State of Vermont

COVID-19 Public Health Emergency Medicaid Section 1115 Demonstration 11-W-00194/1

Final Evaluation Design

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A. General Background Information

The Global Commitment to Health Section 1115(a) demonstration is an all-inclusive program designed to use a multi-disciplinary approach to comprehensive Medicaid reform, including the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, public-private partnership, and program flexibility to align efforts in primary care, behavioral health and Long-Term Services and Supports (LTSS). Consistent with Medicare's payment reform efforts, the demonstration also allows for alignment across public payers.

The Vermont Global Commitment to Health Medicaid Section 1115(a) demonstration (11-W-00194/1) was originally approved by CMS on September 27, 2005 and implemented on October 1, 2005. The Global Commitment to Health demonstration was extended for three years, effective January 1, 2011, and again for three (3) years, effective October 2, 2013. The Choices for Care demonstration was extended for five (5) years effective October 1, 2010 and became part of the Global Commitment to Health demonstration in January 2015. On January 1, 2017, Vermont and CMS extended the Global Commitment to Health demonstration through 2021, to further promote delivery system and payment reform to meet the mutual goals of the State, the Center for Medicaid and CHIP Services, and the Center for Medicare and Medicaid Innovation (CMMI). In July of 2018, the demonstration was amended to continue Substance Use Disorder (SUD) residential services delivered in Institution of Mental Disease (IMD) settings. In December of 2019, the demonstration was amended to continue Federal Financial Participation (FFP) for psychiatric services in IMD settings.

Vermont operates the demonstration using a managed care-like delivery model that complies with federal regulations at 42 CFR part 438 that would be applicable to a non-risk Pre-paid Inpatient Health Plan (PIHP). Specific to this evaluation, the Department of Vermont Health Access (DVHA) is required under 42 C.F.R. Part 438, Subpart F, to have an internal grievance and appeal process for resolving service disagreements between members and the Medicaid Program, representatives of the Medicaid Program, and state designated agencies, including Designated Agencies (DAs) and Specialized Service Agencies (SSAs) for mental health services. These regulations establish formal grievance and appeal procedures that provide an array of crucial rights and protections for Medicaid applicants and beneficiaries. These processes allow Medicaid enrollees to be informed about adverse benefit determinations, as well as challenge such actions in a manner free from retaliation.

In an effort to address the COVID-19 public health emergency, the State of Vermont applied for and was approved for a new section 1115(a) demonstration opportunity available to states under title XIX (Medicaid) of the Social Security Act and described in State Medicaid Director Letter (SMDL) # 20-002[1]. The COVID-19 section 1115 demonstration opportunity makes available a number of authorities and flexibilities to assist states in enrolling and serving beneficiaries in Medicaid and to focus state operations on addressing the COVID-19 pandemic. Under this demonstration opportunity, the state of Vermont requested CMS approval for a number of waiver and expenditure authorities, to assist them in serving beneficiaries in Medicaid, to deliver the most effective care to beneficiaries in light of the COVID-19 public health emergency, and to focus their operations on addressing the COVID-19 pandemic. Specifically, the state requested to waive the requirement, at 42 CFR 438.406(b)(4) Handling of Grievances and Appeals, that allows beneficiaries to provide evidence and testimony "in person" to appeal an adverse benefit determination during the PHE. This application was approved on December 3, 2020.

[1] Available at https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20002-1115template.docx.

CMS subsequently amended STC 24 (e) to modify the application of 42 CFR 438.406(b) during periods of PHEs so that DVHA is not required to offer in person opportunities for beneficiaries to present evidence and testimony and make legal and factual arguments as described in 42 CFR 438.406(b)(4). However, DVHA must provide enrollees reasonable opportunity, in writing, telephonically, and via video or virtual communication, to present evidence and testimony and make legal factual arguments.

