State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115
Demonstration Year: 20
(1/1/2024 – 12/31/2024)

Quarterly Report for the period July 1, 2024 – September 30, 2024

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I. Background and Introduction

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

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

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

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

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

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

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

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

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

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

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

2024: On July 2, 2024, Vermont received approval to amends the Global Commitment to Health Waiver to provide Medicaid coverage for individuals transitioning out of incarceration. As outlined in the federal waiver, sentenced incarcerated individuals will become eligible for Medicaid 90 days before their release.

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit progress reports 60 days following the end of each quarter. ***This is the third quarterly report for waiver year 20, covering the period from July 1, 2024, through September 30, 2024 (QE092024).***

II. Outreach/Innovative Activities

Member and Provider Services

Key updates from QE092024:

- Non-Emergency Medical Transportation (NEMT) Updates.
- Coordination of Benefit Activity

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

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

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

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

NEMT Update

For the third quarter of 2024, VPTA (DVHA's non-emergency medical transportation contractor) continued to complete a steady number of rides to a consistent number of transportation-eligible VT Medicaid members. In July, 24,557 rides were provided to 6,708 members. In August, 24,471 rides were given to 6,688 members; and in September, it was 21,623 rides provided to 6,601members. As has been the case over the past year, the number of both complaints and member no shows has remained consistent with numbers from the previous calendar quarter.

Coordination of Benefit Activity

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

Areas of activities:

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

Coordination of Benefit Collection Table:

MPS – Coordination Recovery Activities "Q3"	
Casualty	$663,347.16
Estate	342,207.22 $
Third-Party & Court-Ordered Medical	138,827.06 $
Medicare Prescription Drug Premium/Claims	$32,780.01
Over Resource/Hospice/Patient Share/Credit Balance	$380,621.95
Annuity/Trust/Waiver	$106,396.97
Lamp/Map, Medicare Claim Recoupment	$88,771.16
Third-Party Claim Recoupment	$10,327.59
Total	**1,763,279.12 $**

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

Coordination of Benefit-Cost Avoidance Table:

Cost Avoidance "Q3"	
Third-Party Liability	$15,930,841.54
Medicare	$254,415,606.04
Total	**$270,346,447.58**

III. Operational/Policy Developments/Issues

Key updates from QE092024:

- The Customer Support Center received 54,815 calls in QE0924, down 19% from the previous year.
- During this period, DVHA has done significant work to create clear external messaging about the changes for this Open Enrollment. This has included developing accessible information and collaborating with key external partners to algin messaging and message timing.
- Increasing numbers of customers are using self-service functions. Self-serve applications comprised slightly under half (47%) of all applications in QE0924.

Vermont Health Connect

Enrollment

As of QE0924, more than 197,630 Vermonters were enrolled in Vermont Health Connect (VHC) health plans either through the marketplace or directly through an insurance carrier. This enrollment consisted of 125,853 in Medicaid for Children and Adults (MCA) and 71,777 in Qualified Health Plans (QHPs), with the latter divided between 30,742 enrolled with VHC, 4,272 direct enrolled with their insurance carrier as individuals, and 36,763 enrolled with their small business employer.

Medicaid Renewals

The new automated individual ex parte system update was first used for renewals initiated in July. VHC

can now renew some members of a household ex parte while setting others up for a manual renewal, instead of sending a renewal form for the whole household. Ex parte success rate for individuals for the quarter was 75%. Continued use of unwind waivers and flexibilities are helping to maintain a high level of automatic renewals.

1095 Tax Forms

The last corrections run for PY 2023 1095B was April 23, 2024. Preparations are currently underway for PY 2024 generation which begins in December.

Customer Support Center

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

The Customer Support Center received 54,815 calls in QE0924, down 19% from the previous year. During the last quarter, Maximus answered 86% of calls within 24 seconds.

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. 8.1% of QE0924 calls were transferred to DVHA-HAEEU staff, up from 6.5% in QE0923. Just as importantly, DVHA strived to answer all calls that were transferred; 96% of transferred calls were answered in five minutes in QE0924.

Timely Processing of Member Requests

In the spring of 2016, DVHA-HAEEU set a goal of completing 75% of member requests within ten business days. In QE0923, more than 98% of the VHC requests were completed within the same ten-day time frame and 99% in QE0924.

In-Person Assistance

Following a successful Annual Conference and Recertification training sessions in September, the Assister Program is nearing the end of the annual recertification process.

Training and support for Assisters is ongoing, with bi-weekly webinars, a bi-weekly newsletter. Current topics are focused on Open Enrollment for Qualified Health Plans.

Current participation in the Assister Program stands at 138 Assisters (129 Certified Application Counselors, 3 Navigators, and 6 Brokers). Recruiting for the Assister program has seen some recent successes, including 19 new Assisters from the State of Vermont Blueprint to Health Program, a scheduled class of 10 Assisters embedded within Vermont businesses through the United Way Working Bridges program, and

some promising meetings with organizations connected to Vermont non-citizen communities – Trusted Community Voices, Grace Initiative, and the Brattleboro Development Credit Corporation.

Outreach

In addition to the work related to clear messaging about the changes for this Open Enrollment, DVHA also planned additional routine Open Enrollment communications like training, website updates, and various other communication mediums.

The Plan Comparison Tool is a key educational tool. It is used by Vermonters to find a health plan that best fits their needs and budget. It is a core piece of DVHA's educational tools. The Tool was used in over 13,000 sessions during the quarter.

Self-Service

During QE0924, DVHA-HAEEU continued to promote self-service options for customers to apply, report changes, renew coverage, 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, self-serve applications comprised under half (47%) of all applications in QE0924.

Global Commitment Register

The Global Commitment Register (GCR) is a database of policy changes to and clarifications of existing Medicaid policy under Vermont's 1115 Global Commitment to Health waiver. Created in November 2015, it is based on the Federal Register and can be used as both a public notice and documentation tool for Medicaid policy. Like the Federal Register, the GCR can be used to publish a proposed policy, including information on public comment submissions, final policy, notices, and policy clarifications. The GCR is available on the Agency of Human Services website to ensure that policy changes are transparent to Vermonters and to provide a forum for public comments.

The GCR listserv is a group of hundreds of interested parties who have elected to receive periodic key updates about Vermont health care programs, which includes policy changes to all Medicaid programs as well as policy changes to Vermont's Health Benefit Exchange. Policy changes posted to the GCR include changes made under the authority of the 1115 waiver, proposed waiver amendments or extensions, administrative rule changes, changes to rate methodologies, and State Plan Amendments. The GCR also contains policy clarifications for when an issue is identified that is not answered in the current policy.

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

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

Policy or Administrative Difficulties

These topics are raised and addressed during monthly wavier monitoring calls with CMS.

Key Operational and Other Challenges

These topics are raised and addressed during monthly wavier monitoring calls with CMS.

State Legislative Developments

There were no state legislative developments that impacted the demonstration during this reporting period.

Marketplace Subsidy Program

Number of individuals served – 13,272 in SFY 2024
Size of the subsidies - $5,627,707 year to date actuals through 6/30/2024

IV. Financial/Budget Neutrality Development/Issues

As is the monthly process, AHS paid DVHA 1/12th of the legislative budget for Global Commitment on the first business day of each month during the July – September 2024 quarter. This payment served as the proxy by which to draw down federal funds for Global Commitment (GC).

As is the process after each quarterly submission of the CMS-64, AHS reconciled the quarterly amount claimed on the CMS-64 with the monthly payments made to DVHA. The State prepared the CMS-64 based upon actual allowable Medicaid expenditures (program, investments, and administration) for the given quarter.

This quarter represents the third quarter of DY20 of the GC Waiver. Vermont calculates $1.104B for without waiver expenditures and reported $1.206B with waiver expenditures, leaving a deficit subtotal of $102M. There are also 10 Hypothetical Tests for various demonstration groups. The hypothetical tests for New Adult, SMI IMD, Maternal Health & Treatment Services, CRT and Moderates reflect a surplus. Whereas the test for SUD IMD, Global Rx, and Marketplace Subsidies shows a moderate deficit. The total of the deficit is $7.67M, which reduces the cumulative Waiver savings to $80.66M deficit. There is nothing to report for the Housing Pilot or SUD CIT because those programs have not yet been operationalized. Lastly, for Investments, Vermont reported $25.36M in expenditures for the quarter which leaves $85M available for the remainder of DY20.

We note the Budget Neutrality deficit, and this will be mitigated through the proposed pmpm updated rates that account for provider rate increases that were implemented beginning 7/1/2022.

Vermont continues to implement HCBS programs using the Reinvestment funds under the American Rescue Plan of 2021. For QE0924, Vermont reported $340K in Program expenses, $2.1M in Investments, and $1.189M in Admin expenses.

Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately

Total contributions, withdrawals, balances, and credits

A comparison of projected costs with actual costs.

SMI/SED Maintenance of Effort (MOE)

V. Member Month Reporting

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

The table below contains Member Month Reporting for DY19 and DY20 and includes the unduplicated count of member months for SUD IMD and SMI IMD stays.

Table 1. Member Month Reporting – ***subject to revision due to retroactive enrollment***

Medicaid Eligibility Group	Total DY 2018	Total DY 2019	Total DY 2020
ABD - Non-Dual - Adult	**38,226**	**88,762**	**67,271**
ABD - Non-Dual - Child	**8,739**	**22,381**	**17,407**
ABD - Duals	**136,650**	**275,676**	**198,694**
Non - ABD Adult	**112,369**	**205,008**	**108,295**
Non - ABD Child	**378,139**	**733,460**	**509,036**
Hypothetical Groups			
New Adult	**454,502**	**874,138**	**553,636**
SUD - IMD ABD	**51**	**142**	**82**
SUD - IMD ABD Dual	**70**	**156**	**80**
SUD - IMD Non ABD	**121**	**430**	**115**
SUD - IMD New Adult	**623**	**1,299**	**974**
SMI - IMD ABD	**55**	**127**	**131**
SMI - IMD ABD Dual	**10**	**28**	**25**
SMI - IMD Non ABD	**20**	**173**	**44**
SMI - IMD New Adult	**174**	**350**	**275**
Housing Pilot	**0**	**0**	**0**

Maternal Health and Treatment Services	**114**	**343**	**173**
CRT	**1,213**	**2,437**	**2,305**
SUD CIT	**0**	**0**	**0**
VT Global RX	**55,178**	**108,758**	**82,471**
Moderate Needs Group	**731**	**1,367**	**1,064**
Marketplace Subsidy	**60,841**	**139,440**	**129,558**

Yearly unduplicated enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement.

VI. Consumer Issues

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

Public Forums

The Medicaid and Exchange Advisory Committee is a federally required committee with the opportunity to participate in Medicaid policy development and program administration. The Medicaid and Exchange Advisory Committee meets 10 times per calendar year, taking a recess in August and December, on the 4th Monday of each month unless otherwise noticed. Meetings are held from 10AM – 12PM and are open to the public. Meeting minutes for each meeting are publicly posted here: https://dvha.vermont.gov/advisory-boards/medicaid-and-exchange-advisory-committee.

Additionally, public forums are occasionally held for administrative rule making or when the 1115 waiver is being amended or renewed. In such instances, information about each forum is publicly posting on Vermont's Global Commitment Register. Forums of this nature will be reported in the Global Commitment Register section of this report.

VII. Quality Improvement

Quality Assurance and Performance Improvement Activities

Key updates from QE092024:

- DVHA submitted, for the first time, results for CMS' HCBS Compliance Measure Set.
- DVHA successfully completed 3 EQR audits. DVHA continued its formal PIP focused on new-to-Medicaid (NTM) screening.

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

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

PIHP Quality Committee

The Quality Committee remained active during QE0924 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. Topics addressed this quarter included annual review of Global Commitment Key Performance Measure Set.

Home and Community-Based Services (HCBS) Quality Subcommittee

The HCBS Quality subcommittee is coordinated by DVHA and includes representatives from DAIL and DMH, the departments that are delegated service delivery to Vermont Medicaid's HCBS special health care needs populations. During this reporting period, the committee submitted data for CMS' HCBS Compliance Measure Set. Committee members also worked with a contracted vendor to develop the state's first HCBS CAHPS survey. This survey will be administered during QE1224.

Formal CMS Performance Improvement Project (PIP)

DVHA's formal PIP topic is focused on new-to-Medicaid (NTM) members receiving an initial screening within 90 days of their enrollment. Regulatory review identified this as an area for improvement. During this reporting period, a cross-Agency team researched and created a crosswalk of NTM reports currently in use. Preferred report parameters will be identified and communicated as part of this project.

Quality Measure Reporting

HEDIS measure production –In addition to producing and reporting on administrative (claims-based) measures annually, the Quality Improvement, Clinical and Data teams work with our quality measures vendor to produce hybrid measures. The Medical Record Review (MRR) process, including chart retrieval and abstraction, was completed during QE0624 for four hybrid measures.

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CAHPS Experience of Care measures – The Quality Unit worked with our contracted vendor to finalize the 2024Health Plan CAHPS surveys for Adults and Children. These surveys will be administered during QE1224.

Vermont Next Generation Medicaid ACO

During QE0924, DVHA's Director of Quality Management received, reviewed, and approved the quarterly VMNG ACO quality management reports. Quality and Clinical staff from DVHA and the VMNG ACO also meet quarterly with a focus on quality measurement and ongoing QI efforts.

Comprehensive Risk Assessment

Staff from DVHA's Quality, Oversight & Monitoring, and Compliance units maintain a comprehensive risk assessment program for Vermont's Medicaid program. The purposes of this joint effort are to:

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

The assessment entails collaboration with other Agency departments and informs updates to inter-agency partner agreements.

During QE092024, the risk assessment team coordinated the successful completion of the following 2024 EQR audits: Managed Care Compliance, Performance Measure Validation (PMV) and a new Network Adequacy Validation (NAV).

Global Commitment (GC) Investment review.

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

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

Payment Models & Performance Monitoring

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

investment is achieving its desired goal), results (performance measure rates for the most recent reporting period), and an interpretation of the results (i.e., comparing actual to expected rates using performance targets and/or benchmarks and to characterize trends or patterns in the data). During this most recent quarter, DMH highlighted the performance of their payment model. The Clear Impact Scorecard for this payment model is included in this report as Attachment 7.

