DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-03-17
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

MAR 0 8 2018

Al Gobeille
Secretary
Vermont Agency of Human Services
280 State Drive
Waterbury, VT 05671

Dear Secretary Gobeille:

The Centers for Medicare & Medicaid Services (CMS) is approving Vermont's evaluation design for the section 1115 demonstration, entitled "Vermont Global Commitment to Health," (Project Number 11-W-00194/1). The Special Terms and Conditions (STCs) were updated to incorporate the approved evaluation design as Attachment K of the STCs.

You may now post the approved evaluation design on the state Medicaid website in accordance with federal requirements at 42 Code of Federal Regulations (CFR) §431.424(e). If you wish to extend the demonstration beyond the current approval period, the state must submit an interim evaluation report consistent with the approved evaluation design at the time of the extension request as outlined in 42 CFR §431.412(c)(2)(vi).

Your CMS project officer for this demonstration is Robin Patrice Magwood. She is available to answer any questions regarding your section 1115 demonstration. Her contact information is:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-03-17
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-0130
Email: Robin.Magwood1@cms.hhs.gov

Please send any official communication regarding program matters simultaneously to Mr. Richard McGreal, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations Program in the Boston Regional Office. Mr. McGreal can be reached at (617) 565-1299 or Richard.McGreal@cms.hhs.gov. Mr. McGreal's contact information is as follows:

Mr. Richard McGreal
Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations Program
JFK Federal Building, Suite 2325
Boston, MA 02202-0003

We look forward to continuing to partner with you and your staff on the Vermont section 1115 demonstration.

Sincerely,

[redacted]

Kim Howell
Director
Division of State Demonstrations and Waivers

Enclosures

cc: Mr. Richard McGreal, Associate Regional Administrator, Boston Regional Office
Gilson DaSilva, Vermont State Lead, CMS Boston Region I

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

NUMBER: **11-W-00194/1**

TITLE: **Global Commitment to Health Section 1115 Demonstration**

AWARDEE: **Vermont Agency of Human Services (AHS)**

Under the authority of Section 1115(a)(1) of the Social Security Act (the Act) the following waivers are granted to enable Vermont to operate the Global Commitment to Health section 1115 demonstration. These waivers are effective beginning January 1, 2017 and are limited to the extent necessary to achieve the objectives below. These waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in the accompanying document.

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project for the period beginning January 1, 2017 through December 31, 2021.

1. Statewideness/Uniformity **Section 1902(a)(1)**

To the extent necessary to enable Vermont to operate the program differently in different geographical areas of the state.

2. Reasonable Promptness **Section 1902(a)(8)**

To allow the state to maintain a waiting list for high and moderate need individuals applying for home and community-based services (HCBS). To allow the state to require applicants for nursing facility and home and community-based services (including demonstration home and community based waiver-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.

3. Amount, Duration, 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) and the special terms and conditions.

To allow the state to provide nursing facility and home and community-based services based on relative need as part of the person-centered and options counseling process for new

applicants for Choices for Care services; to permit certain individuals, based on need, to receive demonstration services that are not available to categorically eligible individuals, or other individuals in the same eligibility group, under the Medicaid state plan; and to limit the amount, duration, and scope of services to those included 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 percent of the Supplemental Security Income payment level) for medically needy beneficiaries.

To allow the state to use institutional income and resource rules for the high and highest need groups of the medically needy in the same manner as it did for the terminated 1915(c) waiver programs that were subsumed under the Choices for Care demonstration in 2005.

Additionally, this waiver permits the state to have a resource standard of $10,000 for high and highest need medically needy individuals who are single and own and reside in their own homes and who select home and community-based services (HCBS) in lieu of institutional services.

5. Payment to Providers **Sections 1902(a)(13), 1902(a)(30)**

To allow the state, through the Department of Vermont Health Access, to establish rates with providers on an individual or class basis without regard to the rates currently set forth in the approved state plan.

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 percent of the Federal poverty level (FPL) as reflected in the Special Terms and Conditions.

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.

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.

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.

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 the Department of Vermont Health Access (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.

11. Direct Payments to Providers **Section 1902(a)(32)**

To permit payments for incidental purchases for Choices for Care HCBS to be made directly to beneficiaries or their representatives.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: **11-W-00194/1**

TITLE: **Global Commitment to Health Section 1115 Demonstration**

AWARDEE: **Vermont Agency of Human Services (AHS)**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Vermont for the items identified below (which are not otherwise included as expenditures under section 1903 of the Act) shall, for the period of this demonstration extension, beginning January 1, 2017 through December 31, 2021, be regarded as expenditures under the state's Medicaid Title XIX plan. These expenditure authorities are granted to enable the state to operate its Global Commitment to Health Section 1115 demonstration and may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in the accompanying document.

All requirements of the Medicaid program expressed in federal law, regulation and policy statements, not expressly waived or identified as not applicable to these expenditure authorities, shall apply to the Global Commitment to Health demonstration for the period of this demonstration extension.

These expenditure authorities promote the objectives of title XIX in the following ways:

- Increase and strengthen overall coverage of low-income individuals in the state;
- Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income individuals in the state;
- Improve health outcomes for Medicaid and other low-income populations in the state; and
- Increase efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

1. Expenditures Related to Eligibility Expansion

Expenditures to provide Medicaid coverage to the following demonstration populations that are not covered under the Medicaid state plan and are enrolled in the Vermont Global Commitment to Health demonstration. (Note: demonstration populations 1, 2, and 3, which are described in the demonstration's special terms and conditions, are covered under the Medicaid state plan.)

a. **Demonstration Population 4: Highest Need**: Expenditures for 217-like individuals receiving Home and Community Based Waiver (HCBW)-like services who meet the clinical standard of need for the highest need group and Program of All-Inclusive Care for the Elderly (PACE) like participants who meet the clinical standards for the highest need group.

b. **Demonstration Population 5: High Need**: Expenditures for 217-like individuals receiving HCBW-like services in the High Need Group and PACE- like participants who meet the clinical standards for the High Need Group.

c. **Demonstration Population 6: Moderate Needs Group (Expansion Group)**: Expenditures for a small subset of HCBW- like services for individuals who are not otherwise eligible under the Medicaid state plan and who would not have been eligible had the state elected eligibility under 42 CFR 435.217, but are at risk for institutionalization and are in need of home and community-based services. Such individuals may have income up to 300 percent of the SSI/Federal Benefit Rate (FBR) and resources below $10,000. Individuals with income below the limit and with excess resources may apply excess resources to income, up to the income limit. These benefits do not meet the requirements of Minimum Essential Coverage.

d. **Demonstration Population 7:** Medicare beneficiaries with income at or below 150 percent of the Federal poverty level (FPL), who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise eligible for full benefits.

e. **Demonstration Population 8:** Medicare beneficiaries with income above 150 percent and up to and including 225 percent of the FPL, who may be enrolled in the MSP, but are not otherwise categorically eligible for full benefits.

2. **Expenditures Related to Additional Services.** Expenditures for additional health care related-services described in STC 19(c) for all populations affected by or eligible through the demonstration.

3. **Expenditures for Public Health Initiatives, Outreach, Infrastructure, and Services Related to State Plan, Demonstration, Uninsured, and Underinsured Populations.** Expenditures to support the goal of providing state-funded health care programs to improve the access and quality of health care services available to uninsured and underinsured individuals in Vermont subject to the terms and limitations set forward in STCs 79 and 80 and up to a maximum of the limits set in STC 81 (and which cannot be rolled over to the next demonstration year (DY)), to reduce the rate of uninsured and 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 including initiatives to support and improve the health care delivery system and promote transformation to value-based and integrated models of care.

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.

5. **Expenditures for the Marketplace Subsidy Program.** Expenditures for state funded subsidy programs that provide assistance to certain individuals who purchase health

insurance through the Marketplace.

6. **Expenditures for Services for Individually Assessed Cost Effective Alternate Services.** Expenditures for direct health care services or other services furnished as alternatives to covered services when the state and treating health care professionals have made an assessment and determination that the service is a medically appropriate and cost effective substitute for the corresponding state plan service or setting.

7. **Expenditures for Mental Health Community Rehabilitation and Treatment (CRT) Services.** Expenditures for mental health community rehabilitation and treatment (CRT) services, as defined by Vermont rule and policy, provided through a state-funded program to individuals with severe and persistent mental illness who have incomes above 133 percent of the FPL and up to and including 185 percent of FPL who are not otherwise Medicaid enrolled.

8. **HCBW-like Services for State Plan Eligibles Who Meet Highest Need, High Need or Moderate Needs Clinical Criteria.** 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. The Moderate Needs Group do not meet all the Choices for Care 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 Choices for Care Expenditures:**

   a. Expenditures for Choices for Care 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 Choices for Care participants spouses; and

   c. Expenditures for incidental purchases paid in cash allowances to participants who are self-directing their services prior to service delivery.

10. **Full Medicaid Benefits for Presumptively Eligible Pregnant Women.** Expenditures to provide full Medicaid State plan benefits to presumptively eligible pregnant women.

Title XIX Requirements not Applicable to Demonstration Expenditure Authorities (Populations 6, 7, and 8)

1. Retroactive Eligibility **Section 1902(a)(34)**

To enable the state to waive the requirement to provide medical assistance for up to three (3) months prior to the date that an application for assistance is made for expansion groups.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00194/1**

TITLE: **Global Commitment to Health Section 1115 Demonstration**

AWARDEE: **Vermont Agency of Human Services (AHS)**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Vermont Global Commitment to Health Section 1115(a) Medicaid demonstration (hereinafter "demonstration"). The parties to this agreement are the Vermont Agency of Human Services (AHS, state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth limitations on the extent of the waivers and expenditure authorities that have been granted to further the demonstration, which are enumerated in separate lists. The STCs also detail the nature, character, and extent of Federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. These STC's are effective as of January 1, 2017 through December 31, 2021 unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below.

The amended STCs have been arranged into the following subject areas:

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Global Commitment to Health Section 1115(a) demonstration was initiated in September 2005, and is designed to use a multi-disciplinary approach including the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, public-private partnership, and program flexibility.

As of January 1, 2017, Vermont is extending the Global Commitment to Health demonstration to further promote delivery system and payment reform to meet the goals of the state working with the Center for Medicaid and CHIP Services and the Center for Medicare and Medicaid Innovation (CMMI) consistent with Medicare's payment reform efforts in order to allow for alignment across public payers. Specifically, Vermont expects to demonstrate its ability to achieve universal access to health care, cost containment, and improved quality of care.

Since 2005, the Global Commitment to Health demonstration has helped reduce Vermont's uninsured rate from 11.4 percent in 2005 to approximately 2.7 percent in 2015 through expansion of eligibility. The demonstration has also enabled Vermont to address and eliminate the bias toward institutional care and offer cost-effective, community-based services. For example, the proportion of Choices for Care participants served in the community has passed fifty percent and continues to increase. In addition, Vermont no longer has a waiting list for individuals in the Highest and High Need Groups under the Choices for Care component of the demonstration.

While expansion of eligibility is no longer the primary focus of the demonstration, in light of the expansion of eligibility under the state plan pursuant to the Affordable Care Act, the demonstration continues to promote delivery system reform and cost-effective community-based services as an alternative to institutional services. The state's goal in implementing the demonstration is 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 long-term services and supports and providing an array of home and community-based alternatives recognized to be more cost-effective than institutional based supports.

The state will employ four major elements in achieving the above goals:

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

2. *Managed Care Delivery System:* Under the demonstration the Agency for Human Services (AHS) will enter into an agreement with the Department of Vermont Health Access (DVHA), which will deliver services through a managed care-like model, subject to the requirements that would be applicable to a non-risk pre-paid inpatient health plan (PIHP) as defined in STC 23;

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

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

The initial Global Commitment to Health and Choices for Care demonstrations were approved in September of 2005, effective October 1, 2005. The Global Commitment to Health demonstration was extended for three years, effective January 1, 2011, again for three (3) years starting effective October 2, 2013. The Choices for Care demonstration was extended for five (5) years effective October 1, 2010, and became part of the Global Commitment to Health demonstration in January 2015. The following amendments have been made to the Global Commitment to Health demonstration:

- 2007: A component of the Catamount Health program was added, enabling the state to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the FPL, and who do not have access to cost effective employer-sponsored insurance, as

determined by the state.

- 2009: The state extended Catamount Health coverage to Vermonters at or below 300 percent of the FPL.

- 2011: The state included a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life-limiting illness that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.

- 2012: CMS provided authority for the state to eliminate the $75 inpatient admission co- pay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid state plan.

- 2013: CMS approved the extension of the Global Commitment to Health demonstration which included sun-setting the authorities for most of the Expansion Populations, including Catamount Health coverage, because these populations would be eligible for Marketplace coverage beginning January 1, 2014. The extension also added the New Adult Group under the state plan to the population affected by the demonstration effective January 1, 2014. Finally, the extension also included premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL.

- 2015: In January 2015, the Global Commitment to Health demonstration was amended to include authority for the former Choices for Care demonstration. In addition, the state received section 1115 authority to provide full Medicaid state plan benefits to pregnant women who are determined presumptively eligible.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state agrees that it must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in federal law, regulation, and policy statement, unless specified otherwise in the STCs, waiver list, or expenditure authorities or otherwise listed as non- applicable, must apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in the applicable federal law, regulation, or policy directive, come into compliance with any changes in federal law, regulation, or policy affecting the

Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified budget neutrality agreements would be effective upon the implementation of the change.

    b. If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the latest day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state is not required to submit title XIX state plan amendments for changes to demonstration-eligible populations covered solely through the demonstration. If a population covered through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. Reimbursement of providers will not be limited to reimbursement described in the state plan.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, and budget neutrality must be submitted to CMS as amendments to the demonstration (and as amendments to the state plan, if eligibility under the state plan is changed). All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state shall not implement changes to these elements of the amendment to the demonstration without prior approval by CMS. In certain instances, amendments to the Medicaid state plan may or may not require amendment to the demonstration as well. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the date of implementation of the change and may not be implemented until approved. Amendment requests will be reviewed by the Federal Review Team and must include, but are not limited to, the following:

    a. An explanation of the public process used by the state to reach a decision regarding the requested amendment;

    b. A data analysis which identifies the specific "with waiver" impact of the proposed

amendment on the current budget neutrality expenditure cap. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level though the approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;

c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d. If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

8. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than five (5) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a thirty (30) day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the thirty (30) day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

b. The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than fourteen (14) days after CMS approval of the phase-out plan.

c. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

d. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the

date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

e. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services andadministrative costs of disenrolling participants.

9. Extension of the Demonstration.

a. Should the state intend to request an extension of the demonstration under section 1115(a) or 1115(f), the state must submit an extension request no later than six (6) months prior to the expiration date of the demonstration. A request to extend an existing demonstration under 1115(e) must be submitted at least twelve (12) months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 8 of this section.

b. Compliance with Transparency Requirements of 42 CFR 431.412. As part of the demonstration extension requests, the state must provide documentation of compliance with the transparency requirements of 42 CFR 431.412 and the public notice and tribal consultation requirements outlined in STC 14 of this section regarding Public Notice, Tribal Consultation and Consultation with Interested Parties. The financial data described in 42 CFR 431.412(c)(2)(v) must include five years of recent historical expenditure and enrollment data for the Medicaid and demonstration populations that are to be included in the demonstration extension, and a proposed budget neutrality test for the extension period based on recent data.

10. CMS Right to Terminate or Suspend. CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. In addition, CMS reserves the right to withdraw expenditure authorities at any time it determines that continuing the expenditure authorities would no longer be in the public interest. If an expenditure authority is withdrawn, CMS shall be liable for only normal close-out costs. CMS will promptly notify the state in writing of the determination and the reasons for suspension or termination of the demonstration, or any withdrawal of an expenditure authority, together with the effective date.

11. Finding of Non-Compliance. The state does not relinquish either its rights to challenge the CMS finding that the state materially failed to comply, or to request reconsideration or appeal of any disallowance pursuant to section 1116(e) of the Act.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

14. **Public Notice and Consultation with Interested Parties.** The state must continue to comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and regulations that implement section 1115(d), as added by section 10201 of the Affordable Care Act.

15. **Dual Role of Managed Care-Like Model and Compliance with Managed Care Regulations.** For purposes of the demonstration the state shall comply with all of the managed care regulations published at 42 CFR section Part 438 et. seq., except as expressly modified or identified as not applicable in the STCs. DVHA shall continue to serve as the unit designated by AHS (the Single State Agency) responsible for administration of the state Medicaid program and operates as a public managed care model solely to carry out the goals and purposes of the demonstration. DVHA's role under the demonstration as a public managed care model does not reduce or diminish its authority to operate as the designated Medicaid unit under the approved state plan, including its authority to implement program policies permissible under a state plan and establish provider participation requirements. DVHA shall comply with federal program integrity and audit requirements as if it were a non-risk pre-paid inpatient health plan (PIHP) for services and populations covered under the demonstration in accordance with STC 23.

16. **Federal Funds Participation (FFP)**. No federal matching for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

The Global Commitment to Health demonstration includes the following fundamental elements: program flexibility; a health care delivery system administered by the state and modeled after a managed care delivery system; comprehensive and person-centered services; and choice in long-term services and supports.

17. Populations Affected and Eligible under the Demonstration.

a. **Generally:** The populations listed in the tables below will receive coverage through the Global Commitment to Health demonstration service delivery system.

b. **State plan groups:** Coverage for mandatory and optional state plan groups described below are subject to all applicable Medicaid laws and regulations, except as expressly waived in these STCs and the waiver list and expenditure authority for this demonstration. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard on January 1, 2014, will apply to this demonstration.

c. **Choices for Care Program Eligibility:** Individuals who receive long term services and supports under the Choices for Care program must meet state plan financial rules and clinical eligibility criteria as defined by state regulation in effect as of February, 9, 2009. These clinical eligibility determinations define highest, high, and moderate needs service groups. See Attachment A for a summary of eligibility definitions, services, and policies. Non-state plan eligible Choices for Care individuals are included in Populations 4, 5, and 6 in the table below.

d. **Other Demonstration Expansion Populations:** Coverage for these populations is subject to Medicaid laws or regulations only as specified in the expenditure authorities for this demonstration.

The general categories of populations affected, or made eligible, by the demonstration are:

Mandatory and Optional State Plan Groups		
Population number	***Population description***	***Benefits***
Population 1	Mandatory state plan populations, except for the Affordable Care Act new adult group (included in population 3) and Medicare Savings Program beneficiaries (included in populations 7 and 8).	Benefits as described in the title XIX state plan and these STCs.
Population 2	Optional state plan populations (including medically needy)	Benefits as described in the title XIX state plan and these STCs.

Population 3	The new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119, pursuant to the approved state plan.	Benefits as described in approved alternative benefit plan state plan amendment and these STCs.

Demonstration Expansion Populations		
Demonstration population number	***Population description***	***Benefits***
Population 4	Individuals age 65 and older and age 21 and older with disabilities, not otherwise eligible under the state plan, who meet the clinical criteria for the highest need group, 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 prior to 2014. 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, with a resource standard of $10,000. This only applies to unmarried individuals who have an ownership interest in their principal residence.	Benefits as described in the Medicaid state plan and HCBS benefits described in these STCs.

Demonstration Expansion Populations		
Demonstration population number	***Population description***	***Benefits***
Population 5	Individuals age 65 and older and age 21 and older with disabilities, not otherwise eligible under the state plan, who meet the clinical criteria for the high need group, 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 prior to 2014. 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, and have a resource standard of $10,000. This only applies to unmarried individuals who have an ownership interest in their principal place of residence.	Benefits as described in the Medicaid state plan and HCBS benefits described in these STCs.

Demonstration Expansion Populations		
Demonstration population	***Population description***	***Benefits***
Population 6	Individuals who have incomes below 300 percent of the SSI Federal Benefit rate and would be described in Populations 4 or 5 except that they meet the clinical criteria for the moderate needs group and are at risk of institutionalization.	Limited HCBS including Adult Day Services, Case Management, and Homemaker services. This coverage does not meet the requirements of minimum essential coverage as communicated by CMS in its February 12, 2016 correspondence to the state.
Population 7	Medicare beneficiaries who are 65 years or older or have a disability with income at or below 150 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise categorically eligible for full benefits.	Medicaid Prescriptions, eyeglasses and related eye exams; MSP beneficiaries also receive benefits as described in the title XIX state plan.
Population 8	Medicare beneficiaries who are 65 years or older or have a disability with income above 150 percent and up to and including 225 percent of the FPL, who may be enrolled in the MSP, but are not otherwise categorically eligible for full benefits.	Maintenance Drugs (defined as a drug approved by the FDA for continuous use and prescribed to treat a chronic condition for a prolonged period of time of 30 days or longer, and includes insulin, an insulin syringe and an insulin needle). MSP beneficiaries also receive benefits as described in the title XIX state plan.

18. **Expansion Eligibility Groups Expenditure and Enrollment Cap.** The state must not impose a waiting list or enrollment cap on any Medicaid state plan population for Medicaid state plan services.

    a. A waiting list for enrollment is permitted for individuals eligible only under demonstration authority. If the state establishes a waiting list for services, the waiting list will be limited to coverage of services available only under demonstration authority. The waiting list for services must give priority to individuals who are eligible under the Medicaid state plan.

b. The state may maintain waiting list policies and procedures for home and community-based services through the Choices for Care Program including a description of how the state will manage wait lists, if and when waiting lists should occur. Waiting list management may include, but not be limited to consideration of clinical need, other risk factors, eligibility status, date of application, and any regulatory legislative mandates. A description of the wait list policy can be found in Attachment F.

19. Benefits.

All covered services may be subject to medical review and prior approval by DVHA based on medical appropriateness. A complete listing of covered services and limitations are contained in the Vermont approved title XIX state plan, Vermont statutes, regulations, and policies and procedures. The Global Commitment to Health demonstration will provide, at a minimum, the benefits covered under the title XIX state plan and these STCs to individuals in populations 1 and 2 and benefits for individuals in population 3 shall be specified in an approved Alternative Benefit plan under the state plan and these STCs.

a. **Hospice.** The state may provide coverage for hospice services concurrently with palliative and curative services. These concurrent services will be available for adults 21 years of age and older who are in populations 1, 2, and 3 who have been diagnosed with a life-limiting illness that is expected to be terminal, if a physician has certified that the adult is within the last months of life. The number of months of life required for such a certification shall be determined under the state plan. The state must under regular state plan rules provide concurrent hospice services for both palliative and curative services for children under age 21.

b. **Individual Assessed Cost Effective Alternative Services.** Vermont may provide individuals with the option to receive cost-effective treatment as patients in in lieu of otherwise covered services in other settings. This option must be voluntary with the individual, and must be based on an assessment and determination that the service is a medically appropriate and cost effective substitute for the corresponding state plan service or setting. The state must not claim any expenditures under this expenditure authority that are otherwise not allowable including, but not limited to institution for mental diseases (IMD), inmates, or room and board.

c. **Special programs.** In addition to the services described in subparagraph (a), the state shall provide the following services, through "special programs" to individuals who would have been eligible under a separate 1915(c) waiver or the state's prior 1115 demonstration. Service definitions for these programs are included in Attachment E.

Special Program Name	Services	Limitations
Traumatic Brain Injury (TBI)	HCBS waiver-like services including crisis/support services, psychological and counseling supports, case management, community supports, habilitation, respite care, supported employment, environmental and assistive technology and self-directed care.	Any limitation on this service is defined by Vermont rules and policies.
Mental Illness Under 22	HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, supported employment, and crisis and community supports.	Any limitation on this service is defined by Vermont rules and policies.
Community Rehabilitation and Treatment	HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, supported employment, and crisis and community supports.	Any limitation on this service is defined by Vermont rules and policies.
Developmental Disability Services	HCBS waiver-like services, including service coordination, residential habilitation, day habilitation, supported employment, crisis services, clinical intervention, respite and self-directed care.	Any limitation on this service is defined by Vermont rules and policies.

d. **Palliative Care Program.** The Palliative Care Program is for children under the age of 21 years in populations 1, 2, and 3 who have been diagnosed with a life-limiting illness that is expected to be terminal before adulthood. The program will allow for children to receive palliative and curative services.

i. **Participation.** Demonstration participants will be identified based on diagnostic codes found on claims data and referrals from medical professionals.

1. Eligibility will be determined by the nurse care manager and/or DVHA Medical Director, based on the assessment tool and supplemental clinical information (as needed). Continued eligibility will be re-assessed at least annually.

2. Care planning activities for children enrolled in the palliative care program will meet the requirements specified in federal managed care

regulations for enrollees with special health care needs.

ii. **Benefits.** In addition to state plan services, children enrolled in the palliative care program may also receive care and services that meet the definition of 'medical assistance' contained in section 1905(a) of the Act if determined to be medically appropriate in the child's care plan.

1. **Care coordination.** Development and implementation of a family centered care plan that includes telephonic and home visits by a licensed nurse.

2. **Respite care.** Short term relief for caretaker relatives from the demanding responsibilities for caring for a sick child.

3. **Expressive Therapies.** Therapies provided by licensed therapist to provide support to the child to help the child to creatively and kinesthetically express their reaction to their illness. The palliative care program offers 52 hours of expressive therapies per year. Additional, expressive therapy may be authorized if medically appropriate.

4. **Family Training.** Training to teach family members palliative care principles, medical treatment regimen, use of medical equipment, and how to provide in-home care.

5. **Bereavement Counseling.** Anticipatory counseling and up to six (6) months after the child's death for the family by a licensed professional trained in grief counseling. Payment for bereavement counseling services may be provided for on-going counseling to family members after the child's death so long as such services were initiated prior to the child's death.

iii. **Cost Sharing.** Cost sharing requirements as described in STC 20 will apply.

V. COST SHARING

20. Premiums and cost sharing

a. Populations 1, 2, and 3.

i. Premiums for populations 1, 2, and 3, must be in compliance with Medicaid requirements that are set forth in statute, regulation and policy. Premiums may be charged for this population in accordance with the approved state

plan.

ii. Cost sharing for populations 1, 2, and 3, must be in compliance with Medicaid requirements that are set forth in statute, regulation and policies. Standard Medicaid exemptions from cost-sharing set forth in 42 CFR 447(b) applies to the demonstration.

b. **Populations 7 and 8.** Detailed cost-sharing and premium requirements for Populations 7 and 8 are included in Attachment G. The state must not apply co-payment requirements to excluded populations (children under age 21, pregnant women or individuals in long-term care facilities) or for excluded services/supplies (e.g., family planning).

c. Premiums for children through age 18 with income above 195 percent of the FPL through 312 percent of the FPL are outlined in Attachment G.

VI. DELIVERY SYSTEMS

21. Delivery System Overview. Costs of all Medicaid covered services will be covered by DVHA and may be furnished through contracts with providers and through interagency agreements with governmental partners. Contracts with providers may include capitated contracts that meet the requirements of 42 CFR Part 438. In addition, DVHA, will, operate on a managed care-like model applying utilization controls and care management. The managed care-like model shall comply with federal regulations at 42 CFR part 438 that would be applicable to a non-risk PIHP, including beneficiary rights and appeal/grievance procedures (unless specifically stated otherwise in the STCs). Requirements under the demonstration shall be documented through an interagency agreement between AHS and DVHA.

22. Submission of Interagency Agreement and Rate Certification. At least ninety (90) days prior to the effective date of the interagency agreement, AHS shall submit for CMS review and approval the interagency agreement and corresponding rate certification as described in 42 CFR 438.7 and these STCs. Any amendments to the interagency agreement and corresponding amendments to the rate certification shall be submitted for CMS review and approval forty-five (45) days prior to the effective date of amendment to the interagency agreement.

23. Managed Care-like Model. – Designated Non-risk PIHP. The managed care-like model shall be subject to 42 CFR 438 requirements as a non-risk PIHP, and AHS shall be subject to 42 CFR 438 requirements as the state, and DVHA shall be subject to 42 CFR 438 requirements as a non-risk PIHP subject to the following clarifications:

a. AHS shall develop a per member per month (PMPM) capitation rate consistent with the requirements for actuarial soundness, rate development, special contract provisions (as applicable), and rate certifications in 42 CFR 438.4 through 438.7;

b. The PMPM capitation rates shall not be used for determination of federal financial participation, rather the PMPM capitation rates and corresponding rate certification shall be used to determine that:

1. The provider reimbursement rates are not based on the rate of Federal financial participation associated with the covered populations;

2. The provider reimbursement rates are appropriate for the populations to be covered and the services to be furnished under the contract;

3. The provider reimbursement rates are adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§438.206, 438.207, and 438.208; and

c. DVHA shall calculate and report a Medical Loss Ratio. The MLR shall be calculated consistent with all applicable parts of 42 CFR 438.8;

d. Neither the capitation rates determined under the interagency agreement nor the underlying provider payments shall be subject to the upper payment limits specified in 42 CFR 447.362; and

e. AHS will be responsible for oversight of the managed care-like model acting as a non-risk PIHP, ensuring compliance with state and federal statutes, regulations, special terms and conditions, waiver, and expenditure authority. AHS shall be responsible for evaluation, interpretation and enforcement of findings issued by the external quality review organization.

