State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 17
(1/1/2022 – 6/30/2022)

Quarterly Report for the period
January 1, 2022 – March 30, 2022

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Table of Contents

I. Background and Introduction

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

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

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

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

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

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

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

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

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

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

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 17, covering the period from January 1, 2022, through March 30, 2022 (QE032022).***

II. Outreach/Innovative Activities

i. Member and Provider Services

Key updates from QE032022:

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

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

Additionally, the unit works to coordinate benefit and collection practices with providers, members, and other insurance companies to ensure that Medicaid is the payer of last resort. The

unit is also responsible for Medicare Part D casework including claims processing assistance, coverage verification, and issue resolution. The MPS Unit works diligently to recover funds from third parties where Medicaid should not have been solely responsible. Those efforts include estate recovery, absent parent medical support recovery, casualty recovery, patient liability recovery, Medicare recovery, Medicare prescription recovery, special needs recovery, and trust recovery.

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

NEMT Update

In the first quarter of calendar year 2022, DVHA's non-emergency medical transportation contractor delivered a total of 72,599 rides to transportation-eligible VT Medicaid members. This represents a steady, measured increase over the same period last year, with roughly 16,000 more rides provided this year as the program continues to rebound from Covid-related low utilization. The number of program-related complaints dropped from the same period last year by 25%, even with the increase in rides and contact.

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 exits 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 billed primary Medicare.
- **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:

Coordination Recovery Activities "Q1"	
Casualty	$323,204.35
Estate	$163,510.52
Third-Party & Court Ordered Medical	$369,809.19
Medicare Prescription Drug Premium/Claims	$35,400.44
Over Resource/Hospice/Patient Share/Credit Balance	$231,465.52
Annuity/Trust/Waiver	$41,070.68
Medicare Claim Recoupment	$144,915.82
Third-Party Claim Recoupment	$181,997.83
Total	**$1,491,374.35**

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

Coordination of Benefit-Cost Avoidance Table:

Cost Avoidance "Q1"	
Third-Party Liability	$29,953,641.77
Medicare	$108,327,422.94
Total	**$138,281,064.71**

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

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

Phase one, Phase two, and Phase three of the project have been completed. Phase One established the technical connections between Globalscape and CMS, and file transmission testing was completed. All five files containing live data were successfully exchanged. Phase two completed the development, programming, and testing for the implementation of the Daily Buy-in file daily exchange. On February 1, 2022, the Daily Buy-In file exchange was successfully implemented. Phase three completed the design, system programming, development, and test of the

Daily MMA file. In compliance with CMS regulations, the Daily MMA file exchange was successfully implemented on April 1, 2022. In addition to the implementation of Daily Buy-In and MMA files, all reports or downstream impacts have been evaluated and updated to ensure operations continued and eligibility was not impacted.

III. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE032022:

- The Customer Support Center received more than 58,500 calls in QE0921. Call volume is down 9% in QE0921 as compared to QE0920.
- DVHA is currently supported by 108 Assisters (98 Certified Application Counselors, 7 Navigators, and 3 Brokers), with 5 Assisters in training, working in 53 organizations including hospitals, clinics, and community-based organizations.
- Increasing numbers of customers are using self-service functions, especially recurring payments. An average of 68% of customers made recurring payments in QE0921. This is a 3% growth from the prior year.

Enrollment

As of QE0322, more than 226,348 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 154,874 in Medicaid for Children and Adults (MCA) and 71,474 in Qualified Health Plans (QHPs), with the latter divided between 25,520 enrolled with VHC, 5,486 direct enrolled with their insurance carrier as individuals, and 40,468 enrolled with their small business employer.

Medicaid Renewals

For each month of the first quarter, and for the duration of the public health emergency, MCA redeterminations are processed only for cases that can be renewed ex parte. Cases that require an application have coverage extended; renewals will be rescheduled once the end date of the PHE is known.

The passive renewal success rate for the quarter averaged 37%. 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. 115,687 initial 1095B's were mailed to customers in advance of the deadline for tax year 2021. For tax year 2021, the federal deadline was March. 1095B corrections began in February and as of mid-April 2022, 772 corrections have been sent.

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 50,690 calls in QE0322. Maximus answered 77% of calls within 24 seconds in January 2022, 89% in February 2022, and 84% in March 2022. 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. 9% of QE0322 calls were transferred to DVHA-HAEEU staff, same as in QE0321. Just as importantly, DVHA strived to answer all calls that were transferred; 91% of transferred calls were answered in five minutes in QE0322, compared to 97% in QE0321

Timely Processing of Member Requests

In the spring of 2016, DVHA-HAEEU set a goal of completing 75% of member requests within ten business days by October 2016 and 85% by June 2017. In QE0316, fewer than 60% of VHC requests were completed within ten days. In QE0317, more than 90% of requests were completed within ten days. In QE0318 and again in QE0319, more than 95% of VHC requests were completed within ten days. QE0320 reached 96% and QE0321 was 91%. QE0322 was 97%.

System Performance

Throughout most of QE0322, 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 (1.4) in each of the three months – which is within the two-second target.

In-Person Assistance

As of April 5, 2022, DVHA is supported by 104 Assisters (94 Certified Application Counselors, 7 Navigators, and 3 Brokers), with 10 Assisters in training (whose application date is January 1, 2022, or later), working in 57 organizations including hospitals, clinics, and community-based organizations. Assister support is available in all of Vermont's 14 counties.
The program continues to run smoothly and is simultaneously undergoing pragmatic enhancements including, but not limited to, procedure documentation, policy review, Assister training enhancements, and process improvement.

Additionally, to ensure the quantity of Assisters remains strong, the program prioritizes recruitment activities.

Outreach

DVHA continued to use advisory meetings and other collaborative engagements with partners

and stakeholders to notify Vermonters about the continued timeline of the programmatic changes related to the COVID-19 pandemic. DVHA has specifically used social media to bring awareness to customers need to update their contact information in preparation for the public health emergency unwind efforts.

The Plan Comparison Tool, which helps customers estimate total costs of coverage based on family members' age, health, and income, was used in more than 15,639 sessions during the quarter, which is more than a 30% increase from QE0321.

Self-Service

During QE0322, DVHA-HAEEU continued to promote self-service options for customers to pay their bills, report changes, and access tax documents and other forms. Self-service leads to an improved customer experience as Vermonters can log in at their convenience. It also has the benefit of using automation to reduce staffing expenses. Year-over-year comparisons show that more customers are using self-service functions, including both online accounts for health coverage applications and reported changes as well as the options of paying premiums through monthly recurring payments rather than one-time payments. Self-serve applications comprised over half (57%) of all applications in QE0322.

Throughout QE0322, zero recurring payments were made per month. This is due to the Premium Processing change from WEX Health to the Issuers, effective 1/1/2022

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

Choices for Care Providers – In quarter 1, 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

Increase in Minimum Wage implemented: In January, DAIL implemented a new minimum wage for independent direct support providers according to the Collective Bargaining

The Initial Spending Plan Narrative was submitted in June 2021. During the reporting Q3 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. Written comments informed the mid-October quarterly update of the Initial Spending Plan. This is an extension of the initial due date for comments that were posted on June 18th. More information is available HERE

Adult Day 11 Adult Day service providers reported that they have reopened. Average enrollment is 44% of the pre-pandemic census. Providers 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 1, Adult Day providers continue to report challenges with staffing, including a lack of drivers to provide transportation to/from the Adult Day Centers

At the end of Q1, CFC enrollment included:

NH – 2187 participants

ERC – 559 participants

Home Based – 1784 participants

Moderate Needs – 1053 participants

Money Follows the Person (MFP)

The MFP grant has been re-authorized through (CY) 2024. The VT Department of Aging and Independent Living (DAIL) Adult Services Division has been awarded funds for CY2021 and CY2022 operations.

This award is funded to help transition fifty-three (53) Choices for Care participants from a SNF to a home-based setting. As part of the grant re-authorization, CMS has also relaxed the eligibility rules for the MFP program. A math model that we created for CMS projects that Vermont should be able to serve 50% more participants. We are currently negotiating for additional funds to cover the additional transitions. We expect to receive funding authorization for CY2022 to CY2024 as part of the CY2022 budget process.

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 by 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

CY2021 transitions = 64 participants and there are currently 17 participants in the process of transitioning.

CY2022 transitions – in the first quarter 15 individuals were transitioned with 19 additional individuals in the pre-transition category

Brain Injury Program: Current enrollment = 80 individuals, 12 individuals are in the process of enrolling. 12 New Applicants pending clinical assessment.

Wait Lists

- There is no wait list for the High Needs Group.
- There continues to be provider wait lists for Moderate Needs Group, estimated at almost 550 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)

Key updates from QE032022:

- We have successfully filled all vacant positions, including the DDSD Director position, which had been vacant since 6/22/2021.
- Coronavirus 19 Response
- Payment Reform Activities
- DDS State System of Care Plan Renewal

Coronavirus 19 Response Update:

The quarter ending 03/2022 saw an adjustment to our response to the coronavirus pandemic. Previously deployed DDSD transitioned back to their primary roles, with one team member remaining to attend to COVID-19-related duties, as necessary.

Continuing Conversion of Unused HCBS Funds for FY 2022 for Shared Living Providers and Unpaid Family Caregivers was extended to continue to provide an option to guard against health and safety risks and mitigate the workforce crisis the system faces. The need to continue this payment mechanism will be reviewed going forward but stakeholders have requested DDSD consider including an option to pay parents with DDS HCBS funds to provide support to their child as part of the System of Care renewal process.

Please see prior report submissions for previous highlights.

Payment and Delivery System Reform Update:

Work continues relative to the Payment and Delivery System Reform initiative. Providers have been submitting encounter data to the MMIS for several months. During this time, DAIL and DDSD staff have been providing training and technical assistance and much progress has been made in the past year (since March 2021) with reporting quality and compliance.

Although it is early still, DDSD can see many ways in which encounter data will be useful in the future and has been looking to our Senior Auditor and Program Consultant to partner around where this information will be helpful.

Additionally, PCG has begun scheduling and conducting the Supports Intensity Scale-Adult (SIS-A) assessment. PCG began conducting assessments in July 2021. The intention is to complete a sample of 500 assessments throughout the state. Once these assessments are complete, the results will be analyzed to determine if, and how, the SIS-A could be used as part of the payment reform design.

Please see prior report submissions for previous highlights.

DDS System of Care Plan Renewal

Every three years, the DDS State System of Care Plan must be renewed. The current SSOCP was in place from 2017-2020. Due to the Public Health Emergency and DDSD staff vacancies, DAIL/DDSD extended this Plan to focus staff attention on addressing those priorities. Because of the interaction between the DDS State System of Care Plan and the Regulations Implementing the Developmental Disabilities Act of 1996, the Regulations must be updated as the System of Care is. In the fall of 2021, DAIL/DDSD secured a long-time, recently retired staff to return in a temporary capacity to spearhead this project. This ensures that the proper processes are followed, the appropriate time is dedicated to this effort, and adequate training for current staff for Plan updates and renewals.

While the entire SSOCP is open for review, input and update, there are "areas of focus" that are highlighted as topics identified for special consideration based on stakeholder feedback. For this renewal cycle, DAIL/DDSD has identified three "areas of focus":

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

The Regulations Implementing the Developmental Disabilities Act of 1996 will be revised to:

- Clarify the definition of "young child" and align this with other programs within the Agency of Human Services,
- Update the eligibility section to reflect the 2019 Supreme Court decision that has the effect of expanding eligibility. and
- Remove the current grievance and appeals section and replace it with a reference to the Global Commitment to Health/HCAR section on grievance and appeals.

This information has been presented to the DDS State Program Standing Committee during the March 2022 meeting; the Committee has 30 days to provide written feedback.

DDSD is in the early stages of planning stakeholder input sessions regarding the "areas of focus," beginning with Housing Options/Alternatives.

iv. Global Commitment Register

Key updates from QE032022:

- 16 policies were posted to the GCR in QE032022.
- Since the Global Commitment Register (GCR) launched in November 2015, 319 final GCR policies have been publicly posted.

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

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

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

A public health emergency (PHE) was declared in March 2020 due to the COVID-19 pandemic. The PHE continues to impact the state budget and Medicaid operations, which is reflected in the number and type of policies being posted to the GCR. There were 5 proposed policies posted in QE0322. A total of 10 final policies were posted in QE0322. One policy clarification was posted to the GCR in QE0322. Changes included updates to rates and/or rate methodologies, clinical coverage changes, administrative rulemaking notices, and changes stemming from the public health emergency and the COVID-19 pandemic, including changes to vaccine coverage.

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

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

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

State	Vermont
Demonstration Name	Global Commitment to Health 1115 Demonstration
Approval Date	July 1, 2018
Approval Period	July 1, 2018 – December 31, 2021
SUD (or if broader demonstration, then SUD Related) Demonstration Goals andObjectives	1. Increased rates of identification initiation, and engagement in treatment; 2. Increase adherence to and retention in treatment; 3. Reductions in overdose deaths, particularly those due to opioids; 4. Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services; 5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and 6. Improved access to care for physical health conditions among beneficiaries.

Key updates for QE032022:

- VT Helplink received 268 calls and 1,775 website visits.
- 13 hospitals are participating in the Recovery Coaches in the Emergency Department Program.

Executive Summary

The State of Vermont continued to have all ASAM levels of care available and no ongoing waitlist to access to Medication Assisted Treatment. Treatment providers continued to provide telemedicine, where appropriate, while others adjusted daily census as needed to mitigate fluctuating risk from COVID-19 and continued social distancing, masking, and other strategies tocontinue serving patients requiring in-person services during the COVID-19 pandemic.

Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were effective January 1, 2020. ADAP met with the DVHA Payment Reform team and plans to explore the value-based

payment model for residential programs, to align with its All-Payer Model Agreement with CMS, as a part of larger discussions around the SUD system of care reform. ADAP has been meeting with residential treatment providers regarding COVID-19 pandemic-related issues and related impacts to services.

ADAP's centralized intake and resource center, "VT Helplink: Alcohol and Drug Support Center" was launched for public use in March 2020. From January 1 to March 31, 2022, VT Helplink received 268 calls and 1,775 website visits. During that time, web visitors searched for services online over 640 times. Major components of VT Helplink include 1) a call center staffed by certifiedScreening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self- screen tool, and 3) an appointment board to connect callers in need of treatmentwith appointments to ADAP's Preferred Provider Network. The Substance Misuse Prevention Oversight and Advisory Council (SMPC) was established within the Vermont Department of Health and encompass all substances of misuse including alcohol; cannabis; controlled substances such as opioids, cocaine, and methamphetamines; and tobacco products, tobacco substitutes, and substances containing nicotine. The SMPC met seven times as a full Council with each of the four subcommittees meeting an additional three times over the calendar year 2021. The SMPC has three goals of the SMPC are the following:

- Increase protective factors and build resilience and feelings of connectedness in Vermont communities, across all ages, cultures, and socioeconomic conditions.
- Decrease risk factors for substance use in Vermont for individuals of all ages, cultures, and socioeconomic conditions.
- Increase efficiency and collaboration on prevention efforts across all state, public, and private entities, through a consolidated and holistic approach to prevention that is sustainable, scalable, and equitable.

Information on the SMPC can be found here: www.healthvermont.gov/SMPC

During this last quarter, the SMPC focused its attention on the Vermont Legislative session to provide information or support to ensure prevention was a focus of all substance-related policy decision-making.

Vermont launched the Recovery Coaches in the Emergency Department Program on July 1, 2018. 13 Hospitals are participating in the program with the final hospital coming on board by July 1, 2022.

Assessment of Need and Qualification for SUD Services

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (ifany)	Summary
Metric Trends			
Discuss any relevant trends that the data shows related to the assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.	DY2 Q2	Medicaid Beneficiaries with SUD Diagnosis (monthly) Medicaid Beneficiaries with SUD Diagnosis (annually) Medicaid Beneficiaries Treated in an IMD for SUD	Vermont experienced a decrease in the number of Medicaid beneficiaries identified with SUDdiagnoses leading to decreases inpeople receiving SUD services other than medication-assisted treatment for opioid use disorder.These changes in the provision of treatment coincide with the COVID-19 pandemic which first peaked in Vermont in April and then again in November/December 2020. People were not seeking care across the healthcare system during the pandemic, which would account for the decrease and ongoing concerns about COVID and the variants have continued to impact people seeking healthcare services. ADAP has worked with VT Helplink and SUD treatment providers to market and educate Vermonters that treatment services are available, and it is safe to seek treatment.
[Add rows as needed]			
The state has no metrics trends to report for this reporting topic.			
Implementation Update			
			There are no planned changes.

Compared to the demonstration design details outlined in the STCs and implementation plan, have there been any changes or does the state expect to make any changes to: A) the target population(s) of the demonstration ? B) the clinical criteria (e.g., SUD diagnoses) that qualify a beneficiary for the demonstration ?			

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any	Summary
Milestone 1 Metric Trends			

Discuss any relevant trend that the data shows related to the assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.	DY2 Q2	6 Any SUD Treatment	Vermont experienced a decrease in people receiving SUD treatment. People were not seeking care across the healthcare system during the pandemic, which would account for the decrease. ADAP has worked with VT Helplink and SUD treatment providers to market and educate Vermonters that treatment services are available, and it is safe to seek treatment. However, it is likely that ongoing concerns about the pandemic and the COVID variants continue to impact peoples' comfort in seeking out healthcare services.
		7 Early Intervention	Services coded as early intervention has been consistently low (averaging one beneficiary per month) as most intervention services in Vermont are provided through other mechanisms or funding.
		8 Outpatient Service	Outpatient services decreased due to COVID and peoples' concerns about seeking healthcare services. Providers ramped up capacity to provide services through telemedicine while the stay-at-home order was in place and are currently able to provide services through telemedicine and in-person, giving more options to those seeking services.

			Telemedicine services have
			been impacted by a lack of access to adequate internet services in some rural areas as well the cost/data limits.
		9 Intensive Outpatient and Partial Hospitalization Services	IOP services remain low due to the difficulty of providing group-based services during The pandemic. Some services are being provided via telemedicine. Telemedicine services are impacted by the rural nature of the state, lack of adequate internet in some areas as well as the impact of limited data/usage for some individuals.
		10 Residential and Inpatient Services	One residential treatment provider experienced a COVID-19 outbreak among clients and had to hold admissions while the provider and Health Department
			staff worked to contain the outbreak through isolation and quarantine protocols. The provider was successful in containing the outbreak to a small number of individuals and admissions were able to resume. Residential providers have continued to experience a reduction in available capacity due to COVID-19 safety precautions to reduce the potential for outbreaks in

			their facilities. Additionally, challenges with ensuring all clients are tested for COVID-19 immediately prior to admission or are able to access a single, isolation room has impacted
			pacing of admissions.
		11 Withdrawal Management	This has been trending downward with some month-to- month variation
		12 Medication Assisted Treatment	The number of beneficiaries receiving MAT has continued to increase quarter by quarter.
		36 Average Length of Stay in IMDs	2020 data not yet available
[Add rows as needed]			

The state has no metrics trends to report for this reporting topic.
Milestone 1 Implementation Update
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to: a. Planned activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries (e.g. outpatient services, intensive outpatient services, medication-assisted treatment, services in intensive residential and inpatient settings, medically supervised withdrawal management)? SUD benefit coverage under the Medicaid state plan or the Expenditure Authority, particularly for residential treatment, medically supervised withdrawal management, and medication-assisted treatment services provided to individuals in IMDs?
Summary: There are no planned changes to access SUD treatment or the SUD benefit coverage.

Are there any other anticipated program changes that may impact metrics related to access to critical levels of care for OUD and other SUDs? If so, please			There is no anticipated program

describe these changes.			
☒ The state has no implementation update to report for this reporting topic.			

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 2 Metric Trends			
☒ The state is not reporting any metrics related to this reporting topic.			
Milestone 2 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes, or does the state expect to make any changes to: Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria? Implementation of a utilization management approach to ensure: Beneficiaries have access to SUD services at the appropriate level of care. Interventions are appropriate for the diagnosis and level of care? Use of independent process for reviewing placement in residential treatment settings? **Summary:** The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 33 substance use disorder treatment provider locations. The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool were effective January 1, 2020. Due to the COVID pandemic, provider site reviews were put on hold until July 2021 when they resumed in a virtual environment. ADAP has completed five remote site visits utilizing the tool this quarter.			

Milestone 2 - Table 1

	Action	Revised Completion Date	Responsible	Status	
	Finalize Substance Use Disorder Treatment Standards	August 1, 2018	Director of Quality Management and Compliance	Completed	
	Update Compliance	August 15, 2018	Director of Quality	Completed	

Assessment Tool with revised Substance Use Disorder Treatment Standards and all residential ASAM criteria		Management and Compliance	
Updated online	October 31, 2018	Director of Quality	Completed
recertification survey		Management and	
to reflect a new revision		Compliance	
of Substance Use			
Disorder Treatment Standards			
Use the Compliance	December 31, 2018	Director of Clinical	Completed
Assessment Tool to		Services; Director of	
certify ASAM Level 3.5 Level of Care provider (Valley Vista Vergennes)		Quality Management and Compliance	
Use the Compliance	December 31, 2018	Director of Clinical	Completed
Assessment Tool to		Services; Director of	
certify ASAM Level		Quality Management	
3.5 Level of Care provider (Valley Vista Bradford)		and Compliance	
Implement the Compliance Assessment Tool	October 3, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed

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

ADAP has met with the DVHA Payment Reform team regarding plans to develop a value-based payment model for residential programs to align with its All-Payer Model Agreement with CMS. The value-based payment component of the residential payment model is still in consideration for inclusion in the larger system reform.

Milestone 2 – Table 2

Action	**Date**	**Responsible**
Develop the criteria for the differential case rate	Completed	ADAP Director of Clinical Services
Model the methodology using the identified criteria for the Vermont team to review	Completed	Payment Reform Team
Work with financial colleagues to finalize budget and rate decisions forthe model	Completed	Payment Reform Team, ADAP Director of Clinical Services, VDH Business Office
Residential providers to provide feedback	Completed	ADAP Director of Clinical Services
Work with the Medicaid fiscal agent to identify and complete the necessary system changes required for the Medicaid billing system	Completed	ADAP Director of Clinical Services, Payment Reform Team, DXC (Fiscal Agent)

Work with the residential providers to provide technical assistance and education around the necessary billing changes	Completed	ADAP Clinical Team	
Regional Managers will partner with the compliance and quality team to determine the appropriate frequency with which the Regional Managers will perform the between audit chart reviews	Completed	ADAP Clinical Team and ADAP Quality Team	
Are there any other anticipated program changes that may impact metrics related to the use of evidence-based, SUD-specific patient placement criteria (if the state is reporting such metrics)? If so, please describe these changes.			
The state has no implementation update to report for this reporting topic.			

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 3 Metric Trends			
☒ The state is not reporting any metrics related to this reporting topic.			
Milestone 3 Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined in the implementation plan, have there been any changes, or does the state expect to make any changes to: **Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards?** **The state review process for residential treatment providers' compliance with qualifications standards?**			

Availability of medication-assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off-site? **Summary:** The current version of the Substance Use Disorder Treatment Standards is beingused. The Compliance Assessment Tool has been utilized with 33 substance use disorder treatment provider locations. The Substance Use Disorder Treatment Standards and corresponding compliance assessment tool was effective January 1, 2020. Due to the COVID pandemic, provider site reviews were put on hold until July 2021 when they resumed in a virtual environment. ADAP has completed five remote site visits utilizing the tool thisquarter.			
Are there any other anticipated program changes that may impact metrics related to the use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities (if the state is reporting such metrics)? If so, please describe these changes.			
the state has no implementation update to report for this reporting topic.			

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

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

Prompts	**Demonstration Year (DY) and quarter first reported**	**Related metric(if any)**	**Summary**
Milestone 4 Metric Trends			

Discuss any relevant trends that the data shows related to the assessment of need and qualification for SUD services. At a minimum, changes (+or -) greater than two percent should be described.		SUD Provider Availability SUD Provider Availability – MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services, including those who meet the standards to provide buprenorphine/methadone as part of MAT, has increased.
[Add rows as needed]			

☒ The state has no metrics trends to report for this reporting topic.

Milestone 4 Implementation Update

Prompts: Compared to the demonstration design and operational details outlined in the implementation plan, have there been any changes, or does the state expect to make anychanges to planned activities to assess the availability of providers enrolled in Medicaidand accepting new patients in across the continuum of SUD care?

Summary:
ADAP met with the DVHA Payment Reform team regarding the value-based payment model for residential programs to align with its All-Payer Model Agreement with CMS. Vermont anticipates resuming work on the model as a part of thework around the entire system of care throughout the fall/winter of 2022.

ADAP's centralized intake and resource center "VT Helplink: Alcohol and Drug Support Center" was launched for public use in March 2020. From January 1 to March 31, 2022, VT Helplink received 268 calls and 1,775 website visits. During that time, web visitors searched for services online over 640 times. Major components of VT Helplink include 1) a call center staffed by certified Screening & Intake Specialists and licensed clinicians, 2) a website with information related to SUD and a self- screen tool, and 3) an appointment board to connect callers in need of treatment with appointments to ADAP's Preferred Provider Network.

Are there any other anticipated program changes that may impact metrics relatedto provider capacity at critical levels of care, including for medication-assisted treatment (MAT) for OUD? If so, please describe these			

changes.			

The state has no implementation update to report for this reporting topic.

