Section I – Global Commitment to Health Vision

Introduction

Vermont is a national leader in health care innovation, with Medicaid, the second-largest payer in the State, as a driving force in the State's reform efforts. The Global Commitment to Health (Global Commitment) Section 1115 demonstration has progressively broken new ground in large-scale Medicaid transformation since it was first approved in 2005. Over the last 15 years, the demonstration has been Vermont's principal vehicle for major expansions of health coverage, building an extensive ecosystem of public health and health-related services, driving all-payer payment reform, and rebalancing long-term services and supports (LTSS). As a result of these efforts, Vermont has nearly universal health coverage, has one of the healthiest populations in the nation (despite also being one of the oldest), and serves nearly 60% of enrollees eligible for nursing facility care in a home or community-based setting. The Global Commitment demonstration has been critical to the State's broad success in improving the health of its residents and provides a strong platform for further innovative reform. **With the pending December 31, 2021 expiration of the Global Commitment demonstration, Vermont seeks to enter into a new, five-year demonstration agreement which will be the foundation of the State's 10-year vision to further Medicaid's role as a driver of all-payer payment and delivery system reform in the State.**

Today, almost the entirety of Vermont's Medicaid program falls under the purview of the Global Commitment demonstration. The demonstration authorizes the Department of Vermont Health Access (DVHA) within the Agency of Human Services (AHS) to act as a non-risk-bearing managed care plan, enabling the State to pursue many of the programmatic and payment flexibilities afforded to commercial managed care plans in operating its Medicaid program. In addition to authorizing traditional Medicaid benefits and home and community-based waiver-like (HCBW-like) programs, the Global Commitment demonstration supports a diverse range of programs that address Vermonters' whole-person needs across the lifespan, from prevention and early intervention services to LTSS to services addressing social determinants of health (SDOH). The demonstration offers coverage beyond typical Medicaid eligibility groups, providing specialized limited benefit packages to Vermonters with significant needs to help prevent their health status from worsening to the extent that they become eligible for full Medicaid benefits in the future. The Global Commitment demonstration also supports vital investments in health-related functions, such as community-based mental health and substance use disorder (SUD) services, emergency medical services, health professional training, and public health. These investments have enabled Vermont to create a robust health ecosystem focused on improving health, reducing health care costs, and promoting health equity for **all Vermonters,** regardless of their insurance status, as evidenced by the State's performance on measures of access to and quality of care. For example:

- In 2018, the Commonwealth Fund ranked Vermont third nationally for access and affordability to care and sixth nationally on a composite measure of "healthy lives" (e.g., prevalence of certain chronic diseases, infant mortality rate, health status, etc.).[1]
- This year, Mental Health America has named Vermont as the top state nationally for access to mental health care.[2]
- Vermont ranks fifth nationally in overall LTSS system performance and third nationally in choice of LTSS setting and provider according to the Long-Term Services and Supports State Scorecard developed by AARP, the AARP Foundation, the Commonwealth Fund, and the Scan Foundation.[3]
- Rates of health coverage between white, non-Hispanic Vermonters and Vermonters of color are not significantly different, according to the 2018 Behavioral Risk Factor Surveillance System survey.[4]
- Vermont's public health infrastructure has performed exceptionally during the COVID-19 crisis, with Vermont having the second-lowest incidence among all states of cases per 100,000 population over the course of the pandemic.[5]

The Global Commitment demonstration has also positioned Medicaid as an accelerator of Vermont's trailblazing payment reform initiatives. Vermont's All-Payer Accountable Care Organization (ACO) Model Agreement is a statewide, total cost of care model, in which providers under Medicaid, Medicare, and commercial contracts participate and can accept full risk. While the All-Payer ACO Model Agreement is authorized by the Centers for Medicare and Medicaid Services (CMS) outside of the Global Commitment 1115 demonstration, CMS has required that the two programs are in sync. Medicaid is the anchor payer for the All-Payer ACO Model Agreement, with over 80% of Medicaid enrollees for whom Medicaid is the primary payer attributed to the ACO (via the Vermont Medicaid Next Generation ACO Program). Medicaid and the Global Commitment demonstration play a crucial role in the State's value-based payment (VBP) initiatives that are central to the success of the All-Payer ACO Model Agreement. The All-Payer ACO Model Agreement has made Vermont a national trendsetter in all-payer payment reform and one of two states[6] nationally with a payment model that meets

[1] The Commonwealth Fund. "Commonwealth Fund Scorecard on State Health System Performance," 2018. https://interactives.commonwealthfund.org/2018/state-scorecard/files/Vermont.pdf.
[2] "Access to Care Data 2021." Mental Health America, https://www.mhanational.org/issues/2021/mental-health-america-access-care-data.
[3] "Long-Term Services & Supports State Scorecard- Vermont." Vermont State Scorecard. http://www.longtermscorecard.org/databystate/state?state=VT.
[4] "Behavioral Risk Factor Surveillance System: 2018 Report." Vermont Department of Health, 2018. https://www.healthvermont.gov/sites/default/files/documents/pdf/HSVR_2018_BRFSSReport.pdf.
[5] "Coronavirus in the U.S.: Latest Map and Case Count." The New York Times, May 9, 2021. https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html.
[6] Costello, Anne Marie, and Brad Smith. "SMD # 20-004 RE: Value-Based Care Opportunities in Medicaid." Medicaid.Gov, September 15, 2020. https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf.

Health Care Payment Learning & Action Network (HCP-LAN) Category 4 criteria under the Alternative Payment Model framework.[7] Vermont is also pursuing cutting edge payment innovation outside of the ACO, including a series of payment reform initiatives for Medicaid providers historically excluded from most VBP arrangements, such as providers offering mental health, SUD, and developmental disabilities services.

Vision and Goals for Global Commitment Renewal

Vermont is seeking a five-year approval of its demonstration renewal, and seeks the opportunity to discuss with CMS a 10-year renewal of limited, long-standing features of the Global Commitment demonstration. Beginning in January 2022, the State seeks to make its boldest move yet toward full population-based payment—transitioning DVHA into a public, state-run, risk-bearing Medicaid managed care plan that will enable Vermont to continue to innovate. Under this framework, DVHA will be at risk for managing under a capitation rate the entire Medicaid population and all Medicaid services—including physical health, mental health, SUD, and pharmacy services, in addition to LTSS including HCBW-like programs.

Today, CMS treats DVHA as a public, non-risk prepaid inpatient health plan (PIHP)—a unique model that does not fit squarely into the federal Medicaid managed care rules. Under the demonstration renewal, Vermont seeks to transition DVHA to a public, state-run managed care organization (MCO) subject to the requirements for risk-bearing Medicaid managed care plans memorialized in 42 CFR 438. In transitioning to a risk-bearing MCO model, Vermont's AHS will pay DVHA a monthly capitation rate for each Medicaid enrollee that will include all Medicaid services, including high-cost services such as pharmacy, plus administration and profit sufficient to cover the cost of DVHA plan administration and many of Vermont's investments as described below.

In collaboration with the Vermont Department of Health, Department of Disabilities, Aging and Independent Living (DAIL), Department of Mental Health (DMH), Alcohol and Drug Abuse Program (ADAP), Department of Corrections (DOC), and Department of Children and Families (DCF), DVHA will be responsible for managing total Medicaid spending and managed care delivery system administration within this capitation rate. Similar to a commercial Medicaid managed care plan, DVHA will have the ability to offer in lieu of services and flexibility in how it uses its profits, including the ability to offer value-added services. Different from a commercial managed care plan, DVHA will use all of its profits to reinvest in delivery system reforms and service initiatives that incentivize and advance whole-person health for the people of Vermont. Over the life of the demonstration period, Vermont intends to transition the majority of its investments authorized under the current Global Commitment demonstration to being covered as medical services (including in lieu of services), care management, quality improvement

[7] "Alternative Payment Model Framework." The MITRE Corporation, HCP LAN, 2017. https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

initiatives, and value-added services/population health initiatives through the administration and profit load under the DVHA capitation rate. Vermont anticipates that as an MCO, DVHA's rate will conform with demonstration special terms and conditions (STCs) and actuarially sound rate setting, including regulatory requirements and industry norms with respect to medical-loss ratio, administrative load, and profit margin.

Importantly, Vermont is not proposing any demonstration flexibilities that would undermine Medicaid as an entitlement for Vermonters. The State is not seeking the ability to cap, cut, or limit Medicaid eligibility or benefits in the event its public managed care plan exceeds the capitation rate. If DVHA is at risk of exceeding the capitation rate, the State will work with CMS to identify appropriate mitigation strategies, which may include seeking a rate adjustment.

Vermont's vision for the Global Commitment demonstration renewal is to improve health outcomes, lower costs for all Vermonters, and promote provider sustainability, by driving farther and faster toward alternative payment models. With this transition, Vermont will have fully evolved its Medicaid program to an HCP-LAN Category 4 population-based payment model, and strengthened its platform for accelerating more advanced alternative payment models among Vermont providers. As a risk-bearing managed care plan, DVHA will be incentivized to deliver value for federal and State Medicaid spending by continuing to develop more innovative care models, improving care coordination, and strengthening DVHA's population health management capabilities. DVHA will continue to lead value-based care reform through implementing VBP arrangements at the level of care delivery, including as an anchor participant in the State's All-Payer ACO Model Agreement. Concurrently, DVHA will leverage the demonstration renewal to mitigate barriers to providers successfully participating in advanced VBP models, such as by addressing challenges in connecting to Vermont's Health Information Exchange (HIE). Finally, within the new managed care framework, DVHA will be able to tackle the "wrong pocket problem," which refers to when expenditures in one delivery system (e.g., mental health) or coverage program (e.g., Medicaid) generate savings in a different delivery system (physical health) or coverage program (e.g., Medicare). As a risk-bearing MCO participating in Vermont's All-Payer ACO Model, DVHA and its contracted providers will be able to align incentives through innovative VBP mechanisms.

Concurrently, Vermont envisions advancing the objectives of the Medicaid program by continuing to invest in programs and interventions that improve population health, impact SDOH, and ensure that those investments are sustainable over the long-term in order to support health improvement and health equity for Vermonters through effective use of state and federal Medicaid dollars.

Vermont's vision of moving to a public, risk-bearing managed care plan stems from its unique track record in health care reform, and the platform the State has built across its long-standing Global Commitment demonstration and All-Payer ACO Model. The next stage of the Global

Commitment demonstration is a Vermont innovation that is uniquely designed and appropriate for the State and for Vermonters. DVHA's transition to a risk-bearing managed care plan is central to the demonstration renewal and creates a new opportunity and incentive for Vermont to evolve its health ecosystem, continue to improve the health and well-being of Vermonters through SDOH targeted health and health-related investments, and drive value in the Medicaid program and health care system overall. Key goals of the demonstration renewal align with the objectives of Title XIX of the Social Security Act and include:

1. Advancing toward population-wide, comprehensive coverage
2. Implementing innovative care models across the care continuum that produce value
3. Engaging Vermonters in transforming their health
4. Strengthening care coordination and population health management capabilities to encompass the full spectrum of health-related services and supports
5. Accelerating groundbreaking payment reform

To achieve these goals, Vermont is seeking to retain and strengthen existing demonstration features, while implementing new initiatives that will advance Vermont's health ecosystem and position DVHA to be successful as a risk-bearing MCO. Underlying all of these goals is Vermont's commitment to leveraging its 1115 demonstration to advance health equity. As detailed in this application and Table 1, Vermont is requesting authority for the following new initiatives, which align with the goals of the demonstration renewal.

The remainder of this application describes Vermont's vision for the continued evolution of the Global Commitment demonstration.

Table 1. Global Commitment Demonstration Renewal Goals and New Waiver and Expenditure Authority Requests

New Waiver and Expenditure Authority Requests	Demonstration Goals Advanced Through Request				
	Advancing toward population-wide comprehensive coverage	**Implementing innovative care models across the care continuum that produce value**	**Engaging Vermonters in transforming their health**	**Strengthening care coordination and population health management capabilities to encompass the full spectrum of health-related services and supports**	**Accelerating groundbreaking payment reform**
Transition DVHA to a risk-bearing MCO	✓	✓	✓	✓	✓
Cover inmates 90 days pre-release	✓		✓	✓	
Provide SUD Community Intervention and Treatment benefits for low- and moderate-income Vermonters with a SUD	✓		✓		
Expand access to family-focused residential mental health and SUD treatment		✓	✓		
Offer a Permanent Supportive Housing Pilot		✓	✓		
Maintain critical workforce development initiatives			✓	✓	
Support public health infrastructure			✓	✓	

New Waiver and Expenditure Authority Requests	Demonstration Goals Advanced Through Request				
	Advancing toward population-wide comprehensive coverage	Implementing innovative care models across the care continuum that produce value	Engaging Vermonters in transforming their health	Strengthening care coordination and population health management capabilities to encompass the full spectrum of health-related services and supports	Accelerating groundbreaking payment reform
Administer Blueprint for Health (Blueprint)		✓	✓	✓	✓
Strengthen providers' ability to participate in HIE, advancing population health				✓	✓
Deploy an electronic patient engagement platform			✓	✓	

Section II—Historical Narrative Summary of the Demonstration

In 2005, CMS first approved the Global Commitment demonstration. Through the demonstration, Vermont sought to make high-quality health care available to all Vermonters; promote well-child services and preventive care; make prescription drugs more affordable; and protect health care coverage for the State's most vulnerable populations. Over more than 15 years of the demonstration to date, Vermont has been successful in meeting and exceeding these goals. Further, Vermont has leveraged the demonstration to expand affordable coverage, more effectively deliver health care services and manage health care resources, and improve the health care system for all Vermonters. The demonstration has continued to evolve to adapt to the changing federal health care landscape and reflect Vermont's desire to be a national leader in health care coverage and payment and delivery innovation.

Original Demonstration: 2005–2010

The original Global Commitment demonstration authorized Vermont to operate almost its entire Medicaid program through an innovative managed care-like model. Under the terms of the first demonstration period, Vermont's AHS—Vermont's single state agency—paid DVHA a per-member per-month capitation rate to cover Medicaid expenditures. If DVHA kept total expenditures within the capitation rate, savings accrued to the State. Vermont could use the savings to make expenditures (called "investments" in later demonstration renewals) that would reduce the rate of uninsured/underinsured Vermonters, increase access to quality health care, implement public health programs to improve health outcomes and quality of life for Medicaid-eligible individuals, and encourage formation and maintenance of public-private health care partnerships. During this period, the demonstration operated under a global cap.

In addition to implementing Vermont's unique managed care-like model, the original demonstration significantly increased Vermonters' access to affordable health care coverage. It offered coverage to two groups of individuals that would not otherwise be covered by Medicaid: (1) "State Plan optional populations," which consisted of children in low-income working families or parents/caregivers with income above mandatory Medicaid coverage levels, and (2) "1115 Expansion Populations," primarily non-disabled, childless adults under age 65 with incomes up to 150% of the federal poverty level (FPL). The demonstration also authorized home and community-based services (HCBS) for individuals with brain injuries, developmental disabilities, or serious mental illness (SMI), and children/families of children with serious emotional disturbance (SED), which were all previously authorized under Section 1915(c) waivers. Concurrently, outside of the Global Commitment demonstration, Vermont obtained CMS approval in 2005 for the Choices for Care (CFC) Section 1115 demonstration, which enabled eligible Vermonters with a need for institutional care to choose between HCBS and nursing facility care, and provided HCBS to individuals at risk for institutional care.

In 2007, CMS approved an amendment to the demonstration that allowed Vermont to implement a premium assistance program for individuals enrolling in the Catamount Health Plan, a commercial health insurance product created by State statute, which provided comprehensive, quality health coverage for uninsured Vermonters at a reasonable cost, regardless of income. Through the demonstration amendment, Vermont was able to offer premium assistance to individuals with incomes up to 200% FPL enrolled in a Catamount Health Plan. In 2009, CMS approved a second amendment that expanded eligibility for the Catamount Health Premium Assistance Program to individuals with incomes up to 300% FPL, further increasing access to affordable coverage for Vermonters. Coverage of optional and expansion populations, as well as the implementation of the Catamount Health Premium Assistance Program, allowed Vermont to begin closing gaps in health care coverage nearly five years prior to the passage of the Affordable Care Act (ACA).

First Renewal: 2011–2013

Vermont renewed the Global Commitment demonstration effective January 1, 2011. Under the renewal, Vermont's managed care model shifted from being at-risk to non-risk; however, Vermont retained the ability to use managed care savings to make investments that would reduce the rate of uninsured/underinsured, increase access to care, develop public health programs, and promote public-private health care partnerships.

Second Renewal: 2014–2016

CMS approved an extension of the demonstration effective January 1, 2014, through December 31, 2016, primarily targeted toward addressing changes in coverage effectuated by the ACA. At this time, Vermont added the New Adult Group to its demonstration and obtained approval to offer premium subsidies to any individual with an income up to 300% FPL enrolled in a qualified health plan through the Marketplace. Concurrently, Vermont sunset the authorities for the 1115 Expansion Populations and the Catamount Health Premium Assistance Program, as individuals in these populations would be eligible for Medicaid State Plan or Marketplace coverage under the ACA beginning on January 1, 2014.

On January 30, 2015, the demonstration was further amended to include authority for the CFC demonstration, allowing Vermont to consolidate its Section 1115 authorities under a single demonstration. Simultaneously, Vermont obtained authority to provide full Medicaid State Plan benefits to presumptively eligible pregnant women, continuing efforts to make health care coverage accessible for all Vermonters.

Third Renewal: 2017–present

Effective January 1, 2017, Vermont renewed the Global Commitment demonstration for five years running through December 31, 2021, the current demonstration period.

With this second renewal, Vermont's managed care model remains largely the same as under the previous demonstration period. However, under the current STCs, the Global Commitment demonstration as a whole is no longer under a global cap, and Vermont is subject to new requirements with regard to spending on its investments. At this point, Vermont can only spend investment dollars on specific programs and services approved by CMS, and the total amount of permitted investment spend is capped.

Over the course of this period, Vermont amended the demonstration to obtain waivers of the institution for mental diseases (IMD) exclusion for SUD and mental health treatment, which were effective July 1, 2018, and December 5, 2019, respectively. These waivers have enabled Vermont to enhance the continuum of services available to Medicaid enrollees with SMI, SED, and SUD, while shoring up critical residential and inpatient treatment capacity.

Goals and Objectives of Current Demonstration Period

The current Global Commitment demonstration has aimed to improve the health status of all Vermonters by:

- Promoting delivery system reform through value-based payment models and alignment across public payers;
- Increasing access to affordable and high-quality health care by assisting lower-income individuals who can qualify for private insurance through the Marketplace;
- Improving access to primary care;
- Improving the health care delivery for individuals with chronic care needs; and
- Allowing beneficiaries a choice in LTSS and providing an array of home and community-based alternatives recognized to be more cost-effective than institutional-based supports.

In addition, Vermont has also worked to meet a series of goals focused on SUD and SMI/SED, which align with the overall goals of the demonstration stated above.

- SUD Goals
    - Increased rates of identification, initiation, and engagement in treatment
    - Increased adherence to and retention in treatment
    - Reductions in overdose deaths, particularly those due to opioids

  - Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services
  - Improved access to care for physical health conditions among beneficiaries
- SMI/SED Goals
  - Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings
  - Reduced preventable readmissions to acute care hospitals and residential settings
  - Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs and psychiatric hospitals and residential treatment settings throughout the State
  - Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care
  - Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities

Vermont has largely been successful in meeting these goals, as addressed in this section and throughout this application. Over the course of the demonstration, Vermont's independent evaluator has measured the State's success in achieving these goals across four domains: increased access to care, improved quality of care, improved community integration, and contained program costs. A sample of findings are described below.[8]

- **Access to care**
  - Access to ambulatory and preventive visits, well-child visits, dental care, and adolescent well care measures have shown statistically significant improvement over baseline as described in Section VII below.
  - Access to medication-assisted treatment (MAT) has increased in each year of the demonstration.
- **Quality of care**

[8] The state's SMI Monitoring Protocol, which includes a monitoring workbook with metrics, received CMS approval on March 29, 2021. The SMI IMD measures identified in the monitoring workbook will be reported using the schedule identified in the Monitoring Protocol and will be considered for inclusion in the draft summative evaluation report due to CMS within 18 months of the end of the demonstration period (6/30/22). In addition, the State did not have the staff resources to generate the SUD IMD utilization and cost of care measures for the final interim evaluation report due to the state's response and priorities to the COVID-19 pandemic. These measures will be included in the draft summative evaluation report.

  - In over 76% of the quality of care measures assessed, the demonstration has outperformed Medicaid programs nationally.
  - The demonstration is associated with improved rates of initiation and engagement in SUD treatment and improved diabetes control.
- **Community integration**
  - The number of CFC enrollees living in home and community-based settings rose from 54% at baseline to 58% in CY2019.
- **Cost containment**
  - The demonstration is containing costs relative to what would have been spent absent the demonstration.
  - The State has achieved savings over expected "without waiver expenditures" in each year of the demonstration thus far; cumulative savings at the end of CY2019 were $110,465,951.

Additional details about how the goals and objectives of the Global Commitment demonstration have been met are included in Sections V and VII of this application.

Moving Forward

Today, Vermont continues to deliver on the historical Global Commitment demonstration goals. In the upcoming renewal period, Vermont seeks to build upon its rich history of innovation and high-quality service delivery and will continue to use the Global Commitment demonstration to foster a healthy Vermont.

Section III—Continuing Demonstration Features and Changes Requested to the Demonstration

Vermont views the fourth renewal of the Global Commitment demonstration as an opportunity to strengthen existing demonstration features, while continuing to advance coverage, implement innovative care models, engage Vermonters in transforming their health, improve care coordination and population health capabilities, and accelerate groundbreaking payment reform. As described throughout this application, existing demonstration features have enabled the State to make progress toward achieving these goals. Over the next five years, Vermont intends to leverage the demonstration renewal to accelerate the State's progress along this trajectory.