24. Capitation Rate Development. In addition to the requirements described in STC 23, the development of the capitation rate must:

a. Be developed consistent with the requirements in 42 CFR 438.5 and based on DVHA's actual experience and expected costs;

b. Be developed for twelve (12) month periods (Note: The first contract under the extension STCs will be for the period April 1, 2017 through December 31, 2017 which is nine (9) months.);

c. Not include any administrative services and costs that are required to be incurred by AHS as the Single State Agency under federal law, regulation, or these STCs. Such administrative services and costs that cannot be part of the capitation rate include: eligibility determinations, Single State Agency Central Office and External Quality Review Organization (EQRO), administration of a State Fair Hearing system, the Beneficiary Support System in 42 CFR 438.71 and STC 30, and the provider screening and enrollment process under 42 CFR 438.602(b);

d. Include only costs for services included under 42 CFR 438.3(c)(1)(ii);

e. Not include any costs for "investments" as described in STC 79;

f. AHS shall require DVHA through its interagency agreement to maintain an 85 percent medical loss ratio calculated consistent with 42 CFR 438.8 and these STCs;

g. To the extent that DVHA does not meet at least an 85 percent medical loss ratio, the PMPM capitation rates must be reduced to the extent necessary to achieve an 85 percent medical loss ratio;

h. DVHA shall not be eligible for an incentive payment above the actuarial sound capitation rate under 438.6(b); and

i. AHS shall be required to comply with 42 CFR 438.6(c) and (d), in that:

   i. Neither AHS, nor DVHA, shall make any pass-through payments, as defined in 42 CFR 438.6(a) to providers;

   ii. Any reimbursement arrangements between DVHA and providers that is based entirely on a fee-for-service style of fee schedule, consistent with the fee schedule described in 42 CFR 438.6(c)(1)(iii), shall not require AHS to obtain prior approval under 42 CFR 438.6(c)(2);

   iii. Any reimbursement arrangements between AHS or DVHA and providers that is not a fee-for-service style fee schedule shall be required to meet the prior approval requirements in 42 CFR 438.6(c)(2) for reimbursement arrangements described in 42 CFR 438.6(c)(1)(i) and (ii);

   iv. AHS is required to obtain prior approval under 42 CFR 438.6(c)(2) for all reimbursement methodologies that are not fee-for-service regardless of whether the reimbursement methodology is included explicitly in the interagency agreement or instituted at DVHA's discretion; and

   v. Fee-for-service (FFS) for the purposes of this STC means any payment system where:

      1. The provider's services are described in terms of "X units of services" where the units of the services are appropriate for the type of service and consistent with units prescribed in national coding standards.

      2. The provider's services are reimbursed at a specific reimbursement rate per unit of service, regardless of how the specific reimbursement rate is determined (e.g. fixed dollar amount, Diagnostic-Related Group (DRG), All Patients Refined Diagnostic Related-Group (APR-DRG), or Prospective Payment System (PPS) rates such as Federally Qualified Health Center (FQHC) or Indian Health Service (IHS) rates.

3. The total provider reimbursement is determined by multiplying:

    a. The provider's "X units of services" delivered to an enrollee; and

    b. The specific reimbursement rate per unit of service.

4. The payment is not for a "bundle of services."

5. For the purposes of distinguishing the concept of FFS in 42 CFR 438.6(c)(1)(iii) versus a "bundle of services" in 42 CFR 438.6(c)(1)(i), a payment is considered a "bundle of services" when the payment system:

    a. Pays a single payment for delivering a set of services, whenever the set of services includes covered services across multiple categories of services in §1905 of the Act.

25. Choice under the Managed Care-like Model. All Medicaid beneficiaries are enrolled in the managed care-like model that operates as if it were a non-risk PIHP. AHS shall not be subject to 42 CFR 438.52(a)(1). AHS shall be required to meet the requirements of 42 CFR 438.52(b) in all counties regardless of the county designation in the Medicare Advantage Health Services Delivery Reference file.

26. Non-Application of 42 CFR 438.3(m). AHS and DVHA shall not be determined out of compliance with 42 CFR 438.3(m) if:

a. AHS and DVHA meet the financial reporting requirements, consistent with requirements in Section IX and X of these STCs, as well as, applicable federal and state accounting principles and controls.

27. Limitation of Freedom of Choice. Freedom of choice is limited to the DVHA network of providers. However, populations must have freedom of choice when selecting enrolled providers within that network (when applicable, the provider must be enrolled in the specific specialty or subprogram applicable to the services at issue). Specifically, demonstration participants enrolled in a special service program such as, but not limited to specialized substance abuse and behavioral health services or a program for home and community-based services may only have access to the providers enrolled under that program, and will not have access to every Medicaid enrolled provider for services under that program. Such participants will have freedom of choice of providers enrolled in the special service program. No restriction on freedom of choice of family planning provider may be imposed.

28. Contracts and Provider Payments. Payments to providers for Global Commitment will be set by DVHA and approved by AHS and will not be required to comply with the payment provisions in the approved state plan.

a. All services provided under the demonstration, including nursing facility and home and community-based services, are included in the actuarially-determined per member per month calculation. Therefore, these payments are subject to the applicable requirements in 42 CFR 438.7.

b. The state must not make any supplemental payments to providers under the Medicaid state plan.

29. **Contracting with Federally Qualified Health Centers (FQHCs).** The state shall not reduce the number of FQHCs and rural health centers available to provide services to beneficiaries under this demonstration.

30. **Beneficiary Support System.** AHS shall develop and implement a beneficiary support system consistent with the requirements of 42 CFR 438.71. AHS shall ensure the independence and conflict of interest requirements in 42 CFR 438.71(c)(2) are satisfied by ensuring that contracts or grants for these activities are managed by staff outside of DVHA and that staff responsible for any beneficiary support system activities report to a department or agency outside of DVHA. AHS will monitor beneficiary support system quarterly reports and take action where systemic issues are identified with managed long term supports and services operated by DVHA.

31. **Appeals and Grievance.** AHS and DVHA shall comply with all aspects of 42 CFR 438, subpart F, with AHS as the state and DVHA as if it were a non-risk PIHP. All requirements related to State Fair Hearings in federal statute and regulations shall be the direct responsibility of AHS and may not be delegated to DVHA.

32. **Program Integrity.** AHS and DVHA shall comply with all requirements of 42 CFR 438, subpart H, with AHS as the state and DVHA as a PIHP unless specified herein. All program integrity requirements in federal statute and regulations that are required of the state in its oversight of a non-risk PIHP shall be the direct responsibility of AHS and may not be delegated to DVHA.

    a. 42 CFR 438.604(a)(4) pertaining to documentation against risk of insolvency is not applicable to DVHA.

    b. The data, information, and documentation submission requirements on DVHA as a non-risk PIHP in 42 CFR 438.604(a)(1) and (a)(2) is satisfied so long as AHS has direct access to the information systems that maintain such data, documentation and information.

33. **Data Sharing.** DVHA acting as a non-risk PIHP under a managed care-like model shall comply with all privacy and confidentiality requirements on PIHPs in 42 CFR 438. Nothing in this STC prohibits AHS from delegating data and information rights and responsibilities to DVHA consistent with federal law, including section 1902(a)(7) of the Act and 42 CFR 431.306(d). To the extent that DVHA has access to data and information under delegation

from AHS that may not otherwise be shared with a non-risk PIHP, AHS must establish administrative, managerial and, technical controls to prevent sharing the data with divisions of DVHA responsible for the managed care-like model acting as a non-risk PIHP.

VII. LONG TERM SERVICES AND SUPPORTS PROTECTIONS FOR CHOICES FOR CARE

34. Person Centered Planning. The state agrees to use person centered planning processes to identify participants' and applicants' long term service and support needs, the resources available to meet those needs, and to provide access to additional service and support options, such as the choice to use spouse caregivers, and access a prospective monthly cash payment. The state assures that person centered planning will be in compliance with the characteristics set out in 42 CFR 441.301(c)(1)-(3).

35. Self- Directed Supports. The state agrees to provide resources to support participants or their proxies (e.g., a surrogate, parent or legal guardian/representative) in directing their own care. This support assures, but is not limited to, participants' compliance with laws pertaining to employer responsibilities and provision for back-up attendants as needs arise. The state agrees to assure that background checks on employees and their results are available to participants. State policies and guidelines will include, but not be limited to: criteria for who is eligible to self-direct, a fiscal agent/intermediary, and consultants to assist participants with learning their roles and responsibilities as an 'employer' and to ensure that services are consistent with care plan needs and allocations.

a. Choices for Care program enrollees will have full informed choice on the requirements and options to: self-direct Choices for Care services; have a qualified designated representative direct Choices for Care services on their behalf, or select traditional agency-based service delivery. State and provider staff will receive training on these options.

36. Participant/Applicant Waiting List Monitoring. The state agrees to report on the status of the waiting lists for Choices for Care services during regular progress calls between CMS and the state and in reports submitted to CMS by the state.

a. The state assures that it has a system as well as policies and procedures in place through which the providers must identify, report and investigate critical incidents that occur within the delivery of Choices for Care Long Term Services and Supports (LTSS). The state also has a system as well as policies and procedures in place through which to prevent, detect report, investigate, and remediate abuse, neglect, and exploitation. Providers and participants are educated about this system. Provider obligations include specific action steps that providers must take in the event of known or suspected abuse, neglect or exploitation. The Vermont policies and procedures are specified in Vermont Statute, 33 V.S.A. Chapter 69, available at: http://www.leg.state.vt.us/statutes/sections.cfm?Title=33&Chapter=069.

37. The state will assure compliance with the characteristics of home and community based settings in accordance with 42 CFR 441.301(c)(4), for those Choices for Care services (e.g., those not found in the Vermont State Plan) that could be authorized under 1915(c) and 1915(i). The Choices for Care services are described in Attachment D.

38. In its role as single state agency, the AHS will ensure a managed LTSS plan for a comprehensive care model is developed that promotes the integration of home and community based services, institutional, acute, primary and behavioral healthcare.

39. To support the beneficiary's experience receiving medical assistance and long term services and supports, the state shall assure that all Choices for Care program enrollees have accessto independent support services that assist them in understanding their coverage options and in the resolution of problems regarding services, coverage, access and rights. Independent support services will:

a. Operate independently from any provider and to the extent possible, services will be provided independently of the state and support transparent and collaborative resolution of issues between beneficiaries and state government;

b. Be easily accessible and available to all Choices for Care enrollees. Activities willbe directed towards enrollees in all settings (institutional, residential and community based) accessible through multiple entryways (e.g., phone, internet, office) and reach out to beneficiaries and/or authorized representatives through various means (mail, phone, in person), as appropriate;

c. Assist with access to services and supports and help individuals understand their choices, resolve problems and address concerns that may arise between the individual and a provider or payer. The state will assure:
    i. Beneficiaries have support in the pre-enrollment stage, such as unbiased options counseling and general program-related information.

    ii. Beneficiaries have an access point for complaints and concerns about Choices for Care enrollment, access to services, and other relatedmatters.
    iii. Enrollees understand the fair hearing, grievance, and appeal rights and processes within the Choices for Care program and assist them through the process if needed/requested.

    iv. Trainings are conducted with providers on community-based resources and covered services and supports.

d. Ensure staff and volunteers are knowledgeable. Training will include information about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; and the health and service needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs. In addition, the state will ensure services are

delivered in a culturally competent manner and are accessible to individuals with limited English proficiency; and

e. Collect and report information on the volume and nature of beneficiary contacts and the resolution of such contacts on a schedule and manner determined by the state, but no less frequently than quarterly. This information will inform the state of any provideror contractor issues and support quarterly reporting requirements to CMS.

VIII. DESIGNATED STATE HEALTH PROGRAMS

40. State-Funded Marketplace Subsidies Program. The state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide premium subsidies for individuals up to and including 300 percent of the FPL who purchase health insurance through the Marketplace. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible; (2) are eligible for the advance premium tax credit (APTC); and (3) whose income is up to and including 300 percent of the FPL. Expenditures for this designated state health program (DSHP) must not include any expenditures listed in STC 82 ("Investment Approval Process"). The state must submit a claiming protocol for this DSHP and the protocol will become Attachment L.

a. Funding Limit. Expenditures for the subsidies are limited on an annual basis as follows (total computable):

	DY 12 CY 2017	DY 13 CY 2018	DY 14 CY 2019	DY 15 CY 2020	DY 16 CY 2021
DSHP – State Funded Exchange Subsidy	$6,520,640	$7,172,704	$7,889,974	$8,678,971	$9,546,869

b. Reporting. The state must provide data regarding the operation of this subsidy program in the annual report required per STC 49. This data must, at a minimum, include:
   i. The number of individuals served by the program;
   ii. The size of the subsidies; and
   iii. A comparison of projected costs with actual costs.

c. Budget Neutrality. This subsidy program will be subject to thebudget neutrality limit.

41. State-funded Mental Health Community Rehabilitation and Treatment (CRT) Services.

a. The state may claim as allowable expenditures under the demonstration payments through a state funded program for CRT services, as defined by Vermont rule and policy, provided to individuals with severe and persistent mental illness who have

incomes above 133 percent of the FPL and up to and including 185 percent of FPL who are not Medicaid enrolled. This program will be subject to the budget neutrality limit. A description of the services can be found in Attachment E: Global Commitment Specialized Program Service Definitions. Expenditures for this DSHP must not include any expenditures listed in STC 82 ("Investment Approval Process"). The state must submit a claiming protocol for this DSHP and the protocol will become Attachment L.

IX. MONITIORING AND REPORTING REQUIREMENTS

42. Monitoring Calls. CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration, including planning for future changes in the program. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda prior to the calls. Areas to be addressed during the monitoring call include, but are not limited to:

Operations and performance;

a. Transition and implementation activities;
b. Stakeholder concerns;
c. Enrollment;
d. Cost sharing;
e. Quality of care;
f. Beneficiary access;
g. Benefit package and wrap around benefits;
h. Audits;
i. Lawsuits;
j. Financial reporting and budget neutrality issues;
k. Progress on evaluation activities and contracts;
l. Related legislative developments in the state; and
m. Any demonstration changes or amendments the state is considering such as the state's section 1115 SUD demonstration amendment.

43. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Quarterly Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

44. **Submission of Post-approval Deliverables.** The state shall submit all required analyses, reports, design documents, presentations, and other items specified in these STCs ("deliverables"). The state shall use the processes stipulated by CMS and within the timeframes outlined within these STCs.

45. **Compliance with Federal Systems Innovation**. As federal systems continue to evolve and incorporate 1115 waiver reporting and analytics, the state shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems. The state will submit the monitoring reports and evaluation reports to the appropriate system as directed by CMS.

46. **Deferral for Failure to Submit Timely Demonstration Deliverables.** The state agrees that CMS may issue deferrals in the amount of $5,000,000 (federal share) when deliverables are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS.

    a) Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

    b) For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Should CMS agree to the state's request, a corresponding extension of the deferral process described below can be provided.

        i. CMS may agree to a corrective action as an interim step before applying the deferral, if requested by the state.

    c) The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

    d) When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.

    e) As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

    f) CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example the structure of the state request for an extension, what quarter the deferral applies to, and how the deferral is released.

47. **Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), should CMS undertake a federal evaluation of the demonstration or any component of the demonstration,

the state shall cooperate fully and timely with CMS and its contractors' evaluation activities. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required by the state under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in Section IX, STC 46.

48. Cooperation with Federal Learning Collaboration Efforts. The state will cooperate with improvement and learning collaboration efforts by CMS.

49. Quarterly and Annual Progress Reports.

a. The state must submit three (3) Quarterly Reports and one (1) compiled Annual Report each DY. The Quarterly Reports are due no later than sixty (60) days following the end of each demonstration quarter. The compiled Annual Report is due no later than ninety (90) days following the end of the DY.

b. The Quarterly and Annual Reports shall provide sufficient information for CMS to understand implementation progress of the demonstration including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The reports will include all required elements and should not direct readers to links outside the report. (Additional links not referenced in the document may be listed in a Reference/Bibliography section).

c. The Quarterly and Annual Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

    i. Operational Updates - The reports shall provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held.

    ii. Performance Metrics – Progress any required monitoring and performance metrics must be included in writing in the Quarterly and Annual Reports.

Information in the reports will follow the framework provided by CMS and be provided in a structured manner that supports federal tracking and analysis.

iii. Budget Neutrality and Financial Reporting Requirements – The state must provide an updated budget neutrality workbook with every Quarterly and Annual Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.

iv. Evaluation Activities and Interim Findings. The state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The state shall specify for CMS approval a set of performance and outcome metrics and network adequacy, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycles assessment in trends for monitoring and evaluation of the demonstration.

v. The Annual Report must include all items outlined in STC 49. In addition, the Annual Report must at a minimum include the requirements outlined below:

1. All items included in the Quarterly Reports must be summarized to reflect the operation/activities throughout the DY;

2. Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately;

3. Total contributions, withdrawals, balances, and credits; and

4. Yearly unduplicated enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement.

50. Compliance with Managed Care, Network Adequacy, Quality Strategy and EQR Reporting Requirements. The state must comply with all managed care reporting regulations at 42 CFR Part §438 et. seq., except as expressly identified as not applicable in the expenditure authorities incorporated into these STCs.

51. State Data Collection.

1. The state must collect data and information necessary to oversee service utilization and rate setting by provider/plan, comply with the Core Set of Children's Health Care

Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP, obtain NCQA and other accreditations that the state may seek, and comply with other existing federal measure sets.

2. The state will use this information in ongoing monitoring of individual well-being, provider/plan performance, and continuous quality improvement efforts, in addition to complying with CMS reporting requirements.

3. The state must maintain data dictionary and file layouts of the data collected.

4. The raw and edited data will be made available to CMS within thirty (30) days of a written request.

X. GENERAL FINANCIAL REQUIREMENTS

52. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports using the form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XI (Monitoring Budget Neutrality).

53. Reporting Expenditures Subject to the Budget Neutrality Cap. In order to track expenditures under this demonstration, Vermont must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System, following routines from CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures subject to the budget neutrality cap must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which the expenditure was made). Reporting for expenditures made subsequent to termination of the demonstration must indicate the demonstration year in which services were rendered. Payment adjustments attributable to expenditures under the demonstration must be recorded on the applicable Global Commitment prior quarter waiver form, identified as either CMS-64.9P Waiver (Medical Assistance Payments) or CMS-64.10P Waiver (Administrative Payments). When populated, these forms read into the CMS-64 Summary sheet, Line 7 for increasing adjustments and Line 10B for decreasing adjustments. Adjustments not attributable to this demonstration should be reported on non-waiver forms, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined in subparagraph (b) below.

a. For each demonstration year, separate form CMS-64.9 waiver and/or 64.9P waiver reports must be submitted reporting expenditures subject to the budget neutrality cap.

All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported. The sum of the expenditures from the separate reports will represent the expenditures subject to the budget neutrality cap (as defined in subparagraph (c) below) Medical expenditures for the new adult group, as described below, are not subject to the demonstration's budget neutrality cap, but they are subject to Supplemental Budget Neutrality Test 1, as defined in STC 64. The Vermont Global Medicaid eligibility groups, for reporting purposes, include the names and definitions described in the table below.

Corresponding Population number per STC 17	Reporting name description	CMS 64 Reporting Name
Populations 1-2	Report expenditures for individuals eligible as aged, blind, or disabled under the state plan.	**"ABD"**
	Report the expenditures for all non-ABD children and adults in the state plan mandatory and optional categories, with the exception of adults eligible under population 3.	**"non-ABD"**
	Report for all expenditures for all non-ABD children and adults in optional categories.	
Population 3	Report for all medical expenditures for the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119.	**"New Adult Group Medical"**
Population 4	Report for all expenditures for individuals eligible as part of the Highest Need Group.	**"ABD"**
Population 5	Report for all expenditures for individuals eligible as part of the High Need Group.	**"ABD"**

Corresponding Population number per STC 17	Reporting name description	CMS 64 Reporting Name
Population 6	Report for all expenditures for individuals eligible as part of the Moderate Needs Group.	**"Moderate Needs"**
Population 7 Population 8	Report for all expenditures for individuals eligible as pharmacy-only expansions through VT Global (previously VHAP Rx).	**"VT Global Rx"**
Investments	Report for all expenditures labeled investments as described in STC 79, except for DSR investments.	**"Investments (formerly referred to as "MCO Investments")**
Delivery System Reform (DSR) Investments	Report for all expenditures labeled DSR investments as described in STC 83.	**"DSR Investments"**
Individually Assessed Cost Effective Services	Report for all expenditures labeled individually assessed cost effective services described in STC 19(b).	**"Ind Cost Eff Serv"**
Designated State Health Programs	Report for designated state health program expenditures for the state-funded Marketplace subsidy program for individuals at or below 300 percent of the FPL who purchase health care coverage in the Marketplace.	**"Marketplace Subsidy"**
Designated State Health Programs	Report for designated state health program expenditures for individuals receiving CRT services who are not Medicaid enrolled.	**"CRT DSHP"**

b. It is understood that individuals receiving Community Rehabilitation and Treatment (CRT) Services are included in MEGs that are reported on the CMS-64. Reporting to CMS will occur via a supplemental information report provided as backup to the CMS-64. This report will be submitted concurrently with the other CMS-64 backup documentation submitted every quarter.

c. For purposes of this section, the term "expenditures subject to the budget neutrality cap" must include all Medicaid expenditures on behalf of the individuals who are enrolled in this demonstration (as described in subparagraph (a) of this section) and who are receiving the services subject to the budget neutrality cap. All Global Commitment to Health program expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and must be reported on line 49 of forms CMS-64.9 waiver and/or 64.9P waiver. The state must continue to report Choices for Care program (nursing facility and HCBS) expenditures on the appropriate service line on the CMS-64.

c. Premiums and other applicable cost-sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS on the CMS-64 Summary Sheet, Line 9D "Other." In order to ensure that the demonstration is properly credited with premium collections, please indicate in the CMS- 64 Certification "Footnotes" section that Line 9D of the Summary Sheet is for Global Commitment Collections only.

d. Administrative costs are not included in the budget neutrality agreement. The state must report administrative costs on the appropriate CMS-64 reporting line. Administrative costs associated with investments that are strictly administrative in nature are subject to the budget neutrality limit and are reported on the "Investments" or "DSR investments" waiver forms. All other administrative costs must be identified on the Forms CMS-64.10 waiver and/or 64.10P Waiver.

e. MBES/CBES Schedule C Reporting Adjustments. The state must submit prior period adjustments subsequent to the routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual to report actual expenditures incurred for demonstration services in DY9 (CY 2014) through DY11 (CY 2016). The state shall complete these reporting adjustments within twelve (12) months of the date of CMS' approval of this extension and provide written certification of the accuracy of the adjusted expenditures upon completion. The state must provide an update on the progress of these adjustments during the CMS monitoring calls described in STC 42.

f. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within two (2) years after the calendar quarter in which the state made the expenditures. Furthermore, all title XIX claims for services during the demonstration period (including any cost settlements and claims incurred during the demonstration but paid subsequent to the end date of the

demonstration) are considered allowable expenditures under the demonstration and must be made within two (2) years after the conclusion or termination of the demonstration. During the latter two (2)-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

g. At the end of the demonstration, all investment claims (as defined in STC 79) for expenditures subject to the budget neutrality cap (including any cost settlements and non-title XIX claims incurred during the demonstration but paid subsequent to the end date of the demonstration) must be made within two (2) quarters (six (6) months) after the calendar quarter in which the state made the expenditures. During the latter six (6) month period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

h. Disproportionate Share Hospital (DSH) payments are not counted as expenditures under the demonstration.

54. Reporting Member Months. The following describes the reporting of member months for demonstration populations.

a. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the state must provide to CMS, as part of the Quarterly Report required under STC 49, the actual eligible member months for each of the EGs described above. The state must submit a statement accompanying the Quarterly Report, which certifies the accuracy of this information. To permit full recognition of "in process" eligibility, reported counts of member months may be subject to revision.

b. The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three (3) months contributes three (3) eligible member/months to the total. Two (2) individuals, who are eligible for two (2) months, each contributes two (2) eligible member months to the total, for a total of four (4) eligible member/months.

55. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. Vermont must estimate matchable Medicaid expenditures on the quarterly form CMS-37 based on the PMPM limit (or a percentage of the PMPM limit) and projected caseload for the quarter. In addition, the estimate of matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality cap must be separately reported by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administrative costs (ADM) outside of the PMPM limit. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state must submit

the form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures, consistent with the definition of an expenditure in 45 C.F.R. 95.13, made in the quarter just ended.

a. Intergovernmental transfers of the individual per member per month fixed amount from AHS to DVHA are not reportable expenditures, but provide funding for reportable DVHA expenditures. CMS will reconcile expenditures reported on the form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

56. **Sources of Non-Federal Share.** The state certifies that the source of the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used as the non-Federal share for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

    a. CMS will review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.

    b. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

57. **State Certification of Public Expenditures.** Nothing in these STCs concerning certification of public expenditures relieves the state of its responsibility to comply with federal laws and regulations, and to ensure that claims for federal funding are consistent with all applicable requirements. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

    a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

    b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. The state must receive prior approval from CMS before implementing any CPEs. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

    c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general

revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers as a source of non-federal share to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the payment for the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment. Intergovernmental transfers are not themselves expenditures, but may be a source of funding for expenditures.

58. Monitoring the Demonstration. The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

59. Program Integrity. The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

60. Limit on Title XIX Funding. Vermont will be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit will consist of two parts, Medicaid Eligibility Groups defined in these Terms and Conditions and the New Adult Group, and are determined by using a per capita cost method. The Supplemental Test 1 for the New Adult Group is described in STC 64. Actual expenditures subject to the budget neutrality expenditure limit must be reported by Vermont using the procedures described in the section for General Financial Requirements under title XIX. The data supplied by the state to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the Medicaid Budget and Expenditure System/ Children's Health Insurance Budget and Expenditure System (MBES/CBES). As described in STC 9(b), when the state submits its extension request, it must include five years of recent historical expenditure and enrollment data for the Medicaid and demonstration populations that are to be included in the demonstration extension, and a proposed budget neutrality test for the

extension period based on recent data.

61. Risk. Vermont will be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, Vermont will not be at risk for changing economic conditions which impact enrollment levels. However, by placing Vermont at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

62. Budget Neutrality Annual Expenditure Limit. For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each Eligibility Group (EG) described as follows:

a. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state for that EG under the section entitled General Reporting Requirements, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (b) below.

b. The PMPMs for each EG used to calculate the annual budget neutrality expenditure limit for this demonstration is specified below.

Medicaid Eligibility Group	Trend Rate	DY 12 PMPM CY 2017	DY 13 PMPM CY 2018	DY 14 PMPM CY 2019	DY 15 PMPM CY 2020	DY 16 PMPM CY 2021
ABD - Non-Medicare – Adult	3.70%	$1,509.69	$1,565.54	$1,623.47	$1,683.54	$1,745.83
ABD - Non-Medicare – Child	3.70%	$2,957.18	$3,066.60	$3,180.06	$3,297.72	$3,419.74
ABD – Dual	3.70%	$2,599.65	$2,695.84	$2,795.58	$2,899.02	$3,006.28
ANFC - Non-Medicare – Adult	4.90%	$644.18	$675.75	$708.86	$743.60	$780.03
ANFC - Non-Medicare – Child	4.60%	$537.35	$562.07	$587.93	$614.97	$643.26

c. Each DY, the net variance between the without-waiver cost and actual with-waiver cost will be reduced. The reduced variance, to be calculated as a percentage of the total variance, will be used in place of the total variance to determine overall budget neutrality for the demonstration. (Equivalently, the difference between the total variance and reduced variance could be subtracted from the without-waiver cost estimate.) The formula for calculating the reduced variance is, reduced variance equals total variance times applicable percentage. The percentages for each EG and DY are determined based on how long the associated population has been enrolled in managed care subject to this demonstration; lower percentages are for longer

established managed care populations. In the Vermont demonstration, the percentages below apply to all EGs in the same manner.

	DY 12 CY 2017	DY 13 CY 2018	DY 14 CY 2019	DY15 CY 2020	DY 16 CY 2021
Savings Percentage	30%	25%	25%	25%	25%

63. Impermissible DSH, Taxes or Donations. The CMS reserves the right to adjust the budget neutrality terms in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or with policy interpretations implemented through letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality terms if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.

64. Monitoring of New Adult Group Spending and the Opportunity to Adjust Projections. For each DY, a separate annual budget limit for the new adult group will be calculated as product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the state under the guidelines set forth in STC 54. The trend rates and per capita cost estimates for the new adult group are listed in the table below.

Medicaid Eligibility Group	Trend Rate	DY 12 PMPM CY 2017	DY 13 PMPM CY 2018	DY 14 PMPM CY 2019	DY 15 PMPM CY 2020	DY 16 PMPM CY 2021
New Adult Group	4.20%	$518.26	$540.03	$562.71	$586.34	$610.97

a. If the state's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above may underestimate the actual costs of medical assistance for the new adult group, the state has the opportunity to submit an adjustment to the PMPM limit, along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. In order to ensure timely adjustments to the PMPM limit for a demonstration year, the revised projection must be submitted to CMS by no later than the end of the third quarter of the demonstration year for which the adjustment would take effect. Additional adjustments to the PMPM limit may be made pursuant to the process outlined in (d) below.

b. The budget limit for the new adult group is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying the total computable budget neutrality cap by the federal share.

c. The state will not be allowed to obtain budget neutrality "savings" from this population.

d. If total FFP reported by the state for the new adult group should exceed the federal share of FFP for the budget limit for the new adult group by more than 3 percent following each demonstration year, the state must submit a corrective action plan to CMS for approval.

