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January 29, 2018

Brian Neale, Director
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Director Neale:

In my capacity as Secretary of Vermont's Agency of Human Services, I am submitting to the Centers for Medicare and Medicaid Services (CMS) a request to amend Vermont's Section 1115 Global Commitment to Health Demonstration (11-W-00194/1).

Vermont and CMS have been meaningful and effective partners in health care reform for many years. Vermont's Global Commitment to Health 1115 demonstration and the Vermont All-Payer Model Agreement are examples of how the federal government and a state can design a program that furthers federal goals while being customized for the strengths and needs of an individual state. Vermont credits much of the success of its approach to fighting the opioid epidemic to the flexibilities granted under the Global Commitment to Health Demonstration and the strong federal-state partnership at its foundation. Vermont's innovative framework to address opioid use disorder has garnered national attention for the effectiveness of its comprehensive approach to providing Medication Assisted Treatment.

However, there is more work needed to create a sustainable system for providing care for those with substance use disorders. Vermont continues to experience deaths due to overdoses and, despite increased capacity, the health and human service systems in most regions are still unable to meet demand for assistance with mental health and health-related social needs that frequently co-occur with substance use disorders. Many people with opioid use disorder are switching from prescription opioids, which have become less readily available, to heroin. The State has seen a dramatic increase in Vermonters who use and are addicted to heroin, as demonstrated by the more than 350% increase in number of people seeking treatment for primary heroin addiction between state fiscal years 2011 and 2015.

To maintain and further build on the success of Vermont's innovative approach to fighting the opioid epidemic, and to promote our mutual goals of the All-Payer Model Agreement, long-term federal flexibility is needed. This amendment request seeks to ensure the continued availability of treatment supports that effectively prevent and treat opioid use disorder and other substance use disorders, and to promote a comprehensive and integrated continuum of mental and physical health, substance use disorder treatment, and long-term services and supports for all Vermonters.

Thank you for your consideration of this amendment request. We appreciate your continued partnership on our 1115 Demonstration as we work to advance our shared goals for health care reform.

Sincerely,

Al Gobeille
Secretary

CC: Cory Gustafson, DVHA
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Global Commitment to Health

11-W-00194/1

Section 1115(a)

Demonstration Amendment Request to CMS

(1/1/2017 – 12/31/2021)

Submitted 1/29/2018

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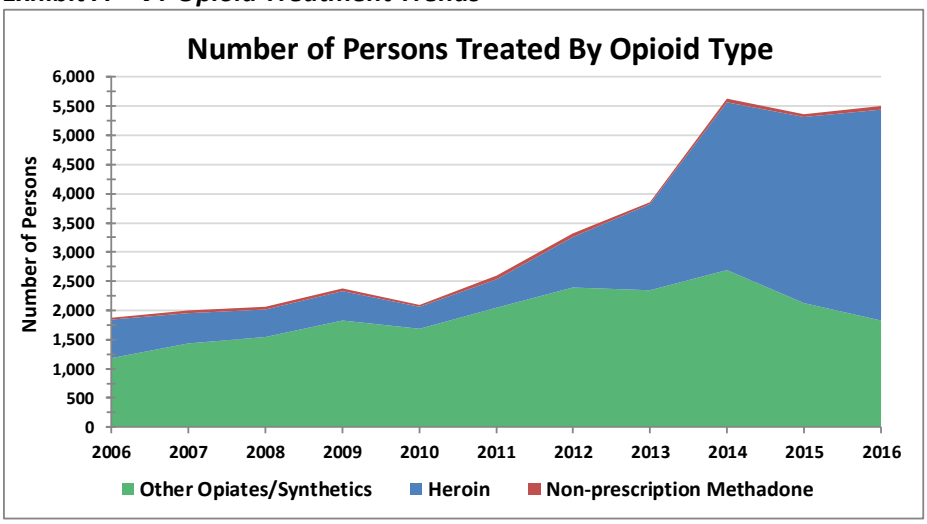
I. Introduction

The State of Vermont and federal government have been meaningful and effective partners in health care reform for many years. The Centers for Medicare and Medicaid Services has provided Vermont with flexibility and tools to improve the delivery of health care in Vermont and improve the health and lives of Vermonters. Specifically, Vermont's Global Commitment to Health 1115 demonstration and the Vermont All-Payer Model Agreement (APM) are examples of how the federal government and a state can design a program that furthers federal goals while being customized for the strengths and needs of an individual state. The APM Agreement and Global Commitment Demonstration are complementary frameworks that support Vermont's health care reform efforts. Each agreement provides federal support to further Vermont's strategic goal of creating an integrated health care system, including increased alignment across payers and providers.

Vermont credits much of the success of its approach to fighting the opioid epidemic to the flexibilities granted under the Global Commitment to Health Demonstration and the strong federal-state partnership at its foundation. Vermont's innovative framework to address opioid use disorder has garnered national attention for the effectiveness of its comprehensive approach to providing Medication Assisted Treatment (MAT). This framework integrates programs providing higher levels of care with programs offering treatment in general medical settings. 2016 data shows, when comparing Vermonters with opioid use disorders (OUDs) receiving MAT (MAT group) against a group receiving one or more inpatient visits, one or more outpatient emergency department visits, or two or more non-hospital outpatient visits with a diagnosis for opioid use disorder but who did not receive MAT (non-MAT group), the MAT group had lower expenditures excluding treatment, lower inpatient hospitalizations, lower inpatient days, lower outpatient emergency department use, and higher primary care visits than the non-MAT group. Richard Baum, the White House "drug czar" (Acting Director of the Office of National Drug Control Policy) visited Vermont in July, 2017 to learn more about Vermont's unique approach to this epidemic. In a press conference at the end of his visit, Mr. Baum said "What Vermont has accomplished by establishing a unique hub and spoke system for responding to the opioid crisis is an incredibly valuable national model."

However, there is more work needed to create a sustainable system for providing care for those with substance use disorders (SUDs). Vermont continues to experience deaths due to overdoses and, despite increased capacity, the health and human service systems in most regions are still unable to meet demand for assistance with mental health and health-related social needs that frequently co-occur with substance use disorders. Many people with opioid use disorder are switching from prescription opioids, which have become less readily available, to heroin. The dangers associated with using heroin, especially if heroin is adulterated with fentanyl, are evident in the alarming rate of overdose deaths in Vermont. In Vermont, drug-related fatalities were 37% higher in 2016 than those recorded in 2015. Of the 148 drug-related fatalities recorded in Vermont for 2016, 112 were opioid-related (Vermont Department of Health, 2017). The State has seen a dramatic increase in Vermonters who use and are addicted to heroin, as demonstrated by the more than 350% increase in number of people seeking treatment for primary heroin addiction between state fiscal years 2011 and 2015.

Exhibit A – VT Opioid Treatment Trends



To maintain and further build on the success of Vermont's innovative approach to fighting the opioid epidemic, and to promote our mutual goals of the APM Agreement, long-term federal flexibility is needed. This amendment request seeks to ensure the continued availability of treatment supports that effectively prevent and treat opioid use disorder and other substance use disorders, and promote a comprehensive and integrated continuum of mental and physical health, OUD/SUD treatment, and long-term services and supports for all Vermonters. Specifically, Vermont is seeking a waiver of all restrictions on payments to Institutions for Mental Disease (IMDs) for individuals ages 21 to 64. Without the long-term flexibility sought in this amendment, the State will be obligated to direct limited budget and staff resources to a fragmented and sub-optimal system, rather than use those resources to promote delivery system reform.

II. Description of the Demonstration

Background

The State of Vermont has been a national leader in making affordable health care coverage available to low-income children and adults, and providing innovative system reforms to support enrollee choice and improved outcomes. Vermont was among the first states to expand coverage for children and pregnant women, accomplished in 1989 through the implementation of the state-funded Dr. Dynasaur program, which in 1992 became part of the state-federal Medicaid program.

In 1995, Vermont implemented a Section 1115(a) Demonstration, the Vermont Health Access Plan (VHAP). The primary goal was to expand access to comprehensive health care coverage through enrollment in managed care for uninsured adults with household incomes below 150% (later raised to 185% of the FPL for parents and caretaker relatives with dependent children in the home). While making progress in addressing the coverage needs of the uninsured through Dr. Dynasaur and VHAP, by 2004 it became apparent that Vermont's achievements were being jeopardized by the ever-escalating cost and complexity of the Medicaid program.

In 2005, Vermont worked in partnership with CMS to develop two new 1115 Demonstration programs, Global Commitment to Health and Choices for Care. These two demonstrations enabled the State to preserve and expand the affordable coverage gains made in the prior decade, provide program flexibility

to more effectively deliver and manage public resources, and improve the health care system for all Vermonters. In 2015, the two demonstrations merged under the Global Commitment to Health 1115 waiver.