Goal 1: Advancing Toward Population-Wide Comprehensive Coverage

Over the past 15 years, the Global Commitment demonstration has advanced comprehensive health coverage in Vermont. Prior to the ACA, the demonstration authorized coverage expansions for children, parents, and childless adults who would not otherwise have been

eligible for Medicaid. Today, Vermont has nearly universal coverage, with almost 97% of Vermonters insured as of 2018 according to the Vermont Household Insurance Survey.[9] The Global Commitment demonstration plays a key role in Vermonters' access to comprehensive, affordable coverage that allows them to lead healthy lives.

Continuing Features to Advance Toward Population-Wide Comprehensive Coverage

Under the demonstration renewal, Vermont intends to continue the coverage initiatives described below.

Continuing Features without Modifications

Presumptive Eligibility for Pregnant Women. The Global Commitment demonstration provides full Medicaid State Plan benefits to presumptively eligible pregnant women to support efforts to extend health care coverage to all Vermonters and engage pregnant women in whole-person care as soon as possible without waiting for a Medicaid eligibility determination.

Continuing Features with Modifications

Moderate Needs Expansion Group for CFC. Under the Global Commitment demonstration, Vermont provides a subset of HCBW-like services available through the CFC program (described in more detail below) to the Moderate Needs Group, comprised of over 1,100 Vermonters with disabilities at risk of requiring nursing home-level care, including over 160 Vermonters who are not otherwise eligible for Medicaid. By covering this expansion population, Vermont provides access to needed services in the community and removes the incentive for deterioration of health or income solely to meet prevailing Medicaid eligibility standards.

Individuals in the Moderate Needs Group may have income up to 300% of the Supplemental Security Income (SSI) Federal Benefit Rate (FBR). The demonstration allows for a resource standard of $10,000. Inclusion in this group does not make participants eligible for full State Plan benefits, nor for the full menu of CFC HCBW-like services. If Moderate Needs Group funds or capacity are not available at the time of application, Vermont may place individuals who are eligible for this group on a waiting list for services.

Currently, individuals meeting one of the following criteria are eligible for the Moderate Needs Group: (1) individuals who require supervision or any physical assistance three or more times in seven days with any single activity of daily living (ADL) or instrumental ADL; (2) individuals

[9] "Health Insurance Coverage of the Total Population." KFF, October 23, 2020. https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Uninsured%22%2C%22sort%22%3A%22asc%22%7D.

who have impaired judgment or decision-making skills who require general supervision on a daily basis; (3) individuals who require at least monthly monitoring for a chronic health condition; and (4) individuals whose health condition will worsen if services are not provided or if services are discontinued. The combination of the broad Moderate Needs Group clinical eligibility criteria and funding limited to annual appropriations has created an unsustainable waitlist system with over 700 applicants statewide. In the renewal period, Vermont seeks to revise the eligibility criteria to ensure that services are targeted to at-risk Vermonters with the most acute needs by:

- Removing criteria (3) and (4) above, and
- Adding a new criterion for eligibility as follows: "unique circumstances: health and welfare at imminent risk without services; health condition would worsen without services."

Community Rehabilitation and Treatment (CRT) Expansion Group. The Global Commitment demonstration provides a robust set of community-based mental health services (described in more detail later in this application) to over 600 individuals (as of February 2021) with incomes above Medicaid limits. CRT provides Vermonters with SMI access to community-based mental health care preemptively, preventing mental health deterioration to the point of requiring residential or inpatient psychiatric care, while also helping to prevent individuals from needing full Medicaid benefits in the future. As part of the demonstration renewal, Vermont is seeking to transition authority for the CRT expansion group from a designated state health program (DSHP) (for individuals with incomes from 133%-185% FPL) and investment (for individuals with incomes above 185% FPL) to expenditure authority under Section 1115(a)(2).

Marketplace Subsidies. To maximize access to affordable coverage, the Global Commitment demonstration provides premium assistance for low- and moderate-income Vermonters purchasing health insurance through the Marketplace. Vermonters purchasing a qualified health plan (QHP) who are (1) not Medicaid eligible; (2) eligible for the advanced premium tax credit; and (3) have incomes up to 300% FPL, are eligible to receive premium subsidies to reduce out-of-pocket medical expenses. More than 20,100 Vermonters currently receive Marketplace subsidies through the Global Commitment demonstration. Vermont is not requesting any programmatic changes to this demonstration feature; however, the State is seeking to transition authority for the subsidies from a DSHP to an expenditure authority under the demonstration. The State is monitoring its application of these Marketplace subsidies in the context of federal ACA subsidy enhancements enacted under the American Rescue Plan.

VPharm. VPharm assists Vermonters enrolled in Medicare Part D, including those over 65 and those with disabilities, with paying for prescription drugs, ensuring that cost is not a barrier to receipt of drugs and medication adherence. VPharm helps individuals pay their monthly Part D premiums, and lowers the co-pay that these individuals pay for many of their prescriptions.

VPharm currently provides pharmaceutical assistance to over 9,900 elderly and disabled Vermonters. To date, VPharm has provided the same pharmaceutical coverage as under the Medicaid State Plan to eligible individuals with incomes up to 150% FPL, and maintenance drug-only coverage for eligible individuals with incomes between 150% and 225% FPL. In the renewal period, Vermont seeks to extend Medicaid-equivalent pharmaceutical coverage to VPharm-eligible individuals at all income levels.

New Features to Advance Toward Population-Wide, Comprehensive Coverage

While Vermont has nearly universal coverage, the State has identified several gaps that limit Vermonters' ability to access appropriate preventive and treatment services, ultimately resulting in more costly care. Through the Global Commitment renewal, Vermont is seeking authority to implement several new coverage initiatives as described below.

1. Medicaid Coverage for Inmates 90 Days Prior to Release from Prison or Jail

Today, there is a gap in coverage for Vermonters who were previously incarcerated and released from Department of Corrections (DOC) facilities. To date, Vermont has taken several steps toward improving continuity of care for individuals exiting the correctional system, including establishing requirements for care coordination and transition of care activities, and referring inmates to primary care, specialty care (including mental health), and other community-based providers in the period prior to release. To build on these foundational efforts, Vermont is looking to be more ambitious in connecting the justice-involved population to coverage. In particular, Vermont is focused on the approximately 5,500 Vermonters who are released from a DOC facility each year.

Nationally, inmates have substantially higher rates of mental illness, addiction, and chronic health conditions, such as high blood pressure, asthma, and hepatitis, than the general population.[10] Vermont is no exception to this trend. Of Vermonters incarcerated in 2019, 33% had an opioid use disorder; 12% had hepatitis C; 11% had a respiratory or pulmonary condition, such as asthma; and 9% had hypertension. In addition, in 2021, 3.5% had a serious functional impairment.[11] With the range of complex health needs that the inmate population experiences, it

[10] Guyer, Jocelyn, Kinda Serafi, Deborah Bachrach, and Alixandra Gould. "State Strategies for Establishing Connections to Health Care for Justice-Involved Populations: The Central Role of Medicaid." Health Care for Justice-Involved Populations: Role of Medicaid | Commonwealth Fund, January 11, 2019. https://www.commonwealthfund.org/publications/issue-briefs/2019/jan/state-strategies-health-care-justice-involved-role-medicaid.

[11] These data are at a point in time. Vermont's DOC defines a serious functional impairment as: a) a substantial disorder of thought, mood, perception, orientation, or memory, any of as diagnosed by a qualified mental health professional, which grossly substantially impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, and which substantially impairs the ability to function within the correctional setting; or b) a developmental disability, traumatic brain injury (TBI) or other organic brain disorder, or various forms of

is imperative that they have established access to the treatment and supports they need prior to their release in order to re-enter the community safely and avoid recidivism. Research indicates that the first several weeks post-release are particularly crucial to justice-involved individuals' health and safety. For example, a small study in Vermont found that of the 109 Vermonters who died of a drug overdose in 2017, 17% had a history of incarceration in the three years prior to their death, and 58% of overdoses among individuals with a recent history of incarceration occurred within the first three months after release from DOC custody.[12]

To date, Vermont has leveraged Global Commitment investments to provide critical supports for justice-involved individuals transitioning to the community, including:

- **Transitional housing.** Currently, demonstration investments support six transitional housing programs that provide evidence-based treatment, therapeutic services, and case management to individuals upon their release from a DOC facility.[13] The transitional housing programs aim to address individuals' needs from a holistic perspective, addressing participants' social needs in addition to their health care. For example, the programs may provide vocational training and refer individuals to employment; offer training on money management; and connect individuals to housing.
- **Community rehabilitative care programs.** Global Commitment investments fund community rehabilitative care programs that provide case planning services targeted toward individuals who have been released from a DOC facility with a legal status of conditional reentry, pre-approved furlough, probation, and/or parole.

With the transition to a risk-bearing managed care model, Vermont intends to transition these initiatives to State Plan authority.

The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018 recognizes that transitions from correctional facilities to the community are high stakes and indicates that 1115 demonstrations are one tool available for promoting successful transitions. With the Global Commitment renewal, Vermont is committed to making further progress on improving transitions from correctional facilities to the community and is seeking to provide all Medicaid-eligible inmates with Medicaid coverage 90 days prior to release. These inmates would have access to the full set of Medicaid State Plan benefits. Given that there is often significant uncertainty around inmates' release dates, authority to provide 90 days of coverage will enable Vermont to assess inmates and connect them to

dementia or other neurological disorder as diagnosed by a qualified mental health professional, which substantially impairs the ability to function in the correctional setting.

[12] Vermont Department of Health. "Vermont Social Autopsy Report: 2017 Data Analysis" Vermont Department of Health. (p. 35, Rep.). https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAPSocialAutopsyReportAug2020.pdf.

[13] The investments do not cover room and board.

physical and mental health appointments in the community in the period immediately following release; ensure that treatment-in-progress is not interrupted; and ensure that medications can be filled prior to release and refilled in a timely manner thereafter. In addition, Vermont will connect inmates to care coordinators during this period, who will link them to community-based supports, such as permanent supportive housing or employment resources, necessary for a successful transition.

Vermont expects that at the end of the demonstration period, there will be lower rates of recidivism in the State. Additionally, Black Vermonters are disproportionately represented in the State's incarcerated population, and Vermont views this request as an important step toward promoting health equity as well as equity in its criminal justice system and health care delivery systems.[14]

2. SUD Community Intervention and Treatment Eligibility Group

Over the past several years, Vermont has had higher rates of SUDs and illicit drug use disorders than the national average.[15,16] In response, Vermont has employed a comprehensive, multifaceted strategy toward fighting the opioid epidemic and rising polysubstance use. The COVID-19 crisis has stymied these efforts, with substance use in the State substantially worsening over the past year. For example, in 2020, overdose deaths increased by 38% and emergency department (ED) visits for nonfatal overdoses increased by 47% as compared to 2019.

Medicaid has been critical to Vermont's efforts to address these concurrent crises, covering over 11,600 Vermonters with a SUD. Vermont offers a full continuum of benefits targeted toward Medicaid enrollees with a SUD, ranging from preventive services, such as administration of the Screening, Brief Intervention and Referral to Treatment tool, to residential and inpatient SUD services. However, not all Vermonters have access to these services; today, many commercial health insurance plans in Vermont and Medicare do not provide the SUD treatment services necessary for individuals to achieve recovery. AHS is working with commercial carriers to improve coverage of SUD services. For example, Vermont's Blueprint program (described in more detail later in this application) has been collaborating with BlueCross BlueShield of

[14] D'Amora, David, Jacqueline Salvi, Cassondra Warney, Ed Weckerly, and Ellen Whelan-Wuest. "Vermont Justice Reinvestment II Working Group Meeting." Legislature Vermont, January 22, 2020. https://legislature.vermont.gov/Documents/2020/WorkGroups/Senate%20Judiciary/Justice%20Reinvestment%20II/W~Ellen%20Whelan-Wuest~VT%20Justice%20Reinvestment%20II%20Working%20Group%20Meeting~1-22-2020.pdf.

[15] "State Level Data National Survey on Drug Use and Health 2017-2018." Vermont Department of Health, December 2019. https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP-NSDUH-Summary-2017-2018.pdf.

[16] For additional information, please see Vermont's 2018 application to waive the IMD exclusion for SUD treatment.

Vermont and MVP Health Care to design pilot payment models for Vermont's Hub and Spoke model for opioid treatment. Irrespective of these efforts, the State has identified a need to expand access to these services to Vermonters with a diagnosed SUD who are uninsured or underinsured and have incomes higher than Medicaid limits. With SUD benefits, these individuals will have the supports needed to achieve recovery, minimizing the likelihood that their addiction will intensify to the extent where they become eligible for full Medicaid benefits in the future.

With the Global Commitment demonstration renewal, Vermont is requesting the creation of a new eligibility group, called the SUD Community Intervention and Treatment group, for Vermonters with a SUD as defined by the DSM-5 who have incomes from 133% FPL up to and including 225% FPL. Individuals in this group will have access to SUD Community Intervention and Treatment benefits, as described in Table 2 below; these benefits are either covered today through Vermont's State Plan or will be added to the State Plan. The SUD Community Intervention and Treatment group will not be eligible to obtain full State Plan benefits. Vermont seeks to apply service and/or program level caps based on available funding levels for this eligibility group and to have the ability to create a waitlist if demand exceeds available funding. Enrollees will be limited to obtaining services from ADAP providers and will only be able to obtain services authorized through their treatment plan. For individuals who have other insurance coverage, Medicaid will be the payer of last resort for these services. Provision of SUD Community Intervention and Treatment benefits for this new eligibility group will be effective upon promulgation of necessary State policy.

Table 2. SUD Community Intervention and Treatment Benefits

SUD Community Intervention and Treatment Service	Description
Service Coordination	▪ Screening and/or assessment, case management, and care coordination to assist individuals and families in: o Planning, gaining access to, coordinating, and monitoring the provision of medical, social, educational, and other services and supports, including discharge planning; and o Advocacy, monitoring and support to assist them in making and assessing their own decisions
Flexible Support	▪ Day recovery/psychoeducation, including recovery education: group recovery activities in a milieu that promote wellness, empowerment, a sense of community, personal responsibility, self-esteem and hope; these activities are consumer-centered; they provide socialization, daily skills development, crisis support, and promotion of self-advocacy ▪ Family psychoeducation and support for families and significant

SUD Community Intervention and Treatment Service	Description
	others
Peer Specialists	▪ Peer specialists use lived experience to help individuals and their families understand and develop the skills to address their SUD and other health conditions; core functions include: o Providing recovery, health, and wellness supports o Supporting individuals in accessing community-based resources and navigating state and local systems o Providing employment supports, including educating individuals regarding services and benefits available to assist in transitioning into and staying in the workforce; and o Promoting empowerment and a sense of hope through self-advocacy
Skilled Therapy Services	▪ Services provided by or under the direction of licensed practitioners that include, but may not be limited to: o Clinical assessment o Individual, group, and family therapy or diagnosis-specific practices; and o Medication evaluation, management, and consultation with primary care and other medical providers
Residential Treatment	▪ Residential treatment: intensive SUD treatment, skill building, community reintegration and/or specialized assessment services to assist recovery and to support community living ▪ Recovery housing supports: SUD services and supports targeted to individuals in recovery residences with a focus on accessing community-based resources including housing and permanent supportive housing
Withdrawal Management	▪ Time-limited services and supports that assist individuals in resolving a severe SUD crisis safely in their community, including: o Screening for withdrawal management needs o Determination of appropriate placement for individuals intoxicated or experiencing withdrawal and in need of withdrawal management services o Medical evaluation and consultation o Individual and group therapies to enhance the individual's understanding of addiction and support the completion of

SUD Community Intervention and Treatment Service	Description
	the withdrawal management process; o Health education services, diversion programs, community crisis placements; and o Individual treatment planning and support in accessing ongoing community-based resources
Counseling	▪ Services directed toward the development and restoration of skills or the elimination of psychosocial barriers that impede the development or modification of skills necessary for independent functioning in the community

Goal 2: Implementing Innovative Care Models Across the Continuum That Produce Value

As a risk-bearing MCO, DVHA will assume responsibility for managing benefits across the full continuum of enrollees' health and health-related needs including those that relate to social factors that influence health. The Global Commitment demonstration authorizes benefits that give Vermonters expanded access to different settings and modalities of services across the care continuum. Many of these services are less costly alternatives to other types of care and are central to Vermont's efforts to address health disparities among Vermonters with disabilities. Today, adults in Vermont who have any disability are nearly seven times more likely to report fair or poor health compared to those who do not have a disability. Vermont provides access to a wide range of HCBW-like services so that, to the maximum extent possible, all State residents can choose community living, while accessing necessary supports to maintain and improve their health. With the demonstration renewal, Vermont is seeking to continue to strengthen its health ecosystem, offering a more comprehensive array of services to enrollees.

Continuing Features Supporting Innovative Care Models

With the waiver renewal, Vermont is seeking to retain authorization for the following programs that are critical to its efforts to improve access to and quality of care, including HCBW-like programs and other innovative benefits.

Continuing Features without Modifications

Enhanced Hospice Benefit. Under the Global Commitment demonstration, Vermont offers an enhanced hospice benefit to individuals with life-limiting illnesses. The hospice benefit allows

individuals with life expectancy of twelve months or less to access hospice care while still continuing curative therapies.

Palliative Care Program. The Palliative Care Program allows children who have been diagnosed with life-limiting illnesses to receive both curative services and palliative care services to ease pain and discomfort from the illness and/or treatment regimen. The program is available to Medicaid-enrolled children under age 21 with incomes up to 300% FPL who are at any stage of illness. Services available to children and their families through the Palliative Care Program include expressive therapy, care coordination, family/caregiver training, respite for caregivers, and family grief support/counseling.

Mental Health Under 22 for Individuals with SMI/SED. The Mental Health Under 22 for Individuals with SMI/SED (previously called Mental Illness Under 22) program enables children and adolescents with an SMI or SED to remain in their homes and communities while receiving the treatment they need to successfully manage their diagnoses. The program extends home and community-based treatment services to over 300 children and adolescents up to age 22 with a primary mental health or SED diagnosis who, in absence of the program, would require care in an inpatient psychiatric care facility. The program authorizes community mental health services such as coordination, flexible support, skilled therapy services, environmental safety devices, counseling, respite, supported employment, and crisis supports.

Continuing Features with Modifications

CFC. CFC plays a vital role in enabling consumer choice and promoting cost-effective, community-based services for individuals who meet nursing home level of care criteria. CFC provides low-income seniors and people with disabilities access to both HCBW-like services and nursing home care, allowing them to select from a range of service options and settings, including nursing facilities, enhanced residential care, personal care, homemaker service, companion care, case management, adult day services, and adult family care. CFC serves over 6,800 individuals, with 60% opting to receive care in a home or community-based setting. CFC enrollees are designated as being in the Highest Needs Group (nursing facility level of care), High Needs Group (nursing facility level of care), or Moderate Needs Group (at-risk for needing nursing facility level of care); individuals in the Highest and High Needs Groups have access to a more extensive HCBW-like benefit package than individuals in the Moderate Needs Group. Individuals in the Moderate Needs Group are not eligible for facility-based care. In the demonstration renewal period, Vermont seeks to add a “life skills aide” service to the CFC service array for members of the Highest Needs Group and High Needs Group to provide support in building individual skills, and thus enhance individual independence.

CRT. CRT provides recovery-oriented community mental health services for over 2,300 individuals with SMI as of February 2021, including service coordination, flexible support,

skilled therapy services, counseling, residential treatment, supported employment, environmental safety devices, and crisis and community supports. In the renewal period, Vermont seeks to add peer supports to the suite of services offered through CRT. Provision of peer supports will be effective upon promulgation of State policy necessary to effectuate this new benefit. In addition, Vermont intends to remove respite from the list of CRT benefits to reflect that the benefit is not in use today.

Developmental Disabilities Services. The Developmental Disabilities Services HCBW-like program supports individuals with developmental disabilities in making choices about how and where they live, allowing them to pursue their individual goals and preferences within their chosen communities. The demonstration authorizes a range of HCBW-like services, including service coordination, residential habilitation, day habilitation, supported employment, crisis services, clinical intervention, respite, and self-directed care. The Developmental Disabilities Services program currently provides HCBW-like services to over 3,200 individuals with developmental disabilities, and has helped 49% of enrolled Vermonters with developmental disabilities who are of working age gain employment. In the renewal period, Vermont seeks authority to reimburse parents of a minor child, spouses, and legal guardians providing personal care and personal care-like services to individuals enrolled in the Developmental Disabilities Services program. Payments to parents, spouses, and legal guardians providing these services will be effective upon promulgation of State policy necessary to effectuate this new benefit.

Brain Injury Program. The Brain Injury Program (previously called the Traumatic Brain Injury Program) provides an alternative to facility-based care by offering rehabilitation-focused services and supports to help individuals with a brain injury. It provides over 80 Vermonters who have brain injuries a range of home and community-based options oriented toward rehabilitation and recovery, such as crisis/support services, psychological and counseling supports, case management, habilitation, respite care, supported employment, environmental and assistive technology, and self-directed care. In the renewal period, Vermont is also seeking authority to provide reimbursement to parents of a minor child, legal guardians, and spouses providing life skills aide services and community supports (including shared living) to individuals enrolled in the Brain Injury Program. Payments to parents of a minor child, legal guardians, and spouses providing these services will be effective upon promulgation of State policy necessary to effectuate this new benefit.

