State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 19
(1/1/2023 – 12/31/2023)

Quarterly Report for the period
July 1, 2023 – September 30, 2023

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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 third quarterly report for waiver year 19, covering the period from July 1, 2023, through September 30, 2023 (QE092023).***

II. Outreach/Innovative Activities

i. Member and Provider Services

Key updates from QE092023:

- 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 third quarter of the calendar year 2023, non-emergency medical transportation utilization remained steady. The trip numbers for this quarter stayed level with the numbers from the previous quarter, with only a slight drop off due to historical summer lessened utilization. Overall program complaint numbers also continue to run well below the contracted performance standard of 5% of all rides provided, still maintaining a monthly rate of less than 1%.

Utilization numbers overall continue to remain only 50-60% of what they were pre-Covid.

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	$366,051.58
Estate	$229,834.49
Third-Party & Court-Ordered Medical	$231,634.18
Medicare Prescription Drug Premium/Claims	$106,038.69
Over Resource/Hospice/Patient Share/Credit Balance	$538,062.98
Annuity/Trust/Waiver	$137,224.72
Lamp/Map, Medicare Claim Recoupment	$251,146.70
Third-Party Claim Recoupment	$26,911.70
Total	**$1,887,905.04**

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	$57,013,169.83
Medicare	$117,790,675.14
Total	**$174,803,844.97**

III. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE092023:

- The Customer Support Center received 67,533 calls in QE0923, up 67% from the previous year.
- Work was done to prepare to run both Open Enrollment and Medicaid renewal process campaigns simultaneously. An updated and improved plan comparison tool was launched.
- Increasing numbers of customers are using self-service functions. Self-serve applications comprised over half (61%) of all applications in QE0923.

Enrollment

As of QE0923, more than 213,890 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 144,505 in Medicaid for Children and Adults (MCA) and 69,385 in Qualified Health Plans (QHPs), with the latter divided between 26,635 enrolled with VHC, 4,651 direct enrolled with their insurance carrier as individuals, and 38,099 enrolled with their small business employer.

Medicaid Renewals

The Medicaid Unwind continued in the second quarter. Renewals due in July and August were bumped out a month in response to the flooding in July. Updated CMS guidance on ex parte at an individual level initiated an effort to revamp the renewal process. Each Unwind renewal batch was reviewed to reinstate individuals in non ex parte cases who could have gone ex parte. The passive renewal success rate for the quarter was 52%.

1095 Tax Forms

The last corrections run for TY 2022 1095B was May 23, 2023. Preparations are currently underway for TY 2023 generation which begins in November.

Customer Support Center

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

The Customer Support Center received more than 67,533 calls in QE0923, up 67% from the previous year. During the last quarter, Maximus answered 46% of calls within 24 seconds. With decreased fully trained staff and higher call volumes, Maximus failed to meet the target in QE0923.

Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to DVHA-HAEEU for resolution and log service requests, which are escalated to the appropriate resolver group. This year has seen an increase in the volume of calls with a slight decrease in the proportion of calls that were escalated. 6.5% of QE0923 calls were transferred to DVHA-HAEEU staff, down from 1.5% in QE0922. Just as importantly, DVHA strived to answer all calls that were transferred; 96% of transferred calls were answered in five minutes in QE0923.

Timely Processing of Member Requests

In the spring of 2016, DVHA-HAEEU set a goal of completing 75% of member requests within ten business days. In QE0922, more than 99% of the VHC requests were completed within the same ten-day time frame and 98% in QE0923.

In-Person Assistance

Between July 1 and September 30, 2023, the program was supported by 5 brokers, 4 navigators, and on average, 94 Certified Application Counselors. Totaling approximately 103 individuals spread across 59 distinct organizations. Notably, this period witnessed a slight reduction in the number of assisters compared to the prior quarter.

During this period, the program undertook a comprehensive reform of its IT record-keeping and automation system. Due to this, the program temporarily halted its recruitment procedures to facilitate a smooth transition. It is worth mentioning that this improvement initiative is currently in the final stages of implementation. Looking ahead to the next quarter, the primary focus will be on revitalizing and prioritizing program recruitment and retention.

Outreach

DVHA continued implementing its multi-modal communication campaign focused on the Medicaid Renewal process. This campaign is designed to engage customers in the renewal process through both direct and indirect messaging. Communication mediums include noticing, text messaging, emails, social media posts, website updates, paid media, Assister training, and stakeholder newsletters. DVHA also took efforts to begin planning for Open Enrollment 2024.

This is the first time both campaigns will run simultaneously. Efforts are being taken to both ensure the campaigns have separate profiles but are also integrated into the overall effort of keeping Vermonters informed of their health options.

The Plan Comparison Tool continues to be a primary tool to help Vermonters' search for health plans that could fit their budget. It is a core piece of DVHA's educational tools, helping customers assess their choice for coverage, whether during Open Enrollment or the Medicaid Renewal period. It was used in over 14,000 sessions during the quarter. Additionally, a newer, more user-friendly, version of the Tool was put into use.

Self-Service

During QE0923, DVHA-HAEEU continued to promote self-service options for customers to report changes, and access tax documents and other forms. Self-service leads to an improved customer experience as Vermonters can log in at their convenience. It also has the benefit of using automation to reduce staffing expenses. Year-over-year comparisons show that more customers are using self-service functions, including both online accounts for health coverage applications and reported changes as well as the options of paying premiums through Self-serve applications comprised over half (61%) of all applications in QE0923.

ii. Choices for Care and Traumatic Brain Injury Program

DAIL

Choices for Care

Electronic Visit Verification:

DAIL Adult Services Division (ASD), in partnership with DVHA and VDH, continues to work with homecare agencies and individuals who self-direct their personal care services to provide access to educational materials to support the adoption of EVV throughout the state. Information on EVV can be found HERE. Beginning July 1, 2022, ARIS Solutions, Vermont's contracted fiscal agent, implemented the policy that Medicaid program funds cannot be used to pay for services if EVV is not used to record in-home personal care services. Extensive communication was provided before implementation and is outlined here. As of August 2023, there continues to be 100% adoption rate for EVV usage for required services.

Choices for Care Providers

In Q3, 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. .

At the end of Q3, CFC enrollment included:

NH – 2768 participants
ERC – 548 participants
Home Based – 2294 participants
Moderate Needs – 824
participants

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 2023 in May.

The goal for the CY2023 award is to fund transitions for sixty-two (62) Choices for Care participants from a SNF to a home-based setting. As part of the grant re-authorization, CMS has also relaxed the eligibility rules for the MFP program. 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

In the 3rd quarter two new staff members joined the MFP team:

Program Director, Sarah Lipton,
Senior Planner & Data Scientist, Ashley Johnson.

In Q3, 37 participants graduated from the program, 33 transitions have been supported, and there are currently 27 active participants moving towards transition.

Due to a CMS-mandated change, retroactive enrollments can no longer take place, so instead of the 62 projected transitions this year, MFP is likely to have 47. Work is underway to increase referrals and enrollments through dedicated training and outreach across the State.

Brain Injury Program

Current enrollment = 88 individuals, and 5 new Applicants are pending clinical assessment.

Wait Lists

- There is no wait list for the High Needs Group.
- There continue to be provider wait lists for Moderate Needs Group, estimated at 700+ people statewide. Because the eligibility criteria for Moderate Needs services are so broad, Vermont does not expect to eliminate the wait list.
- 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 22 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.

iii. Developmental Disabilities Services Division (DDSD)

Payment and Delivery System Reform Update:

Work continues to engage individuals receiving services in the process of receiving needs assessments using the Supports Intensity Scale-Adult. Vermont intends to have the transition from its "home-grown" assessment to use of the SIS-A exclusively within a three-year cycle (by Fall 2025). While this continues to progress, DDSD staff have been working with key stakeholders to develop a "Context Tool" to assist with the person-centered planning process. This Context Tool builds off elements from the SIS-A and is distinct from the Supplement Questions that Vermont chose to add to the tool itself.

Please see prior report submissions for previous highlights.

DDS System of Care Plan Renewal

In January 2023, DAIL/DDSD renewed the State System of Care Plan for Developmental Disabilities. This Plan included several special initiatives as Division priorities and has begun work to achieve these goals.

Using ARPA/enhanced FMAP funding, in a joint effort through the Vermont State Legislature, the Division has released a request for proposals for pilot planning grants for housing innovation within the DDS system. DDSD expects to award at least 3 grants around Vermont later this year. The outcome of these pilot planning grants will be to identify innovative, replicable, sustainable housing options to expand supports available across the State.

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, Department is developing an ombuds-like advocacy pilot program for the Brain Injury and Developmental Disabilities HCBS programs. This pilot project will seek to demonstrate the effectiveness of such an advocacy program for these populations, as well as provide rights' trainings.

Please see prior report submissions for previous highlights.

iv. 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

i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE 092023:

- Overview
- Beneficiary Enrollment
- New To Medicaid Screenings
- Team-Based Care Initiative
- SDOH Screening Update
- Medicaid Eligibility Workflow Updates

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.

In the third quarter of 2023, VCCI has continued to see a decline in the number of new referrals. This is likely due to the decrease in contract staffing over the past few months and the re-deployment of VCCI nurses. This transition was completed at the end of August, so we hope to see new referrals increase in the next quarter. Our goal of increasing the percentage of face-to-face visits remains relatively steady around 69% of visits being in person. Most members request multi-modal interventions. Most prefer a hybrid model with some home visits mixed in with virtual or telephonic visits. Our home visit safety protocols have been updated and implemented. As seen below, VCCI maintained an average case load of roughly 186 people served per month over the second quarter. The length of time and regularity of visits are dependent on the complexity and severity of the needs of the beneficiaries. VCCI case managers work with beneficiaries until the goals of their care plans are met or they are connected to needed services in the community with a lead care coordinator assigned. (See **Figure 1).**

Figure 1. Beneficiary Enrollment and Face to Face Visits

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
# new VCCI eligible members enrolled monthly in care management	49	44	40	27	37	29	31	29	27
Total Open Cases (including newly enrolled – above)	232	241	235	198	207	197	185	177	185
% of VCCI enrolled members with a face-to-face visit during the month	61.21%	61.00%	69.36%	63.13%	67.15%	66.50%	67.57%	71.75%	69.73%

VCCI continued the work started in 2019, of telephonic outreach and screening to beneficiaries new to the health plan. The new Medicaid screening tool poses questions related to access to health care and health care-related issues including Primary Care, Dental, housing, transportation, and food, with direct facilitation to those services desired by the beneficiary. The numbers of people new to Medicaid plan seem to have remained relatively constant since January with the lowest numbers in February and May (**Figure 2).** The number of members who respond to screening is relatively constant.

Figure 2. Number of New to Medicaid Beneficiaries Screened

Updated Dates – month reported	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
# of new to Medicaid (Adults 18+)	405	290	365	351	288	386
# of new to Medicaid reached	84	53	82	60	57	70
# of new to Medicaid screened	189	130	159	120	114	146
% of new to Medicaid screened	46.67%	44.83%	43.56%	34.19%	39.58%	37.82%

VCCI leadership in partnership with Healthcare Reform has developed a project committee for our Team-based Care Initiative with representation from all departments within the Agency of Human Services. We have contracted with the Camden Coalition for technical assistance in reinvigorating our Team-based Care process across departments and within community provider networks. The Camden Coalition has been working with stakeholders across the State to determine their experiences and needs with complex care. Camden is working on synthesizing the information they captured during interviews and will then put together recommendations for the Agency.

Vermont Chronic Care Initiative is working with Agency of Human Services Field Services and the Blueprint Program to launch a Team-Based Care trainings/learning collaborative pilot in Brattleboro to identify regional cultures of care and train health and social health care providers on the complex care model and tools of engagement. The multi-agency team is working on the Social Determinants of Health screening elements which were adapted from the CMS tool. Several programs across the Agency are piloting those screening questions in their programs. The tool is being put into a system called CommCare that Agency of Human Services staff will be able to access to screen people using their services for other needs and make appropriate referrals to other department services or for team-based care services. Our goal is to test the questions with a cohort of people to see if we need to modify any questions. We will then work to roll those out across the agency.

VCCI is also working collaboratively with the State of Vermont Agency of Digital services and VITL to look at adding social determinant of health data into the Health Information Exchange.

In the last quarter, the VCCI team has collaborated with the Department of Health and Department of Vermont Health Access to establish a screening tool and process to begin screening New to Medicaid members under the age of 18. Our current New to Medicaid outreach program only provides outreach to new members over the age of 18. We hope to work with AHS departments to develop an age-appropriate screening tool and efficient process for outreach to avoid any duplication of screening efforts across the care system.
VCCI has also worked with the DVHA eligibility unit to develop a process for expediting Medicaid eligibility process for people who are referred to VCCI case management, but do not have Medicaid and are eligible for the Medicaid

program. VCCI works in collaboration with the Department of Vermont Health Access to develop a workflow so Vermonters could access the services of VCCI expediently.

In the past quarter, our team has been busy working on recruitment for our vacant positions. We have two new hires in Brattleboro and Burlington leaving us 2 vacancies.

ii. Blueprint for Health

Key Updates from QE092023

- The majority of Vermont's primary care practices are Blueprint Patient-Centered Medical Homes, with 132 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.
- As of 2023-Q3, the average monthly number of patients receiving Buprenorphine or Vivitrol prescriptions is 3,811.
- 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 0 practices and 7 Planned Parenthood sites to participate in the Pregnancy Intention Initiative as of September 2023

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. This proposal recommends 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:

1. Strengthen prevention, reduce practice variation, increase coordination oversight, and direct workflow through Quality Improvement Facilitation and analytics;
2. Expand capacity to address mental health and substance use disorders through Community Health Team staffing to include Community Health Workers, Social Workers, and Counselors who will screen for, and in some cases treat, MH, SUD and social determinants of health; and
3. 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.

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

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

all patients that 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).

Q3Highlights

July – September 2023 Quality Improvement

Consumer Assessment of Healthcare Providers and Services (CAHPS)
A total of 123 practices chose to participate in the Statewide Patient Experience Survey. Quality Improvement

Facilitators, based on feedback from participating practices, identified some of the factors which contribute to low response rates and proposed dissemination of standardized communication materials. Promotional posters for use in patient waiting and exam rooms, social media posts, and newsletter templates were created by the Blueprint and translated into Spanish and French for use at the practices.

Patient Centered Medical Home (PCMH) Recognition

Forty-five (45) practices across the State successfully completed their National Committee for Quality Assurance annual recognition process in this period, demonstrating their ongoing commitment to the model and continuous quality improvement. Two practices were randomly audited as part of their annual submission process. This year's audit focused practices on core functions of the medical home, and assessed each audited practice on their performance of the following:

- completing and documenting a comprehensive health assessment (which includes considerations for advance care planning, developmental screening, mental health status, substance use history, and social determinant of health screening)
- maintaining up to date medication lists
- holding care team meetings
- maintaining a directory of community resources
- providing timely advice by telephone
- monitoring patients for care management needs
- person centered care planning
- referral management
- sharing of patient information, and
- quality efforts related to resource utilization and patient/family experience of care

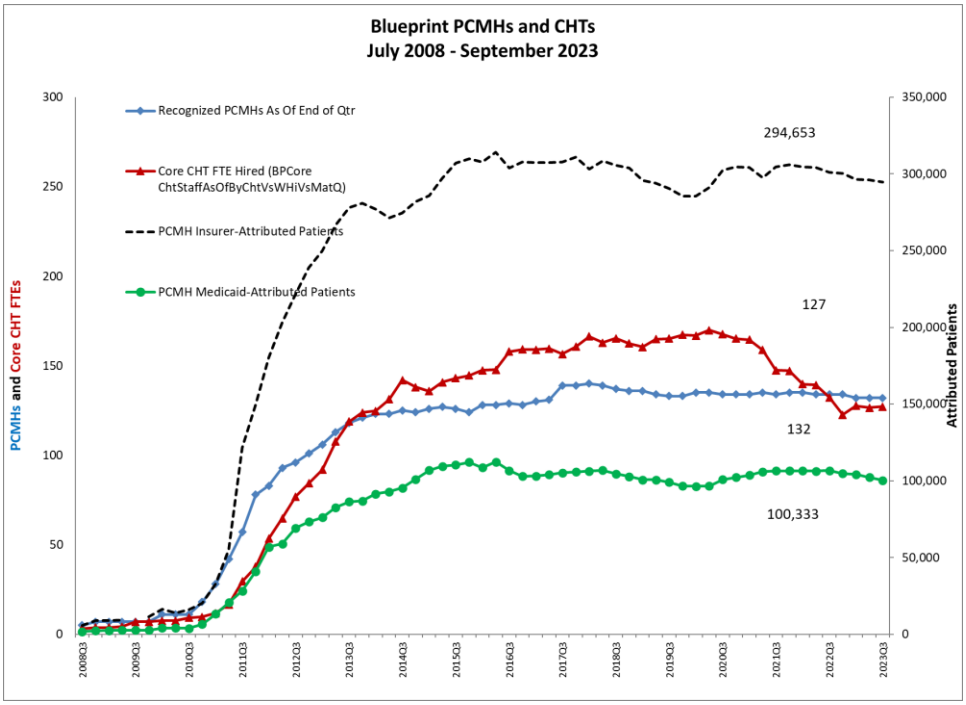
Community Health Team (CHT) Expansion

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 294,653 insurer- attributed patients, of which 100,333 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 127 full-time equivalents of Community Health Team staff.

In Quarter 3(July – September 2023), 132 Vermont practices were operating as Patient-Centered Medical Homes, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of practices participating in the Blueprint for Health program is a key performance measure; the Blueprint estimates that there are about 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.

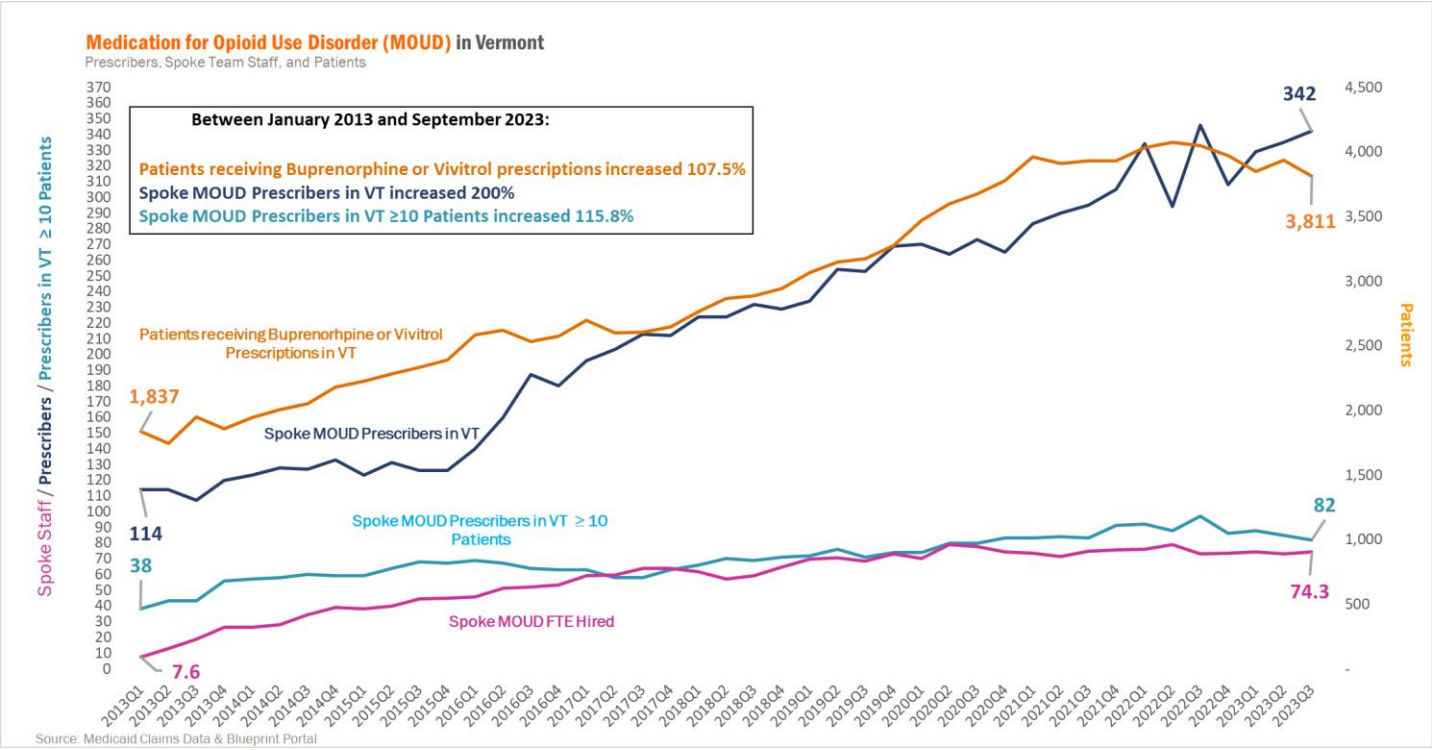
The State Plan Amendment for the Vermont Medicaid Program, approved by the Centers for Medicare and Medicaid Services, established a Health Home for Vermonters with opioid use disorder. As of July 1, 2013, Medicaid beneficiaries receiving MOUD in a Hub or Spoke setting were eligible to receive enhanced 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.

Q3 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. We will be looking at new agenda topics and ensuring we are addressing the connection of mental health and substance use from a whole health perspective. The field continues to have some challenges with work force as many do in hiring nurses and clinicians and the network continues to be creative to recruit.

Vermont continues to demonstrate substantial access to MOUD for Vermonters with opioid use disorder. MOUD is being offered across the State of Vermont by more than 90 different Spoke settings as of September 2023. The monthly average of Medicaid beneficiaries receiving Buprenorphine or Vivitrol prescriptions decreased from 3,934 in Q2 of 2023 to 3,811 in Q3 of 2023. There are 342 providers who prescribe Buprenorphine or Vivitrol in Vermont. There are 74.3 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 July 2023- Sept 2023



<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.

Q3 2023 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 have continued to outreach to practices to share the mission of the PII program and assess interest in incorporating this into their practice and we hope to have some new practices engage in our Franklin County area.

Practices are working hard to engage community partners in education and understanding the WHI program. These partnerships and education around the mission of the program enhance relationships and pathways to care. We have presented a WHI data dashboard to the field in our monthly call every quarter.

We provided the field with a Long-Acting Reversible Contraceptive Training July 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 being able to learn this skill. We will schedule another training in Oct 2023 and provide an update.

Figure 3 below shows PII enrollment and staffing over time. In Q3 2023, the number of PII practices enrolled is 40. 18 women's specialty health care sites and 22 PCMH participated in the Women's Health Initiative as of September2023.

