PHPG

THE PACIFIC HEALTH POLICY GROUP

Vermont Global Commitment to Health Section 1115 Medicaid Demonstration

Substance Use Disorder (SUD) Amendment Mid-Point Assessment Report

December 15, 2020

TABLE OF CONTENTS

1. SUD AMENDMENT OVERVIEW AND MID-POINT ASSESSMENT

In July of 2018, Vermont amended its Section 1115a Medicaid demonstration, the Global Commitment to Health (GC), to include authorities specific to substance use disorder (SUD) treatment. CMS approval allows the State to maintain and enhance the flexibility and availability of treatment for SUD, including opioid use disorder (OUD). The amendment promotes a comprehensive and integrated continuum of treatment through the authorization of federal funding for stays in IMDs for which SUD treatment is the primary purpose.

Since its inception, Vermont's Section 1115 demonstration has included payment flexibilities to support cost-effective alternatives to traditional Medicaid State Plan benefits. As part of its original 1115 demonstration for the Vermont Health Access Plan (VHAP) Medicaid Expansion, Vermont received a waiver of the IMD exclusion, effective January 1, 1996. In 2004, CMS elected to no longer grant IMD waivers under its 1115 demonstration authority; states with existing IMD waivers (including Vermont) were given a schedule to phase out available Medicaid reimbursement. Under the phase-out terms, Vermont was permitted to continue Medicaid reimbursement of IMD services through Calendar Year 2004; reimbursement was limited to 50% of allowable expenditures in Calendar Year 2005.

The Global Commitment to Health, originally approved in 2005, enabled Vermont to operate under a statewide, public managed care model. The public managed care model provided the State with additional flexibility regarding health care service financing, including the purchase of healthcare services that are not traditionally covered by Medicaid. In the past Vermont used this authority to purchase alternative services, provided that services:

- Are determined to be medically appropriate;
- Are delivered by a licensed (and not Medicare de-certified) healthcare provider; and
- Achieve program objectives related to cost, quality and/or access to care in the least restrictive, clinically appropriate setting possible.

Since 2005 Vermont has used its public managed care model authority under Global Commitment to purchase in-state residential SUD treatment in lieu of more costly hospital-based care. In 2017 the demonstration's operating model was modified to that of a non-risk Prepaid Inpatient Health Plan (PIHP). Vermont and CMS collaborated to continue the provision of these vital services. In 2018, Vermont was granted approval to amend the demonstration to include SUD IMD authority to sustain the continuum of treatment programs, including inpatient treatment, detoxification and residential treatment for SUD in IMD settings for Members whose needs align with the American Society of Addiction Medicine (ASAM) placement criteria and treatment guidelines.

The CMS goals for the continuation and enhancement of SUD programs in Vermont include:

1. Increased rates of identification, initiation, and engagement in treatment;
2. Increased adherence to, and retention in, treatment;
3. Reduced overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate, through improved access to other continuum of care services;
5. Reduced readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate; and

6. Improved access to care for physical health conditions among beneficiaries.

As part of the SUD amendment, CMS also approved Vermont's SUD Implementation Plan. The Implementation Plan outlines state-specific steps to achieve CMS defined milestones for SUD treatment. Vermont is required to conduct an assessment of its progress in meeting SUD Implementation Plan goals and its performance on CMS identified metrics. The SUD Mid-Point Assessment includes an examination of:

- Progress toward meeting each milestone and timeframe approved in the SUD Implementation Plan;
- Progress toward closing the gap between baseline and target each year in performance measures as approved in the SUD Monitoring Protocol;
- A determination of factors that affected achievement of milestones and closure of performance measure gaps to date; and
- A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and the risk of missing those milestones and performance targets.

The assessment also requires a status update of budget neutrality requirements. For each milestone or measure target at medium to high risk of not being met, the assessment will provide recommendations for revisions to the State's implementation plan or other pertinent factors that the State can influence to support improvement.

The Mid-Point Assessment report is organized into seven sections. Each of the remaining sections is organized as follows:

- Section 2 offers an overview of the Vermont SUD Implementation Plan and proposed delivery system enhancements;
- Section 3 describes the methodology used to conduct the Mid-Point Assessment, including the provider survey, a qualitative analysis of consumer interviews and an evaluation of the State's progress towards meeting the SUD Monitoring Protocol metrics;
- Section 4 offers an overview of progress to date toward meeting each milestone and timeframes as described in the SUD Implementation Plan and Monitoring Protocol performance.
- Section 5 provides an overview of progress to date on the State's SUD IT Plan;
- Section 6 offers an assessment of the SUD Amendment Budget Neutrality; and
- Section 7 provides an overall assessment of progress to date identifying factors supporting achievement and those putting performance at risk, along with recommendations to support improvement in future performance.

2. VERMONT SUD IMPLEMENTATION PLAN

At the outset of the SUD amendment, Vermont's existing service array, program requirements and delivery system were in alignment with many of the milestones identified by CMS. Through innovation under the Medicaid State Plan and the Global Commitment to Health Demonstration, Vermont offers a comprehensive continuum of care for SUD, including Opioid Use Disorder (OUD). In addition to promoting access to all levels of care defined by the American Society for Addiction Medicine (ASAM), Vermont supports: public education and awareness activities with schools and other community groups; outreach through a public inebriate partnership with corrections and law enforcement; specialized residential programs; case management services; recovery housing; and other recovery supports.

Vermont's SUD system of care follows the ASAM guidelines and consists of the full spectrum of services as outlined by ASAM. All SUD providers must be licensed, meet additional State certifications for SUD/OUD treatment, and be enrolled Medicaid Providers. Exhibit 2-1 below provides a brief overview of the ASAM Levels of Care, as well as the Provider Types and coverage authorities associated with each ASAM Level of Care.

Exhibit 2-1: Overview of ASAM Directed Services in Vermont

ASAM Level of Care	Provider Type	Coverage Authority(ies)
(0.5) Early Intervention	Emergency Departments, PCP, Health Clinics, Student Health Center	State Plan
(1.0) Outpatient	Outpatient Clinics	State Plan
(2.1) Intensive Outpatient	Outpatient Clinics	State Plan
(2.5) Partial Hospitalization Day Treatment Psychosocial Rehabilitation	Outpatient Clinics	State Plan (co-occurring MH diagnosis only)
(3.1) Clinically Managed Low-Intensity Residential	Residential Providers	State Plan
(3.3) Clinically Managed Population Specific High Intensity Residential	Residential Providers (IMD)	1115 Authority
(3.5) Clinically Managed High Intensity Residential	Residential Providers (IMD)	1115 Authority
(3.7) Medically Monitored Intensive Inpatient	Residential Providers (incl. IMD)	State Plan and 1115 Authority
(4.0) Medically Managed Intensive Inpatient	Psychiatric Hospital (IMD)	1115 Authority
Opioid Treatment Program	Specialized Health Homes (Hub & Spoke)	State Plan
Withdrawal Management (WM)	Specialized Health Homes, Hospitals, Residential (IMD)	State Plan and 1115 Authority

At the time of amendment approval, the State identified several efforts to enhance the quality of SUD treatment services. Specifically, initiatives under development included:

- Implementation of value-based purchasing in alignment with the All-Payer Model Agreement to support access;
- Development of a centralized triage and intake call center for persons seeking OUD/SUD services; and
- Enhancement of discharge planning processes to improve transitions between care settings.

This SUD Mid-Point Assessment assesses the progress of planned enhancements as well as the State's performance per CMS-defined metrics, as outlined in its SUD Monitoring Protocol. A high-level overview of the State's Implementation Plan and milestones is presented in Exhibit 2-2 on the following page.

Exhibit 2-2: Overview of Vermont' SUD Implementation Plan and Milestones

Overview of VT SUD Implementation Plan and Milestones	
CMS Milestone	**VT Planned Enhancements**
1. Access to critical levels of care for OUD and other SUDs	Milestone achieved, no planned enhancements at time of amendment
2. Widespread use of evidence-based, SUD-specific patient placement criteria	Milestone achieved; two planned enhancements: • Improving the provider audit and certification process, through the development of a new compliance assessment tool (CAT) and scoring guide • Developing a value-based payment model for residential services
3. Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications	Milestone achieved; two planned enhancements: • Revising residential program contracts to require MAT onsite (MAT was offered in all programs prior to July 1, however contract agreements did not mandate onsite MAT) • Developing new compliance and certification standards to enhance ASAM alignment, targeted for implementation by May 1, 2018
4. Sufficient provider capacity at each level of care	Milestone achieved; one planned enhancement: • Developing a centralized intake system and call center for all Vermonters with the ability to perform an initial screening of individuals to determine the most appropriate referral
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD	Milestone achieved; Vermont will maintain Hub and Spoke specialized health homes and continue work with coordinating councils and special task forces to improve quality and access
6. Improved care coordination and transitions between levels of care.	Milestone achieved; two planned enhancements: • Implementing a "Recovery Coach in the ED" program to connect individuals and families with peer-to-peer support, assist with community engagement, and provide post ED follow up • Centralized intake systems and call center (See Milestone #4)

3. SUD MID-POINT ASSESSMENT METHODOLOGY

PHPG serves as Vermont's independent evaluator for the Global Commitment to Health demonstration and was engaged to conduct the SUD Mid-Point Assessment. In developing the SUD Mid-Point Assessment methodology, PHPG collaborated with the Agency of Human Services (AHS), the Vermont Department of Health's Division of Alcohol and Drug Abuse Programs (ADAP), Department of Vermont Health Access (DVHA) and SUD treatment providers. PHPG performed the following evaluation activities to identify trends in performance and policy issues, as well as successes and barriers to progress:

- Provider Surveys to collect feedback in targeted areas;
- Qualitative Analysis of Consumer Interviews; analysis of de-identified feedback from consumer interviews conducted in 2018, 2019 and early 2020 as part of the ADAP's SUD provider certification process; and
- Analysis of CMS required SUD Monitoring Protocol metrics and reports

Data was collected between January 2019 and August 2020. An overview of Vermont's planned activities and data sources used for the assessment is provided in Exhibit 3-1.

Exhibit 3-1: SUD Mid-Point Assessment Activities

CMS Milestone	VT Implementation Activities	Data Source*
Milestone #1: Access to Critical Levels of Care for OUD and Other SUDs	• Milestone met; the SUD implementation plan does not include new activities	• Required CMS metrics
Milestone #2: Use of Evidence-Based, SUD-Specific Patient Placement Criteria	• Update certification standards and compliance assessment tool (CAT); and • Develop a value-based payment model for residential services	• Provider Survey
Milestone #3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	• Update certification standards and CAT (see Milestone #2)	• ADAP Provider Standards
Milestone #4: Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD	• Develop a centralized intake system and call center for all Vermonters	• Required CMS metrics • Call center data
Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	• Milestone met; ongoing monitoring through legislature and State advisory committees	• Required CMS metrics
Milestone #6: Improved Care Coordination and Transitions between Levels of Care	• Promote placement of Recovery Coaches in the ED • Centralized intake system and call center (see Milestone #4)	• Required CMS metrics • Recovery Coach reports • Call center data
Other SUD Monitoring Protocol Metrics	• Maintain or improve performance	• Required CMS Metrics • Consumer interview data
SUD IT Plan	• Enhance functionality and interfaces within VT Prescription Monitoring System	• Required CMS metrics
Budget Neutrality (BN)	• Maintain expenditures at or below PMPM limits as defined in STCs	• BN workbook

* For all activities, PHPG also reviewed Vermont's quarterly and annual reports to CMS for analysis of policy issues, trends and progress; and other state specific documents as noted in each discussion section.

PROVIDER SURVEYS

To assess the State's progress in achieving Milestone #2 and #3 PHPG worked with SUD Providers and State staff to develop a SUD Provider Survey. Survey questions were designed to solicit information on: the new residential care value-based payment model and enhancements to provider certification standards for all SUD providers. Survey questions included Likert-scaled and open-ended responses. Two survey tools were developed:

1. A non-residential SUD treatment provider survey to address: the updated preferred provider standards, CAT and audit process; and transitions of care (TOC) under the new episodic payment model; and
2. A residential SUD treatment provider survey to address: the residential payment model; and updated preferred provider standards, CAT and audit process.

Questions assessing updated preferred provider standards, CAT and audit process were identical in both surveys. Questions regarding the episodic payment were specific to residential treatment providers. Non-residential providers were asked if they experienced any changes in transitions of care to the community when working with referrals from the three facilities using the new payment model.

Twelve questions were specific to the implementation of an episodic payment model for residential providers. The new payment model became effective for three pilot sites on January 1, 2019. Vermont's goals in developing the episodic payment model include:

- Supporting the appropriate level of care for each enrollee;
- Improving transitions of care;
- Achieving successful outcomes for enrollees through flexible and comprehensive care;
- Offering predictable and timely payments; and
- Reducing administrative burden and costs.

Ten questions were specific to newly enhanced SUD Provider Standards and changes in the State's provider certification process and tools. These changes were made with the goals of:

- Enhancing the use of ASAM criteria in making placement decisions;
- Improving objectivity of audit process through the use of new Compliance Assessment Tool (CAT); and
- Improving consistency of the audit process through the use of the new CAT.

Prior to finalizing the survey, PHPG obtained feedback on the draft instruments and proposed survey methods. For each section and individual survey question stakeholders were asked:

- Is the information presented in the project summary and in the instructions clear?
- Are the questions clear?
- Are there other questions or information you would suggest adding or eliminating?

PHPG incorporated feedback from each discussion session and prepared the final survey tool for distribution. The two surveys are included as Appendix 1.

All providers were surveyed after completion of at least one audit cycle using the updated preferred provider standards and CAT. Providers with more than one site or treatment program were asked to complete surveys for each unique certification.

Residential providers were surveyed after at least six months of experience with the new payment model (i.e., after July 1, 2019). A second survey point was planned after 12 months of experience with the new model to coincide with the implementation of a performance payment component, planned for January 2020. However, due to the State's COVID-19 emergency response, the performance payment component of the model was not implemented. In addition, not all residential providers were able to complete the survey during the 2020 survey period. Thus, the second survey point for residential providers was eliminated from the evaluation methodology. Exhibit 3-2 offers a summary of the survey distribution points during the assessment period.

Exhibit 3-2: SUD Provider Survey Dates

Provider Type	Survey Dates and Content	
	July – August 2019	July – August 2020
Residential Providers	Payment model and standards/CAT questions	Payment Model (suspended due to COVID-19 emergency response priorities)
Non-Residential Providers	Standards/CAT and TOC questions (for providers certified Aug 2018-July 2019)	Standards/CAT and TOC questions (for providers certified Aug 2019-July 2020)

Surveys were conducted in a manner most convenient for the provider. Methods included: telephonic; electronic (fillable form); and hard copy returned by mail. The majority of the providers returned electronic surveys with two respondents opting for a telephone interview to complete the form. Survey respondents included clinical directors and facility managers identified by ADAP as individuals who typically serve as points of contact for certification audits and treatment/delivery model discussions. All responses were returned directly to PHPG. Responses were de-identified and results were aggregated.

