VERMONT

AGENCY OF HUMAN SERVICES

Report to the Vermont Legislature

Medicaid Pathway 2016 Report

Act 113, Section 11

Submitted by the Agency of Human Services and in consultation with Vermont Care Partners, the Green Mountain Care Board and representatives from Preferred Providers

12-30-2016

Act 113 Sec. 11—Medicaid Pathway Report

Contents

Executive Summary

This report is a collaborative effort between Vermont Care Partners and the Agency of Human Services (AHS) and its Departments. The Green Mountain Care Board has provided an addendum to this report.

Designated Agencies (DAs), Specialized Service Agencies (SSAs), and preferred providers deliver services and supports that are critical to Vermont's Medicaid beneficiaries and to the health and wellbeing of all Vermonters. These services and supports are a key component of an integrated health care system that optimizes efficient, effective delivery of care.

This report compiles available data from multiple sources relating to funding, access, quality and performance measurement as well as reporting on plans to implement value-based payment methodologies. In some instances, information is not available or does not support an "apples to apples" comparison. This report identifies the following key points:

Access and Quality of Care

- Quality of care in the DA and SSA system is based on long-lasting, trusting relationships that are disrupted by high staff turnover rates averaging 26.3% annually.
- With 400 staff vacancies system-wide, some agencies have 10% or more empty positions, reducing access to needed services and supports.
- Challenges with recruiting skilled and experienced staff, high turnover and high staff vacancy rates creates increased demands and expenses on other care settings and sectors, including hospitals, State agencies, and Corrections.
- Vermont Care Partners is promoting the quality of its services through its own Centers of Excellence initiative which is currently being piloted. This certification process closely relates to the work the agencies do with the goals of: supporting assessment and related continuous quality improvement between and within agencies; promoting peer learning and support and promoting consistent quality across the network; and articulating the value of the services DAs and SSAs provide to community members, stakeholders, and to current and potentially future employees.

Funding Levels and Compensation

- According to Vermont Care Partners, inadequate funding for DAs and SSAs has led to inadequate compensation rates at DAs and SSAs:
    - There is a pay differential between the State and DAs and SSAs for individuals performing similar work, with similar credentials; State compensation and benefits are both higher (differentials vary from 28.6% to 59.2%). A key distinguishing factor is that state government staff tend to have higher retirement and fringe as a percentage of income. Availability of similar work at the State and health care, educational and human service organizations coupled with these pay differentials contributes to a high vacancy rate at DAs and SSAs.
    - Low resourcing and disparate compensation create an unlevel playing field that inhibits collaborative work across an integrated health system.
    - Vermont Care Partners estimates that raising the DA and SSA direct care workers compensation up to the level of state employee compensation would require an investment of over $43 million to the $385 million system of care.

- Lower compensation levels at DAs and SSAs contribute to both high turnover rates and high vacancy rates.
- Costs related to turnover, such as recruiting, on-boarding, lost productivity, and training average at least $4,160 per position across DAs and SSAs. In FY16, turnover of 1124 staff turnover equated to expenses of $4,675,840 that might otherwise have gone into programming.

Performance Measurement and Evaluation

- Targeted efforts to reduce administrative and reporting burden on DAs and SSAs have made positive impacts, but the overall burden continues to be extremely high and reduces staff availability to serve clients
- AHS departments are working with Vermont Care Partners to streamline reporting while preserving accountability and promoting quality. This requires significant work and inter-departmental collaboration at the State.

Plan to implement Value-based Payment Methodologies

- AHS has engaged with the Agency of Administration (AOA), providers, consumers and advocates to facilitate a planning process called the Medicaid Pathway. These planning efforts are designed to:
    - Systematically review payment models and delivery system expectations across the AHS Medicaid program;
    - Refine State and local operations to better support the integration of Physical Health, Long Term Services and Support, Mental Health, Developmental Disabilities, Substance Use Disorder Treatment, and Children's Services;
    - Develop a financially healthy and sustainable system of care;
    - Streamline payments to providers and reporting back to the State; and
    - Create provider level flexibility to meet need.

Summary

Funding challenges in the current system are linked to workforce development and staff turnover which in turn have a profound impact on access and quality of services delivered. Value-based payment methodologies may lead to additional provider flexibility, however, the senior staff who have the knowledge and ability to lead internal agency reforms are often also responsible for staff recruitment, training and supervision and may also carry a direct service caseload. High turnover rates not only inhibit quality and continuity of direct care for the consumer, but also impacts the organizations' ability to engage in internal innovation and delivery transformation.

Introduction

Section 11 of Act 113 of the Acts of 2016 requires the Agency of Human Services, in consultation with Vermont Care Partners, the Green Mountain Care Board, and representatives from preferred providers to submit a report to the Senate Committee on Health and Welfare and to the House Committees on Health Care and Human Services. The report is to address:

> (1) the amount and type of performance measures and other evaluations used in fiscal year 2016 and 2017 Agency of Human Services (Agency) contracts with designated agencies, specialized service agencies, and preferred providers;
>
> (2) how the Agency's funding levels of designated agencies, specialized service agencies, and preferred providers affect access to and quality of care; and
>
> (3) how the Agency's funding levels for designated agencies, specialized service agencies, and preferred providers affect compensation levels for staff relative to private and public sector pay for the same services.

This report begins with an overview of impacts related to AHS's funding levels (items 2 and 3 above), then discusses performance measures (item 1, above). Additionally, this report contains a plan at Section IV, developed in conjunction with the Vermont Health Care Innovation Project, and Vermont Care Partners (Vermont Care Network and Vermont Council of Developmental and Mental Health Services) to implement a value-based payment methodology for designated agencies, specialized service agencies, and preferred providers that shall improve access to and quality of care, including long-term financial sustainability.

Over the past year, AHS has convened numerous meetings with staff and stakeholders to discuss performance measures. This has been in two major forms:

(1) Performance measures that are aligned, reduce administrative burden and that are informative and support service delivery reform for the AHS designated agency and specialized service agency master grants; and
(2) Development of quality measures to support a value-based payment program.

AHS met with stakeholders in biweekly meetings in addition to *ad hoc* meetings. At these meetings, there was also discussion of funding levels and access to care.[1]

[1] Appendix A provides an overview of this process.

Section I: Funding Levels and Impact on Access and Quality of Care

This section addresses how the Agency's funding levels of designated agencies, specialized service agencies, and preferred providers affect access to and quality of care. This is described by Department, program and entity:

- AHS Overview
- Department of Mental Health (DMH)
- Department of Disabilities, Aging, and Independent Living (DAIL)
- Vermont Department of Health Alcohol and Drug Abuse Programs (ADAP)
- AHS Integrating Family Services (IFS)
- Vermont Care Partners (VCP)

Funding Impact on Access and Quality: AHS Overview

This section of the report discusses access to services. Section III of this report includes information about the quality of care delivered. Federal expectations of provider network and access are provided in Vermont's Global Commitment to Health Demonstration Waiver and are implemented through AHS Departments administering the Vermont Medicaid Program. Policies and practices of AHS regarding access to care are designed to ensure that the Medicaid provider network has a sufficient range and quantity of providers, is easily accessible to members, and complies with federal network adequacy requirements. AHS through the Department of Vermont Health Access (DVHA), publishes an Access to Care Plan, which is required to be updated every 3 years. Vermont's first annual Access to Care Plan was published in the fall of 2016 and describes time, distance, and access standards for various service categories. In the 2016 report, DVHA concludes that the average level of access to the specific types of services in the report are adequate given the characteristics of the State of Vermont. DVHA further describes that Vermont is a rural, mountainous state where it is not uncommon that residents of certain communities must travel longer distances for things like work, school, groceries, and as evidenced in the report, medical care. In the breakdown by county in Appendix B of the report and excerpted below, there are some counties where the average mileage one would have to travel to certain services is above desired thresholds. This is described as an expected result given the rural and mountainous geography of the counties in question. However, on a statewide basis and on average, all services identified in this report can be accessed within the identified mileage threshold. There is one exception that falls outside of the federally defined Behavioral Health and Substance Use Disorder specialty service areas.

Travel Distance and Travel Time Methodologies

Travel distance and travel time between Medicaid recipients' homes and their medical, dental and pharmacy providers is estimated by the following process:

1. Select relevant claims based on a provider's specialty;
2. Choose valid location data; and
3. Assign a travel route between representative origin and destination points.

All Vermont Medicaid claims with service provided during calendar year 2015 were available for the analysis. Claims for specific analyses were selected by provider specialty, and address information for recipient and attending provider were obtained with each query. These addresses were abridged down to the postal code represented by a single point inside a town. This "address point" approach based on

zip code reduces the spatial analysis from 100,000s of addresses down to 300 zip codes and a few thousand provider locations.

A claim can be thought of as a one-way trip, and the summary statistics for each county then is based on the all the claims, or trips, made during the year by the county or state's residents.[2] The spatial analysis was conducted using Geographic Information Systems ArcGIS 10.4 with the goal of connecting the origin points to the destination points along the highway network. The ArcGIS Network Analyst tool was used to find the 'least cost' route based on roadway time for each origin-destination pair. Any address with an invalid zip code was eliminated from the analysis unless location could otherwise be determined.

Both average (mean) and median statistics are present for each county's travel time and distance in Appendix B of the Access to Care Plan. The mean is often skewed as several long trips to reach a far-away hospital mathematically nudges the mean upward. These travel distributions are generally clustered around the low end and tail off with some very long trips. The median–the middle value in rank–is a good alternate measure of central tendency.

ArcGIS Network Analyst is able to use a complex road network data layer, which accounts for intersections, roadway curvature and posted speed limits. Travel time and distance estimates are realistically represented.[3] ArcGIS Network Analyst uses this same representation to determine the maximum spatial distance from each of Vermont's hospitals where one can still be able to reach the facility within 30 or 40 minutes. In the map of Hospital Travel Times, the white areas indicate it may be very difficult to reach a Vermont hospital or nearby non-Vermont hospital in under 40 minutes.

Figure 1, below, shows time and mileage results reported for providers of Behavioral Health and Substance Use Disorder services.

Figure 1: Access to Behavioral Health and Substance Use Disorder Services

Specialty Care	Average (mean)		Median		Distribution		
	Time	Distance	Time	Distance	% under 60 min	% under 60 miles	Recipients
Behavioral, Mental Health & Substance Abuse	27.0	19	16.4	9	85%	93%	47,163

[2] Unlike medical and dental, only the most recent trip to a pharmacy is counted.

[3] There are several limitations to this method. First, not all trips for medical care or pharmacy originate from a patient's home location, though this is always assumed to be the case. Second, the "address point" or postal centroid is made to represent an entire area served by that post office, introducing some error for nearly all locations. Third, trips whose origin and destination are the same cannot be assigned to the network, and are assigned zero (0) distance and time.

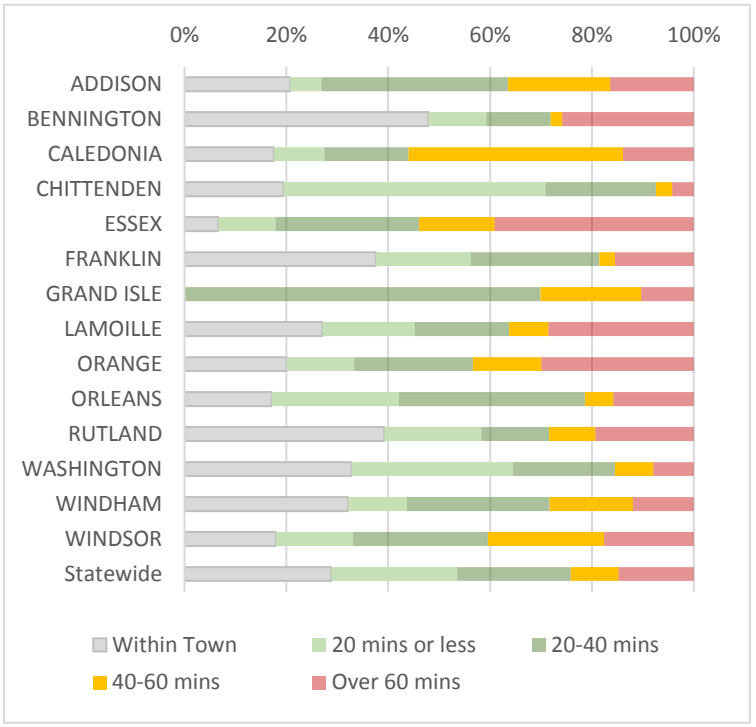
CY 2015 Medicaid Recipients -- travel time (minutes) for BEHAVIORAL, MENTAL HEALTH & SUBSTANCE ABUSE services

COUNTY of Residence	One way travel time to Attending Provider service location			
	Mean	Median	Recipients	%State
ADDISON	36.4	26.9	1,883	4%
BENNINGTON	28.3	10.8	3,228	7%
CALEDONIA	38.6	40.3	2,603	6%
CHITTENDEN	18.0	12.7	10,373	22%
ESSEX	55.0	56.2	490	1%
FRANKLIN	24.3	12.7	3,442	7%
GRAND ISLE	42.9	32.6	454	1%
LAMOILLE	33.1	21.5	1,932	4%
ORANGE	39.9	34.7	2,099	4%
ORLEANS	30.0	22.8	2,095	4%
RUTLAND	29.8	13.6	5,027	11%
WASHINGTON	20.8	12.1	4,846	10%
WINDHAM	27.9	20.2	4,394	9%
WINDSOR	34.6	32.9	4,297	9%
Statewide	27.0	16.4	47,163	100%

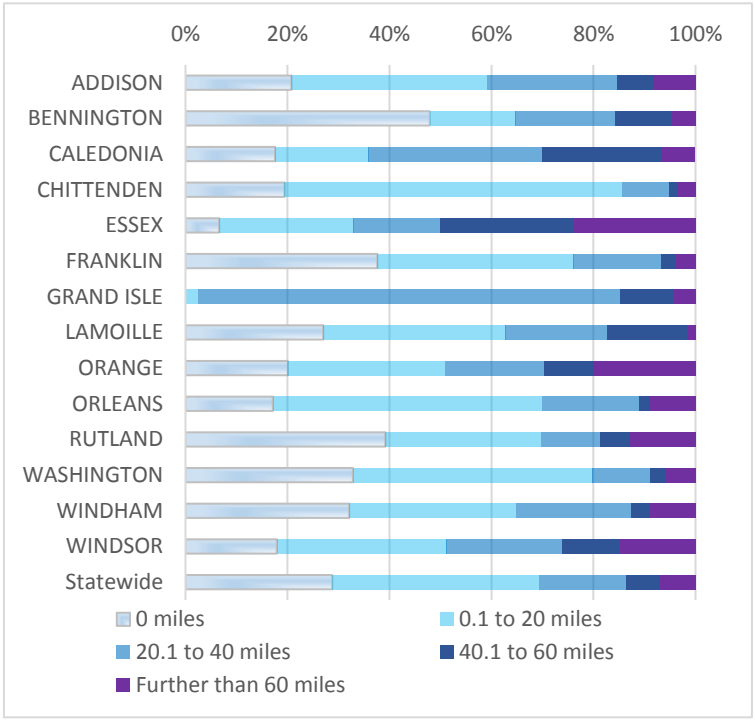
CY 2015 Medicaid Recipients -- distance (miles) for BEHAVIORAL, MENTAL HEALTH & SUBSTANCE ABUSE services

COUNTY of Residence	Network (roadway) distance to Attending Provider service location			
	Mean	Median	Recipients	%State
ADDISON	23.1	14.7	1,883	4%
BENNINGTON	17.6	5.4	3,228	7%
CALEDONIA	30.3	29.5	2,603	6%
CHITTENDEN	12.8	7.7	10,373	22%
ESSEX	41.4	41.9	490	1%
FRANKLIN	15.4	8.8	3,442	7%
GRAND ISLE	31.2	25.1	454	1%
LAMOILLE	19.7	10.7	1,932	4%
ORANGE	30.2	19.9	2,099	4%
ORLEANS	20.6	15.7	2,095	4%
RUTLAND	19.9	7.5	5,027	11%
WASHINGTON	14.9	7.3	4,846	10%
WINDHAM	22.2	14.3	4,394	9%
WINDSOR	28.5	19.2	4,297	9%
Statewide	18.9	8.8	47,163	100%

Behavioral, Mental Health & Substance Abuse Travel distribution (Time)



Behavioral, Mental Health & Substance Abuse Travel distribution (Distance)



Funding Impact on Access and Quality: Department of Mental Health

DMH provides services to adults with severe mental illness and adults with other mental health or emotional issues that disrupt their lives; children and adolescents experiencing a serious emotional disturbance or other mental health or emotional issues and their families; and anyone who is experiencing an acute mental-health crisis. DMH funded services are provided through AHS Master Grant Agreements and contracts with ten DAs and two SSAs.