Figure 3. Pregnancy Intention Initiative Implementation by Region

Health Service Area	PII Specialist Practices as of September 2023	PII PCMH Practices as of September 2023	PII CHT Staff FTE Hired as of September 2023	PII Specialist Quarterly Attributed* Medicaid Beneficiaries as of September 2023	PII PCMH Quarterly Attributed* Medicaid Beneficiaries as of September 2023
Barre	1	0	0.75	655	0
Bennington	1	0	1	936	
Brattleboro	1	0	0.5	966	0
Burlington	2	9	1.2	2382	4551
Middlebury	1	0	0.75	849	0
Morrisville	1	3	0.5	336	1216
Newport	1	0	1	980	0
Randolph	1	0	0.5	159	0
Rutland	1	0	1	1289	0
Springfield	0	5	0	0	1611
St. Albans	0	0	0	0	0
St. Johnsbury	1	2	0.75	931	596
Windsor	0	3	0	0	85
Planned Parenthood (Statewide)	7	0	2.8	3486	0
Total	18	22	10.75	12969	8059

*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.

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

Key updates from QE092023:

- 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.

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. Our unit worked with other departments on developing a system to notify DVHA regarding all children with Medicaid that are awaiting placement in Emergency Departments for DVHA to assist with placements when needed.

The CIU 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. The Senior Autism Specialist is working with the Payment Reform Unit to develop and disseminate VBP letters in early October. These letters will outline each provider's overall VBP score, and the resulting amount earned. The plan is for each VBP letter to be disseminated at the same time as each provider's 2023 Mid-year Reconciliation Letter.

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 members' charts and that clinical documentation follows ABA Policy and Clinical Guideline standards. Five clinical documentation reviews have been completed thus far in calendar year 2023.

iv. Mental Health System of Care

Key updates from QE092023:
- Leadership and Reporting updates

System Overview

The Department of Mental Health (DMH) is responsible for mental health services provided under state funding to special-needs populations, including children with serious emotional disturbances (SED) and adults with serious mental illnesses (SMI). The Vermont Agency of Human Services (AHS) provides funding through Provider Grant Agreements to ten (10) Designated Agencies (DAs) and two (2) Specialized Service Agencies (SSAs). These agencies are located across Vermont for the provision of:

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

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

Inpatient care is provided through a decentralized system that includes one state-run psychiatric care hospital, Vermont Psychiatric Care Hospital (VPCH), and six (6) Designated Hospitals (DHs) located across the state.

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

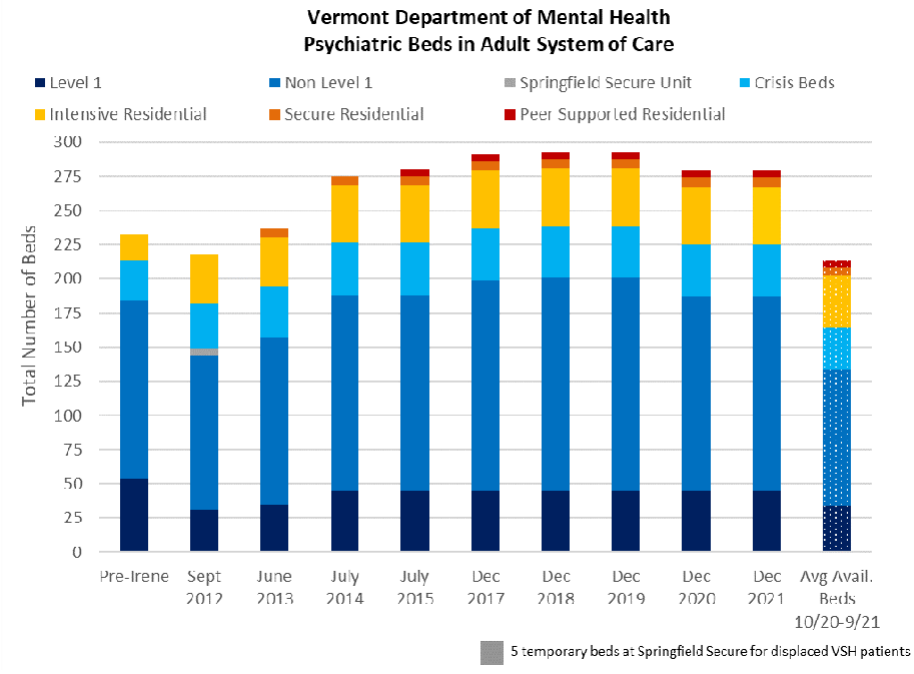
Throughout 2021 and continuing to the present, the Coronavirus Disease 2019 (COVID-19) pandemic has continued to challenge the mental health system of care in Vermont, primarily through statewide staffing shortages and inpatient bed closures.

Updates on the Mental Health System of Care

A. Hospital and Inpatient Care

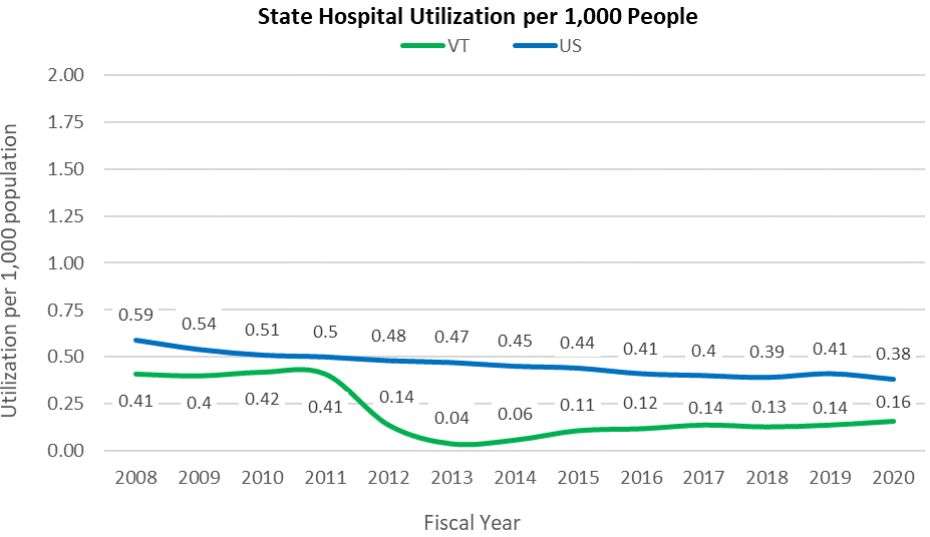
Vermont has 45 Level 1 beds and 159 adult psychiatric inpatient beds across the system of care. During the COVID-19 pandemic, several beds closed due to staffing, construction, patient acuity, and public health safety protocols, as well as an initial decrease in individuals presenting with a need for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

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



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

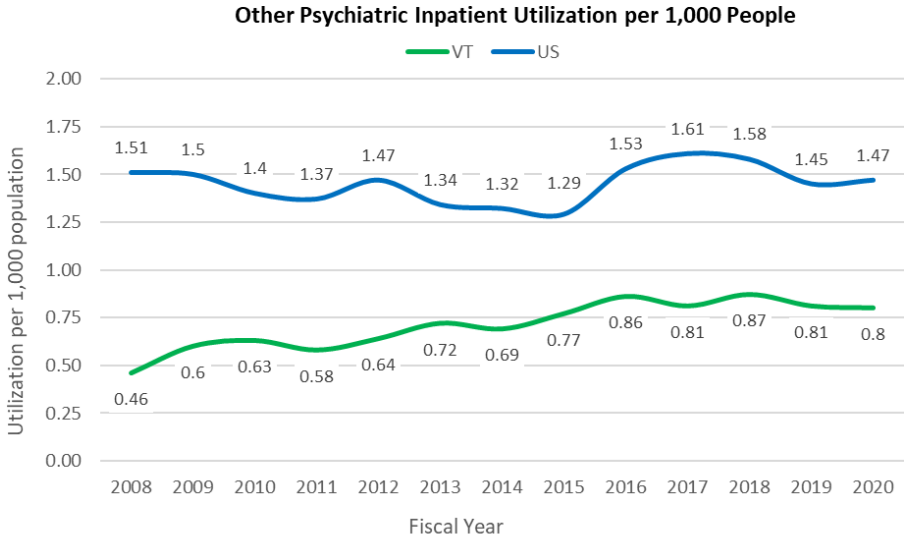
Figure 4. State Hospital Utilization per 1,000 people (in Vermont and the United States)



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

The national rate of state hospital utilization continues to decline year over year. VPCH opened in fiscal year (FY) 2015 with 25 beds, and Vermont's rate of inpatient utilization continues to be lower than the national average in the United States. The significant decrease from FY 2011 to FY 2012 represents the closure of Vermont State Hospital due to flooding from Tropical Storm Irene in August 2011. The Vermont hospital utilization data shows a slowly progressing upward trend since 2012. Vermont is one of a handful of states that only has one state-run psychiatric hospital. The pandemic has significantly increased the need for mental health treatment and support.

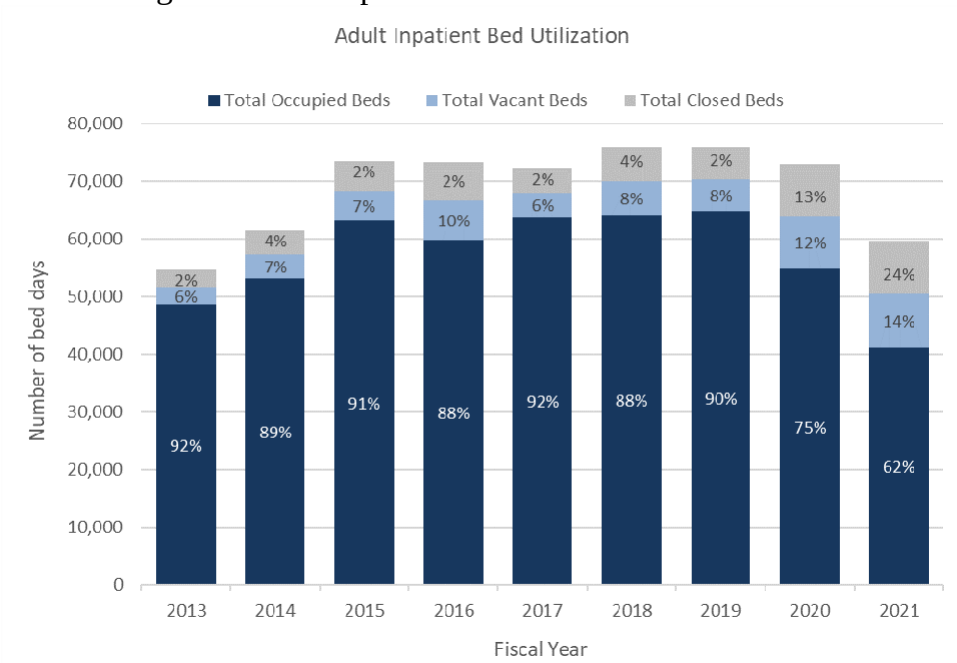
Figure 5. Other Psychiatric Hospital Utilization per 1,000 people (in Vermont and the United States)



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

Other Involuntary Psychiatric Hospital Utilization unit admissions, such as those at DHs, are included in Figure 5. The national rate of psychiatric hospital utilization since 2008 has generally held steady through 2020, while Vermont's rate of utilization continued to increase. Inpatient utilization is still below the national average, while rates of community services utilization in Vermont continue to be markedly higher than national averages (Community Utilization per 1,000 Populations).

Figure 6. Adult Inpatient Utilization and Bed Closures



The Adult Inpatient Utilization and Bed Closures chart depicts the total bed day capacity across the Vermont DH system through FY 2021. The total bed-day availability across the system remained relatively constant in 2018 and 2019, with bed-day utilization decreasing by 15% in 2020 and 13% in 2021. The impact of the COVID-19 pandemic has contributed to the 2% increase in bed vacancies and the 11% increase in beds closed for FY 2020 through FY 2021. Over nine years, 2021 saw the lowest level of adult inpatient bed utilization. Data from 2022 will be illustrated in the upcoming quarterly report.

B. Community-based and Outpatient Services

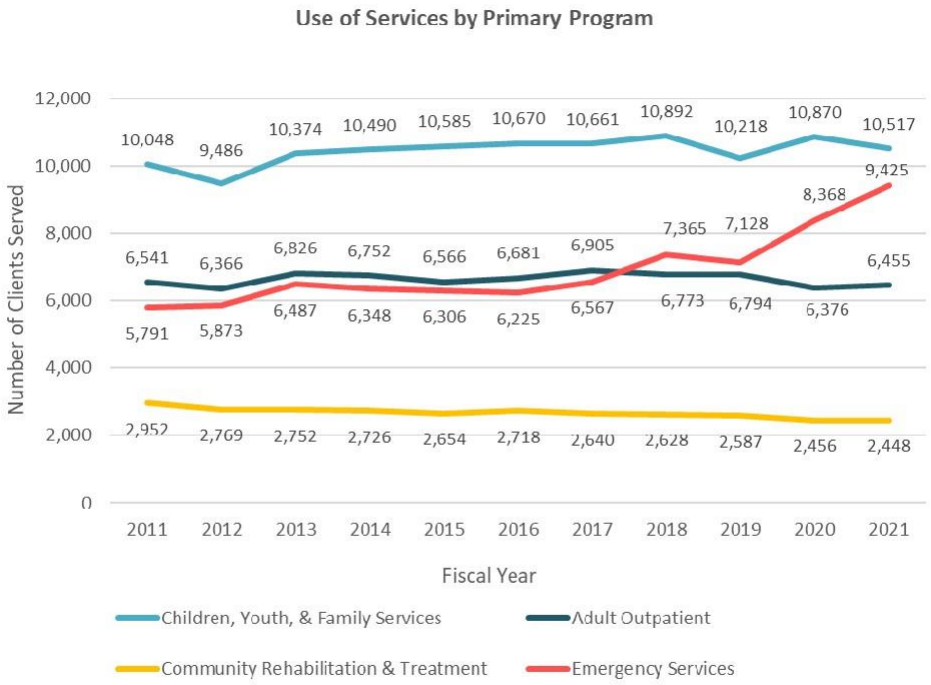
Enhanced community services funding provided by the Vermont legislature through increased appropriations to critical mental health programs in the community over the last several years has helped, but staff recruitment and retention necessary to meet and expand these service capacities continue to be a struggle. Additionally, the payment reform initiative that was implemented on January 1, 2019, has been integral to stabilizing the mental health system of care at the DAs. The initiative has reduced barriers to access to care and promoted a more responsive and "needs" driven service delivery to individuals seeking mental health services. The new payment reform methodology, more flexible service delivery, and value-based incentive payment framework focused on quality and outcomes support a more streamlined approach to adult program access and the service capacity available in each DA catchment area.

Key Efforts Include:

- Established a Workforce Task Group to explore recruitment and retention strategies
- Increased capacity within Community Rehabilitation and Treatment and peer programs to provide community support, outreach, and crisis response continues to develop Broad utilization of non-

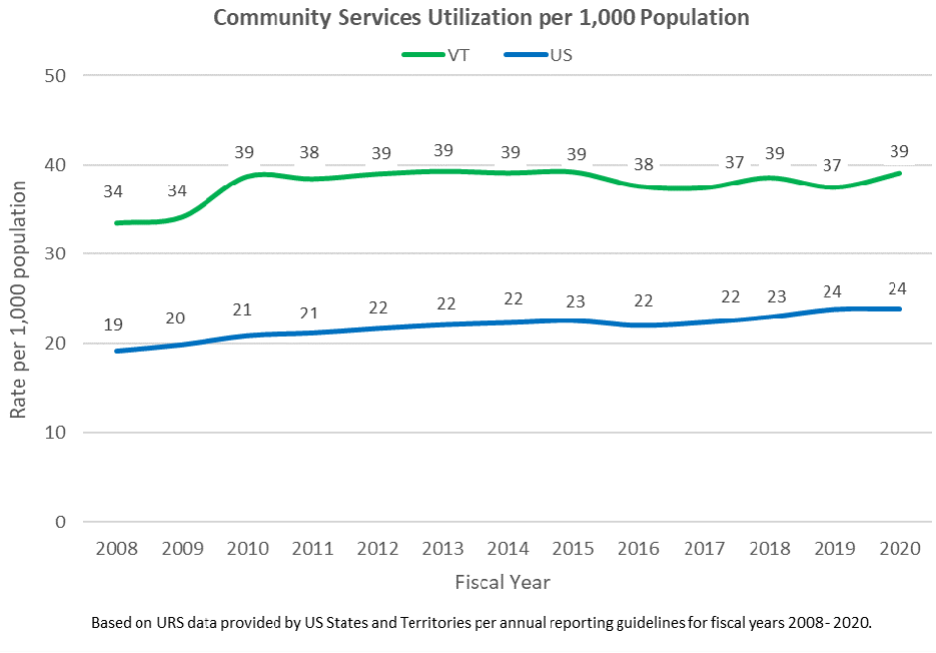
categorical case management services for Adult Outpatient and Emergency Services programs

Figure 7. Use of Services by Primary Program



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

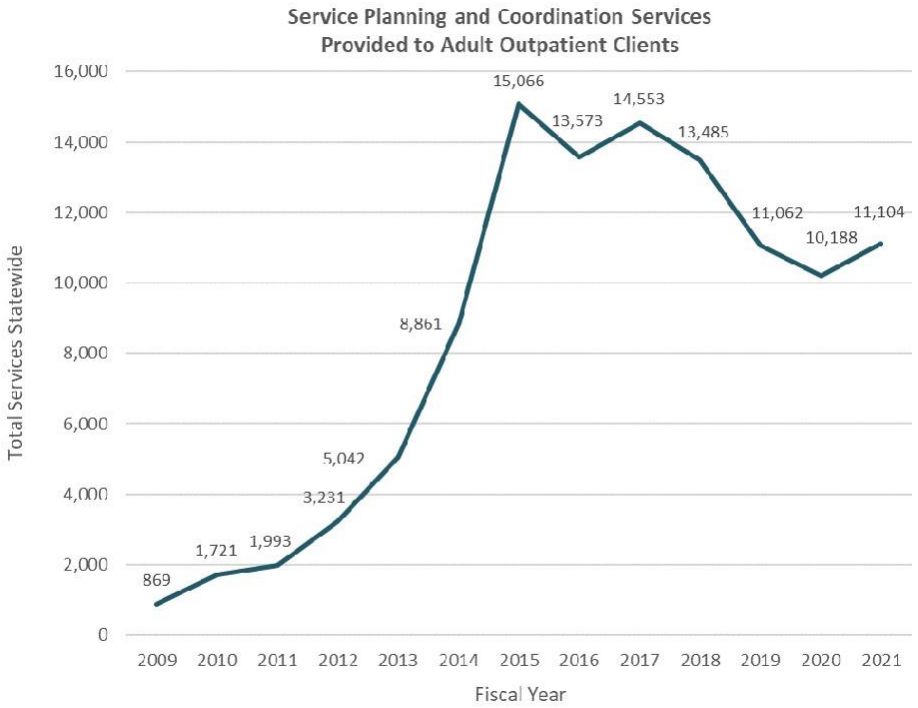
Figure 8. Community Services Utilization per 1,000 Populations



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

The Vermont community mental health system serves nearly 40 out of every 1,000 Vermonters, which is substantially higher than the national utilization rate. The most recent national data available through 2020 continues to highlight that Vermont consistently demonstrates a strong record of service delivery in community-based programs. The system of care is established on the principle that the intensity of services that an individual requires will change over time, specifically that individuals will receive community-based treatment appropriate to their needs and move to higher or lower levels of care only as necessary to support them. For many who have a chronic illness, this is more challenging, as they continuously require a higher level of service needs within the system. Others enter and exit intermittently depending on their individual needs. The payment reform transition away from a fee-for-service model to both an adult and children's case rate with a value-based payment component has provided ongoing flexibility to meet the needs of the individuals.

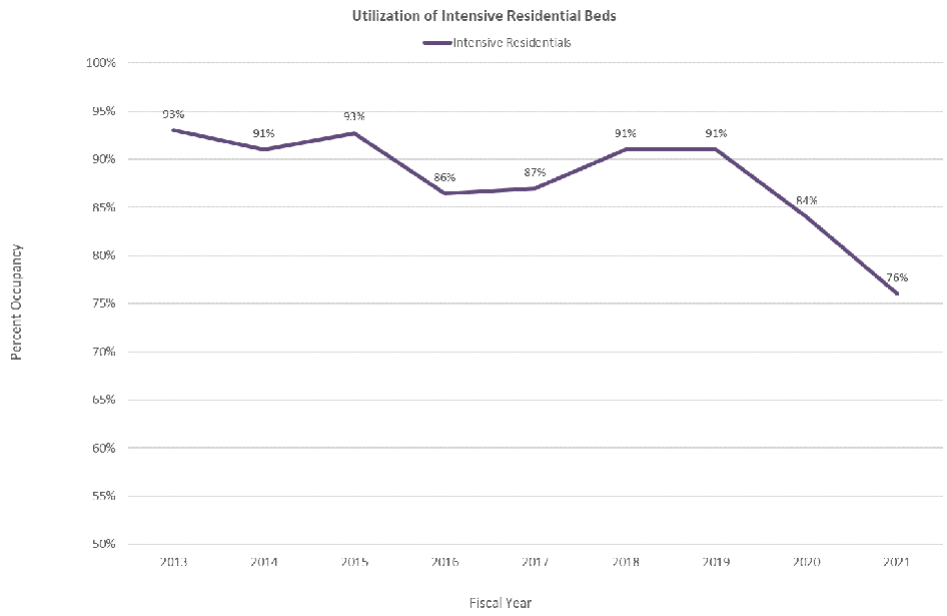
Figure 9. Service Planning and Coordination Services



The support of non-categorical case management led to a steady increase in the number of services provided to adult outpatient clients allowing additional support to those in need but ineligible for case management through CRT services through FY 2015. Levels remained elevated for this population from FY 2016 to FY 2017 with an approximately 30% decline from FY 2017 to FY 2020. Interestingly, there has been a 9% reported in the past fiscal year. This is a noteworthy increase in service planning and coordination to meet this population health-level need for adult case management services. DMH's payment reform initiative launched in January 2019 continues to support flexible service delivery including case management services when needed.

Residential and Transitional Services

Figure 10. Utilization of Intensive Residential Beds



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

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

Performance and Reporting

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

- Implementation of value-based payment measures that allow DAs to earn an additional allocation based on the performance of agreed-upon quality metrics.
- Mental Health Payment Reform utilization scorecard, monitoring caseload, and utilization for all services within the mental health case rate to monitor the impact of the payment model.
- Creation of a "Vermont Psychiatric Care Hospital Outcomes" scorecard to meet legislative reporting requirements.

- Migration of the "DMH Snapshot" and "DMH continued reporting" to the RBA scorecard reporting tool
- Exploration of visualization tools to create more responsive reporting.
- Participation in the development of the AHS Community profiles.

