DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

January 30, 2015

Hal Cohen
Secretary
Vermont Agency of Human Services
208 Hurricane Lane, Suite 103
Williston, VT 05495

Dear Mr. Cohen:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving your request to amend the Vermont section 1115(a) Medicaid demonstration, entitled "Global Commitment to Health" (Project Number 11-W-00194/1). This approval is effective as of the date of this letter through December 31, 2016 unless otherwise specified.

The amendment approval allows the state to consolidate the state's Choices for Care demonstration with the Global Commitment demonstration. In addition, the amendment includes new authority to provide full Medicaid benefits to presumptively eligible pregnant women who have received a presumptive eligibility determination.

The CMS approval of this amendment is conditioned upon continued compliance with the enclosed set of Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated federal involvement in the project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been waived or specifically listed as not applicable to the expenditure authorities. The award is subject to our receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. A copy of the revised STCs, waivers, and expenditure authorities are enclosed.

As discussed with members of your staff, CMS intends to focus on the following areas (among others) as part of the renewal negotiations for 2017: reporting all Global Commitment to Health expenditures by service line on the CMS-64 and having approved payment protocols for all payments that deviate from Medicaid state plan payment methodologies. As part of this amendment, CMS is requiring the state to submit and receive approval of payment protocols for Choices for Care providers prior to any deviation of state plan payment methodologies for Choices for Care providers. Any approved payment protocols will be documented as appendices to the STCs.

Finally, as discussed with members of your staff, the state will work with CMS to ensure compliance with standard Medicaid rules regarding non-payment of premiums. The state must submit its plan on how it will make changes to its current processes within 30 days of approval of this amendment. We continue to be available to assist the state in making changes to its current processes.

Your project officer for this demonstration is Ms. Brenda Blunt. She is available to answer any questions concerning your Section 1115 demonstration. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-8802
Facsimile: (410) 786-5882
E-mail: Brenda.Blunt@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Blunt and to Mr. Richard McGreal, Associate Regional Administrator in our Boston Regional Office.

Mr. McGreal's contact information is as follows:

Centers for Medicare & Medicaid Services
JFK Federal Building, Room 2275
Boston, MA 02203-0003
Telephone: (617) 565-1226
E-mail: Richard.McGreal@cms.hhs.gov

If you have questions regarding this approval, please contact Mr. Eliot Fishman, Director of the Children and Adults Health Programs Group in the Centers for Medicaid & CHIP Services at (410) 786-5647.

Sincerely,

/s/

Vikki Wachino
Acting Director

Enclosures

cc: Mr. Richard McGreal, ARA, Boston Regional Office

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, 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 October 2, 2013 through December 31, 2016, 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 set forth in an accompanying document.

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

Expenditures for individuals who are age 65 and older and adults age 18 and older with disabilities who would otherwise be Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR §435.217 ("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 as of September 30, 2005. This includes the application of the post eligibility rules specified at 42 CFR 435.726 and the spousal impoverishment rules specified at 1924 of the Social Security Act. Single individuals residing in their own homes are excluded from these populations when they have countable resources over $10,000, and resource limits may apply in certain demonstration populations described below. These individuals are described in the following demonstration populations.

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

PACE-like participants who meet the clinical standards for the highest need group.

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

c. **Demonstration Population 6: Moderate Needs Group (Expansion Group):** Expenditures for HCB-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. They are at risk for institutionalization and are in need of home and community-based services. They have income up to 300 percent of the SSI/FBR and resources below $10,000. People with income below the limit and with excess resources may apply excess resources to income, up to the income limit. They only receive a small subset of HCBS services as outlined in the STCs.

d. **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.

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

2. **Expenditures Related to Additional Services.** Expenditures for additional health care related-services for all populations affected by or eligible through the demonstration.

3. **Expenditures for Public Health Initiatives, Outreach, Infrastructure, and Services Related to State Plan, Demonstration, Uninsured, and Underinsured Populations.** Subject to availability of funding within the per member per month limit, expenditures to reduce the rate of uninsured and/or underinsured in Vermont, increase access to quality health care for uninsured, underinsured and Medicaid beneficiaries, provide public health approaches and other innovative programs to improve the health outcomes and quality of life for Medicaid beneficiaries; and encourage the formation and maintenance of public private partnerships in health care.

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

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

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

7. **HCBW-like Services for State Plan Eligibles Who Meet Moderate Needs Clinical Criteria.** Expenditures for HCBW-like services for State plan eligibles who meet all State plan eligibility requirements, who do not meet the Choices for Care clinical criteria for long-term services, but are at risk of institutionalization. These individuals demonstrate a clinical need that shows they would benefit from a subset of HCBW-like services.

8. **Other Choices for Care Expenditures:**

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

    b. Expenditures for personal care services provided by Choices for Care participants spouses;

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

9. **Full Medicaid Benefits for Presumptively Eligible Pregnant Women.** Effective as of the date of the approval letter, expenditures to provide full Medicaid State plan benefits to presumptively eligible pregnant women.

