State of Vermont
Agency of Human Services

Global Commitment to Health
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Section 1115
Demonstration Year: 15
(1/1/2019 – 12/31/2019)

Quarterly Report for the period
January 1, 2019 – March 31, 2019

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Table of Contents

I. Background and Introduction 3
II. Outreach/Innovative Activities 4
III. Operational/Policy Developments/Issues 5
IV. Expenditure Containment Initiatives 28
V. Financial/Budget Neutrality Development/Issues 49
VI. Member Month Reporting 50
VII. Consumer Issues 52
VIII. Quality Improvement 53
IX. Demonstration Evaluation 56
X. Compliance 57
XI. Reported Purposes for Capitated Revenue Expenditures 58
XII. Enclosures/Attachments 59
XIII. State Contact(s) 59

I. Background and Introduction

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

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

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

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

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

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

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

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

- 2016: On October 24, 2016 Vermont received approval for a five-year extension of the Global Commitment to Health 1115 waiver, effective from January 1, 2017 through December 31, 2021.

- 2018: As of July 1, 2018, the Global Commitment to Health demonstration was amended to include authority for Vermont to receive federal Medicaid funding for Substance Use Disorder

treatment services provided to Medicaid enrollees in Institutions for Mental Disease (IMDs).

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the first quarterly report for waiver year 15, covering the period from January 1, 2019 through March 31, 2019 (QE0319).***

II. Outreach/Innovative Activities

i. Provider and Member Relations

Key updates from QE0319:

- Non-Emergency Medical Transportation (NEMT) currently working across agencies to educate people on the NEMT Program.
- MMIS Provider Management Module (PMM) set to go live May 1, 2019.

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

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

<u>The Provider Management Module (PMM)</u>

The Provider Management Module (PMM) is set to go live as of May 1, 2019. This has been a year-long endeavor starting with the signing of Act 166 by Governor Scott on May 1, 2018 mandating enrollment of Medicaid providers in 60 days or less.

The new module will allow the provider community to enroll with Vermont Medicaid online. This eliminates the need for the paper application. The PMM will eliminate the cumbersome time and resources that it takes to fill out forms, process applications, store documentation, etc. The launch of the PMM will effectively eliminate applications being returned for missing information and will greatly speed up the processing time to 45 days or less. Information regarding the module can be found at http://www.vtmedicaid.com/#/provEnrollResources.

<u>Non-Emergency Medical Transportation (NEMT)</u>

Provider and Member Relations (PMR) Unit is currently working across agencies to educate people on the NEMT program. PMR staff have met with the Vermont Chronic Care Initiative (VCCI), worked with the Medicaid Policy Unit to update health care administrative rules on NEMT and Ambulance Services, and engaged with the Vermont Transportation Agency (VTrans) to discuss collaboration with respect to the NEMT program. Collaboration with VTrans will continue in the next quarter. Beginning in May 2019, PMR will begin its annual audit of contracted NEMT transportation provider Vermont Public Transit Association Inc. and their subcontractors. Outcome of the audits will be published in early July 2019.

ii. Global Commitment to Health Post Award Forum

A post award forum for the latest Global Commitment to Health 1115 waiver renewal was held on Monday, February 25, 2019. This forum was conducted in accordance with Special Terms & Condition 44 of the Global Commitment to Health 1115 Demonstration waiver. Public comments were soliticited and accepted at this forum and public notice of the forum was posted to the Global Commitment Register on January 10, 2019. Below is a summary of the public comment received:

- Comment regarding case management rules: A commenter noted federal regulations regarding person centered planning and conflict free case management for home and community based services. Concerns were raised by the comment regarding Vermont's adherence with these provisions.

III. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE0319:

- The Customer Support Center received more than 106,400 calls in QE0319, up 17% from the previous year when there were less than 91,000 calls in the quarter. The higher volume was driven by increased outreach that encouraged customers to take advantage of new Reflective Silver Plans.
- Vermont Health Connect was supported throughout the state by 275 Assisters in QE0319, up from 266 in QE0318. Of the 275 Assisters, there were 2 Navigators, 192 Certified Application Counselors or CACs, and 81 Brokers. The CACs grew 10% by training and certifying staff in hospitals, health centers, and other community organizations.
- Increasing numbers of customers are using self-service functions. Self-serve applications comprised nearly half (45%) of all applications in QE0319. This is the same level as QE0318. In addition, 53% of customers made recurring payments in QE0319. This was a slight growth of 3% compared to the previous year.

Enrollment

As of QE0319, more than 190,000 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 117,589 in Medicaid for Children and Adults (MCA) and 74,876 in Qualified Health Plans (QHPs), with the latter divided between 26,865 enrolled with VHC, 7,177 direct-enrolled with

their insurance carrier as individuals, and 40,834 enrolled with their small business employer.

QE0319 was more eventful than QE0318, largely because of this year's emphasis on outreaching to customers enrolled in silver plans who were eligible for and were expected to have better coverage at a reduced cost by enrolling in a gold plan. Additionally, the contracted customer call center, Maximus, experienced unexpected, higher than normal attrition and had significant difficulty hiring. Customers who had contacted the State of Vermont regarding their health insurance during the open enrollment period were able to enroll until mid-January 2019. During this time, Maximus increased staffing and ended the quarter on a more positive note.

Member Experience

In late December, the State of Vermont conducted a survey of customers enrolled in silver plans who were eligible for and were expected to have better coverage at a reduced cost by enrolling in a gold plan. Of the 246 customers who responded to the survey, 52.3% reported switching to a new plan in 2019 and 38.3% stayed with the 2019 version of their 2018 plan. The majority, 66%, of those who changed plans reported doing so because they received communications from VHC to comparison shop and reduce costs. Of those who decided to stay with the same plan and reported comparing plans, 43.3% said they discovered their current plan was the best choice for them, 42.7% said they did not understand the plans well enough to make a change and 28% responded that they were concerned they would have coverage or billing problems if they made the change. These results will be used to inform and improve the Outreach and Education plan for 2020 Open Enrollment.

Medicaid Renewals

Redeterminations for Medicaid for Children and Adults (MCA) continued on their normal cycle during QE0319. The passive renewal success rate for the quarter averaged 42%, in line with the monthly averages over the last year. Pre-populated renewal applications were sent to the remainder of the population, requiring an active response. As of the last day of the quarter, DVHA-HAEEU had 88 open applications, none of which were older than 45 days.

1095 Tax Forms

DVHA-HAEEU mailed two versions of IRS Form 1095 during QE0319. 1095A serves as proof of coverage and subsidy for QHP members to use when filing taxes. Nearly 25,000 initial forms were mailed to QHP members in January. Corrected forms are sent throughout the winter and spring due to reconciliation efforts or when members pay overdue 2018 bills. 1095-related service requests decreased by nearly 50% from the previous year and DVHA-HAEEU successfully handled the incoming volume.

1095B is an informational form that shows months of coverage for Medicaid members. Just over 113,000 were mailed in January in advance of the deadline. In 2018, the federal deadline was in March.

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 106,400 calls in QE0319, up 17% from the previous year when there were less than 91,000 calls in the quarter. January 2019 was especially busy, with follow up open enrollment and 1095 calls. The higher volume was attributed, in part, by increased call to action for customers to take advantage of new Reflective Silver Plans. Higher call volume translated into increased staffing needs which were difficult to meet in Vermont's tight job market. As of the end of QE0319, Maximus had 96 customer service representatives, up 30% from the 68 on staff at the end of QE0318.

Maximus answered 43% of calls within 24 seconds in January 2019 and 66% in February 2019, missing the 75% target. With increased staffing and lower call volumes, Maximus met the target in March (with 84%). 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 and a slight increase in the proportion of calls that were escalated. 7.92% of QE0319 calls were transferred to DVHA-HAEEU staff, up from 7.45% in QE0318 which was down 10% over QE0317. Just as importantly, DVHA promptly answered the calls that were transferred; 93.05% of transferred calls were answered in five minutes in QE0319, compared to 96.9% in QE0318.

Timely Processing of Member Requests

In the spring of 2016, DVHA-HAEEU set a goal of completing 75% of member requests within ten business days by October 2016 and 85% by June 2017. In QE0316, fewer than 60% of VHC requests were completed within ten days. In QE0317, more than 90% of requests were completed within ten days. In QE0318 and again in QE0319, more than 95% of VHC requests were completed within ten days.

System Performance

Throughout most of QE0319, the system continued to operate as expected. The system had 100% availability in the quarter. The average page load time for the quarter was less than one second (0.86) in each of the three months -- well within the two-second target.

In-Person Assistance

Vermont Health Connect was supported throughout the state by 275 Assisters in QE0319, up from 266 in QE0318. Of the 275 Assisters, there were 2 Navigators, 192 Certified Application Counselors or CACs, and 81 Brokers. The CACs grew 10% by training and certifying staff in hospitals, health centers, and other community organizations. Overall, Navigators and CACs continue to focus on helping Vermonters with Medicaid renewals, particularly new Vermonters for whom English is not their primary language and others with accessibility challenges.

Outreach

Health insurance literacy was also an outreach focus throughout QE0319. DVHA-HAEEU engaged health care providers, libraries, state offices, and legislators in helping Vermonters understand the

importance of responding to Medicaid renewal notices and comparing options for qualified health plans. Vermont Health Connect's website continued to be a key source of information for current and prospective customers alike, receiving more than 200,000 visits in the quarter.

The Plan Comparison Tool, which helps customers estimate total costs of coverage based on family members' age, health, and income, was used in more than 13,400 sessions during the quarter, up 11% over QE0318. Both of these volumes were up from the previous year, with customers calling to continue open enrollment activities and with 1,095 inquiries.

Self-Service

During QE0319, DVHA-HAEEU continued to promote self-service options for customers to pay their bills, report changes, and access tax documents and other forms. Self-service leads to an improved customer experience as Vermonters can log in at their convenience. It also has the benefit of using automation to reduce staffing expenses. Year-over-year comparisons show that more customers are using self-service functions, including both online accounts for health coverage applications and reported changes as well as the options of paying premiums through monthly recurring payments rather than one-time payments. Self-serve applications comprised nearly half (45%) of all applications in QE0319, flat with QE0318 volume. In QE0319, more than 6200 recurring payments were made per month. This is up just over 1000 per month compared to QE0318. Just under 54% of all electronic payments were recurring payments.

ii. Choices for Care and Traumatic Brain Injury Programs

Key updates from QE0319:

- Adult Day Center Closes due to Federal HCBS Regulations
- Conflict Free Case Management System Evaluation in Full Swing

Adult Day Center Closes Due to Federal HCBS Regulations

Green Mountain Adult Day Center in Newport, Vermont closed its doors in January 2019. More than a year prior, the center was assessed against the new federal home and community-based Services (HCBS) settings regulations that prohibits home and community-based services from being provided within a facility setting. Because Green Mountain Adult Day Center was co-located within a nursing facility, they were required to create an action plan that would bring them into compliance with the federal regulations. After considering the options, Green Mountain Adult Day chose to close its doors and provided person-centered plans to transition four Choices for Care participants into alternative services. Fortunately, the transition plans went smoothly and residents of the Newport region who choose to participate in adult day services, have another provider option in their area.

Conflict Free Case Management

During this quarter, DAIL has been working closely with the DVHA Medicaid Policy unit to assess the Choices for Care and Traumatic Brain Injury programs case management services using the federal conflict-free case management regulations. The assessment included a thorough inventory of the factors related to conflict of interest by program, and identifying the number of participants by agency, who receive both case management and direct services. DAIL is currently disseminating the program assessments and working on stakeholder engagement before considering future opportunities for

strengthening Vermont's system of case management with regards to conflict of interest.

Wait Lists

- There is currently no wait list for the High Needs Group.
- There continues to be provider wait lists for Moderate Needs Group, estimated at over 800 people statewide.
- There is currently no wait list for the TBI program.

iii. Developmental Disabilities Services Division

Key updates from QE0319:

- New payment model in development
- HCBS rule implementation
- Waitlist

New Payment Model in Development

The Developmental Disabilities Services Division (DDSD) and DVHA have initiated a project to explore a new payment model for Developmental Disabilities home and community-based services (HCBS). The program has grown significantly over the years from several hundred to several thousand participants. Overall, the goal of this payment reform project is to create a transparent, effective, and administrable payment model for Developmental Disabilities Services that aligns with the broader payment reform and health care reform goals of AHS. The State has engaged stakeholders including recipients, families, advocacy organizations, and providers to participate in workgroups for the development and implementation of the new payment model.

A provider rate study has been completed and it is anticipated that a final report with recommended rates will be published by the end of the second quarter. The information from the rate study will be utilized in developing the new payment model. In addition to the provider rate study, the project is examining alternative assessment tools, resource allocation methods and options for more efficiently capturing encounter data for these services. An RFP for a standardized assessment tool has been posted and the state is awaiting proposals. Ongoing work will be required regarding changes to the payment methodology, including seeking any needed CMS approval.

HCBS Rule Implementation

DDSD continues to work on implementing the HCBS rules to ensure compliance with all requirements by 2022. Currently the state is working on addressing the issue of conflict of interest in case management. DVHA is working with departments who operate HCBS programs, including DDSD, to analyze HCBS case management across the state and is seeking stakeholder input on how to address any potential conflict of interest in each of the programs. During quarters 2 and 3, the State will develop proposals , seek additional stakeholder input on those proposals, and plan for implementation.

Wait List

DDSD collects information from service providers on individuals who request funding for HCBS and other services including Targeted Case Management (TCM), Family Managed Respite (FMR), Flexible Family Funding (FFF) or Post-Secondary Education Initiative (PSEI). The information is

gathered by the State from providers to determine individuals with developmental disabilities (DD) who are waiting for DD services but are not currently eligible. HCBS funding priorities are the method by which Vermont prioritizes who will receive caseload funding allocated annually by the legislature. Individuals are placed on the waiting list if they meet the following criteria:

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

As of 3/31/19, there were no individuals who met a HCBS funding priority who were waiting for services that helps address the need related to the funding priority. The full set of waiting list data is collated on an annual basis. This information will be provided in the 2019 Annual GC Report.

iv. Global Commitment Register

Key updates from QE0319:

- 18 policies were posted to the GCR in Q1 2019.
- Since the Global Commitment Register (GCR) launched in November 2015, 166 final GCR policies have been publicly posted.

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

The GCR listserv is a group of about 450 interested parties who have elected to receive periodic key updates about Vermont health care programs, which includes policy changes to all Medicaid programs as well as policy changes to Vermont's Health Benefit Exchange. A policy change in the GCR could be a change made under the authority of the waiver, a proposed waiver amendment or extension, an administrative rule change or a State Plan Amendment. The GCR also contains policy clarifications for when an issue is identified that is not clearly answered in current policy.

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

A combined total of 18 policies were posted to the GCR this past quarter. This includes 3 proposed changes and 15 final changes. Changes to rates and/or rate methodologies accounted for nearly half of the changes once again. Other changes include clinical coverage changes, updated timely filing guidelines, , State Plan Amendment notices, and updated 2019 financial eligibility standards.

The GCR can be found here: http://dvha.vermont.gov/global-commitment-to-health/global-commitment-register.

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

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

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

2. Executive Summary

During the first quarter of 2019 the State of Vermont continued to have all ASAM levels of care available and no ongoing waitlist to access to Medication Assisted Treatment. The Vermont Department of Health's Division of Alcohol and Drug Abuse Programs (ADAP) implemented the scoring tool to determine the Preferred Providers' compliance and certification status and continued using the tool.

ADAP continues to develop the value-based payment model for residential programs, to align with its All Payer Model Agreement with CMS, for implementation in 2020. ADAP is in the process of executing a contract for the Centralized Intake and Resource Center (CIRC). The major components are: 1) a call center staffed by certified Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self-screen tool, and 3) an appointment board to centrally manage appointments with ADAP's Preferred Provider Network..

The 2019 work of Vermont's Opioid Coordination Council will be informed by a Prevention Committee, and a committee on Intervention, Treatment & Recovery. These committees will engage a cross-section of state agencies and departments, providers, the private sector and other stakeholders to further the development and implementation of the 2019 strategies available at: http://www.healthvermont.gov/sites/default/files/documents/pdf/OCC_2019_Report_Final_1.2_2019_2-5.pdf.

Vermont launched the Recovery Coaches in the Emergency Room Program on July 1, 2018 at three sites. 703 individuals were seen in the emergency rooms with three additional sites now up and running, and two more sites in the planning phase.

3. Narrative Information on Implementation, by Reporting Topic

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

1.2 Assessment of Need and Qualification for SUD Services			
1.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
1.2.2 Implementation Update			
Compared to the demonstration design details outlined in the STCs and implementation plan, have there been any changes or does the state expect to make any changes to: A) the target population(s) of the demonstration? B) the clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration?			There are no planned changes to the target population or clinical criteria.
Are there any other anticipated program changes that may impact metrics related to assessment of need and qualification for SUD services? If so, please describe these changes.			There are no anticipated program changes.
☒ The state has no implementation updates to report for this reporting topic.			

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
2.2 Access to Critical Levels of Care for OUR and other SUDs (Milestone 1)			

2.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
2.2.2 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g. outpatient services, intensive outpatient services, medication assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management)? SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication assisted treatment services provided to individuals in IMDs? **Summary**: There are no planned changes to access to SUD treatment or the SUD benefit coverage.			
Are there any other anticipated program changes that may impact metrics related to access to critical levels of care for OUD and other SUDs? If so, please describe these changes.			There are no anticipated program changes.
☒ The state has no implementation updates to report for this reporting topic.			

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
3.2 Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)			
3.2.1 Metric Trends			
☒ The state is not reporting any metrics related to this reporting topic.			
3.2.2 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria?			

b. Implementation of a utilization management approach to ensure:
    i. Beneficiaries have access to SUD services at the appropriate level of care?
    ii. Interventions are appropriate for the diagnosis and level of care?
    iii. Use of independent process for reviewing placement in residential treatment settings?

Summary: The revised version of the Substance Use Disorder Treatment Standards has been implemented. The Compliance Assessment Tool has also been updated and implemented to reflect the revised version of the Substance Use Disorder Treatment Standards. The Compliance Assessment Tool has been utilized with 12 substance use disorder treatment providers.

The application for the recertification has moved to an online survey process. This online survey makes the utilization of the Compliance Assessment Tool for the different ASAM Levels of Care more efficient. The providers completing the survey will indicate their level of care and will submit documents based on the level of care indicated. This survey has undergone additional changes to ensure that documentation is as thorough as possible.

Milestone 2 - Table 1

Action	Revised Completion Date	Responsible	Status
Finalize Substance Use Disorder Treatment Standards	August 1, 2018	Director of Quality Management and Compliance	Completed
Update Compliance Assessment Tool with revised Substance Use Disorder Treatment Standards and all residential ASAM criteria	August 15, 2018	Director of Quality Management and Compliance	Completed
Updated online recertification survey to reflect new revision of Substance Use Disorder Treatment Standards	October 31, 2018	Director of Quality Management and Compliance	Completed
Use the Compliance Assessment Tool to certify ASAM Level 3.5 Level of Care provider (Valley Vista Vergennes)	December 31, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Use the Compliance Assessment Tool to certify ASAM Level 3.5 Level of Care provider (Valley Vista Bradford)	December 31, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Implement the Compliance Assessment Tool	October 3, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Use of the Compliance Assessment Tool to	March 31, 2019	Director of Clinical Services; Director of	Completed

certify ASAM Level 3.3 Level of Care Provider (Recovery House)		Quality Management and Compliance	
Use of the Compliance Assessment Tool to certify ASAM Level 3.2-WM Level of Care Provider (Act 1/Bridge)	March 31, 2019	Director of Clinical Services; Director of Quality Management and Compliance	Completed

Vermont continues to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS. The implementation of the value-based portion of the new model is planned for implementation in 2020. Milestone 2 – Table 2 (below) will be updated in the second quarter report of 2019.

Milestone 2 – Table 2

Action	**Date**	**Responsible**
Develop the criteria for the differential case rate	Completed	ADAP Director of Clinical Services
Model the methodology using the identified criteria for the Vermont team to review	Completed	Payment Reform Team
Work with financial colleagues to finalize budget and rate decisions for the model	Completed	Payment Reform Team, ADAP Director of Clinical Services, VDH Business Office
Residential providers to provide feedback	Completed	ADAP Director of Clinical Services
Work with the Medicaid fiscal agent to identify and complete the necessary system's changes required for the Medicaid billing system	Completed	ADAP Director of Clinical Services, Payment Reform Team, DXC (Fiscal Agent)
Work with the residential providers to provide technical assistance and education around the necessary billing changes	Completed	ADAP Clinical Team
Regional Managers will partner with the compliance and quality team to determine the appropriate frequency with which the Regional Managers will perform the between audit chart reviews	Completed	ADAP Clinical Team and ADAP Quality Team

Are there any other anticipated program changes that may impact metrics related to the use of evidence-based, SUD-specific			

patient placement criteria (if the state is reporting such metrics)? If so, please describe these changes.			
☐ The state has no implementation updates to report for this reporting topic.			

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
4.2 Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)			
4.2.1 Metric Trends			
☒ The state is not reporting any metrics related to this reporting topic.			
4.2.2 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards? b. State review process for residential treatment providers' compliance with qualifications standards? c. Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site? **Summary**: The revised version of the Substance Use Disorder Treatment Standards has been implemented. The ADAP Compliance Assessment Tool has also been updated and implemented to reflect the revised version of the Substance Use Disorder Treatment Standards. The Compliance Assessment Tool has been utilized with 12 substance use disorder treatment providers. The application for the recertification has moved to an online survey process. This online survey will also make the utilization of the Compliance Assessment Tool for the different ASAM Levels of Care be more efficient. The providers completing the survey will indicate their level of care and will submit documents based on the level of care indicated. This survey has undergone additional changes to ensure that documentation is as thorough as possible. There are no anticipated changes to the residential treatment provider qualifications, the state review process or the availability of medication assisted treatment at the residential facilities.			
Are there any other anticipated program changes that may impact metrics related to the use of nationally recognized SUD-specific program			

standards to set provider qualifications for residential treatment facilities (if the state is reporting such metrics)? If so, please describe these changes.			
☐ The state has no implementation updates to report for this reporting topic.			

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
5.2 Sufficient Provider Capacity at Critical Levels of Care including Medication Assisted Treatment for OUD (Milestone 4)			
5.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
5.2.2 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care? **Summary**: Vermont continues to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS. The implementation of the value-based portion of the new model will be implemented in 2020. ADAP is in the process of executing a contract for the Centralized Intake and Resource Center (CIRC). The major components are: 1) a call center staffed by certified Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self-screen tool, and 3) an appointment board to centrally manage appointments with ADAP's Preferred Provider Network.			

Are there any other anticipated program changes that may impact metrics related to provider capacity at critical levels of care, including for medication assisted treatment (MAT) for OUD? If so, please describe these changes.			
☐ The state has no implementation updates to report for this reporting topic.			

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

This reporting topic focuses on the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD to assess the state's progress towards meeting Milestone 5.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
6.2 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)			
6.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
6.2.2 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD? b. Expansion of coverage for and access to naloxone? **Summary**: The are no planned changes to the prescribing guidelines and other interventions.			
Are there any other anticipated program changes that may impact metrics related to the implementation			

of comprehensive treatment and prevention strategies to address opioid abuse and OUD? If so, please describe these changes.			
☒ The state has no implementation updates to report for this reporting topic.			

Milestone 6: Improved Care Coordination and Transitions between Levels of Care

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
7.2 Improved Care Coordination and Transitions between Levels of Care (Milestone 6)			
7.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
7.2.2 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports? **Summary**: Vermont implemented the Peer Recovery Coaches in the Emergency Department Program in six sites with two more sites in the planning phase. A total of 703 individuals have been seen by recovery coaches.			
Are there any other anticipated program changes that may impact metrics related to care coordination and transitions between levels of care? If so, please describe these changes.			
☐ The state has no implementation updates to report for this reporting topic.			

SUD Health Information Technology (Health IT)

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
8.2 SUD Health Information Technology (Health IT)			
8.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
11.2.2 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined in STCs and implementation plan, have there been any changes or does the state expect to make any changes to: a. How health IT is being used to slow down the rate of growth of individuals identified with SUD? b. How health IT is being used to treat effectively individuals identified with SUD? c. How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD? d. Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels? e. Other aspects of the state's health IT implementation milestones? f. The timeline for achieving health IT implementation milestones? g. Planned activities to increase use and functionality of the state's prescription drug monitoring program? **Summary**: • Vermont has a requirement and funding in the current contract with Appriss to connect VPMS to RxCheck for interstate data sharing. RxCheck is developing functionality for direct integration with EHRs and other health systems. Appriss indicates that because Vermont plans to use RxCheck for connecting to health systems/EHRs it is outside the scope of the Appriss contract; this continues to be worked on. • Funding through the Center for Disease Control and Prevention, and the Bureau for Justice Administration requires the connection to RxCheck. The requirements to update and revise the MOU for the connection to RxCheck is in process. • The current contract for the VPMS will be put out to bid later this year. The request for proposal (RFP) will include high priorities such as improved access and support for providers, integration and data management, and increased reporting functionality. • VPMS, Dr. First and Appriss are testing and verifying Appriss's Gateway integration tool to enable direct population of VPMS data into Dr. First's prescription ordering section, eliminating the need for providers to navigate between systems.			