Mental Health Payment Reform

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

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

An important program accomplishment from payment reform is that providers are now successfully submitting encounter claims to the Medicaid Management Information System (MMIS), which allows the State to monitor service delivery and other aspects of performance. Additionally, the introduction of value-based payments supports quality improvement and accountability for outcomes. During each measurement year, DMH withholds a percentage of each agency's approved adult and child case rate allocations for these payments.

Integrating Family Services (IFS)

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

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

Both IFS regions continue to utilize the Child and Adolescent Needs and Strengths (CANS) tool to holistically assess both the needs and strengths of the children that they are serving. These agencies are using this monitoring tool to track progress over time. Data are showing that through support and services, children and youth are increasing their strengths and decreasing their needs. The regions are also working to implement the Adult Needs and Strengths Assessment (ANSA).

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

Vision 2030

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

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

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

Following the plan submitted to the legislature in January 2020, DMH was anticipating convening a Mental Health Integration Council in the fall of 2020, to begin the work of implementation. The demands of the COVID-19 pandemic on Vermont's health systems, however, delayed that work. The Mental Health Integration Council kicked off on July 13th, 2021, and the Council has since met twice with subgroups convening on specific topics in between meetings.

Leadership and Reporting Updates

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

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

v. Pharmacy Program

Pharmacy Benefit Management Program

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

Pharmacy Operations

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

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

Operational Activity Reports

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

	No PA	Automated Edits						
Period	**Claims Paid w/o PA**	**Claims Paid w/Auto PA**	**Claims Paid with Auto Edit**	**Claims Paid w/Online Override**	**Claims Paid w/Emergency PA**	**Claims Paid due to Grandfathering**	**Claims Paid w/Clinical PA**	**Total Claim Count**
Quarter 3	454,918	67	19,787	201	87	6,242	15,519	496,821
	92%	<1%	4%	<1%	<1%	1%	3%	100%
Quarter 2	504,934	76	20,752	209	111	6,753	16,241	549,076
	92%	<1%	4%	<1%	<1%	1%	3%	100%
Quarter 1	510,392	90	21,366	245	106	7,724	16,171	556,094
	92%	<1%	4%	<1%	<1%	1%	3%	100%

- The total claim count does not include compounded drugs.

Paid Claims and Drug Spend

MEDICAID

Period	# Claims	# Of Members	State Paid Amounts
3Q2023	449,572	78,868	$72,943,219.31
2Q2023	497,307	86,682	$77,657,154.77
1Q2023	502,093	86,585	$75,372,873.84

VPHARM

Period	# Claims	# Of Member	State Paid Amounts

		s	
3Q2023	60,278	6,587	$1,225,510.29
2Q2023	66,327	6,724	$1,363,657.54
1Q2023	68,177	6,853	$1,957,846.70

- The total claim count does not include compounded drugs.

Provider Communications

Updates to Buprenorphine Prior Authorization Requirements	Vermont Legislature passed Act H.222. Sec 8b of the Act requires the Department of Vermont Health Access (DVHA) allow health care providers practicing in an office-based opioid treatment program to prescribe up to 24mg of the preferred buprenorphine formulation(s) without prior authorization. Effective 10/6/23, the maximum daily dose for Buprenorphine/naloxone tablets and Suboxone® (buprenorphine/naloxone) films will change from 16mg to 24mg/day. Quantity limits will also be modified accordingly: 4mg = 1 film per day,8mg = 3 films or tablets per day, or 12mg = 2 films per day. No quantity limit applies for the 2mg dosage form
Covid-19 Vaccinations 2023/2024 Season for Adults and Children	The 2023-2024 updated COVID-19 vaccines will be active in the Pharmacy Point-of Sale system effective 9/22/2023 with claims processing retroactively to the effective date of 9/11/2023. DVHA-enrolled pharmacies may be reimbursed for injectable COVID-19 vaccinations administered to adults 19 years and older who are enrolled in Vermont's publicly funded programs, participation in the Vermont Child Vaccine Program (VCVP) is mandatory for providers who wish to provide vaccinations to children under age 19 insured by Vermont Medicaid. Pharmacies who wish to get reimbursed for administering vaccines to Medicaid-eligible children must enroll in the VCVP program. Currently covered COVID-19 vaccines: Comirnaty (Pfizer), Novavax, Spikevax (Moderna). Pharmacies are reimbursed for the ingredient cost and administration fee for COVID-19 vaccines.
Reminder: Vermont Medicaid \Billing with Primary Commercial Insurance	The Department of Vermont Health Access (DVHA), in conjunction with the Coordination of Benefits Unit and the PBM, Change Healthcare, has reviewed many claims in recent months that were not appropriately billed to the primary commercial insurance prior to billing Vermont Medicaid. As a reminder, pharmacies are required to bill a member's primary commercial insurance before billing Vermont Medicaid as the secondary payer.
Auto Refill Language added to the Pharmacy Provider Manual	Changes to the Pharmacy Manual regarding automatic refills for Medicaid members. Vermont Medicaid does not pay for prescriptions that are not medically necessary or for individuals who are no longer eligible for Vermont Medicaid. Providers may not use automatic refill systems to deliver or provide prescriptions to members. Members and

	providers may not agree to waive the requirements of this section. Providers may contact members to initiate a refill, but members must choose to fill each prescription, and providers must determine that the member remains eligible for Vermont Medicaid before providers deliver or dispense the prescription.
Pharmacy Billing for Blood Pressure Monitors	The Vermont Medicaid Pharmacy program will begin covering blood pressure monitors obtained through pharmacy providers, effective 09/22/2023. This change will allow access to blood pressure monitors at Vermont Medicaid enrolled pharmacies. Reimbursement for claims will be priced at the "lower of" methodology as described in the Pharmacy Provider Manual. A Professional Dispensing Fee of $11.13 may apply. This methodology ensures that blood pressure monitors are reimbursed at no more than the DME payment amount.
Influenza (Flu) 2023/2024 Season	DVHA-enrolled pharmacies may be reimbursed for injectable influenza vaccinations administered by pharmacists to adults 19 years and older who are enrolled in Vermont's publicly funded programs. Pharmacists must be enrolled with Vermont Medicaid, certified to administer vaccines in the State of Vermont and must be compliant with all Vermont laws governing vaccine administration. Failure to comply with all Vermont immunization regulations will subject these claims to recoupment. No PA required for Afluria®, Fluarix®, FluLaval®, and Fluzone®.
Pharmacy Newsletter	Pharmacy Newsletter was sent to pharmacies around recent communications which included changes to incontinence supplies, state of emergency flooding extension, administration fee for vaccines, tobacco cessation, over the counter changes, DUR Board new member, and upcoming meeting dates.
SCC13 Extension Due to Flooding	In continuation to the communication below, "Important Information for Medicaid Beneficiaries", changes to point-of-sale will be extended through 08/22/2023.
Changes to Incontinence Supplies for Medicaid	The Vermont Medicaid program contracted with a single vendor who will provide incontinence supplies for Medicaid members, effective 8/15/2023. All medically necessary incontinence products for Vermont Medicaid members will be supplied solely through a single vendor, ActivStyle. This change provides one point of contact to reduce barriers to access, improve member support, provide product options, and distribute supplies at a lower cost. Disposable incontinence supplies include the following products diapers, pull-up/pull-on briefs, under pads, and underwear guard/shield liners.
Changes to Administration Fee for Vaccines	Administration fee for vaccines will be changing from $16.82 to $17.45, effective with DOS beginning 7/1/23.

Important Information for Medicaid Beneficiaries Extension	In continuation to the communication below, "Important Information for Medicaid Beneficiaries", changes to point-of-sale will be extended through 08/08/2023.
Important Information for Medicaid Beneficiaries	In response to the current state of Emergency in VT due to flooding, to ensure that Medicaid beneficiaries have access to the medications they need, The Department of Vermont Health Access (DVHA) temporarily re-activated SCC 13 as an allowable NCPDP submission clarification code in the adjudication of pharmacy claims. Changes to point-of-sale will be effective from 7/13/23-7/25/23. This code was utilized by the dispensing pharmacist when processing an early refill for the patient and indicates that an override is needed based on an emergency/disaster situation recognized by the payer. The use of SCC 13 will override a Reject 79 (Refill too soon)

Clinical Activities

Hypertension Promoting Interoperability Program (PIP)

The Department of Vermont Health Access (DVHA) is required to run a program of formal and informal performance improvement projects (PIPs). The goal of these PIPs is to make improvements over time on a chosen topic. DVHA chose to focus on hypertension and created a Hypertension PIP program. The goal of this program is to implement increased monitoring and reductions in blood pressure values among members.

One of the goals for this program is to expand access to blood pressure monitors for Vermont Medicaid members. Those with high blood pressure are more likely to get their pressures under control if they record the values at home and share the results with providers. Close monitoring of a member's blood pressure will allow faster medical intervention and may reduce medications utilized and doctor or emergency department visits.

The Vermont Medicaid Pharmacy program began covering blood pressure monitors obtained through pharmacy providers, effective 09/22/2023. Pharmacists will be able to order and dispense blood pressure monitors to Medicaid members, when medically necessary. The Automated Blood Pressure Monitor clinical criteria used to determine medical necessity can be found on the DME criteria page, located on DVHA's website, https://dvha.vermont.gov/sites/dvha/files/doc_library/BloodPressureSet-Up%20for_web.pdf.

This change will allow access to blood pressure monitors at Vermont Medicaid enrolled pharmacies. Reimbursement for claims will be priced at the "lower of" methodology as described in the Pharmacy Provider Manual. A Professional Dispensing Fee of $11.13 may apply. This methodology ensures that blood pressure monitors are reimbursed at no more than the DME payment amount.

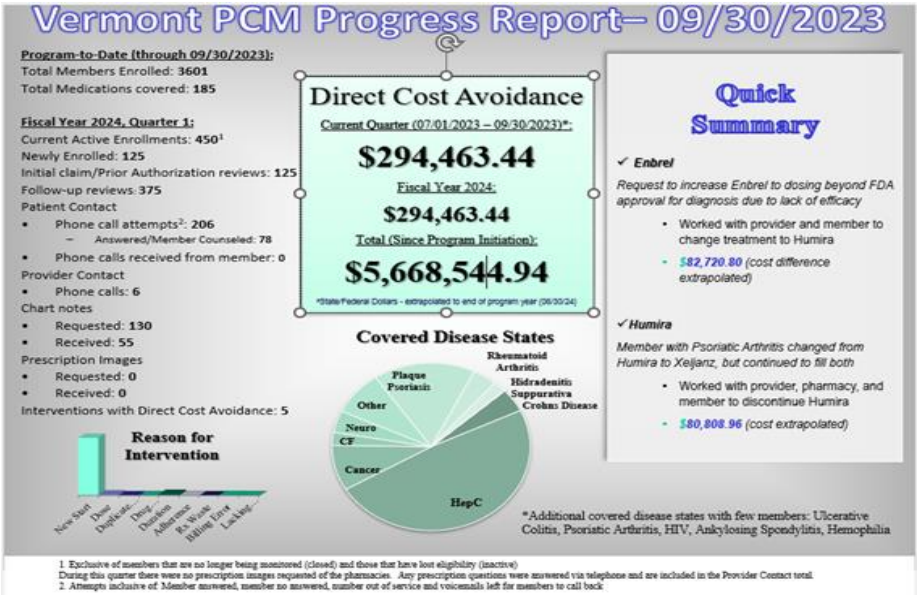
Pharmacy Cost Management (PCM) Program

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

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

Change Healthcare (July 1, 2023, through September 30, 2023). Change Healthcare Pharmacy Management Reporting Suite is a collection of reports recording the process and progress of PCM.

In the third quarter of 2023, the PCM program enrolled an additional 125 members for a total of 3,601 members on 185 unique medications. The program is actively monitoring 450 enrollees. A total of 206 outgoing telephone calls were placed to members, 78 of which resulted in member counseling. During this quarter of the Vermont PCM program, five interventions led to direct and measurable cost avoidance. Furthermore, interventions that do not bring about direct cost avoidance are in place to encourage adherence and thus improve member outcomes and avoid unnecessary medical costs. Through interventions in the PCM program, unnecessary drug spends of $294,463.44 avoided in the third quarter of the state fiscal year 2023. More than $5.6 million in unnecessary drug spend has been avoided throughout the program.



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

Key updates from QE092023:

- Continued conducting financial reconciliation activities for the 2022 performance year, in order to determine financial and quality performance. Results will be available in early Q4 2023.
- Entered into contract amendment negotiations with OneCare for a 2024 performance year.
- Continue to support Vermont's broader efforts to develop an integrated health.

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

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

DVHA and OneCare entered into a subsequent agreement for the 2022 performance year after an RFP was released in mid-2021 for ACO services and OneCare was selected as the 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 and OneCare executed a contract amendment for a 2023 performance year of the VMNG program in Q4 of 2022. Programmatic changes to the model were minor in many areas, with more significant changes around OneCare's care model and care management requirements and minor adjustments to the model's Value-Based Incentive Program. A minimal number of changes in the majority of programmatic areas ensures program stability and continued alignment across payer programs as part of the Vermont All-Payer ACO Model.

DVHA began financial reconciliation activities for its 2022 performance year in Q1 2023 and continued those activities into Q2 and Q3 of 2023. Reconciliation activities will determine the ACO's spend as compared to their financial target and quality performance for the 2022 performance year. Final reconciliation results will be available in early Q4 2023.

DVHA entered into contract negotiations with OneCare for the 2024 performance year in late Q2 of 2023, which continued through Q3 of 2023. Potential changes to the program for the 2024 performance year include minor modifications to the quality component of the program and the inclusion of a pilot payment model for hospitals and independent physician practices participating in the VMNG program called the Global Payment Program (GPP). Other anticipated programmatic changes are minor. Negotiations are expected to continue into Q4 of 2023, and an executed amendment to the contract is anticipated to be in place for January 1, 2024.

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 July – September 2023 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 third quarter of DY19 of the GC Waiver. Vermont calculates

$1.1378B for without waiver expenditures and reported $1.102B in with waiver expenditures, leaving a savings subtotal of $48.26M. There are also 10 Hypothetical Tests for various demonstration groups. The hypothetical tests for New Adult, SMI IMD, Maternal Health & Treatment Services, CRT, Moderates, and Marketplace Subsidies reflect a surplus. Whereas the test for SUD IMD, Global Rx shows a moderate deficit. The total of the deficit is $3M which reduces the cumulative Waiver savings to $48.26M. 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 $74.8M in expenditures for the quarter which leaves $110.2M available for the remainder of DY19.

Vermont continues to implement HCBS programs using the Reinvestment funds under the American Rescue Plan of 2021. For QE0923, Vermont reported $4.7M in Program expenses, $7M in Investments, and $743k 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
ABD - Non-Medicare - Adult	**38,226**	**66,436**
ABD - Non-Medicare - Child	**8,739**	**16,528**
ABD - Dual	**136,650**	**206,587**
Non ABD - Non-Medicare - Adult	**112,369**	**158,752**
Non ABD - Non-Medicare - Child	**378,139**	**554,906**
Hypothetical Groups		
New Adult	**454,502**	**676,605**
SUD - IMD ABD	**51**	**98**
SUD - IMD ABD Dual	**70**	**118**
SUD - IMD Non ABD	**121**	**99**
SUD - IMD New Adult	**623**	**937**
SMI - IMD ABD	**55**	**93**
SMI - IMD ABD Dual	**10**	**22**
SMI - IMD Non ABD	**20**	**161**
SMI - IMD New Adult	**174**	**265**
Housing Pilot	**0**	**0**

Maternal Health and Treatment Services	**114**	**259**
CRT	**1,213**	**1,723**
SUD CIT	**0**	**0**
VT Global RX	**55,178**	**81,239**
Moderate Needs Group	**731**	**1,036**
Marketplace Subsidy	**60,841**	**105,439**

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 3). Member Services works to resolve the issues raised by beneficiaries, and the reports are seen by several management staff at DVHA.

The second mechanism to assess trends in beneficiary issues is the Managed Care Grievance and Appeal report. This report is based on data entered by grievance and appeal coordinators in various locations across the MCE. The database into which they enter information helps them track the timeframes for responding to the grievances and appeals, as well as assists DVHA and AHS in monitoring compliance and assessing if there are trends that may benefit from a performance improvement project.

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

VIII. Quality Improvement

Quality Assurance and Performance Improvement Activities

Key updates from QE092023:

- Through the efforts of DVHA's formal PIP team, the Vermont Medicaid program began covering automatic blood pressure monitors through its pharmacy benefit effective 09/22/23.
- Passed the performance measure validation (PMV) audit without errors.
- Achieved a 97.4% fully Met score on the annual Compliance EQR.

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 QE0923 and consists of representatives from all departments within AHS that serve the Medicaid population. The committee continues to structure its work around the federal managed care quality program guidelines and the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of healthcare. Topics addressed this quarter included annual review of compliance EQRO follow-up activities and quality measure reporting for various special health care needs populations.

Formal CMS Performance Improvement Project (PIP)

DVHA's formal PIP topic is the management of hypertension. Project work focuses on activities related to improving members' access to blood pressure monitors, which supports work being done in other parts of the Agency that focuses on provider and patient education and connecting to community resources. Due to this project team's efforts, the Vermont Medicaid program began covering automatic blood pressure monitors through the pharmacy benefit effective 09/22/23. This change allows providers to prescribe at-home blood pressure monitors for members to obtain at a local Medicaid enrolled retail pharmacy. Pharmacies may now dispense at-home blood pressure monitors and obtain reimbursement via pharmacy billing. Blood pressure monitors will continue to be available through the DME benefit as well.

Other Collaborative Quality Improvement Projects

The Quality Improvement team continued to work with the following groups on collaborative QI projects during QE0923:

- The Department of Mental Health on an Agency-wide alternative payment model (APM) for inpatient services delivered by a regional inpatient psychiatric hospital. The purpose of the APM is to add administrative simplicity in claims processing and a predictable cash flow for inpatient stays that are primarily the responsibility of Vermont Medicaid. QI staff continues to contribute quality of care measures and analysis to ensure that cost and quality incentives are aligned in the APM.

- The Department of Children and Families (DCF), the Vermont Department of Health (VDH), and the Vermont Child Health Improvement Program (VCHIP) wrapped up a CMS-sponsored learning collaborative to improve the timeliness of comprehensive health visits for children and adolescents entering foster care. We decided to continue meeting as a team and extend the work we had started. Therefore, during this reporting period, we continued to collect data on our test of change and worked on expanding that test to other areas within the state...

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. During Q2, the hybrid measure production process was completed for five (5) hybrid measures. DVHA's certified HEDIS vendor performed medical record retrieval (MRR) for all five hybrid measures and

abstracted records for three of those measures. DVHA clinicians abstracted the other two measures. DVHA's administrative and hybrid performance measure production processes were audited by an EQRO during QE0923. DVHA passed the performance measure validation (PMV) audit without errors.
CAHPS Experience of Care measures – during QE0923 DVHA's Director of Quality Management finalized all survey materials with the CAHPS vendor including the addition of the Children with Chronic Conditions (CCC) supplemental question set to the annual Child Health Plan 5.1 survey. Surveys will be mailed to a sample of members during Q42023 and will include a QR code again this year for optional online submission.

Results Based Accountability (RBA)/Process Improvement

Results Based Accountability (RBA) scorecards are developed at DVHA for both internal and external performance management purposes. DVHA Quality Unit staff use this tool to create a *Global Commitment to Health* Core Measure scorecard, Experience of Care, and other performance budgeting scorecards. DVHA's largest scorecard, named the Performance Accountability Scorecard includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services. In addition to those mentioned above, scorecards that were newly developed or actively maintained during QE0923 include the following: Dental Benefit, Applied Behavior Analysis and Programmatic Performance Measure Budget.

Vermont Next Generation Medicaid ACO

During QE0923, DVHA's Director of Quality Management received, reviewed, and approved the quarterly VMNG ACO quality management reports. Quality and Clinical staff from DVHA and the VMNG ACO also meet quarterly with a focus on quality measurement and ongoing QI efforts. A representative from the VMNG ACO is also a standing member of DVHA's formal PIP, the topic of which is managing hypertension.

Comprehensive Risk Assessment

Staff from DVHA's Quality, Oversight & Monitoring, and Compliance units 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 QE092023, the risk assessment team:

- lead the annual Compliance EQR audit, on which DVHA achieved a 97.4% fully Met score.
- Submitted the Annual Report on PI Monitoring Activities to AHS
- Collaborated with AHS on revision of network adequacy standards

Global Commitment (GC) Investment review.

AHS Departments are required to monitor and evaluate the performance of their investments on an ongoing basis and subject them to formal review according to a periodic schedule. Performance monitoring is accomplished via a quarterly and annual review of performance information contained in a web browser-based software application (Clear Impact Scorecard). The scorecard includes the following data elements: investment description (i.e., the goal of the

investment, the activities being supported, and information on how they are provided), performance measures (i.e., the data being collected and analyzed to determine if the investment is achieving its desired goal), results (performance measure rates for the most recent reporting period), and an interpretation of the results (i.e., comparing actual to expected rates using performance targets and/or benchmarks and to characterize trends or patterns in the data).

During this most recent quarter, VDH and DAIL highlighted the performance of a subset of their investments. The Clear Impact Scorecards for these investments are included in this report as Attachment 6.

Payment Models & Performance Monitoring

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

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

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 resource lift necessary to address gaps and implement CMS' HCBS quality requirements.

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 Q3, the state worked with their independent evaluator to develop the workplan for the assessment. Key elements of the workplan include milestones, responsible parties, and due dates. Major milestones included the development/implementation of a survey and interviews. Target population is hospitals and residential treatment centers. The evaluator will start with survey administration and allow that to dictate how they target interviews.

Interviews will take place in the first quarter of 2024.

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).

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 worked with an independent evaluator to develop a 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.

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 worked with an independent evaluator to develop a workplan for the assessment of investments. In addition to the workplan, the state and evaluator identified an overall analytic approach and report template for the assessment. 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 work with the evaluator to finalize the workplan and timeline.

PHE Flexibilities

During this quarter, the state worked with an independent evaluator to draft an evaluation design plan for the reasonable opportunity period extension demonstration. This evaluation design plan similarly included the state's hypotheses, evaluation questions and associated measures, and analytic methods. The state plans to submit a final evaluation design plan for the ROP extension demonstration to CMS during the next quarter.

X. Compliance

Key updates from QE092023:
- EQRO Review Activities

External Quality Review

During this quarter, the state's EQRO, HSAG, performed a fully remote version of their annual review of compliance with standards. Activities included a desk review of documents and conducting virtual interviews with key staff members. These annual audits follow a three-year cycle of standards. During this year's review, HSAG evaluated the degree to which DVHA complied with federal Medicaid managed care regulations and the associated AHS intergovernmental agreement (IGA) in eight performance categories (i.e., standards). The eight standards included requirements associated with federal Medicaid managed care standards found at 42 CFR §438.10, 438.12, 438.100, and 438.214–230.

