State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

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

Quarterly Report for the period
January 1, 2023 – March 31, 2023

Submitted Via PMDA Portal on May 29, 2023

Table of Contents

I. Background and Introduction

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

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

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

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

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

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

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

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

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

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

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

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the first quarterly report for waiver year 19, covering the period from January 1, 2023, through March 31, 2023 (QE032023).***

II. Outreach/Innovative Activities

i. Member and Provider Services

Key updates from QE032023:

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

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

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

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

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

NEMT Update

In the first quarter of the calendar year 2023, DVHA's non-emergency medical transportation program showed a slight decline in utilization factors for the first two months of the year, only to surge ahead again in March. Overall numbers have not completely rebounded since the first major drop during the height of the pandemic, but they are showing signs of an upward trend. The January and February counts do reflect an annual mid-winter drop in utilization. We are expecting the counts to continue the post-winter upward trend as we edge toward warmer weather. Program-related complaints remain mostly constant with the same period last year, with overall complaint numbers continuing to run well below the contracted performance standard of 5% of all rides provided, maintaining a monthly rate of less than 1%.
The recent trip statistics continue to reflect the reality that there remains a steady segment of the Medicaid transportation-eligible population now taking more rides per person per month. While trip counts are increasing, the number of unduplicated members utilizing the available ride services has remained much steadier. This ongoing trend seems to reflect the increasing need for this population to access daily services, such as adult day care and opioid treatment. We do not expect this trend to slow down any time soon.

Coordination of Benefit Activity

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

Areas of activities:

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

skilled nursing facility care.

- **Third-Party Recoupment:** Seek recovery from providers when Medicaid paid for services as primary and the primary payer requires additional information for recovery.

Coordination of Benefit Collection Table:

MPS - Coordination Recovery Activities "Q2"	
Casualty	$377,993.95
Estate	$337,252.16
Third-Party & Court-Ordered Medical	$114,611.10
Medicare Prescription Drug Premium/Claims	$73,662.78
Over Resource/Hospice/Patient Share/Credit Balance	$212,812.06
Annuity/Trust/Waiver	$120,750.97
Lamp/Map, Medicare Claim Recoupment	$242,193.62
Third-Party Claim Recoupment	$60,225.27
Total	**$1,539,501.91**

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

Coordination of Benefit-Cost Avoidance Table:

Cost Avoidance "Q2"	
Third-Party Liability	$26,873,167.14
Medicare	$144,298,809.30
Total	**$171,171,976.44**

III. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE032023:

- The Customer Support Center received more than 50,120 calls in QE0323, down 1% from the previous year.
- DVHA is supported by 107 Assisters (98 Certified Application Counselors, 4 Navigators, and 5 Brokers). Working in 54 organizations including hospitals, clinics, and community-based organizations. 21 Assisters are in training (whose application date is January 1, 2023, thru March 31, 2023).
- Increasing numbers of customers are using self-service functions. Self-serve applications comprised over half (61%) of all applications in QE0323. This is a 4% increase from QE0322.

Enrollment

As of QE0323, more than 228,008 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 160,221 in

Medicaid for Children and Adults (MCA) and 67,787 in Qualified Health Plans (QHPs), with the latter divided between 24,894 enrolled with VHC, 4,905 direct enrolled with their insurance carrier as individuals, and 37,988 enrolled with their small business employer.

Medicaid Renewals

For each month of the first quarter and the duration of the public health emergency, MCA redeterminations are processed only for cases that can be renewed Ex Parte. Cases that require an application have coverage extended.

The passive renewal success rate for the quarter averaged 34%.

Ex Parte success rate has decreased as the PHE has continued.

1095 Tax Forms

1095B is an informational form that shows months of coverage for Medicaid members. 122,204 Initial 1095Bs were generated but not mailed for tax year 2022, unless member requested. For the tax year 2023, the federal deadline was March. The 1095B corrections began in March and as of mid-April, 531 corrections have been generated.

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 50,120 calls in QE0323. Maximus answered 87% of calls within 24 seconds in January 2023, 93% in February 2023, and 97% in March 2023. All three months exceeded the target of 75%.

Maximus is the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to DVHA-HAEEU for resolution and log service requests, which are escalated to the appropriate resolver group. This year has seen a decrease in the volume of calls and a slight decrease in the proportion of calls that were escalated to the Eligibility unit. 6% of QE0323 calls were transferred to DVHA-HAEEU staff. Just as importantly, DVHA strived to answer all calls that were transferred; 98% of transferred calls were answered in five minutes in QE0323.

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. QE0323 was 98%.

System Performance

Throughout most of QE0323, 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 two

seconds (0.88) in each of the three months – which is within the two-second target.

In-Person Assistance

DVHA is supported by 107 Assisters (98 Certified Application Counselors, 4 Navigators, and 5 Brokers). Working in 54 organizations including hospitals, clinics, and community-based organizations.

21 Assisters are in training (whose application date is January 1, 2023, thru March 31, 2023). The program continues to prioritize recruitment activities and quality Assister education and training to ensure equitable and sound service.

In addition, languages other than English, if offered by an Assister, are notated on the Assister Directory for easier access by LEP customers or customers who are more comfortable getting assistance in a preferred language.

Outreach

DVHA continued to reach out to the public and key stakeholders about Open Enrollment and the programmatic changes preparing for the end of Medicaid continuous coverage. On the latter issue, a specific section was created for the website. DVHA specifically focused on bringing awareness to customers on the need to update personal information to ensure they could be reached. DVHA also built on its normal communication mediums of the website, social media, newsletter, and emails, and began texting customers directly.

The Plan Comparison Tool helps customers estimate the total costs of coverage. Vermonters use it to better assess their choices – from potential subsidies, to assess various plan designs and out-of-pocket costs. It is a core piece of DVHA's health insurance literacy, particularly during Open Enrollment. It was used in nearly 15,100 sessions during the quarter.

Self-Service

During QE0322, DVHA-HAEEU continued to promote self-service options for customers to pay their bills, report changes, and access tax documents and other forms. Self-service leads to an improved customer experience as Vermonters can log in at their convenience. It also has the benefit of using automation to reduce staffing expenses. Year-over-year comparisons show that more customers are using self-service functions, including both online accounts for health coverage applications and reporting changes as well as the options of paying premiums through monthly recurring payments rather than one-time payments.
Self-serve applications comprised over half (61%) of all applications in QE0323.

ii. Choices for Care and Traumatic Brain Injury Program

DAIL

Choices for Care

Electronic Visit Verification:

DAIL Adult Services Division, in partnership with DVHA and DPH, continues to work with homecare agencies and individuals who self-direct their personal care services to provide access

to educational materials to support the adoption of EVV throughout the state. Information on EVV can be found HERE. Beginning July 1, 2022, ARIS Solutions, Vermont's contracted fiscal agent, implemented the policy that Medicaid program funds cannot be used to pay for services if EVV is not used to record in-home personal care services. Extensive communication was provided before implementation and is outlined here.

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

Enhanced FMAP spending plan:

The Initial Spending Plan Narrative was submitted in June 2021. During the reporting 2021Q3 reporting period, The Adult Services Division engaged with stakeholders for input on the set of activities included in the Home and Community-Based Services (HCBS) Initial Spending Plan. ASD is now implementing activities as outlined in the plan More information is available HERE

Adult Day

Adult Day Agencies continue to report that difficulty hiring staff has been a limiting factor in increasing enrollment. Ten out of eleven providers require that participants be fully vaccinated, and all require individuals to be able to wear a mask. In quarter 3, Adult Day providers continue to report challenges with staffing, including a lack of drivers to provide transportation to/from the Adult Day Centers. DAIL, in partnership with community stakeholders, will meet with targeted communities that do not have access to Adult Day Services to explore opportunities for reestablishing AD services in those areas. Stakeholder meetings are scheduled for October 2022. During Q3 and Q4, Vermont's Quality Management Unit is scheduled to complete site visits for the recertification of Adult Day providers.

At the end of Q1, CFC enrollment included:

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

Money Follows the Person (MFP)

The MFP grant has been re-authorized through (CY) 2027. The VT Department of Aging and Independent Living (DAIL) Adult Services Division has been awarded funds for CY2021 and CY2022 operations and is awaiting budget approval for CY 2023.

This award is anticipated to be funded for CY 2023 to help transition sixty-two (62) Choices for Care participants from a SNF to a home-based setting. As part of the grant re-authorization, CMS has also relaxed the eligibility rules for the MFP program. A math model that we created

for CMS projects that Vermont should be able to serve 50% more participants. MFP received funding authorization for CY2022, is awaiting budget approval for CY 2023, and expects to receive funding through CY 2027. We will be seeking permission from CMS to increase our service population to include individuals with I/DD and to provide supplemental funds for food for our participants as part of the Demonstration project.

DAIL has been awarded a $5M MFP Supplemental Grant. These dollars will be used to strengthen the systems serving Money Follows the Person and Choices for Care participants by increasing the number of direct service workers, increasing support for unpaid caregivers, and piloting new HCBS services to meet unmet care needs. The Supplemental Grant Funding will be used for the following seven approved initiatives:

1. Direct service workforce development and retention
2. Falls prevention and mobility
3. Use of assistive technology
4. Expansion of volunteer programs
5. Holistic social and mental health supports
6. Brain injury supports
7. Independent living and home modifications
8. In CY 2023 an additional initiative is being added to support discharge planning for complex care individuals at acute care facilities

In the first quarter of CY 2023, MFP has transitioned 13 individuals with 7 more in the pre-transition category.

Brain Injury Program

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

Wait Lists

- There is no wait list for the High Needs Group.
- There continue to be provider wait lists for Moderate Needs Group, estimated at almost 700 people statewide. Because the eligibility criteria for Moderate Needs services are so broad, Vermont does not expect to eliminate the wait list. Agencies are currently using different methods to address priority/acuity – we plan to transition to a statewide method. The state is currently piloting two separate acuity-based models for revising the wait list procedures. The goal of this work is to identify/implement a state-wide standardized approach to the priority scale.
- There is currently no wait list for the Brain Injury program.

iii. Developmental Disabilities Services Division (DDSD)

Payment and Delivery System Reform Update:

After having obtained over 500 Supports Intensity Scale-Adult (SIS-A) assessments, an analysis of the results was performed to help determine the appropriate number of levels of need in Vermont's framework. DAIL/DDSD consulted several stakeholder groups to solicit input regarding framework options (5 vs. 6 levels) and the preferred language to use.

This quarter, the American Association on Intellectual and Developmental Disabilities released the second edition of the SIS-A. Vermont is an early adopter of this edition. Based on internal discussions and input from stakeholders, we will analyze results once a critical number of second edition assessments have been completed to confirm that changes to the new edition do not result in significant changes to scores.

The DAIL/DDSD team expects that this analysis can begin in May 2023.

Please see prior report submissions for previous highlights.

DDS System of Care Plan Renewal

On January 1, 2023, DAIL/DDSD implemented the Vermont State System of Care Plan FY2023-2025.

The State System of Care plan includes several special initiatives including:

- Develop new housing options
- Strengthen the direct support professional workforce through targeted efforts in recruitment, training, supervision and mentoring, skill development, and retention.

Explore the option of paying parents to provide services to their adult children using DS HCBS dollars
Develop training resources for understanding the needs of individuals with autism spectrum disorders and designing individualized person-centered supports.

Please see prior report submissions for previous highlights.

iv. Global Commitment Register

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

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

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

There were 14 proposed policies posted in QE0323. A total of 4 final policies were posted in QE0323.

One policy clarification was posted to the GCR in QE0323. Changes included updates to rates and/or rate methodologies (including appropriations from the Vermont legislature), administrative rulemaking notices, and Medicaid State Plan amendments.

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

IV. Expenditure Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE032023:

- Beneficiary Enrollment.
- New To Medicaid Screenings.
- Team-based Care Initiative Updates.
- SDOH Screening Update.
- Staffing Update.

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

In the first quarter of 2023, VCCI has maintained consistency in caseload despite the re-deployment of some of our staff and onboarding and transition in traveling nurses. Our goal of increasing the percentage of face-to-face visits continues to improve with 69% of visits being in person. Most members request multi-modal interventions. Most prefer a hybrid model with some home visits mixed in with virtual or telephonic visits. We have also been in the process of updating our home visit safety protocols.

As seen below, VCCI provided care management services to 235 unique individuals in Q12023 The length of time and regularity of visits are dependent on the complexity and severity of the needs of the beneficiaries. VCCI case managers work with beneficiaries until the goals of their care plans are met or they are connected to needed services in the community with a lead care coordinator assigned. (See **Figure 1).**

Figure 1. Beneficiary Enrollment and Face To Face Visits

	Jan-23	Feb-23	Mar-23
Measure	2/15/2023	3/15/2023	4/15/2023
# new VCCI eligible members enrolled monthly in care management	49	44	40

Total Open Cases (including newly enrolled - above)	232	241	235
% of VCCI enrolled members with a face-to-face visit during the month	61.21%	61.00%	69.36%

VCCI continued work started in 2019, of telephonic outreach and screening to beneficiaries new to the health plan. The new Medicaid screening tool poses questions related to access to health care and health care-related issues including Primary Care, Dental, housing, transportation, and food, with direct facilitation to those services desired by the

beneficiary. The numbers new to the health plan steadily increased in the last quarter of 2022 (**Figure 2).** Timely access to some services desired by beneficiaries continued to present as a challenge this past quarter. Wait times for the establishment of primary care seem to be improving with 47% of beneficiaries able to get an appointment within 30 days. Access to dental care continues to be a challenge for those without an established dentist.

Figure 2. Number of New to Medicaid Beneficiaries Screened

Updated Dates - month reported	**Oct-22**	**Nov-22**	**Dec-22**
received from data unit	**11/15/2022**	**12/15/2022**	**1/15/2023**
Updated Dates - due date	2/15/2023	3/15/2023	4/15/2023
# of new to Medicaid members (Adults 18+)	376	486	547
# of new to Medicaid members reached	77	91	127
# of new to Medicaid members screened	161	208	248
% of new to Medicaid members screened	42.82%	42.80%	45.34%

VCCI leadership in partnership with Healthcare Reform has developed a project committee for our Team-based Care Initiative with representation from all departments within the Agency of Human Services. We have contracted with the Camden Coalition for technical assistance in reinvigorating our Team-based Care process across departments and within the local communities.

Vermont AHS is committed to providing the best possible care to Vermonters in need. We offer a huge array of

services and programs statewide to support the health and social needs of Vermonters. Pre-Covid, we worked in collaboration with OneCare to launch a Complex Care Initiative and training program. This work has successfully continued in various programs in the state such as Blueprint, VCCI, and in primary care practices across the state. Throughout Covid, we saw many staff transitions in health and social fields. We also have seen people with more complex needs due to the isolation and lack of services over the last several years. AHS is dedicated to enhancing people's experience of our fragmented system of care by reinitiating the work started in 2015. We are working with the Camden Coalition to help us adopt best practices in providing team-based care across various domains of care to improve the experience and outcomes of the people we serve and to provide more efficient communication and care coordination among providers. Our work with Camden is largely organized into a few categories and we will be engaging stakeholders as we progress through this work over the next year:

-assessment and evaluation of Vermont's current model for complex care to identify potential
-refinements, gaps, and opportunities for improvement towards a desired future state.
-Identification of the next steps to implement Vermont's model fully and effectively.
-development and dissemination of a plan to support the implementation of recommended model enhancements

We are seeking to develop training for staff on tools and processes for front-line staff and leaders across the state and to strengthen team-based care ecosystems in each region of the State.

VCCI has been working with other departments in hopes of adapting a common Social Determinants of Health Screening Tool. We have been working with Blueprint, Economic Services, and HireAbility on a common tool. We have also been working with Keypro, VITL, and the Agency of Digital Services Health Information Exchange on this project. We hope it will be helpful for data collection and referral/coordination of services.

In the past quarter, our team has been busy working on recruitment for our vacant positions including traveling nurse positions. We currently have four full-time vacancies across the state.

.

ii. Blueprint for Health

Key updates from QE032023:

- The majority of Vermont's primary care practices are now Blueprint-participating Patient-Centered Medical Homes, as 132 of Vermont's estimated 182 primary care practices are Blueprint-participating practices (and an estimated 148 employ more than one provider).
- As of 2023-Q1, the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs is 3,850.
- Vermont continues to provide access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 42 practices and 7 Planned Parenthood sites to participate in the Women's Health Initiative as of March 2023.

Patient-Centered Medical Home Program

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

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

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

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

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

Q1Highlights

January – March 2023

During this quarter, the Program Manager and Quality Improvement Facilitators worked with practices to encourage participation in the Statewide Consumer Assessment of Healthcare Providers and Services (CAHPS) statewide patient experience surveys. As a result of this outreach and support, 129 practices are participating in this year's cycle. Facilitators, practices, and system leaders are working in partnership to convey messaging to patient populations the importance of participation and thereby increase the annual response rate.
The Blueprint Field Staff recruited and supported practice involvement in State/Regional Quality Improvement opportunities to enhance clinical guideline uptake and innovations, such as suicide prevention grants and chronic disease remote monitoring pilots.

The Blueprint for Health led collaboration between Vermont Quality Improvement professionals to publish the Vermont 2023 Quality Measure Crosswalk. The Quality Measure Crosswalk is intended to provide practices and quality improvement professionals with a basic understanding of quality reporting and payment initiatives relevant to Vermont Primary Care Practices, including the lead organization and purpose of such initiatives, the measures used by each initiative, and any overlap in measures across initiatives. Developed to assist practices with their quality improvement efforts in Vermont's Health Reform landscape, this tool is an interactive resource that allows users to search for measures by domain or participating program, identifies key contacts for each sponsoring organization, and provides additional relevant information about quality measurement.

Quality improvement professionals worked with their respective communities and practices to analyze and review Consumer Assessment of Healthcare Provider and Services (CAHPS) results, and where appropriate, identify areas for opportunities for improving patients' and families' experience of care.

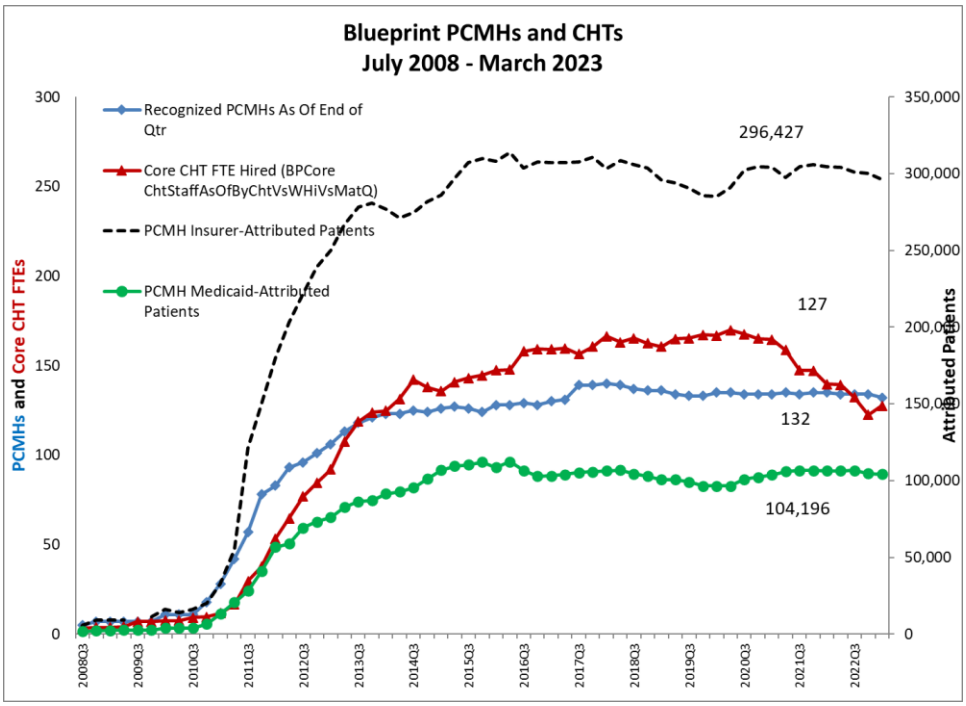
Quality improvement professionals honed their knowledge and skills to assist Vermont practices to address current challenges Vermonters are facing when attempting to access Primary Care Providers. This training translated into the implementation of Quality Improvement strategies for practices willing to embark on an improvement project that addresses supply and demand, including measuring and predicting service needs and demand, optimizing supply capacity within existing resources, and addressing supply and demand mismatches.

As part of the ongoing work of patient-centered medical homes, twenty (20) practices across the State completed their National Committee for Quality Assurance annual recognition process in this period, demonstrating their ongoing commitment to the model and continuous quality improvement.

Blueprint-participating Patient-Centered Medical Homes currently serve 296,427 insurer- attributed patients, of which 104,196 are Medicaid enrollees. Attribution to a practice is determined by the practice at which the patient has received the majority of their primary care within the 24 months before the date the attribution process is conducted. These practices and patients are supported by 127 full-time equivalents of Community Health Team staff.

In Quarter 1(January – March 2023), 132 Vermont practices were operating as Patient-Centered Medical Homes, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of practices participating in the Blueprint for Health program is a key performance measure; the Blueprint estimates that there are about 182 total primary care practices operating in the state.

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



Community Health Profiles

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

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

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

Hub & Spoke Program

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

criminal activity, decreased infectious disease transmission, and increased social functioning and retention in treatment.

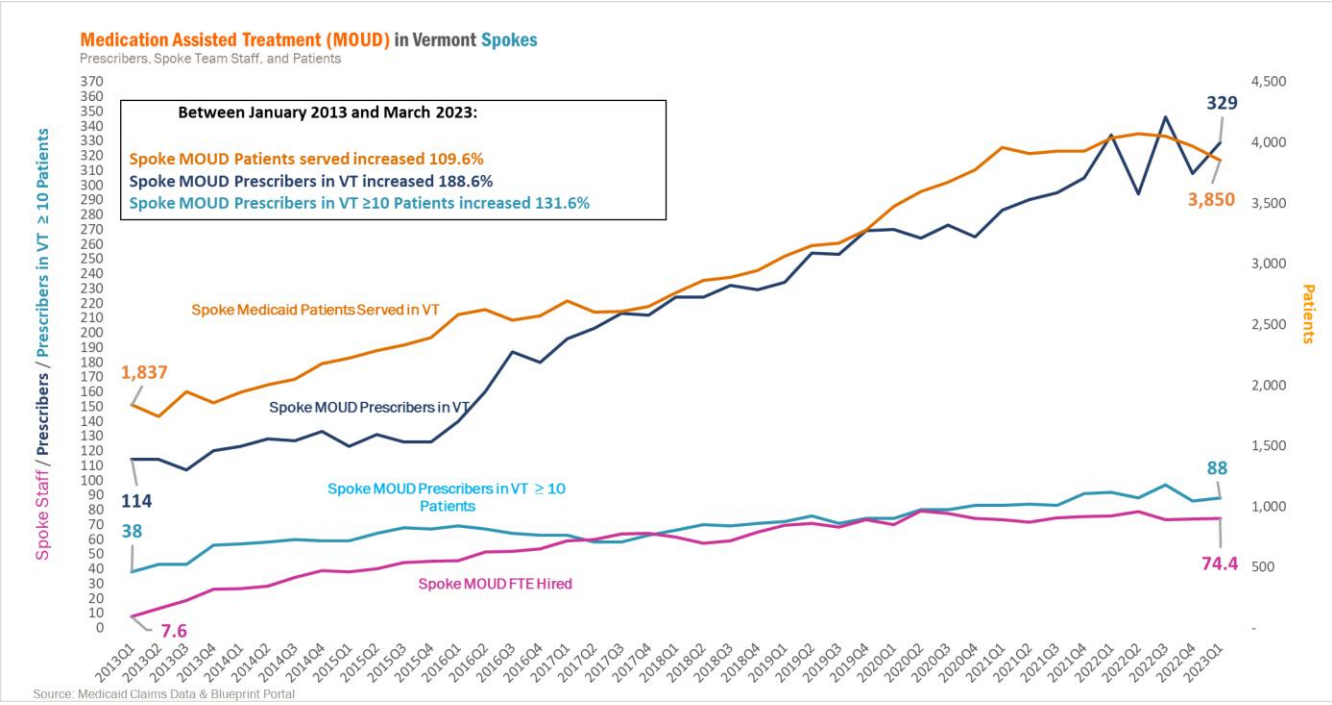
The State Plan Amendment for the Vermont Medicaid Program, approved by the Centers for Medicare and Medicaid Services, established a Health Home for Vermonters with opioid use disorder. As of July 1, 2013, Medicaid beneficiaries receiving medication-assisted treatment for opioid use disorder in a Hub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

Q1 Highlights

The Blueprint, in partnership with the Division of substance use prevention, in conjunction with a contract with Dartmouth allows us to continue to offer learning sessions with expert- led, and peer-supported, training in best practices for providing team-and evidence-based medication-assisted treatment for opioid use disorder. Sessions alternated between didactic and webinars this quarter. Positive feedback via surveys on these sessions to support best practices and evidence-based care. The field continues to have some challenges with work force as many do in hiring nurses and clinicians and the network continues to be creative to recruit.

