medications. This is initiative is aimed at improving the health and safety of beneficiaries.

The VCCI team met in person for the first time since the pandemic began in July for a day-long training event. Our two senior nurses provided an overview of our case management system and process to enhance consistency in our practices statewide. For many new staff, it was their first time meeting their team in person. We have since had another day-long in-person training focused on an

overview of the Vermont Criminal Justice system and programs. VCCI continues to be a part of a pilot program with the Vermont Department of Corrections serving on a multi-disciplinary team focused on service provision to people involved with corrections who have complex needs.

Due to the increase in hMPXV cases, we had a training for our staff on the topic. The training focused on the epidemiology of the disease, risk factors, symptoms, and management.

We have been planning for upcoming training for staff on Motivational Interviewing, Naloxone administration, and overviews of Choices for Care and Brain Injury Programs.

In the past quarter, our team has been busy working on recruitment for our vacant positions. We have had four new staff onboarded in the past quarter and one RN retired. We currently have three vacant RN posi tions. Recruitment and retention continue to be a challenge in our program. Our current staff has been working very hard to be responsive to meet the needs of beneficiaries despite our vacancies.

. **Goals CY 2022**:

1. Increase in the resumption of face-to-face visits with beneficiaries enrolled in VCCI.
2. Increase the number of members who successfully establish primary care with VCCI intervention.
3. Improve and clarify referral processes throughout and within the 6 departments of the AHS and develop further clarified integration of the Agency of Human Services Field Services Division and VCCI.
4. Work with our state systems to develop and provide training on evidence-based practices and complex care models to help create efficiencies and effectiveness in community-based care.

ii. Blueprint for Health

Key updates from QE 092022:

- The majority of Vermont's primary care practices are now Blueprint-participating Patient-Centered Medical Homes, as 132 of Vermont's estimated 169 primary care practices are Blueprint-participating practices (and an estimated 148 employ more than one provider).
- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid-use disorder. As of 2022-Q2, the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs is 3,725.
- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 44 practices and 6 Planned Parenthood sites to participate in the Women's Health Initiative as of September 2022

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

The Blueprint uses national standards to drive improvements in primary care delivery and payment. The program helps primary care providers transform their practices into National Committee for Quality Assurance (NCQA)-certified Patient-Centered Medical Homes. Vermont's Patient-Centered Medical Home (PCMH) model supports care for

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

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

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

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

Q3Highlights

July – September 2022

This quarter Quality Improvement Facilitators and practices have undertaken education and preparation for Annual Reporting requirements that are part of the 2023 Patient-Centered Medical Home participation

requirements (released by NCQA in July 2022). In addition to meeting all the core requirements of functioning as a medical home, practices are preparing to implement and provide evidence that:

- Their quality Improvement meetings involve interdisciplinary team members that meet regularly
- Medication lists are updated and reconciled (for at least 80% of patients)
- Information is collected and analyzed on the diversity of the population served, including a requirement to incorporate sexual orientation and gender identity by 2024
- The practice monitors appointment availability outside regular office hours and how frequently a patient is seen by their preferred provider/care team.
- The practice has a process for risk-stratification and care management identification, and the thresholds for care plans are met
- Appropriate follow-up occurs for unplanned hospital and ED Visits, in addition to planned hospital visits
- They can meet standardized (eCQM) quality measure reporting requirements (Starting January 1, 2024, for the period of January 1, 2023 – December 31, 2023) to report on five clinical quality measures, two resource stewardship measures, and one Patient Experience of Care Measure by 2024

As part of the ongoing work of patient-centered medical homes, thirty-one (31) practices across the State successfully completed their National Committee for Quality Assurance annual recognition process in this period, demonstrating their ongoing commitment to the model and continuous quality improvement.

During this quarter, the Program Manager and Quality Improvement Facilitators worked with practices to encourage participation in the Statewide Consumer Assessment of Healthcare Providers and Services (CAHPS) statewide patient experience surveys. As a result of this outreach and support, 129 practices are participating in this year's cycle. Facilitators, practices, and system leaders are working in partnership to convey messaging to patient populations the importance of participation and thereby increase the annual response rate.

The Blueprint Field Staff recruited and supported practice involvement in State/Regional Quality Improvement opportunities to enhance clinical guideline uptake and innovations, such as suicide prevention grants and chronic disease remote monitoring pilots.

Public Health Emergency

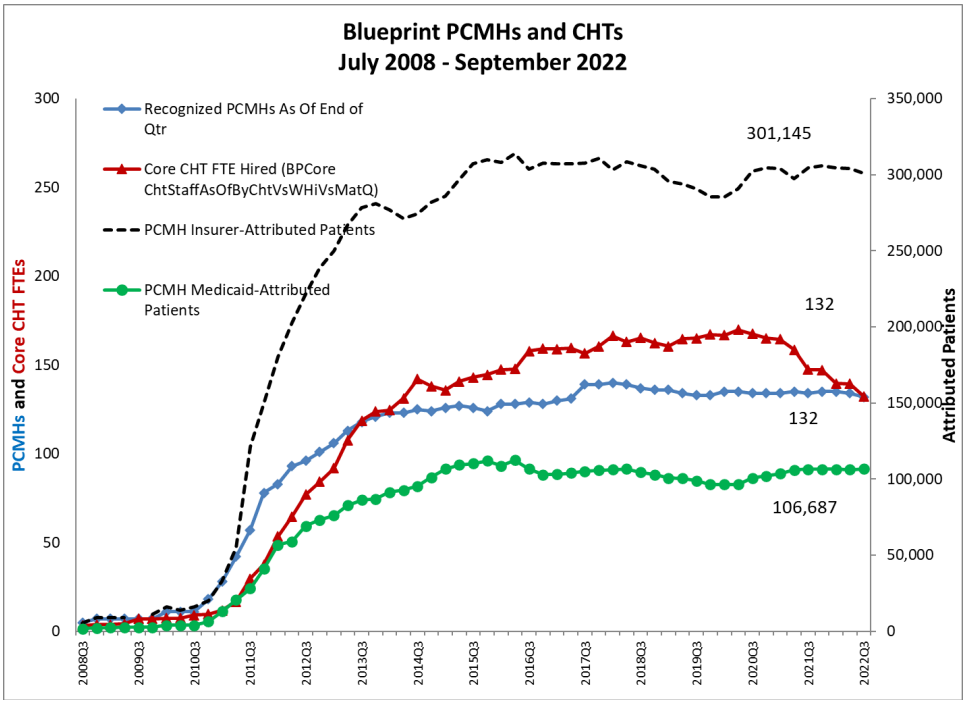
The Blueprint network focused on adaptability, resilience, patience, and continued persistence. We have seen an increase in response within primary care offices for testing, vaccines, and overall care for patients with Covid. We continue to work with VDH to inform our network and keep us up to date on any current information on Covid cases, vaccine clinics, and booster availability. Key members from this department joined our network meeting to share important information and key updates. We will also continue to monitor the impact of monkeypox/hMPXv and other public health emergencies on our communities. Our PCMH will head into the fall season where flu vaccines and boosters will continue to occur within primary care.

Blueprint-participating Patient-Centered Medical Homes currently serve 301,145 insurer-attributed patients, of which 106,687 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 before the date the attribution process is conducted. These practices and patients are supported by 132 full-time equivalents of Community Health Team staff.

In Quarter 3 (July – September l - June 2022), 132 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.

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



Community Health Profiles

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

Hospital Service Area (HSA) community profiles are posted at

http://blueprintforhealth.vermont.gov/community-health-profiles.

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

https://blueprintforhealth.vermont.gov/annual-reports

Hub & Spoke Program

Medication-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.

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.

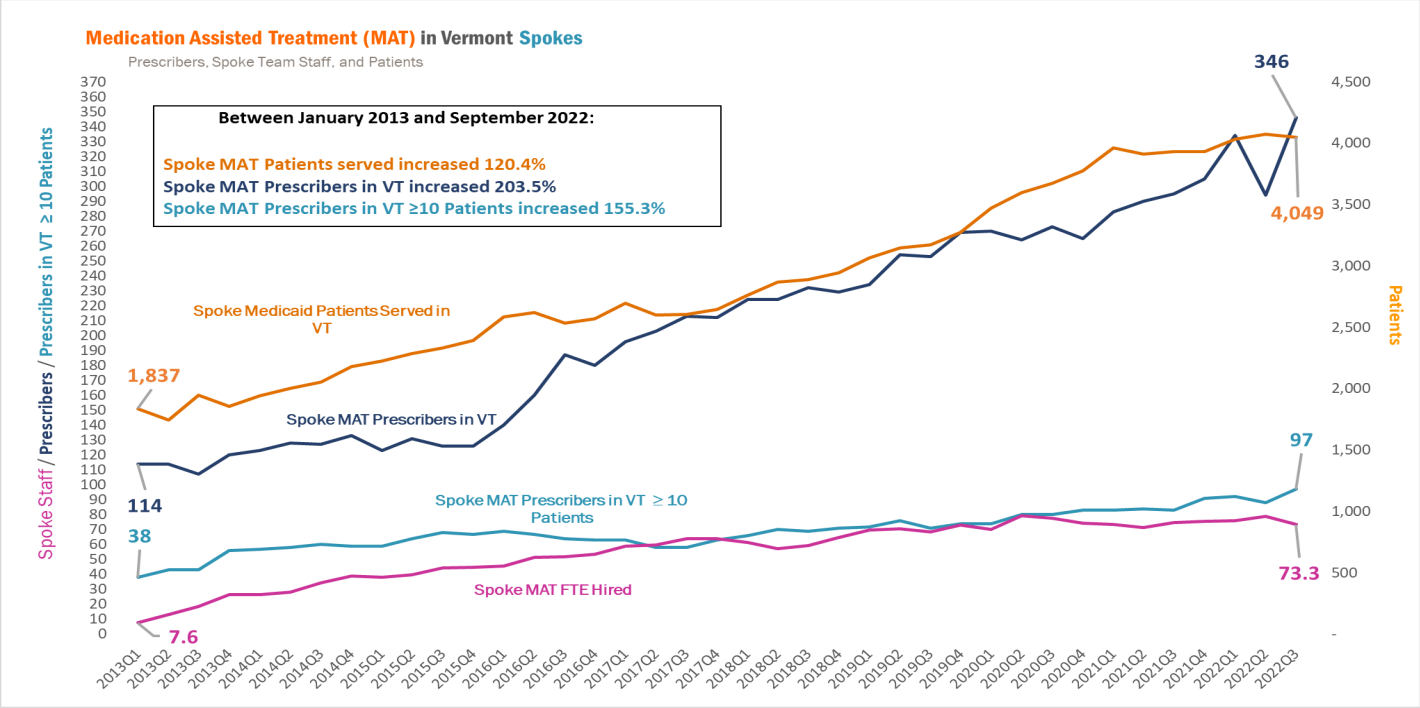
Q3 Highlights

The Blueprint, in partnership with the Division of substance use prevention, in conjunction with a contract with Dartmouth allows us to continue 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. Sessions alternated between didactic and webinars this quarter. We have been actively planning for our two-day hub/spoke conference on the integration of care that will take place in Oct 2022. We continue to have some challenges with work force as many do in hiring nurses and clinicians and the network continues to be creative to recruit.

Vermont continues to demonstrate substantial access to medication-assisted treatment for Vermonters with opioid use disorder. Medication-assisted treatment is being offered across the State of Vermont by more than 75 different Spoke settings as of June 2022.) The monthly average of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs decreased slightly from 4074 to 4049. There are 346 medical doctors, nurse practitioners, and physician assistants who work with 73.3 FTE licensed, registered nurses, and licensed, 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 full-time equivalent Spoke staff working as teams.

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

Figure 2. MAT-SPOKE Implementation Jan 2013 – September 2022



Women's Health Initiative

The Women's Health Initiative (WHI) began as a state initiative to support pregnancy intention. The Women's Health Initiative (WHI) strives to support any persons who can become pregnant in their efforts to experience healthy pregnancies, avoid unintended pregnancies, and build thriving families.

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

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

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

Comprehensive screening includes questions about SDOH needs of food/housing insecurity, interpersonal violence, depression, anxiety, and harm to self or others, in addition to screening for mental health needs and substance use. Positive screens are addressed with referrals to services, and brief interventions and treatment may be provided by the WHI-supported mental health clinician if indicated. WHI clinicians develop mutual referral

agreements with community partners to help establish meaningful relationships to support patients.

Q3 2022 Highlights

WHI Program Lead meets regularly with representatives from all WHI practices to identify process improvement opportunities, ensure the program elements are in place and support improved patient experience of care.

We have continued to outreach to practices to share the mission of the WHI program and assess interest in incorporating this into their practice.

Practices are working hard to engage community partners in referral agreements. These agreements enhance relationships and pathways to care. We have presented a WHI data dashboard to the field in our monthly call every quarter. We received feedback on what would be useful data for the field from claims and will continue to support the field with this information. We have received feedback on being more inclusive in the name of our program. We have an upcoming consult with Boston Medical Center which has done some work with the state of Massachusetts to work with primary /specialty care practices to promote equity and inclusiveness. This includes the name of programs and questionnaires.

The last quarter was significant for our WHI program in that PPNNE closed four offices. They shared that because of limited resources and the national crisis for reproductive health access, they need to reallocate resources. We are working with PPNNE and the community where locations are closed to continue to assess the impact and needs of the community. At this time, there has not been a large, reported shift of patients to the local primary care from PPNNE. PPNNE has a robust telehealth program for all birth control methods except LARC. They have a birth control by mail program for pills, rings, and deprovera/and had shared they believe patients can still maintain easy access to the telehealth program.

- Emergency contraception pills
- HIV prevention (PrEP)
- Gender-affirming hormone therapy
- STI screening and treatment (we have a mail-in testing program now)
- Preventive care up to age 24
- Uncomplicated UTI care
- Care for people with uncomplicated depression and anxiety

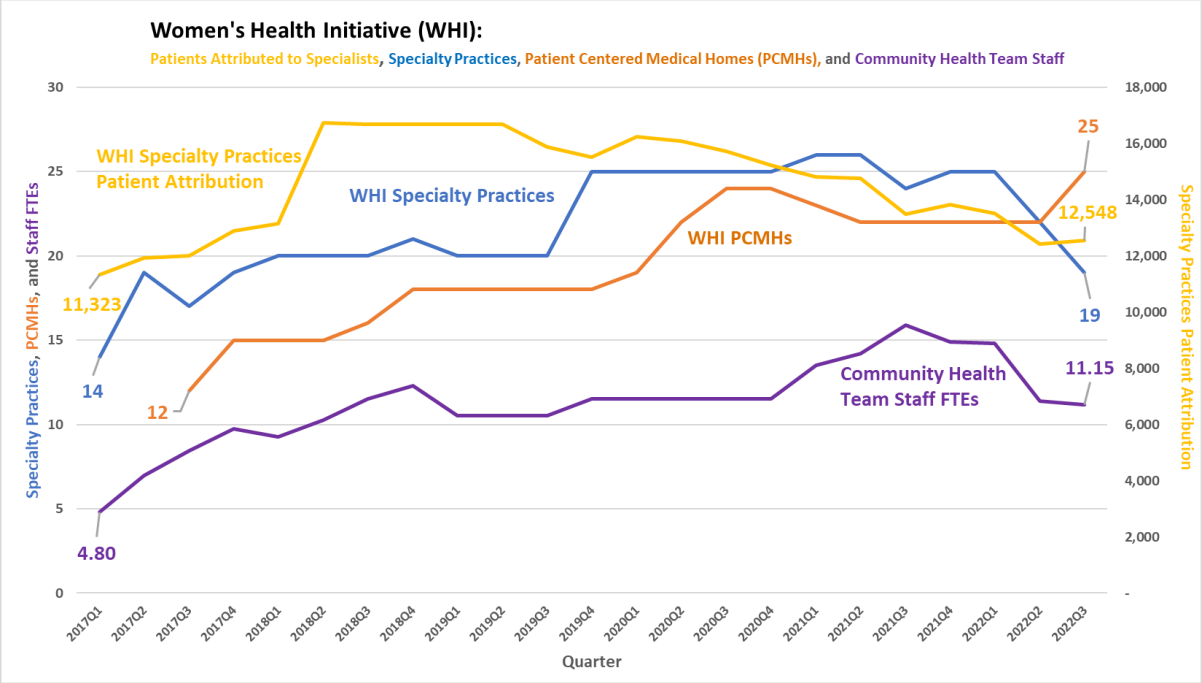
Concerns that were discussed with our health service area field managers were concerns of access generally. We discussed specific topics of accessing pregnancy termination services. Availability of care for uninsured/underinsured/young folks not wanting to be on parents' insurance and ensuring the privacy of these protected services. Alternative sites experiencing an increase in bad debt due to the sliding scale of PPNNE for services. Availability of transportation to other catchment areas Gender affirming (available telehealth) but several specialty/PCMH aren't comfortable with this.

The Blueprint into further training and support for providers who want to increase comfortability and knowledge in transgender care. We are pleased to share that AHEC/UVM Project Echo will work with our network and provide a 1hour training

monthly for 6 months for providers to increase their knowledge and comfortability in transgender care.

Figure 3 below shows WHI enrollment and staffing over time. In 2022, the number of PCMHs enrolled are 44. 19 women's specialty health care sites and 25 PCMH participated in the Women's Health Initiative as of September 2022.

Figure 3. Women's Health Initiative: Practices, Patients, and Community Health Team (CHT)



Staffing Table 4. Women's Health Implementation by Region

Health Service Area	WHI Specialist Practices as of September 2022	WHI PCMH Practices as of September 2022	WHI CHT Staff FTE Hired as of September 2022	WHI Specialist Quarterly Attributed* Medicaid Beneficiaries as of September 2022	WHI PCMH Quarterly Attributed* Medicaid Beneficiaries as of September 2022
Barre	1	1	0.75	530	374
Bennington	1	2	0.6	833	253
Brattleboro	1	0	0.6	900	0
Burlington	2	9	2	1886	4809
Middlebury	1	0	0.75	622	0
Morrisville	1	3	0.5	297	1228
Newport	1	0	1	917	0
Randolph	2	0	0.5	269	0
Rutland**	2	0	1.5	1883	0
Springfield	0	5	0	0	1697
St. Albans	0	0	0	0	0
St. Johnsbury	1	2	0.75	817	691
Windsor	0	3	0	0	87
Planned Parenthood (Statewide)	6	0	2.2	3381	0
Total	18	25	11.15	12335	9139

*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 those in Rutland and the PPNNE statewide field. Patients are allocated to the Rutland HSA. The total WHI Specialist practice count is deduplicated.

iii. Mental Health, Substance Use Disorder, and Behavioral Health

Key Updates: Per Diem Rate for Mental Health Extended Stays in Emergency Departments; Team Care Program; Applied Behavior Analysis

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

As of March 1, 2021, Vermont Medicaid modified the reimbursement methodology for inpatient services delivered by a psychiatric facility. Before implementation Department of Vermont Health, Access & Department of Mental Health reimbursed the facility for services using different methodologies on a fee-for-service, per-claim basis. The newmodel allows for a prospective payment informed by several factors:

- Historical utilization incurred by DMH and DVHA at the facility
  Projected utilization in the coming year
- Recent cost-per-day values incurred by the facility 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 facility have agreed upon performance measures and a monitoring plat form for the model is being built by the Quality and Clinical Integrity team at DVHA. Year one reconciliation was completed on 5/31/22.

The Clinical Integrity Unit began oversight and monitoring of a pilot project to compensate hospitals a per diem rate for extended stays in Emergency Departments due to a lack of more appropriate available placements. Effective 07/01/2022 through 6/30/2023, the DVHA will reimburse hospitals for extended emergency department stays in which a Vermont Medicaid member meets clinical criteria for inpatient psychiatric level of care AND there is no appropriate in- patient bed available. Stays that exceed 24 hours are eligible for reimbursement and there is an authorization process in place. There are 15 participating emergency departments eligible for reimbursement.

The CIU manages the Team Care program which is a care management program and a federally mandated prescription lock-in program to prevent misuse, abuse, and diversion of medications on the FDA Controlled Substance Schedule such as opioid pain medications and sedatives. Team Care can be a useful tool for members who may need additional support getting the most appropriate healthcare available to meet their needs. A clinical review of all available data supports the continued review of current enrollees' need to remain in the program. The unit conducts bi-annual reviews of claims data, including pharmacy and emergency department visits, to identify members who may benefit from the support of the Team Care program. Clinicians review this data and determine the enrollment of potential new members. Team Care program members are also referred to VCCI when appropriate.

Outreach with providers and pharmacies is ongoing. The unit has attended staff meetings of various departments/units and posted advisories for providers. There is also an outward-facing brochure available for Providers. There have been minimal referrals to the program. The lack of referrals may demonstrate the success of the Vermont Prescription Monitoring System (VPMS) and new opioid prescribing standards and practices associated with VPMS.

CIU team members participate in the 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 most efficiently. This is accomplished through participation in state interagency team meetings, the Mobile Crisis Response Initiative, participating in weekly case reviews, and developing 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 CIU also manages the Applied Behavior Analysis (ABA) benefit. In July 2021, DVHA changed the timing of the ABA tier submissions and payments from prospective submissions and payments to post-service delivery submissions and payments after receiving feedback from providers regarding the difficulty of prospectively

determining treatment hours for the subsequent month. An important goal of this program is to increase access to direct services for Medicaid members by giving providers the flexibility to innovate and to use staff more efficiently. To assess progress toward this and other goals, DVHA has established a monitoring framework that includes measures of access, utilization, service intensity, quality, and cost. Early data for some of these measures shows promising results. For example, since the implementation of the payment reform program, a higher proportion of services are in the form of direct services to members rather than assessments and parent education. In addition, total hours of service have been increasing year over year (despite the impacts of the COVID-19 public health emergency). The average monthly census has increased since the implementation of the payment model and has held steady during the past three years. The intensity of service has also increased; there have been substantial increases each year in the average service hours per member per month.

The DVHA ABA team is working with the Payment Reform Unit on a valued based payment project. Beginning with Calendar Year 2023, DVHA's ABA Tiered Payment Model will incorporate provider results on three performance measures into the reconciliation process and calculations. This value-based payment proposal will allow providers to earn up to 10 points and up to 1% of their total earned service level tier payments (the 1% is anticipated to be an added payment for services provided in the calendar year 2023 and a withhold thereafter). The measures include the amount of service provided in member months, the percentage of total billed hours that are direct therapeutic service hours, and timely claims submissions. The Senior Autism Specialist worked with the payment reform and policy teams on provider outreach to ensure information was thoroughly and accurately discussed. The Policy Unit posted a GCR that required a public comment period before implementation in CY '23, which ended on 08/29/2022. Public comments were received and are being reviewed, and a response is being drafted. Overall, public comment feedback focused on clarification of specific measures and collaboration between the State and stakeholders.

The DVHA Senior Autism Specialist conducts annual site visits/audits with Vermont Medicaid enrolled ABA providers who provide services to Vermont Medicaid members. The purpose of these visits/audits is to ensure that members were receiving quality care, that providers are accurately reimbursed for provided services, verify that required documentation is included in members' charts and that clinical documentation follows ABA Policy and Clinical Guideline standards.