The standards included requirements related to the following:

- Provider Discrimination Prohibited/Provider Selection / Provider Selection
- Provider Selection/Credentialing and Recredentialing
- Information Requirements/Beneficiary Information
- Enrollee Rights/Beneficiary Rights
- Confidentiality
- Grievance and Appeal Systems/Grievances
- Grievance and Appeal Systems/Appeals and State Fair Hearings
- Subcontractual Relationships and Delegation

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

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

Finally, during this quarter, the EQRO conducted Performance Improvement Project Validation activities as described in the Quality Improvement Section of this report.

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 began to draft the CY2024 agreement. The CY2024 IGA and Rate Certification is due to CMS on October 3, 2023.

XI. Reported Purposes for Capitate Revenue Expenditures

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

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

XII. State Contact(s)

Fiscal	Richard Donahey, CFO VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	802-241-0442 (P) richard.donahey@vermont.gov
Medicaid Director	Monica Ogelby Vermont Medicaid Director Agency of Human Services 280 State Drive Waterbury, VT 05671-100	802-338-6643 Monica.ogelby@vermont.gov
Policy/Program	Ashley Berliner, Director of HealthCare Policy & Planning VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	802-578-9305 (P) 802-241-0958 (F) ashley.berliner@vermont.gov
Managed Care Entity	Andrea DeLaBruere, Commissioner of the Department of Vermont Health Access 280 State Drive Waterbury, VT 05671-1000	802-585-5356 (P) 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	QE092023Investments (GC Investments)
Attachment 6	Investment Scorecard(s)
Attachment 7	Payment Model Scorecard(s)

Date Submitted to CMS: November 29, 2023

Attachment 1

Budget Neutrality Wookbook production delayed - to be added at a later date.

Attachment 2

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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

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

Questions, Complaints and Concerns Received by Health Access Member Services
July 1, 2023 – September 30, 2023

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

July 2023:

- **Provider Complaint -** Member requested to document that she cannot find a Dentist in the area that will take new VT Medicaid Patients. She states that she had to pay out of pocket to be able to see a Dentist as they would not accept the GMC Insurance. Member is wanting to be reimbursed for the cost as there are no Dentists that are willing to accept new VT Medicaid patients. The Agent apologized for the inconvenience and documented the feedback and assisted with finding a Dentist in the area.
- **Covered Services -** Member received a text message directing him to DVHA website for the following message that is very concerning to him. The statement" Beginning August 1, 2023, the Vermont Medicaid program will discontinue coverage for over-the-counter melatonin, vitamin D, and antihistamine products for Medicaid members ages 21 and older. This coverage change is a result of changes to the State Fiscal Year 2024 Medicaid budget. These items are available for purchase in grocery stores and pharmacies without a prescription. This change also applies to Medicare members enrolled in VPharm." Member is on MABD and is very concerned he won't be able to afford his antihistamines and his Vitamin D . He believes these medicines will cost him 40 dollars a month. He thinks this isn't fair because there was no notice and that he is still recovering from the flood incident.

He says he will call the Governor's office as well. The Agent apologized for the inconvenience and documented the feedback.

- **Covered Services –** Caller, on behalf of her son, (listed as a part of HH in CRM) called as she got a letter stating that as of 08/15/23 they would have to contact XXXXXX as they are going to be the new, sole vendor for incontinence supplies. Caller finds it easier to order diapers for her son from another vendor as she has been getting the right order always and on time. Sandra states it would not make things easier for them as they do not even know if XXXXX has the diapers that her son uses and also it took them a while to find the right diapers. The Agent apologized for the inconvenience and documented the feedback.
- **Covered Services -** Caller stated she got a letter that their incontinence supplies should be ordered from XXXXXX. She said that the style and brand she needs is not available with them. She wished to submit negative feedback as her autistic grandson would have trouble using the brand and style available through the new supplier. Initially it had taken lot a time to adjust to the style he has been using now. Caller said that it would be difficult for her to get him use to the new style again. The Agent apologized for the inconvenience and documented the feedback.

August 2023:

- **Provider Complaint -** Member requested to document feedback as he cannot find a dentist in Rutland that accepts Medicaid. Member also does not have transportation to be able to travel to another town. He feels that there should be more dentists that take new patients and accept Medicaid. The agent apologized for the inconvenience and documented the customers feedback.
- **Covered Services -** Member called because she received a letter from DVHA dated 7/24/2023 informing her she must order incontinence supplies from vendor XXXXXX as of 8/15/2023. She says that she has dealt with them in the past and they are very difficult to deal with. She states the supplies are of inferior quality and the products have actually "given her bloody cuts and rashes". She says they only sell their own brands and she is unable to order any other brand through XXXXXX. She thinks this is unfair because she is now unable to receive the products that work for her and won't cause her harm. The agent apologized for the inconvenience and documented the customer’s feedback. They also mailed the customer a Medical Exception Form.
- **Covered Services -** Member requested to document feedback as she is concerned with the lack of benefits provided by VT MCA for addicts to receive rehab. She states that it is a disease just like cancer, and for VT to serve as one of the highest statics in death amongst addicts in the Nation; the 2 week program set in place on MCA is not realistic. She says that most rehabs are $1000.00 per day and this is why so many of her friends have lost their children. She says she just wants to save her son's life and needs some help. Please do more. She also wants to state that NH & MA has much extensive MCA coverage for addicts offering as little as a year to assist in the recovery of. The agent apologized for the inconvenience and documented the customers feedback. They also mailed the customer a Medical Exception Form.
- **Provider Complaint -** Member requested to submit negative feedback against the provider XXXXXX. She has been going to XXXXXX for 20 years. She was prescribed ten Valium a month, on 02/27/23 her horse died. Her horse died of severe Colic and is now disabled with PTSD. She needs Valium when she is upset. XXXXXX refused the prescription. She

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
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had documentation in hand approving the need for the prescription. She was forced to leave the practice. She states that made the trauma much worse. She is upset XXXXXX sent her prescription to XXXXXXX and they were ones who approved the prescription. She started with another provider 04/17 and requested all her medical records be transferred. She no longer goes to the XXXXXXXX practice and does not want to deal with them. She states it's retraumatizing. The agent apologized for the inconvenience and documented the customers feedback.

- **Covered Services -** Member is calling to document Feedback regarding the new DME supplier XXXXXXX. She states that the products she received were not up to standards, compared to the old supplier. She states she would have to use multiple products at once to fulfill one task. The agent apologized for the inconvenience, documented the feedback and offered to mail the customer a Complaint Form.
- **Provider Complaint -** Member requested to file negative feedback as he feels his doctor is not being responsive to his needs. He believes that they are not being responsive to his needs as his health is going downhill and they haven't done anything to make him get better. He seems to believe he has some sort of lime disease. The agent apologized for the inconvenience, documented the feedback and referred the customer to Legal Aid as well as advised they can switch doctors at any time.

September 2023:

- **Provider Complaint** - Member wanted to submit negative feedback as she hoped it would help to get the word out that there are no dentists available in the area. She states she has called over 40 different dental offices attempting to get in and none are accepting new VT Medicaid patients. The agent apologized for the inconvenience, documented the feedback.
- **Provider Complaint** - Member called to document negative feedback, as she tried calling many Dentists in VT but they are not accepting new patients. She would like to submit this as feedback as it is very hard to find the Dentists. She also mentioned the system is not updated and the Doctors who shows they accept new patient in the system, when she calls they are not accepting any new patients. The agent apologized for the inconvenience, documented the feedback. The agent also provided some dentists that are a little further out from their area.
- **Provider Complaint** - Member called to request to speak with a supervisor. She wanted to document another negative feedback SR as she had to pay out of pocket for Dental services, due to all the dentists in her area not accepting Medicaid. She states she wants to know what is being done by the SOV to improve access to Dental care for people on Medicaid. The supervisor apologized for the inconvenience, documented the feedback. They also provided the customer with Community Resources information and VLA's phone number.

- **Covered Services** - Member called to document negative feedback. His son is running out of pull-ups and the vendor XXXXXXX states they have no idea when his size will be back in stock. XXXXXXXX sent another sample size that do not fit him. When he spoke with XXXXXXX management they told him this issue has been going on for a few months, and that other sizes are also on back order. He asked if he could pay out of pocket and be reimbursed which we are unable to reimburse individuals. He asked to change vendors which is also not possible. He says it's not fair that SOV changed vendors that can't fulfil the order and that he has to pay out of pocket several hundred dollars a month XXXXXX to get his son the necessary products. The agent apologized for the inconvenience, documented the feedback and offered to mail out a Medical Exception Form.

Attachment 3

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
July 1, 2023 – September 30, 2023

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data from the centralized database that were filed from July 1, 2023, through September 30, 2023.

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 thirteen grievances filed and two 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, 69% were filed by the beneficiary, and 31% were filed by a representative. DMH had 84%, DAIL had 8%, and VDH had 8% of the grievances filed.

Grievances were filed for service categories mental health, case management, community social support, and staff contractor issues.

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 thirty-nine appeals filed. Of these thirty-nine appeals, twenty-four were resolved (62%), one was untimely (2%), three were withdrawn (8%), and eleven (28%) were still pending.

Of the twenty-four appeals that were resolved this quarter, 92% 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.

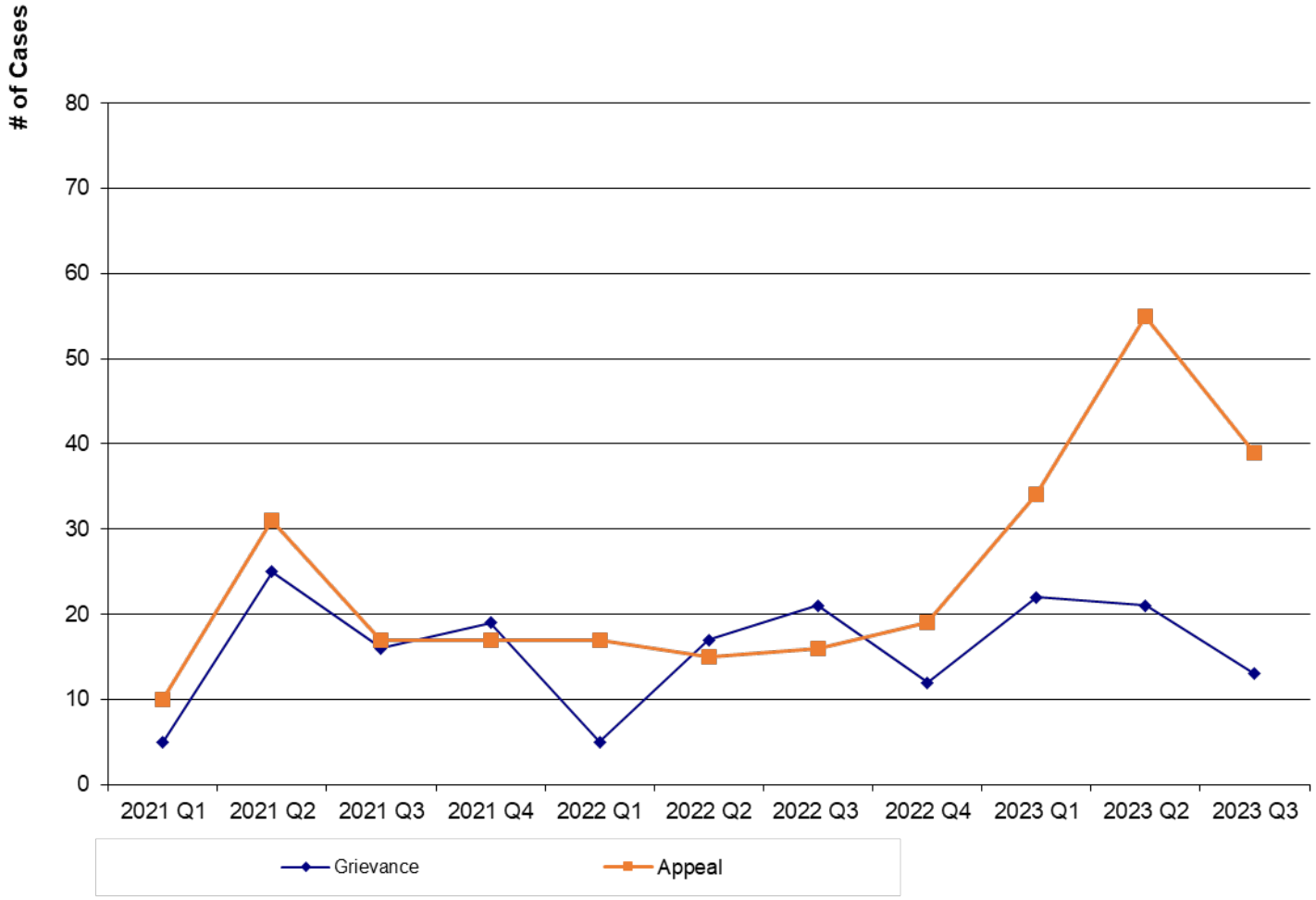
Of the thirty-nine appeals filed, DVHA had thirty-one appeals filed (79%), DAIL had six (15%), DMH had one (3%) and VDH had 1 (3%).

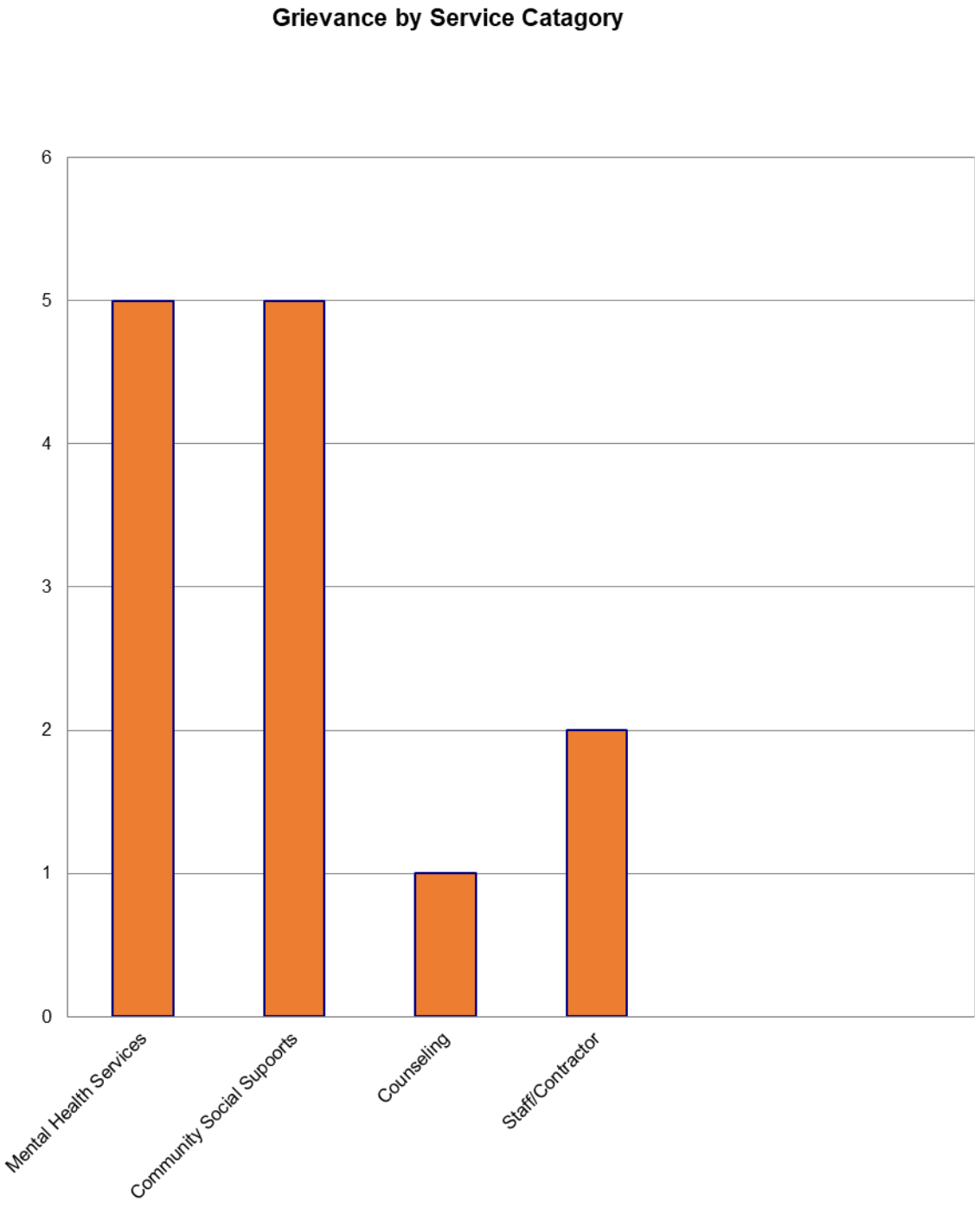
The appeals filed were for service categories dental, outpatient hospital, personal care, prescription, supplies, mental health, developmental and transportation.

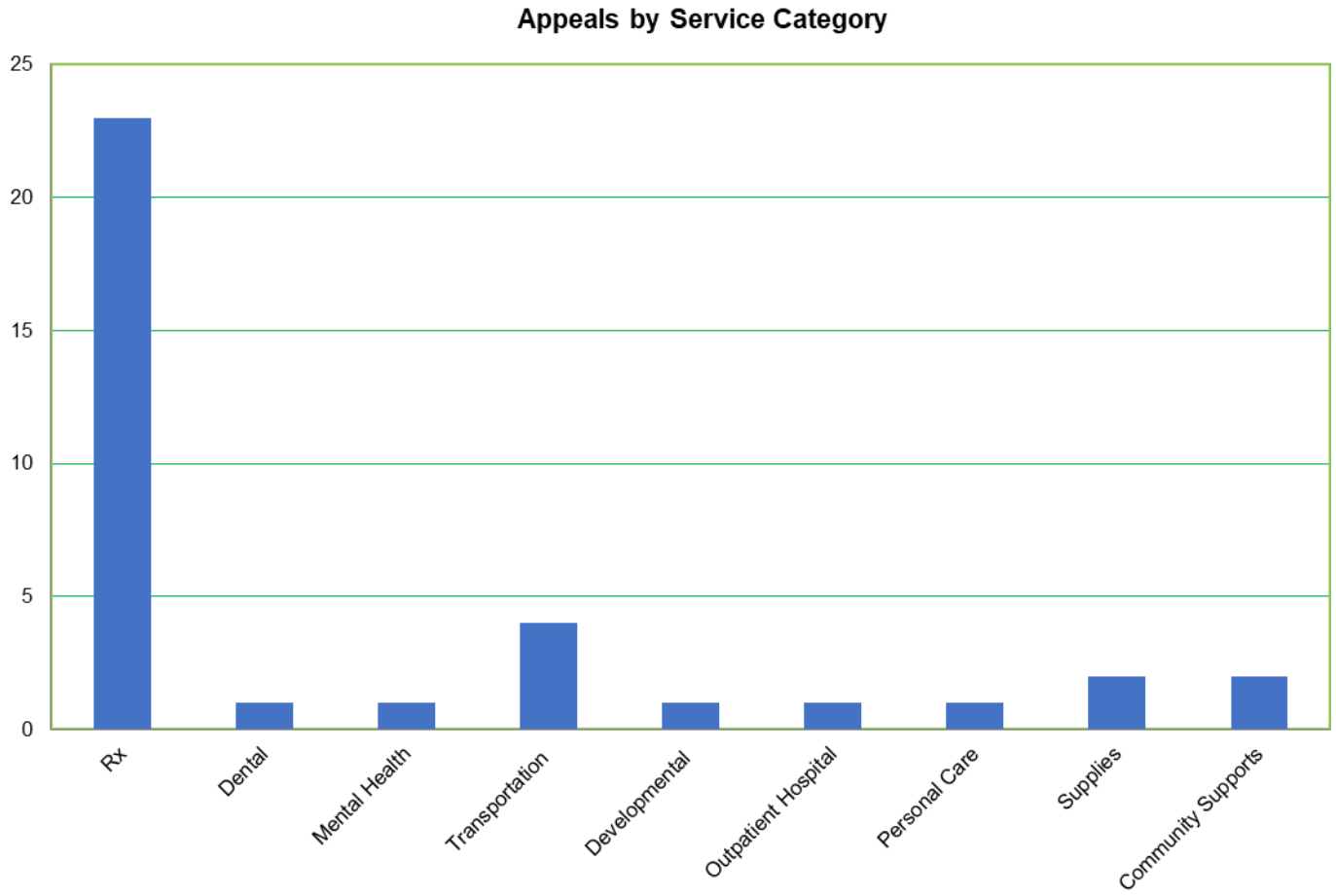
Beneficiaries must exhaust the internal appeal process before they can file a fair hearing if their appeal is not decided in their favor. There was one fair hearing filed this quarter.

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

Grievances and Appeals
January 1, 2021 thru September 30, 2023




Grievance by Service Catagory
6
5
4
3
2
1
0
Mental Health Services
Community Social Supoorts
Counseling
Staff/Contractor


Appeals by Service Category
25
20
15
10
5
0
Rx
Dental
Mental Health
Transportation
Developmental
Outpatient Hospital
Personal Care
Supplies
Community Supports

Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

July 1-September 30, 2023

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

October 21, 2023

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 856 cases this quarter (859, the previous quarter). In this quarter, many Vermonters were grappling with the after-effects of July's catastrophic flooding. The flooding impacted the Medicaid renewal process. Many Vermonters were not able to respond to renewals, or even get mail due to flooding disrupting mail services or destroying their homes. VHC granted extension to those impacted by the flooding in July and August. This meant if you had not completed your renewal when the flooding happened in July, you had an extra month. Those with renewals due in August also had an extra month. The HCA worked to help consumers understand the extensions, and the renewal process. VHC also created a new special enrollment period for those impacted by the flooding. The HCA advocates have already been advising Vermonters on the new special enrollment period, and it is continuing to do outreach and education on the Medicaid renewal process.

The HCA continues to meet regularly with the VHC to discuss issues and give feedback about the renewal process, including providing comments on VHC notices. The HCA also met with CMS for a second time to discuss issues with the Medicaid renewal process in Vermont.

