CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

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

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

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

Under the authority of Section 1115(a)(1) of the Social Security Act (the Act) the following waivers are granted to enable Vermont to operate the Global Commitment to Health Section 1115 Demonstration. These waivers are effective beginning July 1, 2022 and are limited to the extent necessary to achieve the objectives below. These waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in the accompanying document.

Except as provided below with respect to expenditure authority, all requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project for the period beginning July 1, 2022 through December 31, 2027.

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

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

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

To allow the state to maintain a waiting list for high and moderate need individuals applying for home and community-based services (HCBS) under the Choices for Care program. To allow the state to require applicants for nursing facility and home and community-based services (including demonstration home and community-based waiver-like services) to complete a person-centered assessment and options counseling process prior to receiving such services. To permit waiting lists for eligibility for demonstration-only (non-Medicaid State Plan) populations.

3. **Amount, Duration, Scope of Services** **Section 1902(a)(10)(B)**

To enable Vermont to vary the amount, duration and scope of services offered to various mandatory and optional groups of individuals affected by or eligible under the demonstration as long as the amount, duration and scope of covered services meets the minimum requirements under title XIX of the Act for the group (if applicable) and the special terms and conditions.

To allow the state to provide nursing facility and home and community-based services based on relative need as part of the person-centered and options counseling process for new applicants for Choices for Care services; to permit certain individuals, based on need, to receive demonstration services that are not available to categorically eligible individuals, or other individuals in the same eligibility group, under the Medicaid State Plan; and to limit the amount, duration, and

scope of services to those included in the participants' approved care plan.

4. **Financial Eligibility** **Section 1902(a)(10)(C)(i)(III)**

To allow the state to use institutional income rules (up to 300 percent of the Supplemental Security Income Federal Benefit Rate (FBR)) for Choices for Care and special programs described in STC 4.4(c), excluding CRT.

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

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

To allow the state, through the Department of Vermont Health Access, to establish rates with providers on an individual or class basis without regard to the rates currently set forth in the approved State Plan, and to make non-risk prepaid inpatient health plan (PIHP) payments without regard to how the upper payment limit is established in 42 CFR 447.362.

6. **Premium Requirements** **Section 1902(a)(14) In so far as it incorporates Section 1916**

To permit Vermont to impose premiums in excess of statutory limits for optional populations and for children through age 18 with income above 195 percent of the Federal poverty level (FPL) as reflected in the Special Terms and Conditions.

7. **Income/Resource Comparability** **Section 1902(a)(17)**

To the extent necessary to enable the state to use varying income and resource standards and methods for plan groups and individuals.

8. **Spend-Down** **Section 1902(a)(17)**

To enable the state to offer one-month spend-downs for medically needy people receiving community-based services as an alternative to institutionalization, and non-institutionalized persons who are receiving personal care attendant services at the onset of waivers.

9. **Financial Responsibility/Deeming** **Section 1902(a)(17)(D)**

To the extent necessary to exempt the state from the limits under section 1902(a)(17)(D) on whose income and resources may be used to determine eligibility unless actually made available, and so that family income and resources may be used instead.

To enable the state to disregard quarterly income totaling less than $20 from the post-eligibility income determination.

10. **Freedom of Choice** **Section 1902(a)(23)(A)**

To enable the state to restrict freedom of choice of provider for the demonstration participants to the extent that beneficiaries will be restricted to providers enrolled in a provider network through the Department of Vermont Health Access (DVHA) for the type of service at issue and in the appropriate geographic area, but may change providers among those enrolled providers. Freedom of choice of provider may not be restricted for family planning providers.

To enable Vermont to restrict choice of provider for individuals enrolled in the Community Intervention and Treatment (CIT) program. The individual may receive services from any willing provider within that designated provider network.

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

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

12. **Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release** **Section 1902(a)(84)(D)**

To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

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

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

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

Under the authority of Section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Vermont for the items identified below (which are not otherwise included as expenditures under section 1903 of the Act) shall, for the period of this demonstration extension, beginning July 1, 2022 through December 31, 2027, unless otherwise specified, be regarded as expenditures under the state's Medicaid Title XIX plan. These expenditure authorities are granted to enable the state to operate its Global Commitment to Health Section 1115 Demonstration and may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in the accompanying document.

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

1. **Expenditures Related to Eligibility Expansion**. Expenditures to provide Medicaid coverage to the following demonstration populations that are not covered under the Medicaid State Plan and are enrolled in the Vermont Global Commitment to Health demonstration. (Note: Demonstration populations 1, 2, and 3, which are described in the demonstration's STCs, are covered under the Medicaid State Plan.)

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

    b. **Demonstration Population 5: Choices for Care High Needs Group.** Expenditures for 217-like individuals receiving HCBW-like services in the Choices for Care program's High Needs Group and PACE-like participants who meet the clinical standards for the High Needs Group.

    c. **Demonstration Population 6: Choices for Care Moderate Needs Group.** Expenditures for a small subset of Choices for Care HCBW-like services for individuals who are not otherwise eligible under the Medicaid State Plan and who would not have been eligible had the state elected eligibility under 42 CFR 435.217, but are at risk for institutionalization and are in need of home and community-based services. Such individuals may have income up to 300 percent of the SSI FBR and resources below $10,000. Individuals with income below the limit and with excess resources may apply

excess resources to income, up to the income limit. These benefits do not meet the requirements of Minimum Essential Coverage.

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

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

f. **Demonstration Population 9: Substance Use Disorder (SUD) Community Intervention and Treatment Group.** Individuals with a diagnosis of a substance use disorder (SUD), with income at or below 225 percent of the FPL and who are not eligible under the state plan for full benefits.

2. **Expenditures Related to Additional Services for Special Programs.** Expenditures for additional health care related-services described in STC 4.4(c) for all populations affected by or eligible through the demonstration.

3. **Expenditures for Public Health, Health Care, and Health-Related Investments Related to State Plan, Demonstration, Uninsured, and Underinsured Populations.** Expenditures to support the goal of providing state-funded health care programs to improve the access and quality of health care services available to State Plan, demonstration, uninsured, and underinsured individuals in Vermont subject to the terms and limitations set forward in STCs 11.1 and 11.2 and up to a maximum of the limits set in STC 11.4. To the extent that the investments covered under the foregoing STCs benefit low income, uninsured or underinsured individuals who are not eligible for Medicaid State plan benefits under the State plan or under expenditure authority under section 1115(a)(2), the notice, eligibility determination, and appeal rights that apply to State plan eligible individuals shall not be applicable to such individuals.

    a. **HCBS Investments.** The state may spend up to the Investments expenditure authority limit on activities to enhance, expand and strengthen HCBS that are not otherwise eligible for federal match under the State Plan. The state must notify CMS at least 30 days prior to implementing any of the proposed new investments as per STC 11.6. The state will be required to comply with all updated law, regulation and policy related to HCBS.

4. **Expenditures for Hospice Services that Exceed State Plan Limits.** Expenditures for adults eligible under the approved State Plan for hospice services that exceed State Plan limits.

5. **Expenditures for the Marketplace Subsidy Program.** Expenditures for state funded programs that provide premium subsidies to certain individuals who purchase health insurance through the Marketplace and who are not otherwise eligible for Medicaid.

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

7. **Expenditures for Mental Health Community Rehabilitation and Treatment (CRT) Services.** Expenditures for mental health community rehabilitation and treatment (CRT) services, as defined by Vermont rule and policy, provided through a state-funded program to Medicaid enrolled individuals with severe and persistent mental illness who have incomes up to and including 133 percent of the FPL.

   Expenditures for mental health CRT services, as defined by Vermont rule and policy, provided through a state-funded program to individuals not eligible for Medicaid with severe and persistent mental illness who have incomes above 133 percent of the FPL.

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

   a. Expenditures for CFC participants with resources exceeding current limits, who are single, own and reside in their own homes, and select home-based care rather than nursing facility care, to allow them to retain resources to remain in the community.

   b. Expenditures for personal care services provided by CFC participants' spouses and legal guardians.

   c. Expenditures for respite and companion services provided by CFC participants' legal guardians, except if the respite is for the legal guardian as primary caregiver.

   d. Expenditures for personal care services provided by Developmental Disabilities Services participants' parents (when the participant is a minor child), spouses, and legal guardians. The state may not claim FFP for services provided under this authority until CMS has approved the Caregiver Reimbursement Protocol (Attachment P). The flexibility for this population stands under the COVID-19 PHE until 6 months after the PHE expires.

   e. Expenditures for habilitation services and community supports by Brain Injury Program participants' parents (when the participant is a minor child), spouses, and legal guardians.

The state may not claim FFP for services provided under this authority until CMS has approved the provision of these services in the Caregiver Reimbursement Protocol (Attachment P), unless otherwise authorized by flexibilities available under the COVID-19 public health emergency.

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

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

11. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

12. **Residential and Inpatient Treatment for Individuals with Serious Mental Illness.** Expenditures for Medicaid State Plan services furnished to eligible individuals who are primarily receiving short-term treatment for a serious mental illness (SMI) in facilities that meet the definition of an IMD.

13. **Maternal Health and Treatment Services.** Expenditures for otherwise covered services furnished to otherwise Medicaid eligible pregnant women, postpartum women, and mothers 19 to 64 years of age, who are primarily receiving treatment and withdrawal management services for SUD or SMI and who are residents at the Lund Home (or its successor), which meets the definition of an IMD.

14. **Supportive Housing Assistance Pilot.** Expenditures for supportive housing assistance services that are in full alignment with services under 1915(c) and 1915(i) authorities provided to enrollees in the state's Supportive Housing Assistance Pilot program. The state will institute annual enrollment limits for this pilot program and may maintain a waiting list.

15. **Medicaid Data Aggregation and Access Program (MDAAP).** Expenditures for the state's MDAAP incentive program that will strengthen Medicaid providers' ability to participate in the state's health information exchange (HIE), in accordance with the requirements in STC 8.3.

16. **Children's Personal Care Services (CPCS).** Expenditures for personal care services, as authorized and described under the Medicaid State Plan, provided by legally responsible individuals (which could be inclusive of legally responsible family caregivers) following a reasonable assessment by the state that the caregiver is capable of rendering the services. At the conclusion of the COVID-19 PHE, the state will notify CMS of its readiness to effectuate this flexibility and this authority will be active as of the date of the notice. Providers of CPCS, including legally responsible relatives, must meet all existing requirements as described under the Medicaid State Plan, including EVV requirements.

17. **Expenditures for Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid individuals for up to 90 days immediately prior to the expected date of release from a correctional facility that is participating in the Reentry Demonstration Initiative under this demonstration.

18. **Expenditures for Pre-Release Administrative Costs.** Capped expenditures for payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure and interventions, as is detailed in STC 16.12, which may not be recognized as medical assistance under section 1905(a) and may not otherwise qualify for federal matching funds under section 1903, to the extent such activities are authorized as part of the Reentry Demonstration Initiative.

19. **Health-Related Social Needs (HRSN) Services.** Expenditures for allowable HRSN services not otherwise covered that are furnished to individuals who meet the qualifying criteria as described in Section 17. This expenditure authority is contingent upon compliance with Section 18, as well as all other applicable STCs.

20. **Health-Related Social Needs (HRSN) Services Infrastructure.** Expenditures for allowable HRSN administrative and infrastructure costs not otherwise covered under section 1903 of the Act, as described in section 17 of the STCs.

Title XIX Requirements not Applicable to Demonstration Expenditure Authorities (Populations 6, 7, and 8 described in STC 4.2)

21. **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.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release Services:

22. **Amount, Duration, and Scope of Services and Comparability** **Section 1902(a)(10)(B)**

To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.

23. **Freedom of Choice** **Section 1902(a)(23)(A)**

To enable the state to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers.

Title XIX Requirements Not Applicable to the HRSN Expenditure Authority

24. **Statewideness** **Section 1902(a)(1)**

To enable the state to provide housing supports without room and board, home remediations that are medically necessary, home/environmental accessibility modifications, episodic housing interventions with clinical services with room and board, and room and board-only supports only in certain geographic areas of the state.

25. **Comparability; Amount, Duration and Scope** **Section 1902(a)(10)(b) and Section 1902(a)(17)**

To the extent necessary to allow the state to offer HRSN services and to vary the amount, duration, and scope of HRSN services covered for a subset of beneficiaries, depending on beneficiary needs as determined by the application of qualifying criteria, as specified in Section 17 of the STCs.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

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

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

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

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the Vermont Global Commitment to Health Section 1115(a) Medicaid Demonstration (hereinafter "demonstration"). The parties to this agreement are the Vermont Agency of Human Services (AHS, state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth limitations on the extent of the waivers and expenditure authorities that have been granted to further the demonstration, which are enumerated in separate lists. The STCs also detail the nature, character, and extent of Federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. These STCs are effective as of July 1, 2022 through December 31, 2027 unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below.

The STCs have been arranged into the following subject areas:

1. Preface
2. Program Description and Objectives
3. General Program Requirements
4. Eligibility, Benefits, and Enrollment
5. Cost Sharing
6. Delivery Systems
7. Long-Term Services and Supports Protections
8. Other Programs
9. Opioid Use Disorder (OUD)/Substance Use Disorder (SUD)
10. Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED)
11. Use of Demonstration Funds
12. Monitoring and Reporting Requirements
13. General Financial Requirements
14. Monitoring Budget Neutrality for the Demonstration
15. Evaluation of the Demonstration
16. Reentry Demonstration Initiative
17. Health-Related Social Needs (HRSN)
18. Provider Rate Requirements
19. Schedule of State Deliverables for the Demonstration Period

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

Attachment A. Preparing the Evaluation Design
Attachment B. Preparing the Interim and Summative Evaluation Reports
Attachment C. Summary of Choices for Care Eligibility Criteria
Attachment D. Choices for Care Services by Demonstration Group
Attachment E. Choices for Care Long-Term Services and Supports Definitions and Provider Qualifications
Attachment F. Global Commitment Special Program Service Definitions and Provider Qualifications
Attachment G. Premiums and Co-Payments for Demonstration Populations
Attachment H. Medicaid Data Aggregation and Access Program Incentive Payment Protocol
Attachment I. Supportive Housing Assistance Pilot Eligibility Criteria, Services, and Provider Qualifications
Attachment J. SUD Implementation Plan
Attachment K. Emergency Preparedness and Response and COVID-19 Addendum
Attachment L. SMI/SED Implementation Plan
Attachment M. SUD Monitoring Protocol
Attachment N. SMI/SED Monitoring Protocol
Attachment O. Approved Evaluation Design [RESERVED]
Attachment P. Caregiver Reimbursement Protocol
Attachment Q. Home and Community-Based Services (HCBS) Conflict of Interest Corrective Action Plan
Attachment R. Investment Framework
Attachment S. New Investment Application Template
Attachment T. Community Rehabilitation and Treatment Needs and Risk-Based Eligibility Criteria
Attachment U. SUD Community Intervention and Treatment Services Target and Needs-Based Criteria
Attachment V. Reentry Demonstration Initiative Implementation Plan [RESERVED]
Attachment W. Reentry Demonstration Initiative Reinvestment Plan [RESERVED]
Attachment X. Monitoring Protocol
Attachment Y. Protocol for Assessment of Beneficiary Eligibility Needs and Provider Qualifications for HRSN
Attachment Z. HRSN Services Matrix
Attachment AA. HRSN Infrastructure Protocol
Attachment AB. HRSN Implementation Plan [RESERVED]
Attachment AC. Provider Rate Increase Assessment Attestation Table [RESERVED]

2. PROGRAM DESCRIPTION AND OBJECTIVES

The demonstration was initiated in September 2005, and is designed to use a multi-disciplinary approach including the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, and program flexibility. Since 2005, the demonstration has helped reduce Vermont's uninsured rate from 11.4 percent in 2005 to approximately 3.1 percent in 2021 through expansion of eligibility. The demonstration has

also enabled Vermont to address and eliminate the bias toward institutional care and offer cost-effective, community-based services. For example, the proportion of Choices for Care participants served in the community has passed fifty percent and continues to increase. In addition, Vermont no longer has a waiting list for individuals in the Highest and High Needs Groups under the Choices for Care component of the demonstration.

As of July 1, 2022, Vermont extended the demonstration to further promote delivery system and payment reform to meet the goals of the state working with the Center for Medicaid and CHIP Services and the Center for Medicare and Medicaid Innovation (CMMI) consistent with Medicare's payment reform efforts in order to allow for alignment across public payers. Specifically, Vermont expects to demonstrate its ability to achieve universal access to health care, cost containment, and improved quality of care.

The state's goals in implementing the demonstration are to:

- Advance the state toward population-wide comprehensive coverage;
- Implement innovative care models across the continuum that produce value;
- Engage Vermonters in transforming their health;
- Strengthen care coordination and population health management capabilities to encompass the full spectrum of health-related services and supports; and
- Accelerate payment reform.

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

1. *Expanding Benefits and Eligibility:* Vermont is introducing a new SUD Community Intervention and Treatment eligibility group and expanding benefits for some existing programs, including the VPharm cost sharing assistance program, Community Rehabilitation and Treatment (CRT) program, and Developmental Disabilities Services program.

2. *Managed Care Delivery System:* Under the demonstration the Agency for Human Services (AHS) will continue the interagency agreement with the Department of Vermont Health Access (DVHA) to deliver services through a managed care-like model, subject to the requirements that would be applicable to a non-risk pre-paid inpatient health plan (PIHP) as defined in STC 6.3.

3. *Advancing Population Health:* Under the demonstration, Vermont will strengthen care coordination and population health management through public health investments, a new Supportive Housing Assistance Pilot, and a new incentive program that will provide health information technology (HIT) infrastructure support to Medicaid providers in order to increase HIT use and connectivity to the state's health information exchange.

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

The initial Global Commitment to Health and Choices for Care demonstrations were approved in September of 2005, effective October 1, 2005. The Global Commitment to Health

demonstration was extended for 3 years, effective January 1, 2011, and again for 3 years, effective October 2, 2013. The Choices for Care demonstration was extended for 5 years, effective October 1, 2010, and became part of the Global Commitment to Health demonstration in January 2015. The Global Commitment to Health demonstration was extended for another 5 years effective January 1, 2017. The following amendments have been made to the Global Commitment to Health demonstration:

- 2007: A component of the Catamount Health program was added, enabling the state to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the FPL, and who did not have access to cost-effective employer-sponsored insurance, as determined by the state.
- 2009: The state extended Catamount Health coverage to Vermonters at or below 300 percent of the FPL.
- 2011: The state included a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life-limiting illness that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.
- 2012: CMS provided authority for the state to eliminate the $75 inpatient admission co-pay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid State Plan.
- 2013: CMS approved the extension of the Global Commitment to Health demonstration which included sun-setting the authorities for most of the Expansion Populations, including Catamount Health coverage, because these populations would be eligible for Marketplace coverage beginning January 1, 2014. The extension also added the Adult Group under the State Plan to the population affected by the demonstration effective January 1, 2014. Finally, the extension also included premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL.
- 2015: In January 2015, the Global Commitment to Health demonstration was amended to include authority for the former Choices for Care demonstration. In addition, the state received section 1115 authority to provide full Medicaid State Plan benefits to pregnant women who are determined presumptively eligible.
- 2017: In January 2017, CMS approved the extension of the Global Commitment to Health demonstration to further promote delivery system and payment reform to meet the goals of the state working with the Center for Medicaid and CHIP Services and the Center for Medicare and Medicaid Innovation (CMMI), consistent with Medicare's payment reform efforts in order to allow for alignment across public payers.
- 2018: CMS approved an amendment to permit the state to receive federal financial participation (FFP) for the continuum of services to treat addictions to opioids and other substances, including services provided to Medicaid enrollees with a substance use disorder (SUD) who are short-term residents in residential and inpatient treatment facilities that meet the definition of an Institution for Mental Diseases (IMD).
- 2019: CMS approved an amendment to enable Vermont to receive FFP for inpatient services provided to otherwise-eligible Medicaid beneficiaries while residing in IMDs for diagnoses of serious mental illness (SMI) and/or serious emotional disturbance (SED).

- 2020: The Global Commitment to Health demonstration was amended May 22, 2020 to add an Emergency Preparedness and Response Attachment R (now Attachment K) in order to respond to the COVID-19 pandemic. Additionally, the demonstration was amended December 3, 2020 to modify the requirement, at 42 CFR 438.406(b)(4), to allow beneficiaries to provide evidence and testimony "in person" to appeal an adverse benefit determination during the COVID-19 public health emergency. The STCs were amended to grant flexibility during public health emergencies where the Department of Vermont Health Access (DVHA) must provide enrollees reasonable opportunity, in writing, telephonically, and video or virtual communication, to present evidence and testimony and make legal factual arguments.

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in federal law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in the applicable federal law, regulation, or written policy, come into compliance with changes in law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 calendar days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

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

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the State may seek an

amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. **State Plan Amendments.** The state will not be required to submit title XIX State Plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population covered through the Medicaid State Plan is affected by a change to the demonstration, a conforming amendment to the appropriate State Plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid State Plan governs.

3.6. **Changes Subject to the Amendment Process.** Demonstration changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS through an approved amendment to the Medicaid State Plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STCs 3.3.

3.7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

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

c. A data analysis that identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include

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

d. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the Evaluation Design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. **Extension of the Demonstration.** If the state intends to request an extension of the demonstration it must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 CFR §431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 3.9.

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

a. **Notification of Suspension or Termination.** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with the requirements of STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. **Transition and Phase-out Plan Requirements.** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. **Transition and Phase-out Plan Approval.** The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no

sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. **Transition and Phase-out Procedures.** The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. **Exemption from Public Notice Procedures 42 CFR §431.416(g).** CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. **Enrollment Limitation during Demonstration Phase-out.** If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid State Plan.

g. **Federal Financial Participation (FFP).** If the project is terminated or any relevant waivers suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

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

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

3.12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties**. The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates. The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

3.13. **Dual Role of Managed Care-Like Model and Compliance with Managed Care Regulations.** For purposes of the demonstration the state shall comply with all of the managed care regulations published at 42 CFR section Part 438 et. seq., except as expressly modified or identified as not applicable in the STCs. DVHA shall continue to serve as the unit designated by AHS (the Single State Agency) responsible for administration of the state Medicaid program and operates as a public managed care model solely to carry out the goals and purposes of the demonstration. DVHA's role under the demonstration as a public managed care model does not reduce or diminish its authority to operate as the designated Medicaid unit under the approved State Plan, including its authority to implement program policies permissible under a State Plan and establish provider participation requirements. DVHA shall comply with federal program integrity and audit requirements as if it were a non-risk pre-paid inpatient health plan (PIHP) for services and populations covered under the demonstration in accordance with STC 6.1.

3.14. **Federal Financial Participation (FFP)**. No federal matching for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.15. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, managed care organizations (MCOs), and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.16. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid program – including public benefit or service programs, procedures for obtaining Medicaid benefits or services, possible changes in or alternatives to Medicaid programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

3.17. **Payment to Providers.** The state may establish rates with providers on an individual or class basis without regard to the rates currently set forth in the approved State Plan. The state must use a public notice process for setting payment rates in accordance with 42 CFR 447.205, except that, the state must publish a summary of comments, the state's responses, and decisions on the Global Commitment Register website. For purposes of monitoring, the state must submit to CMS a notification of public notice compliance, such as notification of the beginning and end of the public notice period through the Global Commitment Register listserv and noting compliance in the annual report.

4. ELIGIBILITY, BENEFITS, AND ENROLLMENT

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

4.2. **Populations Affected and Eligible under the Demonstration.**

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

b. State Plan groups. Coverage for mandatory and optional State Plan groups described below are subject to all applicable Medicaid laws and regulations, except as expressly waived in these STCs and the waiver list and expenditure authority for this demonstration. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups will apply to this demonstration.

c. Choices for Care Program Eligibility. State Plan-eligible individuals who receive long-term services and supports under the Choices for Care program must meet State Plan financial rules, with the exception of waivers granted through this demonstration, and clinical eligibility criteria as defined by Vermont statutes, regulations, and policies and procedures. See Attachments C and D for a summary of eligibility definitions for the highest, high, and moderate needs groups, services,

and policies. Non-State Plan eligible Choices for Care individuals are included in Populations 4, 5, and 6 in the tables below.

d. **Other Demonstration Expansion Populations.** Coverage for these populations, which derive their eligibility from this demonstration, is subject to all applicable Medicaid laws or regulations, except as expressly not applicable under the waiver authority, expenditure authority, and the STCs. This includes the application of modified adjusted gross income (MAGI) based methodologies and exceptions for non-MAGI based methodologies, as appropriate, used to determine financial eligibility for expansion populations.

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

Mandatory and Optional State Plan Groups		
Population Number	**Population Description**	**Benefits**
Population 1	Mandatory state plan populations, except for the adult group (included in population 3) and Medicare Savings Program beneficiaries (included in populations 7 and 8).	Benefits as described in the title XIX State Plan and these STCs.
Population 2	Optional State Plan populations (including medically needy)	Benefits as described in the title XIX State Plan and these STCs.
Population 3	The adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119, pursuant to the approved State Plan.	Benefits as described in approved alternative benefit plan State Plan amendment and these STCs.

Demonstration Expansion Populations		
Population Number & Name	**Population Description**	**Benefits**
Population 4 CFC Highest Needs Group	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 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 prior to 2014. This includes the application of the post eligibility rules specified at 42 CFR §435.726, and of the spousal impoverishment rules specified at 1924 of the Act. 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.	Benefits as described in the Medicaid State Plan and HCBS benefits described in these STCs.
Population 5 CFC High Needs Group	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 prior to 2014. This includes the application of the post eligibility rules specified at 42 CFR 435.726, and of the spousal impoverishment rules specified at 1924 of the Act. 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.	Benefits as described in the Medicaid State Plan and HCBS benefits described in these STCs.

Demonstration Expansion Populations		
Population Number & Name	**Population Description**	**Benefits**
Population 6 CFC Moderate Needs Expansion Group	Individuals who have incomes below 300 percent of the SSI Federal Benefit rate and would be described in Populations 4 or 5 except that they meet the clinical criteria for the moderate needs group and are at risk of institutionalization. Clinical criteria are detailed in Attachment C.	Limited HCBS including Adult Day Services, Case Management, Homemaker services and Flexible Funds. This coverage does not meet the requirements of minimum essential coverage.
Population 7 VPharm	Medicare beneficiaries who are 65 years or older or have a disability with income at or below 150 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise eligible for full Medicaid benefits.	Medicaid State Plan prescriptions, eyeglasses and related eye exams; MSP beneficiaries also receive benefits as described in the title XIX State Plan.
Population 8 VPharm Expansion	Medicare beneficiaries who are 65 years or older or have a disability with income above 150 percent and up to and including 225 percent of the FPL, who may be enrolled in the MSP, but are not otherwise eligible for full Medicaid benefits.	Medicaid State Plan prescriptions. MSP beneficiaries also receive benefits as described in the title XIX State Plan.

Demonstration Expansion Populations		
Population Number & Name	**Population Description**	**Benefits**
Population 9 SUD Community Intervention and Treatment Group	Individuals with a diagnosis of a substance use disorder (SUD) with income at or below 225 percent of the FPL who are not eligible under the state plan for full benefits. The entry into SUD CIT is less stringent than inpatient hospital level of care. Vermont uses the American Society of Addiction Medicine (ASAM) criteria to determine medically appropriate intensity of services and level of need to best meet the needs for individuals with SUD. Individuals must have a substance use need, where an assessment using the ASAM criteria indicates that the individual meets at least ASAM 1.0.	Benefits as described in the Medicaid State Plan and as described in STC 4.4(d).

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

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

b. The state may maintain waiting list policies and procedures for home and community-based services through the Choices for Care Program and for demonstration-only (non-Medicaid State Plan) populations, including a description of how the state will manage wait lists, if and when waiting lists should occur.

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

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

b. **Individually Assessed Cost-Effective Alternative Services.** Vermont may provide individuals with the option to receive cost-effective treatment as patients in lieu of otherwise covered services in other settings. This option must be voluntary with the individual, and must be based on an assessment and determination that the service is a medically appropriate and cost-effective substitute for the corresponding State Plan service or setting. The state must not claim any expenditures under this expenditure authority that are otherwise not allowable including, but not limited to, institution for mental diseases (IMD), inmates, or room and board. The state may not spend more than the total limits specified in the table below; annual amounts may be rolled over from DY to DY during this demonstration period.

Individually Assessed Cost-Effective Alternative Services Annual Limits						
DY 18	**DY 19**	**DY 20**	**DY 21**	**DY 22**	**DY 23**	**Total**
N/A	$965,233	$3,475,775	$3,475,775	$3,475,775	$3,475,775	$14,868,333

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

Special Programs		
Special Program Name	**Services**	**Limitations**
Brain Injury Program	Services including crisis support, psychological and counseling supports, case management, community supports, habilitation, respite care, supported employment, environmental and assistive adaptations, and self-directed care.	Any limitation on this service is defined by Vermont rules and policies.

Special Programs		
Special Program Name	**Services**	**Limitations**
Mental Health Under 22	Services including case management*, flexible support*, skilled therapy services*, environmental safety devices***, counseling*, residential treatment*, respite**, supported employment*, crisis support*, and community supports*. The state assures that in accordance with EPSDT requirements, individuals under 21 receive all medically necessary 1905(a) services through the State Plan.	Any limitation on this service is defined by Vermont rules and policies.
Community Rehabilitation and Treatment (CRT)	Services including case management*, flexible support*, skilled therapy services*, environmental safety devices***, counseling*, residential treatment*, respite***, supported employment*, enhanced dental, crisis support*, community supports*, and peer supports* (upon approval of a State Plan amendment (SPA) and promulgation of necessary Vermont administrative rules).	Any limitation on this service is defined by Vermont rules and policies.
Developmental Disability Services	Services including case management, residential habilitation, day habilitation, supported employment, crisis support, clinical interventions, respite, enhanced dental, self-directed care, vehicle modifications, home accessibility adaptations, and personal emergency response system.	Any limitation on this service is defined by Vermont rules and policies.

*Services will transition to the State Plan as of the SPA effective date, as approved by CMS. During this transition of authority, the state will ensure there are no gaps in services for beneficiaries.
**As of July 1, 2025, the state will cover respite for the Mental Health Under 22 population using state-only funding. During this transition of authority, the state will ensure there are no gaps in services for beneficiaries.
***Services will no longer be offered as of July 1, 2025, because there is no utilization of the benefit.

d. SUD Community Intervention and Treatment (CIT). SUD CIT services are provided to individuals with a diagnosis of SUD, with income at or below 225

percent of the FPL and who are not eligible under the state plan for full benefits. The clinical eligibility criteria for this program are listed in Attachment U.

i. **Benefits.** Individuals will have access to the following SUD treatment services covered under the Medicaid State Plan: case management, recovery supports, psychoeducation, peer supports (upon approval of a State Plan amendment and promulgation of necessary Vermont administrative rules), residential treatment, withdrawal management, counseling, and skilled therapy services.

ii. For individuals who are enrolled in both the CRT expansion group and the SUD Intervention and Treatment group, Vermont will ensure that there is not duplication of services. The CIT program will have a limited network of providers enrolled.

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

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

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

2. Care planning activities for children enrolled in the palliative care program will meet the requirements specified in federal managed care regulations for enrollees with special health care needs.

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

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

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

3. **Expressive Therapies.** Therapies provided by licensed therapist to provide support to the child to help the child to creatively and kinesthetically express their reaction to their illness. The palliative care program offers 52 hours of expressive therapies per year.

Additional expressive therapy may be authorized if medically appropriate.

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

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

iii. **Cost Sharing.** Cost sharing requirements as described in STC 5.1 will apply.

f. **Supportive Housing Assistance Pilot.** The Supportive Housing Assistance Pilot is for Medicaid enrollees age 18 and older eligible for full Medicaid State Plan benefits who meet the health needs-based and risk-based criteria defined by the state in Attachment I. This pilot will provide eligible individuals with access to pre-tenancy supports and tenancy sustaining services for enrollees moving to supportive housing that are in full alignment with services under 1915(c) and 1915(i) authorities. Benefits are further described in Attachment I.

i. Individuals who are eligible for full State Plan benefits and are enrolled in Choices for Care or one of Vermont's special programs defined in 4.4(c) (i.e., CRT, Developmental Disabilities Services, Brain Injury Program, or Mental Health Under 22) will be eligible for the Supportive Housing Assistance Pilot, but these individuals cannot obtain any services or supports from the pilot that duplicate benefits already available to them. The state will institute annual enrollment limits for the Supportive Housing Assistance Pilot and may maintain a waiting list.

5. COST SHARING

5.1. Premiums and Cost Sharing.

a. Populations 1, 2, and 3.

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

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

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

c. Notwithstanding STC 5.1(a)(i) above, and consistent with the waiver of premiums (section 1902(a)(14) of the Act insofar as it incorporates section 1916 of the Act) in this demonstration project, premiums for children through age 18 with income above 195 percent of the FPL through 312 percent of the FPL are outlined in Attachment G.

6. DELIVERY SYSTEMS

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

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

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

a. AHS shall develop a per member per month (PMPM) capitation rate consistent with the requirements for actuarial soundness, rate development, special contract provisions (as applicable), and rate certifications in 42 CFR 438.4 through 438.7; The PMPM capitation rates shall not be used for determination of federal financial participation, rather the PMPM capitation rates and corresponding rate certification shall be used to determine that:

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

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

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

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

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

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

e. During periods of a public health emergency (PHE), as declared by the Secretary of Health and Human Services as a result of a Presidential declaration under the Stafford Act, the non-risk PIHP (DVHA) is not required to offer in person opportunities for beneficiaries to present evidence and testimony and make legal and factual arguments as described in 42 CFR 438.406(b)(4). However, the non-risk PIHP (DVHA) must provide enrollees reasonable opportunity, in writing, telephonically, and video or virtual communication, to present evidence and testimony and make legal factual arguments. Monitoring and Evaluation requirements for this authority are described in STCs 15.3(a) and 15.6(c).

6.4. **Capitation Rate Development.** In addition to the requirements described in STC 6.3, the development of the capitation rate must:

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

b. Be developed for 12-month periods;

c. Not include any administrative services and costs that are required to be incurred by AHS as the Single State Agency under federal law, regulation, or these STCs. Such administrative services and costs that cannot be part of the capitation rate include: eligibility determinations, Single State Agency Central Office and External Quality Review Organization (EQRO), administration of a State Fair Hearing system, the Beneficiary Support System in 42 CFR 438.71 and STC 6.10, and the provider screening and enrollment process under 42 CFR 438.602(b);

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

e. Not include any costs for "investments" as described in STC 11.1;

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

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

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

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

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

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

   iii. Any reimbursement arrangements between AHS or DVHA and providers that are a value-based payment style fee schedule shall be required to meet the prior approval requirements in 42 CFR 438.6(c)(2) consistent with reimbursement arrangements described in 42 CFR 438.6(c)(1)(i) and (ii).

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

6.6. **Non-Application of 42 CFR 438.3(m).** AHS and DVHA shall not be determined out of compliance with 42 CFR 438.3(m) if AHS and DVHA meet the financial reporting requirements, consistent with requirements in sections 12 and 13 of these STCs, as well as applicable federal and state accounting principles and controls.

6.7. **Limitation of Freedom of Choice.** Freedom of choice is limited to the DVHA network of providers. However, populations must have freedom of choice when selecting enrolled providers within that network (when applicable, the provider must be enrolled in the specific specialty or subprogram applicable to the services at issue). Specifically, demonstration participants enrolled in a special service program such as, but not limited to, specialized substance use and mental health services, a special program as defined in STC 4.4(c), or the CIT program may only have access to the providers enrolled under that program, and will not have access to every Medicaid-enrolled provider for services under that program. Such participants will have freedom of choice of providers enrolled in the

special service program in the appropriate geographic area. No restriction on freedom of choice of family planning provider may be imposed.

6.8. **Contracts and Provider Payments.** Payments to providers for Global Commitment will be set by DVHA and approved by AHS and will not be required to comply with the payment provisions in the approved State Plan.

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

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

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

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

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

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

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

6.13. **Data Sharing.** DVHA acting as a non-risk PIHP under a managed care-like model shall comply with all privacy and confidentiality requirements on PIHPs in 42 CFR 438. Nothing in this STC prohibits AHS from delegating data and information rights and

responsibilities to DVHA consistent with federal law, including section 1902(a)(7) of the Act and 42 CFR 431.306(d). To the extent that DVHA has access to data and information under delegation from AHS that may not otherwise be shared with a non-risk PIHP, AHS must establish administrative, managerial and, technical controls to prevent sharing the data with divisions of DVHA responsible for the managed care-like model acting as a non-risk PIHP.

6.14. **State Quality Strategy.** The state must meet 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 quality strategy must address quality improvement for all components of the state's Medicaid State Plan and its section 1115 demonstration.

a. **Quality Improvement Strategy (QIS) for 1915(c) or 1915(i) approvable HCBS Services.** For services that could have been authorized to individuals under a 1915(c) waiver or under a 1915(i) HCBS State plan amendment, the state's Quality Strategy must encompass LTSS specific measures set forth in the federal managed care rule at 42 CFR 438.330 and should also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal waiver assurances set forth in 42 CFR 441.301 and 441.302(b), as follows:

i. **Administrative Authority.** A performance measure should be developed and tracked for any authority that AHS (State Medicaid Agency) delegates to another agency, unless already captured in another performance measure.

ii. **Level of Care or Eligibility based on 1115 Requirements.** Performance measures are required for the following: applicants with a reasonable likelihood of needing services receive a level of care determination or an evaluation for HCBS eligibility, and the processes for determining level of care or eligibility for HCBS are followed as documented. While a performance measure for annual levels of care/eligibility is not required to be reported, the state is expected to be sure that annual levels of care/eligibility are determined.

iii. **Qualified Providers.** The state must have performance measures that track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to demonstration requirements, and that the state verifies that training is given to providers in accordance with the demonstration.

iv. **Service Plan.** The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. The state must have one or more performance measures that track choice of HCBS and providers where applicable, that service plans address all assessed needs and personal goals commensurate with the scope of services available within the program, and that services are delivered in

accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.

v. **Health and Welfare.** The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants' health and welfare. The state must have one or more performance measures that track that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation, including the use of restraints, and unexplained death; that an incident management system is in place that effectively resolves incidents and prevents further singular incidents to the extent possible; that state policies and procedures for the use or prohibition of restrictive interventions are followed; and, that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved demonstration.

vi. **Financial Accountability.** The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the HCBS program.

vii. To demonstrate the requirements of STC 6.14 (a)(i)-(vi) above, the state must submit performance measures to CMS for review and approval within 90 days following approval of the demonstration extension.

viii. The state will submit a report to CMS following receipt of an Evidence Request letter and report template from the Division of HCBS Operations & Oversight (DHCBSO) no later than 21 months prior to the end of the approved waiver demonstration period that includes evidence on the status of the approved HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers. Following receipt of the state's evidence report, the DHCBSO will issue a draft report to the state and the state will have 90 days to respond. The DHCBSO will evaluate each evidentiary report to determine whether the assurances have been met and will issue a final report to the state 60 days following receipt of the state's response to the draft report.

ix. Beginning with the DY 19 annual monitoring report, the state must report the deficiencies found during the monitoring and evaluation of the HCBS demonstration assurances and measures, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or death, the actions taken regarding the incidents and how they were resolved. The DY19 annual report must also include this information for the months in DY 18 after which CMS has approved the performance measures.

7. LONG-TERM SERVICES AND SUPPORTS PROTECTIONS

7.1. **Person-Centered Planning.** The state assures there is a person-centered service plan for each individual determined to be eligible for HCBS. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR 441.301(c)(1) (1915(c)) or 42 CFR 441.725(a) (1915(i)), and the written person-centered service plan meets federal requirements at 42 CFR 441.301(c)(2) (1915(c)) or 42 CFR 441.725(b) (1915(i)). The state may obtain an electronic signature for the person-centered service plan in cases where permitted under Vermont policies and procedures. The person-centered service plan is reviewed, and revised upon reassessment of functional need as required by 42 CFR 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

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

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

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

7.4. **Single State Agency LTSS oversight.** In its role as single state agency, the AHS will ensure a managed LTSS plan for a comprehensive care model is developed that promotes the integration of home and community-based services, institutional, acute, primary and behavioral health care.

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

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

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

c. Assist with access to services and supports and help individuals understand their choices, resolve problems and address concerns that may arise between the individual and a provider or payer. The state will assure:

   i. Beneficiaries have support in the pre-enrollment stage, such as unbiased options counseling and general program-related information.

   ii. Beneficiaries have an access point for complaints and concerns about Choices for Care enrollment, access to services, and other related matters.

   iii. Enrollees understand the fair hearing, grievance, and appeal rights and processes within the Choices for Care program and assist them through the process if needed/requested.

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

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

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

7.6. **HCBS Electronic Visit Verification System.** The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2021 and home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act, unless the state has received a good faith effort exemption for up to one year from CMS.

7.7. **Conflict of Interest Protections.** Regulations at 42 CFR 441.301(c)(1)(vi) require that providers of HCBS for the individual, or those who have an interest in or are employed by

a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.

a. The safeguards to mitigate and address the potential problems that may arise when the individual's HCBS provider, or an entity with an interest in or employed by a provider of HCBS, performs service plan development (e.g., self-referral) need to include, at a minimum:

    i. Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of HCBS, not just the services furnished by the entity that is responsible for the person-centered service plan development;

    ii. An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

    iii. Direct oversight of the process or periodic evaluation by a state agency;

    iv. Restricting the entity that develops the person-centered service plan from providing services without the direct approval of the state; and

    v. Requiring the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

b. When the state allows for an entity that is responsible for person-centered service plan development to also provide other direct HCBS, the state must:

    i. Demonstrate that the entity is the only willing and qualified provider to develop the person-centered service plan; and

    ii. Describe safeguards that mitigate and address the potential problems that may arise, with the service providers' influence on the person-centered planning process (exercising free choice of providers, controlling the content of the plan, including assessment of risk, services, frequency and duration, and informing the participant of their rights) including:

        1. Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of HCBS, not just the services furnished by the entity that is responsible for the person-centered service plan development;

2. An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;
3. Direct oversight of the process or periodic evaluation by a state agency;
4. Restricting the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
5. Requiring the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

c. On December 17, 2021, Vermont submitted a plan to CMS describing the process it will take to comply with HCBS conflict of interest protections described in STC 7.7(a) and (b). Once approved by CMS, the plan will be appended as Attachment Q.

8. OTHER PROGRAMS

8.1. **State-Funded Marketplace Subsidies Program**. The state may claim as allowable expenditures under the demonstration the payments for premium subsidies made through its state-funded program for individuals who purchase health insurance through the Marketplace. Premium subsidies will be provided on behalf of individuals who:

1. are not Medicaid eligible;
2. are eligible for the advance premium tax credit (APTC) on the Marketplace; and
3. whose household MAGI, as determined for APTC and consistent with all applicable federal laws, is at or below 300 percent of the FPL.

Expenditures for this state health program must not include any expenditures listed in STC 11.5 ("Investment Approval Process").

a. **Reporting.** The state must provide data regarding the operation of this subsidy program in the annual report required per STC 12.7. This data must, at a minimum, include:

ii. The number of individuals served by the program;

iii. The size of the subsidies; and

iv. A comparison of projected costs with actual costs.

b. **Budget Neutrality.** This subsidy program will be subject to the budget neutrality limit specified in STC 14.15.

8.2. **Maternal Health and Treatment Services.** The state may claim as allowable expenditures otherwise covered State Plan services furnished to otherwise Medicaid eligible pregnant women, postpartum women, and mothers ages 19-64 who are residents at the Lund Home facility (or its successor), for the length of treatment as medically necessary.

a. **Services.** The Lund Home (or its successor) provides the following State Plan services:

i. Individual, group, family therapy

ii. Medication assisted treatment

iii. Health screening, education, monitoring and referral

iv. Case management

v. NEMT

b. **Monitoring.** The state must incorporate in the SUD and SMI Monitoring Protocol (as required under STC 9.3 and 10.5, respectively) plans to stratify appropriate monitoring metrics for the Maternal Health and Treatment Services program authorized by this demonstration. In addition, the state will develop in cooperation with CMS a list of maternal health metrics to be reported for this program. If the state discontinues the SMI components (as required under Section 10) of the Global Commitment to Health demonstration but would like to continue to receive expenditure authority for the Lund Home (or its successor), the state will need to submit a separate implementation plan (STC 10.2) to ensure that the Lund Home (or its successor) and the state continue to meet the relevant milestones of the SMI opportunity. Because of its unique care model, the Lund Home (or its successor) will not be required to obtain accreditation from a nationally recognized accreditation entity, but is subject to state licensure and oversight.

c. **Evaluation**. The state's Evaluation Design must include a separate discussion of the maternal health and treatment services provided at the Lund Home (or its successor) including evaluation questions and hypotheses that the state intends to test. Hypotheses related to the maternal health and treatment services should not only address the appropriate SUD and SMI treatment and quality of care goals but should also address the specific maternal health outcomes and goals of this program. For example, the hypotheses should address how the extended residential component and family-centered model contributes to achieving the goals of improved retention in treatment, lower child custody rates, and improved psychosocial outcomes for the family.

d. **Unallowable Expenditures.** Under no circumstances may the state receive FFP under expenditure authority approved for the Lund Home (or its successor) for room and board costs. Treatment for children receiving care within the Lund Home (or its successor) is not authorized by this STC and its associated expenditure authority.

Instead, service expenditures associated with children receiving care within the Lund Home (or its successor) are authorized to the extent allowable under statute, the State Plan, and associated regulations.

8.3. **Medicaid Data Aggregation and Access Program (MDAAP).** The state may claim as allowable expenditures, up to $14.9 million (total computable) for five years, payments to incentivize health information technology (HIT) use. This program is distinct from the investments described in Section 11 of the STCs and will not count towards the annual investment limits in STC 11.4. Incentive payments for Medicaid providers support the state's goals of expanding HIT use, increasing Vermont health information exchange (HIE) connectivity, and assisting providers with improving beneficiary outcomes and reducing disparities through the use of HIE tools.

a. **Eligibility.** Providers that are eligible to receive incentive payments to purchase tools are limited to those whose Medicaid patient volume is at least 20% (Children's Health Insurance Plan (CHIP) does not count toward the Medicaid patient volume criteria) and are mental health providers, SUD treatment providers, LTSS providers, or other provider type identified in Attachment H.

b. **Reporting.** The state will report on the activities of the MDAAP Incentive Payment Program in the Annual Monitoring Reports. The state will report the amount and types of providers participating, the amount of funding given to providers, and an annual update of how the incentive is helping Vermont move its data systems forward. For example, how many providers statewide are connected to the Vermont Health Information Exchange (VHIE). All expenditures must be reported as specified in STC 12.7.

c. **MDAAP Incentive Payment Protocol.** The MDAAP Incentive Payment Protocol establishes rules and guidelines for participation in the MDAAP Incentive Payment Program as well as how the State will claim FFP for incentive payments. The approved MDAAP Incentive Payment Protocol will be appended into these STCs as Attachment H. The state must submit the MDAAP Incentive Payment Protocol to CMS for approval. CMS and Vermont will work collaboratively with the expectation of CMS approval of the protocol within 90 calendar days after it receives the protocol. The state cannot claim FFP for any incentive payments until the MDAAP Incentive Payment Protocol has been submitted to and approved by CMS.

d. **Unallowable Expenditures.** Under no circumstances, may the state receive FFP under this expenditure authority for provider incentive payments made to anyone who was previously included under the Health Information Technology for Economic and Clinical Health (HITECH) Act.

9. OPIOID USE DISORDER (OUD)/SUBSTANCE USE DISORDER (SUD)

9.1. **Opioid Use Disorder/Substance Use Disorder Program.** Since CMS's approval of the SUD Implementation Plan on June 6, 2018, effective July 1, 2018, the demonstration benefit package for Vermont Medicaid recipients has included OUD/SUD services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state is eligible to receive FFP for Vermont Medicaid recipients residing in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Vermont will aim for a statewide average length of stay of 30 days in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in Attachment M below, to ensure short-term residential treatment stays. Under this demonstration component, beneficiaries will have access to high-quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

The coverage of OUD/SUD inpatient, residential treatment and withdrawal management services in IMDs expands Vermont's current OUD/SUD benefit package available to all Vermont Medicaid recipients as outlined in the table below. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Vermont OUD/SUD Benefits Coverage with Expenditure Authority		
SUD Benefit	**Medicaid Authority**	**Expenditure Authority**
Early Intervention (Screening, Brief Intervention and Referral to Treatment)	State plan (Individual services covered)	N/A
Outpatient Services	State plan (Individual services covered)	N/A
Intensive Outpatient Services	State plan (Individual services covered)	N/A
Residential Treatment	State plan (Individual services covered)	Services provided to individuals in IMDs
Medically Supervised Withdrawal Management	State plan	Services provided to individuals in IMDs
Medication-Assisted Treatment (MAT)	State plan	Services provided to individuals in IMDs

The state attests that the services indicated in the table above, as being covered under the Medicaid State Plan authority are currently covered in the Vermont Medicaid State Plan.

9.2. **SUD Implementation Plan.** The state's SUD Implementation Plan, initially approved for the period from July 1, 2018 through December 31, 2021, remains in effect for the approval period from July 1, 2022 through December 31, 2027, and is affixed to the STCs

as Attachment J. Any future modifications to the approved Implementation Plan will require CMS approval. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral. The approved SUD Implementation Plan describes the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of this SUD demonstration project:

a. **Access to Critical Levels of Care for OUD and other SUDs:** Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of OUD/SUD program demonstration approval;

b. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other comparable assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;

c. Patient Placement: Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of SUD program demonstration approval;

d. **Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in the Preferred Provider Substance Use Disorder Treatment Standards of the Vermont Department of Health's Division of Alcohol and Drug Abuse Programs. The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other comparable, nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of OUD/SUD program demonstration approval;

e. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval;

f. **Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval;

g. **Sufficient Provider Capacity at each Level of Care including Medication-assisted Treatment for OUD:** An assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT, within 12 months of SUD program demonstration approval;

h. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

i. **SUD Health IT Plan:** Implementation of the milestones and metrics as detailed in STC 9.6; and

j. **Improved Care Coordination and Transitions between Levels of Care:** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of SUD program demonstration approval.

9.3. **SUD Monitoring Protocol.** The state must submit an updated Monitoring Protocol for the SUD programs authorized by this demonstration within 150 calendar days after approval of the demonstration. The Monitoring Protocol Template must be developed in cooperation with CMS and is subject to CMS approval. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment M. Progress on the performance measures identified in the Monitoring Protocol must be reported via the quarterly and annual monitoring reports. Components of the Monitoring Protocol include:

a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 9.2 and reporting relevant information to the state's Health IT plan described in STC 9.6;

b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section 12 of the demonstration; and

c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

9.4. **SUD Mid-Point Assessment.** The state must conduct an independent mid-point assessment by June 30, 2025. In the design, planning and conduction of the mid-point assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: SMI/SED and/or SUD treatment providers, beneficiaries, and other key partners.

The state must require that the assessor provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than 60 days after June 30, 2025. The state must brief CMS on the report.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the SUD Implementation Plan, and/or SUD Monitoring Plan for ameliorating these risks. Modifications to the applicable Implementation, Financing, and Monitoring Protocol are subject to CMS approval.

a. An examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Plans and toward meeting the targets for performance measures as approved in the SUD Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

c. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's SUD Implementation Plan or to pertinent factors that the state can influence that will support improvement; and

e. An assessment of whether the state is on track to meet the budget neutrality requirements.

9.5. **SUD Evaluation.** The SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as listed in sections 12 (Monitoring and Reporting Requirements) and 15 (Evaluation of the Demonstration) of these STCs.

9.6. **SUD Health Information Technology (Health IT).** The state will provide CMS with an assurance that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, and individual provider) to achieve the goals of the demonstration—or it will submit to CMS a plan to develop the infrastructure/capabilities. This "SUD Health IT Plan," or assurance is included as a section of the state's approved "Implementation Plan" (see STC 9.2), which remains in effect for the approval period from July 1, 2022 through December 31, 2027, and is affixed to the STCs as Attachment J. The SUD Health IT Plan will detail the necessary health IT capabilities in place to

support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of SUD health IT ecosystem improvement.

a. The SUD Health IT section of the Implementation Plan will include implementation milestones and dates for achieving them.

b. The SUD Health IT Plan must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) "Health IT" Plan.

c. The SUD Health IT Plan will describe the state's goals, each DY, to enhance the state's prescription drug monitoring program's (PDMP).[1]

d. The SUD Health IT Plan will address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[2] This will also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan will describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

e. The SUD Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

f. The SUD Health IT Plan will describe how the activities described in (a) through (e) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.[3]

g. In developing the Health IT Plan, states should use the following resources:

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[1] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

[2] *Ibid.*

[3] Shah, Anuj, Corey Hayes and Bradley Martin. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017; 66.

i. States may use resources at Health IT.Gov (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/) in "Section 4: Opioid Epidemic and Health IT."

ii. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans, found at https://www.healthit.gov/topic/advancing-interoperability-medicaid.

iii. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration

h. The state will include in its SUD Monitoring Protocol (see STC 9.3) an approach to monitoring its SUD Health IT Plan which will include performance metrics provided by CMS or State defined metrics to be approved in advance by CMS.

i. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in an addendum to its Annual Reports (see STC 12.7).

j. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

k. Where there are opportunities at the state and provider levels (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally recognized standards, barring another compelling state interest.

l. Where there are opportunities at the state and provider levels to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally recognized ISA standards, barring no other compelling state interest.

9.7. **Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones.** Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plan and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be

deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

10. SERIOUS MENTAL ILLNESS (SMI) AND SERIOUS EMOTIONAL DISTURBANCE (SED)

10.1. **SMI/SED Program Benefits.** Under this demonstration, beneficiaries have access to high quality, evidence-based SMI/SED treatment services. These services range in intensity from short-term acute care in inpatient settings for SMI to ongoing chronic care for such conditions in cost-effective community-based settings. Since CMS's approval of the SMI/SED Implementation Plan on December 5, 2019, the demonstration benefit package for Vermont Medicaid recipients has included mental health services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state is eligible to receive FFP for Vermont Medicaid recipients residing in IMDs under the terms of this demonstration for coverage of medical assistance, including mental health benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. The state is working to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve a statewide average length of stay of no more than 30 days in inpatient treatment settings, to be monitored pursuant to the SMI/SED Monitoring Protocol as outlined in STCs 10.2 – 10.5 below.

Vermont attests that the services indicated in the table below are either already covered under the Medicaid State Plan authority or being authorized under the terms of this demonstration.

SMI/SED Benefits Coverage Authorized with Expenditure Authority			
Benefit	**Type**	**Medicaid Authority**	**Expenditure Authority**
Crisis Stabilization Services	SMI/SED	State plan (Individual services covered)	N/A
Outpatient services	SMI/SED	State plan (Individual services covered)	N/A
Intensive outpatient services	SMI/SED	State plan (Individual services covered)	N/A
Inpatient services	SMI/SED	State plan (Individual services covered)	Services provided to individuals in IMDs
Residential treatment services	SMI	State plan (Individual services covered)	N/A

10.2. **SMI/SED Implementation Plan.**

a. The state's SMI/SED Implementation plan approved on December 5, 2019 for the period from December 5, 2019 to December 31, 2021 remains in effect for the approval period from January 1, 2022 through December 31, 2027.

b. The approved SMI/SED Implementation Plan is incorporated into the STCs as Attachment L, and once incorporated, may be altered only with CMS approval. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 9.7.

c. The approved SMI/SED Implementation Plan describes the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

i. Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings.

1. Participating hospitals must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and be either: a) certified by the state agency as being in compliance with those conditions through a state agency survey, or b) deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.
2. Participating residential treatment providers must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.
3. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;
4. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive

treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;

5. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet federal program integrity requirements and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidating existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure treatment providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);
6. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen enrollees for co-morbid physical health conditions and substance use disorders (SUDs) and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

ii. Improving Care Coordination and Transitions to Community-Based Care.

1. Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that community-based providers participate in transition efforts (e.g., by allowing initial services with a community-based provider while a beneficiary is still residing in these settings and/or by hiring peer support specialists to help beneficiaries make connections with available community-based providers, including, where applicable, plans for employment);
2. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who are homeless or who have unsuitable or unstable housing with community providers that coordinate housing services, where available;
3. Implementation of a requirement that psychiatric hospitals and residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and by contacting the community-based provider they were referred to;

4. Implementation of strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers);
5. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

iii. Increasing Access to Continuum of Care Including Crisis Stabilization Services.

1. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability;
2. Commitment to implementation of the SMI/SED Financing Plan described in STC 10.4;
3. Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;
4. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay.

iv. Earlier Identification and Engagement in Treatment Including Through Increased Integration

1. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI or SED in treatment sooner, including through supported employment and supported education programs;
2. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI or SED conditions sooner and improve awareness of and linkages to specialty treatment providers;
3. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

10.3. **SMI/SED Health IT Plan:** The state will provide CMS with an assurance that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, and individual provider) to achieve the goals of the demonstration.

Vermont has completed this task as demonstrated in its approved HIT plan and Implementation Plan, which remains in effect for the approval period from July 1, 2022 through December 31, 2027, and is appended to the STCs as Attachment L.

a. The SMI/SED Health IT plan applies to all states where the Health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #18-011, states must submit to CMS the applicable Health IT Plans, to be included as sections of the associated Implementation Plans (see STC 10.2), to develop infrastructure and capabilities consistent with the requirements outlined in the SMI/SED demonstration opportunity)

b. The Health IT Plan must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI/SED goals of the demonstration. The plans will also be used to identify areas of health IT ecosystem improvement. The Plan must include implementation milestones and projected dates for achieving them (see Attachment L), and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.

c. The state must include in its SMI/SED Monitoring Protocol (see STC 10.4) an approach to monitoring its SMI/SED Health IT Plan which will include performance metrics to be approved in advance by CMS.

d. The state must monitor progress, each DY, on the implementation of its SMI/SED Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in an addendum to its Annual Report (see STC 12.7).

e. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SMI/SED Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this SMI/SED amendment to this Demonstration.

f. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

g. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

h. Components of the Health IT Plan include:

i. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas:

1. Referrals,
2. Electronic care plans and medical records,
3. Consent,
4. Interoperability,
5. Telehealth,
6. Alerting/analytics, and
7. Identity management.

ii. In developing the Health IT Plan, states should use the following resources:

1. States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).
2. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.
3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

10.4. **SMI/SED Financing Plan.** As part of the SMI/SED Implementation Plan referred to in STC 10.2, the state must submit, within 90 calendar days after approval of the demonstration, a financing plan that will be approved by CMS. Once approved, the SMI/SED Financing Plan will be incorporated into the STCs as part of the SMI/SED Implementation Plan in Attachment L and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI/SED Financing Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI/SED program under this demonstration. Components of the financing plan must include:

a. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and

b. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings;

c. A plan to ensure the on-going maintenance of effort (MOE) on funding outpatient community-based services to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

10.5. **SMI/SED Monitoring Protocol(s).** The state must submit an updated SMI/SED Monitoring Protocol for the SMI/SED program authorized by this demonstration that reflects the changes to the SMI/SED Monitoring Protocol required by STC 10.2(c) within 150 calendar days after approval of the demonstration. The SMI/SED Monitoring Protocol Template must be developed in cooperation with CMS and is subject to CMS approval. The state must submit the revised SMI/SED Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the SMI/SED Monitoring Protocol will be incorporated into the STCs, as Attachment N. Progress on the performance measures identified in the Monitoring Protocol must be reported via the quarterly and annual monitoring reports. Components of the Monitoring Protocol include:

a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 10.2 and STC 10.4, reporting relevant information to the state's SMI/SED Financing Plan described in Attachment L, and reporting relevant information to the state's Health IT plans described in STC 10.3;

b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section 12 of the demonstration; and

c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

10.6. **Evaluation.** The SMI/SED Evaluation will be subject to the same requirements as the overall demonstration evaluation, as described in Sections 12 (Monitoring and Reporting Requirements) and 15 (Evaluation of the Demonstration) of these STCs.

10.7. **Availability of FFP for the SMI/SED Services under the SMI IMD expenditure authority**. FFP is only available for services provided to beneficiaries during short term

stays for acute care in IMDs. The state may claim FFP for stays up to 60 days as long as it shows at its mid-point assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS). Stays in IMDs that exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the mid-point assessment, the state may only claim FFP for stays up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state assures that it will provide coverage for stays that exceed 60 days—or 45 days, as relevant—with other sources of funding if it is determined that a longer length of stay is medically necessary for an individual beneficiary.

10.8. **SMI/SED Mid-Point Assessment.** The state must conduct an independent mid-point assessment by June 30, 2024. In the design, planning and conducting of the mid-point assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: SMI/SED providers, beneficiaries, and other key partners.

The state must require that the assessor provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than 60 days after June 30, 2024. The state must brief CMS on the report.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the SMI/SED Implementation Plan, the SMI/SED Financing Plan, and the SMI/SED Monitoring Protocol for ameliorating these risks. Modifications to the applicable Implementation, Financing, and Monitoring Protocol are subject to CMS approval.

Elements of the mid-point assessment include:

a. An examination of progress toward meeting each milestone and timeframe approved in the SMI/SED Implementation Plan, the SMI/SED Financing Plan, and toward meeting the targets for performance measures as approved in the SMI/SED Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

c. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's SMI/SED Implementation Plan or SMI/SED Financing

Plan or to pertinent factors that the state can influence that will support improvement; and

e. An assessment of whether the state is on track to meet the budget neutrality

10.9. **Unallowable Expenditures Under the SMI and SUD IMD Expenditure Authority.** In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

b. Costs for services provided in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.

c. Costs for services provided to individuals who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

10.10. **Maintenance of effort (MOE).** The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI/SED program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI/SED program under the demonstration. The annual MOE will be reported and monitored as part of the annual monitoring report described in STC 12.7.

11. USE OF DEMONSTRATION FUNDS

11.1. **Use of Demonstration Funds.** The demonstration provides authority for expenditures within the annual limits specified in STC 11.4 for public health, health care, and health-related investments. Advancing health equity and addressing health disparities is a core principle of these investments. The investments are subject to CMS approval and may be denied if they do not promote the objectives of Medicaid. Medicaid beneficiary notice and appeal rights are not applicable to individuals receiving the benefits of the Investments. Investments can include expenditures within the following areas:

a. Reduce the rate of uninsured and/or underinsured in Vermont. Examples of potentially approvable investments under this category:

i. The delivery of 1905(a) benefits to underinsured and uninsured Vermonters.

ii. Programs to promote enrollment in health care plans by Vermonters.

iii. Specialized wraparound benefits for uninsured or underinsured populations with significant needs, comparable to benefits available through the CRT and CIT programs.

b. Increase the access to quality health care by low income, uninsured, underinsured individuals and Medicaid beneficiaries in Vermont. Examples of potentially approvable investments under this category:

i. Workforce development trainings to promote linguistically and culturally appropriate, trauma-informed and disability-competent care.

ii. Initiatives to improve the integration of physical and mental health and SUD treatment needs at the provider level.

iii. Mobile health care clinics or home visitations by health care providers.

iv. Non-emergency health-related transportation.

v. Care management and care transitions programs for low-income, underinsured, and uninsured Vermonters.

vi. Parenting support programs.

vii. Support services, consistent with 1915(c) or 1915(i) services, to address the root causes of homelessness.

viii. Alternative pain management treatments.

ix. Health care workforce capacity building initiatives, including recruitment and retention incentives and initiatives targeted toward increasing representation of members of historically marginalized populations in the workforce. Graduate medical education funding is excluded.

c. Provide public health approaches, investments in social determinants of health, and other innovative programs that benefit low-income, uninsured, underinsured individuals and Medicaid beneficiaries in Vermont. Examples of potentially approvable investments under this category:

i. Initiatives to promote awareness of maternal health-related care needs in the community and improve outcomes in maternal/child health.

ii. Nurse-partnership programs, such as visiting nurse programs.

iii. Initiatives to promote vaccinations (e.g., vaccination drives).

iv. Self-management and tobacco cessation initiatives.

v. Building capacity in community-based organizations to interface with traditional health care providers.

vi. Repairs or remediation for issues such as mold or pest infestation.

vii. Assistance with connecting the enrollee to expert community resources to address legal issues impacting housing or interpersonal violence related issues.

viii. Targeted nutritious food or meal delivery services for individuals with medical or medically-related special dietary needs that do not provide a full nutritional regimen (i.e., must abide by limits in 1915(c) services).

ix. Contingency management.

x. Innovative care models and care transitions initiatives for justice-involved populations and initiatives to prevent recidivism.

xi. Community crisis support and capacity, including, but not limited to, hotlines, mobile crisis, and psychiatric urgent care.

xii. Lead and other environmental health remediation.

xiii. Water fluoridization.

xiv. Early detection and screening programs for mental health conditions and substance use disorders.

xv. Screening for unmet social needs.

xvi. Innovative health-related services and supports to promote family togetherness.

xvii. Weatherization activities that promote health and safety.

d. Implement initiatives to increase transformation to value-based and integrated models of care. Examples of potentially approvable investments under this category:

i. Technical assistance to select providers to prepare them for alternative payment methodologies (APM) following the Healthcare Partnership Learning Action Network (HCP-LAN) criteria.

ii. Technical assistance to select providers for designing alternative care delivery models.

iii. Incentives to providers that engage in delivery system reform, value-based payment, and/or APM.

iv. Systems enhancement for APM readiness where not duplicating other federal/state/private funding.

v. Technical assistance for select providers for organization-wide adoption of financial models and business practices.

vi. Technical assistance for select providers for performance evaluation and management.

vii. Support for the following Blueprint for Health initiatives: practice participation in the State's patient-centered medical home (PCMH) initiative; implementation of local community health teams; implementation of Vermont's care coordination models; quality improvement for PCMHs; and self-management programming.

e. Provide home and community-based services and supports necessary to increase community living for individuals in Vermont at risk of needing facility-based care. Examples of potentially approvable investments under this category:

i. The delivery of 1915(c) and 1915(i)-like services to vulnerable Vermonters who need or are at risk of needing institutional care.

ii. The delivery of innovative care models to vulnerable Vermonters who need or are at risk of needing institutional care.

iii. Programs that support family caregivers.

iv. Provider rate increases and incentive payments to support the LTSS workforce.

v. Mobile Response Program for mental health crisis care.

vi. Programs that promote health and wellness such as preventive healthcare and chronic disease self-management programs designed for people with HCBS, mental health and SUD treatment needs.

11.2. **Investment Framework.** Together, CMS and Vermont have defined an Investment Framework that outlines the investment categories in STC 11.1 and identifies the specific types of investments that may be included in each category in addition to those examples listed in STC 11.1, and any specific constraints beyond those identified in STC 11.5. The Investment Framework is appended as Attachment R.

11.3. **Phase-Down of IMD Investments.** The state must follow the phase-down schedule below for the following IMD investments. The percentages note what proportion of the expenditures the state has authority to spend for DY 18 through DY 23 during the extension period.

Phase-down of IMD Investments						
Facilities	**DY 18**	**DY 19**	**DY 20**	**DY 21**	**DY 22**	**DY 23**
Vermont Psychiatric Care Hospital and Brattleboro Retreat (IMD)	70% of DY 14 spending	60% of DY 14 spending	50% of DY 14 spending	40% of DY 14 spending	30% of DY 14 spending	20% of DY 14 spending

11.4. **Investment Annual Limits.** The table below shows the specific annual limits. These amounts can be rolled over from DY to DY during this demonstration period (DY 18-DY 23).

Annual Investment Limit						
DY 18	**DY 19**	**DY 20**	**DY 21**	**DY 22**	**DY 23**	**Total**
$101,775,000	$185,127,500	$167,083,875	$166,936,534	$149,283,361	$158,047,529	$928,253,798

11.5. **Investment Approval Process.** The state may spend up to the amounts listed in STC 11.4 on approved investments during each DY. Approval is subject to CMS review and approval of state submissions using the Template (Attachment S). All approved investments from the previous demonstration period will continue to be approved under this renewal. The annual limits can be rolled over to the next DY during this demonstration period (DY 18-DY 23). The DY 23 annual limit cannot be rolled over. If the state chooses to add a new investment, it must meet the criteria specified in STC 11.1 and must not supplant other federal involvement (including meeting a maintenance of effort requirement for any federal grant program), must meet requirements in STC 11.5, and must not include the following, including other activities CMS determines are unallowable after review:

a. Construction costs (bricks and mortar) or capital investments;

b. Room and board;

c. Animal shelters and vaccines;

d. Provider or beneficiary debt relief and restructuring;

e. Sheltered workshops;

f. Research grants and expenditures not related to monitoring and evaluation;

g. Ongoing rent and/or utility subsidies that are not allowable under 1915(c) or 1915(i);

h. Costs for prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting;

i. Services provided to individuals who are not lawfully present in the United States or are undocumented;

j. Facility closures;

k. Expenditures that supplant services and activities funded by other state and federal governmental entities;

l. School based programs for children that supplant Medicaid State Plan programs; and

m. Unspecified projects.

11.6. **New Investment Notification.** The state must notify CMS of any new investments. Investments must meet the criteria in STC 11.1 and must not include any of the activities listed in STC 11.5 above. The state must submit information regarding new investments following the template in Attachment S for CMS review and approval. The state must use the Investment Framework (Attachment R) to ensure investments meet the goals in STC 11.1. The state must notify CMS at least 30 days prior to implementing any of the proposed new investments by submitting the completed template (Attachment S) to CMS. The state may not claim FFP for a new investment until CMS has approved the investment. CMS will not approve a new investment if it includes unallowable activities. During the 30-day CMS review period, if CMS notifies the state with concerns or questions, then the proposed investment will be considered under review for an additional 30-day period upon which CMS will issue a disapproval or approval of the new investment.

11.7. **Requirement for Approval of Investments That Do Not Meet Criteria.** The state may request to add an investment that does not meet the requirements of STC 11.1. In this instance, the state must submit a letter to CMS at least 120 days prior to the proposed implementation date, explaining the investment and providing justification for the investment, including how the investment advances the goals of the Medicaid program and demonstration. CMS will review the investment and will issue a disapproval or approval, following 60 days of receipt of the state's letter. The state may not claim FFP for a new investment until CMS has approved the investment.

11.8. **Investment Monitoring and Evaluation**.

a. Consistent with the requirements and timelines outlined in STC 12.7, the quarterly and annual monitoring reports will monitor implementation and performance of the investments to ensure that expenditures advance the goals of the demonstration and the Medicaid program and do not violate the restrictions listed in STC 11.5. The state must maintain a list of active, retired, completed, and new investments in the quarterly monitoring reports described in STC 12.7. The state must identify administrative (i.e., not medical services in nature) investments as to ensure the correct federal matching percentage is utilized.

b. The state will evaluate all investments authorized under this demonstration in accordance with STC 15.3. Where the state introduces a new investment or makes substantial changes to an existing investment, the state must review the Evaluation Design and revise as appropriate to ensure that evaluation plans encompass these changes and/or additions. Any revisions to the Evaluation Design should be submitted for CMS review within 180 days of implementation. Should the state's review find that no changes to the Evaluation Design are needed, the state should

describe in the next monitoring report the results of this review, with reference to existing research questions and data sources, as appropriate.

c. The state's monitoring and evaluation should accommodate data collection and analyses stratified by key subpopulations of interest (e.g., race and ethnicity, income level, and regional population density) to inform a fuller understanding of existing disparities in access and health outcomes, and how the investments might support bridging any such inequities. To that end, the state should collect and submit to CMS stratified data on: rates of uninsured and underinsured in Vermont, enrollment in each of its investment programs, changes in health outcomes for individuals enrolled in investment programs, and outreach efforts to increase enrollment, especially any outreach that targets populations with existing health disparities. Monitoring reports should also incorporate successes and challenges encountered during program implementation.

12. MONITORING AND REPORTING REQUIREMENTS

12.1. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, budget neutrality, the status of investment submissions, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

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

12.3. **Submission of Post-Approval Deliverables.** The state shall submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the state mutually agree to another timeline.

12.4. **Compliance with Federal Systems Innovation**. As federal systems continue to evolve and incorporate 1115 waiver reporting and analytics functions, the state shall work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit all deliverables to the appropriate system as directed by CMS.

12.5. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

The following process will be used: 1) 30 days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) 30days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action steps or still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outline in these STCs, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

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

12.7. **Monitoring Protocol.** The state must submit to CMS a Monitoring Protocol for the reentry and HRSN demonstration initiatives no later than 150 calendar days after the approval of the demonstration amendment. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs as Attachment X. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to the same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol must affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, as applicable and relevant for different policies. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol must describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., those described under the performance metrics section in STC 12.8), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS, as applicable. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography) and demonstration component.

The Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Disparities Sensitive Measure Set, and outlining the corresponding data sources and reporting timelines, as applicable to the demonstration initiatives and populations. If needed, the state may submit an amendment to the Monitoring Protocol within 150 days

after the receipt of the final Disparities Sensitive Measure Set from CMS. This set of measures consists of metrics known to be important for addressing disparities in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e. social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track implementation progress and performance relative to the goals and milestones including relevant transitional, non-service expenditures investments, as captured in these STCs, or other applicable implementation and operations protocols.

In addition, the state must describe in the Monitoring Protocol methods and the timeline to collect and analyze relevant non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include but are not limited to data related to: 1) community resource referral platforms, 2) records of social services receipt from other agencies (such as SNAP or TANF benefits, or housing assistance), 3) other data from social services organizations linked to beneficiaries (e.g., services rendered, resolution of identified need, as applicable), 4) social needs screening results from electronic health records, health plans, or other partner agencies, and 5) carceral status, Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community, as applicable. Across data sources, the state must make efforts to consult with relevant non-Medicaid agencies to collect and use data in ways that support analyses of data on demonstration beneficiaries and subgroups of beneficiaries, in accordance with all applicable requirements concerning privacy and the protection of personal information.

For the qualitative elements (e.g., operational updates as described in STC 12.8), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise of the state's Quarterly and Annual Monitoring Reports.

For the HRSN services authorized through this demonstration, the Monitoring Protocol must also outline the state's planned approaches and parameters to track implementation progress and performance relative to the goals and milestones, as provided in the Implementation Plan, for the HRSN infrastructure investments. The state will also be expected to set up its HRSN service delivery system to allow screening of beneficiaries for identified needs, and to develop an appropriate closed-loop referral system or other feedback loop to ensure beneficiaries receive service referrals and provisions and provide any applicable update on this process via the Monitoring Reports, in alignment with information provided in the Monitoring Protocol.

12.8. **Monitoring Reports.** The state must submit three Quarterly Monitoring Reports and one compiled Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 days following the end of each demonstration quarter. The compiled Annual Monitoring Report (including the fourth quarter information) is due no later than 90 days following the end of the DY. The state must submit a revised Monitoring Report within

60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428. and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. **Operational Updates**. Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. **Performance Metrics**. The demonstration's monitoring activities through quantitative data and narrative information must support tracking the state's progress toward meeting the applicable program-specific goals and milestones—including relative to their projected timelines—of the demonstration's program and policy implementation and infrastructure investments and transitional non-service expenditures, as applicable. Metrics in the state's Monitoring Reports must cover all key policies under this demonstration, including, but not limited to, behavioral health, premiums, waivers of retroactive eligibility, maternal health and treatment services, the reentry demonstration initiative, HRSN, and any investments authorized under this demonstration.

   Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to individuals and the uninsured population, as well as on individuals' outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals.

   Specifically, the state must undertake standardized reporting on categories of metrics for demonstration components outlined in STC 12.8(b)(i), including, but not limited to: beneficiary participation in demonstration components, primary and specialist provider participation, utilization of services, quality of care, and health outcomes. The reporting of metrics focused on quality of care and health outcomes must be aligned with the demonstration's policies and objectives populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex,

age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

i. The state's selection and reporting of quality of care and health outcome metrics outlined above must also accommodate the Reentry Demonstration Initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones of the Reentry Demonstration Initiative. CMS expects such metrics to include, but not be limited to: utilization of applicable pre-release and post-release services as defined in STC 16.4, provision of health or social service referrals pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in its Monitoring Reports narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

ii. For the HRSN component of the demonstration, the state must track beneficiary participation, screening, receipt of referrals and social services over time, as well as narratively report on the adoption of information technology infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations, and contracted providers of applicable services (e.g., managed care plans and their contracted HRSN providers). In alignment with STC 17.20, the state must additionally monitor and provide narrative updates on its progress in building and sustaining its partnership with existing housing agencies to leverage their expertise and existing housing resources instead of duplicating services. Furthermore, the state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as SNAP and WIC) for which they are eligible. The Monitoring Reports must also provide status updates in accordance with the Monitoring Protocol on the implementation of infrastructure investments tied to the HRSN initiatives.

As applicable, if the state, health plans, or health care providers will contract or partner with organizations to implement the demonstration, the state must

use monitoring metrics that track the number and characteristics of contracted or participating organizations in specific demonstration programs, and corresponding payment-related metrics; these metrics are specifically relevant for the state's HRSN initiatives.

c. The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

d. **Budget Neutrality and Financial Reporting Requirements**. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs for this demonstration should be reported separately on the CMS-64.

e. **Evaluation Activities and Interim Findings**. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

f. The Annual Report must include all items outlined in STC 12.8. In addition, the Annual Report must at a minimum include the requirements outlined below:

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

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

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

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

    v. Reporting annual HCBS QIS requirements in accordance with STC 6.14(a)(ix).

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

12.10. **State Data Collection.** The state must collect data and information necessary to oversee service utilization and rate setting by provider/plan, comply with the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP, obtain NCQA and other accreditations that the state may seek, and comply with other existing federal measure sets.

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

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

c. The raw and edited data will be made available to CMS within 30 days of a written request.

12.11. **Corrective Action Plan Related to Demonstration Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS will withdraw an authority, as described in STC 3.10, when metrics indicate substantial, sustained directional change, inconsistent with state targets and goals, as applicable, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

12.12. **Close-Out Report.** If the demonstration is not being extended, within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 15.6 and 15.7, respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out report.

d. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

e. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 12.5.

12.13. **Reentry Demonstration Initiative Mid-Point Assessment.** The state must contract with an independent entity to conduct a mid-point assessment of the Reentry Demonstration Initiative and complete a Reentry Demonstration Initiative Mid-Point Assessment.

The Mid-Point Assessment must integrate all applicable implementation and performance data from the first 2.5 years of implementation of the Reentry Demonstration Initiative. The report must be submitted to CMS by the end of the third year of approval of the Reentry Demonstration Initiative. In the event that the Reentry Demonstration Initiative is implemented at a timeline within the demonstration approval period, the state and CMS will agree to an alternative timeline for submission of the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment within 60 calendar days after receipt of CMS's comments, if any. If requested, the state must brief CMS on the report.

The state must require the independent assessor to provide a draft of the Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies used, the findings on demonstration progress and performance, including identifying any risks of not meeting milestones and other operational vulnerabilities, and recommendations for overcoming those challenges and vulnerabilities. In the design, planning, and execution of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: provider participation in the state's Reentry Demonstration Initiative, eligible individuals, and other key partners in correctional facility and community settings.

For milestones and measure targets at medium to high risk of not being achieved, the state and CMS will collaborate to determine whether modifications to the Reentry Demonstration Initiative Implementation Plan and the Monitoring Protocol are necessary for ameliorating these risks, with any modifications subject to CMS approval.

Elements of the Mid-Point Assessment must include, but not be limited to:

a. An examination of progress toward meeting each milestone and timeframe approved in the Reentry Demonstration Initiative Implementation Plan and toward meeting the targets for performance metrics as approved in the Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and progress toward performance metrics targets to date;

c. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets; and

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's Reentry Demonstration Initiative Implementation Plan or to pertinent factors that the state can influence that will support improvement.

CMS will provide additional guidance for developing the state's Reentry Initiative Mid-Point Assessment.

13. GENERAL FINANCIAL REQUIREMENTS

13.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

13.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

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

13.3. **Sources of Non-Federal Share**. As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. CMS reserves the right to deny FFP in expenditures for which it determines the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

13.4. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.52 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner consistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

13.5. **Financial Integrity for Managed Care and Other Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with all requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60 and 438.74.

13.6. **Requirements for health care related taxes and provider donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903 (w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903 (w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903 (w)(4) of the Act and 42 CFR 433.68(f).

e. All provider related-donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Act, 42 CFR 433.66, and 42 CFR 433.54.

13.7. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to deferral as described in STC 12.5. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under Section 1903(w) of the Act.

13.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in section 14:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State Plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

13.9. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices, including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

13.10. **Medicaid Expenditure Groups (MEG).** MEGs are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Aged, Blind, and Disabled (ABD) Non-Medicare Adult	Main	X		X	Expenditures for aged, blind, and disabled (ABD) adults without Medicare.
ABD Non-Medicare Child	Main	X		X	Expenditures for ABD children without Medicare.
ABD Dual	Main	X		X	Expenditures for ABD with Medicare.
Non-ABD, Non-Medicare Adult	Main	X		X	Expenditures for non-ABD adults who are not in the Affordable Care Act adult group described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119.
Non-ABD, Non-Medicare Child	Main	X		X	Expenditures for non-ABD children.
New Adults	Hypo 1	X		X	Medical expenditures for the Affordable Care Act

Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
					adult group described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119.
Investments	Main			X	Expenditures for investments as described in STC 11.1, as well as HCBS Investments.
SUD IMD ABD	Hypo 2	X		X	Expenditures for costs of medical assistance that could be covered for ABD individuals without Medicare, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.
SUD IMD ABD Duals	Hypo 2	X		X	Expenditures for costs of medical assistance that could be covered for ABD individuals with Medicare, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.
SUD IMD Non-ABD	Hypo 2	X		X	Expenditures for costs of medical assistance that could be covered for non-ABD individuals without Medicare, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.

Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
SUD IMD New Adult	Hypo 2	X		X	Expenditures for costs of medical assistance that could be covered for the Affordable Care Act adult group described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.
SMI IMD ABD	Hypo 3	X		X	Expenditures for costs of medical assistance that could be covered for ABD individuals without Medicare, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.
SMI IMD ABD Duals	Hypo 3	X		X	Expenditures for costs of medical assistance that could be covered for ABD individuals with Medicare, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.
SMI IMD non-ABD	Hypo 3	X		X	Expenditures for costs of medical assistance that could be covered for non-ABD individuals without Medicare, were it not for the IMD prohibition

Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
					under the State Plan, provided to otherwise eligible individuals during a month in an IMD.
SMI IMD New Adult	Hypo 3	X		X	Expenditures for costs of medical assistance that could be covered for the Affordable Care Act adult group described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.
Supportive Housing Assistance Pilot	Hypo 4	X		X	Expenditures for housing supportive services provided to enrollees in the state's Supportive Housing Assistance Pilot.
Maternal Health and Treatment Services	Hypo 5	X		X	Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD or SMI and who are residents at the Lund Home facility.
CRT	Hypo 6	X		X	Expenditures for individuals receiving CRT services.
SUD CIT	Hypo 7	X		X	Expenditures for individuals eligible as part of the SUD CIT

Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
					group (Demonstration Population 9).
VT Global Rx	Hypo 8	X		X	Expenditures for individuals eligible for VPharm cost sharing assistance (Demonstration Populations 7 and 8).
Moderate Needs	Hypo 9	X		X	Expenditures for individuals eligible as part of the CFC Moderate Needs group (Demonstration Population 6).
Marketplace Subsidy	Hypo 10	X		X	Expenditures for the state-funded Marketplace Subsidy Program for individuals at or below 300 percent of the FPL who purchase health care in the Marketplace.
MDAAP	Main			X	Expenditures to conduct MDAAP activities in accordance with the requirements in STC 8.3.
IMD Investments	Main			X	Expenditures for IMD investments phasing down in accordance with STC 11.3.
ADM	N/A				Administrative costs that are directly attributable to the demonstration.
Ind Cost Eff Serv	Main			X	Individually cost-effective services as assessed by the state.
Reentry Services	Hypo 11	X		X	Expenditures for targeted services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days

Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
					immediately prior to release from participating state correctional facilities
Reentry Non-Services	Hypo 11		X	X	Expenditures for planning and supporting the reentry demonstration initiative
HRSN Services	SHAC		X	X	All expenditures for certain HRSN initiatives.
HRSN Infrastructure	SHAC		X	X	All infrastructure expenditures for certain HRSN initiatives.

13.11. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00194/1). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures

subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in section 15, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in section 12, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
ABD Non-Medicare Adult	Report all medical assistance expenditures for non-Medicare adults eligible as ABD under the State Plan	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	10/1/05	12/31/27
ABD Non-Medicare Child	Report all medical assistance expenditures for non-Medicare children eligible as ABD under the State Plan	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	10/1/05	12/31/27
ABD Dual	Report all medical assistance expenditures for ABD adults with Medicare	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	10/1/05	12/31/27
Non-ABD, Non-Medicare Adult	Report all medical assistance expenditures for non-ABD adults who are not in the Affordable Care Act adult group described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	10/1/05	12/31/27

MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
Non-ABD, Non-Medicare Child	Report all medical assistance expenditures for non-ABD children	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	10/1/05	12/31/27
New Adult Group	Report all medical assistance expenditures for the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	1/1/14	12/31/27
Moderate Needs	Report for all expenditures for individuals eligible as part of the Moderate Needs Group.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	10/1/05	12/31/27
VT Global Rx	Report for all expenditures for individuals eligible for VPharm cost sharing assistance (Demonstration Populations 7 and 8)	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	10/1/05	12/31/27

MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
SUD CIT	Report for all expenditures for individuals eligible as SUD Community Intervention and Treatment Group (Demonstration Population 9).	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	1/1/25	12/31/27
Investments	Report for all expenditures labeled investments as described in STC 11.1.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP or ADM	N	10/1/05	12/31/27
Marketplace Subsidy	Report expenditures for the state- funded Marketplace subsidy program for individuals at or below 300 percent of the FPL who purchase health care coverage in the Marketplace.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	N	1/1/14	12/31/27
CRT	Report expenditures for individuals receiving CRT services.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	10/1/05	12/31/27

MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
SUD IMD ABD	Report expenditures for costs of medical assistance that could be covered for ABD individuals without Medicare, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	7/1/18	12/31/27
SUD IMD ABD Duals	Report expenditures for costs of medical assistance that could be covered for ABD individuals with Medicare, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	7/1/18	12/31/27

MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
SUD IMD Non-ABD	Report expenditures for costs of medical assistance that could be covered for non-ABD individuals without Medicare, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.		Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	7/1/18	12/31/27
SUD IMD New Adult	Report expenditures for costs of medical assistance that could be covered for the Affordable Care Act adult group described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	7/1/18	12/31/27

MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
SMI IMD ABD	Report expenditures for costs of medical assistance that could be covered for ABD individuals without Medicare, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	1/1/20	12/31/27
SMI IMD ABD Duals	Report expenditures for costs of medical assistance that could be covered for ABD individuals with Medicare, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	1/1/20	12/31/27

MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
SMI IMD Non-ABD	Report expenditures for costs of medical assistance that could be covered for non-ABD individuals without Medicare, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	1/1/20	12/31/27
SMI IMD New Adult	Report expenditures for costs of medical assistance that could be covered for the Affordable Care Act adult group described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	1/1/20	12/31/27

MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
Maternal Health and Treatment Services	Report expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD or SMI and who are residents at the Lund Home facility.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	Y	7/1/22	12/31/27
Medicaid Data Aggregation and Access Program (MDAAP)	Report expenditures for MDAAP activities in accordance with the requirements in STC 8.3.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	ADM	N	Following approval of the protocol (STC 8.3)	12/31/27
IMD Investments	Report IMD expenditures as described in STC 11.3.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	N	7/1/22	12/31/27
Supportive Housing Assistance Pilot	Report expenditures for housing supportive services provided to enrollees in the state's Supportive Housing Assistance Pilot.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	N	1/1/23	12/31/27

MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
ADM	Administrative costs that are directly attributable to the demonstration.	N/A	Follow standard CMS-64.10 Category of Service Definitions	Date of payment	ADM	N	7/1/22	12/31/27
Ind Cost Eff Serv	Report expenditures for individually assessed cost effective alternative services.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	N	1/1/23	12/31/27
Reentry Services	Expenditures for targeted services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to the expected date of release from participating state correctional facilities	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of service	MAP	N	1/1/26	12/31/27
Reentry Non-Services	Expenditures for planning and supporting the reentry demonstration initiative	N/A	Follow standard CMS-64.10 Category of Service Definitions	Date of service	ADM	N	7/2/24	12/31/27

MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
HRSN Services	Report all expenditures for approved HRSN initiatives	N/A	Follow standard CMS 64.9 or 64.10 Category of Service Definitions	Date of service/ Date of payment	MAP/ ADM	N	01/02/2025	12/31/2027
HRSN Infrastructure	Report all infrastructure expenditures for approved HRSN initiatives	N/A	Follow standard CMS 64.10 Category of Service Definitions	Date of service/ Date of payment	ADM	N	01/02/2025	12/31/2027

13.12. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the Demonstration Years table below.