Site visits/audits are completed in a virtual format. The process includes a virtual tour of the provider's Electronic Health Records system, and the provider electronically submits clinical documentation to be reviewed independently by the DVHA Senior Autism Specialist or designee. Fifteen virtual site visits/audits have been completed so far this year with the goal to visit all 18 ABA providers by December 2022.

iv. Mental Health System of Care

Key updates from QE092022:
- 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 serious mental illnesses (SMI). The Vermont Agency of Human Services (AHS) provides funding through Provider Grant Agreements to ten (10) Designated Agencies (DAs) and two (2) Specialized Service Agencies (SSAs). These agencies are located across Vermont for the provision of:

- **Community Rehabilitation and Treatment (CRT)** services for adults with SMI
- **Adult Outpatient Therapy** for adults who are experiencing mental health 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 (SED) and their families.

DMH also contracts with several peer- and family-run organizations to provide additional support and education for peers and family members 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 that includes one state-run psychiatric care hospital, Vermont Psychiatric Care Hospital (VPCH), and six (6) 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.

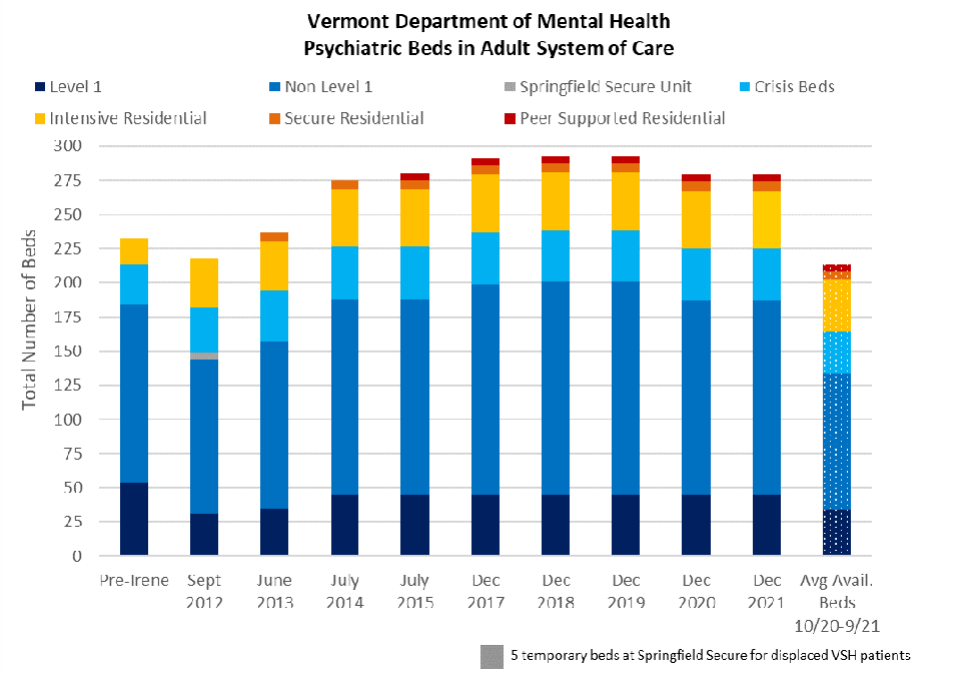
Throughout 2021 and continuing to the present, the Coronavirus Disease 2019 (COVID-19) pandemic has continued to challenge the mental health system of care in Vermont, primarily through statewide staffing shortages and inpatient bed closures.

Updates on the Mental Health System of Care

A. Hospital and Inpatient Care

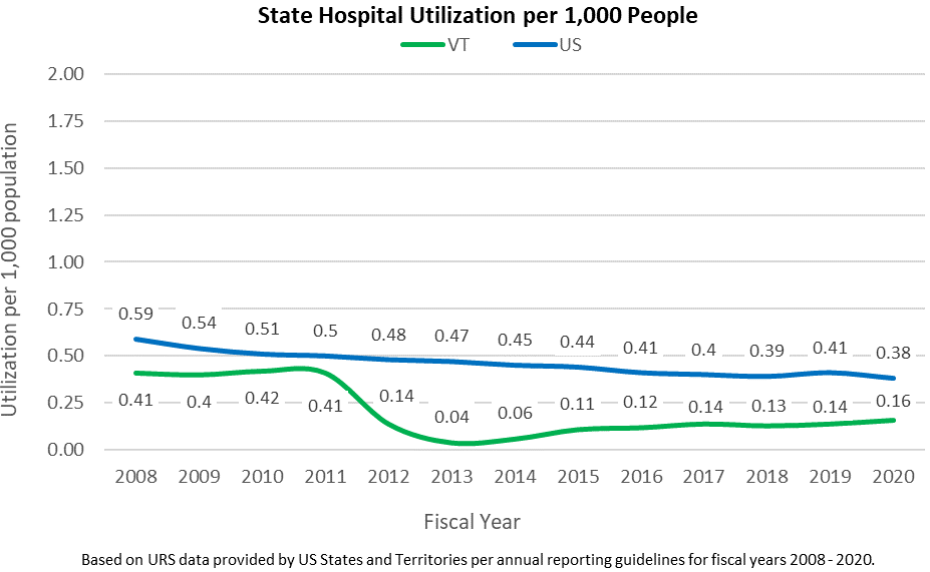
Vermont has 45 Level 1 beds and 159 adult psychiatric inpatient beds across the system of care. During the COVID-19 pandemic, several beds closed due to staffing, construction, patient acuity, and public health safety protocols, as well as an initial decrease in individuals presenting with a need for a higher level of care. The primary reason for bed closures as of October (2021) is a severe workforce shortage across the mental health system. In a state with approximately 3,300 staff across ten designated agencies that 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 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)

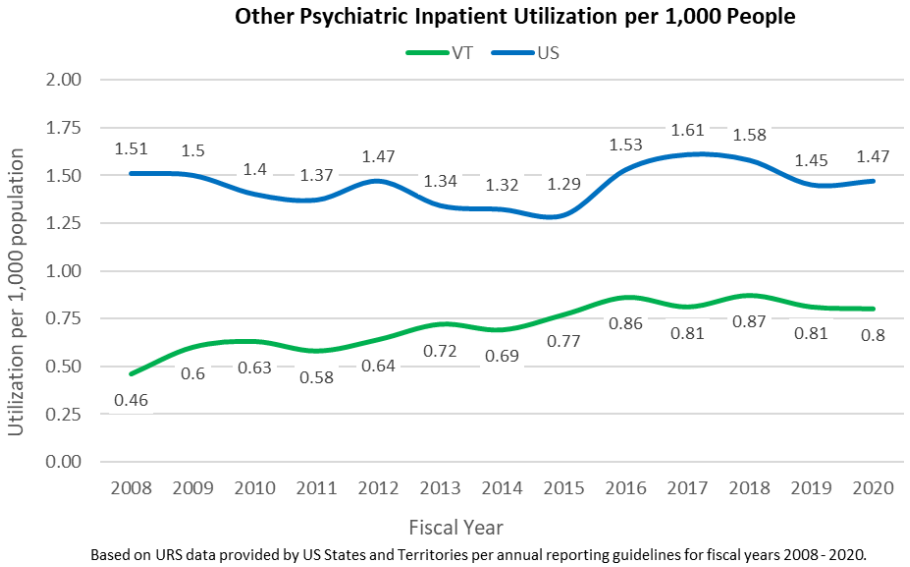


Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2020.

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 shows a

slowly progressing upward trend since 2012. Vermont is one of a handful of states that only has one state-run psychiatric hospital. The pandemic has significantly increased the need for mental health treatment and support.

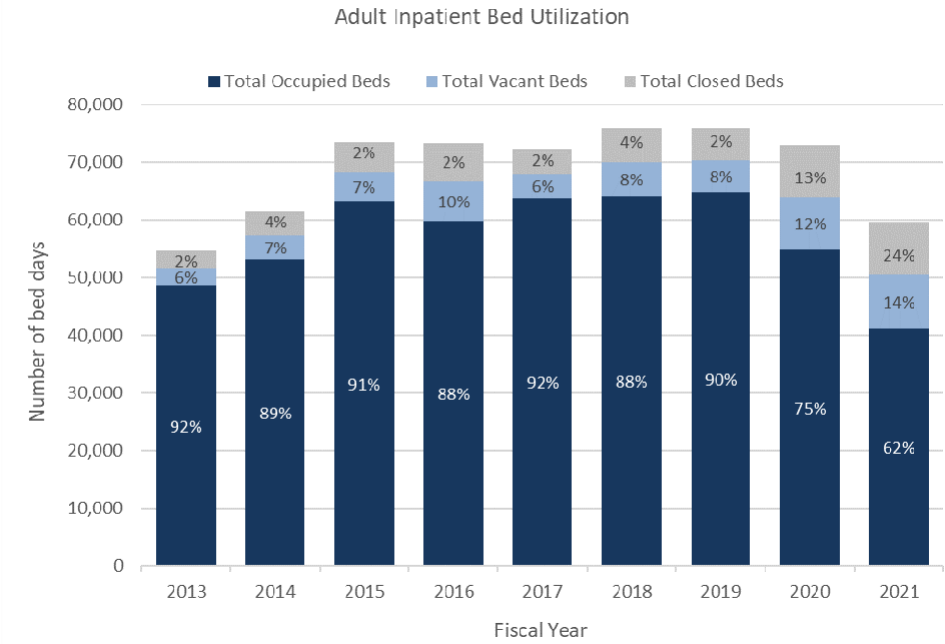
Figure 5. Other Psychiatric Hospital Utilization per 1,000 people (in Vermont and the United States)



Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2020.

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 has generally held steady through 2020, while Vermont's rate of utilization continued to increase. Inpatient utilization is still below the national average, 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 2021. The total bed-day availability across the system remained relatively constant in 2018 and 2019, with bed-day utilization decreasing by 15% in 2020 and 13% in 2021. The impact of the COVID-19 pandemic has contributed to the 2% increase in bed vacancies and the 11% increase in beds closed for FY 2020 through FY 2021. Over nine years, 2021 saw the lowest level of adult inpatient bed utilization. Data from 2022 will be illustrated in the upcoming quarterly report.

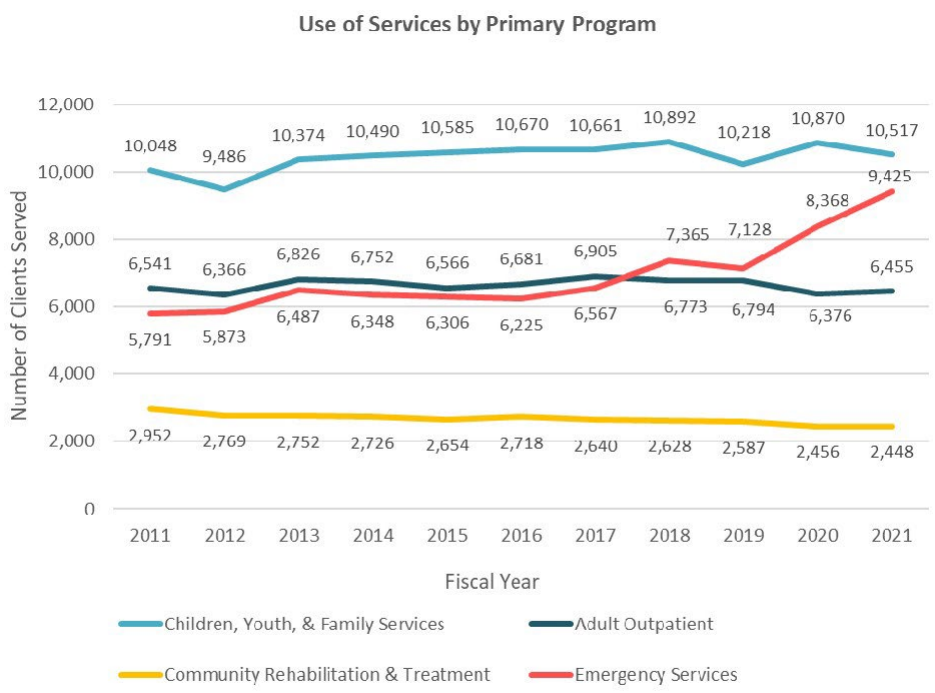
B. Community-based and Outpatient Services

Enhanced community services funding provided by the Vermont legislature through increased appropriations to critical 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 continue to be a struggle. Additionally, the payment reform initiative that was implemented on January 1, 2019, has been integral to stabilizing the mental health system of care at the DAs. The initiative has reduced barriers to access to care and promoted a more responsive and "needs" driven service delivery 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 support a more streamlined approach to adult program access and the service capacity available in each DA catchment area.

Key Efforts Include:

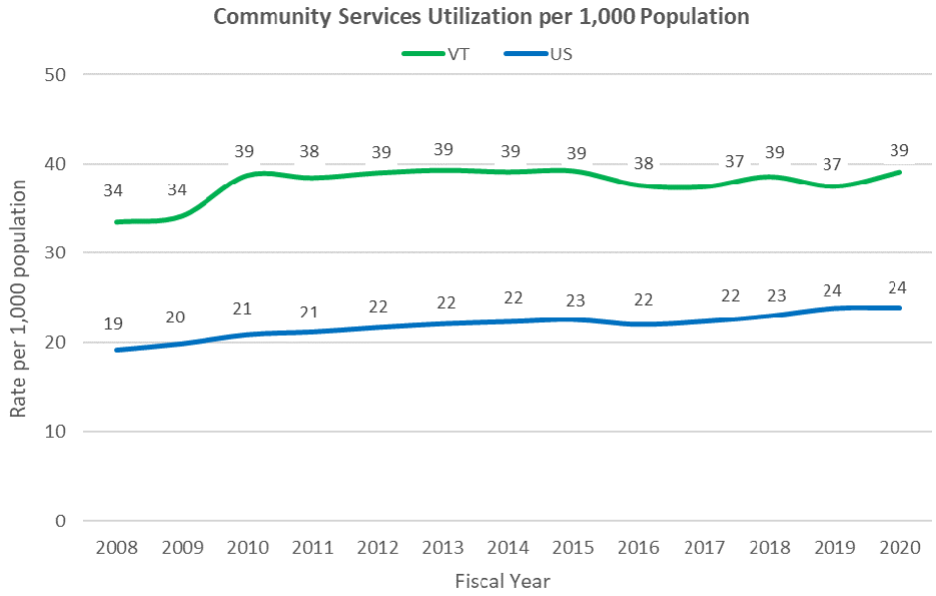
- Established a Workforce Task Group to explore recruitment and retention strategies
- Increased capacity within Community Rehabilitation and Treatment and peer programs to provide community support, outreach, and crisis response continues to develop
  Broad utilization of non-categorical case management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

Figure 7. Use of Services by Primary Program



The highest number of persons served by programs offered by the DAs continues to be in children, youth, and family services (CYFS), as indicated in Figure 7. The 3% decrease from FY 2020 to FY 2021 may be related to the COVID-19 pandemic, but generally use of CYFS services has remained relatively stable during the past 10 years. The Emergency Services (ES) programs had a 32% increase from FY 2019 to FY 2021, which may reflect the ongoing, increased support needs associated with the impacts of COVID-19. The Adult Outpatient Programs (AOP) saw a slight increase in utilization, while the Community Rehabilitation and Treatment (CRT) programs saw a slight decrease from FY 2020 to FY 2021. Both of these adult programs have seen relatively slow trend changes over the ten years reflected. FY 2021 reflects more of the pandemic's impact on system services with ES showing the largest increase in services provided.

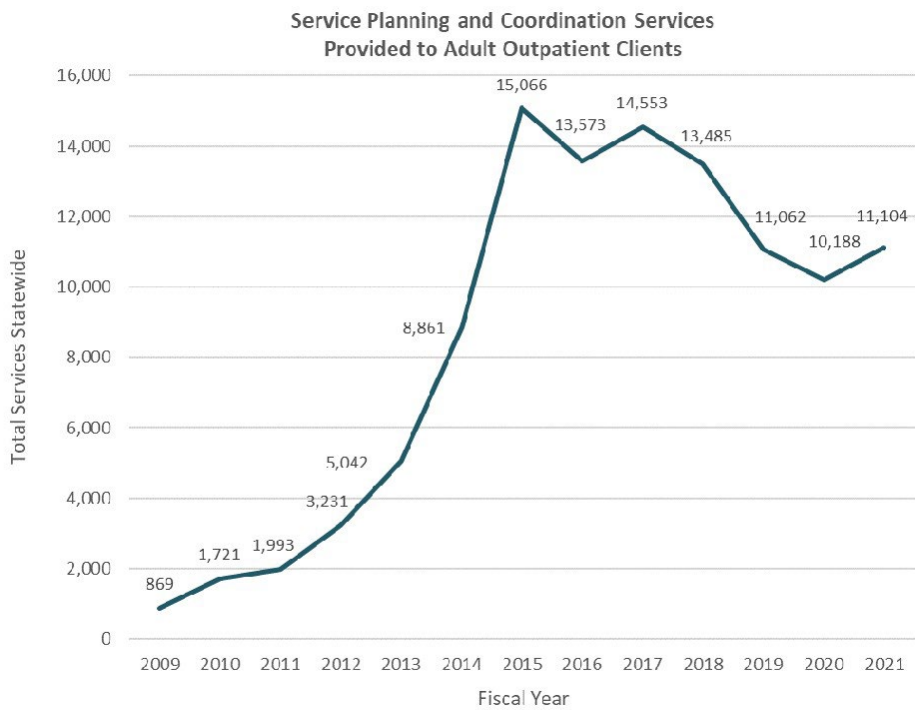
Figure 8. Community Services Utilization per 1,000 Populations



Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2020.

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 2020 continues to highlight that Vermont consistently demonstrates a strong 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, specifically that individuals will 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 a higher level of service needs within the system. Others enter and exit intermittently depending on their individual needs. The payment reform transition away from a fee-for-service model to both an adult and children's case rate with a value-based payment component has provided ongoing flexibility to meet the needs of the individuals.

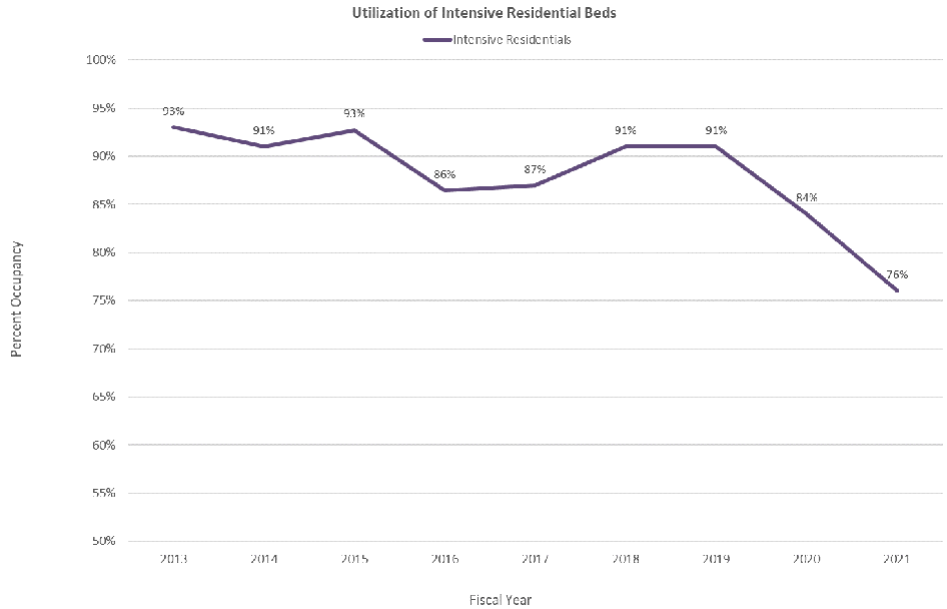
Figure 9. Service Planning and Coordination Services



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 to FY 2017 with an approximately 30% decline from FY 2017 to FY 2020. Interestingly, there has been a 9% reported in the past fiscal year. This is a noteworthy increase in service planning and coordination to meet this 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- to an 18-month time frame for residents.

FY 2020 and 2021 showed a 15% total decrease in utilization over the nine years to 76%. The impact of the pandemic during these fiscal years and the changing capacities of programs to safely transfer and introduce new residents into programs have likely contributed to this drop.

Performance and Reporting

Along with AHS, DMH has adopted the Results-Based Accountability (RBA) framework for assessing the performance of providers via grants and contracts. Continued reporting and data visualizations via the RBA framework are:

- Implementation of value-based payment measures that allow DAs to earn an additional allocation based on the 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" to the RBA scorecard reporting tool
- Exploration of visualization tools to create more responsive reporting.
- Participation in the development of the AHS Community profiles.

Mental Health Payment Reform

In 2019 DMH implemented an alternative Medicaid payment model for the DAs for mental health services. Most notably, the payment model for children's and adult services transitioned from traditional reimbursement mechanisms (a combination of program-specific budgets and fee-for-service payments) to a monthly case rate model. The mental health case rate model is one of the more mature alternative Medicaid payment models implemented by AHS, completing the third performance year on December 31, 2021. The foundational goals and principles driving mental health payment reform have remained unchanged throughout the life of this program. Those goals include:

- Encouraging flexibility in service delivery that supports comprehensive, coordinated care;
- Standardizing the approach to tracking population indicators, progress, and outcomes;
- Simplifying payment structures and improving the predictability of provider payments;
- Improving accountability, equity, and transparency; and
- Shifting to value-based payment models that reward outcomes and incentivize best practices.

An important program accomplishment from payment reform is that providers are now successfully submitting encounter claims to the Medicaid Management Information System (MMIS), which allows the State to monitor service delivery and other aspects of performance.

Additionally, the introduction of value-based payments supports quality improvement and accountability for outcomes. During each measurement year, DMH withholds a percentage of each agency's approved adult and child case rate allocations for these payments.

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 the 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 the measurement of performance improvement in accordance with the broader scope of services included in those regions. Vermont submitted a multi-year 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 the children that they are serving. These agencies are using this monitoring tool to track progress over time. Data are showing that through support and services, children and youth are increasing their strengths and decreasing their needs. The regions are also working to implement the Adult Needs and Strengths Assessment (ANSA).

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 adequately addressed.

Vision 2030

Through the 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 across every 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 submitted 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 Director of Operations, Planning, and Development, Lee Dorf, as well as a new Medical Director, Dr. Kelley Klein. Both these members of the leadership team have oriented quickly to their respective roles and provided guidance and expertise related to DMH's work.

Additionally, DMH has begun to transition to writing shorter reports and increasing the use of RBA Scorecards to provide more real-time based on timeframes (e.g., monthly, quarterly, bi-annual, annual), brief reporting via both quantitative and qualitative data

v. Pharmacy Program

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 support 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 $266 million in annual gross drug spend. The Pharmacy Unit routinely analyzes national and DVHA drug trends reviews drug utilization, and seeks innovative solutions to deliver 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 the Department of Mental Health (DMH) related to the 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, and Supplemental rebate programs
- Preferred Drug list management
- Prior authorization and utilization management programs
- Drug Utilization Review Board activities-therapeutic class reviews, new drug reviews, prior authorization criteria review, and step-therapy protocols.
- Specialty pharmacy management
- Physician-administered drug management

□ Manages exception requests, EPSDT requests, appeals, and fair hearings with Policy Unit.
□ Works with the 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	500,641	85	13,149	210	78	6,690	16,783	537,636
	93%	<1%	2%	<1%	<1%	1%	3%	100%
Quarter 2	508,626	93	10,228	243	94	6,872	16,651	542,807
	94%	<1%	2%	<1%	<1%	1%	3%	100%
Quarter 1	488,631	92	19,851	190	98	7,260	15,777	531,899
	92%	<1%	4%	<1%	<1%	1%	3%	100%

- The total claim count does not include compounded drugs.