Vermonters often call the HCA when they transition to Medicare and find that they cannot afford Medicare costs. This quarter the Helpline spoke to 253 households about Medicare questions regarding eligibility, enrollment, cost, and coverage. We spoke to 29 households about eligibility for Medicare Savings Programs, which help pay for Medicare premiums and cost-sharing. Our webpage on Medicare Savings Programs had 391 page views. In response to this clear need, the HCA launched a Medicare Affordability survey, so we could have a more in-depth understanding of the expenses Vermonters face when they move onto Medicare. HCA advocates often hear how Vermonters struggle to afford Medicare, and this was echoed in most of the nearly hundred survey responses. One respondent noted, "I am paying more for premiums for Medicare and Supplemental coverage than I was paying under Vermont Health Connect. I expected it to be the opposite." Another added, "The premiums are more with much less

Ollie's Story

Ollie called the HCA because he was running into multiple problems and delays with his Medicaid application. Ollie had been covered by Dr. Dynasuar, but he turned nineteen and was no longer eligible for that program. Eligibility for Dr. Dynasuar goes up to age nineteen. He was temporarily leaving Vermont to go back to school for the semester, and he wanted to make sure that he had insurance coverage in place. The HCA advocate learned that Ollie had already applied, but VHC never received that application. Ollie then completed the VHC application for a second time, but VHC made an error processing it. During the summer, Ollie was working a temporary summer job that lasted for only two months. When VHC did its income calculations, however, they considered it a full-time, year-round job. This error made it look like Ollie earned a lot more income than he did. Ollie tried to correct the income mistake, but he was not able to fix it. VHC still had the incorrect income. The HCA advocate was able to resolve the income issue and get VHC to update Ollie's correct income, and helped Ollie submit paystubs to verify his actual income. When his income was verified, VHC approved him for Medicaid for Children and Adults which meant he would be able to start his semester with coverage in place.

coverage - I just don't go to the doctor anymore because of the deductible and copays - I never know what they will be and can't take the chance." The HCA will primarily focus on increasing Medicare affordability for low-income Vermonters this coming legislative session. We continue to advocate for increasing the income limits for Medicare Savings Programs (MSPs). The MSPs pay for Medicare Part B premiums, and in some cases pay Medicare cost-sharing.

The HCA also worked to keep its own website updated with renewal information. This past quarter we had 1785 page views of our webpage on Medicaid limits, 607 of the webpage about VHC and Medicaid, and another 418 on our page about Dr. Dynasaur. Medicaid eligibility was the issue that the Helpline received the most calls about. Dental and prescription access calls were in the top five issues. Our dental services webpage was the second most popular with 1370 page views. We talked to 34 households about dental access. Our news item titled “Medicaid renewals Re-started” had 175 page views. We also had 56 page views for our news item about the new special enrollment period due to the flooding in July. In addition to calling, Vermonters can contact the Helpline on our website, and this past quarter we had 118 online help requests.

During the quarter, the HCA presented two training courses for the Area Agencies on Aging. The first was about eligibility for Medicaid for Aged, Blind and Disabled, and in the second training we discussed eligibility for all types of state health care programs including Medicaid, VPharm, Medicare Savings Programs and Dr. Dynasuar. Advocates from across the state attended both of the trainings, as well as attorneys and paralegals from Vermont Legal Aid and Legal Services Vermont. This quarter, the HCA advocates also attended the annual assister conference in preparation for Open Enrollment. The HCA advocates are preparing to do more outreach about Vermont Health Connect Open Enrollment and Medicaid renewals. The HCA expects call volume about Medicaid eligibility and VHC to increase next quarter as Open Enrollment starts.

Case Stories:

Danica's 's Story:

Danica called the HCA because she could not afford her VHC plan. When she first applied to VHC, she believed she would be eligible for several hundred dollars of Advance Premium Tax Credit (APTC) to help pay for her premium for coverage for herself and her partner. Her children qualified for Dr. Dynasuar. Her children were approved for Dr. Dynasaur coverage, but when they received the first premium, she was getting less than fifty dollars per month in APTC. She could not afford the plan with so little APTC. The HCA advocate investigated and found that VHC had made an error in calculating the income. Eligibility for APTC is based on your projected annual income. VHC used Danica's income from the prior year, which included income from a job that she no longer had. Her annual income for the current year was projected to be much lower than the amount that VHC was using. The HCA advocate helped Danica update her income with VHC, and the APTC was re-calculated. Danica and her spouse were eligible for several hundred dollars of APTC per month, which made the VHC plan much more affordable for them.

Marina's Story:

Marina called the HCA after her Medicaid coverage closed. She was already enrolled on Medicare Part A and Part B. But she was not on a Part D prescription drug plan. She was undergoing treatment for a serious medical condition and needed expensive prescriptions. The HCA advocate explained that that because Marina's Medicaid had closed, she had a special enrollment period to enroll on a Part D plan. Normally, you can only enroll on a Part D plan during Open Enrollment, or if you have a special enrollment period. Under the Part D enrollment rules, the loss of Medicaid qualifies as a special enrollment period. However, when Marina tried to enroll, the drug plan incorrectly told her that she was not eligible to enroll. The HCA advocate intervened and helped submit a Medicaid closure notice to show that Marina qualified for a special enrollment period for the loss of Medicaid. With the notice, the plan allowed Marina to enroll. However, her problems were not over. Marina later got a notice that she was going to be assessed a late enrollment penalty each month. If you do not enroll in Part D when you are first eligible, you are assessed a late enrollment penalty (LEP). The LEP means you must pay a penalty on top of your normal premium. However, if you can show that you had credible prescription coverage for the time you were not enrolled on Part D, you should not be assessed an LEP. It is important to appeal a LEP within the 60-days of the notice of it, or you will miss your time frame to appeal. The HCA advocate helped with the LEP appeal. Marina was able to show she had credible drug coverage, and the LEP was removed. Marina isnow on a Part D plan with a monthly premium she could afford.

Sebastian's Story

Sebastian called the HCA because he needed to pick up critical medical supplies, and he could not afford them. He had applied for Medicaid but did not understand why the application was taking so long. When the HCA advocate investigated, she found that the application was still pending. Sebastian had tried to upload some pay stubs to verify his income, but the upload had not worked, which meant that Sebastian had not been approved and did not have active coverage. The HCA helped Sebastian re-upload the documents to VHC, and he was approved for Medicaid for Children and Adults. This meant Sebastian was able to pick up his medications. Medicaid copayments range from $1 to $3. Sebastian also told the HCA advocate that he was starting a new job the next month. The job would put him over the Medicaid income limit. The HCA advocate explained to Sebastian how to report his income when his job

started, and how he would have a special enrollment period to sign up for a VHC plan after his Medicaid ended. Although the income from his new job would put him over the Medicaid limit, he was still going to be eligible for substantial APTC to help pay for his monthly premium.

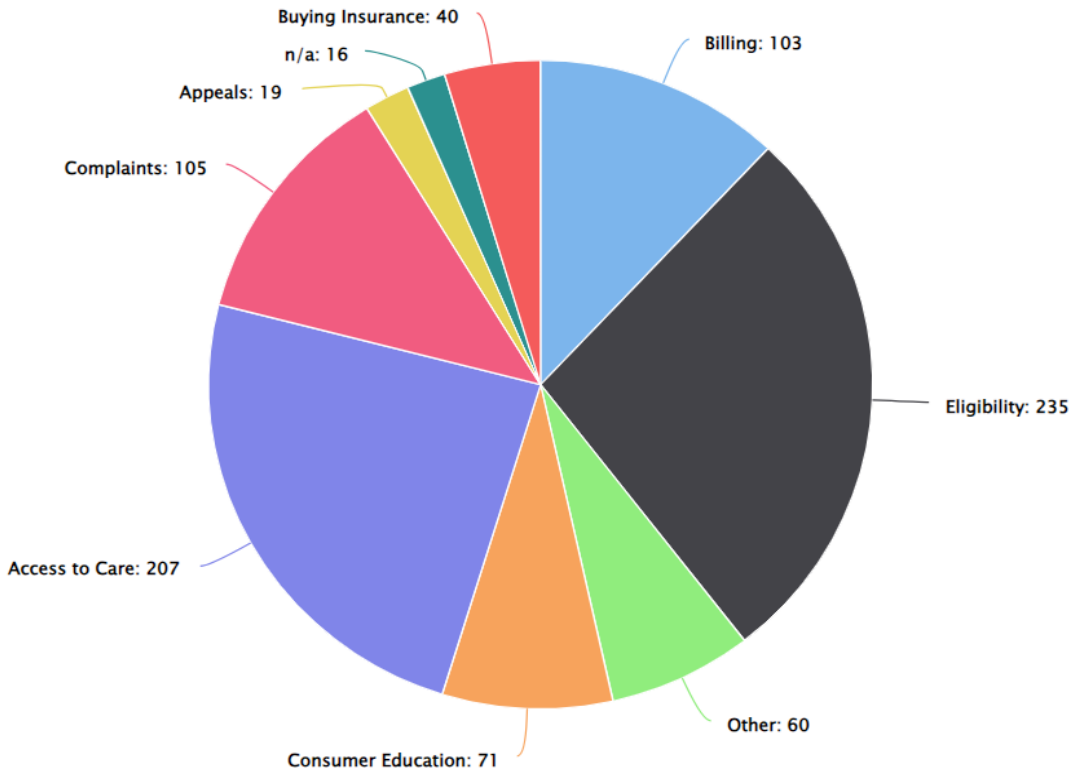
Overview

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 856 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 more than half of all HCA calls. . Callers' primary issue category were as follows:

Chart: Q3 FY2023 Number of Cases by Primary Issue



** 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.

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 499 out of the 856 cases.

Chart: Q3 FY2023 Number of Cases by Insurance

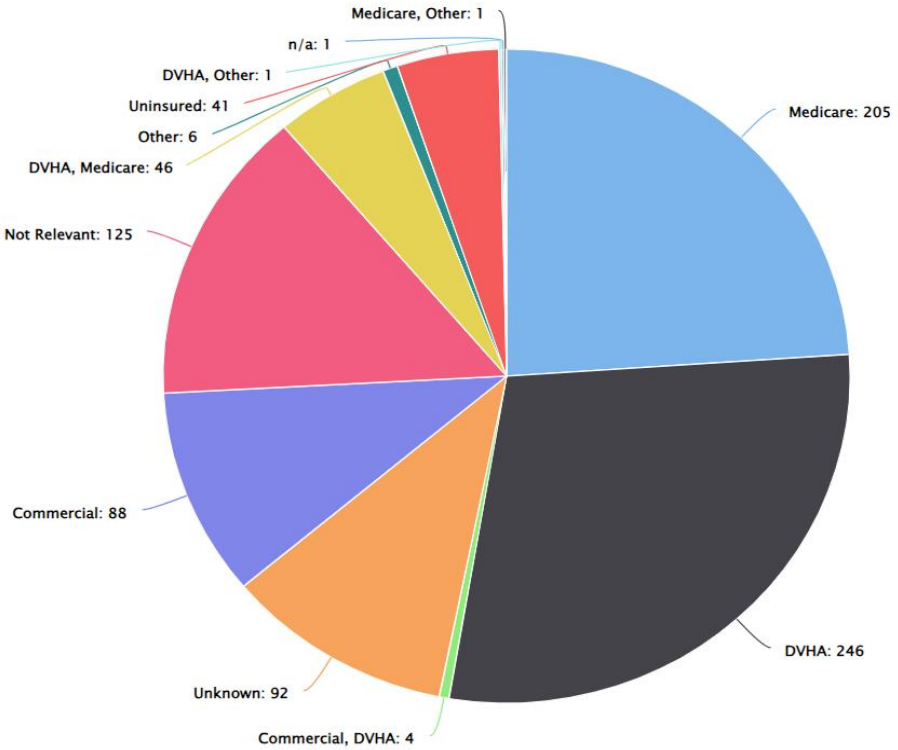


Table: Top Ten Primary Issues of Q3 FY2023:

All Cases

Top Ten Primary Issues

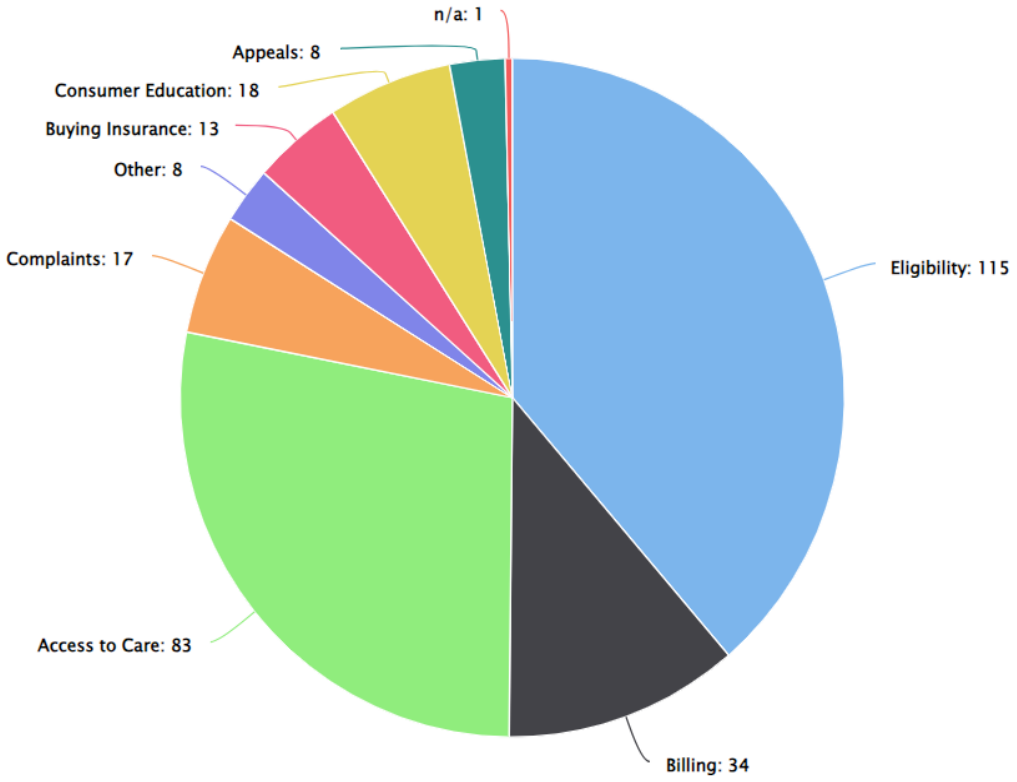
1. **Eligibility for Medicaid-MAGI 67**
2. **Complaints-Provider 54**
3. **Access to Care -Prescription Drugs 37**
4. **Access to Care -Dental & Dentures 34**
5. **Eligibility Medicaid-Non-MAGI 30**
6. **Eligibility for Medicare Savings Programs 29**
7. **Complaints Hospital 25**
8. **Consumer Education-Medicare 20**
9. **Buying Insurance- QHP-VHC- 20**
10. **Access to Care Primary Care 16**

DVHA Cases: total of 297 of 856 total cases

Top Ten Primary Issues

1. **Eligibility for Medicaid-MAGI 41**
2. **Eligibility for Medicaid-non-MAGI 16**
3. **Access to Prescription Drugs 15**
4. **Access to Dental 10**
5. **Access to Care Transportation 9**
6. **Buying Insurance-QHP- VHC 8**
7. **Complaints Provider 8**
8. **Eligibility Medicare Savings Program 8**
9. **Eligibility Long Term Care Medicaid 8**
10. **Consumer Education DVHA 7**

Chart: Q3 FY2023 Number of DVHA cases by Primary Issue



Uninsured Cases: total 42 out of 856 cases

Top Three Primary Issues

1. **Eligibility for MAGI Medicaid 12**
2. **Buying Insurance QHP-VHC 6**
3. **Access to Care Dental, Access to Urgent Medical Need, Consumer Education Grace Periods, Appeals Fair Hearing Eligibility, Access to Care Mental Health, 2 each**

Commercial Cases: total of 92 out of 856 cases

Top Ten Primary Issues

1. **Eligibility for MAGI Medicaid 6**
2. **Eligibility for Premium Tax Credit 6**
3. **Buying Insurance-QHP-VHC 5**
4. **Billing Claim Denials 5**
5. **Eligibility for Katie Beckett Medicaid 4**
6. **Appeals Covered Services 4**
7. **Billing Out Network Claim 3**
8. **Access to Care Prescription Drugs 3**
9. **Appeals Fair Hearing Eligibility 3**
10. **Access to Care DME 2**

Overall Cases Resolution Q2SFY2023

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 Q3FY2023

Brief Analysis and or Advice	403
Direct Intervention	46
Complex Intervention	60
Brief Analysis and or Referral	254
Case Still Open by the End of the Quarter	592
Duplicate Case	35
Other	3
Client Withdrew	1
Test Case	5

Highlights of HCA Outcomes Q3SY2023

During this quarter, we provided **563 households with consumer education**. We got **16 households** on insurance, and estimated eligibility for insurances for another **37 households, and assisted 7 households with applications for insurance**. We helped **10 households** get services covered. We also helped **5 households** get coverage with the Immigrant Health Insurance Plan. We help **two households**

get on the **Breast and Cervical Cancer Treatment Program** and helped **another two** with eligibility for **Medicaid for the Working Disabled**.

Consumer Protection Activities

Rate Review

The HCA reviews and analyzes all commercial insurance carrier requests to the Green Mountain Care Board (Board) to change premium prices. The Board issued decisions on six premium price change requests during the quarter from July 1, 2023, through September 30, 2023. One premium price change request was pending at the close of the quarter.

BCBSVT submitted four premium price change requests decided by the Board this quarter: the BCBSVT 2024 Small Group filing, with a requested increase of 14.5% affecting roughly 21,943 Vermonters; the BCBSVT 2024 Individual filing, with a requested increase of 15.5% affecting roughly 18,517 Vermonters; the BCBSVT Association Health Plan filing, with a requested increase of 7.2% affecting 1,454 Vermonters; and the BCBSVT 2024 LG Unit Cost Trend filing, with a requested increase of 2.8% in addition to the 9.8% approved by the Board in May affecting 5,785 Vermonters. The HCA appeared on behalf of Vermonters in each of these filings. For the Small Group and Individual filings, the HCA reviewed documents and submitted pre-hearing questions, facilitated public comments, engaged in oral advocacy and cross examination of BCBSVT and Board witnesses at the rate hearing, and filed post hearing memorandums. For the Association Health Plan and Large Group Unit Cost Trend filings, the HCA reviewed documents and submitted memorandums in lieu of hearing. The Board approved, but downwardly modified, each rate request, including the Small Group rate increase, which was cut to 13.3%, and the Individual rate increase, which was cut to 14%.

MVP submitted three premium price change requests this quarter. The Board decided on two of these requests this quarter: the MVP Small Group filing, with a requested increase of 12.5% impacting roughly 16,262 Vermonters; and the MVP Individual filing, with requested increase of 12.8% affecting roughly 11,602 Vermonters. The HCA has appeared on behalf of Vermonters in these two matters engaged in the following activities: reviewed documents and submitted pre-hearing questions, facilitated public comments, engaged in oral advocacy and cross examination of MVP and Board witnesses at the rate hearing, and filed post hearing memorandums. The third premium price change request filed by MVP this quarter was the MVP 2024 Large Group rate filing, with requested increases ranging from 7.5% to 9.1% depending on group renewal timing, affecting 1,667 Vermonters. The HCA appeared on behalf of Vermonters, reviewed documents, and submitted a memorandum in lieu of hearing. The Board's decision was pending as of the close of the quarter.

Hospital Budgets

The HCA participated in the FY24 hospital budget process by asking questions of hospitals in public hearings in and submitted a *public comment* with recommendations for the Green Mountain Care Board.

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 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 FY24 budget submissions from OneCare Vermont and Lore Health (a Medicare-only ACO). The HCA is prepared to review the budget from Vytalize Health, another Medicare-only ACO, should it decide to submit a budget to the Board for review. Vytalize Health submitted a request to have elements of the regulatory review process waived. The HCA recommended that the Board deny this request because it is important for the Board, the HCA, and the general public to learn as much as possible about Vytyalize, given that it is a new health entity to the state. 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

Over the last quarter, the HCA attended the Board'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 two times this quarter, taking the month of August off. The content of this quarter's meetings included a focus on the Medicaid redetermination process and initial numbers, the DAIL Age Strong Vermont Plan, review of the FY24 Medicaid budget pressures, and discussion of FY25 budget priorities.

Legislative Advocacy

July through August are particularly quiet months for legislative activities. The HCA worked to build a coalition for this coming year's legislative agenda particularly focused on increasing the eligibility thresholds for the Medicare Savings Program. Our Medicare Affordability story telling project should illuminate Medicare affordability challenges and also serve to build momentum for the coming legislative session. In addition, the Chief Advocate started the process of traveling around the state to visit with key legislative to hear from them about their priorities for the session and to promote our agenda of focusing on Medicare Affordability.

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:

- American Civil Liberties Union of Vermont
- All Copays Count Coalition
- Bi-State Primary Care
- Blue Cross Blue Shield of Vermont
- Committee on Vermont Elders
- Department of Financial Regulation
- Families USA
- The Family Room
- The Howard Center
- IRS Taxpayer Advocate Service
- 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 Association of Hospitals and Health Systems
- Vermont Association of Area Agencies on Aging
- 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 – 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 in order to provide the latest and most accurate information to Vermont consumers.

Popular Web Pages

* means the page moved into the top 20 this quarter

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

1. *Health* - section home page – 1,785 page views
2. *Dental Services* – 1,370
3. *Income Limits - Medicaid* – 1,161
4. *Medicaid, Dr. Dynasaur & Vermont Health Connect* – 607
5. *Medicaid* – 483
6. *Dr. Dynasaur* – 418
7. *Medicare Savings Programs* – 391
8. *Long-Term Care* – 383
9. *Resource Limits - Medicaid* – 349
10. *Services Covered – Medicaid* – 343
11. *HCA Help Request Form* – 336 page views and 118 online help requests
12. *Medical Decisions: Advance Directives* – 334
13. *Advance Directive forms* – 293
14. *Patient Financial Assistance & Affordable Medical Care in Vermont* – 270
15. *Choices for Care Income Limits* – 262
16. *Medical Debt* – 242 *
17. *Choices for Care Giving Away Property or Resources* – 235
18. *Vermont Health Connect* – 215
19. *Medicaid and Medicare (Dual Eligible)* – 196
20. *Complaints About Doctors and Other Providers* – 175

This quarter we had these additional news items:

- People Impacted by Flood Can Sign Up for Health Coverage. Those Who Lost Medicaid Can, Too – *56 page views*
- Medicaid Renewal Process Starts Again in April – 175 page views

Outreach and Education

The Office of the Health Care Advocates (HCA) engaged in both in-person and virtual outreach activities this quarter to raise public awareness about our offices' services and provide accessible information about health insurance options in Vermont. Our messaging continued to prioritize providing accurate and accessible information on the Medicaid renewal process. Additionally, our communications efforts focused on sharing insurance access updates resulting from the flooding that took place in July.

We strive to break down the barriers that Vermonters face in understanding and accessing insurance. This goal is especially pertinent now as many members of our community must evaluate their health insurance eligibility as Medicaid renewals continue. We use a hybrid outreach model to advance this goal as we feel that both in-person and virtual resources make our services more accessible to those who face challenges utilizing traditional intake systems such as seniors, people with disabilities, and those with language needs.