In October 2016, the All-Payer Model (APM) Agreement between the State and the Federal government was signed by the Governor and the Secretary of Human Services. The agreement includes a target for a sustainable rate of growth for health care spending in Vermont across Medicaid, Medicare, and commercial payers. The APM aims to transform health care for the entire state and its population. Through the model, the most significant payers throughout the state – Medicare, Medicaid, and commercial health care payers –aim to incentivize health care value and quality, with a focus on health outcomes, under the same payment structure for the majority of providers throughout Vermont's care delivery system.

In November 2016, CMS approved a five-year extension of the Global Commitment to Health Demonstration. This extension was written in close partnership with the Centers for Medicaid and Medicare Innovation (CMMI) to ensure alignment with the All-Payer Model Agreement include the authorities needed to make Medicaid a full partner in the Vermont All-Payer Model.

The Global Commitment to Health Demonstration includes the following fundamental elements:

1. ***Program Flexibility***: Vermont has the flexibility to invest in specified alternative services and programs designed to achieve the Demonstration's objectives (including the Marketplace subsidy program).

2. ***Managed Care Delivery System***: Under the Demonstration, the Agency for Human Services (AHS) executes an annual agreement with the Department of Vermont Health Access (DVHA), which delivers services through a managed care-like model, subject to the requirements that would be applicable to a non-risk pre-paid inpatient health plan (PIHP) as defined by the Special Terms and Conditions (STCs).

3. ***Removal of Institutional Bias***: Under the Demonstration, Vermont provides a choice of settings for delivery of services and supports to older adults, people with serious and persistent mental illness, people with physical disabilities, people with developmental disabilities, and people with traumatic brain injuries who meet program eligibility and level of care requirements.

4. ***Delivery System Reform***: Under the Demonstration, Vermont supports systemic delivery reform efforts using the payment flexibility provided through the Demonstration to create alignment across public and private payers.

The State's high-level goal for all health reform is to create an integrated health system able to achieve the Institute of Medicine's "Triple Aim" goals of improving patient experience of care, improving the health of populations, and reducing per-capita cost.[1] This is supported in the Global Commitment to

[1] Crossing the Quality Chasm: A New Health System for the 21st Century. Washington DC: National Academy Press, Institute of Medicine; 2001.

Health Demonstration through innovative delivery system reforms, including Medicaid Accountable Care Organizations (ACO) and the development of progressive in-home and community-based services and supports that are cost-effective and support persons who have long-term care service and support needs, complex medical, mental health and/or substance use disorder treatment needs.

Demonstration Amendment Goals

The overall goal of this amendment request is to maintain and enhance the flexibility and availability of OUD, SUD, and mental health treatment supports under the Global Commitment to Health Demonstration, and to promote a comprehensive and integrated continuum of mental and physical health, OUD/SUD treatment, and long-term services and supports for all Vermonters

Vermont recognizes that a continuum of services and evidence based practice include attention to co-occurring mental health disorders and to the physical health impacts of OUD/SUD for persons seeking treatment and recovery services. Vermont intends to build a fully integrated physical health, mental health, OUD/SUD and recovery support continuum. To support this goal, Vermont seeks continued flexibility federal funding for residential treatment programs, and in how the American Society of Addiction Medicine (ASAM) and other evidence-based criteria are applied to triage plans of care for persons struggling with addictions and co-occurring mental health and physical health conditions. This triage includes identifying the settings best suited to serve those enrollees with OUD/SUD and co-occurring conditions. For example, in some cases immediate access and treatment in a residential setting is the best course of treatment, while for others immediate stabilization of a psychiatric crisis or medically managed withdrawal, in a general hospital or specialized inpatient facility, followed by intensive addiction treatment may be clinically warranted.

Vermont shares the CMS goals for OUD/SUD. The State's current Demonstration and approach are fully aligned to realize these goals, as illustrated in Exhibit B below.

Exhibit B – Shared Demonstration Goals

Global Commitment to Health Goals	OUD/SUD Amendment Goals
To increase access to care	• Increase rates of identification, initiation, and engagement in treatment
	• Improve access to care for physical health conditions among beneficiaries
To improve the quality of care	• Increase adherence to and retention in treatment
	• Reduce overdose deaths, particularly those due to opioids
To contain health care cost	• Reduce utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services
To eliminate institutional bias	• Reduce readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate

Demonstration Amendment Milestones

Vermont has initiated programs or met many of the milestones identified by CMS through innovation under the Medicaid State Plan and the Global Commitment to Health Demonstration, however, the State intends to enhance its efforts to include new initiatives and delivery system reforms. Specifically, new initiatives under development include:

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

A high-level overview of plan milestones is presented in Exhibit C, with detailed descriptions in Section III (Vermont's Approach to Addressing Opioid Abuse) and Section IX (Implementation Plan).

Exhibit C – Overview of Plan Milestones

Overview of VT OUD/SUD Milestones		
CMS Milestone	**CMS Specifications**	**VT Plan**
Access to critical levels of care for OUD and other SUDs	Coverage of: a) outpatient b) intensive outpatient services c) medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state) d) intensive levels of care in residential and inpatient settings e) medically supervised withdrawal management	• Seek waiver and expenditure authority to support continued access to highest levels of ASAM care, including medically supervised withdrawal management. • Implement value based payments for residential programs, in alignment with All Payer Model to support access.
Widespread use of evidence-based, SUD-specific patient placement criteria	Implementation of requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines	• Milestone achieved; maintain or enhance current requirements with lessons learned. • Enhance with centralized intake and call center.
	Implementation of a utilization management (UM) approach such that: a) beneficiaries have access to SUD services at the appropriate level of care b) interventions are appropriate for the diagnosis and level of care c) there is an independent process for reviewing placement in residential treatment settings	• Milestone achieved; maintain or enhance current UM. requirements with lessons learned • Place Recovery Supports in the ED to facilitate initiation, engagement and access. • Improve discharge planning and transitions between care settings.

Overview of VT OUD/SUD Milestones		
CMS Milestone	**CMS Specifications**	**VT Plan**
Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications	Implementation of residential provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria, or other nationally recognized, evidence-based SUD specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings	• Milestone achieved; maintain or enhance current requirements with lessons learned.
	Implementation of state process for reviewing residential treatment providers to assure compliance with these standards	• Milestone achieved; maintain or enhance current requirements with lessons learned.
	Requirement that residential treatment facilities offer MAT on-site or facilitate access off-site	• Milestone achieved; maintain or enhance current requirements with lessons learned.
Sufficient provider capacity at each level of care	Completion of the assessment of availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT	• Milestone achieved; maintain or enhance current requirements based on capacity monitoring reports.
Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD	Implementation of opioid prescribing guidelines with other interventions to prevent opioid abuse	• Milestone achieved; maintain or enhance current requirements with lessons learned
	Expanded coverage of, and access to, naloxone for overdose reversal	• Milestone achieved; maintain or enhance current requirements with lessons learned.
	Implementation of strategies to increase utilization and improve functionality, of prescription drug monitoring programs	• Milestone achieved; maintain or enhance current requirements with lessons learned.
Improved care coordination and transitions between levels of care	Implementation of policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities	• Milestone achieved; maintain or enhance current requirements with lessons learned.

III. Vermont's Approach to Addressing Opioid Abuse

Work is well underway to aggressively address the opioid crisis facing Vermont. Under this amendment, Vermont will maintain and enhance a full continuum of addiction treatment based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria, including withdrawal management, inpatient detoxification, short-term and longer-term residential treatment, intensive outpatient treatment, outpatient treatment, partial hospitalization, medication assisted treatment in intensive and office-based settings, and recovery supports across the State.

The following section is broken into six parts to provide a detailed description of Vermont's comprehensive approach to addressing the Opioid crisis, including: (1) efforts and strategies surrounding prevention and treatment of OUD/SUDs, (2) OUD/SUD treatment and recovery continuum of care, (3) alignment with ASAM Level of Care guidelines, (4) use of evidence-based patient placement criteria, (5) monitoring of provider capacity, and (6) planned enhancements under this amendment request.

Efforts and Strategies Surrounding Prevention and Treatment

Through the Medicaid State Plan and the Global Commitment to Health Demonstration, Vermont has developed a continuum of services and supports that provide the foundation to successfully address opioid and other substance use disorders in Vermont.

Vermont's efforts to expand treatment for Vermonters with OUD are broad based and benefit enormously from the commitment of community leaders, partners, and members to support and speak about the importance of this issue. The dedication and commitment of these individuals has resulted in increased treatment capacity in critically needed areas, increased coordination amongst community partners, and focus on treating the factors that contribute to the complexity of OUD.

- Opioid Prescribing Guidelines
  Vermont implemented "Rules Governing the Prescribing of Opioids for Pain" effective July 1st, 2017 (see Opioid Prescribing Rule). This rule provides legal requirements for the appropriate use of opioids in treating pain to minimize opportunities for misuse, abuse, and diversion, and optimize prevention of addiction and overdose and is consistent with CDC guidelines.