Adults receive mental health services through Community Rehabilitation and Treatment and Adult Outpatient programs for the following reasons, including but not limited to: suicidal or homicidal behavior, extreme self-injurious behavior, severe psychoses which diminish or destroy one's ability to care for oneself in ordinary life situations, homelessness, substance abuse, marital and family distress, medical management of symptoms of mental illness, and /or need for rehabilitation and supports to restore the ability to function in the community and avoid hospitalization. Approximately 9,500 clients receive these community-based mental health services annually.

DMH contracted designated agencies also operate mental health Emergency Services programs which are available 24 hours a day, seven days a week, responding to any individual experiencing a mental health crisis and to communities following natural disasters, accidental deaths, suicides, and other traumatic events. The Emergency Services programs were originally designed to serve individuals and families already receiving services at a DA or SSA but, over the years have expanded to be a true community emergency response. The Emergency Services programs also screen situations to determine if there is a need for admission into involuntary and/or acute-care arrangements including hospitalization, crisis beds or other resources to resolve an acute episode. During FY 2013, financial investments were directed towards the community-based mental health and peer services systems for urgent, emergent, and alternative support services for persons at risk of requiring inpatient treatment if underserved. These additional resources allowed the expansion of more outreach and flexible service capacities given the constraints on inpatient hospital beds and unmet needs identified by communities and stakeholders.

In addition, over 10,500 children and adolescents and their families received community-based or residential mental health services in FY2016. These children and adolescents either experience a severe emotional disturbance or are at substantial risk for developing a severe disturbance. They include youth who exhibit behavioral, emotional, or social impairment that disrupts academic or developmental progress or family or interpersonal relationships. They fall into at least one of three categories:

(1) exhibit seriously impaired contact with reality and severely impaired social, academic and self-care functioning;
(2) classified as management or conduct disordered because they manifest long-term behavior problems (e.g., aggressiveness, anti-social acts, suicidal behavior, substance abuse);
(3) suffer serious discomfort from anxiety, depression, or irrational fears whose symptoms may be exhibited as serious eating and sleeping disturbance, or persistent refusal to attend school or may be exhibiting initial mental health concerns that if addressed to not manifest into one of the three categories above.

Children's services are reimbursed through many different mechanisms including but not limited to; waivers, individual service budgets, fee for service, case rates, and residential daily rates.

While the overall number of clients is not increasing in these programs, the agencies are expected to continue serving the population with capped budgets which have remained stagnant, received small increases and in some cases have received cuts. Overall, the result is a net decrease in funding for the

agencies compared to the cost of providing the care. Appropriate funding and combining some or all of these funding mechanisms could result in increased capacity to serve and achieve better outcomes, however, Vermont Care Partners has communicated to AHS that current rates are insufficient and without increased funding, the number of clients served and/or the community response may not be sustainable.

Funding Impact on Access and Quality: Department of Disabilities, Aging, and Independent Living

DAIL Developmental Disabilities Services Division (DDSD) provides funding to 10 DAs and 5 SSAs via the AHS Master Grant Agreements. The parameters for how funding is utilized to provide services for people with developmental disabilities (DD) are outlined in the Regulations Implementing the Developmental Disabilities Act of 1996 (March 2011) and the Vermont State System of Care Plan (SOCP) for Developmental Disabilities Services for SFY 15-17. These documents describe who is eligible and the criteria for who has access to services. The SOCP identifies how funds appropriated by the legislature are allocated and prioritized to meet the needs of people with developmental disabilities.

The funding that is appropriated through the annual State budget process that is available to allocate to DAs and SSAs for services does have an impact on access to services and supports. The Developmental Disabilities Act of 1996 (V.S.A. Title 18, Chapter 204A §8723) requires DAIL to plan, coordinate, administer, monitor, and evaluate services for individuals and families within the limits of available resources. One way that DAIL has done this is by setting priorities for who can access the more comprehensive Developmental Services Home and Community Based Services (DS HCBS, often referred to as "DS waiver"). So, in addition to being found to meet the clinical definition for a developmental disability and financially eligible for Medicaid, an individual must also meet at least one of six funding priorities to receive services. This prioritization limits access to those most in need of support.

According to the *Developmental Disabilities Services 2015 Annual Report,* and based on the DDSD definition of DD, it is estimated that 15,644 of the state's 625,741 citizens have a developmental disability. Of this number, 28% or 4,408 individuals received services funded by DDSD in FY15. It is not known how many people with DD have needs but have not requested services from the DA or SSAs. Not all people with DD need services funded through DDSD. Individuals may:

- Receive natural support through their families and communities
- Not have needs that require paid support
- Have supports funded privately or through other state programs

The SOCP requires that an applicant waiting list be kept by agencies for individuals that do not meet criteria. In FY15, agencies reported that there were 182 people who applied for services, did not meet eligibility criteria to receive services, and who were placed on a waiting list. The DA or SSA is expected to review the needs of all people on the waiting list at least annually or when notified of a significant change in the individual's situation (SOCP section IV). This allows agencies to keep track of individuals and be prepared to offer services and support should needs or criteria to access services change. It is important to note that there is no statewide wait list for individuals who apply for DS HCBS, are found clinically and financially eligible, and who meet one of the six SOCP funding priorities. Over the past two decades, the funds provided by the legislature have supported services for an average of 100 net new individuals with DD each year.

Funding changes over the past two decades and impacts on access and quality of care are described below:

- *Change in Funding Priorities for Comprehensive Services for Children Under Age 18 (2001):* DS HCBS for children is limited to those who need support to prevent institutionalization in a nursing home or psychiatric hospital. The funding priorities for children prior to 2001 were broader, allowing for greater access to services. The rationale for making this change was that children received support from other resources, including but not limited to the state's education system, and therefore the funding for DS HCBS was targeted to meeting other needs. In 2000, 297 children received HCBS. In 2015, only 64 children received those services.
- *Funding for Services Where Individual/Family/Home Provider Hires and Employs Own Staff:* This change supported the ability of families and individuals to direct their services and offered a more cost effective means of support. Referred to as independent direct support providers (IDSP), the cost for IDSPs is less than half the cost for agency-hired workers as they are not provided with benefits. Training and supervision of IDSPs varies because it is provided by the person employing them rather than by an agency. This arrangement works well for many people, but for others it impacts the availability of these IDSPs and the quality of the service.
- *Reductions in DS Funding:* In order to manage DS services within appropriated budgets, following the SOCP, DAIL provides instructions to the DAs and SSAs for how to make the reductions, trying to give as much flexibility as possible to the agencies while ensuring that individuals and families are involved in decision making. DAIL has then collected reports from each agency about the impact of the reductions to both agencies and individuals.
    - As a result of the last rescission in SFY 14, 524 consumers were affected (roughly 19% of the 2,757 people receiving DS HCBS) and the greatest reductions in dollars were made in various types of home supports, community supports, and employment services. Additionally, DS agencies also reduced funding from administration and 298 staff/workers were affected, including the loss of 25 full-time equivalent positions statewide.

While the level of funding for agencies has varied from year to year, agencies are still held to the same standards for those people who are receiving their services. The quality service reviews that DAIL DDSD conduct are not geared to assess the impact of finances on quality. However, anecdotally, when there have been reductions in funding or when funding does not keep pace with inflation, agencies have made adjustments that can impact quality. For example, when funds have been reduced, agencies have increased the caseload of service coordinators, reduced training, or moved services from more individualized support to group support.

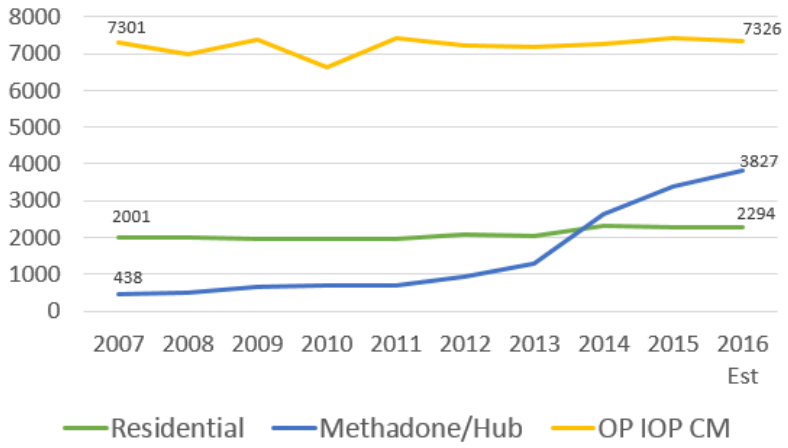
Funding Impact on Access and Quality: Vermont Department of Health Alcohol and Drug Abuse Programs

The ADAP division of the Department of Health was established to help Vermonters prevent, reduce and/or eliminate alcohol and other drug related problems (33 V.S.A., Section 706). In partnership with other public and private organizations, ADAP plans, funds, manages, and evaluates a comprehensive, consistent, and effective system of substance abuse prevention, treatment and recovery services.

Over the past four years, Vermont has experienced a rapid change in the need for substance use disorder treatment. This change has been driven by the number of individuals seeking treatment for opioid addiction. Although in the last 10 years the number of individuals being treated in the ADAP Preferred Provider outpatient system (all payers and substances) has been level (<1% change), there has

been a 15% increase in the number of people receiving residential treatment services, and a 773% increase in the number of people receiving medication assisted treatment (MAT) in in Opiate Treatment Programs/methadone clinics (Hubs).

Figure 2: People Served in the ADAP-Funded System of Care by State Fiscal Year and Level of Care



In response to the increased demand for services, the State has approved increases in the Medicaid expenditures in the Preferred Provider system. ADAP funds 8 Hub locations but only one Designated Agency operates a Hub. An alternative payment methodology has been put into place for these Hubs (bundled payments) in order to provide flexibility in the provision of services and to improve access to care. Only one region in the State continues to experience a significant waiting list for Hub services. In response, additional Medicaid funding has been allocated to open a new Hub to meet this need.

Figure 3: Preferred Provider Medicaid Recipients Served by Type of Care and State Fiscal Year

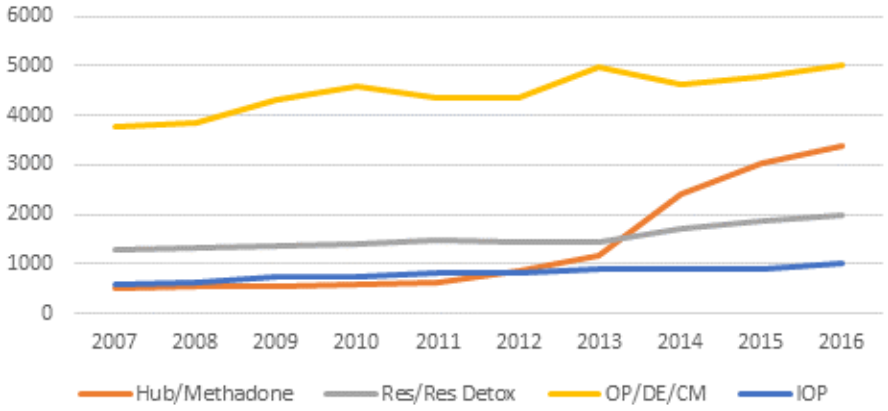
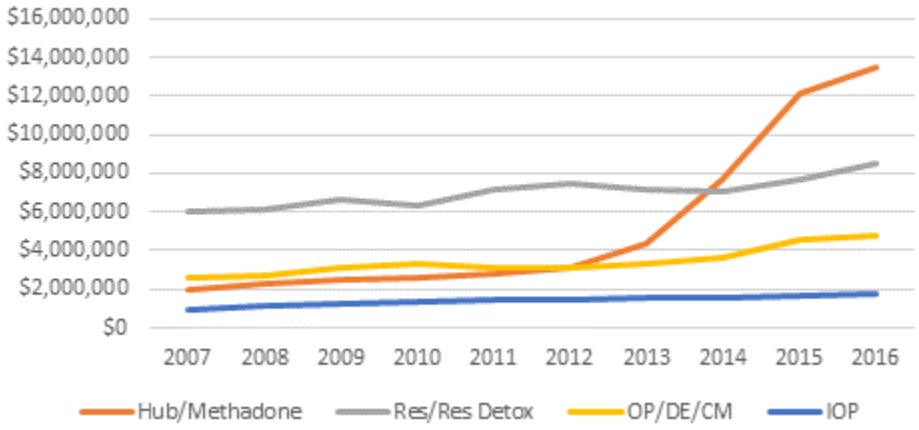


Figure 4: Preferred Provider Medicaid Expenditures by Type of Care and State Fiscal Year



Increases in the rates for residential and outpatient services have been driven by legislative mandates. Over the past few years, ADAP has had no rate decreases or reductions in approved programs. As the data above shows, the number of Medicaid recipients served continues to increase. Although the Designated Agencies are operating within a budget from ADAP, any Medicaid services provided are reimbursed at the ADAP enhanced rates. To ensure access to care, ADAP has continued to fund new programs for outpatient services, but overall patient volume has been relatively stable for the last 10 years.

Funding Impact on Access and Quality: AHS Integrating Family Services

Children's Medicaid services are administered across AHS departments. Programs historically evolved separate and distinct from each other with varying Medicaid waivers, procedures, and rules for managing sub-specialty populations. These were the best approaches available at the time; however, the artifacts of this history are multiple and fragmented funding streams, policies, and guidelines. Often the same provider and family will be captive to varied and conflicting procedures, reporting, and eligibility requirements.

AHS continues to act on opportunities to improve quality and access to care within existing budgets, using flexibilities available through delivery and payment reform. This includes such items as:

- Integration of administrative structures for programs serving the same or similar populations
- Opportunities to increase access to services by decreasing administrative burdens on providers
- Reviewing operations to determine if separate administrative and Medicaid reimbursement structures can be streamlined.

The IFS Initiative seeks to bring state government and local communities together to ensure holistic and accountable planning, support, and service delivery aimed at meeting the needs of Vermont's children, youth, and families. The premise is that giving families early support, education, and intervention will produce more favorable health outcomes at a lower cost than the current practice of 'waiting until circumstances are bad enough' to access funding which often results in treatment programs that are out-of-home or out-of-state. Several efforts are underway through IFS that include: performance-based reimbursement projects, capitated annual budgets, and flexible choices for self-managed services.

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

Addison County's FY17 aggregate annual budget is approximately $3.6 million while Franklin/Grand Isle's is 5.5 million. The financial model supporting this agreement includes a monthly case rate established for the reimbursement of all Medicaid-covered sub-specialty services. Case rates are based on agreed upon annual allocations for covered services divided by the minimum Medicaid caseload expectation. The same case rate is paid for minimal service packages and for intensive service packages. The goal of the funding model is to ensure beneficiaries get a package of EPSDT and outreach services commensurate with their functional needs within an overall annual aggregate reimbursement cap. Case rates are not based on any one group of services being 'loaded' into a claim; they are global aggregate budget/minimum caseload.