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

The quality strategy is intended to serve as a blueprint or road map for states and their contracted health plans in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. In the Special Terms and Conditions (STCs) of the State's recent waiver extension, CMS has included prescriptive 1915(c) HCBS quality requirements for the State's 5 HCBS programs (CFC, DS, BIP, CRT, MH Under 22). As a result, the State is required to extend its existing quality strategy to include HCBS. During this quarter, the State continued to identify the HCBS Quality Improvement Strategy (QIS) guidance as they update their broader waiver Quality Strategy. The QIS for VT HCBS is a part of the state's overall 1115/Medicaid Quality Strategy and as such the HCBS specific QIS may be imbedded within this larger approach. The state continues to review and revise their overall approach and will be updating the sections related to HCBS to reflect the use of the new HCBS measure set that the state is piloting with CMS as well as the new Access and Medicaid Managed Care Rule requirements.

SUD Monitoring Protocol and Reports

The SUD Monitoring Protocol specifies the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements of the demonstration. During this quarter, the state submitted quarterly narrative and data monitoring reports for the substance use disorder (SUD) component of the Global Commitment to Health demonstration, to the Centers for Medicare & Medicaid Services (CMS), as required by the state's special terms and conditions (STC).

SUD Midpoint Assessment

As per STC 9.4 the state must conduct an independent mid-point assessment by June 30, 2025. In the design, planning and conduction of the mid-point assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to SUD treatment providers, beneficiaries, and other key partners. During Q3, the state continued to work with the evaluator to develop the assessment. Specifically, the state worked to help develop the survey instrument that will be completed by SUD stakeholders. AHS will continue to work with the evaluator to complete the midpoint assessment.

SMI Monitoring Protocol and Reports

The SMI Monitoring Protocol specifies the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements of the demonstration. During this quarter, the state submitted quarterly narrative and data monitoring reports for the serious mental illness (SMI) component of the Global Commitment to Health demonstration, to the Centers for Medicare & Medicaid Services (CMS), as required by the state's special terms and conditions (STC).

SMI Midpoint Assessment

As per STC 10.8 the state must conduct an independent mid-point assessment by June 30, 2024. In the design, planning and conducting of the mid-point assessment, the state must require that

the independent assessor consult with key stakeholders including, but not limited to: SMI/SED providers, beneficiaries, and other key partners. During Q2, the mid-point assessment was completed by an independent evaluator and submitted to CMS. The state is currently awaiting CMS feedback.

VIII. Demonstration Evaluation Activities

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

Overall Waiver

During the quarter, the state continued to work with an independent evaluator to assess access to data sources and the availability of metrics to support the overall waiver. The Medicaid Management Information System (MMIS) has been identified as a critical data source. The state plans to use Globalscape EFT as their managed file transfer solution. A request was submitted to create a Globalscape account for the independent evaluator. It is anticipated that this account will be available for use during the next quarter.

Innovative Assessment Evaluation

The state plans to evaluate all investments authorized under the demonstration in accordance with STC 15.3. Hypotheses for investments will reflect appropriate goals for each area of investments as described in STC 11.1 and broadly assess whether they collectively contribute to the goals of the demonstration, such as the reduction of disparities in health outcomes. During this quarter, the state received the first investment assessment report from the independent evaluator. The report included, but was not limited to, the following content: overview, methodology, findings, and discussion. In addition, strengths and challenges were addressed – along with areas for further assessment. The state will continue to support the evaluator as they complete the first set of priority investments.

Summative Evaluation Report

The draft Summative Evaluation Report covers the 2022–2027 demonstration period. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals. During this quarter, the state continued to work with the independent evaluator to plan for the summative evaluation report.

PHE Flexibilities

There was no evaluation activity associated with the COVID-19 public health emergency (PHE) during this quarter.

Waiver Performance Evaluation

During Q3 2024 the state received the first deliverables from their new evaluator, University of Massachusetts. In addition to identifying metrics designed to enhance the state's ability to assess the performance of their Medicaid managed care model, the deliverable identified gaps in metrics, as well as potential data sources needed to produce the metrics. This state will continue to work with the evaluator to update this deliverable over the course of the next quarter.

IX. Compliance

Key updates from QE092024:

- EQRO Review Activities – Planning for all 2024 activities continue. Final review material sent to DVHA.
- SIU Activities are included in this section.

External Quality Review

During this quarter, the state's EQRO, HSAG, performed a fully remote version of their annual review of compliance with standards. Activities included a desk review of documents and conducting virtual interviews with key staff members. These annual audits follow a three-year cycle of standards. During this year's review, HSAG evaluated the degree to which DVHA complied with federal Medicaid managed care regulations and the associated AHS intergovernmental agreement (IGA) in three performance categories (i.e., standards). The three standards included requirements associated with federal Medicaid managed care standards found at 42 CFR §438.236, §438.242, and §438.330.

The standards included requirements related to the following:

- Practice Guidelines
- Quality Assessment and Performance Improvement Program
- Health Information Systems

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

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

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

Lawsuits or Legal Actions

During the last quarter, no audits, investigations, or lawsuits occurred that impacted the demonstration.

Intra-Governmental Agreement (IGA) between AHS and DVHA

The AHS/DVHA IGA documents the Global Commitment to Health demonstration requirements between AHS and DVHA. As per the Special Terms and Conditions (STCs) of the waiver, this agreement must be reviewed and approved annually by CMS. During this quarter, the state began to draft the CY2025 agreement. The CY2025 IGA and Rate Certification is due to CMS on December 31, 2024.

Special Investigations Unit (SIU)

CMS has requested that the state provide them with quarterly reports detailing 1) the number of provider investigations conducted by the SIU as well as 2) the number of suspected fraud referrals provided to the state Medicaid agency by the SIU. This information for the current quarter is included in the table below.

Table 1. SIU Activity Q3 2024

REPORTING ELEMENT	#
The number of provider investigations conducted by the PIHP	37
The number of suspected fraud referrals provided to the state Medicaid agency by the PIHP	2
The number of Personal Care Assistant related suspected fraud referrals provided to the state Medicaid agency by the PIHP	0
Number of Provider Preventable Conditions Identified by the SIU in the second quarter of CY2024	0

X. Reported Purposes for Capitate Revenue Expenditures

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

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

XI. State Contact(s)

Fiscal	Richard Donahey, CFO VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	802-241-0442 (P) richard.donahey@vermont.gov
Medicaid Director	Monica Ogelby Vermont Medicaid Director Agency of Human Services 280 State Drive Waterbury, VT 05671-100	802-338-6643 Monica.ogelby@vermont.gov
Policy/Program	Ashley Berliner, Director of HealthCare Policy & Planning VT Agency of Human Services 280 State Drive Waterbury, VT 05671-1000	802-578-9305 (P) 802-241-0958 (F) ashley.berliner@vermont.gov
Managed Care Entity	Adaline Strumolo, Acting Commissioner of the Department of Vermont Health Access 280 State Drive Waterbury, VT 05671-1000	802-241-0147 (P) 802-879-5962 (F) adaline.strumolo@vermont.gov

XII. Attachments

Attachment 1	Budget Neutrality Workbook
Attachment 2	Complaints Received by Health Access Member Services
Attachment 3	Medicaid Grievance and Appeal Reports
Attachment 4	Office of the Health Care Advocate Report
Attachment 5	QE062024 Investments (GC Investments)
Attachment 6	Investment Scorecard(s)
Attachment 7	Payment Model Scorecard(s)

Date Submitted to CMS: November 29, 2024

Attachment 1

State of Vermont Global Commitment to Health
Budget Neutrality PMPM Projection vs 64 Actuals Summary
QE 0924

ELIGIBILITY GROUP	DY 18 Jul 2022 - Dec 2022	DY 19 Jan 2023 - Dec 2023	DY 20 Jan 2024 - Dec 2024
Without Waiver (Caseload x pmpms)			
ABD - Non-Medicare - Adult	$ 91,924,294	$ 220,931,956	$ 175,309,731
ABD - Non-Medicare - Child	$ 23,320,945	$ 60,980,419	$ 48,760,731
ABD - Dual	$ 289,588,696	$ 600,654,577	$ 449,244,120
Non ABD - Non-Medicare - Adult	$ 88,456,625	$ 168,948,603	$ 94,869,250
Non ABD - Non-Medicare - Child	$ 226,334,361	$ 457,972,821	$ 336,277,210
Total Expenditures Without Waiver	**$ 719,624,921**	**$ 1,509,488,377**	**$ 1,104,461,043**
With Waiver			
ABD - Non-Medicare - Adult	$ 95,250,705	$ 217,911,333	$ 183,372,382
ABD - Non-Medicare - Child	$ 20,360,439	$ 61,080,929	$ 51,086,645
ABD - Dual	$ 283,809,254	$ 616,434,108	$ 505,055,937
Non ABD - Non-Medicare - Adult	$ 56,470,924	$ 100,095,762	$ 66,156,862
Non ABD - Non-Medicare - Child	$ 173,656,454	$ 385,793,986	$ 318,515,688
Individual Cost Effective	$ -	$ -	$ -
Community Transition Services	$ -	$ -	$ -
MDAAP	$ -	$ 582,000	$ 285,500
Investments	$ 73,392,050	$ 110,768,382	$ 82,079,978
Total Expenditures With Waiver	**$ 702,939,826**	**$ 1,492,666,500**	**$ 1,206,552,992**
Waiver Savings Summary			
Subtotal Annual Savings	$ 16,685,095	$ 16,821,876	$ (102,091,949)
Hypothetical Test Deficits	$ (1,204,077)	$ (3,199,061)	$ (7,676,846)
Cumulative Savings	$ 15,481,018	$ 29,103,833	$ (80,664,962)
HYPOTHETICAL TESTS			
Hypothetical Test 1: New Adult			
Limit New Adult PMPM*MM	$ 261,350,820	$ 523,991,581	$ 350,787,104
New Adult Total Expenditures	$ 222,857,284	$ 445,820,821	$ 345,661,047
Surplus (Deficit)	$ 38,493,536	$ 78,170,760	$ 5,126,057
Hypothetical Test 2: SUD IMD			
SUD - IMD ABD - Non-Medicare - Adult	$ 156,312	$ 449,184	$ 270,541
SUD - IMD ABD - Dual	$ 129,959	$ 298,269	$ 159,077
SUD - IMD Non ABD - Non-Medicare - Adult	$ 342,876	$ 1,259,382	$ 351,968
SUD - IMD New Adult	$ 1,941,629	$ 4,220,302	$ 3,344,786
Limit SUD IMD PMPM*MM	**$ 2,570,776**	**$ 6,227,137**	**$ 4,126,372**
SUD - IMD ABD Non Medicare Adult	$ 156,753	$ 455,254	$ 434,248
SUD - IMD ABD - Dual	$ 236,032	$ 503,170	$ 438,081
SUD - IMD Non ABD - Non-Medicare - Adult	$ 380,721	$ 671,824	$ 632,415
SUD - IMD New Adult	$ 2,146,823	$ 4,876,050	$ 4,985,139
SUD IMD Total Expenditures	**$ 2,920,329**	**$ 6,506,298**	**$ 6,489,883**
Surplus (Deficit)	$ (349,553)	$ (279,161)	$ (2,363,511)
Hypothetical Test 3: SMI IMD			
SMI - IMD ABD - Non-Medicare - Adult	$ 3,070,568	$ 7,317,673	$ 7,872,721
SMI - IMD ABD - Dual	$ 357,432	$ 1,030,686	$ 957,066
SMI - IMD Non ABD - Non-Medicare - Adult	$ 726,715	$ 6,497,072	$ 1,726,794
SMI - IMD New Adult	$ 7,128,451	$ 14,947,557	$ 12,413,946
Limit SMI IMD PMPM*MM	**$ 11,283,167**	**$ 29,792,988**	**$ 22,970,527**
SMI - IMD ABD Non Medicare Adult	$ 1,622,662	$ 5,221,278	$ 4,025,807
SMI - IMD ABD - Dual	$ 525,975	$ 1,186,763	$ 818,413
SMI - IMD Non ABD - Non-Medicare - Adult	$ 700,985	$ 1,575,936	$ 1,101,023
SMI - IMD New Adult	$ 5,491,100	$ 13,081,690	$ 10,632,116
SMI IMD Total Expenditures	**$ 8,340,722**	**$ 21,065,667**	**$ 16,577,359**
Surplus (Deficit)	$ 2,942,445	$ 8,727,321	$ 6,393,168
Hypothetical Test 4: Housing Pilot			
Limit Housing Pilot PMPM*MM	$ -	$ -	$ -
Housing Pilot Total Expenditures	$ -	$ -	$ -
Surplus (Deficit)	$ -	$ -	$ -
Hypothetical Test 5: Maternal Health and Treatment Services			
Limit Maternal Health and Treatment Services PMPM*MM	$ 1,105,887	$ 3,361,989	$ 1,719,267
Maternal Health and Treatment Services Total Expenditures	$ 1,179,899	$ 3,212,211	$ 1,041,784
Surplus (Deficit)	$ (74,012)	$ 149,778	$ 677,483
Hypothetical Test 6: CRT			
Limit CRT PMPM*MM	$ 6,149,760	$ 12,788,302	$ 12,664,118
CRT Total Expenditures	$ 4,735,011	$ 11,488,848	$ 9,527,974
Surplus (Deficit)	$ 1,414,749	$ 1,299,454	$ 3,136,144
Hypothetical Test 7: SUD CIT			
Limit SUD CIT PMPM*MM	$ -	$ -	$ -
SUD CIT Total Expenditures	$ -	$ -	$ -
Surplus (Deficit)	$ -	$ -	$ -
Hypothetical Test 8: Global Rx			
Limit Global Rx PMPM*MM	$ 4,928,451	$ 9,714,169	$ 7,366,237
Global Rx Total Expenditures	$ 5,708,962	$ 12,634,069	$ 12,490,207
Surplus (Deficit)	$ (780,511)	$ (2,919,900)	$ (5,123,970)
Hypothetical Test 9: Moderates			
Limit Moderates PMPM*MM	$ 609,493	$ 1,179,722	$ 961,390
Moderates Total Expenditures	$ 445,520	$ 879,923	$ 921,168
Surplus (Deficit)	$ 163,973	$ 299,799	$ 40,222
Hypothetical Test 10: Marketplace Subsidy			
Limit Marketplace Subsidy PMPM*MM	$ 2,027,688	$ 4,782,013	$ 4,615,786
Marketplace Subsidy Total Expenditures	$ 1,955,249	$ 4,623,575	$ 4,805,152
Surplus (Deficit)	$ 72,439	$ 158,438	$ (189,366)

Attachment 2

VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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

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

Questions, Complaints and Concerns Received by Health Access Member Services
July 1, 2024 – September 30, 2024

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 2024:

- **No issues reported**

August 2024:

- **Potential Scam:** Member called to report that she received a call from what she considers to be a scammer. She states the caller knew that she recently enrolled on a GMC program and called to do a survey asking about her recent enrollment asking for personal information, in which the member did not provide. Member states the caller/scammer already had her name and phone number. Member is concerned that information for new enrollments are somehow being accessed by scammers and would like to share her concerns with the state. The agent apologized for the inconvenience, reassured her that call was not from VHC/GMC and documented the feedback.
- **Potential Scam:** Rehabilitation counselor called to report that he is receiving what he suspects to be scam calls from individuals claiming to be Medicaid/Medicare providers trying to get information on behalf of patients and or himself such as Medicaid/Medicare member ID numbers. The agent apologized for the inconvenience, reassured them that call was not from VHC/GMC and documented the feedback.