Over the two-year study period, twenty-eight surveys were sent and twenty-six were returned. The overall survey response rate was 92.86% with 100% of the residential providers involved in payment reform completing the year one survey.

QUALITATIVE ANALYSIS OF CONSUMER INTERVIEWS

As part of the ADAP SUD provider certification process, ADAP staff interview program participants individually or in small groups for each site under review. ADAP reviews client feedback as part of the overall certification. The number of clients interviewed during an ADAP site visit varies from one to six based on program enrollment. PHPG obtained transcripts for client interviews conducted in 2018, 2019 and the first half of 2020. Interviews for calendar year 2020 were conducted through March, prior to the suspension of certification audits due to COVID-19. Interviews with 73 consumers were reviewed.

Consumer interview questions are listed in Exhibit 3-3, on the following page. Core consumer interview questions are asked each year in every program, with little to no variation (see Questions #1-8). For some programs (e.g., Medication Assisted Treatment sites) additional questions regarding safety and community collaboration were added to the interview (See Questions #9-11). Lastly the type of question eliciting open ended feedback (general comments, constructive feedback, etc.) varied from interviewer and year (see Questions 12-14).

For questions that elicit a binary response i.e., yes/no, good/bad (Questions 1-4 and 8-11), each response was categorized, where answered, as positive, negative or neutral. The following types of responses where not scored:

- Responses with no context (e.g., “Emily helps a lot");
- Ambiguous response that could be interpreted as a positive or negative (e.g., "it was really long but went really well”);
- Responses unrelated to the question asked; and
- Responses paraphrased by transcriber with no indication of client intent or context (e.g., "client talked about counselor" or "client talks to Marie").

Interviews conducted in small groups were not used unless the transcript specifically recorded each individual response by client. Small group feedback not attributed to a single respondent was used in the open-ended thematic analysis as it applied to the open-ended questions (Questions 5-7 and 12-14). Exhibit 3-3 provides an overview of each question and the scoring method.

Exhibit 3-3: Overview of Consumer Interview Questions and Scoring Method

ADAP Consumer Interview Questions						
#	Interview Question	PHPG Scoring Method	Interview Year Used			Asked of All Provider Types
			2018	2019	2020	
1	How do you feel about the way you’ve been treated by the staff here?	Positive, Negative, Neutral, No Response	✓	✓	✓	✓
2	When you started this program, did you receive a client handbook?	Positive, Negative, Neutral, No Response	✓	✓	✓	✓
3	How was the intake process and how long did it take?	Positive, Negative, Neutral, No Response		✓	✓	✓
4	If you had a problem or wanted to file a complaint, would you know what to do?	Positive, Negative, Neutral, No Response	✓	✓	✓	✓
5	What keeps you coming back?	Thematic	✓	✓	✓	✓
6	What could they do to make things better for you?	Thematic	✓	✓	✓	✓
7	What part of this program do you think is the most helpful to you?	Thematic	✓	✓	✓	✓
8	How involved are you in helping to develop your treatment plan and setting your goals?	Positive, Negative, Neutral, No Response	✓	✓	✓	✓
9	Do you feel safe at {program name}	Positive, Negative, Neutral, No Response	✓	✓	✓	
10	Do you feel heard by the counselors/clinicians?	Positive, Negative, Neutral, No Response	✓	✓	✓	
11	Does {program} collaborate with other providers	Positive, Negative, Neutral, No Response	✓			
12	Constructive feedback	Thematic	✓			✓
13	Comments	Thematic		✓	✓	✓
14	Positive feedback	Thematic	✓			✓

The following questions were removed from the final analysis:

- Question #3 (*How was the intake process and how long did it take?)*: Investigators were not able to assign a “positive” or “negative” attribute to responses received such as “2-hours”, “30

minutes" "we did it over the course of two days" without specific context related to an acceptable norm for each program setting;
- Question #10 *(Do you feel heard by the counselors/clinicians?)*: Infrequent use/low response rate; and
- Question #11 *(Does {program} collaborate with other providers?)*: Infrequent use/low response rate.

For questions that are open-ended in nature (Question #5-7 and #12-14), the evaluator assigned a theme to each response based on content. Themes were not pre-defined, but rather emerged from the responses. For example, themes emerged in categories such as: clinical model; operations; space/food. Responses in major categories such as "Clinical Model" were then divided into sub-categories as topic clusters emerged. For example, the following sub-categories were identified under the Clinical Model category: individual therapy, group sessions, team structure, collaboration with community partners, and MAT.

CMS REQUIRED MONITORING METRICS

To assess the State's performance in meeting its directional targets, PHPG analyzed results of the CMS required metrics as defined in the State's SUD Monitoring Protocol. Metrics were analyzed for changes in performance. Where applicable, PHPG examined factors that may have negatively impacted performance and developed recommendations for performance improvement.

4. SUD MILESTONES AND MID-POINT ASSESSMENT FINDINGS

At the outset of the SUD amendment, the Global Commitment to Health delivery system was meeting many of the milestones identified by CMS. This SUD Mid-Point Assessment assesses the State's progress in maintaining or improving performance under each Milestone. In addition, enhancements to State protocols were expected in Milestones #2, 3, 4 and 6, as well as in its SUD IT Plan. New initiatives and delivery system reforms for these milestones are summarized in Exhibit 4-1.

Exhibit 4-1: SUD Implementation Plan Enhancements Expected

CMS Milestone	VT Implementation Activities
Milestone #2: Use of Evidence-Based SUD-Specific Patient Placement Criteria	• Update certification standards and compliance assessment tool (CAT); and • Develop a value-based payment model for residential services
Milestone #3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	• Update certification standards and CAT (see Milestone #2)
Milestone #4: Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD	• Develop a Centralized Intake and Call Center for all Vermonters
Milestone #6: Improved Care Coordination and Transitions between Levels of Care	• Placement of Recovery Coaches in the ED • Centralized intake system and call center (see Milestone #4)
SUD IT Plan	• Enhance functionality and interfaces with VT Prescription Monitoring System

To assess the State's risk of not meeting demonstration goals for each of the CMS defined metrics, PHPG compared each year to the base year and reviewed year over year performance. In assessing performance one of the following ratings was assigned to each metric:

> **Meeting** - Performance in the most recent year examined showed that the State was maintaining or improving over the base year;
> **Low Risk** - Performance appeared to be influenced by one or more of the following: measure construction; changes in Medicaid enrollment since the base year; the State's Public Health Emergency Response; or a small population;
> **Medium Risk** - Performance in the most recent year showed a decline from the base year with no known problems in metric construction or other factors in the low-risk category;
> **High Risk** - Performance showed a significant decline from baseline and/or a year over year decline in performance with no known problems in metric construction or other factors in the low-risk category.

The remainder of Section 4 will present findings for each Milestone, including Monitoring Protocol metrics and the State's progress in meeting its action steps and timelines outlined in the SUD Implementation Plan. Following a review of findings, recommendations for performance improvement are provided, where applicable.

MILESTONE #1 ACCESS TO CRITICAL LEVELS OF CARE

Vermont's SUD/OUD system follows the ASAM Level of Care guidelines and consists of the full spectrum of services. All SUD/OUD providers must be licensed, meet additional State certification standards for SUD/OUD treatment, and be enrolled Medicaid Providers. Exhibit 4-2 on the following pages presents a summary of the alignment of ASAM Level of Care and the Vermont system.

Exhibit 4-2: Milestone #1 Vermont's ASAM Levels of Care

ASAM Level of Care	Vermont Program Summary
(0.5) Early Intervention	*Screening Brief Intervention and Referral for Treatment (SBIRT):* Services are provided to emergency departments (ED), free health clinics, primary care offices and a student health clinic across the State. ADAP is working with providers and other State partners to sustain and expand the availability of SBIRT services under the Global Commitment to Health Demonstration. *Public Inebriate/Crisis Intervention*: The program screens and determines appropriate placement for individuals meeting criteria for incapacitation, due to either intoxication or withdrawal from alcohol or other drugs. Presently there is screening capacity in all counties. In addition, diversion beds are located in several areas as alternatives to detention. ADAP continues to address needs and coordinate collaboration between public inebriate programs, ED, law enforcement and the Department of Corrections.
(1.0) Outpatient	Outpatient services are available in each region of the State. Programs offer individual, group and family counseling and provide services specific to elders, adolescents, youth, men and women.
(2.1) Intensive Outpatient	ADAP-Certified, Medicaid-enrolled providers offer intensive outpatient (IOP) services in each region. IOP programs offer nine to 19 hours of treatment per week. Services include a combination of case management and individual, group, and/or family therapy sessions.
(2.5) Partial Hospitalization	Partial hospitalization is provided to individuals with co-occurring mental health and SUD diagnoses, with the primary diagnosis being mental health.
(3.1) Clinically Managed Low-Intensity Residential	A 10-bed, low-intensity 3.1 ASAM level residential program offers a step-down from a 3.5 ASAM-level program. Individuals with higher needs can attend the treatment program and receive MAT at the 3.5-level program. Transportation is provided between the facilities.
(3.3) Clinically Managed, Population Specific High Intensity Residential; and (3.5) Clinically Managed High Intensity Residential	Several residential programs provide clinically managed, high-intensity treatment and withdrawal management services. This includes programs for: women-only; co-ed, specialized programs for adolescents; and pregnant women and mothers with children under the age of five. Programs have access to psychiatric and mental health consultation and offer care for individuals with co-occurring needs. Residential programs are required to provide access to MAT services as clinically necessary.
(3.7) Medically Monitored Intensive Inpatient	Residential programming for adults provides medically monitored, intensive inpatient services with on-site psychiatric services, MAT and care to individuals with a wide range of co-occurring conditions.
(4.0) Medically Managed Intensive Inpatient	A specialized psychiatric facility offers detoxification services and is available to treat persons with co-occurring conditions.
Opiate Treatment Program	Vermont developed the first-in-the-nation Specialized Health Home focused on evidence-based MAT for OUD, known as the Hub and Spoke Program. The program has garnered national attention for its effective, responsive, and comprehensive approach to providing MAT. Vermont accomplishes this through the integration of opioid treatment programs, providing higher levels of care (Hubs) with primary care, obstetrics-gynecology, outpatient addiction treatment, and pain management practices (spokes) providing office-based opioid treatment.

ASAM Level of Care	Vermont Program Summary
	Regional Hubs offer medication, counseling, case management and health home services to complex patients. Spokes provide care to individuals with less complex needs, such as medication, counseling, case management and other health home services. Spoke staff, supported by enhanced care coordination through the Blueprint for Health and local Recovery Support services, assure essential services are provided.
Withdrawal Management (WM)	ADAP certifies two residential programs in three locations and a social detoxification program to provide higher intensity withdrawal management services. In addition, hospitals provide withdrawal management services for individuals who need the full services of a hospital. For individuals with less intense needs, withdrawal management is available through the Hub and Spoke system.
Recovery Support	Twelve Recovery Centers operate across the State along with the statewide Vermont Recovery Network. Recovery Centers provide non-clinical services to support community connections that lead to employment, housing, and other social supports in a safe, drug and alcohol-free environment. Individual services include trained Peer Recovery Coaches. The Recovery Centers also offer group support using Evidence Based Practice models e.g., Making Recovery Easier, Seeking Safety, Wellness Recovery Action Planning (WRAP); and yoga, meditation, acupuncture, age specific groups, AA and NA 12 Step meetings.
Recovery Housing	Recovery Housing is provided through providers affiliated with Recovery Centers as well as independent organizations. Programs connect individuals to community social services, support ongoing treatment, and offer individualized recovery planning and provide general case management.

The following eight performance metrics, as defined in the SUD Monitoring Protocol, were examined related to access to SUD treatment.

- *#6 Any SUD Treatment*: Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period;
- *#7 Early Intervention*: Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period;
- *#8 Outpatient Services*: Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period;
- *#9 Intensive Outpatient and Partial Hospitalization Services*: Number of unique beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period;
- *#10 Residential and Inpatient Services*: Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period;
- *#11 Withdrawal Management*: Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period;
- *#12 Medication Assisted Treatment (MAT)*: Number of beneficiaries who have a claim for MAT for SUD during the measurement period; and
- *#36 Average Length of Stay in IMDs*: The average length of stay for beneficiaries discharged from IMD inpatient or residential treatment for SUD.

Vermont set an annual target to "maintain or increase" community-based outpatient services (Metric #6-8, #12) and a goal to maintain or decrease more intensive services (Metric #9-11). Vermont's IMD

facilities are community-based residential treatment facilities. Vermont's goal is to maintain or increase access to residential SUD treatment as an alternative to hospitalization. Vermont's SUD Monitoring Protocol erroneously indicates an annual goal of "Maintain or Increase" relative to IMD length of stay. It has been corrected in this report as "Maintain or Decrease".

In examining the State's progress relative to Milestone #1, the monthly count of beneficiaries served was converted to an average monthly enrollment for each year studied. Eight metrics were included under Milestone #1. However, for Metric #7 (Early Intervention) the total number of observations over the three-year period was less than 5. Thus, the metric could not be assessed. The State is meeting six of seven of the remaining metrics (87%).

On initial review, access to outpatient services (Metric #8) appears to be at risk. Utilization from 2017 to the first six months of 2020 declined by 4.4%, although the goal is to "maintain or increase" utilization. However, in a closer examination of the underlying data two factors emerged that may have influenced performance:

- Impact of COVID-19: During the first 6 months of 2020 many programs were limited or closed due to COVID-19. Prior to the COVID-19 pandemic the total reduction in outpatient visits between 2017 and 2019 was 1.2%; and
- Declining Medicaid Enrollment: Overall Medicaid enrollment fell from 194,768 in 2017 to 181,065 in 2019, (using denominator counts for Metric #27) representing a decline of 7.0%. While the aggregate number of beneficiaries declined, the percentage of Medicaid beneficiaries that received SUD services increased by 2.8%.

For these reasons, the metric was rated as a "low risk" in meeting the demonstration goal.

Exhibits 4-3a and 4-3b on the following page provide an overview of results by year.