65. Composite Federal Share Ratios. The federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections and pharmacy rebates, by total computable demonstration expenditures for the same period as reported on the same forms.

66. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. The budget neutrality test for the demonstration extension will incorporate net savings from the immediately prior demonstration period of October 1, 2011 through December 31, 2016, but not from any earlier approval period.

67. Exceeding Budget Neutrality. If the budget neutrality expenditure limit defined in STC 62, at the end of this demonstration period, the overall budget neutrality expenditure cap has been exceeded, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

68. Expenditure Review and Cumulative Target Calculation. CMS will enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the state under budget neutrality. Using the schedule below as a guide, if the state exceeds the cumulative target, they must submit a CAP to CMS for approval within thirty (30) days of notification from CMS. The state will subsequently implement the approved corrective action plan.

Year	Cumulative Target Definition	Percentage
Year 12	Year 12 budget estimate plus	3 percent
Year 13	Years 12 and 13 combined budget estimate plus	3 percent
Year 14	Years 12 through 14 combined budget estimate plus	3 percent
Year 15	Years 12 through 15 combined budget estimate plus	1.5 percent
Year 16	Years 12 through 16 combined budget estimate plus	0 percent

XII. EVALUATION OF THE DEMONSTRATION

69. Independent Evaluator. At the beginning of the demonstration period, the state must acquire an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in accord with the CMS-approved, draft evaluation plan. For scientific integrity, every effort should be made to follow the approved methodology, but requests for changes may be made in advance of running any data or due to mid-course changes in the operation of the demonstration.

70. Evaluation Design and Implementation. The state shall submit a draft evaluation design for the Global Commitment to Health demonstration to CMS no later than 120 days after the award of the Demonstration extension. Such revisions to the evaluation design and the STCs shall not affect previously established timelines for report submission for the insert old demo name, if applicable. The state must submit a final evaluation design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the evaluation design, the state must implement the evaluation design and submit their evaluation implementation progress in each of the quarterly and annual progress reports, including the rapid cycle assessments as outlined in the Monitoring Section of these STCs. The final evaluation design will be included as Attachment K to the STCs. Per 42 CFR 431.424(c), the state will publish the approved evaluation design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit their evaluation implementation progress in each of the Quarterly and Annual Reports as outlined in STC 54.

71. Evaluation Budget. A budget for the evaluation shall be provided with the evaluation design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed.

72. Evaluation Requirements.

a. The demonstration evaluation will meet the prevailing standards of scientific evaluation and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings.

    i. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

    ii. The state shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the state will assure no conflict of interest, and a budget for evaluation activities.

b. The state shall also conduct an evaluation pursuant to STC 86 which shall include an investigation of the impact of providing Medicaid reimbursement for IMD services on the following outcomes among beneficiaries in need of acute mental health or substance use disorder treatment:

    i. Emergency room utilization;
    ii. Lengths of stay in emergency rooms;
    iii. Access to acute inpatient treatment for mental health and substance use disorders;
    iv. Lengths of stay in acute inpatient settings for treatment for those conditions;
    v. Quality of acute mental health or substance use disorder treatment;
    vi. Quality of discharge planning in making effective linkages to community-based care;
    vii. Readmissions for inpatient treatment;
    viii. Cost of treatment for acute mental health or substance use disorder conditions;
    ix. Access to care for co-morbid physical health conditions;
    x. Quality of care for co-morbid physical health conditions; and
    xi. Overall cost of care for mental health and substance use disorders and co-morbid physical conditions combined.

73. Evaluation Design Requirements. The Evaluation Design shall include the following core components to be approved by CMS:

a. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration. The state's design must include research questions and testable hypotheses that address the impact of providing Medicaid payment for IMD services including the impacts on the outcomes of interest listed above in STC 72(b). At a minimum, the research questions shall address the goals of the demonstration such as improving access, improving quality of care thereby leading to enhanced health outcomes, and lowering costs. The research questions will have appropriate comparison groups and may be studied in a time series. The analyses of these research questions will provide the basis for robust assessment of cost effectiveness. The following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

   i. The demonstration will result in improved access to care;
   ii. The demonstration will result in improved quality of care;
   iii. Value-based payment models will promote appropriate use of resources;
   iv. Improved access to preventive care will result in lower overall costs for the healthcare delivery system;
   v. Improved access to primary care will result in positive health outcomes; and
   vi. Enhanced care coordination will promote timely access to needed care.

   These hypotheses should be addressed in the demonstration reporting described in STC 49 with regard to progress towards the expected outcomes.

b. Study Design: The design will include a description of the quantitative and qualitative study design to be used (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), as well as a rationale for the methodologies selected. The discussion will include a proposed baseline and approach to comparison; examples to be considered as appropriate include the definition of control and/or comparison groups or within-subjects design and difference in differences design to a discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time. The former will address how the effects of the demonstration will be isolated from those other changes occurring in the state at the same time through the use of comparison or control groups to identify the impact of significant aspects of the demonstration. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered;

c. Study Population: This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The design shall include, for purposes of the investigation of the impact of providing Medicaid

payment for IMDs, a discussion of the feasibility of making comparisons between beneficiaries in need of acute mental health or substance use disorder treatment who reside within the catchment areas in the state for IMDs receiving Medicaid reimbursement and beneficiaries in need of acute mental health or substance use disorder treatment who reside in the state but outside of those catchment areas. The design shall also discuss the feasibility of constructing a comparison group of beneficiaries in need of acute mental health or substance use disorder treatment in another state that does not provide Medicaid payment to IMDs. The design shall also make a recommendation as to which comparison group would be preferable. The discussion may include the sampling methodology for the selected population, as well as support that a statistically reliable sample size is available;

d. Access, Service Delivery Improvement, Health Outcome, Satisfaction and Cost Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the impact on the outcomes of interest listed in STC 72 above. Nationally recognized measures should be used where appropriate. Measures will be clearly stated and described, with the numerator and denominator clearly defined. To the extent possible, the State will incorporate comparisons to national data and/or measure sets. A broad set of performance metrics will be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation, for meaningful use under Health Information Technology (HIT), core measure sets developed by the Core Quality Measures Collaborative, measures identified for the certified community behavioral health clinics (CCBHC) demonstration), and from the CMS Child and Adult Core Measure Sets for Medicaid and CHIP. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care;

e. Data: This discussion shall include: a description of the data sources including a definition/description of the sources and the baseline values for metrics/measures, the frequency and timing of data collection and the method of data collection. The following shall be considered and included as appropriate: i. Medicaid encounter and claims data, ii. Enrollment data, iii. provider network data, iv. consumer and provider surveys, and v. other data needed to support performance measurement relative to access and quality metrics;

f. Assurances Needed to Obtain Data: The design report will discuss the state's arrangements to assure needed data to support the evaluation design are available, including from health plans;

g. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the demonstration to be isolated from other initiatives occurring in the state. The level of analysis may be at the beneficiary, provider, and program level, as appropriate, and shall include population stratifications, for further depth. Sensitivity analyses shall be

used when appropriate. Qualitative analysis methods shall also be described, if applicable;

h. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables outline in this section. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the final summative evaluation report is due;

i. Evaluator: This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities; and

j. State additions: The state may provide to CMS any other information pertinent to the state's research on the policy operations of the demonstration operations. The state and CMS may discuss the scope of information necessary to clarify what is pertinent to the state's research.

74. Evaluation Standards. The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

75. Interim Evaluation Report.

a. The state is required to submit a draft Interim Evaluation Report 90 days following completion of year one (1) of the demonstration extension (April 1, 2018). The interim evaluation shall include an assessment of the impact of providing Medicaid payment for IMD services on the research questions included in the final evaluation design including the outcomes of interest listed above in STC 72 for the four (4) year period preceding the start of this demonstration. The Interim Evaluation Report shall include the same core components as identified in STC 76 for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. The state shall submit the final Interim Evaluation Report within thirty (30) days after receipt of CMS' comments. The interim evaluation will inform the state's IMD phase-down plan which is due December 31, 2018.

b. The state is also required to submit a draft interim evaluation report for the completed years of the demonstration, as outlined in 432 CFR 431.412(c)(2) (vi) one year prior to the current expiration date of the demonstration. The state will submit the final interim evaluation report thirty (30) days after receiving CMS comments.

    i. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.

ii. For demonstration authority that expires prior to the overall demonstration's expiration date, the interim evaluation report must include an evaluation of the authority as approved by CMS.
iii. If the state requests changes to the demonstration, it must identify research questions and hypotheses related to the changes requested and an evaluation design for addressing the revisions.

76. Summative Evaluation Reports. The state shall provide the summative evaluation reports described below to capture the demonstration period covered by this renewal. The summative evaluation shall include an assessment the impact of providing Medicaid payment for IMD services on the research questions included in the summative evaluation design including the outcomes of interest listed above in STC 72(b) for the period from year one through year four of this demonstration extension. The IMD summative evaluation is due ninety (90) days after the completion of DY 4 of the extension period, therefore by April 1, 2021. The state shall provide a Summative Evaluation Report for the demonstration period starting January 1, 2017 through December 31, 2021.

The state is required to submit a preliminary report within ninety (90) days of year four (4) of the demonstration period, therefore by April 1, 2021. This report should include documentation of outstanding assessments due to data lags to complete the interim evaluation.

The second of these is due within eighteen (18) months of the end of the demonstration period, (June 30, 2022). The state shall respond to CMS comments and submit the Final Summative Evaluation Report within thirty (30) days after receipt of CMS' comments. The Summative Evaluation Report shall include the following core components:

a. Executive Summary. This includes a concise summary of the goals of the demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral, what impact the demonstration has on health outcomes, and any policy implications.

b. Demonstration Description. This includes a description of the demonstration programmatic goals and strategies.

c. Study Design. This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the state and any sensitivity analyses, and limitations of the study.

d. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.

e. Policy Implications. This includes an interpretation of the conclusions; the impact of the

demonstration within the health delivery system in the state; the implications for state and federal health policy; and the potential for successful demonstration strategies to be replicated in other state Medicaid programs.

f. Interactions with Other State Initiatives. This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the state's Medicaid program, and interactions with other Medicaid waivers, the SIM award and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This final report shall include a detailed description of Medicaid payment for mental health and substance use disorder services in the state including payment for inpatient and community-based services each year from 2009 through year three (3) of the demonstration extension.

77. State Presentations for CMS. The state will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 73. The state shall present on its interim evaluation in conjunction with STC 75. The state shall present on its summative evaluation in conjunction with STC 76.

78. Public Access. The state shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medicaid website within thirty (30) days of approval by CMS.

a. For a period of twenty-four (24) months following CMS approval of the Summative Evaluation Report, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the State, contractor or any other third party directly connected to the demonstration. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given thirty (30) days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

XIII. USE OF DEMONSTRATION FUNDS

79. Use of Demonstration Funds. Since 2005, the state has been able to make expenditures previously referred to as "Managed Care Organization" (MCO) investments. As part of the 2017 extension these expenditures will be referred to as "investments." The demonstration provides authority for expenditures within the annual limits specified in STC 81 below and can include expenditures within the following areas:

a. Reduce the rate of uninsured and/or underinsured in Vermont;
b. Increase the access to quality health care by uninsured, underinsured, and Medicaid beneficiaries;
c. Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and

d. Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system and promote transformation to value-based and integrated models of care.

80. Phase-Down of Investments. The state must follow the phase-down schedule below for the following investments. The percentages note how much of the SFY 2016 amount the state has authority to spend for DY 1 through DY 5 of the extension period.

	DY 1 of the extension CY 2017 DY 12	DY 2 of the extension CY 2018 DY 13	DY 3 of the extension CY 2019 DY 14	DY 4 of the extension CY 2020 DY 15	DY 5 of the extension CY 2021 DY 16
Vermont Psychiatric Care Hospital, Brattleboro Retreat, Valley Vista, Maple Leaf, Serenity House, and Lund Home (IMD)	100%	100%	100%	100%	Amount to be determined per the phase-down schedule in STC 87
HIT	100%	50%	0%	0%	0%
Non-state plan Related Education Fund Investments, Room and Board, and Physician Training Program not tied to serving in an underserved area	100%	100%	67%	33%	0%

81. Investment Annual Limits. The table below shows the specific annual limits. These amounts cannot be rolled over from DY to DY.

	DY 1 of the extension	DY 2 of the extension	DY 3 of the extension	DY 4 of the extension	DY 5 of the extension	Total
	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	
Annual Investment Limit	$142.5M	$148.5M	$138.5M	$136.5M	$136.5M	$702.5M

82. Investment Approval Process. The state may spend up to the amounts listed in the above "Investment Annual Limits" STC 81 on approved investments during each DY. See Appendix H for a list of approved investments. The state must submit an Investment Claiming Protocol for all current and new investments. This protocol will become attachment M. The annual limits cannot be rolled-over to the next DY. If the state chooses to add a new investment, it must meet the criteria specified in STC 79 "Use of Demonstration Funds" and must not supplant other federal involvement (including meeting a maintenance of effort requirement for any federal grant program) and must not include the following, including other activities CMS determines are unallowable:

i. Construction costs (bricks and mortar);
ii. Room and board;
iii. Animal Shelters and Vaccines;
iv. Provider or Beneficiary Debt Relief and Restructuring;
v. Sheltered Workshops;
vi. Research expenditures;
vii. Rent and/or Utility Subsidies that are normally funded by the United States Department of Housing and Urban Development;
viii. Prisons, correctional Facilities or services for people who are civilly committed and unable to leave an institutional setting;
ix. Services provided to individuals who are not lawfully present in the United States or are undocumented;
x. Facility closures;
xi. Unspecified projects; and
xii. School based programs for children.

83. Accountable Care Organization (ACO) and Medicaid Community Provider Integration Program ("Medicaid Pathway") Investments.

CMS is making one-time funding available under the above investment structure for the state to assist the Accountable Care Organization (ACO) and Medicaid community providers in one-time, developmental start-up funding. STC 84 establishes that Vermont shall notify CMS of delivery system-related investments that fall within the following categories which requires that the state notify CMS ninety (90) days prior to claiming for any of the proposed new investments. If CMS

finds that the proposed investment does not meet the criteria outlined in STC 79 and 84, it must notify Vermont of this finding within forty-five (45) days. For investments that do not fall within the categories below, Vermont must follow the notification and CMS review procedures as described in STC 85. The state must not include any costs listed in STC 82 above.

a. Delivery System Related Investment Categories
The goal of the delivery system-related investments is to support implementation of Vermont's All Payer Accountable Care Organization (ACO) model.

- Category #1 projects consists of funding to the Accountable Care Organization(s). Funding under category #1 is limited to development costs only.
- Category #2 projects consist of funding to providers.

b. Vermont may select time-limited, start-up delivery system investments in DY one (1) through DY four (4) of the extension period and maintenance investments in DY five (5) of the renewal period. These are time-limited investments that are expected to phase down and out at the end of five (5) years. There may not be start-up investments in DY five (5) of the extension period.

c. A project plan is required for each project and shall include an explanation of how the project will provide a return on investment over the demonstration extension period and how the project could be sustainably funded or phased out by the completion of the five (5) year demonstration extension period. The state must include metrics for all projects and the metrics are required for all years that the project receives funding. Detailed requirements are listed in Appendix I.

d. Vermont may include one-time, development start-up funding for its ACO and "Medicaid Pathways" program as an investment as long as the projects meet the criteria in Appendix I. For such projects, Vermont will follow the new investment notification requirements in STC 84 below.

84. New Investment Notification. The state must notify CMS of any new investments. Investments must meet the criteria in STC 79 above and must not include any of the activities listed in STC 82 above. The state must submit information regarding new investments following the template in Attachment J. The state may also choose from a menu of time-limited, start-up, one-time delivery system activities listed in Appendix I and must indicate if the proposed investment is strictly administrative in nature. The state must notify CMS ninety (90) days prior to claiming for any of the proposed new investments. CMS reserves the right to not approve new investments if they do not meet the criteria above or if CMS and the state cannot agree to a phase-down schedule for the Vermont Psychiatric Care Hospital and other IMD costs. If CMS finds that the proposed investment does not meet the criteria above, it must notify Vermont of this finding within forty-five (45) days. If CMS notifies the state with concerns, the proposed investment will be considered under review as outlined in STC 85 below.

85. **Requirement for Approval of Investments That Do Not Meet Criteria.** The state may request to add an investment that that does not meet the requirements of STC 83 or the menu of delivery system projects in Attachment I. In this instance, the state must submit a letter to CMS at least 120 days prior to the proposed implementation explaining the investment and providing justification for the investment, including how the investment advances the goals of the Medicaid program and demonstration. CMS will review the investment and will issue a disapproval or approval within sixty (60) days of receipt of the state's letter.

86. **IMD Evaluation Requirements.** CMS is continuing time-limited expenditure authority for costs not otherwise matchable, subject to the cap described in STC 87 for costs of care to eligible individuals at a specific group of facilities (listed in STC 80) that are IMDs. Furthermore, the state anticipates seeking to amend the demonstration to take advantage of the SUD demonstration opportunity outlined in CMS' July 2015 guidance, entitled "New Service Delivery Opportunities for Individuals with a Substance Use Disorder." Given this unique previously approved authority, CMS is asking the state to perform an extensive evaluation of the IMD expenditure authority (in addition to the evaluation that will be part of a future SUD demonstration opportunity) on individuals with serious mental illness as well as individuals in need of acute mental health and substance use disorder services in the context of system-wide service, payment, and delivery system reforms. The evaluation will help inform broader policy discussions about Medicaid funding for IMD services.

87. **Phase-Down Plan for Vermont Psychiatric Care Hospital and IMD-expenditures.** No later than December 31, 2018, the state must submit a phase-down schedule for the Vermont Psychiatric Care Hospital and other IMD-expenditures. The state must propose a lower amount for the IMD expenditures for Calendar Year 2021 (DY five (5) of the demonstration extension). The reduced IMD expenditures must start January 1, 2021. IMD expenditures must phase down to $0 by December 31, 2025. If the state does not submit the phase-down plan by December 31, 2018, the default percentage for DY five (5) of the extension period (DY 16) is 0 percent.

88. **Application Process for Use of Demonstration Funds**. AHS will use a standardized approach to evaluate new investment applications. Documentation of new and proposed investments will be posted on the state's Global Commitment to Health register website. Where specific program statistics for Medicaid, uninsured, or underinsured members are not available, the state will apply a proxy percentage for allowable expenditures based on the most recent reliable and valid state survey information such as the Vermont Household Health Insurance Survey. Monitoring and evaluation of approved investments will be performed and submitted to CMS in the quarterly and annual reports to ensure that expenditures advance the goals of the demonstration and the Medicaid program and do not violate the restrictions listed in STC 82.

89. **Administrative Investments.** The state may only receive the 50 percent administrative matching rate for investments that are strictly administrative in nature. The following investments have been found to be strictly administrative in nature:

    a. Green Mountain Care Board;

b. Health Research and Statistics;
c. Patient Safety Adverse Events; and
d. Area Health Education Centers (AHEC).

XIV. MEASUREMENT OF QUALITY OF CARE AND ACCESS TO CARE

90. Comprehensive State Quality Strategy (CQS). The state shall expand upon 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 comprehensive quality strategy (CQS) must address quality improvement for all components of the state's Medicaid state plan and its section 1115 demonstration. The CQS must meet all the requirements of 42 CFR 438 and must include LTSS and HCBS quality components.

a. *CQS Elements*. The CQS must also address the following elements , as well as those identified in 42 CFR 438.340(b):

i. Goals. Building on the requirements at 42 CFR 438.340(b)(2), the state's goals for improvement, identified through claims and encounter data, quality metrics, and expenditure data. The goals should align with the three-part aim but should be more specific in identifying pathways for the state to achieve these goals.

ii. Responsibilities. The CQS must identify Single State Agency and public managed care responsibilities. The Single State Agency retains ultimate authority and accountability for public managed care responsibilities and adherence to the CQS, including monitoring and evaluation of the public managed care model's compliance with requirements specific to the MLTSS assurances identified in STC 90(a)(v)(2) below as well as the health and welfare of enrollees.

iii. Performance Improvement Projects (PIPs). Building on the requirements at 42 CFR 438.340(b)(3)(ii), the associated interventions for improvement in the goals. All performance improvement project (PIP) topics, tied to specific goals, must be included in the CQS.

iv. Performance Measures. Building on the requirements at 42 CFR 438.340(b)(3)(i), the specific quality metrics for measuring improvement in the goals. The metrics should be aligned with the CMS Child and Adult Core Measure Sets for Medicaid and CHIP, and should also align with other existing Medicare and Medicaid federal measure sets where possible and appropriate. The metrics should go beyond Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, and should reflect cost of care.

1. Levels of Aggregation. Metrics should be measured at the following levels of aggregation: the state Medicaid agency, specific health care program (such as Choices for Care), if applicable, and potentially at each direct health services provider. The state will work with CMS to further define metrics, as appropriate, for collection.

2. Benchmarks and Targets. The specific methodology for determining benchmark and target performance on these metrics.

v. Populations. Specific metrics related to each population covered by the Medicaid program, including children, pregnant women, non-disabled adults (including parents), individuals receiving HCBS services, and individuals receiving LTSS.

1. HCBS performance measures in the areas of: level of care determinations, person-centered service planning process, outcome of person-centered goals, health and welfare, outcomes, quality of life, effectives process, community integration, and assuring there are qualified providers and appropriate HCBS settings.

2. The CQS must include a special focus on MLTSS populations and address the following:

a. A self-assessment of MLTSS adherence to state and federal standards of care to include:

i. Assessment of existing initiatives designed to improve the delivery of MLTSS, including performance measures or PIPs directed to this population.

ii. Examination of processes to identify any potential corrective action steps toward improving the MLTSS system.

b. Person-Centered Planning and Integrated Care Settings

c. Comprehensive and Integrated Service packages

d. Qualifications of Providers

e. Participant Protections

vi. Timeline. The CQS should include a timeline that considers metric development and specification, contract amendments, data submission and

review, incentive disbursement (if available), and the re-basing of performance data.

vii. Monitoring and Evaluation. This should include specific plans for continuous quality improvement, which includes transparency of performance on metrics and structured learning, as well as a rigorous and independent evaluation of the demonstration, as described in STC 74. The evaluation in STC 74 should reflect all the programs covered by the CQS as mentioned above.

viii. Performance improvement accountability. The state must include in its CQS a determination of how plans for financial incentives, if available, adequately align with the specific goals and performance improvement targets, and whether enhancements to these incentives are necessary (increased or restructured financial incentives, in-kind incentives, contract management, etc.).

b. *State and Provider Responsibilities*. The CQS must include state Medicaid agency and any contracted service providers' responsibilities, includingmanaged care entities, and providers enrolled in the state's FFS program. The state Medicaid agency must retain ultimate authority and accountability for ensuring the quality of and overseeing the operations of the program. The CQS must include distinctive components for discovery, remediation, and improvement.

c. *CQS Development, Evaluation, and Revision*. The state must comply with the requirements at 42 CFR 438.340(c) regarding the development, evaluation, and revision of the CQS. This includes the requirements at 42 CFR 438.340(c)(1) regarding public engagement. The state must revise (and submit to CMS for review) the CQS whenever this demonstration is renewed or materially amended, or when significant changes are made to the associated Medicaid programs and thus the content of the CQS. An outline and/or driver diagram for the revised CQS must be submitted to CMS with ninety (90) days of approval of the demonstration extension or material amendment. A draft of the revised CQS must be submitted to CMS for review within 180 days of approval of the demonstration extension or material demonstration amendment.

i. A material amendment to the demonstration is one that makes changes to the populations that participate in managed care; changes the services included in the managed care program; changes how the managed care program operates; brings an existing program into the demonstration, or otherwise substantially impacts a component of the CQS.

ii. Any further revisions must be submitted accordingly:

1. Modifications to the CQS due to changes in the Medicaid operating authorities must be submitted concurrent with the

proposed changes to the operating authority (e.g., state plan or waiver amendments or waiver extensions); and/or

2. Changes to an existing CQS due to fundamental changes to the CQS must be submitted for review to CMS no later than sixty (60) days prior to the contractual implementation of such changes. If the changes to the CQS do not impact any provider contracts, the revisions to the CQS may be submitted to CMS no later than sixty (60) days following the changes.

iii. At a minimum, the CQS must be revised at least once every three (3) years (pursuant to 42 CFR 438.340(c)(2)), but no more often than once per year (inclusive of any revisions per the requirements of STC 49.

d. *CQS Annual Reports*. Pursuant to STC 49, Annual Report, the state must include information on the implementation and effectives of its CQS in its annual demonstration reports, which should include a discussion of the CQS as it impacts the demonstration.

e. *Availability*. Consistent with 42 CFR 438.340(d), the state must make the CQS available on the Web site required under 42 CFR 438.10(c)(3).

XV. SCHEDULE OF THE STATE DELIVERABLES OF THE DEMONSTRATION PERIOD

Date Specific	Deliverable	STC Reference
Within six (6) months of the demonstration's implementation and annually thereafter.	Post Award Forum	Section IX, STC 43
120 days after approval (~Feb. 14, 2017)	Submit Draft Evaluation Design	Section XII, STC 70
Within sixty (60) days of receipt of CMS comments.	Submit Final Evaluation Design	Section XII, STC 70
90 days following the completion of DY 1 of the extension period, April 1, 2018	Interim Evaluation Report of IMD Expenditures	Section XIII, STC 75(a)

90 days after the completion of DY 4 of the extension period, April 1, 2021	Preliminary Summative Evaluation Report of IMD Expenditures	Section XII, STC 76
One year prior to current expiration date, December 31, 2020	Draft Interim Evaluation Report	Section XII, STC 75(b)
90 days after the completion of DY 4 of the extension period, April 1, 2021	Preliminary IMD Summative Evaluation Report	Section XII, STC 76
Within 18 months of the end of the demonstration period (June 30, 2022)	Summative Evaluation Report	Section XII, STC 76
120 days prior to proposed Implementation	Approval of Investments That Do Not Meet Criteria	Section XIII, STC 85
Ninety (90) days prior to claiming for any of the proposed new investments.	New Investment Notification	Section XIII, STC 84
Within 30 days of CMS written request.	State Data Collected	Section IX, STC 51
No later than December 31, 2018	Phase-Down Plan for Vermont Psychiatric Care Hospital and IMD-expenditures	Section XIII, STC 87

Recurring Date	Deliverable	STC Reference
Not later than April 1st	Draft Annual Report	Section IX, STC 49
Not later than 90 days prior to the effective date.	Interagency Agreement and Rate Certification	Section VI, STC 22

Not later than October 1 of the demonstration year for which the adjustment would take effect.	PMPM limit calculation	Section XI, STC 64(a)
Quarterly	Quarterly Operational Reports	Section IX, STC 49
Quarterly	CMS-64 Expenditure Reports	Section X, STCs 52 & 53
Annually (included in annual report submission)	Comprehensive State Quality Strategy	Section XIV, STC 90

ATTACHMENT A: QUARTERLY REPORT CONTENT AND FORMAT

Under section IX, STC 49, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS sixty (60) days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:
Title Line One – Vermont Global Commitment to Health
Title Line Two – Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 6 (10/1/2010 – 9/30/2011)
Federal Fiscal Quarter: 1/2010 (10/01/2010 – 12/31/2010)

Introduction
Information describing the goal of the demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information
Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

Enrollment Counts

Note: Enrollment counts should be person counts, not member months.

Demonstration Populations	**Current Enrollees: last day of the quarter: xx/xx/xxxx**	**Previously reported enrollees last day of quarter: xx/xx/xxxx**	**Variance**

Demonstration Population 1:
Demonstration Population 2:
Demonstration Population 3:
Demonstration Population 4:
Demonstration Population 5:
Demonstration Population 6:
Demonstration Population 8:

Outreach/Innovative Activities
Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues
Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity. The state must also report on whether any of the HCBW-like programs have waiting lists and an update on the progress of enrolling individuals on the waiting list.

Financial/Budget Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the state's actions to address these issues.

Member Month Reporting
Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Population 1:				
Population 2:				
Population 3:				
Population 4:				
Population 5:				
Population 6:				
Population 7:				
Population 8:				

Consumer Issues
A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also discuss feedback received from the other consumer groups.

Quality Assurance/Monitoring Activity
Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation
Discuss progress of evaluation design and planning.