During this quarter, we worked to meet our outreach goals by engaging with Vermonters through partnerships with community organizations. We developed referral relationships through the delivery of educational presentations. In recent years we have also focused on creating educational content and circulating these resources via social media. The HCA has also prioritized developing a community presence through participating in tabling events and legal clinics.

We partnered with 21 organizations and participated in 19 outreach presentations and events from July to September 2023. We collaborated with the **Howard Center**, **Area Agencies on Aging**, **the University of Vermont**, **the Family Room**, **AALV, the Central Vermont New Direction Coalition**, and the **Boys and Girls Club**.

The HCA used Facebook, Instagram, and Youtube to connect with community members, legislators, and partner organizations. We used these platforms to share important updates pertaining to Medicaid renewals. Through our partnership with the Vermont Language Justice Project, we continued to circulate educational videos on Medicaid and insurance access in 18 languages. These videos have received over 700 views this past quarter.

We also utilized Facebook and Instagram to share updates related to Dr. Dynasaur premiums and reinstatements. This content was shared by 16 organizations across Vermont.

The HCA also focused on increasing our community presence by participating in tabling events across the state. At the end of August, we took part in student orientation on college campuses. We participated at resource fairs at the University of Vermont, Caselton University, and the Community College of Vermont. Members of our advocacy team tabled at the 2023 Assistor Conference, People's Pride, and Neighborhood Planning Assembly Community Dinners.

The HCA also continued in-person outreach and service delivery through a 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

GC Investment Workbook production delayed - to be added at a later date.

Tobacco Prevention and Control

What We Do

The tobacco control program strategies are based on the Centers for Disease Control and Prevention 2014 Best Practices Guide. Best practices include a comprehensive approach to tobacco control in addressing prevention, cessation, countermarketing, surveillance and evaluation.

Who We Serve

The tobacco control program serves all Vermonters across the lifespan; youth, young adult, adult, and older adults. We also serve those disproportionately affected by tobacco use including; adults with mental health and substance use disorders, Indigenous peoples, Lesbian, Gay, Bisexual, Trans and Queer (LGBTQ+) youth, Low-income Vermonters, Medicaid-insured and uninsured adults, Pregnant Vermonters, Vermonters with disabilities, and youth and young adults.

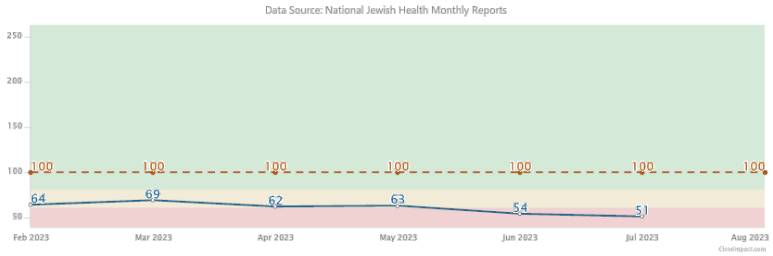
How We Impact

Through early education and intervention, strong prevention policies, accessible treatment services and robust countermarketing campaigns, we protect Vermonters from the harms of tobacco and nicotine.

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

Measures

PM AHS # of registrants to the 802Quits Quitline



Time Period	Current Actual Value	Current Target Value	Current Trend
Jul 2023	51	100	↘ 2
Jun 2023	54	100	↘ 1
May 2023	63	100	↗ 1
Apr 2023	62	100	↘ 1
Mar 2023	69	100	↗ 1
Feb 2023	64	100	↘ 1
Jan 2023	96	100	↗ 2
Dec 2022	61	100	↗ 1
Nov 2022	49	100	↘ 1

Story Behind the Curve

Last Updated: November 2022

Author: Tobacco Control Program, Vermont Department of Health

All states run a Quitline with support from the CDC and in Vermont, with state funding. Quitlines are shown to be effective at helping people to quit and in Vermont, the Quitline is available 24/7, offers multiple sessions of counseling and free access to nicotine replacement therapy (NRT) shipped to participants' homes. When counseling and NRT are used together it more than doubles the chances of quit success.

The curve represents the number of callers who register for the Quitline. Tracking the number of Vermont smokers who register for the Quitline is important for assessing the utilization of the Vermont Tobacco Control Program's (VTCP) cessation programs and services. It is necessary to monitor how well the media and promotion efforts the program implements are driving smokers to use the Quitline.

- The Tobacco Control Program's Annual Report FY22 highlights the outcomes of our cessation work:
  - 802Quits is an evidence-based statewide program that offers 24/7 cessation support through the Quitline, Quit Online and Quit Partners (Quit in Person) programs, serving 4,747 in FY20.
  - In 2020, 94% of quitline registrants had made at least one quit attempt in the past.
  - Four in five Vermonters of color made a quit attempt.

- The program has made promoting cessation among priority populations a goal, including pregnant, low income, those with mental health disorders and LGBTQ.
- In FY20 there was nearly a 13% increase in LGBTQ registrants from 2019.
- More than a third of quitline registrants are Medicaid insured.

Campaign promotions especially using ads broadcast on television are instrumental to driving people to a Quitline. Every year the program airs a minimum of three campaigns designed to reach vulnerable Vermonters who are impacted by tobacco use. These include those with lower incomes and education. Ads include CDC's Quit Tips campaign television ads, Vermont Quit Partner ads, and digital media. During periods when mass reach cessation campaigns are not occurring, digital media help reduce the dips in Quitline registrants.

Smoking cessation and prevention of initiation of smoking can help reduce the risk of onset of many chronic diseases including Type II diabetes. Smoking cessation can also help reduce complications from diabetes and improve self-management.

In FY20, financial incentives were added to the suite of quitline services for specific populations, to increase engagement and utilzation of the quitline by Vermonters.

Partners

- National Jewish Health- The program's quitline contractor who provides the quitline and quit online services and sends the program monthly 802Quits reports.
- Rinck Advertising- The program's media sub-contractor who supports promotional efforts and the 802Quits website.
- Department Vermont Health Access- The Vermont Medicaid office who collaborates with the program on expanding and promoting the cessation benefit and 802Quits resources for Medicaid beneficiaries.
  - Blueprint for Health- The Vermont Blueprint for Health designs community-led strategies for improving health and well-being.
- CDC- The program uses CDC's *Tips from Former Smokers* in mass-reach health communications

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What Works

Hard-hitting and emotionally powerful ads like those from CDC's Tips have been shown to increase cessation activity, especially among lower income tobacco users who represent the majority of smokers in Vermont. The call to action in the ads used in Vermont has directed residents toward the Quitline. Quitlines and the promotion of them through mass-reach health communication interventions are best practice strategies in a comprehensive tobacco program. VTCP receives weekly, monthly, and quarterly Vermont Quitline data from its vendor. The program's current strategy is to engage providers to encourage referrals to the Quitline in addition to providing in-clinic counseling. Continuing and enhancing these efforts will work to turn the curve.

Reducing smoking is important for alleviating chronic disease burden and prevalence. Smoking effects tissues that make up the musculoskeletal system, increasing the risk of injury and disease including a higher risk of low back pain and rheumatoid arthritis. Smoking cessation may help to reduce the prevalence and severity of arthritis among Vermonters.

Smoking increases risk of developing osteoporosis — a weakness of bone that causes fractures. Elderly smokers are 30% to 40% more likely to break their hips than their non-smoking counterparts. Smoking weakens bones in several ways, including:

- Studies have shown that smoking reduces the blood supply to bones, just as it does to many other body tissues.
- The nicotine in cigarettes slows the production of bone-forming cells (osteoblasts) so that they make less bone.
- Smoking decreases the absorption of calcium from the diet. Calcium is necessary for bone mineralization, and with less bone mineral, smokers develop fragile bones (osteoporosis).
- Smoking seems to break down estrogen in the body more quickly. Estrogen is important to build and maintain a strong skeleton in women and men.

Action Plan

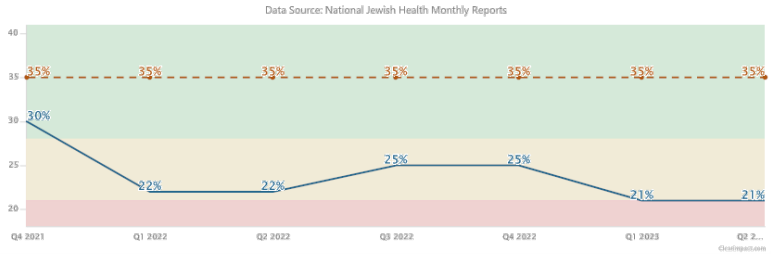
In FY23 the program will:

- analyze the efficacy of its promotional efforts which includes tracking the Quitline data.
- promote the Quitline through CDC Tips, locally produced advertisements, digital media, social media engagement, and mailings. The VTCP is working with several other states to learn and apply their approaches to reach vulnerable populations, including using a sympathetic approach.
- implement and promote new 802Quits protocols, aimed at youth and young adults, and behavioral health.
- increase provider awareness and utilization of 802Quits resources.
- explore with Quitline and media partners cost effective ways for improving awareness of the Quitline, utilization of supports like text programming, and

changing the mix of media outreach to include modes that may more effectively reach Vermont smokers.

- collaborate with partners, such as the Pride Center, to promote Quitline utilization by populations experiencing disparities.
- join other states in supporting a pilot with National Jewish Health to develop and test a protocol to enhance Quitline services for those callers experiencing anxiety and depression.

PM HPDP % of 802Quits callers who heard about the 802Quits from a health professional



Q2 2023	21%	35%	→ 1
Q1 2023	21%	35%	↘ 1
Q4 2022	25%	35%	→ 1
Q3 2022	25%	35%	↗ 1
Q2 2022	22%	35%	→ 1
Q1 2022	22%	35%	↘ 1
Q4 2021	30%	35%	→ 1
Q3 2021	30%	35%	↗ 1
Q2 2021	22%	35%	→ 1

Story Behind the Curve

Last Updated: September 2023

Author: Tobacco Control Program, Vermont Department of Health

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The proportion of callers who heard about the Quitline from a Health Professional has been fluctuating between 19-39% over the past 2 years. The Vermont Tobacco Control Program has started to implement promotional efforts to healthcare professionals describing the tobacco benefits available to them through Medicaid and the Quitline, stressing the importance of provider referrals, and encouraging them to talk with patients about tobacco and making a referral to the Quitline. Quarter 1 of 2019 shows an uptick due to these efforts, however in the end of 2019 and beginning of 2020, we see a decrease in referrals from Health Professionals. Some notes on methodology changes:

- The data is for phone intakes only, so the total number is smaller; effecting our percentage.
- The health professionals included are: dental care provider, doctor/nurse/healthcare professional, doctor/nurse/other healthcare provider, health care professional, health professional, and pharmacist
- The registrants are unique for a six-month period, instead of quarters.

Vermont's Quitline contractor provides the program with a monthly “How Did You Hear" report detailing how callers report hearing about the Quitline. The program recognizes the importance of providers talking with their patients about the Quitline and aims to see the proportion of callers who report hearing about the Quitline from a healthcare professional increase over time to 35%. Up to fairly recently, the program had used brochure racks and community engagement. Over the past year the program has modernized its approach to reach and engage healthcare providers and their role of increasing cessation activity.

Partners

- National Jewish Health (NJH): The Tobacco Program's contractor which provides the Quitline and Quit Online in English, Spanish and other languages per translation services, an incentive-based pregnancy protocol, and text messaging support.
- Rinck- The Tobacco Program's contractor which provides behavior change media interventions and communication tools for youth and adults including the CounterBalance campaign, 802quits.org and adult cessation media. Rescue works with several other companies that have expertise in provider engagement including CrowdProof and Upstream.
- Professional Data Analysts- The Tobacco Control Program's external evaluator who collects and analyzes data, and works to develop strategic plans.

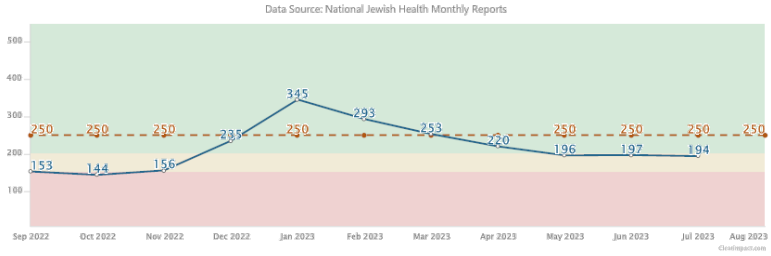
What Works

Increasing provider awareness of the Quitline and their important role in talking with patients about quitting will help to turn the curve. Research shows on best-practices for smoking cessation interventions in primary care shows that providers can strongly influence a patient's smoking outcomes through motivational interviewing and other patient-centered approaches. Healthcare professionals of all types, be it dental hygienists or oncologists, are in a respected position to reach patients and encourage positive quit outcomes. Through increased provider education around cessation resources the proportion of Quitline callers who report hearing about the Quitline from their provider will increase.

Action Plan

- In FY24, the program plans to continue its outreach to providers to encourage them to promote the Quitline, talk with patients, and make referrals. This outreach can take the form of targeted communications, disseminating health advisories, ads in medical newsletters, e-blasts, trainings and Grand Rounds presentations.
- The VTCP will continue its partnership with other chronic disease programs to increase provider education around the Quitline with oncologists, dental hygienists, diabetes educators and other health professionals.
- The program will seek to present on 802quits.org to providers and those who work closely with healthcare teams one or more medical conferences.
- The program will test the userability of the updated provider section of 802Quits and continue to promote it through multiple channels.

PM HPDP # of registrants to 802Quits Quit Online



Jul 2023	194	250	↘ 1
Jun 2023	197	250	↗ 1
May 2023	196	250	↘ 4
Apr 2023	220	250	↘ 3
Mar 2023	253	250	↘ 2
Feb 2023	293	250	↘ 1
Jan 2023	345	250	↗ 3
Dec 2022	235	250	↗ 2
Nov 2022	156	250	↗ 1

Story Behind the Curve

Last Updated: February 2023

Author: Tobacco Control Program, Vermont Department of Health

The curve represents the number of Vermonters who enroll in the Quit Online program, which is implemented by National Jewish Health on the behalf of the Tobacco Control Program. Tracking the number of Vermont smokers who register for the Quit Online is necessary to evaluate the impact that communications and outreach efforts have on the utilization of this free service. Quit Online offers 24/7 accessibility, a quit plan creation tool and other resources to help tobacco users decrease their use or quit altogether.

In 2021 there were 2,244 Vermonters who registered to use the Quit Online program. Digital promotion in particular drives people to these online services. The program continues to monitor this measure to determine if this is a trend and to identify ways to continue to enhance the numbers of individuals assisted.

When looking at previous years there were several months including January and May, where the number of registrants met or nearly met the target goal of 250 registrants. These upswings often coincide with media campaigns. Campaign promotions have included CDC's Quit Tips campaign television ads, Vermont Quit Partner ads, and digital media in addition to radio. During periods when mass reach cessation campaigns are not occurring, digital media helps to reduce the dips in Quit Online registrants seen in previous years. In previous years, the lowest numbers of online registrants was during the summer months.

Partners

- National Jewish Health (NJH)- The program's Quitline contractor who provides the Quitline and Quit Online services and sends the program monthly 802Quits reports.
- Rinck Advertising- The program's media sub-contractor who supports promotional efforts and the 802Quits website.
- Department Vermont Health Access- The Vermont Medicaid office who collaborates with the program on expanding and promoting the cessation benefit and 802Quits resources for Medicaid beneficiaries.
- Centers for Disease Control and Prevention - The program uses CDC's *Tips from Former Smokers* in mass-reach health communications

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What Works

Hard-hitting and emotionally laden ads like those from CDC's Tips are shown to increase cessation activity especially among lower income segments who represent the majority of smokers in Vermont. The call to action in the ads used in Vermont have directed individuals toward the Quitline. Both Quitlines and promoting them are part of best practice in a comprehensive program. Vermont's Tobacco Control Program receives weekly, monthly, and quarterly Vermont Quitline data from NJH. The program's current strategy is to ensure that the appropriate measures are included on the intake questionnaire that will reflect populations or demographics that may require more focused promotion or outreach protocol. For example, Medicaid recipients were the target for the mailings sent out in February of 2014 and 2015, which resulted in an increase of registrants. Based on the curve, increases in registrants can also be attributed to the airing of national CDC Quit Tips campaign ads and

802Quits promotional efforts. Continuing and enhancing these efforts will work to turn the curve.

Action Plan

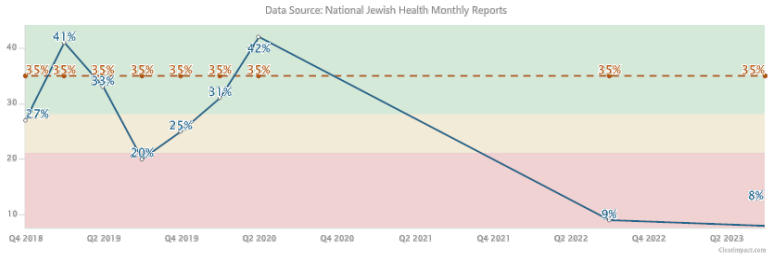
In FY23, the program will:

- analyze the efficacy of its promotional efforts which includes tracking Quit Online data.
- promote Quit Online through CDC Tips, locally produced advertisements, digital media, social media engagement, and mailings.
- work with media partners to raise awareness of engaging Quit Online platform, with enhanced features including chat support with peers.
- increase provider education and engagement
- collaborate with partners, such as the Pride Center, to promote Quit Online utilization by populations experiencing disparities.

Notes on Methodology

Reporting for this data changed in 2016. Prior to February 2016 the reported number of online participants included those who were also enrolled in the phone program. After this date the reported number represents those enrolled in the online program only.

PM Tobacco % of 802Quits registrants who complete 4 or more sessions



Q3 2023	8%	35%	↘ 2
Q3 2022	9%	35%	↘ 1
Q2 2020	42%	35%	↗ 3
Q1 2020	31%	35%	↗ 2
Q4 2019	25%	35%	↗ 1
Q3 2019	20%	35%	↘ 2
Q2 2019	33%	35%	↘ 1
Q1 2019	41%	35%	↗ 1
Q4 2018	27%	35%	↘ 1

Story Behind the Curve

Last Updated: September 2023

Author: Tobacco Control Program, Vermont Department of Health

The curve represents the number of Quitline registrants who completed four or more calls with an 802Quits Quitline counselor. **Methodology for this measure changed in 2022 and 2023 where we are only looking at unique registrants instead of all registrants**, and now rather than quarters, we are seeing a 6-month reporting time frame. This change created a significant decrease in those completing the 4 or more sessions.

The more counseling sessions that a registrant has with a Quitline coach, the greater the likelihood of a successful quit attempt.

The Vermont Tobacco Control Program (VTCP) works closely with their Quitline contractor, National Jewish Health, to monitor the participation of registrants as well as confirm delivery of quality coaching services. National Jewish Health (NJH) trains its coaches to be capable and effective at meeting the needs of those seeking Quitline services. Some populations, including pregnant smokers, may need additional support and tailored counseling sessions that a Quitline like NJH can be prepared to offer through training its coaches. Through the addition of financial incentives, we aim to increase the number of completed counseling sessions.

The tobacco program also works to encourage use of the Quitline through mass reach media. Hard-hitting ads are effective in reaching those who smoke and inciting them to reach out to the Quitline.[1] The VTCP also runs ads that increase awareness and trust in our state's 802Quits resources which in addition to the Quitline includes Online services and Quit Partners, trained tobacco treatment specialists who serve in communities across the state.

[1] Best Practices for Comprehensive Tobacco Control Programs—2014

Why Is This Important?

Together these performance measures focus on whether Vermonters are better off as a result of the Health Department's Tobacco Control Program. They do so by looking at the quality and efficiency of these programs and services. This performance measure is important because it measures if Vermonters are likely to experience successful tobacco treatment counseling.

Partners

- National Jewish Health- The program's quitline contractor who provides the quitline and quit-online services and sends the program monthly

802Quits reports.

- Rinck- The Tobacco Program's contractor which provides behavior change media interventions and communication tools for youth and adults including the CounterBalance campaign, 802quits.org and adult cessation media. Rescue works with several other companies that have expertise in provider engagement including HMC Advertising, CrowdProof, and Upstream.
- Department Vermont Health Access- The Vermont Medicaid office collaborates with the program on expanding and promoting the cessation benefit and 802Quits resources for Medicaid beneficiaries.
- Centers for Disease Control (CDC)- The program uses CDC's Tips from Former Smokers in mass-reach health communications
- Professional Data Analysts- The Tobacco Control's external evaluator who collects and analyzes our data, and helps build strategic plans.

What Works

The CDC emphasizes in *Best Practices for Comprehensive Tobacco Control Programs* the importance of those that want to quit tobacco participating in one ten-minute reactive call as well as three Quitline initiated calls[1]. The more calls that a participant is involved in increases the likelihood of a successful quit. Participating in counselling calls, along with taking advantage of the free short and long acting nicotine replacement therapy, increases the chances of a successful quit attempt.

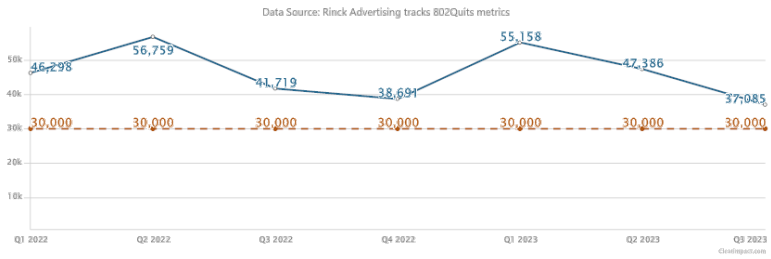
Quitting tobacco has beneficial short and long term health impacts no matter one's age. Chronic disease kills more Vermonters than all other causes combined. Three behaviors (no physical activity, poor diet, and tobacco use) lead to the four diseases of cancer, heart disease, diabetes, and lung disease which result in more than 50% of deaths in Vermont. Reaching Vermonters that want to quit and supplying the needed cessation support will reduce the number of Vermonters suffering from chronic disease.

[1] Best Practices for Comprehensive Tobacco Control Programs—2014

Action Plan

- Review of the efficacy of promotional efforts by reviewing the Quitline data.
- Promote the Quitline through CDC Tips, locally produced advertisements, digital media, social media engagement, and mailings.
- Support the work of the program's Quitline vendor, NJH, to create a protocol for use with callers experiencing depression. Ideally the protocol will increase the number of calls completed by those experiencing depression.
- Expand the suite of tailored Quitline programs by adding one to serve Indigenous Americans.
- Meet with the Quitline vendor 24 times to assure the Quitline meets quality expectations.