- **Provider Complaint:** Member is concerned about not being able to get prescriptions from the pharmacy in a timely manner. Member feels as though it's not fair that XXXXXX pharmacy will not fill her prescription due to it being a high-cost medication. Member says she receives many excuses from the pharmacy when it's time to refill her prescriptions. The pharmacy stated she will need to take her 2 expensive medications to another pharmacy to be filled. The agent apologized for the inconvenience and documented the feedback.

September 2024:

- **Provider Complaint:** Member wanted Feedback submitted to express his frustration about having to keep calling the doctor's office to call Provider Services about facilitating the Prior Authorization. Member believes that Provider Services is not processing the Prior Authorization in a timely manner. His son is unable to pick up this prescription without the PA approved first. The supervisor apologized for the inconvenience and documented the feedback.
- **Covered Services:** Caller called because she wanted to let Medicaid know that the coverage is worthless. She explained that she knows many people who get claims denied and it is all Medicaid's fault. Specifically, her daughter isn't having her chiropractor visits covered. She went on to explain the provider has spent countless hours on the phone with provider services and got nowhere. She states he is no longer accepting Medicaid due to this. She also explained she knows dentists aren't accepting Medicaid anymore because all their claims get denied. She wanted the feedback documented as she believes it is criminal and wants someone to fix Medicaid. She also explained that we need to actively find more providers. The supervisor apologized for the inconvenience and documented the feedback.
- **Provider Complaint:** Member called to submit negative feedback regarding XXXXXX. She said that they keep billing her for services that Medicaid paid and they bill her additional amounts and she does not believe that is right as they are a Medicaid dental provider. The agent documented the feedback and referred her to her Provider to contact Provider Services.
- **Provider Complaint:** Member called in to report that XXXXXXX is refusing to assist with filling prescription. They denied to contact GOOLD services / VHC customer serviced for a manual override or to verify coverage. The agent documented the feedback and referred her to her Provider to contact Provider Services.
- **Other Resources:** Member wanted to pass along a complaint about having a PA denied for a medication her son needs to have prior to treatment for a severe allergy. She did not understand why all of a sudden the medication needs a PA when she has never had to have one prior to this round of injections. She was frustrated that we did not have the answers and referred the provider to provider services to get any kind of form they need. She thinks we should be able to get any necessary forms and not bother the doctors and nurses with this type of necessary paperwork. The agent apologized for the inconvenience, documented the feedback and provided the customer with the information that we do have.

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Agency of Human Services

Grievance and Appeal Quarterly Report
Medicaid Managed Care Model
All Departments Combined Data
July 1, 2024 – September 30, 2024

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, 2024, through September 30, 2024.

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

During this quarter, there were twenty-five grievances filed and nine were addressed. Grievances must be addressed within 90 days of filing, so having pending cases at the end of the quarter is to be expected. Acknowledgement letters of receipt of a grievance must be sent within five days; the average was three days. DMH had 56%, DAIL had 36%, and VDH had 8% of the grievances filed.

Grievances were filed for service categories case management, mental health, community/social support, LTC, nursing, provider issues, psychiatric, and substance abuse.

There were no Grievance Reviews filed this quarter.

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

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

During this quarter, there were twenty-nine appeals filed. Of these twenty-nine appeals, seventeen were resolved, seven were still pending and three were withdrawn.

Of the seventeen appeals that were resolved this quarter, 76% were resolved within the statutory time frame of 30 days. The average number of days it took to resolve these cases was twenty-two days. Acknowledgement letters of receipt of an appeal must be sent within five days; the average was three days.

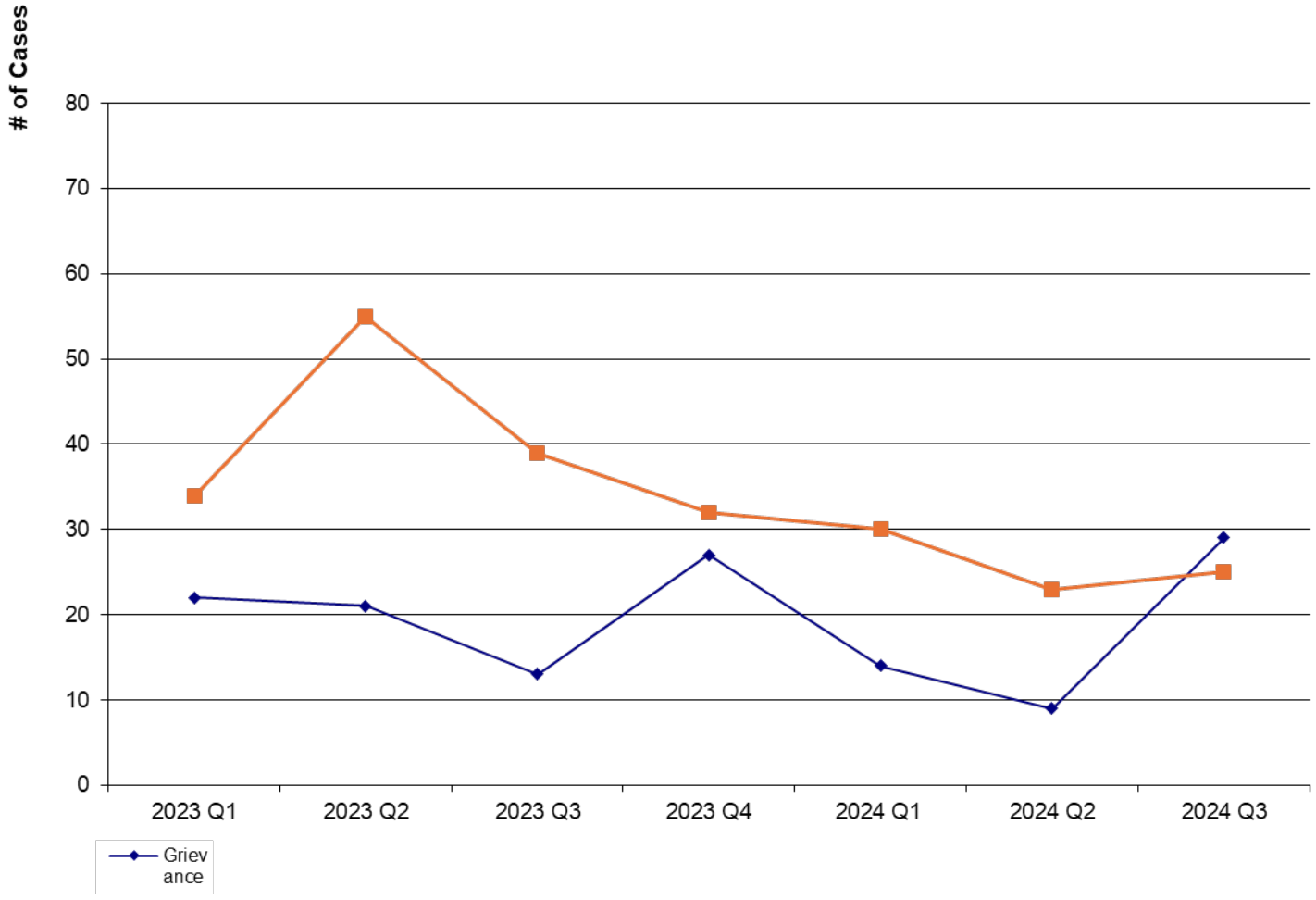
Of the twenty-nine appeals filed, DVHA had twenty-seven appeals filed (93%) and DAIL had two (7%).

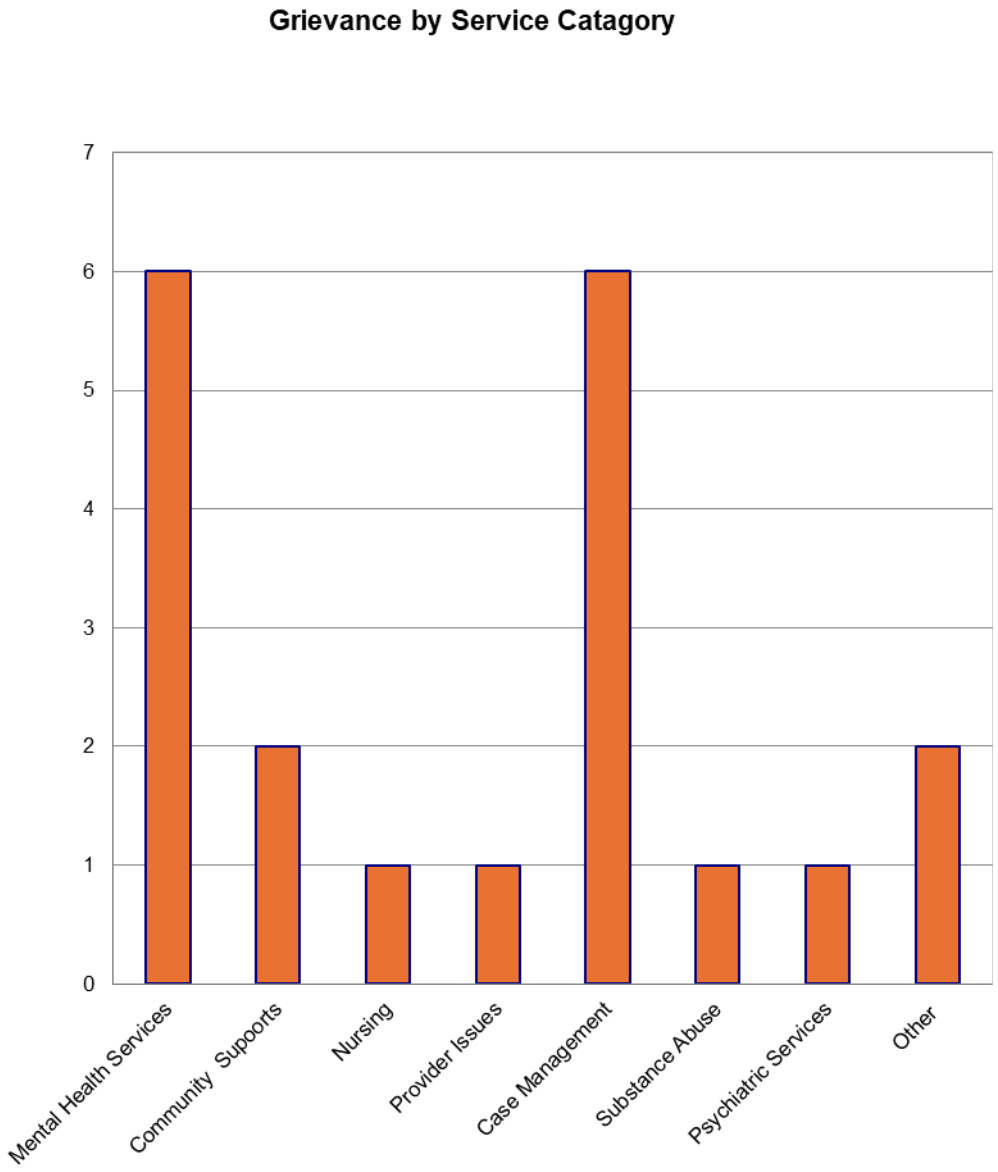
The appeals filed were for service categories dental, LTC, physical therapy, prescription drugs, DME, transportation and developmental.