Enclosures/Attachments
Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT B
Summary of Choices for Care Eligibility Criteria

Choices for Care Eligibility Group	Choices for Care Clinical Eligibility Categories*			
	Need for Assistance with Activities of Daily Living	**Physical Health Needs**	**Behavioral Health Needs/Needs Due to Impaired Decision-Making**	**Unique Circumstances**
Highest	Extensive or total assistance daily with eating, toileting, bed mobility or transfer and limited assistance with any other activity of daily living.	Skilled nursing care on a daily basis for a specific condition/treatment or unstable medical condition.	Severe impairment with decision-making or moderate impairment with behavioral symptoms (e.g., wandering, aggression, resistance to care) that occur frequently and are not easily altered.	Loss of primary caregiver; loss of living situation; health and welfare at imminent risk without services; health condition would be at imminent risk or
High	Extensive or total assistance daily with bathing, dressing, eating, toileting, and mobility.	Skilled nursing care, assessment and monitoring of care on less than daily basis but require an aggregate of personal care, nursing care, therapies and/or medical treatments on a daily basis; skilled teaching to regain or maintain certain skills/control.	Impaired judgment or loss of decision-making that: • Requires controlled environment to maintain safety due to behavioral conditions (e.g., wandering, aggression), • Requires constant or frequent direction to perform certain ADLs.	Health and welfare at imminent risk without services; health condition would worsen without services.

Moderate	Supervision or assistance 3 or more times in 7 days with one ADL or combination of ADL and IADL's.	Chronic condition that requires monitoring at least monthly.	Impaired judgment or decision-making that requires general supervision on a daily basis.	Worsening health condition without services.

*Persons must meet both clinical and financial eligibility requirements detailed in Vermont rule and policy.

ATTACHMENT C

Choices for Care Services by Demonstration Group

All covered services are subject to medical necessity review. A complete description of covered services and limitations is contained in the Vermont approved title XIX State plan, the Choices for Care Operational Protocol, Vermont statutes, regulations, and policies and procedures.

Definitions of each service may be found in Attachment D.

Home and Community-Based Services						
Type of HCBS Service	**Highest Need**	**High Need**	**Moderate Need**	**CRT**	**PACE**	**Limitations**
Adult Day Services	X	X	X	X		Any limitation on this service are defined by Vermont rules and policies.
Assistive Devices and Home Modifications	X	X		X		
Case Management	X	X	X	X		
Companion	X	X		X		Limited in combination with Respite Service.
Homemaker	X	X	X	X		Excluded if participant receives Personal Care services since homemaker activities are included among Personal Care services.
Incidental purchases paid out of cash allotments to participants who are self-directing their services	X	X				Limited to Flexible Choices participants who are self-directing their services.
Nursing Overview	X	X				Limited to participants residing in Enhanced Residential Care.

Type of HCBS Service	Highest Need	High Need	Moderate Need	CRT	PACE	Limitations
Personal Care	X	X		X		Includes assistance with ADLs and limited IADLs; laundry, meal preparation; medication management and non-medical transportation.
Personal Emergency Response System	X	X		X		
Respite Care	X	X		X		Limited in combination with Companion Service for individuals residing at home.
Social and Recreational Activities	X	X				Limited to participants residing in Enhanced Residential Care.
Supervision	X	X				Limited to participants residing in Enhanced Residential Care.
Transportation Services	X	X		X		Non-medical transportation. Limited to participants residing in Enhanced Residential Care. Included in Personal Care for individuals residing at home.

ATTACHMENT D
Choices for Care Long Term Services and Supports Definitions

Long Term Services and Supports Service Definitions & Waiting List Procedures
Comprehensive descriptions and coverage policies, prior authorization, applicant rules and limitations are defined by the Medicaid State Plan, Vermont statutes and rules and program policies.

Choices for Care
Adult day services: Community -based non-residential services that provide a range of professional health, social and therapeutic services delivered in a safe, supportive environment.
Assistive devices and home modifications: An "Assistive Device" is defined as an item which is used to increase, maintain, or improve functional capabilities. Such devices are intended to replace functional abilities lost to the individual because of his or her disability and must be used in performing Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL). A "Home Modification" is defined as a physical adaptation to the home which is necessary to allow safe access to and use of, the individual's primary living space, bathroom, kitchen, or main exit/entrance to the home.
Case management: Assistance to participants in gaining access to needed long-term care Medicaid services and other state plan and/or medical, social and community services. This includes comprehensive assessment and reassessments, treatment and support planning, obtaining and monitoring the provision of services included in the service care plan and assessing the quality, effectiveness and efficiency of CFC services.
Enhanced Residential Care Home Services: A package of services provided by an approved Level III Residential Care Home (RCH) or an Assisted Living Residence (ALR). In addition to services provided to all RCH/ALR residents, these residential settings also provide a Registered Nurse on-site, personal care services and daily social and recreational activity opportunities.
Adult Family Care: 24-hour care and support option in which participants live in and receive services from an Adult Family Care Home which is contracted by an Authorized Agency
Companion care: Non-medical supervision and socialization for participants who are unable to care for themselves.
Homemaker services: Assistance with activities that help to maintain a safe, healthy environment for individuals residing in their homes. Such services contribute to the prevention, delay, or reduction of risk of harm or hospital, nursing home, or other institutional care.

Personal care: Assistance with Activities of Daily Living (ADLs) like eating, dressing, walking, transferring, toileting and bathing and Instrumental Activities of Daily Living (IADLs) such as cooking, cleaning and shopping.
Personal Emergency Systems: Electronic devices which enable individuals at high risk to secure help in an emergency.
Respite care: Alternate care giving arrangements to facilitate planned short term and time limited breaks for unpaid care givers.
Flexible choices (Self Directed Care): Participant or surrogate directed home and community based option which converts a participant's Home Based Service Plan into a cash allowance. Working with a consultant, the participant develops a budget which details expenditure of the allowance and guides the participant's acquisition of services to meet their needs.
Nursing Facility: Health-related services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition that includes provision of or arranging, nursing or related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident.

ATTACHMENT E
Global Commitment Specialized Program Service Definitions

Vermont's specialized programs rely on person centered planning to develop individualized plans of care. Specialized programs support a continuum of care from short term crisis or family support to intensive 24/7 home and community based wraparound services. These programs include both State Plan recognized and specialized non-State Plan services and providers to support enrollees in home and/or community settings. The state may require: additional provider agreements, certifications or training not found in the State plan; specific assessment tools, level of care or other planning processes; and/or prior authorizations to support these programs. This attachment is for summary purposes only, complete service definitions, approved provider types, applicant rules, prior authorizations, limitations and exclusions can be found in Vermont statute, rule and policy.

Traumatic Brain Injury Program (TBI) Services
Crisis Support Services: Time limited services and supports that assist an individual to resolve a severe behavioral, psychological or emotional crisis safely in their community. This includes 24/7 availability, one to one support and case management, hospital diversion programs, mobile outreach, community crisis placements and/or intensive in home support.
Psychological and Counseling Supports: Services provided by or under the direction of licensed practitioners that include, but may not be limited to: clinical assessment; medication and psychiatric consultation; individual, family and group therapy or specialized behavioral or health services.
Case Management: Assistance to enrollees in gaining access to needed waiver, medical, social, educational and other services regardless of the funding source for the services to which accessis gained. Case management includes comprehensive assessment; treatment planning and plan of care development, service coordination, monitoring and collateral contacts with persons involved and/or designated by the enrollee.
Community Supports: Individualized support services that may be provided in a family setting, group home, supervised apartment, other community residential setting or in the individual's own apartment/home. Support may include 24-hour care and supervision as part of authorized treatment plan goals and objectives.
Habilitation: Comprehensive and integrated one to one training and support by authorized Life Skills Aides (LSA) to provide training in specific activities of daily living identified in the treatment plan designed to promote independent living and community re-integration.
Respite Care: Alternative caregiving arrangements to facilitate planned short term and time limited breaks for caregivers.

Supported Employment: Job coaching, on and off site support, and consultation with employers to support competitive employment in integrated community work settings.
Environmental and Assistive Technology: Physical adaptations, devices or technology in the home necessary to ensure health and safety or to enable greater independence. Eligible items may include, but are not limited to: durable medical equipment; safety devices; physical endurance equipment prescribed by a licensed health professional; accessibility devices and equipment. This may include services/supports, deposits, rentals or other items which are determined to be necessary to improve functional independence.
Self-Directed Care: When an individual, their family or surrogate meets requirements and chooses to manage some or all of their TBI services, the person has the responsibility of hiring his or her own staff and overseeing the administrative responsibilities associated with receiving TBI funding, including contracting for services, developing a service plan, fulfilling the responsibilities of the employer, and planning for back-up support or respite in the case of an emergency.

Services for Children and Youth under 21 Experiencing Severe Emotional Disturbance/ Mental Illness and Their Families
Service Coordination: Case management and assistance to individuals and families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of medical, social, educational and other services and supports, including discharge planning, advocacy, monitoring and supporting them to make and assess their own decisions.
Community Supports (Individual or Group): Specific, individualized and goal-oriented services which assist individuals in developing skills and social supports necessary to promote growth.
Skilled Therapy Services: Services provided by or under the direction of licensed practitioners that include, but may not be limited to: clinical assessment; medication and psychiatric consultation; individual, family and group therapy or specialized behavioral and health services.
Residential Treatment: Out of home treatment services that include: • *Transitional Living*: Short-term out of home care for adolescents requiring intensive supports in order to transition to independent living. • *Therapeutic Foster Care*: Short-term out-of-home care to assist in skill development and remediation of intensive mental health issues to support a return to the family. • *Residential Treatment:* Intensive out of home care for mental health treatment, skill building, family reintegration and/or specialized assessment services to assist recovery and skill building that supports return to the family home.
Flexible Support: • *Family Education*: In home support and treatment for the purpose of enhancing the family's ability to meet their child's emotional needs. • *Specialized Rehabilitation or Treatment Plan Services*: Services, supports or devices used to increase, maintain, or improve functional capabilities or health outcomes identified as the result of an approved assessment, treatment plan and/or prior approval.
Counseling: Services directed toward the development and restoration of skills or the elimination of psychosocial or barriers that impede the development or modification of skills necessary for independent functioning in the community. Services may include approved peer supported and recovery services.
Respite: Alternative care giving arrangements to facilitate planned short term and time limited breaks for care givers.
Supported Employment: Job coaching, on and off site support, and consultation with employers to support competitive employment in integrated community work settings.
Crisis Supports: Time limited services and supports that assist an individual to resolve a severe behavioral, psychological or emotional crisis safely in their community. This includes 24/7

Availability, one to one support, and case management, hospital diversion programs, mobile outreach, community crisis placements and/or intensive in home support.
Environmental Safety Devices: Devices or technology necessary to ensure health and safety or to enable independence. This does not include structurally permanent modifications.

Community Rehabilitation and Treatment
Service Coordination: Case management and assistance to individuals and families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of medical, social, educational and other services and supports, including discharge planning, advocacy, monitoring and supporting them to make and assess their own decisions.
Community Supports: (Individual or Group): Specific, individualized and goal-oriented services which assist individuals in developing skills and social supports necessary to promote growth.
Flexible Support: • *Day Recovery/Psychoeducation, Including Recovery Education:* Group recovery activities in a milieu that promotes 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 Others*: To support recovery and assist individual in managing their symptoms
Skilled Therapy Services: Services provided by or under the direction of licensed practitioners that include, but may not be limited to: clinical assessment; individual, group, and family therapy or diagnosis-specific practices; medication evaluation, management and consultation with Primary Care; inpatient behavioral health services; partial hospitalization.
Residential Treatment • *Residential Treatment:* Intensive mental health treatment, skill building, community reintegration and/or specialized assessment services to assist recovery and skill building to support community living, but not provided in institutions for mental disease (IMD). Treatment may include the use of approved peer supported and peer run alternatives. • *Housing and Home Supports*: Mental Health services and supports based on the clinical needs of individuals in and around their residences. This may include support to a person in his or her own home; a family home; sharing a home with others (e.g., in an apartment, group home, shared living arrangement).

Crisis Support: Time limited services and supports that assist individuals to resolve a severe behavioral, psychological or emotional crisis safely in their community. This includes 24-hour/ 7 day a week availability, one to one support, case management, hospital diversion programs, mobile outreach, community crisis placements and/or intensive in home support.
Environmental Safety Devices: Devices or technology necessary to ensure health and safety or to enable independence. This does not include structurally permanent modifications.
Counseling: Services directed toward the development and restoration of skills or the elimination of psychosocial or barriers that impede the development or modification of skills necessary for independent functioning in the community. May include approved peer supported and/or peer run recovery services.
Respite: Alternative care giving arrangements to facilitate planned short term and time limited breaks for care givers.
Supported Employment: Job coaching, on and off site support, and consultation with employers to support competitive employment in integrated community work settings.

Developmental Disability Services
Service Coordination: Case management and assistance to individuals and families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of medical, social, educational and other services and supports, including planning, advocacy, monitoring and supporting them to make and assess their own decisions.
Residential Habilitation: Home supports, services and supervision to an individual in and around their residence up to 24 hours a day. This may include support to a person in his or her own home; sharing a home with others (e.g., in an apartment, group home, shared living arrangement); or who lives with his or her family.
Day Habilitation: Community supports that are specific individualized and goal oriented services which assist individuals in developing skills and social supports necessary to promote positive growth. This may also include support for persons to prevent them from entering more restrictive levels of care such as: • *Flexible Family Funding:* One time support to assist a family not receiving other specialized services in maintaining their family member in home and diverting the use of more costly home and community based services or restrictive levels of care. • *Specialized Treatment Plan Services:* Services, supports or devices used to increase, maintain, or improve functional capabilities or health outcomes identified as the result of an approved assessment, plan of care and/or prior approval.
Supported Employment: Job coaching, on and off site support, and consultation with employers to support competitive employment in integrated community work settings.
Crisis Services: Time limited intensive services and supports that assist individuals to resolve a severe behavioral, psychological or emotional crisis safely in their community. This includes 24/7 availability, case management, hospital diversion programs, mobile outreach, community crisis placements and/or intensive in home support.
Clinical Interventions: Assessment, therapeutic, medication or medical services provided by clinical or medical staff.
Respite: Alternative care giving arrangements to facilitate planned short term and time limited breaks for care givers.
Self-Directed Care: When an individual, their family or surrogate meets requirements and chooses to manage some or all of their developmental services, the person has the responsibility of hiring his or her own staff and overseeing the administrative responsibilities associated with receiving developmental services funding, including contracting for services, developing a service plan, fulfilling the responsibilities of the employer, and planning for back-up support or respite in the case of an emergency.

ATTACHMENT F
Choices for Care Wait List Procedure Description

Choices for Care - Waiting List Procedures High Needs

Active participants who meet the "High Needs" clinical criteria at reassessment will not be terminated from services as long as they continue to meet all other CFC eligibility criteria.

New CFC applicants who meet the "High Needs" clinical criteria may be placed on a waiting list if state funds are not available at the time of referral, using the following procedures:

1. If funds are not available at time of application, Department of Disabilities, Aging and Independent Living (DAIL) staff will complete a High Needs Wait List Score Sheet.

2. A score will be generated based on the individuals Activities of Daily Living (ADL), Cognition, Behavior, Medical Conditions/Treatments and Risk Factors.

3. DAIL staff will then place the individual on a waiting list in order of score.

4. DAIL staff will notify the individual in writing that they have been found clinically eligible for the High Needs Group and have been placed on a wait list. The case management agency that the applicant chose on the application will be in contact with them. Appeal rights will also be included in the notice.

5. DAIL staff will forward a copy of the CFC program application and Wait List Score Sheet to the Case Management (CM) agency indicated on the application. The application will not be sent if the CM agency assisted in completing the application.

6. The case manager/agency will make contact individuals on the "High Needs" wait list on a monthly basis to monitor if they have had a change in their health or functional needs and complete the High Needs Waiting List Monthly Follow-Up Sheet. The initial contact will occur no later than 14 days after receiving the referral.

7. If the individual has had a significant health or functional status change the case manager will contact DAIL staff. DAIL staff shall reassess for clinical eligibility determination and/or rescore for wait list. Agencies are encouraged to use the Triggers for High Needs Wait List Referral for Clinical Review as a guide to determine if another clinical assessment is warranted.

8. DAIL staff and providers will review the wait list with the CFC waiver team at monthly meetings.

9. Each case management agency designee (determined by the CM agency) will ensure that a copy of the follow-up sheet for all applicants on the High Needs wait list monitored by their agency and send to DAIL Waterbury by the 5th of each month.

10. DAIL staff will follow up with the CM agency if any High Needs Waiting List Monthly Follow-up Sheets are missing.

11. Applicants on a waiting list shall be admitted to the Choices for Care waiver as funds become available, according to procedures established by the Department and implemented by regional Choices for Care waiver teams. The Choices for Care waiver teams shall use professional judgment in managing admissions to the Choices for Care waiver, admitting individuals with the most pressing needs. The teams shall consider the following factors:
    a. Unmet needs for ADL assistance;
    b. Unmet needs for IADL assistance;
    c. Behavioral symptoms;
    d. Cognitive functioning;
    e. Formal support services;
    f. Informal supports;
    g. Date of application;
    h. Need for admission to or continued stay in a nursing facility;
    i. Other risk factors, including evidence of emergency need; and
    j. Priority score.

12. When funding is allocated to an individual, DAIL staff will notify the individual and continue the CFC application process.

Choices for Care Moderate Needs Waiting List

Moderate Needs applicants may be placed on a waiting list if funds are not available or capacity at Adult Day is not available at the time of application, using the following procedures:

1. If funding, or capacity at Adult Day, is not available at time of application, the case manager (CM) will notify the individual in writing and will send a copy of the notice and application to the requested Service Providers.

2. The Homemaker Agency or Adult Day provider (Moderate Needs Providers) will place the individual on their waiting list.

3. Applicants on Community Medicaid are considered first priority, then chronological order by date of application.

4. Participants who are already active on Moderate Needs and wish to add a second service will be put on the wait list according to their original Moderate Needs application date

5. The wait list should contain only those people who are still waiting for funding on the last day of the reporting month.

6. The wait list shall not contain the names of people who have an active Moderate Needs service authorization and are waiting for staffing or additional hours.

7. The Moderate Needs Providers must forward a copy of the wait list to DAIL by the 15th of the month following the reporting month. *For example, the January report is due at DAIL by February 15th and must contain everyone waiting for funding as of January 31st.*

8. Providers who have no wait list must either send a blank wait list or send an email to DAIL by the 15th of the month stating they have no wait list.

9. When funding is allocated to an applicant the Moderate Needs Providers will indicate such date on the wait list and notify the Moderate Needs case manager.

10. The CM will notify the applicant when funding becomes available and continue the eligibility process. The CM shall put the date the applicant came off the wait list on the Moderate Needs application.

11. If the individual is already receiving other Moderate Needs services, the CM will complete a Moderate Needs Group Change Form and send to the Moderate Needs Coordinator. The Moderate Needs Coordinator will complete and send a new Service Authorization to the individual, case manager and provider(s).

12. The effective date of the service will be the date the individual was taken off the wait list or a later date as requested by the CM.

13. The DAIL Moderate Needs Coordinator will review the provider's wait list upon receiving a new Moderate Needs application to ensure that Medicaid applicants are served before non-Medicaid applicants.

14. Providers must assure that all people listed on their wait list are still waiting for funding to be served. This is accomplished contacting people on the wait list at least once every six months.

ATTACHMENT G
Premiums and Co-Payments for Demonstration Populations

Premiums for children age 0 through age 18 in Population 1 are charged according to the following chart:

Group	Premiums
Children with income > 195% percent through 237% of the FPL	$15/month/family
Underinsured Children with income > 237% through 312% FPL	$20/month/family
Uninsured Children with income > 237% through 312% of the FPL	$60/month/family

Population	Premiums	Co-Payments	State Program Name
Demonstration Population 7: Medicare beneficiaries with income at or below 150 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise categorically eligible for full benefits.	Premiums not to exceed the following: 0-150% FPL: $15/month/person	Not to exceed the nominal co-payments specified in the Medicaid State plan.	VHAP Pharmacy/ VPharm1
Demonstration Population 8: Medicare beneficiaries with income above 150 percent and up to and including 225 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP), but are not otherwise categorically eligible.	Premiums not to exceed the following: 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.	VScript/VPharm2 or VScript Expanded/ VPharm3

ATTACHMENT H

List of Approved Investments

No.	Investment Name
1.	Residential Care for Youth/Substitute Care
2.	Lund Home: IMD
3.	Institution for Mental Disease Services: DMH
4.	Return House
5.	Northern Lights
6.	Pathways to Housing
7.	Institution for Mental Disease Services: DVHA
8.	Vermont Information Technology Leaders HIT/HIE/HCR
9.	Addison Helping Overcome Poverty's Effects (HOPE) (Challenges for Change)
10.	Vermont Physician Training
11.	Non-state plan Related Education Fund Investments
12.	Mental Health Children's Community Services
13.	Acute Psychiatric Inpatient Services
14.	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)
15.	Northeast Kingdom Community Action
16.	Mental Health CRT Community Support Services
17.	Recovery Centers
18.	Patient Safety Net Services
19.	Emergency Medical Services
20.	Vermont Veterans Home
21.	Area Health Education Centers (AHEC)
22.	Emergency Support Fund
23.	Public Inebriate Program (Challenges for Change)
24.	CHIP Vaccines
25.	Physician/Dentist Loan Repayment Program
26.	Strengthening Families
27.	Flexible Family/Respite Funding
28.	Special Payments for Treatment Plan Services
29.	Emergency Mental Health for Children and Adults
30.	Substance Use Disorder Treatment
31.	Health Laboratory
32.	Health Professional Training
33.	Prevent Child Abuse Vermont: Shaken Baby
34.	Prevent Child Abuse Vermont: Nurturing Parent
35.	Building Bright Futures
36.	Agriculture Public Health Initiatives
37.	WIC Coverage
38.	Fluoride Treatment
39.	Health Research and Statistics
40.	Epidemiology

No.	Investment Name
41.	United Ways 2-1-1
42.	Quality Review of Home Health Agencies
43.	Support and Services at Home (SASH)
44.	Vermont Blueprint for Health
45.	Green Mountain Care Board
46.	Immunization
47.	Patient Safety - Adverse Events
48.	Poison Control
49.	Healthy Homes and Lead Poisoning Prevention Program
50.	Tobacco Cessation: Community Coalitions
51.	Vermont Blueprint for Health
52.	Buy-In
53.	HIV Drug Coverage
54.	Designated Agency Underinsured Services
55.	Medical Services
56.	Aid to the Aged, Blind and Disabled CCL Level III
57.	Aid to the Aged, Blind and Disabled Res Care Level III
58.	Aid to the Aged, Blind and Disabled Res Care Level IV
59.	Essential Person Program
60.	GA Medical Expenses
61.	Therapeutic Child Care
62.	Lamoille Valley Community Justice Project
63.	Mobility Training/Other Services.-Elderly Visually Impaired
64.	DS Special Payments for Medical Services
65.	Seriously Functionally Impaired: DAIL
66.	MH Outpatient Services for Adults
67.	Respite Services for Youth with SED and their Families
68.	Seriously Functionally Impaired: DMH
69.	Intensive Substance Abuse Program (ISAP)
70.	Intensive Domestic Violence Program
71.	Community Rehabilitative Care
72.	Family Supports
73.	Renal Disease
74.	TB Medical Services
75.	Family Planning
76.	Statewide Tobacco Cessation
77.	Home Sharing
78.	Self-Neglect Initiative
79.	Mental Health Consumer Support Programs
80.	Intensive Sexual Abuse Prevention Program

81.	OneCare Vermont Accountable Care Organization (ACO) Quality and Health Management Measurement Improvement Investment
82.	OneCare Vermont ACO Advanced Community Care Coordination

ATTACHMENT I

Menu of Approvable Delivery System Investments

As described in STC 83, Vermont has a unique investment authority under the Global Commitment to Health demonstration to spend up to annual limits on expenditures for the following purposes:

a) Reduce the rate of uninsured and/or underinsured in Vermont;
b) Increase the access to quality health care by uninsured, underinsured, and Medicaid beneficiaries;
c) Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and
d) Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

CMS is making funding available under the above investment structure for the state to assist the Accountable Care Organization (ACO) and providers in one-time, developmental start-up funding, as defined in STC 83. STC 84 establishes that Vermont shall notify CMS of delivery system-related investments that fall within the following categories. For investments that do not fall within the categories below, Vermont must follow the notification and CMS review procedures as described in STC 85.

Delivery System Related Investment Categories
The goal of the delivery system-related investments is to support implementation of Vermont's All Payer Accountable Care Organization (ACO) model.

- Category #1 projects consists of funding to Accountable Care Organization(s). Funding under category #1 is limited to development costs only.
- Category #2 projects consist of funding to providers.

Vermont may select time-limited, start-up delivery system investments in demonstration year (DY) 1 through 4 of the extension period and maintenance investments in DY 5 of the extension period. These are time-limited investments that are expected to phase down and be completed at the end of five years. There may not be start-up investments in DY 5 of the extension period.

A project plan is required for each project and shall include an explanation of how the project will provide a return on investment over the demonstration extension period and how the project could be sustainably funded through the ACO over the five-year demonstration. The state must include metrics for all projects and the metrics are required for all years that the project receives funding.

Category #1: ***Accountable Care Organization (ACO) Infrastructure Improvement Program***

Project funding under category #1 is limited to development costs only. Category #1 projects are only allowed from demonstration year 1 through demonstration year 4 of the extension period. The state must submit a project plan to CMS at the time the state notifies CMS of the proposed project that includes a phasedown of demonstration funding no later than DY 5 of the extension period.

Eligibility: To be eligible to receive any funding under category #1, the ACO must meet the following criteria:

- Once the Green Mountain Care Board full certification and budget review process is implemented (expected by January 1, 2018), meet the state certification standards set by the Green Mountain Care Board under Vermont Act 113 (2016);
- Sign an agreement with the state consistent with the state's All Payer Model Accountable Care Organization agreement with the Centers for Medicare & Medicaid Services; and
- Sign an agreement with at least one other payer consistent with the state's All Payer Model Accountable Care Organization agreement.

Objectives: The ACO must submit a project plan to the state that describes how the funding would help the ACO achieve one or more of the following objectives:

- Develop governance, skills, and capacity to perform under a Medicaid risk-based contract designed to be an integrated part of an all payer approach;
- Manage enrollees' care across Medicaid providers in a manner consistent with unified processes across payers; and
- Successfully operate without decreased access or quality under population-level spending targets set to prospectively provide affordable per-person spending to the payers, programs and employers covering Vermont residents.

Metrics: Project metrics may include, but are not limited to:

- ACO quality measures included in the contract between DVHA and the ACO;
- Improvement in the ACO quality measures included in the contract between DVHA and the ACO; and
- Increase in the number of community providers participating in the ACO network and level of access to Medicaid enrollees.

Eligible Project Categories: Projects may fall under one or more of the categories of projects identified below in category #1(a) through category #1(b)(4).

***Category #1(a). Quality and Health Management Measurement Improvement Projects*:** The purpose of these projects is to provide funding for quality and health improvement information development and dissemination for participating providers of the ACO. Projects under this category must include one or more of the following:

- Learning collaboratives for provider communities to share best practices for using data to support health improvement for Medicaid beneficiaries;
- Technical assistance to providers in setting quality improvement targets for their specific panel of Medicaid patients in order to meet the ACO quality measures or to support the measures in the APM agreement; and
- Technical assistance in testing payment models which reward communities (and their providers across the continuum of care and services) who demonstrate high quality and/or improvement by working together.

Project metrics may include, but are not limited to:

- Yearly participation targets for learning collaboratives which demonstrate greater participation by number or type of provider;

- Quality improvement in one or more of the ACO quality measures (http://dvha.vermont.gov/administration/vermont-medicaid-shared-savings-progam-vmssp);and
- Number of ACO communities who achieve high overall results across a full measure scorecard, or targets identified in the state's Quality Improvement Plan (http://dvha.vermont.gov/global-commitment-to-health/1vt-gc-cqs-september-15-2015-cms-submission.pdf).

Category #1(b): Community-Based Population Health Projects*:*

The goal of this category of projects is to improve the integration of care for Medicaid beneficiaries by improving relationships between Medicaid's community providers and local hospitals. Projects must be designed, at the local/regional level, to promote integration across all types of care and service providers and targeted to the overall goals, including measures agreed to by the state in the All-Payer ACO Model Agreement or in the state's Quality Improvement Plan. The APM measures include:

- Reducing deaths of Vermont residents related to drug overdose;
- Reducing the number of deaths due to suicide;
- Not increase the prevalence of COPD, diabetes and hypertension for Vermont residents;
- Increasing the level and consistency in screening, access, and follow-up for mental health and substance abuse issues; and
- Ensuring most Vermonters have a usual primary care physician.

Projects must include one or more of the types of projects described in category #1(b)(1) through #1(b)(4).

Category #1(b)(1) Primary and Secondary Prevention Development projects, including:

- Expanding disease-specific programs to slow or reverse existing disease state and related co-morbidities at the community or local level;
- Building a statewide, community-focused health and wellness program; and
- Tailoring existing prevention programs to specific characteristics of Medicaid beneficiaries, the uninsured or the underinsured.

Metrics may include, but are not limited to: 1) disease-specific improvement targets, 2) an increase of prevention activities in a specific community, and/or 3) number of participants engaged.

Category #1(b)(2) Community-Based Provider Capacity projects to build integration between essential community providers, such as those who provide mental health, substance use disorder, developmental services, and long term services and supports, and ACO, to ensure community-based providers have the capacity to participate in quality improvement and health management projects with the ACO, and to ensure that Medicaid community providers are able to participate in the other ACO projects funded by investments.