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

This reporting topic focuses on the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD to assess the state's progress towards meeting Milestone5.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (ifany)	Summary
Milestone 5 Metric Trends			
Discuss any relevant trends that the data shows related to the assessment of needand qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.		15 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment 18 Use of Opioids at High Dosage in Persons Without Cancer 21 Concurrent Use of Opioids	The percentage of adults in continuous pharmacotherapy for OUD has decreased which may be an unintended consequence of Vermont's robust access to MAT. Individuals who may be ambivalent about treatment may be less concerned about leaving treatment since they know there will be no wait to get back in; also, there are several cash-only and other Spoke options available which may lead to more movement in and out of treatment.
		Benzodiazepines 22 Continuity of Pharmacotherapy for Opioid Use Disorder	
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			

Milestone 5 Implementation Update

Prompts: Compared to the demonstration design and operational details outlined in theimplementation plan, have there been any changes, or does the state expect to make any changes to: Implementation of opioid prescribing guidelines and other interventions related to the prevention of OUD? Expansion of coverage for and access to naloxone? **Summary**: There are no planned changes to the prescribing guidelines and other interventions.			
Are there any other anticipated program changes that may impact metrics related to the implementation of comprehensive treatment and prevention strategies toaddress opioid abuse and OUD? If so, please describe these changes.			
☒ The state has no implementation update to report for this reporting topic.			

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 6 Metric Trends			
Discuss any relevant		17 Follow-Up	Recovery Coaches are dispatched to 13

trends that the data		After Emergency	emergency departments to support
shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.		Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	individuals who present with a SUD at the ED including providing linkages to follow-up visits upon discharge.

☒ The state has no metrics trends to report for this reporting topic.

Milestone 6 Implementation Update

Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community- based services and supports?

Summary:
Vermont launched the Recovery Coaches in the Emergency Department Program on July 1, 2018. 13 hospitals are participating in the program. Virtual recovery services have been implemented.

Are there any other anticipated program changes that may impact metrics related to care coordination and transitions between levels of care? If so, please describe			

The state has no implementation update to report for this reporting topic.

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) Greater than two percent should be described.		Q1 PDMP Users/ Checks Q2 PDMP Linkages	
		Q3 HIT/HIE Plan	
[Add rows as needed]			
☒ The state has no metrics trends to report for this reporting topic.			
Implementation Update			
Prompts: Compared to the demonstration design and operational details outlined in STCs and implementation plan, have there been any changes or does the state expect to make any changes to: How health IT is being used to slow down the rate of growth of individuals identified with SUD? How health IT is being used to treat effectively individuals identified with SUD? How health IT is being used to effectively monitor "recovery" supports and services for individuals identified with SUD?			

Other aspects of the state's plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels?
Other aspects of the state's health IT implementation milestones?
The timeline for achieving health IT implementation milestones.
Planned activities to increase use and functionality of the state's prescription drugmonitoring program?

Summary:

As of May 2021, Vermont has connected to both the RxCheck and PMPi hubs for interstate data sharing. RxCheck is developing functionality for direct integration with EHRs and other health systems, and PMPi employs the Gateway product for health system integrations.

VPMS, Dr. First, and Bamboo Health (formerly Appriss) are in the process of testing and verifying the Gateway integration tool to enable a direct population of VPMS datainto Dr. First's prescription ordering section, eliminating the need for providers to navigate between systems. However, the deployment of VPMS staff for COVID-19 response has delayed the start of this initiative.

VPMS currently is integrated through Gateway with the Veteran's Affairs health system as required by the Mission Act. This allows VA providers to query the prescription history of their Vermont patients, regardless of if they have a Vermont license. Previously, VA providers were not allowed direct access to the prescription monitoring program without a VT license. As VA providers are not required to have a license within the state that they are working, this created a gap for those providers working in, but not licensed in, Vermont.

VPMS staff are engaged with the NESCSO State HIT Learning Community. This groupworks to create a shared understanding of Federal legislation, the current state of PDMP activities, and identifies opportunities for multi-state alignment.

Vermont continues to offer prescriber reports on a quarterly basis. These reports provide in-depth snapshots of prescriptions dispensed from those prescribers of opioids, sedatives, benzodiazepines and stimulants.

In March 2022, VPMS resumed its regular prescriber compliance after pausing it during the COVID response. Prescribers who had prescribed within a quarter and did not have an active account were notified of the requirement to re-activate or register for a PDMP account. This resulted in large number of new prescribers and prescribers updating their account information.

Are there any other anticipated program changes that may impactmetrics related to SUD Health IT(if the state is reporting such metrics)? If so, please describe these changes.			
The state has no implementation update to report for this reporting topic.			

Other SUD-Related Metrics

Prompts	DemonstrationYear (DY) and quarter first reported	Related metric (ifany)	Summary
9.2 Other SUD-Related Metrics			
9.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and		Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries Inpatient stays for SUD per 1,000 Medicaid beneficiaries.	Overdose deaths are variable. Vermont has seen a significant increase in fentanyl involvement in opioid overdose fatalities. Fentanyl is 50-100 times stronger than heroin and the amount in the drug supply often isn't known to users until it is used. Fentanyl is currently the most prevalent substance involved in opioid-related deaths)
qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be			

described.		Beneficiaries Readmissions Among Beneficiaries with SUD Overdose Deaths (count) Overdose Deaths (rate) 32 Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD	of opioid-related fatalities has increased each year since 2011 (9%). Of note, deaths involving fentanyl can include prescription and/or illicit fentanyl and fentanyl analogs. Vermont has been working to decrease drug overdoses and in 2020, published a social autopsy showing places where individuals who died of a drug overdose interacted with a variety of Vermont programs. Fatal overdoses have increased in 2020 after a decrease in 2019. This is likely due to the stress, social isolation, and disruptions in services and drug supply associated with COVID-19. Community support systems such as recovery groups were moved to a remote format, a method not accessible or accepted by everyone accessing these services. COVID-related social isolation may have resulted in more people using alone and

[Add rows as needed]			anecdotal information suggests that the stimulant payments allowed for larger drug purchases. Medication-assisted treatment provision increased in 2020 but residential and intensive outpatient care was less available due to the group nature of these services, and outpatient care was provided remotely. Provision of harm reduction services, which includes information about safer use and referrals to treatment as well as distribution of naloxone and clean syringes were less able to be provided in- person. There was a 40% reduction in people visiting sites where naloxone is distributed and a 24% decrease in naloxone kits distributed in the first six month of 2020 compared to first six months of 2019.
☒ The state has no metrics trends to report for this reporting topic.			
9.2.2 Implementation Update			

Are there any other anticipated program changes that may impact the other SUD-related metrics? If so, please describe these changes.			As a result of COVID-19, the Vermont Department of Health Division of Alcohol and Drug Abuse (ADAP) is taking the following actions to address the increase in drug overdoses. Naloxone – The Department continues to provide naloxone and training through collaborations with community-based organizations, including getting naloxone to the motels where the state is housing people experiencing homelessness. VT Helplink is a free and confidential referral service available to connect people to resources and treatment (802-565- LINK or VTHelplink.org) Recovery Centers are conducting outreach to reduce relapse and prevent overdoses (e.g. Harm Reduction Pack distribution, peer support specialists, Recovery Coaching referrals, etc.) Providers are increasing outreach to patients and are continually re-evaluating patients' stability to triage for in-person supports, decreased take-homes, etc. ADAP has regular calls with Preferred Providers. The clinical team at ADAP receives critical incidents of overdoses from the preferred providers for people currently in treatment. Overdoses were reported by providers to include people in longer-term recovery and people who had left treatment before COVID. The Department is working with partners to continue to disseminate key harm reduction messaging on the increased risks

			associated with overdose and using alone.
The state has no implementation updates to report for this reporting topic.			

Budget Neutrality

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
10.2 Budget Neutrality			
10.2.1 Current status and analysis			

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

SUD-Related Demonstration Operations and Policy

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

Highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration's approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for moredetail.			
[Add rows as needed]			
☒ The state has no related considerations to report for this reporting topic.			
11.1.2 Implementation Update			
Compared to the demonstration design and operational details outlined in STCs and the implementation plan, have there been any changes or does the state expect to make any changes to: a. How the delivery system operates under the			
demonstration (e.g., through the managed care system or fee for service)? Delivery models affecting demonstration participants (e.g., Accountable Care Organizations, Patient Centered Medical Homes)? Partners involved in service delivery?			

Has the state experienced any significant challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers)? Has the state noted any performance issues with contracted entities?			
What other initiatives is the state working on related to SUD or OUD? How do these initiatives relate to the SUD demonstration? How are they similar to or different from the SUD demonstration?			
☒ The state has no implementation updates to report for this reporting topic.			

SUD Demonstration Evaluation Update

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

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

Other Demonstration Reporting

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
13.1 Other Demonstration Reporting			
13.1.1 General Reporting Requirements			
Have there been any changes in the state's implementation of the			
demonstration that might necessitate a change to approved STCs, implementation plan, or monitoring protocol?			

Does the state foresee the need to make future changes to the STCs, implementation plan, or monitoring protocol, based on expected or upcoming implementation? changes?			
Compared to the details outlined in the STCs and the monitoring protocol, has the state formally requested any changes or does the state expect to formally request any changes to: The schedule for completing and submitting monitoring reports? The content or completeness of submitted reports? Future reports?			Updates on the Monitoring Protocol work, deliverables, and timeline can be found in Section X. Compliance of this report.
Has the state identified any real or anticipated issues submitting timely post-approval demonstration deliverables, including plan for remediation?			
[Add rows as needed]			
☒ The state has no updates on general reporting requirements to report for this reporting topic.			
13.1.2 Post Award Public Forum			
If applicable within the timing of the demonstration, provide summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action			

items or issues. A summary of the post-			
award public forum must be included here for the period during which the forum was held and in the annual report.			
[Add rows as needed]			
☒ There was not a post-award public forum held during this reporting period and this is not an annual report, so the state has no post award public forum update to report for this reporting topic.			

Notable State Achievements and/or Innovations

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
14.1 Notable State Achievements and/or Innovations			
14.1 Narrative Information			

Provide any relevant summary of achievements and/or innovations in demonstration enrollment, benefits, operations, and policies pursuant to the hypotheses of the SUD (or if broader demonstration, then SUD related) demonstration or that served to provide better care for individuals, better health for populations, and/or reduce per capita cost. Achievements should focus on significant impacts to beneficiary outcomes. Whenever possible, the summary should describe the achievement or innovation in quantifiable terms, e.g., number of impacted beneficiaries.			
[Add rows as needed]			
☒ The state has no notable achievements or innovations to report for this reporting topic.			

IV. Expenditure Containment Initiatives

i. Vermont Chronic Care Initiative (VCCI)

Key updates from QE032022:

Resume in person visits

- VCCI Utilization
- New to Medicaid Screening Data
- Collaboration with DVHA and ACOs on Performance Improvement
- Workforce challenges

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 about other needs that would assist them in maintaining +/or improving their health such as housing, food, and safety. The VCCI team works to connect members with medical homes, community-based self-management programs, and local care management teams and assist a member in navigating the system of health and health-related care.

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In the first quarter of 2022, VCCI has focused on updating in-person visit guidance to ensure safe visiting during the pandemic for both staff and members. Prioritization criteria were established so the most vulnerable members resumed home visits first. Most members request multi-modal interventions. Most prefer a hybrid model with some home visits mixed in with virtual or telephonic visits. The percent of visits that are home-based have been slowly yet steadily increasing during the first quarter. The percentages of visits seem to correlate with the prevalence of COVID in communities at the time. Many members deny home visits during COVID due to fear of transmission.

VCCI field-based case managers continued to serve beneficiaries throughout the quarter and continued to meet in person with those most at risk while using virtual and telephonic platforms for those with more stable conditions and status. As seen below, VCCI provided care management services to 379 unique individuals in Q12022 The length of time and regularity of visits are dependent on the complexity and severity of the needs of the beneficiaries. VCCI case managers work with beneficiaries until the goals of their care plans are met.

(See **Figure 1).**

Figure 1. Beneficiary Enrollment and Face To Face Visits

	Jan-22	Feb-22	Mar-22
Measure	2/15/2022	3/15/2022	4/15/2022
# new VCCI eligible members enrolled monthly in care management	33	33	46
Total Open Cases (including newly enrolled - above)	276	280	273
% of VCCI enrolled members with a face to face visit during the month	17.03%	17.86%	25.64%

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 began to ebb in the Spring of 2021, from what is thought to be higher numbers in mid-2020 due to pandemic-related changes in circumstances for individuals. (**Figure 2).** Timely access to some services desired by beneficiaries continued to present as a challenge this past quarter. Wait times for the establishment of primary care are longer in many areas of the state. -

Figure 2. Number of New to Medicaid Beneficiaries Screened January 1 – March 30, 2022

# New to Medicaid members	**464**

# of those members reached	**153**
# of new members screened	**171**

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

% of New to Medicaid members who accepted help with PCP establishment and who successfully established care with practice/medical home	
Measure	4/15/2022
# of "New to Medicaid" members who already had a PCP they saw regularly (of those screened)	483
# who didn't have a PCP and declined help	13
# who didn't have a PCP and accepted help	155
# of members who successfully established care	8
% of members who successfully established care	5.16%

VCCI has collaborated with DVHA and OneCare VT on their Performance Improvement Project on managing hypertension. The project goals are to make blood pressure cuffs accessible and affordable, encourage educational workshops, and increase awareness among providers about the value of ongoing measurement and documentation of one BP readings. VCCI nurses have taken an active role in educating pharmacies on how to bill the proper Medicaid codes for the BP cuffs and encouraging local pharmacies to stock BP cuffs so members have access to this valuable device for monitoring and tracking hypertension.

VCCI continues to face workforce challenges. Over the past quarter, three staff have transitioned either into new jobs or into retirement. VCCI has six RN case manager vacancies and one Outreach Coordinator position. The program is actively recruiting and is focused on identifying retention strategies for current program staff.

. **Goals CY 2022**:

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

ii. Blueprint for Health

Key updates from QE 032022:

- The majority of Vermont's primary care practices are now Blueprint-participating Patient-Centered Medical Homes, as 135 of Vermont's estimated 169 primary care practices are Blueprint-participating practices (and an estimated 148 employ more than one provider).
- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid-use disorder. As of 2021-Q4, the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs increased to 3,930.
- Vermont Continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 46 practices and all 12 Planned Parenthood sites to participate in the Women's Health Initiative as of March 2022?

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

The Blueprint uses national standards to drive improvements in primary care delivery and payment. The program helps primary care providers transform their practices into National Committee for Quality Assurance (NCQA)-certified Patient-Centered Medical Homes. Vermont's Patient-centered Medical Home (PCMH) model supports care for all patients that are patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety, regardless of insurance type. The model is based on the National Committee for Quality Assurance (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 in each of the state's health service areas. These teams provide supplemental services that allow Blueprint-participating primary care practices to focus on promoting prevention, wellness, and coordinated care.

PCMHs in Vermont are supported by Community Health Teams (CHTs)**,** which are multi-disciplinary teams of dedicated health professionals in each of the state's HSAs. The 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. 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.
Program Managers set up the systems through which integrated services can be delivered in the community.

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

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

Q1Highlights

Community Health team members and QI facilitators within the Patient-Centered Medical Homes, specialty practices, and Spokes continue to be flexible in our ever-changing health care landscape to quickly provide continuity of care during our ongoing pandemic response. Some communities have engaged in their Community Health Needs Assessment which engages community partners in understanding the needs of their community. This also helps inform shared goals across the community for the coming years. The Community Health Teams continue to reach out to the patients who have missed annual wellness visits. On these calls, they would also inquire about other social determinants of health, such as access to food, medication, and other factors that could impact health and well-being for whole person

health. While in-person visits have increased substantially telehealth continues to be an option for primary care appointments and screenings Our QI facilitators also continued to ensure our PCMH were meeting all the criteria for NCQA and maintaining their PCMH accreditation.

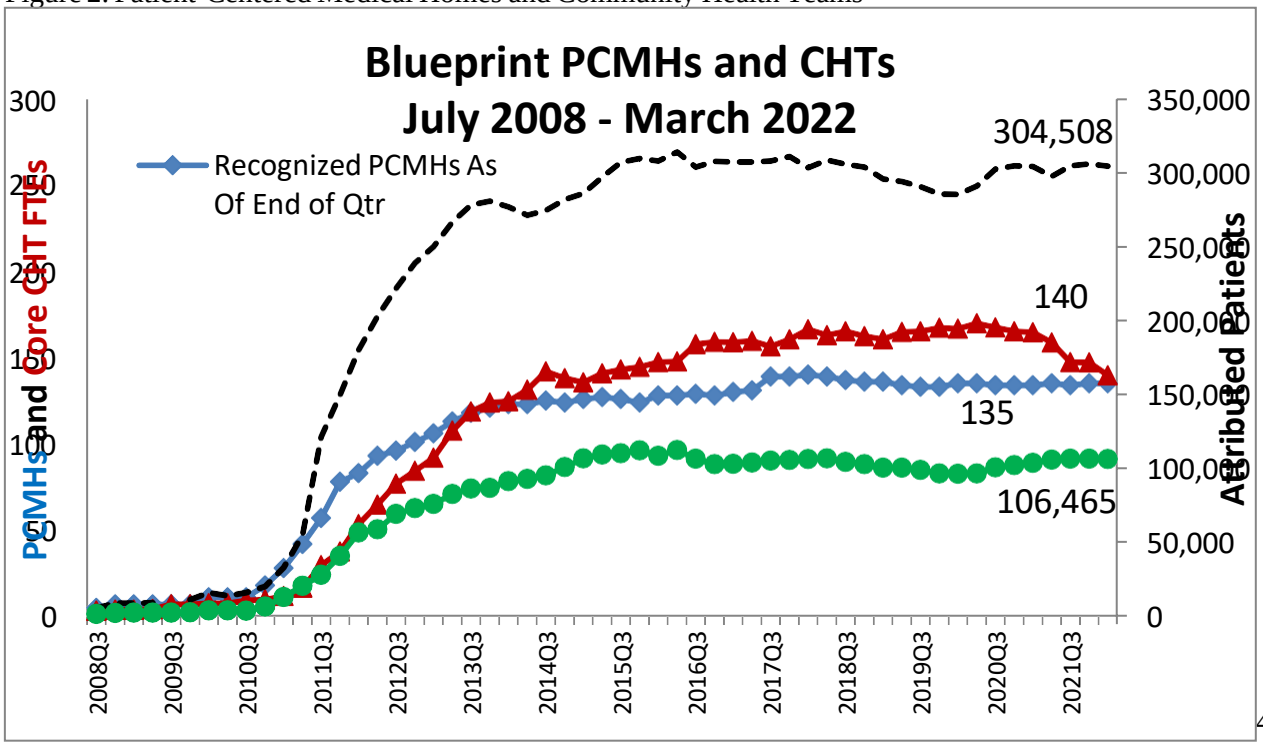
Q1 Covid

The Blueprint network focused on adaptability, resilience, patience, and continued persistence. Blueprint staff and partners have used the lessons learned to further meet the needs of their communities in what has become our 'new normal'.
Incorporating telehealth as appropriate, routinely keeping patients and staff physically and emotionally safe with new protocols, facilitating vaccine distribution, and attending to Vermonters' growing mental health needs were commonplace across the state. We have seen an increase in response within primary care offices for testing, vaccines, and overall care for patients with Covid. As always, Vermonters come together when there is a need.

Blueprint-participating Patient-Centered Medical Homes currently serve 304508 insurer-attributed patients, of which 106,465 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 140 full-time equivalents of Community Health Team staff.

In Quarter 1 (January – March 2022), 135 Vermont practices were operating as Patient-Centered Medical Homes, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of practices participating in the Blueprint for Health program is a key performance measure; the Blueprint estimates that there are about 169 total primary care practices operating in the state.

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



Community Health Profiles

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

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

The Blueprint Annual Report to the Vermont Legislature reviews more in-depth how the Program Managers, Quality Improvement Facilitators, Patient-Centered Medical Homes, 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, and 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.

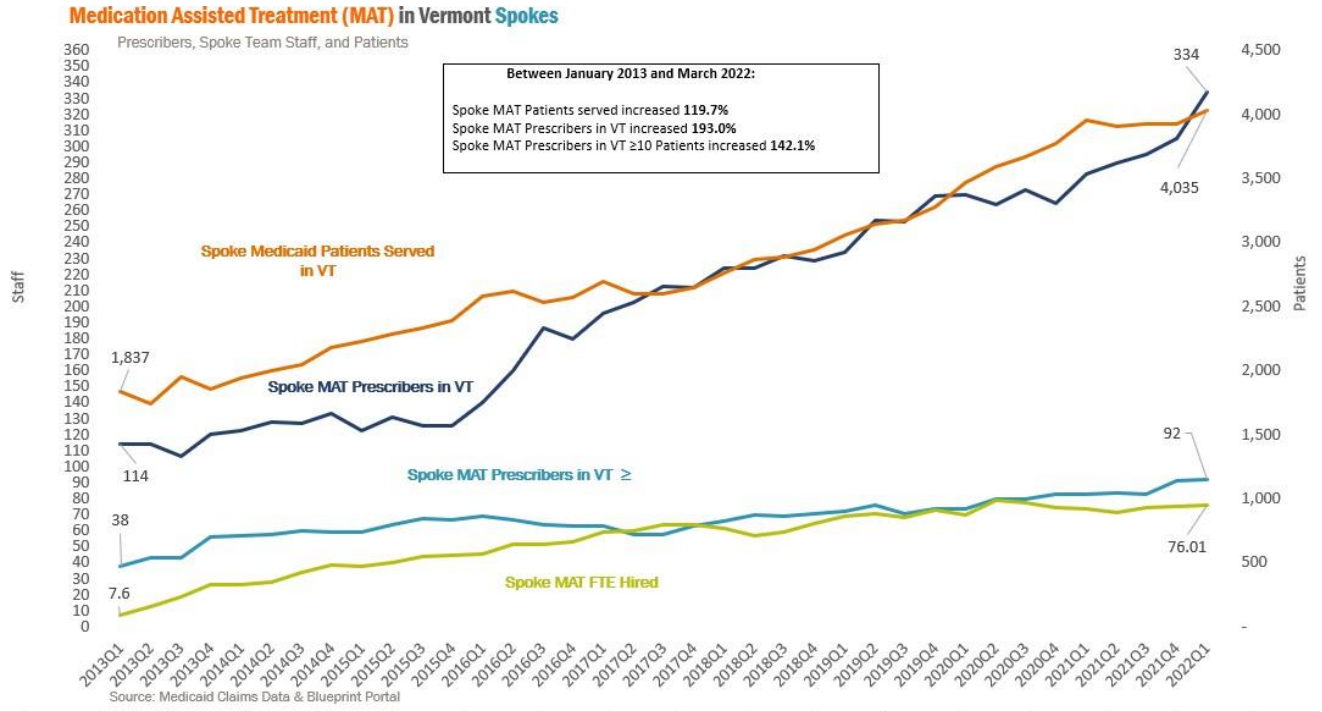
Q1 Highlights

The Blueprint, in partnership with the Division of Alcohol and Drug Abuse Programs (Department of Health), in conjunction with a contract with Dartmouth college 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.

Vermont continues to demonstrate substantial access to medication-assisted treatment for Vermonters with opioid use disorder. Medication-assisted treatment is being offered across the State of Vermont by more than 75 different Spoke settings as of March 2022.) The capacity to serve Vermonters continued to increase, as evidenced by a monthly average of 4035 Medicaid beneficiaries were served by Office-Based Opioid Treatment (OBOT/Spoke) programs.)There are 334 medical doctors, nurse practitioners, and physician assistants who work with 76.00 FTE licensed, registered nurses, and licensed, Master's-prepared, mental health/substance use disorder clinicians as a team to offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder (as of full-time equivalent Spoke staff working as teams.

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

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



Women's Health Initiative

The Women's Health Initiative (WHI) began as a state initiative to support pregnancy intention.

The Women's Health Initiative (WHI) strives to support any persons who can become

pregnant in their efforts to experience healthy pregnancies, avoid unintended pregnancies, and build thriving families. The WHI provides increased mental health and social service staffing at specialty practices and utilizes the existing CHT at Blueprint PCMH practices. If a patient identifies as at-risk, they have immediate access to a WHI mental health clinician for brief interventions, counseling, and navigation to community-based services and treatment as needed.

The Blueprint partners with participating women's specialty providers and PCMH primary care practices to support patients of child-bearing age WHI providers engage with patients at the new patient and annual visits to screen for mental health needs, substance use, and SDOH. They ask about pregnancy intention for the coming year using the One Key Question®, which asks if, when, and under what circumstances a woman would like to become pregnant. Women with a desire to become pregnant receive services to support a healthy pregnancy. If the woman would like to prevent pregnancy, providers conduct comprehensive family planning counseling and provide patients with options for most and moderately effective contraception, which could include access to same-day long-acting reversible contraceptives (LARC) if clinically indicated.

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

Q1 2022 Highlights

WHI practices can access the program's central WHI Quality Improvement (QI) Facilitator to ensure the goals of the program are being met. In 2022, the QI Facilitator and WHI Program Lead met regularly with representatives from all WHI practices to identify process improvement opportunities, ensure the program elements are in place and support improved patient experience of care.

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

Practices are working hard to engage community partners in referral agreements. These agreements enhance relationships and pathways to care. We have presented a WHI data dashboard to the field in our monthly call every quarter. We received feedback on what would be useful data for the field from claims and will continue to support the field with this information. We have received feedback on being more inclusive in the name of our program and we will assess this in future quarters. The field has asked to be more inclusive of pregnant persons and increase asking all Vermonters about pregnancy intention with partners.

Figure 3 below shows WHI enrollment and staffing over time. In 2021, the number of PCMHs enrolled are 47. 25 women's specialty health care sites and 22 PCMH to participate in the Women's Health Initiative as of December 2021.