Vermont continues to demonstrate substantial access to medication-assisted treatment for Vermonters with opioid use disorder. Medication-assisted treatment is being offered across the State of Vermont by more than 82 different Spoke settings as of March 2023.) The monthly average of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs decreased from 3969 in Q4 of 2022 to 3,850. There are 329 medical doctors, nurse practitioners, and physician assistants who prescribe Buprenorphine or Vivitrol in Vermont. There are 74.4 FTE of licensed, registered nurses, and licensed, Master's-prepared, mental health/substance use disorder clinicians who work as a team to offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder.

Figure 2. MAT-SPOKE Implementation Jan 2013 – March 2023



Women's Health Initiative

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

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

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

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

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

members.

Q1 2023 Highlights

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

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

Practices are working hard to engage community partners in education and understanding the WHI program. These partnerships and education around the mission of the program enhance relationships and pathways to care. We have presented a WHI data dashboard to the field in our monthly call every quarter. We received feedback on what would be useful data for the field from claims and will continue to support the field with this information. We have received feedback on being more inclusive in the name of our program. We have consulted Boston Medical Center which has done some work with the state of Massachusetts to work with primary /specialty care practices to promote equity and inclusiveness. We have surveyed the field and have had focus groups to gather input on name change. The expected change is to occur in Sept 2023.

We are working with PPNNE and the community where locations are closed to continue to assess the impact and needs of the community. At this time, there has not been a large reported shift of patients to the local primary care from PPNNE. PPNNE s has a robust telehealth program for all birth control methods except LARC. They have a birth control by mail program for pills, rings, and Deprovera/and had shared they believe patients can still maintain easy access to telehealth and many care options can be provided with this method of support.

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

We are pleased to share that we were approved for an AHEC/UVM Project Echo will work with our network and provide a 1-hour training monthly for 6 months for providers to increase knowledge and comfortability in transgender care. We are halfway through and have received positive feedback thus far that providers appreciate having experts to support learning and expanding their knowledge base.

Figure 3 below shows WHI enrollment and staffing over time. In Q1 2023, the number of WHI practices enrolled is 42. 18 women's specialty health care sites and 24 PCMH participated in the Women's Health Initiative as of March 2023.

Quarter

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

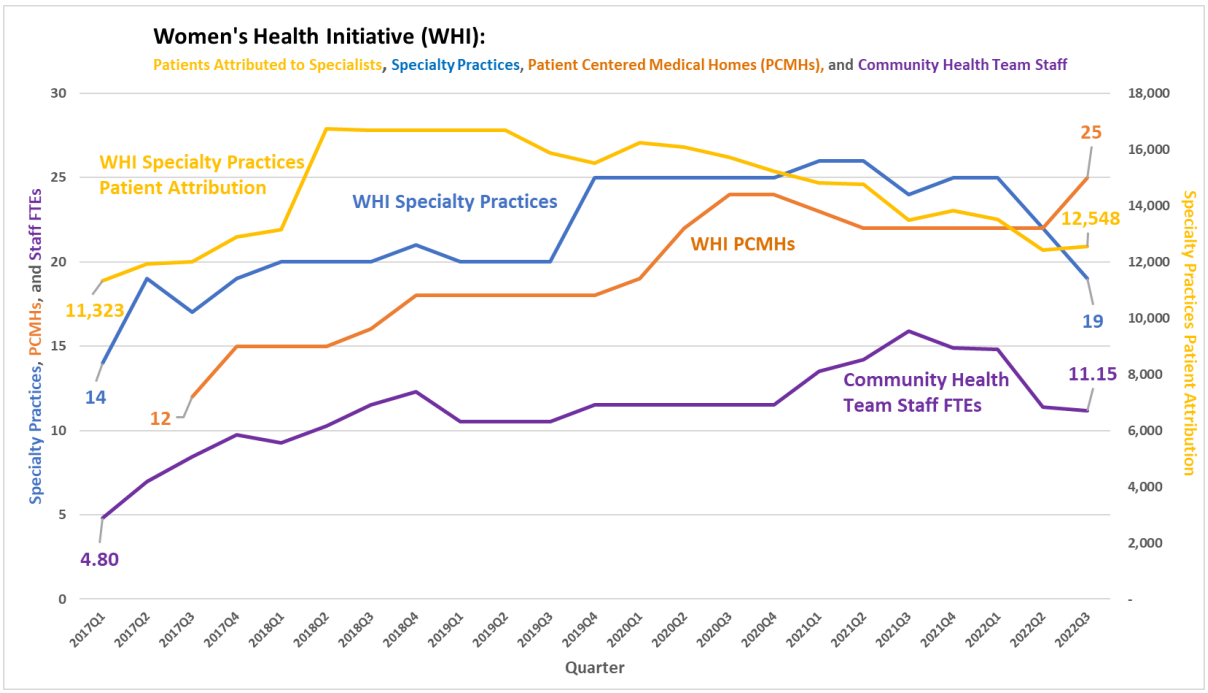


Table 4. Women's Health Implementation by Region

Health Service Area	WHI Specialist Practices as of March 2023	WHI PCMH Practices as of March 2023	WHI CHT Staff FTE Hired as of March 2023	WHI Specialist Quarterly Attributed* Medicaid Beneficiaries as of March 2023	WHI PCMH Quarterly Attributed* Medicaid Beneficiaries as of March 2023
Barre	1	0	0.75	667	470
Bennington	1	2	0.6	821	233
Brattleboro	1	0	0.7	939	0
Burlington	2	9	1.2	2212	4885
Middlebury	1	0	0.75	666	0
Morrisville	1	3	0.5	336	1303
Newport	1	0	1	973	0
Randolph	1	0	0.5	183	0
Rutland	1	0	1	1315	0
Springfield	0	5	0	0	1774
St. Albans	0	0	0	0	0
St. Johnsbury	1	2	0.75	916	669
Windsor	0	3	0	0	86
Planned Parenthood (Statewide)	7	0	3.2	3676	0
Total	18	24	10.95	12704	9420

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

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

Key updates from QE032023:

- Per Diem Rate for Mental Health Extended Stays in Emergency Departments.
- Team Care Program.
- Applied Behavior Analysis (ABA).

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

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

for a prospective payment informed by several factors:

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

The DVHA, DMH, and the psychiatric facility have agreed upon performance measures and a monitoring platform for this payment model. Year two reconciliation is projected to be completed by April 2023.

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

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

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

The CIU manages the Applied Behavior Analysis (ABA) benefit. ABA is a scientific method of observing behavior, teaching new skills, and decreasing problem behaviors in children with Autistic Spectrum Disorder or Early Developmental Disability. In 2021, DVHA changed the timing of the ABA tier submission and payment to post-service delivery after receiving feedback from providers regarding the difficulty of prospectively determining treatment hours for the subsequent month. An important goal of this program is to increase access to direct services for Medicaid members by giving providers the flexibility to innovate and to use staff more efficiently. To assess progress toward this and other goals, DVHA has established a monitoring framework that includes measures of access, utilization, service intensity, quality, and cost. Early data for some of these measures shows promising results. For example, since the implementation of the payment reform program, a higher proportion of services are in the form of

direct services to members rather than assessments and parent education. In addition, total hours of service have been increasing year after year (despite the impacts of the COVID-19 public health emergency). The average monthly census has increased since the implementation of the payment model and has held steady during the past three years. The intensity of service has also increased; there have been substantial increases each year in the average service hours per member per month.

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

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

iv. Mental Health System of Care

Key updates from QE032023:
- Leadership and Reporting updates.

System Overview

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

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

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

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

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

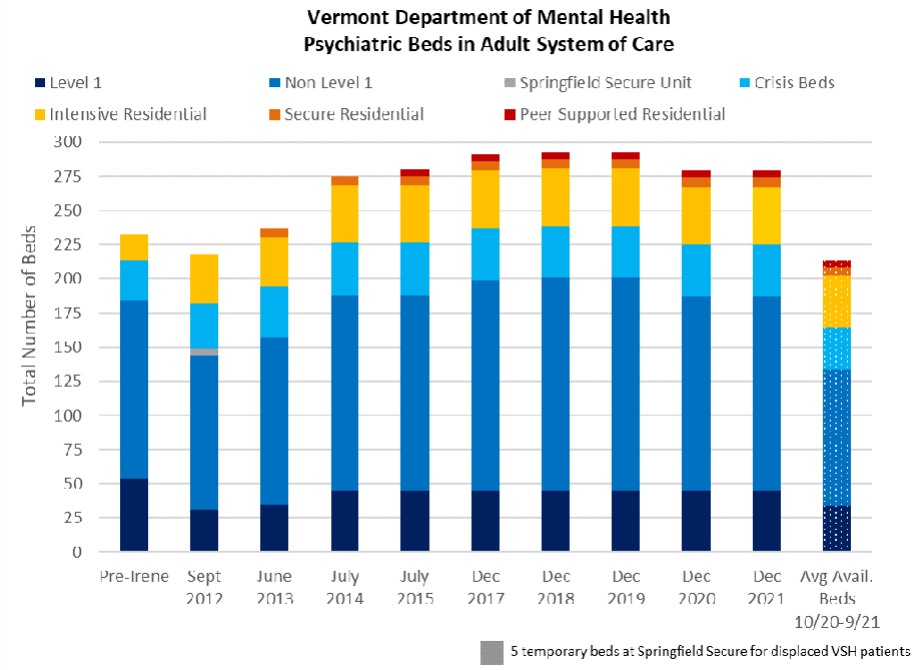
Throughout 2021 and continuing to the present, the Coronavirus Disease 2019 (COVID-19) pandemic has continued to challenge the mental health system of care in Vermont, primarily through statewide staffing shortages and inpatient bed closures.

Updates on the Mental Health System of Care

A. Hospital and Inpatient Care

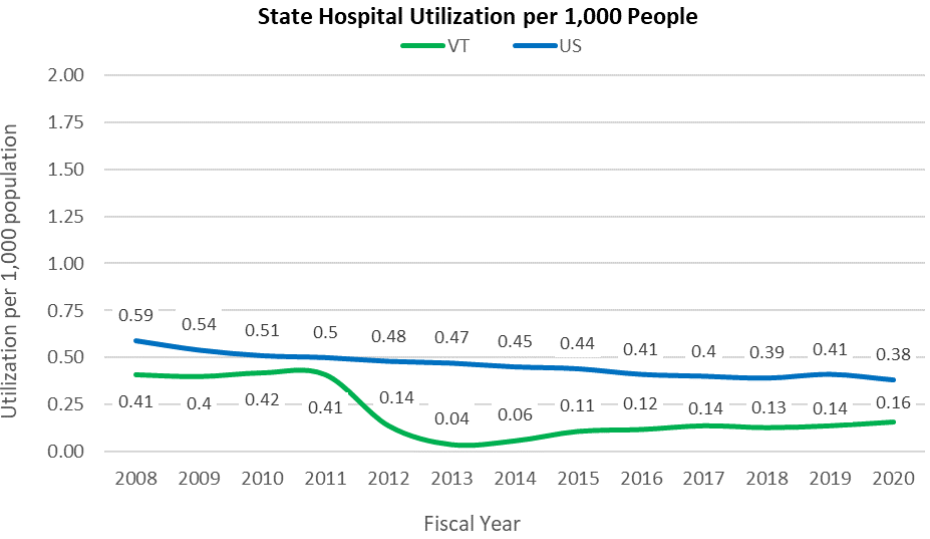
Vermont has 45 Level 1 beds and 159 adult psychiatric inpatient beds across the system of care. During the COVID-19 pandemic, several beds closed due to staffing, construction, patient acuity, and public health safety protocols, as well as an initial decrease in individuals presenting with a need for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

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



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

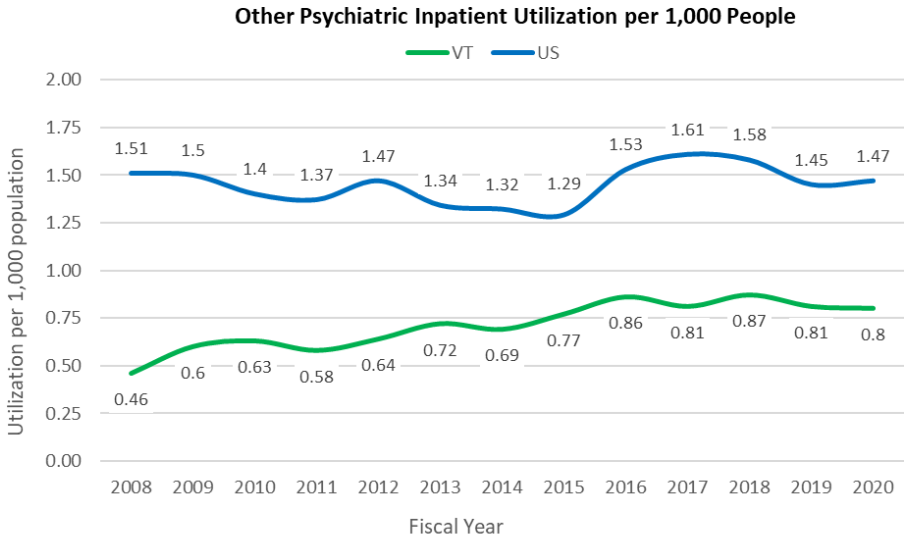
Figure 4. State Hospital Utilization per 1,000 people (in Vermont and the United States)



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

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

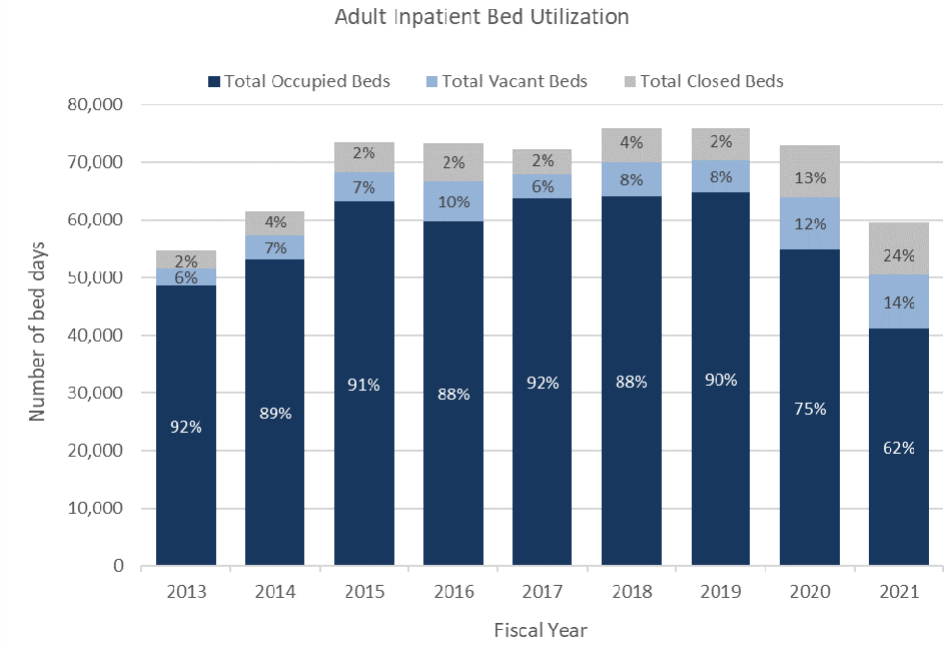
Figure 5. Other Psychiatric Hospital Utilization per 1,000 people (in Vermont and the United States)



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

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

Figure 6. Adult Inpatient Utilization and Bed Closures



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

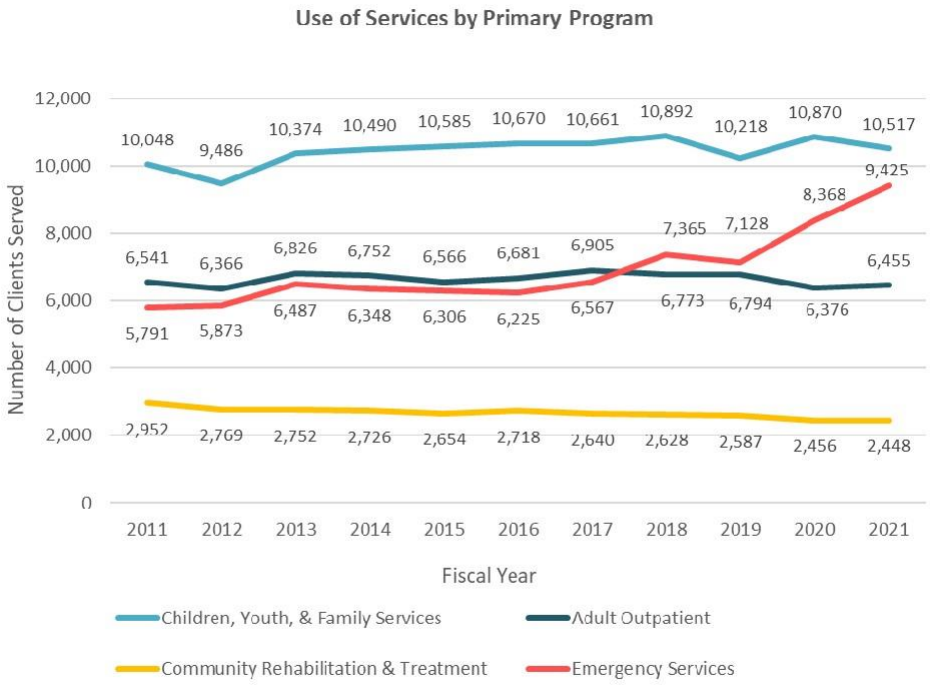
B. Community-based and Outpatient Services

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

Key Efforts Include:

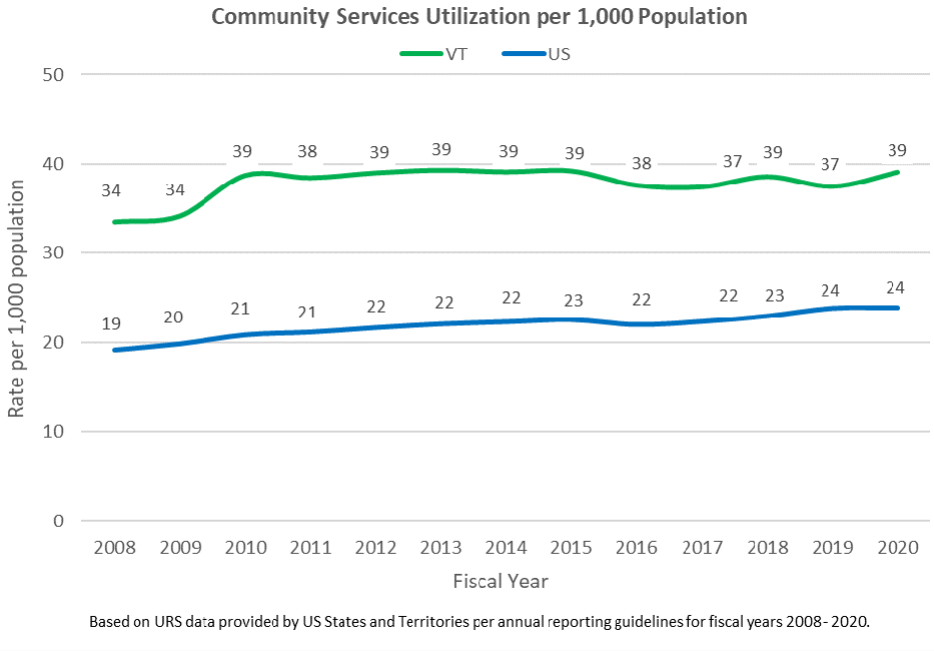
- Established a Workforce Task Group to explore recruitment and retention strategies
- Increased capacity within Community Rehabilitation and Treatment and peer programs to provide community support, outreach, and crisis response continues to develop Broad utilization of non-categorical case management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

Figure 7. Use of Services by Primary Program



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

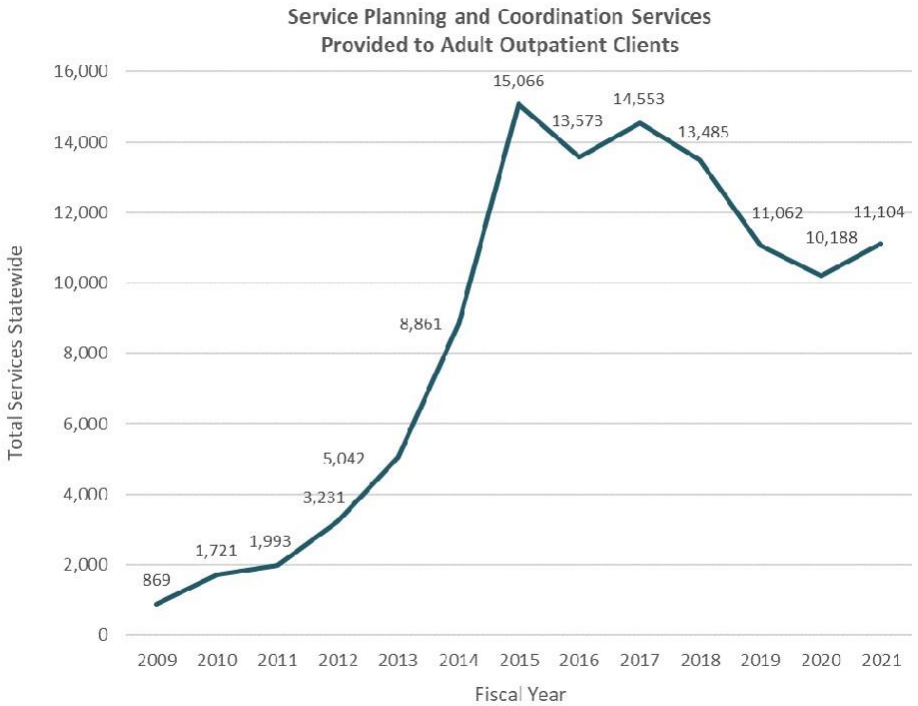
Figure 8. Community Services Utilization per 1,000 Populations



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

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

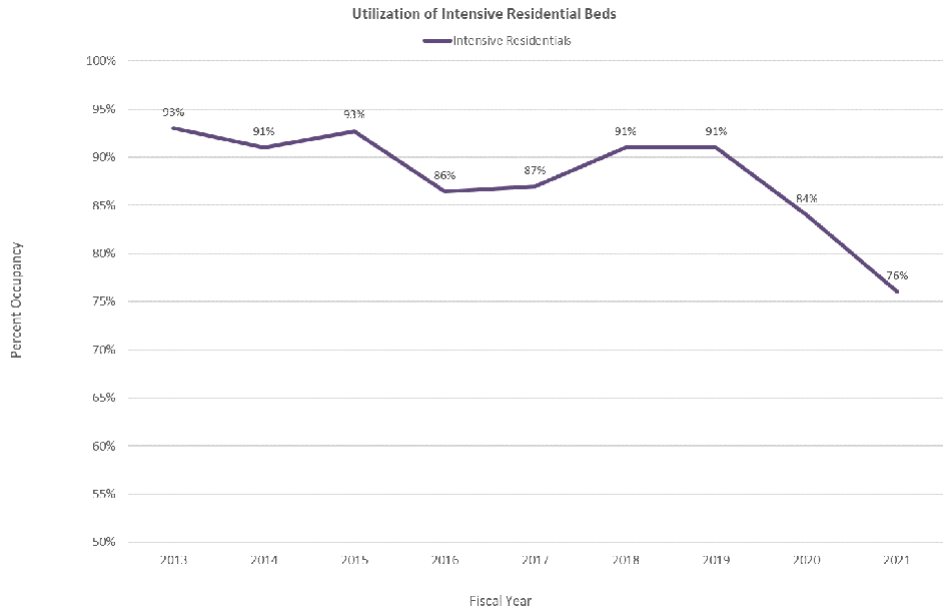
Figure 9. Service Planning and Coordination Services



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

Residential and Transitional Services

Figure 10. Utilization of Intensive Residential Beds



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

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

Performance and Reporting

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

- Implementation of value-based payment measures that allow DAs to earn an additional allocation based on the performance of agreed-upon quality metrics.
- Mental Health Payment Reform utilization scorecard, monitoring caseload, and utilization for all services within the mental health case rate to monitor the impact of the payment model.
- Creation of a "Vermont Psychiatric Care Hospital Outcomes" scorecard to meet legislative reporting requirements.
- Migration of the "DMH Snapshot" and "DMH continued reporting" to the RBA scorecard reporting tool
- Exploration of visualization tools to create more responsive reporting.
- Participation in the development of the AHS Community profiles.