The goal of IFS from a service delivery and payment reform perspective has been to promote an overall shift toward an upstream and proactive approach. This has been found to be achievable with an upfront investment in prevention and promotion, however, existing payment models have not been found to support achieving this transition. Due to the rigidity of the funding streams supporting treatment and intervention, IFS created a payment model that would provide some flexibility to be responsive to the continuum of needs existing within each region. The theory was if funding and expectations were integrated (documentation, outcomes, criteria) providers could spend more time on service delivery, achieve positive outcomes sooner and prevent families from reaching crisis level before services could be provided.

Some additional funding (sometimes referred to as non-categorical) was added in FY 13 (and then partially removed in recessions in 2015) because of the change to Children's Personal Care Services. That funding was used to increase capacity in four areas – MH fee-for-services; DA managed respite; family managed respite; Bridge Case Management. However, this infusion did not fully address underfunding or other unmet needs. In effect, the rigid structures of the pre-IFS system created barriers to care. Once these barriers were removed and families could more easily access the services they needed, the extent to which the system was underfunded became more clear.

From the beginning of IFS implementation, there was clear recognition this model did not solve the resource challenge that existed then and that continues to exist. Since IFS began, other than the non-categorical funding that went to all DAs there have not been any additional funds from any department of AHS added to the IFS portfolio. As well, the results of the flexibility mentioned earlier were realized during the first year at both IFS implementation sites (integrated documents, outcomes, criteria) and have since leveled off. For these reasons, unless additional funding is incorporated into the portfolio and/or requirements of the IFS grantees are further alleviated, successes that have been achieved are expected to plateau.

Early successes of the two pilots include:

- Increased service hours overall, increased number of people served, and simultaneous reduction in requests for children's mental health crisis services.

- Stable trend line for children entering the State's custody in the Addison pilot region while at the same time the State overall has experienced a 30% increase in children coming into DCF custody.
- Increased ability to provide the right services to children and their families more immediately.
- Increased ability to provide services in a child's natural setting.
- Increased ability to work with a variety of providers and bring resources together to support families.
- Reduction in separate and conflicting paperwork, which increases the number of hours clinicians can spend on direct services.
- A more immediate response to families who ask for help.
- Unified local efforts to offer a single onsite response to families combining multiple state and federal programs that would otherwise be offered at differing times and places.
- Initial numbers indicate an ability to serve more children and families with the same amount of resources.
- Increased staff morale at the two Designated Agencies who are IFS grantees.

Funding Impact on Access and Quality: Vermont Care Partners

Vermont Care Partners (VCP) is a collaboration between the Vermont Council and the Vermont Care Network. Their mission is to provide statewide leadership for an integrated, high quality system of comprehensive services and supports. Their sixteen non-profit community-based member agencies offer care to Vermonters affected by developmental disabilities, mental health conditions and substance use disorders.

Vermont Care Network (VCN) is a statewide provider network of 16 non-profit community-based agencies that serve Vermonters affected by developmental disabilities, mental health conditions and substance use disorders. Incorporated as Behavioral Health Network of Vermont in 1994, VCN is a 501(c)(3) non-profit organization that creates effective partnerships and efficiencies to facilitate the provision of accessible, high quality services and supports throughout the state. Committed to excellence and innovation, VCN provides strategic return on investment by serving as a vehicle for collaboration, systems integration and improvement, economies of scale and new opportunities and markets.

The Vermont Council of Developmental and Mental Health Services is the trade association of 16 non-profit community-based agencies that serve Vermonters affected by developmental disabilities, mental health conditions and substance use disorders. Its mission is to promote a statewide, non-profit system of developmental, mental health and substance abuse services for individuals and families. Through their member agencies, they work toward ensuring access to a high-quality continuum of health care and support services in every community throughout the state and to improve the health and safety of Vermont communities through socially responsible alliances and partnerships, information sharing, education and advocacy at the national, state, and local levels. For more than 40 years, the Vermont Council has formed socially responsible alliances and partnerships and conducted information sharing, education and advocacy at the national, state, and local levels to enable individuals and families to achieve their full potential.

VCP describes that chronic underfunding of the DA and SSA system has led to high turnover and vacancy rates because compensation is inadequate and below market rates. According to feedback from DA and SSA HR Directors, Program Directors, and Executive Directors, the high turnover of clinicians,

administrative staff, and other DA service providers leads to reduced access for individuals who would otherwise be able to access these Medicaid services.

VCP additionally describes that funding directly impacts concrete needs of vulnerable Vermonters. When Vermonters are referred to case managers at designated agencies who are trained, experienced, and skilled, they can connect to fuel assistance; housing support; domestic violence support; legal advocacy; employment support; childcare resources, and parenting support. Case managers have an active rolodex, a thorough awareness of community resources, and a team approach. As a result, clients are housed quicker, working sooner, and experiencing less stress. Referrals are frequent and involve "warm hand-offs" to community partners. Families are supported in navigating complicated systems, such as through the Department of Children and Families and education rights, that promote the best possible outcomes for permanency and educational success for children. When Vermonters are referred to case managers who are new to the field, and who may have a limited understanding of community resources and processes. Relationships with competent professionals in other agencies have not been developed, so resources may be missed or errors in referrals may be made, leading people to feel frustration and mistrust of the system.

The DA and SSA system is obligated by law to serve the most vulnerable populations (i.e., adults with a severe and persistent mental illness, individuals with an intellectual/developmental disability and children experiencing a severe emotional disturbance and their families). The State has prioritized available resources to sustain the DA and SSA System of Care for these mandated populations. The DA and SSA system also plays an important role with regard to the provision of Mental Health and Substance Use Disorder treatment services for all Vermonters. However, due to funding constraints the DA and SSA system has faced additional challenges in serving persons other than those mandated by Statute. VCP reports:

- DA and SSA providers maintain waiting list for services including outpatient mental health and substance use disorder treatment for children, families, and adults;
- Recent changes in Medicaid reimbursement rules and rates for group therapy and Applied Behavioral Analysis have led to concerns regarding staff recruitment and subsequent access to care;
- Vermont faces challenges related to the availability of specialists with advanced training in specific fields such as autism, forensics, and child psychiatry; and
- The increasing need for opiate treatment by a growing number of Vermonters has outpaced treatment capacity.

DAs and SSAs are currently experiencing significant challenges in their ability to recruit for needed positions, which has resulted in burgeoning caseloads and delayed access to needed services. VCP reports that underfunding results in less experienced staff, lower quality services, and poorer outcomes, and states that if the chronic underfunding of the DA and SSA system is left unaddressed, continuing erosion of the workforce is inevitable. This has a direct effect on the quality of care the DA and SSA system is able to offer, and reduces the system's ability to offer services that meet the best practice standards for Vermonters. DAs and SSAs are faced with using less educated and uncredentialled staff, who work for lower wages, rather than employing Master-level/licensed staff to perform clinical services. Some specific impacts include:

Hiring Challenges

- Agencies' salaries are not competitive, especially for seasoned candidates, and as a result they are forced to hire less experienced/underqualified candidates for work with increasingly higher acuity clientele. Non-competitive salaries also result in longer recruitment time.

- More than one-fourth of staff have less than 1 year of experience, with half of the direct service professionals in developmental services having less than 2 years of experience. These jobs require significant knowledge about disabilities, techniques for supporting individuals with disabilities, and knowledge about best practices and protocols for compliance with rules and regulations. Hiring less experienced staff requires a greater level of support and supervision, which managers are unable to provide due to the number of less experienced staff they are now required to supervise.

Staff Turnover

- Costs related to turnover, such as recruiting, on-boarding, lost productivity, and training average at least $4,160 per position across DAs and SSAs. In FY16, turnover of 1124 staff turnover equated to expenses of $4,675,840 that might otherwise have gone into programming.
- High turnover impairs relationships between staff and clients. One of the most important factors in developing therapeutic relationships is trust, which takes time to develop. Constant turnover disrupts trusting relationships.

Staff Burnout

- A significant number of staff hold down second or third jobs to make ends meet, and some are forced to use the same state support services that they refer clients to for aid.
- Staff shortages lead to larger caseloads, DA employees working overtime and not taking available leave time to provide coverage.
- Supervisors are being asked to do more. More supervisors must carry caseloads while supervising a greater number of less experienced employees, which reduces time for staff supervision and support.

Insufficient Staffing Levels

- High caseloads limit services to all but those with the most acute needs. This can lead to marginal clients becoming unnecessarily more acute. When staff invest the necessary time and energy to stabilize clients with acute needs, it leaves limited time and energy to ensure that other clients have the ongoing supports to maintain stability in their lives, thereby perpetuating this cycle. This can be true whether addressing homelessness and housing or coping with symptoms of mental illness and/or addiction. Often, it is a combination of clinical interventions and supports that are necessary to support people served by DAs and SSAs.
- The DAs and SSAs individually contract with schools to provide services to students. The lack of staff results in an inability to meet the needs of all students with special needs in the schools. The DAs and SSAs provide a significant number of services to students with special needs, including individualized supports which enable students to participate in normal classes. When staff are not available, some students are unable to attend to school, reducing access to service and education.
- Staff vacancies lead people receiving developmental services to receive only 88% of the hours of support for which they are eligible, reducing their ability to lead active lives integrated in their communities.
- Vacancies can force clients to seek care in more expensive settings, such as emergency rooms, or health care settings which may not be as effective as the DA system. For instance, when mobile crisis teams have significant staff vacancies, they may not be able to provide care in the community, leading to more interventions in emergency rooms and possibly higher rates of inpatient care.
- Competition of Qualified Staff Across DAs, SSAs and Other Organizations

- The need for services continues to grow across all age groups, including elders. There is a growing competition for clinical staff and direct support professionals. DAs and SSAs are currently experiencing an extreme delay in their ability to recruit for these positions, which has resulted in burgeoning caseloads and delayed access to needed services.
- DAs and SSAs struggle to keep specialists and other clinicians with advanced training on staff. While many specialists enjoy their work in the agencies, they are lured away by better paying jobs with other providers. The DAs and SSAs provide a training ground for many master's level clinicians who then leave in favor of higher paying positions following licensure.

Disrupted Treatment

- High turnover rates cause clients to lose valuable ground in their recovery process and force them to retell their story to new staff over and over again. A typical family that is struggling with domestic violence and parental substance use could have their child's case manager change four or five times in a two-year period due to high rates of turnover, leaving families feeling that no help is better than a constantly revolving door of service providers.. DAs and SSAs cannot measure the impact of rebuilding trust, especially for those recovering from trauma, but the overall impact is an ever-lengthening duration of healing and recovery which in turn drives an increase in the cost of service delivery. Clients who have a major mental illness or a developmental disability need the continuity and stability of staff that they have come to trust and recognize. Research shows that higher suicide rates were associated with higher non-medical staff turnover [Healthy Services and Safe Patients, 2015]
- High turnover rates can also negatively impact substance abuse recovery. Relative to adolescents who did not experience any clinician turnover, adolescents who experienced both direct and indirect clinician turnover had significantly higher percent of days using alcohol or other drugs [Garner, 2013]
- High vacancy rates cause clients to wait longer to get an appointment or limit the DA from offering the type of service indicated by the clinical assessment.
- In many regions of the State, group therapy and applied behavioral analysis services have been reduced or eliminated, as the reduced reimbursement rates no longer support the specialist positions to provide the services.
- In some cases, large caseloads require clinicians to increase the interval between appointments in order to see everyone on their caseload.
- Clients with complex needs who require a 2:1 staffing ratio may only be able to have a 1:1 staffing ratio, which is a safety concern for both the client and the employee.
- Treatment teams' effectiveness is reduced by high turnover which de-stabilizes treatment teams. At times, a treatment team and/or clinical supervisors may be unable take on the cases left behind. When this occurs, short-term needs of the people receiving services may fall to the emergency services system. Using emergency staff in this manner delays their ability to respond adequately to crisis situations in the community. This can result in clients in crisis accessing more expensive services such as hospital emergency rooms, calls to 911 or trips to crisis bed programs. This added burden on emergency staff has a domino effect, causing staff turnover within the emergency team, which only compounds the issue.

VCP identifies significant long-term consequences of chronic underfunding. These include:

- More Vermonters have untreated or under-treated mental health conditions, developmental disabilities, and substance use disorders, impacting schools, employers, and communities.

- Increased rates of substance abuse and addiction, when preventative and early interventions are unavailable.
- Increased homelessness, when resources are too limited to take preventative measures to find and stabilize housing, and as DAs close residential programs because the reimbursement rates are insufficient to sustain these services.
- More Vermonters decline referrals to needed services due to cynicism about organizational capacity for continuous care. Research shows that higher organizational stress, such as turnover and staff burnout, is associated with lower client participation [Landrum, 2012]
- Increased incarceration rates and an added strain on the judicial system, particularly for transition-age youth who are at-risk due to limited supports to achieve employment and inclusion in their communities, as was demonstrated by the Youth in Transition grant program.
- A rise in referrals to psychiatric hospitalization when early intervention is limited by wait lists for outpatient services.
- Increased use of emergency rooms to address mental health crises because mobile crisis staff vacancies reduce the ability to provide interventions in the community.
- In addition to these factors, recent federal activity has impacted the DAs:
- As a result of the (now delayed) federal Department of Labor overtime rule, the Designated Agencies modified their pay structure, impacting $0.5 million in annual expenditures. The federal delay occurred just prior to the December 1, 2016, implementation date, after Vermont's DAs had modified salaries for staff. If the new cost is not addressed in the FY16 budget adjustment, this new salary structure will also reduce resources available for services.

Section II: Funding Levels and Impact on Compensation for Staff

This section addresses how the Agency's funding levels of designated agencies, specialized service agencies, and preferred providers affect staff compensation. This is described by Department and program:

- Department of Mental Health (DMH)
- Department of Disabilities, Aging, and Independent Living (DAIL)
- Vermont Department of Health Alcohol and Drug Abuse Programs (ADAP)
- AHS: Integrating Family Services (IFS)
- Vermont Care Partners (VCP)

Funding Impact on Staff Compensation: Department of Mental Health

Current and past funding levels for DAs and SSAs have led to high staff turnover. When compared to their counterparts in the medical sector such as FQHCs, hospitals, and even Blueprint Community Health Teams (CHTs), staff at DAs are paid on average 30% less (see information compiled by VCP starting on page 21 of this section). This contributes to many individuals being hired away from DAs and then often referring their clients in the new setting to the DA because of the broader array of services a DA can provide versus an FQHC, hospital, or Blueprint CHTs. DAs often provide more in-depth services that include in-home and in-community supports. AHS received data from VCP that indicates a 26-27% yearly turnover rate.

Impacts of low compensation rates are varied, and include loss of training investments and expertise when staff leave the DA system, to difficultly moving individuals out of residential or hospital level of care because of low staffing resources.

Funding Impact on Staff Compensation: Department of Disabilities, Aging, and Independent Living

Ninety-seven percent of the funding allocated to DAs and SSAs to provide DD services comes from DS HCBS funding. The funding mechanism is a bundled daily rate which includes a variety of service categories. While DAIL DDSD sets the rate for service coordination, each agency determines their rates for community supports, employment supports, staffed home supports, clinical services, crisis supports, and mileage reimbursement for transportation. The rates for these services are based on allowable costs to deliver the services, which includes personnel costs. DAIL approves agency determined rates when approving new requests for services. The challenge for agencies is that not all costs are allowable, numerous budget cuts have resulted in decreased funds and unless a Cost of Living Adjustment (COLA) or rate increase is provided each year, agencies have limited ability to increase the rates funding individual budgets for clients. Agencies review allocated resources at the end of each fiscal year, throughout the year as individual needs change and may reallocate funds from areas where needs have decreased to areas where costs have increased. DAs and SSAs report that DAIL DDSD rates have not been sufficient to cover increases in personnel and other costs over time. Additionally, in reviewing DA and SSA budgets, DAIL has observed that variations in rates may occur depending on when a person was originally approved to receive services.