Title XIX Requirements not Applicable to Demonstration Expenditure Authorities

1. 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.

2. Amount, Duration, and Scope **Section 1902(a)(10)(B)**

To enable the state to offer different services to different demonstration populations.

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

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

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

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

Under the authority of Section 1115(a)(1) of the Social Security Act (the Act) the following waivers are granted to enable Vermont to operate the Global Commitment to Health Section 1115 demonstration. These waivers are effective beginning January 30, 2015 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 set forth in the accompanying document.

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project for the period beginning January 30, 2015 through December 31, 2016.

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. To allow the state to require applicants for nursing facility and home and community-based services to complete a person-centered assessment and options counseling process. 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 categories 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 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 the provision of services under the demonstration that would not otherwise be available under the Medicaid state Plan; and, to

limit the amount, duration, and scope of services to those included in the participants' approved care plan.

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

To allow the state to use institutional income rules (up to 300 percent of the Supplemental Security Income payment level) for medically needy beneficiaries.

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

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

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

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

6. Premium Requirements **Section 1902(a)(14) insofar 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. 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 for the type of service at issue, but may change providers among those enrolled providers.

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

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

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

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

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

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Vermont Global Commitment to Health Section 1115(a) Medicaid demonstration (hereinafter "demonstration"). The parties to this agreement are the Vermont Agency of Human Services (AHS, state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth limitations on the extent of the waivers and expenditure authorities that have been granted to further the demonstration, which are enumerated in separate lists. The STCs also detail the nature, character, and extent of Federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. The amended STCs are effective as of January 30, 2015 through December 31, 2016 unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below.

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

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility, Benefits, and Enrollment
V. Cost Sharing
VI. Delivery Systems
VII. Long Term Services and Supports Protections for Choices for Care
VIII. Designated State Health Programs
IX. General Reporting Requirements
X. General Financial Requirements
XI. Monitoring Budget Neutrality
XII. Evaluation of the Demonstration
XIII. Use of Demonstration Funds
XIV. Measurement of Quality of Care and Access to Care
XV. Schedule of State Deliverables for the Demonstration Period

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

Attachment A. Quarterly Report Content and Format
Attachment B. Summary of Choices for Care Eligibility Criteria

Attachment C. Choices for Care Services by Demonstration Group
Attachment D. Choices for Care Long Term Services and Supports Definitions
Attachment E. Global Commitment Specialized Program Service Definitions
Attachment F. Choices for Care Wait List Procedure Description
Attachment G. Premiums and Co-Payments for Demonstration Populations
Attachment H. Reserved for Choices for Care Program Payment Protocols

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Global Commitment to Health Section 1115(a) demonstration was initiated in September 2005, and is designed to use a multi-disciplinary approach including the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, public-private partnership, and program flexibility. As of January 30, 2015, Vermont is amending the Global Commitment to Health demonstration to include the Choices for Care section 1115 demonstration. Specifically, Vermont expects to demonstrate its ability to achieve universal access to health care, cost containment, and improved quality of care.

On October 2, 2013, CMS extended the Global Commitment to Health demonstration for three years. Effective January 1, 2014, the state expanded coverage under its approved state plan to the new adult group authorized by the Affordable Care Act. The demonstration project was amended to affect the new adult group and to and terminate the VHAP, CHAP, and ESI demonstration programs, as these programs were no longer necessary. The VHAP-Pharmacy, VScript, and VScript Expanded programs were also terminated effective January 1, 2014, because of the availability of pharmacy and other benefits in the Marketplace. Effective January 1, 2014, Vermont was authorized to provide hospice services to adults concurrently with curative therapy. Also effective January 1, 2014, Designated State Health Program (DSHP) funding was made available to support state programs subsidizing the purchase of insurance in the Marketplace for individuals whose income is above 133 percent of the federal poverty level (FPL) and up to and including 300 percent FPL. Vermont received transitional coverage DSHP authority through April 30, 2014 to assist the state in transitioning individuals in the former Expansion Populations to the appropriate coverage vehicle.

The state's goal in implementing the demonstration is to improve the health status of all Vermonters by:

- Increasing access to affordable and high quality health care;
- Improving access to primary care;
- Improving the health care delivery for individuals with chronic care needs;
- Containing health care costs; and
- Allowing beneficiaries a choice in long-term services and supports and providing an array of home and community-based alternatives recognized to be more cost-effective than institutional based supports.

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

1. *Program Flexibility:* Vermont has the flexibility to invest in alternative services and programs designed to achieve the demonstration's objectives (including the

Marketplace subsidy program);

2. *Managed Care Delivery System:* Under the demonstration the AHS will enter into an agreement with the Department of Vermont Health Access (DVHA), which will operate using a managed care model;

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

4. *Aggregate Budget Neutrality Cap:* Vermont will be at risk for the caseload and the per capita program expenditures, as well as certain administrative costs for all demonstration populations. Vermont will have to manage this program within a total computable aggregate cap of approximately $13.8 billion over the approved eleven and a quarter year demonstration period. Effective January 1, 2014, the new adult group will not be included in the total computable aggregate cap, but will be subject to a separate per member per month (PMPM) budget neutrality limit; and

5. *Marketplace Subsidy Program:* To the extent consistent with Vermont's aggregate budget neutrality cap, effective January 1, 2014, Federal Financial Participation (FFP) will be available for state funds for a Designated State Health Program (DSHP) to provide a premium Marketplace subsidy program to individuals up to and including 300 percent of the FPL who purchase health care coverage in the Marketplace.