- Expanded Coverage of, and Access to, Naloxone for Overdose Reversal
  Vermont began distribution of Naloxone with a pilot in 2013 and has since expanded Statewide. Naloxone is provided free of charge at 27 distribution sites including syringe services programs, substance abuse treatment providers, recovery centers, and medical facilities. Naloxone is available to persons taking opioids, family members, and other community members who may come in contact with people at risk for overdose. In 2016, pursuant to legislation, all Vermont EMS agencies receive naloxone at no charge. Emergency use kits also are offered to individuals being released from a correctional facility who have identified previous opioid use or dependency.

  In August 2016, the Commissioner of Health issued a standing order for naloxone, allowing any pharmacy to dispense the life-saving drug and bill medical insurance, if available. New prescribing rules effective July 1, 2017 require an accompanying naloxone prescription for opioid prescriptions >90 MME, as well as when there are concurrent benzodiazepines prescriptions.

- Implementation of Strategies to Increase Utilization and Improve Functionality of Prescription Drug Monitoring Programs

  The rules implemented July 1, 2017 require that prescribers query the Vermont Prescription Drug Monitoring System prior to the first prescription of an extended release hydrocodone or oxycodone that is not an Abuse-deterrent Opioid; no less frequently than once every 120 days for any patient prescribed 40 mg or greater of hydrocodone or 30 mg or greater of oxycodone per day of an extended release hydrocodone or oxycodone that is not an Abuse-deterrent Opioid as long as the patient possesses a valid prescription for that amount; and no less frequently than as described in the Vermont Prescription Monitoring System rule (see VPMS rule).

  All prescribers and pharmacist dispensing schedule II-IV drugs must register and use the PDMP. Vermont also has been improving functionality of the PDMP through the development of Prescriber Insight Reports which compare a prescriber's opioid prescribing patterns to similar prescribers and Clinical Alerts to notify prescribers when patients' prescription history may be of concern. There has been extensive outreach, technical assistance, and training for prescribers on opioid prescribing and the use of the PDMP.

- Improved Care Coordination and Transitions Between Levels of Care

  ADAP continues to improve coordination between the Hub and Spoke providers and specialty substance use disorder treatment providers (residential) through referral protocols, care coordination, covered benefits, information sharing, etc. These and other collaborations are contributing to stronger relationships between primary care practices and specialty substance use disorder service providers, leading to more effective recovery management of physical and behavioral health services.

  Through Vermont's health reform initiatives, physicians are educated and trained on enhancing their own screening and referral services, so that more clients are screened and directed to OUD/SUD specialists from primary care practices.

  Vermont's OUD/SUD Treatment Standards include discharge planning expectations for all levels of care. Aftercare planning starts as early as possible in the person-centered treatment planning and service delivery process. The aftercare plan is to ensure a seamless transition when a person served is transferred to another level of care or prepares for a planned discharge to recovery support.

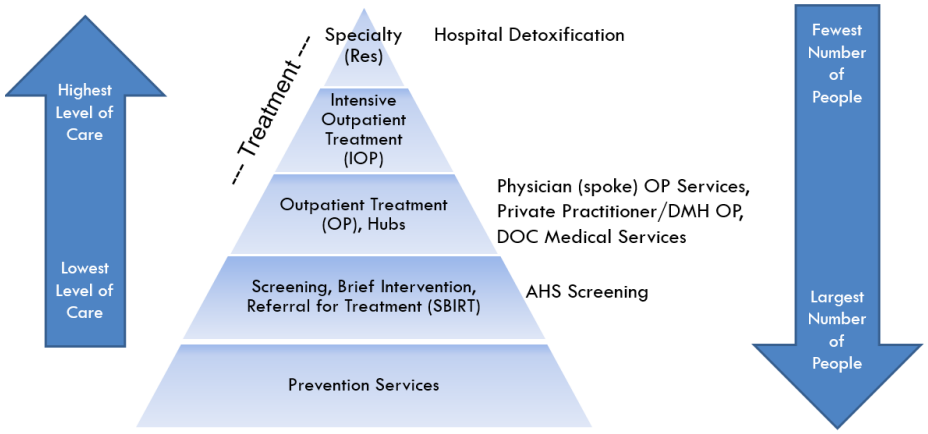
  The aftercare plan identifies the person's need for a recovery support system or other types of service that will assist in continuing the recovery and community integration. The plan also includes referral information made for additional services such as appointment dates, times, contact name, telephone number, and location. The referring provider must provide the receiving provider with the most recent assessment upon receipt of a signed release of information. Upon discharge, the provider, when prescribing medications, will document coordination of care with the primary care provider and/or external prescribing professional regarding, at a minimum, what medications are being prescribed and for what diagnoses. These standards are audited during the annual site review through the medical record audit. Should any provider be out of compliance with these standards, a corrective action plan will be required. State staff also are available to provide technical assistance to the provider on improving in this area. With the development of the centralized intake center in 2018, providers will have enhanced support for ensuring continuity of care during transitions.

OUD/SUD Treatment and Recovery Continuum of Care

Vermont has also been aggressive in public awareness and school based prevention and early intervention, in partnership with Substance Abuse and Mental Health Services Administration (SAMHSA). All treatment options follow the ASAM recommended Levels of Care and include outpatient, residential, and inpatient SUD treatment services, at various levels of intensity, for Medicaid, Medicare, commercial, uninsured, and private (self) payers.

This continuum includes specialized programs for adolescents, pregnant teens, and a specialized residential program for pregnant women and mothers with young children under the age of five (Lund Home). Vermont offers ancillary support services such as case management, recovery and peer-supports, including a statewide network of 12 Recovery Centers that complement the State's treatment programs. Exhibit D below depicts Vermont's overall approach to care.

Exhibit D – Vermont's Substance Abuse Continuum of Care



Recovery Services are Available to Those at All Service Levels

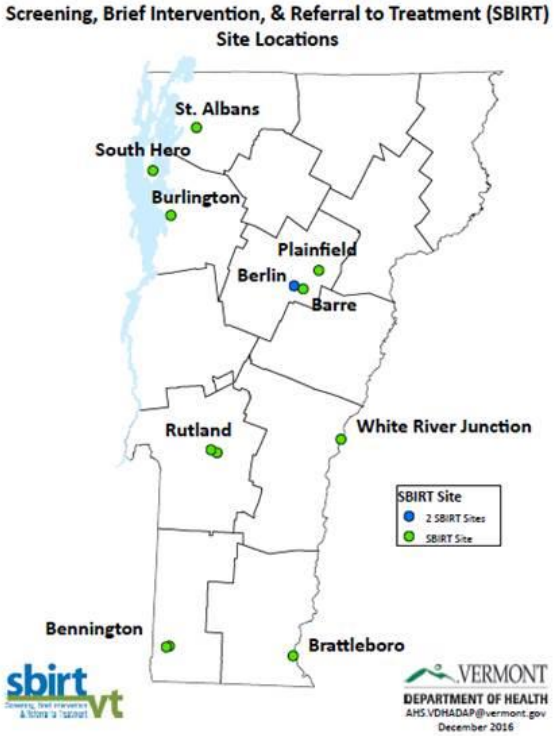
A brief description of each service within Vermont's continuum of care follows below:

- Prevention: Vermont's Alcohol and Drug Abuse Program (ADAP) provides funding to 20 school supervisory unions to help reduce 30-day use of alcohol, marijuana, and any illicit drugs, and to prevent and reduce binge drinking among adolescents. Utilizing the Whole School, Whole Community, Whole Child Model, required funded services include screening and referral to substance abuse and mental health services, and optional activities can include support of classroom health curricula, advising and training of peer leadership groups, delivery of parent information and educational programs, delivery of teacher and support staff training and delivery of educational support groups.

- Screening Brief Intervention and Referral for Treatment: Vermont is in year five of a SAMHSA grant to promulgate 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 expended to a number of emergency rooms, 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.

Exhibit E – Screening, Brief Intervention and Referral to Treatment (SBIRT) Site Locations (2016)



- Public Inebriate/Crisis Intervention: The Public Inebriate (PI) Program is a crisis intervention program for individuals under the influence. The Vermont Public Inebriate 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 13 of 14 counties. In addition to this screening capacity, there are 19-20 "diversion" beds located in several areas across the state designed as alternative's to confined placements. ADAP continues to work to assure a safe and effective response to address the need for additional community inebriate services and coordinated community level collaborations between public inebriate programs, emergency departments, law enforcement and the Department of Corrections.