Waivers of the Institution for Mental Diseases (IMD) Exclusion for Mental Health and SUD Treatment. Vermont's IMDs are a critical part of its mental health and SUD delivery system, offering residential and inpatient levels of care for Vermonters. Waivers of the IMD exclusion for mental health and SUD treatment support the State's ability to provide access to a full continuum of mental health and SUD services, ranging from prevention to community-based treatment to residential and inpatient treatment. Over the course of the current demonstration period, Vermont has met CMS's requirements that statewide average length of stay for mental

health and SUD treatment at IMDs be at or below 30 days. In the renewal period, Vermont anticipates continuing to meet this requirement and requests that CMS align requirements for the two waivers. Specifically, Vermont is requesting that CMS remove its prohibition on federal financial participation (FFP) for individuals obtaining mental health treatment in an IMD for longer than 60 days, as is permitted under Vermont's waiver of the IMD exclusion for SUD treatment. For certain complex patients, longer lengths of stay are medically necessary, and this flexibility is particularly critical to adequately treat Vermont's most severely compromised patients, who are highly acute, clinically complex, and require longer hospitalization. Notably, research indicates that the national direction of "ultrashort" hospital stays has resulted in patients who are discharged too early continuing to present with acute symptoms, resulting in higher readmission rates and higher emergency department utilization post discharge.[17] Vermont IMD data support this request; in Vermont's IMDs, the readmission rate for stays of 30 or more days is lower than shorter stays.[18] The State will continue to meet maintenance-of-effort requirements for spending on outpatient community-based mental health services as specified in its current demonstration.

In addition, during the demonstration renewal period, Vermont is seeking to apply the inpatient exception to the inmate exclusion to care provided at qualifying IMDs. Like any Vermonter, inmates may need medically necessary inpatient mental health or SUD treatment at an IMD. Vermont has two IMDs that operate as inpatient hospitals—the Vermont Psychiatric Care Hospital and the Brattleboro Retreat. Both facilities are held to the same requirements as acute care hospitals. They are licensed by the State of Vermont; maintain Medicare certification; are subject to unannounced regulatory visits; take part in Medicaid utilization review; and are accredited by the Joint Commission as facilities meeting the highest national standards for safety and quality of care. These standards reflect Vermont's commitment to ensuring that all of its hospitals, including IMDs, provide high-quality, patient-focused care, and that there is parity between physical health and mental health care. Inmates obtaining care in an IMD are treated identically to other Vermonters in that setting and are not segregated from other patients.

Under the inpatient exception to the inmate exclusion, states are able to obtain Medicaid reimbursement for Medicaid-eligible inmates when the inmate is admitted as an inpatient at a medical institution for a stay of at least 24 hours. Given that Vermont's IMDs are held to the same standards as acute care hospitals, Vermont believes that its IMDs qualify as medical

[17] Glick, Ira D, Steven S Sharfstein, and Harold I Schwartz. "Inpatient Psychiatric Care in the 21st Century: the Need for Reform." Psychiatric services (Washington, D.C.). U.S. National Library of Medicine, February 2011. https://pubmed.ncbi.nlm.nih.gov/21285100/.

[18] "Letter to: Director, Mary Mayhew." Vermont Global Commitment to Health Section 1115(a) Medicaid Demonstration 11-W-00194/1. State of Vermont, December 31, 2018. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/Global-Commitment-to-Health/vt-global-commitment-to-health-phase-down-plan-12312018.pdf.

institutions under federal rules, and as a result, inmates that are admitted to an IMD for a stay of at least 24 hours qualify for federal Medicaid matching funds.

New Features Supporting Innovative Care Models

While current Global Commitment initiatives have been vital to Vermont achieving expansive statewide access to care and strong health outcomes, Vermont has identified gaps in the continuum of services covered by the Medicaid program. Through the Global Commitment renewal, Vermont seeks to fill the gaps below to better address enrollees' whole-person needs, especially those related to mental health and SUD treatment, as well as social needs like housing.

1. Access to Family-Focused Residential Mental Health and SUD Treatment

Vermont is a national leader in access to and quality of mental health treatment. As noted earlier in this application, Mental Health America has named Vermont as the top state nationally for access to mental health care.[19] Vermont's Hub and Spoke system of care for opioid treatment is consistently cited as a model for other states to emulate. Vermont offers a full continuum of mental health and SUD services, ranging across prevention, community-based treatment, and residential and inpatient treatment services. The waivers of the IMD exclusion under the Global Commitment demonstration provide critical support for maintaining and strengthening Vermont's comprehensive service arrays for mental health and SUD treatment.

While the State endeavors for individuals to obtain community-based mental health and SUD treatment to the maximum extent possible, as referenced above, there are instances when residential or inpatient treatment is medically necessary. Vermont's IMDs provide high-quality residential and inpatient care, performing better than the State's Medicaid program as a whole and the national HEDIS benchmark on measures of the percentage of enrollees with follow-up after hospitalization for mental illness at the 7-day and 30-day mark.[20] In addition, Vermont's IMDs have lower 30- and 180-day readmission rates than psychiatric care provided in general settings (8% v. 9% 30-day readmission rate and 17% v. 20% readmission rate, respectively). Under the Global Commitment renewal, Vermont proposes to expand coverage for mental health and SUD care provided at family-focused residential treatment programs.

Vermont's Lund Home, an IMD with 26 beds, provides mental health and SUD treatment to pregnant women, postpartum women, and mothers with children up to age five in a setting that allows the family to stay and be treated together. Ninety-four percent of women who obtain

[19] "Access to Care Data 2021." Mental Health America, n.d. https://www.mhanational.org/issues/2021/mental-health-america-access-care-data.
[20] "Letter to: Director, Mary Mayhew." Vermont Global Commitment to Health Section 1115(a) Medicaid Demonstration 11-W-00194/1. State of Vermont, December 31, 2018. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/Global-Commitment-to-Health/vt-global-commitment-to-health-phase-down-plan-12312018.pdf.

services at Lund Home have co-occurring SUD and mental health diagnoses, and 52% were homeless at the time of admission to Lund Home.[21] All stays at the Lund Home last more than 60 days because of the holistic set of treatment services and wraparound supports provided to create stability for families during a time of transition. The facility provides a range of family-centered, trauma-informed treatment services, including:

- Screening and assessment
- Trauma and gender-informed individual counseling
- Women's-only group counseling addressing issues specific to parents in recovery
- Case management
- Family therapy
- MAT as a spoke in the Hub and Spoke model
- Children's developmental screening and assessment
- Life skills education
- Transition planning

Research shows that family-centered SUD treatment is associated with a range of benefits for both the parent and child, including stronger retention in treatment, reduced substance use, lower risk of child abuse, and improved psychosocial outcomes for both the parent and child.[22] In 2020, 77% of women discharged from Lund Home showed decreased frequency in substance misuse, and 81% showed improvement in life skills functioning at discharge. Further, Lund Home promoted healthy pregnancies among residents, with 91% of pregnant women in the Lund Home program having healthy pregnancies, and 100% abstaining from illicit substance use while pregnant.[23]

To support mothers in remaining with their children while obtaining treatment and to promote continuity of coverage, Vermont is seeking a limited exception to the IMD exclusion for women obtaining mental health and/or SUD treatment at the Lund Home. Under this exception, Vermont is requesting to obtain Medicaid reimbursement for Lund Home stays of greater than 60 days.

2. Permanent Supportive Housing Pilot

In the past 15 years of the Global Commitment demonstration, Vermont has made significant progress in allowing Medicaid enrollees to obtain care in their homes and communities if they so choose. To further support these individuals in securing and maintaining housing appropriate for their needs, Vermont is seeking expenditure authority for a Permanent Supportive Housing Pilot program. Studies conducted across the United States have shown that permanent supportive

[21] Lund Home. "Lund Home Residential Treatment Program Overview." 2021.
[22] "Implementing a Family-Centered Approach." National Center on Substance Abuse and Child Welfare. Accessed April 13, 2021. https://ncsacw.samhsa.gov/files/fca-practice-module-1.pdf.
[23] Lund Home. "Lund Home Residential Treatment Program Overview." 2021.

housing programs are effective not only in reducing homelessness, but also in preventing ED use and hospitalization, and reducing overall health care costs for high-need individuals.[24]

Improving access to permanent supportive housing is an important strategy for promoting equity and reducing racial disparities in homelessness in Vermont. In 2018, the Family Homelessness Point in Time report found that Black Vermonters were 5.4 times more likely to experience homelessness than white Vermonters.[25] While Vermont has access to supportive housing vouchers through the Department of Housing and Urban Development (HUD), the State has been unable to use all of the vouchers in recent years due to lack of available support services. In establishing the Permanent Supportive Housing Pilot, Vermont seeks to provide individuals with the services they need to successfully transition into and maintain residency in close coordination and collaboration with agencies that provide rental assistance.

Through the Pilot program, eligible individuals would have access to pre-tenancy supports, tenancy sustaining services, and community transition services, as described in more detail in Table 3 below. Vermont will select supportive housing service providers for this program through a procurement process and will ensure that selected providers are skilled in reaching groups that are disproportionately impacted by homelessness, such as Black Vermonters, and those meeting other health- and risk-based eligibility criteria outlined in Table 4.

Table 3. Permanent Supportive Housing Benefits

Permanent Supportive Housing Benefits	Illustrative Services Provided Under Benefit
Pre-tenancy supports	▪ Housing needs assessment ▪ Assistance with locating and applying for housing ▪ Housing support plan development
Tenancy sustaining services	▪ Assistance with maintaining benefits, such as TANF, Section 8 housing vouchers, Shelter Plus, or other rental assistance ▪ Connections to community resources ▪ Provision of supports to develop independent living skills ▪ Eviction prevention services ▪ Home modifications to improve accessibility ▪ Coverage of expenses associated with landlord risk mitigation

[24] "Evidence That Supportive Housing Works." Housing Tool Kit. The City of Santa Clara. Accessed April 13, 2021. https://housingtoolkit.sccgov.org/sites/g/files/exjcpb501/files/Evidence%20That%20Supportive%20Housing%20Works.pdf.
[25] "Data Snapshot: Racial Disparities and Homelessness." National Alliance to End Homelessness, July 16. 2021. https://endhomelessness.org/resource/data-snapshot-racial-disparities-in-homelessness/.

Permanent Supportive Housing Benefits	Illustrative Services Provided Under Benefit
Community transition services for all enrollees moving to permanent supportive housing, regardless of the setting they are moving from	▪ Security deposits ▪ Utility deposits ▪ Moving expenses ▪ Household furnishings ▪ Pest eradication

The Permanent Supportive Housing Pilot-eligible population will include Medicaid enrollees who are age 18 and older, eligible for full Medicaid State Plan benefits, and meet the following health needs-based and risk-based criteria, as described in Table 4.

Table 4. Permanent Supportive Housing Pilot Eligibility Criteria

Health-Based Criteria *Individual meets at least one of the following criteria*	**Risk-Based Criteria** *Individual meets at least one of the following criteria*
▪ Individual has a mental health or substance use need ▪ Individual has an acquired brain injury ▪ Individual assessed to have a need for assistance, demonstrated by the need for assistance with two or more ADLs; or hands-on assistance with one or more ADLs ▪ Individual assessed to have a complex physical health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support), resulting from the presence of a continuing, progressive, or indefinite physical condition, development or cognitive disability, or an emotional medical condition ▪ Individual assessed to have measurable delays in cognitive development and significant observable and measurable delays in at least two of the following	▪ At risk of homelessness, as defined according to the HUD Emergency Shelter Grants Program ▪ Homelessness ▪ History of frequent or lengthy stays in an institutional or residential setting over the past 12 months ▪ History of frequent ED visits and/or hospitalizations over the past 12 months ▪ History of involvement with the criminal justice system over the past 12 months ▪ History of frequent moves or loss of housing as a result of mental health or SUD symptoms ▪ At serious risk of institutionalization

Health-Based Criteria *Individual meets at least one of the following criteria*	Risk-Based Criteria *Individual meets at least one of the following criteria*
areas of adaptive behavior: communication, social/emotional development, motor development, daily living skills ▪ Individual has one or more Medicaid-eligible dependents that meet the health-needs criteria	

Individuals who are eligible for full State Plan benefits and are enrolled in one of Vermont's HCBW-like programs (CFC, CRT, Developmental Disabilities Services, Brain Injury Program, or Mental Health under 22 for SMI/SED) will be eligible for the Permanent Supportive Housing Pilot; however, these individuals cannot obtain any services or supports from the Permanent Supportive Housing Pilot that duplicate benefits already available to them. To manage resources under this Pilot, if demand exceeds resource availability, Vermont seeks to impose an enrollment cap, prioritization criteria, and waitlist for individuals seeking pilot services.

Goal 3: Engaging Vermonters in Transforming Their Health

Under the current Global Commitment demonstration, Vermont has authority to obtain a capped amount of federal Medicaid funding for a diverse set of investments in public health, health care, and health-related services that strengthen the social safety net to address social factors that influence health—all of which are core components of Vermont's health ecosystem. Through these investments, Vermont leverages Medicaid to provide a baseline level of health care and health care-related supports to all State residents, meaning that their current insurance coverage, payer, and benefit gaps are not barriers to accessing critical services. Vermonters have the tools they need to stay healthy, transform their health, and prevent worsening of any existing conditions that could jeopardize their functional status to the point where they become eligible for Medicaid on the basis of job loss or disability. These investments are targeted toward:

- Preventive health services and social supports (e.g., support for community clinics and federally-qualified health center (FQHC) lookalikes, early intervention services, and Special Supplemental Nutrition Program for Women, Infants and Children (WIC) coverage) that enable Vermonters, particularly Medicaid enrollees and other low-income residents, to stay healthy, age at home, and achieve their life goals;
- Optimizing access to essential health care services, such as mental health outpatient services and SUD treatment for all Vermonters, preventing crises or general worsening of

significant health conditions that could lead to job loss and/or a need for facility-based care; and
- Maintaining and improving public health infrastructure, including epidemiology, tobacco cessation initiatives, vaccination, and fluoride treatment.

New Features to Engaging Vermonters in Transforming Their Health

With the Global Commitment renewal, Vermont intends to take a two-pronged approach toward maintaining and improving the sustainability of these investments by: (1) incorporating investments into the risk-bearing managed care model and rate to the maximum extent possible; and, (2) covering certain population health investments that align with Medicaid objectives through expenditure authority under Section 1115(a)(2).

As part of the transition to a risk-bearing managed care framework, Vermont is reviewing its investments and identifying those that are provided to Medicaid enrollees that can be incorporated into the DVHA capitation rate either as State Plan benefits or pre-authorized in lieu of services. Savings generated under the DVHA capitation rate will be strategically invested in:

- **Value-added services** targeted toward the Medicaid population, including a subset of the current investments in addition to new, innovative care models; and
- **Population health initiatives that benefit all Vermonters**, including investments in population health infrastructure, services, and supports intended to reduce costs and improve quality of care across the care continuum.

These value-added services and other initiatives will be at risk in the event that DVHA exceeds its per-member per-month capitation rate. Over the course of the demonstration period, Vermont will monitor and evaluate the services funded through managed care savings so that it can continue to invest in and strengthen those that are most impactful in improving access, cost, and quality of care, while discontinuing funding for those that do not advance value outcomes. The State believes that the results of its demonstration will inform CMS and other states' investments in population health and SDOH interventions through both 1115 waiver demonstrations and state Medicaid managed care vendors. Given that Vermont views the investments as central to achieving population health and limiting growth in the Medicaid population and expenditures over time, DVHA will be incentivized to ensure optimal allocation of funding across health, health-related and population health programs and services in order to improve access, cost, and quality of care for the Medicaid population. Additionally, DVHA will have strong rationale to continue to innovate with provider payment models that induce providers to do the same. At the same time, the incentive to ensure sufficient savings to cover these investments will not outweigh the State's commitment to ensure that the Medicaid population has robust and appropriate access to quality care; AHS will monitor enrollees' access to the full array of Medicaid services and will continue to contract with an external quality review organization

(EQRO) to further monitor access. Indeed, Vermont has over a decade of experience in administering these types of investments, and has produced demonstration results that the State seeks to maintain and build on for all Vermonters—not undermine through underinvestment in the health of its people or the capacity of its providers.

Because moving these investments into the risk-bearing managed care framework will be a significant shift for DVHA and Vermont Medicaid providers, the State proposes gradually transitioning investments into the DVHA capitation rate over the five years of the demonstration period.

Vermont is also seeking to transition a subset of its current investments—workforce development investments, public health investments, and Blueprint investments—to being covered through expenditure authority under the demonstration. These investments reach nearly all Vermonters and have a significant impact on Vermonters' health and access to health care. For example:

- Almost half of all Vermonters are attributed to a Blueprint patient-centered medical home (PCMH).
- In 2017, Vermont's Physician and Dentist Loan Repayment Program made loan repayment grants to 60 nurses, 63 primary care physicians and 10 dentists, who in exchange committed to one or more years of service to an underserved area of the State.[26]
- In 2017, over 1,000 students took part in Vermont's health career awareness programs provided by Area Health Education Centers, including over 500 students from communities that have been economically/socially marginalized.
- In 2018, over 75% of one-year old children and 70% of two-year-old children were tested for blood lead through the lead poisoning prevention program.[27]
- Vermont's tobacco control program prevents 800 deaths each year through initiatives including the tobacco cessation hotline, online tobacco cessation program, and local secondhand smoke mitigation strategies.[28]

Maintaining Global Commitment funding for these initiatives is critical to providing the supports needed to optimize Medicaid enrollees' health, keeping their costs lower than they would be in the absence of this support. In addition, these initiatives promote broad access to preventive and treatment services that help prevent Vermonters who do not currently need Medicaid from needing Medicaid in the future. These investments will not be at risk under DVHA's per-

[26] Physician/Dentist loan repayment program. (n.d.). Retrieved April 14, 2021, from https://embed.resultsscorecard.com/Program/Embed/26557?navigationCount=1.
[27] Patient safety - adverse events. (n.d.). Retrieved April 14, 2021, from https://embed.resultsscorecard.com/Program/Embed/26558?navigationCount=1.
[28] Tobacco cessation community coalition. (n.d.). Retrieved April 14, 2021, from https://embed.resultsscorecard.com/Program/Embed/26574?navigationCount=1.

member per-month capitation rate. Specifically, Vermont is requesting expenditure authority for the following initiatives:

1. **Workforce development** initiatives funded through the Global Commitment demonstration help ensure that Vermont has sufficient access to care—a particular concern given the State's rural nature. These initiatives include loan repayment programs for health care professions, provision of geographically accessible nursing education, and educational partnerships.[29] Vermont seeks $4.75 million (total computable) over the five years of the demonstration to support workforce development initiatives.

2. **Public health infrastructure** supported under the Global Commitment demonstration has provided services critical to creating a healthy Vermont. Vermont's strong public health infrastructure provides Vermonters with services to prevent chronic and infectious diseases; treat and recover from acute and chronic conditions; and respond to crisis situations. These programs include:
    - Preventive services such as immunizations and fluoride treatment
    - Tobacco cessation program
    - Poison control and a lead poisoning prevention program
    - Epidemiology program; and
    - Laboratory testing

    The State requests expenditure authority to fund $38 million (total computable) in public health infrastructure over the five-year demonstration period.

3. **Select Blueprint infrastructure** described in detail under Goal 4.

Goal 4: Strengthening Care Coordination and Population Health Management Capabilities to Encompass the Full Spectrum of Health-Related Services and Supports

Vermont recognizes that strong care coordination, population health management, and health information exchange capabilities will be crucial to DVHA's success in: becoming a risk-bearing MCO; engaging providers in whole-person care models and alternative payment mechanisms; and preparing providers to implement more sophisticated models of care and VBP. In addition, strengthening these capabilities is critical to Vermont's efforts to promote health equity. Today, Vermonters of color are less likely than white Vermonters to have a usual primary care provider, and adults who are Native American/Alaska Native and multi-racial are more likely to report fair or poor general health when compared to other races and ethnicities. Over the life of the Global

[29] Area Health Education Centers Score Card. (2020). Retrieved April 14, 2021, from https://embed.resultsscorecard.com/Program/Embed/26554?navigationCount=1.

Commitment renewal, DVHA intends to build upon its already extensive capabilities in these areas to improve individual and population-level health outcomes. Vermont's priorities for the demonstration period are described below.

Continuing Features to Strengthen Care Coordination and Population Health

Continuing Features without Modification

Vermont has a strong care coordination infrastructure today, comprised of the State's Blueprint program, the All-Payer ACO Model, HCBW-like case management, the Vermont Chronic Care Initiative (VCCI), and targeted case management programs. Together, these initiatives help Medicaid enrollees navigate the full continuum of services available to them.

The Blueprint program—an established multi-payer delivery system reform engine that drives local health reform–touches most Vermonters and offers a suite of care coordination initiatives designed to promote integrated care. Key components of the Blueprint model include:[30]

- **PCMH program.** Today, 134 primary care practices in Vermont—nearly all primary care practices in the State—participate in Blueprint's multi-payer PCMH program.
- **Community Health Teams (CHTs).** Each of Vermont's 13 Health Service Areas has a CHT designed to meet the needs of the local population that is essential to delivering community-based care coordination to Vermonters, including, but not limited to those attributed to the All-Payer ACO, which is largely embedded at PCMHs and other provider sites. CHTs are typically comprised of care coordinators, nurses, social workers, health coaches, health counselors, licensed drug and alcohol counselors, nurses, dieticians, diabetes educators, community health workers, and resource coordinators who are trained to help Vermonters navigate the health ecosystem. CHTs are equipped to connect Vermonters to a wide range of services and supports to address their whole-person needs, including mental health and SUD services and other specialty care; wellness education; economic and community services; and public health programs.
- **Hub and Spoke System of Care.** Vermont's Hub and Spoke system of care is a nation-leading model for opioid use disorder treatment that is recognized by CMS as a Health Home program. In this model, nine opioid treatment programs across the State are "hubs," and 113 primary care practices, family medicine practices, OB-GYN practices, and other types of providers are "spokes" that offer MAT. Given that MAT services are co-located with physical health care settings, spokes provide fully integrated care that addresses the whole spectrum of patients' needs.

[30] "Annual Report on the Vermont Blueprint for Health." Vermont Agency of Human Services, January 31, 2021. http://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/BlueprintforHealthAnnualReportCY2020.pdf.

