

PHILIP B. SCOTT
GOVERNOR



State of Vermont
OFFICE OF THE GOVERNOR

June 29, 2021

The Honorable Xavier Becerra
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, DC 20201

Dear Secretary Becerra:

On behalf of the residents of Vermont, I am pleased to submit to the U.S. Department of Health and Human Services the enclosed application to renew Vermont's Global Commitment to Health (Global Commitment) Section 1115 demonstration (Project No: 11-W-00194/1). With this application, Vermont is seeking to enter into a new, five-year demonstration agreement that will be the foundation of the State's 10-year vision to further Medicaid's role as a driver of all-payer payment and delivery system reform in the State.

Over the last 15 years, the Global Commitment demonstration has been Vermont's principal vehicle for major expansions of health coverage, building an extensive ecosystem of public health and health-related services, driving all-payer payment reform, and rebalancing long-term services and supports (LTSS). As a result of these efforts, Vermont has nearly universal health coverage, has one of the healthiest populations in the nation (despite also being one of the oldest), and serves nearly 60% of enrollees eligible for nursing facility care in a home or community-based setting.

Beginning in January 2022, Vermont is seeking to leverage the Global Commitment demonstration renewal to make its boldest move yet toward full population-based payment—transitioning the Department of Vermont Health Access (DVHA), Vermont's Medicaid delivery system, into a public, state-run, risk-bearing Medicaid managed care plan that will enable Vermont to continue to innovate. Under this framework, DVHA would be at risk for managing under a capitation rate the entire Medicaid population and all Medicaid services, and as a result, would be incentivized to deliver value for federal and State Medicaid spending by continuing to develop more innovative care models, improving care coordination, and strengthening DVHA's population health management capabilities. Through this transformation, Vermont aims to improve health outcomes, lower costs for all Vermonters, and promote provider sustainability, by driving farther and faster toward alternative payment models.

The Honorable Xavier Becerra

June 29, 2021

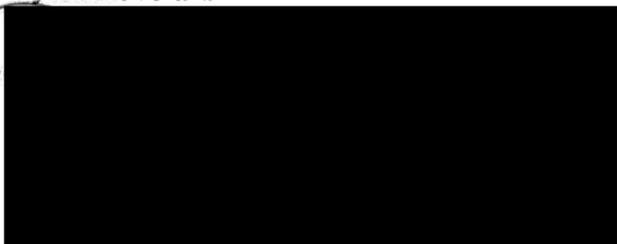
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Concurrently, Vermont envisions advancing the objectives of the Medicaid program by continuing to invest in programs and interventions that improve population health, impact social determinants of health, and ensure that those investments are sustainable over the long-term in order to support health improvement and health equity for Vermonters through effective use of state and federal Medicaid dollars. To achieve this vision, Vermont is requesting authority through this application for the following new demonstration features:

- Cover individuals incarcerated in state prisons and jails for 90 days prior to their release and re-entry to the community;
- Provide substance use disorder (SUD) benefits for low- and moderate-income Vermonters;
- Expand access to family-focused residential mental health and SUD treatment;
- Offer a Permanent Supportive Housing Pilot;
- Support critical Vermont workforce development, public health, and care coordination infrastructure;
- Strengthen provider capacity to participate in health information exchange, advancing population health; and
- Deploy an electronic patient engagement platform.

The next stage of the Global Commitment demonstration is a Vermont innovation that is uniquely designed and appropriate for the State and for Vermonters. We appreciate our longstanding partnership with your Department, and we look forward to your continued support as we pursue this new opportunity for Vermont to evolve its health ecosystem, continue to improve the health and well-being of Vermonters, and drive value in the Medicaid program and health care system overall.

Sincerely,



Philip B. Scott
Governor

PBS/kp

Global Commitment to Health 1115 Demonstration Renewal Application

State of Vermont
Agency of Human Services



June 30, 2021



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Section I – Global Commitment to Health Vision

Introduction

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

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



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

The Global Commitment demonstration has also positioned Medicaid as an accelerator of Vermont’s trailblazing payment reform initiatives. Vermont’s All-Payer Accountable Care Organization (ACO) Model Agreement is a statewide, total cost of care model, in which providers under Medicaid, Medicare, and commercial contracts participate and can accept full risk. While the All-Payer ACO Model Agreement is authorized by the Centers for Medicare and Medicaid Services (CMS) outside of the Global Commitment 1115 demonstration, CMS has required that the two programs be in sync. Medicaid is the anchor payer for the All-Payer ACO Model Agreement, with over 80% of Medicaid enrollees for whom Medicaid is the primary payer attributed to the ACO (via the Vermont Medicaid Next Generation ACO Program). Medicaid and the Global Commitment demonstration play a crucial role in the State’s value-based payment (VBP) initiatives that are central to the success of the All-Payer ACO Model Agreement. The All-Payer ACO Model Agreement has made Vermont a national trendsetter in all-payer payment reform and one of two states⁶ nationally with a payment model that meets Health Care Payment Learning & Action Network (HCP-LAN) Category 4 criteria under the

¹ The Commonwealth Fund. “Commonwealth Fund Scorecard on State Health System Performance,” 2018. <https://interactives.commonwealthfund.org/2018/state-scorecard/files/Vermont.pdf>.

² “Access to Care Data 2021.” Mental Health America, <https://www.mhanational.org/issues/2021/mental-health-america-access-care-data>.

³ “Long-Term Services & Supports State Scorecard - Vermont.” Vermont State Scorecard. <http://www.longtermscorecard.org/databystate/state?state=VT>.

⁴ “Behavioral Risk Factor Surveillance System: 2018 Report.” Vermont Department of Health, 2018. https://www.healthvermont.gov/sites/default/files/documents/pdf/HSVR_2018_BRFSSReport.pdf.

⁵ “Coronavirus in the U.S.: Latest Map and Case Count.” The New York Times, May 9, 2021. <https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html>.

⁶ Costello, Anne Marie, and Brad Smith. “SMD # 20-004 RE: Value-Based Care Opportunities in Medicaid.” Medicaid.Gov, September 15, 2020. <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf>.



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Alternative Payment Model framework.⁷ Vermont is also pursuing cutting-edge payment innovation outside of the ACO, including a series of payment reform initiatives for Medicaid providers historically excluded from most VBP arrangements, such as providers offering mental health, SUD, and developmental disabilities services.

Vision and Goals for Global Commitment Renewal

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

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

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

⁷ “Alternative Payment Model Framework.” The MITRE Corporation, HCP LAN, 2017. <https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf>.



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will conform with demonstration special terms and conditions (STCs) and actuarially sound rate setting, including regulatory requirements and industry norms with respect to medical-loss ratio, administrative load, and profit margin.

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

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

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

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



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central to the demonstration renewal and creates a new opportunity and incentive for Vermont to evolve its health ecosystem, continue to improve the health and well-being of Vermonters through investments targeting SDOH, and drive value in the Medicaid program and health care system overall. In addition, Vermont’s Legislature has recently declared racism a public health emergency, and Vermont views the Global Commitment renewal as a powerful tool for testing new initiatives that promote health equity and address racial and ethnic disparities in access to care and health outcomes in Vermont. Key goals of the demonstration renewal align with the objectives of Title XIX of the Social Security Act and include:

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

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

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



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

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



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



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Section II – Historical Narrative Summary of the Demonstration

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

Original Demonstration: 2005–2010

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

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



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

First Renewal: 2011–2013

Vermont renewed the Global Commitment demonstration effective January 1, 2011. Under the renewal, AHS shifted from paying DVHA a per-member per-month capitation rate to paying DVHA at cost; however, Vermont retained the ability to use managed care savings to make investments that would reduce the rate of uninsured/underinsured, increase access to care, develop public health programs, and promote public-private health care partnerships.

Second Renewal: 2014–2016

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

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

Third Renewal: 2017–Present

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



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

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

Goals and Objectives of Current Demonstration Period

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

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

Vermont has largely been successful in meeting these goals, as addressed in this section and throughout this application. In addition, Vermont has also worked to meet a series of goals focused on SUD and SMI/SED, which align with the overall goals of the demonstration stated above.

- SUD Goals
 - Increased rates of identification, initiation, and engagement in treatment
 - Increased adherence to and retention in treatment
 - Reductions in overdose deaths, particularly those due to opioids
 - Reduced utilization of emergency department and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services
 - Improved access to care for physical health conditions among beneficiaries
- SMI/SED Goals



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

Given that the SUD and SMI/SED portions of the demonstration have been approved in recent years, the State has more limited data on its efforts to achieve these goals.⁸

Over the course of the demonstration, Vermont's independent evaluator has measured the State's success in achieving its goals across four domains: increased access to care, improved quality of care, improved community integration, and contained program costs. Sample findings are described below.

- **Access to care**
 - Access to ambulatory and preventive visits, well-child visits, dental care, and adolescent well care measures have shown statistically significant improvement over baseline as described in Section VII below.
 - Access to medication-assisted treatment (MAT) has increased in each year of the demonstration.
- **Quality of care**
 - In over 76% of the quality of care measures assessed, the demonstration has outperformed Medicaid programs nationally.
 - The demonstration is associated with improved rates of initiation and engagement in SUD treatment and improved diabetes control.
- **Community integration**

⁸ The state's [SMI Monitoring Protocol](#), which includes a monitoring workbook with metrics, was approved by CMS on March 29, 2021. The SMI IMD measures identified in the monitoring workbook will be reported using the schedule identified in the Monitoring Protocol and will be considered for inclusion in the draft summative evaluation report due to CMS within 18 months of the end of the demonstration period (summer/fall 2022). In addition, the State did not have the staff resources to generate the SUD IMD utilization and cost of care measures for the final interim evaluation report due to the state's response to and prioritization of the COVID-19 pandemic. These measures also will be included in the draft summative evaluation report.



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- The number of CFC enrollees living in home and community-based settings rose from 54% at baseline to 58% in CY2019.
- **Cost containment**
 - The demonstration is containing costs relative to what would have been spent absent the demonstration.
 - The State has achieved savings over expected “without waiver expenditures” in each year of the demonstration thus far; cumulative savings at the end of CY2019 were \$110,465,951.

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

Moving Forward

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

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

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

Goal 1: Advancing Toward Population-Wide Comprehensive Coverage

Over the past 15 years, the Global Commitment demonstration has advanced comprehensive health coverage in Vermont. Prior to the ACA, the demonstration authorized coverage expansions for children, parents, and childless adults who would not otherwise have been eligible for Medicaid. Today, Vermont has nearly universal coverage, with almost 97% of Vermonters insured as of 2018 according to the Vermont Household Insurance Survey.⁹ The

⁹ “Health Insurance Coverage of the Total Population.” KFF, October 23, 2020. <https://www.kff.org/other/state-indicator/total->



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Global Commitment demonstration plays a key role in Vermonters' access to comprehensive, affordable coverage that allows them to lead healthy lives.

Continuing Features to Advance Toward Population-Wide Comprehensive Coverage

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

Continuing Features Without Modifications

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

Continuing Features With Modifications

Moderate Needs Expansion Group for CFC. Under the Global Commitment demonstration, Vermont provides a subset of HCBW-like services available through the CFC program (described in more detail below) to the Moderate Needs Group, comprised of over 1,100 Vermonters with disabilities at risk of requiring nursing home-level care, including over 190 Vermonters who are not otherwise eligible for Medicaid. By covering this expansion population, Vermont provides access to needed services in the community and removes the incentive for deterioration of health or income solely to meet prevailing Medicaid eligibility standards.

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

Currently, individuals meeting one of the following criteria are eligible for the Moderate Needs Group: (1) individuals who require supervision or any physical assistance three or more times in seven days with any single activity of daily living (ADL) or instrumental ADL; (2) individuals who have impaired judgment or decision-making skills who require general supervision on a daily basis; (3) individuals who require at least monthly monitoring for a chronic health condition; and (4) individuals whose health condition will worsen if services are not provided or if services are discontinued. The combination of the broad Moderate Needs Group clinical eligibility criteria and funding limited to annual appropriations has created an unsustainable

[population/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Uninsured%22%2C%22sort%22%3A%22asc%22%7D.](#)



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waitlist system with over 700 applicants statewide. In the renewal period, Vermont seeks to revise the eligibility criteria to ensure that services are targeted to at-risk Vermonters with the most acute needs by:

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

Community Rehabilitation and Treatment (CRT) Expansion Group. The Global Commitment demonstration provides a robust set of community-based mental health services (described in more detail later in this application) to over 215 individuals with incomes above Medicaid limits. CRT provides Vermonters with SMI access to community-based mental health care preemptively, preventing mental health deterioration to the point of requiring residential or inpatient psychiatric care, while also helping to prevent individuals from needing full Medicaid benefits in the future. As part of the demonstration renewal, Vermont is seeking to transition authority for the CRT expansion group from a designated state health program (DSHP) (for individuals with incomes from 133%-185% FPL) and investment (for individuals with incomes above 185% FPL) to expenditure authority under Section 1115(a)(2).

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

VPharm. VPharm assists Vermonters enrolled in Medicare Part D, including those over 65 and those with disabilities, with paying for prescription drugs, ensuring that cost is not a barrier to receipt of drugs and medication adherence. VPharm helps individuals pay their monthly Part D premiums and lowers the co-pay that these individuals pay for many of their prescriptions. VPharm currently provides pharmaceutical assistance to over 9,900 Vermonters who are elderly or disabled. To date, VPharm has provided the same pharmaceutical coverage as under the Medicaid State Plan to eligible individuals with incomes up to 150% FPL, and maintenance drug-only coverage for eligible individuals with incomes between 150% and 225% FPL. In the renewal period, Vermont seeks to extend Medicaid-equivalent pharmaceutical coverage to VPharm-eligible individuals at all income levels up to 225% FPL.



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New Features to Advance Toward Population-Wide, Comprehensive Coverage

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

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

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

Nationally, inmates have substantially higher rates of mental illness, addiction, and chronic health conditions, such as high blood pressure, asthma, and hepatitis, than the general population.¹⁰ Vermont is no exception to this trend. Of Vermonters incarcerated in 2019, 33% had an opioid use disorder; 12% had hepatitis C; 11% had a respiratory or pulmonary condition, such as asthma; and 9% had hypertension. In addition, in 2021, 3.5% had a serious functional impairment.¹¹ With the range of complex health needs that the inmate population experiences, it is imperative that they have established access to the treatment and supports they need prior to their release in order to re-enter the community safely and avoid recidivism. Research indicates that the first several weeks post-release are particularly crucial to justice-involved individuals' health and safety. For example, a small study in Vermont found that of the 109 Vermonters who died of a drug overdose in 2017, 17% had a history of incarceration in the three years prior to

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

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



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their death, and 58% of overdoses among individuals with a recent history of incarceration occurred within the first three months after release from DOC custody.¹²

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

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

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

The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018 recognizes that transitions from correctional facilities to the community are high stakes and indicates that 1115 demonstrations are one tool available for promoting successful transitions. With the Global Commitment renewal, Vermont is committed to making further progress on improving transitions from correctional facilities to the community and is seeking to provide all Medicaid-eligible inmates with Medicaid coverage 90 days prior to release. These inmates would have access to the full set of Medicaid State Plan benefits. Given that there is often significant uncertainty around inmates' release dates, authority to provide 90 days of coverage will enable Vermont to assess inmates and connect them to physical and mental health appointments in the community in the period immediately following release; ensure that treatment-in-progress is not interrupted; and ensure that medications can be filled prior to release and refilled in a timely manner thereafter. In addition, Vermont will connect inmates to care coordinators during this period, who will link them to community-based supports, such as permanent supportive housing or employment resources, necessary for a successful transition.

Vermont expects that at the end of the demonstration period, there will be lower rates of recidivism in the State. Additionally, Black Vermonters are disproportionately represented in the

¹² Vermont Department of Health. "Vermont Social Autopsy Report: 2017 Data Analysis" Vermont Department of Health. (p. 35, Rep.).

<https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAPSocialAutopsyReportAug2020.pdf>.



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State’s incarcerated population (9.1% of the incarcerated population v. 1.4% of the population statewide), and Vermont views this request as an important step toward promoting health equity as well as addressing systemic inequities in its criminal justice system and health care delivery systems.¹³ By helping address gaps in coverage and access to care that contribute to recidivism, Vermont seeks to reduce the detrimental physical and psychological impact of time spent in correctional settings—impacts which are disproportionately borne by Black Vermonters.^{14,15}

2. SUD Community Intervention and Treatment Eligibility Group

Over the past several years, Vermont has had higher rates of SUDs and illicit drug use disorders than the national average.^{16,17} In response, Vermont has employed a comprehensive, multifaceted strategy toward fighting the opioid epidemic and rising polysubstance use. The COVID-19 crisis has stymied these efforts, with substance use in the State substantially worsening over the past year. For example, in 2020, overdose deaths increased by 38% and emergency department (ED) visits for nonfatal overdoses increased by 47% as compared to 2019.

Medicaid has been critical to Vermont’s efforts to address these concurrent crises, covering over 11,600 Vermonters with a SUD. Vermont offers a full continuum of benefits targeted toward Medicaid enrollees with a SUD, ranging from preventive services, such as administration of the Screening, Brief Intervention and Referral to Treatment tool, to residential and inpatient SUD services. However, not all Vermonters have access to these services; today, many commercial health insurance plans in Vermont and Medicare do not provide the SUD treatment services necessary for individuals to achieve recovery. AHS is working with commercial carriers to improve coverage of SUD services. For example, Vermont’s Blueprint program (described in more detail later in this application) has been collaborating with BlueCross BlueShield of Vermont and MVP Health Care to design pilot payment models for Vermont’s Hub and Spoke model for opioid treatment. Beyond these efforts, the State has identified a need to expand access to these services to Vermonters with a diagnosed SUD who are uninsured or underinsured and have incomes higher than Medicaid limits. With SUD benefits, these individuals will have the

¹³ D’Amora, David, Jacqueline Salvi, Cassandra Warney, Ed Weckerly, and Ellen Whelan-Wuest. “Vermont Justice Reinvestment II Working Group Meeting.” Legislature Vermont, January 22, 2020.

<https://legislature.vermont.gov/Documents/2020/WorkGroups/Senate%20Judiciary/Justice%20Reinvestment%20II/W~Ellen%20Whelan-Wuest~VT%20Justice%20Reinvestment%20II%20Working%20Group%20Meeting~1-22-2020.pdf>; DOC CY2020 data; “Quick Facts: Vermont.” United States Census, July 2019. <https://www.census.gov/quickfacts/VT>.

¹⁴ Massoglia, Michael, and Brianna Remster. “Linkages Between Incarceration and Health.” *Public Health Reports* 134, no. 1_suppl (May 2019): 8S-14S. <https://doi.org/10.1177/0033354919826563>.

¹⁵ Haney, Craig. “Prison Effects in the Era of Mass Incarceration.” *The Prison Journal*, (July 2012). <https://doi.org/10.1177/0032885512448604>.

¹⁶ “State Level Data National Survey on Drug Use and Health 2017-2018.” Vermont Department of Health, December 2019. <https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP-NSDUH-Summary-2017-2018.pdf>.

¹⁷ For additional information, please see Vermont’s 2018 [application](#) to waive the IMD exclusion for SUD treatment.



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supports needed to achieve recovery, minimizing the likelihood that their addiction will intensify to the extent where they become eligible for full Medicaid benefits in the future.

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

Table 2. SUD Community Intervention and Treatment Benefits

SUD Community Intervention and Treatment Service	Description
Service Coordination	<ul style="list-style-type: none"> ▪ Screening and/or assessment, case management, and care coordination to assist individuals and families in: <ul style="list-style-type: none"> ○ Planning, gaining access to, coordinating, and monitoring the provision of medical, social, educational, and other services and supports, including discharge planning; and ○ Advocacy, monitoring, and support to assist them in making and assessing their own decisions
Flexible Support	<ul style="list-style-type: none"> ▪ Day recovery/psychoeducation, including recovery education: group recovery activities in a milieu that promote wellness, empowerment, a sense of community, personal responsibility, self-esteem, and hope; these activities are consumer-centered; they provide socialization, daily skills development, crisis support, and promotion of self-advocacy ▪ Family psychoeducation and support for families and significant others
Peer Supports	<ul style="list-style-type: none"> ▪ Peer specialists will provide peer support services. Peer specialists use lived experience to help individuals and their families understand and develop the skills to address their SUD and other health conditions; core functions include: <ul style="list-style-type: none"> ○ Providing recovery, health, and wellness supports



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SUD Community Intervention and Treatment Service	Description
	<ul style="list-style-type: none"> ○ Supporting individuals in accessing community-based resources and navigating state and local systems ○ Providing employment supports, including educating individuals regarding services and benefits available to assist in transitioning into and staying in the workforce; and ○ Promoting empowerment and a sense of hope through self-advocacy.
Skilled Therapy Services	<ul style="list-style-type: none"> ▪ Services provided by or under the direction of licensed practitioners that include, but may not be limited to: <ul style="list-style-type: none"> ○ Clinical assessment ○ Individual, group, and family therapy or diagnosis-specific practices; and ○ Medication evaluation, management, and consultation with primary care and other medical providers.
Residential Treatment	<ul style="list-style-type: none"> ▪ Residential treatment: intensive SUD treatment, skill building, community reintegration and/or specialized assessment services to assist recovery and to support community living ▪ Recovery housing supports: SUD services and supports targeted to individuals in recovery residences with a focus on accessing community-based resources including housing and permanent supportive housing
Withdrawal Management	<ul style="list-style-type: none"> ▪ Time-limited services and supports that assist individuals in resolving a severe SUD crisis safely in their community, including: <ul style="list-style-type: none"> ○ Screening for withdrawal management needs ○ Determination of appropriate placement for individuals intoxicated or experiencing withdrawal and in need of withdrawal management services ○ Medical evaluation and consultation ○ Individual and group therapies to enhance the individual’s understanding of addiction and support the completion of the withdrawal management process; ○ Health education services, diversion programs, community crisis placements; and ○ Individual treatment planning and support in accessing ongoing community-based resources.
Counseling	<ul style="list-style-type: none"> ▪ Services directed toward the development and restoration of skills or the elimination of psychosocial barriers that impede the



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SUD Community Intervention and Treatment Service	Description
	development or modification of skills necessary for independent functioning in the community

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

As a risk-bearing MCO, DVHA will assume responsibility for managing benefits across the full continuum of enrollees’ health and health-related needs including those that relate to social factors that influence health. The Global Commitment demonstration authorizes benefits that give Vermonters expanded access to different settings and modalities of services across the care continuum. Many of these services are less costly alternatives to other types of care and are central to Vermont’s efforts to address health disparities among Vermonters with disabilities. Today, adults in Vermont who have any disability are eight times more likely to report fair or poor health compared to those who do not have a disability.¹⁸ Vermont provides access to a wide range of HCBW-like services so that, to the maximum extent possible, all State residents can choose community living, while accessing necessary supports to maintain and improve their health. With the demonstration renewal, Vermont is seeking to continue to strengthen its health ecosystem, offering a more comprehensive array of services to enrollees.

Continuing Features Supporting Innovative Care Models

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

Continuing Features Without Modifications

Enhanced Hospice Benefit. Under the Global Commitment demonstration, Vermont offers an enhanced hospice benefit to individuals with life-limiting illnesses. The hospice benefit allows individuals with life expectancy of twelve months or less to access hospice care while still continuing curative therapies.

Palliative Care Program. The Palliative Care Program allows children who have been diagnosed with life-limiting illnesses to receive both curative services and palliative care services to ease pain and discomfort from the illness and/or treatment regimen. The program is available to Medicaid-enrolled children under age 21 with incomes up to 300% FPL who are at any stage

¹⁸ “Behavioral Risk Factor Surveillance System: 2018 Report.” Vermont Department of Health, 2018. https://www.healthvermont.gov/sites/default/files/documents/pdf/HSVR_2018_BRFSSReport.pdf



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of illness. Services available to children and their families through the Palliative Care Program include expressive therapy, care coordination, family/caregiver training, respite for caregivers, and family grief support/counseling.

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

Continuing Features With Modifications

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

- Reimburse legal guardians of CFC enrollees, in addition to spouses, for providing personal care services when necessary to fulfill a specific unmet need of the enrollee; and
- Reimburse legal guardians of CFC enrollees for providing respite and companion services when necessary to fulfill a specific unmet need of the enrollee.

The State will continue existing safeguards to ensure that care provided by spouses or legal guardians promote the health, safety, and welfare of enrollees.



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CRT. CRT provides recovery-oriented community mental health services for over 2,300 individuals with SMI as of February 2021. The CRT benefits package includes service coordination, flexible support, skilled therapy services, counseling, residential treatment, supported employment, environmental safety devices, and crisis and community supports. In the renewal period, Vermont is seeking to offer an enhanced dental benefit through the CRT program and update the benefit package for the CRT expansion group to include peer supports. (As described elsewhere in this application, Vermont intends to add a peer supports benefit to its State Plan.). Vermont also intends to align the CRT benefit package outlined in the demonstration STCs with the benefit package authorized by State policy, which does not include respite. Practically, while the demonstration STCs will no longer list respite as a benefit, the change will not impact on benefits available to Vermonters enrolled in CRT.

Developmental Disabilities Services. The Developmental Disabilities Services HCBW-like program supports individuals with developmental disabilities in making choices about how and where they live, allowing them to pursue their individual goals and preferences within their chosen communities. The demonstration authorizes a range of HCBW-like services, including service coordination, residential habilitation, day habilitation, supported employment, crisis services, clinical intervention, respite, and self-directed care. The Developmental Disabilities Services program currently provides HCBW-like services to over 3,200 individuals with developmental disabilities and has helped 49% of enrolled Vermonters with developmental disabilities who are of working age gain employment. In the renewal period, Vermont is seeking to offer an enhanced dental benefit through the Developmental Disabilities program. In addition, Vermont seeks authority to reimburse parents of a minor child, spouses, and legal guardians providing personal care services to individuals enrolled in the Developmental Disabilities Services program when necessary to fulfill a specific unmet need of the enrollee. The State will institute safeguards to ensure that services provided by parents of a minor child, spouses, or legal guardians promote the health, safety, and welfare of enrollees. Payments to parents, spouses, and legal guardians providing these services will be effective upon promulgation of State policy necessary to effectuate this new benefit.

Brain Injury Program. The Brain Injury Program (previously called the Traumatic Brain Injury Program) provides an alternative to facility-based care by offering rehabilitation-focused services and supports to help individuals with a brain injury. It provides over 80 Vermonters who have brain injuries a range of home and community-based options oriented toward rehabilitation and recovery, such as crisis/support services, psychological and counseling supports, case management, habilitation, respite care, supported employment, environmental and assistive technology, and self-directed care. In the renewal period, Vermont is seeking authority to provide reimbursement to parents of a minor child, legal guardians, and spouses providing life skills aide services and community supports to individuals enrolled in the Brain Injury Program when necessary to fulfill a specific unmet need of the enrollee. The State will institute safeguards to ensure that services provided by parents of a minor child, spouses, or legal guardians promote the health, safety, and welfare of enrollees. Payments to parents of a minor child, legal guardians,



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and spouses providing these services will be effective upon promulgation of State policy necessary to effectuate this new benefit.

Children’s Personal Care Services. Under its State Plan, Vermont offers children’s personal care services to children with special health needs who need assistance with activities of daily living. During the COVID-19 public health emergency (PHE), Vermont obtained authority through its Appendix K to reimburse parents of a minor child and legal guardians providing personal care services to children. Based on feedback from families, Vermont is requesting to continue this flexibility after the expiration of temporary flexibilities and programmatic changes resulting from the PHE when necessary to fulfill a specific unmet need of the enrollee. The State will institute safeguards to ensure that services provided by parents of a minor child or legal guardians promote the health, safety, and welfare of enrollees. Payments to parents and legal guardians providing these services will be effective upon promulgation of State policy necessary to continue this benefit beyond the PHE. In addition, Vermont is seeking to institute a self-direction option for children’s personal care services.

Waivers of the Institution for Mental Diseases (IMD) Exclusion for Mental Health and SUD Treatment. Vermont’s IMDs are a critical part of its mental health and SUD delivery system, offering residential and inpatient levels of care for Vermonters. Waivers of the IMD exclusion for mental health and SUD treatment support the State’s ability to provide access to a full continuum of mental health and SUD services, ranging from prevention to community-based treatment to residential and inpatient treatment. The State believes this full continuum of care is critical for ensuring there is sufficient community-based treatment capacity to prevent IMD stays, providing access to residential and inpatient treatment when necessary, and supporting individuals in the community upon discharge from a psychiatric facility. Over the course of the current demonstration period, Vermont has met CMS’s requirements that statewide average length of stay for mental health and SUD treatment at IMDs be at or below 30 days. In the renewal period, Vermont anticipates continuing to meet this requirement and requests that CMS align requirements for the two waivers. Specifically, Vermont is requesting that CMS remove its prohibition on federal financial participation (FFP) for individuals obtaining mental health treatment in an IMD for longer than 60 days, as is permitted under Vermont’s waiver of the IMD exclusion for SUD treatment. For certain patients, longer lengths of stay are medically necessary to meet individualized needs, and this flexibility is particularly critical to adequately treat the most acute, clinically complex patients who require longer hospitalization. Notably, research indicates patients staying in state psychiatric hospitals for 32 days or fewer are significantly more likely to be readmitted within 30 days of discharge than patients whose stays last over 32 days.¹⁹ Vermont IMD data support this request; in Vermont’s IMDs, the readmission rate for stays of 30

¹⁹ Ortiz, G., “Predictors of 30-day Post-discharge Readmission to a Multistate National Sample of State Psychiatric Hospitals.” *Journal for Healthcare Quality: official publication of the National Association for Healthcare Quality*, 2019.



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or more days is lower than shorter stays.²⁰ The State will continue to meet maintenance-of-effort requirements for spending on outpatient community-based mental health services as specified in its current demonstration.

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

Under the inpatient exception to the inmate exclusion, states are able to obtain Medicaid reimbursement for Medicaid-eligible inmates when the inmate is admitted as an inpatient at a medical institution for a stay of at least 24 hours. Given that Vermont’s IMDs are held to the same standards as acute care hospitals, Vermont believes that its IMDs qualify as medical institutions under federal rules (42 CFR §435.1010), and as a result, inmates that are admitted to an IMD for a stay of at least 24 hours qualify for federal Medicaid matching funds.

New Features Supporting Innovative Care Models

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

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

Vermont is a national leader in access to and quality of mental health treatment. As noted earlier in this application, Mental Health America has named Vermont as the top state nationally for

²⁰ “Vermont Global Commitment to Health Section 1115(a) Medicaid Demonstration 11-W-00194/1: Phase-Down Plan for Vermont’s Psychiatric Institutions for Mental Disease (IMDs).” Vermont Global Commitment to Health Section 1115(a) Medicaid Demonstration 11-W-00194/1. State of Vermont, December 31, 2018. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/Global-Commitment-to-Health/vt-global-commitment-to-health-phase-down-plan-12312018.pdf>.



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access to mental health care.²¹ Vermont’s Hub and Spoke system of care for opioid treatment is consistently cited as a national model. Vermont offers a full continuum of mental health and SUD services, ranging across prevention, community-based treatment, and residential and inpatient treatment services. The waivers of the IMD exclusion under the Global Commitment demonstration provide critical support for maintaining and strengthening Vermont’s comprehensive service arrays for mental health and SUD treatment.

While the State endeavors for individuals to obtain community-based mental health and SUD treatment to the maximum extent possible, as referenced above, there are instances when residential or inpatient treatment is medically necessary. Vermont’s IMDs provide high-quality residential and inpatient care, performing better than the State’s Medicaid program as a whole and the national HEDIS benchmark on measures of the percentage of enrollees with follow-up after hospitalization for mental illness at the 7-day and 30-day mark. In addition, Vermont’s IMDs have lower 30- and 180-day readmission rates than psychiatric care provided in general settings (8% v. 9% 30-day readmission rate and 17% v. 20% 180-day readmission rate, respectively).²² Under the Global Commitment renewal, Vermont proposes to expand coverage for mental health and SUD care provided at family-focused residential treatment programs.

Vermont’s Lund Home, an IMD with 26 beds, provides mental health and SUD treatment to pregnant women, postpartum women, and mothers with children up to age five in a setting that allows the family to stay and be treated together. Ninety-four percent of women who obtain services at Lund Home have co-occurring SUD and mental health diagnoses, and 52% were homeless at the time of admission to Lund Home.²³ All stays at the Lund Home last more than 60 days because of the holistic set of treatment services and wraparound supports provided to create stability for families during a time of transition. The facility provides a range of family-centered, trauma-informed treatment services, including:

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

²¹ “Access to Care Data 2021.” Mental Health America, n.d. <https://www.mhanational.org/issues/2021/mental-health-america-access-care-data>.

²² Vermont Global Commitment to Health Section 1115(a) Medicaid Demonstration 11-W-00194/1: Phase-Down Plan for Vermont’s Psychiatric Institutions for Mental Disease (IMDs).” Vermont Global Commitment to Health Section 1115(a) Medicaid Demonstration 11-W-00194/1. State of Vermont, December 31, 2018. <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/Global-Commitment-to-Health/vt-global-commitment-to-health-phase-down-plan-12312018.pdf>.

²³ Lund Home. “Lund Home Residential Treatment Program Overview.” 2021.



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- Transition planning

Research shows that family-centered SUD treatment is associated with a range of benefits for both the parent and child, including stronger retention in treatment, reduced substance use, lower risk of child abuse, and improved psychosocial outcomes for both the parent and child.²⁴ In 2020, 77% of women discharged from Lund Home showed decreased frequency in substance misuse, and 81% showed improvement in life skills functioning at discharge. Further, Lund Home promoted healthy pregnancies among residents, with 91% of pregnant women in the Lund Home program having healthy pregnancies, and 100% abstaining from illicit substance use while pregnant.²⁵

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

2. Permanent Supportive Housing Pilot

In the past 15 years of the Global Commitment demonstration, Vermont has made significant progress in allowing Medicaid enrollees to obtain care in their homes and communities if they so choose. To further support these individuals in securing and maintaining housing appropriate for their needs, Vermont is seeking expenditure authority for a Permanent Supportive Housing Pilot program. Studies conducted across the United States have shown that permanent supportive housing programs are effective not only in reducing homelessness, but also in preventing ED use and hospitalization, and reducing overall health care costs for high-need individuals.²⁶

While Vermont has access to supportive housing vouchers through the Department of Housing and Urban Development (HUD), the State has been unable to use all of the vouchers in recent years due to lack of available support services. In establishing the Permanent Supportive Housing Pilot, Vermont seeks to provide individuals with the services they need to successfully transition into and maintain residency in permanent supportive housing in close coordination and collaboration with agencies that provide rental assistance.

Through the Pilot program, eligible individuals would have access to pre-tenancy supports, tenancy sustaining services, and community transition services, as described in more detail in

²⁴ “Implementing a Family-Centered Approach.” National Center on Substance Abuse and Child Welfare. Accessed April 13, 2021. <https://ncsacw.samhsa.gov/files/fca-practice-module-1.pdf>.

²⁵ Lund Home. “Lund Home Residential Treatment Program Overview.” 2021.

²⁶ “Evidence That Supportive Housing Works.” Housing Tool Kit. The City of Santa Clara. Accessed April 13, 2021.

<https://housingtoolkit.sccgov.org/sites/g/files/exjcpb501/files/Evidence%20That%20Supportive%20Housing%20Works.pdf>.



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Table 3 below. Vermont will select supportive housing service providers for this program through a procurement process.

Improving access to permanent supportive housing is an important strategy for promoting equity and reducing racial disparities in homelessness in Vermont. In 2018, a report from the National Alliance to End Homelessness found that Black Vermonters were 5.4 times more likely to experience homelessness than white Vermonters.²⁷ When conducting further design of the Permanent Supportive Housing Pilot, Vermont will seek stakeholder input in refining the Pilot eligibility criteria to ensure that the Pilot pursues equity and targets groups disproportionately impacted by homelessness, including Black Vermonters. In addition, Vermont will ensure that selected providers are experienced in or receive training on conducting outreach and delivering services to these groups.

Table 3. Permanent Supportive Housing Benefits

Permanent Supportive Housing Benefits	Illustrative Services Provided Under Benefit
Pre-tenancy supports	<ul style="list-style-type: none"> ▪ Housing needs assessment ▪ Assistance with locating and applying for housing ▪ Housing support plan development
Tenancy sustaining services	<ul style="list-style-type: none"> ▪ Assistance with maintaining benefits, such as TANF, Section 8 housing vouchers, Shelter Plus, or other rental assistance ▪ Connections to community resources ▪ Supports to develop independent living skills ▪ Eviction prevention services ▪ Home modifications to improve accessibility ▪ Coverage of expenses associated with landlord risk mitigation
Community transition services for all enrollees moving to permanent supportive housing, regardless of the setting they are moving from	<ul style="list-style-type: none"> ▪ Security deposits ▪ Utility deposits ▪ Moving expenses ▪ Household furnishings ▪ Pest eradication

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



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Table 4. Permanent Supportive Housing Pilot Eligibility Criteria

Health-Based Criteria <i>Individual meets at least one of the following criteria</i>	Risk-Based Criteria <i>Individual meets at least one of the following criteria</i>
<ul style="list-style-type: none"> ▪ Individual has a mental health or substance use need ▪ Individual has an acquired brain injury ▪ Individual assessed to have a need for assistance, demonstrated by the need for assistance with two or more ADLs; or hands-on assistance with one or more ADLs ▪ Individual assessed to have a complex physical health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support), resulting from the presence of a continuing, progressive, or indefinite physical condition, development or cognitive disability, or an emotional medical condition ▪ Individual assessed to have measurable delays in cognitive development and significant observable and measurable delays in at least two of the following areas of adaptive behavior: communication, social/emotional development, motor development, daily living skills ▪ Individual has one or more Medicaid-eligible dependents that meet the health-needs criteria 	<ul style="list-style-type: none"> ▪ At risk of homelessness, as defined by AHS/HUD ▪ Homelessness ▪ History of frequent or lengthy stays in an institutional or residential setting over the past 12 months ▪ History of frequent ED visits and/or hospitalizations over the past 12 months ▪ History of involvement with the criminal justice system over the past 12 months ▪ History of frequent moves or loss of housing as a result of mental health or SUD symptoms ▪ At serious risk of institutionalization

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



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Goal 3: Engaging Vermonters in Transforming Their Health

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

- Preventive health services and social supports (e.g., support for community clinics and federally-qualified health center (FQHC) lookalikes, early intervention services, and Special Supplemental Nutrition Program for Women, Infants and Children (WIC) coverage) that enable Vermonters, particularly Medicaid enrollees and other low-income residents, to stay healthy, age at home, and achieve their life goals;
- Optimizing access to essential health care services, such as mental health outpatient services and SUD treatment for all Vermonters, preventing crises or general worsening of significant health conditions that could lead to job loss and/or a need for facility-based care; and
- Maintaining and improving public health infrastructure, including epidemiology, tobacco cessation initiatives, vaccination, and fluoride treatment.