Paid Claims and Drug Spend

MEDICAID

Period	**# Claims**	**# Of Members**	**State Paid Amounts**
3Q2022	**546,695**	**90,556**	**$70,772399.46985.91**
2Q2022	**484,772**	**87,713**	**$68,602,012.81**
1Q2022	471,462	80,819	$65,686,210.08

VPHARM

Period	**# Claims**	**# Of Members**	**State Paid Amounts**
2Q2022	**66,979**	**7,031**	**$1.390.713.66**
1Q2022	67,154	7,157	$2,038,496.04

Provider Communications

ProAir HFA (albuterol sulfate) Inhalation Aerosol Discontinuation	Teva notified the Department of Vermont Health Access (DVHA) and its pharmacy benefits administrator, Change Healthcare, that it will discontinue manufacturing ProAir HFA (albuterol sulfate) inhalation, effective 10/1/22. Alternatives ProAir Respiclick (albuterol sulfate) inhalation powder, Proventi HFA (albuterol sulfate) inhalation Aerosol, and Ventolin HFA (albuterol sulfate) inhalation Aerosol are preferred alternatives with no prior authorization required
Influenza 2022/2023	Communication around Influenza (Flu) vaccines 2022/2023 season for enrolled Medicaid providers on guidance and reimbursement.

Clinical Activities

None currently

Pharmacy Cost Management (PCM) Program

In late SFY 2017, DVHA, in collaboration with Change Healthcare, implemented the Pharmacy Cost Management (PCM) Program. The goal of the program is to mitigate the impact of high-cost specialty drugs on pharmaceutical expenditures while ensuring that the full value of these medications in improving patient outcomes and reducing medical expenditures can be realized. Achieving this goal requires focused and attentive oversight and management of both the drugs and the patients receiving them to ensure that patients are not only prescribed the optimal drug for their specific condition but that they are taking the drug as prescribed and are receiving the appropriate monitoring, testing, and follow-up care.

Change Healthcare (July 1, 2022, through September 30, 2022). Change Healthcare Pharmacy Management Reporting Suite is a collection of reports recording the process and progress of PCM.

In the third quarter of 2022, the PCM program enrolled an additional 162 members for a total of 3,028 members on 1674 unique medications. The program is actively monitoring 480 enrollees. A total of 199 outgoing telephone calls were placed to members, 91 of which resulted in member counseling. During this quarter of the Vermont PCM program, four interventions led to direct and measurable cost avoidance. Furthermore, interventions that do not bring about direct cost avoidance are in place to encourage adherence and thus improve member outcomes and avoid unnecessary medical costs. Through interventions in the PCM program, unnecessary drug spending of nearly $ 290,258 was avoided in the third quarter of the state fiscal year 2022. More than $ 4.6 million in unnecessary drug spend has been avoided throughout the program.

vi. All-Payer Model: Vermont Medicaid Next Generation Program

Key updates from QE092022:

- Executed a new contract with OneCare for the 2022 performance year of the program.
- Continued conducting financial reconciliation activities for the 2021 performance year, in order to determine financial and quality performance. Results will be available at the end of Q4 2022.
- Continued contract amendment negotiations with OneCare for a 2023 performance year.
- Continue to support Vermont's broader efforts to develop an integrated health

In 2016, the Department of Vermont Health Access (DVHA) sought to establish service

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

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

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

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

DVHA continued conducting financial reconciliation activities for its 2021 performance year in Q3 2022. Reconciliation activities will determine the ACO's spend as compared to their financial target and quality performance for the 2021 performance year. Reconciliation activities will continue into Q4 2022, and the final results will be available at the end of Q4 2022.

DVHA continued contract negotiations with OneCare for the 2023 performance year in Q3 of 2022. Potential changes to the program for the 2023 performance year could include modifications to the quality component of the program, changes in the rate development methodology, and the inclusion of a pilot payment model for hospitals participating in the VMNG program. Other anticipated programmatic changes are minor. Negotiations are expected to continue into Q4 of 2022.

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

V. Financial/Budget Neutrality Development/Issues

The narrative below reflects information for the first quarter of DY18. There may be prior quarter

adjustments that would affect DY17 from a budget neutrality and member month perspective and can be supplied upon request.

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 2022 quarter (July through September 2022). 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 on actual allowable Medicaid expenditures (program, investments, and administration) for the given quarter. AHS submitted and certified the CMS64 report for QE0922 on October 30, 2022. This quarter represents the first quarter that Vermont was required to report on categories of service on the CMS-64. For the previous demonstration cycles, Vermont had permission to report all GC expenditures on row 49, "Other." Vermont's internal report of categories of service (known as the financial balancing report, or FBR) was used to report on the CMS-64 categories of service. The FBR categories of service do not exactly align with the CMS-64; however, Vermont is working with the MMIS contractor to develop an automated report that is fully based on the CMS-64 categories of service. This report will not be ready until July 1, 2023.

This quarter represents the first quarter of DY18 of the GC Waiver which begins a new budget neutrality construct. Vermont calculates $357.5M for Without Waiver expenditures, and reported $341.7M in With Waiver expenditures, leaving a savings subtotal of $15.8M. There are also 10 Hypothetical Tests for various demonstration groups. The hypothetical tests for SMI IMD, CRT, Moderates, and Marketplace Subsidies reflect a surplus, whereas the tests for SUD IMD, IMD Lund, and Global Rx show moderate deficits. The total of the deficits is $837k which reduces the overall Waiver savings to $15M. There is nothing to report for the Housing Pilot or SUD CIT because those programs have not yet been operationalized. Lastly, for Investments, Vermont reported $30M in expenditures for the quarter which leaves $45.6M available for the remainder of DY18.

Vermont continues to implement HCBS programs using the Reinvestment funds under the American Rescue Plan of 2021. For QE0922, Vermont reported $3.5M in Program expenses, $9.9M in Investments, and $25k in Admin expenses.

Vermont continued to work with our contracted actuarial consultant, Wakely, to develop the CY 2023 GC rates for the IGA. They will also be preparing an amendment to the CY 2022 GC rates as there were several budgetary changes that passed in the legislative session. Wakely has also been actively reviewing the pre-prints for the CY 2023 rates. The delivery of the final rate certification is targeted for the last week of November.

VI. Member Month Reporting

The State of Vermont certifies the accuracy of the member month reporting. The enrollment report is produced on the 15th of every month. The member months are subject to revision 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 DY18 and includes the unduplicated count of member months for SUD IMD and SMI IMD stays.

Table 1. Member Month Reporting – DY18 (QE0922-QE1222), *subject to revision*

Medicaid Eligibility Group	Total DY 2018
ABD - Non-Medicare - Adult	19,291
ABD - Non-Medicare - Child	4,400
ABD - Dual	67,399
Non ABD - Non-Medicare - Adult	55,687
Non-ABD - Non-Medicare - Child	188,421
Hypothetical Groups	
New Adult	224,967
SUD - IMD ABD	19
SUD - IMD ABD Dual	31
SUD - IMD Non-ABD	48
SUD - IMD New Adult	240
SMI - IMD ABD	24
SMI - IMD ABD Dual	8
SMI - IMD Non-ABD	12
SMI - IMD New Adult	74
Housing Pilot	0
IMD Lund	61
CRT	666
SUD CIT	0
VT Global RX	28,135
Moderate Needs Group	419
Marketplace Subsidy	31,262

VII. Consumer Issues

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

The complaints received by Member Services are reported to DVHA (see Attachment 2). 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 4). 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 QE092022:

- Submitted DVHA's annual formal PIP summary for scoring by our EQRO.
- Continued participation in CMS' Foster Care Learning Collaborative.
- Continued coordination of DVHA's comprehensive risk assessment project.

A decision to more closely align compliance with quality improvement workflows led to recent restructuring within DVHA. The QI unit now partners with the Compliance and Oversight & Monitoring units as part of a larger Risk & Quality Management (RQM) Team. The over-arching goals of this team include:

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

PIHP Quality Committee

The Quality Committee remained active during QE0922 and consists of representatives from all departments within AHS that serve the Medicaid population. The committee continues to structure its work around the federal managed care quality program guidelines 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, the committee followed our work plan and began an annual analysis of our Global Commitment Core Performance Measure Set.

Formal CMS Performance Improvement Project (PIP)

DVHA's formal PIP topic is the management of hypertension. Intervention strategies have been chosen and continued to be implemented and changes tracked during QE0922. Sub-group work focuses on activities related to access to blood pressure monitors, provider and patient education, and connecting to community resources. DVHA's annual PIP summary was reviewed by our EQRO during this reporting period and received a score of 100%.

Other Collaborative Quality Improvement Projects

The Quality Improvement team continued to work with the following groups on collaborative QI projects during QE0922:

- 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. QI staff continue to contribute to the quality of care measures and analysis to ensure that cost and quality incentives are aligned in the APM.

- The Department of Children and Families (DCF), the Vermont Department of Health (VDH), and the Vermont Child Health Improvement Program (VCHIP) are on a learning collaborative to improve the timeliness of comprehensive health visits for children and adolescents entering foster care. During this reporting period, we built on process mapping done with one district office and implemented a small test of change. Data is being collected on this test and decisions will be made to revise or expand based on analysis.

Quality Measure Reporting

HEDIS measure production –In addition to producing administrative (claims-based) measures, the Clinical Services Team produced four (4) HEDIS hybrid measures again in 2022. DVHA's certified HEDIS vendor performed medical record retrieval (MRR) for all four hybrid measures and abstracted records for two of those measures. DVHA clinicians abstracted the other two measures. DVHA's Quality Assurance Manager oversaw the MRR process during QE0622 and submitted the validation sample to our performance measure EQRO during QE0922. All measures successfully passed validation.

The Director of Quality Management represents Vermont Medicaid in the New England Quality Consortium, which provides CMS with input annually on proposed changes to the Quality Core Performance Measure Sets.

Results Based Accountability (RBA)/Process Improvement

Results Based Accountability (RBA) scorecards are developed at DVHA for both internal and external performance management purposes. The use of this performance management framework and corresponding presentation tool has been spearheaded by the Agency's Central Office QI staff. The DVHA Quality Unit staff use this tool to create a *Global Commitment to Health* Core Measure scorecard, Experience of Care, and other performance budgeting scorecards. 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 QE0922 include the following programs: Programmatic Performance Measure Budget (PPMB).

The Quality Improvement Team also maintained its "Green Belt" status during QE0922 by participating in quality improvement activities and Green Belt meetings. Green Belt is the highest level of internal training offered through the State based on LEAN/RBA principles. The training is centered around process improvement and contributes to the Governor's initiative called PIVOT, or Program to Improve Vermont Outcomes Together.

COVID-19 Dashboard

The Quality Team was tasked with creating and maintaining a COVID-19 dashboard at the end of March 2020 to monitor the response to the pandemic: both the impact it has had on operations and the activities staff have engaged in. As an internal evaluation tool, the dashboard is updated monthly and made available to all DVHA staff via our intranet. This work continues into 2022 and will while the PHE is in effect. Measures are retired and additional measures are added to the dashboard as appropriate.

Vermont Next Generation Medicaid ACO

During QE0922, 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. A representative from the VMNG ACO is also a standing member of DVHA's formal PIP, the topic of which is managing hypertension.

Comprehensive Risk Assessment

Staff from DVHA's Quality, Oversight & Monitoring, and Compliance units began developing a comprehensive risk assessment program for Vermont's Medicaid program at the end of 2021. This work will continue throughout 2022. The purposes of the project are to:

- identify, analyze, prioritize and correct compliance risks across all departments and programs responsible for Medicaid service delivery;
- take advantage of opportunities to move beyond compliance and look for ways to improve the services we deliver to Vermonters.

The assessment entails collaboration with other Agency departments. In 2022, this project will also inform updates to DVHA's Intra-Governmental Agreements (IGAs).

Global Commitment (GC) Investment review

AHS Departments are required to monitor and evaluate the performance of their investments on an ongoing basis and subject them to formal review according to a periodic schedule. Performance monitoring is accomplished via a quarterly and annual review of performance information contained in a web browser-based software application (Clear Impact Scorecard). The scorecard includes the following data elements: investment description (i.e., the goal of the investment, the activities being supported, and information on how they are provided), performance measures (i.e., the data being collected and analyzed to determine if the investment is achieving its desired goal), results (performance measure rates for the most recent reporting period), and an interpretation of the results (i.e., comparing actual to expected rates using performance targets and/or benchmarks and to characterize trends or patterns in the data).
During this most recent quarter, VDH and DAIL highlighted the performance of a subset of their investments. The Clear Impact Scorecards for this investment are included in this report as Attachment 6.

Payment Models & Performance Monitoring

AHS Departments are required to monitor and evaluate the performance of their payment models on an ongoing basis and subject them to formal review according to a periodic schedule.
Performance monitoring is accomplished via a quarterly and annual review of performance information contained in a web browser-based software application (Clear Impact Scorecard). The scorecard includes the following data elements: investment description (i.e., the goal of the investment, the activities being supported, and information on how they are provided), performance measures (i.e., the data being collected and analyzed to determine if the investment is achieving its desired goal), results (performance measure rates for the most recent reporting period), and an interpretation of the results (i.e., comparing actual to expected rates using performance targets and/or benchmarks and to characterize trends or patterns in the data).
During this most recent quarter, DMH highlighted the performance of its payment model. The Clear Impact Scorecard for this payment model is included in this report as Attachment 7.

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

This quality strategy is intended to serve as a blueprint or road map for states and their contracted health plans in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. There were no updates to the CQS during this 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 of the demonstration. During this 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). The state awaits CMS feedback to ensure that these monitoring reports provide all the information requested by the templates.

SMI Monitoring Protocol

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

IX. Demonstration Evaluation Activities

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

During the quarter, the state continued to work with its 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. 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.

X. Compliance

Key updates from QE092022:

- EQRO RFP
- AHS/DVHA IGA
- DVHA is preparing subject matter experts for this year's EQRO Audit.

External Quality Review

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 seven performance categories (i.e., standards). The seven standards included requirements associated with the federal Medicaid managed care access standards found at CFR §438.206–438.210, enrollment and disenrollment requirements (§438.54–§438.56), and emergency and post stabilization services (§438.114). The standards included requirements related to the following:

1. Availability of Services
2. Assurances of Adequate Capacity and Services
3. Cultural Competence
4. Coordination and Continuity of Care
5. Coverage and Authorization of Services
6. Emergency and Poststabilization Services
7. Enrollment and Disenrollment Requirements

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 the 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, 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. Key updates from QE092020:

Intra-Governmental Agreement (IGA) between AHS and DVHA

During this quarter, the state continued to work with Manatt Health on the CY2023 Agency of Human Services (AHS) and the Department of Vermont Health Access (DVHA) IGA. The state plans to submit the CY2023 IGA during the next 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 to quality health care to uninsured, underinsured, and Medicaid beneficiaries.
- Provide public health approaches and other innovative programs to improve the health outcomes, health status, and quality of life for uninsured, underinsured, and Medicaid- eligible individuals in Vermont; and
- Encourage the formation and maintenance of public-private partnerships in healthcare, including initiatives to support and improve the healthcare delivery system and promote the transformation to value-based and integrated models of care.

XII. State Contact(s)

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

XIII. Attachments

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

Date Submitted to CMS: December 9, 2022

Attachment 1: Budget Neutrality Workbook

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
QE0922

ELIGIBILITY GROUP	DY 18 Jul 2022 - Dec 2022	DY 19 Jan 2023 - Dec 2023	DY 20 Jan 2024 - Dec 2024	DY 21 Jan 2025 - Dec 2025	DY 22 Jan 2026 - Dec 2026	DY 23 Jan 2027 - Dec 2027	Total
Without Waiver (Caseload x pmpms)							
ABD - Non-Medicare - Adult	$ 46,390,194	$ -	$ -	$ -	$ -	$ -	$ 46,390,194
ABD - Non-Medicare - Child	$ 11,741,865	$ -	$ -	$ -	$ -	$ -	$ 11,741,865
ABD - Dual	$ 142,831,969	$ -	$ -	$ -	$ -	$ -	$ 142,831,969
Non ABD - Non-Medicare - Adult	$ 43,836,682	$ -	$ -	$ -	$ -	$ -	$ 43,836,682
Non ABD - Non-Medicare - Child	$ 112,779,022	$ -	$ -	$ -	$ -	$ -	$ 112,779,022
Total Expenditures Without Waiver	**$ 357,579,731**	$ -	$ -	$ -	$ -	$ -	**$ 357,579,731**
With Waiver							
ABD Non Medicare Adult	$ 115,756,473	$ -	$ -	$ -	$ -	$ -	$ 115,756,473
ABD - Non-Medicare - Child	$ 9,432,590	$ -	$ -	$ -	$ -	$ -	$ 9,432,590
ABD - Dual	$ 71,028,721	$ -	$ -	$ -	$ -	$ -	$ 71,028,721
Non ABD - Non-Medicare - Adult	$ 30,059,602	$ -	$ -	$ -	$ -	$ -	$ 30,059,602
Non ABD - Non-Medicare - Child	$ 85,359,992	$ -	$ -	$ -	$ -	$ -	$ 85,359,992
Individual Cost Effective	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Community Transition Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
HIE	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Investments	$ 30,099,078	$ -	$ -	$ -	$ -	$ -	$ 30,099,078
Total Expenditures With Waiver	**$ 341,736,456**	$ -	$ -	$ -	$ -	$ -	**$ 341,736,456**
Waiver Savings Summary							
Subtotal Annual Savings	$ 15,843,275						
Hypothetical Test Deficits	$ -	$ -	$ -	$ -	$ -	$ -	
Cumulative Savings	$ 15,843,275	$ 15,843,275	$ 15,843,275	$ 15,843,275	$ 15,843,275	$ 15,843,275	$ 15,843,275
HYPOTHETICAL TESTS							
Hypothetical Test 1: New Adult							
Limit New Adult PMPM*MM	$ 129,362,049	$ -	$ -	$ -	$ -	$ -	$ 129,362,049
New Adult Total Expenditures	$ 118,119,866	$ -	$ -	$ -	$ -	$ -	$ 118,119,866
Surplus (Deficit)	$ 11,242,183	$ -	$ -	$ -	$ -	$ -	$ 11,242,183
Hypothetical Test 2: SUD IMD							
SUD - IMD ABD - Non-Medicare - Adult	$ 58,234	$ -	$ -	$ -	$ -	$ -	$ 58,234
SUD - IMD ABD - Dual	$ 57,553	$ -	$ -	$ -	$ -	$ -	$ 57,553
SUD - IMD Non ABD - Non-Medicare - Adult	$ 136,017	$ -	$ -	$ -	$ -	$ -	$ 136,017
SUD - IMD New Adult	$ 747,979	$ -	$ -	$ -	$ -	$ -	$ 747,979
Limit SUD IMD PMPM*MM	**$ 999,783**	$ -	$ -	$ -	$ -	$ -	**$ 999,783**
SUD - IMD ABD Non Medicare Adult	$ 66,266	$ -	$ -	$ -	$ -	$ -	$ 66,266
SUD - IMD ABD - Dual	$ 109,887	$ -	$ -	$ -	$ -	$ -	$ 109,887
SUD - IMD Non ABD - Non-Medicare - Adult	$ 152,498	$ -	$ -	$ -	$ -	$ -	$ 152,498
SUD - IMD New Adult	$ 852,194	$ -	$ -	$ -	$ -	$ -	$ 852,194
SUD IMD Total Expenditures	**$ 1,180,845**	$ -	$ -	$ -	$ -	$ -	**$ 1,180,845**
Surplus (Deficit)	$ (181,062)	$ -	$ -	$ -	$ -	$ -	$ (181,062)
Hypothetical Test 3: SMI IMD							
SMI - MD ABD - Non-Medicare - Adult	$ 1,339,884	$ -	$ -	$ -	$ -	$ -	$ 1,339,884
SMI - MD ABD - Dual	$ 285,946	$ -	$ -	$ -	$ -	$ -	$ 285,946
SMI - MD Non ABD - Non-Medicare - Adult	$ 436,029	$ -	$ -	$ -	$ -	$ -	$ 436,029
SMI - MD New Adult	$ 3,031,640	$ -	$ -	$ -	$ -	$ -	$ 3,031,640
Limit SMI IMD PMPM*MM	**$ 5,093,499**	$ -	$ -	$ -	$ -	$ -	**$ 5,093,499**
SMI - MD ABD Non Medicare Adult	$ 725,840	$ -	$ -	$ -	$ -	$ -	$ 725,840
SMI - MD ABD - Dual	$ 192,096	$ -	$ -	$ -	$ -	$ -	$ 192,096
SMI - MD Non ABD - Non-Medicare - Adult	$ 335,490	$ -	$ -	$ -	$ -	$ -	$ 335,490
SMI - MD New Adult	$ 2,574,524	$ -	$ -	$ -	$ -	$ -	$ 2,574,524
SMI IMD Total Expenditures	**$ 3,827,950**	$ -	$ -	$ -	$ -	$ -	**$ 3,827,950**
Surplus (Deficit)	$ 1,265,549	$ -	$ -	$ -	$ -	$ -	$ 1,265,549
Hypothetical Test 4: Housing Pilot							
Limit Housing Pilot PMPM*MM	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Housing Pilot Total Expenditures	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Surplus (Deficit)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Hypothetical Test 5: IMD Lund							
Limit IMD Lund PMPM*MM	$ 591,746	$ -	$ -	$ -	$ -	$ -	$ 591,746
IMD Lund Total Expenditures	$ 736,526	$ -	$ -	$ -	$ -	$ -	$ 736,526
Surplus (Deficit)	$ (144,780)	$ -	$ -	$ -	$ -	$ -	$ (144,780)
Hypothetical Test 6: CRT							
Limit CRT PMPM*MM	$ 3,376,537	$ -	$ -	$ -	$ -	$ -	$ 3,376,537
CRT Total Expenditures	$ 2,305,143	$ -	$ -	$ -	$ -	$ -	$ 2,305,143
Surplus (Deficit)	$ 1,071,394	$ -	$ -	$ -	$ -	$ -	$ 1,071,394
Hypothetical Test 7: SUD CIT							
Limit SUD CIT PMPM*MM	$ -	$ -	$ -	$ -	$ -	$ -	$ -
SUD CIT Total Expenditures	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Surplus (Deficit)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Hypothetical Test 8: Global Rx							
Limit Global Rx PMPM*MM	$ 2,512,994	$ -	$ -	$ -	$ -	$ -	$ 2,512,994
Global Rx Total Expenditures	$ 3,024,993	$ -	$ -	$ -	$ -	$ -	$ 3,024,993
Surplus (Deficit)	$ (511,999)	$ -	$ -	$ -	$ -	$ -	$ (511,999)
Hypothetical Test 9: Moderates							
Limit Moderates PMPM*MM	$ 349,354	$ -	$ -	$ -	$ -	$ -	$ 349,354
Moderates Total Expenditures	$ 192,809	$ -	$ -	$ -	$ -	$ -	$ 192,809
Surplus (Deficit)	$ 156,545	$ -	$ -	$ -	$ -	$ -	$ 156,545
Hypothetical Test 10: Marketplace Subsidy							
Limit Marketplace Subsidy PMPM*MM	$ 1,041,889	$ -	$ -	$ -	$ -	$ -	$ 1,041,889
Marketplace Subsidy Total Expenditures	$ 971,630	$ -	$ -	$ -	$ -	$ -	$ 971,630
Surplus (Deficit)	$ 70,259	$ -	$ -	$ -	$ -	$ -	$ 70,259

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

Attachment 2: Complaints Received by Health Access Member Services

Questions, Complaints and Concerns Received by Health Access Member Services
July 1, 2022 – September 30, 2022

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 2022:

- Provider Complaint - Caller requested to submit negative feedback regarding the VT Medicaid Provider Look up Portal. Caller stated the providers that are listed on the website, are not accepting SOV Medicaid. Caller is requesting that someone go through the list and update the information accurately to show which providers no longer accept VT Medicaid. The Agent apologized for the inconvenience, assisted with searching for another provider in a different town close to the customer and documented the feedback.
- Provider Complaint - Caller submitted negative feedback regarding her DME (Oxygen Machine). Caller states XXXXX XXXXX has not called them back when they have tried to contact them many times. Caller called the Williston branch and the main branch located in New Hampshire and neither facility has returned their call. Caller has made many phone calls this past week trying to get the issue resolved. The Agent apologized for the inconvenience, documented the feedback and provided the phone number to VT Legal Aid as well as mailed out a Provider Complaint Form.
- Provider Complaint - Caller called to report negative feedback as they cannot find any dental providers in their area that are accepting new Medicaid Patients. Caller states that

they have had to pay out of pocket for visits as the only dentist they could find did not accept VT Medicaid as insurance. Caller feels that they should be reimbursed for those visits. The Agent apologized for the inconvenience, assisted the customer with finding a dental provider that accepts VT Medicaid and mailed out a Provider Complaint Form.