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

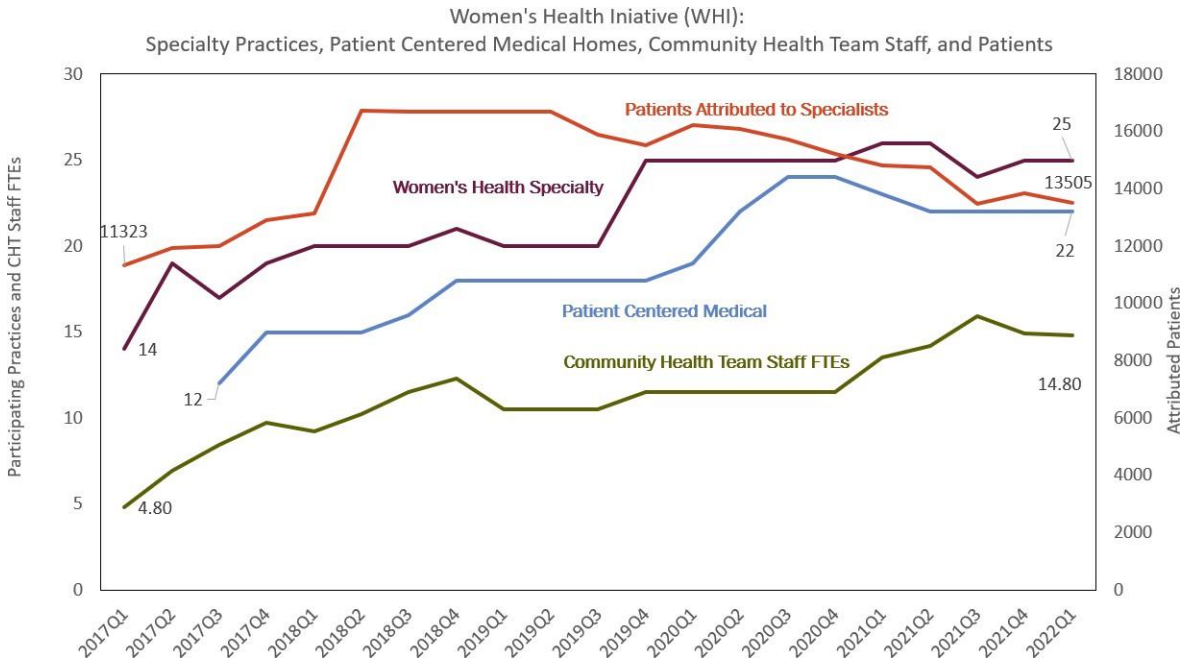


Table 4. Women's Health Implementation by Region

Health ServiceArea / Team	WHI Specialist Practices as of December 2021	WHI PCMH Practices as of December 2021	WHI CHT Staff FTE Hired as of December 2021	WHI Specialist Quarterly Attributed** Medicaid Beneficiaries as of December 2021	WHI PCMH Quarterly Attributed** Medicaid Beneficiaries a December 202
Barre	1	1	1.5	623	291
Bennington	1	2	0.50	949	252
Brattleboro	1	0	.6	834	0
Burlington	3	9	2	2634	4651
Middlebury	1	0	0.75	646==79	0
Morrisville	1	3	0.50	315	1131
Newport	1	0	1	834	0
Randolph	2	0	0.0	491	0
Rutland	2	0	3	1706	0
Springfield	0	5	0	0	1395
St. Albans	0	0	0.0	0	0
St. Johnsbury	1	2	0.75	844	729

*The Windsor Health Service Area does not have women's health specialty practices.
**Quarterly attributed patient counts at the HSA level have a small amount of overlap due to patients moving across HSAs in different months. The statewide quarterly total is deduplicated.
***The PPNNE practice in Rutland is included in both the WHI Specialist field for those Rutland and in the PPNNE statewide field. Patients are allocated to the Rutland HSA. Total WHI Specialist practice count is deduplicated.

iii. Behavioral Health

Key updates from QE092021:
- Alternative payment model
- Team Care
- Applied Behavior Analysis

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

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

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

DVHA, DMH, and the facility have agreed upon performance measures and a monitoring plat form for the model is being built by the Quality and Clinical Integrity team at DVHA. The team is working on a reconciliation schedule for completion on 5/31/22.

The Behavioral Health Team also manages the Team Care program. 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 continued review of current enrollees' need to remain in the program. The unit conducts quarterly reviews of claims data, including pharmacy and emergency department visits, to identify members who may benefit from the support of theTeam Care program. Clinicians review this data and determine the enrollment of potential new members. Team Care program members are also referred to VCCI when appropriate.

Outreach with providers and pharmacies is ongoing. The unit has an outreach plan which includes

attending staff meetings of various departments/units and posting advisories for providers. There is an outward-facing brochure available for Providers and an internal and outward-facing educational campaign for the Team Care program has been developed and implemented. 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.

Team members participate in the SFI Interagency Team and the Youth Service System Enhancement Council (a collaborative with ADAP, DMH, VCRIP, Vocation Rehabilitation, DCF, and more). Team members are active in ensuring that members with multi- department involvement are getting appropriate services delivered most efficiently. This is accomplished through participation in state interagency team meetings, the Mobile Crisis Response Initiative, attending monthly CRC meetings, 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.

In 2019, DVHA implemented an alternative payment model for Applied Behavior Analysis (ABA) services, characterized by a tiered monthly case rate, with tier payments depending on the intensity of services. In 2021, DVHA changed the timing of the tier submissions and payments from prospective submissions and payments to post-service delivery submissions and payments after receiving feedback from providers regarding the difficulty of prospectively determining treatment hours for the subsequent month. Providers received their first post- service delivery ABA payment in August for services rendered in July. An important goal of this program is to increase access to direct services for Medicaid members by giving providers the flexibility to innovate and to use staff more efficiently. To assess progress toward this and other goals, DVHA has established a monitoring framework that includes measures of access, utilization, service intensity, quality, and cost. Early data for some of these measures shows promising results. For example, since the implementation of the payment reform program, a higher proportion of services are in the form of direct services to members rather than assessments and parent education. In addition, total hours of service have been increasing year over year (despite the impacts of the COVID-19 public health emergency). The average monthly census has increased since the implementation of the payment model and has held steady during the past three years, again despite the impacts of COVID-19. 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 conducts annual site visits/audits with Vermont Medicaid enrolled ABA providers who provide services to Vermont Medicaid members. The purpose of these visits/audits is to ensure that members were receiving quality care, that providers are accurately reimbursed for provided services, to verify that required documentation is included in members' charts and that clinical documentation followsABA Policy and Clinical Guideline standards.

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

iv. Mental Health System of Care

Key updates from QE032022:
- 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 severe mental illnesses (SMI). The Vermont Agency of Human Services (AHS) provides funding through Provider Grant Agreements to ten (10) Designated Agencies (DAs) and two (2) Specialized Service Agencies (SSAs). These agencies are located across Vermont for the provision of:

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

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

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

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

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

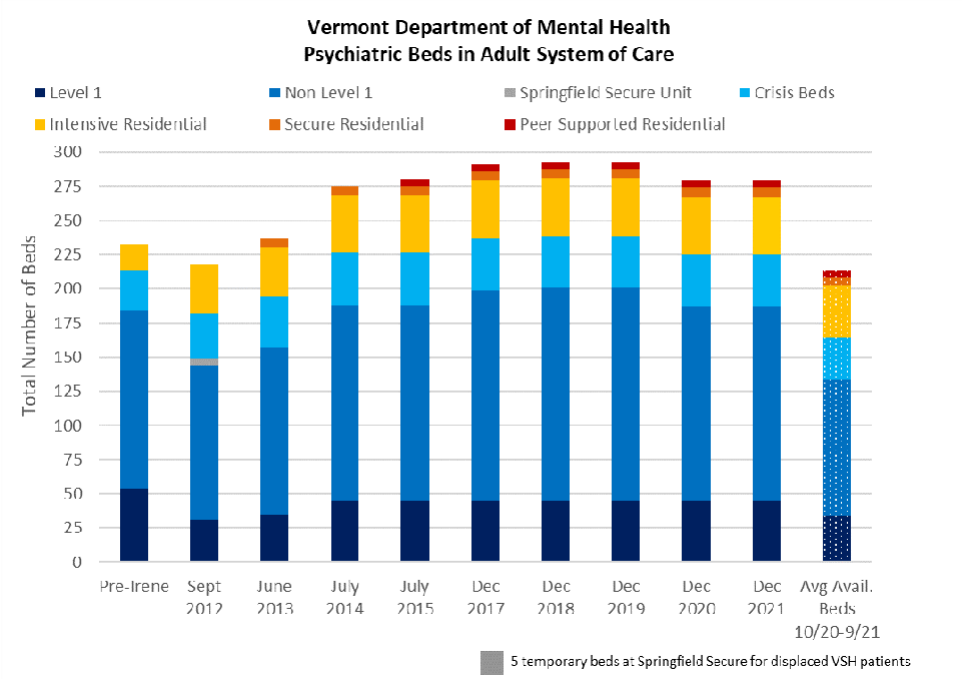
Updates on the Mental Health System of Care

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,

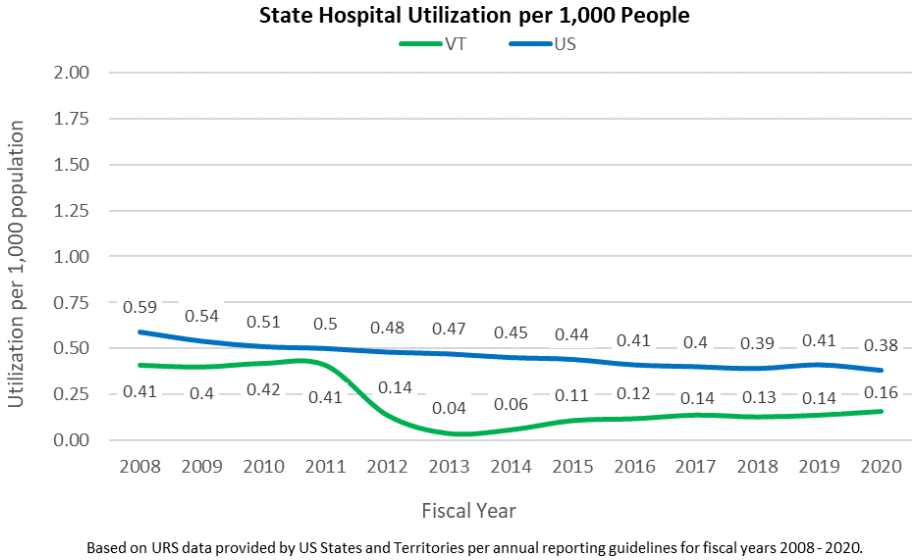
patient acuity, and public health safety protocols, as well as an initial decrease in individuals presenting with a need for a higher level of care. The primary reason for bed closures as of October (2021) is a severe workforce shortage across the mental health system. In a state with approximately 3,300 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.

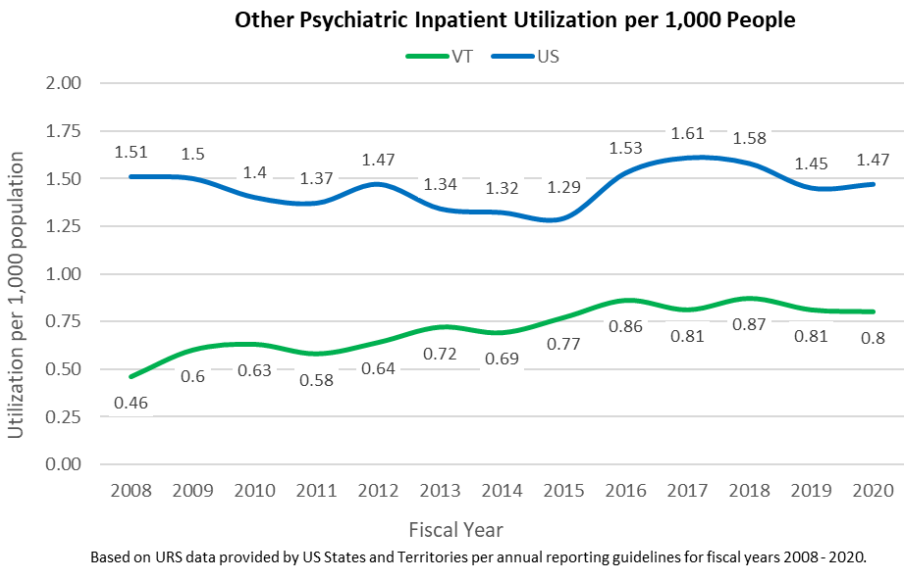
Figure 4. State Hospital Utilization per 1,000 people (in Vermont and the United States)



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

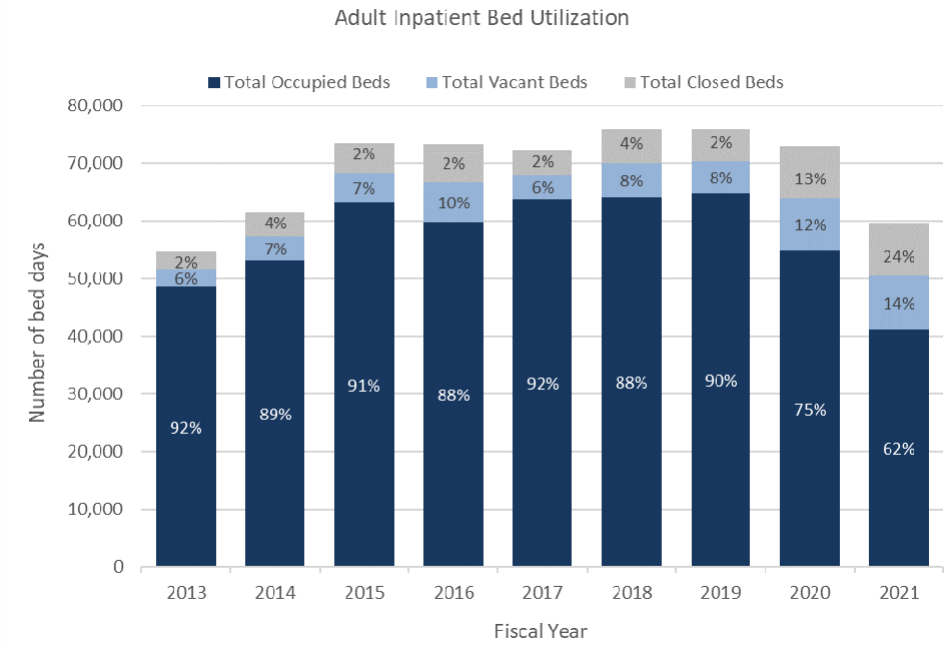
The national rate of state hospital utilization continues to decline year over year. VPCH opened in fiscal year (FY) 2015 with 25 beds, and Vermont's rate of inpatient utilization continues to be lower than the national average in the United States. The significant decrease from FY 2011 to FY 2012 represents 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)



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

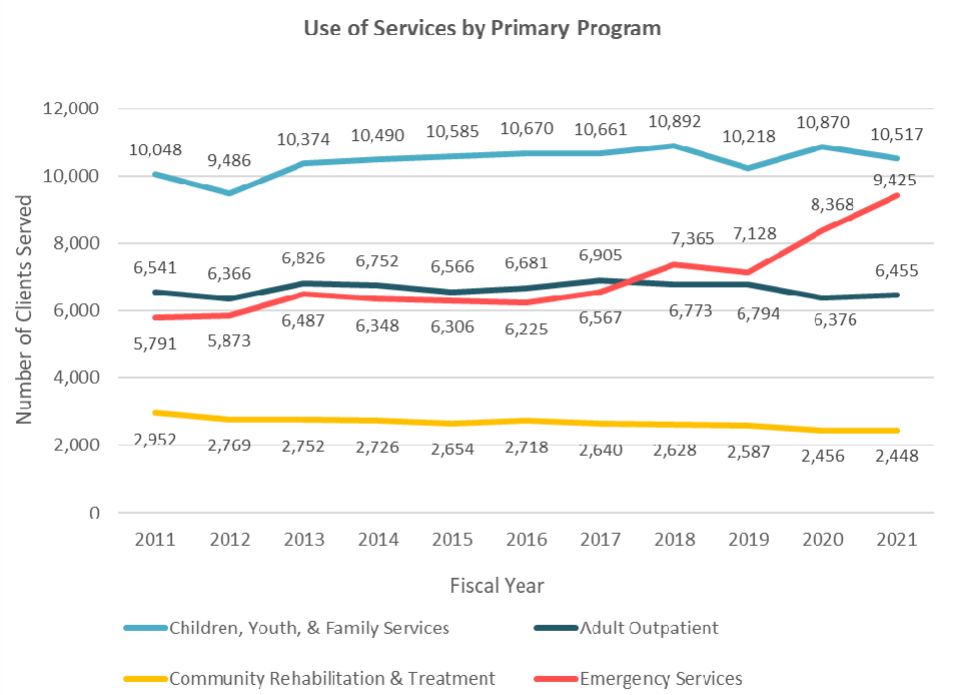
Enhanced community services funding provided by the Vermont legislature through increased appropriations to critical mental health programs in the community over the last several years has helped, but staff recruitment and retention necessary to meet and expand these service capacities continue to be 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 Workforce Task Group to explore recruitment and retention strategies
- Increased capacity within Community Rehabilitation and Treatment and peer programs to provide community support, outreach, and crisis response continues to develop

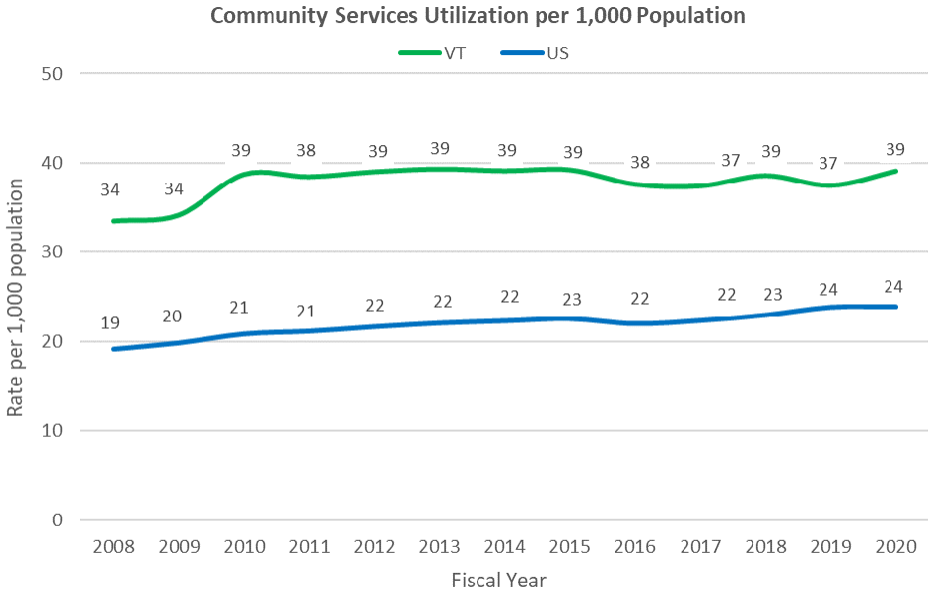
Broad utilization of non-categorical case management services for Adult Outpatient and Emergency Services programs

Figure 7. Use of Services by Primary Program



The highest number of persons served by programs offered by the DAs continues to be in children, youth, and family services (CYFS), as indicated in Figure 7. The 3% decrease from FY 2020 to FY 2021 may be related to the COVID-19 pandemic, but generally use of CYFS services have 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.

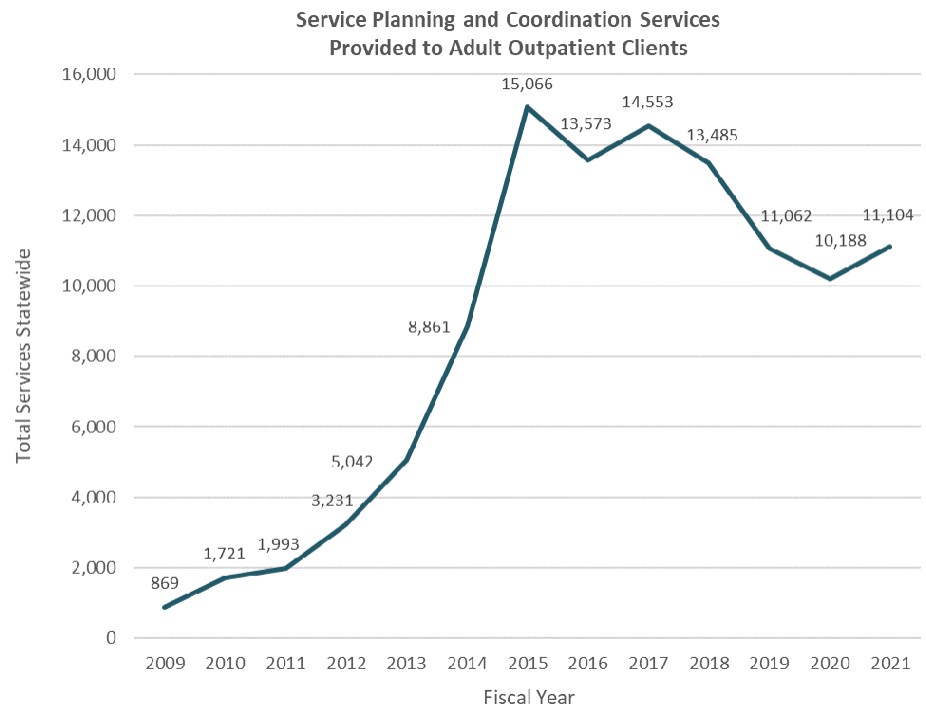
Figure 8. Community Services Utilization per 1,000 Populations



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. For others, they enter and exit intermittently depending on their individual needs. The payment reform transition away from a fee-for-service model to both an adult and children's case rate with a value-based payment component has provided ongoing flexibility to meet the needs of the individuals.

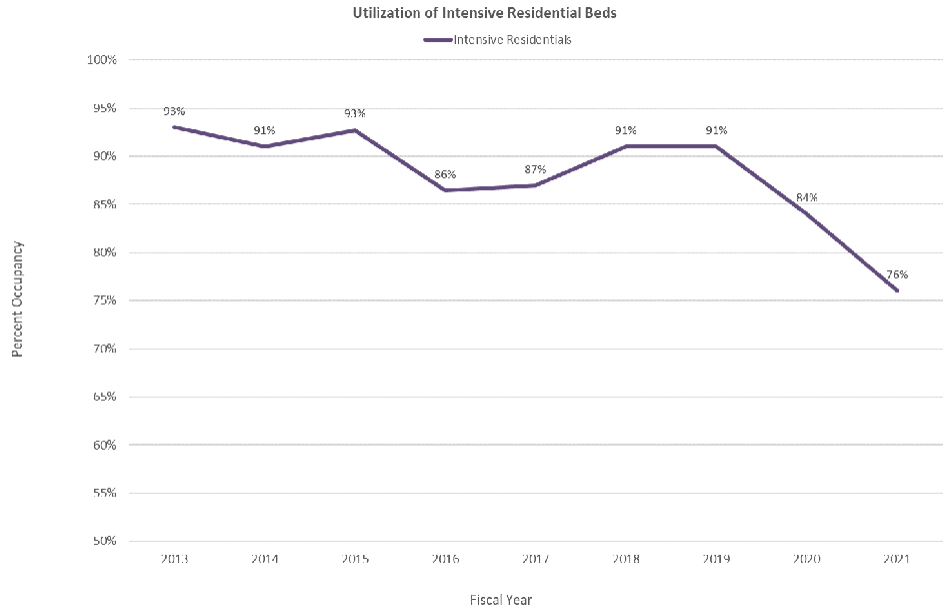
Figure 9. Service Planning and Coordination Services



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

Residential and Transitional Services

Figure 10. Utilization of Intensive Residential Beds



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

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

Performance and Reporting

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

- Implementation of value-based payment measures that allow DAs to earn an additional allocation based on the performance of agreed-upon quality metrics.
- Mental Health Payment Reform utilization scorecard, monitoring caseload, and

utilization for all services within the mental health case rate to monitor the impact of the payment model.
- Creation of a "Vermont Psychiatric Care Hospital Outcomes" scorecard to meet legislative reporting requirements.
- Migration of the "DMH Snapshot" and "DMH continued reporting" to the RBA scorecard reporting tool
- Exploration of visualization tools to create more responsive reporting.
- Participation in the development of the AHS Community profiles.

Mental Health Payment Reform

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

• Encouraging flexibility in service delivery that supports comprehensive, coordinated care;

• Standardizing the approach to tracking population indicators, progress, and outcomes;

• Simplifying payment structures and improving the predictability of provider payments;

• Improving accountability, equity, and transparency; and

• Shifting to value-based payment models that reward outcomes and incentivize best practices.

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

Integrating Family Services (IFS)

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

Parent Child Center). This has created a seamless system of care to ensure no duplication of services for children, youth, and families.