New Features to Engaging Vermonters in Transforming Their Health

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

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

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



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

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

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

- Almost half of all Vermonters are attributed to a Blueprint patient-centered medical home (PCMH).
- In 2017, Vermont's Physician and Dentist Loan Repayment Program made loan repayment grants to 60 nurses, 63 primary care physicians and 10 dentists, who in exchange committed to one or more years of service to an underserved area of the State.²⁷

²⁷ Physician/Dentist loan repayment program. (n.d.). Retrieved April 14, 2021, from <https://embed.resultsscorecard.com/Program/Embed/26557?navigationCount=1>.



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- In 2017, over 1,000 students took part in Vermont’s health career awareness programs provided by Area Health Education Centers, including over 500 students from communities that have been economically/socially marginalized.
- In 2018, over 75% of one-year old children and 70% of two-year-old children were tested for blood lead through the lead poisoning prevention program.²⁸
- Vermont’s tobacco control program prevents 800 deaths each year through initiatives including the tobacco cessation hotline, online tobacco cessation program, and local secondhand smoke mitigation strategies.²⁹

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

1. **Workforce development** initiatives funded through the Global Commitment demonstration help ensure that Vermont has sufficient access to care—a particular concern given the State’s rural nature. These initiatives include loan repayment programs for health care professions, provision of geographically accessible nursing education, and educational partnerships.³⁰ Vermont seeks \$4.75 million (total computable) over the five years of the demonstration to support workforce development initiatives.
2. **Public health infrastructure** supported under the Global Commitment demonstration has provided services critical to creating a healthy Vermont. Vermont’s strong public health infrastructure provides Vermonters with services to prevent chronic and infectious diseases; treat and recover from acute and chronic conditions; and respond to crisis situations. These programs include:
 - Preventive services such as immunizations and fluoride treatment;
 - Tobacco cessation program;
 - Poison control and a lead poisoning prevention program;
 - Epidemiology program; and
 - Laboratory testing.

²⁸ Patient safety - adverse events. (n.d.). Retrieved April 14, 2021, from <https://embed.resultsscorecard.com/Program/Embed/26558?navigationCount=1>

²⁹ Tobacco cessation community coalition. (n.d.). Retrieved April 14, 2021, from <https://embed.resultsscorecard.com/Program/Embed/26574?navigationCount=1>.

³⁰ Area Health Education Centers Score Card. (2020). Retrieved April 14, 2021, from <https://embed.resultsscorecard.com/Program/Embed/26554?navigationCount=1>.



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

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

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

Vermont recognizes that strong care coordination, population health management, and health information exchange (HIE) capabilities will be crucial to DVHA’s success in becoming a risk-bearing MCO; engaging providers in whole-person care models and alternative payment mechanisms; and preparing providers to implement more sophisticated models of care and VBP. In addition, strengthening these capabilities is critical to Vermont’s efforts to promote health equity. Today, Vermonters of color are less likely than white Vermonters to have a usual primary care provider, and adults who are Native American/Alaska Native and multi-racial are more likely to report fair or poor general health when compared to other races and ethnicities.³¹ By building upon its already extensive capabilities in these areas over the course of the Global Commitment renewal, DVHA aims to improve individual and population-level health outcomes while reducing health disparities. Vermont’s priorities for the demonstration period are described below.

Continuing Features to Strengthen Care Coordination and Population Health

Continuing Features Without Modification

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

The Blueprint program—an established multi-payer delivery system reform engine that drives local health reform—touches most Vermonters and offers a suite of care coordination initiatives designed to promote integrated care. Key components of the Blueprint model include:³²

³¹ “State Health Assessment 2018.” Vermont Department of Health, June 1, 2018.

https://www.healthvermont.gov/sites/default/files/documents/pdf/4%20Populations%20in%20Focus_0.pdf

³² “Annual Report on the Vermont Blueprint for Health.” Vermont Agency of Human Services, January 31, 2021.

http://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/BlueprintforHealthAnnualReportCY2020.pdf



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- **PCMH program.** Today, 134 primary care practices in Vermont—nearly all primary care practices in the State—participate in Blueprint’s multi-payer PCMH program.
- **Community Health Teams (CHTs).** Each of Vermont’s 13 Health Service Areas has a CHT designed to meet the needs of the local population that is essential to delivering community-based care coordination to Vermonters, including, but not limited to those attributed to the All-Payer ACO. CHTs are typically comprised of care coordinators, nurses, social workers, health coaches, health counselors, licensed drug and alcohol counselors, nurses, dietitians, diabetes educators, community health workers, and resource coordinators who are trained to help Vermonters navigate the health ecosystem. CHTs are equipped to connect Vermonters to a wide range of services and supports to address their whole person needs, including mental health and SUD services and other specialty care; wellness education; economic and community services; and public health programs.
- **Hub and Spoke System of Care.** Vermont’s Hub and Spoke system of care is a nation-leading model for opioid use disorder treatment that is recognized by CMS as a Health Home program. In this model, nine opioid treatment programs across the State are “hubs,” and 113 primary care practices, family medicine practices, OB-GYN practices, and other types of providers are “spokes” that offer MAT. Given that MAT services are co-located with physical health care settings, spokes provide fully integrated care that addresses the whole spectrum of patients’ needs.
- **Women’s Health Initiative (WHI).** At participating OB-GYN and family medicine practices, WHI provides enhanced services targeting whole-person health, including SDOH screening and access to family planning services.
- **Community Self-Management Program.** Blueprint provides workshops to help Vermonters learn skills to better manage chronic conditions.
- **Data and Analytics.** Analysis of multi-payer claims and clinical data support delivery reform and evaluation of quality and cost outcomes.

In addition, Vermont provides high-quality case management through its HCBW-like programs and operates VCCI, a complex case management program targeted to Medicaid members with complex care and social needs or high utilization. VCCI also provides screening and intervention for new Medicaid enrollees who have not yet been attributed to the All-Payer ACO. The SASH program coordinates the resources of social-service agencies, community health providers and nonprofit housing organizations to support Vermonters who choose to live independently at home.

Finally, Vermont has strong care coordination and population health capabilities through the State’s single All-Payer ACO. The All-Payer ACO contracts with community-based providers including Blueprint PCMHs, Designated Agencies (Vermont’s community-based mental health agencies), Specialized Services Agencies, Home Health Agencies, Area Agencies on Aging, and SASH, to conduct care coordination for individuals attributed to the All-Payer ACO. The All-Payer ACO uses a four-quadrant care model for population health management, which segments the population based on health risk. For each “quadrant” of the population, the All-Payer ACO



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implements programs tailored to the needs of the specific subpopulation. To support these care coordination activities and broader population health management, the All-Payer ACO provides its network with a standardized care management platform and user training.

New Features to Strengthen Care Coordination and Population Health

1. Advancing Integration in Care Coordination

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

While Vermont currently offers a variety of high-quality care coordination models, there are differences across models and regions of the State. Vermont has determined that there are opportunities to advance integration through greater alignment across the State in addition to across programs offering care coordination through Medicaid, the All-Payer ACO, and other payers. Over the course of the Global Commitment renewal, Vermont plans to align statewide expectations for care coordination to ensure that all Vermonters equally benefit from efforts to promote integration. Specific areas where greater alignment is planned include:

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



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

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

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

Recognizing that data exchange is crucial to providing integrated care and conducting effective population health management, in recent years Vermont has prioritized expanding HIE capacity within the State. As of 2020, 568 providers were sharing and receiving data through the VHIE. Simultaneously, Vermont is also significantly expanding the amount of data available through the VHIE, and as of December 2020, over 98% of Vermonters consented to sharing their health data via the VHIE.

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



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

1. **Evaluate gaps in data storage, utilization, and sharing.** Vermont will evaluate how Medicaid providers currently store, access, utilize, and share information about the full range of enrollee needs and associated service utilization. Based on the findings, Vermont will determine how to close gaps that are identified. In particular, Vermont seeks to learn how both medical and specialty providers—including mental health, SUD, and LTSS providers—access and share demographic, eligibility, assessment, care plan, and treatment data to better understand readiness of targeted providers to participate in VBP reforms or transition to higher levels or more integrated VBP arrangements. Vermont seeks expenditure authority for \$500,000 total computable over the five-year demonstration period to implement this initiative.
2. **Reduce inequities in data access and sharing capabilities to allow a cross-sector of providers to participate in VBP reforms.** After evaluating data collection and exchange needs, Vermont will provide funding to assist providers, including historically under-resourced providers, in purchasing data systems, including electronic health records (EHRs) and care coordination tools, and connecting to the VHIE. Concurrently, the State will develop a targeted technical assistance program to provide support for Medicaid providers seeking to access, utilize, and share data to support integrated care coordination and population health management. Vermont anticipates that by enhancing providers' abilities to capture data and use it meaningfully in care coordination and population health management, providers will be better prepared to participate in more sophisticated VBP arrangements. Technical assistance will address:
 - Efforts to capture SDOH, race, and ethnicity data and communication with and referrals to social service providers and state and local human services agencies that have historically not been connected to health data and health systems;
 - Medicaid providers' selection, procurement, and modification of care coordination and EHR data systems to meet care coordination, quality improvement, and reporting needs, and help providers connect to the VHIE; and
 - Efforts to standardize data collection to improve efficiency of data collection processes.

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

3. **Leverage health data to enhance population health management and program improvement.** Vermont will develop a series of analytic reports and tools using data from the VHIE and other sources to improve management of individuals with high utilization across the care continuum, support program monitoring, and analyze impacts



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of service or program changes. Other efforts to improve care coordination, program operations, and analytics will include:

- Developing reports to support effective risk stratification across the Medicaid population, which will supplement risk stratification reports from the ACO by focusing on a broader set of services;
- Aligning measures and reporting requirements across programs to reduce reporting burden and encourage provider participation in quality improvement and VBP arrangements;
- Using electronic clinical quality measure (eCQM) data to optimize providers' ability to assess quality and outcomes;
- Implementing a reporting and analytics platform to standardize and extract reports, for both patient- and population-level measures, through an application programming interface (API) connected to the VHIE;
- Leveraging patient and aggregated population-level data to support rapid sharing of disease surveillance data, inform and monitor public health activities, and improve quality of life; and
- Expanding use of new reporting and analytic technologies to harness the power of integrated data for improving outcomes, reducing cost, and enabling informed decision making.

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

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



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Goal 5: Accelerating Groundbreaking Payment Reform

Continuing Features to Accelerate Groundbreaking Payment Reform

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

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

Reflecting the varying degrees of readiness among different provider types to participate in VBP arrangements, these initiatives are at varying levels of sophistication, spanning HCP-LAN Categories 1 through 3 and ranging from monthly prospective or retrospective case rates to episodic payments, with some initiatives incorporating pay-for-reporting and/or pay-for-performance incentives. Vermont's existing Global Commitment demonstration flexibilities, including the ability to set provider rates on an individual or class basis that departs from State Plan rates, have facilitated the success of these models thus far and will continue to be necessary to advance payment innovation. To support its future vision for payment reform, Vermont is seeking to retain this flexibility as part of its demonstration renewal, while continuing to comply with requirements for states' payments to managed care plans under 42 CFR §438.6(c).

New Features to Accelerate Groundbreaking Payment Reform

During the demonstration renewal period, Vermont will continue refining the mental health, SUD, and developmental disabilities payment models referenced above and will test multiple new models of risk. For example, Vermont is considering demonstrating new payment initiatives for SUD outpatient services, children's palliative care, and school-based mental health services. Ultimately, the targeted payment reform initiatives that the State tests under the demonstration renewal will guide DVHA's strategy for transitioning additional populations and services to HCP-LAN Category 4 arrangements. While Vermont does not require additional waiver authorities to implement these arrangements in the renewal period, the authority to operate as a risk-bearing MCO is essential to the State meeting this goal. The flexibility of the risk-bearing



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MCO model will enable DVHA to institute new and enhanced provider payment models and requirements that incentivize referrals to health and health-related services (including in lieu of services, value-added services, and population health initiatives) that improve population health and address SDOH for all Vermonters. In the longer run, DVHA will consider a transition to a total cost of care model for these services and populations (mental health, SUD, developmental disability, and other LTSS).

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



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Other Demonstration Features

Eligibility and Benefits

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

Table 5. Global Commitment Demonstration Populations

Population	Population Description	Benefits	Proposed Changes for New Demonstration Period
<i>Mandatory and Optional State Plan Groups³³</i>			
1. Mandatory State Plan Populations	Mandatory State Plan populations, except for the ACA new adult group (included in Population 3) and Medicare Savings Program beneficiaries (included in Population 8).	State Plan benefits	State intends to cover a number of new benefits under the State Plan, including a subset of investments authorized under the current demonstration, as described in this application.
2. Optional State Plan Populations	Optional State Plan populations (including medically needy).	State Plan benefits	State intends to cover a number of new benefits under the State Plan,

³³ Inmates who are within 90 days of release will receive the benefit package associated with their eligibility group.



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Population	Population Description	Benefits	Proposed Changes for New Demonstration Period
			including a subset of investments authorized under the current demonstration, as described in this application.
3. New Adult Group	New adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR §435.119, pursuant to the approved State Plan.	Benefits described in approved alternative benefit plan (ABP) State Plan Amendment (SPA)	State will update its ABP SPA to align with changes to the State Plan.
<i>Demonstration Expansion Populations</i>			
4. CFC Highest Needs Population	Individuals age 65 and older and age 18 and older with disabilities, not otherwise eligible under the State Plan, who meet the clinical criteria for the Highest Needs Group for CFC, and who would have been Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR §435.217, in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under the demonstration would have been provided under an HCBS waiver granted to the State under section	State Plan benefits plus HCBS covered for the CFC Highest Needs Group as described in the current demonstration STCs	State proposes minor changes to the CFC benefit package as described on page 24.



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Population	Population Description	Benefits	Proposed Changes for New Demonstration Period
	<p>1915(c) of the Act. This includes the application of the post-eligibility rules specified at 42 CFR §435.726, and of the spousal impoverishment rules specified at 1924 of the Act. This demonstration allows for a resource standard of \$10,000 for an unmarried individual who resides in and has an ownership interest in their principal place of residence.</p>		
<p>5. CFC High Needs Population</p>	<p>Individuals age 65 and older and age 18 and older with disabilities, not otherwise eligible under the State Plan, who meet the clinical criteria for the High Needs Group for CFC, and who would have been Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR §435.217, in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under the demonstration would have been provided under an HCBS waiver granted to the State under section 1915(c) of the Act. This includes the application of the post-eligibility rules specified at 42 CFR §435.726, and of the spousal impoverishment rules specified at 1924 of the Act. This demonstration also allows for a resource standard of \$10,000</p>	<p>State Plan benefits plus HCBS covered for the CFC High Needs Group as described in the current demonstration STCs</p>	<p>State proposes minor changes to the CFC benefit package as described on page 24.</p>



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Population	Population Description	Benefits	Proposed Changes for New Demonstration Period
	for an unmarried individual who resides in and has an ownership interest in their principal place of residence.		
6. CFC Moderate Needs Expansion Group	Individuals who have incomes below 300% SSI FBR and would be described in Populations 4 or 5 except that they meet the clinical criteria for the CFC Moderate Needs Group and are at risk of institutionalization.	Limited HCBS including adult day services, case management, and homemaker services	State proposes minor changes to eligibility criteria described on page 16-17 and minor changes to the CFC benefit package as described on page 24.
7. CRT Expansion Group	Individuals with SMI who have incomes above 133% FPL and are not otherwise eligible for Medicaid.	Limited community mental health services, including service coordination, flexible support, skilled therapy services, counseling, residential treatment, supported employment, environmental safety devices, and crisis and community supports.	State proposes covering CRT expansion group through expenditure authority instead of as a DSHP and investment; no eligibility changes are proposed. State also proposes minor changes to CRT benefit



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Population	Population Description	Benefits	Proposed Changes for New Demonstration Period
			package as described on page 17.
8. VPharm Group	Medicare beneficiaries who are 65 years or older or have a disability with income at or below 225% FPL, who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise categorically eligible for full benefits.	Medicaid prescriptions, eyeglasses and related eye exams; MSP beneficiaries also receive benefits as described in the State Plan	State proposes to expand benefits available to Medicare beneficiaries with incomes from 150% to 225% FPL as described on page 17.
9. SUD Community Intervention and Treatment Expansion Group	Individuals with a SUD as defined by the DSM-5 who have incomes from 133% FPL up to and including 225% FPL and are not otherwise eligible for Medicaid.	SUD Community Intervention and Treatment benefits as described in Table 2	New eligibility group



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Premiums and Cost Sharing

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

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

Vermont may charge Populations 1, 2, and 3 premiums and cost sharing in compliance with Medicaid requirements set forth in statute, regulation, and policy and Vermont’s Medicaid State Plan. Standard Medicaid exemptions from cost-sharing set forth in 42 CFR §447.56(b) will apply to the demonstration; Vermont will not apply co-payment requirements to children under 21, pregnant women, or individuals in long-term care facilities, or for excluded services/supplies (e.g., family planning). Premiums for children ages 0 through 18 who fall into the mandatory State Plan population (Population 1) will be as follows:

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

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

VPharm Group (Population 8)

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

Table 7. VPharm Premiums and Co-Payments

Population	Premiums	Co-Payments
Medicare beneficiaries with income up to and including 225% FPL, who may be enrolled in the MSP but are not otherwise categorically eligible for full benefits.	Premiums cannot exceed the following: <ul style="list-style-type: none"> ▪ 0-150% FPL: \$15/month/person ▪ 151-175% FPL: \$20/month/person ▪ 176-225% FPL: \$50/month/person 	Not to exceed the nominal co-payments specified in the Medicaid State Plan.



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Delivery System

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

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

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



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Section IV – Requested Waivers and Expenditure Authorities

Table 8. Requested Waiver and Expenditure Authorities

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



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Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
	<p>and scope of covered services meets the minimum requirements under title XIX of the Act for the group (if applicable).</p> <p>To allow the State to provide nursing facility services and HCBS based on relative need as part of the person-centered and options counseling process for new applications for CFC services; to permit certain individuals, based on need, to receive demonstration services in the same eligibility group, under the Medicaid State Plan, and to limit the amount, duration, and scope of services to those included in the participants' approved care plan.</p>		
<p>4. Financial Eligibility: Section 1902(a)(10)(C)(i)(III)</p>	<p>To allow the State to use institutional income rules (up to 300% SSI FBR) for HCBW-like programs besides CRT.</p> <p>To allow the State to use institutional income and resource rules for the Highest Need and High Need groups in the same manner as it did for the terminated 1915(c) waiver programs that were subsumed under the CFC demonstration in 2005.</p>	<p>Modified waiver language to clarify that institutional income rules are used for determining eligibility for HCBW-like programs besides CRT for both</p>	<p>✓</p>



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



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Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
	institutionalized persons who are receiving personal care attendant services at the onset of waivers.		
9. Financial Responsibility/ Deeming: Section 1902(a)(17)(D)	<p>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.</p> <p>To enable the State to disregard quarterly income totaling less than \$20 from the post-eligibility income determination.</p>	Currently approved	✓
10. Freedom of Choice: Section 1902(a)(23)(A)	<p>To enable the State to restrict freedom of choice of provider for the demonstration participants to the extent that beneficiaries will be restricted to providers enrolled in a provider network through DVHA for the type of service at issue, but may change providers among those enrolled providers. Freedom of choice of provider may not be restricted for family planning providers.</p>	Currently approved	✓



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Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
11. Direct Payments for Providers: Section 1902(a)(32)	To permit payments for incidental purchases for CFC HCBS to be made directly to beneficiaries or their representatives.	Currently approved	✓
12. Self-Direction of Children’s Personal Care Services: Section 1902(a)(32)	To permit beneficiaries to self-direct expenditures for children’s personal care services.	New request	
13. Retroactive Eligibility: Section 1902(a)(34)	To enable the State to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance is made for expansion groups (for Populations 6 and 8 only).	Currently approved	✓
Expenditure Authorities			
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: Demonstration Populations 4, 5, 6, 7, 8, and 9 as described in Section III of this application.	State requests to modify authority to include SUD Community Intervention and Treatment Expansion Group (Population 9)	✓ (for CFC Highest Needs Population (Population 4), CFC High Needs Population (Population 5), CFC Moderate Needs)



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Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
			Group (Population 6), CRT Expansion Group (Population 7), VPharm Group (Population 8)
2. Expenditures Related to Additional Services for HCBW-Like Programs	Expenditures for additional health care-related services (i.e., HCBW-like services) for all populations affected by or eligible through the demonstration as described in STC 20(c) in the currently approved Global Commitment demonstration.	Currently approved	✓
3. Expenditures for Public Health Initiatives, Outreach, Infrastructure, and Services Related to State Plan, Demonstration, Uninsured and Underinsured Populations	Expenditures to reduce the rate of uninsured and/or underinsured in Vermont, increase access to quality health care for uninsured, underinsured, and Medicaid beneficiaries, provide public health approaches and other innovative programs to improve the health outcomes and quality of life for Medicaid beneficiaries; and encourage the formation and maintenance of public private partnerships in health care; use of this expenditure authority will phase down over the five years of the demonstration.	State proposes that authority will phase down over five years of demonstration	



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Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
4. Expenditures for Hospice Services that Exceed State Plan Limits	Expenditures for adults eligible under the approved State Plan for hospice services that exceed State Plan limits.	Currently approved	✓
5. Expenditures for the Marketplace Subsidy Program	Expenditures for state-funded subsidy programs that aid certain individuals who purchase health insurance through the Marketplace.	Currently approved	✓
6. Expenditures for Mental Health CRT	Expenditures for mental health CRT services, as defined by Vermont rule and policy, to individuals with serious mental illness who have incomes above 133% FPL and are not otherwise eligible for Medicaid.	State proposes to modify request to reflect CRT transitioning to an expenditure authority	✓
7. Expenditures for SUD Community Intervention and Treatment	Expenditures for SUD Community Intervention and Treatment services, as defined by Vermont rule and policy, to individuals with SUD who have incomes above 133% FPL up to 225% FPL and are not otherwise eligible for Medicaid.	New request	
8. HCBW-like Services for State Plan Eligibles Who Meet	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-	Currently approved	✓



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Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
Highest Need, High Need, or Moderate Need Clinical Criteria for CFC	like services for the CFC program. The Moderate Needs Group does not meet all the CFC clinical criteria for long-term services, but are at risk of institutionalization. These individuals demonstrate a clinical need that shows they would benefit from a subset of HCBW-like services.		
9. Other CFC Expenditures	<ul style="list-style-type: none"> a. Expenditures for CFC participants with resources exceeding current limits, who are single, own and reside in their own homes, and select home-based care rather than nursing facility care, to allow them to retain resources to remain in the community. b. Expenditures for personal care services provided by CFC participants' spouses and legal guardians. c. Expenditures for respite and companion services provided by CFC participants' legal guardians. d. Expenditures for incidental purchases paid in cash allowances to participants who are self-directing their CFC services prior to service delivery. 	<p>State requests to modify (b) to indicate that services can be provided by legal guardians in addition to spouses.</p> <p>State requests to add (c) to permit reimbursement for respite and companion services provided by legal guardians.</p>	✓
10. Other HCBW-Like Expenditures	a. Expenditures for personal care services provided by Developmental Disabilities Services participants'	Currently approved for COVID-19 PHE;	



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Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
	<p>parents (for a minor child), spouses, and legal guardians.</p> <p>b. Expenditures for life skills aide services and community supports provided by Brain Injury Program participants' parents (for a minor child), spouses, and legal guardians.</p>	<p>State is seeking to extend authority beyond PHE</p>	
11. Children's Personal Care Expenditures	<p>Expenditures for children's personal care services covered under the State Plan that are provided by participants' parents and legal guardians.</p>	<p>Currently approved for COVID-19 PHE; State is seeking to extend authority beyond PHE</p>	
12. Full Medicaid Benefits for Presumptively Eligible Pregnant Women	<p>Expenditures to provide full Medicaid State Plan benefits to pregnant women determined presumptively eligible by a qualified hospital.</p>	<p>Currently approved</p>	<p>✓</p>
13. Residential and Inpatient Treatment for Individuals with Substance Use Disorder	<p>Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services</p>	<p>State requests waiver to reflect that stays at family-focused residential treatment programs</p>	



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Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
	<p>for SUD who are short-term residents in facilities that meet the definition of an IMD.</p> <p>Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are residents of family-focused residential treatment programs that meet the definition of an IMD, regardless of length of stay.</p>	<p>will be covered, regardless of length of stay</p>	
<p>14. Residential and Inpatient Treatment for Individuals with Serious Mental Illness</p>	<p>Expenditures for Medicaid State Plan services furnished to eligible individuals who are primarily receiving short-term treatment for an SMI in facilities that meet the definition of an IMD.</p> <p>Expenditures for Medicaid State Plan services furnished to eligible individuals who are primarily receiving treatment for an SMI in facilities providing family-focused residential treatment that meet the definition of an IMD, regardless of length of stay.</p>	<p>State requests waiver to reflect that stays at family-focused residential treatment programs will be covered, regardless of length of stay</p>	
<p>15. Permanent Supportive Housing Pilot</p>	<p>Expenditures for permanent supportive housing services provided to enrollees in the State’s Pilot program. The</p>	<p>New request</p>	



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



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Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/Expenditure Authority for Which Vermont Requests CMS Consider 10-Year Approval
20. Public Health Infrastructure	Expenditures not to exceed \$38 million over five years to sustain and strengthen Vermont's public health infrastructure.	New request (currently covered as an investment)	✓



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

External Quality Review (EQR)

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

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

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

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



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Section VI – Financial Data

Expected Enrollment

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

Table 9. Historical Member Months

	Historical Member Months				
	DY12	DY13	DY14	DY15	DY16
Medicaid Eligibility Group	Jan - Dec 2017	Jan - Dec 2018	Jan - Dec 2019	Jan - Dec 2020	Jan - Dec 2021
ABD - Non-Medicare - Adult	94,629	83,071	81,293	79,935	77,526
ABD - Non-Medicare - Child	28,865	25,577	23,855	19,982	19,608
ABD - Dual	255,478	257,263	257,866	259,965	265,735
Non-ABD - Non-Medicare - Adult	157,964	143,377	104,150	111,956	120,331
Non-ABD - Non-Medicare - Child	730,744	723,120	703,957	713,975	714,480
Total Medicaid Population	1,267,680	1,232,408	1,171,121	1,185,813	1,197,680
Hypothetical Populations					
New Adult	715,258	695,768	656,444	720,942	718,657
SUD IMD	-	1,248	2,140	1,769	1,769
SMI IMD	-	-	-	352	352
Other Populations					
Moderate Needs	2,960	2,319	2,208	1,991	1,991
VPharm	131,610	126,280	121,667	119,707	119,707



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

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

Table 10. Projected Member Months

	Projected Member Months				
	DY17	DY18	DY19	DY20	DY21
With Waiver Member Months	Jan - Dec 2022	Jan - Dec 2023	Jan - Dec 2024	Jan - Dec 2025	Jan - Dec 2026
ABD - Non-Medicare - Adult	76,466	75,758	75,056	74,360	73,671
ABD - Non-Medicare - Child	19,547	19,486	19,425	19,365	19,304
ABD - Dual	207,723	209,202	210,691	212,191	213,702
Non-ABD - Non-Medicare - Adult	120,581	119,934	119,290	118,649	118,012
Non-ABD - Non-Medicare - Child	712,877	711,279	709,683	708,092	706,503
Long-Term Care and CFC Highest/High Needs	63,940	64,972	66,021	67,087	68,171



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	Projected Member Months				
	DY17	DY18	DY19	DY20	DY21
New Adults	719,749	714,046	708,388	702,775	697,206
CFC Moderate Needs Group	2,317	2,354	2,392	2,431	2,470
VPharm	115,881	114,014	112,178	110,371	108,593
SUD Community Intervention and Treatment Group	13,825	13,825	13,825	13,825	13,825
CRT Expansion Group	2,621	2,621	2,621	2,621	2,621
Total	2,055,528	2,047,491	2,039,571	2,031,767	2,024,079

Projected Expenditures

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

Table 11. Historical Expenditures

	Historical Expenditures (in \$M)				
	DY 12	DY13	DY14	DY15	DY16
Historical Expenditures	Jan - Dec 2017	Jan - Dec 2018	Jan - Dec 2019	Jan - Dec 2020	Jan - Dec 2021
ABD - Non-Medicare - Adult	\$181.5	\$181.9	\$184.6	\$194.6	\$199.4
ABD - Non-Medicare - Child	\$74.3	\$67.1	\$63.8	\$60.6	\$62.1
ABD - Dual	\$513.6	\$533.1	\$543.0	\$524.9	\$537.7
Non-ABD - Non-Medicare - Adult	\$93.8	\$94.2	\$73.7	\$76.6	\$78.4



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	Historical Expenditures (in \$M)				
	DY 12	DY13	DY14	DY15	DY16
Non-ABD - Non-Medicare - Child	\$341.1	\$375.2	\$384.6	\$365.9	\$374.8
New Adults	\$330.0	\$348.8	\$345.6	\$402.9	\$400.0
Total Expenditures	\$1,534.3	\$1,600.3	\$1,595.4	\$1,625.5	\$1,652.3

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

Projected expenditures include the following program changes:

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

Vermont believes these projections accurately reflect ongoing efforts to ensure adequate access to health coverage while also controlling health care costs statewide. Vermont will continue to work with CMS on these projections to ensure they align adequately to the approved programs and meet the goals of budget neutrality.



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Table 12. Projected Expenditures

	Projected Expenditures (in \$M)				
	DY17	DY18	DY19	DY20	DY21
With Waiver Expenditures*	Jan - Dec 2022	Jan - Dec 2023	Jan - Dec 2024	Jan - Dec 2025	Jan - Dec 2026
ABD - Non-Medicare - Adult	\$188.9	\$194.2	\$199.7	\$205.4	\$211.2
ABD - Non-Medicare - Child	\$67.7	\$69.8	\$72.0	\$74.3	\$76.6
ABD - Dual	\$258.4	\$268.9	\$279.9	\$291.3	\$303.2
Non-ABD - Non-Medicare - Adult	\$98.9	\$101.1	\$103.4	\$105.8	\$108.2
Non-ABD - Non-Medicare - Child	\$451.1	\$460.5	\$470.0	\$479.7	\$489.7
Long-Term Care and CFC Highest/High Needs	\$466.2	\$475.7	\$485.5	\$495.4	\$505.6
New Adults	\$376.5	\$395.3	\$415.1	\$435.9	\$457.8
CFC Moderate Needs Group	\$2.0	\$2.1	\$2.2	\$2.4	\$2.6
VPharm	\$26.6	\$27.2	\$27.8	\$28.4	\$29.0
SUD Community Intervention and Treatment Group	\$3.9	\$4.0	\$4.2	\$4.3	\$4.4
CRT Expansion Group	\$14.8	\$14.8	\$14.8	\$14.8	\$14.8
Marketplace Subsidy**	\$5.8	\$5.7	\$5.7	\$5.6	\$5.6
Other CNOM**	\$16.0	\$16.0	\$16.0	\$16.0	\$16.0
Total Expenditures	\$1,976.7	\$2,035.5	\$2,096.3	\$2,159.3	\$2,224.5

*Expenditures include DVHA plan administrative expense.

**Excluded from DVHA rate.



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Section VII – Evaluation

Evaluation Results from the Current Demonstration

Background

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

1. Increase access to care;
2. Improve quality of care;
3. Improve community integration; and
4. Contain program costs

The Global Commitment to Health is a long-standing demonstration. While new initiatives and programs have been introduced, the demonstration has been using largely the same policies during the extension period that existed before 2017. Therefore, these findings are longitudinal and should not be interpreted as causal evidence for the impacts of the demonstration.³⁴

Findings

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

1. Goal 1: Access to Care

In assessing the demonstration’s performance around Access to Care, two research questions were examined.

Research Question: Will the demonstration result in improved access to care?

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

Hypotheses with interim findings of “True” provide support that the demonstration is associated with improvements in access to medical care. Strong performance in access to ambulatory and

³⁴ Additional information about evaluation of the Global Commitment demonstration can be found at the following link: <https://dvha.vermont.gov/global-commitment-to-health/evaluation-plans>.



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preventive visits, well-child visits, dental care, and adolescent well care was evident. All measures showed statistically significant improvement over baseline. Access to MAT also has increased in each year of the demonstration.

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

Research Question: Will VBP models increase access to care?

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

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

2. Goal 2: Quality of Care

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

Research Question: Will the demonstration result in improved quality of care?

Relative to this research question, interim findings were mixed. Three out of seven hypotheses returned an interim assessment of “True.”

Findings showed that ACO enrollees had statistically significant improvement in diabetes control, while ACO enrollee control of hypertension showed no statistically significant change over baseline. Improved rates of initiation and engagement in SUD treatment were evident for Medicaid members in the general population, ACO members, and those members who received SUD IMD services. In addition, only 3% of Developmental Disabilities Services program participants who participated in the National Core Indicators – Developmental Disabilities (NCI-DD) Survey reported their health status as “poor.”



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

Research Question: Will improved access to primary care result in improved health outcomes?

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

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

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

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

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

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

3. Goal 3: Community Integration

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



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Research Question: Will the demonstration result in increased community integration?

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

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

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

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

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

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

4. Goal 4: Cost Containment

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

Research Question: Will the demonstration maintain or reduce spending?

The interim findings provide support that the demonstration is containing costs relative to what would have been spent absent the demonstration. One of two hypotheses returned an interim assessment of “True.”



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

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

Research Question: Will improved access to preventive care result in lower overall costs?

Relative to this research question, interim findings provide support that the demonstration is meeting its overall goal of containing costs. Both hypotheses returned an interim assessment of “True.” Expenditures for members whose diabetes is in control have declined from \$16,459 to \$14,931 for Medicaid members aged 1-64 years enrolled in the Blueprint. Total risk-adjusted expenditures have remained relatively stable for the Medicaid members aged 1-64 years enrolled in the Blueprint.

5. Delivery System Related Investments

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

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

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



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

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

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

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

Evaluation Trends

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

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



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

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

Table 13. Demonstration Results from Prior Periods

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

Plans for Evaluating Impact of Demonstration Renewal

Vermont intends to contract with an independent evaluator to assess the impact of proposed new demonstration features. Vermont is proposing the research questions, hypotheses, and proposed evaluation approaches described below to include as part of its evaluation design. Vermont intends to incorporate rapid cycle evaluation into its broader evaluation strategy to understand the impact of the services funded through managed care savings in real time. Vermont will use the findings to adjust how it spends its savings to ensure that it is investing in models that advance the demonstration goals, while discontinuing initiatives that are not making an impact.

Recognizing the importance of understanding the impact of the demonstration on populations subject to health disparities, including Vermonters who are Black, Indigenous and People of Color and Vermonters with disabilities, Vermont is working to identify strategies to assess the extent to which the demonstration is promoting health equity. During the demonstration period, Vermont will be working to improve its data systems and collaborate with community partners to strengthen the State’s ability to collect and analyze data on race, ethnicity, and disability.



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Table 14. Proposed Evaluation Hypotheses for New Demonstration Features

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



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



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



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Section VIII – Compliance with Public Notice Process

1. Start and end dates of the state’s public comment period.

The State’s public comment period was from May 13, 2021 to June 12, 2021.

2. Certification that the state provided public notice of the application, along with a link to the state’s web site and a notice in the state’s Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

Vermont certifies that it provided public notice of the application on the State’s Medicaid website <https://humanservices.vermont.gov/> beginning on May 13, 2021. Vermont also certifies that it provided notice of the proposed demonstration in the *Burlington Free Press* on May 13, 2021. Copies of the notices that appeared on the State’s Medicaid website and in the newspaper are included in Section IX.

3. Certification that the state convened at least two public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

Vermont certifies that it convened two public hearings at least twenty days prior to submitting the Demonstration application to CMS. Specifically, Vermont held the following hearings:

- *Virtual Hearing – Thursday, May 27, 2021, from 1:30– 3:30 PM.* Ashley Berliner, DVHA’s Director of Medicaid Policy, and Wendy Trafton, AHS’s Deputy Director of Healthcare Reform, provided an overview of the demonstration. Individuals could access this public hearing by teleconference and webinar.
- *Virtual Hearing – Thursday, June 3, 2021, from 9:00 – 10:30 AM.* Ashley Berliner, DVHA’s Director of Medicaid Policy, and Wendy Trafton, AHS’s Deputy Director of Healthcare Reform, provided an overview of the demonstration. Individuals could access this public hearing by teleconference and webinar.

The slide deck used for the public hearings can be found at the following website:

<https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GC1115Waiver/1115-Renewal-Public-Hearing-Deck.pdf>.

4. Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.)



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Vermont certifies that it used an electronic mailing list to provide notice of the proposed demonstration to the public. Specifically, Vermont provided notice through the Global Commitment Register listserv, which is the State's master listserv of Medicaid stakeholders.

5. Comments received by the state during the 30-day public notice period.

Vermont received 25 letters of public comment during the public notice period.

6. Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

We attach here at Appendix B a document summarizing and responding to the comments received. In addition, we have included all public comments received in Appendix C.

7. Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State Plan, or at least 60 days prior to submitting this demonstration application if the demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

Vermont does not have any federally recognized tribes.



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Section IX – Public Notice

Full Public Notice

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

Global Commitment Register

May 13, 2021

GCR 21-033
PROPOSED

Global Commitment to Health Demonstration Renewal: Public Notice

Policy Summary:

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

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

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



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

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

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

Effective Date:
January 1, 2022

Authority/Legal Basis:
[Global Commitment to Health Waiver](#)

Population Affected:



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

Fiscal Impact:

No impact. The Global Commitment demonstration must be budget neutral.

Public Comment Period:

May 13, 2021-June 12, 2021

All comments must be received no later than 11:59 PM ET (Eastern Time) on June 12, 2021.

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

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

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

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

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

First Public Hearing

May 27th, from 1:30-3:00 pm

Call in: +1 802-552-8456,,23550108#

Phone Conference ID: 235 501 08#

Video Conference: <https://bit.ly/2QeCW4U>

Second Public Hearing

June 3rd, from 9:00-10:30 am

Call in: +1 802-552-8456,,558912170#



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Phone Conference ID: 558 912 170#

Video Conference: <https://bit.ly/3bixAwS>

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

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

Additional Information

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

Goal 1: Advancing Population-Wide, Comprehensive Coverage

Continuing Features without Modifications

- Presumptive Eligibility for Pregnant Women

Continuing Features with Modifications

- Moderate Needs Expansion Group for Choices for Care (CFC) Program. Vermont seeks to revise the CFC Moderate Needs Group clinical eligibility criteria to ensure that services are targeted to at-risk Vermonters with the most acute needs. See the full Global Commitment demonstration renewal [application](#) for additional details.
- Community Rehabilitation and Treatment (CRT) Expansion group. Vermont seeks to transition authority for the CRT expansion group from a designated state health program (DSHP) (for individuals with incomes from 133%-185% FPL) and the expenditure authority for investments under the current demonstration (for individuals with incomes above 185% FPL) to a discrete expenditure authority under the demonstration.
- Marketplace Subsidies for Vermonters purchasing health insurance through the Marketplace who are not Medicaid eligible and have incomes up to 300% of the Federal Poverty Level (FPL). Vermont seeks to transition authority for these subsidies from a DSHP to a discrete expenditure authority under the demonstration.
- VPharm. Vermont is seeking to extend Medicaid-equivalent pharmaceutical coverage to VPharm-eligible individuals with incomes up to 225% FPL.