- Withdrawal Management: Withdrawal management is available at a number of settings throughout Vermont depending on the medical needs of the individual. ADAP certifies two residential programs in three locations and a social detoxification program to provide higher intensity withdrawal management services. In addition, hospitals throughout Vermont also provide withdrawal management services for individuals who need the full services of a hospital. For individuals whose needs are less intense, withdrawal management services are available through the Hub and Spoke system, which includes health home services.

- Case Management: Case Management services are intended to support individuals who have complex needs that can impede access to and engagement in substance use disorder treatment. For intensive outpatient and Hub and Spoke services, case management services are included in the rate structure.

- Outpatient Treatment: Medicaid enrolled Providers currently provide outpatient services to Vermonters throughout each region of the State. Outpatient programs include individual, group and family counseling and provide services specific to elders, adolescents, youth, men and women.

- Intensive Outpatient Treatment: ADAP Certified Medicaid enrolled providers offer intensive outpatient (IOP) services to Vermonters throughout each region the State. IOP programs offer nine to 19 hours of treatment activities per week. These activities consist of a combination of case management, individual, group, and/or family therapy sessions.

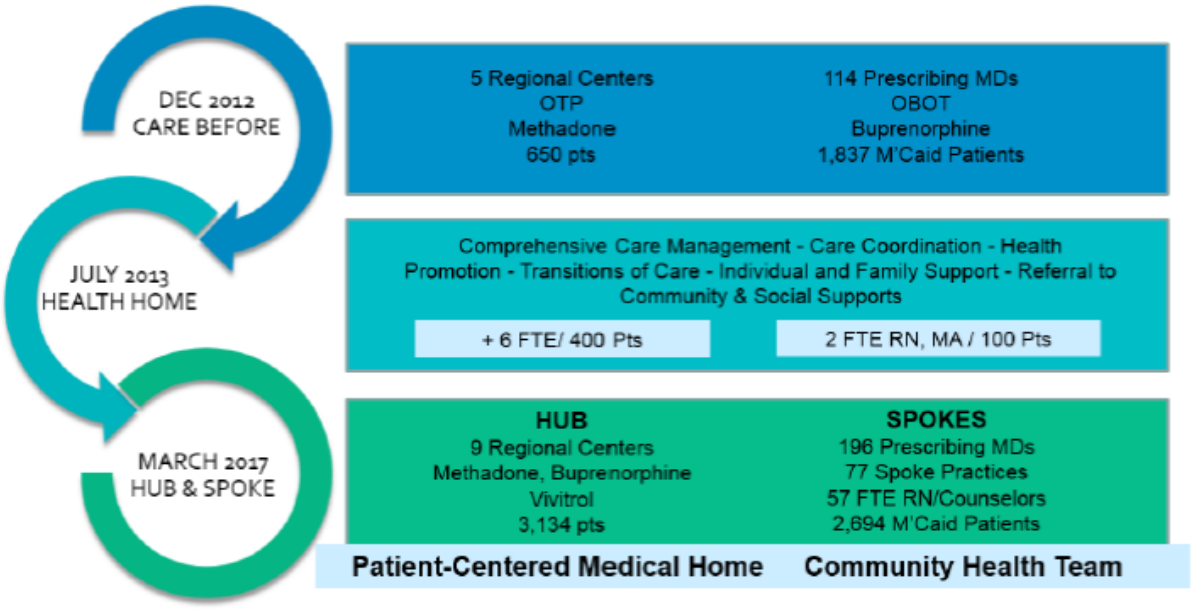
- Partial Hospitalization: Partial hospitalization is provided to individuals with co-occurring mental health and substance use disorder diagnoses, with the primary diagnosis being mental health.

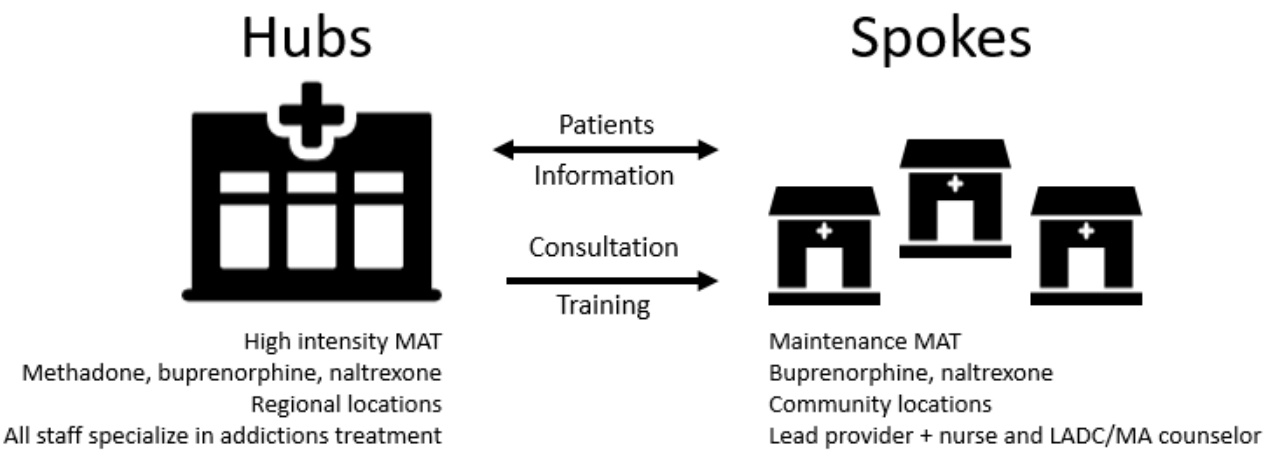
- Opioid Treatment (Hub and Spoke Program): Vermont developed the first in the nation Specialized Health Home focused on expanding evidence-based Medication Assisted Treatment (MAT) for OUD, known as the Hub and Spoke Program. Vermont's Hub and Spoke Program has garnered national attention for its effective, responsive, and comprehensive approach to providing MAT. Vermont accomplishes this through the integration of opioid treatment programs (OTPs), providing higher levels of care (Hubs) with primary care, obstetrics-gynecology, outpatient addiction treatment, and pain management practices (spokes) providing office-based opioid treatment (OBOTs). Regional Hubs offer medication, counseling, case management and health home services to complex patients. Spokes provide care to individuals who have less complex needs and they provide medication, counseling, case management and health home services.

  Hubs offer medication, counseling, case management, and health home services to complex patients. Spokes provide care to individuals who have either been stabilized at a Regional Hub or who needs do not require intensity of services offered by the Regional Hubs. Spoke staff, supported by enhanced care coordination through the Blueprint for Health Community Health Teams and local Recovery Support services, assure essential clinical and counseling support services are provided.

  Vermont uses a 21-Item checklist (Treatment Needs Questionnaire) to help determine whether a Hub or Spoke setting would be most appropriate for new beneficiaries seeking medication assisted treatment. In order to determine the need for additional hub and/or spoke services, ADAP, in partnership with DVHA, monitor the regional utilization of Hub services of Medicaid eligible individuals utilizing the Medicaid transportation benefit as well as capacity and wait time reports from hubs.

Exhibit F – "Hub and Spoke" Health Homes for Opioid Addiction





- Clinically Managed Low-Intensity Residential Care: Vermont funds a 10-bed low-intensity 3.1 ASAM level residential program in the central part of the state. This program is a step-down from a 3.5 ASAM-level program in the same county. Individuals with higher needs are able to attend the treatment programming and MAT at the 3.5-level program. Transportation is provided to individuals between the two facilities.

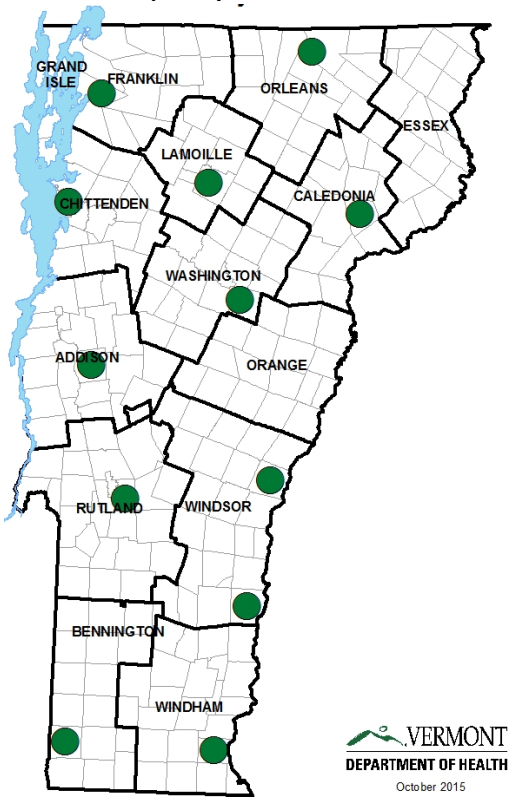
- Clinically Managed High Intensity Residential Care: Vermont supports several residential programs to provide clinically managed high intensity residential services as well as withdrawal management services. This includes women only, co-ed and specialized programs for adolescents and one for pregnant women and mothers with children under the age of five. These programs have access to psychiatric and mental health professionals for consultation and are able to provide care for individuals with co-occurring needs. All of Vermont's residential programs are required to provide access to MAT services as clinically necessary.