On January 1, 2019, the IFS sites became aligned with larger payment reform efforts occurring across AHS, including having value-based measures in alignment with statewide implementation. At the same time, IFS regions have additional requirements for the measurement of performance improvement in accordance with the broader scope of services included in those regions. Vermont submitted a multi-year payment model for consideration to CMS in September 2018 and received approval in late December that goes through 2022. Both IFS regions continue to utilize the Child and Adolescent Needs and Strengths (CANS) tool to holistically assess both the needs and strengths of the children that they are serving. These agencies are using this monitoring tool to track progress over time. Data are showing that through support and services, children and youth are increasing in their strengths and decreasing 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 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

Key updates from QE032022

- Operational Activities
    - Prior Authorization (PA) Data
    - Paid Claims and Drug Spend
    - Provider Communications
- Clinical Activities
    - Hypertension Management Initiative
    - Pharmacy Cost Management (PCM) Program

Pharmacy Benefit Management Program

The DVHA's Pharmacy Unit manages the pharmacy benefits for all of Vermont's publicly funded pharmacy benefit programs. The Pharmacy Unit's goal is to provide the highest quality prescription drug benefits in the most cost-effective manner possible. This is accomplished by providing broad coverage of prescription and over-the-counter pharmaceuticals while controlling pharmacy expenditures through both utilization and cost management strategies. The DVHA utilizes the pharmacy benefit management company, Change Healthcare (CHC), to provide a full complement of operational, clinical, and programmatic support in addition to managing a call center in South Burlington for pharmacies and prescribers. The Pharmacy Unit is also responsible for overseeing the contract with CHC. The Pharmacy Unit manages approximately $231 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, Alcohol& Drug Abuse Programs (ADAP), Asthma, Smoking Cessation, and the Department of Mental Health (DMH) related to the management of psychotherapeutic drug use in children. The Pharmacy Team also works with Vermont Medication Assistance Program (VMAP) and Children with Special Health Needs (CSHN) to assist in the drug and rebate management of the programs.

- □ Clinical Activities include managing drug utilization and cost.
    - Federal, State, 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 Program Integrity Unit on drug utilization issues related to fraud, waste, and abuse.

Operational Activity Reports

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

	No PA	Automated Edits						
Period	**Claims Paid w/o PA**	**Claims Paid w/Auto PA**	****Claims Paid with Auto Edit**	**Claims Paid w/Online Override**	**Claims Paid w/Emergency PA**	**Claims Paid due to Grandfathering**	**Claims Paid w/Clinical PA**	**Total Claim Count**
Quarter 1	488,631	92	19,851	190	98	7,260	15,777	531,899
	92%	<1%	4%	<1%	<1%	1%	3%	100%

- Total claim count does not include compounded drugs.

Paid Claims and Drug Spend

MEDICAID

Period	# Claims	# Of Members	State Paid Amounts
1Q2022	471,462	80,819	$65,686,210.08

VPHARM

Period	# Claims	# Of Members	State Paid Amounts
1Q2022	67,154	7,157	$2,038,496.04

COVID-19 Communications

Information for Treatment Related to COVID-19	To ensure that Vermont Medicaid members continue to have access to the medications they need and in response to evolving conditions related to COVID-19,

	the Department of Vermont Health Access (DVHA) is implementing the following changes to its prescription drug benefits programs: Copayments do not apply to any treatments of underlying conditions that may complicate the treatment of COVID-19 including treatments long-COVID/long haul, copayments for treatments while a Vermont Medicaid beneficiary is diagnosed with or presumed to have COVID-19, effective October 22, 2021. The prescribers shall write a memo/note on the prescription indicating it is being prescribed for treatment of COVID-19 or a COVID-19-related diagnosis.
Update on Pharmacy COVID-19 Antigen Test Coverage	Vermont enrolled pharmacies can bill for select over-the-counter COVID-19 tests for use by Medicaid members in a hoe setting when prescribed by a Vermont Medicaid enrolled provider effective 12/1/2021. A reminder that members may only receive test kits (at no cost) when pharmacies bill them directly to Medicaid with a valid prescription. A reminder that pharmacies must follow the NCPDP standard and use the NDC or UPC products codes found on the package. Copayments will not apply, and the coverage limit is no more than 4 test kits (8 tests) every 30 days.

Provider Communications

Buprenorphine Products Covered List	Hub (OTP) Covered Buprenorphine Products list as updated on March 18, 2022
Update on Synagis® (palivizumab)Dispensing	DVHA continued to monitor RSV activity through their Pharmacy Benefit Manager, Change Healthcare, data from the National Respiratory and Enteric Virus Surveillance System (NREVSS) and has determined that the Synagis® "season" has ended since the percent positives on antigen tests is ≤ 10% for 2 weeks or the percent positives on PCR tests is ≤ 3% for 2 consecutive weeks. Therefore, no further shipments will be authorized after 3/11/2.
Pharmacy Newsletter	A pharmacy newsletter went out in March 2022 giving updates on hypertension management initiative, Team Care program, changes to administration fees for vaccines, pharmacy COVID-19 antigen test coverage, the preferred drug list, new Drug Utilization Review Board (DURB) board member, DURB meeting, website updates and information on how to take the pharmacy satisfaction survey.
Pharmacy Benefit Provider Satisfaction Survey for Prescribers and Pharmacies	On February 14, 2022, a Pharmacy Benefit Provider Satisfaction Survey was distributed to Vermont Medicaid enrolled Prescribers and Pharmacies. The Department of Vermont Health Access (DVHA) contracts with Change Healthcare to support Vermont's publicly funded pharmacy benefit programs. The Change Healthcare Help Desk supports all pharmacies and prescribers enrolled in Vermont's pharmacy benefit programs such as Medicaid and Dr. Dynasaur and is the first point of contact for pharmacy and medical providers for drug prior authorization requests, drug claims processing issues, and other drug-related questions, concerns, and complaints. This survey is required annually by DVHA to assure that enrolled providers are receiving the highest

	quality of service possible from its contracted vendors.
Changes to Administration Fees for Vaccines	Effective 1/1/2022, the pharmacy administration fee for vaccines will be changing from $13.97 to $13.87. This does not apply to COVID-19 vaccination administration rates. This adjustment is being made to align with changes to the physician fee schedule (CPT code 90471) for adult vaccinations by primary care practitioners. DVHA-enrolled pharmacies may be reimbursed for vaccinations administered by pharmacists to adults 19 years and older who are enrolled in Vermont's publicly funded programs. Pharmacists must be compliant with all Vermont laws governing vaccine administration. Failure to comply with all Vermont immunization regulations will subject these claims to recoupment.

Clinical Activities

Hypertension Management Initiative

Pharmacy recently began a collaboration with the Hypertension Performance Improvement Project to improve the Scorecard Measure Controlling High Blood Pressure. You can view the currently targeted measure here https://app.resultsscorecard.com/Measure/Embed/100093207.

One of the first activities the Pharmacy Unit supported was to improve access to blood pressure cuffs. This included communicating with pharmacies on how to bill a prescription for a digital blood pressure monitor as a DME claim.

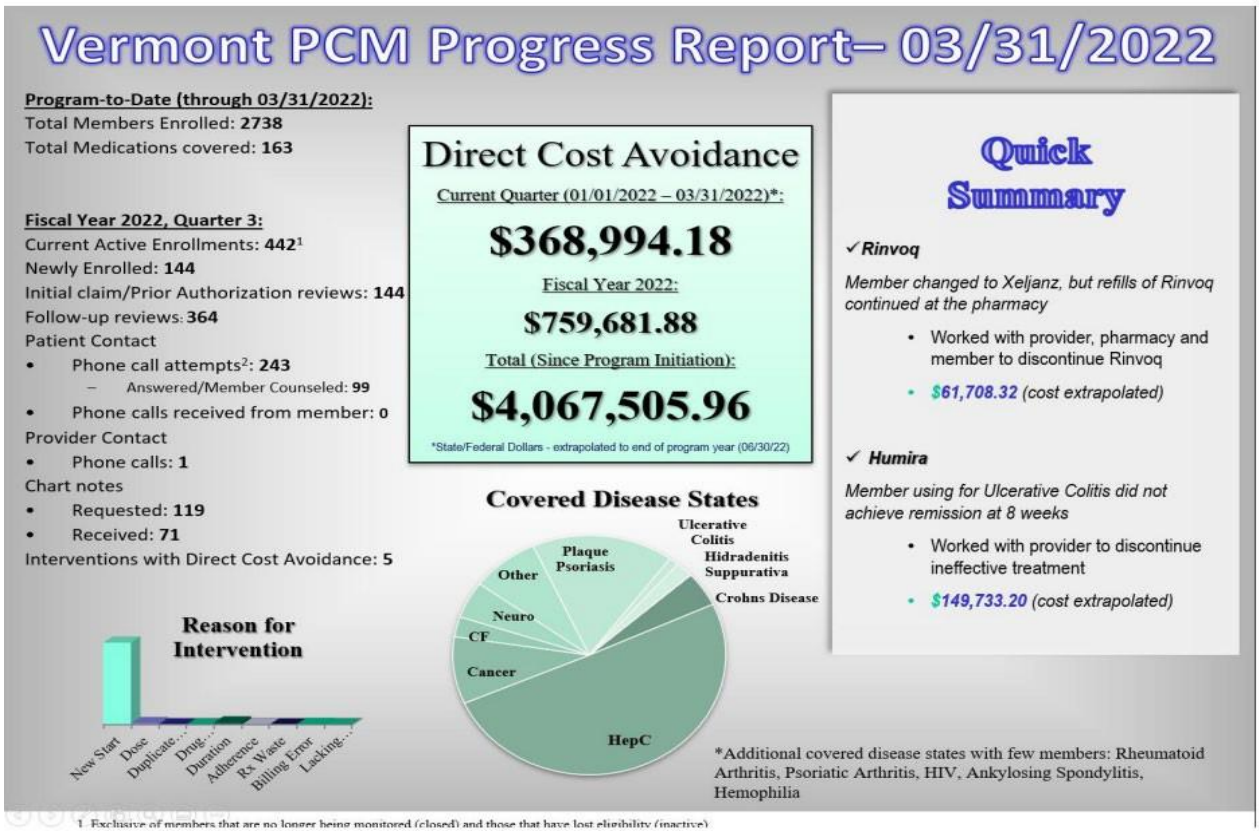
DVHA currently allows the purchase of automatic blood pressure (BP) monitor for the following additional diagnoses: essential hypertension, benign hypertension, nonspecific hypertension, elevated blood pressure without the diagnosis of hypertension, hypertensive heart disease without heart failure, and pregnancy-related hypertension diagnoses. A prescription for the digital BP monitor, along with a diagnosis is needed and claims are processed as a DME claim.

We are continuing to ask pharmacies to consider stocking blood pressure monitors to fulfill the potential demand that may be generated by this program.

The manual sphygmomanometer/blood pressure apparatus with cuff and stethoscope will no longer be allowed for purchase. The criteria for coverage can be found on the Department of Vermont Access (DVHA) website at https://dvha.vermont.gov/forms-manuals/forms/prior-authorizations-tools-and-criteria/durable-medical-equipment

Pharmacy Cost Management (PCM) Program

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



Change Healthcare (January 1, 2022, through March 31, 2022). Change Healthcare Pharmacy Management Reporting Suite is a collection of reports recording the process and progress of PCM.

In the first quarter of 2022, the PCM program enrolled an additional 144 members for a total of 2,738 members on 163 unique medications. The program is actively monitoring 442 enrollees. A total of 243 outgoing telephone calls were placed to members, 99 of which resulted in member counseling. During this quarter of the Vermont PCM program, five interventions led to direct and measurable cost avoidance. Furthermore, interventions that do not bring about direct cost avoidance are in place to encourage adherence and thus improve member outcomes and avoid unnecessary medical costs. Through interventions in the PCM program, unnecessary drug spend of nearly $368,994 was avoided in the first quarter of the state fiscal year 2022. More than $4.06 million in unnecessary drug spend has been avoided throughout the program.

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

Key updates from QE032022:

- Executed a new contract with OneCare for a 2022 performance year of the program.
- Began conducting financial reconciliation activities for the 2021 performance year, in order to determine financial and quality performance. Results will be available in late Q3 or early Q4 2022.
- 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 MedicaidNext Generation* (VMNG) model for the pilot year: the University of Vermont Medicaid Center, Central VermontMedical Center, Northwestern Medical Center, and Porter Hospital, with additional participation from FQHCs, independent practices, home health providers, Designated Agencies, and skilled nursing agencies in the four communities. Since 2017, the number of risk-bearing hospital communities participating in the VMNG model has grown from 4 to 14 and it is now considered a statewide program in terms of provider participation and member attribution.

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

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

DVHA began conducting preliminary financial reconciliation activities for its 2021 performance year in Q1 2022. Reconciliation activities will determine the ACO's spend as compared to their financial target and quality performance for the 2021 performance year. Reconciliation activities will continue into early Q4 2022, and final results will be available in Q4 2022.

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

V. Financial/Budget Neutrality Development/Issues

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 March 2022 quarter (January through March 2022).This payment served as the proxy by which to draw down Federal funds for Global Commitment (GC).

As is the process after each quarterly submission of the CMS-64, AHS reconciled the quarterly amount claimed on the CMS-64 with the monthly payments made to DVHA. The State prepared the CMS-64 based

upon actual allowable Medicaid expenditures (program, investments, and administration) for the given quarter. AHS submitted and certified the CMS64 report for QE322 on April 30, 2022, as is normal.

Because the GC Waiver is being renegotiated, the current waiver has been extended for an additional two quarters: QE 0322 and QE0622.

QE0322 was the final of four quarters that received a temporary 10% FMAP increase for qualifying HCBS services under the American Rescue Plan Act of 2021. Total HCBS expenditures for QE0322 were $191,595, 938, which resulted in an increased FMAP of $18.5 million. Cumulatively, Vermont has earned over $69 million in additional FMAP for the four applicable quarters. These additional matching funds must be used to supplement and not supplant existing state Medicaid HCBS services in effect as of April 1, 2021.

Overall, the budget neutrality exercise indicates that for the March 2022 quarter, the State's total "With Waiver" expenditures were $62,925,363 (16%) lower than the total "Without Waiver" amount (caseloads multiplied by the Budget Neutrality PMPMs), indicating a quarterly surplus.

The QE0322 supplemental budget neutrality tests results are as follows:

- The New Adult test resulted in a surplus of $13,588,281.
- The SMI IMD test resulted in a deficit of $2,403,256.
- The SUD IMD test resulted in a deficit of $98,544.

Deficits in SMI IMD and SUD IMD are applied to the overall budget neutrality test. Currently, there is ample room in the overall budget neutrality test to accommodate SUD IMD and SMI IMD deficits.

Please note, that the above-mentioned budget neutrality calculations are based on Vermont's interpretation of how Budget Neutrality should be calculated. Vermont uploaded the PMDA Budget Neutrality template for DY15 which has different calculations. Vermont is not in agreement with those calculations and looks forward to finding a resolution with CMS on these discrepancies.

AHS continues to actively monitor Investment spending. The total Investment spending for QE0322 was $27,843,706. The total CY2022 Budget Neutrality Investment Limit is $68,250,000 (for QE0322 and QE0622).

VI Member Month Reporting

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

The table below contains Member Month Reporting for QE0322 of CY2022 and includes theunduplicated count of member months for SUD IMD and SMI IMD stays. CY2021 and CY 2020 member months are also reported in the tables below.

Table 1. Member Month Reporting – Calendar Year 2022 (QE0322-QE1222), *subject to revision*, with CY2021 and CY2020.

Demonstration Population	Medicaid Eligibility Group	Total CY 2022 (JAN - MARCH)	Total CY 2021	Total CY 2020
1, 4*, 5*	ABD - Non-Medicare - Adult	19,684	79,621	79,846
	SUD - IMD - ABD	17	71	106
	SMI - IMD - ABD	45	66	71
1	ABD - Non-Medicare - Child	4,527	19,069	20,060
1, 4*, 5*	ABD - Dual	66,581	266,128	260,532
	SUD - IMD - ABD Dual	22	121	136
	SMI - IMD - ABD Dual	10	26	12
2	Non-ABD - Non-Medicare - Adult	45,199	157,914	112,654
	SUD - IMD – Non-ABD	20	145	161
	SMI - IMD – Non-ABD	17	24	26
2	Non-ABD - Non-Medicare - Child	187,612	745,043	713,979
	Medicaid Expansion			
7	Global RX	19,098	77,496	78,064
8	Global RX	9,573	40,107	41,565
6	Moderate Needs	425	1,700	1,963
	New Adults			
3	New Adult without Child	145,769	544,941	453,635
	SUD - IMD New Adult w/o Child	181	971	1,157
	SMI - IMD New Adult w/o Child	116	203	211
3	New Adult with Child	79,754	307,360	267,004
	SUD - IMD New Adult with Child	58	220	209
	SMI - IMD New Adult with Child	28	53	44
	Total	**578,736**	**2,241,279**	**2,031,435**

Table 2. GC Budget Neutrality PMPM Rates, CY 2022 (January 1, 2022 - June 2022)

STC PMPM Budget Neutrality	
Medicaid Eligibility Group	**DY 17 PMPM CY2022**
ABD - Non-Medicare - Adult	$1,745.83
SUD - IMD ABD	$3,798.97
SMI - IMD ABD	$16,054.00
ABD - Non-Medicare - Child	$3,419.74
ABD - Dual	$3,006.28
SUD - IMD ABD Dual	$2,901.13
SMI - IMD ABD Dual	$19,633.00
Non-ABD - Non-Medicare - Adult	$780.03
SUD - IMD Non-ABD	$2,852.36
SMI - IMD Non-ABD	$10,448.00
Non-ABD - Non-Medicare - Child	$643.26
New Adult Group	$610.97
SUD - IMD - New Adult	$ 3,042.23
SMI - IMD - New Adult	$ 12,182.00

Table 3. PMPM Rates Pending **Approval by CMS, CY 2022 (January 1, 2022 – December 31, 2022)**

Medicaid Eligibility Group (MEG)	**Capitation Rates PMPM**	
ABD Dual	$	2,105.97
ABD Non-Dual Adult	$	2,763.84
ABD Non-Dual Child	$	3,330.95
Non - ABD Adult	$	800.57
Non - ABD Child	$	604.59
Moderate Needs Group	$	844.48
New Adult	$	600.96
Global Rx	$	135.26
Total	$	863.83

VII. Consumer Issues

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

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

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

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

VII. **Quality Improvement**

Quality Assurance and Performance Improvement Activities

Key updates from QE032022:

- Intervention implementation and monitoring continued for DVHA's formal PIP topic, management of hypertension. 3 focused sub-groups are working on activities related to: access to blood pressure monitors, provider and patient education and community resources.
- DHVA's Quality Team received the 2021Adult and Children's CAHPS Medicaid 5.0H survey summary report.
-
- Staff from DVHA's Quality, Oversight & Monitoring and Compliance units continued work on a comprehensive risk assessment project.

The DVHA Clinical Services Team monitors evaluates and improves the quality of care to Vermont Medicaid beneficiaries through the use of performance and utilization management frameworks. The Team makes data-driven decisions about beneficiaries' care and improvement projects through measuring and monitoring efforts. Efforts are aligned across the Agency of Human Services (AHS) as well as with community providers. The team is responsible for instilling the principles of quality management throughout DVHA; helping everyone in the organization to achieve excellence. The team's goal is to develop a culture of continuous quality improvement throughout DVHA.

PIHP Quality Committee

The Quality Committee remained active during QE0322 and consists of representatives from all departments within AHS that serve the Medicaid population. The committee continues to structure its work around the federal managed care quality program guidelines and the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of healthcare. During this time, the committee followed our work plan and reviewed the annual AHS Confidentiality report as well as the results of the 2021 CAHPS Experience of Care surveys. identified.

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 QE0322. Sub-groupwork focuses on activities related to access to blood pressure monitors, provider, and patient education, and connecting to community resources.

Other Collaborative Quality Improvement Projects

DVHA's Clinical Services Team strives to realize efficiencies, align priorities and reduce redundancies. With these overarching goals in mind, the Quality team continued to work with the following groups on collaborative QI projects during QE0322:

- 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. The Clinical Services Team lead the work group that established quality of care measures 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) on a learning collaborative to improve the timeliness of comprehensive health visits for children and adolescents entering foster care. During this reporting period we finalized our baseline data and refined our AIM statement. We will begin process mapping for a District Office during QE0622.

Quality Measure Reporting

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey - the DVHA Quality Unit's Director of Quality Management prepared the 2021 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Children's and Adults Medicaid 5.0H survey tools during QE0921. Of note this year, DVHA included the new AHRQ supplement questions regarding access to mental health care services. DVHA works with a contracted vendor, DatStat, Inc., to distribute and collate the surveys according to AHRQ and NCQA protocols. The results of the surveys were delivered to DVHA during this reporting period and were presented by the Director of Quality Management to the PIHP Quality Committee in March 2022.

HEDIS measure production –In addition to producing administrative (claims-based) measures, the Clinical Services Team is preparing to produce four (4) HEDIS hybrid measures again in 2022. DVHA's certified HEDIS vendor performs medical record retrieval for all four hybrid measures and abstracts records for two of those measures. DVHA clinicians will abstract the other two measures. DVHA's Quality Assurance Manager prepared abstraction training, tools, and materials during QE0322.

Quality Unit staff originally spearheaded conversations with staff from Vermont Information Technology Leaders (VITL) in 2019 to explore using the data stored in the Vermont Health Information Exchange (VHIE) for hybrid measure production in the future. Initial system testing was performed in CY 2020 and comparison testing was completed in CY 2021 with increasingly complete results. DVHA is in conversation with the MAC QualityTA team about using this data for reporting purposes.

Results Based Accountability (RBA)/Process Improvement

Results Based Accountability (RBA) scorecards are developed at DVHA for both internal and external performance management purposes. The use of this performance management framework and corresponding presentation tool has been spearheaded by the Agency's Central Office QI staff. The DVHA Quality Unit staff use this tool to create a *Global Commitment to Health* Core Measure scorecard, Experience of Care, and other performance budgeting scorecards. DVHA's largest scorecard, named the Performance Accountability Scorecard includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services. Scorecards that were newly developed oractively maintained during QE0921 include the following initiatives: Adult Core Set of Health Care Quality Measures, Child Core Set of Health Care Quality Measures, and the DVHA Programmatic Performance Budget.

The Quality Improvement Team also maintained its "Green Belt" status during QE0921 by participating in quality improvement activities. Green Belt is the highest level of internal training offered through the State based on LEAN/RBA principles. The training is centeredaround process improvement and contributes to the Governor's initiative called PIVOT, or Program to Improve Vermont Outcomes Together.

COVID-19 Dashboard

The Quality Team was tasked with creating and maintaining a COVID-19 dashboard at the endof 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 dashboardis updated monthly and made available to all DVHA staff via our intranet. This work continues into 2022

and will while the PHE is in effect. Measures are retired and additional measures are added to the dashboard as appropriate.

Vermont Next Generation Medicaid ACO

During QE0322, 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 During our 03/22 meeting, we reviewed OneCare Vermont's 2022 Quality Plan. A representative from the VMNG ACO is also a standing member on DVHA's formal PIP, the topic of which is managing hypertension.

Comprehensive Risk Assessment

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

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

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

Global Commitment (GC) Investment review

AHS Departments are required to monitor and evaluate the performance of their investments on an ongoing basis and subject them to formal review according to a periodic schedule. Performance monitoring is accomplished via a quarterly and annual review of performance information contained in a web browser-based software application (Clear Impact Scorecard). The scorecard includes the following data elements: investment description (i.e., the goal of the investment, the activities being supported, and information on how they are provided), performance measures (i.e., the data being collected and analyzed to determine if the investment is achieving its desired goal), results (performance measure rates for the most recent reporting period), and an interpretation of the results (i.e., comparing actual to expected rates using performance targets and/or benchmarks and to characterize trends or patterns in the data). During this most recent quarter, DMH and DVHA 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, DVHA highlighted the performance of its Dental Incentive payment model. The Clear Impact Scorecard for this payment model is included in this report as Attachment 8.

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

During this quarter, the state received final approval of its CQS/STP. The state will continue discussions regarding the assurance of ongoing compliance with the regulations.

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 described in STC 49 of the demonstration. During the previous quarter, the state submitted quarterly monitoring reports for the substance use disorder (SUD) component of the Global Commitment to Health demonstration, to the Centers for Medicare & Medicaid Services (CMS), as required by the state's special terms and conditions (STC). The state awaits CMS feedback to ensure that these monitoring reports provide all the information requested by the templates.

SMI Monitoring Protocol

The state's special terms and conditions (STCs) for its current five-year demonstration period (July 1, 2017–June 30, 2021) were amended in December 2019 to include a Serious Mental Illness (SMI) component. COVID response has delayed the production and submission of the SMI Monitoring Protocol reports. The state expects to submit its first SMI/SED monitoring report next quarter.

IX. Demonstration Evaluation Activities

Evaluations are crucial to understand and disseminate what is or is not working and why. The principal focus ofthe 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 their 1115 wavier. Specifically, the design identifies the state's hypotheses, evaluation questions, associated measures, andanalytic methods.

During the quarter, the state continued to work with its independent evaluator, PHPG, to collect the necessary data to support the development of the Summative Evaluation Report. The report includes the information in the CMS-approved Evaluation Design. Most data submissions are due next quarter. The state will continue to regularly monitor the availability of data to support the evaluation report and assess its ability to maintain the current timeline. The state will reach out to those supplying data for the evaluation during the next quarter.

X. Compliance

Key updates from QE032022:

- EQRO RFP
- AHS/DVHA IGA

External Quality Review Request for Proposal

The state's external quality review contract expired during QE032022. During this time, the state posted a request for proposals (RFP), put together a proposal review committee, reviewed proposals, requested best and final offers from all bidders, and selected a successful bidder. During the next quarter, the state will develop a new EQR contract and plan for CY2021 review activities.

Intra-Governmental Agreement (IGA) between AHS and DVHA

The CY2022 Agency of Human Services (AHS) and the Department of Vermont Health Access (DVHA) IGA has been submitted to CMS for review/approval and the state is currently awaiting CMS feedback.