August 2022:

- Provider Complaint - Caller states that they do not believe they are ready to leave XXXXX XXXXX and are advised that Medicaid will only cover a certain number of days. Caller states that Dr. XXXXX has mistreated them and has not given them the medication that they need. The Agent apologized for the inconvenience, documented the feedback and offered to mail out a Provider Complaint Form.

September 2022:

- Provider Complaint - Caller is concerned with not being able to find any dentists in the area. Caller states they have reached out to over 25 Dental Offices and none of them are accepting new patients that have Medicaid for insurance. Caller states they have all advised that they are over capacity and have no availability. The Agent apologized for the inconvenience, documented their feedback and provided more numbers to local dentists that are around the area.
- Caller submitted negative feedback regarding the lack of Dental Providers that accept VT Medicaid. Caller states that no one is accepting new dental patients in their area except for one location and they do not have any appointments available until 10/31/22. The Agent apologized for the inconvenience, documented their feedback and offered to provide more numbers to local dentists that are around the area.
- Provider Complaint - Caller would like to document negative feedback as they state that they have called over 26 different PCP Doctors and have received the same response every time, that they are currently not accepting new patients. Member has called Vermont Health Connect a total of six times in one day trying to find a PCP that is accepting new patients. The Agent apologized for the inconvenience, documented the feedback and assisted the customer by providing more PCP's in the customers area.
- Provider Complaint - Caller requested to document negative feedback about her experience at XXXXX XXXXX on 6/1/22. Caller states they had fallen which caused damage to their legs. Caller was in extreme pain and went to the Emergency Room where they had to wait several hours just to be seen. The doctors wrapped their legs in ace bandages very tightly. A couple days later, caller took another trip to a clinic where advised her XXXXX XXXXX should’ve never wrapped their legs so tightly and is in immediate danger of blood clots and infections. Caller states this is very scary, and all could've been avoided. Caller is now suffering from severe neuropathy from the misdiagnosis from XXXXX XXXXX. The Agent apologized for the inconvenience, documented the feedback and offered to mail out a Provider Complaint Form.
- Provider Complaint - Caller wanted to file negative feedback about XXXX XXXX. Caller states that the facility is not ready to release them. Caller feels well enough to take care of their own health now. Caller also stated that they do not get their daily medications on time and they do not provide them with proper meals on time. Caller is on a high protein diet with supplements which they should be getting in a timely manor. The Agent apologized

State of Vermont Agency of Human Services
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for the inconvenience, documented the feedback and offered to mail out a Provider Complaint Form.

- Covered Services - Caller would like to report 3 out of 4 of their children have received flu vaccines on Wednesday, at XXX XXXX. They are on a list to get the flu vaccine, as a priority, due to one of the children is type 1 Diabetic. 4th child was not available to go to appt, is 14yrs old and eligible for the new Covid Booster which is not available at XXXX XXXXX at this time. Caller went to XXXXX hoping to get child's Covid Booster along with the Flu Vaccine, however Medicaid denied coverage for Flu Vaccine. Caller states that "this is not acceptable and does not promote Preventive Health Care. Two of the children cannot get the new Covid Booster as of yet and had to go the Pediatricians Office for the Flu Shot but XXXXX should be able to get the Flu shot and covered at XXXX. What is the difference between XXXXX and XXXXX to get these Vaccinations? By requiring so many different stops many children may not get Vaccinated for the Flu and/ or Covid Booster. Your coverage policy starting Oct. 1st discriminates against Medically Compromised Households, and this needs to be changed". The Agent apologized for the inconvenience and documented the customers feedback.
- Provider Complaint - Caller wanted to document negative feedback regarding the lack of Dental Providers that accept Medicaid. Caller states there are no dentists available in their area to accept Medicaid patients. This causes customers having to travel long distances to find a Dentists. Caller also states there are not many incentives for Dentists to accept Medicaid which could be the reason there are not many that do. The Agent apologized for the inconvenience, documented their feedback and provided more numbers to local dentists that are around the area.
- Provider Complaint - Caller called to report that they do not like their providers and feels discriminated against. Caller also feels that VHC/GMC are not doing enough as we are only Member Services and cannot provide them with much assistance other than resources. The Agent apologized for the inconvenience, documented their feedback and referred the customer to VT Legal Aid for assistance.

Attachment 3: Medicaid Grievance and Appeal Report

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
July 1, 2022 – September 30, 2022

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 July 1, 2022, through September 30, 2022.

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 21 grievances filed; seven were addressed. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was three days. Of the grievances filed, 81% were filed by the beneficiary, and 19% were filed by a representative. DMH had 71%, DAIL had 24%, and DVHA had 5% of the grievances filed.

Grievances were filed for service categories case management and community social supports

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 16 appeals filed. Of these 16 appeals, 14 were resolved (88%). One of these appeals was filed untimely and one is still pending.

Of the 14 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 30 days. The average number of days it took to resolve these cases was 20 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was three days.

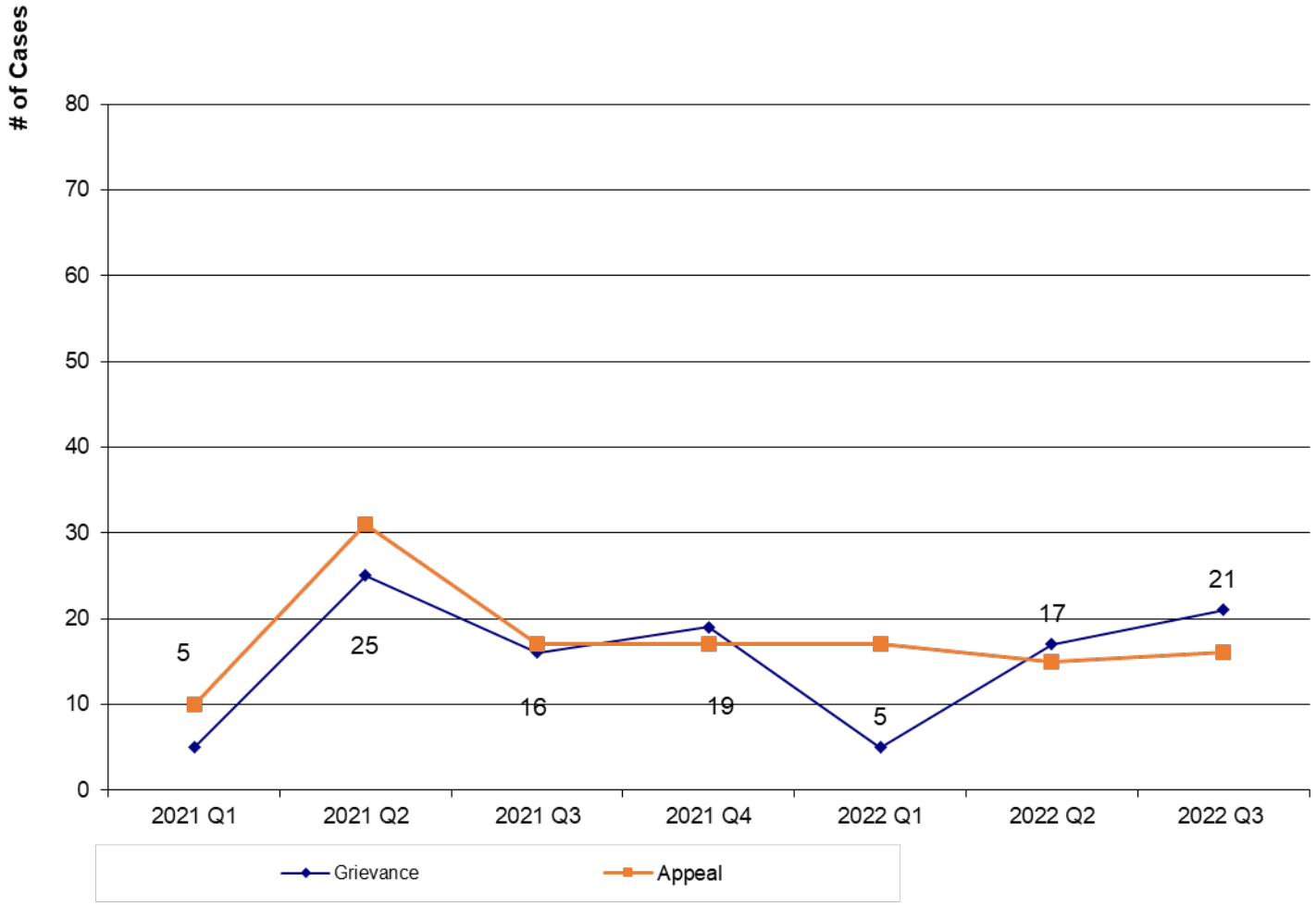
Of the 16 appeals filed, DVHA had 14 appeals filed (88%), DAIL had 1 (6%), and DMH had 1 (1%).

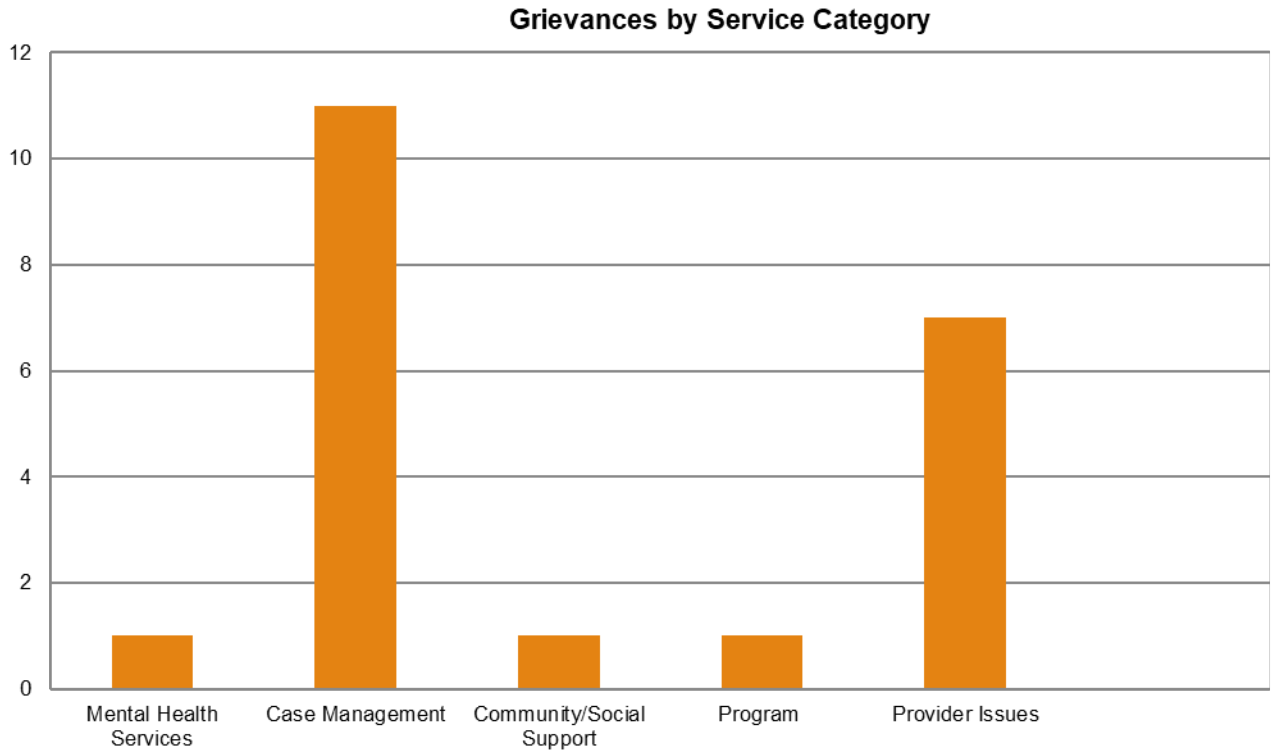
The appeals filed were for service categories mental health, prescriptions, physical therapy, supplies, developmental services and transportation.

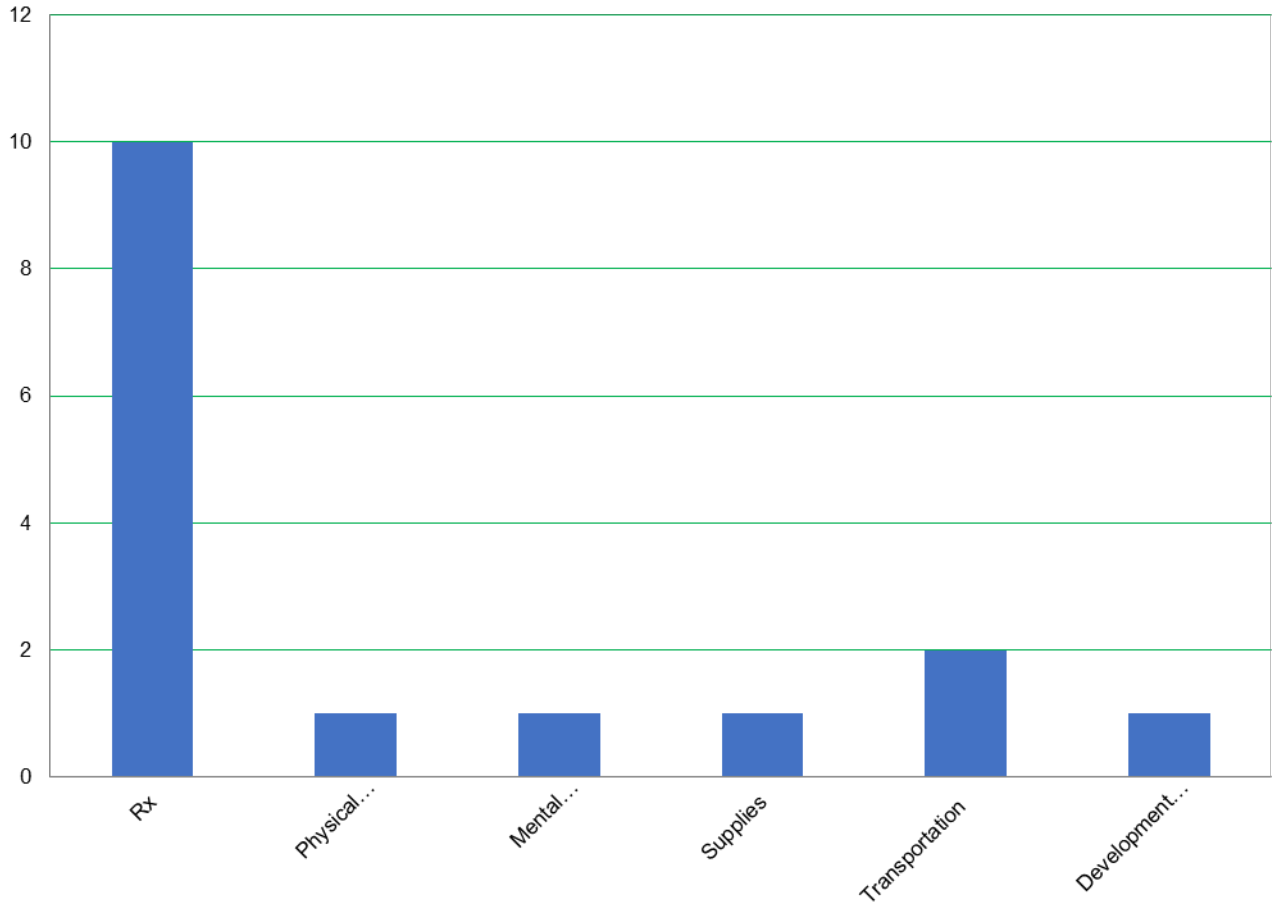
Beneficiaries must exhaust the internal appeal process before they can file a fair hearing if their appeal is not decided in their favor. There were two fair hearing filed this quarter.

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

Grievances and Appeals
January 1, 2021– September 30, 2022




Grievances by Service Category
12
10
8
6
4
2
0
Mental Health Services
Case Management
Community/Social Support
Program
Provider Issues


Appeals by Service Category
12
10
8
6
4
2
0
Rx
Physical…
Mental…
Supplies
Transportation
Development…

Attachment 4: Office of the HCA Report

Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

July 1, 2002 – September 30, 2022

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

October 21, 2022

Summary and Update

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

The HCA Helpline now has eight advocates working to resolve issues, who are also working on a hybrid schedule.

This quarter, the HCA continued to focus on Medicare affordability. We assisted with creating a survey for Medicare enrollees, asking them about their coverage, premiums, and enrollment issues. We also promoted participation in the survey by writing to people who called us about Medicare costs. In the next quarter, we will continue to participate in the work group on Medicare and Medigap enrollment. Every quarter, the HCA gets a substantial number of calls from consumers who cannot afford Medicare costs. We spoke to 55 households about Medicare Savings Programs, which help with Medicare premium costs. We advised another 10 households about their eligibility for VPharm, the state's pharmacy program that helps with Part D premiums and copayments, and 7 households about the Low-Income Subsidy, which is the federal program that helps reduce Part D costs. We also gave 73 households consumer education about Medicare. In August, we also provided training to advocates who work with Medicare enrollees, on eligibility for programs that can reduce Medicare out of pocket costs such as Medicare Savings Programs, Medicaid, and VPharm, and Low-Income Subsidy.

We also spoke to 218 households about all types of Medicaid eligibility. We also continued to get a sizable number of calls about provider complaints (123 calls). On the website, the Medicaid eligibility page had 2,462 page views. Overall, the HCA helpline had 820 calls this quarter.

This quarter the Immigrant Health Insurance Plan also launched. The HCA worked closely with DVHA to prepare for the launch, and it continues to participate on the Communication Council for IHIP. HCA advocates participated in an outreach event in July, and it is planning more direct outreach. The HCA also worked with VHC to develop an educational outreach flier about health care options for immigrants in Vermont.

HCA advocates also worked directly with consumers to help them apply for IHIP (Immigrant Health Insurance Plan) and Emergency Medicaid.

Libby's Story:

Libby called the HCA because she had major surgery scheduled—and had discovered that her Vermont Health Connect (VHC) plan had been terminated. She expected to be in the hospital for up to a week. She was going to need follow-up care and prescriptions after her release. When she was on her VHC plan, Libby was receiving Advance Premium Tax Credit (APTC), which helped lower her monthly premium. She told the HCA advocate that she had been making timely payments. The HCA advocate investigated why the plan was closed. She found that VHC had sent Libby some notices, asking her to verify information. The VHC notices said that if Libby did not provide the information, the plan would terminate. Libby was confused by the VHC notices and did not respond to them immediately. The advocate also discovered that after VHC sent the notices asking for information, it sent another notice finding Libby eligible for increased APTC. The contradictory notices created a confusing situation for Libby because the notice finding her eligible for APTC made her think that the verification issues mentioned in the prior notices had been resolved. The advocate argued that VHC had created this confusion by the conflicting notices, and it needed to reinstate. VHC agreed to reinstate the plan, which meant that Libby had her coverage in place for her surgery.

As Vermont prepares for its fourth winter with COVID, its health care system is under stress. Vermonters continue to call the HCA because they cannot find a provider. Many must wait months for a medical or dental appointment. Our calls about Vermonters having trouble accessing dental care increased again this past quarter (42 calls vs. 34 calls last quarter). We also had 22 calls from consumers who could not access primary care, and 23 having trouble finding a specialist. We spoke to 18 consumers who experienced delayed care because they could not find a provider. Our webpage on dental services had 1080 page views. Consumers must also contend with increasing costs of gas, food, housing, childcare, and find a way to pay for their medical care. The HCA will continue to work to make healthcare more accessible for all Vermonters, and to advocate for a system that is more equitable, responsive, and affordable.

Paul's Story:

Paul called the HCA because he was having trouble getting his prescriptions filled at his new pharmacy. Paul had Medicaid for Children and Adults, which meant that his prescription copayments should have cost $1 to $2. The last time he had picked up his prescriptions, one had been over $100, and he was not able to pick up the other because he was told it needed prior authorization. The HCA advocate researched both prescriptions. She found for the first one, Paul's prior authorization had expired. This meant that the provider needed to submit a new prior authorization, and then the prescription would be covered for $1 or $2. The HCA advocate discussed this issue with the pharmacy, and the pharmacy agreed to re-bill once the prior authorization had been approved. After it was re-billed, Paul would get a refund on the over $100 he had spent. For the other prescription, the HCA advocate found that it should be covered *without* requiring prior authorization. She discussed that with the pharmacist also, who agreed that Paul should have been able to fill the prescription. That meant that Paul was able to pick up that prescription that day.

Noel's Story

Noel called the HCA because she was confused about notices that she was getting from Vermont Health Connect (VHC). Noel had Medicaid for Children and Adults, but she received a letter from VHC saying that they were over income for the program. She was not sure what this meant and was worried about losing coverage. Noel was also preparing to go onto Medicare in the coming months. The HCA advocate explained that Noel's Medicaid coverage was not going to close because of the COVID-19 public health emergency (PHE). Since the PHE was declared in 2020, VHC has not been closing Medicaid or other state health care programs. The HCA advocate explained that when the PHE ends, VHC will start reviewing and closing Medicaid. Noel would get a written notice from VHC before their coverage was closed. Noel also had questions about transitioning to Medicare, and the HCA advocated explained Medicare and how a different type of Medicaid worked with Medicare. The advocate showed Noel how to apply for programs that would reduce the out pockets costs of Medicare costs. Noel planned to apply for those programs when she became Medicare eligible in the coming year.

Adele's Story

Adele moved to Vermont for a new job. Her job, however, did not offer health care coverage for the first six months, and she discovered that she was pregnant soon after starting her job. Adele called the HCA because she needed to see a provider, and she did not know if she was eligible for health care coverage. The HCA advocate discovered that Adele was over-income for Dr. Dynasuar for pregnancy, but she was

eligible for Advance Premium Tax Credit (APTC) to help pay for a Vermont Health Connect plan. Normally, if you have an offer of employer insurance, you are not eligible for APTC. But because Adele's job had a six-month waiting period before she could get on her employer sponsored insurance, Adele was eligible to get APTC. She also had a special enrollment to sign up for a VHC plan outside of Open Enrollment because she had just moved to the state of Vermont. VHC also has a special enrollment period for pregnancy. This meant Adele could sign for a VHC plan and get subsidy to help pay for it, so she would have coverage for her pregnancy. When she became eligible for her employer coverage, she would be able to transition off the VHC plan. The HCA advocate helped Adele apply and sign up for a plan, and Adele was able to schedule an appointment with a provider.