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New Features

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

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

Continuing Features without Modifications

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

Continuing Features with Modifications

- **CFC.** Vermont seeks to add a “life skills aide” service to the CFC service array for the Highest Needs Group and High Needs Group.
- **CRT.** Vermont seeks to add a peer supports benefit³⁵ to CRT. In addition, Vermont intends to remove respite from the list of CRT benefits to reflect that it is not in use today.
- **Developmental Disabilities Services.** Vermont is seeking authority to reimburse parents of a minor child, spouses, and legal guardians providing personal care and personal care-like services to individuals enrolled in the Developmental Disabilities Services program.³⁶
- **Brain Injury Program.** Vermont is seeking authority to reimburse parents of a minor child, spouses, and legal guardians providing life skills aide services and community supports (including shared living) to individuals enrolled in the Brain Injury Program.³⁷

³⁵ Provision of peer supports will be effective upon promulgation of state policy necessary to effectuate this new benefit.

³⁶ Payments to parents of a minor child, spouses, and legal guardians providing these services will be effective upon promulgation of state policy necessary to effectuate this new benefit.

³⁷ Payments to parents of a minor child, spouses, and legal guardians providing these services will be effective upon promulgation of state policy necessary to effectuate this new benefit.



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- **Waivers of the Institution for Mental Disease (IMD) Exclusion for Mental Health and SUD Treatment.** Vermont is requesting that CMS align requirements for the two waivers to remove the prohibition on federal financial participation (FFP) for individuals obtaining mental health treatment in an IMD for longer than 60 days, recognizing that at times, longer lengths of stay are medically necessary. Vermont is also seeking to apply the inpatient exception to the inmate exclusion to care provided at IMDs.

New Features

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

Goal 3: Engaging Vermonters in Transforming Their Health

New Features

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



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- **Workforce Development Investments.** Vermont is requesting \$4.75 million in expenditure authority over five years to support loan repayment programs for health care professions, geographically accessible nursing education, and educational partnerships.
- **Public Health Infrastructure.** Vermont is requesting \$38 million in expenditure authority over five years to support preventive services and public health programs focused on areas such as immunizations and fluoride treatment, tobacco cessation, poison control/lead poisoning prevention, epidemiology, and laboratory testing.

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

New Features

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



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

Goal 5: Accelerating Groundbreaking Payment Reform

Continuing Features without Modifications

Vermont is seeking to retain the flexibility to set provider rates on an individual or class basis that departs from State Plan rates as part of its demonstration renewal.

New Features

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

Demonstration Eligibility, Benefits, Delivery System, and Cost Sharing

Eligibility and Benefits

Vermont's entire Medicaid population – including both State Plan and expansion groups – falls under the purview of the Global Commitment demonstration. Table 1 below outlines the eligibility groups that will be included in the Global Commitment demonstration renewal, along with the benefits that will be covered for each group. Through the demonstration renewal, Vermont is proposing the creation of one new eligibility group – Population 9, the SUD Community Intervention and Treatment Expansion Group. In addition, Vermont is proposing minor benefits changes, as described below.



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Table 1. Global Commitment Demonstration Populations

Population	Population Description	Benefits	Proposed Changes for New Demonstration Period
<i>Mandatory and Optional State Plan Groups³⁸</i>			
1. Mandatory State Plan Populations	Mandatory State Plan populations, except for the ACA new adult group (included in Population 3) and Medicare Savings Program beneficiaries (included in Population 8).	State Plan benefits	State intends to cover a number of new benefits under the State Plan, including a subset of investments authorized under the current demonstration, as described in this application.
2. Optional State Plan Populations	Optional State Plan populations (including medically needy).	State Plan benefits	None
3. New Adult Group	New adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119, pursuant to the approved State Plan.	Benefits described in approved alternative benefit plan (ABP) State Plan Amendment (SPA)	State will update its ABP SPA to align with changes to the State Plan.
<i>Demonstration Expansion Populations</i>			
4. CFC Highest Needs Population	Individuals age 65 and older and age 18 and older with disabilities, not otherwise eligible under the State Plan, who meet the clinical criteria for the Highest Needs Group for CFC, and who would have been Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR §435.217, in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under the demonstration would have been provided under an HCBS waiver granted to the State under section 1915(c) of the Act. This includes the application of the post-eligibility rules specified at 42 CFR §435.726, and of the spousal impoverishment rules specified at 1924 of the Act. This demonstration allows for a resource standard of \$10,000 for an unmarried individual who resides in	State Plan benefits plus HCBS covered for the CFC Highest Needs Group as described in the current demonstration STCs	State proposes minor changes to the CFC benefit package as described earlier in this notice and on pages 21-22 of the full demonstration renewal application.

³⁸ Inmates who are within 90 days of release will receive the benefit package associated with their eligibility group.



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Population	Population Description	Benefits	Proposed Changes for New Demonstration Period
	and has an ownership interest in their principal place of residence.		
5. CFC High Needs Population	Individuals age 65 and older and age 18 and older with disabilities, not otherwise eligible under the State Plan, who meet the clinical criteria for the High Need Group for CFC, and who would have been Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR §435.217, in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under the demonstration would have been provided under an HCBS waiver granted to the State under section 1915(c) of the Act. This includes the application of the post-eligibility rules specified at 42 CFR 435.726, and of the spousal impoverishment rules specified at 1924 of the Act. This demonstration also allows for a resource standard of \$10,000 for an unmarried individual who resides in and has an ownership interest in their principal place of residence.	State Plan benefits plus HCBS covered for the CFC High Needs Group as described in the current demonstration STCs	State proposes minor changes to the CFC benefit package as described as described earlier in this notice and on pages 21-22 of the full demonstration renewal application.
6. CFC Moderate Needs Expansion Group	Individuals who have incomes below 300% SSI FBR and would be described in Populations 4 or 5 except that they meet the clinical criteria for the CFC Moderate Needs Group and are at risk of institutionalization.	Limited HCBS including adult day services, case management, and homemaker services	State proposes minor changes to eligibility criteria described as described as described earlier in this notice and on page 13 of the full demonstration renewal application.
7. CRT Expansion Group	Individuals with SMI who have incomes above 133% FPL.	Limited community mental health services, including service coordination, flexible support, skilled therapy services, counseling, residential treatment, supported employment,	State proposes covering CRT expansion group through expenditure authority instead of as a DSHP and investment; no eligibility changes are proposed. State also proposes minor changes to CRT benefit package as described on page 22 of the full



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Population	Population Description	Benefits	Proposed Changes for New Demonstration Period
		environmental safety devices, and crisis and community supports	demonstration renewal application.
8. VPharm Group	Medicare beneficiaries who are 65 years or older or have a disability with income at or below 225% FPL, who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise categorically eligible for full benefits.	Medicaid prescriptions, eyeglasses and related eye exams; MSP beneficiaries also receive benefits as described in the State Plan	State proposes to expand benefits available to Medicare beneficiaries with incomes from 150% to 225% FPL as described as described earlier in this notice and on page 14-15 of the waiver application.
9. SUD Community Intervention and Treatment Expansion Group	Individuals with a SUD as defined by the DSM-5 who have incomes from 133% FPL up to and including 225% FPL.	SUD Community Intervention and Treatment benefits as described in Table 2	New eligibility group

Delivery System

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

Premiums and Cost-Sharing

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

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

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



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

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

VPharm Group (Population 8)

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

Table 3. VPharm Premiums and Co-Payments

Population	Premiums	Co-Payments
Medicare beneficiaries with income up to and including 225% FPL, who may be enrolled in the MSP but are not otherwise categorically eligible for full benefits	Premiums cannot exceed the following: <ul style="list-style-type: none"> • 0-150% FPL: \$15/month/person • 151-175% FPL: \$20/month/person • 176-225% FPL: \$50/month/person 	Not to exceed the nominal co-payments specified in the Medicaid State Plan

Demonstration Projected Enrollment and Expenditures

Expected Enrollment

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

Table 4. Historical Member Months

	Historical Member Months				
	DY12	DY13	DY14	DY15	DY16
Medicaid Eligibility Group	Jan - Dec 2017	Jan - Dec 2018	Jan - Dec 2019	Jan - Dec 2020	Jan - Dec 2021
Total Medicaid Population	1,267,680	1,232,408	1,171,121	1,185,813	1,197,680
Total Hypothetical Population	715,258	697,016	658,584	723,063	720,778
Total Other Population	134,570	128,599	123,875	121,698	121,698
Total	2,117,508	2,058,023	1,953,580	2,030,574	2,040,156

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

Table 5. Projected Member Months



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

Projected Expenditures

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

Table 6. Historical Expenditures

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

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

Table 7. Projected Expenditures

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

*Expenditures include DVHA plan administrative expenses.

Demonstration Hypotheses and Evaluation Approach

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

- **Goal 1: Advancing Toward Population-Wide, Comprehensive Coverage**
 - The demonstration will result in increased access to treatment services for Medicaid-eligible Vermonters who were previously incarcerated and released from Department of Corrections (DOC) facilities.
 - The demonstration will result in improved access to care for low- and moderate-income Vermonters with a SUD.
- **Goal 2: Implementing Innovative Care Models Across the Care Continuum That Produce Value**



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- The demonstration will result in improved access to family-focused residential services for Medicaid-eligible individuals.
- The demonstration will reduce health care costs for Medicaid-eligible individuals who access permanent supportive housing services.
- The demonstration will result in reducing overall health care costs for high-need individuals.
- ***Goal 3: Engaging Vermonters in Transforming Their Health***
 - The demonstration will result in reduced chronic disease prevalence.
 - The demonstration will increase access to care for Medicaid-eligible individuals.
- ***Goal 4: Strengthening Care Coordination and Population Health Management Capabilities to Encompass the Full Spectrum of Health-Related Services and Supports***
 - The demonstration will result in improved health information exchange capabilities for Medicaid specialty providers.
 - The demonstration will result in more integrated care coordination.
- ***Goal 5: Accelerating Groundbreaking Payment Reform***
 - The demonstration will result in additional populations and services transitioning to HCP-LAN Category 4 arrangements.
 - The demonstration will result in new payment initiatives for SUD outpatient services.
 - The demonstration will result in new payment initiatives for school-based mental health services.

Requested Waiver and Expenditure Authorities

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

Table 8: Requested Waiver and Expenditure Authorities

Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/ Expenditure Authority for Which Vermont Requests CMS Consider 10- Year Approval
Waiver Authorities			



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Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/ Expenditure Authority for Which Vermont Requests CMS Consider 10- Year Approval
1. Statewideness: Section 1902(a)(1)	To allow the State to operate the program differently in different geographical areas of the State.	Currently approved	✓
2. Reasonable Promptness: Section 1902(a)(8)	<p>To allow the State to maintain a waiting list for individuals applying for HCBW-like services through the CFC High Needs and Moderate Needs Groups.</p> <p>To allow the State to require applicants for nursing facility and HCBS (including HCBW-like services) to complete a person-centered assessment and options counseling process prior to receiving such services.</p> <p>To permit waiting lists for eligibility for demonstration-only (non-Medicaid State Plan) populations.</p>	State requests that waiver permitting waiting lists for demonstration-only populations extend to the SUD Community Intervention and Treatment Eligibility group	✓
3. Amount, Duration, and Scope of Services: Section 1902(a)(10)(B)	<p>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).</p> <p>To allow the State to provide nursing facility services and HCBS based on relative need as part of the person-centered and options counseling process for new applications for CFC services; to permit certain individuals, based on need, to receive demonstration services in the same eligibility group, under the Medicaid State Plan, and to limit the amount, duration, and scope of services to those including in the participants' approved care plan.</p>	Currently approved	✓
4. Financial Eligibility: Section	To allow the State to use institutional income rules (up to 300% SSI FBR) for HCBW-like programs besides CRT.	Modified waiver language to clarify that institutional	✓



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Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/ Expenditure Authority for Which Vermont Requests CMS Consider 10- Year Approval
1902(a)(10)(C) (i)(III)	To allow the State to use institutional income and resource rules for the Highest Need and High Need groups in the same manner as it did for the terminated 1915(c) waiver programs that were subsumed under the CFC demonstration in 2005. To permit the State to have a resource standard of \$10,000 for Highest Need and High Need individuals who are single and own and reside in their own homes and who select HCBS in lieu of institutional services.	income rules are used for determining eligibility for HCBW-like programs besides CRT for both categorically and medically needy beneficiaries	
5. Payment to Providers: Sections 1902(a)(13), 1902(a)(30)	To allow the State, through DVHA, to establish rates with providers on an individual or class basis without regard to the rates currently set forth in the approved State Plan.	Currently approved	✓
6. Premium Requirements: Section 1902(a)(14) In so far as it incorporates Section 1916	To permit Vermont to impose premiums in excess of statutory limits for optional populations and for children through age 18 with income above 195% FPL.	Currently approved	✓
7. Income/ Resource Comparability: Section 1902(a)(17)	To the extent necessary to enable the State to use varying income and resource standards and methods for plan groups and individuals.	Currently approved	✓
8. Spend-Down: Section 1902(a)(17)	To enable the State to offer one-month spend-downs for medically needy people receiving community-based services as an alternative to institutionalization, and non-institutionalized persons who are receiving personal care attendant services at the onset of waivers.	Currently approved	✓
9. Financial Responsibility/ Deeming:	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	Currently approved	✓



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Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/ Expenditure Authority for Which Vermont Requests CMS Consider 10- Year Approval
Section 1902(a)(17)(D)	<p>eligibility unless actually made available, and so that family income and resources may be used instead.</p> <p>To enable the State to disregard quarterly income totaling less than \$20 from the post-eligibility income determination.</p>		
10. Freedom of Choice: Section 1902(a)(23)(A)	To enable the State to restrict freedom of choice of provider for the demonstration participants to the extent that beneficiaries will be restricted to providers enrolled in a provider network through DVHA for the type of service at issue, but may change providers among those enrolled providers. Freedom of choice of provider may not be restricted for family planning providers. This waiver allows Vermont to restrict choice of provider in situations where the State requires an individual to receive services through a designated provider. The individual may receive services from any willing provider within that designated provider network.	Currently approved	✓
11. Direct Payments for Providers: Section 1902(a)(32)	To permit payments for incidental purchases for CFC HCBS to be made directly to beneficiaries or their representatives.	Currently approved	✓
Expenditure Authorities			
1. Expenditures Related to Eligibility Expansion	Expenditures to provide Medical Assistance coverage, either in the form of payment for medical services under the State Plan as affected by the waivers and expenditure authorities under this Demonstration, or in the form of premium assistance, to the Demonstration expansion populations listed in Section III of this document, that are not covered under the Medicaid State Plan and are enrolled in the Vermont Global Commitment to Health Demonstration. This authority applies to Demonstration Populations 4, 5, 6, 7, 8, and 9.	State requests to modify request to include SUD Community Intervention and Treatment Expansion Group (Population 9)	✓ (for CFC Highest Needs Population (Population 4), CFC High Needs Population (Population 5), CFC Moderate Needs Group (Population 6), CRT)



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Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/ Expenditure Authority for Which Vermont Requests CMS Consider 10- Year Approval
			Expansion Group (Population 7), VPharm Group (Population 8)
2. Expenditures Related to Additional Services for HCBW-Like Programs	Expenditures for additional health care related-services (i.e., HCBW-like services) for all populations affected by or eligible through the demonstration as described in STC 20(c) in the currently approved Global Commitment demonstration.	Currently approved	✓
3. Expenditures for Public Health Initiatives, Outreach, Infrastructure, and Services Related to State Plan, Demonstration, Uninsured and Underinsured Populations	Expenditures to reduce the rate of uninsured and/or underinsured in Vermont, increase access to quality health care for uninsured, underinsured, and Medicaid beneficiaries, provide public health approaches and other innovative programs to improve the health outcomes and quality of life for Medicaid beneficiaries; and encourage the formation and maintenance of public private partnerships in health care; use of this expenditure authority will phase down over the five years of the demonstration.	State proposes that authority will phase down over five years of demonstration	
4. Expenditures for Hospice Services that Exceed State Plan Limits	Expenditures for adults eligible under the approved State Plan for hospice services that exceed State Plan limits.	Currently approved	✓
5. Expenditures for the Marketplace Subsidy Program	Expenditures for state-funded subsidy programs that aid certain individuals who purchase health insurance through the Marketplace.	Currently approved	✓



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Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/ Expenditure Authority for Which Vermont Requests CMS Consider 10- Year Approval
6. Expenditures for Mental Health CRT	Expenditures for mental health CRT services, as defined by Vermont rule and policy, to individuals with serious mental illness.	State proposes to modify request to reflect CRT transitioning to an expenditure authority	✓
7. Expenditures for SUD Community Intervention and Treatment	Expenditures for SUD Community Intervention and Treatment services, as defined by Vermont rule and policy, to individuals with SUD who have incomes above 133% FPL.	New request	
8. HCBW-like Services for State Plan Eligibles Who Meet Highest Need, High Need, or Moderate Need Clinical Criteria for CFC	Expenditures for HCBW-like services for State Plan eligibles who meet all State Plan eligibility requirements, who have the indicated level of clinical need for HCBW-like services for the CFC program. The Moderate Needs Group does not meet all the CFC clinical criteria for 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.	Currently approved	✓
9. Other HCBW-Like Expenditures	<p>a. Expenditures for CFC participants with resources exceeding current limits, who are single, own and reside in their own homes, and select home-based care rather than nursing facility care, to allow them to retain resources to remain in the community;</p> <p>b. Expenditures for personal care services provided by HCBW-like participants' parents (when participants are minor children), spouses, and legal guardians; and</p> <p>c. Expenditures for incidental purchases paid in cash allowances to participants who are self-directing their CFC services prior to service delivery.</p>	State requests to modify (b), expenditures for personal care services, to incorporate other HCBW-like programs beyond CFC	✓
10. Children's Personal Care Expenditures	Expenditures for State Plan children's personal care services provided by participants' parents and legal guardians.	Currently approved for COVID-19 PHE;	



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



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Waiver/ Expenditure Authority	Use for Waiver/Expenditure Authority	Currently Approved Waiver/ Expenditure Authority?	Waiver/ Expenditure Authority for Which Vermont Requests CMS Consider 10- Year Approval
14. Retroactive Eligibility	To enable the State to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance is made for expansion groups (for Populations 6 and 8 only).	Currently approved	✓
15. Permanent Supportive Housing Pilot	Expenditures for permanent supportive housing services provided to enrollees in the State’s Pilot program. The State will institute annual enrollment limits for this Pilot and will maintain a waiting list.	New request	
16. Coverage for Inmates Pre-Release	Expenditures for Medicaid services rendered to incarcerated enrollees in the 90 days pre-release from a correctional facility.	New request	
17. Health Information Exchange Activities	Expenditures not to exceed \$17 million over five years to conduct activities that will strengthen providers’ ability to participate in health information exchange. Expenditures not to exceed \$5 million over five years to deploy an electronic patient engagement platform.	New request	
18. Blueprint for Health	Expenditures not to exceed \$15 million over five years to administer the Blueprint program.	New request (currently covered as an investment)	✓
19. Workforce Development	Expenditures not to exceed \$4.75 million over five years to support health care workforce development in Vermont.	New request (currently covered as an investment)	✓
20. Public Health Infrastructure	Expenditures not to exceed \$38 million over five years to sustain and strengthen Vermont’s public health infrastructure.	New request (currently covered as an investment)	✓



Vermont Global Commitment to Health 1115 Demonstration Renewal Application

Abbreviated Public Notice

Global Commitment to Health Demonstration Renewal: Abbreviated Public Notice
May 13, 2021

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

Through renewal of the Global Commitment to Health demonstration, which is currently in effect through December 31, 2021, Vermont intends to transition AHS’s Department of Vermont Health Access (DVHA) from being treated as a public, non-risk, prepaid inpatient health plan (PIHP) to a public, state-run, risk-bearing managed care organization (MCO).

The State is seeking to retain and strengthen the following existing demonstration features in the renewal period:

- Presumptive eligibility for pregnant women;
- Marketplace subsidies for individuals with incomes up to 300% of the federal poverty level;
- Home and community-based waiver-like programs: Choices for Care, Community Rehabilitation and Treatment, Mental Health Under 22 for Individuals with Serious Mental Illness/Serious Emotional Disturbance, Developmental Disabilities Services, and Brain Injury Program;
- VPharm prescription drug “wrap” with affordable premiums for low-income Medicare beneficiaries;
- Enhanced hospice benefit;
- Palliative care program for children and families;
- Waivers of the institution for mental diseases (IMD) exclusion for mental health and substance use disorder (SUD) treatment; and
- Flexibility to set provider rates on an individual or class basis that departs from Medicaid State Plan rates.

In addition to requesting authority to transition DVHA to operate as a risk-bearing MCO, Vermont is seeking authority for the following new initiatives:

- Providing Medicaid coverage for inmates 90 days pre-release;
- Providing SUD benefits for low- and moderate-income Vermonters with a SUD;

- Expanding access to family-focused residential mental health and SUD treatment;
- Offering a Permanent Supportive Housing Pilot;
- Covering workforce development and public health infrastructure investments through expenditure authority;
- Advancing integration in care coordination and continuing investing in Blueprint for Health;
- Strengthening providers’ ability to participate in health information exchange; and
- Deploying an electronic patient engagement platform.

A copy of the proposed Global Commitment to Health demonstration renewal application and a detailed public notice with more information about the extension request are available on the AHS website at <https://humanservices.vermont.gov/about-us/medicaid-administration/global-commitment-health-1115-waiver/1115-waiver-documents/2022>.

The 30-day public comment period for the Vermont Global Commitment to Health demonstration renewal is from May 13, 2021, until June 12, 2021. All comments must be received no later than 11:59 PM ET (Eastern Time) on **June 12, 2021**.

Written comments may be sent to the following address; please indicate “1115 Renewal Public Comment” in the written message:
Medicaid Policy Unit
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010

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

AHS will host the following public hearings to solicit stakeholder comments. The two public hearings will be held virtually to promote social distancing and mitigate the spread of COVID-19. The meetings will have online video streaming and telephonic conference capabilities to ensure statewide accessibility.

Public Hearings:
May 27th, from 1:30-3:00pm
call in (audio only):
+1 802-552-8456,,23550108#
Phone Conference ID: 235 501 08#
<https://bit.ly/2QeCW4U>

June 3rd, from 9:00-10:30am
call in (audio only):
+1 802-552-8456,,558912170#
United States, Montpelier
Phone Conference ID: 558 912 170#
<https://bit.ly/3bixAwS>
May 13, 2021





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Appendices



Vermont Global Commitment to Health 1115 Demonstration Renewal Application

Appendix A – External Quality Review

Background

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

Summary of 2020 EQR Findings

EQR Performance Improvement Project

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

HSAG used CMS’ PIP validation protocol³⁹ as the methodology to validate the PIP. HSAG’s validation assessed Steps I through X of the protocol. DVHA’s *Initiation of Alcohol and Other Drug Abuse or Dependence Treatment* PIP received a score of 100 percent for all applicable evaluation elements scored as *Met*, a score of 100 percent for critical evaluation elements scored as *Met*, and an overall validation status of *Met*, as displayed in Table 1.

Table 1. 2020–2021 PIP Validation Summary Overall Score

Percentage Score of Evaluation Elements <i>Met</i>*	100%
Percentage Score of Critical Elements <i>Met</i>**	100%
Validation Status	<i>Met</i>

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

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

³⁹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf>. Accessed on: Nov. 23, 2020.





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EQR Performance Measure Validation

HSAG validated a set of performance measures, selected by AHS and calculated and reported by DVHA, used to assess performance under the Global Commitment Demonstration. The methodology HSAG used to validate the performance measures was based on CMS' validation of performance measures protocol.⁴⁰ The validation findings confirmed that all rates were reportable.

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

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

Review of Compliance with Standards

AHS requested that HSAG continue to review one of the three sets of federal Medicaid managed care standards during each EQR contract year. For EQR contract year 2020–2021, AHS requested that HSAG conduct a review of the Structure and Operations standards. HSAG conducted the review consistent with CMS' *Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.⁴¹ HSAG reviewed DVHA's written operating policies and procedures, program plans, meeting minutes, numerous written reports, and other data and documentation related to DVHA's performance during the review period. Reviewers also conducted staff interviews related to each of the eight standards to allow DVHA staff members to elaborate on the written information HSAG reviewed,

⁴⁰ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf>. Accessed on: Nov. 10, 2020.

⁴¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf>. Accessed on: Nov. 10, 2020.



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to assess the consistency of staff responses given during the interviews against the written documentation, and to clarify any questions reviewers had following the document review.

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

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

Table 0. Standards and Compliance Score

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Total Compliance Score
I	Provider Selection	11	11	11	0	0	0	100%
II	Credentialing and Recredentialing	4	4	4	0	0	0	100%
III	Beneficiary Information	11	11	10	1	0	0	95.5%
IV	Beneficiary Rights	4	4	4	0	0	0	100%
V	Confidentiality	5	5	5	0	0	0	100%
VI	Grievance System—Beneficiary Grievances	16	16	13	3	0	0	90.6%
VII	Grievance System—Beneficiary Appeals and State Fair Hearings	32	32	26	5	1	0	89.1%



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Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Total Compliance Score
VIII	Subcontractual Relationships and Delegation	5	5	5	0	0	0	100%
	Totals	88	88	78	9	1	0	93.8%

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

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

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

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

EQR Performance Trends

EQR Performance Improvement Project

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

The main intervention for the PIP was a focus on promoting telemedicine/telehealth visits for SUD treatment. DVHA pursued the promotion of telehealth with SUD treatment providers and monitored an interim telemedicine indicator quarterly report to gauge progress. DVHA expanded the scope of its work by partnering with the Vermont Program for Quality in Health Care. During Remeasurement 2, DVHA worked with partnering organizations to plan a “Telehealth 101” training for providers. DVHA reported other intervention activities during Remeasurement 2 that included the following:

- Publication of additional provider banners.



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

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

EQR Performance Measure Validation

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

EQR Review of Compliance with Standards

HSAG reviews a different set of standards to evaluate DVHA's compliance with federal CMS Medicaid managed care regulations and the associated AHS/DVHA IGA requirements during each year within a three-year cycle of reviews. The number of standards reviewed each year varies, as does the focus of the review. The three-year cycle consists of the following standards: Year 1, Structure and Operations standards (42 CFR §438.10, §438.100, §438.214–§438.230, and §438.414); Year 2, Measurement and Improvement standards (42 CFR §438.236, §438.242, and §438.330); and Year 3, Access and Enrollment/Disenrollment standards (42 CFR §438.206–§438.210 and §438.54–§438.56).

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



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

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

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

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



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Quality, Timeliness, and Access to Care Domains

The federal Medicaid managed care regulations require that “each contract with a Medicaid managed care organization must provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the care and services for which the organization is responsible.”⁴² CMS has chosen the domains of quality, access, and timeliness as keys to evaluating the performance of MCOs, PIHPs, PAHPs, and PCCMs. Definitions HSAG used to evaluate and draw conclusions about DVHA’s performance in each of these domains are as follows.

Quality

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

Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in §438.310(c)(2)) increases the likelihood of desired health outcomes of its enrollees through its (1) structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidence-based knowledge, and (3) interventions for performance improvement.⁴³

Timeliness

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

“The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation.”⁴⁴ NCQA further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to beneficiaries and that require a timely response by the managed care organization—e.g., processing expedited appeals and providing timely follow-up care.

⁴² Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions*. Available at: https://innovation.cms.gov/files/migrated-medicare-demonstration-x/cc_section4016_bba_1997.pdf. Accessed on: Nov. 23, 2020.

⁴³ Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol 81, May 6, 2016.

⁴⁴ Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol 81, May 6, 2016.



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Access

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

Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).⁴⁵

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

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

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

⁴⁵ Federal Register. *Code of Federal Regulations, Title 42, Volume 4*, May 6, 2016. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=fa076676cc95c899c010f8abe243e97e&mc=true&node=se42.4.438_1320&rgn=div8. Accessed on: Nov. 23, 2020.



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

Other Quality Assurance Monitoring Performance Trends

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

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





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

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

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

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

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

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



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Appendix B – Responses to Public Comments

From May 13 to June 12, 2021, Vermont received 25 letters of public comment on the Global Commitment to Health Section 1115 (Global Commitment) demonstration renewal application. This Appendix summarizes key themes of the public comments received, as well as comments made during public hearings, and provides the State’s responses. The State appreciates the valuable and thoughtful comments submitted and is committed to continuing an open and collaborative process to continue to strengthen Vermont’s Medicaid program and improve health for all Vermonters.

Vision and Goals for Global Commitment Renewal

Transitioning DVHA to a Risk-Bearing MCO

1. **Comment:** Seven commenters expressed support for the transition of the Department of Vermont Health Access (DVHA) to a risk-bearing managed care organization (MCO). One commenter added that their support of this transition is contingent on Vermont’s ability to negotiate a waiver cap and per member per month rates that will be sufficient to allow the State to meet all goals contained in the renewal application.

Response: Vermont thanks commenters for their support. The State agrees that for DVHA’s transition to a risk-bearing MCO to be successful, it is critical that the DVHA capitation rate and budget neutrality cap are sufficient to support the State’s vision for the transformation.

2. **Comment:** One commenter noted that in some states, Medicaid MCOs have created substantial administrative burden for providers, and cautioned Vermont to avoid creating similar burdens in DVHA’s transition to a risk-bearing MCO.

Response: Vermont agrees that it is important to minimize provider administrative burden through this transition. In operating DVHA as a single statewide managed care plan, Vermont has sought to minimize burden for providers, as they only need to contract with a single plan, rather than multiple MCOs. While DVHA’s transition from operating as a non-risk-bearing managed care plan to a risk-bearing MCO will change how DVHA is paid and held accountable for cost of care, the State anticipates that this transition will have minimal impact on how providers contract with DVHA; as a result, the State does not foresee that this change will increase provider administrative burden.

3. **Comment:** One commenter expressed support for Vermont’s proposed strategy for reinvesting managed care profits, and requested that the State ensure openness and transparency in how those profits are being reinvested.

Response: Vermont thanks the commenter for their support. DVHA is exploring strategies to publicly report on how it will reinvest its managed care profits.



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4. **Comment:** One commenter sought clarification on how DVHA will manage risk as a state entity and whether it will have reserves in place to mitigate risk.

Response: First and foremost, Vermont will work with the Centers for Medicare and Medicaid Services (CMS) to negotiate a capitation rate and budget neutrality cap that will be sufficient to cover all costs described in the demonstration renewal application. Over the life of the demonstration, DVHA will closely monitor expenditures to ensure that it is staying within the approved capitation rate. In the event that DVHA identifies that there is a risk of exceeding the capitation rate, Vermont and its actuaries have identified several strategies for mitigating risk. Should material changes in the Medicaid program impact costs during the course of the demonstration period, the State will work with CMS to explore retroactive rate adjustments to account for these changes. Consistent with current practice, DVHA will utilize the legislative budget process if it identifies anticipated deficits. Finally, DVHA anticipates that it will be able to implement risk mitigation strategies authorized under federal Medicaid managed care rules, such as risk corridors and stop-loss arrangements to limit the State's exposure to risk should DVHA's expenditures exceed the capitation rate.

5. **Comment:** One commenter asked that the DVHA MCO not only adhere to Medicaid MCO rules, as proposed, but also adhere to standards laid out in the Department of Financial Regulation H-2009-03 to ensure consistency across payers.

Response: Vermont appreciates this comment, but has determined that State law does not require that Regulation H-2009-03 apply to DVHA. As noted, under the proposed Global Commitment renewal, DVHA would be subject to CMS's robust rules governing Medicaid MCOs at 42 CFR Part 438.

CMS's rules governing MCOs are complex and exhaustive, occupying much of the same field as Regulation H-2009-03, and attempting to adhere to both sets of rules would result in unnecessary duplication of bureaucratic processes. For example, federal regulations (42 CFR Part 438, Subpart F) set out requirements for a grievance and appeals process for adverse benefit determinations and for providers and subcontractors; Regulation H-2009-03 sets out requirements for similar grievance processes. Submitting to Regulation H-2009-03 would also require DVHA to undergo numerous annual and periodic reviews that would duplicate CMS's annual and periodic reviews of DVHA's processes.

6. **Comment:** One commenter noted that Act 113 of 2016 requires that Medicare payments go directly to health care providers without going through the State of Vermont, and asked how DVHA will address this statutory requirement moving forward.

Response: Vermont is still in the early stages of developing its vision for further alignment between Medicare and Medicaid and will seek and welcomes feedback from stakeholders as this vision evolves. If Vermont moves forward with offering the DVHA risk-bearing managed care plan to Medicare-covered Vermonters, it will ensure that it has appropriate State legislative authority to do so.



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7. **Comment:** Two commenters sought clarification on how DVHA’s risk-bearing MCO model will interact with the All-Payer ACO model; one commenter specifically asked how the risk-bearing DVHA MCO model will interact with the All-Payer ACO model for Medicare-enrolled Vermonters.

Response: Both the DVHA MCO and the All-Payer ACO models are critical components of Vermont’s vision for payment reform. With its transition to a risk-bearing MCO, DVHA will assume risk for managing under a capitation rate all services for its enrollees. As a risk-bearing MCO, DVHA will continue to act as an anchor participant in the All-Payer ACO Model Agreement, through which payers share risk for total cost of care with providers. The All-Payer ACO Model Agreement defines how payers pay providers for services incorporated into the total cost of care model. Vermont is still in the early stages of developing its vision for further alignment between Medicare and Medicaid and welcomes additional feedback from stakeholders on this vision.

8. **Comment:** One commenter sought clarification on Vermont’s vision for individuals who are dually eligible for Medicare and Medicaid and questioned why the demonstration renewal application does not include a specific plan for the dual eligible population.

Response: Vermont agrees that dual eligible individuals are a high-priority population for future payment and delivery system reforms. As noted in the demonstration renewal application, the State is considering models for further aligning Medicare and Medicaid during the renewal period. Vermont will collaborate with CMS, including the Center for Medicare and Medicaid Innovation, over the course of the demonstration period as it develops its vision for the dual eligible population.

9. **Comment:** One commenter requested that Vermont’s efforts for long-term services and supports (LTSS) payment reform include increasing total reimbursement for LTSS, noting the perspective that lack of funding for LTSS has caused erosion of LTSS programs in the State.

Response: Vermont appreciates this comment and will continue to work with its payment reform consultants to ensure adequate provider payment rates.

10. **Comment:** Two commenters requested that Vermont ensure Medicaid reimbursement rates match the Medicare fee schedule and, where no Medicare fee schedule exists, identify other mechanisms for regular rate schedule updates.

Response: Vermont works with its actuaries to establish Medicaid provider rates. The process for provider rate-setting will not change under the demonstration renewal.

11. **Comment:** One commenter asked how capitated payments and payment reform will impact Area Agencies on Aging, and requested that the State consider how to build quality incentives to reward Area Agencies on Aging for positive outcomes.



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Response: Vermont does not anticipate that DVHA’s transition from a non-risk-bearing managed care plan to a risk-bearing MCO will impact payments to Area Agencies on Aging. The State looks forward to engaging with stakeholders, including the Area Agencies on Aging, on future payment reform initiatives. Outside of the Global Commitment renewal, Vermont has proposed using \$17 million of the enhanced federal medical assistance percentage (FMAP) for Medicaid home- and community-based service (HCBS) providers to advance value-based payment (VBP) reforms and support additional Medicaid HCBS providers in achieving readiness for reform.

12. **Comment:** One commenter expressed the understanding that the original intent of the Choices for Care (CFC) program was to re-invest shared savings into delivery system reforms, but that community-based providers never received incentive funds. The commenter asked that the State consider this approach as part of the shift to the risk-bearing managed care model.

Response: Vermont appreciates this comment and will continue to comply with the requirements of 33 V.S.A. 7602 regarding the allocation of CFC program savings.

Advancing Toward Population-wide Comprehensive Coverage

Moderate Needs Expansion Group for Choices for Care (Moderate Needs Group)

13. **Comment:** The State received five comments on the changes to Moderate Needs Group eligibility criteria. While some commenters supported the changes, noting that they will help ensure those most in need of services are able to obtain them, others expressed concern about the changes, noting that they could limit access to services. One commenter sought clarification on what the State meant in saying it will revise Moderate Needs criteria to focus on individuals with “the most acute needs.”

Response: Currently, there are over 700 individuals on the Moderate Needs Group waitlist, which means that individuals may wait several years to become eligible for services. Given that funding for this expansion group is set by legislative appropriations, the State believes that the changes to the Moderate Needs criteria will help reduce waitlists and ensure that individuals with the greatest level of need (i.e., the highest risk of requiring nursing home-level care) are able to obtain HCBS in a timelier manner. The State appreciates that commenters have raised concerns that these changes may limit access to services and will monitor the level of need of individuals on the waitlist in addition to nursing home admission rates after implementing these changes.

VPharm

14. **Comment:** Two commenters expressed support for the proposed expansion of VPharm.

Response: Vermont thanks the commenters for their support.



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

15. **Comment:** Two commenters expressed support for coverage for inmates 90 days pre-release.

Response: Vermont thanks the commenters for their support.

16. **Comment:** One commenter expressed concern with the demonstration renewal application's suggestion that, due to the overrepresentation of Black Vermonters in the criminal justice system, expansion of coverage of inmates 90 days prior to release will promote health equity as well as equity in the criminal justice and health delivery systems. The commenter noted that extending Medicaid to inmates upon release will not address the over-incarceration of Black Vermonters, and that because Black Vermonters tend to serve longer prison terms, they are not subject to release at the same frequency and will therefore not access pre-release coverage with the same frequency as non-Black Vermonters.

17. **Response:** Vermont appreciates this comment and is committed to leveraging the Global Commitment demonstration to promote health equity. Vermont agrees that the request to provide coverage to inmates 90 days pre-release is only one component of promoting health equity and equity in the criminal justice and health delivery system and that there is much more work to be done to address the disproportionate rate of incarceration among Black Vermonters. While criminal justice and sentencing policy fall outside the purview of AHS, AHS seeks to ensure that individuals exiting the corrections system can obtain the health services and supports needed to help prevent re-entry into the corrections system. Poor health and poor access to care are associated with higher rates of recidivism among individuals re-entering the community from carceral settings.⁴⁶ By helping address gaps in coverage and access to care that contribute to recidivism, Vermont seeks to reduce the detrimental physical and psychological impacts of time spent in correctional settings—impacts that are disproportionately borne by Black Vermonters.^{47, 48}

AHS has convened a cross-departmental work group to improve transitions from correctional settings to the community, including design of a case management model targeted toward populations making this transition. The expansion of coverage to inmates 90 days prior to release will support a more strategic team-based approach to identifying an individual's goals across a spectrum of health needs and health-related social needs, establishing a plan of care to meet those goals, and establishing connections with key community partners to participate in and/or lead an individual's care team. Ensuring better coordinated transitions can result in decreased corrections reentry prior to the completion of supervision. As part of this work, AHS will require that community-based care management entities be trained in delivering

⁴⁶ Mallik-Kane, K., and Visher C. Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration. Washington, D.C.: Urban Institute. (2008) Available at http://www.urban.org/UploadedPDF/411617_health_prisoner_reentry.pdf.