Exhibit 4-3a: Milestone #1 Summary of Performance Metrics (Converted to Average Monthly Enrollment)

		SUD Monitoring Protocol Measures Milestone #1		Average Monthly Enrollment				
#	**Name**	**Description**	**Demonstration Goal**	**2017**	**2018**	**2019**	**2020 (6-mos)**	**Goal Status**
6	Any SUD Treatment	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period	Maintain or Increase	6,998	7,264	7,098	7,049	**Meeting**
7	Early Intervention	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period	Maintain or Increase	*Sample size too small; total observation over three-year period less than 5*				
8	Outpatient Services	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period	Maintain or Increase	3,602	3,613	3,558	3,444	**Low Risk**
9	Intensive Outpatient and Partial Hospitalization Services	Number of unique beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period	Maintain or Decrease	251	218	202	107	**Meeting**
10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	Maintain or Decrease	203	187	180	132	**Meeting**
11	Withdrawal Management	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period	Maintain or Decrease	47	51	48	40	**Meeting**
12	Medication Assisted Treatment (MAT)	Number of beneficiaries who have a claim for MAT for SUD during the measurement period*	Maintain or Increase	5,226	5,617	5,682	5,920	**Meeting**

**Due to incomplete data for Dec. 2019, we used an 11-month average.*

Exhibit 4-3b: Milestone #1 Summary of Performance Metrics

		SUD Monitoring Protocol Measures Milestone #1 (continued)		Average # of days				
#	**Name**	**Description**	**Demonstration Goal**	**2017**	**2018**	**2019**	**2020 (6-mos)**	**Goal Status**
36	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD inpatient or residential treatment for SUD	Maintain or Decrease	15.46	15.41	14.21	N/A	**Meeting**

MILESTONE #2 USE OF EVIDENCE-BASED SUD-SPECIFIC PATIENT PLACEMENT CRITERIA

Vermont relies on evidence-based practices and clinical practice guidelines for all aspects of provider education and treatment authorization. The need for treatment often starts with a screening at one of the specialized providers, community partners, or primary care practices. Vermont promotes integrated screening for co-occurring substance use disorders and mental health issues.

All of Vermont's certified SUD/OUD providers (Preferred Providers) are required to use evidence-based screening tools, perform a comprehensive assessment which includes elements specified by the State, and utilize ASAM criteria to determine level of care. All State requirements are outlined in *Vermont's Preferred Provider Substance Use Disorder Treatment Standards.* All Preferred Providers have grant agreements with the State outlining their expectations including compliance with the *Preferred Provider Substance Use Disorder Treatment Standards*.

For Preferred Providers to maintain specialty SUD/OUD provider certification in Vermont, they must pass compliance and quality audits conducted by ADAP. These audits are performed every one to three years on all Preferred Providers and are focused on compliance with standardized screening tools, comprehensive assessments, ASAM Levels of Care and evidence-based treatment standards which are verified through client record reviews and agency documentation.

Vermont's SUD Implementation Plan identified two areas for action under Milestone #2. The first action area related to improving the provider audits and certification process and the second related to value-based payments.

Provider Certification and Adherence to ASAM Criteria: ADAP developed a new scoring tool to determine a Preferred Provider's compliance and certification status. The Compliance Assessment Tool (CAT) is a weighted scoring tool that aligns with the Preferred Provider Standards. The Tool includes separate sections, based on the program's ASAM Level of Care, and a scoring guide. The final score provides an objective assessment of the provider's compliance status (e.g., "full" or "provisional" certification). The final compliance status also determines the length of the time between reviews. The tool is expected to reduce error and subjectivity in provider audits and subsequent certification results.

Value-based Payments for Residential Treatment: Payment reform under the SUD amendment aligns with Vermont's All Payer Model Agreement. The SUD payment model is designed to incentivize successful transitions of care, improve outcomes, and reduce costs. The SUD residential payment model uses an episodic payment to reimburse residential care providers a specific, per-admission rate for an individual's care for the entire length of stay, as opposed to a per day rate in the current fee for service model.

The methodology includes a differential case-rate that allows for a higher payment amount for treating individuals with more complex care needs. The methodology considers a number of clinical and social determinates of health (such as withdrawal potential, medical and mental health co-morbidities) that incentivize providers to admit individuals who most closely match the dimensional criteria for admission to the residential level of care based on ASAM criteria (i.e., those with higher care needs).

Paying an episodic rate instead of a per-day rate is expected to disincentivize residential providers from keeping individuals longer than is clinically necessary as there is no added reimbursement for longer

lengths of stay. The payment model further disincentivizes admissions not aligned with residential care criteria (i.e., those with lesser care needs), thereby helping to ensure only those individuals who clinically need residential care are served.

Qualitative methods were used to track the State's progress in refining and finalizing the objective provider audit and certification tools using ASAM level of care standards; and in implementing a value-based payment model to support ASAM alignment. Findings related to the Vermont's performance under Milestone #2 are provided on the following pages.

PROVIDER CERTIFICATION STANDARDS

Seven action steps were proposed by the State to update SUD treatment standards and implement a new Compliance Assessment Tool (CAT) and certification process by the end of calendar year (CY) 2018. Despite an initial delay in the timeline for completion of the tool and expected provider certification visits, all proposed tasks were completed by the end of CY2018.

Nine providers were certified using the new tool by the end of CY2018. This exceeded the State's target of having four certifications complete by the end of January 2019. During CY2019, an additional 25 surveys were completed along with four additional surveys in the first quarter of CY2020.

The goals of updating the SUD Provider Standards and Certification process, including the CAT, were to:

- Enhance the use of ASAM criteria in making placement decisions;
- Improve objectivity of the audit process through the use of the CAT; and
- Improve consistency of the audit process through the use of the new CAT.

To assess the State's effectiveness in achieving these goals, PHPG created a SUD Provider Survey with 10 questions targeting their experience with the new standards, tool and certification process. The first five questions asked participants to rate on a 5-point scale how much they agreed with the five statements listed below.

- The ADAP Preferred Provider standards support evidence-based placement decisions for my clients;
- The use of the ADAP Compliance Assessment Tool (CAT) resulted in an objective review of my program;
- The use of the CAT has improved consistency in the ADAP audit process;
- The use of the CAT has improved clarity in the audit process; and
- The scoring system (weighting and criteria) used by ADAP, to determine audit results, is clear.

  (Response options included: 1 = Strongly Disagree; 2 = Somewhat Disagree; 3 = Somewhat Agree; 4 = Strongly Agree; 0 = Not Sure)

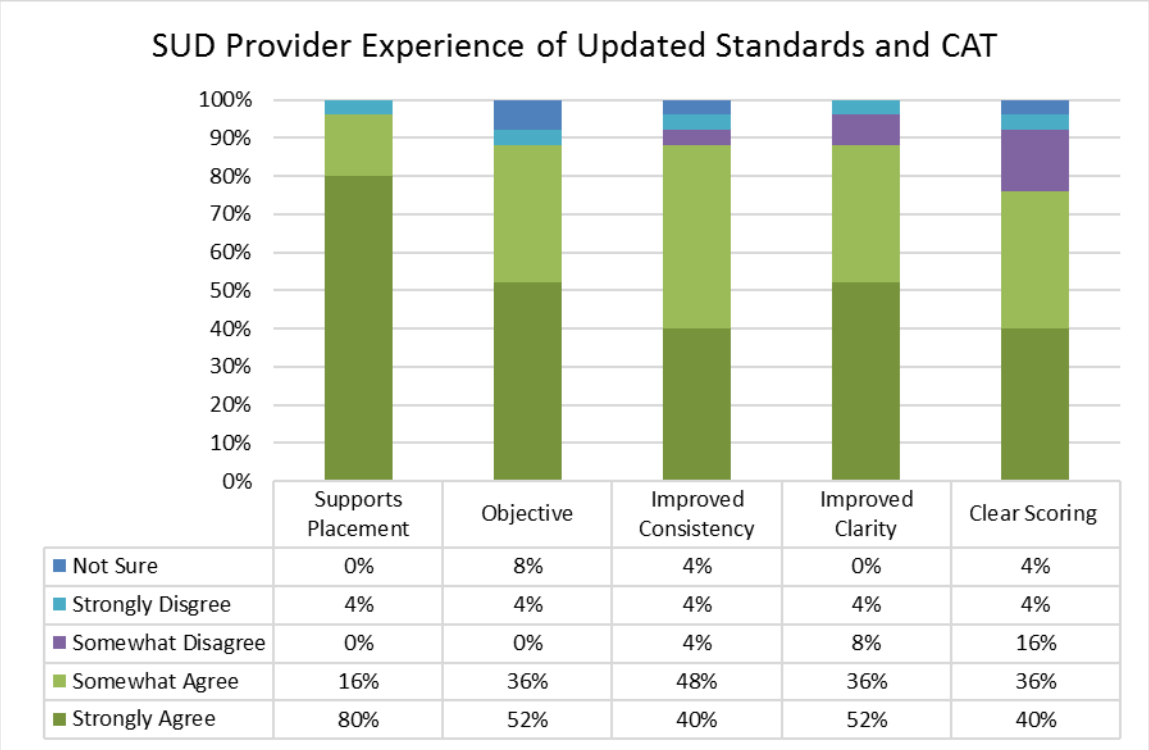
Twenty-six providers returned completed surveys (92.86%). Results for questions regarding the updated provider standards and the new CAT and certification process were overwhelmingly positive. Overall agreement with the statement *"The ADAP Preferred Provider standards support evidence-based placement decisions for my clients"* was 96%, with 80% of respondents strongly agreeing with the statement.

Survey results also suggest that the State was effective in achieving its goals of consistency, objectivity, and clarity. Overall agreement with the following statements was 88%:

- The use of the ADAP Compliance Assessment Tool (CAT) resulted in an objective review of my program;
- The use of the CAT has improved consistency in the ADAP audit process; and
- The use of the CAT has improved clarity in the audit process.

Overall, 76% of respondents agreed that the scoring system used by ADAP to determine certification results was clear. SUD Provider survey results for certification and standard questions are provided in Exhibit 4-4.

Exhibit 4-4: SUD Provider Survey Results



	Supports Placement	Objective	Improved Consistency	Improved Clarity	Clear Scoring
Not Sure	0%	8%	4%	0%	4%
Strongly Disgree	4%	4%	4%	4%	4%
Somewhat Disagree	0%	0%	4%	8%	16%
Somewhat Agree	16%	36%	48%	36%	36%
Strongly Agree	80%	52%	40%	52%	40%

SUD providers were also given the opportunity to offer more detailed information on their experience with the updated standards and CAT with five open-ended questions, outlined below.

- What, if any, changes have you made to align with the August 2018 Preferred Provider standards?
- Has ADAP's use of the CAT changed how you prepare for or experience the certification process? If yes, what has changed?
- Do you have other comments related to the Preferred Provider standards? If yes, please specify.
- Do you have other comments related to the CAT? If yes, please specify.
- Do you have other comments related to the scoring system? If yes, please specify.

Twenty-six comments were received in response to *"What, if any, changes have you made to align with the August 2018 Preferred Provider standards?"* Over 77% of the comments reported positive changes, while the remainder were neutral in nature or indicated no changes were made. Only two comments (12%) were negative, with one reporting that the online upload process was cumbersome and another asking for clarity on the ADAP definition of 'risk management'. Examples of positive comments include:

- *Streamlined the intake process; improved the assessment and treatment planning process and quality; improved discharge planning.*
- *We have clients sign their agency discharge form when possible.*
- *This has allowed us to develop trainings around key target areas of growth for the clinicians.*
- *Monthly peer chart audits modeled after ADAP certification tool with monthly QI presentation outlining our successes and opportunities for improvement.*

Twenty-four comments were received in response to *"Has ADAP's use of the CAT changed how you prepare for or experience the certification process? If yes, what has changed?"* Overall, 63% were positive, 21% were neutral and four comments (17%) were negative. Of the four negative comments, three were related to the cumbersome nature of the online portal and process for uploading documents. Positive comments often related to the use of clear standards and the focus on best practices. Examples of positive comments include:

- *The tool is helpful and seeing the score helps us measure our work.*
- *Yes, it definitely simplified and streamlined that process. The audit checklist was made available to us almost a month in advance which allowed us to do our own internal audit. Knowing exactly what to expect from the site visit, allowed us to prepare for it in a very efficient way.*
- *We are better organized as the expectations are clear.*
- *It allows users to look at areas that need attention and correct those areas in a timely manner.*
- *The tool has given a clearer picture of the compliance standard and a deeper understanding of the care we provide and opportunities of strength and improvement.*

Eight comments were received in response to the question *"Do you have other comments related to the Preferred Provider standards? If yes, please specify."* Overall, 25% of the comments were positive, 63% were critical, and 13% were neutral. Examples of positive statements include:

- *The standards set forth by ADAP are clear and are the reasons preferred providers are a step above others in the field.*

- *Documentation is a part of the counseling profession in any setting and extra documentation only helps the client and the counselor reach the client's goals and objectives in the treatment process.*

Examples of critical statements include:

- *It would be very helpful if ADAP recognized providers with active certification via CARF, NCQA, or other nationally recognized accreditation, as well as Vermont Care Partner's Center of Excellence certification....*
- *Some standards are duplicative with Medicaid rules (e.g., protocols over diagnosis). Duplication is wasteful and detracts from direct service time.*
- *In some ways they are too general; in some ASAM levels of care, the standards are not very detailed. Where ASAM has gaps the State should step in and define written standards.*

Eight comments were received in response to the question *"Do you have other comments related to the CAT? If yes, please specify."* Overall, 50% of the comments were positive; the remainder of the comments were equally split between neutral and negative.

- *Very comprehensive; streamlined our understanding of the evaluation of our program.*
- *I think this represents very good work by the standards team. I would especially like to commend [ADAP staff members] for their work on revising this process. It clearly represented a lot of thoughtful work and resulted in a much clearer and more efficient process for everyone involved.*
- *The clarity was long overdue.*

Examples of critical statements include:

- *We found it to have different language than what we used which lead to a difficulty in interpreting our records....*
- *A larger font or compressed "findings" cells would make it easier to print and read.*

Five comments were received in response to the question *"Do you have other comments related to the scoring system? If yes, please specify."* Overall, 40% of the comments were positive, 40% were neutral and 20% were negative. Examples of positive comments include:

- *The scoring system really helped to clarify deficiencies and target areas for improvement in a measured way.*
- *The scoring system was easy to read and follow. It allowed instant access to areas that need attention.*

Negative comments related to a perceived mismatch between provider and reviewer terminology and semantics.

PROVIDER PAYMENT REFORM

Vermont's SUD Implementation Plan identified six action steps to be completed in 2018, in preparation for a residential payment model effective date of January 1, 2019. Action steps ranged from developing case rate criteria to working with providers on the final model to implement changes within the MMIS system for claims payments and tracking. All expected steps were completed, and the new model was implemented as planned in 2019. A second phase of the payment model was planned for 2020 to add a performance payment component. The 2020 phase was suspended due to delivery system and State priorities related to the COVID-19 pandemic emergency response.

The goals of the SUD residential payment reform were to:

- Support the appropriate level of care for each enrollee;
- Improve transitions of care;
- Achieve successful outcomes for enrollees through flexible and comprehensive care;
- Offer predictable and timely payments; and
- Reduce administrative burden and costs.

To assess the State's effectiveness in achieving these goals, PHPG created a SUD Provider Survey targeting provider experience with the new payment model. The first eight questions asked participants to rate on a 5-point scale how much they agreed with the eight statements listed below.

