# *State of Vermont*
# *Agency of Human Services*

**Global Commitment to Health**
**11-W-00194/1**

**Section 1115**
**Demonstration Year: 20**
**(1/1/2024 – 12/31/2024)**

## Quarterly Report for the period January 1, 2024 – March 31, 2024

**Submitted Via PMDA Portal on May 31, 2024**

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## I. Background and Introduction

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

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

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

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

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

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

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

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

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

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

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

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the first quarterly report for waiver year 20, covering the period from January 1, 2024, through March 31, 2024 (QE032024).***

## II. Outreach/Innovative Activities

*Member and Provider Services*

**Key updates from QE032024:**

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

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

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

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

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

NEMT Update

In the first quarter of calendar year 2024, DVHA's non-emergency medical transportation contractor delivered a total of 75,623 rides to transportation-eligible VT Medicaid members. Calls to both our contractor and associated subcontractors slightly increased over the previous quarter. The number of program-related complaints stayed steady from the previous quarter as well.

Coordination of Benefit Activity

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

Areas of activities:

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

**Coordination of Benefit Collection Table:**

| MPS – Coordination Recovery Activities "Q3" | |
|---|---|
| Casualty | $485,592.20 |
| Estate | $306,574.11 |
| Third-Party & Court-Ordered Medical | $178,654.55 |
| Medicare Prescription Drug Premium/Claims | $46,881.83 |
| Over Resource/Hospice/Patient Share/Credit Balance | $523,246.25 |
| Annuity/Trust/Waiver | $15,136.70 |
| Lamp/Map, Medicare Claim Recoupment | $150,208.34 |
| Third-Party Claim Recoupment | $57,103.82 |
| **Total** | **$1,763,397.80** |

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

**Coordination of Benefit-Cost Avoidance Table:**

| Cost Avoidance "Q3" | |
|---|---|
| Third-Party Liability | $32,708,670.85 |
| Medicare | $123,727,846.65 |
| **Total** | **156,436,517.50 $** |

## III. Operational/Policy Developments/Issues

**Key updates from QE092023:**

- The Customer Support Center received more than 75,035 calls in QE0324, up 49% from the previous year.
- DVHA is supported by 108 Assisters (98 Certified Application Counselors, 4 Navigators, and 6 Brokers). Working in 83 organizations including hospitals, clinics, and community-based organizations.
- 18 Assisters are in training (whose application date is January 1, 2023, thru March 31, 2023).
- Increasing numbers of customers are using self-service functions. Self-serve applications comprised over half (56%) of all applications in QE0324. This is a 5% decrease from QE0323.

*Vermont Health Connect*

Enrollment

As of QE0324, more than 204,297 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 133,499 in Medicaid for Children and Adults (MCA) and 70,798 in Qualified Health Plans (QHPs), with the latter divided between 29,496 enrolled with VHC, 4,278 direct enrolled with their insurance carrier as individuals, and 37,024 enrolled with their small business employer.

Medicaid Renewals

This quarter was the last where renewals were initiated for the Unwind. Ex-parte success rate on a household level was 56% for the quarter. The mitigation strategy for Individual Ex-parte was implemented this quarter in advance of the system updates that will allow VHC to do automatically ex parte on an individual level in June. Workers renewed eligible individuals if a renewal application was not returned by the due date.

<u>1095 Tax Forms</u>

1095B is an informational form that shows months of coverage for Medicaid members. 126,476 Initial 1095Bs were generated but not mailed for tax year 2023, unless member requested. For tax year 2023, the federal deadline was March. The 1095B corrections began in February and as of 3/31/2024 1836 corrections have been generated.

<u>Customer Support Center</u>

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 75,035 calls in QE0324. Maximus answered 89% of calls within 24 seconds in January 2024, 98% in February 2024, and 95% in March 2024. All three months exceeded the target of 75%.

Maximus is the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to DVHA-HAEEU for resolution and log service requests, which are escalated to the appropriate resolver group. This year has seen an increase in the volume of calls and a slight increase in the proportion of calls that were escalated to the Eligibility unit. 7% of QE0324 calls were transferred to DVHA-HAEEU staff. Just as importantly, DVHA strived to answer all calls that were transferred; 95% of transferred calls were answered in five minutes in QE0324.

<u>Timely Processing of Member Requests</u>

In the spring of 2016, DVHA-HAEEU set a goal of completing 75% of member requests within ten business days by October 2016 and 85% by June 2017. In QE0316, fewer than 60% of VHC requests were completed within ten days. QE0324 was 97%.

<u>In-Person Assistance</u>

DVHA is supported by 108 Assisters (98 Certified Application Counselors, 4 Navigators, and 6 Brokers). Working in 83 organizations including hospitals, clinics, and community-based organizations.
18 Assisters are in training (whose application date is January 1, 2023, thru March 31, 2023). Assister education continues to be a primary program objective. Specifically, the program has worked to continuously improve the way Assisters are onboarded, including in-person training and more hands-on technical assistance.

<u>Outreach</u>

With Open Enrollment ending this quarter and the Medicaid Renewal Restart ending early the next quarter, DVHA to time to reflect on outreach operations. Information about Medicaid

renewals will be repurposed and integrated in regular messaging on the website and social media accounts. After successful implementation, DVHA will continue direct customer outreach through email and texting. DVHA will further build on community engagement efforts, by building its partner organizations and enhancing efforts with provider offices.
The Plan Comparison Tool is a key educational tool. It is used by Vermonters to find a health plan that best fits their needs and budget. This was the second full quarter that the more user-friendly version of the Tool was in use. DVHA promoted it as a straightforward aid to help with Open Enrollment and the final months of yearlong Medicaid Unwind. The Tool was used in over 11,600 sessions during the quarter.

Self-Service

During QE0322, DVHA-HAEEU continued to promote self-service options for customers to pay their bills, report changes, and access tax documents and other forms. Self-service leads to an improved customer experience as Vermonters can log in at their convenience. It also has the benefit of using automation to reduce staffing expenses. Year-over-year comparisons show that more customers are using self-service functions, including both online accounts for health coverage applications and reported changes as well as the options of paying premiums through monthly recurring payments rather than one-time payments.
Self-serve applications comprised over half (56%) of all applications in QE0324.

*Choices for Care and Traumatic Brain Injury Program*

DAIL

Choices for Care

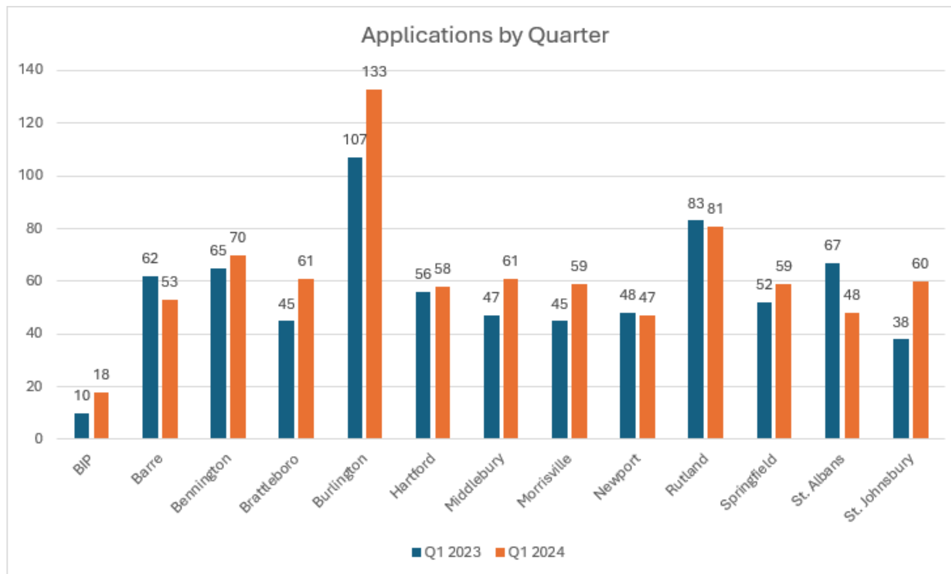
At the end of Q1, CFC enrollment included:

NH – 2901 participants
ERC – 544 participants
Home Based – 2343 participants.
Moderate Needs –761participants

Choices for Care High/Highest Applications Received Q12023 vs Q12024.

ASD had a 10% increase in applications in Q1 2024 vs Q1 2023

Q1 2023 = 715 Applications
Q1 2024 = 790 Applications




**Choices for Care Providers**

In Q1, ASD developed a plan to meet with case management providers at the regional level to prepare for the transition of case management to the Area Agencis on Aging. ASD will meet with regional partners to provide education and support for the transition of clients currently served through home health agencies. ASD plans to meet with providers in Q2. More information can be found here: Project Overview – Vermont HCBS

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

**Enhanced FMAP spending plan**:

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

**Adult Day**

Adult Day Agencies continue to report that difficulty hiring staff has been a limiting factor in increasing attendance. However, attendance continued to slowly increase in Q3. .

Money Follows the Person (MFP)

The MFP grant has been re-authorized through (CY) 2027. The VT Department of Aging and Independent Living (DAIL) Adult Services Division has been awarded funds for both CY2021 and CY2022 and CY2023 operations and received budget approval for CY 2024 in March.

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

MFP Progress in Q1 2024:

5 participants graduated from the program,
19 transitions have been supported,
40 active participants moving towards graduation,
30 participants moving towards transition.

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

In 2021, DAIL was awarded a $5M MFP Supplemental Grant. These dollars are being used to strengthen the systems serving Money Follows the Person and Choices for Care participants by increasing the number of direct service workers, increasing support for unpaid caregivers, and piloting new HCBS services to meet unmet care needs. The Supplemental Grant Funding is being used for the following approved initiatives, spread across 10 contracts:

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

Brain Injury Program

Current enrollment = 86individuals, 3 individuals graduated from the BIP, The BIP received 18 applications in Q1 2024.

Wait Lists

- There is no wait list for the High Needs Group.
- There continues to be provider wait lists for Moderate Needs Group, homemaker providers report a waitlist of approx. 650 individuals, Adult Day providers report a waitlist of 10 individuals. Because the eligibility criteria for Moderate Needs services are so broad, Vermont does not expect to eliminate the wait list. ASD is exploring changes to the MNG allocation process to address the waitlist.
- ASD established a waitlist for individuals waiting for services in the BIP. While funding is available for individuals who have been approved for enrollment, providers are unable to accept new participants due to workforce capacity. The State has clinically approved 20 individuals for services who are currently waiting for services due to provider workforce capacity challenges. While waiting for a provider, individuals are referred to the Brain Injury Alliance for neuro-resource facilitation services. DAIL plans to release an RFI in 5/2024 in preparation for an RFP to award a statewide case management entity for the Brain Injury Program. ASD anticipates that implementing the contract will significantly decrease or eliminate the BIP waitlist.

*Developmental Disabilities Services Division (DDSD)*

Payment and Delivery System Reform Update:

The Division's Payment Reform initiative continues to move along; the current phase involves work to define the State's "model service mix" associated with the Six Level Framework that DAIL has adopted. As noted in previous report submissions, DDSD has adopted a Six Level Framework related to the outcome of the Supports Intensity Scale-Adult needs assessment. Lead by our consultant from Public Consulting Group/Burns and Associates, the State's internal team focused on developing recommendations for "model service mixes" associated with each support need level and residential option. These recommendations will be shared with stakeholders and community partners as part of our Quarter Two work.
*Please see prior report submissions for previous highlights.*

DDS Legally Responsible Individuals Proposal Policy

In addition to establishing workgroups to focus on the issues of the change in the labor market, resulting in workforce challenges with direct support staffing, and input on design for a policy related to the payment of Legally Responsible Individuals, *Please see prior report submissions for previous highlights.*

DDS Ombuds Pilot

The Department has been working with Vermont Legal Aid to develop an ombuds-like advocacy pilot program for the Brain Injury and Developmental Disabilities HCBS programs. Based on data from and discussion with DAIL, Vermont Legal Aid has chosen the Northwestern region of the State (Franklin and Grand Island Counties) for the initial pilot region. Before home-visiting and responding to complaints to occur, the Vermont Legal Aid team will finalize policies and procedures to be approved by the Department. This pilot project will seek to demonstrate the effectiveness of such an advocacy program for these populations, as well as provide rights training. The first of the training courses are scheduled to be presented at Vermont's annual developmental disabilities statewide self-advocacy conference (Voices and Choices) to be held in late-April.
*Please see prior report submissions for previous highlights.*

*Global Commitment Register*

The Global Commitment Register (GCR) is a database of policy changes to and clarifications of existing Medicaid policy under Vermont's 1115 Global Commitment to Health waiver. Created in November 2015, it is based on the Federal Register and can be used as both a public notice and documentation tool for Medicaid policy. Like the Federal Register, the GCR can be used to publish a proposed policy, including information on public comment submissions, final policy, notices, and policy clarifications. The GCR is available on the Agency of Human Services website to ensure that policy changes are transparent to Vermonters and to provide a forum for public comments.

The GCR listserv is a group of hundreds of interested parties who have elected to receive periodic key updates about Vermont health care programs, which includes policy changes to all Medicaid programs as well as policy changes to Vermont's Health Benefit Exchange. Policy changes posted to the GCR include changes made under the authority of the 1115 waiver, proposed waiver amendments or extensions, administrative rule changes, changes to rate methodologies, and State Plan Amendments. The GCR also contains policy clarifications for when an issue is identified that is not answered in the current policy.

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

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

## IV. Expenditure Containment Initiatives

*Vermont Chronic Care Initiative (VCCI)*

Key updates from Q1 2024:

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

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

Vermont has selected Camden Coalition to implement the Team Based Care recommendations from the stake holder engagement and assessment process completed last year. VCCI is an essential partner in this work and will participate in the project team overseeing the work of the Learning Collaborative implementation and will serve on the education team to advise on the Team Based Care Training needs for the state. This work is in the early stage of development and is a collaborative effort between VCCI, Field Services, Blueprint for Health and all AHS departments with the goal of enhancing Team Based Care workflows within each Heath Service Area and providing sustainable training in the form of self-paced online trainings for State and partner staff.

VCCI continues to serve Vermonters experiencing homelessness. Staff are present in hotels providing services to Vermonters who have high needs and no other lead case manager in the community. The staff also work closely with Field Directors and Coordinated Entry to help

identify those that would benefit and who want the services that VCCI offers. Homelessness is a healthcare need and brings with it many complexities that we hope to have a positive impact on to improve the lives of Vermonters.

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

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

**Figure 1. Beneficiary Enrollment and Face to Face Visits**

| | Jan-24 | Feb-24 | Mar-24 |
|---|---|---|---|
| Measure | 2/15/2024 | 3/15/2024 | 4/15/2024 |
| # new VCCI eligible members enrolled monthly in care management | 45 | 34 | 29 |
| Total Open Cases (including newly enrolled - above) | 220 | 224 | 235 |
| % of VCCI enrolled members with a face to face visit during the month | 65.45% | 66.52% | 63.40% |

VCCI continued the work started in 2019, of telephonic outreach and health

related social needs screening to beneficiaries new to the health plan. The Medicaid screening tool poses questions related to access to health care and health care-related issues including primary care, dental, housing, transportation, and food, with direct facilitation to those services desired by the beneficiary. The numbers of people new to Medicaid plan were at the highest in the month of December 2023 at 659 and lowest in October 2023 at 456. The number of members who respond to screening is relatively constant with approximately 39% of all adults New to Medicaid receiving Health Related Social Needs screening. Most of the screenings are done via phone with a few that are returned via mail. The VCCI New to Medicaid team also aids those that need and want help finding a primary care provider.

**Figure 2. Number of New to Medicaid Beneficiaries Screened**

| Updated Dates - month reported | Sep-23 | Oct-23 | Nov-23 | Dec-23 |
|---|---|---|---|---|
| received from data unit | 10/15/2023 | 11/15/2023 | 12/15/2023 | 1/15/2024 |
| Updated Dates - due date | 1/15/2024 | 2/15/2024 | 3/15/2024 | 4/15/2024 |
| # of new to Medicaid members (Adults 18+) | 511 | 456 | 495 | 659 |
| # of new to Medicaid members reached | 139 | 141 | 130 | 153 |
| # of new to Medicaid members outreach screening attempted | 449 | 444 | 405 | 543 |
| # of new to Medicaid members successfully screened | 191 | 196 | 191 | 235 |
| % of new to Medicaid members screened | 37.38% | 42.98% | 38.59% | 35.66% |

*Blueprint for Health*

**Key Updates from QE032024**

- The majority of Vermont's primary care practices are Blueprint Patient-Centered Medical Homes, with 129 of Vermont's estimated 170 primary care practices participating. The number of multi-provider practices is

estimated at 148, further making the proportion of Blueprint practices higher among larger practices.
- The Change Healthcare cyberattack disrupted claims processing for Buprenorphine and Vivitrol prescriptions, meaning the data for the quarter is incomplete. As of 2024-Q1, the incomplete claims data showed that the average monthly number of patients receiving Buprenorphine or Vivitrol prescriptions is 3,203.
- Blueprint received funding for expansion under Act 167

Vermont continues to provide access to enhanced preventive health, psychosocial screening and comprehensive family planning serves as evidenced by the commitment of 40 practices, including 7 Planned Parenthood sites, to participate in the Pregnancy Intention Initiative as of March 2024.

***Blueprint Expansion***

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

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

Patient-Centered Medical Home Program

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

Blueprint Program Managers provide leadership in each community to coordinate healthcare delivery system improvement efforts and set up the systems through which integrated services can be delivered in the community. While they are employed by the hospital or FQHC in the HSA, they help organize, lead, and staff collaborative initiatives with the ACO, local human service agencies, health departments, specialty care providers, mental health providers, and primary care providers to facilitate the integration of services. They are responsible for contacting all primary care practices within their HSA to encourage, engage, and support practice participation in the Blueprint and other health system reform activities. Additionally, Program Managers are responsible for administering funds and staffing plans for the local CHTs on behalf of all participating payers, including core CHT, Spoke staff, and WHI staff. In addition to Program Managers, the Blueprint supports participating practices with a quality improvement coach, called a Quality Improvement (QI) Facilitator. QI Facilitators support practices with data on practice performance and their training and expertise in process improvement methodologies (such as Clinical Microsystems, Model for Improvement, and Lean process improvement). Quality Improvement Facilitators initially help primary care practices to secure National Committee for Quality Assurance (NCQA) PCMH recognition. After the recognition is achieved, the facilitators regularly return to help with quality improvement efforts related to panel management and outreach, care coordination, promotion of individual health and wellness, chronic condition management, and ongoing practice transformation in alignment with State-led health care reform priorities. These priorities include:

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

Q1Highlights

**January – March 2024 Quality Improvement Report**

Selected QI Projects

QI facilitators worked with practices and community collaboratives across their assigned geographic areas to support quality improvement initiatives relevant to population needs and priorities. Some examples of projects led and supported by QI facilitators in Q1 included:

- Organizational standardization of processes and procedures related to high-value care.
- Optimizing practice use of Electronic Medical Records for clinical decision support and quality reporting.
- Implementing Zero-Suicide protocols and workflows.
- Strengthening relationships and referral pathways between pediatric primary care providers, Children Integrated Services, Early Intervention, and Parent Child Centers.
- Improving follow up after discharge from the emergency department and inpatient care by care management teams.

**CHT Expansion**

The Blueprint for Health contracted with Care Transformation Collaborative-RI to provide training to the Quality

Improvement Facilitators to expand their knowledge and skills to support the integration of mental health, substance use, and social determinant of health interventions in Patient Centered Medical Homes. QI Facilitators applied skills during their training to practices to:

a. Analyze organizational structures supporting Behavioral Health Integration
b. Complete standardized assessments for behavioral health integration using the MeHAF which is used to assess levels of primary and behavioral care integration focused on two domains: 1) integrated services and patient and family-centeredness, and 2) practice/organizational readiness.
c. Familiarize and apply standards associated with NCQA distinction in Behavioral Health Integration

QI facilitators provided participating practices with support for integrating newly hired Community Health Team staff, practices related to Social Determinant of Health, Mental Health, and Substance use screening, and enhancing team-based care and community referral pathways.

Quality improvement facilitators also contributed their time and expertise to help inform programmatic and evaluation criteria for year two of the expansion pilot.