Demonstration Years		
Demonstration Year 18	July 1, 2022 to December 31, 2022	6 months
Demonstration Year 19	January 1, 2023 to December 31, 2023	12 months
Demonstration Year 20	January 1, 2024 to December 31, 2024	12 months
Demonstration Year 21	January 1, 2025 to December 31, 2025	12 months
Demonstration Year 22	January 1, 2026 to December 31, 2026	12 months
Demonstration Year 23	January 1, 2027 to December 31, 2027	12 months

13.13. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in Section 14. CMS will provide technical assistance, upon request.[4]

13.14. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

13.15. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:

[4] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

a. To be consistent with enforcement of laws and policy statements, including regulations and letters, regarding impermissible provider payments, health care related taxes, or other payments, CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

13.16. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 13.16(c). If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when

the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

    i. Provider rate increases that are anticipated to further strengthen access to care;

    ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

    iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

    iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

    v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

    vi. High cost innovative medical treatments that states are required to cover; or,

    vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

    i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

    ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

14. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

14.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, and a Supplemental HRSN Aggregate Ceiling (SHAC) Test, if applicable, as described below. CMS' assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

14.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in STC 13.10 Master MEG Chart and STC 13.11(f) MEG Detail for Expenditure and Member Month Reporting. If the per capita method is used, the state is at risk for the per capita cost of State Plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

14.3. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

14.4. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that demonstration waivers granted have not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as

"WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the SHAC Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the SHAC amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Main Budget Neutrality Test										
MEG	**PC or Agg***	**WOW Only, WW Only, or BOTH**	**Base Year**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**
ABD Non-Medicare Adult	PC	Both	2019	5.0%	$2,418.16	$2,625.87	$2,804.92	$2,945.17	$3,092.43	$3,247.05
ABD Non-Medicare Child	PC	Both	2019	5.0%	$2,941.11	$3,106.18	$3,291.81	$3,456.40	$3,629.22	$3,810.68
ABD Dual	PC	Both	2019	4.7%	$2,410.41	$2,637.70	$2,836.30	$2,969.60	$3,109.17	$3,255.30
Non-ABD, Non-Medicare Adult	PC	Both	2019	5.3%	$806.56	$867.65	$933.06	$982.51	$1,034.58	$1,089.41
Non-ABD, Non-Medicare Child	PC	Both	2019	5.3%	$613.52	$657.36	$706.93	$744.39	$783.84	$825.38
Investments	Agg	WW Only	2019	5%	The state must have savings to offset these expenditures.					

Main Budget Neutrality Test										
MEG	**PC or Agg***	**WOW Only, WW Only, or BOTH**	**Base Year**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**
MDAAP	Agg	WW Only	N/A	N/A	The state must have savings to offset these expenditures.					
Individually Assessed Cost Effective Alternative Services	Agg	WW Only	2020	N/A	The state must have savings to offset these expenditures.					

*PC = Per Capita, Agg = Aggregate

14.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid State Plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical;" such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid State Plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which

the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

14.6. **Hypothetical Budget Neutrality Test 1: New Adult Group Spending.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Hypothetical Budget Neutrality Test 1										
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**
New Adult Group	PC	Both	2019	5.5%	$594.31	$634.03	$678.82	$716.16	$755.55	$797.11

14.7. **Hypothetical Budget Neutrality Test 2: SUD Expenditures.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Hypothetical Budget Neutrality Test 2										
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**
SUD IMD ABD	PC	Both	2021	5.0%	$3,649.04	$4,799.69	$5,643.30	$5,925.46	$6,221.73	$6,532.82
SUD IMD ABD Duals	PC	Both	2021	4.7%	$2,362.07	$2,898.52	$3,219.01	$3,370.30	$3,528.70	$3,694.55
SUD IMD Non-ABD	PC	Both	2021	5.3%	$3,187.66	$4,300.86	$5,177.19	$5,451.58	$5,740.51	$6,044.76
SUD IMD New Adult	PC	Both	2021	5.5%	$3,298.57	$3,898.38	$4,394.22	$4,635.91	$4,890.89	$5,159.89

14.8. **Hypothetical Budget Neutrality Test 3: SMI/SED Services.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Hypothetical Budget Neutrality Test 3

MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 18 PMPM	DY 19 PMPM	DY 20 PMPM	DY 21 PMPM	DY 22 PMPM	DY 23 PMPM
SMI IMD ABD	PC	Both	2021	5.0%	$49,328.96	$71,597.34	$94,064.64	$98,767.87	$103,706.26	$108,891.57
SMI IMD ABD Duals	PC	Both	2021	4.7%	$33,970.77	$45,310.43	$56,298.68	$58,944.72	$61,715.12	$64,615.73
SMI IMD Non-ABD	PC	Both	2021	5.3%	$31,763.42	$47,357.20	$63,409.53	$66,770.23	$70,309.05	$74,035.43
SMI IMD New Adult	PC	Both	2021	5.5%	$35,489.57	$49,057.73	$63,204.45	$66,680.69	$70,348.13	$74,217.28

14.9. **Hypothetical Budget Neutrality Test 4: Supportive Housing Assistance.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Hypothetical Budget Neutrality Test 4

MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 18 PMPM	DY 19 PMPM	DY 20 PMPM	DY 21 PMPM	DY 22 PMPM	DY 23 PMPM
Supportive Housing Assistance	PC	Both	2024	4.8%	N/A	N/A	$424.95	$445.35	$466.72	$489.13

14.10. **Hypothetical Budget Neutrality Test 5: Maternal Health and Treatment Services.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 5. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Hypothetical Budget Neutrality Test 5										
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 18 PMPM	DY 19 PMPM	DY 20 PMPM	DY 21 PMPM	DY 22 PMPM	DY 23 PMPM
Maternal Health and Treatment Services	PC	Both	2019	1.4%	$9,700.76	$9,801.72	$9,937.96	$10,076.10	$10,216.16	$10,358.16

14.11. **Hypothetical Budget Neutrality Test 6: CRT Services.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 6. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Hypothetical Budget Neutrality Test 6										
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**
CRT Services	PC	Both	2019	4.7%	$5,232.89	$5,483.07	$5,796.71	$6,069.15	$6,354.40	$6,653.06

14.12. **Hypothetical Budget Neutrality Test 7: SUD CIT.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 7. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Hypothetical Budget Neutrality Test 7										
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**

SUD CIT	PC	Both	2025	4.7%	N/A	N/A	N/A	$757.51	$793.87	$831.98

14.13. **Hypothetical Budget Neutrality Test 8: VT Global Rx**. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 8. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Hypothetical Budget Neutrality Test 8										
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**
VT Global Rx	PC	Both	2019	0%	$91.76	$96.56	$99.01	$99.01	$99.01	$99.01

14.14. **Hypothetical Budget Neutrality Test 9: Moderate Needs Group.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 9. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Hypothetical Budget Neutrality Test 9

MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 18 PMPM	DY 19 PMPM	DY 20 PMPM	DY 21 PMPM	DY 22 PMPM	DY 23 PMPM
Moderate Needs Group	PC	Both	2019	4.7%	$865.70	$945.55	$1,003.98	$1,051.16	$1,100.56	$1,152.29

14.15. **Hypothetical Budget Neutrality Test 10: Marketplace Subsidy.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 10. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Hypothetical Budget Neutrality Test 10										
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 18 PMPM	DY 19 PMPM	DY 20 PMPM	DY 21 PMPM	DY 22 PMPM	DY 23 PMPM
Marketplace Subsidy	PC	Both	2019	3.9%	$33.33	$34.29	$35.63	$37.01	$38.45	$39.94

14.16. **Hypothetical Budget Neutrality Test 11: Reentry Demonstration Initiative Expenditures.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 11. MEGs that are designated "WOW Only" or "Both" are the

components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 11 are counted as WW expenditures under the Main Budget Neutrality Test.

Hypothetical Budget Neutrality Test 11										
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend Rate**	**DY 18**	**DY 19**	**DY 20**	**DY 21**	**DY 22**	**DY 23**
Reentry Services	PC	Both	2022	6.3%	N/A	N/A	N/A	N/A	$1,247.82	$1,326.43
Reentry Non-Services	Agg	Both	N/A	$0	N/A	N/A	$750,539	$2,251,617	$0	$0

14.17. **SHAC Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in section 17), CMS considers these expenditures to be "SHAC" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, SHAC expenditures do not need to be offset by savings, and cannot produce savings however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for SHAC expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent SHAC Budget Neutrality Test, which subjects SHAC expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the SHAC Budget Neutrality Test's expenditure limit for a given demonstration year, the difference is not

considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state's SHAC spending exceeds the SHAC Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the SHAC.

14.18. **SHAC Budget Neutrality Test: HRSN.** The table below identifies the MEGs that are used for the SHAC Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the SHAC Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the SHAC Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

SHAC Budget Neutrality Test								
MEG	**Agg**	**WOW Only, WW Only, or Both**	**DY 18**	**DY 19**	**DY 20**	**DY 21**	**DY 22**	**DY 23**
HRSN Services	Agg	Both	N/A	N/A	N/A	$3,605,889	$34,250,425	$35,033,376
HRSN Infrastructure	Agg	Both	N/A	N/A	N/A	$5,466,727	$5,466,727	N/A

14.19. **Composite Federal Share Ratios.** The Composite Federal Share is the ratio that will be used to covert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through the MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Hypothetical Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

14.20. **Exceeding Budget Neutrality.** CMS will enforce budget neutrality agreement over the life of the demonstration, which extends from July 1, 2022 to December 31, 2027. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward savings, that is, net savings from up to 10 years of the immediately prior demonstration approval period(s) (01/01/2012 to 12/31/2022). If at the end of the demonstration approval period the Main Budget Neutrality Test or a SHAC Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test will be based on the time lapsed through the termination date.

14.21. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Budget Neutrality Test Corrective Action Plan Calculation		
Demonstration Year	**Cumulative Target Definition**	**Percentage**
DY 18	Cumulative budget neutrality limit plus:	2.0 percent
DY 18 through DY 19	Cumulative budget neutrality limit plus:	1.5 percent
DY 18 through DY 20	Cumulative budget neutrality limit plus:	1.0 percent
DY 18 through DY 21	Cumulative budget neutrality limit plus:	0.5 percent

DY 18 through DY 22	Cumulative budget neutrality limit plus:	0.0 percent
DY 18 through DY 23	Cumulative budget neutrality limit plus:	0.0 percent

15. EVALUATION OF THE DEMONSTRATION

15.1. **Independent Evaluator.** The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved, draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

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

15.3. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic) – as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 15.5 and 15.6.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amended Evaluation Design must also be reflected in the state's Interim (as applicable) and Summative Evaluation Reports, described below.

a. **Evaluation Design of PHE flexibilities for Medicaid beneficiaries.** The state has submitted an Evaluation Design to CMS to reflect the December 3, 2020 amendment approval that allows flexibilities during public health emergencies. CMS approved this Evaluation Design on March 29, 2021. CMS provided guidance on an Evaluation Design specifically for the flexibilities approved for the public health emergency. The state posted its Evaluation Design to the state's website within 30 days of CMS approval of the Evaluation Design, per 42 CFR 431.424(e). The state will test whether and how the approved flexibilities affect the state's response to the public health emergency. To that end, the state will use research questions that pertain to the approved flexibilities. The evaluation will also assess cost-effectiveness by tracking administrative costs and health services expenditures for demonstration beneficiaries and assessing how these outlays affected the state's response to the public health emergency.

15.4. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as Attachment O of these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in monitoring reports.

15.5. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment

and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP; Consumer Assessment of Health Care Providers and Systems (CAHPS); the Behavioral Risk Factor Surveillance System (BRFSS) survey; and/or measures endorsed by National Quality Forum (NQF).

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policy components, including but not limited to beneficiary experiences with access to and quality of care. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration components in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—or barriers to—successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Evaluation of the Reentry Demonstration Initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the Reentry Demonstration Initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination; connections between correctional and community services; access to and quality of care in correctional and community settings; preventive and routine physical and behavioral health care utilization; non-emergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

The state must also provide a comprehensive analysis of the distribution of services rendered by type of service over the duration of up to 90-days coverage period before the individual's expected date of release—to the extent feasible—and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes, including utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning; enabled pre-release management and stabilization of clinical, physical, and behavioral health conditions; and helped mitigate any potential

operational challenges the state might have otherwise encountered in a more compressed timeline for coverage of pre-release services.

The demonstration's evaluation efforts will be expected to include the experiences of correctional and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

Evaluation hypotheses for the HRSN component of the demonstration (as described in section 17 of these STCs) must focus on areas such as assessing the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on the prevalence and severity of beneficiaries' HRSNs and the provision of and beneficiary utilization of HRSN services. Furthermore, the HRSN evaluation must include analysis of how the initiatives affect utilization of preventive and routine care; utilization of and costs associated with potentially avoidable, high-acuity health care; utilization of hospital and institutional care; and beneficiary physical and mental health outcomes.

In addition, the state must coordinate with its managed care plans to secure necessary data—for a representative beneficiary population eligible for the HRSN services—to conduct a robust evaluation of the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such an assessment will require setting up a data infrastructure and/or data sharing arrangement to collect data on beneficiary screening and rescreening and prevalence and severity of beneficiaries' HRSNs, among others. If the data system is not operational to capture necessary data for a quantitative evaluation by the time the state's evaluation activities must be conducted, the state must provide applicable qualitative assessment to this effect leveraging suitable primary data collections efforts (e.g., beneficiary surveys).

Hypotheses must be designed to help understand, in particular, the impacts of the HRSN services provided in the demonstration on beneficiary health outcomes and experience. In alignment with the demonstration's objectives to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access to and, quality of care, or health outcomes at the individual, population, and/or community level.

The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must also examine whether and how local investments in housing supports, change over time in concert with new Medicaid funding toward those services. In addition, in light of how demonstration HRSN expenditures are being treated

for purposes of budget neutrality, the evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates and of providing such services. Evaluation of the HRSN initiative is also required to include a robust assessment of potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

Hypotheses must cover all components of demonstration. Hypotheses for the SUD program must include an assessment of the objectives of the SUD component of this section 1115 demonstration. Examples include (but are not limited to): initiation and compliance with treatment, utilization of health services (emergency department and inpatient hospital settings), and a reduction in key outcomes such as deaths due to overdose. Hypotheses for the SMI program must include an assessment of the objectives of the SMI component of this 1115 demonstration. Examples include (but are not limited to): utilization and length of stay in emergency departments, reductions in preventable readmissions to acute care hospitals and residential settings, availability of crisis stabilization services, and care coordination. Hypotheses related to the Maternal Health and Treatment Services should not only address the appropriate SUD and SMI treatment and quality of care goals but should also address the specific maternal health outcomes and goals of this program. For example, they should address how the extended residential component and family-centered model contributes to achieving the goals of improved retention in treatment, lower child custody rates, and improved psychosocial outcomes for the family. Hypotheses for premiums include an assessment of the outcomes of the premium component of this 1115 demonstration. Examples include (but are not limited to) the following outcomes: beneficiary familiarity with premiums as a feature of commercial coverage and likelihood of enrollment and enrollment continuity. Hypotheses for the waiver of retroactive eligibility must include an assessment of the outcomes of the retroactive eligibility component of this section 1115 demonstration. Examples include (but are not limited to) the following outcomes: likelihood of enrollment and enrollment continuity, enrollment when people are healthy, and health status (as a result of greater enrollment continuity). Hypotheses for investments must reflect appropriate goals for each area of investments as described in STC 11.1 and broadly assess whether they collectively contribute to the goals of the demonstration, such as the reduction of disparities in health outcomes.

15.6. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for extension, the Evaluation Report should be posted to the state's website with the application for public comment.

a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, the Interim Evaluation Report

must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state made changes to the demonstration in its application for extension, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting an extension for a demonstration, an Interim Evaluation report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit a revised Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's website.

15.7. **Summative Evaluation Report.** The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Reports) of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's approval period within 18months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit a revised Summative Evaluation Report within 60calendar days of receiving comments from CMS on the draft.

b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 calendar days of approval by CMS.

c. Final Report, PHE flexibilities for Medicaid beneficiaries. The final report will consolidate Monitoring and Evaluation reporting requirements for flexibilities during public health emergencies approved in STC 6.3(e). The state must submit this final report no later than one year after the end of the public health emergency flexibilities. The final report will capture data on the demonstration implementation, lessons learned, and best practices for similar situations. The state will be required to track separately all expenditures associated with these flexibilities, including but not limited to, administrative costs and program expenditures. CMS will provide additional guidance on the structure and content of the final report.

Should the approval period of this flexibility exceed one year, for each year of the demonstration that the state is required to complete per the annual report required under 42 CFR 431.428(a), the state may submit that information in the Final Report.

15.8. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

15.9. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation reports, and/or the Summative Evaluation Report. Presentations may be conducted remotely.

15.10. **Public Access**. The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30calendar days of approval by CMS.

15.11. **Additional Publications and Presentations.** For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 10 business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

15.12. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim

administrative match for these activities. This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable – in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 12.5.

16. REENTRY DEMONSTRATION INITIATIVE

16.1. **Overview of Pre-Release Services and Program Objectives.** This component of the demonstration will provide coverage for pre-release services up to 90 days immediately prior to the expected date of release to qualifying Medicaid individuals who are residing in a state correctional facility as specified in STC 16.5, the implementation timeline in STC 16.9, and the implementation plan in STC 16.10.

16.2. The objective of this component of the demonstration is to facilitate individuals' access to certain healthcare services and case management, provided by Medicaid participating providers, while individuals are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to their communities. This bridge to coverage begins within a short time prior to release and is expected to promote continuity of coverage and care and improve health outcomes for justice-involved individuals. The Reentry Demonstration Initiative provides short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other Substance Use Disorder (SUD) and behavioral health treatments, as appropriate for the individual.

During the demonstration, the state seeks to achieve the following goals:

a. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release;

b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;

c. Improve coordination and communication between correctional systems, Medicaid systems, and community-based providers;

d. Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release;

e. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs, and health-related social needs.

f. Reduce all-cause deaths in the near-term post-release;

g. Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid individuals through increased receipt of preventive and routine physical and behavioral health care;

h. Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release;

i. Lower rates of recidivism;

j. Address systemic inequities in the justice system, and;

k. Improve overall long-term health outcomes for populations that have been incarcerated.

16.3. **Qualifying Criteria for Pre-Release Services.** To qualify to receive services under this component of the demonstration, an individual must meet the following qualifying criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a correctional facility specified in STC 16.5;

b. Be enrolled in Medicaid; and

c. Have a post-adjudication disposition.

16.4. **Scope of Pre-Release Services**. The pre-release services authorized under the Reentry Demonstration Initiative include the following services to be detailed in the implementation plan required under STC 16.10. Contingent upon CMS's approval of the state's Reentry Demonstration Initiative, the state anticipates starting to make expenditures for such services no later than January 1, 2026.

a. The covered pre-release services are:

i. Case management to assess and address physical and behavioral health needs, and health-related social needs;

ii. MAT for all types of SUDs as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies;

iii. A 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid state plan coverage authority and policy;

iv. Prescribed drugs, in addition to MAT and the 30-day supply of prescription medications described above and medication administration;

v. Peer support services;

vi. Treatment for Hepatitis C; and

vii. Screening for common health conditions.

b. The expenditure authority for pre-release services through this initiative constitutes a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the Reentry Demonstration Initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule, effective January 1, 2025, remain subject to the inmate exclusion rule. Accordingly, other benefits and services covered under the Vermont Medicaid State Plan, as relevant, that are not included in the above-described pre-release services benefit for qualifying Medicaid individuals are not available to qualifying individuals through the Reentry Demonstration Initiative.

16.5. **Participating Correctional Facilities**. The pre-release services will be provided at correctional facilities, or outside of the correctional facilities, with appropriate transportation and security oversight provided by the correctional facility, subject to AHS approval of a facility's readiness, according to the implementation timeline described in STC 16.9. Correctional facilities that are also institutions for mental diseases (IMDs) are not allowed to participate in the Reentry Demonstration Initiative.

16.6. **Participating Providers**.

a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under Vermont scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws, and must be enrolled as a Medicaid provider.

b. Participating providers eligible to deliver services under the Reentry Demonstration Initiative may be either community-based or correctional facility-based providers.

c. All participating providers and provider staff, including correctional providers, shall have necessary experience and receive appropriate training, as applicable to a given correctional facility, prior to furnishing demonstration-covered pre-release services under the Reentry Demonstration Initiative.

d. Participating providers of reentry case management services may be community-based or correctional providers who have expertise working with justice-involved individuals.

16.7. **Suspension of Coverage**. Upon entry of a Medicaid enrolled individual into a correctional facility, AHS must not terminate and generally shall suspend their Medicaid coverage.

a. If an individual is not enrolled in Medicaid when entering a correctional facility, the state must ensure that such an individual receives assistance with completing an application for Medicaid and with submitting an application, unless the individual declines such assistance or wants to decline enrollment.

16.8. **Interaction with Mandatory State Plan Benefits for Eligible Juveniles and Targeted Low-Income Children.** To the extent Vermont's reentry demonstration includes coverage otherwise required to be provided under section 1902(a)(84)(D) and section 2102(d)(2) of the Act, and because this coverage is included in the base expenditures used to determine the budget neutrality or allotment neutrality expenditure limit, the state will claim for these expenditures and related transitional non-service expenditures under this demonstration as well as include this coverage in the monitoring and evaluation of this demonstration.

16.9. **Reentry Demonstration Initiative Implementation Timeline**. Delivery of pre-release services under this demonstration will be implemented as described below. All participating correctional facilities must demonstrate readiness, as specified below, prior to participating in this initiative (FFP will not be available in expenditures for services furnished to qualifying individuals who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). AHS will determine that each applicable facility is ready to participate in the Reentry Demonstration Initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

a. Pre-release Medicaid application and enrollment processes for individuals who are not enrolled in Medicaid prior to incarceration and who do not otherwise become enrolled during incarceration;

b. The screening process to determine an individual's qualification for pre-release services, per the eligibility requirements described in STC 16.3;

c. The provision or facilitation of pre-release services for a period of up to 90 days immediately prior to the expected date of release, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth, as applicable.

d. Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to,

physical and behavioral health community-based providers and the state Medicaid agency.

e. Appropriate reentry planning, pre-release case management, and assistance with care transitions to the community, including connecting individuals to physical and behavioral health providers, and making referrals to case management and community supports providers throughout the 90-day pre-release period, and providing individuals with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply as clinically appropriate) upon release, consistent with approved Medicaid state plan coverage authority and policy;

f. Operational approaches related to implementing certain Medicaid requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the Reentry Demonstration Initiative;

g. A data exchange process to support the care coordination and transition activities described in (d), (e), and (f) of this subsection subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

h. Reporting of data requested by AHS to support program monitoring, evaluation, and oversight; and

i. A staffing and project management approach for supporting all aspects of the facility's participation in the Reentry Demonstration Initiative, including information on qualifications of the providers with whom the correctional facilities will partner for the provision of pre-release services.

16.10. **Reentry Demonstration Initiative Implementation Plan**. The state is required to submit a Reentry Demonstration Initiative Implementation Plan in alignment with the expectations outlined in the State Medicaid Director Letter (#23-003 Opportunities to Test Transition-Related Strategies to Support Community Reentry and Improve Care Transitions for Individuals who are Incarcerated). As such, the implementation plan will identify for each milestone, as well as each associated action, what the state anticipates to be the key implementation challenges and the state's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

The state must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the Reentry Demonstration Initiative. The state must submit any required clarifications or revisions to its draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. Once approved, the finalized Implementation Plan will be incorporated into the STCs as Attachment V titled "Reentry

Demonstration Initiative Implementation Plan," and may be revised only with CMS approval.

CMS will provide the state with a template to support developing the Implementation Plan.

16.11. **Reentry Demonstration Initiative Reinvestment Plan**. To the extent that the Reentry Demonstration Initiative covers services that are the responsibility of and were previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals, the state must reinvest all new federal dollars, equivalent to the amount of FFP projected to be expended for such services, as further defined in the Reentry Demonstration Initiative Reinvestment Plan (Attachment W). The Reinvestment Plan will define the amount of reinvestment required over the term of the demonstration, based on an assessment of the amount of projected expenditures for which reinvestment is required pursuant to this STC. FFP projected to be expended for new services covered under the Reentry Demonstration Initiative, defined as services not previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals prior to the facility's implementation of the Reentry Demonstration Initiative (including services that are expanded, augmented, or enhanced to meet the requirements of the Reentry Demonstration Initiative, with respect to the relevant increase in expenditures, as described in Attachment W the Reentry Demonstration Initiative Reinvestment Plan), is not required to be reinvested pursuant to this STC.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments include, but are not limited to:

    i. The state share of funding associated with new services covered under the Reentry Demonstration Initiative, as specified in this STC;

    ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the needs of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

    iii. Improved access to and/or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the Reentry Demonstration Initiative opportunity;

    iv. Improved health information technology (IT) and data sharing subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

vi. Expanded or enhanced community-based services and supports, including services and supports to meet the needs of the justice-involved population; and

vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b. The reinvestment plan will describe whether privately-owned or -operated carceral facilities would receive any of the reinvested funds and, if so, the safeguards the state proposes to ensure that such funds are used for the intended purpose and do not have the effect of increasing profit or operating margins for privately-owned or -operated carceral facilities.

c. Within six months of approval, the state will submit a Reentry Demonstration Initiative Reinvestment Plan (Attachment W) for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan will also identify the types of expected reinvestments that will be made over the demonstration period. Actual reinvestments will be reported to CMS in Attachment W titled "Reentry Demonstration Initiative Reinvestment Plan."

16.12. **Reentry Demonstration Initiative Planning and Implementation.**

a. The Reentry Demonstration Initiative Planning and Implementation Program will provide expenditure authority to fund supports needed for Medicaid pre-release application and suspension/unsuspension planning and purchase of certified electronic health record (EHR) technology to support Medicaid pre-release applications. In addition, Reentry Demonstration Initiative planning and implementation funds will provide funding over the course of the demonstration to support planning and IT investments that will enable implementation of the Reentry Demonstration Initiative services covered in a period for up to 90 days immediately prior to the expected date of release, and for care coordination to support reentry. These investments will support collaboration and planning among AHS and Qualified Applicants listed in STC 16.12(d) below. The specific use of this funding will be proposed by the qualified applicant submitting the application, as the extent of approved funding will be determined according to the needs of the entity. Allowable expenditures are limited to only those that support Medicaid-related expenditures and/or demonstration-related expenditures (and not other activities or staff in the correctional facility) and must be properly cost-allocated to Medicaid. These allowable expenditures may include the following:

i. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants that are to be used for assisting the Reentry Demonstration Initiative population with Medicaid application and enrollment for demonstration coverage. This includes the development of electronic interfaces for Qualified Applicants listed in STC 16.12(d). to communicate with Medicaid IT systems to support Medicaid enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with Qualified Applicants listed in STC 16.12(d), in order to support the provision of pre-release services delivered in the period up to 90 days immediately prior to the expected date of release and reentry planning.

ii. **Hiring of Staff and Training.** Expenditures for Qualified Applicants listed in STC 16.12(d). to recruit, hire, onboard, and train additional and newly assigned staff to assist with the coordination of Medicaid enrollment and suspension/unsuspension, as well as the provision of pre-release services in a period for up to 90 days immediately prior to the expected date of release and for care coordination to support reentry for justice-involved individuals. Qualified Applicants may also require training for staff focused on working effectively and appropriately with justice-involved individuals.

iii. **Adoption of Certified Electronic Health Record Technology.** Expenditures for providers' purchase or necessary upgrades of certified electronic health record (EHR) technology and training for the staff that will use the EHR.

iv. **Purchase of Billing Systems**. Expenditures for the purchase of billing systems for Qualified Applicants.

v. **Development of Protocols and Procedures**. Expenditures to support the specification of steps to be taken in preparation for and execution of the Medicaid enrollment process, suspension/unsuspension process for eligible individuals, and provision of care coordination and reentry planning for a period for up to 90 days immediately prior to the expected date of release for individuals qualifying for Reentry Demonstration Initiative services.

vi. **Additional Activities to Promote Collaboration**. Expenditures for additional activities that will advance collaboration among Vermont's Qualified Applicants in STC 16.12(d). This may include conferences and meetings convened with the agencies, organizations, and other stakeholders involved in the initiative.

vii. **Planning**. Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identifying individuals who are potentially eligible for Medicaid; (2) assisting with the completion of a Medicaid application; (3) submitting the Medicaid application to the state Medicaid agency or coordinating suspension/unsuspension; (4) screening for eligibility for pre-release services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering

necessary services to eligible individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing on-going oversight and monitoring process upon implementation.

viii. **Other activities to support a milieu appropriate for provision of pre-release services.** Expenditures to provide a milieu appropriate for pre-release services in a period for up to 90 days immediately prior to the expected date of release, including accommodations for private space such as movable screen walls, desks, and chairs, to conduct assessments and interviews within correctional institutions, and support for installation of audio-visual equipment or other technology to support provision of pre-release services delivered via telehealth in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry. Expenditures may not include building, construction, or refurbishment of correctional facilities.

b. The state may claim FFP in Reentry Demonstration Initiative Planning and Implementation Program expenditures for no more than the annual amounts outlined in Table 1. In the event that the state does not claim the full amount of FFP for a given demonstration year as defined in STC 13.12, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 1: Annual Limits of Total Computable Expenditures for Reentry Demonstration Initiative Planning and Implementation Program

	DY 20	DY 21	DY 22	DY 23
Total Computable Expenditures	$750,539	$2,251,617	$0	$0

c. Reentry Demonstration Initiative Planning and Implementation funding will receive the applicable administrative match for the expenditure.

d. Qualified Applicants for the Reentry Demonstration Initiative Planning and Implementation Program will include the state Medicaid Agency, correctional facilities, other state agencies supporting carceral health, Probation Offices, and other entities as relevant to the needs of justice-involved individuals, including health care providers, as approved by the state Medicaid agency.

17. HEALTH-RELATED SOCIAL NEEDS (HRSN)

17.1. **Health-Related Social Needs (HRSN) Services.** The state may claim FFP for expenditures for certain qualifying HRSN services identified in STC 17.2 and Attachment Y, subject to the restrictions described below. Expenditures are limited to expenditures for items and services not otherwise covered under Title XIX, but consistent with Medicaid demonstration objectives that enable the state to continue to increase the

efficiency and quality of care. All HRSN interventions must be evidence-based and clinically appropriate for the population of focus based on clinical and social risk factors. The state is required to align clinical and health-related social risk criteria across services and with other relevant, non-Medicaid social support agencies, to the extent possible and appropriate. The HRSN services may not supplant any other available funding sources such as housing supports available to the beneficiary through other local, state, or federal programs. The HRSN services will be the choice of the beneficiary; a beneficiary can opt out of HRSN services anytime; and the HRSN services do not absolve the state or its managed care plans, as applicable, of their responsibilities to make payment for other covered services. Under no circumstances will the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on a beneficiary's receipt of HRSN services. The state must submit additional details on covered services as outlined in STC 17.10 (Service Delivery) and Attachment Y.

17.2. **Allowable HRSN services**. The state may cover the following HRSN services:

a. Housing Interventions, including:

i. Housing supports without room and board, including:

1. One-time transition and moving costs other than rent, to assist with identifying, coordinating, securing, or funding one-time necessary services and modifications to help a person establish a basic household (e.g., security deposit, application and inspection fees, utilities activation fees and payment in arrears as necessary to re-establish utility service (capped at a total of six months of total arrear and prospective payments), movers, relocation expenses, pest eradication, pantry stocking (up to 30 days of food), cooking supplies, and the purchase of household goods and furniture). Allowable utilities include water, garbage, sewage, recycling, gas, electric, internet, and phone services. This does not include clothing.

ii. Home remediations that are medically necessary, including, for example, air filtration devices, air conditioning, ventilation improvements, humidifiers, refrigeration for medication, carpet replacement, mold and/or pest removal, and/or housing safety inspections.

iii. Home/environmental accessibility modifications, including, for example, wheelchair accessibility ramps, handrails, and grab bars.

iv. Episodic housing interventions with clinical services with room and board, limited to a clinically appropriate amount of time, including:

1. Short-term recuperative care, where integrated, clinically oriented recuperative or rehabilitative services and supports are provided for individuals who require ongoing monitoring and continuous access to medical care.

v. Room and board-only supports (also referred to as "rent-only" supports or interventions), limited to a clinically appropriate amount of time, including:

1. Short-term rental assistance with room alone or with room and board together, without clinical services included in the rental assistance payment.

17.3. **HRSN Intervention Duration and Frequency.**

a. Housing interventions with room and board.

i. Housing interventions that are classified as episodic interventions, as described in STC 17.2(a)(iv) may be covered for a qualifying beneficiary, as clinically appropriate, up to a combined 6 months per rolling year. For purposes of this demonstration, rolling year is defined as a continuous 12-month period with the start date beginning when the beneficiary begins receiving the service.

ii. Housing interventions that are classified as room and board-only support, as described in STC 17.2(a)(v), may be covered for a qualifying beneficiary up to a combined 6 months per household per demonstration period.

iii. For each of these 6-month caps, coverage will be permitted in one or more spans or episodes, as long as the total duration remains under the cap for the rolling year or demonstration period. CMS will also apply a total combined cap of 6 months for all types of HRSN housing interventions with room and board (including episodic interventions and room and board-only supports), per beneficiary, in any 12-month period. However, if a beneficiary is considered to have received room and board-only support because that intervention was covered for another member of the beneficiary's household as specified in STC 17.2(a)(v), the beneficiary still may receive up to 6 months of coverage for episodic interventions in the same 12-month period without violating this STC.

b. The state will define other HRSN service duration limitations in Attachment Y, subject to CMS approval as indicated in STC 17.7.

17.4. **Excluded Services.** Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:

a. Construction (bricks and mortar) except as needed for approved medically necessary home modifications specified in STC 17.2;

b. Capital investments;

c. Room and board outside of specifically enumerated care or housing transitions or beyond 6 months, except as specified in STC 17.2 and 17.3;

d. Research grants and expenditures not related to monitoring and evaluation;

e. Services furnished to beneficiaries for which payment is not available under the inmate payment exclusion in the matter following the last numbered paragraph of section 1905(a) of the Act except case management of HRSN services provided as part of an approved reentry demonstration initiative;

f. Services provided to individuals who are not lawfully present in the United States;

g. Expenditures that supplant services and/or activities funded by other local, state and/or federal governmental entities;

h. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and

i. Any other projects or activities not specifically approved by CMS as qualifying for demonstration coverage as a HRSN item or service under this demonstration.

i. For all HRSN housing interventions with room and board, the following setting exclusions apply: Congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, and facilities without private sleeping space.

17.5. **HRSN Infrastructure.**

a. The state may claim FFP for expenditures for infrastructure investments to support the development and implementation of HRSN services, subject to STC 17.3. This FFP will be available for the following activities:

i. Technology – e.g., electronic referral systems, shared data platforms, electronic heath record (EHR) modifications or integrations, screening tool and/or case management systems, licensing, databases/data warehouses, data analytics and reporting, data protections and privacy, and accounting and billing systems.

ii. Development of business or operational practices – e.g., developing policies, procedures and workflows, training and technical assistance, and administrative activities to support or expand HRSN operations.

iii. Workforce development – e.g., recruiting and hiring, salary and fringe benefits for staff, necessary certifications, cultural competency training, trauma-informed training, developing and training staff on new policies and procedures, and training materials.

iv. Outreach, education, and interested parties convening – e.g., design and

production of outreach and education materials, translation, obtaining community input, and interested parties convening and community engagement activities.

b. The state may claim FFP for HRSN infrastructure expenditures for no more than the annual amounts outlined in Table 2. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years, not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table 2. Annual Limits of Allowable Total Computable Expenditures for HRSN Infrastructure							
	DY 18	**DY 19**	**DY 20**	**DY 21**	**DY 22**	**DY 23**	**Total**
Total Computable Expenditures	N/A	N/A	N/A	$5,466,727	$5,466,727	N/A	$10,933,453

c. Infrastructure expenditures will receive the FFP match for applicable administrative costs for the expenditure.

d. This infrastructure funding is separate and distinct from payments for delivery of HRSN services. The state must ensure that HRSN infrastructure expenditures described in STC 17.5 are not included in HRSN service payments (including capitation payments, as applicable) and that there is no duplication of payments to entities providing or administering HRSN service benefits.

e. The state may not claim any FFP in HRSN infrastructure expenditures until Attachment AA is approved, as described in STC 17.9. Once approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the beginning of when the demonstration expenditure authority for HRSN infrastructure was approved.

f. To the extent the state requests any additional infrastructure funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS's consideration.

17.6. **Covered Populations.** Expenditures for HRSN services may be made for the populations of focus specified in Attachment Y, consistent with this STC. To qualify to receive coverage for HRSN services, individuals must be Medicaid-eligible and have a documented medical/clinical need for the services and the services must be determined medically/clinically appropriate, as described in STC 17.1, to address the documented need. Medical appropriateness must be based on clinical and health-related social risk factors. This determination must be documented in the beneficiary's care plan or medical record. Additional detail, including the clinical and other health related-social needs criteria, is outlined in Attachment Y. Attachment Z, the HRSN Service Matrix, describes the full list of clinical and social risk factors the state

anticipates incorporating into Attachment Y over the course of the demonstration at the time of the demonstration approval of the expenditure authority for HRSN services. While Attachment Z reflects the full list of clinical and social risk factors the state is authorized to implement, the state is not required to implement all of the clinical and social risk factors outlined in Attachment Z. Additionally, the state can later include additional clinical and social risk factors in compliance with STCs 17.7 and 17.8.

17.7. **Protocol for Assessment of Beneficiary Eligibility and Needs, and Provider Qualifications for HRSN Services.** The state must submit, for CMS approval, a Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications to CMS no later than 90 days after approval of the HRSN expenditure authority. The protocol must include, as appropriate, a list of the HRSN services and service descriptions, the criteria for defining a clinically appropriate population of focus for each service, the process by which those criteria will be applied including care plan requirements and/or other documented processes, and provider qualification criteria for each service. Any changes to the initial scope of clinical and social risk factors reflected in Attachment Z must be effectuated through the process indicated in STC 17.8. The state must resubmit a revised protocol if required by CMS feedback on the initial submission. The state may not claim FFP for HRSN services until CMS approves the initial protocol. Once the initial protocol is approved, the state can claim FFP in expenditures for HRSN services retrospectively to the date of approval of the expenditure authority for HRSN services. The approved protocol will be appended to the STCs as Attachment Y.

If the state adds new HRSN services beyond those specified in STC 17.2 through a demonstration amendment, the state must also submit revisions to the Protocol to CMS no later than 90 days after the approval of the amendment to the demonstration. The Protocol revisions must include a list of the new services and service descriptions provided through all delivery systems applicable, the criteria for defining a clinically appropriate population of focus for each new service, the process by which those criteria will be applied including service plan requirements and/or other documented processes, and provider qualification criteria for each new service. This revised protocol must comply with applicable STCs.

Specifically, the protocol must include the following information:

a. A list of the covered HRSN services (not to exceed those allowed under STC 17.2), with associated service descriptions and service-specific provider qualification requirements.

b. A description of the process for identifying beneficiaries with health-related social needs, including outlining beneficiary qualifications, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.

c. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may determine the service to be clinically appropriate.

i. Plan to identify medical appropriateness based on clinical and social risk factors.

ii. Plan to publicly maintain these clinical and social risk criteria to ensure transparency for beneficiaries and other interested parties.

d. A description of the process for developing care plans based on assessment of need.

i. Plan to initiate care plans and closed-loop referrals to social services and community providers based on the outcomes of screening.

ii. Description of how the state will ensure that HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma informed, as appropriate.

17.8. **Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services:**

a. The state may choose to cover a subset of the HRSN services and/or beneficiary qualifying criteria specified in Attachments Y and Z. Certain changes to the state's service offerings and qualifying criteria, within what CMS has approved in Attachment Z, do not require additional CMS approval. The state must follow the following process to notify CMS of any such HRSN service or qualifying criteria change in Attachment Y by the following process:

i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.

ii. The state must provide public notice.

iii. The state must submit a letter to CMS no less than 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.

b. In addition to the requirements in a. above, if the state seeks to implement additional clinical and/or social risk factors than what are included in approved Attachment Z, the state must follow the process below to update the protocol:

i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and/or social risk factors through the protocol process described in this STC if CMS determines the criteria are allowable and doing so would not require an increase to the amount of the state's HRSN expenditure authority in STC 14.18.

ii. The state must receive CMS approval for the updated protocol prior to implementation of changes under this STC 17.8(b).

iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process outlined in this STC 17.8(b). This restriction is not applicable to the process and scope of changes outlined in STC 17.8(a).

17.9. **HRSN Infrastructure Protocol.** The state must submit, for CMS approval, an HRSN Infrastructure Protocol to CMS no later than 90 days after approval of the expenditure authority for HRSN infrastructure expenditures. The protocol must include the state's proposed uses of HRSN infrastructure funds. The state must resubmit the revised protocol as may be required by CMS feedback on the initial submission. The protocol may be updated as details are changed or added. The state may not claim FFP for HRSN infrastructure expenditures until CMS approves the protocol. Once the protocol is approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the date of approval of the expenditure authority for HRSN infrastructure. The approved protocol will be appended to the STCs as Attachment AA: HRSN Infrastructure Protocol. If the state adds new HRSN services through a demonstration amendment, the state must submit revisions to the Protocol to CMS no later than 90 days after approval, if required based on changes to expenditures for HRSN infrastructure to support the newly added HRSN services. The revisions must include a list of proposed uses of HRSN infrastructure funds, if different than previously submitted.

Specifically, the protocol(s) must include the following information: Proposed uses of HRSN infrastructure expenditures, including the type of entities to receive funding, the intended purpose of the funding, the projected expenditure amounts, and an implementation timeline.

17.10. **Service Delivery.** HRSN services will be provided through Vermont's managed care-like model and delivered by HRSN service providers. Terms applicable to all HRSN services:

a. When HRSN services are provided to beneficiaries enrolled in Medicaid managed care, the following terms will apply:

i. HRSN services can be provided by Vermont's managed care-like model acting as a non-risk PIHP and paid on a non-risk basis. HRSN services must be appropriately included in contracts.

ii. The managed care plan contracts must clearly document the process and methodology for non-risk payments.

iii. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports on the inclusion of HRSN services in managed care programs.

iv. All expenditures for HRSN services delivered under non-risk contracts must be excluded from MLR reporting.

b. CMS expects the state to have appropriate encounter data associated with each HRSN service. This is necessary to ensure appropriate fiscal oversight for HRSN services as well as monitoring and evaluation. This is also critical to ensure appropriate base data for Medicaid managed care rate development purposes as well as appropriate documentation for claims payment in managed care. Therefore, CMS requires that for HRSN services provided in a managed care delivery system, the state must include the name and definition of each HRSN service as well as the coding to be used on claims and encounter data in the managed care plan contracts. For example, the state must note specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology costs that identify each HRSN service. CMS will also consider this documentation necessary for approval of any rate methodologies per STC 17.18.

17.11. **Phased In Implementation of HRSN Services.** As further discussed in the state's Implementation Plan as required in STC 17.22, the state will phase in HRSN services on the following schedule:

a. No sooner than January 1, 2025, services described in STCs 17.2(a)(i)-(iii) will be provided in the state.

b. No sooner than January 1, 2026, services in STCs 17.2(a)(iv)-(v) will be provided in the state.

17.12. **Contracted Providers.** Managed care plan contracts must provide, applicable to all HRSN services:

a. Managed care plans will contract with providers to deliver the HRSN services authorized under the demonstration and included in the managed care contract.

b. Managed care plans must establish a network of providers and ensure the HRSN service providers have sufficient experience and training in the provision of the HRSN services being offered. HRSN service providers do not need to be licensed, however, staff offering services through HRSN service providers must be licensed when applicable (i.e., when the staff member is performing activities for which a licensure requirement applies in the state).

c. The managed care plan and contracted providers will use rates set by the state for the provision of applicable HRSN services, consistent with state guidance for these services, and in compliance with all related federal requirements.

17.13. **Provider Network Capacity.** Managed care plan contracts must ensure the HRSN services authorized under the demonstration are provided to qualifying beneficiaries in a timely manner and shall develop policies and procedures outlining the managed care plan's approach to managing provider shortages or other barriers to timely provision of the HRSN services, in accordance with the managed care plan contracts and other state Medicaid/operating agency guidance.

17.14. **Compliance with Federal Requirements.** The state shall ensure HRSN services are delivered in accordance with all applicable federal statutes and regulation.

17.15. **Person Centered Plan.** The state shall ensure there is a person-centered service plan for each beneficiary receiving HRSN services that is person-centered, identifies the beneficiary's needs and individualized strategies and interventions for meeting those needs, and developed in consultation with the beneficiary and the beneficiary's chosen support network, as appropriate. The service plan must be reviewed and revised as appropriate at least every 12 months, when the beneficiary's circumstances or needs change significantly, or at the beneficiary's request.

17.16. **Conflict of Interest.** The state shall ensure appropriate protections against conflicts of interest in HRSN service planning and delivery, including by ensuring that appropriate separation of service planning and service provision functions is incorporated into the state's conflict of interest policies.

17.17. **CMS Approval of Managed Care Contracts.** As part of the state's submission of associated managed care plan contracts to implement HRSN services through managed care, the state must include contract requirements including, but not limited to:

a. Beneficiary and plan protections, including but not limited to:

i. HRSN services must not be used to reduce, discourage, or jeopardize beneficiaries' access to covered services.

ii. Beneficiaries always retain their right to receive covered service on the same terms as would apply if HRSN services were not an option.

iii. Beneficiaries who are offered or who utilize an HRSN service retain all rights and protections afforded under 42 CFR Part 438.

iv. Managed care plans are not permitted to deny a beneficiary a covered service on the basis that the beneficiary is currently receiving HRSN services, has requested those services, has previously qualified for or received those services, or currently qualifies or may qualify in the future for those services.

v. Managed care plans are prohibited from requiring a beneficiary to receive HRSN services.

b. Managed care plans must timely submit data requested by the state or CMS, including, but not limited to:

i. Data to evaluate the utilization and effectiveness of the HRSN services.

ii. Any data necessary to monitor health outcomes and quality of care metrics at the individual and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identify),

race, ethnicity, disability status and preferred language to inform health quality improvement efforts, which may thereby mitigate health disparities.

iii. Any data necessary to monitor appeals and grievances for beneficiaries.

iv. Documentation to ensure appropriate clinical support for the medical appropriateness of HRSN services.

v. Any data determined necessary by the state or CMS to monitor and oversee the HRSN services initiative.

c. All data and related documentation necessary to monitor and evaluate the HRSN services initiative, including cost assessment, including but not limited to:

i. The managed care plans must submit timely and accurate encounter data to the state for beneficiaries who qualify for HRSN services. When possible, these encounter data must include data necessary for the state to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts and subsequent efforts to mitigate health disparities undertaken by the state.

ii. Any additional information requested by CMS, the state, or another legally authorized oversight body to aid in ongoing evaluation of the HRSN services initiative or any independent assessment or analysis conducted by the state, CMS, or another legally authorized entity.

iii. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports its progress in building and sustaining its partnership with existing housing agencies to utilize their expertise and existing housing and to avoid duplication of efforts.

iv. Any additional information determined reasonable, appropriate and necessary by CMS.

17.18. **HRSN Rate Methodologies.** For managed care payments and rates (including non-risk payments and state directed payments), the state must comply with all federal requirements, including those in 42 CFR Part 438 and these STCs.

All rates/payment methodologies for HRSN services must be submitted to CMS for review and approval, including any state directed payments that require prior written approval and non-risk payments, as outlined in the STCs. For all payment methodologies and/or rates, in addition to submitting the payment rates and/or methodology, the state must also submit all supporting documentation requested by CMS, including but not limited to how the rates and/or methodology were developed, state responses to any public comments on the rates and/or methodology (when applicable), and information about Medicaid non-federal share financing.

17.19. **Maintenance of Effort (MOE).** The state must maintain a baseline level of state funding for ongoing social services related to housing and housing transition supports for the duration of the demonstration, not including one-time or non-recurring funding. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the HRSN Implementation Plan required by STC 17.22 that specifies how the state will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 12.8, with any justifications, including declines in available state resources, necessary to describe the findings, if the level of state funding is less than the comparable amount of the pre-demonstration baseline.

17.20. **Partnerships with State and Local Entities.** To ensure that expenditures for HRSN services under this demonstration do not supplant any other available funding sources available to the beneficiary through other local, state, or federal programs, the state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authorities) to assist beneficiaries in obtaining non-Medicaid funded housing supports, if available, upon the conclusion of temporary demonstration payment for such supports, in alignment with beneficiary needs identified in the beneficiary's care plan, as appropriate. The state will submit a plan to CMS as part of the HRSN Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Monitoring Reports described in STC 12.8, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Monitoring Reports.

17.21. **Provider Payment Rate Increase.** As a condition of approval of the HRSN services expenditure authority, the state must comply with the provider rate increase requirements in Section 18 of these STCs.

17.22. **HRSN Implementation Plan**

a. The state is required to submit a HRSN Implementation Plan that will elaborate upon and further specify requirements for the provision of HRSN services and will be expected to provide additional details not captured in the STCs regarding implementation of demonstration policies that are outlined in the STCs. The state must submit the MOE information required by STC 17.19 no later than 90 calendar days after approval of demonstration expenditure authority for HRSN services. All other Implementation Plan requirements outlined in this STC must be submitted no later than 9 months after the approval of demonstration expenditure authority for HRSN services. The Implementation Plan shall be submitted to CMS but does not require CMS approval. CMS will ensure it is complete and contains sufficient detail for purposes of on-going monitoring. The state may update the implementation plan

as initiatives are changed or added, with notification to CMS. The Implementation Plan will be appended as Attachment AB.

b. At a minimum, the Implementation Plan must provide a description of the state's strategic approach to implementing the policy, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation. The Implementation Plan does not need to repeat any information submitted to CMS under the Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN services; however, as applicable, the information provided in the two deliverables must be aligned and consistent.

c. The Implementation Plan must include information on, but not limited to, the following:

    i. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services interested parties to the extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation;

    ii. Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries);

    iii. Plans for changes to IT infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, qualification and consent to receive HRSN services, screening, referrals, and service provision;

    iv. A plan for tracking and improving the share of Medicaid beneficiaries in the state who are eligible and enrolled in SNAP, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Temporary Assistance for Needy Families (TANF), and/or federal, state, and local housing and/or other nutrition assistance programs, relative to the number of total eligible demonstration beneficiaries in the state (including those who are eligible but unenrolled);

    v. An implementation timeline and considerations for demonstration evaluation that may be impacted by the timeline (e.g., in the case of a phased rollout of HRSN services), to facilitate robust evaluation designs;

    vi. Information as required per STC 17.19 (MOE); and

vii. Information as required per STC 17.20 (Partnerships with State and Local Entities).

18. PROVIDER RATE REQUIREMENTS

18.1. The provider payment rate increase requirements described hereafter are a condition for the HRSN expenditure authority, as referenced in expenditure authority 19.

18.2. As a condition of approval and ongoing provision of FFP for the HRSN expenditures over this demonstration period of performance, DY 21 through the fifth full demonstration year following the effective date of this amendment, the state will in accordance with these STCs analyze, increase and (at least) subsequently sustain Medicaid fee-for-service provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates, by at least two percentage points in the ratio of Medicaid to Medicare provider rates for one of the service categories that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent. If the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for only the state's Medicaid fee-for-service program or only Medicaid managed care, the state shall only be required to increase provider payments for the delivery system for which the ratio is below 80 percent. If the state's average Medicaid rates already equal or exceed 80 percent of Medicare in any of these three categories for either FFS or managed care, then the state is not subject to a provider rate increase requirement in that service category and delivery system, but the state must at least sustain rates for such categories at existing levels for the remainder of the demonstration period.

a. Subject to CMS approval, in the event that the state cannot implement a rate increase by the end of this limited period of performance (DY 21 through DY 23) as otherwise authorized in STC 18.2, which is due to the HRSN expenditure authority being approved in the middle of the current period of performance, and if HRSN expenditure authority is subsequently approved by CMS for a demonstration extension period, then the state will implement the rate increase no later than the amount of time allowed by STCs 18.9, 18.10, and 18.11 as applicable to the state, beginning from this demonstration effective date into the subsequent period of performance.

18.3. The state may not decrease provider payment rates for other Medicaid or demonstration covered services to make state funds available to finance provider rate increases required under this STC (i.e., cost-shifting).

18.4. The state will, for the purpose of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increases as may be required under this section, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a

manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health care services.

18.5. No later than 90 days of the demonstration effective date, and if the state makes FFS payments, the state must establish and report to CMS the state's average Medicaid to Medicare FFS provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:

a. Provide to CMS the average Medicaid to Medicare provider rate ratios for each of the three categories of services as these ratios are calculated for the state and the service category as noted in the following sources:

i. For primary care and obstetric care services in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3); AND

ii. For behavioral health services (the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." Substance Abuse Treatment, Prevention, and Policy (2022) 17:49 (Table 3)); OR

b. Provide to CMS for approval for any of the three services categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:

i. Service codes must be representative of each service category as defined in STC 18.4.

ii. Medicaid and Medicare data must be from the same year and not older than 2019.

iii. The state's methodology for selecting the year of data, determining Medicaid code-level utilization, the service codes within the category, geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

18.6. To establish the state's ratio for each service category identified in STC 18.4 as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:

a. The average fee-for-service ratio as provided in STC 18.5(a), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average

provider rates paid by managed care plans (e.g., where managed care plans in the State pay providers based on state plan fee-for-service payment rate schedules); or

b. The data and methodology for any or all of the service categories as provided in STC 18.5(b) using Medicaid managed care provider payment rate and utilization data.

18.7. In determining the ratios required under STC 18.5 and 18.6, the state may not incorporate FFS supplemental payments that the state made or plans through December 31, 2029, to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR § 438.6(a) and 438.6(d).

18.8. If the state is required to increase provider payment rates for managed care plans per STC 18.2. and 18.6, the state must:

a. Comply with the requirements for state directed payments in accordance with 42 CFR 438.6(c), as applicable; and

b. Ensure that the entirety of a two-percentage point increase applied to the provider payments rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.

18.9. For the entirety of the third full demonstration year following the effective date of this amendment through the fifth full demonstration year following the effective date of this amendment, the provider payment rate increase for each service in a service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate for each service in DY 21, and such rate will be in effect on the first day of the third full demonstration year following the effective date of this amendment, per the attestation table in STC 18.14. A required payment rate increase shall apply to all services in a service category as defined under STC 18.4.

18.10. If the state uses a managed care delivery system for any of the service categories defined in STC 18.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from the third full demonstration year following the effective date of this amendment through the fifth full demonstration year following the effective date of this amendment, the managed care plans' provider payment rate increase for each service in the affected categories will be no lower than the highest rate in DY 21 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment increase shall apply to all services in a service category as defined under STC 18.4.

18.11. If the state has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing a required payment rate increase by the first day of the third full demonstration year following the effective date of this amendment (or as applicable, the first day of the rating period that starts in the

third full demonstration year following the effective date of this amendment), the state will provide an alternative effective date and rationale for CMS review and approval.

18.12. Vermont will provide the information to document the payment rate ratio required under STC 18.5 and 18.6, via submission to the Performance Metrics Database and Analytics (PMDA) portal for CMS review and approval.

18.13. For demonstration years following the first year of provider payment rate increases, if any, Vermont will provide an annual attestation within the State's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, in the previous year.

18.14. No later than 90 days following the demonstration amendment effective date, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 18.5 and 18.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment AC.

Table 3. Vermont HRSN Related Provider Payment Increase Assessment – Attestation Table

The reported data and attestations pertain to HRSN provider payment increase requirements for the demonstration period of performance DY 21 through the fifth full demonstration year following the effective date of this amendment.		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-Service ratio**	**Medicaid Managed Care to Medicare Fee-for-Service Ratio**
Primary Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]
	[insert approach, either ratio derived under STC 18.5(a) or STC 18.5(b)]	[insert approach, either ratio derived under STC 18.6(a) or STC 18.6(b), insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]

Obstetric Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]
	[insert approach, either ratio derived under STC 18.5(a) or STC 18.5(b)]	[insert approach, either ratio derived under STC 18.6(a) or STC 18.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]
Behavioral Health Care Services	[insert percent, or N/A if state does not make Medicaid fee-for-service payments]	[insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]
	[insert approach, either ratio derived under STC 18.5(a) or STC 18.5(b)]	[insert approach, either ratio derived under STC 18.6(a) or STC 18.6(b) insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]
In accordance with STCs 18.1 through 18.12, including that the Medicaid provider payment rates used to establish the ratios do not reflect fee-for-service supplemental payments or Medicaid managed care pass-through payments under 42 CFR 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in the service category in each delivery system, as applicable to the state's Medicaid or demonstration service delivery model, if for that delivery system the ratio is both the lowest ratio among the three and below 80 percent. Such provider payment increases for each service will be effective beginning on the first day of the third full demonstration year following the effective date of this amendment, and will not be lower than the highest rate for that service code in DY 21 plus a two-percentage point increase relative to the rate for the same or similar Medicare billing code through at least the fifth full demonstration year following the effective date of this amendment approved by CMS. For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a fee-for-service delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health and obstetric care, and to identify applicable service codes and providers		

types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise each service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 18.6(b) will be based on Medicaid managed care provider payment rate and utilization data.

[Select the applicable effective date, must check either a. or b. below]

☐a. The effective date of the rate increases is the first day of the third full demonstration year following the effective date of this amendment and will be at least sustained, if not higher, through the fifth full demonstration year following the effective date of this amendment.

☐b. Vermont has a biennial legislative session that requires provider payment approval, and the timing of that session precludes the state from implementing the payment increase on the first day of the third full demonstration year following the effective date of this amendment. Vermont will effectuate the rate increases no later than the CMS approved date of January 1, 2027, and will sustain these rates, if not made higher, through fifth full demonstration year following the effective date of this amendment.

Vermont *does not* make Medicaid state plan fee-for-service payments for the following categories of service for at least some populations: primary care, behavioral health, and / or obstetric care.

For any such payments, as necessary to comply with the HRSN STCs, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan fee-for-service payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new state plan amendment, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*].

Vermont *does* include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

For any such payments, as necessary to comply with the HRSN STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the

information listed in STC 18.7 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than December 31, 2027.
Per STC 18.2(a), in the event that the state cannot implement a rate increase by the end of this limited period of performance (DY 21 through the fifth full demonstration year following the effective date of this amendment) and if HRSN expenditure authority is subsequently approved by CMS for a demonstration extension period, then the state will implement the rate increase no later than period of time allowed by STC(s) 18.9, 18.10, 18.11 beginning from this demonstration effective date into the subsequent period of performance. If the state intends to use this flexibility, the state will provide to CMS for CMS approval its plan to use this flexibility. ☐a. The state will increase provider payment rates by the end of this demonstration period and will sustain use these rate increases during the demonstration extension period. ☐b. The state will not increase the provider payment rates by the end of this demonstration period and will use this flexibility to increase the provider payment rates during the next demonstration extension period. The state will provide CMS with its timeline for implementing these provider rate increases in the event that the HRSN expenditure authority is extended into a subsequent demonstration period. Proposed start date for provider rate increase: *[Provide date]*
If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 18.8, I attest that necessary arrangements will be made to assure that 100 percent of the two-percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.
Vermont further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC Section 18.
I, *[insert name of SMD or CFO (or equivalent position)] [insert title],* attest that the above information is complete and accurate. [*Provide signature*_____*] [Provide date*_____*]* *[Provide printed name of signatory]*

19. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION PERIOD

Due Date	Deliverable	STC Reference
30 calendar days after approval date[5]	Written acknowledgement of the award letter and acceptance of the STCs	N/A; see Approval letter
150 calendar days after approval date	SUD Monitoring Protocol	STC 9.3
150 calendar days after approval date	SMI/SED Monitoring Protocol	STC 10.5
180 calendar days after the demonstration's implementation and annually thereafter	Post Award Forum	STC 12.2
180 days after demonstration approval	Draft Evaluation Design	STC 15.3
90 days after approval of demonstration extension	HCBS Quality Measures	STC 6.14(a)(vii)
June 30, 2025	SUD Mid-Point Assessment	STC 9.4
June 30, 2024	SMI/SED Mid-Point Assessment	STC 10.8
The end of the third year of implementation of the Reentry Demonstration Initiative	Reentry Mid-Point Assessment	STC 12.13
One year prior to current expiration date (December 31, 2026), or with extension application	Draft Interim Evaluation Report	STC 15.6(c)
Within 18 months of the end of the demonstration period	Draft Summative Evaluation Report	STC 15.7

[5] Approval date refers to the date marked on the approval letter for this demonstration.

Due Date	Deliverable	STC Reference
30 calendar days after CMS approval	Approved Final Summative Evaluation Report published to state's website	STC 15.7(b)
Within 30 days of CMS written request	State Data Collection	STC 12.10
21 months before the end of the demonstration period, in accordance with the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers	HCBS Quality Improvement Strategy Evidentiary Report	STC 6.14(a)(viii)
120 calendar days after approval date of the Reentry Demonstration Initiative	Reentry Demonstration Initiative Implementation Plan	STC 16.10
6 months after approval date of the Reentry Demonstration Initiative	Reentry Demonstration Initiative Reinvestment Plan	STC 16.11

Recurring Date	Deliverable	STC Reference
No later than 60 days after the end of the quarter (except Q4)	Quarterly Monitoring Reports	STC 12.8
No later than 90 days after the end of the Demonstration Year	Annual Monitoring Reports	STC 12.8
Updated every three years in accordance with 42 CFR 438.340 (c)	State Quality Strategy	STC 6.14

Not later than 90 days prior to the effective date	Interagency Agreement and Rate Certification	STC 6.2
No later than 30 days after the end of the quarter	CMS-64 Expenditure Reports	STCs 13.2 & 13.11

ATTACHMENT A
Preparing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-

The roadmap begins with the stated goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations;
E. Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.
2. Address how the hypotheses and research questions promote the objectives of Titles XIX and/or XXI.
3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.
4. Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health

and health care through specific interventions. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

1. **Methodology –** In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate.

   This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

   Specifically, this section establishes:

   1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.
   2. *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.
   3. *Evaluation Period* – Describe the time periods for which data will be included.
   4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

      The state also should include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.) Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally

recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.
6. *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:
    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
    b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
    c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
    d. Consider the application of sensitivity analyses, as appropriate.
7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample, e.g., All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).
2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes;

b. No or minimal appeals and grievances;
c. No state issues with CMS-64 reporting or budget neutrality; and
d. No Corrective Action Plans for the demonstration.

E. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.
2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.
3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

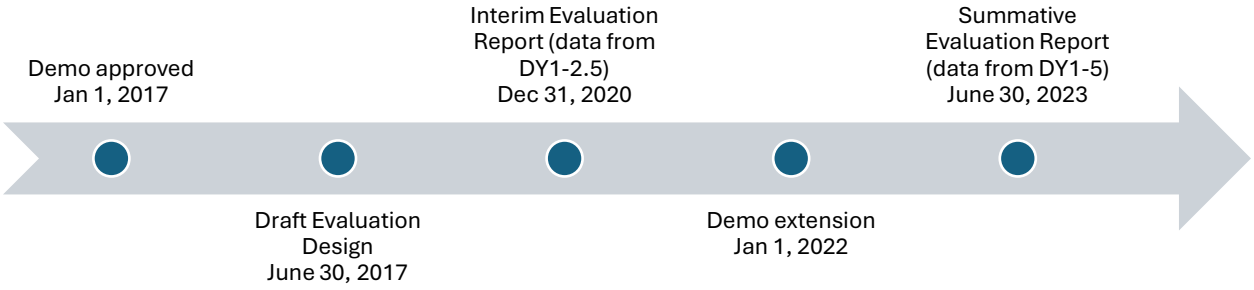
ATTACHMENT B:
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverable's timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within thirty (30) calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the methodology outlined in the approved Evaluation Design. However, the state may request,

and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment
Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports
The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

A. The format for the Interim and Summative Evaluation reports is as follows: Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

A. Executive Summary – A summary of the demonstration, the principal results,

interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
3. A description of the population groups impacted by the demonstration.
4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration.
5. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
4. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an

Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.
2) *Target and Comparison Populations* – Describe the target and comparison populations, describing inclusion and exclusion criteria.
3) *Evaluation Period* – Describe the time periods for which data will be collected.
4) *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.
5) *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.
6) *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

A. Results – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

B. Conclusions – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
    a. If the state did not fully achieve its intended goals, why not?
    b. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

C. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the

demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

D. Lessons Learned and Recommendations – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:

1. What lessons were learned as a result of the demonstration?
2. What would you recommend to other states which may be interested in implementing a similar approach?

a. **Attachment(s)**

1) Evaluation Design: Provide the CMS-approved Evaluation Design

ATTACHMENT C
Summary of Choices for Care Eligibility Criteria

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

Choices for Care Eligibility Group	Choices for Care Clinical Eligibility Categories*			
	Need for Assistance with Activities of Daily Living	**Physical Health Needs**	**Behavioral Health Needs/Needs Due to Impaired Decision Making**	**Unique Circumstances**
Moderate	Supervision or assistance 3 or more times in 7 days with one ADL or combination of ADL and IADLs.	Chronic condition that requires monitoring at least monthly.	Impaired judgment or decision making that requires general supervision on a daily basis.	Worsening health condition without services.

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

The following Moderate Needs Group clinical eligibility criteria will be effective upon the expiration of the American Rescue Plan Act Section 9817 maintenance of effort (MOE) requirements:

Choices for Care Eligibility Group	Choices for Care Clinical Eligibility Categories*			
	Need for Assistance with Activities of Daily Living	**Physical Health Needs**	**Behavioral Health Needs/Needs Due to Impaired Decision Making**	**Unique Circumstances**
Moderate	Supervision or assistance 3 or more times in 7 days with one ADL or combination of ADL and IADLs.	See Unique Circumstances column.	Impaired judgment or decision making that requires general supervision on a daily basis.	Health and welfare at imminent risk without services or health condition would worsen without services

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

ATTACHMENT D
Choices for Care Services by Demonstration Group

All covered services are subject to medical necessity review, level of care, or needs-based criteria as applicable based on the population receiving the services. A complete description of covered services and limitations is contained in the Vermont approved title XIX State plan, Attachment E: Choices for Care Long-Term Services and Supports Definitions and Provider Qualifications, Vermont statutes, regulations, and policies and procedures.

Definitions of each service may be found in Attachment E.

Type of HCBS Service	Highest Need	High Need	Moderate Need	Limitations
Adult Day Services	X	X	X	Any limitation on this service are defined by Vermont rules and policies.
Assistive Devices and Home Modifications	X	X		
Case Management	X	X	X	
Companion	X	X		Limited in combination with Respite Service.
Homemaker	X	X	X	Excluded if participant receives Personal Care services since homemaker activities are included among Personal Care services.
Incidental purchases paid out of cash allotments to participants who are self-directing their services	X	X		Limited to Flexible Choices participants who are self-directing their services.
Habilitation	X	X		Limited to a life skills aide service
Nursing Overview	X	X		Limited to participants residing in Enhanced Residential Care.
Personal Care	X	X		Includes assistance with ADLs and limited IADLs; laundry, meal preparation; medication management and non-medical

Type of HCBS Service	Highest Need	High Need	Moderate Need	Limitations
Personal Emergency Response System	X	X		
Respite Care	X	X		Limited in combination with Companion Service for individuals residing at home.
Social and Recreational Activities	X	X		Limited to participants residing in Enhanced Residential Care.
Supervision	X	X		Limited to participants residing in Enhanced Residential Care.
Transportation Services	X	X		Non-medical transportation. Limited to participants residing in Enhanced Residential Care. Included in Personal Care for individuals residing at home.
Flexible Funds			X	Limited to self-directed services

ATTACHMENT E
Choices for Care Long-Term Services and Supports Definitions and Provider Qualifications

Comprehensive descriptions and coverage policies, prior authorization, applicant rules and limitations are defined by the Medicaid State Plan, Vermont statutes and rules and program policies.

Choices for Care
Adult Day Services: Community-based non-residential services that provide a range of professional health, social and therapeutic services delivered in a safe, supportive environment.
Assistive Devices and Home Modifications: An "Assistive Device" is defined as an item which is used to increase, maintain, or improve functional capabilities. Such devices are intended to replace functional abilities lost to the individual because of his or her disability and must be used in performing Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL). A "Home Modification" is defined as a physical adaptation to the home which is necessary to allow safe access to and use of the individual's primary living space, bathroom, kitchen, or main exit/entrance to the home. Adaptations that add to the total square footage of the home are excluded from this service except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
Case Management: Assistance to enrollees in gaining access to needed waiver, medical, social, educational and other services. Case management includes comprehensive assessment; treatment planning and plan of care development; service coordination; monitoring; and collateral contacts with persons involved and/or designated by the enrollee.
Enhanced Residential Care Home Services: A package of services provided by an approved Level III Residential Care Home (RCH) or an Assisted Living Residence (ALR). In addition to services provided to all RCH/ALR residents, these residential settings also provide a Registered Nurse on-site, personal care services and daily social and recreational activity opportunities.
Homemaker Services: Assistance with activities that help to maintain a safe, healthy environment for individuals residing in their homes. Such services contribute to the prevention, delay, or reduction of risk of harm or hospital, nursing home, or other institutional care.
Personal Care: Assistance with Activities of Daily Living (ADLs) like eating, dressing, walking, transferring, toileting and bathing and Instrumental Activities of Daily Living (IADLs) such as cooking, cleaning and shopping.
Personal Emergency Systems: Electronic devices which enable individuals at high risk to secure help in an emergency.

Respite Care: Alternate caregiving arrangements to facilitate planned short-term and time-limited breaks for caregivers.

Flexible Choices (Self -Directed Care): Participant- or surrogate-directed home and community-based option, which converts a participant's Home-Based Service Plan into a cash allowance.

Working with a consultant, the participant develops a budget that details expenditure of the allowance and guides the participant's acquisition of services to meet their needs.

Nursing Facility: Health-related services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition that includes provision of or arranging nursing or related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident.

Habilitation: Comprehensive and integrated one-to-one training and support by authorized Life Skills Aides (LSA) to provide training in specific Activities of Daily Living (ADLs) identified in the treatment plan designed to promote independent living and community re-integration.

Flexible Funds: Flexible use of funds for self-directed services that contribute to the prevention, delay, or reduction of risk of harm or hospital, nursing home, or other institutional care. Eligible services may include:

- Self-Hired Attendant: Participants (or their surrogate) who are able and willing to hire their own attendant may self-hire an employee to provide homemaker, personal care, respite or companion services. The case manager works together with the participant to determine how much assistance they require and the rate at which they will pay their workers.
- Intermediary Services Organization (ISO): Participants who choose to self-hire attendant services must do so through the state contracted ISO. The ISO manages all payroll services including background checks.
- Goods and Services: Personal Emergency Response Services, assistive devices, home modifications, home goods or appliances that support the individual's performance of Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs), transportation for non-State Plan eligible participants, interpreter services for non-State Plan eligible participants, personal care, respite, and companion services.

Agency Administrative Fees: Case management agencies are responsible for receiving vendor invoices, processing payments to vendors based on the participant's flexible funding budget and reporting these payments to DAIL. The administrative fee must be included in the participants' flexible funding budget and comes directly from the case management agencies Moderate Needs allocation cap.

Provider Qualifications:
All CFC providers must comply with all Department of Disabilities, Aging and Independent Living (DAIL) certification procedures that are applicable to their respective positions.

Providers offering **Adult Day Center services** must meet the following position-specific education requirements outlined below. Additionally, direct service staff and dual-role staff must have a minimum of 12 hours of training per year.

- Administrators must have:
  - A master's degree with 1-year supervisory experience and preferable with 1-year fiscal management experience; OR
  - A bachelor's degree with 3 years supervisory experience in a social or health service settings and preferable with 1-year fiscal management experience; OR
  - Comparable technical and human service experience, fiscal management experience, and demonstrated competence as a manager, preferable in a health or human service setting.

- Program Coordinators must have:
  - A bachelor's degree in health or social services or a related field, with 1-year supervisory experience in a social or health service setting; OR
  - Comparable technical and human service training with demonstrated competence and experience as a manager in a health or human service setting.

- Registered Nurses (RN) must have:
  - A Vermont RN license; AND
  - Minimum of 1-year applicable experience, preferably with elders and/or persons with chronic impairments

- Social Workers/Care Managers must have:
  - A masters of social work degree (MSW) AND at least one year of professional work experience; OR
  - A bachelor's degree in social work (BSW) AND 2 years of experience; OR
  - A current Vermont RN license AND 1 year of experience; OR
  - Two years of experience in a human service field.

- Activities Coordinators must:
  - Be Activity Consultant Certified (ACC) by the National Certification Council of Activities Professionals (NCCAP); OR
  - Be Activity Director Certified (ADC) by NCCAP; OR
  - Have a bachelor's degree in a related field AND one year of experience in developing and conducting activities for the population to be served at the center; OR
  - Have comparable technical and human service training with demonstrated competence and experience in developing and conducting activities for the population to be served at the center.

Provider staff offering **Personal Care and Homemaker services** must meet the following requirements outlined below.

- Be authorized by the home health agency as competent, trained to perform specific tasks for specific patients, and supervised by qualified supervisors (as outlined in the home health agency's policies); AND
- Meet the home health agency's policies and procedures related to qualifications, credential verification, staff orientation, training and evaluation, and, as applicable, policies pertaining to students and volunteers.

Provider staff offering **Case Management** must meet the following requirements outlined below.

- Comply with Vermont's Department of Disabilities, Aging and Independent Living Adult Services Division (ASD) Case Management Standards and Certification Procedures and related case management agency policies; AND
- Continue ongoing case management training designed to ensure that case managers will have the necessary range of knowledge, skills and abilities to provide high quality case management services.

ATTACHMENT F
Global Commitment Special Program Service Definitions and Provider Qualifications

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

Brain Injury Program Services
Crisis Support: Time-limited services and supports that assist an individual to resolve a severe behavioral, psychological or emotional crisis safely in their community. This includes 24/7 availability, crisis assessment, support and referral, one-to-one support and case management, hospital diversion programs, mobile outreach, community crisis placements and/or intensive in-home support.
Psychological and Counseling Supports: Services provided by or under the direction of licensed practitioners that include, but may not be limited to: clinical assessment; medication and psychiatric consultation; individual, family and group therapy; or specialized behavioral or health services.
Case Management: Assistance to enrollees in gaining access to needed waiver, medical, social, educational and other services. Case management includes comprehensive assessment; treatment planning and plan of care development; service coordination; monitoring; and collateral contacts with persons involved and/or designated by the enrollee.
Community Supports: Individualized support services that may be provided in a family setting,

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

Mental Health Under 22 Program Services
Case Management: Case management and assistance to individuals and families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of medical, social, educational and other services and supports, including discharge planning, advocacy, monitoring and supporting them to make and assess their own decisions.
Community Supports (Individual or Group): Specific, individualized, and goal-oriented services that assist individuals in developing skills and social supports necessary to promote growth.
Skilled Therapy Services: Services provided by or under the direction of licensed practitioners that include, but may not be limited to: clinical assessment; medication evaluation, management, and consultation with Primary Care; psychiatric consultation; individual, family and group therapy or diagnosis-specific practices; and specialized behavioral and health services.
Residential Treatment: Out-of-home treatment services that include: • *Transitional Living*: Short-term, out-of-home care for adolescents requiring intensive supports in order to transition to independent living. • *Therapeutic Foster Care*: Short-term, out-of-home care to assist in skill development and remediation of intensive mental health issues to support a return to the family. • *Residential Treatment:* Intensive out-of-home care for mental health treatment, skill building, family reintegration and/or specialized assessment services to assist recovery and skill building that supports return to the family home.

Mental Health Under 22 Program Services
Flexible Support: • *Family Education*: In-home support and treatment for the purpose of enhancing the family's ability to meet their child's emotional needs. • *Specialized Rehabilitation or Treatment Plan Services*: Services, supports or devices used to increase, maintain, or improve functional capabilities or health outcomes identified as the result of an approved assessment, treatment plan and/or prior approval.
Counseling: Services directed toward the development and restoration of skills or the elimination of psychosocial barriers that impede the development or modification of skills necessary for independent functioning in the community. Services may include approved peer-supported and recovery services.
Respite: Alternative caregiving arrangements to facilitate planned short-term and time-limited breaks for caregivers.
Supported Employment: Job placement assistance, job coaching, on- and off-site support, and consultation with employers to support competitive employment in integrated community work settings.
Crisis Support: Time-limited services and supports that assist an individual to resolve a severe behavioral, psychological or emotional crisis safely in their community. This includes 24/7 availability, crisis assessment, support and referral, one-to-one support, and case management, hospital diversion programs, mobile outreach, community crisis placements and/or intensive in-home support.
Environmental Safety Devices: Devices or technology necessary to ensure health and safety or to enable independence. This does not include structurally permanent modifications.

Community Rehabilitation and Treatment
Case Management: Case management and assistance to individuals and families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of medical, social, educational and other services and supports, including discharge planning, advocacy, monitoring and supporting them to make and assess their own decisions.
Community Supports: (Individual or Group): Specific, individualized and goal-oriented services which assist individuals in developing skills and social supports necessary to promote growth.

Community Rehabilitation and Treatment
Flexible Support: • *Day Recovery/Psychoeducation, Including Recovery Education:* Group recovery activities in a milieu that promotes wellness, empowerment, a sense of community, personal responsibility, self-esteem and hope. These activities are consumer-centered; they provide socialization, daily skills development, crisis support, and promotion of self-advocacy. • *Family Psychoeducation and Support for Families and Significant Others*: To support recovery and assist individual in managing their symptoms.
Skilled Therapy Services: Services provided by or under the direction of licensed practitioners that include, but may not be limited to: clinical assessment; individual, group, and family therapy or diagnosis-specific practices; medication evaluation, management and consultation with Primary Care; inpatient behavioral health services; partial hospitalization.
Residential Treatment • *Residential Treatment:* Intensive mental health treatment, skill building, community reintegration and/or specialized assessment services to assist recovery and skill building to support community living, but not provided in institutions for mental disease (IMD). Treatment may include the use of approved peer-supported and peer-run alternatives. • *Housing and Home Supports*: Mental Health services and supports based on the clinical needs of individuals in and around their residences. This may include support to a person in his or her own home; a family home; sharing a home with others (e.g., in an apartment, group home, shared living arrangement).
Crisis Support: Time-limited services and supports that assist an individual to resolve a severe behavioral, psychological or emotional crisis safely in their community. This includes 24/7 availability, crisis assessment, support and referral, one-to-one support, case management, hospital diversion programs, mobile outreach, community crisis placements and/or intensive in-home support.
Environmental Safety Devices: Devices or technology necessary to ensure health and safety or to enable independence. This does not include structurally permanent modifications.
Counseling: Services directed toward the development and restoration of skills or the elimination of psychosocial barriers that impede the development or modification of skills necessary for independent functioning in the community. Services may include approved peer-supported and peer-run recovery services.
Respite: Alternative caregiving arrangements to facilitate planned short-term and time-limited breaks for caregivers.
Supported Employment: Job placement assistance, job coaching, on- and off-site support, and consultation with employers to support competitive employment in integrated community work settings.

Community Rehabilitation and Treatment
Enhanced Dental: An enhanced dental benefit in excess of the limitations set forth in the State Plan to reflect that individuals enrolled in CRT may have more significant dental needs than other Medicaid enrollees. Complete coverage, limitations, and exclusions can be found in Vermont administrative rule.
Peer Supports: 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 mental illness, SUD, and other health conditions. Core functions include providing recovery, health, and wellness supports; 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. This benefit will be effective upon approval of a State Plan amendment and promulgation of necessary Vermont administrative rules.

Developmental Disabilities Services (DS)
Case Management: Case management and assistance to individuals and families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of medical, social, educational and other services and supports, including planning, advocacy, monitoring and supporting them to make and assess their own decisions.
Residential Habilitation: Home supports, services and supervision to an individual in and around their residence up to 24 hours a day. This may include support to a person in his or her own home; sharing a home with others (e.g., in an apartment, group home, shared living arrangement); or who lives with his or her family.
Day Habilitation: Community supports that are specific individualized and goal-oriented services which assist individuals in developing skills and social supports necessary to promote positive growth. This may also include support for persons to prevent them from entering more restrictive levels of care such as: • *Flexible Family Funding:* One-time support to assist a family not receiving other specialized services in maintaining their family member in home and diverting the use of more costly home and community-based services or restrictive levels of care. • *Specialized Treatment Plan Services:* Services, supports or devices used to increase, maintain, or improve functional capabilities or health outcomes identified as the result of an approved assessment, plan of care and/or prior approval.
Supported Employment: Job placement assistance, job coaching, on- and off-site support, and consultation with employers to support competitive employment in integrated community work settings.

Crisis Support: Time-limited services and supports that assist an individual to resolve a severe behavioral, psychological or emotional crisis safely in their community. This includes 24/7 availability, crisis assessment, support and referral, one-to-one support and case management, hospital diversion programs, mobile outreach, community crisis placements and/or intensive in-home support.
Clinical Interventions: Assessment, therapeutic, medication or medical, or other clinical services provided by clinical or medical staff.
Respite: Alternative caregiving arrangements to facilitate planned short-term and time-limited breaks for caregivers.
Self-Directed Care: When an individual, their family or surrogate meets requirements and chooses to manage some or all of their developmental disabilities services, the person has the responsibility of hiring his or her own staff and overseeing the administrative responsibilities associated with receiving developmental disabilities services funding, including contracting for services, developing a service plan, fulfilling the responsibilities of the employer, and planning for back-up support or respite in the case of an emergency.
Enhanced Dental: An enhanced dental benefit in excess of the limitations set forth in the State Plan to reflect that individuals enrolled in DS may have more significant dental needs than other Medicaid enrollees. Complete coverage, limitations, and exclusions can be found in Vermont administrative rule.
Vehicle Modifications: Adaptations or alterations to an automobile or van that is the waiver participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The following are specifically excluded: • Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; • Purchase or lease of a vehicle; and • Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

Home Accessibility Adaptations: Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the participant.

- Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Personal Emergency Response System (PERS): PERS is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. This includes remote support technology, including installation and testing of the personal emergency response system (e.g. Safety Connection).

Provider Qualifications:

Brain Injury Program Services	
Provider	**Minimum Qualifications**
Case managers offering **crisis support** and **case management** services	• BA or BS in a relevant discipline OR licensing as a RN; AND • Minimum of 2 years of experience working in a relevant community service setting; AND • Experience, knowledge and skills specific to working with individuals with traumatic brain injury
Life skills aides offering **crisis support**, **habilitation**, and **supported employment services**	• Minimum of a high school diploma OR GED; AND • 2 years in human services, education, or job service work involving direct client contact OR experience as a full-time homemaker including household management and care of family may be substituted for up to one year of the non-trainee work experience. College training may be substituted for the work experience on a semester for six months basis
Providers offering **psychology and counseling supports**	• Be licensed in Vermont as a psychiatrist, psychologist AND/OR have a Masters in psychotherapy or counseling; OR • Be working under the direction and supervision of a licensed practitioner
Caregivers and respite caregivers offering **community support services** and **respite care**	• 2 years in human services, education, or job service work involving direct client contact OR experience as a full-time homemaker including household management and care of family may be substituted for up to one year of the non-trainee work experience. College training may be substituted for the work experience on a semester for six months basis; AND • 1-2 years prior experience working with individuals with disabilities in the community

Mental Health Under 22 Program Services	
Provider	**Minimum Qualifications**
Providers offering **case management, community supports, supported employment,** and **crisis support**	• Authorized by the Designated Agency's (DA's)/Specialized Services Agency (SSA's) Medical Director as competent to provide the service based on their education, training, or

Mental Health Under 22 Program Services	
Provider	**Minimum Qualifications**
	experience
Providers offering **flexible support services (family education/consultation)**	• Licensed, working within their professional scope of practice, and have appropriate credentialing OR evidence of successfully completing a nationally recognized training program in the specialty area; AND • Authorized by the DA's/SSA's Medical Director as competent to provide the service based on their education, training, or experience
Providers offering **clinical assessments** and **individual/family/group therapy** as part of **skilled therapy services** must meet one of the minimum qualifications	• Licensed physician certified in psychiatry by the American Board of Medical Specialties directly affiliated with the DA/SSA; OR • Licensed psychiatric nurse practitioner directly affiliated with the DA/SSA; OR • Non-licensed psychiatric nurse practitioners must fulfill 24 months and 2,400 hours of supervised practice; OR • DA/SSA staff must hold one of the following: o Licensed psychologist; OR o Licensed marriage and family therapist. OR o Licensed clinical mental health counselor; OR o Licensed independent clinical social worker; OR o Licensed alcohol and drug counselor; OR o Be working under the direction and supervision of a licensed practitioner • Subcontractors must meet both requirements: o Meet staff qualifications described above; AND o Authorized by the DA's/ SSA's Medical Director as competent to provide the service based on their education, training, or experience
Providers offering **medication and medical support** as part of **skilled therapy services** must meet the minimum qualifications	• Physicians who are board-eligible in psychiatry, APRN, or PA operating within the scope of their respective professions
Licensed home providers who offer r**esidential treatment services**	• Licensed by Department for Children and Families (DCF) or child placing agency

Mental Health Under 22 Program Services	
Provider	**Minimum Qualifications**
Staffed living providers who offer r**esidential treatment services**	• Individuals who, based on their education, training, or experience, are determined competent to provide the service by the Medical Director of the DA/SSA

Community Rehabilitation and Treatment (CRT)	
Provider	**Minimum Qualifications**
Providers offering **case management, community supports, flexible support (day services), crisis support,** and **supported employment**	• Authorized by the DA's/SSA's Medical Director as competent to provide the service based on their education, training, or experience.

Providers offering **clinical assessments** and **individual/family/group therapy** as part of **skilled therapy services** must meet one of the minimum qualifications.	• Licensed physician certified in psychiatry by the American Board of Medical Specialties directly affiliated with the DA/SSA; OR
	• Licensed psychiatric nurse practitioner directly affiliated with the DA/SSA; OR
	• Non-licensed psychiatric nurse practitioners must fulfill 24 months and 2,400 hours of supervised practice; OR
	• DA/SSA staff must hold one of the following:
	  ○ Licensed psychologist; OR
	  ○ Licensed marriage and family therapist; OR
	  ○ Licensed clinical mental health counselor; OR
	  ○ Licensed independent clinical social worker; OR
	  ○ Licensed alcohol and drug counselor; OR
	• Be working under the direction and supervision of a licensed practitioner. Subcontractors must meet both requirements:
	  ○ Meet staff qualifications described above; AND
	  ○ Authorized by the DA's/SSA's Medical Director as competent to provide the service based on their education, training, or experience

Community Rehabilitation and Treatment (CRT)	
Provider	**Minimum Qualifications**
Providers offering medication **and medical support** as part of **skilled therapy services must** meet one of the minimum qualifications	• Physicians who are board-eligible in psychiatry, APRN, or PA operating within the scope of their respective professions
Staffed living providers offering **residential treatment services**.	• Individuals who, based on their education, training, or experience, are determined competent to provide the service by the Medical Director of the DA/SSA
Group living providers offering **residential treatment services**.	• Vermont Medicaid-enrolled providers consistent with their licensed scope of practice; OR • DA/SSA staff members who, based on their education, training, or experience, are determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a qualifying provider

Developmental Disabilities Services (DS)	
Provider	**Minimum Qualifications**
All DS providers, except for Home Accessibility Adaptations and Vehicle Modifications	• Be at least 18 years of age; AND • Possess a high school education or equivalent; AND • Must be monitored by appropriate agency staff or employers of record; AND • Must complete state-defined trainings within required timeframes
Staff who perform assessment, care planning, and quality assurance as part of **case management services**	• Must meet the federal or state definition of a Qualified Developmental Disability Professional (QDDP)
Providers offering **residential habilitation services**	• Be at least 21 years of age
Providers offering **crisis support**	• Have a Master's degree in a related human services field
Home Accessibility Adaptations	• Services will be delivered by contractors that meet state requirements for licensure, certification, and permitting as applicable.
Vehicle Modifications	• Services will be delivered by contractors that meet state requirements for licensure, certification, and permitting as applicable.

ATTACHMENT G
Premiums and Co-Payments for Demonstration Populations

Premiums for children age 0 through age 18 in Population 1 may be charged up to the amounts in the following chart:

Group	Premiums
Children with income > 195% percent through 237% of the FPL	
	$60/month/family

Population	Premiums	Co-Payments	State Program Name
Demonstration Population 7: Medicare beneficiaries with income at or below 150 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise categorically eligible for full benefits.	Premiums not to exceed the following: 0-150% FPL: $15/month/person	Not to exceed the nominal co-payments specified in the Medicaid State plan.	VPharm1
Demonstration Population 8: Medicare beneficiaries with income above 150 percent and up to and including 225 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP), but are not otherwise categorically eligible.	Premiums not to exceed the following: 151-175% FPL: $20/month/person 176-225% FPL: $50/month/person	Not to exceed the nominal co-payments specified in the Medicaid State plan.	VPharm2 or VPharm3



State of Vermont

Medicaid Data Aggregation and Access Program (MDAAP)

Incentive Payment Protocol

Version 2.1

January 16, 2025

Revision History

Version	Date	Revision Notes
1.0	August 2023	Final draft
1.1	October 2023	Incorporating CMS feedback
1.2	October 2023	Incorporating CMS feedback
1.3	November 2023	Incorporating CMS feedback
1.4	November 2023	Incorporating CMS feedback
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2.1	January 2025	CMS approval of edits

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1. Executive Summary

Vermont has spent many years developing and streamlining its health data infrastructure including digitizing health records and forging connections to the Vermont Health Information Exchange. Many of our home and community-based providers still have not adopted electronic health record systems and do not have the ability to digitally share health data. The aim of the Medicaid Data Access and Aggregation Program (MDAAP) is to close that gap and scale our prior health records digitization and HIE connectivity successes to all eligible providers. Additionally, due to the challenges our state faces in addressing the opioid epidemic, substance use disorder data is a priority for Vermont to combat this problem in a holistic and effective way. We are looking forward to leveraging MDAAP for that urgent need.