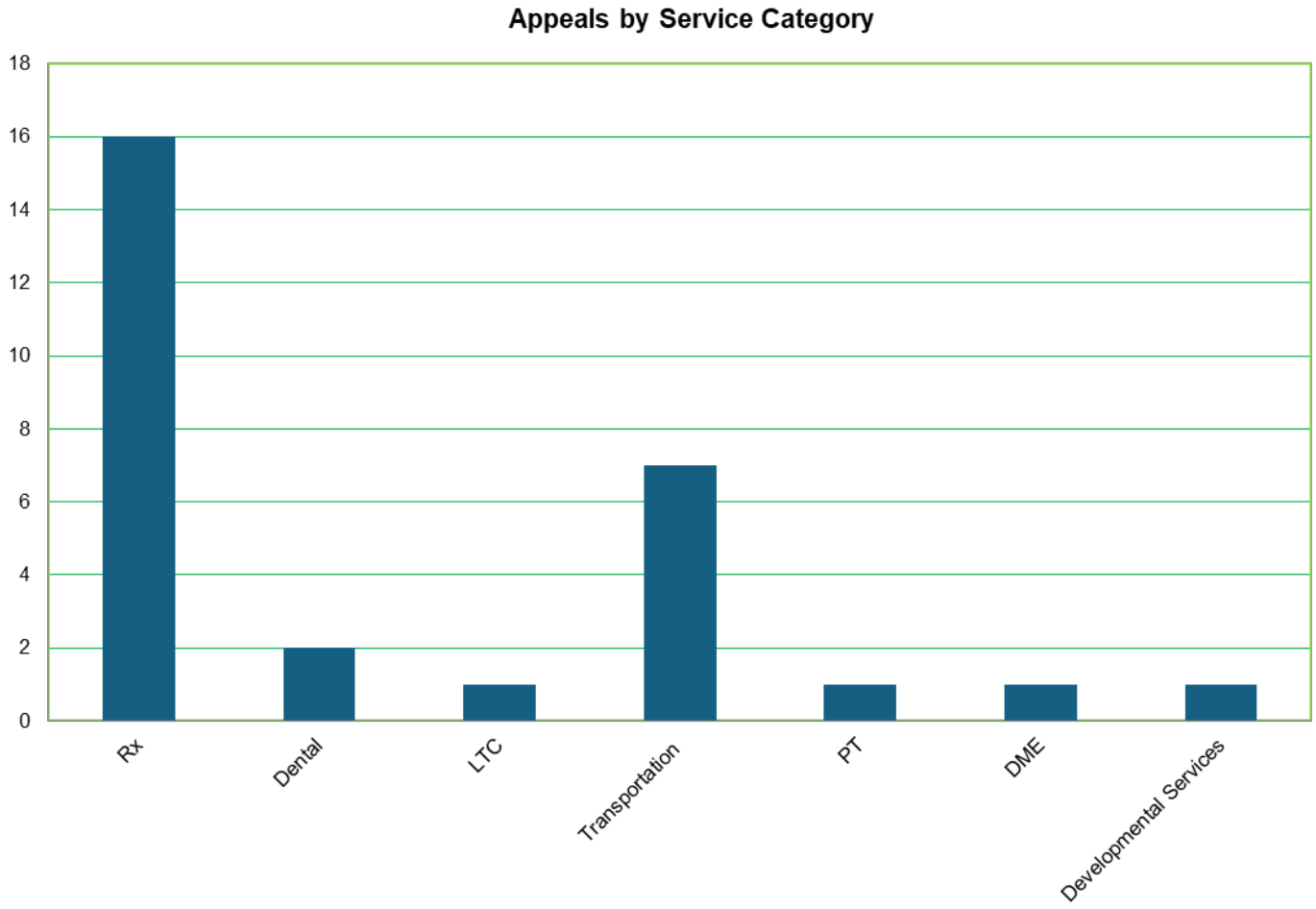
Beneficiaries must exhaust the internal appeal process before they can file a fair hearing if their appeal is not decided in their favor. There were two fair hearings filed this quarter.

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

Grievances and Appeals
January 1, 2023 thru September, 2024




Grievance by Service Catagory
7
6
5
4
3
2
1
0
Mental Health Services
Community Supoorts
Nursing
Provider Issues
Case Management
Substance Abuse
Psychiatric Services
Other


Appeals by Service Category
18
16
14
12
10
8
6
4
2
0
Rx
Dental
LTC
Transportation
PT
DME
Developmental Services

Vermont Legal Aid

Office of the Health Care Advocate

Quarterly Report

July 1-September 30, 2024

to the

Agency of Administration

submitted by

Michael Fisher, Chief Health Care Advocate

Office of the Health Care Advocate

October 21, 2024

Summary and Update

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

The HCA opened 717 cases this quarter (778, the previous quarter). During the quarter, Medicaid eligibility was again the top issue (103 calls), and our website had nearly 2000 page views, and our Medicaid eligibility page had 1145. We also advised 16 households on eligibility and coverage appeals regarding Medicaid and other state health care programs. In the appeal cases, the consumer's health coverage has been denied, closed, or reduced, or they have been found ineligible for a program. We give advice on the eligibility rules and the appeals process. We also received a considerable number of calls from Vermonters having issues getting prescription medication (30), and from those who had complaints about their medical providers (57). Provider complaints were the second most called about issue overall. The complaints about providers covered a wide range of issues including the provider not being responsive or not adequately addressing the patient's medical issues. We also had 21 calls about access to primary care and specialty care.

HCA has been working on consumer education and messaging, so consumers can understand their new opportunities for this Open Enrollment. In 2025, APTC eligible consumers will be eligible for more APTC and have increased buying power for gold and platinum plans on VHC. It is estimated that the improvement could be worth as much as $40 million of increased subsidies and increased buying power for Vermonters. Gold plans are also less expensive than silver plans in 2025, and both gold and platinum plans have lower deductibles and cost-sharing. With the increased APTC, many households could even move to premium free gold plans. VHC will map some of the silver enrollees to the most equivalent gold plan. By mapping some of the consumers, it will ensure that they can take advantage of increased APTC this year. Even if the consumers have been mapped to a gold plan, they still should compare plans because they can save significant money by switching to another gold plan.

Helena's Story:

Helena applied for Medicaid coverage earlier in the year and was denied for being over income. After she was denied, she had a medical emergency. She now had thousands of dollars of bills from the medical emergency, and no health care coverage. After her accident, Helena had to reduce her work hours. When the HCA advocate, reviewed her eligibility, she found that Helena was now income eligible for Medicaid due to her reduced work hours and pay. Helena was able to get Medicaid coverage going forward for the follow up care from her emergency. The HCA advocate also explained that if Helena increased her work hours in the future and her pay went above the Medicaid limit, she would have a special enrollment period for a VHC plan. The advocate also explained that Helena was eligible for financial assistance at the hospital and helped her with the application. Under Act 119, Vermonters with income under 250% FPL, like Helena, are eligible for 100% discount on medically necessary care. This meant that the costs from her medical emergency when she was uninsured would be covered in full by the hospital.

We have been working particularly on our outreach to BC/BS enrollees on Silver 87 and Silver 94 enhanced plans. This year the two insurance carriers on VHC had significantly different premium rate increases. The different premium increases and silver alignment particularly impacted enrollees on BC/BS Silver 94 and Silver 87 Enhanced plans. Enhanced silver plans offer lower out of pocket costs to income eligible Vermonters. To

be on a Silver 87 or Silver 94 you must be at or below 200 FPL. These enrollees were not mapped to gold plans, because the Silver 87 and 94 are more generous than gold plans. However, the BC/BS enrollees will see very significant premium increases unless they switch to an MVP Enhanced Silver Plan. The HCA is concerned if they do not switch, many of these households will not be able to afford the increased premiums. We are working on targeted outreach to this group. We are also going to be doing consumer education about the Special Enrollment Period that is available for Vermonters at or below 200 FPL. This SEP allows them to change plans during the year outside Open Enrollment.

The HCA continued its work on developing educational tools for hospitals and consumers in preparation for the implementation of the new Financial Assistance Policy statute (Act 119). Our news item on the new statute had over 2,271 views (some of these views were from out of state), and our webpage had 460 views. The changes include new definitions of residency and income. Under the law, people who have incomes under 250% of the Federal Poverty level will get a 100% discount from charges, and people with income between 250% FPL and 400% FPL will have a minimum of a 40% discount from charges. The HCA has been hard at work over the last year attempting to assist hospitals in complying with the new law. We talked to 13 households about patient financial assistance and another 16 about hospital billing.

Case Stories:

Willa's Story:

Willa called the HCA because she could not afford her prescription costs. She was signed up on a Medicare Part D plan, but she did not understand how the co-payments and deductible worked. She had also applied for VPharm, the state pharmacy assistance program to help with the costs, but her costs were still too high. The HCA advocate learned that it cost Willa more than $70 to refill three of her prescriptions. When you have VPharm, your copayments should be $1 or $2 per prescription, so the advocate could immediately see that there was a problem with VPharm coverage. VPharm coverage will start the month after the first premium has been received. When the HCA advocate investigated, she found that Willa had sent in her first VPharm premium payment, but the program had not been activated on the first day of the next month. This meant that Willa was not getting assistance with the copayments or the deductible. The HCA advocate helped get Willa's VPharm's coverage activated, which lowered her copayments and covers the Part D deductible. The next time she refilled her three prescriptions, the cost was less than $5.

Lando's Story:

Lando called because he could not pay for his Medicare costs. Lando was on Medicaid for Children and Adults, which does not have premium. But when he turned sixty-five, he lost eligibility for that program. He was also over income for the type of Medicaid that worked with Medicare. That type of Medicaid has a lower income limit than Medicaid for Children and Adults. Now that Lando was on Medicare, he had to pay for a Part B premium ($174.70) and a Part D premium, and he found he did not have enough money to meet all of his needs. The HCA advocate reviewed Lando's monthly income, and he found he was eligible for a Medicare Savings Program (MSP). This meant that the program would pay the Part B premium, and being on an MSP would make Lando eligible for a program called Extra Help, which would pay his Part D premium and reduce his copayments. The advocate helped Lando with the application for the program, and he was approved. This meant he was going to be saving over $200 a month for the costs of his Part B and D premiums alone, and he would also have significant savings on the copayments.

Eva's Story

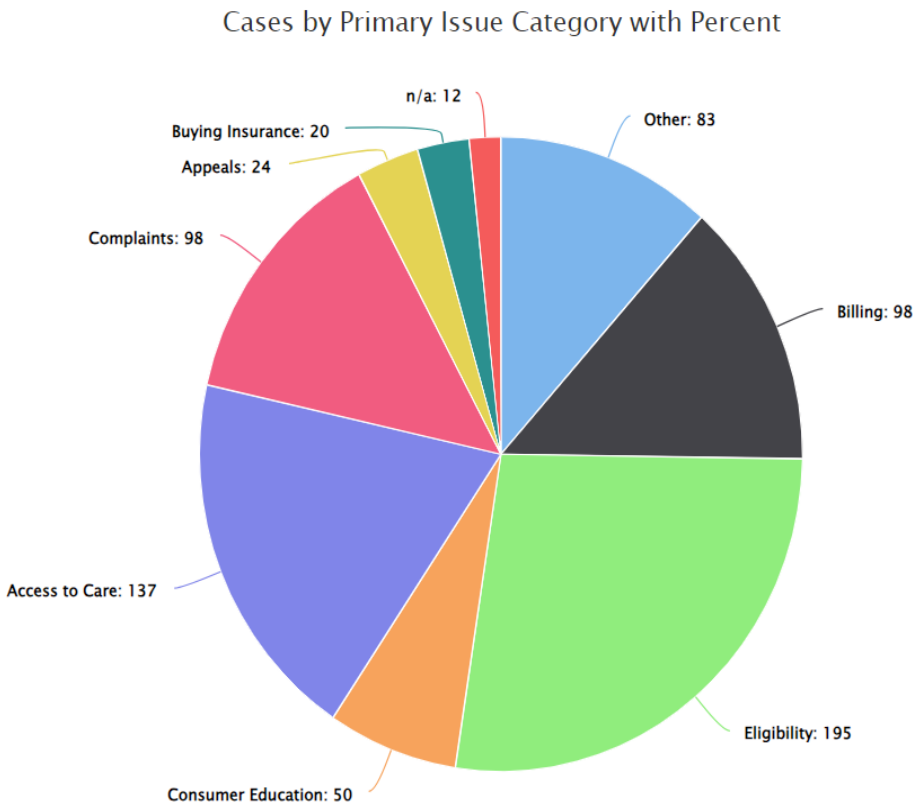
Eva needed help with her sons' health care coverage. She had applied for Dr. Dynasaur soon after she gave birth, but she had not heard about the application, so she did not know if she had been approved or denied. Dr. Dynasuar provides coverage for kids up to age 19, and it has no monthly premium or copayments. It also includes dental coverage. Eva had added the baby to her employer coverage, but the employer coverage had a lot of out of pockets costs, and the monthly premium was expensive. Dr. D would be more affordable for the family and offer better coverage. The HCA advocate investigated and found that the baby's Dr. D application had not been fully processed. The advocate helped complete it, and Eva's baby was approved. She also explained that Eva could apply for three months of retroactive Dr. D coverage. Eva's son had coverage under their employer plan during that time, but Dr. D could act secondary coverage, and possibly help with some of the out-of-pocket costs during those months. Eva was also able to take the baby off the employer plan going forward which saved the family money in premiums and provided more affordable coverage for the baby.

Overview

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

Primary Issue

The HCA received 717 calls this quarter. We assign cases a primary issue, depending on the nature of the legal issue. Normally, we have more Eligibility and Access to Care cases than the other issues, and that was true this quarter, with those two areas making up more than half of all HCA calls. The "Other" primary issue category includes communication problems with health benefit plans, access to medical records, changing providers or plans, confidentiality issues, and complaints about insurance premium rates, as well as other issues Callers' primary issue category.



Insurance Type:

The HCA also tracks its callers by insurance category. We do not collect insurance information for every case because sometimes it is not always relevant to the caller's issue. This quarter DVHA and Medicare cases made up over half of all cases (364 of 771 cases).