Over the years, DAs and SSAs have had various adjustments to funding. Some years COLA or rate increases have been approved. Other years, there have been budget reductions. These variations cause challenges for agencies in maintaining their workforce. A recent Staff Stability Survey Report 2014 from

the National Core Indicators (NCI) organization (see page 28 for more information about NCI), indicates that the turnover rate for direct support staff in Vermont was 33% in 2014. Direct support staff are those hired by agencies to provide hands-on direct support for people in their homes, employment, and communities. Key findings include:

- 19% of the 1,505 workers had been on the job less than 6 months
- 13% for 6-12 months
- 66% for more than a year
- The vacancy rate for positions was 6% for full time workers and 8% for part-time positions.
- Starting salary for these workers was an average of $11.84 hourly and the average for all workers was $12.73 hourly.
- 93% of agencies offered health insurance
- 50% of agencies offered sick/vacation time to full-time workers.

It is important to note that this report addresses staff stability only for those workers who are hired by agencies to provide direct support. It does not address the 3,800 IDSPs hired by individuals receiving services or their family members or hired by home providers. Data on the turnover rate or ability to hire these providers is not currently available, but anecdotally, employers report that hiring these providers can be a significant challenge. These IDSPs are represented by a union who has negotiated a minimum salary of $11.04 an hour or a daily rate of $168 for providing 24-hour care which includes sleeping. These providers do not receive any benefits under the current collective bargaining agreement. The employer of record is allowed to pay a higher rate in order to attract providers; however, if they do this, they do not receive additional funds and this may mean that they are able to pay for fewer services. Hiring and retaining these providers is challenging because the positions are often part-time, pay relatively low wages, lack benefits, and offer limited training and support.

DAIL does not have current information related to non-direct support workers such as service coordinators, program managers, clinicians, and administrative staff, or how funding levels for DAs and SSAs affect compensation levels for these staff relative to private and public sector wages for the same services. (Please also refer to information compiled by VCP starting on page 21 of this section).

It is important to keep in mind that historically, staff turnover, particularly of the direct support staff, has always been an issue. These positions are entry level positions requiring only a high school diploma and generally no prior experience. Factors other than compensation impact staff turnover, including lack of a career track, requirements to work evenings, nights and weekends, and the challenges of working with people who may exhibit unusual or dangerous behavior or require significant levels of physical assistance. The DAs and SSAs have historical data regarding turnover and vacancy rates which show consistent and increasing challenges in recruitment and retention (see figure 12 on page 24).

Funding Impact on Staff Compensation: Vermont Department of Health Alcohol and Drug Abuse Programs

The ADAP Medicaid reimbursement rates are set to incorporate ADAP Preferred Providers' additional administrative requirements. These rates are significantly higher than the DVHA rates for private practitioners. In addition to these enhanced rates, ADAP funds services that cannot be provided by private practitioners, such as intensive outpatient and case management.

Funding Impact on Staff Compensation: AHS Integrating Family Services

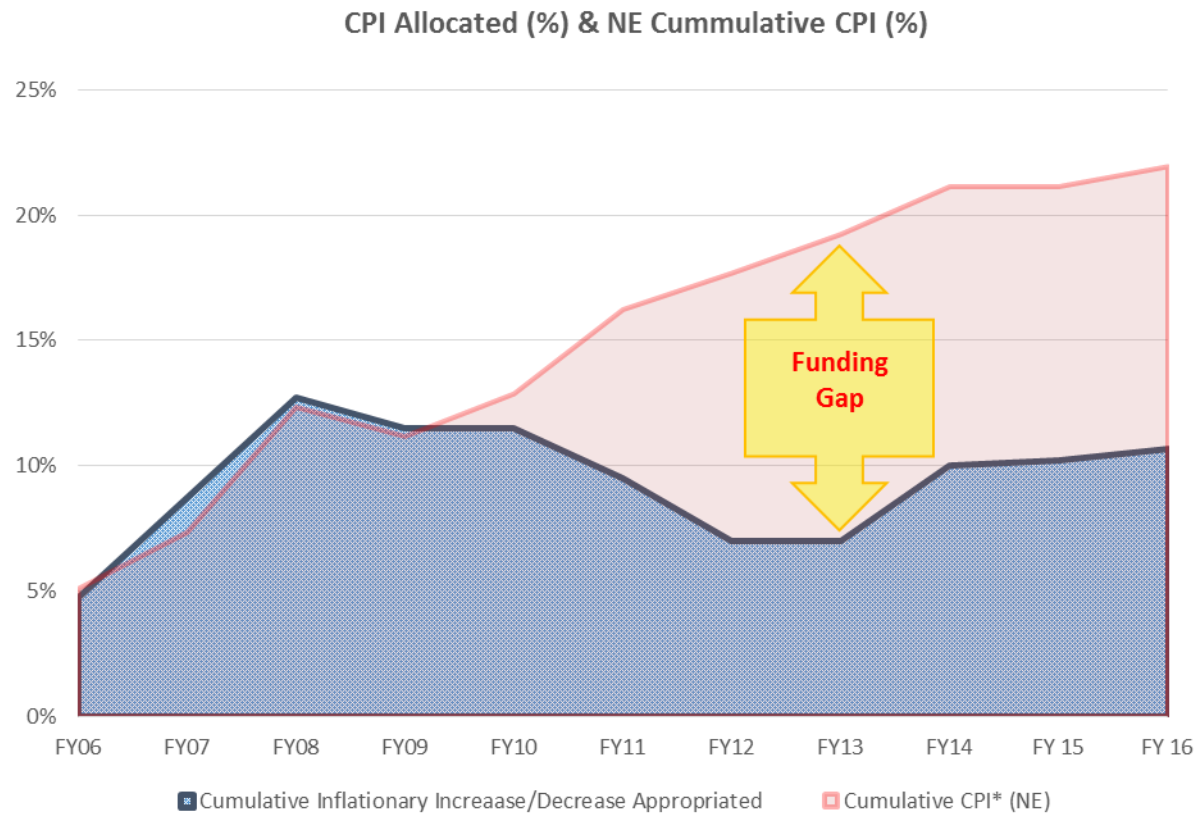
The two regions using the IFS approach to payment and service delivery have the same challenges in staff compensation discussed in the next section from Vermont Care Partners, as two of the three IFS grantees are DAs. Using an IFS approach has not changed staff compensation, however, according to information reviewed from staff surveys and turnover rates, it has led to higher employee satisfaction and staff morale as direct service staff have seen a decrease in the amount of time they spend on administrative tasks and an increase in the time they are able to spend delivering services to children, youth, and families.

Funding Impact on Staff Compensation: Vermont Care Partners

Vermont Care Partners has authored a white paper that discusses the various workforce issues impacting designated agencies.[4]

Figure 5 illustrates the continuing funding gap between the annual Cumulative Inflationary Increase (CPI) and the annual inflationary allocation to the DAs and SSAs. In FY16, there was a 11% discrepancy between the allocation and the CPI, contributing to a cumulative deleterious effect upon the DA and SSA system.

Figure 5: CPI Funding Gap



[4] Vermont Care Partners white paper, "Vermont's Designated and Specialized Service Agency System – A Workforce at Risk," available at: http://vermontcarepartners.org/pdf/files/139_VCP%20workforce%20white%20paper020516s%20(2).pdf.

The following table is a broad-based analysis of compensation levels, but clearly illustrates the pay differentials between DA and SSA staff and staff with similar credentials in state government. The pay differentials vary from 28.6% to 59.2%. A key distinguishing factor in overall compensation is that state government staff tend to have higher retirement and fringe as a percentage of income than the DA or SSA staff.

The data also highlights the impact on length of employment, with nearly half of the developmental services direct care staff having less than 2 years of experience.

Information in Figures 6 through 11 below come from a Vermont Care Partners wage study of the DA and SSA system.

Figure 6: Wage Summary by Education and Licensure Level

Position	Incumbents	Ave. Hourly Rate	Ave. Years with Agency	Ave. Step	Ave. Grade	State Hourly Rate	Hourly Wage Gap	Annual Wage Gap/FTE
Non-Degree	1,488	$14.40	1	5	18	$19.82	$5.42	$11,269
Bachelor's (e.g. Case Mgrs)	834	$16.92	8	6	23	$26.94	$10.02	$20,843
Master's (e.g. Clinician)	362	$20.95	6	6	23	$26.94	$5.99	$12,469
Master's w/ Lic. (Clinician)	1,488	$14.40	1	5	18	$19.82	$5.42	$11,269

Table 7: Annual Wages, DA/SSA vs. State

Position	DA/SSA	State	% Difference	$ Difference
Non-Degree	29,956	$41,226	37.6%	$11,269
Bachelor's (e.g. Case Mgrs)	35,192	56,035	59.2%	$20,843
Master's (e.g. Clinician)	43,566	56,035	28.6%	$12,469
Master's w/ Lic. (Clinician)	47,010	65,250	38.8%	$18,239

Figure 8: Average Years of Service by Education and Division

Position	Developmental Services	Mental Health	Substance Abuse	Mental Health/ Substance Abuse	Total
Non-Degree	4.4	3.7	5.7	3.4	-
Bachelor's (e.g. Case Mgrs)	7.0	4.4	5.9	1.7	5.1
Master's (e.g. Clinician)	7.8	6.4	4.6	3.5	6.0
Master's w/ Lic. (Clinician)	12.0	9.2	10.6	3.5	8.7

Figure 9: Total Positions by Education and Division

Position	Developmental Services	Mental Health/ Substance Abuse	Total
Non-Degree	1,106 (87%)	382 (25%)	1,488 (53%)

Position	Developmental Services	Mental Health/ Substance Abuse	Total
Bachelor's (e.g. Case Mgrs)	157 (12%)	677 (44%)	834 (30%)
Master's (e.g. Clinician)	12 (1%)	350 (23%)	362 (13%)
Master's w/ Lic. (Clinician)	1 (0%)	120 (8%)	121 (4%)

Figure 10: Number and Percentage of Non-Degree DS Staff Hired in Past Two Years

Position	Developmental Services
Non-Degree	533
Total DS Staff	1,106
% of Non-Degree Staff Employed <2 years	48%

Figure 11 illustrates that raising the DA and SSA direct care worker compensation up to the level of state employee compensation would require an investment of over $43 million to the $385 million system of care. To sustain parity in compensation levels, annualized cost of living increases equivalent to state employees salary and benefit increases would be necessary.

Figure 11: DA/SSA Wages Relative to Comparable State Positions- 2016

State Job Title & Step based on Grade and Avg LOS	DA/SSA # equiv. FTES	DA/SSA Average Length of Service	Average Agency Compensation	DA/SSA Ave. Annualized Salary	Equiv. State Salary	State Ave. Annualized Salary	Salary ratio	Per Person Ave. Increase to Meet State Level	Additional Comp for Agency Positions to Reach State Levels
Psych. Tech. Grade 18 - Step 5 (Non-Degree)	1605	4.4	$14.41	$28,100	$19.82	$38,649	72.70%	$10,550	$16,931,948
Reach Up Case Manager II Grade 23 - Step 6 (Bachelor's)	955	4.8	$16.79	$32,741	$26.94	$52,533	62.32%	$19,793	$18,901,838
Psychiatric Social Worker I Grade 23 - Step 6 (Master's)	384	6.2	$20.96	$40,872	$26.94	$52,533	77.80%	$11,661	$4,477,824
Clinical Social Worker Grade 25 -	182	8.5	$22.85	$ 44,558	$31.37	$61,172	72.84%	$16,614	$3,023,748

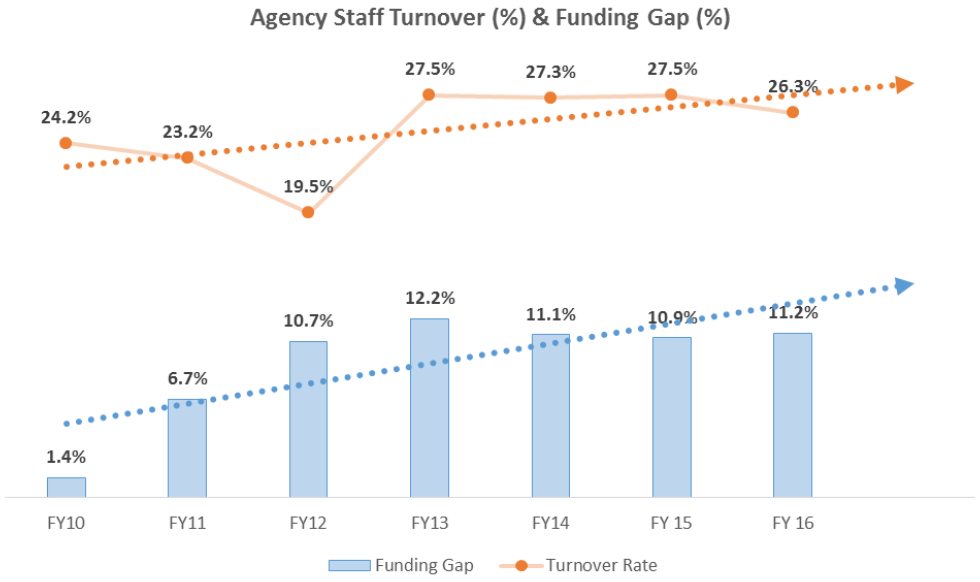
Step 7 (Master's w/License)									
									$43,335,357

Notes:
1. Annualized Salaries Assume: average work week 37.5 hours, 1,950 hours per year
2. State Wages are based on CLS Pay Plan in effect 7/10/16 - 7/8/17.

DAs and SSAs face competition from other employers, like health care providers and schools. Staff often leave employment for pay raises of $20,000 to $30,000. Increase in pay at competing employers is the predominant factor leading staff to terminate employment. Agency data shows that staff leave for higher paying jobs at local schools, substance use disorder providers, hospitals, FQHCs and government positions.

Figure 12, below, depicts the overall staff turnover across the DA and SSA system and the discrepancy between the CPI appropriated and the cumulative CPI in New England. The chart illustrates that over time, as the funding gap between the rising CPI and funding levels for the DA and SSA system grow, staff turnover rates increase on at a similar trend rate. This is evidence that if staff salaries don't keep up with inflation due to insufficient COLAs for DAs and SSAs, more and more staff seek employment elsewhere.

Figure 12: Turnover compared to CPI Gap



Section III: Performance Measurement and Evaluation

This section addresses the amount and type of performance measures and other evaluations used in fiscal year 2017 Agency contracts with DAs, SSAs and preferred providers. This section provides a summary of the performance measures and evaluations and detailed information is found in Appendix D. Performance measures and evaluations are reported by Department and program.

Currently, AHS departments utilize different types of measures to ensure that providers are delivering appropriate care to individuals who receive Medicaid services. The State's measurement strategy must

balance federal and Legislative requirements, the State's ability to monitor and evaluate providers and ensure beneficiaries are receiving care that is efficient and high-quality, and providers' reporting burden.

AHS believes that quality measurement and performance measurement should be aligned across all departments. In addition to aligning within AHS, there is a need to align with other payers of similar services. Seeking to minimize unnecessary measurement and create greater alignment across programs and departments, AHS engaged in an alignment activity in 2015-2016 to improve the efficiency of the AHS Master Grant, a written agreement between AHS and DAs or SSAs. Using a measure classification scheme informed by Results Based Accountability, AHS and the agencies organized the current Master Grant data requirements by quantity, quality, and impact. Measures that described how much or how many services or individuals were served were placed in the quantity category. Those that described how well care was delivered were placed in the quality category. Finally, those measures that described how individuals were better off because of receiving a service were placed in the impact category. At the end of this exercise, it was no surprise that the clear majority of the measures were in the quantity category. During the discussions, a conscious effort was made to reduce the number of measures in the quantity category, and expend those in the quality, and impact categories. Ultimately, this process allows the state and its providers to focus their measurement efforts on consumers and the conditions of well-being that their services can affect.

