

State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 15
(1/1/2020 – 12/31/2020)

Quarterly Report for the period
July 1, 2020 – September 30,
2020

Submitted Via PMDA Portal on December 4, 2020

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I. Background and Introduction

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

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

- 2007: a component of the Catamount Health program was added, enabling the state to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the federal poverty level (FPL), and who do not have access to cost effective employer-sponsored insurance, as determined by the State.
- 2009: the state extended Catamount Health coverage to Vermonters at or below 300 percent of the FPL.
- 2011: inclusion of a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life limiting illnesses that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.
- 2012: CMS provided authority for the State to eliminate the \$75 inpatient admission copay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid State Plan.
- 2013: CMS approved the extension of the GC demonstration which included sun-setting the authorities for most of the 1115 Expansion Populations because they would be eligible for Marketplace coverage beginning January 1, 2014. The renewal also added the New Adult Group to the demonstration effective January 1, 2014. Finally, the renewal also included premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL.
- 2015: As of January 30, 2015, the GC demonstration was amended to include authority for the former Choices for Care demonstration. In addition, the State received section 1115 authority to provide full Medicaid State Plan benefits to pregnant women who are determined presumptively eligible.
- 2016: On October 24, 2016 Vermont received approval for a five-year extension of the Global Commitment to Health 1115 waiver, effective from January 1, 2017 through December 31, 2021.

- 2018: As of July 1, 2018, the Global Commitment to Health demonstration was amended to include authority for Vermont to receive federal Medicaid funding for Substance Use Disorder treatment services provided to Medicaid enrollees in Institutions for Mental Disease (IMDs).
- 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 42 CFR §438. DVHA also has sub-agreements with the other State entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, and specialized child and family services).

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the third quarterly report for waiver year 15, covering the period from July 1, 2020 through September 30, 2020 (QE092020).***

II. Outreach/Innovative Activities

i. Member and Provider Services

Key updates from QE092020:

- COVID-19

The Member and Provider Services (MPS) Unit ensures members have access to appropriate health care 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 implementation of the enrollment, screening, and revalidation of providers in accordance with Title 42 Code of Federal Regulations (CFR) §455.410 and §455.450 requiring that all participating providers be screened upon initial enrollment and revalidation of enrollment.

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

III. Operational/Policy Developments/Issues

i. Vermont Health Connect

Key updates from QE092020:

- The Customer Support Center received more than 64,000 calls in QE0920. Call volume is down 26% in QE0920 as compared to QE0919.
- The State of Vermont Assister program has continued to provide support to Vermonters during the public health emergency despite limitations to in-person visits and mobility challenges. Assisters have continued to receive regular trainings and support on a regular basis oriented to both their traditional Assister role expectations and the additional complexities of assisting Vermonters during the pandemic. The second Navigator organization was onboarded increasing the number of State Navigators from 2 to 4.
- Increasing numbers of customers are using self-service functions, especially recurring payments. An average of 65% of customers made recurring payments in QE0920. This is a 3% growth from the prior quarter.

Enrollment

As of QE0920, more than 208,642 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 135,387 in Medicaid for Children and Adults (MCA) and 73,255 in Qualified Health Plans (QHPs), with the latter divided between 24,678 enrolled with VHC, 7,536 direct-enrolled with their insurance carrier as individuals, and 41,041 enrolled with their small business employer.

Member Experience

In preparing for this year's open enrollment, the State is leveraging previous year's communication efforts with minor changes due to the COVID-19 public health emergency. Some updates to our communication plan will include strategic improvements to social media posts and changing our library events to become virtual this year. This open enrollment there will be continued efforts on ensuring each Vermonter has clear, concise, and direct information on:

- Plan comparison tool
- Direct enrollment for Vermonters with no financial assistance
- Ability to self-serve online or to call the call centers.

Medicaid Renewals

For each month of the third 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 52%. 1095 Tax Forms
The last corrections run for 2019 1095B was 8/20/20. Preparations are currently underway for the EOY 2020 generation which will begin in December.

Customer Support Center

DVHA continues to contract with Maximus to staff and manage the VHC Customer Support 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 just over 64,000 calls in QE0920. Call volume is down 26% in QE0920. Maximus answered 87% of calls within 24 seconds in July 2020, 88% in August 2020, and 90% in September 2020. Maximus exceeded the target of 75% of calls answered within 24 seconds for QE0920.

Maximus is continuing to hire staff as they prepare for Open Enrollment 2021. Presently, they have 93 staff and plan to be at 120 before Open Enrollment starts on 11/1/20.

Maximus is also the entry point for individuals requiring greater levels of assistance with case resolution. Maximus representatives transfer such calls to DVHA-HAEEU for resolution and log service requests, which are escalated to the appropriate resolver group. In July of QE0920, the transfer rate was 7.7%, in August the transfer rate was 8.2%, and in September the transfer rate went down to 6.3%. In QE0920, DVHA-HAEEU answered 91% of all transferred calls within five minutes compared to 95% in QE0919.

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 this past quarter, 86% of the VHC requests were completed within the same ten-day time period.

System Performance

The system continued to operate as expected throughout most of QE0920, achieving 100% availability outside of scheduled maintenance. The average page load time for the quarter was 1.83 seconds – well within the two-second target.

In-Person Assistance

As of October 2020, DVHA was supported by 112 Assisters (104 Certified Application Counselors, 4 Navigators, and 4 Brokers), serving all of Vermont's 14 counties and located in, but not limited to, hospitals, clinics, and community-based organizations. Some Assisters have been limited to providing remote support and/or shortened hours since the pandemic. Leading up to 2021, Open Enrollment Assister engagement is expected to increase, and new Assisters are in training.

Outreach

Vermont Health Connect's website continued to be a key source of information for current and prospective customers alike, receiving more than 62,449 visits in the quarter – a 3% increase over the previous quarter. The decrease from last year is still most likely due to the programmatic changes related to the COVID-19 pandemic in which we are not actively mailing out notices that would cause website traffic.

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 14,112 sessions during the quarter.

Self-Service

During QE0920, 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. Automatic recurring payments ensure that members' premiums are paid on time, helping them to avoid going into a grace period – and ultimately losing coverage – due to late payments.

Self-serve applications comprised over half (56%) of all applications in QE0920, up slightly from QE0919 (49%). More than 6,700 customers made recurring payments per month in QE0920. Overall, 43% of all payments made per month are recurring payments and 66% of all electronic payments in QE0920 were recurring payments.

ii. Choices for Care and Traumatic Brain Injury Programs

Key updates from QE092020:

- DAIL extended COVID-19 related flexibilities for providers in response to continuation of Vermont State of Emergency.
- DAIL working with stakeholders to develop an acuity-based procedure for the Moderate Need Group waitlist.

DAIL has responded to the COVID-19 pandemic by requesting increased flexibility in the established Waiver. These flexibilities will be continued through the state of emergency. DAIL COVID-19 resources can be found online here: <https://dail.vermont.gov/novel-coronavirus-information>.

Nursing Homes use CMP Funds to purchase technology

33 Nursing Homes in Vermont applied for and received grants of up to \$3000 to purchase technology that is intended to facilitate both social visits and telemedicine visits for residents impacted by the State of Vermont Stay Home/Stay Safe order.

Choices for Care Regulations

DAIL began working with stakeholders to develop an acuity-based screening tool for use when a waitlist is required for the Moderate Need Program. Piloting of the screening tool is scheduled for 11/2020, with further implementation planned for Q1 2021.

Adult Day Services

Adult Day Centers were required to close on March 17, 2020 as a result of the State of Vermont declaration of emergency and Stay Home/Stay Safe order. DAIL continues to support providers and participants whose services have been disrupted. Stakeholder engagement has continued to explore

opportunities mitigate the effect of social isolation of those impacted by Adult Day closure. DAIL is working closely with Adult Day providers on their plans to safely reopen at reduced capacity. Several Adult Day providers are targeting 11/2020 for reopening, while others plan to open in 2021.

Money Follows the Person (MFP)

DAIL secured federal funding for calendar year (CY) 2020 to continue this grant. The \$2.8M federal dollars received should allow for the transitioning of 44 MFP participants. COVID-19 restrictions have significantly impaired DAIL's ability to transition participants safely to the community.

DAIL is in continued negotiations with CMS for more than a year to year commitment to this grant program. Currently, funds are expected to be available for MFP transitions through CY2021 and grant closeout activities scheduled for CY2022.

CMS has notified Vermont that we are eligible for an MFP supplemental grant of up to \$5M dollars. Under this supplemental funding opportunity, MFP grant funds are being made available to state MFP demonstrations that are currently operating MFP funded transition programs, for planning and capacity building activities to accelerate LTSS system transformation design and implementation and to expand HCBS capacity. This funding is expected to strengthen focus and attention on LTSS rebalancing among states participating in the MFP demonstration and to support MFP grantees with making meaningful progress with LTSS rebalancing.

Wait Lists

- There is currently no wait list for the High Needs Group.
- There continues to be provider wait lists for Moderate Needs Group, estimated at almost 450 people statewide. Because the eligibility criteria for Moderate Needs services is so broad, Vermont does not expect to eliminate the wait list in the near future. However, the state is in the process of revising the wait list procedures from chronological to acuity-based in order to serve applicants with the greatest needs first.
- There is currently no wait list for the TBI program.

iii. Developmental Disabilities Services Division

Key updates from QE092020:

- Coronavirus 19 Response
- Resumption of Payment Reform activities
- New annual Waitlist information

Coronavirus 19 Response

The quarter ending 092020 continued to be dominated by responses to the coronavirus pandemic. The Developmental Disabilities Services Division (DDSD) took continuing steps to protect the health and safety of developmental services recipients, introducing tools for assessing risk and resuming service delivery, as well as continuing to explore new means of connecting with providers, recipients and advocates. Actions taken include:

- 1.** Resumption of some community activities and employment supports after meeting with the

- person and their team to conduct a person-centered assessment of risk.
2. Continuation of changes to service delivery requirements supporting health and safety, including but not limited to; personal protective equipment requirements, allowances for telehealth services, transportation guidelines, home-visiting requirements, signature requirements, and redeployment of support staff.
 3. The temporary change to the DDS/D HCBS daily rate payment model initiated at the start of the pandemic was ended in August in follow up to guidance allowing resumption of many face-to-face services and the availability of new financial relief through the Cares Act and Vermont's Coronavirus Relief Funds.
 4. Continuation of weekly provider video calls and monthly advocacy and stakeholder video town-halls.
 5. Continuation of Difficult of Care stipends for unpaid family caregivers who were providing care in lieu of typically available supports.
 6. Continuation of Difficult of Care stipends for shared living providers who were providing additional care in lieu of typically available supports.

Payment and Delivery System Reform

The Developmental Disabilities Services Division (DDS/D) and DVHA have initiated a project to explore a new payment model for Developmental Disabilities home and community-based services (HCBS). This project was put on hold during the quarter ending 06/2020 due to the coronavirus pandemic.

The DD HCBS program has grown significantly over the years from several hundred to several thousand participants. This has provided the impetus for modernization to allow for more efficient oversight of the program. Overall, the goal of this payment reform project is to create a transparent, effective, and administrable payment model for Developmental Disabilities Services that aligns with the broader payment reform and health care reform goals of AHS. The State has engaged stakeholders including recipients, families, advocacy organizations, and providers to participate in workgroups for the development and implementation of the new payment model.

DVHA previously engaged a Medicaid reimbursement consultant firm to assist the State in completing a provider rate study. The rate study collected detailed information from providers regarding actual costs to deliver the defined categories of service under HCBS. The rate study was completed and new rates for services were proposed. The information gathered will be utilized initially in developing the future payment model. It will later be decided whether these new rates can be adopted in the program. In addition to the provider rate study, the project has examined alternative assessment tools, resource allocation methods and options for more efficiently capturing encounter data for these services. A new methodology was established for providers to report encounter data regarding services being delivered to participants. Provider agencies are still adapting their electronic health records and business processes to prepare to report the data using the new method that will lead to increased transparency and accountability in the use of funds. The State has resumed work on preparing providers to report encounter data in the first quarter of CY21. The State developed an RFP for a contractor to conduct needs assessments using a standardized assessment tool, the Supports Intensity Scale. However, this RFP was interrupted due to the pandemic. The RFP was reposted in September and the State will be reviewing bids in the final quarter of CY20. Design of the new payment model will be continuing as the tempo of state response to the pandemic abates. Ongoing work will be required, including seeking any needed CMS approval.

HCBS Rules Implementation

HCBS Settings Requirements - Work on HCBS rules implementation continued to be paused in the quarter ending 092020 due to the coronavirus pandemic. DDS plans to resume work on implementing the HCBS rules to ensure compliance with all requirements by 2022.

Summary of work to date- the Division completed site visits to validate survey information submitted by providers in September 2019. Providers are mostly in compliance with the setting requirements with minor changes being required. It is anticipated that all providers will be able to comply with the setting requirements and none will need to transition recipients to other settings. This information was included in the Vermont's State Transition Plan in February 2020. In addition, DDS is developing policy guidance for providers to ensure compliance with the rules. The DDS Quality Management Unit has incorporated oversight of HCBS rule requirements into their overall quality review process to ensure ongoing compliance with the rules. With the completion of the site visits and information incorporated in the Vermont STP, the DDS Quality Management Unit is preparing and sending reports to each provider agency requiring a plan of correction to address the areas of non-compliance by the 2022 deadline.

Conflict of Interest in Case Management- In QE 092020, the State re-engaged in the development of its plan to comply with the requirement to provide conflict-free case management by engaging in free technical assistance (TA) available through CMS. Baseline information was shared with the TA contractor regarding the current DS system of care and progress to date in DS, including draft elements of the stakeholder driven "Choice Model" that was shared with CMS in QE 122019. Vermont also engaged with its TA contractor to confirm its understanding of prior communications with CMS in QE 032020, confirming that the current system appears to comport with the home and community-based services conflict of interest regulation as long as Vermont also meets the safeguard requirements found on page 180-181 of the Technical Guide. With this confirmation, the Division resumed design activities focused on mitigation strategies and continued to engage with its TA contractor. A key component of Vermont's mitigation strategies includes reissuing the RFP for an independent developmental service needs assessor, also described in the section above regarding payment reform. The Division continues to work with the Department of Vermont Health Access and other AHS Departments on a plan for inclusion in the next Global Commitment to Health waiver renewal application.

Wait List

DDS collects information from service providers on individuals who request funding for Home and Community-Based Services (HCBS) and other services including Targeted Case Management (TCM), Family Managed Respite (FMR), Flexible Family Funding (FFF) or Post-Secondary Education Initiative (PSEI). The information is gathered by the State from providers to determine individuals with developmental disabilities (DD) who are waiting for DD services but are not currently eligible. HCBS funding priorities are the method by which Vermont prioritizes who will receive caseload funding allocated annually by the legislature. Individuals are placed on the waiting list if they meet the following criteria:

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

whom there are insufficient funds.

There were no individuals who met a HCBS funding priority who were waiting for services that helps address the need related to the funding priority. As of 6/30/20, there were 243 people who requested HCBS services but were denied because they did not meet a funding priority. 7 people were waiting for FMR and 5 were waiting for FFF. There was no one waiting for TCM or PSEI. The waiting list is monitored by providers to determine if people have a change in circumstance that makes them eligible to receive HCBS. The waiting list is also reviewed when additional funds become available for other programs.

iv. *Global Commitment Register*

Key updates from QE092020:

- 16 policies were posted to the GCR in Q3 2020.
- Since the Global Commitment Register (GCR) launched in November 2015, 225 final GCR policies have been publicly posted.

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

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

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

A combined total of 16 policies were posted to the GCR this past quarter. This includes 4 proposed changes and 12 final changes. Changes include updates to rates and/or rate methodologies, clinical coverage changes, an administrative rulemaking notice, and policy changes stemming from the public health emergency and the COVID-19 pandemic.

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)*

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

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

Key updates for QE062020:

- Reporting on metrics begins with the second quarter report of 2020 (QE0620).
- Recovery Coaches in the Emergency Room Program services are now virtual.
- ADAP has begun work on collecting stakeholder feedback in anticipation of a Request for Information related to the overall SUD treatment system.

2. 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 have shifted to telemedicine, where appropriate while others have adjusted daily census and implemented social distancing and other strategies to continue 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 put on hold plans to develop the value-based payment model for residential programs, to align with its All Payer Model Agreement with CMS, due to the COVID-19 pandemic. The episodic payments were adjusted for a January 1, 2020 effective date. ADAP has begun work on collecting stakeholder feedback in anticipation of a Request for Information related to the overall SUD treatment system. The value-based payment component of the residential payment model is in consideration for inclusion in the larger system reform.

ADAP’s centralized intake and resource center, “VT Helplink: Alcohol and Drug Support Center” launched for public use in March 2020. Since launch VT Helplink has received over 1,500 calls and 10,600 website visits. Major components 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. ADAP continues work to onboard SUD treatment providers into the provider portal and expand the database of SUD resources available to consumers.

The Substance Misuse Prevention Oversight and Advisory Council (SMPC) was established within the Vermont Department of Health and encompasses 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 has met ten times between October 2019 to October 2020. The SMPC has three goals of the SMPC are the following:

1. Increase protective factors and build resilience and feelings of connectedness in Vermont communities, across all ages, cultures, and socioeconomic conditions.
2. Decrease risk factors for substance use in Vermont for individuals of all ages, cultures, and socioeconomic conditions.
3. 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

The SMPC began work on the recommendations they will propose to the Vermont Legislature as part of their 2021 Annual Report for consideration in this upcoming legislative session. A focus of these recommendations will be to ensure parity across statutes for all substances with risk of misuse.

Vermont launched the Recovery Coaches in the Emergency Department Program on July 1, 2018. 10 hospitals are participating in the program. Virtual recovery services have been implemented.

Assessment of Need and Qualification for SUD Services

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.		3 Medicaid Beneficiaries with SUD Diagnosis (monthly) 4 Medicaid Beneficiaries with SUD Diagnosis (annually) 5 Medicaid Beneficiaries Treated in an IMD for SUD	Vermont experienced a decrease in the amount of services rendered which appears to coincide with the COVID pandemic which peaked in Vermont in April 2020. 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.
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
Implementation Update			

<p>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?</p>			<p>There are no planned changes to the target population or clinical criteria.</p>
<p>Are there any other anticipated program changes that may impact metrics related to assessment of need and qualification for SUD services? If so, please describe these changes.</p>			<p>There are no anticipated program changes.</p>
<p><input checked="" type="checkbox"/> The state has no implementation update to report for this reporting topic.</p>			

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

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

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
Milestone 1 Metric Trends			
<p>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.</p>		<p>6 Any SUD Treatment</p> <p>7 Early Intervention</p> <p>8 Outpatient Services</p> <p>9 Intensive Outpatient and Partial Hospitalization Services</p> <p>10 Residential and Inpatient Services</p> <p>11 Withdrawal Management</p> <p>12 Medication Assisted Treatment</p> <p>36 Average Length of Stay in IMDs</p>	<p>Vermont experienced a decrease in the amount of services rendered which appears to coincide with the COVID pandemic which peaked in Vermont in April 2020. 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.</p>
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
Milestone 1 Implementation Update			
<p>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:</p> <p>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)?</p> <p>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?</p>			

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 describe these changes.			There are no anticipated program changes.
<input checked="" type="checkbox"/> 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			
<input checked="" type="checkbox"/> The state is not reporting any metrics related to this reporting topic.			
Milestone 2 Implementation Update			
<p>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:</p> <ul style="list-style-type: none"> a. Planned activities to improve providers’ use of evidence-based, SUD-specific placement criteria? b. Implementation of a utilization management approach to ensure: <ul style="list-style-type: none"> i. Beneficiaries have access to SUD services at the appropriate level of care? ii. Interventions are appropriate for the diagnosis and level of care? iii. Use of independent process for reviewing placement in residential treatment settings? 			
<p>Summary: The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 32 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. ADAP has completed one remote site visit utilizing the tool this quarter.</p>			
Milestone 2 - Table 1			
Action	Revised Completion Date	Responsible	Status
Finalize Substance Use Disorder Treatment Standards	August 1, 2018	Director of Quality Management and Compliance	Completed

Update Compliance Assessment Tool with revised Substance Use Disorder Treatment Standards and all residential ASAM criteria	August 15, 2018	Director of Quality Management and Compliance	Completed
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Updated online recertification survey to reflect new revision of Substance Use Disorder Treatment Standards	October 31, 2018	Director of Quality Management and Compliance	Completed
Use the Compliance Assessment Tool to certify ASAM Level 3.5 Level of Care provider (Valley Vista Vergennes)	December 31, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Use the Compliance Assessment Tool to certify ASAM Level 3.5 Level of Care provider (Valley Vista Bradford)	December 31, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Implement the Compliance Assessment Tool	October 3, 2018	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Use of the Compliance Assessment Tool to certify ASAM Level 3.3 Level of Care Provider (Recovery House)	March 31, 2019	Director of Clinical Services; Director of Quality Management and Compliance	Completed
Use of the Compliance Assessment Tool to certify ASAM Level 3.2-WM Level of Care Provider (Act 1/Bridge)	March 31, 2019	Director of Clinical Services; Director of Quality Management and Compliance	Completed

Vermont put on hold plans to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS due to the impact of the COVID-19 pandemic. The rates for the episodic payments were adjusted effective January 1, 2020. ADAP has begun work on collecting stakeholder feedback in anticipation of a Request for Information related to the overall SUD treatment system. The value-based payment component of the residential payment model is 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
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Work with financial colleagues to finalize budget and rate decisions for the model	Completed	Payment Reform Team, ADAP Director of Clinical Services, VDH Business Office
Residential providers to provide feedback	Completed	ADAP Director of Clinical Services
Work with the Medicaid fiscal agent to identify and complete the necessary system's changes required for the Medicaid billing system	Completed	ADAP Director of Clinical Services, Payment Reform Team, DXC (Fiscal Agent)
Work with the residential providers to provide technical assistance and education around the necessary billing changes	Completed	ADAP Clinical Team
Regional Managers will partner with the compliance and quality team to determine the appropriate frequency with which the Regional Managers will perform the between audit chart reviews	Completed	ADAP Clinical Team and ADAP Quality Team
Are there any other anticipated program changes that may impact metrics related to the use of evidence-based, SUD-specific patient placement criteria (if the state is reporting such metrics)? If so, please describe these changes.		
<input type="checkbox"/> 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			
<input checked="" type="checkbox"/> 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 the implementation plan, have there been any changes or does the state expect to make any changes to:

- a. Implementation of residential treatment provider qualifications that meet the ASAM Criteria or other nationally recognized, SUD-specific program standards?
- b. State review process for residential treatment providers' compliance with qualifications standards?
- c. Availability of medication assisted treatment at residential treatment facilities, either on-site or through facilitated access to services off site?

Summary:

The current version of the Substance Use Disorder Treatment Standards is being used. The Compliance Assessment Tool has been utilized with 32 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. ADAP has completed one remote site visit utilizing the tool this quarter.

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.			
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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 Treatment for OUD

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

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

<p>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</p>		<p>13 SUD Provider Availability 14 SUD Provider Availability – MAT</p>	<p>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.</p>
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percent should be described.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
Milestone 4 Implementation Update			
<p>Prompts: Compared to the demonstration design and operational details outlined the implementation plan, have there been any changes or does the state expect to make any changes to planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients in across the continuum of SUD care?</p> <p>Summary: Vermont put on hold plans to develop a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS due to the COVID-19 pandemic. The episodic payments were adjusted effective January 1, 2020. Vermont anticipates resuming work on the residential value-based payment model in fall of 2020 if the impact of the COVID pandemic on the residential providers and state staff involved in the project stabilizes.</p> <p>ADAP’s centralized intake and resource center “VT Helplink: Alcohol and Drug Support Center” launched for public use March 2020. Since launch VT Helplink has received over 1,500 calls and 10,600 website visits. Major components 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. ADAP continues work onboard SUD treatment providers into the provider portal and expand the database of SUD resources available to consumers.</p>			
Are there any other anticipated program changes that may impact metrics related to provider capacity at critical levels of care, including for medication assisted treatment (MAT) for OUD? If so, please describe these changes.			
<input type="checkbox"/> 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 Milestone 5.

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
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Milestone 5 Metric Trends			
<p>Discuss any relevant trends that the data</p>		<p>15 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment</p> <p>18 Use of Opioids at High Dosage in Persons Without Cancer</p> <p>21 Concurrent Use of Opioids and Benzodiazepines</p> <p>22 Continuity of Pharmacotherapy for Opioid Use Disorder</p>	<p>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 a number of cash only and other Spoke options available which may lead to more movement in and out of treatment. Additionally, Vermont had a period where Medicaid renewal was assumed and then a significant push to revalidate eligibility which may have led to more instability in people's Medicaid coverage, leading to treatment lapses.</p>

shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be described.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
Milestone 5 Implementation Update			
<p>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:</p> <p>a. Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD?</p> <p>b. Expansion of coverage for and access to naloxone?</p>			
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 to address opioid abuse and OUD? If so, please describe these changes.			
<input checked="" type="checkbox"/> 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 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.		17 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence	Recovery Coaches are dispatched to 10 emergency departments to support individuals who present with a SUD at the ED including providing linkages to follow-up visits upon discharge.

<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
Milestone 6 Implementation Update			
<p>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?</p> <p>Summary: Vermont launched the Recovery Coaches in the Emergency Department Program on July 1, 2018. 10 hospitals are participating in the program. Virtual recovery services have been implemented.</p>			
Are there any other anticipated program changes that may impact metrics related to care coordination and transitions between levels of care? If so, please describe these changes.			
<input type="checkbox"/> 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	In 2019, Vermont implemented provider verification which resulted in removing individuals that were no longer licensed and removing residents who had completed their residencies.
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no metrics trends to report for this reporting topic.			
Implementation Update			
<p>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:</p> <ol style="list-style-type: none"> 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? 			

- d. Other aspects of the state’s plan to develop the health IT infrastructure/capabilities at the state, delivery system, health plan/MCO, and individual provider levels?
- e. Other aspects of the state’s health IT implementation milestones?
- f. The timeline for achieving health IT implementation milestones.
- g. Planned activities to increase use and functionality of the state’s prescription drug monitoring program?

Summary:

- Vermont has a requirement and funding in the current contract with Appriss to connect VPMS to RxCheck for interstate data sharing. RxCheck is developing functionality for direct integration with EHRs and other health systems. Appriss has provided a change order to connect to RxCheck.
- VPMS, Dr. First and Appriss are in the process of testing and verifying Appriss’s Gateway integration tool to enable direct population of VPMS data into Dr. First’s prescription ordering section, eliminating the need for providers to navigate between systems.
- VPMS staff are engaged with the NESCSO State HIT Learning Community. This group works to create a shared understanding of Federal legislation, the current state of PDMP activities, and identifies opportunities for multi-state alignment.
- Vermont continues to offer prescriber reports on a quarterly basis.
- Vermont has enabled permissions for the Veteran’s Association to integrate with VPMS as required by the Mission Act. Once this project goes live, VPMS data will be available for VA providers nationwide who are providing services to Vermonters.

Are there any other anticipated program changes that may impact metrics related to SUD Health IT (if the state is reporting such metrics)? If so, please describe these changes.

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

Other SUD-Related Metrics

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
9.2 Other SUD-Related Metrics			
9.2.1 Metric Trends			
Discuss any relevant trends that the data shows related to assessment of need and qualification for SUD services. At a minimum, changes (+ or -) greater than two percent should be		23 Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries 24 Inpatient Stays for SUD per 1,000 Medicaid	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. In 2019, it was found in 86%

described.		<p>Beneficiaries</p> <p>25 Readmissions Among Beneficiaries with SUD</p> <p>26 Overdose Deaths (count)</p> <p>27 Overdose Deaths (rate)</p> <p>32 Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD</p>	<p>of opioid-related fatalities and has increased each year since 2011 (9%). Of note, deaths involving fentanyl can include prescription and/or illicit fentanyl and fentanyl analogues.</p> <p>Vermont has been working to decrease drug overdoses and in 2020, published a <u>social autopsy</u> showing places where individuals who died of a drug overdose interacted with a variety of Vermont programs.</p>
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<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> 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.			
<input checked="" type="checkbox"/> 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. <i>Financial/Budget Neutrality Development/Issues</i> of this report.
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> 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.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> 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			
<p>Highlight significant SUD (or if broader demonstration, then SUD-related) demonstration operations or policy considerations that could positively or negatively impact beneficiary enrollment, access to services, timely provision of services, budget neutrality, or any other provision that has potential for beneficiary impacts. Also note any activity that may accelerate or create delays or impediments in achieving the SUD demonstration’s approved goals or objectives, if not already reported elsewhere in this document. See report template instructions for more detail.</p>			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no related considerations to report for this reporting topic.			
11.1.2 Implementation Update			

<p>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:</p> <p>a. How the delivery system operates under the</p>			
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demonstration (e.g. through the managed care system or fee for service)? b. Delivery models affecting demonstration participants (e.g. Accountable Care Organizations, Patient Centered Medical Homes)? c. Partners involved in service delivery?			
Has the state experienced any significant challenges in partnering with entities contracted to help implement the demonstration (e.g., health plans, credentialing vendors, private sector providers)? Has the state noted any performance issues with contracted entities?			
What other initiatives is the state working on related to SUD or OUD? How do these initiatives relate to the SUD demonstration? How are they similar to or different from the SUD demonstration?			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no implementation updates to report for this reporting topic.			

SUD Demonstration Evaluation Update

Prompts	Demonstration Year (DY) and quarter first reported	Related metric (if any)	Summary
12.1 SUD Demonstration Evaluation Update			

12.1.1 Narrative Information

Provide updates on SUD evaluation work and timeline. The appropriate content will depend on when this report is due to CMS and the timing for the demonstration. See report template instructions for more details.			Updates on the SUD evaluation work, deliverables, and timeline can be found in Sections VIII. <i>Quality Improvement</i> and IX. <i>Demonstration Evaluation</i> of this report.
Provide status updates on deliverables related to the demonstration evaluation and indicate whether the expected timelines are being met and/or if there are any real or anticipated barriers in achieving the goals and timeframes agreed to in the STCs.			
List anticipated evaluation-related deliverables related to this demonstration and their due dates.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> 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.			
<i>[Add rows as needed]</i>			
<input type="checkbox"/> 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			
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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: <ul style="list-style-type: none"> a. The schedule for completing and submitting monitoring reports? b. The content or completeness of submitted reports? Future reports? 			Updates on the Monitoring Protocol work, deliverables, and timeline can be found in Section X. <i>Compliance</i> of this report.
Has the state identified any real or anticipated issues submitting timely post-approval demonstration deliverables, including a plan for remediation?			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> The state has no updates on general reporting requirements to report for this reporting topic.			
13.1.2 Post Award Public Forum			

<p>If applicable within the timing of the demonstration, provide a summary of the annual post-award public forum held pursuant to 42 CFR § 431.420(c) indicating any resulting action items or issues. A summary of the post-</p>			
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award public forum must be included here for the period during which the forum was held and in the annual report.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> 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.			
<i>[Add rows as needed]</i>			
<input checked="" type="checkbox"/> 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 QE092020:

- Alignment of VCCI with state health care reform and ACO
- Enhanced VCCI Population
- COVID-19 Response
- Working on bidirectional interface with VITL

The VCCI provides case management services to Medicaid beneficiaries throughout Vermont. 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. In QE092020, VCCI continued efforts toward improved alignment with health care reform and the system of care; formalizing its shift from historically serving only those who were predicted to be high cost/high risk to needs based eligibility and outreach. The VCCI team delivers short term, intensive case management to beneficiaries with complex health needs. In alignment with the ACO model, the VCCI implements the complex care model, utilizing patient engagement tools, pulling together care teams and helping beneficiary in the identification of a long-term lead care coordinator. In addition to the beneficiary, potential care team members may include primary care providers, hospital case managers, community and designated mental health agency providers, AHS partners such as Economic Services Division and Employment Specialists. Lead Care Coordinators help to support the member in goal setting and in the development of the shared care plan. With goal of further alignment, VCCI is meeting with OCV Care Coordination Supervisor bi-weekly to ensure consistent messaging with and within communities on healthcare reform goals. VCCI continues to communicate discrepancies seen and heard from communities, currently on the knowledge and scope of understanding of the Expanded Attribution and updates, as appropriate, on development of community workflows. Conversations are ongoing on continued inconsistency with reflection of a lead care coordinator on members, who may not yet be engaged in care. This miscommunication within the communication platform may present a challenge when identifying members who need complex case management.

With the goal of helping to manage the cohorts within the Expanded Attribution population, VCCI has shared our tools and workflows that will be utilized in part of this work. All VCCI field-based staff have been trained in using Care Navigator, the Accountable Care Organization's communication platform. This has enabled VCCI staff to share brief updates with other care team members on goal progression for complex members, while maintaining its own documentation in our own care management system. Our team continues to receive referrals, from ACO providers, on ACO attributed members, presenting with complex health and social needs. Reasons cited for referral to VCCI versus referral to in-house care coordinator is due to the 1) members complexity requiring intensive case management 2) VCCI ability to meet with members in-person, where member may physically be whether a motel, shelter, apartment, etc. 3) Practice focus on high and very high risk members, and member being referred does not meet that criteria. VCCI works to stabilize members while building long term community care team.

With the COVID-19 pandemic, VCCI ceased outreach to new plan beneficiaries with goal of screening and facilitating access to medical homes, as primary care offices needed to focus efforts on serving patients on current panels in non-traditional ways. Beginning in June, our team resumed telephonic outreach to those new to the health plan for screening to facilitate access to health and health related services as primary care offices indicated increase in operations. Access to dental care presents with challenges. Dental clinics may not be open to new patient appointments and dental cleaning appointments for established patients remains with limited appointments due to the health crisis. Resumption of face to face visits with our complex Medicaid beneficiaries is planned for October 2020 in tandem with our Agency of Human Services partners to ensure safe resumption of in person visits. Referrals to VCCI for complex care decreased initially, but has increased significantly as the State opens up, members are seeking assistance toward health improvement, and Providers are focused on member's total health picture.

Although direct requests of VCCI have drastically decreased over the last couple of months, VCCI remains committed to aid in efforts as called upon.

VCCI anticipates resumption of other work which was suspended in March due to the pandemic over the next quarter. This includes outreach and initial screening to beneficiaries <18; collaboration with DVHA colleagues on coordination of care on those being released from incarceration; and resumption of meeting with beneficiaries for intensive case management.

Another area that VCCI is working on with our partners at VITL and the Blueprint is to have the data related to social determinants of health that VCCI collects on members through our comprehensive surveys to be part of the member's record in the VHIE. This will assist the ACO with a more accurate way of predicting risk for members and being able to intervene on those members with issues earlier, so they do not become part of that very high-risk group.

The clinical documentation system that VCCI utilizes through eQ Health is CMS certified and VCCI has exercised the option to extend the contract with the Vendor for the two additional years. The system contains clinical information via an interface with Vermont's HIE vendor, VITL to enhance case managers' ability to formulate and put into motion a true patient centered, clinically focused plan of care.

ii. *Blueprint for Health*

Key updates from QE092020:

- The majority of Vermont’s primary care practices are now Blueprint-participating Patient-Centered Medical Homes, as evidenced by 134 of Vermont’s primary care practices are Blueprint-participating practices. The estimated total number of primary care practices operating in the state is 169, of which an estimated 148 employ more than one provider.
- Vermont continues to demonstrate increased access to medication-assisted treatment for Vermonters with opioid use disorder. As of June 2020, the number of clients enrolled in Regional Opioid Treatment Programs (OTP/Hubs) was 2,933, and the average monthly number of Medicaid beneficiaries served by Office-Based Opioid Treatment (OBOT/Spoke) programs increased to 3,675.
- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 49 practices and all 12 Planned Parenthood sites to participate in the Women’s Health Initiative as of June 2020

Patient-Centered Medical Home Program

The Blueprint uses national standards to drive improvements in primary care delivery and payment. The program helps primary care providers transform their practices into National Committee for Quality Assurance (NCQA)-certified Patient-Centered Medical Homes. The Patient-Centered Medical Home model supports care that is patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety. The model also promotes care that is provided when and where the patient needs it, and in a way that the patient understands it. Patient-Centered Medical Homes in Vermont are supported by multi-disciplinary teams of dedicated health professionals in each 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. The Community Health Team support primary care providers in identifying root causes of health problems, including mental health and screening for social determinants of health. They also connect patients with effective interventions, manage chronic conditions, or provide additional opportunities to support improved well-being.

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

process improvement). Quality Improvement Facilitators initially help launch patient-centered practices and secure NCQA Patient-Centered Medical Home recognition. After 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 include:

- focusing quality improvement activities on All-Payer Model and AccountableCare Organization quality measures;
- team-based care;
- implementation of new initiatives (e.g. Spoke program, Women’s Health Initiative, improving opioid prescribing patterns);
- prevention and management of chronic conditions (e.g. for diabetes and hypertension through connections with learning collaboratives, self-management programs, health coaches, registered dietitians, and care management).

Blueprint-participating Patient-Centered Medical Homes currently serve 302,548 insurer-attributed patients, of which 100,829 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 prior to the date the attribution process is conducted. These practices and patients are supported by 168 full-time equivalents of Community Health Team staff.