• VPMS staff are engaged with the NESCSO State HIT Learning Community. This group works to create a shared understanding of Federal legislation, the current state of PDMP activities, and identifies opportunities for multi-state alignment. • VDH promoted the availability of technical assistance at the prescriber level. Promotion was integrated into the implementation of prescriber insight reports; the impact of implementation of the insight reports is being evaluated. Insight reports include metrics for providers about the prescriptions dispensed that they prescribed and comparisons with other providers within their specialty. Vermont continues to offer prescriber reports on a quarterly basis. • VDH is conducting an impact evaluation of the 7/1/17 pain prescribing rule change; evaluation plan in place 12/2018. The goals are: assess the impact of the new prescribing rules on prescribing patterns, determine if new prescribing rules affect awareness/usage of VPMS and evaluate impact of stricter prescribing rules on future prescription opioid misuse. VDH continues to monitor trends to look for sustained change over time. • The Centralized Intake and Resource Center (CIRC) will encompass a call center, public-facing informational website, and a web-based appointment board that will be leveraged to support waitlist management and interim services provision. The contract is processing for execution.			
Are there any other anticipated program changes that may impact metrics related to SUD Health IT (if the state is reporting such metrics)? If so, please describe these changes.			
☐ The state has no implementation updates to report for this reporting topic.			

Other SUD-Related Metrics

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
9.2 Other SUD-Related Metrics			
9.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
9.2.2 Implementation Update			
Are there any other anticipated program changes that may			

impact the other SUD-related metrics? If so, please describe these changes.			
☒ The state has no implementation updates to report for this reporting topic.			

Budget Neutrality

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
10.2 Budget Neutrality			
10.2.1 Current status and analysis			
Discuss the current status of budget neutrality and provide an analysis of the budget neutrality to date. If the SUD component is part of a comprehensive demonstration, the state should provide an analysis of the SUD-related budget neutrality and an analysis of budget neutrality as a whole.			Updates on Budget Neutrality can be found in Section V. *Financial/Budget Neutrality Development/Issues* of this report.
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
10.2.2 Implementation Update			
Are there any anticipated program changes that may impact budget neutrality? If so, please describe these changes.			
[Add rows as needed]			
☐ The state has no implementation updates to report for this reporting topic.			

SUD-Related Demonstration Operations and Policy

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
11.1 SUD-Related Demonstration Operations and Policy			
11.1.1 Considerations			

Highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.			Through the episodic payment, Vermont Medicaid developed a methodology for setting rates that created parity among providers statewide. Overall the budget in the first quarter is showing an increase in cost of 14.4% statewide. The increase is a result of a higher per person average cost (rather than an increase in the total number of members served). The increase may be due to the base rate methodology, which had initially projected more higher acuity clients. Vermont Medicaid is currently examining whether to rebase the rates in 2020 to account for the variation. Currently, providers are not operating at full bed-capacity and are citing workforce issues. However, providers are also reporting that the decrease in administrative burden resulting from the reform has allowed them to use staff time more efficiently and effectively.
[Add rows as needed]			
☐ The state has no related considerations to report for this reporting topic.			
11.1.2 Implementation Update			
Compared to the demonstration design and operational details outlined in STCs and the implementation plan, have there been any changes or does the state expect to make any changes to: a. How the delivery system operates under the demonstration (e.g. through the managed care system or fee for service)? b. Delivery models affecting demonstration			

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

SUD Demonstration Evaluation Update

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
12.1 SUD Demonstration Evaluation Update			
12.1.1 Narrative Information			
Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.			Updates on the SUD evaluation work, deliverables, and timeline can be found in Sections VIII. *Quality Improvement* and IX. *Demonstration Evaluation* of this report.

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

Other Demonstration Reporting

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
13.1 Other Demonstration Reporting			
13.1.1 General Reporting Requirements			
Have there been any changes in the state's implementation of the demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol?			No change.
Does the state foresee the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or			Not at this time.

upcoming implementation changes?			
Compared to the details outlined in the STCs and the monitoring protocol, has the state formally requested any changes or does the state expect to formally request any changes to: a. The schedule for completing and submitting monitoring reports? b. The content or completeness of submitted reports? Future reports?			Updates on the Monitoring Protocol work, deliverables, and timeline can be found in Section X. *Compliance* of this report.
Has the state identified any real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation?			Not at this time.
[Add rows as needed]			
☐ The state has no updates on general reporting requirements to report for this reporting topic.			
13.1.2 Post Award Public Forum			
If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-award public forum must be included here for the period during which the forum was held and in the annual report.			The description of the latest annual post-award public forum for this 1115 demonstration waiver can be found under Section II. Outreach/Innovative Activities, subsection ii. *Global Commitment to Health Post Award Forum* of this report.
[Add rows as needed]			
☐ There was not a post-award public forum held during this reporting period and this is not an annual report, so the state has no post award public forum update to report for this reporting topic.			

Notable State Achievements and/or Innovations

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
14.1 Notable State Achievements and/or Innovations			
14.1 Narrative Information			
Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.			The first quarter data for the SUD Residential Payment Reform effort has preliminarily shown positive outcomes. As of April 22, 2019, the providers had admitted a total of 320 clients (296 unique members). The multifactorial rate, which was developed to incentivize providers to prioritize the higher acuity clients, has resulted in an overall increase in the number of intakes with a primary diagnosis of alcohol and/or benzodiazepines in the first quarter compared to the 2018 trends. Vermont Medicaid initially hypothesized that the presence of a co-morbidity at intake would contribute to both the length of stay (LOS) and the financial cost of providing care. Based on the preliminary data, the LOS appears to remain relatively stable across cohorts; however the data does suggest that the presence of a co-morbidity may increase the likelihood of a readmit to a residential detoxification provider. Providers are reporting that the decrease in administrative burden has allowed more time to focus on clinical services and improvements to discharge planning, which has resulted in more uniformity in the length of stays across providers. The State has also seen a significant improvement in the data quality and an increase in the co-morbidity diagnoses captured on the MMIS claims submissions. Vermont Medicaid plans to use this enhanced quality data to improve tracking of population health, and to be more strategic in approaches to improving population health outcomes.
[Add rows as needed]			
☐ The state has no notable achievements or innovations to report for this reporting topic.			

IV. Expenditure Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE0319:

- Strategic planning continues with DVHA Payment Reform Team and ACO for continued alignment of service delivery to Vermont.
- Collaboration with DVHA Blueprint, Community Health Teams and Bi-State to assess both challenges and best practices with access to primary care.
- Assessment of Geographic Attribution Methodology in one HSA.
- Initial review of report and workflow for members impending Medicaid health plan loss.
- System acceptance of the AHS MMIS Enterprise Care Management system; CMS certification is in process.
- VITL Single Sign On (SSO) was deployed to the Care Management system.

The VCCI is a statewide Medicaid case management service for Medicaid beneficiaries. VCCI is comprised of licensed, field-based case managers and two non-licensed professional staff who operate in a decentralized VCCI model statewide, providing case management resources at the community level. Facilitation of access to clinically appropriate health care information and services; coordination of the efficient delivery of health care by attempting to remove barriers, bridge gaps, and avoid duplication of services; and education and empowering beneficiaries to eventually self-manage their chronic conditions are longstanding goals. Historically, VCCI has provided intensive, short term case management services to those who were predicted to be high cost/high risk. This was premised on reports highlighting that the top 5% of Medicaid beneficiaries accounted for ~39% of Medicaid expenditures. The emergence of the Accountable Care Organization (ACO) and a subsequent increase in the number of attributed lives to the Vermont Next Generation Medicaid ACO prompted the review of who VCCI would deliver case management services to and how best to deliver these services, as ACO attributed beneficiaries are not eligible to receive VCCI services. At the end of 4th quarter 2018, VCCI had implemented state-wide the enhancements to population served, and to the model of service delivery. The VCCI program shifted from a model of serving only high-risk beneficiaries, to include at -risk population and members new to the health plan. The at-risk population may include beneficiaries identified by their healthcare and social service community providers, as in need and potentially able to benefit from VCCI case management services - due to healthcare needs as well as challenges with social determinants of health such as housing, food security, and transportation issues. Outreach to beneficiaries new to Medicaid continues with initial screen of members and their access to primary care, current health conditions, risky behaviors, and social determinants of health. Current revision to new to Medicaid screening includes edit of question about PCP wait times to ask specific wait times for preventive care/wellness appointment, and the addition of dental care access questions. The goals are to 1) orient the beneficiary to the system of care, including navigation of services for health-related needs such as housing/food security and facilitating connections to local domestic violence resources, and 2) onboard beneficiaries ahead of their anticipated ACO attribution to facilitate access to primary care and connect to community resources, including self-management programs. Beneficiaries' responses to screening questions coupled with the clinical judgment of VCCI case managers allows stratification into 1 of 4 risk levels – mirroring the ACO's framework.

Table 1. Q1 CY data on new to Medicaid beneficiaries screened & establishment of primary care home

% of New to Medicaid members who accepted help with PCP establishment and who successfully established care with practice/medical home	Q3
Measure	4/15/2019
# of "New to Medicaid" members who already had a PCP they saw regularly (of those screened)	458
# who didn't have a PCP and declined help	70
# who didn't have a PCP and accepted help	95
# of members who successfully established care	16
% of members who successfully established care	16.84%

Total number of members screened was 628, with 458 reporting they had PCP established. As a program, the VCCI are indicating successful establishment when actual appointment is scheduled. Identified barriers to timely PCP establishment include: 1) Primary care offices' requirement for former medical records prior to scheduling new patient appointment, and 2) practices not accepting any new members due to shortage of providers. VCCI has been working with DVHA leadership, community health teams and Bi-State Primary Care Association to begin to learn processes, establish and share best practices and subsequent collaboration to create solutions.

In continued efforts to align with the healthcare reform and the ACO, the VCCI has been meeting with DVHA leadership and colleagues to include Payment Reform and the Blueprint; and the ACO. Initial work is focused on assessing opportunities for alignment in service delivery of the Care Model. Pilot effort is underway in one health service area to assess non-ACO members for collaborative and strategic member outreach. Pilot team includes Payment Reform, Blueprint, ACO, health service area leaders, and community team members. The population cohort includes members without any claims that demonstrate access to primary care, community providers with the initial received data file received and shared with OCV. Data will be analyzed by the ACO and loaded into a common communication platform, Care Navigator; anticipated mid-June 2019. The pilot will build upon the current foundation of the strong local partnerships and communication that exist in this service area in the service delivery of the Care Model; as well as community team readiness. Initial outreach to members without any demonstrated connectedness will utilize the outreach screening tool currently used by VCCI in the new to Medicaid outreach.

The VCCI approaches case management from the lens that a holistic model of service delivery to encompass both health and health related issues, helps to support likelihood of sustained health improvement and overall quality of life. Assessment of the presence of social determinants of health occurs early in VCCI's outreach and work, followed by appropriate referrals and navigation to services. In addition to the experience out in the field, VCCI case managers easily navigate the web of various state services available to Vermonters. To that end, VCCI is working on the receipt of a report highlighting Vermonters who are impending loss of health coverage. VCCI will review members who are enrolled with VCCI, with the goal that the assigned field-based case manager would support and

help facilitate action steps needed to ensure continued coverage. DVHA colleagues at the Blueprint will assess the population receiving medication assisted treatment.

This past year marks the 3rd year that the VCCI team has been functional in the eQHealthCare Management system. System acceptance was achieved, and CMS certification is in process. Single Sign On (SSO) for Vermont Information Technology Leaders (VITL) within the eQ Suite was deployed, facilitating ease in access to health records. All VCCI staff have been trained in VITL access (outside of eQHealth) in order to view patient information, as appropriate, to help better inform the case management plan and will have subsequent training in 2019. During the next quarter, VCCI is deploying Gaps in Care (GiC) functionality, adding VITL interface features, and launching Admissions/Discharges/Transfers (ADT) messaging. VITL interface allows users to utilize data that was previously viewed in other systems such as provider or facility systems. Users will soon have the ability to see facility visits, Continuing Care Documents, and labs. The users will also get ADT notifications when a member is admitted to a facility. With this new information, case managers will be able to conduct timelier outreach to members during their inpatient stay. Through the new GiC functionality, the system will identify any gaps in care for medications, wellness, and disease. For example, if a member has diabetes and has not had their A1-C test, the system will show the members GiC section of their case, that the member needs that test. In the future, this will also be an alert. All of these changes and enhancements help the system better support the services provided to the members and improve workflow efficiencies.

ii. Blueprint for Health

Key updates from QE0319:

- The majority of Vermont's primary care practices are now Blueprint-participating Patient Centered Medical Homes, as evidenced by the fact that 137 of Vermont's primary care practices are Blueprint-participating practices, out of an estimated 169 total primary care practices operating in the state, of which an estimated 148 employ more than one provider;
- Vermont continues to demonstrate increased access to medication assisted treatment for Vermonters with opioid use disorder, as evidenced by the 3,157 clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) as of December 2018 and the 3,064 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs as of March 2019;
- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 38 practices to participate in the Women's Health Initiative as of March 2019.

<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. Patient Centered Medical Homes provide care that is patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety. The Patient Centered Medical Home model changes the way a patient experiences care by promoting care that is provided when and where the patient needs it, and in a way that the patient understands it. Patient Centered Medical Homes in Vermont are supported by multi-

disciplinary teams of dedicated health professionals in each health service area of the state who provide supplemental services that allow Blueprint-participating primary care practices to focus on promoting prevention, wellness, and coordinated care. The support and services of the Community Health Team give primary care providers the confidence to work alongside patients to identify the cause of health problems, including those that may have a psychosocial component, and connect patients with effective interventions upon identification, manage chronic conditions, or simply provide additional opportunities to support improved well-being.

Blueprint Program Managers, who are local leaders in each community, are responsible for contacting all primary care practices within their health service area to encourage, engage, and support practice participation in the Blueprint for Health and learning health system activities. Annually, Program Managers report on the remaining primary care practices in each region that have not begun the process of transforming their practice into Patient Centered Medical Homes, indicating the rationale provided by each practice contact. Importantly, Blueprint Program Managers report very few practices in each health service area remaining who are not currently engaged with the Blueprint for Health program. Beyond the support of regional Program Managers, the Blueprint further supports each participating practice with a quality improvement coach, called a Quality Improvement Facilitator. Quality Improvement Facilitators bring Blueprint generated all-payer data about practice performance (Blueprint Practice Profiles, Blueprint Community Health Profiles) and their own training and expertise in process improvement methodologies (such as Clinical Microsystems, Model for Improvement, and Lean process improvement). Quality Improvement Facilitators initially help launch patient-centered practices and secure NCQA-Patient Centered Medical Home recognition, and then return regularly 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, including:

- focusing quality improvement activities on All Payer Model agreement and Accountable Care Organization quality measures;
- integration of the care model;
- implementation of new initiatives (e.g. Spoke program, Women's Health Initiative, improving opioid prescribing patterns);
- prevention and management of chronic conditions (e.g. for diabetes and hypertension through connections with learning collaboratives, self-management programs, health coaches, registered dieticians, and care management).

Blueprint-participating Patient Centered Medical Homes currently serve 295,772 Insurer-attributed patients (identified and attributed as a current active patient if the patient has had a majority of their primary care visits in the primary care practice within the 24 months prior to the date the attribution process is conducted), 100,651Medicaid-attributed patients, and are supported by 160 full-time equivalents of Community Health Team staff.

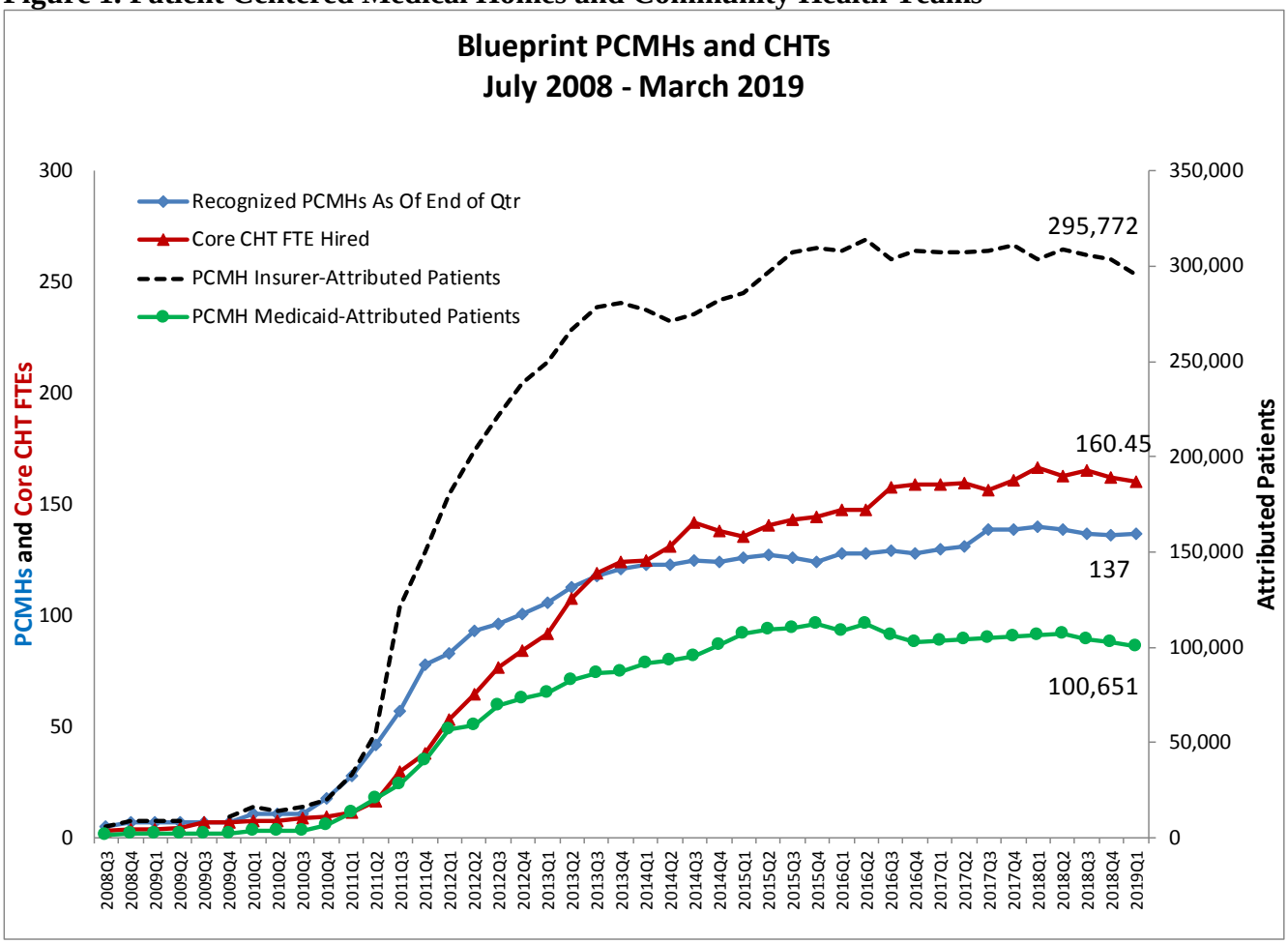
Quarterly Highlights

At the end of the 1st quarter of 2019, 137 Vermont practices were operating as Patient Centered Medical Homes, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of practices participating in the Blueprint for Health program is a key performance measure; the Blueprint estimates that there

are about 169 total primary care practices operating in the state, of which an estimated 148 employ more than one provider.

During the first quarter of 2019, new and renewing practices went through the 2017 PCMH recognition process. This process has been modified and streamlined such that all practices achieving this recognition must obtain a consistent standard of performance on the criteria (vs. previous levels of recognition) and to minimize the time requirements on quality assurance, allowing instead for greater focus on quality improvement.

Figure 1. Patient Centered Medical Homes and Community Health Teams



Practice Health Profiles and Community Health Profiles

The Blueprint for Health supports data-driven population health improvement by producing biannual profiles that describe the health status, health care utilization, health care expenditures, and health care outcomes of the patients in each Blueprint practice and community. Practice-level and community-level (by Hospital Service Area) profiles of all-payer healthcare outcomes data, for adult and pediatric patient populations, combine claims, clinical, and survey information, and continue to be produced by Onpoint Health Data for the Blueprint roughly every 6 months. Practice Health Profiles help practices identify ways that they can better serve their patients, and to track the success of quality improvement initiatives. Community Health Profiles, organized by hospital-service area level data, are used by the

regional Accountable Communities for Health (Community Collaboratives) and other local workgroups to inform and complement Community Health Needs Assessments and other community data products. Practice Health Profiles and Community Health Profiles have been distributed to practices and healthcare organizations for the following data time periods:

i. 01/2013 - 12/2013
ii. 07/2013 - 06/2014
iii. 01/2014 - 12/2014
iv. 07/2014 - 06/2015
v. 01/2015 – 12/2015
vi. 07/2015 – 06/2016
vii. 01/2016 – 12/2016
viii. 07/2016 – 06/2017
ix. 01/2017 – 12/2017

Practice Health and Community Health Profiles for the data period 01/2017 – 12/2017 were produced and distributed in February 2019. The information in the most recent set of profiles gives practices the most up-to-date overview of total utilization and expenditures as compared to peers and the rest of the state. The Community Health Profiles, including the latest ones for the data period 01/2017 – 12/2017, are posted at http://blueprintforhealth.vermont.gov/community-health-profiles. The profiles distributed this quarter represented some significant changes in how data is collated and reported back to the communities, including:

- Providing data for all individuals with claims in the Vermont All Payer Claims Database (VHCURES) that reside within a specified geographic boundary (vs. individuals attributed to a practice within the geographic boundary), representing a more true "whole population" sample.
- Breaking out reporting on individuals attributed to a Blueprint for Health Primary Care Practice, those attributed to a non-Blueprint for Health Practice (e.g. receiving majority of their primary care from specialists or out of state), and for those with health care claims but no primary care visits within the last two years (thus, no attribution to primary care)

The next set of profiles are expected to be distributed June 2019.

The Blueprint for Health Central Office team has been actively working with data stakeholders to revamp and refresh the practice level profiles and intent to offer a refined data products within the next 6-12 months.

Hub & Spoke Program

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

and increased social functioning and retention in treatment.

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

The Blueprint, in partnership with the Division of Alcohol and Drug Abuse Programs (Department of Health), continues to offer learning sessions with expert-led, and peer-supported, training in best practices for providing team- and evidence-based medication assisted treatment for opioid use disorder. For many physicians, nurse practitioners, and physician assistants, access to specialized staffing and ongoing training opportunities provide the support and confidence the providers need to accept the challenge of treating opioid use disorder in community-based medical practice settings (Spokes). For patients, the Spoke staff become a critical part of their care team, working together week-by-week and month-by-month towards long-term recovery and improved health and well-being. At the end of the 1st quarter of 2019, capacity for receiving medication assisted treatment in Spoke settings continued to increase, as evidenced by 3,064 Vermonters with Medicaid insurance receiving medication assisted treatment for opioid use disorder from 234 prescribers and 69.59 full-time equivalent Spoke staff, working as teams, across more than 86 different Spoke settings (as of March 2019).

Quarterly Highlights

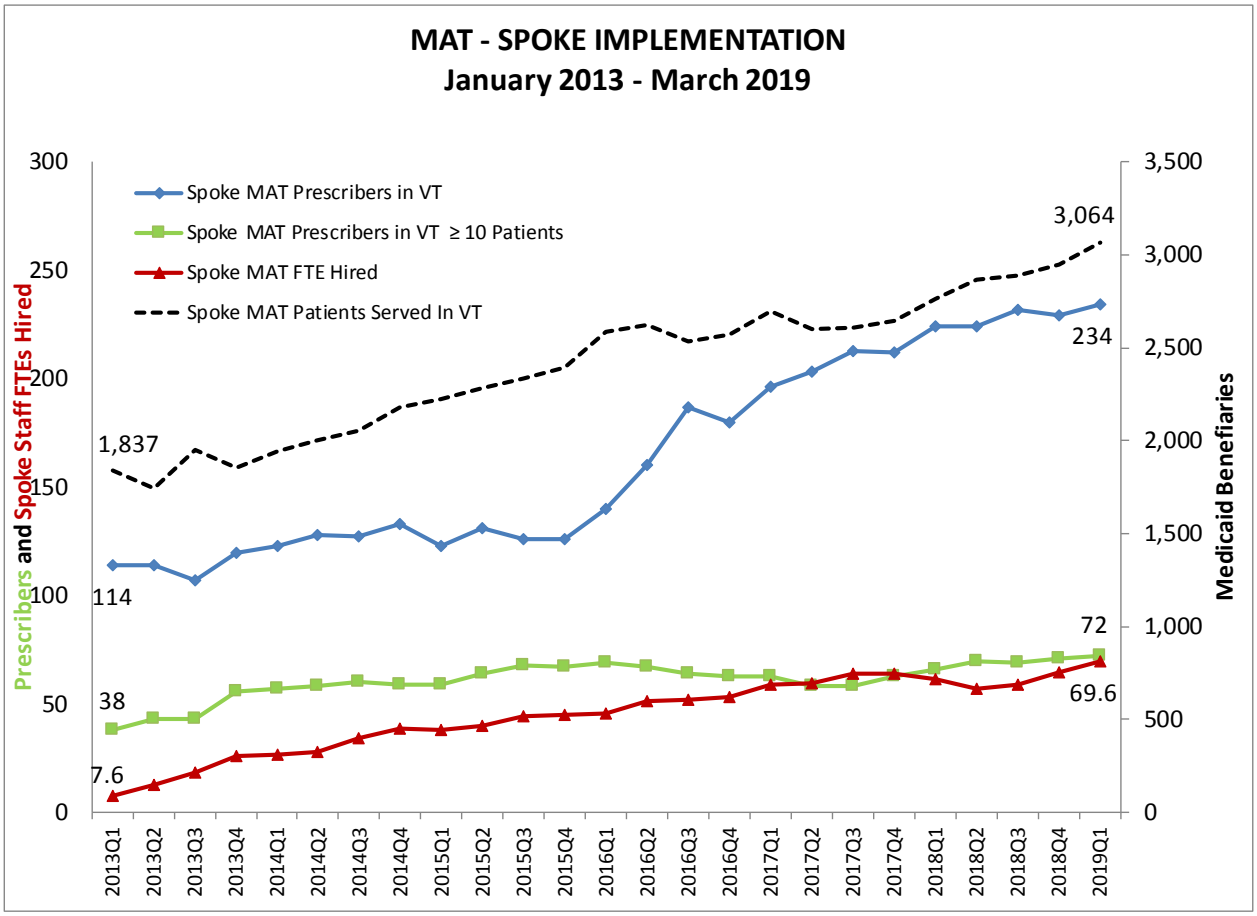
- Vermont continues to demonstrate increased access to medication assisted treatment for Vermonters with opioid use disorder, as evidenced by the 3,157 clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) as of December 2018 and the 3,064 Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs as of March 2019.