**Patient Centered Medical Home (PCMH) Recognition**

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

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

**January – March 2024 Quality Improvement**

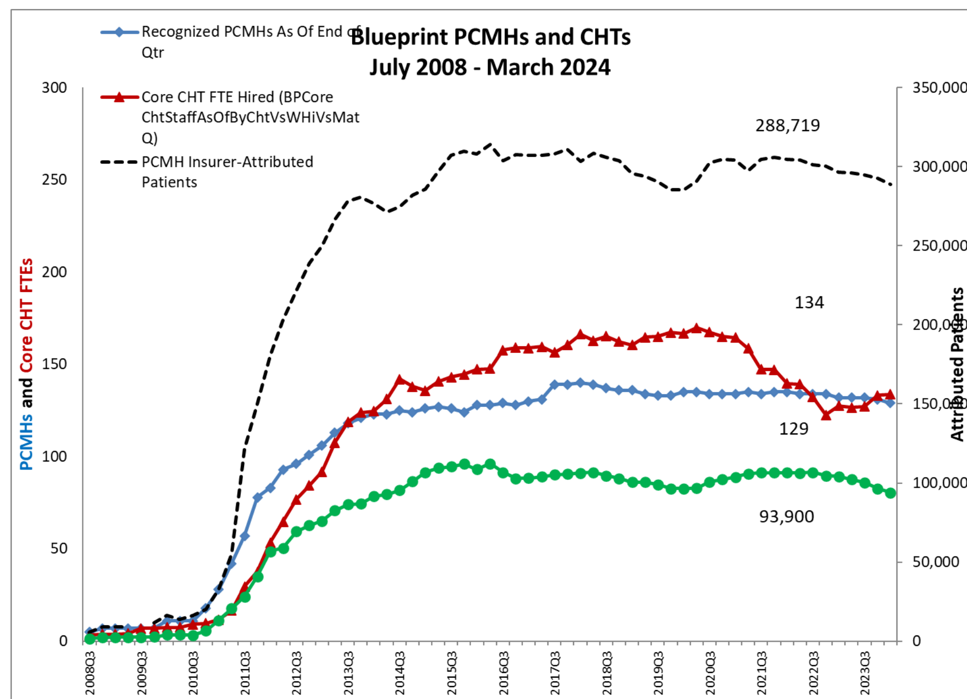
Quality Improvement Facilitators, along with Program Managers, met with PCMH practices to assist them to understand the program requirements and practice needs associated with participating in the CHT expansion and understand the implementation requirements and quality improvement focus areas for systematic screening for mental health, substance use, and social needs, integrating mental health and substance use treatment provision into Primary Care practice settings, and establishing strong referral and co-management relationships with community partners. As of the end of September, 105 PCMHs have agreed to participate in this work, and have committed to working at least monthly with a Quality Improvement Facilitator on related implementation and quality improvement goals, starting with participation in a chart review.

Blueprint-participating Patient-Centered Medical Homes currently serve 288,719 insurer- attributed patients, of which 93,900 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 134 full-time equivalents of Community Health Team staff.

In Quarter 1(January-March 2024), 129 Vermont practices were operating as Patient-Centered Medical Homes, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of

practices participating in the Blueprint for Health program is a key performance measure; the Blueprint estimates that there are about 170 total primary care practices operating in the state.

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




Community Health Profiles

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

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

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

Hub & Spoke Program

Medication for opioid use disorder (MOUD) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole patient" approach to the treatment of opioid use disorder. The Hub and Spoke system of care in Vermont provides MOUD in two settings – regional, specialty Opioid Treatment Programs (OTPs, Hubs), which provide higher intensity treatment, and office-based opioid treatment (OBOT, Spokes) in community-based medical practice settings. The Blueprint administers the Spoke part of the Hub & Spoke system of care. Peer-reviewed literature has established that MOUD

(also known previously as medication-assisted treatment) is an evidence-based, effective approach to the treatment of opioid use disorder, based upon notable, published outcomes such as decreased opioid use, decreased opioid-related overdose deaths, decreased criminal activity, decreased infectious disease transmission, and increased social functioning and retention in treatment.

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

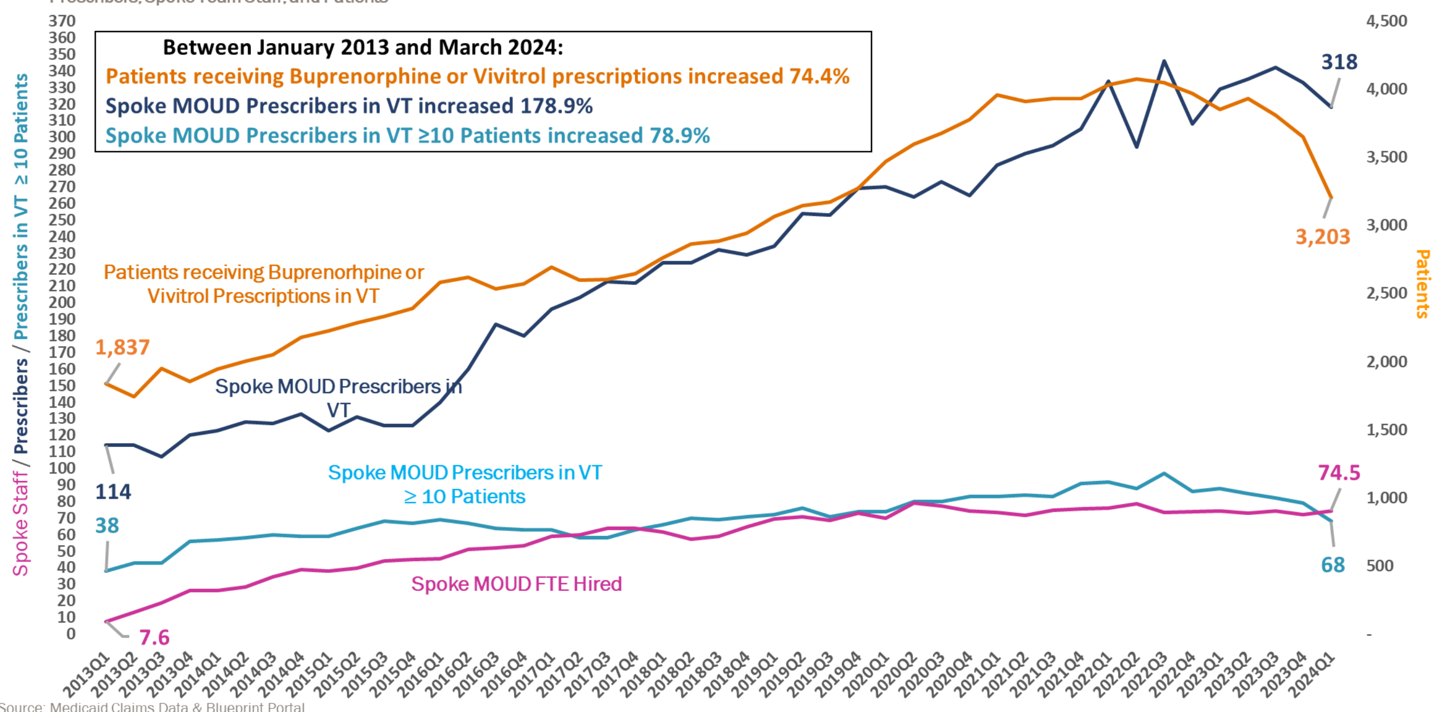
Jan – March 2024 Highlights

The Blueprint, in partnership with the Division of substance use prevention, in conjunction with a contract with Dartmouth, who was our successful bidder this quarter and will allow us to continue to offer learning sessions with expert- led, and peer-supported, training in best practices for providing team-and evidence-based medication- for opioid use disorder for the next two years. Sessions alternated between didactic and webinars this quarter and that will be the ongoing plan. We have changed the name of our services to CARE which stands for **C**ollaborative to **A**dvance Mental Health Treatment & Substance Use **R**ecovery for **E**veryone. This quarter we focused on Rapid Access for Alcohol use disorder, treating alcohol across clinical settings and pain management with substance use disorder . We continue to meet with the managers across our health service to offer support and hear ways to engage folks and community partners. The field continues to have some challenges with the 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 MOUD for Vermonters with opioid use disorder. MOUD is being offered across the State of Vermont by more than 78 different Spoke settings as of March 2024. The Change Healthcare cyberattack disrupted claims processing for Buprenorphine and Vivitrol prescriptions in February and March. Because of this, the data for the quarter is incomplete. This incomplete data is reflected in the Q1 2024 numbers discussed in the following sentences and in the MOUD-Spoke implementation graph. The monthly average of Medicaid beneficiaries receiving Buprenorphine or Vivitrol prescriptions was 3,203 in Q1 of 2024. There were 318providers who prescribed Buprenorphine or Vivitrol in Vermont. There are 74.5 FTE of licensed, registered nurses, and licensed, Master's-prepared, mental health/substance use disorder clinicians who work as a team to offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder.

Figure 2. MOUD-SPOKE Implementation January 2024- March 2024*

*Data is incomplete due to missing prescription claims as a result of the Change Healthcare Cyberattack.




<u>Women's Health Initiative-</u>

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

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

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

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

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

relationships to support patients and to support community partners in supporting community members.

Q1 2024 Highlights

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

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

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

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

We provided the field with a Long-Acting Reversible Contraceptive Training July 2023 and Oct 2023 that was attended by 13 providers which is the maximum amount for Nexplanon certification. Dr. Lauren MacAfee through UVM is an amazing teacher and the field truly appreciates the training. The next training is scheduled in June 2024.

Figure 3 below shows PII enrollment and staffing over time. In Q1 2024, the number of PII practices enrolled is 40. 18 women's specialty health care sites and 22 PCMH participated in the Pregnancy Intention Initiative as of March 2024.

Figure 3. Pregnancy Intention Initiative Implementation by Region

| Health Service Area | PII Specialist Practices as of Q1 2024 | PII PCMH Practices as of Q1 2024 | PII CHT Staff FTE Hired as of Q1 2024 | PII Specialist Quarterly Attributed* Medicaid Beneficiaries as of Q1 2024 | PII Quarterly Attributed* Medicaid Beneficiaries as of Q1 2024 |
|---|---|---|---|---|---|
| Barre | 1 | 0 | 0.75 | 609 | 0 |
| Bennington | 1 | 0 | 1 | 988 | 0 |
| Brattleboro | 1 | 0 | .5 | 807 | 0 |
| Burlington | 2 | 9 | 1.2 | 2,115 | 4384 |
| Middlebury | 1 | 0 | 0.75 | 786 | 0 |
| Morrisville | 1 | 3 | 0.50 | 329 | 1195 |
| Newport | 1 | 0 | 1 | 885 | 0 |
| Randolph | 1 | 0 | 0.50 | 121 | 0 |
| Rutland | 1 | 0 | 1 | 1,027 | 0 |
| Springfield | 0 | 5 | 0.00 | 0 | 1554 |
| St. Albans | 0 | 0 | 0.00 | 0 | 0 |
| St. Johnsbury | 1 | 2 | 0.75 | 847 | 573 |
| Windsor | 0 | 3 | 0.00 | 0 | 90 |
| Planned Parenthood (Statewide) | 7 | 0 | 2.8 | 2,653 | 0 |
| Total | 18 | 22 | 10.75 | 11,167 | 7796 |

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

*Mental Health, Substance Use Disorder, and Behavioral Health*

**Key updates from QE032024:**
- Per Diem Rate for Mental Health Extended Stays in Emergency Departments
- Team Care Program
- Applied Behavior Analysis (ABA)

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

As of March 1, 2021, Vermont Medicaid modified the reimbursement methodology for inpatient services delivered by one of Vermont's largest psychiatric facilities. Before the implementation of this payment reform project, the DVHA & Department of Mental Health (DMH)reimbursed this facility for services using different methodologies on a fee-for-service, per-claim basis. The new

model allows for a prospective payment informed by several factors:

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

The DVHA, DMH, and the psychiatric facility have agreed upon performance measures and a monitoring platform for this payment model. Year two reconciliation has been completed and the model is now in year 3.

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

Effective 07/01/2022, the DVHA began reimbursement for extended Emergency Department (ED) stays in which a Vermont Medicaid member was meeting clinical criteria for inpatient psychiatric level of care (LOC) AND there were no inpatient beds available for placement. Requesting hospitals may submit a request after a Vermont Medicaid member meeting inpatient psychiatric LOC has had an initial 24-hour stay in an ED. The CIU is reviewing and making authorization determinations for these requests. We are now in year 2 of the benefit and are seeing an increase in requests.

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

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

The CIU manages the Applied Behavior Analysis (ABA) benefit. In 2021, DVHA changed the timing of the ABA tier

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

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

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

*Pharmacy Program*

**Pharmacy Benefit Management Program**

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

## Pharmacy Operations

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

## Operational Activity Reports

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

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

- The total claim count does not include compounded drugs.

***Paid Claims and Drug Spend***

**MEDICAID**

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

**VPHARM**

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

- The total claim count does not include compounded drugs.

## Provider Communications

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

| | |
|---|---|
| Claims Processing Information | Pharmacy claims resumed processing on 3/18/24. Instructions on copayment requirements that were lifted during the cyber outage. Reject codes that were allowed to be bypassed during the outage are brought back online. Reject code 72 – PA required, 76- Plan Limitations Exceeded, and 79- Refill Too Soon continue to be bypassed. |
| Update on Change Healthcare Cyber Security Incident | Communication sent to providers providing updates on the Change Healthcare system still being down and claim processing may resume in the coming weeks. DVHA is starting to hold informational meetings twice a week with pharmacies to answer questions and provide guidance. |
| Vermont Medicaid Voice Response System (VRS) Instructions During the Change Healthcare Network Outage | Due to the Cyber incident on 2/21/24 the Department of Vermont Health Access offered an option and instructions to providers to verify eligibility in the interim. |

| Regulations and Best Practice for Pharmacists Dispensing Controlled Substances During the Network Service Outage | Prescription limitations for short-acting opioid prescriptions. Patients 18 years and older are limited to 50 MME per day and a maximum of 7 days' supply. Patients 17 years of age and younger are limited to 24 MME per day and a maximum of 3 days' supply. |
|---|---|
| Change Healthcare Cyber Security Issue Update | Communication to providers giving guidance to claim processing, eligibility and prior authorizations |
| Claims processing and Medicaid Member Billing | Vermont Medicaid regular weekly payments are affected due to the cyber incident outage. To ensure provider do not experience cash flow issues the State of Vermont and Gainwell issued a payout for the average amount of weekly paid claims. |
| Submission process for prior authorizations physician administered drugs (J-Codes) during outage | Instructions on a temporary process for prescribers around prior authorization request for physician administered dugs through the medical benefit. |
| Change Healthcare Outage FAQ's | Communication to providers around frequently asked questions related to the cyber security incident. |
| Important Change Healthcare Outage | Guidance to providers around claim processing, emergency fills, eligibility, prior authorizations, controlled substances, and helpdesk access during the cyber security outage. |
| Change Healthcare Outage | Communication from Change Healthcare around their cyber security issue, who was impacted and pharmacy actions to take. |
| Changes to Coverage for COVID-19 Home Test | Effective 2/15/24, the Vermont Medicaid/ program will change the number of over the counter Covid-19 self-test allowed per prescription to 4 test, every 15 days. |
| Levemir Discontinuation | Novo Nordisk will be discontinuing Levemir (insulin detemir) injection in the U.S. on 12/31/24. |
| Flovent Discontinuation Update for Kids under 6 | Effective 1/12/2024 preferred alternative inhalers without prior authorization for patients under the age of 6 include Fluticasone HFA, Asmanex HFA, Arnuity Ellipta, Asmanex Twisthaler, Pulmicort Flexhaler and Qvar Redihaler. |
| Preferred Diabetic Supply List | The list of preferred diabetic supplies for 2024 has been updated and can be found on the DVHA website |
| Update on Dispensing Paxlovid | The U.S. Government Patient Assistance Program operated by Pfizer will continue to provide patients on Medicaid access to Paxlovid for free through December 31, 2024. For Vermont Medicaid to reimburse pharmacies and access Paxlovid free of change please they will need to submit claims via point of save, excluding 340B supplied Paxlovid. |
| Change to Administration Fee for Vaccines | Effective 01/01/2024 the administration fee for vaccines is $17.85. Adjustment was made to align the changes to the physician fee schedule for adult vaccinations. |

## Clinical Activities

## Hypertension Promoting Interoperability Program (PIP)

**High-Cost Drugs:** The Department of Vermont Health Access (DVHA) changed how it pays for certain

high-cost carve-out inpatient drugs, in accordance with the proposed Global Commitment Register GCR 22-002. This change was made to ensure that providers are being paid their actual cost for the drug and to allow the State to take advantage of available federal rebates. The Pharmacy Unit monitors for new FDA approved drugs that would be appropriate for addition to this policy. The following HCPCS codes will be added to the list: J1411, J1412, J1413 and the following HCPCS codes will be removed from the list: J3398. DVHA continually monitors for new high-cost drugs that may be administered inpatient for addition on the High-Investment Carve-Out Drug List.

**Discontinued Drug Products:** The Pharmacy Unit continually monitors new and discontinued drug products to notify pharmacies and providers appropriately. Recently, Novo Nordisk announced the discontinuation of Levemir ® FlexPen®, this product is regularly used in the Vermont Medicaid population and a notice to providers was developed to assist with transitions to covered alternatives. The supply disruptions of Levemir® FlexPen® are expected in mid-January 2024, lasting up until the discontinuation date on April 1, 2024. The following are preferred alternatives for Vermont Medicaid, available without prior authorization: LANTUS® (insulin glargine), TOUJEO® (insulin glargine), TOUJEO® MAX (insulin glargine), TRESIBA® (insulin degludec).

In addition, the Pharmacy Unit has been monitoring provider and patient impact following the discontinuation of Flovent® Diskus (fluticasone propionate powder) and Flovent® HFA (fluticasone propionate inhalation aerosol), which occurred December 31,2023. According to The Global Strategy for Asthma Management and Prevention (GINA) 2023 report, “the choice of inhaler device should be based on the child’s age and capability. The preferred device is a pressurized metered dose inhaler and spacer, with face mask for <3 years and mouthpiece for most children aged 3–5 years.” To accommodate members transitioning to new inhalers, the Department of Vermont Health Access changed the following inhalers to preferred status: patients UNDER THE AGE OF 6- FLUTICASONE HFA pressurized metered dose inhaler (pMDI) and patients UNDER THE AGE OF 12- ASMANEX® HFA (mometasone furoate) pressurized metered dose inhaler (pMDI). The following inhalers are preferred alternatives available without prior authorization for ALL AGES: ARNUITYT ELLIPTA® (fluticasone furoate) dry powder for inhalation, ASMANEX® TWISTHALER (mometasone furoate) dry powder for inhalation, PULMICORT FLEXHALER® (budesonide) dry powder for inhalation, QVAR REDIHALER® (beclomethasone dipropionate) breath-actuated inhaler.

## Pharmacy Cost Management (PCM) Program

**! Department of Vermont Health Access (DVHA), Pharmacy Benefit Manager, Change Healthcare which operates Vermont’s Medicaid pharmacy claims system, experienced a significant cyber security issue on February 1, 2024. We currently do not have data to share for this quarter.**

### *All-Payer Model: Vermont Medicaid Next Generation Program*

**Key updates from QE032024:**

- Executed a contract extension with OneCare Vermont for a 2024 performance year of the program.
- Implemented a Global Payment Program (GPP) pilot as a complementary payment model to the VMNG program.
- Began reconciliation (financial and quality) for the 2023 performance year.
- Continue to support Vermont’s broader efforts to develop an integrated healthcare delivery

system under an All-Payer Model through incremental programmatic improvements, iteration, and evolution.

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

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

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

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

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

DVHA and OneCare executed a contract amendment for a 2024 performance year of the VMNG program in Q4 of 2023. This amendment included a new, voluntary, complementary payment model (the Global Payment Program, or GPP) to issue separate "global" monthly prospective payments to current hospital and independent primary care participants in the VMNG ACO program. These prospective payments are for Vermont Medicaid members who are not attributed to the VMNG ACO program for Total Cost of Care-related services at participating hospital and independent physician practice participants, and this payment model is reconciled to actual fee-for-service experience separately and distinctly from the prospective payments issued to OneCare Vermont for VMNG ACO-

attributed members. Independent physician practices began participating in the GPP at the beginning of Q1 2024, and it is anticipated that hospitals who opt into the program will begin participating at the beginning of Q3 2024. This approach begins to separate the provider payment methodology from an attribution methodology and is an incremental step toward a more global, budget-based payment model, as Vermont looks forward to the next iteration of an All-Payer Model agreement through potential future participation in the federal AHEAD model. Other programmatic changes to the model were minor, to ensure program stability and. continued alignment across payer programs as part of the Vermont All-Payer ACO Model. Changes included increasing the risk corridor to ±3% and combining the traditional and expanded attribution cohorts for the purposes of financial reconciliation.

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

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

## V. Financial/Budget Neutrality Development/Issues

As is the monthly process, AHS paid DVHA 1/12th of the legislative budget for Global Commitment on the first business day of each month during the January – March 2024 quarter. This payment served as the proxy by which to draw down federal funds for Global Commitment (GC).

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

This quarter represents the first quarter of DY20 of the GC Waiver. Vermont calculates $375M for without waiver expenditures and reported $389M with waiver expenditures, leaving a savings subtotal of $18.8M. There are also 10 Hypothetical Tests for various demonstration groups. The hypothetical tests for New Adult, SMI IMD, Maternal Health & Treatment Services, CRT and Moderates reflect a surplus. Whereas the test for SUD IMD, Global Rx, and Marketplace Subsidies shows a moderate deficit. The total of the deficit is $1.5M, which reduces the cumulative Waiver savings to $12.8M. 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 $24.2M in expenditures for the quarter which leaves $142.8M available for the remainder of DY20.

Vermont continues to implement HCBS programs using the Reinvestment funds under the American Rescue Plan of 2021. For QE0324, Vermont reported $3.5M in Program expenses,

$1.6M in Investments, and $1M in Admin expenses.

## VI. Member Month Reporting

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

The table below contains Member Month Reporting for DY18 and DY19 and includes the unduplicated count of member months for SUD IMD and SMI IMD stays.