Overall Demonstration Goals

The State's high-level goal for all health reforms is to create an integrated health system able to achieve the Institute of Medicine's "Triple Aim" goals of improving patient experience of care, improving the health of populations, and reducing per-capita cost.[2] This is supported in the Global Commitment to Health demonstration through supporting innovative delivery system reforms, including Medicaid Accountable Care Organizations (ACO) and the development of progressive, in-home and community- based services and supports that are cost-effective and support persons who have long-term care service and support needs, complex medical, mental health and/or substance use disorder treatment needs. Overarching demonstration goals are described below:

- *To increase access to care*: All enrollees must have access to comprehensive care, including financial, geographic, physical, and communicative access. This means having health insurance, appropriate providers, timely access to services, culturally sensitive services, and the opportunity for second opinions as needed.

- *To contain health care cost*: Cost-effectiveness takes into consideration all costs associated with providing programs, services, and interventions. It is measurable at the category-of-service, individual enrollee, aid category, and aggregate program levels.

- *To improve the quality of care*: Quality refers to the degree to which programs, services and activities increase the likelihood of desired outcomes. The six domains necessary for assuring quality health care identified by the Institute of Medicine (IOM, 2001) are:
    - *Effectiveness*: Effective health care provides evidence-based services to all who can benefit, refraining from providing services that are not of benefit.
    - *Efficiency*: Efficient health care focuses on avoiding waste, including waste of equipment, supplies, ideas, and energy.
    - *Equity*: Equal health care provides care without variation in quality due to gender, ethnicity, geographic location, or socioeconomic status.
    - *Patient Centeredness*: Patient-centered care emphasizes a partnership between provider and consumer.
    - *Safety*: Safe health care avoids injuries to consumers from care that is intended to help.
    - *Timeliness*: Timely health care involves obtaining needed care and minimizing unnecessary delays in receiving care.

- *To eliminate institutional bias**:*** By allowing specialized program participants choices in where they receive long-term services and supports and by offering a cost-effective array of in-home and community services for older adults, people with serious and persistent mental illness, people with

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

developmental disabilities and people with traumatic brain injuries who meet program eligibility and level of care requirements.

Grievance and Appeals Goals

The overall goal of the grievance and appeal system is to resolve disputes fairly, to enhance member and public confidence in the equity and integrity of the service system, to ensure members access to medically necessary, covered, benefits, and to allow for the independent review of Medicaid Program staff decisions concerning appealable actions. Members initiating or pursuing a grievance or appeal will be free from retaliation.

Public Health Emergency (PHE) Flexibility Goals

CMS has determined that the COVID-19 PHE amendment to the Vermont Global Commitment to Health section 1115(a) demonstration – including the revised terms detailed below – is necessary to assist the state in delivering the most effective care to its beneficiaries in light of the COVID-19 PHE. The demonstration amendment is intended to assist in promoting the objectives of the Medicaid statute because it is expected to help the state furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19.

B. Evaluation Questions and Hypotheses

To support the aims of the state's broader 1115 demonstration and the goals of the grievance and appeal system, the evaluation questions and hypotheses are aligned with the broader goal of increasing access to care. Specifically, this evaluation will examine evidence that the flexibilities support the overarching demonstration goal of increased access to care. The design utilizes both performance measurement results (providing more real-time data focused on whether a program is implemented as intended and achieving measurable objectives) and analyzes results for key dependent variables during two different time periods.

Research Questions

The following are qualitative research questions aimed at understanding the challenges presented by the COVID-19 public health emergency to the Medicaid program:

1. *What were the principal challenges associated with engagement with Medicaid beneficiaries during this public health emergency?*
2. *What strategies did states pursue to address those challenges?*
3. *What policies and procedures were most helpful to states and providers in leveraging flexibilities to reduce barriers and ensure access to care, including accessing medical supplies and equipment?*
4. *What population groups were principally affected by this demonstration?*
5. *What were the unresolved or ongoing challenges related to implementation of the demonstration flexibilities?*

Because Vermont also has an approved Global Commitment to Health demonstration, it plans to track expenditures, including administrative and program costs for demonstration beneficiaries, and assess these outlays in light of its response to the public health emergency. The state will draw on the findings from this

cost assessment and provide a narrative on the extent to which the administrative and program costs related to this demonstration were effective at achieving the objective of the demonstration to furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19.

Hypotheses

In addition to answering the aforementioned research questions, this evaluation will seek to test certain hypotheses using a set of dependent variables. Both hypotheses and dependent variables are identified in the table below.