⁴⁷ Massoglia, M., and Remster, Brianna. "Linkages Between Incarceration and Health." *Public Health Reports* 134, no. 1_suppl (May 2019): 8S-14S. <https://doi.org/10.1177/0033354919826563>.

⁴⁸ Haney, Craig. "Prison Effects in the Era of Mass Incarceration." *The Prison Journal*, (July 2012). <https://doi.org/10.1177/0032885512448604>.



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culturally competent care coordination and addressing the diverse needs of the populations they will be serving.

Substance Use Disorder (SUD) Community Intervention and Treatment Eligibility Group

18. **Comment:** One commenter asked what type of State policy will need to be promulgated before all SUD Community Intervention and Treatment benefits will be available to eligible Vermonters, and asked which entity within the State holds authority for promulgating such policy. Other commenters asked whether peer specialists will be eligible for Medicaid funding regardless of where the services are provided and whether Vermont intends to amend the State Plan to include recovery peer specialists as qualified providers.

Response: Upon obtaining CMS approval to implement the SUD Community Intervention and Treatment eligibility group as part of the demonstration renewal, AHS will promulgate State policy necessary to implement the peer supports benefit and authorize this eligibility group. The promulgation process typically takes six to eight months. The policy will specify additional details about the delivery of the benefit, including the qualifications of peer specialists who will be permitted to provide the benefit and the settings where the benefit can be delivered. All proposed changes will be published in the Global Commitment Register and will be open for a 30-day public comment period.

19. **Comment:** One commenter expressed support for the proposal to implement an eligibility group for Vermonters with SUD with incomes up to 225% of the federal poverty level (FPL), and requested that the State clarify whether funding for withdrawal management will continue to be funded on a capacity basis or will switch to a fee-for-service reimbursement model.

Response: Vermont has not yet determined the payment methodology for services provided to the SUD Community Intervention and Treatment eligibility group and will release additional information after CMS approves the demonstration renewal.

20. **Comment:** One commenter asked which proposed SUD Community Intervention and Treatment benefits are currently covered by Medicaid, and which will be added to Vermont's State Plan.

Response: Vermont intends to add peer supports to the State Plan. The other SUD Community Intervention and Treatment benefits are currently covered under the State Plan.

Other

21. **Comment:** One commenter noted that in 2018, 11% of patients treated in emergency departments (EDs) for psychiatric conditions were uninsured, though only 3% of patients ultimately admitted for psychiatric care were uninsured. The commenter asked how Vermont intends to ensure coverage for these uninsured patients and increase their access to care.



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Response: Vermont thanks the commenter for raising this issue and is committed to advancing toward population-wide comprehensive coverage. Vermont is proud that almost 97% of its population is insured, while also recognizing that it is important to continue to work toward covering Vermonters who remain uninsured. Through the Global Commitment renewal, Vermont is proposing to start or continue several initiatives that promote coverage and access to care for uninsured populations, including individuals needing psychiatric care. For example:

- The existing Community Rehabilitation and Treatment (CRT) Expansion Group offers community-based mental health services to individuals who have serious mental health needs but whose incomes exceed Medicaid limits. Coverage of this group gives individuals who are not otherwise Medicaid-eligible access to community-based mental health treatment.
- The new SUD Community Intervention and Treatment eligibility group will provide access to SUD treatment benefits for low- and moderate-income Vermonters with a SUD whose income exceeds Medicaid limits.
- The demonstration funds Marketplace subsidies to help lower- and moderate- income Vermonters who are not Medicaid eligible purchase health insurance through the Marketplace.
- Finally, as a risk-bearing MCO, DVHA will have new flexibility, including the ability to use its savings to invest in population health initiatives that benefit all Vermonters. DVHA anticipates that a meaningful portion of its savings will be used to improve access to care for uninsured Vermonters.

Implementing Innovative Care Models Across the Continuum that Produce Value

Enhanced Hospice Benefit and Children's Palliative Care

22. **Comment:** One commenter expressed support for the continued inclusion of the hospice benefit and children's palliative care program.

Response: Vermont thanks the commenter for their support.

Choices for Care

23. **Comment:** One commenter noted that Vermont should ensure the reimbursement rate for life skills aides is sufficient to enable providers to recruit aides, maintain adequate staffing levels, and cover the cost of provider training.

Response: Vermont thanks the commenter for making this suggestion and will work with its reimbursement unit to set adequate rates for the life skills aide benefit.

24. **Comment:** One commenter suggested adding the life skills aide benefit to the Moderate Needs Group.

Response: Vermont thanks the commenter for their input. The State anticipates that the life skills aide service will most benefit CFC participants in the Highest- and High-Needs groups



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and can consider adding the service for the Moderate Needs Group in the future. Currently, individuals in the Moderate Needs Group may utilize flexible funding to address unmet needs, and life skills aides can be included in this category.

Community Rehabilitative Treatment

25. **Comment:** One commenter expressed concern about the proposal to remove respite services from the CRT program and asked that the State explore whether respite services under CRT could be better utilized to help reduce ED visits and wait times.

Response: Vermont thanks the commenter for sharing their concern. Vermont intends to align the CRT benefit package outlined in the demonstration STCs with the benefit package authorized by State policy, which does not include respite. Practically, while the demonstration STCs will no longer list respite as a benefit, the change will not impact the benefits available to Vermonters enrolled in CRT. The State has updated the demonstration renewal application to clarify this point.

26. **Comment:** Two commenters sought clarification on the use of the term “peer supports.” One asked whether “peer supports” as referenced in the CRT program narrative differed from “peer services” as referenced in the SUD Community Intervention and Treatment eligibility group narrative. The commenter also requested a timeline of when peer supports will be available to individuals in the SUD Community Intervention and Treatment eligibility group and CRT program, and asked whether these benefits will be available to individuals ineligible for the SUD Community Intervention and Treatment eligibility group and CRT program but otherwise eligible for Medicaid. Additionally, one commenter also asked when the State planned to promulgate the policy necessary to effectuate the peer supports benefit and whether peer supports will then be added to the State Plan so that individuals outside of the CRT program can access the benefit.

Response: Vermont thanks the commenters for seeking clarification. Both “peer supports” and “peer services” refer to the set of services provided by peers; moving forward, Vermont will refer to these services as “peer supports” (one of the terms currently used) or “peer support services.” “Peer specialists” refers to the peer providers delivering these services. Vermont has updated the demonstration renewal application to ensure consistent usage of these terms. As noted in the full Global Commitment demonstration renewal application, peer supports will be added to the State Plan and will be available to Medicaid enrollees eligible under the State Plan, in addition to members of the SUD Community Intervention and Treatment eligibility group and CRT expansion group.

Vermont is in the process of determining the timing for effectuating the benefits changes discussed in this application and will provide stakeholders with updates on the expected timing for implementing the peer supports benefit. Vermont will need to promulgate State policy to implement this benefit, which typically takes six to eight months. All proposed



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changes will be published in the Global Commitment Register and will be open for a 30-day public comment period.

27. **Comment:** One commenter requested details on Vermont’s plans to develop a peer specialist workforce, and asked whether a portion of the expenditure authority requested for workforce development will be used to develop this workforce.

Response: At a minimum, Vermont intends for the proposed workforce development expenditure authority to support loan repayment programs for health care professions, provision of geographically accessible nursing education, and educational partnerships. However, Vermont anticipates that it will have flexibility to determine how to best use these funds to address gaps in the health care workforce and will consider whether to use these funds to support other types of workforce development initiatives.

Concurrently, outside of the 1115 demonstration, Vermont is actively pursuing mechanisms for strengthening the peer specialist workforce. Vermont’s proposed spending plan for the enhanced FMAP for HCBS made available under the American Rescue Plan includes \$15 million for training, recruitment, and retention of the HCBS workforce, including peer specialists.

Developmental Disabilities Services and Brain Injury Programs

28. **Comment:** Commenters expressed mixed reactions to Vermont’s proposal to offer reimbursement to parents, legal guardians, and spouses providing personal care services under the Developmental Disabilities Services program and life skills aide and community support services under the Brain Injury program. Several commenters expressed support for this approach, though one sought clarification on how the State plans to ensure accountability and provide oversight for services provided. Other commenters suggested that the State conduct additional research, stakeholder engagement, and design of its oversight policy before implementing this type of policy, noting that there needs to be a distinction between services provided to children and adults, and that there should be an appropriate mechanism to ensure self-determination and prevent exploitation in any payments for services provided to adults.

Response: Vermont appreciates these comments and recognizes the importance of monitoring to ensure that all services are of high quality and have appropriate oversight mechanisms in place. Having these flexibilities would align the Developmental Disabilities Services and Brain Injury programs with CFC, through which spouses can already be paid caregivers with some limitations. The same safeguards would be put into place for the Developmental Disabilities Services and Brain Injury programs as currently exist for CFC to ensure services provided by parents of a minor child, spouses, or legal guardians promote the health, safety, and welfare of enrollees. In addition, the State will only permit parents of a minor child, spouses, or legal guardians to be reimbursed for these services when necessary to fulfill a specific unmet need of the enrollee.



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As noted in the demonstration renewal application, after the expiration of temporary flexibilities and programmatic changes resulting from the COVID-19 public health emergency (PHE), the State will not make payments for personal care, life skills aide, and community support services provided by parents, legal guardians, or spouses for programs that are only authorized due to the PHE until new State policies for these benefits go into effect. During the policy development process, the State will seek public comment and work with other stakeholders to define the scope and expectations of this authority to ensure that there is sufficient monitoring and accountability and oversight of instances in which parents, legal guardians, or spouses provide personal care services, life skills aide, or community support services.

Waivers of the Institution for Mental Disease (IMD) Exclusion for Mental Health and SUD Treatment and Access to Family-Focused Residential Mental Health and SUD Treatment

29. **Comment:** Two commenters expressed support for the State’s request to obtain federal financial participation (FFP) for IMD stays over 60 days for individuals obtaining mental health treatment. One commenter sought clarification on whether the State could still meet the federal requirement to have an average length of stay of 30 days in IMDs if it applies the inpatient exception to the inmate exclusion to IMDs.

Response: Vermont thanks the commenters for their support of its request to obtain FFP for IMD stays for mental health treatment that last more than 60 days. Vermont will still meet federal requirements for a 30-day average length of stay in IMDs for both mental health and SUD treatment if it applies the inpatient exception to the inmate exclusion to IMDs.

30. **Comment:** One commenter expressed concern about the proposal to eliminate the prohibition on FFP for IMD stays for mental health treatment that are longer than 60 days. The commenter noted that anecdotal evidence suggests many long IMD stays are attributable to a failure to engage individuals in treatment before their condition deteriorates. Further, the commenter raised concerns that without appropriate supports in the community, individuals with serious mental illness (SMI) in IMDs may not have an appropriate setting to which they can discharge, resulting in these individuals becoming “stuck” in the hospital.

Response: Vermont thanks the commenter for raising these concerns. The State agrees that it is critical to have sufficient community-based treatment capacity to prevent IMD stays and to support and integrate individuals into the community upon discharge from a psychiatric facility. Vermont is committed to ensuring that Medicaid enrollees with SMI are linked to the level of care that appropriately meets their individualized needs and that length of stay in residential or inpatient facilities is based on medical necessity. Vermont is not advocating for long IMD stays when not appropriate. Individuals with SMI may need less intensive levels of care as they progress in treatment and may need more intensive treatment if they suffer a setback, which is why Vermont offers a full continuum of mental health services, ranging from preventive services to residential and inpatient treatment. Through the life of the Global Commitment demonstration, Vermont has expanded access to community-based treatment



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for individuals with SMI and serious emotional disturbance (SED), such as through the CRT program and Mental Health Under 22 for Individuals with SMI or SED programs, which allow individuals who may otherwise require institutional care to obtain treatment and supports in their homes and communities, preventing their conditions from deteriorating to the point of requiring inpatient or residential psychiatric services. Through the demonstration renewal period, Vermont is seeking to retain these programs and also institute new initiatives that will provide community-based supports for Vermonters with SMI, SED, and/or SUD.

For example, Vermont intends to:

- Add a peer supports benefit under its State Plan.
- Implement the Permanent Supportive Housing Pilot program to help, among others, individuals with SMI and SUD successfully transition into and maintain residency in permanent supportive housing.
- Create the SUD Community Intervention and Treatment eligibility group to expand access to community-based SUD treatment for low- and moderate-income Vermonters, many of whom are likely to have co-occurring mental health conditions.

31. **Comment:** One commenter noted that the article “Inpatient Psychiatric Care in the 21st Century: The Need for Reform” is an opinion piece, and asked whether there is any research on the impact of “ultrashort” hospital stays on premature discharge for patients with acute symptoms. The commenter also asked whether Vermont considered hospital stays of 30 days to be “ultrashort.”

Response: Vermont appreciates the commenter’s interest in ensuring the demonstration advances evidence-based care. Vermont is committed to offering the full continuum of mental health services to ensure that people are able to obtain the appropriate level of care based on their needs, whether it is community-based treatment or residential or inpatient treatment. When an individual needs care in a psychiatric facility, Vermont believes their length of stay should be determined according to their individualized needs, which at times may be greater than 30 or 60 days. Several research articles note that shorter length of stay for psychiatric patients can be correlated with greater likelihood of readmission. For example, a cross-sectional analysis of over 60,000 discharges from state psychiatric hospitals published in the Journal for Healthcare Quality found that length of stay under 92 days was significantly related to readmission within 30 days of discharge, with the greatest likelihood of readmission within 30 days of discharge found among individuals whose stays lasted 32 days or less.⁴⁹ Vermont has updated the application to include these citations.

32. **Comment:** One commenter asked whether the State believes that rational hospital treatment for SUD is the same as for psychiatric patients, such that similar maximum average length of stay rules should apply, and requested any research that would support this belief.

⁴⁹ Ortiz, G. “Predictors of 30-day Post-discharge Readmission to a Multistate National Sample of State Psychiatric Hospitals.” Journal for Healthcare Quality: official publication of the National Association for Healthcare Quality, 2019.



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Response: Vermont is committed to ensuring that Medicaid enrollees with SMI are linked to the level of care that appropriately meets their individualized needs and that length of stay in residential or inpatient facilities is based on medical necessity. For both psychiatric and SUD treatment, there are instances where shorter and longer lengths of stay are appropriate, depending on an individual’s needs. CMS has established that all states that have obtained a waiver of the IMD exclusion for mental health or SUD treatment must achieve a 30-day average length of stay statewide. Vermont meets this metric for both mental health and SUD treatment.

33. **Comment:** One commenter asked under which federal rule the Vermont Psychiatric Care Hospital and the Brattleboro Retreat qualify as medical institutions.

Response: Vermont Psychiatric Care Hospital and the Brattleboro Retreat qualify as medical institutions under 42 CFR §435.1010.

34. **Comment:** One commenter noted that Act 57 of the 2021 Session directs the Department of Mental Health to convene a working group to draft and submit a report to the legislature addressing models for forensic treatment, including the size, scope, and fiscal impact of any forensic treatment facility, and asked whether the construction of such a facility would render the inpatient exception to the inmate exclusion unnecessary.

Response: Under the inpatient exception to the inmate exclusion, states are able to obtain Medicaid reimbursement for Medicaid-eligible inmates when the inmate is admitted as an inpatient at a medical institution for a stay of at least 24 hours. If Vermont builds a forensic facility, it is likely that some inmates would still be admitted to other IMDs, and the State believes that it should be able to claim FFP for these individuals since the IMDs meet the definition of a medical institution under federal regulations. A forensic facility would not meet the definition of a medical institution under federal regulations, and Vermont recognizes that it would not be able to obtain Medicaid reimbursement for patients in these facilities.

35. **Comment:** Two comment letters shared that while the demonstration renewal application suggests the State has been “largely successful” in meeting goals and objectives from the current demonstration period pertaining to SMI/SED, original analysis of Vermont Uniform Hospital Discharge Data suggests that ED wait times and lengths of stay for psychiatric patients have not improved. The comment letters also noted that they were not aware of any new investments in community mental health supports. Another comment letter asked which of the SMI/SED goals the State had met.

Response: Vermont’s statement in the application narrative regarding its success in meeting the goals and objectives from the current demonstration period refers to the State’s success in meeting the overall goals of the Global Commitment demonstration. Based on this feedback, the State has revised this portion of the application for clarity. The SMI/SED goals outlined



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on page 11 of the application are specific to the waiver of the IMD exclusion for mental health treatment that was approved by CMS on December 5, 2019. This amendment authorized Vermont to receive Medicaid reimbursement for individuals obtaining psychiatric treatment in IMD settings. As noted in footnote #8, Vermont will report SMI- and SED-related metrics defined by CMS in the future. As part of this IMD amendment, Vermont was also required to submit SMI/SED Implementation and Financing Plans. These plans describe planned future investments in community mental health.

The Global Commitment evaluation design was revised as a result of the amendment approving the waiver of the IMD exclusion for mental health treatment. CMS approved the revisions to the evaluation design in late 2020; the evaluation will examine ED utilization for Medicaid enrollees using Medicaid claims data but does not rely on the Vermont Uniform Hospital Discharge Data as a source. Results will be included in the final summative evaluation report in the summer/fall of 2022.

36. **Comment:** One commenter asked how the public can access the State’s latest SMI Monitoring Protocol.

Response: The Global Commitment special terms and conditions (STCs) have been updated to include the SMI Monitoring Protocol approved by CMS on March 29, 2021. It is also available at the following link: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-ca.pdf>.

37. **Comment:** Two commenters expressed support for Vermont’s request to obtain FFP for stays longer than 60 days for women and children obtaining services in the Lund Home.

Response: Vermont thanks the commenters for their support.

Permanent Supportive Housing Pilot

38. **Comment:** Ten commenters supported the request for the Permanent Supportive Housing Pilot.

Response: Vermont thanks commenters for their support of the Permanent Supportive Housing Pilot.

39. **Comment:** Three commenters requested that Vermont expand eligibility for the Permanent Supportive Housing Pilot beyond the highest-needs individuals, as housing instability and homelessness also impact individuals in lower-needs groups. One commenter recommended that the State only require an individual to meet one criterion in either the health-based or risk-based category.

Response: Vermont thanks commenters for their input. Vermont intends to implement this program as a pilot to test and evaluate permanent supportive housing-related benefits. If



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evaluation of this pilot yields positive results, the State will consider expanding the Permanent Supportive Housing Pilot beyond the initial pilot population in the future.

40. **Comment:** One commenter asked for additional information on the prioritization criteria that Vermont will adopt if demand for permanent supportive housing services exceeds resource availability.

Response: Upon approval of the demonstration renewal application, Vermont will develop prioritization criteria for this program and seek stakeholder input. Vermont will make these criteria publicly available.

41. **Comment:** Multiple commenters offered suggestions for design of the Permanent Supportive Housing Pilot, including recommending that as part of program design, Vermont engage individuals experiencing homelessness, the Vermont Housing Finance Agency, the Vermont Housing and Conservation Board, behavioral health agencies, Housing Opportunities for Persons with AIDS (HOPWA), Continuum of Care, and other housing and social service providers across the State.

Response: Vermont appreciates commenters' willingness to engage in program design efforts. After submission of the Global Commitment renewal application, the State will begin more intensive implementation planning for this program and will seek additional input from stakeholders as it continues the design of the Permanent Supportive Housing Pilot.

42. **Comment:** Multiple commenters recommended that with the planned implementation of the Permanent Supportive Housing Pilot, the State offer capacity-building funds and/or technical assistance to housing agencies, which may have less experience in billing Medicaid services than other types of providers. Commenters also recommended use of daily or capitated rates for supportive housing services to allow housing agencies to focus on addressing client needs, rather than monitoring the amount of time spent delivering specific services.

Response: Vermont appreciates these recommendations and intends to develop guidance and provide technical assistance to providers on billing for these services. The State has not yet developed the payment methodology for services that are part of the Pilot and will take this feedback into account as it embarks on this work.

43. **Comment:** One commenter noted that the demonstration renewal application suggests that one of the goals of the Permanent Supportive Housing Pilot is to reduce racial disparities in homelessness in Vermont, and highlighted that while data do show that Black Vermonters face higher rates of homelessness than white Vermonters, there are not sufficient data to suggest that Black Vermonters experiencing homelessness are also likely to meet the health- and risk-based criteria required for Permanent Supportive Housing Pilot eligibility. The commenter raised concerns that the Pilot is not designed to address the disproportionate homelessness of Black Vermonters and that prioritization criteria used to determine Pilot eligibility may itself lead to racial disparities.



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Response: Vermont thanks the commenter for raising this concern. The State remains committed to promoting racial equity in all programs and services in the Global Commitment demonstration. As Vermont undertakes further design of the Permanent Supportive Housing Pilot, it will explicitly account for equity when refining the eligibility criteria and selecting and training supportive housing service providers. The State will solicit ongoing stakeholder input through this process to ensure that the Pilot meets the needs of groups disproportionately impacted by homelessness, including Black Vermonters.

Through ongoing monitoring and evaluation of the Global Commitment demonstration, Vermont's independent evaluator will aim to assess the extent to which this program is promoting health equity and identify potential disparities in access to Pilot services and permanent supportive housing more broadly, to the extent that necessary data are available. Vermont recognizes that today, AHS does not have sufficient data to optimally assess racial and ethnic disparities in access to Medicaid services and programs. Over the next several years, AHS will be working to improve its data systems and collaborate with community partners to strengthen the State's ability to better understand how Vermont's health ecosystem serves members of different racial and ethnic groups.

The State has made edits to the demonstration renewal application to clarify its vision and intent for the Permanent Supportive Housing Pilot.

44. **Comment:** One commenter asked which support services Vermont lacked such that the State was unable to use all of its HUD vouchers, and whether the proposed Permanent Supportive Housing would address the inability to use HUD vouchers.

Response: According to a 2019 legislative report, the Specialized Housing Vouchers Working Group estimated that roughly 55% of the households eligible for Continuum of Care (CoC) Shelter + Care (S+C) or Rapid Rehousing (RRH) cannot be served due to a lack of service capacity or subsidy in the communities where they are needed.⁵⁰ There are currently programs operated by the Department for Children and Families (DCF), Department of Mental Health (DMH), Department of Corrections (DOC), and Vermont Department of Health (VDH) that offer housing-related services to certain populations but these programs alone do not meet the intensive supportive housing needs of all Vermonters eligible for vouchers due to program eligibility criteria and separate targeting or prioritization of each program.

The Permanent Supportive Housing Pilot will address the full range of pre-tenancy supports, tenancy sustaining services, and community transition services that enable Vermonters with intensive service needs to achieve and maintain housing. Vermont will work with stakeholders during the operational planning process to align this benefit in such a way as to

⁵⁰ "Specialized Housing Vouchers Working Group: Report to the Vermont Legislature." November 15, 2019. <https://legislature.vermont.gov/assets/Legislative-Reports/Specialized-Housing-Voucher-Report-FINAL.pdf>.



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maximize the use of federal permanent supportive housing vouchers and is committed to working with the Homeless Continuums of Care to identify those opportunities.

45. **Comment:** One commenter asked whether the proposed Pilot program differs from programs offered by organizations such as Pathways Vermont, and what impact the Pilot will have on housing programs in Vermont that already offer similar services to Medicaid-eligible individuals.

Response: Vermont recognizes that existing housing programs are important contributors to the State’s overall approach to reducing homelessness and housing instability. When conducting further design of the Permanent Supportive Housing Pilot, Vermont intends to identify ways to leverage existing programs to connect Medicaid-enrolled individuals to permanent supportive housing.

Engaging Vermonters in Transforming Their Health

46. **Comment:** One commenter highlighted the important role of in lieu of services in addressing social determinants of health (SDOH) and requested that Vermont meet criteria in 42 CFR § 438.3(e)(2) in its provision of in lieu of services. The commenter also requested clarification on how Vermont will ensure that it has a transparent process for meeting the federal regulatory requirements for in lieu of services and demonstrating that the State is providing appropriate in lieu of services to address Medicaid enrollees’ needs.

Response: In transitioning to a risk-bearing managed care model, the Agency of Human Services (AHS) will ensure that DVHA complies with Medicaid managed care rules set forth in 42 CFR Part 438, including those requirements related to provision of in lieu of services. AHS will post approved in lieu of services on its website and evaluate them as part of the broader Global Commitment evaluation.

47. **Comment:** One commenter asked that the State support nontraditional partnerships for effective, efficient service delivery, particularly with respect to efforts to integrate food access and medically appropriate diets.

Response: Vermont thanks the commenter for their recommendation and will continue to explore innovative service delivery models. With DVHA’s transition to acting as a risk-bearing MCO, Vermont anticipates that DVHA will have increased flexibility to test new models addressing SDOH.

48. **Comment:** Several commenters expressed support for the expenditure authority for public health infrastructure. One commenter recommended that investments in public health infrastructure include capacity building for housing and homelessness organizations. Another commenter asked that the State ensure it invests in nonmedical population health initiatives, such as efforts to improve capacity for coordination of services to address SDOH. Another commenter recommended that the State model aspects of its population health program after



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the Ryan White HIV/AIDS Program to ensure population health efforts support the complex needs of individuals with HIV/AIDS.

Response: Vermont thanks the commenters for their support. While the proposed expenditure authority for public health infrastructure will largely support existing programs, with DVHA's transition to a risk-bearing MCO, DVHA will have new flexibility, including through use of MCO savings, to test innovative care models addressing both medical and nonmedical drivers of health. Vermont looks forward to collaborating with stakeholders to identify priorities for innovation.

49. **Comment:** Three commenters expressed support for the proposed expenditure authority for workforce investments. One commenter asked that Vermont also use workforce investments to support and expand the intellectual/developmental disability (I/DD) and mental health provider workforce. Another commenter recommended prioritizing initiatives for workers who commit to working for some length of time (e.g., 2-5 years) in long-term care settings.

Response: Vermont thanks these commenters for their support and appreciates the suggestions to explore opportunities to invest in the I/DD and mental health provider workforce and prioritize initiatives to build the long-term care workforce. Outside of the Global Commitment demonstration, Vermont has proposed putting \$15 million of the enhanced FMAP for HCBS available under the American Rescue Plan toward HCBS workforce development initiatives.

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

Advancing Integration of Care Coordination

50. **Comment:** Two commenters expressed support for Vermont's intent to better align care coordination programs across the State. They noted the need for the State to both allow sufficient time to work with stakeholders on specific proposals and ensure sufficient funding for care coordination services under the capitation rate.

Response: Vermont thanks the commenters for their support, and will continue to seek input from stakeholders as it strengthens its care coordination infrastructure across the many successful care coordination programs that exist in Vermont today, including Blueprint, VCCI, targeted case management programs, home- and community-based waiver (HCBW)-like case management, and Support and Services at Home (SASH), among others. AHS will continue to provide the funding required to support the full array of Medicaid care coordination services.

51. **Comment:** One commenter sought clarification on how Area Agencies on Aging fit into the proposed vision for integrated care coordination. They noted that the State mentions Designated Agencies and patient-centered medical homes (PCMHs) as examples of lead care



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coordination entities, and requested that Area Agencies on Aging be able to serve in a lead role for high-risk older adults as the care coordination model evolves.

Response: Vermont considers Area Agencies on Aging important partners in the care coordination system and envisions them maintaining their role in ensuring high-quality integrated care for older Vermonters. In addition to providing care coordination for the CFC populations, Vermont anticipates that Area Agencies on Aging will continue to serve as lead care coordination entities for Medicaid enrollees attributed to the All-Payer ACO. Vermont has updated the demonstration renewal application to reflect the important role that Area Agencies on Aging play in Vermont’s care coordination system.

52. **Comment:** One commenter sought clarification on the proposed expenditure authority for Blueprint for Health, including how planned staffing compares to existing Blueprint staffing.

Response: Vermont is seeking expenditure authority for \$15 million (total computable) over the five-year demonstration to fund a network of three types of staff who supervise and support the following Blueprint initiatives: (1) program managers, who monitor practices’ participation as PCMHs, integration with the local Community Health Teams, and implementation of Vermont’s care coordination models; (2) quality improvement facilitators, who assist PCMHs in identifying and implementing quality improvement projects; and (3) self-management regional coordinators, who administer self-management programming in each of the Health Service Areas. Today, these existing positions are funded as Global Commitment investments.

53. **Comment:** One commenter requested that the State’s plan for integrated care coordination extend beyond Blueprint for Health and include care coordination at other types of community providers beyond those participating in Blueprint.

Response: Vermont agrees that it is critical that care coordination be available through a variety of types of community-based providers, including PCMHs, Designated and Specialized Services Agencies, Home Health Agencies, Area Agencies on Aging, and SASH, that deliver care coordination through Blueprint, the All-Payer ACO, and HCBW-like programs.

54. **Comment:** One commenter asked that Vermont ensure compliance with CMS’s rules regarding conflict-free case management, recommending that the State decouple case management from service delivery and implement a “choice model,” in which individuals can choose to use an independent case management entity (as the default option) or continue to obtain case management from the entity that delivers their services. If the State pursues a choice model, the commenter requests that it include an ombudsman program and independent options counseling.



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Response: Vermont appreciates this comment and is working with CMS to ensure that its case management for HCBW-like programs aligns with CMS’s principles for avoiding conflicts of interest.

Strengthening Providers’ Ability to Participate in Health Information Exchange (HIE), Advancing Population Health

55. **Comment:** One commenter requested that the State simplify and align data and reporting systems whenever possible and ensure systems for working with diverse partners in support of population health goals are not so technically complex and disjointed that they are cumbersome to those using them.

Response: Vermont is committed to reducing administrative burden on providers and will seek to align and streamline data and reporting systems and requirements wherever feasible.

56. **Comment:** One commenter expressed support for the proposed expenditure authority for improving providers’ ability to participate in HIE and requested that the State eliminate state-mandated reporting systems that exist outside of electronic health records to avoid duplicative record keeping.

Response: Vermont aims to reduce provider administrative burden and will continue to explore opportunities for reducing reporting burden.

57. **Comment:** One commenter asked that Vermont include SASH providers in its effort to strengthen providers’ ability to participate in HIE to advance population health.

Response: Vermont recognizes that it is important that all provider types, including specialty providers and social service organizations, have the ability to access and share data through the Vermont Health Information Exchange (VHIE). If CMS approves Vermont’s HIE-related requests, Vermont anticipates making funding available to a wide range of providers that are not yet connected to the VHIE.

Accelerating Groundbreaking Payment Reform

58. **Comment:** Two commenters expressed support for the continued participation of DVHA in the All-Payer ACO Model to promote alignment of payment reform efforts across payers.

Response: Vermont thanks the commenters for their support.

59. **Comment:** One commenter asked that Vermont preserve funding structures, such as the federally qualified health center (FQHC) prospective payment system (PPS) rate, which allows FQHCs to support the range of quality services they currently provide.

Response: Vermont does not intend to change FQHC payment methodologies, and DVHA will continue to pay FQHCs using the PPS methodology.



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60. **Comment:** One commenter requested that the State provide sufficient funding for transition costs associated with implementation of any new payment reform structures.

Response: Vermont appreciates the commenter's request. The State recognizes that there are costs to providers associated with implementation of new payment models and seeks to support providers in making these transitions. Through the demonstration renewal, the State is seeking the ability to obtain federal Medicaid matching funds for several initiatives that will strengthen providers' ability to participate in HIE. Vermont intends for this funding to support providers in enhancing their population health management capabilities and their ability to succeed in VBP arrangements. Outside of the Global Commitment renewal, Vermont has proposed using \$17 million of the enhanced FMAP for HCBS available under the American Rescue Plan to advance VBP reforms for Medicaid HCBS providers historically excluded from VBP arrangements.

61. **Comment:** One commenter expressed concern about the proposal to expand VBP in HCBW-like programs. The commenter noted that models that condition payment on providers' performance on quality metrics can have unintended consequences for HCBS providers. Because many HCBS providers operate within tight margins, even a small financial penalty could place significant stress on the provider. The commenter asked that the State consider implementing VBP arrangements across the system of care, rather than in individual agency contracts, and ensuring any system-level VBP benefits are used to support the lowest-performing providers. Finally, the commenter asked that the State ensure HCBS recipients and their families are represented in the governance of any HCBS VBP models. Another commenter asked the State to engage HCBS providers when designing these models.

Response: Vermont appreciates these commenters' concerns and is committed to ensuring that Vermont has a robust, sustainable network of HCBW-like providers. The State recognizes the challenges associated with implementing VBP arrangements for HCBW-like providers. As Vermont continues to refine its payment model for Developmental Disabilities Services and develops new payment models for other HCBW-like programs, the State will work closely with HCBW-like providers, consumers and their families, and other stakeholders to ensure models incentivize high-quality care without jeopardizing provider financial sustainability. In addition, as part of the demonstration renewal, Vermont intends to both strengthen HCBW-like providers' ability to participate in future VBP arrangements by assessing gaps in their ability to store, share, and utilize electronic health data and provide funding to providers to assist them in gaining the electronic data capabilities needed to participate in VBP arrangements. Finally, outside of the Global Commitment renewal, Vermont has proposed using \$17 million of the increased FMAP for HCBS available under the American Rescue Plan to advance VBP reforms for Medicaid HCBS providers historically excluded from VBP arrangements.



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62. **Comment:** Three commenters expressed concern that the demonstration renewal application does not seek to change Vermont’s current policy of reimbursing out-of-state, in-network providers at a lower rate than in-state providers.

Response: While DVHA’s transition from operating as a non-risk-bearing managed care plan to a risk-bearing MCO will change how DVHA is paid and held accountable for cost of care, the State anticipates that this transition will not have an impact on how DVHA pays out-of-state providers.

Evaluation

63. **Comment:** One commenter requested clarification on how the proposed evaluation approach of analyzing the percentage of permanent supportive housing service recipients with a principal diagnosis of alcohol or other drug dependence who had a follow-up after ED visits following the demonstration renewal would test the stated hypothesis that “the demonstration will reduce health care costs for Medicaid-eligible individuals [who] access permanent supportive housing services.” The commenter noted that an evaluation of whether individuals who accessed permanent supportive housing services had a reduced number of ED visits would be a more appropriate way to test the hypothesis.

Response: The State plans to work with CMS and an independent evaluator to identify hypotheses and evaluation approaches to be included in the demonstration final evaluation design that best assess the impact that permanent supportive housing services have on health care costs for Medicaid enrollees. The State agrees that assessing whether individuals that accessed permanent supportive housing services had reduced ED visits is a way to measure costs as an outcome. The State has included this input as a proposed approach in the demonstration renewal application and will consider it as it develops the final evaluation design in collaboration with CMS and the demonstration evaluation team.

64. **Comment:** One commenter requested a more substantive evaluation of the CRT program and whether it is meeting its goals.

Response: Vermont is committed to ensuring that there is robust independent evaluation of the 1115 demonstration, including the ability to perform rapid cycle evaluation to demonstrate the impact of Global Commitment programs, including CRT. Vermont has updated the demonstration renewal application to address its plans to use rapid cycle evaluation. The evaluation hypotheses in the application are drafts to be discussed and refined with the State’s independent evaluator after CMS approves the demonstration renewal.



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Other Areas of Comment

65. **Comment:** One commenter asked the State to collaborate with community organizations on innovative projects that are identified by communities and patients and to offer support in scaling up successful pilot projects.

Response: Vermont appreciates the commenter’s suggestion and will continue to work with organizations across the State—including community organizations—to advance innovative projects that improve health.

66. **Comment:** One commenter asked that the State cover HIV counseling and education through the demonstration, including counseling on HIV PrEP and HIV testing policies for individuals who inject drugs.

Response: Vermont thanks the commenter for their suggestion. Several HIV PrEP drugs are on the Vermont Medicaid Preferred Drug List, and Vermont Medicaid currently covers HIV counseling and education.

67. **Comment:** One commenter noted that while the demonstration renewal application addresses racial disparities in insurance coverage, it does not address racial disparities in experience of care.

Response: Vermont is committed to addressing racial disparities in experience of care both within and beyond the purview of the Global Commitment demonstration. In June 2021, the Vermont Department of Health was awarded a \$28.5 million grant from the United States Centers for Disease Control and Prevention as part of the National Initiative to Address COVID-19 Health Disparities Among Populations at High-Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities. Vermont is planning to use these funds for a variety of initiatives that aim to promote equity in Vermonters’ experiences of care, such as:

- Improving culturally and linguistically appropriate health information, health education, COVID-19 testing, and clinical services
- Creating a Mental Health Cultural Liaison Program with community partners
- Creating and implementing baseline and advanced health equity trainings for providers health care professionals
- Investing in programs to ensure black, indigenous, and other people of color (BIPOC), refugee, and immigrant communities can pursue health and allied health degrees, increasing opportunities for Vermonters who are BIPOC to seek care from providers who are part of the same racial or ethnic group.

Vermont is also exploring strategies to expand the implementation of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. Vermont welcomes and appreciates further input from stakeholders on strategies to promote health equity and looks forward to identifying opportunities to address structural racism in



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Vermont's health care system through the newly created Health Equity Advisory Commission and future Office of Health Equity established per Act 33 of 2021.

68. **Comment:** One commenter noted that a group of Vermont's peer organizations published a white paper in 2019, which made several recommendations for addressing challenges in Vermont's mental health system, including development of a network of peer-run respite and community centers, and development of a two-bed peer respite with attached community centers. The commenter asked why Vermont has not requested expenditure authority to develop peer-run respite and community centers and has not proposed a pilot demonstration of the two-bed peer respite.

Response: Vermont thanks the commenter for this question. At this time, Vermont has decided to prioritize expansion of peer support services, which are less costly than the proposals cited from the 2019 white paper. In addition to adding peer supports to the State Plan, Vermont's proposed spending plan for the enhanced FMAP for HCBS made available under the American Rescue Plan includes \$15 million for training, recruitment, and retention of the HCBS workforce, including peer specialists.

69. **Comment:** One commenter recommended that the State allow funding for Medicaid-eligible individuals served by an expansion of the current SASH model to younger populations, as proposed as part of the Open Meeting Call for Proposals on February 25, 2021.

Response: Vermont thanks the commenter for this recommendation. While the State has not requested explicit expenditure authority for SASH, the proposed risk-bearing MCO model will allow the State flexibility to use managed care savings to invest in SASH services.

70. **Comment:** One commenter asked why Vermont did not delay its demonstration renewal after the State passed legislation to delay the renewal process by one year. The commenter also asked whether the public comment period could be extended.

Response: Vermont appreciates the commenter's interest in the demonstration renewal. CMS required Vermont to submit its Global Commitment demonstration renewal application by June 30, 2021. In accordance with federal regulations governing the 1115 demonstration renewal process, the State held a 30-day state public comment period from May 13 to June 12, 2021. After Vermont submits its application to CMS and CMS determines that the application is complete, CMS will hold another 30-day public comment period on the application. Vermont encourages stakeholders to submit any additional feedback during that period, which will likely begin in mid-July.