- The episodic payment model supports our residents in receiving the right amount of care.
- The episodic payment model supports our residents in receiving timely care.
- The episodic payment model has supported enhancements in our approach to discharge planning.
- The episodic payment model has supported enhancements in our clinical practice within the facility.
- The episodic payment model has supported enhancements in our coordination with providers outside the facility.
- The episodic payment model supports improved outcomes for the people we serve.
- The episodic payment model creates a stable financial structure for our facility.
- The elimination of concurrent reviews for continued stays has increased the time our staff have available for direct client services.

  (Response options included: 1 = Strongly Disagree; 2 = Somewhat Disagree; 3 = Somewhat Agree; 4 = Strongly Agree; 0 = Not Sure)

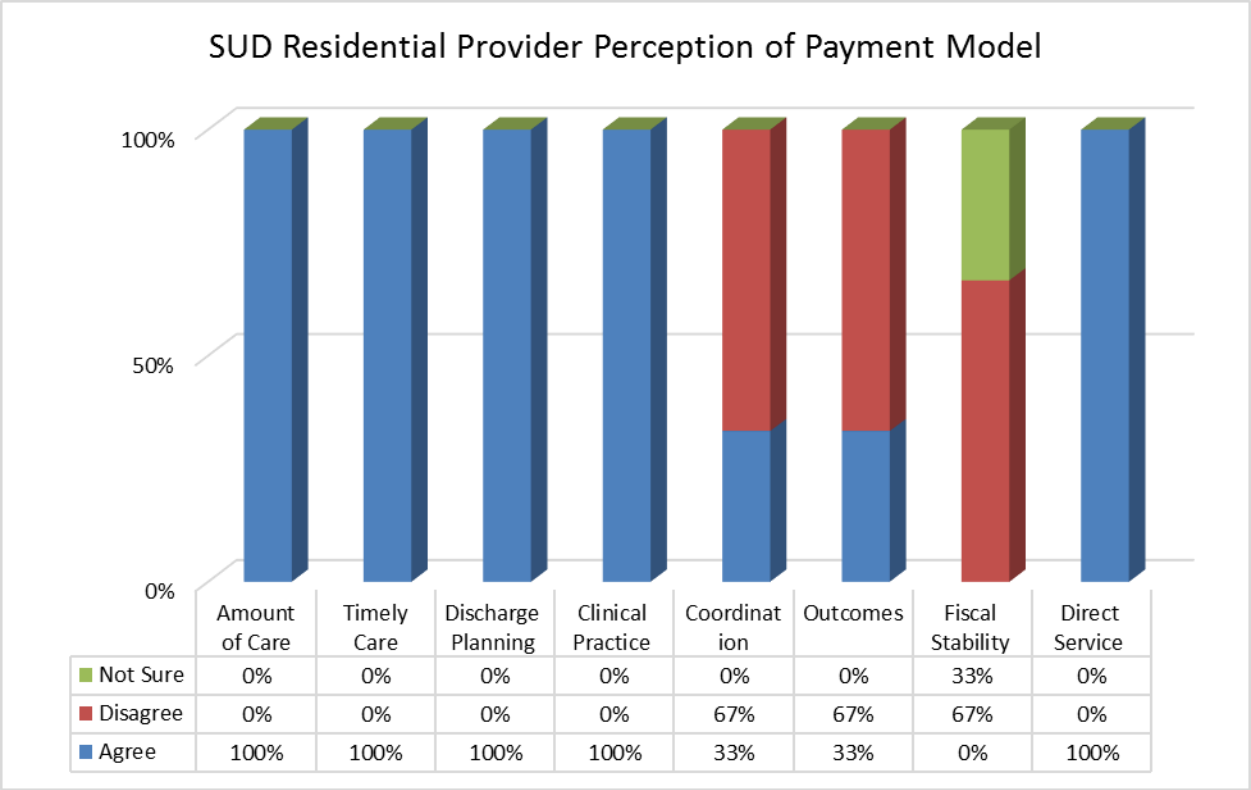
Responses to questions regarding the impact on clinical practices were overwhelmingly positive. All providers agreed that the payment model supported clients in receiving the right amount of care and timely care. In addition, providers agreed that payment approach supported enhancements in discharge planning and clinical practice within the facility.

The majority of providers (67%) disagreed that the payment model supported care coordination, better client outcomes or improved fiscal stability. Most noted that more time was needed to assess any direct impact on outcomes and program finances. Regarding the elimination of concurrent review and

Medicaid authorizations for continued stays, 100% of the providers agreed that staff time available for direct client services increased.

Exhibit 4-5 provides an overview of SUD residential provider survey results.

Exhibit 4-5: SUD Residential Provider Survey Results



	Amount of Care	Timely Care	Discharge Planning	Clinical Practice	Coordination	Outcomes	Fiscal Stability	Direct Service
Not Sure	0%	0%	0%	0%	0%	0%	33%	0%
Disagree	0%	0%	0%	0%	67%	67%	67%	0%
Agree	100%	100%	100%	100%	33%	33%	0%	100%

SUD providers also were given the opportunity to provide more detailed information on their experience with the revised payment model through three open-ended questions, outlined below.

- Has the episodic payment model enhanced your approach to discharge planning? If yes, what aspects have changed?
- Has the episodic payment model enhanced how you coordinate services with other providers? If yes, what aspects have changed?
- What impact has the elimination of concurrent reviews had on your practice (clinical or administrative)?

In general providers reported that programs were of high quality prior to the implementation of the episodic payment model. Many noted that the payment model offered a better fit for what they were already doing.

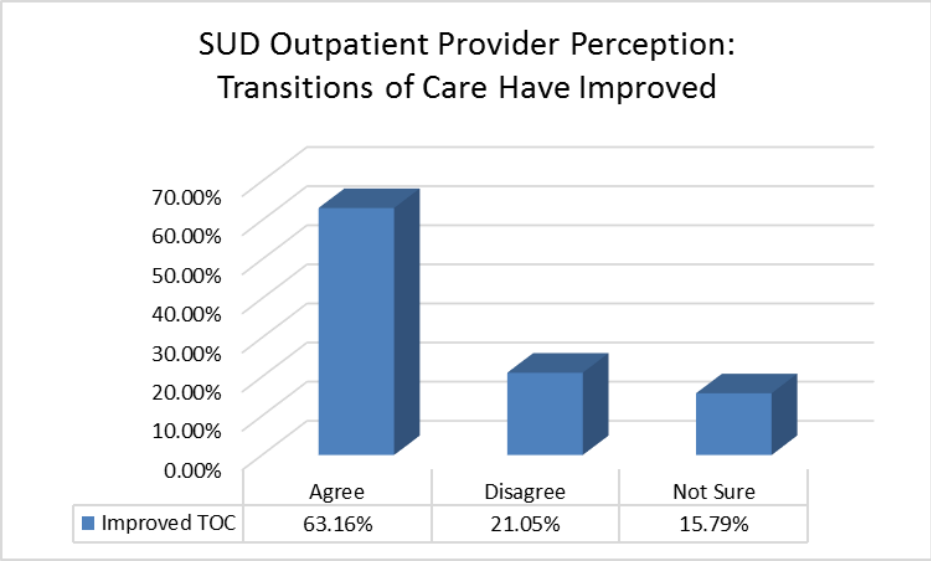
All residential providers reported that the elimination of concurrent reviews allowed for more direct service time and thus greater attention to all aspects of clinical care. For example, rather than focusing on continued stay approvals, a clinician could spend more time teaming with community providers or coordinating a discharge for a client with particularly complex needs.

In assessing the payment model impact on transitions of care, SUD outpatient treatment providers were asked if they had worked with clients from any of the residential programs involved in the payment reform since its effective date. For those responding yes, two additional questions were included in the survey.

First, using the same 5-point scale, respondents were asked how much they agreed with the following statement: *Since January 1, 2019, there has been an improvement in coordination with my services from these facilities.* Nineteen providers indicated they worked with the target programs. Over 63% indicated that they had noticed improvement in coordination.

Exhibit 4.6 provides an overview of SUD provider responses regarding transitions of care.

Exhibit 4-6. SUD Outpatient Provider Perceptions of Transition of Care



Second, providers were given the opportunity to offer more detail by responding to: *If you have noticed an improvement in residential provider coordination with your services, please describe the improvements.* Providers' responses included the following:

- *Residential providers are more often coming to community meetings to discuss referrals and transitions.*
- *Improved communication between providers. Advanced notice of pending discharge, allowing time for coordination of care. Bridge prescriptions are provided when necessary.*
- *Since January 1st, any client that has been referred to us by {program}, has had a complete assessment and after care plan sent to this facility. Continuum of care planning has been discussed in advance of clients discharge date.*
- *There has been a more coordinated effort to exchange information prior to discharge. This is allowing the client to have a smoother transition of care from residential treatment to Intensive Outpatient services. The feedback from clients has been very positive with this change.*

MILESTONE #3 USE OF NATIONALLY RECOGNIZED SUD-SPECIFIC PROGRAM STANDARDS

Vermont's provider certification process, described in Milestone #2 above, includes the certification of residential programs to be designated at an ASAM level of care. The Preferred Provider's compliance and certification compliance tool, described in Milestone #2 above, includes separate sections for each provider type according to the program's ASAM Level of Care. The Standards identify specific requirements a residential provider must meet to receive certification at ASAM Level 3.1, 3.3, 3.5 or 3.7. These requirements include performance expectations, operations (including hours of operation), staffing, human resources, quality improvement, policies and procedures, intensity of services, discharge planning and billing.

All of Vermont's residential programs at ASAM Level 3.3 or higher offer medication assisted treatment (MAT) on site. However, provider grant agreements in place at the beginning of the SUD amendment (July 2018) did not specifically require the residential programs to offer MAT.

Beginning July 1, 2018, ADAP added specific requirements for residential programs to offer MAT in order to receive certification as a Preferred Provider, which allows them to be reimbursed by Medicaid.

The new compliance and certification standards with enhanced ASAM alignment were targeted for implementation by the ADAP Quality Unit by May 1, 2018. ADAP's Clinical Unit and Quality Unit was expected to certify four residential providers using the Compliance Assessment Tool through January 2019.

Certifications were completed for four residential providers in ASAM Levels 3.2 and above by the end of the end of CY2018. During CY2019, an additional 25 surveys (at all levels of care) were completed, along with four in the first quarter of CY2020.

MILESTONE #4 SUFFICIENT PROVIDER CAPACITY AT CRITICAL LEVELS OF CARE

Vermont adheres to all Medicaid Managed Care requirements regarding network adequacy and access standards. ADAP collaborates with DVHA to use Medicaid utilization data and provider encounter data to explore the patterns of utilization for residential care and Specialized Health Home services throughout the State. Under the SUD demonstration, the State planned the development and implementation of a centralized intake system and call center for all Vermonters. The SUD Implementation Plan included process steps for the procurement of a call center vendor.

The centralized intake and resource center, "VT Helplink: Alcohol and Drug Support Center" launched for public use in March 2020. Major components include:

1. A call center staffed by certified Screening & Intake Specialists and licensed clinicians;
2. A website with information related to SUD and a self-screening tool; and
3. An appointment board to connect callers in need of treatment with appointments within ADAP's Preferred Provider Network.

Since its "go live" date in March, VT Helplink has received a total of 1,345 calls and over 9,383 website visits. A total of 758 self-screens for treatment needs were completed via the website. Website users also initiated 77 "online chats" in the first six months.

Over 2,100 referrals were made during the measurement period, with 28% of the referrals for SUD outpatient. Referrals included all levels of care, including 23% for residential services, 15% for MAT services, and 23% for harm reduction or recovery supports. Other referrals related to prevention, public inebriate and impaired driver programs.

To support full functionality of the call center, continued work is planned in 2020 and beyond to engage providers in the use of a SUD provider portal.

SUD Monitoring Protocol measures for Milestone #4 showed positive gains in capacity, with an increase of over 500 SUD treatment providers since 2017 (one year prior to the SUD amendment). A total of 3,051 SUD treatment providers were enrolled in 2019. Also, 120 additional providers were enrolled that are certified to deliver MAT for a total of 466 in 2019. Exhibit 4-7 provides an overview of results.

Exhibit 4-7: SUD Monitoring Protocol Metrics Milestone #4

SUD Monitoring Protocol Measures Milestone #4							
#	Name	Description	Demonstration Goal	2017	2018	2019	Goal Status
13	SUD provider availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Maintain or Increase	2,536	2,830	3,051	**Meeting**
14	SUD provider availability - MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	Maintain or Increase	N/A	346	466	**Meeting**

MILESTONE #5 IMPLEMENTATION OF COMPREHENSIVE TREATMENT AND PREVENTION STRATEGIES

As described in Milestones #1 through #4, Vermont has developed a continuum of services and supports that provide the foundation to successfully address opioid and other substance use disorders in the State. In addition, Vermont's efforts include implementation of prescribing guidelines, harm reduction and prescription drug monitoring.

At the outset of the SUD amendment, Vermont was meeting all CMS requirements for Milestone #5. PHPG examined the following performance metrics, as defined in the SUD Monitoring Protocol, related to the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD:

- *#15 Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)*: Initiation of AOD Treatment—percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of the diagnosis; Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.
- *#18 Use of Opioids at High Dosage in Persons Without Cancer*: Rate per 1,000 beneficiaries included in the denominator without cancer who received prescriptions for opioids with a daily dosage greater than 120 morphine milligram equivalents for 90 consecutive days or longer.
- *#21 Concurrent Use of Opioids and Benzodiazepines*: Percentage of beneficiaries with concurrent use of prescription opioids and benzodiazepines.
- *#22 Continuity of Pharmacotherapy for Opioid Use Disorder*: Percentage of adults in the denominator with pharmacotherapy for OUD who have at least 180 days of continuous treatment.

Vermont set an annual target of "maintain or increase" for Metric #15 (Initiation and Engagement of Alcohol and Other Drug Dependence Treatment) and for Metric #22 (Continuity of Pharmacotherapy for Opioid Use Disorder). Vermont set a goal of "maintain or decrease" for metrics related to opioid prescribing (Metric # 18 and 21). All but one metric "Continuity of Pharmacotherapy for Opioid Use Disorder" performed as expected.

On closer examination, the measure specifications for Continuity of Pharmacotherapy showed that results may be artificially suppressed due to variation in monthly billing practices for patients receiving center-based MAT (Hub) services. Monthly bills at times create an artificial gap that exceeds the 7-day gaps allowed by the measure, thus reporting service breaks that may not be true gaps in care.

Exhibit 4-8 on the following page, provides an overview of results by year.