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

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

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

- 2011: inclusion of a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life limiting illnesses 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 GC demonstration which included sun-setting the authorities for most of the 1115 Expansion Populations because they would be eligible for Marketplace coverage beginning January 1, 2014. The renewal also added the New Adult Group to the demonstration effective January 1, 2014. Finally, the renewal also included premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL.

- 2015: As of January 30, 2015, the GC demonstration was amended to include authority for the former Choices for Care demonstration. In addition, the state received section 1115 authority to provide full Medicaid state plan benefits to pregnant women who are determined presumptively eligible.

III. GENERAL PROGRAM REQUIREMENTS

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

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

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in the applicable law, regulation, or policy directive, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified budget neutrality agreements would be effective upon the implementation of the change.
    b. If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the latest day such legislation was required to be in effect under the law.

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

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

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

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

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

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

7. **Frequency of Demonstration Amendments**. Vermont's expectation is that changes to the demonstration will occur at the same time of year each year, based on the outcomes of the legislative session. At the end of the legislative session, the state must submit amendments governed by the process outlined in STC 6 of this section. Any approved changes must be reflected in the annual rate-setting process for the upcoming year.

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

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

day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

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

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

d. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

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

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

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

11. **Withdrawal of Waiver Authority**. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure

authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

12. **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.

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

14. **Compliance with Managed Care Regulations.** 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. The per member, per month fixed amount pursuant to STC 46 must be developed and certified as actuarially sound in accordance with 42 CFR 438.6. 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 managed care organization for services and populations covered under the demonstration.

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

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

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

16. **Populations Affected and Eligible under the Demonstration.**
    a. **Generally:** The following populations listed in the tables below will receive coverage

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

Those non-Medicaid eligible groups described below who are made eligible for the demonstration by virtue of the expenditure authorities expressly granted in this demonstration are subject to Medicaid laws or regulations only as specified in the expenditure authorities for this demonstration.

b. **Choices for Care Program Eligibility:** Individuals who receive long term services and supports under the Choices for Care program must meet state plan financial rules and clinical eligibility criteria as defined by state regulation in effect as of February, 9, 2009. These clinical eligibility determinations define highest, high, and moderate needs service groups. See Attachment A for a summary of eligibility definitions, services, and policies.

The general categories of populations included under the demonstration are:

Mandatory and Optional State Plan Groups		
Population number	***Population description***	***Benefits***
Population 1	Mandatory categorically needy, except for the Affordable Care Act new adult group (included in population 3) and Medicare Savings Program beneficiaries (included in populations 7 and 8).	Benefits as described in the title XIX state plan and these STCs.
Population 2	Optional categorically and medically needy.	Benefits as described in the title XIX state plan and these STCs.
Population 3	Effective January 1, 2014, the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119, pursuant to the approved state plan.	Benefits as described in approved alternative benefit plan state plan amendment and these STCs.

Demonstration Expansion Populations		
Demonstration population number	***Population description***	***Benefits***
Population 4	Individuals age 65 and older and age 21 and older with disabilities, not otherwise eligible under the state plan, who meet the clinical criteria for the highest need group, and who would have been Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR §435.217, in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under the demonstration would have been were provided under an HCBS waiver granted to the state under section 1915(c) of the Act prior to 2014. This includes the application the application of the post eligibility rules specified at 42 CFR 435.726, and of the spousal impoverishment rules specified at 1924 of the Social Security Act, and have a resource standard of $10,000, but only for single individuals residing in their own homes.	Benefits as described in the Medicaid state plan and HCBS benefits described in these STCs.

Demonstration Expansion Populations		
Demonstration population number	***Population description***	***Benefits***
Population 5	Individuals age 65 and older and age 21 and older with disabilities, not otherwise eligible under the state plan, who meet the clinical criteria for the high need group, and who would have been Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR §435.217, in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under the demonstration would have been were provided under an HCBS waiver granted to the state under section 1915(c) of the Act prior to 2014. This includes the application the application of the post eligibility rules specified at 42 CFR 435.726, and of the spousal impoverishment rules specified at 1924 of the Social Security Act, and have a resource standard of $10,000, but only for single individuals residing in their own homes.	Benefits as described in the Medicaid state plan and HCBS benefits described in these STCs.
Population 6	Individuals who have incomes below 300 percent of the SSI Federal Benefit rate and would be described in Populations 4 or 5 except that they meet the clinical criteria for the moderate needs group and are at risk of institutionalization.	Limited HCBS including Adult Day Services, Case Management, and Homemaker services.
Population 7	Medicare beneficiaries who are 65 years or older or have a disability with income at or below 150 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise categorically eligible for full benefits.	Medicaid Prescriptions, eyeglasses and related eye exams; MSP beneficiaries also receive benefits as described in the title XIX state plan.