**Table 1. Member Month Reporting –** ***subject to revision due to retroactive enrollment***

| Medicaid Eligibility Group | Total DY 2018 | Total DY 2019 | Total DY 2020 |
|---|---|---|---|
| ABD - Non-Dual - Adult | **38,226** | **88,821** | **22,491** |
| ABD - Non-Dual - Child | **8,739** | **22,343** | **5,724** |
| ABD - Duals | **136,650** | **275,379** | **66,415** |
| Non - ABD Adult | **112,369** | **204,897** | **41,194** |
| Non - ABD Child | **378,139** | **733,379** | **172,912** |
| **Hypothetical Groups** | | | |
| New Adult | **454,502** | **874,071** | **191,788** |
| SUD - IMD ABD | **51** | **142** | **17** |
| SUD - IMD ABD Dual | **70** | **156** | **27** |
| SUD - IMD Non ABD | **121** | **430** | **25** |
| SUD - IMD New Adult | **623** | **1,299** | **221** |
| SMI - IMD ABD | **55** | **127** | **44** |
| SMI - IMD ABD Dual | **10** | **28** | **6** |
| SMI - IMD Non ABD | **20** | **173** | **16** |
| SMI - IMD New Adult | **174** | **350** | **97** |
| Housing Pilot | **0** | **0** | **0** |
| Maternal Health and Treatment Services | **114** | **343** | **94** |
| CRT | **1,213** | **2,437** | **749** |
| SUD CIT | **0** | **0** | **0** |
| VT Global RX | **55,178** | **108,797** | **27,605** |
| Moderate Needs Group | **731** | **1,377** | **379** |
| Marketplace Subsidy | **60,841** | **139,440** | **41,675** |

## 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 QE032024:

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

The QI unit partners with the Compliance and Oversight & Monitoring units as part of a larger Risk & Quality Management (RQM) Team. The over-arching goals of this team include:

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

PIHP Quality Committee

The Quality Committee remained active during QE0324 and consists of representatives from all departments within AHS that serve the Medicaid population. The committee continues to structure its work around the federal managed care quality program guidelines. Topics addressed this quarter included annual review of the privacy and confidentiality report, as well as quality measure reporting for various special health care needs populations.

Home and Community-Based Services (HCBS) Quality Subcommittee

During this reporting period the Quality Unit drafted a charter and work plan for a new HCBS Quality subcommittee. This group includes representatives from DAIL and DMH, the departments that are delegated service delivery to Vermont Medicaid's HCBS special health care needs populations. Work plan activities include, but are not limited to, implementing strategies for HCBS measure set reporting and developing an HCBS stakeholder engagement plan.

Formal CMS Performance Improvement Project (PIP)

During this reporting period, DVHA initiated a new formal PIP topic focused on new-to-Medicaid (NTM) members receiving an initial screening within 90 days of their enrollment. Regulatory review identified this as an area for improvement. A cross-Agency team and baseline data are being developed.

Quality Measure Reporting

HEDIS measure production –In addition to producing and reporting on administrative (claims-based) measures annually, the Quality Improvement and Data teams work with our quality measures vendor to produce hybrid measures. DVHA's data unit provided extracts to our quality measure vendor at the end of the year for Measurement Year (MY) 2023. Test runs were completed in December 2023. The first HEDIS production run occurred in early 2024 and the Medical Record Review (MRR) sample was drawn in March 2024 for hybrid measures.

-

CAHPS Experience of Care measures – The Quality Unit received the 2023 Health Plan CAHPS survey result summaries for Adults and Children from our contracted vendor during Q1 2024. The Children with Chronic Conditions question set was added to the survey; thus, a new scorecard tool was created by the Quality Unit to better incorporate these results. Reporting will follow in Q2 to both the Quality Committee and the Clinical Utilization Review Boar (CURB).

Vermont Next Generation Medicaid ACO

During QE0324, DVHA's Director of Quality Management received, reviewed, and approved the quarterly VMNG ACO quality management reports. Quality and Clinical staff from DVHA and the VMNG ACO also meet quarterly with a focus on quality measurement and ongoing QI efforts.

Comprehensive Risk Assessment

Staff from DVHA's Quality, Oversight & Monitoring, and Compliance units maintain a comprehensive risk assessment program for Vermont's Medicaid program. The purposes of this joint effort are to:

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

The assessment entails collaboration with other Agency departments and informed updates to DVHA's Inter-Governmental Agreement (IGA) with AHS.

Also, during QE032024, the risk assessment team:

- Submitted the Annual Risk Assessment Report to AHS
- Collaborated with staff across the Agency to follow through on 2023 corrective action plans.
- Began preparing for the 2024 Compliance audit.

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, DMH highlighted the performance of a subset of their investments. The Clear Impact Scorecard for these investments is included in this report as Attachment 6.

Payment Models & Performance Monitoring

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

During this most recent quarter, Dental and CIS highlighted the performance of their payment models. The Clear Impact Scorecards for these payment models are included in this report as Attachment 7.

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

The quality strategy is intended to serve as a blueprint or road map for states and their contracted health plans in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. In the Special Terms and Conditions (STCs) of the State's recent waiver extension, CMS has included prescriptive 1915(c) HCBS quality requirements for the State's 5 HCBS programs (CFC, DS, BIP, CRT, MH Under 22). As a result, the State is required to extend its existing quality strategy to include HCBS. During this quarter, the State continued to identify the HCBS Quality Improvement Strategy (QIS) guidance as they update their broader waiver Quality Strategy. The QIS for VT HCBS is a part of the state's overall 1115/Medicaid Quality Strategy and as such the HCBS specific QIS may be imbedded within this larger approach. The state continues to review and revise their overall approach and will be updating the sections related to HCBS to reflect the use of the new HCBS measure set and Access Rule requirements that the state is piloting with CMS.

SUD Monitoring Protocol and Reports

The SUD Monitoring Protocol specifies the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements of the demonstration. During this quarter, the state submitted quarterly narrative and data monitoring reports for the substance use disorder (SUD) component of the Global Commitment to Health demonstration, to the Centers for Medicare & Medicaid Services (CMS), as required by the state's special terms and conditions (STC).

SUD Midpoint Assessment

As per STC 9.4 the state must conduct an independent mid-point assessment by June 30, 2025. In the design, planning and conduction of the mid-point assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to SUD treatment providers, beneficiaries, and other key partners. During Q1, the state continued to work with their independent evaluator to develop the timeline and workplan for the assessment.

SMI Monitoring Protocol and Reports

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

SMI Midpoint Assessment

As per STC 10.8 the state must conduct an independent mid-point assessment by June 30, 2024. In the design, planning and conducting of the mid-point assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: SMI/SED providers, beneficiaries, and other key partners. During Q1, the state continued to work with the evaluator to develop the assessment. Specifically, the state provided quantitative monitoring data, supported key stakeholder interviews, and reviewed and provided feedback on a draft version of the assessment. A final version of the assessment is expected during the next quarter.

## IX. Demonstration Evaluation Activities

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

Overall Waiver

During the quarter, the state received CMS feedback on their draft evaluation design for the overall waiver. The draft Evaluation Design is being developed in accordance with the following CMS guidance (including but not limited to): (1) STC Attachment A (Preparing the Evaluation Design), all applicable technical assistance on applying robust evaluation approaches, including using comparison groups and beneficiary surveys to develop a draft Evaluation Design; and (2) all applicable evaluation design guidance, including guidance about substance use disorder, serious mental illness, premiums, and overall demonstration sustainability. The draft design includes hypotheses that cover all components of the demonstration and is due to CMS during the next quarter. Key recommendations for strengthening the design included the following: elaborate on key details of the evaluation design and comparison group selection; clarify time periods for all quantitative outcome measures; avoid causal language when using descriptive or pre-post analyses; provide more details in quantitative analysis plans; include further detail on investment assessments; and include additional detail on primary data collection plans. The state reviewed the feedback with the independent evaluator and

plans to submit a revised design next quarter.

Innovative Assessment Evaluation

The state plans to evaluate all investments authorized under the demonstration in accordance with STC 15.3. Hypotheses for investments will reflect appropriate goals for each area of investments as described in STC 11.1 and broadly assess whether they collectively contribute to the goals of the demonstration, such as the reduction of disparities in health outcomes. During this quarter, the state continued to work with an independent evaluator on the assessment of investments. In addition to the workplan, the state and evaluator finalized the overall analytic approach, report template, and timeline for the assessments. The analysis plan will include the different types of potential analyses depending on data sources available (quantitative-only, qualitative-only, mixed-methods, etc.), as well as the decision-making process the evaluator will use to select the analytic approach. The state will continue to support the evaluator as they begin to assess the first set of priority investments.

Summative Evaluation Report

During this quarter, the state received CMS feedback on the Vermont Global Commitment to Health Summative Evaluation Report. The draft Summative Evaluation Report covers the 2017–2021 demonstration period. Recommendations for improvements to the Summative Evaluation Report include the following: ensure consistency in the reported hypotheses and measures and include a description of the status of all measures listed in the Evaluation Design; conduct tests of statistical significance for all quantitative measures and add results to summary tables or provide a rationale for not feasible; revise language to clarify key concepts in the evaluation; define acronyms and terms used, particularly in the Executive Summary; present uncertainty around estimates; and clarify the multiple testing approach. The state will work with the independent evaluator that produced the report and submit a revised Summative Evaluation Report during the next quarter.

PHE Flexibilities

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

Waiver Performance Evaluation

During Q1 2024 the state signed a contract with the University of Massachusetts to conduct evaluation activities associated with Vermont’s Global Commitment to Health 1115 research and demonstration waiver. The overall responsibilities of the contractor are to enhance the state’s ability to assess the performance of their Medicaid managed care model as well as to support the future development of partnerships with appropriate research partners. Initial activities included the following: identifying a business lead, recruiting a project manager, setting up a SharePoint site, and developing a workplan and timeline. Introductory meetings were also scheduled during the quarter with the MDWAS Project team and contractors as well as the current overall evaluation contractor, NORC.

## X. Compliance

**Key updates from QE032024:**
- EQRO Review Activities – Network Adequacy Validation (NAV) is added as a required EQR activity. Planning for all 2024 activities is underway.
- AHS DVHA IGA – amended CY2023 actuarial certification.
- SIU Activity – summary of quarterly activities is included in this section.

External Quality Review

During the last quarter, the state worked with the External Quality Review Organization (EQRO) to develop the material necessary for each of the required annual external quality review activities (i.e., performance improvement project validation, performance measure validation, compliance review, and network adequacy validation). Performance Improvement Project (PIP) validation items included the PIP validation timeline, review templates, and report outlines. Performance Measure Validation items included the PMV timeline, a document request letter, a rate reporting template, and a HEDIS roadmap. Review of Compliance with Standards items included a document request letter as well as desk and documentation review forms. Network Adequacy Validation (NAV) is a new CMS-required External Quality Review (EQR) activity for 2024. During this quarter, the state worked with the EQRO to create all NAV document request packet materials. Items included the NAV timeline, memo, ISCAT, etc.). Letters and materials for all EQRO-related activities are expected to be sent to DVHA during the next quarter.

Intra-Governmental Agreement (IGA) between AHS and DVHA

The AHS/DVHA IGA documents the Global Commitment to Health demonstration requirements between AHS and DVHA. As per the Special Terms and Conditions (STCs) of the waiver, this agreement must be reviewed and approved annually by CMS. During this quarter, the state received an amendment to the CY2023 actuarial certification that was submitted to CMS on 12/20/2022. This amendment resulted in a change to the PMPM rates included in the table found on p. 43 of the AHS-DVHA CY2023 Intergovernmental Agreement (IGA). There were no other changes to the IGA because of the amendment to the CY2023 actuarial certification. To document this amendment, the state edited the CY2023 Inter-Governmental Agreement (IGA) by and between the Vermont Agency of Human Services and the Department of Vermont Health Access and submitted the modified IGA, the amended actuarial certification, the workbook of the capitation rates for Vermont's Global Commitment to Health for the contract period 1/1/23-12/31/23, and an amended CMS Contract and Rate Submission Cover Sheet to CMS.

Special Investigations Unit (SIU)

CMS has requested that the state provide them with quarterly reports detailing 1) the number of provider investigations conducted by the SIU as well as 2) the number of suspected fraud referrals provided to the state Medicaid agency by the SIU. This information for the current quarter is included in the table below.

Table 1. SIU Activity Q1 2024

| REPORTING ELEMENT | # |
|---|---|
| The number of provider investigations conducted by the PIHP | 20 |
| The number of suspected fraud referrals provided to the state Medicaid agency by the PIHP | 1 |
| The number of Personal Care Assistant related suspected fraud referrals provided to the state Medicaid agency by the PIHP | 0 |
| Number of Provider Preventable Conditions Identified by the SIU in the fourth quarter of CY2023 | 0 |

### XI. Reported Purposes for Capitate Revenue Expenditures

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

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

### XII. State Contact(s)

| | | |
|---|---|---|
| Fiscal | Richard Donahey, CFO<br>VT Agency of Human Services<br>280 State Drive<br>Waterbury, VT 05671-1000 | 802-241-0442 (P)<br>richard.donahey@vermont.gov |
| Medicaid Director | Monica Ogelby<br>Vermont Medicaid Director<br>Agency of Human Services<br>280 State Drive<br>Waterbury, VT 05671-100 | 802-338-6643<br>Monica.ogelby@vermont.gov |
| Policy/Program | Ashley Berliner, Director of<br>HealthCare Policy & Planning<br>VT Agency of Human Services<br>280 State Drive<br>Waterbury, VT 05671-1000 | 802-578-9305 (P)<br>802-241-0958 (F)<br>ashley.berliner@vermont.gov |
| Managed Care Entity | Andrea DeLaBruere,<br>Commissioner of the Department of<br>Vermont Health Access<br>280 State Drive<br>Waterbury, VT 05671-<br>1000 | 802-585-5356 (P)<br>Andrea.delabruere@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 | QE032024 Investments (GC Investments) |
| Attachment 6 | Investment Scorecard(s) |
| Attachment 7 | Payment Model Scorecard(s) |

**Date Submitted to CMS: May 30, 2024**

**State of Vermont Global Commitment to Health**
**Budget Neutrality PMPM Projection vs 64 Actuals Summary**
**QE 0324**

| ELIGIBILITY GROUP | DY 18<br>Jul 2022 - Dec 2022 | DY 19<br>Jan 2023 - Dec 2023 | DY 20<br>Jan 2024 - Dec 2024 |
|---|---|---|---|
| **Without Waiver (Caseload x pmpms)** | | | |
| ABD - Non-Medicare - Adult | $ 91,924,294 | $ 221,078,810 | $ 58,612,049 |
| ABD - Non-Medicare - Child | $ 23,320,945 | $ 60,876,882 | $ 16,034,148 |
| ABD - Dual | $ 289,588,696 | $ 600,007,461 | $ 150,163,308 |
| Non ABD - Non-Medicare - Adult | $ 88,456,625 | $ 168,857,127 | $ 36,087,020 |
| Non ABD - Non-Medicare - Child | $ 226,334,361 | $ 457,922,244 | $ 114,228,394 |
| **Total Expenditures Without Waiver** | **$ 719,624,921** | **$ 1,508,742,525** | **$ 375,124,920** |
| **With Waiver** | | | |
| ABD - Non-Medicare - Adult | $ 95,250,705 | $ 217,911,333 | $ 60,803,186 |
| ABD - Non-Medicare - Child | $ 20,360,439 | $ 61,080,929 | $ 17,825,440 |
| ABD - Dual | $ 283,809,254 | $ 616,434,108 | $ 163,993,005 |
| Non ABD - Non-Medicare - Adult | $ 56,470,924 | $ 100,095,762 | $ 23,101,241 |
| Non ABD - Non-Medicare - Child | $ 173,656,454 | $ 385,793,986 | $ 99,086,848 |
| Individual Cost Effective | $ - | $ - | $ - |
| Community Transition Services | $ - | $ - | $ - |
| MDAAP | $ - | $ 582,000 | $ 32,000 |
| Investments | $ 73,392,050 | $ 110,768,382 | $ 24,261,624 |
| **Total Expenditures With Waiver** | **$ 702,939,826** | **$ 1,492,666,500** | **$ 389,103,344** |
| **Waiver Savings Summary** | | | |
| **Subtotal Annual Savings** | $ 16,685,095 | $ 16,076,024 | $ (13,978,424) |
| **Hypothetical Test Deficits** | $ (1,204,077) | $ (3,195,577) | $ (1,554,611) |
| **Cumulative Savings** | $ 15,481,018 | $ 28,361,465 | $ 12,828,430 |
| **HYPOTHETICAL TESTS** | | | |
| **Hypothetical Test 1: New Adult** | | | |
| Limit New Adult PMPM*MM | $ 261,350,820 | $ 523,951,418 | $ 121,518,032 |
| New Adult Total Expenditures | $ 222,857,284 | $ 445,820,821 | $ 110,308,959 |
| **Surplus (Deficit)** | $ 38,493,536 | $ 78,130,597 | $ 11,209,073 |
| **Hypothetical Test 2: SUD IMD** | | | |
| SUD - IMD ABD - Non-Medicare - Adult | $ 156,312 | $ 449,184 | $ 56,088 |
| SUD - IMD ABD - Dual | $ 129,959 | $ 298,269 | $ 53,688 |
| SUD - IMD Non ABD - Non-Medicare - Adult | $ 342,876 | $ 1,259,382 | $ 76,515 |
| SUD - IMD New Adult | $ 1,941,629 | $ 4,220,302 | $ 758,930 |
| **Limit SUD IMD PMPM*MM** | **$ 2,570,776** | **$ 6,227,137** | **$ 945,221** |
| SUD - IMD ABD Non Medicare Adult | $ 156,753 | $ 455,254 | $ 89,311 |
| SUD - IMD ABD - Dual | $ 236,032 | $ 503,170 | $ 131,523 |
| SUD - IMD Non ABD - Non-Medicare - Adult | $ 380,721 | $ 671,824 | $ 122,197 |
| SUD - IMD New Adult | $ 2,146,823 | $ 4,876,050 | $ 1,019,542 |
| **SUD IMD Total Expenditures** | **$ 2,920,329** | **$ 6,506,298** | **$ 1,362,573** |
| **Surplus (Deficit)** | $ (349,553) | $ (279,161) | $ (417,352) |
| **Hypothetical Test 3: SMI IMD** | | | |
| SMI - IMD ABD - Non-Medicare - Adult | $ 3,070,568 | $ 7,317,673 | $ 2,644,273 |
| SMI - IMD ABD - Dual | $ 357,432 | $ 1,030,686 | $ 229,696 |
| SMI - IMD Non ABD - Non-Medicare - Adult | $ 726,715 | $ 6,497,072 | $ 627,925 |
| SMI - IMD New Adult | $ 7,128,451 | $ 14,947,557 | $ 4,378,737 |
| **Limit SMI IMD PMPM*MM** | **$ 11,283,167** | **$ 29,792,988** | **$ 7,880,631** |
| SMI - IMD ABD Non Medicare Adult | $ 1,622,662 | $ 5,221,278 | $ 1,342,006 |
| SMI - IMD ABD - Dual | $ 525,975 | $ 1,186,763 | $ 294,261 |
| SMI - IMD Non ABD - Non-Medicare - Adult | $ 700,985 | $ 1,575,936 | $ 359,781 |
| SMI - IMD New Adult | $ 5,491,100 | $ 13,081,690 | $ 3,317,114 |
| **SMI IMD Total Expenditures** | **$ 8,340,722** | **$ 21,065,667** | **$ 5,313,162** |
| **Surplus (Deficit)** | $ 2,942,445 | $ 8,727,321 | $ 2,567,469 |
| **Hypothetical Test 4: Housing Pilot** | | | |
| Limit Housing Pilot PMPM*MM | $ - | $ - | $ - |
| Housing Pilot Total Expenditures | $ - | $ - | $ - |
| **Surplus (Deficit)** | $ - | $ - | $ - |
| **Hypothetical Test 5: Maternal Health and Treatment Services** | | | |
| Limit Maternal Health and Treatment Services PMPM*MM | $ 1,105,887 | $ 3,361,989 | $ 934,168 |
| Maternal Health and Treatment Services Total Expenditures | $ 1,179,899 | $ 3,212,211 | $ 859,427 |
| **Surplus (Deficit)** | $ (74,012) | $ 149,778 | $ 74,741 |
| **Hypothetical Test 6: CRT** | | | |
| Limit CRT PMPM*MM | $ 6,149,760 | $ 12,788,302 | $ 4,115,152 |
| CRT Total Expenditures | $ 4,735,011 | $ 11,488,848 | $ 3,547,466 |
| **Surplus (Deficit)** | $ 1,414,749 | $ 1,299,454 | $ 567,686 |
| **Hypothetical Test 7: SUD CIT** | | | |
| Limit SUD CIT PMPM*MM | $ - | $ - | $ - |
| SUD CIT Total Expenditures | $ - | $ - | $ - |
| **Surplus (Deficit)** | $ - | $ - | $ - |
| **Hypothetical Test 8: Global Rx** | | | |
| Limit Global Rx PMPM*MM | $ 4,928,451 | $ 9,717,653 | $ 2,465,654 |
| Global Rx Total Expenditures | $ 5,708,962 | $ 12,634,069 | $ 3,498,584 |
| **Surplus (Deficit)** | $ (780,511) | $ (2,916,416) | $ (1,032,930) |
| **Hypothetical Test 9: Moderates** | | | |
| Limit Moderates PMPM*MM | $ 609,493 | $ 1,188,352 | $ 342,450 |
| Moderates Total Expenditures | $ 445,520 | $ 879,923 | $ 290,703 |
| **Surplus (Deficit)** | $ 163,973 | $ 308,429 | $ 51,747 |
| **Hypothetical Test 10: Marketplace Subsidy** | | | |
| Limit Marketplace Subsidy PMPM*MM | $ 2,027,688 | $ 4,782,013 | $ 1,484,763 |
| Marketplace Subsidy Total Expenditures | $ 1,955,249 | $ 4,623,575 | $ 1,589,092 |
| **Surplus (Deficit)** | $ 72,439 | $ 158,438 | $ (104,329) |

Attachment 2

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

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

**Questions, Complaints and Concerns Received by Health Access Member Services**
**January 1, 2024 – March 31, 2024**

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

**January 2024:**

- **Provider Complaint –** Member requested to document feedback as he feels that there are not enough Dental specialists that accept VT Medicaid as insurance. He feels that there should be a reimbursement program for customers that have to pay out of pocket for a non Medicaid provider. The agent apologized for the inconvenience and documented the feedback.