Overview

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

The HCA received 820 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:

- **31.58%** about **Access to Care**
- **9.88 %** about **Billing/Coverage**
- **1.83 %** about **Buying Insurance**
- **12.07%** about C**omplaints**
- **11.83%** about **Consumer Education**
- **22.07%** about **Eligibility** for state and federal programs
- **9.76%** 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 181 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, an additional 326 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 VHC and Medicaid programs fell into all three insurance status categories.

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

The full quarterly report for July – September 2022 includes:

- This narrative
- Five data reports, including three based on the caller's insurance status:
  - **All Calls/All Coverages**: 820
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 275
  - **Commercial Plan Beneficiaries**: 128
  - **Uninsured Vermonters**: 62
  - **Vermont Health Connect (VHC)**: 130

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 820 (vs. 794 last quarter)

1. Complaints about Providers 123 (100)
2. MAGI Medicaid Eligibility 107 (84)
3. Medicare Consumer Education 73 (73)
4. Other Issues (Not Health-related) 55 (45)
5. Medicaid Eligibility (non-MAGI) 55 (64)
6. Buy-in Programs/Medicare Savings Programs 55 (60)
7. Information/Applying for DVHA Programs 50 (53)
8. Premium Tax Credit 50 Eligibility (28)
9. Complaints about Hospital 47 (40)
10. Special Enrollment Period Eligibility 42 (42)
11. Access to Prescription Drugs/Pharmacy 39 (49)
12. Long Term Care Medicaid & Choices for Care Eligibility 36 (26)
13. Other Issues (Health-related) 35 (33)
14. Quality of Care 29 (15)
15. Mental Health Treatment 28 (28)

Vermont Health Connect Calls 130 (vs. 83 last quarter)

1. Medicaid Eligibility – MAGI 70 (43)
2. Premium Tax Credit Eligibility 47 (26)
3. Special Enrollment Period Eligibility 34 (28)
4. Information about DVHA 21 (14)
5. Buying QHPs through VHC 18 (20)
6. Termination of Insurance 16 (17)
7. IRS Reconciliation Education 13 (8)
8. Information about ACA Tax Issues 11 (7)
9. Citizenship & Identity 8 (5)

10. Grace Periods Consumer Education 6 (3)
11. Information about ACA 6 (7)

DVHA Beneficiary Calls 275 (vs. 249 last quarter)

1. Medicaid – MAGI Eligibility 42 (42)
2. Complaints about Providers 30 (30)
3. Information about DVHA 29 (30)
4. Information about Medicare 28 (32)
5. Access to Dental 27 (19)
6. Non-MAGI Medicaid Eligibility 27 (33)
7. Eligibility for MSPs/Buy-In Programs 25 (24)
8. Access to Prescription Drugs 22 (16)
9. Other (Not Health-related) 18 (6)
10. Access to Transition of Care 17 (7)
11. Medicare Eligibility 17 (18)

Commercial Plan Beneficiary Calls 128 (vs. 119 last quarter)

1. Premium Tax Credit Eligibility 31 (16)
2. Eligibility for MAGI Medicaid 19 (24)
3. Eligibility for Special Enrollment Period 19 (15)
4. Buying QHPs through VHC 12 (13)
5. IRS Reconciliation Consumer Education 11 (7)
6. Termination of Insurance 11 (13)
7. Billing – Claim Denials 10 (5)
8. Medicare Consumer Education 9 (7)
9. Billing – Coverage & Contract Questions 8 (4)
10. Billing – Provider Billing 8 (4)
11. ACA Tax Issues Education 8 (5)

The HCA received **820** total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as "dual eligible"): 33.54% (275 calls)
- **Medicare**[1] **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): 22.07% (181 calls)
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans) 15.61% (128 calls)
- **Uninsured:** 7.56 % (62 calls)

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

Dispositions of Closed Cases and Money Saved

We closed 881 cases this quarter. Overall, 410 were resolved by brief analysis and advice, and another 316 were resolved by brief analysis and referral. There were 100 complex interventions involving complex analysis and more than two hours of an advocate's time, and 493 cases that involved at least one direct intervention on behalf of a consumer. The HCA provided consumer education in 631 cases. We also estimated eligibility for insurance coverage and helped enroll people onto coverage in 55 cases. We saved consumers $184,342.12 this quarter.

Consumer Protection Activities

Rate Review

The HCA reviews and analyzes all commercial insurance carrier requests to the Green Mountain Care Board (Board) to change premium prices. The Board decided seven premium price change requests during the quarter from July 1, 2022, through September 30, 2022. Additionally, there are two premium price change requests pending at the close of the quarter.

The Vermont Health Plan (TVHP) submitted a premium price change request decided by the Board this quarter: the TVHP Large Group Unit Cost Trend Q4 2022 filing. TVHP requested that the medical unit cost trend for the large group manual rate formula be set the same as ordered in the Vermont Health Connect filings. This premium price change request was consolidated with Blue Cross Blue Shield of Vermont's (BCBSVT) Large Group Unit Cost Trend Q4 2022 price change request. On August 18th, 2022, the Board approved the proposed change to the medical unit coat trend. The HCA appeared on behalf of Vermonters in this matter.

BCBSVT submitted four premium price change requests decided by the Board this quarter: the BCBSVT 2023 Small Group filing; the BCBSVT 2023 Individual filing; the BCBSVT Association Health Plan (AHP) filing; the BCBSVT Large Group Unit Cost Trend Q4 2022 filing. As noted above, the BCBSVT Large Group filing was consolidated with the TVHP Large Group filing. The 2023 Individual and 2023 Small Group filings were also treated as one filing. For 2023, as was the case in 2022, there are two filings for individual and small group plans instead of two, because the legislature opted to keep the individual and small group markets unmerged for another year.

The BCBSVT Small Group filing impacts 19,581 Vermonters. BCBSVT is requesting an average premium price increase of +12.5%. The BCBSVT Individual filing impacts 16,556 Vermonters. BCBSVT is requesting an average premium increase of +12.3%. After filing these premium price increases, BCBSVT amended their requested premium price increase of +15.4% for the Small Group filing and +14.9% for the Individual filing. The HCA appeared on behalf of Vermonters in this matter. Representing Vermonters' interests in these matters including, but was not limited to, developing and implementing a public comment platform, participating the rate hearing, and filing a post hearing memorandum.

The two other premium price change requests by BCBSVT this quarter were the Large Group Unit Cost Trend Q4 2022 filing and the AHP filing. The HCA appeared on behalf of Vermonters in both matters.

MVP submitted two premium price change requests decided by the Board this quarter: the 2023 MVP Small Group VHC filing (MVP Small Group); and the 2023 MVP Individual Group VHC filing (MVP Individual). For 2023, as was the case in 2022, there are two filings for individual and small group plans instead of two, because the legislature opted to keep the individual and small group markets unmerged for another year.

The MVP Small Group filing impacts roughly 20,900 Vermonters. MVP is requesting an average premium increase of +16.6%. The MVP Individual filing affects roughly 15,026 Vermonters. MVP is requesting an average premium price increase of +17.4%. After filing these premium price increases, BCBSVT amended their requested premium price increase of +23.44% for the Small Group filing and +24.45% for the Individual filing. The HCA appeared on behalf of Vermonters in this matter. Representing Vermonters' interests in these matters including, but was not limited to, developing and implementing a public comment platform, participating the rate hearing, and filing a post hearing memorandum.

The two premium price change requests pending as of the close of this quarter are the MVP 22023 Large Group HMO filing and the Cigna Health and Life Insurance Company Large Group filing. The HCA has appeared on behalf of Vermonters in these matters and will provide all appropriate representation to represent Vermonters' interests in this matter.

Hospital Budgets

The HCA participated in hospital budget hearings and submitted written comments with recommendations to the GMCB. Our hearing questions and post-hearing comments focused specifically on hospitals' commitment to health equity, financial transparency, consumer affordability and access, as well as cost accounting and health care prices. We look forward to working with the hospitals to support reforms aligned with Act 119, which relates to improving patient financial assistance policies.

Certificate of Need Review Process

The HCA has statutory authority to assert interested party status in certificate of need (CON) proceedings before the GMCB. In the last quarter, one new CON application was received by the Board. As the application met the requirements for expedited review, the HCA did not intervene. We will continue to actively monitor certificate of need applications as they are submitted and assert party status when the interests of Vermonters are clearly implicated.

Oversight of Accountable Care Organizations

The HCA provided written questions and recommendations that were incorporated in written follow-up questions and review for two upcoming ACO budget processes for OneCare Vermont (OCV) and Gather Health. Our questions focus on the importance of establishing clear methods of quantitative and qualitative evaluation of ACO performance, financial transparency, and the prioritization of population health programs rooted in a social determinants of health approach. The HCA looks forward to focusing on these areas in the hearings in October and November and collaborating with the GMCB ACO Budget team in their oversight of ACOs operating in Vermont.

Additional 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, quarterly Prescription Drug Technical Advisory meetings, and several other legislatively established workgroups focused on affordability and access.

H.489 Market Structure and Affordability Workgroup

This workgroup was formed with a particular charge by the legislature to consider what policy options should be evaluated if the ARPA enhanced premium tax credits were not extended. The workgroup focused on whether the individual and small groups should be merged/unmerged and if the enhanced subsidies were not extended and what actions could be taken to protect the individual market for the 2023 plan year. The workgroup met three times during the quarter to consider perspectives of the small group, and the individual market. The premium tax credits were extended, and the pressure was taken off the group for the current year. Current law will maintain a notwithstanding of the merged market statute for the 2023 plan year. There was broad agreement that the merged market statutes should continue to be not withstood if the enhanced premium tax credits are maintained by the Federal government.

The HCA raised additional concerns about the adverse selection dynamics between the self-funded market and the QHP small group. We note that in the current environment, the QHP small group can be used as a safety net for small groups with higher morbidity and that healthier small groups would migrate to the self-funded market. The workgroup recognized the relatively narrow charge of this workgroup, and therefore did not engage in this area of health policy. The HCA will continue to raise this concern in future policy discussions.

S.239 Medicare Supplemental DFR workgroup

This work group was created in response to a policy proposal that the HCA brought to the Legislature last biennium. The workgroup met three times during the quarter. The HCA participated in these meetings, assisted in the development of a consumer survey. The survey focused on Vermonters' experiences with Medicare supplemental coverage and Medicare Part C coverage. The survey also focused on Vermonters without any secondary coverage. We helped with the distribution of the survey. In addition, we brought a proposal to the workgroup to increase Medicare Savings Plan eligibility limits to the Connecticut levels for these programs. The workgroup will continue to evaluate reasonable steps to take both for improved access to supplemental plans as well as expand eligibility for Medicare Savings Plans.

Global Budget Work Group

In response to Act 167 of 2022, the administration formed a workgroup focused on providing input to CMS about the next All Payer Model agreements as well as hospital sustainability. The HCA was not invited to participate in the earlier stages of this workgroup. Two subgroups were subsequently formed, one on Total Cost of Care and one on Global Budgets. The HCA has been invited to participate in these two workgroups. The first meeting of the Global Budget work group was held during this quarter.

The Medicaid and Exchange Advisory Committee

The Advisory Committee met two times this quarter taking the month of August off. The content of this quarter's meetings included a DVHA and Medicaid orientation, presentations and discussions about the new Global Commitment 1115 waiver, Personal Care Assistant Services, Interoperability and Patient Access and a preview of the coming year's open enrollment communications strategies.

Mental Health Integration Council

The HCA is a member of the Mental Health Integration Council. The Chief Advocate participated in meetings of the full council as well as the Pediatric integration subgroup during this quarter. The council continued its work in understanding the efforts already underway and defining potential ways to improve on those efforts.

Legislative Advocacy

The Vermont Legislature was not in session this quarter. This being an election year, the HCA reached out to candidates for the General Assembly to offer to be a resource for the people who reach out to candidates with individual access to care concerns as well as to assist candidates who are considering health policy positions. The HCA also asked candidates for assistance in getting the word out about information that could be of assistance to Vermonters.

Medical Debt Story Telling Project

The HCA has long recognized the impact of medical debt on Vermonters and health care access issues related to the cost of services. This quarter, in addition to ongoing casework and the regulatory work, we continued to work on a medical debt project to highlight the experiences of Vermonters with these issues.

Our Medical Debt Story Telling Project was an integral part of our legislative strategy to pass H.287 that created a statewide minimum standard for hospital free care policies. This quarter, our efforts were largely put hold due to the volume of rate review and hospital budget work. That being said, we implemented a set of back-end changes to *www.vtmedicaldebt.org* and completed initial planning for a Fall social media campaign to promote the web application.

Collaboration with Other Organizations

The HCA regularly collaborates with other organizations to advance consumer-oriented policy objectives and to conduct outreach and education:

- American Civil Liberties Union of Vermont
- Bi-State Primary Care
- Bridges to Health
- Blue Cross Blue Shield of Vermont
- Burlington Brigade of Code for America
- Burlington Code Academy
- Committee on Vermont Elders
- Department of Financial Regulation
- Families USA
- IRS Taxpayer Advocate Service
- Let's Grow Kids
- Mexican Consulate
- Migrant Justice
- MVP Health Care
- National Academy for State Health Policy
- NHeLP, National Health Law Program
- New American Clinic/Family Room
- OneCare Vermont
- Open Door Clinic
- Planned Parenthood of Northern New England
- Rights and Democracy (RAD)
- Rural Vermont
- South Royalton Legal Clinic
- SHIP, State Health Insurance Assistance Program
- U.S. Based Committee for Refugees and Immigrants Vermont
- 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* – 2,462 pageviews
2. *Health* - section home page – 1,790
3. *Dental Services* – 1,080
4. *Medicaid, Dr. Dinosaur & Vermont Health Connect* – 818
5. *Medicaid* – 619
6. *HCA Help Request Form* – 593 pageviews and 133 online help requests
7. *Services Covered – Medicaid* – 526
8. *Long-Term Care* – 503
9. *Resource Limits - Medicaid* – 447
10. *Medicare Savings Programs* – 394
11. *Choices for Care Income Limits* – 324
12. *Medical Decisions: Advance Directives* – 294
13. *Dr. Dynasaur* – 287
14. *Advance Directive forms* – 275
15. *Choices for Care* – 266
16. *Choices for Care Giving Away Property or Resources* – 255
17. *Choice for Care Resource Limits* – 246 *
18. *Vermont Long-Term Care Ombudsman Project* – 243 *
19. *Requirements for Getting Choices for Care* – 234 *
20. *Buying Prescription Drugs* – 231 *

This quarter we had these additional news items:

- *Your Benefits and the Public Charge Rule for Immigration* – 65 pageviews
- *You May Be Eligible for New Financial Help for Health Insurance (ARPA)* – 9

Outreach and Education

The Office of the Health Care Advocates (HCA) engaged in multiple in person outreach events this quarter. Some highlights include:

- **July 16**: Two HCA advocates attended the Migrant Justice Soccer Tournament to provide consumer education about the HCA and Vermont health care programs.

- **August 11**: The HCA Helpline Director and HCA advocate presenting an online training on Vermont health care programs and eligibility for the Vermont Association Area on the Aging. Over 25 people attended the training and were able to ask questions about the programs.

- **September 7**: UVM Graduate Student Fair. Two HCA advocates spoke to 22 people about health care issues. Specific topics included health coverage for people with disabilities, network adequacy, IHIP, and losing insurance when turning 26. The HCA also networked with community partners at this event.

- **September 18:** Burlington Pride Festival. Two HCA advocates set up a table, in the health resources tent along with community partners like the Dept of Health and Planned Parenthood. The HCA talked to 33 individual people about the HCA and health care as well as handing out business cards and brochures. The HCA advocates advised on health insurance options when you turn 26, getting health insurance when you are new to the state, Medicare, and access to mental health services. The advocates also spoke with providers who will make referrals to the HCA when their patients are having issues or questions.

- **September 24**: Inner Space Wellness Fair. Two HCA advocates tabled in Landry Park, Winooski for the day. This was a smaller event hosted by a new community organization who serves communities of color and aims to decolonize access to health care. This fair's target demographic was wellness specifically for trans youth. The HCA spoke with 6 people about the HCA services and health care.

Office of the Health Care Advocate

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

https://vtlawhelp.org/health

Attachment 5: Investments (GC Investments)

DY18 Investment Expenditures

Department	Final Receiver Suffix	Investment Description	QE 0922	QE 1222	DY18 Total
AHSCO	9091	Investments (STC-79) - 2-1-1 Grant (41)			-
AHSCO	9090	Investments (STC-79) - Designated Agency Underinsured Services (54)	1,704,648		**1,704,648**
AHSCO	9421	HCBS Investment	9,928,667		
AOE	n/a	Non-state plan Related Education Fund Investments			-
DCF	9402	Investments (STC-79) - Medical Services (55)	107,476		**107,476**
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)	973,859		**973,859**
DCF	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	26,515		**26,515**
DCF	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	59,070		**59,070**
DCF	9408	Investments (STC-79) - Essential Person Program (59)	190,058		**190,058**
DCF	9409	Investments (STC-79) - GA Medical Expenses (60)	32,349		**32,349**
DCF	9411	Investments (STC-79) - Therapeutic Child Care (61)	363,073		**363,073**
DCF	9412	Investments (STC-79) - Lund Home (2)			-
DCF	9413	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)			-
DCF	9414	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34)	18,091		**18,091**
DCF	9415	Investments (STC-79) - Challenges for Change: DCF (9)	31,537		**31,537**
DCF	9416	Investments (STC-79) - Strengthening Families (26)	225,190		**225,190**
DCF	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	45,903		**45,903**
DCF	9418	Investments (STC-79) - Building Bright Futures (35)	58,585		**58,585**
DCF	9419	Investments (STC-79) - United Ways 2-1-1 (41)	113,235		**113,235**
DAIL	9421	HCBS Investment			
DAIL	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	89,128		**89,128**
DAIL	9603	Investments (STC-79) - DS Special Payments for Medical Services (64)	71,918		**71,918**
DAIL	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)			-
DAIL	9605	Investments (STC-79) - Quality Review of Home Health Agencies (42)			-
DAIL	9606	Investments (STC-79) - Support and Services at Home (SASH) (43)			-
DAIL	9607	Investments (STC-79) - HomeSharing (77)	73,451		**73,451**
DAIL	9608	Investments (STC-79) - Self-Neglect Initiative (78)	126,099		**126,099**
DAIL	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)			-
DMH	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	22,221		**22,221**
DMH	9502	Investments (STC-79) - Mental Health Outpatient Services for Adults (66)	27,083		**27,083**
DMH	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79)	55,948		**55,948**
DMH	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16)			-
DMH	9506	Investments (STC-79) - Mental Health Children's Community Services (12)	66,669		**66,669**
DMH	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)			-
DMH	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)			-
DMH	9510	Investments (STC-79) - Emergency Support Fund (22)			-
DMH	9511	Investments (STC-79) - Institution for Mental Disease Services: DMH (3) - VPCH	7,467,669		**7,467,669**
DMH	9512	Investments (STC-79) - Institution for Mental Disease Services: DMH (3) - BR	(4,316)		**(4,316)**
DMH	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	9,405		**9,405**
DMH	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	217,650		**217,650**
DMH	9914	Investments (STC-79) - CRT Global Commitment			-
DOC	n/a	Return House	107,075		**107,075**
DOC	n/a	Northern Lights			-
DOC	n/a	Pathways to Housing - Transitional Housing	267,180		**267,180**
DOC	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)			-
DOC	n/a	Northeast Kingdom Community Action	2,296		**2,296**
DOC	n/a	Intensive Substance Abuse Program (ISAP)			-
DOC	n/a	Intensive Domestic Violence Program			-
DOC	n/a	Community Rehabilitative Care	854,120		**854,120**
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)	644,937		**644,937**
DVHA	9103	Investments (STC-79) - Buy-In (52)	1,021		**1,021**
DVHA	9104	Investments (STC-79) - HIV Drug Coverage (53)			-
DVHA	9106	Investments (STC-79) - Patient Safety Net Services (18)	181		**181**
DVHA	9107	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	1,301,961		**1,301,961**
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			-
VAAFM	n/a	Agriculture Public Health Initiatives			-
VDH	9201	Investments (STC-79) - Emergency Medical Services (19)	168,200		**168,200**
VDH	9203	Investments (STC-79) - TB Medical Services (74)	501		**501**
VDH	9204	Investments (STC-79) - Epidemiology (40)	243,388		**243,388**
VDH	9205	Investments (STC-79) - Health Research and Statistics (39)	312,978		**312,978**
VDH	9206	Investments (STC-79) - Health Laboratory (31)	867,223		**867,223**
VDH	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	335,124		**335,124**
VDH	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)			-
VDH	9209	Investments (STC-79) - Family Planning (75)	259,050		**259,050**
VDH	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)	353,500		**353,500**
VDH	9211	Investments (STC-79) - Renal Disease (73)			-
VDH	9213	Investments (STC-79) - WIC Coverage (37)	315,422		**315,422**
VDH	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	355,239		**355,239**
VDH	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	22,559		**22,559**
VDH	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)	549,503		**549,503**
VDH	9220	Investments (STC-79) - Recovery Centers (17)	436,133		**436,133**
VDH	9221	Investments (STC-79) - Enhanced Immunization (46)	85,875		**85,875**
VDH	9222	Investments (STC-79) - Poison Control (48)			-
VDH	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	258,998		**258,998**
VDH	9224	Investments (STC-79) - Fluoride Treatment (38)	17,480		**17,480**
VDH	9225	Investments (STC-79) - Medicaid Vaccines (24)			-
VDH	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)	47,416		**47,416**
VDH	9228	Investments (STC-79) - VT Blueprint for Health (44)	190,201		**190,201**
VDH	9421	HCBS Investment	333		
VSC	n/a	Health Professional Training			-
VVH	n/a	Vermont Veterans Home			-

Attachment 6: Investment Scorecard(s)
Substance Use Treatment

What We Do

Substance abuse treatment includes outpatient, intensive outpatient, residential, detoxification and pharmacological treatment services, including Medication Assisted Treatment (MAT) for opioid dependency. The need for these services is determined by a comprehensive clinical assessment done by a licensed substance abuse counselor or physician. The clinical assessment determines the diagnosis and the treatment that is medically necessary based on guidelines from the American Society of Addiction Medicine. This category also funds other kinds of services and activities to provide support to people with substance abuse issues or in need of treatment. Examples include drug court case management and administration and planning for re-entry activities; Student Assistance Professionals who provide identification and referral for at-risk middle and high school students.

Who We Serve

People with substance abuse issues and those in need of treatment.

How We Impact

Investment objective:

Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries

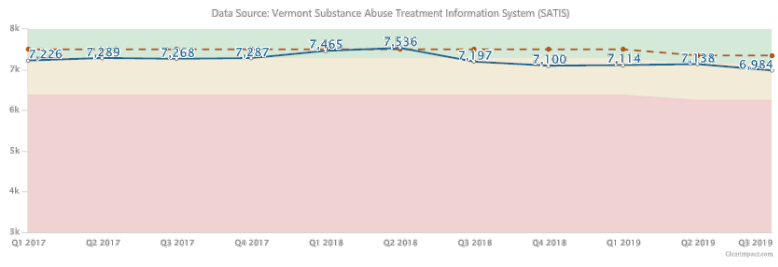
Performance Monitoring Plan

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

PM Substance Use System Capacity: Number of people treated through the ASAM Guided, DSU Preferred Provider system.