PM Tobacco # of visitors to 802quits.org



Q3 2023	37,085	30,000	↘ 2
Q2 2023	47,386	30,000	↘ 1
Q1 2023	55,158	30,000	↗ 1
Q4 2022	38,691	30,000	↘ 2
Q3 2022	41,719	30,000	↘ 1
Q2 2022	56,759	30,000	↗ 2
Q1 2022	46,298	30,000	↗ 1
Q4 2021	27,539	30,000	↘ 2
Q3 2021	32,886	30,000	↘ 1

Story Behind the Curve

Last Updated: December 2022

Author: Tobacco Control Program, Vermont Department of Health

Website traffic is measured in visits, sometimes called sessions. While there are nuances to the quality of web traffic, more visitors to the site can create more opportunities to generate leads, and ultimately, assist Vermonters who are interested in quitting tobacco.

For this performance measure, the tobacco program tracks the total number of visitors to 802quits.org each quarter from all traffic sources. As resources allow, the program runs paid digital or traditional media advertising throughout the year. The program aims to have media always in market to maximize website visits and maintain continuous visibility during the audience's moment of need. Because our mass media is purchased to reach specific individuals most at-risk (household income of less than $50,000; education of high school or less; at risk of using tobacco), the visitors to 802quits.org are most likely to come from this population.

While we focus on increasing the volume of overall website visitors, we also take measures to ensure users are engaging and taking enrollment actions once on the site. Therefore, in this case, website visits should be evaluated as a consideration to quit, either for the visitor or for someone they care about.

In Quarter 4, 2022, a mass media campaign launched in market, along with paid social media and Google search ads, which drove visitors to the website. The remaining traffic to the site came from unpaid sources.

Why Is This Important?

Together these performance measures focus on whether Vermonters are better off as a result of the Health Department's Tobacco Control Program. They do so by looking at the quality and efficiency of these programs and services. This performance measure is important because it measures HOW WELL the program is doing in reaching and educating Vermonters about free available resources through 802Quits.org.

Partners

Rinck Advertising

CDC's Media Campaign Resource Center (MCRC)

What Works

The CDC's 2014 Best Practices for Comprehensive Tobacco Control Programs "recommends mass-reach health communication interventions on the basis of strong evidence of effectiveness" for decreasing prevalence of tobacco use. Increasingly, all Americans are using the web as a credible source for health information. Therefore, having information online, optimized for mobile phones, and a website easy to navigate with elements important to our audience (real stories, free resources, and nicotine replacement therapy--NRT) is key to motivating more smokers to consider quitting.

Action Plan

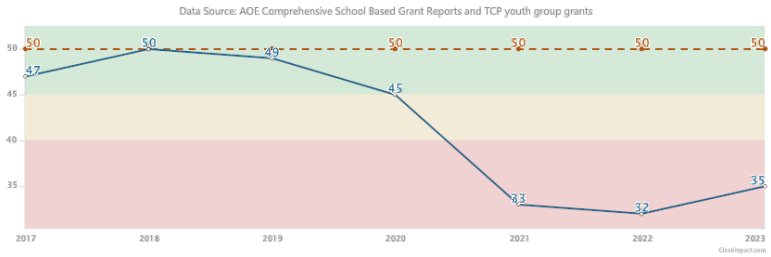
We plan to maintain or increase this number of visitors in the future by tailoring our mass media campaigns to Vermonters facing tobacco health disparities.

The program will use best and promising practice and a mix of communication channels to motivate and assist Vermonters with quitting tobacco. Quitting tobacco can take, on average, 8 - 11 attempts, and well above that to succeed for some people. Mass reach and digital promotion contribute to driving quit attempts.

Ad buys will continue to be purchased in alignment with CDC's best practice.

We continue to increase our use of digital promotion. Research shows that digital is increasingly an efficient way to reach our population. All ad buys include digital.

PM Tobacco # of youth groups that educate local or state decisionmakers on tobacco harm and protective policies



2023	35	50	↗ 1
2022	32	50	↘ 4
2021	33	50	↘ 3
2020	45	50	↘ 2
2019	49	50	↘ 1
2018	50	50	↗ 1
2017	47	50	→ 1
2016	47	50	↗ 1
2015	33	50	↘ 2

Story Behind the Curve

Last Updated: October 2022

Author: Tobacco Control Program, Vermont Department of Health

Two things happened in FY2020 that dramatically dropped the overall number of youth groups in Vermont. The COVID-19 pandemic caused schools to move to remote learning with many extracurricular activities being canceled. The Agency of Education also stopped requiring the implementation of youth groups in their school-based substance use grants. In an effort to bolster these numbers the Tobacco Control Program began providing funding for a small number of community-based youth group grants. As the school environment has shifted post-COVID we must continually evaluate our youth groups efforts and shift as necessary.

Youth empowerment and engagement around tobacco is an identified method for preventing tobacco initiation and lowering use. National organizations including Campaign for Tobacco Free Kids monitor the burden and progress youth, advocates and state programs are making in

reducing tobacco's impact. The Vermont Department of Health and the Agency of Education fund two youth tobacco prevention groups – Our Voices Xposed (OVX) in high schools and Vermont Kids Against Tobacco (VKAT) in middle schools.

OVX and VKAT educate peers and their community about the impact tobacco has on Vermont youth. The groups hold events inside schools and outside in the community to raise awareness on the actions decision makers can take to reduce the toll of tobacco. Evidence-based strategies that communities can enact include passing smoke-free policies at local parks and playgrounds, which reduce secondhand smoke exposure and create positive social norms around tobacco use, and changing the tobacco retail environment, where exposure to product and advertising causes youth tobacco use initiation.

Whether youth coalitions successfully educate decision makers depends on:

- Grant support from state partners like Agency of Education and training and materials from the Department of Health
- Motivation and passion among youth coalition members
- Community support for their activities, including in schools
- Understanding of tobacco issues among local decision makers

Why Is This Important?

Together these performance measures focus on whether Vermonters are better off as a result of Health Department's Tobacco Control Program. They do so by looking at the quality and efficiency of these programs and services. This performance measure is important because it measures HOW MUCH the program is doing in terms of youth prevention and the amount of program effort.

Partners

- Youth Groups: OVX and VKAT youth are the central change agents for this activity.
- Tobacco Community Coalitions: Coalitions support OVX and VKAT youth by connecting them to local and statewide policy initiatives, providing them with the resources they need to communicate to decision makers, and creating opportunities for education around the diverse issues surrounding tobacco prevalence in Vermont.
- Local decision makers (such as select boards, boards of trustees, town officers): Local decision makers are the audience for OVX and VKAT education and invite youth to participate in the policy process.
- Vermont Agency of Education: The Vermont Agency of Education also funds school-based tobacco prevention activities, and some Local Education Agencies choose to work on youth empowerment and community mobilization.
- Rinck Advertising: the media and youth engagement contractor of the VTCP .

What Works

Youth can be the most effective advocates for anti-tobacco measures. Tobacco use is started and established primarily during adolescence. According to the Center for Disease and Control (CDC) Youth and Tobacco Use Fact Sheet, 90% of smokers begin before they are 18 years of age. Each day in the United States, more than 3,200 youth aged 18 years or younger smoke their first cigarette, and an additional 2,100 youth and young adults become daily cigarette smokers. Youth are not desensitized to the impact that tobacco has on important adults in their lives. Youth-led engagement, when supported by community engagement strategies, is an evidence-based way to move tobacco policy initiatives forward.

A recent example of a successful youth engagement campaign are OVX groups providing their stories and local data at the state legislature. In 2019 three OVX groups testified in front of committees, answering questions about vaping, flavors and tobacco use in their school community. Over the past years youth have been involved in educating on the dangers of exposure from smoking in cars, the thousands of flavors available in vaping products and the concerning rise of electronic vapor products in local schools. In 2019, the Vermont State Legislature passed three prevention bills to increase the age to purchase to 21, restrict online purchasing of e-cigarettes and establish a first-ever tax on e-cigarettes and price parity among tobacco products in Vermont. garettes. On July 1, 2016, Act 108 was passed, making Vermont became the ninth state to prohibit the use of electronic cigarettes (defined as tobacco substitutes in Vermont) in the same manner and in the same locations as lighted tobacco products

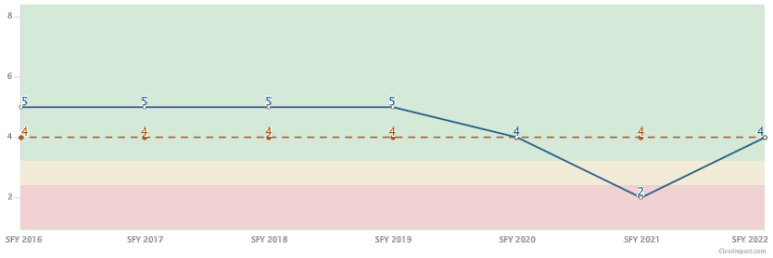
The collaboration between Agency of Education and the Vermont Department of Health turns the curve by providing funding to youth groups along with training and technical assistance. This includes providing guidance on how to run effective youth groups, distributing information to motivate and inform coalition leaders, and connecting youth groups with opportunities to talk with decision makers or the media.

Counter marketing is a CDC recommended best practice area in tobacco control. Over the last several years, tobacco control efforts have begun to address the impact of point-of-sale, which combines restriction and reduction of advertising and youth access. This area of work is designed to counteract the retail environment, which research finds is more influential on youth smoking than peer pressure.

Action Plan

- The Vermont Tobacco Control and Prevention Program will continue to partner with the Agency of Education to fund OVX and VKAT groups. OVX and VKAT groups are active from September through May of each school year.
- The annual Youth Rally has been combined with Prevention Day at the Vermont statehouse, which is on February 13 this fiscal year (2024) and will seek to educate legislators on current products, flavors and youth use.
- The Tobacco Control Program's CounterBalance campaign continues to provide education and engagement materials for parents, community and youth.

PM HPDP # of local secondhand smoke strategies adopted



SFY 2022	4	4	↗ 1
SFY 2021	2	4	↘ 2
SFY 2020	4	4	↘ 1
SFY 2019	5	4	→ 3
SFY 2018	5	4	→ 2
SFY 2017	5	4	→ 1
SFY 2016	5	4	↗ 1
SFY 2015	2	4	→ 1
SFY 2014	2	4	↘ 1

Story Behind the Curve

Updated: January 2023

Author: Tobacco Control Program, Vermont Department of Health

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Reducing secondhand smoke exposure is one of the major objectives of the Vermont Department of Health's Tobacco Program. Nationally the rate of exposure to secondhand smoke has been decreasing; however, in Vermont adult exposure has not significantly changed from 2008 (56%) to 2016 (50%).

The Vermont Tobacco Program funds 12 community grantees and the Agency of Education funds 18 supervisory unions to host school-based youth groups for tobacco prevention activities, including what is recommended by the CDC as state and community interventions. Examples of interventions include protective policies including local secondhand smoke ordinances. These are official town or city policies that create smoke-free spaces – for example, town greens, town office campuses, and parks and recreational areas. Community grantees and their youth allies help to educate policymakers about the benefits of smoke-free policies, which include reducing secondhand smoke exposure and creating positive social norms that discourage youth initiation and promote cessation.

Whether a town adopts a smoke-free policy can depend upon several factors including:

- Community support for the policy
- Youth engagement in educating on the need for a policy
- Political will among local decision makers
- Presence of community champions who work for the policy over the long term

This performance measure fluctuates from fiscal year based on local leadership awareness, the frequency of town meetings, recent events such as the passing of protective policies in a nearby town, and the grant cycle. Community grantees receive grants on the state fiscal year, which runs from July 1 to June 30. Often grantees work on new initiatives in the first one or two quarters (January through June) and see results in quarters three and four of their grants, with increased activity around Town Meeting Day in March. Also, it is common practice for grantees to work on educating for protective language over several years; this effort can remain in the grantee's workplan until final adoption and implementation.

Why Is This Important?

Smoke free, and now vape free, policies are impetrative to tobacco prevention and an important tobacco control intervention. Such policies not only protect the health and well-being of our population but also our environment. Secondhand smoke from burning tobacco products is a known risk factor for disease and premature death among non-smokers and there is no risk-free level of secondhand smoke.

Partners

- Community Grantees: create yearly work plans with local secondhand smoke objectives, point-of-sale objectives to reduce youth access to tobacco and youth use, among other objectives.
- Youth Groups: OVX and VKAT members often support tobacco coalition initiatives through youth activism, educating school and community members, and becoming the face of tobacco prevention.

- Local decision makers e.g. select boards, boards of trustees, town officers: Local decision makers have the authority to change secondhand smoke policy, and may work with community coalitions to receive technical guidance.
- Local residents: Secondhand smoke policies can only change with a groundswell of support and demand from local residents. Community coalitions educate residents and decision makers to create demand for change. Residents that feel passionately about secondhand smoke exposure are also important champions for the issue.

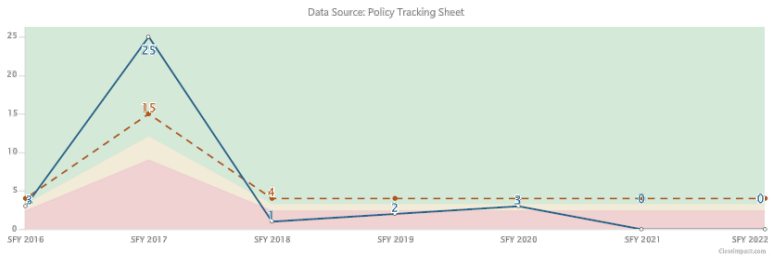
What Works

Smoke-free laws are an evidence-based way to protect the public from secondhand smoke, create and maintain strong social norms, assist smokers to quit and maintain their quit status, and reduce smoking prevalence. The Vermont Department of Health turns the curve by providing ongoing support and technical assistance to community grantees and youth groups working with towns on smoke-free policies. This means providing model policies at the request of decision makers, distributing background information and research around the positive impact of secondhand smoke ordinances, and creating forums where community grantees and outside experts can share experiences and advice.

Action Plan

- The program will continue to provide support to community grantees around secondhand smoke ordinances and to promote youth engagement as a successful strategy to educate on the harms of secondhand smoke. Since 2009, 309 local secondhand smoke ordinances have passed in Vermont with support from community grantees. These ordinances include restricting smoking on business, hospitals and college campuses; around municipal buildings; at town swimming pools and in parks and playgrounds; along pedestrian shopping districts, at town beaches and fairgrounds, among others.
- The program has had strong yearly performance for this indicator and anticipates local communities will continue to see results with the support local champions, Office of Local Health staff and the Vermont Tobacco Control and Prevention Program provides.

PM Tobacco # of durable local or state interventions introduced that address the tobacco point of sale environment.



SFY 2022	0	4	→ 1
SFY 2021	0	4	↘ 1
SFY 2020	3	4	↗ 2
SFY 2019	2	4	↗ 1
SFY 2018	1	4	↘ 1
SFY 2017	25	15	↗ 1
SFY 2016	3	4	→ 1
SFY 2015	3	4	↗ 1

Story Behind the Curve

Updated: January 2023

Author: Tobacco Control Program, Vermont Department of Health

The Vermont Department of Health's Tobacco Program funds 12 local Community Grantees and Youth Groups for tobacco prevention activities. The program also educates on the need for state-level policy change to reduce youth and young adult access to products, to prevent initiation and use, and to support Vermonters seeking to quit and successfully maintain their abstinence from tobacco.

According to the Surgeon's General's 2012 Report, the tobacco point of sale environment is more influential on youth initiation of tobacco use than peer pressure. A point of sale environment that exposes youth and adults to tobacco through ads, price discounts and displays of tobacco products also makes it harder for smokers to quit and/or to maintain their quit. There are several point of sale solutions that effectively minimize exposure and access to tobacco marketing and price promotions, including:

- limit the location, size and number of signs for tobacco and other products in a town or municipality
- remove the promotions on the exterior of a store
- pass an ordinance to restrict new paraphernalia stores, which sell products that can be used for tobacco, cannabis, or e-cigarettes
- amend town plans and bylaws to preserve the character of a town or village by limiting the location and density of businesses that sell products that can't be sold to minors

Several of our grantees worked hard to implement interventions to address point-of-sale in their region of impact. **Brattleboro Area Prevention Coalition** (BAPC), for example, has created and implemented the "Star Store" program, which consists of store audits and public recognition of retailers using best practices around tobacco sales. Stores that sell no tobacco receive a gold star window cling. Stores that sell tobacco but have no tobacco advertising receive a silver star, and stores that have no external advertising receive a bronze star. Qualifying stores are also featured in a large window display at a local bank, BAPC's Facebook page, and positive mention in a press release.

As a result of the Star Store audits, the local Hannaford grocery store manager was surprised to learn their grocery store was the last one in town to still be selling and marketing tobacco and wanted to do something about it. Through continued conversation with BAPC, the store manager had the tobacco display case turned so ninety degrees to the checkout area to remove the branding images from the customer's view in the check-out line. Some of the advertising was also removed.

Through the Health Department's CounterBalance campaign, since 2014 community grantees and youth groups have been educating local community about the influence of tobacco point of sale and the tactics the industry uses with flavors to entice youth to tobacco use. Flavors are federally restricted in cigarettes (except for menthol) but are unregulated in smokeless and e-cigarette products. If interested in finding out more regarding the work and achievements of the tobacco prevention grantees, email tobaccovt@vermont.gov.

Partners

Community Coalitions: tobacco-funded grantees create yearly work plans with local point of sale objectives, smoke- and tobacco-free objectives, earned media and several other activities.

Youth Groups: OVX and VKAT members and other youth groups often support coalition initiatives through youth activism and becoming the face of tobacco prevention.

Local Decision Makers: Select boards, boards of trustees, town officers, and town planners have the authority to enact, incorporate or change prevention policies that reduce exposure, access and promotion of tobacco. They may work with the Health Department and other coalitions and partners to receive technical guidance.

Local Residents: Tobacco policy progress benefits from the participation of concerned residents who can help create the understanding, support and movement for protective policies. Often policy advancement is aided when there is a groundswell of support and demand from local residents. Coalitions educate residents and decision makers to create demand for change. Residents and retailers that are willing to envision healthier retail environment are critical champions for the issue.

Vermont Department of Health: The Vermont Tobacco Control Program helps to support policy change at the state level by presenting research and best practice to statewide decision makers. These efforts are supported by Health Department leadership and the member agencies of the Vermont Tobacco Evaluation and Review Board.

What Works

Addressing the tobacco point of sale is an established practice, especially at the local level, to address the upstream causes of tobacco use.

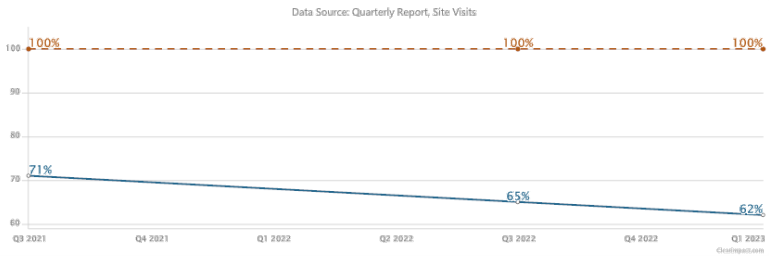
The Vermont Department of Health is working to create momentum in reducing the impact of point of sale by:

- providing ongoing support and technical assistance to tobacco coalitions and youth groups as they educate community members and decision makers
- educating on the harms of tobacco and the strategies used by the industry to increase youth access and initiation,
- providing model policies to inform decision makers,
- supporting store audit activities,
- implementing point of sale surveillance tools,
- distributing background information and research around promising practices,
- reaching out to new partners such as the Vermont Association of Planning and Development Agencies, and,
- conducting media campaigns.

Action Plan

The program will continue to provide support to community grantees and Office of Local Health around how the industry uses point of sale tactics and the strategies and policies that can counteract that impact to create healthier communities for youth and young adults. One-on-one technical assistance with Vermont Department of Health central and Office of Local Health staff is provided on an ongoing basis. The program has also invested in conducting a statewide media campaign called CounterBalance. CounterBalance will continue to collect information on community perceptions about the point of sale and educate decision makers about local and state options.

PM	Tobacco	% of Vermonters covered by a local tobacco-funded coalition	Q1 2023	62%	100%	↘ 2



Q3 2022	65%	100%	↘ 1
Q3 2021	71%	100%	→ 0

Story Behind the Curve

Last Updated: October 2023

Author: Tobacco Control Program, Vermont Department of Health

The Vermont Department of Health funds 11 tobacco community coialitions, down from 12 in FY2022, and 14 in FY2021 and FY2020. A Tobacco Control Program, per the CDC 2014 Best Practice Guide, aligns state and local initiatives to produce protective measures that over time reduce tobacco initiation and use, support successful tobacco cessation, and limit exposure to secondhand smoke. Community support and involvement at the grassroots level in educating on effective policy and planning interventions can result in creating content neutral advertising laws and smoke-free public and private environments, and at the state level state statutes that limit youth access, exposure and use of tobacco and support all adults in never starting tobacco use or quitting if they do. The program's technical assistance seeks to enhance and guide the community coalitions' efforts by playing a key role in providing resources that will aid in successful implementation of workplan activities.

The Vermont Department of Health seeks to provide support to community coalitions through:

- Providing best practice guidance and technical assistance
- Giving feedback on community coalition tobacco workplans and quarterly reporting
- Arranging trainings and strategy sessions among the coalitions
- Coordinating site visits with coalitions
- Providing presentation templates, data and other resources for tobacco coalitions at community events and presentations

Why Is This Important?

Together these performance measures focus on whether Vermonters are better off as a result of Health Department's Tobacco Control Program. They do so by looking at the quality and efficiency of these programs and services. This performance measure is important because it measures HOW MUCH the program and its partners are doing in terms of community engagement for tobacco prevention.

Partners

- Community grantees: Tobacco-funded grantees create yearly work plans with local point of sale objectives, smoke- and tobacco-free objectives, earned media and several other activities.
- Office of Local Health (OLH) : The Vermont Department of Health operates 12 District Offices located throughout the state. Tobacco-funded grantees collaborate with the office of local health personnel in their service area to provide support for implementation of grantee work plan activities.
- Quarterly workgroup consisting of Attorney General's Office, Department of Liquor and Lottery, Agency of Education and the legal and policy team of the Department of Health. Together we identify and work together on emerging issues, such as new tobacco products, violations, rise in youth use of e-cigarettes among other issues.

What Works

According to CDC's 2014 Best Practice Guide, state and community coalitions are essential partnerships to achieve tobacco control and prevention statewide goals. Research has demonstrated the importance of community support and involvement at the grassroots level in implementing several of the most highly effective policy interventions.

The Vermont Tobacco Control Program in collaboration with the Office of Local Health, provides technical assistance through feedback and input on coalition workplans, quarterly reports and meetings such as trainings with content experts, strategy sessions, and site visits. In the spirit of peer learning, the program has been inviting coalitions to share their growing expertise, successes and challenges with each other.