**February 2024:**

- **System Efficiency –** Member states that he received a recording upon his first attempt to contact GMC that indicated that his phone number was not recognized and member's call was disconnected. Member would like to share this information with SOV as he states he's concerned that his area code could of caused this as his area code is not a Vermont area code. Member is concerned that he may not be the only one who has experienced it and wants this issue investigated. The agent apologized for the inconvenience and documented the customers feedback.

**March 2024:**

- **Provider Complaint -** Member is calling in to document feedback about the Pharmacy outage. He states due to the outage his wife was unable to get her prescriptions. He states the provider services number that the pharmacy told him to contact for verification is unreliable. The agent apologized for the inconvenience and did explain the PBM process as well as documented the feedback.
- **Other Resources -** Member feels that XXXXX XXXXX company drivers discriminated against him due to his hearing disability. He also feels violated that the driver refused to drive him any further after finding out member submitted a complaint on him previously. He says he feels it is unfair for driver to not want to drive him anymore just because he complained. He also states an additional driver treated him in the same manner because he stated that he would be complaining about him as well. The agent apologized for the inconvenience and documented the feedback. They also offered to file a Formal Grievance.

# Grievance and Appeal Quarterly Report
# Medicaid Managed Care Model
# All Departments Combined Data
# January 1, 2024 – March 31, 2024

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data from the centralized database that were filed from January 1, 2024, through March 31, 2024.

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

During this quarter, there were thirty grievances filed and twenty-three were addressed. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of receipt of a grievance must be sent within five days; the average was three days. Of the grievances filed, 80% were filed by the beneficiary, and 20% were filed by a representative. DMH had 67%, DAIL had 30%, and VDH had 3% of the grievances filed.

Grievances were filed for service categories mental health, case management, community social support, counseling, employment services and substance abuse services.

There were no Grievance Reviews filed this quarter.

Appeals: Health Care Administrative Rule 8.100 defines adverse benefit determinations that the Managed Care Model makes that are subject to an internal appeal. These actions are:

1. denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service;
2. reduction, suspension or termination of a previously authorized covered service or a service plan;
3. denial, in whole or in part, of payment for a covered service;
4. failure to provide a clinically indicated, covered service, when the Managed Care provider is a DA/SSA;
5. failure to act in a timely manner when required by state rule;
6. denial of a beneficiary's request to obtain covered services outside the network.

During this quarter, there were fourteen appeals filed. Of these fourteen appeals, twelve were resolved (86%), one was untimely (7%), and one was withdrawn (7%).

Of the twelve appeals that were resolved this quarter, 98% were resolved within the statutory time frame of 30 days. The average number of days it took to resolve these cases was twenty days. Acknowledgement letters of receipt of an appeal must be sent within five days; the average was two days.

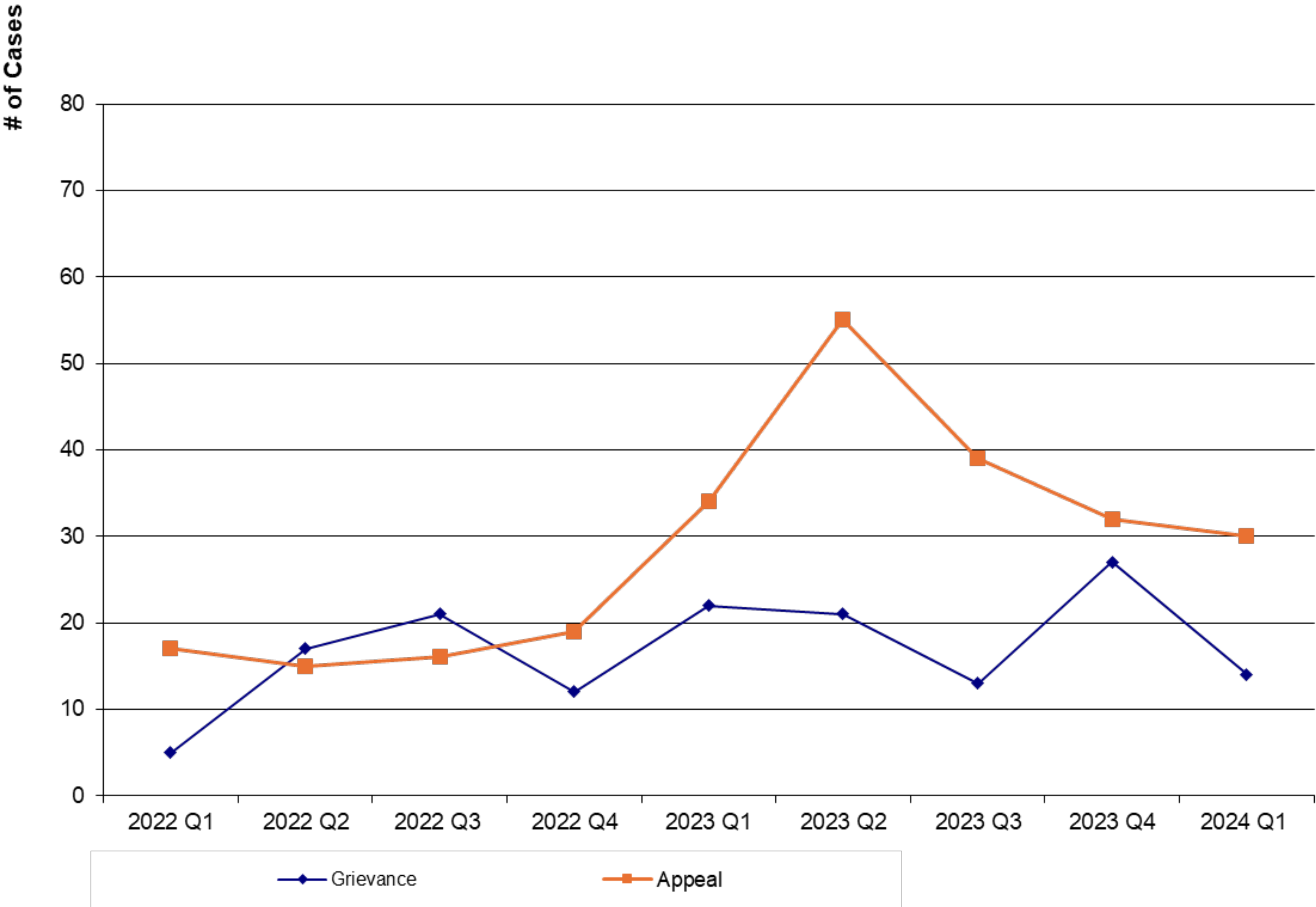
Of the fourteen appeals filed, DVHA had eleven appeals filed (79%), and DAIL had (21%).

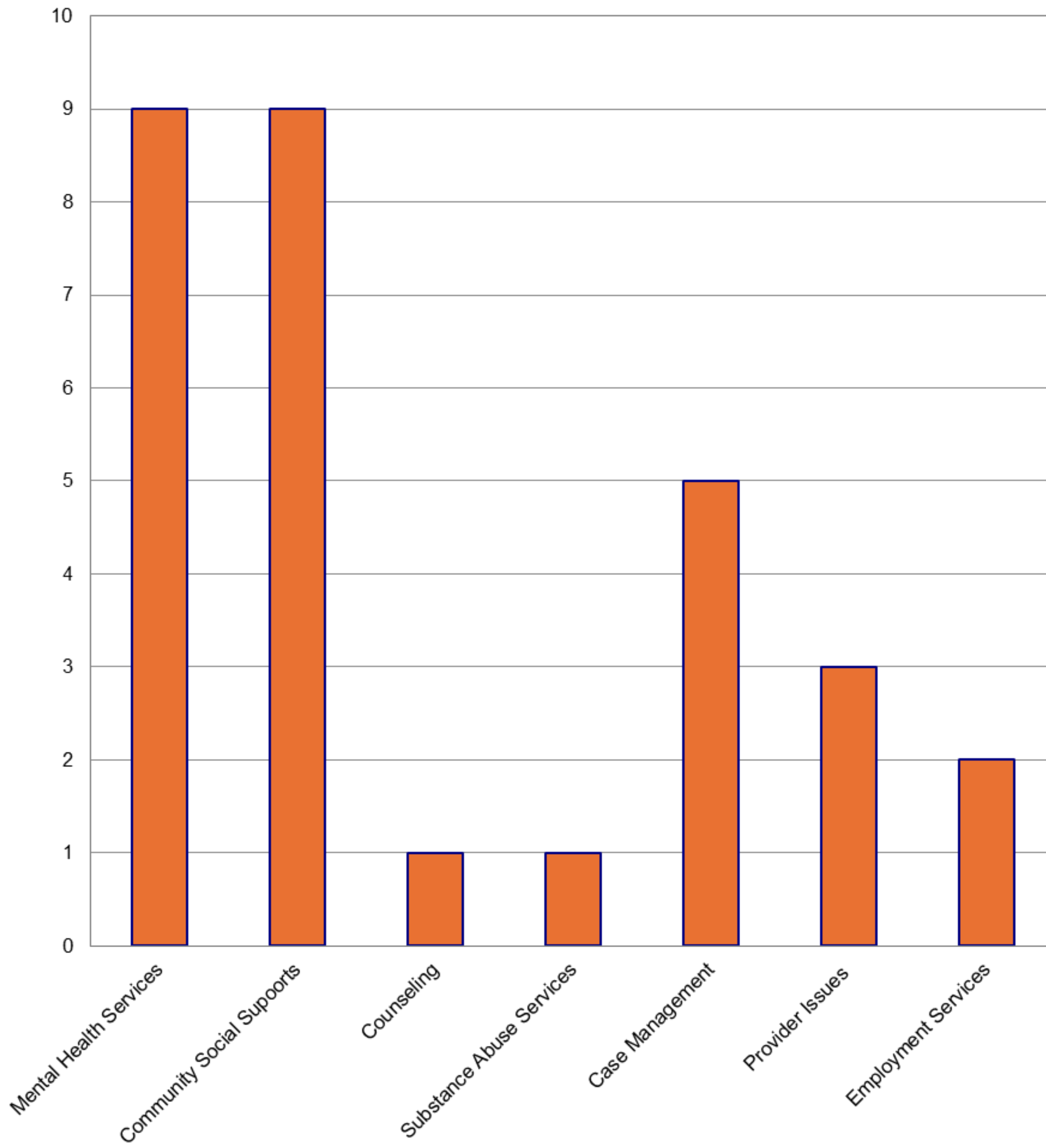
The appeals filed were for service categories outpatient hospital, prescription, case management and transportation.

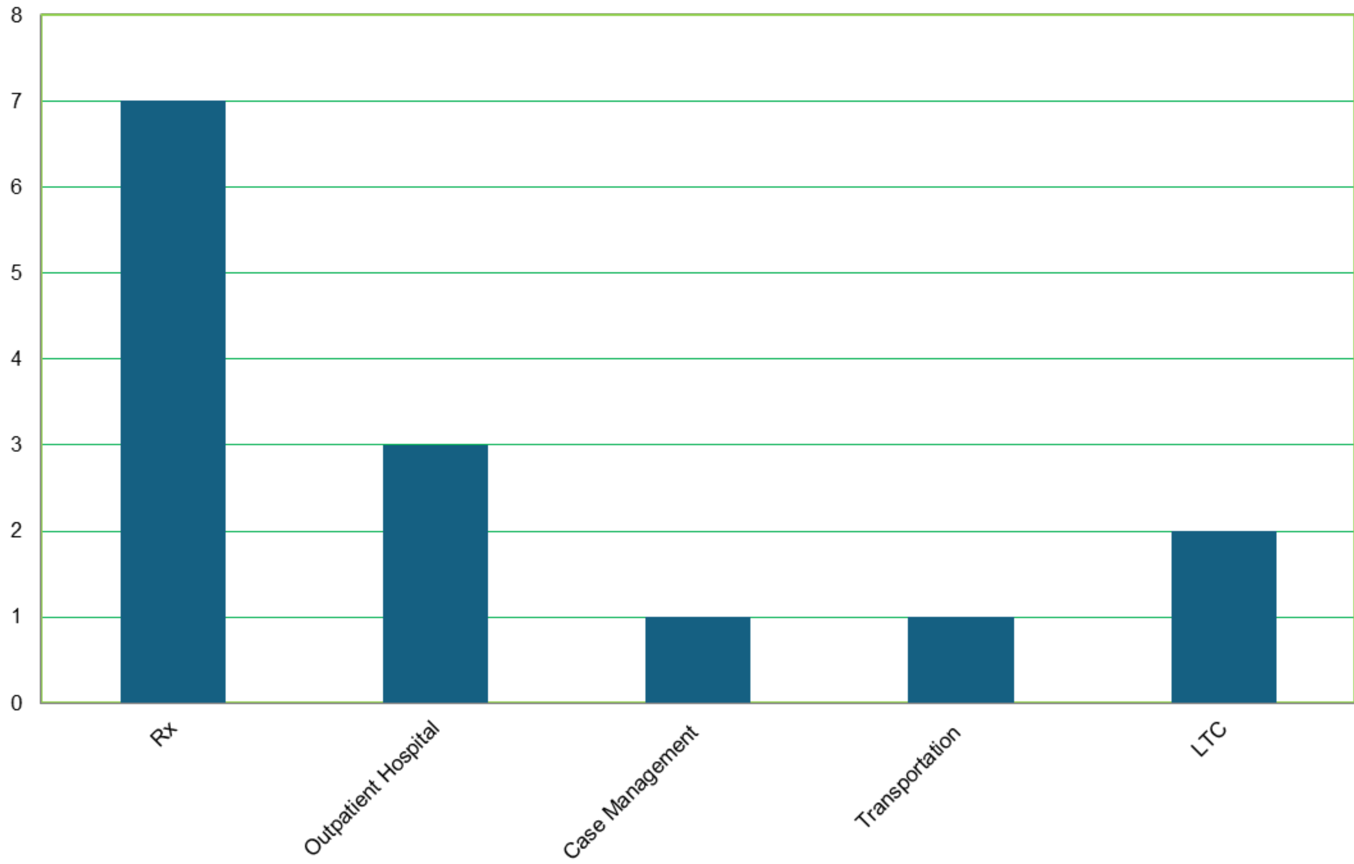
Beneficiaries must exhaust the internal appeal process before they can file a fair hearing if their appeal is not decided in their favor. There were three fair hearings filed this quarter.

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

## Grievances and Appeals
## January 1, 2022 thru March 31, 2024




Grievance by Service Catagory
10
9
8
7
6
5
4
3
2
1
0
Mental Health Services
Community Social Supoorts
Counseling
Substance Abuse Services
Case Management
Provider Issues
Employment Services


Appeals by Service Category
8
7
6
5
4
3
2
1
0
Rx
Outpatient Hospital
Case Management
Transportation
LTC

Vermont Legal Aid

# Office of the Health Care Advocate

Quarterly Report

January 1-March 31, 2024

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

April 21, 2024

## Summary and Update

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

The HCA opened 901 cases this quarter (882, the previous quarter). During the quarter, Medicaid prescription drug access was impacted by the nationwide cyberattack on Change Healthcare. We had 50 calls about prescription access, and our update about the cyberattack on our website was viewed 76 times. During the cyberattack, the HCA advocates worked with VHC to quickly resolve cases when Medicaid enrollees could not get their prescriptions or were being charged full price for the prescriptions instead of the Medicaid copayment rate. The HCA is also working to help get reimbursements for enrollees who paid full price for their prescriptions during the cyberattack.

Our calls also reflected that VHC's annual open enrollment ended. We continue to receive calls about signing up for a plan on Vermont Health Connect; eligibility for Premium Tax Credit; and eligibility for Special Enrollment Periods. We talked to over 100 households about Medicaid Eligibility: 65 for MAGI Medicaid, 40 for MABD Medicaid and 10 about Medicaid Spenddown. The Medicaid eligibility page on our website had 1839 page views.

The HCA also did a training on Medicaid eligibility and coverage rules for Vermont Association of Area Agencies on the Aging. The training was attended by about 20 caseworkers, who often help Vermonters apply for Medicaid and other state health care programs.

Starting this quarter, Dr. Dynasaur has a continuous eligibility provision for children up to age 19. This means that a household will stay on Dr. Dynsaur for the 12 months after they review, even if there is an income change that puts the household above the Dr. Dynasuar income limit. Continuous eligibility helps ensure that children don't miss preventive care or pediatric visits. It also reduces the administrative burden and the churn of children going on and off coverage. HCA advocates have been providing consumer education on this provision and what it will mean for families and caregivers. Our webpage on Dr. Dyansuar had 363 pageviews this quarter. Dr. Dyansur for pregnancy also

**Holden's Story**

Holden called the HCA because his Medicaid was closing at the end of the month. He had a job that offered insurance but was worried because the costs. The insurance had high premiums and out of pockets costs. Because of the costs, he considered not enrolling on the employer plan. The HCA advocate first explained that when his Medicaid closed, he would have a special enrollment period to get on his employer plan. But she also explored what the insurance plan would cost. If you have an offer of affordable and adequate employer coverage, you can't get Advance Premium Tax Credit (APTC) to help pay for a plan on Vermont Health Connect. When calculating if the employer coverage is affordable, VHC looks at how much it costs and your household income. Affordability in 2024 is based on whether a plan costs more than 8.39% of the household income. When the advocate got Holden's insurance costs and income information, it was clear that the plan was not affordable. It was going to cost nearly 10 percent of his household income. This meant that Holden was eligible for APTC to help pay his premiums for a VHC plan. When his Medicaid closed, he planned on enrolling on a VHC plan with APTC to help with the plan premiums.

has a continuous coverage provision for the pregnancy and for one year of post-partum coverage.

This quarter also coincided with the Medicare General Enrollment Period and the Medicare Advantage Plan enrollment period. We had 283 calls from Medicare enrollees this quarter. We provided 20 households with consumer education about Medicare. We also advised another 26 households on their eligibility for Medicare Savings Programs, which help with the Medicare costs. Our website on Medicare Savings Programs had 660 page views. The HCA is continuing its work to expand the eligibility of these programs.

Th HCA continues to update its Medicare webpage, which features the stories of Vermonters who are struggling with the costs: [Medicare Stories | Vermont Legal Aid (vtlegalaid.org)] Expanding the limits to Medicare Savings Program will make a significant and immediate financial impact on many Vermont seniors and disabled Vermonters. It will help them afford the health care they need, and it will be a step towards creating a more equitable system for seniors and disabled Vermonters. The Affordable Care Act expanded coverage for those under 65, and expanding Medicare Savings Programs will be a similar step for Vermonters on Medicare.

The HCA continued its work on developing educational tools for hospitals and consumers in preparation for the implementation of the new Financial Assistance Policy statute (Act 119). We talked to 11 households about patient financial assistance and another 8 about hospital billing. The HCA plans on working with hospitals to help ensure that the patient financial assistance policies are updated and reflect the changes in the statute. We want to ensure that policies are easily accessible and understandable to all patients. We are also planning consumer outreach. The HCA plans to do major consumer education to make Vermonters know about the changes to policy.

The HCA also continued its work on Silver alignment for Open Enrollment 2025. Silver alignment is a change to how Silver plans on VHC are valued. For APTC eligible consumers, the net result from this change will mean they will be eligible for more APTC and have increased buying power for gold and platinum plans on VHC. The gold and platinum plans have lower deductibles and cost-sharing. With the increased APTC many households could even move to premium free gold plans. The HCA has started meeting with VHC and other stakeholders to develop a plan to educate consumers about the impact of these changes.

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**Case Stories:**

**Calla's Story**:

Calla reached out to the HCA because she had just turned 65 and was unsure of how she was going to pay for Medicare. Calla had been on Medicaid for Children and Adults (MCA), but eligibility for that program ends when you turn 65. She had been sent a notice from Vermont Health Connect (VHC) telling her that her MCA was closing. The HCA advocate explained that a different type of Medicaid worked with Medicare. This type of Medicaid is called Medicaid for Aged Blind and Disabled (MABD). It has both income and resource rules. This is different from MCA, which only has income rules. The resource rules mean there is a limit to how much money you can have saved and still be eligible. For single adults the limit is $2000. The HCA advocate found that Calla was income eligible for MABD because her monthly income was under $1000, but because she had a retirement account of about $10,000, she was not going to be resource eligible. It is possible to spend down your resources to become eligible, but this account was all of Calla's savings. The HCA advocate explained that Vermont has another program called QMB. QMB provides much of the same coverage as Medicaid. Medicare Savings Programs do not have resource tests, and QMB covers both Medicare premiums and cost-sharing. With this program Calla could get assistance with paying for Medicare and covering the cost-sharing. She could also preserve her small retirement account. The HCA advocate helped apply for the Medicare Savings Program, and she was found eligible.

**Elena's Story**

Elena called the HCA because she needed coverage. Elena was pregnant and was applying for the Immigrant Health Insurance Plan (IHIP). IHIP provides health care coverage for kids and pregnant individuals who are not eligible for Medicaid because of their immigration status. IHIP provides medical, prescription, and dental coverage like Dr. Dynasaur. Like Dr. Dynasaur, IHIP provides coverage during pregnancy and for a 12-month post-partum period after the birth of the baby. Elena already had one baby who was born in Vermont and had Dr. Dynasaur. She was pregnant, however, and did not have a documented legal status, which meant that she could not get Dr. Dynasaur for pregnancy or a VHC plan. The HCA advocate found that Elena's application had been denied, because VHC needed more information about her household and income. The HCA advocate investigated what had been submitted with Elena's application and found that Elena and her caseworker had attempted to provide verification of her income and residency. However, when they submitted the additional information, the copies were not readable. The HCA advocate helped Elena re-submit the documents. VHC was able to read the documents and Elena was approved for IHIP.