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Appendix C – Letters of Public Comment

525 Clinton Street
Bow, NH 03304
Voice: 603-228-2830
Fax: 603-228-2464



61 Elm Street
Montpelier, VT 05602
Voice: 802-229-0002
Fax: 802-223-2336

June 11, 2021

AHS Medicaid Policy Unit
280 State Drive, Center Building
Waterbury, VT 05671-1000

Submitted via e-mail to AHS.MedicaidPolicy@vermont.gov

Thank you for the opportunity to comment on Global Commitment Register (GCR) proposed policy 21-033.

Bi-State Primary Care Association (Bi-State) is a 501(c)3 nonprofit organization, formed by two health and social service leaders in 1986 to expand access to health care in Vermont and New Hampshire. Today, Bi-State represents 31 member organizations across both states that provide comprehensive primary care services to over 300,000 patients at 142 locations. Our members include Federally-Qualified Health Centers (FQHCs), clinics for the uninsured, rural health clinics, Area Health Education Center programs, and Planned Parenthood of Northern New England.

Bi-State is a member of the coalition of provider associations and participated in compiling the comments submitted by that coalition. We are submitting these separate comments as a complement to that correspondence to highlight some of our association's priorities.

Federally-qualified health centers began as a movement to ensure comprehensive health services to all community members. Our understanding of good health has always been rooted in both medical treatment and addressing foundational social and lifestyle factors. This perspective is true in both prevention and treatment. We work to find approaches that address root causes of illness, not only manage symptoms, and to clear barriers to patients completing treatment designed with their clinicians.

Reimbursement structures have not always kept pace with emerging best practices to support a systems-based perspective on health. We appreciate the need to balance flexibility and support of innovation with safeguarding quality and prudent fiscal management. Our interventions need to be effective in promoting good health outcomes, promote those outcomes at a reasonable cost, and be appropriately matched to the best funding source, including by not duplicating services more appropriately funded outside of health care. At the same time, the administrative and evidentiary burden of demonstrating these elements cannot be so high that providers are unable to participate. We appreciate the willingness of Vermont state officials to work with all stakeholders to find options that navigate these factors in a reasonable way.

We recognize that many states utilize an MCO structure to achieve responsible flexibility in reaching health care goals. We recognize that the Vermont Agency of Human Services has determined that a non-traditional risk-bearing MCO arrangement, with broad in lieu of services flexibilities combined with designated funding for pilot programs and priority areas, represents the best path forward to achieving this goal. We also recognize that Vermont's small population, older demographic, and small geographic size (which leads to frequent cross-over with health care services between neighboring states) complicate all available models. We support the general approach outlined in proposed policy 21-033, with the guardrails articulated in the coalition letter. However, based on the previous response to similar proposals, we are concerned that this approach may not be approved and we want to ensure that the state will work with stakeholders on other pathways to reach our larger goals if necessary.

We agree with the comments, considerations, and priorities submitted by the health care provider coalition. Below we highlight some objectives for future work with the state that build from that framework:

- Preserving the basic funding structure that supports the range of quality services currently provided to all patients by FQHCs. For example, we acknowledge that there are certain services, including the FQHC PPS rate, that cannot be replaced by structures such as in lieu of services.
- Supporting innovative projects that address needs identified by our communities and patients, often in partnership with other community organizations. An example of this is Beacon Apartments project with the Community Health Centers of Burlington, addressed in detail in separate comments submitted by CHCB.
- Supporting non-traditional partnerships to deliver services in efficient, effective ways. An example of this is the ongoing efforts of our members to integrate food access and medically appropriate diet into their practices. Bi-State recently completed an assessment of “food as medicine” strategies through a HRSA planning grant. Challenges we face include:
 - Payment options for covering food as medical treatment, including prepared meals, which other states have resolved through in lieu of services arrangements.
 - Referral systems that allow for coordinated management of patients with our food-focused community partners, which can be supported by investments in data and information systems along with care coordination.
 - Options for engaging with patients more frequently, using the full care team. This structure allows for the necessary coaching to facilitate lifestyle change. This approach can be supported with alternative payment structures that complement the traditional FQHC Encounter and by using alternative “visit” modalities, such as telephone and online tools.
 - Strategies to address co-occurring barriers to health, for example when we look at “food insecurity” that often means transportation barriers to reach full-service groceries and other healthy food sources. Flexibility in benefits such as NEMT,

and programs such as Blueprint for Health that engage stakeholders at a community level, can help address complex barriers to good health.

- Funding and support for scaling up successful projects. While we celebrate the innovative spirit of pilot programs, they need a path towards sustainability (including financial sustainability that does not rely on recurring philanthropic donations) and expansion. We believe the CHCB comments on their Beacon Apartments project illustrate this challenge well.
- Simplifying and aligning systems wherever possible. The coalition comments address this concern in detail. We would add the observation that reaching the state’s goals for population and individual health require collaboration with diverse partners. If health care systems are so technically complex and disjointed as to be incomprehensible to anyone outside of our sector, that has a chilling effect on engagement and results in siloed approaches to common goals.
- Maintaining continuity with previous health care reform efforts and integrating with the All-Payer Model. A critical component of reaching the state’s goals of “accelerating groundbreaking payment reform” is providing sufficient funding, in the correct structure, for providers to make the necessary practice changes – there are transition costs to new structures that must be addressed for reform to result in better quality care.

We look forward to continuing to work with the Vermont Agency of Human Services on the process of designing and implementing the next stage of the Global Commitment to Health 1115 Demonstration project.

Sincerely,



Helen Labun
Director, Vermont Public Policy



June 12, 2021

State of Vermont
Agency of Human Services
Medicaid Policy Unit
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010

Submitted via e-mail to: AHS.MedicaidPolicy@vermont.gov

Re: 1115 Renewal Public Comment

On behalf of Littleton Hospital Association, Inc. d/b/a Littleton Regional Healthcare (“LRH”), please accept these comments on Vermont’s Global Commitment to Health Demonstration (“1115 Waiver”) Renewal. Because of Vermont’s geography and location, more Vermont residents obtain out-of-state hospital services than residents of any other state.¹ Vermont residents rely on border-state hospitals like LRH to provide necessary medical services within their particular localities.

LRH is a New Hampshire non-profit healthcare charitable foundation licensed for 25 beds located in Littleton, New Hampshire, approximately six (6) miles from the Vermont border. LRH is designated as a critical access hospital (“CAH”).

LRH is a high-volume provider of medical services to Vermont Medicaid enrollees. LRH is designated as an “Out-of-State In-Network Hospital” within Vermont’s Green Mountain Care Network, due to its close proximity to Vermont and the general practice of Vermont’s residents to secure care and services at this hospital.² LRH treats Vermont Medicaid and uninsured patients of all acuity levels, and incurs similar costs and expends similar resources as Vermont’s comparatively-sized and similarly-situated in-state CAH hospitals in order to provide care to Vermont residents.

Yet, under Vermont’s current 1115 Waiver, and under the proposed 1115 Waiver Renewal, Vermont reimburses LRH for inpatient and outpatient hospital services rendered to Vermont Medicaid patients at significantly lesser rates than in-state Vermont hospitals—solely because LRH is located across the border in New Hampshire.

This discriminatory reimbursement to LRH is unlawful and unconstitutional. LRH has joined three other border-state Plaintiff Hospitals serving Vermont Medicaid patients to sue Vermont and its

¹ Nineteen percent (19%) of all hospital stays for Vermont Medicaid recipients are out-of-state stays. See Medicaid and CHIP Payment Access Commissions, “Medicaid Payment Policy for Out-of-State Hospital Services” (January 2020), Appendix A, available at <https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid-Payment-Policy-for-Out-of-State-Hospital-Services.pdf> (last accessed 6/9/2021).

² See Agency of Human Services’ Provider Network Info, available at <https://dvha.vermont.gov/providers/provider-network-info/green-mountain-care-network> (last accessed 6/9/2021).

federal counterparts in the United States District Court for the District of Vermont to enjoin these illegal policies. That lawsuit remains pending. *Alice Peck Day Memorial Hospital, et al. v. Smith, et al.*, Civil Action No. 21-cv-00102-kjd (D. Vt.).

These comments address the Waiver/Expenditure Authority No. 5, “Payment to Providers,” 42 U.S.C. §§ 1396a(a)(13), (30).³ The 1115 Waiver Renewal seeks to extend Vermont’s ongoing practice of setting hospital rates on an individual or class basis that departs from State Plan rates to other costly Medicaid services, including mental health, SUD, LTSS, and developmental disabilities services.⁴ If approved, the 1115 Renewal will endorse Vermont’s continuation of this illegal and discriminatory rate discrepancy for out-of-state hospitals.

Although Vermont’s stated goals for the 1115 Waiver Renewal are to accelerate groundbreaking payment reform and to limit healthcare cost growth, Vermont improperly relies on the 1115 Waiver to underpay out-of-state hospitals that deliver Medicaid services to Vermonters.

For inpatient hospital services, Vermont reimburses in-state hospitals at base inpatient rates of \$8,835.00 for Prospective Payment System (“PPS”) hospitals, \$8,390.00 for Teaching Hospitals, and \$9,273.00 for CAHs. In contrast, Vermont reimburses out-of-state CAH and PPS hospitals at a rate of \$2,900.00 for the same services—a facial disparity of nearly seventy percent (70%). For LRH, this disparate treatment for inpatient reimbursements amounts to an annual deficiency of more than \$462,200, compared to what it would receive if in-state rates were applied.

For outpatient hospital services, Vermont reimburses in-state hospitals classified as CAHs at a rate of “113.00% of the Medicare 2019 OPPS national APC payment rate without local adjustment.” In contrast, Vermont reimburses LRH (also a CAH) at the lesser rate of “82.00% of the Medicare 2019 OPPS national APC payment rate without local adjustment.” This disparity of over thirty percent (30%) amounts to an annual deficiency of approximately \$338,000 for LRH.

Vermont’s materially lower reimbursement of out-of-state hospitals for the same inpatient and outpatient services threatens a core Medicaid objective: the provision of medical coverage to the needy. Since the last 1115 Waiver extension in 2016, Vermont has claimed that the 1115 Waiver permits the State to pay significantly lower rates to out-of-state hospitals, in conjunction with Vermont’s unique federally-approved “All-Payer Model.” The 1115 Waiver has allowed Vermont to implement a novel system of healthcare financing and service delivery facilitated by an All-Payer Accountable Care Organization. However, Vermont’s actions in setting discriminatory rates

³ See Vermont Global Commitment to Health 1115 Demonstration Renewal Application (5/13/2021) at 48, available at https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GC1115Waiver/FINAL_Global%20Commitment_Renewal_Application_5-13-2021_Public_Comment.pdf (last accessed 6/9/2021); see also Proposed GCR 21-033 Public Notice (5/13/2021) at 13, available at <https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GCRProposedPolicies/21-033-Proposed-GCR-1115Waiver-VT-Full-Public-Notice-5.13.2021.pdf> (last accessed 6/9/2021).

⁴ See *id.*, Vermont Global Commitment to Health 1115 Demonstration Renewal Application (5/13/2021) at 37-38.



have caused material financial harm to LRH, potentially leading to the diminishment of patient access to services.

Indeed, LRH's obstetrics program loses more than one million dollars (\$1,000,000) per year. This is unsustainable. Inadequate reimbursements adds to the financial pressure which may ultimately result in the permanent closure of LRH's obstetrics program. Vermont's disparate Medicaid reimbursement, in this regard, violates the core objectives of the Medicaid program.

The 1115 Waiver language Vermont relies upon to justify these substantial rate discrepancies has no rational connection to the All-Payer Model. The 1115 Waiver authorizes Vermont to act only to the extent necessary to achieve its stated objectives. But Vermont construes this limited authority as an expansive license to eliminate any and all statutory and regulatory requirements related to methodologies and justifications for establishing reimbursement rates. Vermont further construes the 1115 Waiver to absolve the state from its obligation to assure that payments for services provided by out-of-state hospitals are "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A).

Accordingly, LRH opposes the 1115 Waiver Renewal to the extent its implementation will continue to deprive LRH of substantial reimbursement for inpatient and outpatient hospital services solely due to its location in the bordering state of New Hampshire, even though a great many Vermont Medicaid patients utilize this border-state hospital's services and benefit from its proximity, convenience, and quality of care.

Sincerely,


Robert F. Nutter
President & CEO
Littleton Regional Healthcare



June 12, 2021

Via Email: AHS.MedicaidPolicy@vermont.gov

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

Re: *1115 Renewal Public Comment*

Dear Medicaid Policy Unit:

I write on behalf of MadFreedom, a human and civil rights advocacy organization whose mission is to secure political power and influence to end the discrimination and oppression of people based on perceived mental state. MadFreedom envisions a world where every person regardless of race, gender, sexuality, ableness, class and mental state has the freedom to live their life on their own terms without coercion and with equality under the law.

MadFreedom's constituents comprise every demographic. Thus, MadFreedom's advocacy reflects the multi-dimensional ways that our constituents experience discrimination and oppression. MadFreedom is just as much a racial justice organization as it is a LGBTQ advocacy organization as it is a Mad advocacy organization.

We welcome the opportunity to comment on Vermont's 1115 Renewal. Both for what it includes and also for what it excludes, Vermont's 1115 Renewal application will directly affect the lives of MadFreedom's constituents.

MadFreedom is particularly concerned about (1) the request to waive the Institution for Mental Diseases exclusion for mental health treatment; (2) the permanent supportive housing pilot; (3) the references to peer services and peer supports; (4) whether the SMI/SED goals under the current demonstration period have been met; and (5) the proposed evaluation of the hypotheses for the new demonstration features.

[POST OFFICE BOX 38 • POULTNEY, VT 05764-0038 • T: (802) 779-0570 • F: (802) 775-5284]

[INFO@MADFREEDOM.ORG • WWW.MADFREEDOM.ORG]

I. **Waivers of the Institution for Mental Diseases (IMD) Exclusion for Mental Health and SUD Treatment**

Vermont is requesting that CMS remove its prohibition on federal financial participation (FFP) for individuals obtaining mental health treatment in an IMD for longer than 60 days, as is permitted under Vermont's waiver of the IMD exclusion for SUD treatment. In support of this request, Vermont cites research that allegedly indicates that the national direction of "ultrashort" hospital stays has resulted in patients who are discharged too early, resulting in higher readmission rates and higher emergency department utilization post discharge. Currently, CMS requires Vermont to maintain average length of stay for mental health and SUD treatment at IMDs at or below 30 days.

The cited article, "Inpatient Psychiatric Care in the 21st Century: The Need for Reform," does not state what the renewal application alleges. The cited article explicitly states that "there are no data from controlled studies on outcome of ultra-short-stay hospitalizations to guide clinicians or public policy." In addition, the article cited is not research. Rather, it is an opinion piece published as an Open Forum article in the publication, *Psychiatric Services*. Furthermore, the article does not consider a 30-day hospital stay "ultrashort." According to the article, in the current prevalent hospitalization model, the average length of stay is five to six days. Thus, the article should be given no consideration when deciding whether to remove the prohibition on federal financial participation for hospital stays that exceed 60 days.

MadFreedom is concerned that waiving the prohibition will further mask deficiencies in Vermont's mental health care system. MadFreedom has anecdotal evidence that in many instances long hospital stays are attributable to a failure to engage individuals in treatment before their conditions deteriorate. For example, a Burlington resident who was ultimately killed by law enforcement in his apartment, was a patient at a local community health agency and a participant, at least nominally, in the agency's Community Rehabilitation and Treatment program. He stopped attending appointments and the agency never attempted to re-engage him in treatment. After a year of no treatment, he was arrested for refusing to leave a public establishment and thereafter spent nine months in the hospital. A few years later, he stopped treatment again, the agency did not re-engage him in treatment, which led to his untimely death.

MadFreedom is also concerned that waiving the prohibition will allow individuals to become stuck in the hospital because Vermont has not made sufficient investments in community-based resources. A 2017 University of Vermont study revealed that 62 percent of patients who

had lengths of stay greater than 30 days at UVM Medical Center between October 2014 and March 2017 were hospitalized longer than medically necessary because of a lack of community resources.¹ The unavailable community resources that precluded discharge included (1) housing; (2) step-down programs; (3) transportation to outpatient treatment; and (4) a support system.² The Brattleboro Retreat, a Vermont IMD, has also identified “bottlenecks in the system,” and a lack of step-down services as a barrier to discharge for its patients.³

Finally, Vermont’s waiver of the IMD exclusion for SUD treatment should not influence the decision whether to waive the IMD exclusion for mental health treatment. Rational treatment for substance use disorders differs from that for mental health treatment.

II. Permanent Supportive Housing Pilot

Vermont intends to seek expenditure authority for a Permanent Supporting Housing Pilot that is expected to begin in 2023. According to the renewal application, “[i]mproving access to permanent supportive housing is an important strategy for promoting equity and reducing racial disparities in homelessness in Vermont. In 2018, the Family Homelessness Point in Time report found that Black Vermonters were 5.4 times more likely to experience homelessness than white Vermonters.”

MadFreedom is concerned that while Vermont’s renewal application seems to suggest that one of the goals of the permanent supportive housing pilot is to remedy the racial disparities in homelessness in Vermont, the program as described is not structured to do so.

MadFreedom does not dispute the data which suggests that black Vermonters are overrepresented among Vermonters experiencing homelessness, as illustrated by the following chart.⁴

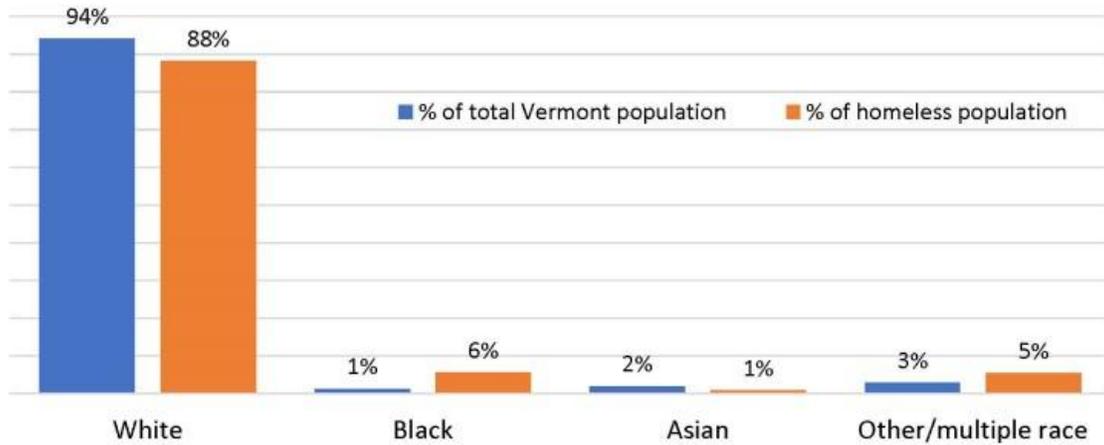
¹ Hoar, Eve MBA; Desjardins, Isabelle, MD; Whalen, Eileen MHA, RN. “Inpatient Psychiatry Barrier Days Analysis,” p. 1. (May 31, 2017: University of Vermont Medical Center).
https://mcusercontent.com/4c0f316156312742402b0121c/files/b18de1af-1d89-846d-e6e1-ddb4f20d9b91/5T3Yco_Inpatient_Psychiatry_Barrier_Days_Analysis.pdf. Last accessed June 12, 2021.

² Id. at p. 4.

³ Josephson, Louis, PhD. “Brattleboro Retreat: Overview & Update,” Capitol Plaza Hotel, Montpelier, Vermont, p. 11 (February 22, 2019: Brattleboro Retreat).

⁴ <https://www.vhfa.org/news/blog/vermont-housing-needs-assessment-reveals-racial-disparities>

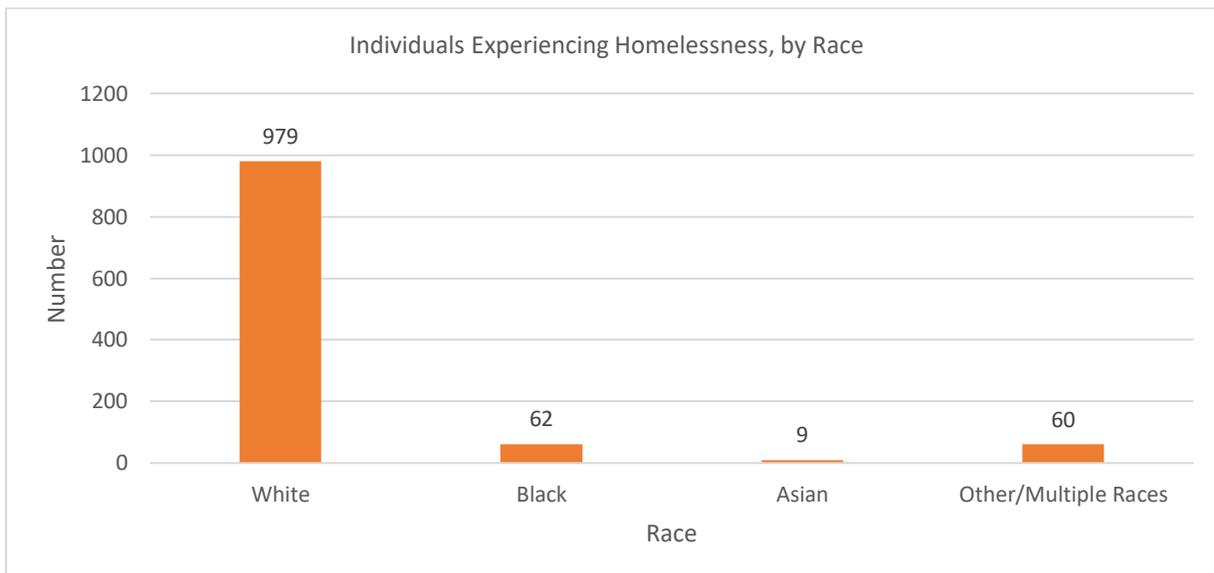
Vermont homelessness by race and share of population



Source: U.S Census Bureau 1-year estimates, 2018; Vermont Coalition to End Homelessness, 2020 Point in Time Count

Source: [2020 Point in Time Count](#)

However, the actual number of black Vermonters experiencing homelessness in 2020 as reported by the Point in Time Count was 62.⁵



Source: [2020 Point in Time Count](#)

⁵HousingData.org <https://www.housingdata.org/profile/population-household/homelessness>, last accessed June 11, 2021

The 2020 Point in Time Count did not tabulate the reasons individuals were experiencing homelessness nor did it collect, by race, any information about medical or mental health histories.

Vermont's proposed permanent supportive housing pilot would only be available to individuals who meet both health-based criteria and risk-based criteria. There is not sufficient information to determine how many or if any of the black Vermonters experiencing homelessness would meet the criteria to participate in the program. The homelessness of black Vermonters could be attributable to economic reasons rather than reasons of mental health or lack of available supports. For example, 57 percent of Vermont, black households earn less than 80 percent of Vermont's median income.⁶ Nearly 24 percent of black Vermonters live in poverty.⁷

MadFreedom finds it disingenuous to reference the disparate impact of homelessness on Black Vermonters as a reason for the permanent supportive housing pilot and at the same time design the program in a way that is not calculated to address the disproportionate homelessness of black Vermonters.

MadFreedom is also concerned about what prioritization criteria Vermont might impose should demand exceed resource availability. Prioritization criteria, while neutral on its face, could itself lead to racial disparities because of structural racism.

III. Peer Services and Peer Supports

The renewal application is overly vague and ambiguous in its references to peer services (SUD) and peer supports (CRT). The application leaves the reader to wonder whether peer services differ from peer supports.

It would also be helpful to include a timeline of when these interventions will be offered and whether these interventions will be available to individuals who are ineligible for the SUD program or the CRT program but otherwise eligible for Medicaid.

MadFreedom supports the expansion of what we understand to be peer services and peer supports if they are broadly offered and those offering the services are well-trained by people with lived experience.

More detail about what Vermont is contemplating in this regard would be helpful.

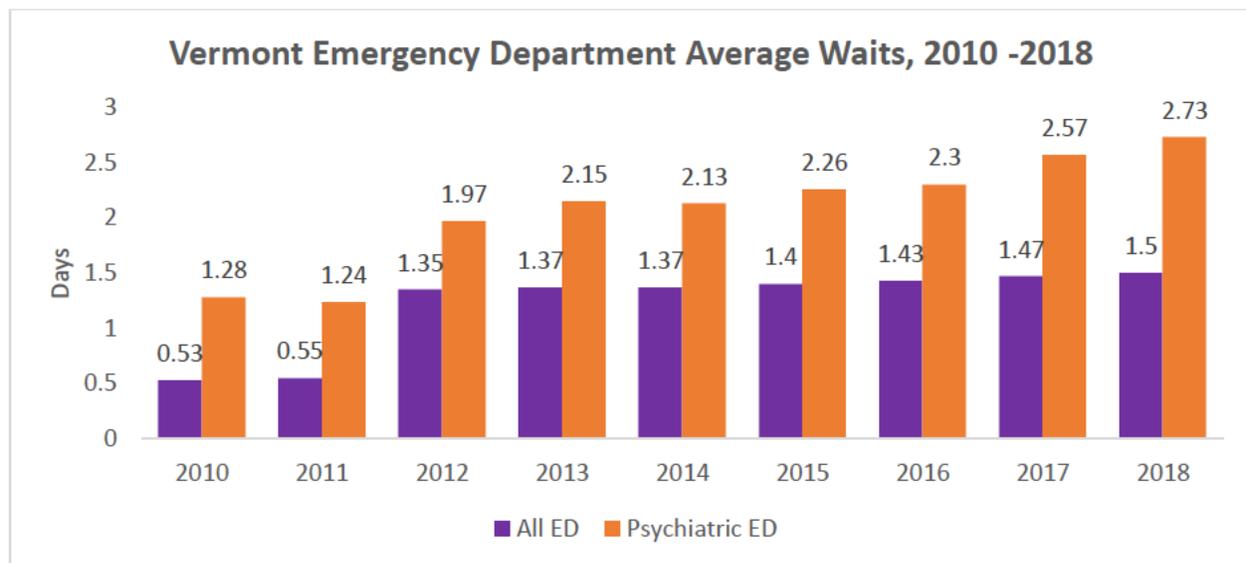
⁶ [Vermont Housing Finance Agency](#)

⁷ [U.S. Census Bureau 2018 5 year ACS Table S1701](#)

IV. Whether the SMI/SED Goals Under the Current Demonstration Period Have Been Met

The renewal application lists a set of goals and objectives of the current demonstration period for SMI/SED and asserts that “Vermont has largely been successful in meeting these goals.” The renewal application does not specify what is meant by “largely” successful.

MadFreedom’s own analysis of publicly available hospital discharge data does not support the conclusion that Vermont has been largely successful in meeting its SMI/SED goals⁸. At the below chart illustrates, average wait times in emergency departments for psychiatric patients have not improved.



Vermont legislators recently declared a crisis regarding emergency department waits for children seeking mental health care.

The following is a sampling of newspaper reporting on Vermont’s emergency departments and psychiatric patients.

[As kids wait for mental health care, their parents cry for help](#)

By Katie Jickling, May 17 2021

⁸ MadFreedom’s analysis was based on the Vermont Uniform Hospital Discharge data set publicly available upon request. See <http://www.healthvermont.gov/health-statistics-vital-records/health-care-systems-reporting/hospital-discharge-data>. Last accessed on June 12, 2021.

[Lawmakers want accountability as state officials try to reduce wait times for kids in ERs](#)

By Katie Jickling, May 11 2021

[State to propose solutions for kids stuck in emergency rooms waiting for mental health care](#)

By Katie Jickling, Apr 29 2021

['A crisis': Kids seeking mental health care are waiting for days in emergency rooms](#)

By Katie Jickling, Apr 27 2021

[Gifford among ERs feeling the strain from psychiatric wait times](#)

By [Valley News](#), Feb 16 2020

[New stats show mental health patients waiting for treatment](#)

By Mike Faher, Feb 12 2019

MadFreedom is also unaware of any new investments in community-based resources. For example, Vermont's investment in peer services has stayed flat at one percent of the Department of Mental Health budget over the last six years

V. Proposed evaluation of the hypotheses for the new demonstration features

There seems to be a disconnect between the goal of the new demonstration features and the research question, hypothesis and evaluation approach.

For example, the renewal application suggests the hypothesis that the "demonstration will reduce health care costs for Medicaid-eligible individuals that access permanent supportive housing services." The evaluation approach is to "analyze percentage of permanent supportive housing service recipients with a principal diagnosis of alcohol or other drug dependence who had a follow up after emergency department visits after demonstration renewal." It is unclear to us how this evaluation approach tests the hypothesis. That is, whether someone had a follow up after an emergency department visit will not prove that the demonstration reduced health care costs.

MadFreedom would be more interested in an evaluation of whether individuals that accessed permanent supportive housing services had reduced visits to emergency departments.

It is also unclear why people with a principal diagnosis of alcohol or other drug dependence are being singled out for evaluation. MadFreedom would appreciate more information about the basis for this decision.

MadFreedom would also like to see more substantive evaluation of the Community Rehabilitation and Treatment program and whether it is meeting its goals.

VI. Other Issues

MadFreedom very much supports the proposal advanced by the four statewide, peer-run organizations that would create a network of peer-run, two-bed peer respite with attached community centers. In fact, we are disappointed that Vermont did not see fit to include this innovative program in the renewal application. It is an ideal candidate for expenditure authority. We urge you to reconsider including a pilot of this program in the 1115 renewal application. More details about the proposal can be found in the White Paper entitled "[Creating A Network of Peer-Run Community Centers and Two-Bed Peer Respite: Narrowing the Gap in Recovery-Oriented Community Services.](#)"

Finally, MadFreedom takes issue with a statement in the renewal application regarding expanding Medicaid coverage for inmates 90 days prior to release from prison or jail. MadFreedom does not oppose the provision. However, we do take issue with the following statement:

"Additionally, Black Vermonters are disproportionately represented in the State's incarcerated population and Vermont views this request as an important step toward promoting health equity as well as equity in its criminal justice system and health care delivery systems."

It is the case that black Vermonters are disproportionately represented in the State's incarceration. However, the quoted statement betrays an ignorance about the equity issues raised by this disproportionate incarceration. Providing Medicaid to inmates upon release does nothing to address the over-incarceration of black Vermonters. In fact, black people tend to serve longer prison terms such that they are not even subject to release at the same frequency as non-black Vermonters. Providing Medicaid coverage to inmates 90 days before their release is not a step toward either racial health equity or racial equity in the criminal justice system. Vermont has much work to do to achieve equity in this realm. It is misleading and offensive to suggest that this proposed policy addresses the disproportionate incarceration of black Vermonters.

We are also troubled that while the renewal application includes information about the health insurance status of black Vermonters Vermont and their relative lack of primary care providers, the renewal application fails to acknowledge that black Vermonters, and others who experience health inequities, report being dissatisfied with the quality of medical care they receive in Vermont.

Specifically, according to Vermonters who experience health inequities, they

- (a) Face discrimination, prejudice, racism, continually, that is often invisible to others;
- (b) Don't trust and feel misunderstood by "the system";
- (c) Don't feel valued, included or safe;
- (d) Feel like services aren't designed to support them;
- (e) Feel a lack of agency over their health and their own lives; and
- (f) Believe this takes place because our society has been structured to maintain a status quo that provides them with unequal opportunities.⁹

The 1115 renewal application does not address any of these issues, which MadFreedom considers another missed opportunity.

Thank you for the opportunity to comment on Vermont's 1115 Renewal application. MadFreedom supports the goals of the demonstration proposal. However, we do think the application falls short in the areas outlined above. We look forward to more clarification and information and a reconsideration of the peer-run network proposal.

Very truly yours,



Wilda L. White, JD, MBA
Founder

⁹ Vermont Department of Health, "Health Equity in Vermont: Preliminary Data from the 2018 State Health Assessment," House Health Care Committee, January 2018, p. 35.

June 12, 2021

Via Email: AHS.MedicaidPolicy@vermont.gov

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

Re: *1115 Renewal Public Comment*

Dear Medicaid Policy Unit:

I am a consultant and I submit this public comment on Vermont's 1115 renewal on behalf of four Vermont organizations: Alyssum; Another Way Community Center; Pathways Vermont; and Vermont Psychiatric Survivors. Hereafter, the four organizations will be referred to collectively as "peer organizations."

About the Peer Organizations

Located in Rochester, Vermont, **Alyssum** is a two-bed, holistic, peer staffed mental health crisis respite. **Another Way Community Center**, which grew out of the psychiatric survivor movement to counter oppressive systems of control, provides a safe and friendly place to share community in Montpelier, Vermont.

Founded in 2009 with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement a Housing First¹ program, today, **Pathways Vermont** offers a statewide network of permanent housing and support services to address chronic and veteran homelessness. In May 2014, the Department of Mental Health designated Pathways a Specialized Services Agency.

Vermont Psychiatric Survivors is an independent, statewide mutual support and civil rights advocacy organization run by and for psychiatric survivors. Founded in 1983, its mission is to provide advocacy and mutual support that seeks to end psychiatric coercion, oppression and discrimination.

¹ Housing First declares that housing is a basic human right and provides a model for supporting individuals with long histories of homelessness and multiple disabilities to access and maintain permanent housing through long-term mental health services and psychosocial support.

1115 Renewal Public Comments

The peer organizations appreciate Vermont's desire to implement innovative programs to better serve those eligible for Medicaid and to promote the objectives of the Medicaid program. However, the renewal application raises several questions, which are itemized below.

I. Permanent Supportive Housing Pilot

According to the renewal application, Vermont intends to seek expenditure authority for a Permanent Supporting Housing Pilot that is expected to begin in 2023. The program to seeks to provide individuals with the services they need to transition successfully into and maintain residency "in close coordination and collaboration with agencies that provide rental assistance."

Vermont intends to select supportive housing services providers for this program through a procurement process. The Permanent Supportive Housing Pilot-eligible population will include Medicaid enrollees who are 18 and older, eligible for full Medicaid State plan benefits, and meet certain health needs-based and risk-based criteria. To manage resources under the Pilot, if demand exceeds resource availability, Vermont intends to impose an enrollment cap, prioritization criteria, and waitlist for individuals seeking pilot services.

The renewal application indicates that Vermont currently has access to supportive housing vouchers through the Department of Housing and Urban Development (HUD), however, according to the renewal application, in recent years Vermont has been unable to use all of the vouchers because of a lack of available support services.

Questions:

1. What support services did Vermont lack that rendered Vermont unable to use all of the available HUD vouchers?
2. Is the proposed permanent supportive housing pilot program intended to address Vermont's inability in recent years to use HUD vouchers? If so, how?
3. Does the proposed permanent supportive housing pilot program differ from programs offered by organizations such as Pathways Vermont? If so, how?
4. What impact will the proposed permanent supportive housing pilot program have on programs in Vermont which already offer such services to Medicaid eligible individuals?

5. What prioritization criteria will Vermont adopt if demand exceeds resource availability?

II. SUD Community Intervention and Treatment Eligibility Group

Vermont is requesting the creation of a new eligibility group, called the SUD Community Intervention and Treatment group, for Vermonters meeting certain eligibility criteria. According to the renewal application, eligible Vermonters will have access to SUD Community Intervention and Treatment benefits, as described in Table 2 on page two, upon promulgation of necessary State policy. According to the renewal application, the benefits described in Table 2 are either covered today through Vermont's State Plan or will be added to the State Plan. Among the benefits listed are "peer specialists."

Questions:

1. Which benefits listed in Table 2 are covered today and which will be added to the State Plan?
2. Does the State of Vermont intend to amend the State Plan to include recovery peer specialists as a qualified provider? If so, when?
3. What State policy is necessary to be promulgated before all the benefits listed in Table 2 will be available to eligible Vermonters?
4. Who has authority or responsibility for promulgating the necessary State policy?

III. Community Rehabilitation Treatment (CRT)

In its renewal application, Vermont seeks to add "peer supports to the suite of services offered through CRT. Provision of peer supports will be effective upon promulgation of State policy necessary to effectuate this new benefit."

Questions:

1. What is meant by the term "peer supports"?
2. Is there a difference in meaning between the term "peer supports" as used in the CRT section of the renewal application and the term "peer specialists" as used in the SUD Community Intervention and Treatment Eligibility Group section of the renewal application?

3. When does the State anticipate promulgating the policy necessary to effectuate this new benefit?
4. Do you anticipate making “peer supports” available through a State Plan amendment or a waiver?
5. Once the necessary policy is promulgated, will “peer supports” be available to eligible Vermonters outside of the CRT program?
6. What are Vermont’s plans to develop a workforce which can provide peer supports?
7. Vermont has requested expenditure authority for workforce development. If such authority is granted will a portion of those funds be used to develop a workforce which can provide peer supports? If no, why?

IV. Waivers of the Institution for Mental Diseases (IMD) Exclusion for Mental Health and SUD Treatment

Vermont is requesting that CMS remove its prohibition on federal financial participation (FFP) for individuals obtaining mental health treatment in an IMD for longer than 60 days, as is permitted under Vermont’s waiver of the IMD exclusion for SUD treatment. In support of this request, Vermont cites research that it alleges indicates that the national direction of “ultrashort” hospital stays has resulted in patients who are discharged too early continuing to present with acute symptoms, resulting in higher readmission rates and higher emergency department utilization post discharge. Currently, CMS requires Vermont to maintain average length of stay for mental health and SUD treatment at IMDs at or below 30 days.

Vermont is also seeking to apply the inpatient exception to the inmate exclusion to care provided at qualifying IMDs. In its application, Vermont identifies two IMDs that operate as inpatient hospitals – the Vermont Psychiatric Care Hospital and the Brattleboro Retreat. In its renewal application, Vermont argues that its IMDs qualify as medical institutions under federal rules, and as such, inmates that are admitted to an IMD for a stay of at least 24 hours qualify for federal Medicaid matching funds.

Questions:

1. The renewal application references the article “Inpatient Psychiatric Care in the 21st Century: The Need for Reform,” and states that it is based on research that indicates that “ultrashort” hospital stays result in premature discharge for patients with acute symptoms. The article, however, is an opinion piece, is not evidence based, and states

explicitly that “data are lacking on outcomes of ultrashort-stay hospitalizations.” Was this article erroneously cited? If so, what is the correct citation?