- Medically Monitored Intensive Inpatient Care: Vermont offers residential programming for men and women that provides medically monitored intensive inpatient services. This program has on-site psychiatric services and provides care to individuals with a wide range of co-occurring conditions, including MAT.

- Medically Managed Intensive Inpatient Care: Vermont funds inpatient services at a specialized psychiatric facility for detoxification, this program is also available to treat persons with co-occurring mental health and psychiatric conditions. Once an individual has completed the detoxification they are transferred to an appropriate level of care, typically a community residential program or Specialized Health Home (Hub).

- Recovery Support Services: Recovery services in Vermont focus on the following: helping people find, maintain, and enhance their recovery experience through peer support, sober recreation, and educational opportunities. This includes both 12 Recovery Centers located throughout Vermont and centralized Vermont Recovery Network.

Exhibit G – Recovery Center Locations (2015)



Recovery Centers provide non-clinical services that assist with establishing community connections that lead to employment, housing, and other social supports in a safe, drug and alcohol-free environment. Recovery centers are committed to supporting a person's efforts in preventing relapse and should relapse occur, in quickly returning to recovery. Individual services revolve around the support from the Peer Recovery Coach, an individual in active recovery from substance

use disorder who has received Peer Recovery Coach training. The Recovery Centers also offer several groups to support recovery, such as:

- Evidence Based Practice (EBP) groups
  - Making Recovery Easier
  - Seeking Safety
  - Wellness Recovery Action Planning (WRAP)

- Community Groups
  - Yoga, Meditation, Acupuncture
  - Age specific recovery groups
  - Ongoing 12 Step meetings

- Recovery Housing: Recovery Housing is provided to Vermonters through a number of transitional housing providers, some connected to a Recovery Center and some independent organizations. ADAP has recently begun a new partnership with the Vermont Foundations of Recovery to add new sober transitional housing beds. These programs offer supports to connect individuals to appropriate community social service and ongoing treatment and recovery resources such as individualized planning and general case management.

Alignment with ASAM Level of Care Guidelines

Vermont's OUD/SUD system follows the ASAM Level of Care guidelines and consists of the full spectrum of services, as outlined in Exhibit H beginning below. All OUD/SUD providers must be licensed and enrolled Medicaid Providers, including meeting additional State certifications for OUD/SUD treatment.

Exhibit H – ASAM Treatment Levels, Providers and Medicaid Availability

ASAM Level of Care	Brief Description	Provider	Existing Medicaid Service (Y/N)
0.5 Early Intervention	• Screening, Brief Intervention and Referral for Treatment (SBIRT)	ER, PCP, Health Clinics, Student Health Center	Y
1 Outpatient Services	• Adult: Less than 9 hours of services per week • Youth: Less than 6 hours of services per week • Individual, Family, and Group Counseling Case Management	Outpatient Clinics	Y
2.1 Intensive Outpatient Services	• Adult: 9 or more hours of services per week • Youth: 6 or more hours of services per week to treat multi-dimensional instability • Bundled rate includes case management	Outpatient Clinics	Y
2.5 Partial Hospitalization Day Treatment	• 20 hours or more per week • Clinically intensive programming	Outpatient Clinics	Y

ASAM Level of Care	Brief Description	Provider	Existing Medicaid Service (Y/N)
Psychosocial Rehabilitation Services	• Direct access to psychiatric, medical and lab services		(co-occurring only, MH diagnosis)
3.1 Clinically Managed Low-Intensity Residential Services	• 24-hour structure, at least 5 hours of clinical service/week	Residential Providers	Y
3.3 Clinically Managed Population Specific High Intensity Residential Services	• 24-hour structure, high intensity clinical services • Less intense milieu • Group treatment for those with cognitive or other impairments	Residential Providers (IMD)	Pending Continued 1115 Authority
3.5 Clinically Managed High Intensity Residential Services	• 24-hour care, high intensity services for persons who cannot be treated in less intensive levels • To stabilize multi-dimensional needs and/or safety issues	Residential Providers (IMD)	Pending Continued 1115 Authority
3.7 Medically Monitored Intensive Inpatient Services	• 24-hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3 • 16 hour/day counselor availability	Residential Providers (IMD)	Y
4 Medically Managed Intensive Inpatient	• 24-hour nursing care and daily physician care for severe unstable problems in Dimensions 1, 2 or 3 • Counseling available to engage patient in treatment (detox only)	Psychiatric Hospital (IMD)	Pending Continued 1115 Authority
Opioid Treatment Program	• Daily or several times weekly opioid agonist medication and counseling to maintain multidimensional stability for those with severe opioid use	Specialized Health Homes (Hub & Spoke)	Y
Withdrawal Management (WM)	• Levels 1 – 4	Specialized Health Homes (Hub & Spoke), Hospitals, Residential providers (IMD)	Y, Pending Continued 1115 Authority for Higher Levels

Use of Evidence-Based SUD-Specific Patient Placement Criteria

Vermont relies on evidence-based practices and clinical practice guidelines for all aspects of provider development, treatment authorization and recovery. 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 for co-occurring mental health issues.

All of Vermont's certified OUD/SUD providers are required to use evidence-based screening tools and perform a comprehensive assessment which includes elements specified by the State. All State requirement are outlined in Vermont's Preferred Provider Substance Use Disorder Treatment Standards.

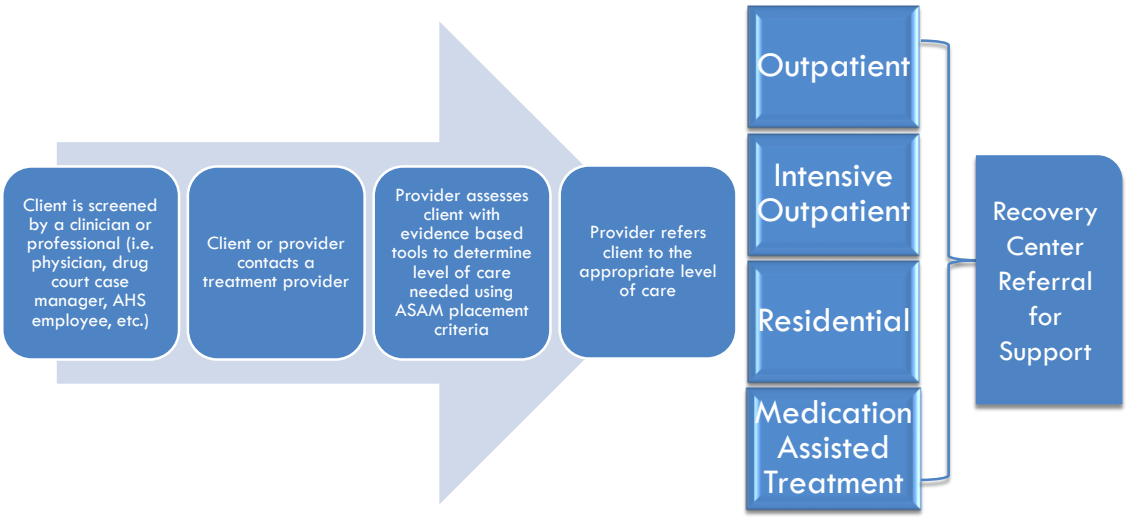
Assessments include age appropriate elements, such as, but not limited to: mental health status; OUD/SUD history; physical health status; medications; allergies; living arrangements; family and interpersonal history; social support needs; criminal justice involvement; school history; cultural and spiritual preferences; trauma history; participant strengths, goals and priorities; caregiver status; education and employment.

For a provider to maintain specialty OUD/SUD provider certification in Vermont, they must pass quality audits conducted by ADAP. These audits are performed every one to three years on all providers and are focused on compliance with standardized screening tools, comprehensive assessments, ASAM Levels of Care and evidence-based treatment standards. ADAP conducts random chart audits and reviews provider policies and procedures to ensure adherence to standards.

Vermont inpatient detoxification and residential levels of care are designated as short-term acute care for the purpose of stabilizing an individual, so they can successfully transition to clinically appropriate lower levels of care.

Vermont currently ensures that individuals are appropriately placed in residential programs and inpatient detoxification through the process of concurrent review and prior authorization. Residential programs are required to screen and assess appropriateness of admission. All programs utilize the Addiction Severity Index (ASI) multi-dimensional assessment tool. Within 24 hours or next business day of admission the Medicaid Utilization Management (UM) unit is notified. By the end of the fifth day the residential programs send the ASI results and other clinical information to the UM team for concurrent review and authorization. The UM team use the nationally recognized McKesson Interqual® decision support tool to determine continued authorization. Exhibit II-8 provides an overview of Vermont's process for accessing treatment services.