**Sage's Story**

Sage called the HCA because he needed some help with his prescription drug coverage. He was on Medicare, but he had not signed up for a Part D plan. Sage was a veteran and was eligible for VA benefits. He was getting his prescription coverage through the VA but wanted additional coverage. He wanted to know if he could sign up for a Part D plan. He was also worried about a late enrollment penalty. Medicare Part D has a late enrollment penalty when you fail to sign up when you are first eligible. But you do not get a penalty if you have coverage that is considered "credible" equivalent coverage to a Part D plan. The HCA advocate established that Sage's VA coverage was considered credible, which meant that he would not have a late enrollment penalty added onto his premium. To sign up for a Part D plan, however, you need to either sign up during the annual open enrollment period

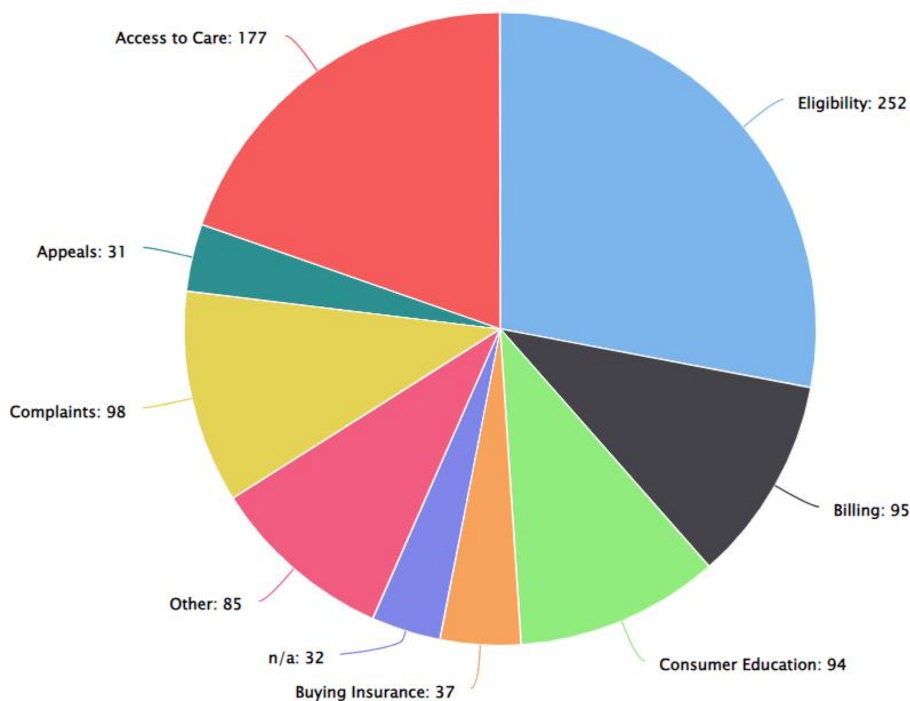
or have a special enrollment period. Sage was outside the annual open enrollment period, but HCA advocate found that he had a special enrollment period. When talking to Sage, she found that that he was eligible for a Medicare Savings Program. The MSP would pay his Part B premiums. In addition, being on an MSP made him automatically eligible for Extra Help (also called Low Income Subsidy). Extra Help is a federal program that helps with the Part D premium, deductible and copayments. If you are on Extra Help, you are also eligible for special enrollment periods to enroll on a Part D plan outside the annual open enrollment. Sage was able to get a Part D plan, and Extra Help paid the premium and reduced the cost-sharing. The MSP also paid for his Part B premium.

## Overview

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

**Primary Issue**

The HCA received 901 calls this quarter. We assign cases a primary issue, depending on the nature of the legal issue. Normally, we have more Eligibility and Access to Care cases than the other issues, and that was true this quarter, with those two areas making up nearly half of all HCA calls. The "Other" primary issue category includes communication problems with health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues Callers' primary issue category.



**Insurance Type:**

The HCA also tracks its callers by insurance category. We don't collect insurance information for every case because sometimes it is not always relevant to the caller's issue. This quarter DVHA and Medicare cases made up 513 of the 901 cases.

**Number of Cases by Insurance: January 1 to March 31, 2024.**

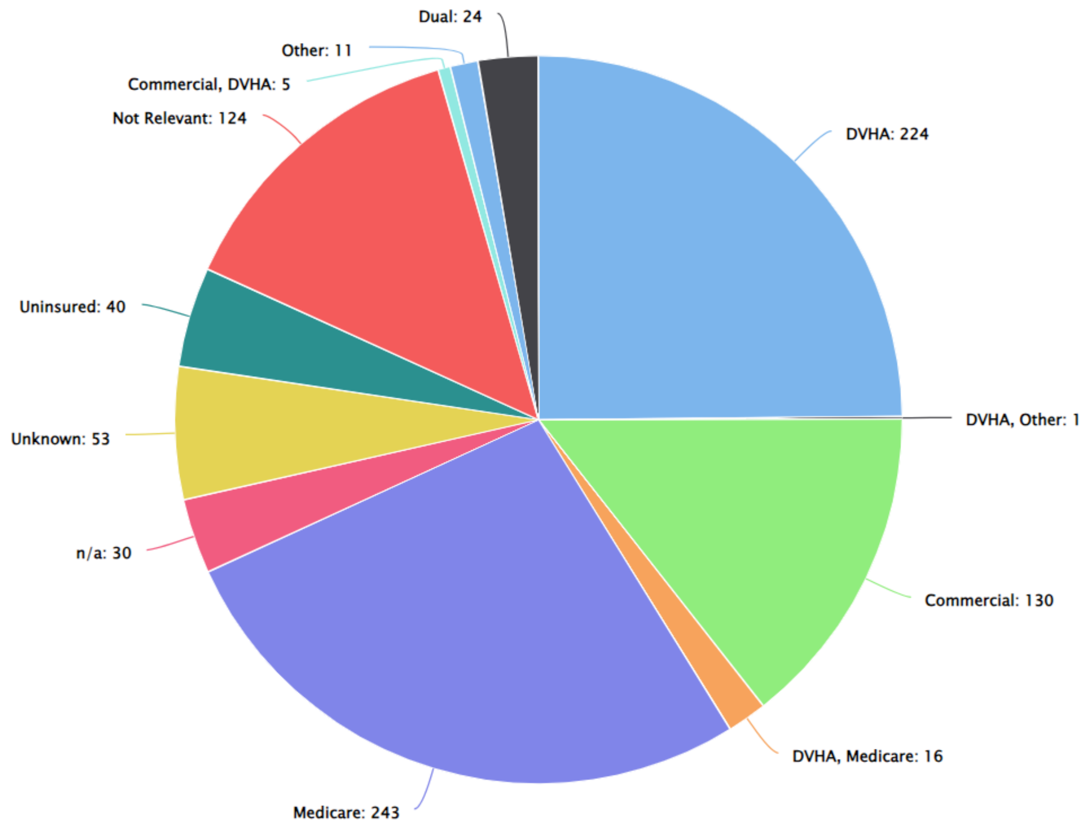


**Table: Top Ten Primary Issues: January 1 to March 31, 2024**

**All Cases: 901**

**All Cases: Top Ten Primary Issues**

1. **Eligibility for MAGI Medicaid 65**
2. **Provider Complaints 61**
3. **Access to Care Prescription Drugs 50**
4. **Eligibility for non-MAGI Medicaid 40**
5. **Eligibility for MSPs 26**
6. **Buying Insurance 22**
7. **Consumer Education Medicare 20**
8. **Access to Dental Care 17**
9. **Consumer Education Applying for DVHA programs 13**
10. **Eligibility for Premium Tax Credit 12**

**DVHA Cases: total of 246 of 901 total cases**

**Top Five Primary Issues**

1. **Eligibility for MAGI Medicaid 43**
2. **Access to Prescription Drugs 20**
3. **Provider Complaints 14**
4. **Medicaid Renewals 10**
5. **Consumer Education Medicare 7**
6. **Internal Appeals Medicaid 7**

**Uninsured Cases: total 40 out of 901 cases**

**Top Three Primary Issues**

1. **Eligibility for MAGI Medicaid 12**
2. **Buying Insurance on VHC 4**
3. **Eligibility for Special Enrollment Period 4**

**Commercial Cases: total of 135 out of 901 cases**

**Top Five Primary Issues**

1. **Buying Insurance 13**
2. **Eligibility for Premium Tax Credit 9**
3. **Appeals for Covered Services 8**
4. **Eligibility for MAGI Medicaid 6**
5. **Access to Care Dental 5**

**Overall Cases Resolution**

HCA tracks how it resolves its cases. A complex intervention means that the Advocate spent more than two hours on the case. A direct intervention means that the HCA Advocate made at least one call on behalf of the client.

**Case Outcomes January 1 to March 31, 2024**

| | |
|---|---|
| Brief Analysis and or Advice | 399 |
| Direct Intervention | 71 |
| Complex Intervention | 80 |
| Brief Analysis and or Referral | 271 |
| Inquiry Answered During Initial Call | 1 |
| Duplicate Case | 21 |
| Other | 3 |
| Client Withdrew | 2 |

**Highlights of HCA**

During this quarter, we provided 597 households with consumer education. We helped 50 households estimate their eligibility for insurance or get onto coverage. We assisted 21 households with their health care applications. We helped with 8 applications for the Immigration Health Insurance Plan. We helped 10 households obtain coverage for services. We saved consumers $3,318,845.00 this quarter.

## Consumer Protection Activities

**Rate Review**

The HCA reviews and analyzes all commercial insurance carrier requests to the Green Mountain Care Board (GCMB) to change premium prices. During the quarter from January 1, 2024 through April 1, 2024, there were no pending rate requests, and therefore the GCMB did not issue any rate review decisions. Two rate requests were filed during and are pending as of the close of the quarter. Blue Cross Blue Shield of Vermont filed proposed rates for the Large Group, with an average annual increase of 8.4% requested, affecting 33 groups and 4,264 lives. CIGNA Health and Life Insurance Company also file proposed rates for the Large Group, with an average annual increase of 9.6% requested, affecting 15 groups and 3,914 covered lives. The HCA appeared on behalf of Vermonters in both dockets, reviewed documents and submitted questions about the filings to the carriers. As of the close of the quarter, both dockets remain active. The HCA will monitor both dockets and submit memoranda when appropriate.

**Hospital Budgets**

The HCA submitted recommendations to the GMCB for the FY25 hospital budget guidance process as well as a public comment related to Copley Hospital's request for a mid-year budget adjustment.

**Certificate of Need Review Process**

The HCA has statutory authority to assert interested party status in certificate of need (CON) proceedings before the GMCB. The HCA continues to advise the GMCB as they review a CON application by University of Vermont Medical Center (UVMMC) to build a new Outpatient Surgery Center (MCB-004-23con). We also entered as an interested party in the CON application for Southwestern Vermont Medical Center, Development of Adolescent Inpatient Medical Health Unit (GMCB-014-23con). We continue to actively monitor certificate of need applications as they are submitted and assert party status when the interests of Vermonters are clearly impacted.

**Oversight of Accountable Care Organizations**

The HCA is currently reviewing, preparing questions and feedback for the GMCB as we begin the revised budget process for OneCare Vermont and Medicare-only ACOs submit their budgets for the upcoming fiscal year. Common themes of our comments to the GMCB related to concerns about the lack evidence of evaluation and effectiveness of population health programs. The HCA looks forward to continuing to work with the GMCB ACO Budget team and Board members to provide recommendations to improve their oversight of OCV's budget and programs.

**Additional Green Mountain Care Board and other agency workgroups**

This Quarter coincides with the first three months of the second year of the Over the last quarter, the HCA attended the GMCB's weekly board meetings, monthly Data Governance meetings and several other legislatively established workgroups focused on affordability and access.

**Global Budget Technical Advisory Group**

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

**The Medicaid and Exchange Advisory Committee**

The Advisory Committee met three times this quarter. The content of this quarter's meetings included an ongoing focus on the Medicaid redetermination process, presentations on the AHEAD Model Funding Opportunity, FY25 Medicaid Budget Presentation, Change Healthcare outage update, and a presentation on proposed updates to the Global Commitment Waiver Presentation.

**Legislative Advocacy**

This quarter coincides with the beginning of the second year of Vermont's Legislative biennium. The Legislature jumped into gear on several important health care policy proposals. Chief among them is a proposal to consider changes to Vermont's Medicaid eligibility that would improve access. This became

the vehicle for the Medicare Savings Program changes that the HCA has been working to advance for a few years.

**Below is a list of bills that the HCA worked on.**

*H.721* - An act relating to expanding access to Medicaid and Dr. Dynasaur. The HCA played an active role in this Legislative proposal from inception through the House Health Care, Ways and Means and Appropriations Committees. The expansion of the Medicare Savings Program section of this bill is a part of a multiyear effort by the HCA to improve Medicaid policy for low-income Vermonters on Medicare. H. 721 has passed the House and was awaiting action in Senate Health and Welfare as of the end of the quarter.

*H.233* - An act relating to licensure and regulation of pharmacy benefit managers. The HCA worked on this bill with the bill sponsor and a small group of stakeholders. The HCA participated in numerous meetings and suggested edits to the bill along the way. We testified in the House and supported the final version out of the House Health Care Committee. The bill is currently in the Senate Health and Welfare.

*S.109* - An act relating to Medicaid coverage for doula services. HCA supported and provided testimony for this bill through both the Senate and the House. At the end of the Quarter, the bill passed the Senate and was assigned to House Health Care.

*S.98* - An act relating to Green Mountain Care Board authority over prescription drug costs. The HCA participated in a stakeholder group that led to this bill's introduction. We supported the bill though the Senate Health and Welfare Committee. The bill passed the Senate and is currently in the House Health Care Committee.

*H.766* - An act relating to prior authorization and step therapy requirements, health insurance claims, and provider contracts. The HCA supported several provisions of this bill. We expressed some concerns about whether the prior authorization provisions could raise commercial rates in the coming years.

## Collaboration with Other Organizations

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

- AARP Vermont
- American Civil Liberties Union of Vermont
- All Copays Count Coalition
- Bi-State Primary Care Association
- Blue Cross Blue Shield of Vermont
- Department of Financial Regulation
- Disability Rights Vermont
- Families USA
- The Family Room
- The Howard Center

- IRS Taxpayer Advocate Service
- League of Women Voters of Vermont
- Let's Grow Kids
- Migrant Justice
- MVP Health Care
- National Academy for State Health Policy
- NHeLP, National Health Law Program
- New American Clinic/Family Room
- OneCare Vermont
- Open Door Clinic
- Planned Parenthood of Northern New England
- Rights and Democracy (RAD)
- Rural Vermont
- South Royalton Legal Clinic
- SHIP, State Health Insurance Assistance Program
- University of Vermont Medical Center
- University of Vermont Migrant Health, Bridges to Health
- Vermont Alzheimer's Association
- Vermont Association of Hospitals and Health Systems
- Vermont Association of Area Agencies on Aging
- Vermont Businesses for Social Responsibility (VBSR)
- Vermont Commission on Women
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Health Connect
- Vermont Health Care for All
- Vermont Interfaith Action (VIA) Vermont Language Justice Project
- Vermont Medical Society
- Vermont – National Education Association (NEA)
- Vermont Professionals of Color Network
- Vermont Public Interest Research Group (VPIRG)
- Vermont Workers' Center
- You First

## Increasing Reach and Education Through the Website

VTLawHelp.org is a statewide website maintained by Vermont Legal Aid and Legal Services Vermont. The site includes a substantial Health section (*https://vtlawhelp.org/health*) with more than 170 pages of consumer-focused health information maintained by the HCA.

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

Popular Web Pages

* means the page moved into the top 20 this quarter

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

1. Health - section home page – 2,349 pageviews
2. Income Limits - Medicaid – 1,839
3. Dental Services – 1,645
4. Buying Prescription Drugs – 1,289
5. Medicare Savings Programs – 660
6. Long-Term Care – 513
7. Medical Decisions: Advance Directives – 469
8. Resource Limits - Medicaid – 445
9. Medicaid – 393
10. Medicaid, Dr. Dynasaur & Vermont Health Connect – 363
11. HCA Help Request Form – 360 pageviews and 138 online help requests
12. Choices for Care Income Limits – 353
13. Dr. Dynasaur – 339
14. Choices for Care Giving Away Property or Resources – 310
15. Prescription Assistance State Programs – 272
16. Medicaid and Medicare (Dual Eligible) – 257
17. Choice for Care Resource Limits – 254
18. Advance Directive forms – 253
19. Vermont Health Connect – 253
20. Services Covered – Medicaid – 247

This quarter we had these additional news items:

- It's Open Enrollment Time for Health Care Plans – 77 pageviews
- Some Problems with Medicaid Prescriptions – 76
- Medicaid Renewal Starts Again – 75
- People Impacted by Flood Can Sign Up for Health Coverage. Those Who Lost Medicaid Can, Too – 33

## Outreach and Education

The Office of the Health Care Advocates (HCA) engaged in both in-person and virtual outreach activities this quarter to raise awareness about our offices' services and provide accessible information about health insurance options in Vermont. Our messaging prioritized providing accurate and accessible information on the Medicaid renewal process, Vermont Health Connect Special Enrollment Periods (SEP), and the new continuous coverage rules for Dr. Dynasaur for Children Under 19. We hosted two legal clinics, facilitated ten trainings, and rolled out three social media campaigns to connect Vermonters with our services and proactively provide consumer education on health insurance and health law topics.

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

We partnered with 14 organizations and participated in ten outreach presentations this quarter. Some of our partnerships included work with the Family Room, the Ethiopian Community Development Council (ECDC), AALV, USCRI, the IRS Taxpayer Advocate, the United Immigrant and Refugee Communities of Vermont, and the CORE Adult Center.

The HCA utilized Facebook, Instagram, and Youtube to connect with community members, legislators, and partner organizations. We used these platforms to share important updates pertaining to the new Vermont Health Connect Special Enrollment Periods. We specifically promoted the flooding SEP, the under-200 percent FPL SEP, and the extended loss of Medicaid SEP. We circulated virtual advertisements through social media on the suspension of Dr. Dynasaur premiums for children under 19 and the new continuous coverage rules for this program.

The HCA also continued our legal help partnership with Vermont Legal Aid and the Old North End Community Center. The Old North End Community Center hosts organizations such as AALV, the Family Room, the New American Clinic, and the Champlain Senior Center. The HCA organized two clinics where community members connected with legal advocates to get free and confidential advice. Childcare and in-person interpretation were available to support people seeking our assistance. These clinics are primarily designed to connect seniors and those with language needs with legal support.