Number of Cases by Insurance: July 1 to September 30, 2024

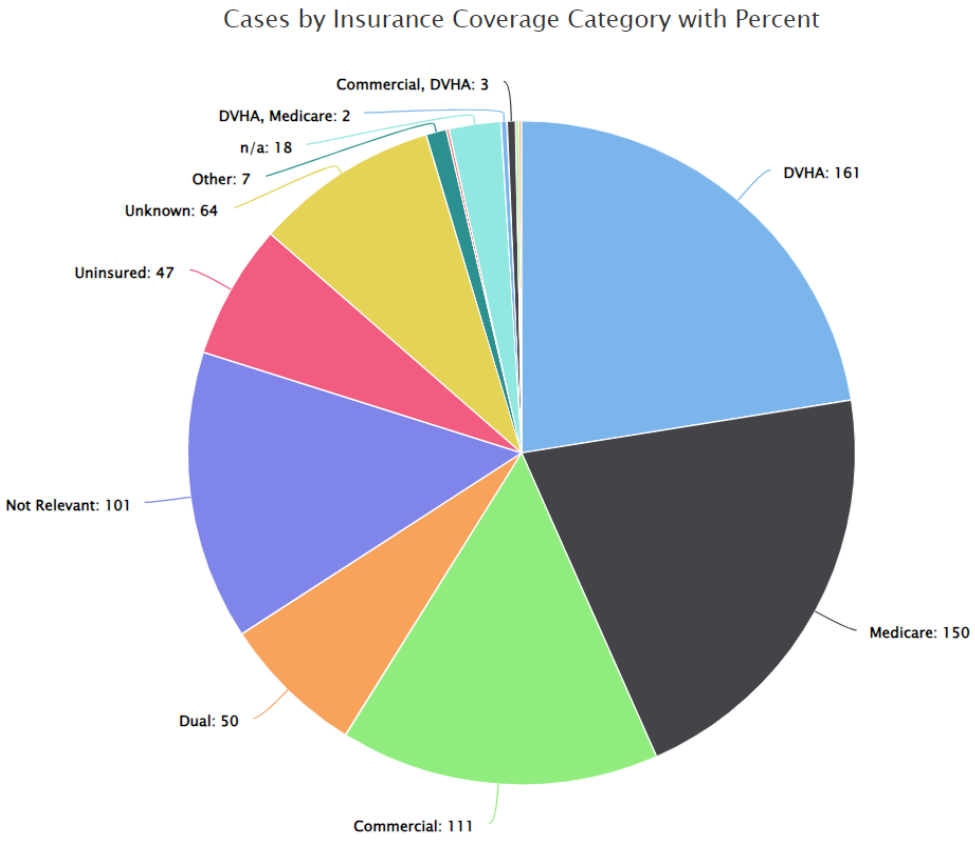


Table: Top Ten Primary Issues: July to September 30, 2024

All Cases: 717

All Cases: Top Ten Primary Issues

1. Eligibility for MAGI Medicaid 66
2. Provider Complaints 57
3. Eligibility for non-MAGI Medicaid 31
4. Access to Care Prescription Drugs 30
5. Access to Dental Care 24
6. Eligibility for Medicare Savings Programs 21
7. Complaints Hospitals 22
8. Billing Hospitals 16
9. Consumer Education Medicare 12
10. Provider Billing 11

DVHA Cases: total of 167 of 717 total cases

Top Five Primary Issues

1. Eligibility for MAGI Medicaid 36
2. Provider Complaints 11
3. Access to Non-MAGI Medicaid 10
4. Access to Dental 9
5. Provider Billing 5

Uninsured Cases: total 48 out of 717 cases

Top Three Primary Issues

1. Eligibility for MAGI 17
2. Eligibility for Premium Tax Credit 4
3. Eligibility for Special Enrollment Period 4

Commercial Cases: total of 115 out of 717 cases

Top Three Primary Issues

1. Eligibility for MAGI Medicaid 9
2. Buying Insurance QHP-VHC 8
3. Complaints Provider 6

Overall Cases Resolution

HCA tracks how it resolves its cases. A complex intervention means that the Advocate spent more than two hours on the case. A direct intervention means that the HCA Advocate made at least one call on behalf of the client.

Case Outcomes April1 to June 30, 2024

Brief Analysis and or Advice	315
Direct Intervention	66
Complex Intervention	41
Brief Analysis and Referral	225
Inquiry Answered During Initial Call	0
Duplicate Case	4
Other	5
Client Withdrew	1

Highlights of HCA

During this quarter, we provided 458 households with consumer education. We helped 48 households estimate their eligibility for insurance or get onto coverage. We assisted 7 households with their health insurance applications and prevented 4 households from losing their health insurance. We helped with 9 applications for the Immigration Health Insurance Plan and Emergency Medicaid. We saved consumers $420,958 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. The Board decided 6 premium price change requests during the quarter from July 1, 2024, through September 30, 2024. Two premium price change requests were pending at the close of the quarter.

Blue Cross and Blue Shield of Vermont (BCBSVT) submitted four of the premium price change requests decided by the Board this quarter: the BCBSVT 2025 Small Group filing, with a requested average increase of 21% that would affect roughly 22,018 Vermonters; the BCBSVT 2025 Individual filing, with a requested average increase of 24% that would affect roughly 23,164 Vermonters; the BCBSVT Association Health Plan filing, with a requested increase of 13.3% that would affect 1,610 Vermonters; and the BCBSVT 2025 Large Group Unit Cost Trend filing, with a requested increase that would affect 4,264 Vermonters. The HCA appeared on behalf of Vermonters in each of these filings. For the Small Group and Individual filings, the HCA reviewed documents and submitted pre-hearing questions,

facilitated public comments, engaged in oral advocacy and cross examination of BCBSVT and Board witnesses at the rate hearing, and filed post-hearing memorandums. Roughly 250 Vermonters submitted comments to the Board connected to the BCBSVT & MVP 2025 Individual and Small Group rate filings. For the Association Health Plan and Large Group Unit Cost Trend filings, the HCA reviewed documents and submitted memorandums in lieu of hearing. The Board approved, but modified, each of the four premium price change requests.

MVP submitted the other two premium price change requests decided by the Board this quarter: the MVP Small Group filing, with a requested increase of 11.5% that would affect roughly 15,027 Vermonters; and the MVP Individual filing, with requested increase of 14.9% that would affect roughly 10,616 Vermonters. The HCA has appeared on behalf of Vermonters in these two matters engaged in the following activities: reviewed documents and submitted pre-hearing questions, facilitated public comments, engaged in oral advocacy and cross examination of MVP and Board witnesses at the rate hearing, and filed post-hearing memorandums. Roughly 250 Vermonters submitted comments to the Board connected to the BCBSVT & MVP 2025 Individual and Small Group rate filings.

There were two premium price change requests pending at the close of this quarter: the Cigna Health and Life Insurance 2025 Large Group filing and the MVP 2025 Large Group filing. The HCA has appeared in both matters and will continue to take all appropriate actions to represent the best interests of Vermonters in the matters.

Hospital Budgets

The HCA actively participated in the hospital budget review process, providing oral and written public recommendations to the GMCB. The HCA recommended that the Board reduce hospital budget increase requests to the amount established in the Board's guidance and reduce the requests for hospitals that exceeded their budget orders from FY23. The HCA continues to advocate that the Board exercise its provider rate setting to address Vermont's affordability crisis. The HCA continues to actively provide feedback to inform state-wide discussions focused on hospital sustainability and transformation as a part of Act 167.

Certificate of Need Review Process

The HCA has statutory authority to assert interested party status in certificate of need (CON) proceedings before the GMCB. The HCA continues to monitor the CON application for Southwestern Vermont Medical Center, Development of Adolescent Inpatient Medical Health Unit (GMCB-014-23con). We actively monitor certificate of need applications as they are submitted and assert party status when the interests of Vermonters are clearly impacted.

Oversight of Accountable Care Organizations

The HCA is currently reviewing, preparing questions and feedback for the GMCB as a part of their review of OneCare Vermont's FY25 budget (it's final in the All-Payer Model) as well as the FY25 budgets for Medicare-only ACOs operating in Vermont (Lore Health, Aledade, and Vytalize Health).

Additional Green Mountain Care Board and other agency workgroups

The HCA attended the GMCB's weekly board meetings, monthly Data Governance meetings and several other legislatively established workgroups focused on affordability and access.

Global Budget Technical Advisory Group

The HCA is a member of the Global Budget Technical Advisory Group convened by the GMCB and the Agency of Human Services. This group met three times this quarter exploring the technical aspects of global budgets and numerous decisions that Vermont must make if it is to pursue this option with CMS. We learned officially this quarter that CMS is particularly interested in building on Vermont's existing payment reform model.

The Medicaid and Exchange Advisory Committee

The Advisory Committee met two times this quarter. The content of this quarter's meetings included an ongoing focus on the Assister program, DVHA budget priorities, the Medicaid redetermination process, Medicaid Fiscal Outlook, Advisory Committee Budget recommendations, the coming open enrollment period, and Silver Boosting.

Collaboration with Other Organizations

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

- AARP Vermont
- American Civil Liberties Union of Vermont
- All Copays Count Coalition
- Bi-State Primary Care Association
- Blue Cross Blue Shield of Vermont
- Department of Financial Regulation
- Disability Rights Vermont
- Families USA
- The Family Room
- The Howard Center
- IRS Taxpayer Advocate Service
- League of Women Voters of Vermont
- Let's Grow Kids
- Migrant Justice
- MVP Health Care
- National Academy for State Health Policy
- NHeLP, National Health Law Program
- New American Clinic/Family Room
- OneCare Vermont
- Open Door Clinic
- Planned Parenthood of Northern New England
- Rights and Democracy (RAD)

- Rural Vermont
- South Royalton Legal Clinic
- SHIP, State Health Insurance Assistance Program
- University of Vermont Medical Center
- University of Vermont Migrant Health, Bridges to Health
- Vermont Alzheimer's Association
- Vermont Association of Hospitals and Health Systems
- Vermont Association of Area Agencies on Aging
- Vermont Businesses for Social Responsibility (VBSR)
- Vermont Commission on Women
- Vermont Department of Health
- Vermont Department of Taxes
- Vermont Health Connect
- Vermont Health Care for All
- Vermont Interfaith Action (VIA) Vermont Language Justice Project
- Vermont Medical Society
- Vermont – National Education Association (NEA)
- Vermont Professionals of Color Network
- Vermont Public Interest Research Group (VPIRG)
- Vermont Workers' Center
- You First

Increasing Reach and Education Through the Website

VTLawHelp.org is a statewide website maintained by Vermont Legal Aid and Legal Services Vermont. The site includes a substantial Health section (*https://vtlawhelp.org/health*) with more than 170 pages of consumer-focused health information maintained by the HCA.

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

Popular Web Pages

The top 20 health pages on our website this quarter:

1. Health - section home page – 1,937 pageviews
2. Dental Services – 1,761
3. Income Limits - Medicaid – 1,145
4. Patient Financial Assistance & Affordable Medical Care – 460
5. Long-Term Care – 385
6. Medical Decisions: Advance Directives – 365
7. Medicaid, Dr. Dynasaur & Vermont Health Connect – 335
8. Vision – 333
9. Medicare Savings Programs – 316
10. Medicaid – 314
11. HCA Help Request Form – 294 pageviews and 99 online help requests
12. Resource Limits - Medicaid – 263

13. Choices for Care Giving Away Property or Resources – 245
14. Choices for Care Income Limits – 227
15. Advance Directive forms – 218
16. Choice for Care Resource Limits – 212
17. Transportation for Health Care – 192*
18. Medical debt – 190
19. Vermont Health Connect – 186*
20. Dr. Dynasaur – 179

* signifies that this page moved into the top 20 this quarter

This quarter we had these additional news items:

- *New Patient Financial Assistance Law Goes Into Effect* – 2,271 pageviews (this includes a lot of out-of-state traffic)
- *Medicaid Renewal Starts Again* – 14
- *People Impacted by Flood Can Sign Up for Health Coverage. Those Who Lost Medicaid Can, Too* – 12
- *Some Problems with Medicaid Prescriptions* – 7

Outreach and Education

The Office of the Health Care Advocates (HCA) engaged in both in-person and virtual outreach activities this quarter to raise awareness about our offices' services and provide accessible information about health insurance options in Vermont. Our messaging prioritized providing accurate and accessible information on the health insurance access for non-citizens, Vermont Health Connect Special Enrollment Periods (SEP) and financial help, and Hospital Financial Assistance Policies. We hosted two legal clinics, three community listening sessions facilitated six trainings, and implemented two social media campaigns to connect Vermonters with our services and proactively provide consumer education on health insurance and health law topics.

We strive to break down the barriers that Vermonters face in understanding and using insurance. This goal is especially important now as many members of our community are evaluating their health insurance options due to changes in employer sponsored insurance, the loss of Medicaid, or the transition to Medicare. We use a hybrid outreach model to advance this goal. We feel that both in-person and virtual resources make our services more accessible to those who face challenges utilizing our telephonic and online intake systems. We strive to meet the needs of seniors, people with disabilities, and those with language needs by hosting in-person clinics in community spaces virtual trainings in partnership with local non-profits and community centers.

We partnered with 19 organizations and participated in seven outreach presentations this quarter. Some of our partnerships included work with the Vermont Asylum Assistance Project, AALV, the Robert Larner College of Medicine, and the Vermont Association of Area Agencies on Aging. We led training on

eligibility for health insurance at the UVM Graduate School conference, the Montpelier Harvest Fest, and the Root Social Justice Center.

The HCA connected with community members, legislators, and partner organizations through Facebook, Instagram, YouTube, and Reddit. We used these platforms to share important updates pertaining to scam health insurance awareness, Hospital Financial Assistance Policies, and the health insurance rate review, public comment process.

The HCA and other VLA staff coordinated legal help events with the Family Room and the Burlington Electric Department at Ethan Allen Homestead. The HCA community dinners and legal needs listening sessions in Winooski, St. Johnsbury, and Brattleboro. We hosted three events where community members connected with legal advocates to learn more about emerging legal needs and connect with resources. Childcare and in-person interpretation was available to support people seeking our assistance.