Demonstration Expansion Populations		
Demonstration population number	***Population description***	***Benefits***
Population 8	Medicare beneficiaries who are 65 years or older or have a disability with income above 150 percent and up to and including 225 percent of the FPL, who may be enrolled in the MSP, but are not otherwise categorically eligible for full benefits.	Maintenance Drugs; MSP beneficiaries also receive benefits as described in the title XIX state plan.

17. **Optional and Expansion Eligibility Groups Expenditure and Enrollment Cap.** The state must seek approval to modify program eligibility via the demonstration amendment process, as described in STC 6 of section III "General Program Requirements." Regardless of any extension of eligibility, the state will be limited to federal funding reflected in the budget neutrality requirements set forth in these STCs.

    If program eligibility is expanded or reduced, the state must give priority to extension or continuation of eligibility for optional populations prior to extension or continuation of eligibility for expansion groups. In the event of any reduction in eligibility for expansion and optional populations, the state may continue eligibility for all individuals already enrolled in the program. No waiting list will be permitted for eligibility for population whose eligibility is derived from the state plan. A waiting list for eligibility may be permitted for the non-state plan populations. If the state establishes a waiting list for services, priority will be given to populations 1 and 3 over population 2, and last priority will be given to expansion populations, except for waiting lists based on clinical need and other factors (described below) for the Choices for Care program.

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

18. **Benefits**.

    a. 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.

b. 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.

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

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

19. **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.

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

   i. 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.

   ii. 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.

b. **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

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

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

   iii. **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.

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

   v. **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.

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

V. COST SHARING

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

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

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

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

VI. DELIVERY SYSTEMS

21. **Delivery System Overview.** Benefits will be provided by DVHA which will operate on a managed care model and will be responsible for the delivery of all Medicaid covered services. The DVHA must be authorized by state statute and must adhere to federal regulations at 42 CFR part 438 that would be applicable to a managed care entity unless specifically stated otherwise in the STCs.

22. **Non-application of 42 CFR 438.806.** The interagency agreement between AHS and DVHA is not considered an MCO contract. Further, the per member, per month fixed amount referenced in STC 46 (PMPM Limits) will only be reviewed by CMS for the purpose of monitoring the aggregate spending limit and not for the purpose of determining expenditures or FFP under the demonstration.

23. **Submission of Interagency Agreement and PMPM Limit Actuarial Certification.**
    - **a.** AHS shall provide a copy of the interagency agreement between AHS and DVHA to CMS' Boston regional office no less frequently than annually to ensure compliance with these STCs.

    - **b.** AHS shall provide the actuarial certification for the PMPM Limit calculation no less frequently than annually to ensure accurate calculation of the aggregate spending limit.

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

25. **Contracts and Provider Payments.** Payments to providers for Global Commitment will be set by DVHA and will not be required to comply with the payment provisions in the approved state plan. Payments to providers for the Choices for Care program (nursing facility and home and community-based services) must comply with the payment provisions in the approved state plan. The state may deviate from payment provisions in the approved state plan for the Choices for Care program only to the extent the payments are described in Attachment H. The state must receive CMS approval of the Attachment H and any changes to Attachment H before implementing such payment provisions.,. The AHS will be responsible for oversight of DVHA, 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.

    Procurement of health care services by AHS (the Single State Agency) through selective contracting or similar processes, and the subsequent final contracts developed to implement selective contracting by the AHS with any provider group, must be subject to CMS regional office approval prior to implementation.

26. **Contracting with Federally Qualified Health Centers (FQHCs).** The state must maintain its existing agreements with FQHCs and rural health centers.

27. **Data Sharing**. DVHA as a state agency may share enrollee data with other state agencies if the use or release of such data is for a purpose directly connected with administration of the plan as defined in section 1902(a)(7) of the Act. DVHA is authorized to use or release de-identified data, as defined in federal privacy regulations, to enable participation in statewide program studies. As a purpose directly connected with plan administration, DVHA is permitted to release enrollee-specific information to providers in order to enable the provider to seek payment for services rendered under the plan. Any other release of enrollee-specific information for a purpose not directly connected with plan administration is prohibited. Consent of the enrollee is required whenever release of enrollee information for a purpose directly connected with plan administration is sought by an outside source, except in an emergency. Release under these conditions is defined in federal regulations at 42 CFR sections 431.306(d).