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 of quality health care to uninsured, underinsured, and Medicaid beneficiaries.
- Provide public health approaches and other innovative programs to improve the health outcomes, health status, and the quality of life for uninsured, underinsured, and Medicaid- eligible individuals in Vermont; and
- Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the 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 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	Enrollment and Expenditures Report
Attachment 3	Complaints Received by Health Access Member Services
Attachment 4	Medicaid Grievance and Appeal Reports
Attachment 5	Office of the Health Care Advocate Report
Attachment 6	QE032020 Investments (GC Investments)
Attachment 7	Investment Scorecard(s)
Attachment 8	Payment Model Scorecard(s)

Date Submitted to CMS: July 29, 2022

Budget Neutrality New Adult
New Adult (w/ and w/o Child) Medical Costs Only

	DY 14 – PMPM				DY 15 – PMPM				DY 16 – PMPM			
	QE 0319	**QE 0619**	**QE 0919**	**QE 1219**	**QE 0320**	**QE 0620**	**QE 0920**	**QE 1220**	**QE 0321**	**QE 0621**	**QE 0921**	**QE 1221**
(A) New Adult Group PMPM Projection	$562.71	$562.71	$562.71	$562.71	$586.34	$586.34	$586.34	$586.34	$610.97	$610.97	610.97	610.97
(B-1) eligible member months w/ Child	57,969	58,516	58,610	58,199	60,037	65,214	66,459	67,867	75,413	76,917	78,509	79,940
(B-2) eligible member months w/o Child	110,736	106,927	103,710	101,777	102,648	110,982	116,878	118,707	129,659	134,078	139,285	142,810
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	$ 32,619,735.99	$ 32,927,538.36	$ 32,980,433.10	$ 32,749,159.29	$ 35,202,094.58	$ 38,237,576.76	$ 38,967,570.06	$ 39,793,136.78	$ 46,075,080.61	$ 46,993,979.49	$ 47,966,643.73	$ 48,840,941.80
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	$ 62,312,254.56	$ 60,168,892.17	$ 58,358,654.10	$ 57,270,935.67	$ 60,186,628.32	$ 65,073,185.88	$ 68,530,246.52	$ 69,602,662.38	$ 79,217,759.23	$ 81,917,635.66	$ 85,098,956.45	$ 87,252,625.70
(D-1) New Adult FMAP w/ Child	53.89%	53.89%	53.89%	53.86%	60.06%	60.06%	60.06%	60.77%	60.77%	60.77%	60.77%	62.67%
(D-2) New Adult FMAP w/o Child	93.00%	93.00%	93.00%	93.00%	90%	90%	90%	90%	90%	90%	90%	90%
(E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child	$ 17,578,775.73	$ 17,744,650.42	$ 17,773,155.40	$ 17,638,697.19	$ 21,142,378.00	$ 22,965,488.60	$ 23,403,922.58	$ 24,182,289.22	$ 27,999,826.49	$ 28,558,241.34	$ 29,149,329.39	$ 30,608,618.23
(E-2 = C2 x D-2) Federal Share of Supplemental Cap 1 w/o Child	$ 57,950,396.74	$ 55,957,069.72	$ 54,273,548.31	$ 53,261,970.17	$ 54,167,965.49	$ 58,565,867.29	$ 61,677,221.87	$ 62,642,396.14	$ 71,295,983.31	$ 73,725,872.09	$ 76,589,060.81	$ 78,527,363.13
Subtotal Federal Share Supplemental Cap 1	$ 75,529,172.47	$ 73,701,720.14	$ 72,046,703.71	$ 70,900,667.37	$ 75,310,343.49	$ 81,531,355.89	$ 85,081,144.45	$ 86,824,685.36	$ 99,295,809.79	$ 102,284,113.43	$ 105,738,390.20	$ 109,135,981.36
Total FFP reported for New Adult Group	$ 67,854,834.87	$ 68,588,592.26	$ 63,276,555.83	$ 54,245,264.74	$ 82,218,290.81	$ 68,092,015.38	$ 69,686,466.57	$ 73,806,046.32	$ 74,243,005.17	$ 83,784,434.33	$ 83,439,260.42	$ 76,989,045.50
Supplemental Budget Neutrality Test 1 over/(under) - report any negative # under main GC budget	$ 7,674,337.60	$ 5,113,127.88	$ 8,770,147.88	$ 16,655,402.63	$ (6,907,947.32)	$ 13,439,340.51	$ 15,394,677.88	$ 13,018,639.04	$ 25,052,804.62	$ 18,499,679.10	$ 22,299,129.78	$ 32,146,935.86

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
May 13, 2022

ELIGIBILITY GROUP	DY 12 JAN - DEC 2017	DY 13 JAN - DEC 2018	DY 14 JAN - DEC 2019	DY 15 JAN - DEC 2020	DY 16 JAN - Dec 2021	DY 17 JAN - JUNE 2022	Total
Total Expenditures Without Waiver	**$ 1,386,795,376**	**$ 1,405,356,354**	**$ 1,416,427,318**	**$ 1,478,708,857**	**$ 1,606,705,054**	**$ 405,947,080**	**$ 7,699,940,039**
With Waiver							
Total Expenditures With Waiver	**$ 1,239,374,215**	**$ 1,285,189,954**	**$ 1,273,088,069**	**$ 1,244,172,817**	**$ 1,241,857,946**	**$ 343,021,718**	**$ 6,626,704,718**
Hypothetical Test 1: New Adult							
Limit New Adult PMPM*Mem-Mon	$ 370,689,611	$ 375,735,593	$ 369,387,603	$ 422,539,471	$ 520,730,342	$ 137,787,787	$ 2,196,870,408
With Waiver New Adult Total Expenditures	$ 295,620,338	$ 312,104,578	$ 315,240,526	$ 368,166,529	$ 394,240,162	$ 124,199,506	$ 1,809,571,638
Surplus (Deficit)	*$ 75,069,273*	*$ 63,631,015*	*$ 54,147,078*	*$ 54,372,942*	*$ 126,490,180*	*$ 13,588,281*	*$ 387,298,770*
Hypothetical Test 2: SUD IMD							
SUD - IMD ABD - Non-Medicare - Adult		$ 268,039	$ 529,433	$ 389,449	$ 269,727	$ 64,582	$ 1,521,231
SUD - IMD ABD - Dual		$ 214,495	$ 442,312	$ 387,577	$ 351,037	$ 63,825	$ 1,459,245
SUD - IMD Non ABD - Non-Medicare - Adult		$ 533,391	$ 633,224	$ 459,230	$ 413,592	$ 57,047	$ 2,096,485
SUD - IMD New Adult		$ 2,704,249	$ 4,842,747	$ 4,130,907	$ 3,623,296	$ 727,093	$ 16,028,291
Limit SUD IMD Without Waiver PMPM*Mem-Mon	**$ -**	**$ 3,720,174**	**$ 6,447,715**	**$ 5,367,163**	**$ 4,657,652**	**$ 912,548**	**$ 21,105,252**
SUD - IMD ABD Non Medicare Adult		$ 249,820	$ 646,440	$ 411,251	$ 206,455	$ 46,744	$ 1,560,711
SUD - IMD ABD - Dual		$ 199,224	$ 545,837	$ 342,450	$ 213,896	$ 79,991	$ 1,381,398
SUD - IMD Non ABD - Non-Medicare - Adult		$ 540,841	$ 803,762	$ 516,507	$ 388,888	$ 71,067	$ 2,321,066
SUD - IMD New Adult		$ 2,826,119	$ 5,869,169	$ 4,250,210	$ 3,463,348	$ 813,290	$ 17,222,136
Limit SUD IMD With Waiver (Total Expenditures)	**$ -**	**$ 3,816,005**	**$ 7,865,208**	**$ 5,520,418**	**$ 4,272,587**	**$ 1,011,092**	**$ 22,485,310**
Surplus (Deficit)	*$ -*	*$ (95,830)*	*$ (1,417,494)*	*$ (153,255)*	*$ 385,065*	*$ (98,544)*	*$ (1,281,514)*
Hypothetical Test 3: SMI IMD							
SMI - IMD ABD - Non-Medicare - Adult				$ 1,106,677	$ 1,059,564	$ 722,430	$ 2,888,671
SMI - IMD ABD - Dual				$ 226,752	$ 510,458	$ 196,330	$ 933,540
SMI - IMD Non ABD - Non-Medicare - Adult				$ 261,456	$ 250,752	$ 177,616	$ 689,824
SMI - IMD New Adult				$ 2,975,595	$ 3,118,592	$ 1,754,208	$ 7,848,395
Limit SMI IMD Without Waiver PMPM*Mem-Mon	**$ -**	**$ -**	**$ -**	**$ 4,570,480**	**$ 4,939,366**	**$ 2,850,584**	**$ 12,360,430**
SMI - IMD ABD Non Medicare Adult				$ 1,726,684	$ 3,495,784	$ 1,376,586	$ 6,599,054
SMI - IMD ABD - Dual				$ 188,470	$ 884,861	$ 228,775	$ 1,302,106
SMI - IMD Non ABD - Non-Medicare - Adult				$ 727,204	$ 825,373	$ 145,047	$ 1,697,624
SMI - IMD New Adult				$ 5,348,474	$ 9,785,706	$ 3,503,432	$ 18,637,612
Limit SMI IMD With Waiver (Total Expenditures)	**$ -**	**$ -**	**$ -**	**$ 7,990,832**	**$ 14,991,724**	**$ 5,253,840**	**$ 28,236,396**
Surplus (Deficit)		*$ -*	*$ -*	*$ (3,420,352)*	*$ (10,052,358)*	*$ (2,403,256)*	*$ (15,875,966)*
Waiver Savings Summary							
Annual Savings	**$ 147,421,162**	**$ 120,166,400**	**$ 143,339,249**	**$ 234,536,040**	**$ 364,847,108**	**$ 62,925,363**	**$ 1,073,235,322**
Shared Savings Percentage	30%	25%	25%	25%	25%	25%	
Shared Annual Savings	$ 44,226,348	$ 30,041,600	$ 35,834,812	$ 58,634,010	$ 91,211,777	$ 15,731,341	$ 275,679,888
Hypothetical Test 2 & 3 adjustment	***$ -***	***$ (95,830)***	***$ (1,417,494)***	***$ (3,573,607)***	***$ (10,052,358)***	***$ (2,501,800)***	***$ (17,641,089)***
Total Cumulative Savings		**$ 74,172,118**	**$ 108,589,437**	**$ 163,649,840**	**$ 244,809,259**	**$ 258,038,799**	**$ 258,038,799**

New Adult Waiver Savings Not Included in Waiver Savings Summary
See Budget Neutrality New Adult tab (STC#64)
See CY2022 Investments tab
See EG MM CY 2022 Tab for Member Month Reporting

Report to
The Vermont Legislature

Medicaid Program Enrollment and Expenditures Quarterly Report

In Accordance with 33 V.S.A. § 1901f

Submitted to: The General Assembly

Submitted by: Mike Smith, Secretary
Agency of Human Services

Prepared by: Richard Donahey, Chief Financial Officer
Agency of Human Services

Report Date: December 1, 2021

VERMONT
AGENCY OF HUMAN SERVICES

TABLE OF CONTENTS

VERMONT
AGENCY OF HUMAN SERVICES

BACKGROUND

In accordance with 33 V.S.A. § 1901f, a quarterly report on enrollment and total expenditures by Medicaid eligibility group for all programs paid for by the Department of Vermont Health Access shall be submitted to the General Assembly by March 1, June 1, September 1, and December 1 of each year. To the extent such information is available, total expenditures for Medicaid-related programs paid for by other departments within the Agency of Human Services shall be included.

KEY TERMS

Caseload: Average monthly member enrollment

PMPM: Per Member Per Month

MEG: Medicaid Eligibility Group

ABD Adult: Beneficiaries aged 19 or older; categorized as aged, blind, disabled, and/or medically needy

ABD Dual: Beneficiaries eligible for both Medicare and Medicaid; categorized as aged, blind, disabled, and/or medically needy

General Adult: Beneficiaries age 19 or older; pregnant women or parents/caretaker relatives of minor children receiving cash assistance and those receiving transitional Medicaid after the receipt of cash assistance

New Adult Childless: Beneficiaries age 19 or older and under 65; who are at or below 133% of the FPL who do not have dependent children

New Adult w/Child: Beneficiaries age 19 or older and under 65; who are at or below 133% of the FPL who have dependent children

BD Child: Beneficiaries under age 19; categorized as blind, disabled, and/or medically needy

General Child: Beneficiaries under age 19, and below the protected income level, categorized as those eligible for cash assistance including Reach Up (Title V) and foster care payments (Title IV-E)

Underinsured Child: Beneficiaries under age 19 with household income 237-312% FPL with other (primary) insurance

CHIP: Children's Health Insurance Program; Beneficiaries under age 19 with household income 237-312% FPL with no other insurance

Sunsetted Programs: Expenditures still being incurred for programs no longer active such as VHAP, VHAP ESI, and Catamount.

Vermont Premium Assistance: Individuals enrolled in qualified health plans (QHP) with incomes at or below 300% FPL

Vermont Cost Sharing: Individuals enrolled in qualified health plans (QHP) with incomes at or below 300% FPL

Pharmacy Only: Assistance to help pay for prescription medicines based on income, disability status, and age

Choices for Care (Traditional): Vermont's Long-Term Care Medicaid Program for Vermonters in nursing homes, home-based settings, and/or enhanced residential care (ERC)

Choices for Care (Acute): Long-Term Care Medicaid for Vermonters who would otherwise qualify for Choices for Care (Traditional), but who are currently receiving a lower level of care

Agency of Human Services
Caseload and Expenditure Report

DVHA Only YTD SFY'22

	SFY'22 Gov Rec			SFY'22 Actuals Thru September 30, 2021				
Medicaid Eligibility Group	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	% of Expenses to Budget Line Item	Ending Enrollment as of September 2021
ABD Adult	6,475	$ 59,377,463	$ 764.19	6,208	$ 14,783,414	$ 793.74	24.90%	6,193
ABD Dual	17,649	$ 54,564,094	$ 257.64	18,185	$ 12,899,818	$ 236.46	23.64%	18,197
General Adult	10,049	$ 60,588,292	$ 502.44	13,107	$ 17,225,892	$ 438.08	28.43%	13,252
New Adult Childless	35,802	$ 201,971,935	$ 470.11	46,304	$ 57,968,872	$ 417.31	28.70%	46,450
New Adult w/Child	22,258	$ 108,106,667	$ 404.75	26,186	$ 31,786,862	$ 404.63	29.40%	26,278
Dr. D Expansion - State Only*	22	$ 252,420	$ 956.14	-	$ -	$ -	0.00%	-
BD Child	1,594	$ 20,428,886	$ 1,068.01	1,561	$ 4,574,887	$ 977.12	22.39%	1,542
General Child	59,588	$ 160,461,685	$ 224.40	61,466	$ 42,447,390	$ 230.19	26.45%	61,322
Underinsured Child	530	$ 433,667	$ 68.19	555	$ 93,431	$ 56.08	21.54%	554
CHIP	4,374	$ 8,683,881	$ 165.45	4,554	$ 2,396,010	$ 175.39	27.59%	4,586
Dr. D Expansion - State Only*	100	$ 1,147,580	$ 956.32	-	$ -	$ -	0.00%	-
Vermont Premium Assistance	15,937	$ 5,615,851	$ 29.36	13,920	$ 1,245,999	$ 29.84	22.19%	13,479
Vermont Cost Sharing	*3,236*	$ 1,130,724	$ 29.12	*2,840*	$ 235,294	$ 27.61	20.81%	2,812
Pharmacy Only	9,568	$ 5,453,791	$ 47.50	9,830	$ 1,811,328	$ 61.42	33.21%	9,837
Choices for Care - Traditional	-	$ -	$ -	-	$ -	$ -	0.00%	-
Choices for Care - Acute	4,596	$ 40,104,146	$ 727.16	*4,361*	$ 9,538,302	$ 729.06	23.78%	4,320
Total Medicaid	188,542	$ 728,321,082	$ 321.91	206,238	$ 197,007,499	$ 318.41	27.05%	206,010
**New for SFY22, no expenditures for QE 0921*								

All AHS YTD SFY'22

	SFY'22 Gov Rec			SFY'22 Actuals Thru September 30, 2021				
Medicaid Eligibility Group	Caseload	Budget	PMPM	Caseload	Expenses	PMPM	% of Expenses to Budget Line Item	Ending Enrollment as of September 2021
ABD Adult	6,475	$ 155,543,053	$ 2,001.84	6,208	$ 36,214,443	$ 1,944.40	23.28%	6,193
ABD Dual	17,649	$ 245,013,848	$ 1,156.88	18,185	$ 56,823,833	$ 1,041.59	23.19%	18,197
General Adult	10,049	$ 76,671,455	$ 635.81	13,107	$ 20,903,632	$ 531.61	27.26%	13,252
New Adult Childless	35,802	$ 242,809,235	$ 565.17	46,304	$ 66,792,251	$ 480.83	27.51%	46,450
New Adult w/Child	22,258	$ 125,071,773	$ 468.27	26,186	$ 35,513,701	$ 452.07	28.39%	26,278
Dr. D Expansion - State Only*	22	$ 252,420	$ 956.14	-	$ -	$ -	0.00%	-
BD Child	1,594	$ 42,041,945	$ 2,197.93	1,561	$ 8,619,963	$ 1,841.09	20.50%	1,542
General Child	59,588	$ 313,379,879	$ 438.26	61,466	$ 70,263,785	$ 381.04	22.42%	61,322
Underinsured Child	530	$ 1,026,899	$ 161.46	555	$ 168,990	$ 101.43	16.46%	554
CHIP	4,374	$ 11,166,929	$ 212.75	4,554	$ 2,878,202	$ 210.69	25.77%	4,586
Dr. D Expansion - State Only*	100	$ 1,147,580	$ 956.32	-	$ -	$ -	0.00%	-
Vermont Premium Assistance	15,937	$ 5,615,851	$ 29.36	13,920	$ 1,245,999	$ 29.84	22.19%	13,479
Vermont Cost Sharing	*3,236*	$ 1,130,724	$ 29.12	*2,840*	$ 235,294	$ 27.61	20.81%	2,812
Pharmacy Only	9,568	$ 5,453,791	$ 47.50	9,830	$ 1,811,328	$ 61.42	33.21%	9,837
Choices for Care - Traditional	4,724	$ 232,616,220	$ 4,103.45	4,509	$ 58,378,371	$ 4,316.01	25.10%	4,467
Choices for Care - Acute	*4,596*	$ 45,065,763	$ 817.12	*4,361*	$ 10,686,560	$ 816.83	23.71%	4,320
Total Medicaid	188,670	$ 1,504,007,364	$ 664.30	206,385	$ 370,536,354	$ 598.45	24.64%	206,157
**New for SFY22, no expenditures for QE 0921*								

VERMONT
AGENCY OF HUMAN SERVICES

All AHS and AOE YTD SFY'22

Medicaid Eligibility Group	SFY'22 Gov Rec Caseload	Budget	PMPM	SFY'22 Actuals Thru September 30, 2021 Caseload	Expenses	PMPM	% of Expenses to Budget Line Item	Ending Enrollment as of September 2021
ABD Adult	6,475	$ 156,675,672	$ 2,016.42	6,208	$ 36,447,587	$ 1,956.92	23.26%	6,193
ABD Dual	17,649	$ 245,096,109	$ 1,157.27	18,185	$ 56,840,195	$ 1,041.89	23.19%	18,197
General Adult	10,049	$ 76,907,184	$ 637.77	13,107	$ 20,968,761	$ 533.27	27.27%	13,252
New Adult Childless	35,802	$ 242,904,809	$ 565.39	46,304	$ 66,812,165	$ 480.97	27.51%	46,450
New Adult w/Child	22,258	$ 125,086,349	$ 468.32	26,186	$ 35,514,092	$ 452.07	28.39%	26,278
Dr. D Expansion - State Only*	22	$ 252,420	$ 956.14	-	$ -	$ -	0.00%	-
BD Child	1,594	$ 51,986,699	$ 2,717.83	1,561	$ 10,323,593	$ 2,204.95	19.86%	1,542
General Child	59,588	$ 351,090,716	$ 491.00	61,466	$ 76,662,409	$ 415.74	21.84%	61,322
Underinsured Child	530	$ 1,328,975	$ 208.96	555	$ 213,007	$ 127.86	16.03%	554
CHIP	4,374	$ 12,391,819	$ 236.09	4,554	$ 3,133,242	$ 229.36	25.28%	4,586
Dr. D Expansion - State Only*	100	$ 1,147,580	$ 956.32	-	$ -	$ -	0.00%	-
Vermont Premium Assistance	15,937	$ 5,615,851	$ 29.36	13,920	$ 1,245,999	$ 29.84	22.19%	13,479
Vermont Cost Sharing	*3,236*	$ 1,130,724	$ 29.12	*2,840*	$ 235,294	$ 27.61	20.81%	2,812
Pharmacy Only	9,568	$ 5,453,791	$ 47.50	9,830	$ 1,811,328	$ 61.42	33.21%	9,837
Choices for Care - Traditional	4,724	$ 232,616,220	$ 4,103.45	4,509	$ 58,378,371	$ 4,316.01	25.10%	4,467
Choices for Care - Acute	*4,596*	$ 45,082,446	$ 817.42	*4,361*	$ 10,687,816	$ 816.92	23.71%	4,320
Total Medicaid	188,670	$ 1,554,767,364	$ 686.72	206,385	$ 379,273,860	$ 612.57	24.39%	206,157
**New for SFY22, no expenditures for QE 0921*								

The Vermont Cost Sharing Reduction (VCSR) population are also eligble for Vermont Premium Assistance (VPA) and the caseload counts are included in the VPA caseload counts and are not duplicatively reflected in the total. The budget and expenses are specific to each program.

The Choices for Care Acute caseload counts are included within the Choices for Care Traditional caseload counts. The Choices for Care Traditional caseload also includes the Waiver Moderate only population. The Waiver Moderate only population are categorically ineligible for Acute Medicaid services.

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

State of Vermont
Department of Vermont Health Access
280 State Drive, NOB 1 South
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Agency of Human Services
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Questions, Complaints and Concerns Received by Health Access Member Services
January 1, 2022 – March 31, 2022

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

January 2022:

- Provider Complaint - member called about dental care; they cannot find a dentist that will accept Medicaid. Member has called many Dentists this morning and only one office is accepting Medicaid patients in Ludlow, VT. Member is very frustrated and feels that people are being discriminated against because Medicaid is their insurance. Member is worried that if they have a dental emergency, they will not be able to get care. Member feels that they are being discriminated against for having a lower income. Member feels it should not be like this in Vermont. The Agent apologized for the inconvenience, used the VT Medicaid Portal to help find a Dentist accepting new patients and documented the feedback.
- Covered Services - member wishes to report feedback regarding the at-home COVID test limitations. Member feels that 4 tests per 30 days is not sufficient enough for an average household. The Agent reviewed The Medicaid Covered Services Chart with the member and documented their feedback.
- Provider Complaint - member requested to submit feedback regarding a prescription that they need. Member states that they cannot pick it up due to the prescription requiring a Prior Authorization. Member states they cannot take the generic brand due to it causing a headache. Member also tried to contact the provider and is put on a call back list and never

receives a call back. Supervisor assisted with finding a new doctor in the member's area and submitted their negative feedback.

February 2022:

- Provider Complaint - member requested to file negative feedback regarding their provider. Member states that the provider refuses to prescribe a 90-day supply of their medication which is affecting their ability to get medications delivered. Member cannot drive to pick up medications at their local pharmacy. The agent apologized for the inconvenience, documented their feedback and mailed the customer a Provider Complaint Form.
- Provider Complaint - member requested to submit negative feedback as there are not any providers in their area that are accepting new patients, and if they are, they do not have any availability until June. The agent apologized for the inconvenience and attempted to help the customer search for a new provider accepting new patients.
- Provider Complaint - member request to submit negative feedback as they are having issues finding a provider that will see them prior to May. Member is frustrated with the VT Medicaid Portal as it is not up to date with who is or isn't accepting new patients. The supervisor apologized for the inconvenience, attempted to help the customer search for a new Provider accepting new patients and referred to VT Legal Aid if they were unable to get into one of the referred providers.
- Other Resources - member requested to submit negative feedback regarding an Accident Questionaire that they received. Member feels that they shouldn't have to complete these extra steps. The doctor stated it was not an accident and no one is liable. The member has been trying to reach the department regarding the Accident Questionaire and cannot get a hold of a live person for days. The voicemail states that there are no agents currently available. The supervisor apologized for the inconvenience and documented the feedback.

March 2022:

- Covered Services - member requested to document negative feedback regarding Vpharm co-pays. Member states that their co-pay for a specific medication increased by $3.00 and thinks this is not okay. The agent apologized to the customer for the inconvenience and offered to document their feedback.
- Provider Complaint - member reports that they called numerous dental providers in Brattleboro area that were provided by a Customer Service Representative. When they call the specific offices, they advise that they are not accepting Medicaid as insurance. Many offices explained that dentists who previously accepted Medicaid as payment have left the area. Member states that they know dentists should update with VT Medicaid but complains that VT Medicaid Provider List should be updated. Member offered to send the results of their contact with dental providers in Brattleboro area to state. The agent apologized to the customer for the inconvenience and provided the customer with additional providers listed with VT Medicaid, along with transportation resources and assured that their feedback would be sent to the State of VT.
- Provider complaint - member requested to have negative feedback documented. Member feels that the State should make it easier for customers who receive Medicaid to find a provider. The agent directed the customer to the VTMedicaid Portal and assisted with helping choose a provider based off the specialty.

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- DVHA Feedback - member wanted to document negative feedback stating that the DVHA website does not clearly display "Medicare Savings Program" Information. Member states that it should be clearer that the 201P can be used to only apply for the Medicare Savings Program. The agent apologized to the customer for the inconvenience, explained what application she should be completing and documented the feedback.