Time Period	Current Actual Value	Current Target Value	Current Trend
Q3 2019	6,984	7,350	1
Q2 2019	7,138	7,350	2
Q1 2019	7,114	7,500	1
Q4 2018	7,100	7,500	2
Q3 2018	7,197	7,500	1
Q2 2018	7,536	7,500	3
Q1 2018	7,465	7,500	2
Q4 2017	7,287	7,500	1
Q3 2017	7,268	7,500	1

Story Behind the Curve

Last Updated: August 2022

Author: Division of Substance Use Programs, Vermont Department of Health

Note: Data reporting lags have prevented reporting -- primarily due to COVID. The last generally complete data is from Q4 2019. Data will be updated when over 90% of data has been received.

The Division Substance Use Programs (DSU) requires the preferred provider network employ evidence-based practices as outlined by the American Society of Addiction Medicine (ASAM; see reference below).It is important to note that not every person in formal or informal treatment is in the DSU preferred provider network. The number of people in the DSU system is a function of system capacity capacity both in and outside the preferred provider system. As spoke capacity has increased substantially throughout the state, people with opioid use disorder have more opportunity and choice in accessing medication assisted treatment outside the preferred provider system. The DSU goal is to have the capacity to treat at least 7350 individuals per quarter in the preferred provider system. Capacity in an evidence-based network is an important measure of the ability of the system to quickly and effectively respond to addiction treatment demand. The increase in overall capacity has been driven largely by increases in medication for opioid use disorder (MOUD). As we achieve enough capacity and access to MOUD, DSU continues to look for opportunities to increase participation in and options for treatment focusing on other use disorders, such as alcohol.

Reference:

American Society of Addiction Medicine (2013).The ASAM Criteria:Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.Carson City, NV:The Change Companies.

Partners

Division of Substane Use Programs (DSU) Preferred Provider network.

What Works

ASAM evidence-based treatment criteria.

Action Plan

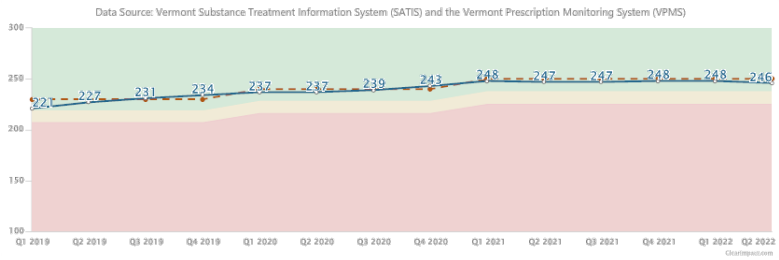
Continue offering ASAM guided treatment through the DSU provider system.

Notes on Methodology

These data are based on the Substance Abuse Treatment Information System (SATIS) which collects admission, service, and discharge information for each treatment Preferred Provider funded by DSU

Delays in the receipt of data by the Preferred Providers may impact the measures.

PM Substance Use Access to MOUD: Are adults seeking help for opioid addiction receiving treatment? Measured as the number of people receiving Medications for Opioid Use Disorder per 10,000 Vermonters age 18-64.



Q2 2022	246	250	1
Q1 2022	248	250	1
Q4 2021	248	250	1
Q3 2021	247	250	1
Q2 2021	247	250	1
Q1 2021	248	250	3
Q4 2020	243	240	2
Q3 2020	239	240	1
Q2 2020	237	240	1

Story Behind the Curve

Last Updated: August 2022

Author: Division of Substance Use Programs, Vermont Department of Health

Access to Medications for Opioid Use Disorder has steadily increased in the last 10 years. Compared to 2012, over 3 times as many people are receiving help for opioid addiction treatment.

The use of heroin and misuse of other opioids (e.g., prescription narcotics) has been identified as a major public health challenge in Vermont. The potential health, social, and economic consequences of this problem have led to the development of a comprehensive treatment system that is focused on opioid addiction. This system, known as the Hub and Spokes, has significantly increased access to care and treatment, including medication for opioid use disorder (MOUD), in Vermont.

NOTE: Numbers for Q1 2020 and forward are estimates due to late reporting by some Hub locations. Numbers will be retroactively updated as new information is available.

Partners

- Individuals receiving treatment and their families
- Community Providers-such as Licensed Alcohol & Drug Counselors (LADCs), primary care physicians and mental health practitioners
- DSU Preferred Providers
- Spoke facilities providing medication assisted treatment for those with opioid use disorders
- Recovery Centers
- Vermont Agency of Human Services (Department of Vermont Health Access, Vermont Department of Health-Division of Substance Use Programs, Department for Children and Families, Department of Corrections, Department of Aging and Independent Living, Department of Mental Health)

What Works

Vermont has a multifaceted approach to addressing opioid use disorder that involves multiple community partners. Programs and services include regional prevention efforts, drug take back programs, intervention services through the monitoring of opioid prescriptions with the Vermont Prescription Monitoring System (VPMS), recovery services at eleven Recovery Centers, overdose death prevention through the distribution of Naloxone rescue kits, and a full array of treatment modalities of varying intensities to fit individual needs.

Action Plan

The primary focus of the Hub and Spoke system has been to expand access to care for individuals with opioid use disorders. The number of people receiving MOUD services has continued to increase statewide.

Vermont is also working with communities on initiatives, including Rapid Access to Medication (RAM) for Opioid Use Disorder and Recovery Coaching in Emergency Departments to both increase ways people with opioid use disorders can get into treatment and to support them in staying in treatment.

Why Is This Important?

Medication for opioid use disorder is an effective evidence-based treatment for opioid addiction.

For those with opioid dependence, treatment with methadone or buprenorphine, medications used to reduce cravings for opioids (e.g., heroin, prescription pain relievers, etc.), can allow individuals the opportunity to lead normal lives. MOUD was originally developed because detoxification followed by abstinence-oriented treatment was not very effective in preventing a return to opioid use. People who use opioids after detoxing are at high risk over overdose. There is clear evidence that medication assisted treatment using either methadone or buprenorphine helps reduce the risk of overdose deaths and can increase the likelihood that people will stay in treatment and achieve recovery. The positive effects of medication assisted treatment can include: abstinence or reduced use of opioids; reduction in non-opioid drug use (e.g., cocaine); decreased criminal behavior; and decreased risk behavior linked to HIV and hepatitis C infections.

Notes on Methodology

Numbers are based on the number of people receiving medication for opioid use disorder (MOUD) in hubs and spokes during the first month of the quarter as to minimize churn and not over represent the number of people receiving care. Please note that numbers are subject to change due to lags in receipt of data and the most recent four measures should be considered estimates.

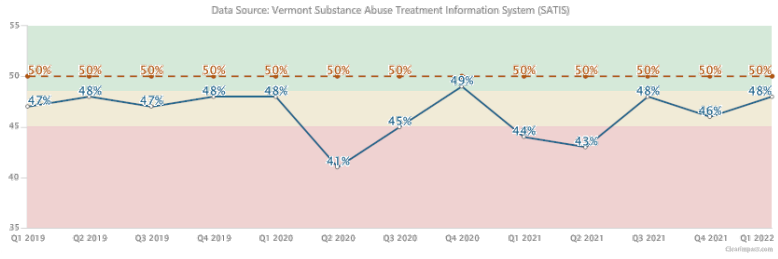
The **numerator** is the number of hub and spoke clients receiving services in a month

Hub client – an individual receiving a MOUD service that is reported in the Substance Abuse Treatment Information System (SATIS) dataset. This includes all payers.

Spoke client – an individual receiving a prescription for buprenorphine during the month. The data source is the Vermont Prescription Monitoring System (VPMS) which includes all scheduled II-IV drugs dispensed by Vermont Licensed Pharmacies. Please note that it does not include prescriptions filled by Vermonters in other states which means that the actual number may be somewhat higher. It also excludes any prescription filled in Vermont by a person who does not live in Vermont.

The **denominator** is the number of Vermonters aged 18-64 (based on Vermont Health Department and Census estimates) divided by 10,000.

PM Substance Use Discharge Reason: Percent of people giving treatment completion or transfer as the reason for ending treatment.



Q1 2022	48%	50%	1
Q4 2021	46%	50%	1
Q3 2021	48%	50%	1
Q2 2021	43%	50%	2
Q1 2021	44%	50%	1
Q4 2020	49%	50%	2
Q3 2020	45%	50%	1
Q2 2020	41%	50%	1
Q1 2020	48%	50%	1

Story Behind the Curve

Last Updated: August 2022

Author: Division of Substance Use Programs, Vermont Department of Health

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Note: Reporting lags have resulted in incomplete reporting -- generally, data after Q4 2019 is subject to change.

Treatment for a substance use disorder is a process that requires commitment from both the person seeking treatment and the treatment provider staff as well as coordination of the client's care between substance use disorder treatment providers and other medical and community resources. In addition, people with substance use disorders need to be supported and included as a valued part of their communities. There are several levels of state-funded treatment that are available to addicted individuals including:

1. Outpatient
2. Intensive outpatient
3. Residential
4. Case management
5. Medication for Opioid Use Disorder

Each of these treatment options has several possible outcomes:

1. Treatment completion
2. Transferred for further care
3. Dropped out
4. Terminated
5. Other (e.g.incarcerated, died, moved became ill, were hospitalized)

The Division of Substance Use Programs (DSU) seeks to maximize treatment completion or transfer to another appropriate level of care to continue treatment with the understanding that addiction is best viewed as a chronic disease requiring continuing care. The DSU goal for this measure is that 50% of clients complete treatment or are transferred. DSU has made significant investments to increase the availability of peer recovery support services through the statewide network of Recovery Centers. Recovery Coaches can be invaluable in supporting people to remain in treatment.

These data are derived from the Vermont Substance Abuse Treatment Information System (SATIS).

Partners

DSU network of preferred providers, clients engaged in the treatment process, Recovery Centers and recovery coaches.

What Works

Combined efforts between treatment providers, clients, and communities; placement at an appropriate level of care; safe environment; evidence-based treatment approaches; client social, community and recovery, supports.

Action Plan

Continue providing support to the preferred provider network and encouraging treatment completion among clients.

Attachment 6: Investment Scorecard(s)
DAIL Global Commitment Investments

This scorecard shows the program and performance scorecard information for Global Commitment investments in DAIL, for reporting to AHS and CMS.

https://app.resultsscorecard.com/Scorecard/Embed/46690

O GCI 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

Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change

P DAIL SASH

Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change

Budget information

Appropriation ID:3460020000	FY22 Actual	FY23 Budget	FY24 Governor Recommend
Appropriation	$22,679,909	$19,709,925	$18,623,625 not final
Program budget	$974,023	$974,023	$432,076 not final

What We Do

SASH coordinates the resources of social-service agencies, community health providers and nonprofit housing organizations to support Vermonters who choose to live independently at home. Individualized, on-site support is provided by a Wellness Nurse and a SASH Care Coordinator.

Who We Serve

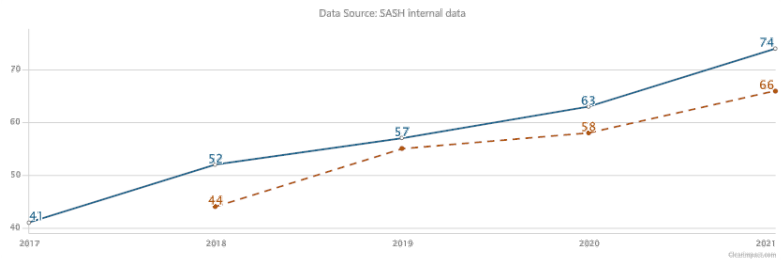
SASH serves older adults as well as people with special needs who receive Medicare support. SASH touches the lives of approximately 4,500 people throughout Vermont.

How We Impact

Benefits to SASH Participants:

- Improved quality of life
- Comprehensive health and wellness assessments
- Individualized Healthy Living Plans
- Money savings through preventive health care
- Regular check-ins by caring staff
- Health coaching and access to wellness nurses
- Help in planning for successful transitions (e.g., following hospitalization), navigating long-term care options and during a crisis
- Access to prevention and wellness programs
- Support in self-managing medications

PM DAIL SASH: Social Isolation



2021	74	66	4	80%
2020	63	58	3	54%
2019	57	55	2	39%
2018	52	44	1	27%
2017	41		0	0%

Story Behind the Curve

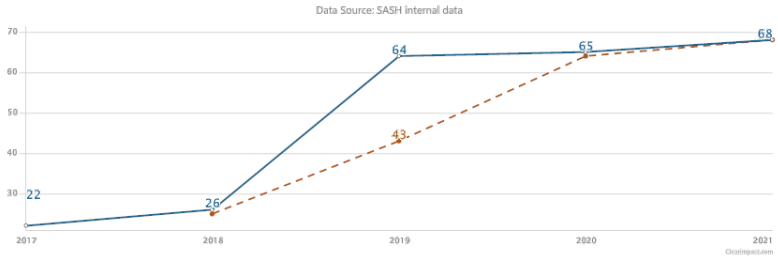
Partners

What Works

Action Plan

a. Subrecipient will improve identification of SASH participants with social isolation and or loneliness and plan for interventions that will reduce the incidence of participants who score as “lonely” on UCLA Loneliness Scale. Assessment rates will increase by 3% (from May 15th 2018 report %) for all participants as of May 15, 2019.

PM DAIL SASH: Suicide prevention: participant screening



2021	68	68	4	209%
2020	65	64	3	195%
2019	64	43	2	191%
2018	26	25	1	18%
2017	22		0	0%

Story Behind the Curve

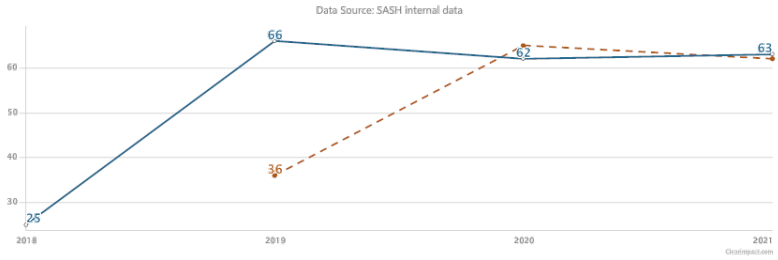
Partners

What Works

Action Plan

a. Subrecipient will improve the identification of participants at risk of suicide and train 25% of staff in Gatekeeper and/or UMatter training:
   i. Subrecipient will raise the rate of administering the one-question suicide screen by at least 3% (from May 15, 2018 %) by May 15, 2019.

PM DAIL SASH: Substance Use Screening



2021	63	62	1	152%
2020	62	65	1	148%
2019	66	36	1	164%
2018	25		0	0%

Story Behind the Curve

Partners

What Works

Action Plan

a. Subrecipient will improve the identification of participants at risk of adverse substance use and systematically provide basic education materials to participants:

i. Subrecipient will raise the rate of administering the validated pre-S-MAST-G screening question by at least 3% (from May 15, 2018 %) by May 15, 2019.

P DAIL HomeShare Vermont

Budget information

Appropriation ID:3460020000	FY22 Actual	FY23 Budget	FY24 Governor Recommend
Appropriation	$22,679,909	$19,709,925	$18,623,625 not final
Program budget	$280,000	$280,000	$280,000 not final

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

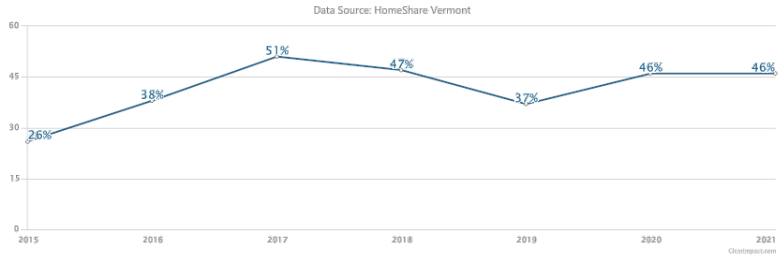
HomeShare Vermont serves Vermonters who are looking to share housing for mutual benefit. Most people sharing their homes (hosts) are older Vermonters or Vermonters with disabilities. People looking for housing (guests) are financially challenged by market rents or are in housing transitions. HomeShare 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

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%

Story Behind the Curve

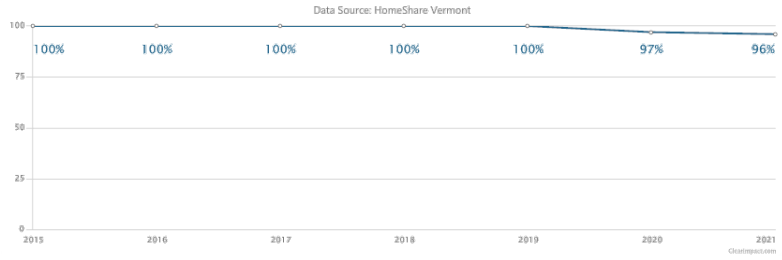
Partners

What Works

Action Plan

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

Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
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%

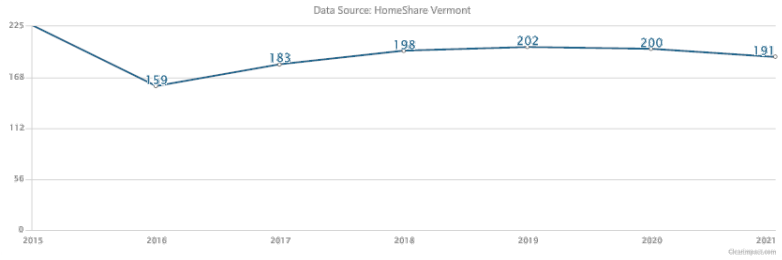
Story Behind the Curve

Partners

What Works

Action Plan

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%

Story Behind the Curve

Partners

What Works

Action Plan

P ASD Area Agencies on Aging (AAA) - Self-Neglect Response

Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change

Budget information

Appropriation ID: 3460020000	FY22 Actual	FY23 Budget	FY24 Governor Recommend
Appropriation	$22,679,909	$19,709,925	$18,623,625 not final
Program budget	$265,000	$265,000	$265,000 not final

Area Agency on Aging receives an annual $53,000 grant award. The grant term is two years.

What We Do

Vermont's Area Agencies on Aging build a coordinated response to self-neglect through a variety of activities. These include raising awareness, providing education, training and case management to individuals considered self-neglecting.

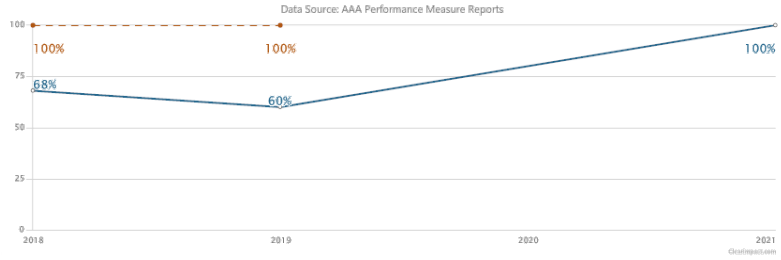
Who We Serve

Adults, 60 years and older, who can be described as self-neglecting.

How We Impact

The Area Agencies on Aging respond to self-neglect referrals and provide case management services to those who are identified as self-neglecting. Case managers work with individuals who are self-neglecting to develop goals identified by the individual and by use of a risk and safety evaluation tool. Goals may be related to food, shelter, medical/mental/financial health or in other areas. To help achieve these goals community partners and resources are accessed and leveraged. Where resources don't exist, the Area Agencies on Aging work to build awareness and capacity.

PM ASD % of consumers considered to be self-neglect cases with complete assessments



2021	100%		1	47%
2019	60%	100%	1	-12%
2018	68%	100%	0	0%

Story Behind the Curve

"The term 'self-neglect' means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self- care tasks including (A) obtaining essential food, clothing, shelter, and medical care; (B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or (C) managing one's own financial affairs. This definition excludes peoples who make a conscious and voluntary choice not or provide for certain basic needs as a matter of life style personal preference or religious belief and who understand the consequences of their decision. " Vermont Department of Disabilities, Aging and Independent Living, Self-Neglect Task Force (2012)

The work on self-neglect is informed by a study in 2012 that was undertaken to estimate the number of individuals less than 60 and 60 or older in Vermont who could be described as self-neglecting; and to provide information to develop a community response to self-neglect. Estimating the number of self-neglecting individuals was challenging due to varying definitions, reporting processes and where to make reports and referrals. However, there were valuable recommendations on developing a community response to self-neglect.

In 2014 funding was provided to Vermont's 5 Area Agencies on Aging (AAA) to enhance the response to self-neglect. Since then the AAAs have been building a community response to self-neglect through raising awareness, education, training and collaboration with old and new community partners. To identify the services and supports self-neglecting individuals need they have also been using a common assessment tool.

The nature of working with self-neglecting individuals is that it often takes multiple attempts and then visits to establish rapport and the trusting relationship needed to begin a risk assessment. Completion of a risk assessment is over a period of time.

Partners

Public Safety

Housing Authorities

Hoarding Task Force

SASH

Local Interagency Team

Hospital Emergency Departments

Home Health Agencies

Community Health Teams

Community Adult Resource Teams

Community Action Agencies

AHS Field Directors

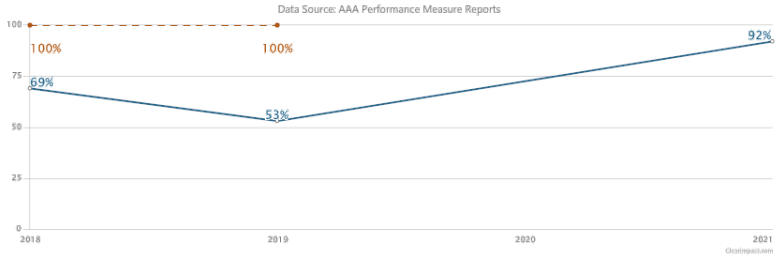
Choices for Care Team Meetings

Mental Health Providers

What Works

Action Plan

PM ASD % of consumers considered self-neglect cases with goals



2021	92%		1	33%
2019	53%	100%	1	-23%
2018	69%	100%	0	0%

Story Behind the Curve

"The term 'self-neglect' means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self- care tasks including (A) obtaining essential food, clothing, shelter, and medical care; (B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or (C) managing one's own financial affairs. This definition excludes peoples who make a conscious and voluntary choice not or provide for certain basic needs as a matter of life style personal preference or religious belief and who understand the consequences of their decision. " Vermont Department of Disabilities, Aging and Independent Living, Self-Neglect Task Force (2012)

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The nature of working with self-neglecting individuals is that it often takes multiple attempts and then visits to establish rapport, a trusting relationship and to complete a risk assessment. Working with the self-neglecting individual to establish goals follows the completion of the risk assessment. Goal areas include food, shelter, medical, mental health, financial health or another area of importance to the self-neglecting individual.