Metrics include, but are not limited to: 1) an increase in the number of participating community-based providers in the ACO's network or in specific ACO projects.

Category #1(b)(3) Socio-Economic Risk and Mitigation projects to develop a screening profile for socio-economic, environmental, and behavior risks for low income Vermonters that builds on the Screening, Brief Intervention Referral to Treatment (SBIRT) program. These projects will ensure that individuals' unique needs and challenges are incorporated in care planning and that coordination is expanded beyond medical providers and Medicaid community providers. The purpose is to develop projects promoting a whole-person approach to care that takes into consideration the socio-economic needs of specific individuals.

Metrics may include, but are not limited to: 1) the number of individuals with unique care plans that include addressing socio-economic needs or 2) the number of providers who have integrated the tool into their work flow or electronic medical record.

Category #1(b)(4) Advanced Community Care Coordination projects would organize and expand upon current care management programs to create an efficient and effective approach, eliminating duplication in this arena. The project would include development of capacity to identify individuals needing supplemental coordination and management through risk scoring and other methods. This will involve codifying more standardized levels of care coordination, and developing programs and plans to best deliver the services based on existing capacity and community approaches. For example, projects would develop formats for shared care plans for complex (high risk scoring) patients and enhancement of existing community-based care management programs where necessary to meet the population health measures.

Metrics include, but are not limited to: 1) patients under active management, 2) percentage of patients engaged out of those who meet the criteria, and 3) the utilization and quality outcomes for patients under the more coordinated and advanced coordinated care management system.

Category #2: Medicaid Community Provider Integration Program ("Medicaid Pathway")

Goal: The goal of these projects is to assist Vermont's Medicaid community-based service providers to be able to manage population health for Medicaid beneficiaries and be able to participate in the All Payer model, including being able to accept value-based and risk-based payments.

Target: The following providers will propose projects under this category: Medicaid community-based providers, including designated mental health, disability support, substance use disorder providers and long term services and support providers.

Metrics include, but are not limited to: 1) targets identified in the Agency's comprehensive quality strategy, 2) the ACO measures included in the Medicaid contract, or 3) the APM measures included in the APM agreement with CMS.

ATTACHMENT J
Investment Application Template

During the extension negotiations, CMS reviewed the current 80 investments. For each new investment, the state must submit the following information to CMS as described in STC 84.

Date	
Investment Title	
Estimated Amount	
Time Period	
Department	
Category	
Project Objective (Must be time-limited)	
Project Description, including Phasedown Strategy	
Project Outcomes	
Project Specific Measurements (include measures and targets for each measure)	
How does the state ensure there is no duplication of federal funding?	
Source of non-federal share	
How does the project provide a return on investment?	
How does the state ensure that the investment does not include any activities listed in STC #82 (Investment Approval Process)?	
Performance Monitoring Plan	
The state assures that in reporting cost, the state and providers must adhere to 45 CFR §75 Uniform Administration Requirements, Cost Principles, and Audit Requirements for Health and Human Services (HHS) Awards and 42 CFR §413 Principles of Reasonable Cost Reimbursement. Pursuant to 45 CFR §75.302(a) the state must have proper fiscal control and accounting procedures in place to permit the tracing of funds to a level of expenditures adequate to establish that such funds have not been used in violation of applicable statutes. Costs must be supported by adequate source documentation.	

ATTACHMENT K
Evaluation Design
Approved March 8, 2018

I. GLOBAL COMMITMENT TO HEALTH OVERVIEW

The Vermont Global Commitment to Health Medicaid Section 1115(a) Demonstration was originally approved on September 27, 2005, and implemented on October 1, 2005. The Global Commitment to Health Section 1115(a) Demonstration is designed to use a multi-disciplinary approach to comprehensive Medicaid reform, including the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, public-private partnership, and program flexibility.

As of January 1, 2017, Vermont and CMS extended the Global Commitment to Health Demonstration to further promote delivery system and payment reform to meet the goals of the State working with the Center for Medicaid and CHIP Services, and the Center for Medicare and Medicaid Innovation (CMMI). Consistent with Medicare's payment reform efforts the Demonstrations allow for alignment across public payers. Specifically, Vermont expects to demonstrate its ability to achieve universal access to health care, cost containment, and improved quality of care.

Since 2005, the Global Commitment to Health Demonstration has reduced Vermont's uninsured rate from 11.4 percent in 2005 to approximately 2.7 percent in 2015 through expansion of eligibility and other Accountable Care Act reforms. The Demonstration has also enabled Vermont to address and eliminate bias toward institutional care and offer cost-effective, community-based services. For example, the proportion of Choices for Care participants served in the community has passed fifty percent and continues to increase. In addition, Vermont no longer has a waiting list for individuals in the Highest and High Need Groups under the Choices for Care component of the Demonstration.

Due to the expansion of eligibility under the Vermont State Plan, pursuant to the Affordable Care Act, expansion of eligibility is no longer the primary focus of the Demonstration. However, the Demonstration continues to promote delivery system reform and cost-effective community-based services as an alternative to institutional care. The State's goal in implementing the Demonstration is 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 long-term services and supports and providing an array of home and community-based (HCBS) alternatives recognized to be more cost-effective than institutional based supports.

The State employs four major elements in achieving the above goals:

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

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

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

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

The initial Global Commitment to Health and Choices for Care Demonstrations were approved in September of 2005 and became effective October 1, 2005. The Global Commitment to Health Demonstration was extended for three years, effective January 1, 2011, and again for three (3) years, effective October 2, 2013. The Choices for Care Demonstration was extended for five (5) years effective October 1, 2010, and became part of the Global Commitment to Health Demonstration in January 2015. The following amendments have been made to the Global Commitment to Health Demonstration:

- 2007: A component of the Catamount Health program was added, enabling the State to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the FPL, and who do not have access to cost-effective employer-sponsored insurance, as determined by the state.

- 2009: The State extended Catamount Health coverage to Vermonters at or below 300 percent of the FPL.

- 2011: The State included a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life limiting illness that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.

- 2012: CMS provided authority for the State to eliminate the $75 inpatient admission co-

pay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid state plan.

- 2013: CMS approved the extension of the Global Commitment to Health Demonstration which included sun-setting the authorities for most of the Expansion Populations, including Catamount Health coverage, because these populations would be eligible for Marketplace coverage beginning January 1, 2014. The extension also added the New Adult Group under the State Plan to the population affected by the Demonstration effective January 1, 2014. Finally, the extension also included premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL.

- 2015: In January 2015, the Global Commitment to Health Demonstration was amended to include authority for the former Choices for Care Demonstration. In addition, the State received Section 1115 authority to provide full Medicaid State Plan benefits to pregnant women who are determined presumptively eligible.

A. Demonstration Goals

The State's high-level goal for all health reforms is to create an integrated health system able to achieve the Institute of Medicine's "Triple Aim" goals of improving patient experience of care, improving the health of populations, and reducing per-capita cost.[1] This is supported in the Global Commitment to Health Demonstration through supporting innovative delivery system reforms, including Medicaid Accountable Care Organizations (ACO) and the development of progressive in-home and community based services and supports that are cost-effective and support persons who have long-term care service and support needs, complex medical, mental health and/or substance use disorder treatment needs. Overarching Demonstration goals are described below:

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

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

- ***To improve the quality of care***: Quality refers to the degree to which programs/services and activities increase the likelihood of desired outcomes. The six domains necessary for assuring quality health care identified by the Institute of Medicine (IOM, 2001) are:

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

- *Effectiveness*: Effective health care provides evidence-based services to all who can benefit, refraining from providing services that are not of benefit.
- *Efficiency*: Efficient health care focuses on avoiding waste, including waste of equipment, supplies, ideas, and energy.
- *Equity*: Equal health care provides care without variation in quality due to gender, ethnicity, geographic location, or socioeconomic status.
- *Patient Centeredness*: Patient-centered care emphasizes a partnership between provider and consumer.
- *Safety*: Safe health care avoids injuries to consumers from care that is intended to help.
- *Timeliness*: Timely health care involves obtaining needed care and minimizing unnecessary delays in receiving care.

- ***To eliminate institutional bias:*** By allowing specialized program participants choices in where they receive long-term services and supports and by offering a cost-effective array of in-home and community services for older adults, people with serious and persistent mental illness, people with developmental disabilities and people with traumatic brain injuries who meet program eligibility and level of care requirements.

B. Public Managed Care Delivery System, Investments and All-Payer Model

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

In addition to the Demonstration, the State has also begun its first year of implementation planning for the Vermont All-Payer Accountable Care Organization Model Agreement (All-Payer Model), Section 1115A Medicare Demonstration through the Center for Medicare and Medicaid Innovation (CMMI). The All-Payer Model Medicare Demonstration and the Global Commitment to Health Medicaid Demonstration are expected to complement each other to support systemic delivery reform efforts. Using the payment flexibility provided through both Demonstrations, alignment across public and private payers is expected. A brief description of the Medicaid public managed care-like model and current reform efforts is provided below.

Public Managed Care-Like Model

The Agency of Human Services (AHS), as Vermont's Single State Medicaid Agency, is responsible for oversight of the managed care-like Medicaid delivery system. The Department of Vermont Health Access (DVHA) operates the Medicaid program as if it were a Managed Care Organization in accordance with federal managed care regulations. Program requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. DVHA also has sub-agreements with the other State entities that provide specialty care for Global Commitment (GC) enrollees (e.g., mental health services, developmental disability services, and specialized child and family services). As such, since the inception of the GC

Demonstration, DVHA and its IGA partners have modified operations to meet Medicaid managed care requirements, including requirements related to network adequacy, access to care, beneficiary information, grievances, quality assurance, and quality improvement. Per the External Quality Review Organization's annual findings, DVHA and its IGA partners have achieved exemplary compliance rates in meeting Medicaid managed care requirements. Departments of Vermont State government that participate in the provision of covered services to enrollees under the Demonstration are outlined, in brief, below.

Department of Vermont Health Access (DVHA): DVHA, which operates the Medicaid program as if it were a public MCO under Global Commitment Demonstration, has a three-fold mission:

- To assist beneficiaries in accessing clinically appropriate health services;
- To administer Vermont's public health insurance system efficiently and effectively; and
- To collaborate with other health care system entities in bringing evidence-based practices to Vermont Medicaid beneficiaries.

Department of Mental Health (DMH): The mission of DMH is to promote and improve the mental health of Vermonters and to provide Vermonters with access to effective prevention, early intervention, and mental health treatment and supports as needed to live, work, learn, and participate fully in their communities. DMH consists of two programmatic divisions: Adult Mental Health Services Division and the Child, Adolescent, and Family Mental Health Services Division. DMH has primary responsibility for overseeing the quality of psychiatric and mental health care provided for two of Vermont's Special Health Needs populations defined under the Global Commitment Demonstration, including persons with a severe and persistent mental illness and children who are experiencing a severe emotional disturbance.

Department of Disabilities, Aging, and Independent Living (DAIL): DAIL assists older Vermonters and people with disabilities to live as independently as possible. It provides support to families of children with disabilities to help maintain them in their home. It helps adults with disabilities find and maintain meaningful employment, and it ensures quality of care and life for individuals receiving health care and/or long-term care services from licensed or certified health care providers. DAIL also protects vulnerable adults from abuse, neglect, and exploitation and provides public guardianship to elders and people with developmental disabilities. DAIL operates the several specialized Medicaid programs under the Demonstration including, Choices for Care, Developmental Disability Services and Traumatic Brain Injury Services.

Vermont Department of Health (VDH): VDH's goal is to have the nation's premier system of public health, enabling Vermonters to lead healthy lives in healthy communities. VDH leads the state and communities in the development of systematic approaches to health promotion, safety, and disease prevention. VDH continuously assesses, vigorously pursues, and documents measurable improvements to the health and safety of Vermont's population. VDH will succeed through excellence in individual achievement, organizational competence, and teamwork within and outside of VDH. VDH's division of Alcohol and Drug Abuse Programs supports the innovated Medicaid Health Home program for Medication Assisted Opioid Treatment in partnerships with DVHA, as well as extensive outpatient and residential treatment and recovery support for alcohol and other drugs use disorders.

Department for Children and Families (DCF): DCF promotes the social, emotional, physical, and economic well-being of Vermont's children and families. It achieves this mission by providing Vermonters with protective, developmental, therapeutic, probation, economic, and other support services. To this end, DCF works in statewide partnership with families, schools, businesses, community leaders, and service providers. DCF offers specialized Medicaid services to children and families at risk of or experiencing trauma and early childhood intervention for families with children birth to age six with developmental needs.

Agency of Education (AOE): The AOE is responsible for overseeing coverage and reimbursement under the School-Based Health program. The Special Education Medicaid School-Based Health Services Program is used by the State to support health-related services provided to special education students who are enrolled in Medicaid and receive eligible services in accordance with their individualized education plans (IEPs). The AOE is established as an "Organized Delivery System" under Medicaid and is responsible for the program adherence to all State and Federal Medicaid and Education laws and regulations.

Delivery System Investments

Under the public managed care-like model, the Demonstration provides the State with flexibility to invest in health care innovations that:

a. Reduce the rate of uninsured and/or underinsured in Vermont;
b. Increase the access to quality health care by uninsured, underinsured, and Medicaid beneficiaries;
c. Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and
d. Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system and promote transformation to value-based and integrated models of care.

In addition, CMS has provided the State with one-time spending authority to support Accountable Care Organizations and Medicaid community providers in delivery system reform through activities such as, but not limited to:

- Infrastructure improvement;
- Quality and heath improvement information development and dissemination;
- Community related population health projects;
- Socio-economic risk assessment and mitigation; and
- Provider integration to build integration across physical health, mental health substance use disorder treatment and long-term services and supports.

Investment awards are expected to give preference to activities that promote collaboration, build capacity across the care continuum, consider social determinates of health, and promote an integrated health care system consistent with the framework set forth in the Vermont All-Payer Model Agreement and the Global Commitment Demonstration. Specifically, the State would like to encourage ACO-based provider led reform that features (a) collaboration between providers, (b) reimbursement models that move away from Fee-For-Service payment, and (c)

rigorous quality measurement that aligns with the All-Payer Model quality framework.

All-Payer Model Alignment

The All-Payer Model agreement between the State and the Federal government was approved by the Green Mountain Care Board on October 26, 2016 and signed by the Governor and the Secretary of Human Services on October 27, 2016. The agreement includes a target for a sustainable rate of growth for health care spending in Vermont across Medicaid, Medicare, and commercial payers, and would build on past programs like Vermont's Medicaid and commercial Shared Savings Programs. When implemented, this model will focus on a set of health care services roughly equivalent to Medicare Parts A and B (hospital and physician services). The agreement includes quality and performance measurement and Next Generation's value-based payment models, such as capitation or global budgets. The State must provide a plan in 2019 for integrating any institutional long-term services and supports in the total cost of care in the next Demonstration period.

The All-Payer Model Agreement and Global Commitment Medicaid Demonstration are complementary frameworks that support Vermont's health care reform efforts. Each agreement provides federal support to further Vermont's strategic goal of creating an integrated health care system, including increased alignment across payers and providers.

C. Eligibility, Benefits and Cost Sharing

Eligibility under the Demonstration includes the following Medicaid and Demonstration groups:

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

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

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

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

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

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

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

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

All covered services may be subject to review and prior approval by DVHA and/or its partner departments in the Agency of Human Services, based on medical appropriateness. A complete listing of covered services and limitations are contained in the Vermont approved Title XIX State Plan, Vermont statutes, regulations, and policies and procedures. Premiums and cost-sharing for populations 1, 2, and 3, must follow Medicaid requirements that are set forth in statute, regulation and policy. Standard Medicaid exemptions from cost-sharing set forth in 42 CFR 447(b) applies to the Demonstration. The state must not apply co-payment requirements to excluded populations (children under age 21, pregnant women or individuals in long-term care facilities) or for excluded services/supplies (e.g., family planning). Vermont charges premiums for children through age 18 with income above 195 percent of the FPL through 312 percent of the FPL. Premium populations are outlined in Exhibit 1 below.

Exhibit 1: Vermont Premium Populations

Population	Premiums	Co-Payments	State Program Name
Children with income > 195% percent through 237% of the FPL	$15/month/family	N/A	Dr. Dynasaur
Underinsured Children with income > 237% through 312% FPL	$20/month/family	N/A	Dr. Dynasaur
Uninsured Children with income > 237% through 312% of the FPL	$60/month/family	N/A	Dr. Dynasaur
Medicare beneficiaries with income at or below 150 percent of the FPL, who may be enrolled in the Medicare Savings Program but are not otherwise categorically eligible for full benefits (Demonstration Population 7).	0-150% FPL: $15/month/person	Not to exceed the nominal co-payments specified in the Medicaid State plan.	VHAP Pharmacy; VPharm1
Medicare beneficiaries with income above 150 percent and up to and including 225 percent of the FPL, who may be enrolled in the Medicare Savings Program, but are not otherwise categorically eligible (Demonstration Population 8).	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.	VScript; VPharm2; VScript Expanded; VPharm3

D. Specialized Programs

Under the GC Demonstration, Vermont is authorized to provide an array of cost-effective in-home and community services. Providers of these services must meet designation, certification and/or additional licensing requirements to be approved by the State to serve the most vulnerable of Vermont's citizens. These specialized programs are designed to support a unique group of beneficiaries, each is outlined below.

- *Choices for Care*: long-term services and supports for persons with disabilities and older Vermonters. The Demonstration authorizes HCBS waiver-like and institutional services such as: nursing facility; enhanced residential care; personal care; homemaker services; companion care; case management; adult day services; and adult family care.

- *Developmental Disability Services*: provides long-term services and supports for persons with intellectual disabilities. The Demonstration authorizes HCBS waiver-like services, including service coordination, residential habilitation, day habilitation, supported employment, crisis services, clinical intervention, respite and self-directed care.

- *Traumatic Brain Injury Services*: provides recovery oriented and long-term services and supports for persons with a traumatic brain injury. The Demonstration authorizes HCBS

waiver-like services including crisis/support services, psychological and counseling supports, case management, community supports, habilitation, respite care, supported employment, environmental and assistive technology and self-directed care.

- *Enhanced Family Treatment*: provides intensive in-home and community treatment services for children who are experiencing a severe emotional disturbance and their families. The Demonstration authorizes HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, supported employment, crisis and community supports.

- *Community Rehabilitation and Treatment Program*: provides recovery oriented, in-home and community treatment services for adults who have a severe and persistent mental illness. The Demonstration authorizes HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, supported employment, crisis and community supports.

  Through a special provision as a Designated State Health Program, Community Rehabilitation and Treatment benefits can be extended to individuals with severe and persistent mental illness with incomes between 133 and 150 percent of the federal poverty level, under the Demonstration.

In addition, the Demonstration authorizes the:

- *Children's Palliative Care Program*: provides care coordination, respite care, expressive therapies, family training, and bereavement counseling, for children under the age of 21 years in populations 1, 2, and 3 who have been diagnosed with a life-limiting illness that is expected to be terminal before adulthood.

- *Adult Hospice Program*: allows for hospice services to be delivered concurrently with curative therapy to adults in populations 1, 2, and 3.

Lastly, as a Designated State Health Program, the Demonstration allows:

Marketplace Subsidies: The State offer subsidies for premiums for individuals with incomes at or below 300 percent of the federal poverty level who are purchasing health care coverage from a Qualified Health plan in Marketplace. The program is known as Vermont Premium Assistance (VPA) as part of the state-based health benefits exchange. Special Considerations for Mental Health and Substance Use Disorder Treatment

E. Special Considerations for Mental Health and Substance Use Disorder Treatment

Since its inception, Vermont's Demonstration has included payment flexibilities to support cost-effective alternatives to traditional Medicaid State Plan benefits. The State has used this authority to provide a continuum of treatment programs for persons who need inpatient psychiatric treatment, detoxification and/or residential treatment for substance use disorder. In several cases services are rendered by providers whose bed capacity is over 16 beds. Thus, these programs are considered Institutions for Mental Disease (IMD) facilities. CMS is continuing time-limited expenditure authority for services in several facilities that meet the definition of an IMD pursuant to an evaluation of their role and effectiveness in Vermont's Medicaid Demonstration.

CMS is asking the State to perform an evaluation of its IMD expenditure authority in the context of system-wide service, payment, and delivery system reforms and the State's extensive investments in cost effective community-based alternatives to institutional care. The evaluation will help inform broader policy discussions about Medicaid funding for IMD and community based services.

In addition to the study of IMD related services, the State is exploring opportunities and options for delivery system reforms that will promote a continuum of Substance Use Disorder Treatment Services and the State's alignment with CMS's Substance Use Disorder opportunities outlined in its July 2015 guidance, entitled "New Service Delivery Opportunities for Individuals with a Substance Use Disorder." The State will include measures in the Demonstration evaluation design that will serve as baseline metrics for monitoring the full continuum of Substance Use Disorder Treatment services in the future.

II. EVALUATION AND PROCUREMENT STRATEGY

The evaluation strategy for the Global Commitment Demonstration is designed to measure the degree to which its purposes, aims, goals, and objectives have been achieved. The evaluation is designed to not only address the long-term impact, but also to provide intermediate and short-term data on its performance through rapid cycle assessments.

In addition to assessing its overall impact, the evaluation examines the specific effects of the innovative changes made possible because of the Demonstration. Thus, the plan utilizes both performance measurement results (providing more real-time data focused on whether a program is achieving measurable objectives) and more rigorous program evaluation findings that analyzes findings against national benchmarks, changes over time and attempts to isolate key variables influencing outcomes.

To ensure that the new aspects of the Demonstration extension are implemented as intended and achieve the related goals/objectives and desired outcomes, this evaluation plan includes full alignment with the State's Comprehensive Quality Strategy, Rapid Cycle Assessment and Summative evaluation designs. It will employ qualitative and quantitative methods to collect and analyze data. This evaluation will not focus on outcomes exclusively, but is interested in capturing any evidence that the Demonstration supports: increased access to care; improved quality of care; cost containment; and stable in-home and community alternatives to institutional care.

A. Comprehensive Quality Strategy and Rapid Cycle Assessment

Vermont has a Comprehensive Quality Strategy (CQS) that integrates all aspects of quality improvement programs, processes, and requirements across the State's Medicaid program. The CQS is intended to serve as a blueprint or road map for Vermont and its Medicaid managed care-like operations in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. As approved by CMS, the CQS is the vehicle for demonstrating Vermont's compliance with the new HCBS regulations (comparable to 'transition plans' in other states). The CQS meets all requirements of 42 CFR 438 and includes LTSS and HCBS quality components. Key elements addressed in the CQS include: goals; responsibilities; performance improvement projects; performance measures; populations; timelines; monitoring and evaluation; and performance improvement accountability.

The Demonstration's evaluation will align with the goals, measures and monitoring activities outlined in the AHS CQS. AHS will regularly monitor the Demonstration on the key outcome measures and performance targets and make changes as appropriate (obtaining CMS or legislative approval where needed). The CQS is reviewed and updated as needed, but no less than once every three years.

The State must also routinely evaluate policy changes and new initiatives to rapidly assess effectiveness, promote continuous improvement and to identify success and barriers without

delay. The State will retain responsibility for conducting rapid cycle assessments for any new payment and service delivery and/or payment reform implemented or supported by the Demonstration (e.g., Next Generation Medicaid ACO) as well as any new Delivery System Reform Investments. Results from the rapid cycle assessments will directly influence decision-making by giving AHS insights into any potential shortcomings, oversights and successes. Documenting the development of new initiatives and their operational impact provides an understanding of the reasons for successful or unsuccessful performance, provides direction in shaping program modifications and improvement, and provides information about whether evaluation findings can be generalized.

This rapid analysis will be based on grantee reporting, key informant information from the AHS, as well as community leaders, administrators, physician leaders, and others directly responsible for, or knowledgeable about, the new initiative or investment. As appropriate, fiscal analysis will be conducted to analyze expenditure information. Reports will be used to provide program staff with specific details for the month, quarter, or year, and/or provide direction in shaping modifications that may be required to support more effective investments.

This type of rapid cycle approach blurs some of the classic differentiation between formative and summative evaluation approaches. The selection of similar evaluation methods for different purposes will allow the State and providers to focus on adjusting the process aspects of an innovation – while at the same time improving the impact of the innovation overall. It is important to note that the rigor of the evaluation should not be sacrificed for the sake of speed. To do so, advanced statistical methods to measure effectiveness should be used, including the appropriate selection of comparison groups whenever possible.

In practice, this commitment to alignment of performance oversight will create a feedback loop across evaluation activities, rapid cycle assessment reports and summative evaluation findings. This process of regularly measuring, monitoring, and making changes should result in continuous performance improvement in terms of achieving its performance targets and intended outcomes.

*B. **Summative Evaluation***

In addition to the activities described above, summative evaluation techniques will be used to measure how the Demonstration has changed or improved the health and well-being of the GC population. The summative evaluation will address each of the hypotheses identified in Section III A.

Additionally, DVHA and its IGA partners are required to submit annual performance measurement data to AHS. These metrics will be used to help define and measure progress towards the Demonstration's ability to increase access to care; improve quality of care (including outcomes and consumer satisfaction); contain the cost of care and support stable in-home and community alternatives to institutional care for enrollees.

The required performance measures include HEDIS® (see Section III D). DVHA will also be required to report enrollee experience based on the Consumer Assessment of Healthcare

Providers and Systems (CAHPS) or CAHPS-like model, with the potential for findings to be supplemented by targeted surveys for special needs populations. Specifically, the State is exploring the use of CAHPS-Home and Community Based Services (HCBS) module for participants in several of its specialized programs. Items under consideration for use are outlined in Exhibit 2 on the following page.

Exhibit 2: Potential CAHPS-HCBS Performance Measures

Potential CAHPS-HCBS Measures	
Performance Area	**Metric**
Quality of Care	Percent of enrollees who rate the help they get from staff as very good or excellent
Health	Percent of enrollees who rate their overall health as good, very good or excellent
Courtesy and Respect	Percent of enrollees who report that in the last 3 months, staff usually or always treat them with courtesy and respect
Case Manager	Percent of enrollees who rate the help they get from their case manager as very good or excellent
Choice and Control	Percentage of people who report that in the last 3 months, their service plan included most or all of things that were important to them
Employment	Percent of enrollees who report that in the last 3 months, they usually or always could do things in the community that they liked, when they wanted

In addition, inpatient and outpatient utilization, cost, and quality indicators for GC enrollees before and after their enrollment in specialized programs and Demonstration initiatives will be analyzed and compared to benchmarks and/or targets to assess the attainment of these goals. This analysis will determine whether statistically significant differences exist year to year in access to care; improved quality of care; cost containment; and stable in-home and community alternatives to institutional care. Annual data will be tracked and trended over time (when available).

Summative evaluation techniques will also be applied to study the impact and effectiveness of IMD services in the Vermont system of care for persons who are experiencing a psychiatric emergency and/or who have substance use disorder treatment needs.

C. Procurement Strategy and Evaluator Qualifications

Procurement for an evaluation contractor to assist the State in executing its Demonstration evaluation plan was pursuant to the State of Vermont Agency of Administration Bulletin 3.5 processes found here. The State retains responsibility for rapid cycle assessment reports, monitoring delivery system and other investments and overall Demonstration performance monitoring. Global Commitment to Health HEDIS® measures are independently validated by the State's External Quality Review Organization (EQRO). To mitigate any potential conflict of interest, the evaluation contractor is responsible for secondary analysis of the State's findings,

benchmarking performance to national standards, evaluating changes over time, isolating key variables and interpreting results. As part of the focused IMD evaluation, the evaluator is responsible for final measure selection, identifying, if viable other State systems that may serve as comparisons, conducting all data analysis, measuring change overtime and developing sensitivity models as necessary to address study questions.

The State anticipates issued one procurement for all summative evaluation activities and the production of required CMS reports. Bidders were given the option of working with a subcontractor on the IMD and/or other components of the design. The successful bidder demonstrated, at a minimum, the following qualifications:

- The extent to which the evaluator can meet State RFP minimum requirements;
- The extent to which the evaluator has sufficient capacity to conduct the proposed evaluation, in terms of technical experience and the size/scale of the evaluation;
- The evaluator's prior experience with similar evaluations;
- Past references; and
- Value, e.g., the assessment of an evaluator's capacity to conduct the proposed evaluation with their cost proposal, with consideration given to those that offer higher quality at a lower cost.

*D. **Evaluation Budget and Timeline***

The State's evaluation budget and timelines are tentative pending data sharing schedules established with the evaluation contractor. The budget may be modified if terms of the current Demonstration agreement are amended during the project period. AHS will report on progress and any known challenges to the evaluation budget, timelines and implementation in its quarterly and annual Demonstration reports to CMS. Appendix 1 provides an overview of the AHS proposed evaluation budget. Outlined below and on the following pages are the expected timelines and major evaluation related milestones.