Mental Health Payment Reform

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

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

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

Integrating Family Services (IFS)

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

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

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

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

Vision 2030

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

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

Vision 2030 leverages the system's current strengths to shape an integrated system of whole health with holistic mental health promotion, prevention, recovery, and care in all areas of healthcare across every Vermont community. This requires improved coordination across sectors and between providers, community organizations, and DAs. The workforce must use the best technologies, as well as evidence-

based practices and tools, for making data-informed decisions, supporting systems learning, and producing measurable outcomes. Links to materials generated throughout this process are posted at this link: https://mentalhealth.vermont.gov/about- us/department- initiatives/10-year-planning-process-mental- health-think-tank

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

Leadership and Reporting Updates

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

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

v. Pharmacy Program

Pharmacy Benefit Management Program

The DVHA's Pharmacy Unit manages the pharmacy benefits for all of Vermont's publicly funded pharmacy benefit programs. The Pharmacy Unit's goal is to provide the highest quality prescription drug benefits in the most cost-effective manner possible. This is accomplished by providing broad coverage of prescription and over-the-counter pharmaceuticals while controlling pharmacy expenditures through both utilization and cost management strategies. The DVHA utilizes the pharmacy benefit management company, Change Healthcare (CHC), to provide a full complement of operational, clinical, and programmatic support in addition to managing a call center for pharmacies and prescribers.

The Pharmacy Unit is also responsible for overseeing the contract with CHC. The Pharmacy Unit manages approximately $266 million in gross drug spend and routinely analyzes national and DVHA drug trends reviews drug utilization, and seeks innovative solutions to delivering high-quality customer service, assuring optimal drug therapy for DVHA members while managing drug utilization and cost.

Pharmacy Operations

- Pharmacy claims processing – Assuring that members have access to medically-necessary medications within the coverage rules for DVHA's various pharmacy benefits.
- Pharmacy provider assistance – Assisting pharmacies and prescribers with various issues related to claims processing, prior authorizations, and other operational and clinical issues.
- Pharmacy Interface to Coordination of Benefits Unit/Part D Plan Team/Eligibility/Member Call Center to coordinate benefits and resolve member issues.
- Liaison to Vermont Department of Health (VDH) in multiple clinical areas-Vaccines including COVID vaccines, the Division of Substance Use Program, Asthma, Smoking Cessation, and the Department of Mental Health (DMH) related to the management of psychotherapeutic drug use in children. The Pharmacy Team also

works with Vermont Medication Assistance Program (VMAP) and Children with Special Health Needs (CSHN) to assist in the drug and rebate management of the programs.

- Clinical Activities include managing drug utilization and cost.
  - Federal, State, and Supplemental rebate programs
  - Preferred Drug list management
  - Prior authorization and utilization management programs
  - Drug Utilization Review Board activities-therapeutic class reviews, new drug reviews, prior authorization criteria review, and step-therapy protocols.
  - Specialty pharmacy management
  - Physician-administered drug management
- Manages exception requests, EPSDT requests, appeals, and fair hearings with Policy Unit.
- Works with Special Unit on drug utilization issues related to fraud, waste, and abuse.

Operational Activity Reports

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

	No PA	Automated Edits						
Period	**Claims Paid w/o PA**	**Claims Paid w/Auto PA**	****Claims Paid with Auto Edit**	**Claims Paid w/Online Override**	**Claims Paid w/Emergency PA**	**Claims Paid due to Grandfathering**	**Claims Paid w/Clinical PA**	**Total Claim Count**
Quarter 1	510,392	90	21,366	245	106	7,724	16,171	556,094
	92%	<1%	4%	<1%	<1%	1%	3%	100%

- The total claim count does not include compounded drugs.

Paid Claims and Drug Spend

MEDICAID

Period	# Claims	# Of Members	State Paid Amounts
1Q2023	502,093	86,585	$75,372,873.84

VPHARM

Period	# Claims	# Of Members	State Paid Amounts
1Q2023	68,177	6,853	$1,957,846.70

- The total claim count does not include compounded drugs.

Paid Claims and Drug Spend

Provider Communications

Prescription Signature Requirements	In response to the COVID-19 Public Health Emergency (PHE), the Department of Vermont Health Access (DVHA) temporarily waived signature requirements for the receipt or delivery of prescriptions. In line with the end of the PHE, signature requirements will resume on May 11, 2023. Documentation of the offer to counsel and proof of delivery will be required for every prescription, effective 5/11/2023.
Update on Early Refill Overrides with Submission Clarification Code (SCC) 13	In response to the COVID-19 Public Health Emergency (PHE), Vermont Statute authorized pharmacies to override the early refill edit. This was implemented using the NCPDP Submission Clarification Code (SCC) =13 for the adjudication of pharmacy claims. This code indicates that an override is needed based on an emergency/disaster situation recognized by the payer. The state requirement to allow the early refill expires on 3/31/2023. Effective 4/3/2023, DVHA will no longer allow the use of SCC 13.
Point of Sale (POS) Blackout Period	Due to the need to perform system maintenance, the Department of Vermont Health Access POS system will be unavailable for approximately 8 hours starting at 8:00 PM EST on Wednesday, March 29, 2023.
Limitation on Cost-Sharing for Vermont Medicaid Members	Effective April 1, 2023, the Department of Vermont Health Access (DVHA) is improving its systems for tracking and charging copays for Vermont Medicaid members. The new process will streamline copay information available to Vermont Medicaid-enrolled providers and will ensure Vermont Medicaid members are not charged more than 5% of their household's total income on cost-sharing.
Changes to Administration Fee for Vaccines	Effective 3/15/23, the pharmacy administration fee for vaccines will be changing from $13.87 to $16.82. This adjustment is being made to align with changes to the physician fee schedule (CPT code 90471) for adult vaccinations. DVHA-enrolled pharmacies may be reimbursed for vaccinations administered at pharmacies to adults 19 years and older who are enrolled in Vermont's publicly funded programs. Pharmacists must be certified to administer vaccines in the State of Vermont and must be compliant with all Vermont laws governing vaccine administration. Failure to comply with all Vermont immunization regulations will subject these claims to recoupment. Children age 6 months through 18 years presenting for vaccination at pharmacies should be referred to their healthcare provider for state-supplied vaccines.
Buprenorphine Prior Authorization Form	The Omnibus FY23 spending package was signed into law by President Biden on December 29, 2022. This included the Mainstreaming Addiction Treatment Act (H.R. 1384/S. 445) which removes the X DEA (DATA 2000) waiver requirement. All providers with a standard DEA license number can now prescribe buprenorphine for opioid use disorder. As a result, the requirements for X DEA licensure have been removed from the Buprenorphine prior authorization form. With the removal of this requirement, the Division of Substance Use at the Vermont Department of Health supports the focus on safety by prescribing buprenorphine. Both ASAM and DVHA Guidelines recommend monitoring for medication diversion and the appropriateness of continued treatment. In response to feedback from the treatment community and to decrease the prescriber burden, the safety checklist has been updated for ease of use in documenting

	the current diversion monitoring practices utilized.
Synagis (Palivizumab) Dispensing	The Department of Vermont Health Access (DVHA), in coordination with their Pharmacy Benefits Manager Change Healthcare, review data from the National Respiratory and Enteric Virus Surveillance System (NREVSS) to track the epidemic season for Synagis® (palivizumab). Synagis® is indicated for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) in pediatric patients. The DVHA's normal determination for the end of Synagis® "season" is when the percent positives on antigen tests are ≤ 10% for 2 weeks or the percent positives on PCR tests are ≤ 3% for 2 consecutive weeks. Currently, since positivity rates have remained below 3% for 3 weeks, the RSV season is considered to have ended. Synagis® prophylaxis is of unproven value when administered outside of the RSV season as defined by the Centers for Disease and Prevention (CDC) surveillance reports (https://www.cdc.gov/surveillance/nrevss/rsv/state.html#VT). Therefore, no further shipments will be authorized after 3/3/23.
Preferred Albuterol Sulfate Inhaler Availability	The Department of Vermont Health Access (DVHA) and its pharmacy benefits administrator, Change Healthcare, previously communicated that Teva discontinued the manufacturing of ProAir® HFA (albuterol sulfate) Inhalation on 10/1/22**.** We have recently become aware of supply issues with some of the preferred alternatives. Proventil® HFA (albuterol sulfate) Inhalation Aerosol (NDC 66758095985) is on backorder with a target release date of 04/24/23. Ventolin® HFA (albuterol sulfate) Inhalation Aerosol (NDC 00173068220 and 00173068224) is available and being allocated to wholesalers, however, intermittent shortages may still exist. DVHA is not aware of any supply issues currently with ProAir Respiclick® (albuterol sulfate) Inhalation Powder (NDC 59310058020). The following will be temporarily opened as preferred options with no prior authorization required: ProAir Digihaler® (albuterol sulfate) Inhalation Powder NDC 59310011720, and Albuterol sulfate HFA, Teva labeler only NDC 00093317431
Changes to Differin® (adapalene) Coverage	Effective 1/1/23, Vermont Medicaid will be discontinuing coverage of the following NDCs and providing generic alternative options. Select Galderma products are no longer participating in the Medicaid Drug Rebate Program. Therefore, Differin® (adapalene) 0.1% Cream NDC 00299591545 and Differin® (adapalene) 0.3% Gel NDC 00299591825 are no longer considered covered outpatient drugs and will be excluded from Vermont Medicaid coverage.

Changes to Medicaid Copay	Effective 2/1/23, Vermont Medicaid will reinstate copays from Medicaid members for the following prescription and over-the-counter medications: analgesics (e.g., acetaminophen and ibuprofen), antihistamines, cough suppressants, cough & cold combination products, inhalers, and leukotriene receptor antagonists. These copays were put on hold in 2020 due to the COVID-19 public health emergency.

Reimbursement for High-Investment Carve-Out Drugs	Effective 1/1/2023, the Department of Vermont Health Access (DVHA) will be changing the way it pays for certain high-cost carve-out inpatient drugs per the proposed Global Commitment Register (GCR 22-002). This change is to ensure providers are being paid their actual cost for the drug and to allow the State to take advantage of available federal rebates. Hospitals will be required to separate the high-cost drug from the inpatient claim. The inpatient claim will pay using the standard Diagnosis-Related Group (DRG) methodology minus the carved-out high-cost drug. Prior Authorization will be required for the drug and inpatient stay. Along with billing the high-cost drug on the CMS-1500 claim form, the provider will be required to submit the invoice for the drug. These drugs cannot be acquired through the 340B program and reimbursement will be paid at the actual acquisition cost. DVHA will conduct a post-payment review to ensure the high-cost drug was only billed on the HCFA-1500 claim form. In the event of duplicate billing, the inpatient payment will be recouped, and the billing entity will be instructed to re-bill appropriately. The list below includes the drugs and associated HCPCS codes that will require a carve-out from the inpatient claim. This list will be periodically updated with notifications accompanying future additions.

Clinical Activities

High-Cost Drugs

The Department of Vermont Health Access (DVHA) has changed how it pays for certain high-cost carve-out inpatient drugs per the proposed Global Commitment Register GCR 22-002. This change was made to ensure that providers are being paid their actual cost for the drug and to allow the State to take advantage of available federal rebates.

As of January 1, 2023, hospitals are required to separate the high-cost drug from the inpatient claim. The inpatient c claim will pay using the standard Diagnosis-Related Group (DRG) methodology minus the carved-out high-cost drug. Prior Authorization will be required for the drug and inpatient stay. Along with billing the high-cost drug on the CMS 1500 claim form, the provider will be required to submit the invoice for the drug. These drugs cannot be acquired through the 340B program and reimbursement will be paid at the actual acquisition cost.

DVHA will conduct a post-payment review to ensure the high-cost drug was only billed on the HCFA-1500 claim f form. In the event of duplicate billing, the inpatient payment will be recouped, and the billing entity will be instructed to re-bill appropriately. The High- investment carve out list can be found in drug-covered lists. https://dvha.vermont.gov/providers/pharmacy/drug-coverage-lists.

Pharmacy Cost Management (PCM) Program

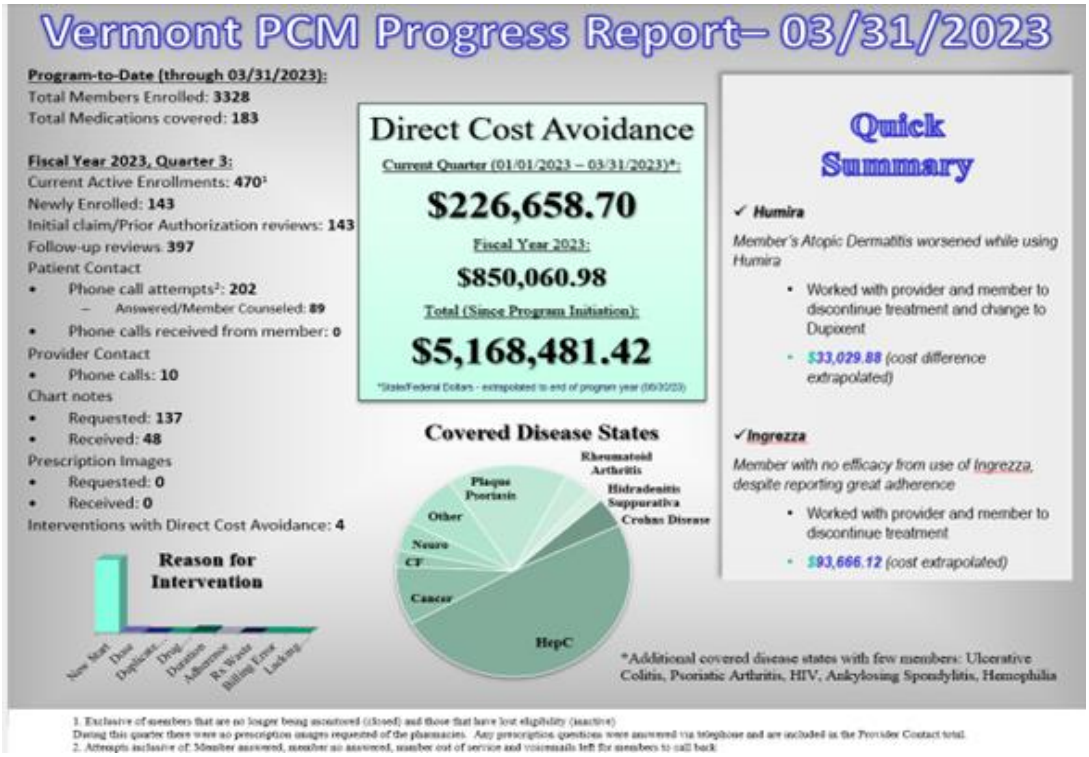
In late SFY 2017, DVHA, in collaboration with Change Healthcare, implemented the Pharmacy Cost Management (PCM) Program. The goal of the program is to mitigate the impact of high-cost specialty drugs on pharmaceutical expenditures by ensuring the full value of these medications in improving patient outcomes.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

The PCM pharmacist provides direct outreach to prescribers and pharmacies to discuss the goals of therapy as well as

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

Change Healthcare (January 1, 2023, through March 31, 2023). Change Healthcare Pharmacy Management Reporting Suite is a collection of reports recording the process and progress of PCM.

In the first quarter of 2023, the PCM program enrolled an additional 143 members for a total of 3,328 members on 183 unique medications. The program is actively monitoring 470 enrollees. A total of 202 outgoing telephone calls were placed to members, 89 of which resulted in member counseling. During this quarter of the Vermont PCM program, four interventions led to direct and measurable cost avoidance. Furthermore, interventions that do not bring about direct cost avoidance are in place to encourage adherence and thus improve member outcomes and avoid unnecessary medical costs. Through interventions in the PCM program, unnecessary drug spending of $226,658 was avoided in the first quarter of the state fiscal year 2023. More than $5.1 million in unnecessary drug spend has been avoided throughout the program.



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

Key updates from QE032023:

- Executed a contract amendment with OneCare for a 2023 performance year of the program.
- Began conducting financial reconciliation activities for the 2022 performance year, in order to determine financial and quality performance. Results will be available in late Q3 or early Q4 2023.
- Continue to support Vermont's broader efforts to develop an integrated health.

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

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

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

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

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

DVHA began financial reconciliation activities for its 2022 performance year in Q1 2023. Reconciliation activities will determine the ACO's spend as compared to their financial target and quality performance for the 2022 performance year. Reconciliation activities will continue into Q3 2022, and the final results will be available in Q3 or Q4 2022.

The VMNG program saw provider participation remain consistent between the 2022 and 2023 performance years, which indicates that the program may have reached scale in the state. The number of risk-bearing hospital communities remained constant at fourteen for the 2023 performance year. The number of attributed lives for the 2023 performance year increased from approximately 126,291 lives (95,727 through the traditional attribution methodology and 30,564 lives through the expanded attribution methodology) to 142,101(105,101 through the traditional attribution methodology and 37,000 through the expanded attribution methodology).

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

V. Financial/Budget Neutrality Development/Issues

As is the monthly process, AHS paid DVHA 1/12th of the legislative budget for Global Commitment on the first business day of each month during the January - March 2023 quarter). This payment served as the proxy by which to draw down Federal funds for Global Commitment (GC).

As is the process after each quarterly submission of the CMS-64, AHS reconciled the quarterly amount claimed on the CMS-64 with the monthly payments made to DVHA. The State prepared the CMS-64 based upon actual allowable Medicaid expenditures (program, investments, and administration) for the given quarter. AHS reported some notable PQAs for the ABD Adult and ABD Dual MEGs during this reporting cycle. Expenses associated with the former Choices for Care MEG were reported as ABD instead of split between ABD and ABD Dual for QE0922 and QE1222. This was corrected in QE0323. In addition, IMD Investments were grouped on the regular Investments form for QE0922 and QE1222. This was also corrected in QE0323.

This quarter represents the first quarter of DY19 of the GC Waiver. Vermont calculates $376.1M for Without Waiver expenditures, and reported $347.1M in With Waiver expenditures, leaving a savings subtotal of $29M. There are also 10 Hypothetical Tests for various demonstration groups. The hypothetical tests for New Adult, SUD IMD, Maternal Health & Treatment Services, CRT, Moderates, and Marketplace Subsidies reflect a surplus, whereas the tests for SMI IMD and Global Rx show moderate deficits. The total of the deficits is $1.3M which reduces the cumulative Waiver savings to $35.7M. There is nothing to report for the Housing Pilot or SUD CIT because those programs have not yet been operationalized. Lastly, for Investments, Vermont reported $35.6M in expenditures for the quarter which leaves $123.4M available for the remainder of DY19.

Vermont continues to implement HCBS programs using the Reinvestment funds under the American Rescue Plan of 2021. For QE0323, Vermont reported $3.5M in Program expenses, $3.3M in Investments, and $380k in Admin expenses.

VI. Member Month Reporting

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

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

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

Medicaid Eligibility Group	Total DY 2018
ABD - Non-Medicare - Adult	**38,305**
ABD - Non-Medicare - Child	**8,737**
ABD - Dual	**135,865**
Non ABD - Non-Medicare - Adult	**112,487**
Non ABD - Non-Medicare - Child	**378,179**
Hypothetical Groups	
New Adult	**454,348**
SUD - IMD ABD	**51**
SUD - IMD ABD Dual	**70**
SUD - IMD Non ABD	**121**
SUD - IMD New Adult	**624**
SMI - IMD ABD	**55**
SMI - IMD ABD Dual	**10**
SMI - IMD Non ABD	**20**
SMI - IMD New Adult	**156**
Housing Pilot	**0**
Maternal Health and Treatment Services	**114**
CRT	**1,213**
SUD CIT	**0**
VT Global RX	**55,697**
Moderate Needs Group	**731**
Marketplace Subsidy	**60,841**

Table 1B. Member Month Reporting – DY19 (QE0323), *subject to revision*

Medicaid Eligibility Group	Total DY 2019
ABD - Non-Medicare - Adult	**20,411**
ABD - Non-Medicare - Child	**4,790**
ABD - Dual	**67,946**
Non ABD - Non-Medicare - Adult	**55,987**
Non ABD - Non-Medicare - Child	**189,083**
Hypothetical Groups	
New Adult	**233,267**
SUD - IMD ABD	**36**
SUD - IMD ABD Dual	**63**
SUD - IMD Non ABD	**72**
SUD - IMD New Adult	**574**
SMI - IMD ABD	**9**
SMI - IMD ABD Dual	**3**
SMI - IMD Non ABD	**11**
SMI - IMD New Adult	**75**
Housing Pilot	**0**
Maternal Health and Treatment Services	**75**
CRT	**560**
SUD CIT	**0**
VT Global RX	**27,402**
Moderate Needs Group	**340**
Marketplace Subsidy	**34,566**

VII. Consumer Issues

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

The complaints received by Member Services are reported to DVHA (see Attachment 3). Member Services works to resolve the issues raised by beneficiaries, and the reports are seen by several management staff at DVHA.