- **Women's Health Initiative (WHI).** At participating OB-GYN and family medicine practices, WHI provides enhanced services targeting whole-person health, including SDOH screening and access to family planning services.
- **Community Self-Management Program.** Blueprint provides workshops to help Vermonters learn skills to better manage chronic conditions.
- **Data and Analytics.** Analysis of multi-payer claims and clinical data support delivery reform and evaluation of quality and cost outcomes.

In addition, Vermont provides high-quality case management through its HCBW-like programs and operates VCCI, a complex case management program targeted to Medicaid members with complex care and social needs or high utilization. VCCI also provides screening and intervention for new Medicaid enrollees who have not yet been attributed to the All-PayerACO.

Finally, Vermont has strong care coordination and population health capabilities through the State's single All-Payer ACO. The ACO uses a four-quadrant care model for population health management, which segments the population based on health risk. For each "quadrant" of the population, the ACO implements programs tailored to the needs of the specific subpopulation. To support these care coordination activities and broader population health management, the ACO provides its network with a standardized care management platform and user training.

New Features to Strengthen Care Coordination and Population Health

1. Advancing Integration in Care Coordination

As part of its efforts to improve care for all Vermonters, Vermont is continuously working to strengthen Blueprint and other care coordination and case management programs in the State. During the Global Commitment renewal, Vermont is aiming to advance integration of care across physical health, mental health, SUD, LTSS (including HCBW-like programs), human services, and SDOH. With improved integration, providers and care coordinators will be better able to understand the full scope of an enrollee's whole-person needs, ensuring that care is tailored to the individual. Concurrently, Vermonters will benefit from their care coordinator having a more holistic view of their needs and as a result, will be more engaged in managing their health and achieving wellness goals. On a population level, Vermont believes tighter integration of care will lead to improved health outcomes, helping the State achieve success under a risk-bearing managed care model.

While Vermont currently offers a variety of high-quality care coordination models, there are differences across models and regions of the State. Vermont has determined that there are opportunities to advance integration through greater alignment across the State in addition to across programs offering care coordination through Medicaid, the All-Payer ACO, and other payers. Over the course of the Global Commitment renewal, Vermont plans to align statewide

expectations for care coordination to ensure that all Vermonters equally benefit from efforts to promote integration. Specific areas where greater alignment is planned include:

- **Components of integrated care coordination,** including a more standardized set of activities that individuals accessing care coordination can obtain regardless of program or care coordination entity (e.g., regular care team meetings, closed loop referrals to health and social services across Vermont's health ecosystem).
- **Composition of care teams** so that a baseline set of expertise and supports are available to Vermonters statewide. Vermont will continue to allow for some flexibility in care team composition based on patient need and regional resources.
- **Processes for care coordination assignments** that match enrollees to care coordinators at organizations that can best meet their needs while also empowering enrollees to choose their preferred lead care coordinator during the outreach and engagement process and as preferences or needs change. For example, ideally, an enrollee with SMI would initially be assigned to care coordination at a designated agency (Vermont's community-based mental health agencies), while an enrollee with comorbid diabetes and hypertension would be initially assigned to care coordination at a PCMH.

The State is also considering whether there are additional opportunities to further align Blueprint programs and HCBW-like case management to bridge siloes across enrollees' needs. The State believes that the changes outlined above do not necessitate new waiver authority with one exception. Vermont is seeking expenditure authority for $15 million (total computable) over the five-year demonstration to fund a network of three types of staff who supervise and support the following Blueprint initiatives: (1) program managers, who monitor practices' participation as a PCMH, integration with the local CHT, and implementation of Vermont's care coordination models; (2) quality improvement (QI) facilitators, who assist PCMHs in identifying and implementing QI projects; and (3) self-management regional coordinators who administer self-management programming in each of the Health Service Areas.

Concurrently, Vermont is continuing discussions with CMS on conflict-free case management requirements for its HCBW-like populations. Moving forward, Vermont anticipates that its HCBW-like programs for individuals with developmental or physical disabilities and older adults will permit enrolled individuals to choose whether their case manager is independent from their service provider. However, pending the outcome of conversations with CMS, Vermont may seek flexibility in case management delivery models.

2. Strengthen Providers' Ability to Participate in Health Information Exchange, Advancing Population Health

Recognizing that data exchange is crucial to providing integrated care and conducting effective population health management, in recent years Vermont has prioritized expanding health information exchange (HIE) capacity within the State. As of 2020, 568 providers were sharing

and receiving data through the Vermont Health Information Exchange (VHIE). Simultaneously, Vermont is also significantly expanding the amount of data available through the VHIE, and as of December 2020, over 98% of Vermonters consented to sharing their health data via the VHIE.

In the demonstration renewal period, Vermont seeks to enhance HIE capabilities across the State to support strong care coordination and effective population health management, which will both improve care for enrollees and help DVHA effectively manage costs as a risk-bearing MCO. Further, by increasing access to high-quality data across the whole spectrum of individuals' needs, Vermont will enable the full range of providers, including specialty providers and social service organizations, to have the information they need to successfully participate in more advanced VBP arrangements as the State considers moving toward incorporating all services into a total cost of care model. As part of this assessment, Vermont will seek to determine potential inequities in HIE capacity and resources among providers, including providers that have been historically under-resourced or that disproportionately serve populations experiencing health disparities, such as providers and community based organizations where at least 51% of the business is owned by one or more persons who are members of groups that have been economically or socially marginalized due to race, ethnicity, LGBTQ status, disability, or other factors.

Under the Global Commitment renewal, Vermont seeks expenditure authority to pursue the following initiatives that will enable the State to reach its goals:

1. **Evaluate gaps in data storage, utilization, and sharing**. Vermont will evaluate how Medicaid providers currently store, access, utilize, and share information about the full range of enrollee needs and associated service utilization. Based on the findings, Vermont will determine how to close gaps that are identified. In particular, Vermont seeks to learn how both medical and specialty providers—including mental health, SUD, and LTSS providers—access and share demographic, eligibility, assessment, care plan, and treatment data to better understand readiness of targeted providers to participate in VBP reforms or transition to higher levels or more integrated VBP arrangements. Vermont seeks expenditure authority for $500,000 total computable over the five-year demonstration period to implement this initiative.

2. **Reduce inequities in data access and sharing capabilities to allow a cross-sector of providers to participate in VBP reforms**. After evaluating data collection and exchange needs, Vermont will provide funding to assist providers, including historically under-resourced providers, in purchasing data systems, including electronic health records (EHRs) and care coordination tools, and connecting to the VHIE. Concurrently, the State will develop a targeted technical assistance program to provide support for Medicaid providers seeking to access, utilize, and share data to support integrated care coordination and population health management. Vermont anticipates that by enhancing providers'

abilities to capture data and use it meaningfully in care coordination and population health management, providers will be better prepared to participate in more sophisticated VBP arrangements. Technical assistance will address:

- Efforts to capture SDOH data and communication with and referrals to social service providers and state and local human services agencies that have historically not been connected to health data and health systems;
- Medicaid providers' selection, procurement, and modification of care coordination and EHR data systems to meet care coordination, quality improvement, and reporting needs, and help providers connect to the VHIE; and
- Efforts to standardize data collection to improve efficiency of data collection processes.

Vermont seeks expenditure authority for $15 million total computable over the five-year demonstration renewal to purchase the technology and provide the technical assistance required to implement this initiative.

3. **Leverage health data to enhance population health management and program improvement**. Vermont will develop a series of analytic reports and tools using data from the VHIE and other sources to improve management of individuals with high utilization across the care continuum, support program monitoring, and analyze impacts of service or program changes. Other efforts to improve care coordination, program operations, and analytics will include:
    - Developing reports to support effective risk stratification across the Medicaid population, which will supplement risk stratification reports from the ACO by focusing on a broader set of services;
    - Aligning measures and reporting requirements across programs to reduce reporting burden and encourage provider participation in quality improvement and VBP arrangements;
    - Using electronic clinical quality measure (eCQM) data to optimize providers' ability to assess quality and outcomes;
    - Implementing a reporting and analytics platform to standardize and extract reports, for both patient- and population-level measures, through an application programming interface (API) connected to the VHIE;
    - Leveraging patient and aggregated population-level data to support rapid sharing of disease surveillance data, inform and monitor public health activities, and improve quality of life; and
    - Expanding use of new reporting and analytic technologies to harness the power of integrated data for improving outcomes, reducing cost, and enabling informed decision making.

Vermont seeks expenditure authority for $1.5 million total computable over the five-year demonstration renewal to implement this initiative.

4. **Use an electronic patient engagement platform to close health data gaps, support chronic disease prevention and management, and enable person-centric optimized care.** Vermont will assess the feasibility of embedding a patient engagement platform into the State's delivery system. If determined to be feasible, Vermont will procure a tool to enhance care delivery and patient engagement with optimized health data, including care plan information with details on services across the care continuum that the enrollee has obtained. Medicaid enrollees will be able to add to their care records by entering information or linking to health monitoring, self-management, or wellness applications; this data will then be linked with their EHRs and Medicaid care coordination tools. Integrating this person-centered data into health records will allow Vermont to improve enrollee access to care; avoid high-cost care episodes; reroute in-network referrals; increase patient satisfaction; improve adherence to treatment plans; and help Vermonters achieve their health and wellness goals. Vermont seeks expenditure authority for $5 million total computable over the five-year demonstration to implement this initiative.

Goal 5: Accelerating Groundbreaking Payment Reform

Continuing Features to Accelerate Groundbreaking Payment Reform

As DVHA assumes risk for all Medicaid populations and services, Vermont will accelerate its payment reform efforts with providers and care teams. While Vermont's All-Payer ACO Model Agreement has transformed the way that physical health care is delivered and paid for in Vermont, some of the costliest Medicaid services, including mental health, SUD, and LTSS, as well as developmental disabilities services, are currently excluded from this model. The State seeks to address this issue through the demonstration renewal, and has already taken significant steps that lay the groundwork for transitioning toward VBP arrangements for these services through the payment reform initiatives in the following areas:

- Child and Adult Mental Health
- Applied Behavioral Analysis
- Children's Integrated Services
- Residential Substance Use Disorder Treatment
- Developmental Disabilities Services
- High-Technology Nursing

Reflecting the varying degrees of readiness among different provider types to participate in VBP arrangements, these initiatives are at varying levels of sophistication, spanning HCP-LAN Categories 1 through 3 and ranging from monthly prospective or retrospective case rates to

episodic payments, with some initiatives incorporating pay-for-reporting and/or pay-for-performance incentives. Vermont's existing Global Commitment demonstration flexibilities, including the ability to set provider rates on an individual or class basis that departs from State Plan rates, have facilitated the success of these models thus far and will continue to be necessary to advance payment innovation. To support its future vision for payment reform, Vermont is seeking to retain this flexibility as part of its demonstration renewal, while continuing to comply with requirements for states' payments to managed care plans under 42 CFR 438.6(c).

New Features to Accelerate Groundbreaking Payment Reform

During the demonstration renewal period, Vermont will continue refining the mental health, SUD, and developmental disabilities payment models referenced above and will test multiple new models of risk. For example, Vermont is evaluating demonstrating new payment initiatives for SUD outpatient services, children's palliative care, and school-based mental health services. Ultimately, the targeted payment reform initiatives that the State tests under the demonstration renewal will guide DVHA's strategy for transitioning additional populations and services to HCP-LAN Category 4 arrangements. While Vermont does not require additional waiver authorities to implement these arrangements in the renewal period, the authority to operate as a risk-bearing MCO is essential to the State meeting this goal. The flexibility of the risk-bearing MCO model will enable DVHA to institute new and enhanced provider payment models and requirements that incentivize referrals to health and health-related services (including in lieu of and value-added services) that improve population health and address SDOH for all Vermonters. In the longer run, DVHA will consider a transition to a total cost of care model for these services and populations (mental health, SUD, developmental disability, and LTSS).

In addition, Vermont believes strongly that there is an opportunity to further align payment reform across Medicaid and Medicare—particularly for the dual eligible population, which is currently attributed to Medicare for the All-Payer ACO Model. The State is interested in exploring with CMS how to further advance solutions to the "wrong pocket problem" and account for shared savings across Medicare and Medicaid that could accrue from improved coordination across the two programs. Finally, based on its success in achieving its demonstration goals, Vermont believes its risk-bearing model could be extended to Medicare-covered Vermonters. The State would welcome the opportunity to explore and implement these ideas in partnership with CMS over the course of its demonstration.

Other Demonstration Features

Eligibility and Benefits

Vermont's entire Medicaid population—including both State Plan and expansion groups—falls under the purview of the Global Commitment demonstration. Table 5 below outlines the eligibility groups that will be included in the Global Commitment demonstration renewal, along with the benefits that will be covered for each group.

Table 5. Global Commitment Demonstration Populations

Population	Population Description	Benefits	Proposed Changes for New Demonstration Period
Mandatory and Optional State Plan Groups[31]			
1. Mandatory State Plan Populations	Mandatory State Plan populations, except for the ACA new adult group (included in Population 3) and Medicare Savings Program beneficiaries (included in Population 8).	State Plan benefits	State intends to cover a number of new benefits under the State Plan, including a subset of investments authorized under the current demonstration, as described in this application.

[31] Inmates who are within 90 days of release will receive the benefit package associated with their eligibility group.

Population	Population Description	Benefits	Proposed Changes for New Demonstration Period
2. Optional State Plan Populations	Optional State Plan populations (including medically needy).	State Plan benefits	None
3. New Adult Group	New adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119, pursuant to the approved State Plan.	Benefits described in approved alternative benefit plan (ABP) State Plan Amendment (SPA)	State will update its ABP SPA to align with changes to the State Plan.
Demonstration Expansion Populations			
4. CFC Highest Needs Population	Individuals age 65 and older and age 18 and older with disabilities, not otherwise eligible under the State Plan, who meet the clinical criteria for the Highest Needs Group for CFC, and who would have been Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR §435.217, in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under the demonstration would have been provided under an HCBS waiver granted to the State under section 1915(c) of the Act. This includes the application of the post-eligibility rules specified at 42 CFR §435.726, and of the spousal impoverishment	State Plan benefits plus HCBS covered for the CFC Highest Needs Group as described in the current demonstration STCs	State proposes minor changes to the CFC benefit package as described on page 21-22.

Population	Population Description	Benefits	Proposed Changes for New Demonstration Period
	rules specified at 1924 of the Act. This demonstration allows for a resource standard of $10,000 for an unmarried individual who resides in and has an ownership interest in their principal place of residence.		
5. CFC High Needs Population	Individuals age 65 and older and age 18 and older with disabilities, not otherwise eligible under the State Plan, who meet the clinical criteria for the High Need Group for CFC, and who would have been Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR §435.217, in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under the demonstration would have been provided under an HCBS waiver granted to the State under section 1915(c) of the Act. This includes the application of the post-eligibility rules specified at 42 CFR 435.726, and of the spousal impoverishment rules specified at 1924 of the Act. This demonstration also allows for a resource standard of $10,000 for an unmarried individual who resides in and	State Plan benefits plus HCBS covered for the CFC High Needs Group as described in the current demonstration STCs	State proposes minor changes to the CFC benefit package as described on pages 21-22.

Population	Population Description	Benefits	Proposed Changes for New Demonstration Period
	has an ownership interest in their principal place of residence.		
6. CFC Moderate Needs Expansion Group	Individuals who have incomes below 300% SSI FBR and would be described in Populations 4 or 5 except that they meet the clinical criteria for the CFC Moderate Needs Group and are at risk of institutionalization.	Limited HCBS including adult day services, case management, and homemaker services	State proposes minor changes to eligibility criteria described on page 13.
7. CRT Expansion Group	Individuals with SMI who have incomes above 133% FPL.	Limited community mental health services, including service coordination, flexible support, skilled therapy services, counseling, residential treatment, supported employment, environmental safety devices, and crisis and community supports.	State proposes covering CRT expansion group through expenditure authority instead of as a DSHP and investment; no eligibility changes are proposed. State also proposes minor changes to CRT benefit package as described on page 22.
8. VPharm Group	Medicare beneficiaries who are 65 years or older or have a disability with income at or below 225% FPL, who may be enrolled in the	Medicaid prescriptions, eyeglasses and related eye exams; MSP beneficiaries	State proposes to expand benefits available to Medicare

Population	Population Description	Benefits	Proposed Changes for New Demonstration Period
	Medicare Savings Program (MSP) but are not otherwise categorically eligible for full benefits.	also receive benefits as described in the State Plan	beneficiaries with incomes from 150% to 225% FPL as described on page 14-15.
9. SUD Community Intervention and Treatment Expansion Group	Individuals with a SUD as defined by the DSM-5 who have incomes from 133% FPL up to and including 225% FPL.	SUD Community Intervention and Treatment benefits as described in Table 2	New eligibility group

Premiums and Cost Sharing

Vermont is proposing to retain premiums and cost sharing authorized through the current Global Commitment demonstration, as described below. All other cost sharing aligns with Vermont's State Plan.

Mandatory State Plan Populations, Optional State Plan Populations, and the New Adult Group (Populations 1, 2, and 3)
Vermont may charge Populations 1, 2, and 3 premiums and cost sharing in compliance with Medicaid requirements set forth in statute, regulation, and policy and Vermont's Medicaid State Plan. Standard Medicaid exemptions from cost-sharing set forth in 42 CFR 447(b) will apply to the demonstration; Vermont will not apply co-payment requirements to children under 21, pregnant women, or individuals in long-term care facilities, or for excluded services/supplies (e.g., family planning). Premiums for children ages 0 through 18 who fall into the mandatory State Plan population (Population 1) will be as follows:

Table 6. Premiums for Children Ages 0 to 18 in Population 1

Group	Premiums
Children with incomes >195% through 237% FPL	$15/month/family
Underinsured children with incomes >237% through 312% FPL	$20/month/family
Uninsured children with incomes >237% through 312% FPL	$60/month/family

VPharm Group (Population 8)
Premiums and co-payments for the VPharm group are outlined in the table below.

Table 7. VPharm Premiums and Co-Payments

Population	Premiums	Co-Payments
Medicare beneficiaries with income up to and including 225% FPL, who may be enrolled in the MSP but are not otherwise categorically eligible for full benefits.	Premiums cannot exceed the following: ▪ 0-150% FPL: $15/month/person ▪ 151-175% FPL: $20/month/person ▪ 176-225% FPL: $50/month/person	Not to exceed the nominal co-payments specified in the Medicaid State Plan.

Delivery System

As described earlier in this application, Vermont's proposed transition of DVHA, its Medicaid delivery system, from being considered a non-risk-bearing PIHP to a risk-bearing MCO is at the core of Vermont's vision and goals for the Global Commitment demonstration renewal. As a risk bearing managed care plan, DVHA will be subject to the same regulations and protections that other states' risk-bearing Medicaid managed care plans are under 42 CFR 438. With this framework, Vermont's AHS will pay DVHA a capitated per-member per-month rate for all Medicaid enrollees that is set according to federal Medicaid managed care rate-setting rules. The capitation rate will include all Medicaid services, including high-cost services such as pharmacy, plus administration and profit sufficient to cover the cost of DVHA plan administration and the transition of Vermont's investments to managed care value-added services, as described in more detail below. DVHA will be responsible for managing costs within that capitation rate. As a risk-bearing MCO, DVHA will have access to all risk-sharing strategies permitted under 42 CFR 438, such as stop-loss limits and risk corridors.

Over the life of the demonstration period, DVHA intends to transition many of its investments authorized under the current Global Commitment demonstration to being covered as medical services (including in lieu of services), care management, quality improvement initiatives, and value-added services/population health initiatives through the administrative load and profit margin under the DVHA capitation rate. Given the administrative complexity associated with this task, Vermont anticipates that it will take several years to make this transition, but anticipates completing it by the end of Year 5 of the renewal period. Accordingly, contingent on CMS approval of the IMD-related requests described earlier in this application, Vermont proposes phasing down authorization of its current investments by the end of the demonstration renewal period.

As noted above, similar to other states' Medicaid managed care programs, DVHA will have the ability to use plan profits to pay for value-added services and other health-related services that will address the needs of all Vermonters, including those who are not enrolled in Medicaid. Vermont is seeking to use this profit to cover investments that cannot be covered as medical services, care management, or quality improvement initiatives. Funding for these investments will be at risk if DVHA fails to manage the Medicaid population within the capitation rate. Vermont anticipates that as an MCO, DVHA's rate will conform with demonstration STCs and actuarially sound rate setting, including regulatory requirements and industry norms with respect to medical-loss ratio, administrative load, and profit margin.