Exhibit 4-8: SUD Monitoring Protocol Metrics Milestone #5

SUD Monitoring Protocol Measures Milestone #5							
#	Name	Description	Demonstration Goal	2017	2018	2019	Goal Status
15	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET)	Initiation of AOD Treatment—percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of the diagnosis	Maintain or Increase	44.2%	46.7%	49.3%	Meeting
		Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit	Maintain or Increase	23.9%	25.0%	27.9%	Meeting
18	Use of Opioids at High Dosage in Persons Without Cancer	Rate per 1,000 beneficiaries included in the denominator without cancer who received prescriptions for opioids with a daily dosage greater than 120 morphine milligram equivalents for 90 consecutive days or longer.	Maintain or Decrease	111.69	117.37	98.07	Meeting
21	Concurrent Use of Opioids and Benzodiazepines	Percentage of beneficiaries with concurrent use of prescription opioids and benzodiazepines.	Maintain or Decrease	15.31%	14.87%	11.80%	Meeting
22	Continuity of Pharmacotherapy for Opioid Use Disorder	Percentage of adults in the denominator with pharmacotherapy for OUD who have at least 180 days of continuous treatment	Maintain or Increase	68.19%	65.76%	58.89%	Low Risk

MILESTONE #6 IMPROVED CARE COORDINATION AND TRANSITIONS BETWEEN LEVELS OF CARE

Vermont's SUD Implementation Plan identified two program enhancements to contribute to Milestone #6: Recovery Coaches in the Emergency Department (ED) and Implementation of the VT Helplink Call Center (See Milestone #4). Performance assessment for each enhancement relative to Milestone #6 are provided below.

RECOVERY COACHES IN THE EMERGENCY DEPARTMENT (ED)

This program connects individuals presenting in the ED or other parts of the hospital with peer-to-peer support provided by Recovery Coaches. Recovery Coaches are on-call to the ED 24 hours per day, 7 days per week. Recovery Coaches offer support, guidance and information on topics such as overdose, treatment and recovery to both individuals and their family/support system. Recovery Coaches assist individuals by helping them navigate the treatment system, arranging appointments, securing transportation and connecting them to other social services and community resources. The connection initiated in the ED is supplemented by extensive post-ED follow-up by Recovery Coaches through in-person meetings and phone calls.

The SUD Implementation Plan outlines process steps for implementing the program through three recovery centers by the end of 2018. Steps include the creation of Memoranda of Understanding, recruiting and training staff, including providing ED-specific training. All steps were completed as planned.

As of September 2020, ten recovery centers partnered with twelve hospitals to provide Recovery Coach services in the ED. Data October 1, 2019 through September 30, 2020 shows that 1,129 individuals were seen by Recovery Coaches in the ED. Exhibit 4-9 offers an overview of the primary reason (substance) identified during ED visit.

Exhibit 4-9: Primary Reason for SUD ED Visit 10/1/19 – 9/30/2020

Recovery Coach in the ED 10/1/2019 – 9/30/2020	
Reason for ED Visit	**Percent**
Alcohol	60.2%
Opioids	24.7%
Cocaine	4.0%
Amphetamines	0.4%
Benzodiazepines	1.1%
Buprenorphine	2.0%
Hallucinogens	0.4%
Marijuana/Cannabis	1.1%
Methamphetamines	1.5%
Methadone	1.1%
Other	3.5%

Recovery Coaches also attempt to initiate contact with individuals starting the day following their initial visit in the Emergency Department and continue to attempt contact for 10 consecutive days or until the individual requests that the follow-up be modified or discontinued. Over 13,700 follow-up attempts were made with 4,191 follow-up contacts during the 2019-2020 measurement period.

Recovery Coaches assist individuals by recommending services and supports based on the circumstances and multiple needs/issues identified. It is common for Recovery Coaches to offer more than one recommendation. Exhibit 4-10 provides a summary of the number and types of referral supports recommended by Recovery Coaches.

Exhibit 4-10: Recovery Coach in the ED Referrals

Recovery Coach in ED: Referrals to Community Services 10/1/2019 – 9/30/2020	
Type of Referral	**Number**
Community Partner (e.g., visiting nurse association; runaway and homeless youth programs)	628
Detoxification Services	337
MAT (center-based "Hub")	75
Intensive Outpatient Services	97
Mental Health Services	311
Outpatient SUD Treatment Services	139
Public Inebriate Program	5
Recovery Center	855
Residential SUD Treatment Services	463
MAT (office based "Spoke")	93
Support Group (Alcoholics Anonymous, Narcotics Anonymous)	662
Total Referrals	3,665

CALL CENTER SERVICES – VT HELPLINK

Goals relative to VT Helplink procurement and implementation were reported under Milestone #4. In addition to providing intake, screening and appointment scheduling services, call center staff contact individuals who have been discharged from a facility-based program to remind them of their follow-up appointments. Center staff also make regular contact with individuals who are waiting for services. Both of these functions are based on an "opt-in" model, whereby the consumer may request follow-up support. As of August 30, 2020, fewer than ten consumers have requested follow-up services from VT Helplink. For those who chose to "opt-in," successful follow-up contacts were made nearly 60% of the time. Call center staff ensure individuals have information on community supports and other resources (such as recovery centers) and assist individuals in making those contacts.

SUD MONITORING PROTOCOL MEASURES

SUD Monitoring Protocol measures for Milestone #6 show improvements in performance for "Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (AOD)". Seven-day follow-up for AOD increased from 17.42% in 2017 to 24.34% in 2019. Thirty-day follow-up for AOD increased from 26.27% in 2017 to 36.34%. Both 7-day and 30-day follow-up for mental health related ED visits increased over 2017 rates. The 7-day follow-up rate moved from 60% in 2017 to 63.43% in 2019. The 30-day follow-up rate increased from 70.86% in 2017 to 71.47% in 2019.

Exhibit 4-11 on the following page, provides an overview of results for each measure.

Exhibit 4-11: SUD Monitoring Protocol Metrics Milestone #6

SUD Monitoring Protocol Measures Milestone #6							
#	**Name**	**Description**	**Demonstration Goal**	**2017**	**2018**	**2019**	**Goal Status**
17	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	Percentage of ED visits for beneficiary's diagnosis of AOD abuse or dependence and who had a follow-up visit for AOD within 7-days of the ED visit	Maintain or Increase	17.42%	16.94%	24.34%	**Meeting**
		Percentage of ED visits for which the beneficiary received a follow-up visit for AOD within 30 days of the ED visit		26.27%	27.85%	36.34%	**Meeting**
		Percentage of ED visits for beneficiary's diagnosis of mental illness which the beneficiary received a follow-up visit for mental illness within 7 days of the ED visit		60.00%	60.89%	63.43%	**Meeting**
		Percentage of ED visits for which the beneficiary received a follow-up visit for mental illness within 30 days of the ED visit		70.86%	69.31%	71.47%	**Meeting**

CONSUMER INTERVIEWS AND OTHER SUD MONITORING PROTOCOL METRICS

In reviewing Vermont performance with its SUD Implementation Plan and Monitoring Protocol, consumer interview data was examined as well as Monitoring protocol measures not associated with a specific SUD Milestone. Results of these analyses are presented in the sections below.

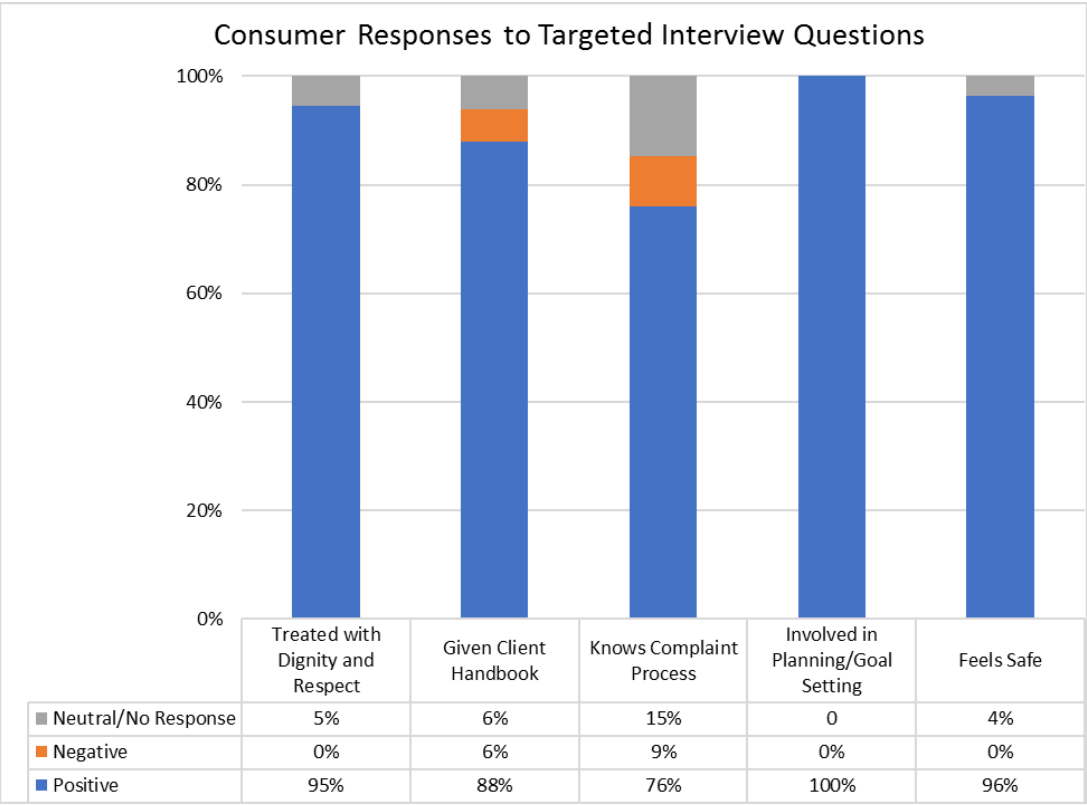
CONSUMER INTERVIEWS

Overall, 73 consumer interview transcripts were examined. Targeted interview questions designed to elicit a binary type (e.g., yes/no, good/bad) of response from consumers include the following:

- How do you feel about the way you've been treated by the staff here?
- When you started this program, did you receive a client handbook?
- If you had a problem or wanted to file a complaint, would you know what to do?
- How involved are you in helping to develop your treatment plan and setting your goals?
- Do you feel safe at {program name}?

Responses were overwhelmingly positive with 95% of respondents reporting being treated with dignity and respect; 88% receiving handbooks; 76% understanding program grievance and complaint processes; 100% being involved in their goal setting and treatment planning and 96% reporting feeling safe at the program site. Exhibit 4-12 offers an overview of results for each targeted question.

Exhibit 4-12: Consumers Responses to Targeted Interview Questions



	Treated with Dignity and Respect	Given Client Handbook	Knows Complaint Process	Involved in Planning/Goal Setting	Feels Safe
Neutral/No Response	5%	6%	15%	0	4%
Negative	0%	6%	9%	0%	0%
Positive	95%	88%	76%	100%	96%

Open ended questions solicited consumer feedback using the following questions/prompts:

- What keeps you coming back?
- What could they do to make things better for you?
- What part of this program do you think is the most helpful to you?
- Do you have any constructive feedback for {program}?
- Do you have any other comments?
- Do you have any positive feedback for {program}?

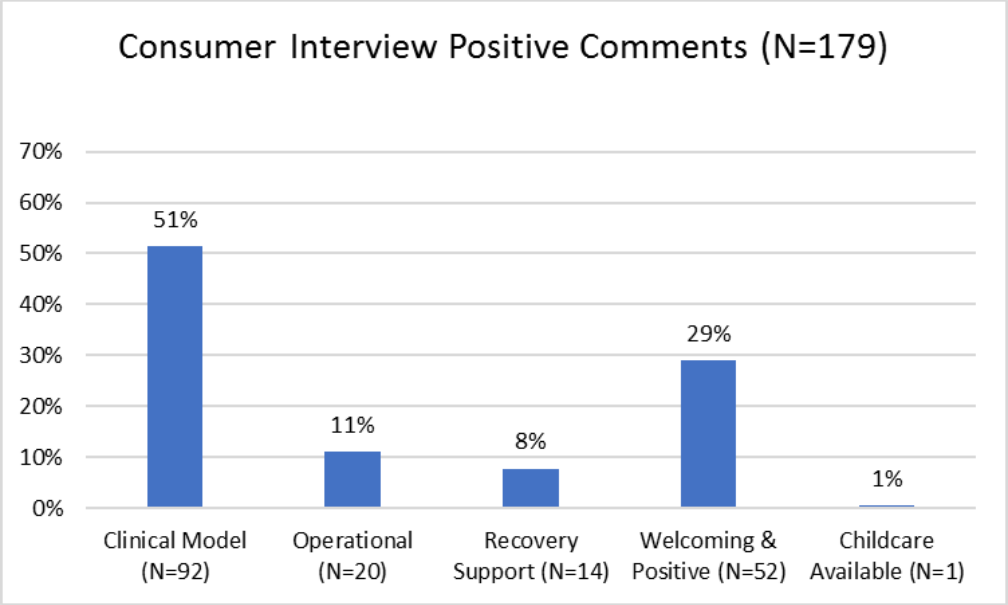
In performing a thematic analysis, responses were categorized as follows: clinical model; operational aspects: childcare; recovery support; and having a welcoming, positive environment. Each major theme was then broken down into several subcategories. Major themes that emerged from open-ended responses, their sub-categories and a brief definition of each is provided in Exhibit 4-13.

Exhibit 4-13. Overview of Consumer Interview Themes

Consumer Interview Thematic Analysis		
Category	**Sub-Category**	**Definition**
Childcare	N/A	Helpfulness of having childcare at facility or lack of access as a barrier
Clinical	Individual Therapy	Specific mention of 1:1 session, individual therapy or counselor
	Caseload, Staffing	Needing more staff, counselors overworked, too many people on caseload
	Group Sessions	Specific groups (parenting, anger management, art, writing) or general references to groups being available, helpful or needed
	Other Services	Services and supports for lifestyle changes (yoga, meditation, smoking cessation, Zumba), physical activity or service needs (acupuncture, medical)
	Personal Goal	Client specific comments (e.g., my kids, my family, relapse, court rules)
	Structure, Team	Overall program structure or model, support, teams, communication, getting questions answered
	Coordination, Community Partners	Reference to working with DOC, DCF, other community agencies, assistance with navigating community services or making referrals
	Medication Assisted Treatment (MAT)	Reference to specific medication types (suboxone, buprenorphine, doctors' orders, etc.)
	MAT Dosing Hours	Availability of hours for receiving medication dose, med times
	MAT Take Homes	Availability of take-home doses, rules around receiving, number of allowable doses
Operational	Operational	General program rules e.g., use of phone, cost, supervision
	Hours	Operating hours, times of day or week (morning, evening, weekends) or specific time slot references (e.g., 5:30-6)
	Wait Times	Wait to get into the program or see counselor
	Physical Environment	Food, furniture, beds, space
	Privacy	Confidentiality, privacy in waiting or other areas of program
	Security/Safety	Holding people accountable, security staff, kicking people out or illegal activity
	Transportation	Getting to/from program, specific transportation issues e.g., bus routes, Medicaid funded and timeliness of transportation
Recovery Support	N/A	Aftercare programs, access to peers who are not using, staff with lived experience, AA, NA
Welcoming, Positive Climate	N/A	Feeling welcome, non-judgmental atmosphere, being comfortable, treated like family, easy to come to program, inviting

Over 175 positive comments were recorded, 51% were related to the clinical model such as 1:1 and group counseling, team structure, coordination with community partners and availability of MAT. Positive statements and praise for programs establishing a welcoming and non-judgmental environment represented 29% of the positive comments. The remainder of positive comments related to the operational model (hours, wait times, security), availability of childcare and recovery supports. Exhibit 4-14 offers and overview of positive comments, followed by a sample of interview excerpts related to each subcategory.