**Office of the Health Care Advocate**

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

*https://vtlawhelp.org/health*

Attachment 5

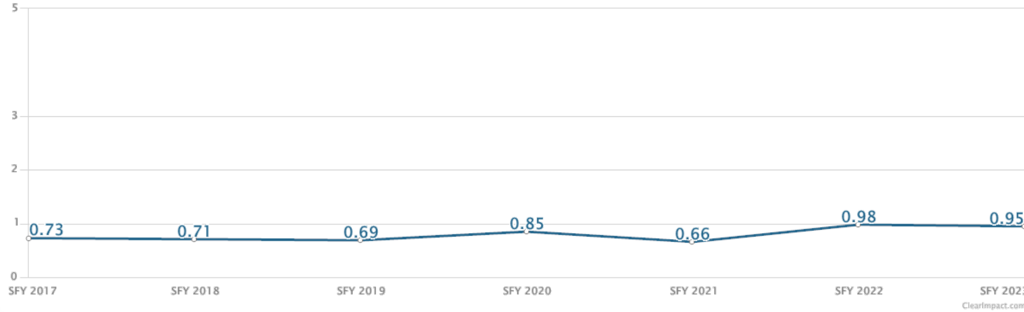
## DY20 Investment Expenditures

| Department | Final Receiver | Investment Description | QE 0324 | QE 0624 | QE 0924 | QE 1224 | DY20 Total |
|---|---|---|---|---|---|---|---|
| AHSCO | 9090 | Designated Agency Underinsured Services | 1,821,625 | - | - | - | **1,821,625** |
| AHSCO | 9421 | HCBS Investment - Workforce Recruitment & Retention Program | - | - | - | - | **-** |
| AHSCO | 9421 | HCBS Investment - Innovative Solutions to Enhance and Strengthen HCBS | 288,126 | - | - | - | **288,126** |
| AOE | n/a | Non-state plan Related Education Fund Investments | 474,166 | - | - | - | **474,166** |
| DCF | 9400 | Investments - Balance and Restorative Justice | 606,298 | - | - | - | **606,298** |
| DCF | 9402 | Medical Services | 45,716 | - | - | - | **45,716** |
| DCF | 9403 | Residential Care for Youth/Substitute Care (1) | - | - | - | - | **-** |
| DCF | 9405 | Aid to the Aged, Blind and Disabled CCL Level III | 1,094,376 | - | - | - | **1,094,376** |
| DCF | 9406 | Aid to the Aged, Blind and Disabled Res Care Level III | 13,740 | - | - | - | **13,740** |
| DCF | 9407 | Aid to the Aged, Blind and Disabled Res Care Level IV | 29,478 | - | - | - | **29,478** |
| DCF | 9408 | Essential Person Program | 215,927 | - | - | - | **215,927** |
| DCF | 9409 | GA Medical Expenses | 46,231 | - | - | - | **46,231** |
| DCF | 9411 | Therapeutic Child Care | 453,327 | - | - | - | **453,327** |
| DCF | 9412 | Lund Home | - | - | - | - | **-** |
| DCF | 9413 | Prevent Child Abuse Vermont: Shaken Baby | - | - | - | - | **-** |
| DCF | 9414 | Prevent Child Abuse Vermont: Nurturing Parent | 38,535 | - | - | - | **38,535** |
| DCF | 9415 | Challenges for Change: DCF | 54,609 | - | - | - | **54,609** |
| DCF | 9416 | Strengthening Families | 172,705 | - | - | - | **172,705** |
| DCF | 9417 | Lamoille Valley Community Justice Project | - | - | - | - | **-** |
| DCF | 9418 | Building Bright Futures | 122,813 | - | - | - | **122,813** |
| DCF | 9419 | United Ways 2-1-1 | - | - | - | - | **-** |
| DCF | 9421 | Lund Substance Abuse Screening & Referral | - | - | - | - | **-** |
| DCF | 9425 | Lund Substance Abuse Screening & Referral | 170,498 | - | - | - | **170,498** |
| DAIL | 9421 | HCBS Investment - Independent Direct Support Providers | 699,646 | - | - | - | **699,646** |
| DAIL | 9421 | HCBS Investment - Independent Direct Support Providers | - | - | - | - | **-** |
| DAIL | 9602 | Mobility Training/Other Svcs.-Elderly Visually Impaired | 94,970 | - | - | - | **94,970** |
| DAIL | 9603 | DS Special Payments for Medical Services | 518,557 | - | - | - | **518,557** |
| DAIL | 9604 | Flexible Family/Respite Funding | 304,933 | - | - | - | **304,933** |
| DAIL | 9605 | Quality Review of Home Health Agencies | - | - | - | - | **-** |
| DAIL | 9606 | Support and Services at Home (SASH) | 245,205 | - | - | - | **245,205** |
| DAIL | 9607 | HomeSharing | 36,251 | - | - | - | **36,251** |
| DAIL | 9608 | Self-Neglect Initiative | 126,009 | - | - | - | **126,009** |
| DMH | 9421 | HCBS Investment | - | - | - | - | **-** |
| DMH | 9501 | Special Payments for Treatment Plan Services | 7,047 | - | - | - | **7,047** |
| DMH | 9502 | Mental Health Outpatient Services for Adults | 447,321 | - | - | - | **447,321** |
| DMH | 9504 | Mental Health Consumer Support Programs | 108,677 | - | - | - | **108,677** |
| DMH | 9505 | Mental Health CRT Community Support Services | - | - | - | - | **-** |
| DMH | 9506 | Mental Health Children's Community Services | 434,058 | - | - | - | **434,058** |
| DMH | 9507 | Emergency Mental Health for Children and Adults | 510,054 | - | - | - | **510,054** |
| DMH | 9508 | Respite Services for Youth with SED and their Families | 317,509 | - | - | - | **317,509** |
| DMH | 9510 | Emergency Support Fund | - | - | - | - | **-** |
| DMH | 9511 | Institution for Mental Disease Services: DMH - VPCH | 5,067,670 | - | - | - | **5,067,670** |
| DMH | 9512 | Institution for Mental Disease Services: DMH - BR | - | - | - | - | **-** |
| DMH | 9514 | Seriously Functionally Impaired: DMH | - | - | - | - | **-** |
| DMH | 9516 | Acute Psychiatric Inpatient Services | (536,563) | - | - | - | **(536,563)** |
| DMH | 9521 | Suicide Prevention | 270,368 | - | - | - | **270,368** |
| DMH | 9914 | CRT Global Commitment | - | - | - | - | **-** |
| DMH | 9421 | HCBS Investment - Lund Substance Abuse Screening & Referral | 108,035 | - | - | - | **108,035** |
| DMH | n/a | QE 202403 64.9 Waiv Line 69 reporting; PQA to be submitted QE 202406 | (626,400) | - | - | - | **(626,400)** |
| DOC | n/a | Elevate Youth (formerly Return House) | 17,597 | - | - | - | **17,597** |
| DOC | n/a | Northern Lights | - | - | - | - | **-** |
| DOC | n/a | Pathways to Housing - Transitional Housing | 326,055 | - | - | - | **326,055** |
| DOC | n/a | St. Albans and United Counseling Service Transitional Housing (Challenges f | 38,836 | - | - | - | **38,836** |
| DOC | n/a | Northeast Kingdom Community Action | 32,815 | - | - | - | **32,815** |
| DOC | n/a | Intensive Substance Abuse Program (ISAP) | - | - | - | - | **-** |
| DOC | n/a | Intensive Domestic Violence Program | - | - | - | - | **-** |
| DOC | n/a | Community Rehabilitative Care | 829,791 | - | - | - | **829,791** |
| DOC | n/a | Intensive Sexual Abuse Program | - | - | - | - | **-** |
| DOC | n/a | Vermont Achievment Center | - | - | - | - | **-** |
| DVHA | 9421 | HCBS Investment | 41,642 | - | - | - | **41,642** |
| DVHA | 9423 | HCBS Spend Plan Investment GC CNOM | - | - | - | - | **-** |
| DVHA | 9101 | Vermont Information Technology Leaders/HIT/HIE/HCR | - | - | - | - | **-** |
| DVHA | 9102 | Vermont Blueprint for Health | 838,774 | - | - | - | **838,774** |
| DVHA | 9103 | Buy-In | (8,025) | - | - | - | **(8,025)** |
| DVHA | 9104 | HIV Drug Coverage | - | - | - | - | **-** |
| DVHA | 9106 | Patient Safety Net Services | 174,037 | - | - | - | **174,037** |
| DVHA | 9107 | Institution for Mental Disease Services: DVHA | - | - | - | - | **-** |
| DVHA | 9108 | Family Supports | - | - | - | - | **-** |
| DVHA | 9109 | One Care VT ACO Quality & Health Management | - | - | - | - | **-** |
| DVHA | 9110 | One Care VT ACO Advanced Community Care Coordination | - | - | - | - | **-** |
| DVHA | 9111 | One Care VT ACO Primary Prevention Development | - | - | - | - | **-** |
| DVHA | 9113 | Blueprint Expansion and Dulce | 1,046,511 | - | - | - | **1,046,511** |
| DVHA | 9209 | Family Planning | 55,866 | - | - | - | **55,866** |
| VDH | 9201 | Emergency Medical Services | 177,558 | - | - | - | **177,558** |
| VDH | 9203 | TB Medical Services | 6,040 | - | - | - | **6,040** |
| VDH | 9204 | Epidemiology | 343,844 | - | - | - | **343,844** |
| VDH | 9205 | Health Research and Statistics | 318,545 | - | - | - | **318,545** |
| VDH | 9206 | Health Laboratory | 805,457 | - | - | - | **805,457** |
| VDH | 9207 | Tobacco Cessation: Community Coalitions | 316,372 | - | - | - | **316,372** |
| VDH | 9209 | Family Planning | 150,438 | - | - | - | **150,438** |
| VDH | 9210 | Physician/Dentist Loan Repayment Program | 264,171 | - | - | - | **264,171** |
| VDH | 9211 | Renal Disease | - | - | - | - | **-** |
| VDH | 9213 | WIC Coverage | 1,215,588 | - | - | - | **1,215,588** |
| VDH | 9214 | Area Health Education Centers (AHEC) | 167,011 | - | - | - | **167,011** |
| VDH | 9217 | Patient Safety - Adverse Events | 19,147 | - | - | - | **19,147** |
| VDH | 9219 | Substance Use Disorder Treatment | 1,337,456 | - | - | - | **1,337,456** |
| VDH | 9220 | Recovery Centers | 894,619 | - | - | - | **894,619** |
| VDH | 9221 | Enhanced Immunization | 69,844 | - | - | - | **69,844** |
| VDH | 9222 | Poison Control | - | - | - | - | **-** |
| VDH | 9223 | Public Inebriate Services, C for C | 225,478 | - | - | - | **225,478** |
| VDH | 9224 | Fluoride Treatment | 30,628 | - | - | - | **30,628** |
| VDH | 9226 | Healthy Homes and Lead Poisoning Prevention Program | 59,141 | - | - | - | **59,141** |
| VDH | 9228 | VT Blueprint for Health | 461,965 | - | - | - | **461,965** |
| VDH | 9421 | HCBS Investment - Pediatric Pallative Care Program Supply Carts | - | - | - | - | **-** |
| VDH | 9421 | HCBS Investment - Expand VTHelplink | 222,906 | - | - | - | **222,906** |
| VSC | n/a | Health Professional Training | - | - | - | - | **-** |
| VVH | n/a | Vermont Veterans Home | - | - | - | - | **-** |
| | | | - | - | - | - | **-** |

# GC Investments - Department of Mental Health

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

### PM How_Well Rate of Seclusion and Restraint per 1,000 Patient Hours




| Most Recent Period | Current Actual Value | Current Trend |
|---|---|---|
| SFY 2023 | 0.95 | ↘ 1 |
| SFY 2022 | 0.98 | ↗ 1 |
| SFY 2021 | 0.66 | ↘ 1 |
| SFY 2020 | 0.85 | ↗ 1 |
| SFY 2019 | 0.69 | ↘ 2 |
| SFY 2018 | 0.71 | ↘ 1 |
| SFY 2017 | 0.73 | ↗ 1 |
| SFY 2016 | 0.40 | ↘ 2 |
| SFY 2015 | 1.00 | ↘ 1 |

#### Story Behind the Curve

**We want the rate of seclusion and restraint to go down.**

The Vermont Psychiatric Care Hospital (VPCH) is dedicated to improving the health and well-being of one of Vermont's most vulnerable populations. Offering a state-of-the-art facility designed to promote and enhance recovery, the 25-bed, acute care hospital offers patient areas designed for comfort, dignity, and safety.

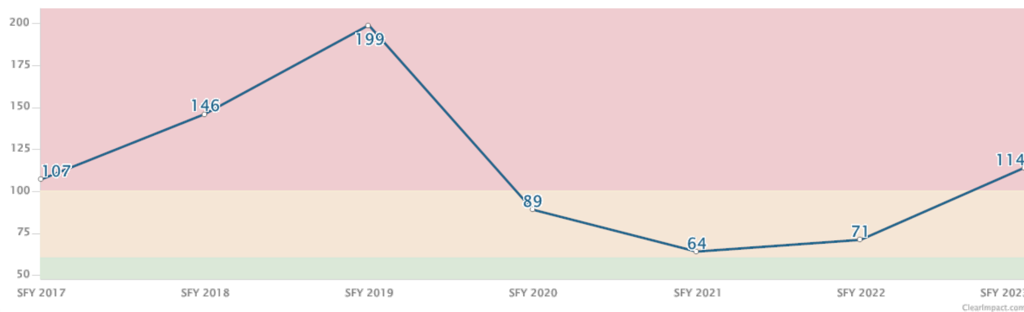
Providing patient care in an environment that is safe and supportive is important for recovery. VPCH, through its ongoing work with the developers of "Six Core Strategies for Reducing Seclusion and Restraint", has lowered its rate of seclusion and restraint over time.

*Updated March 2024*

#### Notes on Methodology

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

### PM VPCH Average length of stay in days for discharged patients



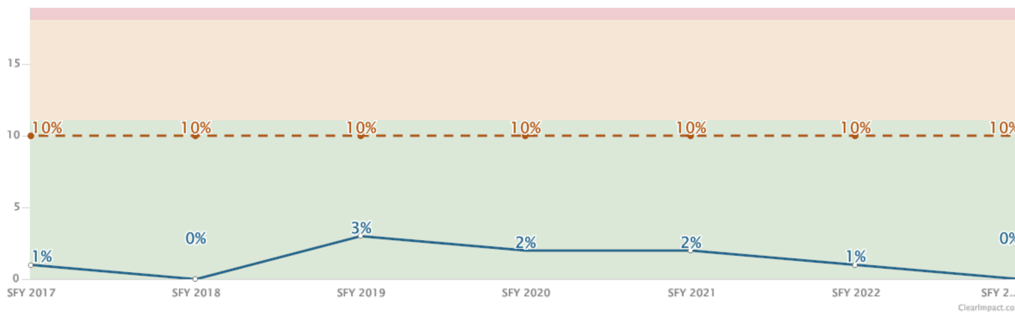

| Most Recent Period | Current Actual Value | Current Trend |
|---|---|---|
| SFY 2023 | 114 | ↗ 2 |
| SFY 2022 | 71 | ↗ 1 |
| SFY 2021 | 64 | ↘ 2 |
| SFY 2020 | 89 | ↘ 1 |
| SFY 2019 | 199 | ↗ 2 |
| SFY 2018 | 146 | ↗ 1 |
| SFY 2017 | 107 | ↘ 1 |
| SFY 2016 | 121 | ↗ 1 |
| SFY 2015 | 80 | ↘ 1 |

#### Story Behind the Curve

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

### PM How_Well Percentage of discharges readmitted involuntarily within 30 days of discharge

| Most Recent Period | Current Actual Value | Current Trend |
|---|---|---|
| SFY 2023 | 0% | ↘ 2 |




| | | |
|---|---|---|
| SFY 2022 | 1% | ↘ 1 |
| SFY 2021 | 2% | → 1 |
| SFY 2020 | 2% | ↘ 1 |
| SFY 2019 | 3% | ↗ 1 |
| SFY 2018 | 0% | ↘ 3 |
| SFY 2017 | 1% | ↘ 2 |
| SFY 2016 | 7% | ↘ 1 |

### Story Behind the Curve

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

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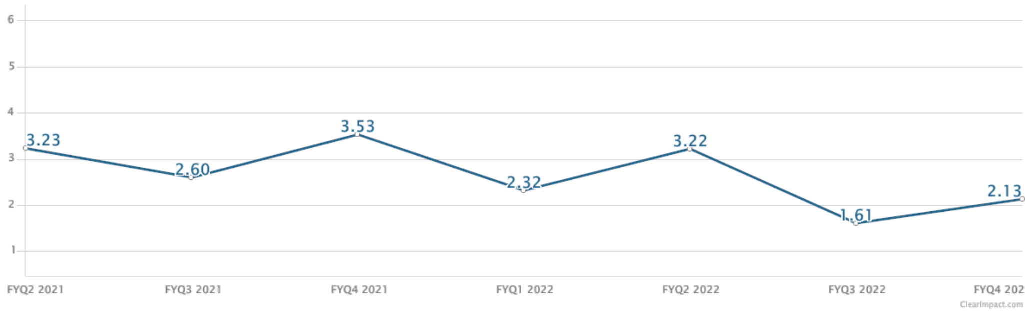
## P GC_Investment Institution for Mental Disease (IMD) Services: DMH (3) - Brattleboro Retreat

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




| Most Recent Period | Current Actual Value | Current Trend |
|---|---|---|
| FYQ4 2022 | 2.13 | ↗ 1 |
| FYQ3 2022 | 1.61 | ↘ 1 |
| FYQ2 2022 | 3.22 | ↗ 1 |
| FYQ1 2022 | 2.32 | ↘ 1 |
| FYQ4 2021 | 3.53 | ↗ 1 |
| FYQ3 2021 | 2.60 | ↘ 1 |
| FYQ2 2021 | 3.23 | ↗ 1 |
| FYQ1 2021 | 2.66 | ↘ 1 |
| FYQ4 2020 | 5.04 | ↗ 4 |

### Story Behind the Curve

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

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

*Updated February 2018*

### Partners

### What Works

### Action Plan

### Notes on Methodology

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

**Ratio calculation:**

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

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

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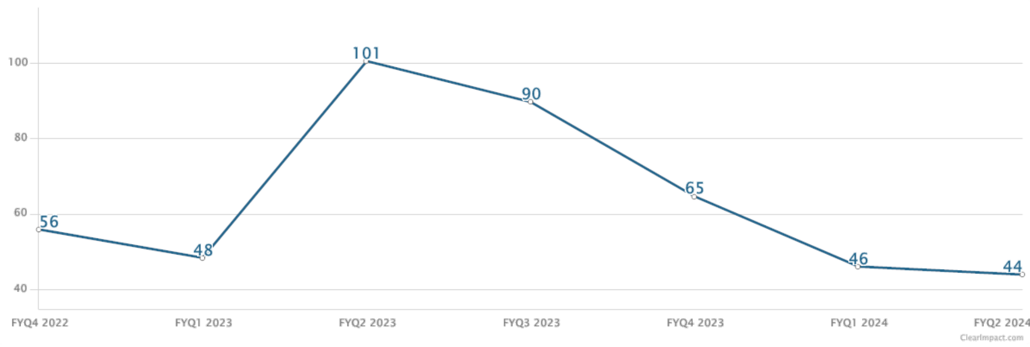
### PM How_Well Length of stay (mean) for discharged Level 1 patients (BR - Level 1)

| | | |
|---|---|---|
| FYQ2 2024 | 44 | ↘ 4 |




| | | |
|---|---|---|
| FYQ1 2024 | 46 | ↘ 3 |
| FYQ4 2023 | 65 | ↘ 2 |
| FYQ3 2023 | 90 | ↘ 1 |
| FYQ2 2023 | 101 | ↗ 1 |
| FYQ1 2023 | 48 | ↘ 2 |
| FYQ4 2022 | 56 | ↘ 1 |
| FYQ3 2022 | 62 | ↗ 1 |
| FYQ2 2022 | 37 | ↘ 3 |

Story Behind the Curve

Partners

What Works

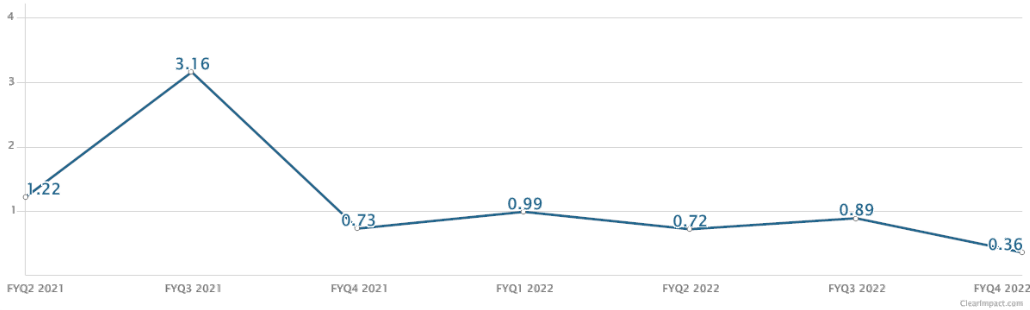
Action Plan

Notes on Methodology

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

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

Data Source: EIP CONs; DMH electronic bed board




| Most Recent Period | Current Actual Value | Current Trend |
|---|---|---|
| FYQ4 2022 | 0.36 | ↘ 1 |
| FYQ3 2022 | 0.89 | ↗ 1 |
| FYQ2 2022 | 0.72 | ↘ 1 |
| FYQ1 2022 | 0.99 | ↗ 1 |
| FYQ4 2021 | 0.73 | ↘ 1 |
| FYQ3 2021 | 3.16 | ↗ 1 |
| FYQ2 2021 | 1.22 | ↘ 1 |
| FYQ1 2021 | 1.96 | ↗ 2 |
| FYQ4 2020 | 1.08 | ↗ 1 |

Story Behind the Curve

Partners

What Works

Action Plan

Notes on Methodology

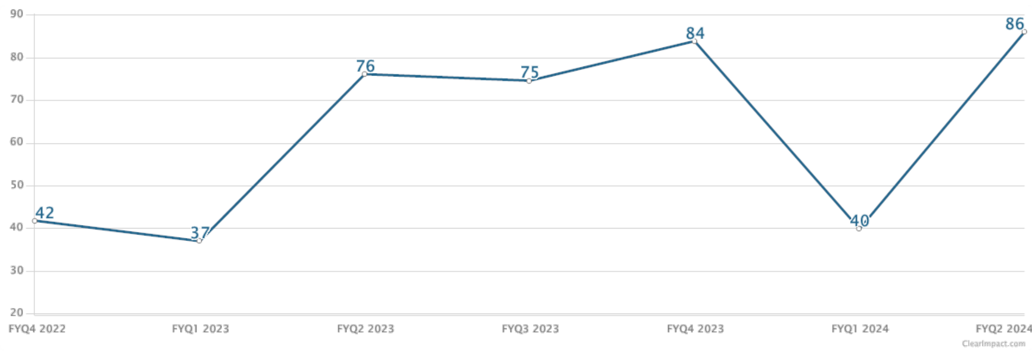
Based on data submitted by Designated Hospitals to the Department in compliance with department requests for submittal of Certificates of Need (CON) following emergency involuntary procedures for patients located on Level 1 Units and electronic bed board data submitted to the Department for Level 1 Units.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

**Ratio calculation:**

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

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

PM How_Well Length of stay (mean) for discharged Level 1 patients (RRMC - Level 1) | FYQ2 2024 | 86 | ↗ 1




| | | |
|---|---|---|
| FYQ1 2024 | 40 | ↘ 1 |
| FYQ4 2023 | 84 | ↗ 1 |
| FYQ3 2023 | 75 | ↘ 1 |
| FYQ2 2023 | 76 | ↗ 1 |
| FYQ1 2023 | 37 | ↘ 1 |
| FYQ4 2022 | 42 | ↗ 2 |
| FYQ3 2022 | 30 | ↗ 1 |
| FYQ2 2022 | 21 | ↘ 1 |