Section IV - Requested Waivers and Expenditure Authorities

Table 8. Requested Waiver and Expenditure Authorities

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
Waiver Authorities			
1. Statewideness: Section 1902(a)(1)	To allow the State to operate the program differently in different geographical areas of the State.	Currently approved	✓
2. Reasonable Promptness: Section 1902(a)(8)	To allow the State to maintain a waiting list for individuals applying for HCBW-like services through the CFC High Needs and Moderate Needs Groups. To allow the State to require applicants for nursing facility and HCBS (including HCBW-like services) to complete a person-centered assessment and options counseling process prior to receiving such services. To permit waiting lists for eligibility for demonstration-only (non-Medicaid State Plan) populations.	State requests that waiver permitting waiting lists for demonstration-only populations extend to the SUD Community Intervention and Treatment Eligibility group	✓
3. Amount, Duration, and Scope of	To enable Vermont to vary the amount, duration, and scope of services offered to various mandatory and optional groups of individuals affected by or eligible	Currently approved	✓

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
Services: Section 1902(a)(10)(B)	under the demonstration as long as the amount, duration, and scope of covered services meets the minimum requirements under title XIX of the Act for the group (if applicable). To allow the State to provide nursing facility services and HCBS based on relative need as part of the person-centered and options counseling process for new applications for CFC services; to permit certain individuals, based on need, to receive demonstration services in the same eligibility group, under the Medicaid State Plan, and to limit the amount, duration, and scope of services to those including in the participants' approved care plan.		
4. Financial Eligibility: Section 1902(a)(10)(C)(i)(III)	To allow the State to use institutional income rules (up to 300% SSI FBR) for HCBW-like programs besides CRT. To allow the State to use institutional income and resource rules for the Highest Need and High Need groups in the same manner as it did for the terminated	Modified waiver language to clarify that institutional income rules are used for determining eligibility for HCBW-like	✓

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
	1915(c) waiver programs that were subsumed under the CFC demonstration in 2005. To permit the State to have a resource standard of $10,000 for Highest Need and High Need individuals who are single and own and reside in their own homes and who select HCBS in lieu of institutional services.	programs besides CRT for both categorically and medically needy beneficiaries	
5. Payment to Providers: Sections 1902(a)(13), 1902(a)(30)	To allow the State, through DVHA, to establish rates with providers on an individual or class basis without regard to the rates currently set forth in the approved State Plan.	Currently approved	✓
6. Premium Requirements: Section 1902(a)(14) In so far as it incorporates Section 1916	To permit Vermont to impose premiums in excess of statutory limits for optional populations and for children through age 18 with income above 195% FPL.	Currently approved	✓
7. Income/Resource Comparability: Section 1902(a)(17)	To the extent necessary to enable the State to use varying income and resource standards and methods for plan groups and individuals.	Currently approved	✓

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
8. Spend-Down: Section 1902(a)(17)	To enable the State to offer one-month spend-downs for medically needy people receiving community-based services as an alternative to institutionalization, and non-institutionalized persons who are receiving personal care attendant services at the onset of waivers.	Currently approved	✓
9. Financial Responsibility/ Deeming: Section 1902(a)(17)(D)	To the extent necessary to exempt the State from the limits under section 1902(a)(17)(D) on whose income and resources may be used to determine eligibility unless actually made available, and so that family income and resources may be used instead. To enable the State to disregard quarterly income totaling less than $20 from the post-eligibility income determination.	Currently approved	✓
10. Freedom of Choice: Section 1902(a)(23)(A)	To enable the State to restrict freedom of choice of provider for the demonstration participants to the extent that beneficiaries will be restricted to providers enrolled in a provider network through DVHA for the type of service at issue, but may change providers among those enrolled providers. Freedom of choice of provider may not be restricted for family planning providers. This	Currently approved.	✓

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
	waiver allows Vermont to restrict choice of provider in situations where the State requires an individual to receive services through a designated provider. The individual may receive services from any willing provider within that designated provider network.		
11. Direct Payments for Providers: Section 1902(a)(32)	To permit payments for incidental purchases for CFC HCBS to be made directly to beneficiaries or their representatives.	Currently approved.	✓
Expenditure Authorities			
1. Expenditures Related to Eligibility Expansion	Expenditures to provide Medical Assistance coverage, either in the form of payment for medical services under the State Plan as affected by the waivers and expenditure authorities under this Demonstration, or in the form of premium assistance, to the Demonstration expansion populations listed in Section III of this document, that are not covered under the Medicaid State Plan and are enrolled in the Vermont Global Commitment to Health Demonstration. This authority applies to Demonstration Populations 4, 5, 6, 7, 8, and 9.	State requests to modify request to include SUD Community Intervention and Treatment Expansion Group (Population 9)	✓ (for CFC Highest Needs Population (Population 4), CFC High Needs Population (Population 5), CFC Moderate Needs Group (Population 6), CRT Expansion Group (Population 7),

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
			VPharm Group (Population 8)
2. Expenditures Related to Additional Services for HCBW-Like Programs	Expenditures for additional health care related-services (i.e., HCBW-like services) for all populations affected by or eligible through the demonstration as described in STC 20(c) in the currently approved Global Commitment demonstration.	Currently approved	✓
3. Expenditures for Public Health Initiatives, Outreach, Infrastructure, and Services Related to State Plan, Demonstration, Uninsured and Underinsured Populations	Expenditures to reduce the rate of uninsured and/or underinsured in Vermont, increase access to quality health care for uninsured, underinsured, and Medicaid beneficiaries, provide public health approaches and other innovative programs to improve the health outcomes and quality of life for Medicaid beneficiaries; and encourage the formation and maintenance of public private partnerships in health care; use of this expenditure authority will phase down over the five years of the demonstration.	State proposes that authority will phase down over five years of demonstration	
4. Expenditures for Hospice Services	Expenditures for adults eligible under the approved State Plan for hospice services that exceed State Plan limits.	Currently approved	✓

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
that Exceed State Plan Limits			
5. Expenditures for the Marketplace Subsidy Program	Expenditures for state-funded subsidy programs that aid certain individuals who purchase health insurance through the Marketplace.	Currently approved	✓
6. Expenditures for Mental Health CRT	Expenditures for mental health CRT services, as defined by Vermont rule and policy, to individuals with serious mental illness.	State proposes to modify request to reflect CRT transitioning to an expenditure authority	✓
7. Expenditures for SUD Community Intervention and Treatment	Expenditures for SUD Community Intervention and Treatment services, as defined by Vermont rule and policy, to individuals with SUD who have incomes above 133% FPL.	New request	
8. HCBW-like Services for State Plan Eligibles Who Meet Highest Need, High Need, or Moderate	Expenditures for HCBW-like services for State Plan eligibles who meet all State Plan eligibility requirements, who have the indicated level of clinical need for HCBW-like services for the CFC program. The Moderate Needs Group does not meet all the CFC clinical criteria for	Currently approved	✓

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
Need Clinical Criteria for CFC	long-term services, but are at risk of institutionalization. These individuals demonstrate a clinical need that shows they would benefit from a subset of HCBW-like services.		
9. Other HCBW-Like Expenditures	a. Expenditures for CFC participants with resources exceeding current limits, who are single, own and reside in their own homes, and select home-based care rather than nursing facility care, to allow them to retain resources to remain in the community; b. Expenditures for personal care services provided by HCBW-like participants' parents (when participants are minor children), spouses, and legal guardians; and c. Expenditures for incidental purchases paid in cash allowances to participants who are self-directing their CFC services prior to service delivery.	State requests to modify (b), expenditures for personal care services, to incorporate other HCBW-like programs beyond CFC	✓
10. Children's Personal Care Expenditures	Expenditures for State Plan children's personal care services provided by participants' parents and legal guardians.	Currently approved for COVID-19 public health emergency (PHE); State is seeking to	

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
		extend authority beyond PHE	
11. Full Medicaid Benefits for Presumptively Eligible Pregnant Women	Expenditures to provide full Medicaid State Plan benefits to presumptively eligible pregnant women.	Currently approved	✓
12. Residential and Inpatient Treatment for Individuals with Substance Use Disorder	Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an IMD. Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are residents of family-focused residential treatment programs that meet the definition of an IMD, regardless of length of stay.	State requests waiver to reflect that stays at family-focused residential treatment programs will be covered, regardless of length of stay	
13. Residential and Inpatient Treatment	Expenditures for Medicaid State Plan services furnished to eligible individuals who are primarily receiving short-	State requests waiver to reflect that	

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
for Individuals with Serious Mental Illness	term treatment for an SMI in facilities that meet the definition of an IMD. Expenditures for Medicaid State Plan services furnished to eligible individuals who are primarily receiving treatment for an SMI in facilities providing family-focused residential treatment that meet the definition of an IMD, regardless of length of stay.	stays at family-focused residential treatment programs will be covered, regardless of length of stay	
14. Retroactive Eligibility	To enable the State to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance is made for expansion groups (for Populations 6 and 8 only).	Currently approved	✓
15. Permanent Supportive Housing Pilot	Expenditures for permanent supportive housing services provided to enrollees in the State's Pilot program. The State will institute annual enrollment limits for this Pilot and will maintain a waiting list.	New request	
16. Coverage for Inmates Pre-Release	Expenditures for Medicaid services rendered to incarcerated enrollees in the 90 days pre-release from a correctional facility.	New request	

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
17. Health Information Exchange Activities	Expenditures not to exceed $17 million over five years to conduct activities that will strengthen providers' ability to participate in health information exchange. Expenditures not to exceed $5 million over five years to deploy an electronic patient engagement platform.	New request	
18. Blueprint for Health	Expenditures not to exceed $15 million over five years to administer the Blueprint program.	New request (currently covered as an investment)	✓
19. Workforce Development	Expenditures not to exceed $4.75 million over five years to support health care workforce development in Vermont.	New request (currently covered as an investment)	✓
20. Public Health Infrastructure	Expenditures not to exceed $38 million over five years to sustain and strengthen Vermont's public health infrastructure.	New request (currently covered as an investment)	✓

Section V—Summaries of External Quality Review Organization (EQRO) Reports, Managed Care Organization (MCO), and State Quality Assurance Monitoring

External Quality Review (EQR)

To date, Vermont's waiver monitoring has complied with the requirements set forth in the Balanced Budget Act of 1997, Public Law 105.33. High-level findings from Vermont's EQR include:

- *Strong performance in access to care, preventive care, and SUD treatment.* DVHA performed at or above the 75th percentile in 16 out of 46 measures used to assess performance under the Global Commitment demonstration, including measures of well-child visits, adult access to routine and emergency health services, appropriate ED utilization, and engagement of alcohol and other drug (AOD) abuse or dependence treatment.
- *Accelerated progress toward performance targets.* By 2017, DVHA had met or exceeded six of its performance targets in advance of its 2021 target date, including targets for child and adolescent well-care, annual dental visits for children ages 2-22, and follow-up after hospitalization for mental illness.
- *Opportunities for improvement in routine screenings and counseling.* DVHA's performance on measures related to counseling children and adolescents for BMI percentage, nutrition, and physical activity, as well as screening young women for chlamydia and breast cancer fell below the 50th percentile, indicating room for improvement in these areas.
- *Strong compliance with Medicaid and CHIP regulations.* DVHA met 78 regulatory elements and partially met nine elements, giving DVHA an overall percentage-of-compliance score of 93.8% across all 88 regulatory elements assessed.

Additionally, the EQRO assessed DVHA's performance improvement project (PIP), Initiation of Alcohol and Other Drug Abuse or Dependence Treatment. The EQRO found that DVHA has performed well in meeting the requirements in the Design and Implementation stages of the PIP, and that the PIP design was valid to measure reliable study indicator outcomes. Further, the EQRO found that DVHA's PIP achieved statistically significant and sustained improvement in measures used to assess the project's outcomes.

For additional information on Vermont's EQR, see Appendix A.

Section VI - Financial Data

Expected Enrollment

Table 9 provides historical data on Member Months for the Global Commitment 1115 demonstration populations from DY12 (CY2017) – DY16 (CY2021). Since 2021 is not complete, DY16 is a projection based on Vermont's most recent state forecast. Member Months decreased significantly between 2017 and 2019 due to the reinstatement of renewals in mid-2017, improvements in the economy that resulted in fewer members qualifying for Medicaid coverage, and demographic changes. Vermont's Member Months increased in 2020 due to the COVID-19 pandemic and suspension of most redeterminations during the public health emergency period.

Table 9. Historical Member Months

	Historical Member Months				
	DY12	**DY13**	**DY14**	**DY15**	**DY16**
Medicaid Eligibility Group	**Jan - Dec 2017**	**Jan - Dec 2018**	**Jan - Dec 2019**	**Jan - Dec 2020**	**Jan - Dec 2021**
ABD - Non-Medicare - Adult	94,629	83,071	81,293	79,935	77,526
ABD - Non-Medicare - Child	28,865	25,577	23,855	19,982	19,608
ABD - Dual	255,478	257,263	257,866	259,965	265,735
Non-ABD - Non-Medicare - Adult	157,964	143,377	104,150	111,956	120,331
Non-ABD - Non-Medicare - Child	730,744	723,120	703,957	713,975	714,480
Total Medicaid Population	**1,267,680**	**1,232,408**	**1,171,121**	**1,185,813**	**1,197,680**
Hypothetical Populations					
New Adult	715,258	695,768	656,444	720,942	718,657

	Historical Member Months				
	DY12	DY13	DY14	DY15	DY16
SUD IMD	-	1,248	2,140	1,769	1,769
SMI IMD	-	-	-	352	352
Other Populations					
Moderate Needs	2,960	2,319	2,208	1,991	1,991
Global Rx (VPharm)	131,610	126,280	121,667	119,707	119,707

Table 10 provides the estimated enrollment for the five years of the 1115 demonstration renewal from DY17 to DY21. Overall, Member Months are expected to stay flat at 2 million from DY17 to DY21. Enrollment changes are based on the most recent Vermont census projections. Note that individuals using long-term care or who were enrolled in the CFC High or Highest Needs Groups were split out into a separate Medicaid Eligibility Group (MEG) since these individuals experience higher costs per person relative to the other individuals in the MEG. Historically, these individuals were primarily in the ABD - Dual and ABD - Non-Medicare - Adult MEGs. Additional individuals are expected to be enrolled in Medicaid. These additional populations include:

- Inmates with 90 days of coverage
  - Enrollment is projected based on the average number of releases per month and includes three months of coverage for each expected release.
- Inclusion of additional IMD waiver expenditures for Lund Home, 60-plus day IMD stays, and additional IMD inclusion cases.
  - Enrollment is projected based on actual 2019 IMD cases that have occurred for these stays. Member Months are included for each expected month a patient is in the IMD facility.

Table 10. Projected Member Months

	Projected Member Months				
	DY17	DY18	DY19	DY20	DY21
With Waiver Member Months	**Jan - Dec 2022**	**Jan - Dec 2023**	**Jan - Dec 2024**	**Jan - Dec 2025**	**Jan - Dec 2026**
ABD - Non-Medicare - Adult	76,466	75,758	75,056	74,360	73,671
ABD - Non-Medicare - Child	19,547	19,486	19,425	19,365	19,304

	Projected Member Months				
	DY17	**DY18**	**DY19**	**DY20**	**DY21**
ABD - Dual	207,723	209,202	210,691	212,191	213,702
Non-ABD - Non-Medicare - Adult	120,581	119,934	119,290	118,649	118,012
Non-ABD - Non-Medicare - Child	712,877	711,279	709,683	708,092	706,503
Long-Term Care and CFC Highest/High Needs	63,940	64,972	66,021	67,087	68,171
New Adults	719,749	714,046	708,388	702,775	697,206
Moderate Needs Group	2,208	2,208	2,208	2,208	2,208
VT Global RX (VPharm)	115,881	114,014	112,178	110,371	108,593
Total	**2,038,973**	**2,030,899**	**2,022,940**	**2,015,098**	**2,007,371**

Projected Expenditures

Table 11 provides historical data on the total expenditures for the Global Commitment 1115 demonstration services and populations from DY12 to DY16. The total expenditures include costs and populations not otherwise matchable, which are allocated to the MEGs based on actual spend of each MEG. These additional demonstration costs for services and populations not otherwise matchable include: Moderate Needs Group, Investments, Marketplace Subsidy, Global Rx (VPharm), SUD IMD, and SMI IMD. The total expenditures of the Global Commitment 1115 demonstration are reported in millions and reconcile to the CMS-64 reports that are submitted to CMS on a quarterly basis for federal claiming.

Table 11. Historical Expenditures

	Historical Expenditures (in $M)				
	DY 12	**DY13**	**DY14**	**DY15**	**DY16**
Historical Expenditures	**Jan - Dec 2017**	**Jan - Dec 2018**	**Jan - Dec 2019**	**Jan - Dec 2020**	**Jan - Dec 2021**
ABD - Non-Medicare - Adult	$181.5	$181.9	$184.6	$194.6	$199.4

	Historical Expenditures (in $M)				
	DY 12	**DY13**	**DY14**	**DY15**	**DY16**
ABD - Non-Medicare - Child	$74.3	$67.1	$63.8	$60.6	$62.1
ABD - Dual	$513.6	$533.1	$543.0	$524.9	$537.7
Non-ABD - Non-Medicare - Adult	$93.8	$94.2	$73.7	$76.6	$78.4
Non-ABD - Non-Medicare - Child	$341.1	$375.2	$384.6	$365.9	$374.8
New Adults	$330.0	$348.8	$345.6	$402.9	$400.0
Total Expenditures	**$1,534.3**	**$1,600.3**	**$1,595.4**	**$1,625.5**	**$1,652.3**

The projected expenditures include the impact from the new programs for which the State is requesting expenditure authority under the 1115 demonstration renewal. Table 12 provides the projected expenditures for the 1115 demonstration renewal from DY17 to DY21.

Projected expenditures include the following program changes:

- The impact on DVHA going to a full-risk capitation rate wherein DVHA will act as the MCO within the State and administer the benefits, care, and provider payments for the 1115 demonstration services and populations. The cost impact includes the additional margin that DVHA will require in its at-risk capitation rate to cover contribution to reserves, administrative expenses, care management and quality initiatives, potential value-added benefits, and additional program benefits. The projected expenditures assume a managed care-based trend that DVHA is expected to maintain as an MCO.
- 90 days pre-release Medicaid coverage for inmates.
- Expanded drug coverage in the Global Rx (VPharm) MEG for higher income individuals.
- Permanent Supportive Housing Pilot that is expected to begin in 2023.
- Expanded personal care provider qualifications to allow parents of minor children, legal guardians, and spouses to be providers.
- Other costs not otherwise matchable (CNOM) including the SUD Community Intervention and Treatment eligibility group, the CRT expansion group, HIE activities, Blueprint administration, workforce development, public health infrastructure, and IMD stays longer than 60 days.

Vermont believes these projections accurately reflect ongoing efforts to ensure adequate access to health coverage while also controlling health care costs statewide. Vermont will continue to

work with CMS on these projections to ensure they align adequately to the approved programs and meet the goals of budget neutrality.

Table 12. Projected Expenditures

	Projected Expenditures (in $M)				
	DY17	**DY18**	**DY19**	**DY20**	**DY21**
With Waiver Expenditures*	**Jan - Dec 2022**	**Jan - Dec 2023**	**Jan - Dec 2024**	**Jan - Dec 2025**	**Jan - Dec 2026**
ABD - Non-Medicare - Adult	$188.9	$194.2	$199.7	$205.4	$211.2
ABD - Non-Medicare - Child	$67.7	$69.8	$72.0	$74.3	$76.6
ABD - Dual	$258.4	$268.9	$279.9	$291.3	$303.2
Non-ABD - Non-Medicare - Adult	$98.9	$101.1	$103.4	$105.8	$108.2
Non-ABD - Non-Medicare - Child	$451.1	$460.5	$470.0	$479.7	$489.7
Long-Term Care and CFC Highest/High Needs	$466.2	$475.7	$485.5	$495.4	$505.6
New Adults	$376.5	$395.3	$415.1	$435.9	$457.8
Moderate Needs Group	$1.9	$2.0	$2.1	$2.2	$2.3
VT Global RX (VPharm)	$26.6	$27.2	$27.8	$28.4	$29.0
Marketplace Subsidy**	$5.8	$5.7	$5.7	$5.6	$5.6
Other CNOM**	$40.3	$41.0	$41.7	$42.5	$43.3
Total Expenditures	**$1,982.1**	**$2,041.5**	**$2,102.9**	**$2,166.5**	**$2,232.3**

*Expenditures include DVHA plan administrative expense.
**Excluded from DVHA rate.

Section VII - Evaluation

Evaluation Results from the Current Demonstration

Background

On April 22, 2021, the State submitted an Interim Evaluation Report for the completed years of its Global Commitment to Health Section 1115 demonstration to CMS. This report was produced by an independent evaluator using CMS tools and guidance to ensure alignment with the State's STCs and CMS's expectations. Specifically, the evaluation examined evidence that the demonstration supports its four defined goals:

1. Increase Access to Care;
2. Improve Quality of Care;
3. Improve Community Integration; and
4. Contain Program Costs

The Global Commitment to Health is a long-standing demonstration. While new initiatives and programs have been introduced, the demonstration has been using largely the same policies during the extension period that existed before 2017. Therefore, these findings are longitudinal and should not be interpreted as causal evidence for the impacts of the demonstration.[32]

Findings

An overview of findings for each of the demonstration goals is described below.

1. Goal 1: Access to Care
In assessing the demonstration's performance around Access to Care, two research questions were examined.

Research Question: Will the demonstration result in improved access to care?
Interim findings for this research question provide support that the demonstration is associated with overall improvement in Access to Care across a broad array of services. For all measures under the Access to Care goal, where a national benchmark was available and applied, the demonstration outperformed Medicaid programs nationally. Four of the seven hypotheses returned an interim assessment of "True." Three hypotheses were "Not Proven."

[32] Additional information about evaluation of the Global Commitment demonstration can be found at the following link: https://dvha.vermont.gov/global-commitment-to-health/evaluation-plans.

Hypotheses with interim findings of "True" provide support that the demonstration is associated with improvements in access to medical care. Strong performance in access to ambulatory and preventive visits, well-child visits, dental care, and adolescent well care was evident. All measures showed statistically significant improvement over baseline. Access to MAT also has increased in each year of the demonstration.

In studying the impact of premium requirements for eligible families above 195% FPL, the premiums do not appear to impede access to enrollment. At baseline and in each year of the demonstration, the State maintained a high rate of coverage for children found eligible for Medicaid with a premium. In 2017, the percentage of effectuated coverage was 95% for families with premiums. In 2018 and 2019, the results show that coverage was effectuated for over 99% of families with a premium. The State has maintained a low rate of uninsured Vermonters with the Vermont Household Insurance Survey returning an uninsured rate of 3.2% in 2018.

Research Question: Will VBP models increase access to care?
Interim findings for this research question provide preliminary support that the VBP model supporting the Vermont Medicaid Next Generation Accountable Care Organization ("the Medicaid ACO") is associated with improvements in access to care. Two out of three hypotheses studied were deemed "True" with one hypothesis "Not Proven." In assessing Adolescent Access to Well-Care, ACO performance when compared to the control group was higher, with statistically significant results in each of the two years studied. In addition, each year the ACO is showing statistically significant increases in engagement with eligible enrollees.