Partners

Public Safety

Housing Authorities

Hoarding Task Force

SASH

Local Interagency Team

Hospital Emergency Departments

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Community Health Teams

Community Adult Resource Teams

Community Action Agencies

AHS Field Directors

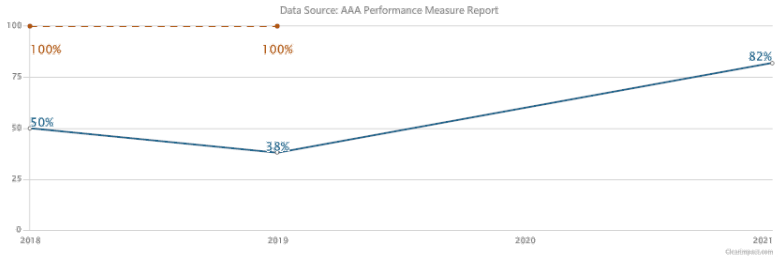
Choices for Care Team Meetings

Mental Health Providers

What Works

Action Plan

PM ASD % of consumers considered to be self-neglect cases with provider engagement



2021	82%		1	64%
2019	38%	100%	1	-24%
2018	50%	100%	0	0%

Story Behind the Curve

"The term 'self-neglect' means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self- care tasks including (A) obtaining essential food, clothing, shelter, and medical care; (B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or (C) managing one's own financial affairs. This definition excludes peoples who make a conscious and voluntary choice not or provide for certain basic needs as a matter of life style personal preference or religious belief and who understand the consequences of their decision. " Vermont Department of Disabilities, Aging and Independent Living, Self-Neglect Task Force (2012)

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In 2014 funding was provided to Vermont's 5 Area Agencies on Aging (AAA) to enhance the response to self-neglect. Since then the AAAs have been building a community response to self-neglect through raising awareness, education, training and collaboration with old and new community partners. Developing a community response to self-neglect includes engaging partners in helping to meet the goals of the self-neglecting consumer.

This measure is meaningful in that it assists in identifying gaps within the service community and provides the type of feedback the AAAs need to build a coordinated community response to self-neglect that engages the public, relevant service organizations and community partners.

Partners

Public Safety

Housing Authorities

Hoarding Task Force

SASH

Local Interagency Team

Hospital Emergency Departments

Home Health Agencies

Community Health Teams

Community Adult Resource Teams

Community Action Agencies

AHS Field Directors

Choices for Care Team Meetings

Mental Health Providers

What Works

Action Plan

P DBVI Older Blind Program: Mobility training and other services for older people who are visually impaired

Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change

Budget information

MCO Investment Expenditures for Mobility Training and other services for Elderly Visually Impaired: includes indirect allocations to GC MCO (per DAIL Business Office):

Appropriation ID: 3460030000	FY22 Actual	FY23 Budget	FY24 Governor Recommend (not final)
Appropriation	1,661,457	1,761,457	1,761,457
Program budget	357,272	369,000	369,000

What We Do

Through the Older Blind Program the Vermont Association for the Blind and Visually Impaired (VABVI) provides vision rehabilitation services to Vermonters over the age of 55. These services include:

- Teaching individuals to understand their visual impairment and its medical implications
- Teaching individuals to maximize their functional vision and independence
- Teaching adaptive skills of daily living and use of assistive technology to compensate for vision loss (cooking, cleaning, organization, money management, time management, reading, writing, braille, etc.)
- Teaching adaptive skills for travel in the home and community (traveling with a long white cane, public transportation, room familiarization, protective techniques, etc.). This helps to prevent falls and promote community integration.
- Assisting individuals through the seven stages of adjustment to vision loss (similar to the 5 stages of grief) through direct instruction and participation in Peer Assisted Learning and Support Groups (PALS).

Clients who cannot afford to purchase recommended aids and devices such as magnifiers, labeling tools, white canes, etc. can access up to $125 worth of assistive devices under the grant funding.

Who We Serve

Vermonters over the age of 55 with vision loss.

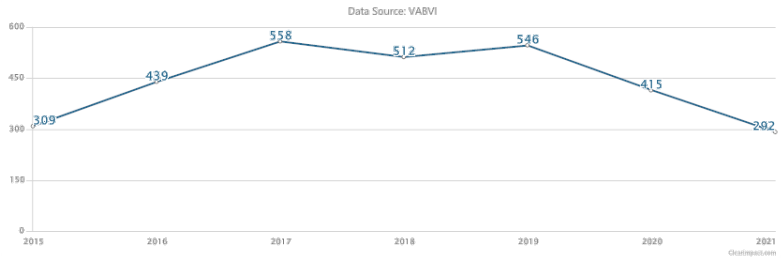
How We Impact

Studies show that the earlier these interventions occur, the more independent an individual remains, and the individual is far less likely to experience falls or move to a residential facility. Services also promote independence and community integration.

Measures of how much: # served, units of service:

- Hours of Orientation and Mobility, Rehabilitation and Peer Assisted Learning and Support Provided
  - FY 16 = 5820
  - FY 17 = 6542
  - FY18 = 5248
  - FY19 = 5501
  - FY 20 = 3846
  - FY 21 = 2303
- Numbers of clients who received training in assistive technology
  - FY 16 = 642
  - FY 17 = 653
  - FY 18 = 694
  - FY 19 = 737
  - FY 20 = 638
  - FY 21 = 538
- Numbers of clients who received training in orientation and mobility
  - FY 16 = 115
  - FY 17 = 115
  - FY 18 = 134
  - FY 19 = 172
  - FY 20 = 140
  - FY 21 = 92
- Numbers of clients who received training in communication skills
  - FY 16 = 658
  - FY 17 = 763
  - FY 18 = 819
  - FY 19 = 830
  - FY 20 = 658
  - FY 21 = 549
- Numbers of clients who received training in skills of daily living
  - FY 16 = 251
  - FY 17 = 343
  - FY 18 = 619
  - FY 19 = 338
  - FY 20 = 274
  - Fy 21 = 214

PM	DBVI	Older Blind Program: number of people with improved functional ability through assistive technology	**2021**	**292**		**2**	**-6%**



2020	415	1	34%
2019	546	1	77%
2018	512	1	66%
2017	558	2	81%
2016	439	1	42%
2015	309	0	0%

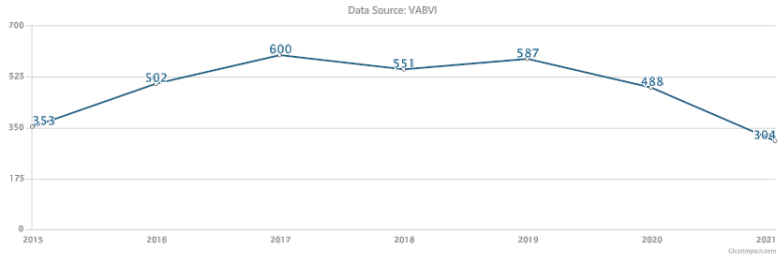
Story Behind the Curve

Partners

What Works

Action Plan

PM DBVI Older Blind Program: number of people with improved functional ability through training in communication skills



2021	304	2	-14%
2020	488	1	38%
2019	587	1	66%
2018	551	1	56%
2017	600	2	70%
2016	502	1	42%
2015	353	0	0%

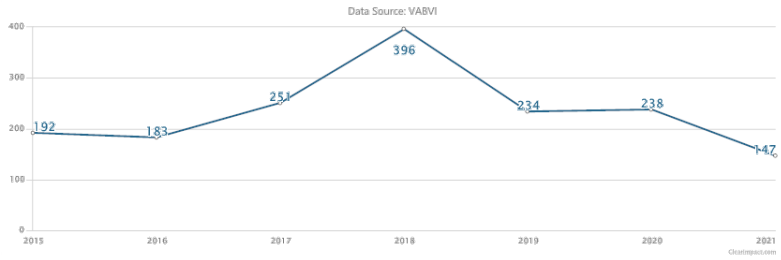
Story Behind the Curve

Partners

What Works

Action Plan

PM DBVI Older Blind Program: number of people with improved functional ability through training in daily living skills



2021	147	1	-23%
2020	238	1	24%
2019	234	1	22%
2018	396	2	106%
2017	251	1	31%
2016	183	1	-5%
2015	192	0	0%

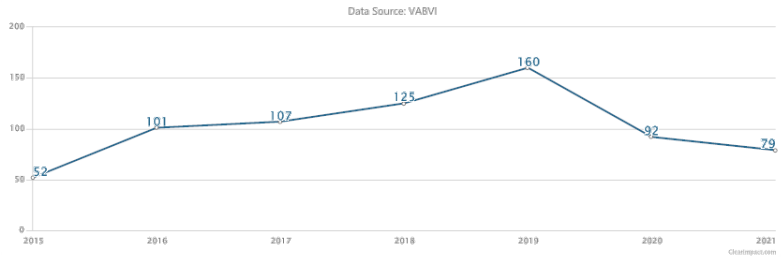
Story Behind the Curve

Partners

What Works

Action Plan

PM DBVI Older Blind Program: number of people with improved functional ability through training in orientation and mobility



2021	79	2	52%
2020	92	1	77%
2019	160	4	208%
2018	125	3	140%
2017	107	2	106%
2016	101	1	94%
2015	52	0	0%

Story Behind the Curve

Partners

What Works

Action Plan

P DDSD Developmental Disabilities Special Payments

Most Recent Period | Current Actual Value | Current Target Value | Current Trend | Baseline % Change

Budget information

MCO Investment Expenditures for Developmental Disabilities Special Payments: includes indirect allocations to GC MCO (per DAIL Business Office):

Appropriation ID: 2460050000	FY22 Actual	FY23 Budget	FY24 Governor Recommend (not final)
Appropriation	242,760,692	282,169,830	284,304,460
Program budget	2,515,499	2,249,546	2,249,546

What We Do

Developmental Disabilities Special Payments support people with developmental disabilities through a variety of specialized services:

- Post-Secondary Education Supports: College Steps, Project SEARCH and Global Campus
- Supported Employment: Enhanced employment supports and provider performance incentive
- Vermont Communication Support Project: Support for meaningful participation of adults with communication deficits in judicial and administrative proceedings.
- One-Time Funding: Funding allocated on a one-time basis to support individualized services that meet special criteria (address health and safety; improve quality of life; increase self-advocacy skills; avert crisis placement; increase independent living skills; maintian housing stability and/or increase communication).

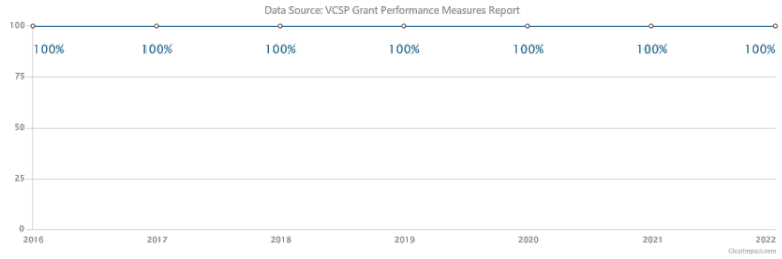
Who We Serve

Developmental Disabilities Special Payments support people with intellectual and developmental disabilities.

How We Impact

The specialized services provided through Developmental Disabilities Special Payments support people with developmental disabilities to live with dignity and independence in their own homes and communities. (See Performance Measures below.)

PM DDSD Vermont Communication Support Project New Referral Response Rate

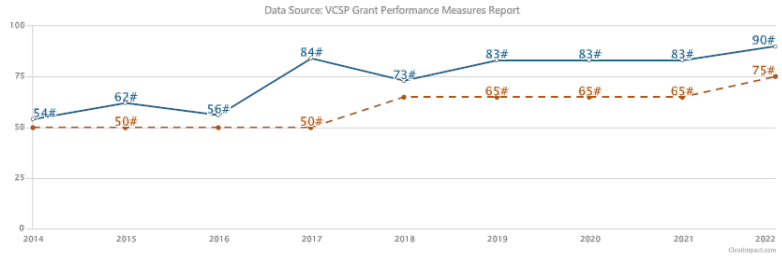


2022	100%	100%	8	0%
2021	100%	100%	7	0%
2020	100%	100%	6	0%
2019	100%	100%	5	0%
2018	100%	100%	4	0%
2017	100%	100%	3	0%
2016	100%	100%	2	0%
2015	100%	100%	1	0%

Story Behind the Curve

The Vermont Communication Support Project has maintained long standing success in responding to all new referrals that meet the project criteria regardless of the type and geographic location of the referral. The 100% responsiveness to referrals by the project is impressive considering the wide variety of sources of referrals and types of communication needs across recipients of the service. The VCSP strives to provide equal access to the Vermont system of justice and State services for people whose disabilities affect comprehension, verbal expression as well as effective participation and focus. The support and accommodations that were provided assisted the individuals in overcoming barriers and challenges as a result of disability. Of particular importance and the hallmark of the success of the project is the flexibility and attention to each person's individualized needs to get at what works best for each individual in each situation.

PM DDSD Vermont Communication Support Project Number of Cases Worked

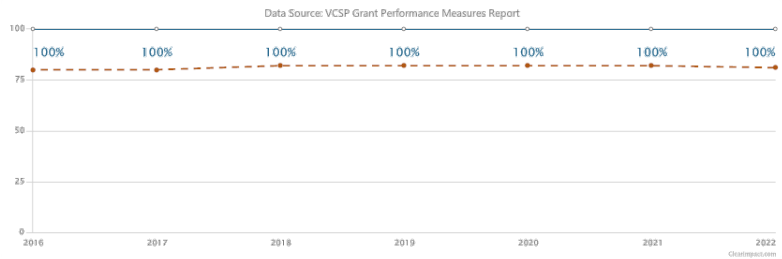


2022	90#	75#	1	67%
2021	83#	65#	2	54%
2020	83#	65#	1	54%
2019	83#	65#	1	54%
2018	73#	65#	1	35%
2017	84#	50#	1	56%
2016	56#	50#	1	4%
2015	62#	50#	1	15%

Story Behind the Curve

The overall increase of number of cases worked over time shows the need for the service provided by the Vermont Communication Support Project. While the project does not have direct control over when and what cases may be referred to the project, these data show the effectiveness of the ongoing outreach to the courts; Department for Children and Family Services District Offices; Agency of Human Services Field Services Directors; and State Public Defenders, among others.

PM DDSD Vermont Communication Support Project Rate of Successful Contacts for Outreach Purposes



2022	100%	81%	8	0%
2021	100%	82%	7	0%
2020	100%	82%	6	0%
2019	100%	82%	5	0%
2018	100%	82%	4	0%
2017	100%	80%	3	0%
2016	100%	80%	2	0%
2015	100%	80%	1	0%

Story Behind the Curve

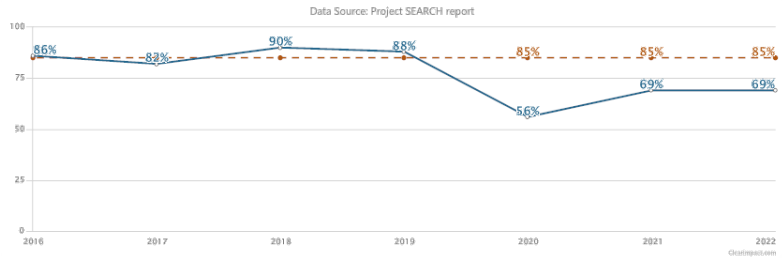
The Vermont Communication Support Project conducts a variety of outreach to organizations (Agency of Human Services Field Services Directors, Department for Children and Families district offices, courts and State Public Defender offices) to help build awareness of the service and provide educate on the process for accessing Communication Support Specialists.

Partners

What Works

Action Plan

PM DDSD Employment rate of Project SEARCH student-interns at the time of graduation



2022	69%	85%	1	-24%
2021	69%	85%	1	-24%
2020	56%	85%	2	-38%
2019	88%	85%	1	-3%
2018	90%	85%	1	-1%
2017	82%	85%	2	-10%
2016	86%	85%	1	-5%
2015	91%	85%	0	0%

Story Behind the Curve

Job skill acquisition in complex internships arranged by Project SEARCH is achieved through several internship rotations over ten months at the host business. Job placement upon graduation is assured through vigorous job development provided by Project SEARCH staff, Advisory Council members, and the host businesses. For participants not employed at graduation, job development services continue until employment is achieved. There may be times when students go into higher education instead of directly into employment and would, therefore, not be considered employed.

During the first four years of the project, only one Specialized Service Agency and school district were involved with Project SEARCH. While the employment rate was 100%, there were only a total or 2-3 student interns each year. The project expanded in FY 16 to three school districts and two additional developmental disabilities services agencies resulting in total of 20 student interns. In FY 17, an additional developmental disabilities services agency participated resulting in 22 student interns.

In FY 20, three graduates refused employment due to COVID-19 safety concerns. This caused a precipitous drop in the employment rate. There were 16 interns who graduated in FY 20 of which 9 were employed. If it had been safe for the three to accept employment, it would have raised the employment rate to 75%; lower than in recent years but still a respectable rate. The FY 21 69% rate was lower than past years due to COVID-19.

Partners

This initiative is based on a partnership with National Project SEARCH, a model recognized for its effectiveness in preparing youth with developmental disabilities for the workforce. The developmental disabilities services agencies who facilitate Project SEARCH are Lincoln Street Incorporated, Rutland Mental Health Services and HowardCenter. Project SEARCH training programs in FY 22 were hosted by Dartmouth Hitchcock Medical Center, Rutland Regional Medical Center and University of Vermont Medical Center.

The high schools who participated in Project SEARCH are within the South Burlington, Rutland City and Hartford school districts. The Vermont Agency of Education and the HireAbility Vermont participate on the state and local steering committees along with the Developmental Disabilities Services Division and local developmental disabilities services agencies. In addition, Project SEARCH is monitored by the National Cincinnati Children Hospital Project SEARCH and guided by a local business advocacy council at each site.

What Works

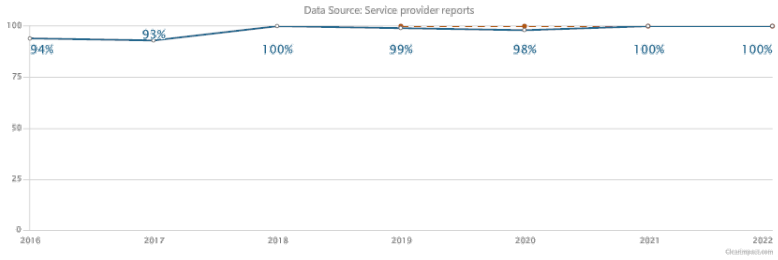
The success of Project SEARCH is founded on a model that provides total immersion across genuine work settings in Vermont businesses. Department heads provide mentoring, training, continuous feedback, and job search references to young workers learning complex skill sets in the real job market. Host sites hire from the internship class and job development in other businesses results in very high employment rates upon graduation from high school or shortly thereafter.

Notes on Methodology

Action Plan

The Developmental Disabilities Services Division will continue to provide ongoing support to Project SEARCH by facilitation of the state and local steering committees. Continued work on securing stable participant school district participation will take place as per the recommendation of the National Project SEARCH audit.

PM DDSD Proportion of people who received One-Time Funding who demonstrated achieving one or more possible outcomes



2022	100%	100%	1	6%
2021	100%	100%	1	6%
2020	98%	100%	2	4%
2019	99%	100%	1	5%
2018	100%		1	6%
2017	93%		1	-1%
2016	94%		0	0%

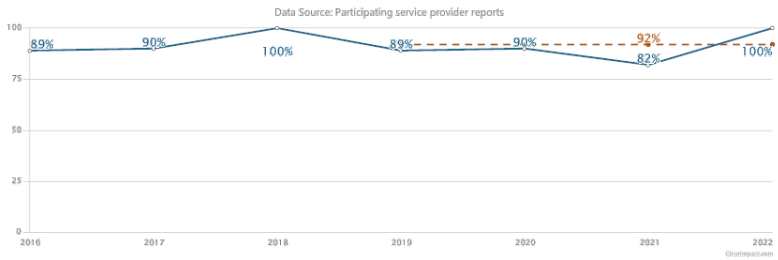
Story Behind the Curve

Partners

What Works

Action Plan

PM DDSD Employment rate of College Steps participants at the time of graduation



2022	100%	92%	1	12%
2021	82%	92%	1	-8%
2020	90%	92%	1	1%
2019	89%	92%	1	0%
2018	100%		2	12%
2017	90%		1	1%
2016	89%		0	0%

Story Behind the Curve

Funds are used for transition age youth with developmental disabilities, to receive direct support assistance to attend college. Each student is supported with staffing on Vermont college campuses to acquire “Certificate of Higher Learning” with a goal of competitive employment in a career path at graduation. This is a two-year college program.

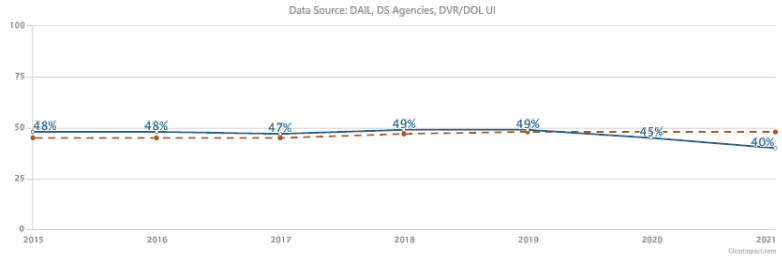
The program objective is to produce employment for youth with developmental disabilities in viable careers upon graduation from this post-secondary program. By learning independent living and vocational skills, youth are able to more independently engage in employment which diverts the need for higher cost services. By participating in the College Steps Program, youth are also averted from homelessness, crisis, and are able to remain living with natural families instead of coming into DDSD residential services.

Partners

What Works

Action Plan

PM DDSD Employment rate among people age 18 to 64 who are served by Developmental Disabilities Services HCBS



2021	40%	48%	2	-7%
2020	45%	48%	1	5%
2019	49%	48%	1	14%
2018	49%	47%	1	14%
2017	47%	45%	1	9%
2016	48%	45%	1	12%
2015	48%	45%	1	12%
2014	46%	45%	1	7%
2013	48%	45%	2	12%

Story Behind the Curve

The growth in the employment rate for people with ID/DD who receive Home and Community-Based Services is due to several factors. Each designated and specialized service agency had individualized employment rate targets within the larger context of striving for a 45% statewide employment rate. This individualized approach provided tangible and feasible benchmarks while recognizing that each organization has unique circumstances associated with increasing the number of people employed. DAIL's Supported Employment Specialists provided technical assistance via regular meetings with each agency to review progress and offer help. DAIL's ability to access Vermont Department of Labor's (VTDOL) database allowed DAIL to identify every employed person served by the providers. In some cases, the utilization of the VTDOL data base actually increased the employment rate as it picked up workers beyond what providers' data system had available for employment rates. In addition, four transition age youth educational options; SUCCEED, College Steps, Think College Vermont, and Project SEARCH, had a significant influence on the growth in employment with each achieving a high employment rate for their students upon graduation. Participating colleges in the post-secondary education programs include Castleton University, Northern Vermont University - Johnson and Lyndon Campuses, Southern Vermont College and University of Vermont (UVM). Vermont Project SEARCH has expanded to three Vermont licensed programs (Burlington, Rutland, Springfield). This growth has tremendously broadened the menu of employment supports for transition aged youth with developmental disabilities.

The number of individuals receiving supported employment and employed during FY 21 was negatively impacted by the COVID-19 pandemic. The lower count is due to fewer individuals retaining employment due to business closures, job offers being declined due to health risks concerns, elimination of employment services due to staff shortages, individual's declining job development services to minimize being in public, and families and guardians being opposed to a return to work even when vaccinated.

Partners

Designated Agency (DA) and Specialized Services Agency Supported Employment Coordinators and Developmental Disabilities Services Directors; DDSD Supported Employment Specialist; HireAbility Vermont Supported Employment Specialist; UVM's Center on Disability and Community Inclusion (CDCI/UVM) faculty; Vermont businesses; regional HireAbility Vermont Counselors; and post-secondary college support programs (Think College, SUCCEED, College Steps Program).