- Medication Assisted Treatment (MAT) for opioid use disorder is being offered across the State of Vermont by more than 86 different practices and by 234 medical doctors, nurse practitioners and physician assistants who work with 69.59 FTE licensed, registered nurses and licensed, Master's-prepared, mental health / substance use disorder clinicians as a team to offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder (as of March 2019).

- A collaborative team, comprised of the Department of Vermont Health Access - Blueprint for Health and the Vermont Department of Health – Division of Alcohol and Drug Abuse Programs staff and clinical content experts, was convened for the design and delivery of learning sessions intended to enhance best practice adoption by providers and practice teams. The planning team offered one learning sessions in the first quarter of 2019; the learning

sessions are open to MAT teams, with CMEs and CEUs offered. The learning sessions will be dedicated to enhancing best practices for comprehensive transitional care and prevention in practice, focusing on strategies to improve seamless transitions from one treatment setting to another, that improve patient and provider satisfaction and patient outcomes, and strategies that support patient-oriented wellness and recovery.

Figure 2. MAT-SPOKE Implementation Jan 2013 – March 2019



The table below shows the caseload of regional Hub programs, the number of clients receiving buprenorphine, methadone, or Vivitrol, and indicates that there continues to be no waitlist at any of the regional Hub settings as of the most recent report (December 2018).

Table 2. Hub Implementation by Region as of December 2018

VERMONT
VT Department of Health

VERMONT
Department of VT Health Access

Hub Census and Waitlist: December 2018

Region	# Clients	# Buprenorphine	# Methadone	# Vivitrol	# Receiving Treatment but Not Yet Dosed	# Waiting
Chittenden, Addison	1006	284	722	0	0	0
Franklin, Grand Isle	395	170	224	1	0	0
Washington, Lamoille, Orange	495	168	327	0	0	0
Windsor, Windham	637	120	515	0	2	0
Rutland, Bennington	420	104	302	0	14	0
Essex, Orleans, Caledonia	797	223	571	1	2	0
Total	3750	1069	2661	2	18	0

Note: The Franklin/Grand Isle location opened in July 2017. Some clients are transferring from the Chittenden/Addison hub to the FGI hub.

The table below shows the number of Medicaid beneficiaries receiving medication assisted treatment in Spoke settings, the number of providers prescribing medication assisted treatment for opioid use disorder, the number of providers prescribing to 10 or more patients, and the full-time-equivalents for hired Spoke staff (licensed, registered nurses and licensed mental health clinicians) by region and statewide.

Table 3. Spoke Implementation by Region as of March 2019

VERMONT Agency of Human Services

VERMONT Blueprint for Health
Smart choices. Powerful tools.

Spoke Patients, Providers & Staffing: March 2019

Region	Total # Providers prescribing patients	# Providers prescribing to ≥ 10 pts	Staff FTE Hired	Medicaid Beneficiaries
Bennington	12	5	5.60	315
St. Albans	21	14	12.25	422
Rutland	17	9	9.80	414
Chittenden	87	15	15.85	665
Brattleboro	12	4	3.19	134
Springfield	6	2	1.55	51
Windsor	15	7	4.50	272
Randolph	6	3	2.70	108
Barre	21	5	4.75	243
Lamoille	13	7	4.90	189
Newport & St. Johnsbury	12	2	2.00	117
Addison	16	3	2.50	134
Total	**234***	**72**	**69.59**	**3,064**

Table Notes: Beneficiary count based on pharmacy claims for Buprenorphine and Vivitrol, January 2019 – March 2019; an additional **321** Medicaid beneficiaries are served by **49** out-of-state providers. Staff hired based on Blueprint portal report, as of 3/31/19. *4 providers prescribe in more than one region.

Women's Health Initiative

Like the Hub & Spoke program, the Women's Health Initiative began as a challenge from state leadership to improve the health of women and families by addressing the high percentage of unintended pregnancies. Initially, the Initiative was a design project for the Blueprint, in partnership with the Vermont Department of Health and other policy makers, providers, and experts, and subsequently developed into a statewide intervention that now helps Vermonters with accessing evidence-based care.

The Women's Health Initiative offers participating providers and practices new training, staffing, payments, and community connections. With these supports, practices can now offer women enhanced preventative care, screenings and follow-up to address health and social risks, comprehensive family planning counseling, and timely access to the most effective forms of contraception, including Long Acting Reversible Contraceptives (LARC), when chosen by the patient and clinically appropriate. Women who visit Women's Health Initiative-participating women's health practices (OB-GYN offices, midwifery practices, and family planning clinics) and primary care practices engage in enhanced psychosocial screening for mental health and substance use disorders, interpersonal violence, and access to housing and food.

Women identified as at-risk are immediately connected to a licensed mental health clinician for brief intervention, counseling, and referral to more intensive treatment as needed. The clinicians connect women with their local network of health, social, economic and community services. Women also engage in comprehensive family planning counseling at participating practices and community-based organizations. Women who wish to become pregnant receive pre-conception counseling and services to support the healthiest pregnancies possible. For those women who indicate they do not want to have a baby in the coming year, they have access to the full spectrum of contraception options, including immediate access to LARC.

The payments associated with participating in the Women's Health Initiative support women's health and primary care practices in designing workflows that support the enhanced psychosocial screening, comprehensive family planning counseling, and same-day LARC insertion and support the provision of effective interventions by licensed mental health clinicians. A key aspect of the initiative is the focus on improving clinical-community linkages, which involves collaboration between participating practices and community-based organizations in order to successfully address health care and non-medical health related social needs. Communities that have practices participating in the Women's Health Initiative have developed coalitions that include the participating medical practices and community organizations in order to develop bidirectional referrals pathways that support Vermonters with accessing necessary services more efficiently.

Quarterly Highlights

- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 38 practices to participate in the Women's Health Initiative as of March 2019.

- The Women's Health Initiative now includes 38 participating practices (20 women's health and 18 primary care) across the State of Vermont.

- The Women's Health Initiative (WHI) is approaching statewide coverage, as all but two Hospital Service Areas have a specialized women's health practice now participating in the

WHI. Furthermore, continued expansion of the WHI is expected among Planned Parenthood of Northern New England women's health practices and within Blueprint Patient-Centered Medical Homes (PCMHs).

- The Blueprint for Health, in collaboration with an analytics contractor, Onpoint Health Data, is developing data profiles that will provide valuable information regarding demographic and health status information, and outcome measures for the Women's Health Initiative; the WHI profiles will be used to guide future program improvement initiatives. These are scheduled for release in the 2nd quarter of 2019.

Figure 3. Women's Health Initiative: Practices, Patients, and CHT Staffing

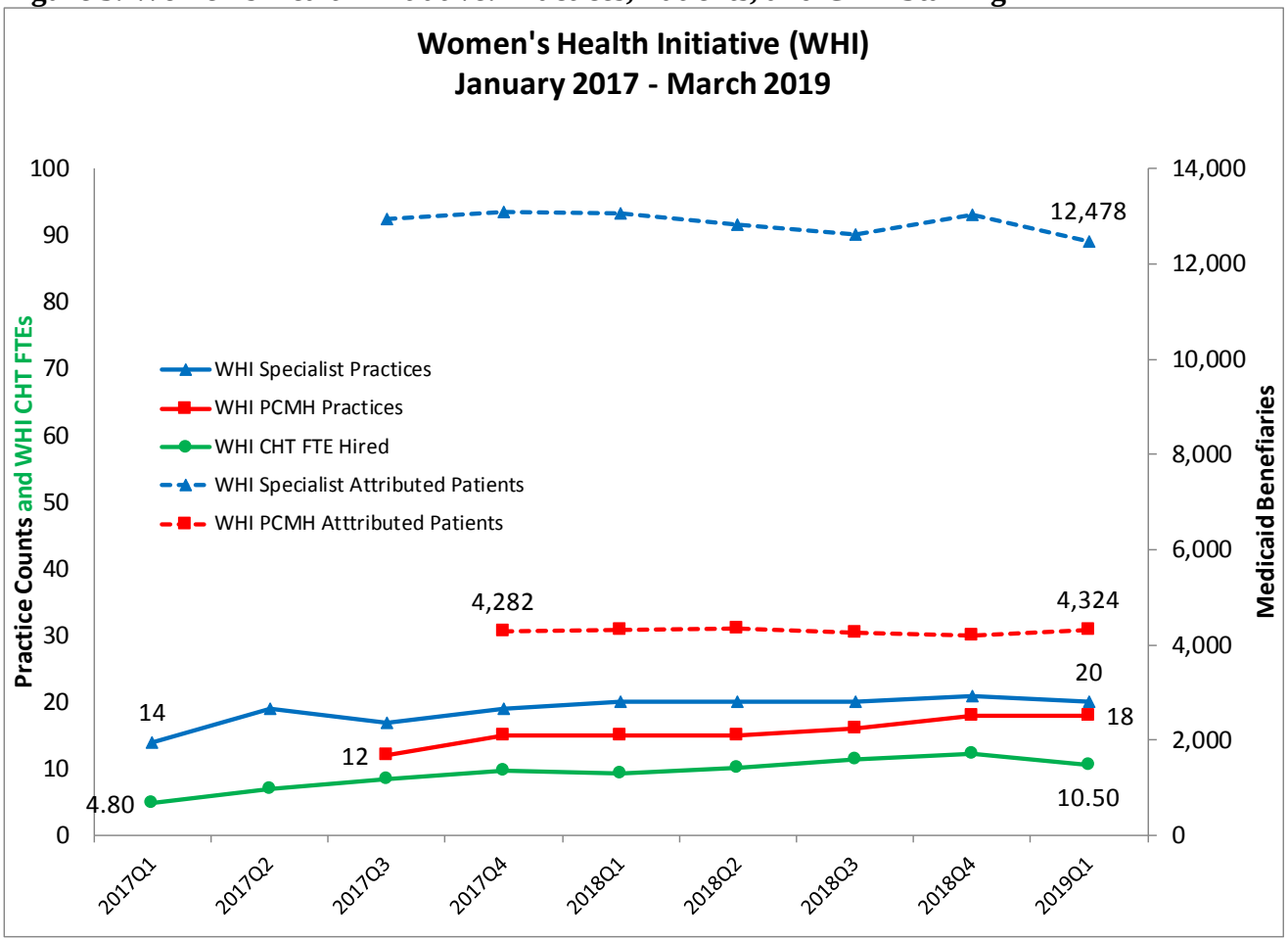


Table 4. Women's Health Implementation by Region

Health Service Area / Team	WHI Specialist Practices as of March 2019	WHI PCMH Practices as of March 2019	WHI CHT Staff FTE Hired as of March 2018	WHI Specialist Quarterly Attributed** Medicaid Beneficiaries as of December 2018	WHI PCMH Quarterly Attributed** Medicaid Beneficiaries as of December 2018
Barre	1	1	1.00	800	(With Burlington)
Bennington	1	2	0.50	906	52
Brattleboro	1	0	1.00	365	0
Burlington	3	6	3.00	2,230	1,657
Middlebury	1	0	0.75	388	0
Morrisville	1	2	0.50	536	446
Newport	0	0	0.00	0	0
Randolph	2	0	0.50	538	0
Rutland	1	1	1.50	1,185	174
Springfield	1	4	1.00	427	1,278
St. Albans	1	0	0.00	1,057	0
St. Johnsbury	1	2	0.75	662	593
Windsor*	0	0	0.00	0	0
Planned Parenthood (Statewide)	6	0	N/A	4,236	0
Total	20	18	10.50	13,020	4,195

*The Windsor Health Service Area does not have women's health specialty practices.
**Quarterly attributed patient counts at the HSA level have a small amount of overlap due to patients moving across HSAs in different months. The statewide quarterly total is deduplicated.

iii. Behavioral Health

Key updates from QE0319:

- Pilot Project Analysis and Extension
- Team Care program revisions
- Applied Behavior Analysis
- Administrative Authorization Pilot Review
- Onboarding providers

The Behavioral Health Team is responsible for concurrent review and authorization of inpatient psychiatric, eating disorder, and detoxification services for Medicaid primary beneficiaries. The team maintains a high level of inter-rater reliability through clinical supervision and testing. The team has developed a system to ensure internal consistency and educate providers on documentation requirements. The team consists of master's level clinicians called Behavioral Health Concurrent Care Managers. The care managers engage with discharge planners at inpatient and residential facilities to ensure timely and appropriate discharge plans. Care managers collaborate with other departments to support coordination of care and assist in mitigating barriers to discharge. Through collaboration with Vermont Chronic Care Initiative (VCCI) partners, a referral process for VCCI services has been established. The referrals support continuity of care for new enrollees and members already receiving VCCI services.

In recognition of the inherent challenges in providing strong clinical documentation to justify admission and continued stay within 24 hours of admission, DVHA has engaged in a pilot project in which there is automatic initial authorization of 5 days for all members meeting the acute level of care criteria at the Brattleboro Retreat. This practice allows time for the assessment and formulation of an individualized plan of care and discharge plan for each member admitted. Qualitative reviews on a large sample of pilot project authorizations were conducted to ensure appropriate utilization. The reviews found that the admissions would have been authorized under the previous system. There continues to be a decline in the average lengths of stay. This decrease allows for an increase in access and may be attributable to a stronger focus on discharge planning upon admission. There has also been a significant decrease in contested authorization decisions. The pilot project was extended through July 1, 2019. Close monitoring and quarterly qualitative reviews continue with similar results. The team is also evaluating whether members attributed to the Accountable Care Organization have similar average lengths of stay.

In an effort to reduce the number of members waiting in emergency departments for placement, staff from the quality unit joined colleagues from other departments to develop a system for identifying and supporting transition. A practice was developed to support high needs members in accessing care and other proposals are being explored.

The Behavioral Health Team also manages the Team Care program (the lock-in program). The annual review has begun of clinical documentation and data to support ongoing member inclusion in the program. The team also conducted a complete review of Team Care protocol. Standards (objective and subjective) for inclusion and disenrollment were defined and are being operationalized by the team. A Standard Operating Procedure was developed, and staff have been trained on the new procedure. The practice of referring Team Care program members to VCCI when appropriate has been incorporated in the protocol. New methods for identification of potential members are being explored as there have been minimal referrals this quarter. The lack of referrals may demonstrate success of the

Vermont Prescription Monitoring System (VPMS) and new opiate rules associated with VPMS. The team is also developing a method to more accurately assess cost savings attributable to inclusion in the Team Care program.

The Unit also manages the Applied Behavior Analysis (ABA) benefit. The Autism Specialist, a member of the Behavioral Health Team, has worked collaboratively with the Policy Unit and sister departments to evaluate and improve the program. DVHA is currently working on development of a new payment model that would continue to support members and providers, as well as attract new ABA providers to serve members. A new model has been established and following stakeholder feedback it was determined the team would visit each site and educate providers on the changes. New quality review procedures have been developed. The Clinical Guidelines were updated and the benefit has been rewritten. The revisions were posted for public comment and revisions were made following receipt of feedback. The QICI Autism Specialist participates in the Autism Workgroup, which happens on a bi-monthly basis and includes community partners, including several ABA providers across the State. This meeting gives ABA providers the opportunity to ask questions and allows them to provide feedback directly to the Autism Specialist. Ongoing collaboration with sister departments has allowed for coordination of services and increasing supports to Medicaid members. DVHA also continues to identify and onboard providers specializing in services for children with autism. The team is currently exploring telemedicine opportunities for communities without access to services.

iv. Mental Health System of Care

Key updates from QE0319:

- Implementation of Vermont State Legislative requirements
- IMD Phase Down
- Home and Community Based Services- Site Self-Assessments and Validation
- Delivery System and Payment Reform
- Integrating Family Services updates

<u>System Overview</u>

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

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

DMH also contracts with several peer and family-run organizations to provide additional support and education for peers and family members who are seeking supplemental or alternative supports outside

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

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

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

Updates

Residential Capacity

In the first quarter of the calendar year, the Department has worked with the Vermont State Legislature on a bill that formalizes plans for replacement of the temporary, secure residential treatment facility in Middlesex, Vermont. The Department has proposed as a replacement a permanent, 16-bed, state-run, physically secure, residential facility with increased clinical capacity. The intended outcome is to improve flow and inpatient bed availability in the system of care.

Funds to support the planning and development of a larger, permanent facility are included in the proposed Fiscal Year 2020 Capital Bill to the Vermont Legislature. Specifications include a better permanent facility design and footprint for a next generation, physically secure residential facility, ideally located somewhere in Central Vermont.

Current Residency Statistics of the Secure Middlesex Residential Facility

- 45 individuals served since opening
- Average Length of Stay (LOS) is currently 217 days (just under 8 months)
- 67% stepped down to less restrictive facilities or independent housing

Inpatient Capacity

This quarter also saw the start of renovations at the Brattleboro Retreat that will support 12 new inpatient level-1 beds, which are expected to come online in the first half of calendar year 2020. There are currently a total of 201 adult psychiatric inpatient beds across the system of care, of which 45 beds are level 1.

Stakeholder Engagement

The Department of Mental Health has started planning a robust stakeholder engagement process for the summer of 2019 in order to create the outline of a 10-year vision for the mental health system of care spanning children, youth, families and adults, accompanied by clear action steps for achievement. The Department intends to use the 2019 engagement process to inform a shared vision, shared commitment, and shared accountability for the long-term vision of an integrated, holistic health care system. The process is meant to consider implementation of current system changes resulting from healthcare reform, planned changes in inpatient capacity and other commitments of the Department of Mental Health, the Agency of Human Services, and the many partners, providers and payers who are responsible for the State's mental health system of care. The resulting vision will be used to create a

framework for implementation strategies and a process to achieve a comprehensive continuum of integrated care.

Payment Reform

As part of the State's efforts to develop health care payment reform models that align with Vermont's All-Payer ACO Model agreement and advance implementation of Vermont's Global Commitment to Health waiver, DMH has worked with other departments in the AHS and with stakeholders to design and implement a payment model for children's and adult mental health services provided by Designated and Specialized Services Agencies (Mental Health Clinics). DMH successfully executed all Agreements necessary for implementation on January 1, 2019 and spent the first quarter of the calendar year providing technical support to providers and monitoring for potential implementation issues.

In the month of March, the Department sent out all initial caseload reports for the month of January, showing that providers were well on target for the first month of service under the new payment model.

All Designated Agencies – Caseload Monitoring

Children's Case Rate

Total January Caseload:	3,603
Target January Caseload:	3,214

Adult Case Rate

Total January Caseload:	3,821
Target January Caseload:	3,649

- "Target" Caseload is 90% of the Agency's 3-year, weighted, average historic caseload.

This alternative payment model is intended to improve the predictability of payments to providers of mental health services, and to increase their flexibility to meet the needs of the Vermonters they serve. The new model places additional focus on quality—at first by providing an incentive for providers to report complete, accurate, and timely information, and in the future by linking a portion of payments to providers' performance on certain quality measures. The new payment model shares many characteristics of other value-based payment models that the State is implementing or considering for future implementation; such alignment should contribute to both State and provider readiness for an increasingly integrated health care delivery system over time and should aid the State in developing a strategy for inclusion of additional services in All-Payer financial targets in future.

In the Month of March, the Department was also able to report on achievement of value-based payments for process measures related to standardized and timely submission of service data for January dates of service.

Table 5. Value-Based Payments

	Jan-19		
Agency	Timely	% Complete	Met 20% Complete
1	Yes	99%	Yes
2	Yes	53%	Yes
3	Yes	98%	Yes
4	Yes	66%	Yes
5	Yes	86%	Yes
6	Yes	100%	Yes
7	Yes	100%	Yes
8	Yes	94%	Yes
9	Yes	100%	Yes
10	Yes	92%	Yes

Integrating Family Services

The initial IFS implementation site in Addison County began on July 1, 2012, and the second pilot region in Franklin/Grand Isle counties began on April 1, 2014. These pilots included consolidation of over 30 state and federal funding streams into one unified whole through one AHS Master Grant agreement. The State created an annual aggregate spending cap for two providers in Addison County (the Designated Agency and the Parent Child Center) and one in Franklin/Grand Isle (this provider 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 and families.

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

As part of quality oversight, this spring both IFS sites are undergoing an integrated quality chart review. This review occurs every two years and includes an interagency team from AHS doing a minimum standards chart review across all funding streams that are included in the IFS case rates in addition to mental health funds-this includes the Department of Health, Child Development Division, Family Services Division, and Developmental Services. This process will result in a report being issued to both regions focusing on their strengths and areas that need improvement or corrective action.

Both IFS regions have been utilizing the Child and Adolescent Needs and Strengths (CANS) to look at the needs and strengths of children they are serving. The agencies are using this progress monitoring tool to track progress over time. The data in both regions is being used to launch population health efforts to do more prevention and promotion work-a key goal of having the flexibility within bundled payments.

v. Pharmacy Program

Key updates from QE0319:

- The Drug Utilization Review Board (DURB) held one meeting in February.
- Bulletins and Advisories

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, controlling pharmacy expenditures through managing cost, brand and generic utilization, and reducing state administrative costs. The State of Vermont utilizes the pharmacy benefit management company, Change Healthcare (CHC), to provide an array of operational, clinical, and programmatic support in addition to managing a call center in South Burlington, Vermont, for pharmacies and prescribers. The Pharmacy Unit is also responsible for overseeing the contract with CHC. The Pharmacy Unit manages over $185 million in gross drug spend, and routinely analyzes national and DVHA drug trends, reviews drug utilization, and seeks innovative solutions to delivering high-quality customer service, assuring optimal drug therapy for DVHA members while managing drug utilization and cost.

Pharmacy Operations

- Pharmacy claims processing - enforcing coverage rules for various program.
- Pharmacy provider assistance - DVHA, Change Healthcare Technical and Clinical Call Centers.
- Liaison to Coordination of Benefits Unit/Part D Plan Team/Eligibility/Maximus to resolve issues. Vermont Department of Health (VDH)-Vaccine Program, Substance Abuse Program, Department of Mental Health (DMH) management of antipsychotics.
    - Works with Vermont Medication Assistance Program (VMAP)and Children with Special Health Needs (CSHN) to assist in the management of the programs.

Clinical

- Manages drug utilization and cost
    - Federal, State, Supplemental rebate programs
    - Preferred Drug list
    - Drug Utilization Review/Pharmaceutical & Therapeutics Board activities
        - therapeutic class reviews, prior authorization criteria reviews and step-therapy protocols
        - Specialty Pharmacy
- Manages exception requests, second reconsiderations, appeals and fair hearings with the Policy Unit
- Works with Program Integrity Unit on drug utilization issues

Bulletins and Advisories/Communications

The following communications went out in January and February to pharmacies and providers:

1. PHARMACY BENEFIT PROGRAMS PROVIDER SATISFACTION SURVEY

   The Department of Vermont Health Access (DVHA) contracts with Change Healthcare to support Vermont's publicly funded pharmacy benefit programs. The Change Healthcare help desk supports all pharmacies and prescribers enrolled in Vermont's pharmacy benefit programs such as Medicaid and Dr. Dynasaur and is the first point of contact for pharmacy and medical providers for drug prior authorization requests, drug claims processing issues, and other drug-related questions, concerns and complaints.

   Change Healthcare is conducting a provider satisfaction survey of pharmacies and prescribers. This survey is required annually by DVHA to assure that enrolled providers are receiving the highest quality of service possible from its contracted vendors. Your participation in this survey is very important to DVHA as responses from this survey will be used for quality improvement efforts.

2. DVHA PHARMACY NEWSLETTER

   Hematopoietics: Colony Stimulating Factors

   Due to the availability of many new products, a new therapeutic category entitled "Hematopoietics: Colony Stimulating Factors" was added to the Department of Vermont Health (DVHA) Preferred Drug List (PDL) on 1/1/19. To view medications that that are preferred with NO prior authorization required can be found http://dvha.vermont.gov/for-providers/1colony-stimulating-factors-final.pdf

   Pharmacy Benefit Update – Preferred Drug List (PDL) News

   To view the Pharmacy Benefit Updates containing January 1, 2019 changes to the Preferred Drug List as well as updates on the Vermont pharmacy benefit changes please go to http://dvha.vermont.gov/for-providers/2019-pdl-changes-newsletter-final.pdf

Department of Vermont Health Access (DVHA) Website Updates

1. NDC Rebatable Drug List: http://dvha.vermont.gov/for-providers/drug-coverage-lists-1

2. Over the Counter (OTC) Drugs: http://dvha.vermont.gov/for-providers/drug-coverage-lists-1

3. Specialty Drug List: http://dvha.vermont.gov/for-providers/pharmacy

4. State Maximum Allowable Cost (SMAC): http://dvha.vermont.gov/for-providers/pharmacy

5. Preferred Drug List (PDL): http://dvha.vermont.gov/for-providers/pharmacy

6. Preferred Diabetic Supply Listing (PDSL): http://dvha.vermont.gov/for-providers/pharmacy

7. Metabolic Formulas List: http://dvha.vermont.gov/for-providers/1metabolic-formulas-list-012219.pdf

Drug Utilization Review Board

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

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

Additionally, per State statute requiring the DVHA Commissioner establish a pharmacy best practice and cost control program, the DURB was designated as the entity to provide clinical guidance on the development of a Preferred Drug List for Medicaid beneficiaries. The DURB typically includes 10-12 members, who are appointed to two - year terms with the option to extend to a four - year term. At least one-third, but not more than half, of the Board's members are licensed and actively practicing physicians and at least one-third of its members are licensed and actively practicing pharmacists, in addition to one member at large who is currently a nurse practitioner. Board members are recommended by the DVHA Commissioner and approved by the Governor.