Eligibility

To qualify for MDAAP, a provider must be an organization or solo provider registered in the Medicaid Management Information System providing home and community-based services including mental health treatment, substance use disorder treatment, or long-term services and supports. Providers who received funds under Medicaid Promoting Interoperability Programs do not qualify for MDAAP, though the organization they work for may still qualify if it operates under an eligible provider type. At least 20% of the provider's patient encounters during a 90 day look back window must have been with a Medicaid-eligible patient consistent with 42 CFR Part 495.

MDAAP Tracks and Milestones

Track 1: Implement Certified Electronic Health Record Technology (CEHRT)

- Signed Participation Agreement to implement CEHRT- $2,000
- Signed Scope of Services Agreement to implement CEHRT- $2,000
- New CEHRT purchase- $23,000 to $49,000
- New CEHRT go-live- $4,000
- Conduct or review a security risk analysis- $4,000
- Complete VITLAccess credentialing, training, and usage- $500 to $2,000
- Vendor Contract for ADT interface- $10,000
- Vendor Contract for CCD interface- $16,000
- Go-live achieved and sending ADT data to the VHIE using CEHRT- $4,000
- Go-live achieved and sending CCD data to the VHIE using CEHRT- $4,000

Track 2: Upgrading from no EHR System to an EHR Lite System

- Signed Participation Agreement to implement eligible EHR Lite- $500
- Signed Scope of Services Agreement to implement EHR Lite - $500
- Complete VITLAccess credentialing, training, and usage- $500 to $2,000
- New eligible EHR Lite system purchase and go-live checklist- $500 to $9,000
- Conduct or review a security risk analysis- $4,000

Track 3: VHIE Connection with a CEHRT system

- Signed Participation Agreement to connect to VHIE with CEHRT- $2,000
- Signed Scope of Services Agreement to connect to VHIE- $2,000
- Service Agreement Amendment for 42 CFR Part 2 Data (3a only)- $10,000
- Approved Connectivity Plan Proposal required by a DA/SSA Provider Agreement (CPP only)- $27,000
- Conduct or review a security risk analysis- $4,000
- Vendor Contract for ADT interface- $10,000
- Vendor Contract for CCD interface- $16,000
- Go-live achieved and sending ADT data to the VHIE- $4,000
- Go-live achieved and sending CCD data to the VHIE- $4,000

Track 4: VHIE Connection with a selected EHR Lite system

- Signed Participation Agreement to explore connection to the VHIE with EHR Lite- $2,000
- Signed Scope of Services Agreement to explore VHIE connection- $2,000
- Complete VITLAccess credentialing, training, and usage- $500 to $2,000
- Conduct or review a security risk analysis- $4,000
- Vendor Contract for EHR Lite connection to the VHIE- $20,000
- Go-live achieved and sending data to the VHIE using EHR Lite System- $6,000

Track 5: VITLAccess Connection and Training	
• Signed Participation Agreement for VITLAccess credentialing, training, and usage- $1,000	• Complete VITLAccess credentialing, training, and usage- $500 to $2,000

Prescreening and Audit

When applications or attestations are received, the prescreening reviewer will look over materials to ensure that all fields are entered and required signatures are present. If information or documents are missing, the prescreening reviewer will reach out to the organization to request completion of those items. A statistically significant number of milestone attestations will be selected for audit. Relevant notes, comments, and references to supporting documentation will be recorded by state administrators during both the prescreening and audit phases, and written communication will be sent to organizations explaining the results. Organizations who are not found to be eligible for participation or a milestone payment may request reconsideration. If recoupment of funds is required, overpayment will be remitted by the State to CMS within the 1-year federal period to repay the Federal Financial Participation (FFP) regardless of whether recovery has been completed by the State.

2. Introduction

As part of Vermont's Global Commitment to Health Demonstration, authorized pursuant to Section 1115 of the Social Security Act by the Centers for Medicare and Medicaid Services (CMS), within the Department of Health and Human Services, and approved effective July 1, 2022 through December 31, 2027, Vermont is creating a new incentive-based program, titled Medicaid Data Aggregation and Access Program (MDAAP), that will provide health information technology (HIT) infrastructure support to Medicaid providers in order to increase HIT use and connectivity to the state's health information exchange. The Demonstration Waiver includes the requirement that the State develop the MDAAP Incentive Payment Protocol to establish rules and guidelines for participation in the MDAAP Incentive Payment Program.

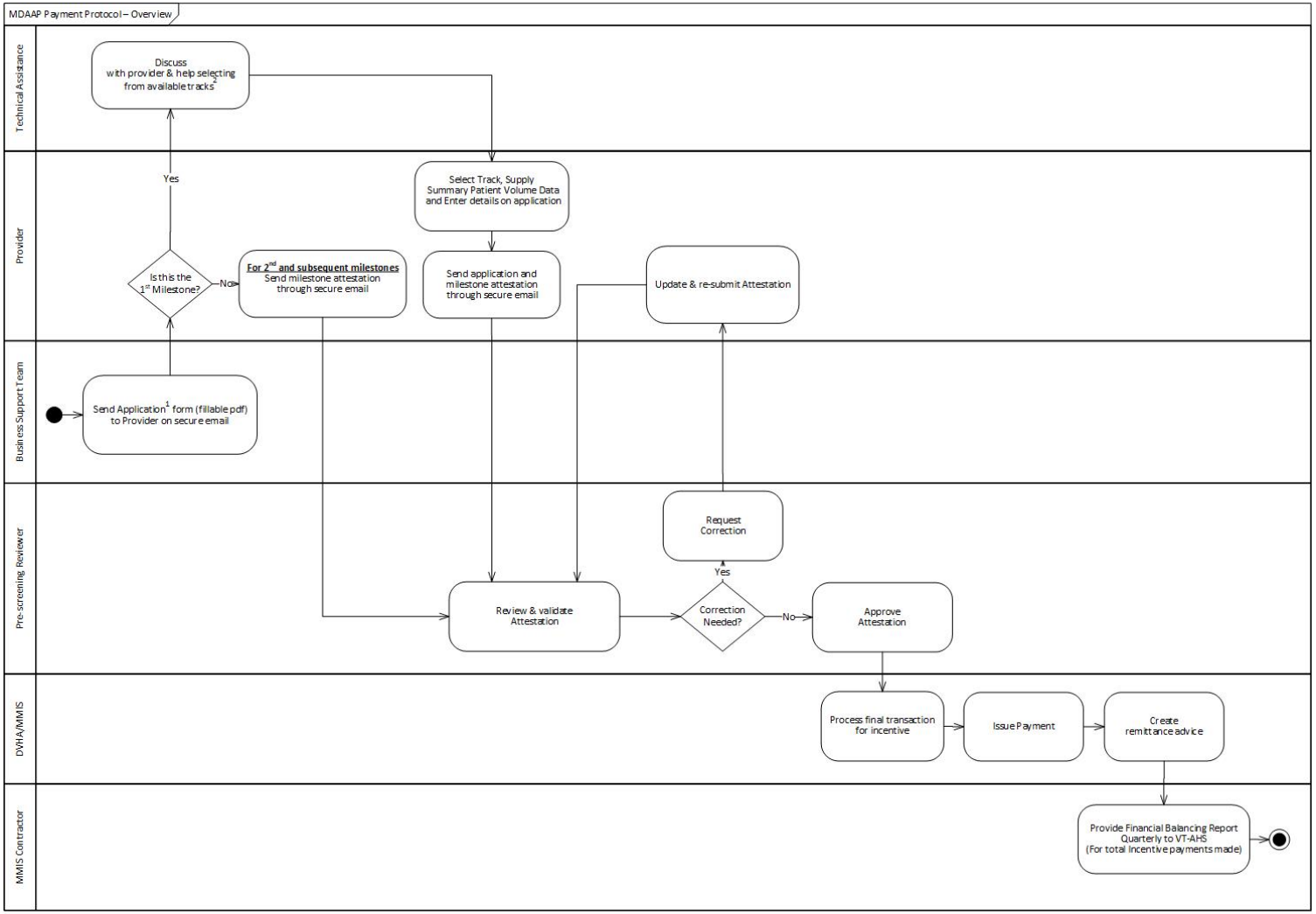
Health data collection and exchange is crucial to integrated care, effective population health management, and a data-informed Medicaid program. Vermont has spent many years developing and streamlining its health data infrastructure, connecting providers to the central health data repository (Vermont's health information exchange [VHIE]), and incentivizing the Meaningful Use of certified electronic health record (EHR) technology through the Medicaid Promoting Interoperability Program (PIP). There remain Medicaid providers who lack the ability to electronically collect and exchange health data. To remedy this gap, Vermont is establishing the MDAAP, an incentive program to encourage these providers to acquire and use electronic data record technology, which will inform the State's management of the Medicaid program, serve Medicaid enrollees, and support participation in Medicaid-driven value-based payment models. The program's initial focus will be on mental health providers, substance use disorder (SUD) treatment providers, and long-term services and supports (LTSS) providers that predominantly serve the Medicaid population. These providers (1) disproportionately serve populations experiencing health disparities; (2) were ineligible for the federal EHR incentive programs or the programs were not designed with their technical needs in mind; and (3) may lack data collection, use, and analytic capabilities, hindering their participation in Medicaid-driven value-based payment models and integrated care models.

The State of Vermont issued a request for proposals to aid the State in developing the MDAAP by evaluating how Medicaid providers currently store, access, utilize, and share information. Public Consulting Group was selected and conducted a stakeholder evaluation, including a provider survey, focus groups, and targeted interviews. The stakeholder evaluation and analysis of the results is included in the Appendix, and these findings were the basis for the MDAAP program design.

The MDAAP has been designed to allow for flexibility in selected data collection tools and to meet providers where they are at. There are different program tracks based on the type of technology and where providers are along their HIT journey. For example, certified EHR technology, connection to the VHIE, use of VITLAccess, the VHIE's clinical portal, to view patient data, and for providers using paper, affordable non-certified EHRs that meet program-eligibility requirements. For each track, incentives will be provided based on milestones to progress technology and interoperability projects forward.

In accordance with the Demonstration Waiver, the State of Vermont's Agency of Human Services (AHS) has developed the MDAAP Incentive Payment Protocol to define rules for MDAAP participation, to ensure the accuracy of incentive payments disbursed to eligible providers and organizations, to avoid making improper MDAAP payments, to detail MDAAP reporting activities to be completed by the State, and to explain how the State will claim FFP for incentive payments. Here is an overview of the MDAAP process:

Figure 1: MDAAP Payment Protocol Overview



[1]For every milestone the provider will submit an application/attestation

[2]**Available Tracks**

- Implement Certified Electronic Health Record Technology (CEHRT)
- Upgrading from no EHR System to an EHR Lite System
- VHIE Connection with a CEHRT system
- VHIE Connection with a selected EHR Lite system
- VITLAccess Connection and Training

3. Objectives

The primary objective is to ensure that state and federal funds are expended appropriately and accounted for in a transparent manner. The purpose of this MDAAP Incentive Payment Protocol is to set forth the process and procedures designed for conducting pre-screening reviews and performing post-payment audits of the MDAAP administered by the AHS, as well as detail MDAAP reporting activities and how the State will claim FFP for incentives.

4. Application Review & Audit Strategy

There are two MDAAP State of Vermont staff members, titled Medicaid Operations Administrators, responsible for pre-screening reviews of attestations. The pre-screening reviewers are responsible for provider outreach and education, as well as maintaining and updating our Microsoft Access Case Management database. There is one MDAAP state staff member, titled Medicaid Operations Administrator, who is responsible for audits of MDAAP incentive payment applications. A statistically significant number of milestone payments will be selected for audit to ensure the integrity of the program. Pre-screening and post-payment audit steps for MDAAP eligibility are described in Table 2 published on the MDAAP website upon approval of the Payment Protocol. All audits are also reviewed by the auditor's supervisor, the Program Compliance & Oversight Director. A case management database will be used to manage applicants to the Vermont MDAAP. This database includes case notes from the pre-screening reviewer, the auditor, and case status. MDAAP eligibility verification, including summary patient volume and provider type and specialty are screened for completeness during pre-screening and subject to random audit. As providers progress and attest to the next milestone, they will be asked to provide documentation to support the new milestone; however, patient volume and eligibility will not be asked for a second time. While practices will be encouraged and supported to complete all milestones, each milestone is considered voluntary and program participants can skip milestones.

5. Medicaid Provider Types and Specialties

To be eligible to participate in MDAAP, providers must be mental health, SUD treatment, or LTSS home and community-based services providers. Specifically, only the following combination of Medicaid provider type and provider specialty codes per our Vermont MMIS will be eligible for MDAAP incentives:

Table 1: MDAAP Eligible Medicaid Provider Type & Provider Specialty Codes

Provider Type Code and Specialty	Provider Type Code Description		Provider Specialty Description
010 - S20	Home Health Agency	☐ MH ☐ SUD ☒ LTSS	• Skilled Nursing Care • Physical Therapy • Occupational Therapy

			• Home Health Aide Services • Medication Management
017 - 065	Physical therapy	☐ MH ☐ SUD ☒ LTSS	• Assessment and evaluation • Treatment planning • Therapeutic exercise • Education • Pain Management
017 - 067	Occupational therapy	☐ MH ☐ SUD ☒ LTSS	• Interventions (Physical exercise, adaptive techniques, cognitive training, sensory integration). • Environmental modifications • Rehabilitation
017 - S30	Speech pathologist	☐ MH ☐ SUD ☒ LTSS	• Speech therapy • Language therapy • Voice therapy • Communication skills • Early intervention
019 - 062	Master's level psychologist	☒ MH ☐ SUD ☐ LTSS	• Psychotherapy/Counseling • Behavioral interventions • Family and couples therapy • Group therapy • School psychology
019 - 079	Master's level addiction medicine	☐ MH ☒ SUD ☐ LTSS	• Treatment Planning • Psychotherapy • Medication-assisted treatment (MAT) • Relapse prevention • Dual diagnosis treatment
019 - 080	Master's level psychologist/social worker	☒ MH ☐ SUD ☐ LTSS	• Therapy (individual, couples, family, group) • Crisis intervention • Prevention services • Treatment Planning • Substance abuse counseling
019 - S70	Licensed clinical mental health counselor	☒ MH ☐ SUD ☐ LTSS	• Therapy (individual, group, couples, family) • Crisis intervention • Treatment planning • Psychoeducation • Prevention & wellness services
019 - S71	Marriage family therapist	☐ MH ☒ SUD ☐ LTSS	• Couples counseling (often as part of underlying mental health or SUD treatment) • Family therapy • Pre-marital counseling • Divorce counseling • Grief and loss counseling
030 - 062	Doctorate level psychologist	☒ MH ☐ SUD ☐ LTSS	• Psychotherapy/Counseling • Behavioral interventions

			• Family and couples therapy • Group therapy • School psychology
030 - S72	Clinical psychologist/Ph.D	☒ MH ☐ SUD ☐ LTSS	• Assessment and diagnosis • Psychotherapy/counseling • Treatment planning • Psychological testing • Consultation
035 - 064	Audiologist	☐ MH ☐ SUD ☒ LTSS	• Hearing evaluations • Hearing Aid services • Cochlear implant services • Auditory rehabilitation • Assistive listening devices
037 - S12	Community behavioral health clinic	☒ MH ☐ SUD ☐ LTSS	• Assessment and diagnosis • Therapy (individual and group) • Medication management • Crisis intervention • Substance abuse treatment
038 - S13	Intellectual disability services	☐ MH ☐ SUD ☒ LTSS	• Early intervention • Special education • Vocational training and Employment support • Residential services • Day programs and activities
039 - S25	Child and Family Community Behavioral Health Services	☒ MH ☒ SUD ☐ LTSS	• Therapy (individual & family) • Medication management • Skill-building and psychoeducation • Crisis intervention • Collaboration with schools and other agencies
042 - S25	Aging Community Behavioral Health Services	☒ MH ☐ SUD ☒ LTSS	• Counseling and therapy • Medication management • Care coordination • Family and caregiver support • Crisis support
T04 - S21	Personal care services	☐ MH ☐ SUD ☒ LTSS	• Bathing and showering • Dressing and grooming • Toileting • Care (Oral, skin, nail, hair) • Meal preparation and feeding
T07 - S22	Registered nurse	☐ MH ☐ SUD ☒ LTSS	• Medication Administration • Wound care • IV therapy • Chronic disease management • Pain management

T07 - S28	High tech nurse	☐ MH ☐ SUD ☒ LTSS	• Coordinating treatments • Medical supplies • Sophisticated medical equipment
T14 - S25	Residential care waiver	☐ MH ☐ SUD ☒ LTSS	• Assistance with activities of daily living • Meal preparation • Medication management • Personal Care
T15 -S25	Aging waiver case manager	☐ MH ☐ SUD ☒ LTSS	• Assessing individual's needs • Planning • Coordinating services • Helping individuals and families navigate the service system
T16 - S26	Targeted case management	☐ MH ☒ SUD ☐ LTSS	• Assessment • Planning • Coordinating • Advocacy • Monitoring • Support
T17 - S26	Individual case manager	☒ MH ☐ SUD ☐ LTSS	• Assessment • Planning • Coordinating • Advocacy • Monitoring • Support
T19 - S25	Vocational rehabilitation	☐ MH ☐ SUD ☒ LTSS	• Eligibility assessment/individualized plan • Counseling • Job placement • Skills training • Assistive technology and accommodations
T20 - 060	Family support management	☒ MH ☒ SUD ☐ LTSS	• Counseling and therapy • Teen and youth programs • Financial assistance • Support groups • Health and wellness services
T20 - S26	Case management	☒ MH ☒ SUD ☐ LTSS	• Assessment • Planning • Coordinating • Advocacy • Monitoring • Support
T21 - 060	Children's Integrated Services	☒ MH ☐ SUD ☒ LTSS	• Early intervention • Maternal and child health • Family support & education • Care coordination

			• Community resources • Developmental screening • Individualized plans
T23 - 061	Residential treatment services	☒ MH ☐ SUD ☐ LTSS	• Substance abuse residential treatment • Mental health residential treatment • Youth residential treatment • Co-occurring disorders treatment • Recovery housing
T23 - S04	Residential rehabilitation services	☐ MH ☒ SUD ☐ LTSS	• Residential treatment programs • Therapeutic community residences • Group homes • Halfway houses • Supported independent living programs • Specialized programs
T23 - S26	Case management	☐ MH ☐ SUD ☒ LTSS	• Assessment • Planning • Coordinating • Advocacy • Monitoring • Support
T25 - S18	Substance abuse treatment services	☐ MH ☒ SUD ☐ LTSS	• Assessment and referral • Detoxification services • Inpatient rehabilitation • Outpatient treatment • Medication-Assisted treatment • Counseling and therapy • Prevention and education
T26 - S04	Adult day facility	☐ MH ☐ SUD ☒ LTSS	• Nursing care and monitoring of medical conditions • Medication management and administration • Nutritious meals • Physical, occupational, and speech therapy • Assistance with ADLs
T27 - 060	Public school-based services	☒ MH ☐ SUD ☒ LTSS	• Care coordination • Developmental screening • Individualized plans • Counseling and therapy
T34 - S31	Community behavioral health services	☒ MH ☐ SUD ☐ LTSS	• Mental health services • Substance abuse services • Crisis intervention • Prevention and education • Recovery-oriented services
T36 - S22	High tech Registered Nurse (RN)	☐ MH ☐ SUD ☒ LTSS	• Medication Administration • Wound care • IV therapy

			• Chronic disease management • Pain management
T36 - S23	High tech Licensed Practical Nurse (LPN)	☐ MH ☐ SUD ☒ LTSS	• Medication Administration • Wound care • IV therapy • Chronic disease management • Pain management
T38 - 079	Licensed alcohol drug counselor	☐ MH ☒ SUD ☐ LTSS	• Assessment & evaluation • Treatment planning • Counseling and therapy • Education and support • Referrals and collaboration
T41 - 065	Physical therapy assistant	☐ MH ☐ SUD ☒ LTSS	• Assessment and evaluation • Treatment planning • Therapeutic exercise • Education • Pain Management
T44 - 098	Diabetic counselors	☐ MH ☐ SUD ☒ LTSS	• Diabetes education • Nutritional guidance • Blood glucose monitoring • Medication management • Lifestyle management
T44 - S38	Registered dietician	☐ MH ☐ SUD ☒ LTSS	• Nutrition assessment • Dietary counseling • Meal planning • Nutrition education • Medical nutrition therapy
T46 - S50	Behavioral analyst	☒ MH ☐ SUD ☐ LTSS	• Assessment • Behavior intervention plans • ABA therapy • Collaboration
T46 - S51	Assistant behavioral analyst	☒ MH ☐ SUD ☐ LTSS	• Assessment • Behavior intervention plans • ABA therapy • Collaboration
T47 - S53	Family Supportive Housing	☒ MH ☒ SUD ☒ LTSS	• Emergency shelter • Rapid Re-housing • Transitional housing • Homeless prevention services • Supportive services

Provider types that were eligible for HITECH incentives will not be eligible for MDAAP incentives.[1] If a provider has received funds from another MDAAP-related source (for example, as a business support vendor) they are not eligible for incentive payments.

6. Practices Attesting for MDAAP Incentives

Providers will attest as a solo provider of a practice (individual), or a group practice or facility (group). Solo practice providers will have the ability to attest as an individual and use an individual Medicaid patient volume calculation. Group practices and facilities must attest as a group and use a group Medicaid patient volume calculation. Providers not practicing independently must participate through their employers. MDAAP incentives will be issued based on the payment information on file in MMIS for the Medicaid provider ID on the approved MDAAP application.

Incentive payment amounts for the milestones 'New CEHRT technology purchase' and 'New electronic program eligible non-CEHRT technology purchase' will be based on the total number of user licenses in the technology contract. Solo providers will be eligible for a base incentive amount, practices with 2-9 user licenses a larger incentive amount, and practices with 10 plus user licenses the largest amount, as detailed in Table 6 published on the MDAAP website upon approval of the Payment Protocol. VITLAccess milestones in each track will be based on the number of new accounts linked to an organization. When a provider registers for VITLAccess, their provider information is verified by Vermont Information Technology Leaders to ensure that the person registering is a health care provider who isn't already registered for VITLAccess.

6.1 Patient Volume

The MDAAP Special Term and Condition (STC) 8.3 of the Global Commitment to Health Demonstration states that providers eligibility for MDAAP incentives will be limited to those whose Medicaid patient volume is at least 20%. The definition of Medicaid patient encounter and Medicaid patient volume for MDAAP are as follows, consistent with the standards used for the EHR Technology Incentive Program**,** **42 CFR Part 495** at the Electronic Code of Federal Regulations (e-CFR)**.**

- A patient encounter is any service rendered to an individual on any one day.
- A Medicaid encounter is any service rendered to an individual on any one day where:
    - Medicaid paid for part or all of the service,
    - Medicaid paid all or part of the individual's premiums, co-payments, and cost-sharing, or

[1] Specifically, the following VT Medicaid provider types will not be eligible for MDAAP: physicians (provider type code 005), dentists (provider type code 004), certified nurse midwives (provider type code T06 with specialty code 042 midwife), nurse practitioners (provider type code T06), physician assistants (provider type code T37), podiatrists (provider type code 006), optometrists (provider type code 007), chiropractors (provider type code 018), pediatricians (provider type code 005 with specialty code pediatric medicine 037), and acute care hospitals (provider type code 001).

  - The individual was enrolled in a Medicaid program at the time the billable service was provided.
- To calculate Medicaid patient volume, a provider must divide:

  The total Medicaid encounters in any representative, continuous 90-day period in the prior calendar year, or in the 12 months before the provider's attestation (M90) by

  The total for all patient encounters in the same 90-day period (A90).

  M90 ÷ A90 = Medicaid Patient Volume

- Do not count multiple claims for services for the same patient by the same provider on the same day. The patient volume calculation assesses encounters, not claims, and requires the provider to remove duplicate encounters on the same day for both the numerator (M90) and denominator (A90).
- Services rendered to the same patient by different providers on the same day are allowed to be counted discreetly by each provider.
- Individual/solo providers may choose one (or more) clinical sites of practice in order to calculate patient volume. This calculation does not need to be across all of a provider's sites of practice. However, at least one of the locations where the provider is participating in MDAAP must be included in the patient volume and must be within the State of Vermont. A provider may calculate patient volume across all practice sites, or just at one site.
- Group practices or facilities will calculate patient volume at the group practice/clinic level, in accordance with all of the following limitations:
  - (1) The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way.
  - (2) If a provider works both within and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the provider's encounters unaffiliated with the clinic or group practice.
- For each provider/practice attesting with Group Patient Volume, a Group Definition must be provided at the time of attestation. The Group Definition must contain:
  - The complete set of Billing NPIs and Medicaid IDs across all of their client services programs defining the Group.
- The calculation/compilation of the Group Patient Volume must incorporate ALL encounters under the practice's set of billing NPIs and Medicaid IDs.

As part of initial attestations for the first milestone, all providers will be required to submit a patient volume spreadsheet including details of their Medicaid patient volume metrics, including the selected 90-day patient volume reporting period, numerator value,

denominator value, and overall Medicaid patient volume percentage. The spreadsheet must contain the following fields:

* ColumnName: Description
* BillNpi: Billing provider NPI.
* BillMdId: Billing provider Medicaid ID
* Pid: Patient unique ID. (Do not include PHI such as social security numbers, dates of birth, or names.)
* Ruid: Medicaid Recipient Unique ID. The Medicaid ID ONLY should populate this column. No other insurance policy number or ID is relevant for this data field. The field should remain blank if the patient was not eligible for Medicaid on the date of service.
* MdState: State in which the patient was enrolled in Medicaid. This field should remain blank if the patient was not eligible for Medicaid on the date of service.
* EnctrDate: Patient encounter date.
* Group: For all **group attestations** based on a subpart of the billing provider NPI: Clinic name, group practice name, service location, or organizational subpart NPI. You should be prepared to show that a subpart group has an identifiable and distinct physical location or business function within the billing-NPI organization other than for the purpose of establishing minimum Medicaid patient volume for the MDAAP.

The pre-screener will check the spreadsheet for duplicates, ensure the encounters fall within the attested 90-day patient volume period, check random Medicaid IDs to ensure that there is only one patient ID for all identical Medicaid Patient IDs, and that the percentage of Medicaid encounters meets the threshold. If a Provider Agreement milestone and the accompanying application is randomly selected for post-payment audit, the auditor will analyze the patient volume data ensuring all prechecks were correct and evaluating Vermont Medicaid recipient eligibility on encounter dates using MMIS data. A query of our VT MMIS database can be run to help validate the Medicaid patient volume numerator. This query is for Vermont Medicaid claims based on NPI or Medicaid ID. Limitations of the query include that it may not be able to document all encounters that are part of global charge bundled services, mental health case rate, or Medicaid mental health or developmental waiver services, and it only captures paid claims. Therefore, documentation of encounters for the Medicaid numerator and total encounters for the denominator will be collected from the provider and analyzed. If the Medicaid patient volume ratio is at least 20% (19.5% will be rounded up to 20) the provider is considered having met the patient volume eligibility requirement. The auditor will request documentation as needed from the provider or organization to conclude on the patient volume eligibility. If a provider fails to meet the patient volume eligibility requirement, then they will be deemed not eligible to receive an MDAAP incentive payment. Providers will have the ability to amend their attested 90-day patient volume reporting in order to find a timeframe that meets the 20% Medicaid patient volume requirement.

The Designated Agency and Specialized Service Agency providers will use the Vermont Agency of Human Services Department of Mental Health annual Statistical Report and the most recently available data for their Medicaid patient volume and will not supply a patient volume spreadsheet. This most recent public report was prepared in May 2023 and includes Table 2-4, Responsibility for Fee of Clients Served, which includes the

percentage of clients that are covered by Medicaid for each of the state's Designated and Specialized Service Agencies. The range of percent of clients served by these agencies that are covered by Medicaid is 51% to 100% and the overall average is 67%. This table will be reviewed by the pre-screener to document the percentage of clients that are covered by Medicaid for each agency.

Public school supervisory unions/districts enrolled in MMIS as T27 – 060 Public School Based Services providers will use Vermont Agency of Education Medicaid Enrollment Rate data for their Medicaid patient volume and will not supply a patient volume spreadsheet. The Medicaid enrollment rate data will be supplied by the Vermont Agency of Education and this data will be reviewed by the pre-screener for each supervisory union/district to document the percentage of students covered by Medicaid and to confirm it is at least 20% (19.5% will be rounded up to 20). This data will also be reviewed by the auditor for those selected for post payment audit.

6.2 Children's Health Insurance Plan (CHIP) Encounters

Per section 8.3 (a) of the Medicaid Waiver, MDAAP participants will have an eligibility requirement of a 20% Medicaid patient volume, and Children's Health Insurance Plan (CHIP) enrollee encounters cannot be counted as Medicaid encounters. CHIP is a Title XXI program, while Medicaid is Title XIX.

Vermont proposes to embed a proxy calculation within a fillable PDF to create a reasonably accurate estimation of what the Medicaid patient volume would be without CHIP encounters.

When Vermont implemented its CHIP program in 1998, it was designed to be identical to our Dr. Dynasaur (traditional Medicaid and Medicaid 1115 waiver expansion) program. To beneficiaries and providers, CHIP coverage is under Dr. Dynasaur, and to administrators, Dr. Dynasaur is supported with Medicaid and CHIP funds which are tracked through specific Aid Category Codes for each program. Vermont CHIP operates the same as the Medicaid program, using the same eligibility system, health care benefits, provider network, billing, and other infrastructure to deliver health care services to beneficiaries. This includes all Dr. Dynasaur children (Medicaid & CHIP) having the same Green Mountain Care enrollment card. We do not believe that providers or beneficiaries would know which Federal program a child was receiving services from. In essence, the state has trained the providers to consider CHIP and Medicaid as synonymous coverage. Providers would not be able to exclude CHIP encounters from their current data.

Instead, we propose using a proxy calculation to remove the estimated percentage of CHIP encounters to the total pool of Medicaid and CHIP encounters and then apply that proxy to the patient volume numerator. We performed an analysis of CHIP enrollment rates to understand the likely impact of CHIP on total Medicaid and CHIP encounters. From the **Data.Medicaid.gov website**, per the 3/1/2023 preliminary report, the Vermont Medicaid program has 189,065 individuals enrolled and the CHIP program has 4,584 individuals enrolled. This is a total enrollment of 193,649, of which the CHIP population is 2.37% and Medicaid only population is 97.63%. If financial expenditure data were to be used to create the proxy, it would be even smaller. From **Medicaid.gov expenditure data**, in 2019 Vermont had a total of $1,815,991,126 in Medicaid expenditures, and $13,843,553 in CHIP

expenditures. The percentage of CHIP to total Medicaid expenditures is 0.762%. Vermont suggests using 97.63% as the proxy to determine the number of Medicaid enrollees in a CHIP/Medicaid sample because enrollment and encounters are more closely linked than encounters and expenditures.

For MDAAP eligibility, Vermont will make a fillable PDF form that will direct providers to fill in the number of Medicaid encounters and the number of total encounters during a 90 day period they select either within the previous 12 months or during the previous calendar year.

Numerator= Total Medicaid and CHIP encounters during the period multiplied times the Medicaid proxy
Denominator= Total encounters during the period
Proxy= 97.63%, the estimated percentage of Medicaid encounters in a Medicaid and CHIP sample

$$\text{Medicaid patient volume} = \frac{(\text{Medicaid \& CHIP encounters})(0.9763)}{\text{Total encounters}}$$

The resulting Medicaid-only patient volume after the proxy calculation must be at least 19.5% in order to round up to a 20% patient volume.

There would be a significant administrative overhead to exclude exact CHIP encounter data from MDAAP incentive payment attestations. The State would have to provide a report to providers indicating which children served are CHIP and which are Medicaid. And while the State has security procedures around protected health information, any transmission of an electronic report of Medicaid versus CHIP eligibility has a small security risk.

Using an embedded proxy calculation will ensure that a reasonably accurate number of CHIP encounters are removed from the Medicaid patient volume calculation, remove administrative overhead burden and, ensure a well-received message to communicate to the MDAAP provider community.

7. Pre-screening & Post-Payment Audit Details for Eligibility

Table 2 published on the MDAAP website upon Payment Protocol approval details the pre-screening and post-payment audit procedures for each of the MDAAP eligibility requirements. Please note that some items are designated for the pre-screening reviewer, while others are for the post-payment auditor. Table 2 serves as the audit checklist. It is used with additional columns for results/calculations and a work paper reference.

All providers participating in MDAAP will be required to submit documentation to validate their attested milestones. Providers should retain all supporting documentation used for attestation for at least six years. Providers may submit documentation via the State's encrypted email portal or via an online web portal data solution.

The results of each audit step will be recorded. Relevant notes, comments, and references to supporting documentation will also be recorded. Use of standardized documentation and data collection will ensure that all providers are evaluated according to the same criteria. While no PHI or PII will be requested for participation in MDAAP, the case electronic files are stored on secure state servers in a folder that can be accessed only by MDAAP staff through an Access Control List (ACL). This ACL is maintained by the state's Agency of Humans Services IT group, under the Agency of Administration's Department of Information and Innovation, and periodically reviewed to ensure only authorized individuals are allowed access.

7.1 Payments

State administrators will collect signed attestations including provider information and eligibility requirements via email and secure email can be used to receive supporting documentation such as patient volume files. A pre-screening reviewer will collect an initial application with the first milestone. The application will include the practice name, contact information, address, phone number, NPI, Medicaid ID, Medicaid provider type and specialty, patient volume date period, group patient volume definition, patient volume numerator and denominator values, MDAAP track and milestone selection, and milestone supporting documentation. This information will be collected on a document signed via script signature or e-mail signature by a leadership member of the practice.

After collecting and saving the attestation information, the pre-screening reviewer will perform checks to validate the submitted documentation as described in Table 2. Once all validation has been completed, payment will be remitted through a standard payment channel used to pay Medicaid providers.

8. MDAAP Program Tracks and Milestones

8.1 Program Tracks

Adoption of New EHR Technology

Track One: Implement Certified Electronic Health Record Technology (CEHRT)

- **Expands HIT use by providing financial incentive payments and business support to adopt Certified Electronic Health Record Technology**
- **Increases Vermont Health Information Exchange connectivity by connecting CEHRT systems to send ADT and CCD interfaces to the VHIE**
- **Assists providers with improving beneficiary outcomes and reducing disparities by helping providers achieve the initial investment, installation and training in an interoperable record system and HIE connection for reduced provider burden, better communication among providers, and more robust data collection and reporting.**

Track Two: Upgrade from no EHR System to an EHR Lite or Other Program- Eligible System

- **Expands HIT use by providing financial incentive payments and business support to adopt EHR Lite Technology**
- **Increases Vermont Health Information Exchange connectivity by teaching providers how to view patient data in VITLAccess**
- **Assists providers with improving beneficiary outcomes and reducing disparities by helping providers implement digital record systems for reduced provider burden, increased telehealth especially in rural areas, more robust data collection and reporting.**

This pathway involves implementing new EHR technology, either certified EHR technology (CEHRT) or an “EHR Lite” solution that is not certified by ONC but meets HIPAA Security Rule requirements.

Vermont hired a consultant to engage the home and community-based provider community as key stakeholders. Through a survey, focus groups, speaking to other states and subject matter experts, state administrators learned that EHR Lite systems are systems that are tailored to capture all of the health care data that arises during a typical encounter in specific health care settings. These systems are easy to learn to use for providers who do not have a dedicated reception or IT staff, often provide billing or telemedicine features, and importantly are affordable. The average maintenance cost of a CEHRT system is $8,000 per year, whereas the price of EHR Lite systems for mental health professionals- over half of Vermont’s HCBS providers- were $360 to $1,200 per year (Of importance to note, the average salary for a mental health counselor in the US is $49,777). While CEHRT systems are the most interoperable and able to be connected to an HIE, funding EHRs that targeted providers would not continue to use or purchase after the MDAAP incentive program ends will not achieve systems change. Vermont decided instead to create a digitization track for the roughly one third of HCBS providers

who do not use an EHR system. The financial incentives of this track and especially the provider business support in this track gives providers the assistance they need to digitize their clinical records. Additionally, the telehealth tools allow providers to connect with health care users in rural areas or those who may need to receive their health care in a home setting, and a use of an EHR's efficient billing system allows providers to spend more time caring for more patients or maintaining a healthy work-life balance for job satisfaction. Many of Vermont's more rural areas have been hit with catastrophic flooding in recent months; use of a cloud-based EHR Lite system has allowed many HCBS providers to mobilize in communities where they are needed most. Colorado, who is also incentivizing a full array of EHR systems, shared with Vermont that digitization of health records decreases provider burden associated with paper clinical and billing records, increases provider job satisfaction, and results in better data reporting even when providers are not directly connected to an HIE.

Program Tracks 1 and 2 are similar in requiring documentation of the technology purchase (i.e., executed vendor contract), completion of a Security Risk Analysis (SRA) as defined by VITL, and activation or "go-live" of the new system, defined as the date upon which the provider began using the new technology to document ongoing services for active client records.

Track 1 includes additional incentive payment milestones for providers who wish to connect their EHR system electronically to VITL via interfaces to share data with the VHIE. These additional milestones require agreements with VITL as well as contracts with the provider's EHR vendor for developing, testing, and activating interfaces. Track 1 concludes with the "go-live" of interfaces to begin sharing production data with the VHIE.

Although Track 2 does not encompass interface connectivity to VITL, the final incentive payment milestone for Track 2 involves obtaining VITLAccess, the web-based clinical portal that allows users to view client/patient data submitted to the VHIE from participating organizations. This milestone for VITLAccess is incorporated into multiple program tracks.

VHIE Connection Only

Track Three: VHIE Connection with a CEHRT System

- **Increases Vermont Health Information Exchange connectivity by connecting CEHRT systems to send ADT and CCD interfaces to the VHIE**
- **Assists providers with improving beneficiary outcomes and reducing disparities by helping providers achieve the initial investment in HIE connections for reduced provider burden, better communication among providers, and more robust data collection and reporting.**

Track Four: VHIE Connection with a selected EHR Lite or Other Program-Eligible System

- **Increases Vermont Health Information Exchange connectivity by connecting systems to send data to the VHIE**
- **Increases Vermont Health Information Exchange connectivity by teaching providers how to view patient data in VITLAccess**

- **Assists providers with improving beneficiary outcomes and reducing disparities by helping providers achieve the initial investment, installation and training in an HIE connection for reduced provider burden, better communication among providers, and more robust data collection and reporting.**

This program pathway is for providers who already have either a CEHRT system or an EHR Lite/Other Program-Eligible System and desire to develop electronic connectivity to the VHIE. Track 3 is unique in that it is designed for two types of provider groups who currently utilize CEHRT: 1) Vermont Designated Agencies and Specialized Services Agencies required to connect to the VHIE under an Approved Connectivity Plan Proposal, and 2) All other eligible Vermont providers. Within Track 3, participating DA providers will be eligible for two alternative incentive payments: A signed VHIE Service Agreement Amendment for 42 CFR Part 2 Data and an Approved Connectivity Plan Proposal as required by an existing DA Provider Agreement. The incentive payment structure is higher because the hours that are put into developing and writing an approved Connectivity Plan Proposal are significant. All other Track 3 providers will complete milestones for the standard Signed Participation Agreement and Signed Scope of Services Agreement with VITL. (See the next section for program track milestones.)

Track 4 is designed for providers utilizing an "EHR Lite" (or other system that meets the eligibility standards set out in Track 2) that desire to develop electronic connectivity with the VHIE. Instead of milestones tied to development of specific interface types (i.e., ADT and CCD interfaces), this program track will require working with each HIT vendor and VITL to determine the appropriate data fields, file or message types, and method of secure data exchange to accomplish electronic connectivity. Both tracks within the VHIE Connection Only pathway culminate with milestones associated with the "go-live" of interfaces that will send production data to the VHIE.

VITLAccess Only

Track Five: VITLAccess Connection and Training

- **Increases Vermont Health Information Exchange connectivity by teaching providers how to view patient data in VITLAccess**

The third program pathway includes just one track for providers who only desire obtaining VITLAccess. Even though these providers will not be purchasing any vendor software or services, they will still be required to complete a Participation Agreement to ensure program eligibility and a Services Agreement with VITL as part of the documentation process for VITLAccess credentialing, training, and usage.

8.2 Milestones, Required Supporting Documentation, and Incentive Amount

Table 3: Adoption of New EHR Technology

Track 1: Implement Certified EHR Technology (CEHRT)			
Milestones	**Incentive Payments**		
	1 license	**2-9 licenses**	**10+ licenses**
Signed Participation Agreement to implement CEHRT	$2,000	$2,000	$2,000
Signed Scope of Services Agreement to implement CEHRT	$2,000	$2,000	$2,000
New CEHRT technology purchase (2015 Cures Edition)	$23,000	$38,000	$49,000
New CEHRT Go-Live	$4,000	$4,000	$4,000
Conduct or review a security risk analysis	$4,000	$4,000	$4,000
Completed VITL Access credentialing, training, and usage	$500	$1,000	$2,000
Vendor contract for ADT interface	$10,000	$10,000	$10,000
Vendor contract for CCD interface	$16,000	$16,000	$16,000
Go-live achieved & sending production encounter data (ADT) to the VHIE	$4,000	$4,000	$4,000
Go-live achieved and sending production clinical data (CCD) to the VHIE	$4,000	$4,000	$4,000
Total	**$69,500**	**$85,000**	**$97,000**
Track 2: Implement an EHR Lite or Other Program-Eligible System			
Milestones	**Incentive Payments**		
	1 license	**2-9 licenses**	**10+ licenses**
Signed Participation Agreement to implement program-eligible system	$500	$500	$500
Signed Scope of Services Agreement to implement program-eligible system	$500	$500	$500
New electronic program-eligible technology purchase and go-live checklist	$500	$2,000	$9,000
Conduct or review a security risk analysis	$4,000	$4,000	$4,000
Completed VITL Access credentialing, training, and usage	$500	$1,000	$2,000
Total	**$6,000**	**$8,000**	**$16,000**

Table 4: VHIE Connection Only Tracks

Track 3: VHIE Connection with a CEHRT System		
Milestones	**Incentive Payments**	
		Track 3a
Signed Participation Agreement	$2,000	
Signed VHIE Service Agreement Amendment for 42 CFR Part II Data (*Track 3a only)*		$10,000
Signed Scope of Services Agreement to connect to the VHIE	$2,000	
Approved Connectivity Plan Proposal (CPP) as required by an existing Designated Agency Provider Agreement (*Track 3a only)*		$27,000
Conduct or review a security risk analysis	$4,000	
Vendor contract for ADT interface	$10,000	$10,000
Vendor contract for CCD interface	$16,000	$16,000

Go-live achieved & sending production encounter data (ADT) to the VHIE	$4,000	$4,000
Go-live achieved and sending production clinical data (CCD) to the VHIE	$4,000	$4,000
Total	**$42,000**	**$71,000**

Track 4: VHIE Connection with a Selected EHR Lite or Other Program-Eligible System			
Milestones	**Incentive Payments**		
	1 license	**2-9 licenses**	**10+ licenses**
Signed Participation Agreement to explore connection to the VHIE	$2,000	$2,000	$2,000
Signed Scope of Services Agreement to explore connection to the VHIE	$2,000	$2,000	$2,000
Conduct or review a security risk analysis	$4,000	$4,000	$4,000
Completed VITLAccess credentialing, training, and usage	$500	$1,000	$2,000
Vendor contract for EHR Lite or other system to connect to the VHIE	$20,000	$20,000	$20,000
Go-live achieved and sending production data to the VHIE	$6,000	$6,000	$6,000
Total	**$34,500**	**$35,000**	**$36,000**

Table 5: VITLAccess Only Track

Track 5: VITLAccess Connection and Training			
Milestones	**Incentive Payments**		
	1 license	**2-9 licenses**	**10+ licenses**
Signed Participation Agreement for VITLAccess	$1,000	$1,000	$1,000
Completed VITLAccess credentialing, training, and usage	$500	$1,000	$2,000
Total	**$1,500**	**$2,000**	**$3,000**

After selecting their MDAAP program track, providers will apply to the program and attest to their first milestone. Each milestone is voluntary and program participants can skip milestones. Eligible providers currently have a variety of record systems and practice needs. In making the milestones optional, Vermont is trying to meet providers where they are to help them join our health data vision. Change Management is a critical component of this systems building program. Rather than disrupt the provider's workflow, we want to meet them where they currently are and encourage them. Depending on their business and their computer and data skills, not every milestone will be helpful for every provider to achieve, therefore optionality is a key component to change management and business assistance in MDAAP. For example, a provider or practice that already has a certified EHR system may opt only to participate in milestones related to connecting and sending electronic data to the VHIE. Providers will not receive payment for milestones skipped.

Early into program participation, participants will be contacted by the business support team. The business support team will educate providers about the program and help the provider to sign a Participation Agreement outlining the expectations of the program. Though all milestones are voluntary, the Participation Agreement states that the provider must engage with the business support team for a needs assessment. This is important so that the provider is able to fully explore their needs and goals for the program. A

provider who does not participate in a needs assessment must return the incentive payment, as explained in the Participation Agreement.[2]

Each milestone will have specific supporting documentation requirements. Providers will supply their attestation with a handwritten or e-mail signature and documentation via the State's encrypted email portal or software system. The pre-screening reviewer will evaluate the milestone selection and confirm that appropriate supporting documentation has been supplied.

If needed, the reviewer will reach out to the provider for corrections or documentation requests via email, telephone, or secure screen sharing. The requests will detail the file(s) and information that must be submitted to support the eligibility data and milestone selection the provider entered into the MDAAP application. If that milestone is randomly selected for post-payment audit, the auditor will evaluate the milestone selection and supporting documentation for completeness and request additional documentation as necessary. For each milestone audited, the auditor will record the findings in an audit program (Table 6). All findings will be documented to provide a complete history of data evaluated. If the post-payment auditor identifies an area of concern, they will continue to follow-up with the provider to obtain additional clarification and/or information needed to perform the audit procedure and conclude on the results. When the auditor is able to reach a conclusion on the results of an attestation milestone, they will submit to their supervisor for final approval. All post-payment audit results will be recorded in our case management database, specifically whether or not the provider was able to support their attestation and meet the eligibility, track, and milestone requirements to receive a MDAAP incentive.

9. Claiming Federal Financial Participation (FFP) for Incentive Payments

The MDAAP incentive payments to providers will be made via the State's MMIS contractor, Gainwell. Gainwell will supply VT-AHS with a quarterly report (Financial Balancing Report – FBR) of the total incentive payments made. AHS will claim the total computable of these costs on the CMS 64.9 MDAAP form in order to report and draw down the FFP at the applicable Federal Medical Assistance Percentage (FMAP) rate.

10. Denial of MDAAP Incentive Notification Letter

If an MDAAP applicant is denied an incentive payment, then the pre-screening reviewer will document the findings from the MDAAP application pre-payment review in a denial of MDAAP incentive notification letter. The letter will be sent by email to the provider/practice. The letter will include a description of the results of the review, including any identified discrepancies and findings about program eligibility and documentation requirements. Included in the notification will be instructions on how to submit a request for reconsideration, the first level of our appeals process. The provider will have 30 days from the receipt of the letter to file for reconsideration.

[2] A small number of providers who are required to submit a Connectivity Plan Proposal to the State may count that document as a needs assessment due to the similar purpose.

11. Audit Results Notification Letter

The auditor will document the findings from their review in a standardized audit results notification letter. The letter will be sent by email to the provider or practice. The letter will include a description of the audit results, including any identified discrepancies, if the provider has successfully met the requirements of the audit, if further action of the provider is required, and details related to any identified overpayments, as applicable. Included in the audit results letter will be instructions on how to submit a request for reconsideration, the first level of our appeals process. The provider/practice will have 30 days from the receipt of the letter to file for reconsideration. If an overpayment was identified, the provider/practice will be asked to remit the amount with 30 days from receipt of the audit results notice. If the provider/practice does not remit within 30 days, the necessary steps will be taken to recoup the overpayment from future Medicaid payments.

12. Reconsideration & Appeals Process

Providers may request reconsideration if they feel that they have been denied an incentive payment, have received an inaccurate payment, or believe audit findings are incorrect. The Reconsideration and Appeal process for MDAAP will align with the process used for Vermont's Promoting Interoperability/EHR Incentive Program, detailed in Section 8 of the Green Mountain Care General Provider Manual, available here: `http://www.vtmedicaid.com/Downloads/manuals.html`. This process is also in alignment with the reconsideration and appeals process for the Medicaid Program Integrity Program, also known as the Special Investigations Unit. Once the MDAAP Incentive Payment Protocol has been approved by CMS, then the Green Mountain Care General Provider Manual will be updated to include Reconsideration and Appeals for the MDAAP.

12.1 Reconsideration of MDAAP Decisions

The provider has 30 days to file for reconsideration from the date of receipt of the denial of MDAAP incentive notification letter or receipt of the audit results notification letter. If the provider deems the review findings are incorrect, they must submit a written detailed explanation of the reason for the disagreement on a Request for MDAAP Reconsideration form and describe how they met the requirements to receive a MDAAP incentive payment along with supporting documentation. This reconsideration will be submitted by the provider to the mailing address for MDAAP Appeals, Office of the General Counsel, Department of Vermont Health Access. Briefly, the reconsideration review is conducted by a qualified member within the MDAAP, and they may schedule a meeting with the provider. They will review the reconsideration and decide whether or not to adjust the original findings of the review/audit. A response will be generated within 30 days from the date of receipt for the request for reconsideration, following a meeting with the provider, following receipt of additionally requested information from the provider, or the provider will be notified that an additional 14-day extension has been invoked. The findings of this review will be documented in our MDAAP case management database. If the overpayment is reduced to zero based upon the auditor's review of rebuttal documents, then an amended audit results notification letter is sent to the provider/practice. If the auditor's review of the reconsideration documents does not reduce the overpayment to zero, a letter is sent via email with the results of the review of the reconsideration request and states the intent to recover the funds through future Medicaid payments if the provider

does not remit the overpayment, and includes their next level of appeal rights if they are dissatisfied with the reconsideration decision.

If the provider/practice finds that the audit findings are correct, and they did not meet the requirements for the payment, then they can remit the funds or set up a payment plan with Gainwell Technologies, who is the fiscal agent for Vermont Medicaid.

12.2 Recoupment of Incentive Payments

If the provider/practice does not contact the Vermont MDAAP within 30 days of receipt of the Audit Results Notification Letter with a request for Reconsideration, or to inform them of their intent to repay the overpayment, then recovery of the funds and the 1-year Federal pay-back period begins. This will be done in accordance with current procedures for recoupment through future remittances via the fiscal agent, Gainwell Technologies. The fiscal agent will create an accounts receivable record for the amount to be recovered indicating the fund code to use in tracking the recoupment and the date the liability was established. This information will be reported to CMS through the CMS-64. If recoupment cannot be made in this manner, the recoupment will go to the collections department for their actions. The provider/practice can arrange for a repayment plan by signing a promissory note.

The identified overpayment will be returned to CMS within the 1-year Federal period to repay FFP. This repayment will occur with or without the recovery having been completed by the State. Vermont will report to CMS on the CMS-64 recoupments through established accounts receivable records that indicate the Medicaid MDAAP fund code. In the report, the State will indicate whether the funds have been recovered from the provider or if they are still outstanding.

12.3 Appeal of MDAAP Reconsideration

A provider who is dissatisfied with the result of the reconsideration may appeal that decision, within 30 days from the date on the Reconsideration decision notice, to the Chief Medical Officer (CMO), Department of Vermont Health Access (DVHA) Commissioner, or designee, depending on the overpayment dollar amount.

Cases regarding an overpayment of $15,000 or less will be reviewed by the CMO or designee. At the discretion of the CMO or designee, written instructions will be issued to the provider explaining the process or providing for a meeting with the provider. Cases regarding an overpayment of $15,000 or more will be reviewed by the DVHA Commissioner, or designee, who may convene a hearing to be scheduled within 90 days from the date of the receipt of the appeal. The appeal hearing shall be conducted under the same rules of conduct as in current use for hearings before the Human Services Board.

Within 14 days of either a meeting by the CMO or designee, or an appeal hearing by the Commissioner or their designee, the following will be mailed to the provider: (1) A written request for additional information or an additional meeting to discuss, or (2) a decision letter. The decision notice will indicate the next level of appeal should the provider be dissatisfied with the decision. The next level of appeal is the Vermont Superior Court.

13. Detection of Fraud, Waste, or Abuse

In the event that a MDAAP reviewer suspects or discovers potential fraud, waste, or abuse, they will immediately notify the Special Investigations Unit within 7 days to determine what additional procedures should be performed. Actions will be taken to recover any overpayment made to the provider. The MDAAP will initiate the recovery of mis-payments, suspension of future payments, the termination of agreements with providers, or other action(s) that may be necessary. The Special Investigations Unit will be consulted as needed during this process and will meet its obligation to report to the Attorney General's Office's Medicaid Fraud Unit any fraud deemed as intent to steal.

14. Returning an MDAAP Incentive

Our MMIS fiscal agent will handle any adjustments, returns or recoupments through established processes. MDAAP will create a return payment form and post it to its website, similar to the return payment form used for the HITECH meaningful use program. Providers wishing to return payment will be able to send a check to our fiscal agent along with the return payment form. Providers will also be able to request a repayment plan, or the incentive can be collected through future Medicaid remittances. These funds will be returned to CMS within the 1-year period to repay Federal Financial Participation.

15. MDAAP Reporting

The state will report on the Activities of the MDAAP in Vermont's Global Commitment for Health Demonstration Annual Monitoring Reports. This will include the amount and types of providers participating, the program tracks selected, milestones achieved, and the amount of incentives paid for each track and milestone.

ATTACHMENT I
Supportive Housing Assistance Pilot Eligibility Criteria, Services, and Provider Qualifications

Eligibility Criteria This benefit is targeted to Medicaid enrollees age 18 and older eligible for full Medicaid state plan benefits, and the individual is assessed to meet at least one of the following needs-based criteria and at least one of the following risk factors:	

	• At risk of homelessness, as defined by HUD as codified at 24 CFR Part 91.5
	• Homeless, as defined by HUD as codified at 24 CFR Part 91.5
	• History of frequent or lengthy stays in an institutional or residential setting
	  o Frequent is defined as one or more stays in the past 12 months.
	  o Lengthy is defined as 28 or more consecutive days.
	• History of frequent ED visits and/or hospitalizations
	  o Frequent is defined as two or more visits within the past six months or four or more visits within a year.
	• 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
	  o Frequent is defined as one or more moves/loss of housing due to a mental health or SUD symptoms in the past six months.
	• At serious risk of institutionalization due to the lack of available community supports

• 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	

Eligibility Criteria	
This benefit is targeted to Medicaid enrollees age 18 and older eligible for full Medicaid state plan benefits, and the individual is assessed to meet at least one of the following needs-based criteria and at least one of the following risk factors:	
Needs-Based Criteria	**Risk Factors**
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	

Service Descriptions	
Benefit Categories*	**Description of Services**
Pre-Tenancy Supports	• Housing needs and preferences assessment • Assistance with locating and applying for housing • Housing support plan development • Assistance in securing resources and benefits, such as TANF, Section 8 housing vouchers, Shelter Plus, or other rental assistance
Tenancy Sustaining Services	• 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

*Note: A description of community transition services is available in Attachment Y HRSN Services Protocol.

Provider Qualifications	
Provider	**Minimum Qualifications**
Staff providing pre-tenancy supports and tenancy sustaining services.	• Bachelor's degree or associate degree in a human/social services field or a relevant field; and/or • At least one year of relevant experience and/or training in the field of service.
Case management staff	• Bachelor's Degree in Education, Human Services, Counseling or a related field; and • At least one year of relevant experience and/or training in the field of service.

ATTACHMENT J
SUD Implementation Plan

Introduction

The overall goal of this amendment request is to maintain and enhance the flexibility and availability of opioid use disorder (OUD), substance use disorder (SUD), and mental health treatment supports under the Global Commitment to Health Demonstration, and to promote a comprehensive and integrated continuum of mental and physical health, OUD/SUD treatment, and long-term services and supports for all Vermonters receiving Medicaid services.

Vermont recognizes that a continuum of services and evidence-based practices include attention to co-occurring mental health disorders and to the physical health impacts of OUD/SUD for persons seeking treatment and recovery services. Vermont intends to build a fully integrated physical health, mental health, OUD/SUD and recovery support continuum. To support this goal, Vermont seeks continued flexible federal funding for residential treatment programs, and in how the American Society of Addiction Medicine (ASAM) and other evidence-based criteria are applied to triage plans of care for persons struggling with addictions and co-occurring mental health and physical health conditions. This triage includes identifying the settings best suited to serve those enrollees with OUD/SUD and co-occurring conditions. For example, in some cases immediate access and treatment in a residential setting is the best course of treatment, while for others immediate stabilization of a psychiatric crisis or medically managed withdrawal, in a general hospital or specialized inpatient facility, followed by intensive addiction treatment may be clinically warranted. Under the SUD demonstration opportunity, only stays in IMDs for which SUD treatment is the primary purpose of treatment are allowed.

The goals of Vermont's section 1115 demonstration are fully aligned with CMS OUD/SUD demonstration goals, as illustrated in Exhibit A below.

Exhibit A – Shared Demonstration Goals

Global Commitment to Health Goals	OUD/SUD Amendment Goals
To increase access to care	• Increase rates of identification, initiation, and engagement in treatment
	• Improve access to care for physical health conditions among beneficiaries
	Reduce utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services

To eliminate institutional bias	• Reduce readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate

Milestones
Vermont has initiated programs or met many of the milestones identified by CMS through innovation under the Medicaid State Plan and the Global Commitment to Health Demonstration, however, the State intends to enhance its efforts to include new initiatives and delivery system reforms. Specifically, new initiatives under development include:

- Implementation of value-based purchasing in alignment with the All-Payer Model Agreement to support access.
- Development of a centralized triage, intake, and call center for persons seeking OUD/SUD services.
- Improvement of discharge planning and transitions between care settings.

1. **Access to Critical Levels of Care for OUD and Other SUDs**
Vermont's OUD/SUD system follows the ASAM Level of Care guidelines and consists of the full spectrum of services, as outlined in Exhibit B beginning below. All OUD/SUD providers must be licensed and enrolled Medicaid Providers, including meeting additional State certification standards for OUD/SUD treatment.

Exhibit B – ASAM Treatment Levels, Providers and Medicaid Availability

ASAM Level of Care	Brief Description	Provider	Existing Medicaid Service (Y/N)
0.5 Early Intervention	• Screening, Brief Intervention and Referral for Treatment (SBIRT)	ER, PCP, Health Clinics, Student Health Center	Y
1 Outpatient Services	• Adult: Less than 9 hours of services per week • Youth: Less than 6 hours of services per week • Individual, Family, and Group Counseling Case Management	Outpatient Clinics	Y
2.1 Intensive Outpatient Services	• Adult: 9 or more hours of services per week • Youth: 6 or more hours of services per week to treat multi-dimensional instability • Bundled rate includes case management	Outpatient Clinics	Y
2.5 Partial Hospitalization	• 20 hours or more per week	Outpatient Clinics	Y (co-occurring

ASAM Level of Care	Brief Description	Provider	Existing Medicaid Service (Y/N)
Day Treatment Psychosocial Rehabilitation Services	• Clinically intensive programming • Direct access to psychiatric, medical and lab services		only, MH diagnosis)
3.1 Clinically Managed Low-Intensity Residential Services	• 24-hour structure, at least 5 hours of clinical service/week	Residential Providers	Y
3.3 Clinically Managed Population-Specific, High-Intensity Residential Services	• 24-hour structure, high-intensity clinical services • Less intense milieu • Group treatment for those with cognitive or other impairments	Residential Providers (IMD)	Continued 1115 Authority
3.5 Clinically Managed High-Intensity Residential Services	• 24-hour care, high-intensity services for persons who cannot be treated in less intensive levels • To stabilize multi-dimensional needs and/or safety issues	Residential Providers (IMD)	Continued 1115 Authority
3.7 Medically Monitored Intensive Inpatient Services	• 24-hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3 • 16 hour/day counselor availability	Residential Providers (IMD)	Y
4 Medically Managed Intensive Inpatient	• 24-hour nursing care and daily physician care for severe unstable problems in Dimensions 1, 2 or 3 • Counseling available to engage patient in treatment (detox only)	Psychiatric Hospital (IMD)	Continued 1115 Authority
Opioid Treatment Program	• Daily or several times weekly opioid agonist medication and counseling to maintain multidimensional stability for those with severe opioid use	Specialized Health Homes (Hub & Spoke)	Y
Withdrawal Management (WM)	• Levels 1 – 4	Specialized Health Homes (Hub & Spoke), Hospitals, Residential	Y, Continued 1115 Authority for Higher Levels

ASAM Level of Care	Brief Description	Provider	Existing Medicaid Service (Y/N)
		providers (IMD)	

Level of Care: 0.5 Early Intervention

Current State:

Screening Brief Intervention and Referral for Treatment: Vermont is in year five of a SAMHSA grant to promulgate Screening, Brief Intervention and Referral for Treatment (SBIRT) throughout Vermont. SBIRT services are intended to identify individuals with risky alcohol and drug behavior and provide a brief intervention or a referral to treatment, if necessary. Throughout the life of the grant, SBIRT has provided services to emergency rooms, free health clinics, primary care offices and a student health clinic across the State. ADAP is working with providers and other State partners to sustain and expand the availability of SBIRT services under the Global Commitment to Health Demonstration.

Public Inebriate/Crisis Intervention: The Public Inebriate (PI) Program is a crisis intervention program for individuals under the influence. The Vermont Public Inebriate Program screens and determines appropriate placement for individuals meeting criteria for incapacitation, due to either intoxication or withdrawal from alcohol or other drugs. Presently there is screening capacity in all counties with one provider covering two counties. In addition to this screening capacity, there are 19-20 "diversion" beds located in several areas across the state designed as alternatives to confined placements. ADAP continues to work to assure a safe and effective response to address the need for additional community inebriate services and coordinated community-level collaborations between public inebriate programs, emergency departments, law enforcement and the Department of Corrections.

Future State:

No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None

Level of Care: 1.0 Outpatient Services

Current State:

Outpatient Treatment: Medicaid-enrolled providers currently provide outpatient services to Vermonters throughout each region of the State. Outpatient programs include individual, group and family counseling and provide services specific to elders, adolescents, youth, men and

women.

Future State:

No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None

Level of Care: 2.1 Intensive Outpatient Services

Current State:

Intensive Outpatient Treatment: ADAP-Certified, Medicaid-enrolled providers offer intensive outpatient (IOP) services to Vermonters throughout each region the State. IOP programs offer nine to 19 hours of treatment activities per week. These activities consist of a combination of case management, individual, group, and/or family therapy sessions.

Future State:

No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None

Level of Care: 2.5 Partial Hospitalization

Current State:

Partial Hospitalization: Partial hospitalization is provided to individuals with co-occurring mental health and substance use disorder diagnoses, with the primary diagnosis being mental health.

Future State:

No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None

Level of Care: 3.1 Clinically Managed Low-Intensity Residential Services

Current State:

Clinically Managed Low-Intensity Residential Care: Vermont funds a 10-bed, low-intensity 3.1 ASAM level residential program in the central part of the state. This program is a step down from a 3.5 ASAM-level program in the same county. Individuals with higher needs can attend the treatment programming and receive MAT at the 3.5-level program. Transportation is provided to individuals between the two facilities.

Future State:

No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None

Level of Care: 3.3 Clinically Managed, Population-Specific High-Intensity Residential Services

Level of Care: 3.5 Clinically Managed, High-Intensity Residential Services

Current State:

Clinically Managed, High-Intensity Residential Care: Vermont supports several residential programs to provide clinically managed, high-intensity residential services as well as withdrawal management services. This includes women-only, co-ed and specialized programs for adolescents and one for pregnant women and mothers with children under the age of five. These programs have access to psychiatric and mental health professionals for consultation and can provide care for individuals with co-occurring needs. All of Vermont's residential programs are required to provide access to medication-assisted treatment (MAT) services as clinically necessary.

Future State:

No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None

Level of Care: 3.7 Medically Monitored Intensive Inpatient Services

Current State:

Medically Monitored Intensive Inpatient Care: Vermont offers residential programming for adults that provides medically monitored intensive inpatient services. This program has on-site psychiatric services and provides care to individuals with a wide range of co-occurring conditions, including MAT.

Future State:

No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None

Level of Care: 4.0 Medically Managed Intensive Inpatient

Current State:

Medically Managed Intensive Inpatient Care: Vermont funds inpatient services at a specialized psychiatric facility for detoxification. This program is also available to treat persons with co-occurring mental health and psychiatric conditions. Once an individual has completed the detoxification they are transferred to an appropriate level of care, typically a community residential program or Specialized Health Home (Hub).

Future State:

No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None

Level of Care: Opiate Treatment Program

Current State:

Opioid Treatment (Hub and Spoke Program): Vermont developed the first-in-the-nation Specialized Health Home focused on expanding evidence-based MAT for OUD, known as the Hub and Spoke Program. Vermont's Hub and Spoke Program has garnered national attention for its effective, responsive, and comprehensive approach to providing MAT. Vermont accomplishes this through the integration of opioid treatment programs (OTPs), providing higher levels of care (Hubs) with primary care, obstetrics-gynecology, outpatient addiction treatment, and pain management practices (spokes) providing office-based opioid treatment (OBOTs). Regional Hubs offer medication, counseling, case management and health home services to complex patients. Spokes provide care to individuals who have less complex needs and they provide medication, counseling, case management and health home services.

Hubs offer medication, counseling, case management, and health home services to complex patients. Spokes provide care to individuals who have either been stabilized at a Regional Hub or whose needs do not require the intensity of services offered by the Regional Hubs. Spoke staff, supported by enhanced care coordination through the Blueprint for Health Community

Health Teams and local Recovery Support services, assure essential clinical and counseling support services are provided.

Vermont uses a 21-item checklist (Treatment Needs Questionnaire) to help determine whether a Hub or Spoke setting would be most appropriate for new beneficiaries seeking MAT. In order to determine the need for additional hub and/or spoke services, ADAP, in partnership with the Department of Vermont Health Access (DVHA), monitors the regional utilization of Hub services of Medicaid eligible individuals utilizing the Medicaid transportation benefit as well as capacity and wait time reports from Hubs.

Future State:

No changes are expected at this ASAM level of care.

Summary of Actions Needed

- None

Level of Care: Withdrawal Management

Current State:

Withdrawal Management: Withdrawal management is available at several settings throughout Vermont depending on the medical needs of the individual. ADAP certifies two residential programs in three locations and a social detoxification program to provide higher-intensity withdrawal management services. In addition, hospitals throughout Vermont provide withdrawal management services for individuals who need the full services of a hospital. For individuals whose needs are less intense, withdrawal management services are available through the Hub and Spoke system, which includes health home services.

Future State:

No changes are expected at this ASAM level of care.

Summary of Actions Needed:

- None

Recovery Support Services

Recovery Support services in Vermont focus on the following: helping people find, maintain, and enhance their recovery experience through peer support, sober recreation, and educational opportunities. This includes both 12 Recovery Centers located throughout Vermont and the centralized Vermont Recovery Network.

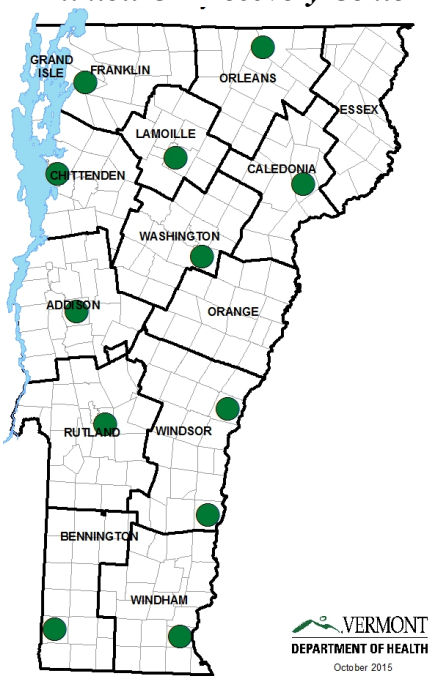
Recovery Centers provide non-clinical services that assist with establishing community connections that lead to employment, housing, and other social supports in a safe, drug- and

alcohol-free environment. Recovery Centers are committed to supporting a person's efforts in preventing relapse and, should relapse occur, in quickly returning to recovery. Individual services revolve around the support from the Peer Recovery Coach, an individual in active recovery from substance use disorder who has received Peer Recovery Coach training. The Recovery Centers also offer several groups to support recovery, such as:

- Evidence-Based Practice (EBP) groups
  - Making Recovery Easier
  - Seeking Safety
  - Wellness Recovery Action Planning (WRAP)

- Community Groups
  - Yoga, Meditation, Acupuncture
  - Age-specific recovery groups
  - Ongoing 12 Step meetings

Exhibit C – Recovery Center Locations (2015)



Recovery Housing

Recovery Housing is provided to Vermonters through several transitional housing providers, some connected to a Recovery Center and some independent organizations. ADAP has recently begun a new partnership with the Vermont Foundations of Recovery to add new sober transitional housing beds. These programs offer supports to connect individuals to appropriate community social services and ongoing treatment and recovery resources such as individualized planning and general case management.

2. Use of Evidence-Based SUD-Specific Patient Placement Criteria

Patient Assessment

Current State:

Vermont relies on evidence-based practices and clinical practice guidelines for all aspects of provider development, treatment authorization and recovery. The need for treatment often starts with a screening at one of the specialized providers, community partners, or primary care practices. Vermont promotes integrated screening for co-occurring substance use disorders and for co-occurring mental health issues.

All of Vermont's certified OUD/SUD providers (Preferred Providers) are required to use evidence-based screening tools, perform a comprehensive assessment which includes elements specified by the State, and utilize ASAM criteria to determine level of care. All State requirements are outlined in *Vermont's Preferred Provider Substance Use Disorder Treatment Standards.* All Preferred Providers have grant agreements with the State outlining their expectations including compliance with the *Preferred Provider Substance Use Disorder Treatment Standards* (Standards). Assessments include age appropriate elements, such as, but not limited to: mental health status; OUD/SUD history; physical health status; medications; allergies; living arrangements; family and interpersonal history; social support needs; criminal justice involvement; school history; cultural and spiritual preferences; trauma history; participant strengths, goals and priorities; caregiver status; education; and employment. The Standards require that the assessment process results in a written and dated document that includes diagnosis, co-occurring disorders, treatment recommendations, and the risk ratings across the ASAM Criteria.

For Preferred Providers to maintain specialty OUD/SUD provider certification in Vermont, they must pass compliance and quality audits conducted by ADAP. These audits are performed every one to three years on all Preferred Providers and are focused on compliance with standardized screening tools, comprehensive assessments, ASAM Levels of Care and evidence-based treatment standards which are verified through client record reviews and agency documentation. The period between audits is determined by the audit results.

Vermont inpatient detoxification and residential levels of care are designated as short-term acute care for the purpose of stabilizing an individual, so they can successfully transition to clinically appropriate lower levels of care.

ADAP has organized its oversight and management of the Preferred Providers into regions of the State where an individual on the Clinical Services Team is responsible for oversight of all of the Preferred Providers, including residential levels of care, in each region. These individuals, known as Regional Managers, participate in the provider certification process with the compliance team and are included in the compliance and quality audits.

The Regional Managers also provide oversight and technical assistance throughout each certification period, between audits, with at least yearly on-site visits and ongoing

communication regarding the areas of opportunity identified by audits as well as Statewide and regionally identified areas for performance or practice improvement.

Future State:

ADAP has developed a new scoring tool to determine a Preferred Provider's compliance and certification status. The Compliance Assessment Tool (Tool) is a weighted scoring tool to align with the Preferred Provider Standards. The Tool includes separate sections according to the program's ASAM Level of Care and is currently being piloted, with one provider audit completed using the Tool. Accompanying this Tool will be a compliance guide which will outline the scoring of the Tool. The score will determine the provider's compliance status ("full" or "provisional") and will help inform the length of the time before the subsequent review. The implementation of this Tool is more transparent and objective than the auditing process used in the past, which was subject to error and bias, and was not flexible to address the ASAM Levels of Care.

Summary of Actions Needed:

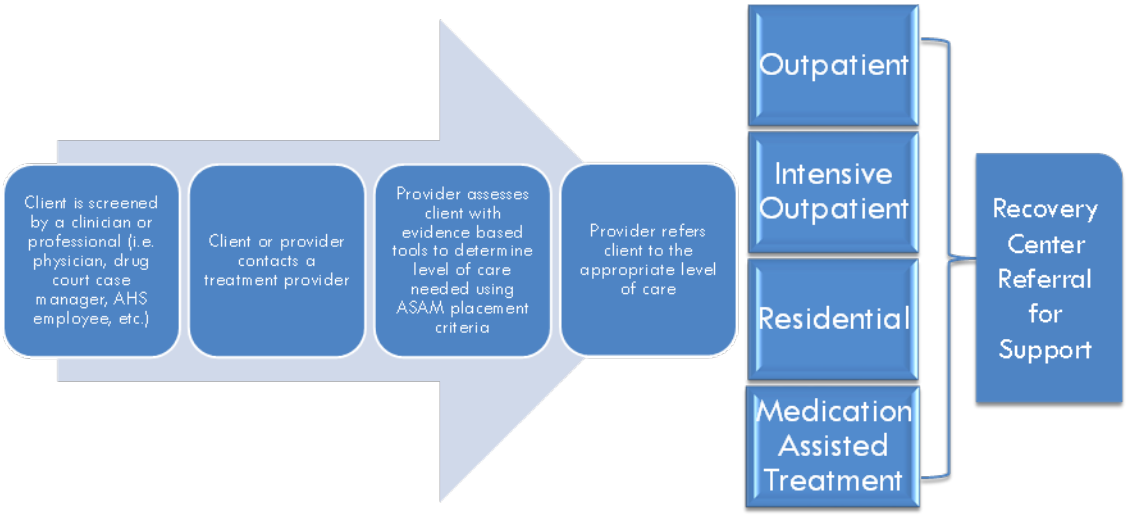
The Standards are under internal review and will be finalized by the ADAP Quality Unit for implementation by May 1, 2018. ADAP's Clinical Unit and Quality Unit will certify four residential providers using the Compliance Assessment Tool through January 2019.

Action	Date	Responsible
Finalize Substance Use Disorder Treatment Standards	May 1, 2018	Director of Quality Management and Compliance
Update Compliance Assessment Tool with Revised Substance Use Disorder Treatment Standards and all Residential ASAM Criteria	May 15, 2018	Director of Quality Management and Compliance
Use the Compliance Assessment Tool to Certify ASAM Level 3.5 Level of Care Provider (Valley Vista Vergennes)	June 30, 2018	Director of Clinical Services; Director of Quality Management and Compliance
Use the Compliance Assessment Tool to Certify ASAM Level 3.5 Level of Care Provider (Valley Vista Bradford)	September 30, 2018	Director of Clinical Services; Director of Quality Management and Compliance
Implement the Compliance Assessment Tool with Seven Providers	Monthly - December 2018	Director of Clinical Services; Director of Quality Management and Compliance
Use of the Compliance Assessment Tool to Certify ASAM Level 3.3 Level of Care Provider (Recovery House)	December 2018	Director of Clinical Services; Director of Quality Management and Compliance
Use of the Compliance Assessment Tool to Certify ASAM Level 3.2-WM Level of Care Provider (Act 1/Bridge)	January 31, 2019	Director of Clinical Services; Director of Quality Management and Compliance

<u>Utilization Management</u>

Current State:

Vermont currently ensures that individuals are appropriately placed in residential programs and inpatient detoxification through the process of concurrent review and prior authorization. Residential programs are required to screen and assess appropriateness of admission. All programs utilize the Addiction Severity Index (ASI) multi-dimensional assessment tool. Within 24 hours or next business day of admission the Medicaid Utilization Management (UM) unit is notified. By the end of the fifth day the residential programs send the ASI results and other clinical information to the UM team for concurrent review and authorization. The UM team use the nationally recognized McKesson Interqual® decision support tool to determine continued authorization. Exhibit II-8 provides an overview of Vermont's process for accessing treatment services.



Future State:

Vermont is developing a value-based payment model for residential programs to align with its All-Payer Model Agreement with CMS. The goal of this value-based design is to incentivize successful transitions of care, improve outcomes, and reduce costs. The value-based payment and enhanced support model is targeted for implementation in 2018.

The value-based payment model Vermont is pursuing is a case rate-like payment methodology. This methodology will reimburse residential care providers a specific per-admission rate for an individual's care for the entire length of the residential stay, as opposed to a per-day rate, as in the current fee for service per diem, per-person payment model. Paying a per-admission case-like rate instead of a per-day rate will disincentivize residential providers from keeping individuals longer than is clinically appropriate as there is no additional reimbursement based on the increase in number of days the individual is in care.

The new case rate-like methodology will result in a differential case rate such that admissions for individuals with more complex care needs will be reimbursed at a higher rate than an admission for an individual with less complex care needs. The methodology considers a number of clinical and social determinates of health (such as withdrawal potential, medical and mental health co-

morbidities) that incentivize providers to admit individuals who most closely match the dimensional criteria for admission to the residential level of care based on the ASAM Criteria (i.e. those with higher care needs). The methodology further disincentivizes the admission of individuals who are less aligned with the dimensional criteria for admission to residential level of care (i.e. those with lesser care needs), thereby helping to ensure only those individuals who clinically need access to residential care are served there.

The methodology will complement the already existing expectations that residential providers utilize the ASAM criteria to determine level of care needs and recommended treatment placement by aligning the reimbursement methodology's inherent (dis)incentives with the dimensional assessment of ASAM. The providers' compliance with the utilization of ASAM criteria will be monitored through the compliance and quality audits as well as the ADAP Regional Management Approach described in the next paragraph.

ADAP has organized their oversight and management of the Preferred Providers into regions of the State where an individual on the Clinical Services Team is responsible for oversight of all the Preferred Providers, including residential levels of care, in each region. These individuals, known as Regional Managers, participate in the provider certification process with the compliance team and are included in the compliance and quality audits and, as a part of this process, complete chart reviews.

Regional Managers also provide oversight and technical assistance throughout each certification period, between audits, with at least yearly on-site visits and ongoing communication regarding the areas of opportunity identified by audits as well as Statewide and regionally identified areas for performance or practice improvement. These Regional Managers will perform periodic chart reviews, outside the audit cycles, to review for and provide any needed technical assistance regarding the clinically appropriate utilization of residential level of care. To further ensure the appropriate utilization of residential care services, the State will explore performance measures such as readmission rates to the same or higher levels of care, initiation and engagement in treatment, and treatment length of stay. These performance metrics will be shared with the providers by the Regional Managers and technical assistance will be provided if indicated.

Summary of Actions Needed:

Vermont is currently working collaboratively with the Payment Reform Team at the Department of Vermont Health Access to develop the case rate-like methodology.

Action	Date	Responsible
Develop the criteria for the differential case rate	Completed April 2018	ADAP Director of Clinical Services
Model the methodology using the identified criteria for the Vermont team to review	April 25, 2018	Payment Reform Team
Work with financial colleagues to finalize budget and rate decisions for the model	May 9, 2018	Payment Reform Team, ADAP Director of Clinical Services, VDH Business

		Office
Residential providers to provide feedback	May 16, 2018	ADAP Director of Clinical Services
Work with the Medicaid fiscal agent to identify and complete the necessary systems changes required for the Medicaid billing system	October 1, 2018	ADAP Director of Clinical Services, Payment Reform Team, DXC (Fiscal Agent)
Work with the residential providers to provide technical assistance and education around the necessary billing changes	October 1, 2018	ADAP Clinical Team
Regional Managers will partner with the compliance and quality team to determine the appropriate frequency with which the Regional Managers will perform the between audit chart reviews	October 1, 2018	ADAP Clinical Team and ADAP Quality Team

3. **Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities**

Current State:

Vermont's new certification process, as indicated above, also includes the certification of residential programs to be designated at an ASAM level of care. Residential providers can receive reimbursement from Vermont Medicaid through grant agreements with the Vermont Department of Health's Division of Alcohol and Drug Abuse Programs (ADAP). These grant agreements outline the expectations including compliance with the *Preferred Provider Substance Use Disorder Treatment Standards* (Standards). The Standards outline the specific requirements for a provider to receive certification at an ASAM level 3.1, 3.3, 3.5 or 3.7. These requirements include performance expectations, operations (including hours of operations), staffing, human resources, quality improvement, policies and procedures, intensity of services, discharge planning and billing.

Each provider is audited by the State on a regular schedule to ensure compliance with these requirements. The State utilizes an audit tool with a score for each element along with weighted elements. Final scores determine a full certification or limited certification with corrective action plan. The amount of time between audits is determined by the final score.

Future State:

ADAP has developed a new scoring tool to determine a Preferred Provider's compliance and certification status. The Compliance Assessment Tool (Tool) is a weighted scoring tool to align with the Standards. The Tool includes separate sections according to the program's ASAM Level of Care and is currently being piloted, with one provider audit completed using the Tool. Accompanying this Tool will be a compliance guide which will outline the scoring of the Tool. The score will determine the provider's compliance status ("full" or "provisional") and will help inform the length of the time before the subsequent review. The implementation of this Tool is

more transparent and objective than the auditing process used in the past, which was subject to error and bias, and was not flexible to address the ASAM Levels of Care. (Note tabs at bottom of spreadsheet) The Tool will include separate sections according to the program's ASAM Level of Care.

All of Vermont's residential programs at ASAM level 3.3 or higher offer medication-assisted treatment (MAT) on site. The current grant agreements, expiring June 30, 2018 do not specifically require the residential programs to offer MAT. The new grant agreements beginning July 1, 2018 will clearly require the residential programs to offer MAT in order to receive certification as a Preferred Provider thus allowing them to be reimbursed by Vermont Medicaid.

Summary of Actions Needed:

The *Preferred Provider Substance Use Disorder Treatment Standards* are under internal review and will be finalized by the ADAP Quality Unit for implementation by May 1, 2018. ADAP's Clinical Unit and Quality Unit will certify four residential providers using the Compliance Assessment Tool through January 2019.

Action	**Date**	**Responsible**
Finalize Substance Use Disorder Treatment Standards	May 1, 2018	Director of Quality Management and Compliance
Update Compliance Assessment Tool with revised Substance Use Disorder Treatment Standards and all residential ASAM criteria	May 15, 2018	Director of Quality Management and Compliance
Use the Compliance Assessment Tool to certify ASAM Level 3.5 Level of Care provider (Valley Vista Vergennes)	June 30, 2018	Director of Clinical Services; Director of Quality Management and Compliance
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Use of the Compliance Assessment Tool to certify ASAM Level 3.2-WM Level of Care Provider (Act 1/Bridge)	January 31, 2019	Director of Clinical Services; Director of Quality Management and Compliance

4. **Sufficient Provider Capacity at Critical Levels of Care including for Medication-Assisted Treatment for OUD**

Current State:

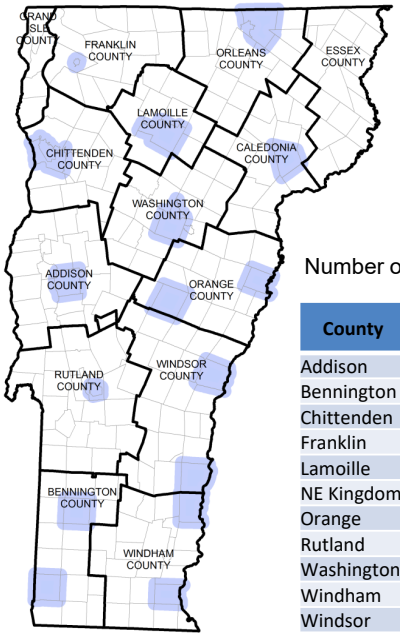
Vermont adheres to all Medicaid Manage Care requirements regarding network adequacy and access standards. ADAP collaborates with DVHA to use Medicaid utilization data and non-Medicaid services provider encounter data to explore the patterns of utilization for residential care and care at Specialized Health Homes throughout the State.

ADAP has several reporting requirements as a part of the granting process with the Preferred Providers in order to monitor and ensure that the State has sufficient provider capacity for critical levels of care, including access to MAT. Specialized Health Homes "Hubs" are required to report within seven days of reaching 90 percent capacity for serving individuals who are intravenous drug users, and provide immediate notice if a pregnant woman is unable to be served. In addition, "Hubs" are required to submit monthly summaries of wait times for service and service requests, and census reports with numbers of individuals at each phase of treatment (induction, stabilization, maintenance) and numbers of individuals who have been transferred to office-based "Spokes". ADAP collaborates with DVHA on Medicaid medical transportation utilization data (e.g., distance to services) to monitor the need for MAT providers statewide.
Residential programs are also required to submit monthly summaries of wait times for services and daily information to an electronic bed-board, which tracks utilization of and availability of beds across residential programs statewide.

Occupancy in Vermont's OUD/SUD residential programs remains under 100 percent, suggesting capacity is at adequate levels. With the addition of a new Specialized Health Home "Hub" in 2017, wait time reports from across the Specialized Health Home "Hubs" demonstrate timely access across the State.

Exhibit J – Maps of Treatment Locations

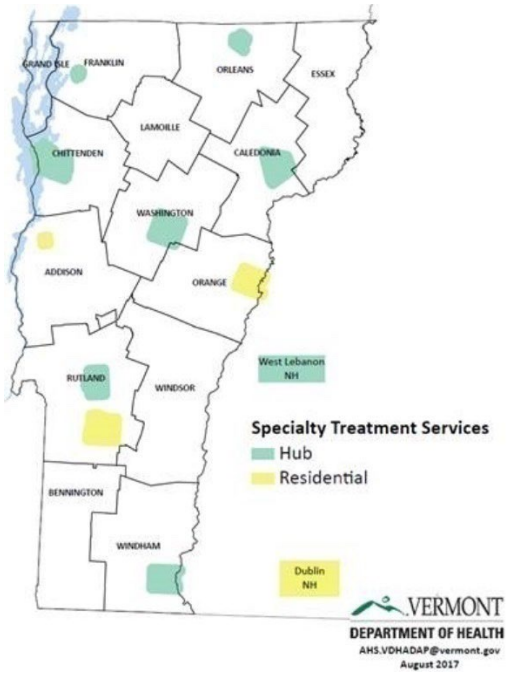
Outpatient/Intensive Outpatient Facilities



Number of Programs

County	OP	IOP
Addison	1	
Bennington	2	
Chittenden	7	3
Franklin	1	
Lamoille	2	1
NE Kingdom	2	2
Orange	2	
Rutland	2	1
Washington	2	1
Windham	1	1
Windsor	2	2

Hub and Residential Facilities



Because all specialty SUD programs are certified by ADAP, Vermont is able to maintain an inventory of the number of providers at all levels of care. To determine adequacy of access, ADAP reviews the monthly wait list reports to identify areas of increasing or sustained long waiting lists. The State team assesses data points on the wait list such as place of residence, distance of travel, length of time on the wait list and any special needs. By using these data points, in the past year Vermont identified the need for an additional Hub in the northern part of the state and successfully opened a new Hub in 2018 resulting in elimination of the wait list for Hub services.

Future State:

Vermont will be enhancing its access and evidence-based placement process in 2018 and beyond. To improve timely access to care and placement at the appropriate level of care, the State is in the process of developing a Centralized Intake and Call Center (Center) for all Vermonters. The Center is under development and start-up is funded through the Opioid State's Targeted Response (STR) SAMHSA grant. The Center will perform an initial screening of individuals to determine the most appropriate referral. The Center will have current information on provider availability and be able to schedule appointment times, across all levels of care, for comprehensive assessments. Individuals having longer wait times will receive regular calls from the center to maintain engagement and facilitate initiation into treatment.

The Center will maintain data on access to care and manage wait lists for services. The Center will determine availability of treatment at each level of care as well as availability of MAT and medically supervised withdrawal management throughout the state. The Center will provide monthly reports to the State with data elements that will allow the State to monitor access to care

and to identify the largest areas of need. The Center will be self-collecting the data within their own system.

Summary of Actions Needed:

The below activities are the responsibility of the ADAP Division within the Department of Health.

Action	Date
CALL CENTER RFP ISSUE DATE	March 30, 2018
BIDDERS CONFERENCE	April 9, 2018– 1:00PM EST – 2:00PM EST
QUESTIONS DUE	April 13, 2018 – 3:00PM EST
RFP RESPONSES DUE BY	April 30, 2018 – 3:00PM EST
FINALIST DEMONSTRATIONS	Week of May 21, 2018
SELECTION NOTIFICATION	On or before June 15, 2018
INDEPENDENT REVIEW Following the selection of a proposal for contract award, the selected proposal will be the subject of an independent review before a contract can be completed. The time required for this process is approximately ten weeks.	To be completed on or before August 24, 2018
ANTICIPATED PROJECT START DATE	October 1, 2018
Anticipated Go-Live	On or before 4/1/2019

The State is in the process of hiring an IT Project Manager and Substance Abuse Program Manager who will be the primary managers of the program and the contract(s).

5. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD**

Current State:

Through the Medicaid State Plan and the Global Commitment to Health Demonstration, Vermont has developed a continuum of services and supports that provide the foundation to successfully address opioid and other substance use disorders in Vermont.

Vermont's efforts to expand treatment for Vermonters with OUD are broad-based and benefit enormously from the commitment of community leaders, partners, and members to support and speak about the importance of this issue. The dedication and commitment of these individuals has resulted in increased treatment capacity in critically needed areas, increased coordination amongst community partners, and focus on treating the factors that contribute to the complexity of OUD.

- Opioid Prescribing Guidelines

Vermont implemented "Rules Governing the Prescribing of Opioids for Pain" effective July 1, 2017 (see Opioid Prescribing Rule). This rule provides legal requirements for the appropriate use of opioids in treating pain to minimize opportunities for misuse, abuse, and diversion, and optimize prevention of addiction and overdose and is consistent with CDC guidelines.

- Expanded Coverage of, and Access to, Naloxone for Overdose Reversal

Vermont began distribution of Naloxone with a pilot in 2013 and has since expanded Statewide. Naloxone is provided free of charge at 27 distribution sites including syringe services programs, substance use treatment providers, recovery centers, and medical facilities. Naloxone is available to persons taking opioids, family members, and other community members who may come in contact with people at risk for overdose. In 2016, pursuant to legislation, all Vermont EMS agencies receive naloxone at no charge. Emergency use kits also are offered to individuals being released from a correctional facility who have identified previous opioid use or dependency.

In August 2016, the Commissioner of Health issued a standing order for naloxone, allowing any pharmacy to dispense the lifesaving drug and bill medical insurance, if available. New prescribing rules effective July 1, 2017 require an accompanying naloxone prescription for opioid prescriptions >90 MME, as well as when there are concurrent benzodiazepines prescriptions.

- Implementation of Strategies to Increase Utilization and Improve Functionality of Prescription Drug Monitoring Programs

The rules implemented July 1, 2017 require that prescribers query the Vermont Prescription Drug Monitoring System (VPMS) prior to the first prescription of an extended release hydrocodone or oxycodone that is not an Abuse-deterrent Opioid; no less frequently than once every 120 days for any patient prescribed 40 mg or greater of hydrocodone or 30 mg or greater of oxycodone per day of an extended release hydrocodone or oxycodone that is not an Abuse-deterrent Opioid as long as the patient possesses a valid prescription for that amount; and no less frequently than as described in the Vermont Prescription Monitoring System rule (see VPMS rule).

All prescribers and pharmacists dispensing Schedule II-IV drugs must register and use the VPMS. Vermont also has been improving functionality of the VPMS through the development of Prescriber Insight Reports, which compare a prescriber's opioid prescribing patterns to similar prescribers and Clinical Alerts to notify prescribers when patients' prescription history may be of concern. There has been extensive outreach, technical assistance, and training for prescribers on opioid prescribing and the use of the VPMS.

Vermont Medicaid has several strategies to address the opioid epidemic through the clinical management of opioids and drugs used to treat substance use disorder. DVHA employs prior authorization, quantity limits, days' supply limits, and maximum dosages to reduce inappropriate use of these drugs.

Management of Short-Acting Opiates

Vermont Medicaid has implemented prescription limits for opiates used in treating acute pain to align with rule changes made by the Vermont Department of Health effective July 5, 2017. Initial prescriptions for opioids for patients 18 years of age and older are limited to 50 Morphine Milligram Equivalents (MME) per day and a maximum of 7 days' supply. Patients 17 years of age and younger are limited to 24 MME per day and a maximum of 3 days' supply. The prescription limits apply only to the first prescription filled in an outpatient setting for a given course of treatment and do not apply to renewals or refills. The limits do not apply to long-acting opioids, as they are not indicated for acute pain. Supply limits can be exceeded with prior authorization. Limits are enforced at point of sale. If no prior opiate prescription is found in the member profile within the past 45 days, the claim will reject if MME or days' supply is exceeded.

Management of Long-Acting (LA) Opioids

Vermont Medicaid requires prior authorization for most long-acting (LA) opioids. Prescribers are notified on Medicaid's Preferred Drug List (PDL) of precautions around prescribing LA opioids. The following statements appear in Medicaid's PDL: *"Long-acting opioid dosage forms are intended for use in opioid-tolerant patients only. These tablet/capsule/topical medications may cause fatal respiratory depression when administered to patients not previously exposed to opioids. LA opioids should be prescribed for patients with a diagnosis or condition that requires a continuous, around-the-clock analgesic. LA opioids should be reserved for use in patients for whom alternative treatment options (such as non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. LA opioids are NOT intended for use as 'prn' analgesic. LA opioids are NOT indicated for pain in the immediate post-operative period (the first 12-24 hours following surgery) or if the pain is mild, or not expected to persist for an extended period. LA opioids are not intended to be used in a dosage frequency other than FDA approved regimens. Patients should not be using other extended release opioids prescribed by another physician. Prescribers must consult the VPMS (Vermont Prescription Monitoring System) to review a patient's Schedule II - IV medication use before prescribing long-acting opioids."*

Drug-specific criteria is applied to prior authorization requests. In addition, DVHA has applied system edits for quantity limits and maximum dosages.

Abuse-Deterrent Formulations (ADF)

Medicaid covers one long-acting, abuse-deterrent opiate formulation on its PDL without prior authorization. Currently, this formulation is Embeda (morphine sulfate/naltrexone) and is limited to two tablets per day. DVHA continues to monitor the clinical and cost benefits of covering additional ADFs.

Management of Drugs used to Treat Substance Use Disorder (SUD)

Medicaid covers all buprenorphine-containing drugs and naltrexone to treat opiate dependency. Vermont Medicaid manages outpatient Suboxone and buprenorphine utilization to ensure these

highly utilized, high-cost medications are used appropriately. All buprenorphine and Suboxone products require prior authorization and have quantity and dose limits. All patients receiving buprenorphine and Suboxone products must have one "pharmacy home" for all prescriptions. Oral naltrexone is available without restriction, and injectable naltrexone is available with a diagnosis of SUD and if oral tolerability of naltrexone has been established. In addition to methadone, Medicaid also covers buprenorphine products for use in our OTP programs.

Retrospective Drug Utilization Review

Medicaid routinely performs retrospective DUR regarding controlled-substance topics such as methadone use, Long-Acting Stimulant Use, etc. In these initiatives, both medical and pharmacy data is used to identify trends. An upcoming initiative will analyze buprenorphine use with benzodiazepines and/or opiates.

Overdose Prevention

Medicaid has developed a statewide opioid antagonist pilot program that emphasizes access to opioid antagonists to and for the benefit of individuals with a history of opioid use. Along with the pilot program, a policy was generated for "Standing Order for Distribution of Naloxone Prescription for Overdose Prevention" which allows Naloxone Hydrochloride (Narcan ®) to be covered without a prescription. This policy can be found at: http://www.vtpharmacists.com/resources/RESPNaloxonestandingorder.pdf

This policy is in accordance to Standing Order issued pursuant to 18 V.S.A. § 4240 (c) (1) and ensures that residents of the State of Vermont who are at risk of opioid-related overdose, along with other persons such as family members and friends, can obtain Naloxone without a prescription. The statue can be found at: http://legislature.vermont.gov/statutes/section/18/084/04240.

In support of this program and the standing order, Medicaid has available two Naloxone products preferred on the Preferred Drug List (PDL) without any prior authorization requirement:

- Narcan® (naloxone HCL) Nasal Spray with a quantity limit of 4 single-use sprays every 28 days.
- Naloxone HCL Prefilled leur-locked needless syringe plus intranasal mucosal atomizing device

Future State:

Vermont currently has two provider and stakeholder groups through which the Vermont Department of Health (VDH) receives feedback and recommendations. These groups are the Controlled Substances and Pain Management Advisory Council and the Prescription Drug Overdose Prevention Stakeholder Workgroup. VDH utilizes these groups to receive feedback on the Prescribing Rules and identify any changes that may be needed. Vermont is currently in process of finalizing updates to the Rule based on feedback from stakeholders. The ADAP Policy Director's responsibility is to keep current on changes at the national level related to the field of SUD. The Policy Director will identify areas that may impact the prescribing rules and

work with the VDH Senior Policy and Legal Advisor to make changes to Vermont's rules when necessary.

On January 5, 2017 Vermont's Governor Phil Scott created the position of Director of Drug Prevention Policy and the Vermont Opioid Coordination Council in his second Executive Order. In the executive order, Governor Scott charged the Council *"to lead and strengthen Vermont's response to the opiate crisis by ensuring full interagency and intra-agency coordination between state and local governments in the areas of prevention, treatment, recovery and law enforcement activities."* The Council's first meeting was on May 8, 2017.

The Council's first report to Governor Scott includes 22 recommendations for next steps to continue Vermont's progress in addressing the opioid crisis. These recommendations are designed to empower local communities, align the delivery of services within state government, and between government and private services, to ensure effective results in:

- **Prevention:** Addressing the drivers of demand for opioids, including prescribing practices, education at all levels, and social and community engagement.
- **Treatment:** Ensuring timely, affordable and effective treatment is available to all in need.
- **Recovery:** Making recovery from addiction sustainable through support systems, with emphasis on employment, housing, social supports, and engagement.
- **Law Enforcement:** Reducing supply through investigation and prosecution; policy changes to address the rising presence of fentanyl, and continued work against the diversion of prescription opioids.

The following list includes all recommendations:

A. Implement a statewide comprehensive system to deliver school-based primary prevention programs.
B. Expand health care education, monitoring and screening for providers and patients, including provider participation in the *Vermont Prescription Monitoring System (VPMS)*; *provider training, and patient education*, in alternatives to opioids for pain management including *non-pharmacological options*; and expansion of *Screening, Brief Intervention and Referral to Treatment (SBIRT)* in primary care, emergency departments, corrections and schools.
C. Build, replicate and support strong community-based models through multi-sector partnerships, innovation, and research resulting in outcomes that exceed previous, less collaborative efforts.
D. Create a comprehensive drug prevention messaging campaign designed to raise public awareness, reduce stigma, provide hope for families, and strengthen resilience in Vermont's communities.

Intervention

E. Expand Vermont's syringe exchange programs and services to increase geographic reach and hours of operation. Support access to increased case management services for all participants.
F. Supply naloxone and provide training to all Vermont law enforcement, emergency medical services (EMS) and people likely to be near a person who may overdose.

Harm Reduction

G. Expand drug disposal options and events, and increase public participation across the state.
H. Improve sharps collection and disposal with a statewide strategy and community toolkit.

Treatment: These strategies build on Vermont's nationally recognized treatment system and call for assessment and new strategies to make treatment and recovery possible for more Vermonters.

A. Support, evaluate and improve Vermont's Hub and Spoke system for opioid treatment to sustain, and expand where needed, Hub and Spoke treatment services across the state.
B. Expand access to medication-assisted treatment (MAT) in all Vermont correctional facilities.
C. Maximize the use of non-pharmacological approaches (integrative health care professions) for pain management, and for addiction treatment and recovery.
D. Support the Vermont Judiciary's plan to explore expanded access to treatment docket techniques.
E. Support efforts to expand Medicare and Medicaid coverage for opioid treatment.

Recovery: Vermont's investment in delivering treatment must be reinforced with strong recovery strategies that help Vermonters sustain their recovery. Housing, employment, health care and social supports are essential.

A. Ensure Vermont has a strong statewide network of recovery centers, recovery coaches, and supports.
B. Expand the availability of and equal access to recovery housing; explore expansion of the Department for Children and Families' (DCF) Family Supportive Housing Program to ensure individuals and families throughout Vermont have access to a stable home environment.
C. Expand Employment in Recovery. (See "Overarching/Systemic.")

Enforcement: Enforcement strategies focus on keeping Vermont's roadways safe, interrupting drug trafficking, and ensuring Vermont's law enforcement and first responders have training they need.

A. Support research and development of an accurate, cost-effective roadside drugged driving test.
B. Increase Vermont's resources for drug trafficking investigations.
C. Provide drug recognition training for law enforcement and first responders and increase the number of drug recognition experts (DREs).

6. **Improved Care Coordination and Transitions between Levels of Care**

Current State:

ADAP continues to improve coordination between the Hub and Spoke providers and specialty substance use disorder treatment providers (residential) through referral protocols, care coordination, covered benefits, information sharing, etc. These and other collaborations are contributing to stronger relationships between primary care practices and specialty substance use disorder service providers, leading to more effective recovery management of physical and behavioral health services.

Through Vermont's health reform initiatives, physicians are educated and trained on enhancing their own screening and referral services, so that more clients are screened and directed to OUD/SUD specialists from primary care practices.

Vermont's *Preferred Provider Substance Use Disorder Treatment Standards* (Standards) include discharge planning expectations for all levels of care. Aftercare planning starts as early as possible in the person-centered treatment planning and service delivery process. The aftercare plan is to ensure a seamless transition when a person served is transferred to another level of care or prepares for a planned discharge to recovery support.

The aftercare plan identifies the person's need for a recovery support system or other types of service that will assist in continuing the recovery and community integration. The plan also includes referral information made for additional services such as appointment dates, times, contact name, telephone number, and location. The referring provider must provide the receiving provider with the most recent assessment upon receipt of a signed release of information. Upon discharge, the provider, when prescribing medications, will document coordination of care with the primary care provider and/or external prescribing professional regarding, at a minimum, what medications are being prescribed and for what diagnoses. These standards are audited during the annual site review through the medical record audit. Should any provider be out of compliance with these standards, a corrective action plan will be required. State staff also are available to provide technical assistance to the provider on improving in this area. With the development of the Centralized Intake and Call Center in 2018, providers will have enhanced support for ensuring continuity of care during transitions.

Future State:

Recovery Coach in the Emergency Department (ED)
Utilizing funding through the Opioid State's Targeted Response (STR) SAMHSA grant to cover start-up costs, Vermont is implementing a Recovery Coach in the Emergency Department (ED) program modeled after Rhode Island's Anchor ED program. This program is currently being implemented in three counties and expanding to two additional counties in 2018.

Vermont's Recovery Coach in the Emergency Department (ED) initiative connects individuals presenting in the ED or other parts of the hospital with peer-to-peer support provided by Recovery Coaches. Recovery Coaches are on-call to the ED 24 hours a day, 7 days a week. The

purpose of the interaction is for the Recovery Coaches to offer support, guidance and information on topics such as overdose, treatment and recovery, to both the individual and their family/support system. The Recovery Coach will assist in connecting the individual to treatment and other community resources, in securing transportation and other supports in order for the individual to engage in SUD treatment as well as necessary medical appointments, and to assist in navigating the system of care. The connection initiated in the ED is supplemented by extensive post-ED follow-up by Recovery Coaches such as in-person meetings and phone calls.

Centralized Intake and Call Center
Vermont will be enhancing its access and evidence-based placement process in 2018 and beyond. To improve timely access to care (including transitions of care), and placement at the appropriate level of care, the State is in the process of developing a Centralized Intake and Call Center for all Vermonters. The Center is under development and start-up is funded through the Opioid State's Targeted Response (STR) SAMHSA grant. The Center will perform an initial screening of individuals to determine the most appropriate referral. The Center will have current information on provider availability and be able to schedule appointments times, across all levels of care, for comprehensive assessments. Individuals having longer wait times will receive regular calls from the center to maintain engagement and facilitate initiation into treatment. The Center will also be the mechanism for providers to access appointments for individuals transitioning between levels of care. The Center staff will contact individuals who have discharged to remind them of their follow-up appointments and make regular contact with individuals who are waiting for services. The Center staff will ensure individuals have information on community supports and other resources such as recovery centers and will assist individuals in making those contacts.

Summary of Actions Needed:

Recovery Coach in the Emergency Department (ED)

Action	Date	Responsible
Executed memorandums of understanding (MOUs) with each of the recovery centers defining roles and responsibilities are in place.	Completed	Project Manager
Recovery centers are in the process of developing MOUs with the hospitals to define roles and responsibilities.	June 1, 2018	Recovery Center, Hospitals, Project Manager
Once the MOUs are executed with the hospitals, recovery coaches will begin formal deployment.	June 1, 2018	Recovery Centers
All three recovery centers are staffed and initial training has been conducted, including the first phase of ED-specific training.	June 1, 2018	Recovery Centers and Project Manager

Centralized Intake and Call Center

The below activities are the responsibility of the ADAP Division within the Department of Health.

Action	Date
CALL CENTER RFP ISSUE DATE	March 30, 2018
BIDDERS CONFERENCE	April 9, 2018– 1:00PM EST – 2:00PM EST
QUESTIONS DUE	April 13, 2018 – 3:00PM EST
RFP RESPONSES DUE BY	April 30, 2018 – 3:00PM EST
FINALIST DEMONSTRATIONS	Week of May 21, 2018
SELECTION NOTIFICATION	On or before June 15, 2018
INDEPENDENT REVIEW Following the selection of a proposal for contract award, the selected proposal will be the subject of an independent review before a contract can be completed. The time required for this process is approximately ten weeks.	To be completed on or before August 24, 2018
ANTICIPATED PROJECT START DATE	October 1, 2018
Anticipated Go-Live	On or before 4/1/2019

Section II – Implementation Administration

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Section III – Relevant Documents

1. Preferred Providers: Substance Use Disorder Treatment Standards
2. Preferred Providers Compliance Assessment Tool

Attachment A – Template for SUD Health Information Technology (IT) Plan

Vermont's PDMP, known as the Vermont Prescription Monitoring System (VPMS), was implemented as a result of legislation passed in 2006 with data collection beginning in 2009. Vermont uses the VPMS as a clinical tool to address the epidemic of prescription drug misuse and dependence by tracking the dispensing of controlled substances that are most likely to lead to misuse, addiction, or patient harm. Law enforcement do not have access to this system. The VPMS is overseen by the Vermont Department of Health (VDH) Division of Alcohol and Drug Abuse Programs (ADAP). There is a dedicated program manager and in-house analytic capacity. It is administered through a contract and has changed platforms twice in the past two years, first as a result of a routine State bid process followed by a second change a year later when the chosen vendor was purchased, and all clients were moved to a newly developed platform. Due to these changes, many of Vermont's in-state resources were engaged in

planning, transition, and user acceptance testing activities to ensure that the data in the system is accurate and usable by prescribers and pharmacists.

All Vermont-licensed pharmacies, including mail-order pharmacies, are required to provide prescription information on all Schedule II – IV drugs dispensed within 24 hours or one business day of dispensing. In 2017, the upload frequency increased from weekly to daily and the Vermont overall pharmacy upload compliance rate is over 95%.

In 2014, Vermont-licensed prescribers of controlled substances were mandated to register for VPMS and query the system under specific circumstances. In 2017, new Administrative Rules were implemented which increased the circumstances under which prescribers were required to query VPMS and added requirements for querying by pharmacists. Prescribers and pharmacists may appoint delegates to query the system on their behalf.
http://www.healthvermont.gov/sites/default/files/documents/pdf/REG_vpms-20170701.pdf

Through the use of VPMS, prescriber education programs, Rule changes, and messaging, Vermont has seen a 26 percent decrease in total MME opioid analgesics prescribed in Vermont between 2015 and 2017.

Please note that the PDMP measures that Vermont currently uses to monitor the dispensing of Schedule II-IV drugs are as follows:

1. Average daily morphine milligram equivalents (MME) per opioid analgesic prescription
2. Average days supply per opioid analgesic prescription
3. Portion of opioid analgesic prescriptions:
    a. < 50 MME
    b. 50-90 MME
    c. >90 MME
4. Total MME dispensed
5. Percent of the Vermont population receiving at least one prescription for:
    a. Opioid analgesics
    b. Medication-Assisted Treatment drug
    c. Benzodiazepine
    d. Stimulants
6. Pharmacy uploading compliance rates
7. Prescribers registered with PDMP
8. Pharmacists registered with PDMP
9. Number of PDMP linkages to other states/health systems
10. Number of system queries
11. Multiple provider episodes for prescription opioids (five or more prescribers and five or more pharmacies in a six-month period) per 100,000 residents
12. Patients prescribed long-acting/extended-release (LA/ER) opioids who were opioid-naive (i.e., patients who have not taken opioid analgesics in 30 days).
13. Patient prescription days with overlapping opioid prescriptions (percentage)
14. Patient prescription days with overlapping opioid and benzodiazepine prescriptions (percentage)

Prescription Drug Monitoring (PDMP) Functionalities

Current State:

- Vermont currently shares prescription data with CT, MA, ME, NH, NJ, NY, and RI.
- Prescriber and pharmacy delegates are allowed. Delegates are linked to their providers account and can query on their behalf. This helps to streamline use of VPMS in busy medical settings.
- Quarterly and annual reports showing state- and county-level prescribing patterns are available on our website for needs assessment and monitoring purposes: http://www.healthvermont.gov/alcohol-drugs/reports/data-and-reports
- Vermont has evaluated integrating PDMP data into electronic medical records and the health information technology platform and has determined that it may be feasible through the currently available tool through PMP Gateway. This has not yet been tested by the State for compliance to state security and audit requirements and there is a cost to the end user that some VT health systems may not be willing to pay.
- Prescriber Insight Reports, which allow prescribers to compare their prescribing to similar prescriber types and specialties, were implemented March 28, 2018. ADAP, through a grant from the Centers for Disease Control and Prevention, has capacity to provide quality improvement activities to prescribers and as part of the dissemination Prescriber Insight Report process, has highlighted the availability of these services.

Future State:

- Under the guidance of a recently established Health Information Exchange (HIE) Steering Committee, the Department of Vermont Health Access is currently working to develop a statewide Health Information Exchange/Health-IT strategic plan. The plan will address the state's health-IT network and needs, which includes SUD efforts overall, including VPMS. By November 2018, the Steering Committee will produce a final plan for submission to the Green Mountain Care Board, the State's health system regulatory body. The Board is statutorily obligated to review the plan for approval.
- Vermont's current contract with the PDMP provider includes funding to build connectivity between the VMPS and the RxCheck hub. This hub is a state PDMP-owned and governed solution to data sharing between states or health systems. RxCheck is building the capacity for audit trails of PDMP use, which will address concerns which are preventing current connectivity. Vermont is ready to pursue this, however the VPMS vendor is still working on meeting Vermont's contract-required system functionality. This is the top VPMS priority after the project is fully implemented. The program manager participates in the RxCheck governing group.
- PMP Gateway claims to be able to fulfill all safety and security audits for connectivity to health systems/EHRs although there are several outstanding concerns.
    - When querying within the VPMS, close matches of patient names are returned as a "pick list" to the provider to ensure the most complete and accurate prescription

histories. This functionality does not exist within a Gateway connection, as results for only exact matches of records are populated into the connected health system. This increases the possibility that incorrect prescription records could be populated into the report or that incomplete prescription histories would be returned.
    - Registration within VPMS is required to access the system and is only allowed for certain specific roles and provider types. Gateway must be able to validate that no unregistered users are able to access VPMS system data through their health system and be able to respond immediately to deactivate or discontinue any access that a deactivated VPMS user may have.
    - The ability to obtain VPMS records through court order is a separate process from that required to obtain medical records. Gateway must validate that no record of the VPMS data will be stored within the connected health system.
    - Audit trails from the system must include records of patients queried, by whom, what results were returned, and when. Currently, the accuracy of the records of which patient data was viewed has yet to be validated.
    - This system also comes at a cost to the health care systems. VT statute requires there be a no-cost option to prescribers, thus the interest in RxCheck hub. Ideally, both options will be available.
- Connectivity with other states is based on the likelihood of people traveling to or from those states. As a tourist destination, Vermont pulls tourists primarily from the New England area, so these areas were connected first. The next priority is Florida, due to Vermonters who live there in the winter. After that, states with highest rates of opioid prescribing, closest proximity, and the result of Vermont's assessment of the sharing states' data controls will be prioritized. Timing is based largely on availability of internal resources.

Summary of Actions Needed:

- ADAP to negotiate data sharing with FL after July 1, 2018 when FL statue allows for sharing. By year end, connect a total of at least three new states.
- ADAP to work with vendor to complete contract deliverables and develop the linkage to RxCheck hub by October 31, 2018.
- VDH to test PMP Gateway connectivity for compliance with VT safety and security audits by December 31, 2018.

Current and Future PDMP Query Capabilities

Current State:

- Vermont contracts for the PDMP and because of this, use the vendor's algorithm for patient grouping. The vendor has an automated matching algorithm. However, some groupings are tagged for manual review, which is done routinely by VPMS program

staff. System users also notify the program when they find improperly matched records, and these are also manually corrected.
- Interstate data sharing queries require an exact or a manually grouped match to pull records. This increases the possibility that incorrect prescription records could be populated into the interstate reports or that incomplete prescription histories could be returned.
- There is a master patient index developed by the State for patient grouping for analytical and reporting purposes.

Future State:

- In an ideal future state, it would be possible to integrate the VT master patient index with the vendor system.

Summary of Actions Needed:

- VDH will explore feasibility of integrating the VT MPI with the vendor system through discussions with the vendor. If deemed possible, determine timing, cost, and process. Discussions to begin by December 31, 2018.
- As discussions continue around EHR integration, interstate data sharing, RxCheck and PMP Gateway, be cognizant of the need for an MPI.

Use of PDMP – Supporting Clinicians with Changing Office Workflows/Business Processes

Current State:

- VT statute and rule dictates limits on prescribing that are consistent with CDC prescribing guidelines and went into effect July 1, 2017. http://www.healthvermont.gov/sites/default/files/documents/pdf/REG_opioids-prescribing-for-pain.pdf
- VT has a prescribing toolkit and has provided associated training on workflow. The toolkit has been updated to reflect VT rules and the CDC prescribing guidelines. https://www.med.uvm.edu/ahec/workforceresearchdevelopment/toolkits-and-workbooks/opioid_prescribing
- The PDMP allows querying by delegates as well as batch processing of queries to increase the efficiency of use of the system.
- VT has held learning collaboratives with prescribers around prescribing practices and on alternatives to opioids in treating chronic pain.
- Technical assistance in office workflow and best prescribing practice is available to any prescriber.
- VDH has provided prescribers with tools and materials to assist them in working with pain patients. http://www.healthvermont.gov/alcohol-drugs/professionals/resources-patients-and-providers

- Focus groups and interviews have been conducted to determine the best ways of communicating with prescribers.

Future State:

- See integration into EHR discussion above.
- Beginning in April 2018, VDH is implementing Project ECHO which is a mechanism to build pain management expertise among primary care physicians through mentorship with experts in the field. Due to high demand, additional sessions will be added.
- Additional learning collaboratives are scheduled in 2018.
- VDH is revamping the website to make all prescriber and patient resources easier to find.
- Ongoing technical assistance is available.
- Clinical Alerts will be implemented in the system. These alerts provide proactive reporting within VPMS to prescribers to highlight prescribing patterns or concerns of which to be aware. Alerts are available for multiple situations that may indicate an increased risk of overdose, dependence, or misuse.

Summary of Actions Needed:

- VDH is promoting the availability of technical assistance at the prescriber level. Promotion has been integrated into the March 2018 implementation of prescriber insight reports listed above and the impact of implementation of the insight reports is being evaluated.
- VDH is conducting an impact evaluation of the July 1, 2017 pain prescribing rule change. Planned completion is expected by December 31, 2018.
- VDH began user acceptance testing of the clinical alerts February 2018 and has a target implementation date of July 1, 2018.

Master Patient Index / Identity Management

Current State:

- See discussion of Master Patient index above as it pertains to the PDMP.
- Improved patient grouping in VPMS allows more accurate identification of patients meeting multiple prescriber episodes. Prescribers are notified of patients with potentially risky opioid use (through a letter or within the system) with instructions to review with patients and refer to external SUD treatment, if needed.
- The State of Vermont has an established health IT infrastructure that supports the provision of care and measurement of the health care system and reform initiatives. The State's health-IT infrastructure includes, but is not limited to, a PDMP, public health registries (immunization, births/deaths, and cancer), a statewide health information exchange with supporting data extraction capabilities, behavioral health registry, an All-Payer Claims Database, and a clinical registry within the Medicaid Agency that is

operated by the Blueprint for Health program. Additionally, a care coordination platform supports providers participating in Vermont's All-Payer Model and all of Vermont's hospitals and a considerable number of eligible providers have taken advantage of the Meaningful Use program to adopt electronic health record systems. Incorporation of substance use treatment information will require compliance with 42 CFR Part 2.
- Some systems are integrated, others are not. There are a variety of mechanisms for addressing identity management.

Future State:

- Greater interoperability between existing systems, with appropriate identity management.
- Increased use of existing and updated systems.
- VPMS threshold letters will be system generated.

Summary of Actions Needed:

- Under the guidance of a recently established Health Information Exchange (HIE) Steering Committee, the Department of Vermont Health Access is currently working to develop a statewide Health Information Exchange/Health-IT strategic plan. The Plan will address the state's health-IT network and needs, including SUD efforts. By November 2018, the Steering Committee will produce a final plan for submission to the Green Mountain Care Board, the State's health system regulatory body. The Board is statutorily obligated to review the plan for approval. Actions, responsibilities, and timelines will be guided by the strategic plan.
- VDH is currently working with the VPMS vendor on threshold reporting. This is a contract deliverable and should be available by 12/31/18.

Overall Objective for Enhancing PDMP Functionality & Interoperability

Current State:

- VT rules require use of the PDMP by prescribers and pharmacists to prevent overprescribing and identify potentially risky opioid use. VT is also providing training to prescribers and pharmacists on both appropriate prescribing and use of the PDMP.
- Pharmacists are required to query the PDMP if an individual presents a prescription and does not pay for it with the insurance on file.
- VT Medicaid has a pharmacy lock in program for Medicaid recipients who may be doctor or pharmacy shopping.
- Prescriber Insight Reports, listed above, were implemented March 2018.

Future State:

- Vermont has a fully integrated VPMS with proactive reporting to prescribers and pharmacists to decrease initiation and misuse of prescription drugs.
- Those Vermonters with opioid use disorders, identified through this and other avenues, are referred to and receive treatment.

Summary of Actions Needed:

- Implement actions outlined in the "future" sections throughout Attachment A.

ATTACHMENT K
(Previously Attachment R)

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] *This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.*

General Information:

A. State: Vermont

B. Waiver Title(s): Global Commitment to Health Section 1115 Demonstration; Choices for Care (CFC) and Special Programs, as indicated in STC 20(c): Traumatic Brain Injury, Mental Illness Under 22, Community Rehabilitation and Treatment, and Developmental Disability Services

C. Control Number(s): 11-W-00194/1

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
O	**Natural Disaster**
O	**National Security Emergency**
O	**Environmental**

individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This amendment will apply across Vermont's 1115 waiver for CFC and Special Programs, as indicated in Section B, to all individuals impacted by the virus or the response to the virus (e.g. closure of day programs, etc.)

This Attachment R was originally approved with an end date of 1/26/2021. The flexibilities below that do not have an explicit end date will be extended until no later than six months after the expiration of the Public Health Emergency.

F. Proposed Effective Date: Start Date: January 27, 2020 **Anticipated End Date:** No later than six months after the expiration of the Public Health Emergency.

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across CFC and Special Programs, as indicated in Section B, to all individuals impacted by the COVID-19 virus.

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable:***

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a.___ Access and Eligibility:

i.___ Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

ii.___ Temporarily modify additional targeting criteria.
[Explanation of changes]

b.__X_ Services

i.___ Temporarily modify service scope or coverage.
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ___Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.
[Explanation of changes]

iii. ___Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).
[Complete Section A-Services to be Added/Modified During an Emergency]

iv. _X__Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:
[Explanation of modification, and advisement if room and board is included in the respite rate]:

*Please note that this flexibility was never implemented because it was found to be not necessary.

Residential Habilitation, including Adult Family Care (also known as Shared Living) and Enhanced Residential Care Home services, Residential Treatment Facilities, and other licensed residential programs (also known as group home or staffed living) may be provided in alternative settings when the participant is displaced from their home because of quarantine or hospitalization or when providers are unavailable due to illness or business closure during the COVID-19 emergency, at the State's discretion. Examples of alternative settings where services may be provided include hotels, shelters, churches, vacant settings (e.g. school, day care, senior center, adult day program) or alternative facility-based settings or the home of a direct care worker.

v.___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c._X__ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

Temporarily permit payment for services rendered by family caregivers or legally responsible individuals in lieu of care that would have been provided by paid caregivers, within the limits of the existing plan of care, as the State determines necessary. Applicable services by program include:

Choices for Care: personal care, companion, respite
Developmental Disability Services: respite, residential habilitation, and day habilitation
Traumatic Brain Injury Program: respite, life skills aid, community supports

Case management monitoring and oversight of care plans and service delivery will remain in effect during the emergency.

d.___ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i.___ Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ii.___ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the provider type for each service].

iii.___ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e. __X_Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

Suspend or extend requirements for level of care re-evaluation and/or annual review of continued clinical eligibility, as the State determines necessary. This flexibility ended on 1/1/2021 for the following programs: Community Rehabilitation and Treatment, and Mental Illness Under 22. This flexibility ended in August 2020 for the following programs: Choices for Care and Traumatic Brain Injury.

f.___ Temporarily increase payment rates.

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

g.__X_ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

The State may modify timeframes for completing or revising individual service plans and may allow retroactive approval for service needs identified to mitigate harm or risk directly related to COVID-19 impacts, as the State determines necessary. The State will ensure the service plan is modified to allow for additional supports and/or services to respond to the COVID-19 pandemic. The specificity of such services including amount, duration and scope will be appended in as soon as possible but no later than sixty (60) days from the date the service was initiated to ensure that the specific service is delineated according to the date it began to be received. This flexibility ended on 1/1/2021 for the following programs: Community Rehabilitation and Treatment, and Mental Illness Under 22. This flexibility ended in August 2020 for the following programs: Choices for Care and Traumatic Brain Injury.

h.__ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i.__ Temporarily allow for payment for services for the purpose of supporting waiver participants

in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.
[Specify the services.]

j.___ Temporarily include retainer payments to address emergency related issues.
[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k.___ Temporarily institute or expand opportunities for self-direction.
[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

l.___ Increase Factor C.
[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m.___ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Appendix K Addendum: COVID-19 Pandemic Response

1. **HCBS Regulations**
   a. ☒ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. **Services**

a. ☒ Add an electronic method of service delivery (e.g,. telephonic) allowing services to continue to be provided remotely in the home setting for:
    i. ☒ Case management
    ii. ☒ Personal care services that only require verbal cueing
    iii. ☒ In-home habilitation
    iv. ☒ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
    v. ☒ Other *[Describe]:*

GC Specialized Program Services as indicated in Attachment D and Attachment E of the Global Commitment to Health Demonstration Waiver: service coordination, community supports (less than 24-hour), skilled therapy services, flexible supports, counseling, respite*, supported employment, crisis supports**, and clinical interventions***.

Only those services deemed as non-essential and clinically appropriate may be provided via telehealth, which includes audio-only service delivery. Essential services are required to be delivered in-person to assure the health and safety of a person. Non-essential services are permitted to continue if alternative, remote methods of delivery were available and clinically appropriate to provide via telehealth. The determination of delivery via telehealth must be made by the provider of services and is based on individual need and level of risk.

Health Care Administrative Rule 3.101 on telehealth indicates that HIPAA compliance is one of the conditions for coverage. Provider communications reference both this telehealth rule and the 3/17/2020 announcement from the Office for Civil Rights regarding its enforcement discretion.

Providers are expected to take appropriate steps to establish the provider-patient relationship and conduct all appropriate evaluations and history of the beneficiary consistent with traditional standards of care. Providers are expected to meet or exceed state and federal requirements for medical and health information privacy, including compliance with HIPAA. As part of an individual's informed consent, provided in a language that the beneficiary understands, the case management provider must establish that: conditions are appropriate for a telehealth encounter, including that the patient is not in need of alternative care given the patient's current status; security measures have been taken with the use of telemedicine technologies to ensure patient safety and privacy; and an emergency protocol exists for when care indicates that acute or emergency treatment is necessary for the safety of the patient.

Through quality oversight such chart reviews and ongoing monitoring meetings with agency directors, providers are monitored to ensure that they were taking steps to confirm the health and safety of individuals being served, which could include observations like the room/home is clean and safe and the individual has no injuries/bruising, through video chat and/or a phone conversation.

*Respite: The Department of Mental Health established protections regarding informed consent, assurance of the health and safety of the person being served, and appropriate documentation in the clinical record. Additionally, respite for children may only be provided via telehealth when there is a family member in the home. Mandated reporting requirements have remained in place during the public health emergency.

As with all services, respite providers are acting within the scope of their practice and are not endangering patients in delivering services to them. In the midst of the COVID-19 crisis, respite has been provided as an activity break and as an effort maintain a connection and engagement with the child; not as a child care activity.

**Crisis supports: Some crisis support services have been deemed to be essential, including crisis stabilization, hospital diversion programs, and intensive supports. Other crisis supports, to the extent they could be provided in a clinically appropriate way without compromising the health and safety of the individual being served, could be provided via telehealth to reduce the possible spread of COVID-19. ***Clinical interventions: clinical interventions are considered to be non-essential services that could be provided via telehealth when clinically appropriate, such as health risk assessments, brief emotional/behavioral risk assessments, medication therapy management assessments, and non-acute therapy. These services must meet clinically accepted standards of medical practice and delivery methods that are considered effective in providing health care services to patients, including for purposes of evaluation, diagnosis, consultation, or treatment.

b. ☐ Add home-delivered meals
c. ☐ Add medical supplies, equipment and appliances (over and above that which is in the state plan)
d. ☐ Add Assistive Technology

3. **Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.**
   a. ☒ Current safeguards authorized in the approved waiver will apply to these entities.
   b. ☐ Additional safeguards listed below will apply to these entities.

N/A

4. **Provider Qualifications**
   a. ☒ Allow spouses and parents of minor children to provide personal care services
   b. ☒ Allow a family member to be paid to render services to an individual.
   c. ☐ Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

   d. ☐ Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. **Processes**
   a. ☒ Allow an extension for reassessments and reevaluations for up to one year past the due date.
   b. ☒ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.

c. ☒ Adjust prior approval/authorization elements approved in waiver.
d. ☒ Adjust assessment requirements
e. ☒ Add an electronic method of signing off on required documents such as the person-centered service plan.

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name:	Wendy
Last Name	Trafton
Title:	Deputy Director of Health Reform
Agency:	Agency of Human Services
Address 1:	280 State Drive
Address 2:	Click or tap here to enter text.
City	Waterbury
State	Vermont
Zip Code	05671
Telephone:	802-585-4723
E-mail	Wendy.trafton@vermont.gov
Fax Number	Click or tap here to enter text.

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Ashley
Last Name	Berliner
Title:	Director of Medicaid Policy
Agency:	Department of Vermont Health Access
Address 1:	280 State Drive
Address 2:	Click or tap here to enter text.
City	Waterbury
State	Vermont
Zip Code	05671
Telephone:	802-578-9305
E-mail	Ashley.berliner@vermont.gov
Fax Number	Click or tap here to enter text.

8. Authorizing Signature

Signature: [redacted] **Date:** 1/26/2021

State Medicaid Director or Designee

First Name:	*Cory*
Last Name	*Gustafson*
Title:	Commissioner
Agency:	Department of Vermont Health Access
Address 1:	280 State Drive
Address 2:	Click or tap here to enter text.
City	Waterbury
State	VT
Zip Code	05671
Telephone:	802-585-0041
E-mail	Cory.gustafson@vermont.gov
Fax Number	Click or tap here to enter text.

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification				
Service Title:				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:				
Service Definition (Scope)**:**				
Specify applicable (if any) limits on the amount, frequency, or duration of this service:				
Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☐	Agency. List the types of agencies:

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☐	Provider managed

[i] Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.

Overview: The implementation plan documents the state's approach to implementing SMI/SED demonstrations. It also helps establish what **information** the state will report in its quarterly and annual monitoring reports. The implementation plan does not usurp or replace standard CMS approval processes, such as advance planning documents, verification plans, or state plan amendments.

This template only covers SMI/SED demonstrations. The template has three sections. Section 1 is the uniform title page. Section 2 contains implementation questions that states should answer. The questions are organized around six SMI/SED reporting topics:

1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care
3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services
4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration
5. Financing Plan
6. Health IT Plan

State may submit additional supporting documents in Section 3.

Implementation Plan Instructions: This implementation plan should contain information detailing state strategies for meeting the specific expectations for each of the milestones included in the State Medicaid Director Letter (SMDL) on "Opportunities to Design Innovative Service Delivery Systems for Adults with [SMI] or Children with [SED]" over the course of the demonstration. Specifically, this implementation plan should:

1. Include summaries of how the state already meets any expectation/specific activities related to each milestone and any actions needed to be completed by the state to meet all of the expectations for each milestone, including the persons or entities responsible for completing these actions; and
2. Describe the timelines and activities the state will undertake to achieve the milestones.

The tables below are intended to help states organize the information needed to demonstrate they are addressing the milestones described in the SMDL. States are encouraged to consider the evidence-based models of care and best practice activities described in the first part of the SMDL in developing their demonstrations.
The state may not claim FFP for services provided to Medicaid beneficiaries residing in IMDs, including residential treatment facilities, until CMS has approved a state's implementation plan.

Memorandum of Understanding:
The Vermont State Mental Health Authority, the Vermont Department of Mental Health (DMH), is a department under the Vermont Agency of Human Services (AHS). AHS serves as Vermont's

Single State Medicaid Agency, of which DMH is a part. Therefore, no formal agreement is needed to delineate how these organizations will work together to design, deliver, and monitor services for beneficiaries with SMI or SED.

State Point of Contact:

Name and Title: Ashley Berliner, Director of Medicaid Policy
Telephone Number: 802-578-9305
Email Address: ashley.berliner@vermont.gov

1. Title page for the state's SMI/SED demonstration or SMI/SED components of the broader demonstration

The state should complete this transmittal title page as a cover page when submitting its implementation plan.

STATE	Vermont
DEMONSTRATION NAME	Global Commitment to Health 11-W-00194/1
APPROVAL DATE	*December 5, 2019*
APPROVAL PERIOD	*January 1, 2017 – December 31, 2027*
IMPLEMENTATION DATE	*January 1, 2020*

2. Required implementation information, by SMI/SED milestone

Answer the following questions about implementation of the state's SMI/SED demonstration. States should respond to each prompt listed in the tables. Note any actions that involve coordination or input from other organizations (government or non-government entities). Place "NA" in the summary cell if a prompt does not pertain to the state's demonstration. Answers are meant to provide details beyond the information provided in the state's special terms and conditions. Answers should be concise, but provide enough information to fully answer the question.

This template only includes SMI/SED policies.

Prompts	Summary
SMI/SED. Topic_1. Milestone 1: Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	
To ensure that beneficiaries receive high quality care in hospitals and residential settings, it is important to establish and maintain appropriate standards for these treatment settings through licensure and accreditation, monitoring and oversight processes, and program integrity requirements and processes. Individuals with SMI often have co-morbid physical health conditions and substance use disorders (SUDs) and should be screened and receive treatment for commonly co-occurring conditions particularly while residing in a treatment setting. Commonly co-occurring conditions can be very serious, including hypertension, diabetes, and substance use disorders, and can also interfere with effective treatment for their mental health condition. They should also be screened for suicidal risk. *To meet this milestone, state Medicaid programs should take the following actions to ensure good quality of care in psychiatric hospitals and residential treatment settings.*	
Ensuring Quality of Care in Psychiatric Hospitals and Residential Treatment Settings	

Prompts	Summary
1.a Assurance that participating hospitals and residential settings are licensed or otherwise authorized by the state primarily to provide mental health treatment; and that residential treatment facilities are accredited by a nationally recognized accreditation entity prior to participating in Medicaid	**Current Status:** Milestone achieved. Participating IMD facilities are licensed by the State and are accredited by the Joint Commission. The Vermont Department of Health's Hospital Licensing Rule requires that, "No organization or individual may establish, conduct, or maintain operation of a Hospital in Vermont without being granted a license by the State Licensing Agency." Additionally, this rule requires that hospitals comply with all CMS Conditions of Participation, and incorporates 42 CFR 482.60-482.66 specific to psychiatric hospitals and units: *5.1 Compliance with CMS Conditions of Participation* *5.1.1 To be licensed and retain licensure in Vermont, each Hospital shall comply with all applicable CMS Conditions of Participation referenced in Section 3.4 of this rule or be operating under a Plan of Correction as described in Section 7.0 of this rule.* *5.1.2 To demonstrate compliance with CoPs, each Vermont Hospital shall make themselves available for a comprehensive, on-site and unannounced survey by the State Survey Agency:* *5.1.2.1 Occurring on average once every three years or at a frequency determined by CMS.* *5.1.2.2 Whenever CMS requires a Validation Survey for an accredited Hospital with Deemed Status.* *5.1.2.3 Whenever the Department or its designee determines that a survey is required as referenced in Section 5.3 of this rule.* *5.1.3 As part of the annual Hospital licensing process, each Hospital shall provide to the Department any documents necessary to verify that the applicant Hospital has met the requirements of the CoPs.* *5.1.4 A Hospital license is not transferable or assignable and shall be issued only for the premises and persons named in the application. A licensed Hospital contemplating a change of ownership or the elimination or significant reduction of clinical services shall provide at least ninety (90) days advance notice to the Licensing Agency.* *5.1.5 The Hospital license shall be posted in a conspicuous place on the licensed facility's premises.*
	Future Status: No changes are expected.
	Summary of Actions Needed: None.

Prompts	Summary
1.b Oversight process (including unannounced visits) to ensure participating hospital and residential settings meet state's licensing or certification and accreditation requirements	**Current Status:** Milestone achieved. The Vermont Department of Health's Hospital Licensing Rule requires that hospitals comply with all CMS Conditions of Participation, including: *5.1 Compliance with CMS Conditions of Participation 5.1.1. To be licensed and retain licensure in Vermont, each Hospital shall comply with all applicable CMS Conditions of Participation referenced in Section 3.4 of this rule or be operating under a Plan of Correction as described in Section 7.0 of this rule.* *5.1.2 To demonstrate compliance with CoPs, each Vermont Hospital shall make themselves available for a comprehensive, on-site and unannounced survey by the State Survey Agency:* *5.1.2.1 Occurring on average once every three years or at a frequency determined by CMS.* *5.1.2.2 Whenever CMS requires a Validation Survey for an accredited Hospital with Deemed Status.* *5.1.2.3 Whenever the Department or its designee determines that a survey is required as referenced in Section 5.3 of this rule.* *5.1.3 As part of the annual Hospital licensing process, each Hospital shall provide to the Department any documents necessary to verify that the applicant Hospital has met the requirements of the CoPs.* The Vermont Division of Licensing and Protection performs the survey and certification hospital oversight functions on behalf of CMS. These functions include unannounced visits to ensure that the participating IMD facilities are meeting licensure and accreditation requirements.
	Future Status: No changes are expected.
	Summary of Actions Needed: None.
1.c Utilization review process to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight on lengths of stay	**Current Status:** Milestone achieved. The Vermont Department of Health's Hospital Licensing Rule adopts the federal standards in 42 C.F.R. 482.30, which details requirements for utilization review.

Prompts	Summary
	The Department of Vermont Health Access (DVHA) conducts numerous utilization management and review activities to ensure that quality services, those which increase the likelihood of desired health outcomes and are consistent with prevailing professionally recognized standards of medical practice, are provided to members and that providers are using the program appropriately, effectively and efficiently. DVHA and DMH staff utilize clinical criteria for making utilization review decisions that are objective and based on sound medical evidence. In 2012, DMH and DVHA collaborated to create a unified, consistent utilization management system for all Vermont Medicaid-funded inpatient psychiatric and detoxification services. In addition to the joint DMH/DVHA Utilization Review Team, DMH formed an expanded Care Management Unit to actively support the system of care in Vermont and facilitate flow throughout the highest levels of care. Additionally, Medicaid holds utilization review calls weekly with the Brattleboro Retreat, the only inpatient mental health facility for children and adolescents in Vermont, to help coordinate inpatient care. The goals for the utilization management system are as follows: • Inpatient care is provided only as long as necessary for safety and/or other acute needs; • There are standardized criteria for admission, continued stay, and discharge throughout the system of care; • Care is continuous between the ongoing community treatment teams and episodes of inpatient care. The hospital or residential facility and community teams develop and share a common treatment plan developed in partnership with the individual and his/her family, beginning within 24 hours of admission; • Resources of the public system are effectively and efficiently used; and • The care management system will ensure access to effective, appropriate, recovery-based services that promote health, wellness, resiliency, and successful integration into the community.
	Future Status: No changes are expected.
	Summary of Actions Needed: None.
1.d Compliance with program integrity requirements and state compliance assurance process	**Current Status:** Milestone achieved. All Medicaid-enrolled providers, including the participating IMD facilities, are required to comply with all applicable

Prompts	Summary
	state and federal laws. The terms of the Medicaid Provider Contract state: *5.1 The parties to this Agreement acknowledge and expect that over the term of this Agreement laws may change. Specifically, the parties acknowledge and expect (i) federal Medicaid statutes and regulations, (ii) state Medicaid statutes and rules, (iii) state statutes and rules governing practice of health care professions, and (iv) any other laws cited in the Agreement may change. The parties shall be mutually bound by such changes.* Additionally, Article VI. Audit Inspection of the Medicaid Provider Contract outlines Medicaid program integrity requirements, which incorporates applicable federal program integrity regulation. The participating IMD facilities are signatories to the Medicaid Provider Contract and are in compliance with its terms.
	Future Status: No changes are expected.
	Summary of Actions Needed: None.
1.e State requirement that psychiatric hospitals and residential settings screen beneficiaries for co-morbid physical health conditions, SUDs, and suicidal ideation, and facilitate access to treatment for those conditions	**Current Status:** Milestone achieved. The Vermont Department of Health's Hospital Licensing Rule requires that hospitals comply with all CMS Conditions of Participation, including 42 CFR 482.60-482.66 specific to psychiatric hospitals and units. The following Federal Conditions of Participation required for State Hospital licensure are related to this milestone: **§482.61 Condition of participation: Special medical record requirements for psychiatric hospitals.** **The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.** *(a) Standard: Development of assessment/diagnostic data. Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.* *(1) The identification data must include the patient's legal status.*

Prompts	Summary
	(2) A provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses. ***§482.62*** *Condition of participation: Special staff requirements for psychiatric hospitals.* ***The hospital must have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures****, and engage in discharge planning.* *(a) Standard: Personnel. The hospital must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to:* *(1) Evaluate patients;* *(2) Formulate written individualized, comprehensive treatment plans;* *(3) Provide active treatment measures; and* *(4) Engage in discharge planning.* *(b) Standard: Director of inpatient psychiatric services; medical staff. Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services.* *(1) The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.* *(2) The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.* ***(c) Standard: Availability of medical personnel. Doctors of medicine or osteopathy and other appropriate professional personnel must be available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic and treatment services are not available within the institution, the institution must have an agreement with an outside source of these services to ensure that they are immediately available or a satisfactory agreement must be established for transferring patients to a general hospital that participates in the Medicare program.*** All participating IMD facilities are currently engaged in these activities.
	Future Status: No changes are expected.

Prompts	Summary
	Summary of Actions Needed: None.
1.f Other state requirements/policies to ensure good quality of care in inpatient and residential treatment settings.	**Current Status:** DMH uses the Results Based Accountability (RBA) framework to evaluate the performance of programs and initiatives. RBA is a framework that helps programs improve the lives of children, families, and communities and their performance. Hospital Inpatient Units: • As discussed above, for a hospital to be licensed to operate in Vermont it must abide by the Vermont Hospital Licensing Rule. This rule requires a hospital to meet CMS regulations, which are tied to Joint Commission requirements. • DMH also must designate hospital inpatient psychiatric units in order for involuntary patients to be treated there. This is governed by DMH's Designated Hospitals Manual and Standards. o It is the Designated Hospital's responsibility to provide DMH with copies of specific documentation demonstrating compliance with each requirement. The Commissioner requires re-designation of Designated Hospitals every two years. To enable adequate oversight by the Department, Departmental staff arrange for a visit in advance of the designation expiration date. This visit includes interviews with key staff, a review of outcomes, and a review of policies and procedures. A written decision letter and feedback is provided to the Designated Hospital following the visit. The review may require the Designated Hospital to address any missing information or provide a corrective action plan. Residential Treatment Settings: • Adult residential treatment centers must be licensed by the Vermont Department of Aging and Independent Living (DAIL) (https://dail.vermont.gov/resources/regulations). • Child residential treatment centers must be licensed by the Vermont Department for Children and Families (DCF) (https://dcf.vermont.gov/sites/dcf/files/FSD/pubs/RTP-Regs.pdf)
	Future Status: No changes are expected.
	Summary of Actions Needed: None.
SMI/SED. Topic_2. Milestone 2: Improving Care Coordination and Transitioning to Community-Based Care	
Understanding the services needed to transition to and be successful in community-based mental health care requires partnerships between hospitals,	

Prompts	Summary
residential providers, and community-based care providers. To meet this milestone, state Medicaid programs, must focus on improving care coordination and transitions to community-based care by taking the following actions.	
Improving Care Coordination and Transitions to Community-based Care	
2.a Actions to ensure psychiatric hospitals and residential settings carry out intensive pre-discharge planning, and include community-based providers in care transitions.	**Current Status:** Milestone achieved. The Vermont Department of Health's Hospital Licensing Rule requires that hospitals comply with all CMS Conditions of Participation and adopts 42 CFR 482.43, which details discharge planning requirements that align with this milestone. Additionally, DMH contracts with Community Mental Health Clinic providers, called Designated Agencies, to participate in transition efforts and discharge planning. Designated Agencies are private, non-profit service providers that are responsible for ensuring needed services are available through program delivery, local planning, service coordination, and monitoring outcomes within their region. Requirements for Designated Agencies are specified in the Mental Health Provider Manual: *Transition planning is critical for the support of the individual's ongoing treatment, recovery or wellbeing. If for any reason a transition or discharge plan cannot be developed in the timelines below, the circumstances prohibiting the planning will be documented.* *A transition plan must be developed for any individual who requires treatment intervention and/or family support who is transitioning to other services or providers outside the local network or moving to another region including but not limited to a transition from one level of care to another or a transition from one programming area to another. A transition plan must be developed with the individual and/or family/guardian prior to transition date.* *A discharge plan must be developed anytime an individual or child and family have completed services, chosen to discontinue services, or for whom services have been terminated. A discharge plan must be developed with the individual and/or family/guardian prior to discharge date for all individuals where the discharge is planned.* *Plans should include the following components and be developed with the individual and other appropriate participants, such as the family, whenever possible:*

Prompts	Summary
	• progress towards goals during program participation, *• reason for discharge or transition,* *• condition at last contact, and* *• referrals made, if clinically indicated.* *For a child or adult who is in an out-of-home treatment setting, the local team supports the facility or out of home treatment provider for discharge planning.* *This includes settings such as* *• out-of-home community home provider placements,* *• private non-medical institutions/residential programs (in and out of state),* *• hospital diversion/emergency beds,* *• inpatient psychiatric hospitalization, and* *• arrangements with other providers.* All participating IMD facilities are currently engaged in intensive discharge planning and care coordination services.
	Future Status: Maintain and enhance current discharge planning and care coordination with improved strategies for connection with local community-based services. DMH is working on the following strategies to improve connection with local community-based services: • Collaborative Network Approach - Vermont's version of "Open Dialogue" practice, to better inform transition to community with the patients' and their families' direct involvement; • Increase awareness of available community work supports for staff and individuals in psychiatric hospital care (e.g. offer short training on Evidence Based Practices for Supported Employment (EBP SE), Specialized Service Agency (SSA) work incentive; • Host employment-related in-house groups based on individuals' lead (employing a Recovery-Orientated Cognitive Therapy approach); and • Develop ways for the local community employment specialist or Vocational Rehabilitation counselor to meet with patients and staff prior to discharge, whenever possible.
	Summary of Actions Needed: None.

Prompts	Summary
2.b Actions to ensure psychiatric hospitals and residential settings assess beneficiaries' housing situations and coordinate with housing services providers when needed and available.	**Current Status:** Participating IMD Facilities Current Practice: • Assessment of the beneficiaries housing situation and community supports and clinical needs begins at the time of the referral, continues in assessment and evaluation and on units with Treatment Planning. • Active discharge planning takes place with Social Work staff working with each of the state's Designated Agencies to coordinate after care planning, which includes housing and residential step-down services. DMH has a housing coordinator that works with Vermont landlords to aid in securing and financing stable housing for those who are homeless or have unsuitable or unstable housing.
	Future Status: Establish State policy to maintain current efforts around housing coordination and services that ensure alignment across participating IMD facilities. This policy effort will require changes to the Vermont Department of Health (VDH) hospital licensing rule and anticipate this will take 18 months.
	Summary of Actions Needed: None.
2.c State requirement to ensure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible, e.g., email, text, or phone call within 72 hours post discharge	**Current Status:** Vermont does not currently meet these requirements.
	Future Status: Promulgate administrative rule that requires facilities to develop protocol for meeting this expectation. The VDH licenses IMDs through their Hospital Licensing Rule. VDH will begin rulemaking in 2020 to assure psychiatric hospitals and residential settings contact beneficiaries and community-based providers through most effective means possible. Vermont administrative rulemaking requires a robust process, likely to take up to 12 months to go into effect. The State will establish a process to ensure facilities adhere to the requirements of the future administrative rule.
	Summary of Actions Needed: Establish state policy to ensure that facilities are providing high quality follow-up care that aligns with this milestone.
2.d Strategies to prevent or decrease lengths of stay in EDs among beneficiaries with SMI or SED prior to admission	**Current Status:** Strategies include: • Analyze and adjust (if warranted) bed capacity: o Vermont is in the process of adding additional inpatient and residential capacity to better meet the growth in numbers of people in need of inpatient services. • Telepsychiatry:

Prompts	Summary
	o Using telepsychiatry, Vermont Medicaid is able to fund consultation to Emergency Department (ED) staff regarding medication needs for patients to help facilitate them moving to the next appropriate level of care. In addition, telepsychiatry helps to determine the level of care that is needed for an individual in the ED. Telepsychiatry is also being increasingly used to reach people in the more remote areas of the state. With this capability, Vermont is better able to provide psychiatric supports for individuals who have traditionally only reached these supports by presenting at an ED. • Peer-to-peer support services: o Peer supports in EDs help provide a safe and stabilizing environment for the patient, which has an impact on the current psychiatric crisis and can help a patient access the appropriate level of care from the ED. Vermont already has one peer run crisis stabilization facility and a peer run intensive residential program. Vermont is considering the expansion of peer run crisis and stabilization units to help further prevent unnecessary ED visits. • SBINS - Screening, Brief Intervention, and Navigation to Services: o SBINS is an approach that helps health care providers identify risks to their patients' health and wellbeing, from a wide range of sources including drug and alcohol use, housing and food insecurity, inter-partner violence, and more. When risks are present, trained counselors offer patients support and help them access the services they need to address risk factors and maintain or improve their health. Through this process, risk factors can be addressed prior to rising to the level that requires an ED visit. SBINS is not a statewide strategy at this time, but the program is active in some EDs. • Vermont Psychiatric Survivors (VPS) peers in EDs: o VPS has a 1.0 FTE peer support staff as part of the Rutland County Community Links Program; of which one of the roles of the position is to provide support for people in crisis in emergency rooms or other places where it may be needed. Vermont anticipates additional discussion regarding a more comprehensive peer-outreach program statewide. VPS peers in EDs help provide a safe and stabilizing environment which often results in patients stabilizing and being safely discharged from the ED with supports from the VPS peer.
	Future Status: • Maintain and enhance efforts to prevent and decrease lengths of ED stays by continuing to pursue the strategies outlined above. In addition: o DMH is currently drafting a report to review and analyze residential capacity across the system of care, identifying the priority areas as well as the geographic areas that are in need of additional capacity. This

Prompts	Summary
	report will be provided to the legislature in January of 2020. There is a current proposal to expand intensive residential capacity in Rutland County, Vermont; o DMH is currently issuing a Request for Proposal (RFP) for peer workforce development that includes review of other state workforce certification standards and funding methodologies to inform strategies for expansion of peer supports; and o DMH is concluding a major stakeholder engagement effort this CY19, resulting in the creation of a 10-year plan for a holistic and integrated system of care (2020-2030). This plan will include action areas for the system of care that will be supported by short, mid and long-term strategies. The plan will be provided to the legislature in January of 2020 and used to inform future policy and financial priorities of the system.
	Summary of Actions Needed: DMH will work within required processes for the state's executive branch and must defer to the state's legislative process for any future decisions on investments that may be possible.
2.e Other State requirements/policies to improve care coordination and connections to community-based care	**Current Status:** Milestone achieved. Vermont currently has technical assistance grants through the National Governor's Association and Actionable Intelligence for Social Policy. The State's goals are to develop and enhance interoperability and data sharing on a variety of different issues, including physical health, SUD, and mental health providers. Vermont is also investing in care coordination through the All-Payer Accountable Care Organization (ACO) Model. OneCare Vermont makes payments to community providers for complex care coordination. This care coordination includes: • Outreach to engage/maintain patients in care coordination, • Provide care coordination services for patient panels, • Create shared care plans and community among care team members, • Participate in shared care planning and care conferences to facilitate the patient's goals of care, • Support effective transitions of care (e.g. ED follow-up calls, post hospital discharge visits), • Partner with continuum of care and human services organizations, and • Attend care coordination skills trainings. Complex care coordination payments to primary care, Home Health Agencies, Designated Mental Health Agencies,

Prompts	Summary
	and Area Agencies on Aging were approximately $ 9.1M in CY18. Children Specific: Medicaid holds utilization review calls weekly with the Brattleboro Retreat, the only inpatient mental health facility for children and adolescents in Vermont, to help coordinate inpatient care. In addition, the Vermont Department of Mental Health's Provider Manual and Minimum Standards Guidelines for children's mental health requires coordination of designated agencies (local providers of community mental health care) with inpatient and residential providers to transition children/youth to community-based care.
	Future Status: Maintain and enhance current efforts around care coordination.
	Summary of Actions Needed: None.
SMI/SED. Topic_3. Milestone 3: Increasing Access to Continuum of Care, Including Crisis Stabilization Services	
Adults with SMI and children with SED need access to a continuum of care as these conditions are often episodic and the severity of symptoms can vary over time. Increased availability of crisis stabilization programs can help to divert Medicaid beneficiaries from unnecessary visits to EDs and admissions to inpatient facilities as well as criminal justice involvement. On-going treatment in outpatient settings can help address less acute symptoms and help beneficiaries with SMI or SED thrive in their communities. Strategies are also needed to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible. To meet this milestone, state Medicaid programs should focus on improving access to a continuum of care by taking the following actions.	
Access to Continuum of Care Including Crisis Stabilization	
3.a The state's strategy to conduct annual assessments of the availability of mental health providers including psychiatrists, other practitioners, outpatient, community mental health centers, intensive outpatient/partial hospitalization, residential, inpatient, crisis	**Current Status:** Milestone achieved. DMH provides this information in the form of an annual report to the Vermont State Legislature, pursuant to Vermont Act 79, An act relating to reforming Vermont's mental health system.
	Future Status: Continue to conduct an annual assessment of mental health services throughout Vermont. The state will include the contents of this assessment in its annual demonstration report to CMS.

Prompts	Summary
stabilization services, and FQHCs offering mental health services across the state, updating the initial assessment of the availability of mental health services submitted with the state's demonstration application. The content of annual assessments should be reported in the state's annual demonstration monitoring reports.	**Summary of Actions Needed:** None.
3.b Financing plan	**Current Status:** Vermont funds a peer-run warm line that operates 18 hours per day/seven days a week. Vermont recently received a grant from the National Suicide Prevention Lifeline (NSPL) to support training and accreditation in suicide risk assessment and intervention for the warm line program. This grant has not yet been approved by Vermont's Joint Fiscal Office (JFO) but is in process. Two additional crisis call centers are also slated to be recipients of the NSPL grant pending JFO approval in Vermont, which would expand coverage to 22 hours a day for in-state call response to the Lifeline. A decision on approval is expected by January 2020 and if approved, full expansion of the Lifeline call response is planned for the end of FY21. All ten Designated Agencies have 24-hour crisis call centers and mobile crisis units, and many Designated Agencies have embedded mental health professionals within local and state law enforcement. DMH continues to sponsor the Team Two training that is building working relationships between local law enforcement and local mental health crisis teams.
	Future Status: Continue to explore strategy to enhace availability of community-based SMI services in Vermont through the following approaches: • Continued annual reporting to the legislature required by Act 79 (2012) on the current status of community-based and facility-based care and the balance between these programming areas including recommendations for change;

Prompts	Summary
	• Payment reform caseload and rate analysis. Payment reform efforts implemented in 2019 seek to provide Vermont with new tools for analyzing needs, strengths, volume and caseloads in community-based mental health programs. DMH will be phasing in use of these tools from CY2020 through CY2023; and • 10-Year Plan for a holistic and integrated system of care. DMH is concluding a major stakeholder engagement effort this CY2019, resulting in the creation of a 10-year plan for the system of care (2020-2030). This plan will include action areas for the system of care that will be supported by short, mid and long-term strategies. The plan will be provided to the legislature and used to inform future policy and financial priorities of the system.
	Summary of Actions Needed: None.
3.c Strategies to improve state tracking of availability of inpatient and crisis stabilization beds	**Current Status:** Milestone achieved. Medicaid maintains a bed board of all hospitals and residential placements funded by Medicaid.
	Future Status: Enhancements are planned to update the bed board data to include SUD placements.
	Summary of Actions Needed: None.
3.d State requirement that providers use a widely recognized, publicly available patient assessment tool to determine appropriate level of care and length of stay	**Current Status:** All participating IMD facilities currently use InterQual/McKesson to help determine appropriate level of care and length of stay.
	Future Status: The state will establish a policy to require the use of evidence-based, publicly-available patient assessment tool(s) in order to achieve this milestone. The implementation of this policy will need to go through the rulemaking process in Vermont and it is anticipated that this will take 18 months.
	Summary of Actions Needed: Establish state policy to require the use of evidence-based, publicly-available patient assessment tool(s) in order to achieve this milestone.

Prompts	Summary
3.e Other state requirements/policies to improve access to a full continuum of care including crisis stabilization	**Current Status:** Vermont has an array of community-based systems of supports: • There are local crisis bed alternative programs in all Designated Agency catchment areas, as well as regional Intensive Residential Recovery Programs, to provide transitionary treatment and recovery-oriented support environments. Peer supported crisis bed and medication-alternative residential programs exist around the state. Additionally, Middlesex Therapeutic Community Residential Program also supports step-down opportunities for individuals from more restrictive hospital-based care. • Emergency Services are provided by Designated Agencies and include mobile crisis teams to respond to needs in the community, as well as phone support and prevention services. o When needed, clients are referred to crisis beds, which are part of a community-based hospital diversion program that offers emergency, short-term, 24-hour residential supports in a setting other than the person's home. They are operated by the Designated Agencies and Specialized Services Agencies. o DMH supports a peer-run crisis bed program, called Alyssum. o The total crisis bed count in Vermont is 38 for adult mental health and 18 for children and youth. For children and youth: • Expansion of Hospital Diversion Program o An additional six new beds have been created in the southern part of VT. • Utilization Review of continued stay requests in children's crisis programs (including community-based hospital diversion and crisis stabilization programs)
	Future Status: Mobile Response and Stabilization Services (MRSS): Vermont is evaluating the possibility of adding more resources for MRSS, which is a face-to-face response provided during a family-defined crisis to provide support and intervention for a child/youth and their family before emotional and behavioral difficulties escalate. MRSS has been shown in other states to be responsive to child, youth and family needs, clinically and cost effective in "averting unnecessary" higher levels of care in settings such as EDs, inpatient psychiatric care, residential treatment or other placement disruptions, and is often the first point of contact with families (NASMHPD 2018). MRSS takes a "just go" approach to responding to a family-defined crisis. These situations may not rise to the level of warranting screening for inpatient admission like danger to self or others, but nonetheless are a crisis situation for the family. Without stabilization, these situations could escalate to a more significant crisis over time. Other states have shown positive outcomes for children and families following successful implementation of MRSS,

Prompts	Summary
	including reductions in the use (utilization and lengths of stay) of higher levels of care such as EDs, inpatient psychiatric care, and residential treatment, as well as reduced foster placement disruptions. Evaluation efforts related to implementing the MRSS model in Vermont have included: • The creation of a cross-agency and stakeholder learning community; • Learning opportunities both in-person and by webinar to learn from other states' models of implementation; • Publication of a white paper that explores the model and implementation in Vermont; and • Review of baseline needs and utilization data which could be tracked over time to evaluate the impact of MRSS.
	Summary of Actions Needed: DMH will work within required processes for the state's executive branch and must defer to the state's legislative process for any future decisions on investments that may be possible.
SMI/SED. Topic_4. Milestone 4: Earlier Identification and Engagement in Treatment, Including Through Increased Integration	
Critical strategies for improving care for individuals with SMI or SED include earlier identification of serious mental health conditions and focused efforts to engage individuals with these conditions in treatment sooner. To meet this milestone, state Medicaid programs must focus on improving mental health care by taking the following actions.	
Earlier Identification and Engagement in Treatment	
4.a Strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner, e.g., with supported education and employment	**Current Status:** Milestone achieved. The State continues to employ a number of strategies to better identify and engage individuals in treatment earlier including: • Developing strategies to expand Intentional Peer Support (IPS) services to all Designated Agencies for young adults (16-22 yrs) with SED and adults with serious and persistant mental illness (SPMI); • Implementing Collaborative Network Approach (CNA) as a tool for better engaging transition-age young adults (early episode psychosis for adults) and SPMI adults; • Regularly conducting training on Dialectical Behavior Therapy (DBT) specifically for transition age youth and adults and sustaining availability of adult DBT consultation team to DAs; • Funding Jump On Board for Success (JOBS) programs in every Vermont region, with the objective of young adults with SED or SMI developing employment/education goals; • Impacting employment by maintaining funding support for Supported Employment for adults with SPMI and, within Designated Agency capacity, the adult population with mental health needs;

Prompts	Summary
	• Funding Mental Health First Aid, an 8-hour public education program which introduces participants to the unique risk factors and warning signs of mental health conditions in youth or adults, builds understanding of the importance of early intervention, and teaches individuals how to help when a person is in crisis or experiencing a mental health challenge; and • Funding of peer-run Community Centers to engage young adults experiencing mental health issues and adults with SPMI, who may be reluctant to engage traditional mental health services in a variety of ways and offering IPS supported employment and educational supports.
	Future Status: Maintain and build upon existing strategies for identifying and engaging beneficiaries with or at risk of SMI or SED in treatment sooner.
	Summary of Actions Needed: None.
4.b Plan for increasing integration of behavioral health care in non-specialty settings to improve early identification of SED/SMI and linkages to treatment	**Current Status:** Milestone achieved. Vermont Medicaid supports a number of programs, initiatives, and practices that support the goal of increased integration. These include, but are not limited to: • Advancing Wellness and Resilience in Education (AWARE): Medicaid has partnered with the Vermont Agency of Education in a five-year SAMHSA grant to promote on-going collaboration at the state and local level regarding best practices to increase awareness of mental health issues, enhance wellness and resiliency skills for school age youth, and support system improvements for school-based mental health services; • Children's Health Integration Linkage and Detection (CHILD): Five-year SAMHSA-funded grant to promote the integration and collaboration in clinical practice between primary and behavioral healthcare with the goal to improve the health and wellness of children with, or at-risk for, SED and their families; • DULCE (Developmental Understanding and Legal Collaboration for Everyone): DULCE's purpose is to ensure that newborns and their families receive quality medical care as well as all the social services and community support they need during the first six months of the newborn's life. A social worker is embedded in a pediatrician's office as a way to increase access and support to new parents; • Early Childhood and Family Mental Health (ECFMH): The Early Childhood and Family Mental Health system of care for children under the age of six and their families in Vermont provides a comprehensive cross-system, cross-agency infrastructure that sustains services and supports;

Prompts	Summary
	• Psychiatric consult for primary care: DMH contracts with child psychiatrists to provide psychiatric consultation to pediatric and family medicine primary care providers to support their management of psychiatric needs in children. This consultation supports the PCP's mental health assessments, intervention planning and implementation; • School Mental Health: Success Beyond Six supports the provision of mental health services by a Designated Agency in a school to address the mental health needs of identified students and provide mental health consultation for the school's multi-tiered systems of supports; • Vermont's Screening Treatment, & Access for Mothers and Perinatal Partners (STAMPP) Grant: Five-year cooperative agreement with HRSA that works to improve the mental health and well-being of pregnant and postpartum women and their children and families by developing and sustaining a coordinated system of mental health supports (screening, referral, access to treatment and community supports) for pregnant and postpartum women; and • JOBS programs: Community and school-based program focused on keeping youth in school who are at risk of dropping out, or re-engaging youth who have stopped attending.
	Future Status: Maintain and build upon existing strategies for increasing integration of behavioral health care in non-specialty care settings.
	Summary of Actions Needed: None.
4.c Establishment of specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI	**Current Status:** Milestone achieved. Vermont Medicaid continues to foster specialized settings and services for youth with SED or SMI, including through: • Crisis respite services for youth, • The Early Episode Psychosis Initiative to improve access and early interventions to individuals first experiencing symptoms of serious mental illness, and • Intensive residential programs specializing in working with youth SED/SMI populations.
	Future Status: Maintain and expand Vermont's capacity and access for specialized settings and services for young people experiencing SED or SMI.
	Summary of Actions Needed: None.
4.d Other state strategies to	**Current Status:**

Prompts	Summary
increase earlier identification/engagement, integration, and specialized programs for young people	Vermont Act 264 of 1989 requires that Human Services and Public Education work together, involve parents and coordinate services for better outcomes for children and families. The Act developed a coordinated system of care so that children and adolescents with emotional issues and their families receive appropriate educational, mental health, child welfare, juvenile justice, residential, and other treatment and support services in accordance with an individual plan. The Vermont Children's Health Improvement Program (VCHIP) administered through the University of Vermont: DMH partners with the Vermont Department of Health Maternal Child Health and VCHIP to improve screening for child developmental and mental health, as well as perinatal mood disorders during well-child visits. VCHIP also leads an annual quality improvement project with specific Pediatric and Family Practices, called Child Health Advances Measured in Practice (CHAMP), in which DMH partners in the planning and year-long project as it relates to mental health and behavioral topics. Payment Reform expanded the use of the Child and Adolescent Needs and Strengths (CANS) nationally recognized tool for standardized measurement of child and caregiver needs and strengths.
	Future Status: Maintain and expand Vermont's strategies to increase earlier identification/engagement, integration, and specialized programs for young people. Work with Agency of Education (AOE), AHS staff and stakeholders to provide technical assistance in using the coordination mechanisms supported by Act 264 (Coordinated Services Plans, Local and State Interagency Teams) to improve community collaboration on a case basis and system basis. This work is underway and will continue over the next year. Focus on pivotal transition points in the System of Care for children, youth and families such as moving from Early Care and Learning to school-based services and youth transitioning to the adult system of care. This work is underway and will continue over the next year, facilitated by the Director of Interagency Coordination that works with DMH, DCF and DAIL.
	Summary of Actions Needed: None.
SMI/SED.Topic_5. Financing Plan	
State Medicaid programs should detail plans to support improved availability of non-hospital, non-residential mental health services including crisis	

Prompts	Summary
stabilization and on-going community-based care. The financing plan should describe state efforts to increase access to community-based mental health providers for Medicaid beneficiaries throughout the state, including through changes to reimbursement and financing policies that address gaps in access to community-based providers identified in the state's assessment of current availability of mental health services included in the state's application.	
5.a Increase availability of non-hospital, non-residential crisis stabilization services, including services made available through crisis call centers, mobile crisis units, observation/assessment centers, with a coordinated community crisis response that involves collaboration with trained law enforcement and other first responders.	**Current Status:** In CY19, Vermont Medicaid implemented payment reform for community mental health services. Mental Health Payment Reform represents a large operational and cultural shift towards focusing on how well Vermont is doing rather than simply how much it is doing. The shift gives communities more flexibility with funding to meet the needs of the children, youth, adults, and families they serve. By simplifying the baseline payment structures and adding Value-Based payments that reward outcomes and incentivize best practice, the state aims to make it easier for Medicaid providers to meet the goal of providing efficient and effective care for Vermonters with mental health needs. DMH and the Department of Public Safety continue to support Team Two Training around the state that brings together mental health providers, law enforcement and emergency responders in a learning collaborative to produce more effective mental health response tools to community crises. DMH funding and local community funding has provided for the expansion of mobile outreach in its most urban area that now encompasses six communities. Some Designated Agencies have also dedicated funding to support local police and mental health services coordination initiatives to deter escalation of incidents that can be addressed through treatment response rather than law enforcement intervention. In addition to the above, • Vermont already has one peer run crisis stabilization facility and a peer run intensive residential program; Vermont is looking to expand peer run crisis and stabilization units to help further prevent unnecessary ED visits; • Vermont is evaluating the possibility of adding more resources for Mobile Response and Stabilization Services (MRSS), which is a face-to-face response provided to a family-defined crisis to provide support and intervention for a child/youth and their family before emotional and behavioral difficulties escalate; and • Vermont is stablishing state policy to maintain and enhance current efforts around housing coordination and services that ensure alignment across participating IMD facilities.
	Future Status: Payment reform efforts aim to streamline payment structures and break down silos that can sometimes be barriers to individuals and families receiving services. The first phase of payment reform, which started in CY19, combined many different funding streams into a single funding stream in order to meet this aim. However, additional siloed funding streams continue to exist that were not included in this first phase (Alcohol and Drug Abuse Programs, Elder care, etc). Future efforts will examine the potential for incorporating more programs and services into the case rate bundle, and aligning quality and outcome goals. Process steps include:

Prompts	Summary
	• CY19 (first year of implementation): A workgroup was created to explore the potential addition of two funding streams through DCF; • CY20: AHS is required to submit a plan for the potential inclusion of behavioral health services into the financial target services of the All-Payer Model Agreement by the end of CY20. This opportunity will help to solidify the existing alignment between the State's payment reform models and will build off of that alignment for future possible enhancements through the ACO-based payment reform model. • CY19-CY23: The state has a multi-year phase-in plan for measures and targets for the newly implemented mental health alternative payment model for community-based mental health services that were carved out of the All-Payer Model Agreement. By CY23, the state expects to have fully implemented all value-based payment measures and will be able to more fully evaluate progress on the state's primary goal of improving access to care in the community.
	Summary of Actions Needed: Continue to implement required elements of current payment reform models as documented for and approved by CMS.
6.b Increase availability of on-going community-based services, e.g., outpatient, community mental health centers, partial hospitalization/day treatment, assertive community treatment, and services in integrated care settings such as the Certified Community Behavioral Health Clinic model.	**Current Status:** Mental Health Payment Reform represents a large operational and cultural shift towards focusing on quality over quantity. The shift gives communities more flexibility with funding to meet the needs of the children, youth, adults, and families they serve. By simplifying the baseline payment structures and adding value-based payments that reward outcomes and incentivize best practice, Medicaid aims to make it easier for providers to meet the goal of efficient and effective care for Vermonter with mental health needs.
	Future Status: Payment reform efforts aim to streamline payment structures and break down silos that can sometimes be barriers to individuals and families receiving services. The first phase of payment reform combined many different funding streams into a single funding stream in order to meet this aim. However, additional siloed funding streams continue to exist that were not included in this first phase (Alcohol and Drug Abuse Programs, Elder care, etc). Future efforts will examine the potential for incorporating more programs and services into the case rate bundle, and aligning quality and outcome goals. Process steps include: • CY19 (first year of implementation): A workgroup was created to explore the potential addition of two funding streams through DCF. • CY20: AHS is required to submit a plan for the potential inclusion of behavioral health services into the financial target services of the All-Payer Model Agreement by the end of CY20. This opportunity will help to solidify the existing alignment between the state's payment reform models and will build off of that alignment for future possible enhancements through the ACO-based payment reform model.

Prompts	Summary
	• CY19-CY23: The state has a multi-year phase-in plan for measures and targets of the newly implemented mental health alternative payment model for community-based mental health services that were carved out of the All-Payer Model Agreement. By CY23, the state expects to have fully implemented all value-based payment measures and will be able to more fully evaluate progress on the state's primary goal of improving access to care in the community.
	Summary of Actions Needed: Continue to implement required elements of current payment reform models as documented for and approved by CMS.
SMI/SED. Topic_6. Health IT Plan	
As outlined in State Medicaid Director Letter (SMDL) #18-011, "[s]tates seeking approval of an SMI/SED demonstration … will be expected to submit a Health IT Plan ("HIT Plan") that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals."[1] The HIT Plan should also describe, among other items, the: • *Role of providers in cultivating referral networks and engaging with patients, families and caregivers as early as possible in treatment; and* • *Coordination of services among treatment team members, clinical supervision, medication and medication management, psychotherapy, case management, coordination with primary care, family/caregiver support and education, and supported employment and supported education.* *Please complete* all *Statements of Assurance below—and the sections of the Health IT Planning Template that are relevant to your state's demonstration proposal.*	
Statements of Assurance	
Statement 1: Please provide an assurance that the state has a sufficient health IT infrastructure/ecosystem at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration. If this is not	The State of Vermont has an established health IT infrastructure that supports the provision of care and measurement of the health care system and reform initiatives. The state's health-IT infrastructure includes, but is not limited to, a PDMP, public health registries (immunization, births/deaths, and cancer), a state-wide health information exchange with supporting data extraction capabilities, behavioral health registry, and an All-Payer Claims Database. A care coordination platform supports providers participating in Vermont's All-Payer Model and all of Vermont's hospitals and a considerable number of eligible providers have taken advantage of the Meaningful Use program to adopt electronic health record systems. Additionally, the state legislature has decided to support the purchase and roll-out of integrated Electronic Health Record systems for the state's Designated Agencies and Specialized Service Agencies which is a move to further electronically integrate otherwise outlying sectors of the health care system.

[1] See SMDL #18-011, "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.

Prompts	Summary
yet the case, please describe how this will be achieved and over what time period	
Statement 2: Please confirm that your state's SUD Health IT Plan is aligned with the state's broader State Medicaid Health IT Plan and, if applicable, the state's Behavioral Health IT Plan. If this is not yet the case, please describe how this will be achieved and over what time period.	Vermont's SUD Health IT efforts are aligned with the state's broader Health IT Plan. In 2017, DVHA convened the Health Information Exchange Steering Committee, which is now statutorily obligated to support DVHA in the annual development of a statewide health-IT/exchange strategic plan. This plan is referred to as the HIE Plan. The purpose of the plan is to provide a strategy for the implementation of an integrated electronic health information infrastructure for the sharing of electronic health information among health care facilities, health care professionals, public and private payers, and patients. Per state statute, the plan must be approved by the Green Mountain Care Board annually. The latest HIE Plan is available here: https://healthdata.vermont.gov/sites/healthdata/files/HIE%20Strategic%20Plan.pdf. Full membership details and meeting information is available here: https://healthdata.vermont.gov/HIESteeringCommittee. The 2019 Health Information Exchange Steering Committee is heavily focused on the development of a 3-5 year health-IT/exchange investment strategy. An essential component of this strategy is bolstering public health and general data infrastructure to enable clinical decision support across the continuum, including treatment of SUD. The investment strategy will envelope work currently being done (CMS-funded via HITECH) to develop an informatics strategy at VDH. Additionally, the Vermont General Assembly appropriated $1.5M to the State's Designated Agency network to offset the cost of purchasing electronic medical records for the behavioral health system. As part of this appropriation, the Vermont Care Partners, the contracted not-for-profit agency that connects the Designated and Specialized Service Agencies that function on behalf of AHS, was asked to demonstrate how the implementation of these new systems would work to further the HIT goals set forth in the state-wide strategic plan and how they are to advance the state's "Connectivity Criteria" (specific standards to guarantee quality data transmissions across the network) with a targeted look at the exchange of SUD and mental health data. The state's recently approved HIT Implementation Advanced Planning Document (IAPD) includes funding to assess and plan the integration of the Prescription Drug Monitoring Program (PDMP) into the HIE (See a more detailed description in statement 3 below). The State Medicaid HIT Plan (SMHP) is currently being updated and the state is ensuring that there is alignment among the HIE Plan, the SMHP, and this waiver application. The State Medicaid Health IT Plan was submitted 12/18/2019.

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Statement 3: Please confirm that the state intends to assess the applicability of standards referenced in the Interoperability Standards Advisory (ISA)[2] and 45 CFR 170 Subpart B and, based on that assessment, intends to include them as appropriate in subsequent iterations of the state's Medicaid Managed Care contracts. The ISA outlines relevant standards including but not limited to the following areas: referrals, care plans, consent, privacy and security, data transport and encryption, notification, analytics and identity management.	All of Vermont's interoperability efforts adhere to and/or are in direct alignment with federal guidance. As illustrated in the state-wide strategic HIE Plan, Vermont continues to demonstrate success in implementing the federal Promoting Interoperability Program and has based all strategic planning on architecture and standards set forth by CMS and the Office of the National Coordinator. Vermont has received approved HITECH funds to support an assessment to determine the best, most cost-effective strategy to integrate the PDMP and Health Information Exchange data. It is anticipated that a vendor would help the state to understand steps required to develop Vermont's PDMP into a "qualified PDMP"[3]; assess how best to connect the HIE and the PDMP; determine the best strategy to facilitate integration through a PDMP hub; identify use cases and roles-based access requirements as it relates to PDMP data access; develop an auditing process that meets the needs of the PMDP manager (VDH), state law, federal law, and aligns with processes at the HIE; and support implementation of strategic design to achieve PDMP integration and interoperability. The HIE Plan, currently being updated, sustains a commitment to standards and tracks current activity at the federal level including recent advancement of the Trusted Exchange Framework and Common Agreement (TEFCA) and the ongoing advancement of the Fast Healthcare Interoperability Resource (FHIR) standard.
To assist states in their health IT efforts, CMS released SMDL #16-003 which outlines enhanced federal funding opportunities available to states "for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers." For more on the availability of this "HITECH funding," please contact your CMS Regional Operations Group	

[2] Available at https://www.healthit.gov/isa/.

[3] Under section 1944 of the Social Security Act, beginning October 1, 2021, states must have a qualified PDMP and must require that certain Medicaid providers check information about certain Medicaid beneficiaries' prescription drug history in the qualified PDMP before prescribing controlled substances to the beneficiary.

Prompts	Summary
contact. [4] *Enhanced administrative match may also be available under MITA 3.0 to help states establish crisis call centers to connect beneficiaries with mental health treatment and to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions. States may also coordinate access to outreach, referral, and assessment services—for behavioral health care--through an established "No Wrong Door System."*[5]	
Closed Loop Referrals and e-Referrals (Section 1)	
1.1 Closed loop referrals and e-referrals from physician/mental health provider to physician/mental health provider	**Current State:** Closed loop referrals are not currently supported. However, there are current initiatives underway which relate to closed loop referrals and which will support such referrals when additional work (see "Summary of Actions Needed" below) is completed, including: • Implementation of a care navigation tool to support care coordination for patients in the OneCare Vermont ACO (see discussion in 2.1 below). All entities involved in a patient's care will have access to this tool which will serve as the mechanism for documenting referrals and the subsequent encounters from those referrals. In addition, near term tactics identified in a draft HIE Strategic Plan update include determining care coordination requirements, assessing current tools, and expanding adoption of the care coordination platform. Near term is considered to be the next 12-18 months; • Vermont has a new opt-out consent policy for the sharing of electronic health information in the Vermont HIE (VHIE). Implementation planning for that policy is underway and the policy will become effective on March 1, 2020. Vermont anticipates that the percentage of people with records in the VHIE whose information can be shared with their providers will increase to approximately 95% once the consent policy is in place. Although e-referrals are not currently supported in the VHIE (see next bullet), having the data in the VHIE for most Vermonters will improve the effectiveness of e-referral functionality when it becomes available. Vermont Care Partners is a statewide network of 16 State-designated, community-based agencies providing a comprehensive array of services and supports to people living with mental health conditions, substance use disorders,

[4] See SMDL #16-003, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers." Available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd16003.pdf.

[5] Guidance for Administrative Claiming through the "No Wrong Door System" is available at https://www.medicaid.gov/medicaid/finance/admin-claiming/no-wrong-door/index.html.