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

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

VII. **Quality Improvement**

Quality Assurance and Performance Improvement Activities

Key updates from QE032023:

- Presented CAPHS results to the Quality Committee.
- Launched the annual medical record review (MRR) process.
- Continued coordination of DVHA's comprehensive risk assessment project.

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

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

PIHP Quality Committee

The Quality Committee remained active during QE0323 and consists of representatives from all departments within AHS that serve the Medicaid population. The committee continues to structure its work around the federal managed care quality program guidelines and the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of healthcare. During this reporting period, the committee adjusted our annual work plan to run on a monthly, instead of bi-monthly, schedule. Topics addressed this quarter included confidentiality, experience of care survey results, and quality measure reporting for various special health care needs populations.

Formal CMS Performance Improvement Project (PIP)

DVHA's formal PIP topic is the management of hypertension. Intervention strategies have been chosen and continued to be implemented and changes tracked during QE0323. Project work focuses on activities related to improving members' access to blood pressure monitors, which supports work being done in other parts of the Agency that focuses on provider and patient education and connecting to community resources.

Other Collaborative Quality Improvement Projects

The Quality Improvement team continued to work with the following groups on collaborative QI projects during QE0323:

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

ensure that cost and quality incentives are aligned in the APM.

- The Department of Children and Families (DCF), the Vermont Department of Health (VDH), and the Vermont Child Health Improvement Program (VCHIP) are on a learning collaborative to improve the timeliness of comprehensive health visits for children and adolescents entering foster care. During this reporting period, we collected data on our test of change, worked on expanding that test to other areas within the state, and participated in all CMS-led learning collaborative meetings.

Quality Measure Reporting

HEDIS measure production –In addition to producing and reporting on administrative (claims-based) measures annually, the Quality Improvement and Data teams work with our quality measures vendor to produce hybrid measures. During this reporting period, the hybrid measure production process began in 2023 with five (5) hybrid measures planned. DVHA's certified HEDIS vendor will perform medical record retrieval (MRR) for all five hybrid measures and abstract records for three of those measures. DVHA clinicians will abstract the other two measures. DVHA's Quality Assurance Manager oversees the MRR process and has submitted all training materials to DVHA's performance measure validation (PMV) EQRO.

CAHPS Experience of Care measures - during QE0323 DVHA received the results of the 2022 Adult and Child Health Plan 5.1 surveys. These results were added to DVHA's Experience of Care Scorecard and presented to the Quality Committee in March 2023.

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

Results Based Accountability (RBA)/Process Improvement

Results Based Accountability (RBA) scorecards are developed at DVHA for both internal and external performance management purposes. DVHA Quality Unit staff use this tool to create a *Global Commitment to Health* Core Measure scorecard, Experience of Care, and other performance budgeting scorecards. DVHA's largest scorecard, named the Performance Accountability Scorecard includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services. Scorecards that were newly developed or actively maintained during QE0323 include the following: Experience of Care and Dental Benefit.

COVID-19 Dashboard

The Quality Team was tasked with creating and maintaining a COVID-19 dashboard at the end of March 2020 to monitor the response to the pandemic: both the impact it has had on operations and the activities staff have engaged in. As an internal evaluation tool, the dashboard is updated monthly and made available to all DVHA staff via our intranet. This work continues into 2022 and will while the PHE is in effect. Measures have been retired and additional measures added to the dashboard as appropriate. QE0323 will be the last reporting period during which the Dashboard will be actively maintained in its entirety.

Vermont Next Generation Medicaid ACO

During QE0323, DVHA's Director of Quality Management received, reviewed, and approved the

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

Comprehensive Risk Assessment

Staff from DVHA's Quality, Oversight & Monitoring, and Compliance units developed a comprehensive risk assessment program for Vermont's Medicaid program at the end of 2021. This work is ongoing. The purposes of the project are to:

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

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

In addition to researching managed care standards, the risk assessment team began preparing for the annual Compliance EQR audit during QE0323.

Global Commitment (GC) Investment review

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

During this most recent quarter, DMH highlighted the performance of a subset of their investments. The Clear Impact Scorecards for these investments are included in this report as Attachment 7.

Payment Models & Performance Monitoring

AHS Departments are required to monitor and evaluate the performance of their payment models on an ongoing basis and subject them to formal review according to a periodic schedule.

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

characterize trends or patterns in the data). During this most recent quarter, Dental and CIS highlighted the performance of their payment models. The Clear Impact Scorecard for this payment model is included in this report as Attachment 8.

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

This quality strategy is intended to serve as a blueprint or road map for states and their contracted health plans in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. In the Special Terms and Conditions (STCs) of the State's recent waiver extension, CMS has included prescriptive 1915(c) HCBS quality requirements for the State's 5 HCBS programs (CFC, DS, BIP, CRT, MH Under 22). As a result, the State is required to extend its existing quality strategy to include HCBS. During this quarter, AHS engaged Manatt Health to identify the resource lift necessary to address gaps and implement CMS' HCBS quality requirements.

SUD Monitoring Protocol

The SUD Monitoring Protocol specifies the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements of the demonstration. During this quarter, the state submitted quarterly monitoring reports for the substance use disorder (SUD) component of the Global Commitment to Health demonstration, to the Centers for Medicare & Medicaid Services (CMS), as required by the state's special terms and conditions (STC). Also, during this quarter, the state received CMS feedback on their previously submitted Monitoring Reports. Feedback was received for both Part A and Part B of the report. During the quarter, AHS has worked with colleagues at DSU and DVHA to review and respond to feedback. A number of the Part A spreadsheets were resubmitted during the quarter. The state anticipates receiving feedback on subsequent submissions to ensure that these monitoring reports provide all the information requested by the templates.

SMI Monitoring Protocol

The SMI Monitoring Protocol specifies the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements of the demonstration. During this quarter, the state submitted quarterly monitoring reports for the serious mental illness (SMI) component of the Global Commitment to Health demonstration, to the Centers for Medicare & Medicaid Services (CMS), as required by the state's special terms and conditions (STC). Also, during this quarter, the state received CMS feedback on their previously submitted Monitoring Reports. Feedback was received for Part A of the report. During the quarter, AHS has worked with colleagues at DMH and DVHA to review and respond to feedback. The state anticipates receiving feedback on subsequent submissions to ensure that these monitoring reports provide all the information requested by the templates.

IX. Demonstration Evaluation Activities

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

Specifically, the design identifies the state's hypotheses, evaluation questions, associated measures, and analytic methods.

During the quarter, the state continued to work with its independent evaluator, PHPG, to develop the Summative Evaluation Report. The report includes the information in the CMS-approved Evaluation Design. The state anticipates a draft report to be submitted for review during the next quarter.
Also, during this quarter, AHS continued to work with Manatt Health on the Evaluation RFP for the waiver extension period. The RFP was posted on March 20, 2023, with responses due April 21, 2023.

X. Compliance

Key updates from QE032023:

- EQRO Document Preparation.

External Quality Review

During the last quarter, the state worked with the External Quality Review Organization (EQRO) to develop the material necessary for each of the required annual external quality review activities (i.e., performance improvement project validation, performance measure validation, and compliance review). Performance Improvement Project (PIP) validation items included the PIP validation timeline, review templates, and report outlines. Performance Measure Validation items included the PMV timeline, a document request letter, a rate reporting template, and a HEDIS roadmap. Review of Compliance with Standards items included a document request letter as well as desk and documentation review forms. All letters and materials are expected to be sent to DVHA during the next quarter.

Intra-Governmental Agreement (IGA) between AHS and DVHA

During this quarter, there was no activity associated with the AHS / DVHA IGA.

XI. Reported Purposes for Capitate Revenue Expenditures

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

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

XII. State Contact(s)

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

XIII. Attachments

Attachment 1	Budget Neutrality Workbook
Attachment 2	Complaints Received by Health Access Member Services
Attachment 3	Medicaid Grievance and Appeal Reports
Attachment 4	Office of the Health Care Advocate Report
Attachment 5	QE032023 Investments (GC Investments)
Attachment 6	Investment Scorecard(s)
Attachment 7	Payment Model Scorecard(s)

Date Submitted to CMS: May 29, 2023

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
QE 0323

ELIGIBILITY GROUP	DY 18 Jul 2022 - Dec 2022	DY 19 Jan 2023 - Dec 2023	DY 20 Jan 2024 - Dec 2024	DY 21 Jan 2025 - Dec 2025	DY 22 Jan 2026 - Dec 2026	DY 23 Jan 2027 - Dec 2027	Total
Without Waiver (Caseload x pmpms)							
ABD - Non-Medicare - Adult	$ 92,114,270	$ 50,803,747	$ -	$ -	$ -	$ -	$ 142,918,017
ABD - Non-Medicare - Child	$ 23,315,607	$ 13,051,079	$ -	$ -	$ -	$ -	$ 36,366,687
ABD - Dual	$ 287,925,124	$ 148,043,631	$ -	$ -	$ -	$ -	$ 435,968,755
Non ABD - Non-Medicare - Adult	$ 88,549,514	$ 46,139,299	$ -	$ -	$ -	$ -	$ 134,688,813
Non ABD - Non-Medicare - Child	$ 226,358,303	$ 118,063,528	$ -	$ -	$ -	$ -	$ 344,421,830
Total Expenditures Without Waiver	**$ 718,262,819**	**$ 376,101,283**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 1,094,364,102**
With Waiver							
ABD - Non-Medicare - Adult	$ 95,250,705	$ 46,481,363	$ -	$ -	$ -	$ -	$ 141,732,068
ABD - Non-Medicare - Child	$ 20,360,439	$ 12,245,349	$ -	$ -	$ -	$ -	$ 32,605,788
ABD - Dual	$ 283,809,254	$ 138,532,625	$ -	$ -	$ -	$ -	$ 422,341,879
Non ABD - Non-Medicare - Adult	$ 56,470,924	$ 23,312,189	$ -	$ -	$ -	$ -	$ 79,783,113
Non ABD - Non-Medicare - Child	$ 180,085,944	$ 90,926,848	$ -	$ -	$ -	$ -	$ 271,012,792
Individual Cost Effective	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Community Transition Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -
HIE	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Investments	$ 73,022,505	$ 35,646,207	$ -	$ -	$ -	$ -	$ 108,668,712
Total Expenditures With Waiver	**$ 708,999,771**	**$ 347,144,581**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 1,056,144,352**
Waiver Savings Summary							
Subtotal Annual Savings	$ 9,263,048	$ 28,956,702					
Hypothetical Test Deficits	$ -	$ -	$ -	$ -	$ -	$ -	
Cumulative Savings	$ 9,263,048	$ 38,219,750	$ 38,219,750	$ 38,219,750	$ 38,219,750	$ 38,219,750	$ 38,219,750
HYPOTHETICAL TESTS							
Hypothetical Test 1: New Adult							
Limit New Adult PMPM*MM	$ 261,262,266	$ 139,829,116	$ -	$ -	$ -	$ -	$ 401,091,382
New Adult Total Expenditures	$ 222,857,284	$ 109,936,626	$ -	$ -	$ -	$ -	$ 332,793,910
Surplus (Deficit)	$ 38,404,982	$ 29,892,490	$ -	$ -	$ -	$ -	$ 68,297,472
Hypothetical Test 2: SUD IMD							
SUD - IMD ABD - Non-Medicare - Adult	$ 156,312	$ 113,878	$ -	$ -	$ -	$ -	$ 270,190
SUD - IMD ABD - Dual	$ 129,959	$ 120,455	$ -	$ -	$ -	$ -	$ 250,414
SUD - IMD Non ABD - Non-Medicare - Adult	$ 342,876	$ 210,873	$ -	$ -	$ -	$ -	$ 553,749
SUD - IMD New Adult	$ 1,944,745	$ 1,864,860	$ -	$ -	$ -	$ -	$ 3,809,605
Limit SUD IMD PMPM*MM	**$ 2,573,893**	**$ 2,310,066**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 4,883,958**
SUD - IMD ABD Non Medicare Adult	$ 156,753	$ 81,105	$ -	$ -	$ -	$ -	$ 237,858
SUD - IMD ABD - Dual	$ 236,032	$ 162,222	$ -	$ -	$ -	$ -	$ 398,254
SUD - IMD Non ABD - Non-Medicare - Adult	$ 380,720	$ 188,586	$ -	$ -	$ -	$ -	$ 569,306
SUD - IMD New Adult	$ 2,146,822	$ 1,203,159	$ -	$ -	$ -	$ -	$ 3,349,981
SUD IMD Total Expenditures	**$ 2,920,327**	**$ 1,635,072**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 4,555,399**
Surplus (Deficit)	$ (346,434)	$ 674,994	$ -	$ -	$ -	$ -	$ 328,559
Hypothetical Test 3: SMI IMD							
SMI - IMD ABD - Non-Medicare - Adult	$ 3,070,568	$ 518,575	$ -	$ -	$ -	$ -	$ 3,589,143
SMI - IMD ABD - Dual	$ 357,432	$ 110,431	$ -	$ -	$ -	$ -	$ 467,863
SMI - IMD Non ABD - Non-Medicare - Adult	$ 726,715	$ 413,109	$ -	$ -	$ -	$ -	$ 1,139,824
SMI - IMD New Adult	$ 6,391,025	$ 3,203,048	$ -	$ -	$ -	$ -	$ 9,594,073
Limit SMI IMD PMPM*MM	**$ 10,545,741**	**$ 4,245,162**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 14,790,903**
SMI - IMD ABD Non Medicare Adult	$ 1,622,662	$ 1,159,179	$ -	$ -	$ -	$ -	$ 2,781,841
SMI - IMD ABD - Dual	$ 525,974	$ 285,778	$ -	$ -	$ -	$ -	$ 811,752
SMI - IMD Non ABD - Non-Medicare - Adult	$ 700,983	$ 457,938	$ -	$ -	$ -	$ -	$ 1,158,921
SMI - IMD New Adult	$ 5,491,100	$ 3,492,256	$ -	$ -	$ -	$ -	$ 8,983,356
SMI IMD Total Expenditures	**$ 8,340,719**	**$ 5,395,151**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 13,735,870**
Surplus (Deficit)	$ 2,205,022	$ (1,149,989)	$ -	$ -	$ -	$ -	$ 1,055,033
Hypothetical Test 4: Housing Pilot							
Limit Housing Pilot PMPM*MM	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Housing Pilot Total Expenditures	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Surplus (Deficit)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Hypothetical Test 5: Maternal Health and Treatment Services							
Limit Maternal Health and Treatment Services PMPM*MM	$ 1,105,887	$ 735,129	$ -	$ -	$ -	$ -	$ 1,841,015
Maternal Health and Treatment Services Total Expenditures	$ 1,179,899	$ 534,822	$ -	$ -	$ -	$ -	$ 1,714,721
Surplus (Deficit)	$ (74,012)	$ 200,307	$ -	$ -	$ -	$ -	$ 126,294
Hypothetical Test 6: CRT							
Limit CRT PMPM*MM	$ 6,149,760	$ 2,938,633	$ -	$ -	$ -	$ -	$ 9,088,393
CRT Total Expenditures	$ 4,735,011	$ 2,840,235	$ -	$ -	$ -	$ -	$ 7,575,246
Surplus (Deficit)	$ 1,414,749	$ 98,398	$ -	$ -	$ -	$ -	$ 1,513,147
Hypothetical Test 7: SUD CIT							
Limit SUD CIT PMPM*MM	$ -	$ -	$ -	$ -	$ -	$ -	$ -
SUD CIT Total Expenditures	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Surplus (Deficit)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Hypothetical Test 8: Global Rx							
Limit Global Rx PMPM*MM	$ 4,974,807	$ 2,447,523	$ -	$ -	$ -	$ -	$ 7,422,330
Global Rx Total Expenditures	$ 5,708,962	$ 2,649,518	$ -	$ -	$ -	$ -	$ 8,358,480
Surplus (Deficit)	$ (734,155)	$ (201,995)	$ -	$ -	$ -	$ -	$ (936,150)
Hypothetical Test 9: Moderates							
Limit Moderates PMPM*MM	$ 609,493	$ 293,420	$ -	$ -	$ -	$ -	$ 902,913
Moderates Total Expenditures	$ 445,519	$ 196,763	$ -	$ -	$ -	$ -	$ 642,282
Surplus (Deficit)	$ 163,974	$ 96,657	$ -	$ -	$ -	$ -	$ 260,631
Hypothetical Test 10: Marketplace Subsidy							
Limit Marketplace Subsidy PMPM*MM	$ 2,027,688	$ 1,185,421	$ -	$ -	$ -	$ -	$ 3,213,108
Marketplace Subsidy Total Expenditures	$ 1,955,249	$ 1,116,332	$ -	$ -	$ -	$ -	$ 3,071,581
Surplus (Deficit)	$ 72,439	$ 69,089	$ -	$ -	$ -	$ -	$ 141,527

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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

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

Questions, Complaints and Concerns Received by Health Access Member Services
January 1, 2023 – March 31, 2023

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

January 2023:

- Provider Complaint – Caller wanted to document that dentist enrollment should not be done with a dentist that does not accept GMC as insurance. XXXXXX XXXXX was assigned as the caller's dentist, but when they called to set up an appointment, the office indicates that they do not accept GMC as insurance. The Agent apologized for the inconvenience, documented the feedback, and assisted the customer with finding another Dentist in the area.
- Provider Complaint - Caller has extreme difficulty finding a PCP and would like to give feedback that this situation is very difficult even for someone who is knowledgeable about health care systems. Caller is concerned that their insurance will not work without a PCP for referrals, PA's and Medical Care. They have called customer service and many MD offices to resolve finding a PCP without success. The PCP they want to use is XXXX XXXXX, at XXX XXXXXX but this MD is not listed as PCP in Maxstar, ACCESS or VTMedicaid Portal. The only PCP that is listed in Maxstar XXXX is XXXXXXX XXXX. Caller was assigned to XXXX XXXXXX, when they call this office they say XXXX XXXXX is not PCP there and that they are sure XXXX XXXXXXX is PCP with VT Medicaid. The Agent apologized for the inconvenience, documented the feedback and ensured the customer the feedback will be passed on.

- Covered Services - Caller is requesting to submit negative feedback regarding Medicaid's limitation on dental coverage. Caller feels that the $1000 per calendar year limit is too prohibitive and does not provide enough coverage for even basic dental work for an adult in a single year. Caller also claims that the limit is discriminatory against low income people, because many dentists choose to not accept Medicaid because of the lower reimbursement they receive. The Agent apologized for the inconvenience and documented the feedback. They also explained the Dental Voucher through DCF.
- Provider Complaint - Caller spoke with a supervisor and is frustrated that they ran out of their RX and the pharmacist won't refill until next week. The RX is also over the counter so on occasion they have had to pay out of pocket, however member is unable to afford to do so this month. Caller advised the bottle says "Take 2 tablets by mouth twice a day or as directed". Caller has been taking 3 tablets instead of 2 and has discussed this with their provider, because the language on her bottle says "or as directed" they are confused as to why they can't refill her RX today instead of next week. The Supervisor referred the caller to their provider and recommend they discuss the prescription with them if an adjustment is needed. I offered Ombuds number as well, however caller declined due to needing this RX ASAP.
- Payment Issue - Caller requested to document negative feedback as they want to be able to pay the Vpharm coverage by phone. Caller believes this option should be available to all customers and not just VHC customers. The Agent documented the feedback and explained the payment options that we have available for Vpharm.

February 2023:

- Provider Complaint - Caller called to state the Providers that are listed on the VTMedicaid.com website are not up to date, most that they had called are not accepting Medicaid or are only accepting Children up to a specific age. The Agent apologized for the inconvenience, documented the feedback and assisted the customer with finding more Providers that accept Medicaid in the area.
- Provider Complaint - Caller can not find a dentist that will except the VT Medicaid as insurance. Caller says that there are no dentist in their area which is Brattleboro that takes Medicaid. Caller states they will take you if you pay cash but not Medicaid. This a health concern and they have missed work due to not being able to locate a Dentist that will except Medicaid. The Agent apologized for the inconvenience, documented the feedback and assisted the customer with finding more Providers that accept Medicaid in the area.
- Provider Complaint - Caller wanted to express how hard it is to locate a Dental Surgeon that's willing to accept VT Medicaid. They state they had called all over the state of VT and heard the same thing from most VT Dentist/Dental Surgeons. Medicaid had been amazing for most things, right now caller's child has to have their wisdom teeth out due to being in pain. The soonest we could schedule an appointment is in June. Caller can't even get in with their Dentist to try and be referred somewhere sooner. Most providers say they stopped accepting Medicaid patients due to how little they get paid for their services. They cant afford to take anymore patients. Also caller had been dropped by their PCP out of nowhere just for having VT Medicaid as insurance. Caller would like to see the rate VT Dentist are paid increased to allow them to take on more patients easier. The Supervisor apologized for the inconvenience, documented the feedback and assisted the customer with finding more Providers that accept Medicaid in the area.

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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

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

March 2023:

- Provider Complaint - Caller requested to file negative feedback. Caller states the Provider list on VTMedicaid.com is not accepting new patients. Caller states every place that they have called is not accepting new patients. Caller feels this is unfair as they are trying to seek healthcare needs. The Agent apologized for the inconvenience, documented the feedback and assisted the customer with finding more Providers that accept Medicaid in the area.
- Covered Services - Caller feels that the State of Vermont is paying more for prescriptions than their primary PDP Atena is. Caller states that they have been on Medicare for two months now and Atena has only paid 49 cents for a $203.00 medication and Vpharm picked up the rest. Caller feels this is unfair as their medications get denied if Vpharm will not pay. The Agent apologized for the inconvenience and referred the customer to Vermont Legal Aid for further research.
- Provider Complaint - Caller requested to document that they are not satisfied with the fact that VTMedicaid.com provider lookup list is not up to date. When searching for a provider on the site they have encountered the wrong number for a provider and then learned the provider is now retired. Caller would like to see us update the list more often so it can be of more assistance. The Agent apologized for the inconvenience, documented the feedback and assisted the customer with finding more Providers that accept Medicaid in the area.
- Covered Services - Caller called in regards to a procedure not being covered. Caller had gender reassignment surgery but has had complications such as, breast implant causing signification issues and facial feminization surgery. Caller is trying to get the repairs to the implants and have the initial facial feminization surgery covered. Caller has been told by their provider that Medicaid will not cover the facial feminization surgery and is now currently seeking psychology help in trying to manage their anxiety, depression and suicidal ideations to exist as a transwoman in the current political society. The Agent apologized for the inconvenience as well as documented the customers feedback. The Agent reviewed GAC options and referred the customer to Vermont Legal Aid for further research.
- Provider Complaint - Caller requested to document negative feedback regarding finding a Dentist that accepts VT Medicaid as insurance. Caller feels that Dentists no longer are accepting Medicaid because of how little the SOV will pay for services. Caller states this is an issue throughout Vermont. People with Medicaid need to be able to get assistance with their Oral Health needs. Caller feels it is not fair that people with low income have to suffer to be able to get the care that they need because of the insurance carrier they have.

The Agent apologized for the inconvenience, documented the feedback and assisted the customer with finding more Providers that accept Medicaid in the area.

- Provider Complaint - Caller requested to document feedback as none of the Dentists in the Bennington area are accepting new patients as the VTMedicaid.com portal shows. Caller also stated that some of the offices that are listed on the Medicaid Portal are no longer accepting Medicaid insurance as payment. The Agent apologized for the inconvenience, documented the feedback and assisted the customer with finding more Providers that accept Medicaid in the area.
- Covered Services - Caller would like to submit negative feedback regarding Transportation benefits being denied. Caller is highly upset due to her being Disabled. They cannot move on their own and is unable to drive, walk and hardly stand. Caller is very dissatisfied with this decision. The Agent apologized for the inconvenience, documented feedback and offered the customer a Fair Hearing/Appeal.