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
January 1, 2022 – March 31, 2022

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data from the centralized database that were filed from January 1, 2022, through March 31, 2022.

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

During this quarter, there were 5 grievances filed; one was addressed. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was three days. Of the grievances filed, 80% were filed by the beneficiary, and 20% were filed by a representative. DMH had 100% of the grievances filed.

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

There were no Grievance Reviews filed this quarter.

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

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

During this quarter, there were 17 appeals filed. Of these 17 appeals, 12 were resolved (71%).

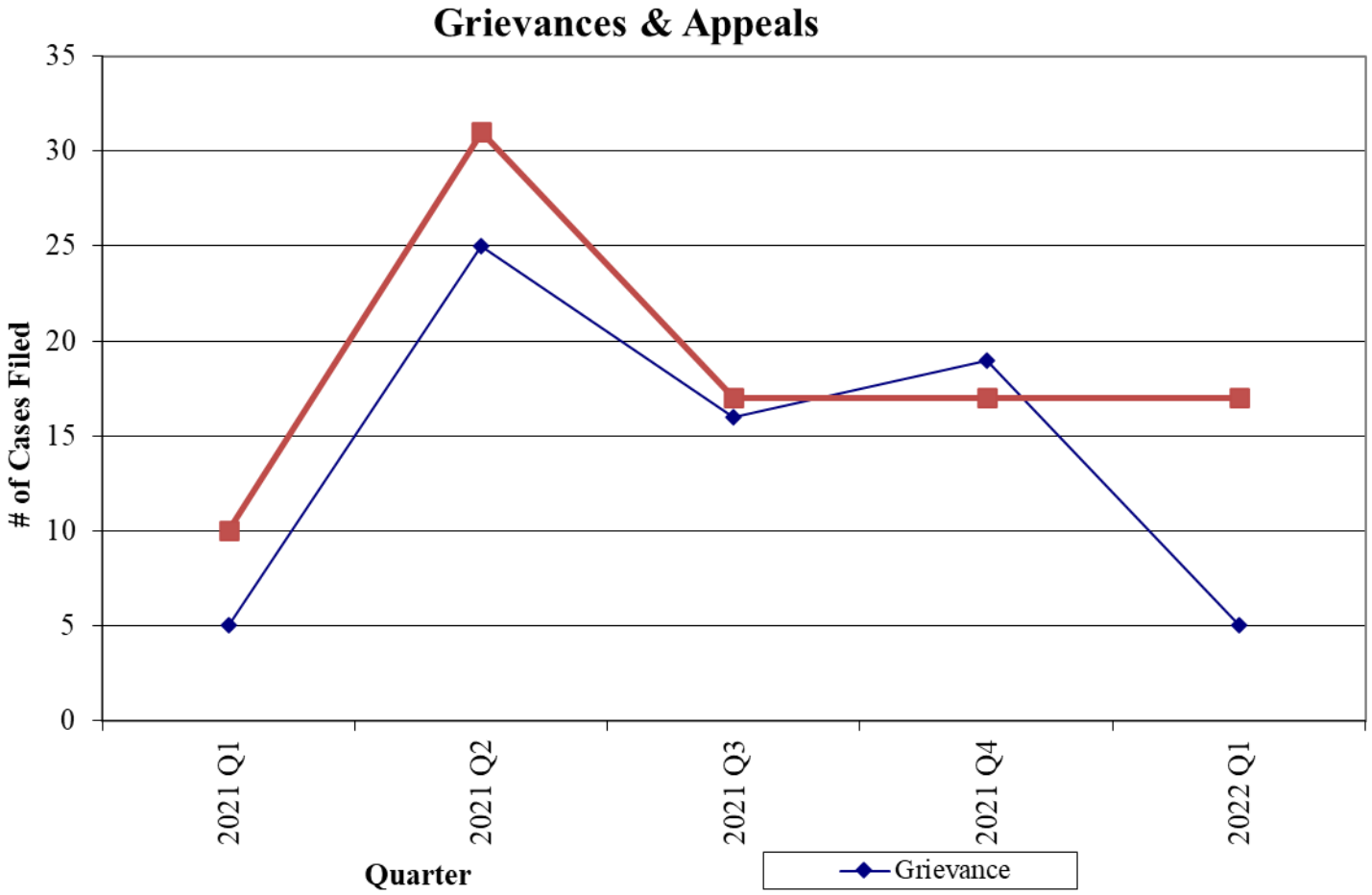
Of the 12 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 30 days. The average number of days it took to resolve these cases was 15 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

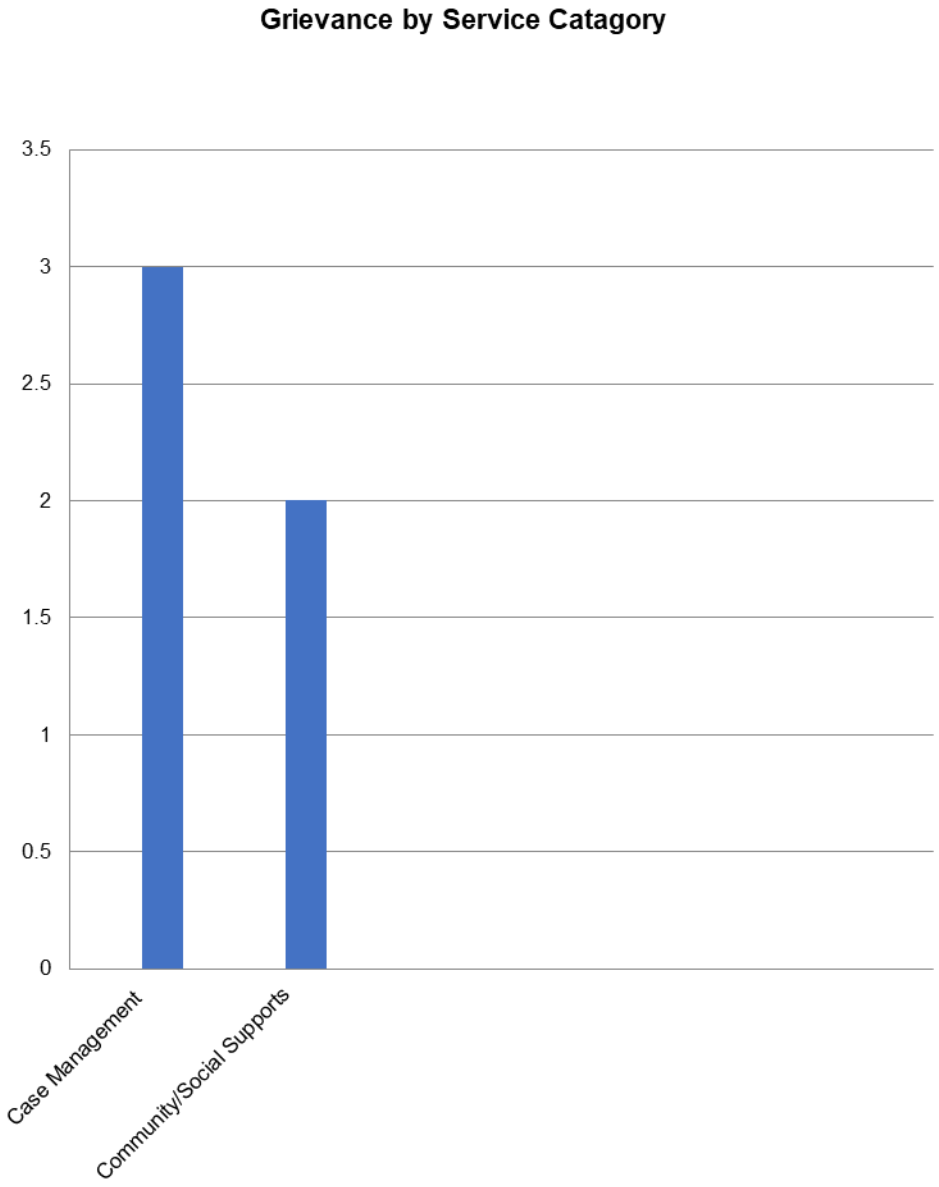
Of the 17 appeals filed, DVHA had 12 appeals filed (71%), DAIL had 4 (24%), VDH had 1 (5%) and DMH had none.

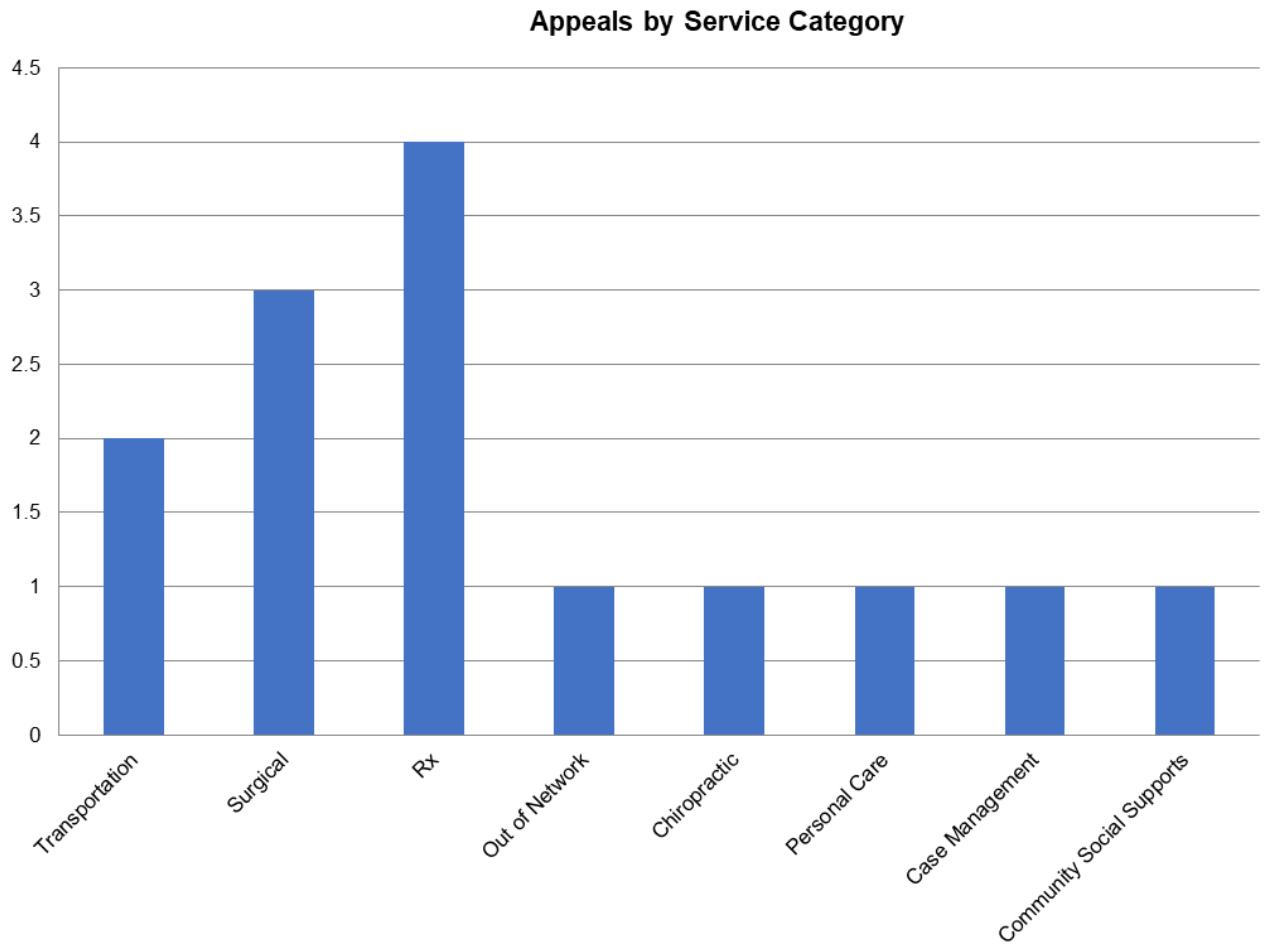
The appeals filed were for service categories, case management, chiropractic services, personal care services, out of network services, RX, developmental services, respite, surgical services, and transportation services.

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

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


Grievances & Appeals
35
30
25
20
15
10
5
0
# of Cases Filed
2021 Q1
2021 Q2
2021 Q3
2021 Q4
2022 Q1
Quarter
Grievance


Grievance by Service Catagory
3.5
3
2.5
2
1.5
1
0.5
0
Case Management
Community/Social Supports


Appeals by Service Category
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Transportation
Surgical
Rx
Out of Network
Chiropractic
Personal Care
Case Management
Community Social Supports

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.

Since Governor Scott's "stay at home" order on March 24, 2020, the HCA has been operating remotely, and it anticipates operating on a hybrid schedule starting in the summer of 2022. The HCA Helpline now has eight advocates working to resolve issues.

The first quarter of the calendar year is typically a busy one, with many consumers calling about their new Medicare Part D plans. It is also the start of the Open Enrollment period for Medicare Advantage Plans. We spoke to 92 households about Medicare eligibility and enrollment this quarter. We also talked to another 24 households about their Part D plans, and 52 household about Medicare Savings Programs, which help consumers pay for their Medicare premiums and cost-sharing. We talked to 8 household about Extra Help, a program which helps households pay for Medicare Part D. We advised 18 household about Medicare late enrollment penalties, as well. Overall, the HCA helpline had 820 calls this quarter.

We had a significant number of calls about DVHA programs. This last quarter we had 70 calls on that issue (45 the previous quarter). We also had 168 calls about all types of Medicaid eligibility. Our website had 2,336 pageviews on Medicaid eligibility limits, and over 1,000 page views on Vermont Health Connect.

In January, VHC enrollees started to pay their premiums directly to carriers. VHC and other stakeholders had done significant consumer education and outreach on the premium payment transition. The helpline did not get many calls from consumers with questions or who were having problems with the transition because of the advance preparation and outreach. We only had two calls on the issue, although we expect we may get more calls in the coming months.

With the start of the legislative session this quarter, the HCA put considerable resources into our legislative priorities which included bills focused on hospital free care policies, Medigap open enrollment, PBM regulation, insurance marketplace considerations given Congress's failure to extend expanded premium tax subsidies for 2023, and various other issues.

Lynn's Story:

Lynn had just moved to Vermont from out of state and needed help filling her prescription. Before moving to Vermont, she had been able to fill a 90-day supply of her prescription, but it was running out and Lynn could not find a provider in Vermont. The HCA advocate established that Lynn had been approved for Vermont Medicaid. But because she could not find a Vermont Medicaid provider, she could not get her prescription re-filled. Since Lynn was new to Vermont Medicaid and in need of a primary care provider, the HCA advocate was able to refer Lynn to Vermont Chronic Care Initiative (VCCI). VCCI provides short-term case management—and it also works with new Medicaid members to assist them with finding providers. Lynn spoke with VCCI—and she was able to get an appointment within a week, which meant she would not run out of her prescription.

The contract dispute between United Health Care and the University of Vermont Health Network impacted both our helpline and the policy team this quarter. We received calls from Vermonters who

were frustrated and panicked at the prospect of losing network coverage for the providers that they needed for their care. We talked to many consumers who depended on specialists at UVMMC, and who just did not have an adequate alternative to care at UVMMC. In partnership with state leaders in the administration, the Green Mountain Care Board, state legislative leaders, and state congressional staff, the HCA planned a meeting for Vermonters impacted by this issue. Because the parties reached an agreement at the last minute, the meeting did not happen. However, the HCA's willingness to convene this group was a motivating factor for the parties to find agreement.

The HCA continues to focus on medical debt and how it impacts access to care for Vermonters. This quarter we launched the next phase of this project with the creation of a *Medical Debt website*. The VTmedicaldebt.org website will help us continue to focus policy makers and the public on the devastating impacts that medical debt has on Vermonters' access to necessary care.

As we start to emerge from the COVID-19 pandemic, Vermont's health care system is still under stress. Vermonters are still having trouble accessing the care they need. Many must wait months for a medical or dental appointment. We had 31 calls from households having trouble accessing dental care, 25 about primary care, and 26 having trouble finding a specialist. Consumers must also contend with high costs and medical debt. Along with stakeholders, we will continue to address accessibility and affordability issues as the state moves forward, so that Vermonters will be able to get appointments to see their providers. The HCA will continue to work to make healthcare more accessible for all Vermonters, and to make the system more equitable, responsive, and affordable.

Steven's Story:

Steven was losing his employer insurance, and he was not sure what to do next. He was hopeful that he could get a job with insurance in a few months, but he did not have a concrete job offer. He was also 65 and Medicare eligible. He wanted to know if he should enroll in Medicare or COBRA. He was also thinking about waiting to enroll on the employer insurance at his next job. The HCA advocate explained his options. First, COBRA allows you to continue employer group coverage from your past employer. However, it is often very expensive. Because Steven was already 65, he also had to consider how COBRA and Medicare interacted. If you enroll on COBRA, and then you sign up for Medicare, your COBRA benefits usually end. If you are enrolled on Medicare first, and then sign up for COBRA, COBRA would act as secondary insurance. Steven also had to consider the timing of his plans. Because he had lost his employer insurance, he had an eight-month special enrollment period for Part B, but he had a much shorter time to sign up for Part D, prescription drug coverage. If you have a gap in credible prescription coverage for more 63 days, you might be charged a Part D penalty. The HCA advocate helped Steven understand enrollment rules and assisted him with weighing the risks and benefits of each choice. Ultimately, Steven decided against enrolling in COBRA because of the expense. He also did not want to take the risk of waiting to enroll in employer coverage, because he was not sure when he would find another job that offered employer insurance. He decided to enroll in Medicare so he could have coverage while he continued with his job search.

Deedee's Story:

Deedee was new to Medicare, and she could not afford the premiums. She had not realized that when she signed up for Medicare Part B, the $170.10 monthly premium would be deducted from her Social Security. Medicare Part B covers outpatient treatment, and the monthly cost increased significantly in 2022. Deedee did not have enough money for her monthly bills after the premium was deducted and had been forced to borrow from family members. She was considering dis-enrolling from Part B. The HCA advocate explained that if she disenrolled, she would not have a special enrollment period to enroll again if she needed Part B coverage. That would mean she could have a gap in coverage. Also, if she tried to enroll in the future, she could have a late enrollment penalty, which would make Part B even more expensive. The HCA advocate investigated and found that Deedee was eligible for a Medicare Savings Program called QMB, that would pay for both her premiums and her Medicare cost-sharing. She helped Deedee with the application, and Deedee was found eligible for the Medicare Savings Program, which meant that the premium would no longer be deducted from her Social Security.

Jack's Story:

Jack had a surgery scheduled for later in the month, but he was losing his employer insurance. Because he had used up all his leave time, his employer was putting him on unpaid leave. That meant the was no longer going to be eligible for insurance through his employer. He was also not getting paid. Jack did not want to re-schedule the surgery because it had already been delayed due to the COVID pandemic, and he needed surgery to return to work. The HCA advocate investigated and found that because Jack was on unpaid leave, he would now be income-eligible for Medicaid. She helped him with the application and requested that it be expedited because of the scheduled surgery. Jack was approved for Medicaid and Children and Adults (MCA). This meant that he could go forward with his surgery, and he hopes to be able to return to his job in the coming months.

Overview

The HCA provides assistance to 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 819 calls[1] this quarter. We divided these calls into broad categories. The figures below are based on the All Calls data. The percentage and number of calls in each issue category, based on the caller's primary issue, were as follows:

- **30.53%** about **Access to Care**
- **11.11%** about **Billing/Coverage**
- **3.42%** about **Buying Insurance**
- **13.31%** about **Complaints**
- **13.68%** about **Consumer Education**
- **17.46%** about **Eligibility** for state and federal programs
- **8.91**% were categorized as **Other**, which includes communication problems with health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

We have a customized case management system that allows us to track more than one issue per case. This enables us to see the total number of calls that involved multiple issues. For example, although 143 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, an additional 307 cases had eligibility listed as a secondary concern.

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

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

The full quarterly report for January – March 2022 includes:

- This narrative
- Five data reports, including three based on the caller's insurance status:
  - **All Calls/All Coverages**: 819
  - **Department of Vermont Health Access (DVHA) beneficiaries**: 86

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

- **Commercial Plan Beneficiaries**: 160
- **Uninsured Vermonters**: 48
- **Vermont Health Connect (VHC)**: 118

The Top Issues Generating Calls

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

All Calls 819 (vs. 766 last quarter)

1. Complaints about Providers 103 (111)
2. Medicare Consumer Education 92 (77)
3. MAGI Medicaid Eligibility 82 (82)
4. Information/Applying for DVHA Programs 70 (45)
5. Access to Prescription Drugs/Pharmacy 61 (45)
6. Other Issues (Not Health-related) 58 (41)
7. Medicaid Eligibility (non-MAGI) 57 (56)
8. Buy-in Programs/Medicare Savings Programs 52 (55)
9. Premium Tax Credit Eligibility 46 (60)
10. Special Enrollment Period Eligibility 46 (19)
11. Access to Nursing Home & Home Health 43 (37)
12. Complaints about Hospital 38 (36)
13. Hospital Billing & Financial Assistance 37 (33)
14. Complaints about Carrier 34 (27)
15. Access to Dental Care 31 (28)

Vermont Health Connect Calls 118 (125)

1. Medicaid Eligibility – MAGI 48 (45)
2. Premium Tax Credit Eligibility 45 (60)
3. Buying QHPs through VHC 28 (43)
4. Special Enrollment Period Eligibility 27 (14)
5. Information about DVHA 20 (15)
6. IRS Reconciliation Education 16 (17)
7. Termination of Insurance 16 (6)
8. Premiums Billing 12 (9)
9. VHC – 1095 Problems 12 (0)
10. ACA Tax Issues 12 (17)

DVHA Beneficiary Calls 86 (vs. 217 last quarter)

1. Information about Medicare 13 (26)
2. Non-MAGI Medicaid Eligibility 12 (35)

3. Nursing Home & Home Health Access 9 (9)
4. Complaints about Providers 8 (32)
5. Eligibility for MSPs/Buy-In Programs 7 (32)
6. Part D Plan Eligibility 7 (13)
7. Information about Enrollment Penalties 5 (2)
8. Information about DVHA 5 (21)
9. VPharm Eligibility 5 (8)
10. Access to DME & Supplies 4 (6)
11. Not Health Related 4 (7)

Commercial Plan Beneficiary Calls 160 (vs. 147 last quarter)

1. Premium Tax Credit Eligibility 27 (40)
2. Access to Prescription Drugs/Pharmacy 21 (10)
3. Carrier Complaints 21 (13)
4. Buying QHPs through VHC 20 (29)
5. Eligibility for MAGI Medicaid 16 (14)
6. Billing – Hospital Billing & Financial Assistance 15 (7)
7. Billing - Premiums 15 (12)
8. Eligibility for Special Enrollment Period 15 (10)
9. VHC – 1095 Problems 12 (0)
10. IRS Reconciliation Consumer Education 12 (13)
11. Medicare Consumer Education 12 (17)

The HCA received **819** total calls this quarter. Callers had the following insurance status:

- **DVHA program beneficiaries** (Medicaid, Medicare Savings Program also called Buy-In program, VPharm, or both Medicaid and Medicare also known as "dual eligible"): 35.50%. (283 calls)
- **Medicare**[2] **beneficiaries (**Medicare only, Medicare Advantage Plans, Medicare and a Medicare Supplemental Plan aka Medigap, Medicare and Medicaid also known as "dual eligible," Medicare and Medicare Savings Program also called Buy-In program, Medicare and Part D, or Medicare and VPharm): 21.3% (175 calls)
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans) 16.3% (134 calls)
- **Uninsured:** 5.86 % (48 calls)

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

Dispositions of Closed Cases

All Calls: We closed 804 cases this quarter. Overall, 356 were resolved by brief analysis and advice. Another 262 were resolved by brief analysis and referral. There were 99 complex interventions involving complex analysis and more than two hours of an advocate's time, and 61 cases that involved at least one direct intervention on behalf of a consumer. The HCA provided consumer education in 289 cases. We also estimated eligibility for insurance coverage and helped enroll people onto coverage in 61 cases. We saved consumers $41,695.50 this quarter.

Consumer Protection Activities

Rate Review

The HCA monitors all commercial insurance carrier requests to the Green Mountain Care Board (Board) for changes to premium rates. These are usually requests for rate increases.

On August 5, 2021, the Board issued a Decision and Order related to Blue Cross Blue Shield of Vermont (BCBSTV) 2022 insurance premiums for the individual and small group markets (Order). On August 18, 2021, BCBSVT filed a Motion to Reconsider (Motion) with the Board challenging the Order. BCBSVT argued, in the Motion, that the Board should have used the affordability statutory factor rather than the word "excessive" when it reduced BCBSVT's allowed profit. The HCA filed a response to the Motion and argued that the Board properly reduced BCBSVT's proposed rate. On August 24, 2021, the Board denied BCBSVT's Motion.

On September 3, 2021, BCBSVT filed notice that it would appeal the Order to the Vermont Supreme Court arguing that the Board should not have used the word "excessive" when it reduced BCBSVT's proposed profit. The parties to the Vermont Supreme Court suit are BCBSVT, represented by Stris and Maher, the Board, represented by the Attorney General, and the HCA. BCBSVT filed their initial brief on January 3, 2022. The Attorney General and the HCA filed their briefs on February 14, 2022. BCBSVT filed a reply brief to the HCA's and the GMCB's. The Vermont Supreme Court has scheduled the case for oral argument on April 28, 2022. The HCA has taken and will continue to take all appropriate steps to represent the interests of Vermonters in this matter.