Quarterly Highlights

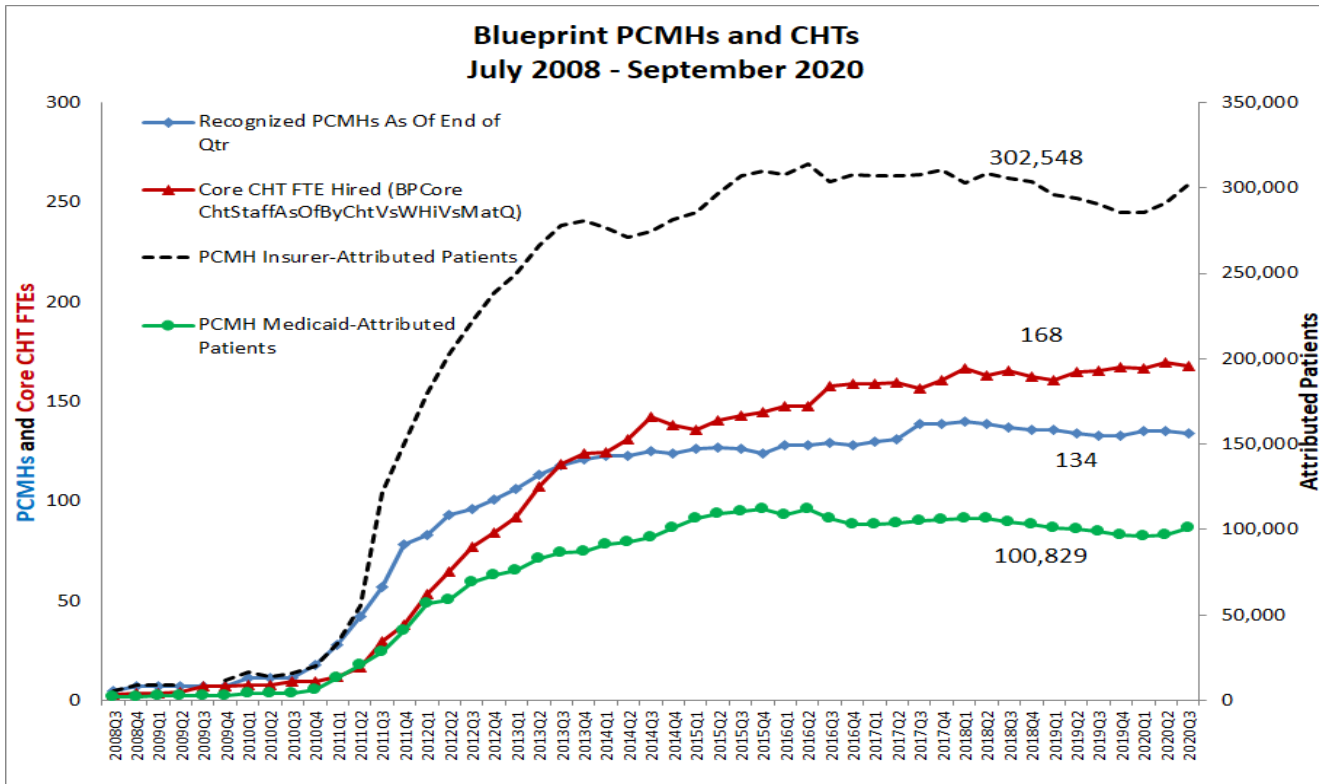
In Quarter 3 (July - September 2020), 134 Vermont practices were operating as Patient-Centered Medical Homes, thanks to the commitment of providers and staff, the support of Program Managers, and the technical assistance of Quality Improvement Facilitators. The number of practices participating in the Blueprint for Health program is a key performance measure; the Blueprint estimates that there are about 169 total primary care practices operating in the state, of which an estimated 148 employ more than one provider.

In collaboration with the Blueprint for Health, NCQA has extended the Recognition status of PCMH practices with Annual Reporting deadlines between March and December 2020. The adjusted deadlines now reflect an Annual Reporting date of December 1, 2020, and a Recognition End date of December 31, 2020

Since Governor Phil Scott has declared a state of emergency in Vermont, which continued through the 3rd quarter, Patient-Centered Medical Homes, specialty practices, and Spokes have acted quickly to provide continuity of care. Most of the network used their electronic health records to run various reports based on a few factors of risk: Age greater than 60 with chronic conditions, John Hopkins ACG scale, potential for fragmented care, mental health and substance use diagnosis, and high healthcare resource usage. They also cross-referenced patients who missed appointments and who needed follow up as soon as possible. The community health teams reached out to the patients who met these criteria. On these calls, they would also inquire about other social determinants of health, such as access to food and medicine. While in-person visits have increased, telehealth continues to be an option for primary care appointments and screenings. The network continues to work diligently to

ensure excellent patient care and care coordination for the best health outcomes.

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



Practice Health Profiles and Community Health Profiles

The Blueprint for Health supports data-driven population health improvement by producing profiles that describe the health status and health care utilization, expenditures, and outcomes of individuals in each health service area and patients in each Patient-Centered Medical Home. Both practice-level and community-level profiles use all-payer administrative data, clinical outcomes, and survey information for adult and pediatric populations. Practice Health Profiles help practices identify ways that they can better serve their patients.

Community Health Profiles are used by the regional Accountable Communities for Health (Community Collaboratives) and other local workgroups to inform and complement Community Health Needs Assessments and other community data products. These profiles report on the whole population of patients residing in each health service area (the closest possible approximation of “whole population” reporting from available claims data). Some measures are also broken out into three categories: patients attributed to area Blueprint-participating Patient-Centered Medical Homes, patients receiving most of their primary care in a non-Blueprint practice (such as a specialty practice or an out-of-state practice), and patients with no record of a primary care visit within the last two years. The whole-population reporting approach was new in 2018, and feedback suggests it has made the Community Health Profiles more useful. The Community Health Profiles are now part of Vermont’s hospital budget approval process and Health Resource Allocation Plan, both responsibilities of the state’s health care regulatory body, the Green Mountain Care Board. Onpoint Health Data produced

these profiles. Practice Health Profiles and Community Health Profiles have been distributed to practices and healthcare organizations for the following data time periods:

- i. 01/2013 - 12/2013
- ii. 07/2013 - 06/2014
- iii. 01/2014 - 12/2014
- iv. 07/2014 - 06/2015
- v. 01/2015 – 12/2015
- vi. 07/2015 – 06/2016
- vii. 01/2016 – 12/2016
- viii. 07/2016 – 06/2017
- ix. 01/2017 – 12/2017
- x. 01/2018 – 12/2018

Practice Health and Community Health Profiles for the data period 01/2018 – 12/2018 were distributed in November 2019. Practice profiles are sent to the practices directly, while Community Health Profiles are posted at <http://blueprintforhealth.vermont.gov/community-health-profiles>.

Hub & Spoke Program

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

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

The Blueprint, in partnership with the Division of Alcohol and Drug Abuse Programs (Department of Health), continues to offer learning sessions with expert-led, and peer-supported, training in best

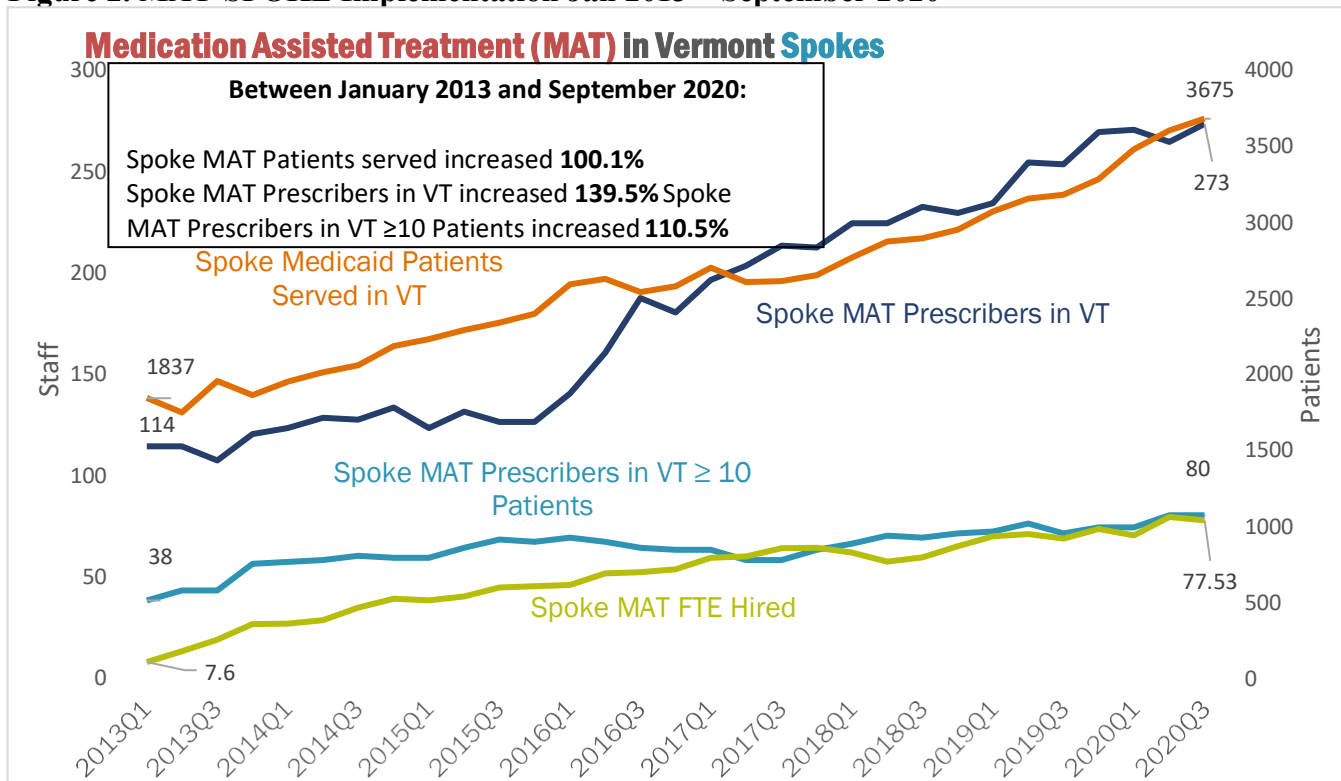
practices for providing team- and evidence-based medication-assisted treatment for opioid use disorder. For many physicians, nurse practitioners, and physician assistants, access to specialized staffing and ongoing training opportunities provide the support and confidence the providers need to accept the challenge of treating opioid use disorder in community-based medical practice settings (Spokes). For patients, the Spoke staff become a critical part of their care team, working together week-by-week and month-by-month towards long-term recovery and improved health and well-being. At the end of the 3rd quarter of 2020, capacity for receiving medication-assisted treatment in Spoke settings continued to increase, as evidenced by 3675 Vermonters with Medicaid insurance receiving medication-assisted treatment for opioid use disorder from 273 prescribers and 77.53 full-time equivalent Spoke staff, working as teams, across more than 114¹ different Spoke settings (as of September 2020).

Quarterly Highlights

- Vermont continues to demonstrate substantial access to medication-assisted treatment for Vermonters with opioid use disorder. As of September 2020, a monthly average of 3,675 Medicaid beneficiaries were served by Office-Based Opioid Treatment (OBOT/Spoke) programs. Also, in Quarter 3 2,933 clients were enrolled in Regional Opioid Treatment Programs (OTP/Hubs). While fewer clients enrolled in OTPs, the dip appears to be linked to a peak in the COVID-19 epidemic.
- Medication-assisted treatment for opioid use disorder is being offered across the State of Vermont by more than 114 different Spoke settings and by 273 medical doctors, nurse practitioners and physician assistants who work with 77.53 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 September 2020).
- Toward the end of Q1 2020, all Spoke sites began transitioning to remote and telehealth services in response to Vermont's "Stay Home, Stay Safe" emergency order that went into effect on March 13, 2020. At the end of Q3 2020, many Spoke nurses were providing care in both telehealth and in-person visits, and the Spoke counselors were continuing to deliver care remotely.
- As of November 1, 2019, the Blueprint has a contract with Dartmouth College for the 2019-2020 MAT Learning Collaborative. The 2019-2020 MAT Learning Collaborative will include a series of five webinars, six regional in-person training sessions, and one statewide conference. For the 3rd quarter of 2020, the Learning Collaborative events orchestrated by Dartmouth College, in conjunction with Blueprint for Health and Vermont Department of Health's Division of Alcohol and Drug Abuse Programs, consisted of two webinars and one statewide virtual training session. In response to the COVID-19 pandemic and Vermont's "Stay Home, Stay Safe" emergency declaration, Dartmouth College restructured the remainder of the Learning Collaborative to accommodate entirely virtual sessions as of June 2020.

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 – September 2020



Women’s Health Initiative

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

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

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

immediate access to LARC.

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

Quarterly Highlights

- Vermont continues to increase access to enhanced preventative health, psychosocial screening, and comprehensive family planning services, as evidenced by the commitment of 49 practices (25 women’s health and 24 primary care) to participate in the Women’s Health Initiative as of September 2020.
- This quarter we have, after conversations with program managers, rolled out new WHI attestation forms and shared co-management referral agreements that needed to be updated.
- The Community Quality Improvement Facilitator and Assistant Director have met with all practices to systematically review attestation elements. They also have worked together to discuss targets for next quarter. Program Managers reported that these were helpful to continue keeping a focus on this program.

The WHI is approaching statewide coverage, as all but two Hospital Service Areas have a specialized women’s health practice now participating in the WHI. We have had additional practices in both Springfield and Morrisville health service area join the WHI this past quarter.

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

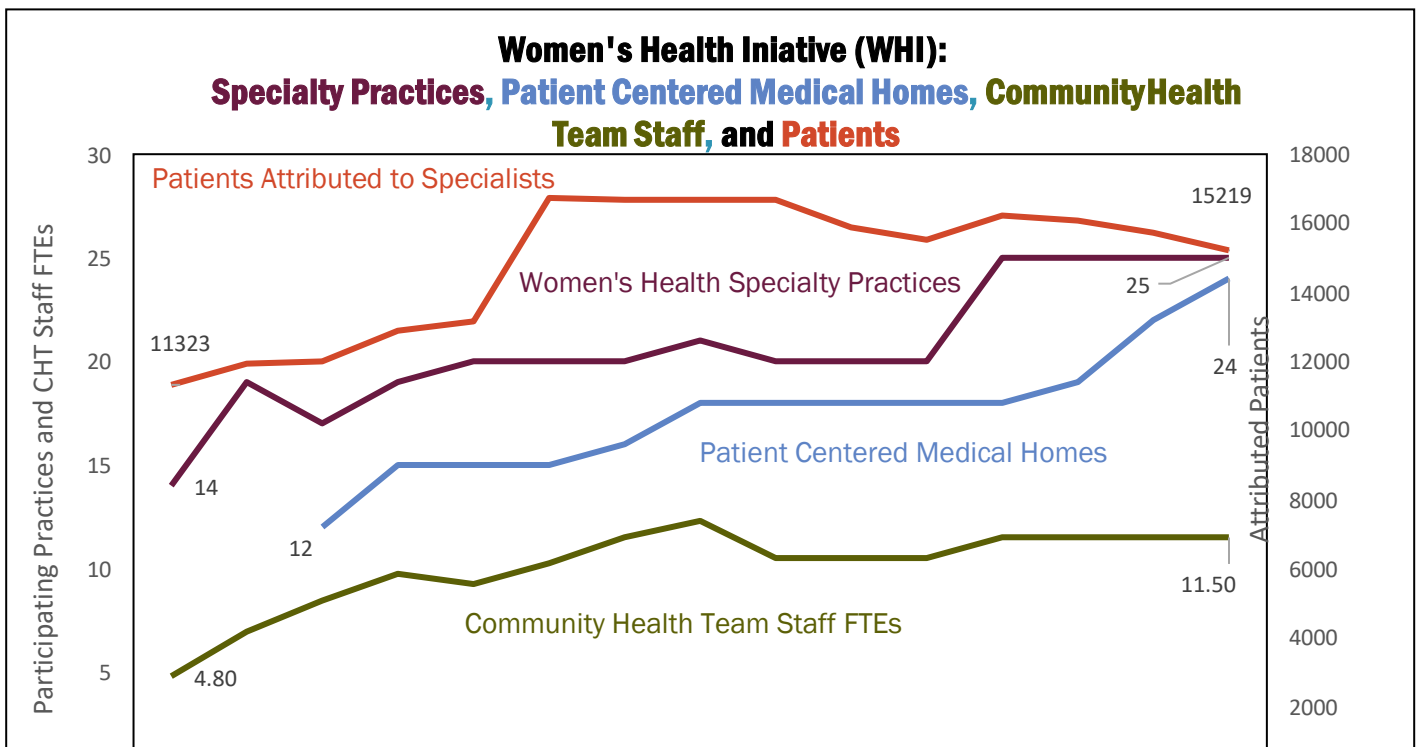


Table 4. Women’s Health Implementation by Region

Health Service Area / Team	WHI Specialist Practices as of September 2020	WHI PCMH Practices as of September 2020	WHI CHT Staff FTE Hired as of September 2020	WHI Specialist Quarterly Attributed** Medicaid Beneficiaries as of September 2020	WHI PCMH Quarterly Attributed** Medicaid Beneficiaries as of September 2020
Barre	1	1	1.00	719	566
Bennington	1	2	0.50	969	274
Brattleboro	1	0	1.00	841	0
Burlington	3	8	3.00	2589	4518
Middlebury	2	0	0.75	1235	0
Morrisville	1	4	0.50	485	1304
Newport	0	0	0.00	0	0
Randolph	2	0	0.50	524	0
Rutland	2	1	1.50	1721	152
Springfield	1	5	1.00	0	1685
St. Albans	1	0	0.00	1030	0
St. Johnsbury	1	2	0.75	855	749
Windsor*	0	0	0.00	0	0
Planned Parenthood (Statewide)	12	0	1	4251	0
Total	25	24	11.5	15219	9248

*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.

***PPNNE practices in Rutland and Middlebury are included in both the WHI Specialist field for those HSA’s and in the PPNNE statewide field. Patients are allocated to the Rutland and Middlebury HSA’s. Total WHI Specialist practice count is deduplicated.

iii. Behavioral Health

Key updates from QE092020:

- Inpatient psychiatric placements
- Applied Behavior Analysis

The Behavioral Health Team is responsible for concurrent review and authorization of inpatient psychiatric and detoxification services for Medicaid primary beneficiaries. Team members work closely with discharge planners at inpatient facilities to ensure timely and appropriate discharge plans.

DVHA collaborates with Agency partners to support coordination of care. The team refers members to VCCI services and helps ensure continuity of care for beneficiaries already enrolled with VCCI.

iv. Mental Health System of Care

Key updates from QE092020:

- Activities related to the COVID-19 pandemic
- Integrating Family Services Activity
- Implementation of DMH 10-Year Plan | Vision 2030: An Integrated and Holistic System of Care

System Overview

The Department of Mental Health 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). Funding is provided through the Vermont Agency of Human Services (AHS) Provider Agreements (formerly termed Master Grants/Agreements) to ten Designated Agencies and two Specialized Service Agencies. These agencies are located across the state of Vermont for the provision of:

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

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

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

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

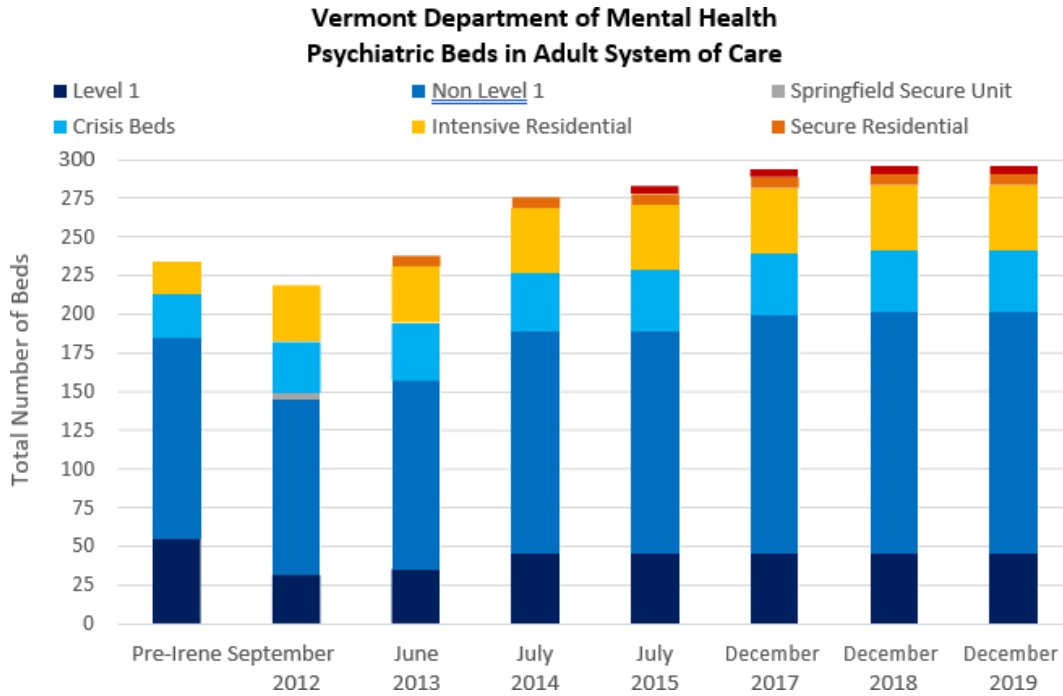
There are several policy and programmatic updates below related to the COVID-19 pandemic. The Governor of Vermont, Phil Scott, declared a state of emergency on March 13, 2020 that has been [extended to November 15, 2020](#). As well, on March 24, 2020 Governor Scott issued a “Stay Home, Stay Safe” order that ordered Vermonters to restrict and minimize activities outside of the home and directed non-essential businesses and non—profits to cease in person operations. These orders have had a tremendous impact on the service delivery of mental health services throughout Vermont in all community-based settings and inpatient facilities.

Enhancements of the Mental Health System of Care through DMH:

Hospital Services

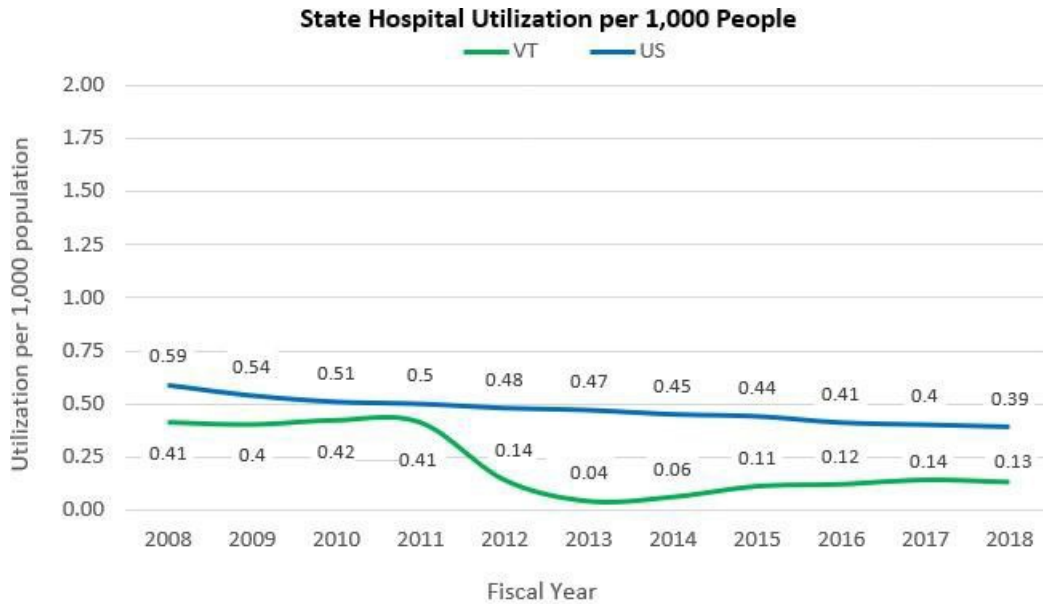
- There are 45 Level 1 beds and a total of 199 adult psychiatric inpatient beds across the system of care. During the COVID pandemic, a number of beds closed due to low staffing, converting double occupancy rooms to single occupancy, need for quarantine spaces, and an initial decrease in individuals presenting with a need for a higher level of care. Vermont anticipates staffing levels and beds that were needed prior to the pandemic will become a necessity again as we have been seeing a steady increase in the number of individuals presenting with a need for hospital level of care over the past month.
- Act 190 (2018) provided \$5.5 million dollars for the development of 12 inpatient Level I beds at the Brattleboro Retreat. This work is continuing but has been delayed due to the COVID-19 pandemic. These beds are expected to come online in January 2021.
- With the COVID-19 pandemic creating pressure on different parts of the adult system of care, a new partnership has been established and a contract has been signed with the Windham Center, which is a part of the Springfield Hospital System in Southern Vermont. The Windham Center has converted their 10-bed unit for adults into a COVID + adult unit for people who test positive for COVID – 19 and require psychiatric hospital level of care. This unit became available to Vermonters in late August 2020. During the construction of the Windham Center, Springfield Hospital agreed to allow DMH to use its two designated psychiatric rooms in their Emergency Department for individuals testing positive for COVID 19 and are in need of psychiatric hospitalization. The Springfield ED served two people during the construction phase of the Windham Center and these individuals received psychiatry and ancillary services from the Windham Center psychiatric staff. Since the Windham Center's opening, they have served one individual who has tested positive for COVID – 19.

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 utilization as compared to national benchmarks. Data from these two charts are calculated by the Substance Abuse and Mental Health Services Administration’s (SAMSHA) Uniform Reporting System (URS), which generates the National Outcomes Measures (NOMs). FY 2018 is the most recent data available.

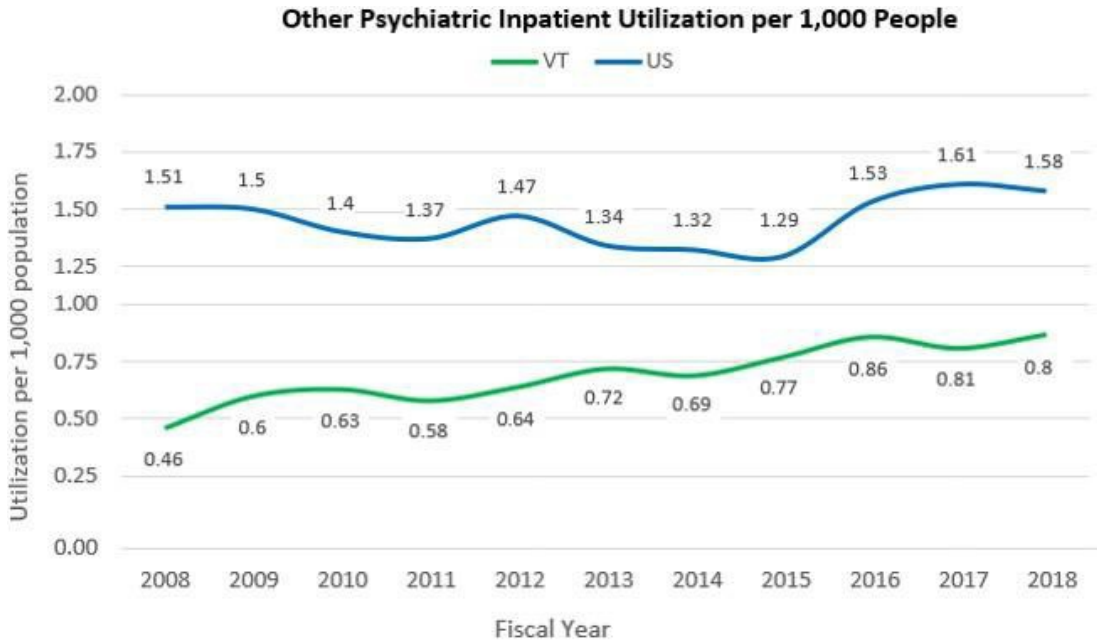
Figure 4. State Hospital Utilization per 1,000 people (in Vermont and the United States)



Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2018.

The national rate of state hospital utilization continues to decline year-over-year. Vermont Psychiatric Care Hospital opened in 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 is showing a slowly progressing upward trend since 2012. Vermont is one of a handful of states that only has one state hospital. Nationally, the number of state hospital beds and residents at the end of the year has been steadily decreasing. DMH will be paying close attention to these rates as there is anticipation and evidence already that this pandemic and the social isolation that has occurred because of it will increase the needs for mental health treatment and support.

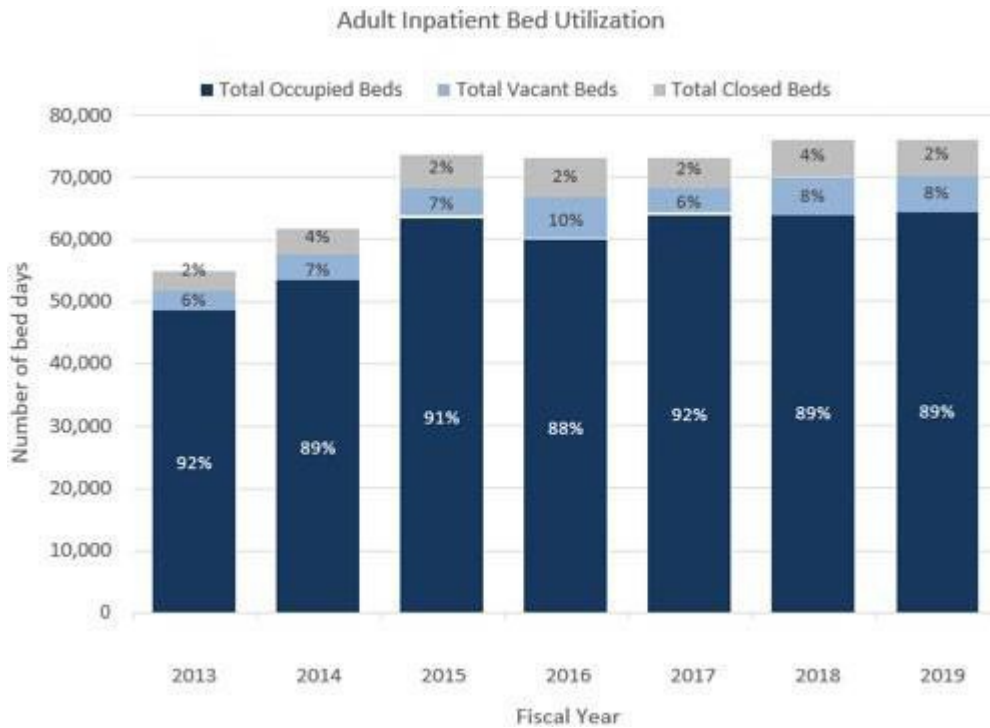
Figure 5. Other Psychiatric Hospital Utilization per 1,000 people (in Vermont and the United States)



Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2018.

Other involuntary psychiatric hospital unit admissions, such as those at Designated Hospitals, are included in chart above. The national rate of psychiatric hospital utilization since 2008 has generally declined year-over year through 2016 while Vermont’s rate of utilization has increased. However, in both 2017 and 2018 there have been substantial increases in national utilization of psychiatric hospital beds. Vermont experienced a slight decline in 2017. Inpatient utilization is still below the national averages while rates of community services utilization in Vermont continues to be markedly higher than national averages (Community Utilization per 1,000 Populations).

Figure 6. Adult Inpatient Utilization and Bed Closures



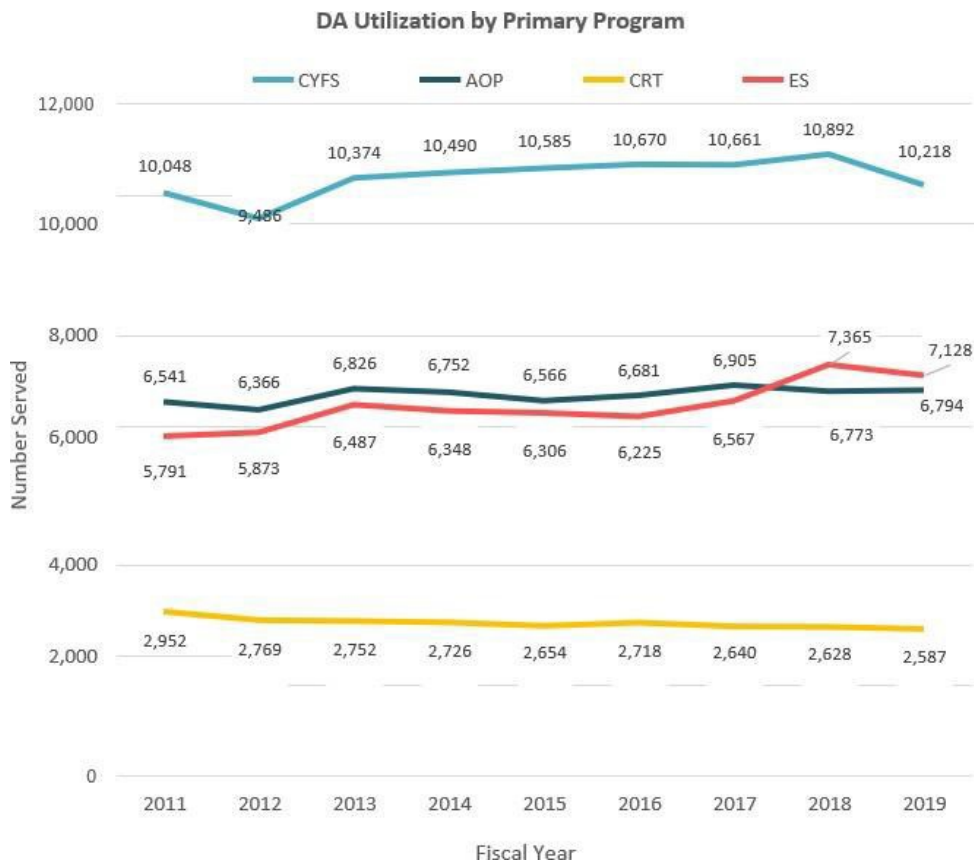
This chart depicts the total bed day capacity across the Vermont Designated Hospital system through FY 2019. The total bed day availability across the system has remained relatively constant in 2018 and 2019 with new bed capacity coming online in 2020. In 2019, bed closures represented 2% of adult inpatient utilization. Vacant beds have remained consistent at 8% in the two most recent years and have fluctuated between a low of 6% (2013, 2017) and a high of 10% in 2016. Adult inpatient bed utilization has remained consistently at 88% or above during this seven-year period. The Department, in concert with the Designated Hospitals, works to maximize utilization of inpatient beds through the bed board system.

Community Services

- Establish Community Outreach Team in Washington County (Collaboration with Public Safety)
- 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
- Increased capacity to provide mobile crisis responses to those needing screening and intervention in the community
- Increased and additional training for Team Two collaboration between law enforcement and mental health responders
- Additional availability of soft-restraints for law enforcement transports for involuntary mental health hospitalizations
- Resources to assist individuals in finding and keeping stable housing
- Expansion of peer-supported warmline hours

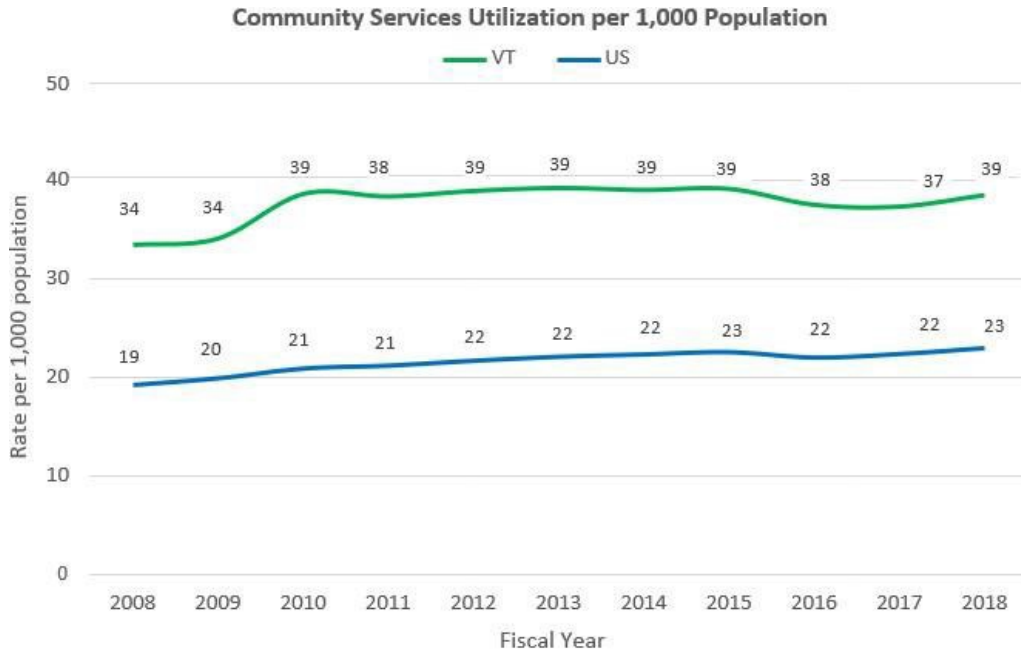
Enhanced community services funding provided by the legislature through increased appropriations to key mental health programs in the community over the last several years has helped, but staff recruitment and retention necessary to meet and expand these service capacities continues to be a struggle. The payment reform initiative beginning 1/1/2019 has also been an effort to reduce barriers to access and promote more “needs” driven service delivery that can be more responsive 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 supports a more streamlined approach to adult program access and the service capacity available in each DA catchment area.

Figure 7. Designated Agency Volume by Program



The highest number of persons served by programs offered by the Designated Agencies (DAs) continues to be in services for children, youth, and families. This program has until FY 2019 shown a slow upward trend for a seven-year period with FY 2019 showing a nearly 6% decrease in numbers served. The Emergency services Programs also experienced a slow upward progression over a number of years and likewise demonstrated a slight decline in FY 2019 of just 3%. Adult Outpatient programs remain reasonably level in performance to resources available. Community Rehabilitation and Treatment (CRT) programs continue a slow overall declining trend in adults engaged in the services of this program.