Action Plan

- The program will continue to support tobacco coalitions with the technical assistance needed on a one-on-one basis through site visits, trainings, networking meetings, and monthly check-ins in collaboration with Office of Local Health staff as available.

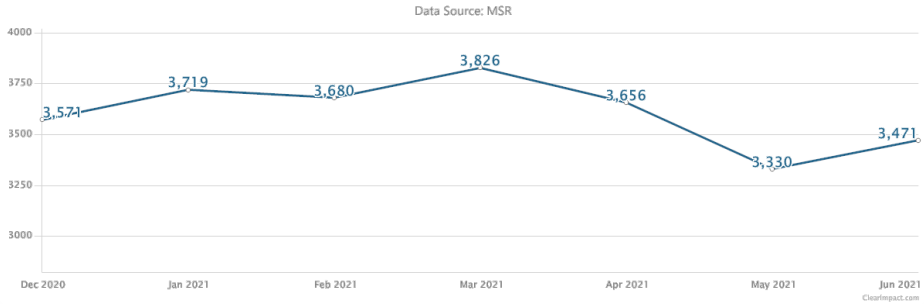
Attachment 7

DMH Value Based Payment Measures

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

O How_Much VBP: Number of Individuals Served

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



Most Recent Period	Current Actual Value	Current Target Value	Current Trend
Jun 2021	3,471	–	–
May 2021	3,330	–	–
Apr 2021	3,656	–	–
Mar 2021	3,826	–	–
Feb 2021	3,680	–	–
Jan 2021	3,719	–	–
Dec 2020	3,571	–	–
Nov 2020	3,478	–	–
Oct 2020	3,132	–	–

Story Behind the Curve

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

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

Partners

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

Notes on Methodology

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

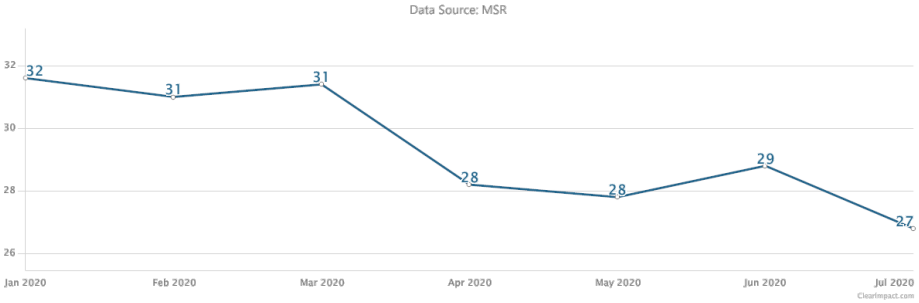
Data analyzed from Monthly Service Reporting system. Clients counted if they received one qualifying service within the month. Qualifying services are those that count a person toward the caseload and allow the agency to earn the full PMPM for that client.

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

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

Report figure on a designated agency level basis

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



Jul 2020	27	–	–
Jun 2020	29	–	–
May 2020	28	–	–
Apr 2020	28	–	–
Mar 2020	31	–	–
Feb 2020	31	–	–
Jan 2020	32	–	–
Dec 2019	31	–	–
Nov 2019	31	–	–

Story Behind the Curve

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

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

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

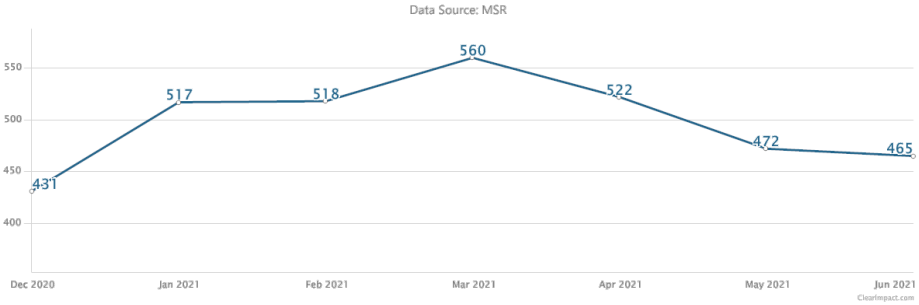
Partners

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

Notes on Methodology

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

How_Much Number of young adults (18-21) served



Jun 2021	465	–	–
May 2021	472	–	–
Apr 2021	522	–	–
Mar 2021	560	–	–
Feb 2021	518	–	–
Jan 2021	517	–	–
Dec 2020	431	–	–
Nov 2020	408	–	–
Oct 2020	409	–	–

Story Behind the Curve

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

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

Partners

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

Notes on Methodology

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

- Pull MSR services
- Calculate age of client from the midpoint

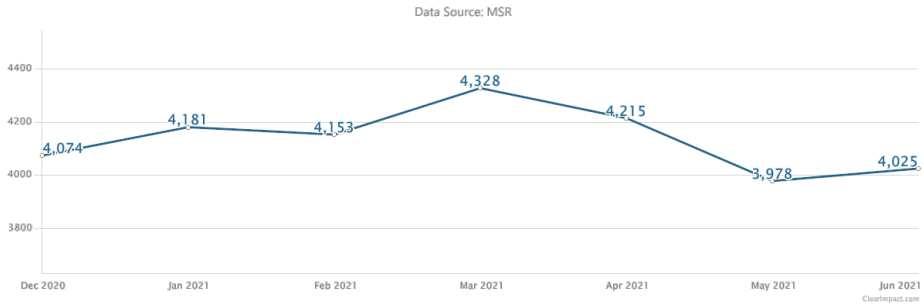
of the service year (June 30, XXXX)

- Select clients who are aged 18-21
- Aggregate to clinic client level, with flag for total services during fiscal year
- Select clients who have a least 1 unit (as defined in the *Provider Manual*)

Report figure on a designated agency level basis

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

I How_Much Number of Adults served



Jun 2021	4,025	–	–
May 2021	3,978	–	–
Apr 2021	4,215	–	–
Mar 2021	4,328	–	–
Feb 2021	4,153	–	–
Jan 2021	4,181	–	–
Dec 2020	4,074	–	–
Nov 2020	4,128	–	–
Oct 2020	4,031	–	–

Story Behind the Curve

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

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

Partners

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

Notes on Methodology

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

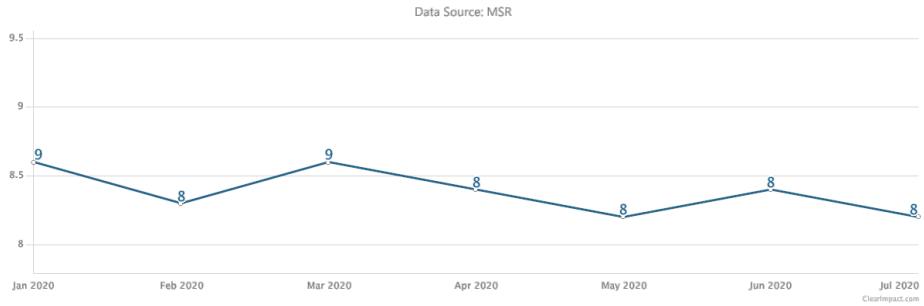
- Pull MSR services
- Calculate age of client from the midpoint of the service year (June 30, XXXX)
- Select clients who are aged 18 or older
- Aggregate to clinic client level, with flag for total services during fiscal year
- Select clients who have a least 1 unit (as defined in the *Provider Manual*)

Report figure on a designated agency level basis

The age of the individual served is captured as “point in time” and thus an individual may be served by more than one age-specific program in the calendar

year, but they will only be captured in one. These counts are designed to help us understand the total number of clients each program served and are not used to inform the case rates.

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



Jul 2020	8	–	–
Jun 2020	8	–	–
May 2020	8	–	–
Apr 2020	8	–	–
Mar 2020	9	–	–
Feb 2020	8	–	–
Jan 2020	9	–	–
Dec 2019	8	–	–
Nov 2019	8	–	–

Story Behind the Curve

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

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

Partners

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

Notes on Methodology

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

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

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

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

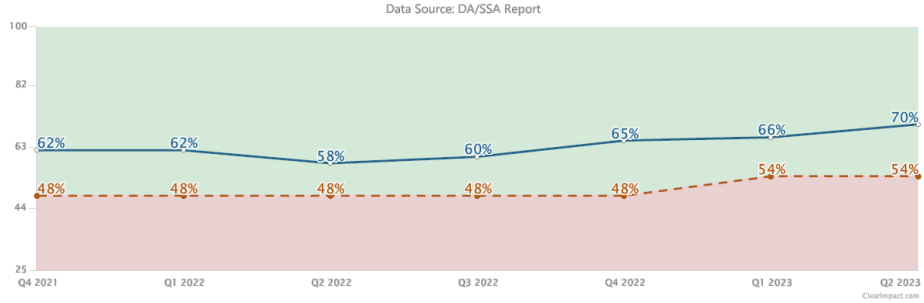
R = 1,000 C / P

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

Report figure on a designated agency level basis.

O How_Well **VBP: How Well Individuals Were Served**

PM How_Well Percentage of clients offered a face-to-face contact within five calendar days of initial request



Most Recent Period	Current Actual Value	Current Target Value	Current Trend
Q2 2023	70%	54%	↗ 4
Q1 2023	66%	54%	↗ 3
Q4 2022	65%	48%	↗ 2
Q3 2022	60%	48%	↗ 1
Q2 2022	58%	48%	↘ 1
Q1 2022	62%	48%	→ 1
Q4 2021	62%	48%	↘ 1
Q3 2021	68%	48%	↗ 1
Q2 2021	67%	48%	↘ 1

Story Behind the Curve

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

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

Partners

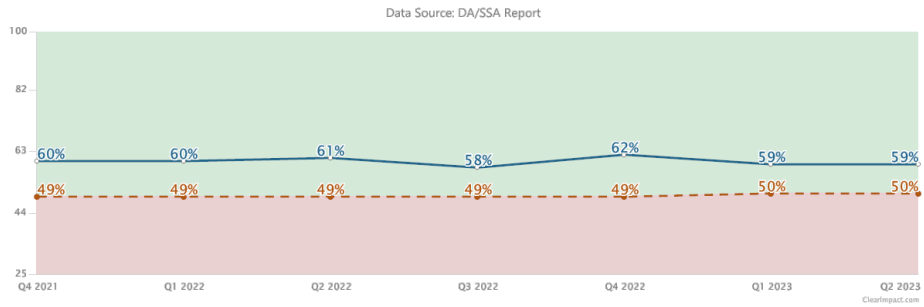
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

Notes on Methodology

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

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

PM How_Well Percentage of clients seen for treatment within 14 calendar days of assessment



Q2 2023	59%	50%	→ 1
Q1 2023	59%	50%	↘ 1
Q4 2022	62%	49%	↗ 1
Q3 2022	58%	49%	↘ 1
Q2 2022	61%	49%	↗ 1
Q1 2022	60%	49%	→ 1
Q4 2021	60%	49%	↘ 1
Q3 2021	63%	49%	↗ 1
Q2 2021	53%	49%	↘ 1

Story Behind the Curve

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

Partners

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

Notes on Methodology

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

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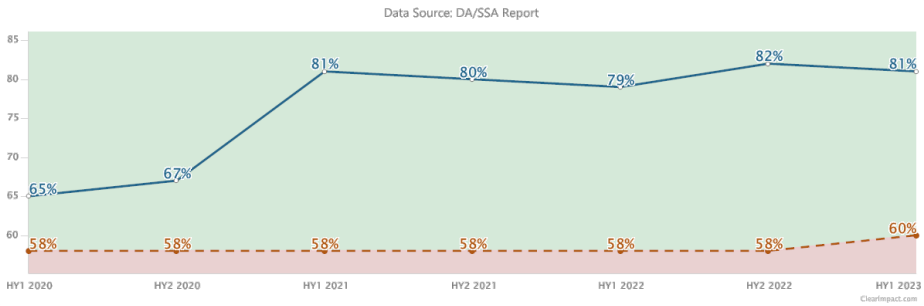
PM How_Well Percentage of youth clients with a CANS update recorded within the last 6 months.

HY1 2023	81%	60%	↘ 1



HY2 2022	82%	58%	↗ 1
HY1 2022	79%	58%	↘ 2
HY2 2021	80%	58%	↘ 1
HY1 2021	81%	58%	↗ 2
HY2 2020	67%	58%	↗ 1
HY1 2020	65%	58%	→ 0

Story Behind the Curve

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

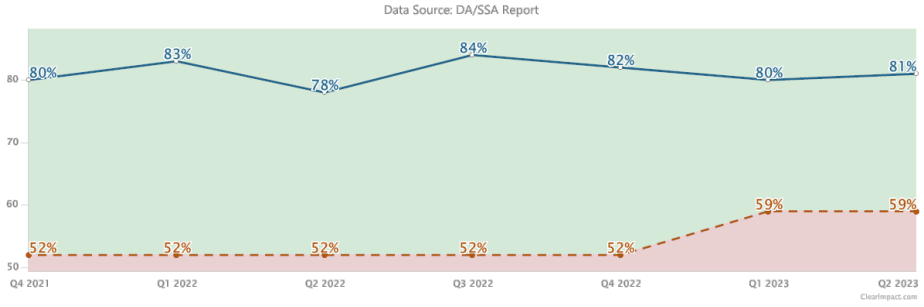
Partners

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

Notes on Methodology

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

PM How_Well Percentage of adult clients screened for substance use at intake



Q2 2023	81%	59%	↗ 1
Q1 2023	80%	59%	↘ 2
Q4 2022	82%	52%	↘ 1
Q3 2022	84%	52%	↗ 1
Q2 2022	78%	52%	↘ 1
Q1 2022	83%	52%	↗ 1
Q4 2021	80%	52%	↘ 1
Q3 2021	82%	52%	↗ 1
Q2 2021	76%	52%	↘ 1

Story Behind the Curve

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

Partners

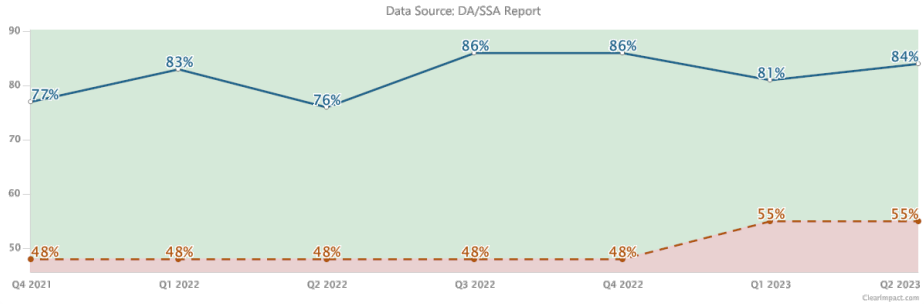
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric

Notes on Methodology

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

PM How_Well Percentage of adult clients screened for psychological trauma history at intake

Q2 2023	84%	55%	↗ 1



Q1 2023	81%	55%	↘ 1
Q4 2022	86%	48%	→ 1
Q3 2022	86%	48%	↗ 1
Q2 2022	76%	48%	↘ 1
Q1 2022	83%	48%	↗ 1
Q4 2021	77%	48%	↘ 1
Q3 2021	78%	48%	↗ 1
Q2 2021	73%	48%	→ 1

Story Behind the Curve

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

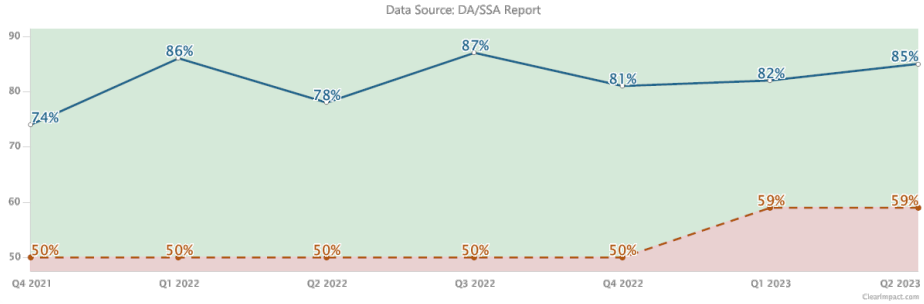
Partners

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

Notes on Methodology

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

PM How_Well Percentage of adult clients screened for depression at intake



Q2 2023	85%	59%	↗ 2
Q1 2023	82%	59%	↗ 1
Q4 2022	81%	50%	↘ 1
Q3 2022	87%	50%	↗ 1
Q2 2022	78%	50%	↘ 1
Q1 2022	86%	50%	↗ 1
Q4 2021	74%	50%	↘ 1
Q3 2021	77%	50%	↗ 1
Q2 2021	74%	50%	↘ 1

Story Behind the Curve

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

Partners

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

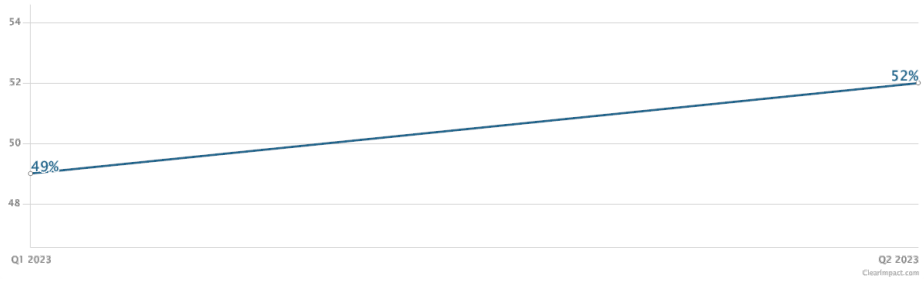
Notes on Methodology

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

PM How_Well Percentage of youth clients screened for substance use at intake

Q2 2023	52%	–	↗ 1

Data Source: direct report



Q1 2023 49% – → 0

Story Behind the Curve

Calendar year 2023 is pay for reporting only, with no target.

Partners

What Works

Action Plan

Notes on Methodology

PM How_Well Percentage of youth clients screened for depression at intake

Q2 2023 52% – → 1

Q1 2023 52% – → 0

Data Source: direct report

Story Behind the Curve

Calendar year 2023 is pay for reporting only, with no target.

Partners

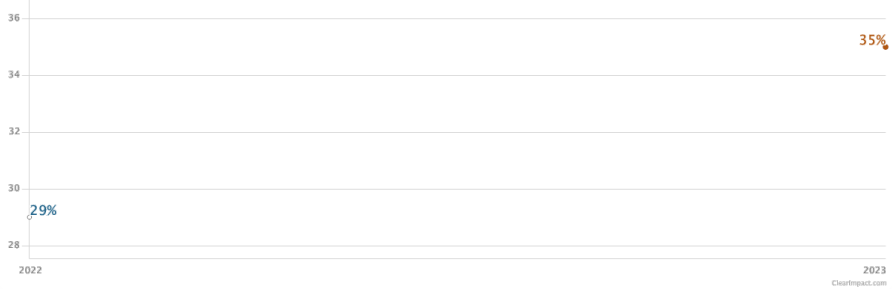
What Works

Strategy

Notes on Methodology

PM How_Well Percentage of adult clients with an ANSA update recorded within the last 12 months.

2022 29% – → 0



Story Behind the Curve

Partners

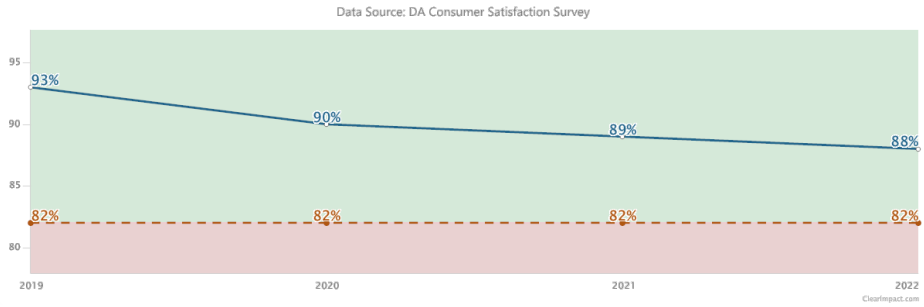
What Works

Action Plan

Notes on Methodology

O How_Well **VBP: Survey Measures**

PM How_Well Percentage of clients indicate they received the services they "needed"



Most Recent Period	Current Actual Value	Current Target Value	Current Trend
2022	88%	82%	↘ 3
2021	89%	82%	↘ 2
2020	90%	82%	↘ 1
2019	93%	82%	→ 0

Story Behind the Curve

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

Partners

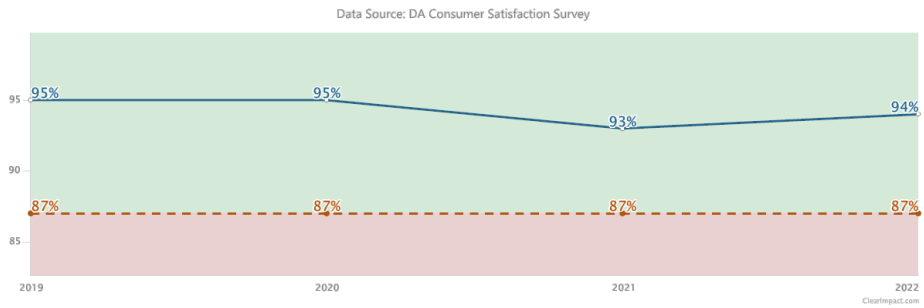
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

Notes on Methodology

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

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

PM How_Well Percentage of clients indicate they were treated with respect



2022	94%	87%	↗ 1
2021	93%	87%	↘ 1
2020	95%	87%	→ 1
2019	95%	87%	→ 0

Story Behind the Curve

Provides agency with client feedback about their perception of whether staff were respectful. When interpreted alongside the other Universal Consumer

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

Partners

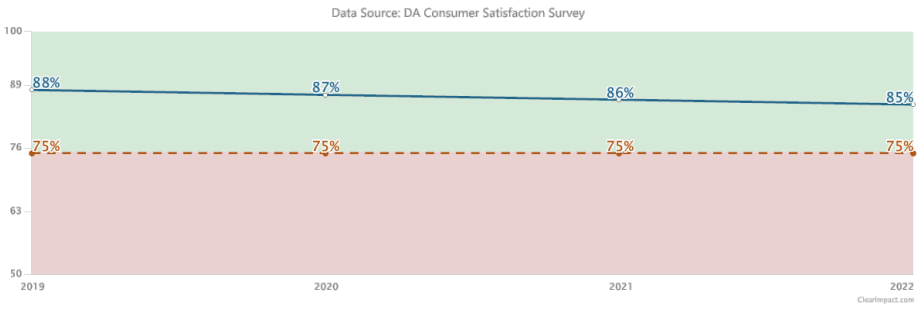
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

Notes on Methodology

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

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

PM Better_Off Percentage of clients indicate services made a difference



2022	85%	75%	↘ 3
2021	86%	75%	↘ 2
2020	87%	75%	↘ 1
2019	88%	75%	→ 0

Story Behind the Curve

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

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