Demo Year 12: (1/1/2017-12/31/2017)

	Extension Year 1 (2017)											
	Month											
Activity/ Milestone	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Draft Evaluation Design	X	X										X
CMS Review			X									
Incorporate CMS Revisions				X								
Final Evaluation Design				X								
Publish Evaluation Design				X								

Procure Independent Evaluator				X	X	X	X	X				
Finalize Research Methods									X			
Finalize Performance Measures									X			
Collect, Analyze, Interrupt Data									X	X	X	X
Disseminate AHS Rapid Cycle Assessment Findings for Feedback				X			X			X		

Demo Year 13: (1/1/2018-12/31/2018)

	Extension Year 2 (2018)											
	Month											
Activity/Milestone	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Collect, Analyze, Interpret Data	X	X	X	X	X	X	X	X	X	X	X	X
Create Draft Interim Evaluation Report #1	X	X										
Disseminate Preliminary Findings for Feedback		X										
Submit Draft Interim Evaluation Report #1 to CMS (IMD focus)				X								
Submit Final Interim Evaluation Report #1 to CMS						X						
Disseminate AHS Rapid Cycle Assessment Findings for Feedback				X			X			X		

Demo Year 14: (1/1/2019-12/31/2019)

	Extension Year 3 (2019)											
	Month											
Activity/Milestone	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Revise design as needed	X											
Collect, Analyze, Interpret Data	X	X	X	X	X	X	X	X	X	X	X	X
Disseminate AHS Rapid Cycle Assessment Findings for Feedback				X			X			X		

Demo Year 15: (1/1/2020 – 12/31/2020)

	Extension- Year 4 (2020)											
	Month											
Activity/Milestone	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Collect, Analyze, Interpret Data	X	X	X	X	X	X	X	X	X	X	X	X
Create Draft Interim Evaluation Report #2								X				
Disseminate Interim Evaluation Report #2 Findings for Feedback								X	X			
Finalize Draft Interim Evaluation Report #2										X	X	
Submit Interim Evaluation Report #2 to CMS												X
Disseminate AHS Rapid Cycle Assessment Findings for Feedback				X			X			X		

Demo Year 16: (1/1/2021-12/31/2021)

	Extension Year 5 (2021)											
	Month											
Activity/Milestone	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Create Draft Summative Evaluation Report #1	X	X	X									
Submit Draft Summative Evaluation Report #1 to CMS				X								
Incorporate CMS Comments					X							
Submit Final IMD Summative Evaluation Report #1						X						
Publish Final Summative Evaluation Report #1							X					
Disseminate AHS Rapid Cycle Assessment Findings for Feedback				X			X			X		

Post Demo: (1/1/2022-9/30/2022)

	Post Extension (2022)											
	Month											
Activity/Milestone	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Create Draft Summative Evaluation Report #2	X	X			X							
Disseminate Draft Summative Evaluation Report #2 Findings for Feedback			X	X								
Submit Draft Summative Evaluation Report #2 to CMS						X						
Incorporate CMS Comment								X				

Submit Final Summative Evaluation Report #2 to CMS								X				
Publish Final Summative Evaluation Report #2									X			

III. EVALUATION DESIGN AND METHODS

In updating its existing Medicaid Demonstration evaluation strategy as reflected in this document, the State has refined overarching Demonstration hypotheses and identified study populations and levels of stratification for specialized programs and projects. The design identifies additional data sources related to IMD study, reviews general methods, data analytics and defines on-going reporting requirements for the term of the Demonstration. However, final techniques, technical specifications and study groups will be determined following engagement of the independent evaluator.

A. Hypothesis

The State has identified the following overarching hypotheses for the Demonstration.

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

B. Study Populations

The evaluation will study the impact of the Demonstration on all enrollees e.g., total Medicaid population (enrollees participating in specialized programs (e.g., ID/DD, CFC, CRT, TBI, ACO Attributed), enrollees participating in non-specialized programs) as well as provide stratification for various hypothesis and key measures by specialized program participants. In addition, focused analysis will address:

- The impact of marketplace subsidies for Qualified Health Plans on continuity of coverage; if feasible based on sample size, staff and budget considerations, the State will stratify impact by income level;
- Access to care for children in families who are required to make premium payments; if feasible based on sample size, staff and budget considerations the State will stratify impact by income level;
- Access, cost and quality for substance use disorder and psychiatric IMD services (See Section IV for more detailed description).

An overview of each hypothesis, the research questions and the expected study populations is provided in Exhibit 3 on the following page.

Exhibit 3: Hypotheses and Study Populations

Summary of Study Populations by Hypotheses		
Research Question	**Hypothesis**	**Study Populations & Levels of Stratification**
Will the Demonstration result in improved access to care?	• The demonstration will result in improved access to community based medical, mental health, substance use disorder and dental care. • The demonstration will reduce the rate of potentially avoidable ED visits and unplanned hospital admissions. • Premium requirements for eligible families above 195% FPL will not impede access to enrollment. • The VPA Qualified Health Plan subsidy program will result in improved access to health care.	• Total Medicaid • Specialized Program Enrollees (CFC, CRT, DDS, SUD, TBI) • Children's Premium Population • VT Premium Assistance (VPA-marketplace subsidies) population • IMD Service Recipients
Will the Demonstration result in improved quality of care?	• The demonstration will improve: o asthma care; o preventative health screenings for female enrollees; o mental health follow-up after psychiatric hospitalization; and o Initiation and engagement in SUD treatment. • The demonstration will improve enrollee experience of care and satisfaction with the health plan.	• Total Medicaid • Specialized Program Enrollees (CFC, CRT, DDS, SUD, TBI) • Blueprint Advanced Primary Care Practice Enrollees • IMD Service Recipients
Will value-based payment models increase access to care?	• The Medicaid ACO will show a lower overall cost of care. • The Medicaid ACO will improve access to mental health care and substance use disorder treatment. • ACO enrollees will receive: o timely prenatal care; and o developmental screenings in the first 3 years of life • ACO enrollees will show improved diabetes and hypertension outcomes.	• ACO Attributed Enrollees

Exhibit 3: Hypotheses and Study Populations

Summary of Study Populations by Hypotheses		
Research Question	**Hypothesis**	**Study Populations & Levels of Stratification**
Will improved access to preventive care result in lower overall costs for the healthcare delivery system?	• The Blueprint for Health initiative will reduce per capita expenditures for enrollees whose diabetes is in control. • The Blueprint for Health initiative will contain or reduce total per capita expenditures for enrollees ages 1-64 years.	• Total Medicaid • Specialized Program Enrollees (CFC, CRT, DDS, SUD, TBI) • Blueprint Advanced Primary Care Practice Enrollees
Will improved access to primary care result in improved health outcomes?	• The Blueprint for Health will improve diabetes control for members age 18-75.	• Blueprint Advanced Primary Care Practice Enrollees
Will enhanced care coordination increase timely access to needed care?	• Blueprint for Health enrollees will report timely access and satisfaction with their experience of care,	• Blueprint Advanced Primary Care Practice Enrollees
Will the Demonstration increase community integration?	• The demonstration will increase community living and integration for persons needing LTSS. • The demonstration will increase choice and autonomy for persons needing LTSS. • The demonstration will increase integrated employment options for persons needing LTSS.	• Specialized Program Enrollees (CFC, CRT, DDS, SUD, TBI) • IMD Service Recipients
Will Demonstration maintain or reduce spending in comparison to what would have been spent absent the Demonstration?	• The demonstration will contain or reduce spending.	• Total Medicaid

C. Data Collection and Assurances

Vermont's public managed care-like model is managed by AHS through delegation to DVHA. Encounter, claims and cost data is available through the MMIS and will be made available to evaluators as needed for purpose of evaluation. Existing agreements with departments require that all IGA partners under the Demonstration make data available to support evaluations and performance monitoring efforts. AHS does not anticipate problems with data collection and reporting.

AHS will use a variety of sources and methods to test the above hypotheses, including beneficiary surveys and provider claims data. AHS staff and independent evaluators will also analyze data from third-party sources, such as the U.S. Census Bureau and, if available through the All-Payer Model, Medicare claims data. Vermont data sources used to evaluate performance against Demonstration goals will include:

- Medicaid Management Information System (MMIS) encounter and utilization data from claims
- State Medicaid information system files that include eligibility and enrollment data
- VT Health Connect Premium Assistance (VPA) data files
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- DAIL Social Assistance Management System (SAMS)
- ADAP Substance Abuse Treatment Information System (SATIS)
- DMH Monthly Service Reports (MSR)
- VT Health Care Quality Reports prepared by the state's External Quality Review Organization
- Quarterly Ombudsman Reports
- VT Department of Financial Regulation Household Health Insurance Surveys
- VT Department of Labor Employment (DOL)
- VT Department of Health, Healthy Vermonters 2020 Population Health Outcomes
- VT Department of Health, Substance Abuse Treatment Information System (SATIS)
- Vermont Health Care Uniform Reporting and Evaluation System (VHCURES)

To limit administrative burden on providers, consumers and staff and to eliminate duplicate evaluation efforts, this evaluation will coordinate and compile measures from existing evaluation and performance monitoring efforts aimed at studying the impact of various health care initiatives under the Demonstration. A preliminary inventory of existing and planned evaluation and performance monitoring projects are provided in Exhibit 4 below.

Exhibit 4: Existing and Planned Evaluation and Monitoring Projects

Existing or Planned VT Evaluation Projects
All-Payer Model
Vermont Health Care Innovation Project
Medicaid Health Home - Medication Assisted Opioid Treatment
AHS Performance Monitoring Projects
Global Commitment to Health Comprehensive Quality Measures, including HEDIS®

AHS Results Based Accountability Scorecards
Healthy Vermonters 2020
National Core Indicators Project, Developmental Disability, Aging and Other Disability Programs
Medicaid ACO Quality Measures
Blueprint for Health Multi-Payer Delivery Reform Initiative

D. Performance Measures, Data Source, Frequency and Sampling Methods

This Evaluation Plan incorporates the use of performance measures based on the following criteria: 1) evidenced based; 2) potential for improvement; 3) prevalence or incidence; 4) substantial impact on health status and/or health outcomes; 5) Alignment with national measures; and 6) to the extent possible, adaptable measures across various practice settings. The Demonstration uses HEDIS® and AHS Results Based Accountability Scorecards for most of the targeted performance measures. Additionally, the evaluation will align measures and priorities with those collected as part of the All-Payer Model Medicare Demonstration Agreement Appendix 1 Found Here on page 36, which includes alignment with the development of the Global Commitment to Health Medicaid ACO.

Using these measures, AHS will determine whether efforts to improve access (e.g., primary care visits, ED visits, and providers accepting Medicaid), enhance quality (e.g., follow-up after hospitalization, medication management for those with asthma, and patient experience of care), contain costs (e.g., budget neutrality, inpatient, and ED) and improve community integration were achieved. Performance measures specific to specialized programs and in-home and community services will also be included, such as ability of participants to live longer in their communities and experience an improved quality of life, choice and control.

The performance measures give trend information, which provides guidance in designing focused interventions for quality improvement. Reported HEDIS rates also can be benchmarked to NCQA Medicaid HEDIS means and percentiles, and compared to results from other states. Current performance targets and national benchmarks are identified in the States Comprehensive Quality Strategy Found Here.

One other important source of information to initiate and guide improvement efforts is the beneficiary. The most widely used instrument for collecting reports and ratings of health care services from the beneficiary's perspective is the CAHPS. CAHPS survey data allows entities to: 1) analyze performance compared to benchmarks; 2) identify changes or trends in performance; and/or 3) consider other indicators of performance. Vermont will combine CAHPS data with information collected through periodic surveys of targeted groups of Demonstration enrollees.

Demonstration objectives and performance measures for each hypothesis are presented in Exhibits 5 through 10 starting on page 22. All Exhibits also address data collection methods for each measure, alignment with other State or National measures, sampling methodology, source of data, and frequency of measurement.

Three hypotheses (listed below) will be measured through evaluation efforts associated with the

Blueprint for Health Multi-Payer Advance Primary Care Practice initiative:

- Improved access to primary care will result in positive health outcomes;
- Enhanced care coordination will promote timely access to needed care; and
- Improved access to primary care will result in overall lower cost for the healthcare delivery system.

The Blueprint for Health is a state-led, multi-payer program dedicated to achieving well-coordinated and seamless health services, with an emphasis on prevention and wellness. As such, the Blueprint employs several different approaches to incentivizing delivery system reform and increased quality and performance through payment reform. The foundation of the Blueprint model is a Multi-Payer Advanced Primary Care Practice (MAPCP) program. Participation is optional for providers, but mandatory for Vermont's commercial payers (with the exception of self-insured plans) and Medicaid.

Current participating payers in the Blueprint for Health include Medicaid, Medicare, Blue Cross Blue Shield of Vermont, MPV and CIGNA. As such, some measures reflect population health outcomes across payers and are not specifically stratified for Medicaid enrollees. As feasible within available resources, Blueprint performance and evaluation findings may include sub-analysis relative to Medicaid only participants.

Acronyms used in Exhibits 5 through 10 are outlined below:

ACO: Accountable Care Organization
CC: Chronic Condition
CFC: Choices for Care
CRT: Community Rehabilitation and Treatment
DDS: Developmental Disabilities Services
ED: Emergency Department
EPSDT: Early Periodic Screening Diagnosis & Treatment
HCBS: Home & Community Based Services
LTSS: Long Term Services and Supports
MAT: Medication Assisted Treatment
MMIS: Medicaid Management Information System
NCI-AD: National Core Indicators Aging & Disabilities
NCI-DD: National Core Indicators Developmental Disabilities
QHP: Qualified Health Plan
SUD: Substance Use Disorder
TBI: Traumatic Brain Injury
VCCI: VT Chronic Care Initiative
VPA: Vermont Premium Assistance

Exhibit 5: Access to Care Measures

Research Question: Will the Demonstration Result in Improved Access to Care?					
Performance Measure	**Metric**	**Sampling Methodology**	**Source of Data**	**Frequency of Measurement[2]**	**Alignment**
Ambulatory Care	Percent of adult enrollees who had an ambulatory or preventive care visit	Total Medicaid; Stratification for SUD, DDS, CFC, TBI & CRT	MMIS	Annual	N/A
Well-Child Visits	Percent of children under age 12 who received well-child care from a PCP in accordance with EPSDT periodicity schedule	Total Medicaid	MMIS	Annual	CMS Child Core Set
Adolescent Well- Care Visits	Percent of adolescents ages 12 to 21 who receive one or more well-care visits with a PCP during the measurement year	Total Medicaid; Stratification for ACO Attributed Members	MMIS	Annual	CMS Child Core Set All-Payer Model
Access to Dental Care	Percent of Medicaid enrollees with at least one dental visit	Total Medicaid	MMIS	Annual	N/A
Emergency Department Visits	Rate of ED visits per 1,000-member months	Total Medicaid; Stratification for SUD, DDS, CFC, TBI & CRT	MMIS	Annual	N/A
	Rate of Potentially Avoidable ED Utilization	Total Medicaid; Stratification for SUD, DDS, CFC, TBI & CRT	MMIS	Annual	N/A
Inpatient Admissions	Rate of inpatient admissions per 1,000-member months	Total Medicaid	MMIS	Annual	N/A
	All cause unplanned admissions for patients with multiple chronic conditions	Medicaid ACO Attributed Members	MMIS	Annual	All-Payer Model
Effect of Children's Premiums	Percent of families that activate enrollment by paying the first month's premium	Total Premium	Eligibility Records	Annual	N/A

[2] NCI-AD Surveys are expected to start in State Fiscal Year 2018 and be conducted annually thereafter.

Exhibit 5: Access to Care Measures

Research Question: Will the Demonstration Result in Improved Access to Care?					
Performance Measure	**Metric**	**Sampling Methodology**	**Source of Data**	**Frequency of Measurement[2]**	**Alignment**
Impact of VPA Program	Percent of enrollees receiving VPA subsidy who maintain QHPs with no breaks in coverage	Total VPA	VPA Data	Annual	N/A
Getting Needed Care	Percent of survey respondents indicating they received necessary care	Random Medicaid	CAHPS (Adult, Child, Child w/CC)	Annual	CMS Adult & Child Core Measure Set
Physician Participation in Medicaid	Percent of active physicians participating in Medicaid – primary care and specialists	Total Vermont	Vermont Medical Association and MMIS	Annual	N/A
Health Coverage	Percent of uninsured Vermonters	Total Vermont	Vermont Household Insurance Survey	Every 3 years (2018, 2021)	N/A
Mental Health Utilization	Percent of enrollees receiving mental health services	Total Medicaid	MMIS	Annual	N/A
Substance Use Disorder Treatment Utilization	Percent of enrollees receiving substance use disorder treatment services	Total Medicaid; Stratification for CFC, CRT, DDS	MMIS	Annual	N/A
Medication Assisted Treatment (MAT) for Opioid Addiction	Number of people receiving MAT per 10,000 Vermonters age 18-64	Total Vermont	VDH	Quarterly	All-Payer Model
Drug Over Dose Deaths	Deaths related to drug overdose	Total Vermont	VDH	Annual	All-Payer Model

Exhibit 6: Quality of Care Measures

Research Question: **Will the Demonstration Result in Improved Quality of Care?**					
Performance Measure	**Metric**	**Sampling Methodology**	**Source of Data**	**Frequency of Measurement**[3]	**Alignment**
Medication Management for People with Asthma	Percent of enrollees receiving appropriate asthma medication management	Total Medicaid	MMIS	Annual	All-Payer Model
Breast Cancer Screening	Percent of female enrollees age 50 to 74 who receive screening at appropriate intervals	Total Medicaid	MMIS	Annual	CMS Adult Core Set
Chlamydia Screening	Percent of female enrollees screened	Total Medicaid	MMIS	Annual	CMS Adult Core Set
Follow-up after Hospitalization for Mental Illness	Percent of enrollees discharged who had follow-up at 7 & 30 days	Total Medicaid; ACO Attributed Members	MMIS; MSR	Annual	CMS Adult & Child Core Measure Set
Substance Use Disorder Treatment	Percent of enrollees using substances who initiate and engage in treatment	Total Medicaid; ACO Attributed Members	MMIS	Annual	CMS Adult Core Set; All-Payer Model
Health Wellness	The proportion of people who describe their overall health as poor	Random CFC & TBI	NCI-AD	Annual	NCI
Health Wellness	The proportion of people described as having poor health	Random DDS	NCI-DD	Annual	NCI
Health Plan	Enrollee rating of satisfaction with health plan	Random Medicaid	CAHPS (Adult, Child, Child w/CC)	Annual	CMS Adult & Child Core Measure Set
Quick Care	Enrollee rating of ability to get care quickly	Random Medicaid	CAHPS (Adult, Child, Child w/CC)	Annual	CMS Adult & Child Core Measure Set
Overall Rating of Care	Enrollee rating of care received	Random Medicaid	CAHPS (Adult,	Annual	CMS Adult &

[3] CAHPS-HCBS Module and NCI-AD Surveys are expected to start in State Fiscal Year 2018 and be conducted annually thereafter.

Exhibit 6: Quality of Care Measures

Research Question**: Will the Demonstration Result in Improved Quality of Care?**					
Performance Measure	**Metric**	**Sampling Methodology**	**Source of Data**	**Frequency of Measurement**[3]	**Alignment**
			Child, Child w/CC)		Child Core Measure Set
Customer Service	Enrollee rating of customer service	Random Medicaid	CAHPS (Adult, Child, Child w/CC)	Annual	CMS Adult & Child Core Measure Set
Communication	Enrollee rating of how well their physician explains things, listens to their concerns, shows respect and spends enough time with them	Random Medicaid	CAHPS (Adult, Child, Child w/CC)	Annual	CMS Adult & Child Core Measure Set
Chronic Care Management	Percent of enrollees with targeted chronic conditions enrolled in chronic care management program	Total VCCI	VCCI Ad hoc reports	Annual	N/A
Getting Needed LTSS	Proportion of participants needing assistance who always get enough assistance with everyday activities when needed	Random CFC & TBI	NCI- AD	Annual	NCI
Getting Needed LTSS	The rate at which people report that they do not get the services they need	Random DDS	NCI- AD	Annual	NCI

Exhibit 7: Value Based Payment Measures

Research Question: Will Value Based Payment Models Improve Access to Care					
Performance Measure	**Metric**	**Sampling Methodology**	**Source of Data**	**Frequency of Measurement**	**Alignment**
ACO Attributed Members	Percent of Medicaid enrollees aligned with ACO	Total Medicaid	Enrollment Files (PCP selection) and MMIS	Annual	All-Payer Model
ACO Cost Per Enrollee	Cost of Care for Medicaid enrollees aligned with ACO	ACO Attributed Members	MMIS	Annual	N/A
ACO Access to Mental Health Treatment*	30-day follow-up after discharge from ED for mental health	ACO Attributed Members	MMIS	Annual	All-Payer Model
ACO Access to Substance Use Disorder Treatment	7 and 30-day follow-up after discharge from ED for alcohol or other drug dependence mental health	Total Medicaid; ACO Attributed Members	MMIS	Annual	All-Payer Model
ACO Depression Screening and Follow-up	Screening for clinical depression and follow-up plan	ACO Attributed Members	MMIS; ACO Medical Records	Annual	All-Payer Model
Prenatal Care	Timeliness of Prenatal Care	ACO Attributed Members	MMIS	Annual	N/A
Prevention	Developmental Screening in the first 3 years of life	ACO Attributed Members	MMIS; ACO Medical Records	Annual	N/A
Health Outcomes	Diabetes Mellitus: Hemoglobin A1c poor control (>9%)	ACO Attributed Members	MMIS	Annual	All-Payer Model
Health Outcomes	Hypertension: Controlling High Blood Pressure	ACO Attributed Members	MMIS	Annual	All-Payer Model

* Vermont will be collecting data for NQF 2605 as part of the Vermont Medicaid Next Generation (VMNG) ACO program

Exhibit 8: Primary Care and Enhanced Care Coordination

Research Questions: Will Improved Access to Primary Care Result in improved health outcomes?; Will Enhanced Care Coordination improve Timely Access to Needed Care?; and Will Improved access to primary care result in lower cost for the healthcare delivery system					
Performance Measure	**Metric**	**Sampling Methodology**	**Source of Data**	**Frequency of Measurement**	**Alignment**
Cost	Total expenditures per capita, excluding specialized program services, for enrollees ages 1-64 years	Blueprint Medicaid Enrollees	MMIS	Annual	N/A
Cost	Specialized Medicaid expenditures per capita, for enrollees ages 1-64 years	Blueprint Medicaid Enrollees	MMIS	Annual	N/A
Access to Care	Enrollee rating of ability to get desired appointment or information	Random Blueprint[4]	CAHPS - PCMH	Annual	Nat'l CAHPS-PCMH
Communication	Enrollee rating of how well their physician explains thigs, listens to their concerns, shows respect and spends enough time with them	Random Blueprint[5]	CAHPS - PCMH	Annual	Nat'l CAHPS-PCMH
Health Outcomes & Cost	Number of continuously enrolled members, ages 18-75 whose Diabetes HbA1c was in control compared to those with poor control	Blueprint[6]	VCHURES; Medical Records	Annual	All-Payer Model
	Expenditures per capita for continuously enrolled members, ages 18-75 whose Diabetes HbA1c was in control compared to those with poor control	Blueprint[7]	VCHURES; Medical Records	Annual	N/A

[4] If feasible based on staff and budget constraints the State will conduct a sub-analysis of Blueprint Medicaid Enrollees

[5] ibid

[6] ibid

[7] ibid

Exhibit 8: Primary Care and Enhanced Care Coordination

Research Questions: Will Improved Access to Primary Care Result in improved health outcomes?; Will Enhanced Care Coordination improve Timely Access to Needed Care?; and Will Improved access to primary care result in lower cost for the healthcare delivery system					
Performance Measure	**Metric**	**Sampling Methodology**	**Source of Data**	**Frequency of Measurement**	**Alignment**
	Inpatient hospitalizations per 1,000 members for continuously enrolled members, ages 18-75 whose Diabetes HbA1c was in control compared to those with poor control	Blueprint[8]	VCHURES; Medical Records	Annual	N/A

[8] Ibid

Exhibit 9: Enhanced Community Integration

Research Question: Will the Demonstration Result in Increased Community Integration?					
Performance Measure	**Metric**	**Sampling Methodology**	**Source of Data**	**Frequency of Measurement[9]**	**Alignment**
Eliminating Institutional Bias	Average number of people served per month by setting: nursing facility, home, licensed residential facility	Total CFC population	MMIS	Annual	LTSS Re-balancing
Community Access	Proportion of people who do things they enjoy outside of their home when and with whom they want to	Random CFC & TBI population	NCI-AD	Annual	NCI
Community Access	The proportion of people who regularly participate in everyday integrated activities in their communities	Random DDS population	NCI-DD	Annual	NCI
Choice and Control	Proportion of people who can choose or change what kind of services they get and determine how often and when they get them	Random CFC & TBI	NCI-AD	Annual	NCI
Choice and Control	The proportion of people who make choices about their everyday lives, including: housing, roommates, daily routines, jobs, support staff or providers, what to spend money on, and social activities	Random DDS	NCI-DD	Annual	NCI
Employment	Proportion of people who have a paying job in the community, either full-time or part-time	Random CFC & TBI	NCI-AD	Annual	NCI
Employment	Proportion of people who would like a job (if not currently employed)	Random CFC & TBI	NCI-AD	Annual	NCI
Employment	The proportion of people who have a job in the community	Random DDS	NCI-DD	Annual	NCI

[9] CAHPS-HCBS Module is expected to start in State Fiscal Year 2018 and be conducted annually thereafter.

Exhibit 9: Enhanced Community Integration

Research Question: Will the Demonstration Result in Increased Community Integration?					
Performance Measure	**Metric**	**Sampling Methodology**	**Source of Data**	**Frequency of Measurement[9]**	**Alignment**
Employment	The proportion of people who do not have a job in the community but would like to have one	Random DDS	NCI-DD	Annual	NCI
Employment	Employment rate of people of working age	DDS, TBI, CRT	Vermont Department of Labor; VT Division of Vocational Rehabilitation	Annual	N/A

Exhibit 10: Cost and Budget Neutrality

Research Question: Will Demonstration Maintain or Reduce Spending in Comparison to What Would Have Been Spent Absent the Demonstration?					
Performance Measure	**Metric**	**Sampling Methodology**	**Source of Data**	**Frequency of Measurement**	**Alignment**
Emergency Department Cost	Average annual per enrollee cost of ED visits	Total Medicaid	MMIS	Annual	N/A
Inpatient Hospital Cost	Average annual per enrollee cost of inpatient hospital	Total Medicaid	MMIS	Annual	N/A
Pharmacy Cost	Average annual per enrollee cost of prescription drugs	Total Medicaid	MMIS	Annual	N/A
Total Cost per Enrollee	Average annual total cost per enrollee	Total Medicaid	MMIS	Annual	N/A
Total Cost per Major Aid Category	Average annual total cost per major aid category group	Total Medicaid	MMIS	Annual	N/A
Chronic Care Management Costs	Average annual per enrollee costs for chronic care management program participants	Total Medicaid	MMIS	Annual	N/A
Budget Neutrality	Actual aggregate expenditures versus budget neutrality limit	Total Medicaid	MMIS	Annual	STC

E. METHODS

Both qualitative and quantitative methods will be used to address the research questions. Qualitative designs will be used to better understand the process of Demonstration implementation, and will include the use of purposeful sampling, interviews, and inductive analysis to discover patterns, themes, and interrelationships. Qualitative methods will be employed for new delivery system reforms supported with Demonstration investment funds as a part of a formative study where applicable.

Quantitative methods will be used to better understand the impact of Demonstration implementation (i.e., the relationship that Demonstration participation has on: access to care; quality of care; cost containment; and stable in-home and community alternatives to institutional care) and will include the use of probability sampling, descriptive/inferential statistics, and deductive analysis to generate relationships between variables that can be generalized to the broader Medicaid population. Methodological considerations are provided below.

ISOLATION FROM OTHER INITIATIVES

In general, external factors are not expected to significantly affect the assessment of hypotheses presented in this evaluation plan. Over the past several years the State sought to align its health care reforms across all populations and payers. The final Medicaid Demonstration extension and Medicare All-Payer Model were designed to create a seamless system. However, where market conditions and other contextual factors (e.g., provider or geographical differences) could have an impact, AHS and its evaluators will develop approaches to quantify and/or isolate the impact of such factors. The Demonstration supports a comprehensive approach across settings. Based on staff, budget and data considerations, the State will explore the feasibility of comparing outcomes for members who may be attributed to a specific initiative with those who are not involved in the initiative.

GENERALIZABILITY OF RESULTS

Vermont's small size, statewide model and AHS single state agency 'umbrella' structure supports rapid adoption of programs. This provides an ideal environment for testing innovations that can be brought to scale in other states on a county or state-wide level. In several instances, Vermont's health care and long-term service and support programs have become models for other states (e.g., Blueprint for Health, Choices for Care, Self/Surrogate-directed care). It is expected that specific aspects of the Demonstration and its evaluation design will continue to support generalizability.

DATA LIMITATIONS & MITIGATION

Many participants in Vermont's specialized programs are dually eligible for Medicare and Medicaid. The absence of Medicare claims data presents challenges for certain metrics such as total cost of care, rates of preventive screens, follow-up after hospitalization. If feasible, the AHS will seek access to Medicare data as part of its involvement in the All-Payer Model Medicare Demonstration.