Although this process was fruitful, more alignment work is necessary for the measures that impact these providers. Written agreements with ADAP preferred providers mirror DA and SSA master grants when the services delivered are identical, other Substance Use Disorder Treatment Services not aligned with DA and SSA operations are addressed outside of the master grant and thus were not in scope for the 2015-2016 group activities.

HEDIS Measures

HEDIS, or Healthcare Effectiveness Data and Information Set, is one of the most widely used sets of health care performance measures in the United States. The HEDIS measures set was entrusted to the NCQA in the early 1990s, who since then has expanded the size and scope of the measures set. There are currently 91 measures across 17 domains, all of which AHS runs, primarily through DVHA. Not all HEDIS runs currently result in reliable data due to collection methods (claims + chart review) that are still under development. The Behavioral Health measure domain within HEDIS consists of the following measures:

(1) Antidepressant Medication Management (AMM)
(2) Follow-Up Care for Children Prescribed ADHD Medication (ADD)
(3) Follow-Up After Hospitalization for Mental Illness (FUH)
(4) Follow-Up After Emergency Department Visit for Mental Illness (FUM)
(5) Follow-Up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA)
(6) Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)
(7) Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)
(8) Cardiovascular Monitoring for People with Diabetes and Schizophrenia (SMC)
(9) Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
(10) Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

HEDIS makes it possible to produce measures in a standardized way and enables us to compare our own performance over time, as well as Vermont Medicaid's performance against national benchmarks.

Figure 13: Vermont Medicaid Performance in HEDIS Behavioral Health Measure Domains

	Measure	2016 Rate	National Percentile
1.a	Antidepressant Medication Management - Acute	69.42%	P90
1.b	Antidepressant Medication Management - Continuation	52.62%	P90
2.a	Follow-Up Care for Children Prescribed ADHD Medication - Initiation	66.35%	P90
2.b	Follow-Up Care for Children Prescribed ADHD Medication - Continuation	73.82%	P90
3.a	Follow-Up After Hospitalization for Mental Illness – w/in 7 days	43.11%	P25
3.b	Follow-Up After Hospitalization for Mental Illness – w/in 30 days	59.55%	P25
4	Follow-Up After Emergency Department Visit for Mental Illness	New in 2017 set	N/A
5	Follow-Up After Emergency Department Visit for Alcohol or Other Drug Dependence	New in 2017 set	N/A
6	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications	74.17%	P50
7	Diabetes Monitoring for People with Diabetes and Schizophrenia	66.67%	P25
8	Cardiovascular Monitoring for People with Diabetes and Schizophrenia	66.67%	P10
9	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	76.66%	P25
10	Metabolic Monitoring for Children and Adolescents on Antipsychotics – Total	27.74%	P90

The NCQA-certified contracted vendor follows HEDIS' measure specifications when building the logic behind how each measure is run. This process and the measure results for a Core Set of Global Commitment to Health measures are then validated each year by an External Quality Review Organization (EQRO).

That Core Global Commitment to Health Measure Set is reported to AHS annually, and then subsequently to CMS. The DVHA Quality Unit also reports the Adult and Child Health Care Quality Core Set measures to CMS annually, which consist of many HEDIS measures, including many of the behavioral health measures mentioned above in the HEDIS behavioral health domain.

The Quality Committee and the Managed Care Medical Committee (MCMC) regularly review the HEDIS measure results, particularly those within the Global Commitment Core Set in order to assess Medicaid program performance and to prioritize areas for improvement. The last formal Performance Improvement Project (PIP) reported to CMS focused on the Follow-Up After Hospitalization (FUH) measure. The MCE's new PIP is using the Initiation and Engagement in Treatment for Alcohol and Other Drug Dependence (IET) measure as the study measure. These 3-year projects, both with behavioral health focuses, involve root cause analysis that invariably take the entire system of care into perspective. The projects are also validated (both the improvement process and the data management plan) by an EQRO annually.

Communicating HEDIS results across the healthcare system allows for and fosters collaboration across the MH/SA system in the interest of improving results and identifying improvement opportunities.

AHS Master Grant Alignment Process

In October 2015, AHS convened an Outcomes Work Group[5] comprised of quality management representatives from State, provider, and stakeholder entities. The Outcomes Work Group was initially tasked with developing a standardized template for Attachment A of the SFY17 Master Grant, which included developing standardized performance measure and monitoring activity tables. The group initially identified approximately 150 "measures" in the SFY16 master grant that the DAs and SSAs were required to report to AHS. While the group was developing the tables, they reviewed their SFY16 "measures" to assess goodness of fit. During the process, some departments dropped performance measures or monitoring activities that were no longer required or determined redundant, while others developed performance measures or monitoring activities where none existed previously. Using the standardized tables, the group split performance measures and reporting activities. At the end of the activity, a total of 100 measures (50 performance measures and 50 monitoring activities) across all programs and providers were agreed upon for the SFY17 Master Grant, a net reduction of 50 reporting requirements. An aggregate table of all measures and monitoring activities for all DAs and SSAs was included in the SFY17 AHS Master Grants as an appendix.

After the execution of the SFY17 AHS Master Grants, the Outcomes Work Group reviewed the monitoring activities to determine if there were any opportunities for further consolidation/reduction. If such a determination was made, the group agreed to recommend an amendment to the current grant. Since both Federal regulations and the Vermont Legislature via Act 186 require the collection of certain data elements, special attention was placed on activities required by AHS Departments – as opposed to those required by our Federal partners or the Vermont Legislature. Questions considered include:

- Does the activity support AHS priorities?
- Are we getting what we need from the activity?
- Are we asking for this information in other ways?

This process sought to identify inefficiencies (e.g., can activities be minimized, eliminated, combined, etc.). While the group identified several DMH, ADAP, and DDSD monitoring activities that would benefit from additional Department/VCP follow up, they did not think that a formal grant amendment was necessary. As a final task the group agreed to recommend a process for reviewing measures using Results Based Accountability moving forward with future AHS Master Grant negotiations.

All-Payer Model Measure Alignment

In October 2016, the State of Vermont signed an "All-Payer Accountable Care Organization Model Agreement" with the Centers for Medicare and Medicaid Services. The five-year Agreement contains a comprehensive quality framework that has the potential to improve quality of care and the health of the entire Vermont population, including people benefiting from Medicaid services and providers.

The Agreement's quality framework establishes a clear focus for Vermont's quality efforts for the foreseeable future. It consists of 20 measures (see GMCB Addendum for a complete listing) related to the following overarching population health goals:

- Improving access to primary care

[5] The various departments of AHS use different contracts, grants, and other payment processes to reimburse DAs, SSAs, and Preferred Providers. A subset of these services is codified in Master Grants between the State and the DAs. The Master Grants cover approximately 90% of DA budgets.

- Reducing deaths from suicide and drug overdose
- Reducing prevalence and morbidity of chronic disease (specifically Chronic Obstructive Pulmonary Disease, Diabetes, and Hypertension)

Some of the measures in the Agreement that are particularly relevant to Medicaid providers and beneficiaries have been considered by the Medicaid Pathway Outcomes Subgroup (Appendix A, Page 20 of the Medicaid Pathway Overview) as it reviews measures already in use in Vermont.

Performance Measures: Department of Mental Health

DMH utilizes numerous measures for the Designated Agencies, which are detailed in Appendix D.

DMH Monitoring & Reporting Activities

Each DA and SSA that administers mental health programs must comply with the Administrative Rule on Agency Designation. Re-designation occurs every four years in accordance with the rule and the Department schedule (for more information, see DMH Administrative Rules on Agency Designation.)

Evaluation includes minimum standards chart review, site visit, annual program reporting, and submission of data via Monthly Service Reporting and the Electronic Bed Board to assess utilization. Selected Agencies must also participate in SAMHSA Substance Abuse Prevention and Treatment Block Grant compliance visits which occur every five years according to schedules set by SAMHSA.

Performance Measures: Department of Disabilities, Aging, and Independent Living

DAIL utilizes numerous measures for the Designated Agencies, which are detailed in Appendix D.

DAIL DDSD oversees services provided to individuals with developmental disabilities by 10 Designated DAs and 5 SSAs. The charts provided include annual performance measures and the monitoring and reporting activities required of DAs and SSAs for SFY 2017.

DAIL Monitoring & Reporting Activities

In addition to these monitoring activities, DAIL also has additional processes for providing oversight and accountability for services provided by the DAs and SSAs. The quality of services provided by each agency is reviewed every two years through on-site visits by the DDSD quality team. The standards and process for these reviews is included in the Guidelines for the Quality Review Process of Developmental Disability Services. The designation and quality review processes include oversight of areas of agency structure, fiscal management, compliance with all state and federal policies, guidelines and regulations, service quality, and consumer satisfaction. The DAIL Business Office also provides ongoing fiscal oversight and monitoring.

In SFY 2014, Vermont joined the National Core Indicators (NCI), a voluntary effort by public developmental disabilities agencies to track and measure their own performance. Standard measures are used across states to assess the outcomes of services provided to individuals and families which address key areas such as rights, individual choice, health and safety, service planning and employment[6]. Going forward, DDSD will be exploring incorporating measures from the NCI and other tools into the performance measurement and evaluation of DD services in Vermont.

[6] http://www.nationalcoreindicators.org/

Performance Measures: Vermont Department of Health Alcohol and Drug Abuse Programs

ADAP utilizes numerous measures for preferred providers, including certain Designated Agencies, which are detailed in Appendix D.

ADAP Monitoring & Reporting Activities by Year

Certification is required for any substance abuse treatment organization that wishes to seek state or federal funding. Pursuant to 8 V.S.A § 4089b and 18 V.S.A § 4806, the Substance Abuse Treatment Certification Rule provides the VDH/ADAP Preferred and Approved Providers (Provider) with the certification and operational requirements. Each Provider must comply with these Rules and the ADAP Substance Abuse Treatment Guidelines. To determine compliance, ADAP performs on-site reviews of the providers on a regularly scheduled basis. For providers who are found to be out of compliance, corrective action plans are required with approval from ADAP and follow-up occurs to ensure the corrective actions are put in place. Recommendations are also provided to improve operations or quality of service, with technical assistance being available to the Provider.

Performance Measures: AHS Integrating Family Services

IFS utilizes a streamlined set of measures for the Designated Agencies, which are detailed in Appendix D. From May 2015 through May 2016 a diverse group of stakeholders came together including DAs, all AHS departments, Agency of Education, Vermont Care Partners and other interested parties in order to identify common IFS population indicators and IFS performance measures. This group relied heavily on Results-Based Accountability and taking time to answer the question of: "*Is what we are doing helping children, youth and families to be better off*?" The workgroup reviewed and analyzed all current performance measures to ensure alignment with other measures being used and to build upon that work, rather than layering additional work onto community partners. The following are the finalized measurements which were embedded into the FY17 AHS Master Grants for IFS regions.

IFS Performance Measures and Population Indicators

Population Indicators			
a. % of children who are ready for kindergarten in all five domains of healthy development	a. Rate of child abuse and neglect b. Number of Vermont families with one or more children who are experiencing homelessness	a. % of high school seniors who have a plan following high school b. % of adolescents in grades 9-12 who drank alcohol before age 13 c. Number of youth (12-21) who have adolescent well-care visits with a PCP or Ob/Gyn	a. Rate of children living below the 200% poverty rate b. % of infants and toddlers likely to need care who do not have access to high quality, regulated child care program

How Much?	**How Well?**	**Is Anyone Better Off?**
1. Number of children served by fiscal quarter	5. % of children with a plan developed collaboratively with families	12.% of children/youth that have shown improvement

2. Number of children served by age 3. Number of hours of service 4. % of services provided to child/youth with Medicaid	6. Satisfaction measure from family perspective 7. % of children with a plan completed within 90 days of referral 8. % of children (Prenatal to 6) that received initial contact within 5 calendar days 9. % of children (Prenatal to 6) that had a transition plan (30 or 90 days before transition) upon discharge 10. % of children/youth receiving non-emergency service within 7 days of emergency service 11. % of children/youth living at home or close to home in a family-like setting	on the CANS or an approved assessment tool 13. % of children whose CANS score shows improvement in the family domain *OR* % of families who show improvement on an approved assessment tool
14. Report any novel, innovative and successful initiatives taken in any arena (such as: quality, teaming, services, system, fiscal, or data sharing) in your region.		

Performance Measures: Vermont Care Partners

Vermont Care Partners and its network agencies have been working on the Medicaid Pathway Outcomes internally and with the State, as well as striving to work with the State on streamlining the various required reporting measures through the AHS Master Grants. Additionally, VCP and its network agencies have been working internally on the development of a System of Excellence to guide their quality improvement efforts.

In the Fall of 2014, the Boards of VCP identified the need for a certification process that more closely relates to the work the agencies do. The Vermont Care Partners Centers of Excellence certification process was developed to help with the goals of:

- Articulating the value of the services DAs and SSAs provide to community members, stakeholders, and to current and potentially future employees
- Support assessment and related continuous quality improvement between and within agencies
- Promote peer learning and support
- Promote consistent quality across the network

Despite the fact that some agencies were Commission on Accreditation of Rehabilitation Facilities (CARF), National Committee for Quality Assurance (NCQA), or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredited, a consistent and affordable method of accreditation was not available that worked for all agencies given the variability of some of the services provided across network agencies. The National Council for Behavioral Health, through Dale Jarvis, had begun to develop the idea of a Center of Excellence (COE). The Designated Agency Executive Directors' decided they should tailor COE and its five elements to Vermont as a starting point for this process. The elements are:

- Easy Access
- World Class Customer Services
- Comprehensive Care
- Excellent Outcomes
- Excellent Value

Throughout the subsequent months, a group composed of members of each network agency met and articulated the measures that are listed within the VCP COE Manual and the process an agency follows to become certified.

Measures are a combination of quantitative and qualitative elements that overlap with other existing measures when possible (e.g., from the AHS Master Grant and National Measures), acknowledging that measures to promote quality improvement are at times different from those that are used to measure a program's impact. The tables below list measures being used for the VCP COE pilot process. Elements that are related to or informed by AHS Master Grant measures are highlighted with an asterisk. Further, programs within agencies can choose measures to include in their quarterly Master Grant reporting that they feel best represents their work. Several agencies are choosing a measure from the list below.