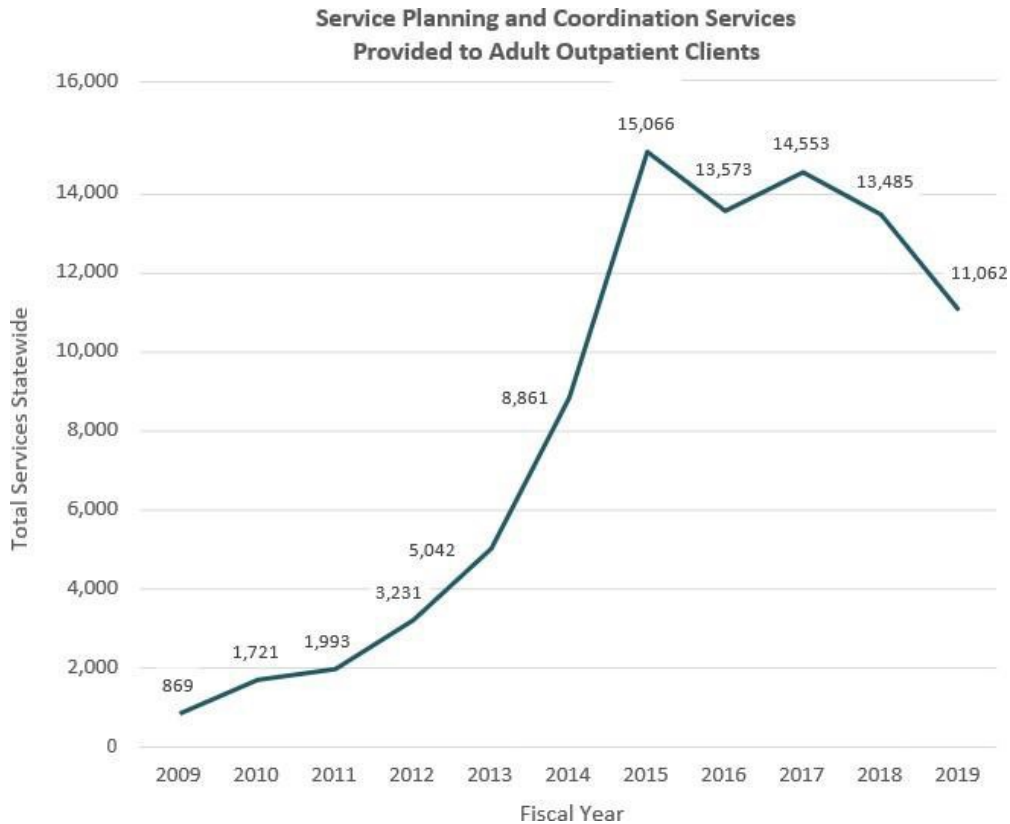
Figure 8. Community Utilization per 1,000 Populations



Based on URS data provided by US States and Territories per annual reporting guidelines for fiscal years 2008 - 2018.

The Vermont community mental health system serves nearly 40 out of every 1,000 Vermonters, which is substantially higher than the national figure. The most recent national data available through 2018 shows that Vermont has a strong and fairly consistent record of service delivery in community-based programs. While the progress appears to be static, data shown in Figure 9 below, indicates that significantly higher rates of service are being provided to fewer numbers of clients who may otherwise have needed hospital levels of care. This number however is also showing a downward trend since 2015.

Figure 9. Service Delivery: Planning and Coordination

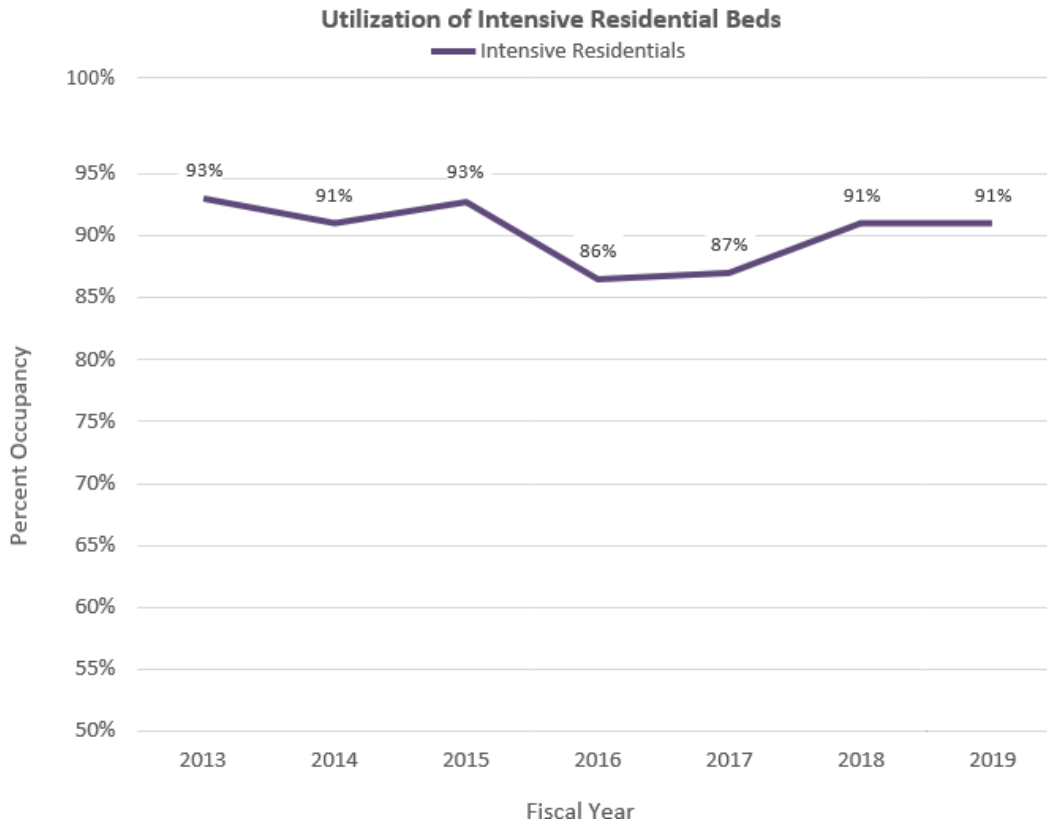


The support of non-categorical case management led to a steady increase in the number of services provided to adult outpatient clients allowing additional support to those in need but ineligible for case management through Community Rehabilitation and Treatment services through FY 2015. Levels remain elevated for this population FY 2016 through FY 2018, but the data shows a decline in recent years. It is still worth noting that the expansion of services provided for service planning and coordination has met a population need for this level of case management services for adults. The Department’s payment reform launched in January 2019 continues to support flexible service delivery including case management services.

The system of care is established on the principle that the intensity of services an individual requires will change over time. Individuals 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 higher level of service needs within the system. For others, they enter and exit intermittently depending on their individual needs. The system must have the flexibility to meet the needs of the individuals and provide the necessary services.

Residential and Transitional Services

Figure 10. Intensive Residential Bed Utilization



The secure residential recovery program, the Middlesex Therapeutic Community Residence, has the capacity to serve 7 individuals at a time and has served 45 individuals since opening. In late-March, the individuals who resided at MTCR were moved to the Vermont Psychiatric Care Hospital-on a separate wing and with allowances that maintained the flexibilities they had when living at MTCR. This change was made due to low staffing availability at MTCR and VPCH resulting from the impacts of COVID 19. As well, the one secure juvenile rehabilitation center (Woodside) in Vermont needed a place for the youth who resided there as Woodside was reconfigured by DMH to create a facility that would be appropriate for positive COVID individuals who also needed an inpatient treatment facility. Because Vermont did not see a surge of patients needing this level of care, the youth returned to Woodside and the individuals who resided at MTCR have returned to their facility in mid-October 2020 as staffing levels stabilized.

The Intensive Residential Recovery Programs (IRRs) 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 utilization of beds in these programs. Fiscal year 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 12-18-month time frame for residents.

Performance and Reporting

- Along with AHS, DMH has adopted the Results-Based Accountability (RBA) framework for assessing performance of providers via grants and contracts.
 - Creation of a “Vermont Psychiatric Care Hospital Outcomes” scorecard to meet legislative reporting requirements
 - Migration of the “DMH Snapshot” and the “DMH continued reporting” report to the RBA scorecard reporting tool
- Exploration of visualization tools to create more responsive reporting
- Participation in development of the Agency of Human Services Community profiles
- DMH has several RBA scorecards containing data and performance measures related to the system of care.

Regulation and Guidance

To align with federal policy shifts brought on by the COVID-19 pandemic, DMH issued new guidance to providers this past quarter on:

- COVID-19 Hospital Discharge Guidance
- General Guidance to Designated Agencies
- Critical Incident Reporting Requirements
- Medical Clearance Guidance
- The use of telehealth and HIPAA requirements
- Recommended Precautions for Caregivers

Payment Reform

DMH continues to work on payment reform, building off the Medicaid Pathways work and aligning necessary changes in the provider system with the All-Payer Model. The Department has created a case rate for children/youth mental health services, and a case rate for adult mental health services. The goal of this work is to move toward a simple, but accountable system that reduces the complexities of payment and shifts the focus of the providers and the department on outcomes and quality. DMH is committed to reforming the system to better serve Vermont’s population and continue to move towards full integration.

Integrating Family Services

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

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

Both IFS regions continue to utilize the Child and Adolescent Needs and Strengths (CANS) to look at the needs and strengths of children they are serving. The agencies are using this progress monitoring tool to track progress over time. They are showing that in the majority of situations children and youth are increasing in their strengths and decreasing needs.

During COVID, as has been true with all mental health agencies, there has been additional stress on providers and strong commitment to providing services and supports in new and creative ways. Both IFS regions, have significantly increased their offering of telehealth, treatment and intervention in outdoor spaces and providing services to students whether they are doing online or in school learning.

Vision 2030

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

The Vision 2030 Plan aims to provide Vermonters timely access to whole health, person-led care that achieves the Quadruple Aim of healthcare: 1) increasing the quality of care and patient experience; 2) improving population health, wellness and equity; 3) lowering per capita costs; and 4) creating a better environment for Vermont’s care teams. By fully embracing an integrated system that works collectively to address population health, wellness and equity, Vermonters will have improved access to care, will be healthier and happier, and the state will realize significant economic benefits as a whole.

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, between providers, community organizations and agencies. The workforce must use the best technologies, evidence-based tools and practices 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/departments-initiatives/10-year-planning-process-mental-health-think-tank>

In June 2020 legislation was passed in Vermont (H.960/Act 140) to enact a Mental Health Integration Council which is charged with overseeing and advising the implementation of the Vision 2030 plan. The Council was planned to convene every month from October 2020 through July 2023. The demands of the COVID19 pandemic on Vermont's health systems, however, has delayed that work. Work that was called for in the plan, however, has in many instances been advanced in direct response to the pandemic. Telehealth options, for example, are now available for anyone seeking mental health care, and are fully reimbursable. Much work has been undertaken to ensure children's mental health services are available even if children are not in the school building. We are creating an inventory of work that is moving ahead and supporting that work when we can. We look forward to convening the Mental Health Integration Council as soon as circumstances allow.

v. *Pharmacy Program*

Key updates from QE092020:

- Medication Assisted Treatment (MAT) Rebate Issue- SUPPORT ACT
- Value Based Purchasing
- Operational Activities
- Change Healthcare Call Center Statistics
- Pharmacy Provider Communications
- Drug Utilization Review Board (DURB)

Pharmacy Benefit Management Program

The DVHA's Pharmacy Unit manages the pharmacy benefits for all of Vermont's publicly funded pharmacy benefit programs. The Pharmacy Unit's goal is to provide the highest quality prescription drug benefits in the most cost-effective manner possible. This is accomplished by providing broad coverage of prescription and over-the-counter pharmaceuticals, controlling pharmacy expenditures through managing cost, brand, and generic utilization, and reducing state administrative costs. The State of Vermont utilizes the pharmacy benefit management company, Change Healthcare (CHC), to provide a full complement of operational, clinical, and programmatic support in addition to managing a call center in South Burlington, Vermont, for pharmacies and prescribers. The Pharmacy Unit is also responsible for overseeing the contract with CHC. The Pharmacy Unit manages approximately \$200 million in gross drug spend, and routinely analyzes national and DVHA drug trends, reviews drug utilization, and seeks innovative solutions to delivering high-quality customer service, assuring optimal drug therapy for DVHA members while managing drug utilization and cost.

Pharmacy Operations

- Pharmacy claims processing - enforcing coverage rules for various pharmacy benefits
- Pharmacy provider assistance - DVHA, Change Healthcare Clinical Call Centers.
- Liaison to Coordination of Benefits Unit/Part D Plan Team/Eligibility/Member Call Center to resolve issues.
- Liaison to Vermont Department of Health (VDH)-Vaccine Program, Substance Use Disorder/Opioid Treatment Program, Asthma Program, Smoking Cessation Program, and

Department of Mental Health (DMH) management of antipsychotics.

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

Clinical

- Manages drug utilization and cost
 - Federal, State, Supplemental rebate programs
 - Preferred Drug list
 - 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.

Medication Assisted Treatment (MAT) Rebate Issue

The “Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act” or the “SUPPORT Act” passed in 2018 contains language requiring states to cover all Medication-Assisted Treatments (MAT) for Opioid Use Disorder (OUD) under a “mandatory benefit”. Due to the placement of this language in Title 19 and outside of Section 1927 of the SSA where the Medicaid federal rebate language exists, states were notified in June 2020 that all MAT drug treatments would no longer be eligible for federal or supplemental rebates effective October 1st, 2020. This would have had a huge impact on DVHA’s drug spend since we collect nearly \$16 million on this entire class of drugs. To remedy this impact, a change to federal law was required. The National Association of Medicaid Directors and our Congressional delegation was made acutely aware, and the DVHA Pharmacy Unit prepared a mitigation plan which included negotiating State only rebate agreements, and rapidly changing preferred products on the Preferred Drug List (PDL). A final mitigation plan and fiscal impact was presented to Senior Leadership in July.

Based on information collected at the SSDC Annual Meeting during rebate negotiations, it was determined that the generic buprenorphine/naloxone tablets are now a cost-effective choice compared to the brand Suboxone Film which has been a preferred product on DVHAs PDL for several years. On August 21st, DVHA moved the generic buprenorphine/naloxone tablets to preferred status, to be co-preferred with Suboxone Film.

We expected that Congress would fix the MAT rebate issue in the continuing resolution to fund the federal government that was a top legislative priority in September. The MAT rebate fix is a federal cost saver, and had bipartisan and bicameral support, and corrects a statutory interpretation that Congress did not initially intend, therefore we did not expect any barriers to passage. DVHA confirmed with NAMD and our congressional delegation in August that corrective language was drafted retroactive to October 1st, 2020 and confirmed that legislation was signed on that date, therefore rebates will continue to be in place for MAT without interruption.

In summary, DVHA was faced with a potentially large impact to net drug spend, largely mitigated that potential impact through negotiating new rebate agreements and making changes to its PDL, while working with the congressional delegation on a successful federal law change. We will continue to monitor the net cost of MAT drugs and determine if any further changes in the PDL are warranted.

CMS Proposed Rule on Value Based Purchasing and other topics

CMS Issued a new rule CMS-2482-P-Medicaid Program “Establishing Minimum Standards in Medicaid State Drug Utilization Review and Supporting Value-Based Purchasing for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third-Party Liability Requirements”. The primary component of these proposed rules relates to value-based purchasing arrangements (VBPA), specifically with how they impact Best Price (BP) and Average Manufacturer Price (AMP). The proposed rule also proposes revisions to regulations regarding: Authorized generic sales when manufacturers calculate average manufacturer price (AMP); pharmacy benefit managers (PBM) accumulator programs and their impact on AMP and best price; state and manufacturer reporting requirements to the Medicaid Drug Rebate Program (MDRP); new Medicaid Drug Utilization Review (DUR) provisions designed to reduce opioid related fraud, misuse and abuse; the definitions of CMS-authorized supplemental rebate agreement, line extension, new formulation, oral solid dosage form, single source drug, multiple source drug, innovator multiple source drug for purposes of the MDRP; payments for prescription drugs under the Medicaid program; and coordination of benefits (COB) and third party liability (TPL) rules related to the special treatment of certain types of care and payment in Medicaid and Children’s Health Insurance Program (CHIP). The DVHA Pharmacy staff reviewed the rule in detail and determined there are potentially significant negative implications to the Medicaid Drug Rebate Program, and no clear benefit to states in terms of Value-Based Purchasing. DVHA prepared thorough comments and submitted them to both NASHP for submission to CMS, and to CMS directly on July 21st, 2020. CMS collected over 30,000 comments on the rule nationally and has not yet published a Final Rule. It is unclear at this time when the rule will be published, and what changes to the rule will be made.

Operational Activities

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

Month	Claims Paid w/o PA	Claims Paid w/Auto PA	Claims Paid w/Online Override	Claims Paid with Clinical PA	Claims Paid w/ Emergency PA	Claims Paid due to Grandfathering	Total Claim Count
July	122,495	25	118	6,545	15	2,424	131,622
	93.1%	0.02%	0.1%	5.0%	0.01%	1.8%	100%
August	126,609	28	125	6,481	12	2,427	135,682
	93.3%	0.02%	0.1%	4.8%	0.01%	1.8%	100%
September	162,452	45	105	7,513	30	2,929	173,074
	93.9%	0.03%	0.1%	4.3%	0.02%	1.7%	100%
QE 0920 Total	411,556	98	348	20,539	57	7,780	440,378
	93.4%	0.03%	0.1%	4.7%	0.01%	1.8%	100%

Paid Claims and Drug Spend:

Month	# of Claims	# of Members	State Paid Amounts
July	125,356	71,411	\$15,812,505
August	129,492	73,640	\$16,004,707
September	166,218	94,284	\$20,698,711
Total QE0920	421,066	239,335	\$52,515,923

Appeals and Fair Hearings QE 0920

Period	Number	Medication
Jul-20	2	Rexulti 0.5 MG Tab, Neupro Dis 1mg/24hr
Aug-20	2	Nucala Inj100 MG/ML, Neupro Dis 1mg/ 24hr
Sep-20	2	BB Liquid Soy Formula, Nucynta 50 MG Tab
Total #		
Appeals/Fair Hearings	6	

Pharmacy Call Center Statistics

There were 7,717 calls received in QE0920, with an average speed answered within 12 seconds and >93% of calls answered by a live agent, with a weekly call abandonment rate of <5%, which meets the service level agreement requirements. There were 2,565 calls made to the Provider Prior Authorization Help Desk and 5,152 of the calls were made to the Pharmacy Claims Help desk.

Pharmacy Communications Issued

There were four communications issued in QE0920.

1. An “Important Update on Early Refill Overrides with Submission Clarification Code (SCC)=13” which was effective on July 24, 2020. DVHA no longer allows the use of SCC=13 (overrides refill too soon) for controlled substances. Pharmacies must call the Help Desk for an override.
2. Influenza (Flu) 2020 – 2021 Provider Notice. This notice provided an update on the 2020-2021 Flu season preferred vaccines.
3. Changes to Buprenorphine/Naloxone Tablet PDL Status. Effective 8/21/20, generic buprenorphine/naloxone combination tablets will be moving to preferred status and will be co-preferred with Suboxone® Film. To align with the Suboxone® Film criteria, a prior authorization will not be required for the combination tablets unless the daily dose exceeds 16mg.
4. Important Information about COVID-19 Specimen Collection by Pharmacists. The Department of Vermont Health Access (DVHA) is implementing changes to support specimen collection by pharmacists for COVID-19 testing. In addition, since pharmacists are authorized to order and administer COVID-19 tests in accordance with their scope of practice and state and federal law, pharmacists performing specimen collection must enroll with Vermont Medicaid as ordering providers.

Drug Utilization Review Board Activities QE0920

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

- 1) Review and approve drug use criteria and standards for both retrospective and prospective drug use

reviews.

- 2) Apply these criteria and standards in the application of DURB activities.
- 3) Review and report the results of DUR programs; and
- 4) Recommend and evaluate educational intervention programs.

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

Drug Utilization Review Board Meetings

Drug Utilization Review Board meetings occur seven times per year. In QE0920, the DURB held one meeting. The DURB is scheduled to hold two meetings next quarter. Information on the DURB and its activities in 2020 is available at this link: <https://dvha.vermont.gov/advisory-boards/drug-utilization-review-board>

Reviewed and discussed by the DUR Board at the September Meeting:

Therapeutic Drug Classes

- Allergen Immunotherapy (New Drug Review Palforzia (arachis hypogaea) was included)
- Cytokine and CAM antagonists (changes eff. 1/1/21), including the following PDL classes:
 - Ankylosing Spondylitis
 - Gastrointestinal: Inflammatory Disease Biologics
 - Interleukin-1 Receptor Blockers
 - Psoriasis
 - Rheumatoid, Juvenile, & Psoriatic Arthritis
- Iron Chelating Agents
- Analgesics-NSAIDs (New Drug Review Relafen DS (nabumetone) will be included)
- Opioid Dependence and Overdose Treatments
- Otic Antibiotics
- Phosphate Binders
- Topical Analgesics
- Ulcerative Colitis and Crohn's Agents (Oral & Rectal)

Retrospective and Prospective DUR

- Introduce: Discussion Topics for 2021 RetroDUR Initiatives
- Data presentation: PrEP Therapy to Prevent HIV in at-risk Populations

Full New Drug Reviews

- Caplyta® (lumateperone)
- Esperoct® (antihemophilic factor (recombinant), glycopegylated-exei
- Jatenzo® (testosterone undecanoate)

- Secuado® (asenapine)
- Talicia® (omeprazole magnesium, amoxicillin and rifabutin)
- Xepi Cream® (ozenoxacin cream)
- Zerviate Drops® (cetirizine)

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

Key updates from QE092020:

- Completed financial reconciliation activities for the 2019 performance year and notified stakeholders of final 2019 program results for quality performance.
- Continued consideration of programmatic adjustments to address impacts of COVID-19 on contractual obligations and OneCare provider network.
- Continued contract negotiations with OneCare for the 2021 performance year.
- Continue to support Vermont’s broader efforts to develop an integrated health care delivery system under an All Payer Model through future program planning and implementation.

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

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

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.

The VMNG program saw provider participation expand to all geographic regions of the state for the 2020 performance year, which, coupled with an expanded attribution methodology, led to a significant increase in scale for the program. The number of risk-bearing hospital communities increased from thirteen to fourteen for the 2020 performance year, with continued participation from other providers within the communities. The number of attributed lives for the 2020 performance year increased from approximately 79,140 lives to

approximately 114,335 lives (85,937 lives through the traditional methodology and an additional 28,398 lives through the expanded attribution methodology).

DVHA completed financial reconciliation activities for its 2019 performance year in Q3 2020, though results were released in October (Q4). OneCare spent \$13.5 million more during the program year than its expected total cost of care and will return \$6.7 million of those funds to DVHA, which is the portion within the risk corridor for which OneCare is liable. OneCare demonstrated a quality score of 95% on 10 payment measures from its measure set, demonstrating significant improvement over its quality performance in 2018 on 5 of the 10 measures. Some measures continue to present a good opportunity for improvement in future years. Further information regarding the VMNG's 2019 performance can be found here:

<https://dvha.vermont.gov/sites/dvha/files/VMNG%202019%20Report%20FINAL%2010-12-2020.pdf>

DVHA and OneCare continue to explore options for flexibility in the VMNG program to hold providers harmless for negative impacts related to the COVID-19 pandemic and State of Emergency. DVHA identified opportunities for aligning with the Medicare Next Generation ACO program changes due to COVID-19, which it will implement in a contract amendment in Q4 of 2020.

DVHA entered into contract negotiations with OneCare for the 2021 performance year in mid-Q2 of 2020 and negotiations are ongoing as of the end of Q3 2019. Programmatic changes between performance years 2020 and 2021 will be minimal to ensure stability in the program during the COVID-19 pandemic. Negotiations are expected to continue into Q4 of 2020, after which further detail of changes to the model will be available.

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

V. Financial/Budget Neutrality Development/Issues

As is the monthly process, AHS paid DVHA 1/12th of the legislative budget for Global Commitment on the first business day of each month during the September 2020 quarter (July through September 2020). 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 QE0920 on October 30, 2020, as is normal.

Overall, the budget neutrality exercise indicates that for the September 2020 quarter, the State's total "With Waiver" expenditures were \$106,040,937 lower than the total "Without Waiver" amount (caseloads multiplied by the Budget Neutrality PMPMs). This is a significant change from QE 0620 when the expenditures were \$57,407,156 lower than the "Without Waiver" amount, and QE 0320 when expenditures were just \$8,312,341 lower. A significant decrease in expenditures is consistent with expectations that utilization of health care services would decrease during the COVID public health emergency. On a calendar year cumulative basis, "With Waiver" expenditures are \$170,929,184.53 lower than Without Waiver amount.

For the supplemental budget neutrality tests, only the SMI IMD category is showing a cumulative annual deficit of \$753,176. As of the writing of this report, AHS Fiscal Operations staff continue to research this deficit. They will report their finding during the next quarterly report (for QE 1220). When analyzed on a quarter-to-quarter basis (QE0620 to QE0920), we are observing:

Supplemental Test: New Adult: In QE 0920, there was a surplus of \$19,883,261 compared to a surplus of \$18,014,703 in QE 0620 and -\$7,346,817 in QE0320. This illustrates increased enrollment with decreased utilization for this population, which is an expected result of the public health emergency.

Supplemental Test: IMD SUD: While there is a cumulative surplus of \$23,115 for SFY 20, the last two quarters have shown deficits, with QE 0920 reporting a deficit of \$29,279 and QE 0620 reporting a deficit of \$57,002.

Claims reporting indicate a significant decrease in enrollment in the IMD SUD eligibility groups (see enrollment section of this report), but as enrollment for IMD SUD is derived from claims data, this enrollment decline could be due to claims lag and late billing at the IMDs.

AHS continues to actively monitor Investment spending. The total Investment spending for QE 0920 was \$18,548,023, which while lower than the previous two quarters, is still within expectations.

COVID's effect on budget neutrality is becoming clearer now that we have experienced three full quarters of CY20. As expected, the State experienced significant decreased utilization during the QE 0920.

VI. Member Month Reporting

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

The table below contains Member Month Reporting for QE0920 of CY2020 and includes the unduplicated count of member months for SUD IMD stays. CY2019 and CY 2018 member months are also reported in the tables below.

Table 1. Member Month Reporting – Calendar Year 2020 (QE0320, QE0620 and QE0920) subject to revision, with CY2019 and CY2018

Demonstration Population	Medicaid Eligibility Group	Total CY 2020 (QE 0320, QE 0620 and QE 0920)	Total CY 2019	Total CY 2018
1, 4*, 5*	ABD - Non-Medicare - Adult	59,903	81,306	83,071
	SUD - IMD - ABD	82	149	78
	SMI - IMD - ABD	44		
1	ABD - Non-Medicare - Child	15,039	23,854	25,577
1, 4*, 5*	ABD - Dual	194,165	257,810	257,263
	SUD - IMD - ABD Dual	107	158	78
	SMI - IMD - ABD Dual	10		
2	Non ABD - Non-Medicare - Adult	79,873	104,127	143,377
	SUD - IMD - Non ABD	131	222	187
	SMI - IMD - Non ABD	26		
2	Non ABD - Non-Medicare - Child	530,665	703,925	723,120
	Medicaid Expansion			
7	Global RX	58,438	77,498	79,488
8	Global RX	31,188	44,169	46,792
6	Moderate Needs	1,530	2,211	2,319
	New Adults			
3	New Adult without Child	330,445	423,147	471,886
	SUD - IMD New Adult w/o Child	897	1,352	791
	SMI - IMD New Adult w/o Child	195		
3	New Adult with Child	194,603	233,285	223,882
	SUD - IMD New Adult with Child	157	259	114
	SMI - IMD New Adult with Child	30		
	Total	1,497,528	1,953,472	2,058,023

Table 2. PMPM Capitated Rates CY 2020 (January 1, 2020 – December 31, 2020)

PMPM Budget Neutrality	
Medicaid Eligibility Group	DY 15 PMPM CY2020
ABD - Non-Medicare – Adult	\$ 1,683.54
SUD - IMD ABD	\$ 3,674.05
SMI - IMD ABD	\$ 15,587.00
ABD - Non-Medicare – Child	\$ 3,297.72
ABD – Dual	\$ 2,899.02
SUD - IMD ABD Dual	\$ 2,849.83
SMI - IMD ABD Dual	\$ 18,896.00
Non ABD - Non-Medicare – Adult	\$ 743.60
SUD - IMD Non-ABD	\$ 2,852.36
SMI- IMD NonABD	\$ 10,056.00
Non-ABD - Non-Medicare – Child	\$ 614.97
New Adult Group	\$ 586.34
SUD - IMD - New Adult	\$ 3,024.09
SMI - IMD - New Adult	\$ 11,669.00

Table 3. Medicaid Non-BN Rates Effective CY 2020

Medicaid Non-BN Rates - Effective 1/1/20 - 12/31/20	CY 2020 Per Member, Per Month
ABD Adult	\$ 2,386.28
ABD Child	\$ 3,062.78
ABD Dual	\$ 2,089.93
Global Rx	\$ 107.13
Moderate Needs	\$ 682.52
New Adult	\$ 499.41
Non-ABD Adult	\$ 666.60
Non-ABD Child	\$ 531.99

VII. Consumer Issues

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

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

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

VIII. Quality Improvement

Key updates from QE092020:

- The Quality Committee reviewed our performance for the measures within DVHA's Global Commitment Core Measure Set and based on those results recommended a new formal PIP topic focused on managing hypertension.
- The Quality Team created a COVID-19 dashboard at the end of March 2020 and maintained it throughout QE0920 to monitor the response to the pandemic: both the impact it has had on operations and the activities staff have engaged in.

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 QE0920 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 health care. During this reporting period, the Quality Committee reviewed our performance for the measures within DVHA's Global Commitment Core Measure Set and based on those results recommended a new formal PIP topic focused on managing hypertension (see next item).

Formal CMS Performance Improvement Project (PIP)

Submission of the PIP Summary Report during QE0620 marked the completion of a 3-year cycle for the substance use disorder treatment study topic. During QE0920, DVHA followed our standard operating procedure (SOP) for selection of a new formal CMS PIP topic. DVHA's Quality Committee reviewed our performance on all measures within our Global Commitment Core Measure Set. A short list of measures for improvement resulted from that review. Senior clinical staff were consulted and managing hypertension was chosen as our recommended study topic. This recommendation was written up as a project charter proposal and submitted to DVHA's Commissioner for review. Approval to move forward with this topic was given during QE0920. The project team will begin work during QE1220.

Other Collaborative Quality Improvement Projects

The Quality Improvement & Clinical Integrity Unit merged with two other units (Clinical Operations and Pharmacy) during the QE0320. The new combined group is called the Clinical Services Team. Goals of this new team include realizing efficiencies, aligning priorities and reducing redundancies. During QE0620 the Director of Quality Management lead a team of clinical and financial staff through an improvement project focused on aligning and streamlining DVHA's process for reviewing high dollar inpatient stays. During QE0920 an additional focus on palliative care was chosen for review. Starting during QE1220 the Director of Quality Management will support a palliative care review to identify potential project pathways.

Quality Measure Reporting

- CMS Medicaid Quality Core Measure Sets - During the last reporting period DVHA Quality staff began working with the Data Unit on our Core Measure Set reporting spreadsheets in preparation for reporting into MACPro during QE1220.
- HEDIS measure production – The Director of Quality Management formed an RFP team for the HEDIS/Quality Measures contract during the QE0320. The team finalized the scope of this contract during QE0620. The RFP was posted, and a vendor selected during QE0920.
- Clinical Services Team staff continued conversations with staff from Vermont Information Technology Leaders (VITL) 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 during QE0920 and indicated a need for further analysis. This work will continue into CY 2021 as we discuss with VITL the best approach to the data comparisons we need to make.

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 received training and has used this tool to create a Global Commitment Core Measure scorecard, Experience of Care, and other performance budgeting scorecards. The largest scorecard effort during the last reporting period was made to the DVHA Performance Accountability Scorecard - which includes key performance measures for each unit within the Department for use by the Management Team to evaluate programs and services. This scorecard includes close to 100 measures, all of which will be reviewed with an eye towards narrative alignment and standardization by the end of QE1220.

The Clinical Services Team also maintained their Green Belt status during QE0920 by attending development courses and participating in regular Agency-level meetings. Green Belt is the highest level of internal training offered through the State based on LEAN/RBA principles. The trainings are centered around process improvement and contribute 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 end of March 2020 to monitor the response to the pandemic: both the impact it has had on operations and the activities staff have engaged in. Currently an internal evaluation tool, the dashboard is updated weekly and made available to all DVHA staff via our intranet. DVHA's Management Team highlights certain metrics within the dashboard at its regular meetings. This work was maintained during QE0920 and additional measures were added to the dashboard during that time period.

Vermont Next Generation Medicaid ACO

During the QE0920 the DVHA's Director of Quality Management received, reviewed and approved the quarterly VMNG ACO quality management reports. Quality and Clinical staff from both organizations meet quarterly with a focus on quality measurement and ongoing QI efforts. A representative from the VMNG ACO is a standing member on DVHA's new formal PIP, the topic of which is managing hypertension.

AHS Performance Accountability Committee

During this quarter, the state continued to review the following meeting factors: urgency and importance of goals, tenure of participants, relevancy of topics, and interdependence. The latter factor was reviewed in light of the role/responsibilities of the compliance committee. The discussion was focused on how best to accomplish reciprocal strengthening of each other's functions. The state will continue to explore their interactions and how they both contribute to achieving the goals of the agency.

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 most recent reporting period), and an interpretation of the results (i.e., comparing actual to expected rates using performance targets and/or benchmarks and to characterize trends or patterns in the data). During this most recent quarter, VDH and DAIL highlighted the performance of a subset of their investments. The Clear Impact Scorecards for these investments is 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).

During this most recent quarter, DVHA and DMH highlighted the performance of their payment models. DVHA shared the performance of its Blueprint for Health Initiative's three (3) payment models for: Patient-Centered Medical Homes, Community Health Teams and the Women's Health Initiative. The Clear Impact Scorecards for these payment models are included in this report as Attachment 8.

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

During this quarter, the state received feedback from CMS re: their recently submitted CQS/STP. The feedback focused on the following aspects of the plan: site-specific settings assessment, validation of the HCBS settings, remediation strategies, ongoing monitoring of settings, and heightened scrutiny. In their resubmission, the state added the number of settings subject to the HCBS settings rule by specialized service population group. The state will work to classify the numbers by residential and non-residential settings and indicate the type of setting within the residential and non-residential categories for each of the specialized service population groups. The state will also work to add additional information around the specific methods used for validation of each setting. Specific to remediation, the state will include how they will assure that any discrepancies between the consumer responses and/or other validation strategy and provider self-assessments are addressed as well as how they will track the progress of site-specific CAPs to assure compliance by 3/2022. In addition, the state will include additional detail around integration of HCBS beneficiaries to the broader community and information or steps they will be taking in order to assure capacity building among providers to increase non-disability specific settings options across home and community-based services. Finally, the state will update information about how existing settings are being assessed for institutional characteristics of all three heightened scrutiny categories and include a timeline that reflects sufficient time to complete all remediation, communication, and relocation activities by March 2022. The state's response to the COVID-19 public health emergency has limited in-person, on-site visits which as caused a delay in confirming the implementation of assessment and validation generated corrective actions. The state continues to address those action items that can be resolved remotely and will reevaluate its progress during the next quarter.

SUD Monitoring Protocol

At the end of this quarter, the state uploaded the Global Commitment to Health - SUD Quarterly Monitoring Report - DY2Q4 to the PMDA for CMS review. 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. These metrics consist of (1) established quality measures endorsed by NQF or included in other Medicaid Quality Measures measure sets, (2) CMS-constructed implementation performance metrics and (3) state-defined Health Information Technology (HIT) metrics. For each performance measure, the SUD Monitoring Protocol identifies a baseline, a target to be achieved by the end of the demonstration and an annual goal for closing the gap between baseline and target expressed as percentage points. This report brings the state up to date with their SUD data reporting obligations. During this quarter, the state worked with their independent evaluator to review ADAP Monitoring Protocol Metrics Workbook to determine which metrics could be used in the SUD Mid-Point Assessment.

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. As per the new STCs, the state is required to submit a SMI Monitoring Protocol to CMS within 150 calendar days after approval of SMI implementation plan. As per the STCs, the Monitoring Protocol Template was submitted to CMS during last quarter. Components of the Monitoring Protocol included the following: 1) an assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 103(c) and STC 104(c), reporting relevant information to the state's SMI/SED financing plan described in Attachment C, and reporting relevant information to the state's Health IT plans described in STC 104(d); 2) a description of 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 Section IX of the demonstration; and 3) a description of baselines and targets to be achieved by the end of the demonstration. The state anticipates receiving CMS feedback during the next quarter.

IX. Demonstration Evaluation Activities (including SUD & SMI)

Last quarter, the state submitted their revised design to CMS for review/approval. No feedback was received from CMS on overall design by the end of the quarter. Specifically, the document was revised to meet the requirements specified by the demonstration's Special Terms and Conditions (STCs), include CMS SMI monitoring and evaluation tools, and align with CMS SMI evaluation design guidance. No feedback was received from CMS on the overall design by the end of the quarter.