Exhibit 4-14: Positive Themes from Consumer Interviews



Exhibits 4-15 through 4-17 on the following pages offer examples of positive comments by major category and sub-category, where applicable.

Exhibit 4-15: Clinical Model – Examples of Positive Comments

Clinical Model – Positive Comments	
Subcategories	**Consumer Comment Examples**
1:1 Counselor	• *Therapist is great* • *My counselor understands and listens* • *1:1 time is extremely helpful for me*
Group Sessions	• *Learning about my addiction, the groups are very helpful* • *Groups are most helpful (budgeting, parenting, SUD, anger management, recovery and mindfulness)*
Other Services	• *Morning intentions* • *Mindfulness and focus on gratitude* • *Yoga and meditation, Zumba helps with relaxing*
Structure, Team	• *Openness, easy to come with questions, flexible, they explain things* • *Having a team and my own people, the clinicians stay on top of things* • *The program can also work on my medical issues* • *Nurses are great, they answer questions or find someone with the answer*
Coordination, Community Partners	• *Without this program I would not have known about other resources in community e.g., adult learning* • *The program and DCF work together, it's been good* • *IPLAN w/DOC was very helpful* • *Staff communicate with other care partners* • *Work with community partners and parole officer is positive*
MAT	• *Coming here every day is easy* • *Small doses (MAT) get me through and keep me working* • *Medication keeps me coming back*

Exhibit 4-16: Operational Model - Examples of Positive Comments

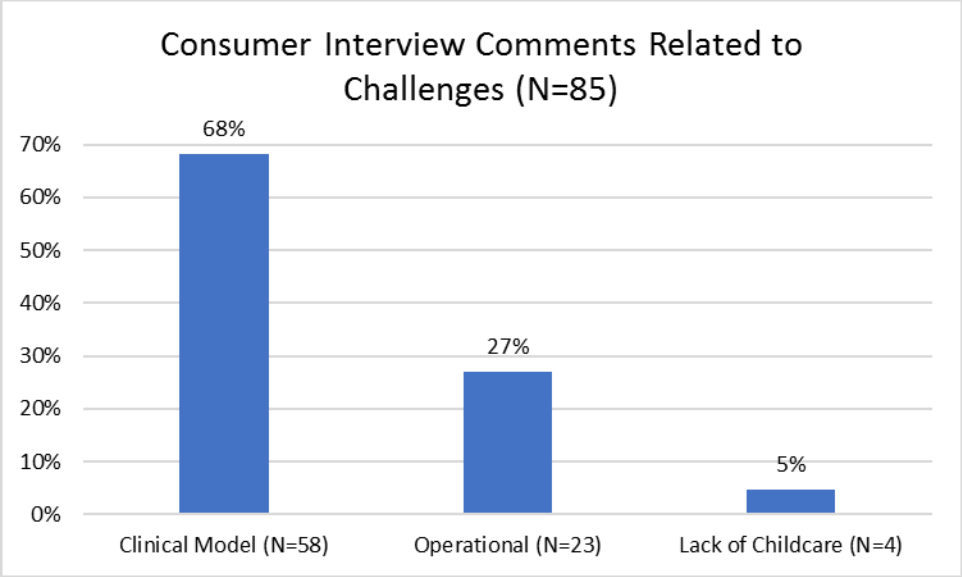
Operational Model - Positive Comments	
Subcategories	**Consumer Comment Examples**
General	• *They are flexible with scheduling if you miss an appointment* • *We are allowed to have visitors* • *We can meet with Doctor without submitting a request* • *Appointment reminders are helpful* • *Groups summaries are emailed*
Hours	• *They stay after 6* • *Hours and notices are posted*
Wait Times	• *Got in quick, met mid-week, in on Monday*
Physical Environment or Food	• *Convenient, I can walk here* • *Program accommodates special dietary needs* • *Food is awesome*
Privacy	• *Staff in community are always discrete*
Security/Safety	• *Safe environment* • *Security is really good; they handle issues* • *They are on top of safety*

Exhibit 4-17: Recovery Support and Welcoming Environment - Examples of Positive Comments

Recovery Support and Welcoming – Positive Comments	
Category	**Consumer Comment Examples**
Recovery Support	• *Meeting new people who are not using* • *Aftercare and counselor help* • *AA groups in the evening help* • *Assisted me with self-help group; they kept in touch* • *Staff in recovery can relate to what's going on*
Welcoming and Positive	• *Everyone is very accepting* • *Friendly and comfortable, non-judgmental* • *The professionalism and way you are treated, you are a person* • *Everyone has a positive attitude/respectful, nurses and secretaries too* • *The staff is like family* • *So inviting, always leave a little lighter* • *First priority is you; they are caring*

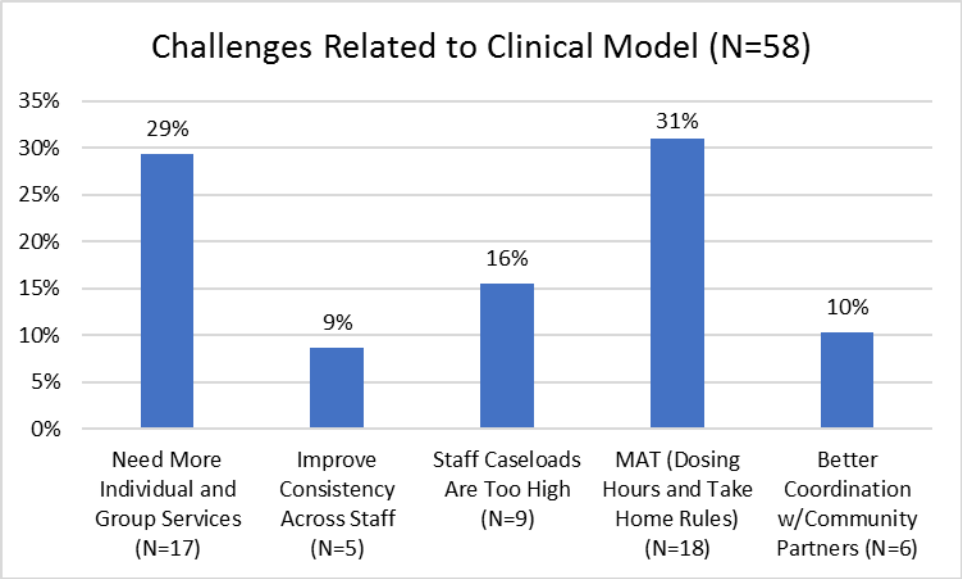
Eighty-five comments citing challenges with program services were scored; 68% of the comments were related to the clinical model, such as the need for more 1:1 and group counseling and challenges with the MAT model; 27% of the comments were related to the operational model and 5% were related to a lack of childcare. Exhibit 4-18 offers an overview of challenges identified by consumers.

Exhibit 4-18: Challenging Themes Emerging from Consumer Interviews



In a further examination of the comments related to the clinical model, the majority were related to not having enough individual and group time (29%), including that clinician caseloads were too high (16%). In addition, 31% of the comments related to the MAT dosing schedules and rules for receiving take home doses. Exhibit 4-19 offer examples of challenges described by consumers by major category and sub-category where applicable.

Exhibit 4-19: Challenges with the Clinical Model



Twenty-three comments related to challenges with the operational model, the majority were related to difficulty with transportation (Medicaid funded and bus routes), general program rules and food. Two of the twenty-three comments suggested a need for better security and privacy. Four of the twenty-three comments noted that a lack of onsite childcare made it difficult to attend program services. Exhibit 4-20 illustrates examples of challenges described by consumers by major category and sub-category.

Exhibit 4-20: Challenges Reported During Consumer Interviews

Challenges		
Category	**Subcategory**	**Consumer Comment Examples**
Childcare	N/A	• *Support for single parents, hard to come so often with kids* • *Groups that you can bring your kids to would help*
Clinical Model	Individual	• *Add more 1:1 time; individual counseling*
	Caseload, Staffing	• *Clinical staff caseload are too high; staff overworked; quality still good, but clinicians can't give as much time* • *More time with the doctor, only get 1/2 hour* • *A lot of staff changes, get comfortable with one, then switches* • *Short staffed - weekend have a lot of free time*
	Groups	• *More groups and longer groups; by the time you start, it's over* • *More groups on weekends*
	Other Services	• *Medical marijuana would be good to treat my lower back pain* • *Need help quitting smoking* • *More options for physical activity*
	Coordination, Community Partners	• *More info about housing vouchers* • *More knowledge of different things (housing, transportation) would be good* • *Support w/rides and housing in community*
	MAT – Dosing Hours	• *Start a number system when you first come in for wait* • *Extend dosing hours when weather is really bad* • *More dosing hours/different hours*

Challenges		
Category	**Subcategory**	**Consumer Comment Examples**
		• *Give priority to people who work when a lot of people waiting*
	MAT - Take Homes	• *Add more take homes* • *Let people who have shown consistent recovery do a month of take homes*
Operational	Physical Environment	• *Better physical accommodations for persons with disabilities* • *Parking too small for capacity*
	Privacy	• *25 people waiting, nurses yell {your name}; a number counter would work*
	Security	• *Kick people out faster that have issues*
	Transportation	• *Transportation is a challenge, no bus stop in close proximity*

OTHER SUD MONITORING PROTOCOL METRICS

In addition to SUD Monitoring Protocol Metrics reported for each CMS Milestone, a set of additional metrics were required by CMS as part of the Monitoring Protocol. These include:

- *#23 Emergency Department Utilization*: Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period;
- *#24 Inpatient Admissions*: Total number of inpatient discharges per 1,000 beneficiaries in the measurement period;
- *#25 Readmissions for SUD*: The rate of all-cause readmissions during the measurement period among beneficiaries with SUD;
- *#26 Overdose deaths (count)*: Number of overdose deaths during the measurement period among Medicaid beneficiaries affected by the demonstration;
- *#27 Overdose deaths (rate)*: Rate of overdose deaths during the measurement period per 1,000 adult Medicaid beneficiaries affected by the demonstration; and
- *#32 Access to preventive/ ambulatory health services*: The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period.

Vermont's annual goal was to maintain or decrease utilization for ED, inpatient admissions/readmissions and overdose deaths. For Access to preventive/ ambulatory health services, the annual goal was to maintain or increase access for beneficiaries.

In examining the State's progress relative to CMS metrics #23 (Emergency Department Utilization) and #24 Inpatient Admissions, the total count of beneficiaries served monthly was converted to an average monthly number for each year studied.

Utilization of ED has remained below than 3 visits per 1,000 members throughout the assessment period. The first six months of 2020 (2.26/1,000) show a slight increase over the baseline 2017 (2.36/1,000). However, the rates for 2018 increased to 2.55/1,000 and 2019 increased to 2.68/1,000. Inpatient hospitalizations per 1,000 members has remained fewer than 2 per 1,000. The rate dropped from the 2017 baseline of 1.82/1,000 to 1.55/1,000 in 2019. It is possible that ED and Inpatient utilization were on the rise and utilization has been suppressed due to fear of accessing ED or hospital care for SUD during the COVID-19 pandemic. Continued monitoring is warranted.

The rate of all-cause readmissions during the measurement period among beneficiaries with SUD has fluctuated over baseline moving from .17 in 2027 to .21 in 2018, before declining to .18 in 2019. The most current data show a slight deviation from the base year. The State appears at low risk for poor performance in this metric, however continued monitoring of ED use is warranted.

Counts of overdose deaths per 1,000 adult Medicaid members in 2019 was 70, at or below the count of 72 in 2017. 2019 counts are preliminary as cause of death data may lag up to one year. When counts are translated into a rate among adult Medicaid beneficiaries there is a slight increased due to the overall drop in Medicaid enrollment from 194,768 in 2017 to 181,065. The total number of deaths for Medicaid members is low; slight variations will cause sharp increases or decreases in rates. In addition, 2019 and 2020 counts are preliminary due to the lag in death records. The decline in death rates between 2018 and 2019 is encouraging. However, continued surveillance by the State shows overdose deaths are increasing in the general population during the 2020 pandemic year. Continued monitoring is warranted.

Access to preventive/ ambulatory health services for adult Medicaid beneficiaries with SUD was high in 2017 with 90.62% and remains high in 2019 with 91.95%.

Other data examined supports the conclusion that Vermont is meeting and exceeding expected performance under its SUD Implementation Plan and SUD demonstration amendment.

Exhibit 4-21 on the following page provides an overview of all “Other” SUD Monitoring Protocol metrics.

Exhibit 4-21: Other SUD Monitoring Protocol Metrics

Other SUD Monitoring Plan Metrics								
#	Name	Description	Demonstration Goal	2017	2018	2019	2020 (6-mos)	Goal Status
23	Emergency Department Utilization	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period (converted to average monthly for each year)	Maintain or Decrease	2.36	2.55	2.68	2.26	Meeting
24	Inpatient Admissions	Total number of inpatient discharges per 1,000 beneficiaries in the measurement period (converted to average monthly for each year)	Maintain or Decrease	1.82	1.98	1.93	1.55	Meeting
25	Readmissions for SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD	Maintain or Decrease	0.17	0.21	0.18	N/A	Low Risk
26	Overdose deaths (count)	Number of overdose deaths during the measurement period among Medicaid beneficiaries affected by the demonstration	Maintain or Decrease	72	84	70	N/A	Meeting
27	Overdose deaths (rate)	Rate of overdose deaths during the measurement period per 1,000 adult Medicaid beneficiaries affected by the demonstration	Maintain or Decrease	0.37	0.45	0.39	N/A	Low Risk
32	Access to preventive/ ambulatory health services	The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period	Maintain or Increase	90.62	90.34	91.95	N/A	Meeting

5. SUD HEALTH IT PLAN

The SUD IT Plan focuses on enhancements for the State's prescription drug monitoring program, the Vermont Prescription Monitoring System (VPMS). The system was implemented as a result of legislation passed in 2006, with data collection beginning in 2009. Vermont uses the VPMS as a clinical tool to address prescription drug misuse and dependence, by tracking the dispensing of controlled substances that are most likely to lead to misuse, addiction, or patient harm.