Drug Utilization Review Board meetings occur seven times per year. In QE0319, the DURB held 1 meetings. The DURB is scheduled to hold 3 meetings next quarter. Information on the DURB and its activities in 2019 is available: http://dvha.vermont.gov/advisory-boards.

Drug Utilization Review Board Meetings

Seven new drugs and nine therapeutic classes were reviewed at the DURB meeting held this quarter; two RetroDur reviews and one safety alerts was also presented.

vi. All Payer Model: Vermont Medicaid Next Generation Program

Key updates from QE0319:

- DVHA and OneCare executed a contract extension to the program for a 2019 performance year, which included adjustments to the program's attribution methodology.
- DVHA began conducting financial reconciliation activities for the 2018 performance year, in order to determine financial and quality performance. Results will be available in early Q3 2019.

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

public health care programs.

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

DVHA issues a prospective Per-Member-Per-Month (PMPM) payment to the ACO; the ACO distributes payments to providers participating in the program per contractual arrangements between the ACO and providers. The ACO is paid for each attributed member according to their Medicaid Eligibility Group, and the ACO is accountable for the cost and quality of care of each attributed member. 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 to extend the VMNG program into a 2019 performance year. A notable adjustment to the VMNG program for 2019 was to the methodology by which members are attributed to the model, to more accurately reflect relationships between members and providers. Additionally, a pilot geographic attribution methodology was put into place for one VMNG-participating Health Service Area (HSA), through which all Medicaid members are attributed to the ACO based on their residence in that HSA. This pilot will be studied throughout 2019 to assess whether expanding a geographic approach to attributing members to the program is feasible to expand to other HSAs in the state. Other programmatic changes were minimal, as the primary focus for the 2019 year continues to be on growing the model and expanding the number of participating providers and attributed members, while maintaining alignment across payer programs as part of Vermont's All-Payer ACO Model. The number of risk-bearing hospital communities increased from ten to thirteen for the 2019 performance year, with continued participation from other providers within the communities. The number of attributed lives for the 2019 performance year increased from approximately 42,000 lives to approximately 79,000 lives.

DVHA began conducting financial reconciliation activities for its 2018 performance year in Q1 2019. Reconciliation activities will determine the ACO's spend as compared to their financial target and quality performance for the 2018 performance year. Reconciliation activities will continue through June, 2019, and final results will be available by the end of Q3 2019.

Quarterly reporting requirements to the Vermont legislature on the VMNG program for 2019 are not known at this time. DVHA's most recent submission to the Vermont legislature can be found here: https://legislature.vermont.gov/assets/Legislative-Reports/VMNG-Report-to-Legislature-December-15-2018-FINAL.pdf

DVHA and OneCare continue discussions of potential modifications for future program years, while remaining 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 1/12 of the legislative budget for Global Commitment on the first business day of every month during the March 2019 quarter. This payment served as the proxy

by which to draw down Federal funds for Global Commitment (GC). The State prepared the CMS-64 based upon actual allowable Medicaid expenditures (program, investments and admin; please note admin is now claimed outside of GC neutrality) for the given quarter. After each quarterly submission, AHS reconciles what was claimed on the CMS-64 versus the monthly payments made to DVHA.

AHS submitted and certified the CMS64 report for QE0319 on April 30, 2019, as is normal. There were minimal prior quarter adjusting entries needed for program during this period. One type of prior quarter adjusting entry to highlight is for drug rebate interest. AHS discovered two issues with reporting drug rebate interest. First, the allocation of drug rebate interest was not being done correctly; in previous quarters, the interest was only allocated to CHIP, but a portion should have also been allocated to GC. Second, AHS discovered it was duplicating the reporting of drug rebate interest on line 5 of the CMS-64 summary form. AHS did a lump sum adjustment to reverse this entry on line 5. Going forward, AHS will no longer be reporting drug rebate interest on line 5, but rather will be reporting it on line 7A1 of the respective 64.9 Waiver form.
There were some members enrolled in the "presumptively eligible pregnant woman" category this quarter. The GC STCs do not specifically identify how to report this population on the CMS-64. AHS determined that this category of enrollees best fit in the non-ABD category and reported the member months and expenditures as such.
DVHA and AHS continue to work on fine-tuning the CY2017 MLR calculation and will be submitting to the CMS Regional Office for review.
AHS continues to actively monitor Investment spending. The total Investment spending for QE0319 was $26,425,180. There was no spending for Delivery System Reform Investments. While reconciling to the MBES Schedule C, AHS noticed that Investment spending for CY2018 exceeded the annual cap by $84,046. AHS will enter a prior quarter adjustment in QE0619 to reduce the Investment claim for CY2018 by that amount. CY2019 marks the first year in which room & board and physician training program Investments must be phased down by 33%. The HIT and non-State plan related Education fund Investments have already been fully phased-down.

VI. Member Month Reporting

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

GC quarterly reports prior to 2017 provided an enrollment count by Demonstration Population only. Medicaid Eligibility Groups have been added for the new Budget Neutrality (see Attachment 1). To maintain continuity, the table below crosswalks the count from Medicaid Eligibility Group to Demonstration Population. Both counts use the same unduplicated enrollment count information.

The table below contains Member Month Reporting for QE0319 of CY2019 reflects the unduplicated count of member months for SUD IMD stays. CY2018 and CY 2017 member months are also reported in the tables below.

Table 6. Member Month Reporting – Calendar Year 2019, QE0319, *subject to revision*

Demonstration Population	Medicaid Eligibility Group	Total CY 2019
1, 4*, 5*	ABD - Non-Medicare - Adult	**20,683**
	SUD - IMD - ABD	**21**
1	ABD - Non-Medicare - Child	**6,283**
1, 4*, 5*	ABD - Dual	**63,695**
	SUD - IMD - ABD Dual	**24**
2	ANFC - Non-Medicare - Adult	**28,403**
	SUD - IMD - ANFC	**41**
2	ANFC - Non-Medicare - Child	**176,797**
	Medicaid Expansion	
7	Global RX	**19,568**
8	Global RX	**11,396**
6	Moderate Needs	**643**
	New Adults	
3	New Adult with out child	**110,343**
	SUD - IMD New Adult w/o child	**236**
3	New Adult with child	**57,917**
	SUD - IMD New Adult with child	**50**
	Total	**496,100**
*** Long Term Care Group**	**Total CY 2019**	
4 only	ABD Long Term Care Highest Need	**8,528**
5 only	ABD Long Term Care High Need	**3,664**

Demonstration Population	Medicaid Eligibility Group	Total CY 2018
1, 4*, 5*	ABD - Non-Medicare - Adult	**83,219**
	SUD - IMD - ABD	**78**
1	ABD - Non-Medicare - Child	**25,524**
1, 4*, 5*	ABD - Dual	**257,039**
	SUD - IMD - ABD Dual	**78**
2	ANFC - Non-Medicare - Adult	**143,790**
	SUD - IMD - ANFC	**187**
2	ANFC - Non-Medicare - Child	**722,876**
	Medicaid Expansion	
7	Global RX	**79,509**
8	Global RX	**46,835**
6	Moderate Needs	**2,654**
	New Adults	
3	New Adult with out child	**471,868**
	SUD - IMD New Adult w/o child	**791**
3	New Adult with child	**223,956**
	SUD - IMD New Adult with child	**114**
	Total	**2,058,518**
*** Long Term Care Group**	**Total CY 2018**	
4 only	ABD Long Term Care Highest Need	**34,780**
5 only	ABD Long Term Care High Need	**14,079**

Demonstration Population	Medicaid Eligibility Group	Total CY 2017
1, 4*, 5*	ABD - Non-Medicare - Adult	**94,629**
1	ABD - Non-Medicare - Child	**28,865**
1, 4*, 5*	ABD - Dual	**255,478**
2	ANFC - Non-Medicare - Adult	**157,964**
2	ANFC - Non-Medicare - Child	**730,744**
	Medicaid Expansion	
7	Global RX	**84,049**
8	Global RX	**47,561**
6	Moderate Needs	**2,960**
	New Adults	
3	New Adult with out child	**490,537**
3	New Adult with child	**224,721**
	Total	**2,117,508**
*** Long Term Care Group**	**Total CY 2017**	
4 only	ABD Long Term Care Highest Need	**35,052**
5 only	ABD Long Term Care High Need	**13,202**

Table 7. PMPM Capitated Rates CY 2019

	includes SUD	
	1/1/2019-12/31/2019	
Medicaid Eligibility Group		
ABD Adult	**$**	**2,115.84**
ABD Child	**$**	**2,668.98**
ABD - Dual	**$**	**1,787.87**
non-ABD Adult	**$**	**590.64**
non-ABD Child	**$**	**464.71**
GlobalRx	**$**	**103.91**
New Adult	**$**	**463.29**
Moderates	**$**	**512.98**

VII. Consumer Issues

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

The second mechanism to assess trends in beneficiary issues is the Managed Care Grievance and Appeal report. This report is based on data entered by grievance and appeal coordinators in various locations across the MCE. The database into which they enter information helps them track the timeframes for responding to the grievances and appeals, as well as assists DVHA and AHS in

monitoring compliance and assessing if there are trends that may benefit from a performance improvement project.

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

VIII. Quality Improvement

Key updates from QE0319:

- The Quality Unit continued to lead a formal CMS PIP project focused on improving substance use disorder treatment.
- The DVHA Quality Unit staff continued to lead two QI projects.
- The Quality Unit met the CMS Adult and Child Quality Measure Set January 2019 reporting deadline. They spearheaded the planning for eventual mandatory reporting of various core set measures by exploring hybrid measure production options with the HEDIS vendor and by starting conversations with CMS and other states about reporting through DVHA's clinical registry.

The DVHA Quality Improvement (QI) and Clinical Integrity Unit monitors, evaluates and improves the quality of care to Vermont Medicaid beneficiaries by improving internal processes, identifying performance improvement projects and performing utilization management. Efforts are aligned across the Agency of Human Services as well as with community providers. The unit is responsible for instilling the principles of quality throughout DVHA; supporting the organization to achieve excellence. The Unit's goal is to develop a culture of continuous quality improvement throughout DVHA.

Managed Care Entity (MCE) Quality Committee

The MCE Quality Committee consists of representatives from all Departments within the Agency of Human Services that serve the Medicaid population. The committee continues to structure its work around the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of health care. During this most recent quarter the committee met twice. In January the committee completed its annual review of the Global Commitment Core Measure Set. Recommendations include working with the MCMC to set more meaningful targets. The annual review of Grievances & Appeals was completed. In March the committee completed its annual review of the AHS Confidentiality/HIPAA Breach summary report. It also reviewed the 2018 Medicaid Health Plan CAHPS Experience of Care survey results for both adults and children.

Managed Care Medical Committee (MCMC)

The Managed Care Medical Committee has begun the year focusing on defining the purpose of the committee and outlining the scope of work. The team reviewed requirements as identified in the Global Commitment Waiver, compliance standards, and needs of the Agency. The team hopes to

redefine its charter and develop a workplan.

Formal CMS Performance Improvement Project (PIP)

The Quality Unit continues to coordinate VT Medicaid's formal CMS Performance Improvement Project (PIP) – the topic of which is substance use treatment initiation. The cross-departmental PIP team is focused on a multi-pronged telehealth-related intervention. Targeted communications about telehealth continue to be dispersed via provider banners and newsletter articles. Telehealth resources have been added to the provider section of the VT Medicaid website, and continued to be updated during the QE0319. Additionally, presentations were made to various stakeholder groups during this quarter, including the department's Clinical Utilization Review Board (CURB), the Chittenden County Opioid Alliance (CCOA) and the Alcohol and Drug Abuse Program's (ADAP) Preferred Provider Directors meeting.

The CY 2018 HEDIS IET study rate will be available during the next quarter. Interim indicator data on telehealth use is being collected to monitor progress. Data points include: # of telehealth episodes of care, # of unduplicated providers billing for telehealth and # of unduplicated members receiving telehealth services. There was an increase in all metrics from the baseline of Q2 SFY 18. The Quality Unit is also starting to sort these episodes of care by HEDIS diagnosis code value sets for mental health and substance use disorder. Preliminary data shows that SUD treatment providers are using telehealth in comparatively small numbers and focus here could be meaningful.

Other Collaborative Quality Improvement Projects

The Quality Unit is leading informal PIPs on two topic areas: chlamydia screening and adults' access to preventive/ambulatory health services. These topics were selected after annual review of program performance by the MCE Quality Committee, Managed Care Medical Committee and the Clinical Utilization Review Board (CURB). Project charters and work plans have been developed and meetings are ongoing.

During the most recent quarter the chlamydia project team designed a modified learning collaborative through the Blueprint's Women's Health Initiative. The collaborative will include 8 monthly webinars, running from April-September 2019. The adults' access to preventive/ambulatory services team collected additional appointment access data during the QE0319, including through the Vermont Chronic Care Initiative (VCCI). VCCI has recently taken on a new task of screening all new to Medicaid members. Their screening tool includes questions related to access time for PCP appointments. Their data did not indicate long wait times for PCP appointments, but they did learn of appointment delays due to record transfers for new patients. The QI team will work on interventions related to this finding during the next quarter.

Quality Measure Reporting

- CMS' Adult and Child Quality Measure Core Sets – The Quality Unit and the Data Unit prepared and submitted the Adult and Child Quality Core Set reports by the deadline of 01/11/2019.

  The Quality Unit is working with DVHA's Deputy Commissioner on a larger vision for quality measure production that will enable DVHA to reach full reporting capacity on these measure sets by the year 2024. During QE0319 the Unit coordinated a conference call with staff from

CMS, Mathematica and the state of Oregon to discuss the development and use of clinical registries for reporting Core Set measures.

- Healthcare Effectiveness Data & Information Set (HEDIS) measure production – During QE0319 the Quality Unit worked with the contracted HEDIS vendor, Cotiviti, on both administrative and hybrid measure runs. Cotiviti is performing medical record retrieval for three hybrid measures and abstraction for one measure. The Quality Unit clinicians will abstract for the remaining two hybrid measures. The Quality Assurance Manager is coordinating the internal hybrid measure production process. She submitted training materials and the MRR quality assurance process to HSAG, the EQRO during the most recent quarter; these were approved with no changes. Clinicians will receive training, perform the IRR, and begin chart abstraction next quarter.

- Customer Satisfaction Measures– CAHPS Survey – The most recent surveys were conducted from mid-October through mid-December 2018. The summary of findings was received by the Quality Unit on 1/23/19. The DVHA Experience of Care Scorecard has been updated with 2018 data and narrative and was reviewed by the Quality Committee on 3/15/19.

Results Based Accountability (RBA)/Process Improvement

The Quality Unit continues to lead the Results Based Accountability (RBA) scorecard development effort at DVHA. The use of this performance management framework and corresponding presentation tool has been spearheaded by the Agency's Central Office QI staff. The DVHA Quality Unit staff received training and has used this tool to create a Global Commitment Core Measure scorecard, Experience of Care scorecard, and other performance budgeting scorecards. Additional scorecards that were actively maintained or newly created during QE0319 include the following: , DVHA Strategic Priorities, Experience of Care, GC Investments, Payment Reform Models,, and an overall DVHA performance accountability scorecard - which includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services.

Quality Unit staff are also actively engaged in the Agency's Improvement Network. This is a group of staff trained in process improvement, facilitation and tools that can be deployed to help on improvement projects around the Agency.

AHS Performance Accountability Committee

During this quarter, the AHS Performance Accountability Committee (PAC) continued to discuss how they can best support the new Data Governance Initiation (DGI) project currently underway at AHS. Specifically, the group reviewed and recommended performance measures that could be used by the Data Governance Council to assess the impact of data governance activities across the Agency. The group stopped short of recommending measures – instead they supported the inclusion of a statement of intent re: the use of data governance metrics. This approach allows for the continued implementation of data governance policies and the flexibility to identify the most meaningful measures. In addition, the group also reviewed the reporting schedule for Investment and Payment Model Scorecards. The schedule has been expanded to include the new Department of Mental Health Payment Model. In addition, both Payment Model and Investment scorecard due dates were combined in one schedule. This change was made to accommodate scorecard champions – as many of them are responsible for their Departments Payment Model and Investment scorecards.

Global Commitment (GC) and Delivery System Reform (DSR) 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). During this most recent quarter, DMH highlighted the performance of one of its investments. The Clear Impact Scorecard for this DMH investment is included in this report as Attachment 7.

Payment Models & Performance Monitoring

During this quarter, the AHS QIM reviewed a draft version of the DMH Payment Model scorecard. Suggestions were provided to enhance the description, rates, and interpretation of results sections of the scorecard. Specifically, it was suggested that DMH add a bit more detail re: the activities being supported, add directional targets, and expand on what the data is telling them. Reporting on the payment model begins with the Q4:2019 report. In addition, the AHS QIM reviewed the DVHA Dental Payment Model scorecard. This is the second submission of the Dental scorecard – so trends over time were observed.

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).

During this most recent quarter, DVHA highlighted the performance of its Dental payment model. In addition, DCF highlighted the performance of its Children's Integrated Services payment model. Both Clear Impact Scorecards for these payment models are included in this report as Attachment 8.

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

During this quarter, the HCBS Implementation Team continued to work on implementing the site-specific setting assessments. The team continues to review individual program response rates and suggested next steps. Next steps include item specific analysis by quality improvement staff to determine level of compliance with the new regulations and any necessary corrective action. Also, during this quarter, the AHS QIM attended a CMS-sponsored webinar that focused on Heightened Scrutiny. The core of the presentation focused on breaking down the guidance and was followed by a Q&A component. Highlights included discussion of a six-state pilot that CMS recently undertook to better understand what states needed to comply with the heightened scrutiny requirement and discussion about potential future guidance on the HCBS Settings Rule coverage of new construction. Information obtained during this webinar will be used to finalize Vermont's CQS/STP.

IX. Demonstration Evaluation

In June 2018, the Global Commitment to Health demonstration was amended to include Opioid Use Disorder (OUD/SUD) and recovery services through covering Medication Assisted Treatment (MAT). As per the amended STCs, the State is required to modify their current Evaluation Design to accommodate the evaluation requirements associated with the SUD amendment. Last quarter, the State submitted its updated Evaluation Design. During this quarter, the State received feedback from CMS

re: its modified Evaluation Design. Overall, CMS found that Vermont's draft design was moderately responsive to the requirements specified in the STCs and the Evaluation Design TA document. In addition, CMS identified places where Vermont should make revisions or provide clarification in order to fulfill the requirements specified in the aforementioned documents. Specifically, CMS asked the following: reorganize table with evaluation goals, questions, and hypotheses, provide more detail re: planned design and analyses, and provide a description of the planned cost analysis. The AHS QIM met with the evaluation team to review the feedback and consider appropriate responses. At the end of the quarter, the group had put together a document containing state responses. This document was forwarded to CMS. During the next quarter, the State will modify the evaluation design to accommodate the CMS feedback. Within 60 days of receiving the feedback, it will be posted to the CMS PMDA site for CMS review/approval.

X. Compliance

Key updates from QE0319:

- EQRO Compliance Audit Preparation
- Compliance Committee
- Electronic Visit Verification

EQRO Compliance Audit

During this quarter, the DVHA Medicaid Compliance Officer reviewed this year's compliance audit standards with staff from relevant units and departments. These reviews were designed to ensure completion of prior-year corrective actions, review procedures for changes and begin collecting documents for the EQRO audit document request. In addition, the AHS Quality Improvement Manager (QIM) worked with the EQRO to develop the material necessary for each of the required annual external quality review activities. Performance Improvement Project (PIP) validation items included the PIP validation templates and report outline. Performance Measure Validation items included a document request letter, a rate reporting template, and HEDIS roadmap. Review of Compliance with Standards items included a document request letter as well as desk and documentation review forms. All letters and materials are expected to be sent to DVHA during the next quarter.

Compliance Committee

During the March meeting, the Compliance Committee reviewed the upcoming EQRO audit standards, developed better lines of communication/coordination with the Medical and Quality committees, and discussed progress on the annual workplan.

Electronic Visit Verification

In response to section 12006 of the 21st Century Cures Act, Vermont is implementing an electronic visit verification system (EVV) to electronically verify personal care service visits in home and community settings. Since the last report, the following milestones for this project were met:

- CMS approval of Advance Planning Document
- Procurement of a contract amendment through the fiscal agent to purchase an EVV solution
- Business requirements were completed

- A project timeline was completed
- Outreaching external stakeholders

Substance Use Disorder (SUD) Monitoring Protocol

The State's 1115 waiver special terms and conditions (STCs) for its current five-year demonstration period (January 1, 2017–December 31, 2021) were amended in June 2018 to include a SUD component. As per the new STCs, the state is required to submit a SUD Monitoring Protocol to CMS within 150 calendar days after approval of SUD program. During the last quarter, the protocol was submitted to CMS for review/approval. At a minimum, the SUD Monitoring Protocol includes reporting relevant to each of the program implementation areas listed in STC 42. The protocol also describes the data collection, reporting and analytic methodologies for performance measures identified by the state and CMS for inclusion. In addition, the SUD Monitoring Protocol specifies the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 49 of the demonstration. Finally, for each performance measure, the SUD Monitoring Protocol identifies a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points.

During this quarter, the state received feedback from CMS on their protocol. Feedback was provided in the following categories: compliance with STCs and alignment with 1115 SUD monitoring protocol guidance. Examples of STC feedback included the following: identifying targets and goals for monitoring metrics while examples of alignment with 1115 SUD monitoring protocol guidance included the following: aligning metric names, definitions, and data sources with those described in the current version of the SUD Metrics Workbook (SUD Metrics Workbook 3.1), providing missing information, adjusting the baseline reporting period, and addressing deviations from CMS technical specifications. Also, during this quarter, the state provided responses to the CMS feedback. During the next quarter, the state will modify their SUD Monitoring Protocol to accommodate the CMS feedback and submit the updated version of the protocol for CMS review/approval.

XI. Reported Purposes for Capitated Revenue Expenditures

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

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

Attachment 6 is a summary of Investments, with applicable category identified, for QE0319.