28. **External Quality Review (EQR).** The state is required to meet all requirements for EQR found in 42 CFR 438, subpart E, as if it were a managed care organization for services and populations covered under the demonstration.

    a. *Non-application of 42 CFR 438.370*. The state may not claim the 75 percent match described in 42 CFR 438.370, as the managed care entity is neither an MCO nor a prepaid inpatient health plan (PIHP).

    b. *Annual EQR Technical Report*.
        i. The state must contract with a qualified external quality review organization (EQRO) (see sections 438.354 and 438.356) to produce the annual EQR technical report specified at 438.364(a).

        ii. The state must make the annual EQR technical report publicly available on its website. The state must submit this report to CMS no later than April 30th of each year.

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

29. **Person Centered Planning.** The state agrees to use person centered planning processes to identify participants' and applicants' long term service and support needs, the resources available to meet those needs, and to provide access to additional service and support options, such as the choice to use spouse caregivers, and access a prospective monthly cash payment. The state assures that person centered planning will be in compliance with the characteristics set out in 42 CFR 431.301(c)(1)-(3).

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

    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.

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

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

32. 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.

33. 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.

34. 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 towards enrollees in all settings (institutional, residential and community based) accessible through multiple entryways (e.g., phone, internet, office) and reach out to beneficiaries and/or authorized representatives through various means (mail, phone, in person), as appropriate.

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

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

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

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.

VIII. DESIGNATED STATE HEALTH PROGRAMS

35. **State-Funded Marketplace Subsidies Program**. Effective January 1, 2014, the state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide premium subsidies for individuals up to and including 300 percent of the FPL who purchase health insurance through the Marketplace. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible; (2) are eligible for the advance premium tax credit (APTC); and (3) whose income is up to and including 300 percent of the FPL.

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

	DY 9b	DY 10	DY 11
DSHP - State-Funded Exchange Subsidy Limit	$9,616,669	$10,247,721	$11,055,193

b. Reporting. The state must provide data regarding the operation of this subsidy program in the annual report required per STC 44. This data must, at a minimum, include:
i. The number of individuals served by the program;

ii. The size of the subsidies; and
iii. A comparison of projected costs with actual costs.

c. Budget Neutrality. This subsidy program will be subject to the aggregate budget neutrality limit.

36. **State-funded Mental Health Community Rehabilitation (CRT) Services.**

Effective January 1, 2014, the state may claim as allowable expenditures under the demonstration payments through a state funded program for CRT services, as defined by Vermont rule and policy, provided to individuals with severe and persistent mental illness who have incomes above 133 percent of the FPL and up to and including 185 percent of FPL who are not Medicaid enrolled. This program will be subject to the aggregate budget neutrality limit.

IX. GENERAL REPORTING REQUIREMENTS

37. **General Financial Requirements.** The state must comply with all general financial reporting requirements under title XIX set forth in section X "General Financial Requirements".

38. **Compliance with Managed Care Reporting Requirements.** The state must comply with all managed care reporting regulations at 42 CFR 438 et. seq., except as expressly identified as not applicable in these STCs.

39. **Reporting Requirements Relating to Budget Neutrality.** The state must comply with all reporting requirements for monitoring budget neutrality set forth in section XI "Monitoring Budget Neutrality".

40. **Reporting on Participants Receiving Community Rehabilitation and Treatment (CRT) Services.** The state agrees to track and report expenditures for CRT services to participants with severe and persistent mental illness. Expenditures for CRT mental health services will be included under the budget neutrality agreement for the Vermont Global Commitment to Health section 1115 demonstration.

41. **Managed Care Data Requirements.** The DVHA must maintain an information system that collects, analyzes, integrates, and reports data. The system must provide information that would be required from managed care entities as set forth in federal regulations at 42 CFR section 438, on program elements including, but not limited to, service utilization, grievances, appeals, and disenrollments for reasons other than loss of Medicaid eligibility. The management information system must collect data on member and provider characteristics, as specified by the AHS, and on services as set forth under the intergovernmental agreement. DVHA must collect, retain and report encounter data in accordance with the demonstration terms and conditions. All collected data must be available to AHS, and to CMS, upon request.

42. **Quarterly Calls.** CMS will schedule at least quarterly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, DVHA operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, DVHA financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. CMS will update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS (both the project officer and the regional office) will jointly develop the agenda for the calls.

43. **Quarterly Reports.** The state must submit progress reports in the format specified in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the state's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

    a. An updated budget neutrality monitoring spreadsheet;
    b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; benefits; enrollment; grievances; quality of care; access; health plan financial performance that is relevant to the demonstration; pertinent legislative activity; and other operational issues;
    c. Action plans for addressing any policy and administrative issues identified;
    d. A separate discussion of the state efforts related to the collection and verification of claims and encounter data;
    e. Evaluation activities and interim findings and a description of state progress towards demonstration goals;
    f. Updates on any intended changes in the nominal cost-sharing as stated in the Medicaid state plan, if applicable;
    g. The state must report demonstration program enrollment on a quarterly basis using the quarterly report format in Attachment A; and
    h. Updates on the Marketplace subsidy program.
    i. Updates on the number of children who are disenrolled for failure to pay premiums.