Prompts	Summary
	and intellectual and developmental disabilities. The network has approximately 32,000 clients and serves nearly 50,000 Vermonters. Nine agencies are in the process of undergoing a very robust process to implement electronic medical record (EMR)/care coordination platforms that will enable data driven practices and empower full participation in an integrated health care delivery system.
	Future State: Expand existing Vermont HIT road map to include closed loop referrals and e-referral functionality.
	Summary of Actions Needed: An update to the Vermont HIE Strategic Plan includes a technology roadmap. The roadmap identifies care coordination and support for e-referrals as a near term tactic. Near term is considered the next 12-18 months. Closed loop referrals are components that will eventually be covered as part of the Collaborative Services project which encompasses Master Patient Index, Terminology Services, and a data integration engine designed to support sensitive data management to further establish the functionality of closed loop referrals. The work of collaborative services is represented in the technology roadmap for completion in the 3-5 year timeframe, though some components will be available in January 2021. Additional information: The HIT Roadmap (section 3.2.1.6, Care Coordination Tools) recommends tactical plan steps for the near term (12 -18 months). The State's HIE Steering Committee will utilize a sub-committee or task force to assess, and potentially execute the following: • Define care coordination tool requirements, • Assess current tools in use against the requirements, and • Expand the adoption of care coordination tools.
1.2 Closed loop referrals and e-referrals from institution/hospital/clinic to physician/mental health provider	**Current State:** Vermont does not currently have closed loop referrals or e-referrals occurring between hospitals/clinics/intuitions and physician and mental health providers.
	Future State: Expand existing Vermont HIT roadmap to include closed loop referrals and e-referral functionality.
	Summary of Actions Needed: See responses to 1.1 above. Within the OneCare Vermont ACO, providers and hospitals have access to the CareNavigator tool (see discussion in 2.1 below). The adoption of new EHR technology by Designated Agencies (as

Prompts	Summary
	described above) will facilitate their participation in the Care Coordination platform. Completion dates for new EHR systems in the Designated Agencies are tentatively scheduled for August 2020. The foundational elements necessary for closed loop referrals are part of the State's Collaborative Services project which includes the deployment of a centralized Master Patient Index, Terminology Services, and a data integration engine, designed to support sensitive data management. These elements coupled with the Designated Agency EMR project will further establish the technical functionalities necessary for closed loop referrals. The work of collaborative services is represented in the technical roadmap for 3-5 year investment. See the Summary of Actions needed in section 1.1 above for a description of the tactical plan steps that will be undertaken by the HIE Steering Committee in the near term (12-18 month) period.
1.3 Closed loop referrals and e-referrals from physician/mental health provider to community based supports	**Current State:** Vermont does not currently have closed loop referrals or e-referrals occurring between and physician and mental health providers to community-based supports.
	Future State: Expand existing Vermont HIT road map to include closed loop referrals and e-referral functionality.
	Summary of Actions Needed: See responses to 1.1 and 1.2 above. In addition, the HIE Technology Roadmap portion of the HIE Strategic Plan update identifies the importance of social determinants of health (SDOH), which are typically in the domain of community-based supports. A key objective in the roadmap is to develop tools and methods to collect, aggregate, and share SDOH data. Workflows associated with such tools and methods would involve community-based organizations and achieving this key objective would be the basis for supporting closed loop referrals to community-based supports. The Roadmap identifies SDOH-related tactics to be pursued in the near term, with a time frame of 12-18 months.
Electronic Care Plans and Medical Records (Section 2)	
2.1 The state and its providers can create and use an electronic care plan	**Current State:** To achieve the vision of a Complex Care Coordination model, in 2017-2018, OneCare Vermont deployed Care Navigator as a tool for organizations implementing community-based care coordination. The tool acts as a collaboration, communication, and engagement solution designed to deliver scalable care coordination recognizing ACO attribution, geography, and accessibility. A major component of Care Navigator is an electronic shared care plan which is used to facilitate communication among cross-organizational multi-disciplinary care teams for high and very high risk individuals.

Prompts	Summary
	In addition, Care Navigator and WorkBench One work in concert to support clinical care and enable patient engagement and care coordination. For example, care coordination data, such as goals and barriers to care, are fed from OneCare's Care Navigator software tool into WorkBenchOne where the data are combined with utilization, cost, and quality data to create a comprehensive view of the impact of the complex care coordination program across care-settings. These outputs are then used to identify care gaps, drive clinical insights, and identify variations in engagement and care across organizations and communities. The advanced analytics tools can be accessed by care team members, providers, and clinical governance committees to drive reform efforts, including refinements to advance the ACO's clinical model, quality foci, and payment models designed to drive clinical improvements (e.g. complex care coordination payment model). Under HITECH IAPD version 3.3, approved February 21, 2019, funding was distributed to OneCare Vermont to support the development and use of the care coordination tool for Medicaid providers participating in Vermont's All-Payer Model. As originally planned, the development and implementation of these tools continued in CY19.
	Future State: In the current annual IAPD update submitted to CMS, DVHA is seeking continued and expanded HITECH funding to support Vermont Medicaid Next Generation ACO-participating providers in exchanging health information, coordinating care, and utilizing trusted data sources to support clinical decision making related to priority health areas. The developments of OneCare's systems are also aimed at engaging patients in their care
	Summary of Actions Needed: Work to expand support to Vermont Medicaid Next Generation ACO -participating providers in exchanging health information, coordinating care, and utilizing trusted data sources to support clinical decision making related to priority health areas. The state's contracts with the ACO run on a calendar year and there is an anticipated funding need for HIT activities in CY20 and CY21. Additional information: In the HIT Roadmap, leveraging SDOH Data is a key objective with the intent to develop tools and methods to collect, aggregate, and share SDOH data. To accomplish this, the exchange service of data extraction and aggregation must be further developed. Eight planning tactical steps, responsible entities and timelines have been identified: • Review state data on SDOH: Review state data repositories (from AHS, AOE, others) to determine potential reuse as SDOH data. o HIE Steering Committee o Agency of Digital Services

Prompts	Summary
	○ Agency of Human Services ○ Near term (12-18 months) • Review VHIE SDOH data: Review and identify where SDOH information is captured in the VHIE today. ○ HIE Steering Committee ○ VITL(Vermont Information Technology Leaders) ○ Near term (12-18 months) • Align VHIE SDOH with national standards: Assess the alignment of VHIE SDOH information with emerging standards including an HL7 FHIR SDOH implementation guide and the ICD-10 Z-codes. ○ HIE Steering Committee ○ VITL ○ Near term (12-18 months) • Map and align state agency data to data standards: Explore mapping state agency data to healthcare standards and promoting alignment where mapping is problematic. ○ HIE Steering Committee ○ Agency of Digital Services ○ Agency of Human Services ○ Mid-term (18-36 months) • Monitor standards for capture of SDOH at point of care: Stay current with studies/pilots on capture of SDOH at point of care. ○ VITL ○ Near term (12-18 months) • Pilot integration of AHS data into VHIE and Care Management Tools: Design pilot to study the impact of integration of state repository data into ACO Care Management Tools. ○ VITL ○ VHIE Participants ○ Agency of Digital Services ○ Agency of Human Services ○ Mid-term (18-36 months) • Explore document management services: Explore options and value propositions for increasing access to provider-generated notes, including existing capabilities to share, store and reference documents. ○ HIE Steering Committee ○ VITL ○ VHIE Stakeholders

Prompts	Summary
	○ Near term (12-18 months) • Develop RFP for statewide clinical repository: Work with engaged repository stakeholders to develop an RFP targeting statewide repository solutions. ○ HIE Steering Committee ○ Department of Vermont Health Access ○ Agency of Digital Services ○ VITL ○ Near term (12-18 months)
2.2 E-plans of care are interoperable and accessible by all relevant members of the care team, including mental health providers	**Current State***:* Participating IMD facility treatment plans are interoperable and accessible by all relevant members of the care team because they are accessed and contributed to by multiple clinical staff members while in draft form in the shared drive. Plans are then refined, printed, signed and scanned into the patient's electronic medical record. Hard copies remain on the units. Care plans in the patient's electronic medical record can be shared with other providers outside the IMD via fax or Direct Secure Messaging.
	Future State: See responses to item 1 topics above for additional background. The HIT Roadmap provides an analysis of current functionality and future needs across multiple provider types, including mental health providers. Multiple tactics for achieving interoperability and the sharing of health information, including care plans, are identified across Vermont's three-tier architecture of foundational services, exchange services, and end-user services. Sharing care plans is considered an end-user service supported by foundational services such as identity management and provider directory and exchange services such as interoperability. The HIT Roadmap includes a commitment to standards that support interoperability and alignment with federal initiatives such as TEFCA and the expansion of the FHIR data exchange standard. Enabling this architecture through standards supporting interoperability will ultimately expand the capacity to share care plans across disparate systems. Additionally, the new opt-out consent policy (see response to section 1.1 above) will support the sharing of care plan information in the VHIE. Vermont anticipates that once the opt-out policy is implemented in March of 2020 that 95% of Vermonters' health information will be available for treating providers to access via Vermont's HIE.
	Summary of Actions Needed: • Implement the new opt-out consent policy March 1, 2020 (Owner: HIE Steering Committee and Consent Implementation Team) • Continue consent planning for sensitive information and information related to 42CFR Part 2 providers – near term 12-18 months (Owner: HIE Steering Committee and Consent Implementation Team)

Prompts	Summary
2.3 Medical records transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	**Current State:** Vermont does not currently meet this HIT milestone.
	Future State: Expand existing Vermont HIT Roadmap to include functionality that provides for medical records to transition from youth-oriented systems of care to the adult behavioral health system through electronic communications.
	Summary of Actions Needed: Medical records transition from one setting to another can be accommodated through the VHIE if the two settings have such a connection. Alternatively, Direct Secure Messaging can be employed, but Direct Secure Messaging may not satisfy a need to transition structured data into the target medical record system. It is important to note that Vermont's HIE strategies are focused on connecting the entire system of care and ensuring that appropriate, treating providers have access to a patient's health data to support the provision of high-quality care. While the state is dedicated to addressing specific data exchange issues, such as sharing of SUD and mental health data, it also understands that sharing across the health care system is essential as patients are people with changing lives and needs, who are not necessarily defined by the type of care or the institution that serves them at one point in time. Additional information: Several elements of the HIT Roadmap address different aspects of the solution called for in 2.3, including notification services, EHR integration, care coordination tools (see discussion in 1.1 above), data extraction and aggregation, interoperability, identity management, and consent management. The HIE Steering Committee has overall responsibility for the planning work associated with each of these topics, with other entities sharing responsibility in different combinations depending on the topic. In all instances the planning work is near term (12-18 months).
2.4 Electronic care plans transition from youth-oriented systems of care to the adult behavioral health system through electronic communications	**Current State:** Vermont does not currently meet this HIT milestone.
	Future State: Expand existing Vermont HIT Roadmap to include functionality that provides for the transitioning of electronic care plans from youth-oriented systems of care to the adult behavioral health system through electronic communications.
	Summary of Actions Needed: See summary of action needed in item 2.5 below. These comments also apply to planning for the transitioning of electronic care plans from youth-oriented systems of care to the adult behavioral health system through electronic communication.

Prompts	Summary
2.5 Transitions of care and other community supports are accessed and supported through electronic communications	**Current State:** For electronic communications for transitions of care to community providers, Medical records departments scan and fax clinical information to community providers. Direct access to the electronic medical record is restricted almost exclusively to internal employees at each facilities. Prescribers have the ability to prescribe electronically to remote pharmacies during the patient discharge process.
	Future State: Expand HIT Roadmap to ensure alignment across facilities. The HIE Technical Roadmap supports further development of notifications, and the utilization of notification services throughout the HIE network in Vermont. The HIE received IAPD funds to support this work through 2021.
	Summary of Actions Needed: The HIE Technical Roadmap includes planning for improvements in notification services. In particular, transitions of care can be supported by ADT (Admit, Discharge, Transfer) notifications and care summaries and medication lists can be made available in the VITL Access portal. There are financial barriers to accessing the provider portal and this may be a burden to community support organizations. Vermont's HIE has traditionally offered services through Patient Ping, an event notification system. Planning to expand technical solutions for notifications is a near term (12-18 month) activity in the roadmap. Additional information: See the additional comments in the Summary of Actions Needed in item 2.3 above, including comments on responsibility and time frames. Those comments apply to item 2.5 as well.
Consent - E-Consent (42 CFR Part 2/HIPAA) (Section 3)	
3.1 Individual consent is electronically captured and accessible to patients and all members of the care team, as applicable, to ensure seamless sharing of sensitive health care information to all relevant parties consistent with applicable law and regulations (e.g., HIPAA, 42 CFR part 2 and state laws)	**Current State:** The VHIE currently captures health information regulated under HIPAA. Several existing workflows provided by VITL for HIPAA covered health care data are: • NVRH HL7 Consent Process, • UVMMC HL7 Consent Process, • All HL7 General Consent Setting Process, • All VHIE for patient search, including "breaking the glass", • Meditech Expanse – External Application, • VCCI Query Process, • Setting VITLAccess Consent Process, and • Changing Existing VITLAccess Consent Process.

Prompts	Summary
	VITL currently cannot segregate 42 CFR Part 2 data and thus restricts data flow so that it does not include 42 CFR Part 2 provider data into the VHIE. VITL does not currently receive information or collect consent from designated 42 CFR Part 2 programs. Note: the Collaborative Services Project is on track to put in place the foundational tools necessary to segregate SUD data from the broader health care data set in 2020. Further, the current consent policy in Vermont is opt-in, but will change on March 1, 2020 to opt-out. The understanding is that 42 CFR Part 2 consent will remain opt-in and granular consent will be necessary. In CY20, VITL will develop procedures, use cases and workflows to protect and allow access to this sensitive data. See additional comments in the "Summary of Actions Needed" section below. Pilot projects conducted under the ONC's Data Segmentation for Privacy Initiative (DS4P) have illustrated ways that the 42 CFR Part 2 prohibition on re-disclosure notice can be transmitted, along with health information, when a patient has consented to its disclosure. For an example, an individual may view a 5-minute video Web Site Disclaimers or 14-minute video Web Site Disclaimers of the U.S. Department of Veterans Affairs (VA)/Substance Abuse and Mental Health Services Administration (SAMHSA) demonstration project.
	Future State: Utilize above workflows to inform the future state process. Additional activities include: • Aggregating steps in HL7 ALL and facility specific HL7 diagrams, • Utilizing and restructuring the VHIE internal process after policy options are made; and • Utilizing Vermont Chronic Care Initiative (VCCI)[6] diagrams to create a template that will inform other parties of a patient's consent choice.
	Summary of Actions Needed: Begin to build future state use case/workflow diagrams based on process options. Also consider developing and providing guidance materials to providers/health care facilities on best practice workflows. Additional activities include: • A new opt-out consent policy goes into effect in March 2020 and there will be mechanisms established in the VHIE to ensure that a patient's consent to share information in the VHIE is known and maintained. When a query is made

[6] VCCI is an integrated model of case management supports and services provided by a staff of nurses, licensed and unlicensed social workers and substance abuse professionals with clinical, mental health, and substance abuse experience and education. A major objective of the case managers is to help a member stabilize.

Prompts	Summary
	for sensitive data, and the provider has a treating relationship with the patient, consent will still be verified before any information is shared. • The opt-out consent policy will initially be implemented as an all-in or all-out choice. The HIE Technology Roadmap identifies an activity to determine how to manage sensitive information, including information associated with 42 CFR Part 2 providers, so that selective consent choices can be made for sensitive information. This is a near term planning activity with a 12-18 month timeline. • The HIE Steering Committee and the Consent Implementation Team are responsible for planning and implementing the consent policy in the time frames identified here.
Interoperability in Assessment Data (Section 4)	
4.1 Intake, assessment and screening tools are part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem	**Current State:** Intake: The Electronic Health Record (EHR) software application "Evident" or "Thrive" by CPSI includes a registration module where patient intake information is input by admissions staff. Any information known about the patient, such as name, personal information, address, condition, family, and insurance is entered into the system. Intake/assessment: The admitting doctor fills out an admissions template in the physicians' side of the EHR software ("Thrive UX"). The medical director requests changes to the admissions template as needed, such as compliance with Joint Commission requirements. Point of care (POC, nursing) also has their own documentation for an initial assessment via a flowsheet. All clinical staff have ways to continue documenting their patient assessments in the EHR during the patients' stays and upon discharge. Doctors and social workers have a selection of templates to guide their input into patient care issues in the Thrive UX application. This can include progress notes, medical consults, certificates of need for involuntary procedures, discharge, etc. Nursing staff, dietary staff, and recovery staff may document in the Thrive POC application via flowsheets (nursing) and e-forms (nursing, dietary, recovery). However, while doctors/social workers in Thrive UX may view Thrive POC documentation and nursing/dietary/recovery staff in Thrive POC may view the Thrive UX documentation, there is no cross-platform interactivity.
	Future State: Integrate tools into part of a structured data capture process so that this information is interoperable with the rest of the HIT ecosystem.
	Summary of Actions Needed: This is currently under assessment. Implementation would follow based on the assessment study and analysis.

Prompts	Summary
Electronic Office Visits – Telehealth (Section 5)	
5.1 Telehealth technologies support collaborative care by facilitating broader availability of integrated mental health care and primary care	**Current State:** The mental health care system in Vermont is a public-private collaboration between DMH and regional Designated Agencies. A unified electronic health record or case/care management system between state and private partners has not been established. Each entity of the system of care uses proprietary applications to coordinate and manage a client/patient's care. The EHR for DMH has telehealth capability. Therapeutic and counselling services for individuals in the custody of DMH are provided on-site. Psychiatric specialists (DMH and Designated Agencies) also interview and assess their patients on-site. If a patient is to be discharged and referred to a Designated Agency, coordination and transition is done by telephone. Telehealth services are used through an independent application to consult non-psychiatric specialists (internal medicine, neurology, endocrinology, podiatry, etc.) and interact with the legal/justice system.
	Future State: Broader use of telehealth technologies leading to improved statewide mental health and primary care access.
	Summary of Actions Needed: VITL provides HIE services to the State. Those services include data extraction and access to/from providers for continuity of care, and data aggregation for population health and analytics. Currently, no sensitive data (including mental health data) is part of VITL's scope of work due to technical limitations. However, the state & VITL are currently planning to expand VT HIE services to include 42 CFR part 2 data that will cover mental health data exchange and aggregation allowing care coordination and collaboration. Planning and policy creation for this effort will start in 2020. A new identity management solution currently in development will ensure the correct association of sensitive data to a patient, and will help to ensure the proper patient match when a patient's provider seeks to access the information – part of services being implemented in January 2021. A new opt-out consent policy goes into effect in March 2020 and there will be mechanisms established in the VHIE to ensure that a patient's consent to share information in the VHIE is known and maintained. When a query is made for sensitive data, and the provider has a treating relationship with the patient, consent will still be verified before any information is shared. The opt-out consent policy will initially be implemented as an all-in or all-out choice. The HIE Technology Roadmap identifies an activity to determine how to manage sensitive information, including information associated with 42 CFR Part 2 providers, so that selective consent choices can be made for sensitive information.

Prompts	Summary
	The consent policy implementation is the responsibility of the HIE Steering Committee and the consent policy implementation team. The identity management solution is being implemented by VITL.
Alerting/Analytics (Section 6)	
6.1 The state can identify patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes (Note: research shows that 50% of patients stop engaging after 6 months of treatment[7])	**Current State:** Vermont does not currently meet this HIT milestone.
	Future State: Expand existing Vermont HIT Roadmap to include functionality that identifies patients that are at risk for discontinuing engagement in their treatment, or have stopped engagement in their treatment, and can notify their care teams in order to ensure treatment continues or resumes. OneCare Vermont is working with AHS to obtain SDOH data to inform risk stratification for patients identified as potentially at-risk. SDOH data will inform care teams of related risk factors..
	Summary of Actions Needed: A key objective in the HIT Roadmap is to share appropriate information with a patient's care team to support care management and care coordination. Related to this objective is a near term activity of identifying and evaluating care coordination tools. Functionality described here in section 6.1 requires analysis of data in care coordination tools to determine when to generate a notification of a patient at risk, based on rules that may have to be added to the tools. For Designated Agencies who may be acquiring new EHRs or adding functions to existing EHRs there may be an opportunity to include a notification solution as indicated here in section 6.1. VCCI, a component of Vermont Medicaid, has recently launched a new initiative whereby staff reach out to new Medicaid beneficiaries to ensure they understand their benefits and link them with a primary care home. In summary, the possible steps described here are planning considerations to be determined in the near-term timeframe of 12-18 months. The HIE Steering Committee is responsible for ensuring near term planning activities.
6.2 Health IT is being used to advance the care coordination workflow for patients	**Current State:** Vermont does not currently meet this HIT milestone.
	Future State:

[7] Interdepartmental Serious Mental Illness Coordinating Committee. (2017). *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/ismicc_2017_report_to_congress.pdf

Prompts	Summary
experiencing their first episode of psychosis	Expand existing Vermont HIT Roadmap to ensure that Health IT is being used to advance the care coordination workflow for patients experiencing their first episode of psychosis. The primary barrier to be addressed is access to necessary health information to ensure timely and appropriate care coordination actions. Access to the information requires a technical solution to query and view the necessary information and obtaining consent to view the information across all providers involved in the patient's care.
	Summary of Actions Needed: See response to item 6.1 above. The same planning activities that will consider care coordination in the context of notifications can include planning for advancing care coordination workflow for patients experiencing their first episode of psychosis. This is an identified near term, 12-18-month, activity.
Identity Management (Section 7)	
7.1 As appropriate and needed, the care team has the ability to tag or link a child's electronic medical records with their respective parent/caretaker medical records	**Current State:** Vermont does not currently meet this HIT milestone.
	Future State: Expand existing Vermont HIT Roadmap to include functionality for the care team to tag or link a child's electronic medical records with their respective parent/caretaker medical records.
	Summary of Actions Needed: The VHIE has an active project to implement a new identity management system which will establish a universal identity key for each person with records in the VHIE. That functionality will be active in January 2021. However, relating one individual's universal identity key with another's introduces another level of complexity, which is not currently anticipated. Records can be tagged by adding parental or caretaker relationship information as demographic data in the health record, which can then be queried by field name. In addition to implementing new identity management tools, the state will determine the feasibility of using existing fields in EHR records to tag relationships. This can be incorporated into current planning activities for identity management (including a patient relationship directory) in the roadmap's tactical plan, as a near term action (12-18 months).
7.2 Electronic medical records capture all episodes of care, and are linked to the correct patient	**Current State:** All participating SMI IMD facilities maintain electronic records that capture all episodes of care at their facilities and are linked to the correct patient. Other providers who have seen or will see the patient capture episodes of care in their own systems. EHR systems have functionality to identify the patients with records in individual EHR systems.
	Future State:

Prompts	Summary
	Maintain current EMR functionality as described in the current state. As new identity management tools become available through the VHIE, match patients to ensure that patient records in different EHR systems are correctly associated with the same individual. Until such time as sensitive data is captured in a repository and consent to share sensitive information is resolved by both policy and technology, the sharing of information will occur through requests from facility to facility. Information requests can be satisfied through fax or attachments to Direct Secure Messages.
	Summary of Actions Needed: Participate in requirements and planning for the new identity management solution. Begin utilizing the new identity management functionality to match patients when the tools are available in January 2021.

Section 3: Relevant documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan. This information is not meant as a substitute for the information provided in response to the prompts outlined in Section 2. Instead, material submitted as attachments should support those responses.

Medicaid Section 1115 Substance Use Disorder Demonstrations
Monitoring Protocol Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's substance use disorder (SUD) demonstration or the SUD component of the broader demonstration

The state should complete this title page as part of its SUD monitoring protocol. Definitions for certain rows are provided below the table. The Performance Metrics Database and Analytics (PMDA) system will populate some rows of the table. The state should complete the rest of the table. The state can revise the demonstration goals and objectives if needed. PMDA will use this information to populate part of the title page of the state's monitoring reports.

State	Vermont
Demonstration name	Global Commitment to Health
Approval period for section 1115 demonstration	*Enter the current approval period for the section 1115 demonstration as listed in the current special terms and conditions (STC), including the start date and end date (MM/DD/YYYY – MM/DD/YYYY).* *Start Date:* 07/01/2022 *End Date:* 12/31/2027
SUD demonstration start date[a]	*Enter the start date for the section 1115 SUD demonstration or SUD component if part of a broader demonstration (MM/DD/YYYY).* 07/01/2022
Implementation date of SUD demonstration, if different from SUD demonstration start date[b]	*Enter SUD demonstration implementation date (MM/DD/YYYY).* 07/01/2018
SUD (or if broader demonstration, then SUD-related) demonstration goals and objectives	*Enter summary of the SUD (or if broader demonstration, then SUD-related) demonstration goals and objectives.* Over the demonstration period, Vermont, in addition to the overall demonstration goals, includes the following six new goals to support the substance use disorder (SUD) program. 1. Increased rates of identification initiation, and engagement in treatment; 2. Increase adherence to and retention in treatment; 3. Reductions in overdose deaths, particularly those due to opioids; 4. 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; 5. Fewer readmissions to the same or higher level of care where the readmission is

[a] **SUD demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SUD demonstration approval. For example, if the state's STCs at the time of SUD demonstration approval note that the SUD demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SUD demonstration. Note that the effective date is considered to be the first day the state may begin its SUD demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on December 15, 2020, with an effective date of January 1, 2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SUD demonstration:** The date the state began claiming or will begin claiming federal financial participation for services provided to individuals in institutions for mental disease.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in the Monitoring Report Template provided by CMS and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested narrative information (with no modifications).

3. Acknowledgement of budget neutrality reporting requirements

☒ The state has reviewed the Budget Neutrality Workbook (which can be accessed via PMDA – see Monitoring Protocol Instructions for more details) and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (with no modifications).

4. Retrospective reporting

The state is not expected to submit metrics data until after monitoring protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to monitoring protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

For a state that has monitoring protocols approved after one or more initial quarterly monitoring report submissions, it should report metrics data to CMS retrospectively for any prior quarters (Qs) of the section 1115 SUD demonstration that precede the monitoring protocol approval date. A state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data— in its second monitoring report submission that contains metrics. The retrospective monitoring report for a state with a first SUD demonstration year (DY) of less than 12 months, should include data for any baseline period Qs preceding the demonstration, as described in Part A of the state's monitoring protocols. (See Appendix B of the Monitoring Protocol Instructions for further instructions on determining baseline periods for first SUD DYs that are less than 12 months.) If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its section 1115 SUD demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this information in Part B of its monitoring report submission (Section 3: Narrative information on implementation, by milestone and reporting topic). This general assessment is not intended to be a comprehensive description of every trend observed in the metrics data. Unlike other monitoring report submissions, for instance, the state is not required to describe all metric changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for a state to provide context on its retrospective metrics

data and to support CMS's review and interpretation of these data. For example, consider a state that submits data showing an increase in the number of medication-assisted treatment (MAT) providers (Metric #14) over the course of the retrospective reporting period. This state may decide to highlight this trend for CMS in Part B of its monitoring report (under Milestone 4) by briefly summarizing the trend and explaining that during this period, a grant supporting training for new MAT providers throughout its state was implemented.

For further information on how to compile and submit a retrospective monitoring report, the state should review Section B of the Monitoring Report Instructions document.

☐ The state will report retrospectively for any Qs prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after monitoring protocol approval.

☒ The state proposes an alternative plan to report retrospectively for any Qs prior to monitoring protocol approval: *Insert narrative description of proposed alternative plan for retrospective reporting. Regardless of the proposed plan, retrospective reporting should include retrospective metrics data and a general assessment of metric trends for the period. The state should provide justification for its proposed alternative plan.*

Not applicable; monitoring protocol applies to a demonstration extension period

Attachment N: SMI Monitoring Protocol

What follows are the SMI-SED definitions, Planned Metrics, Planned Subpopulations, and Reporting Schedule tabs from the SMI monitoring protocol workbook (part A). The full workbook is also available in spreadsheet format on Medicaid.gov.

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - SMI/SED Definitions (Version 2.0, revised)

State	*Vermont*
Demonstration Name	*Global Commitment to Health*

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Definitions

Narrative description of the SMI/SED demonstration population

Adults age 21 or older with serious mental illness or children under the age of 21 with a serious emotional disturbance living within the state.

	Serious Mental Illness (SMI)	Serious Emotional Disturbance (SED)
Narrative description of how the state defines the population for purposes of monitoring (including age range, diagnosis groups, and associated service use requirements)	*Individuals over 21 years of age with at least one acute inpatient claim/encounter at the Brattleboro Retreat or Vermont Psychiatric Care Hospital (VPCH) regardless of diagnosis during the measurement period or 11 months prior.*	*Individuals under the age of 21 years of age with at least one acute inpatient claim/encounter at the Brattleboro Retreat or Vermont Psychiatric Care Hospital (VPCH) regardless of diagnosis during the measurement period or 11 months prior.*
Codes used to identify population[b] *States may use ICD‐10 diagnosis codes or state‐specific treatment, diagnosis, or other types of codes to identify the population. When applicable, states should supplement ICD‐10 codes with state‐specific codes.*	*State‐specified codes: The state plans to use provider billing codes for Brattleboro Retreat and Vermont Psychiatric Care Hospital to identify the population*	*State‐specified codes: The state plans to use provider billing codes for Brattleboro Retreat and Vermont Psychiatric Care Hospital to identify the population*
Procedure (e.g., CPT, HCPCS) or revenue codes used to identify/define service requirements[b] *If the state is not using procedure or revenue codes, the state should include the data source(s) (e.g., state‐specific codes) used to identify/define service requirements.*	*State‐specified codes: The state plans to use DRG assignement and the type of bill to identify inpatient psychiatric care*	*State‐specified codes: The state plans to use DRG assignement and the type of bill to identify inpatient psychiatric care*

[a]The examples are based on a definition of SMI from the National Committee for Quality Assurance (NCQA). The examples provided are intended to be illustrative only. The example codes provided are not comprehensive.
[b]States may choose to include codes as separate tabs in this workbook.

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) | Planned metrics (Version 2.0, revised)
State *Vermont*
Demonstration Name *Global Commitment to Health*

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Planned Metrics

Standard information on CMSprovided metrics											Baseline, annual goals, and demonstration target			Alignment with CMSprovided technical specifications manual		Phasedin metrics reporting		
#	Metric name	Metric description	Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline Reporting Period (MM/DD/YYYY to MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMSprovided technical specifications manual (Y/N)	Explanation of any deviations from the CMSprovided technical specifications manual (different data source, definition, codes, target population, etc.)	State plans to phase in reporting (Y/N)	Report in which metric will be phased in (Format SMI/SED DYQ; Ex. DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: 14 (Do not delete or edit this row)	*EXAMPLE: Screening for Depression and FollowUp Plan: Age 18 and Older (CDF/AD)*	*EXAMPLE: Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, AND if positive, a followup plan is documented on the date of the positive screen.*	*EXAMPLE: Milestone 4*	*EXAMPLE: Established quality measure*	*EXAMPLE: Annual metrics that are an established quality measure*	*EXAMPLE: Claims Medical records*	*EXAMPLE: Year*	*EXAMPLE: Annually*	*EXAMPLE: Recommended*	*EXAMPLE: Y*	*EXAMPLE: 01/01/2021to12/31/2021*	*EXAMPLE: Increase*	*EXAMPLE: Increase*	*EXAMPLE: N*	*EXAMPLE: The Department will use state/defined procedure codes (list specific codes) to calculate this metric.*	*EXAMPLE: Y*	*EXAMPLE: DY3Q2*	*EXAMPLE: We are transitioning to a new tool to screen for depression in adults (i.e., we are transitioning from the Data: Anxiety/Depression Scale (DASS) to the Patient Health Questionnaire (PHQ)2 & PHQ9)). We anticipate that this transition will be complete across sites by mid to late 2023 (DY2).*
1	SUD Screening of Beneficiaries Admitted to Psychiatric Hospitals or Residential Treatment Settings (SUD2)	Two rates will be reported for this measure: 1. SUD2: Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. 2. SUD2a: Patients who received the brief intervention during the hospital stay.	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Medical record review or claims	Year	Annually	Recommended	N								
2	Use of FirstLine Psychosocial Care for Children and Adolescents on Antipsychotics (APP/CH)	Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as firstline treatment.	Milestone 1	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	increase	increase	Y		N		
3	AllCause Emergency Department Utilization Rate for Medicaid Beneficiaries who may Benefit From Integrated Physical and Behavioral Health Care (PMH: 20)	Number of allcause ED visits per 1,000 beneficiary months among adult Medicaid beneficiaries age 18 and older who meet the eligibility criteria of beneficiaries with SMI.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	decrease	decrease	Y		N		
4	30Day AllCause Unplanned Readmission Following Psychiatric Hospitalization in an Inpatient Psychiatric Facility (IPF)	The rate of unplanned, 30day, readmission for demonstration beneficiaries with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease. The measurement period used to identify cases in the measure population is 12 months from January 1 through December 31.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	decrease	decrease	Y		N		
5	Medication Reconciliation Upon Admission	Percentage of patients for whom a designated prior to admission (PTA) medication list was generated by referencing one or more external sources of PTA medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Electronic/paper medical records	Year	Annually	Recommended	N								
6	Medication Continuation Following Inpatient Psychiatric Discharge	This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidencebased medication within 2 days prior to discharge and 30 days postdischarge.	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2019 t 12/31/2020	increase	increase	Y		N		
7	Followup After Hospitalization for Mental Illness: Ages 6\17 (FUH/CH)	Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional selfharm diagnoses and who had a followup visit with a mental health practitioner. Two rates are reported: • Percentage of discharges for which the child received followup within 30 days after discharge • Percentage of discharges for which the child received followup within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	increase	increase	Y		N		
8	Followup After Hospitalization for Mental Illness: Age 18 and older (FUH/AD)	Percentage of discharges for beneficiaries age 18 years and older who were hospitalized for treatment of selected mental illness diagnoses or intentional selfharm and who had a followup visit with a mental health practitioner. Two rates are reported: • Percentage of discharges for which the beneficiary received followup within 30 days after discharge • Percentage of discharges for which the beneficiary received followup within 7 days after discharge	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	increase	increase	Y		N		
9	Followup After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA/AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of alcohol or other drug (AOD) abuse dependence who had a followt up visit for AOD abuse or dependence. Two rates are reported: • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received followup within 30 days of the ED visit • Percentage of ED visits for AOD abuse or dependence for which the beneficiary received followup within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	increase	increase	Y		N		
10	FollowtUp After Emergency Department Visit for Mental Illness (FUM/AD)	Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a primary diagnosis of mental illness or intentional selfharm and who had a followup visit for mental illness. Two rates are reported: • Percentage of ED visits for mental illness for which the beneficiary received followup within 30 days of the ED visit • Percentage of ED visits for mental illness for which the beneficiary received followup within 7 days of the ED visit	Milestone 2	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	increase	increase	Y		N		
11	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (count)	Number of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health.	Milestone 2	CMSticonstructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended	N								
12	Suicide or Overdose Death Within 7 and 30 Days of Discharge From an Inpatient Facility or Residential Treatment for Mental Health Among Beneficiaries With SMI or SED (rate)	Rate of suicide or overdose deaths among Medicaid beneficiaries with SMI or SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health.	Milestone 2	CMSticonstructed	Other annual metrics	State data on cause of death	Year	Annually	Recommended	N								
13	Mental Health Services Utilization ↑ Inpatient	Number of beneficiaries in the demonstration population who use inpatient services related to mental health during the measurement period.	Milestone 3	CMSticonstructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 t 12/31/2020	decrease	decrease	Y		N		
14	Mental Health Services Utilization ↑ Intensive Outpatient and Partial Hospitalization	Number of beneficiaries in the demonstration population who used intensive outpatient and/or partial hospitalization services related to mental health during the measurement period.	Milestone 3	CMSticonstructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 t 12/31/2020	consistent	consistent	Y		N		
15	Mental Health Services Utilization ↑ Outpatient	Number of beneficiaries in the demonstration population who used outpatient services related to mental health during the measurement period.	Milestone 3	CMSticonstructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 t 12/31/2020	increase	increase	Y		N		
16	Mental Health Services Utilization ↑ ED	Number of beneficiaries in the demonstration population who use emergency department services for mental health during the measurement period.	Milestone 3	CMSticonstructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 t 12/31/2020	decrease	decrease	Y		N		
17	Mental Health Services Utilization ↑ Telehealth	Number of beneficiaries in the demonstration population who used telehealth services related to mental health during the measurement period.	Milestone 3	CMSticonstructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 t 12/31/2020	increase	increase	Y		N		
18	Mental Health Services Utilization ↑ Any Services	Number of beneficiaries in the demonstration population who used any services related to mental health during the measurement period.	Milestone 3	CMSticonstructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 t 12/31/2020	increase	increase	Y		N		
19a	Average Length of Stay in IMDs	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD. Three rates are reported: • ALOS for all IMDs and populations • ALOS among shortterm stays (less than or equal to 60 days) • ALOS among longterm stays (greater than 60 days)	Milestone 3	CMSticonstructed	Other annual metrics	Claims Statespecific IMD database	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	decrease	no more than 30 days	Y	Vermont has a small number of IMD providers ↑ and as a result they ↓ N			
19b	Average Length of Stay in IMDs (IMDs receiving FFP only)	Average length of stay (ALOS) for beneficiaries with SMI discharged from an inpatient or residential stay in an IMD receiving federal financial participation (FFP). Three rates are reported: • ALOS for all IMDs and populations • ALOS among shortterm stays (less than or equal to 60 days) • ALOS among longterm stays (greater than 60 days)	Milestone 3	CMSticonstructed	Other annual metrics	Claims Statespecific IMD database	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	decrease	no more than 30 days	Y	Vermont has a small number of IMD providers ↑ and as a result they ↓ N			
20	Beneficiaries With SMI/SED Treated in an IMD for Mental Health	Number of beneficiaries in the demonstration population who have a daim for inpatient or residential treatment for mental health in an IMD during the reporting	Milestone 3	CMSticonstructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	decrease	decrease	Y	Vermont has a small number of IMD providers ↑ and as a result they ↓ N			
21	Count of Beneficiaries With SMI/SED (monthly)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 11 months before the measurement period.	Milestone 4	CMSticonstructed	Other monthly and quarterly metrics	Claims	Month	Quarterly	Required	Y	01/01/2020 t 12/31/2020	consistent	consistent	Y		N		
22	Count of Beneficiaries With SMI/SED (annually)	Number of beneficiaries in the demonstration population during the measurement period and/or in the 12 months before the measurement period.	Milestone 4	CMSticonstructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	consistent	consistent	Y		N		
23	Diabetes Care for Patients with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI: AD)	Percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) whose most recent Hemoglobin A1c (HbA1c) level during the measurement year is >9.0%.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	decrease	decrease	Y		N		
24	Screening for Depression and FollowtUp Plan: Age 18 and Older (CDF/AD)	Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, AND if positive, a followup plan is documented on the date of the positive screen.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Medical records	Year	Annually	Recommended	N								
25	Screening for Depression and FollowtUp Plan: Ages 12–17 (CDF/CH)	Percentage of beneficiaries ages 12 to 17 screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, AND if positive, a followup plan is documented on the date of the positive screen.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims Electronic medical records	Year	Annually	Recommended	N								
26	Access to Preventive/Ambulatory Health Services for Medicaid Beneficiaries With SMI	The percentage of Medicaid beneficiaries age 18 years or older with SMI who had an ambulatory or preventive care visit during the measurement period.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	increase	increase	Y		N		
27	Tobacco Use Screening and Followtup for People with SMI or Alcohol or Other Drug Dependence	The percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and followup for those identified as a current tobacco user. Two rates are reported: • Percentage of adults with SMI who received a screening for tobacco use and followup for those identified as a current tobacco user • Percentage of adults with AOD who received a screening for tobacco use and followup for those identified as a current tobacco user	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Recommended	N								
28	Alcohol Screening and Followtup for People with SMI	The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other followtup care if identified as an unhealthy alcohol user.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Recommended	N								
29	Metabolic Monitoring for Children and Adolescents on Antipsychotics	The percentage of children and adolescents ages 1 to 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: •Percentage of children and adolescents on anapsychoacs who received blood glucose testing •Percentage of children and adolescents on anapsychoacs who received cholesterol testing •Percentage of children and adolescents on anapsychoacs who received blood glucose and cholesterol testing	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	increase	increase	Y		N		
30	FollowtUp Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication	Percentage of Medicaid beneficiaries age 18 years and older with new antipsychotic prescriptions who have completed a followup visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.	Milestone 4	Established quality measure	Annual metrics that are an established quality measure	Claims	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	increase	increase	Y		N		
32	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED ↑ Not Inpatient or Residential	The sum of all Medicaid spending for mental health services not in inpatient or residential settings during the measurement period.	Other SMI/SED metrics	CMSticonstructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	increase	increase	Y	FFS‡Equivalent Estimates; No SMI/SED Tx services are excluded from t	N		
33	Total Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED ↑ Inpatient or Residential	The sum of all Medicaid costs for mental health services in inpatient or residential settings during the measurement period.	Other SMI/SED metrics	CMSticonstructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	decrease	decrease	Y	FFS‡Equivalent Estimates; No SMI/SED Tx services are excluded from t	N		
34	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED ↑ Not Inpatient or Residential	Per capita costs for nonimpatient, nonresidential services for mental health, among beneficiaries in the demonstration population during the measurement period.	Other SMI/SED metrics	CMSticonstructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	decrease	decrease	Y		N		
35	Per Capita Costs Associated With Mental Health Services Among Beneficiaries With SMI/SED ↑ Inpatient or Residential	Per capita costs for inpatient or residential services for mental health among beneficiaries in the demonstration population during the measurement period.	Other SMI/SED metrics	CMSticonstructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 t 12/31/2020	decrease	decrease	Y		N		
36	Grievances Related to Services for SMI/SED	Number of grievances filed during the measurement period that are related to services for SMI/SED.	Other SMI/SED metrics	CMSticonstructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	01/01/2020 t 12/31/2020	decrease	decrease	Y		N		

Standard information on CMSprovided metrics											Baseline, annual goals, and demonstration target			Alignment with CMSprovided technical specifications manual		Phasedin metrics reporting		
#	Metric name	Metric description	Milestone or reporting topic	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline Reporting Period (MM/DD/YYYY)± MM/DD/YYYY	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMSprovided technical specifications manual (Y/N)	Explanation of any deviations from the CMSprovided technical specifications manual (different data source, definition, codes, target population, etc.)	State plans to phase in reporting (Y/N)	Report in which metric will be phased in (Format SMI/SED DYQ; Ex. DY1Q3)	Explanation of any plans to phase in reporting over time
EXAMPLE: 24 (Do not delete or add this row)	*EXAMPLE: Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)*	*EXAMPLE: Percentage of beneficiaries age 18 and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool, AND if positive, a follow-up plan is documented on the date of the positive screen*	*EXAMPLE: Milestone 4*	*EXAMPLE: Established quality measure*	*EXAMPLE: Annual metrics that use an established quality measure*	*EXAMPLE: Claims, Medical records*	*EXAMPLE: Year*	*EXAMPLE: Annually*	*EXAMPLE: Recommended*	*EXAMPLE: Y*	*EXAMPLE: 01/01/2020±12/31/2020*	*EXAMPLE: increase*	*EXAMPLE: increase*	*EXAMPLE: N*	*EXAMPLE: The Department will use state/defined procedure codes (list specific codes) to calculate this metric.*	*EXAMPLE: Y*	*EXAMPLE: DY3Q1*	*EXAMPLE: We are transitioning to a new tool to screen for depression in adults (i.e., we are transitioning from the Duke Anxiety/Depression Scale (DADS) to the Patient Health Questionnaire (PHQ2 & PHQ9)). We anticipate that this transition will be complete across what by end to late 2021 (DY2).*
37	Appeals Related to Services for SMI/SED	Number of appeals filed during the measurement period that are related to services for SMI/SED.	Other SMI/SED metrics	CMSconstructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	01/01/2020 ± 12/31/2020	decrease	decrease	Y		N		
38	Critical Incidents Related to Services for SMI/SED	Number of critical incidents filed during the measurement period that are related to services for SMI/SED.	Other SMI/SED metrics	CMSconstructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Required	Y	01/01/2020 ± 12/31/2020	decrease	decrease	Y		N		
39	Total Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Total Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year.	Other SMI/SED metrics	CMSconstructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 ± 12/31/2020	decrease	decrease	Y	Vermont has a small number of IMD providers ± and as a result they ex	N		
40	Per Capita Costs Associated With Treatment for Mental Health in an IMD Among Beneficiaries With SMI/SED	Per capita Medicaid costs for beneficiaries in the demonstration population who had claims for inpatient or residential treatment for mental health in an IMD during the reporting year.	Other SMI/SED metrics	CMSconstructed	Other annual metrics	Claims	Year	Annually	Required	Y	01/01/2020 ± 12/31/2020	decrease	decrease	Y	Vermont has a small number of IMD providers ± and as a result they ex	N		
Q1	*Number of Behavioral Health Providers Connected to HIE*	This metric is a count of all Vermontbased Designated Agencies that participate in bidirectional data exchange with VITL during the measurement year. Designated Agencies are private, nonprofit, communitybased providers that are responsible for serving the mental health, substance use, and developmental disability needs of Vermonters.	Health IT	Statespecific	*Health IT*	Vermont Information	Year	Annually	Required	Y	01/01/2020 ± 12/31/2020	increase	increase			N		
Q2	*Consent Management*	A count of individuals for whom consent to disclose or access information per state policy (both covered and noncovered 42CFR Part 2 and HIPPA) has been obtained and captured. Bidirectional data exchange is the twoway sharing of PHI data between correctional facilities and VITL	Health IT	Statespecific	*Health IT*	Vermont Information	Year	Annually	Required	Y	01/01/2020 ± 12/31/2020	increase	increase			N		
Q3	*Number of connections live*	This metric is a count of all Vermontbased correctional facilities that participate in bidirectional data exchange with VITL during the measurement year.	Health IT	Statespecific	*Health IT*	Vermont Information	Year	Annually	Required	Y	01/01/2020 ± 12/31/2020	increase	increase			N		
Statespecific metrics																		
Add rows for any additional statespecific metrics																		

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - Planned subpopulations (Version 2.0, revised)

State: *Vermont*

Demonstration Name: *Global Commitment to Health*

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Planned Subpopulations

Planned subpopulation reporting						Alignment with CMS-provided technical specifications manual			
						Subpopulations		Relevant metrics	
Subpopulation category	Subpopulations	Reporting priority	Relevant metrics	Subpopulation type	State will report (Y/N)	Attest that planned subpopulation reporting within each category matches the description in the CMS-provided technical specifications manual (Y/N)	If the planned reporting of subpopulations does not match (i.e., column G = "N"), list the subpopulations state plans to report (Format: comma separated)	Attest that metrics reporting for subpopulation category matches CMS-provided technical specifications manual (Y/N)	If the planned reporting of relevant metrics does not match (i.e., column I = "N"), list the metrics for which state plans to report for each subpopulation category (Format: metric number, comma separated)
EXAMPLE: *Age group* *(Do not delete or edit this row)*	*EXAMPLE:* *Children (Age<16), Transition-age youth (Age 16-24), Adults (Age 25–64), Older adults (Age 65+)*	*EXAMPLE:* *Required*	*EXAMPLE:* *Metrics #11, 12, #13, 14, 15, 16, 17, 18, 21, 22*	*EXAMPLE:* *CMS-provided*	*EXAMPLE:* *Y*	*EXAMPLE:* *N*	*EXAMPLE:* *Children/Young adults (ages 12-21), Adults (ages 21-65)*	*EXAMPLE:* *Y*	*EXAMPLE:*
Standardized definition of SMI	Individuals who meet the standardized definition of SMI	Required	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y			Y	
State-specific definition of SMI	Individuals who meet the state-specific definition of SMI	Required	Metrics #13, 14, 15, 16, 17, 18, 21, 22	State-specific	Y			Y	
Age group	Children (Age<16), Transition-age youth (Age 16-24), Adults (Age 25–64), Older adults (Age 65+)	Required	Metrics #11, 12, 13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y		Y	
Dual–eligible status	Dual-eligible (Medicare-Medicaid eligible), Medicaid only	Required	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	N	The state uses the same methods, data source(s), and data elements that it uses for its SUD demonstration to identify dual-eligible beneficiaries for its SMI/SED demonstration. Individuals with Medicare insurance coverage in our system for that month.	Y	
Disability	Eligible for Medicaid on the basis of disability, Not eligible for Medicaid on the basis of disability	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y		Y	
Criminal justice status	Criminally involved, Not criminally involved	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y		Y	
Co-occurring SUD	Individuals with co-occurring SUD	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	Y	Y		Y	
Co-occurring physical health conditions	Individuals with co-occurring physical health conditions	Recommended	Metrics #13, 14, 15, 16, 17, 18, 21, 22	CMS-provided	N				
[Insert row(s) for any state-specific subpopulation(s)]									

Medicaid Section 1115 SMI/SED Demonstrations Monitoring Protocol (Part A) - SMI/SED Reporting schedule (Version 2.0, revised)

State *Vermont*
Demonstration Name *Global Commitment to Health*

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED) Reporting Schedule
Instructions:

(1) In the reporting periods input table (Table 1), use the prompt in column A to enter the requested information in the corresponding row of column B. All report names and reporting periods should use the format DY#Q# or CY# and all dates should use the format MM/DD/YYYY with no spaces in the cell. The information entered in these cells will auto-populate the SMI/SED demonstration reporting schedule in Table 2. All cells in the input table must be completed in entirety for the standard reporting schedule to be accurately auto-populated.

(2) Review the state's reporting schedule in the SMI/SED demonstration reporting schedule table (Table 2). For each of the reporting categories listed in column E, select Y or N in column G, "Deviations from standard reporting schedule (Y/N)" to indicate whether the state plans to report according to the standard reporting schedule. If a state's planned reporting does not match the standard reporting schedule for any quarter and/or reporting category (i.e. column G= "N"), the state should describe these deviations in column H, "Explanation for deviations (if column G="Y")" and use column I, "Proposed deviations from standard reporting schedule," to indicate the SMI/SED measurement periods with which it wishes to overwrite the standard schedule (column F). All other columns are locked for editing and should not be altered by the state.

Table 1. Reporting Periods Input Table

	Demonstration reporting periods/dates
Dates of first SMI/SED reporting quarter:	
Reporting period (Format SMI/SED DYQ; Ex. DY1Q1)	DY18Q3
Start date (MM/DD/YYYY)[a]	07/01/2022
End date (MM/DD/YYYY)	09/30/2022
Broader section 1115 demonstration reporting period corresponding with the first SMI/SED reporting quarter, if applicable. If there is no boarder demonstration, fill in the first SMI/SED reporting period. (Format DYQ; Ex. DY3Q1)	DY18Q3
First SMI/SED report due date (per STCs) (MM/DD/YYYY)	11/29/2022
First SMI/SED report in which the state plans to report annual metrics that are established quality measures (EQMs):	
Baseline period for EQMs (Format CY; Ex. CY2019)	CY2022
SMI/SED DY and Q associated with report (Format SMI/SED DYQ; Ex. DY1Q1)	DY19Q3
Start date (MM/DD/YYYY)	07/01/2023
End date (MM/DD/YYYY)	09/30/2023
Dates of last SMI/SED reporting quarter:	
Start date (MM/DD/YYYY)	10/01/2027
End date (MM/DD/YYYY)	12/31/2027

Table 2. SMI/SED Demonstration Reporting Schedule

Dates of SMI/SED reporting quarter (MM/DD/YYYY - MM/DD/YYYY)		Report due (per §1115 (MM/DD/YYYY))	Broader section 1115 reporting period, if applicable, else SMI/SED reporting period (Format SY[], ex. SY1[Q3])	Reporting category	For each reporting category, measurement period for which information is captured in monitoring report per standard reporting schedule (Format SY[], ex. SY1[Q3]*		Deviation from standard reporting schedule (Y/N)	Explanation for deviations (if column G="Y")	Proposed deviations from standard reporting schedule (Format SY[], ex. SY1[Q3]
Start date	End date				SMI/SED				
07/01/2022	09/30/2022	11/29/2022	SY1[Q3]	Narrative information	SY1[Q3]	N			
				Grievances and appeals	SY1[Q3]	N			
				Other monthly and quarterly metrics		N			
				Annual availability assessment		N			
				Annual metrics that are established quality measures		N			
				Other annual metrics		N			
10/01/2022	12/31/2022	03/31/2023	SY1[Q4]	Narrative information	SY1[Q4]	N			
				Grievances and appeals	SY1[Q4]	N			
				Other monthly and quarterly metrics	SY1[Q3]	N			
				Annual availability assessment	AA1	N			
				Annual metrics that are established quality measures	CY2021	Y	Reporting to continue per previous demonstration reporting schedule. Vermont will report EQMs in its Quarter 4 Monitoring Reports to give the state more time to program EQMs according to the technical specifications manual.	CY2021	
				Other annual metrics		N			
01/01/2023	03/31/2023	06/30/2023	SY1[Q1]	Narrative information	SY1[Q1]	N			
				Grievances and appeals	SY1[Q1]	N			
				Other monthly and quarterly metrics	SY1[Q4]	N			
				Annual availability assessment		N			
				Annual metrics that are established quality measures		N			
				Other annual metrics	SY1	N			
04/01/2023	06/30/2023	09/29/2023	SY1[Q2]	Narrative information	SY1[Q2]	N			
				Grievances and appeals	SY1[Q2]	N			
				Other monthly and quarterly metrics	SY1[Q1]	N			
				Annual availability assessment		N			
				Annual metrics that are established quality measures		N			
				Other annual metrics		N			
07/01/2023	09/30/2023	11/29/2023	SY1[Q3]	Narrative information	SY1[Q3]	N			
				Grievances and appeals	SY1[Q3]	N			
				Other monthly and quarterly metrics	SY1[Q2]	N			
				Annual availability assessment		N			
				Annual metrics that are established quality measures	CY2022	Y	Vermont will report annual metrics that are EQMs in its Quarter 4 Monitoring Reports to give the state more time to program EQMs according to the technical specifications manual.	n.a. – state not reporting	
				Other annual metrics		N			
10/01/2023	12/31/2023	03/31/2024	SY1[Q4]	Narrative information	SY1[Q4]	N			
				Grievances and appeals	SY1[Q4]	N			
				Other monthly and quarterly metrics	SY1[Q3]	N			
				Annual availability assessment	AA2	N			
				Annual metrics that are established quality measures		Y	Vermont will report annual metrics that are EQMs in its Quarter 4 Monitoring Reports to give the state more time to program EQMs according to the technical specifications manual.	CY2022	
				Other annual metrics		N			
01/01/2024	03/31/2024	06/30/2024	SY2[Q1]	Narrative information	SY2[Q1]	N			
				Grievances and appeals	SY2[Q1]	N			
				Other monthly and quarterly metrics	SY1[Q4]	N			
				Annual availability assessment		N			
				Annual metrics that are established quality measures		N			
				Other annual metrics	AA2	N			
04/01/2024	06/30/2024	09/29/2024	SY2[Q2]	Narrative information	SY2[Q2]	N			
				Grievances and appeals	SY2[Q2]	N			
				Other monthly and quarterly metrics	SY2[Q1]	N			
				Annual availability assessment		N			
				Annual metrics that are established quality measures		N			
				Other annual metrics		N			
07/01/2024	09/30/2024	11/29/2024	SY2[Q3]	Narrative information	SY2[Q3]	N			
				Grievances and appeals	SY2[Q3]	N			
				Other monthly and quarterly metrics	SY2[Q2]	N			
				Annual availability assessment		N			
				Annual metrics that are established quality measures	CY2023	Y	Vermont will report annual metrics that are EQMs in its Quarter 4 Monitoring Reports to give the state more time to program EQMs according to the technical specifications manual.	n.a. – state not reporting	
				Other annual metrics		N			
10/01/2024	12/31/2024	03/31/2025	SY2[Q4]	Narrative information	SY2[Q4]	N			
				Grievances and appeals	SY2[Q4]	N			
				Other monthly and quarterly metrics	SY2[Q3]	N			
				Annual availability assessment	AA2	N			
				Annual metrics that are established quality measures		Y	Vermont will report annual metrics that are EQMs in its Quarter 4 Monitoring Reports to give the state more time to program EQMs according to the technical specifications manual.	CY2023	
				Other annual metrics		N			
01/01/2025	03/31/2025	06/30/2025	SY3[Q1]	Narrative information	SY2[Q1]	N			
				Grievances and appeals	SY2[Q1]	N			
				Other monthly and quarterly metrics	SY2[Q4]	N			
				Annual availability assessment		N			
				Annual metrics that are established quality measures		N			
				Other annual metrics	SY3	N			
04/01/2025	06/30/2025	09/29/2025	SY3[Q2]	Narrative information	SY2[Q2]	N			
				Grievances and appeals	SY2[Q2]	N			
				Other monthly and quarterly metrics	SY2[Q1]	N			
				Annual availability assessment		N			
				Annual metrics that are established quality measures		N			
				Other annual metrics		N			
07/01/2025	09/30/2025	11/29/2025	SY3[Q3]	Narrative information	SY2[Q3]	N			
				Grievances and appeals	SY2[Q3]	N			
				Other monthly and quarterly metrics	SY2[Q2]	N			
				Annual availability assessment		N			
				Annual metrics that are established quality measures	CY2024	Y	Vermont will report annual metrics that are EQMs in its Quarter 4 Monitoring Reports to give the state more time to program EQMs according to the technical specifications manual.	n.a. – state not reporting	
				Other annual metrics		N			
10/01/2025	12/31/2025	03/31/2026	SY3[Q4]	Narrative information	SY2[Q4]	N			
				Grievances and appeals	SY2[Q3]	N			
				Other monthly and quarterly metrics	SY2[Q3]	N			
				Annual availability assessment	AA3	N			
				Annual metrics that are established quality measures		Y	Vermont will report annual metrics that are EQMs in its Quarter 4 Monitoring Reports to give the state more time to program EQMs according to the technical specifications manual.	CY2024	
				Other annual metrics		N			
01/01/2026	03/31/2026	06/30/2026	SY3[Q1]	Narrative information	SY2[Q1]	N			
				Grievances and appeals	SY2[Q4]	N			
				Other monthly and quarterly metrics	SY2[Q4]	N			
				Annual availability assessment		N			
				Annual metrics that are established quality measures		N			
				Other annual metrics	SY4	N			
04/01/2026	06/30/2026	09/29/2026	SY3[Q2]	Narrative information	SY3[Q2]	N			
				Grievances and appeals	SY3[Q2]	N			
				Other monthly and quarterly metrics	SY3[Q1]	N			
				Annual availability assessment		N			
				Annual metrics that are established quality measures		N			
				Other annual metrics		N			
07/01/2026	09/30/2026	11/29/2026	SY3[Q3]	Narrative information	SY3[Q3]/[Q1]	N			
				Grievances and appeals	SY3[Q3]	N			
				Other monthly and quarterly metrics	SY3[Q2]	N			
				Annual availability assessment		N			
				Annual metrics that are established quality measures	CY2025	Y	Vermont will report annual metrics that are EQMs in its Quarter 4 Monitoring Reports to give the state more time to program EQMs according to the technical specifications manual.	n.a. – state not reporting	
				Other annual metrics		N			
10/01/2026	12/31/2026	03/31/2027	SY3[Q4]	Narrative information	SY3[Q3]/[Q4]	N			
				Grievances and appeals	SY3[Q3]	N			
				Other monthly and quarterly metrics	SY3[Q3]	N			
				Annual availability assessment	AA3	N			
				Annual metrics that are established quality measures		Y	Vermont will report annual metrics that are EQMs in its Quarter 4 Monitoring Reports to give the state more time to program EQMs according to the technical specifications manual.	CY2025	
				Other annual metrics		N			
01/01/2027	03/31/2027	06/30/2027	SY3[Q1]	Narrative information	SY3[Q3]/[Q1]	N			
				Grievances and appeals	SY3[Q4]	N			
				Other monthly and quarterly metrics	SY3[Q4]	N			
				Annual availability assessment		N			
				Annual metrics that are established quality measures		N			
				Other annual metrics	SY5	N			
04/01/2027	06/30/2027	09/29/2027	SY3[Q2]	Narrative information	SY3[Q4]/[Q1]	N			
				Grievances and appeals	SY4[Q1]	N			
				Other monthly and quarterly metrics	SY4[Q1]	N			
				Annual availability assessment		N			
				Annual metrics that are established quality measures		N			
				Other annual metrics		N			
Add rows for all additional demonstration reporting quarters									

Notes:

* **SMI/SED demonstration start date**: For monitoring purposes, CMS defines the start date of the demonstration as the effective date listed in the state's STC) at time of SMI/SED demonstration approval. For example, if the state's STCs at the time of SMI/SED demonstration approval note that the demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the demonstration. Note that that the effective date is considered to be the first day the state may begin its SMI/SED demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on 12/15/2020, with an effective date of 1/1/2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

* The auto-populated reporting schedule in Table 2 outlines the data the state is expected to report for each SMI/SED demonstration year and quarter. However, the state is not expected to begin reporting any metrics data until after protocol approval. The state should see Section 8 of the Monitoring Report Instructions for more information on retrospective reporting of data following protocol approval.

Ann refers to the Annual Assessment of the Availability of Mental Health Services ("Annual Availability Assessment") and the SMI/SED SY in which the Annual Availability Assessment will be submitted (for example, "AA1" refers to the Annual Availability Assessment that will be submitted with the state's annual monitoring report for SMI/SED SY1). Data in each Annual Availability Assessment should be reported as of the month and day indicated in the state's approved monitoring protocol. If the state cannot submit its Annual Availability Assessments when it submits its annual monitoring reports, it should propose and describe a reporting deviation in Columns G and H.

Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance Demonstrations
Monitoring Protocol Template

Note: PRA Disclosure Statement to be added here

1. Title page for the state's serious mental illness and serious emotional disturbance (SMI/SED) demonstration or the SMI/SED component of the broader demonstration

The state should complete this title page as part of its SMI/SED monitoring protocol. This form should be submitted as the title page for all monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are below the table.

State	*Vermont*
Demonstration name	*Global Commitment to Health*
Approval period for section 1115 demonstration	*07/01/ 2022 – 12/31/2027*
SMI/SED demonstration start date[a]	*07/01/2022*
Implementation date of SMI/SED demonstration, if different from SMI/SED demonstration start date[b]	*01/01/2020*
SMI/SED (or if broader demonstration, then SMI/SED - related) demonstration goals and objectives	*During the demonstration period, the state seeks to achieve the following SMI/SED goals:* *1. Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with* *SMI or SED while awaiting mental health treatment in specialized settings;* *2. Reduced preventable readmissions to acute care hospitals and residential settings;* *3. 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;* *4. 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; and* *5. Improved care coordination, especially continuity of care in the community following episodes of acute*

[a] SMI/SED demonstration start date: For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SMI/SED demonstration approval. For example, if the state's STCs at the time of SMI/SED demonstration approval note that the SMI/SED demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SMI/SED demonstration. Note that the effective date is considered to be the first day the state may begin its SMI/SED demonstration. In many cases, the effective date is

distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on 12/15/2020, with an effective date of 1/1/2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SMI/SED demonstration:** The date the state began claiming federal financial participation for services provided to individuals in institutions of mental disease.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in the Monitoring Report Template provided by CMS and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested narrative information (with no modifications).

3. Annual Assessment of the Availability of Mental Health Services reporting

☒ The state will use data as of the following month and day of each calendar year to conduct its Annual Assessment of the Availability of Mental Health Services: *12/01*

4. Acknowledgement of budget neutrality reporting requirements

☒ The state has reviewed the Budget Neutrality Workbook provided by the CMS demonstration team and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (with no modifications).

5. Retrospective reporting

The state is not expected to submit metrics data until after monitoring protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to monitoring protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

For a state that has monitoring protocols approved after one or more initial quarterly monitoring report submissions, it should report metrics data to CMS retrospectively for any prior quarters of the section 1115 SMI/SED demonstration that precede the monitoring protocol approval date. A state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data—in its second monitoring report submission that contains metrics. The retrospective report for a state with a first SMI/SED DY of less than 12 months should include data for any baseline period quarters preceding the demonstration, as described in Part A of the state's monitoring protocol (see Appendix B of the instructions for further guidance determining baseline periods for first SMI/SED DYs that are less than 12 months). If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its SMI/SED demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this information in Part B of its report submission (Section 3. Narrative information on implementation, by milestone and reporting topic). This general assessment is not intended to be a comprehensive description of every trend observed in metrics data. Unlike other monitoring report submissions, for instance, the state is not required to describe all metrics changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for the state to provide context for its

retrospective metrics data, to support CMS's review and interpretation of these data. For example, consider a state that submits data showing an increase in the utilization of telehealth services for mental health (Metric #15) over the course of the retrospective reporting period. The state may decide to highlight this trend to CMS in Part B of its monitoring report (under Milestone 3) by briefly summarizing the trend and providing context that during this period, the state implemented a grant to improve access to mental health treatment in rural areas through the use of telemedicine.

For further information on how to compile and submit a retrospective report, the state should review Section B of the Monitoring Report Instructions document.

☒ The state will report retrospectively for any quarters prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after monitoring protocol approval.

☐ The state proposes an alternative plan to report retrospectively for any quarters prior to monitoring protocol approval: *Insert narrative description of proposed changes to retrospective reporting. The state should provide justification for its proposed alternative plan.*

NORC at the University of Chicago

EVALUATION DESIGN

APRIL 2024

Vermont Global Commitment to Health Section 1115 Demonstration

Presented by:
NORC at the University of Chicago

Presented to:
Vermont Agency of Human Services

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List of Acronyms

ACA	Affordable Care Act
ACO	Accountable Care Organization
ACS	American Community Survey
AHRF	Area Health Resources File
AHS	Agency of Human Services
CAHPS	Consumer Assessment of Health Care Providers and Systems
CFC	Choices for Care
CIT	Community Intervention and Treatment
CITS	Comparative Interrupted Time Series
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
CRT	Community Rehabilitation and Treatment
DiD	Difference-In-Difference
DSHP	Delivery System and Health Payment
DSM-V	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
DVHA	Department of Vermont Health Access
EB	Entropy Balancing
ECHO	Experience of Care and Health Outcomes
ED	Emergency Department
FFP	Federal Financial Participation
FPL	Federal Poverty Levels
GMCB	Green Mountain Care Board
HCBS	Home and Community-Based Services
HEDIS	Health Care Effectiveness Data and Information Set
HIT	Health Information Technology
IEP	Individual Education Plan
ID/DD	Intellectual and Developmental Disabilities
IMD	Institution for Mental Disease
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MDAAP	Medicaid Data Aggregation and Access Program
MDE	Minimum Detectable Effects
MMIS	Medicaid Management Information System
MPA	Mid-Point Assessment
MSP	Medicare Savings Program
NCQA	National Committee for Quality Assurance
OUD	Opioid Use Disorder
PHE	Public Health Emergency

ROP	Reasonable Opportunity Period
SATIS	Substance Abuse Treatment Information System
SDOH	Social Determinants of Health
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SUD	Substance Use Disorder
TBI	Traumatic Brain Injury
VHIS	Vermont Household Insurance Survey
VT	Vermont
VTAPM	Vermont's All-Payer ACO Model

General Background Information

Vermont's Global Commitment to Health Demonstration ("the Demonstration") has been instrumental in implementing large-scale Medicaid transformation in Vermont since its initial approval in 2005. This evaluation design is in response to the extension approved by the Centers for Medicare & Medicaid Services (CMS) effective July 1, 2022, through December 31, 2027.

Demonstration Purpose & Goals

Vermont's Global Commitment to Health Demonstration is an agreement between the Vermont Agency of Human Services (AHS) and the Centers for Medicare and Medicaid Services (CMS) that is designed to use principles of public health, effective administration of a Medicaid managed care delivery system, and programmatic flexibilities to improve the health and welfare of Vermonters. Since its inception, the Demonstration has made significant strides toward care delivery and payment transformation. This Demonstration has extended coverage beyond the traditional Medicaid eligibility groups, aiming to enhance health care access for Vermont residents. It has also funded social services and programs related to social determinants of health (SDOH) to reduce long-term health care costs. The initiatives under the Demonstration align with Vermont's All-Payer ACO Model (VTAPM), an all-payer model funded by CMS, which started in 2017 and aims to improve overall population health outcomes while reducing health care spending across the state. Because over 80 percent of Vermont Medicaid members are enrolled in the VTAPM Medicaid ACO, CMS required the VTAPM to align with the Demonstration.[i]

Vermont's legislative actions have long supported the goals of the Global Commitment Demonstration. For instance, the Health Care Affordability Act of 2006 incorporated the Blueprint for Health Program into law.[ii] This program has executed various initiatives, such as the patient-centered medical home, community health teams, and the "hub and spoke" system of care.[iii] Another significant legislative development was Act 48, which established the Green Mountain Care Board (GMCB).[iv] The GMCB plays a crucial role in improving health care quality and stabilizing costs for Vermonters by overseeing payment and delivery system reforms, provider rate-setting, hospital and ACO budget approval, insurer rate approval, and the state's all-payer claims database.[v,vi]

As a result of these efforts, Vermont, despite having one of the oldest populations in the country, has been recognized as in the top five states for state health system performance, access to mental health care, and overall long-term services and supports (LTSS) system performance.[vii,viii]

The Demonstration enables Vermont's Medicaid program to advance payment and care delivery transformation, positioning Vermont as a national leader in health care innovation. For example, the Demonstration granted the Department of Vermont Health Access (DVHA), within AHS, the authority to act as a non-risk-bearing managed care plan, allowing the Medicaid program to pursue programmatic and payment flexibilities similar to commercial managed care plans. This unique approach has earned Vermont recognition as one of only two states with a payment model meeting the Health Care Payment Learning & Action Network category 4 criteria under the Alternative Payment Model framework.[ix]

AHS has identified five high-level goals that provide a framework for the implementation of the Global Commitment Demonstration:

- GOAL 1: Advance the state toward population-wide comprehensive coverage.
- GOAL 2: Implement innovative care models across the continuum that produce value.
- GOAL 3: Engage Vermonters in transforming their health.
- GOAL 4: Strengthen care coordination and population health management capabilities to encompass the full spectrum of health-related services and supports.
- GOAL 5: Accelerate payment reform.

To achieve the five stated goals of the Demonstration, the state will employ four major elements:

- **Benefits and eligibility expansion.** The Demonstration introduces a SUD Community Intervention and Treatment eligibility group and a Maternal Health and Treatment Services Initiative. Additionally, the state will expand benefits for the VPharm cost-sharing assistance program, Community Rehabilitation and Treatment (CRT) program, and Developmental Disabilities Services program.[x]

- **Managed care delivery system.** AHS will maintain the managed care-like model, through the interagency agreement with DVHA, that was approved during the 2016 extension. As part of this model, Vermont has the authority to fund investments that further the goals of the Demonstration. In the current extension period, Vermont will leverage this authority to advance updated investment goals, such as investing in Home and Community Based Services (HCBS) and SDOH.[xi]

- **Advancing population health.** The Demonstration will strengthen care coordination and population health through several initiatives, including a Supportive Housing Assistance Pilot aimed at providing services that aid in the transition to and maintenance of residency. The Demonstration renewal also authorizes a Medicaid Data Aggregation and Access Program (MDAAP) to incentivize improved health IT infrastructure and connectivity. These efforts will support individuals during care transitions and engage providers across the continuum of care.[xii]

- **Delivery system reform**. The Demonstration will enable delivery system reform efforts by leveraging the payment flexibilities of Medicaid's managed care-like model. Vermont's delivery system reform efforts aim to align with public payers and advance universal access to health care, cost containment, and improved quality of care.[xiii]

Demonstration History

The Demonstration has been renewed four times since its initial approval in 2005:

- Through the **original Global Commitment to Health Demonstration (2005),** nearly all of Vermont's Medicaid program transitioned to function as a managed care-like model. Also in 2005, Vermont obtained a separate demonstration known as the Choices for Care (CFC) Section 1115 Demonstration, allowing individuals in need of institutional care access to HCBS or nursing facility care. The CFC Demonstration became part of the Global Commitment to Health Demonstration in January 2015.
- During the **First Renewal (2011)**, Vermont's managed care model evolved from an at-risk to a non-risk arrangement[xiv], though Vermont still was able to utilize the savings from managed care to reach the goals of the Demonstration.[xv]
- The goal of the **Second Renewal (2014)** was to address the changes in health care coverage from the Affordable Care Act (ACA). In 2015, Vermont consolidated the CFC Demonstration with the Global Commitment Demonstration.
- In the **Third Renewal (2017),** the Demonstration increased focus on health care treating serious mental illness (SMI), serious emotional disturbance (SED), substance use disorder (SUD), and institutions for mental diseases (IMD). The Demonstration no longer operates under global capitation where physicians are paid a set amount per month for each patient and accept full financial risk for patients' overall health care costs.[xvi]
- In the **Fourth Renewal (2022)**, Vermont is implementing a new eligibility group for Vermonters with low-income and SUD, coverage of services providing mental health and SUD treatment for pregnant and postpartum individuals, a pilot program for access to housing, and a program to expand technology capabilities for mental health, SUD, and LTSS providers.

New In This Extension Period

Vermont will continue to focus on improving equity, coverage, and access for Medicaid beneficiaries and low-income individuals by adding funding for its investments and strengthening its waiver programs. During this extension period, Vermont will implement the following notable new initiatives[xvii]:

- A new **Community Intervention and Treatment (CIT) eligibility group** for residents with SUD and low to moderate income (between 133 to 225% Federal Poverty Level [FPL]). Individuals in this eligibility group are not eligible for full State Plan benefits but will have access to SUD treatment services including case management, recovery supports, psychoeducation, peer support, residential treatment, withdrawal management, counseling, and skilled therapy services.
- A **Maternal Health and Treatment Services initiative** through Vermont's Lund programs (Lund) to provide treatment for residential mental health and SUD for pregnant and postpartum mothers.
- A **Supportive Housing Assistance Pilot** to offer services for individuals to successfully transition and maintain residency, assisted by rental assistance agencies.

- A new incentive-based program called the **Medicaid Data Aggregation and Access Program** to incentivize mental health, SUD, and LTSS providers to increase their health information technology (HIT) capabilities.

Delivery Model

AHS operates as the single state agency responsible for implementing and delivering all human service programs in Vermont.[xviii] One of the six departments within AHS is the **Department of Vermont Health Access (DVHA)** which operates the state's Medicaid program. In 2005, AHS entered into an intergovernmental agreement with DVHA to operate a managed care-like model for Vermont, the only public Medicaid managed care entity in the country.[xix]

DVHA contracts with government agencies within the state to provide services to Vermonters, including care for mental health, maternal health, developmental disabilities, and children. Below are descriptions of the state agencies involved in offering services through the Demonstration.

- **The Department of Mental Health** within AHS aims to improve the health care of Vermonters of all ages with their mental health through its two divisions: the Adult Mental Health Services Division and the Child, Adolescent, and Family Mental Health Services Division. This department manages community-based and inpatient services to allow for early intervention mental health treatment and support that allow Vermonters to succeed in their daily life and their community. The Department of Mental Health manages the health care of two of the high-needs populations involved in the demonstration: people with severe and persistent mental illness and children experiencing severe emotional disturbance.
- The vision of the **Vermont Department of Health** is to protect and promote the best health for all Vermonters, focusing on prevention first. The Demonstration's investment programs support Medicaid beneficiaries and other Vermonters and may be offered by organizations that are not typically Medicaid-enrolled providers, such as the Vermont Department of Health. Two divisions within the Department demonstrate its focus on prevention and health promotion for Vermonters and its alignment with the goals of the Demonstration:
    - The Division of Substance Use Programs (DSU) supports Vermonter's access to SUD prevention, intervention, and treatment by offering services such as family programs, community prevention programs, prescription drug disposal, safe needle disposal, and an impaired driver rehabilitation program.[xx]
    - The division focused on Children with Special Health Needs (CSHN) includes medical social workers, nurses, and specialty providers that support Vermont children and youth with special health needs. CSHN provides a variety of services based on a holistic, family-centered approach. Services include palliative care, personal care services, care consultation, and nutrition services.[xxi]
- The mission of the **Department of Disabilities, Aging, and Independent Living** is to "make Vermont the best state in which to grow old or to live with a disability with dignity, respect, and

independence." Under the Demonstration, this department manages several specialty Medicaid programs including CFC, developmental disability services, and traumatic brain injury (TBI) services. Among the Demonstration's investments include the Flexible Family/Respite Funding to provide $1,000 to families of children and adults with developmental disabilities and the Mental Health Consumer Support Programs to provide support to children with serious mental illness.

- The **Department of Children and Families** aims to improve Vermonter's health by offering benefits and services to support children and families. Specifically, Medicaid provides intensive residential treatment for children and youth, including those placed in foster care, through the Enhanced Family Treatment Program.[xxii] The mission of the **Agency of Education** is to "empower educators and school leaders to innovate and collaborate and to scale local excellence across the state.**"** Vermont utilizes the Medicaid School-Based Health Services Program to obtain Medicaid reimbursement for services through its Individual Education Plan. This agency provides a monthly grant to schools based on their Medicaid claims.[xxiii]
- **CMMI All-Payer Model Alignment.** In 2016, the GMCB approved the five-year all-payer model agreement from 2018-2022 between Vermont and the federal government to shift from a fee-for-service system to a value-based care system. [xxiv] The All-Payer Model Agreement was extended by Vermont and CMMI in 2022 for a further year (2023), with an optional transition year in 2024. Both the Demonstration and the All-Payer Model Agreement support Vermont's goal of the triple aim to improve the experience of care, improve the health of the population, and reduce the costs of care.[xxv]

Eligibility, Benefits & Cost Sharing

The Global Commitment to Health demonstration aims to expand eligibility and benefits for Vermonters and includes expenditures aimed at increasing program flexibility, comprehensive and person-centered services; and choice in long-term services and supports.

Eligibility. Eligibility under the Demonstration falls under the nine population categories, as described below. Three population categories are continuing features from the previous Demonstration (Populations 1 through 3), five population categories have modified rules under the new Demonstration (Populations 4 through 8), and one population category is new under this Demonstration (Population 9):

Population 1: Mandatory State Populations. Individuals who fall under the Mandatory State Plan populations, apart from the ACA new adult group (which is included in Population 3) and beneficiaries of the Medicare Savings Program (included in Population 8). This is a continuing feature of the Demonstration.[xxvi]

Population 2: Optional State Populations. Individuals eligible for the State Plan but belonging to optional groups such as the medically needy. This is a continuing feature of the Demonstration and there are no new benefits under the new Demonstration.[xxvii]

Population 3: New Adult Group. The New Adult Group refers to a segment of newly eligible adults. This is a continuing feature of the Demonstration, although the State plans to amend the benefits for this group during this renewal period to align it with the proposed modifications to the State Plan.[xxviii]

Population 4: CFC Highest Needs Population. Individuals aged 65 and older and those aged 18 and older with disabilities who are not eligible under the State Plan, who meet clinical criteria for the Highest Needs Group for CFC. The CFC Highest Needs Group will continue to receive State Plan benefits and HCBS coverage as it did under the previous Demonstration, and the State made minor changes under the new Demonstration period, such as adding a "life skills aide" to the CFC Highest Needs service offerings.[xxix]

Population 5: CFC High Needs Population. The CFC High Needs Population includes individuals aged 65 and older, as well as individuals aged 18 and older with disabilities, who are not eligible under the State Plan, and meet the clinical criteria for the High Needs Group for CFC. The CFC High Needs Group will continue to receive State Plan benefits and HCBS as it did under the previous Demonstration, and the State made minor changes to the CFC benefit package under the new Demonstration, such as adding a "life skills aide" services to the CFC High Needs service offerings.[xxx]

Population 6: CFC Moderate Needs Expansion Group. The CFC Moderate Needs Expansion Group comprises individuals with incomes below 300% of the Supplemental Security Income Federal Benefit Rate. Under the new Demonstration period, this group will now be eligible for limited HCBS, including adult day services, case management, and homemaker services. The State intends to make minor changes to the eligibility criteria, such as adding new criteria around the imminent risk of health and welfare without services and removing existing criterion around requiring monthly monitoring for a chronic health condition.[xxxi]

Population 7: CRT Expansion Group. The CRT Expansion Group consists of individuals with SMI who have incomes above 133% of the federal poverty level. For this group, the State proposes to provide limited community mental health services, which include service coordination, flexible support, skilled therapy services, counseling, residential treatment, supported employment, environmental safety devices, and crisis and community supports. Under the new Demonstration period, the CRT Expansion Group will be covered through expenditure authority instead of being treated as a Delivery System and Health Payment (DSHP) and investment. The State made minor changes to the CRT benefit package in the new Demonstration, such as adding peer supports to the services offered through CRT. The State also plans to remove respite from the list of CRT benefits, since respite is not in use today.[xxxii]

Population 8: VPharm Group. The VPharm Group comprises Medicare beneficiaries who are 65 years or older or have a disability, with income at or below 225% of the FPL. These individuals may be eligible for enrollment in the Medicare Savings Program (MSP), but they are not otherwise categorically eligible for full benefits. Under the new Demonstration period, the State is to expand benefits available to Medicare beneficiaries with incomes ranging from 150% to 225% of the FPL. This expansion will include Medicaid coverage for prescriptions, eyeglasses, and related eye exams. Additionally, MSP beneficiaries in this group will continue to receive benefits as described in the State Plan.[xxxiii]

Population 9: SUD Community Intervention and Treatment Expansion Group. The SUD Community Intervention and Treatment Expansion Group encompasses individuals with an SUD as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V), who have incomes ranging from 133% of the FPL up to and including 225% of the FPL. For this group, the State intends to provide comprehensive community-based intervention and treatment services aimed at

addressing SUD. Benefits include service coordination, flexible support, peer supports, skilled therapy services, residential treatment, withdrawal management, and counseling. Services offered will be tailored to the needs of those facing substance use disorders.[xxxiv] This is a new feature in the current Demonstration; prior to this Demonstration, this group did not receive any Medicaid benefits.

Benefits. The Demonstration offers many services to eligible populations based on medical appropriateness and is subject to review by the DVHA and/or appropriate departments within AHS[xxxv]. Of the ten benefit programs, six are continuing unchanged from the previous Demonstration, three are continuing programs with minor modifications under the new Demonstration, and one is a new benefit (the Supportive Housing Assistance Pilot):

Adult Hospice Program. The Demonstration extends benefits for those with life-limiting illnesses, such as offering state expenditures for hospice services that exceed State Plan limits. This benefit also allows individuals with a life expectancy of twelve months or less to access hospice care while continuing curative treatments.[xxxvi] This is a continuing feature of the Demonstration.

Children's Palliative Care Program. The children's palliative care program offers services for children who are at or below 300 percent of the FPL and have been diagnosed with life-limiting illnesses. Services offered include expressive therapy, care coordination, family training, and respite for caregivers.[xxxvii] This is a continuing feature of the Demonstration.

Supportive Housing Assistance Pilot. This pilot will allow Vermont to cover pre-tenancy supports, tenancy-sustaining services, and community transition services for adults who meet specific health- and risk-based criteria. Example services include housing needs assessments, connections to community resources, and coverage of expenses associated with landlord risk mitigation.[xxxviii] This is a new benefit under this Demonstration with an implementation date to be determined. In February 2024, AHS issued a Request for Information to gather information from potential service providers for this pilot.[xxxix]

Coverage for Presumptively Eligible Pregnant Women. The Demonstration provides full Medicaid State Plan benefits to presumptively eligible pregnant Women. As a result, pregnant women do not have to wait for a Medicaid eligibility determination.[xl] This is a continuing feature of the Demonstration.

Residential and Inpatient Treatment for Individuals with SUD and SMI. This program provides expenditures to short-term residents of IMD treatment facilities who are receiving treatment services for SUD or SMI.[xli] This is a continuing feature of the Demonstration.

Specialized HCBS Programs. The Demonstration authorizes the provision of several in-home and community services, which rely on person-centered planning and are intended to support a continuum of care.

- **Brain Injury Program.** This program offers specialized and long-term services and support for individuals with traumatic brain injuries. The program enables the provision of HCBS, including services such as crisis and support services, psychological and counseling support, case management, community support, habilitation, respite care, supported employment, as well as assistance with environmental and assistive technology. Additionally, the program allows for self-directed care, empowering individuals to have more control over their care and support choices.[xlii] This is a continuing feature of the Demonstration but, under the new Demonstration, the State provides reimbursement to parents, spouses, and legal guardians for providing life skills aide services and community supports.

- **Mental Health Under 22.** This program supports children and adolescents diagnosed with SMI or SED by allowing them to stay in their homes and communities while receiving the necessary treatment. The program provides home and community-based treatment services to more than 300 young individuals, aged up to 22, who have a primary mental health or SED diagnosis. Services offered include coordination, flexible support, skilled therapy services, environmental safety devices, counseling, respite care, supported employment, and crisis supports.[xliii] This is a continuing feature of the Demonstration.
- **Community Rehabilitation and Treatment.** This program offers recovery-oriented and personalized treatment services for adults facing severe and persistent mental illness in their homes and communities. The Demonstration provides authorization for HCBS, including services such as service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite care, supported employment, as well as crisis and community supports. Additionally, a special provision as a Designated State Health Program allows for the extension of CRT benefits to individuals with severe and persistent mental illness who fall within an income range of 133 to 150 percent of the federal poverty level.[xliv] This is a continuing benefit of the Demonstration, but peer support was added to the list of eligible services for this population under the new Demonstration.
- **Developmental Disability Services.** This program offers long-term services and support for individuals with intellectual disabilities. The Demonstration allows for the authorization of HCBS, including services such as service coordination, residential habilitation, day habilitation, supported employment, crisis services, clinical intervention, respite care, and self-directed care.[xlv] This is a continuing feature of the Demonstration but, under the new Demonstration, the State provides reimbursement to parents, spouses, and legal guardians for providing life skills aide services and community supports.
- **Choices for Care.** This program offers long-term services and support for members with disabilities and older Vermonters, including enhanced residential care, personal care, homemaker services, companion care, case management, adult day services, and adult family care. This is a continuing feature of the Demonstration.

Other Programs. In addition, the Demonstration also authorizes:

- **Marketplace Subsidies Program.** This program will aid individuals at or below 300% of the FPL who purchase health insurance through the Marketplace.[xlvi] This is a continuing feature of the Demonstration, previously covered by DSHP funds, but the State sought to transition authority for the subsidies to an expenditure authority under the Demonstration.
- **Maternal Health and Treatment Services.** This program would provide access to residential/inpatient mental health/SUD services for pregnant and postpartum individuals and mothers with children up to age 5 obtaining care in Lund.[xlvii] This is a new feature of the Demonstration.
- **Medicaid Data Aggregation and Access Program (MDAAP).** This program will provide HIT infrastructure to Medicaid providers. This program aims to increase the use and connectivity of HIT systems. Mental health, SUD treatment, and LTSS providers who meet the Medicaid patient volume criteria are eligible for this program.[xlviii] This is a new feature of the Demonstration; the

program was launched in January 2024 and providers can enroll throughout CY2024. All payments will be made to providers by March 31, 2025.

Expenditures for Public Health, Health Care, and Health-Related Investments. AHS has obtained federal Medicaid matching funds for 66 programs focused on public health, health care, and health-related investments in Vermont.[xlix] These programs serve a combination of Medicaid members and other Vermonters and may be delivered by non-traditional Medicaid providers. Many of the most recently approved investments focus on HCBS services and will collectively help the state strengthen care for individuals with disabilities and avoid facility-based care.[l] The goals of these investments fall into five categories:

1. Reduce the rate of uninsured and/or underinsured in Vermont;
2. Increase the access to quality health care by low-income, uninsured, underinsured individuals and Medicaid beneficiaries in Vermont;
3. Provide public health approaches, investments in social determinants of health, and other innovative programs that benefit low-income, uninsured, underinsured individuals and Medicaid beneficiaries in Vermont;
4. Implement initiatives to increase transformation to value-based and integrated models of care; and
5. Provide home and community-based services and supports necessary to increase community living for individuals in Vermont at risk of needing facility-based care.

Premiums and Cost Sharing. Premiums for populations 1, 2, and 3, comply with Medicaid statutory requirements. The state charges premiums for children through age 18 with income above 195% FPL and below 312% FPL and for dually enrolled Medicare beneficiaries participating in the VPharm program.

Opioid Use Disorder and Substance Use Disorder

The Demonstration has a strong focus on providing and expanding OUD/SUD services across the continuum of care, as evidenced by the state's SUD implementation plan. The SUD implementation plan was initially approved on July 1, 2018, and remains in effect throughout the current Demonstration renewal period. Since CMS approved the implementation plan, Vermont can receive federal financial participation (FFP) to access OUD/SUD benefits for Medicaid recipients residing in residential and inpatient facilities that qualify as IMDs. The implementation plan has several components (**Exhibit 1**). The goals of Vermont's SUD Demonstration are to:[li]

1. Increase rates of identification, initiation, and engagement in treatment.
2. Increase adherence to and retention in treatment.
3. Reductions in overdose deaths, particularly those due to opioids.
4. Reduce 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.

5. Reduce readmissions to the same or higher level of care where readmission is preventable or medically inappropriate.
6. Improve access to care for physical health conditions among beneficiaries.

These goals reflect the components of the SUD implementation plan.[lii] These components will guide the topics on which the state will report.

Exhibit 1. SUD Implementation Plan Components

SUD Implementation Plan Component	Description
Access to critical levels of care for OUD and other SUDs.	Access to new benefits such as residential treatment and withdrawal management within 12-24 months of OUD/SUD program Demonstration approval.
Use of evidence-based SUD-specific patient placement criteria.	Requirement for providers to assess treatment needs based on SUD-specific multidimensional assessment tools within 12-24 months of OUD/SUD program Demonstration approval.
Patient placement.	Creation of utilization management approach within 12-24 months of OUD/SUD program Demonstration approval that ensures that beneficiaries have access to SUD services at the appropriate level of care.
Use of Nationally Recognized SUD-specific program standards to set provider qualifications for residential treatment facilities.	Establishment of residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements
Standards of care.	Establishment of a provider review process to ensure residential treatment providers deliver care that aligns with nationally recognized SUD program standards, within 12-24 months of SUD program Demonstration approval. Requirement for residential treatment providers to offer medication-assisted treatment (MAT) on-site or facilitate MAT access off-site, within 12-24 months of SUD program Demonstration approval.
Sufficient provider capacity at each level of care, including MAT for OUD.	Assessment of the available providers throughout the state, including those who offer MAT, within 12 months of SUD program Demonstration approval.
Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.	Implementation of opioid prescribing guidelines, and other interventions to prevent prescription drug abuse, improve access to naloxone, and improve existing prescription drug monitoring programs.
SUD health IT plan.	Creation of a plan to ensure sufficient health IT infrastructure at the state, delivery system, and provider levels to advance the implementation plan's goals. The plan will improve the implementation of the state's prescription drug monitoring program.
Improved care coordination and transitions between levels of care.	Creation and implementation of policies within 12-24 months of SUD program Demonstration approval that ensure residential and inpatient

	facilities connect recipients with community-based services and support.