Comprehensive Care	Standard
Clients indicate services were "right" for them	C.1
Clients indicate they received the services they "needed"	C.2
The agency asks clients if they have a primary care provider	C.3a*
The agency helps clients who report not having a primary care provider enroll with a primary care provider	C.3b
Follow up after discharge from psychiatric hospitalization	C.4

Easy Access	Standard
Schools have co-located services	EA.1
Clients are offered a face-to-face contact within 5 days of initial request	EA.2*
Agency provides co-located services in primary care offices	EA.3
Clients are seen for treatment within 14 calendar days of assessment	EA.4*

Excellent Outcomes	Standard
Clients indicate services made a difference	EO.1
Clients indicate services improved their quality of life	EO.2
Clients are "improved" upon discharge	EO.3*
Clients receive 6 or more employment supportive services	EO.4*
Clients have more than 90 days of continuous employment	EO.5*
Clients are assessed for tobacco use	EO.6*
Reduction in risk level for individuals supported by Developmental Services who have offended sexually	EO.7

World Class Customer Service	Standard
Clients indicate they were treated with respect	W.1
Clients indicate they would refer a friend or family to agency	W.2
Clients with Developmental Disabilities indicate they like where they live	W.3
Staff feel driven to help the agency succeed	W.4
Staff would recommend agency to a friend or family for employment	W.5
Staff would recommend the agency to a friend or family member for services	W.6
Staff are satisfied with the culture of the workplace	W.7
Staff turnover in past year	W.8
Staff retained after three years of employment	W.9
Staff are encouraged to take action when they see a problem	W.10
Staff are satisfied with their benefits package	W.11
Staff pay is comparable to similar jobs in the non-profit community	W.12
Agency has a plan or process to promote cultural competency and training in the organization	W.13

Excellent Value	Standard
Evidence that agency has a workflow that demonstrates integration with healthcare team	EV.1
Evidence that depression screening is integrated into intake process	EV.2
Agency has a process that refers or offers tobacco cessation services to clients	EV.3*

Agency has a system to improve response rate to customer satisfaction surveys	EV.4
Agency has a process for utilization review to allocate and monitor the use of clinical services.	EV.5
Agency maintains programs that are known to reduce use of more expensive community resources and monitors their utilization.	EV.6*

VCP agencies are entering the pilot phase of this certification process during which VCP will be asking agencies to volunteer to test the certification process consisting of:

- A self-evaluation using the measures listed in the manual as a guide
- A review of these results by a committee composed of VCP staff, network peers who are considered "expert" in their program area, and one committee member from outside the VCP Network
- A site visit by review committee members
- Review of results by review committee

Certification will not be granted during the pilot phase because we will use agency feedback from this phase to refine the process.

The Certification IS **NOT:**	The Certification **IS:**
…meant to limit an agency's quality improvement efforts.	… a standard measure set from which agencies can build their quality improvement program. Many already have quality improvement processes in place that include these some of these measures.
… a replacement for designation	… meant to supplement the meaning of designation with specific measures that provide more information about the impact of our programs.
… mandatory	… a voluntary process that VCP hopes all agencies will participate in since the Executive Directors have supported the development of this process since 2014.
… a process to find out which agency is the best and which is the worst	… a process to promote peer support and learning. We are the "experts" in community-based care. It makes sense to use some of this expertise to improve the quality of our services.
… meant to be a time consuming endeavor that does not provide helpful feedback to improve programming	… meant to pull upon data agencies already collect or can readily collect that is meaningful to the programs they provide to promote quality improvement
… set in stone	… being reviewed annually by the review committee composed of staff from DAs and SSAs and the Executive Directors, using feedback about the process, to ensure that we are using the most relevant and timely measures to assess program quality.

To support the use of the COE process to inform quality improvement, participating agencies and Vermont Care Partners will be utilizing the Clear Impact Scorecard. This online scorecard allows agencies to supply information for their application online as well as to use the cards for project management as they develop their quality improvement plans. The final VCP scorecard linked above will provide the overall scorecard for the Vermont Care Partners network when available.

Section IV: Plan to Implement Value-Based Payment Methodology

AHS, in collaboration with AOA launched the Medicaid Pathway in the Fall of 2015. The Medicaid Pathway is a process that supports Medicaid payment and delivery system reforms and through this process, AHS would develop any proposed plans to implement value-based payments for Medicaid providers. As of the date of the submission of this report, there are no specific plans for DAs, SSAs, and Preferred Providers beyond that which is contained within the Medicaid ACO Population-Based Payment Contract; participation of DAs, SSAs, and PPs with the ACO is voluntary, though the ACO is encouraged to establish such relationships within its network. More information about the Medicaid Pathway work completed today can be found in the Act 113 Section 12 report included in Appendix C.

AHS and AOA have engaged in innovative Health Care Reform with the recognition that:

- The rate of overall health care cost growth is not sustainable, however targeted investments in certain sectors will be necessary to support the most efficient and effective care;
- Health care needs have evolved since the fee-for-service system was established more than fifty years ago;
- More people are living today with multiple chronic conditions;
- The World Health Organization reports that chronic conditions often result in conjunction with social determinants and social determinants are driving factors for people in experiencing chronic conditions;
- The Center for Disease Control reports that treating chronic conditions accounts for 86% of our health care costs;
- Fee-for-service reimbursement is a barrier for providers trying to coordinate patient care and to promote health; and
- Care coordination and health promotion activities are not rewarded by fee-for-service compensation structure.
- Reforms should be provider led, and new payment models should allow for flexibility in service delivery to the greatest extent possible.

One overarching goal of moving away from traditional fee-for-service payment models is to allow for providers to have a greater focus on wellness and prevention, health promotion, early detection, and intervention. The Medicaid Pathway process focuses on Medicaid funded programs across the AHS such that the social determinants of health can be addressed on balance with goals of a traditionally medically focused health system.

The Medicaid Pathway is a planning process led by AHS in partnership with AOA. These planning efforts are designed to:

- Systematically review payment models and delivery system expectations across the AHS Medicaid program to refine State and local operations to better support the integration of Physical Health, Long Term Services and Support, Mental Health, Developmental Disabilities, Substance Use Disorder Treatment, and Children's Service providers;
- Develop a financially healthy and sustainable system of care;
- To streamline payments to providers and reporting back to the State; and
- To create flexibility to meet need.

The Medicaid Pathway work is aligned with the planning efforts around the All-Payer Model. Both of these frameworks build towards a more integrated health care system in Vermont.

Current discussions and planning efforts relative to All-Payer Model and Accountable Care Organization development offer the opportunity to more fully realize Vermont's Model of Care[7] throughout the entire health care system including long term services and supports and behavioral and mental health treatment services.

The Medicaid Pathway advances payment and delivery system reform for those services not subject to the additional caps and regulation that is expected under the State's All Payer Model, however some of the Medicaid Pathways services do operate within a capped budget in relation to the departments reimbursing certain services. The ultimate goal of Medicaid's multi-year planning efforts is the alignment of payment and delivery system principles that support a more integrated system of care for all Medicaid supported services and enrollees.

Implementing alternatives to fee-for-service payment can also provide an opportunity for the State and providers to more fully support wellness and early intervention. Establishing alternative payment approaches may provide greater flexibility to support:

- Health Promotion
- Early Intervention and a Reduction of Client Risk Factors
- Provider Flexibility to Decide on Necessary Services
- Reduced Incentives for Volume
- Non-traditional (Home and Community Based) Services based on a Person's Unique Treatment and/or Support Plan Needs and Social Determinants of Health

Information Gathering Process and Stakeholder Engagement

As part of this work, the State released an Information Gathering Document (see Appendix B) in September 2016. This document put forth proposed reforms for the payment and delivery of mental health, substance use treatment, and development disabilities services. The State received comment in October 2016 and as a result of this feedback revised the initial proposal. This details regarding this proposal are found in the Legislative Report entitled: *Report on the Medicaid Pathway: 2016*.

In addition to this formal information gathering, AHS convened stakeholders for over a year to discuss potential value-based payments. These meetings focused on several areas including: care models to support an integrated delivery system alternative payment models for services delivered by Designated and Specialized Service Agencies and Preferred Providers. Four groups were convened:

- *Mental Health, Substance Use Disorder, and Developmental Services*. This included a sub-group convened in August 2016 which focused on measures for the following purposes: payment (i.e., to inform incentive payment and/or withhold return); monitoring (i.e., to inform contract compliance activity or track measures not suitable for payment); and evaluation (i.e., to track cost and utilization). Sub-group members included quality management representatives from State, Regulatory, Provider, and Stakeholder entities.
- Long-Term Services and Supports/Choices for Care
- State of Vermont Staff Group

More detail about these meetings is found in Appendix A.

[7] Vermont's Model of Care is more fully described in the Medicaid Pathway Overview found in Appendix A.

Alignment with All-Payer Model

In addition to the Stakeholder Engagement process, AHS is working with the Green Mountain Care Board and AOA to ensure alignment of any reforms with the All-Payer ACO Model Agreement. At the time of submission of this report, the specific payment model and focus of those reforms is still under discussion.

As part of delivery system reform, providers across the AHS Medicaid enterprise are being asked to rethink their relationships to each other and to organize service delivery into a seamless continuum of Medicaid-funded health and human services. The goal of which is to support the overall health and social well-being of individuals, their families, and communities. AHS recognizes that positive health outcomes require equal attention to physical health care and social and emotional well-being, including a focused effort to address the social determinants of health and maintain quality of life through community living. The Vermont Model of Care[8] requires coordination and enhanced integration across physical, mental health, substance use disorder treatment, and disability and long-term services and supports providers. Additionally, Vermont's Health Care Reform efforts call for increased attention to wellness, prevention, early intervention, and overall population health.

Through the Medicaid Pathway process, departments are performing baseline analysis of the extent to which current activities support or fall short of Vermont Model of Care expectations. DAIL took the lead in analyzing the various types of developmental disabilities services and how well they align with the Vermont Model of Care. ADAP and DMH are undertaking the same task to better understand the implications, areas of improvement, and successful application of the Vermont Model of Care. For DAIL, the specific service types being reviewed include self- and family-managed services within DS HCBS, DS HCBS broadly, and children's services. For DMH, the review includes adult services and children's services and within community based and higher levels of care. The goal of this exercise is to identify some shorter-term improvements that can be made to better align service delivery and payment with the Model of Care. Next steps in overall AHS implementation planning include defining a common baseline of provider expectations for delivery system integration and adoption of the Model of Care. The objective of this review and the development of common Model of Care standards is to articulate what the delivery system is expected to achieve without becoming prescriptive about how providers will achieve the desired results.

It is expected that implementation of the work plan will begin in SFY18, with full implementation in future years, depending on the type and extent of changes needed to be made.

Substance Use Disorder Treatment Waiver

In July, 2015, CMS offered states the opportunity to apply for demonstration projects approved under Section 1115 of the Social Security Act to ensure that a continuum of care is available to individuals with substance use disorder (SUD). Vermont is in the process of submitting an application for a demonstration project which would allow Vermont to receive federal financial participation for costs not otherwise matchable, focusing on enhancing the availability of short-term acute care and recovery supports for individuals with SUD, improving care delivery, integrating behavioral and physical care, increasing provider capacity, and raising quality standards. Vermont will be developing comprehensive strategies to ensure a full continuum of services, focusing greater attention on integration efforts with primary care and mental health treatment, and working to deliver services that are considered

[8] Vermont's Model of Care is more fully described in the Medicaid Pathway Overview found in Appendix X.

promising practices or have fidelity to evidence-based models consistent with industry standards. The aim is to better identify individuals with a SUD, increase access to care for these individuals, increase provider capacity, to deliver effective treatments for SUD and use quality metrics to evaluate the success of these interventions.

Appendix A: Medicaid Pathway Overview

An overview of the Medicaid Pathway planning process, goals, workgroup descriptions and detail on efforts to date can be found at this link: http://dvha.vermont.gov/global-commitment-to-health/medicaid-pathway-planning-overview-12.19.16-update.pdf

Appendix B: Medicaid Pathway Information Gathering Document

AHS engaged in an information gathering process regarding a potential alternative payment model for Cohort 1 in September 2016.

Information Gathering Document

AHS then responded to the feedback in November 2016.

Information Gathering Document Responses

Appendix C: Medicaid Pathway 2016 Report (Act 113 Sec. 12)

Posted online at this link: http://legislature.vermont.gov/reports-and-research/find/2016

Appendix D: Performance Measures

DMH Performance Measures by Year

Please note that there may be additional measures associated with other grants such as grants to crisis beds or grants for specific children's programs. Those measures are not included as they are not universally used by every Designated Agency.

Table 1: DMH SFY2017 Master Grant Performance Measures

AHS Dept/Div	Program	Measure	Target	Time Period	Monitoring Method	Type
DMH	Child, Adolescent & Family Mental Health	% of clients with improvement on standardized assessment selected by the DA	Maintain or increase	Quarterly	DA calculation	Impact
		% of children living at home or close to home in a family-like setting	Maintain or increase	FY	DMH calculation	Quality
		% of youth/ parents or guardians satisfied with services	Maintain or increase	FY Alternating youth/parent	DMH calculation	Impact
		Existing performance measure provided by DA using DMH PM template.doc	Determined by DA	Quarterly	DA calculation	Determined by DA
	Early Periodic Screening Diagnosis & Treatment (Admin)	Percent of people (children under age 21) who have a specific source of ongoing primary care (medical home).	Maintain or increase	Quarterly	DA Calculation	Quantity
		Percent of children seen by the social worker who have a dental home.	Maintain or increase	Quarterly	DA Calculation	Quantity
		Percent of people (children under age 21) with health insurance for all or part of the year.	Maintain or increase	Quarterly	DA Calculation	Quality
		Percent of children with mental health problems who receive treatment.	Maintain or increase	Quarterly	DA Calculation	Impact
	Early Childhood Mental Health	N/A				
	Youth in Transition	N/A				
	Mental Health Adult Outpatient Program	# of people served	Maintain or increase	Quarterly	DMH calculation	Quantity
		% of people improved upon discharge from AOP	Maintain or increase	Quarterly	DMH calculation	Impact
		Existing performance measure provided by DA using DMH PM template.doc	Determined by DA	Quarterly	DA calculation	Determined by DA
	Community Rehabilitation and Treatment Program	% of working age clients who are employed	Maintain or Increase	FY	DMH calculation	Impact
		% of CRT enrollees that are living independently in community settings (and not living in institutional settings including residential facilities)	Maintain or Increase	Quarterly	DMH calculation	Quality
		% of CRT clients reporting positive outcomes	Maintain or Increase	FY	DMH calculation	Impact
		Existing performance measure provided by DA using DMH PM template.doc	Determined by DA	Quarterly	DA calculation	Determined by DA

AHS Dept/Div	Program	Measure	Target	Time Period	Monitoring Method	Type
	Emergency Mental Health Services	% of crisis services occurring within the community	Maintain or increase	Quarterly/ End of month following the close of the quarter	DMH calculation	Quality
		% of clients receiving non-emergency services within 7 days of emergency services	Maintain or increase	Quarterly/ End of month following the close of the quarter	DMH calculation.	Quality
		Existing performance measure provided by DA using DMH PM template.doc	Determined by DA	Quarterly	DA calculation	Determined by DA
	Adult Crisis Stabilization Beds	% occupancy of crisis bed programs	Maintain or increase Target: 80%	Quarterly	DMH Bed/Board	Quality

Table 2: DMH SFY2017 Master Grant Monitoring and Reporting Activities

AHS Dept/Div	Program	Monitoring Activities	Format	Frequency/Due Date	Recipient/ Attendees	Purpose/Information Required
DMH	Child, Adolescent & Family Mental Health	Performance measure reporting	DMH PM template.doc	Quarterly (Last day of following month)	DMH CAFU administrative assistant	Performance monitoring/Measurement (#1-6 above), story behind the curve, strategy, notes on methodology
		Program Narrative	Word Document, send via email	FY Annually (Sept 30 following close of FY)	DMH CAFU Quality Chief	Periodic monitoring for Designation, system of care planning, and strategic planning / staffing composition, staffing qualifications, types of strategies employed, population served, use of evidence based practices (including efforts for fidelity review), brief assessment of strengths, weaknesses, opportunities, and threats to the program. Should include discussion of EPSDT, ECMH, and YIT (as applicable for each DA)
		Minimum Standards Chart Review	Site Visit	Every 2-4 years	DMH Site Visit Team, DMH CAFU Operations Chief	Quality assurance. Chart review is conducted for Children's MH services at the agency as a whole and is not duplicated for each sub-program.
		Quarterly Report of DMH Respite Care Recipients (formerly in Att.B)	Prescribed by DMH	Quarterly (Last day of following month)	DMH CAFU Operations Chief	Report of all respite care recipients, in a format prescribed by DMH
	EPSDT	Performance measure reporting	DMH PM template.doc, send via email	Quarterly (Last day of following month)	DMH CAFU Operations Chief	Performance monitoring
		ACCESS Report (Part A grantees only)	Document, send via email	FY Annually (Sept 30 following close of FY)	DMH CAFU Operations Chief	Report on impact of First Call as summarized in a copy of the annual ACCESS report
		Pediatric Collaborative Program Report (Part B grantees)	Document, send via email	FY Annually (Sept 30 following close of FY)	DMH CAFU Operations Chief	brief (no more than 1 page) annual report describing the work in basic terms, any changes from past year and identifying any gaps and or duplication in mental health services available to children in the participating practice and strategies to improve delivery/coordination
	Mental Health Adult Outpatient Program	Performance measure reporting	DMH PM template.doc, send via email	Quarterly (Last day of following month)	DMH Adult Services Director	Performance monitoring/ Measurement, story behind the curve, strategy, notes on methodology
		Report on triage process	Word Document, send via email	Upon request/30 days from DMH request	DMH Adult Services Director	Performance monitoring/ The triage process used, description of how the available resources were targeted