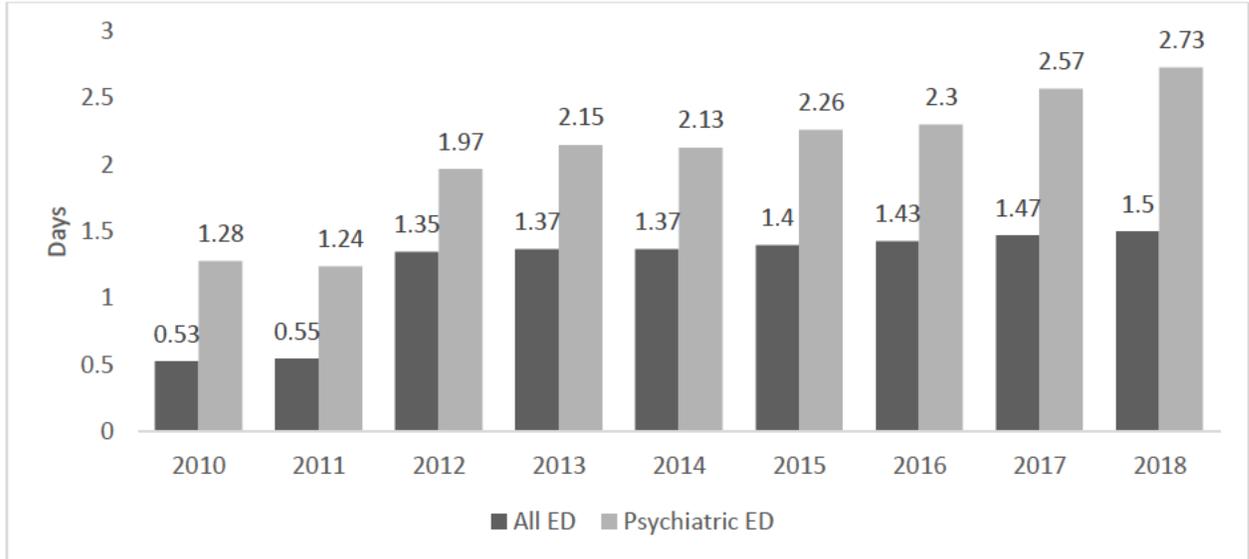
2. Is it your contention that hospital stays of 30 days are “ultrashort”? If yes, what is the basis for this contention?
3. Is it your contention that rational hospital treatment for SUD is the same for psychiatric patients such that the same maximum average length of stay should apply? If this is your contention, please cite the research that supports this contention?
4. What is the federal rule to which you refer under which the State argues that the Vermont Psychiatric Care Hospital and the Brattleboro Retreat qualify as medical institutions?
5. Act 57 (2021 Session) directs the Department of Mental Health to convene a working group to draft and submit a report to the legislature addressing “models for forensic treatment, including the size, scope, and fiscal impact of any forensic treatment facility.” If Vermont were to construct a forensic facility, would the inpatient exception to the inmate exclusion to care provided at qualifying IMDs be unnecessary?

V. SMI/SED Goals

The renewal application lists a set of goals and objectives of the current demonstration period for SMI/SED and asserts that “Vermont has largely been successful in meeting these goals.” The goals include “reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.”

Questions:

1. An analysis of Vermont Uniform Hospital Discharge data set that is publicly available online at <http://www.healthvermont.gov/health-statistics-vital-records/health-care-systems-reporting/hospital-discharge-data>, shows no overall reduction in lengths of stay for psychiatric patients in emergency departments. Such data show the following lengths of stay for psychiatric patients in Vermont emergency departments from 2010 to 2018, the last year for which data are publicly available.



What is the basis for your assertion that “Vermont has largely been successful in meeting the SMI/SED goals”?

2. Which of the goals listed under SMI/SED goals has Vermont met and what is the evidence that Vermont has met the goal?
3. How can the public access the state’s SMI Monitoring Protocol, which is referenced in footnote 8 on page 11?
4. The renewal application states that in 2018, 97 percent of Vermonters had health insurance. However, in that same year, 11 percent of the patients treated in emergency departments for psychiatric conditions were uninsured.² Interestingly, only three percent of patients ultimately admitted for inpatient psychiatric care were uninsured. How will Vermont’s proposed 1115 demonstration waiver ensure Medicaid coverage for these uninsured patients and increase their access to health care, including community-based and inpatient mental health care?

² 2018 Vermont Uniform Hospital Discharge data set publicly available upon request. See <http://www.healthvermont.gov/health-statistics-vital-records/health-care-systems-reporting/hospital-discharge-data>. Last accessed on June 11, 2021.

VI. Unaddressed Issues

In April 2019, the peer organizations published a commissioned [White Paper](#)³ that offered an analysis of the risks and challenges posed by Vermont's planned investment in additional inpatient psychiatric beds and made recommendations to mitigate the risks, address the challenges, and realize Vermont's goal of a "recovery-oriented" system of mental health care.

The White Paper identified deficiencies in Vermont's community-based, mental health resources. One of the recommendations was the development of a network of peer-run respites and community centers. The program meets many of the goals and objectives of Vermont's 1115 renewal application, including impacting the social determinants of health, investing in community-based mental health, improving health outcomes, and lowering health care costs.

Questions:

1. Why has Vermont not requested expenditure authority to develop the network of peer-run respites and community centers outlined in the White Paper?
2. Why has Vermont not proposed a Pilot demonstration of the recommended two-bed peer respite with attached community centers?

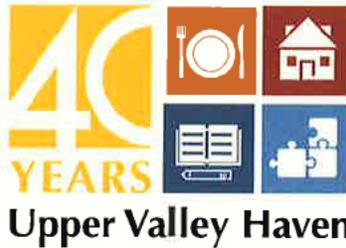
Thank you for the opportunity to comment on Vermont's 1115 renewal application. The peer organizations look forward to your responses.

Very truly yours,



Wilda L. White, JD, MBA

³ Alyssum, Another Way Community Center, Pathways Vermont, and Vermont Psychiatric Survivors. "[Creating A Network of Peer-Run Community Centers and Two-Bed Peer Respites: Narrowing the Gap in Recovery-Oriented Community Services](#)" (March 2019).



713 Hartford Avenue | White River Junction, VT 05001 | (802) 295-6500 | uppervalleyhaven.org

June 11, 2021

Vermont Agency of Human Services
Medicaid Policy Unit
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
AHS.MedicaidPolicy@vermont.gov

Re: 1115 Renewal Public Comment

To the leadership at Vermont's Agency of Human Services (AHS):

I am writing in support of the proposed AHS Medicaid Section 1115 Demonstration Waiver with specific support for the **Permanent Supportive Housing Pilot** currently included in the draft language. Permanent Supportive Housing has been extensively researched and found to be effective as measured by reduced incidences of homelessness and expensive emergency services and improved health outcomes.

The Upper Valley Haven has direct experience with the benefits of this service approach with our work under contract with AHS OEO for the Family Supportive Housing program. We have also operated a supportive housing project in Lebanon, New Hampshire targeted to single adults who were chronically homeless who were provided with the opportunity to have their own apartment, rent support vouchers and supportive services from the Haven. In the three years we have operated this program we have stabilized the residents' housing experience, helped them connect with physical and mental health services, reduced isolation and increased their quality of life. One can only imagine the positive outcomes for a pilot project that uses the principles of supportive housing across a statewide population.

I do offer some comments as you consider the design of your program. I suggest that the pilot enroll not just those with highest needs but rather focus on the broadest possible eligibility for participation. Our experience shows that successful outcomes including reduction in homelessness and health care expenses and improved health can occur. To that end, I encourage that the Agency to engage the agencies that provide services to people who are experiencing homelessness including shelters in the design of the program. Our experience of working on the ground will be invaluable.

I also believe that technical assistance to agencies that have less experience in billing Medicaid services will be very helpful and I urge the Agency to build this support into your pilot. On the subject of billing, I encourage the use of daily or capitated rates to focus program energies on addressing client needs and not on counting minutes of service which divert focus.

page 2

In closing, I again extend my deepest appreciation to AHS and its staff for seeking this waiver to help the most vulnerable citizens of Vermont. Working in partnership with AHS and OEO we have achieved outstanding success in the Family Supportive Housing Program and are confident we can achieve our mutual goals of ending homelessness, improving health and efficiency in use of public resources in this pilot project.

I wish you best of luck with this application and look forward to working with you on its implementation.

Sincerely,

A handwritten signature in black ink that reads "Michael Redmond". The signature is written in a cursive, flowing style.

Michael Redmond
Executive Director

June 4, 2021

Medicaid Policy Unit
280 State Drive
NOB 1 South Waterbury, VT 05671-1010 3
Re: 1115 Renewal Public Comment

Via Email

AHS.MedicaidPolicy@vermont.gov

To Whom it May Concern:

Thank you for the opportunity to comment on [Global Commitment Register \(GCR\) proposed policy 21-033](#), and for making senior policy officials available to answer our questions. The provider organizations listed below have considered this proposal and together offer the following comments:

Transition to a Risk-bearing MCO

- (1) Our understanding is that the AHS policy team believes the transition to an MCO structure is the path that will afford Vermont the most flexibility and the best chance at favorable spending caps. Our coalition supports those goals. At the same time, we are aware that in some states, Medicaid MCOs have created substantial administrative burdens for providers and barriers to care for patients, which of course we could not support.
- (2) If Vermont transitions to an MCO model, we think it's important that the MCO work from a clear regulatory framework. Working from the federal Medicaid MCO rules as proposed is a step in the right direction, but we think it's important that the MCO also adhere to the standards laid out in Department of Financial Regulation [Reg. H-2009-03](#) so there is consistency across all payers.
- (3) We recognize the State's interest in being able to provide *in lieu of services* as it affords opportunities for addressing the social determinants of health. For example, many states utilize *in lieu of services* to provide programs like medically-tailored meals. Our understanding of 42 CFR 438.3(e)(e)(2) is that an MCO may cover, for enrollees, services or settings that are in *lieu of* the services and settings covered under the State plan. These flexibilities must meet four criteria, which are enumerated in the regulation (subsections (e)(2)(i-iv)). Given that the State of Vermont is proposing a non-traditional MCO arrangement, we request the State ensure that these criteria are met through a transparent process that allows for stakeholder input. We are

happy to work with you to create a process that is not cumbersome and meets our mutual goal of ensuring Vermonters receive optimal services. We look forward to working with the State to identify other services that meet similar federal statutory definitions. We are interested in working with you to identify ways to provide the appropriate services, utilizing *in lieu of services* or other mechanisms should that not be the best solution, through the 1115 waiver for Vermont's Medicaid beneficiaries.

- (4) The AHS policy team reported to our coalition that the State will only agree with a renegotiated Global Commitment Waiver cap and PMPM rates that are generous enough to allow the State to meet all of the goals contained in the draft renewal application, including new waiver requests, flexibility to fund workforce and public health initiatives and all core services, without service, benefit, or rate cuts; Our coalition supports the waiver request assuming an adequate cap to meet these goals.
- (5) Our coalition supports the goal of using an MCO model to continue as an "anchor participant in the State's All-Payer ACO Model Agreement" rather than pursuing fragmented payment reform goals, especially at time when health care providers and facilities have faced unprecedented regulatory fatigue during the COVID-19 pandemic.

Comments on Goals

Goal 1

- (1) Home health Agencies and Adult Day centers have different views on the changes to the moderate needs criteria and will submit individual comments on that issue. Both groups would be glad to work collaboratively to develop a model that makes sense for both settings.
- (2) We support filling coverage gaps by extending Medicaid coverage to inmates 90 days prior to release from prison and creating an SUD Community Intervention and Treatment benefit that includes, among other services, "medication evaluation, management, and consultation with primary care and other medical providers."

Goal 2

- (1) We support the continued inclusion of an enhanced hospice benefit and children's palliative care program in Vermont's waiver.
- (2) We are generally support the proposal to provide reimbursement to parents of a minor child, legal guardians, and spouses providing the newly defined "life skills aide" services and community supports (including shared living) to individuals enrolled in the Brain Injury

Program. That said, we have questions about reimbursement to parents, legal guardians and spouses for life skills and community supports. How will the state ensure accountability for services provided? How will services be documented? What will the oversight mechanism be?

- (3) We are concerned about the proposal to remove respite services from the CRT program. We need to understand the plan in greater detail before we can comment about its impact. For example, we understand that respite services under the CRT program are underutilized, but before eliminating them, we recommend exploring whether respite services could be used to reduce emergency department visits and wait times. Vermont Care Partners may submit additional comments if they are able to obtain more detailed information in time.
- (4) We support removing the prohibition on FFP for patient stays at IMDs for longer than 60 days. We would like to understand the impact on applying the inpatient exception to inmate exclusion for IMDs to the 30- day average length of stay.

Goal 3

- (1) We strongly support moving investments in workforce to “expenditure authority under the demonstration” outside the per member per month capitation rate. As we understand it, doing so will allow those programs to be funded under the total Medicaid cap, rather than be subject to the availability of “savings” under the “investment” program. In addition, we would support incorporating funding within the expenditure authority for workforce development investments consistent with the Healthcare Workforce Development Strategic Plan required by Act 155 (2020), to the extent appropriate. We expect the Act 155 plan to address a broader spectrum of workforce needs than the existing “investment” program.
- (2) For similar reasons, we support moving public health infrastructure investments to “expenditure authority” and continuing to fund Vermont’s core prevention programs that minimize downstream healthcare costs, including tobacco cessation services, immunization programs and lead poisoning prevention.

Goal 4

- (1) Our understanding is that Goal 4, “Advancing Integration in Care Coordination” signals Vermont’s intent to re-examine care coordination, the Blueprint and strategies to better align Blueprint programs and various case management services without committing to specific policy changes. Further work is necessary to fully utilize existing care management resources and coordinate care management efforts. The proposed approach appears to allow time for

AHS to work with stakeholders on specific proposals. Assuming our understanding is correct, and assuming that the overall negotiated waiver cap allows adequate funding for care coordination services, we support the inclusion of Goal 4.

- (2) We share your goal of strengthening providers' ability to participate in health information exchange. Transitioning to electronic health records has been a substantial expense for health care providers; payer support, has been limited and inconsistent between provider types. Any adjustments providers need to make to electronic health record vendors in service of Vermont's health care reform goals require state support; they are often expensive, and it can be difficult to get buy-in from vendors. Vermont should seek to eliminate duplicative record keeping for initiatives like care coordination and state-mandated reporting systems like SAMS that exist outside electronic health records.

Goal 5

Our top Medicaid policy priority is adequate Medicaid reimbursement to support the services we provide. Budget-neutral "payment reform" and payment models that have no routine rate schedule update will not adequately support the health care delivery system. To that end:

- (1) We urge the agency to ensure that Medicaid reimbursement rates at a minimum match Medicare fee schedules for core services where a Medicare fee schedule exists. Where no Medicare fee schedule exists, Vermont should identify other mechanisms for regular rate schedule updates.
- (2) We would like more information on how using the Medicaid risk-bearing model for *Medicare*-covered Vermonters impacts the All-Payer ACO Model. While we support the overall goal of integrating a risk-bearing MCO model with the All-Payer Model, we do not have adequate information to assess how these two risk-bearing models will work together at the statewide or individual provider level. We would not support efforts that make implementation of payment reform for providers more administratively complex or ask providers to take on additional financial risk.
- (3) Goal 5 references AHS' intent to consider payment reform for Vermont's successful LTSS initiatives. LTSS "reform" must include increasing total reimbursement for the services. Vermont's successful LTSS programs across the continuum are eroding because Vermont has failed to adequately invest in them – almost since their inception. Absent new dollars to adequately fund LTSS programs, new payment models will not improve Vermont's ability to deliver LTSS. Planning must also account for the need to increase capacity because of

increasing demand. Too often, Vermont has budgeted only for caseload increases, without reimbursement increases.

Jessa Barnard
Vermont Medical Society

Devon Green
Vermont Association of Hospitals and Health Systems

Georgia Maheras
Bi-State Primary Care Association

Jill Mazza Olson
VNAs of Vermont

Laura Pelosi, on behalf of
Vermont Health Care Association
BAYADA Home Health Care

Virginia Renfrew, on behalf of
Vermont Association of Area Agencies on Aging

Susan Ridzon
HealthFirst Independent Practice Association

Julie Tessler
Vermont Care Partners: VT Council

Stephanie Winters
Vermont Academy of Family Physicians
American Academy of Pediatrics – Vermont Chapter



Cathedral Square

Advancing Healthy Homes, Caring Communities & Positive Aging since 1977

June 12, 2021

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

RE: 1115 Renewal Public Comment

To Whom It May Concern:

Thank you for the opportunity to provide comments on the proposed Global Commitment to Health Demonstration Renewal. We fully support the Agency's stated vision for the renewal: *"to improve health outcomes, lower costs for Vermonters, and promote provider sustainability, by driving farther and faster toward alternative payment models.* We stand ready, as both a housing developer/provider for vulnerable populations and the statewide administrator for SASH®, to contribute to achieving this vision. Included in the state's successful application to the Centers for Medicare and Medicaid Services (CMS) back in 2010 to add Medicare as a payer in the Blueprint for Health program through the MAPCP Demonstration, SASH has been a part of the state's advance towards a transformational alternate payment model and delivery system for over a decade. During this time, SASH has had positive results in improving health outcomes for participants and lowering the growth of both Medicare and Medicaid spending so we are therefore excited at the possibility of building on this success by way of some of the proposed additions and new features included in the renewal proposal. Our comments are organized around the key demonstration goals as outlined in the Public Notice dated May 13, 2021.

Goal 1: Advancing Towards Population-Wide Comprehensive Coverage

Our comments around this goal are limited to the proposal to continue with modifications the Moderate Needs Expansion Group for CFC and VPharm modifications. **We do not support the change proposed** which would limit eligibility by eliminating two of the criteria that allow for enrollment. Instead, we strongly recommend increasing access to the Moderate Needs Group. Our SASH staff across the state reports that SASH participants with Moderate Needs services are able to live independently and with a higher quality of life for longer periods of time, putting off transitions to more expensive services such as those provided in High and Highest Need groups, Assisted Living, Residential Care home and Skilled Nursing Facilities. The funding for the Moderate Needs group should be increased and all four criteria remain intact. We believe that over time, savings will accrue from this investment in prevention and help to meet the long-held State goal for Vermonters to be able to age in place and remain active in their home communities.

We also recommend the State consider adding SASH to the menu of services available for the Moderate Needs Group. SASH is currently capped at 54 programs across the state (approximately 5,000 participants) and demand is ever increasing with growth in the older population. SASH already serves low-income older adults and adults with disabilities and has been shown to reduce health care spending and improve health of those enrolled by providing comprehensive and consistent preventative support and evidence based programs where people live. Adding SASH as an eligible service would allow for limited but meaningful expansion of the SASH program across the state.

We strongly support the expansion of the VPharm program by extending Medicaid-equivalent coverage to VPharm eligible individuals at all income levels. Too often, we see our Cathedral Square residents and SASH participants having to make difficult decisions in their household budgets to afford their medications. This change would provide a population health approach to medication management.

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

We are supportive of the renewal's focus on innovative models that provide value across the entire continuum of Vermonters' health in the broadest sense including the social factors that influence health- the health ecosystem. That said, we note in the proposed continuing features with modifications section under Goal 2 a lack of emphasis on the *preventative* approaches that will postpone or possibly eliminate the needs for more restrictive and costly care for older Vermonters and those with disabilities. Specifically **we recommend including Moderate Needs Group in the group eligible for a "life skills aid."** This kind of support for those people "at-risk" for needing nursing home facility level of care can have an amplified effect on postponing or eliminating the need for costlier institutional care. Our experience with our residents and SASH participants is that that they often need small but specific and targeted support to get back on track to living independently- just the type of support a life skills aid can provide. For instance, help with developing a system for medication self-management, setting up technology for telehealth appointments, signing up for benefits, etc. We believe investing more in prevention with the Moderate Needs group will, in the short and long run; provide savings to the system and therefore more to invest in the risk-based MCO model proposed. SASH staff, already deployed across the state, in Community Health Worker roles should be accessed to provide this kind of support and we would be happy to investigate this option more fully.

We strongly support the addition of a Permanent Supportive Housing Pilot to the renewal plan. High quality and stable housing is crucial to the health of Vermonters AND the provision of holistic, person-centered services provided where people live by people residents trust which allows for increased housing stability and improved health and quality of life. The effectiveness of supportive housing models is well documented in research. SASH has been providing a comprehensive system of supports operated by the non-profit and public housing network to older adults and adults with disabilities since 2011 and has seen first-hand a reduction of housing instability and evictions. Based on this success and existing structure we recommend that non-profit and public housing organizations be part of the planning for the pilot and be eligible to be "supportive housing service providers." We recommend funds be available for capacity building for housing and services organizations to ensure they receive the training and resources needed to be administratively efficient. Additionally, we note with concern the described limits on participation and plan for waiting lists. Given the proven effectiveness of these models across the country, we urge you to provide for broader and more flexible eligibility criteria than is currently proposed. This pilot should be looking to provide supports across the continuum of care needs- from lowest to highest. A population-based approach will provide the most expansive and

sustaining benefits and cost reductions. The proposed eligibility criteria which requires meeting a minimum of two criteria categories – health based and risk based - is overly restrictive and will be administratively burdensome. We recommend paring this down to require an individual to meet only one of the criteria in either the health-based or risk based category.

Lastly, we believe that Goal #2 focused on implementing innovative care models would be well served by allowing funding for Medicaid eligible beneficiaries served by an expansion of the current SASH model and the SASH for ALL (or Family SASH) model which is being planned to serve younger adults and families with children. These proposals were submitted to AHS as part of the Open Meeting call for Proposals on February 25, 2021.

Goal #3: Engaging Vermonters in Transforming Their Health

Cathedral Square fully support this goal, which recognizes the broad factors that influence health and focuses on prevention and improved access to health services across the continuum of care. We believe the decision to transition DVHA to a risk-bearing MCO will serve the state well by driving innovation and strategically investing in value added services and population health initiatives that benefit all Vermonters. The current SASH model and proposed expansion to younger populations (SASH for All) fits squarely into both categories. SASH has already proven that it impacts population and individual health positively, reduces spending and empowers Vermonters to set their own health and wellness goals. Further investment is warranted and we welcome the opportunity to broaden and deepen the impact on Vermonters of all ages.

We fully support the workforce development initiatives proposed such as loan repayment programs and training programs. We recommend prioritizing initiatives to workers who commit to some length of time (2-5 years) in long-term care settings including skilled nursing facilities AND licensed Assisted Living and Residential Care Homes.

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

We appreciate the priority put on data in this goal and its role in helping facilitate more comprehensive and appropriate care coordination and the promotion of health equity. All innovative approaches that will bear risk must have robust data tracking and reporting systems that can provide feedback to practitioners and participants in real time. We fully support the Blueprint for Health programs and SASH partners fully with the Blueprint and is an extender of the Community Health Teams in people's homes. We urge you to include SASH in all discussions regarding advancing integration in care coordination, as we have been an active partner with all providers mentioned in the proposal for over a decade. We have a robust statewide data management and reporting system for SASH, which allows SASH staff and participants to make data driven decisions to improve health. We support the efforts to further align Blueprint programs and HCBS programs to reduce the silo environment that does not serve Vermonters well.

We support the efforts to strengthen providers' ability to participate in the HIE to advance population health and ask that SASH providers are part of this effort so that our staff can share and utilize data through the VHIE. SASH providers are fully trained in HIPAA and are considered health care entities with Business Associate Agreements in place and should therefore be fully integrated with the VHIE. It is

unclear to us where these efforts align with the Care Navigator care coordination data system owned by OneCare and used by SASH and other care coordination and health entities such as the Area Agencies on Aging and Home Health Agencies. We do not want yet another data system to learn and manage.

We strongly support the plan to explore the use of an electronic patient engagement platform so that Vermonters will have easy access to their health records and an ability to participate in care coordination activities by entering their own information and linking to programs of their choice. This will empower Vermonters to be active and engaged participants in their health and wellness.

Thank you for the commitment you are making to the most vulnerable Vermonters through the vision and goals articulated in the renewal application. We appreciate the opportunity to comment and please reach out with any questions.

Sincerely,

A handwritten signature in blue ink that reads "Molly Dugan" followed by a horizontal flourish.

Molly Dugan, MPA
Director of Policy and Strategic Initiatives



617 Riverside Avenue

Burlington, VT 05401

Phone: (802) 864-6309

Fax: (802) 860-4325

www.chcb.org

June 9, 2021

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

Re: Medicaid 1115 Waiver Public Comment Period

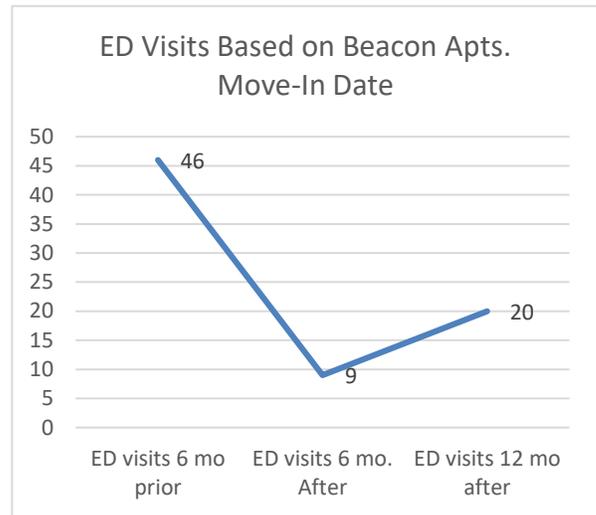
To the Agency of Human Services,

This letter intends to serve as public comment in support of the Medicaid 1115 Waiver, specifically the Permanent Supportive Housing Pilot outlined under “New Features.” As the only federally-granted Healthcare for Homeless Program in the entire State of Vermont, we serve over 1,500 patients experiencing homelessness or who are marginally housed each year. In addition to providing no-cost preventive and primary medical care, dental services, and psychiatry/behavioral health counseling, we have a team of social workers dedicated to performing outreach services including housing assistance. Simply put, this PSH Pilot would bolster the sustainability and depth of these life-saving support services within our organization.

As a Federally Qualified Health Center, we know the tremendous positive impact of safety net support services, especially for those with addiction, mental health needs and histories of trauma. As just one example, all of those who have found stability through our collaborative housing project at Beacon Apartments fall into at least one of these categories. Beacon Apartments has been a successful partnership between the Community Health Centers of Burlington (CHCB), the Champlain Housing Trust, Burlington Housing Authority, and University of Vermont Medical Center since January 2016. This collaborative project was designed to address the supportive housing needs of 19 of our community’s most medically-complex and vulnerable homeless individuals. CHCB provides the daily delivery of social services and clinical treatment using longstanding, proven programmatic characteristics to enable participants to transition out of their homeless circumstance, in an environment of high-efficiency apartments that encourage self-management and self-empowerment.

The Beacon Apartments staff, which includes one onsite Case Manager and three part-time Caseworkers, provides a client-centered approach, use of motivational interviewing, and relationship building to support people in keeping their housing and building their skills for greater independence. The staff provides ongoing support to residents during the day and early evening. The full-time Case Manager assists residents in enrolling in public benefit programs such as food stamps Medicaid, and SSI for those with disabilities. Each resident has an Individual Service Plan that is tailored to meet their goals (e.g., creating and following a budget, increasing income, maintaining housing) and which renews twice a year.

CHCB has been saying ‘housing is health care’ for over a decade and we now have the data to prove it. Homeless individuals experience high rates of behavioral health disorders and both acute and chronic physical conditions. Many of these individuals use the emergency department (ED) as a primary care office, shelter, and a source of food. In addition, exacerbation of untreated symptoms can also increase ED visits and inpatient admissions in this population. At Beacon Apartments, ED visits were tallied six months prior to a person’s move-in date and for six and 12 months after their move-in date. In comparing ED visits prior to the move-in date to six months post move-date and 12 months after the move in date, ED visits decreased by 80% and 57% respectively.



CHCB relies on philanthropic support to fund the case management services at Beacon Apartments, but it’s simply not sustainable when the ongoing need is so great. It should be noted that this waiver would not be just for those experiencing homelessness; all of our Licensed Clinical Social Workers and Case Managers throughout each of our eight sites could work with patients identified at risk of becoming homeless, taking a more preventive approach to this issue. Allowing these services to be billable through Medicaid would be transformational in the sustainability of our case management services and the vulnerable adults and families we for whom we care. As one formerly homeless patient said about his social worker, Stephanie: “I’ve been through a lot and I’m not scared of anything - except for disappointing Stephanie.”

Thank you for your consideration of supporting the solution that we’ve always known was there, but has been just out of reach until now.

Sincerely,

Jeffrey McKee, CEO



Comments from the Champlain Housing Trust on Vermont's Global Commitment to Health 1115 Demonstration Renewal Application

Submitted by: Michael Monte, CEO
mmonte@champlainhousingtrust.org

Date: June 4, 2021

The Champlain Housing Trust supports the Vermont Agency of Human Services inclusion of a Permanent Supportive Housing Pilot in its renewal application for the Global Commitment Demonstration Renewal Application.

As a housing provider and property manager for approximately 2,500 low-income Vermont households, we acutely understand the intersection between health and housing. Almost 600 of CHT's residents have a current or recent relationship with a social service provider, about half of them with a designated agency. Almost all receive these outside services unattached to their housing.

Some residents need more, yet there is no stable funding source to provide service enriched housing. We have seen firsthand the health benefits enjoyed by residents who secure stable housing with services connected, as the Permanent Supportive Housing model works. This model is one that, as the application describes, has been demonstrated to improve health outcomes of Medicaid recipients while reducing health care expenditures.

CHT's relationship with the Safe Harbor Homeless Health Program of the Community Health Centers of Burlington (our local Federally Qualified Health Center) has provided such benefits at two dedicated locations serving 25 households in the past few years as well as in scattered site locations. Safe Harbor provides services to roughly 45 households overall in our portfolio, focusing on the most vulnerable and difficult to serve and combining tenancy supports with access to primary care. CHT's collaborative efforts with Safe Harbor are always done in partnership with the University of Vermont Medical Center, and together we have yielded system-wide benefits to the vulnerable populations we all serve.

Now is the time to secure and expand the Permanently Supportive Housing model at the very time that we need it most as 2,900 Vermonters temporarily housed in motels through the pandemic seek permanent housing.

As one example, Safe Harbor – the agency with which we have the most well-established partnership in serving those with the greatest combined housing and health challenges – will be unable to rise to the challenge of expansion of services without such a pilot project. CHT is excited to see the inclusion of the Permanent Supportive Housing pilot in this 1115 renewal application, and eager to work with the Agency of Human Services to implement this vision.

Thank you.



Vermont Developmental Disabilities Council

100 State Street, suite 342
Montpelier, Vermont 05633-0206

(802) 828-1310
vtddc@vermont.gov
www.ddc.vermont.gov

June 11, 2021

To: Agency of Human Services
Department of Vermont Health Access (DVHA)

From: Kirsten Murphy, Executive Director

RE: Vermont's Global Commitment to Health 1115 Waiver renewal

Thank you for the opportunity to provide input as the Agency of Human Services (AHS) negotiates the terms of the renewal of Vermont's Global Commitment to Health 1115 Waiver.

The Vermont Developmental Disabilities Council (hereafter "the Council") is a statewide board created by the federal Developmental Disabilities Assistance and Bill of Rights (hereafter "the DD Act"), first adopted by Congress in 1970. Our constituents are healthcare users who have an important stake in the cost, quality, and availability of both traditional healthcare and disability long term services and supports (DLTSS) through the Medicaid Program. An estimated 86,000 Vermonters experience a developmental disability as defined by the DD Act, with approximately 5,100 receiving Medicaid-funded, community-based support through the Developmental Services System of Care or, in some cases, the Choices for Care Program.

In order to receive the federal funding that supports the Developmental Disabilities Council, the Vermont Agency of Human Services assures that it will not interfere with the Council's advocacy work and further, that it will engage the Council in all quality improvement efforts that impact the services provided to Vermonters with developmental disabilities. Accordingly, while the Vermont Developmental Disabilities Council is housed in the Agency of Human Services, the Council does not speak on behalf of AHS, nor do we need to agree with the AHS' public policy positions.

The Council fully supports the State's intention in crafting a demonstration waiver that will promote the meaningful integration of care, enhance the role of primary prevention, and increase access to quality healthcare.

Our comments focus on three issues: First, the potential unintended consequences of DVHA's plan to expand value-based payments in Medicaid home-and community-based services (HCBS); second, new payments for family members of people with disabilities; and third, the need to ensure that Vermont implements the person-centered planning rules, in effect since 2014, to ensure individual rights are protected and conflicts of interest in the service delivery system are eliminated.

Part I: Value-based Payments in HCBS

Value-based payment originated in acute care, but the concept is gaining momentum across the broader health care system, including in Home and Community Based Services (HCBS). In simple terms, it is a payment model that incentivizes providers to meet specific quality metrics through the promise of higher reimbursement, the threat of lower reimbursement, or a combination of both. In migrating value-based payments from traditional medical settings to HCBS, the Council sees potential problems that the State must address.

The Problem: Value-based payment assumes that providers have enough capital to absorb the losses associated with the failure to meet quality targets. Without this buffer, the consequences of assuming risk are likely to fall on the beneficiaries themselves, rather than the organization delivering their care.

It is well known that Vermont's Designated and Specialized Services Agencies (DA/SSAs) operate with tight margins and cash reserves far below what is typically recommended for a healthy non-profit health care services provider. Even a small penalty – or the withholding of a bonus -- would place further stress on the agency and its fragile workforce. Ultimately, care would be compromised, and a downward spiral would begin. The smaller the agency, the greater the consequences of assuming risk in that these providers typically have the least capital. However, some of these smaller agencies were created to meet the needs of the Developmental Service System's most challenging beneficiaries – for example, Lincoln Street serves people with Intellectual and Developmental Disabilities (I/DD) and complex medical conditions, Upper Valley Services works with people who have behavior challenges. To be successful overall, the system needs these specialty providers.

Objective: Individual beneficiaries have no control over agency operations and as a practical matter, only a very limited ability to change their provider when unsatisfied with performance. They should be protected from the consequences of any value-based arrangement. In addition, any new payment model must ensure the financial health of agencies that have evolved to meet the needs of underserved regions or populations.

Recommendations:

1. The State should consider whether – in the case of HCBS -- a value-based payment scheme is better implemented across the system of care, rather than through individual agency contracts. The system as a whole is better positioned to absorb risk and share benefits than the individual non-profits that make up that system.
2. The system should view risk and benefit through an equity lens. For example, if the system receives a bonus for achieving employment goals, the system should invest this reward not in its highest achieving members but in its lowest achievers with the goal of spurring the system as a whole to still greater improvement.
3. This kind of forward thinking is more likely if beneficiaries are a central part of the decision-making process. For this reason, the Council further recommends that the State ensure that recipients of service and their family members are well represented in the governance of any collective that may be formed in order to pool risk and share benefits.

Reimbursement of Family Members Providing Personal Care

Vermont is seeking new authority to reimburse parents of a minor child, spouses, and legal guardians for providing personal care and personal care like services to individuals enrolled in the Developmental Disabilities Services and Brain Injury Programs.

While the Council applauds the AHS for the temporary financial relief it has provided to families of people with disabilities during the Covid-19 pandemic, we are concerned that seeking authority to make such arrangements permanent is premature. The implications of paying family members for personal care services, especially family members of adults with disabilities, have not been adequately explored. If CMS grants permission for such payments, the State has an obligation to engage stakeholders in a thorough examination of the risks and benefits before implementing what would be a significant change to our System of Care for Developmental Disabilities Services.

The Problem: The renewal application makes no distinction between reimbursements for personal care services provided by family members to minors and personal care services provide by family members to adults. Payments for services provided to adults raises a raft of issues including the need to ensure self-determination and prevent the exploitation of vulnerable adults.

Recommendation:

As the renewal application makes clear, new Medicaid policies that allow for the reimbursement of family members and legal guardians of people with disabilities will need to be promulgated before this new benefit may be utilized. The DD Council urges the State to conduct a robust stakeholder education and engagement process as it develops the new policies necessary to support the proposed new benefits. That process should make a clear distinction between services provided by parents and guardians to minors and those provide by parents or spouses of adults.

Conflict of Interest Free Case Management

The Council applauds the State’s continued efforts to address the social determinants of health through the meaningful integration of mental health, physical health, and Home and Community Based services. For example, it does little good to treat a beneficiary’s asthma if they lack stable housing that is reasonably free of allergens. Treating a beneficiary’s depression is unlikely to be successful if they are isolated from the community. Employment – even for people with the most significant disabilities – increases social interaction, provides a sense of financial agency (control over one’s money), and validates a person’s worth in our society.

Case management is the service that ties all these complex supports together. In the background, the State continues to invest in the information technology that connects a widening scope of services. However, there is no substitute for the human service provider who is positioned to translate this information into a creative approach to client needs. For Vermonters with Intellectual and/or Developmental Disabilities who receive Home and Community Based Services, this is their “service coordinator” at their Designate of Specialized Services Agency (DA/SSA) or, for those enrolled in Choices for Care, their case manager.

The Problem: The Council would like to take this opportunity to again remind the State that it’s case management services for HCBS continue to operate in clear violation of the conflict of interest component of the Centers for Medicare and Medicaid’s final rules

regarding Home and Community-based Services, issued January 16, 2014. Federal regulations clearly require that providers of HCBS for the individual must not also provide case management activities or develop that individual's person-centered service plan.¹ In other words, an entity, agency, or organization (or their employees) cannot provide both direct service and case management activities to the same individual except in unique circumstances set forth in regulation.

The details supporting this assertion were covered in the Council's comments of October 26, 2020 at the State's 2020 annual post-award forum for Global Commitment (attached). They included reference to DVHA's own website, where these conflicts are catalogued.² The Council's subsequent research has further indicated that the only circumstance where CMS permits case management services to be conducted wholly outside of the HCBS Rule is when a State employs a medical home model as the overarching paradigm for the coordination of care. This is not the model that Vermont has chosen to pursue in Global Commitment.³

Why does this matter to the successful achievement of Vermont's goals under Global Commitment? Conflicts of interest have real consequences. When incentives are misaligned, agencies may recommend and/or plan for specific personnel, services, and approaches that the agency, not the individual, prefers. During public input sessions across the State, self-advocates and family members shared – often with hesitation because of their fear of retaliation – that they have experienced case managers who withhold information, steer them toward services that they have indicated they do not want, been insensitive to client choice, and created barriers to client complaints. The Council wants to be clear that this does not happen in all cases, nor does it occur out of malice. Case managers are often doing their very best, but in a situation where incentives are misaligned, it is only natural that mistakes and poor practice occur.

Underlying the four goals of Global Commitment is the intention that Vermonters are healthier and less likely to incur preventable health conditions and associated costs. Research by the Vermont Department of Health has demonstrated that Vermonters with disabilities experience health disparities across many indicators.⁴ People with I/DD are certainly among those complex beneficiaries that Medicaid should target for the

¹ 42 CFR 441.301(c)(1)(vi).

² <https://dvha.vermont.gov/global-commitment-to-health/conflict-of-interest-home-and-community-based-services> .

³ In fact, in the current waiver, the phrase "medical home" appears only once and then in reference to a subgroup of beneficiaries receiving care coordination through the Blueprint for Health³, not Medicaid beneficiaries as a whole. See page 138 at <https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GC1115Waiver/VT-GCH-STCs-IMD-Phasedown-Approval-01-13-2021.pdf>

⁴ https://www.healthvermont.gov/sites/default/files/documents/pdf/DisabilityDataPages_AccessibleVersion.pdf

meaningful integration of care. Ultimately, conflicts of interest erode trust, and this does not bode well for successfully widening the scope of care under the purview of case management for Vermonters with I/DD.

Objectives: To integrate at least a portion of traditional medical care and HCBS for adults with developmental disabilities as a means toward improving health outcomes for this population, which is known to experience significant health disparities.