Attachment 3

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
January 1, 2023 – March 31, 2023

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data from the centralized database that were filed from January 1, 2023, through March 31, 2023.

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

During this quarter, there were twenty-two grievances filed and ten were addressed. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of receipt of a grievance must be sent within five days; the average was three days. Of the grievances filed, 77% were filed by the beneficiary, and 23% were filed by a representative. DMH had 72%, DAIL had 14%, and DVHA had 14% of the grievances filed.

Grievances were filed for service categories mental health, case management, community social supports, dental, nursing, prescriptions, provider issues, and quality of care.

There were no Grievance Reviews filed this quarter.

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

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

During this quarter, there were thirty-four appeals filed. Of these thirty-four appeals, twenty four were resolved (71%), two were untimely (6%), one was withdrawn (3%), and seven (20%) were still pending.

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

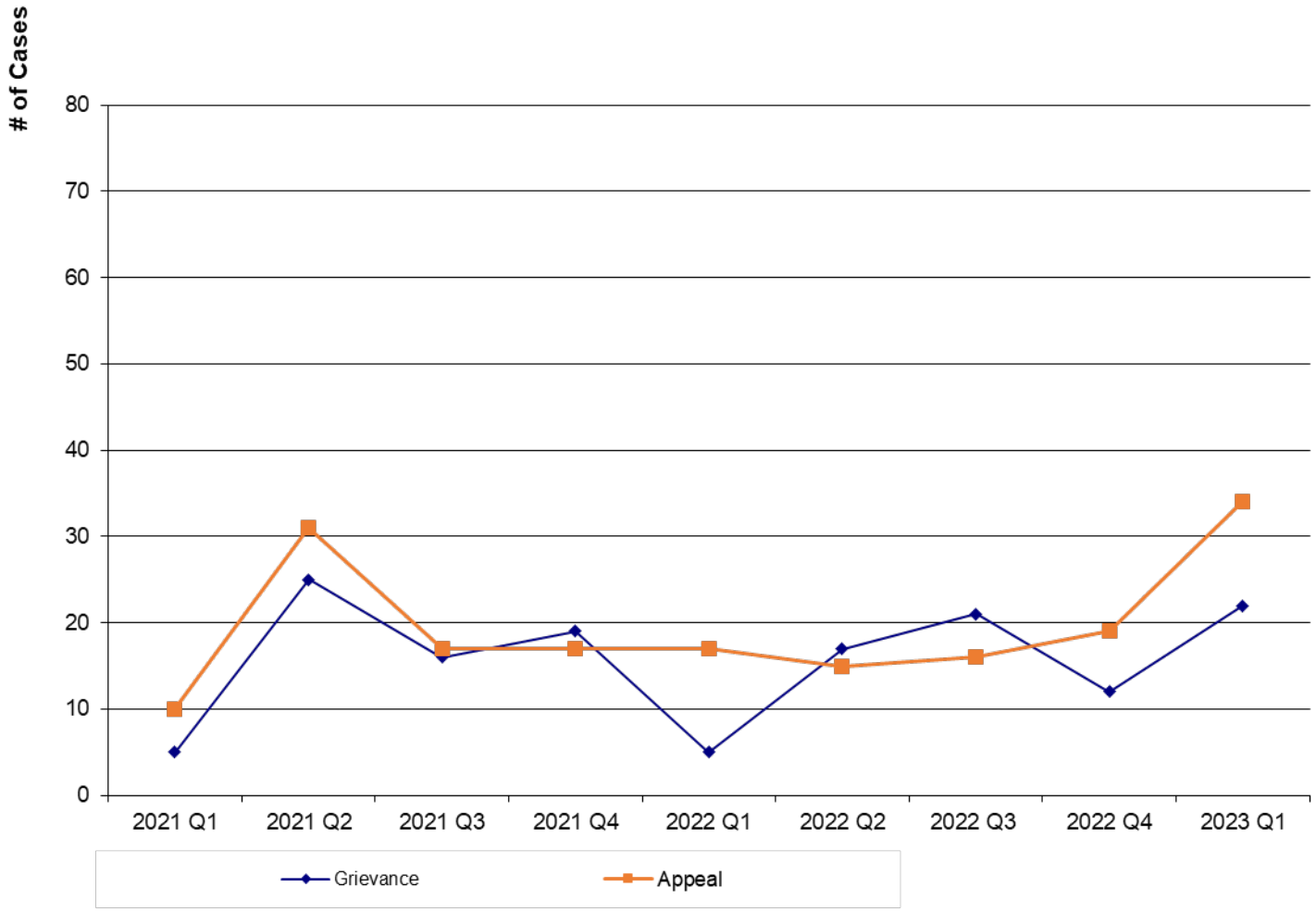
Of the thirty-four appeals filed, DVHA had 26 appeals filed (76%), VDH had 5 (15%), and DMH had 3 (9%). There were no appeals filed for DAIL or DMH this quarter.

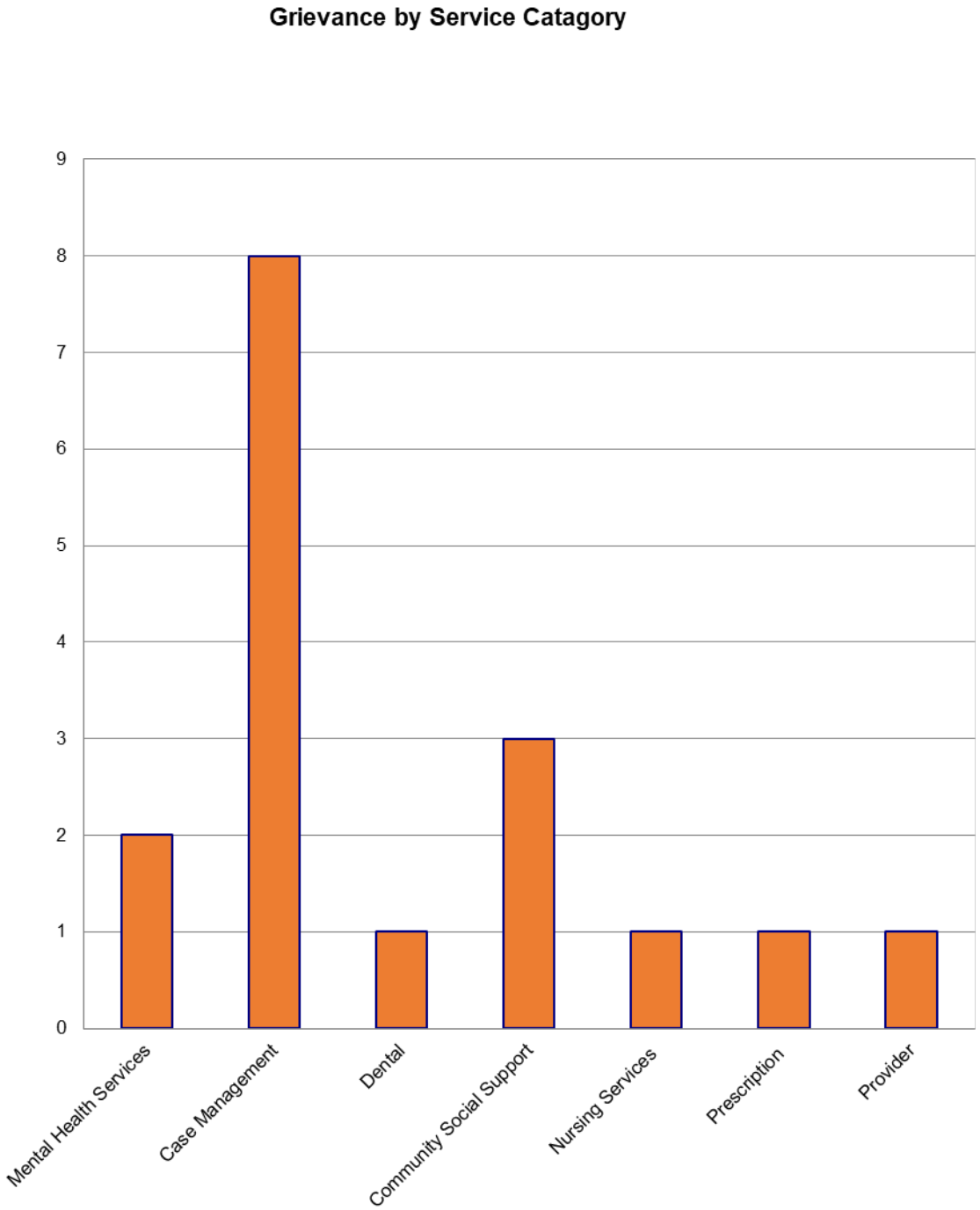
The appeals filed were for service categories dental, mental health, CRT, outpatient hospital, personal care, prescription, supplies and transportation.

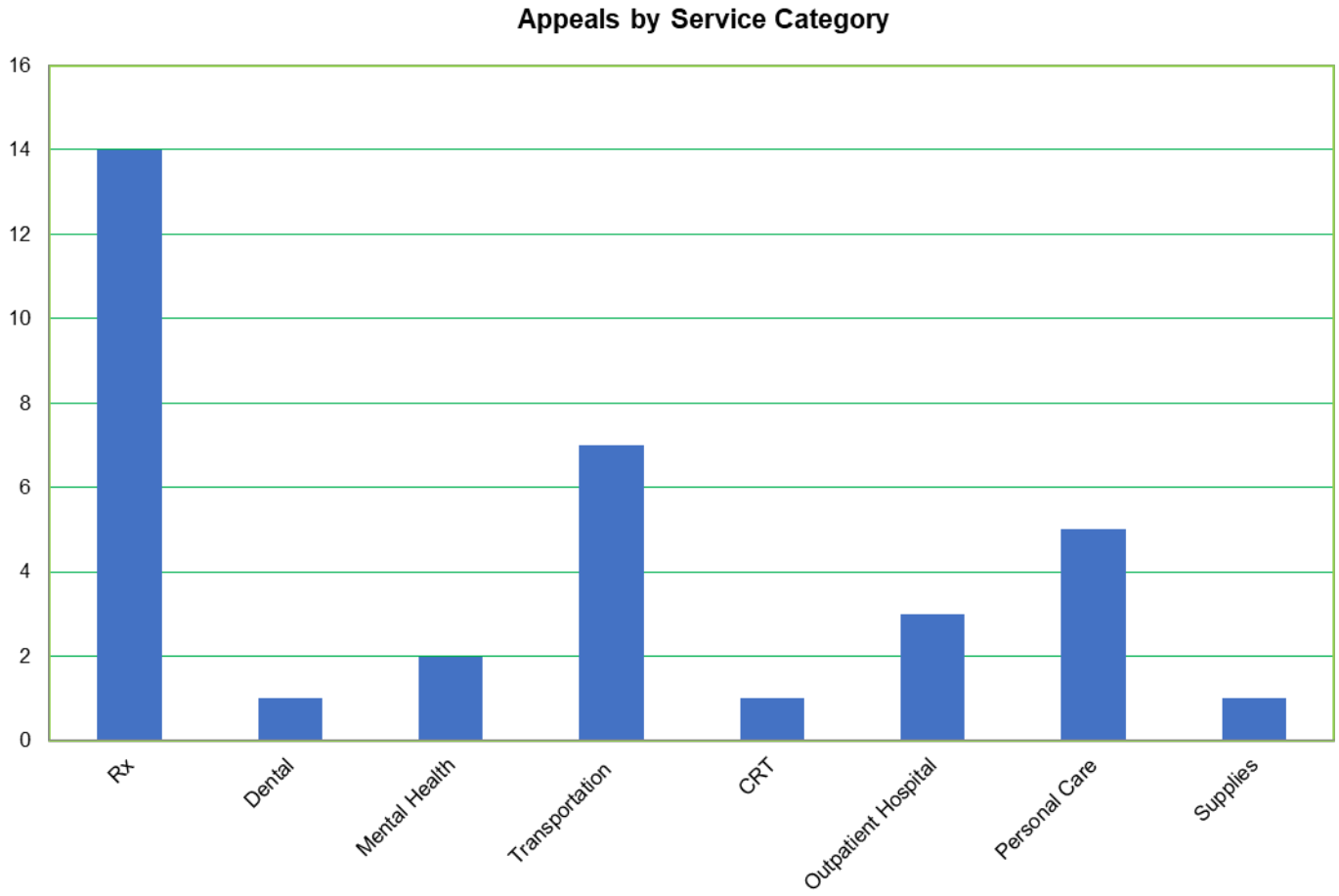
Beneficiaries must exhaust the internal appeal process before they can file a fair hearing if their appeal is not decided in their favor. There were no fair hearings filed this quarter.

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

Grievances and Appeals
January 1, 2021– March 31, 2023




Grievance by Service Catagory
9
8
7
6
5
4
3
2
1
0
Mental Health Services
Case Management
Dental
Community Social Support
Nursing Services
Prescription
Provider


Appeals by Service Category
16
14
12
10
8
6
4
2
0
Rx
Dental
Mental Health
Transportation
CRT
Outpatient Hospital
Personal Care
Supplies

Attachment 4

Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

January 1– March 31, 2023

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

April 21, 2023

Summary and Update

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

The HCA began advocating over a year ago for an adjustment to the way Silver plans in the individual market are rated to recognize the value of the Cost Sharing Reduction (CSR) subsidies. On the individual market, Vermont Health Connect (VHC) offers Silver plans that include CSR subsidies for income eligible consumers. These plans reduce the deductible and cost-sharing consumer pay. For example, a regular standard silver plan has a $4000 deductible for individuals. The highest-level standard silver CSR plan, called a Silver 94, has a $250 deductible for an individual. The HCA proposed a change in how these plans are valued. This quarter the GMCB voted in favor of a modified version of the HCA proposal. This change will ultimately make consumers eligible for up to $10 million dollars more Advance Premium Tax Credits (APTC). It will help all Vermonters who are eligible for tax credits, even those who are not eligible for the CSR plans. With the increased subsidies, Vermonters can buy more generous Gold or even Platinum plans that have lower out of pockets costs for consumers.

The HCA Helpline now has eight advocates working to resolve issues and answer questions. We opened 897 cases this quarter. (821 the previous quarter) Many consumers called with questions about their health care plans that they had signed for in the VHC Open enrollment. Consumers had questions about the plan coverage and premiums. VHC Open Enrollment also lasted until January 15th, so the Helpline also had calls from consumers who were trying to sign up for a VHC plan before the end of the enrollment period.

Sam's Story:

Sam had been diagnosed with a serious chronic condition, and he needed to go to multiple appointments and pick up prescriptions. But Sam was uninsured, and he had missed the Vermont Health Connect (VHC) Open enrollment period. Sam had a part-time job, but he did not work enough hours to qualify for employer coverage. Since he was outside VHC open enrollment, Sam would need a special enrollment to get a plan. The HCA advocate discovered that Sam qualified for one of VHC's new special enrollment periods. If you have an income under 200% of the Federal Poverty Level and meet the other eligibility requirements for Advance Premium Tax Credit, you can enroll outside the Open Enrollment. The HCA advocate helped Sam fill out the application and enroll in a plan. He qualified for significant APTC and cost-sharing reductions. This meant that he would be able to go to his appointments and afford his prescriptions.

We also had calls from Medicare enrollees who were confused about their enrollment on a Medicare Part C plan. Medicare Part C plans, also called Advantage plans, are private health plans that offer Medicare benefits. Some of the plans may also offer benefits beyond Original Medicare such as dental or hearing aid coverage. The plans, however, may also have limited provider networks and prior authorization requirements. Often, consumers told the HCA advocates, that they had not meant to enroll on an Advantage plan, or they did not fully understand that they were signing up for. Medicare consumers enrolled on Part C plans have an annual enrollment period from January to March, where they can switch back to Original Medicare or to another Advantage plan. The HCA advised these consumers about that process. Consumers who discover that they were not happy with their Advantage plan enrollment within the first year that they were eligible for Medicare, also have another guaranteed issue period to enroll in a Medigap plan. Medicare generally covers 80 percent of covered services, and

Medigap plans help cover the remaining 20 percent of the cost. If you enroll outside of the guaranteed issue period or special enrollment, you can be charged more or even denied enrollment. Enrollees outside the first year can still switch back to Original Medicare or another Part C plan during the annual Medicare Advantage Open Enrollment, but you won't have a guaranteed issue to get a Medigap plan. That means people who discover that their Part C plan does not meet their needs after the first year may have very limited options for Medigap enrollment and may have to pay more if they do enroll. Consumer education about Medicare was in the top three areas that HCA advocates advised on this past quarter.

The HCA also started to prepare for the end of the continuous coverage requirement. Since the start of the COVID emergency in March of 2020, Medicaid closures and closures for Medicare Savings Programs and VPharm, have been on hold. Starting in April, VHC will re-start the renewal process. Vermonters will get notices about their eligibility, and will need to respond, or they may lose coverage. Some people currently on Medicaid will also need to transition to an individual plan on VHC. The HCA started to get some phones calls about renewals re-starting. It has prepared consumer education including a video and flyers about Medicaid renewals, and we anticipate doing more consumer education as the process gets underway. The HCA will also be doing outreach and consumer education about the new eligibility rules for Dr. Dynasaur for pregnancy. As of April 1, the post-partum coverage period increased from 60 days to 12 months. Eligibility for Medicaid remains the top issue that we get calls about. We had over 2500 page views on our website about Medicaid eligibility. Our news item on Medicaid renewals re-starting also had 158 page views. We expect our calls on Medicaid eligibility and renewals, and special enrollment on VHC plans will increase in the next few quarters.

VHC will review 12,000 households per month, and about 200,000 individuals in the next year. This will be the first time that some Medicaid enrollees will undergo the renewal process. Some enrollees will have to transition from Medicaid to a VHC plan or Employer insurance. The HCA will continue to work on increasing affordability for all and making the complicated process as accessible as possible for all Vermonters.

Case Stories:

Daniel's Story

Daniel called the HCA because he was leaving his job, and that meant his employer health care coverage was ending soon. When he applied on the VHC website, it told him that he was not eligible for APTC to lower his monthly premiums. When the HCA advocate investigated, she found that VHC was saying that Daniel was eligible for Medicaid for Children and Adults. If you are eligible for Medicaid, that means you will be ineligible for APTC to help pay for a VHC plan. When the HCA advocate reviewed his income, however, she found that it was above the Medicaid income limit, and that Daniel should have been eligible for APTC to help pay for a plan on VHC. She escalated the case with VHC and was able to get the eligibility decision fixed. Daniel's employer was also paying for one extra month of employer coverage after he left the job. Daniel wanted to make sure that he avoided any gaps in his coverage. This meant he was applying ahead of time to get a start date on a VHC plan the day after his employer coverage ended. He was having trouble getting the correct start date with VHC, and the HCA advocate again intervened to make sure that the VHC plan started the day after his employer coverage ended.

Irina's Story:

Irina called the HCA because she was having trouble using her VPharm. VPharm is a state of Vermont program that helps pay for Medicare Part D premiums and reduces the co-payments for medications to $1 or $2. She was also enrolled on a Medicare Advantage Plan. Medicare Advantage Plans are private health plans that offer Medicare benefits. Frequently, Advantage plans include prescription coverage, which means you do not need a separate Part D plan. When Irina tried to tell her pharmacy to bill VPharm, she was directed to call the Advantage plan. When she called the Medicare Advantage Plan, she was directed back to the pharmacy. The HCA advocate investigated and found that Irina was getting her prescriptions with a pharmacy that was not enrolled with Vermont Medicaid. That meant that her prescriptions could not be billed to VPharm, and she was not getting the reduced copayment The HCA helped Irina find a pharmacy enrolled with Vermont Medicaid that would cover her prescriptions and bill VPharm. Irina switched pharmacies and was able to get her prescriptions at the VPharm co-payment rate.

Andrew's Story

Andrew needed to get transportation to an urgent medical appointment. He had an appointment for a biopsy, and he could not drive himself because he was going to be under anesthesia. The HCA advocate confirmed with Andrew that he had Medicaid coverage. Medicaid covers transportation to appointments, but you must show that you don't have access to a vehicle in your household. You also need to get prior authorization approved ahead of time. Andrew was not sure his prior authorization had been approved, and his appointment was only a couple days away. He lived by himself, and he had a car. But he was not going to be able to drive himself because of the anesthesia, and he had no one else who could drive him. The advocate confirmed that the prior authorization request had been submitted to Vermont Medicaid. She explained that although there was a car in the household that it could not be used for this appointment because of the anesthesia and asked for the process to be expedited. Andrew's prior authorization for transportation was approved and was relieved that he could get to his appointment.

Overview

The HCA assists consumers through our statewide helpline (**1-800-917-7787**) and through the Online Help Request feature on our website, Vermont Law Help (*https://vtlawhelp.org/health)*. We have a team of advocates located in Vermont Legal Aid's Burlington office that provides this help to any Vermont resident free of charge, regardless of income. The HCA received 897 calls this quarter. We assign callers a primary issue category. Callers' primary issue category were as follows:

Table: Q1 FY2023 Caller Primary Issue Category

Primary Issue Category	Percent *
Eligibility	25%
Access to Care	22%
Complaints	14%
Consumer Education	13%
Other **	9%
Buying Insurance	3%

*Column may not sum to 100 due to rounding.

** The "Other" primary issue category includes communication problems with health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

The HCA's new industry-standard case management system (CMS), LegalServer, captures information about eligibility for state programs by insurance coverage. The CMS captured insurance coverage for 56% of callers. The HCA is working to further optimize internal processes and the structure of our CMS, which was implemented in Q4 of 2022, to increase the capture rate for caller insurance coverage. We currently do not know a time certain for completion of this optimization work although the work has started and is being actively pursued. Insurance coverage of callers for whom insurance coverage is known is:

Table: Insurance Coverage for Q1 FY2023 Callers for whom Insurance Coverage is Known

Insurance Coverage	Percent *
DVHA	35%
Commercial	18%
Medicare	38%
Uninsured	9%

*Column may not sum to 100 due to rounding.

The top issues Q1 FY2023 callers had were:

Table: Top Ten Issues of Q1 FY2023 Callers

Issue	Percent *
Eligibility - Medicaid - MAGI	8.6%
Complaints - Provider	7.7%
Complaints - Hospital	4.1%
Consumer Education - Medicare	4.0%
Eligibility - Medicaid - Non-MAGI	3.2%
Access to Care - Prescription Drugs	2.9%
Access to Care - Dental	2.8%
Other **	2.1%
Eligibility - MSPs/Buy-In Programs	1.8%
Access to Care - DME & Supplies	1.7%

*Column does not sum to 100 as only top ten most frequent issues presented. Percentage is of all callers.

** The “Other” primary issue category includes communication problems with health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

The top issues Q1 FY2023 callers on DVHA programs had were:

Table: Top Issues of Q1 FY2023 Callers Who Participated in DVHA Programs

Issue	Percent *
Eligibility: Medicaid - MAGI	24.2%
Access to Care: Dental	4.7%
Complaints: Provider	4.2%
Consumer Education: Information about DVHA	4.2%
Consumer Education: Medicare	4.2%
Eligibility: Medicaid - Non-MAGI	3.7%
Other **	2.6%
Consumer Education: Info/Applying for DVHA Programs	2.1%
Unanswered After Multiple Attempts to Contact	2.1%
Access to Care: Specialty Care	1.6%
Eligibility: Long Term Care Medicaid & Choices for Care	1.6%
Eligibility: Medicaid for Working People with Disabilities	1.6%
Billing: General Billing Questions	1.6%
Eligibility: Medicare	1.6%

*Column does not sum to 100 as only top issues presented. Percentage is of callers who participate in DVHA programs.