Office of the Health Care Advocate

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

https://vtlawhelp.org/health

Attachment 5

DY20 Investment Expenditures

Department	Final Receiver Suffix	Investment Description	QE 0324	QE 0624	QE 0924	QE 1224	DY20 Total
AHSCO	9090	Designated Agency Underinsured Services	1,821,625	1,821,623	1,809,523	-	**5,452,771**
AHSCO	9093	Health Care Reform	-	1,460,558	781,700	-	**2,242,258**
AHSCO	9421	HCBS Investment - Workforce Recruitment & Retention Program	-	-	-	-	**-**
AHSCO	9421	HCBS Investment - Innovative Solutions to Enhance and Strengthen HCBS	288,126	1,068,556	1,313,991	-	**2,670,673**
AOE	n/a	Non-state plan Related Education Fund Investments	-	-	-	-	**-**
DCF	9400	Investments - Balance and Restorative Justice	606,298	557,153	726,297	-	**1,889,748**
DCF	9402	Medical Services	45,716	18,050	15,865	-	**79,631**
DCF	9403	Residential Care for Youth/Substitute Care (1)	-	-	-	-	**-**
DCF	9405	Aid to the Aged, Blind and Disabled CCL Level III	1,094,376	1,011,117	975,655	-	**3,081,148**
DCF	9406	Aid to the Aged, Blind and Disabled Res Care Level III	13,740	26,438	25,321	-	**65,499**
DCF	9407	Aid to the Aged, Blind and Disabled Res Care Level IV	29,478	58,158	52,535	-	**140,171**
DCF	9408	Essential Person Program	215,927	225,551	225,109	-	**666,587**
DCF	9409	GA Medical Expenses	46,231	36,203	18,999	-	**101,433**
DCF	9411	Therapeutic Child Care	453,327	496,554	497,266	-	**1,447,147**
DCF	9412	Lund Home	-	-	-	-	**-**
DCF	9413	Prevent Child Abuse Vermont: Shaken Baby	-	-	-	-	**-**
DCF	9414	Prevent Child Abuse Vermont: Nurturing Parent	38,535	36,790	16,817	-	**92,142**
DCF	9415	Challenges for Change: DCF	54,609	40,997	55,297	-	**150,903**
DCF	9416	Strengthening Families	172,705	241,232	319,027	-	**732,964**
DCF	9417	Lamoille Valley Community Justice Project	-	-	-	-	**-**
DCF	9418	Building Bright Futures	122,813	126,981	203,147	-	**452,941**
DCF	9419	United Ways 2-1-1	-	396,221	205,672	-	**601,893**
DCF	9421	HCBS Investment	-	-	-	-	**-**
DCF	9425	Lund Substance Abuse Screening & Referral	170,498	340,997	258,214	-	**769,709**
DAIL	9421	HCBS Investment - Independent Direct Support Providers	699,646	111,728	163,359	-	**974,733**
DAIL	9602	Mobility Training/Other Svcs.-Elderly Visually Impaired	94,970	124,761	70,650	-	**290,381**
DAIL	9603	DS Special Payments for Medical Services	518,557	1,192,395	212,230	-	**1,923,182**
DAIL	9604	Flexible Family/Respite Funding	304,933	305,066	(32,094)	-	**577,905**
DAIL	9605	Quality Review of Home Health Agencies	-	-	-	-	**-**
DAIL	9606	Support and Services at Home (SASH)	245,205	245,271	122,703	-	**613,179**
DAIL	9607	HomeSharing	36,251	118,855	126,983	-	**282,089**
DAIL	9608	Self-Neglect Initiative	126,009	-	127,265	-	**253,274**
DAIL	9609	Seriously Functionally Impaired: DAIL	-	-	-	-	**-**
DMH	9501	Special Payments for Treatment Plan Services	7,047	33,543	2,824	-	**43,414**
DMH	9502	Mental Health Outpatient Services for Adults	447,321	256,908	111,824	-	**816,053**
DMH	9504	Mental Health Consumer Support Programs	108,677	97,949	50,579	-	**257,205**
DMH	9505	Mental Health CRT Community Support Services	-	-	-	-	**-**
DMH	9506	Mental Health Children's Community Services	434,058	591,808	270,421	-	**1,296,287**
DMH	9507	Emergency Mental Health for Children and Adults	510,054	582,177	85,172	-	**1,177,403**
DMH	9508	Respite Services for Youth with SED and their Families	317,509	305,963	22,940	-	**646,412**
DMH	9510	Emergency Support Fund	-	-	-	-	**-**
DMH	9511	Institution for Mental Disease Services: DMH - VPCH	5,067,670	5,694,070	4,441,270	-	**15,203,010**
DMH	9512	Institution for Mental Disease Services: DMH - BR	-	-	-	-	**-**
DMH	9514	Seriously Functionally Impaired: DMH	-	-	-	-	**-**
DMH	9515	Mobile Crisis Uninsured/Underinsured	-	-	-	-	**-**
DMH	9516	Acute Psychiatric Inpatient Services	(536,563)	446,987	198,674	-	**109,098**
DMH	9521	Suicide Prevention	270,368	363,761	270,342	-	**904,471**
DMH	9522	Alternatives to Emergency Room MH Crisis Care	-	71,295	-	-	**71,295**
DMH	9523	MH Peer and Consumer Supports	-	893,278	423,395	-	**1,316,673**
DMH	9914	CRT Global Commitment	-	-	-	-	**-**
DMH	9421	HCBS Investment	108,035	1,271,410	147,094	-	**1,526,539**
DMH	n/a	QE 202403 64.9 Waiv Line 69 reporting; PQA to be submitted QE 202406	(626,400)	-	626,400	-	**-**
DOC	n/a	Elevate Youth (formerly Return House)	17,597	-	-	-	**17,597**
DOC	n/a	Northern Lights	-	-	-	-	**-**
DOC	n/a	Pathways to Housing - Transitional Housing	326,055	-	594,746	-	**920,801**
DOC	n/a	St. Albans and United Counseling Service Transitional Housing (Challenges fo	38,836	-	71,345	-	**110,181**
DOC	n/a	Northeast Kingdom Community Action	32,815	(630)	36,574	-	**68,759**
DOC	n/a	Intensive Substance Abuse Program (ISAP)	-	-	-	-	**-**
DOC	n/a	Intensive Domestic Violence Program	-	-	-	-	**-**
DOC	n/a	Community Rehabilitative Care	829,791	90,825	-	-	**920,616**
DOC	n/a	Intensive Sexual Abuse Program	-	-	-	-	**-**
DOC	n/a	Vermont Achievment Center	-	-	-	-	**-**
DVHA	9421	HCBS Investment	41,642	-	211,002	-	**252,644**
DVHA	9423	HCBS Spend Plan Investment GC CNOM	-	-	-	-	**-**
DVHA	9101	Vermont Information Technology Leaders/HIT/HIE/HCR	-	-	-	-	**-**
DVHA	9102	Vermont Blueprint for Health	838,774	1,100,188	780,727	-	**2,719,689**
DVHA	9103	Buy-In	(8,025)	1,398	1,572	-	**(5,055)**
DVHA	9104	HIV Drug Coverage	-	-	-	-	**-**
DVHA	9106	Patient Safety Net Services	174,037	154,390	30,679	-	**359,106**
DVHA	9107	Institution for Mental Disease Services: DVHA	-	-	-	-	**-**
DVHA	9108	Family Supports	-	-	-	-	**-**
DVHA	9109	One Care VT ACO Quality & Health Management	-	-	-	-	**-**
DVHA	9110	One Care VT ACO Advanced Community Care Coordination	-	-	-	-	**-**
DVHA	9111	One Care VT ACO Primary Prevention Development	-	-	-	-	**-**
DVHA	9113	Blueprint Expansion and Dulce	1,046,511	1,083,501	1,232,066	-	**3,362,078**
DVHA	9114	Blueprint for Health Spoke	-	-	1,257,010	-	**1,257,010**
DVHA	9115	Pregnancy Intention Initiative	-	-	25,258	-	**25,258**
DVHA	9209	Family Planning	55,866	105,810	53,273	-	**214,949**
VDH	9201	Emergency Medical Services	177,558	205,085	108,368	-	**491,011**
VDH	9203	TB Medical Services	6,040	-	23,163	-	**29,203**
VDH	9204	Epidemiology	343,844	68,580	129,000	-	**541,424**
VDH	9205	Health Research and Statistics	318,545	422,660	348,714	-	**1,089,919**
VDH	9206	Health Laboratory	805,457	1,004,911	863,970	-	**2,674,338**
VDH	9207	Tobacco Cessation: Community Coalitions	316,372	467,308	222,771	-	**1,006,451**
VDH	9208	Statewide Tobacco Cessation	-	-	-	-	**-**
VDH	9209	Family Planning	150,438	75,219	75,219	-	**300,876**
VDH	9210	Physician/Dentist Loan Repayment Program	264,171	(2,640)	256,471	-	**518,002**
VDH	9211	Renal Disease	-	-	-	-	**-**
VDH	9213	WIC Coverage	1,215,588	2,175,282	56,599	-	**3,447,469**
VDH	9214	Area Health Education Centers (AHEC)	167,011	(31,000)	-	-	**136,011**
VDH	9217	Patient Safety - Adverse Events	19,147	11,529	14,516	-	**45,192**
VDH	9219	Substance Use Disorder Treatment	1,337,456	1,249,158	64,518	-	**2,651,132**
VDH	9220	Recovery Centers	894,619	1,790,421	975,894	-	**3,660,934**
VDH	9221	Enhanced Immunization	69,844	141,624	69,061	-	**280,529**
VDH	9222	Poison Control	-	102,607	-	-	**102,607**
VDH	9223	Public Inebriate Services, C for C	225,478	635,305	303,666	-	**1,164,449**
VDH	9224	Fluoride Treatment	30,628	27,570	18,709	-	**76,907**
VDH	9225	Medicaid Vaccines	-	-	-	-	**-**
VDH	9226	Healthy Homes and Lead Poisoning Prevention Program	59,141	69,429	55,622	-	**184,192**
VDH	9228	VT Blueprint for Health	461,965	530,028	391,370	-	**1,383,363**
VDH	9421	HCBS Investment - Pediatric Pallative Care Program Supply Carts	-	-	-	-	**-**
VDH	9421	HCBS Investment - Expand VTHelplink	222,906	308,706	29,962	-	**561,574**
VSC	n/a	Health Professional Training	474,166	-	2,116,373	-	**2,590,539**
VVH	n/a	Vermont Veterans Home	-	-	-	-	**-**

Attachment 6

P Immunization Programs AOA

What We Do

The Vermont Department of Health Immunization Program provides vaccines to provider practices, educates health care providers and the public regarding immunizations, implements the state immunization regulations, and conducts ongoing assessments of population health status to identify populations at risk for vaccine-preventable diseases. Program activities are developed based on best practices to ensure access to affordable vaccines, support vaccination in the medical home, and provide the public with information needed to vaccinate with confidence.

Who We Serve

The Immunization Program serves all Vermonters with targeted efforts for parents, health care providers, provider practices, and school nurses.

How We Impact

The Immunization Program ensures adults and children have access to all recommended vaccines at their medical home and works to effectively limit vaccine preventable disease. Together with population indicators, the following performance measures focus on whether Vermonters are better off as a result of this program. They do so by looking at the quality and efficiency of these programs and services.

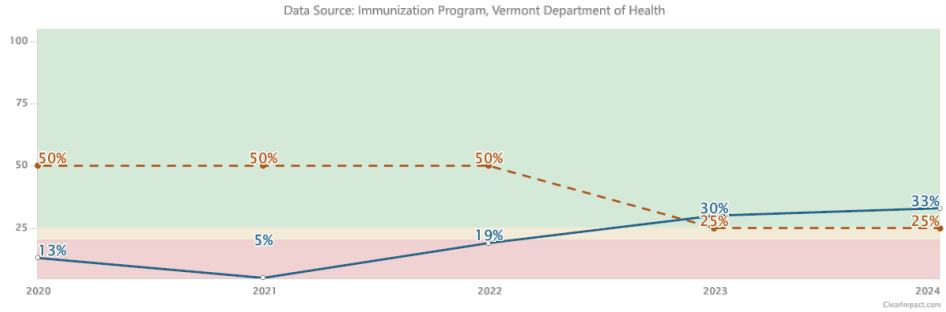
Investment objective: Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

Budget Information

This represents a portion of the Public Health appropriation #3420021000

Measures

PM Immunization % of public and private providers enrolled in Vaccines for Children who have received a quality improvement visit that includes feedback on registry completeness and coverage rates



Most Recent Period	Current Actual Value	Current Target Value	Current Trend
2024	33%	25%	↗ 3
2023	30%	25%	↗ 2
2022	19%	50%	↗ 1
2021	5%	50%	↘ 4
2020	13%	50%	↘ 3
2019	45%	50%	↘ 2
2018	52%	50%	↘ 1
2017	97%	95%	↗ 3
2016	95%	95%	↗ 2

Story Behind the Curve

Last updated: October 2024

Author: Immunization Program, Vermont Department of Health

Quality Improvement visits are part of the IQIP - Immunization Quality Improvement program for providers. This program was formerly known as AFIX, but changed in 2019. Primary care providers enrolled in the Vaccines for Children (VFC) program receive a site visit every 24 months to receive feedback on Immunization Registry (IMR) completeness and coverage. These site visits were paused during most of the COVID-19 pandemic. The number for 2022 is reported as of October 1, 2022.

During these visits education is provided and practices must demonstrate full compliance with the CDC program requirements which include but are not limited to provision of all CDC recommended vaccines, vaccine storage and handling and parent education. Onsite training on the use of the Vermont Immunization Registry by Health Department staff is also conducted so practices have accurate information on the immunization status of children. Visits focused on quality improvement, known as AFIX, are also offered to providers. At the visit, practice specific immunization rates are reviewed and and evidence-based strategies to increase immunization rates are selected for implementation.

Prior to 2018, this measure was calculated differently, see Notes on Methodology.

Why Is This Important?

Ensuring that Vermonters have access to recommended vaccines that are safe is an important way to protect our population from preventable disease. This program is essential to assist and educate providers to make sure we can provide this important service to Vermonters. It is also important to increase immunization rates through evidence-based strategies that educate parents and lower barriers to accessing vaccines.

This measure looks at the quality and efficiency of the Immunization Programs to measure how well the program is doing.

Partners

- Primary care providers
- Vermont Child Health Improvement Program

- National Improvement Partnership Network
- Centers for Disease Control and Prevention

What Works

Good communication, consistent messaging and a strong working relationship between the Health Department Immunization Program and the primary care provider practices enrolled in the Vaccines for Children (VFC) program.

Action Plan

Strengthen the educational aspects of provider site visits.

Reduce the number of staff that conduct site visits in order to ensure effective evaluation and clear messaging so that practices can meet all CDC requirements.

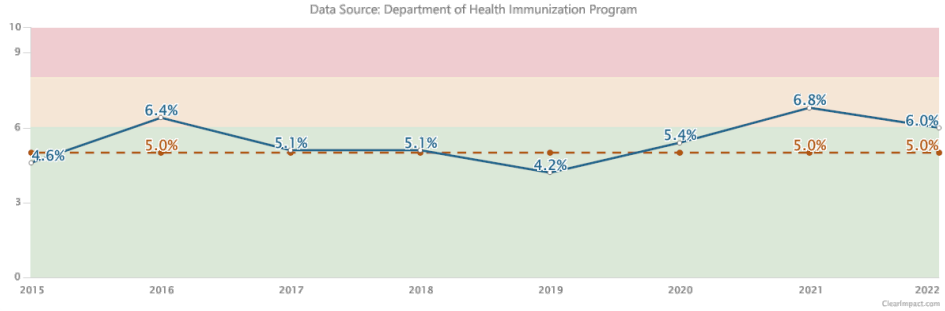
Notes on Methodology

The reporting period for this performance measures now runs from July through the following June. The most recent data point for 2024 is for the reporting period of July 2023 to June 2024.

Prior to 2018 this was calculated as the number of visits that include feedback on practice level IMR completeness and coverage rates. Since that time all site visits include this feedback and thus the number would be 100%.

Since 2018, this is measured as the percent of practices who have received a quality improvement-focused visit during the calendar year (previously through the AFIX program, now through IQIP). Site visits are conducted every 24 months.