SOURCE: Current CMS Approved Global Commitment to Health Section 1115 Waiver (March 7, 2023).

Serious Mental Illness and Serious Emotional Disturbance

In 2019, CMS approved an amendment for Vermont to receive FFP for inpatient services for Medicaid beneficiaries with SMI and SED staying in an IMD.[liii] In 2019, CMS approved Vermont's SMI/SED implementation plan through 2027 (**Exhibit 2**). The goals of Vermont's SMI and SED Demonstration are to[liv]

1. Reduce utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.
2. Reduce preventable readmissions to acute care hospitals and residential settings.
3. Improve 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 and short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the State.
4. Improve 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.
5. Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

These goals reflect the components of the SMI/SED implementation plan.[lv] These components will guide the topics on which the state will report.

Exhibit 2. SMI/SED Implementation Plan Components

SMI/SED Implementation Plan Component	Description
Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings	• Set and uphold standards for psychiatric hospitals and residential settings through licensure and accreditation, monitoring and oversight processes, and requirements and processes. • Ensure individuals with SMI or SED and co-morbid health conditions and SUD be screened and receive treatment for commonly co-occurring conditions while in a treatment setting.
Improving Care Coordination and Transitioning to Community-Based Care	• Confirm patients have the services needed to transition to and be successful in community-based mental health care. • Create partnerships between hospitals, residential providers, and community-based care providers. • Ensure state Medicaid programs focus on improving care coordination and transitions to community-based care

SMI/SED Implementation Plan Component	Description
Increasing Access to Continuum of Care, Including Crisis Stabilization Services	• Understand the need for access to a continuum of care as mental health disorders can be episodic and symptoms can vary. • Increase the availability of crisis stabilization programs to redirect Medicaid beneficiaries from unnecessary visits to EDs or inpatient facilities. • Establish ongoing treatment in outpatient settings to address less acute symptoms and help beneficiaries with SMI or SED in their communities. • Create strategies to help connect individuals who need inpatient or residential treatment with that level of care as soon as possible.
Earlier Identification and Engagement in Treatment, Including Through Increased Integration	• Establish critical strategies for improving care for individuals with SMI or SED • Create opportunities for earlier identification and treatment for patients with SMI or SED.
Financing Plan	• Create a detailed plan to support treatment in non-hospital and non-residential mental health services, including crisis stabilization and community-based care. • Detail the state's efforts to increase access to community-based mental health providers for Medicaid beneficiaries in Vermont, including through changes to reimbursement and financing policies.
Health IT Plan	• Describe the state's ability to leverage health IT, and advance health information exchanges. • Ensure health IT interoperability to support the Demonstration's goals. • Explain the role of providers to create referral networks and engage with patients and caregivers as early as possible.

SOURCE: Current CMS Approved Global Commitment to Health Section 1115 Waiver (March 7, 2023).

Evaluation Questions & Hypotheses

Driver Diagrams

Over the past 18 years, Vermont has successfully expanded access, improved quality of care, and community integration through the Global Commitment Demonstration. In achieving its outcomes, the Demonstration relies on interrelated drivers of success, through its special programs, expanded eligibility, and expanded accessibility. Driver diagrams in support of the five Demonstration goals are provided in **Exhibits 3-7**.

Exhibit 3. Drivers for Advancing the State Towards Population-Wide Comprehensive Coverage (Goal #1)

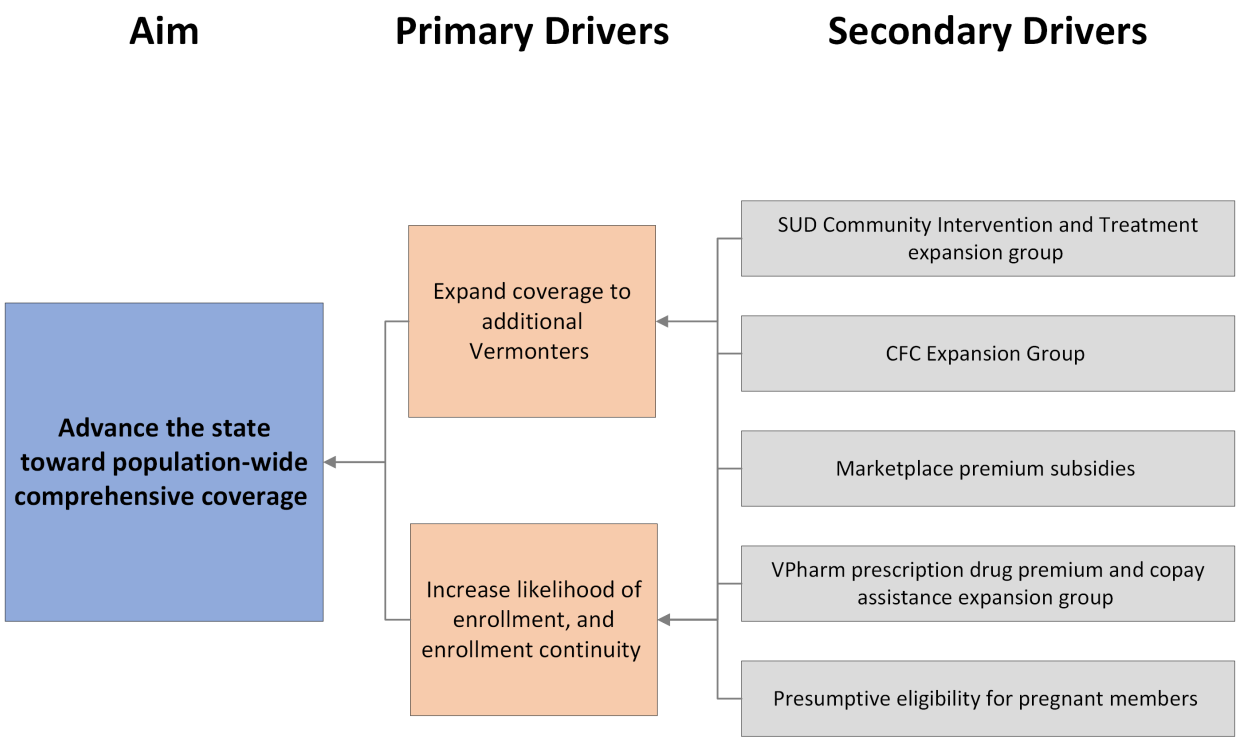


Exhibit 4. Drivers for Implementing Innovative Care Models Across the Continuum that Produce Value (Goal #2)

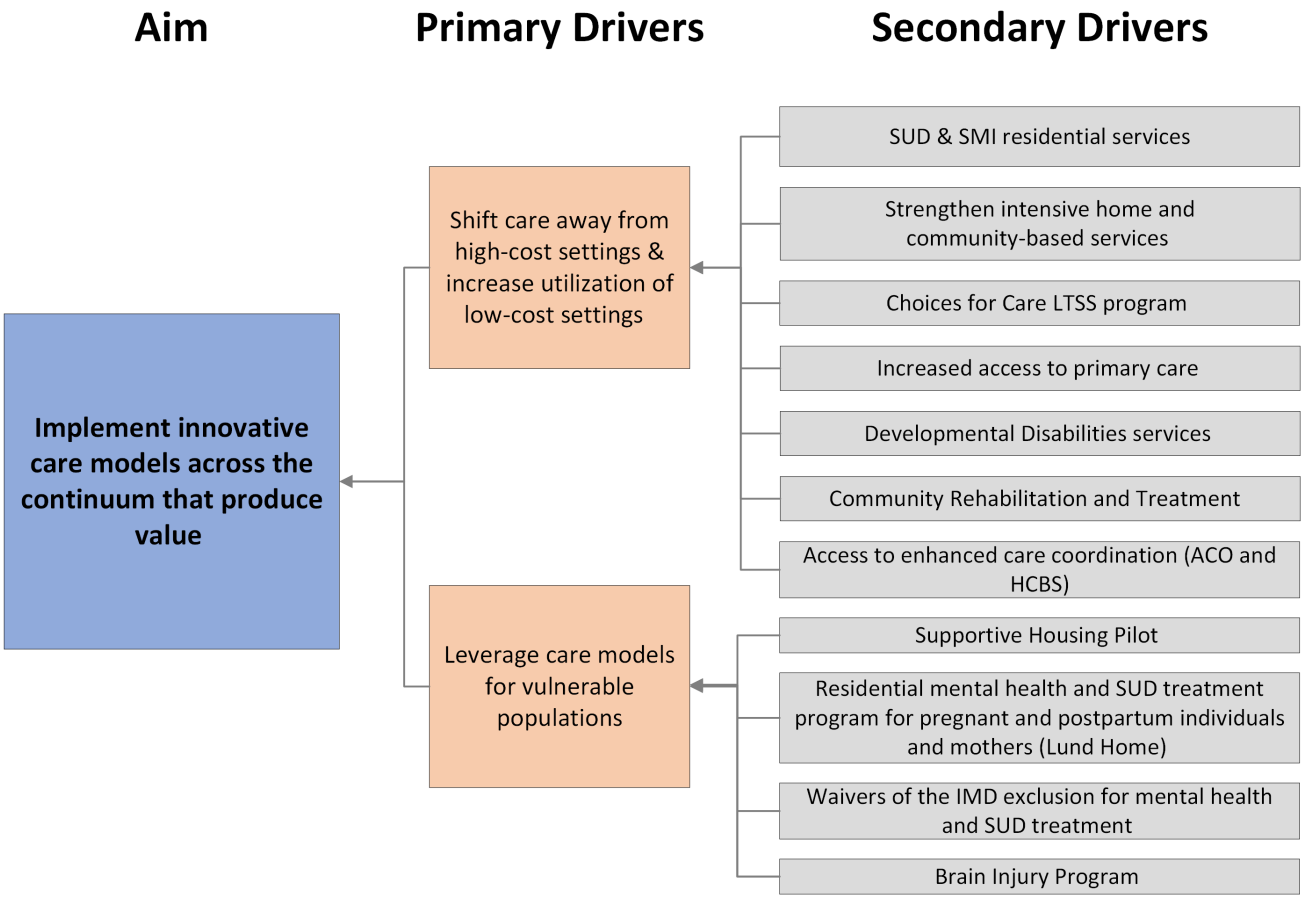


Exhibit 5. Drivers for Engaging Vermonters in Transforming Their Health (Goal #3)

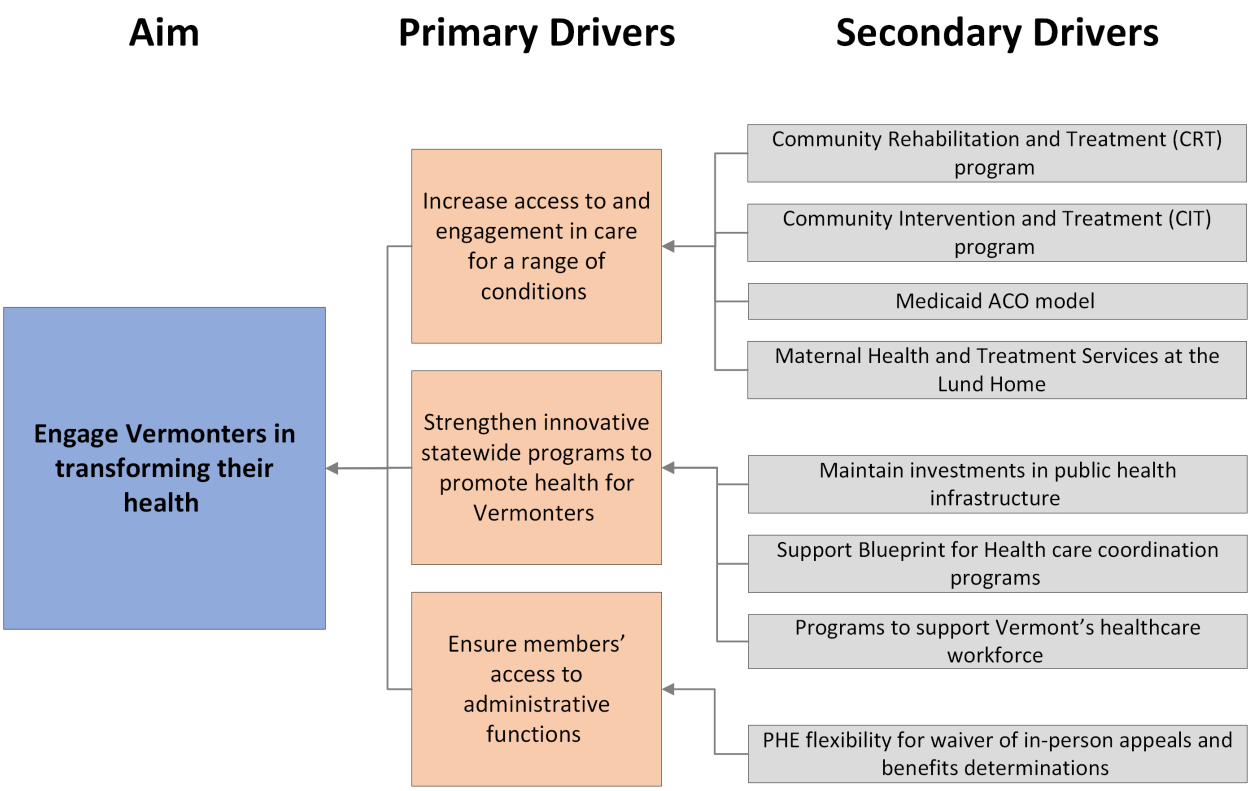


Exhibit 6. Drivers for Strengthening Care Coordination and Population Health Management Capabilities (Goal #4)

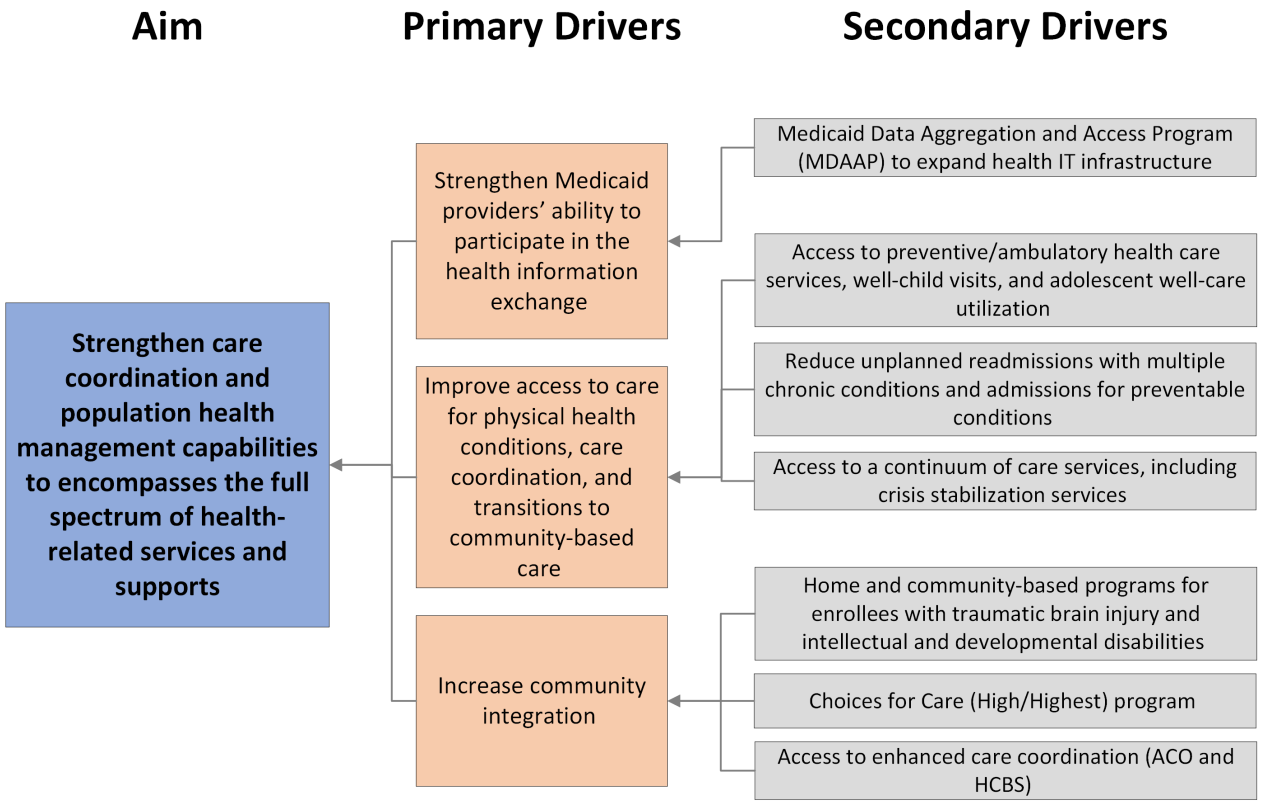
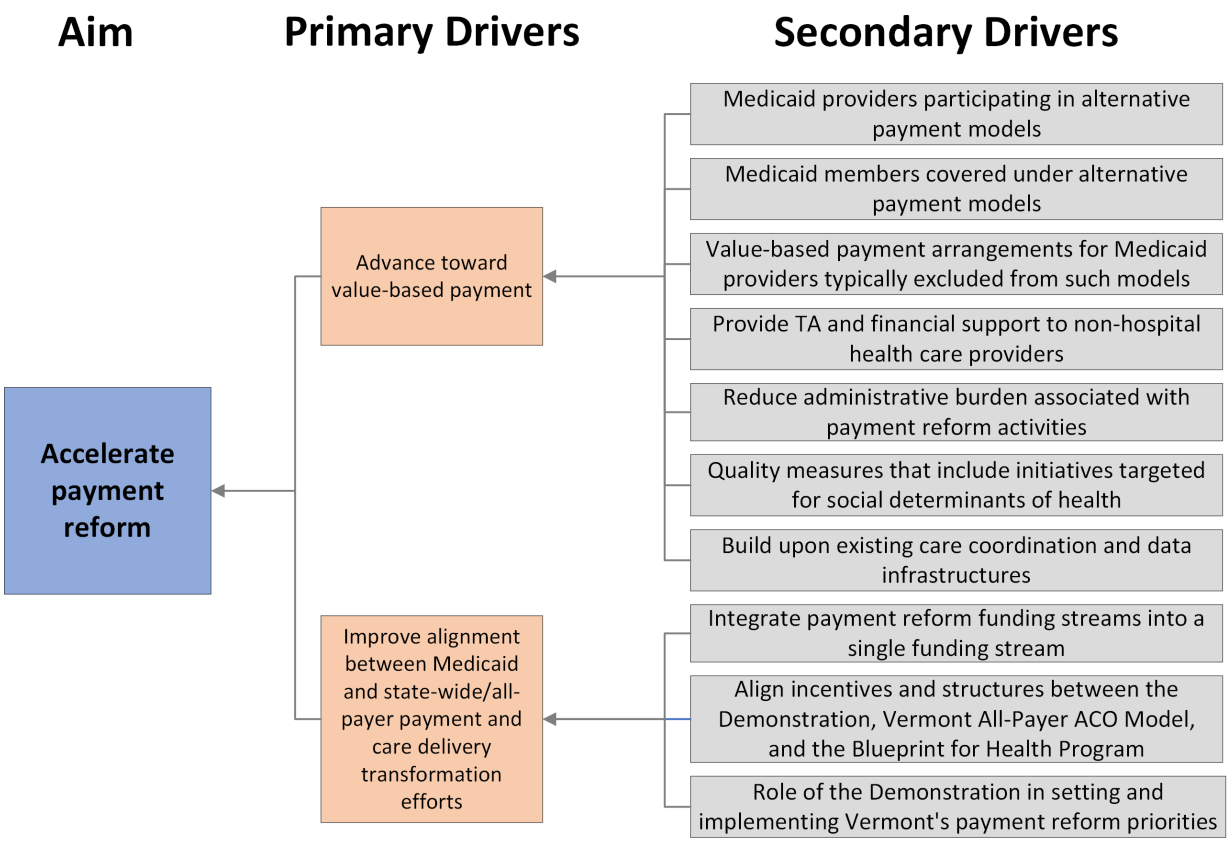


Exhibit 7. Drivers for Accelerating Payment Reform (Goal #5)



Hypotheses & Research Questions

The evaluation will assess the overall impact of the Demonstration by analyzing changes over time and the Demonstration's progress toward its overall goals, while contextualizing changes and progress with the history and background of the Demonstration. **Exhibits 8-10** provide an overview of Demonstration goals and proposed high-level hypotheses for the overall Demonstration, SMI/SED, and SUD components, respectively.

Exhibit 8. Global Commitment Demonstration Goals and Evaluation Hypotheses

Overall Demonstration Goals
GOAL 1: Advance the state toward population-wide comprehensive coverage
• Hypothesis #1: The Demonstration will expand coverage to additional Vermonters. • Hypothesis #2: The Demonstration will increase overall enrollment, likelihood of enrollment, and enrollment continuity. • Hypothesis #3: The Demonstration will contribute to a statewide increase in insurance coverage for Vermonters. • Hypothesis #4: Premium requirements for eligible populations will not reduce access to care. • Hypothesis #5: Waivers of retroactive eligibility for Demonstration Populations 6,7, and 8 will not reduce access to care.
GOAL 2: Implement innovative care models across the continuum that produce value
• Hypothesis #1: The Demonstration will reduce utilization and overall Medicaid spending while maintaining quality of care for VT Medicaid members. • Hypothesis #2: The Demonstration will shift care away from high-cost settings (e.g., the ED), reducing spending while increasing utilization in lower-cost settings.
GOAL 3: Engage Vermonters in transforming their health
• Hypothesis #1: The Demonstration will increase access and engagement in care for a range of conditions. • Hypothesis #2: The Demonstration will support innovative statewide programs and services that promote Vermonters' health. • Hypothesis #3: The Public Health Emergency (PHE) flexibility that grants a waiver of in-person appeals of benefits determinations will not negatively affect members' appeals rights.
GOAL 4: Strengthen care coordination and population health management capabilities to encompass the full spectrum of health-related services and supports
• Hypothesis #1: The Supportive Housing Assistance Pilot will create more stable housing circumstances for members with SUD or SMI/SED. • Hypothesis #2: The MDAAP will strengthen Medicaid providers' ability to participate in the health information exchange. • Hypothesis #3: The Demonstration will improve access to care for physical health conditions, care coordination, and transitions to community-based care. • Hypothesis #4: The Maternal Health and Treatment Services program at Lund will improve SUD and SMI treatment and quality of care outcomes, maternal health outcomes, and family health and well-being.
GOAL 5: Accelerate payment reform
• Hypothesis #1: The Demonstration will continue to stimulate payment reform across the state by advancing toward value-based payment.

Overall Demonstration Goals
• Hypothesis #2: The Demonstration will improve alignment between Medicaid and state-wide/all-payer payment and care delivery transformation efforts.

Exhibit 9. SUD Demonstration Goals and Evaluation Hypotheses

SUD Demonstration Goals
GOAL 1: Increase rates of identification, initiation, and engagement in treatment
• Hypothesis #1: The Demonstration will sustain high rates of identification, of SUD. • Hypothesis #2: The Demonstration will sustain high rates of initiation and engagement in treatment
GOAL 2: Increase adherence to and retention in treatment
• Hypothesis #1: The Demonstration will increase adherence to and retention of treatment
GOAL 3: Reductions in overdose deaths, particularly those due to opioids
• Hypothesis #1: The Demonstration will contribute to a reduction in overdose deaths, particularly those due to opioids
GOAL 4: Reduce 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
• Hypothesis #1: The Demonstration will decrease the rate of emergency department and inpatient visits for members receiving care for SUD
GOAL 5: Reduce readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate
• Hypothesis #1: The Demonstration will reduce readmissions to the same or higher level of care for beneficiaries receiving care for SUD
GOAL 6: Improve access to care for physical health conditions among beneficiaries
• Hypothesis #1: The Demonstration will increase the percentage of beneficiaries with SUD who receive care for chronic conditions

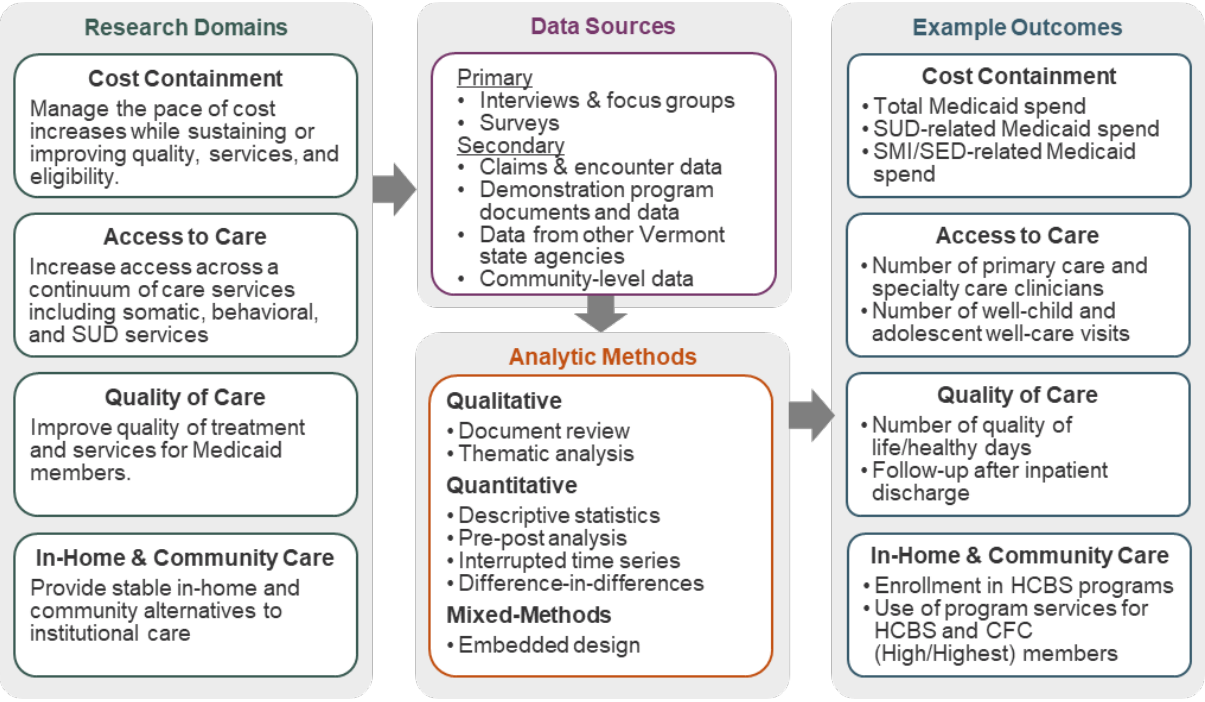
Exhibit 10. SMI/SED Demonstration Goals and Evaluation Hypotheses

SMI/SED Demonstration Goals
GOAL 1: Reduce utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings
• Hypothesis #1: The Demonstration will contribute to reductions in utilization and length of stay in emergency departments for members with SMI/SED.
GOAL 2: Reduce preventable readmissions to acute care hospitals and residential settings
• Hypothesis #1: The Demonstration will contribute to reductions in preventable readmissions to acute care hospitals and residential settings
GOAL 3: Improve 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.
• Hypothesis #1: The Demonstration will contribute to increased availability of crisis stabilization services throughout the state
GOAL 4: Improve 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
• Hypothesis #1: The Demonstration will improve access to community-based services for mental health care needs.
GOAL 5: Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.
• Hypothesis #1: The Demonstration will contribute to better follow-up care after acute episodes in hospitals and residential treatment facilities

Methodology

This evaluation is grounded in an integrated mix of quantitative and qualitative methods. We will assess the overall impact of the waiver by analyzing data on the process, outcomes, and impacts of the Demonstration. The proposed approach reflects the aims that Vermont has identified as priorities for this Demonstration, which in turn will guide the framing of hypotheses and the selection of data sources, measures, analytic approaches, and findings. **Exhibit 11** provides a visual overview of the overall evaluation design.

Exhibit 11. Evaluation Approach for Overall Waiver Impact



NOTE: Example outcomes include only a subset of proposed measures for illustrative purposes.

The evaluation will use a mixed-methods approach to measure change over time and will rely on both primary and secondary data sources to describe populations and findings. Generally, qualitative analysis will be used to provide in-depth insight into specific programs, investments, or events. Quantitative analysis will be used to better understand trends in utilization, quality, and cost that can be generalizable to the larger Medicaid population. **Exhibits 12-14** describe research questions, outcome measures, populations impacted, data sources, and proposed analytics methods that map to each Demonstration goal. Final methods and analytic approaches will be determined following a thorough review of the quality and completeness of existing data.

Exhibit 12. Overall Evaluation Design Table

Research Question	Outcome Measures	Population(s)*	Data Source(s)	Proposed Analytic Methods**
Demonstration Goal 1: Advance the state toward population-wide comprehensive coverage				
Evaluation Hypothesis: The Demonstration will expand coverage to additional Vermonters.				
How many Vermonters gained Medicaid coverage under the Demonstration?	• New Medicaid enrollment, by eligibility category • New Medicaid enrollment under CIT expansion population	Overall waiver; CIT expansion group	Medicaid Management Information System (MMIS)	Descriptive analyses (frequencies)
Evaluation Hypothesis: The Demonstration will increase overall enrollment, likelihood of enrollment, and enrollment continuity.				
What are trends in Medicaid enrollment under the Demonstration?	• Total Medicaid enrollment, by eligibility category • Continuous Medicaid enrollment, by eligibility category • Total CIT expansion population enrollment • Continuous CIT expansion population enrollment	Overall waiver; CIT expansion group	MMIS	Descriptive trend analyses
Evaluation Hypothesis: The Demonstration will contribute to a statewide increase in insurance coverage for Vermonters.				
What are trends in state-wide insurance rates under the Demonstration?	• Statewide insurance coverage	All Vermonters	Vermont Household Insurance Survey (VHIS)	Descriptive trend analyses
Evaluation Hypothesis: Premium requirements for eligible populations will not reduce access to care.				
What is the association between premium requirements and access to care?	• Total Medicaid enrollment • Continuous Medicaid enrollment • Well-child care • Adolescent well-care • Preventive/ambulatory health services	Eligible populations subject to premiums	MMIS	Descriptive analyses
Evaluation Hypothesis: Waivers of retroactive eligibility for Demonstration Populations 6, 7, and 8 will not reduce access to care.				

Research Question	Outcome Measures	Population(s)*	Data Source(s)	Proposed Analytic Methods**
What is the association between waiving retroactive eligibility for Demonstration Populations 6,7, and 8 and Medicaid enrollment?	• Medicaid enrollment • Continuous Medicaid enrollment	Demonstration Populations 6, 7, and 8	MMIS	Descriptive trend analyses
Demonstration Goal 2: Implement innovative care models across the continuum that produce value				
Evaluation Hypothesis: The Demonstration will reduce Medicaid spending while maintaining quality of care for VT Medicaid members.				
What are trends in member per month Medicaid spending under the Demonstration?	• Total Medicaid spending • SUD-related Medicaid spending • SMI/SED-related Medicaid spending	Overall waiver; SMI/SED; SUD; CIT; HCBS; maternal health; non-specialized program participants	MMIS	Pre-post analyses *(Paired t-tests; chi-squared tests*); interrupted time-series
What are trends in utilization and quality of preventive care?	• Well-child care • Adolescent well-care	Overall waiver; SMI/SED; SUD; HCBS; maternal health; non-specialized program participants	MMIS; interviews with providers and provider organizations	Pre-post analyses *(Paired t-tests; chi-squared tests*); interrupted time-series*; Qualitative analysis to inform interpretation of quantitative findings
Evaluation Hypothesis: The Demonstration will shift care away from high-cost settings (e.g., the ED) while increasing utilization in lower-cost settings				
What are trends in utilization of high-cost services?	• Hospitalizations • All-cause readmissions • Ambulatory Care ED visits	Overall waiver; SMI/SED; SUD HCBS; maternal health; non-specialized program participants	MMIS; interviews with providers and provider organizations	Pre-post analyses (*Paired t-tests; chi-squared tests)*; interrupted time-series*; CITS analyses*; Qualitative analysis to inform interpretation of quantitative findings
What are trends in utilization of services in lower-cost settings?	• Primary care utilization	Overall waiver; SMI/SED; SUD HCBS; maternal health; non-specialized program participants	MMIS; interviews with providers and provider organizations	Pre-post analyses (*Paired t-tests; chi-squared tests)*; interrupted time-series; CITS analyses**; Qualitative analysis to inform interpretation of quantitative findings
Demonstration Goal 3: Engage Vermonters in transforming their health				

Research Question	Outcome Measures	Population(s)*	Data Source(s)	Proposed Analytic Methods**
Evaluation Hypothesis: The Demonstration will increase access and engagement in care for a range of conditions				
How many members is the Demonstration reaching in programs designed to engage them in care?	• Demonstration program enrollment (e.g., CRT program, CIT program, Medicaid ACO, Maternal Health and Treatment Services program)	Overall waiver; SMI/SED; SUD HCBS; maternal health; non-specialized program participants	MMIS; program documents and data	Descriptive analyses
Is the Demonstration reaching members with in lieu of services (ILOS)?	• Types of ILOS covered under Demonstration • Use of ILOS among Medicaid members	Overall waiver; non-specialized program participants	MMIS; program documents and data	Descriptive analyses
Are ILOS associated with total Medicaid spending and key utilization?	• Total Medicaid spending • Ambulatory Care ED visits	ILOS recipients	MMIS; program documents and data	Pre-post analyses *(Paired t-tests; chi-squared tests)*; interrupted time-series; CITS analyses*; Qualitative analysis to inform interpretation of quantitative findings
*Evaluation Hypothesis: The Demonstration will support innovative statewide programs and services that promote Vermonters' health. ******				
Have Demonstration-funded investments contributed to increasing access to key groups of Vermonters? *(Category 2)*	• Statewide insurance coverage • Preventive/ambulatory health services • Self-reported delays in care due to cost • Number of primary care and specialty care clinicians in Vermont • Travel time and distance to providers	All Vermonters; overall waiver; investment program participants (as appropriate)	MMIS; NHIS; AHRF; DVHA Access to Care Plans; program documents and data	Descriptive analyses; pre-post analyses *(Paired t-tests; chi-squared tests)*
Have Demonstration-funded investments provided public health approaches, investments in social determinants of health,	• Drug overdose deaths in Vermont residents • Quality of life/healthy days • Depressive disorder prevalence	All Vermonters; investment program participants (as appropriate)	Program data and documents; Vermont Adult Tobacco Survey	Descriptive analyses; pre-post analyses (*Paired t-tests; chi-squared tests)*

Research Question	Outcome Measures	Population(s)*	Data Source(s)	Proposed Analytic Methods**
and other innovative programs to key groups of Vermonters? *(Category 3)*	• Tobacco use			
Have Demonstration-funded investments contributed to increased transformation to value-based and integrated care models? *(Category 4)*	• Number of Vermonters receiving services under value-based and integrated care models • Number of investments increasing spread and/or reach of value-based and integrated care models	All Vermonters; overall waiver; investment program participants (as appropriate)	Program data and documents; MMIS	Descriptive analyses; pre-post analyses (*Paired t-tests; chi-squared tests)*
Have Demonstration-funded investments provided HCBS services for community living to Vermonters at risk of needing facility-based care? *(Category 5)*	• Number of investments providing HCBS services for community living • Enrollment in HCBS programs • Use of program services for HCBS and CFC (High/Highest) members	All Vermonters; overall waiver; investment program participants (as appropriate)	Program data and documents; MMIS	Descriptive analyses; pre-post analyses (*Paired t-tests; chi-squared tests)*
Evaluation Hypothesis: The PHE flexibility that grants a waiver of in-person appeals of benefits determinations will not negatively affect members' appeals rights.				
What are trends in the number of grievances/appeals filed before and during the PHE?	• Number of grievances/appeals filed	Overall waiver	Demonstration documents and data	Descriptive analyses; pre-post analyses (*Paired t-tests; chi-squared tests)*
Demonstration Goal 4: Strengthen care coordination and population health management capabilities to encompass the full spectrum of health-related services and supports				
Evaluation Hypothesis: The Supportive Housing Assistance Pilot will create more stable housing circumstances and better health outcomes for members with SUD or SMI/SED.				

Research Question	Outcome Measures	Population(s)*	Data Source(s)	Proposed Analytic Methods**
How many Medicaid members receive housing supports under the Supportive Housing Assistance Pilot?	• Supportive Housing Assistance Pilot service utilization • Supportive Housing Assistance Pilot waiting list length	Medicaid members in the Supportive Housing Assistance Pilot	Pilot program documents and data	Descriptive analyses
What are the characteristics of housing services providers participating in the Supportive Housing Assistance Program?	• Supportive Housing Assistance Pilot provider engagement	Housing services providers in the Supportive Housing Assistance Pilot	Pilot program documents and data	Descriptive analyses
What are trends in ED visits among members participating in the Supportive Housing Assistance Pilot?	• Ambulatory Care ED visits	Medicaid members in the Supportive Housing Assistance Pilot	MMIS	Descriptive analyses
Evaluation Hypothesis: The MDAAP will strengthen Medicaid providers' ability to participate in the health information exchange.				
What are trends in the number of providers receiving incentive payments?	• Providers receiving MDAAP incentive payments	Providers enrolled in the MDAAP	MDAAP documents and data	Descriptive analyses
What perceived impact did the MDAAP have on providers' HIT capabilities?	• N/A	Providers enrolled in the MDAAP	Interviews with providers and provider organizations	Qualitative analyses
Evaluation Hypothesis: The Demonstration will improve access to care for physical health conditions, care coordination, and transitions to community-based care.				
Has access to preventive/ambulatory health services changed under the Demonstration?	• Preventive/ambulatory health services • Well-child visits • Adolescent well-care visits • Follow-up after inpatient discharge	Overall waiver	MMIS	Pre-post analyses (*Paired t-tests; chi-squared tests)*; interrupted time-series**

Research Question	Outcome Measures	Population(s)*	Data Source(s)	Proposed Analytic Methods**
Have unplanned and preventable complications for individuals with chronic conditions changed under the Demonstration?	• Unplanned admissions for patients with multiple chronic conditions	Overall waiver	MMIS; interviews with providers and provider organizations	Pre-post analyses (*Paired t-tests; chi-squared tests)*; interrupted time-series*; CITS analyses**; qualitative analysis to inform interpretation of quantitative findings
Has access to home and community-based care to members changed after the implementation of the Demonstration?	• Enrollment in HCBS programs • Use of program services for HCBS and CFC (High/Highest) members	HCBS	MMIS	Pre-post analyses (*Paired t-tests; chi-squared tests)*; Descriptive analyses
Has the quality of life for HCBS care changed after the implementation of the Demonstration?	• Admission to a Facility from the Community • Successful discharge from a facility to the community within 100 days of admission	HCBS	MMIS	Pre-post analyses (*Paired t-tests; chi-squared tests)*; Descriptive analyses
Has experience of care for HCBS recipients changed after the implementation of the Demonstration??	• Choosing the services that matter to you compositive measure • Unmet needs composite measure	HCBS	CAHPS	Pre-post analyses (*Paired t-tests; chi-squared tests)*; Descriptive analyses
Evaluation Hypothesis: The Maternal Health and Treatment Services program will improve SUD and SMI treatment and quality of care outcomes, maternal health outcomes, and family health and well-being.				
What are the trends for residents' quality of care outcomes for SUD and SMI?	• Initiation, engagement, and retention in SUD or SMI treatment	Lund residents participating in the Maternal Health and Treatment Services program	Demonstration documents and data; interviews with providers and provider organizations	Descriptive analyses (*Paired t-tests; chi-squared tests)*; qualitative analysis to inform interpretation of quantitative findings
Does the Maternal Health and Treatment Services program improve maternal health outcomes?	• Prenatal visits • Postnatal visits • Severe maternal morbidity	Lund residents participating in the Maternal Health and Treatment Services program	MMIS; program documents and data	Descriptive analyses

Research Question	Outcome Measures	Population(s)*	Data Source(s)	Proposed Analytic Methods**
Does the Maternal Health and Treatment Services program improve family health and well-being for participants?	• Participation in Lund services • Child custody rates • Foster care placement • Psychosocial outcomes	Lund residents participating in the Maternal Health and Treatment Services program	MMIS; program documents and data	Descriptive analyses; Pre-post analyses (*Chi-squared tests; Paired t-tests*)
Demonstration Goal 5: Accelerate payment reform				
Evaluation Hypothesis: The Demonstration will continue to stimulate payment reform across the state by advancing towards value-based payment.				
How has total Medicaid per member spending changed over the course of the Demonstration?	• Total Medicaid spending	Overall waiver	MMIS	Interrupted time-series; CITS analyses**
How many Medicaid members are enrolled or covered under alternative payment models?	• Member enrollment in alternative payment models	Overall waiver	Program documents and data (e.g., DVHA Performance Accountability Scorecard)	Descriptive analyses
What are trends in provider participation in alternative payment models?	• Provider enrollment in alternative payment models	All Medicaid providers	Program documents and data	Descriptive analyses
What perceived impact has the Demonstration had on payment reform across the state?	• Qualitative data	N/A	Document review; interviews with state officials, providers, and provider organizations	Qualitative analysis
Evaluation Hypothesis: The Demonstration will improve alignment between Medicaid and state-wide/all-payer payment and care delivery transformation efforts.				
How has the Demonstration sought to align payment reform efforts with new and existing state-wide and all-payer reforms?	• Qualitative data	N/A	Document review; interviews with state officials, providers, and provider organizations	Qualitative analysis

Research Question	Outcome Measures	Population(s)*	Data Source(s)	Proposed Analytic Methods**
What perceived role does the Demonstration play in setting or implementing payment reform priorities in the state? How has this changed over time?	• Qualitative data	N/A	Document review; interviews with state officials, providers, and provider organizations	Qualitative analysis

*See “Evaluation Populations” below for more information.

** For each population/outcome, we will carry out the most rigorous analysis feasible based on evaluability assessments. Statistical testing will not be conducted for descriptive frequency or descriptive trend analyses. Where baseline data are available, we will consider pre-post analyses and conduct chi-square tests or paired t-tests, as appropriate. Where a comparison group is also available, we will apply DiD and/or CITS models to test for the significance of program impacts. —

*** We anticipate a wide variation in program goals, relevant outcomes, and data availability across the innovative investments. This table lists some broad example questions and outcome measures that may be considered across assessments; we will tailor specific questions and measures to each assessment based on program goals and the availability of interviewees and data elements.

Exhibit 13. SUD Evaluation Design Table

Research Question	Outcome Measures	Population(s)*	Data Source(s)	Analytic Methods**
SUD Goal 1: Increased rates of identification, initiation, and engagement in treatment				
Evaluation Hypothesis: The Demonstration will increase rates of identification of members with an SUD diagnosis				
What are trends in the number of members diagnosed with SUD?	• Members with an SUD diagnosis	Medicaid adult and adolescent members	MMIS	Descriptive analyses
Evaluation Hypothesis: The Demonstration will sustain high rates of initiation and engagement in treatment				
How has use of medication for opioid use disorder (MOUD) changed in Vermont?	• Any SUD treatment • Members receiving MOUD	SUD	MMIS	Descriptive analyses; Pre-post analyses (*Chi-squared tests; Paired t-tests*)
What are trends in initiation and engagement of treatment after a diagnosis of Alcohol and Other Drug Abuse or Dependence (AOD)?	• Initiation in AOD treatment • Engagement in AOD treatment	SUD	MMIS	Descriptive analyses; Pre-post analyses (*Chi-squared tests; Paired t-tests*)
What are trends in the delivery of SUD-related services for members?	• Members treated in an IMD for SUD • Members receiving SUD services in outpatient, ED, and inpatient settings for SUD • Use of evidence-based, SUD-specific patient placement criteria among providers	SUD	MMIS; MPA provider survey	Descriptive analyses; Pre-post analyses (*Chi-squared tests; Paired t-tests*)
SUD Goal 2: Increase adherence to and retention in treatment				
Evaluation Hypothesis: The Demonstration will increase adherence to and retention in treatment				
What are trends in use of pharmacotherapy and health services for SUD?	• Continuity of pharmacotherapy for OUD • Any SUD treatment	SUD	MMIS	Descriptive analyses; Pre-post analyses (*Chi-squared tests; Paired t-tests*)
How has appropriate follow-up care for high-intensity AOD/SUD treatment changed?	• Follow-up after ED visit for AOD abuse or dependence	SUD	MMIS	Descriptive analyses; Pre-post analyses (*Chi-squared tests; Paired t-tests*)
SUD Goal 3: Reductions in overdose deaths, particularly those due to opioids				

Research Question	Outcome Measures	Population(s)*	Data Source(s)	Analytic Methods**
Evaluation Hypothesis: The Demonstration will contribute to a reduction in overdose deaths, particularly those due to opioids				
Have high-risk opioid prescriptions declined?	• Use of opioids at high dosages in persons without cancer • Concurrent use of opioids and benzodiazepines	Overall waiver	MMIS	Descriptive analyses; Pre-post analyses (*Chi-squared tests; Paired t-tests*)
What are trends in drug overdose deaths among Vermont Medicaid members?	• Drug overdose deaths among Medicaid members • Opioid-related overdose deaths among Medicaid members	Overall waiver	MMIS; vital statistics data	Descriptive analyses
What are trends in drug overdose deaths in Vermont overall?	• Drug overdose deaths in Vermont residents • Opioid-related overdose deaths in Vermont residents • Overdose deaths with gabapentin	Adult and adolescent Vermonters	VDH data and reports; vital statistics data	Descriptive analyses
SUD Goal 4: 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				
Evaluation Hypothesis: The Demonstration will decrease the rate of emergency department and inpatient visits for members receiving care for SUD				
What are trends in ED visits and inpatient admissions for SUD/OUD diagnoses?	• ED utilization for SUD • ED utilization for OUD • Inpatient stays for SUD • Inpatient stays for OUD	SUD	MMIS	Descriptive analyses; Pre-post analyses (*Chi-squared tests; Paired t-tests*)
What approaches did providers take to improve care coordination?	• Qualitative data	N/A	Interviews with providers and provider organizations	Qualitative analysis
SUD Goal 5: Reduced readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate				
Evaluation Hypothesis: The Demonstration will reduce readmissions to the same or higher level of care for beneficiaries receiving care for SUD				
Has the rate of 30-day readmissions after discharge for SUD care declined?	• All-cause readmissions after discharge for SUD care • SUD-related readmissions after discharge for SUD care	SUD	MMIS	Descriptive analyses; Pre-post analyses (*Chi-squared tests; Paired t-tests*)
SUD Goal 6: Improved access to care for physical health conditions among beneficiaries				
Evaluation Hypothesis: The Demonstration will increase the percentage of beneficiaries with SUD who receive care for chronic conditions				

Research Question	Outcome Measures	Population(s)*	Data Source(s)	Analytic Methods**
What are trends in use and quality of preventive services among members with SUD/AOD?	• Access to preventive/ambulatory health services for members with SUD Ambulatory Care ED visits for members with SUD	SUD	MMIS	Descriptive analyses; Pre-post analyses (*Chi-squared tests; Paired t-tests*)
Have rates of screening increased among members with SUD/AOD?	• Breast cancer screening • Colorectal cancer screening	SUD	MMIS	Descriptive analyses; Pre-post analyses (*Chi-squared tests; Paired t-tests*)

*See “Evaluation Populations” below for more information.

** For each population/outcome, we will carry out the most rigorous analysis feasible based on evaluability assessments. Statistical testing will not be conducted for descriptive frequency or descriptive trend analyses. Where baseline data are available, we will consider pre-post analyses and conduct chi-square tests or paired t-tests, as appropriate. Where a comparison group is also available, we will apply DiD and/or CITS models to test for significance of program impacts. —

Exhibit 14. SMI/SED Evaluation Design Table

Research Question	Outcome Measures	Population(s)*	Data Source(s)	Analytic Methods**
SMI/SED Goal 1: Reduce utilization and lengths of stay in emergency departments among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings				
Evaluation Hypothesis: The Demonstration will contribute to reductions in utilization and length of stay in emergency departments for members with SMI/SED.				
What are trends in overall ED visits among members with SMI/SED?	• All-cause Emergency department utilization rate for Medicaid beneficiaries who may benefit from integrated physical and behavioral health care (PMH-20)	SMI/SED	MMIS	Descriptive analyses; Pre-post analyses (*Chi-squared tests; Paired t-tests*)
What are trends in use of ED for mental health services?	• Mental health services utilization - ED	SMI/SED	MMIS	Descriptive analyses; Pre-post analyses (*Chi-squared tests; Paired t-tests*)
How has length of ED visits/observation stays changed among members with SMI/SED?	• Length of all-cause Emergency department visits for Medicaid beneficiaries who may benefit from integrated physical and behavioral health care	SMI/SED	MMIS	Descriptive analyses; Pre-post analyses (*Chi-squared tests; Paired t-tests*)
What perceived impact did the Demonstration have on utilization and length of stay in ED among members with SMI/SED?	• N/A	N/A	MPA provider survey; interviews with providers and provider organizations	Survey analysis; Qualitative analysis
SMI/SED Goal 2: Reduce preventable readmissions to acute care hospitals and residential settings				
Evaluation Hypothesis: The Demonstration will contribute to reductions in preventable readmissions to acute care hospitals and residential settings				
Has there been a decline in the rate of all-cause 30-day unplanned readmissions following psychiatric hospitalizations?	• 30-day all-cause unplanned readmissions following psychiatric hospitalization in an Inpatient Psychiatric Facility (IPF)	SMI/SED	MMIS	Descriptive analyses; pre-post analyses (*Chi-squared tests; Paired t-tests*)
SMI/SED Goal 3: Improve 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.				

Research Question	Outcome Measures	Population(s)*	Data Source(s)	Analytic Methods**
Evaluation Hypothesis: The Demonstration will contribute to increased availability of crisis stabilization services throughout the state				
Has the availability of crisis stabilization services increased in Vermont?	• Number of community crisis resources • Mental health facilities offering 24-hour residential or hospital inpatient treatment • Hospitals with psychiatric child/adolescent services or geriatric services	Vermont community and health care services	Demonstration program documents and data; Area Health Resources Files	Descriptive analyses; pre-post analyses (*Chi-squared tests; Paired t-tests*)
SMI/SED Goal 4: Improve 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				
Evaluation Hypothesis: The Demonstration will improve access to community-based services for mental health care needs.				
What are trends in the rate of use of community-based services among Medicaid members with SMI/SED?	• Mental health utilization – Outpatient • Mental health utilization – Telehealth • Access to preventive/ambulatory health services for Medicaid beneficiaries with SMI • Alcohol screening and follow-up for people with SMI	SMI/SED	MMIS	Descriptive analyses; pre-post analyses (*Chi-squared tests; Paired t-tests*)*
What are trends in screening for depression?	• Screening for depression: age 18 and older • Screening for depression: age 12-17	Medicaid population age 12+	MMIS	Descriptive analyses; pre-post analyses (*Chi-squared tests; Paired t-tests*)
What are trends in follow-up care following new antipsychotic medication prescriptions?	• Follow-up care for adult Medicaid beneficiaries who are newly prescribed an antipsychotic medication	SMI/SED	MMIS	Descriptive analyses; pre-post analyses (*Chi-squared tests; Paired t-tests*)
Has there been an increase in the availability of outpatient mental health providers?	• Availability of outpatient mental health professionals	Vermont health care providers	Area Health Resources Files	Descriptive analyses
SMI/SED Goal 5: Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.				

Research Question	Outcome Measures	Population(s)*	Data Source(s)	Analytic Methods**
Evaluation Hypothesis: The Demonstration will contribute to better follow-up care after acute episodes in hospitals and residential treatment facilities				
How has follow-up care following acute episodes for mental health treatment in hospital and residential facilities changed?	• Follow-up after hospitalization for mental illness (FUH-AD) • Follow-up after emergency department visit for mental illness (FUM-AD) • Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH) • Follow-up after emergency department visit for mental illness: Ages 6-17 (FUM-AD) • Medication continuation following inpatient psychiatric discharge	SMI/SED	MMIS	Descriptive analyses; pre-post analyses (*Chi-squared tests; Paired t-tests*)
How have outcomes following acute episodes for mental health treatment changed?	• Suicide or overdose death within 7 and 30 days of discharge from an inpatient facility or residential treatment for mental health among beneficiaries with SMI or SED	SMI/SED	MMIS	Descriptive analyses; pre-post analyses (*Chi-squared tests; Paired t-tests*)
Has perceived access to the continuum of care for members with SMI/SED increased?	• N/A	N/A	NORC provider survey	Qualitative analysis
What approaches did providers take to improve care coordination?	• N/A	N/A	Interviews with providers and provider organizations	Qualitative analysis

*See “Target and Comparison Populations” subsection below for more information.

** For each population/outcome, we will carry out the most rigorous analysis feasible based on evaluability assessments. Statistical testing will not be conducted for descriptive frequency or descriptive trend analyses. Where baseline data are available, we will consider pre-post analyses and conduct chi-square tests or paired t-tests, as appropriate. Where a comparison group is also available, we will apply DiD and/or CITS models to test for significance of program impacts. —

Public health, health care, and health-related investments. To assess the overarching effects of Vermont's public health, health care, and health-related investments, we will collectively analyze a common set of outcome measures for investments aligned with each investment goal.[1] For further details on the planned evaluation activities for these investments overall, see **Exhibit 12** above. In addition to this aggregate analysis by goal, we will examine the effects of AHS' innovative investment programs individually by conducting brief assessments to measure the impact of changes to specific program operations and services. Of the 66 funded investments, AHS will identify approximately 40 that would benefit from an assessment throughout the evaluation contract.[lvi] **Supplement 3** includes a list of confirmed investments for assessment in 2024. NORC will evaluate eight to ten individual investments each year, for a total of forty investments throughout the full evaluation period. NORC will work with AHS to determine the order of investment assessments to balance state priorities and reduce burden on providers and agencies for data collection and sharing. Ultimately, NORC anticipates including 16 to 20 investments as part of the interim evaluation report, and all forty as part of the summative evaluation report.

For each investment, NORC will conduct evaluability assessments and consider several factors to select an assessment design (see "Methodology" section for more information on evaluability assessments). Based on a review of selected investments, goals, and associated changes since the renewal and the results of a preliminary data review, we will work with AHS to determine the most appropriate analytic approach. The selection of analytic approaches among the quantitative and/or qualitative methods described above will be investment-specific and driven by several considerations:

- **History of investment:** Newer investments that have not been evaluated prior will likely warrant a mixed-methods approach to provide implementation context. Qualitative methods will be used to gain a better understanding of investment implementation processes and outcomes, while quantitative methods will be used to describe investment participation and outcomes for which data are available. For well-established investments, we will leverage findings from prior evaluations where possible.

- **Size of investment:** Small sample sizes typically do not allow for meaningful analysis or interpretation of quantitative data. Thus, the evaluation of investments with small numbers of participants will rely primarily on qualitative methods and descriptive statistics.

- **Data availability and quality:** Lack of data availability or poor data quality (e.g., high degree of missingness or errors) precludes the ability to conduct meaningful quantitative analysis. Thus, we will draw more heavily on qualitative research methods to evaluate investments with limited or low-quality quantitative data.

[1] Reduce the rate of uninsured and/or underinsured in Vermont; Increase the access to quality health care by low income, uninsured, underinsured individuals and Medicaid beneficiaries in Vermont; Provide public health approaches, investments in social determinants of health, and other innovative programs that benefit low-income, uninsured, underinsured individuals and Medicaid beneficiaries in Vermont; Implement initiatives to increase transformation to value-based and integrated models of care; and Provide home and community based services and supports necessary to increase community living for individuals in Vermont at risk of needing facility-based care.

- **Availability of comparison group:** For investments for which we can identify individuals who can serve as an appropriate comparison group to investment participants, we can consider more rigorous quasi-experimental methods (e.g., DiD and CITS).

- **Unanticipated quantitative results:** We will use qualitative methods to better understand the drivers of unanticipated investment performance reflected in quantitative data, including both positive outcomes, as well as unexpected outcomes (e.g., low participation, low rates of service utilization).

Where appropriate, we will use causal research methods to identify a link between program changes and outcomes when possible, recognizing that in some cases only descriptive quantitative and/or qualitative analyses may be possible due to data availability, small sample size, and/or program design.

Once AHS and NORC have selected eight to ten investments to be evaluated each year, NORC will meet with investment teams to inform their assessment design, timeline of data collection, and analytic activities. Our approach will be designed to reduce burden, where possible, on investment staff, frontline providers, and service organizations. The specific research questions will be tailored to each investment, depending on where they are in implementation and the availability of data. For all assessments, we will begin with a common set of high-level research questions. Example research questions include: 1) What implementation facilitators and/or barriers did investment personnel encounter? and 2) What are trends in healthcare utilization for investment participants? The final set of research questions for each assessment will be informed by investment design, goals, and data availability. We will develop specific research questions, hypotheses, and/or domains of inquiry that will inform each investment assessment.

Example quantitative measures and qualitative discussion topics are presented in **Exhibit 15**. Different measures will be available and relevant for different investments. For example, the use of MMIS-based outcomes necessitates participant linkage to or flags in the MMIS data. Outcomes may also be informed by data that are actively monitored and collected by investment personnel. NORC will work with each investment's personnel to determine the set of quantitative measures to be used in the assessments. Qualitative discussion topics will be tailored to each investment assessment and will be informed by tailored research questions, relevant investment documents, and data.

Exhibit 15. Example Quantitative and Qualitative Measures by Domain

Domain	Example quantitative measures**	Example qualitative discussion topics
Investment/innovation		• Description of investment • Evolution of investment • Innovation
Implementation	• Cost of investment implementation • Number of personnel FTEs required to implement the investment	• Program design and associated implementation approach • Changes to design/approach

		• Context and relationship to other programs/models • Settings where program is implemented • Perceptions of impact of investment activities • Implementation successes and challenges
Participation	• Number of participants receiving direct support through the investment. • Number of participants on waitlist to receive direct support. • Number of participants actively engaged and receiving services. • Number and types of participating providers.	• Participant outreach/recruitment successes and challenges • Provider/program staff outreach, recruitment, and retention successes and challenges
Outcomes	• ED utilization* • ED utilization for SUD and SMI/SED* • Hospitalizations* • Unplanned admissions* • Primary care, preventive care, and ambulatory care utilization* • Medicaid cost of care* • Incarceration recidivism rate • Foster care placement rate • Use of appropriate prenatal and postnatal services • Other relevant outcome data collected by the investments	• Perceived impact of the investment to meet Demonstration goals • Perceived implementation success • Personnel and providers' experience and satisfaction with the investment • Any unmet needs of participants that the investment can consider addressing

* Measure will be constructed using Medicaid claims data (MMIS), if available.

**This exhibit is not a comprehensive list of assessment measures, and not all measures in this exhibit will be used for each assessment. For each investment assessment analytic plan, we will select appropriate measures based on the results of the evaluability assessment.

Assessments will take place on a rapid cycle basis and will involve shorter data collection and analyses cycles and leverage timely data to measure the impact of specific investment operations and services. This rapid cycle methodology aims to help the state generate evidence and assess progress towards goals adaptively and efficiently. Findings from each assessment will be presented in a brief investment report. Reports will be submitted in the order in which they are completed over the course of the year. Findings from these assessments will also be incorporated into the Interim and Summative Evaluation

results. Details on the investments to be evaluated in the first round of assessments are listed in **Supplement 3**.

SMI/SED Mid-Point Assessment. As part of the evaluation, the study team will examine progress towards SMI/SED milestones, including facilitators and barriers, and assess risk in achieving those milestones. The mid-point assessment will also include an examination of whether the state is on track to meet budget neutrality requirements. This mid-point assessment will be delivered to CMS on June 30, 2024, and the final version will be submitted to CMS within 60 days of receiving comments on the draft version. For the assessment, we will use a mixed-methods approach involving both primary and secondary data sources.

NORC will work closely with AHS to finalize the types of data used to address each milestone in the planning stages for this deliverable. We plan to use four main data sources to address the State's progress on the milestones:

- **Document review.** For all milestones, we will first conduct a thorough review of all relevant documentation, including the SMI/SED Implementation Plan, progress reports, and other internal and public documentation produced by AHS and other State agencies.
- **Claims-based metrics.** We will use data from the SMI/SED quarterly and annual monitoring reports to track progress on milestones between the baseline and the time of the Mid-Point Assessment.
- **Key informant interviews.** To better understand the status and progress of the State's SMI/SED activities, we will conduct targeted key informant interviews with groups implementing or impacted by programs, including SMI/SED providers, and AHS and State leadership. We will work closely with AHS to determine the best perspectives and contacts for the interviews. To ensure efficiency, our interview questions will target milestones for which there are no or few claims-based metrics, as well as any follow-up questions from survey responses. To reduce respondent burden, we will align and coordinate the interviews with any interviews needed to address evaluation hypotheses relevant to the overall waiver evaluation.
- **Provider survey.** We will conduct a brief provider survey to better understand the SMI/SED provider's perspectives to address milestone 2: improving care coordination and transitioning to community-based care and milestone 3: increasing access to continuum of care, including crisis stabilization services. We will prioritize keeping the survey short to reduce burden and will include both multiple-choice questions and open-ended questions to capture the provider experience more fully.

More information on data sources can be found in the "Quantitative Data Sources" and "Qualitative Data Sources" subsections.

SUD Mid-Point Assessment. We will submit the draft SUD mid-point assessment to CMS by June 30, 2025, and submit the final version to CMS within 60 days of receiving comments on the draft version.

This assessment will identify progress and successes, as well as potential risks and limitations, to the SUD implementation plan. we will work alongside SUD treatment providers, beneficiaries, and other key partners to analyze primary and secondary data sources using a mixed-methods approach.

We will use four main data sources to address the State's progress on the milestones:

- **Document review.** We will conduct a thorough review of all relevant documentation, including the SUD Implementation Plan, progress reports, and other internal and public documentation produced by AHS and other State agencies.
- **Claims-based metrics.** We will use data from the SUD quarterly and annual monitoring reports to track progress on milestones between the baseline and the time of the Mid-Point Assessment.
- **Key informant interviews.** We will conduct targeted key informant interviews with groups implementing or impacted by programs, such as SUD treatment providers, AHS and State leadership, and Medicaid members to better understand the status and progress of the State's SUD activities. Our interview questions will focus on goals with few or no claims-based data and follow-up questions from the survey results. We will coordinate and align these interviews with any required interviews for the overall waiver evaluation to reduce the number of requirements on the respondents.
- **Provider survey.** We will conduct a survey to receive input from providers on components of the SUD implementation relevant to them including the establishment of evidence-based SUD-specific patient placement criteria, the creation of a utilization management approach, and the requirement that residential treatment providers offer MAT on-site.

More information on data sources can be found in the "Quantitative Data Sources" and "Qualitative Data Sources" subsections.

Approach Overview

This evaluation integrates both qualitative and quantitative data, making full use of existing data sources and using streamlined primary data collection to contextualize findings. We will conduct mixed methods analyses for the evaluation, using an integrated approach where qualitative and quantitative analyses inform each other to provide a detailed and nuanced understanding of whether, how, and why waiver programs achieve their overall goals. For example, we will incorporate secondary data into embedded design approaches to better understand the relationship between waiver program implementation and quantitative measures and outcomes.

Evaluation Period

The evaluation period will cover the Demonstration's fourth renewal period of July 2022 through December 2027 (the post-implementation, or performance, period). In the Interim Evaluation Report, our analyses will include all data available up to the time of analysis (likely through CY2025), and in the Summative Evaluation Report, we will be able to evaluate the entire post-implementation period.

For each target population and program, we will assess whether a pre-implementation or baseline period is feasible to include in our analyses. For broad target populations (e.g., the overall Medicaid, SUD, SMI/SED, and HCBS populations) in which we are assessing claims-based measures, we propose a four-year baseline period of pre-implementation data (July 2018 through June 2022). A four-year baseline period will allow for a full year of data before the onset of the COVID-19 pandemic in early 2020 and includes sufficient data to assess pre-implementation trends.

However, we anticipate that constructing a full four-year baseline period will not be feasible for smaller or new initiatives and programs (e.g., the Supportive Housing Assistance Pilot, new benefit groups), and assessments for which we will primarily rely on program documents and data. For each program, we will assess data quality and availability to determine whether baseline data is available and feasible, with the goal of incorporating a two-year baseline period in our evaluation of that program (see "Quantitative Evaluability Assessments" subsection below).

Quantitative Analysis

In keeping with CMS guidance on evaluation design for 1115 waivers, the quantitative analyses for this evaluation will comprise descriptive analyses (e.g., summary statistics) and multivariate analyses to detect impact on key evaluation measures. This approach is designed to identify any patterns across outcomes by service setting or member subgroup and to gain insights from contextual data from secondary sources such as program implementation plans or policy documents.

Target and Comparison Populations

Evaluation Populations. Based on Demonstration programs, goals, and research questions, the populations we will analyze for the evaluation include:

- **Overall waiver population:** All Vermont Medicaid and Dr. Dynasaur members.
- **SMI/SED population:** Medicaid members receiving SMI or SED services.
- **SMI/SED IMD population:** Subset of SMI/SED population receiving SMI or SED services in an IMD.
- **SUD population**: Medicaid members receiving SUD services.
- **SUD IMD population:** Subset of SUD population receiving SUD services in an IMD.
- **Community Intervention and Treatment (CIT) eligibility group**: Medicaid members with SUD and low- to moderate-income (between 133 to 225% Federal Poverty Level [FPL]) receiving limited SUD treatment benefits.
- **HCBS population (specialized program participants):** Medicaid members who receive home and community-based services through five specialized HCBS programs (Choices for Care, Brain Injury Program, Mental Health Under 22, Community Rehabilitation and Treatment, and Developmental Disabilities Services).
- **Lund Home participants:** Pregnant and postpartum Medicaid members with SUD and/or SMI receiving maternal health and treatment services in the Lund Home.
- **Premium Assistance**: Medicaid members subject to premiums in Demonstration Population Categories 1 (Mandatory State Populations), 2 (Optional State Populations), 3 (New Adult Group), and 8 (VPharm).
- **Retroactive Eligibility Waiver**: Medicaid members subject to waivers of retroactive eligibility in Demonstration Population Categories 6 (CFC Moderate Needs Expansion Group), 7 (CRT Expansion Group), and 8 (VPharm Group). Medicaid members who enroll in Medicaid based on eligibility for these population categories receive benefits starting on the date of enrollment, and do not receive retroactive benefits for 90 days prior to enrollment as other population groups do.
- **Supportive Housing Assistance Pilot**: Medicaid members receiving services through the new Supportive Housing Assistance Pilot. This is a new program under the Demonstration with an implementation date to be determined. In February 2024, AHS issued a Request for Information to gather information from potential service providers for this pilot.
- **MDAAP participants**: Medicaid providers who participate in the MDAAP to strengthen HIT infrastructure and capabilities. This is a new program under the Demonstration; MDAAP was launched in January 2024 and providers can enroll throughout CY2024. All payments will be made to MDAAP participants by March 31, 2025.
- **Investment program participants:** Medicaid members receiving services through the 66 programs focused on public health, health care, and health-related investments. This population will be assessed as a whole and investment category (e.g., reducing uninsurance, increasing

access, addressing SDOH, increasing value-based and integrated models of care, and supporting community living).

Comparison Populations. Because the entirety of Vermont's Medicaid population is subject to the Demonstration, our assessment of overall Demonstration outcomes will not include an in-state comparison group. Similarly, the SUD and SMI/SED amendments are statewide models, and it will not be possible to identify a comparison group within Vermont. Constructing an out-of-state comparison group using Medicaid enrollees from other states also poses several challenges; because of Vermont's unique population and long history of health reform, it may not be feasible to identify a suitable comparison state with similar demographics and health reform initiatives. Given the resources that would be required to acquire, prepare, and analyze data from other state Medicaid programs, we deemed an out-of-state comparison group infeasible.

To contextualize findings from this evaluation in the absence of a demonstration-wide comparison group, we will compare our results to national Medicaid-specific benchmarks where possible (for example, Adult and Child Core Set measures, Medicaid and CHIP Scorecard data, T-MSIS SUD Data Book findings, meta-evaluations of 1115 demonstrations, HEDIS and CAHPS data).

Where possible, we will identify program-specific comparison groups; these may include within-state comparison groups comprising eligibility groups not subject to a particular program or enrollees residing in regions not served by a program. See **Exhibit 16** for additional considerations on comparison group identification for each target population. To define inclusion and exclusion criteria for program-specific comparison groups, we will consider several factors including sample size, data availability, and the comparability of the proposed comparison group to the target population based on observable characteristics. More detail on the process of identifying potential comparison groups can be found under Evaluability Assessments, below. For some program populations (such as the Maternal Health and Treatment Services program), we anticipate that it will not be possible to construct a suitable comparison group due to small sample sizes or other data quality issues. Where possible, we will contextualize all findings with national data and historical in-state benchmarks.

For each of the 8-10 innovative investments that we will be evaluating each year, we will identify investment-specific within-state comparison groups where possible, which may include individuals on investment waitlists, or investment-eligible Medicaid members who are not receiving investment services. The feasibility of identifying a comparison group appropriate for use in DiD or CITS analyses will depend on factors including data availability, sample size, and comparability of proposed comparison group with the target population.

Exhibit 16. Considerations for Identifying Comparison Groups for Target Populations

Population	Considerations for Comparison Group Identification
Overall Waiver	

Population	Considerations for Comparison Group Identification
All SMI/SED, SMI/SED IMD **All SUD, SUD IMD**	• Statewide coverage of the Demonstration and its SMI/SED and SUD benefits precludes the use of an in-state comparison group. • Identifying an out-of-state comparison is infeasible because Vermont's unique population and long history of health reform efforts makes it very difficult to identify a single state (or states) that have similar health care reform trajectories and care patterns. Additionally, the level of resources required to acquire, prepare, and analyze data from one or more other state Medicaid agencies is high. • In lieu of a comparison group, we can contextualize findings with relevant national and/or regional benchmarks, where available. • ***No comparison group proposed***
CIT Eligibility Group	• The research questions for this population focus on descriptive trends in enrollment and spending; a comparison group is not applicable for these analyses. • The CIT eligibility group receives a limited set of benefits focused on SUD treatment services and comparing them to other Vermont Medicaid members who receive the full set of benefits may be inappropriate. • Because this is a new eligibility group and similar Medicaid members did not have Medicaid benefits in the past, we cannot use historical data to compare outcomes in a similar group before and after the Demonstration. • ***No comparison group proposed***
HCBS	• Because the five HCBS programs are administered statewide, and the majority of members who are eligible for the five HCBS programs receive services under those programs, an in-state comparison group is not feasible for this population. • Due to the complexities of constructing an out-of-state comparison group for this population (e.g., differences in state Medicaid policies, covered populations, and benefit structures), an out-of-state comparison group is not feasible for this population. • ***No comparison group proposed***
Lund	• Lund has only 26 beds; a small sample size may limit our ability to draw conclusions from a comparison group, particularly for the Interim Evaluation Report. • If sample size is sufficient, a potential comparison group would be pregnant and postpartum Vermont Medicaid members with SUD and/or SMI not receiving treatment services at the Lund Home. • ***Recommendation: Assess the feasibility of identifying a comparison group for the Summative Evaluation Report.***

Population	Considerations for Comparison Group Identification
Premium Assistance	• The research question for this population focuses on enrollment and care use, for which we will conduct descriptive analyses; a comparison group is not applicable for these analyses. • ***No comparison group proposed***
Retroactive Eligibility Waiver	• The research question for this population focuses on trends in Medicaid enrollment among members for whom retroactive eligibility is waived; a comparison group is not applicable for these analyses. • The Demonstration populations for whom retroactive eligibility is waived receive a limited set of benefits. Comparing them to other Vermont Medicaid members who receive the full set of benefits may be inappropriate, as changes in enrollment or outcomes may be more closely associated with benefit status than retroactive eligibility. • ***No comparison group proposed***
Supportive Housing Assistance Pilot	• Initial participation in the pilot will be limited to 100 Medicaid members, which may be insufficient to draw conclusions to a comparison group. • If sample size is sufficient, a potential comparison group could be identified if the pilot program identifies a waitlist, or if they identify a list of eligible members with MMIS IDs. • ***Recommendation: Assess the feasibility of identifying a comparison group for the Summative Evaluation Report.***
MDAAP Participants	• The research questions for this population focuses on whether the MDAAP will strengthen Medicaid providers' ability to participate in the health information exchange, and the analyses will be based on provider count data and qualitative analysis. A comparison group is not applicable for these research questions. • ***Recommendation: No comparison group***
Investment Program Participants	• We will assess the feasibility of including a comparison group for each individual assessment (see "Quantitative Evaluability Assessments" subsection and **Supplement 3** for additional details on the investment assessments for 2024).

Entropy Balancing. Because enrollment in demonstration programs is non-random, individuals in the treatment groups may be systematically different from those in the program-specific comparison groups, a phenomenon known as selection bias. To obtain unbiased estimates of model impacts when comparison groups are available, we propose addressing selection bias using entropy balancing (EB). The greatest advantage in using EB is that, unlike other matching or weighting methods such as propensity scores, ensuring a balance between groups on key covariates is the primary objective.[lvii] EB methods also reweight units smoothly to achieve balance so that the weights will be as close as possible to the base weights (i.e., 1 for every unit in the unweighted sample), so that as much information is retained as possible. Researchers can specify the desired balance on first, second, or

third moments (in other words, mean, variance, or skewness) for each covariate between treatment and comparison groups.

When using EB, comparable data must be available for the comparison groups (and the baseline period, if relevant) to ensure we can effectively measure differences between the groups and/or time periods. We will incorporate the following domains as covariates in our EB models:

- **Member-level demographics and coverage characteristics**. Examples include age, sex, race/ethnicity, dual eligibility status, type of Medicaid coverage, and months of enrollment in Medicaid. We will use MMIS data as the source for these variables.
- **Member-level clinical characteristics**. Examples include number and type of chronic conditions and disability status. We will use MMIS data as the source for these variables.
- **Area-level community characteristics**. Examples include rurality, educational attainment, provider density, unemployment rate, and area deprivation index. We will use a range of public datasets for these variables (e.g., the American Community Survey, Area Health Resources File, the Neighborhood Atlas) and will incorporate variables at the level of area measurement for each characteristic (e.g., ZIP, county).

Because we are using MMIS and publicly available data to conduct EB, we anticipate these data sources will be readily available for all analytic time periods and samples of Vermonters. We do not propose to integrate baseline outcomes into our EB weights, as that has the potential to introduce bias into the weights.[lviii]

After producing EB weights based on the three covariate domains above, we will assess the resulting balance of each key characteristic as measured by the standardized difference between the treatment and comparison groups. We will consider a characteristic to be adequately balanced if the standardized difference between the groups is within (-0.1, 0.1), and will document this with covariate balance plots and/or tables in reports.

Quantitative Evaluability Assessments

The overall evaluation of the Demonstration will include an assessment of the impact on all Medicaid members, as well as stratifications or separate analyses for key populations (e.g., SUD, SMI/SED, Maternal Health and Treatment Services, and other members participating in specialized programs as appropriate). Upon receipt of the MMIS data for the IER (expected 2025Q2) and SER (expected 2028Q1), we will begin with evaluability assessments, and where appropriate, comparison group selection, to determine which methods are best aligned with measuring Demonstration outcomes for each waiver population of interest. Specifically, we will begin with data quality and availability checks, which may include, but are not limited to, assessment for missingness, systematic errors, any unexpected outliers, and for Medicaid data, year-to-year consistency via frequency checks. Next, for each population of interest, we will identify potential populations from which comparison groups may be drawn. Considerations for the feasibility of constructing a comparison group may include the availability of data, program eligibility requirements (e.g., thresholds for participation, waiting lists, geographic requirements), sample size of program participants, and implementation timing (e.g., staggered

enrollment). All comparison groups will be weighted using entropy balancing, as described above, to ensure that the treatment and comparison groups are similar in key characteristics.

Finally, we will conduct power calculations to identify minimum detectable effects (MDE) for each outcome, overall and within subgroups of interest, to determine whether true meaningful differences between treatment and comparison groups can be detected given sample size restrictions and methodological approach. These assessment results will inform discussions with AHS to determine the appropriateness of different modeling and analytical approaches for each population.

We will also conduct evaluability assessments for each innovative investment assessment to inform an appropriate quantitative approach. We will first determine the availability of quantitative data based on input from and conversations with investment staff. Given a sufficient array of data elements, we will determine the feasibility of identifying a comparison group based on a variety of considerations, including investment size, investment timing and availability of baseline data, waitlist availability, and investment eligibility criteria. As described above (Entropy Balancing), we will apply entropy balancing to weigh any available comparison groups and conduct power analyses to identify the MDE for each outcome. We will discuss these considerations and the proposed analytical approach for each investment assessment with AHS staff.

Wherever possible, our preferred approach will be to use a DiD or CITS design with a comparison group. Where comparison groups are not feasible and observations at sufficient time points are available for the baseline and performance periods, we will employ an ITS design to assess changes in trends in outcomes over time before and after Demonstration or program implementation. However, in cases where data may not be available for multiple time points during the pre-and/or post-implementation periods (i.e., delayed implementation timelines for newer programs may limit data availability), we will employ a pre-post design. For programs or populations where baseline data are not available, we will conduct descriptive or descriptive trend analyses for the performance period only.

Quantitative Data Sources

We will draw on several secondary sources of data for the quantitative analyses, as listed in **Exhibit 15.** For each source, we will begin with data quality and availability checks, which may include assessment for missingness, systematic errors, any unexpected outliers and, for Medicaid data, year-to-year consistency via frequency checks.

NORC will also design and field two provider surveys as part of the SUD and SMI/SED Mid-Point Assessments to solicit feedback from providers on their perceptions of progress on the State's SUD and SMI/SED Implementation Plans to provide context for the State's performance on the SMI/SED and SUD monitoring metrics (see **Exhibits 13 and 14** for a description of the SUD and SMI/SED Progress Milestones). NORC will work with AHS to create a contact list for survey recipients. To increase response rates, we will email a Letter of Support, signed by AHS and the NORC evaluation team leadership, to survey participants one week prior to survey launch. We anticipate fielding the

SMI/SED survey to all Vermont hospitals and designated agencies- approximately 30 provider organizations that provide mental health services. The SUD survey will be fielded to approximately 100 providers/organizations that provide SUD services and treatment. Because the target population for the surveys is relatively small, we will rely on descriptive statistics (see ”Statistical Analyses” subsection) of close-ended survey questions. Provider survey responses will inform our interview outreach and interview guide tailoring, thereby reducing the burden placed on providers to participate in qualitative interviews (see details in “Qualitative Data Source” subsection). Surveys will be administered through Qualtrics, and we will email the link to the contact list that AHS provides with follow-up at periodic intervals to maximize response. We anticipate that surveys will include a mix of approximately 15-20 closed- and open-ended questions and will take 15 minutes to complete.

Exhibit 17. Quantitative Data Sources

Data source	Description
Medicaid enrollment, claims, and encounter data	
Medicaid Management Information System (MMIS)	Claims data submitted to the State by providers used to support HEDIS® and HEDIS®-like performance, Medication Assisted Treatment, service utilization and cost metrics for all members
Demonstration program documents and data	
Vermont data/programs	Data extracted from various state- and program-specific documents and reports
Data from other Vermont state agencies	
Vital Statistics System	Public health birth, death, and other vital records used to track overdose deaths attributed to Vermont residents
SATIS	Provider, member, and encounter data used to assess rates of Medication Assisted Treatment and successful completion of residential treatment
Household Health Insurance Survey	Point-in-time survey data collected on Vermonters used to determine rates of uninsured Vermonters
Consumer Assessment of Health Care Providers and Systems (CAHPS)	CAHPS: Point-in-time survey data collected on Medicaid beneficiaries used to assess member experience of care. ECHO: CAHPS subset point-in-time survey data used to assess beneficiary experiences with behavioral health services.
Community-level data	
American Community Survey (ACS)	Demographic, economic, social, and housing data across U.S. geographic areas (including at the zip level).
Area Health Resources File (AHRF)	Data on health care providers and facilities, as well as population characteristics and hospital utilization at the county levels.
Primary quantitative data	
NORC provider survey	SMI/SED and SUD provider-surveys fielded by NORC

Quantitative Evaluation Measures

Outcome Measures. The evaluation design will include a set of outcome measures associated with each Demonstration goal, hypothesis, and research question (**Exhibits 12** to **14**). We will use Vermont Medicaid claims and encounter data to construct key outcome measures to assess the evaluation's associated effects on Medicaid coverage and beneficiary health, cost, utilization, and quality outcomes. Where possible, we will use nationally recognized and validated measures, such as those maintained by the National Committee for Quality Assurance (NCQA), and aim to align them to Vermont's state monitoring metrics to the extent possible. Of note, AHS is working with CMS to finalize the state's HCBS Assurance Measure Set, with reporting planned to begin in August 2025. When these become available, we will work with AHS to expand on the set of HCBS quality and experience of care metrics (beyond those listed in the current Exhibits) for evaluation to include in the summative report. The proposed set of measures is detailed in **Exhibit 16**, **Exhibit 17**, and **Exhibit 18**.

However, use of any given measure may be constrained by data quality and/or availability (see details in "Quantitative Evaluability Assessments" subsection above). We will also draw data from other Vermont state agencies and community-level data sources to track area-level trends, as well as to provide context for the evaluation. We will work closely with AHS to refine these measures as informed by data quality assessments and ongoing evaluation work, as well as to assign priority to measures for evaluation each year. We will include descriptive annual assessments of each measure in all evaluation reports, along with national benchmarks where available.