    Quarterly report for the quarter ending September 30 is due **November 30**
    Quarterly report for the quarter ending December 31 is due **February 28**
    Quarterly report for the quarter ending March 31 is due **May 31**
    Quarterly report for the quarter ending June 30 is due **August 31**

44. **Annual Report.** The state must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy and administrative difficulties in the operation of the demonstration, implementation and effectiveness of the Comprehensive Quality Strategy (CQS) as described in STC 69, including a discussion of the CQS as it impacts the demonstration. The state must submit the

draft annual report no later than April 1 after the close of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted and posted to the internet.

X. GENERAL FINANCIAL REQUIREMENTS

45. **Aggregate Budget Neutrality Limit.** As defined in STCs 55 and 57, Federal funding will be limited to an aggregate amount of $13,752,420,438 over the 11.25 year term of this demonstration for populations receiving benefits through the demonstration (other than medical expenses for the new adult population designated as population 3) and for designated state health program expenditures under the aggregate budget neutrality agreement. In any year in which the state exceeds the annual target amount set forth in section XI "Monitoring Budget Neutrality" below, the state will develop a plan to ensure that the budget neutrality limit is not exceeded, pursuant to the process set forth in section XI "Monitoring Budget Neutrality."

46. **Per Member Per Month Limit**: In addition to the aggregate budget neutrality limit described in STC 55 and 57, total federal funding for medical assistance will be limited over the life of the demonstration extension to an aggregate spending limit based on the actuarially-determined, per member per month limits. Total allowable demonstration expenditures will be reconciled against the aggregate budget neutrality limit and the sum of the annual limits for the extension period (per member per month limits multiplied by actual caseload). The fixed per member per month amount, established in accordance with the requirements set forth under STC 14 and 23, shall be determined no more frequently than annually unless approved by CMS, and must be developed and certified as actuarially sound in accordance with 42 CFR 438.6. The fixed per member per month amount may vary based upon rate cells that take into account different categories of individuals and benefits. The designated state health programs described in STCs 35 and 36 are not included in the per member per month limits, but all Choices for Care expenditures and state supplemental provider payments (excluding Disproportionate Share Hospital payments) are included in such limits.

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

48. **Reporting Expenditures Subject to the Budget Neutrality Cap.** In order to track expenditures under this demonstration, Vermont must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System, following routines from CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures subject to the budget neutrality cap must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P

Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which the expenditure was made*).* Reporting for expenditures made subsequent to termination of the demonstration must indicate the demonstration year in which services were rendered. Payment adjustments attributable to expenditures under the demonstration must be recorded on the applicable Global Commitment prior quarter waiver form, identified as either CMS-64.9P Waiver (Medical Assistance Payments) or CMS-64.10P Waiver (Administrative Payments). When populated, these forms read into the CMS-64 Summary sheet, Line 7 for increasing adjustments and Line 10B for decreasing adjustments. Adjustments not attributable to this demonstration should be reported on non-waiver forms, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined in subparagraph (b) below.

a. For each demonstration year, separate form CMS-64.9 waiver and/or 64.9P waiver reports must be submitted reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported. The sum of the expenditures from the separate reports will represent the expenditures subject to the budget neutrality cap (as defined in subparagraph (b) below) Medical expenditures for the new adult group, as described below, are not subject to the demonstration's aggregate cap, but they are subject to Supplemental Budget Neutrality Test 1, as defined in STC 59. As needed and subject to CMS approval, the state will develop reasonable methods to allocate allowable demonstration expenditures (e.g. allocation of administrative costs and managed care investments based on quarterly distribution of medical claims) across demonstration population reporting groups. The Vermont Global Medicaid eligibility groups, for reporting purposes, include the names and definitions described in the table below.

Corresponding Population number per STC 16	**Reporting name description**	**CMS 64 Reporting Name**
Populations 1-2	Report expenditures for individuals eligible as aged, blind, or disabled under the state plan	**"ABD"**
	Report the expenditures for all non-ABD children and adults in the state plan mandatory and optional categories, with the exception of adults eligible under population 3	**"non-ABD"**
	Report for all expenditures for all non-ABD children and adults in optional categories	

Corresponding Population number per STC 16	Reporting name description	CMS 64 Reporting Name
Population 3	Report for all medical expenditures for the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119	**"New Adult Group Medical"**
	Report for any MCO investments or other administrative expenses made for the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119.	**"New Adult Group MCO investments"**
Population 4	Report for all expenditures for individuals eligible as part of the Highest Need Group	**"ABD"**
Population 5	Report for all expenditures for individuals eligible as part of the High Need Group	**"ABD"**
Population 6	Report for all expenditures for individuals eligible as part of the Moderate Needs Group	**"Moderate Needs"**
Population 7 Population 8	Report for all expenditures for individuals eligible as pharmacy-only expansions through VT Global (previously VHAP Rx).	**"VT Global Rx"**
Designated State Health Programs (Note: As described in STCs 36 and 37, these expenditures are not	Report for designated state health program expenditures for the state-funded Marketplace subsidy program for individuals at or below 300 percent of the FPL who purchase health care coverage in the Marketplace.	**"Marketplace Subsidy"**