Story Behind the Curve

Partners

What Works

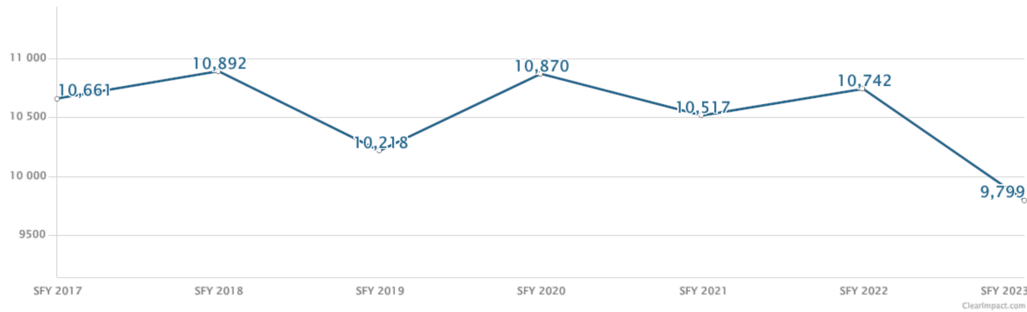
Action Plan

Notes on Methodology

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

PM How_Much Number of children and youth served in CYFS

Data Source: Monthly Service Report (MSR)




| Most Recent Period | Current Actual Value | Current Trend |
|---|---|---|
| SFY 2023 | 9,799 | ↘ 1 |
| SFY 2022 | 10,742 | ↗ 1 |
| SFY 2021 | 10,517 | ↘ 1 |
| SFY 2020 | 10,870 | ↗ 1 |
| SFY 2019 | 10,218 | ↘ 1 |
| SFY 2018 | 10,892 | ↗ 1 |
| SFY 2017 | 10,661 | ↘ 1 |
| SFY 2016 | 10,670 | ↗ 4 |
| SFY 2015 | 10,585 | ↗ 3 |

Story Behind the Curve

Partners

What Works

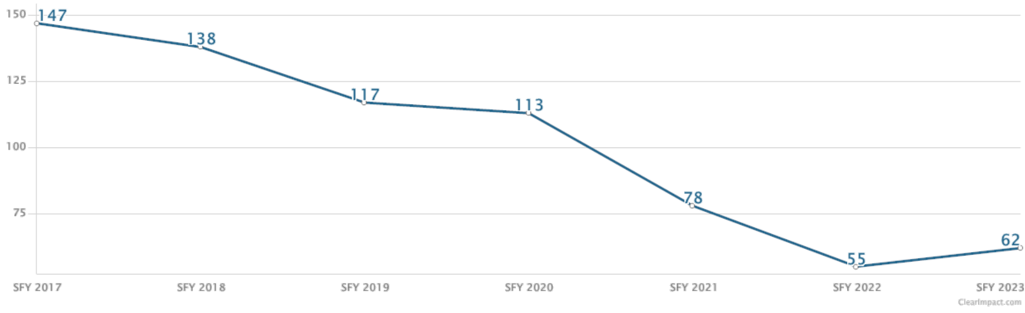
Action Plan

Notes on Methodology

## P GC_Investment Special Payments for Treatment Plan Services (28)

PM How_Much Number of CRT clients served with special services funding

| Most Recent Period | Current Actual Value | Current Trend |
|---|---|---|
| SFY 2023 | 62 | ↗ 1 |




| | | |
|---|---|---|
| SFY 2022 | 55 | ↘ 5 |
| SFY 2021 | 78 | ↘ 4 |
| SFY 2020 | 113 | ↘ 3 |
| SFY 2019 | 117 | ↘ 2 |
| SFY 2018 | 138 | ↘ 1 |
| SFY 2017 | 147 | → 0 |

### Story Behind the Curve

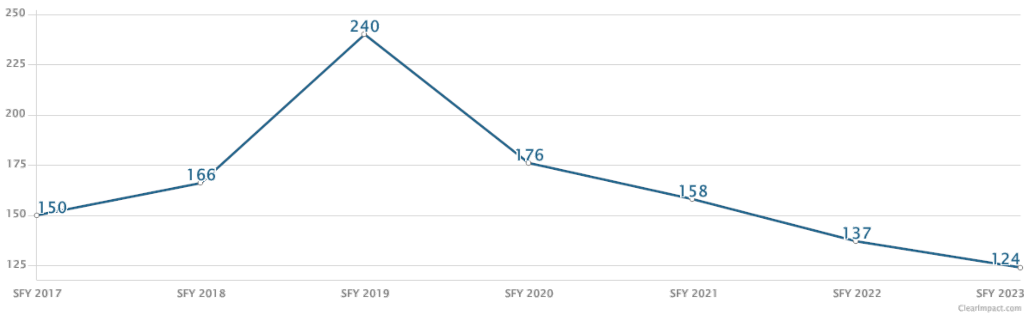
### Partners

### What Works

### Action Plan

### Notes on Methodology

PM How_Well Number of youth served with special services funding




| | | |
|---|---|---|
| SFY 2023 | 124 | ↘ 4 |
| SFY 2022 | 137 | ↘ 3 |
| SFY 2021 | 158 | ↘ 2 |
| SFY 2020 | 176 | ↘ 1 |
| SFY 2019 | 240 | ↗ 3 |
| SFY 2018 | 166 | ↗ 2 |
| SFY 2017 | 150 | ↗ 1 |
| SFY 2016 | 124 | ↘ 2 |
| SFY 2015 | 162 | ↘ 1 |

### Story Behind the Curve

Dental costs, which were covered by special services funding through DMH through Fiscal Year 2023, are now paid directly from the Dept.of Vermont Health Access.

### Partners

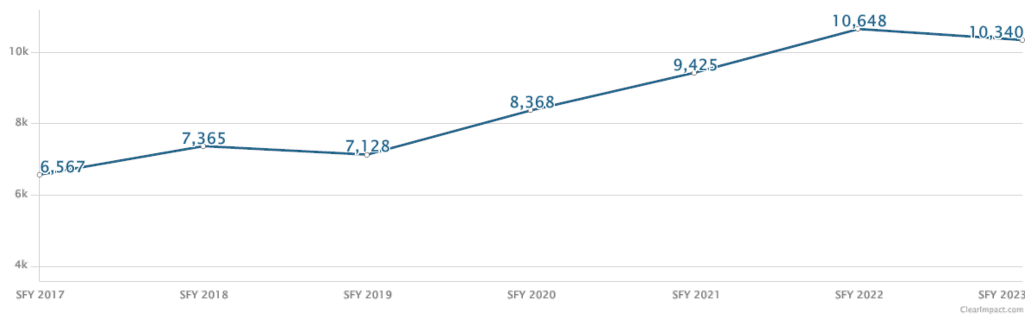
### What Works

### Action Plan

### Notes on Methodology

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

| | Most Recent Period | Current Actual Value | Current Trend |
|---|---|---|---|
| PM How_Much Number of People Served by Emergency Services | SFY 2023 | 10,340 | ↘ 1 |




| | | |
|---|---|---|
| SFY 2022 | 10,648 | ↗ 3 |
| SFY 2021 | 9,425 | ↗ 2 |
| SFY 2020 | 8,368 | ↗ 1 |
| SFY 2019 | 7,128 | ↘ 1 |
| SFY 2018 | 7,365 | ↗ 2 |
| SFY 2017 | 6,567 | ↗ 1 |
| SFY 2016 | 6,225 | ↘ 3 |
| SFY 2015 | 6,306 | ↘ 2 |

## Story Behind the Curve

- Emergency Services (ES) provided by Vermont's Designated Agencies (DAs) are intensive, time-limited and are intended to resolve or stabilize the immediate crisis through direct treatment, support services to significant others, or arrangement of other more appropriate resources.
    - These services may be provided face-to-face, by telephone, or through telemedicine.
- Services may be initiated by, or on behalf of, a person experiencing an acute mental health crisis as evidenced by:
    - a sudden change in behavior with negative consequences for well-being.
    - a loss of effective coping mechanisms.
    - presenting danger to self or others.
- Over the duration of this reporting period, ES has continued to experience an increase in the number of people served, in particular a 32% increase from state fiscal year (SFY) 2019 to SFY 2021.

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## Partners

- Vermont Care Partners
- Designated Agencies
    - Clara Martin Center
    - Counseling Service of Addison County
    - Health Care and Rehabilitation Services
    - Howard Center
    - Lamoille County Mental Health Services
    - Northeast Kingdom Human Services
    - Northwestern Counseling and Support Services
    - Rutland Mental Health Services
    - United Counseling Service
    - Washington County Mental Health Services

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## Notes on Methodology

- Data are obtained from the Department's Monthly Service Report (MSR) system and are submitted to this system by DAs.

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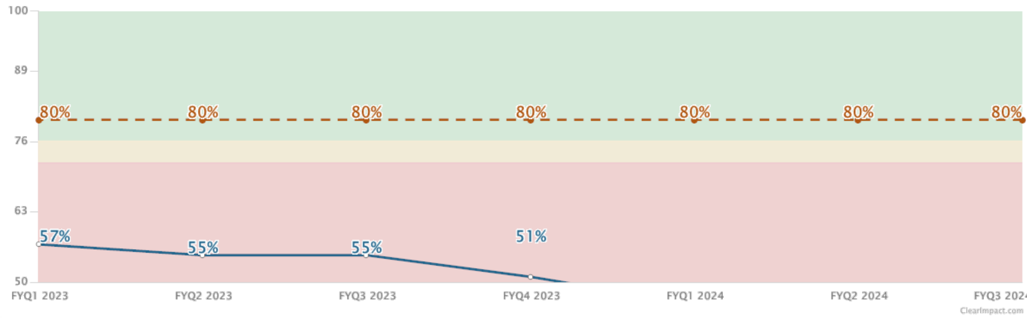
PM How_Much Percent occupancy of Designated Agency adult crisis bed programs




| | | |
|---|---|---|
| FYQ3 2024 | 48% | ↗ 2 |
| FYQ2 2024 | 47% | ↗ 1 |
| FYQ1 2024 | 46% | ↘ 2 |
| FYQ4 2023 | 51% | ↘ 1 |
| FYQ3 2023 | 55% | → 1 |
| FYQ2 2023 | 55% | ↘ 1 |
| FYQ1 2023 | 57% | ↗ 2 |
| FYQ4 2022 | 52% | ↗ 1 |
| FYQ3 2022 | 50% | ↘ 3 |

## Story Behind the Curve

## Partners

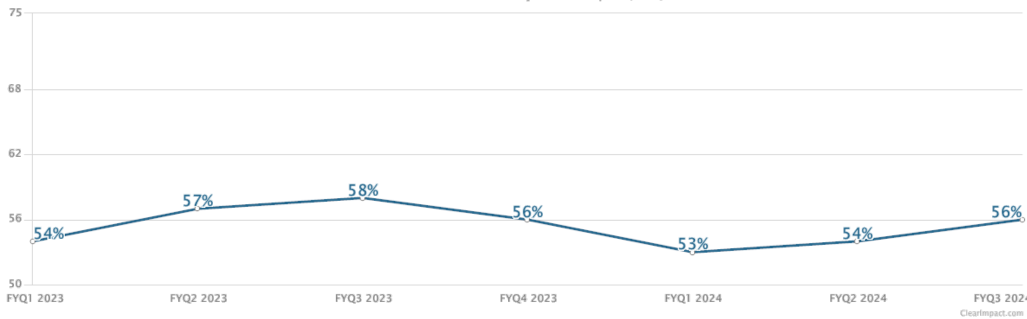
## What Works

## Action Plan

## Notes on Methodology

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

PM How_Well Percentage of people receiving non-emergency services within 7 days of emergency services




| | | |
|---|---|---|
| FYQ3 2024 | 56% | ↗ 2 |
| FYQ2 2024 | 54% | ↗ 1 |
| FYQ1 2024 | 53% | ↘ 2 |
| FYQ4 2023 | 56% | ↘ 1 |
| FYQ3 2023 | 58% | ↗ 2 |
| FYQ2 2023 | 57% | ↗ 1 |
| FYQ1 2023 | 54% | ↘ 2 |
| FYQ4 2022 | 59% | ↘ 1 |
| FYQ3 2022 | 60% | ↗ 1 |

## Story Behind the Curve

## Partners

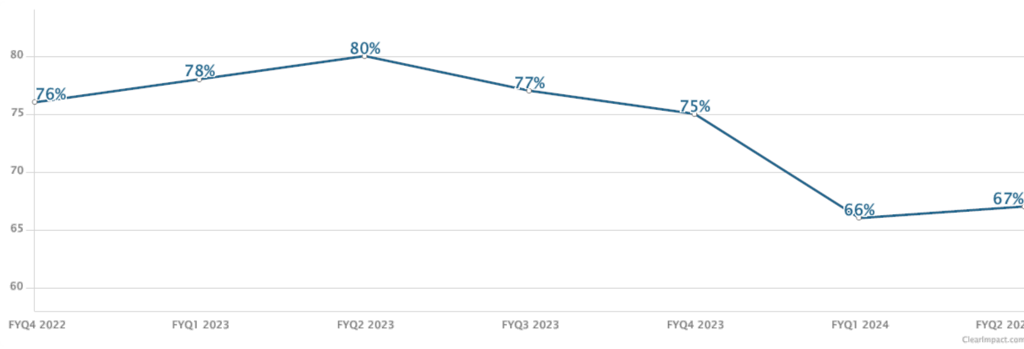
## Strategy

## Notes on Methodology

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

PM How_Well Percentage of Total Served in Community Settings by Emergency Services

| | | |
|---|---|---|
| FYQ2 2024 | 67% | ↗ 1 |




| | | |
|---|---|---|
| FYQ1 2024 | 66% | ↘ 3 |
| FYQ4 2023 | 75% | ↘ 2 |
| FYQ3 2023 | 77% | ↘ 1 |
| FYQ2 2023 | 80% | ↗ 3 |
| FYQ1 2023 | 78% | ↗ 2 |
| FYQ4 2022 | 76% | ↗ 1 |
| FYQ3 2022 | 72% | ↘ 1 |
| FYQ2 2022 | 74% | ↗ 2 |

### Story Behind the Curve

### Partners

### What Works

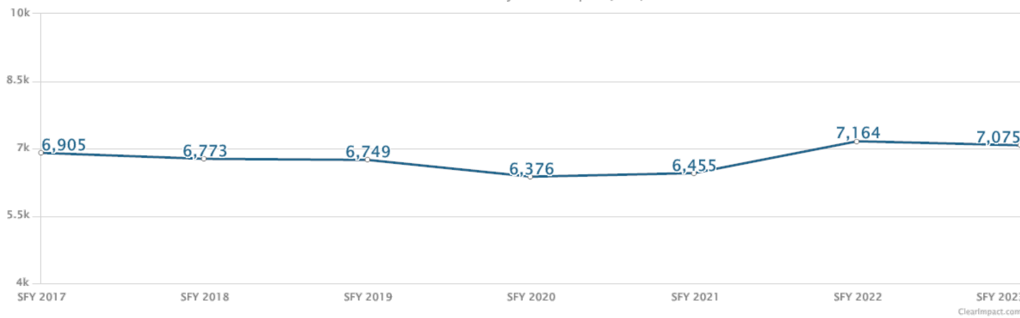
### Action Plan

### Notes on Methodology

## P GC_Investment Mental Health Outpatient Services for Adults (66)

PM How_Much Number of Adults Served in Designated Agency Adult Outpatient Programs

| Most Recent Period | Current Actual Value | Current Trend |
|---|---|---|
| SFY 2023 | 7,075 | ↘ 1 |
| SFY 2022 | 7,164 | ↗ 2 |
| SFY 2021 | 6,455 | ↗ 1 |
| SFY 2020 | 6,376 | ↘ 3 |
| SFY 2019 | 6,749 | ↘ 2 |
| SFY 2018 | 6,773 | ↘ 1 |
| SFY 2017 | 6,905 | ↗ 1 |
| SFY 2016 | 6,681 | ↘ 3 |
| SFY 2015 | 6,685 | ↘ 2 |




### Story Behind the Curve

- Adult outpatient (AOP) programs at Vermont Designated Agencies (DAs) include both Community Rehabilitation and Treatment (CRT) and outpatient therapy, as well as programs provided by Vermont Specialized Service Agencies (SSAs).
- The Department of Mental Health monitors the number of adults serviced by these programs on an annual basis.
- Overall, the number of adults served by these programs has remained consistent for the above reporting period.

### Partners

- Vermont Care Partners
- Designated Agencies
  - Clara Martin Center
  - Counseling Service of Addison County
  - Health Care and Rehabilitation Services
  - Howard Center

- Lamoille County Mental Health Services
- Northeast Kingdom Human Services
- Northwestern Counseling and Support Services
- Rutland Mental Health Services
- United Counseling Service
- Washington County Mental Health Services

- Specialized Service Agencies
    - Northeastern Family Institute, VT
    - Pathways Vermont

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## Notes on Methodology

- Data are obtained from the Department's Monthly Service Report (MSR) system by both DAs and SSAs.

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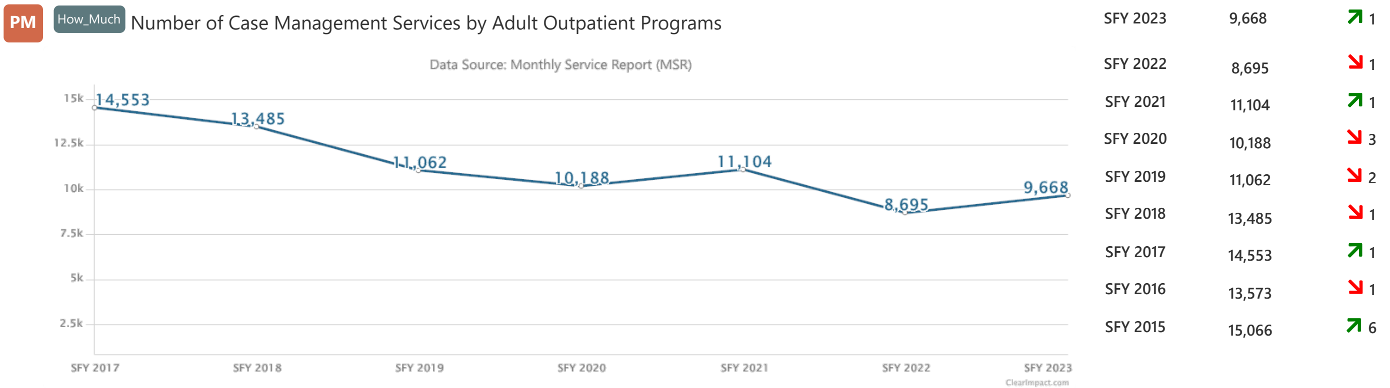


| Year | Value | Trend |
|---|---|---|
| SFY 2023 | 9,668 | ↗ 1 |
| SFY 2022 | 8,695 | ↘ 1 |
| SFY 2021 | 11,104 | ↗ 1 |
| SFY 2020 | 10,188 | ↘ 3 |
| SFY 2019 | 11,062 | ↘ 2 |
| SFY 2018 | 13,485 | ↘ 1 |
| SFY 2017 | 14,553 | ↗ 1 |
| SFY 2016 | 13,573 | ↘ 1 |
| SFY 2015 | 15,066 | ↗ 6 |

## Story Behind the Curve

- Case management services are forms of assistance that include planning, developing, choosing, gaining access to, coordinating and monitoring of the provision of medical, social, educational, and other services and supports, such as discharge planning, advocacy, monitoring, and supporting them to make and assess their own decisions.
    - The mental health field has recognized that some individuals can benefit from additional supports beyond therapy and case management services offers additional support for individuals.
- The support of case management services has led to an increase in the number of adults receiving these services throughout the reporting period.
- The Department's Payment Reform initiative, launched in January 2019, continues to support flexible service delivery including case management services.

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## Partners

- Vermont Care Partners
- Designated Agencies
    - Clara Martin Center
    - Counseling Service of Addison County

- Health Care and Rehabilitation Services
- Howard Center
- Lamoille County Mental Health Services
- Northeast Kingdom Human Services
- Northwestern Counseling and Support Services
- Rutland Mental Health Services
- United Counseling Service
- Washington County Mental Health Services

- Specialized Service Agencies
  - Northeastern Family Institute, VT
  - Pathways Vermont

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## Notes on Methodology

- Data are obtained from the Department's Monthly Service Report (MSR) system by both DAs and SSAs.

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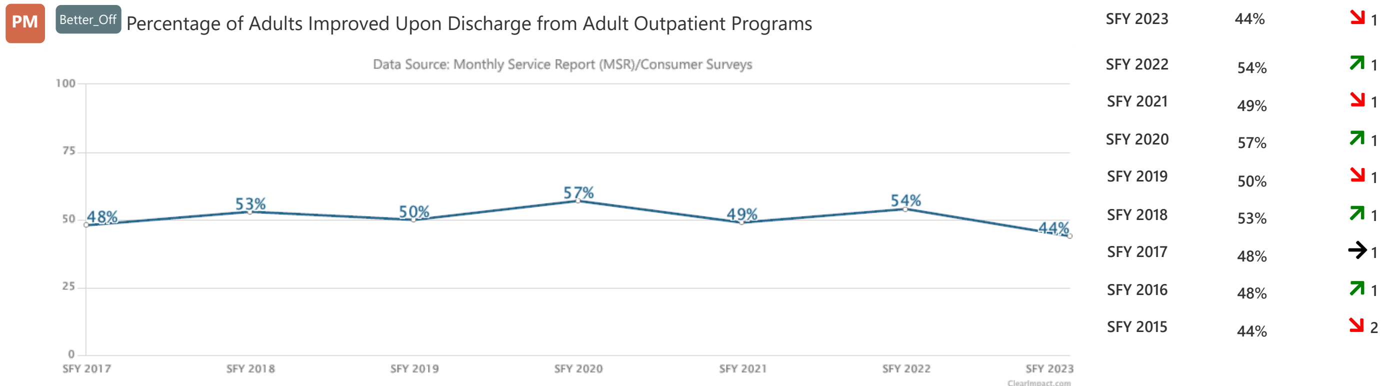


## Story Behind the Curve

- "Improved upon discharge" from an adult outpatient program is a measure identified when treatment is completed .
- Vermont Designated Agencies (DAs) and one adult Specialized Service Agency (SSA) continue to report a steady percentage of adults who are discharged from adult outpatient programs.
  - As greater percentages of clients are reported, the percent with positive outcomes appears to decline, which may be due to greater percentages of clients with ongoing difficulties being reported.
- Vermont DAs and the one SSA are targeting this measure as a quality improvement initiative for 2022, in order to work towards better reliability and validity across providers in determining how "improved" is defined and endorsed.