Two commercial rate filings were made this quarter: the BCBSVT Association Health Plan filing, GMCB-002-22rr, and the BCBSVT Large Group filing, GMCB-001-22rr. The HCA has appeared in both matters and both matters remain pending. The HCA has and will continue to take all appropriate steps to represent the interests of Vermonters in these two matters.

Hospital Budgets

The HCA submitted written questions and recommendations to the Green Mountain Care Board (Board) as a part of the annual hospital budget process. We also submitted written comments to the Board in response to midyear charge requests from three hospitals – University of Vermont Medical Center, Central Vermont Medical Center, and Rutland Regional Medical Center. The Board incorporated two recommendations from the HCA to their Policy on Budget Amendments and Adjustments requiring hospitals to provide the written notice in plain language and offer a phone number/contact information for patients to access free hospital interpretation services.

Certificate of Need Review Process

The GMCB currently has an unusually large number of open certificates of need applications. In the last quarter, the HCA monitored several ongoing and new applications and filed two notices of appearance (NOA) requests for GMCB-009-21con: 1) The Kahm Clinic – New Eating Disorder Treatment Program, which will have a public hearing this spring, and 2) GMCB-008-21con: The Collaborative Surgery Center, in which the HCA submitted written comments and recommendations to the Board, specifically that the Board approve the application with conditions requiring the Collaborative Surgery Center to complete implicit bias training, include patient and consumer representation on their Quality and Performance Committee, adhere to a PFA policy at least as generous as UVMMC, and provide a plain language summary of their PFA policy to patients. We continue to actively monitor certificate of need applications as they are submitted and updated with the Board.

Oversight of Accountable Care Organizations

The HCA participated in the GMCB's budgetary and regulatory review of Clover Health, a Medicare-only ACO, by submitting written comments and participating in public Board meeting discussions. The HCA recommended that the Board deny Clover Health's request to waive their regulatory authority over Clover Health. The Board supported this recommendation and agreed to regulate Clover Health's business activities pursuant to their statutory authority over accountable care organizations operating in the state. The HCA is also scheduled to meet with the Board staff to discuss the upcoming budget for OneCare Vermont (OCV) as well as accompanying budgetary guidance.

Additional Green Mountain Care Board and other agency workgroups

Over the last quarter, the HCA attended the Board's weekly board meetings, monthly Data Governance meetings, and weekly Prescription Drug Technical Advisory subgroup meetings (which includes the Out-of-Pocket Costs and Pharmacy Benefit Manager subgroups). The HCA submitted a policy proposal related to improving affordability in the QHP market in the state. The Board agreed to convene a group of stakeholders to study the proposal.

Vermont Hospital Quality Framework Workgroup

The HCA joined the recently-convened Vermont Hospital Quality Framework Workgroup – whose charge is to "design a framework of meaningful metrics that provides relevant information and accurately reflects the hospital system's quality of care within the healthcare reform environment in Vermont."

The Medicaid and Exchange Advisory Committee

The Advisory Committee met three times this quarter. The Chief Advocate stepped in to facilitate one of these meetings due to absences of the chairs. The content of this quarter's meetings included a focus on Global Commitment negotiations, Advisory committee membership, MABD Self-Service Application, 2020 Next Generation performance results, 2023 DVHA budget Overview and the Home and Community Based Services Spending Plan Update.

Mental Health Integration Council

The HCA is a member of the Mental Health Integration Council. The Chief Advocate continued to attend and participate in meetings of the full council as well as the Pediatric integration subgroup. The council spent meeting time understanding the integration work successes already underway in Vermont including the efforts of our Blueprint for Health. In addition, the effort to organizing the subgroups and developing a process for how the subgroups work on overlapping issues has been a significant focus.

Legislative Advocacy

This quarter represents the most active part of the Legislative session. The Chief Advocate spent considerable time in the State House both advocating for changes to Vermont laws, as well as being responsive to legislators and legislative committees. The following bills represent the majority of our advocacy this quarter:

H. 353: The HCA worked with stakeholders on House Bill H. 353 – which establishes a framework for regulating pharmacy benefit managers (PBMs) and improving transparency. The bill successfully passed the House on March 23rd and is currently being considered in the Senate Health and Welfare Committee. We worked with the Department of Financial Regulation regarding specific provisions contained in the bill related to fiduciary responsibilities being considered in the pending legislation.

H.287: An act relating to patient financial assistance policies and medical debt protection. Passage of H.287 has been a significant priority for the HCA this year. The bill addresses some of the challenges that Vermonters face when seeking patient financial assistance, and that we hear about from consumers who call the HCA helpline. We worked in collaboration with the Vermont Association of Hospitals and Health Systems to find common ground that we presented to the House Health Care Committee. The bill passed the house and is now in the Senate Health and Welfare Committee.

S.239: An act relating to enrollment in Medicare supplemental insurance policies. This bill as introduced would have created an annual open enrollment period for Medigap plans and created a study group to look at insurance coverage issues impacting Vermonters on Medicare. The HCA has been promoting this bill over the last two bienniums. This year, the bill was first taken up by Senate Health and welfare who passed the bill with only small adjustments to section two of the bill. The bill then moved to Senate Finance where the carriers opposed the bill due to their concern that the creation of an annual open enrollment period would lead to higher rates. The Senate Finance Committee removed the annual open enrollment period and forwarded the study sections of the bill.

The House Health and Welfare Committee moved the bill as passed by the Senate with the inclusion of a study group question about the advisability of updating Vermont's Medicare Savings Plan eligibility standards.

At the close of the quarter the bill was moving into the final phases of reconciliation between the two bodies with no real issues of contention.

S.285: An act relating to health care reform initiatives, data collection, and access to home- and community-based services. This bill started in Senate Health and Welfare, motivated significantly by the Green Mountain Care Board's interest in moving forward on a plan to address hospital sustainability. The bill costs $5 million. The HCA supported the bill due to its promise of public engagement and honest conversations with Vermont communities about the financial and workforce challenges facing Vermont hospitals. The bill passed the Senate and moved over to House Health Care where is currently lies at the end of the quarter.

H.489: An act relating to miscellaneous provisions affecting health insurance regulation. Merged/Unmerged market. This bill started as a largely uncontroversial bill from the Department of Financial regulation. The HCA supported it in the House with minor edits that were agreed to. On the Senate side, in the Senate Finance Committee, Blue Cross and Blue Shield proposed permanently unmerging the individual and small group QHP marketplace, whether or not Congress extends the ARPA Premium Tax Credits. The HCA opposed unmerging the market as long as there is no system and funding to support the individual market from the significant rate increases that would result.

Medical Debt Story Telling Project

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

Our work on the Medical Debt Story Telling Project this quarter focused on the development of an interactive web application to showcase Vermonters' experiences with medical debt and the impact of cost on access to health care services. Working in collaboration with the Burlington Brigade of Code for America and the Burlington Code Academy, the HCA developed and deployed a web application with roughly 300 stories from Vermonters related to medical debt and the cost of care. Users can interact with a web map to view stories by county in addition to being able to filter stories by topic and/or geography. The web application is available at *www.vtmedicaldebt.org*. The stories were drawn from responses to a survey on medical debt that we fielded in 2021.

Next quarter, the HCA will focus on outreach to communities to increase the number of Vermonters who choose to share their stories related to medical debt and to increase awareness of *www.vtmedicaldebt.org* to stakeholders in the health policy arena and Vermont legislators.

Collaboration with Other Organizations

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

- American Civil Liberties Union of Vermont
- Bi-State Primary Care
- Bridges to Health
- Blue Cross Blue Shield of Vermont
- Burlington Brigade of Code for America
- Burlington Code Academy
- Department of Financial Regulation
- Families USA
- IRS Taxpayer Advocate Service
- Let's Grow Kids
- Mexican Consulate
- Migrant Justice
- MVP Health Care
- National Academy for State Health Policy
- NHeLP, National Health Law Program
- New American Clinic/Family Room
- OneCare Vermont
- Open Door Clinic
- Planned Parenthood of Northern New England
- Rights and Democracy (RAD)
- RISPnet Group
- Rural Vermont
- South Royalton Legal Clinic
- Spectrum Youth and Family Services
- SHIP, State Health Insurance Assistance Program
- U.S. Based Committee for Refugees and Immigrants Vermont
- University of Vermont Medical Center
- University of Vermont Migrant Health, Bridges to Health Vermont Association of Hospitals and Health Systems
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Health Connect
- Vermont Health Care for All
- Vermont Interfaith Action (VIA)
- Vermont Medical Society
- Vermont - NEA
- Vermont Workers' Center
- VPIRG
- You First

Increasing Reach and Education Through the Website

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

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

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

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

1. Income Limits - Medicaid – 2,336
2. Health - section home page – 1,950 pageviews
3. Medicaid, Dr. Dinosaur & Vermont Health Connect – 1,034
4. Dental Services – 886
5. Medicaid – 682
6. Services Covered – Medicaid – 682
7. Medicare Savings Programs – 530
8. Long-Term Care – 513
9. Resource Limits - Medicaid – 423
10. HCA Help Request Form – 371 pageviews and 150 online help requests
11. Dr. Dynasaur – 338
12. Prescription Help – State Pharmacy Programs – 333
13. Choices for Care Income Limits – 324
14. Vermont Health Connect – 308
15. Choices for Care – 285
16. Medical Decisions: Advance Directives – 273
17. Choices-care-giving-away-property-or-resources 242 *
18. Advance Directive forms – 233 *
19. Buying-prescription-drugs 227 *
20. Vermont Long-Term Care Ombudsman Project – 227

This quarter we had these additional news items:

- Coronavirus and Long-Term Care – 170 pageviews
- More Financial Help Available for Vermont Health Connect Plans for 2022; Enroll Now! – 70
- You May Be Eligible for New Financial Help for Health Insurance (ARPA) – 37
  Coronavirus SEP for Vermont Health Connect

Outreach and Education

The Office of the Health Care Advocates (HCA) used both in-person and virtual platforms to connect with Vermonters this quarter. We plan to utilize this hybrid outreach model moving forward to make our services more accessible to community members and partner organizations as we move into the next phase of the COVID-19 pandemic.

Our office continued to use virtual platforms such as Facebook, Zoom, and YouTube to connect with partner organizations and deliver legal education presentations. We partnered with 14 organizations and participated in 10 outreach presentations as a means of providing accurate and accessible information on insurance eligibility health care policy.

In January of 2022 we launched our own Facebook page. Because of way the COVID-19 public health emergency has impacted health care access and eligibility, we decided to create our own social media presence that would allow Vermonters to get easy access to information on health law-related topics.

We have used this page to deliver messaging on a variety of healthcare related topics, but most notably, we produced and distributed an outreach video that discussed our office's free services. This video has been viewed over 450 times.

Additionally, we used this page to circulate educational material on the right to access vaccines regardless of health insurance coverage or immigration status. This video was produced and distributed in collaboration with the Vermont Language Justice Project. It was translated into 14 different languages and circulated online and through the Burlington and Winooski School Districts.

From February 5th to March 15th the HCA connected with seven organizations from across Vermont that provide direct service to immigrants and refugees. We disseminated information about the free assistance our office can offer. We dedicated more outreach capacity to this group because health insurance eligibility rules can be complicated for these populations.

We partnered with organizations such as AALV, the Vermont Language Justice Project, the Family Room, the University of Vermont's Bridges to Health Program, Vermont USCRI, the Open Door Clinic, and the Mexican Consulate to deliver legal education about immigration status and health insurance eligibility and distribute translated outreach material in Spanish.

The HCA has also tried to re-establish in-person outreach and service delivery through a legal help clinic partnership with Vermont Legal Aid and the Old North End Community Center. This community center hosts organizations such as AALV, the Family Room, the New American Clinic, and the Champlain Senior Center. Our office organizes monthly in-person events where community members can connect with legal advocates to get free and confidential advice. In-person and telephonic interpretation and childcare are available to support people seeking our assistance. We hope to expand these clinics to different geographic areas in the future.

Office of the Health Care Advocate

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

https://vtlawhelp.org/health

CY 2022 Investment Expenditures

Department	Criteria	STC #	Final Receiver	Final Receiver Suffix	Investment Description	QE 0322	QE 0622	CY 2022 Total
AHSCO	4	41	99999	9091	Investments (STC-79) - 2-1-1 Grant (41)			-
AHSCO	2	54	99999	9090	Investments (STC-79) - Designated Agency Underinsured Services (54)			-
AOE		11	n/a	n/a	Non-state plan Related Education Fund Investments			-
DCF	2	55	99999	9402	Investments (STC-79) - Medical Services (55)	29,886		**29,886**
DCF	2	1	99999	9403	Investments (STC-79) - Residential Care for Youth/Substitute Care (1)			-
DCF	2	56	99999	9405	Investments (STC-79) - Aid to the Aged, Blind and Disabled CCL Level III (56)	1,015,016		**1,015,016**
DCF	2	57	99999	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level III (57)	27,165		**27,165**
DCF	2	58	99999	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Res Care Level IV (58)	60,495		**60,495**
DCF	2	59	99999	9408	Investments (STC-79) - Essential Person Program (59)	199,586		**199,586**
DCF	2	60	99999	9409	Investments (STC-79) - GA Medical Expenses (60)	37,180		**37,180**
DCF	2	61	99999	9411	Investments (STC-79) - Therapeutic Child Care (61)	291,853		**291,853**
DCF	2	2	99999	9412	Investments (STC-79) - Lund Home (2)	1,018,417		**1,018,417**
DCF	2	33	99999	9413	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)			-
DCF	2	34	99999	9414	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturing Parent (34)	36,225		**36,225**
DCF	2	9	99999	9415	Investments (STC-79) - Challenges for Change: DCF (9)	54,412		**54,412**
DCF	2	26	99999	9416	Investments (STC-79) - Strengthening Families (26)	259,426		**259,426**
DCF	1	62	99999	9417	Investments (STC-79) - Lamoille Valley Community Justice Project (62)	113,155		**113,155**
DCF	2	35	99999	9418	Investments (STC-79) - Building Bright Futures (35)	116,423		**116,423**
DCF				9419	Investments (STC-79) - United Ways 2-1-1 (41)	113,203		**113,203**
DDAIL	2	63	99999	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly Visually Impaired (63)	142,394		**142,394**
DDAIL	2	64	99999	9603	Investments (STC-79) - DS Special Payments for Medical Services (64)	437,186		**437,186**
DDAIL	2	27	99999	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)	288,412		**288,412**
DDAIL	2	42	99999	9605	Investments (STC-79) - Quality Review of Home Health Agencies (42)			-
DDAIL	4	43	99999	9606	Investments (STC-79) - Support and Services at Home (SASH) (43)	245,165		**245,165**
DDAIL	4	77	99999	9607	Investments (STC-79) - HomeSharing (77)	69,470		**69,470**
DDAIL	4	78	99999	9608	Investments (STC-79) - Self-Neglect Initiative (78)	140,627		**140,627**
DDAIL	4	65	99999	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (65)			-
DMH	2	28	99999	9501	Investments (STC-79) - Special Payments for Treatment Plan Services (28)	15,618		**15,618**
DMH	2	66	99999	9502	Investments (STC-79) - MH Outpatient Services for Adults (66)	613,644		**613,644**
DMH	2	79	99999	9504	Investments (STC-79) - Mental Health Consumer Support Programs (79)	110,675		**110,675**
DMH	4	16	99999	9505	Investments (STC-79) - Mental Health CRT Community Support Services (16)	1,421,292		**1,421,292**
DMH	2	12	99999	9506	Investments (STC-79) - Mental Health Children's Community Services (12)	569,189		**569,189**
DMH	2	29	99999	9507	Investments (STC-79) - Emergency Mental Health for Children and Adults (29)	2,324,813		**2,324,813**
DMH	2	67	99999	9508	Investments (STC-79) - Respite Services for Youth with SED and their Families (67)	310,397		**310,397**
DMH	2	22	99999	9510	Investments (STC-79) - Emergency Support Fund (22)	93,455		**93,455**
DMH	2	3	99999	9511	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - VPCH	7,505,908		**7,505,908**
DMH	2	3	99999	9512	Investments (STC-79) - Institution for Mental Disease Servcies: DMH (3) - BR	615,596		**615,596**
DMH	2	68	99999	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (68)	26,486		**26,486**
DMH	2	13	99999	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (13)	106,888		**106,888**
DMH				9914	Investments (STC-79) - CRT Gloabal Commitment			-
DOC	2	4	n/a	n/a	Return House			-
DOC	2	5	n/a	n/a	Northern Lights			-
DOC	2	6	n/a	n/a	Pathways to Housing - Transitional Housing			-
DOC		14	n/a	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)			-
DOC	4	15	n/a	n/a	Northeast Kingdom Community Action			-
DOC	2	69	n/a	n/a	Intensive Substance Abuse Program (ISAP)			-
DOC	2	70	n/a	n/a	Intensive Domestic Violence Program			-
DOC	2	71	n/a	n/a	Community Rehabilitative Care	2,338,304		**2,338,304**
DOC	2	80	n/a	n/a	Intensive Sexual Abuse Program			-
DOC		87		n/a	Vermont Achievment Center			-
DVHA	4	8	99999	9101	Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8)			-
DVHA	4	51	99999	9102	Investments (STC-79) - Vermont Blueprint for Health (51)	587,252		**587,252**
DVHA	1	52	99999	9103	Investments (STC-79) - Buy-In (52)	3,358		**3,358**
DVHA	1	53	99999	9104	Investments (STC-79) - HIV Drug Coverage (53)			-
DVHA	1	18	99999	9106	Investments (STC-79) - Patient Safety Net Services (18)			-
DVHA	1	7	99999	9107	Investments (STC-79) - Institution for Mental Disease Services: DVHA (7)	1,433,991		**1,433,991**
DVHA	1	72	99999	9108	Investments (STC-79) - Family Supports (72)			-
DVHA	1	81	99999	9109	DSR Investment (STC-83) – One Care VT ACO Quality & Health Management (81)			-
DVHA	1	82	99999	9110	DSR Investment (STC-83) – One Care VT ACO Advanced Community Care Coordination (82)			-
DVHA		83		9111	DSR Investment (STC-83) - One Care VT ACO Primary Prevention Development (83)			-
GMCB	4	45	n/a	n/a	Green Mountain Care Board			-
UVM	4	10	n/a	n/a	Vermont Physician Training			-
VAAFM	3	36	n/a	n/a	Agriculture Public Health Initiatives			-
VDH	2	19	99999	9201	Investments (STC-79) - Emergency Medical Services (19)	188,129		**188,129**
VDH	2	74	99999	9203	Investments (STC-79) - TB Medical Services (74)	741		**741**
VDH	2	40	99999	9204	Investments (STC-79) - Epidemiology (40)	112,702		**112,702**
VDH	2	39	99999	9205	Investments (STC-79) - Health Research and Statistics (39)	309,495		**309,495**
VDH	2	31	99999	9206	Investments (STC-79) - Health Laboratory (31)	945,283		**945,283**
VDH	4	50	99999	9207	Investments (STC-79) - Tobacco Cessation: Community Coalitions (50)	608,501		**608,501**
VDH	2	76	99999	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)			-
VDH	2	75	99999	9209	Investments (STC-79) - Family Planning (75)	248,354		**248,354**
VDH	3	25	99999	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)	48,000		**48,000**
VDH	2	73	99999	9211	Investments (STC-79) - Renal Disease (73)			-
VDH	2	37	99999	9213	Investments (STC-79) - WIC Coverage (37)	491,701		**491,701**
VDH	3	21	99999	9214	Investments (STC-79) - Area Health Education Centers (AHEC) (21)	(12,000)		**(12,000)**
VDH	3	47	99999	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	7,674		**7,674**
VDH	3	30	99999	9219	Investments (STC-79) - Substance Use Disorder Treatment (30)	1,069,403		**1,069,403**
VDH	3	17	99999	9220	Investments (STC-79) - Recovery Centers (17)	451,852		**451,852**
VDH	4	46	99999	9221	Investments (STC-79) - Enhanced Immunization (46)	69,322		**69,322**
VDH	4	48	99999	9222	Investments (STC-79) - Poison Control (48)	15,354		**15,354**
VDH	4	23	99999	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	304,575		**304,575**
VDH	4	38	99999	9224	Investments (STC-79) - Fluoride Treatment (38)	21,825		**21,825**
VDH	4	24	99999	9225	Investments (STC-79) - Medicaid Vaccines (24)			-
VDH	4	49	99999	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Prevention Program (49)	18,272		**18,272**
VDH	4	44	99999	9228	Investments (STC-79) - VT Blueprint for Health (44)	171,960		**171,960**
VSC	2	32	n/a	n/a	Health Professional Training			-
VVH	2	20	n/a	n/a	Vermont Veterans Home			-
						27,843,706	**-**	**27,843,706**

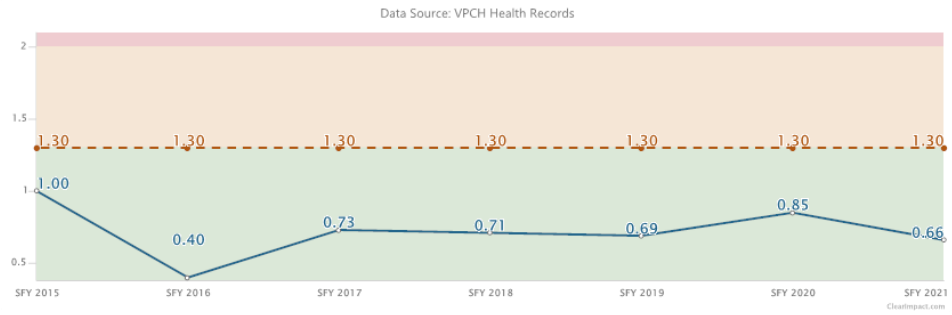
GC Investments - Department of Mental Health

O Increase the access of quality healthcare to the uninsured, underinsured, and Medicaid beneficiaries

Most Recent Period	Current Actual Value	Current Trend

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

Most Recent Period	Current Actual Value	Current Trend



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
SFY 2014	1.38	0

Story Behind the Curve

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

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

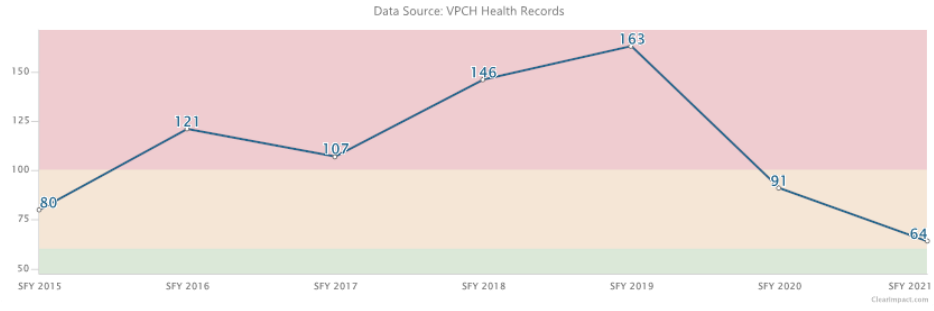
Updated February 2018

Partners

Strategy

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.



SFY 2020	91	1
SFY 2019	163	2
SFY 2018	146	1
SFY 2017	107	1
SFY 2016	121	1
SFY 2015	80	1
SFY 2014	81	0

Story Behind the Curve

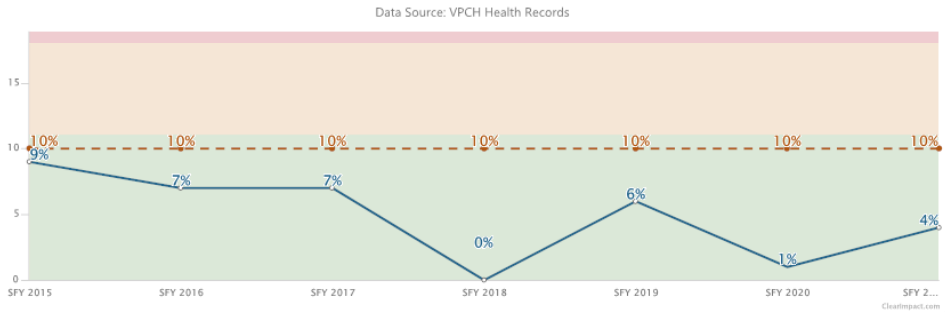
While the average length of stay at VPCH is higher than the target rate, the length of stay has decreased over the past year by 2 weeks. VPCH has also been accepting more acute patients resulting in longer stays, thereby creating a slight drop in the inpatient census over the year.

Partners

Strategy

Notes on Methodology

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



SFY 2021	4%	1
SFY 2020	1%	1
SFY 2019	6%	1
SFY 2018	0%	1
SFY 2017	7%	1
SFY 2016	7%	1
SFY 2015		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.