Law enforcement do not have access to this system. All Vermont-licensed pharmacies, including mail-order pharmacies, are required to provide prescription information on all Schedule II – IV drugs dispensed within 24-hours or one business day of dispensing. In 2017, the upload frequency increased from weekly to daily and the Vermont overall pharmacy upload compliance rate was over 95% in 2018.

During the course of the demonstration, the State has completed many of the action steps identified in the SUD IT Plan. Exhibit 5-1 provides an overview of each SUD IT area, action steps originally proposed by the State and the status of each task in Vermont.

Exhibit 5-1: SUD IT Plan Progress

VT Actions Needed	VT Status
Prescription Drug Monitoring Functionalities	
• ADAP to negotiate data sharing with Florida after 7/1/18 when Florida Statue allows for sharing. By year end, connect a total of at least three new states. • ADAP to work with vendor to complete contract deliverables and develop the linkage to RxCheck hub by 10/31/18. • VDH to test the vendor's software "PMP Gateway" and connectivity for compliance with VT safety and security audits by 12/31/18.	*Data-Sharing with Additional States* • Vermont currently shares prescription data with CT, MA, ME, NH, NJ, NY, RI. • One state, Delaware, has been added in 2019 • Florida does not have the capability to connect directly with Vermont. Vermont assesses the addition of state systems to the VPMS based on shared data needs between systems. The State is procuring a new PDMP vendor. Future enhancements will be assessed following contract initiation. *PMP Gateway* • Vermont has tested the vendor's software and determined that it is in compliance with VT requirements.
Current and Future PDMP Query Capabilities	
• VDH will explore feasibility of integrating the VT Master Person Index (MPI) with the vendor system. If deemed possible, determine timing, cost, and process. Discussions to begin by 12/31/18.	• VDH has completed the assessment and determined that it is not feasible to integrate the VT MPI with the current vendor system. This integration will not be pursued. The State is also procuring a new PDMP vendor and may reassess needs and capabilities following contract initiation.
Use of PDMP – Supporting Clinicians with Changing Office Workflows/Business Processes	
• TA availability has been integrated into the Prescriber Insight Report process. The impact of implementation is being evaluated. • VDH is conducting an impact evaluation of the 7/1/17 pain prescribing rule change, expected by 12/31/18. • User acceptance testing of clinical alerts began 2/2018; implementation planned 7/1/18.	*Prescriber Insight Reports* • Insight Reports were evaluated. *Pain Management Rule Impact Study* • Prescribing Rules Report were evaluated. *Clinical Alert System* • Clinical Alerts were implemented for three areas: Concurrent prescribing of benzodiazepines and opioids; opioid prescribing in excess of 90 MME;

VT Actions Needed	VT Status
	and multiple concurrent prescriptions or pharmacies for opioids.
Master Patient Index / Identity Management	
• The HIE Steering Committee, and DVHA are working to develop a state-wide Health Information Exchange/Health-IT strategic plan. The Plan will address health-IT network and needs, including SUD efforts. By November 2018, the plan will be submitted for Green Mountain Care Board (GMCB) approval. • VDH is working with the VPMS vendor on threshold reporting by 12/31/18.	*HIE plan* • SUD IT Plan was incorporated into the State's HIE plan. *Threshold Reporting* • Threshold reporting was incorporated into the clinical alert system (above) for each of the alerts noted.
Overall Objective for Enhancing PDMP Functionality & Interoperability	
• Vermont has a fully integrated VPMS with proactive reporting to prescribers and pharmacists to decrease initiation and misuse of prescription drugs. • Those Vermonters with opioid use disorders, identified through this and other avenues, are referred to and receive treatment.	• VT is working with leadership of Vermont's Children's Hospital, Dr. First and its vendor, Appriss to test integration functionality that enables the VPMS information to populate EHRs with important prescribing detail, eliminating the need for physicians to work in two separate systems. • State staff are engaged with the New England States Consortium Systems Organization (NESCSO) State HIT Learning Community. This group works to create a shared understanding of Federal legislation, the current state of PDMP activities, and identifies opportunities for multi-state alignment and EHR integration. • Clinical Alerts, Prescriber Insight Reports and updated rules for opioid prescribing have contributed to identification and referral to education and treatment for Vermonters who may be at risk of misuse.

In 2016, Act 173 was enacted by the Vermont State Legislature to strengthen existing opioid prescribing requirements. As part of this enhancement, the administrative rule governing the prescribing of opioids for pain was updated, effective July 1, 2017. An impact analysis of Vermont's prescribing rule was released by the Vermont Department of Health in January of 2020. The study looked at the following three objectives of the rule.

- *Increase prescriber participation in the VPMS*: The study showed that, as of the 3rd quarter of 2019, 90% of prescribers were registered with the system. In addition, queries by prescribers who wrote opioid prescriptions had increased by 35% in 2018.
- *Reduce the use of opioids prescribed in dangerous amounts*: Total Morphine Milligram Equivalents (MME) dispensed declined by 22% since the implementation of the rule. The percent of the population prescribed at least one prescription also declined by 19%. Prescribing opioids at high doses (greater that 90 MME/day) decreased from 15% to 12% and prescribing at 50 MME or less increased from 67% to 71%, suggesting that more patients are receiving prescriptions at lower amounts to manage pain.

- *Reduce prescribing of opioids to youth 17 and younger*. After the implementation of the rule, the total number of opioid prescriptions decreased by 25%, the total number of opioid recipients declined by 24%, MME decreased by 42% and the average daily MME declined by 18%.

In 2018, VPMS began sending Prescriber Insight Reports. These reports offer an overview of provider prescribing patterns and where available, compare prescribing patterns to other providers in their specialty areas. Approximately 1,900 Prescriber Insight Reports were sent in the first two quarters of 2018; 80 providers who received reports responded to a 2019 VPMS survey regarding the usefulness of the report.

Of the 80 survey respondents who received a Prescriber Insight Report, almost all (92%) indicated that they reviewed the report. Nearly half (47%) found the reports useful. When asked what actions they took as a result of the report 14% of respondents indicated that they checked patient prescription histories; 9% changed prescribing practices; and 7% shared the report with colleagues for discussion. When asked to rank what sections of the report were most useful, respondents indicated that "the number of patients for which you prescribed opioids" was the most useful. Exhibit 5-2 provides a summary of provider rankings for each section of the Prescriber Insight Report.

Exhibit 5-2: Provider Ranking of Prescriber Insight Report Sections

Prescriber Insight Reports: Report Section Rankings (1 = Most useful)	
1	Number of patients for which you prescribed opioids
2	Number of prescriptions you wrote for opioids
3	Comparisons with 3 similar providers and state for selected measures
4	Dangerous combination therapy
5	Opioid analgesic prescriptions by daily MME
6	Patients exceeding multiple provider thresholds
7	Anxiolytic/Sedative/Hypnotic prescribing
8	Top medications prescribed
9	Opioid treatment duration
10	Prescription volumes
11	Prescription Drug Monitoring Program Usage (queries)

CMS METRICS

In addition to the Vermont-specific study, CMS-required metrics also were examined. Results of these measures align with other findings showing an increased number of VPMS users since 2015 and increased number of checks during the measurement period. In 2019, Vermont implemented provider verification which resulted in removing practitioners who were no longer licensed in Vermont; and removing residents who had completed their residencies.

In 2019 there were 700 more PDMP users than in 2017 and nearly 80,000 more inquiries than the base year. Exhibit 5-3 on the following page, provides an overview of the SUD IT Plan Metrics.

Exhibit 5-3: SUD IT Plan Monitoring Protocol Metrics

SUD Monitoring Plan Measures – SUD Health IT Plan							
#	Name	Description	Demonstration Goal	2017	2018	2019	Goal Status
Q1	PDMP users	Number of PDMP users	Maintain or Increase	5,722	7,768	6,422	Meeting
Q1	PDMP Checks	Number of PDMP checks during the measurement period	Maintain or Increase	275,653	344,182	355,361	Meeting
Q2	PDMP linkages	Number of PDMP linkages to other states/health systems during the measurement period	Maintain or Increase	7	7	8	Meeting
Q3	HIT/HIE Plan	Existence of an annually updated health-IT/health information exchange plan that targets health-IT matters intended to improve or further SUD efforts during the measurement period	N/A	N/A	Yes	Yes	Meeting

6. SUD AMENDMENT BUDGET NEUTRALITY FINDINGS

For CY2019, the Supplemental Budget Neutrality Test for SUD Expenditures shows that SUD IMD expenses for ABD Adult, ABD Dual and non-ABD Adult have exceeded the without waiver limits by $391,071 gross. The SUD expenses for the New Adult MEG have also exceeded the without waiver limit by $1,026,423 gross.

The demonstration's Special Terms and Conditions (STC #66) note that is the FFP for the SUD IMD eligibility groups exceed the federal share of the SUD Budget Neutrality Test, the difference must be reported as a cost against the Demonstration's overall budget neutrality limit. The Global Commitment to Health Demonstration's Budget Neutrality is in a favorable position. The overall BN limit and the non-SUD IMD New Adult budget neutrality limit can accommodate the SUD IMD overage.

Exhibits 6-1 and 6-2 below provide an overview of the SUD-IMD PMPM limits through CY2019.

Exhibit 6-1: SUD-IMD PMPM Expenditures and Limits CY2018 (6-months)

SUD -IMD PMPM CY2018 (6-months) *						
Approved STCs			Actuals CY2018 (6 months)			
MEG	Approved Trend	Limit	Gross	Member Months	PMPM	Variance
SUD IMD ABD	3.40%	$3,436.40	$249,820	78	$3,202.83	$233.57
SUD IMD ABD Dual	1.80%	$2,749.94	$199,224	78	$2,554.16	$195.78
SUD IMD Non-ABD	0.00%	$2,852.36	$540,841	187	$2,892.20	($39.84)
SUD IMD New Adult	0.60%	$2,988.12	$2,826,119	905	$3,122.78	($134.66)

**From VT AHS-CO Budget Neutrality Workbook QE 0320 updated April 30, 2020 received June 25, 2020*

Exhibit 6-2: SUD-IMD PMPM Expenditures and Limits CY2019

SUD -IMD PMPM CY2019*						
Approved STCs			Actuals CY2019			
MEG	Approved Trend	Limit	Gross	Member Months	PMPM	Variance
SUD IMD ABD	3.40%	$3,553.24	$646,440	149	$4,338.52	($785.28)
SUD IMD ABD Dual	1.80%	$2,799.44	$545,837	158	$3,454.66	($655.22)
SUD IMD Non-ABD	0.00%	$2,852.36	$803,762	222	$3,620.55	($768.19)
SUD IMD New Adult	0.60%	$3,006.05	$5,869,169	1611	$3,643.18	($637.13)

**From VT AHS-CO Budget Neutrality Workbook QE 0320 updated April 30, 2020 received June 25, 2020*

7. ASSESSMENT SUMMARY AND RECOMMENDATIONS

Overall, the progress to date for the State's SUD amendment as measured through its Implementation Plan and Monitoring Protocol is strong. Expected enhancements to the system were made within planned timelines and performance goals related to delivery system enhancements have been met. Consumer interview responses regarding the SUD delivery system were overwhelmingly positive with:

- 95% reporting being treated with dignity and respect;
- 88% receiving program handbooks;
- 76% understanding program grievance and complaint processes;
- 100% being involved in their goal setting and treatment planning; and
- 96% reporting feeling safe at the program site.

Consumers identified some challenges with caseload size and staff turnover, indicating that more 1:1 and groups sessions would be helpful. Challenges were also noted with MAT dosing hours and rules around take home doses. However, over 68% of the comments recorded for thematic analysis were positive. Consumers provided positive feedback for the clinical model and recovery supports. Many consumers specifically commented that the SUD delivery system (at every ASAM level of care) provided a welcoming, caring and non-judgmental environment for treatment and recovery.

In addition, the majority of the SUD Monitoring Protocol measures are trending in a positive direction.

Exhibit 7-1: provides an overview of progress to-date and key findings.

Exhibit 7-1: SUD Mid-Point Assessment Findings

SUD Mid-Point Assessment Overview		
CMS Milestone	**Assessment of Progress**	**Key Findings**
Milestone #1: Access to Critical Levels of Care for OUD and Other SUDs	**Meeting**	Six of the seven metrics reviewed (87%) are trending positive • One metric warrants monitoring to ensure that the observed decline in utilization is related to lower Medicaid enrollment and potential impact of COVID-19. • One metric (Early Intervention) could not be assessed
Milestone #2: Use of Evidence-Based, SUD-Specific Patient Placement Criteria	**Meeting**	The State successfully implemented all planned enhancements. • 96% of Providers report agreement that ADAP's enhanced Preferred Provider standards support evidence- based placement. • Residential providers report that the new episodic payment model supports clients in receiving the right amount of care, and timely care.
Milestone #3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	**Meeting**	The State successfully implemented all planned enhancements.
Milestone #4: Sufficient Provider Capacity at	**Meeting**	Two of the two metrics reviewed (100%) are trending positive. Changes since 2017 show:

SUD Mid-Point Assessment Overview		
CMS Milestone	**Assessment of Progress**	**Key Findings**
Critical Levels of Care including for Medication Assisted Treatment for OUD		• An increase of over 500 SUD treatment providers; • 120 more providers qualified to deliver MAT; and • The successful development of the VT Helplink, a centralized call center and online hub. VT Helplink has assisted consumers with over 2,100 referrals to SUD treatment services, including MAT.
Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	**Meeting**	Four of the five (80%) of the metrics reviewed are trending positive. Change since 2017 includes: • An increase in initiation and engagement of alcohol and other drug dependence treatment; • Total MME dispensed declined by 22%; • The percent of the population prescribed at least one prescription declined by 19%; • Prescribing opioids at high dose (greater that 90 MME/day) deceased from 15% to 12%; and • Prescribing at 50 MME or less increased from 67% to 71%.
Milestone #6: Improved Care Coordination and Transitions between Levels of Care	**Meeting**	Four of the four (100%) of the metrics reviewed are trending positive. • 63% of outpatient treatment providers noted improvements in continuity of care for those facilities involved in payment reform (Milestone #2). • Ten recovery centers have partnered with twelve hospitals to provide Recovery Coach services in the ED. 1,129 individuals have been supported by a Recovery Coach in the ED October 1, 2019 through September 30, 2020.
SUD IT Plan	**Meeting**	Four out of four (100%) of the metrics reviewed are trending positive. • The State has seen a steady increase in VPMS users and queries; and added one state, Delaware, to the interstate data-sharing database. • Plans to add new states are on hold, pending the procurement of a new vendor and reassessment of the State's needs.
Budget Neutrality	**Meeting**	The State is exceeding the established PMPM limits for the SUD amendment, however the STCs allows for these overages if the overall demonstration limit is not exceeded. To date, the State's overall limit is not in jeopardy.
Other Monitoring Protocol Metrics	**Meeting**	Four of the six (67%) of the metrics reviewed are trending positive.