Also, during this quarter, the state continued to work with the evaluator to implement Substance Use Disorder (SUD) evaluation activities. Time was spent finalizing the provider survey – which was released at the end of the quarter. The state also continued to work with the evaluator on the SMI Mid-Point Assessment. During the quarter, a design and discussion meeting was held with DMH as well as a follow-up meeting which included DMH, DVHA and IT staff. Finally, the state worked with departments to ensure evaluation data is submitted to independent evaluator according to the established schedule. Response to the COVID-19 public health emergency has slowed progress – but the current timeline remains applicable. 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.

X. Compliance

Key updates from QE092020:

- The 2020 EQRO review activities were conducted remotely
- CY2020 AHS/DVHA IGA approval
- Compliance Committee reorganization

During this quarter, our EQRO, HSAG, performed a fully remote version of their annual review of compliance with standards. Activities included a desk review of documents and conducting virtual interviews with key staff members. These annual audits follow a three-year cycle of standards. During this year's review, HSAG evaluated the degree to which DVHA complied with federal Medicaid managed care regulations and the associated AHS intergovernmental agreement (IGA) in eight performance categories (i.e., standards). The eight standards included requirements associated with the federal Medicaid managed care Structure and Operations standards found at CFR §438.214–438.230. The standards included requirements related to the following: to

- Provider Selection;
- Credentialing and Recredentialing;
- Beneficiary Information;
- Beneficiary Rights;
- Confidentiality;
- Grievance System – Beneficiary Grievances;
- Grievance System – Beneficiary Appeals and State Fair Hearings; and
- Sub contractual Relationships and Delegation

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

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

EQRO Performance Improvement Project Validation activities are described in the Quality Improvement Section of this report.

Compliance Committee Review Continues

During this quarter, DVHA and AHS continued to discuss a new format for the Compliance Committee. A Charter and Draft procedures were developed and will be presented to the reconfigured Compliance Committee next quarter. The Charter outlines the following aspects of the committee: purpose, membership, scope of work, duties/responsibilities, and accountability. The procedure document outlines how the committee will conduct its day to day operations including the following: assessment of Operational Areas of the Medicaid Program, development of annual work plan, use of reportable events, as well as an overview of compliance monitoring processes. These documents create new lines of communications and accountability across the agency and will help us to better coordinate our Medicaid compliance activities.

Intra-Governmental Agreement (IGA) between AHS and DVHA

During this quarter, the AHS QIM received notice from CMS that the 2020 Agency of Human Services (AHS) and the Department of Vermont Health Access (DVHA) IGA was approved. All requested changes to the 2020 agreement are expected to be incorporated into the 2021 version and sent to CMS for review/approval during the next quarter.

XI. Reported Purposes for Capitated Revenue Expenditures

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

- a. Reduce the rate of uninsured and/or underinsured in Vermont.
- b. Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
- c. 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
- d. Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system and promote transformation to value-based and integrated models of care.

Attachment 6 is a summary of Investments, with applicable category identified, for QE092020.

XII. Enclosures/Attachments

- Attachment 1: Budget Neutrality Workbook
- Attachment 2: Enrollment and Expenditures Report
- Attachment 3: Complaints to Member Services
- Attachment 4: Medicaid Grievance and Appeal Reports
- Attachment 5: Office of the Health Care Advocate Report
- Attachment 6: QE092020 GC Investments

Attachment 7: Investment Scorecard
Attachment 8: Payment Model Scorecard

XIII. State Contact(s)

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

Date Submitted to CMS: December 4, 2020

ATTACHMENTS

Attachment 1 - Budget Neutrality

State of Vermont Global Commitment to Health
 Budget Neutrality PMPM Projection vs 64 Actuals Summary
 November 5, 2020

ELIGIBILITY GROUP	DY 12	DY 13	DY 14	DY 15	DY 16	Total
	JAN - DEC 2017	JAN - DEC 2018	JAN - DEC 2019	JAN - DEC 2020	JAN - DEC 2021	
Without Waiver (Caseload x pmpms)						
ABD - Non-Medicare - Adult	\$ 142,860,455	\$ 130,050,973	\$ 131,976,747	\$ 100,849,097	\$ -	\$ 505,737,272
ABD - Non-Medicare - Child	\$ 85,359,001	\$ 78,434,428	\$ 75,860,331	\$ 49,594,411	\$ -	\$ 289,248,171
ABD - Dual	\$ 664,153,383	\$ 693,539,886	\$ 720,885,032	\$ 562,888,218	\$ -	\$ 2,641,466,519
Non ABD - Non-Medicare - Adult	\$ 101,757,250	\$ 96,887,008	\$ 73,827,769	\$ 59,393,563	\$ -	\$ 331,865,589
Non ABD - Non-Medicare - Child	\$ 392,665,288	\$ 406,444,058	\$ 413,877,439	\$ 326,343,055	\$ -	\$ 1,539,329,841
Total Expenditures Without Waiver	\$ 1,386,795,376	\$ 1,405,356,354	\$ 1,416,427,318	\$ 1,099,068,344	\$ -	\$ 5,307,647,392
With Waiver						
ABD Non Medicare Adult	\$ 162,602,154	\$ 162,728,372	\$ 168,382,861	\$ 134,383,917	\$ -	\$ 628,097,303
ABD - Non-Medicare - Child	\$ 66,593,208	\$ 60,077,015	\$ 58,176,676	\$ 41,344,693	\$ -	\$ 226,191,591
ABD - Dual	\$ 445,847,909	\$ 461,739,496	\$ 484,543,363	\$ 354,491,248	\$ -	\$ 1,746,622,016
Non ABD - Non-Medicare - Adult	\$ 84,040,228	\$ 84,275,155	\$ 67,221,781	\$ 52,758,341	\$ -	\$ 288,295,504
Non ABD - Non-Medicare - Child	\$ 305,543,574	\$ 335,706,591	\$ 350,804,595	\$ 251,728,582	\$ -	\$ 1,243,783,343
Premium Offsets	\$ (655,991)	\$ (772,935)	\$ (774,152)	\$ (334,092)	\$ -	\$ (2,537,169)
Moderate Needs Group	\$ 1,488,408	\$ 1,378,915	\$ 1,429,868	\$ 603,137	\$ -	\$ 4,900,328
Marketplace Subsidy	\$ 6,355,286	\$ 6,242,717	\$ 5,915,336	\$ 4,487,249	\$ -	\$ 23,000,589
VT Global Rx	\$ 13,824,166	\$ 15,300,919	\$ 10,692,124	\$ 2,372,852	\$ -	\$ 42,190,061
VT Global Expansion VHAP	\$ 414,824	\$ (0)	\$ 0	\$ -	\$ -	\$ 414,824
CRT DSHP	\$ 10,331,787	\$ 9,240,772	\$ 6,787,058	\$ 4,441,359	\$ -	\$ 30,800,976
Investments	\$ 142,332,671	\$ 148,500,000	\$ 119,133,231	\$ 81,861,873	\$ -	\$ 491,827,775
Total Expenditures With Waiver	\$ 1,238,718,223	\$ 1,284,417,019	\$ 1,272,312,740	\$ 928,139,159	\$ -	\$ 4,723,587,141
Supplemental Test: New Adult (Gross)						
Limit New Adult	\$ 370,689,611	\$ 375,735,593	\$ 369,387,603	\$ 307,856,644	\$ -	\$ 1,423,669,452
Without Waiver SUD - IMD New Adult Expenditures		\$ 2,704,249	\$ 4,842,747	\$ 3,187,391	\$ -	\$ 10,734,386
Without Waiver SMI - IMD New Adult Expenditures				\$ 2,625,525	\$ -	\$ 2,625,525
With Waiver New Adult Expenditures	\$ 295,620,340	\$ 312,104,578	\$ 315,241,704	\$ 275,876,591	\$ -	\$ 1,198,843,212
With Waiver SUD - IMD New Adult Expenditures		\$ 2,826,119	\$ 5,869,169	\$ 3,035,622	\$ -	\$ 11,730,910
With Waiver SMI - IMD New Adult Expenditures				\$ 4,256,200	\$ -	\$ 4,256,200
<i>Surplus (Deficit)</i>	\$ 75,069,271	\$ 63,509,145	\$ 53,119,477	\$ 30,501,147	\$ -	\$ 222,199,041
Supplemental Test: IMD SUD (Gross)						
SUD - IMD ABD - Non-Medicare - Adult		\$ 268,039	\$ 529,433	\$ 301,272	\$ -	\$ 1,098,744
SUD - IMD ABD - Dual		\$ 214,495	\$ 442,312	\$ 304,932	\$ -	\$ 961,739
SUD - IMD Non ABD - Non-Medicare - Adult		\$ 533,391	\$ 633,224	\$ 373,659	\$ -	\$ 1,540,274
Limit SUD IMD Without Waiver		\$ 1,015,926	\$ 1,604,968	\$ 979,863	\$ -	\$ 3,600,757
SUD - IMD ABD Non Medicare Adult		\$ 249,820	\$ 646,440	\$ 289,683	\$ -	\$ 1,185,944
SUD - IMD ABD - Dual		\$ 199,224	\$ 545,837	\$ 252,499	\$ -	\$ 997,560
SUD - IMD Non ABD - Non-Medicare - Adult		\$ 540,841	\$ 803,762	\$ 414,566	\$ -	\$ 1,759,170
Limit SUD IMD With Waiver		\$ 989,886	\$ 1,996,039	\$ 956,748	\$ -	\$ 3,942,673
<i>Surplus (Deficit)</i>		\$ 26,040	\$ (391,071)	\$ 23,115	\$ -	\$ (341,916)
Supplemental Test: IMD SMI (Gross)						
SMI - IMD ABD - Non-Medicare - Adult				\$ 685,828	\$ -	\$ 685,828
SMI - IMD ABD - Dual				\$ 188,960	\$ -	\$ 188,960
SMI - IMD Non ABD - Non-Medicare - Adult				\$ 261,456	\$ -	\$ 261,456
Limit SMI IMD Without Waiver		\$ -	\$ -	\$ 1,136,244	\$ -	\$ 1,136,244
SMI - IMD ABD Non Medicare Adult				\$ 965,399	\$ -	\$ 965,399
SMI - IMD ABD - Dual				\$ 244,918	\$ -	\$ 244,918
SMI - IMD Non ABD - Non-Medicare - Adult				\$ 679,103	\$ -	\$ 679,103
Limit SMI IMD With Waiver		\$ -	\$ -	\$ 1,889,420	\$ -	\$ 1,889,420
<i>Surplus (Deficit)</i>		\$ -	\$ -	\$ (753,176)	\$ -	\$ (753,176)
Waiver Savings Summary						
Annual Savings	\$ 148,077,153	\$ 120,939,335	\$ 144,114,578	\$ 170,929,185	\$ -	\$ 584,060,251
Shared Savings Percentage	30%	25%	25%	25%	25%	
Shared Annual Savings	\$ 44,423,146	\$ 30,234,834	\$ 36,028,645	\$ 42,732,296	\$ -	\$ 153,418,920
Total Savings	\$ 44,423,146	\$ 30,234,834	\$ 36,028,645	\$ 42,732,296	\$ -	\$ 153,418,920
Cumulative Savings	\$ 44,423,146	\$ 74,657,980	\$ 110,686,624	\$ 153,418,920	\$ 153,418,920	\$ 153,418,920

\$ 10,711,916
 \$ -

11% 9% 10% 16%

New Adult Waiver Savings Not Included in Waiver Savings Summary
 See Budget Neutrality New Adult tab (STC#64)
 See CY2020 Investments tab
 See EG MM CY 2020 Tab for Member Month Reporting

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

	DY 13 – PMPM				DY 14 – PMPM				DY 15 – PMPM			
	QE 0318	QE 0618	QE 0918	QE 1218	QE 0319	QE 0619	QE 0919	QE 1219	QE 0320	QE 0620	QE 0920	QE 1220
(A) New Adult Group PMPM Projection	\$540.03	\$540.03	\$540.03	\$540.03	\$562.71	\$562.71	\$562.71	\$562.71	\$586.34	\$586.34	\$586.34	\$586.34
(B-1) eligible member months w/ Child	55,583	55,408	55,889	57,002	57,969	58,516	58,610	58,199	60,052	65,285	66,559	66,559
(B-2) eligible member months w/o Child	120,870	119,755	116,895	114,366	110,736	106,927	103,710	101,777	102,708	111,034	116,898	116,898
(C-1 = (A x B-1) Supplemental Cap 1 w/ Child	\$ 30,016,487.49	\$ 29,921,982.24	\$ 30,181,736.67	\$ 30,782,790.06	\$ 32,619,735.99	\$ 32,927,538.36	\$ 32,980,433.10	\$ 32,749,159.29	\$ 35,210,889.68	\$ 38,279,206.90	\$ 39,026,204.06	\$ 39,026,204.06
(C-2 = (A x B-2) Supplemental Cap 1 w/o Child	\$ 65,273,426.10	\$ 64,671,292.65	\$ 63,126,806.85	\$ 61,761,070.98	\$ 62,312,254.56	\$ 60,168,892.17	\$ 58,358,654.10	\$ 57,270,935.67	\$ 60,221,808.72	\$ 65,103,675.56	\$ 68,541,973.32	\$ 68,541,973.32
(D-1) New Adult FMAP w/ Child	53.47%	53.47%	53.47%	53.89%	53.89%	53.89%	53.89%	53.86%	60.06%	60.06%	60.06%	60.06%
(D-2) New Adult FMAP w/o Child	89.95%	89.95%	89.95%	89.99%	93.00%	93.00%	93.00%	93.00%	90%	90%	90%	90%
(E-1 = C-1 x D-1) Federal Share of Supplemental Cap 1 w/ Child	\$ 16,049,815.86	\$ 15,999,283.90	\$ 16,138,174.60	\$ 16,588,845.56	\$ 17,578,775.73	\$ 17,744,650.42	\$ 17,773,155.40	\$ 17,638,697.19	\$ 21,147,660.34	\$ 22,990,491.66	\$ 23,439,138.16	\$ 23,439,138.16
(E-2 = C2 x D-2) Federal Share of Supplemental Cap 1 w/o Child	\$ 58,713,446.78	\$ 58,171,827.74	\$ 56,782,562.76	\$ 55,578,787.77	\$ 57,950,396.74	\$ 55,957,069.72	\$ 54,273,548.31	\$ 53,261,970.17	\$ 54,199,627.85	\$ 58,593,308.00	\$ 61,687,775.99	\$ 61,687,775.99
Subtotal Federal Share Supplemental Cap 1	\$ 74,763,262.64	\$ 74,171,111.64	\$ 72,920,737.36	\$ 72,167,633.34	\$ 75,529,172.47	\$ 73,701,720.14	\$ 72,046,703.71	\$ 70,900,667.37	\$ 75,347,288.19	\$ 81,583,799.67	\$ 85,126,914.15	\$ 85,126,914.15
Total FFP reported for New Adult Group	\$ 62,183,045.44	\$ 63,756,150.76	\$ 62,666,336.47	\$ 61,269,677.13	\$ 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	\$ 69,686,466.57
Supplemental Budget Neutrality Test 1												
over/(under) - report any negative # under main GC budget neutrality	\$ 12,580,217.20	\$ 10,414,960.88	\$ 10,254,400.88	\$ 10,897,956.21	\$ 7,674,337.60	\$ 5,113,127.88	\$ 8,770,147.88	\$ 16,655,402.63	\$ (6,871,002.62)	\$ 13,491,784.29	\$ 15,440,447.58	\$ 15,440,447.58

**Attachment 2 - Enrollment and
Expenditures Report**

**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: **Michael K. Smith, Secretary
Agency of Human Services**

Prepared by: **Cory Gustafson, Commissioner
Department of Vermont Health Access**

Report Date: **September 1, 2020
(Revised October 1, 2020)**

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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 age 19 or older; categorized as aged, blind, disabled, and/or medically needy

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

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

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

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

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

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

Underinsured Child: Beneficiaries under age 19 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 ESL, 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

MEDICAID PROGRAM ENROLLMENT AND EXPENDITURES

The Medicaid program enrollment and expenditure reports have traditionally reported caseload representative of a year-to-date average monthly member enrollment. The Per Member Per Month (PMPM) is calculated using the average monthly enrollment and expenses/budget for each Medicaid Eligibility Group. Due to the impact of the public health emergency produced by the novel coronavirus, SARS-CoV-2, this report is being revised to include an additional column that indicates point-in-time enrollment, as of the last month of the quarter, into the Medicaid program. The “Ending Enrollment” column was included to communicate the observed increases in enrollment during the public health emergency.

The Department of Vermont Health Access

Caseload and Expenditure Report

All AHS and AOE YTD SFY'20

Medicaid Eligibility Group	SFY'20 BAA2			SFY'20 Actuals Thru June 30, 2020			% of Expenses to Budget Line Item	Ending Enrollment as of June 2020
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM		
ABD Adult	6,475	\$ 180,315,261	\$ 2,320.66	6,298	\$ 144,689,782	\$ 1,914.47	80.24%	6,244
ABD Dual	17,828	\$ 299,575,358	\$ 1,400.30	17,521	\$ 226,244,970	\$ 1,076.05	75.52%	17,434
General Adult	9,657	\$ 71,277,457	\$ 615.08	8,287	\$ 64,603,420	\$ 649.64	90.64%	8,996
New Adult Childless	35,559	\$ 228,537,967	\$ 535.58	35,009	\$ 226,756,641	\$ 539.76	99.22%	37,185
New Adult w/Child	19,550	\$ 105,905,193	\$ 451.43	20,178	\$ 111,464,776	\$ 460.34	105.25%	22,053
BD Child	2,138	\$ 77,718,086	\$ 3,029.24	1,758	\$ 55,631,340	\$ 2,636.68	71.58%	1,642
General Child	58,256	\$ 426,194,781	\$ 609.66	57,692	\$ 340,328,506	\$ 491.59	79.85%	58,451
Underinsured Child	540	\$ 1,802,962	\$ 278.23	561	\$ 1,155,169	\$ 171.57	64.07%	524
CHIP	4,399	\$ 10,914,620	\$ 206.76	4,535	\$ 13,602,322	\$ 249.96	124.62%	4,231
Vermont Premium Assistance	16,988	\$ 5,986,200	\$ 29.36	16,237	\$ 5,732,382	\$ 29.42	95.76%	16,039
Vermont Cost Sharing	3,879	\$ 1,355,401	\$ 29.12	3,518	\$ 1,170,612	\$ 27.73	86.37%	3,252
Pharmacy Only	10,050	\$ 5,038,270	\$ 41.78	9,988	\$ 3,451,390	\$ 28.80	68.50%	10,158
Choices for Care - Traditional	4,135	\$ 223,970,679	\$ 4,513.72	4,515	\$ 223,809,460	\$ 4,130.62	99.93%	4,500
Choices for Care - Acute	4,135	\$ 36,280,841	\$ 731.17	4,515	\$ 41,837,929	\$ 772.16	115.32%	4,500
Total Medicaid	185,575	\$ 1,674,873,074	\$ 752.11	182,579	\$ 1,460,478,699	\$ 666.60	87.20%	187,457

The Department of Vermont Health Access
Caseload and Expenditure Report
All AHS YTD SFY'20

Medicaid Eligibility Group	SFY'20 BAA2			SFY'20 Actuals Thru June 30, 2020			% of Expenses to Budget Line Item	Ending Enrollment as of June 2020
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM		
ABD Adult	6,475	\$ 187,939,498	\$ 2,418.78	6,298	\$ 143,539,978	\$ 1,899.25	76.38%	6,244
ABD Dual	17,828	\$ 337,463,951	\$ 1,577.41	17,521	\$ 226,109,248	\$ 1,075.40	67.00%	17,434
General Adult	9,657	\$ 89,474,139	\$ 772.10	8,287	\$ 64,401,879	\$ 647.61	71.98%	8,996
New Adult Childless	35,559	\$ 212,160,334	\$ 497.20	35,009	\$ 226,660,912	\$ 539.54	106.83%	37,185
New Adult w/Child	19,550	\$ 82,110,571	\$ 350.00	20,178	\$ 111,461,688	\$ 460.33	135.75%	22,053
BD Child	2,138	\$ 64,653,237	\$ 2,520.00	1,758	\$ 43,634,364	\$ 2,068.08	67.49%	1,642
General Child	58,256	\$ 367,602,054	\$ 525.84	57,692	\$ 306,451,522	\$ 442.66	83.37%	58,451
Underinsured Child	540	\$ 1,425,116	\$ 219.93	561	\$ 911,542	\$ 135.38	63.96%	524
CHIP	4,399	\$ 15,292,861	\$ 289.70	4,535	\$ 12,073,760	\$ 221.87	78.95%	4,231
Vermont Premium Assistance	16,988	\$ 5,986,200	\$ 29.36	16,237	\$ 5,732,382	\$ 29.42	95.76%	16,039
Vermont Cost Sharing	3,879	\$ 1,355,401	\$ 29.12	3,518	\$ 1,170,612	\$ 27.73	86.37%	3,252
Pharmacy Only	10,050	\$ 5,038,270	\$ 41.78	9,988	\$ 3,451,390	\$ 28.80	68.50%	10,158
Choices for Care - Traditional	4,135	\$ 223,970,679	\$ 4,513.72	4,515	\$ 223,809,460	\$ 4,130.62	99.93%	4,500
Choices for Care - Acute	4,135	\$ 29,640,763	\$ 597.36	4,515	\$ 41,809,018	\$ 771.63	141.05%	4,500
Total Medicaid	185,575	\$ 1,624,113,074	\$ 729.32	182,579	\$ 1,411,217,757	\$ 644.11	86.89%	187,457

The Department of Vermont Health Access
Caseload and Expenditure Report
DVHA Only YTD SFY'20

Medicaid Eligibility Group	SFY'20 BAA2			SFY'20 Actuals Thru June 30, 2020			% of Expenses to Budget Line Item	Ending Enrollment as of June 2020
	Caseload	Budget	PMPM	Caseload	Expenses	PMPM		
ABD Adult	6,475	\$ 58,151,996	\$ 748.42	6,298	\$ 57,489,532	\$ 760.67	98.86%	6,244
ABD Dual	17,828	\$ 55,019,826	\$ 257.18	17,521	\$ 53,812,435	\$ 255.94	97.81%	17,434
General Adult	9,657	\$ 48,717,821	\$ 420.40	8,287	\$ 51,559,566	\$ 518.47	105.83%	8,996
New Adult Childless	35,559	\$ 180,640,323	\$ 423.33	35,009	\$ 192,985,152	\$ 459.37	106.83%	37,185
New Adult w/Child	19,550	\$ 88,271,162	\$ 376.26	20,178	\$ 98,886,805	\$ 408.40	112.03%	22,053
BD Child	2,138	\$ 21,308,947	\$ 830.56	1,758	\$ 22,103,589	\$ 1,047.61	103.73%	1,642
General Child	58,256	\$ 156,319,234	\$ 223.61	57,692	\$ 161,637,128	\$ 233.48	103.40%	58,451
Underinsured Child	540	\$ 430,248	\$ 66.40	561	\$ 468,699	\$ 69.61	108.94%	524
CHIP	4,399	\$ 9,083,015	\$ 172.07	4,535	\$ 9,136,532	\$ 167.90	100.59%	4,231
Vermont Premium Assistance	16,988	\$ 5,986,200	\$ 29.36	16,237	\$ 5,732,382	\$ 29.42	95.76%	16,039
Vermont Cost Sharing	3,879	\$ 1,355,401	\$ 29.12	3,518	\$ 1,170,612	\$ 27.73	86.37%	3,252
Pharmacy Only	10,050	\$ 5,038,270	\$ 41.78	9,988	\$ 3,451,390	\$ 28.80	68.50%	10,158
Choices for Care - Traditional	4,135	\$ -	\$ -	4,515	\$ -	\$ -	0.00%	4,500
Choices for Care - Acute	4,135	\$ 29,022,963	\$ 584.90	4,515	\$ 36,665,867	\$ 676.70	126.33%	4,500
Total Medicaid	185,575	\$ 659,345,405	\$ 296.08	182,579	\$ 695,099,689	\$ 317.26	105.42%	187,457



State of Vermont

Department of Vermont Health Access

280 State Drive, NOB 1 South

Waterbury, VT 05671-1010

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Agency of Human Services

Questions, Complaints and Concerns Received by Health Access Member Services July 1, 2020 – September 30, 2020

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

July 2020:

- Member called and gave negative feedback regarding a medical practice documented. Member called in regards to a service that was received from Brandon Medical. The member states that they were going to receive blood work from a provider and didn't come in with a mask due to breathing condition called hyplexia. Member was then made to complete blood work services outside. The member asked if they could possibly just wear paper taped to their nose; nurses refused to service member due to no mask for office appointment. The member also states that there was another patient who walked in with a pet that was seen prior to receiving his services. Member did mention that they were able to speak to the nurses in regards to the dissatisfaction of the services and they apologized. CSR apologized for their experience with the doctor, offered to assist in finding a new doctor and offered to document their feedback.

August 2020:

- Member wanted to submit feedback about Dental Providers. Member feels that it is unethical for dental providers to be on the provider list if they are not willing to accept Medicaid patients. Member has found that the providers are willing to see her if she pays in full price. CSR apologized for their frustration and tried to assist in finding a dentist. DVHA MPS attempted to follow up with member for further info but was unable to make contact with the member.

September 2020:

- Member wanted to submit feedback regarding a doctor's office. Member states that the staff at UVM GI Clinic were very rude to them and did not cater to their needs. Member states that they did not touch them and made them feel alienated due to their disability. They will not be going back to this provider. CSR apologized for their experience and offered to assist in finding a new provider and documented their feedback. DVHA MPS attempted to contact the member for additional information and the member did not return DVHA staff calls.

Attachment 4 - Grievance & Appeals Report



Agency of Human Services

Grievance and Appeal Quarterly Report Medicaid Managed Care Model All Departments Combined Data July 1, 2020 – September 30, 2020

The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL. Each entity should have at least one assigned grievance and appeal coordinator who enters data into the centralized grievance and appeals database. This report is based on data from the centralized database that were filed from July 1, 2020 through September 30, 2020.

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 18 grievances filed; seven were addressed. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of the receipt of a grievance must be sent within five days; the average was three days. Of the grievances filed, 83% were filed by the beneficiary and 17% were filed by an authorized representative. DMH had 78%, DAIL had 17%, and DVHA had 5% of the grievances filed. There were no grievances filed for DCF or VDH during this quarter.

Grievances were filed for service categories case management, program/policy concerns, psychiatric, and mental health services.

There were two 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 16 appeals filed. Of these 16 appeals, 16 were resolved (100%).

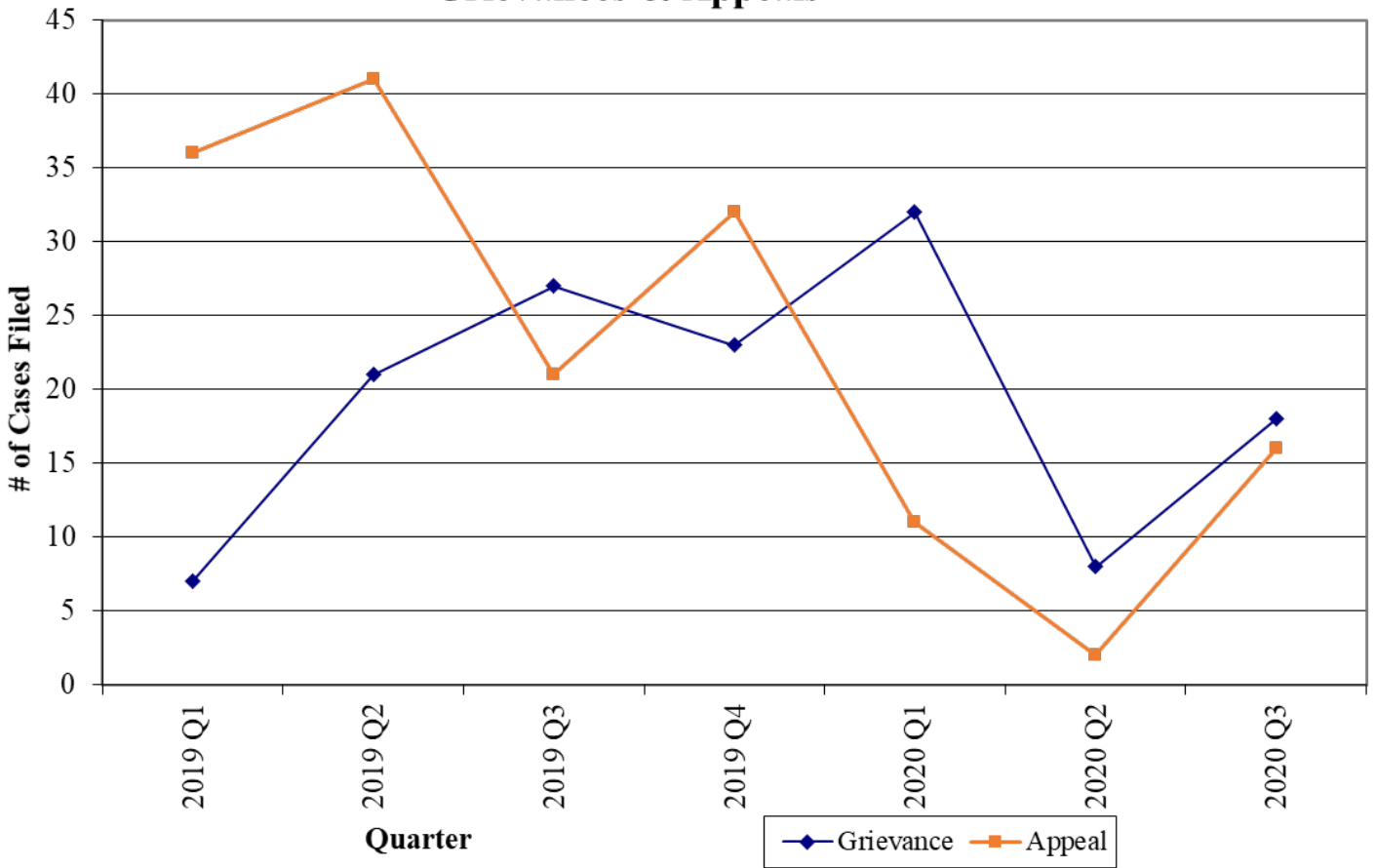
Of the 16 appeals that were resolved this quarter, 100% were resolved within the statutory time frame of 30 days. The average number of days it took to resolve these cases was 15 days. Acknowledgement letters of the receipt of an appeal must be sent within five days; the average was two days.

Of the 16 appeals filed, DVHA had 12 appeals filed (75%), DAIL had 2 (12.5%), and DMH had 2 (12.5%).

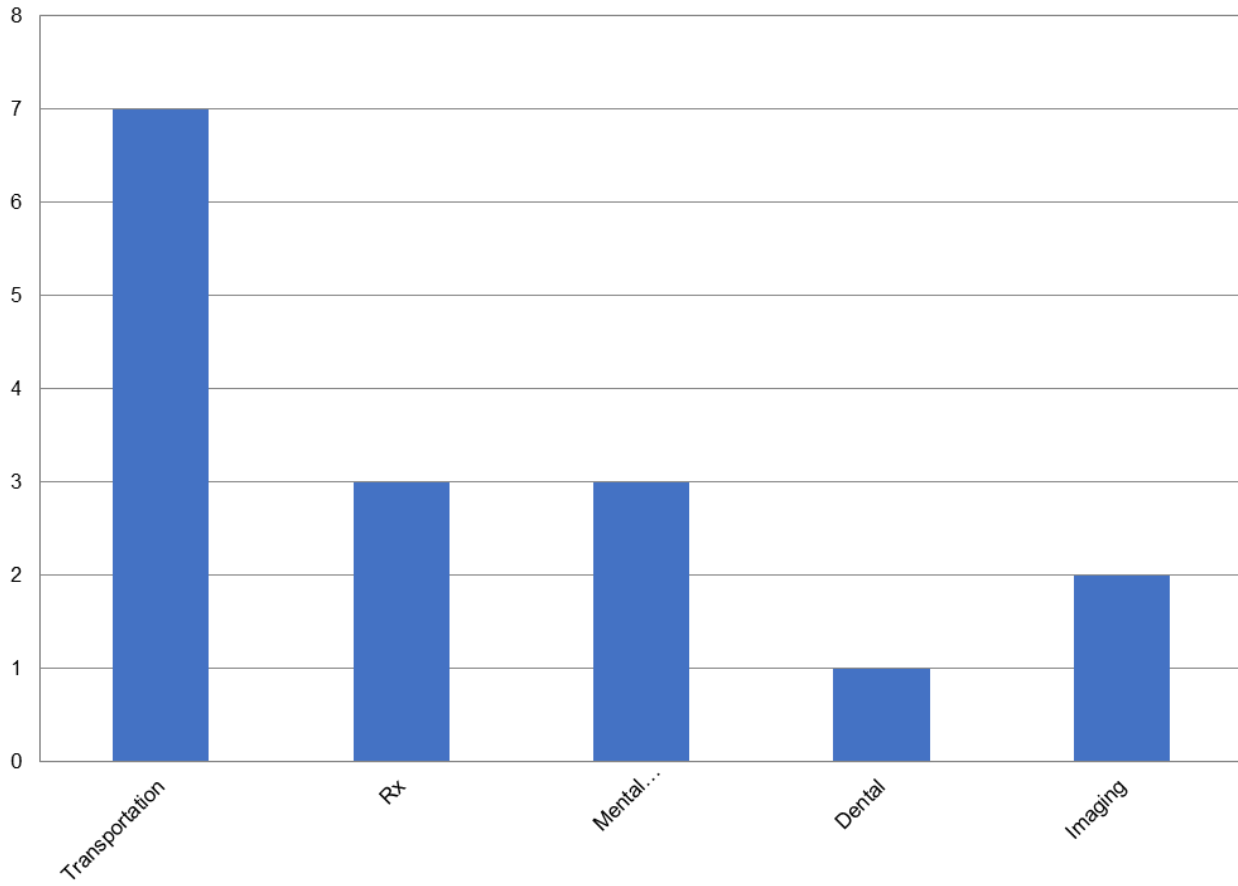
The appeals filed were for service categories, transportation, dental, imaging, prescriptions, and mental health services.