** The “Other” primary issue category includes communication problems with health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

The top issues Q1 FY2023 callers with commercial insurance had were:

Table: Top Issues of Q1 FY2023 Callers with Commercial Insurance

Issue	Percent*
Consumer Education: ACA Tax Issues	9%
Buying Insurance: QHP - VHC	6%
Consumer Education: IRS Reconciliation	5%
Eligibility: Premium Tax Credit	4%
1095-A Problems	4%
Appeals: Private Insurance - Covered Service	4%
Access to Care: Transition of Care	4%
Billing: Mammography	3%
Eligibility: Termination of Insurance	3%
Consumer Education: Medicare	3%
Complaints: Hospital	2%
Billing: Copayments & Coinsurance	2%
Billing: Provider Billing	2%
Appeals: Fair Hearing - Eligibility	2%
Eligibility: Citizenship & Identity	2%

*Column does not sum to 100 as only top issues presented. Percentage is of callers who have commercial insurance.

The top topics Q1 FY2023 callers called the HCA to ask questions about were:

Table: Top Topics Q1 FY2023 Callers Asked About

Topic	Percentage*
Medicare	31%
ACA Tax issues	10%
Information about DVHA	10%
Info/Applying for DVHA Programs	9.5%
HIPAA	7.8%
Information about HCA	6%
General Questions About Insurance	6%
Unanswered After Multiple Attempts to Contact	4%
IRS Reconciliation	4%
Other Insurance Laws and Regulations	2.6%
Enrollment Penalties	2.6%
Accountable Care Organization	1.7%
Information about ACA	0.9%
Grace Periods	0.9%
Family Law and Health Insurance Interactions	0.9%

*Column does not sum to 100 as only top issues presented. Percentage is of callers who had consumer specific consumer education needs.

Consumer Protection Activities

Rate Review

The HCA reviews and analyzes all commercial insurance carrier requests to the Green Mountain Care Board (Board) to change premium prices. The Board did not decide any premium price change requests during the quarter from January 1, 2023, through March 31, 2023. There is one premium price change request pending at the close of the quarter.

Blue Cross and Blue Shield of Vermont (BCBSVT) submitted a premium price change request for its Large Group book of business. BCBSVT's proposed premium price change impacts approximately 5,785 Vermonters. BCBSVT requested a total annual increase of 10.8% for large groups renewing in the first quarter of 2024. The HCA filed an appearance in the matter, reviewed the carrier's submissions, and submitted questions regarding the filing. The HCA will file a Memo In Lieu of Hearing in the next quarter. The Board's decision on the request is due in early May.

Hospital Budgets

The HCA provided comments, edits, and questions that were incorporated into the FY24 Hospital Budget guidance adopted by the GMCB.

Certificate of Need Review Process

The HCA has statutory authority to assert interested party status in certificate of need (CON) proceedings before the GMCB. In the last quarter, the HCA filed and was granted Interested Party status in the CON application by University of Vermont Medical Center (UVMMC) to build a new Outpatient Surgery Center (MCB-004-23con). We continue to actively monitor certificate of need applications as they are submitted and assert party status when the interests of Vermonters are clearly impacted.

Oversight of Accountable Care Organizations

The HCA has continued to provide both written and oral comments as a part of the FY23 OneCare Vermont (OCV) budget hearing process, which includes review of a new data analytics contract with the University of Vermont Health Network. The HCA looks forward to continuing to work with the GMCB ACO Budget team and Board members to provide recommendations to improve their oversight of OCV's budget and programs. The HCA has also provided questions, comments, and recommendations to the GMCB in regard to the FY23 budget submission from Lore Health, a Medicare-only ACO that is operating in Vermont.

Additional Green Mountain Care Board and other agency workgroups

Over the last quarter, the HCA attended the Board's weekly board meetings, monthly Data Governance meetings, quarterly Prescription Drug Technical Advisory meetings, and several other legislatively established workgroups focused on affordability and access.

Global Budget Technical Advisory Group

The HCA is a member of the Global Budget Technical Advisory group convened by both the GMCB and the Agency of Human Services. This group met four times this quarter exploring the technical options that may be available to Vermont. This discussion hinges significantly on decisions at CMS and whether there are options for a Vermont agreement with CMS that will work for our state.

The Medicaid and Exchange Advisory Committee

The Advisory Committee met three times this quarter. The content of this quarter's meetings included a focus on messaging and planning for the PHE Unwind, Medicaid Dental Access, non-emergency Medicaid transportation, DVHA Language access planning, telehealth and a discussion of DVHA budget priorities.

Legislative Advocacy

This quarter started at the beginning of the new Legislative Biennium. The Chief Advocate spent considerable time this quarter engaging with new and older legislators to make sure they are aware of the HCA as a resource for their constituents as well as promoting an agenda which continues to focus on key improvements to our health care system. Our primary focus on Medicare Savings Plan eligibility as well as Immigrant Health Insurance coverage resulted in the introduction of bills in the house and senate on both topics. We remain hopeful that next year the Legislature will devote some of its precious time on these policy areas.

The HCA participated in several legislative discussions on the following bills.

H.494 An act relating to making appropriations for the support of government. The HCA actively advocated for an increase in the Medicaid dental cap as well as funding for the Bridges to Health program in addition to stated support for numerous other parts of the bill. The bill has passed the House and is currently in Senate Appropriations.

S.54An act relating to individual and small group insurance markets. The HCA supported this bill which extends the current practice of rating the individual and small groups separately for 2024 and 2025. The bill has passed both the House and the Senate and was delivered to the Governor on April 12th.

S.36An act relating to permitting an arrest without a warrant for assaults and threats against health care workers and disorderly conduct at health care facilities. The HCA supported a balanced approach to this bill that recognized the stated needs of the workers in Emergency Departments and first responders and recognized the risks of bringing more law enforcement into the health care setting. We supported a narrowing of the disorderly conduct in this bill as well a significant narrowing of the health care facilities where warrantless arrests could be called for. The bill has passed the Senate and is currently in House Judiciary.

S.9An act relating to the authority of the State Auditor to examine the books and records of State contractors. The HCA supported this bill in the Senate recognizing the importance of an independent

auditor's ability to safeguard taxpayer dollars even when those monies flow through independent contractors. The bill passed the Senate and is currently in House Government Operations.

S.37 An act relating to access to legally protected health care activity and regulation of health care providers. The HCA supported this bill. The bill passed the senate and is in House Health Care where it is actively being worked on.

S.65 An act relating to commercial insurance coverage of epinephrine auto-injectors. The HCA supported this bill once it was fashioned to comply with high deductible health plans. The bill passed the Senate and is currently in House Health Care.

S.79 An act relating to limitations on hospital liens. The HCA Supported this bill and joined with a small group of advocates to find a compromise. The HCA had fought for protections for patients who are eligible for a hospital's free care policy from Hospital Liens, but compromised as the bill is a step in the right direction. The bill passed the Senate Judiciary Committee after crossover and is currently in Senate Rules.

Collaboration with Other Organizations

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

- American Civil Liberties Union of Vermont
- All Copays Count Coalition
- Bi-State Primary Care
- Bridges to Health
- Blue Cross Blue Shield of Vermont
- Committee on Vermont Elders
- Department of Financial Regulation
- Families USA
- IRS Taxpayer Advocate Service
- Let's Grow Kids
- Migrant Justice
- MVP Health Care
- National Academy for State Health Policy
- NHeLP, National Health Law Program
- New American Clinic/Family Room
- OneCare Vermont
- Open Door Clinic
- Planned Parenthood of Northern New England
- Rights and Democracy (RAD)
- Rural Vermont
- South Royalton Legal Clinic
- SHIP, State Health Insurance Assistance Program
- University of Vermont Medical Center
- University of Vermont Migrant Health, Bridges to Health
- Vermont Association of Hospitals and Health Systems
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Health Connect
- Vermont Health Care for All
- Vermont Interfaith Action (VIA)
- Vermont Medical Society
- Vermont - NEA
- Vermont Public Interest Research Group (VPIRG)
- Vermont Workers' Center
- You First

Increasing Reach and Education Through the Website

VTLawHelp.org is a statewide website maintained by Vermont Legal Aid and Legal Services Vermont. The site includes a substantial Health section (https://vtlawhelp.org/health) with more than 180 pages of consumer-focused health information maintained by the HCA.

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

Popular Web Pages
* means the page moved into the top 20 this quarter

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

1. *Income Limits - Medicaid* – 2,522 pageviews
2. *Health* - section home page – 1,984
3. *Dental Services* – 1,494
4. *Medicaid, Dr. Dynasaur & Vermont Health Connect* – 687
5. *Long-Term Care* – 499
6. *Resource Limits - Medicaid* – 483
7. *Medicaid* – 461
8. *Medicare Savings Programs* – 459
9. *Services Covered – Medicaid* – 401
10. *HCA Help Request Form* – 338 pageviews and 123 online help requests
11. *Choices for Care Income Limits* – 314
12. *Advance Directive forms* – 298
13. *Buying Prescription Drugs* – 291
14. *Medical Decisions: Advance Directives* – 284
15. *Choices for Care Giving Away Property or Resources* – 283 *
16. *Transportation for Health Care* – 264 *
17. *Vermont Health Connect* – 262
18. *Dr. Dynasaur* – 259
19. *Federally Qualified Health Centers* – 245 *
20. *Choices for Care* – 240

This quarter we had these additional news items:

- *Medicaid Renewal Process Starts Again in April* – 158 pageviews
- *It's Time to Consider Health Insurance Plans (VHC and Medicare)* – *62*
- *Your Benefits and the Public Charge Rule for Immigration* – 36
- *You May Be Eligible for New Financial Help for Health Insurance (ARPA)* – 9

Outreach and Education

The Office of the Health Care Advocates (HCA) engaged in both in-person and virtual outreach this quarter. This hybrid model has made our services more accessible to community members who are seniors or have limited English proficiency. These activities included engaging with Vermonters via social media, partnering with community organizations to develop referral relationships and deliver outreach presentations, circulating virtual education videos, and hosting legal clinics.

We partnered with 23 organizations and participated in 15 outreach presentations as a means of providing accurate and accessible information on insurance eligibility health care policy. These organizations included the:

- Vermont Worker's Center,
- The Family Room,
- Bridges to Health,
- The Social Equity Caucus, and
- The Vermont Professionals of Color Network- just to name a few.

These partnerships included the delivery of outreach presentations, the development of streamlined referral systems, and coordinated messaging on important health law topics such as:

- Medicaid renewals,
- Qualified Health Plans and financial help,
- Medicare eligibility,
- And the Immigrant Health Insurance Plan.

Our office continued to use virtual platforms such as Facebook, Instagram, Zoom, and YouTube to connect with partner organizations and deliver legal education presentations. We used Facebook and Instagram to share important updates on a variety of health care related information, but we primarily focused on messaging about Medicaid renewals.

We prepared a communications toolkit to help community partners share accurate and accessible information with their networks. This toolkit included an informational flyer (that was translated into 13 languages), our Medicaid renewal video, a video about the Office of the Health Care Advocate (which was translated into 13 languages), and sample language on Medicaid and the renewal process that was designed to be posted and shared on social media. Our Medicaid renewal video has been viewed 2,800 times, and our toolkit has been circulated to 200 legislators and community partners. These materials have been disseminated to approximately 5,000 Vermont residents through our partner network.

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

Office of the Health Care Advocate

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

https://vtlawhelp.org/health

DY19 Investment Expenditures

Department	Final Receiver Suffix	Investment Description
AHSCO	9091	Investments (STC-79) - 2-1-1 Grant (41)
AHSCO	9090	Investments (STC-79) - Designated Agency Underinsured Services (54)
AHSCO	9421	HCBS Investment
AOE	n/a	Non-state plan Related Education Fund Investments
DCF	9402	Investments (STC-79) - Medical Services (55)
DCF	9403	Investments (STC-79) - Residential Care for Youth/Substitute Care (1)
DCF	9405	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56)
DCF	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)
DCF	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)
DCF	9408	Investments (STC-79) - Essential Person Program (59)
DCF	9409	Investments (STC-79) - GA Medical Expenses (60)
DCF	9411	Investments (STC-79) - Therapeutic Child Care (61)
DCF	9412	Investments (STC-79) - Lund Home (2)
DCF	9413	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)
DCF	9414	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34)
DCF	9415	Investments (STC-79) - Challenges for Change: DCF (9)
DCF	9416	Investments (STC-79) - Strengthening Families (26)
DCF	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62)
DCF	9418	Investments (STC-79) - Building Bright Futures (35)
DCF	9419	Investments (STC-79) - United Ways 2-1-1 (41)
DAIL	9421	HCBS Investment
DAIL	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)
DAIL	9603	Investments (STC-79) - DS Special Payments for Medical Services (64)
DAIL	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)
DAIL	9605	Investments (STC-79) - Quality Review of Home Health Agencies (42)
DAIL	9606	Investments (STC-79) - Support and Services at Home (SASH) (43)
DAIL	9607	Investments (STC-79) - HomeSharing (77)
DAIL	9608	Investments (STC-79) - Self-Neglect Initiative (78)
DAIL	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)
DMH	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28)
DMH	9502	Investments (STC-79) - Mental Health Outpatient Services for Adults (66)
DMH	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79)
DMH	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16)
DMH	9506	Investments (STC-79) - Mental Health Children's Community Services (12)
DMH	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)
DMH	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)
DMH	9510	Investments (STC-79) - Emergency Support Fund (22)
DMH	9511	Investments (STC-79) - Institution for Mental Disease Services: DMH (3) - VPCH
DMH	9512	Investments (STC-79) - Institution for Mental Disease Services: DMH (3) - BR
DMH	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)
DMH	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)
DOC	n/a	Return House
DOC	n/a	Northern Lights
DOC	n/a	Pathways to Housing - Transitional Housing
DOC	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)
DOC	n/a	Northeast Kingdom Community Action
DOC	n/a	Intensive Substance Abuse Program (ISAP)
DOC	n/a	Intensive Domestic Violence Program
DOC	n/a	Community Rehabilitative Care
DOC	n/a	Intensive Sexual Abuse Program

DOC	n/a	Vermont Achievment Center
DVHA	9101	Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8)
DVHA	9102	Investments (STC-79) - Vermont Blueprint for Health (51)
DVHA	9103	Investments (STC-79) - Buy-In (52)
DVHA	9104	Investments (STC-79) - HIV Drug Coverage (53)
DVHA	9106	Investments (STC-79) - Patient Safety Net Services (18)
DVHA	9107	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)
DVHA	9108	Investments (STC-79) - Family Supports (72)
DVHA	9109	DSR Investment (STC-83) – One Care VT ACO Quality & Health Management (81)
DVHA	9110	DSR Investment (STC-83) – One Care VT ACO Advanced Community Care Coordination (82)
DVHA	9111	DSR Investment (STC-83) - One Care VT ACO Primary Prevention Development (83)
GMCB	n/a	Green Mountain Care Board
UVM	n/a	Vermont Physician Training
VAAFM	n/a	Agriculture Public Health Initiatives
VDH	9201	Investments (STC-79) - Emergency Medical Services (19)
VDH	9203	Investments (STC-79) - TB Medical Services (74)
VDH	9204	Investments (STC-79) - Epidemiology (40)
VDH	9205	Investments (STC-79) - Health Research and Statistics (39)
VDH	9206	Investments (STC-79) - Health Laboratory (31)
VDH	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)
VDH	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)
VDH	9209	Investments (STC-79) - Family Planning (75)
VDH	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)
VDH	9211	Investments (STC-79) - Renal Disease (73)
VDH	9213	Investments (STC-79) - WIC Coverage (37)
VDH	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21)
VDH	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)
VDH	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)
VDH	9220	Investments (STC-79) - Recovery Centers (17)
VDH	9221	Investments (STC-79) - Enhanced Immunization (46)
VDH	9222	Investments (STC-79) - Poison Control (48)
VDH	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)
VDH	9224	Investments (STC-79) - Fluoride Treatment (38)
VDH	9225	Investments (STC-79) - Medicaid Vaccines (24)
VDH	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)
VDH	9228	Investments (STC-79) - VT Blueprint for Health (44)
VDH	9421	HCBS Investment
VSC	n/a	Health Professional Training
VVH	n/a	Vermont Veterans Home

QE 0323	QE 0623	QE 0923	QE 1223	DY19 Total
-	-	-	-	**-**
1,778,704	-	-	-	**1,778,704**
3,365,373	-	-	-	**3,365,373**
-	-	-	-	**-**
51,809	-	-	-	**51,809**
-	-	-	-	**-**
1,194,513	-	-	-	**1,194,513**
32,943	-	-	-	**32,943**
70,334	-	-	-	**70,334**
193,603	-	-	-	**193,603**
32,345	-	-	-	**32,345**
325,485	-	-	-	**325,485**
-	-	-	-	**-**
-	-	-	-	**-**
20,163	-	-	-	**20,163**
38,787	-	-	-	**38,787**
243,244	-	-	-	**243,244**
-	-	-	-	**-**
114,319	-	-	-	**114,319**
113,200	-	-	-	**113,200**
-	-	-	-	**-**
92,642	-	-	-	**92,642**
619,132	-	-	-	**619,132**
368,699	-	-	-	**368,699**
-	-	-	-	**-**
245,011	-	-	-	**245,011**
69,427	-	-	-	**69,427**
130,158	-	-	-	**130,158**
-	-	-	-	**-**
12,761	-	-	-	**12,761**
1,070,339	-	-	-	**1,070,339**
104,739	-	-	-	**104,739**
13,104	-	-	-	**13,104**
337,504	-	-	-	**337,504**
-	-	-	-	**-**
311,344	-	-	-	**311,344**
-	-	-	-	**-**
8,472,209	-	-	-	**8,472,209**
-	-	-	-	**-**
13,178	-	-	-	**13,178**
1,550,673	-	-	-	**1,550,673**
49,807	-	-	-	**49,807**
-	-	-	-	**-**
374,723	-	-	-	**374,723**
76,432	-	-	-	**76,432**
29,245	-	-	-	**29,245**
-	-	-	-	**-**
-	-	-	-	**-**
1,810,081	-	-	-	**1,810,081**
-	-	-	-	**-**

-	-	-	-	**-**
-	-	-	-	**-**
914,380	-	-	-	**914,380**
1,319	-	-	-	**1,319**
20	-	-	-	**20**
35,538	-	-	-	**35,538**
4,081,769	-	-	-	**4,081,769**
-	-	-	-	**-**
-	-	-	-	**-**
-	-	-	-	**-**
-	-	-	-	**-**
-	-	-	-	**-**
-	-	-	-	**-**
-	-	-	-	**-**
252,798	-	-	-	**252,798**
-	-	-	-	**-**
238,553	-	-	-	**238,553**
310,605	-	-	-	**310,605**
816,411	-	-	-	**816,411**
526,666	-	-	-	**526,666**
-	-	-	-	**-**
266,059	-	-	-	**266,059**
908,466	-	-	-	**908,466**
-	-	-	-	**-**
1,025,841	-	-	-	**1,025,841**
174,030	-	-	-	**174,030**
11,726	-	-	-	**11,726**
880,802	-	-	-	**880,802**
661,381	-	-	-	**661,381**
72,609	-	-	-	**72,609**
38,822	-	-	-	**38,822**
567,220	-	-	-	**567,220**
18,319	-	-	-	**18,319**
-	-	-	-	**-**
53,208	-	-	-	**53,208**
463,589	-	-	-	**463,589**
49	-	-	-	**49**
-	-	-	-	**-**
				-

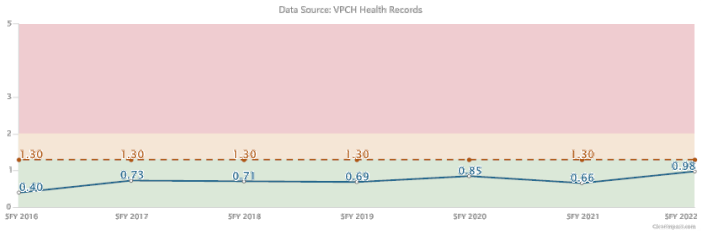
O GC_Investment Increase the Access of Quality Healthcare to the Uninsured, Underinsured, and Medicaid Beneficiaries

	Time Period	Current Actual Value	Current Trend

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

	Time Period	Current Actual Value	Current Trend

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



SFY 2022	0.98	1
SFY 2021	0.66	1
SFY 2020	0.85	1
SFY 2019	0.69	2
SFY 2018	0.71	1
SFY 2017	0.73	1
SFY 2016	0.40	2
SFY 2015	1.00	1

Story Behind the Curve

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

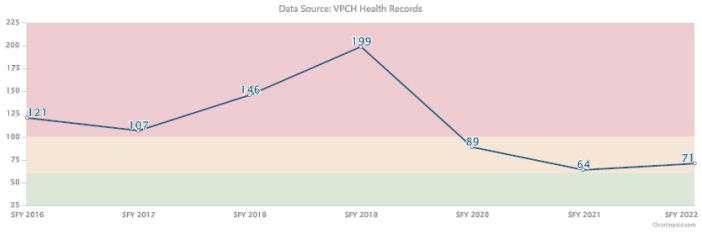
Providing patient care in an environment that is safe and supportive is important for recovery. VPCH, through its work with the SAMHSA Six Core Strategies for Reducing seclusion and restraint has lowered its rate of seclusion and restraint to approximately one half-hour per 1,000 patient hours, which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

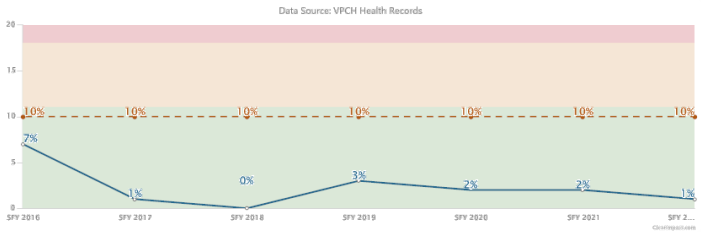


SFY 2022	71	1
SFY 2021	64	2
SFY 2020	89	1
SFY 2019	199	2
SFY 2018	146	1
SFY 2017	107	1
SFY 2016	121	1
SFY 2015	80	1

Story Behind the Curve

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

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



SFY 2022	1%	1
SFY 2021	2%	1
SFY 2020	2%	1
SFY 2019	3%	1
SFY 2018	0%	3
SFY 2017	1%	2
SFY 2016	7%	1
SFY 2015	9%	0

Story Behind the Curve

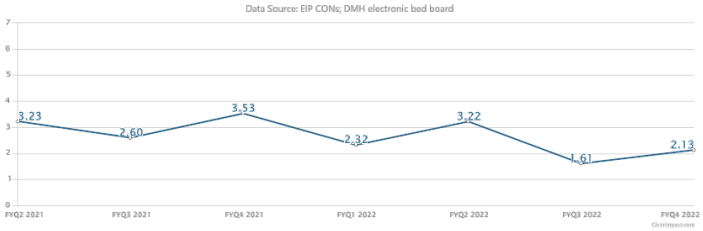
In 2017, VPCH maintained its target of 10% of patients' that were discharged were readmitted involuntarily within 30 days. VPCH exceeded this expectation for 2018, with 0% of patients who were discharged were readmitted involuntarily within 30 days.