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## Partners

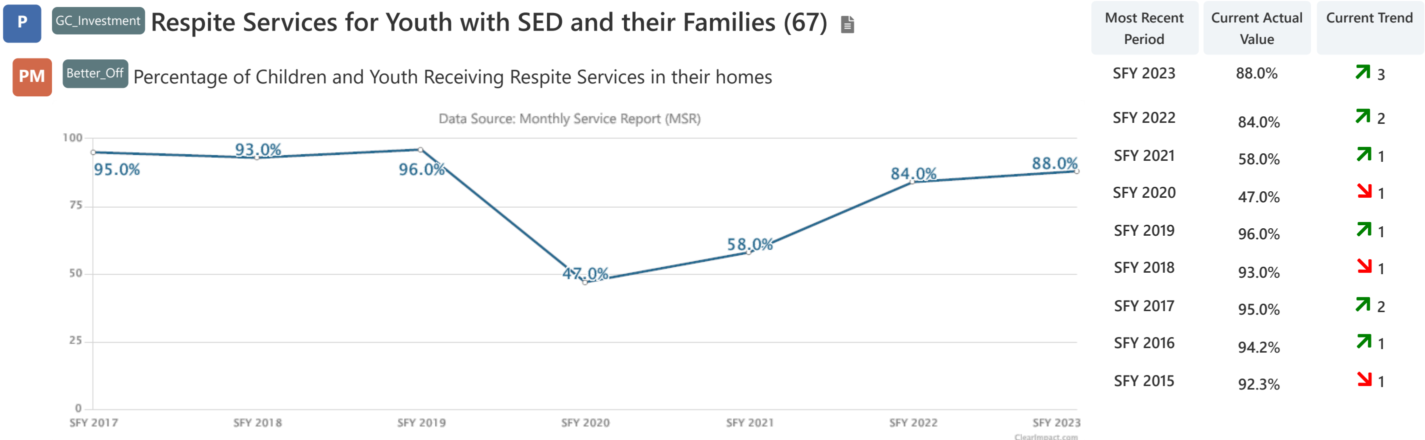
- Vermont Care Partners
- Designated Agencies

- Clara Martin Center
- Counseling Service of Addison County
- Health Care and Rehabilitation Services
- Howard Center
- Lamoille County Mental Health Services
- Northeast Kingdom Human Services
- Northwestern Counseling and Support Services
- Rutland Mental Health Services
- United Counseling Service
- Washington County Mental Health Services

- Specialized Service Agency
  - Pathways Vermont

## Notes on Methodology

- Percentages are based on MSR data submitted to the Department by DAs and one SSA, Pathways Vermont, who serves adults.



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

PM Better_Off Percentage of Children and Youth Receiving Respite Services in their homes



| Most Recent Period | Current Actual Value | Current Trend |
|---|---|---|
| SFY 2023 | 88.0% | ↗ 3 |
| SFY 2022 | 84.0% | ↗ 2 |
| SFY 2021 | 58.0% | ↗ 1 |
| SFY 2020 | 47.0% | ↘ 1 |
| SFY 2019 | 96.0% | ↗ 1 |
| SFY 2018 | 93.0% | ↘ 1 |
| SFY 2017 | 95.0% | ↗ 2 |
| SFY 2016 | 94.2% | ↗ 1 |
| SFY 2015 | 92.3% | ↘ 1 |

## Story Behind the Curve

## Partners

## What Works

## Action Plan

## Notes on Methodology

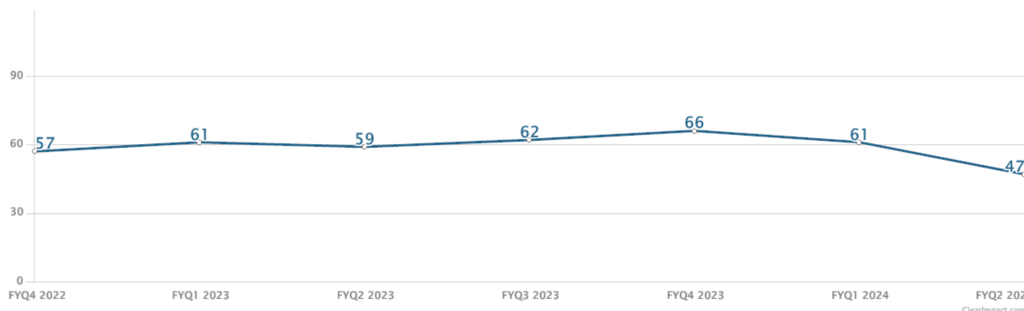
Based on data reported the Department of Mental Health by Designated Agencies via the monthly service report (MSR) for children and adolescents receiving services. "Children and youth receiving respite services who remain in their homes" is defined as those receiving respite services who are currently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

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

## P GC_Investment Mental Health CRT Community Support Services (16)

PM How_Much Number of new CRT enrollees

| Most Recent Period | Current Actual Value | Current Trend |
|---|---|---|
| FYQ2 2024 | 47 | ↘ 2 |
| FYQ1 2024 | 61 | ↘ 1 |
| FYQ4 2023 | 66 | ↗ 2 |
| FYQ3 2023 | 62 | ↗ 1 |
| FYQ2 2023 | 59 | ↘ 1 |
| FYQ1 2023 | 61 | ↗ 2 |
| FYQ4 2022 | 57 | ↗ 1 |
| FYQ3 2022 | 46 | ↘ 2 |
| FYQ2 2022 | 57 | ↘ 1 |




### Story Behind the Curve

### Partners

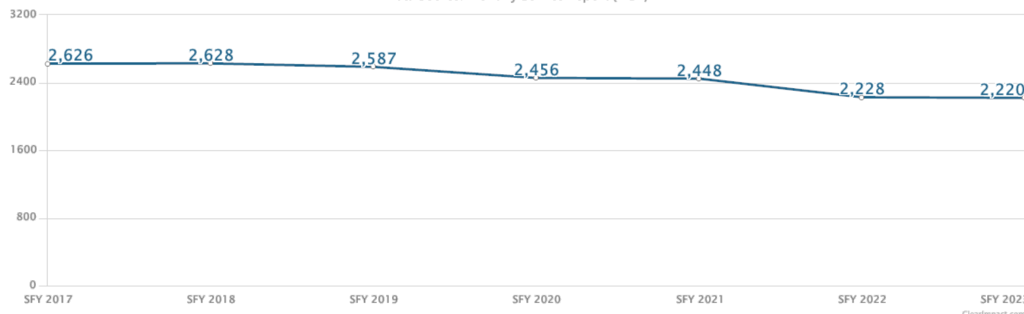
### What Works

### Action Plan

### Notes on Methodology

PM How_Much Number of Adults Served in CRT Programs

| Period | Value | Trend |
|---|---|---|
| SFY 2023 | 2,220 | ↘ 5 |
| SFY 2022 | 2,228 | ↘ 4 |
| SFY 2021 | 2,448 | ↘ 3 |
| SFY 2020 | 2,456 | ↘ 2 |
| SFY 2019 | 2,587 | ↘ 1 |
| SFY 2018 | 2,628 | ↗ 1 |
| SFY 2017 | 2,626 | ↘ 1 |
| SFY 2016 | 2,718 | ↗ 1 |
| SFY 2015 | 2,708 | ↘ 7 |




### Story Behind the Curve

- The purpose of Community Rehabilitation and Treatment (CRT) is to provide comprehensive services, using a multi-disciplinary treatment team approach, for adults with severe mental illnesses.
    - CRT offers a wide range of support options to help people remain integrated in their local communities in social, housing, school, and work settings based on their preferences, while building strategies to live more interdependent and satisfying lives.
- Adults who are eligible for CRT programs are defined as individuals 18 years old or over with schizophrenia, or other psychotic disorders and seriously debilitating mood disorders, and meet certain other criteria.
- The number of adults served by CRT programs has remained relatively steady for the above reporting period with a slow declining trend.

### Partners

- Vermont Care Partners

- Designated Agencies
    - Clara Martin Center
    - Counseling Service of Addison County
    - Health Care and Rehabilitation Services
    - Howard Center
    - Lamoille County Mental Health Services
    - Northeast Kingdom Human Services
    - Northwestern Counseling and Support Services
    - Rutland Mental Health Services
    - United Counseling Service
    - Washington County Mental Health Services
- Specialized Service Agency
    - Pathways Vermont

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## Notes on Methodology

- Total numbers are based on Monthly Service Report (MSR) data submitted annually to the Department by DAs and one SSA, Pathways Vermont, who serves adults.

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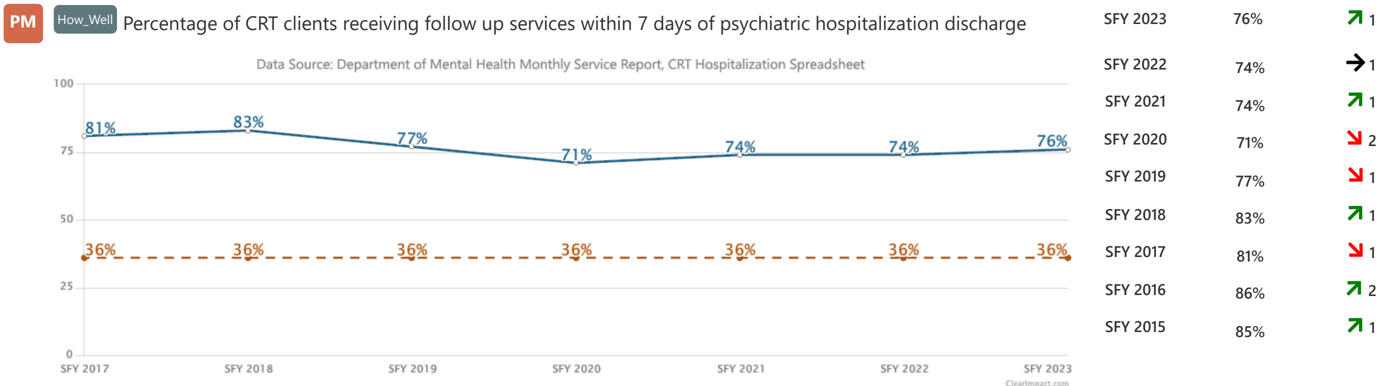



| | | |
|---|---|---|
| SFY 2023 | 76% | ↗ 1 |
| SFY 2022 | 74% | → 1 |
| SFY 2021 | 74% | ↗ 1 |
| SFY 2020 | 71% | ↘ 2 |
| SFY 2019 | 77% | ↘ 1 |
| SFY 2018 | 83% | ↗ 1 |
| SFY 2017 | 81% | ↘ 1 |
| SFY 2016 | 86% | ↗ 2 |
| SFY 2015 | 85% | ↗ 1 |

## Story Behind the Curve

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

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

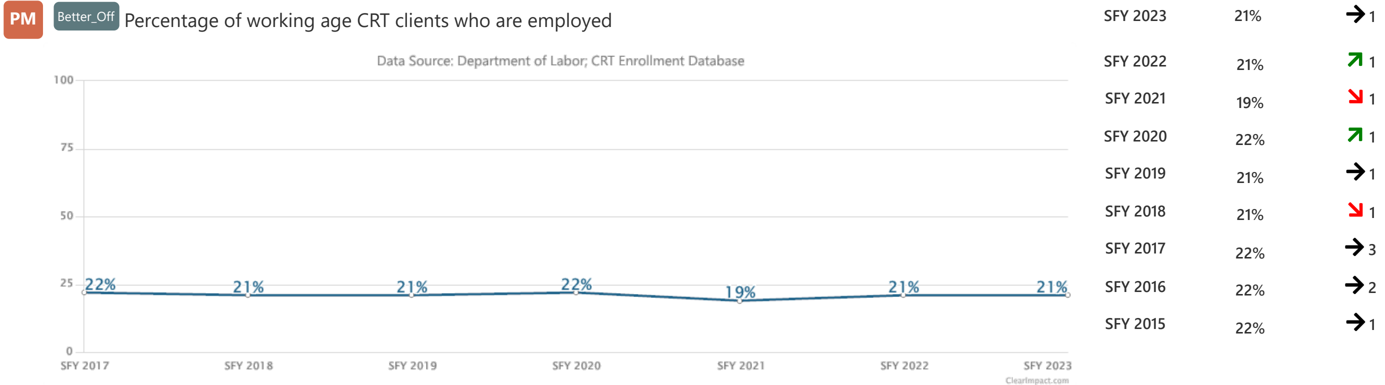
---

## Partners

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

## Strategy

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




| Period | Value | Trend |
|---|---|---|
| SFY 2023 | 21% | → 1 |
| SFY 2022 | 21% | ↗ 1 |
| SFY 2021 | 19% | ↘ 1 |
| SFY 2020 | 22% | ↗ 1 |
| SFY 2019 | 21% | → 1 |
| SFY 2018 | 21% | ↘ 1 |
| SFY 2017 | 22% | → 3 |
| SFY 2016 | 22% | → 2 |
| SFY 2015 | 22% | → 1 |

## Story Behind the Curve

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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


## Partners

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

## What Works

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

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

## Action Plan

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

## Notes on Methodology

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

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

P **CDD, Children's Integrated Services**

## What We Do

Children's Integrated Services (CIS) delivers early intervention, family support, and prevention services that help ensure the healthy development and well-being of children, from before birth up through age 5. The CIS State Team within the Child Development Division (CDD) administers CIS. **Children's Integrated Services (CIS) | Department for Children and Families (vermont.gov)**

## Who We Serve

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

- Early Intervention: Services for children from birth up to age 3 who have or are at risk of a developmental delay or disability.
- Strong Families VT Home Visiting: Services delivered in the home for pregnant and postpartum parents and young children who have concerns about factors that impact healthy family development, including nursing supports.
- Early Childhood and Family Mental Health: Services to promote healthy social-emotional development for children and their families from birth to age 6 who may have mental health concerns.
- Specialized Child Care: Services to help children with high needs connect to and experience success in high quality child care settings. It also supports child care programs in accessing training and resources so they are able to support the safe and successful inculsion of all children in their programs.

## How We Impact

CIS is an innovative model unique to Vermont. It is designed to improve child, family, and program outcomes by providing client-centered holistic services, effective service coordination, individualized service plans, and flexible funding to tailor services to client and regional needs. A CIS Coordinator and three collaborative teams (administrative, consultative, and referral/intake) in each region guide and sustain service integration.

There are 4 key sets of services within CIS. They all promote healthy child development, connect clients with community resources, and employ a strengths-based approach. They are:

- Early Intervention (EI): Services for infants and toddlers, birth to age 3, who are experiencing a developmental delay or have a medical condition with a high probability of resulting in developmental delay or disability, and their families.
- Strong Families Vermont Home Visiting (SFVT HV): Home or community visits for families during pregnancy, as well as with young children from birth to age 6, who have questions or concerns about parenting or seek short term support to address needs. Health and well-being, feeding and nutrition, early learning, and social emotional development are all possible areas of focus. SFVT includes two evidence-based models: Maternal Early Childhood Sustained Home Visiting (MECSH) delivered by nurses and Parents As Teachers (PAT) delivered by family support home visitors.
- Early Childhood and Family Mental Health (ECFMH): Services for children birth to age 6 who are experiencing social, emotional, or behavioral challenges, and/or seek support to effectively utilize community services, and their families. ECFMH also consults with and educates early childhood education programs and other organizations regarding children's healthy development, social interactions, self-regulation, and access to mental health services.
- Specialized Child Care (SCC): Services for families with children ages 6 weeks to age 13 with high needs who seek to connect to and experience success in high-quality early childhood education and afterschool regulated programs. SCC also supports regulated programs in accessing training and resources so they are able to safely and successfully include all children in their programs.

## Measures

| Measures | Most Recent Period | Current Actual Value | Current Target Value | Current Trend | Baseline % Change |
|---|---|---|---|---|---|
| PM CDD % CIS Clients Lost to Follow Up | HY2 2023 | 12% | – | ↗ 1 | 29% ↗ |
| PM CDD % of Referrals Triaged by CIS Coordinator | HY2 2023 | 73% | – | ↗ 2 | -6% ↘ |
| PM CDD % of Clients with One Plan Completed within 45 days | HY2 2023 | 91% | – | ↗ 1 | 4% ↗ |

# DVHA Dental Incentive Program

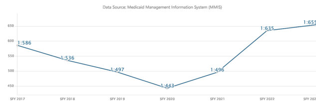
DVHA Dental

## What We Do

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

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

## Measures

| Measures | Most Recent Period | Current Actual Value | Current Target Value | True | Current Trend | Baseline % Change |
|---|---|---|---|---|---|---|
| PM DVHA # of VT Medicaid-enrolled dental providers relative to the total # of VT Medicaid beneficiaries | SFY 2023 | 1:655 | – | – | ↗ 3 | 11% ↗ |
|  | SFY 2022 | 1:635 | – | | ↗ 2 | 8% ↗ |
| | SFY 2021 | 1:496 | – | | ↗ 1 | -16% ↘ |
| | SFY 2020 | 1:443 | – | | ↘ 4 | -25% ↘ |
| | SFY 2019 | 1:497 | – | | ↘ 3 | -15% ↘ |
| | SFY 2018 | 1:536 | – | | ↘ 2 | -9% ↘ |
| | SFY 2017 | 1:586 | – | | ↘ 1 | 0% → |
| | SFY 2016 | 1:660 | – | | ↗ 1 | 12% ↗ |

### Notes on Methodology

- The data value used for beneficiary enrollment is the number of full-benefit Vermont Medicaid enrollees on active status as of January 1 each year.
- The data value used for dentists is the number of dentists enrolled in Vermont Medicaid on active status with an address in Vermont as of January 1 each year.

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### Story Behind the Curve

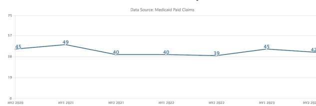
This measure shows the number of Vermont Medicaid enrolled dentists relative to the number of VT

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

The trend line above shows that the ratio of dentists to the Medicaid population was lower in SFY 2020 when the pre-COVID-19 enrollment counts were at a five-year low. In SFY 2021, the slightly higher ratio was the result of an increased supply of dentists, but also an increase in Medicaid enrollment. The ratio continued to climb in SFY 2022 due to an increase in the number of Medicaid enrolled individuals and a decrease in the number of dental providers. The continuous eligibility requirements during the COVID-19 Public Health Emergency are responsible for increased enrollment. Retirements and pressures experienced by providers during the COVID emergency has caused some dental offices to close.

## Partners

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

| | | | | | | |
|---|---|---|---|---|---|---|
| PM DVHA # of dental practices eligible for dental incentive payment (total Medicaid paid claims of $50k or more) | HY2 2023 | 42 | – | – | ↘ 1 | 27% ↗ |
|  | HY1 2023 | 45 | – | | ↗ 1 | 36% ↗ |
| | HY2 2022 | 39 | – | | ↘ 1 | 18% ↗ |
| | HY1 2022 | 40 | – | | → 1 | 21% ↗ |
| | HY2 2021 | 40 | – | | ↘ 1 | 21% ↗ |
| | HY1 2021 | 49 | – | | ↗ 2 | 48% ↗ |
| | HY2 2020 | 45 | – | | ↗ 1 | 36% ↗ |
| | HY1 2020 | 32 | – | | ↘ 1 | -3% ↘ |
| | HY2 2019 | 47 | – | | → 1 | 42% ↗ |

## Notes on Methodology

This measure is calculated on the half calendar year (CY). Payments are made in the fall for services provided January - June of each year (HY1), and then again in the spring for services provided July - December of each year (HY2).

## Story Behind the Curve

For SFY 2008 and beyond, the Vermont Legislature authorized DVHA to begin distributing $292,836 annually to support the program. The DVHA and the VSDS agreed that the funds would be distributed bi-annually; distributions of $146,418 are made in the spring and fall, for an annual total of $292,836. Each dental practice that receives $50,000 or more biannually in Medicaid paid claims is eligible for the payment. The amount paid is calculated as a percentage of the Medicaid claims paid. Historically, 36-50 dentists have qualified for semi-annual payouts and a share of the $146,418 available.

The relatively low number of dental practices eligible for the dental incentive payment in HY1 (2020) reflected the fact that many dental practices closed between mid-March to early June in 2000 due to the pandemic. Since then, practices eligible for incentive payment returned to within the historically normal range. Though Vermont is experiencing a significant loss of dentists, we are fortunate to continue to have a number of strong dental "border" supporters, particularly in New Hampshire.

## Partners

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

## Action Plan

The Dental Incentive program data is reviewed two times per year. In addition, the Agency collects and analyzes additional dental measures in order to make system improvements.