Recommendations:

1. Decouple case management services from the day-to-day service coordination that takes place at community agencies. With an expanded skill set and in time, the State's improved information technology, case managers can both create, implement, and oversee a client's person-centered service plan and ensure attention to primary prevention activities, chronic conditions, and emergent healthcare needs.
2. Deliver case management in a manner that adequately addressed conflicts of interest across Vermont's HCBS. This will require more than one change in how HCBS are delivered. The Council has provided a detailed description of a comprehensive set of mitigating strategies that include: Conducting independent needs assessments; providing options counseling to all potential HCBS recipients through a venue independent of the designated agency system; and an independent advocate for developmental services similar to the ombudsman program available to people enrolled in Choices for Care (letter from October 5, 2019, attached).
3. Most important of all, the State must create a case management system that provides the opportunity for beneficiaries to plan for and have oversight of their services free from conflict of interest. The State has suggested that Vermont adopt a "choice model," where individuals can choose to use an independent case management entity or continue to receive service coordination through the same entity that delivers their services. The Council has expressed modest support for the choice model, as the easiest path toward providing beneficiaries with the option that the Council believes fully protects individual civil rights from conflicts of interest.

At this time, the Council would like to make clear several qualifications to its support for the choice model:

- 2.1. The choice model must be accompanied by mitigating strategies such as those outlined above, including an ombudsman program for developmental services and independent options counseling.
- 2.2. Case management services through an independent entity should be the default option for beneficiaries under a choice model. Individuals should have to affirmatively opt-in to a situation where they are entering into a situation where they are agreeing to a conflict of interest on the part of their service provider.

In closing, the Council would again like to thank AHS Policy Analysts for the opportunity to share these concerns and recommendations.



For 30 years, the Source for Housing Solutions

June 10th, 2021

Vermont Agency of Human Services
Medicaid Policy Unit
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
AHS.MedicaidPolicy@vermont.gov

Re: 1115 Renewal Public Comment

To the national leaders at Vermont's Agency of Human Services (AHS):

CSH is writing to express our strong support for the state's renewal proposal of the Global Commitment to Health 1115 Demonstration Waiver. The state of Vermont continues in their role as a national leader with their commitment to equity, to innovation and to a healthcare system that prioritizes access to quality care for all Vermonters. While the waiver proposal as a whole is very exciting, we will focus our comments on number of areas of interest, including the Permanent Supportive Housing (PSH) Pilot, health care coverage for justice involved individuals and expansion of Behavioral Health services.

CSH is excited to see the PSH pilot included into the waiver. The definition of the eligible populations is expansive and aligns well with those eligible for many affordable housing programs offered throughout the state. The definition of services is broad and robust and should meet the need to connect residents to needed community services. In other pilots we have seen a cost shift from emergency department and acute care settings to outpatient settings and higher costs on prescription drugs, as persons become medication compliant. We believe this cost shift to be indicative of improved health for participants and communities at large. While describing access points is not a part of the waiver proposal, we suggest a close collaboration with the Continuum of Care in the state to ensure priority access for persons experiencing literal homelessness.

CSH Main Headquarters
61 Broadway
Suite 2300
New York, New York, 10006
www.csh.org

CSH is currently engaged with a variety of states and communities to implement similar pilots including Connecticut, Oregon, Minnesota, New Hampshire and Washington state. WA state in particular is seeing [promising results](#) and they are also using an 1115 Medicaid waiver authority and single administrator, as VT has proposed. Other aspects to WA's success that we consider critical include:

- A per diem rate structure for housing support services so agencies are striving towards quality, effective services, not primarily billable time.
- Capacity building for community providers because for many community-based organizations (CBOs), this is their first efforts billing Medicaid and that transition is challenging and expensive for small CBOs.
- Alignment of referral systems, priority populations and services with housing resources throughout the state. AHS' partnership with Vermont Housing and Conservation Board (VHCS) and Vermont Housing Finance Agency (VHFA) will be crucial to these efforts.

Vermont's leadership in Substance Use and Mental Health services is recognized nationally. We encourage the state, as part of the growing partnership with the housing sector to work to align the Behavioral Health and Housing sectors to ensure smooth referrals processes and access to each sector's programming and support.

CSH holds a strong commitment to racial equity and we applaud AHS for the same commitment. Aspects of the waiver that we believe will move towards more equitable communities include:

- Healthcare coverage 90 days prior to release from incarceration
- Expected longer stays in residential Mental Health and Substance Use Disorder programs, with Federal Financial Participation (FFP) allowable for 60 days rather than just 30 days. Stays longer than 60 days will also be allowable for the women and children who receive services at the LUND Home.
- Investments in Public Health infrastructure.

CSH applauds the innovative reinvestment strategy allowable under the plan. CSH would recommend that AHS ensure openness and transparency in how that strategy is develop and how those investments are made. In particular, centering the voice of people with lived expertise (PLE) to share the barriers they face in improving their health should have great influence in those investments. The proposal's commitment to data infrastructure and data sharing efforts are also the smartest way to achieve the waivers outcomes.

The draft Global Commitment to Health waiver will be the next step in Vermont's national leadership around health care coverage, access, quality and equity. CSH looks forward to the impact of the waiver for the residents of Vermont.

Sincerely,

Marcella Maguire

Marcella Maguire
Jun 10 2021 4:22 PM 

Marcella A Maguire, Ph.D.
Director, Health Systems Integration



John P. Kacavas

CHIEF FINANCIAL OFFICER & GENERAL COUNSEL

Dartmouth-Hitchcock Medical Center

One Medical Center Drive
Lebanon, NH 03756-0001

Phone (603) 650-5160

Dartmouth-Hitchcock.org

June 12, 2021

State of Vermont
Agency of Human Services
Medicaid Policy Unit
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010

RECEIVED
JUN 14 2021
DEPARTMENT OF VERMONT
HEALTH ACCESS

Submitted via e-mail to: AHS.MedicaidPolicy@vermont.gov

Re: 1115 Renewal Public Comment

On behalf of Alice Peck Day Memorial Hospital (“APD”) and Cheshire Medical Center (“Cheshire”), please accept these comments on Vermont’s Global Commitment to Health Demonstration (“1115 Waiver”) Renewal. Because of Vermont’s geography and location, more Vermont residents obtain out-of-state hospital services than residents of any other state.¹ Vermont residents rely on border-state hospitals like APD and Cheshire to provide necessary medical services within their particular localities.

APD is a New Hampshire non-profit healthcare charitable trust licensed for 25 beds located in Lebanon, New Hampshire, approximately ten (10) miles from the Vermont border. APD has been a member of the Dartmouth-Hitchcock Health (“D-HH”) System since 2016. APD is designated as a critical access hospital (“CAH”).

Cheshire is a New Hampshire non-profit healthcare charitable trust licensed for 169 beds located in Keene, New Hampshire, approximately twenty (20) miles from the Vermont border. Cheshire has been a member of the D-HH System since 2015. Cheshire is a Prospective Payment System (“PPS”) hospital.

Both APD and Cheshire are high-volume providers of medical services to Vermont Medicaid enrollees. Both APD and Cheshire are designated as “Out-of-State In-Network Hospitals” within Vermont’s Green Mountain Care Network, due to their close proximity to Vermont and the general practice of Vermont’s residents to secure care and services at these hospitals.² APD and Cheshire treat Vermont Medicaid and uninsured patients of all acuity levels, and incur similar costs and

¹ Nineteen percent (19%) of all hospital stays for Vermont Medicaid recipients are out-of-state stays. *See* Medicaid and CHIP Payment Access Commissions, “Medicaid Payment Policy for Out-of-State Hospital Services” (January 2020), Appendix A, available at <https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid-Payment-Policy-for-Out-of-State-Hospital-Services.pdf> (last accessed 6/7/2021).

² *See* Agency of Human Services’ Provider Network Info, available at <https://dvha.vermont.gov/providers/provider-network-info/green-mountain-care-network> (last accessed 6/7/2021).

expend similar resources as Vermont's comparatively-sized and similarly-situated in-state CAH and PPS hospitals in order to provide care to Vermont residents.

Yet, under Vermont's current 1115 Waiver, and under the proposed 1115 Waiver Renewal, Vermont reimburses APD and Cheshire for inpatient and outpatient hospital services rendered to Vermont Medicaid patients at significantly lesser rates than in-state Vermont hospitals—solely because APD and Cheshire are located across the border in New Hampshire.

This discriminatory reimbursement to APD and Cheshire is unlawful and unconstitutional. APD and Cheshire, along with two other border-state Plaintiff Hospitals serving Vermont Medicaid patients, have sued Vermont and its federal counterparts in the United States District Court for the District of Vermont to enjoin these illegal policies. That lawsuit remains pending. *Alice Peck Day Memorial Hospital, et al. v. Smith, et al.*, Civil Action No. 21-cv-00102-kjd (D. Vt.).

These comments address the Waiver/Expenditure Authority No. 5, "Payment to Providers," 42 U.S.C. §§ 1396a(a)(13), (30).³ The 1115 Waiver Renewal seeks to extend Vermont's ongoing practice of setting hospital rates on an individual or class basis that departs from State Plan rates to other costly Medicaid services, including mental health, SUD, LTSS, and developmental disabilities services.⁴ If approved, the 1115 Renewal will endorse Vermont's continuation of this illegal and discriminatory rate discrepancy for out-of-state hospitals.

Although Vermont's stated goals for the 1115 Waiver Renewal are to accelerate groundbreaking payment reform and to limit healthcare cost growth, Vermont improperly relies on the 1115 Waiver to underpay out-of-state hospitals that deliver Medicaid services to Vermonters.

For inpatient hospital services, Vermont reimburses in-state hospitals at base inpatient rates of \$8,835.00 for Prospective Payment System ("PPS") hospitals, \$8,390.00 for Teaching Hospitals, and \$9,273.00 for CAHs. In contrast, Vermont reimburses out-of-state CAH and PPS hospitals at a rate of \$2,900.00 for the same services—a facial disparity of nearly seventy percent (70%). For APD and Cheshire, this disparate treatment for inpatient reimbursements amounts to annual deficiencies of more than \$500,000 and \$575,000, respectively, compared to what each would receive if in-state rates were applied.

³ See Vermont Global Commitment to Health 1115 Demonstration Renewal Application (5/13/2021) at 48, available at https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GC1115Waiver/FINAL_Global%20Commitment_Renewal_Application_5-13-2021_Public_Comment.pdf (last accessed 6/7/2021); see also Proposed GCR 21-033 Public Notice (5/13/2021) at 13, available at <https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GCRProposedPolicies/21-033-Proposed-GCR-1115Waiver-VT-Full-Public-Notice-5.13.2021.pdf> (last accessed 6/7/2021).

⁴ See Vermont Global Commitment to Health 1115 Demonstration Renewal Application (5/13/2021) at 37-38, available at https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GC1115Waiver/FINAL_Global%20Commitment_Renewal_Application_5-13-2021_Public_Comment.pdf (last accessed 6/7/2021)

For outpatient hospital services, Vermont reimburses in-state hospitals classified as CAHs at a rate of “113.00% of the Medicare 2019 OPPS national APC payment rate without local adjustment.” In contrast, Vermont reimburses APD (also a CAH) at the lesser rate of “82.00% of the Medicare 2019 OPPS national APC payment rate without local adjustment.” This disparity of over thirty percent (30%) amounts to an annual deficiency of approximately \$200,000 for APD. The same disparate treatment extends to out-of-state PPS hospitals like Cheshire. Vermont reimburses in-state PPS hospitals for outpatient services at a rate of “89.00% of the Medicare 2019 OPPS national APC payment rate without local adjustment.” By contrast, Vermont reimburses Cheshire (a PPS hospital) at the lesser rate of “82.00% of the Medicare 2019 OPPS national APC payment rate without local adjustment.” This seven percent (7%) disparity amounts to an annual deficiency for Cheshire of approximately \$80,000.

Vermont’s materially lower reimbursement of out-of-state hospitals for the same inpatient and outpatient services threatens a core Medicaid objective: the provision of medical coverage to the needy. Since the last 1115 Waiver extension in 2016, Vermont has claimed that the 1115 Waiver permits the State to pay significantly lower rates to out-of-state hospitals, in conjunction with Vermont’s unique federally-approved “All-Payer Model.” The 1115 Waiver has allowed Vermont to implement a novel system of healthcare financing and service delivery facilitated by an All-Payer Accountable Care Organization. However, Vermont’s actions in setting discriminatory rates have caused material financial harm to APD and Cheshire, potentially leading to the diminishment of patient access to services.

The 1115 Waiver language Vermont relies upon to justify these substantial rate discrepancies has no rational connection to the All-Payer Model. The 1115 Waiver authorizes Vermont to act only to the extent necessary to achieve its stated objectives. But Vermont construes this limited authority as an expansive license to eliminate any and all statutory and regulatory requirements related to methodologies and justifications for establishing reimbursement rates. Vermont further construes the 1115 Waiver to absolve the state from its obligation to assure that payments for services provided by out-of-state hospitals are “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” 42 U.S.C. § 1396a(a)(30)(A).

Accordingly, APD and Cheshire oppose the 1115 Waiver Renewal to the extent its implementation will continue to deprive APD and Cheshire of substantial reimbursement for inpatient and outpatient hospital services solely due to their location in the bordering state of New Hampshire, even though a large volume of Vermont Medicaid patients utilize these border-state hospitals’ services and benefit from their proximity, convenience, and quality of care.

Sincerely,



John P. Kacavas
Chief Legal Officer
and General Counsel

June 3, 2021

To Whom It May Concern,

Evernorth, as a nonprofit organization that houses approximately 6,000 low-income Vermonters, is in support of the Permanent Supportive Housing Pilot outlined in the proposed Medicaid Section 1115 Demonstration Waiver. Studies of supportive housing programs have shown that wraparound resident services programs are effective at addressing social determinants of health.¹ These types of support services can improve affordable housing residents' physical and mental health and decrease healthcare expenditures.² One program based in Los Angeles demonstrated significant decreases in emergency room visits and inpatient care including a 24.4% decrease in Medicaid hospital days. This contributed to a 60% decrease in costs to the public health and service system and a 20% net savings overall.³

The Permanent Supportive Housing Pilot is an opportunity to support an innovative program that not only improves the health outcomes of affordable housing residents but also decreases Medicaid costs. Evernorth strongly urges the Agency of Human Services to keep this program in the proposed waiver and support the use of housing as a platform for health services.

Sincerely,



W. Eric Schmitt
Senior Vice President of Asset Management and Portfolio Initiatives

From: AHS - Medicaid Policy <AHS.MedicaidPolicy@vermont.gov>
Sent: Thursday, June 3, 2021 9:57 AM
To: Berliner, Ashley; Lipson, Mindy; Blanford, Kathryn
Subject: FW: 1115 Renewal Public Comment

Categories: Addressed

[EXTERNAL] Please do not reply, click links, or open attachments unless you recognize the source of this message and know the content is safe.

From: Jill Olson <jill@vnavt.org>
Sent: Thursday, June 3, 2021 12:51 PM
To: AHS - Medicaid Policy <AHS.MedicaidPolicy@vermont.gov>
Subject: 1115 Renewal Public Comment

EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.

Thank you for the opportunity to comment on the 1115 Waiver Renewal. The VNAs of Vermont supports the comments that will be submitted tomorrow by a coalition of health care associations. In addition, we have one comment on an issue where the coalition could not reach consensus.

Home health and hospice agencies **support the proposed change to the Moderate Needs Group criteria** outlined on pages 13 and 14 of the waiver application. We agree that the criteria need to be more targeted so that services are available to those in the greatest need.

Assuming it moves forward, the transition to a new eligibility model will require substantial resources and we look forward to working with our partners at DAIL to identify a manageable process. Home health agencies with large waiting lists do not have the workforce resources to re-examine eligibility for every person on the waitlist.

We understand that our Adult Day partners are concerned about the impact of this change on the people they serve. We would be glad to work collaboratively with our partners at AHS and Adult Day to identify an approach we could all support. We agree with our partners at Adult Day that there are important differences between at-home homemaker services and Adult Day services and that Adult Days are generally not managing long waiting lists. However, the situation for home health agencies and homemaker services is currently untenable, and under the current system it is not always the people with the most need who are served first. That issue is important to resolve.

Jill Mazza Olson
Executive Director
(802) 249-8491 (mobile)



From: AHS - Medicaid Policy <AHS.MedicaidPolicy@vermont.gov>
Sent: Wednesday, May 19, 2021 11:37 AM
To: Berliner, Ashley; Lipson, Mindy; Blanford, Kathryn
Subject: FW: Comment GCR 21-033

Categories: Addressed

[EXTERNAL] Please do not reply, click links, or open attachments unless you recognize the source of this message and know the content is safe.

Forwarding this comment on the waiver.

When comments come in I will acknowledge receipt from the policy mailbox and save in the 2nd comment period folder.
Susan

From: Amy Stoecklein <astoecklein@gmail.com>
Sent: Wednesday, May 19, 2021 1:57 PM
To: AHS - Medicaid Policy <AHS.MedicaidPolicy@vermont.gov>
Subject: Comment GCR 21-033

EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.

Hi,

I'm writing to say thank you for including payment to parents and caregivers for children's personal care services to extend beyond the public health emergency period.

I'm in support!

Thanks,
Amy

From: AHS - Medicaid Policy <AHS.MedicaidPolicy@vermont.gov>
Sent: Friday, May 28, 2021 5:02 AM
To: Berliner, Ashley
Cc: Lipson, Mindy; Blanford, Kathryn
Subject: FW: Global Commitment to Health Demonstration Renewal, 1115 Demonstration Waiver Inquiry
Categories: Addressed

[EXTERNAL] Please do not reply, click links, or open attachments unless you recognize the source of this message and know the content is safe.

See below, 1115 Waiver comment and questions. I will leave this one in the policy mailbox, if you would like to reply.

From: Mitchell Sobolevsky <mrs@stateside.com>
Sent: Thursday, May 27, 2021 3:28 PM
To: AHS - Medicaid Policy <AHS.MedicaidPolicy@vermont.gov>
Subject: Global Commitment to Health Demonstration Renewal, 1115 Demonstration Waiver Inquiry

EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.

Hi there,

I am with Stateside Associates and we do regulatory tracking and monitoring. I am inquiring about GCR 21-033, the Global Commitment to Health Demonstration Renewal public notice for Vermont's intent to seek a five-year renewal of its Medicaid Section 1115 Demonstration Waiver.

Specifically, I have a couple of questions:

- 1) I understand that Vermont passed legislation this year that made it seem like the entire process would be delayed by one year. Why was an extension passed, and then not used?
- 2) Is there any chance that the comment period could be extended beyond 6/12/2021?

Thank you,

Mitchell R. Sobolevsky, Esq.
Senior Regulatory Counsel, Health Care Team Lead
Health Care Team
1101 Wilson Boulevard
Sixteenth Floor
Arlington, Virginia 22209
Phone: (703) 525-7466 ext. 399



See Stateside's Coverage of State and Local Responses to COVID-19 [here](#).



1115 Renewal Public Comment
Medicaid Policy Unit
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010

June 10, 2021

To Whom It May Concern:

I am writing in strong support of the State of Vermont's Global Commitment to Health 115 Demonstration Renewal Application. This proposal represents a priority commitment by the State to increased health access, cost control, and prevention. Specifically, the proposal includes a focus on family-centered mental health and substance use disorder treatment at Lund, highlighting the program's multi-tiered impacts on parents, children and the community. Lund is well-positioned to continue to support the State's goal of improving health outcomes through prevention through our innovative family-based programming.

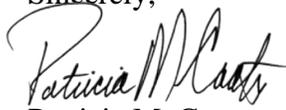
Lund's Residential Treatment Program improves health outcomes for pregnant and parenting women, 94% of whom present with co-occurring mental health and substance use disorders. 52% are homeless when they come to our program, and 72% are involved with either the State's Departments of Children and Families or Corrections.

Families in residential treatment receive coordinated, comprehensive services with proven outcomes, including improved child custody and corrections status, improved self-sufficiency and life-skills, healthy pregnancies and improved parenting skills.

Lund's Residential Treatment Program is an essential part of Vermont's system of prevention for families, supporting positive health outcomes for over 50 families annually. We are pleased to continue our partnership with the State of Vermont as part of its strategy to innovate to advance access to effective and innovative care.

On behalf of the clients we serve, we appreciate your consideration of Vermont's renewal.

Sincerely,


Patricia M. Coates
President/CEO





TO: Vermont Agency of Human Services
Medicaid Policy Unit
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
AHS.MedicaidPolicy@vermont.gov

FROM: Gus Seelig, Executive Director; Jenny Hyslop, Housing Director
RE: **1115 Renewal Public Comment - Permanent Supportive Housing Pilot**
DATE: June 9, 2021

We write to you in support of and with comments regarding the proposed AHS Medicaid Section 1115 Demonstration Waiver, Vermont Global Commitment to Health, in particular for the Permanent Supportive Housing Pilot. Below you will find context for our comments, as well as some recommendations regarding the proposed pilot.

In our 34 year history, Vermont Housing and Conservation Board has funded the creation of more than 13,000 homes for low and moderate income Vermonters, including more than 1200 homes for populations needing special supports. Partnership and collaboration with non-profit housing developers and managers has been foundational to this success.

The non-profit affordable housing network in Vermont has long been committed to serving the most vulnerable Vermonters. In addition to the purpose-built housing mentioned above, since Executive Order 03-16, which established that 15% of all publicly funded housing units must be targeted to those experiencing homelessness, our partners have consistently met and exceeded that threshold – with many organizations reporting 25-40% of their units being used to house Vermonters experiencing homelessness or those at serious risk.

Financial participation in housing developments, sanctioned by a health care authority – first by the UVM Medical Center and more recently the Rutland Regional Medical Center – make clear that Housing is Healthcare, and these institutions recognize that health care and mental health costs increase when housing is lost. Further, the efficacy and effectiveness of the SASH program has been demonstrated, and is now being replicated across the United States, with three federal evaluations showing that a population based model with housing at the heart of service delivery is a cost effective approach.

For the past year, VHCB has been convening a monthly gathering of affordable housing organizations, in which we discuss the challenges and opportunities related to providing services for their tenants. Housing organizations report that, across the spectrum of their



58 East State Street, Montpelier, Vermont 05602 TEL: 802-828-3250 WEB: www.vhcb.org

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tenants, there is a deep unmet need for services that address both pre-tenancy support and housing retention. We have also provided planning funds to develop a family SASH model and in partnership with VHFA we are contracting with the Corporation for Supportive Housing to address the systemic gaps in service delivery which lead to housing instability.

We know that there is ample evidence to support the efficacy and cost effectiveness of the PSH model, and for that reason we offer the following suggestions and comments:

- We note that this pilot is designated for those with highest needs. We encourage the Agency to consider the broadest possible eligibility for participation in the Pilot. Our housing partners report that it is not just the highest needs tenants who have unmet service needs – and that their tenants’ needs may be cyclical, with periods of crisis and stability alternating. We encourage a program design that is responsive to this reality.
- We note that the pilot is described as being limited in size, with discussion related to the establishment of a waiting list. Given that PSH is a proven model, and the significant unmet need for services, we encourage the Agency to consider the broadest possible enrollment in the Pilot, and that it be offered with geographic distribution throughout Vermont.
- As conveners of a number of regular gatherings of affordable housing organizations, we would welcome the opportunity to support the Agency in working with our housing partners to fine tune program and policy development. We believe that Vermont’s affordable housing network, with its demonstrated commitment to serving the very Vermonters most likely to benefit from this Pilot, have valuable insights to offer about how best to meet the needs of these tenants.
- We believe that partnership across agencies as you consider implementing this Pilot will be critical, and we ask the Agency to consider convening a working group including VHFA, VHCB, and other statewide entities. Siloing between housing and services has been a long standing challenge, and this Pilot offers an opportunity to ensure that the delivery and design of services is crafted with input from both housing and service providers.
- The Waiver does not address how much and with what methodology providers will be paid. We hope for clarification and the opportunity to comment regarding whether providers will be paid based on time increments, per diem, or per member per month.
- The Waiver includes funds for “population health infrastructure”. We recommend that the Pilot include capacity building for housing and homeless organizations that already have expertise in working with the target population, but who could benefit from support and training regarding billing for services.

In closing, we want to express our appreciation for the work that the Agency has done to begin considering addressing the need for services related to housing the most vulnerable Vermonters with Medicaid funding. With more than 3000 Vermonters homeless over the course of the pandemic, we know that the need is vast, and we look forward to partnering with you to support the implementation of the Permanent Supportive Housing Pilot.

From: Patrick Flood <pflood001@aol.com>
Sent: Thursday, May 27, 2021 8:37 PM
To: AHS - Medicaid Policy <AHS.MedicaidPolicy@vermont.gov>
Subject: Medicaid 1115 renewal

EXTERNAL SENDER: Do not open attachments or click on links unless you recognize and trust the sender.

To Whom It May Concern::

I have reviewed the proposal for the renewal of the Global Commitment Waiver. I find there are some very positive developments including the proposal to provide housing supports and coverage for prisoners. However some provisions are not clear to me and I hope you can provide answers to the following questions so I can make fully informed comments on the proposal.

1. When the proposal refers to DVHA as an MCO being a "anchor participant" of the All Payer Model, what does that mean exactly? What will be different than DVHA's current role with the APM?
2. The proposal refers to revising the criteria for the Moderate Needs Group in CFC to focus on the "most acute needs". What does this mean? The Moderate Needs Group was specifically designed to be preventive and there was evidence in the past that provision of Moderate Needs Group services actually resulted in the delay for High Needs Group Services.
3. The proposal describes funding for more staff for the Blueprint. Please detail how the planned staffing compares to existing staffing.
4. One glaring omission for the proposal is the lack of any mention or planning for the so-called "dual eligibles". This represents a significant missed opportunity. The "duals " are the most expensive and challenging group involved in the Medicaid program, having the most complex needs for which integrated care would be especially beneficial. To not fully take advantage of the opportunity to blend Medicare and Medicaid services and funding for this group seems like an oversight. Please provide some explanation for this decision.
5. The decision to convert DVHA to a fully functioning MCO appears to be a sound one. However, it does raise the central question: if DVHA is acting as an MCO and taking risk and reinvesting savings, why does the state continue to invest in a private ACO? The ACO seems unnecessary and redundant.

Thank you in advance for your response to these questions. I look forward to the answers so I can provide complete and relevant formal comments on the proposal.

Please acknowledge receipt of this request.

Patrick Flood

PROPOSAL FOR A DUAL ELIGIBLES PROGRAM

PATRICK FLOOD

JUNE 2021

The State of Vermont can make best use of new federal money for long term care services by using it to fund a new initiative to integrate services for people dually eligible for Medicare and Medicaid.

It is well known that as a group, the so-called “dually eligible” have the most challenging and complex needs of any group in the Medicaid or Medicare programs and on average are the most expensive recipients. This is largely because they are elderly, disabled and poor. They tend to have more disabilities and care needs, and tend to use more long term care services, including nursing home care.

For many years, services for this group have been poorly coordinated. In fact, the two programs, Medicare and Medicaid, have in reality cost shifted to each other, increasing overall costs. Stipulations in one program often conflict with the other, leaving recipients ill-served or underserved. Now that Vermont has embraced an All Payer Model of health care reform, an excellent opportunity exists to fully integrate services for the dually eligible population, provide better care, lower overall costs and eliminate duplication and cost shifting.

Key elements of this initiative would include:

1. Eliminating the differences between Medicare home care and Medicaid home care services. Any dually eligible person would be eligible immediately for a full range of in-home services based on clinical needs including skilled nursing, physical and occupational therapies, personal care and supervision.
2. Providing nursing home care based solely on clinical need whether skilled nursing, personal care and supervision or respite without limitation on duration. If comprehensive services are provided as described in #1 above, the need for institutional services would be greatly reduced, reducing overall costs. But when they are needed they should be provided immediately and without restriction.
3. Use new federal funds to expand in-home care beyond traditional and usual services. Persons who receive in home support services or post hospital or rehab services would be able to receive unrestricted home visits to monitor health and well-being, prevent exacerbation and thus prevent unnecessary re-hospitalizations.
4. Federal funds can be used to expand access to hospice services, both to receive them early and to extend them if a recipient improves (which often happens).
5. There would need to be a higher level of care management to ensure recipients are closely monitored so that any deterioration is quickly addressed to prevent avoidable hospitalizations. Care managers should be given the authority to intervene in care decisions to ensure the recipient receives the proper care and the care they choose. Care managers also need access to flexible funds to pay for needed services, including non-medical determinants of well-being, not otherwise covered by Medicare and Medicaid funds.
6. These key elements can be achieved with no reduction or limitation in overall traditional Medicare services; the key change would be that recipients would have full and timely access to

a comprehensive range of preferred in-home services -before utilizing institutional services. This will result in expanded Medicare-type services, not a reduction.

7. Once savings materialize from reduced nursing home and hospital utilization, those savings should be re-invested in improving services for duals. The first step should be to subsidize the cost of medications to ensure people receive -and use -necessary medications. The second should be to reduce co-pays and deductibles to ensure people will not hesitate to access care.



Vermont
Association of
Area Agencies
on Aging

145 Pine Haven Shores Road
Ste 2217
Shelburne, VT 05482
(802) 578-7094
www.Vermont4A.org

Member Agencies:

CVAA
Central Vermont Council on Aging
Northeast Kingdom Council on Aging
Southwestern Vermont Council on Aging
Senior Solutions

Public Comment RE: Vermont Global Commitment to Health 1115 Demonstration Renewal Application

We are writing on behalf of the V4A, which represents all five Area Agencies on Aging (AAA) in the state of Vermont. We serve older Vermonters, aged 60 years and older and anyone under the age of 60 with a disability on Medicaid. As designated agencies serving older adults, regulated by the Department of Disabilities, Aging and Independent Living (DAIL) we are integral to the fabric of the Home and Community Based Service arena in all of our regional catchment areas. Not only do we provide Care Management Services through Choices for Care and One Care Vermont, we combine these with many of our other services such as Options Counselling, Intake and Referral, our Meals on Wheels programs and our Volunteer Friendly Visitor/Care Companion Programs. We ensure our clients are able to stay in their homes instead of higher cost alternatives such as hospitals and nursing homes and our work is becoming ever more impactful as we continue to focus on the SDOH, which is at the center of our mission.

We believe health begins at home, and we are concerned that several of the goals outlined in the 1115 Waiver application may have significant impacts on the AAA network. The application has defined DVHA as evolving to a managed care organization (MCO) - with a capitated payment model, while also highlighting several proposals for change over this next five-year period. The issues we are highlighting are as follows:

Capitation and Payment Reform:

1. We are unclear what capitation will mean for the robust system of care management provided through the AAA network. The AAA's are an integral part of the systems approach to managing the Social Determinants of Health and should be included in the integrated care management system proposed within the application. In addition to the home health agencies, and the Designated Mental Health Agencies, the AAA's have been the cornerstone in what has evolved to be a positive shift towards the delivery of HCBS through the value of the case management system in Vermont for all clients we serve, and especially for high and very risk clients. The payment reform model must take our AAA system into consideration as this evolves; to keep the AAA's 'whole', while considering how quality incentives could also be built in to reward positive quality outcomes for our system of service.

2. While we appreciate the focus to re-invest shared savings into delivery system reforms under DVHA's proposed capitation model, we do note that this was the original intent of the CFC program. Community based providers such as AAA's, have never received



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incentive funds to further develop the model that they helped to successfully create. We ask that this approach be considered as part of this proposal.

Integrated Care Management:

1. The Global Commitment Waiver notes, “Vermont is aiming to advance integration of care across physical health, mental health, SUD, LTSS (including HCBW-like programs), human services, and SDOH.” The Area Agencies on Aging are unclear where they fit into this advanced integration of care coordination model described, and we believe this must be strongly considered as planning moves forward. In order to be maximally successful and impactful, any proposal must be inclusive of our agencies and the impactful work that we do, to serve older Vermonters with low, medium and high- risk conditions.

2. The application notes “Vermont has determined that there are opportunities to advance integration through greater alignment across the State in addition to across programs offering care coordination through Medicaid, the All-Payer ACO, and other payers”. This seems to imply further payment reform decisions are under way and again, the AAA’s must be included in these discussions especially if this affects us through the proposed changes. Our revenue sources from the ACO and through Choices for Care programs are a mainstay of our budgets each year, so any proposed changes that affect these must involve us. We are requesting level funding, with consideration for incentive payments for positive quality outcomes

3. The application also highlights many specific changes expected within the care management delivery model including more standardized activities, composition of care teams with flexibility based on patient need and regional resources, which we believe could be inclusive of the AAA’s and be effective. The notion of empowering enrollees to choose their preferred lead care coordination during outreach is also a positive step, however, the examples noted in the application refer to Designated Agencies (Mental Health) and PCMH as the only options. AAA’s have served as lead care coordinators for High and Very High Risk older adult clients with great success. The roles of the AAA’s and our value related to the overall system of care coordination in this proposed integrated model, has been overlooked, and we ask for this to be reassessed and re-addressed.

Workforce Development:

1. We strongly support the need for critical workforce development initiatives to ensure a well - educated and well- rounded workforce. Caregiver shortages are creating significant challenges in our ability to provide needed care in the home. These proposed investments are integral, as they will provide needed and critical supports to allow people to remain in their homes, versus more costly alternatives- such as nursing homes.



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Population Health:

1. While the Blueprint model offers focus on advancing innovative health initiatives, we see a need to be more inclusive of models that are not “medically based”. The ability to help transform our system with a strong focus on population health relies on a truly collaborative approach with members of the HCBS. Health begins at home and yet funding is consistently directed to the medical systems, including primary care and hospitals versus investments in Home and Community Based provider systems. We support a shift in those investments to allow for greater capacity for coordination of the SDOH in the community-based model of service, especially through the AAA’s.

VPHARM:

1. We strongly support the proposed expansion of this program as outlined in the application. This is a critical program, especially beneficial to older Vermonters receiving services through the AAA’s.

VBP Systems:

1. DVHA proposes to advance VBP systems, which will surely influence HCBS-LTCC programs especially given CMS’ recent requests for public comment on their proposed Core Measures. AAA’s are offering low cost alternatives to enrollees and clients in the community setting, advancing population health strategies and supporting older adults to stay in their homes instead of higher cost alternatives. We are prepared to be part of these VBP program discussions and encourage DVHA to be inclusive of the HCBS providers, including the AAA’s, as these decisions are advanced.

Thank you for the opportunity to provide feedback to the Vermont Global Commitment to Health 1115 Demonstration Renewal Application.

Sincerely,

Jane Catton, BScN, MSOL, RN, NE-BC
Chief Executive Office, Age Well
President, V4A

Meg Burmeister, MSW
Executive Director, Northeast Kingdom Council on Aging
Secretary, V4A



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Senior Solutions

A handwritten signature in black ink that reads 'Rosemary Greene'.

Rosemary Greene,
Business Operations Director, Southwestern Vermont Council on Aging
Treasurer, V4A

A handwritten signature in black ink that reads 'Mark Boutwell'.

Mark Boutwell,
Executive Director, Senior Solutions

A handwritten signature in black ink that reads 'Davoren Carr'.

Davoren Carr,
Co-Interim Executive Director, Central Vermont Council on Aging

A handwritten signature in blue ink that reads 'Pam Zagorski'.

Pam Zagorski, MBA/JD,
Executive Director, Southwestern Vermont Council on Aging

June 11, 2021

Medicaid Policy Unit
280 State Drive
NOB 1 South Waterbury, VT 05671-1010 3
Re: 1115 Renewal Public Comment

Via e-mail: AHS.MedicaidPolicy@vermont.gov

Re: 1115 Renewal Public Comment

To Whom it May Concern:

Thank you for the opportunity to comment on Global Commitment Register (GCR) proposed policy 21-033. The Vermont Association of Hospitals and Health Systems represents all 15 of Vermont's nonprofit hospitals.

Our organization signed on to the June 4th letter from health care associations. We appreciate the Department's efforts to move towards a risk-bearing MCO that will ensure flexibility for innovative health care programs to address the social determinants of health while ensuring the sustainability of our health care providers. We have a few additional questions and comments:

- **Transition to a risk-bearing MCO:** How is DVHA going to manage risk as a state entity? Commercial insurers who take on the MCO role for Medicaid in other states have reserves if the MCO must bear risk. Will DVHA have reserves? If not, how will DVHA bear the risk?
- **Medicaid risk-bearing model for Medicare:** Act 113 of 2016 requires Medicare payments to go directly to health care providers without going through the State of Vermont. How will DVHA address this statutory requirement going forward?

Thank you, again, for your work on this effort. Please feel free to contact me with questions or concerns.

Sincerely,



Devon Green
Vice President, Government Relations
Vermont Association of Hospitals and Health Systems



June 12, 2021

State of Vermont
Agency of Human Services
Medicaid Policy Unit
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010

Submitted via e-mail to: AHS.MedicaidPolicy@vermont.gov

Re: 1115 Renewal Public Comment

On behalf of Valley Regional Hospital, Inc. (“VRH”), please accept these comments on Vermont’s Global Commitment to Health Demonstration (“1115 Waiver”) Renewal. Because of Vermont’s geography and location, more Vermont residents obtain out-of-state hospital services than residents of any other state.¹ Vermont residents rely on border-state hospitals like VRH to provide necessary medical services within their particular localities.

VRH is a New Hampshire non-profit healthcare charitable trust licensed for 25 beds located in Claremont, New Hampshire, approximately five (5) miles from the Vermont border. VRH is designated as a critical access hospital (“CAH”).

VRH is a high-volume provider of medical services to Vermont Medicaid enrollees. VRH is designated as an “Out-of-State In-Network Hospital” within Vermont’s Green Mountain Care Network, due to its close proximity to Vermont and the general practice of Vermont’s residents to secure care and services at this hospital.² VRH treats Vermont Medicaid and uninsured patients of all acuity levels, and incurs similar costs and expends similar resources as Vermont’s comparatively-sized and similarly-situated in-state CAH hospitals in order to provide care to Vermont residents.

Yet, under Vermont’s current 1115 Waiver, and under the proposed 1115 Waiver Renewal, Vermont reimburses VRH for inpatient and outpatient hospital services rendered to Vermont Medicaid patients at significantly lesser rates than in-state Vermont hospitals—solely because VRH is located across the border in New Hampshire.

This discriminatory reimbursement to VRH is unlawful and unconstitutional. VRH has joined three other border-state Plaintiff Hospitals serving Vermont Medicaid patients to sue Vermont and

¹ Nineteen percent (19%) of all hospital stays for Vermont Medicaid recipients are out-of-state stays. *See* Medicaid and CHIP Payment Access Commissions, “Medicaid Payment Policy for Out-of-State Hospital Services” (January 2020), Appendix A, available at <https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid-Payment-Policy-for-Out-of-State-Hospital-Services.pdf> (last accessed 6/9/2021).

² *See* Agency of Human Services’ Provider Network Info, available at <https://dvha.vermont.gov/providers/provider-network-info/green-mountain-care-network> (last accessed 6/9/2021).

its federal counterparts in the United States District Court for the District of Vermont to enjoin these illegal policies. That lawsuit remains pending. *Alice Peck Day Memorial Hospital, et al. v. Smith, et al.*, Civil Action No. 21-cv-00102-kjd (D. Vt.).