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

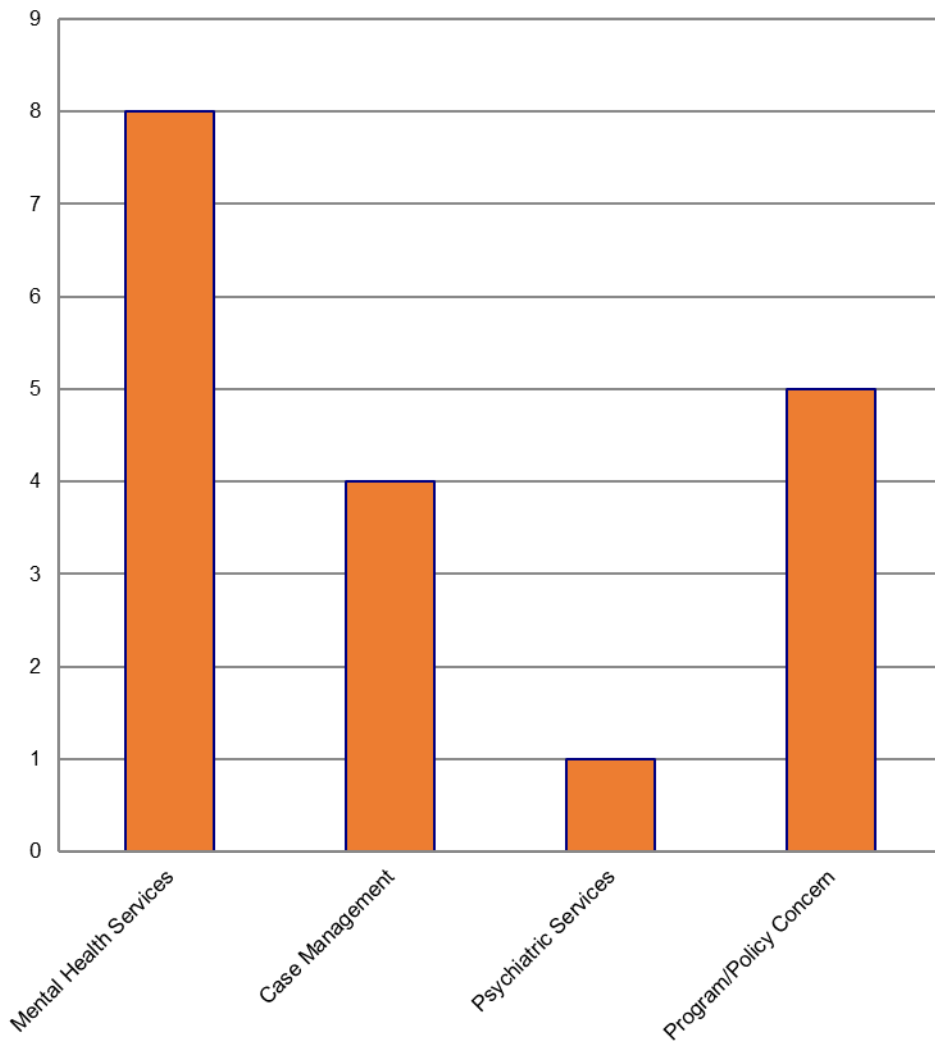
Grievances & Appeals



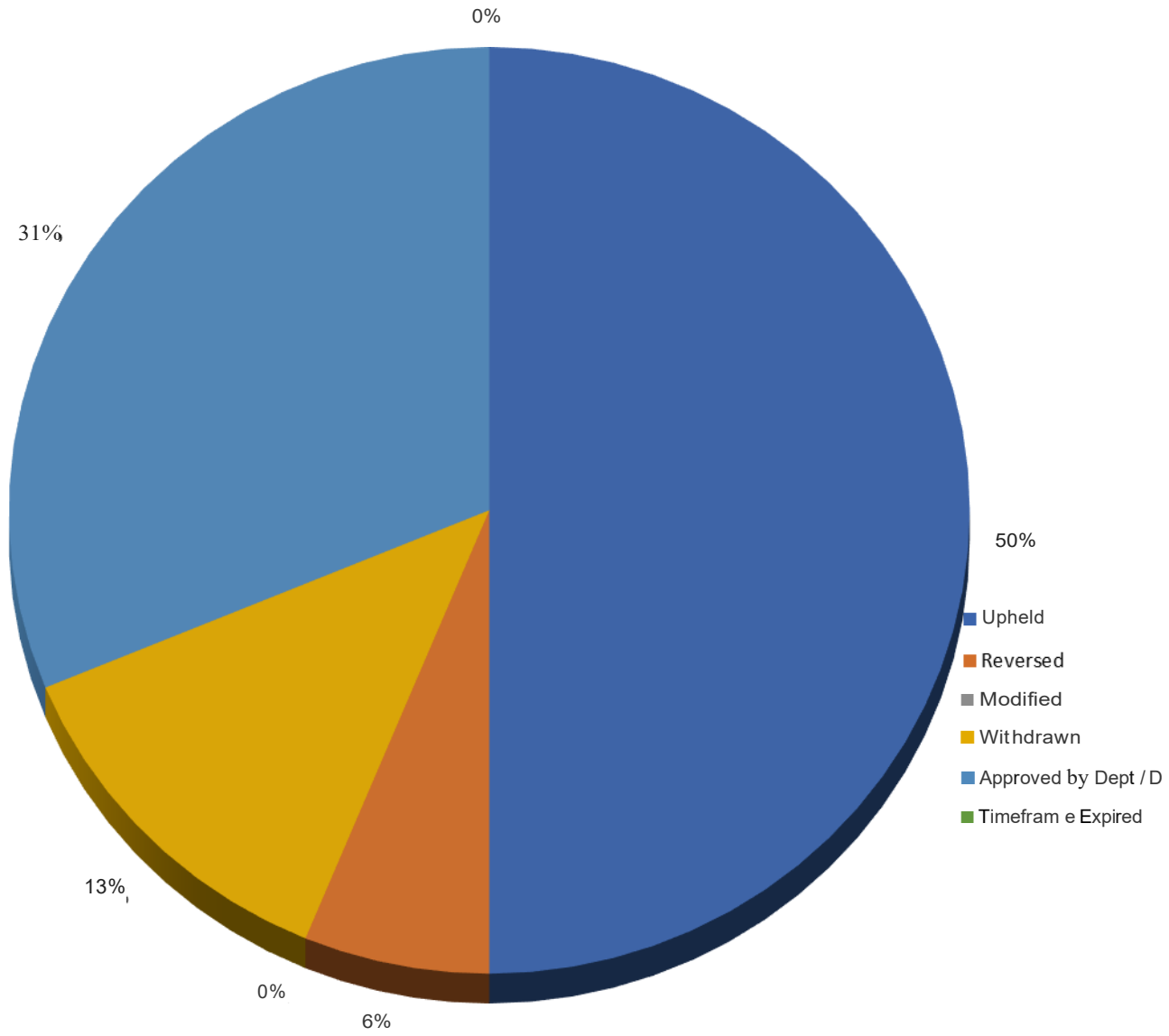
Appeals by Service Category



Grievance by Service Catagory



Appeal Resolutions 7/1/2020 thru 9/30/2020



Vermont Legal Aid
Office of the Health Care Advocate

Quarterly Report
July 1, 2020 - September 30, 2020
to the
Agency of Administration
submitted by
Michael Fisher, Chief Health Care Advocate
Office of the Health Care Advocate

October 16, 2020



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, 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 remotely through the end of 2020, at least. The HCA helpline is fully staffed continues to advocate and resolve issues during this crisis.

The HCA continued to focus on consumer outreach. The HCA tax attorney and an HCA advocate conducted a "virtual town hall" on Advance Premium Tax Credits and tax questions related to health care. We had 10 people watching it live and had 275 people who viewed it later. We hosted five town halls this quarter. The APTC town hall was directly related to health care, and the others related to social determinants of health. We also hosted an unemployment town hall and discussed how unemployment compensation impacted Medicaid and other health care programs.

The HCA also conducted a virtual training on state health care programs for advocates working with seniors. We reviewed the eligibility requirements for state health care programs such as Medicaid for Aged Blind and Disabled, VPharm, and Medicare Savings Programs and answered questions from advocates.

The HCA again focused on making Vermonters aware of their healthcare coverage options. This quarter we talked to nearly 165 households about Medicaid eligibility. We talked to another 67 households about eligibility for other state of Vermont health programs. We also continue to focus on special enrollment periods. We talked to 50 households about eligibility for special enrollments periods. The COVID SEP which allowed uninsured Vermonters to enroll in a Qualified Health Plan, ended during this quarter, but we were able to talk to an additional 10 households about the COVID SEP before it ended.

We continued to do regular, periodic outreach on social media and post ads on Front Porch Forum to reach more consumers. We are planning to increase our outreach and education efforts as open enrollment for VHC approaches.

The HCA helpline had 738 calls this quarter. During the COVID-19 crisis, the State of Vermont has not been conducting Medicaid reviews or closing state health care programs. Medicaid eligibility is typically a top issue for the HCA, so it is not surprising to see a decrease in some of those calls. We expect calls to continue to increase as Open Enrollment for Vermont Health Connect starts and for Medicare Part D plans later in the fall.

Vermont Legal Aid also resolved and recovered from its computer network incident that had occurred in the past quarter. This meant we had full access to our databases this quarter.

The HCA helpline continues collaborating with other parts of Vermont Legal Aid to make sure the community understands the impact on health care programs of both new unemployment programs, hazard pay, and the stimulus checks created in the CARES ACT. We are continually working on updating our website, so consumers can access the latest information on how these programs will impact their Medicaid and other public benefits. The HCA is participating with the Disability Law Project at Vermont Legal Aid on a workgroup to make sure that Vermonters on Medicaid for the Working Disabled who

have temporarily lost their jobs due to COVID-19 will not lose their Medicaid coverage. The HCA policy team continues to advocate for accessible COVID testing.

As Vermont continues to grapple with the COVID-19 crisis, we will continue to advocate for accessible and affordable coverage for all.

Case Stories:

Jason's Story

Jason called the HCA because he was returning to college to complete his degree. He had no insurance, and his school was telling him that he needed to have proof of coverage before the start of the semester. The school plan cost nearly \$2,000 and had a limited network of providers. He needed some advice on whether he should enroll in that plan, which would mean more student loan debt. The HCA advocate investigated and found that Jason was eligible for Medicaid for Children and Adults. The advocate helped him complete the application. Jason was found eligible which meant that he did not need to enroll in the expensive student plan and take on more student loan debt.

Elaine's Story

Elaine called the HCA because her entire family had been quarantining—and they needed to get a COVID-19 test. When she spoke to her provider, she found out that they did not have Medicaid coverage. The HCA advocate investigated and discovered that Elaine had applied and been approved for Medicaid and her children were approved for Dr. Dynasaur. But because of a glitch in the system, her coverage was not showing as active. The HCA advocate asked for the coverage to be expedited. VHC was able to get the coverage activated by the next day—and Elaine and her children were able to get their COVID-19 tests and ultimately get out of the quarantine.

Richard's Story

Richard called the HCA because he needed help paying his Medicare premiums. He could not afford his monthly \$144.60 Part B premium, and he was told by the State of Vermont that he did not qualify for a Medicare Savings Program (MSP) to help pay for the premium. Medicare Savings Programs help pay for Part A and/or Part B premiums for eligible Vermonters. When the HCA advocate investigated, she found that Richard should have been found eligible for the MSP to help with his costs. Richard had been receiving \$600 per week in Pandemic Unemployment Compensation (PUC). The income had been counted when he applied for the MSP and was found ineligible. This income, however, should not have been counted for Medicaid or Medicare Savings Program eligibility. Even more importantly, Richard was no longer receiving the weekly PUC. The HCA advocate helped Richard re-apply, and he was found eligible for the MSP which meant that the State of Vermont will pay his Part B premium for him.

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 738 calls¹ 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:

- **24.63%** about **Access to Care**
- **11.23%** about **Billing/Coverage**
- **1.76%** about **Buying Insurance**
- **16.64%** about **Complaints**
- **9.88%** about **Consumer Education**
- **22.87%** about **Eligibility** for state and federal programs
- **12.87%** were categorized as **Other**, which includes Medicare Part D, communication problems with providers or health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues.

We have a customized case management system that allows us to track more than one issue per case. This enables us to see the total number of calls that involved multiple issues. For example, although 169 of our cases had eligibility for state and federal healthcare programs listed as the primary issue, an additional 332 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 Vermont Health Connect and Medicaid programs fell into all three insurance status categories.

The full quarterly report for July-September2020, includes:

- This narrative

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

- Seven data reports, including three based on the caller's insurance status:
 - **All Calls/All Coverages:** 738
 - **Department of Vermont Health Access (DVHA) beneficiaries:** 230
 - **Commercial Plan Beneficiaries:** 116
 - **Uninsured Vermonters:** 62
 - **Vermont Health Connect (VHC):** 137
 - **Reportable Activities (Summary & Detail):** 16 activities and 1 document

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 738

1. Complaints about Providers 123
2. MAGI Medicaid Eligibility 100
3. Information/applying for DVHA programs 67
4. Medicaid eligibility (non-MAGI) 65
5. Eligibility for Special Enrollment Periods 50
6. Buy-in programs/Medicare Savings Programs 44
7. Not health related 43
8. Medicare Consumer Education 42
9. Premium Tax Credit Eligibility 42
10. Complaints about Hospitals 35
11. Information about HCA 35
12. Termination of Insurance 35
13. Nonfinancial Eligibility Requirements 34
14. Medicare Eligibility 32
15. Hospital Billing & Financial Assistance 30

Vermont Health Connect Calls 137

1. MAGI Medicaid Eligibility 67
2. Premium Tax Credit eligibility 40
3. Eligibility for Special Enrollment Periods 38
4. Information about DVHA 29
5. Termination of Insurance 25
6. IRS Reconciliation Education 23
7. Information about ACA 21
8. Nonfinancial Eligibility Requirements 20
9. Buying QHPs through VHC 13
10. COVID-19 SEP Eligibility 10

DVHA Beneficiary Calls 230

1. Medicaid Eligibility (non-MAGI) 37
2. MAGI Medicaid Eligibility 34
3. Complaints about Providers 31
4. Access to Prescription Drugs/Pharmacy 22
5. Information about DVHA 22
6. Complaints about VHC Notices 20
7. Access to Nursing Homes & Home Health 14
8. Access to Transportation 13
9. Buy-In Programs/MSPs eligibility 13
10. Not Health Related 13

Commercial Plan Beneficiary Calls 116

1. MAGI Medicaid eligibility 23
2. Termination of Insurance 20
3. Special Enrollment Period Eligibility 19
4. Premium Tax Credit Eligibility 18
5. Information about DVHA 14
6. Information about ACA 13
7. IRS Reconciliation Education 13
8. Nonfinancial Eligibility Requirements 11
9. Information about HCA 9

The HCA received 738 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”): 31.2% (230 calls)
- **Medicare² 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): 35.6% (263 calls)
- **Commercial plan beneficiaries** (employer-sponsored insurance, small group plans, or individual plans 15.7% (116 calls)
- **Uninsured:** 8.4% (62 calls)

Dispositions of Closed Cases

All Calls We closed 681 cases this quarter. Overall, 276 were resolved by brief analysis and advice. Another 259 were resolved by brief analysis and referral. There were 73 complex interventions

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

involving complex analysis, and more than two hours of an advocate's time and 33 cases that involved at least one direct intervention on behalf of a consumer. The HCA provided consumer education to more than half of all the cases (392). We also estimated eligibility for insurance coverage and got people onto coverage in 75 cases. We saved consumers \$239,144.88 this quarter.

Consumer Protection Activities

Rate Review

The HCA reviews and analyzes all commercial insurance carrier requests to the Green Mountain Care Board (Board) to change premium prices. Insurers typically request an increase in the premium prices that Vermonters must pay.

The Board decided five premium price increase requests during the quarter from July 1, 2020 through September 30, 2020. Additionally, there is one premium price increase request pending as of the end of this quarter.

Blue Cross Blue Shield of Vermont (BCBSVT) submitted three of the premium price increase requests decided by the Board this quarter, namely, the VT Health Connect 2021 Filing, the Association Health Plan Rate Filing, and the Large Group Rate Filing.

The BCBSVT VT Health Connect 2021 Rate Filing affected approximately 39,200 Vermonters who obtain coverage through their small employers, Vermont Health Connect, or directly through BCBSVT. BCBSVT proposed increasing the premium by, on average, 6.3% for this book of business. The HCA appeared on behalf of Vermonters, filed questions to the carrier, filed various motions, represented the interests of Vermonters at the public hearing for this filing, and submitted a post-hearing memorandum in this matter. As we discuss below, the HCA also engaged in multiple strategies to facilitate public comment on this filing including, but not limited to, the development and implementation of web-based public comment tools. The Board reduced BCBSVT's average premium increase to an average 4.2%.

The BCBSVT Association Health Plan Rate Filing affected 0 Vermonters as this book of business had no members. The HCA appeared on behalf of Vermonters, filed questions to the carrier, and objected to a broad request to treat elements of the rate filing as confidential in this matter.

The final BCBSVT premium price increase request decided this quarter, the BCBSVT Large Group Rate Filing, was decided in combination with the TVHP Large Group Rate Filing. The two filings affected approximately 7,900 Vermonters. BCBSVT requested changes to the manual rate that would increase premium prices for this book of business by 5.9%. The HCA appeared on behalf of Vermonters, filed questions to the carrier, filed various motions, and submitted a memorandum in lieu of hearing in the combined matter. The Board reduced the average premium price increase to 4.7%.

MVP Health Plan, Inc. (MVP) submitted one premium price increase request decided by the Board this quarter, the MVP VT Health Connect 2021 Filing. This premium price increase affected approximately 36,980 Vermonters who obtain coverage through their small employers, Vermont Health Connect, or directly through MVP. MVP proposed increasing premiums by, on average, 7.3% for this book of business. The HCA appeared on behalf of Vermonters, filed questions to the carrier, filed various motions, represented the interests of Vermonters at the public hearing for this filing, and submitted a

post-hearing memorandum in this matter. As discussed below, the HCA engaged in multiple strategies to facilitate public comment on this filing including, but not limited to, the development and implementation of web-based public comment tools. The Board reduced MVP's average premium to approximately 2.7%.

The final premium price increase request the Board decided this quarter was the TVHP Large Group Filing. As discussed above, this premium price increase request was decided together with the BCBSVT Large Group Filing. The HCA's activities in connection with this combined premium price increase request are detailed above.

The HCA engaged in substantial efforts during the reporting quarter to facilitate increased public comment on both the BCBSVT and MVP VT Health Connect 2021 Filings. Activities included direct outreach, development and deployment of web-based public comment tools, media public awareness campaigns, and outreach to consumer interest organizations. The number of submitted public comments on the two "Exchange" filings increased substantially this year. In 2016, Vermonters submitted 120 written comments on the "Exchange" filings. Vermonters submitted 114 written comments in 2017, 168 written comments in 2018, and 620 comments in 2019. This year, Vermonters submitted 969 written comments.

There is one premium price increase request pending at the end of this quarter, the MVP 2021 Large Group HMO. The HCA appeared on behalf of Vermonters in this matter. We intend to file all appropriate memoranda and other documents to represent the interests of Vermonters in this matter.

Hospital Budget Review

The HCA participates in the Board's annual hospital budget review process, which took place this quarter. First, the HCA reviewed the fourteen hospital budgets submitted to the Board. These submissions included answers to our first set of written questions which were included in the Board's budget guidance. Our questions focused on hospitals' commercial prices compared to Medicare reimbursement, COVID-19-related changes to hospitals' Financial Assistance Policies and practices, and provider recruitment using the J-1 visa program. After reviewing the materials, we submitted follow-up questions as needed. The HCA participated in each hospital's budget hearing, including asking questions of the hospitals and making oral comments.

Following the hearings, we submitted written comments thanking the provider community for its efforts during the COVID-19 pandemic and outlining our concerns about the budgets. We highlighted the economic crisis faced by Vermonters and the racial disparities in health care that have been exacerbated by COVID-19. We argued that large commercial rate increases in the context of COVID-19 are unjustifiable, and specifically requested that the Board disapprove the large increases requested by UVM Medical Center, Northwestern Medical Center, and Copley Hospital. We once again asked the Board to implement its rate setting authority, and to further standardize the data it collects from each hospital.

HCA staff attended the public meetings at which the Board deliberated and then voted on each hospital's budget, as well as the meeting at which the Board reconsidered its previous hospital budget decisions.

Oversight of Accountable Care Organizations

The HCA participates in the Board's annual ACO budget review process. This quarter, the Board released the ACO FY2021 Budget Guidance, which included questions proposed by the HCA. Throughout the quarter, the HCA had regular meetings and communication with the Board's ACO budget staff to prepare for the FY2021 budget review process. We also reviewed the ACO's re-certification materials as well as deliverables related to the ACO's FY2020 budget.

Other Green Mountain Care Board and other agency workgroups

Over the last quarter, the HCA attended the Board's weekly board meetings and monthly Data Governance meetings. In addition, we reviewed and submitted a first round of comments on the Board's regulatory alignment white papers.

The HCA has continued to participate in a stakeholder work group run by the Department of Financial Regulation (DFR). The DFR work group dealt with ongoing regulatory issues related to the Covid-19 pandemic.

The HCA participated in the Statewide Telehealth Clinical Quality & Audio-Only Telemedicine workgroup organized by VPQHC this quarter. These weekly meetings included presentations by national and local experts who gave testimony on the many dynamics when care is delivered over audio-only and telemedicine platforms and the impacts on quality and cost.

The Chief Health Care Advocate stepped down as co-chair of the Medicaid and Exchange Advisory Board this quarter but continued to participate in the monthly meetings. The MEAB focused on a number of important access to care issues during the COVID crisis including Medicaid and QHP enrollment numbers, updates from providers and the HCA during the crisis, APM scale agreement and updates on the provider stabilization financial relief grants.

Legislative Advocacy

Advocacy in the Vermont Legislature this session ended this quarter. This was a very complicated and challenging year to represent Vermonters in the Statehouse. The HCA was actively involved in numerous issues and provided testimony in front of many Legislative Committees. We continued in our role of both proposing and advocating for "simple" fixes where we see opportunities that will improve access to care for Vermonters, as well as voicing concern about the more significant obstacles to care in our very complicated health care system. This quarter we were particularly focused on budgetary issues, including the Coronavirus Relief funding, as well as H. 795, an act relating to increasing hospital price transparency, and H.734, an act relating to prohibiting certain provisions in dental insurance contracts with dentists.

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
- Blue Cross Blue Shield of Vermont
- Community Catalyst
- Vermont Department of Financial Regulation
- Families USA
- Georgetown University Health Policy Institute
- IRS Taxpayer Advocate Service
- MVP Health Care
- National Center for Transgender Equality
- NHeLP, National Health Law Program
- OneCare Vermont
- Outright Vermont
- Pride Center of Vermont
- Planned Parenthood of Northern New England
- Rights and Democracy Vermont
- Rural Vermont
- SHIP, State Health Insurance Assistance Program
- United States of Care
- University of Vermont Medical Center
- Vermont Association of Hospitals and Health Systems
- Vermont Businesses for Social Responsibility
- Vermont Care Partners
- Vermont CARES
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Developmental Disabilities Council
- Vermont Health Connect
- Vermont Medical Society
- Vermont Program for Quality in Health Care
- Vermont Workers' Center
- VPRIG
- 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 — which was during the COVID-19 emergency:

1. *Income Limits – Medicaid* – 1,610 pageviews
2. *Health* – section home page – 1,380
3. *Medicaid* – 573
4. *News: Health Insurance Premium Increases Public Comment* – 530
5. *Dental Services* – 528
6. *News: Coronavirus and Long-Term Care* – 457
7. *Medicare Savings Programs* – 369
8. *Resource Limits – Medicaid* – 345
9. *Long-term Care* – 337
10. *Advance Directive forms* – 328
11. *Medical Decisions: Advance Directives* – 298
12. *HCA Help Request Form* – 297 pageviews and 77 online help requests (form was down for a time due to an IT problem)
13. *Medicaid, Dr. Dynasaur & Vermont Health Connect* – 283
14. *News: Coronavirus SEP for Vermont Health Connect* – 275
15. *Choices for Care* – 243
16. *Medicaid and Medicare Dual Eligible* – 199
17. *Transportation for Health Care* – 166*
18. *Prescription Help – State Pharmacy Programs* – 164
19. *Vermont Health Connect* – 163*
20. *Federally Qualified Health Centers* – 161*

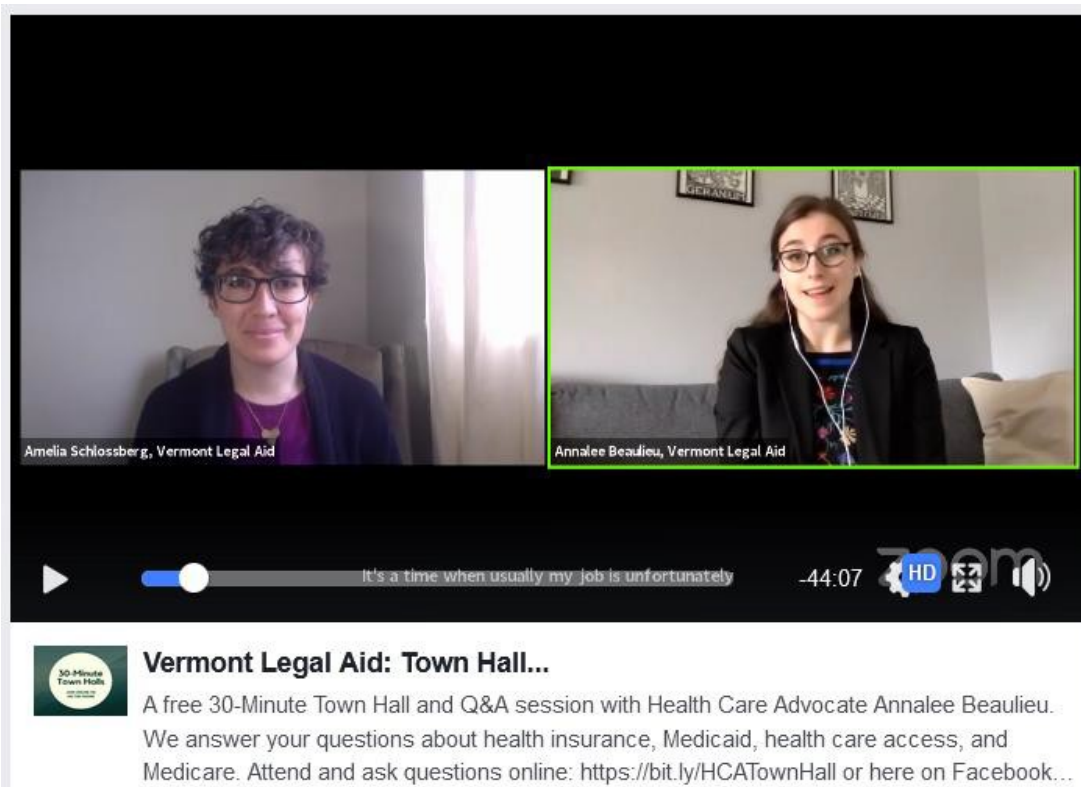
The top-10 health pages **during last week of the quarter**:

1. *Income Limits – Medicaid* – 158
2. *Health* – section home page – 97
3. *Resource Limits – Medicaid* – 67
4. *Dental Services* – 67
5. *Medicaid* – 61
6. *Medicaid, Dr. Dynasaur & Vermont Health Connect* – 53
7. *Medicare Savings Programs* – 45
8. *Medicaid and Medicare Dual Eligible* – 29
9. *Long-term Care* – 27
10. *Health Care Complaints* – 20

Outreach and Education

Virtual Town Halls and Q&A Sessions from June 1-September 30, 2020. The Office of the Health Care Advocate hosted seven town halls on a variety of timely health care topics and social determinants of health topics.

- 7/9: Taxes and Health Insurance
- 7/23: Rental Assistance
- 8/13: Unemployment Compensation Changes
- 8/26: Fair Housing Protections
- 9/24: Money to Move, Rental Assistance and Mortgage Assistance Review.



Promoting Plain Language in Health Communications

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

- October Stuffer for Open Enrollment
- September Stuff for Open Enrollment
- Medicaid Income Verification
- Medicaid Renewal Delay
- Medicaid Resources Notice

Office of the Health Care Advocate

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

<https://vtlawhelp.org/health>

Attachment 6 - GC Investments

CY 2020 Investment Expenditures

Department	Receiver Suffix	Investment Description	QE 0320	QE 0620	QE 0920	QE 1220	CY 2020 Total
AHSCO	9091	Investments (STC-79) - 2-1-1 Grant (41)	113,118	113,663	75,500		302,281
AHSCO	9090	Investments (STC-79) - Designated Agency Underinsured Serv	1,654,744	1,639,345	1,673,017		4,967,106
AOE	n/a	Non-state plan Related Education Fund Investments					-
DCF	9402	Investments (STC-79) - Medical Services (55)	19,357	13,078	8,689		41,125
DCF	9403	Investments (STC-79) - Residential Care for Youth/Substitute C	1,912,130	265,814	1,200,635		3,378,579
DCF	9405	Investments (STC-79) - Aid to the Aged, Blind and Disabled CC	1,044,408	474,808	1,583,997		3,103,213
DCF	9406	Investments (STC-79) - Aid to the Aged, Blind and Disabled Re	29,590		6,604		36,194
DCF	9407	Investments (STC-79) - Aid to the Aged, Blind and Disabled Re	64,468		15,322		79,790
DCF	9408	Investments (STC-79) - Essential Person Program (59)	219,628	209,048	196,661		625,337
DCF	9409	Investments (STC-79) - GA Medical Expenses (60)	51,744	47,631	38,508		137,883
DCF	9411	Investments (STC-79) - Therapeutic Child Care (61)	376,070	271,275	237,396		884,741
DCF	9412	Investments (STC-79) - Lund Home (2)	736,919	675,522	778,541		2,190,982
DCF	9413	Investments (STC-79) - Prevent Child Abuse Vermont: Shaken Baby (33)					-
DCF	9414	Investments (STC-79) - Prevent Child Abuse Vermont: Nurturin	60,572	(60,572)	8,683		8,683
DCF	9415	Investments (STC-79) - Challenges for Change: DCF (9)	53,402		8,757		62,159
DCF	9416	Investments (STC-79) - Strengthening Families (26)	273,766	219,326	225,256		718,348
DCF	9417	Investments (STC-79) - Lamoille Valley Community Justice Pro	39,744	57,461	71,948		169,153
DCF	9418	Investments (STC-79) - Building Bright Futures (35)	67,756	140,506	67,209		275,470
DDAIL	9602	Investments (STC-79) - Mobility Training/Other Svcs.-Elderly V	91,642	92,368	93,734		277,745
DDAIL	9603	Investments (STC-79) - DS Special Payments for Medical Serv	1,857,013	310,534	808,478		2,976,024
DDAIL	9604	Investments (STC-79) - Flexible Family/Respite Funding (27)	983,521		75,281		1,058,801
DDAIL	9605	Investments (STC-79) - Quality Review of Home Health Agenc es (42)					-
DDAIL	9606	Investments (STC-79) - Support and Services at Home (SASH)	204,345	281,716	245,070		731,131
DDAIL	9607	Investments (STC-79) - HomeSharing (77)	77,635	77,592	81,580		236,807
DDAIL	9608	Investments (STC-79) - Self-Neglect Initiative (78)	75,990	75,447	64,026		215,462
DDAIL	9609	Investments (STC-79) - Seriously Functionally Impaired: DAIL (12,503	11,735			24,238
DMH	9501	Investments (STC-79) - Special Payments for Treatment Plan S	35,672	21,303	16,620		73,595
DMH	9502	Investments (STC-79) - MH Outpatient Services for Adults (66)	1,610,793	32,902	398,193		2,041,888
DMH	9504	Investments (STC-79) - Mental Health Consumer Support Prog	166,746	61,620	91,959		320,325
DMH	9505	Investments (STC-79) - Mental Health CRT Community Support	1,113,801	771,062	1,086,396		2,971,258
DMH	9506	Investments (STC-79) - Mental Health Children's Community S	1,375,069	301,214	403,388		2,079,671
DMH	9507	Investments (STC-79) - Emergency Mental Health for Children	6,186,457		1,217,902		7,404,359
DMH	9508	Investments (STC-79) - Respite Services for Youth with SED a	813,840		168,260		982,100
DMH	9510	Investments (STC-79) - Emergency Support Fund (22)	376,000		68,296		444,297
DMH	9511	Investments (STC-79) - Institution for Mental Disease Services:	5,575,018	3,147,877	3,392,466		12,115,361
DMH	9512	Investments (STC-79) - Institution for Mental Disease Services:	2,453,215	2,409,092	1,260,479		6,122,787
DMH	9514	Investments (STC-79) - Seriously Functionally Impaired: DMH (18,855	8,803	80,661		108,319
DMH	9516	Investments (STC-79) - Acute Psychiatric Inpatient Services (1	788,263	766,198	93,629		1,648,089
DOC	n/a	Return House	138,725	90,306	85,638		314,669
DOC	n/a	Northern Lights	98,438	98,438	98,438		295,314
DOC	n/a	Pathways to Housing - Transitional Housing	254,634	259,415	221,855		735,904
DOC	n/a	St. Albans and United Counseling Service Transitional Housing	67,477	67,641	44,619		179,736
DOC	n/a	Northeast Kingdom Community Action					-
DOC	n/a	Intensive Substance Abuse Program (ISAP)					-
DOC	n/a	Intensive Domestic Violence Program					-
DOC	n/a	Community Rehabilitative Care		1,268,475			1,268,475
DOC	n/a	Intensive Sexual Abuse Program					-
DOC	n/a	Vermont Achievement Center		172,674	102,059		274,733
DVHA	9101	Investments (STC-79) - Vermont Information Technology Leaders/HIT/HIE/HCR (8)					-
DVHA	9102	Investments (STC-79) - Vermont Blueprint for Health (51)	791,428	757,323	713,879		2,262,630
DVHA	9103	Investments (STC-79) - Buy-In (52)	11,704	11,984	10,845		34,532
DVHA	9104	Investments (STC-79) - HIV Drug Coverage (53)	682	1,154	1,074		2,910
DVHA	9106	Investments (STC-79) - Patient Safety Net Services (18)	(2,817)		60		(2,757)
DVHA	9107	Investments (STC-79) - Institution for Mental Disease Services:	837,327	34,627	18,923		890,877
DVHA	9108	Investments (STC-79) - Family Supports (72)					-
DVHA	9109	DSR Investment (STC-83) - One Care VT ACO Quality & Health	-				-
DVHA	9110	DSR Investment (STC-83) - One Care VT ACO Advanced Com	-		1,399,689		1,399,689
DVHA	9111	DSR Investment (STC-83) - One Care VT ACO Primary Preven	-				-
GMCB	n/a	Green Mountain Care Board					-
UVM	n/a	Vermont Physician Training	505,932	674,582	505,934		1,686,448
VAAF	n/a	Agriculture Public Health Initiatives					-
VDH	9201	Investments (STC-79) - Emergency Medical Services (19)	156,190	90,293	79,105		325,587
VDH	9203	Investments (STC-79) - TB Medical Services (74)	670	12,234	22		12,926
VDH	9204	Investments (STC-79) - Epidemiology (40)	283,856	160,267	54,144		498,267
VDH	9205	Investments (STC-79) - Health Research and Statistics (39)	341,770	226,815	216,102		784,687
VDH	9206	Investments (STC-79) - Health Laboratory (31)	812,356	221,215	345,646		1,379,218
VDH	9207	Investments (STC-79) - Tobacco Cessation: Community Coaliti	329,282	499,626	335,187		1,164,095
VDH	9208	Investments (STC-79) - Statewide Tobacco Cessation (76)					-
VDH	9209	Investments (STC-79) - Family Planning (75)	394,479	284,428	237,205		916,112
VDH	9210	Investments (STC-79) - Physician/Dentist Loan Repayment Program (25)		354,600	86,300		440,900
VDH	9211	Investments (STC-79) - Renal Disease (73)					-
VDH	9213	Investments (STC-79) - WIC Coverage (37)	949,286	325,995			1,275,281
VDH	9214	Investments (STC-79) - Area Health Education Centers (AHEC	108,295		443,419		551,715
VDH	9217	Investments (STC-79) - Patient Safety - Adverse Events (47)	12,770	8,563	120		21,453
VDH	9219	Investments (STC-79) - Substance Use Disorder Treatment (30	1,230,889	1,380,046	418,216		3,029,151
VDH	9220	Investments (STC-79) - Recovery Centers (17)	427,012	487,183	66,974		981,169
VDH	9221	Investments (STC-79) - Enhanced Immunization (46)	99,642	16,046	17,825		133,514
VDH	9222	Investments (STC-79) - Poison Control (48)		61,918	32,501		94,419
VDH	9223	Investments (STC-79) - Public Inebriate Services, C for C (23)	475,043	263,300	301,322		1,039,665
VDH	9224	Investments (STC-79) - Fluoride Treatment (38)	8,505	11,641	6,661		26,807
VDH	9225	Investments (STC-79) - Medicaid Vaccines (24)					-
VDH	9226	Investments (STC-79) - Healthy Homes and Lead Poisoning Pr	47,836	88,019	23,686		159,541
VDH	9228	Investments (STC-79) - VT Blueprint for Health (44)	269,056	95,931	198,824		563,812
VSC	n/a	Health Professional Training	204,730		102,365		307,095
VVH	n/a	Vermont Veterans Home					-
			39,388,991	20,461,104	22,011,778	-	81,861,873

Attachment 7 - Investment Scorecard

DAIL Global Commitment Investments

This scorecard shows the program and performance scorecard information for Global Commitment investments in DAIL, for reporting to AHS and CMS.

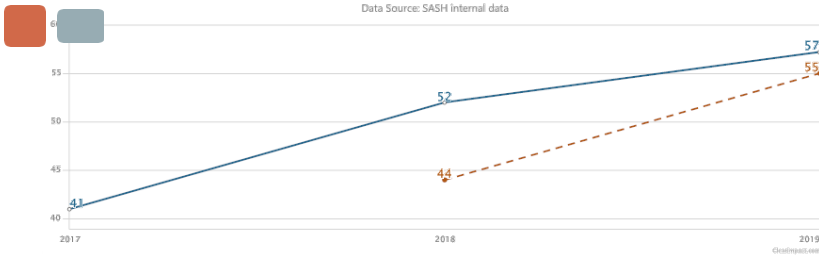
<https://app.resultsscorecard.com/Scorecard/Embed/46690>

O **GCI** Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured, and Medicaid-eligible individuals in Vermont

Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
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P **DAIL SASH**

Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
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2018	52	44	▲ 1	27%
2017	41	□	□ 0	0%

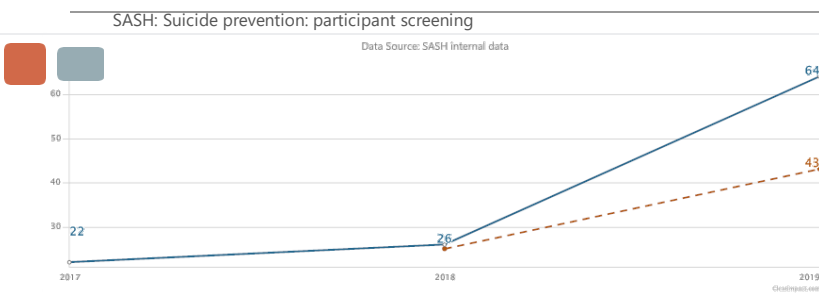
Story Behind the Curve

Partners

What Works

Action Plan

- Subrecipient will improve identification of SASH participants with social isolation and or loneliness and plan for interventions that will reduce the incidence of participants who score as “lonely” on UCLA Loneliness Scale. Assessment rates will increase by 3% (from May 15th 2018 report %) for all participants as of May 15, 2019.



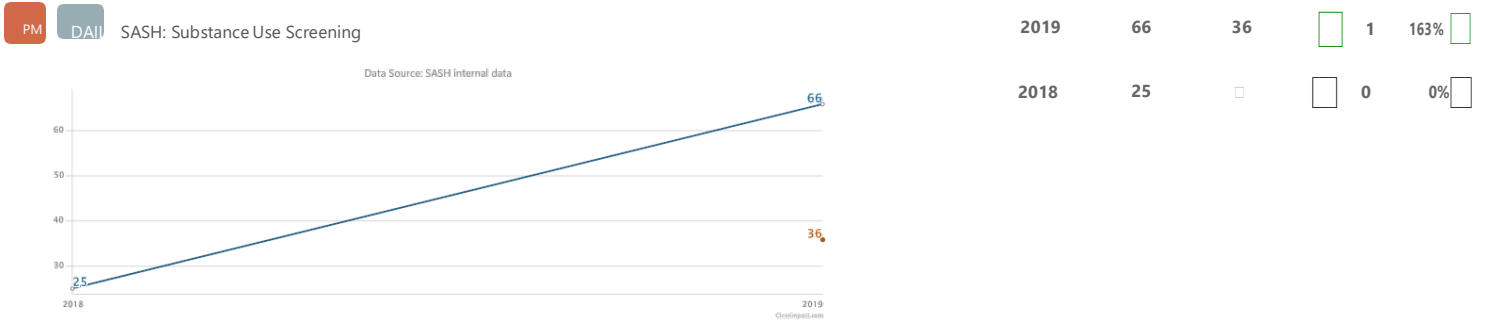
2019	64	43	▲ 2	191%
2018	26	25	▲ 1	18%
2017	22	□	□ 0	0%

Story Behind the Curve

Partners

Action Plan

- a. Subrecipient will improve the identification of participants at risk of suicide and train 25% of staff in Gatekeeper and/or UMMatter training:
 - i. Subrecipient will raise the rate of administering the one-question suicide screen by at least 3% (from May 15, 2018 %) by May 15, 2019.