Exhibit 18. Quantitative Overall Evaluation Measures, Data Sources, and Demonstration Goals

Measure	Definition	Steward	Numerator	Denominator	Analytical period; Measure frequency *	Data Source	Goal(s)
New Medicaid enrollment	Count of newly-enrolled Medicaid members in a calendar year	N/A	Count of newly-enrolled Medicaid members in a calendar year	N/A	July 2018 – December 2027; Annual	MMIS	1
Total Medicaid enrollment	Total number of members with any Medicaid enrollment	N/A	Total number of members with any Medicaid enrollment	N/A	July 2018 – December 2027 Annual	MMIS	1
Continuous Medicaid enrollment	Percentage of members with continuous Medicaid enrollment	N/A	Members with continuous enrollment	Total Medicaid members	July 2018 – December 2027; Annual	MMIS	1
Statewide insurance coverage	Percentage of Vermonters insured during reporting year	VDH	N/A	N/A	2018 – 2027; Annual	VT Household Insurance Survey	1
Total Medicaid spending	Total Medicaid expenditures per member per month.	N/A	Total Medicaid expenditures in reporting month	Number of members per reporting month	July 2018 – December 2027; Annual	MMIS	2, 5
Per member per month SUD-related Medicaid spending	Total SUD-related Medicaid expenditures per member per month	N/A	Total SUD-related Medicaid expenditures in reporting month	Number of members with SUD-related spending per reporting month	July 2018 – December 2027; Annual	MMIS	2
Per member per month total SMI/SED-related Medicaid spending	Total SMI/SED-related Medicaid expenditures per member per month	N/A	Total SMI/SED-related Medicaid expenditures in reporting month	Number of members with SMI/SED-related spending per reporting month	July 2018 – December 2027; Annual	MMIS	2
Well-child care	Percent of enrollees with Well-child visits first 15 months of life, 6 or more visits (HEDIS W15)	NCQA	Number of children turning 15 months old during measurement year who had at least six well-child visits with PCP during the first 15 months of life	Children who turned 15 months old during measurement year	July 2018 – December 2027; Annual	MMIS	2, 4
Adolescent well-care	Percent of adolescents ages 12-21 who receive one or more well-care visits with a PCP during the measurement year	NCQA	Children 3-21 years of age receiving 1+ well-care visits with PCP or OB/GYN provider	Children 3-21 years of age	July 2018 – December 2027; Annual	MMIS	
Hospitalizations	Number of all-cause acute care inpatient stays per 1,000 Medicaid members. In the case of a hospital-to-hospital transfer, only one stay is counted.	NCQA	Number of all-cause acute care inpatient stays	Medicaid members	July 2018 – December 2027; Annual	MMIS	2

Measure	Definition	Steward	Numerator	Denominator	Analytical period; Measure frequency *	Data Source	Goal(s)
All-cause readmissions	Occurrences of unplanned hospitalization within 30 days of discharge from hospital, per 1,000 Medicaid members. This analysis will be done only for members with an index hospitalization, as those without an index hospitalization cannot subsequently have a 30-day readmission.	NQF	Number of index hospitalizations followed by a readmission within 30 days of discharge	Number of index hospitalizations	July 2018 – December 2027; Annual	MMIS	2
Ambulatory Care ED visits	Number of emergency department (ED) visits and observation stays per 1,000 Medicaid member months	NCQA	Number of ED visits and observation stays not resulting in an inpatient admission	Medicaid members	July 2018 – December 2027; Annual	MMIS	2, 4
ED utilization for SUD	Rate of ED utilization for SUD per 1,000 Medicaid members	N/A	Number of ED visits for SUD	All Medicaid members	July 2018 – December 2027; Annual	MMIS	2
Members receiving services for SMI/SED in the ED	Number of SMI/SED-related emergency department (ED) visits and observation stays per 1,000 Medicaid members	N/A	Number of SMI/SED-related ED visits and observation stays not resulting in an inpatient admission	Medicaid members	July 2018 – December 2027; Annual	MMIS	2
Primary care utilization	Rate of primary care visits per 1,000-member months	N/A	Number of primary care visits	Medicaid members	July 2018 – December 2027; Annual	MMIS	2
Demonstration program enrollment	• Number of members enrolled in Demonstration programs including: o CRT program o CIT program o Medicaid ACO o Maternal Health and Treatment Services program	N/A	Number of members enrolled in program	N/A	July 2018 (CRT, CIT, Medicaid ACO), March 2020 (Maternal Health), -December 2027; Annual	Program documents and data	3
Grievances and appeals	Number of grievances/appeals filed	N/A	Number of grievances/appeals filed	N/A	July 2018 – December 2027; Annual [b]	Program documents and data	3
Supportive Housing Assistance Pilot service utilization	Number of members receiving pre-tenancy supports, tenancy sustaining services, community transition services	N/A	Number of members receiving pre-tenancy supports, tenancy sustaining services,	N/A	January 2023 – December 2027; Annual	Program documents and data	4

Measure	Definition	Steward	Numerator	Denominator	Analytical period; Measure frequency *	Data Source	Goal(s)
			community transition services				
Supportive Housing Assistance Pilot waiting list	Number of members on Supportive Housing Pilot waiting list	N/A	Number of members on Supportive Housing Pilot waiting list	N/A		Program documents and data	4
Supportive Housing Assistance Pilot provider engagement	Number and types of participating providers (e.g., case management, pre-tenancy support staff) in the Supportive Housing Pilot	N/A	Number and types of participating providers (e.g., case management, pre-tenancy support staff) in the Supportive Housing Pilot	N/A		Program documents and data	4
Providers receiving MDAAP incentive payments	Number of providers receiving MDAAP incentive payments, by provider type	N/A	Number of providers receiving MDAAP incentive payments, by provider type	N/A	July 2022 – December 2027; Annual	Program documents and data	4
Access to preventive/ambulatory health services for members with SUD	Percentage of Medicaid members with SUD who had an ambulatory or preventive care visit during the measurement period	NCQA	Number of Medicaid members with SUD who had an ambulatory or preventive care visit during the measurement period	Medicaid members with an SUD diagnosis	July 2018 – December 2027; Annual	MMIS	4
Follow-up care after inpatient discharge	Rates of office visits and home health visits provided within 30 days after inpatient discharge	N/A	Number of inpatient discharges followed by an office visit or home visit within 30 days	Number of inpatient discharges	July 2018 – December 2027; Annual	MMIS	4
Unplanned admissions for members with multiple chronic conditions	All-cause unplanned admissions for patients with multiple chronic conditions	CMS	Inpatient admissions to an acute care hospital for any cause unless an admission is identified as “planned" (as defined in CMS’s Planned Readmission Algorithm Version 3.0)	Adult Medicaid members with diagnoses that fall into two or more of eight chronic disease groups: Acute myocardial infarction, Alzheimer’s disease, atrial fibrillation, chronic kidney disease, chronic obstructive pulmonary disease/asthma, depression, heart failure, stroke/transient ischemic attack	July 2018 – December 2027; Annual	MMIS	4

Measure	Definition	Steward	Numerator	Denominator	Analytical period; Measure frequency *	Data Source	Goal(s)
Enrollment in HCBS programs	Number of members with TBI, ID/DD, and CFC enrolled in HCBS programs	N/A	Number of members with TBI, ID/DD, and CFC enrolled in HCBS programs	N/A		Program data; MMIS	4
Medicaid Managed Long-Term Services and Supports Admission to a Facility from the Community	Rate of admissions to a facility among Medicaid MLTSS participants age 18 and older residing in the community for at least one month	CMS	Number of admissions to a facility for: - Short-term stay (1-20 days) - Medium-term stay (21-100 days) - Long-term stay (101+ days)	Medicaid MLTSS participants ages 18+ living in the community for at least 1 month (participant-months)	July 2018 – December 2027; Annual	MMIS	4
Medicaid Managed Long-Term Services and Supports Minimizing Facility Length of Stay	The proportion of admissions to a facility among Medicaid MLTSS participants age 18 and older that result in successful discharge to the community (community residence for 60 or more days) within 100 days of admission	CMS	Discharges to the community within 100 days of admission	Medicaid MLTSS participants ages 18+ with an admission to a facility between July 1 of the year prior to the measurement year and June 30 of the measurement year	July 2018 – December 2027; Annual	MMIS	4
HCBS: Choosing the Services that Matter to You Composite measure	Composite measure derived from top-box scores of questions 56 and 57 on the HCBS CAHPS Survey:	CAHPS	Measure summary score	NA	2018 – 2027; Annual	CAHPS	4
HCBS: Unmet Needs Composite Measure	Composite measure derived from top-box scores of questions 18, 22, 25, 27, and 40 on the HCBS CAHPS Survey:	CAHPS	Measure summary score	NA	2018 – 2027; Annual	CAHPS	4
Use of program services for HCBS and CFC (High/Highest) members	Number of HCBS and CFC (High/Highest) members using program services	N/A	Number of HCBS and CFC (High/Highest) members using program services	NA	July 2018-December 2027; Annual	Program data	4
Members receiving MOUD	Percentage of members with a claim for MOUD for OUD	N/A	Number of unique members with a claim for a MOUD dispensing event for OUD.	Medicaid members with an OUD diagnosis	July 2018 – December 2027; Annual	MMIS	4
Initiation of AOD treatment	Percentage of adult Medicaid members who initiated AOD treatment	NCQA	Number of members age 18+ with a new episode of AOD abuse or	Medicaid members age 18+	July 2018 – December 2027; Annual	MMIS	4

Measure	Definition	Steward	Numerator	Denominator	Analytical period; Measure frequency *	Data Source	Goal(s)
			dependence who received initiation of AOD treatment				
Engagement of AOD treatment	Percentage of adult Medicaid members who engaged in AOD treatment	NCQA	Number of unique members age 18+ with a new episode of AOD abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of initiation visit	Medicaid members age 18+	July 2018 – December 2027; Annual	MMIS	4
Follow-up after ED visit for AOD	Follow-up after emergency department visit for alcohol and other drug abuse of dependence (FUA)	NCQA	Number of visits for which member received a follow-up visit within 30 days of ED visit; Number of visits for which member received a follow-up visit within 7 days of ED visit;	ED visits with a principal diagnosis of alcohol or other drug abuse or dependence among members ages 13+	July 2018 – December 2027; Annual	MMIS	4
Use of SMI treatment	Percentage of members receiving mental health services	NCQA	Number of members receiving the following mental health services: inpatient, intensive outpatient or partial hospitalization, outpatient, ED, telehealth, any services	Medicaid members age 18+	July 2018 – December 2027; Annual	MMIS	4
Follow-up after ED visit for mental illness	Follow-up after emergency department visit for mental illness (FUM)	NCQA	Number of visits for which member received a follow-up visit within 30 days of ED visit; Number of visits for which member received a follow-up visit within 7 days of ED visit;	ED visits with a principal diagnosis of mental illness or intentional self-harm among members ages 13+	July 2018 – December 2027; Annual	MMIS	4
Prenatal visits	Percentage of deliveries in which mother had prenatal care visit in first trimester, on or before the enrollment start date or within 42 days of enrollment	HEDIS	Number of deliveries in which mother had prenatal care visit in first trimester, on or before the enrollment start date or within 42 days of enrollment	Number of deliveries	July 2018 – December 2027; Annual	MMIS	4

Measure	Definition	Steward	Numerator	Denominator	Analytical period; Measure frequency *	Data Source	Goal(s)
Postnatal visits	The percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery.	HEDIS	Number of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery.	Number of deliveries	July 2018 – December 2027; Annual	MMIS	
Severe maternal morbidity	Rate of delivery hospitalizations with one or more of 21 severe maternal morbidity outcomes.	ACOG	Number of deliveries with one or more severe maternal morbidity outcomes.	Number of delivery hospitalizations	July 2018 – December 2027; Annual	MMIS	4
Participation in Lund services	Number of patients participating in specific Lund services	N/A	Number of patients participating in specific Lund services	N/A	July 2018 – December 2027; Annual	Program data	4
Child custody rates	Percentage of Medicaid members at Lund retaining child custody	N/A	Number of Medicaid members with children who retain custody of their child(ren)	Number of Medicaid members at Lund with one or more children	July 2018 – December 2027; Annual	Program data	4
Foster care placement	Percentage of families with foster care placement among Medicaid members at Lund	N/A	Number of Lund Medicaid members with one or more children in foster care	Number of Lund Medicaid members with one or more children	July 2018 – December 2027; Annual	Program data	4
Psychosocial outcomes	Rate of positive psychosocial outcomes among Medicaid members at Lund	N/A	Number of Medicaid members at Lund who show improvement in psychosocial outcomes	Number of Lund Medicaid members	July 2018 – December 2027; Annual	Program data	4
Member enrollment in alternative payment models	Percentage of Medicaid members covered under alternative payment models	N/A	Number of Medicaid members enrolled in or covered under an alternative payment model	Total number of Medicaid members	July 2018 – December 2027; Annual **	Program data	5
Provider enrollment in alternative payment models	Percentage of Medicaid providers participating in alternative payment models	N/A	Number of Medicaid providers enrolled in or receiving payments under an alternative payment model	Total number of Medicaid providers	July 2018 – December 2027; Annual **	Program data	5

NOTES: MMIS= Medicaid Management Information System; SUD= Substance use disorder; SMI= Serious mental illness; SED= Serious emotional disturbance; PCP= Primary care provider; CMS= Center for Medicare and Medicaid Services; AHRQ= Agency for Healthcare Research and Quality; HCBS= Home- and community-based services; ACO= Accountable care organization; TBI= Traumatic brain injury; ID/DD= Intellectual disability/developmental disability; CFC= Choices for Care; NCQA= National Committee for Quality Assurance; ED= Emergency department; OUD= Opioid use disorder; MOUD= Medications for opioid use disorders; AOD= Alcohol use disorder; CQMS= Clinical Quality Management System

* Outcomes will be assessed repeatedly at the stated frequencies across the stated analytical periods. For the summative evaluation report (SER), the analytical period covers the full post-implementation period, through December 2017. However, for the interim evaluation report (IER), the analytical period will run through approximately December 2024

(assuming a six-month data run-out period with a data request date of June 2025). Because the demonstration renewal period is 5.5 years, and the majority of our measures are annual, the last data point will be based on six months of data (July 2027 – December 2027); we will conduct sensitivity analysis by dropping the last data point as necessary. For each measure/population, the period between the stated start of the analytical period and July 2022 (start of the waiver renewal period) constitutes the baseline; where possible, we plan to include analyses of a four-year pre-implementation/baseline period (July 2018 – June 2022), which allows for at least one full year of data before the onset of the COVID-19 pandemic.

** Analytical period and time unit of analysis for measures derived from program data are provisional, and may change depending on program implementation status, data availability, and reporting conventions.

Exhibit 19. Quantitative SUD Evaluation Measures, Data Sources, and Related SUD Demonstration Goals

Measure	Definition	Steward	Numerator	Denominator	Analytical period; Measure frequency *	Data Source	Goal(s)
Members with an SUD diagnosis	Number of members with an SUD diagnosis	N/A	Number of unique members enrolled in the measurement period who receive MAT or have qualifying facility, provider, or pharmacy claims with an SUD diagnosis and a SUD-related treatment service	N/A	July 2018 – December 2027; Annual	MMIS	SUD 1
Any SUD treatment	Members receiving any SUD treatment service, facility claim, or pharmacy claim	N/A	Number of unique members receiving at least one SUD treatment service or pharmacy claim during the measurement period	N/A	July 2018 – December 2027; Annual	MMIS	SUD 1, SUD 2
Members receiving MOUD	Percentage of members with a claim for MOUD for OUD	N/A	Number of unique members with a claim for an MOUD dispensing event for OUD	Medicaid members with an OUD diagnosis	July 2018 – December 2027; Annual	MMIS	SUD 1
Initiation of AOD treatment	Percentage of adult Medicaid members who initiated AOD treatment	NCQA	Number of members age 18+ with a new episode of AOD abuse or dependence who received initiation of AOD treatment	Medicaid members age 18+	July 2018 – December 2027; Annual	MMIS	SUD 1
Engagement of AOD treatment	Percentage of adult Medicaid members who engaged in AOD treatment; assessed separately for Total AOD Abuse or Dependence, Alcohol Abuse or Dependence, Opioid Abuse or Dependence, Other Drug Abuse or Dependence	NCQA	Number of unique members age 18+ with a new episode of AOD abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of initiation visit	Medicaid members age 18+	July 2018 – December 2027; Annual	MMIS	SUD 1
Members treated in an IMD for SUD	Number of members with a claim for inpatient/residential treatment for SUD in an IMD	N/A	Number of unique members who received inpatient/residential treatment in an IMD for SUD diagnosis	N/A	July 2018 – December 2027; Annual	MMIS	SUD 1

Measure	Definition	Steward	Numerator	Denominator	Analytical period; Measure frequency *	Data Source	Goal(s)
Outpatient SUD services	Number of members who used outpatient services for SUD	N/A	Number of unique members who received outpatient services for SUD	N/A	July 2018 – December 2027; Annual	MMIS	SUD 1
Residential and inpatient SUD services	Number of members who used residential or inpatient services for SUD	N/A	Number of unique members who used residential or inpatient services for SUD	N/A	July 2018 – December 2027; Annual	MMIS	SUD 1
ED utilization for SUD	Rate of ED utilization for SUD per 1,000 Medicaid members	N/A	Number of ED visits for SUD	All Medicaid members	July 2018 – December 2027; Annual	MMIS	SUD 4, SUD 5
Inpatient stays for SUD	Rate of inpatient stays for SUD per 1,000 Medicaid members	N/A	Number of inpatient discharges related to an SUD stay	All Medicaid members	July 2018 – December 2027; Annual	MMIS	SUD 1, SUD 4
Continuity of pharmacotherapy for OUD	Percentage of adults with pharmacotherapy for OUD with at least 180 days of continuous treatment	USC	Number of Medicaid members age 18+ with pharmacotherapy for OUD with at least 180 days of continuous treatment	Medicaid members age 18+	July 2018 – December 2027; Annual	MMIS	SUD 1
Follow-up after ED visit for AOD abuse or dependence	Percentage of ED visits for adult Medicaid members with a principal diagnosis of AOD who received follow-up within 7 and 30 days	NCQA	Number of ED visits for members age 18+ with a principal diagnosis of AOD who received follow-up within 7 and 30 days	Medicaid members age 18+	July 2018 – December 2027; Annual	MMIS	SUD 2
Use of opioids at high dosages in persons without cancer	Percentage of adult Medicaid members without a cancer diagnosis who received prescriptions for opioids with an average daily dose greater than or equal to 90 morphine milligram equivalents over a period of 90 days or more	PQA	Number of Medicaid members age 18+ without a cancer diagnosis who received prescriptions for opioids with an average daily dose greater than or equal to 90 morphine milligram equivalents over a period of 90 days or more	Medicaid members age 18+	July 2018 – December 2027; Annual	MMIS	SUD 3
Concurrent use of opioids and benzodiazepines	Percentage of adult Medicaid members without cancer who have concurrent use of prescription opioids and benzodiazepines	PQA	Number of adult Medicaid members without cancer who have concurrent use of prescription opioids and benzodiazepines	Medicaid members age 18+	July 2018 – December 2027; Annual	MMIS	SUD 3

Measure	Definition	Steward	Numerator	Denominator	Analytical period; Measure frequency *	Data Source	Goal(s)
Drug overdose deaths among Medicaid members	Rate of overdose deaths among Medicaid members	N/A	Number of overdose deaths among Medicaid members	All Medicaid members	July 2018 – December 2027; Annual	MMIS; SATIS	SUD 3
Opioid-related overdose deaths among Medicaid members	Rate of overdose deaths due to opioids among Medicaid members	N/A	Number of opioid-related overdose deaths among Medicaid members	All Medicaid members	July 2018 – December 2027; Annual	MMIS, SATIS	SUD 3
Drug overdose deaths among Vermont residents	Rate of overdose deaths among all Vermonters	N/A	Number of overdose deaths among all Vermonters	Vermont population	July 2018 – December 2027; Annual	SATIS, VDH	SUD 3
Opioid-related overdose deaths among Vermont residents	Rate of opioid-related overdose deaths among all Vermont residents	N/A	Number of opioid-related overdose deaths among all Vermonters	Vermont population	July 2018 – December 2027; Annual	SATIS, VDH	SUD 3
Opioid-related overdose deaths with gabapentin among Vermont residents	Rate of opioid-related overdose deaths with gabapentin among all Vermont residents	N/A	Number of opioid-related overdose deaths with gabapentin among all Vermonters	Vermont population	July 2018 – December 2027; Annual	VDH	SUD 3
ED utilization for OUD	Rate of ED utilization for OUD per 1,000 Medicaid members	N/A	Number of ED visits for OUD	All Medicaid members	July 2018 – December 2027; Annual	MMIS	SUD 4
Inpatient stays for OUD	Rate of inpatient stays for OUD per 1,000 Medicaid members	N/A	Number of inpatient discharges related to an OUD stay	All Medicaid members	July 2018 – December 2027; Annual	MMIS	SUD 4
All-cause readmissions after discharge for SUD care	Rate of all-cause readmissions after discharge for SUD care	N/A	Number of members with all-cause readmissions within 30 days	Members with an index hospitalization for SUD care	July 2018 – December 2027; Annual	MMIS	SUD 5
SUD-related readmissions after discharge for SUD care	Rate of SUD-related readmissions after discharge for SUD care	N/A	Number of members with SUD-related readmissions within 30 days	Members with an index hospitalization for SUD care	July 2018 – December 2027; Annual	MMIS	SUD 5
Access to preventive/ambulatory health services for members with SUD	Percentage of Medicaid members with SUD who had an ambulatory or preventive care visit during the measurement period	NCQA	Number of Medicaid members with SUD who had an ambulatory or preventive care visit during the measurement period	Medicaid members with an SUD diagnosis	July 2018 – December 2027; Annual	MMIS	SUD 6

Measure	Definition	Steward	Numerator	Denominator	Analytical period; Measure frequency *	Data Source	Goal(s)
Breast cancer screening	Percentage of female Medicaid members ages 50-74 who had a mammogram to screen for breast cancer	NCQA	Number of female Medicaid members ages 50-74 who had a mammogram to screen for breast cancer	Female Medicaid members ages 50-74	July 2018 – December 2027; Annual	MMIS	SUD 6
Colorectal cancer screening	Percentage of Medicaid members ages 45-74 who had appropriate screening for colorectal cancer	CQMS	Number of Medicaid members ages 45-74 who had appropriate screening for colorectal cancer	Medicaid members ages 45-74	July 2018 – December 2027; Annual	MMIS	SUD 6

NOTES: MMIS= Medicaid Management Information System; SUD= Substance use disorder; SMI= Serious mental illness; SED= Serious emotional disturbance; PCP= Primary care provider; CMS= Center for Medicare and Medicaid Services; AHRQ= Agency for Healthcare Research and Quality; NCQA= National Committee for Quality Assurance; ED= Emergency department; OUD= Opioid use disorder; MOUD= Medications for opioid use disorders; AOD= Alcohol use disorder; PQA= Pharmacy quality alliance; CQMS= Clinical Quality Management Syste

* Outcomes will be assessed repeatedly at the stated frequencies across the stated analytical periods. For the summative evaluation report (SER), the analytical period covers the full post-implementation period, through December 2017. However, for the interim evaluation report (IER), the analytical period will run through approximately December 2024 (assuming a six-month data run-out period with a data request date of June 2025). Because the demonstration renewal period is 5.5 years, and the majority of our measures are annual, the last data point will be based on six months of data (July 2027 – December 2027); we will conduct sensitivity analysis by dropping the last data point as necessary. For each measure/population, the period between the stated start of the analytical period and July 2022 (start of the waiver renewal period) constitutes the baseline; where possible, we plan to include analyses of a four-year pre-implementation/baseline period (July 2018 – June 2022), which allows for at least one full year of data before the onset of the COVID-19 pandemic.

Exhibit 20. Quantitative SMI/SED Evaluation Measures, Data Sources, and Related SMI/SED Demonstration Goals

Measure	Definition	Steward	Numerator	Denominator	Analytical period; Measure frequency *	Data Source	Goal(s)
All-cause emergency department utilization rate for Medicaid beneficiaries who may benefit form integrated physical and behavioral health care (PMH-20)	Rate of all-cause ED utilization per 1,000 Medicaid members with SMI/SED	CMS	Number of all-cause ED visits	Number of Medicaid members with SMI/SED	July 2018 – December 2027; Annual	MMIS	SMI 1
Mental health services - ED	Rate of mental health-related ED visits per 1,000 Medicaid members with SMI/SED	CMS	Number of mental health-related ED visits	Number of Medicaid members with SMI/SED	July 2018 – December 2027; Annual	MMIS	SMI 1

Measure	Definition	Steward	Numerator	Denominator	Analytical period; Measure frequency *	Data Source	Goal(s)
Length of all-cause Emergency department visits for Medicaid beneficiaries who may benefit form integrated physical and behavioral health care	Average length of stay in the ED (including observation stays) per 1,000 members with SMI/SED	N/A	Number of days in ambulatory care ED visit/observation stay	Number of Medicaid members with SMI/SED	July 2018 – December 2027; Annual	MMIS	SMI 1
30-day all-cause unplanned readmissions following psychiatric hospitalization in an Inpatient Psychiatric Facility (IPF)	Rate of unplanned 30-day readmissions for members with a primary discharge diagnosis of a psychiatric disorder or dementia/Alzheimer's disease	CMS	Count of 30-day readmissions that occur within 30 days after the discharge date from an eligible index admission to an IPF, except those considered planned.	Count of index hospital admissions to IPFs	July 2018 – December 2027; Annual	MMIS	SMI 2
Number of community crisis resources	Number of crisis call centers, mobile crisis centers, crisis observation/assessment centers, and coordinated community response teams	N/A	Number of crisis call centers, mobile crisis centers, crisis observation/assessment centers, and coordinated community response teams	N/A	2018 – 2017; Annual**	Program data	SMI 3
Mental health facilities offering 24-hour residential or hospital inpatient treatment	Number of mental health facilities offering 24-hour residential or hospital inpatient treatment	N/A	Number of mental health facilities offering 24-hour residential or hospital inpatient treatment	N/A	2018 – 2017; Annual**	Program data	SMI 3
Hospitals with psychiatric child/adolescent services or geriatric services	Number of hospitals with psychiatric child/adolescent services or geriatric services	N/A	Number of hospitals with psychiatric child/adolescent services or geriatric services	N/A	2018 – 2017; Annual**	Program data	SMI 3
Mental health utilization - Outpatient	Number/rate of beneficiaries with SMI/SED that used outpatient services for mental health during the measurement year	CMS	Number of beneficiaries with SMI/SED who used outpatient services related to mental health	Number of Medicaid members with SMI/SED	July 2018 – December 2027; Annual	MMIS	SMI 4
Mental health utilization - Telehealth	Number/rate of beneficiaries with SMI/SED that used telehealth services for mental health during the measurement year	CMS	Number of beneficiaries with SMI/SED who used telehealth services related to mental health	Number of Medicaid members with SMI/SED	July 2018 – December 2027; Annual	MMIS	SMI 4
Access to preventive/ambulatory health services for	Percentage of Medicaid beneficiaries with an SMI who had an ambulatory or	HEDIS (adjusted)	Number of Medicaid beneficiaries with an SMI	Number of Medicaid members with SMI	July 2018 – December 2027; Annual	MMIS	SMI 4

Measure	Definition	Steward	Numerator	Denominator	Analytical period; Measure frequency *	Data Source	Goal(s)
Medicaid beneficiaries with SMI	preventive care visit during the measurement year		who had an ambulatory or preventive care visit				
Alcohol screening and follow-up for people with SMI	Percentage of Medicaid beneficiaries age 18+ with SMI who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as unhealthy alcohol user	NQF	Number of Medicaid members with SMI who received screening for unhealthy alcohol use	Number of Medicaid members with SMI	July 2018 – December 2027; Annual	MMIS	SMI 4
			Number of Medicaid members with SMI identified as unhealthy alcohol users who received brief counseling or other follow-up care	Number of Medicaid members with SMI who were identified as unhealthy alcohol users			
Screening for depression: age 18 and older; age 12-17	Percentage of beneficiaries ages 18+ / 12-17 screened for depression	CMS	Number of Medicaid members ages 18+ / 12-17 screened for depression	Number of Medicaid members ages 18+ / 12-17	July 2018 – December 2027; Annual	MMIS	SMI 4
Follow-up care for adult Medicaid beneficiaries who are newly prescribed an antipsychotic medication	Percentage of new antipsychotic prescriptions for Medicaid beneficiaries ages 18+ with a completed follow-up visit with a provider with prescribing authority within 28 days of prescription	NQF	Number of Medicaid beneficiaries ages 18+ with a new antipsychotic medication prescription who completed a follow-up visit with a provider with prescribing authority within 28 days of prescription issuance	Number of Medicaid beneficiaries ages 18+ with a new antipsychotic medication prescription	July 2018 – December 2027; Annual	MMIS	SMI 4
Availability of outpatient mental health professionals	Number of outpatient mental health professionals per 1,000 Vermont residents, overall and by type of provider	N/A	Number of outpatient mental health professionals	Vermont population	2018 – 2027; Annual	AHRF	SMI 4
Follow-up after hospitalization for mental illness (FUH-AD)	Percentage of discharges ages 18+ who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit within 7 and 30 days with a mental health practitioner	NQF	Number of discharges ages 18+ who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit within 7 and 30 days with a mental health practitioner	Number of discharges among Medicaid members age 18+ who were hospitalized for mental illness diagnoses	July 2018 – December 2027; Annual	MMIS	SMI 5
Follow-up after emergency department visit for mental illness (FUM-AD)	Percentage of ED visits for beneficiaries age 18+ with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up	NQF	Number of ED visits for beneficiaries age 18+ with a principal diagnosis of mental illness or intentional self-harm, who	Number of ED visits for beneficiaries age 18+ with a principal diagnosis of mental	July 2018 – December 2027; Annual	MMIS	SMI 5

Measure	Definition	Steward	Numerator	Denominator	Analytical period; Measure frequency *	Data Source	Goal(s)
	visit for mental illness within 7 days and 30 days of visit		had a follow-up visit for mental illness within 7 days and 30 days of visit	illness or intentional self-harm			
Follow-up After Hospitalization for Mental Illness: Ages 6-17 (FUH-CH)	Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. within 7 days and 30 days of visit	NQF	Number of discharges ages 6-17 who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit within 7 and 30 days with a mental health practitioner	Number of discharges among Medicaid members ages 6-17 who were hospitalized for mental illness diagnoses	July 2018 – December 2027; Annual	MMIS	SMI 5
Follow-up after emergency department visit for mental illness: Ages 6-17 (FUM-AD)	Percentage of ED visits for beneficiaries ages 6-17 with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days and 30 days of visit	NQF	Number of ED visits for beneficiaries ages 6-17 with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days and 30 days of visit	Number of ED visits for beneficiaries ages 6-17 who had a principal diagnosis of mental illness or intentional self-harm	July 2018 – December 2027; Annual	MMIS	SMI 5
Medication continuation following inpatient psychiatric discharge	Percentage of adult Medicaid members admitted to an inpatient psychiatric facility filled a prescription for an evidence-based medication within 2 days prior to discharge and 30 days post-discharge	CMS	Number of Medicaid members age 18+ admitted to an inpatient psychiatric facility who filled a prescription for an evidence-based medication within 2 days prior to discharge and 30 days post-discharge	Number of Medicaid members age 18+ admitted to an inpatient psychiatric facility	July 2018 – December 2027; Annual	MMIS	SMI 5
Suicide or overdose death within 7 and 30 days of discharge from an inpatient facility or residential treatment for mental health among beneficiaries with SMI or SED	Number/rate of suicide or overdose deaths among Medicaid beneficiaries with SMI/SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health	CMS	Number of suicide or overdose deaths among Medicaid beneficiaries with SMI/SED within 7 and 30 days of discharge from an inpatient facility or residential stay for mental health	Number of Medicaid beneficiaries with an inpatient facility or residential stay for mental health	July 2018 – December 2027; Annual	MMIS	SMI 5

NOTES: MMIS= Medicaid Management Information System; CMS= Center for Medicare and Medicaid Services; SMI/SED= Serious mental illness/Serious mental disturbance; AHRF= Area Health Resource Files; ED= Emergency department; HCBS= Home- and community-based services; OUD= Opioid use disorder; MOUD= Medications for opioid use disorders; AOD= Alcohol use disorder.

* Outcomes will be assessed repeatedly at the stated frequencies across the stated analytical periods. For the summative evaluation report (SER), the analytical period covers the full post-implementation period, through December 2017. However, for the interim evaluation report (IER), the analytical period will run through approximately December 2024 (assuming a six-month data run-out period with a data request date of June 2025). Because the demonstration renewal period is 5.5 years, and the majority of our measures are annual, the last data point will be based on six months of data (July 2027 – December 2027); we will conduct sensitivity analysis by dropping the last data point as necessary. For each measure/population, the period between the stated start of the analytical period and July 2022 (start of the waiver renewal period) constitutes the baseline; where possible, we plan to include analyses of a four-year pre-implementation/baseline period (July 2018 – June 2022), which allows for at least one full year of data before the onset of the COVID-19 pandemic.

** Analytical period and time unit of analysis for measures derived from program data are provisional, and may change depending on program data availability and reporting conventions.

Statistical Analyses

Based on the results of our evaluability assessments, we will conduct one or more of the following statistical analyses for relevant measures in each waiver population:

- **Descriptive analyses**, including frequency distributions and rates over time (time series), will be calculated to highlight trends in member, provider, and organizational characteristics, program features, and key process and outcome measures over time. In cases where data is available on non-Demonstration populations, descriptive results for populations of interest will allow us to assess whether the Demonstration (treatment) and non-Demonstration (comparison) populations are meaningfully and/or statistically different in demographic or clinical characteristics, which will inform our analytical approach for any impact analyses. We will present the results of our descriptive analyses in tables and visuals in both the interim and final evaluation reports. Where available, we will also present descriptive findings alongside benchmarks at the national level or from other states, and apply appropriate statistical testing (e.g., t-tests, chi-square tests) to evaluate differences.
- **Pre-post analyses** will allow us to track progress in key process and outcome measures of the Demonstration over time, as well as to compare and detect any statistically significant changes between the pre- and post-Demonstration periods. The analyses will also inform the development of more rigorous analytical methods (including ITS and DiD analyses described below) for evaluating impact.
- **Interrupted time series (ITS) analyses.** Where data quality and sample size allow, we will use observations over an extended period to assess impact where appropriate comparison groups are not available. Specifically, we will use outcome data from a baseline period of at least two years prior to program implementation, along with outcome data from the demonstration period to allow for observation of changes in performances over time. We will apply multivariate segmented regression models to estimate baseline-period and demonstration-period specific trends in outcomes, and to detect any statistically significant changes between the pre-and post-implementation periods using the following model:

$$Y = \beta_0 + \beta_1 T + \beta_2 X + \beta_3 T * X + \gamma COVAR$$

where *Y* represents the outcome of interest, *T* represents time elapsed, and *X* is an indicator for post-program implementation. β_2 estimates the level change, while β_3 estimates the slope change in the outcome following program implementation. *COVAR* represents individual-level characteristics. Robustness and validity of the ITS model rests on having sufficient data points across time, both before and after the intervention. We will present results from ITS analyses in tabular and graphical forms.

- **Difference-in-differences (DiD) and comparative interrupted time series (CITS) analyses** will be used to estimate impacts for programs for which appropriate comparison groups are available. DiD models compare the changes in pre- to post-intervention means s between treatment and comparison groups, controlling for any time-invariant differences between the intervention and comparison groups, to estimate the impact of an intervention. The CITS approach is similar and allows for examination of differential changes in pre- vs. post-intervention trends between the intervention and comparison groups. If our evaluability assessment indicates that appropriate in-state comparison groups are feasible for specific programs, we will use DiD or CITS models to estimate the impact of the Demonstration, including relevant covariates based on our empirical model of causality, and adjusting standard errors to account for clustering of observations within appropriate groups.

  A CITS model is an expansion of the standard ITS model, with the addition of an indicator (Z) for treatment group (vs. comparison group), as follows:

  $$Y_{it} = \beta_0 + \beta_1 T + \beta_2 X_t + \beta_3 Z_i + \beta_4 T * X_t + \beta_5 T * Z_i + \beta_6 Z_i * X_t + \beta_7 T * Z_i * X_t + \gamma COVAR_{it}$$

  In this model, *i* indexes individual and *t* indexes time. β_6 estimates the change in level while β_7 estimates the change in slope in the outcome of interest (Y) in the treatment group (Z=1) relative to the comparison group (Z=0) following program implementation (X).

  Alternatively, we would implement a DiD model using the following model:

  $$g[E(Y_{it})] = \beta_0 + \beta_1 Z_i + \beta_2 X_t + \beta_3 Z_i * X_t + \gamma COVAR_{it}$$

  where *i* indexes individual and *t* indexes time. As with the CITS model, Y represents outcome of interest, *Z* is an indicator for treatment group individuals, and X is an indicator for post-program implementation. In this model, β_3 represents the program impact (difference-in-difference) estimate of interest.

  We note that validity of DiD models rests on the parallel trends assumption, i.e., that any differences in outcomes between intervention and comparison groups remains constant over time in the absence of the intervention. We will test for violations of the parallel trends assumption indirectly by comparing changes over time during the baseline period between the intervention and comparison groups, and proceed with DiD analyses only if differences between the two groups are not significant.

  The CITS approach is slightly more flexible than the DiD approach and allows for baseline trends to differ between the intervention and comparison groups. Specifically, the

appropriate CITS model is informed by baseline trends in the intervention and comparison groups: where trends are parallel, a baseline mean model, which is similar to the DiD model, can be used; where the trends diverge, a baseline linear-trend model can be used to account for baseline intervention and comparison group trend differences. Finally, the more flexible baseline non-linear trend model is also available to allow for more complex baseline trends.[lix] However, application of the CITS, like the ITS model, requires more data points across time to ensure greater validity.

Where baseline data and comparison groups are available, we will evaluate whether we have the statistical power to use DiD or CITS models and determine the more appropriate model to implement based on a few factors. First, we will test for differences in pre-intervention/baseline trends between the treatment and comparison groups. If there are no significant differences, either a DiD or CITS approach is possible. Because the CITS approach allows for changes in both the level and the slope of the outcome in the treatment group relative to the comparison group due to the intervention, it may be preferable over the DiD approach if there are sufficient data points over time. We may also consider applying both approaches as a sensitivity check. If significant differences in outcome trends during the pre-intervention period exists between the treatment and comparison groups, the feasibility of a baseline linear trend or baseline non-linear trend model will rest on the availability of repeated observations over time.

Covariate Adjustment. In models with covariate adjustment, we will account for key sociodemographic, health status, and area-level covariates based on our empirical model of causality. Potential beneficiary-level covariates will be derived from Vermont MMIS data and may include Medicaid enrollment category, demographic characteristics such as age, sex, and race/ethnicity, as well as clinical characteristics such as presence of behavioral health or chronic somatic conditions. For each model, we will also consider the feasibility and appropriateness of including area-level socioeconomic (e.g., median household income, area-level rates of poverty, unemployment, and education) and health care market characteristics (e.g., availability of primary care or behavioral health providers) derived from publicly available datasets including the American Community Survey (ACS) and the Area Health Resource File (AHRF). Finally, to account for potential differential effects of the COVID-19 Public Health Emergency, we will adjust for area-level COVID-related variables, such as Pandemic Vulnerability Index and rates of COVID vaccinations and COVID-related deaths.

Because beneficiary- and market-level characteristics are largely time-invariant (e.g., race/ethnicity, sex, provider availability), we expect that these covariates will be measured at baseline and included as time-invariant variables. COVID-related covariates will be allowed to vary over time. For all models, we will consider interactions and higher-order terms, including interactions between time-varying covariates and time periods, as appropriate.

Subgroup analyses. Recognizing that program impacts may be heterogeneous across individuals, we will consider subgroup analyses to evaluate whether and how program impacts vary. As with the overall analyses, we will conduct evaluability assessments (including data availability and quality assessments, sample size assessments, and power evaluations) and confirm that relevant assumptions for any proposed statistical analyses are met (e.g. parallel trends assumption for DiD and CITS) within subgroups of interest. We will first consider analyses within subgroups defined by beneficiary characteristics (including beneficiary age, gender, race/ethnicity) and eligibility category. We may also explore other subgroups as informed by claims data (e.g., health status indicators including chronic conditions and substance use disorders) based on ongoing evaluation work and data quality and availability. Selection and approach of subgroup analyses will be informed by results from evaluability assessments and relevant assumption testing.

Survey Analysis. The evaluation will include an analysis of provider survey data for the SUD and SMI/SED Mid-Point Assessments and Interim and Summative Evaluation Reports. Once the SMI/SED and SUD provider surveys have been fielded, raw data will be cleaned to produce final analytical files. Results from provider surveys will be assessed using descriptive and bivariate statistics, preserving the confidentiality of individual respondents, and we will highlight findings from statistical tests of significance in the descriptive tables. Open-ended responses will be coded using the qualitative codebook, and key themes will be summarized (see details in "Qualitative Analytic Methods" subsection) in Mid-Point Assessments and evaluation reports.

Qualitative Data Sources and Analysis

The goal of the qualitative analysis will be to inform an in-depth, multi-faceted understanding of the complexities involved in implementing the demonstration, including the public health, health care, and health-related investments, over time. The analysis will provide a thorough understanding of the evolution of Demonstration implementation, about barriers and facilitators to implementation, and of perceptions about the demonstration's impact.

Qualitative Data Sources

We will use qualitative data to describe implementation progress, including barriers and facilitators, and inform the design and interpretation of quantitative analyses and measure set development. We propose to conduct the following data collection activities:

- **Document review**. NORC will conduct document reviews throughout the study period, incorporating newly released program documents into the study as they become available. We will use as much existing information as possible to inform our data collection instruments, including Demonstration program assessments and reports**,** quarterly and annual operational reports**,** legislative reports and public meeting minutes**,** SUD and SMI/SED implementation plans and monitoring reports, and public health, health care, and

health-related investment program documents. The document review will provide valuable information on upcoming programmatic changes and updates, and program implementation status.

- **Surveys**. NORC will design and field two provider surveys as part of the data collection for the SMI/SED and SUD mid-point assessments. These surveys will include open-ended questions (see details in "Quantitative Data Sources" subsection).
- **Interviews.** Individual and small-group interviews will provide the opportunity to gather rich information from AHS officials, Demonstration program staff, providers, innovative investment staff, and others knowledgeable about and affected by Vermont's Demonstration. Where applicable, we will also conduct interviews with providers and organizations implementing specific public health, health care, and health-related investments. Interviews will be particularly important to understand the implementation experience and impacts of waiver activities targeted at subpopulations too small for constructing a suitable comparison group for impact analyses (for example, the Maternal Health and Treatment Services Program).
    - **Timing:** Interviews will be conducted over the course of the evaluation (evaluation contract Years 1-6) using a purposive sampling approach.
        - To inform our SMI/SED and SUD mid-point assessments, we will prioritize conducting interviews with SMI/SED and SUD treatment providers, respectively, in evaluation contract Years 1, 2, and 3. In Years 4-6, we will prioritize state-level interviews and interviews with a subset of community organizations and providers based on themes that emerge in the analysis of data from prior years and gaps in our data.
        - Beginning in contract Year 1, we will also conduct qualitative interviews or focus groups to inform our investment assessments. For investment assessments where qualitative data is included in the analytic approach, we may use a combination of purposive and snowball sampling to conduct interviews with investment participants.
    - **Mode:** The interviews will take place over Zoom and be between 45- and 90-minutes. We will establish efficiencies wherever possible to reduce burden on service providers. Each interview will be conducted by a trained qualitative researcher, as well as a staff member for note-taking.

We will use interviews and focus groups to understand implementation experience, challenges, and context; members' perceptions of their access to and quality of care; and drivers of key outcomes. See **Exhibit 19** for a preliminary overview of interview groups and research areas we expect to cover. Interviews will be conducted with providers from across the state to inform our understanding of how implementation progress and challenges may vary across diverse geographic regions with different provider organizations (for example, those with local hospitals designated to provide psychiatric inpatient care).

Exhibit 21. Example Interviewee Types, Demonstration Goals and Topics

Demonstration Goals	Topics
State	
• GOAL 3: Engage Vermonters in transforming their health • GOAL 5: Accelerate payment reform	• Perceptions of impact of Demonstration activities to meet Demonstration goals • Perceptions of impact of the Demonstration on payment reform and how this has evolved over time • Implementation successes and challenges • Use of evidence-based criteria for provider qualifications
Community Organizations	
• GOAL 2: Implement innovative care models across the continuum that produce value • GOAL 3: Engage Vermonters in transforming their health • GOAL 4: Strengthen care coordination and population health management capabilities to encompass the full spectrum of health-related services and supports • GOAL 5: Accelerate payment reform	• How health-care delivery and community providers collaborate to reach Demonstration goals and barriers they encounter • Ability to reach target populations • Impact of Demonstration on care delivery over time • Implementation successes and challenges
Providers and Provider Organizations	
• GOAL 2: Implement innovative care models across the continuum that produce value • GOAL 3: Engage Vermonters in transforming their health • GOAL 4: Strengthen care coordination and population health management capabilities to encompass the full spectrum of health-related services and supports • GOAL 5: Accelerate payment reform	• How health-care delivery and community providers collaborate to reach Demonstration goals and barriers they encounter • Evolution and perceptions of HIT capabilities • Implementation successes and challenges • Use of evidence-based criteria for patient placement • Perceptions of quality of care in residential settings, access to care across the continuum, and provider capacity

Qualitative Analytic Methods

The goal of the qualitative analysis will be to inform an in-depth, multi-faceted understanding of the complexities involved in implementing the Demonstration over time. The analysis will provide a thorough understanding of the evolution of Demonstration implementation, about barriers and facilitators to implementation, and of perceptions about the Demonstration's impact. We will apply this understanding to inform the design and interpretation of impact assessments and to develop a measure set to monitor and evaluate the Maternal Health Treatment and Services program. Recognizing that states face challenges in implementing 1115 demonstrations, which in turn may create challenges for the evaluation process, we note that challenges will likely arise in implementing mixed-methods and quasi-experimental designs in this evaluation. For instance, many demonstration programs are implemented statewide, making construction of an in-state comparison group infeasible. Experience has taught us that evaluation of 1115 demonstrations

requires a flexible and adaptive approach; **Exhibit 20** below describes anticipated challenges and NORC's proposed mitigation strategies.

First, the NORC team will review and sort all qualitative and primary data collected through document review, interviews, and survey open-ended responses. We will begin by developing an initial coding frame and by systematically applying a reliable code list. NORC will use an inductive and deductive approach to create the qualitative codebook. We will pilot test and refine codes and revisit refinements over the evaluation period. To organize program documents and interview transcripts for coding, NORC will use Dedoose, a cloud-based analysis application. Before coders analyze study data, they will be trained and will complete several rounds of sample coding exercises to establish robust inter-rater reliability, to ensure that the team can apply codes consistently. Whenever possible, coders will have been involved in primary data collection, to leverage their insights gained through first-hand experience. NORC will employ a thematic analysis to analyze qualitative data, guided by the Demonstration goals and evaluation questions. We will begin the analysis of existing and emergent themes during the coding process and continue throughout the analysis phase. Existing themes are topics derived from the study's research questions and categories, while emergent themes arise out of the coding process. Early identification of emergent themes will help inform future primary data collection instruments.

Reporting

Interim & Summative Evaluation Reports. We plan to include all quantitative outcome measures included in **Exhibits 12-14** in both the Interim and Summative Reports (pending data quality and availability) for the following populations: overall Demonstration population, SUD, SMI/SED, HCBS, Premium Assistance, Retroactive Eligibility. Depending on sample size and program implementation timelines, we anticipate that some analyses included in the IER may be limited to descriptive trends due to small sample size and/or a limited number of time points for observation. In such cases, we will use more rigorous analyses in the SER if more data has become available in the interim due to increased program participation or longer length of implementation. Because the Lund and Supportive Housing Pilot programs are in the early stages of implementation, we anticipate that analyses for these populations will appear only in the Summative Report. Finally, because all payments made under the Medicaid Data Aggregation and Access Program (MDAAP) will be completed by March 31, 2025, analyses for this program will only appear in the Interim Report.

Brief Investment Assessment Reports. We will conduct up to 10 assessments of specific public health, health care, and health-related investments per year, for a total of 40 investment assessments throughout the evaluation period. NORC will work with AHS to determine the order of the investment assessments. Each assessment will result in a brief report, which will include an overview of the investment being assessed and the research questions of interest, the analytic

approach, a summary of the findings, a discussion of the implications of the findings, and appendices with additional detail as needed. Individual reports will be included as appendices to the Interim and Summative Reports. In addition to the brief investment-specific reports, findings from our analysis of a common set of outcome measures (detailed in **Exhibit 16**) for investments aligned to each investment goal will be included in both the IER and SER. The IER will include findings and individual reports as appendices from the approximately 16 assessments completed prior to the IER (see **Supplement 3** for a list of investment assessments for 2024). The SER will include findings and individual reports as appendices from all assessments.

Methodological Limitations

Recognizing that states face challenges in implementing 1115 demonstrations, which in turn may create challenges for the evaluation process, we note that challenges will likely arise in implementing mixed-methods and quasi-experimental designs in this evaluation. For instance, many demonstration programs are implemented statewide, making construction of an in-state comparison group infeasible. Experience has taught us that evaluation of 1115 demonstrations requires a flexible and adaptive approach; **Exhibit 20** below describes anticipated challenges and NORC's proposed mitigation strategies.

Exhibit 22. Anticipated Evaluation Challenges and Proposed Mitigation Strategies

Challenge	Proposed Mitigation Strategy
Timeliness and quality of claims and encounter data	• Work closely with AHS data stewards to receive the most recent data, identify appropriate timeframes for claims run out, and quickly address any data quality issues. • Create automated reports that flag quality issues (for example, missingness, disallowed values).
Creation of new eligibility group for uninsured/ underinsured Vermonters between 133-225% FPL with SUD	• Expansion may increase the number of people seeking SUD treatment in Vermont, leading to an increase in the percentage of persons with an unmet need for treatment. NORC can examine other states that have expanded Medicaid for this population and use those states as a benchmark for change in unmet need. • Conduct sensitivity analyses.
Inability to capture delayed impacts in interim and mid-point reports	• Integrate qualitative information from document reviews to assess implementation progress and integrate those data to add context to claims-based outcomes.
Bias or data inaccessibility for potential comparison groups	• Consider feasibility of analytic methods for each population separately. • Implement entropy balancing methods. • Employ interrupted time-series or pre-post analyses.
Difficulty isolating program-specific effects of overlapping Demonstration programs in the context of other reform initiatives	• Leverage NORC's understanding of the Vermont health care landscape and use document review processes to assess the impact of the program within the context of other state/federal interventions. • Where possible (for example, if data exist in encounter claims), adjust for participation in the overlapping programs/delivery system initiatives in the state.

Challenge	Proposed Mitigation Strategy
	• Integrate qualitative data to assess the extent to which members are enrolled in multiple programs and/or initiatives.
Small survey sample	• Leverage surveys to collect information from organizations that would otherwise need to be collected through interviews to reduce respondent burden. • Use survey data to inform interview tailoring to maximize the utility of interviews.
Low survey response rates	• Design the survey to be as brief as possible to reduce burden and increase response rate. • Include only questions that we cannot answer through other sources.
Primary data collection respondent burden	• Thoroughly assess and leverage existing data sources (for example, program documents) before considering primary data collection. • Utilize provider surveys to minimize the number of qualitative interviews needed. • Where possible, (for example, when organizations are implementing several investments that NORC is assessing), target qualitative data collection activities to minimize respondent burden. • Conduct most primary data collection over videoconferencing rather than in person to be more flexible with respondents' time.
Shifts in utilization and spending during the COVID-19 pandemic	• Where possible, include a four-year baseline to allow for a full year of data before the onset of the COVID-19 pandemic. • Descriptively assess the community- and individual-level outcomes of the COVID-19 pandemic in quantitative analyses. • Conduct sensitivity checks assessing the community-level effect of the pandemic in Vermont and accounting for community-level COVID-19 outcomes in regression models and analytic weights
Shifts in the composition of the demonstration population or any comparison groups (for example, due to changes in eligibility)	• Evaluate year-to-year distributions in demonstration population (and where applicable comparison population) characteristics (including age, gender, race/ethnicity, and program enrollment) • Assess the distribution of full vs. partial-year enrollment and conduct sensitivity analyses to determine whether results are sensitive to churn • Where applicable, we will control for population characteristics in multivariate analyses

Attachment 1: Independent Evaluator

In May 2023, AHS selected NORC at the University of Chicago as the Independent Evaluator for the Global Commitment to Health 1115 Demonstration via a competitive procurement process. NORC will conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. NORC agreed to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved, draft Evaluation Design.

In addition to the design, NORC will be responsible for developing draft and final versions of the evaluation design, final measure selection, conducting data collection and analysis, interpreting results, and drafting the Interim and Summative Evaluation Reports and the SUD and SMI/SED Mid-Point Assessments.

NORC CONFLICT OF INTEREST STATEMENT & COMPLIANCE PROCESS

Overview

NORC has robust policies and procedures for avoiding and mitigating potential conflicts of interest on programs such as this. For this solicitation, ***Evaluation of the Vermont Global Commitment to Health 1115 Waiver,*** NORC has no known actual or potential conflict of interest. NORC has no known organizational or personal conflicts of interest that might cause biased judgment. NORC does not have access to nonpublic information that will provide an unfair competitive advantage.

Introduction

National Opinion Research Center ("NORC") is a prominent not-for-profit research firm that is well known for its scientific excellence, independence, and integrity. The majority of NORC's business is performed through contracts and grants with the federal government. Given the importance of NORC's reputation for successful business activity and its position as a federal contractor, a robust and well-proven Conflict of Interest ("COI") regime is in place to ensure (1) the prevention of COIs from developing in the first place, and (2) the identification and remediation of any COIs effectively and immediately in the rare cases they do occur. NORC has developed COI procedures described herein to fulfill the requirements set forth in ***Evaluation of the Vermont Global Commitment to Health 1115 Waiver***. We provide details on our tailored COI processes in the remainder of this document.

NORC Compliance Officer

A NORC Vice President and senior Institutional Review Board ("IRB") member, Kathleen Parks, serves as NORC's Conflicts Compliance Officer. Due to her role on the IRB and her position on NORC's senior management team, Ms. Parks is independent and impartial. In addition to being a senior member of NORC's IRB, Ms. Parks is also responsible for administrative oversight of the IRB and is a member of NORC's Conflicted Transactions Committee which oversees the administration of NORC's Financial Conflict of Interest policies and procedures. The Conflicts Compliance Officer reports directly to NORC's Board of Trustees for all compliance and conflicts matters. NORC's Conflicts Compliance Officer reviews and has auditing authority for all business and contractual relationships and activities of NORC.

Independent and Impartial

NORC is an independent 501 (c) 3 not-for-profit organization. NORC has its own Board of Trustees (16). NORC is affiliated with the University of Chicago in that the President of the University can nominate 51% of NORC's Trustees. However, all of NORC's Trustees have a fiduciary responsibility to act in NORC's best interest while making decisions as Trustees of NORC. The University of Chicago has its own independent Board of Trustees which is required to make decisions in the best interest of the University.

Conflicts Policies and Procedures

NORC maintains policies and procedures for organizational conflicts of interest and personal conflicts of interest, each described in turn below. Each item below describes the particular conflicts oversight process including how conflicts are identified and resolved.

1. Organizational Conflicts

All staff are required to identify potential conflicts of interest on an ongoing basis. All NORC staff receive annual conflicts and ethics training that includes a series of self-administered training modules and exams supplemented by regularly conducted training sessions. NORC's Conflicts Compliance Officer reviews all existing and potential new business for NORC and its staff, subcontractors, consultants, and vendors to determine if there are any actual, potential, or apparent conflicts. Any actual, potential, or apparent conflicts are categorized into any or all of the following conflict types: unequal access to information, biased ground rules, or impaired objectivity. If any of the aforementioned conflicts exist as determined by the Conflicts Compliance Officer, the Conflicts Compliance Officer works with the project team and NORC's Contracts department to create a mitigation plan for submission to the cognizant awarding agency's conflicts officer and/or the program's assigned Contracting Officer along with any other information that may be useful in assisting the review of NORC's proposed solution to mitigate or neutralize the conflict.

Additionally, the Conflicts Compliance Officer has full authority to audit all relevant areas of NORC's business and individual projects to determine if staff and management are complying with NORC's conflicts policies and procedures at all times. NORC maintains a reporting hotline where anyone can call in to report an issue. Issues reported to the hotline are resolved by the Conflicts Compliance Officer and Board of Trustees members that participate in NORC's Conflict Transactions Committee. All such reported issues are treated seriously and investigated thoroughly.

2. Personal Financial Conflicts

NORC also adheres to a robust Personal Financial Conflict of Interest (FCOI) Policy. This is a federally mandated policy by certain agencies of the government including HHS. Under this policy, all principal investigators, and other staff who can influence the results of an affected government contract, are required to at least annually complete a certificate identifying potential conflicts of interest with the work they are performing on the affected contract (Personal Conflicts disclosures are also completed on per project and/or per proposal basis as required by individual sponsors). These employees are also required to undergo specific training on how to identify a potential conflict of interest and the requirements to disclose it. FCOI compliance is overseen by the NORC FCOI Committee, of which the Conflicts Compliance Officer is a member. All personal conflict disclosures are evaluated by the Conflicts Compliance Officer. Under the direction of NORC's Conflicts Compliance Officer, the Contracts department administers the annual certifications and trainings required to satisfy the organization's compliance obligations for FCOI. If an FCOI disclosure is identified, it is immediately sent to the FCOI Committee for review, discussion, and further remediation by other cognizant NORC officers, if necessary. The Conflicts Compliance Officer ensures a mitigation plan is created and

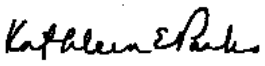
submitted to the appropriate governing agency for review where any actual, potential, or apparent conflict has been identified. Conflicted and/or potentially conflicted individuals are prohibited from participating in any component of the program or work that gave rise to the conflict until the conflict has been neutralized and cleared by the governing agency.

Authority, Audits and Remediation

NORC's Conflicts Compliance Officer has independent authority to audit all relevant areas of NORC's business and individual projects to determine if staff and management are complying with NORC's conflicts policies and procedures at all times. In coordination with NORC's Contracts department, Accounting and Finance, and other stakeholders within the organization, the Conflicts Compliance Officer conducts regular random audits of project and personnel activities to ensure compliance with NORC's conflicts policies and procedures. Additionally, NORC contracts with an independent external auditor to conduct an independent audit of any mitigation plans as directed. The findings and recommendations of any external audit including any corrective action plan developed by NORC will be shared with our client for review and approval.

NORC maintains a third-party administered Hotline for reporting conflicts, fraud, misconduct, and illegal or unethical practices. Staff, contractors, sponsors, or interested parties can anonymously call this third-party administrator and report any suspected wrongdoing including conflict of interest at any time. The third-party administrator reports directly to the Board of Trustees Chairman of the Audit and Finance Committee and NORC's Conflicts Compliance Officer. All such reported issues are treated seriously and investigated thoroughly. In accordance with FAR 52.203-14, the Conflicts Compliance Officer works with NORC's Human Resources and Facilities Departments to ensure these conflicts policies and hotline number are posted in locations that are accessible to all staff including hard copy posters in common areas of office sites and on NORC's intranet. NORC routinely prompts staff to review these policies.

Violation of NORC's conflicts policies and procedures are handled in a manner commensurate to the nature of the violation. Violations may range from corrective action by a supervisor, termination of employment/contractor, referral to authorities, as well as civil and criminal prosecution where warranted or necessitated by law.



Vice President and COI Compliance Officer

Attachment 2: Evaluation Budget

The estimated budget for the Independent Evaluator for the contract period (June 12, 2023 through December 1, 2029) is $1,965,147 (**Exhibit A2.1**). The estimated budget will cover all expenses related to the independent evaluation, including project management, data collection and analysis, measure development and programming, and development of deliverables for CMS (evaluation design, interim evaluation report, summative evaluation report, SMI/SED mid-point assessment, and SUD mid-point assessment).

Exhibit A2.1. Budget for Independent Evaluator

Evaluation Activity	Contract Year							TOTAL
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	
Project Management	$21,656	$21,656	$21,656	$21,656	$21,656	$21,656	$10,827	$140,763
Evaluation Design	$26,184							$26,184
ROP Evaluation Design	$13,381							$13,381
Investment Assessments	$61,151	$221,656	$221,656	$221,656	$221,656			$947,775
ROP Final Report			$38,320					$38,320
Data Collection and Analysis Activities	$89,535	$89,535	$89,535	$89,535	$89,535	$89,533		$537,208
Interim Evaluation Report				$70,500				$70,500
Summative Evaluation Report						$62,387	$9,649	$72,036
SMI/SED Mid-Point Assessment		$59,490						$59,490
SUD Mid-Point Assessment			$59,490					$59,490
TOTAL	$211,907	$392,337	$430,657	$403,347	$332,847	$173,576	$20,476	$1,965,147

NOTE: Contract years start on June 12 of each year. Year 7 is a partial year, ending December 1, 2029.

Attachment 3: Timeline and Major Milestones

Exhibit A3.1 shows the projected timeline for evaluation activities and major deliverables. All deliverables in this exhibit (evaluation design, evaluation reports, and mid-point assessment) reflect the date the draft version is due to CMS; a final version of those deliverables will be due to CMS 60 days after receiving their comments on the draft version. The due dates for submitting drafts of the major deliverables to CMS are as follows:

- Evaluation Design Draft: August 25, 2023
- Evaluation Design for Reasonable Opportunity Period (ROP) Extension: September 5, 2023
- COVID-19 PHE Amendment Draft Final Report: May 10, 2024
- SMI/SED Mid-Point Assessment: June 30, 2024
- SUD Mid-Point Assessment: June 30, 2025
- Final Report for ROP Extension: January 2, 2026
- Interim Evaluation Report: December 31, 2026 (or with extension application)
- Summative Evaluation Report: June 30, 2029

The interim evaluation will incorporate all data available to date, and the summative evaluation will incorporate data from the entire waiver extension period (July 1, 2022 through December 31, 2027).

Exhibit A3.1. Evaluation Timeline

Evaluation Activity	Year 1 (6/23-6/24)				Year 2 (6/24-6/25)				Year 3 (6/25-6/26)				Year 4 (6/26-6/27)				Year 5 (6/27-6/28)				Year 6 (6/28-6/29)				Year 7 (6/29-12/29)			
Project Management																												
Assessment of Investments																												
COVID-19 PHE Amendment Draft Final Report																												
Evaluation Design for Demonstration																												
Evaluation Design for ROP Extension																												
Final Report for ROP Extension																												
Interim Evaluation Report Draft								*	*																			
Summative Evaluation Report Draft																	*	*	*	*								
SMI/SED Mid-Point Assessment																												
SUD Mid-Point Assessment																												

NOTE: Dark orange indicates a due date for the deliverable; light orange indicates evaluation activities (e.g., primary data collection, measure programming and analysis) related to that deliverable. Asterisks (*) indicate approximate timelines for quantitative evaluability assessments and selection of comparison groups, which will be dependent on data acquisition.

Supplement 1: Driver Diagrams for SMI/SED

Exhibits S1.1-S1.5 show the multiple, interconnected drivers that aim to support the Demonstration's SMI/SED goals.

Exhibit S1.1. Drivers for Reduced Utilization and Length of Stay in Emergency Departments.

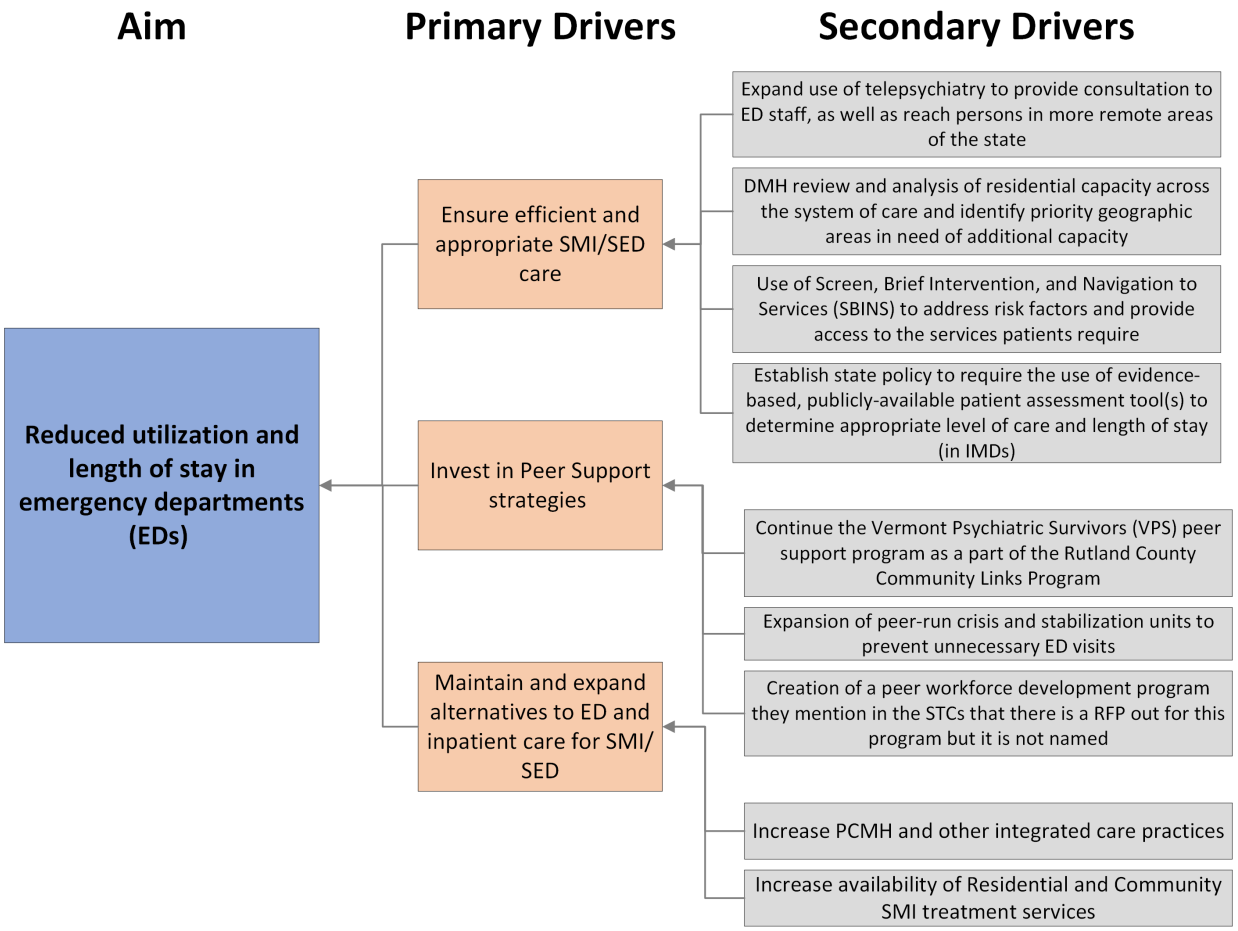


Exhibit S1.2. Drivers for Reduced Preventable Readmissions.

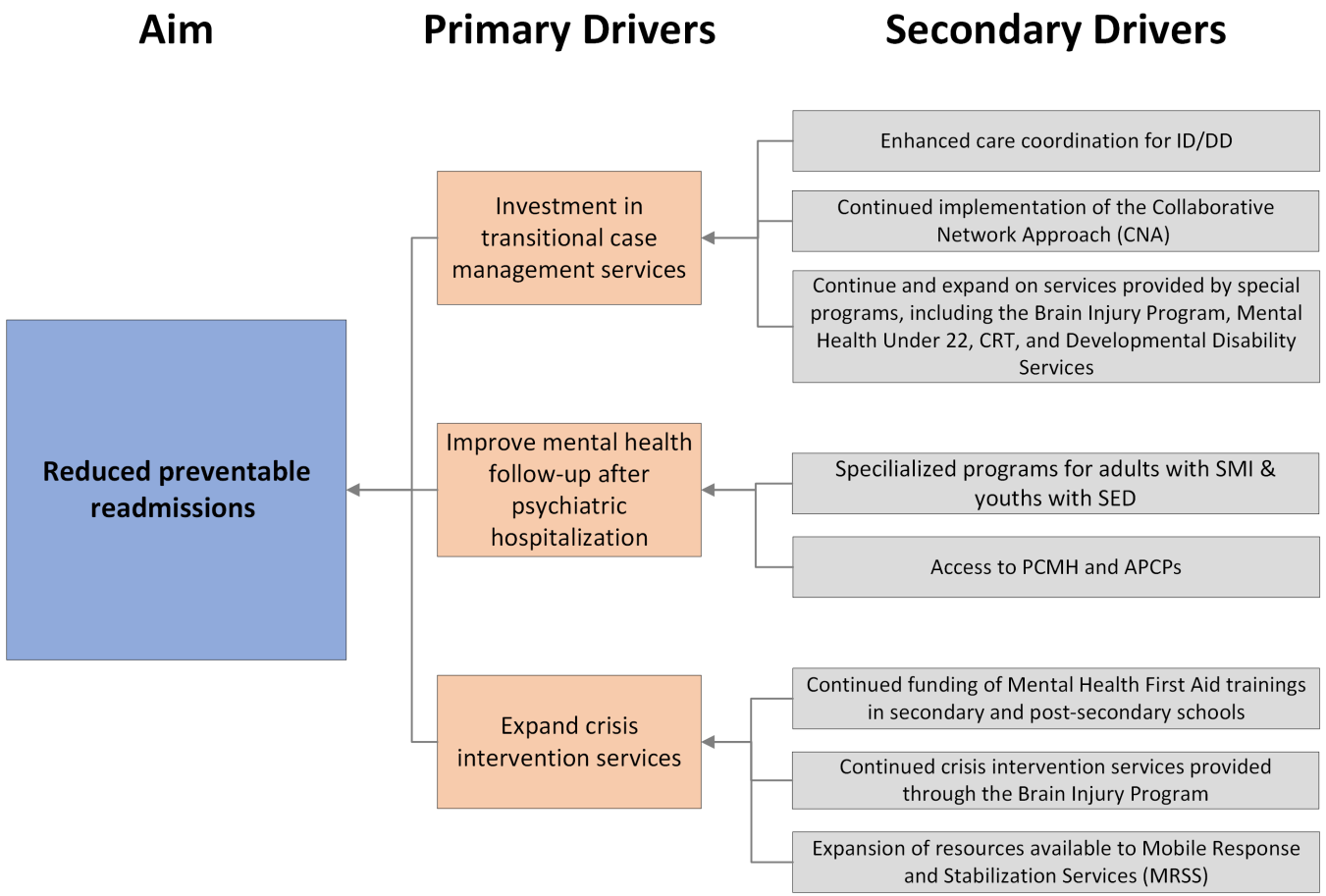


Exhibit S1.3. Drivers for Improved Availability of Crisis Stabilization Services.

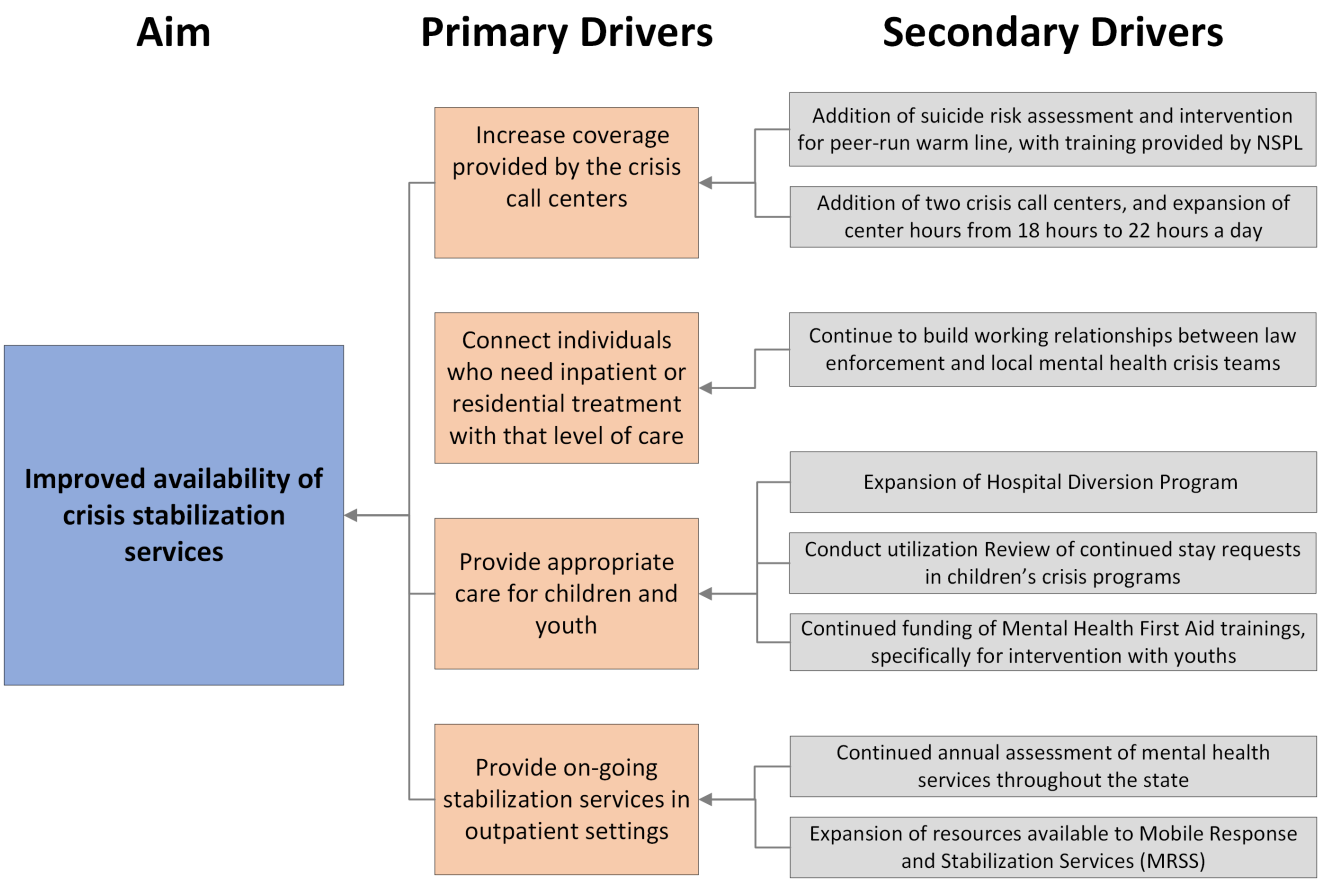


Exhibit S1.4. Drivers for Improved Access to Community-Based Services.

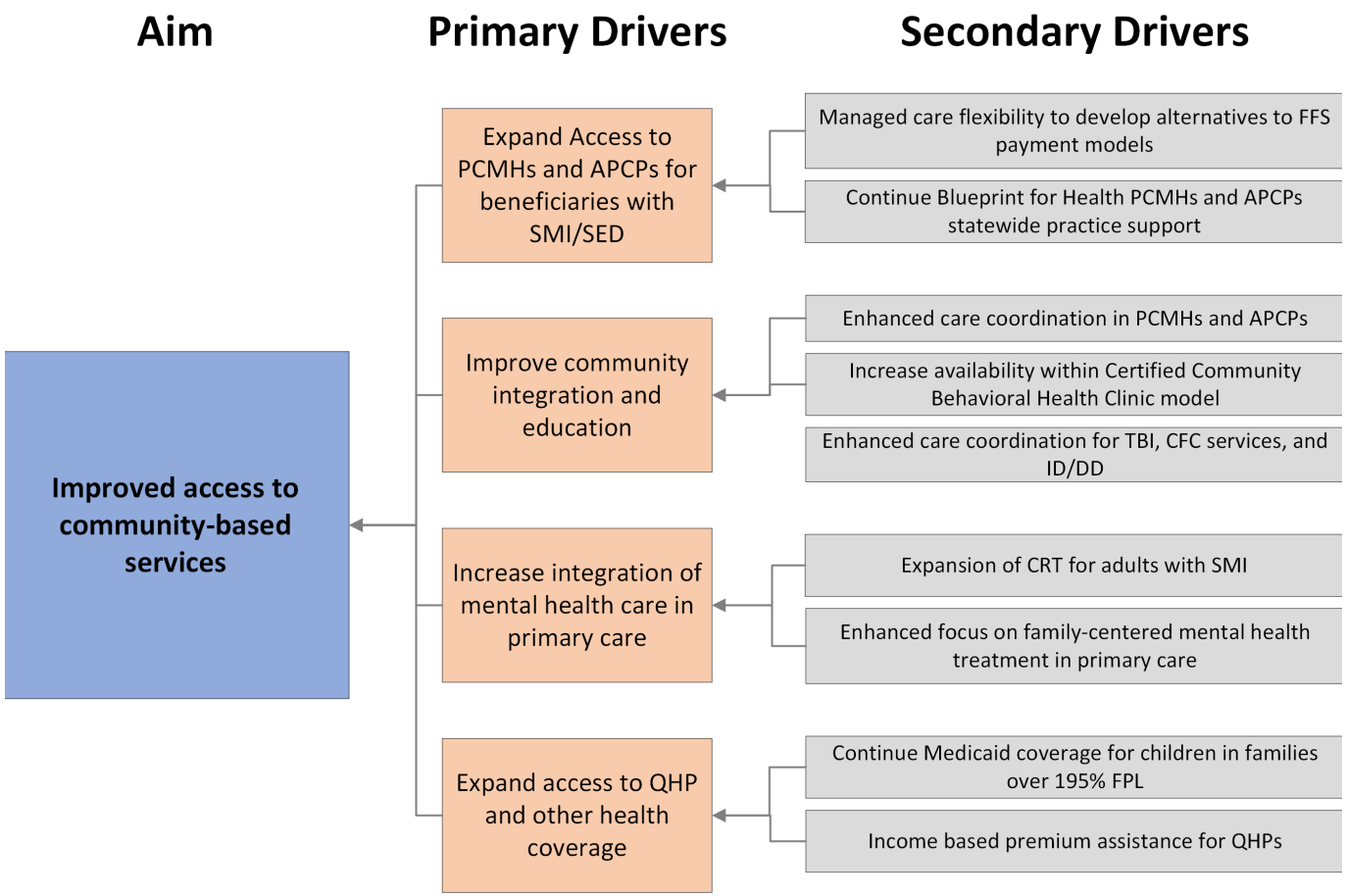
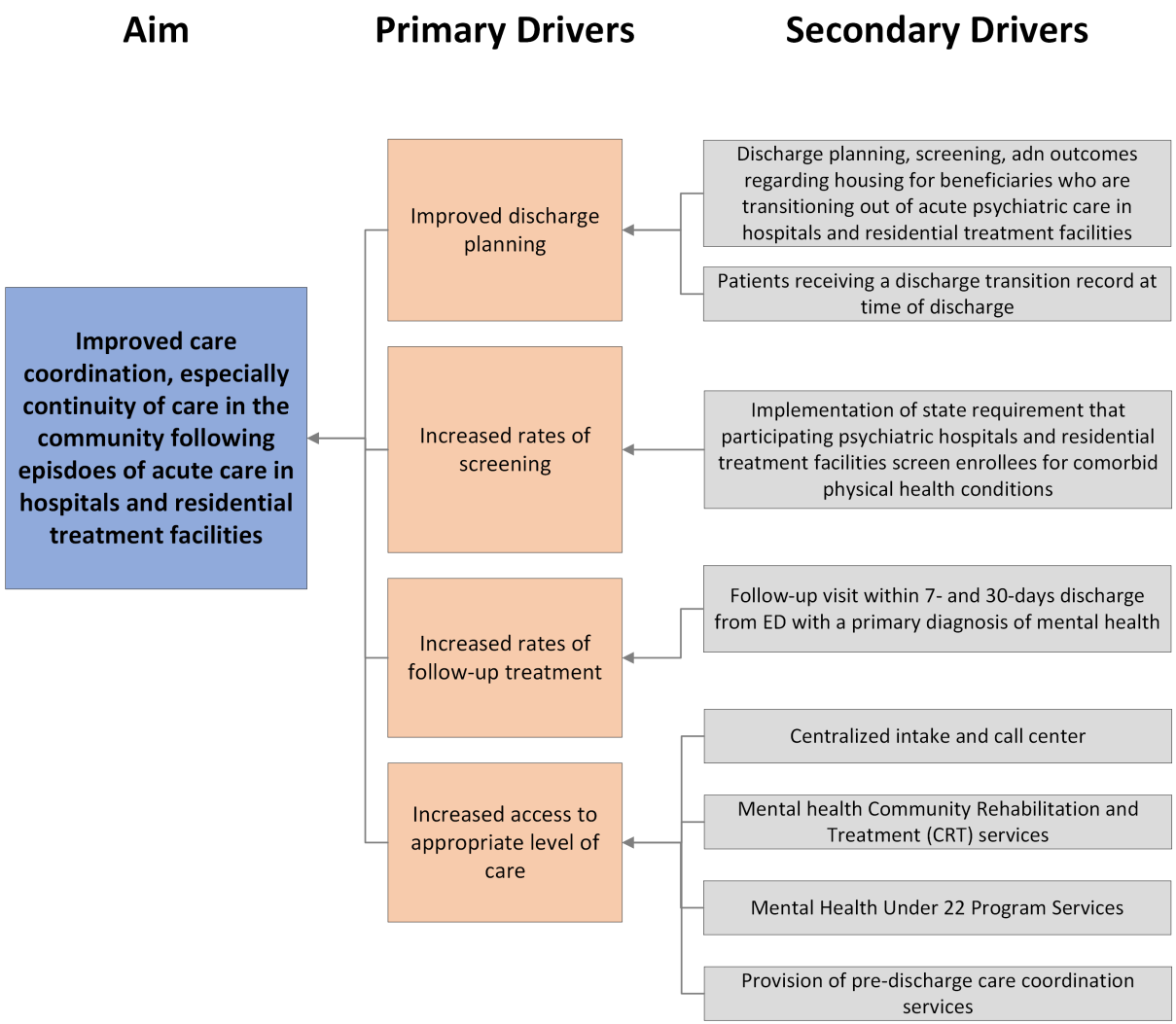


Exhibit S1.5. Drivers for Improved Care Coordination, Especially Continuity of Care in the Community Following Episodes of Acute Care in Hospitals and Residential Treatment Facilities.



Supplement 2: Driver Diagrams for SUD

Exhibits S2.1-S2.5 show the multiple, interconnected drivers that aim to support the Demonstration's SUD goals.

Exhibit S2.1. Drivers for Increased Rates of Identification, Initiation, and Engagement in Treatment.

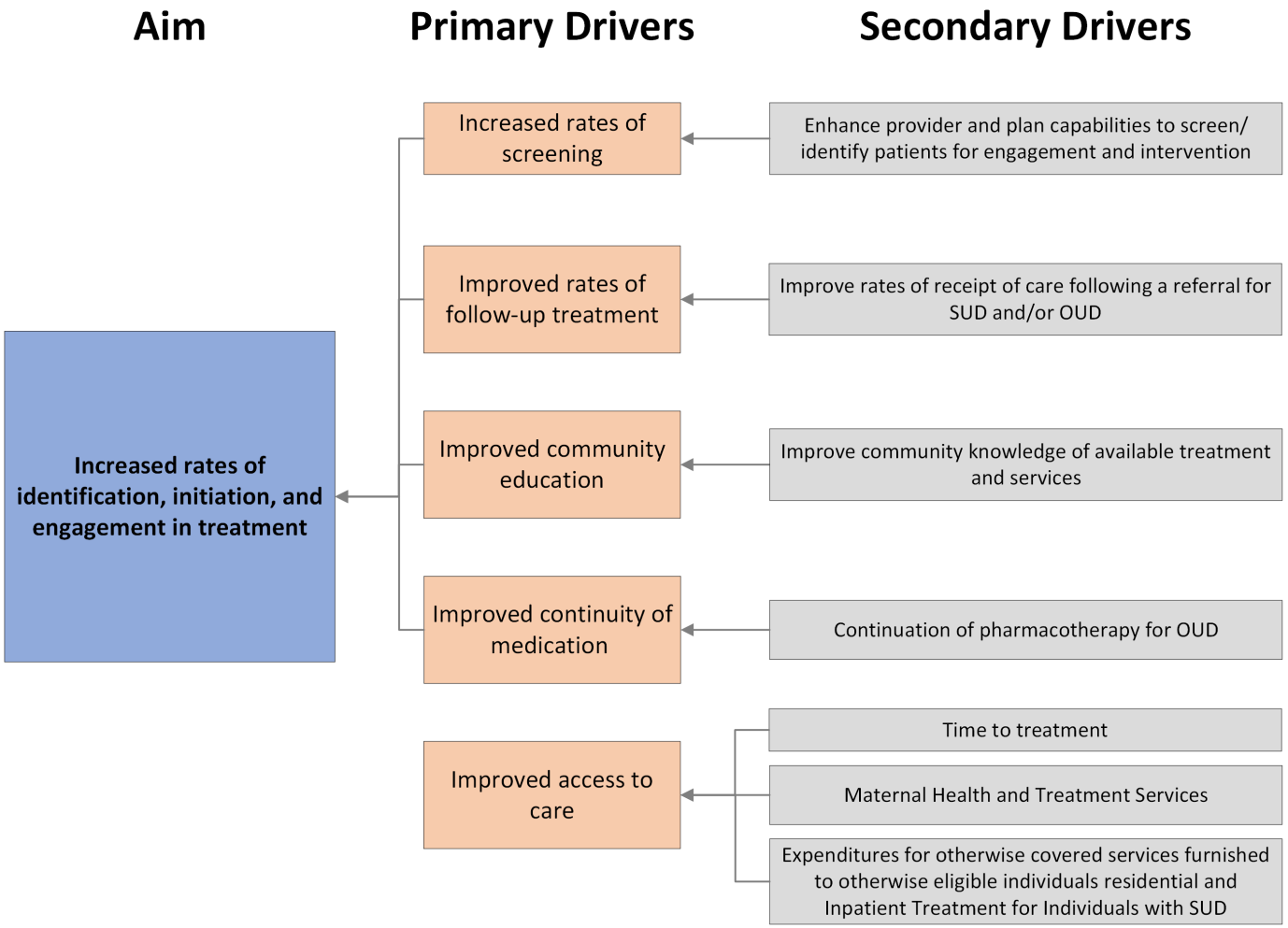


Exhibit S2.2. Drivers for Increased Adherence to and Retention in Treatment.

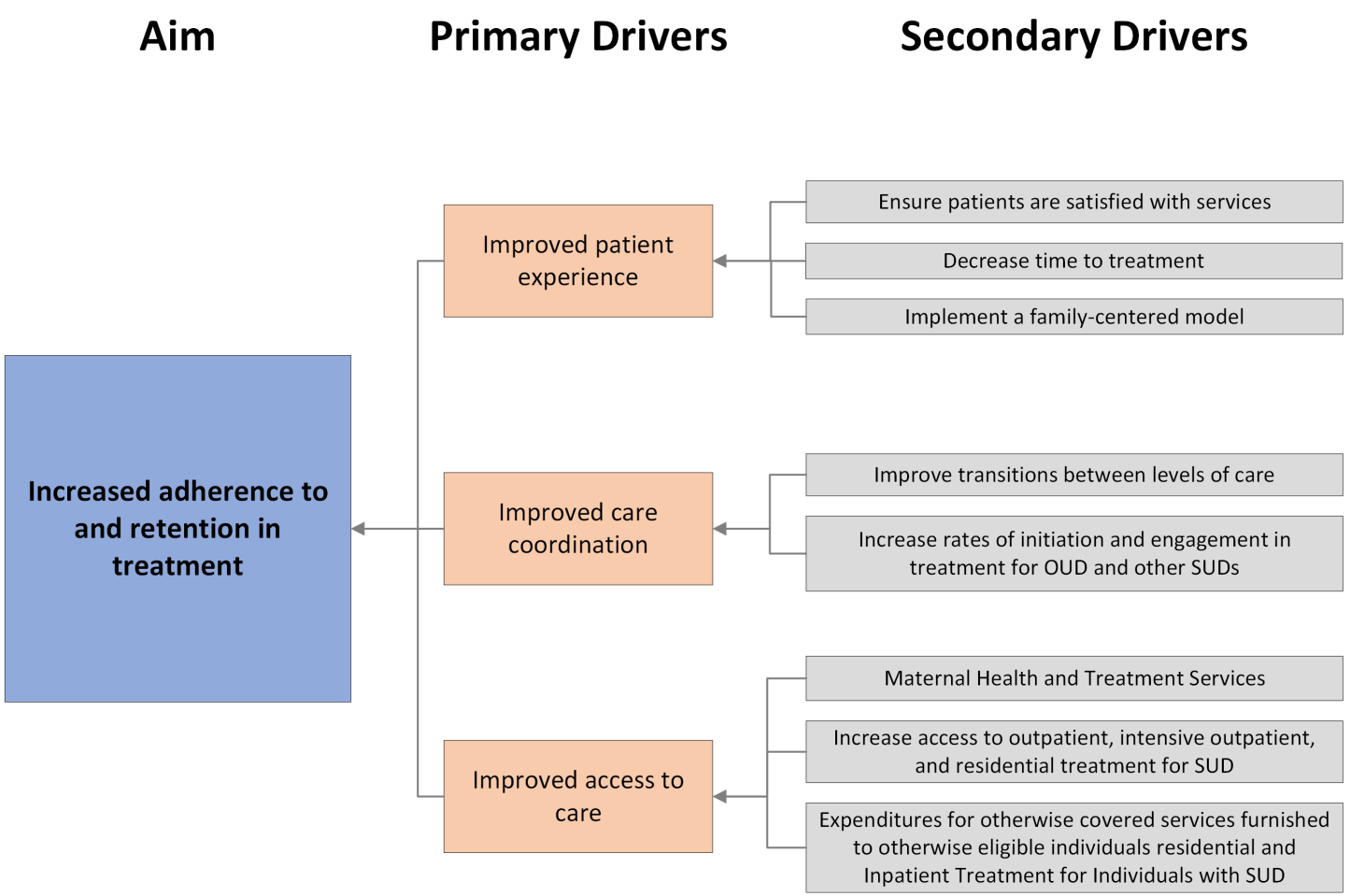


Exhibit S2.3. Drivers for reductions in overdose deaths.

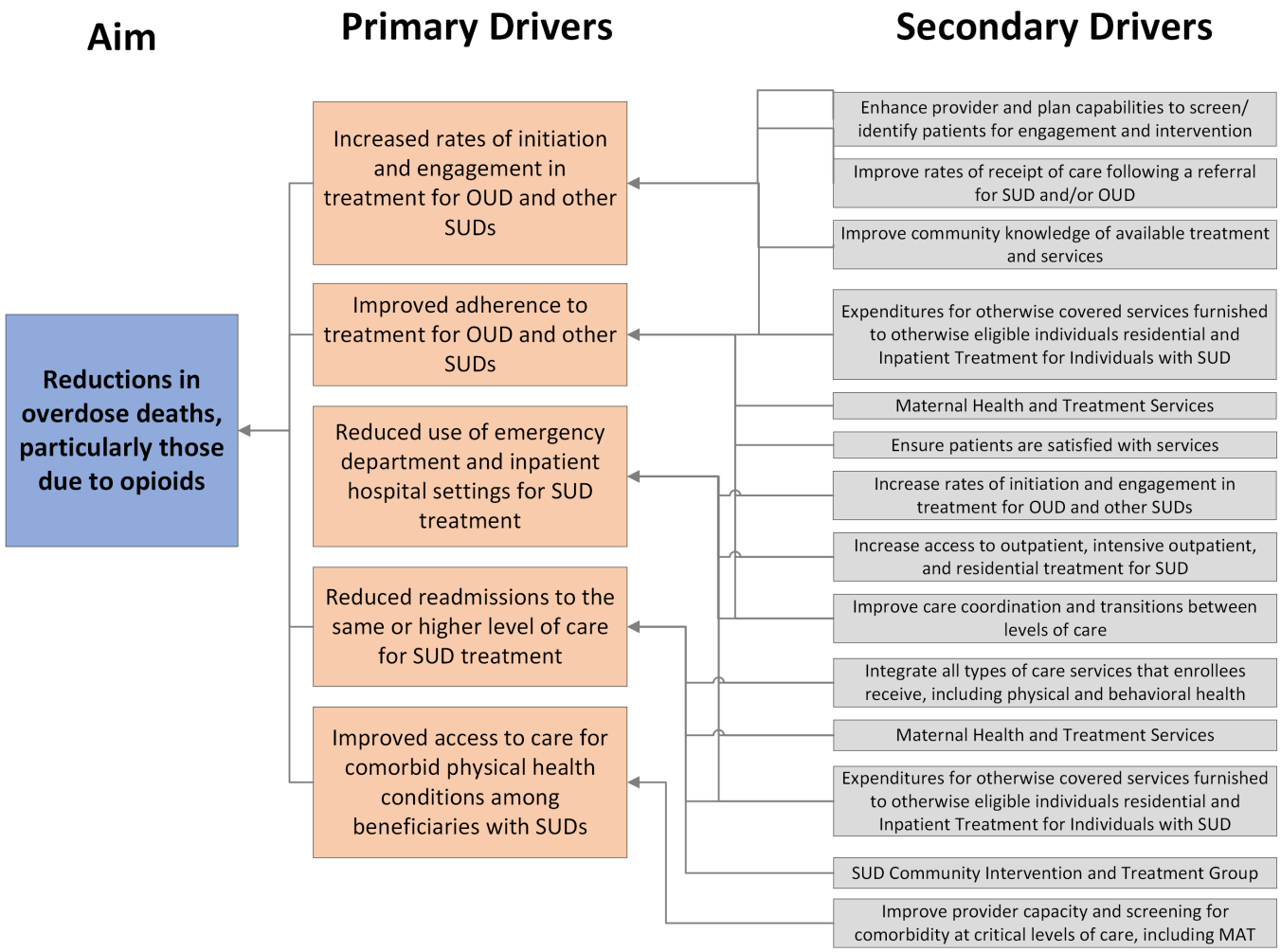


Exhibit S2.4. Drivers for Reduced Utilization of Emergency Departments and Inpatient Hospital Settings for SUD Treatment, and Fewer Readmissions to the Same or Higher Level of Care Where Readmission is Preventable or Medically Inappropriate.