These comments address the Waiver/Expenditure Authority No. 5, “Payment to Providers,” 42 U.S.C. §§ 1396a(a)(13), (30).³ The 1115 Waiver Renewal seeks to extend Vermont’s ongoing practice of setting hospital rates on an individual or class basis that departs from State Plan rates to other costly Medicaid services, including mental health, SUD, LTSS, and developmental disabilities services.⁴ If approved, the 1115 Renewal will endorse Vermont’s continuation of this illegal and discriminatory rate discrepancy for out-of-state hospitals.

Although Vermont’s stated goals for the 1115 Waiver Renewal are to accelerate groundbreaking payment reform and to limit healthcare cost growth, Vermont improperly relies on the 1115 Waiver to underpay out-of-state hospitals that deliver Medicaid services to Vermonters.

For inpatient hospital services, Vermont reimburses in-state hospitals at base inpatient rates of \$8,835.00 for Prospective Payment System (“PPS”) hospitals, \$8,390.00 for Teaching Hospitals, and \$9,273.00 for CAHs. In contrast, Vermont reimburses out-of-state CAH and PPS hospitals at a rate of \$2,900.00 for the same services—a facial disparity of nearly seventy percent (70%). For VRH, this disparate treatment for inpatient reimbursements amounts to an annual deficiency of approximately \$37,000, compared to what it would receive if in-state rates were applied.

For outpatient hospital services, Vermont reimburses in-state hospitals classified as CAHs at a rate of “113.00% of the Medicare 2019 OPPS national APC payment rate without local adjustment.” In contrast, Vermont reimburses VRH (also a CAH) at the lesser rate of “82.00% of the Medicare 2019 OPPS national APC payment rate without local adjustment.” This disparity of over thirty percent (30%) amounts to an annual deficiency of approximately \$70,000 for VRH.

Vermont’s materially lower reimbursement of out-of-state hospitals for the same inpatient and outpatient services threatens a core Medicaid objective: the provision of medical coverage to the needy. Since the last 1115 Waiver extension in 2016, Vermont has claimed that the 1115 Waiver permits the State to pay significantly lower rates to out-of-state hospitals, in conjunction with Vermont’s unique federally-approved “All-Payer Model.” The 1115 Waiver has allowed Vermont to implement a novel system of healthcare financing and service delivery facilitated by an All-Payer Accountable Care Organization. However, Vermont’s actions in setting discriminatory rates have caused material financial harm to VRH, potentially leading to the diminishment of patient access to services.

³ See Vermont Global Commitment to Health 1115 Demonstration Renewal Application (5/13/2021) at 48, available at https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GC1115Waiver/FINAL_Global%20Commitment_Renewal_Application_5-13-2021_Public_Comment.pdf (last accessed 6/9/2021); see also Proposed GCR 21-033 Public Notice (5/13/2021) at 13, available at <https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GCRProposedPolicies/21-033-Proposed-GCR-1115Waiver-VT-Full-Public-Notice-5.13.2021.pdf> (last accessed 6/9/2021).

⁴ See *id.*, Vermont Global Commitment to Health 1115 Demonstration Renewal Application (5/13/2021) at 37-38.



Valley Regional Hospital

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The 1115 Waiver language Vermont relies upon to justify these substantial rate discrepancies has no rational connection to the All-Payer Model. The 1115 Waiver authorizes Vermont to act only to the extent necessary to achieve its stated objectives. But Vermont construes this limited authority as an expansive license to eliminate any and all statutory and regulatory requirements related to methodologies and justifications for establishing reimbursement rates. Vermont further construes the 1115 Waiver to absolve the state from its obligation to assure that payments for services provided by out-of-state hospitals are “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” 42 U.S.C. § 1396a(a)(30)(A).

Accordingly, VRH opposes the 1115 Waiver Renewal to the extent its implementation will continue to deprive VRH of substantial reimbursement for inpatient and outpatient hospital services solely due to its location in the bordering state of New Hampshire, even though a great many Vermont Medicaid patients utilize this border-state hospital’s services and benefit from its proximity, convenience, and quality of care.

Sincerely,

Jocelyn Caple
CEO

Valley Regional Hospital, Inc.



Ena Backus
Director Health Reform
Agency of Human Services

Thank you for the opportunity to comment on [Global Commitment Register \(GCR\) proposed policy 21-033](#), and for your thorough response to our previous questions. Overall, we are extremely pleased with the how this application continues Vermont's commitment to innovative health care system and its commitment to comprehensive health care services with attention to the social determinants of health.

Goal 1

New Features

SUD Community Intervention and Treatment Eligibility Group

We support the expansion of the eligibility group for Vermonters with SUD up to 225% FFL and support their access to the services in Table 2 as part of their Medicaid benefit.

Comments:

1. **Peer Specialists:** It should be clarified that peer specialist services will be eligible for Medicaid funding regardless of where the services are provided, recovery centers or designated agencies.
2. **Withdrawal Management:** The Waiver application should indicate that funding for Withdrawal Management, if it includes the current Public Inebriate Programs run by designated agencies, will continue to be funded on a capacity basis to maintain staffing, facility, and other infrastructure costs regardless of utilization levels. If the payment model is switched from capacity to a fee-for-service reimbursement it could create fiscal instability. We would like to see the funding for these services continue to cover costs on an ongoing capacity basis which could use a value-based payment model.

Goal 2

Continuing Features

- **CFC.** Vermont seeks to add a "life skills aide" service to the CFC service array for the Highest Needs Group and High Needs Group.

Comment: Vermont Care Partners understands that the new "life skills aides" will impact both our brain injury and choices for care programs. It will be important that the reimbursement rate enable providers to recruit and retain adequate staffing levels. We will look forward to working with DAIL and other stakeholders to address outstanding questions: What services are provided and what training is necessary? How will the funding cover the cost of training?

- **Developmental Disabilities Services.** Vermont is seeking authority to reimburse parents of a minor child, spouses, and legal guardians providing personal care and personal care-like services to individuals enrolled in the Developmental Disabilities Services program.²

Comment: Vermont Care Partners looks forward to working with DAIL as it promulgates policy and regulations to address our questions and concerns about recent temporary changes to state

DS policy and the potential for future reimbursement parents of minor children, spouses, and legal guardians providing personal care and personal care-like services to individuals enrolled in I/DD services programs. Our critical questions include:

- Under what circumstances will parents/guardians be reimbursed?
- What will that criteria look like?
- How will the people in services be supported to share perspectives on family members being reimbursed?
- What will oversight look like?
- If it does go forward, can it be begun on a pilot bases to evaluate if the investment results in improved client outcomes?
- Will the self-advocates be able to object to family members being reimbursed?
- The new encounter data system is designed to hold agency staff accountable for services delivered, what will that look like for family members?

• **Brain Injury Program.** Vermont is seeking authority to reimburse parents of a minor child, spouses, and legal guardians providing life skills aide services and community supports (including shared living) to individuals enrolled in the Brain Injury Program.

Comment: We look forward to working with DAIL as it promulgates policy and regulations to address our questions and concerns about reimbursing parents of minor children, spouses, and legal guardians providing personal care and personal care-like services to individuals enrolled in brain injury services programs. Our critical questions include:

- Under what circumstances with parents/guardians be reimbursed?
- What will eligibility criteria look like?
- How will the people in services be supported to share perspectives on family members being reimbursed?
- What will oversight look like?
- The new encounter data system is designed to hold agency staff accountable for services delivered, what will that look like for family members
- If it does go forward, can it be begun on a pilot bases to evaluate if the investment results in improved client outcomes?
- **How will family members be held accountable for services delivered**

Permanent Supportive Housing Pilot In the past 15 years of the Global Commitment demonstration, Vermont has made significant progress in allowing Medicaid enrollees to obtain care in their homes and communities if they so choose. To further support these individuals in securing and maintaining housing appropriate for their needs, Vermont is seeking expenditure authority for a Permanent Supportive Housing Pilot program. Studies conducted across the United States have shown that permanent supportive housing programs are effective not only in reducing homelessness, but also in preventing ED use and hospitalization, and reducing overall health care costs for high-need individuals.

Improving access to permanent supportive housing is an important strategy for promoting equity and reducing racial disparities in homelessness in Vermont. In 2018, the Family Homelessness Point in Time report found that Black Vermonters were 5.4 times more likely to experience homelessness than white Vermonters.²⁵ While Vermont has access to supportive housing vouchers through the Department of Housing and Urban Development (HUD), the State has been unable to use all of the vouchers in recent years due to lack of available support services. In establishing the Permanent Supportive Housing Pilot,

Vermont seeks to provide individuals with the services they need to successfully transition into and maintain residency in close coordination and collaboration with agencies that provide rental assistance.

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

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

Comment: Vermont Care Partners strongly supports this program. The people we serve in CFC, CRT, Developmental Disabilities Services, Brain Injury Program, or Mental Health under 22 for SMI/SED often require extensive support with accessing and maintaining housing stability. Without support to access and maintain stable housing it is difficult for them to achieve stability and recovery from health conditions.

Goal 3

New Features

- **Covering Certain Investments Through Expenditure Authority.** Vermont is seeking to transition a subset of its current investments to being covered through expenditure authority under the demonstration.

- o **Workforce Development Investments.** Vermont is requesting \$4.75 million in expenditure authority over five years to support loan repayment programs for health care professions, geographically accessible nursing education, and educational partnerships.

Comment: Vermont Care Partners urges the Agency of Human Services to include the workforce serving the I/DD and mental health populations in this program. Specific needs include: MA level clinicians, direct support professionals, BA level case managers. What opportunities are there for the 1115 waiver resources be used to incentivized work at DA/SSAs?

New Features

- **Advancing Integration in Care Coordination.** Vermont intends to align statewide expectations across care coordination programs through Medicaid, the All-Payer ACO, and other payers with respect to care coordination activities, composition of care teams, and processes for care coordination assignments. Vermont is requesting \$15 million (total computable) in expenditure authority over five years to fund a network of three types of staff who supervise and support the Blueprint for Health (Blueprint) initiatives: (1) program managers, who monitor practices' participation as a patient centered medical home (PCMH), integration with the local community health team (CHT), and implementation of Vermont's care coordination models; (2) quality improvement (QI) facilitators, who assist PCMHs in identifying and implementing QI projects; and (3) self-management regional coordinators, who administer self-management programming in each of the State's health service areas.

Comment: integration in care coordination should include a structure that goes beyond Blueprint staffing to understand/reflect care coordination at the community provider level. With the understanding that no additional resources are planned for care coordination services provided by the Blueprint for Health, we recommend that AHS work with providers to better organize care coordination efforts across the continuum of services and to determine the relative value of investment in care coordination compared to investment in direct services and supports.

Goal 5:

New Features

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

Comment: As Vermont further transitions to Health Care Payment Learning & Actions Network Category 4 for mental health, SUD and developmental disability services it is critical that challenges with payment rates and capacity be addressed. If we do not more fully meet community-based services needs of the mental health and developmental disability populations inpatient and institutional services will increase in demand and cost, and the financial and structural sustainability of designated agency system of care will be at risk. We reiterate the comments made the Health Associations in our letter dated June 4, 2020.

“Our top Medicaid policy priority is adequate Medicaid reimbursement to support the services we provide. Budget-neutral “payment reform” and payment models that have no routine rate schedule update will not adequately support the health care delivery system. To that end: (1) We urge the agency to ensure that Medicaid reimbursement rates at a minimum match Medicare fee schedules for core services where a Medicare fee schedule exists. Where no Medicare fee schedule exists, Vermont should identify other mechanisms for regular rate schedule updates. (2) We would like more information on how using the Medicaid risk bearing model for Medicare-covered Vermonters impacts the All-Payer ACO Model. While we support the overall goal of integrating a risk bearing MCO model with the All-Payer Model, we do not have adequate information to assess how these two risk-bearing models will work together at the statewide or individual provider level. We would not support efforts that make implementation of payment reform for providers more administratively complex or ask providers to take on additional financial risk. (3) Goal 5 references AHS’ intent to consider payment reform for Vermont’s successful LTSS initiatives. LTSS “reform” must include increasing total reimbursement for the services. Vermont’s successful LTSS programs across the continuum are eroding because Vermont has failed to adequately invest in them – almost since their inception. Absent new dollars to adequately fund LTSS programs, new payment models will not improve Vermont’s ability to deliver LTSS. Planning must also account for the need to increase capacity because of increasing demand. Too often, Vermont has budgeted only for caseload increases, without reimbursement increases.”

Thank you for considering our feedback.

Sincerely,

Julie Tessler
Executive Director
Vermont Care Partners: VT Council

Simone Rueschemeyer
Executive Director
Vermont Care Partners: VCN

June 11, 2021

Vermont Agency of Human Services
Medicaid Policy Unit
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010
AHS.MedicaidPolicy@vermont.gov

Re: **1115 Renewal Public Comment** - support for **Permanent Supportive Housing Pilot**

To our partners at AHS:

Vermont Housing Finance Agency (VHFA) has served Vermonters for over 47 years, with the goal of financing and promoting affordable, safe and decent housing opportunities for low- and moderate-income Vermonters.

With our mission at heart, we write to you today in support of the proposed AHS Medicaid Section 1115 Demonstration Waiver, Vermont Global Commitment to Health (Global Commitment), with specific support for the **Permanent Support Housing Pilot** currently included in the draft language.

Permanent supportive housing (PSH) has been extensively researched and is found to reduce incidences of homelessness while also reducing the cost and burden on public services. “Cost studies in six different states and cities found that supportive housing results in tenants’ decreased use of homeless shelters, hospitals, emergency rooms, jails and prisons.”¹ These service reductions have generated cost savings up to 2.5 times the initial investment of housing and services for PSH.

Vermont’s 2016 “Roadmap to End Homelessness”² quantified the need for housing and services for those experiencing homelessness, noting that 1,100 Vermonters were experiencing homelessness, while also laying out a path to house and serve those individuals and families. This path identifies the need to fund affordable housing, specifically including **360+ new units of supportive housing by 2021**. The numbers of households experiencing homelessness has only grown during the pandemic, as the household count staying in motels and shelters exceeded 3,000 at its peak in the past year.

Vermont’s housing funder network has a long tradition of working strategically and building strong interagency networks to house low- and moderate-income Vermonters. Housing funders like VHFA are ready and willing partners to support AHS and the Department of Vermont Health Access (DVHA) in the PSH Pilot proposal. Such a partnership between AHS / DVHA, VHFA, and other housing funders is critical to implement in the PSH Pilot design process, as the challenge of navigating distinct, separated housing systems and service systems cannot fall to residents with high needs to maneuver alone.

Similarly, Vermont’s network of local affordable housing developers and property managers has a deep-seated mission to house and serve low- and moderate-income Vermonters. Affordable housing developers and managers are ready and willing partners to support AHS in the PSH Pilot proposal implementation and design.

¹ Corporation for Supportive Housing. *FAQ’s about Supportive Housing Research: Is Supportive Housing Cost Effective?* retrieved from <https://d155kuxfl1aozz.cloudfront.net/wp-content/uploads/2018/06/Cost-Effectiveness-FAQ.pdf>

² Vermont Roadmap to End Homelessness (2016, December 20). Retrieved from <https://www.vtaffordablehousing.org/wp-content/uploads/2019/01/VT-Roadmap-to-End-Homelessness-Final-Report-2016.12.20.pdf>

To begin the design feedback process, VHFA recognizes that key details for the current PSH Pilot proposal will still need to be developed. As one example, the proposed enrollment cap is one program element for which we encourage robust public comment and feedback.

Additionally, VHFA encourages program rates to be based either on per diem or per member, per month basis. We would oppose a rate design based on 15-minute increments as being inflexible in best serving clients and their variable needs.

Finally, VHFA notes that the waiver includes funds for population health infrastructure, and we would recommend explicitly including capacity building for housing and homeless agencies that have expertise in working with these populations but may need training capacity or technical assistance to gain similar expertise in billing DVHA for services. This kind of capacity building will be critical to ensure that all local partners working together on this PSH pilot have similar knowledge of the program.

We look forward to working with you to bring this proposed PSH Pilot to serve those Vermonters in need.

Warmly,



Maura Collins
Executive Director, VHFA



June 11, 2021

Submitted via email: AHS.MedicaidPolicy@vermont.gov

Mr. Michael Smith
Secretary
Agency of Human Services
Medicaid Policy Unit
280 State Drive, NOB 1 South
Waterbury, VT 05671-1010

Re: Vermont Global Commitment demonstration 1115 Renewal Public Comment

Dear Secretary Smith,

ViiV Healthcare Company (ViiV), appreciates the opportunity to submit comments to the Vermont Agency of Human Services (AHS) on its Vermont Global Commitment to Health 1115 Demonstration Renewal Application.¹

ViiV is the only independent, global specialist company devoted exclusively to delivering advancements in human immunodeficiency virus (HIV) treatment and prevention to support the needs of people with HIV. From its inception in 2009, ViiV has had a singular focus to improve the health and quality of life of people affected by this disease and has worked to address significant gaps and unmet needs in HIV care. In collaboration with the HIV community, ViiV remains committed to developing meaningful treatment advances, improving access to its HIV medicines, and supporting the HIV community to facilitate enhanced care and treatment.

As an exclusive manufacturer of HIV medicines, ViiV is proud of the scientific advances in the treatment of this disease. These advances have transformed HIV from a terminal illness to a manageable chronic condition. Effective HIV treatment can help people with HIV to live longer, healthier lives, and has been shown to reduce HIV-related morbidity and mortality at all stages of HIV infection.^{2,3} Furthermore, effective HIV treatment can also prevent the transmission of the disease.⁴

¹ Vermont Global Commitment to Health 1115 Demonstration Renewal Application, (Accessed June 10, 2021) [21-033-Proposed-GCR-1115Waiver-VT-Full-Public-Notice-5.13.2021.pdf \(vermont.gov\)](#)

² Severe P, Juste MA, Ambrose A, et al. Early versus standard antiretroviral therapy for HIV-infected adults in Haiti. *N Engl J Med*. Jul 15 2010;363(3):257-265. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=20647201.

³ Kitahata MM, Gange SJ, Abraham AG, et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. *N Engl J Med*. Apr 30 2009;360(18):1815-1826. Available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=19339714.

⁴ Rodger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. *The Lancet*. Published Online May 2, 2019 [https://dx.doi.org/10.1016/S0140-6736\(19\)30418-0](https://dx.doi.org/10.1016/S0140-6736(19)30418-0).

HIV and Medicaid

An estimated 1.2 million people in the United States are living with HIV and at least thirteen percent are unaware that they have the virus.⁵ Despite groundbreaking treatments that have slowed the progression and burden of the disease, treatment of the disease is low – only half of diagnosed and undiagnosed people with HIV are retained in medical care, according to the Center for Disease Control and Prevention (CDC).⁶

Since the earliest days of the epidemic, Medicaid has played a critical role in HIV care. Nationally, Medicaid is the largest source of coverage for people with HIV.⁷ In fact, more than 42 percent of people with HIV who are engaged in medical care have incomes at or below the federal poverty level.⁸ The program is an essential source of access to medical care and antiretroviral therapy (ART) drug coverage for people with HIV. This medical care and drug treatment not only preserve the health and wellness of people with HIV and improves health outcomes, but it also prevents new HIV transmissions.

In 2019, the U.S. Department of Health and Human Services (DHHS) released the “Ending the HIV Epidemic: A Plan for America (EHE).”⁹ This plan proposes to use scientific advances in antiretroviral therapy to treat people with HIV and expand proven models of effective HIV care and prevention. The EHE Initiative¹⁰ is not only a landmark policy by all federal health agencies, it is also supported by the HIV community, and the President’s Advisory Council on HIV/AIDS (PACHA).¹¹ The plan coordinates efforts across government agencies to stop the HIV epidemic and focuses its efforts on local areas. In order to promote the state and federal goal to end the HIV epidemic, it is imperative that state Medicaid programs participate in local and national efforts and promote policies that contribute to HIV public health goals.

Therefore, in providing our comments, ViiV wishes to bring to the Agency’s attention the unique opportunity for the waiver’s renewal to align with the goals of the nation’s public health effort to end the HIV epidemic, which has set a goal of reducing new cases of HIV 90 percent by 2030,¹² as well as to continue to advance the care, treatment, and prevention needs of their enrollees with HIV and those at risk for acquiring HIV.

⁵ Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2019. HIV Surveillance Supplemental Report 2021;26(No. 2). <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published May 2021. Accessed June 2, 2021.

⁶ Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2019. HIV Surveillance Supplemental Report 2021;26(No. 2). <http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published May 2021. Accessed June 2, 2021.

⁷ Kaiser Family Foundation. Medicaid and HIV, <http://www.kff.org/hiv/aids/fact-sheet/medicaid-and-hiv/>

⁸ Centers for Disease Control and Prevention. Behavioral and Clinical Characteristics of Persons with Diagnosed HIV Infection—Medical Monitoring Project, United States, 2016 Cycle (June 2016–May 2017). HIV Surveillance Special Report 21. Revised edition. <https://www.cdc.gov/hiv/library/reports/hiv-surveillance.html>. Published June 2019. Accessed February 2021. <https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-21.pdf>

⁹ HIV.gov “Ending the HIV Epidemic” <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview> (Accessed: April 20, 2021)

¹⁰ Ending the HIV Epidemic: A Plan for America <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview>

¹¹ Presidential Advisory Council on AIDS (PACHA) Resolution in Support of “Ending the HIV Epidemic: A Plan for America” <https://files.hiv.gov/s3fs-public/PACHA-End-HIV-Elimination-Resolution-passed.pdf>

¹² HIV.gov “Ending the HIV Epidemic” <https://www.hiv.gov/federal-response/ending-the-hiv-epidemic/overview> (Accessed: April 20, 2021)

1. HIV and Substance Use Disorder Population

The opioid epidemic represents a significant public health crisis in the United States, with an estimated 2.1 million Americans having an opioid use disorder in 2016.^{13,14} The opioid epidemic also indicates an increased risk of HIV transmission. While many individuals with opioid use disorder start with pills, an estimated 10-20 percent of people who abuse prescription opioids move on to inject opioids or heroin.^{15,16} Substance misuse can lead to increases in risky behaviors for disease transmission and injection drug use in a population can fuel transmission of blood-borne infectious diseases such as HIV.¹⁷ The CDC estimates that 19 percent of the more than 1 million people with HIV in the United States are injection drug users,¹⁸ and injection drug users accounted for 9 percent (3,425) of new diagnoses of HIV in the United States in 2016.¹⁹ Individuals who inject drugs intravenously in their lifetime are over 30 times as likely to have HIV/AIDS.²⁰ In 2015, there was an increase in new HIV diagnoses among injection drug users for the first time in two decades.²¹ Health officials in some states and regions have reported increased HIV transmissions as a result of the opioid epidemic.^{22,23,24} As policymakers and public health officials work towards the goal of “Ending the HIV Epidemic,” the impact of the opioid epidemic on these efforts must be considered.

HIV testing is a vital yet overlooked part of substance use treatment efforts. The CDC recommends routine opt-out HIV screening for all adults, adolescents, and pregnant women in health care settings as a normal part of medical practice, but those with specific risk factors for the disease (such as injection drug users) should be tested more frequently.²⁵ It is possible that many new HIV infections are not being detected due to a lack of routine testing for those at risk due to the opioid epidemic. Some individuals may not be aware of the highly increased risk factor for HIV due to substance misuse.

Studies show that the earlier a person is diagnosed and treated for HIV, the better their health outcomes. Early initiation of antiretroviral therapy significantly improves survival, as compared to deferred therapy.²⁶

¹³ Kaiser Family Foundation HIV and the Opioid Epidemic: 5 Key Points <https://www.kff.org/hivaids/issue-brief/hiv-and-the-opioid-epidemic-5-key-points/>

¹⁴ SAMHSA. 2016 National Survey on Drug Use and Health. <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf>

¹⁵ Peters, P., et al. (2016.) “HIV Infection Linked to Injection Use of Oxycodone in Indiana, 2014–2015.” *New England Journal of Medicine*. 375:229-239.

¹⁶ Van Handle, M., et al. (2016). “County-level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections among Persons who Inject Drugs, United States.” *Journal of AIDS*. 73:3, 323-331

¹⁷ “Drug Use and Viral Infections (HIV, Hepatitis)” National Institute of Drug Abuse, NIH, April 2018

<https://www.drugabuse.gov/publications/drugfacts/drug-use-viral-infections-hiv-hepatitis>

¹⁸ The National Survey of Substance Abuse Treatment Services (N-SSATS) Report: HIV Services Offered by Substance Abuse Treatment Facilities. <https://www.samhsa.gov/sites/default/files/hiv-services-offered-by-sa-facilities.pdf>

¹⁹ CDC, HIV Among People Who Inject Drugs, <https://www.cdc.gov/hiv/group/hiv-idu.html>

²⁰ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (December 1, 2010). The National Survey on Drug Use and Health (NSDUH) Report: HIV/AIDS and Substance Use. Rockville, MD.

<https://www.samhsa.gov/sites/default/files/hiv-aids-and-substance-use.pdf>

²¹ Kaiser Family Foundation HIV and the Opioid Epidemic: 5 Key Points <https://www.kff.org/hivaids/issue-brief/hiv-and-the-opioid-epidemic-5-key-points/>

²² Northern Kentucky Health Department. Press Release: “Health Officials See Increase in HIV Infection Among Individuals Who Inject Drugs.” January 9, 2018. <https://nkyhealth.org/2018/01/09/health-officials-see-increase-in-hiv-infection-among-individuals-who-inject-drugs/>

²³ Massachusetts, Department of Public Health, MDPH Clinical Advisory, HIV Transmission through Injection Drug Use, November 27, 2017 https://hmcrcg3.org/wp-content/uploads/sites/90/2017/12/112707ClinicalAdvisory_HIV.pdf

²⁴ Morbidity and Mortality Weekly Report (MMWR), “Community Outbreak of HIV Infection Linked to Injection Drug Use of Oxycodone — Indiana, 2015” May 1, 2015 <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6416a4.htm>

²⁵ CDC. Revised Recommendations for HIV Testing of Adolescents, and pregnant Women in Health-Care Settings. MMWR 2006; 55 (No. RR-14). Access ble via the web at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>

²⁶ Kitahata MM, Gange SJ, Abraham AG, et al. Effect of early versus deferred antiretroviral therapy for HIV on survival. *N Engl J Med*. 2009 Apr 30 National Institutes of Health; US National Library of Medicine <https://www.ncbi.nlm.nih.gov/pubmed/19339714>

Effective HIV treatment can help people with HIV to live longer, healthier lives.²⁷ When treated effectively, HIV can be managed similar to a chronic disease. In an analysis across six major American cities, targeted on-site HIV testing for patients receiving medication for opioid use disorder was projected to be cost saving or highly cost-effective.²⁸

In addition, both the USPSTF and the American Society of Addiction Medicine (ASAM) have recommended frequent HIV screening for people who inject drugs, as well as screening for HIV while assessing and diagnosing opioid use disorders.^{29,30} The CDC recommends HIV screening as routine care for all adults and adolescents, but advocates for more frequent screening for people who inject drugs.³¹

Therefore, ViiV encourages the state to include HIV counseling and education requirements within this demonstration, including counseling on HIV PrEP and adopting HIV testing policies for people who inject drugs. Use of PrEP by at-risk populations is a key part of the EHE national plan. Unfortunately, PrEP is an underutilized biomedical tool to reduce the incidence of new HIV cases. In 2019, according to CDC data, only 18.8 percent of the more than 1.2 million individuals who are in the United States that were indicated for PrEP actually were prescribed PrEP therapy (in Vermont this percentage was an even lower 17.7 percent.)³² In addition, the US Preventive Services Taskforce (USPSTF) recently issued a “Grade A” rating of HIV PrEP treatment.³³ The new USPSTF recommendation means that Medicaid programs that cover PrEP without cost-sharing along with other preventive services can receive an FMAP increase under the ACA, similar to coverage of HIV testing.

2. HIV and Social Determinates of Health (SDOH)

HIV continues to have a disproportionate impact on certain populations, particularly racial and ethnic minorities, and gay and bisexual men. Populations disproportionately affected by HIV are also often affected by stigma due to, among other things, their gender, sexual orientation, gender identity, race/ethnicity, drug use, or sex work.³⁴

In 2020, the DHHS released The HIV National Strategic Plan (HIV Plan),³⁵ which includes a focus on the role of social determinants of health in ending the HIV epidemic. The HIV Plan notes that housing instability or homelessness represents a significant barrier to health care access, and states that: “Inequities in the social determinants of health are significant contributors to health disparities and

²⁷ Severe P, Juste MA, Ambrose A, et al. Early versus standard antiretroviral therapy for HIV-infected adults in Haiti. *N Engl J Med*. Jul 15 2010;363(3):257-265. Available at

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=20647201

²⁸ Krebs E, et al. The impact of localized implementation: determining the cost-effectiveness of HIV prevention and care interventions across six United States Cities. *AIDS* 2020, 34:447-458.

²⁹ American Society of Addiction Medicine (2015). The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. Accessed at <https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24>.

³⁰ USPSTF (2019). Screening for HIV: U.S. Preventive Services Task Force Recommendation Statement. *JAMA* 321(23):2326-2336. <https://jamanetwork.com/journals/jama/fullarticle/2735345>.

³¹ Branson BM, Handsfield HH, Lampe MA, Janssen RS, Taylor AW, Lyss SB, Clark JE (2006). Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. *MMWR*. 55(RR14);1-17. <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>.

³² Centers for Disease Control and Prevention. Monitoring selected national HIV prevention and care objectives by using HIV surveillance data—United States and 6 dependent areas, 2018. HIV Surveillance Supplemental Report 2020;25(No. 2). [Monitoring Selected National HIV Prevention and Care Objectives by Using HIV Surveillance Data—United States and 6 Dependent Areas, 2018 \(cdc.gov\)](https://www.cdc.gov/hiv/surveillance/reports-and-materials-files/25-2-2018-2018-cdc.gov) Published May 2020. Accessed June 8, 2021. Pg. 53-54

³³ Branson BM, Handsfield HH, Lampe MA, Janssen RS, Taylor AW, Lyss SB, Clark JE (2006). Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. *MMWR*. 55(RR14);1-17. <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>.

³⁴ HIV.gov “Standing Up to Stigma” <https://www.hiv.gov/hiv-basics/overview/making-a-difference/standing-up-to-stigma> Accessed August 10, 2020

³⁵ National Strategic Plan A Roadmap to End the Epidemic for the United States | 2021–2025 <https://files.hiv.gov/s3fs-public/HIV-National-Strategic-Plan-2021-2025.pdf>

highlight the need to focus not only on HIV prevention and care efforts, but also on how programs, practices, and policies affect communities of color and other populations that experience HIV disparities.”³⁶

SDOH are an emerging policy priority in many federal and state programs. This includes people with HIV who often face a variety of medical challenges that impede access to, engagement in, and adherence to HIV care and treatment. For over thirty years the Ryan White HIV/ AIDS Program (RWHAP) has developed a model of successfully addressing the complex needs of HIV/AIDS patients and producing unparalleled success in health and medical care among this population. The RWHAP provides services that demonstrated success in supporting the health and well-being of patients. These services offer best practice examples for how interventions focused on the social determinants of health can contribute to medical success. The RWHAP provides medical support services such as medical case management, medical transportation, and medical nutrition services, as well as oral health and dental care. The program also offers individual support services including food services, meal delivery, housing, transportation, legal services, linguistic services, case management, childcare, psychosocial and mental health services, rehabilitation and respite care, and substance abuse services. As a result of the program’s services, in 2018, 87.1 percent of Ryan White HIV/AIDS Program clients were reported to be virally suppressed. This far exceeds the national viral suppression average of 62.7 percent at the time of this report.³⁷

ViiV notes the state’s commitment to invest in programs and interventions that improve population health and impact the SDOH ³⁸ and therefore urges the state to review and model elements of the RWHAP that have proven to be effective in supporting optimal patient care and driving treatment success in HIV. The success of specific RWHAP interventions could help to inform the state’s goals for SDOH efforts and help to refine requirements for the managed care plans, and the program’s data could also provide a basis for measuring outcomes of these interventions.

3. HIV and Housing

ViiV applauds the state for implementing a permanent supportive housing pilot in this waiver to cover pre-tenancy supports, tenancy sustaining services, and community transition services for adults who meet specific health- and risk-based criteria.³⁹ We urge the state to include people with HIV as a target population of the demonstration in an effort to improve health outcomes.

According to the National AIDS Housing Coalition, “It is clear that housing improves health outcomes of those living with HIV disease and reduces the number of new HIV infections. The end of HIV/AIDS critically depends on an end to poverty, stigma, housing instability, and homelessness.”⁴⁰

Access to stable housing can be a key intervention in stabilizing medical care for many vulnerable populations. According to the National AIDS Housing Coalition,

³⁶ Id.

³⁷ HIV.gov Blog, “HRSA Announces Highest HIV Viral Suppression Rate in New Ryan White HIV/AIDS Program Client-Level Data Report,” Cheever, December 11, 2019 <https://www.hiv.gov/blog/hrsa-announces-highest-hiv-viral-suppression-rate-new-ryan-white-hivaids-program-client-level-0>

³⁸ Vermont Global Commitment to Health 1115 Demonstration Renewal Application, page 4, [21-033-Proposed-GCR-1115Waiver-VT-Full-Public-Notice-5.13.2021.pdf \(vermont.gov\)](#) (Accessed June 5, 2021)

³⁹ Vermont Global Commitment to Health 1115 Demonstration Renewal Application, page 25, [21-033-Proposed-GCR-1115Waiver-VT-Full-Public-Notice-5.13.2021.pdf \(vermont.gov\)](#) (Accessed June 5, 2021)

⁴⁰ The National AIDS Housing Coalition <http://nationalaidshousing.org/>

“For people with HIV, housing is one of the strongest predictors of their access to treatment, their health outcomes, and how long they will live. To obtain and benefit from life-saving HIV treatments, people with HIV must have safe, stable housing.

People with HIV/AIDS who are homeless or unstably housed:

- Are more likely to enter HIV care late
- Have lower CD4 counts and higher viral loads
- Are less likely to receive and adhere to antiretroviral therapy
- Are more likely to be hospitalized and use emergency rooms
- Experience higher rates of premature death

Housing status has more impact on health outcomes than demographics, drug and alcohol use, mental health status or receipt of social services.”⁴¹

Two large-scale intervention studies examined the impact of housing on health care utilization and outcomes among homeless/unstably housed people with HIV and other chronic medical conditions. The Chicago Housing for Health Partnership followed 407 chronically ill homeless persons over 18 months following discharge from hospitals. The Housing and Health (H&H) study examined the impact of housing on HIV risk behaviors and medical care among 630 homeless/unstably housed people with HIV. Both studies found that investments in housing are cost effective.⁴²

Among homeless people with AIDS who received supportive housing, there was an 80 percent reduction in mortality.⁴³ This is not surprising given that people with HIV with stable housing are much more likely to access health services, attend primary care visits, receive ongoing care and receive care that meets clinical practical standards.

When a person with HIV receives and maintains effective HIV treatment and receives quality medical care, they can reach viral suppression. Viral suppression means that the virus has been reduced to an undetectable level in the body with standard tests.⁴⁴ Viral suppression results in reduced mortality and morbidity and leads to fewer costly medical interventions.⁴⁵

Viral suppression also helps to prevent new transmissions of the virus. When successful treatment with an antiretroviral regimen results in virologic suppression, secondary HIV transmission to others is effectively eliminated.^{46, 47} Multiple studies have shown that people with HIV on ART who had undetectable HIV levels in their blood, had no risk of passing the virus on to their HIV-negative partners

⁴¹ The National AIDS Housing Coalition <http://nationalaidshousing.org/housing-and-health/>

⁴² The National Center for Innovations in HIV Care, “Housing as a Determinant of HIV Health Outcomes: Results from a Systematic Review of Research 1996-2014 & Implications for Policy and Program,” <https://targethiv.org/sites/default/files/supporting-files/Housing%20and%20HIV%20Health%20Outcomes%20Final.pdf>

⁴³ The National AIDS Housing Coalition <http://nationalaidshousing.org/housing-and-health/>

⁴⁴ National Institutes of Health (NIH) “Ten things to Know about HIV Suppression” <https://www.niaid.nih.gov/diseases-conditions/10-things-know-about-hiv-suppression>

⁴⁵ “Retention in Care and Adherence to ART are Critical Elements of HIV Care Interventions,” Stricker, et al, AIDS and Behavior, October 2014, Volume 18, Supplement 5, pp 465–47.; <https://link.springer.com/article/10.1007/s10461-013-0598-6>

⁴⁶ Rodger et al. Risk of HIV transmission through condomless sex in serodifferent gay couples with the HIV-positive partner taking suppressive antiretroviral therapy (PARTNER): final results of a multicentre, prospective, observational study. The Lancet. Published Online May 2, 2019 [http://dx.doi.org/10.1016/S0140-6736\(19\)30418-0](http://dx.doi.org/10.1016/S0140-6736(19)30418-0) .

⁴⁷ NIAID, “The Science Is Clear—With HIV, Undetectable Equals Untransmittable | NIH: National Institute of Allergy and Infectious Diseases” <https://www.niaid.nih.gov/news-events/science-clear-hiv-undetectable-equals-untransmittable> (Accessed 4/20/2021)

sexually.^{48, 49, 50} As a result, the CDC estimates viral suppression effectiveness in preventing HIV transmission at 100 percent.⁵¹

The Housing Opportunities for Persons with AIDS (HOPWA) program was created in 1992 to address the housing needs of people with HIV. The program is coordinated by the Office of Community Planning and Development in the U.S. Department of Housing and Urban Development (HUD). We see this program and the state's housing efforts as complimentary and encourage the state to reach out to local HOPWA program officials and seek coordination and best practices between their efforts.

Conclusion

Thank you for your considering our recommendations. We look forward to continuing this conversation in the very near future and hope that we can collaborate and partner with the state to improve the lives and health of people with HIV in the AHS program. Please feel free to contact me with any questions.

Sincerely,



Stephen F. Novis
Director, Government Relations
Steve.f.novis@viivhealthcare.com
201-306-2394 (c)
973-263-9194 (o)

⁴⁸ Bavinton, et al. The Opposites Attract Study of viral load, HIV treatment and HIV transmission in serodiscordant homosexual male couples: design and methods. [BMC Public Health](https://doi.org/10.1186/1471-2458-14-917). 2014; 14: 917. doi: [10.1186/1471-2458-14-917](https://doi.org/10.1186/1471-2458-14-917).

⁴⁹ Cohen, et al. Antiretroviral Therapy for the Prevention of HIV-1 Transmission. September 1, 2016. N Engl J Med 2016; 375:830-839. DOI: 10.1056/NEJMoa1600693.

⁵⁰ "HIV Undetectable=Untransmittable (U=U), or Treatment as Prevention" National Institute of Allergy and Infectious Diseases <https://www.niaid.nih.gov/diseases-conditions/treatment-prevention>.

⁵¹ Centers for Disease Control and Prevention (CDC) "Effectiveness of Prevention Strategies to Reduce the Risk of Acquiring or Transmitting HIV" <https://www.cdc.gov/hiv/risk/estimates/preventionstrategies.html> Accessed November 23, 2020