Exhibit I – Process for Accessing Treatment Services



Ensuring and Monitoring Provider Capacity at Critical Levels of Care

Vermont adheres to all Medicaid Manage Care requirements regarding network adequacy and access standards. ADAP collaborates with DVHA to use Medicaid utilization data and non-Medicaid services

provider encounter data to explore the patterns of utilization for residential care and care at Specialized Health Homes throughout the State.

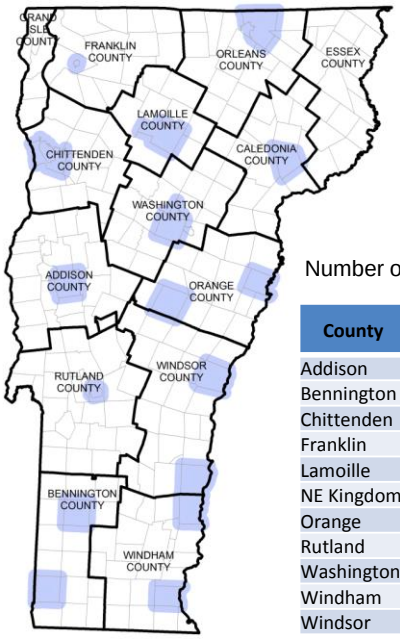
ADAP has a number of reporting requirements as a part of the granting process with the certified providers in order to monitor and ensure that the State has sufficient provider capacity for critical levels of care, including access to medication assisted treatment. Specialized Health Homes "Hubs" are required to report within seven days of reaching 90 percent capacity for serving individuals who are intravenous drug users, and immediate notice if a pregnant woman who is using intravenously is unable to be served. In addition, "Hubs" are required to submit monthly summaries of wait times for service and service requests, and census reports with numbers of individuals at each phase of treatment (induction, stabilization, maintenance) and numbers of individuals who have been transferred to office-based "Spokes". ADAP collaborates with DVHA to Medicaid medical transportation utilization data (e.g., distance to services) to monitor the need for MAT providers statewide.

Residential programs are also required to submit monthly summaries of wait times for services and daily information to an electronic bed-board, which tracks utilization of and availability of beds across residential programs statewide.

Occupancy in Vermont's OUD/SUD residential programs remain under 100 percent, suggesting capacity is at adequate levels. With the addition of a new Specialized Health Home "Hub" in 2017, wait time reports from across the Specialized Health Home "Hubs" demonstrate timely access across the State.

Exhibit J – Maps of Treatment Locations

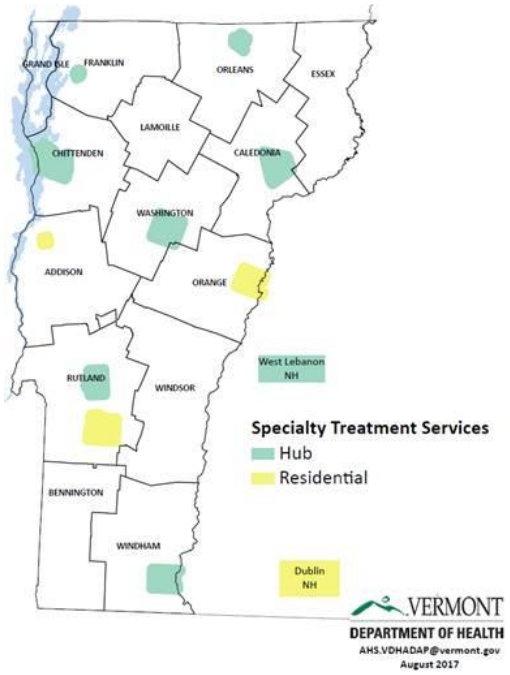
Outpatient/Intensive Outpatient Facilities



Number of Programs

County	OP	IOP
Addison	1	
Bennington	2	
Chittenden	7	3
Franklin	1	
Lamoille	2	1
NE Kingdom	2	2
Orange	2	
Rutland	2	1
Washington	2	1
Windham	1	1
Windsor	2	2

Hub and Residential Facilities



Planned Enhancements

Vermont will be enhancing its evidenced based placement process with two initiatives in 2018 and beyond. First, to improve timely access to care and placement at the appropriate level of care, the State is in the process of developing a Centralized Intake and Call Center for all Vermonters. The Center is under development in partnership with SAMHSA, through an Opioid State's Targeted Response (STR) SAMHSA grant.

The Center will perform an initial screening of individuals to determine the most appropriate referral. The Center will have current information on provider availability and be able to schedule appointments times, across all levels of care, for comprehensive assessments. Individuals having longer wait times will receive regular calls from the center to maintain engagement and facilitate initiation into treatment.

The Call Center will manage wait lists for services, assist individuals with obtaining transportation to their appointments, and assist in the transitions of individuals between levels of care. Vermont is in the initial stages of vendor procurement.

Second, Vermont is developing a value-based payment model for residential programs to align with its All Payer Model Agreement with CMS. The goal of this value- based design is to incentivize successful transitions of care, improve outcomes, and reduce costs. State staff will perform periodic chart reviews to ensure the programs are utilizing ASAM and that interventions are appropriate for the diagnosis and level of care. The value based payment and enhanced support model is targeted for implementation in 2018.

IV. Vermont's Health Care Delivery System

Vermont operates the Demonstration using a managed care-like model that complies with federal regulations at 42 CFR part 438 that would be applicable to a non-risk PIHP, including beneficiary rights and protections such as independent beneficiary support systems and formal grievance and appeal procedures.

Vermont is not proposing any change in the structure of the health care delivery system under this Amendment. The sections below provide overviews of the Demonstration's public managed care-like model, OUD/SUD delivery system of care, eligibility requirements, benefit coverage, and cost sharing.

Public Managed Care-Like Model

Vermont's Single State Medicaid Agency – the Agency of Human Services (AHS) – is responsible for oversight of the managed care-like Medicaid model. DVHA operates the Medicaid program as if it were a Managed Care Organization and in accordance with Federal managed care regulations. Program requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. DVHA also has sub-agreements with the other State entities that provide specialty care for Global Commitment enrollees (e.g., mental health services, developmental disability services, and specialized child and family services). As such, since the inception of the Global Commitment to Health Demonstration, DVHA and its IGA partners have modified operations to meet Medicaid managed care requirements, including requirements related to network adequacy, access to care, beneficiary information, grievances, quality assurance, and quality improvement.

Departments of Vermont State government that participate in the provision of covered services to enrollees under the Demonstration include:

- *Department of Vermont Health Access (DVHA)*: DVHA, which operates the Medicaid program as if it were a public managed care-like model under the Global Commitment to Health Demonstration.

- *Department of Mental Health (DMH)*: The mission of DMH is to promote and improve the mental health of Vermonters and to provide Vermonters with access to effective prevention, early intervention, and mental health treatment and supports as needed to live, work, learn, and participate fully in their communities.

- *Department of Disabilities, Aging, and Independent Living (DAIL)*: DAIL assists older Vermonters and people with disabilities to live as independently as possible.

- *Vermont Department of Health (VDH)*: VDH's goal is to have the nation's premier system of public health, enabling Vermonters to lead healthy lives in healthy communities.

- *Department for Children and Families (DCF)*: DCF promotes the social, emotional, physical, and economic well-being of Vermont's children and families.

- *Agency of Education (AOE)*: The AOE is responsible for overseeing coverage and reimbursement under the School-Based Health program.

OUD/SUD and Mental Health Delivery System

The Vermont Department of Health's Division of Alcohol and Drug Abuse Programs (ADAP), an IGA partner of DVHA in the public managed care-like model, is the unit of government designated to ensure quality and accountability, in collaboration with DVHA, for OUD/SUD prevention, treatment, and recovery services in Vermont. ADAP supports the innovative "Hub and Spokes" Medicaid Health Home program for Medication Assisted Opioid Treatment in partnerships with DVHA, as well as extensive outpatient and residential treatment and recovery support for alcohol and other drugs use disorders. All providers receiving Medicaid reimbursement must meet Medicaid requirements and enroll in the Medicaid program. Providers designated by the State for specialized funding (State or federal) must meet and maintain ADAP certification standards to receive additional State grants.

In partnership with DVHA, the Department of Children and Families is responsible for quality oversight of the Lund Home, which is Vermont's unique residentially based program for pregnant women and mothers with young children. Initially started as a program for pregnant teens, Lund Home has evolved as the state's needs have grown. Lund offers OUD/SUD and co-occurring mental health treatment for women of all ages who are struggling with addiction during their pregnancy and beyond. Pregnant women may enroll in the program for the length of their pregnancy and through a post-partum period based on their individual needs. Mothers of young children under the age five (regardless of pregnancy status) are also eligible for Lund's residential program. In this unique model, both mothers and their children live on-site. Children receive all EPSDT-required well-child screens and services, and mothers learn parenting skills, healthy eating and lifestyle routines, and receive mental health and addictions counseling. Women who are pregnant also receive prenatal care, skills training, and childbirth support.