XII. Enclosures/Attachments

Attachment 1: Budget Neutrality Workbook
Attachment 2: Enrollment and Expenditures Report
Attachment 3: Complaints Received by Health Access Member Services
Attachment 4: Medicaid Grievance and Appeal Reports
Attachment 5: Office of the Health Care Advocate Report
Attachment 6: QE0319 Investments
Attachment 7: Investment Scorecard: Department of Mental Health
Attachment 8a: Payment Model Scorecard: DVHA Dental Incentive Payment
Attachment 8b: Payment Model Scorecard: Children's Integrated Services

XIII. State Contact(s)

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

Date Submitted to CMS: May 30, 2019

ATTACHMENTS

Attachment 1

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
May 3, 2019

ELIGIBILITY GROUP	DY 12 JAN - DEC 2017	DY 13 JAN - DEC 2018	DY 14 JAN - DEC 2019	DY 15 JAN - DEC 2020	DY 16 JAN - DEC 2021	Total
Without Waiver (Caseload x pmpms)						
ABD - Non-Medicare - Adult	$ 142,860,455	$ 130,282,673	$ 33,578,230	$ -	$ -	$ 306,721,358
ABD - Non-Medicare - Child	$ 85,359,001	$ 78,271,898	$ 19,980,317	$ -	$ -	$ 183,611,216
ABD - Dual	$ 664,153,383	$ 692,936,018	$ 178,064,468	$ -	$ -	$ 1,535,153,869
ANFC - Non-Medicare - Adult	$ 101,757,250	$ 97,166,093	$ 20,133,751	$ -	$ -	$ 219,057,093
ANFC - Non-Medicare - Child	$ 392,665,288	$ 406,306,913	$ 103,944,260	$ -	$ -	$ 902,916,462
Total Expenditures Without Waiver	**$ 1,386,795,376**	**$ 1,404,963,595**	**$ 355,701,026**	**$ -**	**$ -**	**$ 3,147,459,997**
With Waiver						
ABD Non Medicare Adult	$ 162,602,154	$ 162,728,372	$ 45,864,286	$ -	$ -	$ 371,194,811
ABD - Non-Medicare - Child	$ 66,593,208	$ 60,077,015	$ 15,736,620	$ -	$ -	$ 142,406,843
ABD - Dual	$ 445,847,909	$ 461,739,496	$ 126,054,494	$ -	$ -	$ 1,033,641,899
ANFC - Non-Medicare - Adult	$ 84,040,228	$ 83,558,956	$ 18,193,244	$ -	$ -	$ 185,792,428
ANFC - Non-Medicare - Child	$ 305,543,574	$ 335,706,591	$ 88,199,572	$ -	$ -	$ 729,449,737
Premium Offsets	$ (655,991)	$ (772,935)	$ (183,233)	$ -	$ -	$ (1,612,159)
Moderate Needs Group	$ 1,488,408	$ 1,378,915	$ 330,023	$ -	$ -	$ 3,197,346
Marketplace Subsidy	$ 6,355,286	$ 6,242,717	$ 1,585,393	$ -	$ -	$ 14,183,396
VT Global Rx	$ 13,824,166	$ 15,300,919	$ 2,660,158	$ -	$ -	$ 31,785,243
VT Global Expansion VHAP	$ 414,824	$ 716,198	$ 567,398	$ -	$ -	$ 1,698,421
CRT DSHP	$ 10,331,787	$ 9,240,772	$ 4,235,609	$ -	$ -	$ 23,808,168
Investments	$ 142,332,671	$ 148,584,046	$ 26,425,179	$ -	$ -	$ 317,341,897
Total Expenditures With Waiver	**$ 1,238,718,223**	**$ 1,284,501,065**	**$ 329,668,742**	**$ -**	**$ -**	**$ 2,852,888,030**
Supplemental Test: New Adult (Gross)						
Limit New Adult	$ 370,689,611	$ 375,765,835	$ 94,681,585	$ -	$ -	$ 841,137,030
Without Waiver SUD - IMD New Adult Expenditures		$ 2,704,249	$ 859,730	$ -	$ -	$ 3,563,979
With Waiver New Adult Expenditures	$ 295,620,340	$ 312,104,578	$ 83,860,146	$ -	$ -	$ 691,585,064
With Waiver SUD - IMD New Adult Expenditures		$ 2,826,119	$ 1,240,043	$ -	$ -	$ 4,066,162
Surplus (Deficit)	*$ 75,069,271*	*$ 63,539,387*	*$ 10,441,126*	$ -	$ -	$ 149,049,784
Supplemental Test: IMD SUD (Gross)						
SUD - IMD ABD - Non-Medicare - Adult		$ 268,039	$ 74,618	$ -	$ -	$ 342,657
SUD - IMD ABD - Dual		$ 214,495	$ 67,187	$ -	$ -	$ 281,682
SUD - IMD ANFC - Non-Medicare - Adult		$ 533,391	$ 116,947	$ -	$ -	$ 650,338
Limit SUD IMD Without Waiver		**$ 1,015,926**	**$ 258,751**	**$ -**	**$ -**	**$ 1,274,677**
SUD - IMD ABD Non Medicare Adult		$ 249,820	$ 88,728	$ -	$ -	$ 338,548
SUD - IMD ABD - Dual		$ 199,224	$ 119,208	$ -	$ -	$ 318,432
SUD - IMD ANFC - Non-Medicare - Adult		$ 540,841	$ 183,880	$ -	$ -	$ 724,722
Limit SUD IMD With Waiver		**$ 989,886**	**$ 391,815**	**$ -**	**$ -**	**$ 1,381,701**
Surplus (Deficit)		*$ 26,040*	*$ (133,064)*	$ -	$ -	$ (107,024)
Waiver Savings Summary						
Annual Savings	$ 148,077,153	$ 120,462,531	$ 26,032,284	$ -	$ -	$ 294,571,968
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	$ 44,423,146	$ 30,115,633	$ 6,508,071	$ -	$ -	$ 81,046,850
Total Savings	$ 44,423,146	$ 30,115,633	$ 6,508,071	$ -	$ -	$ 81,046,850
Cumulative Savings	***$ 44,423,146***	***$ 74,538,779***	***$ 81,046,850***	***$ 81,046,850***	***$ 81,046,850***	***$ 81,046,850***
		11%	9%	7%		

New Adult Waiver Savings Not Included in Waiver Savings Summary
See Budget Neutrality New Adult tab (STC#64)
See CY2019 Investments tab
See EG MM CY 2019 Tab for Member Month Reporting

Budget Neutrality New Adult

New Adult (w/ and w/o Child) Medical Costs Only	**DY 12 – PMPM**				**DY 13 – PMPM**				**DY 14 – PMPM**			
	QE 0317	**QE 0617**	**QE 0917**	**QE 1217**	**QE 0318**	**QE 0618**	**QE 0918**	**QE 1218**	**QE 0319**	**QE 0619**	**QE 0919**	**QE 1219**
(A) New Adult Group PMPM Projection	$518.26	$518.26	$518.26	$518.26	$540.03	$540.03	$540.03	$540.03	$562.71			
(B-1) eligible member months w/ Child	55,223	57,077	56,789	55,632	55,583	55,409	55,976	57,102	55,585			
(B-2) eligible member months w/o Child	124,999	124,981	121,338	119,219	120,870	119,756	117,390	114,643	120,877			
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	$ 28,619,871.98	$ 29,580,726.02	$ 29,431,467.14	$ 28,831,840.32	$ 30,016,487.49	$ 29,922,522.27	$ 30,228,719.28	$ 30,836,793.06	$ 31,278,235.35			
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	$ 64,781,981.74	$ 64,772,653.06	$ 62,884,631.88	$ 61,786,438.94	$ 65,273,426.10	$ 64,671,832.68	$ 63,394,121.70	$ 61,910,659.29	$ 68,018,696.67			
(D-1) New Adult FMAP w/ Child	54.46%	54.46%	54.46%	53.47%	53.47%	53.47%	53.47%	53.89%	53.89%			
(D-2) New Adult FMAP w/o Child	86.89%	86.89%	86.89%	86.69%	89.95%	89.95%	89.95%	89.99%	93.00%			
(E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child	$ 15,586,382.28	$ 16,109,663.39	$ 16,028,377.00	$ 15,416,385.02	$ 16,049,815.86	$ 15,999,572.66	$ 16,163,296.20	$ 16,617,947.78	$ 16,855,841.03			
(E-2 = C2 x D-2) Federal Share of Supplemental Cap 1 w/o Child	$ 56,289,063.93	$ 56,280,958.24	$ 54,640,456.64	$ 53,562,663.92	$ 58,713,446.78	$ 58,172,313.50	$ 57,023,012.47	$ 55,713,402.30	$ 63,257,387.90			
Subtotal Federal Share Supplemental Cap 1	$ 71,875,446.21	$ 72,390,621.63	$ 70,668,833.64	$ 68,979,048.94	$ 74,763,262.64	$ 74,171,886.15	$ 73,186,308.67	$ 72,331,350.08	$ 80,113,228.93			
Total FFP reported for New Adult Group	$ 62,816,665.28	$ 61,830,391.33	$ 54,643,069.28	$ 51,158,852.52	$ 62,183,045.44	$ 63,756,150.76	$ 62,666,336.47	$ 61,269,677.13	$ 67,854,834.87			
Supplemental Budget Neutrality Test 1 over/(under) - report any negative # under main GC budget neutrality	$ 9,058,780.94	$ 10,560,230.30	$ 16,025,764.37	$ 17,820,196.41	$ 12,580,217.20	$ 10,415,735.39	$ 10,519,972.19	$ 11,061,672.95	$ 12,258,394.06			

Attachment 2

State of Vermont
Department of Vermont Health Access
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
http://dvha.vermont.gov

[Phone] 802-879-5900

Agency of Human Services

Medicaid Program Enrollment and Expenditures Report

Q2 SFY 2019

Quarterly Report to the General Assembly
Pursuant to 33 V.S.A. § 1901f

Al Gobeille, Secretary
Vermont Agency of Human Services

Cory Gustafson, Commissioner
Department of Vermont Health Access

March 1, 2019

Key Terms

Caseload – Average monthly member enrollment

MEG – Medicaid Eligibility Group

ABD Adult – Beneficiaries age 19 or older; categorized as aged, blind, disabled, and/or medically needy
ABD Dual – Beneficiaries eligible for both Medicare and Medicaid; categorized as aged, blind, disabled, and/or medically needy
General Adult – Beneficiaries age 19 or older; pregnant women or parents/caretaker relatives of minor children receiving cash assistance and those receiving transitional Medicaid after the receipt of cash assistance
New Adult Childless - Beneficiaries age 19 or older and under 65; who are at or below 133% of the FPL who do not have dependent children
New Adult w/Child - Beneficiaries age 19 or older and under 65; who are at or below 133% of the FPL who have dependent children

BD Child – Beneficiaries under age 19; categorized as blind, disabled, and/or medically needy
General Child – Beneficiaries under age 19, and below the protected income level, categorized as those eligible for cash assistance including Reach Up (Title V) and foster care payments (Title IV-E)
Underinsured Child – Beneficiaries under age 19 or under with household income 237-312% FPL with other (primary) insurance
CHIP – Children's Health Insurance Program – Beneficiaries under age 19 with household income 237-312% FPL with no other insurance

Sunsetted Programs - Expenditures still being incurred for programs no longer active such as VHAP, VHAP ESI, and Catamount.
Vermont Premium Assistance - Individuals enrolled in qualified health plans (QHP) with incomes at or below 300% FPL
Vermont Cost Sharing - Individuals enrolled in qualified health plans (QHP) with incomes at or below 300% FPL
Pharmacy Only – Assistance to help pay for prescription medicines based on income, disability status, and age
Choices for Care - Traditional - Vermont's Long Term Care Medicaid Program; for Vermonters in nursing homes, home-based settings, and/or enhanced residential care (ERC)
Choices for Care - Acute - Long Term Care Medicaid for Vermonters who would otherwise qualify for Choices for Care - Traditional, but who are currently receiving a lower level of care

PMPM – Per Member Per Month

The Department of Vermont Health Access

Caseload and Expenditure Report
All AHS and AOE YTD SFY'19

Medicaid Eligibility Group	SFY'19 BAA Caseload	SFY'19 BAA Budget	SFY'19 BAA PMPM	SFY'19 Actuals Thru December 31, 2018 Caseload	SFY'19 Actuals Thru December 31, 2018 Expenses	SFY'19 Actuals Thru December 31, 2018 PMPM	% of Expenses to Budget Line Item
ABD Adult	6,250	$ 146,702,165	$ 1,956.03	6,500	$ 68,366,231	$ 1,753.03	46.60%
ABD Dual	17,742	$ 242,706,736	$ 1,139.98	17,562	$ 108,289,577	$ 1,027.68	44.62%
General Adult	12,958	$ 88,656,569	$ 570.15	11,141	$ 39,837,399	$ 595.97	44.93%
New Adult Childless	39,248	$ 227,769,694	$ 483.61	38,413	$ 113,533,213	$ 492.61	49.85%
New Adult w/Child	18,813	$ 87,998,161	$ 389.79	18,767	$ 44,763,261	$ 397.53	50.87%
BD Child	2,166	$ 64,844,308	$ 2,494.78	2,040	$ 27,459,057	$ 2,243.75	42.35%
General Child	59,811	$ 332,852,007	$ 463.76	59,103	$ 158,112,965	$ 445.87	47.50%
Underinsured Child	584	$ 1,469,272	$ 209.66	535	$ 676,044	$ 210.54	46.01%
CHIP	4,697	$ 12,551,135	$ 222.68	4,425	$ 5,493,445	$ 206.91	43.77%
Sunsetted Programs	-	$ -		-	$ 351,857		
Vermont Premium Assistance	19,085	$ 6,614,098	$ 28.88	17,072	$ 3,016,111	$ 29.45	45.60%
Vermont Cost Sharing	5,309	$ 1,520,434	$ 23.87	5,856	$ 850,461	$ 24.21	55.94%
Pharmacy Only	10,497	$ 11,278,883	$ 89.54	10,521	$ 3,912,702	$ 61.98	34.69%
Choices for Care - Traditional	4,390	$ 209,074,560	$ 3,968.77	4,281	$ 100,929,650	$ 3,929.06	48.27%
Choices for Care - Acute	4,390	$ 31,288,498	$ 593.94	4,281	$ 16,533,448	$ 643.63	52.84%
Total Medicaid	196,241	$ 1,465,326,521	$ 622.25	190,360	$ 692,125,421	$ 605.98	47.23%

The Department of Vermont Health Access

Caseload and Expenditure Report

All AHS YTD SFY'19

Medicaid Eligibility Group	SFY'19 BAA Caseload	SFY'19 BAA Budget	SFY'19 BAA PMPM	SFY'19 Actuals Thru December 31, 2018 Caseload	SFY'19 Actuals Thru December 31, 2018 Expenses	SFY'19 Actuals Thru December 31, 2018 PMPM	% of Expenses to Budget Line Item
ABD Adult	6,250	$ 146,644,178	$ 1,955.26	6,500	$ 67,877,738	$ 1,740.50	46.29%
ABD Dual	17,742	$ 245,148,578	$ 1,151.45	17,562	$ 108,223,462	$ 1,027.05	44.15%
General Adult	12,958	$ 88,621,911	$ 569.93	11,141	$ 39,735,970	$ 594.45	44.84%
New Adult Childless	39,248	$ 228,050,283	$ 484.21	38,413	$ 113,508,186	$ 492.50	49.77%
New Adult w/Child	18,813	$ 88,060,301	$ 390.07	18,767	$ 44,762,950	$ 397.53	50.83%
BD Child	2,166	$ 49,597,023	$ 1,908.16	2,040	$ 22,055,111	$ 1,802.18	44.47%
General Child	59,811	$ 296,053,250	$ 412.48	59,103	$ 144,448,472	$ 407.34	48.79%
Underinsured Child	584	$ 1,078,976	$ 153.96	535	$ 563,151	$ 175.38	52.19%
CHIP	4,697	$ 10,740,115	$ 190.55	4,425	$ 4,865,313	$ 183.25	45.30%
Sunsetted Programs	-	$ -		-	$ 351,857		
Vermont Premium Assistance	19,085	$ 6,614,098	$ 28.88	17,072	$ 3,016,111	$ 29.45	45.60%
Vermont Cost Sharing	5,309	$ 1,520,434	$ 23.87	5,856	$ 850,461	$ 24.21	55.94%
Pharmacy Only	10,497	$ 11,278,883	$ 89.54	10,521	$ 3,912,702	$ 61.98	34.69%
Choices for Care - Traditional	4,390	$ 209,074,560	$ 3,968.77	4,281	$ 100,929,650	$ 3,929.06	48.27%
Choices for Care - Acute	4,390	$ 32,083,931	$ 609.03	4,281	$ 16,533,448	$ 643.63	51.53%
Total Medicaid	196,241	$ 1,414,566,521	$ 600.69	190,360	$ 671,634,583	$ 588.04	47.48%

The Department of Vermont Health Access

Caseload and Expenditure Report

DVHA Only YTD SFY'19

Medicaid Eligibility Group	SFY'19 BAA Caseload	SFY'19 BAA Budget	SFY'19 BAA PMPM	SFY'19 Actuals Thru December 31, 2018 Caseload	SFY'19 Actuals Thru December 31, 2018 Expenses	SFY'19 Actuals Thru December 31, 2018 PMPM	% of Expenses to Budget Line Item
ABD Adult	6,250	$ 57,191,818	$ 762.56	6,500	$ 29,416,179	$ 754.28	51.43%
ABD Dual	17,742	$ 57,507,834	$ 270.11	17,562	$ 28,054,130	$ 266.24	48.78%
General Adult	12,958	$ 75,554,021	$ 485.89	11,141	$ 33,966,723	$ 508.14	44.96%
New Adult Childless	39,248	$ 202,267,933	$ 429.47	38,413	$ 101,136,541	$ 438.82	50.00%
New Adult w/Child	18,813	$ 81,007,952	$ 358.83	18,767	$ 41,545,815	$ 368.96	51.29%
BD Child	2,166	$ 20,395,140	$ 784.67	2,040	$ 10,412,258	$ 850.81	51.05%
General Child	59,811	$ 155,918,142	$ 217.24	59,103	$ 79,476,311	$ 224.12	50.97%
Underinsured Child	584	$ 502,278	$ 71.67	535	$ 224,488	$ 69.91	44.69%
CHIP	4,697	$ 8,362,970	$ 148.37	4,425	$ 3,986,651	$ 150.16	47.67%
Sunsetted Programs	-	$ -		-	$ 351,857		
Vermont Premium Assistance	19,085	$ 6,614,098	$ 28.88	17,072	$ 3,016,111	$ 29.45	45.60%
Vermont Cost Sharing	5,309	$ 1,520,434	$ 23.87	5,856	$ 850,461	$ 24.21	55.94%
Pharmacy Only	10,497	$ 11,278,883	$ 89.54	10,521	$ 3,912,702	$ 61.98	34.69%
Choices for Care - Traditional	4,390	$ 209,074,560	$ 3,968.77	4,281	$ 100,929,650	$ 3,929.06	48.27%
Choices for Care - Acute	4,390	$ 28,306,765	$ 537.33	4,281	$ 15,398,844	$ 599.46	54.40%
Total Medicaid	196,241	$ 915,502,828	$ 388.77	190,360	$ 452,678,721	$ 396.34	49.45%

VERMONT

State of Vermont *Agency of Human Services*
Department of Vermont Health Access [Phone] 802-879-5900
312 Hurricane Lane, Suite 201 [Fax] 802-879-5651
Williston VT 05495-2807
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Questions, Complaints and Concerns Received by Health Access Member Services
January 1, 2019 – March 31, 2019

The following information represents the weekly 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. Provider and Member Relations, 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.

December 31 – January 4

- Caller wanted to submit negative feedback regarding DME suppliers. He states that the DVHA has inadequate power chair evaluation services in the state of Vermont. The state has allowed UVM Medical Center to become a monopoly in power chair evaluations. UVM Medical Center does not have the capacity to serve their clients. Caller was upset that there is a 4 month wait to get a power chair evaluation from UVM Medical Center and there isn't one through DHMC. CSR apologized for his frustrations and explained to him that his PCP could submit an exception form to see about getting an evaluation through DHMC. Also offered to take his feedback.

January 7 – January 11

- Caller wanted to file negative feedback about an eye doctor she brought her daughter to. She states she called the eye doctor's office and was told only the eye exam was covered and not glasses. Provider did not offer a selection of Medicaid glasses and did not make them aware. She feels if they accept Medicaid, they should let her know this information. In not doing this, she had to pay $289 out of pocket for the glasses as she was told just the exam was covered. CSR apologized for her frustrations, explained the vision coverage for her child and offered provider complaint form as well as to document her feedback.
- Caller wanted to submit negative feedback regarding his PCP. He states he has been trying to get an appointment with him for quite some time and has been unable to get one. He states he spoke to legal aid and was instructed to contact us. He states he needs testing done that is time sensitive and has not been able to be seen by his provider. CSR

apologized for his frustrations, offered to help find a new PCP and to document his feedback.

January 14 – January 18

- Caller wanted to submit negative feedback regarding the Prior Authorization process. He feels the reasonable cost concern is that the state is wasting time and money for a Provider to submit the PA when a customer has the available time to complete this process. He wanted to speak to someone who has created this round about process and to see why it is only the Provider who can submit the PA. CSR apologized for his frustrations and explained the process to him. Also advised to pass along his feedback as well.
- Caller wanted to submit negative feedback regarding the Healthy Vermonters Program. She doesn't even know why we offer it as it's not a useable program and it doesn't offer any help. She states when she advises the pharmacy she is on the program they laugh at her and tell her it doesn't cover anything. CSR apologized for her frustrations and offered to document her feedback.
- Caller wanted to submit negative feedback about dentists or oral surgeons who accept VT Medicaid. She states she cannot find an oral surgeon in her area or even one close to her that accepts Medicaid. She feels there is a shortage of available dentists that she can go to in Southern Vermont and we should have more. CSR apologized for her frustrations and tried to help her find a dental provider. Offered her feedback as well.

January 21 – January 25

- No issues to report.

January 28 – February 1

- VPharm/VPharm Review/Reinstatements
- Caller wanted to submit negative feedback about Medicaid and covered services. He called because his dentist does not take Medicaid and he said that they should have to and its discrimination that they do not. He stated that we should be forcing providers to take Medicaid. Caller feels that DVHA is discriminating against people who are poor because DVHA won't force every provider to take Medicaid. He also stated that he was going to call his legislator and was going to sue for income discrimination. He stated that we were only going to give him a dentist in a back alley that had no medical training or sanitary practices. He is unhappy with the level of covered providers/services and wanted to make it known. CSR apologized for his frustrations, offered to assist him in finding another provider that accepts Medicaid. She also offered to document his feedback.

February 4 – February 8

- 100% LIS - PDP cost being deducted from SS check

February 11 – February 15

- No issues to report.

February 18 – February 22

- VPharm/VPharm Review/Reinstatements

State of Vermont *Agency of Human Services*
Department of Vermont Health Access [Phone] 802-879-5900
312 Hurricane Lane, Suite 201 [Fax] 802-879-5651
Williston VT 05495-2807
dvha.vermont.gov

February 25 – March 1

- Caller wanted to submit feedback about a provider. She just found it concerning that this dentist works alone without hygienists. She had to assist in her own son's filling and was uncomfortable having to partake in the procedure. She also wanted it noted that he is very nice and doesn't want to get him in trouble. CSR apologized for her experience with the dentist and offered to document her feedback.
- Caller wanted to leave negative feedback as she states the Fair Hearing Unit never returns her calls. She is very frustrated because their message states she will be called within 24 hours. She explained that she has called several times and has not received a call back. She is trying to remove the appeal so she can discuss her information with the CSC. CSR Supervisor apologized for her frustrations and offered to document her feedback.

March 4 – March 8

- No issues to report.

March 11 – March 15

- No issues to report.

March 18 – March 22

- No issues to report.

March 25 – March 29

- No issues to report.

VERMONT

Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
January 1, 2019 – March 31, 2019

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 compiled on April 15, 2019 from the centralized database that were filed from January 1, 2019 through March 31, 2019.

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 7 grievances filed; two were addressed and one was withdrawn during the quarter. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was three days. Of the grievances filed, 100% were filed by beneficiaries. Of the 7 grievances filed, DMH had 57%, DAIL had 29% and DVHA had 14%. There were no grievances filed for VDH or DCF during this quarter.

Grievances were filed for service categories case management, counseling services, and mental health services.

There were no Grievance Reviews filed this quarter.

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

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

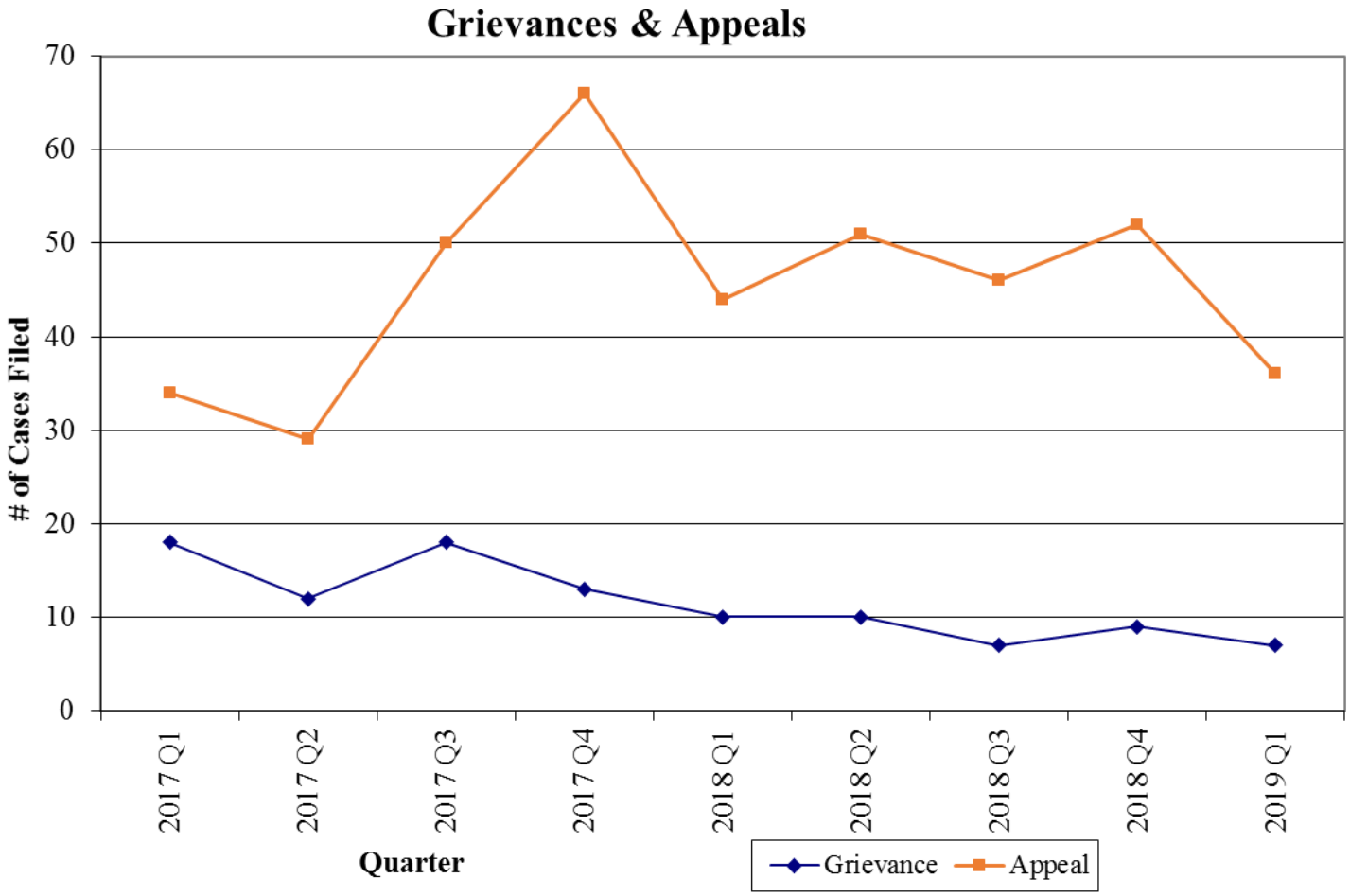
During this quarter, there were 36 appeals filed. Of these 36 appeals, 21 were resolved (58%), 14 were still pending (39%), and 1 was withdrawn (3%).