AHS Dept/Div	Program	Monitoring Activities	Format	Frequency/Due Date	Recipient/ Attendees	Purpose/Information Required
	Community Rehabilitation and Treatment Program	Performance measure reporting	DMH PM template.doc (email)	Quarterly (Last day of following month)	DMH Adult Svcs Director	Performance monitoring/Measurement, story behind the curve, strategy, notes on methodology
		Log of requests for eligibility	As maintained	FY Annually (Sept 30 following close of FY)	DMH Adult Svcs Director	MCO Monitoring. . Must include/the triage process used, clinical rationale for enrollment/disenrollment decision, description of resources used to provide the service
		Minimum Standards Chart Review	Site visit and records review	Every 4 years in alignment with the Agency Designation	DMH site visit team	Performance monitoring, Designation, MCO requirements for specialized populations
	Emergency Mental Health Services	Performance measure reporting	DMH PM template.doc (email)	Quarterly (Last day of following month)	DMH Mental Health Services Director	Performance Monitoring
		Act 79 Quarterly Report	Word Document, using Act 79 Reporting Form 2015-10	Quarterly (Last day of following month)	DMH Quality Management Director	2012 Act 79 Enhanced Funding Oversight
	Adult Crisis Stabilization Beds	Performance measure reporting	Electronic Report	Monthly	N/A, DMH will calculate via bed board	Performance Monitoring
	Adult Crisis Stabilization Beds	Crisis Beds Program Narrative	Word Document, send via email	FY Annually (Sept 30 following close of FY)	DMH Adult Svcs Director	Performance Monitoring. A brief report to DMH annually for each crisis bed setting. Programs shall consider the following elements in their narrative: Individual and stakeholder satisfaction with the service rendered; average and range of length of stay in days for discharges from the program during the measurement year; 30-day readmission rate for discharges from the program; and # of admissions for step-down from hospitalization and # of admissions for avoiding hospitalization
		DMH Electronic Bed Board Updates for Crisis Beds	Update to bed board system	Daily, at minimum	N/A, DMH will calculate via bed board	System monitoring
	Residential Bed Services	DMH Electronic Bed Board Updates for Residential Beds	Update to bed board system	Daily, at minimum	N/A, DMH will calculate via bed board	System monitoring
		Residential Bed Program Narrative	Word Document, send via email	FY Annually (Sept 30 following close of FY)	DMH Adult Services Director	Performance Monitoring/ Brief report to DMH annually for each group residential setting, including: Average LOS for discharged individuals; admission and discharge criteria used; a brief description of the program and setting; and a brief description of the screening tool.

Table 3: DAIL SFY2017 Master Grant Performance Measures

AHS Dept/Div	Program	Measure	Target	Time Period	Monitoring Method	Type
DAIL	Flexible Family Funding	Percentage of people who receive Flexible Family Funding for the purpose of addressing specific anticipated areas of need.	Considered baseline data.	SFY 2017	Flexible Family Funding quarterly report	Quality
	Home and Community Based Services	Preventative Health Services – Percentage of adults age 22 and over served by Developmental Disabilities Home and Community Based Services who have access to one or more annual preventive health services during the calendar year.	85%	Calendar Year 2016	AHS report of percentage based on MMIS and DD HCBS paid claims data	Quantity
		Participate in transition steps for alignment to Centers for Medicare and Medicaid Services Home and Community Based Services Rules – Complete self- assessment on alignment.	100%	SFY 2017	Submission of DDSD approved survey	Quantity
		Percentage of people who receive One Time Funding who demonstrated achieving one or more of the eight possible outcomes. Percent for each outcome area that was demonstrated as being achieved.	Considered baseline data.	SFY 2017	Quarterly submission of One Time Funding spreadsheets	Impact
		Percentage of adults age 18 and over and out of high school, served by Developmental Disabilities HCBS, who report they like (the home) where they live.	Considered baseline data.	SFY 2017	NCI – Adult Consumer Survey	Impact
		Percentage of adults age 18 and over and out of high school, served by Developmental Disabilities HCBS, who report they choose (helped pick) the place where they live.	Considered baseline data.	SFY 2017	NCI – Adult Consumer Survey	Impact
		Percentage of adults age 18 and over and out of high school, served by Developmental Disabilities HCBS, who report their staff (support workers) treat them with respect.	Considered baseline data.	SFY 2017	NCI – Adult Consumer Survey	Impact
		Percentage of adults age 18 and over and out of high school, served by Developmental Disabilities HCBS, who report they can see their friends when they want.	Considered baseline data.	SFY 2017	NCI – Adult Consumer Survey	Impact
		Percentage of adults age 18 and over and out of high school, served by Developmental Disabilities HCBS, who report they feel lonely (don't have anyone to talk to).	Considered baseline data.	SFY 2017	NCI – Adult Consumer Survey	Impact
	Supported Employment	Employment Rate	45% employment rate. Average wages at least 70% of DA/SSA average.	SFY 2017	Collating VT DOL unemployment data and DA and DVR self-reporting of employment data.	Quality
	Bridge Program	Provide services to children eligible for Bridge Program	300 children served	SFY 2017	Data obtained by DAIL through paid claims. DA will notify DAIL if approaching need for additional funding to avoid waiting list.	Quantity

AHS Dept/Div	Program	Measure	Target	Time Period	Monitoring Method	Type
	Project SEARCH	Number of Project SEARCH students who receive job development	Up to 12 Project SEARCH students	Fiscal Year 2017	Year-end data submission	Quantity
	Global Campus	Percentage of student faculty who demonstrate improvements in personal development as a result of participating in Global Campus	Considered baseline data	SFY 2017	Submission of monitoring spreadsheets provided by DAIL at the end of each semester	Quality
		Number of student faculty, classroom participants, classes, and venues	Considered baseline data	SFY 2017	Submission of utilization progress report provided by DAIL at the end of each semester	Quantity
		Establish partnerships with community entities who will agree to promote and assist individuals to achieve adult learning goals	Establish at least one partnership	SFY 2017	Submission of utilization progress report provided by DAIL at the end of each semester	Quantity

Table 4: DAIL SFY2017 Master Grant Monitoring & Reporting Activities

AHS Dept/Div	Program	Monitoring Activities	Format	Frequency/Due Date	Recipient/Attendees	Purpose/Information Required
DAIL	Flexible Family Funding	Flexible Family Funding spreadsheets	Electronic spreadsheets – via GlobalSCAPE	Quarterly (Last day of following month)	Diane Bugbee (Children's Services Specialist – DDSD DAIL)	Financial and Programmatic Reporting / Specific consumer data and Flexible Family Funding expenditures in accordance with the Flexible Family Funding Program Guidelines.
	Home and Community Based Services	Waiting List	Electronic spreadsheets – via GlobalSCAPE	Quarterly (Last day of following month)	June Bascom (Program Development and Policy Analyst – DDSD DAIL)	Programmatic Monitoring and Program Planning for Anticipated Service Needs / Specific consumer data and specific services consumers are waiting for in accordance with Waiting List Guidelines
		One-Time Funding	Electronic spreadsheets – via GlobalSCAPE	Quarterly (Last day of following month)	Joanne Herring (Fiscal Administrator –Business Office DAIL)	Financial and Programmatic Monitoring / Specific consumer data and one-time funding expenditures, identified outcomes and actual outcomes in accordance with One-Time Funding Guidance
		Public Safety reporting of individuals who receive services who are on the public safety list or received public safety funding	Electronic reporting – via fax or secure email	As needed – Initial Public Safety Assessment Annually – Annual Report Evaluation of Risk (upon request)	Ed Riddell (Public Safety Specialist – DDSD DAIL)	Programmatic Monitoring / Specific consumer information in accordance with the Protocols for People with Intellectual/ Developmental Disabilities who Pose a Risk to Public Safety
		Residential Survey	Electronic reporting – via email	Annually – no later than the last day of August following the end of the fiscal year	June Bascom (Program Development and Policy Analyst – DDSD DAIL)	Legislative Reporting / Fiscal year end data on number of people living in which type of living arrangement
		Housing Safety and Accessibility Review	Hard copy via US Postal Service	As needed	Tammi Provencher (Program Technician – DDSD DAIL)	Monitoring Housing Safety and Accessibility / Data based on housing inspections and required changes/ accommodations
	PASRR Specialized Services	Review Medicaid (MMIS) Paid Claims	n/a	n/a	Jim Euber (Financial Director – Business Office DAIL)	Review Medicaid paid claims to monitor utilization.
	Supported Employment	Employment rate data reporting	Electronic reporting – via GlobalSCAPE	1/31/17 – for the prior fiscal year-end data	Betsey Choquette (VR Gen. Asst. Program Coordinator – DVR DAIL), DA Supported Employment Coord.	Provides an objective, external reporting source of data to verify employed consumers in the prior fiscal year.
		Employment rate data reconciliation	Electronic reporting – via	2/28/17 – one month after the initial release	Jennie Masterson (Supported Employment Specialist –	To review VDOL data and note excluded individuals from the employment rate and

AHS Dept/Div	Program	Monitoring Activities	Format	Frequency/Due Date	Recipient/Attendees	Purpose/Information Required
			GlobalSCAPE	of VDOL data	DDSD DAIL), Betsey Choquette (VR General Asst. Program Coordinator – DVR DAIL), DA Supported Employment Coordinator	add employed consumers that were not included in data.
		Final Employment rate verification	Electronic reporting – via GlobalSCAPE	No later than 6/30/16 – Collected and verified in the final quarter of SFY 2017	Betsey Choquette (VR General Asst. Program Coordinator – DVR DAIL), Sent by DA Supported Employment Coordinator	Verification for employed consumers that may not be included in VDOL data (out of state, self-employed, etc.)
		Employment rate final review	In-person meeting	No later than 6/30/17 – Annually in the final quarter of the SFY 2017	Jennie Masterson (Supported Employment Specialist – DDSD DAIL), Betsey Choquette (VR General Asst. Program Coordinator – DVR DAIL (DA Supported Employment Coordinator), DA DS Director, Regional Manager/staff – DVR DAIL	Conduct an in-person review of employment rate findings with all key stakeholders present, modify data as needed, and arrive at a final employment rate.
	Targeted Case Management	Review Medicaid (MMIS) Paid Claims	n/a	n/a	Jim Euber (Financial Director – Business Office DAIL)	Review Medicaid paid claims to monitor utilization
	Bridge Program	Track and report the number of service goals identified and the number of service goal outcomes achieved	Electronic reporting – via e-mail	Submit report no later than 4/1/17 for information related to goals and outcomes achieved between 7/1/16 to 3/1/17	Diane Bugbee (Children's Services Specialist – DDSD DAIL)	Financial and Programmatic Reporting / Number of service goals identified for recipients and the number of service goal outcomes achieved in accordance with The Bridge Program: Care Coordination for Children with Developmental Disabilities Guidelines.
		Review Medicaid (MMIS) Paid Claims	n/a	n/a	Jim Euber (Financial Director – Business Office DAIL)	Review Medicaid (MMIS) paid claims to monitor utilization. If there is a significant difference in numbers served from what was targeted, funding may be reallocated. Utilization will be used to determine the next fiscal year allocation.
	Family Managed Respite	Family Managed Respite (FMR) spreadsheet	Electronic spreadsheets – via GlobalSCAPE	Quarterly (Last day of following month)	Diane Bugbee (Children's Services Specialist – DDSD DAIL)	Programmatic Reporting. Specific consumer data and Family Managed Respite allocations in accordance with the Family Managed Respite Program Guidelines.
		Review Medicaid (MMIS) Paid Claims	n/a	n/a	Jim Euber (Financial Director – Business Office DAIL)	Review Medicaid (MMIS) paid claims or ARIS report to monitor utilization.

AHS Dept/Div	Program	Monitoring Activities	Format	Frequency/Due Date	Recipient/Attendees	Purpose/Information Required
						Utilization will be used to determine the next fiscal year allocation.
	Post-Secondary Education	Post-Secondary Education Initiative Reports	Electronic reporting – via GlobalSCAPE	a. No later than 10/30/16. b. No later than 6/30/17; Any student placed after 6/30/17 will be reported to DAIL no later than 8/31/17.	Jennie Masterson (Supported Employment Specialist – DDSD DAIL)	a. Specific student data: student name and funding allocation b. Specific student documentation: course names and grades; type of Individual College Plan and career goals; types of student internship; job development efforts for 2nd year; and placement data to include name of employer, job title, hours, wages
	Project SEARCH	Project SEARCH Reports	Electronic reporting – via GlobalSCAPE	a. Report program census by 9/30/16. b. Report student documentation for students working by 6/30/17. c. Report student documentation for students not working by 6/30/17; provide dates/documentation for any students who start working after 6/30/17 as placed.	Jennie Masterson (Supported Employment Specialist– DDSD DAIL)	Identify specific student documentation: student name, job placement status; name of employer; and job position, hours of work per week and rate of pay
	Global Campus	Utilization progress report and monitoring spreadsheets	Electronic spreadsheets – via GlobalSCAPE	No later than the last day of the month following the end of each semester (1/31 and 7/31)	Jennie Masterson (Supported Employment Specialist – DDSD DAIL)	Programmatic reporting and assessment of outcomes.
	Intermediate Care Facility	DAIL Utilization Review	Site visit and file review	Every six months	Joy Barrett (Nurse Surveyor), Chris O'Neill (Quality Management Team Leader – DDSD DAIL)	Verify eligibility and criteria for continued stay

ADAP Measures by Year

Please note that there may be additional measures associated with demonstration grants such as the Youth Treatment Enhancement Grant or the Medication Assisted Treatment (MAT) grant that have specific or new pilot programs such as the Maple Leaf outpatient program. Those measures are not included as they are not universally used.