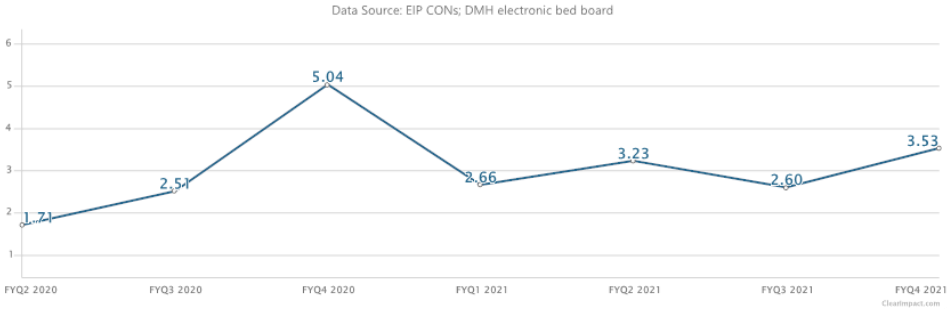
Partners

Strategy

Notes on Methodology

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

	Most Recent Period	Current Actual Value	Current Trend
	FYQ3 2021	2.60	1
	FYQ2 2021	3.23	1
	FYQ1 2021	2.66	1
	FYQ4 2020	5.04	4
	FYQ3 2020	2.51	3
	FYQ2 2020	1.71	2
	FYQ1 2020	1.65	1
	FYQ4 2019	1.13	3



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

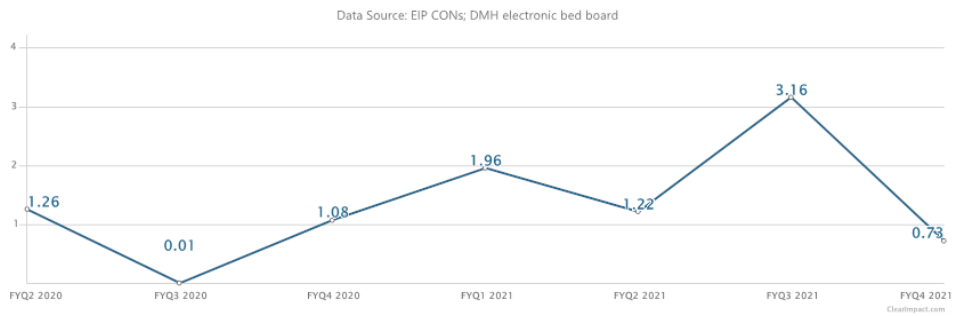
Partners

What Works

Action Plan

Notes on Methodology

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



	Most Recent Period	Current Actual Value	Current Trend
FYQ3 2021	3.16		1
FYQ2 2021	1.22		1
FYQ1 2021	1.96		2
FYQ4 2020	1.08		1
FYQ3 2020	0.01		2
FYQ2 2020	1.26		1
FYQ1 2020	1.35		1
FYQ4 2019	0.06		1

Story Behind the Curve

Partners

What Works

Action Plan

Notes on Methodology

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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

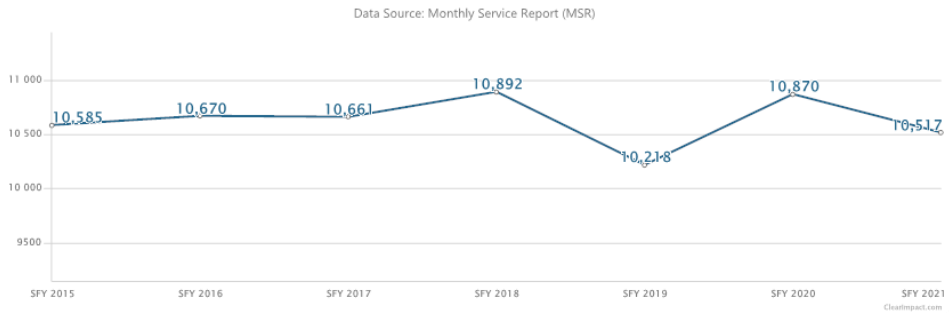
Partners

What Works

Action Plan

Notes on Methodology

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



	Most Recent Period	Current Actual Value	Current Trend
	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
	SFY 2013	10,374	1

Story Behind the Curve

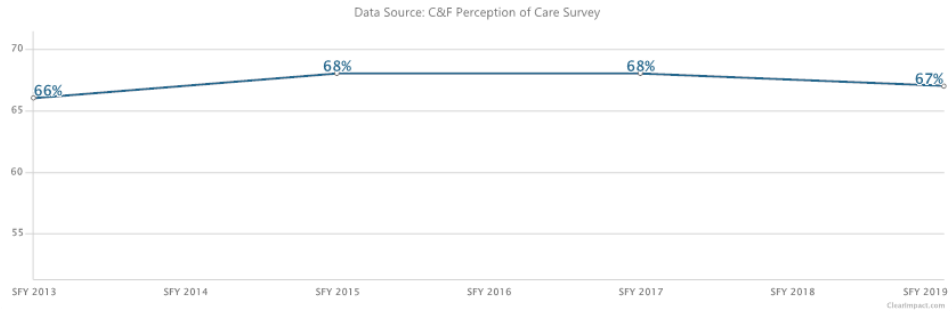
Partners

What Works

Action Plan

Notes on Methodology

PM Better_Of % 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.

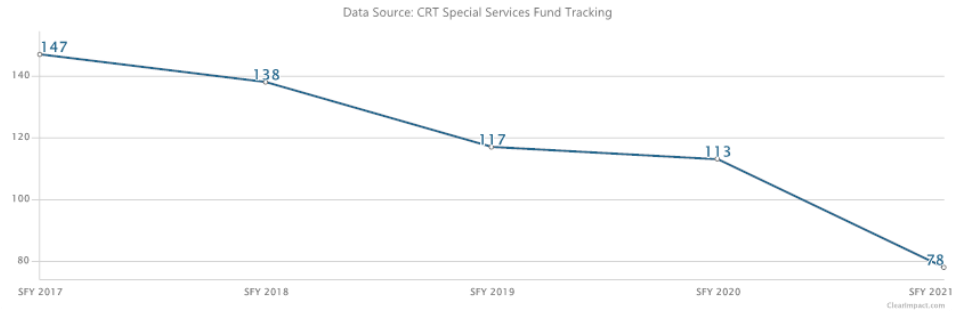
P GC_Investment (WIP) Emergency Support Fund (22)

Most Recent Period	Current Actual Value	Current Trend

P GC_Investment Special Payments for Treatment Plan Services (28)

PM How_Much # of CRT clients served with special services funding

Most Recent Period	Current Actual Value	Current Trend
SFY 2021	78	4



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

Story Behind the Curve

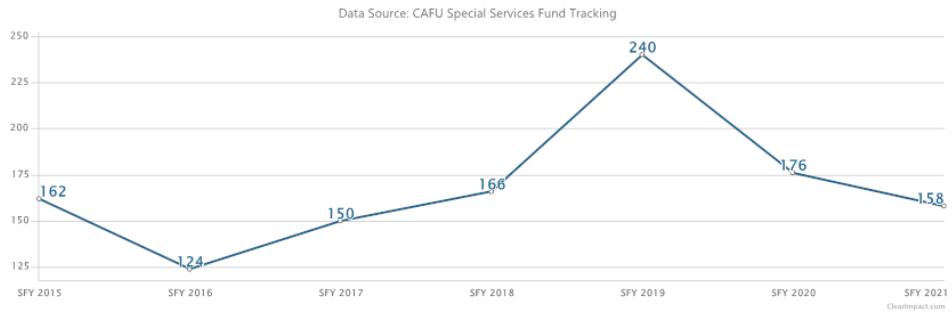
Partners

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

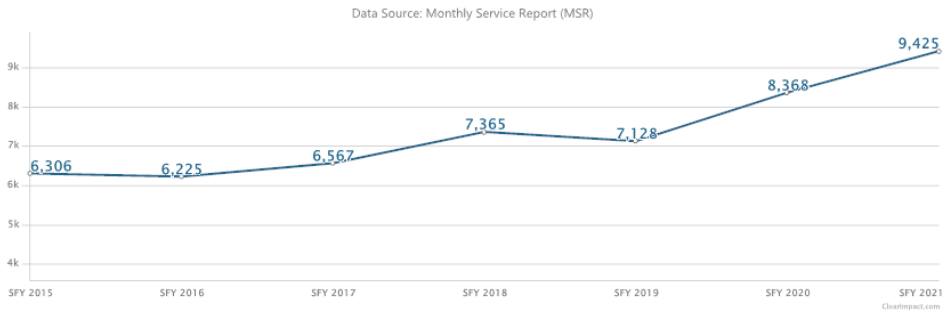
Action Plan

Notes on Methodology

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

Most Recent Period | Current Actual Value | Current Trend

PM How_Much Number of People Served by Emergency Services



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
SFY 2013	6,487	4

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.

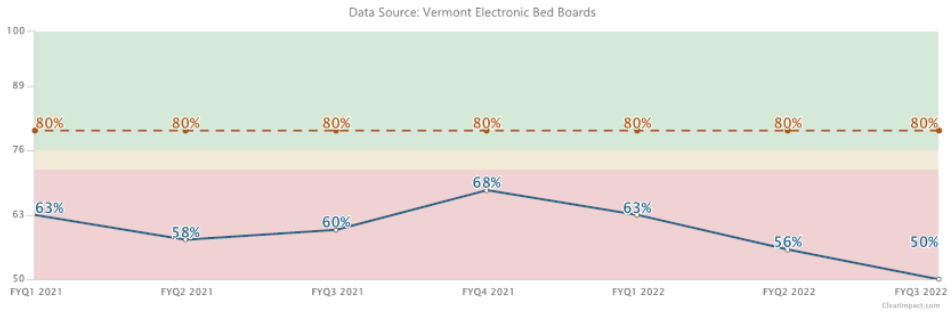
Partners

- 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 % occupancy of Designated Agency adult crisis bed programs FYQ3 2022 50% 3



FYQ2 2022	56%	2
FYQ1 2022	63%	1
FYQ4 2021	68%	2
FYQ3 2021	60%	1
FYQ2 2021	58%	1
FYQ1 2021	63%	1
FYQ4 2020	50%	5
FYQ3 2020		4

Story Behind the Curve

Partners

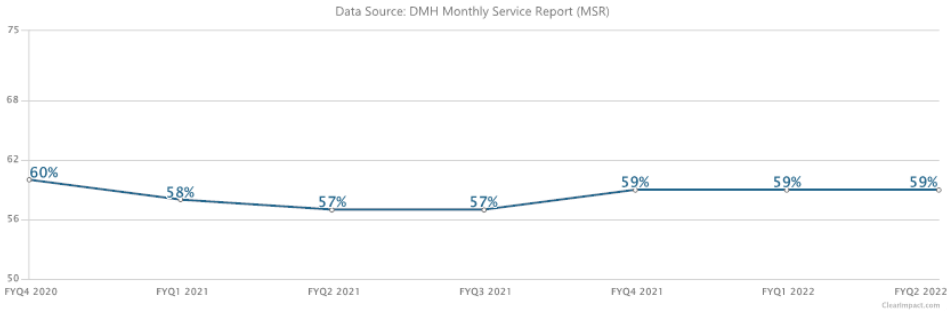
What Works

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_We % of people receiving non-emergency services within 7 days of emergency services



FYQ2 2022	59%	2
FYQ1 2022	59%	1
FYQ4 2021	59%	1
FYQ3 2021	57%	1
FYQ2 2021	57%	2
FYQ1 2021	58%	1
FYQ4 2020	60%	2
FYQ3 2020	60%	1
FYQ2 2020	60%	1

Story Behind the Curve

Partners

Strategy

Notes on Methodology

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

Story Behind the Curve

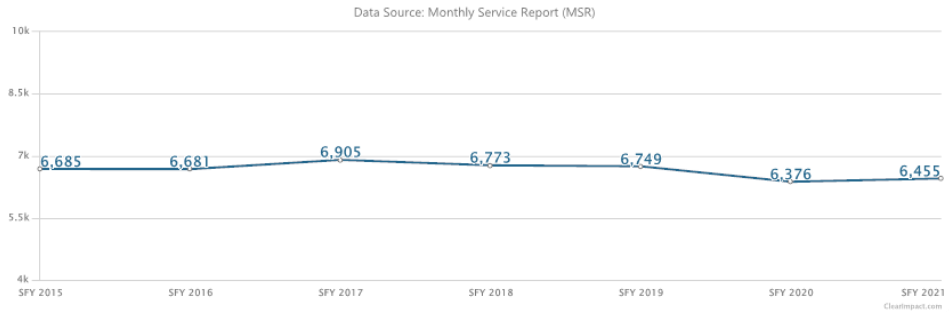
Partners

What Works

Action Plan

Notes on Methodology

P GC_Investment Mental Health Outpatient Services for Adults (66)



	Most Recent Period	Current Actual Value	Current Trend
	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
	SFY 2013	6,826	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.

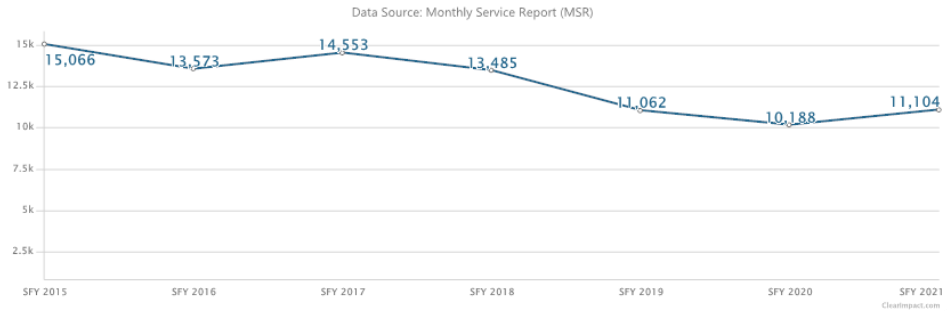
Partners

- 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_Muc 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

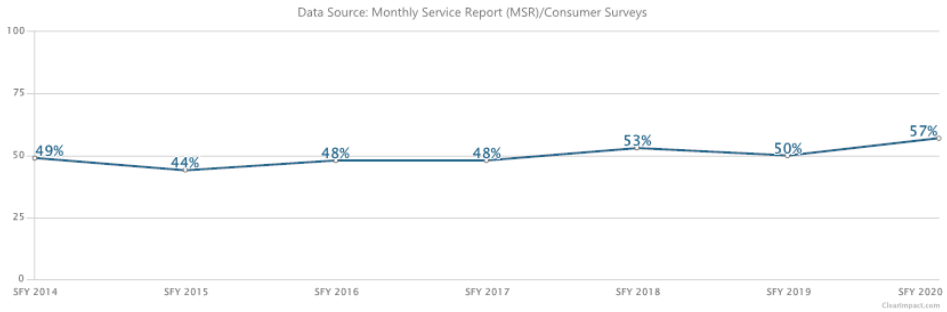
- Vermont Care Partners

- 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_O 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

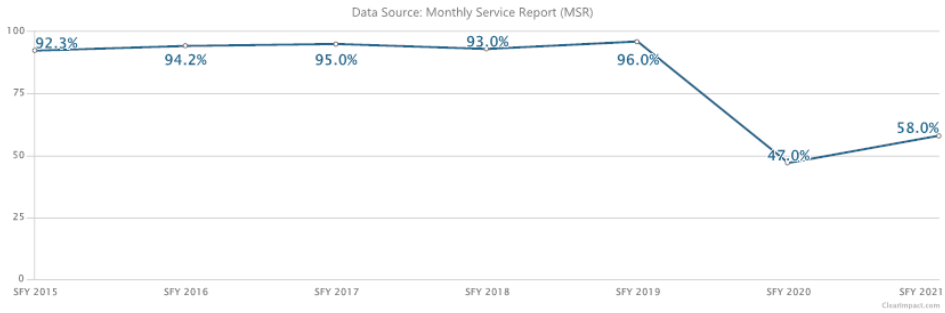
- Vermont Care Partners

- 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)



	Most Recent Period	Current Actual Value	Current Trend
	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
	SFY 2013	92.0%	1

Story Behind the Curve

Partners

What Works

Action Plan

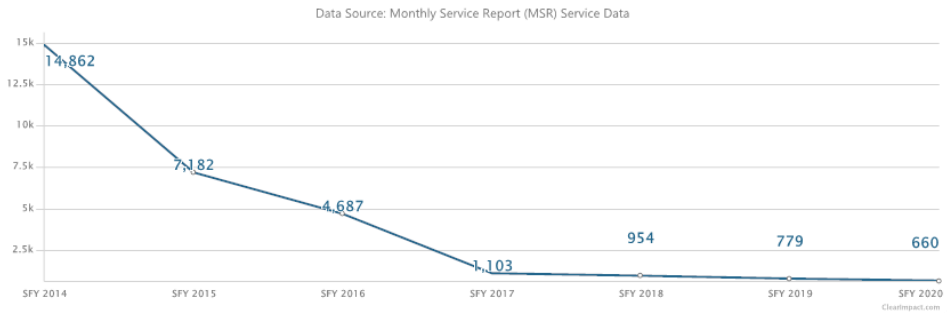
Notes on Methodology

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)

Most Recent Period	Current Actual Value	Current Trend



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)

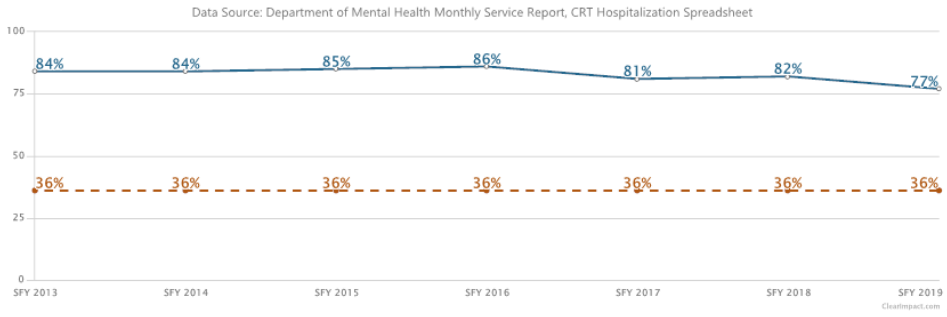
Most Recent Period	Current Actual Value	Current Trend

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

Most Recent Period	Current Actual Value	Current Trend

P GC_Investment Mental Health CRT Community Support Services (16)

Most Recent Period	Current Actual Value	Current Trend



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

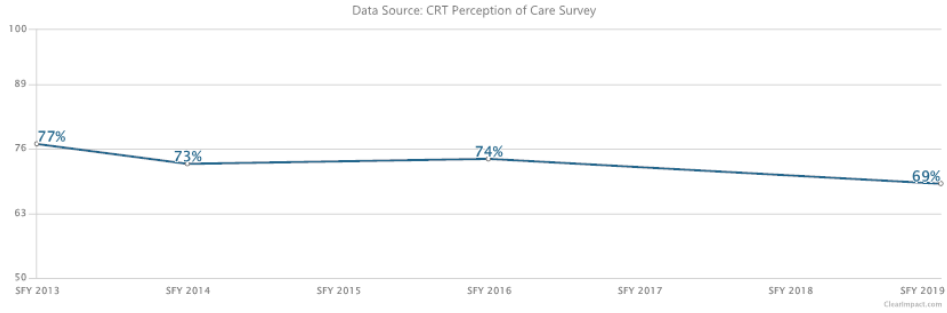
The CRT system of care includes CRT services at each of the Designated Agencies which includes psychiatry services. Many of the Designated Agencies have Intensive Residential Recovery, Group Homes, Crisis Beds, Community Cadre, and Employment Services. CRT programs partner with local Medical Providers, 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.

Notes on Methodology

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



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.

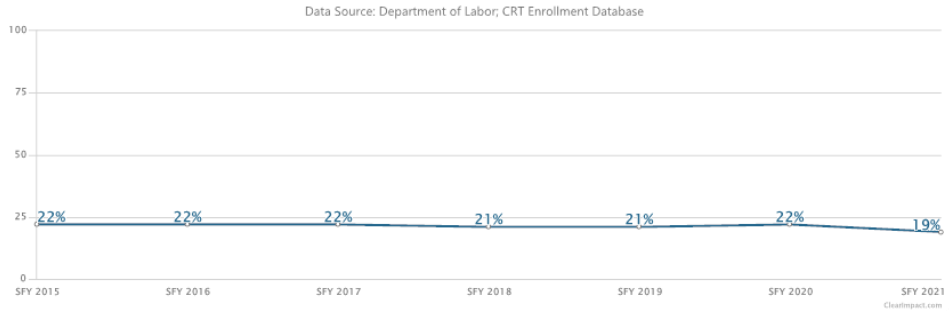
Partners

- 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_O % of working age CRT clients who are employed



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
SFY 2013	20%	1

Story Behind the Curve

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Partners

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

What Works

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

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

Action Plan

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

Notes on Methodology

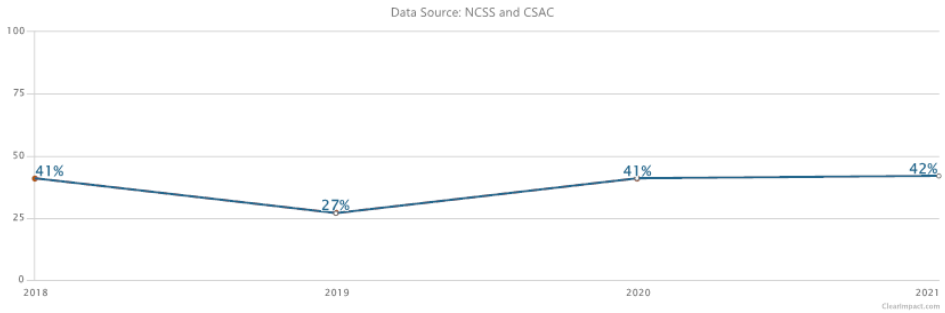
This report is based on record linkage of the Vermont Department of Mental Health (DMH) and Department of Labor (DOL) databases. DMH client data are submitted by Community Programs in conformance with contractual requirements. DOL data are submitted by employers in conformance with state and federal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

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

IFS Payment Model

P CMS Integrating Family Services

	Most Recent Period	Current Actual Value	Current Trend
	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

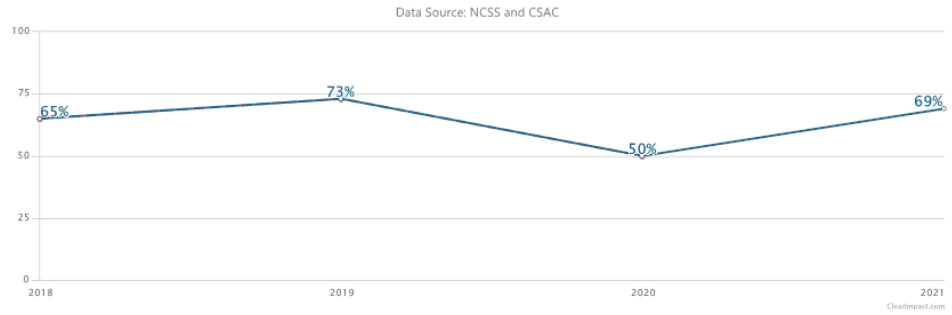
NCSS and CSAC

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

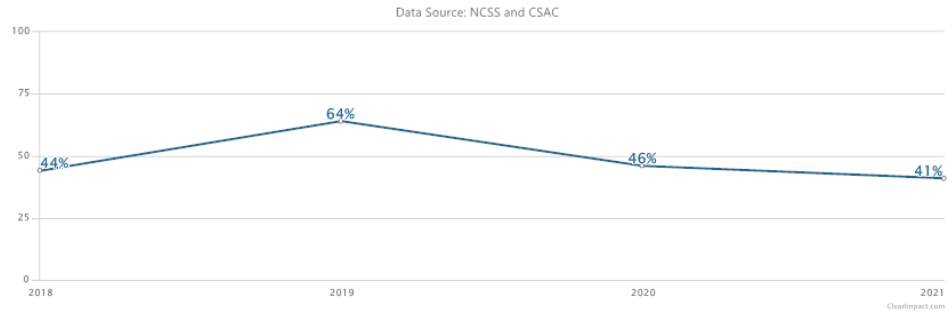
Notes on Methodology

Numerator: All children with a first CANS administered

Denominator: All children eligible for a CANS receiving services

% 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.

DVHA Dental Incentive Program

DVHA Dental

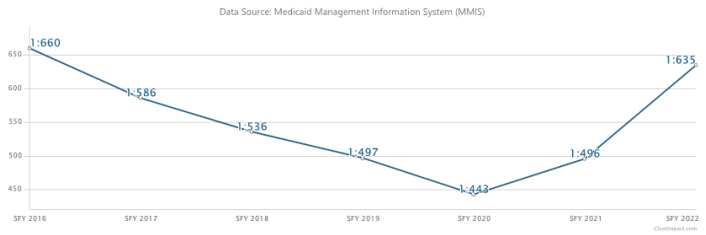
What We Do

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

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

Measures

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



Most Recent Period	Current Actual Value	Current Target Value	True	Current Trend	Baseline % Change
SFY 2022	1:635			2	8%
SFY 2021	1:496			1	-16%
SFY 2020	1:443			4	-25%
SFY 2019	1:497			3	-15%
SFY 2018	1:536			2	-9%
SFY 2017	1:586			1	0%
SFY 2016	1:660			1	12%
SFY 2015	1:588			0	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

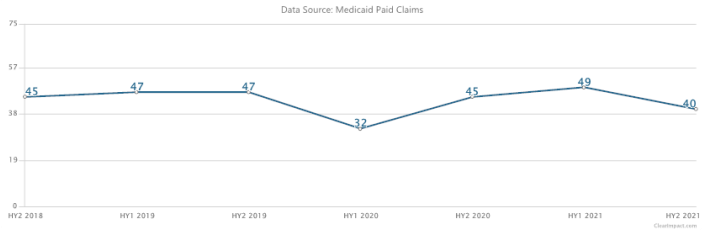
- Department of Vermont Health Access (DVHA): Clinical Operations (Dental staff), Provider & Member Relations, Data, Policy and Quality Units
- Vermont Department of Health's Oral Health Program
- Vermont Dentists
- Vermont State Dental Society (VSDS)

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.

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



HY2 2021	40			1	21%
HY1 2021	49			2	48%
HY2 2020	45			1	36%
HY1 2020	32			1	-3%
HY2 2019	47			1	42%
HY1 2019	47			1	42%
HY2 2018	45			1	36%
HY1 2018	46			1	39%
HY2 2017	44			1	33%

Notes on Methodology

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

Partners

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

Story Behind the Curve

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

Actions

Name	Assigned To	Status	Due Date	Progress

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