Of the 21 appeals that were resolved this quarter, 95% were resolved within the statutory time frame of 30 days. One appeal was resolved after the 30-day timeframe, this appeal was extended at the request of the beneficiary. The average number of days it took to resolve these cases was 25 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

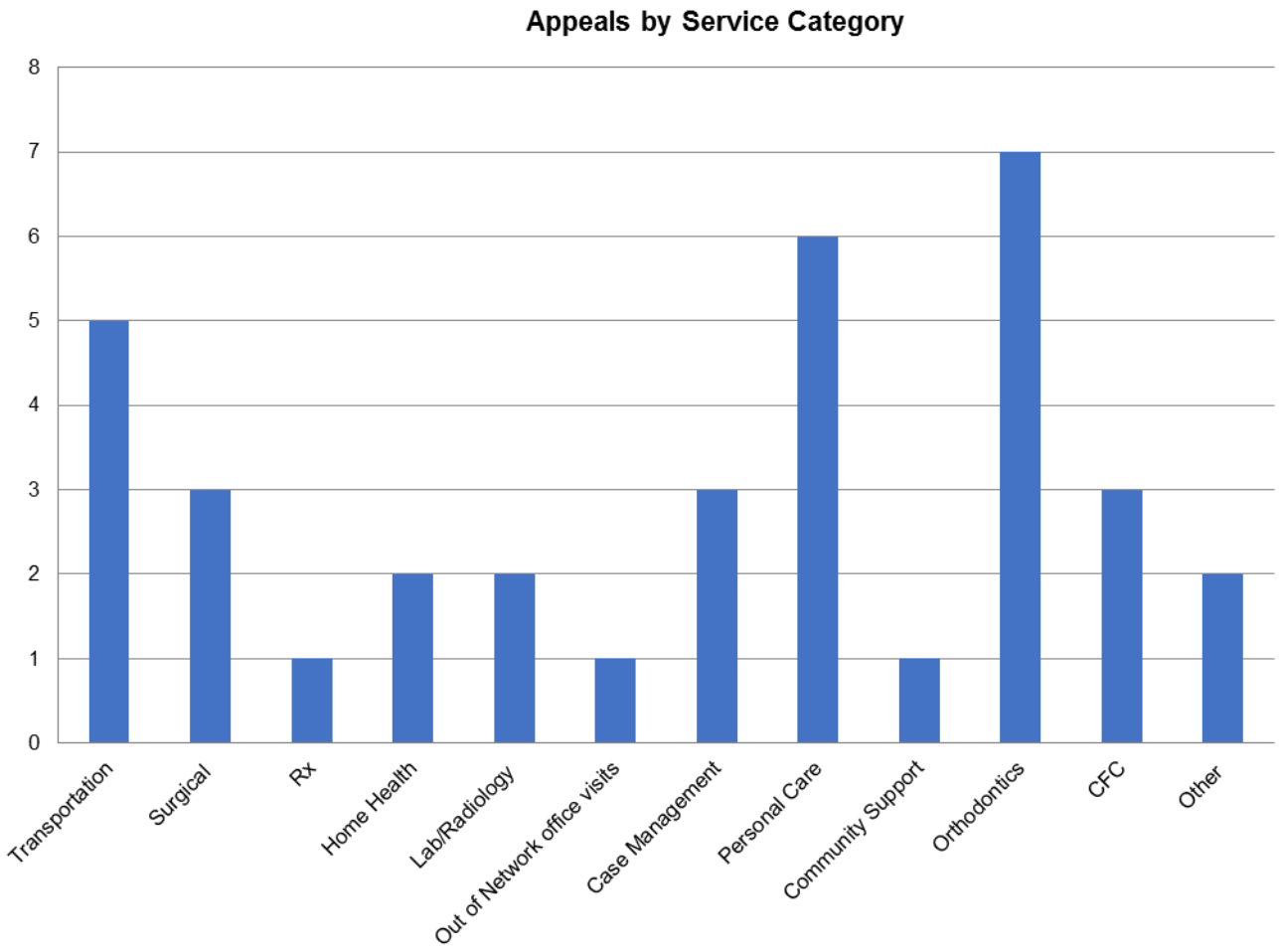
Of the 36 appeals filed, DVHA had 20 appeals filed (56%), DAIL had 8 (22%), VDH had 5 (14%) and DMH had 3 (8%).

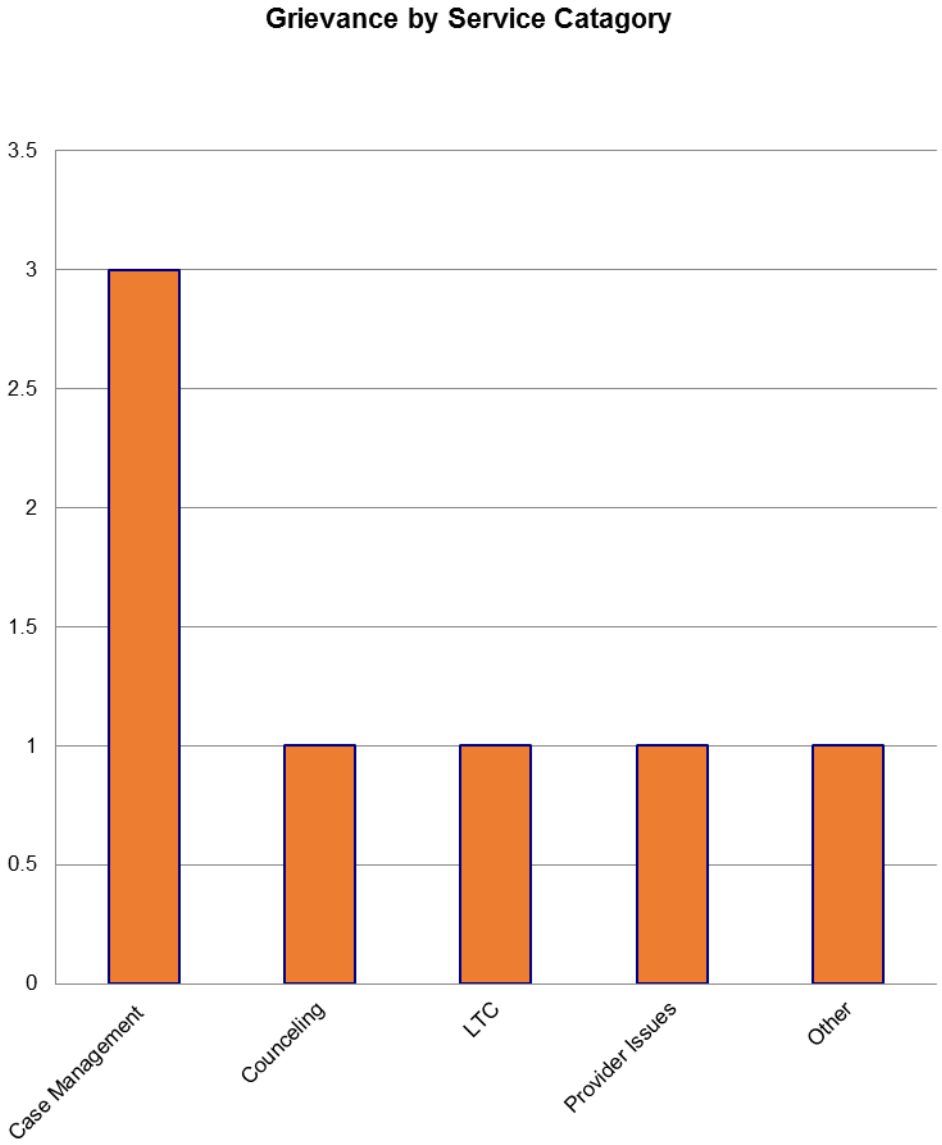
The appeals filed were for service categories; choices for care, personal care, orthodontics, home health, radiology, transportation, surgical, community supports, imaging, inpatient hospital services, prescriptions, community/social supports and case management.

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

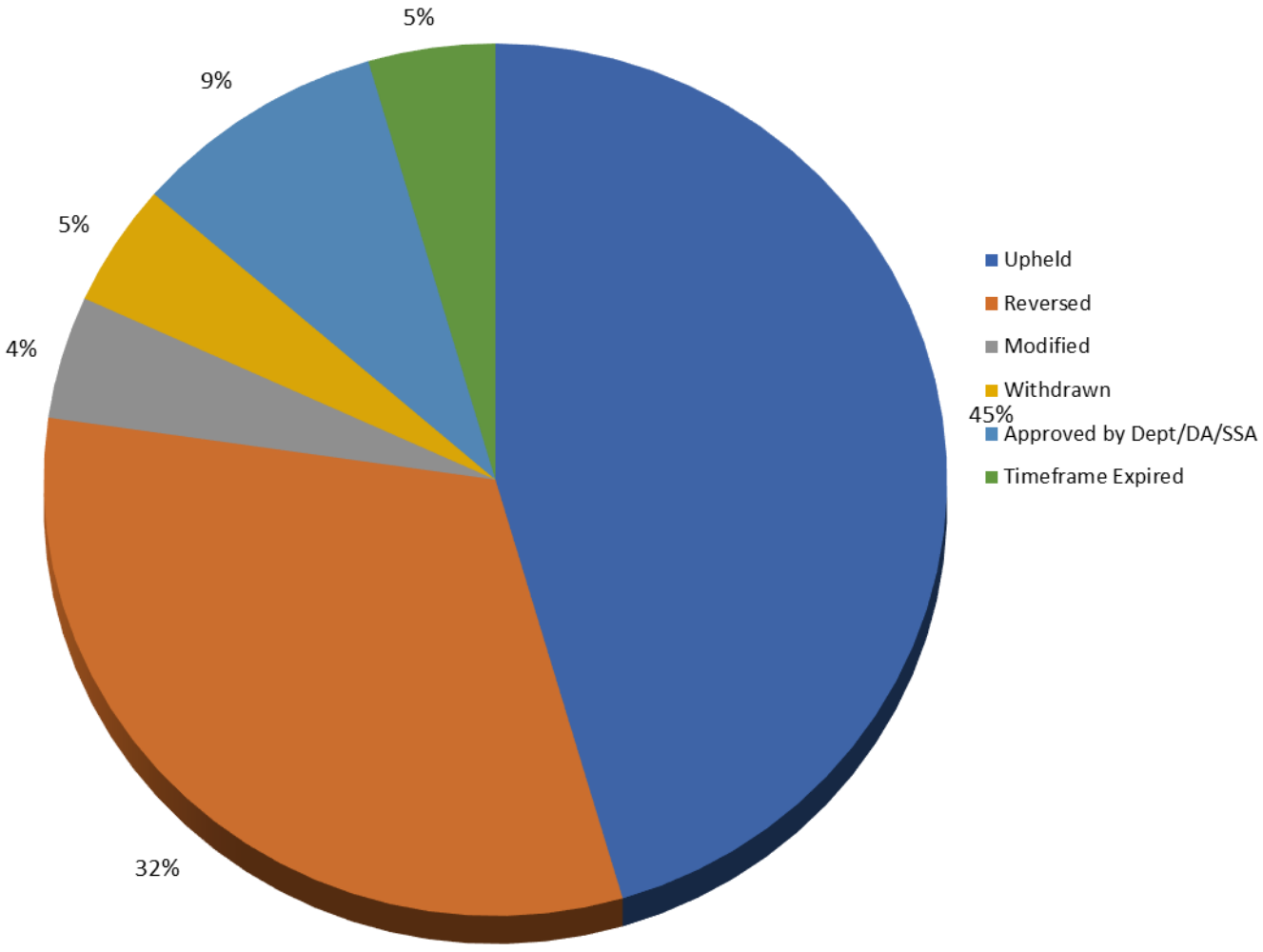

Grievances & Appeals
70
60
50
40
30
20
10
0
# of Cases Filed
2017 Q1
2017 Q2
2017 Q3
2017 Q4
2018 Q1
2018 Q2
2018 Q3
2018 Q4
2019 Q1
Quarter
Grievance
Appeal

r


Appeals by Service Category
8
7
6
5
4
3
2
1
0
Transportation
Surgical
Rx
Home Health
Lab/Radiology
Out of Network office visits
Case Management
Personal Care
Community Support
Orthodontics
CFC
Other


Grievance by Service Catagory
3.5
3
2.5
2
1.5
1
0.5
0
Case Management
Counceling
LTC
Provider Issues
Other

MCO Appeal Resolutions
1/1/2019 thru 3/31/2019



Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

January 1, 2019- March 31, 2019

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

April 21, 2019

TABLE OF CONTENTS

Introduction **3**

Individual Consumer Assistance **6**

Case Examples 6

Priorities **8**

Consumer Protection Activities **14**

A. Rate Review 14

B. Hospital Budget Review 14

C. Oversight of Accountable Care Organizations 14

D. Certificate of Need Applications 15

E. Other Green Mountain Care Board Activities 15

F. Other Activities 15

Outreach and Education **19**

G. Increasing Reach and Education through the Website 19

H. Other Outreach and Educational Activities 21

I. Promoting Plain Language in Health Communications 22

Introduction

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

This quarter, the HCA continued to see Vermonters struggle with affordability and access to health care. We saw a jump in cases where affordability was impacting Vermonters' access to care (126 vs. 86 last quarter) and where families struggled to get the prescriptions that they needed (88 vs. 61 last quarter).

The HCA helpline advocates also spent more time educating consumers about Medicare related issues this quarter. The transition to Medicare can be complex and expensive. We had an increase in cases where we provided consumer education about Medicare (80 vs. 53 last quarter). The HCA also had a significant number of cases where Vermonters were looking for help reducing their out of pocket Medicare costs. For example, we had 70 cases on Medicare Savings Programs which help pay for Medicare premiums; 43 on VPharm which reduces Medicare Part D out of pocket costs; and 74 on MABD Medicaid which reduces Medicare cost-sharing for eligible Vermonters.

The HCA is also working with Vermont Health Connect on the new integrated application for Health Care programs. The HCA has been giving feedback on how to make the application more accessible for all Vermonters.

Andrew's Story:

Andrew called because his Vermont Health Connect (VHC) plan was going to close for non-payment. In 2018, Andrew had been getting a substantial Advance Premium Tax Credit (APTC) to help him pay for his monthly premium. In early December 2018, he received his first invoice for 2019, and it did not include the APTC. Without the APTC, Andrew could not afford to make the payment. Andrew's APTC had been removed by VHC because VHC believed that he had not filed his taxes. To be eligible for APTC, you are required to file taxes. However, Andrew **had** filed his federal taxes. He had called VHC in early December of 2018 to report this. He could not get through to VHC because of heavy call volume, but requested a callback. When someone from VHC called back, Andrew tried to communicate that his taxes had been filed. He believed the issue had been resolved, but it was not. When he received his invoice in January, it still showed the full premium amount and his coverage was in danger of closing. The HCA advocate was able to show that Andrew had contacted VHC with his tax filing information and had also filed his taxes. VHC reinstated the APTC, and Andrew was able to make the payments and prevent his coverage from closing.

The HCA represents Vermonters through individual, administrative, and legislative advocacy. Our policy priorities reflect our daily work with Vermonters struggling with a health care system that often does not meet their needs. We work to control unnecessary costs and make the health care system sustainable, and to ensure that Vermont consumers are heard by providers and policy-makers.

Overview

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

The HCA received 1,018 calls[1] this quarter. We divided these calls into broad categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category, based on the caller's primary issue, were as follows:

- **26.57%** (271) about **Access to Care**
- **10.49%** (107) about **Billing/Coverage**
- **2.65%** (27) about **Buying Insurance**
- **12.97%** (132) **about Complaints**
- **11.37%** (116) about **Consumer Education**
- **25.49%** (260) about **Eligibility** for state and federal programs
- **10.31%** (105) were categorized as **Other**, which includes Medicare Part D, communication problems with providers or health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

We have a customized case management system that allows us to track more than one issue per case. This enables us to see the total number of calls that involved a particular issue. For example, although 260 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, an additional 439 cases had eligibility listed as a secondary concern.

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

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

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

The full quarterly report for January 1- March 31, 2019 includes:

- This narrative, which contains sections on **Individual Consumer Assistance**, **Consumer Protection Activities,** and **Outreach and Education**
- Seven data reports, including three based on the caller's insurance status:
  - **All Calls/All Coverages**: 1,018 calls (compared to 898 last quarter)
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 328 calls (291 calls last quarter)
  - **Commercial Plan Beneficiaries**: 236 calls (160 calls last quarter)
  - **Uninsured Vermonters**: 77 calls (84 calls last quarter)
  - **Vermont Health Connect (VHC)**: 262 calls (209 calls last quarter)
  - **Reportable Activities (Summary & Detail)**: 135activities and 12 documents (51 activities, 10 documents)

Individual Consumer Assistance

Case Examples

These case summaries illustrate the types of problems we helped Vermonters resolve this quarter:

Allister's Story:

Allister called the HCA because his Vermont Health Connect (VHC) plan had been closed. He was confused because he thought that he had renewed his coverage for 2019 and had been paying his premiums on time. When the HCA advocate researched Allister's case, she found that during 2018, the amount of Vermont Premium Assistance (VPA) Allister received to help pay for his monthly premium had decreased by about 5 cents. VPA is a state subsidy that helps income eligible Vermonters pay their monthly premiums. The advocate found out that such a small change should not have been applied by the VHC system, but it had been. The change only showed up in the payment system, where it looked like Allister owed 5 cents more. But Allister's invoices still listed the original amount, so he kept paying that amount and did not realize that he was "behind" on his premium payments. Eventually this caused his coverage to close for non-payment at the end of 2018, which meant that he did not have coverage in place for 2019. Because this change should not have been implemented and was not reflected in his invoices, the HCA advocate was able to get his coverage reinstated for the end of 2018, and activated for 2019.

Hanne's Story:

Hanne called because after completing her Medicaid renewal paperwork, she had been found ineligible for Medicaid. VHC had sent her a notice that her Medicaid coverage was going to close at the end of the month, and that she would have a special enrollment period to sign up for a VHC plan. Hanne was worried about a disruption in her coverage and worried about affording her monthly premiums. When the HCA advocate reviewed Hanne's application, however, she found that VHC had made a mistake in counting Hanne's household income. Hanne was contributing to her 401(k) at work, and also purchasing a dental plan. Under the Medicaid eligibility rules, the money that she contributed to her 401(k) and the purchase of the dental plan should not have been included in the countable income for Medicaid eligibility. When the correct amount of income was calculated, Hanne's was found eligible for Medicaid again.

Alina's Story:

Alina called the HCA because she found herself without Medicaid coverage. She had been on a special type of Medicaid while she was getting treatment for breast cancer. This type of Medicaid covers eligible Vermonters who are getting treatment for breast cancer or cervical cancer. She had recently finished treatment for cancer. Since she was no longer in need of treatment, she was no longer eligible for that type of Medicaid. When the HCA advocate investigated, she found that VHC had not sent Alina the required closure notice for Medicaid. Before a Medicaid beneficiary's coverage is closed, they need to be sent a notice explaining the reason why and giving the date of closure. The HCA advocate asked for reinstatement for failure to send the notice, and VHC reinstated the coverage. This allowed Alina time to fill out an application for health care programs, so she could be screened for other health care programs now that her eligibility for Medicaid had ended.

Richard's Story

Richard went to the pharmacy to pick up his inhaler, and found out that he no longer had VPharm. VPharm is the state pharmacy assistance program that helps reduce Medicare Part D out of pocket costs. If you are enrolled on VPharm 1, your copayments are generally $1 to $2. Without VPharm, the copayment for Richard's rescue inhaler was nearly $25, and he could not afford that cost. When the HCA advocate looked into what had happened to Richard's VPharm coverage, she found that it had been closed. He had gotten a notice about the closure, but the notice did not clearly identify what program was closing and why and when it was closing. So Richard had not realized that his coverage was closing. The HCA advocate asked for reinstatement because of the inadequate notice. She also learned that Richard had not done his annual renewal and that is what had triggered the closure. After the coverage was reinstated, the HCA advocate helped Richard complete the annual renewal application. Richard was able to go back to the pharmacy and pick up his inhaler for $2.

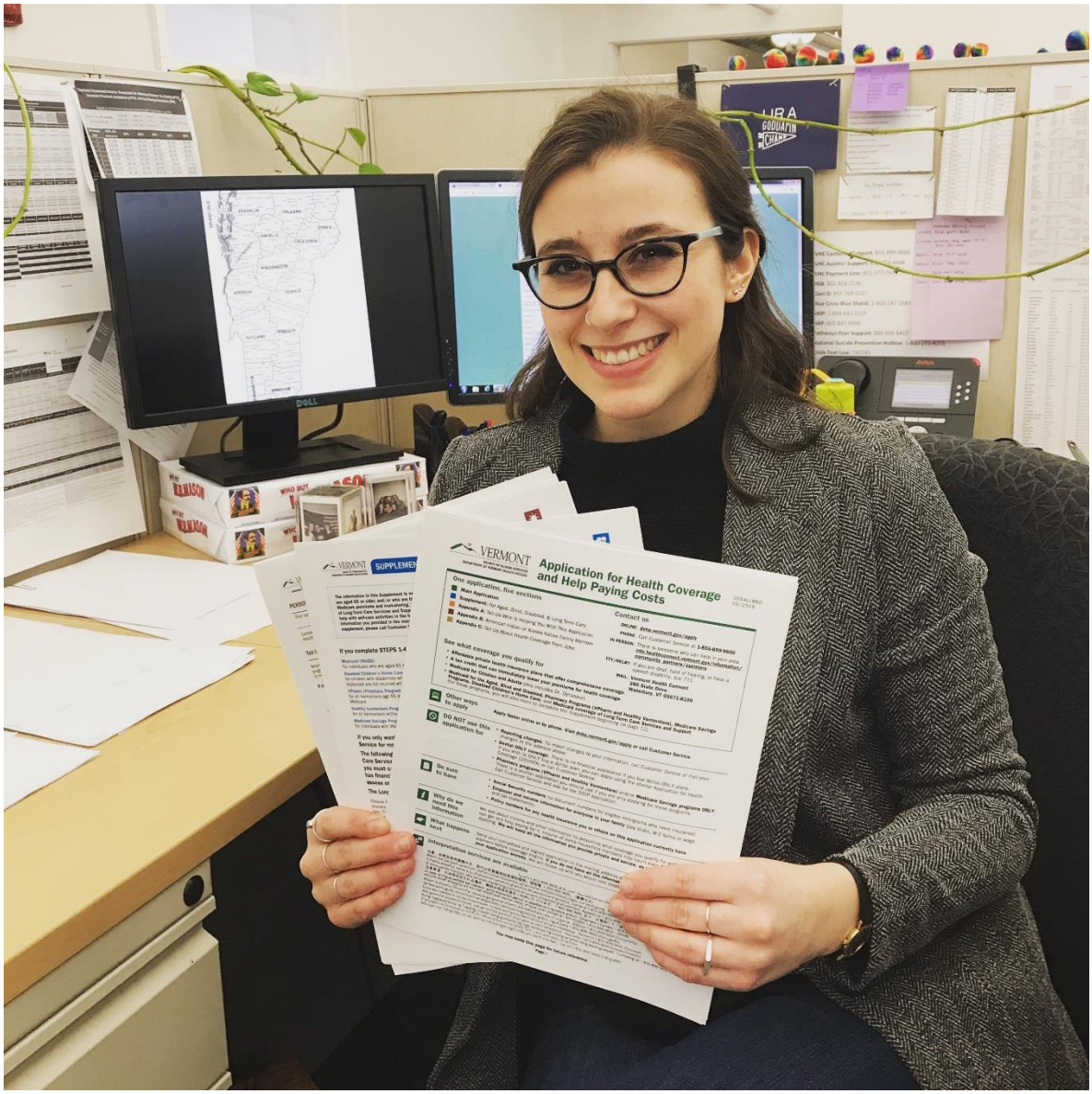
Nora's Story

After taking her son, Will, to the pediatrician, Nora went to the pharmacy to pick up the newly-prescribed medications. At the pharmacy, she found out that Will's Dr. Dynasaur was not active. This meant she had to pay $180 for three prescriptions. The cost was more than she could afford, but she paid it. When the HCA advocate took the case, she called VHC to find out why the coverage was not active. Will's family was income-eligible for Dr. Dynasaur. The family also had not been sent any closure notices. The advocate found out that the coverage had been closed due to a glitch in the system. There was a discrepancy about Will's birthdate. The system had two different birth dates, and this had caused the coverage to close without generating a notice. The HCA advocate verified Will's correct birthdate and the coverage was immediately reinstated. Nora was able to return to the pharmacy and have the prescriptions re-billed to Medicaid and was refunded the $180.

Priorities

A. The HCA is working with VHC on the revised Health Care Application.

The HCA is partnering with VHC to provide feedback about its new streamlined paper application for Health Care programs. The new integrated application allows Vermonters to apply for multiple health care programs with one application, including both Medicaid for Children and Adults, and Medicaid for the Aged, Blind and Disabled. The advocates are filling out the applications with Vermonters who do not have insurance. The HCA is providing feedback about the application and how applicants experience and understand it. It has also been able to get some Vermonters enrolled in health care coverage.



B. The HCA developed tax messaging encouraging Vermonters to take advantage of Advanced Premium Tax Credits.

The HCA distributed a simple fact sheet to inform consumers and tax preparers of the Premium Tax Credit's benefit cliff at 400% of the federal poverty line. The fact sheet tells consumers they may be able to save significantly on their health insurance and tax credits by contributing money to a retirement plan. The HCA partnered with the Vermont Department of Taxes to distribute the form on their website and social media. The HCA also distributed this tax messaging in a new online HCA newsletter to community partner organizations, including 2-1-1, Disability Rights Vermont, and the Pride Center of Vermont.