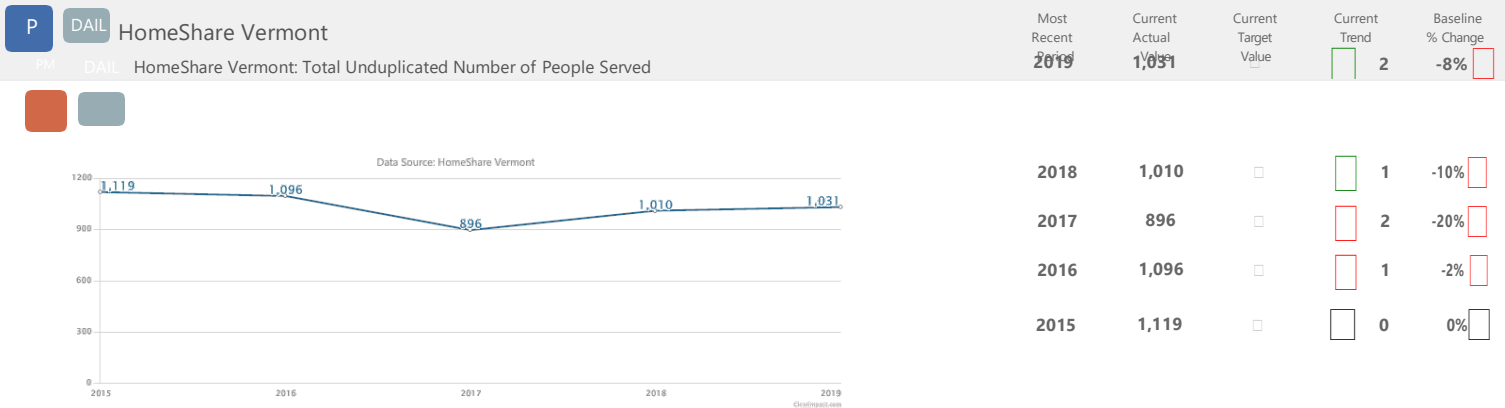
Story Behind the Curve

Partners

What Works

Action Plan

- a. Subrecipient will improve the identification of participants at risk of adverse substance use and systematically provide basic education materials to participants:
 - i. Subrecipient will raise the rate of administering the validated pre-S-MAST-G screening question by at least 3% (from May 15, 2018 %) by May 15, 2019.



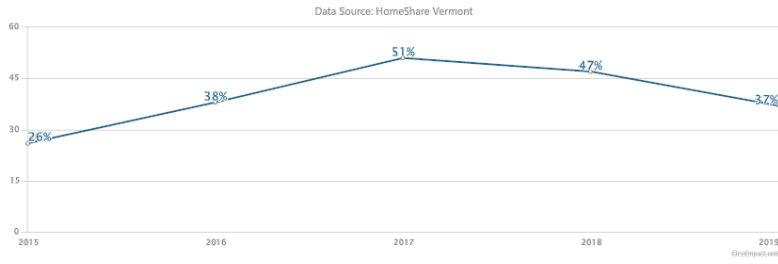
Story Behind the Curve

Partners

What Works

Action Plan

2019	37%	<input type="checkbox"/>	<input type="checkbox"/>	2	42%
2018	47%	<input type="checkbox"/>	<input type="checkbox"/>	1	81%
2017	51%	<input type="checkbox"/>	<input type="checkbox"/>	2	96%
2016	38%	<input type="checkbox"/>	<input type="checkbox"/>	1	46%
2015	26%	<input type="checkbox"/>	<input type="checkbox"/>	0	0%



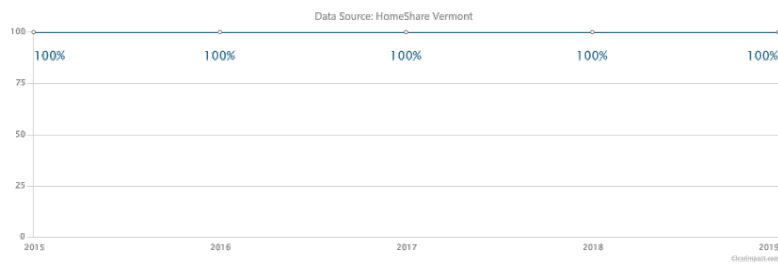
Story Behind the Curve

Partners

What Works

Action Plan

2019	100%	<input type="checkbox"/>	<input type="checkbox"/>	4	0%
2018	100%	<input type="checkbox"/>	<input type="checkbox"/>	3	0%
2017	100%	<input type="checkbox"/>	<input type="checkbox"/>	2	0%
2016	100%	<input type="checkbox"/>	<input type="checkbox"/>	1	0%
2015	100%	<input type="checkbox"/>	<input type="checkbox"/>	0	0%



Story Behind the Curve

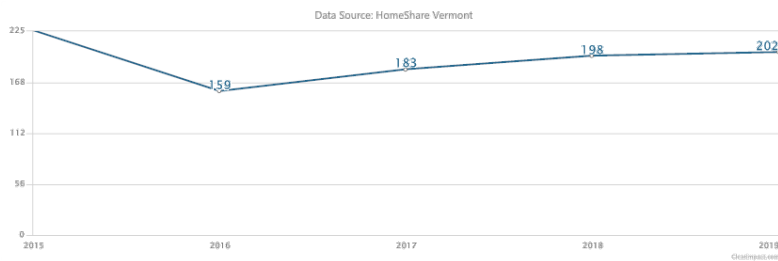
Partners

What Works

Action Plan



2018	198	<input type="checkbox"/>	<input type="checkbox"/>	2	-12%
2017	183	<input type="checkbox"/>	<input type="checkbox"/>	1	-19%
2016	159	<input type="checkbox"/>	<input type="checkbox"/>	1	-30%
2015	226	<input type="checkbox"/>	<input type="checkbox"/>	0	0%

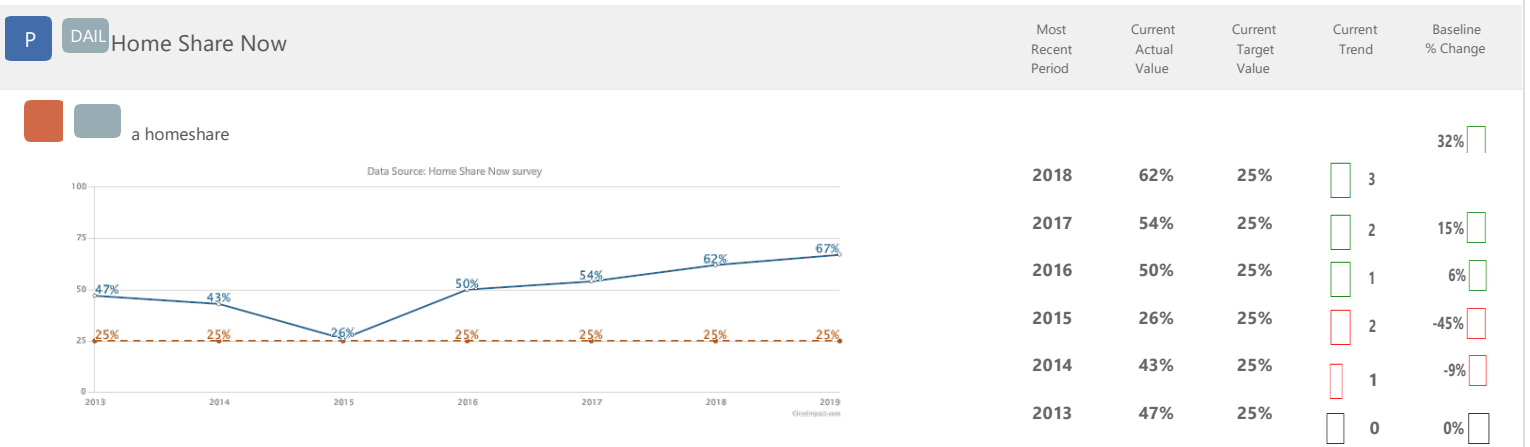


Story Behind the Curve

Partners

What Works

Action Plan

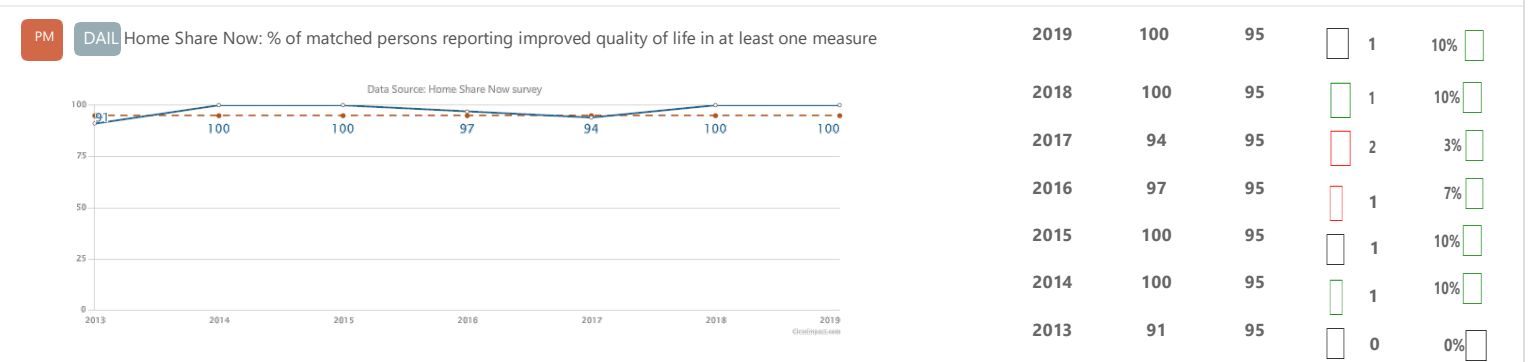


Story Behind the Curve

Partners

What Works

Action Plan



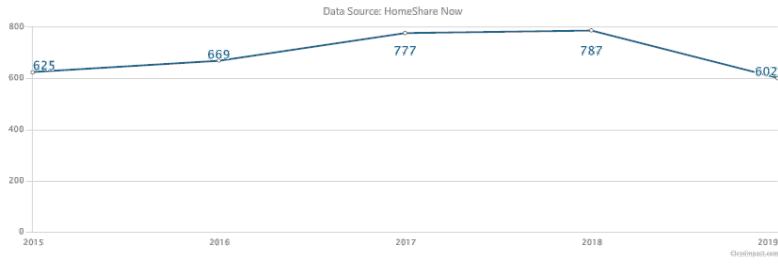
Story Behind the Curve

Partners

What Works

Action Plan

PM DAIL HomeShare Now: Total unduplicated number of people served



Year	Value	Target	Delta	% Change
2019	602	625	-23	-4%
2018	787	787	0	0%
2017	777	777	0	0%
2016	669	669	0	0%
2015	625	625	0	0%

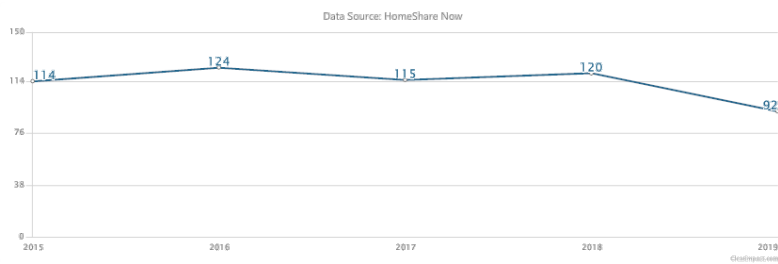
Story Behind the Curve

Partners

What Works

Action Plan

PM DAIL HomeShare Now: Total Unduplicated Number of People in a Match



Year	Value	Target	Delta	% Change
2019	92	114	-22	-19%
2018	120	120	0	0%
2017	115	115	0	0%
2016	124	124	0	0%
2015	114	114	0	0%

Story Behind the Curve

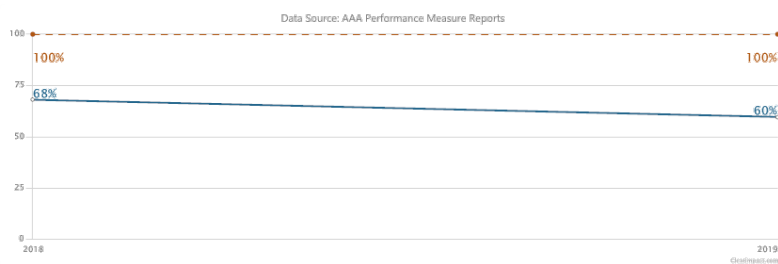
Partners

What Works

Action Plan

P ASD Area Agencies on Aging (AAA) - Self-Neglect Response

Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
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2018	68%	100%	-32	-32%
2019	60%	100%	-40	-40%

Story Behind the Curve

"The term 'self-neglect' means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including (A) obtaining essential food, clothing, shelter, and medical care; (B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or (C) managing one's own financial affairs. This definition excludes peoples who make a conscious and voluntary choice not or provide for certain basic needs as a matter of life style personal preference or religious belief and who understand the consequences of their decision." Vermont Department of Disabilities, Aging and Independent Living, Self-Neglect Task Force (2012)

The work on self-neglect is informed by a study in 2012 that was undertaken to estimate the number of individuals less than 60 and 60 or older in Vermont who could be described as self-neglecting; and to provide information to develop a community response to self-neglect. Estimating the number of self-neglecting individuals was challenging due to varying definitions, reporting processes and where to make reports and referrals. However, there were valuable recommendations on developing a community response to self-neglect.

In 2014 funding was provided to Vermont's 5 Area Agencies on Aging (AAA) to enhance the response to self-neglect. Since then the AAAs have been building a community response to self-neglect through raising awareness, education, training and collaboration with old and new community partners. To identify the services and supports self-neglecting individuals need they have also been using a common assessment tool.

The nature of working with self-neglecting individuals is that it often takes multiple attempts and then visits to establish rapport and the trusting relationship needed to begin a risk assessment. Completion of a risk assessment is over a period of time.

Partners

Public Safety

Housing Authorities

Hoarding Task Force

SASH

Local Interagency Team

Hospital Emergency Departments

Home Health Agencies

Community Health Teams

Community Adult Resource Teams

Community Action Agencies

AHS Field Directors

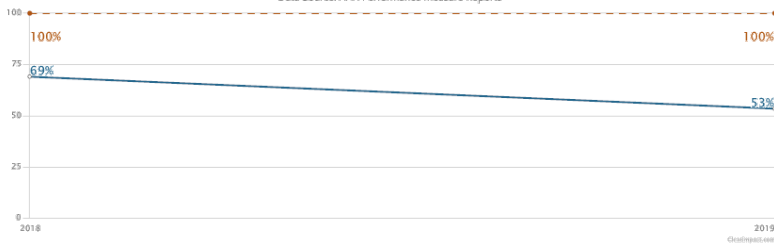
Choices for Care Team Meetings

Mental Health Providers

What Works

Action Plan





Story Behind the Curve

“The term ‘self-neglect’ means an adult’s inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including (A) obtaining essential food, clothing, shelter, and medical care; (B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or (C) managing one’s own financial affairs. This definition excludes peoples who make a conscious and voluntary choice not or provide for certain basic needs as a matter of life style personal preference or religious belief and who understand the consequences of their decision.” Vermont Department of Disabilities, Aging and Independent Living, Self-Neglect Task Force (2012)

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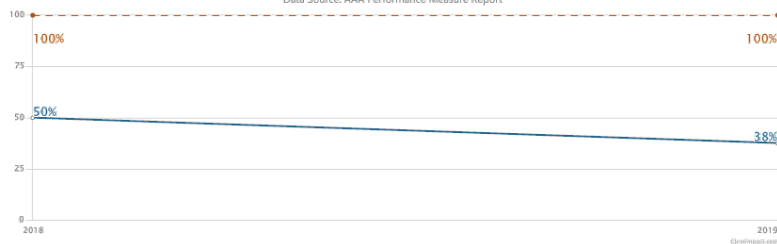
The nature of working with self-neglecting individuals is that it often takes multiple attempts and then visits to establish rapport, a trusting relationship and to complete a risk assessment. Working with the self-neglecting individual to establish goals follows the completion of the risk assessment. Goal areas include food, shelter, medical, mental health, financial health or another area of importance to the self-neglecting individual.

Partners

- Public Safety
- Housing Authorities
- Hoarding Task Force
- SASH
- Local Interagency Team
- Hospital Emergency Departments
- Home Health Agencies
- Community Health Teams
- Community Adult Resource Teams
- Community Action Agencies
- AHS Field Directors
- Choices for Care Team Meetings
- Mental Health Providers

What Works

Action Plan



Story Behind the Curve

“The term ‘self-neglect’ means an adult’s inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including (A) obtaining essential food, clothing, shelter, and medical care; (B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or (C) managing one’s own financial affairs. This definition excludes peoples who make a conscious and voluntary choice not to provide for certain basic needs as a matter of life style personal preference or religious belief and who understand the consequences of their decision.” Vermont Department of Disabilities, Aging and Independent Living, Self-Neglect Task Force (2012)

The work on self-neglect is informed by a study in 2012 that was undertaken to estimate the number of individuals less than 60 and 60 or older in Vermont who could be described as self-neglecting; and to provide information to develop a community response to self-neglect. Estimating the number of self-neglecting individuals was challenging due to varying definitions, reporting processes and where to make reports and referrals. However, there were valuable recommendations on developing a community response to self-neglect.

In 2014 funding was provided to Vermont’s 5 Area Agencies on Aging (AAA) to enhance the response to self-neglect. Since then the AAAs have been building a community response to self-neglect through raising awareness, education, training and collaboration with old and new community partners. Developing a community response to self-neglect includes engaging partners in helping to meet the goals of the self-neglecting consumer.

This measure is meaningful in that it assists in identifying gaps within the service community and provides the type of feedback the AAAs need to build a coordinated community response to self-neglect that engages the public, relevant service organizations and community partners.

Partners

Public Safety

Housing Authorities

Hoarding Task Force

SASH

Local Interagency Team

Hospital Emergency Departments

Home Health Agencies

Community Health Teams

Community Adult Resource Teams

Community Action Agencies

AHS Field Directors

Choices for Care Team Meetings

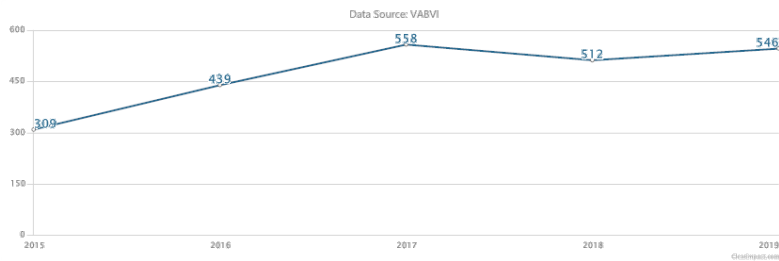
Mental Health Providers

What Works

Action Plan

PM DBV Older Blind Program: number of people with improved functional ability through assistive technology

2019	546		1	77%
2018	512		1	66%
2017	558		2	81%
2016	439		1	42%
2015	309		0	0%



Story Behind the Curve

Partners

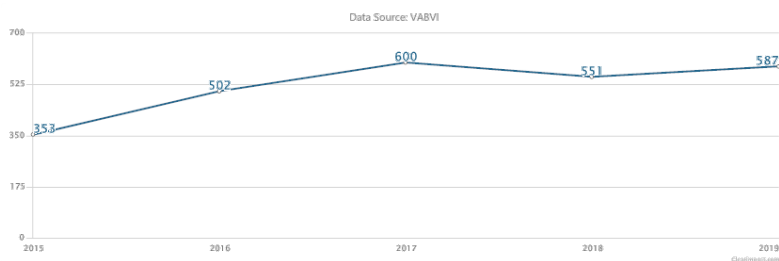
What Works

Action Plan

Older Blind Program: number of people with improved functional ability through training in communication

2019	587		1	66%
------	-----	--	---	-----

skills



2018	551		1	56%
2017	600		2	70%
2016	502		1	42%
2015	353		0	0%

Story Behind the Curve

Partners

What Works

Action Plan

Older Blind Program: number of people with improved functional ability through training in daily living skills

2019	234		1	22%
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2018	396	<input type="checkbox"/>	<input type="checkbox"/>	2	106%	<input type="checkbox"/>
2017	251	<input type="checkbox"/>	<input type="checkbox"/>	1	31%	<input type="checkbox"/>
2016	183	<input type="checkbox"/>	<input type="checkbox"/>	1	-5%	<input type="checkbox"/>
2015	192	<input type="checkbox"/>	<input type="checkbox"/>	0	0%	<input type="checkbox"/>

Story Behind the Curve

Partners

What Works

Action Plan

Older Blind Program: number of people with improved functional ability through training in orientation and mobility

2019	160	<input type="checkbox"/>	<input type="checkbox"/>	4	208%	<input type="checkbox"/>
2018	125	<input type="checkbox"/>	<input type="checkbox"/>	3	140%	<input type="checkbox"/>
2017	107	<input type="checkbox"/>	<input type="checkbox"/>	2	106%	<input type="checkbox"/>
2016	101	<input type="checkbox"/>	<input type="checkbox"/>	1	94%	<input type="checkbox"/>
2015	52	<input type="checkbox"/>	<input type="checkbox"/>	0	0%	<input type="checkbox"/>

Story Behind the Curve

Partners

What Works

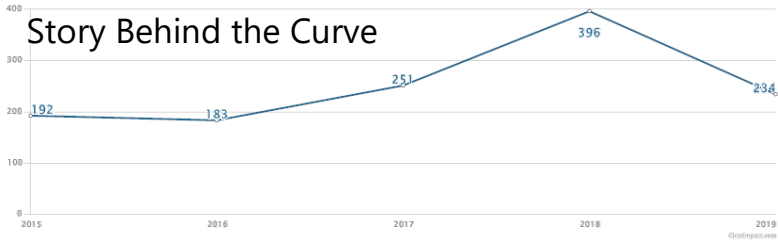
Action Plan

Developmental Disabilities Special Payments

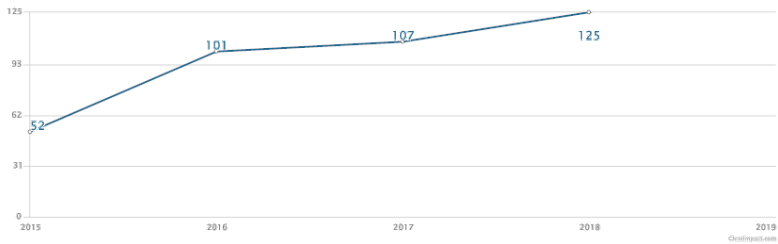
	Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change	
Vermont Communication Support Project New Referral Response Rate	2020	100%	100%	<input type="checkbox"/>	6	
	0%	<input type="checkbox"/>	2019 100%	100%	<input type="checkbox"/>	5
					<input type="checkbox"/>	0%
	2018	100%	100%	<input type="checkbox"/>	4	0%
	2017	100%	100%	<input type="checkbox"/>	3	0%
	2016	100%	100%	<input type="checkbox"/>	2	0%
	2015	100%	100%	<input type="checkbox"/>	1	0%
	2014	100%	100%	<input type="checkbox"/>	0	0%

Data Source: VABVI

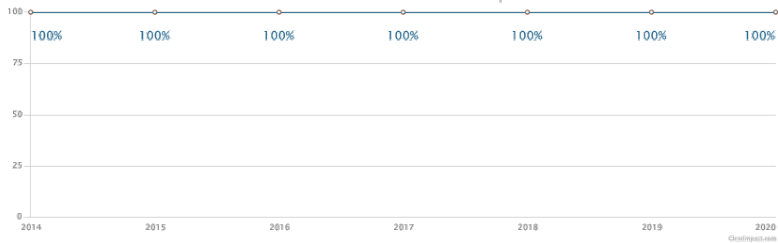
Story Behind the Curve



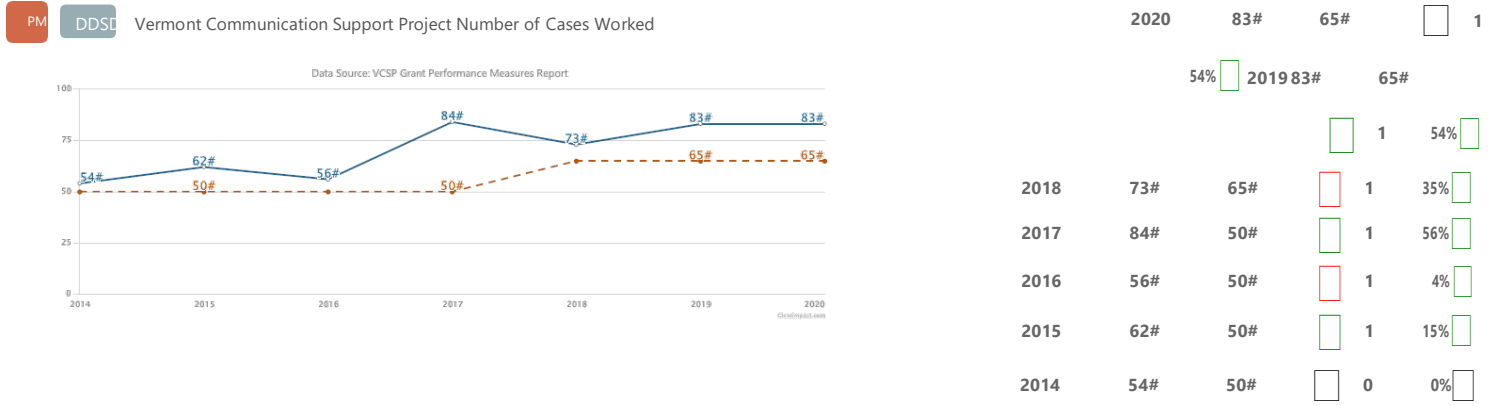
Data Source: VABVI



Data Source: VCSP Grant Performance Measures Report

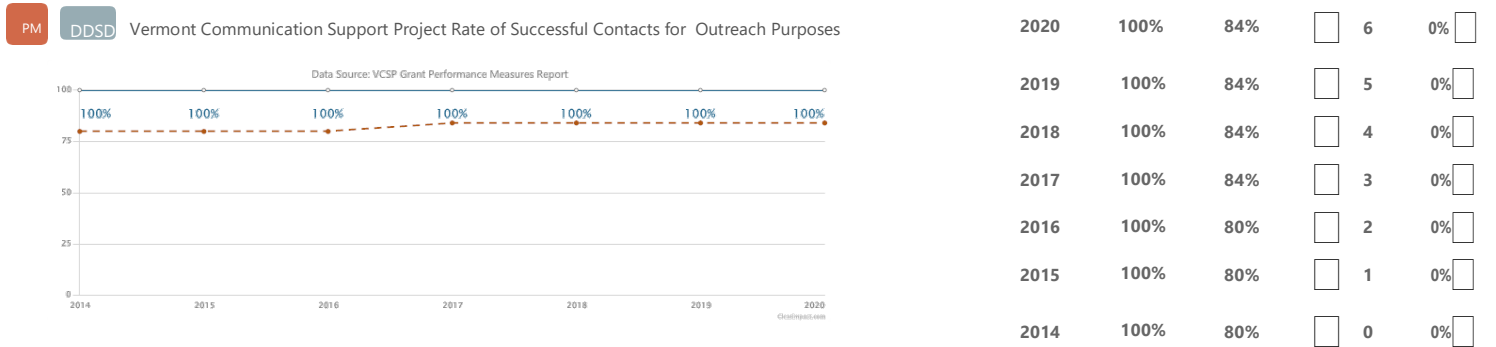


The Vermont Communication Support Project has maintained long standing success in responding to all new referrals that meet the project criteria regardless of the type and geographic location of the referral. The 100% responsiveness to referrals by the project is impressive considering the wide variety of sources of referrals and types of communication needs across recipients of the service. The VCSP strives to provide equal access to the Vermont system of justice and State services for people whose disabilities affect comprehension, verbal expression as well as effective participation and focus. The support and accommodations that were provided assisted the individuals in overcoming barriers and challenges as a result of disability. Of particular importance and the hallmark of the success of the project is the flexibility and attention to each person's individualized needs to get at what works best for each individual in each situation.



Story Behind the Curve

The overall increase of number of cases worked over time shows the need for the service provided by the Vermont Communication Support Project. While the project does not have direct control over when and what cases may be referred to the project, these data show the effectiveness of the ongoing outreach to the courts, Department for Children and Family Services District Offices, Agency of Human Services Field Services Directors and State Public Defenders, among others.



Story Behind the Curve

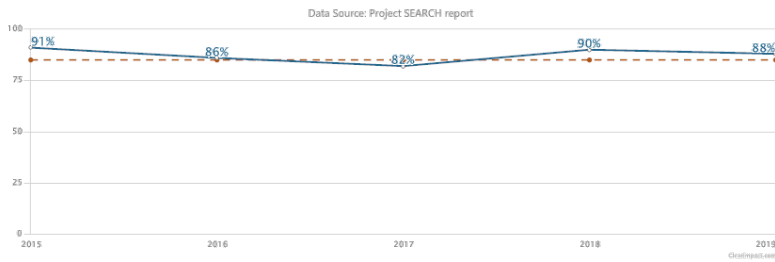
The Vermont Communication Support Project conducts a variety of outreach to organizations (Agency of Human Services Field Services Directors, Department for Children and Families district offices, courts and State Public Defender offices) to help build awareness of the service and provide educate on the process for accessing Communication Support Specialists.

Partners

What Works

Action Plan

2019	88%	85%	1	-3%
2018	90%	85%	1	-1%
2017	82%	85%	2	-10%
2016	86%	85%	1	-5%
2015	91%	85%	0	0%



Story Behind the Curve

Job skill acquisition in complex internships arranged by Project SEARCH is achieved through several internship rotations over ten months at the host business. Job placement upon graduation is assured through vigorous job development provided by Project SEARCH staff, Advisory Council members, and the host businesses. For participants not employed at graduation, job development services continue until employment is achieved. There may be times when students go into higher education instead of directly into employment and would, therefore, not be considered employed.

During the first four years of the project, only one SSA and school district were involved with Project SEARCH. While the employment rate was 100%, there were only a total of 2-3 student interns each year. The project expanded in FY 16 to three school districts and two additional developmental disabilities services agencies resulting in total of 20 student interns. In FY 17, an additional developmental disabilities services agency participated resulting in 22 student interns.

Partners

This initiative is based on a partnership with National Project SEARCH, a model recognized for its effectiveness in preparing youth with developmental disabilities for the workforce. The developmental disabilities services agencies who facilitate Project SEARCH are Lincoln Street Incorporated, Rutland Mental Health Services and HowardCenter. Project SEARCH training programs in FY 17 were hosted by Dartmouth Hitchcock Medical Center, Rutland Regional Medical Center and The Edge Sports and Fitness.

The high schools who participated in Project SEARCH are within the South Burlington, Rutland City and Hartford school districts. The Vermont Agency of Education and the Division of Vocational Rehabilitation participate on the state and local steering committees along with the Developmental Disabilities Services Division and local developmental disabilities services agencies. In addition, Project SEARCH is monitored by the National Cincinnati Children Hospital Project SEARCH and guided by a local business advocacy council at each site.

What Works

The success of Project SEARCH is founded on a model that provides total immersion across genuine work settings in Vermont businesses. Department heads provide mentoring, training, continuous feedback, and job search references to young workers learning complex skill sets in the real job market. Host sites hire from the internship class and job development in other businesses results in very high employment rates upon graduation from high school or shortly thereafter.

Notes on Methodology

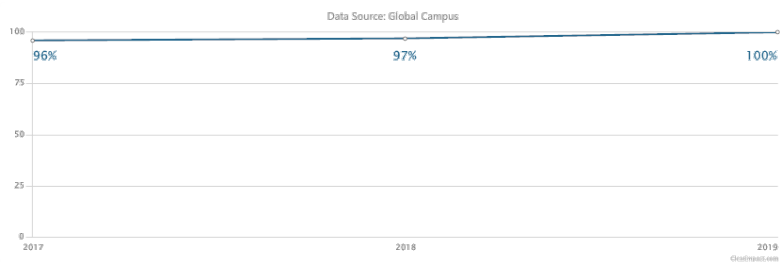
Action Plan

The Developmental Disabilities Services Division will continue to provide ongoing support to Project SEARCH by facilitation of the state and local steering committees. Continued work on securing stable participant school district participation will take place as per the recommendation of the National Project SEARCH audit.

PM

DDSD Proportion of Global Campus student faculty who demonstrate improvements in personal development

2019	100%	<input type="checkbox"/>	<input type="checkbox"/>	2	4%
2018	97%	<input type="checkbox"/>	<input type="checkbox"/>	1	1%
2017	96%	<input type="checkbox"/>	<input type="checkbox"/>	0	0%



Story Behind the Curve

Partners

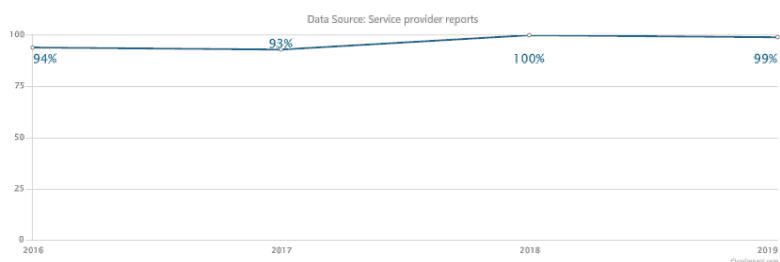
What Works

Action Plan

PM

DDSD Proportion of people who received One-Time Funding who demonstrated achieving one or more possible outcomes

2019	99%	<input type="checkbox"/>	<input type="checkbox"/>	1	5%
2018	100%	<input type="checkbox"/>	<input type="checkbox"/>	1	6%
2017	93%	<input type="checkbox"/>	<input type="checkbox"/>	1	-1%
2016	94%	<input type="checkbox"/>	<input type="checkbox"/>	0	0%

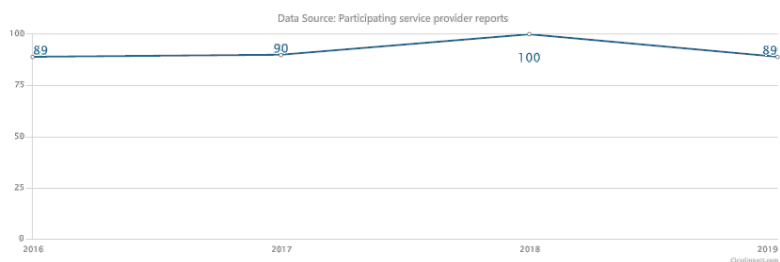


Story Behind the Curve

Partners

What Works

Action Plan



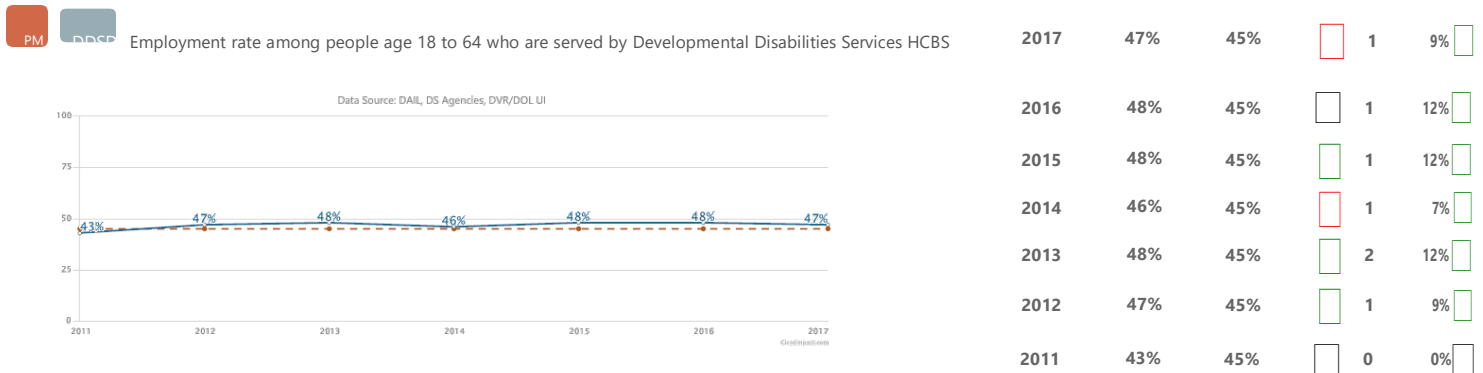
2018	100	<input type="checkbox"/>	<input type="checkbox"/>	2	12%
2017	90	<input type="checkbox"/>	<input type="checkbox"/>	1	1%
2016	89	<input type="checkbox"/>	<input type="checkbox"/>	0	0%

Story Behind the Curve

Partners

What Works

Action Plan



Story Behind the Curve

The growth in the employment rate for people with ID/DD who receive HCBS is due to several factors. Each designated and specialized service agency had individualized employment rate targets within the larger context of striving for a 45% statewide employment rate. This individualized approach provided tangible and feasible benchmarks while recognizing that each organization has unique circumstances associated with increasing the number of people employed. DAIL's Supported Employment Specialists provided technical assistance via regular meetings with each agency to review progress and offer help. DAIL's ability to access Vermont Department of Labor's (VTDOL) database allowed DAIL to identify every employed person served by the providers. In some cases, the utilization of the VTDOL data base actually increased the employment rate as it picked up workers beyond what providers' data system had available for employment rates. In addition, four transition age youth educational options; SUCCEED, College Steps, Think College Vermont, and Project SEARCH had a significant influence on the growth in employment with each achieving a high employment rate for their students upon graduation. Participating colleges in the post-secondary education programs include Castleton University, Northern Vermont University - Johnson and Lyndon Campuses, Southern Vermont College and University of Vermont. Vermont Project SEARCH has expanded to three Vermont licensed programs (Burlington, Rutland, Springfield). This growth has tremendously broadened the menu of employment supports for transition aged youth with developmental disabilities.