The Department of Mental Health (DMH) contracts with community providers of mental-health services for adults with severe mental illness. The public mental-health system has ten Commissioner-designated nonprofit agencies in all major geographical areas of Vermont and one Specialized Services Agency. DMH central office staff provide leadership and direction for the community-based public mental-health system as well as program and service monitoring and assessment to assure adherence to state and federal regulations and to monitor the quality of services and supports delivered by DAs. DMH also operates the Vermont Psychiatric Care Hospital (VPCH), which provides Level 1 and non-Level 1 involuntary care for adults and is dedicated to improving the health and well-being of one of Vermont's most vulnerable populations. The 25-bed, acute care hospital offers patient areas designed for comfort and safety to promote and enhance patient recovery. A collaborative, multi-disciplinary team focuses on recovery, safety, education, and quality to provide a therapeutic environment for patients while maintaining clinical and operational best practices. Additionally, DMH contracts with Designated Hospitals for emergency inpatient psychiatric assessment and treatment of adults and youth in need of acute care that cannot be provided in a less restrictive setting. Designated Hospitals also provide voluntary inpatient psychiatric services and limited partial hospitalization.

Eligibility, Benefits and Cost Sharing

Vermont is not proposing any changes to current eligibility, premiums, or cost sharing arrangements under this amendment. The current Demonstration includes the following eight Medicaid and Demonstration groups:

- **Population 1**: Mandatory State Plan populations (except for the new adult group). This group receives benefits as described in the Medicaid State Plan and may receive HCBS benefits described in the STCs if they meet additional program eligibility standards.

- **Population 2**: Optional State Plan populations. This group receives benefits as described in the Medicaid State Plan and may receive HCBS benefits described in the STCs if they meet additional program eligibility standards.

- **Population 3**: Affordable Care Act new adult group. This group receives benefits as described in the Medicaid State Plan and may receive HCBS benefits described in the STCs if they meet additional program eligibility standards.

- **Population 4**: Individuals receiving home and community based waiver (HCBW)-like services who meet the clinical standard in the Choices for Care program for the Highest Need Group. This group receives benefits as described in the Medicaid State Plan and Choices for Care program benefits as described in the STCs.

- **Population 5**: Individuals receiving HCBW-like services who met the clinical standard in the Choices for Care program for the High Need Group. This group receives benefits as described in the Medicaid State Plan and Choices for Care program benefits as described in the STCs.

- **Population 6**: Individuals who are not otherwise eligible under the Medicaid State Plan and who would not have been eligible had the State elected eligibility under 42 CFR § 435.217, but are at risk for institutionalization and need home and community-based services. This group receives a limited HCBW-like service benefit including Adult Day Services, Case Management, and Homemaker services in the Choices for Care program as outlined in the (STCs).

- **Population 7**: Medicare beneficiaries who are 65 years or older or have a disability with income at or below 150 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise eligible for full benefits. This group receives a limited pharmacy benefit including Medicaid Prescriptions, eyeglasses and related eye exams; MSP beneficiaries also receive benefits as described in the Title XIX State Plan.

- **Population 8**: Medicare beneficiaries who are 65 years or older or have a disability with income above 150 percent and up to and including 225 percent of the FPL, who may be enrolled in the MSP, but are not otherwise eligible for full benefits. This group receives a limited pharmacy benefit including maintenance drugs; MSP beneficiaries also receive benefits as described in the Title XIX State Plan.

All covered services may be subject to review and prior approval by DVHA and/or its partner departments in the Agency of Human Services, based on medical appropriateness. OUD/SUD and mental health services are covered benefits for persons in Demonstration Populations 1 through 5.

A complete listing of covered services and limitations are contained in Vermont's approved Title XIX State Plan and statutes, regulations, and policies and procedures. Premiums and cost-sharing for populations 1, 2, and 3 must follow Medicaid requirements that are set forth in statute, regulation, and policy. Standard Medicaid exemptions from cost-sharing set forth in 42 § CFR 447(b) apply to the

Demonstration. The State does not apply co-payment requirements to excluded populations (children under age 21, pregnant women, or individuals in long-term care facilities) or for excluded services/supplies (e.g., family planning). Vermont currently charges premiums for children through age 18 with income above 195 percent of the FPL through 312 percent of the FPL.

V. List of Waivers and Expenditure Authorities Requested

Vermont seeks to maintain all current Demonstration waivers and expenditure authorities and requests to add expenditure authority for and waiver of all restrictions on payments to Institutions for Mental Disease (IMDs) for individuals ages 21 to 64 (§1905(a)(29)(B)).

Vermont's residential and hospital inpatient programs make up the highest level of OUD/SUD/mental health services in Vermont's continuum of care. Vermont's success in treating individuals with OUD/SUD is predicated on the availability of a comprehensive, flexible, and integrated range of services to meet an individual's needs, including those with co-occurring mental health and psychiatric needs.

As Vermont's needs have grown, so have providers and facilities that are now large enough to be considered IMDs. Currently, these residential facilities, specialized inpatient detoxification, and inpatient psychiatric programs are funded through a time-limited authority as Global Commitment to Health Investments under the Demonstration. Vermont seeks recognition of its residential and hospital programs, including those providing psychiatric care for persons with co-occurring SUD and mental health issues, as essential services under the continuum of Global Commitment to Health Section 1115 Medicaid program benefits.

This proposed OUD/SUD amendment will allow the State to sustain its continuum and move toward the full integration envisioned in the All Payer Model Agreement and Global Commitment to Health Demonstrations.

Exhibit K – Type and Size of IMD Facilities

Facility	Type and Target Group(s)	Treatment Focus	# of Beds
Lund Home	Residential treatment for pregnant and parenting women with children under 5 years old	OUD/SUD	26
Valley Vista (Bradford)	Residential treatment for women, men, and adolescents	OUD/SUD	80
Valley Vista (Vergennes)	Residential treatment for women	OUD/SUD	19
Serenity House	Residential treatment adults	OUD/SUD	24
Brattleboro Retreat: Substance Use Disorder	Inpatient detoxification and treatment for adults	OUD/SUD	30
Brattleboro Retreat: Inpatient Psychiatric Hospital	Inpatient stabilization for adults	Psychiatric, Co-occurring SUD	89
Vermont Psychiatric Care Hospital	Inpatient stabilization for adults under the care and custody of DMH	Psychiatric, Co-occurring SUD	25

VI. Estimate of Annual Aggregate Expenditures

The Vermont Global Commitment to Health Demonstration Budget Neutrality agreement includes all Medicaid program service expenditures and covered populations contemplated under this Amendment. Therefore, Vermont is not requesting any changes to the current budget neutrality agreement as part of this Amendment.

Exhibit L – Summary of Medicaid Expenditures for the Treatment of OUD/SUD and Mental Health in IMDs, State Fiscal Year 2017 (July 1, 2016 - June 30th, 2017)

Facility	Annual Expenditure (Gross)
Brattleboro Retreat Substance Use Treatment	$1,731,415
Lund	$3,256,810
Valley Vista -Bradford	$3,700,114
Serenity House	$1,244,510
Maple Leaf	$1,409,584
Vermont Psychiatric Care Hospital	$21,804,310
Brattleboro Retreat	$11,337,146
Total	**44,483,888**

Valley Vista-Vergennes began operations in 2017, therefore is not represented in data. Maple Leaf ceased operations in 2017.

VII. Enrollment Data

The Vermont Global Commitment to Health Demonstration includes all Medicaid populations who will receive coverage under this Amendment request. Vermont therefore is not requesting any changes to the Global Commitment's covered populations as part of this Amendment.

The Vermont OUD/SUD treatment system serves approximately 17,000 Medicaid participants annually (see Exhibit N). More than 3,000 Medicaid participants access IMD services annually.

Exhibit N – Number of Medicaid Participants Receiving Services and IMD Services, State Fiscal Year 2017 (July 1, 2016 - June 30th, 2017)

Facility	Annual Expenditure (Gross)
Brattleboro Retreat Substance Use Treatment	261
Lund	226
Valley Vista -Bradford	861
Serenity House	390
Maple Leaf	305
Vermont Psychiatric Care Hospital	88
Brattleboro Retreat	661
Total	**2,792**

Valley Vista-Vergennes began operations in 2017, therefore is not represented in data. Maple Leaf ceased operations in 2017.

VIII. Research Hypothesis

The State has identified the following overarching hypotheses for the current Demonstration and proposes no change to the hypotheses related to this amendment.