Vermont has been engaged in health care and payment reform since the inception of the Demonstration in 2005. In many cases, specialized programs no longer employ fee-for-service claiming and encounter data may be stored in multiple legacy systems across AHS. In cases where programs have moved away from fee-for-service payment models, modified HEDIS® protocols will be used to assure data is complete and accurately adjusted when stratified for specialized populations.

Two data sets available for benchmarking performance are the VDH Hospital Discharge data and VHCURES. These data warehouses provide valuable information on claims over time, however information is de-identified. The Blueprint for Health and the Department of Mental Health have employed various techniques to match data and examine population trends overtime and by payer. The DMH technique involves the use of probabilistic estimation. Probabilistic Population Estimation (PPE) is a statistical technique used by DMH that measures the number of people represented in data sets that do not share unique person identifiers. PPE reports how many people are represented in and across data sets without the need for identifiable protected health information.[10] These estimates are based on a comparison of the observed distribution of dates of birth in HIPAA-compliant "limited data sets" with the expected distribution of dates of birth. The validity and reliability of this procedure have been demonstrated by Banks and Pandiani (2001).[11] This approach is unobtrusive and it protects the personal privacy of individuals and the confidentiality of medical records because it does not depend on personally identifying information[12].

Through its analytics vendor Onpoint Health Data Blueprint to Health links clinical data to de-identified VHCURES claims data. Onpoint de-identifies the clinical data using the same algorithms to hash the identifiers as was used by insurers for the VHCURES data, using this method the vendor is able to link records between the two de-identified datasets using the hashed, or encrypted, identifiers.

F. DATA ANALYSIS

The evaluation data analysis will consist of both exploratory and descriptive strategies and incorporate univariate, bi-variate, and multi-variate techniques. SAS software will be used to systematically apply statistical and/or logical techniques to describe, summarize, and compare data within the state and across time, and to prepare data, wherever possible in a manner that permits comparison to results from other states applying the same methodology (e.g., HEDIS reports).

Descriptive statistics will be used to describe the basic features of the data and what they depict, and to provide simple summaries about the sample and the measures. Together with simple

[10] NASMHPD Research Institute, Inc. (2006) https://pdfs.semanticscholar.org/839b/1b6326b0142356fe6da4c43d241b41b2432b.pdf.

[11] Banks SM & Pandiani JA .(2001) Probabilistic population estimation of the size and overlap of data sets based on date of birth. Statistics in Medicine; 20: 1421-1430.

[12] Pandiani JA, Banks SM & Schacht LM. (1998) Personal privacy vs. public accountability: A technological solution to an ethical dilemma. Journal of Behavioral Health Services and Research; 25 (4): 456-463.

graphics analysis, the descriptive statistics form the basis of quantitative analysis of data. They are also used to provide simple summaries about the participants and their outcomes. An exploratory data analysis is used to compare many variables in the search for organized patterns. Data will be analyzed as rates, proportions, frequencies, measures of central tendency (e.g., mean, median, mode), and/or qualitatively analyzed for themes.

Whenever possible the evaluation will use longitudinal methods to measure change over time. As available, from other evaluation efforts related to the Demonstration (See Section III C), evaluators may employ secondary analysis to reexamine existing data to address Demonstration hypothesis or isolate Medicaid enrollees from the general population. Difference in Differences and Interrupted Time Series designs are proposed for various aspects of the design. Difference in differences methods will be used to characterize differences between groups when data exists before and after intervention for a group of individuals similar to participants (treatment group) that will not be receiving services/benefits (comparison group). It is anticipated that Accountable Care Organization (ACO) and Blueprint (BP) practice attribution will allow measurement in at least one time period before ACO/BP practice intervention and at least one time period after ACO/BP practice intervention. Appropriate measures associated with value based payments, primary care, and enhanced care coordination outlined in this document will be assessed relative to internal comparison groups when available. Anticipated data sources are also identified in aforementioned tables. When using these methods, the evaluator is expected to consider and address various issues that might compromise the results. If necessary, alternative methods might be required. Time-series methods will be used to characterize differences over time for waiver participants or subpopulations when data for a measure of interest exists sequentially in time at successive equally spaced intervals. The length of the pre/post study periods is expected to be a minimum of 12 months. When employed, this method will look for trends and patterns in the data. Appropriate measures of access, cost, and quality outlined in this document will be compared to suitable benchmarks and assessed relative to a baseline to test the associated hypotheses. Anticipated data sources are also identified in the aforementioned tables. It is anticipated that time series methods will be used for measures associated with aggregate demonstration and specialty program populations (including IMD and those impacted by premium payments and subsidies). When using these methods, the evaluator is expected to consider and address various issues that might compromise the results. If necessary, alternative methods might be required. Final determination of methods and analytics will be made following the review of sample size and available data points over the life of the Demonstration.

Inferential statistics will be used to try to reach conclusions that extend beyond the immediate data alone. Fundamentals statistics will be used to describe inferences about the populations from which they were drawn. Sensitivity analysis to address IMD study questions will be considered.

COMPARISON GROUPS

In Vermont's Demonstration, Medicaid eligibility is synonymous with enrollment in the public managed care-like model making general comparison and/or control groups difficult. Whenever possible matched samples for participants in specialized programs or reform initiatives (e.g., ACO, Blueprint, and Chronic Care Initiative) and those not receiving programs services will be

used to explore differences. Synthetic control techniques[13] will be considered if suitable comparison states and/or data exists. When feasible given sample size, sub-sets of program participants may be compared to statewide or national benchmarks. Additionally, the State will work with its evaluation contractor to determine if neighboring New England or other states may be comparable in size, provider network and reform initiatives.

POPULATION STRATIFICATION AND LEVELS OF ANALYSIS

Levels of analysis will include the total Medicaid population, specialized program recipients and when appropriate to the study question major Medicaid aid category group (e.g., Aged Blind Disabled, Adults, Children, and MAGI). Please see Exhibits 5 through 10 for proposed stratification and levels of analysis by specialized program and measure.

G. DATA REPORTING

In addition to the four evaluation report deliverables listed below, the State will compile data and summarize Demonstration performance to-date for CMS in quarterly and annual reports. An independent evaluator will support all Demonstration evaluation reporting requirements.

- Interim Evaluation Report #1 (April 1, 2018)
- Interim Evaluation Report #2 (December 31, 2020)
- Summative Evaluation Report #1 (April 1, 2021)
- Summative Evaluation Report #2 (June 30, 2022)

The independent evaluator will support the State of Vermont efforts to complete rapid cycle assessments for new payment and service delivery reform models including but not limited to ACO model enhancements, efforts to support integration across providers and new delivery system investments.

H. BASELINE

Vermont's Section 1115 Demonstration has been in operation for 11 years, Vermont's baseline data refers to historical data points available for review, trend analysis and longitudinal examination. Data from the following performance monitoring and existing evaluation efforts can be found online as outlined below.

Blueprint for Health Found Here
Medicaid HEDIS Measures Found Here
Medicaid CAHPS Survey Results Found Here
Medicaid ACO Shared Savings Found Here
Developmental Disability Services National Core Indicators Results Found Here
AHS Results Based Scorecards Found Here

[13] Abadie Alberto, Alexis Diamond and Jens Hainmueller" Synthetic Control Methods for Comparative Case Studies: Estimating the Effect of California's Tobacco Control Program" Journal of American Statistical Association Vol. 105, No. 490, 2010 pp. 493-505.

IV. MENTAL HEALTH AND SUBSTANCE USE DISORDER IMD EVALUATION

CMS is continuing time-limited expenditure authority during the extension period (January 1, 2017 – December 31, 2021) for services in several facilities that are IMDs. This authority is pursuant to an evaluation of the IMD role and effectiveness in Vermont's Medicaid Demonstration. Vermont has agreed to phase-down IMD expenditures in CY 2021 and phase-out expenditures by 12/31/2025. In addition, Vermont is actively working with CMS on a SUD demonstration amendment that will allow SUD expenditures to continue once approved. This Section of the evaluation plan provides an overview of IMD programs and allowances in Vermont, study questions and tentative design components for both psychiatric and substance use disorder treatment programs.

A. HISTORY AND BACKGROUND

As part of its original 1115 Demonstration for the Vermont Health Access Plan (VHAP) Medicaid Expansion, Vermont received a waiver of the IMD exclusion. This waiver, effective January 1, 1996, permitted Vermont to reimburse IMDs for individuals enrolled under the 1115 Demonstration. The rationale behind this waiver was to permit the use of IMDs as alternatives to potentially more costly, general acute hospital services.

The 1115 Demonstration was amended in April 1999 to include the Community Rehabilitation and Treatment (CRT) program for adults who had a severe and persistent mental illness. The CRT model recognized the Department of Mental Health as a managed care entity, responsible for the provision of all behavioral health services in exchange for a capitated payment. Capitation payments included funding for all inpatient hospital services, including the Vermont State Hospital and the Brattleboro Retreat. Prior to approval of the CRT managed care model, Vermont (like several other states) relied on Disproportionate Share Hospital (DSH) funding as the mechanism to bring federal Medicaid dollars to support its State Hospital.

In 2004, CMS elected to no longer grant IMD waivers under its 1115 Demonstration authority; states with existing IMD waivers (including Vermont) were given a schedule to phase out available Medicaid reimbursement. Under the phase-out terms Vermont was permitted to continue Medicaid reimbursement of IMD services through Calendar Year 2004; reimbursement was limited to 50% of allowable expenditures in Calendar Year 2005. When the former Vermont State Hospital (VT) lost its Medicare certification in 2005, CMS sought assurances that Medicaid funds would not be used to support VT. Vermont removed funding for VT from the CRT capitation rates in 2005. The IMD waiver was completely phased out January 1, 2006.

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

- Services are determined to be medically appropriate;

- Care is delivered by a licensed (and not Medicare de-certified) healthcare provider; and
- Coverage of the service achieves program objectives related to cost, quality and/or access to care in the least restrictive, clinically appropriate setting possible.

Since 2005 Vermont has used its "in lieu of" authority under Global Commitment to purchase in-state residential substance use disorder and inpatient psychiatric treatment in lieu of more costly hospital-based care from several private facilities; Brattleboro Retreat, The Lund Home, Valley Vista and Serenity House.

In 2011, the former State psychiatric hospital was shut down by Tropical Storm Irene. As part of the planning process for building a new 25-bed State psychiatric hospital, post- Tropical Storm Irene, Vermont sought clarification from CMS in 2012 regarding its authority to access Medicaid funding, once certified, to support the new facility. In response to this request, CMS indicated that costs of psychiatric inpatient services for individuals between the ages of 21 and 65 residing in an IMD could not be included in the calculating the annual Medicaid managed care PMPM limits. However, Vermont was assured that it had authority under the Demonstration to fund IMD services by using its "managed care savings." Facilities that will be involved in the focused study of mental health and substance use disorder IMD treatment services are described in Exhibit 11 below.

Exhibit 11: Type and Size of IMD Facilities

Facility	Type and Target Group(s)	Treatment Focus	# of beds
Lund Home	Residential treatment for pregnant and parenting women w/children under 5 years old. Both mothers and children live on-site. Pregnant women may enroll in the program for the length of their pregnancy and through a post-partum period based on their individual needs	Substance Use Disorder; Mental Health	26
Valley Vista	Residential treatment for women, men, and adolescents	Substance Use Disorder	80
Serenity House	Residential treatment adults	Substance Use Disorder	24
Brattleboro Retreat: Substance Use Disorder	Inpatient detoxification and treatment for adults	Substance Use Disorder	30
Brattleboro Retreat: Inpatient Psychiatric Hospital	Inpatient stabilization for adults	Psychiatric	89
Vermont Psychiatric Care Hospital	Inpatient stabilization for adults under the care and custody of DMH	Psychiatric	25

B. STUDY QUESTIONS, POPULATIONS AND DESIGN

The State is seeking to examine variables related to psychiatric and substance abuse treatment in two separate analysis. Analysis from this study will help inform the State's decisions related to next steps for substance use disorder and psychiatric treatment capacity, coverage and limitations in Vermont's system of care. Variables identified for study include, but are not limited to:

- Emergency room utilization;
- Lengths of stay in emergency rooms;
- Access to acute inpatient treatment for mental health and substance use disorders;
- Lengths of stay in acute inpatient settings for treatment for those conditions;

Quality of acute mental health or substance use disorder treatment

- Quality of discharge planning in making effective linkages to community-based care;
- Readmissions for inpatient treatment;
- Cost of treatment for acute mental health or substance use disorder conditions;
- Access to care for co-morbid physical health conditions;
- Quality of care for co-morbid physical health conditions; and
- Overall cost of care for mental health and substance use disorders and co-morbid physical conditions combined.

C. IMD REPORT

The State recognizes that data from the IMD sub-evaluation is required at the same time as Interim Evaluation Report #1, April 1, 2018. The State and its evaluation contractor will:

1. Implement data collection for any identified IMD data gaps (psychiatric and SUD);
2. Conduct analysis of psychiatric related IMD related data, including the four-year period preceding the start of the current demonstration (CY2013-2016).
3. Review preliminary psychiatric IMD findings;
4. Conduct analysis of ADAP and DCF data and refine DMH psychiatric analysis as needed to finalize;
5. Collect, analyze and interpret performance measure data;
6. Prepare IMD sub-evaluation findings as part of Interim Evaluation Report #1 for April 1, 2018;
7. Revise Interim Evaluation Report #1 within 30 days of receipt of CMS feedback post April 1, 2018;
8. Continue to collect and analyze IMD related data for the period 2018 – 2020;
9. Prepare final IMD sub-evaluation findings as part of Interim Evaluation Report #2 for December 31, 2020 CMS submission; and
10. Revise Interim Evaluation Report #2 within 30 days of receipt of CMS feedback post December 31, 2020.

Outlined in the following sub-sections are the hypotheses, study questions and design elements for each of the two IMD target areas, psychiatric and substance use disorder treatment.

I. PSYCHIATRIC IMD TREATMENT

The State's two inpatient IMDs provided services for persons who are experiencing psychiatric crisis. Persons receiving inpatient treatment may be enrolled in the DMH Community Rehabilitation and Treatment program or be considered for involuntary admission. In both these cases, individuals must undergo a pre-placement screening by designated DMH crisis screeners. Enhanced care coordination and community service planning is also supported by DMH through utilization management staff in the central office and a network of designated and specialized program providers through-out the state. Persons who are receiving services from independent physicians, psychologists and/or other counselors, not overseen by DMH, are prior approved and reviewed for continued stay and discharge planning support by DVHA staff. The following hypotheses and study questions have been identified:

- Research Question: Will expanded IMD authority support enrollees to receive care in the least restrictive most clinically appropriate setting possible?

The projected elimination psychiatric IMD capacity will negatively impact:

  - Emergency room utilization and lengths of stay; access to acute inpatient treatment and length of stay; and cost of community hospital care.
  - IMD services result in improved quality of care and community integration as evidenced by: lower re-admission rates and/or access to primary care.

- Research Question: Is expanded IMD authority necessary to support Vermont's small size and community hospital system?
  - There is no capacity in the current community hospital system in Vermont to absorb the downsizing necessary to eliminate IMD claiming.

- Research Question: Will elimination of federal participation result in reductions in community -based treatment capacity due to increased pressure on that State budget?
  - The projected impact of removing Federal Financial Participation (FFP) for psychiatric IMD on other services and providers in the community will be negative.

PSYCHIATRIC DESIGN, MEASURES AND DATA SOURCES

Vermont's IMD facilities are statewide providers. Their state-wideness coupled with the historic nature of the State's funding and utilization of these programs, make evaluation design options such as pre/post Demonstration extension, regional or other in-state comparison groups difficult. However, due to damage to the state psychiatric hospital, associated with Tropical Storm Irene in August of 2011, the State may be in a unique situation to employ interrupted time series and/or sensitivity analysis related to the provision of psychiatric treatment services and impact in the community-based system of care pre/post Tropical Storm Irene.

Specifically, the former 54-bed Vermont State psychiatric hospital, funded primarily through the State general fund, was shut down due to damage sustained during Tropical Storm Irene. Patients and staff were moved into general hospital settings and retrofitted facilities across the State until a replacement facility could be built. During the ensuing 3-year period, the State invested

significant resources into mobile outreach, crisis stabilization and psychiatric treatment services in the community. At that time, DMH also initiated a contract for the use of 14-beds at the Brattleboro Retreat.

DMH collects data that includes information on increased community hospital payments, emergency room utilization and wait times, and psychiatric inpatient services for persons who would have otherwise been served at the former State hospital and who require additional resources during their hospitalization (known as patients with a "Level 1" designation). Additionally, DMH has historic data on hospital and temporary facility staffing needed during Tropical Storm Irene. This data and the information available pre/post Tropical Storm Irene and following the opening of the new 25-bed Vermont Psychiatric Care Hospital in July of 2014, may provide valuable insights into the impact of IMD services on the overall service system. Data may allow for the construction of a mathematical model to support sensitivity analysis related to how future changes in psychiatric bed-capacity may impact cost and utilization of other community mental health services. Data sources available for this analysis are detailed below.

- **DMH Core Data Elements** – Identifiable information on all significant dates and times for adults and children waiting for inpatient care under the custody of the commissioner. Data are generally available mid-month after the month of interest.
- **DMH Adult Involuntary Tracking** – Identifiable information on all inpatient admissions under the custody of the commissioner. Data are generally available one month after the quarter of interest.
- **DMH Financials** – Financial tracking and accounting for all payments, including Medicaid that are not processed through the MMIS. Data are generally available one month after the month of interest.
- **DVHA Adult Inpatient Tracking** – Identifiable information on all Medicaid-paid inpatient admissions for adults, including Level 1 inpatient stays. Data are generally available mid-month after the month of interest.
- **VPCH Electronic Health Record** – Identifiable information on all inpatient stays at VPCH, the state-run IMD. VPCH stays are paid by MCO investment and therefore there are no claims presented to Medicaid for those stays. Data are close to real-time and would require HIPPA compliant procedures for access.
- **Brattleboro Retreat (BR) Electronic Health Record** – Identifiable information on all inpatient stays. Data are close to real-time and would require HIPPA compliant procedures for access.
- **VHCURES Data Warehouse** – Unidentifiable information on all paid claims for medical care in Vermont for insurers covering 200+ lives. Matches possible using probabilistic estimation. VPCH is not captured in VHCURES, but BR is captured. Data are generally available one year after quarter of interest.
- **DMH Monthly Service Report** – Identifiable information from community service

providers (Designated Agencies) for all services provided via DMH-funded programs. Data are generally available two months after the month of interest.

- **MMIS** – Identifiable information on all Medicaid-paid claims for care in Vermont. Data are generally available three months after the quarter of interest.
- **VDH General Hospital Discharge Dataset** – Unidentifiable information on all discharges from Vermont hospitals regardless of payer or ability to pay. Data are generally available two to three years after the year of interest.

A list of potential measures is outlined in Exhibit 12 on the following page. This Exhibit provides options for psychiatric IMD measurement. It is not expected that all measures will be included in the final design. Follow-up after hospitalization is included as a continuity of care metric in Exhibit 12. Vermont will use the NCQA measure "Follow-Up After Hospitalization for Mental Illness" (NQF #0576). Vermont will work with its independent evaluator to ensure that additional relevant and obtainable continuity of care measures are included in the psychological IMD evaluation. Measures will be selected and finalized once evaluators have had an opportunity to review and discuss available data, assess data integrity and determine sample sizes with AHS, DVHA and DMH staff. Once data integrity review is final, the hypotheses, research questions and measures will be clarified and presented in the interim findings report. If feasible based on staff and budget considerations data will be stratified to assess Access, Cost and Quality.

Exhibit 12: Potential Measures for Psychiatric IMD Evaluation

Potential Psychiatric IMD Treatment Evaluation Measures, Sampling Method & Data Source				
Performance Measure	**Metric**	**Alignment**	**Sampling Method**	**Data Source**
Emergency Department (ED) Psychiatric Boarding[14]	Average number of people per day in ER waiting for inpatient psychiatric care	N/A	Persons in care and custody of DMH	DMH Core Data Elements
	Time from need for hospitalization to disposition, less time for medical clearance			
ED Room utilization[15]	% population with avoidable ED utilization	HEDIS®	IMD admissions	MMIS
	% population ED utilization	HEDIS®	IMD admissions	MMIS
Access to acute inpatient treatment for mental health	State Hospital Utilization per 1,000 population	SAMHSA URS	Total Vermont	MMIS
	Other Psychiatric Utilization per 1,000 population	SAMHSA URS	Total Vermont	MMIS
Lengths of stay (LOS) in acute inpatient psychiatric IMD	Median and Mean LOS for discharged patients	SAMHSA URS	IMD admissions	MMIS
	Median and Mean LOS for resident patients in facility ≤ 1 year	SAMHSA URS	IMD admissions	MMIS
	Median and Mean LOS for resident patients in facility > 1 year	SAMHSA URS	IMD admissions	MMIS
Quality of acute mental health IMD treatment	Hours of physical restraint use	HBIPS-2	IMD admissions	DMH
	Hours of seclusion use	HBIPS-3	IMD admissions	DMH
	Patients discharged on multiple antipsychotic medications with appropriate justification	HBIPS-5	IMD admissions	Medical Records
	Alcohol use screening	SUB-1	IMD admissions	Medical Records
	Alcohol use brief intervention provided or offered and the subset alcohol use brief intervention	SUB-2/-2A	IMD admissions	Medical Records
	Tobacco use screening	TOB-1	IMD admissions	Medical Records
	Tobacco use treatment provided or offered and the subset tobacco use treatment	TOB-2/-2A	IMD admissions	Medical Records
	Screening for metabolic disorders	IPFQR[16] FY2018	IMD admissions	Medical Records

[14] Vermont Statutes require people to go to the emergency dept. if inpatient care is needed and a placement cannot be made. Utilization is high because it is SOP for people to arrive at the ED prior to inpatient admission.

[15] Ibid.

[16] FY2018 Inpatient Psychiatric Facility Quality Review (IPFQR) requirements, Joint Commission on Hospital Accreditation: https://manual.jointcommission.org/Manual/WebHome.

Exhibit 12: Potential Measures for Psychiatric IMD Evaluation

Potential Psychiatric IMD Treatment Evaluation Measures, Sampling Method & Data Source				
Performance Measure	**Metric**	**Alignment**	**Sampling Method**	**Data Source**
Experience of Care	Assessment of patient experience of care	IPFQR FY2018	IMD admissions	CAHPS
Quality of discharge planning in making effective linkages to community -based care	Transition record with specified elements received by discharge patients	IPFQR FY2018	IMD admissions	Medical Records
	Timely transition of transition record	IPFQR FY2018	IMD admissions	Medical Records
	Follow-up after hospitalization for mental illness	HEDIS	IMD admissions	MMIS
	Transition record with specified elements received by discharge patients	IPFQR FY2018	IMD admissions	Medical Records
Readmissions for IMD inpatient treatment	State Hospital Readmissions: 30 days	SAMHSA URS	IMD admissions	DMH
	State Hospital Readmissions: 180 days	SAMHSA URS	IMD admissions	DMH
Overall Cost of Care	Average cost per enrollee for IMD services	N/A	IMD admissions	MMIS; DMH Financial Data
	Average cost per enrollee for all mental health services	N/A	IMD admissions	MMIS; DMH Financial Data
	Average cost per enrollee for all Medicaid services	N/A	IMD admissions	MMIS; DMH Financial Data
Quality of care for co-morbid physical health conditions	Preventative care and screening: Adult BMI screening and follow up	CMS NQF 0419	IMD admissions	MMIS
	Controlling high blood pressure (CBP-BH)	NCQA NQF 0018	IMD admissions	MMIS
	Preventative care and screening: unhealthy alcohol use: screening and brief counseling (ASC)	AMA-PCP1 NQF 2152	IMD admissions	MMIS
	Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)	NCQA NQF 1932	IMD admissions	MMIS
	Diabetes care for people with SMI: Hemoglobin A1c (HbA1c) poor control (>9.0%)(SMI-PC)	NCQA NQF 2607	IMD admissions	MMIS
	Cardiovascular monitoring for people with cardiovascular disease and schizophrenia (SMC)	NCQA NQF 1933	IMD admissions	MMIS

ii. Substance Use Disorder IMD Treatment

Substance Use Disorder placement is supported by multiple Medicaid programs across AHS. VDH-ADAP staff review programs and designate program as "preferred providers" certified to receive additional funding from ADAP for underinsured and uninsured Vermonters; while DVHA provides prior approval and level of care screening for residential treatment, detoxification and inpatient care at the Brattleboro Retreat, Valley Vista and Serenity House. Services at the Lund Home for pregnant and parenting women with young children under the age of 5 are authorized by DCF. The following hypotheses and study questions have been identified:

- Research Question: Will expanded IMD authority support enrollees to receive care in the least restrictive most clinically appropriate setting possible?
  - IMD capacity has a positive impact on emergency room utilization.
  - IMD services result in improved quality of care and community integration as evidenced by: lower re-admission rates and/or access to primary care.
  - The projected amount and scope of current IMD services is adequate to meet the need.

Substance Use Disorder Design, Measures and Data Sources

Vermont's substance use disorder IMD treatment facilities are statewide providers. Their state-wideness coupled with the historic nature of the State's funding and utilization of these programs, make evaluation design options such as pre/post Demonstration extension, regional or other in-state comparison groups difficult. The IMD evaluation is designed to measure outcomes for persons who receive residential services in an IMD. Wherever possible IMD enrollees will be compared to non-enrollees on standard measures of cost, quality and access.

Measures supporting the review of quality of care, community integration and the projected impact of including substance use disorder IMD services in the Demonstration are provided on Exhibit 13 on the following page. Final measures will be selected once evaluators have had an opportunity to review and discuss available data, assess data integrity and determine sample sizes with AHS, DVHA and ADAP staff. Measure selection will consider continuity of care metrics such as follow-up after hospitalization, records transfer and medication assisted treatment while receiving IMD services. Once data integrity review is final, the hypotheses, research questions and measures will be clarified and presented in the interim findings report. If feasible based on staff and budget considerations data will be stratified to assess Access, Cost and Quality.

Exhibit 13: Potential Measures for SUD IMD Evaluation

Potential SUD IMD Treatment Evaluation Measures, Sampling Method & Data Source			
Performance Measure	**Metric**	**Sampling Method**	**Data Source**
ED Room utilization	% population ED utilization	Total SUD; IMD Admissions	MMIS
Inpatient Utilization	Inpatient Utilization per 1,000 population	Total SUD; IMD Admissions	MMIS
Access to Residential SUD Treatment	Residential Utilization per 1,000 population	Total Medicaid	MMIS
Lengths of stay (LOS) in Residential SUD Treatment	Median and Mean LOS for discharged patients	Total SUD	MMIS
Quality of Care	Assessment of patient experience of care	IMD Admissions	Survey
Quality of discharge planning in making effective linkages to community -based care	Percent of IMD enrollees using substances who initiate and engage in treatment*	IMD Admission	MMIS
	Percent of persons discharged who have PCP visit (well or sick) within 30 days of discharge from IMD	IMD Admission	MMIS
Readmissions for Same Level of Care	SUD IMD Readmissions: 30 days	Total Medicaid	MMIS
	SUD IMD Readmissions: 180 days	Total Medicaid	MMIS
	Readmission rates by length of stay (<16 days, 30+ days)	Total Medicaid	MMIS
Overall Cost of Care	Average cost per enrollee for IMD services	IMD Admissions	MMIS
	Average cost per enrollee for all SUD services	Total Medicaid; IMD Admissions	MMIS
	Average cost per enrollee for all Medicaid services	Total Medicaid; IMD Admissions	MMIS

*__Note__: *Vermont's IET measure is aligned with NCQA NQF measure 0004, however, it has been modified to incorporate billing practices unique to Vermont's Specialized Health Home model.*

APPENDIX 1. AHS Proposed Evaluation Budget

Below is the tentative budget for the Vermont Global Commitment to Health 1115 Demonstration Evaluation. The budget includes total estimated costs for each year of the demonstration, as well as an annual breakdown of estimated staff, contractual, administrative, and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses, and reports generation.