C. The HCA participated in the 2020 QHP Benefits planning work-group.

The HCA participated in a workgroup with other stakeholders and Vermont Health Connect (VHC) to discuss and make recommendations for plan designs for 2020 Qualified Health Plans on VHC. The HCA stressed keeping out of pocket costs as low as possible for Vermonters.

D. Overall call volume increased by 13% and was similar to the call volume in the same quarter in 2018.

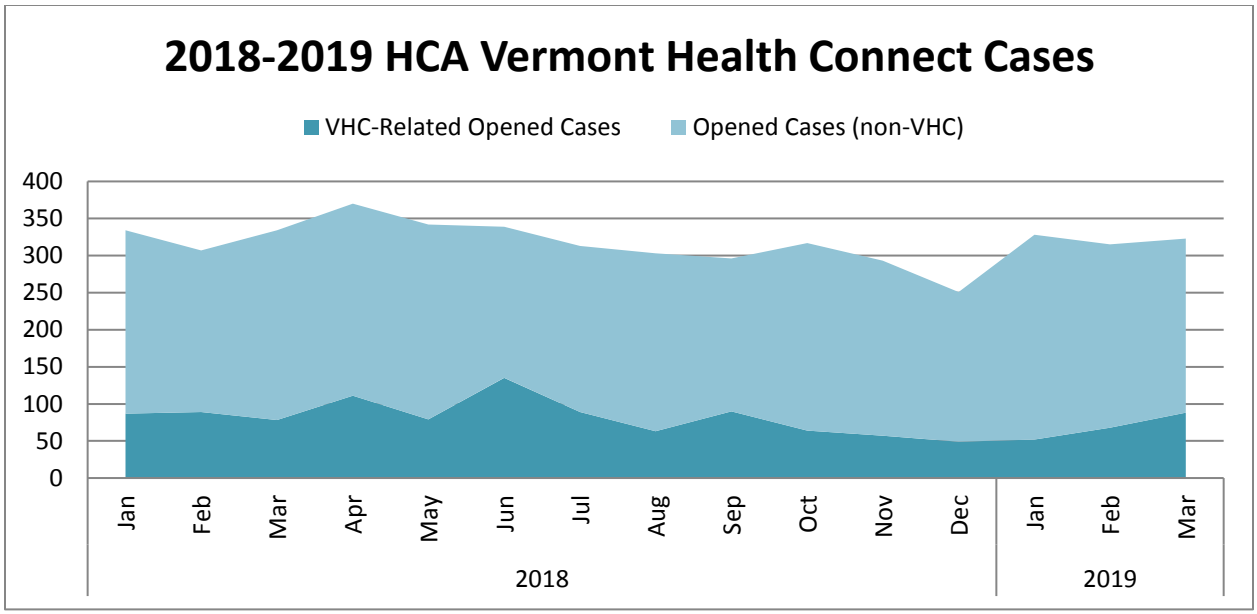
The total call volume increased by 13% (1018 this quarter vs. 898 last quarter). Call volume this quarter is very similar to call volume in the same quarter in 2018. In 2018, the HCA had 1046 calls in the third quarter compared to 1018 in 2019. About 11% of those calls involved getting consumers onto new coverage, preventing the loss of coverage, or obtaining coverage for services. We saved consumers $149,430.88 this quarter.

E. Calls concerning Vermont Health Connect increased by 25% this quarter.

The volume of calls concerning Vermont Health Connect increased this quarter (262 vs. 209). The top two VHC issues were eligibility for Medicaid - MAGI (91), and eligibility for Premium Tax Credits (79). This quarter, 59 VHC cases required complex interventions that took more than two hours of an advocate's time to resolve, and another 48 cases required a direct intervention to resolve the case.

The HCA continues to resolve its cases by working directly with Tier 3 Health Access Eligibility Unit (HAEU) workers, who are trained to resolve all aspects of complex cases. In addition, the HCA meets with VHC as needed to discuss cases and has regular email contact with Tier 3. This quarter we had 37 escalated cases (46 last quarter). Of the 37 escalated cases, 32 were resolved within the quarter.

Tier 3 also now works on resolving Green Mountain Care cases (VPharm, Medicaid for Aged Blind and Disabled (MABD), Medicare Saving Programs, and Medicaid Spenddowns). This quarter we continued to receive significant numbers of consumers calling with questions about Medicare Savings Programs (70), MABD (74), and VPharm eligibility (43).



F. Medicaid eligibility calls represented 28% of all our cases (283 cases/1018 total cases). Consumers need assistance with all types of Medicaid.

Medicaid eligibility was again the top issue generating calls. We had 125 calls about eligibility for Medicaid for Children and Adults (MCA) Medicaid, 74 about eligibility for Medicaid for the Aged Blind and Disabled (MABD), 21 about Medicaid Spenddowns, and 18 about Medicaid for Working Disabled. We also had 40 calls about Long Term Care Medicaid. MAGI Medicaid and MABD Medicaid have different eligibility and income rules, and HCA advocates assess and advise on eligibility for both programs. Consumers frequently have questions about what counts as income, who should be counted in their household, what expenses can be used to meet a Spenddown, how to complete renewal paperwork, and whether their eligibility decision is correct.

G. The top issues generating calls

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

All Calls 1018 (compared to 898 last quarter)

1. Affordability affecting access to care 126 (86)
2. MAGI Medicaid eligibility 125 (116)
3. Complaints about providers 92 (74)
4. Access to Prescription Drugs/Pharmacy 88 (61)
5. Premium Tax Credit eligibility 83 (91)
6. Information about Medicare 80 (53)
7. Information/applying for DVHA programs 79 (50)
8. Medicaid eligibility (non-MAGI) 74 (78)
9. Buy-in programs/Medicare Savings Programs 70 (56)
10. Termination of Insurance 70 (10)
11. Not health related 60 (50)
12. VPharm Eligibility 43 (43)

13. Nursing Home & Home Health access 42 (3)
14. Long Term Care Medicaid & Choices for Care eligibility 40 (15)

Vermont Health Connect Calls 262 (compared to 209 last quarter)

1. MAGI Medicaid eligibility 91 (78)
2. Premium Tax Credit eligibility 79 (83)
3. Special Enrollment Periods 45 (35)
4. Affordability affecting access to care 39 (25)
5. Information about DVHA 38 (11)
6. Termination of Insurance 37 (4)
7. Complaints about VHC – Invoices or Payment 33 (2)
8. Buying QHPs through VHC 31 (52)
9. Complaints about VHC – Maximus 31 (2)
10. Complaints about VHC – Eligibility Error 26 (1)
11. IRS Reconciliation 26 (15)

DVHA Beneficiary Calls 328 (compared to 291 last quarter)

1. MAGI Medicaid eligibility 59 (53)
2. Medicaid eligibility (non-MAGI) 36 (44)
3. Affordability affecting access to care 35 (29)
4. Access to Prescription Drugs/Pharmacy 34 (21)
5. Complaints about providers 29 (19)
6. Information about DVHA 28 (17)
7. Buy In Programs/MSPs eligibility 26 (21)
8. Termination of Insurance 21 (3)
9. Balance billing 19 (18)
10. Provider billing 18 (10)
11. Access to transportation 15 (16)
12. Hospital billing and financial assistance 15 (12)

Commercial Plan Beneficiary Calls 236 (compared to 160 last quarter)

1. Premium Tax Credit eligibility 49 (53)
2. Complaints about VHC - Invoices or Payment 28 (2)
3. Affordability affecting access to care 27 (13)
4. Eligibility for Special Enrollment Periods 24 (18)
5. IRS Reconciliation issues 21 (11)
6. MAGI Medicaid eligibility 21 (18)
7. Buying QHP through VHC 20 (27)
8. Termination of Insurance 20 (3)
9. Access to Prescription Drugs/Pharmacy 19 (8)
10. Information about Medicare 19 (8)
11. Complaints about VHC – Eligibility Error 16 (not tracked)
12. Complaints about VHC - Maximus 15 (1)

The HCA received 1018 total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as "dual eligible"): 32.2% (328 calls), compared to 31.8 % (284 calls) last quarter
- **Medicare**[2] **beneficiaries (**Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as "dual eligible," Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 30.8% (313 calls), compared to 32.6% (291 calls), last quarter
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans 23.2% (236 calls) , compared to 18.0% (161 calls) last quarter
- **Uninsured:** 7.56% (77 calls), compared to 9.40% (84 calls last quarter)

Case Results

A. Dispositions of Closed Cases

All Calls

We closed 986 cases this quarter, compared to 915 last quarter:

- 37% (363 cases) were resolved by brief analysis and advice
- 29% (287) were resolved by brief analysis and referral
- 19% (184) of the cases were complex interventions involving complex analysis, usually direct intervention, and more than two hours of an advocate's time
- 11% (109) were resolved by direct intervention, including calling an insurance company, calling providers, writing letters, gathering supporting medical documentation, etc.
- In the remaining cases, 43 clients withdrew, resolved the issue on their own, or had some other outcome.

Appeals: The HCA assisted worked on 45 cases related to appeals: 21 Fair Hearings, 10 Commercial Insurance appeals; 6 Medicare Part A, B, or C appeal, 3 Medicare Part D appeals, and 5 Medicaid MCO Internal appeals.

DVHA Beneficiary Calls

We closed 321 DVHA cases this quarter, compared to 300 last quarter:

- 34% (109 cases) were resolved by brief analysis and/or advice
- 25% (81) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 25% (80) were resolved by brief analysis and/or referral
- 13% (42) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- In the remaining cases, 9 clients resolved the issue on their own, or had some other outcome.

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

Commercial Plan Beneficiary Calls

We closed 222 cases involving individuals on commercial plans, compared to 151 last quarter:

- 45% (101 cases) were resolved by brief analysis and/or advice
- 28% (62) were considered complex intervention, which involves complicated analysis, usually direct intervention, and more than two hours of an advocate's time
- 11% (25) were resolved by direct intervention on the caller's behalf, including advocacy with the carrier and providers, writing letters, and gathering medical information
- 11% (24) were resolved by brief analysis and/or referral
- In the remaining cases, 10 clients withdrew, resolved the issue on their own, or had some other outcome.

B. All Calls Case Outcomes

The HCA helped 561 people with advice and education about health insurance questions about problems. We got 61 households onto insurance. We assisted 17 people with applications for or enrollment in insurance plans and prevented 9 insurance terminations or reductions. We obtained coverage for services for 23 people. We got 24 claims paid, written off, or reimbursed. We estimated VHC insurance program eligibility for 52 more. We provided other billing assistance to 25 individuals. We obtained other access or eligibility outcomes for 107 additional people.

Consumer Protection Activities

A. Rate Review

The HCA monitors all commercial insurance carrier requests to the Green Mountain Care Board (Board) for changes to premium prices. These requests are typically requests to increase the premiums that Vermonters must pay for commercial health insurance.

MVP Health Plan, Inc. (MVP) submitted the single filing decided this quarter, the MVP 2019 Large Group HMO and Large Group POS Riders. Approximately 2,171 people are covered by products affected by this filing. MVP proposed increasing the average annual premium price paid by Vermonters for these products by 13.7 percent. The HCA appeared on behalf of Vermonters in this matter, filed questions for the carrier, file a response to an objection by the carrier to the questions asked, and filed a memorandum in lieu of hearing. The Board reduced MVP's proposed price increase from 13.7 percent to an average of 11.5 percent. This premium price reduction translates into approximately $250,000 of savings for Vermonters.

B. Hospital Budget Review

The HCA participates in the Board's annual hospital budget review process. This quarter, the HCA continued to participate in the Board's work group, which also includes hospital Chief Financial Officers, Board staff, and the Hospital Association. The purpose of the group was to provide input prior to the Board's fiscal year 2020 hospital budget review process. The HCA participated in 5 meetings of the work group this quarter and submitted written feedback to Board staff on the draft budget guidance.

In February, Board staff presented the draft FY2020 hospital budget guidance to the Board. The HCA submitted written comments expressing concern about the Board's proposed 2 year 3.5% hospital net patient revenue (NPR) cap. We noted that NPR increases disproportionately affect commercially insured Vermonters and asked the Board to consider affordability and implement a cap more in line with inflation and wage growth. We also expressed concern about the state's ability to meet the all-payer model growth target of 3.5% if the Board allows the regulated hospitals to build their budgets around 3.5% revenue growth.

This quarter the HCA also submitted our first set of FY2020 hospital budget questions, which were included with the Board's hospital budget guidance.

C. Oversight of Accountable Care Organizations

The HCA participates in the Board's annual ACO budget review process. This quarter, the Board reviewed OneCare Vermont's December 2018 request to amend its 2018 budget. The HCA reviewed OneCare's budget amendment request and submitted written comments to the Board. We expressed concern about OneCare's request to reduce the percentage of its budget that pays for population health management and payment reform programs.

In January, the Department of Vermont Health Access solicited comments on its Vermont Medicaid Next Generation (VMNG) ACO program. The HCA submitted comments expressing concern about discrimination against transgender individuals codified in DVHA's proposed policy. We also outlined concerns about the attribution methodology used, quality measurement and accountability, grievance and appeals processes, and case management.

This quarter, the HCA also provided feedback to the Department of Vermont Health Access on its patient notice for a St. Johnsbury region ACO pilot program being implemented in the St. Johnsbury region. We met with DVHA staff and suggested edits related to clarity, readability, and accuracy.

D. Certificate of Need Applications

In 2017, the Board approved a Certificate of Need (CON) for the Green Mountain Surgery Center, an ambulatory surgery center. The CON required the center to submit regular updates on the project. The CON also required the center to appear before the Board to prove that it had satisfied several conditions prior to commencing operations. During the last quarter, the Board began preparing for this phase in the process. As an interested party in the proceeding, the HCA has been reviewing the submissions by the surgery center and preparing for the hearing which will take place on April 17. The HCA has requested and been granted time to question the surgery center at the hearing.

E. Other Green Mountain Care Board Activities

The HCA continues to attend the weekly Green Mountain Care Board meetings and the Board's bi-monthly Data Governance Council meetings.

F. Other Activities

Administrative Advocacy

- **Comments on Proposed Federal Exchange Program Integrity Rules:**

In January, the HCA submitted comments to the Centers for Medicare and Medicaid Services on their Exchange Program Integrity Rule. The rule proposed to require carriers who sell insurance on health insurance exchanges to separately bill consumers monthly for the portion of their premiums that pay for abortion services. We argued that this change would increase administrative burden and costs for both insurers and the state. Most significantly, the change would create significant confusion and put Vermonters at risk for losing their insurance if they were to miss the second monthly bill.

- **Comments on Proposed HHS Notice of Benefit and Payment Parameters for 2020**

In February, the HCA submitted comments to the U.S. Department of Health and Human Services on their 2020 Notice of Benefit and Payment Parameters for health insurers selling on state exchanges. We opposed a number of proposed rule changes including loosening the federal standards for essential health benefits required to be included in exchange plans; altering the premium tax credit methodology, which would reduce these subsidies; encouraging mid-year pharmacy formulary changes; and requiring all insurers selling exchange plans that include abortion services to sell identical plans on the exchange except excluding the abortion services.

✧ Individual Mandate Working Group

The HCA was named in the statute forming this group. Its purpose was to consider pros and cons and potential structure for a Vermont individual mandate penalty to replace the federal penalty that was removed by congress in the 2017 Tax Cuts and Jobs Act. The removal of the federal penalty resulted in a premium increase of $7.9 million in 2019 rates. The Chief Advocate testified before legislative committees of jurisdiction to report on the process and the outcome of the work group and the HCA's position on and individual mandate penalty.

✧ Access to Treatment for Hepatitis C Virus

The HCA continues to advocate for increased access to hepatitis C virus (HCV) treatment. This quarter, we met with the Department of Corrections (DOC), UVMMC, and AHS to discuss HCV treatment procedures in Corrections. Subsequently, we sent two letters to the Vermont Department of Corrections (DOC) asking for more information about the state's treatment of people with HCV within the correctional system. We received a partial response to our first set of questions and have reached out to DOC asking for a meeting to discuss the information that DOC has not yet provided. We are encouraged that DOC is now treating some people in custody with hepatitis C, but remain concerned that the vast majority of people in need of treatment are still not receiving it.

✧ Health Care in the Department of Corrections

In addition to the hepatitis C advocacy described above, this quarter the HCA submitted a letter to the Department of Corrections outlining our concerns about the payment model used in the Department's health care contract with Centurion of Vermont. We described our concerns about using a capitated payment model in the context of corrections, where people do not have provider choice and there is little accountability for quality of care and access to care.

✧ University of Vermont Medical Center Mental Health Program Quality Committee

The HCA continues to participate in the UVMMC Mental Health Program Quality Committee (PQC). The PQC meets monthly and discusses mental health quality, programs, infrastructure, and planning.

✧ Vermont Crisis Standards of Care Work Group

The HCA participated in three meetings of this workgroup in this quarter, in order to review and provide feedback on the state's Crisis Standards of Care plan.

✧ Hospital-Associated Infections Advisory Committee

The HCA provided a health care consumer perspective during the January meeting, regarding surveillance of antimicrobial resistance and WHONET.

✧ Global Commitment Register Comments

The HCA continues to monitor Global Commitment rule and policy changes. This quarter we reviewed several proposed rule and policy changes.

✧ **Vermont Health Connect Escalation Path**

The HCA and VHC continue to collaborate to resolve complex VHC issues. The VHC escalation path now also works to resolve issues regarding Medicaid for Aged, Blind and Disabled (MABD), Medicare Savings Programs, Medicaid Spenddowns and V-Pharm. We communicate with VHC multiple times a day and meet as needed to discuss the most difficult cases.

✧ **Comments on Vermont Health Connect Notices**

At VHC's request, the HCA commented on 6 notices, in an effort to make them more readable and consumer-friendly. See **Promoting Plain Language in Health Communications** below.

✧ **Medicaid and Exchange Advisory Board**

This quarter, the Chief Health Care Advocate continued to co-chair and actively participate in Vermont's Medicaid and Exchange Advisory Board (MEAB). The MEAB focused on the Medicaid budget in DVHA as well as other key parts of the Agency including DAIL, DCF and DMH. We also focused on the administrations legislative agenda as well as general functioning of open enrollment and health care IT projects. The Chief attended and co-chaired three meetings of the MEAB this quarter.

✧ **Federal Issues Work Group: Silver Stacking Contingency Planning**

The HCA participated in legislative testimony on the outcome of the narrow focus of silver stacking contingency planning. This work group resulted in a legislative proposal to allow for broad loading if the Feds expressly disallow the continuation of silver loading. The HCA also advocated for continued funding of Vermont Cost Sharing Allowance monies in the state budget.

Legislative Activities

The HCA has been active in the State House this quarter with a number of legislative projects. We represented the consumer perspective in various legislative discussions including open enrollment, silver loading, transparency in medical billing, abortion access, HIE consent policy, and various other issues discussed in the Legislature this year.

The most significant legislative project this this year for the HCA has been to protect consumers from federal efforts to undermine the Affordable Care Act. It has been a priority for the HCA to inform policy makers as well as the public about the potential impact on rates due to the creation of Association Health Plans that will move participating small businesses out of the QHP risk pool and separately rate their risk in the large group.

Collaboration with Other Organizations

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

- Altarum Health Care Value Hub
- American Civil Liberties Union of Vermont
- Bi-State Primary Care
- Blue Cross Blue Shield of Vermont
- Burlington School District
- Community Catalyst
- Dartmouth Institute for Health Policy & Clinical Practice

- Families USA
- IRS Taxpayer Advocate Service
- Ladies First
- MVP Health Care
- NHelp, National Health Law Program
- OneCare Vermont
- Outright Vermont
- Pride Center of Vermont
- Planned Parenthood of Northern New England
- SHIP, State Health Insurance Assistance Program
- University of Pennsylvania Leonard Davis Institute of Health Economics
- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems
- Vermont Care Partners
- Vermont CARES
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Developmental Disabilities Council
- Vermont Health Connect
- Vermont Medical Society
- Vermont Program for Quality in Health Care

Outreach and Education

Quarterly report – website stats – Jan - March 2019

*Note: Office pageviews of the health web pages are included in the numbers here. The **only** numbers where office traffic is **excluded** are the Online Help Tool numbers.*

G. 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 225 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

- The total number of **health pageviews increased by 4.5%** in the reporting quarter ending March 31, 2019 (12,442 pageviews), compared with the same quarter in 2018 (11,910 pageviews).

- The **top-20 health pages** on our website this quarter with change over last year:
  - *Income Limits – Medicaid* – 3,238 pageviews (2% ↓)
  - *Health* – section home page – 1,847 (22% ↑)
  - *Choices for Care* – 420 (2% ↓)
  - *Dental Services* – 418 (13% ↑)
  - *Services Covered by Medicaid* – 396 (20% ↓)
  - *Resource Limits – Medicaid* – 383 (23%↓)
  - *HCA Online Help Request Form* – 379 (33% ↑)
  - *Health Insurance, Taxes and You* – 278 (28% ↑)
  - *Medicaid* – 258 (74% ↑)
  - *Medicare Savings / Buy-In Programs* – 207 (25% ↑)
  - *Advance Directive Forms* – 180 (22% ↑)
  - *Federally Qualified Health Centers* – 164 (2% ↓)
  - *Medicaid and Medicare Dual Eligible* – 160 (22% ↑)
  - *Choices for Care Income Limits* – 155 (5%↑)
  - *Health Statement Form 1095* – 148 (63% ↑)
  - *Choices for Care Resource Limits* – 142 (24% ↓)
  - *Long-term Care* – 140 (26% ↓)
  - *Prescription Help – State Pharmacy Programs* – 137 (4% ↓)
  - *Dr. Dynasaur* – 136 (147% ↑)
  - *Medicaid Transportation* – 133 (5% ↑)

- Besides the pages listed above, other **spikes in interest** in our pages included:
  - *Supplemental Medicare Plans* – 120 (650% ↑)
  - *VHC Coverage for Small Employers* – 63 (385% ↑)
  - *Vermont Health Connect* – 107 (53% ↑)
  - *Health Insurance* – 126 (38% ↑)
  - *Green Mountain Care* – 126 (35% ↑)

Popular Downloads

31 out of 123 or 25% **of the unique PDF, Word or other files downloaded** from the VTLawHelp.org website were on health care topics. Of those unique health-related PDF titles:

- The top five consumer-focused PDF downloads were:
  - *Advance Directive, short form* (117 downloads)
  - *Advance Directive, long form* (85 downloads)
  - *Vermont Dental Clinics Chart* (77 downloads)
  - *Vermont Medicaid Coverage Exception Standards & Form* (53 downloads)
  - *5-Step Guide to Getting DME from Medicaid* (11 downloads)
- The top advocate-focused PDF download was:
  - *PTC Rule Allocation Summary* (21 downloads)
- The top policy-focused PDF download was:
  - *VT ACO Shared Savings Program Quality Measures* (3 downloads)

The *Advance Directive Short Form* is the **third most downloaded of all PDFs** downloaded from the entire VTLawHelp.org website. The *Long Form* is the **fourth most downloaded**. The *Vermont Dental Clinics Chart* is the **fifth most downloaded**.

Online Help Tool Adds to Our Reach

In 2017 we added a new Health section to the online help tool on our website. It is found at *https://vtlawhelp.org/triage/vt_triage* and it can be accessed from most pages of our website. The website visitor answers a few questions to find specific health care information they need. The new feature addresses some of the most popular questions that are posed to the HCA. In addition to our deep collection of health-related web pages, the online help tool adds a new way to access helpful information — at all hours of the day and night. The website user can also call us or fill in our online form to get personal help from an advocate.

Website visitors used this new tool to access health care information **140 times** during this quarter. That's slightly down from 151 in the previous quarter (October – December 2018).

Of the **41** health care topics that were accessed using this tool, the top topics were:

- Dental Services – I need help finding a low-cost dentist and paying for dental care.
- Long-Term Care – I want to go over my long-term care options (nursing homes, in-home care and more).
- Long-Term Care – How do I know if I can get Choices for Care Long-Term Care Medicaid?
- Medicaid – I want to apply for Medicaid or Dr. Dynasaur for myself or for my children.
- VHC – When can I enroll in Vermont Health Connect?
- Complaints – I want to file a complaint against a doctor or hospital.

H. Other Outreach and Educational Activities

- **State House Card Room Tabling, January 11, 2019.** The HCA answered health care program questions and distributed information on constituent services to senators, representatives, constituents, and State House employees.
- **Spectrum Multicultural Youth Program, January 22, 2019**. The HCA presented on the HCA, how to resolve health insurance issues, and distributed brochures to seven Spectrum staff members.
- **State House Legislative Day, January 27, 2019**. The HCA participated in an outreach event at the Statehouse. HCA advocates talked about constituent services and distributed brochures.
- **Vermont Family Network, January 29, 2019.** The HCA presented to ten staff members on the HCA, answered questions about health care access and resources for children with disabilities.
- **Community Health Centers of Burlington, February 1, 2019.** The HCA presented on the HCA, civil legal issues, health care program issues, and health insurance tax issues to seven social workers, nutritionists, patient services staff members.
- **NFI Vermont's Youth and Family Resource Expo, February 9, 2019.** The HCA tabled and distributed information and brochures to 38 people.
- **Vermont Health Connect Program Assister Meeting, February 14, 2019.** The HCA met with the Assister Program Manager to share information about the HCA and evaluate how to improve client referrals from the assister program.
- **LGBTQ Older Adults Needs Assessment Focus Group, February 27, 2019.** The HCA presented on common Medicare issues, general health insurance resources, and the services that the HCA provides to an audience of 27 adults that are LGBTQ+ and over 60 years old.
- **2-1-1, March 1, 2019.** The HCA presented to seven Information and Referral Specialists about the services that HCA provides on the HelpLine and with the legislative/policy advocacy team. HCA answered questions about Medicaid transportation, billing, appeals, and taxes.
- **Vermont Family Network, March 13, 2019** The HCA returned to the Vermont Family Network in March to deliver a webinar to an additional 16 staff, community partners, and clients of the Vermont Family Network. The webinar was recorded and published on Vermont Family Network's website, YouTube channel, and Facebook page.
- **Brattleboro Senior Center, March 20, 2019.** The HCA presented general information about HCA services, Medicare, and Medicaid to seven attendees over the age of 50. HCA also answered questions and completed intake for attendees who needed individual HCA help.
- **Brattleboro Senior Meals—Meals on Wheels**, **March 20, 2019.** The HCA met with the Executive Director of the program to share information about the HCA and answer general questions about referrals for participants in the Meals on Wheels program.
- **Parent University Kick-Off, March 27, 2019.** The HCA met and distributed general HCA materials to four fellow presenters, two interpreters, and five adult learners.
- **Medicare Training, March 28, 2019.** The HCA met fellow attendees and distributed HCA brochures and business cards to four SHIP staff members and four health insurance brokers.
- **Social Media Outreach.** The HCA published eight posts on Facebook, with a total of 5,132 views.