Of the 29 SUD Monitoring Protocol measures reviewed, four are not trending in the targeted direction. However, differences in performance from baseline to 2020 are minor. As previously discussed, factors impacting these metrics include:

- Declining Medicaid enrollment;
- Impact of COVID-19 on utilization;
- Low counts such that small changes may not be indicative of program performance; and
- Metric construction.

The following four metrics are designated as "Low Risk" for meeting performance expectations due to the influences outlined above:

- Metric #8 Outpatient utilization;
- Metric #22 Continuity of pharmacotherapy;
- Metric #25 All cause readmission rate; and
- Metric #27 Rate of overdose deaths per 1,000 adult Medicaid beneficiaries.

One measure (Metric #7), beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) yielded fewer than 5 observations over the 3-year measurement period and could not be assessed. SBIRT services are not currently billed through the MMIS. Vermont has completed a five-year SAMHSA grant to promote Screening, Brief Intervention and Referral for Treatment (SBIRT) throughout Vermont. SBIRT services are intended to identify individuals with risky alcohol and drug behavior and provide a brief intervention or a referral to treatment, if necessary. Throughout the life of the grant, SBIRT has been expanded to multiple settings including: emergency rooms, free health clinics, primary care, and a student health clinic.

As a result of the State's efforts to increase the use of the SBIRT practices, the model has been renamed and expanded. The initiative, Screening, Brief Intervention, and Navigation to Services (SBINS), includes the identification of a broader range of risk factors including depression, substance use, and social determinants of health. Under the SBIRT framework, providers refer patients to treatment; under the SBINS model, care management staff help patients navigate the support system and stay engaged.

SBINS expansion is now an optional practice component under the State's Blueprint for Health for Patient Centered Medical Homes and Multi-payer Advanced Primary Care Practice providers. SBINS planning guides, staffing models, training, screening tools and best practice models are available as part of the Blueprint for Health statewide network. As part of the Blueprint framework, SBINS services are often provided by care management staff and not billed separately through traditional fee-for-service payment systems.

In 2019, SUD expenditures exceeded the without waiver limits by $391,071 gross, in addition, the SUD expenses for the New Adult MEG also exceeded the without waiver limit by $1,026,423 gross. AHS is exploring the impact of a rate increase for SUD IMD services as well as examining other cost drivers for the SUD PMPM. As allowed for in the demonstration's Special Terms and Conditions the difference in the SUD PMPM rates must be reported as a cost against the demonstration's overall budget neutrality limit. At the end of 2019, the Global Commitment to Health Demonstration's Budget Neutrality was in a favorable position and could accommodate the SUD IMD overage. The State does not appear to be at risk for meeting its budget neutrality obligation under the demonstration.

APPENDIX 1: SUD PROVIDER SURVEY INSTRUMENTS

Survey instruments begin on the following page.

PHPG

THE PACIFIC HEALTH POLICY GROUP

100 SOUTH MAIN STREET • SUITE 3 • WATERBURY • VERMONT • 05676 • TEL 802-882-8228

To: VT SUD Preferred Providers July 2019

You are receiving this packet as a Preferred Provider in the Vermont Department of Health/Alcohol and Drug Abuse Programs (ADAP) Substance Use Disorder (SUD) treatment system who has recently completed Preferred Provider Certification. The Center for Medicare and Medicaid Services (CMS) requires that Vermont conduct an independent assessment of progress under the GC Section 1115 Medicaid Demonstration's July 1, 2018 SUD amendment; this is the federal agreement that allows Medicaid to pay for certain SUD treatment services in Vermont.

AHS has engaged the Pacific Health Policy Group (PHPG) to design and conduct the required "SUD Mid-Point Assessment", including a brief SUD provider survey. The purpose of the provider survey is to collect your input regarding the following implementation activities:

Milestone #2 Use of Evidence-Based SUD placement criteria:

- Improving the provider audit and certification process, through the development of a new compliance assessment tool and scoring guide; and
- Developing a Value-based payment model for residential services.

Milestone #3 Use of Nationally Recognized SUD-specific program standards to set provider qualifications for residential treatment facilities: The improved provider audit and certification process, identified in Milestone #2, also serves to enhance ASAM alignment for residential treatment facilities.

We are asking for approximately 10-20 minutes of your time to complete a brief survey about your recent experience with the Preferred Provider Certification process. All responses will be de-identified. Survey results will be aggregated, and themes will be presented as part of a report to CMS at the end of December 2020. Surveys will not be shared with State staff and will be destroyed following the completion of the project. You may complete the survey electronically or manually and return via:

Electronic Submission: ssantarcangelo@phpg.com
Hard Copy Submission: Suzanne Santarcangelo, Ph.D.
Pacific Health Policy Group
100 South Main St, Suite #3
Waterbury Vermont 05676

Please return the completed materials by August 16th. PHPG will contact you in the next week to confirm receipt of these materials and to discuss any questions you may have about the survey. You may also complete the survey over the phone, if that is preferable. You may contact us at any time with questions at 802-882-8228.

Thank-you for your time and participation.

Suzanne Santarcangelo, Ph.D., Senior Associate
VT SUD Mid-Point Assessment Project Manager

ADAP Non-Residential Treatment Provider Survey		
For PHPG tracking purposes only, please provide your name and program information below.		
Provider Name:	Name of Person Completing Survey:	Date Survey Completed:
What was the date of your most recent ADAP certification audit? (mm/year):		

Section 1: ADAP Preferred Provider Standards, updated August 1, 2018

In collaboration with stakeholders and providers, ADAP's Preferred Provider standards were updated effective August 1, 2018. At the same time ADAP developed a Compliance Assessment Tool for use during on-site provider audits. Questions 1-10 relate to your experience of the standards and audit process, that were effective August 2018.

"Objective Review" refers to the reviewer using an unbiased approach e.g., not influenced by personal feelings or opinions in considering and representing facts.

"Coordination" refers to the process used to engage and communicate with providers outside of the facility such as scheduling post-discharge appointments, soliciting your input for purposes of client assessment, treatment planning, discharge planning and outcome monitoring.

"Compliance Assessment Tool (CAT)" refers to the instrument sent to you in advance of your most recent review and used by ADAP to organize and conduct your Preferred Provider Certification.

For each question below, please place a "✓" in the number box that indicates how strongly you agree with the statement: "1" being strong disagreement and "4" being strong agreement. If you have no opinion or are not sure, check "0".

Question	1 Strongly Disagree	2 Somewhat Disagree	3 Somewhat Agree	4 Strongly Agree	0 Not Sure
1. The ADAP Preferred Provider standards support evidence-based placement decisions for my clients.					
2. The use of the ADAP Compliance Assessment Tool (CAT) resulted in an objective review of my program.					
3. The use of the CAT has improved consistency in the ADAP audit process.					
4. The use of the CAT has improved clarity in the audit process.					
5. The scoring system (weighting and criteria) used by ADAP, to determine audit results, is clear.					

In questions 6-10 below, provide us with more detail on your experience. If you do not have additional comments, indicate "N/A".

6. What, if any, changes have you made to align with the August 2018 Preferred Provider standards?

7. Has ADAP's use of the CAT changed how you prepare for or experience the certification process? If yes, what has changed?

8. Do you have other comments related to the Preferred Provider standards? If yes, please specify.
9. Do you have other comments related to the CAT? If yes, please specify.
10. Do you have other comments related to the scoring system? If yes, please specify.

The following questions relate to recent residential payment reform and how it impacts transitions of care					
11. Since January 1, 2019, have you served any client, *within 30 days of their discharge*, from Recovery House or a Valley Vista facility?	If Yes, please move to questions 12-13		If No, thank-you, your survey is complete.		
Please place a "✓"in the number box that indicates how strongly you agree with the following statement	1 Strongly Disagree	2 Somewhat Disagree	3 Somewhat Agree	4 Strongly Agree	0 Not Sure
12. Since January 1, 2019, there has been an improvement in coordination with my services from these facilities.					
13. If you have noticed an improvement in residential provider coordination with your services, please describe the improvements.					

THANK-YOU FOR YOUR TIME!
Please Return the Completed Survey to PHPG by:

Electronic Submission: ssantarcangelo@phpg.com
Hard Copy Submission: Pacific Health Policy Group
100 South Main St, Suite #3
Waterbury Vermont 05676
Questions: 802-882-8228

PHPG

THE PACIFIC HEALTH POLICY GROUP

100 SOUTH MAIN STREET • SUITE 3 • WATERBURY • VERMONT • 05676 • TEL 802-882-8228

To: VT Residential SUD Treatment Providers July 2019

You are receiving this packet as a Preferred Provider in the Vermont Department of Health/Alcohol and Drug Abuse Programs (ADAP) Substance Use Disorder (SUD) treatment system, who is involved in Residential Payment Reform. The Center for Medicare and Medicaid Services (CMS) requires that Vermont conduct an independent assessment of progress under the GC Section 1115 Medicaid Demonstration's July 1, 2018 SUD amendment; this is the federal agreement that allows Medicaid to pay for certain SUD treatment services in Vermont.

AHS has engaged the Pacific Health Policy Group (PHPG) to design and conduct the required "SUD Mid-Point Assessment", including a brief SUD provider survey. The purpose of the provider survey is to collect your input regarding the following implementation activities:

Milestone #2 Use of Evidence-Based SUD placement criteria:

- Improving the provider audit and certification process, through the development of a new compliance assessment tool and scoring guide; and
- Developing a Value-based payment model for residential services.

Milestone #3 Use of Nationally Recognized SUD-specific program standards to set provider qualifications for residential treatment facilities: The improved provider audit and certification process, identified in Milestone #2, also serves to enhance ASAM alignment for residential treatment facilities.

We are asking for approximately 20 minutes of your time to complete a brief survey today and a shorter survey again in August of 2020. All responses will be de-identified. Survey results will be aggregated, and themes will be presented as part of a report to CMS at the end of December 2020. Surveys will not be shared with State staff and will be destroyed following the completion of the project. You may complete the survey electronically or manually and return via:

Electronic Submission: ssantarcangelo@phpg.com
Hard Copy Submission: Suzanne Santarcangelo, Ph.D.
Pacific Health Policy Group
100 South Main St, Suite #3
Waterbury Vermont 05676

Please return the completed materials by August 16th. PHPG will contact you in the next week to confirm receipt of these materials and to discuss any questions you may have about the survey. You may also complete the survey over the phone, if that is preferable. You may contact us at any time with questions at 802-882-8228.

Thank-you for your time and participation.

Suzanne Santarcangelo, Ph.D., Senior Associate
VT SUD Mid-Point Assessment Project Manager

ADAP Residential Treatment Provider Survey

For PHPG tracking purposes only, provide your name and program information below.

Facility Name:	Name of Person Completing the Survey:	Date Survey Completed:

Section 1: Episodic Residential Payment Model, effective January 1, 2019

In collaboration with the Department of Vermont Health Access, ADAP has implemented an episodic payment model for residential treatment stays longer than 3-days. Questions 1-11 relate to your experience of the new payment model, effective January 1, 2019.

"Coordination" refers to the process used to engage and communicate with providers outside of the facility such as scheduling post-discharge appointments with other service providers, soliciting input from other service providers for purposes of client assessment, treatment planning, discharge planning and outcome monitoring. "Other providers" refers to any provider outside of the facility including outpatient treatment providers, primary care physicians/practices (PCPs), specialists, peer recovery and other social services.

For each question below, please place a "✓" in the number box that indicates how strongly you agree with the statement: "1" being strong disagreement and "4" being strong agreement. If you have no opinion or are not sure, check "0".

Question	1 Strongly Disagree	2 Somewhat Disagree	3 Somewhat Agree	4 Strongly Agree	0 Not Sure
1. The episodic payment model supports our residents in receiving the right amount of care.					
2. The episodic payment model supports our residents in receiving timely care.					
3. The episodic payment model has supported enhancements in our approach to discharge planning.					
4. The episodic payment model has supported enhancements in our clinical practice within the facility.					
5. The episodic payment model has supported enhancements in our coordination with providers outside the facility.					
6. The episodic payment model supports improved outcomes for the people we serve.					
7. The episodic payment model creates a stable financial structure for our facility.					
8. The elimination of concurrent reviews for continued stays has increased the time our staff have available for direct client services.					

In questions 9-11 below, provide us with more detail on your experience. If you have not experienced changes, indicate "N/A".

9. Has the episodic payment model enhanced your approach to discharge planning? If yes, what aspects have changed?

10. Has the episodic payment model enhanced how you coordinate services with other providers? If yes, what aspects have changed?

11. What impact has the elimination of concurrent reviews had on your practice (clinical or administrative)?

Section 2: ADAP Preferred Provider Standards

In collaboration with stakeholders and providers, ADAP's Preferred Provider standards were updated effective August 1, 2018. At the same time ADAP developed a Compliance Assessment Tool for use during on-site provider audits. Questions 12-22 relate to your experience of the standards and audit process, that were effective August 1, 2018.

"Objective Review" refers to the reviewer using an unbiased approach e.g., not influenced by personal feelings or opinions in considering and representing facts.

"Compliance Assessment Tool (CAT)" refers to the instrument sent to you in advance of your most recent review and used by ADAP to organize and conduct your Preferred Provider Certification.

For each question below, please place a "✓" in the number box that indicates how strongly you agree with the statement: "1" being strong disagreement and "4" being strong agreement. If you have no opinion or are not sure, check "0".

Question	1 Strongly Disagree	2 Somewhat Disagree	3 Somewhat Agree	4 Strongly Agree	0 Not Sure
12. The ADAP Preferred Provider standards support evidence-based placement decisions for my clients.					
13. The use of the ADAP Compliance Assessment Tool (CAT) resulted in an objective review of my program.					
14. The use of the CAT has improved consistency in the ADAP audit process.					
15. The use of the CAT has improved clarity in the audit process.					
16. The scoring system (weighting and criteria) used by ADAP, to determine audit results, is clear.					

In questions 17-22 below, provide us with more detail on your experience. If you do not have additional comments, indicate "N/A".

17. What, if any, changes have you made to align with the August 2018 Preferred Provider standards?

18. Has ADAP's use of the CAT changed how you prepare for or experience the certification process? If yes, what has changed.

19. Do you have other comments related to the Preferred Provider standards? If yes, please specify.
20. Do you have other comments related to the CAT? If yes, please specify.
21. Do you have other comments related to the scoring system? If yes, please specify.
22. Please verify the date of your most recent ADAP certification audit? (mm/yy):
THANK-YOU FOR YOUR TIME! Please Return the Completed Survey to PHPG by: Electronic Submission: ssantarcangelo@phpg.com Hard Copy Submission: Pacific Health Policy Group 100 South Main St, Suite #3 Waterbury Vermont 05676 Questions: 802-882-8228