Table 1. List of Hypotheses by Dependent Variables

DEPENDENT VARIABLE	NULL HYPOTHESES	ALTERNATIVE HYPOTHESES
Number of appeals filed	no difference in the number of appeals filed before the PHE waiver or after the PHE waiver	there is a difference in the number of appeals filed after the PHE waiver
Percent of appeals meeting 30-day appeal resolution timeframe	no difference in the percent of appeals meeting 30-day appeal resolution timeframe before the PHE waiver or after the PHE waiver	there is a difference in the percent of appeals meeting 30-day appeal resolution timeframe after the PHE waiver
Number of appeals reversed	no difference in number of appeals reversed before the PHE waiver or after the PHE waiver	there is a difference in number of appeals reversed after the PHE waiver
Number of DMH appeals	no difference in number of Department of Mental Health (DMH) appeals before the PHE waiver or after the PHE waiver	there is a difference in number of Department of Mental Health (DMH) appeals after the PHE waiver
Number of transportation appeals	no difference in number of transportation appeals before the PHE waiver or after the PHE waiver	there is a difference in number of transportation appeals after the PHE waiver

C. Evaluation Design and Methods

Design

We are interested in examining the impact of introducing a policy eliminating in-person appeals for Medicaid members on several dependent variables. A list of the dependent variable can be found in Table 1 above. All dependent variables will be measured using discrete data. The evaluation uses a quasi-experimental research design without the use of a control/comparison group. Specifically, the design uses a one-group pretest-posttest design in which the same dependent variables are measured in a group of participants before (pretest) and after (posttest) the implementation of the PHE flexibility (i.e., waiver of in-person appeals). The evaluation design compares rates for all Medicaid members on a series of dependent variables before and after the approval of the PHE waiver. Specifically, the state will compare pretest and posttest scores for all Medicaid members. In a pretest-posttest design, the dependent variable is measured once before the treatment is implemented and once after it is implemented. This approach allows the state to measure performance on the selected dependent

variables during a time when in-person appeals were allowed and then measure performance on the same set of dependent variables when in person appeals are not allowed. Using this design, we measure results before and again following the waiver of in-person appeals, then compare the difference between pretest and posttest results. The pre and posttest results for Medicaid members are not matched and no comparison/control groups are used.

Analytic Methods

The state has no reason to believe that removing the in-person appeals option will negatively impact a member's appeal rights. The evaluation will assess changes in dependent variables for those affected by PHE flexibility compared to a group not affected by the PHE flexibility. The dependent variables identified above are measured once before in-person appeals are waived and once after they are waived. Using this approach, we measure results once before and then again following the waiver of in-person appeals, then compare the difference between pretest and posttest results. The statistical question is whether the posttest scores differed significantly from the pretest scores. The evaluation will use a one-sample *Poisson* test at a 5% significance level to determine if there is evidence to support the claim that waiving the in-person appeals option significantly impacts performance of the dependent variables.

The Poisson probability law gives the probability distribution of the number of events occurring in a specified period of time. The Poisson distribution is often used to fit count data during a time period, and thus is appropriate for the type of data available for this evaluation. The Poisson distribution is characterized by a single parameter, λ, which is the number of occurrences during the time period. This procedure calculates the power or sample size for testing whether λ is less than or greater than the specified pre-test value.

In addition, the state plans to solicit qualitative data from DVHA staff to consider and address various issues that might compromise the results, such as unexpected changes in program operations, enrollment or implementation of new program initiatives. This data will be reviewed for themes that can be used to shed light on the broader evaluation questions and hypotheses.

Finally, the state will consider augmenting the data referenced above with associated data from the Medicaid Management Information System (MMIS) that may assist them in providing contextual information to better understand the extent of the challenges presented by this public health emergency. Additional information on the MMIS can be found in Table 3 below.

Target Population

The evaluation studies the impact of the PHE flexibility on all enrollees (e.g., total Medicaid population). The total Medicaid population was defined as those members enrolled with full benefits and Medicaid as their primary payer during the measurement periods. Dependent variable responses are not paired across the measurement periods.