COST ESTIMATE FOR GLOBAL COMMITMENT TO HEALTH WAIVER EVALUATION for YEAR 12: July 1, 2017 – December 31, 2017

ITEM	TITLE	RATE per HOUR	Hours	Evaluation Management	Evaluation Design and Planning (Framework, Research Questions, Hypothesis, Survey/Measure development, etc.)	Evaluation Implementation (develop tools, train staff, collect data, etc.)	Data Analysis (data cleaning, etc.)	Communication (prepare reports, communicate, etc.)	Estimated Salary and Contractual Cost	Estimated Fringe Benefits (Internal Staff)	Total Estimated Cost
Personnel/ Contractual											
1115 Waiver											
AHS	AHS Quality Improvement Manager	45.23	52	x	x			x	2,351.96	823.19	3,175.15
AHS	Financial Director II	38.99	26		x			x	1,013.74	354.81	1,368.55
DMH	Quality Mgnt Director	35.39	26		x	x	x	x	920.14	322.05	1,242.19
VDH	Director of Perf Mgt & Evaluation	39.00	26		x	x	x	x	1,014.00	354.90	1,368.90
DAIL	Director Policy, Planning & Analysis	46.89	26		x	x	x	x	1,219.14	426.70	1,645.84
DVHA	Health Care Project Director	43.04	26		x	x	x	x	1,119.04	391.66	1,510.70

Contractor	Project Director	200.00	52	x	x	x		x	10,400.00	-	10,400.00
Contractor	Evaluation Lead	150.00	26		x	x		x	3,900.00	-	3,900.00
Contractor	Data Analyst	100.00	26			x	x	x	2,600.00	-	2,600.00
Contractor	Evaluation Support	75.00	26			x		x	1,950.00	-	1,950.00
IMD										-	-
AHS	AHS Quality Improvement Manager	45.23	52	x	x	x		x	2,351.96	823.19	3,175.15
AHS	Financial Director II	38.99	26		x	x		x	1,013.74	354.81	1,368.55
DMH	Quality Mgnt Director	35.39	26		x	x	x	x	920.14	322.05	1,242.19
DMH	Financial Director III	40.23	26		x	x	x	x	1,045.98	366.09	1,412.07
VDH	Director of Perf Mgt & Evaluation	39.00	26		x	x	x	x	1,014.00	354.90	1,368.90
VDH	Financial Manager III	44.93	26		x	x	x	x	1,168.18	408.86	1,577.04
Contractor	Project Director	200.00	52	x	x	x		x	10,400.00		10,400.00
Contractor	Evaluation Lead	150.00	52		x	x	x		7,800.00		7,800.00
Contractor	Data Analyst	100.00	26				x		2,600.00		2,600.00

Contractor	Evaluation Support	75.00	26				x	x	1,950.00		1,950.00
INVESTMENTS										-	-
AHS	AHS Quality Improvement Manager	45.23	52	x	x	x	x	x	2,351.96	823.19	3,175.15
AHS	Financial Director II	38.99	52	x	x	x	x	x	2,027.48	709.62	2,737.10
DCF	Director of Operations	55.59	26		x	x	x	x	1,445.34	505.87	1,951.21
DCF	Senior Policy & Operations	42.94	26		x	x	x	x	1,116.44	390.75	1,507.19
DMH	Quality Mgnt Director	35.39	26		x	x	x	x	920.14	322.05	1,242.19
DMH	Financial Director III	40.23	26		x	x	x	x	1,045.98	366.09	1,412.07
DAIL	Director Policy, Planning & Analysis	46.89	26		x	x	x	x	1,219.14	426.70	1,645.84
DAIL	Financial Director II	40.31	26		x	x	x	x	1,048.06	366.82	1,414.88
DVHA	Quality Improvement Admin	36.53	26		x	x	x	x	949.78	332.42	1,282.20
DVHA	Financial Director IV	50.52	26		x	x	x	x	1,313.52	459.73	1,773.25

VDH	Performance Improvement Programs	32.27	26		x	x	x	x	839.02	293.66	1,132.68
VDH	Financial Manager III	44.93	26		x	x	x	x	1,168.18	408.86	1,577.04
Contractor	Project Director	200.00	26	x				x	5,200.00		5,200.00
Contractor	Evaluation Lead	150.00	12			x			1,800.00		1,800.00
Contractor	Data Analyst	100.00	0						-		-
Contractor	Evaluation Support	75.00	12					x	900.00		900.00
Salary & Contractual :											
Total Estimated Internal Salary & Fringe Cost									30,597.06	10,708.97	41,306.03
Total Estimated Contractual Cost									49,500.00	-	49,500.00
	Subtotal								**80,097.06**	**10,708.97**	**90,806.03**
Administrative Cost:											
Travel											1,500.00
Supplies											0.00
Equipment											0.00
Meetings											500.00
	Subtotal										**2,000.00**
Other Direct Admin Cost											500.00
	Subtotal										**2,500.00**

Indirect Cost:											
Indirect Cost	10% of Internal Staff Salary Cost								3,059.71		3,059.71
	Subtotal								**3,059.71**		**3,059.71**
Total Cost:											
State of Vermont YR12 Estimated Total Cost:	**Grand Total**								**SOV YR12 Total**		**96,365.74**

COST ESTIMATE FOR GLOBAL COMMITMENT TO HEALTH WAIVER EVALUATION for YEAR 13: January 1, 2018 – December 31, 2018

ITEM	TITLE	RATE per HOUR	Hours	Evaluation Management	Evaluation Design and Planning (Framework, Research Questions, Hypothesis, Survey/Measure development, etc.)	Evaluation Implementation (develop tools, train staff, collect data, etc.)	Data Analysis (data cleaning, etc.)	Communication (prepare reports, communicate, etc.)	Estimated Salary and Contractual Cost	Estimated Fringe Benefits (Internal Staff)	Total Estimated Cost
Personnel/Contractual											
1115 Waiver											
AHS	AHS Quality Improvement Manager	45.23	104	x		x		x	4,703.92	1,646.37	6,350.29
AHS	Financial Director II	38.99	52			x		x	2,027.48	709.62	2,737.10
DMH	Quality Mgnt Director	35.39	52			x	x	x	1,840.28	644.10	2,484.38
VDH	Director of Perf Mgt & Evaluation	39.00	52			x	x	x	2,028.00	709.80	2,737.80
DAIL	Director Policy, Planning & Analysis	46.89	52			x	x	x	2,438.28	853.40	3,291.68
DVHA	Health Care Project Director	43.04	52			x	x	x	2,238.08	783.33	3,021.41
Contractor	Project Director	200.00	104	x		x		x	20,800.00	-	20,800.00
Contractor	Evaluation Lead	150.00	52			x		x	7,800.00	-	7,800.00
Contractor	Data Analyst	100.00	52			x	x	x	5,200.00	-	5,200.00
Contractor	Evaluation Support	75.00	52			x	x	x	3,900.00	-	3,900.00

IMD										-	-
AHS	AHS Quality Improvement Manager	45.23	104	x	x	x		x	4,703.92	1,646.37	6,350.29
AHS	Financial Director II	38.99	52		x	x		x	2,027.48	709.62	2,737.10
DMH	Quality Mgnt Director	35.39	52		x	x	x	x	1,840.28	644.10	2,484.38
DMH	Financial Director III	40.23	52		x	x	x	x	2,091.96	732.19	2,824.15
VDH	Director of Perf Mgt & Evaluation	39.00	52		x	x	x	x	2,028.00	709.80	2,737.80
VDH	Financial Manager III	44.93	52		x	x	x	x	2,336.36	817.73	3,154.09
Contractor	Project Director	200.00	104	x	x	x		x	20,800.00		20,800.00
Contractor	Evaluation Lead	150.00	104		x	x	x		15,600.00		15,600.00
Contractor	Data Analyst	100.00	52				x		5,200.00		5,200.00
Contractor	Evaluation Support	75.00	52				x	x	3,900.00		3,900.00
INVESTMENTS										-	-
AHS	AHS Quality Improvement Manager	45.23	104	x	x	x	x	x	4,703.92	1,646.37	6,350.29
AHS	Financial Director II	38.99	104	x	x	x		x	4,054.96	1,419.24	5,474.20
DCF	Director of Operations	55.59	52		x	x	x	x	2,890.68	1,011.74	3,902.42
DCF	Senior Policy & Operations	42.94	52		x	x	x	x	2,232.88	781.51	3,014.39

DMH	Quality Mgnt Director	35.39	52		x	x	x	x	1,840.28	644.10	2,484.38
DMH	Financial Director III	40.23	52		x	x	x	x	2,091.96	732.19	2,824.15
DAIL	Director Policy, Planning & Analysis	46.89	52		x	x	x	x	2,438.28	853.40	3,291.68
DAIL	Financial Director II	40.31	52		x	x	x	x	2,096.12	733.64	2,829.76
DVHA	Quality Improvement Admin	36.53	52		x	x	x	x	1,899.56	664.85	2,564.41
DVHA	Financial Director IV	50.52	52		x	x	x	x	2,627.04	919.46	3,546.50
VDH	Performance Improvement Programs	32.27	52		x	x	x	x	1,678.04	587.31	2,265.35
VDH	Financial Manager III	44.93	52		x	x	x	x	2,336.36	817.73	3,154.09
Contractor	Project Director	200.00	52	x				x	10,400.00		10,400.00
Contractor	Evaluation Lead	150.00	24			x			3,600.00		3,600.00
Contractor	Data Analyst	100.00	0						-		-
Contractor	Evaluation Support	75.00	24					x	1,800.00		1,800.00
Salary & Contractual:											
Total Estimated Internal Salary & Fringe Cost									61,194.12	21,417.94	82,612.06
Total Estimated Contractual Cost									99,000.00	-	99,000.00
	Subtotal								**160,194.12**	**21,417.94**	**181,612.06**
Administrative Cost:											
Travel											1,500.00
Supplies											0.00

Equipment											0.00
Meetings											500.00
	Subtotal										**2,000.00**
Other Direct Admin Cost											500.00
	Subtotal										**2,500.00**
Indirect Cost:											
Indirect Cost	10% of Internal Staff Salary Cost								6,119.41		6,119.41
	Subtotal								**6,119.41**		**6,119.41**
Total Cost:											
State of Vermont YR13 Estimated Total Cost:	**Grand Total**								**SOV YR13 Total**		**190,231.47**

COST ESTIMATE FOR GLOBAL COMMITMENT TO HEALTH WAIVER EVALUATION for YEAR 14: January 1, 2019 – December 31, 2019

ITEM	TITLE	RATE per HOUR	Hours	Evaluation Management	Evaluation Design and Planning (Framework, Research Questions, Hypothesis, Survey/Measure development, etc.)	Evaluation Implementation (develop tools, train staff, collect data, etc.)	Data Analysis (data cleaning, etc.)	Communication (prepare reports, communicate, etc.)	Estimated Salary and Contractual Cost	Estimated Fringe Benefits (Internal Staff)	Total Estimated Cost
Personnel/Contractual											
1115 Waiver											
AHS	AHS Quality Improvement Manager	45.23	104	x				x	4,703.92	1,646.37	6,350.29
AHS	Financial Director II	38.99	52					x	2,027.48	709.62	2,737.10
DMH	Quality Mgnt Director	35.39	52			x	x	x	1,840.28	644.10	2,484.38
VDH	Director of Perf Mgt & Evaluation	39.00	52			x	x	x	2,028.00	709.80	2,737.80
DAIL	Director Policy, Planning & Analysis	46.89	52			x	x	x	2,438.28	853.40	3,291.68
DVHA	Health Care Project Director	43.04	52			x	x	x	2,238.08	783.33	3,021.41
Contractor	Project Director	200.00	104	x		x		x	20,800.00	-	20,800.00
Contractor	Evaluation Lead	150.00	52			x		x	7,800.00	-	7,800.00
Contractor	Data Analyst	100.00	52			x	x	x	5,200.00	-	5,200.00
Contractor	Evaluation Support	75.00	52			x		x	3,900.00	-	3,900.00

IMD										-	-
AHS	AHS Quality Improvement Manager	45.23	104	x		x		x	4,703.92	1,646.37	6,350.29
AHS	Financial Director II	38.99	52			x		x	2,027.48	709.62	2,737.10
DMH	Quality Mgnt Director	35.39	52			x	x	x	1,840.28	644.10	2,484.38
DMH	Financial Director III	40.23	52			x	x	x	2,091.96	732.19	2,824.15
VDH	Director of Perf Mgt & Evaluation	39.00	52			x	x	x	2,028.00	709.80	2,737.80
VDH	Financial Manager III	44.93	52			x	x	x	2,336.36	817.73	3,154.09
Contractor	Project Director	200.00	104	x		x		x	20,800.00		20,800.00
Contractor	Evaluation Lead	150.00	104			x	x		15,600.00		15,600.00
Contractor	Data Analyst	100.00	52				x		5,200.00		5,200.00
Contractor	Evaluation Support	75.00	52				x	x	3,900.00		3,900.00
INVESTMENTS										-	-
AHS	AHS Quality Improvement Manager	45.23	104	x	x	x	x	x	4,703.92	1,646.37	6,350.29
AHS	Financial Director II	38.99	104	x	x	x	x	x	4,054.96	1,419.24	5,474.20
DCF	Director of Operations	55.59	52		x	x	x	x	2,890.68	1,011.74	3,902.42
DCF	Senior Policy & Operations	42.94	52		x	x	x	x	2,232.88	781.51	3,014.39

DMH	Quality Mgnt Director	35.39	52		x	x	x	x	1,840.28	644.10	2,484.38
DMH	Financial Director III	40.23	52		x	x	x	x	2,091.96	732.19	2,824.15
DAIL	Director Policy, Planning & Analysis	46.89	52		x	x	x	x	2,438.28	853.40	3,291.68
DAIL	Financial Director II	40.31	52		x	x	x	x	2,096.12	733.64	2,829.76
DVHA	Quality Improvement Admin	36.53	52		x	x	x	x	1,899.56	664.85	2,564.41
DVHA	Financial Director IV	50.52	52		x	x	x	x	2,627.04	919.46	3,546.50
VDH	Performance Improvement Programs	32.27	52		x	x	x	x	1,678.04	587.31	2,265.35
VDH	Financial Manager III	44.93	52		x	x	x	x	2,336.36	817.73	3,154.09
Contractor	Project Director	200.00	52	x				x	10,400.00		10,400.00
Contractor	Evaluation Lead	150.00	24			x			3,600.00		3,600.00
Contractor	Data Analyst	100.00	0						-		-
Contractor	Evaluation Support	75.00	24					x	1,800.00		1,800.00
Salary & Contractual:											
Total Estimated Internal Salary & Fringe Cost									61,194.12	21,417.94	82,612.06
Total Estimated Contractual Cost									99,000.00	-	99,000.00
	Subtotal								**160,194.12**	**21,417.94**	**181,612.06**
Administrative Cost:											
Travel											1,500.00
Supplies											0.00

Equipment											0.00
Meetings											500.00
	Subtotal										**2,000.00**
Other Direct Admin Cost											500.00
	Subtotal										**2,500.00**
Indirect Cost:											
Indirect Cost	10% of Internal Staff Salary Cost								6,119.41		6,119.41
	Subtotal								**6,119.41**		**6,119.41**
Total Cost:											
State of Vermont YR14 Estimated Total Cost:	**Grand Total**								**SOV YR14 Total**		**190,231.47**

COST ESTIMATE FOR GLOBAL COMMITMENT TO HEALTH WAIVER EVALUATION for YEAR 15: January 1, 2020 – December 31, 2020

ITEM	TITLE	RATE per HOUR	Hours	Evaluation Management	Evaluation Design and Planning (Framework, Research Questions, Hypothesis, Survey/Measure development, etc.)	Evaluation Implementation (develop tools, train staff, collect data, etc.)	Data Analysis (data cleaning, etc.)	Communication (prepare reports, communicate, etc.)	Estimated Salary and Contractual Cost	Estimated Fringe Benefits (Internal Staff)	Total Estimated Cost
Personnel/Contractual											
1115 Waiver											
AHS	AHS Quality Improvement Manager	45.23	104	x	x			x	4,703.92	1,646.37	6,350.29
AHS	Financial Director II	38.99	52		x			x	2,027.48	709.62	2,737.10
DMH	Quality Mgnt Director	35.39	52		x	x	x	x	1,840.28	644.10	2,484.38
VDH	Director of Perf Mgt & Evaluation	39.00	52		x	x	x	x	2,028.00	709.80	2,737.80
DAIL	Director Policy, Planning & Analysis	46.89	52		x	x	x	x	2,438.28	853.40	3,291.68
DVHA	Health Care Project Director	43.04	52		x	x	x	x	2,238.08	783.33	3,021.41
Contractor	Project Director	200.00	104	x	x	x		x	20,800.00	-	20,800.00
Contractor	Evaluation Lead	150.00	52			x		x	7,800.00	-	7,800.00
Contractor	Data Analyst	100.00	52			x	x	x	5,200.00	-	5,200.00
Contractor	Evaluation Support	75.00	52			x		x	3,900.00	-	3,900.00

IMD										-	-
AHS	AHS Quality Improvement Manager	45.23	104	x		x		x	4,703.92	1,646.37	6,350.29
AHS	Financial Director II	38.99	52			x		x	2,027.48	709.62	2,737.10
DMH	Quality Mgnt Director	35.39	52			x	x	x	1,840.28	644.10	2,484.38
DMH	Financial Director III	40.23	52			x	x	x	2,091.96	732.19	2,824.15
VDH	Director of Perf Mgt & Evaluation	39.00	52			x	x	x	2,028.00	709.80	2,737.80
VDH	Financial Manager III	44.93	52			x	x	x	2,336.36	817.73	3,154.09
Contractor	Project Director	200.00	104	x		x		x	20,800.00		20,800.00
Contractor	Evaluation Lead	150.00	104			x	x		15,600.00		15,600.00
Contractor	Data Analyst	100.00	52				x		5,200.00		5,200.00
Contractor	Evaluation Support	75.00	52				x	x	3,900.00		3,900.00
INVESTMENTS										-	-
AHS	AHS Quality Improvement Manager	45.23	104	x	x	x	x	x	4,703.92	1,646.37	6,350.29
AHS	Financial Director II	38.99	104	x	x	x	x	x	4,054.96	1,419.24	5,474.20
DCF	Director of Operations	55.59	52		x	x	x	x	2,890.68	1,011.74	3,902.42
DCF	Senior Policy & Operations	42.94	52		x	x	x	x	2,232.88	781.51	3,014.39

DMH	Quality Mgnt Director	35.39	52		x	x	x	x	1,840.28	644.10	2,484.38
DMH	Financial Director III	40.23	52		x	x	x	x	2,091.96	732.19	2,824.15
DAIL	Director Policy, Planning & Analysis	46.89	52		x	x	x	x	2,438.28	853.40	3,291.68
DAIL	Financial Director II	40.31	52		x	x	x	x	2,096.12	733.64	2,829.76
DVHA	Quality Improvement Admin	36.53	52		x	x	x	x	1,899.56	664.85	2,564.41
DVHA	Financial Director IV	50.52	52		x	x	x	x	2,627.04	919.46	3,546.50
VDH	Performance Improvement Programs	32.27	52		x	x	x	x	1,678.04	587.31	2,265.35
VDH	Financial Manager III	44.93	52		x	x	x	x	2,336.36	817.73	3,154.09
Contractor	Project Director	200.00	52	x				x	10,400.00		10,400.00
Contractor	Evaluation Lead	150.00	24			x			3,600.00		3,600.00
Contractor	Data Analyst	100.00	0						-		-
Contractor	Evaluation Support	75.00	24					x	1,800.00		1,800.00
Salary & Contractual:											
Total Estimated Internal Salary & Fringe Cost									61,194.12	21,417.94	82,612.06
Total Estimated Contractual Cost									99,000.00	-	99,000.00
	Subtotal								**160,194.12**	**21,417.94**	**181,612.06**
Administrative Cost:											
Travel											1,500.00

Supplies											0.00
Equipment											0.00
Meetings											500.00
	Subtotal										**2,000.00**
Other Direct Admin Cost											500.00
	Subtotal										**2,500.00**
Indirect Cost:											
Indirect Cost	10% of Internal Staff Salary Cost								6,119.41		6,119.41
	Subtotal								**6,119.41**		**6,119.41**
Total Cost:											
State of Vermont YR15 Estimated Total Cost:	**Grand Total**								**SOV YR15 Total**		**190,231.47**

COST ESTIMATE FOR GLOBAL COMMITMENT TO HEALTH WAIVER EVALUATION for YEAR 16:
January 1, 2021 – December 31, 2021

ITEM	TITLE	RATE per HOUR	Hours	Evaluation Management	Evaluation Design and Planning (Framework, Research Questions, Hypothesis, Survey/Measure development, etc.)	Evaluation Implementation (develop tools, train staff, collect data, etc.)	Data Analysis (data cleaning, etc.)	Communication (prepare reports, communicate, etc.)	Estimated Salary and Contractual Cost	Estimated Fringe Benefits (Internal Staff)	Total Estimated Cost
Personnel/Contractual											
1115 Waiver											
AHS	AHS Quality Improvement Manager	45.23	104	x				x	4,703.92	1,646.37	6,350.29
AHS	Financial Director II	38.99	52					x	2,027.48	709.62	2,737.10
DMH	Quality Mgnt Director	35.39	52			x	x	x	1,840.28	644.10	2,484.38
VDH	Director of Perf Mgt & Evaluation	39.00	52			x	x	x	2,028.00	709.80	2,737.80
DAIL	Director Policy, Planning & Analysis	46.89	52			x	x	x	2,438.28	853.40	3,291.68
DVHA	Health Care Project Director	43.04	52			x	x	x	2,238.08	783.33	3,021.41
Contractor	Project Director	200.00	104	x		x		x	20,800.00	-	20,800.00
Contractor	Evaluation Lead	150.00	52			x		x	7,800.00	-	7,800.00
Contractor	Data Analyst	100.00	52			x	x	x	5,200.00	-	5,200.00
Contractor	Evaluation Support	75.00	52			x		x	3,900.00	-	3,900.00

IMD										-	-
AHS	AHS Quality Improvement Manager	45.23	104	x		x		x	4,703.92	1,646.37	6,350.29
AHS	Financial Director II	38.99	52			x		x	2,027.48	709.62	2,737.10
DMH	Quality Mgnt Director	35.39	52			x	x	x	1,840.28	644.10	2,484.38
DMH	Financial Director III	40.23	52			x	x	x	2,091.96	732.19	2,824.15
VDH	Director of Perf Mgt & Evaluation	39.00	52			x	x	x	2,028.00	709.80	2,737.80
VDH	Financial Manager III	44.93	52			x	x	x	2,336.36	817.73	3,154.09
Contractor	Project Director	200.00	104	x		x		x	20,800.00		20,800.00
Contractor	Evaluation Lead	150.00	104			x	x		15,600.00		15,600.00
Contractor	Data Analyst	100.00	52				x		5,200.00		5,200.00
Contractor	Evaluation Support	75.00	52				x	x	3,900.00		3,900.00
INVESTMENTS										-	-
AHS	AHS Quality Improvement Manager	45.23	104	x	x	x	x	x	4,703.92	1,646.37	6,350.29
AHS	Financial Director II	38.99	104	x	x	x		x	4,054.96	1,419.24	5,474.20
DCF	Director of Operations	55.59	52		x	x	x	x	2,890.68	1,011.74	3,902.42
DCF	Senior Policy & Operations	42.94	52		x	x	x	x	2,232.88	781.51	3,014.39

DMH	Quality Mgnt Director	35.39	52		x	x	x	x	1,840.28	644.10	2,484.38
DMH	Financial Director III	40.23	52		x	x	x	x	2,091.96	732.19	2,824.15
DAIL	Director Policy, Planning & Analysis	46.89	52		x	x	x	x	2,438.28	853.40	3,291.68
DAIL	Financial Director II	40.31	52		x	x	x	x	2,096.12	733.64	2,829.76
DVHA	Quality Improvement Admin	36.53	52		x	x	x	x	1,899.56	664.85	2,564.41
DVHA	Financial Director IV	50.52	52		x	x	x	x	2,627.04	919.46	3,546.50
VDH	Performance Improvement Programs	32.27	52		x	x	x	x	1,678.04	587.31	2,265.35
VDH	Financial Manager III	44.93	52		x	x	x	x	2,336.36	817.73	3,154.09
Contractor	Project Director	200.00	52	x				x	10,400.00		10,400.00
Contractor	Evaluation Lead	150.00	24			x			3,600.00		3,600.00
Contractor	Data Analyst	100.00	0						-		-
Contractor	Evaluation Support	75.00	24					x	1,800.00		1,800.00
Salary & Contractual:											
Total Estimated Internal Salary & Fringe Cost									61,194.12	21,417.94	82,612.06
Total Estimated Contractual Cost									99,000.00	-	99,000.00
	Subtotal								**160,194.12**	**21,417.94**	**181,612.06**
Administrative Cost:											
Travel											1,500.00
Supplies											0.00

Equipment											0.00
Meetings											500.00
	Subtotal										**2,000.00**
Other Direct Admin Cost											500.00
	Subtotal										**2,500.00**
Indirect Cost:											
Indirect Cost	10% of Internal Staff Salary Cost								6,119.41		6,119.41
	Subtotal								**6,119.41**		**6,119.41**
Total Cost:											
State of Vermont YR16 Estimated Total Cost:	**Grand Total**								**SOV YR16 Total**		**190,231.47**

COST ESTIMATE FOR GLOBAL COMMITMENT TO HEALTH WAIVER EVALUATION for Post Demo: January 1, 2022 – September 30, 2022

ITEM	TITLE	RATE per HOUR	Hours	Evaluation Management	Evaluation Design and Planning (Framework, Research Questions, Hypothesis, Survey/Measure development, etc.)	Evaluation Implementation (develop tools, train staff, collect data, etc.)	Data Analysis (data cleaning, etc.)	Communication (prepare reports, communicate, etc.)	Estimated Salary and Contractual Cost	Estimated Fringe Benefits (Internal Staff)	Total Estimated Cost
Personnel/Contractual											
1115 Waiver											
AHS	AHS Quality Improvement Manager	45.23	78	x				x	3,527.94	1,234.78	4,762.72
AHS	Financial Director II	38.99	39					x	1,520.61	532.21	2,052.82
DMH	Quality Mgnt Director	35.39	39				x	x	1,380.21	483.07	1,863.28
VDH	Director of Perf Mgt & Evaluation	39.00	39				x	x	1,521.00	532.35	2,053.35
DAIL	Director Policy, Planning & Analysis	46.89	39				x	x	1,828.71	640.05	2,468.76
DVHA	Health Care Project Director	43.04	39				x	x	1,678.56	587.50	2,266.06
Contractor	Project Director	200.00	78	x				x	15,600.00	-	15,600.00
Contractor	Evaluation Lead	150.00	39					x	5,850.00	-	5,850.00
Contractor	Data Analyst	100.00	39				x	x	3,900.00	-	3,900.00
Contractor	Evaluation Support	75.00	39					x	2,925.00	-	2,925.00

IMD										-	-
AHS	AHS Quality Improvement Manager	45.23	78	x				x	3,527.94	1,234.78	4,762.72
AHS	Financial Director II	38.99	39					x	1,520.61	532.21	2,052.82
DMH	Quality Mgnt Director	35.39	39				x	x	1,380.21	483.07	1,863.28
DMH	Financial Director III	40.23	39				x	x	1,568.97	549.14	2,118.11
VDH	Director of Perf Mgt & Evaluation	39.00	39				x	x	1,521.00	532.35	2,053.35
VDH	Financial Manager III	44.93	39				x	x	1,752.27	613.29	2,365.56
Contractor	Project Director	200.00	78	x				x	15,600.00		15,600.00
Contractor	Evaluation Lead	150.00	78				x		11,700.00		11,700.00
Contractor	Data Analyst	100.00	39				x		3,900.00		3,900.00
Contractor	Evaluation Support	75.00	39				x	x	2,925.00		2,925.00
INVESTMENTS										-	-
AHS	AHS Quality Improvement Manager	45.23	78	x			x	x	3,527.94	1,234.78	4,762.72
AHS	Financial Director II	38.99	78	x				x	3,041.22	1,064.43	4,105.65
DCF	Director of Operations	55.59	39				x	x	2,168.01	758.80	2,926.81
DCF	Senior Policy & Operations	42.94	39				x	x	1,674.66	586.13	2,260.79

DMH	Quality Mgnt Director	35.39	39				x	x	1,380.21	483.07	1,863.28
DMH	Financial Director III	40.23	39				x	x	1,568.97	549.14	2,118.11
DAIL	Director Policy, Planning & Analysis	46.89	39				x	x	1,828.71	640.05	2,468.76
DAIL	Financial Director II	40.31	39				x	x	1,572.09	550.23	2,122.32
DVHA	Quality Improvement Admin	36.53	39				x	x	1,424.67	498.63	1,923.30
DVHA	Financial Director IV	50.52	39				x	x	1,970.28	689.60	2,659.88
VDH	Performance Improvement Programs	32.27	39				x	x	1,258.53	440.49	1,699.02
VDH	Financial Manager III	44.93	39				x	x	1,752.27	613.29	2,365.56
Contractor	Project Director	200.00	39	x				x	7,800.00		7,800.00
Contractor	Evaluation Lead	150.00	18				x		2,700.00		2,700.00
Contractor	Data Analyst	100.00	0						-		-
Contractor	Evaluation Support	75.00	18					x	1,350.00		1,350.00
Salary & Contractual:											
Total Estimated Internal Salary & Fringe Cost									45,895.59	16,063.46	61,959.05
Total Estimated Contractual Cost									74,250.00	-	74,250.00
	Subtotal								**120,145.59**	**16,063.46**	**136,209.05**
Administrative Cost:											
Travel											1,500.00
Supplies											0.00

Equipment											0.00
Meetings											500.00
	Subtotal										**2,000.00**
Other Direct Admin Cost											500.00
	Subtotal										**2,500.00**
Indirect Cost:											
Indirect Cost	10% of Internal Staff Salary Cost								4,589.56		4,589.56
	Subtotal								**4,589.56**		**4,589.56**
Total Cost:											
State of Vermont Post Demo Estimated Total Cost:	**Grand Total**								**SOV Post Demo Total**		**143,298.61**

ATTACHMENT L
DSHP Claiming Protocol [RESERVED]

ATTACHMENT M
Investment Claiming Protocol [RESERVED]