What Works

- Ongoing support and technical assistance from DAIL Supported Employment Specialists.
- Quarterly Supported Employment Coordinators' Meetings to share resources, ideas, and cross mentor.

- Connecting youth to Project SEARCH Industry based training and to post-secondary college course work.

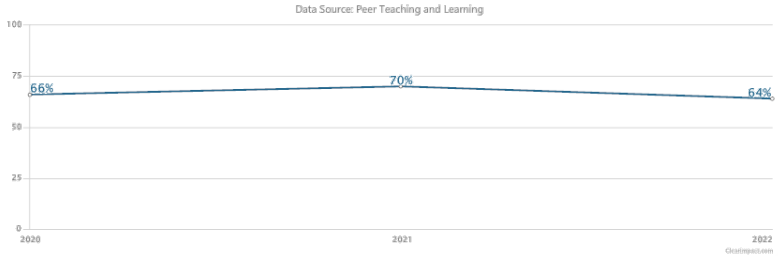
Notes on Methodology

The Unemployment Insurance (UI) data that makes up this outcome is supplied by the Vermont Department of Labor and has a six months lag time in its availability. There is a further delay during which time the agencies and VR and DDSD review the data. Therefore, Calendar Year is not available until the following Spring**.**

Action Plan

- Facilitate annual regional Youth Transition Core Teams to come together quarterly and provide an annual team development day for Core Teams and statewide stakeholders.
- DAIL continues to provide a CCV based online Supported Employment certification course to provide training to first year agency Supported Employment Specialists.
- Develop sustainability of the three Project SEARCH sites in Vermont. Work with the post-secondary programs to assure continuation of the five Vermont college campus-based programs (Castleton University, Northern Vermont University - Johnson and Lyndon Campuses, Southern Vermont College, University of Vermont).

PM DDSD Proportion of Peer Teaching and Learning student faculty who increased opportunities for community inclusion



2022	64%	1	-3%
2021	70%	1	6%
2020	66%	0	0%

Story Behind the Curve

The Peer Teaching and Learning (PTL), formerly Global Campus, measures were changed in FY 20 to reflect more meaningful subcategories of the overall personal development. Two new score cards were created to track the percentage of participants who developed new relationships and the percentage of participants who increasesed opportunities for community inclusion. These performance measures are still in baseline so no targets have been established.

The adverse affects of the COVID-19 pandemic negatively impacted the DA/SSA's ability to reach out to organizations within their communmities to partner with their Peer Teaching and Learning programs.

Partners

DAIL partners with six designated agencies and specialized service agencies that facilitate PTL opportunities for participants. Each agency coordinates a close working relationship with PTL through the combined efforts of agency staff and PTL staff to assure participants have community inclusion and opportunities to develop new relationships.

What Works

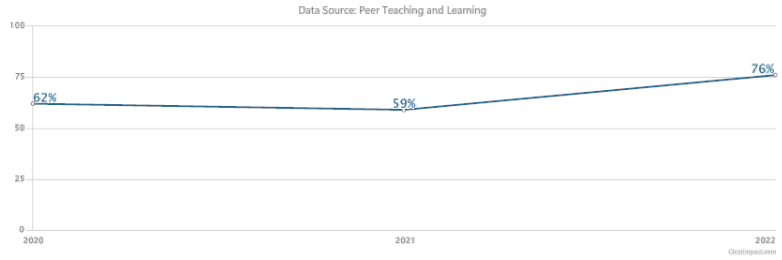
Participants identify community members with expertise in the participant’s teaching/learning topic. Networking occurs with these community members to become educated about a topic. Often, community members attend PTL classes to co-present with the teaching participant. PTL organizes class visits at community organizations/businesses to broaden understanding of community resources. This exposure often leads to community involvement in PTL and acquaintanceships that endure over time.

Action Plan

Collaborate with host agencies and PTL so more individuals can participate in PTL.

Collaborate with PTL on a plan to broaden access to participants not available during the day through the addition of evening and weekend classes. Monitor sustainability of PTL to assure opportunities for teaching and learning continue for participants.

PM DDSD Proportion of Peer Teaching and Learning student faculty who developed new relationships



2022	76%	1	23%
2021	59%	1	-5%
2020	62%	0	0%

Story Behind the Curve

The Peer Teaching and Learning (PTL - formerly Global Campus) measures were changed in FY 20 to reflect more meaningful subcategories of the overall personal development. Two new score cards were created to track the percentage of participants who developed new relationships and the percentage of participants who increasesed opportunities for community inclusion. These performance measures are still in baseline so no targets have been established.

Partners

DAIL partners with six designated agences and specialized service agencies that facilitate PTL opportunities for participants. Each agency coordinates a close working relationship with PTL through the combined efforts of agency staff and PTL staff to assure participants have community inclusion and opportunities to develop new relationships.

What Works

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Action Plan

Collaborate with host agencies and PTL so more individuals can participate in PTL.
Collaborate with PTL on a plan to broaden access to participants not available during the day through the addition of evening and weekend classes. Monitor sustainability of PTL to assure opportunities for teaching and learning continue for participants.

P DDSD Serious Functional Impairment (SFI) Designation

Most Recent Period | Current Actual Value | Current Target Value | Current Trend | Baseline % Change

Budget information

MCO investment expenditures; includes indirect allocations to GC MCO (per DAIL business office):

Appropriation ID:3460050000	FY22 Actual	FY23 Budget	FY24 Governor Recommend (not final)
Appropriation	242,760,692	282,169,830	284,304,460
Program budget	0	0	0

What We Do

Serious Functional Impairment (SFI) designation allows for the Department of Corrections and Developmental Disabilities Services Division to help meet the needs of inmates who have developmental disabilities or other related disabilities and whose needs fall outside traditional Medicaid eligibility. A comprehensive community service plan is provided for individuals determined to be in need of enhanced re-entry planning on release from custody. Assistance is provided to meet specific goals to transition to appropriate and available community-based programs with traditional funding streams and/or independent living.

Who We Serve

How We Impact

P DDSD Flexible Family Funding

Most Recent Period | Current Actual Value | Current Target Value | Current Trend | Baseline % Change

Budget information

MCO Investment expenditures for Flexible Family Funding: includes indirect allocations to GC MCO (per DAIL business office):

Appropriation ID:3460050000	FY22 Actual	FY23 Budget	FY24 Governor Recommend (not final)
Appropriation	242,760,692	282,169,830	284,304,460
Program budget	1,152,166	1,200,000	1,200,000

What We Do

Flexible Family Funding is used to offer support to individuals with developmental disabilities and their families to enhance their ability to live together. The maximum payment is $1,000. The funds are used for services or supports that benefit the individual and/or family and may include respite, assistive technology, individual and household needs and/or recreational services. These income-based funds, determined by a sliding scale, are used at the discretion of the family.

Who We Serve

To be eligible for Flexible Family Funding (FFF), a recipient must be a person with an developmental disability who lives with his/her family.

Family members are defined as unpaid biological or adoptive parents, step-parents, adult siblings, grandparents, aunts/uncles, nieces/nephews and legal guardians.

Exclusions - The following individuals are not eligible for FFF:

- Individuals who receive home and community-based services.
- Individuals who live independently or with their spouse or partner.
- Applicants whose income exceeds the upper limit of the sliding scale.

How We Impact

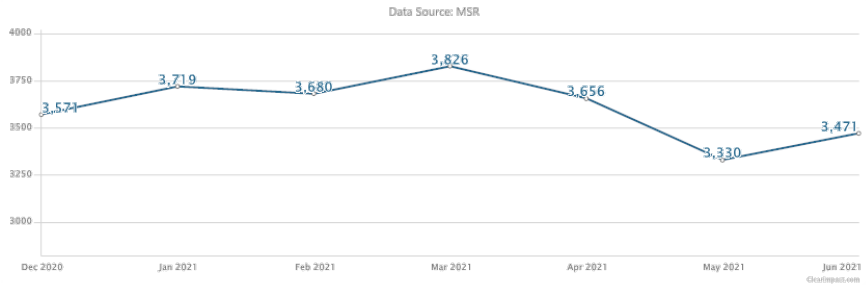
Individuals who recieve Flexible Family Funding report on the outcomes they and their family anticipate achieving through their use of the funding. Anticipated outcomes may address health and safety, improve quality of life by addressing accessibility and accommodation needs, avert crises, increase communication, increase independent living skills, enhance family stability and maintain housing stability.

DMH Value Based Payment Measures

This Scorecard is shared with the Center for Medicare and Medicaid Services (CMS for the Global Commitment Quarterly Report. Questions about this data can be directed to the Vermont Department of Mental Health Quality Team.

O How_Much VBP: Number of Individuals Served

I 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		

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.

Notes on Methodology

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

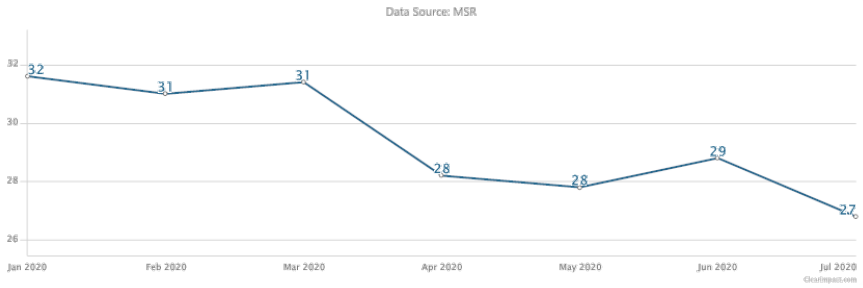
Data analyzed from Monthly Service Reporting system. Clients counted if they received one qualifying service within the month. Qualifying services are those that count a person toward the caseload and allow the agency to earn the full PMPM for that client.

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

I How_Much Number of Mediciad-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

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.

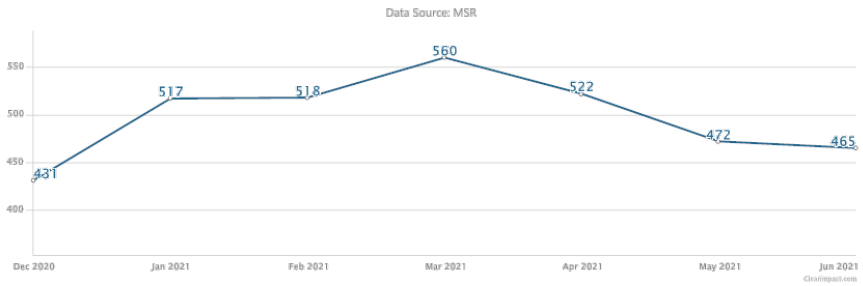
Partners

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

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

I How_Much 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

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.

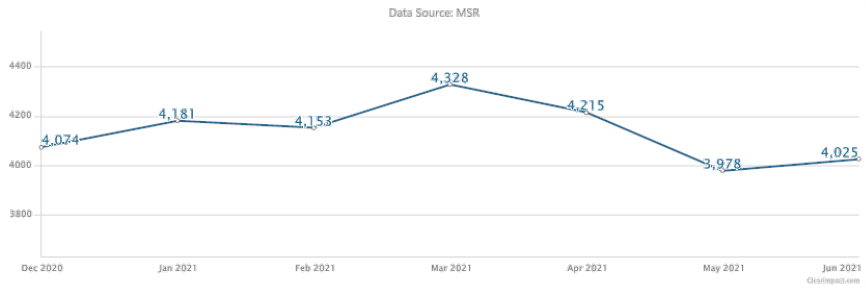
Notes on Methodology

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

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.

Notes on Methodology

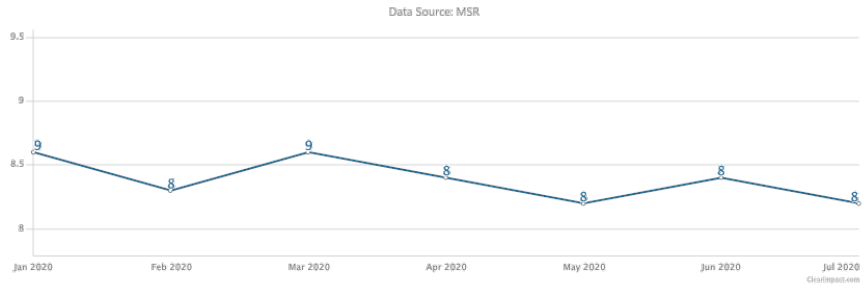
For any given year of service (Jan - Dec):

- 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.

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

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.

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:

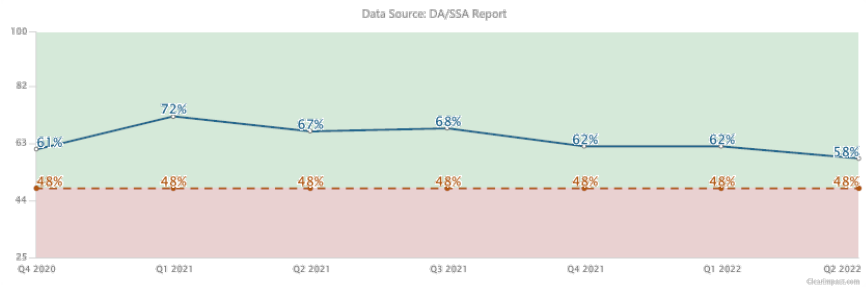
R = 1,000 C / P

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.

O How_Well VBP: How Well Individuals Were Served

	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
PM How_Well Percentage of clients offered a face-to-face contact within five calendar days of initial request	Q2 2022	58%	48%	1
	Q1 2022	62%	48%	1
	Q4 2021	62%	48%	1
	Q3 2021	68%	48%	1
	Q2 2021	67%	48%	1
	Q1 2021	72%	48%	1
	Q4 2020	61%	48%	2
	Q3 2020	68%	48%	1
	Q2 2020	73%	48%	1



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

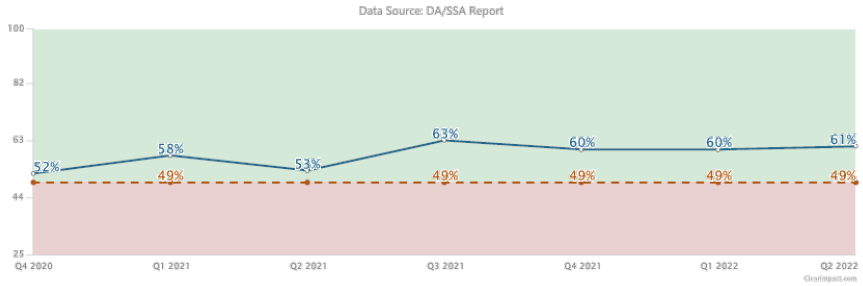
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

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.

PM How_Well Percentage of clients seen for treatment within 14 calendar days of assessment	Q2 2022	61%	49%	1



Q1 2022	60%	49%	1
Q4 2021	60%	49%	1
Q3 2021	63%	49%	1
Q2 2021	53%	49%	1
Q1 2021	58%	49%	1
Q4 2020	52%	49%	1
Q3 2020	73%	49%	2
Q2 2020	63%	49%	1

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.

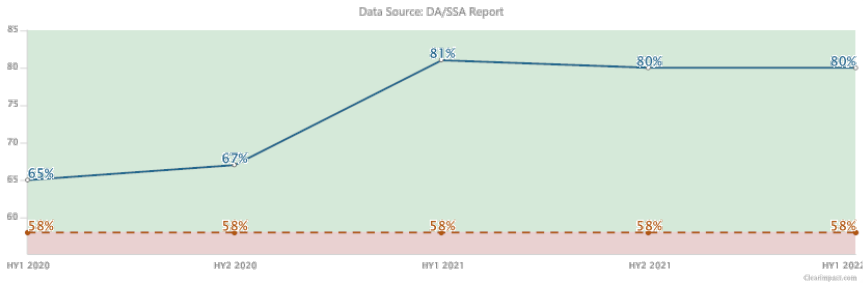
Partners

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

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

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



HY1 2022	80%	58%	1
HY2 2021	80%	58%	1
HY1 2021	81%	58%	2
HY2 2020	67%	58%	1
HY1 2020	65%	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.

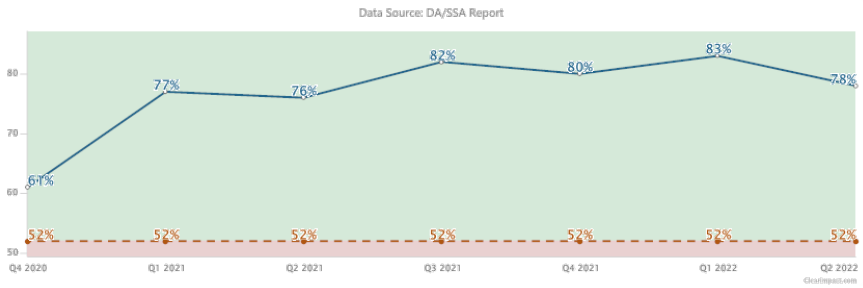
Partners

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

Notes on Methodology

• Numerator = # of children and youth who have had a CANS administered or re-administered on them within the past 6 months of programming
• Denominator = All youth enrolled in CYFS programming* who have received a clinical (not emergency) assessment and have passed the threshold of at least 75 days since their original care inquiry call to that agency
Client defined as 0-22 years old.

PM How_Well Percentage of adult clients screened for substance use.



Q2 2022	78%	52%	1
Q1 2022	83%	52%	1
Q4 2021	80%	52%	1
Q3 2021	82%	52%	1
Q2 2021	76%	52%	1
Q1 2021	77%	52%	1
Q4 2020	61%	52%	1
Q3 2020	66%	52%	2
Q2 2020	63%	52%	1

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

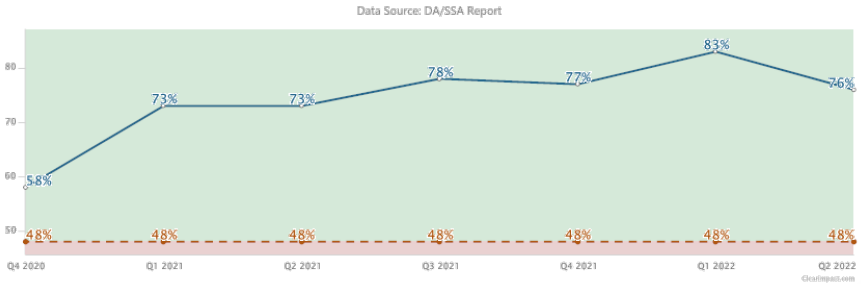
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric

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

PM How_Well Percentage of clients screened for psychological trauma history

Q2 2022	76%	48%	1



Q1 2022	83%	48%	1
Q4 2021	77%	48%	1
Q3 2021	78%	48%	1
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

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.

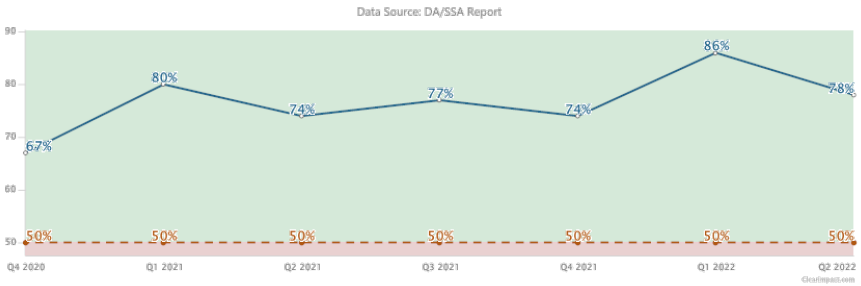
Partners

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

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

PM How_Well Percentage of clients screened for depression



Q2 2022	78%	50%	1
Q1 2022	86%	50%	1
Q4 2021	74%	50%	1
Q3 2021	77%	50%	1
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

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

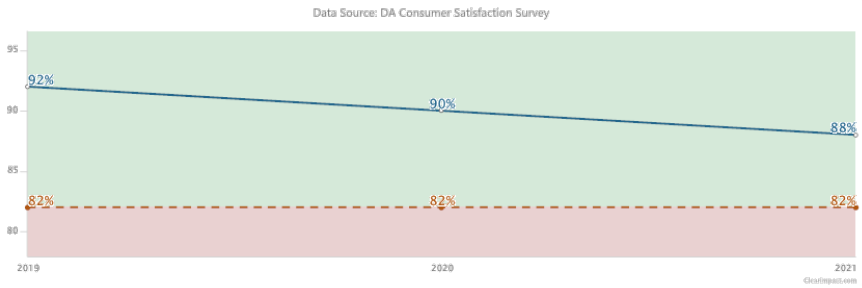
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

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

O How_Well VBP: Survey Measures

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
PM	How_Well Percentage of clients indicate services were "right" for them	2021	88%	82%	2
		2020	90%	82%	1
		2019	92%	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

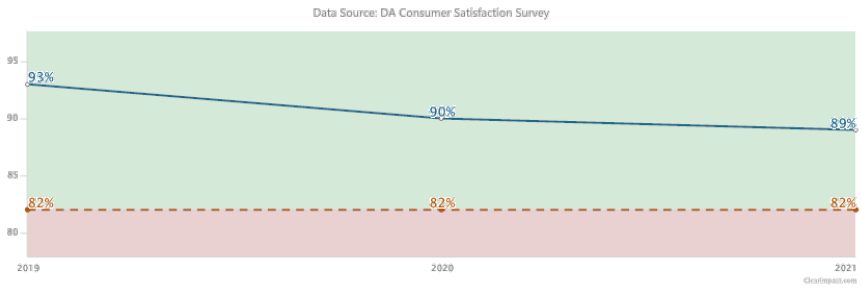
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

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

PM	How_Well Percentage of clients indicate they received the services they "needed"	2021	89%	82%	2



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

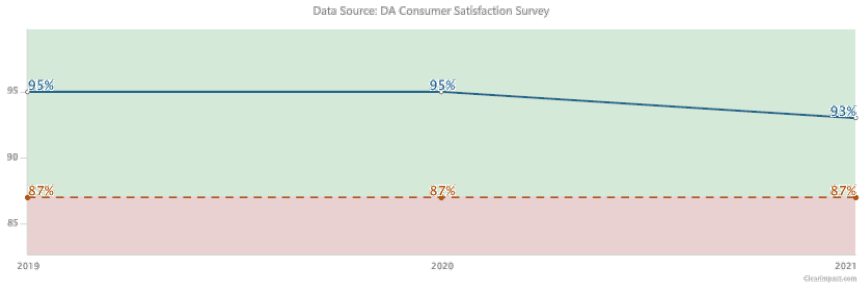
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

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

PM How_Well Percentage of clients indicate they were treated with respect



2021	93%	87%	1
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

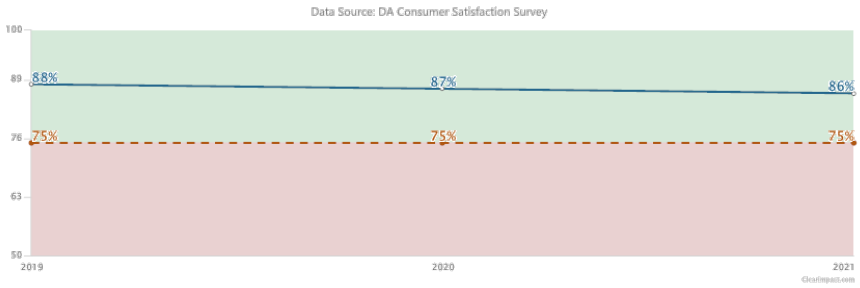
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

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

PM Better_Off Percentage of clients indicate services made a difference



2021	86%	75%	2
2020	87%	75%	1
2019	88%	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.

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.

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