PM Immunization % of Kindergarteners provisionally admitted to school



2022	6.0%	5.0%	↘ 1
2021	6.8%	5.0%	↗ 2
2020	5.4%	5.0%	↗ 1
2019	4.2%	5.0%	↘ 1
2018	5.1%	5.0%	→ 1
2017	5.1%	5.0%	↘ 1
2016	6.4%	5.0%	↗ 1
2015	4.6%	5.0%	↘ 2
2014	6.2%	5.0%	↘ 1

Story Behind the Curve

Last updated: January, 2024

Author: Immunization Program, Vermont Department of Health

The percent of students provisionally admitted to kindergarten remained steady for many years. Recent years have seen higher numbers of kindergarteners provisionally admitted. Specifically, for 2020-2021, disruptions related to the COVID-19 pandemic likely resulted in children missing well-child visits where they would normally have received scheduled vaccines, and overburdened school staff not having the capacity to follow up when immunizaton records are missing.

We hope to see this number continue to decrease below 5% again in the near future.

Students are provisionally admitted if they are not up-to-date on all required immunizations but are in the process of complying or have a signed exemption.

Why Is This Important?

Vermont school immunization regulations require that all children be vaccinated prior to enrollment in a public or private school. This protects school-age children, their families, school staff, and all Vermonters from outbreaks of preventable infectious disease.

The Health Department website has clear guidance and provides forms and templates for use by schools. Health Department staff visit school nurses to provide education and provide assistance in meeting the immunization requirements.

Partners

- School nurses and administrators
- Primary care providers and staff
- Offices of Local Health public health nurses

What Works

Factors contributing to the decreased provisional admittance rate include: excellent follow-up by school nurses with support from school administrators, outreach by Health Department public health nurses and increased parental awareness of Vermont's immunization rules.

Action Plan

Continued education for parents and schools, enforcement of school immunization regulations and ongoing evaluation.

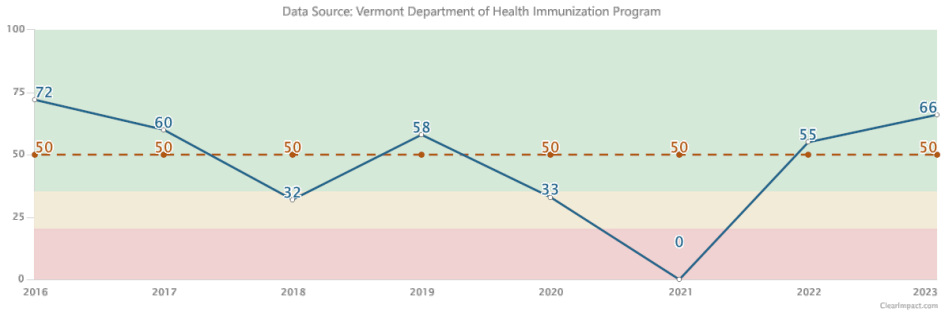
Notes on Methodology

The year reported corresponds to the beginning of the school year. The data for 2022 is the % of students provisionally admitted for the 2022-2023 school year.

These aggregated data are reported to the Vermont Department of Health by the school nurse or administrator in all Vermont public schools and independent schools by January 1, each year.

You can find more information and related data on the Department of Health Immunization Program School Vaccination dashboard.

PM Immunization # of provider offices that receive Immunization Registry (IMR) training



2023	66	50	↗2
2022	55	50	↗1
2021	0	50	↘ 2
2020	33	50	↘ 1
2019	58	50	↗1
2018	32	50	↘ 2
2017	60	50	↘ 1
2016	72	50	↗2
2015	59	50	↗1

Story Behind the Curve

Last updated: January, 2024

Author: Immunization Program, Vermont Department of Health

The number of trainings for providers on the Vermont Immunization Registry has been steady for many years. For the entirety of 2021, live trainings were canceled as a result of the COVID-19 pandemic. However, the immunization program wasn't idle. The program crafted multiple videos and support materials to provide trainings to users, which will continue to supplement provider trainings in the future.

Keeping children up to date for immunizations requires medical providers to have easy access to immunization records. This is often challenging, as people move and change providers. Immunization Registries, also known as Immunization Information Systems (IIS), provide a centrally located, secure repository for immunizations administered in Vermont. The Registry provides scheduling guidance to providers, which can be helpful if children have fallen behind for immunizations. And with Registry access, providers can assess their practice to help improve immunization delivery through reports that help identify children who are not up to date for specific vaccine series.

Why Is This Important?

Complete immunization records can prevent unnecessary immunizations, ensure children can attend school, and help providers identify persons in their practice who can benefit from addition protection against a preventable disease.

This performance measures focuses on whether Vermonters are better off as a result of Health Department's Immunization Program and Registry.

Partners

- Primary Care Providers
- American Academy of Pediatrics
- American Academy of Family Practitioners
- Vermont Hospitals
- Vermont Health Insurers
- Vermont Pharmacies
- School Nurses
- Head Start
- Vermont Information Technology Leaders (VITL)

What Works

As more Vermont medical providers adopt electronic medical records in their practice, sending immunization records to the Vermont Immunization Registry becomes much easier. Virtually everyone agrees it is helpful to have access to a single record for each individual so that no matter where that person seeks care, their immunization history is available to credentialed users. The Immunization Registry continues to seek all available sources of immunization records, including pharmacy records and billing information.

Action Plan

Health professionals at each of Vermont's 12 district offices train medical practices in their area to use the Registry.

More videos and resources will be available on the Vermont Department of Health website to help new users get familiar with the Registry.

The Immunization Registry actively solicits and imports batch files of historical immunization records from many other sources including health insurance billing records, provider offices, and pharmacies to compile the most complete and accurate immunization record possible for all Vermonters.

The Immunization Registry is collaborating with Vermont Information Technology Leaders to enable electronic medical records at provider offices and hospitals to send immunization records directly to the Immunization Registry via secure HL7 message.

The Immunization Registry also seeks data from out of state entities who provide immunization services to VT residents. The Registry is also importing "real time" data from Dartmouth Hitchcock Medical Center.

P SASH DAIL

Budget information

This is associated with Appropriation ID #3460020000.

What We Do

SASH coordinates the resources of social-service agencies, community health providers and nonprofit housing organizations to support Vermonters who choose to live independently at home. Individualized, on-site support is provided by a Wellness Nurse and a SASH Care Coordinator.

Who We Serve

SASH serves older adults as well as people with special needs who receive Medicare support. SASH touches the lives of approximately 4,500 people throughout Vermont.

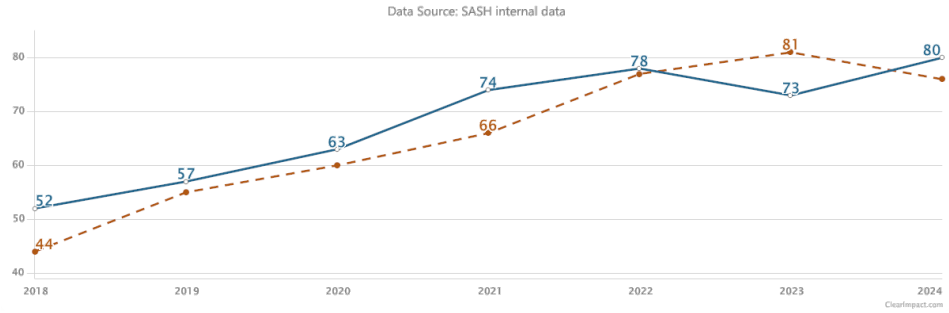
How We Impact

Benefits to SASH Participants:

- Improved quality of life
- Comprehensive health and wellness assessments
- Individualized Healthy Living Plans
- Money savings through preventive health care
- Regular check-ins by caring staff
- Health coaching and access to wellness nurses
- Help in planning for successful transitions (e.g., following hospitalization), navigating long-term care options and during a crisis
- Access to prevention and wellness programs
- Support in self-managing medications

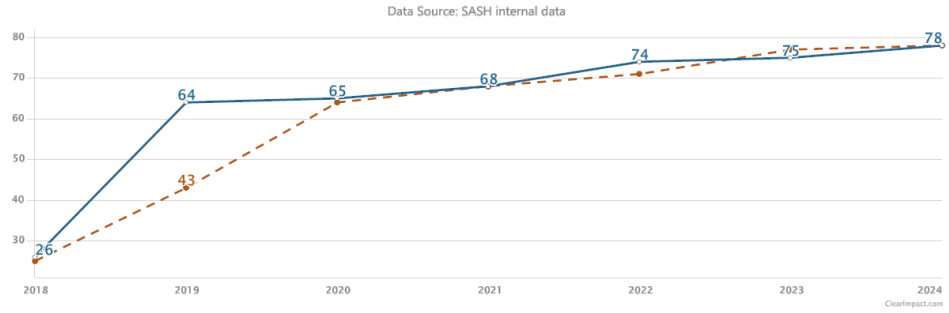
Measures

PM DAIL SASH: Social Isolation



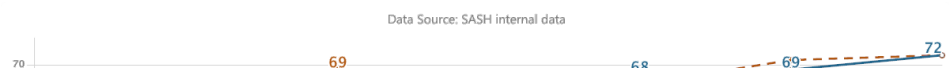
Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
2024	80	76	↗1	95%↗
2023	73	81	↘ 1	78% ↗
2022	78	77	↗5	90% ↗
2021	74	66	↗4	80% ↗
2020	63	60	↗3	54% ↗
2019	57	55	↗2	39% ↗
2018	52	44	↗1	27% ↗
2017	41	—	→ 0	0% →

PM DAIL SASH: Suicide prevention: participant screening

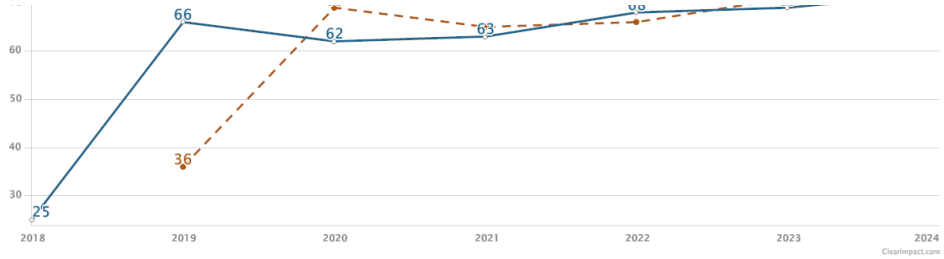


Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
2024	78	78	↗7	255%↗
2023	75	77	↗6	241% ↗
2022	74	71	↗5	236% ↗
2021	68	68	↗4	209% ↗
2020	65	64	↗3	195% ↗
2019	64	43	↗2	191% ↗
2018	26	25	↗1	18% ↗
2017	22	—	→ 0	0% →

PM DAIL SASH: Substance Use Screening



Most Recent Period	Current Actual Value	Current Target Value	Current Trend	Baseline % Change
2024	72	72	↗4	188%↗
2023	69	71	↗3	176% ↗
2022	68	66	↗2	172% ↗



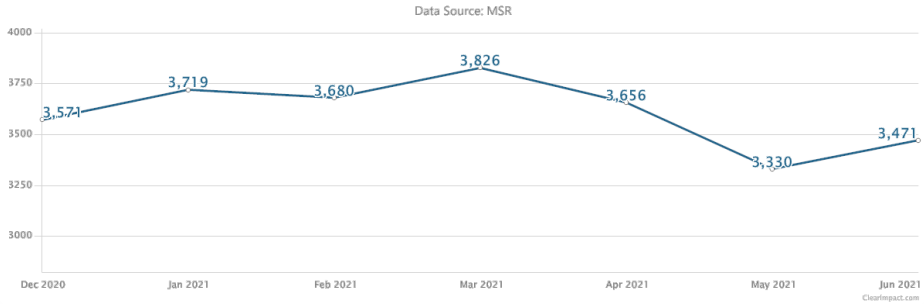
2021	63	65	↗1	152% ↗
2020	62	69	↘ 1	148% ↗
2019	66	36	↗1	164% ↗
2018	25	–	→ 0	0% →

DMH Value Based Payment Measures

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

O How_Much VBP: Number of Individuals Served

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



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

Story Behind the Curve

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

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

Partners

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

Notes on Methodology

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

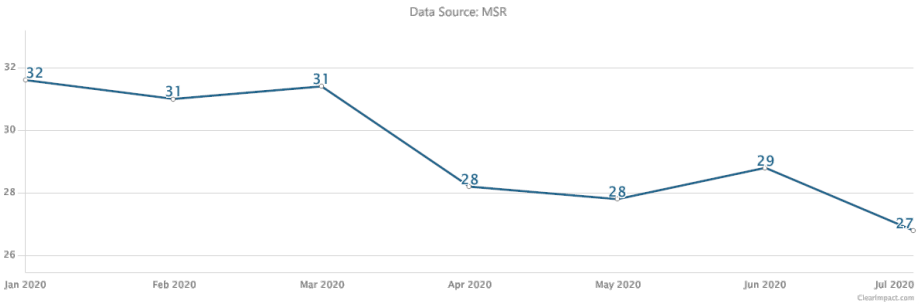
Data analyzed from Monthly Service Reporting system. Clients counted if they received one qualifying service within the month. Qualifying services are those that count a person toward the caseload and allow the agency to earn the full PMPM for that client.