I. Promoting Plain Language in Health Communications

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

- MEC Medicare Verification Notice
- MEC Verification Notice
- Final MEC Verification Notice
- Notice for Approval for an SEP for Exceptional Circumstances
- Notice of Denial for an SEP for Exceptional Circumstances
- RTA language for GMC notices

Office of the Health Care Advocate

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

https://vtlawhelp.org/health

Attachment 6

CY 2019 Investment Expenditures

Department	STC #	Receiver Suffix	Investment Description	QE 0319	QE 0619	QE 0919	QE 1219	CY 2019 Total
AHSCO	41	9091	Investments (STC-79) - 2-1-1 Grant (41)	113,067				**113,067**
AHSCO	54	9090	Investments (STC-79) - Designated Agency Underinsured Services (54)	3,309,488				**3,309,488**
AOE	11	n/a	Non-state plan Related Education Fund Investments					**-**
DCF	1	9403	Investments (STC-79) - Residential Care for Youth/Substitute Care (1)	2,232,488				**2,232,488**
DCF	2	9412	Investments (STC-79) - Lund Home (2)	366,961				**366,961**
DCF	9	9415	Investments (STC-79) - Challenges for Change: DCF (9)	48,807				**48,807**
DCF	26	9416	Investments (STC-79) - Strengthening Families (26)	308,531				**308,531**
DCF	33	9413	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)	-				**-**
DCF	34	9414	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34)	44,660				**44,660**
DCF	35	9418	Investments (STC-79) - Building Bright Futures (35)	206,047				**206,047**
DCF	55	9402	Investments (STC-79) - Medical Services (55)	23,713				**23,713**
DCF	56	9405	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56)	1,047,295				**1,047,295**
DCF	57	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	27,795				**27,795**
DCF	58	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	68,004				**68,004**
DCF	59	9408	Investments (STC-79) - Essential Person Program (59)	209,725				**209,725**
DCF	60	9409	Investments (STC-79) - GA Medical Expenses (60)	70,191				**70,191**
DCF	61	9411	Investments (STC-79) - Therapeutic Child Care (61)	285,108				**285,108**
DCF	62	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	68,790				**68,790**
DDAIL	27	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)	289,997				**289,997**
DDAIL	42	9605	Investments (STC-79) - Quality Review of Home Health Agencies (42)	-				**-**
DDAIL	43	9606	Investments (STC-79) - Support and Services at Home (SASH) (43)	232,386				**232,386**
DDAIL	63	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	120,100				**120,100**
DDAIL	64	9603	Investments (STC-79) - DS Special Payments for Medical Services (64)	353,476				**353,476**
DDAIL	65	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)	16,175				**16,175**
DDAIL	77	9607	Investments (STC-79) - HomeSharing (77)	86,397				**86,397**
DDAIL	78	9608	Investments (STC-79) - Self-Neglect Initiative (78)	110,761				**110,761**
DMH	3	9511	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - VPCH	5,513,064				**5,513,064**
DMH	3	9512	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - BR	1,390,537				**1,390,537**
DMH	12	9506	Investments (STC-79) - Mental Health Children's Community Services (12)	1,096,710				**1,096,710**
DMH	13	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	43,293				**43,293**
DMH	16	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16)	(5,624,184)				**(5,624,184)**
DMH	22	9510	Investments (STC-79) - Emergency Support Fund (22)	287,906				**287,906**
DMH	28	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	38,771				**38,771**
DMH	29	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)	2,723,842				**2,723,842**
DMH	66	9502	Investments (STC-79) - MH Outpatient Services for Adults (66)	665,517				**665,517**
DMH	67	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)	465,823				**465,823**
DMH	68	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	11,939				**11,939**
DMH	79	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79)	130,269				**130,269**
DOC	4	n/a	Return House	117,936				**117,936**
DOC	5	n/a	Northern Lights	98,438				**98,438**
DOC	6	n/a	Pathways to Housing	278,587				**278,587**
DOC	14	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)	130,237				**130,237**
DOC	15	n/a	Northeast Kingdom Community Action	-				**-**
DOC	69	n/a	Intensive Substance Abuse Program (ISAP)	-				**-**
DOC	70	n/a	Intensive Domestic Violence Program	-				**-**
DOC	71	n/a	Community Rehabilitative Care	-				**-**
DOC	80	n/a	Intensive Sexual Abuse Program	2,500				**2,500**
DVHA	7	9107	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	2,306,138				**2,306,138**
DVHA	8	9101	Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8)	-				**-**
DVHA	18	9106	Investments (STC-79) - Patient Safety Net Services (18)	-				**-**
DVHA	51	9102	Investments (STC-79) - Vermont Blueprint for Health (51)	772,376				**772,376**
DVHA	52	9103	Investments (STC-79) - Buy-In (52)	14,170				**14,170**
DVHA	53	9104	Investments (STC-79) - HIV Drug Coverage (53)	682				**682**
DVHA	72	9108	Investments (STC-79) - Family Supports (72)	-				**-**
DVHA	81	9109	DSR Investment (STC-83) – One Care VT ACO Quality & Health Management (81)	-				**-**
DVHA	82	9110	DSR Investment (STC-83) – One Care VT ACO Advanced Community Care Coordination (82)	-				**-**
GMCB	45	n/a	Green Mountain Care Board	437,029				**437,029**
UVM	10	n/a	Vermont Physician Training	844,804				**844,804**
VAAFM	36	n/a	Agriculture Public Health Initiatives	-				**-**
VDH	17	9220	Investments (STC-79) - Recovery Centers (17)	310,887				**310,887**
VDH	19	9201	Investments (STC-79) - Emergency Medical Services (19)	123,846				**123,846**
VDH	21	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	268,800				**268,800**
VDH	23	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	279,443				**279,443**
VDH	24	9225	Investments (STC-79) - Medicaid Vaccines (24)	-				**-**
VDH	25	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)	18,722				**18,722**
VDH	30	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)	473,797				**473,797**
VDH	31	9206	Investments (STC-79) - Health Laboratory (31)	810,186				**810,186**
VDH	37	9213	Investments (STC-79) - WIC Coverage (37)	808,915				**808,915**
VDH	38	9224	Investments (STC-79) - Fluoride Treatment (38)	14,144				**14,144**
VDH	39	9205	Investments (STC-79) - Health Research and Statistics (39)	270,241				**270,241**
VDH	40	9204	Investments (STC-79) - Epidemiology (40)	174,421				**174,421**
VDH	44	9228	Investments (STC-79) - VT Blueprint for Health (44)	466,192				**466,192**
VDH	46	9221	Investments (STC-79) - Enhanced Immunization (46)	90,214				**90,214**
VDH	47	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	12,065				**12,065**
VDH	48	9222	Investments (STC-79) - Poison Control (48)	26,246				**26,246**
VDH	49	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)	58,791				**58,791**
VDH	50	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	210,907				**210,907**
VDH	73	9211	Investments (STC-79) - Renal Disease (73)	-				**-**
VDH	74	9203	Investments (STC-79) - TB Medical Services (74)	10,095				**10,095**
VDH	75	9209	Investments (STC-79) - Family Planning (75)	406,196				**406,196**
VDH	76	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)	-				**-**
VSC	32	n/a	Health Professional Training	204,730				**204,730**
VVH	20	n/a	Vermont Veterans Home					**-**
				26,425,179	**-**	**-**	**-**	**26,425,179**

138,500,000 CY19 limit
112,074,821 remaining

Attachment 7 - Investment Scorecard

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

DMH GC Investment

What We Do

Description/Objective:

This investment pays for direct care costs (i.e. psychiatric care, medication therapy, counseling, activities of daily living, etc.) at Vermont Psychiatric Care Hospital (VPCH). VPCH is a 25-bed, acute care hospital located in Berlin, Vermont that offers patient areas designed for care, comfort, and safety. Patients are encouraged to engage in all aspects of prescribed treatment and participate in activities that will facilitate recovery. The investment funds staff time and patient care at VPCH.

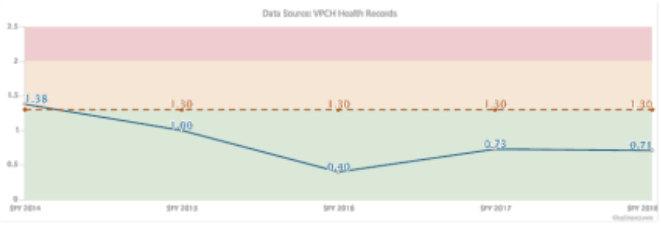
Interpretation of Results

Since its opening in FY 2015, VPCH has been committed to several initiatives related to patient care and patient satisfaction with services.

Seclusions and restraints have been below established targets for 3 of the last 4 years of reporting, due to VPCH's participation in SAMHSA's Six Core Strategies for reducing seclusion and
restraint. As VPCH has been accepting more acute inpatient stays across the system of care, it has still been able to decrease average length of stay for discharged patients and involuntary readmissions have remained stable over the past year. In 2016 VPCH met its target of lowering readmission rates.

Performance Measures

PM How_Well # hours of seclusion and restraint per 1,000 patient hours



	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
SFY 2018		0.71	1.30	↘ 1
SFY 2017		0.73	1.30	↗ 1
SFY 2016		0.40	1.30	↘ 2
SFY 2015		1.00	1.30	↘ 1
SFY 2014		1.38	1.30	→ 0

Story Behind the Curve

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

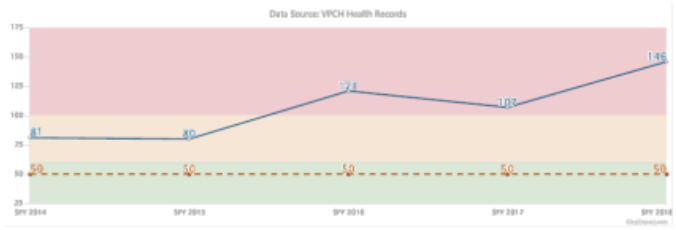
Providing patient care in an environment that is safe and supportive is important for recovery. VPCH, through its work with the SAMHSA Six Core Strategies for Reducing seclusion and restraint has lowered its rate of seclusion and restraint to approximately one half-hour per 1,000 patient hours, which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

Updated February 2018

Notes on Methodology

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

PM VPCH Average length of stay in days for discharged patients

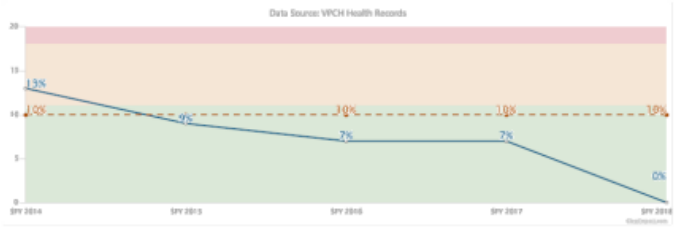


SFY 2018	146	50	↗ 1
SFY 2017	107	50	↘ 1
SFY 2016	121	50	↗ 1
SFY 2015	80	50	↘ 1
SFY 2014	81	50	→ 0

Story Behind the Curve

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

PM How_Well % of discharges readmitted involuntarily within 30 days of discharge



SFY 2018	0%	10%	↘ 1
SFY 2017	7%	10%	→ 1
SFY 2016	7%	10%	↘ 2
SFY 2015	9%	10%	↘ 1
SFY 2014	13%	10%	→ 0

Story Behind the Curve

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

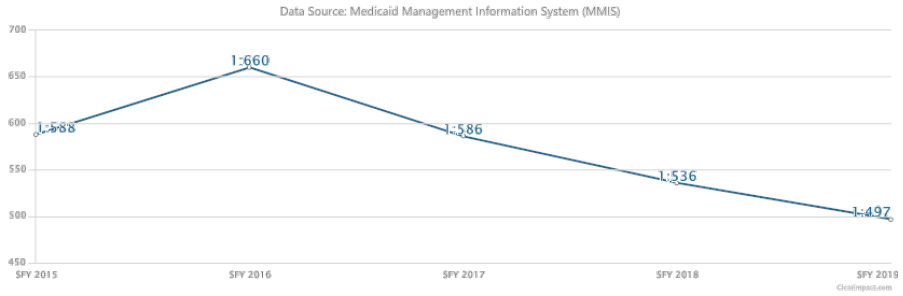
What We Do

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

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

Performance Measures

	Most Recent Period	Current Actual Value
PM DVHA # of VT Medicaid-enrolled dental providers relative to the total # of VT Medicaid beneficiaries	SFY 2019	1:497
	SFY 2018	1:536
	SFY 2017	1:586
	SFY 2016	1:660
	SFY 2015	1:588



Notes on Methodology

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

Partners

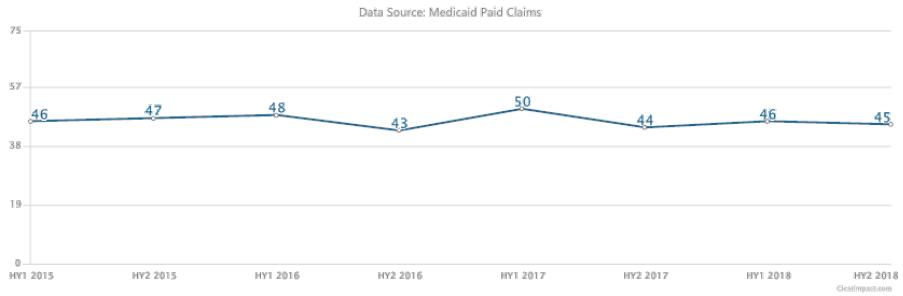
- Department of Vermont Health Access (DVHA): Clinical Operations (Dental staff), Provider & Member Relations, Data, Policy and Quality Units
- Vermont Department of Health's Oral Health Program
- Vermont Dentists

- Vermont State Dental Society (VSDS)

Story Behind the Curve

This measure shows the number of Vermont Medicaid enrolled dentists relative to the number of VT Medicaid beneficiaries. For this measure, a lower ratio is better. The baseline for this measure is SFY 2015 to align with Medicaid Expansion which led to an increase in the number of adults eligible for the Medicaid dental benefit.
The data trend indicates that the number of enrolled dentists has increased while the number of eligible beneficiaries has decreased. Also, Vermont began enrolling independently practicing dental hygienists in July 2016.

PM DVHA # of dental practices eligible for dental incentive payment (total Medicaid paid claims of $50k or more)



HY2 2018	45
HY1 2018	46
HY2 2017	44
HY1 2017	50
HY2 2016	43
HY1 2016	48
HY2 2015	47
HY1 2015	46
HY2 2014	43

Notes on Methodology

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

Partners

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

Story Behind the Curve

For SFY 2008 and beyond, the Vermont Legislature authorized DVHA to begin distributing $292,836 annually to support the program. The DVHA and the VSDS agreed that the funds would be distributed bi-annually; distributions of $146,418 are made in the spring and fall, for an annual total of $292,836. Each dental practice that receives $50,000 or more biannually in Medicaid paid claims is eligible for the payment. The amount paid is calculated as a percentage of the Medicaid claims paid. Historically, 36-48 dentists have qualified for semi-annual payouts and a share of the $146,418 available.

Action Plan

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

Attachment 8b - Payment Model Scorecard

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

What We Do

Children's Integrated Services is a unique model for integrating early childhood health, mental health, evidence based home visiting, early intervention and specialized child care services for pregnant and postpatum women and children birth to age six.

Who We Serve

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

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

How We Impact

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

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

Referrals Triaged by CIS Coordinator: An increase in referrals made directly to the CIS coordinator, rather than directly to individual service providers, indicates growing community awareness that CIS is a comprehensive source for early childhood services.

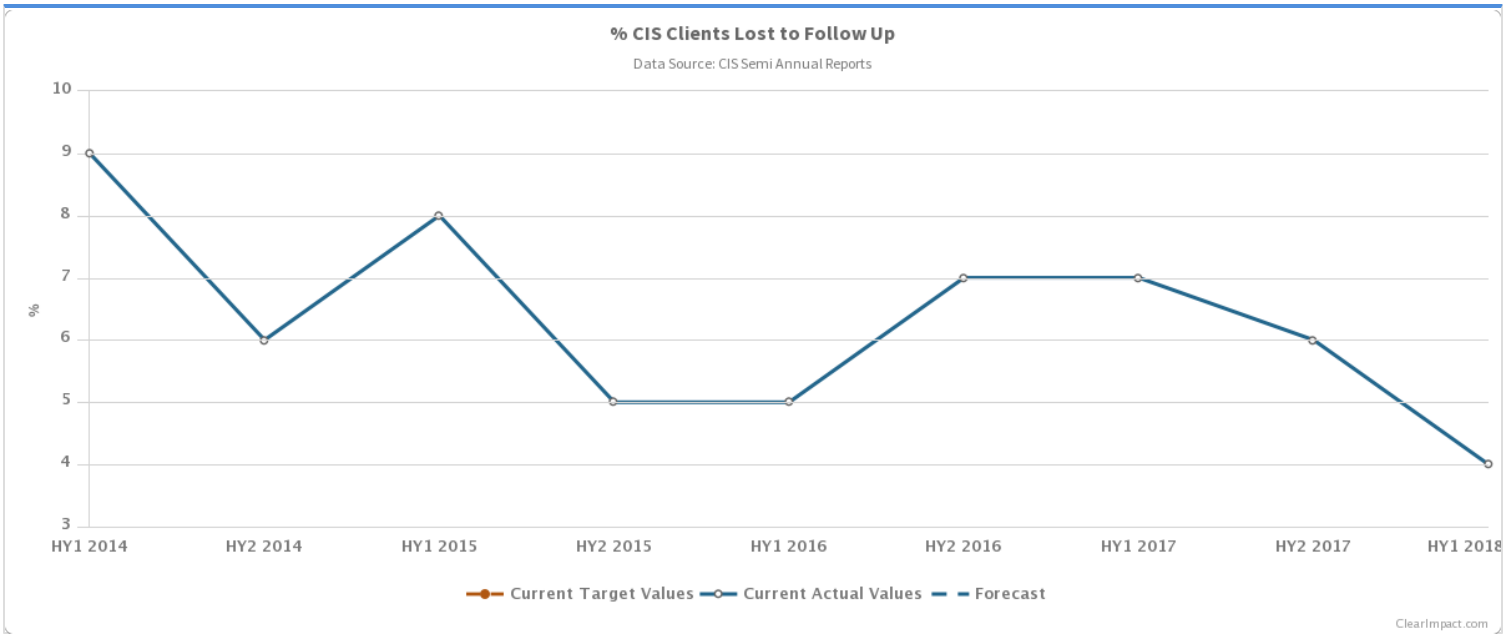
Clients with One Plan Completed within 45 Days: A key step in engaging families and beginning timely service delivery is the completion of a One Plan, the individualized service plan used in CIS. Starting services in a timely manner ensures that every client has the best opportunity to maximize their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

Performance Measures	Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
PM CDD % CIS Clients Lost to Follow Up	HY1 2018	4%	–	↘ 2	-56% ↓
PM CDD % of Referrals Triaged by CIS Coordinator	HY1 2018	83%	–	↗ 2	8% ↑
PM CDD % of Clients with One Plan Completed withing 45 days	HY1 2018	85%	–	→ 1	9% ↑

PM

% CIS Clients Lost to Follow Up

CDD CIS Half Year | Lower is Better | Not Calculated



Story Behind the Curve

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

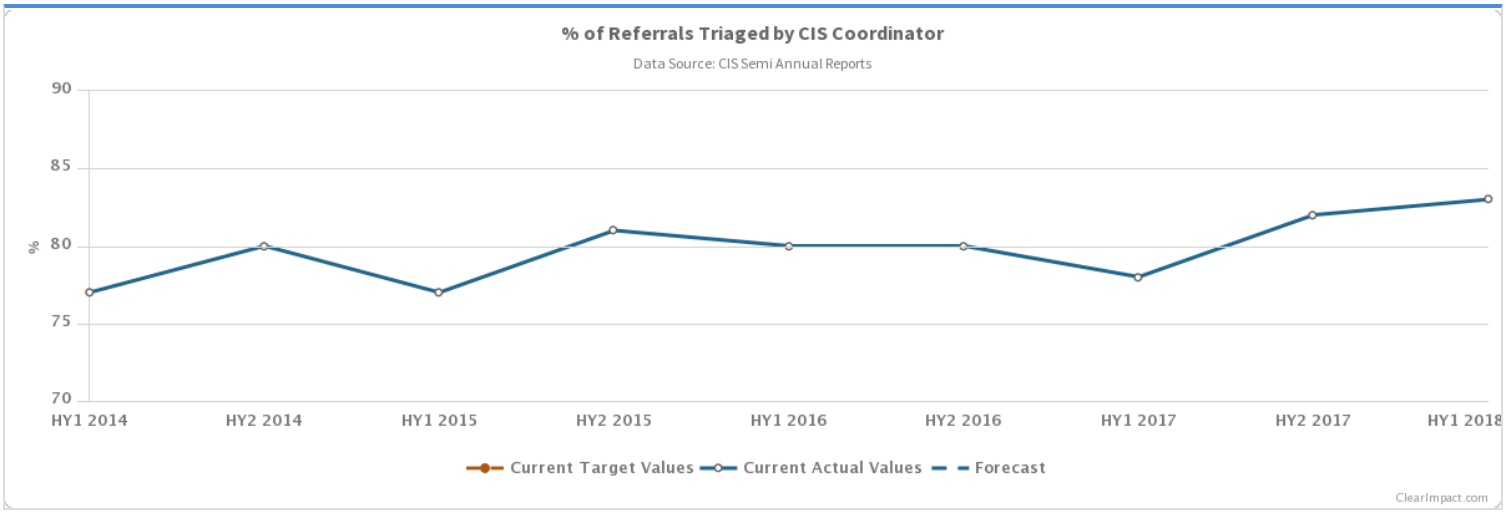
Partners

Children's Integrated Services (CIS) partners with local agencies to provide services to families. A list of partners is available on the Department for Children and Families website here https://dcf.vermont.gov/partners/cis

PM

% of Referrals Triaged by CIS Coordinator

CDD CIS Half Year | Higher is Better | Not Calculated



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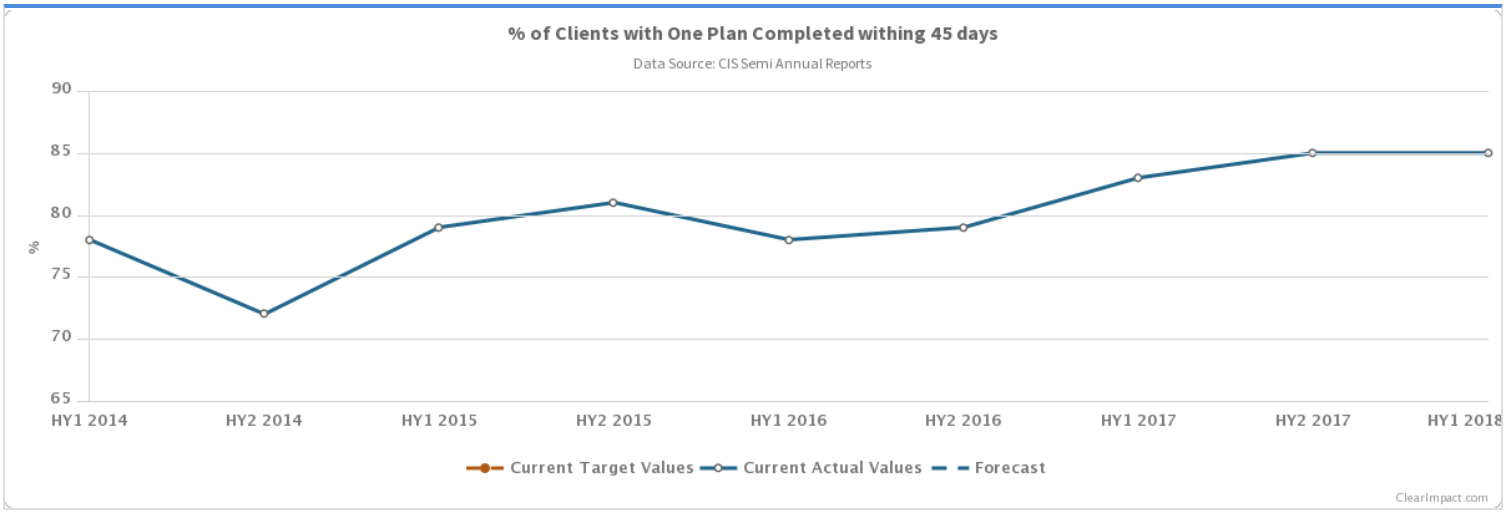
PM

% of Clients with One Plan Completed withing 45 days

CDD CIS Half Year | Higher is Better | Not Calculated



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