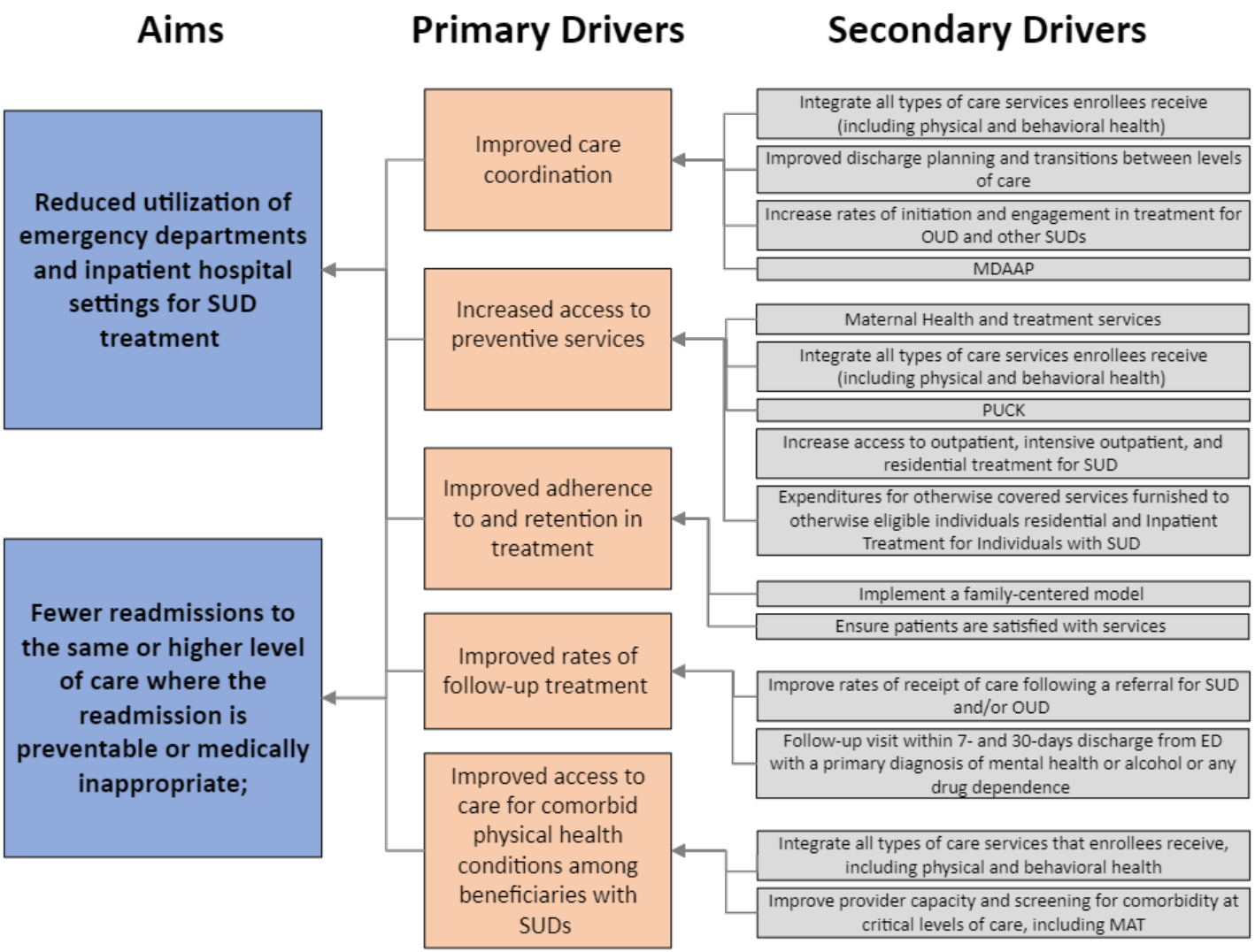
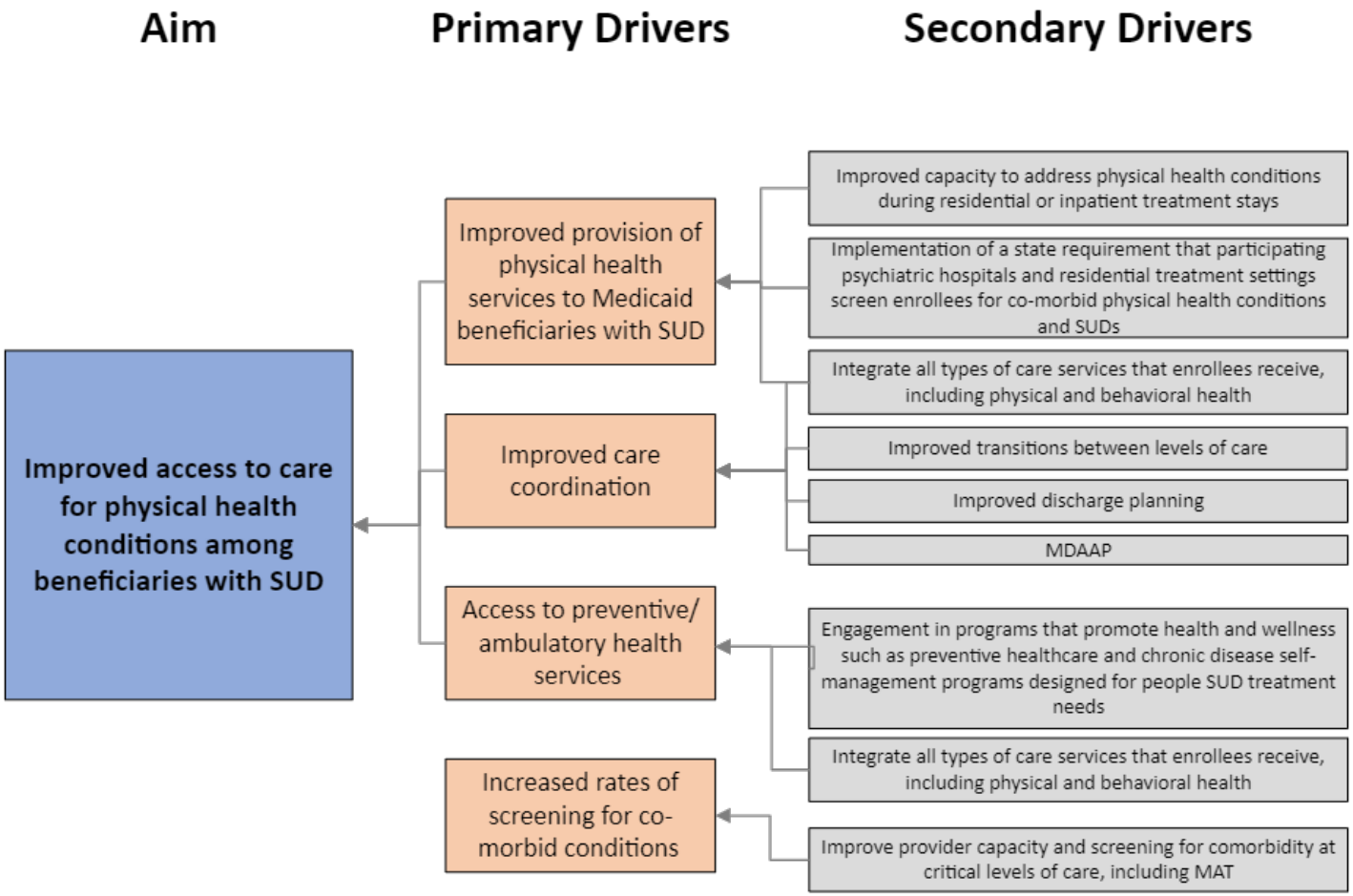


Exhibit S2.5. Drivers for Improved Access to Care for Physical Health Conditions Among Beneficiaries with SUD.



Supplement 3: Year 1 Investments

Investment	Description	Implementation start date	Target Population	Investment Goals
Respite Services for Youth with SED and their Families	Respite services provide short-term support and relief to the families of children and adolescents with significant mental health issues. Services are intended to help maintain family stability and to enhance mental health within the family, which may help prevent out-of-home placements, de-escalate crisis situations, and/or assist youth to transition back into the home and community. Respite services are planned breaks for parents who are caring for a child experiencing a severe emotional disturbance. These breaks allow the parents time to spend with their other children, schedule necessary appointments, or simply rest and recharge. Respite also gives the child a positive social experience apart from the family with an individual who is trained and can offer safe, stimulating activities	Included in prior waiver (implemented pre-2016)	All Vermonters	• Help maintain family stability. • Enhance mental health within the family. • De-escalate crisis situations. • Assist youth in transitioning back into the home and community
Emergency Mental Health	The Emergency Mental Health Program provides coverage of mental health care services for uninsured, underinsured, and Medicaid beneficiaries, both children and adults. Services are also being provided to communities in response to tragedies, and other disaster responses. Services include 24/7 triage, assessment, mobile outreach, short-term family stabilization, and referral and screening for hospitalization or hospital diversion for children, youth, and families.	Included in prior waiver (implemented pre-2016)	All Vermonters	• Provide 24/7 triage, assessment, mobile outreach, short-term family stabilization, and referral and screening for hospitalization or hospital diversion for children, youth, and families.

Alternatives to ED Mental Health Crisis Care	This investment will enable the development and expansion of four models of crisis care, including Psychiatric Urgent Care for Kids (PUCK) programs, emPATH (emergency Psychiatric Assessment, Treatment & Healing unit), The Living Room Model, and CAHOOTS (Crisis Assistance Helping Out On The Streets). The PUCK program is an initiative where a designated mental health agency and a hospital provide a safe alternative crisis intervention site for elementary-aged children who are in mental or psychological distress at school instead of directing them to a hospital emergency department. The emPATH model is a hospital-based outpatient program that can accept all medically appropriate individuals experiencing a psychiatric crisis. The Living Room Model is a peer-run community crisis center that provides a safe space for someone in crisis to connect with peers as an alternative to the emergency room. Lastly, CAHOOTS is a mobile crisis intervention program that operates with a team composed of a crisis intervention worker and a medic. This investment meets the requirement of STC #83(b) by increasing the availability of community-based crisis supports. As this investment involves the provision of services, the state will claim at its federal medical assistance percentage. The state expects this investment will cost $4.8 million (total computable) for State Fiscal Year 2022	Funding approved May 2022	All Vermonters (varies by specific program)	• Increase availability of community-based crisis supports. • Reduce the level of adverse experiences that children face by limiting encounters with law enforcement and ED visits. • Help children with SED re-enter and stay in school.
Bonus Payments to HCBS Providers	This investment will provide bonus payments to eligible part-time and full-time direct support providers who commit to a service agreement of one calendar quarter. This investment meets the requirement of STC 11.1(b) as it supports the state's goal of increasing the access to quality health care by low-income,	Bonus payments disbursed between July 2022 and July 2023	Medicaid providers only	• Increase access to quality health care by low-income, uninsured, underinsured individuals, and Medicaid beneficiaries in Vermont.

		uninsured, underinsured individuals, and Medicaid beneficiaries in Vermont. The state expects this investment will cost $5,750,000 (total computable) through March 31, 2024.			
Sustained Home Visiting Reimburse-ments	Family Support Home Visiting Model	The Sustained Home Visiting Program will provide reimbursements for eligible costs that a family may incur when participating in the sustained home visiting activities offered, including monthly group connection activities in the community, play materials, community outings with the home visitor, etc. Examples of eligible costs include mileage reimbursement, gas, bus or public transit fees, infant hygiene items, and play materials such as arts and crafts materials, blocks, and boards. Each Sustained Home Visiting Program will be granted funds to assist families with the costs listed above. Each Program will serve a certain caseload size and each family on the Program's caseload can receive up to $320 per year as a stipend. Each Program will document the family, amount received, and purpose of the stipend.	Effective January 2023	Medicaid-eligible pregnant and parenting people, infants, and children	• Increase parent knowledge of early childhood development and improved parenting practices. • Early detection of developmental delays and health issues. • Prevent child abuse and neglect. • Increase children's school readiness and success.
	Sustained Nurse Home Visiting Model				• Improve transition to parenting by supporting mothers through pregnancy. • Improve child health and development by helping parents to interact with their children in developmentally supportive ways. • Improve maternal health and well-being by helping mothers to care for themselves. • Develop and promote parents' aspirations for themselves and their children. • Improve family and social relationships and networks by helping parents to foster relationships within the family and with other families and services.

Flexible Family/Respite Funding	Provides grants of up to $1,000 to families of children and adults with developmental disabilities who are not eligible for other waiver services. Families may use the funds at their discretion for respite and any goods or services to support the family to care for the person at home. There are no limits, only broad criteria for how the funds may be used. All are Medicaid enrolled.	Included in prior waiver (implemented pre-2016)	Medicaid only – Individuals with developmental disabilities and their families. Excludes individuals receiving home- and community-based services. Individuals living independently, or with their spouse.	• Offer support to individuals with developmental disabilities and their families to enhance their ability to live together. • Provide services or supports that benefit the individual and/or family and may include respite, assistive technology, individual and household needs, and/or recreational services.
Balanced and Restorative Justice (BARJ) Program	BARJ provides a balanced, restorative approach to juvenile justice. BARJ offers supports and services that are tailored to the individual needs of the youth and family and that focus on interventions that encourage youth to choose healthy behaviors, ultimately aiming to reduce involvement/further involvement in the juvenile justice system. Services include restorative processes such as circles, panels, and family group conferences, screenings and assessments, case management, and skills-based classes in areas such as conflict resolution, social skills, problem-solving, and other areas. The BARJ program is overseen by the Department for Children and Families.	Included in prior waiver (implemented pre-2022)	Youth (specifically between the ages of 10-22) who are involved with, or at risk of being involved with the juvenile justice system in VT.	• Enhance youth-focused restorative justice in Vermont.
Integrating Family Services (IFS)	IFS is an AHS initiative that consolidated over 30 state and federal funding streams into one unified case rate, with the intent to prevent more intense needs, achieve better outcomes, and spend funding more efficiently. IFS provides flexible funding that allows service providers to meet families' needs once they become known, integrating youth and family services, offering families supports and services based on need rather than program eligibility, and shifting toward value-based care delivery.	Began in 2008	Children, youth, and families	• Improve the delivery of services and ultimately the health and well-being of pregnant/postpartum women, infants, children, and young adults. • Advance maternal and child health and safety, family stability, and optimal healthy development through the transition to adulthood.

Support and Services at Home (SASH)	The SASH Program is designed to provide personalized coordinated care to help adult participants stay safely at home regardless of their age or residential setting. SASH (Support and Services at Home) is part of the Blueprint for Health. SASH helps Vermont's most vulnerable citizens, seniors, and individuals with special needs, access the care and support they need to stay healthy while living comfortably and safely at home. This Investment provides administrative and managerial infrastructure necessary to build and maintain SASH partnerships and systems throughout Vermont.	Began in VT in 2011; funded in 2022	Medicare beneficiaries living with disabilities in affordable housing properties	• Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont. • Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

References

[i] Global Commitment to Health 1115 Demonstration Renewal Application. State of Vermont, Agency of Human Services. Published June 30, 2021. https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GC1115Waiver/VT-Global-Commitment-Renewal-Final-6.30.2021.pdf

[ii] Bielaszka-DuVernay, C. Vermont's Blueprint for Medical Homes, Community Health Teams, And Better Health At Lower Cost. *Health Affairs.* 2011;30(3):383-386. doi: 10.1377/hlthaff.2011.0169.

[iii] Vermont Blueprint for Health. Primary Care Collaborative. Updated February 2016. https://www.pcpcc.org/initiative/vermont-blueprint-health#:~:text=The%20Blueprint%20for%20Health%20(Blueprint,Chapter%2013

[iv] Vermont Legislature. No. 48. An act relating to a universal and unified health system. Published 2011. https://legislature.vermont.gov/Documents/2012/Docs/BILLS/H-0202/ACT0048%20Act%20Summary.htm

[v] About GMCB. State of Vermont, Green Mountain Care Board. https://gmcboard.vermont.gov/board#:~:text=The%20Green%20Mountain%20Care%20Board,Vermont's%20landmark%20health%20reform%20legislation

[vi] Vermont All-Payer ACO Model. CMS. Updated July 20, 2023. https://innovation.cms.gov/innovation-models/vermont-all-payer-aco-model

[vii] Vermont: A collection of resources on health system performance in Vermont. The Commonwealth Fund. Published June 16, 2022. https://www.commonwealthfund.org/datacenter/vermont

[viii] AARP, The Commonwealth Fund, & The Scan Foundation. Vermont: 2020 Long-Term Services and Supports (LTSS) State Scorecard. https://www.longtermscorecard.org/databystate/state?state=VT

[ix] Global Commitment to Health 1115 Demonstration Renewal Application. State of Vermont, Agency of Human Services. Published June 30, 2021. https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GC1115Waiver/VT-Global-Commitment-Renewal-Final-6.30.2021.pdf

[x] Tsai, D. Vermont Global Commitment to Health Waiver Approval Letter. State of Vermont, Agency of Human Services. Published June 28, 2022. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT%20GCH%20Extension%20Approval%20Letter%20only%2006-28-2022.pdf

[xi] Tsai, D. Vermont Global Commitment to Health Waiver Approval Letter. State of Vermont, Agency of Human Services. Published June 28, 2022. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT%20GCH%20Extension%20Approval%20Letter%20only%2006-28-2022.pdf

[xii] Tsai, D. Vermont Global Commitment to Health Waiver Approval Letter. State of Vermont, Agency of Human Services. Published June 28, 2022. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT%20GCH%20Extension%20Approval%20Letter%20only%2006-28-2022.pdf

[xiii] Tsai, D. Vermont Global Commitment to Health Waiver Approval Letter. State of Vermont, Agency of Human Services. Published June 28, 2022. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT%20GCH%20Extension%20Approval%20Letter%20only%2006-28-2022.pdf

[xiv] Request for Proposal: Evaluation of the Global Commitment to Health Waiver. State of Vermont, Agency of Human Services. Published March 16, 2017. https://dvha.vermont.gov/sites/dvha/files/documents/Administration/1gc-evaluation-rfp-march-16-2017-final-posted.pdf

[xv] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xvi] Global Capitation Payments Result in the Highest-Quality Primary Care for Seniors. UnitedHealth Group. Published August 2020. https://www.unitedhealthgroup.com/content/dam/UHG/PDF/2020/UHG-Global-Capitation-Research.pdf

[xvii] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xviii] About Us. State of Vermont, Agency of Human Services. https://humanservices.vermont.gov/about-us

[xix] Langweil, N. Global Commitment to Health: A Primer. Vermont Legislative Joint Fiscal Office. Updated November 3, 2022. https://ljfo.vermont.gov/assets/Subjects/Global-Commitment-to-Health/be0af3634e/GENERAL-363911-v4-Global_Commitment_Primer.pdf

[xx] Vermont Department of Health. Division of Substance Use Programs. https://www.healthvermont.gov/alcohol-drugs/programs-services

[xxi] Vermont Department of Health. Children with Special Health Needs. https://www.healthvermont.gov/family/children-special-health-needs

[xxii] State of Vermont Comprehensive Quality Strategy Systemic Assessment. Department of Vermont Health Access. https://dvha.vermont.gov/sites/dvha/files/documents/Administration/dmh-childrens-services-eft-hcbs-draft-alignment-report-2.28.16.pdf

[xxiii] Medicaid. State of Vermont, Agency of Education. https://education.vermont.gov/student-support/special-education/funding/medicaid

[xxiv] Vermont's All-Payer Model. State of Vermont, Green Mountain Care Board. https://gmcboard.vermont.gov/payment-reform/APM

[xxv] Berwick, D.M., Thomas, N.W., Whittington, J. The Triple Aim: Care, Health, and Cost. *Health Affairs*. 2008;27(3). doi: 10.1377/hlthaff.27.3.759

[xxvi] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xxvii] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xxviii] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xxix] Global Commitment to Health 1115 Demonstration Renewal Application. State of Vermont, Agency of Human Services. Published June 30, 2021.

https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GC1115Waiver/VT-Global-Commitment-Renewal-Final-6.30.2021.pdf

[xxx] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xxxi] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xxxii] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xxxiii]Global Commitment to Health 1115 Demonstration Renewal Application. State of Vermont, Agency of Human Services. Published June 30, 2021. https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GC1115Waiver/VT-Global-Commitment-Renewal-Final-6.30.2021.pdf

[xxxiv] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xxxv] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xxxvi] Global Commitment to Health 1115 Demonstration Renewal Application. State of Vermont, Agency of Human Services. Published June 30, 2021. https://humanservices.vermont.gov/sites/ahsnew/files/documents/MedicaidPolicy/GC1115Waiver/VT-Global-Commitment-Renewal-Final-6.30.2021.pdf

[xxxvii] 1115 Waiver Documents. State of Vermont, Agency of Human Services. https://humanservices.vermont.gov/about-us/medicaid-administration/global-commitment-health-1115-waiver/1115-waiver-documents

[xxxviii] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xxxix] Request for Information Medicaid Permanent Supportive Housing (PSH) Assistance. State of Vermont, Agency of Human Services. Published February 29, 2024. http://www.bgs.state.vt.us/pca/bids/pdf/RFI_Medicaid_Permanent_Supportive_Housing_Assistance_.pdf

[xl] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xli] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xlii] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xliii] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xliv] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xlv] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xlvi] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xlvii] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xlviii] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[xlix] Samuelson, J. Global Commitment Fund Investment Report. State of Vermont, Agency of Human Services. Published October 12, 2022. https://legislature.vermont.gov/assets/Legislative-Reports/Global-Commitment-Fund-Investment-Report-SFY22-10.12.22.pdf

[l] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[li] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[lii] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[liii] VT IMD Phasedown DY16 Approval Letter. State of Vermont, Agency of Human Services. Published January 13, 2021. https://www.medicaid.gov/sites/default/files/2021-04/vt-global-commitment-to-health-stc-smi-eval-dsgn-20210329.pdf

[liv] VT IMD Phasedown DY16 Approval Letter. State of Vermont, Agency of Human Services. Published January 13, 2021. https://www.medicaid.gov/sites/default/files/2021-04/vt-global-commitment-to-health-stc-smi-eval-dsgn-20210329.pdf

[lv] Global Commitment To Health Section 1115 Demonstration Vermont STCs With Attachment. State of Vermont, Agency of Human Services. Published March 27, 2023. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/VT-GCH-STCs-with-Attachment-Q-03-07-23.pdf

[lvi] Samuelson, J. Global Commitment Fund Investment Report. State of Vermont, Agency of Human Services. Published October 12, 2022. https://legislature.vermont.gov/assets/Legislative-Reports/Global-Commitment-Fund-Investment-Report-SFY22-10.12.22.pdf

[lvii] Hainmueller J. Entropy balancing for causal effects: A multivariate reweighting method to produce balanced samples in observational studies. Political Analysis. 2012;(1):25-46.

[lviii] Daw, Jamie R., and Laura A. Hatfield. Matching and Regression to the Mean in Difference-in-Differences Analysis. Health Services Research. 2018;53(6):4138–56.

[lix] Hallberg, K., Williams, R., Swanlund, A., and Eno, J. Short Comparative Interrupted Time Series Using Aggregate School-Level Data in Education Research. Educational Researcher. 2018;47(5):295-306.

State of Vermont

Agency of Human Services

Attachment P Caregiver Reimbursement Protocol

Health Care Administrative Rules 7.200

Developmental Disability Services—Payment for Services Provided by Legally Responsible Individuals

7.200 Developmental Disability Services—Payment for Services Provided by Legally Responsible Individuals

7.200.1 Introduction

(a) The intent of this policy is to operationalize how to pay Legally Responsible Individuals to provide extraordinary care to their adult children with developmental disabilities through Developmental Disabilities Home- and Community-Based Services ("DD HCBS"). The use of this policy, to pay an adult child's Legally Responsible Individual to provide personal care and similar services, is not intended to replace other paid direct support professionals or natural supports. This policy does not apply to Family Managed Respite ("FMR").
(b) This policy is intended to be used when direct support professionals and/or independent direct support workers are not available to provide the services an individual has been approved for to ensure a person's health and safety.
(c) It is expected that the use of the policy will be reviewed periodically during its use for the appropriateness of continued application.

7.200.2 Definitions

For the purposes of this rule, the term:

(a) **"Activities of Daily Living"** is defined as the actions of dressing, bathing, grooming, eating, toileting, mobility and physical transfers.

(b) **"Adult Child"** means an individual enrolled in Developmental Disabilities Home- and Community-Based Services age 21 and older.

(c) **"Community Support"** is defined as: support provided to assist individuals to develop skills and social connections. The support may include teaching and/or assistance in daily living, support to participate in community activities, and building and sustaining healthy personal, family and community relationships. Community support may involve individual support or group support (two or more people). Community support includes transportation to access the community. Support must be provided in accordance with the desires of the individual and their Individual Support Agreement and take place within settings that afford opportunities for choice and inclusion that are consistent with federal HCBS rules.[1]

(d) **"Extraordinary Care"** means care provided to an adult child that exceeds the range of activities that a Legally Responsible Individual would ordinarily perform in the household on behalf of an individual without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the individual and avoid institutionalization.

(e) **"In-Home Family Support"** is defined as regularly scheduled, or intermittent hourly supports provided to an individual who lives in the home of unpaid family caregivers. Supports are provided on a less than full time (not 24/7) schedule.[2]

(f) **"Instrumental Activities of Daily Living"** means light housework, laundry, meal preparation, transportation, shopping, communication, medication management, and money management.

(g) **"Legally Responsible Individual"** means an individual's spouse, or legal guardian, or the biological parent, adoptive parent, or stepparent of an adult child. Legally Responsible Individual does not include an adult child's Power of Attorney.

[1] Developmental Disabilities Services Codes and Definitions for Home- and Community-Based Services
[2] Developmental Disabilities Services Codes and Definitions for Home- and Community-Based Services

(h) **"Personal Care or Similar Services"** means hourly services performed in the home or community provided to acquire, maintain, and promote skills related to independent living, including activities of daily, instrumental activities of daily living, navigation and engagement of community, and coordination of and participation in personal appointments. For Vermont Developmental Disabilities Home and Community Based Services, these services are provided within the services "Community Supports" and "Home Supports".

7.200.3 Conditions for Payment

(a) Payments can be made to Legally Responsible Individuals for extraordinary care provided to the designated adult child according to the conditions of this policy.

(b) Legally Responsible Individuals can be paid to provide[3]:
(1) Community Supports as defined in the Developmental Disabilities Services Codes and Definitions for Home- and Community-Based Services.
In-home Family Supports as defined in the Developmental Disabilities Services Codes and Definitions for Home- and Community-Based Services.

(c) Legally Responsible Individuals can be paid to provide care to their adult child due to the complexity of support needs including:
(1) A lack of qualified direct support professionals or independent direct support workers, resulting in consistent gaps in services provision for 45 days or more.
- This is defined as the individual receiving 50% of the community supports and/or in-home family supports authorized to the individual, within a 45-consecutive calendar day period.
- This is reviewed and documented by the adult child's case manager.
- The Legally Responsible Individual must remain in the home to care for the adult child, or

(2) Complex medical support needs, as defined by the need for:
- 2:1 staffing,
- Support provided by clinically trained/credentialed staff (i.e., Licensed Nursing Assistant, Licensed Practical Nurse, etc.)
- Nursing oversight,
- Assessed to fall within the Supports Intensity Scale-Adult "Extraordinary medical support need" level of support. or

(3) Complex behavioral support needs, as defined by the need for:
- 2:1 staffing,
- Support provided by clinically trained/credentialed staff,
- Clinical/psychiatric oversight,
- Assessed to fall within the Supports Intensity Scale-Adult "Extraordinary behavior support need" level of support.

(4) Complex communication support needs, as defined by the need for:
- Access to community aids, devices, programs, or other assistive technology,
- Communication plan,
- Consistent access to interpreters, facilitators, etc.

(d) The individual's team, consisting of case manager, direct service provider agency staff, individual, guardian (when there is one) and other people invited by the individual, will review the arrangement relating to paying the individual's Legally Responsible Individuals based on the criteria included in this policy.

[3] Refer to payment details in §7.200.5

(e) Prior to making the determination that the Legally Responsible Individuals will be paid, the team will decide on the schedule for regular review of the arrangement. Once the plan is developed, the direct service provider agency will notify the Fiscal Employer/Agency (FE/A).

(f) Monthly, the Adult Child's Case Manager will audit the Legally Responsible Individual's notes, which should include date and times of services provided, and progress toward Individual Service Agreement (ISA) goals made in the previous 30 days. Services must be accounted for and provided in accordance with the ISA in order for payment authorization to be rendered to the Fiscal Employer/Agent (FE/A).

(1) Whenever possible, the Case Manager will confirm the dates, times, amount, and nature of services provided with the Adult Child.

(g) Payment will be calculated based on the current Collective Bargaining Agreement (CBA) minimum rate (inclusive of employer tax rate) and the amount of services provided by the Legally Responsible Individual, with a maximum of level of number of hours to be submitted for payment equal to the individual's authorized level of support or 40 hours per week, whichever is less.

(h) Key components in making the determination to approve the arrangement must include:

- Honoring the individual's choice,
- Providing a confidential outlet for the individual to voice preference,
- Ensuring the individual's health and safety is being appropriately met,
- Lack of or limited availability of qualified staff,
- Culturally and linguistically appropriate care,
- Maintenance of unpaid family time,
- Involvement of the person's circle of support, and
- Process to review the efficacy of the arrangement and ongoing need to continue to have legally responsible Individuals as paid caregiver.

7.200.4 Non-Covered Services

(a) Legally Responsible Individuals cannot be paid to provide:

- Service Coordination/Case Management
- Clinical Services
- Crisis Services
- Employment Supports
- Respite
- Supportive Services

(b) Legally Responsible Individuals cannot be paid to provide Shared Living, Shared Living Hourly, Supervised Living, or Staffed Living supports.

(c) Only one Legally Responsible Individual per Adult Child can be designated for the paid arrangement at a time. Payment to a Legally Responsible Individual, alongside another caregiver, is allowable to provide support when the Adult Child requires 2:1 care.

7.200. Oversight and Review

(a) The arrangement will be reviewed periodically to ensure that it continues to meet the desires and best interests of the individual. The frequency of reviews will depend on individual circumstances and may be as frequent as monthly (30-days) but no less frequent than bi-annually (6-months).

(b) Reviews will be completed by members of the individual's support team, including:

(1) Case Manager Entity—through monthly in-home/in-person visits, which may include unannounced home visits. More frequent visits may be provided when needed. The Legally Responsible Individual cannot deny the Case Manager access to the home.
(2) Developmental Disabilities Services Division Quality Management Team—through an in-person/in-home visit as part of the agency's annual onsite quality services review process, if the arrangement is in place during the Agency's scheduled annual onsite quality review.
(3) Direct Service Provider Agency—through monthly in-home/in-person visits, which may include unannounced home visits and the agency's internal quality services review process. The Legally Responsible Individual cannot deny representatives from the Direct Services Provider agency access to the home.
(4) Provide the Adult Child opportunities to speak privately with the Case Manager, representative of the Direct Service Provider Agency and DDSD Quality Management Team (as applicable; where these occurred and what was discussed should be documented by the Case Manager.

(c) Monthly in-home/in-person visits by team members should occur independently to allow maximum opportunity to assess the arrangement.

(d) Legally Responsible Individuals must comply with all state and federal rules and regulations[4] to receive payment for care provided. Failure to meet these requirements will result in discontinuation of payment of Medicaid dollars to the Legally Responsible Individual.

(e) Legally Responsible Individuals must meet the "Worker Qualifications" as described in Medicaid Manual for Developmental Disabilities Services (§1.8).
(1) Any required training will be provided or arranged by the Adult Child's case manager.

(f) During the periodic review of the arrangement, the team should document efforts made to move away from reliance on Legally Responsible Individuals(s) as paid support. These efforts should include recruitment of direct support workers, community integration activities, expansion of the individual's circle of support, discussions with the individual about the decision, and desire to have it continue, and alternative options.
(1) Periodic review will consist of the Adult Child, the Legally Responsible Individual, the Adult Child's Case Manager, a representative of the Direct Service Agency and any person of the Adult Child's choosing to support them.
(2) The Adult Child, with the support of their Case Manager, and any person of their choosing, will direct the periodic review of the arrangement and be afforded the opportunity to speak privately about their preferences.

(g) Documentation of the periodic review must include how the family maintains unpaid family time, how the team supports the individual and how the individual's voice is heard and respected, how the Legally Responsible Adult(s) is supported, and the next steps for the team for the next review period.

(h) Refusal to accept available staff does not support continued payment of a Legally Responsible Individual.

7.200.5 Payments

[4] Behavior Support Guidelines for Support Workers Paid with Developmental Services Funds
Critical Incident Reporting Guidelines
DAIL Background Check Policy
Health and Wellness Guidelines
Individual Support Agreement Guidelines
Vermont State System of Care Plan for Developmental Disabilities Services
42 CFR Parts 430, 431, 435, 436, 440, 441 and 447

(a) The Case Manager would determine if a Legally Responsible Individual were to be paid based on a review of the previous 45 consecutive calendar days of an individual's support needs and level of service provided, as well as other qualifying factors.
   (1) The payment amount would be based on the level of support provided during the month, up to 40 hours per week, based on the process detailed in 7.200.5(b).
      i. Payment amount is based the Adult Child's level of need as evidenced by their needs assessment, Individual Support Agreement (ISA) ISA, ISA goals, the specific services provided in a given month, and the authorized funding levels authorized by the Developmental Disabilities Services Division.
   (2) The Legally Responsible Individual must perform the work that any other direct support staff would be required to do, based on job duties and Individual Support Agreement goals.
   (3) If a significant staffing change occurs mid-month, a Legally Responsible Adult could be provided with payment for the number of affected weeks, (i.e., partial payment).

(b) Legally Responsible Individuals may be compensated under the following conditions:
   (1) After providing an attestation to the adult child's team, kept on file by the Case Manager and reviewed at the agreed upon intervals, that community and/or in-home family services are unavailable due to significant and recurring barriers.
   (2) After providing an attestation to the adult child's team, kept on file by the Case Manager and reviewed at the agreed upon intervals, that they are able to deliver the community and/or in-home family services as indicated in the adult child's ISA.
   (3) The Legally Responsible Individual must agree to use the state sanctioned Fiscal/Employer Agent for billing and administrative services.
   (4) Legally Responsible Individuals must be paid the current Collectively Bargained minimum rate (Collective Bargained minimum wage plus associated employer tax rate), not a flexible rate.

(c) Authorization Form submitted by the Case Manager to Fiscal Employer/Agency (FE/A) for payment. The authorization form must include, at a minimum:
   - Legally Responsible Individual's (payee's) demographic information required to process payment,
   - Demographic information of individual receiving services required to process payment,
   - Service category,
   - Dates of service covered,
   - Total number of hours per week and weeks per month approved,
   - Approved rate (i.e., minimum for the state fiscal year),
   - Total amount authorized for payment, by service category and total, for the month,
   - Signature of authorized Case Manager.
   - Signature and attestation of Legally Responsible Individual of the work performed during the month as indicated on the Authorization Form.

(d) Prior to initial payment, any time payments are restarted, or at the start of each state fiscal year, the FE/A will ensure that any payee is not contained on the Office of Inspector General (OIG) Exclusion List prior to making a payment.[5]

(e) These payments will not be considered "tax-exempt Difficulty of Care Payments" as the individuals receiving the services will not have been placed in the Legally Responsible Individual's home by a placement agency, as

[5] This means that if a Legally Responsible Individual receives an initial or restarted payment for the month of June that an OIG Exclusion List check will be made for the initial/restarted payment in June and then again in July, at the beginning of the new state fiscal year.

required by the Internal Revenue Service (IRS Bulletin 2014-7). At the end of the tax year, the FE/A will supply a Form 1099 for any payee (Legally Responsible Individual) for whom payments processed exceed $600 in the calendar year.

(f) Case Managers are responsible to submit payment authorizations for services provided by Legally Responsible Individuals individual's authorized service plan. If the number of hours submitted exceeds the total authorized services for individual Community Supports or In-Home Family support, the Legally Responsible Individual may receive partial or no payment.

(g) Payments will not exceed authorized service levels. Case Managers must ensure payment authorizations are within the scope of the approved service plan for the adult child.

State of Vermont

Agency of Human Services

Attachment P Caregiver Reimbursement Protocol

Health Care Administrative Rules 7.101

Brain Injury Program—Payment for Services Provided by Legally Responsible Individuals

Attachment P

7.101Brain Injury Program—Payment for Services Provided by Legally Responsible Individuals

7.101.1 Introduction

(a) The intent of this policy is to operationalize how to pay Legally Responsible Individuals to provide extraordinary care to Brain Injury Program (BIP) participants. The use of this policy, to pay a participant's Legally Responsible Individual to provide personal care and similar services, is not intended to replace other paid direct primary or unpaid caregivers.
(b) This policy is intended to be used when direct support professionals and/or independent direct support workers are not available to provide the services a participant has been approved for to ensure a person's health and safety.
(c) It is expected that the use of the policy will be time-limited and reviewed monthly by the case manager during its use for the appropriateness of continued application.

7.101.2 Definitions

For the purposes of this rule, the term:

(a) **"Extraordinary Care"** means care to a BIP participant that exceed[s] the range of activities that a Legally Responsible Individual would normally perform in the household on behalf of a participant without a disability or chronic illness, and which are necessary to assure the health and welfare of the participant and avoid institutionalization. Circumstances identified as "extraordinary care" are defined below.

(b) **"Legally Responsible Individual"** means a participant's spouse, or legal guardian, or the biological parent, adoptive parent, or stepparent of a minor child. Legally Responsible Individual does not include an BIP participant's Power of Attorney.

(c) **"Life Skill Supports"** means services that implement a BIP Service Plans with the BIP participant on a one–to-one basis, providing training in specific activities of daily living in all necessary settings. Services are provided through the supervision of the case manager, and the supports carry out the specific therapeutic program that will be designed in consultation (when appropriate) with licensed speech, physical and occupational therapists, physicians, psychologist, vocational counselors, educators, family members, and others experienced in serving individuals with a traumatic brain injury.

(d) **"Respite Care"** means relief from caregiving and supervision for primary caregivers.

(e) **"Personal Care or Similar Services"** means hourly services performed in the home or community provided to acquire, maintain and promote skills related to independent living, including activities of daily, instrumental activities of daily living, navigation and engagement of community, and coordination of and participation in personal appointments. For Vermont Brain Injury Program, these services are provided within the services "Respite Services" or "Life Skills Supports".

7.101.3 Conditions for Approval of Payment

(a) Payment may be granted to allow Legally Responsible Individuals to provide the following services:
  (1) Brain Injury Program services defined in *Vermont Traumatic Brain Injury Provider Manual*, available on the Adult Services Division's website.
    - Respite Care
    - Life Skills Supports

(b) Payments may be granted upon a determination that:
  (1) The payment will otherwise meet the goals of the Brain Injury Program, and
  (2) The payment is necessary to protect or maintain the health, safety, or welfare of the participant.

(c) Applicants, participants, and providers may submit requests for payment to the Department of Disabilities, Aging and Independent Living (DAIL) at any time.

(d) Requests must be submitted in writing to DAIL and include:
(1) A description of the participant's specific unmet need(s) for which the request is necessary,
(2) An explanation of why the unmet need(s) cannot be met, and other options that have been explored,
(3) A description of the actual/immediate risk posed to the participant's health, safety, or welfare.
(4) Payment requests must include the following key components:
- Honoring the participant's choice,
- Providing a confidential outlet for the participant to voice preference,
- Ensuring the participant's health and safety is being appropriately met,
- Lack of or limited availability of qualified staff,
- Culturally and linguistically appropriate care,
- Maintenance of unpaid family time,
- Involvement of the person's circle of support, and
- Process to review the efficacy of the arrangement and ongoing need to continue to have Legally Responsible Individuals as paid caregivers.

(e) Legally Responsible Individuals may be paid to provide care to a BIP participant due to one or more of the following:
(1) A lack of qualified direct support professionals or independent direct support workers, resulting in consistent gaps in services provision for 45 consecutive calendar days or more.
- This is defined as the participant receiving less than 50% of authorized life skills or respite services for 45 or more consecutive days.
- This is reviewed and documented by the case manager.

(2) Complex support needs, as defined by the need for:
- 2:1 staffing,
- Clinical/psychiatric oversight,
- Cognitive status is assessed to fall within the ILA (Independent Living Assessment) to be "severely impaired" ability to make decisions regarding tasks of daily life,
- Requires 24/7 supervision or oversight.

(3) Communication support needs, as defined by the need for:
- Access to community aids, devices, programs, or other assistive technology,
- Communication plan,
- Consistent access to interpreters, facilitators, etc.

(4) Payment to a Legally Responsible Individual, alongside another caregiver, is allowable to provide support when the BIP participant requires 2:1 care.

7.101.4 Non-Covered Services

(a) Legally Responsible Individuals cannot be paid to provide the following services defined in *Vermont Traumatic Brain Injury Provider Manual*, available on the Adult Services Division website.
- Case Management
- Community Supports
- Employment Support
- Rehabilitation Services
- Psychology & Counseling Supports

7.101.5 Oversight and Review

(a) The arrangement will be reviewed periodically to ensure that it continues to meet the desires and best interests of the BIP participant. The frequency of reviews will depend on the BIP participant's circumstances and may be as frequent as monthly (30-days) but no less frequent than bi-annually (6-months).

(b) Reviews will be completed by:
  (1) Case Manager—through monthly in-home/in-person visits, which may include unannounced home visits.
  (2) Adult Services Division Quality Management Unit—through an in-person/in-home visit as part of the provider agency's annual onsite quality services review process.

(c) Monthly in-home/in-person visits by the case manager should occur *independently* to allow maximum opportunity to assess the arrangement. The Legally Responsible Individual cannot deny the Case Manager access to the home.

(d) During the monthly review, the case manager must document efforts made to move away from reliance on Legally Responsible Individuals as paid support. These efforts should include recruitment of direct support workers, community integration activities, expansion of the participant's circle of support, discussions with the participant about the arrangement and desire to have it continue, and alternative options.

(e) Documentation of the monthly review must include how the family maintains unpaid family time, how the case manager supports the participant and how the participant's voice is heard and respected and the next steps for the next review period.

7.101.6 Payments

(a) The Legally Responsible Individuals may be compensated under the following conditions:
  (1) The Legally Responsible Individual must provide an attestation, to be kept on file by the Case Manager and reviewed at the agreed upon intervals, that community and/or in-home family services are unavailable due to significant and recurring barriers.
  (2) The Legally Responsible Individual must provide an attestation, to be kept on file by the Case Manager and reviewed at the agreed upon intervals, that they are able to deliver the community and/or in-home family services as indicated in the person-centered care plan.
  (3) The Legally Responsible Individual will be paid according to the existing employer and employee relationship as outlined in the handbook Handbooks | Adult Services Division (vermont.gov)
  (4) The Legally Responsible Individual must complete all required Fiscal Employer/Agency (FE/A, i.e., ARIS Solutions) paperwork and be approved BIP employee prior to submitting timesheets and being paid for care provided.
  (5) The Legally Responsible Individual must perform the work that any other direct support staff would be required to do, based on job duties and Person-Centered Plan goals.
  (6) Legally Responsible Individuals will only be paid for services authorized within the participant's budget. If the number of hours submitted exceeds the total amount available in the budget to pay the Legally Responsible Individual, the Legally Responsible Individual may receive partial or no payment.
  (7) Legally Responsible Individuals must be paid the current Collectively Bargained minimum rate (Collective Bargained minimum wage plus associated employer tax rate), not a flexible rate.
  (8) Refusal to accept available workers does not support continued payment of a Legally Responsible Individual.

(b) Case Managers are responsible for submitting payment authorizations for services provided by Legally Responsible Individuals pursuant to a BIP participant's authorized service plan.

(c) Payments will not exceed authorized service levels. Case Managers must ensure payment authorizations are within the scope of the approved service plan for the BIP participant.

VERMONT GLOBAL COMMITMENT TO HEALTH SECTION 1115 DEMONSTRATION

ATTACHMENT Q

HCBS Conflict of Interest Corrective Action Plan

The state will adhere to the timelines and activities outlined in the CMS approved Corrective Action Plan (CAP) to ensure full compliance with the CMS regulatory requirements at 42 CFR section 441.730(b).

Vermont's Agency of Human Services operates five specialized programs under its Global Commitment to Health Section 1115 demonstration that offer a combination of Home- and Community-Based Services (HCBS) and rehabilitation services. The programs are as follows:

1) Choices for Care Program; 2) Brain Injury Program; 3) Developmental Disabilities Services Program; 4) Community Rehabilitation and Treatment Program; and 5) Mental Health Under 22 Program.

The Centers for Medicare and Medicaid Services (CMS) determined that these HCBS, or HCBS-like, programs are subject to federal HCBS conflict of interest regulations at 42 CFR 441.730(b), which require the state ensure the independence of entities performing evaluations of eligibility, needs assessments, and person-centered plan development.

stakeholders and when/how each stakeholder will be involved.

Establish advisory stakeholder group(s) consisting of consumers, providers, families, guardians, advocates, and other groups. Convene regularly for input/working sessions and regular updates.																																								
Develop and provide diverse and accessible methods of informing/engaging stakeholders (webinars, letters, brochures, surveys, interviews, regional meetings etc.). Offer safe spaces for input.																																								
2: HCBS System Assessment																																								
Review available data (NCI, SAMS, claims, etc.) regarding eligibility, Individual assessment of needs, person-centered-plan development, and HCBS delivery. Collect other data as recommended by the TA contractor.																																								
Map current eligibility, individual assessment of needs, person-centered plan development, and service system.																																								
3: Establish New Eligibility, Individual Assessment of Needs, Person-Centered-Plan Development, and Service Delivery Systems																																								
Determine desired assessor and case manager qualifications, roles, and responsibilities, which will be separate from direct service providers.																																								
Conduct impact analysis of individual assessment of needs/case management options: should independent case management be provided by the State, an existing non-state entity, or a new entity?																																								
4: Reimbursement Methodologies and Financial Modeling																																								
Revise existing reimbursement methodologies/rates and value-based payment models based on new scope of work.																																								
Establish reimbursement methodology for new individual assessment of needs																																								
process, provider enrollment, etc.) for entity(ies) to conducting individual																																								
assessments of need and/or case management.																																								
Develop readiness review plan.																																								
B: Implement New Eligibility, Individual Assessment of Need, Person-Centered-Plan Development, and Service Delivery Systems																																								
Conduct readiness review																																								
Update MMIS based on new billing/reimbursement structures, quality, and financial reporting.																																								
Provide training and orientation to providers, assessors, case managers, consumers, families, advocates, community partners, etc.																																								
Transition individuals to new assessment and case management system(s).																																								

ATTACHMENT R
Investment Framework

The demonstration provides authority for expenditures within the annual limits specified in STC 11.4 for public health, health care, and health-related investments. Advancing health equity and addressing health disparities is a core principle of these investments. Consistent with STC 11.1, the Investment Framework below outlines the investment categories, examples of the types of investments that will be allowed in each category, example metrics to assess improvements in health outcomes and equity, and any specific constraints beyond those identified in STC 11.5. The state may spend up to the amounts listed in STC 11.4 on approved investments during each DY, and investment amounts may be rolled over from DY to DY during this demonstration period. The state must also meet the monitoring and evaluation requirements in STC 11.8

Investment Goals/Purpose	**Example Investment Types**	**Example Measures of Health Outcomes and Equity** *Measures will be stratified by race, ethnicity, disability, and rural status to the extent feasible and relevant*
Reduce the rate of uninsured and/or underinsured in Vermont insurance literacy, so long as dem does not supplant other federal or available for this purpose.	onstration funding state funding 3. Specialized wraparound benefits for uninsured or underinsured populations with significant needs, comparable to benefits available through the Community Rehabilitation and Treatment (CRT) and Community Intervention and Treatment (CIT) programs.	• Number of new Medicaid enrollees by race, ethnicity, and county • Number of community partners hosting enrollment events • Metrics will vary based on benefits delivered, but examples may include: o Number of adults served in designated agency adult outpatient programs o Percentage of individuals receiving non-emergency services within seven days of emergency services o Number of children receiving dental services

Investment Goals/Purpose	**Example Investment Types**	**Example Measures of Health Outcomes and Equity** *Measures will be stratified by race, ethnicity, disability, and rural status to the extent feasible and relevant*
Increase the access to quality health care by low income, uninsured, underinsured individuals and Medicaid beneficiaries in Vermont	1. Workforce development trainings to promote linguistically and culturally appropriate, trauma-informed and disability-competent care. 2. Initiatives to improve the integration of physical and mental health and SUD treatment needs at the provider level, such as technical assistance to providers implementing the Collaborative Care model or capacity building funds for providers establishing co-located practice settings. 3. Mobile health care clinics or home visitations by health care providers. 4. Non-emergency health-related transportation. 5. Care management and care transitions programs for low-income, underinsured, and uninsured Vermonters. 6. Support services to address the root causes of homelessness, such as interpersonal violence support resources and linkage to legal assistance, consistent with 1915(c) and 1915 (i) services. 7. Alternative pain management treatments, such as massage, yoga, or acupuncture. 8. Health care workforce capacity building initiatives, including recruitment and retention incentives and initiatives targeted toward increasing representation of members of historically marginalized populations in the workforce.	• Number of workforce development trainings conducted that promote linguistically and culturally appropriate, trauma-informed and disability-competent care • Number of providers implementing integrated care models • Number of individuals receiving care through integrated care models • Number of adults provided case management services by adult outpatient programs • Percentage of individuals readmitted to hospitals • Percentage of individuals who report an improved quality of life • Percentage of individuals who are followed up with after discharge from emergency department for mental health • Percentage of individuals who are followed up with after discharge from emergency department for alcohol and other drug dependence

Investment Goals/Purpose	**Example Investment Types**	**Example Measures of Health Outcomes and Equity** *Measures will be stratified by race, ethnicity, disability, and rural status to the extent feasible and relevant*
Provide public health approaches, investments in social determinants of health, and other innovative programs that benefit low-income, uninsured, underinsured individuals and Medicaid beneficiaries in Vermont	1. Initiatives to promote awareness of maternal health-related care needs in the community and improved outcomes in maternal/child health, such as implementing the Parents as Teachers program. 2. Nurse-partnership programs, such as visiting nurse programs. 3. Initiatives to promote vaccinations, e.g. vaccination drives. 4. Self-management and tobacco cessation initiatives. 5. Building capacity in community-based organizations to interface with traditional health care providers, such as by providing training to community-based organizations on Vermont's health care system and providing technical assistance to community-based organizations on facilitating data sharing with traditional health care providers. 6. Repairs or remediation for issues such as mold or pest infestation. 7. Assistance with connecting the enrollee to expert community resources to address legal issues impacting housing or interpersonal violence related issues. 8. Targeted nutritious food or meal delivery services for individuals with medical or medically-related special dietary needs. 9. Contingency management	• Percentage of children with high blood lead levels who have received either a phone call or a home visit • Percentage of deliveries that received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization • Percentage of Vermonters who have optimal levels of fluoride in their drinking water • Percentage of children in Vermont who are up to date on childhood immunizations • Percentage of Vermonters who were screened for health-related social needs • Among those screened for health-related social needs, percentage of positive screens by health-related social need (e.g., food insecurity, housing insecurity, etc.) • Improvement in social risk factors (e.g., food insecurity, housing insecurity, etc.) • Percentage of Vermonters who have received tobacco screening • Number of Vermonters screened using the SBIRT, PQ-2, and other mental health or substance use screening tools

Investment Goals/Purpose	Example Investment Types	Example Measures of Health Outcomes and Equity *Measures will be stratified by race, ethnicity, disability, and rural status to the extent feasible and relevant*
	10. Innovative care models and care transitions initiatives for justice-involved populations and initiatives to prevent recidivism. 11. Community crisis support and capacity, including, but not limited to, hotlines, mobile crisis, and psychiatric urgent care. 12. Lead and other environmental health remediation. 13. Water fluoridization 14. Early detection and screening programs for mental health conditions and substance use disorders. 15. Screening for unmet social needs. 16. Parenting support programs and health-related services and supports to promote family togetherness, such as the Parents as Teachers program, the Nurse-Family Partnership, or Maternal Early Childhood Sustained Home-Visiting program. 17. Weatherization activities that remediate the hazardous environmental conditions that cause or are associated with negative health outcomes, including low indoor air quality, poor movement of heat and moisture, radon, and other environmental toxins.	• Percentage of justice-involved individuals remaining crime-free while in a program
Implement initiatives to increase transformation to value-based and integrated models of care	1. Technical assistance to select providers to prepare them for alternative payment methodologies (APM) following the Healthcare Partnership Learning Action Network (HCP-LAN) criteria.	• Number of providers implementing alternative care delivery models • Number of providers that pilot new APMs • Number of providers receiving technical assistance on designing and

Investment Goals/Purpose	Example Investment Types	Example Measures of Health Outcomes and Equity *Measures will be stratified by race, ethnicity, disability, and rural status to the extent feasible and relevant*
	2. Technical assistance to select providers for designing and implementing alternative care delivery models. 3. Incentives to providers that engage in delivery system reform, value-based payment, and/or APM 4. Systems enhancement for APM readiness, such as for providers to upgrade their population health management and analytics tools, where not duplicating other federal/state/private funding. 5. Technical assistance for select providers for organization-wide adoption of financial models and business practices, such as identifying challenges and opportunities of transitioning to value-based purchasing models, developing models for financial forecasting and developing workflows and data systems to collect quality measures. 6. Technical assistance for select providers for performance evaluation and management, including technical assistance on improving data quality and reporting performance measures. 7. Support for the following Blueprint for Health initiatives: practice participation in the State's patient-centered medical home (PCMH) initiative; implementation of local community health teams; implementation of Vermont's care coordination models; quality improvement for PCMHs; and self-management programming.	implementing alternative care delivery models or performance evaluation and management • Number of providers earning quality incentives for delivery system reform initiatives • Percentage of children and adolescents ages 3-21 with a well-care visit • Percentage of individuals with hypertension whose blood pressure is under control • Percentage of children with a developmental screening in the first three years of life • Percentage of individuals with diabetes whose HbA1c is poorly controlled • Percentage of individuals who have been screened for chlamydia

Investment Goals/Purpose	**Example Investment Types**	**Example Measures of Health Outcomes and Equity** *Measures will be stratified by race, ethnicity, disability, and rural status to the extent feasible and relevant*
Provide home and community-based services and supports necessary to increase community living for individuals in Vermont at risk of needing facility-based care	1. The delivery of 1915(c) and 1915(i) services to vulnerable Vermonters who meet the 1915(c) or 1915(i) criteria. 2. The delivery of innovative care models to vulnerable Vermonters who need or are at risk of needing institutional care who are not currently eligible for Medicaid to prevent their condition from worsening to the extent that they become Medicaid eligible. 3. Programs that support family caregivers, such as training for caregivers (e.g., topics may include treatment regimens, use of equipment, stress management, coping strategies). 4. Programs that promote health and wellness such as preventive healthcare and chronic disease self-management programs designed for people with HCBS, mental health and SUD treatment needs (e.g., HealthMatters program, nutrition and exercise programs for people with intellectual disabilities, and the Living Well with a Disability program).	• Employment rate among people participating in an investment • Percentage of people who report they are able to stay safely at home because of an investment • Number of people with improved functional ability through assistive technology or training in daily living skills • Number of family caregivers participating in training programs • Percentage of long-term institutional facility stays that result in successful transitions to the community • Number of hours per week of physical activity among people participating in health and wellness programs

ATTACHMENT S
New Investment Application Template

For each new investment, the state must submit the following information to CMS as described in STC 11.6.

Date	
Investment Title	
Estimated Amount	
Time Period	
Department	
Category	
Project Objective, Targeted Outcomes, and Impact to Health Equity	
Project Description This must include descriptions of specific terms associated with eligibility, benefits and services, and how the state intends to operationalize the program (e.g., population served, provider types, provider qualifications, methodology for incentive payments)	
How does the state ensure there is no duplication of federal funding?	
Source of non-federal share	
Medical Assistance Payment (MAP) or Medicaid Administrative Claiming (ADM)	
How does the state ensure that the investment does not include any activities listed in STC 11.6 (Investment Approval Process)?	

The state assures that in reporting cost, the state and providers must adhere to 45 CFR §75 Uniform Administration Requirements, Cost Principles, and Audit Requirements for Health and Human Services (HHS) Awards and 42 CFR §413 Principles of Reasonable Cost Reimbursement. Pursuant to 45 CFR §75.302(a) the state must have proper fiscal control and accounting procedures in place to permit the tracing of funds to a level of expenditures adequate to establish that such funds have not been used in violation of applicable statutes. Costs must be supported by adequate source documentation.

ATTACHMENT T
Community Rehabilitation and Treatment (CRT) Needs and Risk-Based Eligibility Criteria

Attachment T includes the Community Rehabilitation and Treatment (CRT) program needs and risk-based eligibility criteria. CRT service descriptions and provider qualifications are available in Attachment F.

CRT Eligibility:
CRT eligibility requires significant functional limitations, resulting from a severe, persistent mental illness that has not responded to less intensive treatment. The minimum criteria for entry into CRT is less stringent than institutional level of care.

Target Criteria:
CRT eligibility targets adults age 18 or over with a primary DSM-V diagnosis of at least one of the following:

- Schizophrenia
- Schizophreniform disorder
- Schizoaffective disorder
- Delusional disorder
- Unspecified schizophrenia spectrum and other psychotic disorders
- Major depressive disorder
- Bipolar I disorder
- Bipolar II disorder, and other specified bipolar and related disorders
- Panic disorder
- Agoraphobia
- Obsessive-compulsive disorder, including hoarding disorder, other specified obsessive-compulsive and related disorders, and unspecified obsessive-compulsive and related disorders.
- Borderline personality disorder.

CRT Needs-Based Criteria:
In addition to meeting the targeting criteria, individuals must meet both the following needs-based criteria and risk factor for CRT enrollment:

Individuals must require assistance with social, occupational or self-care skills as a result of the DSM-V diagnosis, including demonstrated evidence of two of the following during the last twelve months, with a duration of at least six months:

- Assistance with money management
- Assistance managing maladaptive, dangerous, and impulsive behaviors
- Assistance developing supportive social systems in the community
- Assistance with life skills, such as hygiene, food preparation, and household cleanliness, to support independent living

Individuals must also haves a history of treatment and also meet at least one of the following risk

factors:

- A history of continuous inpatient psychiatric treatment with a duration of at least sixty days
- A history of three or more episodes of inpatient psychiatric treatment and/or a community-based hospital diversionary program (e.g. crisis bed program) during the last twelve months
- A history of six months of continuous residence or three or more episodes of residence in one or more of the following during the last twelve months:
    - Residential program
    - Community care home
    - Living situation with paid person providing primary supervision and care
- Participation in a mental health program or treatment modality for a six-month period during the last twelve months with no evidence of improvement
- The individual is on a court Order of Non-Hospitalization.[1]

[1] An Order of Non- Hospitalization (ONH) is a court order that contains conditions by which the person named must abide or face the possibility of hospitalization or re-hospitalization. An ONH places an individual in the custody of the Commissioner of the Department of Mental Health. It names a designated agency/specialized service agency that has been delegated by the Commissioner to provide the necessary supports and treatment to the individual and to monitor adherence to the ONH conditions. The goal of an ONH is provide structure around treatment engagement.

ATTACHMENT U
SUD Community Intervention and Treatment Services Target and Needs-Based Criteria

The eligibility for entry into Substance Use Disorder Community Intervention and Treatment Services (SUD CIT) is less stringent than inpatient hospital level of care.

SUD CIT Target and Needs-Based Criteria:
SUD CIT is targeted to individuals with substance use disorders. Individuals must be assessed to have substance use disorder needs, where an assessment using the American Society of Addiction Medicine (ASAM) Criteria indicates that the client meets at least ASAM 1.0 Level of Care. A score of ASAM 1.0 indicates that an individual requires ongoing monitoring and assistance with managing and engaging in SUD treatments.

Provider Qualifications:

Provider	Minimum Qualifications
Providers offering **case management, flexible support**	• Authorized by the Preferred Provider agency as competent to provide the service based on their education, training, or experience
Providers offering **clinical assessments** and **individual/family/group therapy** as part of **skilled therapy services** must meet one of the minimum qualifications	• Licensed physician certified in Addiction Medicine by the American Board of Medical Specialties directly affiliated with the Preferred Provider; OR • Licensed nurse directly affiliated with the Preferred Provider; OR • Preferred Provider staff must hold one of the following: o Licensed psychologist; OR o Licensed marriage and family therapist; OR o Licensed clinical mental health counselor; OR o Licensed independent clinical social worker; OR o Licensed alcohol and drug counselor • Subcontractors must meet both requirements: o Meet staff qualifications described above; AND o Authorized by the Preferred Provider to provide the service based on their education, training and experience
Providers offering **medication and medical support** as part of **skilled therapy services** must meet one of the minimum qualifications	• Physicians who are board-eligible in Addiction Medicine or psychiatry, APRN, PA, or RN operating within the scope of their respective professions
Providers offering **residential treatment services**	• Individuals who, based on their education, training, or experience, are determined competent

Provider	Minimum Qualifications
	to provide the service by the Preferred Provider residential program
Providers offering **withdrawal management services**	• Vermont Medicaid-enrolled providers consistent with their licensed scope of practice; OR • Preferred Provider staff members who, based on their education, training, or experience, are determined competent to provide the covered service by the Preferred Provider agency and whose work is directly supervised by a qualifying provider
Providers offering **counseling services**	• Vermont Medicaid-enrolled providers consistent with their licensed scope of practice; OR • Preferred Provider staff members who, based on their education, training, or experience, are determined competent to provide the covered service by the Preferred Provider agency and whose work is directly supervised by a qualifying provider

ATTACHMENT V
Reentry Demonstration Initiative Implementation Plan
[RESERVED]

ATTACHMENT W
Reentry Demonstration Initiative Reinvestment Plan
[RESERVED]

ATTACHMENT X
Monitoring Protocol
[RESERVED]

Attachment Y: Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services

In accordance with the Special Terms and Conditions (STCs) of Vermont's Section 1115 Demonstration, this protocol provides additional detail on the requirements for the delivery of services for the Health-Related Social Needs (HRSN) program, as specifically required by STC 17.7.

1. Individual Eligibility

a. The following qualifying criteria for HRSN services must take into account an individual's health status (including both physical and behavioral health) and unmet, non-medical needs.
b. To ensure that services are medically appropriate, Vermont's Agency of Human Services (AHS) will require that individuals identified as in need of HRSN services meet the following clinical and social risk criteria. To qualify for an HRSN service, an individual must:
    i. Be an individual aged 18+, and must be receiving full State Plan benefits;
    ii. Have at least one HRSN qualifying health criteria (described below); and,
    iii. Have at least one HRSN qualifying social risk factor (described below).
c. AHS will maintain the qualifying health criteria and social risk criteria for HRSN services on a public facing webpage. The webpage content will be updated if the criteria are changed.

2. HRSN Qualifying Health Criteria

In order to receive HRSN services, individuals must meet at least one of the qualifying health criteria listed below. All qualifying health criteria must be included in the individual's care plan.

Table 1: HRSN Qualifying Health Criteria

Service	HRSN Qualifying Health Criteria
Short-term recuperative care (medical respite)	An individual requires ongoing recovery in order to heal from an injury or illness; **<u>and</u>** Meets at least two of the conditions listed below: • An individual with co-occurring mental health and substance use needs, which are defined as: ○ A mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a serious mental illness (SMI); and

Service	HRSN Qualifying Health Criteria
	○ A substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) criteria indicates that the individual meets at least an ASAM level 2.0, indicating the need for intensive outpatient SUD treatment. • An individual who needs assistance with one or more activities of daily living (ADLs), instrumental activities of daily living (IADLs), or other daily life skills, resulting from the presence of an acquired brain injury. • An individual who is 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. • An individual who is 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. • An individual who is 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, or daily living skills.
Short-term rental assistance	An individual must be enrolled in the Supportive Housing Assistance Pilot, which requires meeting needs-based criteria as defined Attachment Z: HRSN Services Matrix and in the Supportive Housing Assistance Pilot Eligibility Criteria, Services, and Provider Qualifications Attachment of the Global Commitment to Health 1115 Demonstration STCs.
One-time transition and moving costs *other than* rent (Community transition services[1])	An individual must be enrolled in the Supportive Housing Assistance Pilot, which requires meeting needs-based criteria as defined in Attachment Z: HRSN Services Matrix and the Supportive Housing Assistance Pilot Eligibility Criteria, Services, and Provider Qualifications Attachment of the Global Commitment to Health 1115 Demonstration STCs.
Home remediations that are medically necessary (Community transition services)	An individual must be enrolled in the Supportive Housing Assistance Pilot, which requires meeting needs-based criteria as defined in Attachment Z: HRSN Services Matrix and the Supportive Housing Assistance Pilot Eligibility Criteria, Services, and Provider

[1] Vermont's community transition services benefit includes a range of housing and home environment interventions without room and board: home modifications to improve accessibility, security deposits, utility deposits, one-time transition and moving costs, essential household furnishings, and pest eradication.

Service	HRSN Qualifying Health Criteria
	Qualifications Attachment of the Global Commitment to Health 1115 Demonstration STCs.
Home/environmental accessibility modifications (Community transition services)	An individual must be enrolled in the Supportive Housing Assistance Pilot, which requires meeting needs-based criteria as defined in Attachment Z: HRSN Services Matrix and the Supportive Housing Assistance Pilot Eligibility Criteria, Services, and Provider Qualifications Attachment of the Global Commitment to Health 1115 Demonstration STCs.

3. HRSN Qualifying Social Risk Factors

In order to receive HRSN services, enrollees must meet at least one of the qualifying social risk factors listed below. All qualifying social risk factors must be included in the individual's care plan.

Table 2: HRSN Qualifying Social Risk Factors

Service	HRSN Qualifying Social Risk Factors

Short-term recuperative care (medical respite)	• Homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5
	• At-risk of homelessness, as defined in 24 CFR 91.5, with two adjustments:
	  ○ Individuals do not need to meet HUD's income standards; and
	  ○ Housing characteristics associated with instability and an increased risk of homelessness do not need to be identified in a HUD Consolidated Plan

Short-term rental assistance	• Homeless, as defined by HUD in 24 CFR 91.5
One-time transition and moving costs *other than* rent (Community transition services)	• An individual must be enrolled in the Supportive Housing Assistance Pilot, which requires meeting the risk factors as defined in Attachment Z: HRSN Services Matrix and the Supportive Housing Assistance Pilot Eligibility Criteria, Services, and Provider Qualifications Attachment of the Global Commitment to Health 1115 Demonstration STCs.
Home remediations that are medically necessary (Community transition services)	• An individual must be enrolled in the Supportive Housing Assistance Pilot, which requires meeting the risk factors as defined in Attachment Z: HRSN Services Matrix and the Supportive Housing Assistance Pilot Eligibility Criteria, Services, and Provider Qualifications Attachment of the Global Commitment to Health 1115 Demonstration STCs.
Home/environmental accessibility modifications	• An individual must be enrolled in the Supportive Housing Assistance Pilot, which requires meeting the risk factors as defined in Attachment Z: HRSN Services Matrix and the

Service	HRSN Qualifying Social Risk Factors
(Community transition services)	Supportive Housing Assistance Pilot Eligibility Criteria, Services, and Provider Qualifications Attachment of the Global Commitment to Health 1115 Demonstration STCs.

4. HRSN Services

AHS will cover the following HRSN services, defined below:

Table 3: HRSN Service Definitions

Service	Definition
Short-term recuperative care (medical respite)	Medical respite settings provide a safe and stable place for eligible individuals transitioning out of institutions, and who are at risk of incurring other Medicaid state plan services, such as inpatient hospitalizations or emergency department visits. This setting may include full room and board, including up to 3 meals per person, per day. This service may be offered for up to 6 months in duration once every 12 months (assessed on a rolling basis) and is intended to provide short-term residential and post-acute medical care for patients experiencing homelessness or who are at-risk of homelessness who are too ill or frail to recover from an injury or illness to recover in the community but who are not ill enough to be hospitalized. Coverage is permitted in one or more spans or episodes, as long as the total duration remains under the 6-month cap for the rolling year. Medical respite provides a clinical environment for recuperative care. Eligible settings for medical respite: • Must have access to clinicians onsite who can provide appropriate medical and/or behavioral health care. • May not be primarily used for room and board without the necessary additional clinical support services. For example, a hotel room in a commercial hotel, where there are no medical or behavioral health supports provided onsite appropriate to the level of need, would not be considered an appropriate setting, but if a hotel had been converted to a recuperative care facility with appropriate clinical supports, then it would be an eligible setting.

Service	Definition

	• Other examples of eligible settings may include:
	  o Interim housing facilities with additional on-site support
	  o Shelter beds with additional on-site support
	  o Converted homes with additional on-site support
	  o Publicly operated or contracted recuperative care facilities
	
	• Eligible settings do not include congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, or facilities without private sleeping space.

Short-term rental assistance	This service includes payment for rent and/or short-term, temporary stays for up to 6 months per household, per demonstration period. Allowable costs include: • Past or prospective rent payments for non-congregate settings, including: apartments, single room occupancy (SRO) units, single-family homes, multifamily homes, mobile home communities, accessory dwelling units (ADUs), co-housing communities, middle housing types, trailers, manufactured homes, manufactured home lots, motel or hotel when it is serving as the individual's primary residence, transitional and recovery housing including bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming. • Renter's insurance if required by the lease • Storage fees, when required to secure a rental unit • Landlord paid utilities that are part of the rent payment This service is subject to a cap of 6 months per household per demonstration period. Coverage may be permitted in one or more episodes, so long as the total duration remains under the cap for the demonstration period. Individuals may receive both the short-term recuperative care (medical respite) and short-term rental assistance during the demonstration period, so long as the total number of months is below 6 months per rolling year and all costs are non-duplicative.
One-time transition and moving costs *other than* rent (Community transition services)	One-time transition and moving costs other than rent, to assist with establishing a basic household, such as: • Payments needed to secure housing (i.e., security deposit) that a landlord may require as part of a lease agreement • Application and inspection fees • Utilities fees and payment in arrears as necessary to activate, re-

Service	Definition
	establish, or maintain utility service, which are capped at a total of six months of total arrear and prospective payments (allowable utilities include telephone, gas, electricity, heating, water, and other necessary utility services for a safe and habitable environment) • First month's costs for essential utilities (allowable utilities include telephone, gas, electricity, heating, water, garbage, sewage, and recycling) • Movers, including costs for labor and materials to pack, transport, and unpack belongings • Purchase of household goods and furniture (e.g., bed and bedding, seating, table, storage, essential kitchen items)
Home remediations that are medically necessary (Community transition services)	Remediation services to a beneficiary's private primary residence required by their care plan which are necessary to ensure the health, welfare and safety of the beneficiary, or which enable the beneficiary to function with greater independence in the home or community. Examples include: • Pest eradication: Costs for extermination of insects, rodents, or other pests to ensure a clean and safe living environment • Deep cleaning services: Professional cleaning to address unsanitary conditions that pose health risks. • Carpet or mold removal; installation of washable curtains or synthetic blinds to prevent allergens. • Home safety measures: Addressing hazards such as mold removal, debris cleanup, or other safety-related services. • Essential repairs: Minor repairs necessary for habitability (e.g., fixing broken locks, addressing plumbing or heating issues).
Home/environmental accessibility modifications (Community transition services)	Home and environmental accessibility modifications to a beneficiary's private primary residence to eliminate known home-based health and safety risks and ensure the occupants' health and safety in a living environment. • Environmental modifications may include: ramps, hand rails, pathways, grip bars, electric door openers, widening of doorways, door and cabinet handles, bathroom facilities, kitchen cabinet or sinks, non-skid surfaces, sound proofing, overhead track systems, among other modifications necessary for access, health, and safety, subject to AHS approval. • Home modifications may include: chore services (inclusive of heavy housecleaning, removal of hazardous debris or dirt, and removal of yard hazards).

5. Provider Qualifications for HRSN Services

a. HRSN providers are expected to meet certain qualifications that ensure they are capable of providing high-quality HRSN services to qualifying individuals.
b. Service providers will be required to meet minimum qualifications to provide HRSN services, as assessed by AHS. HRSN provider qualifications may include:

HRSN Provider Experience and Expertise

i. Demonstrate the capacity or the experience to provide HRSN services or closely related services;
ii. Maintain a physical presence in Vermont, if required to deliver the service;
iii. Demonstrate that hours of operation and staffing are sufficient to serve needs of enrollees;
iv. Demonstrate non-discriminatory practices;
v. Business licensing or accreditation that meets industry standards, if required to provide the service to HRSN participants; and,
vi. Demonstrated history of responsible financial stewardship and integrity. In a case where an organization is new or does not have a recent audit or other mechanism for demonstrating financial stewardship, the organization must demonstrate the capacity to develop responsible financial stewardship and integrity.

HRSN Provider Readiness

i. Demonstrate a readiness to participate as an HRSN provider and serve individuals with qualifying physical, behavioral and social needs;
ii. The ability to receive referrals for HRSN services and to close the loop on referrals by reporting service delivery outcomes;
iii. The ability to submit invoices or claims for HRSN services using AHS-defined processes;
iv. The ability to comply with all reporting and oversight requirements; and,
v. Agree to not use HRSN funds to refinance or displace activities already in process or performed by the HRSN provider.

6. Member Identification and Assessment of Service Need

a. **Identifying Potentially Eligible Members**

i. AHS will use a "no wrong door" approach to ensure individuals can be identified for HRSN services through a variety of pathways.
ii. At a minimum, the following strategies may be utilized to identify eligible members for HRSN services:

1. Proactive identification of potentially HRSN-eligible members through data mining.
2. Proactive identification through the Supportive Housing Assistance Pilot, as appropriate.
3. Referral by a health care provider, including a care manager or care management entity.
4. Referral by a community-based organization that may or may not be an HRSN provider.

5. Self/family referral by individuals.

iii. Upon identification of an individual who is potentially eligible for HRSN services, that individual will be assessed for eligibility and needed services.

b. **HRSN Eligibility and Service Assessments**

i. In order to receive HRSN services, individuals must be assessed for their qualifying clinical and social risk factors (i.e., an eligibility assessment) and for which HRSN services will best meet their needs (i.e., a service assessment).

ii. Multiple entities may perform HRSN eligibility and service assessments, based on the pathway through which a member is identified for HRSN services. Entities that may be eligible to perform the eligibility and service assessment may include but are not limited to:

1. The Department of Vermont Health Access (DVHA) or a sister state department responsible for an individual's care (e.g., the Department for Children and Families (DCF)),
2. Care management entities (e.g., Vermont Chronic Care Initiative (VCCI), an AHS care management program),
3. Health care providers, and
4. Community-based organizations, including HRSN service providers

iii. The assessment should assess and document the following related to eligibility and needed services:

1. Member contact information;
2. Qualifying health and social risk factors supporting eligibility;
3. Recommended service(s); and,
4. Required documentation for specific services (as needed).

iv. The results of the assessment must be documented in a consistent manner.

c. **HRSN Eligibility Determination and Service Authorization**

i. AHS, one of its departments (e.g., DVHA, DCF), or VCCI will review all eligibility and service assessments, determine eligibility, and authorize services.

ii. Once all information is obtained, the following steps are expected to occur to determine a member eligible and authorize them to receive one or more HRSN services:

1. Verify enrollment in Medicaid, based on information provided.
2. Verify that the individual is 18+ years of age and eligible for full state plan benefits.
3. Verify that the individual meets at least one qualifying clinical factor and at least one social risk factor.
4. Review the HRSN service(s) the individual is recommended to receive.
5. Ensure individual is not enrolled in other duplicative programs or services.

iii. AHS or one of its departments (e.g., DCF, DVHA) will ensure there is a record of authorization for HRSN services.

iv. AHS or one of its departments (e.g., DCF, DVHA) will ensure that individuals are notified of approval or denial of a service and provide information about grievance, appeals and state fair hearing rights. Individuals who are denied HRSN services or are authorized for HRSN services but such authorization is limited in scope, amount, or duration, have grievance and appeals rights.

d. **Referral to Authorized HRSN Services**
   i. Upon notification of service authorization, the individual will be referred to receive the authorized HRSN services.
   ii. The referral should consider the individual's preference for specific HRSN service providers.
   iii. The entity generating the referral must track the status to ensure that an HRSN service provider 1) accepts the referral; and 2) that HRSN service delivery is initiated.
   iv. All HRSN service referrals are expected to be "closed-loop" referrals, in which the outcome of the referral is communicated back to the referring entity.

e. **Care Coordination for HRSN**
   i. AHS, or one of its departments (e.g., DCF, DVHA) will ensure that all members receiving HRSN services are offered ongoing support in coordinating their HRSN services, performed by an appropriate care management entity (e.g., VCCI or DCF, when appropriate).
   ii. Care coordination for HRSN services will include, at a minimum:
      1. Developing a care plan that is reviewed at least annually, or more frequently if required for the particular service, or when the individual's needs change significantly. This review process may include the following activities, based on the member's needs:
         a. Understand if HRSN services are meeting the individual's needs;
         b. Identify whether additional/new services are needed;
         c. Confirm the individual is still eligible for HRSN; and,
         d. Determine whether HRSN services are duplicating other services they are receiving.
      2. Coordinating with the HRSN providers delivering the individual's authorized HRSN services, as needed.

f. **Discontinuation of HRSN Services**
   i. An individual's HRSN services will be discontinued when any of the following reasons apply:
      1. The individual is no longer enrolled in Vermont Medicaid.
      2. The individual's needs have been met.
      3. The individual no longer meets HRSN eligibility criteria.
      4. The individual requests to no longer receive the services.

Attachment Z - Vermont 1115 HRSN Services Matrix

Service Category	Service	Individuals ages 18+ receiving full State Plan benefits
Housing Interventions with Room and Board (Episodic Interventions)	Short-term recuperative care (Medical respite)	**X**
Housing Interventions with Room and Board (Rent Only Interventions)	Short-term rental assistance	**X**
Housing and Home Environment Interventions without Room and Board	One-time transition and moving costs *other than* rent (Community transition services[1])	**X**
Housing and Home Environment Interventions without Room and Board	Home Remediations that are medically necessary (Community transition services[1])	**X**
Housing and Home Environment Interventions without Room and Board	Home/environmental accessibility modifications (Community transition services[1])	**X**

[1] Vermont's community transition services benefit includes a range of housing and home environment interventions without room and board: home modifications to improve accessibility, security deposits, utility deposits, one-time transition and moving costs, essential household furnishings, and pest eradication.

	Service	Population	Social Risk Factor	Clinical Criteria
Housing Interventions with Room and Board (Episodic Interventions)	Short-term recuperative care (Medical respite)	- Individuals ages 18+ receiving full State Plan benefits	- Homeless or At-risk of Homelessness	Requires Ongoing Recovery, **and** Meets at least two of the following clinical criteria: - Co-occurring Mental Health and Substance Use Disorder - Needs Assistance with ADLs and IADLs due to Acquired Brain Injury - Needs Assistance with ADLs/IADLs - Complex Physical Health Need - Developmental Disability Need
Housing Interventions with Room and Board (Rent Only Interventions)	Short-term rental assistance	- Individuals ages 18+ receiving full State Plan benefits	- Homeless	- Enrollment in the Supportive Housing Assistance Pilot
Housing and Home Environment Interventions without Room and Board	One-time transition and moving costs *other than* rent (Community transition services[1])	- Individuals ages 18+ receiving full State Plan benefits	- Enrollment in the Supportive Housing Assistance Pilot	- Enrollment in the Supportive Housing Assistance Pilot
Housing and Home Environment Interventions without Room and Board	Home Remediations that are medically necessary (Community transition services[1])	- Individuals ages 18+ receiving full State Plan benefits	- Enrollment in the Supportive Housing Assistance Pilot	- Enrollment in the Supportive Housing Assistance Pilot
Housing and Home Environment Interventions without Room and Board	Home/environmental accessibility modifications (Community transition services[1])	- Individuals ages 18+ receiving full State Plan benefits	- Enrollment in the Supportive Housing Assistance Pilot	- Enrollment in the Supportive Housing Assistance Pilot

1 Vermont's community transition services benefit includes a range of housing and home environment interventions without room and board: home modifications to improve accessibility, security deposits, utility deposits, one-time transition and moving costs, essential household furnishings, and pest eradication.

Clinical Risk Factor	Clinical Criteria Detail
1. Requires Ongoing Recovery	An individual requires ongoing recovery in order to heal from an injury or illness.
2. Co-occurring Mental Health and Substance Use Disorder	An individual with co-occurring mental health and substance use needs, which are defined as: 1) A mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of an SMI; and 2) A substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) criteria indicates that the individual meets at least an ASAM level 2.0, indicating the need for intensive outpatient SUD treatment.
3. Needs Assistance with ADLs/IADLs due to Acquired Brain Injury	An individual who needs assistance with one or more activities of daily living (ADLs), instrumental activities of daily living (IADLs), or other daily life skills, resulting from the presence of an acquired brain injury.
4. Needs Assistance with ADLs/IADLs	An individual who is assessed to have a need for assistance with two or more ADLs or hands-on assistance with one or more ADLs.
5. Complex Physical Health Need	An individual who is 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.
6. Developmental Disability Need	An individual who is 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, or daily living skills.
7. Enrollment in the Supportive Housing Assistance Pilot	An individual must be enrolled in the Supportive Housing Assistance Pilot, which requires meeting needs-based criteria as defined in Attachment I[4] of the Global Commitment to Health STCs. The individual is assessed to meet at least one of the following needs-based criteria: • A mental health or substance use need which is defined as one or more of the following criteria: o A mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a serious mental illness; and/or o A substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) criteria indicates that the individual meets at least an ASAM level 1.0, indicating the need for outpatient Substance Use Disorder (SUD) treatment • Assistance with one or more activities of daily living (ADLs), instrumental activities of daily living (IADLs), or other daily life skills, resulting from the presence of an acquired brain inquiry • 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

[1] To receive Short-term recuperative care (medical respite), individuals must meet Clinical Factor 1 **and** at least two criterion between Clinical Factors 2 to 7.

[2] To receive Short-term rental assistance, individuals must meet Clinical Factor 7.

[3] To receive Housing Supports, Home Remediations that are medically necessary, and Home/environmental accessibility modifications (community transition services), individuals must meet Clinical Factor 7.

[4] Attachment I of the Global Commitment to Health STCs: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/vt-global-commitment-to-health-appvl-tech-correct-09112024.pdf

Social Risk Factor	Social Criteria Detail
1. Homeless or At-risk of Homelessness	Enrollees must meet the US Department of Housing and Urban Development's (HUD's) definitions of homeless or at-risk of homelessness as codified at 24 CFR part 91.5.
2. Homeless	Enrollees must meet HUD's definition of homeless as codified at 24 CFR part 91.5.
3. Enrollment in the Supportive Housing Assistance Pilot	An individual must be enrolled in the Supportive Housing Assistance Pilot, which requires meeting risk factors defined in Attachment I[4] of the Global Commitment to Health STCs. The individual is assessed to meet at least one of the following risk factors: • At risk of homelessness, as defined by HUD's definition as codified at 24 CFR part 91.5 • Homeless, as defined by HUD's definition as codified at 24 CFR part 91.5 • History of frequent or lengthy stays in an institutional or residential setting o Frequent is defined as one or more stays in the past 12 months. o Lengthy is defined as 28 or more consecutive days. • History of frequent ED visits and/or hospitalizations o Frequent is defined as two or more visits within the past six months or four or more visits within a year. • 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 o Frequent is defined as one or more moves/loss of housing due to mental health or SUD symptoms in the past six months. • At serious risk of institutionalization due to the lack of available community supports

[1] To receive Short-term recuperative care (medical respite), individuals must meet Social Risk Factor 1.

[2] To receive Short-term rental assistance, individuals must meet Social Risk Factor 2.

[3] To receive Housing Supports, Home Remediations that are medically necessary, and Home/environmental accessibility modifications (community transition services), individuals must meet Social Risk Factor 3.

[4] Attachment I of the Global Commitment to Health STCs: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/vt-global-commitment-to-health-appvl-tech-correct-09112024.pdf

Attachment AA: Health Related Social Needs (HRSN) Infrastructure Protocol

HRSN Infrastructure. In accordance with Vermont's Section 1115 Demonstration and Special Terms and Conditions (STCs), this protocol provides additional detail on how Vermont's Agency of Human Servies (AHS) will utilize Health-Related Social Needs (HRSN) infrastructure funding, as specifically required by STC 17.9. Over the course of the demonstration, AHS is authorized to spend up to $10.9M on infrastructure investments necessary to support the implementation of HRSN services. This protocol outlines the proposed uses of HRSN infrastructure expenditures, types of entities that will receive funding, intended purposes of funding, projected expenditure amounts, and implementation timeline.

I. Implementation Timeline and Approach

i. Timeline for Disbursement of Infrastructure Funding

a. AHS intends to begin utilizing infrastructure funding no sooner than July 1, 2025.
b. AHS will utilize a phased approach over the demonstration period to disburse infrastructure funds to ensure providers launching HRSN services at different times can access funding.
c. Eligible entities will be able to apply for infrastructure funding once during the demonstration period for each new HRSN service they are offering.

ii. Approach for Infrastructure Funding Applications and Disbursements

a. AHS will review requests from eligible entities for HRSN infrastructure funding.
b. AHS plans to conduct the following activities to solicit and award requests for HRSN infrastructure funding and monitor use of HRSN infrastructure funding on an ongoing basis:
    1. Develop a consistent methodology (e.g., HRSN infrastructure request form, template, application, etc.) of soliciting infrastructure funding requests from eligible entities.
    2. Conduct outreach and education to eligible entities regarding the opportunity to access infrastructure funding.
    3. Review infrastructure funding request descriptions and amounts to ensure compliance with requirements.
    4. Award infrastructure funding to eligible entities.
    5. Disburse funding to awardees.
    6. Monitor infrastructure funding uses amongst HRSN infrastructure funding awardees to prevent fraud, waste, and abuse.
    7. Collect data from awardees on HRSN infrastructure funding uses.
    8. Review and analyze data from awardees on HRSN infrastructure funding uses.

iii. **Monitoring and Oversight**

a. AHS will ensure that any HRSN infrastructure funding disbursements are consistent with Vermont's STCs. AHS will utilize consistent monitoring and program integrity strategies to promote appropriate use of funding. Strategies may include, for example:

1. **Monitoring eligible entities' use of infrastructure funding.** AHS will require eligible entities to report on their uses of infrastructure funding across allowable use categories (e.g., technology, workforce, etc.).
2. **Monitoring for fraud, waste, and abuse.** AHS will oversee the use of infrastructure funding through regular reporting, audits and other strategies to monitor for fraud, waste, and abuse. AHS will investigate suspected instances of fraud, waste, and abuse related to uses of infrastructure funding. AHS will ensure that action is taken to address any identified non-compliance with infrastructure funding parameters.
3. **Ensuring non-duplication of funds.** Eligible entities will be required to attest to non-duplication of funding with other federal, state and local funds. AHS will monitor for funding irregularities and potential duplication of funds.

II. Eligible Entities. The following entities may be eligible to apply for, receive and utilize HRSN infrastructure funding:

a. Providers of HRSN services, including but not limited to:
   1. Housing services and supports providers, including providers of rental assistance
   2. Medical respite providers
   3. Community transition services providers

b. Entities providing operational support to ensure effective HRSN service administration. This may include entities that are providing support for the following HRSN activities:
   1. Member identification;
   2. Eligibility assessment/determination;
   3. Service authorization and service referral;
   4. Care coordination;
   5. Contracting/network development;
   6. Invoicing; and,
   7. Reporting.

III. Intended Purpose and Proposed Uses of HRSN Infrastructure Funding. AHS may claim federal financial participation (FFP) for infrastructure investments to support the development and implementation of HRSN services across the following areas: technology, development of business or operational practices, workforce development and outreach, education and stakeholder convening. The state intends to provide infrastructure funding to eligible entities for the following activities:

i. **Technology**

1. Cost of procuring and implementing information technology (IT) infrastructure/data platforms/systems to support HRSN service delivery
2. Cost of licensing and other related/ongoing fees for technology platforms supporting HRSN service delivery
3. Modifying existing systems to support HRSN
4. Integration of data platforms/systems/tools
5. Onboarding to new, modified or existing systems
6. Training for use of new, modified or existing systems

ii. **Development of business or operational practices**

1. Development of polices/procedures related to:
    a. Program management and administration;
    b. HRSN referral and service delivery workflows;
    c. Billing/invoicing;
    d. Data sharing/reporting;
    e. Program oversight/monitoring;
    f. Evaluation; and,
    g. Privacy and confidentiality.
2. Training/technical assistance on HRSN program and roles/responsibilities or other related topics.
3. Administrative or overhead startup costs that support delivery of HRSN services and/or expand HRSN service delivery capacity (e.g., initial month of lease payments for new or an extension of existing office spaces needed to support HRSN operations).
4. Costs of office furnishings, supplies, and equipment that support the delivery of HRSN services (e.g., desks, chairs, etc.).

iii. **Workforce development**

1. Cost of recruiting, hiring and training new staff to provide HRSN services.
2. Salary and fringe for staff that will have a direct role in overseeing, designing, implementing, operationalizing and/or executing HRSN responsibilities.
    a. Requires percentage allocation of time if portions of time are devoted to non-HRSN programs and functions.

3. Necessary certifications, training, technical assistance and/or education for staff participating in the HRSN program (e.g., on culturally competent and/or trauma informed care).
4. Privacy/confidentiality training/technical assistance (TA) related to HRSN service delivery.
5. Contracting with experts to deliver trainings and production costs for training materials on the HRSN program.

iv. **Outreach, education, and stakeholder convening**

1. Production of materials necessary for marketing, outreach, stakeholder convening, training and/or education related to HRSN.
2. Translation of materials.
3. Planning for and facilitation of community-based outreach events to support awareness of HRSN services.
4. Planning for and facilitation of learning collaboratives or stakeholder convenings for HRSN.
5. Community engagement activities necessary to support HRSN program implementation and launch and ongoing refinement.
6. Administrative or overhead costs associated with outreach, education or convening directly tied to HRSN.
7. Costs related to convening HRSN-participating entities and community stakeholders on topics related to HRSN, including sharing of best practices, soliciting feedback on design, and discussing barriers.

If an HRSN Provider's contract to provide HRSN services is terminated, that HRSN Provider surrenders any unspent infrastructure funds to the Agency.

IV. Projected Expenditure Amounts. AHS estimates the following infrastructure expenditure amounts by allowable use category over the course of the demonstration. AHS used the annual infrastructure spending amounts articulated in the state's STCs. AHS anticipates that the percentage of spend in each of the permissible use categories (as illustrated in the table below) will stay relatively constant across the Demonstration Years.

Category	Estimated Percentage Spend	Estimated Amount
Technology	55%	$6,013,399
Development of business or operational practices	15%	$1,640,018
Workforce development	15%	$1,640,018
Outreach, education, and stakeholder convening	15%	$1,640,018

ATTACHMENT AB
HRSN Implementation Plan
[RESERVED]

ATTACHMENT AC
Provider Rate Increase Assessment Attestation Table
[RESERVED]