Table 5: ADAP SFY2017 Master Grant Performance Measures

AHS Dept/Div	Program	Measure	Target	Time Period	Monitoring Method	Type
VDH	ADAP Treatment	Social Supports	Percentage of treatment clients (excluding residential detoxification and treatment) who maintain high levels of support (4 or more times per week) or have more social supports on discharge than on admission	CY2016	Substance Abuse Treatment Information System (SATIS) data	Quality
		Treatment Engagement	Percentage of outpatient and intensive outpatient clients with 2 or more substance abuse services within 30 days of treatment initiation. Initiation is defined as the date of initial diagnosis and evaluation (D&E) or treatment assessment if it occurs within 30 days of treatment admission. For clients with no D&E/assessment, initiation is the treatment admission date.	CY2016	SATIS	Quality
		Number of persons served OP/IOP	Number of unique individuals served in OP/IOP programs	CY2016	SATIS	Quantity
		Encounter Days of Service	Total # of transactions days on which a unique OP/IOP client received at least one unit of DE, OP ind, OP group, OP family, CM, or IOP service	CY2016	SATIS	Quantity
VDH	ADAP Prevention	Percent of group leaders receive and complete curriculum training from Rocking Horse Program Developer	100%	Grant Period	Training Attendance Sheet	Quality
		Percent of group leaders attend Annual Rocking Horse Training	100%	Grant Period	Training Attendance Sheet	Quality
		Rocking Horse Curriculum implemented with fidelity to the model	100%		Group Implementation Checklist	Quality

Table 6: ADAP Opioid Hub and Residential Treatment Preferred Providers Performance Measures

AHS Dept/Div	Program	Measure	Target	Providers Included	Monitoring Method	Definition	Required By
VDH	ADAP Treatment	Treatment Retention	80%	Hub	Substance Abuse Treatment Information System (SATIS) data	Percentage of clients admitted for Medication Assisted Treatment, retained in treatment for 90 days or longer. Excludes those who complete treatment, were transferred to another level of care (such as a spoke), those who died, and those who are incarcerated within 90 days of admission.	State Requirement
		Successful Discharge	81%	Res	Substance Abuse Treatment Information System (SATIS) data	Percent of treatment discharges with discharge reasons of "Completed Treatment" or "Transferred"	State Requirement
		Days of Service Provided	Maintain	Res	Substance Abuse Treatment Information System (SATIS) data	Percent of treatment discharges with discharge reasons of "Completed Treatment" or "Transferred"	State Requirement

Table 7: ADAP SFY2017 Master Grant Monitoring and Evaluation Activities

AHS Dept/Div	Program	Monitoring Activities	Format	Frequency/ Due Date	Recipient/ Attendees	Purpose / Information Required
VDH	ADAP	Direct substance abuse treatment services	Substance Abuse Treatment Information System (SATIS) Electronic data set	Monthly (Last day of following month)	ADAP FTP Site	Performance Monitoring The SATIS Manuals for services provided before and after ICD-10 implementation date is available of the VDH/ADAP website.
		Rocking Horse Program Fidelity	Paper template	At the discretion of the State	ADAP Grants Email Account	Performance Monitoring
		Public Inebriate Incapacitation Screening and Disposition Summary Report	Paper and electronic template	Monthly (Last day of following month)	ADAP Grants Email Account	Performance Monitoring
		Crash School rosters for each course and a Face Sheet for each person completing the course	Paper and electronic template	Due on or before 24 hours prior to official class start date	Project CRASH/ Fax: 802-651-1573	Performance Monitoring
		Waiting List Reports	Paper and electronic template	Monthly (Last day of following month)	ADAP Grants Email Account	Substance Abuse Block Grant Federal Mandate
		Drug Court Screening reports	Paper and electronic template	Quarterly (Last day of following month)	ADAP Grants Email Account	Performance Monitoring
		Special Populations: This includes the Northern Lights program. Quarter Narrative progress reports that include services provided and number of people served	Paper and electronic template	Quarterly (Last day of following month)	ADAP Grants Email Account	Performance Monitoring
		Financial Reports	Paper and electronic template	Quarterly (Last day of following month)	ADAP Grants Email Account	Performance Monitoring
		Audited Annual Financial Report	Paper template	To Be Determined	First Class Mail	Performance Monitoring
		Site Visit	In person/on-site meeting	At the discretion of the State, annually	N/A	Grant Monitoring Compliance

Table 8: ADAP SFY2017 Opioid Hub and Residential Treatment Preferred Providers

AHS Dept/Div	Program	Monitoring Activities	Format	Frequency/ Due Date	Recipient/ Attendees	Purpose / Information Required
VDH	ADAP	Hub Census Report	Paper template	Monthly	ADAP Grants Email Account	Performance Monitoring
		Verification of Services Received	Paper template	As requested	ADAP Grants Email Account	Performance Monitoring
		EMR or DVHA Blueprint for Health HIT System	Paper template	As requested	ADAP Grants Email Account	Performance Monitoring
		Uninsured Buprenorphine Client Report	Paper template	Quarterly	ADAP Grants Email Account	Performance Monitoring

Table 9: DCF SFY2017 Master Grant Performance Measures

AHS Dept/Div	Program	Measure	Target	Time Period	Monitoring Method	Type
AHS/DCF	IFS	Number of children served by fiscal quarter	Maintain or increase	Annually	Data and/or narrative reports	Quantity
		Number of children served by age	Maintain or increase	Annually	Data and/or narrative reports	Quantity
		Number of hours of service	Maintain or increase	Annually	Data and/or narrative reports	Quantity
		% of services provided to child/youth with Medicaid	Maintain or increase	Annually	Data and/or narrative reports	Quantity
		% of children with a plan developed collaboratively with families	Maintain or increase	Annually	Data and/or narrative reports	Quality
		Satisfaction measure from family perspective	Maintain or increase	Annually	Data and/or narrative reports	Quality
		% of children with a plan completed within 90 days of referral	Maintain or increase	Annually	Data and/or narrative reports	Quality
		% of children (Prenatal to 6) that received initial contact within 5 calendar days	Maintain or increase	Annually	Data and/or narrative reports	Quality
		% of children (Prenatal to 6) that had a transition plan (30 or 90 days before transition) upon discharge	Maintain or increase	Annually	Data and/or narrative reports	Quality
		% of children/youth receiving non-emergency service within 7 days of emergency service	Maintain or increase	Annually	Data and/or narrative reports	Quality
		% of children/youth living at home or close to home in a family-like setting	Maintain or increase	Annually	Data and/or narrative reports	Quality
		% of children/youth that have shown improvement on the CANS or an approved assessment tool	Maintain or increase	Annually	Data and/or narrative reports	Impact
		% of children whose CANS score shows improvement in the family domain *OR* % of families who show improvement on an approved assessment tool	Maintain or increase	Annually	Data and/or narrative reports	Impact
DCF - CDD	Children Integrated Services (CIS)	% served by CIS achieving one or more plan goals by annual review or exit from CIS services (whatever is earliest)	Increase	Semi annually	Data and narrative reports	Quality
		% served by CIS within timelines documented in CIS Guidance Manual	Increase			Quantity
		% served by CIS who have no further need for immediate related supports upon exiting CIS services	Increase			Quality
		Average number of service professionals interacting directly with clients	Maintain or decrease			Quantity
		Demonstrated improvement on performance measures		Annually	CDD	Impact

AHS Dept/Div	Program	Measure	Target	Time Period	Monitoring Method	Type
DCF - FSD	Intensive-based Family Services (IFBS)	Development of a Plan of Care for families referred by state, approved and monitored by a licensed practitioner of the healing arts. Plan of Care will, at a minimum, include the following: a. Objectives which are measurable, realistic and achievable; b. A plan specifying services to be received, including level of weekly services; c. Projected time-frames for achievement of child and family goals; d. Responsibilities of treatment providers, the child/youth and family for the assigned tasks; e. A plan for coordinating the services with other agencies, especially coordination with the existing state case plan.	100%	Quarterly Progress Reports	IFBS Program Progress Report Program Discharge Report	Quality Quantity

Addendum: Green Mountain Care Board

MEMORANDUM

To: The House Committee on Health Care, and the Committee on Human Services

From: The Green Mountain Care Board

Re: Act 113 (2016) Sec. 11, Agency of Human Services Contracts Report Addendum

Date: December 19, 2016

Cc: Hal Cohen, Secretary of Agency of Human Services
Al Gobeille, Secretary of Agency of Human Services Designate
Trey Martin, Secretary of Administration
Susanne Young, Secretary of Administration Designate

Section 11 of Act 113 of 2016 requires that the Green Mountain Care Board consult with the Agency of Human Services (AHS, or the Agency) on a legislative report addressing the subject of AHS contracts with designated agencies (DAs), specialized service agencies, and preferred providers. More specifically, the report must address three areas: first, the amount and type of performance measures and other evaluations imposed; second, the funding levels and how they affect access to and quality of care; and third, the effect of such funding levels on staff compensation relative to private and public pay for the same services. The Board has reviewed the Agency's legislative report and commends it for the extensive work it has performed to date. This addendum offers supplemental background information and a summation of the Board's observations[9].

Prior to the legislative charge to consult with the Agency on the report required by Act 113, the Board reviewed the FY 2015 budget of Howard Center, the designated agency (DA) in Chittenden County. The Board's analysis remains relevant to this report and revealed that Howard Center's budget, as provided for in part through its contracts with the Agency, does not provide adequate funding for the institution to accomplish its client service missions. At the time of the Board's budget review, Howard Center produced evidence of lengthy waiting lists, over 100 staff vacancies, and closure of valued community services. It also had no budgeted operating margin and very low days' cash on hand. Medicaid funding, which comprises over 80 percent of Howard Center's revenue, decreased from 2014 to 2016. While not explicitly studied by the Board, its findings suggest that these conditions would limit a designated agency's ability to provide adequate access to quality care. Indeed, the Board concluded that the underfunding and resulting understaffing of Howard Center results in substantial unmet needs of Vermonters seeking crucial services[10].

In addition to the Howard Center review, on December 8, 2016 at a public Board meeting, AHS gave a presentation regarding its progress on the Medicaid Pathways for payment reform. During the presentation, the Board heard two key concerns relevant to AHS contracts: first, that the funding sources for designated agencies were fragmented and sometimes complex, and second, that the designated agencies' budgets were not adequately funded. As noted by one Board member, the fragmentation of income streams results in varied and

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[9] This addendum does not address public and private pay compensation because the Board did not adequately study this issue. However, the Howard Center budget review unveiled significant understaffing, which could be attributed to comparatively low staff compensation.

[10] The Howard Center budget report was authored by the Board pursuant to Section 28 of Act 54 (2015), and is available on the Board's website. *See* Report on the Green Mountain Care Board's Analysis of Howard Center's Budget (Jan. 29, 2016).

inconsistent restrictions and limitations on usage of funds, based on their source, which in turn limits holistic, whole-person treatment. Advocates present at the meeting echoed the Board's concerns.

Concurrent with the Howard Center budget review, Vermont had begun the process of negotiating an all-payer model (APM) agreement with the federal government. As envisioned in the APM model, the designated agencies and other community-based providers must play a critical role in the evolution of our health care delivery and payment model, including being able to realize their full potential as part of an integrated health care system focusing on upstream prevention. On October 27, 2016, the Vermont All-Payer Accountable Care Organization Model Agreement was signed by the Governor, the Board Chair, the Vermont Secretary of Human Services, and the Center for Medicare & Medicaid Innovation[11]. Under the Agreement, AHS, in collaboration with the Board, will prepare a plan, by 2020 (Year 3 of the APM), for inclusion of Medicaid Behavioral Health Services and Medicaid Home and Community-based Services in the All-payer Financial Targets. Indeed, streamlining funding and ensuring financial viability are critical for the designated agencies, specialized service agencies, and preferred providers if they are to succeed in meeting the demands of, and providing appropriate care for, Vermonters seeking their services. Further, the Board Chair observed during the December 2016 Medicaid Pathways presentation, a payment model that shifts from fee-for-service towards population-based payment, coupled with an Accountable Care Organization (ACO) and network of health care providers from across the care continuum, may lead to a redistribution of health care resources and a greater emphasis on funding for those services that best maintain Vermonters' health and wellbeing. Others present at the meeting, including stakeholders, voiced concerns whether the current Medicaid funding model has the capability and capacity to direct health care resources to their most efficient and advantageous use.

The Agency's report also discusses the numerous measures that designated agencies, specialized service agencies, and preferred providers are required to report. The overarching goals in the APM — (1) to increase access to care, (2) reduce deaths related to suicide and overdose, and (3) reduce prevalence and morbidity of chronic disease (COPD, hypertension, diabetes) — are designed to have a population health impact on the entire community. (A complete APM measures list is included in the table at the end of this document.) The measures listed in the Agency report, however, shows no overlap between the APM and Agency measures. The Agency and its departments will need to work in tandem with health care professionals and community service providers to meet the APM goals. To that end, the Agency should take into consideration the APM measures as it works to reduce reporting burdens and align measures across the entire care continuum, including traditional hospital and physician medical care, care provided through community services and supports, and mental health and substance abuse treatment.

Finally, the Board is encouraged that AHS has provided a framework that the designated agencies, specialized service agencies and preferred providers can follow as the State continues the progression towards high quality, value-based care for all Vermonters. The Board looks forward to collaborating with the Agency as Vermont implements the APM.

Vermont All-Payer Accountable Care Organization Model Agreement

Domain	Measure	Data Source	Proposed Target
Goal #1: Increase Access to Primary Care			

[11] The APM was signed October 27, 2016 by the Vermont's Governor, the Chair of the Green Mountain Care Board, the Vermont Secretary of Human Services, and the Center for Medicare and Medicaid Innovation.

Population Health	Percentage of adults with usual primary care provider*	Behavioral Risk Factor Surveillance System (BRFSS)	89% of adults statewide
Health Care Delivery System	Medicare ACO composite of 5 questions on Getting Timely Care, Appointments and Information*‡	ACO CAHPS Survey	75th percentile compared to Medicaid Nationally
Health Care Delivery System	Medicaid patient caseload for specialist and non-specialist physicians	TBD; potential measure	Monitoring only for at least first 2 years
Process	Percentage of Medicaid adolescents with well-care visits*‡	Claims	50th percentile compared to Medicaid Nationally
Process	Percentage of Medicaid enrollees aligned with ACO*	PCP selection and Claims	No more than 15 percentage points below % of VT Medicare beneficiaries aligned to VT ACO
Goal #2: Reduce Deaths Related to Suicide and Drug Overdose			
Population Health	Deaths related to suicide*	Vital Statistics	16 per 100,000 VT residents or 20th highest rate in US
Population Health	Deaths related to drug overdose*	Vital Statistics	Reduce by 10%
Health Care Delivery System	Multi-Payer ACO initiation of alcohol and other drug dependence treatment*‡	Claims	50th percentile
Health Care Delivery System	Multi-Payer ACO engagement of alcohol and other drug dependence treatment*‡	Claims	75th percentile
Health Care Delivery System	Multi-Payer ACO 30-day follow-up after discharge from ED for mental health	Claims	60%
Health Care Delivery System	Multi-Payer ACO 30-day follow-up after discharge for alcohol or other drug dependence	Claims	40%
Health Care Delivery System	Number of mental health and substance abuse-related ED visits*	Hospital Discharge Data	Reduce rate of growth (target TBD)
Process	% of Vermont providers checking prescription drug monitoring program before prescribing opioids*	Vermont Prescription Monitoring System (VPMS)	Increase percentage (target TBD)
Process	Multi-Payer ACO screening and follow-up for clinical depression and follow-up plan*‡	Clinical	75th percentile compared to Medicare Nationally
Process	# per 10,000 population ages 18-64 receiving medication assisted treatment (MAT)*	Vermont Department of Health (VDH)	150 per 10,000 (or up to rate of demand)
Goal #3: Reduce Prevalence and Morbidity of Chronic Disease (COPD, Hypertension, Diabetes)			
Population Health	Statewide prevalence of chronic disease: COPD*	BRFSS	Increase statewide prevalence by no more than 1%
Population Health	Statewide prevalence of chronic disease: hypertension*	BRFSS	Increase statewide prevalence by no more than 1%
Population Health	Statewide prevalence of chronic disease: diabetes*	BRFSS	Increase statewide prevalence by no more than 1%
Health Care Delivery System	Medicare ACO chronic disease composite: Diabetes HbA1c poor control; controlling high blood pressure; and all-cause unplanned	Claims, Clinical	75th percentile compared to Medicare nationally

	admissions for patients with multiple chronic conditions*‡		
Process	Percentage of VT residents receiving appropriate asthma medication management	Claims	25th percentile compared to national
Process	Multi-Payer ACO tobacco use assessment and cessation intervention*‡	Clinical	75th percentile compared to Medicare nationally