Corresponding Population number per STC 16	Reporting name description	CMS 64 Reporting Name
demonstration populations but are eligible for Federal Financial Participation and are counted against the demonstration's aggregate budget neutrality cap)	Report for designated state health program expenditures for individuals receiving CRT services who are not Medicaid enrolled	**"CRT DSHP"**

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

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

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

d. Administrative costs relative to the operations of the Global Commitment demonstration are included in the PMPM rate setting and must be included in the aggregate budget neutrality limit except for expenditures related to Medicaid management information systems enhancements, including any new procurements related to claims processing, program management, and eligibility. To the extent that that state is eligible for enhanced FMAP for special initiatives recognized by CMS pursuant to subparagraph (h) below, the state will separately identify and report these administrative expenses in a format agreed upon with CMS. All administrative costs not included in the expenditures reported on line 49 of forms CMS-64.9 waiver and/or 64.9 waiver (described in 40.b of this section) must be identified on the forms CMS-64.10 waiver and/or 64.10P waiver.

e. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all title XIX claims for services during the demonstration period (including any cost settlements and claims incurred during the demonstration but paid subsequent to the end date of the demonstration) are considered allowable expenditures under the demonstration and must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

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

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

h. The demonstration does not prohibit the state from requesting to implement special initiatives available, and taking advantage of enhanced Federal Medical Assistance Percentage (FMAP) for these initiatives, under ACA subject to the federal approval process established for these initiatives.

49. **Reporting Member Months.** The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member/months to the total. Two individuals, who are eligible for 2 months, each contributes 2 eligible member months to the total, for a total of 4 eligible member/months

50. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. Vermont must estimate matchable Medicaid expenditures on the quarterly form CMS-37 based on the PMPM limit (or a percentage of the PMPM limit) and projected caseload for the quarter. In addition, the estimate of matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality cap must be separately reported by quarter for each federal fiscal year on the form CMS-37.12 for both the medical assistance program and administrative costs outside of the PMPM limit. CMS will 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 must submit the form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures, consistent with the definition of an expenditure in 45 C.F.R. 95.13, made in the quarter just ended.

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.

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

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

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

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

    a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.
    b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
    c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.
    d. The state may use intergovernmental transfers as a source of non-federal share to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the payment for the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between health care providers and state and/or local

government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment. Intergovernmental transfers are not themselves expenditures, but may be a source of funding for expenditures.

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

54. **MSIS Data Submission.** The state must submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards. The state must ensure, within 120 days of the approval of the demonstration, that all prior reports are accurate and timely.

XI. MONITORING BUDGET NEUTRALITY

55. **Aggregate Limit on Title XIX Funding.** The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration, which is comprised of an aggregate limit plus a supplemental test for new adult group medical expenditures. All other expenditures under the demonstration (including non-medical expenses for the new adult group and expenditures for designated state health programs) are subject to the aggregate limit. The aggregate budget neutrality limit over the life of the demonstration is defined in STC 57. The Supplemental Test 1 is described in STC 59. Any excess spending from Supplemental Test 1 is counted towards the aggregate cap. The per member per month budget neutrality expenditure limits are set on a yearly basis with a cumulative per member per month expenditure limit for the length of the entire demonstration extension.

56. **Risk.** The state shall be at risk for the both the number of enrollees in the demonstration as well as the per capita cost for demonstration eligibles under the aggregate budget neutrality agreement as defined in STCs 55 and 57. The cumulative, per member per month limit will vary based on actual caseload.

    The state shall not be at risk for the number of enrollees in the new adult group, as described in Supplemental Test 1 in STC 59.

57. **Budget Neutrality Aggregate Cap.** Budget neutrality is determined on an aggregate cap basis as shown below:

DY/ FFY	Annual Budget Neutrality Cap (total computable)
DY 1/ FFY 2006	$ 841,266,663
DY 2/ FFY 2007	$ 843,594,654

DY/ FFY	Annual Budget Neutrality Cap (total computable)
DY 3/ FFY 2008	$ 919,247,991
DY 4/ FFY 2009	$ 1,002,321,263
DY 5/ FFY 2010	$ 1,093,591,603
Subtotal Initial Approval Period (DY 1 to DY 5)	***$ 4,700,022,174***
DY 6/ FFY 2011	$ 1,165,191,563
DY 7/ FFY 2012	$ 1,248,077,166
DY 8/ FFY 2013	$ 1,337,393,583
Subtotal First Extension Period (DY 6 to 8)	***$ 3,750,662,312***
DY 9a/ 10/01/2013 – 12/31/2013	$ 505,202,312
DY 9b/ CY 2014	$ 1,334,452,085
DY 10/ CY 2015	$ 1,679,019,063
DY 11/ CY 2016	$ 1,783,062,493
Subtotal for Second Extension Period (DY 9 to 11)	***$ 5,301,735,953***
Cumulative Total (Initial Approval Plus Extension Periods)	**$13,752,420,439**

58. **Impermissible DSH, Taxes or Donations**. The CMS reserves the right to adjust the budget neutrality ceiling in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or with policy interpretations implemented through letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality cap 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.