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

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

Report figure on a designated agency level basis

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



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

Story Behind the Curve

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

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

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

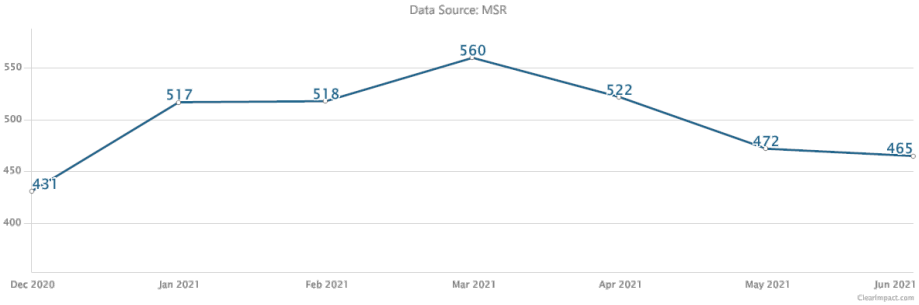
Partners

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

Notes on Methodology

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

How_Much Number of young adults (18-21) served



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

Story Behind the Curve

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

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

Partners

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

Notes on Methodology

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

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

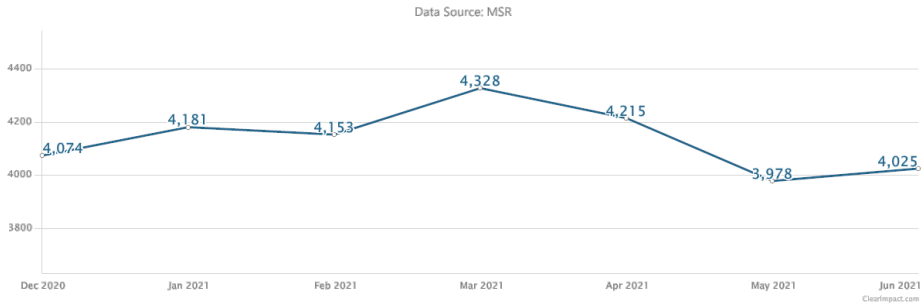
of the service year (June 30, XXXX)

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

Report figure on a designated agency level basis

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

I How_Much Number of Adults served



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

Story Behind the Curve

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

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

Partners

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

Notes on Methodology

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

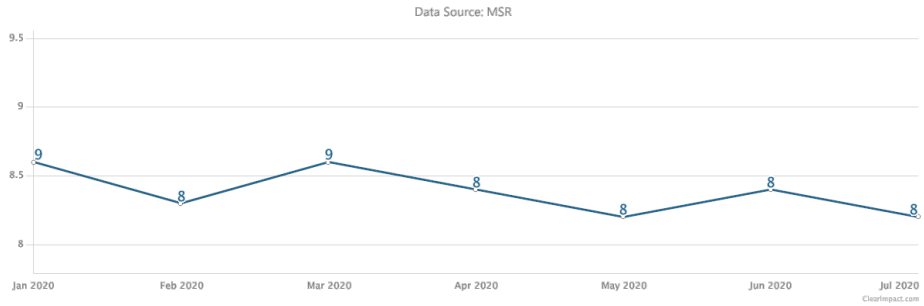
- Pull MSR services
- Calculate age of client from the midpoint of the service year (June 30, XXXX)
- Select clients who are aged 18 or older
- Aggregate to clinic client level, with flag for total services during fiscal year
- Select clients who have a least 1 unit (as defined in the *Provider Manual*)

Report figure on a designated agency level basis

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

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

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



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

Story Behind the Curve

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

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

Partners

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

Notes on Methodology

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

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

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

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

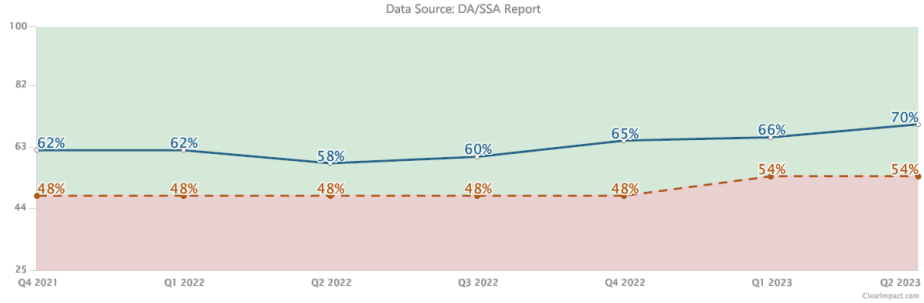
R = 1,000 C / P

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

Report figure on a designated agency level basis.

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

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



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

Story Behind the Curve

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

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

Partners

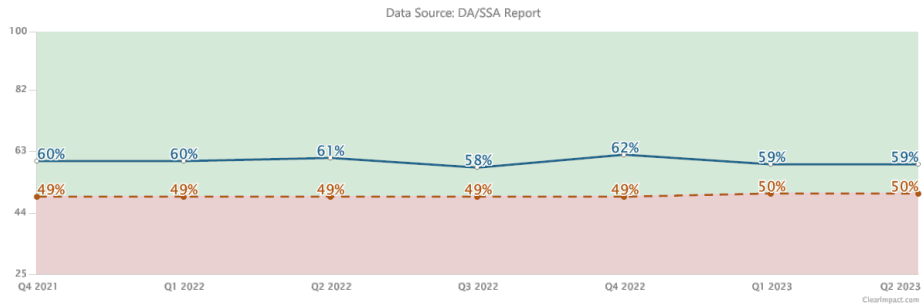
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

Notes on Methodology

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

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

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



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

Story Behind the Curve

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

Partners

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

Notes on Methodology

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

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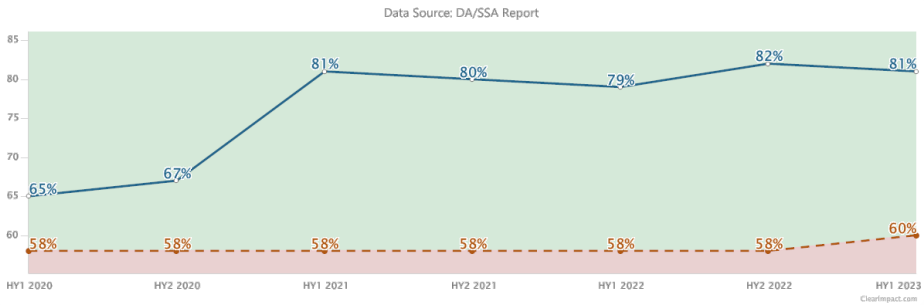
PM How_Well Percentage of youth clients with a CANS update recorded within the last 6 months.

HY1 2023	81%	60%	↘ 1



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

Story Behind the Curve

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

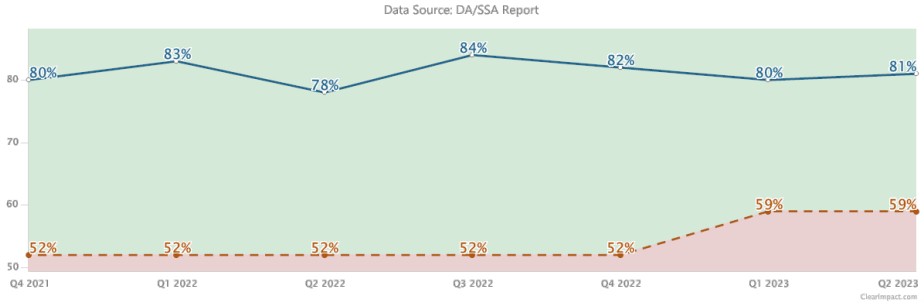
Partners

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

Notes on Methodology

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

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



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

Story Behind the Curve

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

Partners

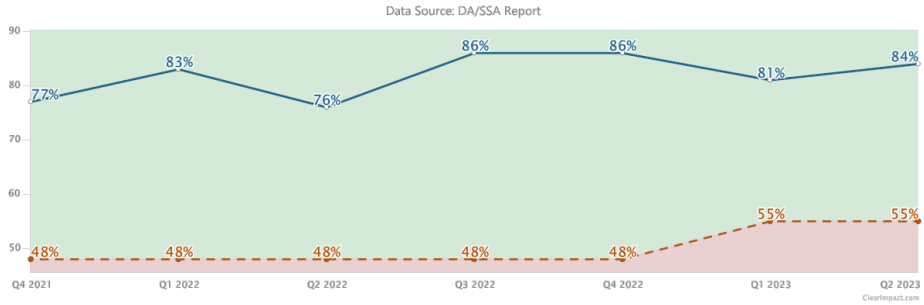
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric

Notes on Methodology

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

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

Q2 2023	84%	55%	↗ 1



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

Story Behind the Curve

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

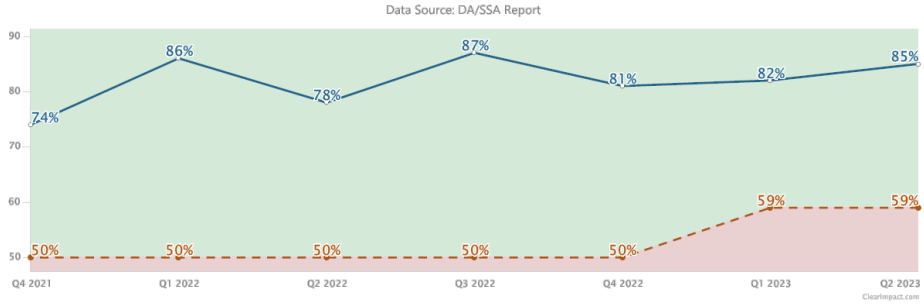
Partners

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

Notes on Methodology

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

PM How_Well Percentage of adult clients screened for depression at intake



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

Story Behind the Curve

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

Partners

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

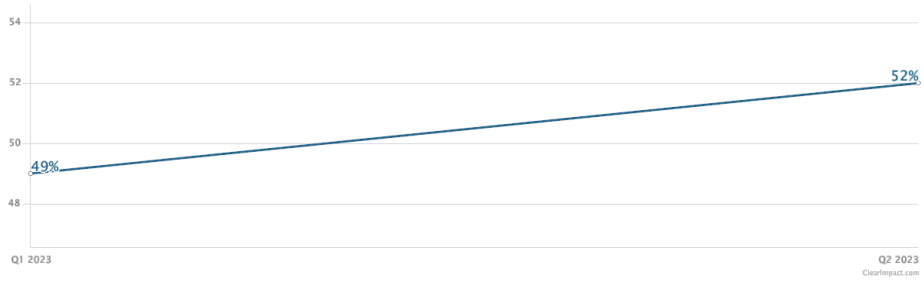
Notes on Methodology

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

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

Q2 2023	52%	–	↗ 1

Data Source: direct report



Q1 2023 49% – → 0

Story Behind the Curve

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

Partners

What Works

Action Plan

Notes on Methodology

PM How_Well Percentage of youth clients screened for depression at intake

Q2 2023 52% – → 1

Q1 2023 52% – → 0

Data Source: direct report

Story Behind the Curve

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

Partners

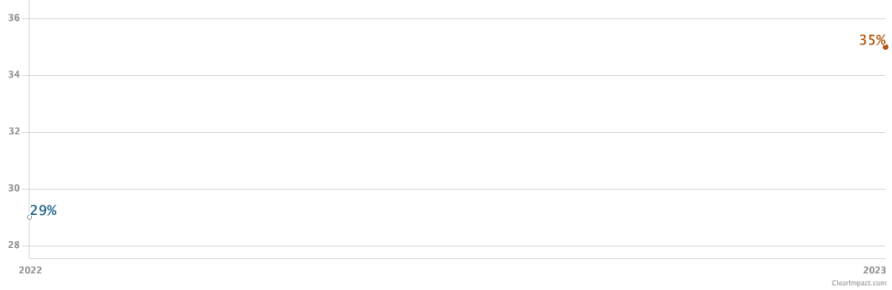
What Works

Strategy

Notes on Methodology

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

2022 29% – → 0



Story Behind the Curve

Partners

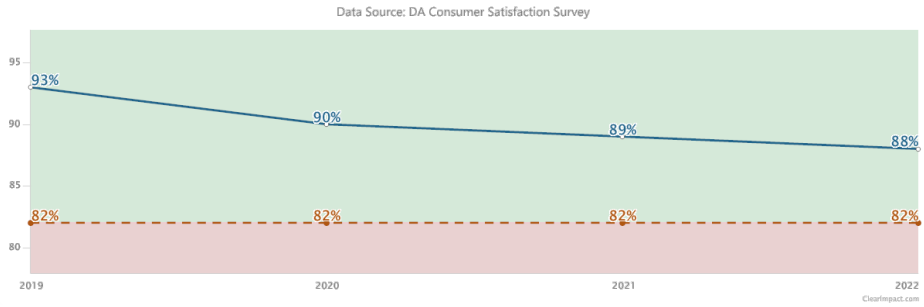
What Works

Action Plan

Notes on Methodology

O How_Well **VBP: Survey Measures**

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



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

Story Behind the Curve

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

Partners

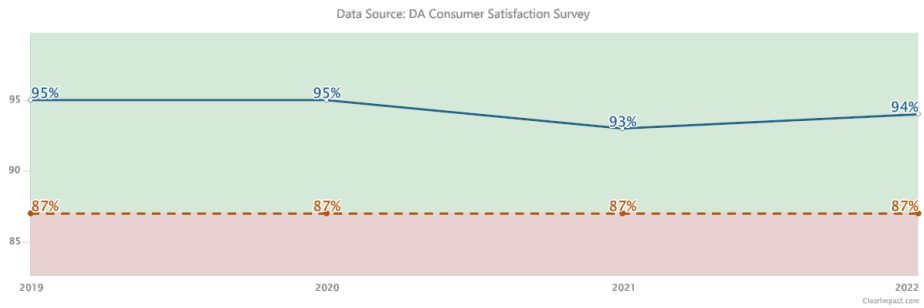
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

Notes on Methodology

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

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

PM How_Well Percentage of clients indicate they were treated with respect



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

Story Behind the Curve

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

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

Partners

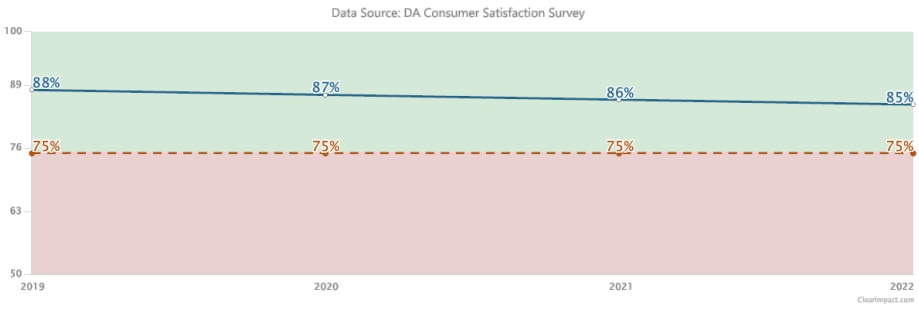
All community mental health agencies within payment reform, and the statewide outcomes committee who worked to standardize the definition and operation of this metric.

Notes on Methodology

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

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

PM Better_Off Percentage of clients indicate services made a difference



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

Story Behind the Curve

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

Partners

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

Notes on Methodology

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

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