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

	Time Period	Current Actual Value	Current Trend

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

FYQ4 2022	2.13	1



FYQ3 2022	1.61	1
FYQ2 2022	3.22	1
FYQ1 2022	2.32	1
FYQ4 2021	3.53	1
FYQ3 2021	2.60	1
FYQ2 2021	3.23	1
FYQ1 2021	2.66	1
FYQ4 2020	5.04	4

Story Behind the Curve

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

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

Updated February 2018

Partners

What Works

Action Plan

Notes on Methodology

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

Ratio calculation:

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

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

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

Story Behind the Curve

Partners

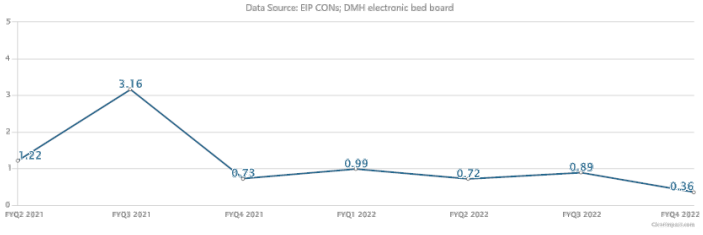
What Works

Action Plan

Notes on Methodology

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

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



Time Period	Current Actual Value	Current Trend
FYQ4 2022	0.36	1
FYQ3 2022	0.89	1
FYQ2 2022	0.72	1
FYQ1 2022	0.99	1
FYQ4 2021	0.73	1
FYQ3 2021	3.16	1
FYQ2 2021	1.22	1
FYQ1 2021	1.96	2
FYQ4 2020	1.08	1

Story Behind the Curve

Partners

What Works

Action Plan

Notes on Methodology

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

Ratio calculation:

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

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

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

Story Behind the Curve

Partners

What Works

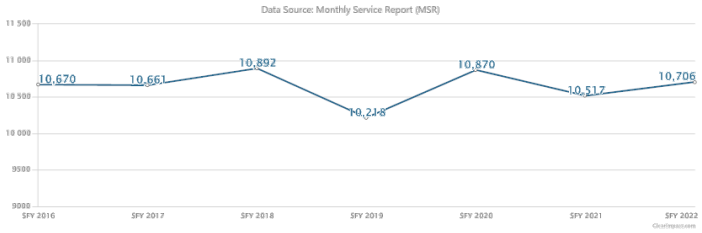
Action Plan

Notes on Methodology

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

Time Period	Current Actual Value	Current Trend

PM How_Much Number of children and youth served in CYFS



SFY 2022	10,706	1
SFY 2021	10,517	1
SFY 2020	10,870	1
SFY 2019	10,218	1
SFY 2018	10,892	1
SFY 2017	10,661	1
SFY 2016	10,670	4
SFY 2015	10,585	3
SFY 2014	10,490	2

Story Behind the Curve

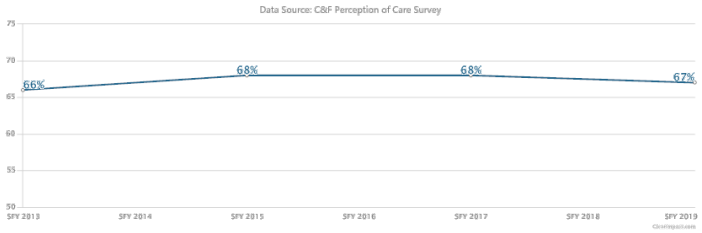
Partners

What Works

Action Plan

Notes on Methodology

PM Better_Off % of adolescents reporting positive outcomes



SFY 2019	67%	1
SFY 2017	68%	1
SFY 2015	68%	2
SFY 2013	66%	1
SFY 2011	65%	1
SFY 2009	65%	2
SFY 2007	63%	1
SFY 2003	54%	1

Story Behind the Curve

Partners

What Works

Action Plan

Notes on Methodology

Report based on the Children and Family Perception of Care Survey, administered bi-annually by the Department of Mental Health to adolescents age 13-17 receiving services from Designated Agencies who are Medicaid enrolled.

P GC_Investment (WIP) Emergency Support Fund (22)

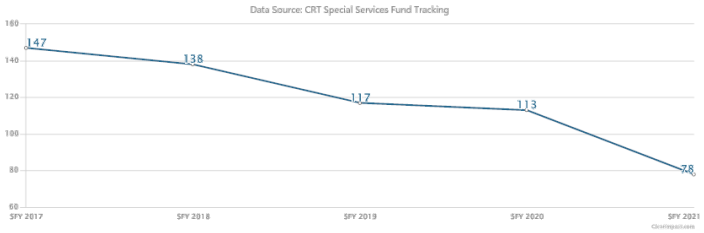
Time Period	Current Actual Value	Current Trend

P GC_Investment Special Payments for Treatment Plan Services (28)

Time Period	Current Actual Value	Current Trend

PM How_Much # of CRT clients served with special services funding

SFY 2021	78	4



SFY 2020	113	3
SFY 2019	117	2
SFY 2018	138	1
SFY 2017	147	0

Story Behind the Curve

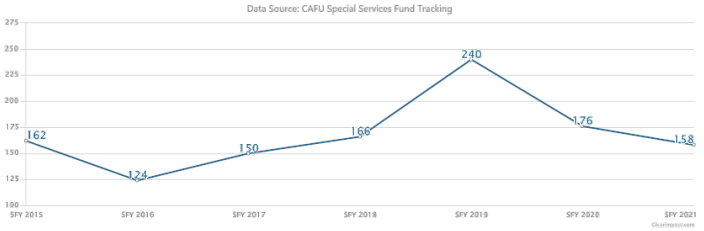
Partners

What Works

Action Plan

Notes on Methodology

PM How_Well # of youth served with special services funding



SFY 2021	158	2
SFY 2020	176	1
SFY 2019	240	3
SFY 2018	166	2
SFY 2017	150	1
SFY 2016	124	2
SFY 2015	162	1
SFY 2014	166	0

Story Behind the Curve

Partners

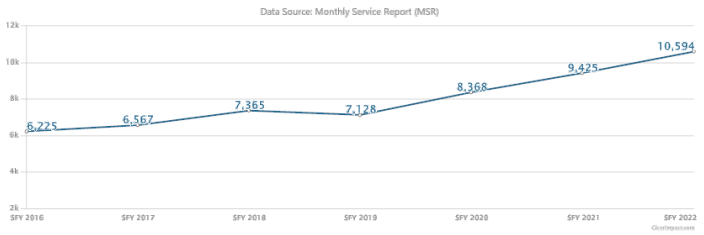
What Works

Action Plan

Notes on Methodology

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

PM How_Much Number of People Served by Emergency Services



Time Period	Current Actual Value	Current Trend
SFY 2022	10,594	3
SFY 2021	9,425	2
SFY 2020	8,368	1
SFY 2019	7,128	1
SFY 2018	7,365	2
SFY 2017	6,567	1
SFY 2016	6,225	3
SFY 2015	6,306	2
SFY 2014	6,348	1

Story Behind the Curve

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

Partners

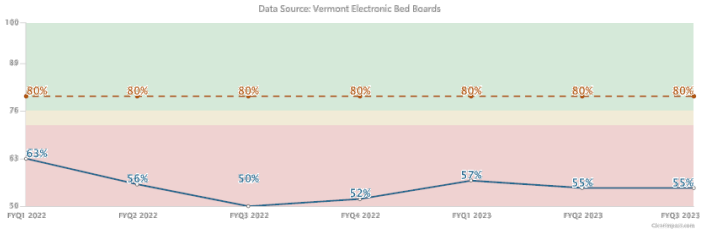
- Vermont Care Partners

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

Notes on Methodology

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

PM How_Much Percent occupancy of Designated Agency adult crisis bed programs



FYQ3 2023	55%	1
FYQ2 2023	55%	1
FYQ1 2023	57%	2
FYQ4 2022	52%	1
FYQ3 2022	50%	3
FYQ2 2022	56%	2
FYQ1 2022	63%	1
FYQ4 2021	68%	2
FYQ3 2021	60%	1

Story Behind the Curve

Partners

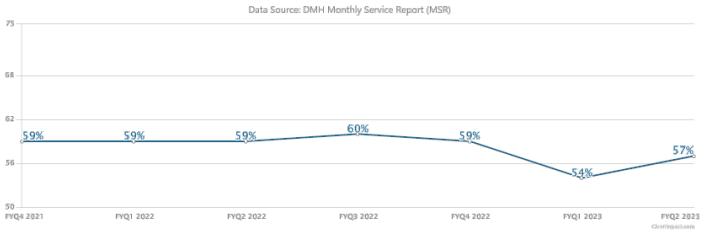
What Works

Action Plan

Notes on Methodology

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

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



FYQ2 2023	57%	1
FYQ1 2023	54%	2
FYQ4 2022	59%	1
FYQ3 2022	60%	1
FYQ2 2022	59%	2
FYQ1 2022	59%	1
FYQ4 2021	59%	1
FYQ3 2021	57%	1
FYQ2 2021	57%	2

Story Behind the Curve

Partners

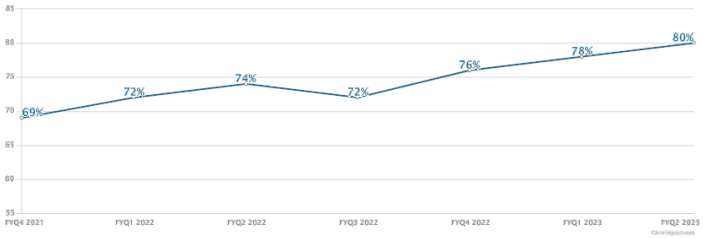
Strategy

Notes on Methodology

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

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

FYQ2 2023	80%	3



FYQ1 2023	78%	2
FYQ4 2022	76%	1
FYQ3 2022	72%	1
FYQ2 2022	74%	2
FYQ1 2022	72%	1
FYQ4 2021	69%	1
FYQ3 2021	71%	2
FYQ2 2021	70%	1

Story Behind the Curve

Partners

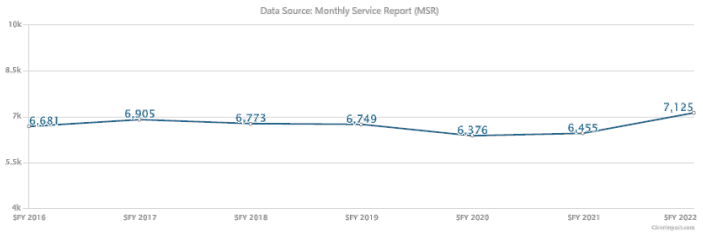
What Works

Action Plan

Notes on Methodology

P GC_Investment Mental Health Outpatient Services for Adults (66)

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



Time Period	Current Actual Value	Current Trend
SFY 2022	7,125	2
SFY 2021	6,455	1
SFY 2020	6,376	3
SFY 2019	6,749	2
SFY 2018	6,773	1
SFY 2017	6,905	1
SFY 2016	6,681	3
SFY 2015	6,685	2
SFY 2014	6,752	1

Story Behind the Curve

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

Partners

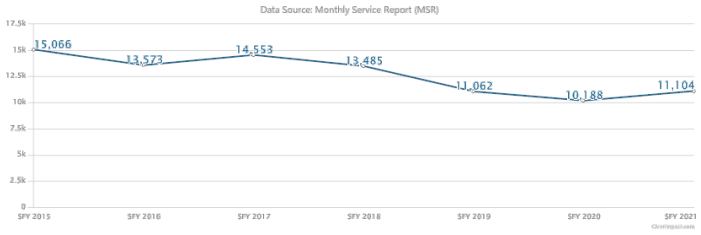
- Vermont Care Partners
- Designated Agencies
  - Clara Martin Center
  - Counseling Service of Addison County
  - Health Care and Rehabilitation Services
  - Howard Center
  - Lamoille County Mental Health Services
  - Northeast Kingdom Human Services
  - Northwestern Counseling and Support Services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

Notes on Methodology

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

PM How_Much Number of Adults Provided Case Management Services by Adult Outpatient Programs

SFY 2021	11,104	1



SFY 2020	10,188	3
SFY 2019	11,062	2
SFY 2018	13,485	1
SFY 2017	14,553	1
SFY 2016	13,573	1
SFY 2015	15,066	6
SFY 2014	8,861	5
SFY 2013	5,042	4

Story Behind the Curve

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

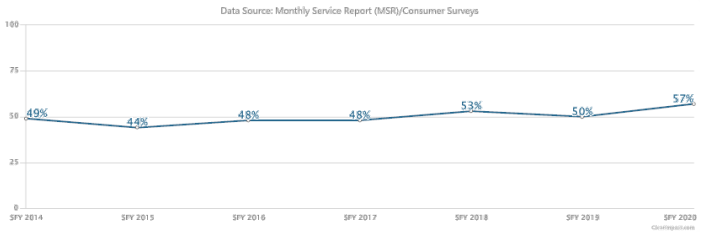
Partners

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

Notes on Methodology

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

PM Better_Off Percentage of Adults Improved Upon Discharge from Adult Outpatient Programs



SFY 2020	57%	1
SFY 2019	50%	1
SFY 2018	53%	1
SFY 2017	48%	1
SFY 2016	48%	1
SFY 2015	44%	2
SFY 2014	49%	1
SFY 2013	51%	1
SFY 2012	48%	2

Story Behind the Curve

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

Partners

- Vermont Care Partners

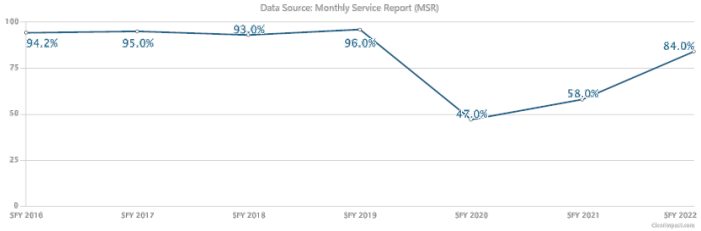
- Designated Agencies
  - Clara Martin Center
  - Counseling Service of Addison County
  - Health Care and Rehabilitation Services
  - Howard Center
  - Lamoille County Mental Health Services
  - Northeast Kingdom Human Services
  - Northwestern Counseling and Support Services
  - Rutland Mental Health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

Notes on Methodology

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

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

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



Time Period	Current Actual Value	Current Trend
SFY 2022	84.0%	2
SFY 2021	58.0%	1
SFY 2020	47.0%	1
SFY 2019	96.0%	1
SFY 2018	93.0%	1
SFY 2017	95.0%	2
SFY 2016	94.2%	1
SFY 2015	92.3%	1
SFY 2014	93.6%	1

Story Behind the Curve

Partners

What Works

Action Plan

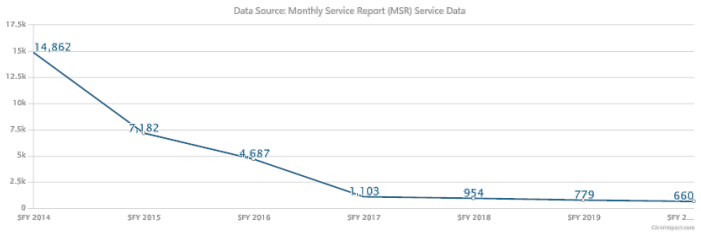
Notes on Methodology

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

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

P GC_Investment Seriously Functionally Impaired: DMH (68)

PM MCO_Investment # Units of service funded by SFI



Time Period	Current Actual Value	Current Trend
SFY 2020	660	6
SFY 2019	779	5
SFY 2018	954	4
SFY 2017	1,103	3
SFY 2016	4,687	2
SFY 2015	7,182	1
SFY 2014	14,862	3
SFY 2013	4,013	2
SFY 2012	1,445	1

Story Behind the Curve

Partners

What Works

Action Plan

Notes on Methodology

P GC_Investment (WIP) Mental Health Consumer Support Programs (79)

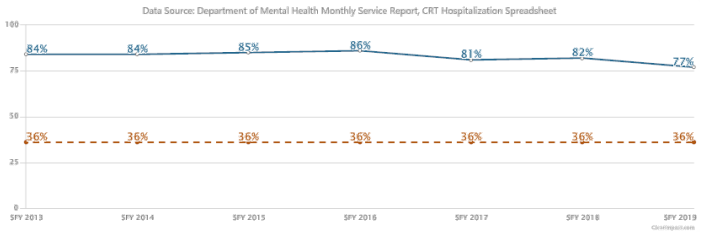
Time Period	Current Actual Value	Current Trend

O GC_Investment Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system

Time Period	Current Actual Value	Current Trend

P GC_Investment Mental Health CRT Community Support Services (16)

PM How_Well Percentage of CRT clients receiving follow up services within 7 days of psychiatric hospitalization discharge



Time Period	Current Actual Value	Current Trend
SFY 2019	77%	1
SFY 2018	82%	1
SFY 2017	81%	1
SFY 2016	86%	2
SFY 2015	85%	1
SFY 2014	84%	1
SFY 2013	84%	1
SFY 2012	82%	1

Story Behind the Curve

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

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

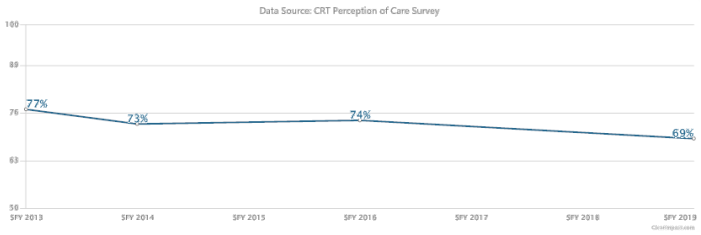
Partners

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

Strategy

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

PM Better_Off Percentage of Adults in Community and Rehabilitation Treatment Programs Reporting Positive Outcomes



Time Period	Current Actual Value	Current Trend
SFY 2019	69%	1
SFY 2016	74%	1
SFY 2014	73%	1
SFY 2013	77%	1
SFY 2012	71%	1
SFY 2011	71%	1
SFY 2010	74%	2
SFY 2009	72%	1

Story Behind the Curve

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

Partners

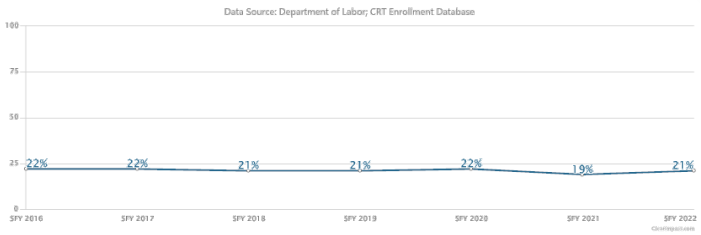
- Vermont Care Partners

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

Notes on Methodology

- Percentage of CRT clients reporting positive outcomes is calculated by the total number of CRT clients reporting positive outcomes divided by the total number of clients surveyed for outcomes.

PM Better_Off % of working age CRT clients who are employed



SFY 2022	21%	1
SFY 2021	19%	1
SFY 2020	22%	1
SFY 2019	21%	1
SFY 2018	21%	1
SFY 2017	22%	3
SFY 2016	22%	2
SFY 2015	22%	1
SFY 2014	22%	2

Story Behind the Curve

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

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

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

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

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

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

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

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

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

---

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

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

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

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

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

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

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

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

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

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

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

Partners

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

What Works

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

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

Action Plan

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

Notes on Methodology

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

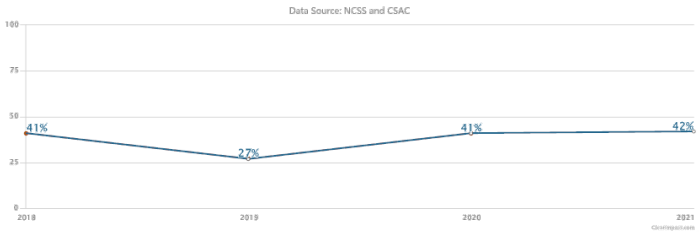
Numbers include Community Rehabilitation and Treatment (CRT) clients aged 18 - 64 who were active during each reporting year and includes all employment reported for each year.

IFS Payment Model

P CMS Integrating Family Services

PM CMS % of clients seen within 5 days of their first call requesting services.

Time Period	Current Actual Value	Current Trend
2021	42%	2
2020	41%	1
2019	27%	1
2018	41%	0



Story Behind the Curve

This measure is used to monitor from an access perspective. When a family calls requesting services, IFS regions are looking to provide them supports and services as quickly as possible. Important to note is that while we are looking for quick access, families are also being asked when they would like services which may impact the timeline for services beginning.

For NCSS, their intake team was comprised of 5 individuals, and they are now down to a screener. As they have improvised to ensure that clients are getting screened, training around data entry has been simplified due to strain on workforce. This has impacted the numbers, as interim staff were unaware of some reporting requirements. This has since been rectified and screener is completing Access to Care portion of screening.

Another important factor to consider with this performance measure is that the majority of services provided to families are home and community-based which can also impact how quickly clients are seen upon their first call. Families are often provided support by phone and that does not get counted in this measure.

For both of these agencies, as is true for the entire mental health system in Vermont and nationwide the COVID pandemic and workforce shortages has put tremendous stress on the system. Due to that fact, DMH is not surprised by fluctuations in data which is being experienced in all agencies.

Target: IFS grantees will demonstrate a 2% decrease in the average wait time (in days) between first call requesting services and first appointment offered.

The definition of first call is when contact with the client/family themselves has been made and they have stated they would like or need services

---

Partners

NCSS and CSAC

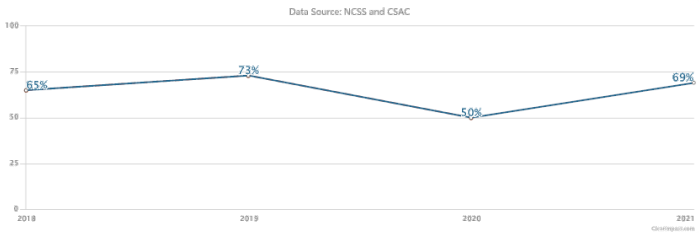
Notes on Methodology

Numerator: Time in days between first call requesting services and appointment offered.

Denominator: Total number of inactive clients requesting services.

PM CMS % of eligible clients with a CANS administered

2021	69%	1
2020	50%	1
2019	73%	1
2018	65%	0



Story Behind the Curve

The CANS is a comprehensive tool that integrates client-level data in one place, while revealing areas that need intense or immediate action, moderate action, or watchful waiting. The simple scoring and clear visual representations help to inform treatment plans and services, by allowing children and caregivers to identify and envision their needs and strengths and communicate them easily to multiple providers. One unique feature of the CANS is that it also focuses on the strengths of children and their caregivers; this positive lens can prove instrumental in a personalized treatment plan.

Vermont began implementation of the CANS in 2015 with the IFS regions being early adopters. This meant the regions have had to invest time and resources in training their staff in the CANS, tracking data and embedding the CANS information in their EHR systems. These regions have begun utilizing the data to track individual's progress over time and to look at program data to assess if children are better off as a result of interventions provided by their interdisciplinary teams.

For both of these agencies, as is true for the entire mental health system in Vermont and nationwide the COVID pandemic has put tremendous stress on the system. Due to that fact, DMH is not surprised by fluctuations in data which is being experienced in all mental health agencies across the state.

Target: IFS grantees will demonstrate a 2% increase of children who have the CANS administered per the eligibility guidelines in the IFS Procedures Manual

---

Partners

NCSS and CSAC.