Measurement Period

The resulting evaluation uses two measurement periods to test the hypotheses designed to assess the impact of the PHE flexibility on a set of dependent variables. The table below outlines the time periods associated with the measurement periods. Please note that the post-PHE amendment measurement period ends February 28,

2021 – but the waiver of in-person appeals is in effect through the date that is 60 days after the end of the PHE (including any renewal of the PHE). Responses to the research questions are not limited to the same post-PHE amendment measurement periods as the ones used for hypotheses testing.

Table 2. Measurement Periods and Appeal Approaches

	Pre-PHE Amendment	PHE Amendment Approval Effective Date	Post-PHE Amendment
Measurement Period	March 1, 2019 – February 29, 2020	March 1, 2020*	March 1, 2020 – February 28, 2021
Appeal Approaches	The state must offer opportunities to handle grievances and appeals 1) in person and 2) in writing	No in-person handling of grievances or appeals	The state must offer opportunities to handle grievances and appeals, 1) in writing, 2) by telephone, and 3) by video or virtual communication

*Note. State received CMS approval letter on December 3, 2020 with a retroactive effective date.

Data Collection and Data Sources

The evaluation design uses secondary discrete data. There is no collection of raw or primary data associated with this evaluation. All data used to support the evaluation design was taken from existing Grievance System Data Base and encounter, claims, utilization, and cost data were derived from the Medicaid Management Information System (MMIS). Qualitative data will be collected from DVHA staff familiar with the PHE flexibility and the Medicaid Grievance and Appeal System. Vermont data sources used to evaluate performance against demonstration goals are described in the table below.

Table 3. PHE Data Sources

PHE Evaluation Data Sources	
Data Source	**Brief Description**
Grievance System Database	Appeal information collected throughout the appeal process. Specific data elements include but are not limited to the following: date of appeal, party proceeding the appeal, notification date, resolution date, other notice dates.
Medicaid Management Information System (MMIS)	Claims data submitted to the State by providers used to support HEDIS® and HEDIS®-like performance measure development, as well as service utilization and cost metrics for all enrollees
DVHA Staff Interviews	The state plans to solicit qualitative data from DVHA staff to consider and address various issues that might compromise the results, such as unexpected changes in program operations, enrollment or implementation of new program initiatives.

Data on appeals is documented in the Grievance and Appeals relational database, along with Fair Hearing requests and outcomes for those cases. The database organizes data into tables which can be linked—or related—based on data common to each. This capability enables users to retrieve an entirely new table from data in one or more tables with a single query. It also allows the user to better understand the relationships among all available data and gain new insights for making better decisions or identifying new opportunities. The MMIS is an automated computerized processing system that gathers Medicaid program information. The

Grievance and Appeals database is maintained by the Department of Vermont Health Access (DVHA) while the MMIS is managed via a vendor contract with DVHA oversight and monitoring.

D. Methodological Limitations

The main limitations to this evaluation are related to its design and data. These limitations are summarized in the paragraphs below.

Design

To test hypotheses, this evaluation relies on a single group pretest posttest design. As with most evaluations, its results must be interpreted with caution and a number of limitations should be borne in mind as there may be other explanations for why the posttest results might have changed. First, the current design does not include a no-treatment control or comparison group as the waiver of in-person appeals applied to all Medicaid beneficiaries post March 1, 2020. Second, other actions might have happened between the pretest and the posttest time periods that caused a change in the pretest to posttest dependent variable rates (history). A final limitation to the evaluation design is that Medicaid members might have changed between the pretest and the posttest in ways that they were going to anyway because they are growing and learning (maturation).

Data

Only data that was readily available was used to answer the research questions and test the hypotheses. This decision required the state to limit the scope of its analysis and was a significant obstacle in assessing differences associated directly with the in-person appeal option. In addition, the current Grievance and Appeal database does not include a field or flag for the in-person appeal option. If the flexibilities brought about by the PHE are expected to become permanent – then it might make sense to modify the data fields in the Grievance and Appeal database so that other variables associated with in-person appeal request could be examined. Also, before this evaluation, the state assessed appeal resolution time frames or other outcomes in aggregate – and not by member filing method (e.g., in-person, via phone, in writing, etc.). As a result, there is little or no prior evaluation results to build upon. It is hoped that this evaluation serves as a catalyst for future inquiry.