Several hypotheses under Access to Care were not proven. Factors influencing inconclusive results included the lack of a clear trend in statistically significant results for hypotheses with multiple measures; lack of a comparison group for all years studied; and a decline in performance.

2. Goal 2: Quality of Care

In assessing the demonstration's performance around Quality of Care, two research questions were examined.

Research Question: Will the demonstration result in improved quality of care?
Relative to this research question, interim findings were mixed. Three out of seven hypotheses returned an interim assessment of "True."

Findings showed that ACO enrollees had statistically significant improvement in diabetes control, while ACO enrollee control of hypertension showed no statistically significant change over baseline. Improved rates of initiation and engagement in SUD treatment were evident for Medicaid members in the general population, ACO members, and those members who received SUD IMD services. In addition, only 3% of Developmental Disabilities Services program

participants who participated in the National Core Indicators – Developmental Disabilities (NCI-DD) Survey reported their health status as "poor."

In over 76% of the measures studied under Quality of Care, where a benchmark was available and applied, the demonstration outperformed Medicaid programs nationally.

Research Question: Will improved access to primary care result in improved health outcomes?
Relative to this research question, interim findings provide support that Blueprint is associated with improved diabetes control for Medicaid members who are receiving services. Fewer than 23% of Medicaid members with diabetes show poor control in each year of the demonstration. However, over time, the number of enrollees with poor control has increased from 11% at baseline to 22% in CY2018, the most recent data available. Inpatient hospitalizations, while remaining lower for those members with good control, is also increasing for the Blueprint Medicaid members studied.

With the migration of former demonstration populations to the Marketplace under the ACA and the resumption of Medicaid eligibility reviews in 2016 and 2017, Blueprint Medicaid enrollees represent a population that is older with more chronic conditions than prior years.

In addition, IT challenges and the use of multiple data extracts across the demonstration period may be influencing results. Blueprint results for Medicaid members historically relied on extracting information from the State's multi-payer claims database and matching it with information in the State's clinical registry. Many providers who serve Medicaid members lack the IT infrastructure to submit data to the registry, resulting in an undercount of Medicaid members. Thus, the historic data does not provide a complete assessment of program performance.

The State is making significant improvements to VHIE. This includes expanding the number of providers connected to the exchange and thus information available in its data warehouse. The Blueprint clinical registry has been retired. In the future, clinical information used for the Blueprint Medicaid measures will be obtained through the VHIE. Prior year results will be reproduced in the final summative report to minimize potential undercounts.

Several hypotheses under Quality of Care were inconclusive. An assessment of "Not Proven" was given to hypotheses under Quality of Care for the following reasons:

- The hypothesis included multiple measures that returned a mix of statistically significant results;
- There was a statistically significant decline in performance; or
- A change in measure specifications occurred after the baseline period.

3. Goal 3: Community Integration

In assessing the demonstration's performance around Community Integration, one research question was examined.

Research Question: Will the demonstration result in increased community integration?
Relative to this research question, interim findings provide support that the demonstration is associated with improvements in Community Integration for persons with LTSS, including individuals in HCBW-like programs, and participants with behavioral health needs. Three out of six hypotheses returned an interim assessment of "True," two were "Not Proven," and one was "Not Tested."

The percentage of CFC enrollees served in the home and community showed statistically significant increases in each year of the demonstration. The number of enrollees living in home and community-based settings rose from 54% at baseline to 58% in CY2019. Participants in the Developmental Disabilities Services program reported participation in integrated community activities at 84% during baseline and participation increased to 87% in CY2018, the most recent year for which survey data is available.

The percentage of National Core Indicators-Developmental Disabilities (NCI-DD) survey respondents who did not have a job, but wanted one, dropped from 52% at baseline to 48% in CY2018. Vermont employment data from the Department of Labor and other reporting agencies showed that 49% of Developmental Disabilities Services program participants of working age were employed in CY2019, up from 48% at baseline. The program target set by the State for each year of the demonstration was 45%.

Two hypotheses under Community Integration were inconclusive. An assessment of "Not Proven" was given for the following reasons:

- The hypothesis included multiple measures that returned a mix of statistically significant results; or
- There was a decline or minimal change in performance over baseline, without statistical significance.

An assessment of "Not Tested" was given when updated data for the demonstration measurement period was not available.

4. Goal 4: Cost Containment

In assessing the demonstration's performance around Cost Containment, two research questions were examined.

Research Question: Will the demonstration maintain or reduce spending?
The interim findings provide support that the demonstration is containing costs relative to what would have been spent absent the demonstration. One of two hypotheses returned an interim assessment of "True."

The State has achieved savings over expected "without waiver expenditures" in each year of the demonstration thus far. Total expenditures under the demonstration were $1,238,718,223 in CY2017, $1,284,417,019 in CY2018, and $1,272,312,741 in CY2019. Expenditures without the waivers approved under the demonstration were limited to $1,386,795,376 in CY2017, $1,405,356,354 in CY2018, and $1,415,544,626 in CY2019. Cumulative savings at the end of CY2019 were $110,465,951.

In CY2018, per member, per month (PMPM) expenses were exceeded in the SUD IMD Non-ABD group and the SUD IMD New Adult group. CY2018 represented six months of operation for the SUD amendment. For CY2019, the first full year of the demonstration, the Supplemental Budget Neutrality Test for SUD Expenditures shows that SUD IMD expenses for all Medicaid eligibility groups exceeded the approved limits. However, the STCs allow for overages in the SUD IMD budget neutrality if the overall Global Commitment demonstration budget neutrality cap is not exceeded. Vermont's overall cap to date can accommodate the SUD IMD overage.

Research Question: Will improved access to preventive care result in lower overall costs?
Relative to this research question, interim findings provide support that the demonstration is meeting its overall goal of containing costs. Both hypotheses returned an interim assessment of "True." Expenditures for members whose diabetes is in control have declined from $16,459 to $14,931 for Medicaid members aged 1-64 years enrolled in the Blueprint. Total risk-adjusted expenditures have remained relatively stable for the Medicaid members aged 1-64 years enrolled in the Blueprint.

5. Delivery System Related Investments
The evaluation also examined two delivery system investments: 1) OneCare Vermont ACO Advanced Community Care Coordination, and 2) OneCare Vermont ACO Quality Health Management Measurement Improvements. Under investment #1, OneCare Vermont ACO Advanced Community Care Coordination, the evaluation examined results for seven measures. Four of these measures were administrative process measures such as community care manager participation in training, care teams, and other coordination initiatives. In 2019, the number of communities participating in care coordination statewide rose to 87%; performance is on track to meet the goal of 100% participation in the coming year.

The three remaining measures are clinical process measures related to care planning for members who are designated at high-risk or very high-risk levels. Two of the three measures are performing at or above the targets established by the State.

- The percentage of high-risk and very high-risk level patients who are engaged in care coordination is at 14% with an ACO target set by the State of 5%; and
- The percentage of high-risk and very high-risk level patients who are engaged in care coordination who have a shared care plan initiated is at 78% with an ACO target set by the State of 50%.

For investment #2, OneCare Vermont ACO Quality Health Management Measurement Improvement, results show 100% of Vermont's health service areas are receiving data literacy training and technical support. Performance in this investment is meeting State expectations.

Demonstration results suggest that Vermont's delivery system and program policies are associated with access to high-quality health care and support members with LTSS, including those in HCBW-like programs, in maintaining community living and integration. Positive trends are seen across the general Medicaid population as well as demonstration participants enrolled in specialized programs.

Over the course of the demonstration, the State implemented several innovative programs and delivery system reforms that have an enduring impact. These include the promotion of advanced primary care practices under the Blueprint (including the Women's Health Initiative and Specialized Health Homes for Opioid Addiction [Hub and Spoke model]) and CFC. In addition, one recent delivery system reform, the Vermont Medicaid Next Generation ACO, is showing promising results.

Opportunities for further study include focused quality planning in underperforming areas; further examination and modification of the technical specifications and data used to calculate results; and potential revisions to the evaluation approach or analytics. In addition, the impact of the pandemic will result in a considerable amount of uncertainty and variability in the CY2020 data and potentially CY2021 data, the last two years of the evaluation period. AHS staff and evaluators will consider how the pandemic may impact the evaluation methodology and findings for the demonstration and identify strategies to address these impacts.

Evaluation Trends

As noted in Interim Evaluation Report #1 (issued in April of 2018), demonstration performance at baseline suggested a mature delivery system with strong provider participation. Evaluation designs were significantly different for the evaluation periods prior to 2017. However, five measures related to Access to Care and one related to Community Integration were included in the State's 2015 report to CMS and the current design:

- Percentage of adult enrollees who had an ambulatory or preventive care visit

- Percentage of enrollees with well-child visits first in first 15 months of life, six or more visits
- Percentage of enrollees with well-child visits third, fourth, fifth, or sixth year of life
- Percentage of adolescents aged 12 to 21 who receive one or more well-care visits with a PCP during the year
- Percentage of children aged 2 to 20 with at least one dental visit
- Persons served under the CFC program in community settings

In five of the six measures reported in 2015, performance has improved. Significance testing could not be conducted to assess the changes from prior demonstration periods; however, the demonstration continues to show gains across the years.

Table 13 offers an overview of results across the demonstration years.

Table 13. Demonstration Results from Prior Periods

Measure	2014	2019
Percentage of adult enrollees who had an ambulatory or preventive care visit	87.32%	83.30%
Percentage of enrollees with well-child visits first 15 months of life, six or more visits	75.96%	76.58%
Percentage of enrollees with well-child visits third, fourth, fifth, or sixth year of life	71.49%	77.37%
Percentage of adolescents aged 12 to 21 who receive one or more well-care visits with a PCP during the year	46.97%	54.05%
Percentage of children aged 2 to 20 with at least one dental visit	67.72%	72.37%
Percentage of CFC participants living in home and community settings	52.00%	58.01%

Plans for Evaluating Impact of Demonstration Renewal

Vermont intends to contract with an independent evaluator to assess the impact of proposed new demonstration features. Vermont is proposing the following research questions, hypotheses, and proposed evaluation approaches to include as part of its evaluation design. Recognizing the importance of understanding the impact of the demonstration on populations subject to health disparities, including Vermonters of color and Vermonters with disabilities, Vermont is working to identify strategies to assess the extent to which the demonstration is promoting health equity.

Table 14. Proposed Evaluation Hypotheses for New Demonstration Features

Aim	Research Question	Hypothesis	Evaluation Approach	Data Sources
Advancing Toward Population-Wide Comprehensive Coverage	Will the demonstration result in increased access to care for Medicaid beneficiaries?	1. The demonstration will result in increased access to treatment services for Medicaid-eligible Vermonters who were previously incarcerated and released from DOC facilities.	Analyze number or percentage of previously incarcerated Medicaid-eligible individuals utilizing treatment services before and after demonstration renewal.	MMIS, Corrections Health Data
		2. The demonstration will result in improved access to care for low- and moderate-income Vermonters with a SUD.	Analyze number of low- and moderate-income Medicaid enrollee deaths related to drug overdose before and after demonstration renewal.	Vital Statistics, MMIS
Implementing Innovative Care Models Across the Care Continuum That Produce Value	Will the demonstration result in implementation of innovative care models across the care continuum that produce value?	1. The demonstration will result in improved access to family-focused residential services for Medicaid-eligible individuals.	Analyze number or percentage of Medicaid enrollees receiving family-focused residential services before and after demonstration renewal.	MMIS
		2. The demonstration will reduce health care costs for Medicaid-eligible individuals that access	Analyze percentage of permanent supportive housing service recipients with a principal diagnosis of alcohol or other drug dependence who had a	MMIS, Administrative Data

Aim	Research Question	Hypothesis	Evaluation Approach	Data Sources
		permanent supportive housing services.	follow up after emergency department visit after demonstration renewal.	
		3. The demonstration will result in reducing overall health care costs for high-need individuals.	Analyze total cost of care for high-need Medicaid enrollees before and after demonstration renewal.	MMIS
Engaging Vermonters in Transforming Their Health	Will the demonstration result in Vermonters having the tools they need to stay healthy and transform their health?	1. The demonstration will result in reduced chronic disease prevalence.	Analyze percentage of Vermonters reporting that they have been told they have hypertension before and after demonstration renewal.	BRFSS Data
		2. The demonstration will increase access to care for Medicaid-eligible individuals.	Analyze percentage of Medicaid enrollees who had an ambulatory or preventive care visit before and after demonstration renewal.	MMIS
			Analyze initiation and engagement of alcohol and other drug dependence treatment before and after demonstration renewal.	TBD
Strengthening Care Coordination and Population Health Management Capabilities to Encompass the	Will the demonstration enhance care coordination, population health management, and health information	1. The demonstration will result in improved health information exchange capabilities for Medicaid specialty providers.	Analyze number of Medicaid specialty providers connected to HIE before and after demonstration renewal.	VHIE data
		2. The demonstration will result in more integrated care coordination.	Analyze percentage of high-risk and very high-risk level patients who are	Blueprint and ACO Data

Aim	Research Question	Hypothesis	Evaluation Approach	Data Sources
Full Spectrum of Health-Related Services and Supports	exchange capabilities?		engaged in care coordination who have a shared care plan initiated.	
Accelerating Groundbreaking Payment Reform	Will the demonstration result in advanced payment innovation?	1. The demonstration will result in additional populations and services transitioning to HCP-LAN Category 4 arrangements.	Analyze percentage of Medicaid payment models that fall into each of the HCP LAN APM Framework categories after demonstration renewal.	Administrative Data
		2. The demonstration will result in new payment initiatives for SUD outpatient services.	Analyze percentage of SUD outpatient services that are subject to payment models that fall into one of the HCP LAN APM Framework categories after demonstration renewal.	MMIS
		3. The demonstration will result in new payment initiatives for school-based mental health services.	Analyze percentage of school-based mental health services that are subject to payment models that fall into one of the HCP LAN APM Framework categories after demonstration renewal.	MMIS

Section VIII - Compliance with Public Notice Process

To be completed after completion of public comment period.

Section IX – Public Notice

State of Vermont
Agency of Human Services
280 State Drive, Center Building
Waterbury, VT 05671-1000

Global Commitment Register

May 13, 2021

GCR 21-033
PROPOSED

Global Commitment to Health Demonstration Renewal: Public Notice

Policy Summary:
Vermont's Agency of Human Services (AHS) is providing public notice of its intent to seek a five-year renewal of its Medicaid Section 1115 Demonstration Waiver, Vermont Global Commitment to Health (Global Commitment), and to discuss with the federal Centers for Medicare & Medicaid Services (CMS) the potential for 10-year renewal of limited, long-standing features of the Global Commitment demonstration. The State is soliciting public comment on these requests before submitting its renewal application to CMS.

The Global Commitment to Health demonstration has progressively broken new ground in large-scale Medicaid transformation since it was first approved in 2005. Over the past 15 years, the demonstration has been Vermont's principal vehicle for major expansions of health coverage, building an extensive ecosystem of public health and health-related services, driving all-payer payment reform, and rebalancing long-term services and supports (LTSS).

Vermont's vision for the Global Commitment demonstration renewal is to improve health outcomes, lower costs for all Vermonters, and promote provider sustainability, by driving farther and faster toward alternative payment models. Concurrently, Vermont aims to advance the objectives of the Medicaid program by continuing to invest in programs and interventions that improve population health, impact social determinants of health, and ensure that these investments are sustainable over the long term in order to support health improvement and health equity for Vermonters through effective use of state and federal Medicaid dollars.

Vermont seeks to further Medicaid's role as a driver of all-payer payment and delivery system reform through the following **key demonstration goals that promote the objectives of Title XIX of the Social Security Act**:

- Advancing toward population-wide, comprehensive coverage;
- Implementing innovative care models across the care continuum that produce value;
- Engaging Vermonters in transforming their health;
- Strengthening care coordination and population health management capabilities to encompass the full spectrum of health-related services and supports; and
- Accelerating groundbreaking payment reform.

To achieve these goals, Vermont is seeking to retain and strengthen existing demonstration features, while implementing new initiatives that will advance Vermont's health ecosystem. Central to Vermont's key demonstration goals is Vermont's intent to transition AHS's Department of Vermont Health Access (DVHA) from being treated as a public, non-risk, prepaid inpatient health plan (PIHP) to a public, state-run, risk-bearing managed care organization (MCO). Under this framework, AHS will pay DVHA a monthly capitation rate for each Medicaid enrollee that will include all Medicaid services. In collaboration with the Vermont Department of Health, Department of Disabilities, Aging and Independent Living (DAIL), Department of Mental Health (DMH), Alcohol and Drug Abuse Program (ADAP), Department of Corrections (DOC), and Department of Children and Families (DCF), DVHA will be responsible for spending within this capitation rate. Similar to a commercial Medicaid managed care plan, DVHA will have the ability to offer in lieu of services and flexibility in how it uses its profits, including the ability to offer value-added services. Different from a commercial managed care plan, DVHA will use all of its profits to reinvest in delivery system reforms and service initiatives that incentivize and advance whole-person health for the people of Vermont. Over the life of the demonstration period, Vermont intends to transition many of its investments authorized under the current Global Commitment demonstration to become covered as medical services (including in lieu of services), care management, quality improvement initiatives, and value-added services/population health initiatives through the administrative load and profit margin under the DVHA capitation rate. DVHA will also continue to lead value-based care reform through implementing value-based payment (VBP) arrangements at the level of care delivery, including as an anchor participant in the State's All-Payer Accountable Care Organization (ACO) Model Agreement.

Effective Date:
January 1, 2022

Authority/Legal Basis:
Global Commitment to Health Waiver

Population Affected:
Vermont's entire Medicaid population – including both State Plan and expansion groups – falls under the purview of the Global Commitment demonstration.

Fiscal Impact:
No impact. The Global Commitment demonstration must be budget neutral.

Public Comment Period:
May 13, 2021-June 12, 2021
All comments must be received no later than 11:59 PM ET (Eastern Time) on June 12, 2021.

The full draft Global Commitment demonstration renewal application can be found at: https://humanservices.vermont.gov/about-us/medicaid-administration/global-commitment-health-1115-waiver/1115-waiver-documents/2022. A hard copy of the Global Commitment demonstration renewal application can be obtained by sending a written request to the postal or email address listed below. All information regarding the Global Commitment demonstration renewal application can be found on the AHS website. AHS will update this website through the public comment and application process. To be added to the GCR email list, send an email to AHS.MedicaidPolicy@vermont.gov.

Written comments may be sent to the following address; please indicate "1115 Renewal Public Comment" in the written message:

Medicaid Policy Unit
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010

Comments may also be emailed to AHS.MedicaidPolicy@vermont.gov. Please indicate "1115 Renewal Public Comment" in the subject line of the email message.

AHS will host the following public hearings to solicit stakeholder comments. The public hearings will be held virtually to promote social distancing and mitigate the spread of COVID-19.

First Public Hearing
May 27th, from 1:30-3:00 pm
Call in: +1 802-552-8456,,23550108#
Phone Conference ID: 235 501 08#
Video Conference: https://bit.ly/2QeCW4U

Second Public Hearing
June 3rd, from 9:00-10:30 am
Call in: +1 802-552-8456,,558912170#
Phone Conference ID: 558 912 170#
Video Conference: https://bit.ly/3bixAwS

Upon submission to CMS, a copy of the Global Commitment demonstration renewal, including a summary of comments received during this State public comment period, will be published at the following internet address: https://humanservices.vermont.gov/about-us/medicaid-administration/global-commitment-health-1115-waiver/1115-waiver-documents/2022

Interested parties will also have the opportunity to officially comment on the Global Commitment demonstration renewal application during the federal public comment period; the submitted application will be available for comment on the CMS website at https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html.

Additional Information

Summary of Current Demonstration Features to Be Continued and New Medicaid Program Features to Be Included Under the 1115 Demonstration Renewal

Goal 1: Advancing Population-Wide, Comprehensive Coverage

Continuing Features without Modifications

- **Presumptive Eligibility for Pregnant Women**

Continuing Features with Modifications

- **Moderate Needs Expansion Group for Choices for Care (CFC) Program.** Vermont seeks to revise the CFC Moderate Needs Group clinical eligibility criteria to ensure that services are targeted to at-risk Vermonters with the most acute needs. See the full Global Commitment demonstration renewal application for additional details.
- **Community Rehabilitation and Treatment (CRT) Expansion group.** Vermont seeks to transition authority for the CRT expansion group from a designated state health program (DSHP) (for individuals with incomes from 133%-185% FPL) and the expenditure authority for investments under the current demonstration (for individuals with incomes above 185% FPL) to a discrete expenditure authority under the demonstration.
- **Marketplace Subsidies** for Vermonters purchasing health insurance through the Marketplace who are not Medicaid eligible and have incomes up to 300% of the Federal

Poverty Level (FPL). Vermont seeks to transition authority for these subsidies from a DSHP to a discrete expenditure authority under the demonstration.

- **VPharm.** Vermont is seeking to extend Medicaid-equivalent pharmaceutical coverage to VPharm-eligible individuals with incomes up to 225% FPL.