Partners

Designated Agency (DA) and Specialized Services Agency Supported Employment Coordinators and Directors; DDSD Supported Employment Specialist (Jennie Masterson); DVR Supported Employment Specialist (Betsy Choquette); UVM Center on Disability and Community Inclusion (CDCI/UVM) faculty (Bryan Dague); Vermont businesses, regional VR Counselors, Post-Secondary college support programs (Think College, SUCCEED, College Steps Program).

What Works

- Ongoing support and technical assistance from DAIL Supported Employment Specialists.
- Quarterly Supported Employment Coordinators' Meetings to share resources, ideas, and cross mentor.
- Connecting youth to Project SEARCH Industry based training and to post-secondary college course work.

Notes on Methodology

The Unemployment Insurance (UI) data that makes up this outcome is supplied by the Vermont Department of Labor and has a six months lag time in its availability. There is a further delay during which time the agencies and VR and DDSD review the data. Therefore, Calendar Year 2017 data will not be available until Spring 2018.

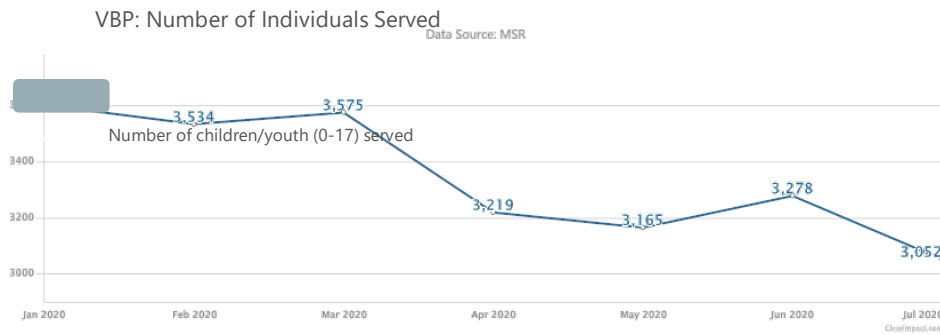
Action Plan

- Facilitate annual regional Youth Transition Core Teams to come together quarterly and provide an annual team development day for Core Teams and statewide stakeholders.
- DAIL continues to provide a CCV based online Supported Employment certification course to provide training to first year agency Supported Employment Specialists.
- Develop sustainability of the three Project SEARCH sites in Vermont. Work with the post-secondary programs to assure continuation of the five Vermont college campus-based programs (Castleton University, Northern Vermont University - Johnson and Lyndon Campuses, Southern Vermont College, University of Vermont).

P	DDSD	Serious Functional Impairment (SFI) Designation	Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
P	DDSD	Flexible Family Funding	Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change

Attachment 8 - Payment Model Scorecard

DMH Value Based Payment Measures



Current Actual Value	Current Target Value	Current Trend
3,052	<input type="checkbox"/>	<input type="checkbox"/>
3,278	<input type="checkbox"/>	<input type="checkbox"/>
3,165	<input type="checkbox"/>	<input type="checkbox"/>
3,219	<input type="checkbox"/>	<input type="checkbox"/>
3,575	<input type="checkbox"/>	<input type="checkbox"/>
3,534	<input type="checkbox"/>	<input type="checkbox"/>
3,602	<input type="checkbox"/>	<input type="checkbox"/>
3,478	<input type="checkbox"/>	<input type="checkbox"/>
3,503	<input type="checkbox"/>	<input type="checkbox"/>

Story Behind the Curve

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

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

Partners

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

What Works

Strategy

Notes on Methodology

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

-
-
-
-
-

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

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

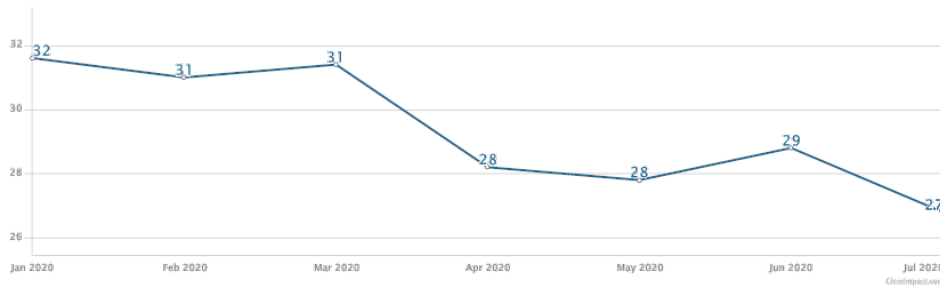
- Pull MSR services
- Calculate age of client from the midpoint of the service year (June 30, XXXX)
- Select clients who are aged 0-17
- Aggregate to clinic client level, with flag for total services during fiscal year
- Select clients who have a least 1 unit (as defined in the *Provider Manual*)

Report figure on a designated agency level basis

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

- 27
- 29
- 28
- 28
- 31
- 31
- 32
- 31
- 31

Data Source: MSR



Story Behind the Curve

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

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

Partners

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

What Works

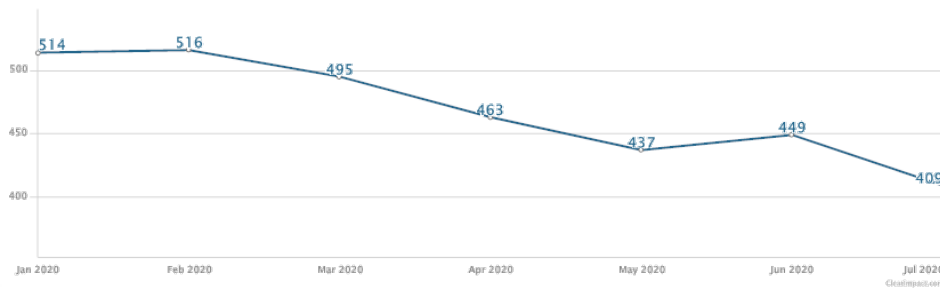
Strategy

Notes on Methodology

1 How_Much Number of young adults (18-21) served

- 409
- 449
- 437
- 463
- 495
- 516
- 514
- 371
- 379

Data Source: MSR



Story Behind the Curve

This measure is used to monitor the total number of clients served by the Designated Agency, and to further the State’s understanding of changes and/or variations in the mental health needs of the catchment area. By acting as the denominator in other measures, this helps the State to assess the breadth of impact of other work performed by the Designated Agencies. The Department of Mental Health is particularly interested in the number of transition aged youth served, as we have identified historical gaps in service for those transitioning from children and youth services to adult services.

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

Partners

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

What Works

Strategy

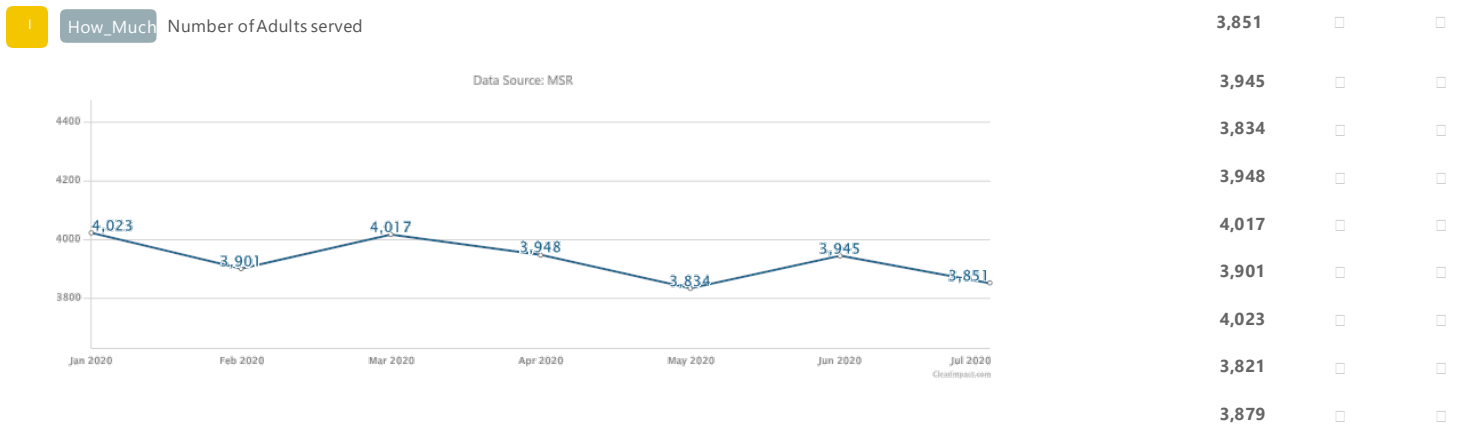
Notes on Methodology

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

- Pull MSR services
- Calculate age of client from the midpoint of the service year (June 30, XXXX)
- Select clients who are aged 18-21
- Aggregate to clinic client level, with flag for total services during fiscal year
- Select clients who have a least 1 unit (as defined in the *Provider Manual*)

Report figure on a designated agency level basis

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



Story Behind the Curve

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

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

Partners

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

What Works

Strategy

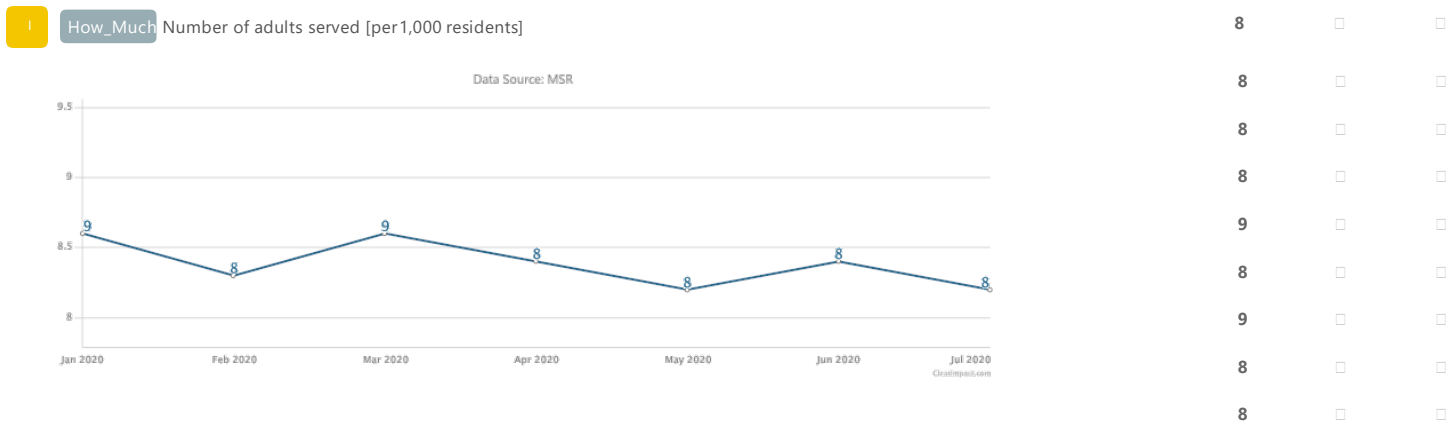
Notes on Methodology

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

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

Report figure on a designated agency level basis

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



Story Behind the Curve

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

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

Partners

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

What Works

Strategy

Notes on Methodology

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

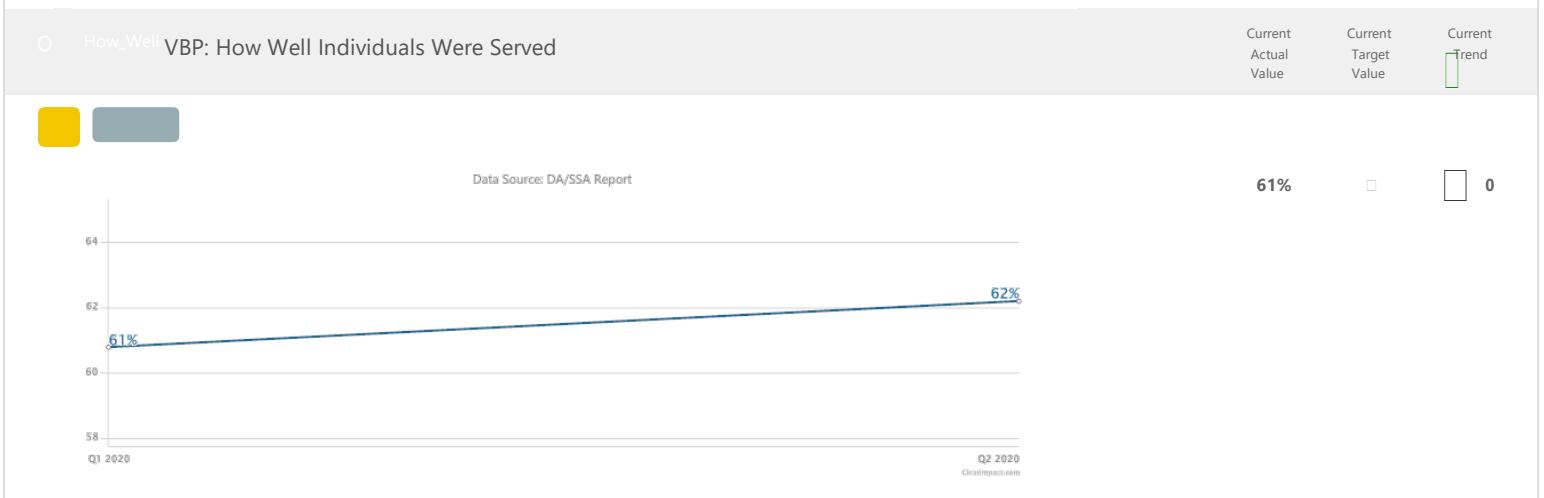
- Follow steps for measure 8(Number of Adults (18+) served)
- Request most recent demographic data from VDH on a catchment level basis
- Calculate per capita rate based on formula below

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

$$R = 1,000 C / P$$

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

Report figure on a designated agency level basis.



Story Behind the Curve

Calendar Year 2020 is the first year that agencies are reporting on this measure. DMH will be using this data to determine a baseline for the percentage of clients offered an appointment within five days, and utilize that information to set future year quality and performance targets. It should be noted that "face to face" includes telehealth visits.

Partners

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

What Works

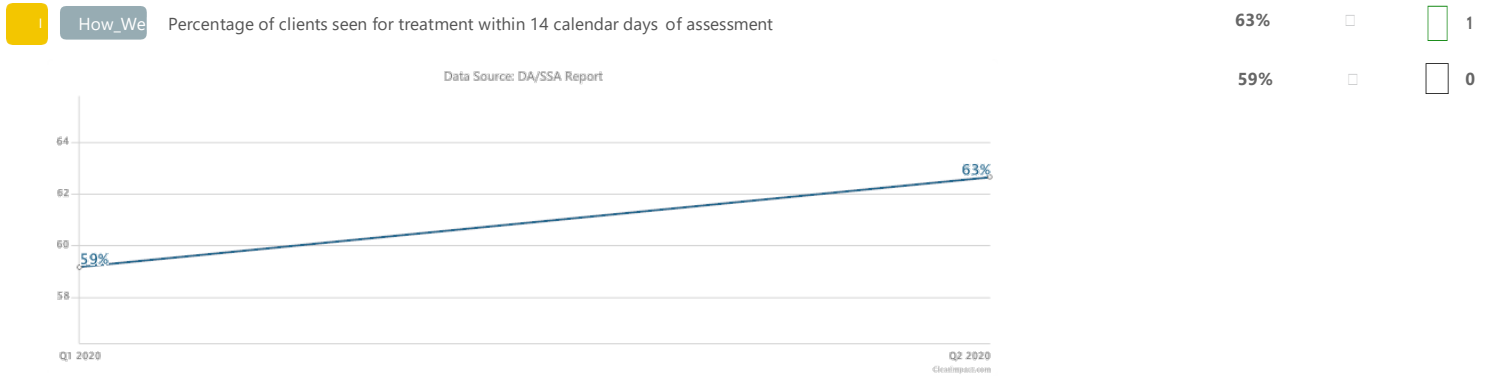
Strategy

Notes on Methodology

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

- Numerator = # of inactive clients offered a face to face (or telehealth) appointment within five calendar days

- Denominator = Total # of inactive clients calling saying they need help.



Story Behind the Curve

Calendar Year 2020 is the first year that agencies are reporting on this measure. DMH will be using this data to determine a baseline for the percentage of clients seen for treatment within 14 calendar days of their initial assessment, and utilize that information to set future year quality and performance targets. DMH utilized this measure because clients who receive continuous care are more likely to remain engaged in care.

Partners

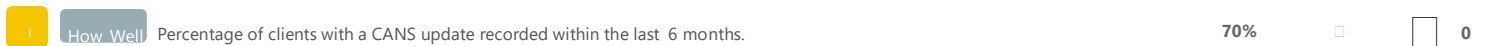
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

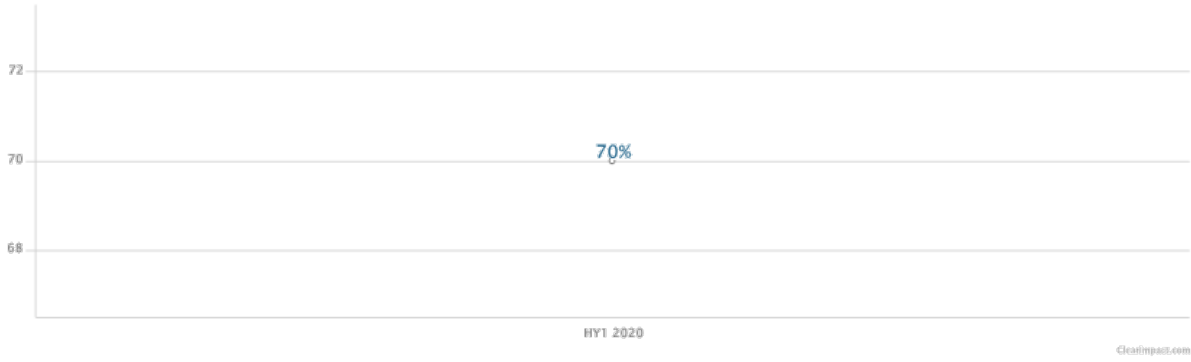
What Works

Strategy

Notes on Methodology

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





Story Behind the Curve

Partners

What Works

Strategy

Notes on Methodology

How We Percentage of clients screened for substance use. 57% 1

Data Source: DA/SSA Report

57% 0



Story Behind the Curve

Calendar Year 2020 is the first year that agencies are reporting on this measure. DMH will be using this data to determine a baseline for the percentage of clients screened for substance use with the CAGE-AID and utilize that information to set future year quality and performance targets.

Partners

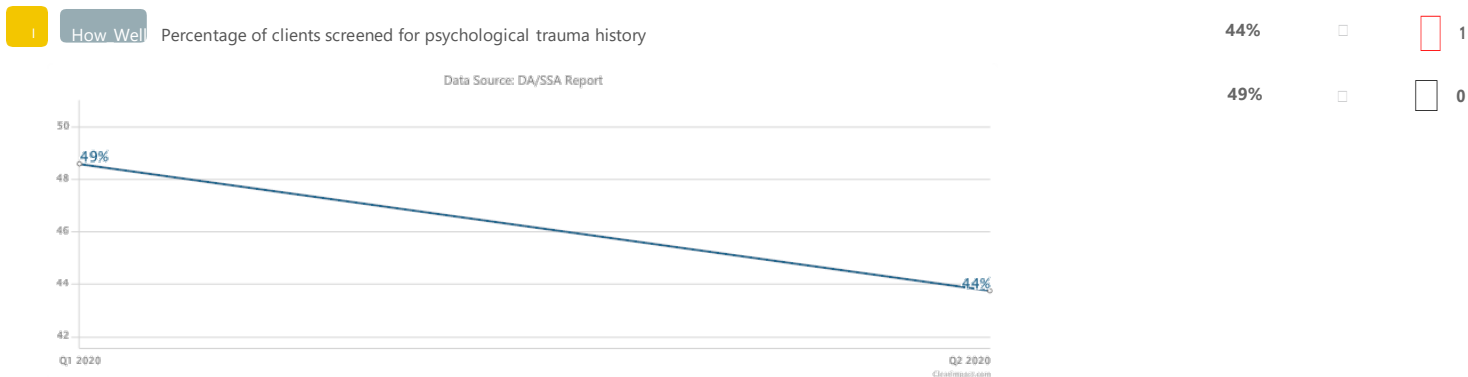
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric

What Works

Strategy

Notes on Methodology

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



Story Behind the Curve

Calendar Year 2020 is the first year that agencies are reporting on this measure. DMH will be using this data to determine a baseline for the percentage of clients screened for psychological trauma using the PC-PTSD-5, and utilize that information to set future year quality and performance targets.

Partners

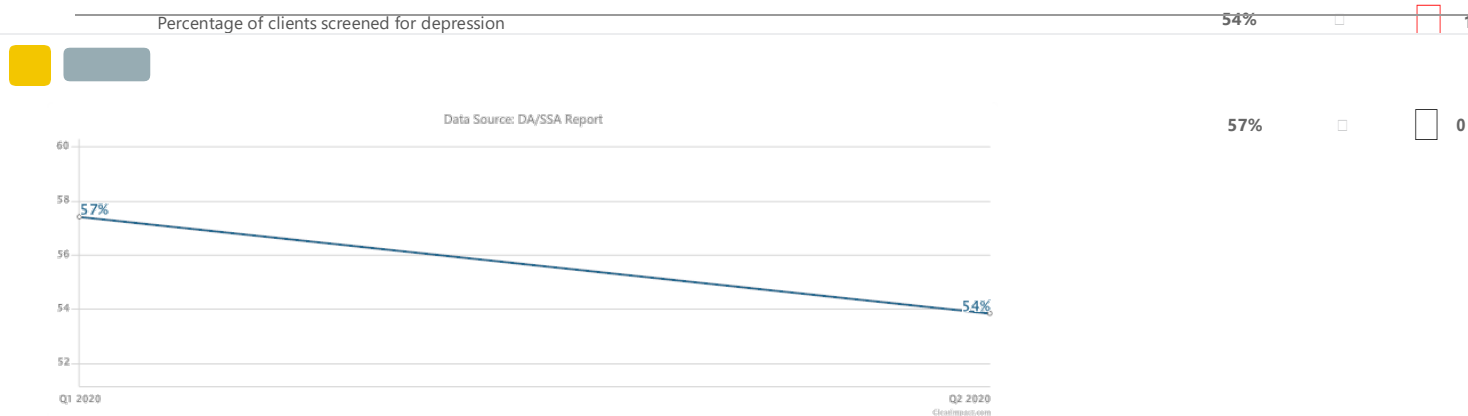
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

What Works

Strategy

Notes on Methodology

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



Story Behind the Curve

Calendar Year 2020 is the first year that agencies are reporting on this measure. DMH will be using this data to determine a baseline for the percentage of clients screened for depression using the PhQ2/9, and utilize that information to set future year quality and performance targets.

Partners

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

What Works

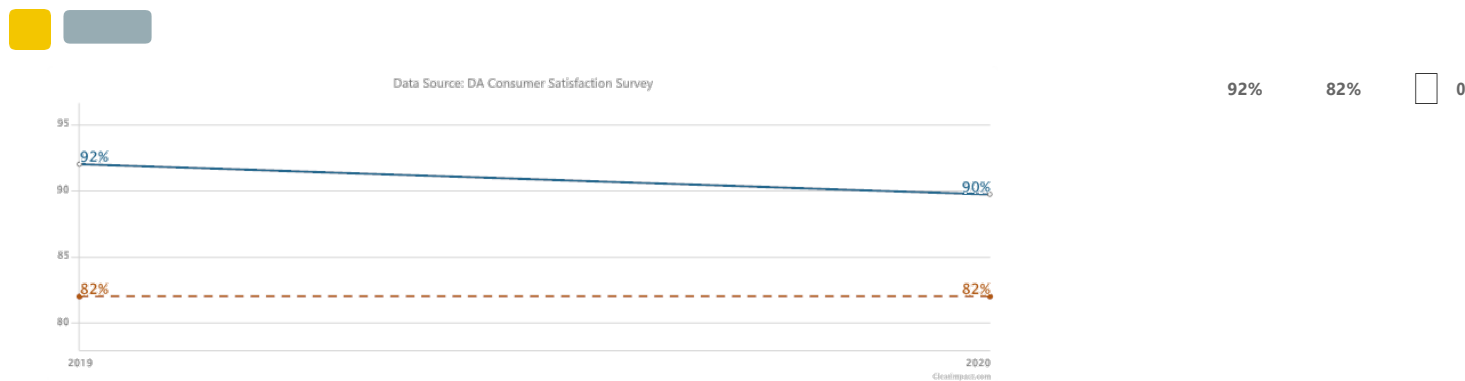
Strategy

Notes on Methodology

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

Better Off VBP: Better Off Measures

Current Actual Value 92%
Current Target Value 82%
Current Trend 0



Story Behind the Curve

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

Partners

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

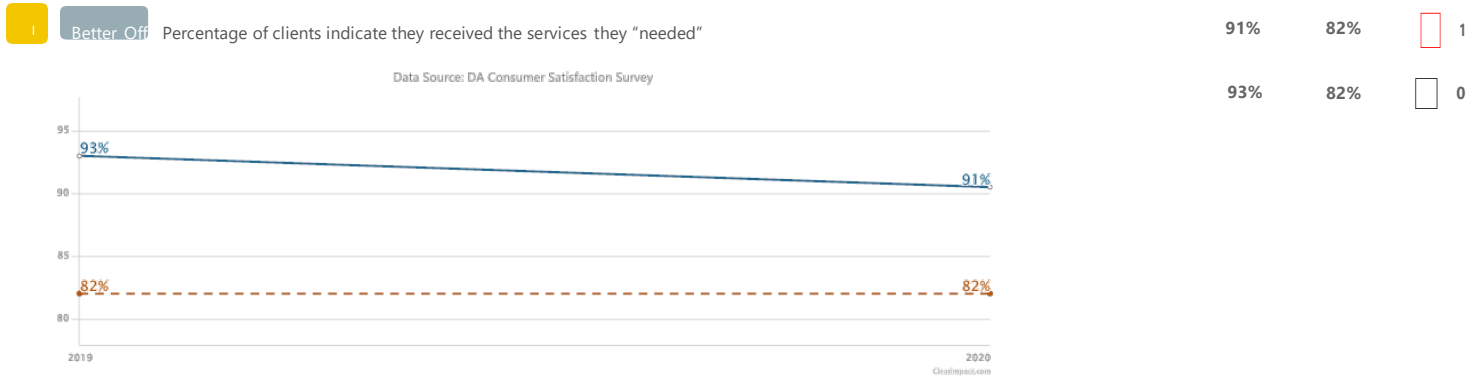
What Works

Strategy

Notes on Methodology

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

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



Story Behind the Curve

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

Partners

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

What Works

Strategy

Notes on Methodology

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

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

Percentage of clients indicate they were treated with respect

95% 87% 1



Story Behind the Curve

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

Partners

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

What Works

Strategy

Notes on Methodology

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

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

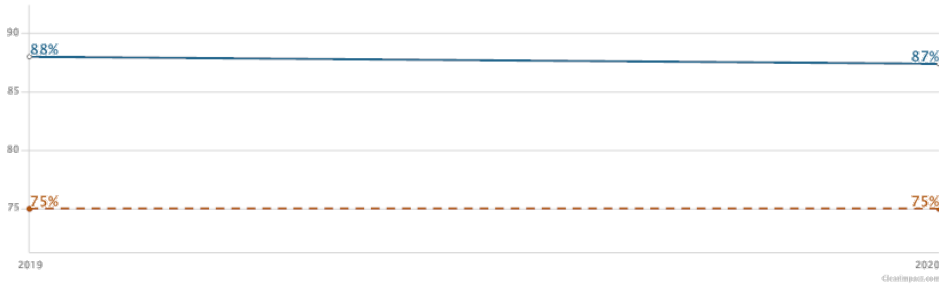


Percentage of clients indicate services made a difference

87% 75% 1

88% 75% 0

Data Source: DA Consumer Satisfaction Survey



Story Behind the Curve

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

Partners

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

What Works

Strategy

Notes on Methodology

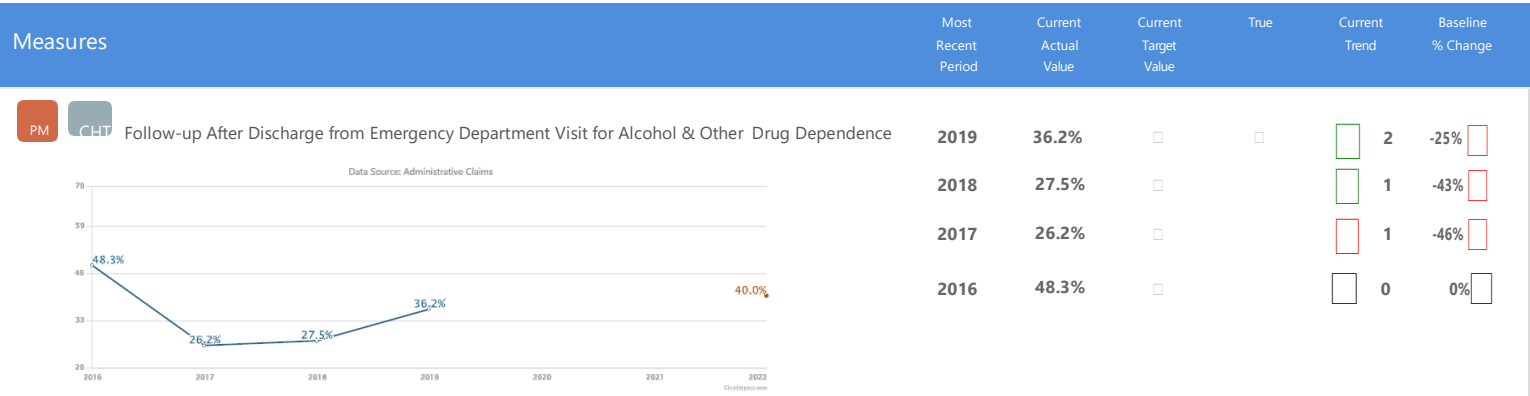
Annual. At the time of review, agencies are required to submit their most recent, complete survey results.

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

What We Do

The Vermont Blueprint for Health is a nationally recognized initiative that designs community-led strategies for improving health and well-being. The Blueprint invests in and supports Patient-Centered Medical Homes, Community Health Teams, the Women’s Health Initiative, Accountable Communities for Health, the Hub & Spoke system of care, Support and Services at Home (SASH), Self-Management and Healthier Living workshops, and a series of learning collaboratives for communities and teams. Blueprint interventions have been shown to maintain or improve health outcomes while controlling growth in health care costs. Of note, the first three have payment models authorized under Vermont’s Global Commitment to Health 1115 waiver.

Community Health Teams partner with patient-centered medical homes, hospital systems, health care and social service organizations to supplement the services available in primary care, support coordinated care, and promote prevention and wellness. A per patient per month payment is made to regional entities accountable for managing ongoing Community Health Team operations, including hiring and management of staffing, in order to meet identified community health priorities while offering services that are available for patients to access with minimal barriers (no eligibility requirements, prior authorizations, referrals or co-pays). Measures used to evaluate the overall impact of the Community Health Teams are representative of the provision of coordinated care in each region (follow-up after discharge from the emergency department for mental health or substance use disorders and patient experience of coordinated care composite).



Notes on Methodology

New, as of the 2020 report year, the population for the above data points consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes, and who therefore have access to Community Health Teams. The red dot on the graph above represents the target value the State aims to achieve by the year 2022 for this measure as outlined in the Vermont All-Payer ACO model Agreement. The solid blue trend line represents the actual data values for Medicaid-primary members.

This HEDIS measure shows the percent of emergency department (ED) visits for members, age 18 years and older, with a principal diagnosis of substance use disorder who had a follow-up visit for substance use disorder within 30 days of the ED visit. (NQF #2605)

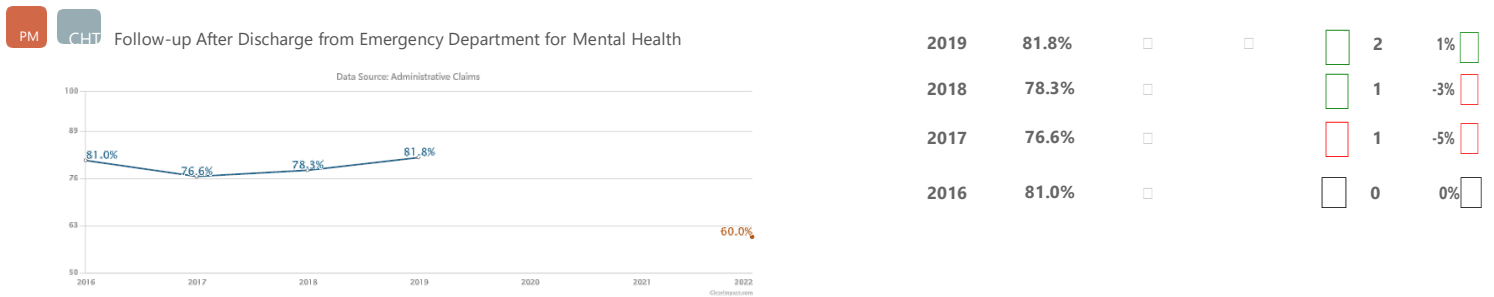
Partners

1. Patient-Centered Medical Homes
2. Community Health Teams
3. Vermont Department of Health
4. Green Mountain Care Board
5. OneCareVermont

Story Behind the Curve

In support of people with substance use disorders, Vermont has committed to expanding access to treatment and services that can address factors contributing to these disorders, in much the same way that other chronic conditions are managed. This effort requires coordination and partnership among social, medical, and mental health providers. Community Health Teams play a critical role in this coordination and navigating individuals to the most appropriate level of treatment and support services. Following up with individuals who have an Emergency Department visit due to substance use is an important point of contact and an opportunity to engage a person in treatment if needed. Measuring whether this contact is made is one way to monitor the Community Health Team's engagement in the health care system.

The population for the above data points consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes, and who therefore have access to Community Health Teams. Between 2016 and 2019, the rate of follow-up among this population remained substantially below the target in the Vermont All-Payer ACO Model Agreement. One factor that could have affected the outcomes was the reinstatement of eligibility redetermination after 2016, which led to a number of individuals (often healthier and younger) removed from the Medicaid rolls, thereby changing the composition of the Medicaid population. Community Health Teams, in collaboration with practices, OneCare Vermont, and community-based services, continue to work on strategies to address improving these rates.



Notes on Methodology

New, as of the 2020 report year, the population for the above data points consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes, and who therefore have access to Community Health Teams. The red dot on the graph above represents the target value the State aims to achieve by the year 2022 for this measure as outlined in the Vermont All-Payer ACO model Agreement. The solid blue trend line represents the State's actual values for Medicaid-primary members.

This measure shows the percent of emergency department (ED) visits for members, age 18 years and older, with a principal diagnosis of mental illness who had a follow-up visit for mental health within 30 days of the ED visit. (NQF #2605)

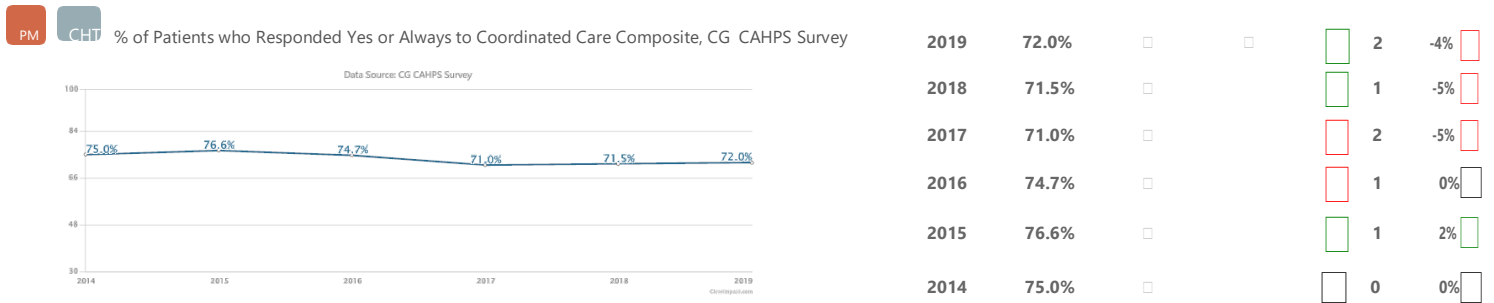
Partners

1. Patient-Centered Medical Homes
2. Community Health Teams
3. Vermont Department of Health
4. Green Mountain Care Board
5. OneCareVermont

Story Behind the Curve

The population for the above data points consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes, and who therefore have access to Community Health Teams. While the Community Health Team payments are not dependent on performance measurement, the Blueprint for Health closely follows this measure to identify service areas that that may benefit from additional assistance to improve this measure.