What Works

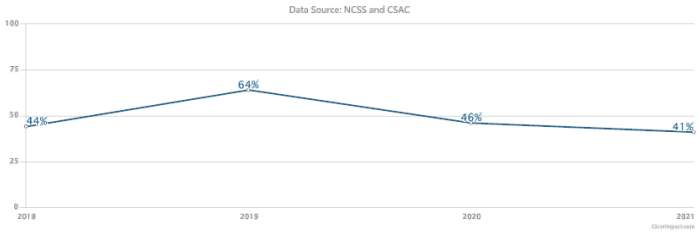
Notes on Methodology

Numerator: All children with a first CANS administered

Denominator: All children eligible for a CANS receiving services

---

PM CMS % of clients who have a plan of care completed within 45 days of referral



2021	41%	2
2020	46%	1
2019	64%	1
2018	44%	0

Story Behind the Curve

This measurement is a Medicaid standard which indicates access to care.

Access to care data is being focused on across all the designated agency systems and having operationalized definitions of referral date is being worked on. Through the process of payment reform, it became clear that across the system this was an area to work on and the engagement from both the state and DA system has been strong.

For both of these agencies, as is true for the entire mental health system in Vermont and nationwide the COVID pandemic has put tremendous stress on the system. Due to that fact, DMH is not surprised by fluctuations in data which is being experienced in all mental health agencies in Vermont.

Target: IFS grantees will demonstrate a 2% increase in the percent of clients that have a plan completed within 45 days of referral during the measurement period.

Partners

NCSS and CSAC

What Works

Notes on Methodology

Numerator: All children who have a plan of care completed within 45 days

Denominator: All children eligible for a plan of care

DVHA Dental Measures Scorecard

This scorecard is used by an internal team at DVHA made up of dentists, clinicians, quality consultants, policy and data analysts to monitor process and outcomes measures for Vermont Medicaid beneficiaries (children and adults) related to Vermont Medicaid's dental benefits.

O GC Core All Medicaid Members are Healthy

Most Recent Period | Current Actual Value | Current Trend

Child Dental Measures

P Dental Child Dental Program

Most Recent Period | Current Actual Value | Current Trend

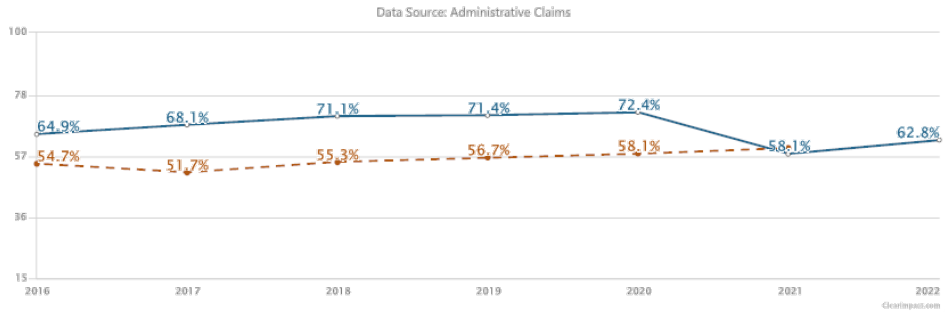
What We Do

Vermont Medicaid offers dental programs for both children (through Dr. Dynasaur) and adults. Dental coverage for children under Dr. Dynasaur is a robust benefit that includes the dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

Who We Serve

Vermont Medicaid beneficiaries

PM GC Core ADV: Annual Dental Visits - Child



2022	62.8%	1
2021	58.1%	1
2020	72.4%	4
2019	71.4%	3
2018	71.1%	2
2017	68.1%	1
2016	64.9%	3
2015	66.1%	2
2014	67.7%	1

Notes on Methodology

- The annual reported rate captures activity during the previous calendar year.
- This is a Healthcare Effectiveness & Data Information Set (HEDIS) administrative measure.
- Based on the advice of their External Quality Review Organization (EQRO), DVHA's rates include only Medicaid Primary beneficiaries in HEDIS administrative measures as of 2014.
- The red dashed trend line above is the 50th percentile national benchmark for Medicaid programs. The blue solid trend line is Vermont Medicaid's actual values.

Partners

- Medicaid beneficiaries
- Dentists
- Vermont Department of Health - Office of Oral Health

Story Behind the Curve

This measure looks at the percentage of Medicaid beneficiaries ages 2 through 20 with dental coverage who had a dental check-up during the past year. Guidelines set by the American Academy of Pediatric Dentistry (AAPD), the American Dental Association (ADA) and the American Academy of Pediatrics (AAP) recommends the first dental visit occur for children by one year of age. Regular visits to the dentist provide access to cleaning, early diagnosis and treatment, as well as education on how to prevent problems.

The data provided above is the DVHA's Annual Dental Visit Total rate (all age groups combined). Separate visit rates for the various age group sub-sets are also tracked.

Pandemic-related reduction in dental office availability contributed to the steep decline in dental visits shown in the 2021 value above (for measurement year 2020).

Last updated: August 2021

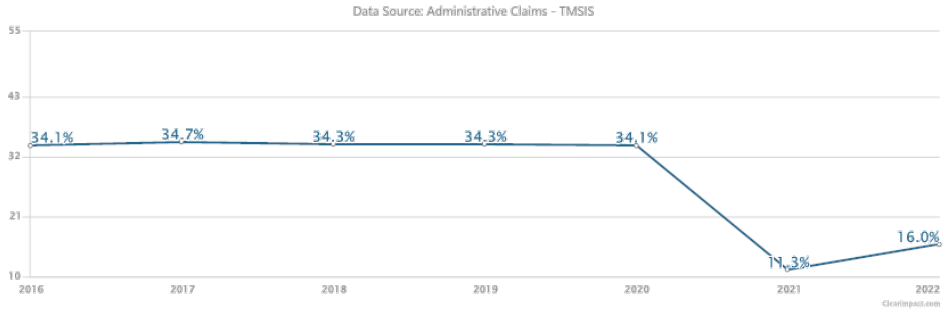
Author: DVHA Quality Unit

Action Plan

For information on dental care and oral health in Vermont, please follow this link:

http://www.healthvermont.gov/wellness/oral-health

PM 2019 SEAL: Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (CCS-19)



2022	16.0%	1
2021	11.3%	2
2020	34.1%	1
2019	34.3%	1
2018	34.3%	1
2017	34.7%	1
2016	34.1%	1
2015	35.0%	0

Notes on Methodology

- The annual reported rate captures activity during the previous calendar year.
- This is a American Dental Association (ADA) / Dental Quality Alliance (DQA) measure.

Story Behind the Curve

This measure has been retired. A new child dental sealant measure will be added to the DVHA Dental Measures Scorecard in calendar year 2023.

Percentage of enrolled children ages 6 to 9 at elevated risk of dental caries (i.e. "moderate" or "high") who received a sealant on a permanent first molar tooth within the reporting year.

Dental caries is the most common chronic disease in children in the United States. In 2009-2010, 14% of children aged 3-5 years had untreated dental caries. Among children aged 6-9 years, 17% had untreated dental caries, and among adolescents aged 13-15, 11% had untreated dental caries. Identifying caries early is important to reverse the disease process, prevent progression of caries, and reduce incidence of future lesions. Approximately three quarters of children younger than age 6 years did not have at least one visit to a dentist in the previous year. Evidence based Clinical Recommendations recommend that sealants should be placed on pits and fissures of chilren's primary and permanent teeeth when it is determined that the tooth, or the patient, is at risk of experiencing caries. The evidence for sealant effectiveness in permanent molars is stronger than evidence for primary molars.

During 2020, dental offices were closed for several months due to the COVID-19 public health emergency. These changes led to a decline in the number of children receiving a sealant and then started to rebound in calendar year 2021.

Last updated: April 2023

Adult Dental Measures

P Dental Adult Dental Program

What We Do

The Agency of Human Services (AHS) made the following changes to the Medicaid adult dental benefit effective January 1, 2020.
•Increased the annual maximum dollar limit on adult dental services from $510 to $1,000.
•Allowed up to two visits for preventive services per calendar year that do not count towards the $1000 annual maximum dollar limit and removing copayments from preventive dental services listed below, including D0120 Periodic Oral Exam.

These changes are a result of Act 72 enacted during the 2019 legislative session. The changes are intended to expand adult Medicaid beneficiaries' access to dental care and encourage the utilization of preventive dental care. These changes apply to Medicaid beneficiaries age 21 and older, who are not pregnant or in the postpartum period.

Codes for preventive services outside of the annual maximum dollar amount include:

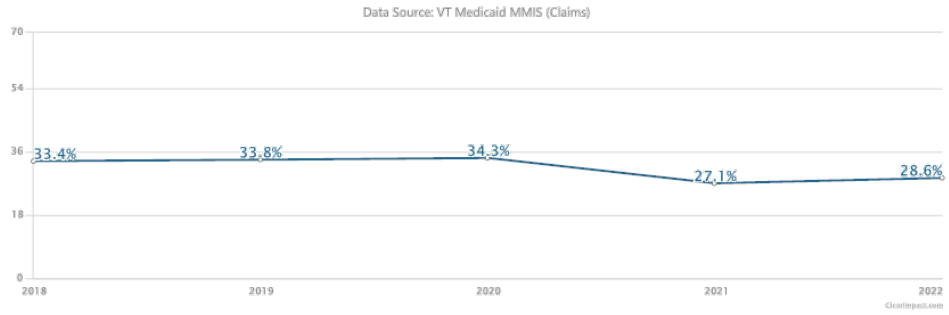
Preventive Services
D1110 Prophylaxis – Adult "cleaning"
D1206 Topical Fluoride Varnish
D1208 Topical Application of Fluoride
D1354 Silver Diamine Flouride
D1320 Tobacco Counseling for the Control and Prevention of Oral Disease
Office Visit
D0120 Periodic Oral Exam

Who We Serve

Vermont Medicaid beneficiaries

PM DVHA ADV-AD: Any Dental Visit - Adult (GC-20)

	Most Recent Period	Current Actual Value	Current Trend
2022	28.6%	1	
2021	27.1%	1	
2020	34.3%	2	
2019	33.8%	1	
2018	33.4%	0	



Notes on Methodology

- The annual reported rate captures activity during the previous calendar year.
- This is a DVHA custom measure that is based on the specifications for the Healthcare Effectiveness & Data Information Set (HEDIS) child dental visit administrative measure.
- The solid blue line in the graph above represents all adults ages 21+

Partners

- Medicaid beneficiaries
- Dentists
- Vermont Department of Health - Office of Oral Health

Story Behind the Curve

This measure looks at the percentage of Medicaid beneficiaries ages 21 and older who had any dental visit during the past year. It is a DVHA custom measure that follows the HEDIS any dental visit specifications for children. Regular visits to the dentist provide access to cleaning, early diagnosis and treatment, as well as education on how to prevent problems.

The Agency of Human Services (AHS) made the following changes to the Medicaid adult dental benefit effective January 1, 2020.

• Increasing the annual maximum dollar limit on adult dental services from $510 to $1,000.
• Allowing up to two visits for preventive services per calendar year that do not count towards the $1000 annual maximum dollar limit.
• Removing copayments from preventive dental services.

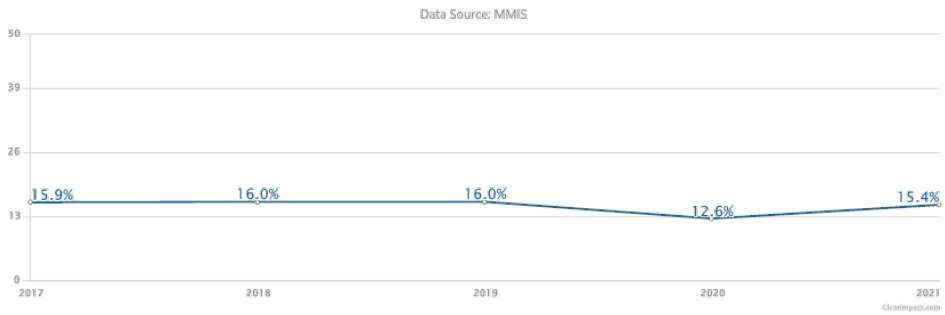
The changes are intended to expand adult Medicaid beneficiaries' access to dental care and encourage the utilization of preventive dental care. These changes apply to Medicaid beneficiaries age 21 and older, who are not pregnant or in the postpartum period.

AHS is also removing the prior authorization requirements for periodic prophylaxis to allow more than two cleanings per year without prior authorization when medically necessary. This prior authorization change applies to all Medicaid beneficiaries.

Pandemic-related eligibility increases resulted in a larger denominator for this measure in 2021 (for measurement year 2020). This, combined with reduced dental office availability, resulted in the decline in % of adults with a dental visit. The changes to the adult dental benefit along with dental offices being open more consistently in 2021 may have had a positive impact, as evidenced by the most recent data point in the graph above. Although the demoniminator (adult Medicaid members aged 21+) continued to increase, a slightly higher percentage of members had a dental visit.

Last updated: July 2022

PM Dental % of adults who received preventative service(s) during the measurement year



2021	15.4%	1
2020	12.6%	1
2019	16.0%	1
2018	16.0%	1
2017	15.9%	0

Notes on Methodology

Numerator – Adults aged 21 and older were included if they had a paid claim during the calendar year for any of the following procedures:

D1110 Prophylaxis – Adult Cleaning
D1206 Topical Fluoride Varnish
D1208 Topical Application of Fluoride

Denominator – Adults aged 21 and older with any eligibility segment during the calendar year which included Medicaid full benefit.

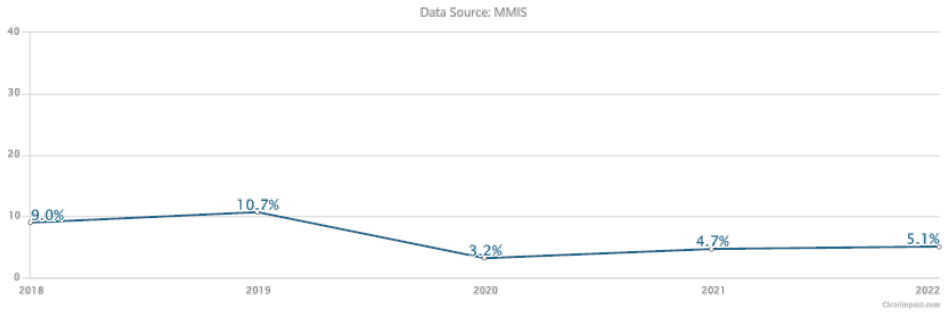
Story Behind the Curve

As a result of Act 72 passed during the 2019 legislative session, preventive service visits were removed from the annual cap on services effective January 1, 2020. Preventive visits do not require a copayment. Removing preventive visits from the annual cap encourages utilization of preventive services and allows adults up to $1,000 for diagnostic and treatment services.

During 2020, dental offices were closed for several months due to the COVID-19 public health emergency. These changes may have contributed to a decline in the number of adults receiving preventive services. In 2021, adult preventative visits returned to levels observed prior to the public health emergency.

Last updated: October 2022

PM Dental % of adults who meet their dental benefit cap



2022	5.1%	2
2021	4.7%	1
2020	3.2%	1
2019	10.7%	1
2018	9.0%	0

Notes on Methodology

The rates above represent the % of adult beneficiaries who met their dental benefit cap for that calendar year.

Numerator – Adults aged 21 and older with dental claims that reached the cap during the calendar year. In 2020 the cap was raised from $510 to $1,000 per calendar year.

Denominator – Adults aged 21 and older with any dental services during the calendar year.

Story Behind the Curve

In January of 2020, the adult annual cap on expenditures increased from $510-$1,000 per calendar year as a result of Act 72.

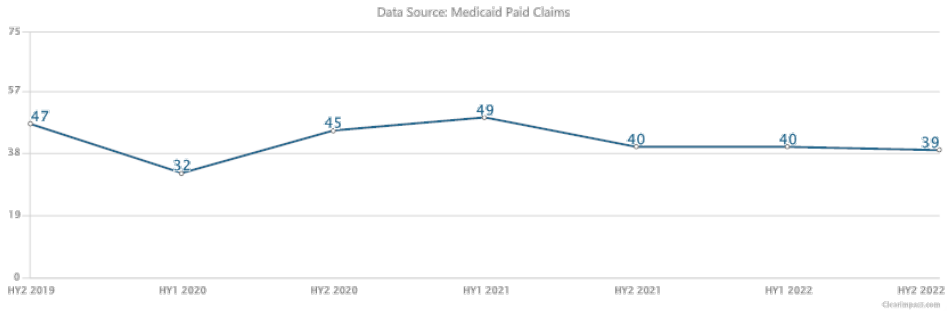
During 2020, dental offices were closed for several months due to the COVID-19 public health emergency. These changes led to a decline in the number of adults reaching the annual cap on expenditures.

Last updated: August 2021

Dental Payment Model Measures

P Dental Dental Payment Model

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



Most Recent Period	Current Actual Value	Current Trend
HY2 2022	39	1
HY1 2022	40	1
HY2 2021	40	1
HY1 2021	49	2
HY2 2020	45	1
HY1 2020	32	1
HY2 2019	47	1
HY1 2019	47	1
HY2 2018	45	1

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).

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

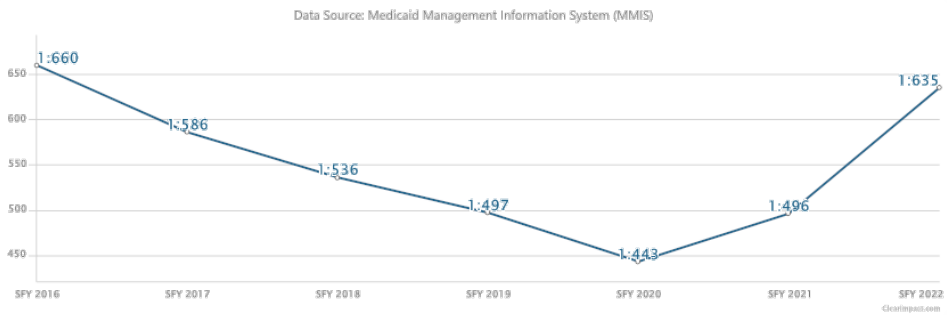
For SFY 2008 and beyond, the Vermont Legislature authorized DVHA to begin distributing $292,836 annually to support the program. The DVHA and the VSDS agreed that the funds would be distributed bi-annually; distributions of $146,418 are made in the spring and fall, for an annual total of $292,836. Each 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, 36-50 dentists have qualified for semi-annual payouts and a share of the $146,418 available.

The relatively low number of dental practices eligible for the dental incentive payment in HY1 (2020) reflects the fact that many dental practices closed between mid-March to early June in 2000 due to the pandemic. Fewer practices met the payout requirement. In HY2 (2020), practices returned to more normal activity. Practices eligible for incentive payment returned to within the historically normal range. Though Vermont is experiencing a significant loss of dentists, we are fortunate to continue to have a number of strong dental “border” supporters, particularly in New Hampshire. Of our 40 incentive qualifiers for HY2 2021, six are located in New Hampshire, close across the state border.

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.

PM DVHA # of VT Medicaid-enrolled dental providers relative to the total # of VT Medicaid beneficiaries



SFY 2022	1:635	2
SFY 2021	1:496	1
SFY 2020	1:443	4
SFY 2019	1:497	3
SFY 2018	1:536	2
SFY 2017	1:586	1
SFY 2016	1:660	1
SFY 2015	1:588	0

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.

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

CDD, Children's Integrated Services

CDD CIS

What We Do

The Child Development Division (CDD), 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 postpartum women and children birth to age six.

Who We Serve

CDD, 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.

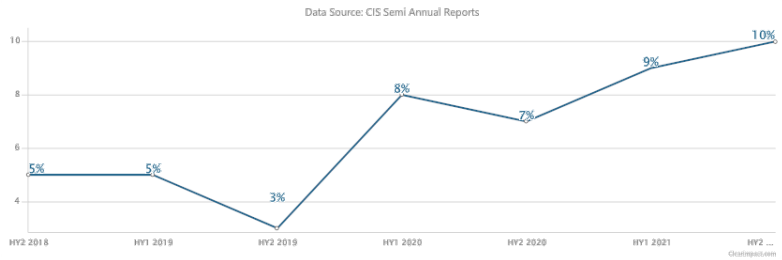
CIS Clients Lost to Follow Up: When a CIS client discontinues services without notice and does not respond to repeated attempts at contact, they are considered "lost to follow up." CIS teams attempt to decrease this outcome through strong family engagement and effective outreach, so a decrease in this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

Referrals Triaged by CIS Coordinator: A goal is to increase community awareness that CIS is a comprehensive source for early childhood services. Over time this performance measure has stayed between 78% - 83% of referrals made directly to the CIS coordinator, which indicates a high community awareness.

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 over the base in clients with completion of a One Plan within 45 Days is the target.

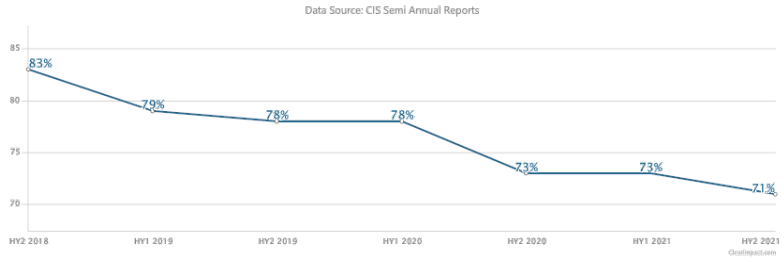
Measures

PM CDD % CIS Clients Lost to Follow Up



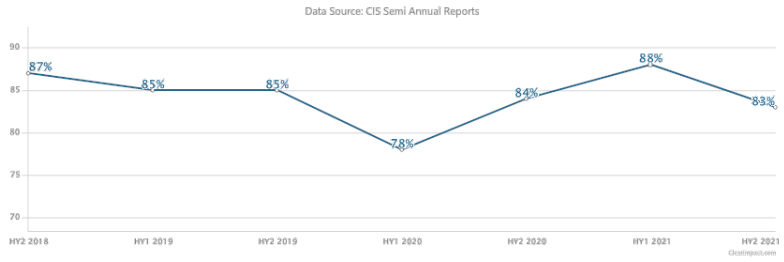
Most Recent	Current Actual	Current Target	Current Trend	Baseline % Change
HY2 2021	10%		2	11%
HY1 2021	9%		1	0%
HY2 2020	7%		1	-22%
HY1 2020	8%		1	-11%
HY2 2019	3%		1	-67%
HY1 2019	5%		1	-44%
HY2 2018	5%		1	-44%
HY1 2018	4%		2	-56%
HY2 2017	6%		1	-33%

PM CDD % of Referrals Triaged by CIS Coordinator



HY2 2021	71%	1	-8%
HY1 2021	73%	1	-5%
HY2 2020	73%	1	-5%
HY1 2020	78%	1	1%
HY2 2019	78%	2	1%
HY1 2019	79%	1	3%
HY2 2018	83%	1	8%
HY1 2018	83%	2	8%
HY2 2017	82%	1	6%

PM CDD % of Clients with One Plan Completed withing 45 days



HY2 2021	83%	1	-6%
HY1 2021	88%	2	0%
HY2 2020	84%	1	-5%
HY1 2020	78%	1	-11%
HY2 2019	85%	1	-3%
HY1 2019	85%	1	-3%
HY2 2018	87%	1	-1%
HY1 2018	85%	1	-3%
HY2 2017	85%	3	-3%

Actions

Name	Assigned To	Status	Due Date	Progress