- The Demonstration will result in improved access to care;
- The Demonstration will result in improved quality of care;
- Value-based payment models will improve access to care;
- Improved access to preventive care will result in lower overall costs for the healthcare delivery system;
- Improved access to primary care will result in improved health outcomes;
- Enhanced care coordination will improve timely access to needed care;
- The Demonstration will result in increased community integration; and
- The Demonstration will maintain or reduce spending in comparison to what would have been spent absent the Demonstration.

Exhibit P – Current Global Commitment to Health Evaluation Measures

Performance Areas	Metrics	Sampling Methodologies
MAT	• Number of people receiving MAT per 10,000 Vermonters age 18-64	Total Vermont
Drug Overdose Deaths	• Deaths related to drug overdose	Total Vermont
Utilization	• ED utilization (HEDIS®)	IMD (SUD & Psychiatric), Total SUD
	• Inpatient Utilization per 1,000 population	Total Medicaid, IMD (SUD & Psychiatric)
	• Residential Utilization per 1,000 population	Total Medicaid, IMD (SUD & Psychiatric)
Lengths of stay (LOS) in Residential SUD Treatment	• Median and Mean LOS for discharged patients	SUD Residential, IMD (SUD & Psychiatric)
Readmissions for Same Level of Care (LOC)	• SUD IMD Readmissions: 30-days and 180-days	IMD (SUD & Psychiatric)
	• SUD Readmission rates by length of stay: <16 days, 16-29 days, 30 or more days	IMD - SUD
Quality of Discharge planning	• Percent of IMD enrollees using substances who initiate and engage in treatment (Modified HEDIS®)	IMD - SUD
	• Percent of persons discharged who have PCP visit (well or sick) within 30 days of discharge from IMD (Modified HEDIS®)	IMD - SUD
Overall Cost of Care	• Average cost per enrollee for IMD services	IMD (SUD & Psychiatric)
	• Average cost per enrollee for all MH/SUD services	IMD(SUD & Psychiatric), Total Medicaid

Performance Areas	Metrics	Sampling Methodologies
	• Average cost per enrollee for all Medicaid Services	IMD(SUD & Psychiatric), Total Medicaid
SUD Treatment	• Percent of enrollees using substances who initiate and engage in treatment (Modified HEDIS®)	Total Medicaid, ACO Members
Follow up after Hospitalization for Mental Illness	• Percent of enrollees discharged who had follow-up at 7-days and 30-days (Modified HEDIS®)	Total Medicaid, ACO Members
ACO Access to SUD Treatment	• VII-day and 30-day follow-up after discharge from emergency department for alcohol or other drug dependence (Modified HEDIS®)	ACO Members
ACO Depression Screening and Follow-up	• Screening for clinical depression and follow-up plan (Modified HEDIS®)	ACO Members

All measures currently collected appear to represent alignment with those recommended by CMS. The State will work with CMS to assure measure specifications are in alignment with those HEDIS and utilization measures outlined in the November 1, 2017 State Medicaid Directors Letter #17-003 *Strategies to Address the Opioid Epidemic* to the extent possible given the State's unique payment and delivery models, data collection methods, resources and budget.

IX. Implementation Plan

Vermont has been aggressively pursuing OUD/SUD treatment and delivery system innovations over the lifetime of the Global Commitment to Health Demonstration. Vermont is seeking CMS partnership to allow the full continuum of services for Medicaid beneficiaries. The State will maintain and enhance existing efforts to develop a fully integrated system of physical and mental health and OUD/SUD services with our Medicaid ACO, OUD/SUD and mental health specialty providers. A high-level summary of planned activities to support the CMS OUD/SUD goals is provided below in Q.

Exhibit Q – Goals, Activities and Timelines

CMS and VT Goals	VT Activities to Address	Timeline
Increase Rates of Identification, Initiation, And Engagement in Treatment	• Pilot 'Respondent Driven Sampling' to identify individuals in need of treatment for opioid use disorder but not receiving treatment and treatment on demand	CY 2018 pilot launch
	• Develop Performance Improvement Project (PIP) to increase the rates of initiation and engagement in treatment	In progress
	• Expand screening brief intervention referral and treatment expansion in primary care	In progress
	• Increase OUD/SUD provider workforce through education and training	In progress
Increase Adherence to and Retention in Treatment	• Develop Performance Improvement Project (PIP) to increase the rates of initiation and engagement in treatment	In progress
	• Continue Quality Facilitators – practice staff who are placed in OUD/SUD practices for two years to focus on improvement in quality of care and engagement rates	In progress
Reduce Overdose Deaths, Particularly Those Due to Opioids	• Maintain naloxone distribution: ○ Free distribution (27 sites across the state, including syringe services programs and recovery centers) ○ Broad availability for non-users (e.g., family, EMS personnel) ○ Distribution with prison reentry for persons with OUD/SUD history	In progress
	• Enhance Vermont's Prescription Monitoring System, as needed	In progress
	• Expand needle exchanges	In progress
	• Monitor prescribing rules and enhance legislative policy, as needed	In progress
	• Continue public education and awareness efforts	In progress
	• Continue Medication Assisted Treatment	In progress

CMS and VT Goals	VT Activities to Address	Timeline
Reduce Utilization of Emergency Departments and Inpatient Hospital Settings for Treatment Where the Utilization Is Preventable or Medically Inappropriate Through Improved Access to Other Continuum of Care Services	• Centralize triage, intake, scheduling and call center	2018 Procurement
	• Co-locate recovery supports in emergency rooms	2018 Launch
Reduce Readmissions to The Same or Higher Level of Care Where the Readmission Is Preventable or Medically Inappropriate	• Improve discharge planning and transitions of care with care management support from MAT Teams	In progress
	• Implement value based payment structure for critical levels of care	2018 Launch
	• Disseminate and train evidence based practice	In progress
Improve Access to Care for Physical Health Conditions Among Beneficiaries	• Continue funding of care coordination services through the Vermont Blueprint for Health	In progress
	• Continue funding of health home services in opiate treatment programs	In progress

X. Public Process

The public process for submitting this amendment request conforms with the requirements of STC 7 and 42 CFR §431.408. Vermont is committed to engaging stakeholders and providing meaningful opportunities for input as policies are developed and implemented.

Public Comment Period

The State's public comment period on the Global Commitment to Health 1115 Waiver amendment request was from December 14, 2017 through January 14, 2018.

Public Notice

Vermont released the draft amendment request for a thirty-day public comment period starting on December 14, 2017 by posting the amendment request, including a summary of the proposed amendment and instructions for submitting comments, on DVHA's website. Notice of the proposed amendment and the public comment period was also published in the Burlington Free Press. The Burlington Free Press is the Vermont's newspaper with the widest statewide distribution and paid subscribers.

Comprehensive description of the proposed waiver extension: The State posted a comprehensive description of the proposed waiver amendment on December 14, 2017 on the above-cited website. The document included: program description; goals and objectives; a description of the beneficiary groups impacted by the demonstration; the proposed health delivery system and benefit and cost-sharing requirements impacted by the demonstration; estimated increases or decreases in enrollment and in expenditures; the hypothesis and evaluation parameters of the proposal; and the specific waiver and expenditure authorities sought.

Public Hearings: The State convened to two public hearing on the Global Commitment to Health 1115 Waiver amendment request.

> On December 18, 2017, a presentation on the proposed amendment was given to the Medicaid and Exchange Advisory Board in Waterbury, Vermont. A public hearing was held immediately following the Medicaid and Exchange Advisory Board meeting, from 12:00 to 12:30 PM, at the Agency of Human Services in Waterbury, VT.
>
> On January 5th, from 12:00 to 12:30 PM, a public hearing was held at the Vermont Department of Corrections in Waterbury, VT.
>
> Both hearings offered teleconferencing for individuals who could not attend in person.

Use of an electronic mailing list to notify the public: On December 14, 2017, the Draft *Global Commitment to Health Demonstration* amendment request was distributed simultaneously to the Medicaid and Exchange Advisory Board and the Global Commitment Register Listserv, which represents a wide array of interests in Vermont health care. The Global Commitment Register Listserv includes, but is not limited to, the following parties: health care providers; hospitals; health care Advocates; Vermont Legal Aid; Medicaid beneficiaries; QHP beneficiaries; Agencies on Aging; lobbyists; law firms; various State staff, managers, and directors, including all key leadership with the Agency of Human Services; Designated Agencies; state legislators; health insurance carriers; dental insurance carriers; concerned Vermont residents;

vendor partners; non-profit organizations for low-income Vermonters; federal government partners; other national organizations or companies with an interest in Vermont health care policy.

Tribal Government Notification: The State of Vermont has no federally recognized Indian tribes or groups.

Public Comments: No formal public comments were received regarding Vermont's Draft Global Commitment amendment request. This proposed amendment does not include any changes to the Global Commitment to Health Demonstration's covered populations or current budget neutrality agreement, therefore it was not unexpected that no comments were submitted.