New Features

- **Medicaid Coverage for Inmates 90 Days Prior to Release from Prison or Jail.** Vermont seeks to provide all Medicaid-eligible inmates with Medicaid coverage 90 days prior to release to improve transitions from correctional facilities to the community.
- **Community Intervention and Treatment Eligibility Group for Low and Moderate-Income Vermonters with a Substance Use Disorder (SUD).** Vermont seeks to create a new eligibility group for Vermonters with a SUD who have incomes from 133% FPL up to and including 225% FPL. Individuals in this group will have access to a set of SUD community intervention and treatment benefits outlined in the Global Commitment demonstration renewal application**.**

Goal 2: Implementing Innovative Care Models Across the Continuum That Produce Value

Continuing Features without Modifications

- **Enhanced Hospice Benefit**
- **Palliative Care Program**
- **Mental Health Under 22 for Individuals with Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED)**

Continuing Features with Modifications

- **CFC.** Vermont seeks to add a "life skills aide" service to the CFC service array for the Highest Needs Group and High Needs Group.
- **CRT.** Vermont seeks to add a peer supports benefit[33] to CRT. In addition, Vermont intends to remove respite from the list of CRT benefits to reflect that it is not in use today.
- **Developmental Disabilities Services.** Vermont is seeking authority to reimburse parents of a minor child, spouses, and legal guardians providing personal care and personal care-like services to individuals enrolled in the Developmental Disabilities Services program.[34]

[33] Provision of peer supports will be effective upon promulgation of state policy necessary to effectuate this new benefit.

[34] Payments to parents of a minor child, spouses, and legal guardians providing these services will be effective upon promulgation of state policy necessary to effectuate this new benefit.

- **Brain Injury Program.** Vermont is seeking authority to reimburse parents of a minor child, spouses, and legal guardians providing life skills aide services and community supports (including shared living) to individuals enrolled in the Brain Injury Program.[35]
- **Waivers of the Institution for Mental Disease (IMD) Exclusion for Mental Health and SUD Treatment.** Vermont is requesting that CMS align requirements for the two waivers to remove the prohibition on federal financial participation (FFP) for individuals obtaining mental health treatment in an IMD for longer than 60 days, recognizing that at times, longer lengths of stay are medically necessary. Vermont is also seeking to apply the inpatient exception to the inmate exclusion to care provided at IMDs.

New Features

- **Access to Family-Focused Residential Mental Health and SUD Treatment.** Vermont is seeking a limited exception to the IMD exclusion for women obtaining longer-term treatment at a family-focused residential treatment program in order to obtain Medicaid reimbursement for stays at Lund Home greater than 60 days.
- **Permanent Supportive Housing Pilot.** Vermont is seeking expenditure authority for a Permanent Supportive Housing Pilot program to provide Medicaid enrollees age 18 and older who are eligible for full Medicaid State Plan benefits and meet specific health needs-based and risk-based eligibility criteria as outlined in the demonstration renewal application with pre-tenancy supports, tenancy sustaining services, and community transition services. Vermont seeks to impose an enrollment cap, prioritization criteria, and a waitlist for Pilot services.

Goal 3: Engaging Vermonters in Transforming Their Health

New Features

- **Incorporating Investments into the Risk-Bearing MCO Model.** Vermont currently has authority to obtain a capped amount of federal Medicaid funding for a diverse set of investments in public health, health care, and health-related services. With the demonstration renewal, Vermont intends to identify investments that are provided to Medicaid enrollees that can be incorporated into the DVHA capitation rate either as State Plan benefits or pre-authorized in lieu of services, care management, or quality improvement. Any savings generated under the DVHA capitation rate will be strategically invested in value-added services targeted toward the Medicaid population and population health initiatives that benefit all Vermonters. These value-added services and population health initiatives will be at risk in the event that DVHA exceeds its per-member per-month capitation rate. The State

[35] Payments to parents of a minor child, spouses, and legal guardians providing these services will be effective upon promulgation of state policy necessary to effectuate this new benefit.

proposes gradually transitioning investments into the DVHA capitation rate over the five years of the demonstration period.

- **Covering Certain Investments Through Expenditure Authority.** Vermont is seeking to transition a subset of its current investments to being covered through expenditure authority under the demonstration.
    - **Workforce Development Investments.** Vermont is requesting $4.75 million in expenditure authority over five years to support loan repayment programs for health care professions, geographically accessible nursing education, and educational partnerships.
    - **Public Health Infrastructure.** Vermont is requesting $38 million in expenditure authority over five years to support preventive services and public health programs focused on areas such as immunizations and fluoride treatment, tobacco cessation, poison control/lead poisoning prevention, epidemiology, and laboratory testing.

Goal 4: Strengthening Care Coordination and Population Health Management Capabilities to Encompass the Full Spectrum of Health-Related Services and Supports

New Features

- **Advancing Integration in Care Coordination.** Vermont intends to align statewide expectations across care coordination programs through Medicaid, the All-Payer ACO, and other payers with respect to care coordination activities, composition of care teams, and processes for care coordination assignments. Vermont is requesting $15 million (total computable) in expenditure authority over five years to fund a network of three types of staff who supervise and support the Blueprint for Health (Blueprint) initiatives: (1) program managers, who monitor practices' participation as a patient-centered medical home (PCMH), integration with the local community health team (CHT), and implementation of Vermont's care coordination models; (2) quality improvement (QI) facilitators, who assist PCMHs in identifying and implementing QI projects; and (3) self-management regional coordinators, who administer self-management programming in each of the State's Health Service Areas.
- **Strengthening Providers' Ability to Participate in Health Information Exchange (HIE), Advancing Population Health.** Vermont seeks expenditure authority under the demonstration to pursue the following initiatives:
    - **Evaluate gaps in data storage, utilization, and sharing.** Vermont is requesting $500,000 (total computable) in expenditure authority over five years to evaluate how Medicaid providers store, access, utilize, and share information about enrollee needs and service utilization.
    - **Reduce inequities in data access and sharing capabilities to allow a cross-sector of providers to participate in VBP reforms.** Vermont is requesting $15 million (total computable) in expenditure authority over five years to provide funding to assist providers in purchasing data systems, including electronic health records (EHRs) and

care coordination tools, and connecting to the Vermont Health Information Exchange (VHIE). Vermont will also develop a targeted technical assistance program to provide support for Medicaid providers seeking to access, utilize, and share data for integrated care coordination and population health management.

- **Leverage health data to enhance population health management and program improvement.** Vermont is requesting $1.5 million (total computable) in expenditure authority over five years to develop analytic reports and tools using data from the VHIE and other sources to improve management of individuals with high utilization across the care continuum, support program monitoring, and analyze impacts of service or program changes.
- **Use an electronic patient engagement platform to close health data gaps, support chronic disease prevention and management, and enable person-centric optimized care.** Vermont is requesting $5 million (total computable) in expenditure authority over five years to assess how to embed a patient engagement platform into the State's delivery system, and if determined to be feasible, procure a tool that will allow Medicaid enrollees to enter information or link to health monitoring applications.

Goal 5: Accelerating Groundbreaking Payment Reform

Continuing Features without Modifications
Vermont is seeking to retain the flexibility to set provider rates on an individual or class basis that departs from State Plan rates as part of its demonstration renewal.

New Features
Vermont intends to continue to refine payment models for mental health, SUD, and developmental disabilities services and will test multiple new models of risk. Ultimately, the payment reform initiatives that are tested under the demonstration renewal will guide DVHA's strategy for transitioning additional populations and services to Health Care Payment Learning & Action Network (HCP-LAN) Category 4 arrangements.

Demonstration Eligibility, Benefits, Delivery System, and Cost Sharing

Eligibility and Benefits
Vermont's entire Medicaid population – including both State Plan and expansion groups – falls under the purview of the Global Commitment demonstration. Table 1 below outlines the eligibility groups that will be included in the Global Commitment demonstration renewal, along with the benefits that will be covered for each group. Through the demonstration renewal, Vermont is proposing the creation of one new eligibility group – Population 9, the SUD

Community Intervention and Treatment Expansion Group. In addition, Vermont is proposing minor benefits changes, as described below.

Table 1. Global Commitment Demonstration Populations

Population	Population Description	Benefits	Proposed Changes for New Demonstration Period
Mandatory and Optional State Plan Groups[36]			
1. Mandatory State Plan Populations	Mandatory State Plan populations, except for the ACA new adult group (included in Population 3) and Medicare Savings Program beneficiaries (included in Population 8).	State Plan benefits	State intends to cover a number of new benefits under the State Plan, including a subset of investments authorized under the current demonstration, as described in this application.
2. Optional State Plan Populations	Optional State Plan populations (including medically needy).	State Plan benefits	None
3. New Adult Group	New adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119, pursuant to the approved State Plan.	Benefits described in approved alternative benefit plan (ABP) State Plan Amendment (SPA)	State will update its ABP SPA to align with changes to the State Plan.
Demonstration Expansion Populations			
4. CFC Highest Needs Population	Individuals age 65 and older and age 18 and older with disabilities, not otherwise eligible under the State Plan, who meet the clinical criteria for the Highest Needs Group for CFC, and who would have been Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR §435.217, in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under the demonstration would have been provided under an HCBS waiver granted to the State under section 1915(c) of the Act. This includes the application of the post-eligibility rules specified at 42 CFR §435.726,	State Plan benefits plus HCBS covered for the CFC Highest Needs Group as described in the current demonstration STCs	State proposes minor changes to the CFC benefit package as described earlier in this notice and on pages 21-22 of the full demonstration renewal application.

[36] Inmates who are within 90 days of release will receive the benefit package associated with their eligibility group.

Population	Population Description	Benefits	Proposed Changes for New Demonstration Period
	and of the spousal impoverishment rules specified at 1924 of the Act. This demonstration allows for a resource standard of $10,000 for an unmarried individual who resides in and has an ownership interest in their principal place of residence.		
5. CFC High Needs Population	Individuals age 65 and older and age 18 and older with disabilities, not otherwise eligible under the State Plan, who meet the clinical criteria for the High Need Group for CFC, and who would have been Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR §435.217, in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under the demonstration would have been provided under an HCBS waiver granted to the State under section 1915(c) of the Act. This includes the application of the post-eligibility rules specified at 42 CFR 435.726, and of the spousal impoverishment rules specified at 1924 of the Act. This demonstration also allows for a resource standard of $10,000 for an unmarried individual who resides in and has an ownership interest in their principal place of residence.	State Plan benefits plus HCBS covered for the CFC High Needs Group as described in the current demonstration STCs	State proposes minor changes to the CFC benefit package as described as described earlier in this notice and on pages 21-22 of the full demonstration renewal application.
6. CFC Moderate Needs Expansion Group	Individuals who have incomes below 300% SSI FBR and would be described in Populations 4 or 5 except that they meet the clinical criteria for the CFC Moderate Needs Group and are at risk of institutionalization.	Limited HCBS including adult day services, case management, and homemaker services	State proposes minor changes to eligibility criteria described as described as described earlier in this notice and on page 13 of the full demonstration renewal application.
7. CRT Expansion Group	Individuals with SMI who have incomes above 133% FPL.	Limited community mental health services, including service	State proposes covering CRT expansion group through expenditure authority instead

Population	Population Description	Benefits	Proposed Changes for New Demonstration Period
		coordination, flexible support, skilled therapy services, counseling, residential treatment, supported employment, environmental safety devices, and crisis and community supports	of as a DSHP and investment; no eligibility changes are proposed. State also proposes minor changes to CRT benefit package as described on page 22 of the full demonstration renewal application.
8. VPharm Group	Medicare beneficiaries who are 65 years or older or have a disability with income at or below 225% FPL, who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise categorically eligible for full benefits.	Medicaid prescriptions, eyeglasses and related eye exams; MSP beneficiaries also receive benefits as described in the State Plan	State proposes to expand benefits available to Medicare beneficiaries with incomes from 150% to 225% FPL as described as described as described earlier in this notice and on page 14-15 of the waiver application.
9. SUD Community Intervention and Treatment Expansion Group	Individuals with a SUD as defined by the DSM-5 who have incomes from 133% FPL up to and including 225% FPL.	SUD Community Intervention and Treatment benefits as described in Table 2	New eligibility group

Delivery System

Vermont's proposed transition of DVHA, its Medicaid delivery system, from being considered a non-risk-bearing PIHP to a risk-bearing MCO is at the core of Vermont's vision and goals for the Global Commitment demonstration renewal. As a risk-bearing MCO, DVHA would be subject to the same regulations and protections that other states' risk-bearing Medicaid managed care plans are under 42 CFR 438.

Premiums and Cost-Sharing

Vermont is proposing to retain premiums and cost sharing authorized through the current Global Commitment demonstration, as described below. All other cost sharing aligns with Vermont's State Plan.

Mandatory State Plan Populations, Optional State Plan Populations, and the New Adult Group (Populations 1, 2, and 3)

Vermont may charge Populations 1, 2, and 3 premiums and cost sharing in compliance with Medicaid requirements set forth in statute, regulation, policy, and Vermont's Medicaid State Plan. Standard Medicaid exemptions from cost-sharing set forth in 42 CFR 447(b) will apply to the demonstration. Premiums for children ages 0 through 18 who fall into the mandatory State Plan population (Population 1) will be as follows:

Table 2. Premiums for Children Ages 0 to 18 in Population 1

Group	Premiums
Children with incomes >195% through 237% FPL	$15/month/family
Underinsured children with incomes >237% through 312% FPL	$20/month/family
Uninsured children with incomes >237% through 312% FPL	$60/month/family

VPharm Group (Population 8)

Premiums and co-payments for the VPharm group are outlined in the table below.

Table 3. VPharm Premiums and Co-Payments

Population	Premiums	Co-Payments
Medicare beneficiaries with income up to and including 225% FPL, who may be enrolled in the MSP but are not otherwise categorically eligible for full benefits	Premiums cannot exceed the following: • 0-150% FPL: $15/month/person • 151-175% FPL: $20/month/person • 176-225% FPL: $50/month/person	Not to exceed the nominal co-payments specified in the Medicaid State Plan

Demonstration Projected Enrollment and Expenditures

Expected Enrollment

Table 4 provides historical data on Member Months for the Vermont 1115 demonstration populations from DY12 (CY2017) - DY16 (CY2021). Since 2021 is not complete, DY16 is a projection based on Vermont's most recent state forecast.

Table 4. Historical Member Months

	Historical Member Months				
	DY12	DY13	DY14	DY15	DY16
Medicaid Eligibility Group	**Jan - Dec 2017**	**Jan - Dec 2018**	**Jan - Dec 2019**	**Jan - Dec 2020**	**Jan - Dec 2021**
Total Medicaid Population	1,267,680	1,232,408	1,171,121	1,185,813	1,197,680
Total Hypothetical Population	715,258	697,016	658,584	723,063	720,778

	Historical Member Months				
	DY12	DY13	DY14	DY15	DY16
Medicaid Eligibility Group	Jan - Dec 2017	Jan - Dec 2018	Jan - Dec 2019	Jan - Dec 2020	Jan - Dec 2021
Total Other Population	134,570	128,599	123,875	121,698	121,698
Total	**2,117,508**	**2,058,023**	**1,953,580**	**2,030,574**	**2,040,156**

Table 5 provides the estimated enrollment for the five years of the demonstration renewal from DY17 to DY21.

Table 5. Projected Member Months

	Projected Member Months				
	DY17	DY18	DY19	DY20	DY21
With Waiver Member Months	Jan - Dec 2022	Jan - Dec 2023	Jan - Dec 2024	Jan - Dec 2025	Jan - Dec 2026
Total	**2,038,973**	**2,030,899**	**2,022,940**	**2,015,098**	**2,007,371**

Projected Expenditures

Table 6 provides historical data on the total expenditures for the Global Commitment 1115 demonstration services and populations from DY12 to DY16.

Table 6. Historical Expenditures

	Historical Expenditures (in $M)				
	DY 12	DY13	DY14	DY15	DY16
Historical Expenditures	Jan - Dec 2017	Jan - Dec 2018	Jan - Dec 2019	Jan - Dec 2020	Jan - Dec 2021
Total Expenditures	**$1,534.3**	**$1,600.3**	**$1,595.4**	**$1,625.5**	**$1,652.3**

The projected expenditures include the impact from the new programs that are being requested to be covered under the 1115 demonstration. Table 7 provides the projected expenditures for 1115 demonstration expenditures from DY17 to DY21.

Table 7. Projected Expenditures

	Projected Expenditures (in $M)				
	DY17	DY18	DY19	DY20	DY21
With Waiver Expenditures*	Jan - Dec 2022	Jan - Dec 2023	Jan - Dec 2024	Jan - Dec 2025	Jan - Dec 2026
Total Expenditures	**$1,982.1**	**$2,041.5**	**$2,102.9**	**$2,166.5**	**$2,232.3**

*Expenditures include DVHA plan administrative expenses.

Demonstration Hypotheses and Evaluation Approach

Vermont intends to contract with an independent evaluator to assess the impact of proposed new demonstration features. Vermont is proposing the following hypotheses to include as part of its evaluation design.

- ***Goal 1: Advancing Toward Population-Wide, Comprehensive Coverage***
  - The demonstration will result in increased access to treatment services for Medicaid-eligible Vermonters who were previously incarcerated and released from Department of Corrections (DOC) facilities.
  - The demonstration will result in improved access to care for low- and moderate-income Vermonters with a SUD.
- ***Goal 2: Implementing Innovative Care Models Across the Care Continuum That Produce Value***
  - The demonstration will result in improved access to family-focused residential services for Medicaid-eligible individuals.
  - The demonstration will reduce health care costs for Medicaid-eligible individuals who access permanent supportive housing services.
  - The demonstration will result in reducing overall health care costs for high-need individuals.
- ***Goal 3: Engaging Vermonters in Transforming Their Health***
  - The demonstration will result in reduced chronic disease prevalence.
  - The demonstration will increase access to care for Medicaid-eligible individuals.
- ***Goal 4: Strengthening Care Coordination and Population Health Management Capabilities to Encompass the Full Spectrum of Health-Related Services and Supports***
  - The demonstration will result in improved health information exchange capabilities for Medicaid specialty providers.
  - The demonstration will result in more integrated care coordination.
- ***Goal 5: Accelerating Groundbreaking Payment Reform***
  - The demonstration will result in additional populations and services transitioning to HCP-LAN Category 4 arrangements.
  - The demonstration will result in new payment initiatives for SUD outpatient services.
  - The demonstration will result in new payment initiatives for school-based mental health services.

Requested Waiver and Expenditure Authorities

Vermont is requesting the following waivers and expenditure authorities to operate the Global Commitment renewal demonstration:

Table 8: Requested Waiver and Expenditure Authorities

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/ Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
Waiver Authorities			
12. Statewideness: Section 1902(a)(1)	To allow the State to operate the program differently in different geographical areas of the State.	Currently approved	✓
13. Reasonable Promptness: Section 1902(a)(8)	To allow the State to maintain a waiting list for individuals applying for HCBW-like services through the CFC High Needs and Moderate Needs Groups. To allow the State to require applicants for nursing facility and HCBS (including HCBW-like services) to complete a person-centered assessment and options counseling process prior to receiving such services. To permit waiting lists for eligibility for demonstration-only (non-Medicaid State Plan) populations.	State requests that waiver permitting waiting lists for demonstration-only populations extend to the SUD Community Intervention and Treatment Eligibility group	✓
14. Amount, Duration, and Scope of Services: Section 1902(a)(10)(B)	To enable Vermont to vary the amount, duration, and scope of services offered to various mandatory and optional groups of individuals affected by or eligible under the demonstration as long as the amount, duration, and scope of covered services meets the minimum requirements under title XIX of the Act for the group (if applicable). To allow the State to provide nursing facility services and HCBS based on relative need as part of the person-centered and options counseling process for new applications for CFC services; to permit certain individuals, based on need, to receive demonstration services in the same eligibility group, under the Medicaid State Plan, and to limit the	Currently approved	✓

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/ Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
	amount, duration, and scope of services to those including in the participants' approved care plan.		
15. Financial Eligibility: Section 1902(a)(10)(C)(i)(III)	To allow the State to use institutional income rules (up to 300% SSI FBR) for HCBW-like programs besides CRT. To allow the State to use institutional income and resource rules for the Highest Need and High Need groups in the same manner as it did for the terminated 1915(c) waiver programs that were subsumed under the CFC demonstration in 2005. To permit the State to have a resource standard of $10,000 for Highest Need and High Need individuals who are single and own and reside in their own homes and who select HCBS in lieu of institutional services.	Modified waiver language to clarify that institutional income rules are used for determining eligibility for HCBW-like programs besides CRT for both categorically and medically needy beneficiaries	✓
16. Payment to Providers: Sections 1902(a)(13), 1902(a)(30)	To allow the State, through DVHA, to establish rates with providers on an individual or class basis without regard to the rates currently set forth in the approved State Plan.	Currently approved	✓

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/ Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
17. Premium Requirements: Section 1902(a)(14) In so far as it incorporates Section 1916	To permit Vermont to impose premiums in excess of statutory limits for optional populations and for children through age 18 with income above 195% FPL.	Currently approved	✓
18. Income/ Resource Comparability: Section 1902(a)(17)	To the extent necessary to enable the State to use varying income and resource standards and methods for plan groups and individuals.	Currently approved	✓
19. Spend-Down: Section 1902(a)(17)	To enable the State to offer one-month spend-downs for medically needy people receiving community-based services as an alternative to institutionalization, and non-institutionalized persons who are receiving personal care attendant services at the onset of waivers.	Currently approved	✓
20. Financial Responsibility/ Deeming: Section 1902(a)(17)(D)	To the extent necessary to exempt the State from the limits under section 1902(a)(17)(D) on whose income and resources may be used to determine eligibility unless actually made available, and so that family income and resources may be used instead. To enable the State to disregard quarterly income totaling less than $20 from the post-eligibility income determination.	Currently approved	✓
21. Freedom of Choice: Section 1902(a)(23)(A)	To enable the State to restrict freedom of choice of provider for the demonstration participants to the extent that beneficiaries will be restricted to providers enrolled in a provider network through DVHA for the type of service at issue, but may change providers among those enrolled providers. Freedom of choice of provider may not be restricted for family planning providers. This waiver allows Vermont to restrict choice of provider in situations where the State requires an individual to receive	Currently approved	✓