The Vermont rate of follow-up to an Emergency Department visit with a primary diagnosis of mental health condition is higher among the Medicaid-primary member population than the All-Payer ACO Model Agreement target. One factor that could have affected outcomes was the reinstatement of eligibility redetermination after 2016, which led to a number of individuals (often healthier and younger) removed from the Medicaid rolls, thereby changing the composition of the Medicaid population. Nevertheless, the state continues to work on improving how people with mental health conditions move through the system and receive the services they need. To do so requires coordination and partnership among social, medical, and mental health providers. Community Health Teams play a critical role in this coordination and navigating individuals to the most appropriate level of treatment and support services. Following up with individuals who have an Emergency Department visit due to mental health is an important point of contact and an opportunity to engage a person in treatment if needed. Measuring whether this contact is made is one way to monitor the Community Health Team's engagement in the health care system.



Notes on Methodology

The Department of Vermont Health Access annually administers CG CAHPS survey with PCMH supplemental questions to patients of patient-centered medical homes. All practices are offered the option to participate, and typically more than 75% do. Of note, almost all primary care practices in the state are recognized as patient-centered medical homes. This measure represents responses from patients covered by all major payers, including Medicare and commercial, and is therefore not Medicaid specific.

Partners

1. Patients
2. Patient-Centered Medical Homes
3. DVHA Payment Reform Unit
4. Green Mountain Care Board
5. OneCare Vermont

Story Behind the Curve

How patients experience their care is a core element in assessing the quality of their care. As the state of Vermont works to increase integration and coordination across medical and community services, supported by Community Health Teams, to improve health outcomes and reduce unnecessary or duplicative care, the state needs to understand whether patients are seeing the results of these efforts in their own experience.

Over the last few years, more than 70% of respondents reported that their primary care provider was always up-to-date on and discussed with them the care received from specialists, prescription medicines they were taking, and/or tests they had received. However, more work can be done to improve this measure. Shifting this trend involves continual improvement in person-to-person communication, practice workflows, and information technology. While the community health team payments are not dependent on performance measurement, the Blueprint for Health closely follows this measure to identify service areas that that may benefit from additional assistance to improve this measure.

Actions

Name	Assigned To	Status	Due Date	Progress
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File Attachments

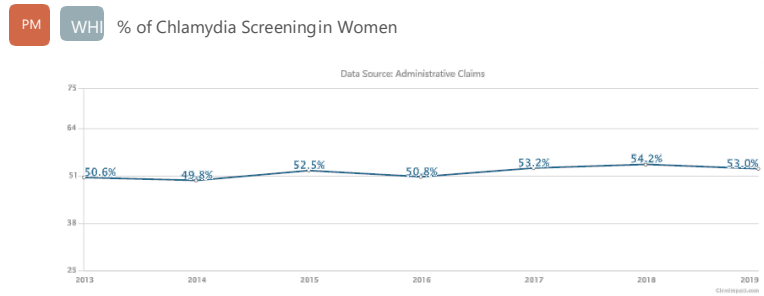
File Name

What We Do

The Vermont Blueprint for Health is a nationally recognized initiative that designs community-led strategies for improving health and well-being. The Blueprint invests in and supports Patient-Centered Medical Homes, Community Health Teams, the Women's Health Initiative, Accountable Communities for Health, the Hub & Spoke system of care, Support and Services at Home (SASH), Self-Management and Healthier Living workshops, and a series of learning collaboratives for communities and teams. Blueprint interventions have been shown to maintain or improve health outcomes while controlling growth in health care costs. Of note, the first three have payment models authorized under Vermont's Global Commitment to Health 1115 waiver.

The Women's Health Initiative includes 3 types of payments designed to incentivize Women's Health practices, and patient-centered medical homes providing women's health services, to provide high quality, integrated, and well-coordinated preventative care for women aged 15-44. Participating practices implement enhanced psychosocial screening and evidence-based interventions for depression, substance use disorder, interpersonal violence, housing instability, and food insecurity are provided by Women's Health Initiative-funded licensed mental health clinicians. Participating practices also offer comprehensive family planning services and increase access to long acting reversible contraceptives when chosen by the patient and clinically appropriate (by removing barriers that frequently prevent patients from being able to access these devices). As a result, measures that are indicative of access to care and preventative care were chosen to evaluate the overall impact of the Women's Health Initiative.

Measures	Most Recent Period	Current Actual Value	Current Target Value	True	Current Trend	Baseline % Change
PM WHI % of Chlamydia Screening in Women	2019	53.0%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 1	5% <input type="checkbox"/>
	2018	54.2%	<input type="checkbox"/>		<input type="checkbox"/> 2	7% <input type="checkbox"/>
	2017	53.2%	<input type="checkbox"/>		<input type="checkbox"/> 1	5% <input type="checkbox"/>
	2016	50.8%	<input type="checkbox"/>		<input type="checkbox"/> 1	0% <input type="checkbox"/>
	2015	52.5%	<input type="checkbox"/>		<input type="checkbox"/> 1	4% <input type="checkbox"/>
	2014	49.8%	<input type="checkbox"/>		<input type="checkbox"/> 1	-2% <input type="checkbox"/>
	2013	50.6%	<input type="checkbox"/>		<input type="checkbox"/> 0	0% <input type="checkbox"/>



Notes on Methodology

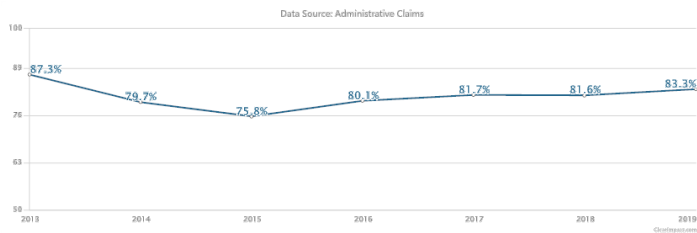
New, as of the 2020 report year, the population for the above data points consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes. This measure shows the percentage of female members, ages 16 to 24, identified as sexually active and who had at least one test for chlamydia in the measurement year. This measure is derived from claims data.

Partners

1. DVHA Quality Unit
2. VT Department of Health
3. Planned Parenthood of Northern New England

Story Behind the Curve

The rate of chlamydia screening in Medicaid-primary Women 16-24 years old has remained steady in recent years, just above 50%. In 2018 and 2019, the Blueprint for Health has worked with DVHA's Quality Unit, the Vermont Department of Health, and Planned Parenthood of Northern England to identify strategies to improve chlamydia screening rates in Women's Health Initiative participating practices.



Year	Percentage	Target	Delta	Change	Delta %
2019	83.3%	84.3%	-1.0%	1	-5%
2018	81.6%	88.6%	-7.0%	1	-7%
2017	81.7%	87.7%	-6.0%	2	-6%
2016	80.1%	88.1%	-8.0%	1	-8%
2015	75.8%	88.8%	-13.0%	2	-13%
2014	79.7%	88.7%	-9.0%	1	-9%
2013	87.3%	87.3%	0.0%	0	0%

Notes on Methodology

New, as of the 2020 report year, the population for the above data points consists of Medicaid-primary members, over 70% of whom are attributed to patient-centered medical homes. This measure shows the percentage of Medicaid-primary members 20 years and older who had an ambulatory or preventive care visit during the measurement year.

This is a Healthcare Effectiveness & Data Information Set (HEDIS) administrative measure. Based on the advice of their External Quality Review Organization (EQRO), DVHA's rates include only Medicaid Primary beneficiaries in HEDIS administrative measures as of 2014.

Partners

1. DVHA Quality Unit
2. VT Department of Health
3. Planned Parenthood of Northern New England

Story Behind the Curve

This measure looks at whether adult members receive preventive and ambulatory services. It looks at the percentage of Vermont adults with Medicaid who have had a preventative or ambulatory visit to their physician. Consider the other side of this measure: How many patients never access the system? If they never access the healthcare system, how does preventive care and counseling (diet, exercise, smoking cessation, seat belt use, etc.) occur? This measure is an indicator as to whether there may be barriers to our beneficiaries accessing preventive care.

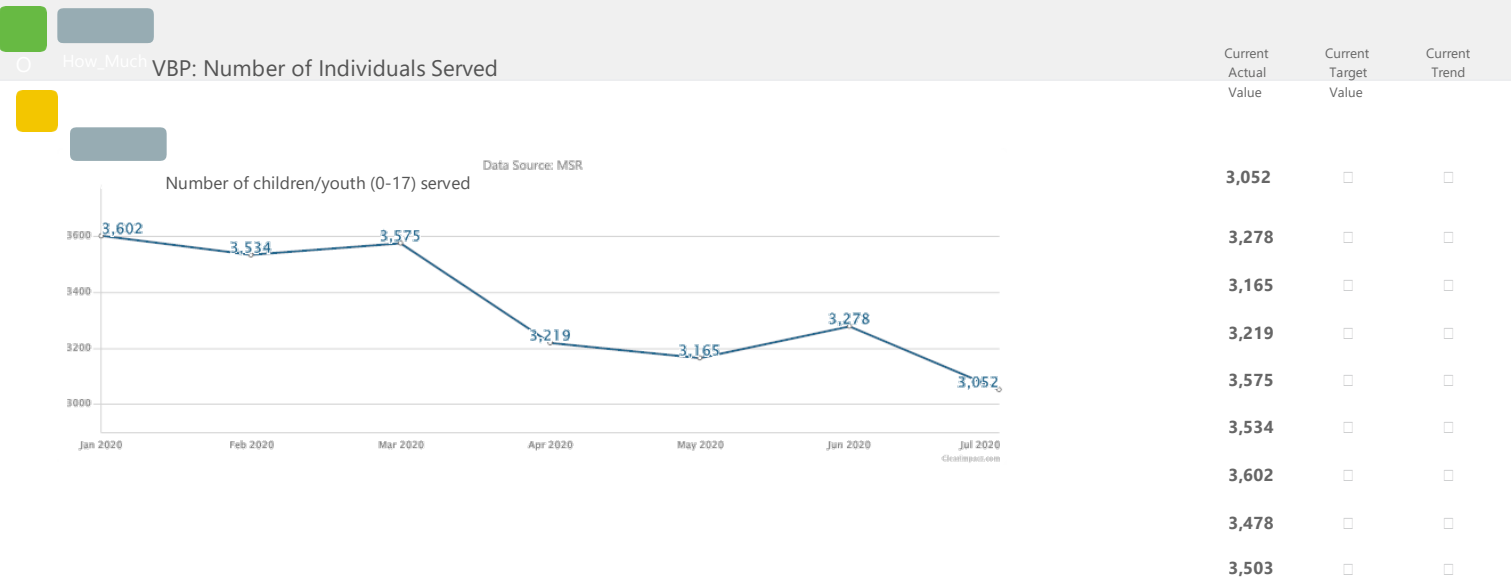
Actions

Name	Assigned To	Status	Due Date	Progress

File Attachments

File Name

DMH Value Based Payment Measures



Story Behind the Curve

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

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

Partners

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

What Works

Strategy

Notes on Methodology

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

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

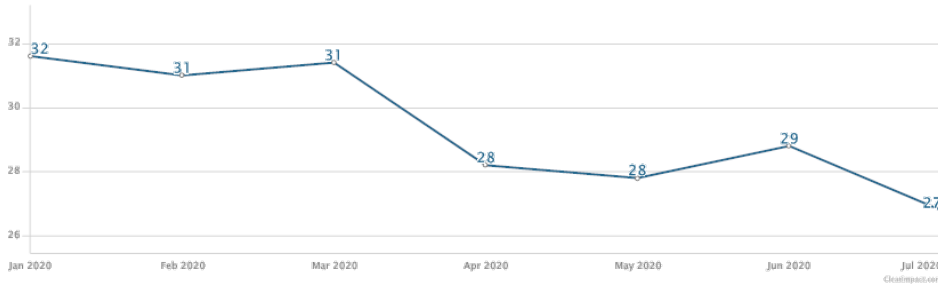
- For any given year of service (Jan - Dec):
- Pull MSR services
 - Calculate age of client from the midpoint of the service year (June 30, XXXX)
 - Select clients who are aged 0-17
 - Aggregate to clinic client level, with flag for total services during fiscal year
 - Select clients who have a least 1 unit (as defined in the *Provider Manual*)
- Report figure on a designated agency level basis

client.

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

- 27
- 29
- 28
- 28
- 31
- 31
- 32
- 31
- 31

Data Source: MSR



Story Behind the Curve

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

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

Partners

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

What Works

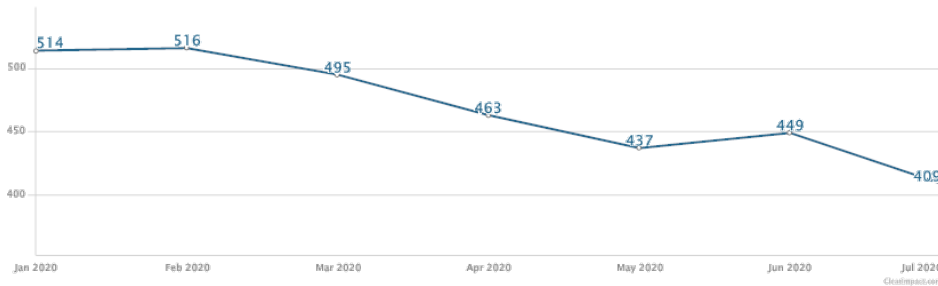
Strategy

Notes on Methodology

1 How_Much Number of young adults (18-21) served

- 409
- 449
- 437
- 463
- 495
- 516
- 514
- 371
- 379

Data Source: MSR



Story Behind the Curve

This measure is used to monitor the total number of clients served by the Designated Agency, and to further the State’s understanding of changes and/or variations in the mental health needs of the catchment area. By acting as the denominator in other measures, this helps the State to assess the breadth of impact of other work performed by the Designated Agencies. The Department of Mental Health is particularly interested in the number of transition aged youth served, as we have identified historical gaps in service for those transitioning from children and youth services to adult services.

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

Partners

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

What Works

Strategy

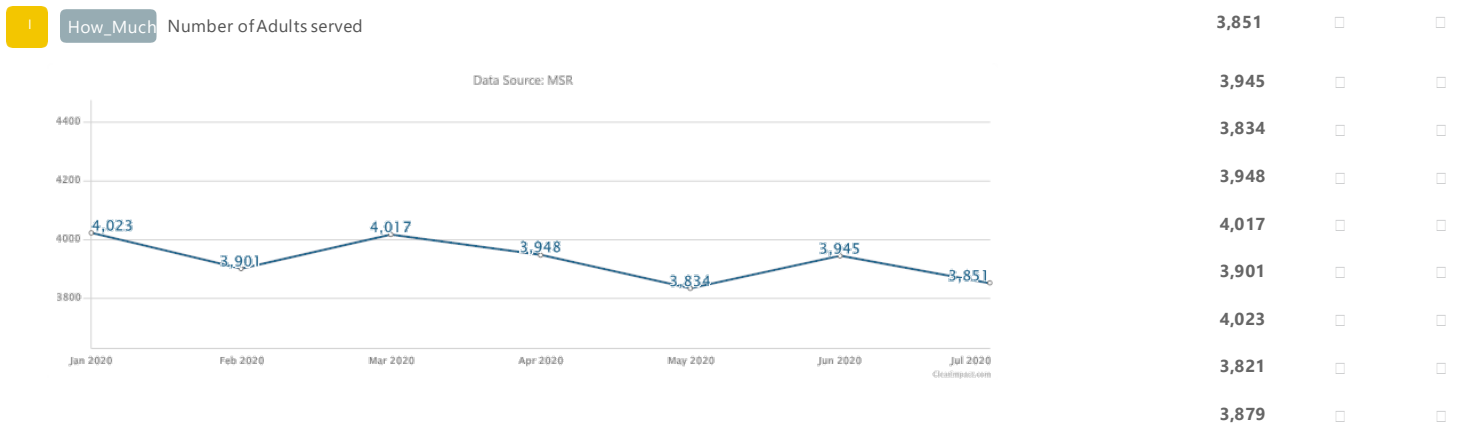
Notes on Methodology

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

- Pull MSR services
- Calculate age of client from the midpoint of the service year (June 30, XXXX)
- Select clients who are aged 18-21
- Aggregate to clinic client level, with flag for total services during fiscal year
- Select clients who have a least 1 unit (as defined in the *Provider Manual*)

Report figure on a designated agency level basis

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



Story Behind the Curve

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

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

Partners

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

What Works

Strategy

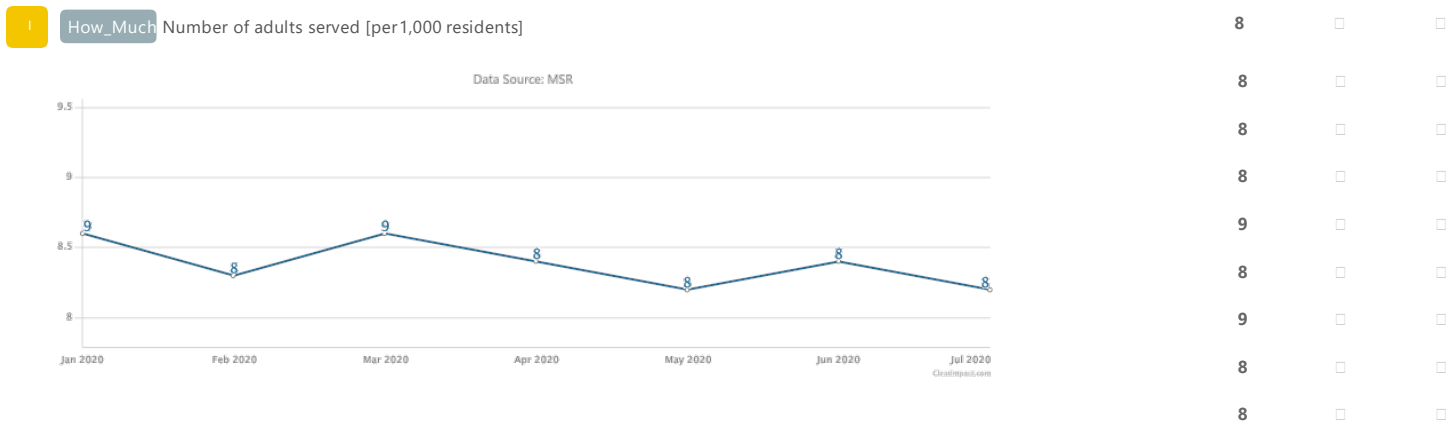
Notes on Methodology

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

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

Report figure on a designated agency level basis

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



Story Behind the Curve

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

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

Partners

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

What Works

Strategy

Notes on Methodology

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

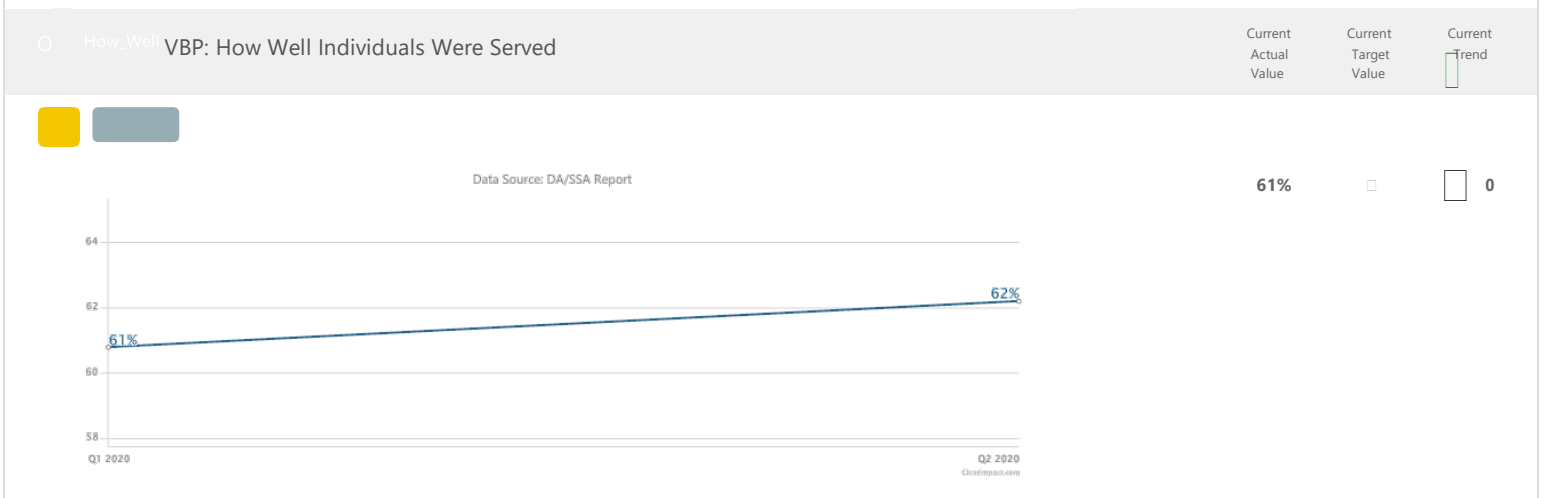
- Follow steps for measure 8 (Number of Adults (18+) served)
- Request most recent demographic data from VDH on a catchment level basis
- Calculate per capita rate based on formula below

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

$$R = 1,000 C / P$$

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

Report figure on a designated agency level basis.



Story Behind the Curve

Calendar Year 2020 is the first year that agencies are reporting on this measure. DMH will be using this data to determine a baseline for the percentage of clients offered an appointment within five days, and utilize that information to set future year quality and performance targets. It should be noted that "face to face" includes telehealth visits.

Partners

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

What Works

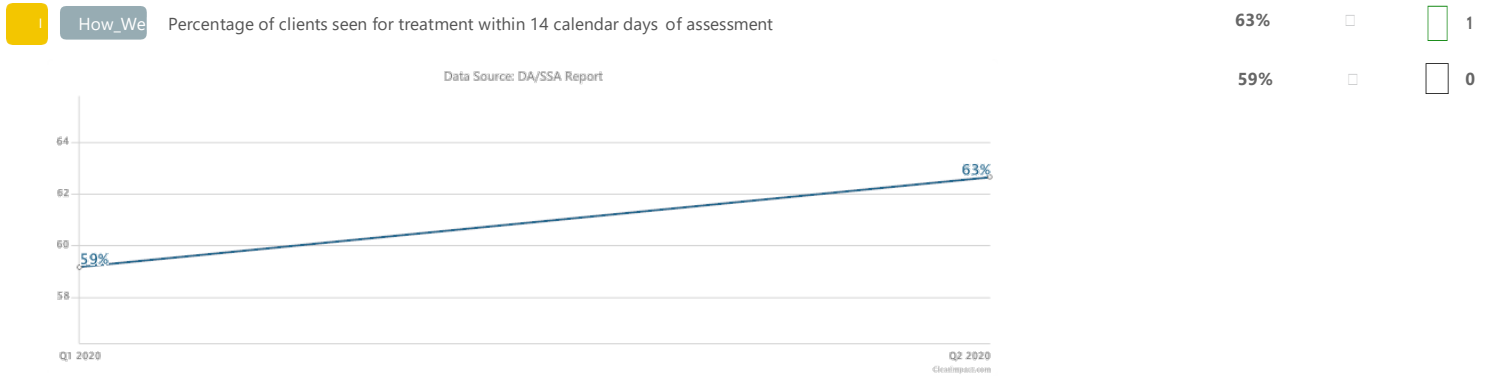
Strategy

Notes on Methodology

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

- Numerator = # of inactive clients offered a face to face (or telehealth) appointment within five calendar days

- Denominator = Total # of inactive clients calling saying they need help.



Story Behind the Curve

Calendar Year 2020 is the first year that agencies are reporting on this measure. DMH will be using this data to determine a baseline for the percentage of clients seen for treatment within 14 calendar days of their initial assessment, and utilize that information to set future year quality and performance targets. DMH utilized this measure because clients who receive continuous care are more likely to remain engaged in care.

Partners

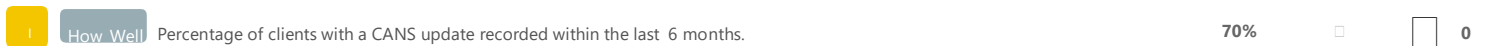
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

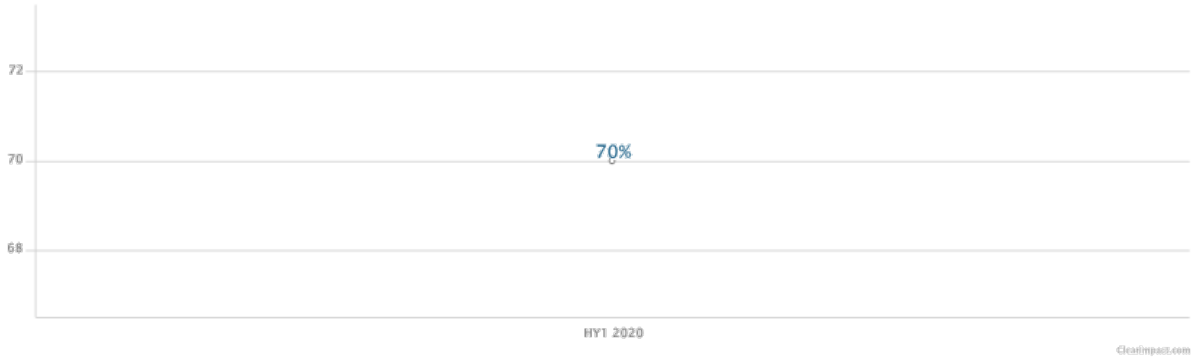
What Works

Strategy

Notes on Methodology

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





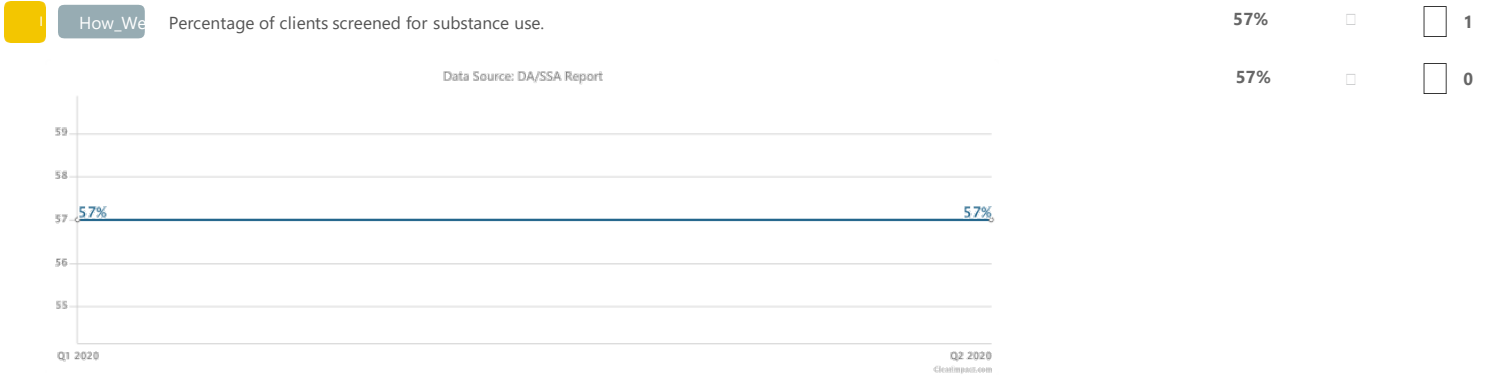
Story Behind the Curve

Partners

What Works

Strategy

Notes on Methodology



Story Behind the Curve

Calendar Year 2020 is the first year that agencies are reporting on this measure. DMH will be using this data to determine a baseline for the percentage of clients screened for substance use with the CAGE-AID and utilize that information to set future year quality and performance targets.

Partners

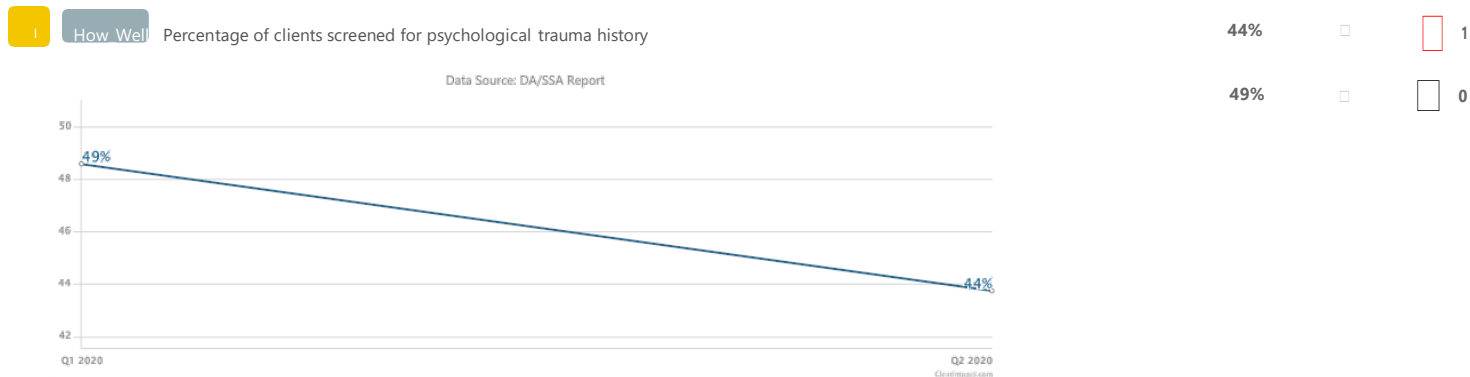
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric

What Works

Strategy

Notes on Methodology

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



Story Behind the Curve

Calendar Year 2020 is the first year that agencies are reporting on this measure. DMH will be using this data to determine a baseline for the percentage of clients screened for psychological trauma using the PC-PTSD-5, and utilize that information to set future year quality and performance targets.

Partners

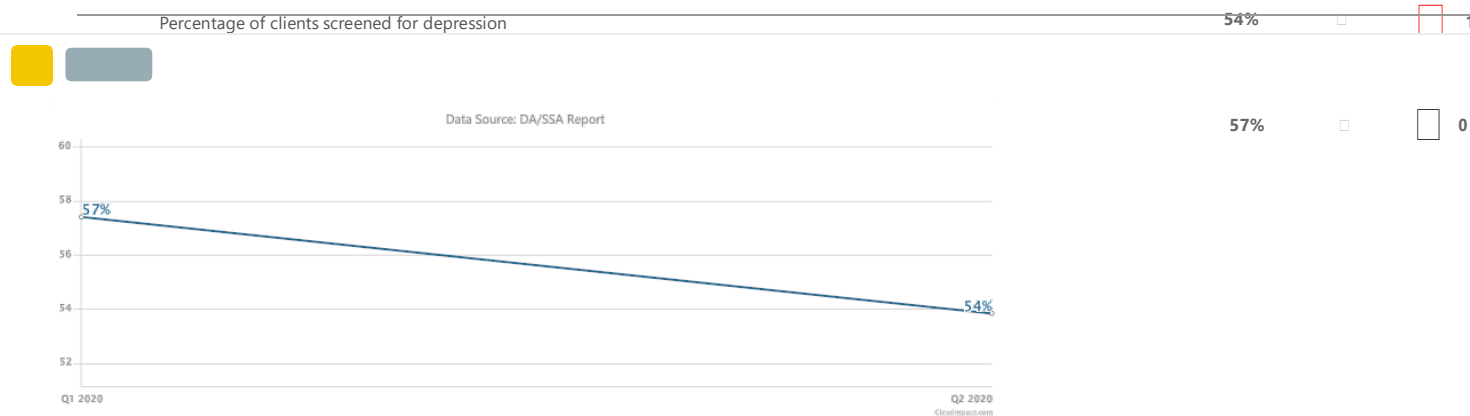
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

What Works

Strategy

Notes on Methodology

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



Story Behind the Curve

Calendar Year 2020 is the first year that agencies are reporting on this measure. DMH will be using this data to determine a baseline for the percentage of clients screened for depression using the PhQ2/9, and utilize that information to set future year quality and performance targets.

Partners

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What Works

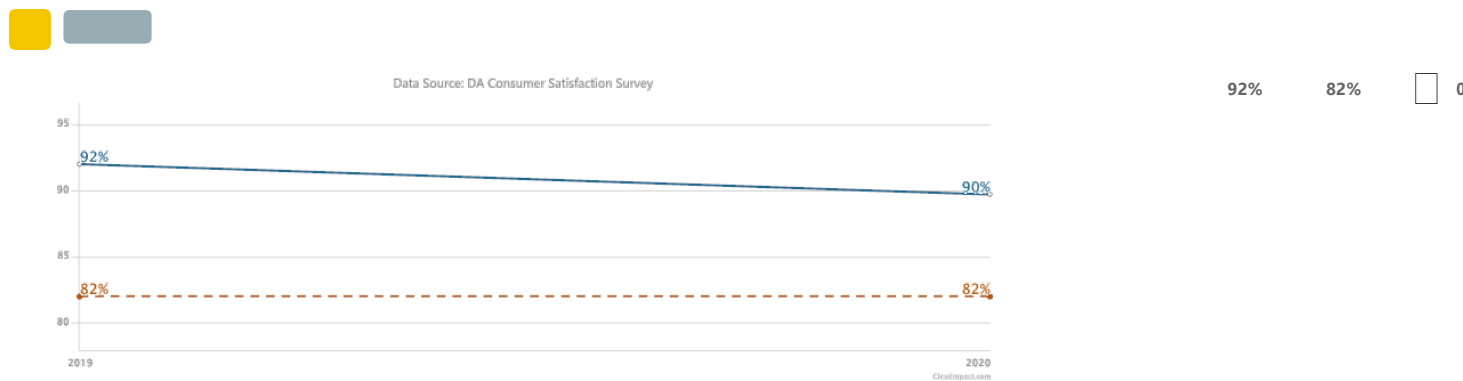
Strategy

Notes on Methodology

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

Better Off VBP: Better Off Measures

Current Actual Value 92%
Current Target Value 82%
Current Trend 0



Story Behind the Curve

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

Partners

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

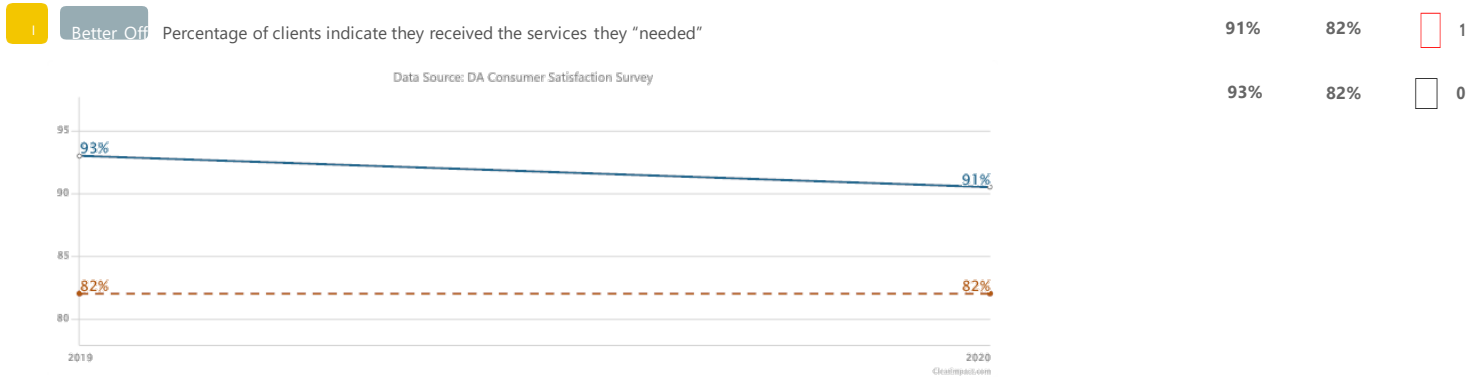
What Works

Strategy

Notes on Methodology

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

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



Story Behind the Curve

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

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What Works

Strategy

Notes on Methodology

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

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

Percentage of clients indicate they were treated with respect

95% 87% 1



Story Behind the Curve

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

Partners

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

What Works

Strategy

Notes on Methodology

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

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

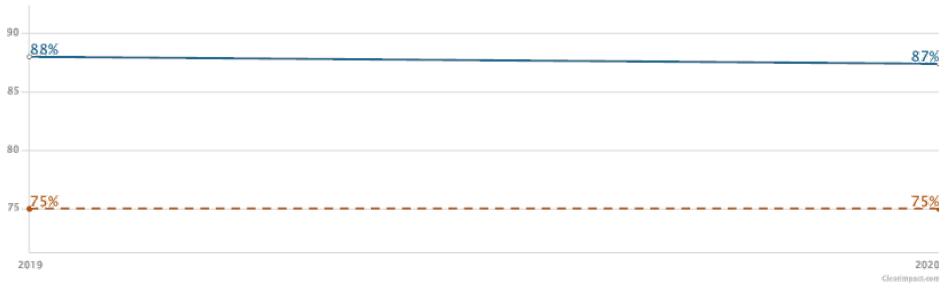


Percentage of clients indicate services made a difference

87% 75% 1

88% 75% 0

Data Source: DA Consumer Satisfaction Survey



Story Behind the Curve

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

Partners

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What Works

Strategy

Notes on Methodology

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