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/ Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
	services through a designated provider. The individual may receive services from any willing provider within that designated provider network.		
22. Direct Payments for Providers: Section 1902(a)(32)	To permit payments for incidental purchases for CFC HCBS to be made directly to beneficiaries or their representatives.	Currently approved	✓
Expenditure Authorities			
1. Expenditures Related to Eligibility Expansion	Expenditures to provide Medical Assistance coverage, either in the form of payment for medical services under the State Plan as affected by the waivers and expenditure authorities under this Demonstration, or in the form of premium assistance, to the Demonstration expansion populations listed in Section III of this document, that are not covered under the Medicaid State Plan and are enrolled in the Vermont Global Commitment to Health Demonstration. This authority applies to Demonstration Populations 4, 5, 6, 7, 8, and 9.	State requests to modify request to include SUD Community Intervention and Treatment Expansion Group (Population 9)	✓ (for CFC Highest Needs Population (Population 4), CFC High Needs Population (Population 5), CFC Moderate Needs Group (Population 6), CRT Expansion Group (Population 7), VPharm Group (Population 8)
2. Expenditures Related to Additional Services for HCBW-Like Programs	Expenditures for additional health care related-services (i.e., HCBW-like services) for all populations affected by or eligible through the demonstration as described in STC 20(c) in the currently approved Global Commitment demonstration.	Currently approved	✓

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/ Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
3. Expenditures for Public Health Initiatives, Outreach, Infrastructure, and Services Related to State Plan, Demonstration, Uninsured and Underinsured Populations	Expenditures to reduce the rate of uninsured and/or underinsured in Vermont, increase access to quality health care for uninsured, underinsured, and Medicaid beneficiaries, provide public health approaches and other innovative programs to improve the health outcomes and quality of life for Medicaid beneficiaries; and encourage the formation and maintenance of public private partnerships in health care; use of this expenditure authority will phase down over the five years of the demonstration.	State proposes that authority will phase down over five years of demonstration	
4. Expenditures for Hospice Services that Exceed State Plan Limits	Expenditures for adults eligible under the approved State Plan for hospice services that exceed State Plan limits.	Currently approved	✓
5. Expenditures for the Marketplace Subsidy Program	Expenditures for state-funded subsidy programs that aid certain individuals who purchase health insurance through the Marketplace.	Currently approved	✓
6. Expenditures for Mental Health CRT	Expenditures for mental health CRT services, as defined by Vermont rule and policy, to individuals with serious mental illness.	State proposes to modify request to reflect CRT transitioning to an expenditure authority	✓
7. Expenditures for SUD Community Intervention and Treatment	Expenditures for SUD Community Intervention and Treatment services, as defined by Vermont rule and policy, to individuals with SUD who have incomes above 133% FPL.	New request	
8. HCBW-like Services for State Plan	Expenditures for HCBW-like services for State Plan eligibles who meet all State Plan eligibility requirements, who have the indicated level of	Currently approved	✓

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/ Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
Eligibles Who Meet Highest Need, High Need, or Moderate Need Clinical Criteria for CFC	clinical need for HCBW-like services for the CFC program. The Moderate Needs Group does not meet all the CFC clinical criteria for long-term services, but are at risk of institutionalization. These individuals demonstrate a clinical need that shows they would benefit from a subset of HCBW-like services.		
9. Other HCBW-Like Expenditures	a. Expenditures for CFC participants with resources exceeding current limits, who are single, own and reside in their own homes, and select home-based care rather than nursing facility care, to allow them to retain resources to remain in the community; b. Expenditures for personal care services provided by HCBW-like participants' parents (when participants are minor children), spouses, and legal guardians; and c. Expenditures for incidental purchases paid in cash allowances to participants who are self-directing their CFC services prior to service delivery.	State requests to modify (b), expenditures for personal care services, to incorporate other HCBW-like programs beyond CFC	✓
10. Children's Personal Care Expenditures	Expenditures for State Plan children's personal care services provided by participants' parents and legal guardians.	Currently approved for COVID-19 public health emergency (PHE); State is seeking to extend authority beyond PHE	
11. Full Medicaid Benefits for Presumptively Eligible Pregnant Women	Expenditures to provide full Medicaid State Plan benefits to presumptively eligible pregnant women.	Currently approved	✓

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/ Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
12. Residential and Inpatient Treatment for Individuals with Substance Use Disorder	Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an IMD. Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are residents of family-focused residential treatment programs that meet the definition of an IMD, regardless of length of stay.	State requests waiver to reflect that stays at family-focused residential treatment programs will be covered, regardless of length of stay	
13. Residential and Inpatient Treatment for Individuals with Serious Mental Illness	Expenditures for Medicaid State Plan services furnished to eligible individuals who are primarily receiving short-term treatment for an SMI in facilities that meet the definition of an IMD. Expenditures for Medicaid State Plan services furnished to eligible individuals who are primarily receiving treatment for an SMI in facilities providing family-focused residential treatment that meet the definition of an IMD, regardless of length of stay.	State requests waiver to reflect that stays at family-focused residential treatment programs will be covered, regardless of length of stay	
14. Retroactive Eligibility	To enable the State to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance is made for expansion groups (for Populations 6 and 8 only).	Currently approved	✓
15. Permanent Supportive Housing Pilot	Expenditures for permanent supportive housing services provided to enrollees in the State's Pilot program. The State will institute annual enrollment limits for this Pilot and will maintain a waiting list.	New request	

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/ Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
16. Coverage for Inmates Pre-Release	Expenditures for Medicaid services rendered to incarcerated enrollees in the 90 days pre-release from a correctional facility.	New request	
17. Health Information Exchange Activities	Expenditures not to exceed $17 million over five years to conduct activities that will strengthen providers' ability to participate in health information exchange. Expenditures not to exceed $5 million over five years to deploy an electronic patient engagement platform.	New request	
18. Blueprint for Health	Expenditures not to exceed $15 million over five years to administer the Blueprint program.	New request (currently covered as an investment)	✓
19. Workforce Development	Expenditures not to exceed $4.75 million over five years to support health care workforce development in Vermont.	New request (currently covered as an investment)	✓
20. Public Health Infrastructure	Expenditures not to exceed $38 million over five years to sustain and strengthen Vermont's public health infrastructure.	New request (currently covered as an investment)	✓

Appendices

Appendix A- External Quality Review

Background

AHS contracts with Health Services Advisory Group, Inc. (HSAG) to perform the external quality review (EQR) activities. As part of this role, HSAG provides technical guidance to DVHA to assist them in conducting activities related to the mandatory activities that provide information for the EQR and the resulting EQR technical report.

Summary of 2020 EQR Findings

EQR Performance Improvement Project

HSAG validated DVHA's performance improvement project (PIP), *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment.* The PIP addressed the initiation of alcohol and other drug abuse or dependence treatment for adolescent and adult beneficiaries with a new alcohol or other drug abuse or dependence diagnosis. This PIP topic represents a key area of focus for improvement by DVHA. Members receiving the appropriate care and services for alcohol or other drug abuse or dependence in the recommended timeframes is essential to the recovery process.

HSAG used CMS' PIP validation protocol[37] as the methodology to validate the PIP. HSAG's validation assessed Steps I through X of the protocol. DVHA's *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment* PIP received a score of 100 percent for all applicable evaluation elements scored as *Met*, a score of 100 percent for critical evaluation elements scored as *Met*, and an overall validation status of *Met*, as displayed in Table 1.

Table 1. 2020–2021 PIP Validation Summary Overall Score

Percentage Score of Evaluation Elements *Met**	**100%**
Percentage Score of Critical Elements *Met***	**100%**
Validation Status	***Met***

* The percentage score is calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*.

[37] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Nov. 23, 2020.

** The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

EQR Performance Measure Validation

HSAG validated a set of performance measures, selected by AHS and calculated and reported by DVHA, used to assess performance under the Global Commitment Demonstration. The methodology HSAG used to validate the performance measures was based on CMS' validation of performance measures protocol.[38] The validation findings confirmed that all rates were reportable.

Excluding information-only measures, DVHA demonstrated strength with 15 measure rates meeting or exceeding the 90th percentile and only six measure rates falling below the 25th percentile. Of the 46 reportable rates with comparable benchmarks, five rates exceeded the 95th percentile and ten rates met or exceeded the 90th percentile but were below the 95th percentile. DVHA demonstrated opportunities for improvement, with six rates falling below the 25th percentile.

DVHA performed at or above the 75th percentile for 16 of 46 (34.8 percent) measure rates appropriate for comparison to benchmarks, demonstrating strengths in well-child visits, adult access to routine and emergency health services, appropriate ED utilization, and engagement of AOD abuse or dependence treatment. Conversely, 17 of 46 rates (37.0 percent) fell below the 50th percentile, indicating efforts should be focused on ensuring young children and adolescents are receiving necessary well-child/well-care visits; young children and adolescents receive counseling for BMI percentage, nutrition, and physical activity; and young women are appropriately screened for chlamydia and breast cancer. Initiation of AOD abuse or dependence treatment and controlling blood pressure are additional areas of focus for DVHA.

Review of Compliance with Standards

AHS requested that HSAG continue to review one of the three sets of federal Medicaid managed care standards during each EQR contract year. For EQR contract year 2020–2021, AHS requested that HSAG conduct a review of the Structure and Operations standards. HSAG conducted the review consistent with CMS' *Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[39] HSAG reviewed DVHA's written operating policies and procedures, program plans, meeting minutes,

[38] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Nov. 10, 2020.

[39] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Nov. 10, 2020.

numerous written reports, and other data and documentation related to DVHA's performance during the review period. Reviewers also conducted staff interviews related to each of the eight standards to allow DVHA staff members to elaborate on the written information HSAG reviewed, to assess the consistency of staff responses given during the interviews against the written documentation, and to clarify any questions reviewers had following the document review.

The primary objective of HSAG's review was to identify and provide meaningful information to AHS and DVHA about DVHA's performance strengths and any areas requiring corrective actions. The information included HSAG's report of its findings related to the extent to which DVHA's performance complied with the applicable federal Medicaid managed care regulations and AHS' associated IGA contract requirements for providing accessible, timely, and quality services to beneficiaries. Table 2 presents a summary of DVHA's performance results for the eight standard areas reviewed. The information includes:

- The total number of elements (i.e., requirements) and the number of applicable elements for each of the standards.
- The number of elements for each of the standards that received a score of *Met*, *Partially Met*, *Not Met*, or a designation of NA (not applicable), as well as the totals across the seven standards.
- The total compliance score for each of the standards.
- The overall compliance score across all standards.

Table 2. Standards and Compliance Score

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
I	Provider Selection	11	11	11	0	0	0	**100%**
II	Credentialing and Recredentialing	4	4	4	0	0	0	**100%**
III	Beneficiary Information	11	11	10	1	0	0	**95.5%**
IV	Beneficiary Rights	4	4	4	0	0	0	**100%**
V	Confidentiality	5	5	5	0	0	0	**100%**
VI	Grievance System—Beneficiary Grievances	16	16	13	3	0	0	**90.6%**

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
VII	Grievance System—Beneficiary Appeals and State Fair Hearings	32	32	26	5	1	0	**89.1%**
VIII	Subcontractual Relationships and Delegation	5	5	5	0	0	0	**100%**
	Totals	**88**	**88**	**78**	**9**	**1**	**0**	**93.8%**

***Total # of Elements*:** The total number of elements in each standard.

***Total # of Applicable Elements*:** The total number of elements within each standard minus any elements that received a score of *NA.*

***Total Compliance Score*:** The overall percentages were calculated by adding the number of elements that received a score of *Met* to the weighted number (multiplied by 0.50) that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

As displayed in Table 2, HSAG reviewed DVHA's performance related to 88 elements across the eight standards. Of the 88 elements, DVHA obtained a score of *Met* for 78 elements (88.6 percent) and a *Partially Met* score for 9 elements (10.2 percent). DVHA obtained a *Not Met* score for one element (1.1 percent). As a result, DVHA obtained a total percentage-of-compliance score across the 88 elements of 93.8 percent.

EQR Performance Trends

EQR Performance Improvement Project

DVHA continued its PIP topic, *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment*, in contract year 2020–2021. DVHA has performed well in meeting the requirements in the Design and Implementation stages of the PIP, achieving all the validation criteria in Steps I through VIII. HSAG determined that DVHA designed a methodologically sound study. The technical design of the PIP was valid to measure reliable study indicator outcomes. DVHA indicated that the fishbone diagram, corresponding prioritization of barriers, and provider survey analysis that it had completed continued to guide the improvement work during Remeasurement 2. The highest priority barrier reported by DVHA was timely access to treatment.

The main intervention for the PIP was a focus on promoting telemedicine/telehealth visits for SUD treatment. DVHA pursued the promotion of telehealth with SUD treatment providers and monitored an interim telemedicine indicator quarterly report to gauge progress. DVHA expanded

the scope of its work by partnering with the Vermont Program for Quality in Health Care. During Remeasurement 2, DVHA worked with partnering organizations to plan a "Telehealth 101" training for providers. DVHA reported other intervention activities during Remeasurement 2 that included the following:

- Publication of additional provider banners.
- Publication of a provider advisory newsletter article in May 2019.
- Continued presentations to stakeholder groups about the need for the PIP.
- Continued the build of a section on the DVHA website.

For outcomes in Step IX and Step X, DVHA's PIP achieved statistically significant and sustained improvement in the study indicator results. DVHA reported the baseline result for the PIP as 44.2 percent. For the first remeasurement, DVHA reported the result as 46.7 percent, a 2.5 percentage point increase from the baseline. The improvement from the baseline to the first remeasurement was statistically significant. Using a Chi-square test to compare the baseline to the first remeasurement, the *p* value = 0.0086. For the second remeasurement, DVHA reported a result of 49.3 percent. The improvement was a 2.6 percentage point increase from the first remeasurement and a 5.1 percentage point increase from the baseline. The improvement from the baseline to the second remeasurement was statistically significant. Using a Chi-square test to compare the baseline to the second remeasurement, the *p* value was < 0.0001.

EQR Performance Measure Validation

Overall, 12 of the 20 (60 percent) measure rates that could be trended showed an improvement in performance since HEDIS 2017 (excluding information-only measures). Further, the *Adults' Access to Preventive/Ambulatory Health Services—65+ Years* rate improved by nearly 20 percentage points from HEDIS 2017 to HEDIS 2020. Of the eight measure rates that showed a decline in performance, *Ambulatory Care (ED Visits)—65–74 Years* declined by over 40 percentage points, *Ambulatory Care (ED Visits)—75–84 Years* declined by over 30 percentage points, *Ambulatory Care (ED Visits)—85+ Years* declined by over 20 percentage points, and *Ambulatory Care (ED Visits)—45–64 Years* declined by over 15 percentage points.

EQR Review of Compliance with Standards

HSAG reviews a different set of standards to evaluate DVHA's compliance with federal CMS Medicaid managed care regulations and the associated AHS/DVHA IGA requirements during each year within a three-year cycle of reviews. The number of standards reviewed each year varies, as does the focus of the review. The three-year cycle consists of the following standards: Year 1, Structure and Operations standards (42 CFR §438.10, §438.100, §438.214–§438.230, and §438.414); Year 2, Measurement and Improvement standards (42 CFR §438.236, §438.242,

and §438.330); and Year 3, Access and Enrollment/Disenrollment standards (42 CFR §438.206–§438.210 and §438.54–§438.56).

For 2020 (the 13th year of review), HSAG evaluated the Structure and Operations standards, the same standards it reviewed in 2008, 2011, 2014, and 2017. Table 3 documents DVHA's performance across 13 years of compliance reviews conducted by HSAG.

Table 3. Comparison/Trending of Scores Achieved During Compliance Reviews

Year of the Review	Structure and Operations Standards			Measurement and Improvement Standards			Access and Enrollment/Disenrollment Standards		
	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*	Elements	Score	Corrective Action %*
2008	90	84%	30%						
2009				29	98%	3%			
2010							76	97%	7%
2011	89	90%	20%						
2012				30	100%	0%			
2013							71	99%	3%
2014	93	92%	15%						
2015				31	97%	3%			
2016							80	97%	6%
2017	84	90%	19%						
2018				33	100%	0%			
2019							68	86%	22%
2020	88	94%	11%						

***** The percentage of requirements for which HSAG scored **DVHA**'s performance as either partially meeting or not meeting the requirement.

For the Structure and Operations standards, the overall scores DVHA received across the five years these standards were reviewed ranged from 84 percent to 94 percent, with the overall corrective action percentages ranging from 11 percent to 30 percent. During the prior review, DVHA scored 90 percent across the eight standards.

Quality, Timeliness, and Access to Care Domains

The federal Medicaid managed care regulations require that "each contract with a Medicaid managed care organization must provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the care and services for which the organization is responsible."[40] CMS has chosen the domains of quality, access, and timeliness as keys to evaluating the performance of MCOs, PIHPs, PAHPs, and PCCMs. Definitions HSAG used to evaluate and draw conclusions about DVHA**'s** performance in each of these domains are as follows.

Quality

CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:

> Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in §438.310(c)(2)) increases the likelihood of desired health outcomes of its enrollees through its (1) structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidence-based knowledge, and (3) interventions for performance improvement.[41]

Timeliness

The National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as follows:

> "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[42] NCQA further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to beneficiaries and that require a timely response by the managed care organization—e.g., processing expedited appeals and providing timely follow-up care.

[40] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions.* Available at: https://innovation.cms.gov/files/migrated-medicare-demonstration-x/cc_section4016_bba_1997.pdf. Accessed on: Nov. 23, 2020.
[41] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol 81, May 6, 2016.
[42] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol 81, May 6, 2016.

Access

CMS defines "access" in the final rule at 42 CFR §438.320 as follows:

> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).[43]

To draw conclusions about the quality and timeliness of, and access to, care DVHA provided, HSAG determined which components of each EQR activity could be used to assess these domains (as indicated in Table 4). The measures marked N/A relate to utilization of services.

Table 4. EQR Activity Components Assessing Quality, Timeliness, and Access

	Quality	Timeliness	Access
PIP			
Initiation of Alcohol and Other Drug Abuse or Dependence Treatment	✓	✓	✓
Performance Measures			
Adolescent Well-Care Visits	✓		✓
Adults' Access to Preventive/Ambulatory Health Services			✓
Ambulatory Care	N/A	N/A	N/A
Breast Cancer Screening	✓		
Chlamydia Screening in Women	✓		
Controlling High Blood Pressure	✓		
Developmental Screening in the First Three Years of Life	✓	✓	✓
Follow-Up After ED Visit for AOD Abuse or Dependence	✓	✓	✓
Performance Measures			
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓

[43] Federal Register. *Code of Federal Regulations, Title 42, Volume 4*, May 6, 2016. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=fa076676cc95c899c010f8abe243e97e&mc=true&node=se42.4.438_1320&rgn=div8. Accessed on: Nov. 23, 2020.

	Quality	Timeliness	Access
Follow-Up After ED Visit for Mental Illness	✓	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment	✓	✓	✓
Prenatal and Postpartum Care	✓	✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Well-Child Visits in the First 15 Months of Life	✓		✓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		✓
Compliance Review Standards			
Standard I—Provider Selection	✓	✓	✓
Standard II—Credentialing and Recredentialing	✓	✓	✓
Standard III—Beneficiary Information	✓	✓	✓
Standard IV—Beneficiary Rights	✓	✓	✓
Standard V—Confidentiality	✓		
Standard VI—Grievance System—Beneficiary Grievances	✓	✓	✓
Standard VII—Grievance System—Beneficiary Appeals and State Fair Hearings	✓	✓	✓
Standard VIII—Subcontractual Relationships and Delegation	✓	✓	✓

Other Quality Assurance Monitoring Performance Trends

As per the waiver's Special Terms and Conditions (STCs), Vermont shall expand on the managed care quality strategy requirements at 42 CFR 438.340 and adopt and implement a comprehensive, dynamic, and holistic continuous quality improvement strategy that integrates all aspects of quality improvement programs, processes, and requirements across the State's Medicaid program. This document is known as the Comprehensive Quality Strategy (CQS). Vermont's CQS is intended to serve as a blueprint for Vermont and its contracted health plan in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. In doing so, it describes specifications for quality assessment and performance improvement activities that the AHS will implement to ensure the delivery of quality health care.

Achievements in quality planning since the initial Comprehensive Quality Strategy (CQS) was developed in 2005 include:

- Implementation and engagement of the External Quality Review Organization
- Selection and reporting of HEDIS, and select child core set and adult core set measures
- Selection of performance goals and implementation of a performance accountability framework
- Maturation of the PIPs with technical assistance from the EQRO

In addition, the State has met six of its performance targets in advance of the 2021 target date identified in the CQS. Specifically, a five-percentage point increase was achieved in 2017 in the following areas:

- Adolescent well-care visits (51.6% achieved with a 2021 target of 49.2%)
- Well-child visits in the first 15 months of life, six or more visits (72.8% achieved with a 2021 target of 70.75%)
- Well-child visits in the third, fourth, fifth and sixth years of life (76.7% achieved with a 2021 target of 76.23%)
- Annual dental visits for children 2-22 years of age (71.1% achieved with a 2021 target of 68.11%)
- Adult access to preventive care/ambulatory care (81.7% achieved with a 2021 target of 79.57%)
- Follow-up after hospitalization for mental illness at seven and 30 days (52.7% and 71.8% achieved with a 2021 target of 45.27% and 62.53% respectively)
- Initiation and engagement in alcohol and other drug dependency treatment (46.6% and 23.9% achieved with a 2021 target of 36.74% and 15.04% respectively)

During that same time, the remaining measures are within three percentage points of their 2021 targets. Work continues to maintain and improve all scores and focus on achievement of 2021 quality targets in the following areas:

- Breast cancer screening (54.3% in 2017, with a 2021 target of 56.93%)
- Chlamydia screening (53.2% in 2017, with a 2021 target of 55.15%)
- Medication management for people with asthma (73.9% in 2017, with a 2021 target of 74.68%)

Finally, the State's performance regarding performance improvement projects (PIPs) and many performance measures has improved over time. The State's External Quality Review Organization, Health Services Advisory Group, Inc., has also noted that the Agency of Human Services has significantly enhanced the overall monitoring of compliance review activities.