59. **Supplemental Budget Neutrality Test 1: New Adult Group**. Effective January 1, 2014, adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act are included in this demonstration, and in the budget neutrality. However, medical expenses related to the new adult group are not added to the demonstration's aggregate cap. Therefore, a separate expenditure cap is established for medical expenditures for this group, based on an aggregated per member per month budgetary limit to be known as Supplemental Budget Neutrality Test 1.

    a. The MEG listed in the table below is included in Supplemental Budget Neutrality Test 1.

MEG	TREND	DY 9 – PMPM	DY 10 – PMPM	DY 11 – PMPM
New Adult Group Medical	4.7%	$453.72	$475.04	$497.37

b. If the state's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in subparagraph (a) may underestimate the actual costs of medical assistance for the new adult group, the state may submit an adjustment to subparagraph (a) for CMS review without submitting an amendment pursuant to STC 6. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.

c. The Supplemental Cap 1 is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The Federal share of the Supplemental Cap 1 is
obtained by multiplying total computable Supplemental Cap 1 by the Composite Federal Share 1, defined in subparagraph (d) below.

d. Supplemental Budget Neutrality Test 1 is a comparison between the Federal share of the Supplemental Cap 1 and total FFP reported by the state for the new adult group.

e. If total FFP for the new adult group should exceed the Federal share of Supplemental Cap 1 after any adjustments made to the budget neutrality limit as described in subparagraph (b), the difference must be reported as a cost against the aggregate budget neutrality cap described in STC 57.

f. Savings generated from the medical expenses related to the new adult group may not be used for MCO investments, designated state health programs, or any other expenditures under the aggregate budget neutrality cap.

   As described in STC 48, all expenses related to administrative expenses and MCO investments for the new adult group are reported as a cost against the aggregate budget neutrality cap and are paid for by savings derived from elsewhere in the demonstration.

g. The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. There is 1 Composite Federal Share Ratio for this demonstration: Composite Federal Share 1, based on the expenditures for the new adult group under this STC. Should the demonstration be terminated prior to the end of the extension approval period, the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. 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 upon method.

60. **How the Limits will be Applied.** The limits set forth in STC 57 will apply to actual expenditures for the demonstration including claims incurred during the demonstration period but paid after the end of the demonstration, as reported by the state under section IX "Evaluation of the Demonstration." If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess federal funds will be returned to CMS. There will be no new limit placed on the FFP that the state can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the eleven and a quarter-year period, the budget neutrality test will be pro-rated based on the time period through the termination date.

61. **Enforcement of Budget Neutrality.** CMS will enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the state's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval.

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

Year	Cumulative Target (Total Computable Cost)	Cumulative Target Definition	Percentage
Year 9b	$10,290,338,883	Year 9b budget estimate plus	3 percent
Year 10	$12,014,560,012	Years 9b and 10 combined budget estimate plus	1.5 percent
Year 11	$13,752,420,439	Years 9b through 11 combined budget estimate plus	0 percent

XII. EVALUATION OF THE DEMONSTRATION

63. **Submission of Draft Evaluation Design.** The state must submit to CMS for approval a draft evaluation design for an overall evaluation of the demonstration no later than 120 days after CMS' approval of the demonstration amendment. At a minimum, the draft design must include a discussion of the goals and objectives set forth in section II "Program Description and Objectives", as well as the specific hypotheses that are being tested, including those indicators that focus specifically on the target populations and the public health outcomes

generated from the use of demonstration funds. The evaluation must take into account lessons learned from the evaluation of demonstration periods prior to the current renewal period. The evaluation design must also discuss the state's plans to evaluate the Marketplace subsidy program. The draft design must discuss the outcome measures that will be used in evaluating the impact of the demonstration during the period of approval. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include how the state will evaluate the impact that charging premiums has on children's coverage. The draft evaluation design must include a detailed analysis plan that describes how the effects of the demonstration must be isolated from other initiatives occurring in the state. The draft design must identify whether the state will conduct the evaluation, or select an outside contractor for the evaluation.

64. **Interim Evaluation of Marketplace Subsidy Program.** The state must submit an interim evaluation of the Marketplace subsidy program to CMS by September 1, 2014 that meets the requirements specified in the CMS-approved evaluation design.

65. **Interim Evaluation Reports.** In the event the state requests to extend the demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the state must submit an interim evaluation report as part of the state's request for each subsequent renewal.

66. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft evaluation design described in STC 63 within 60 days of receipt, and the state must submit a final design within 60 days after receipt of CMS comments. The state must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The state must submit to CMS a draft of the evaluation report within 120 days after the expiration of the demonstration. CMS must provide comments within 60 days after receipt of the report. The state must submit the final evaluation report within 60 days after receipt of CMS comments.

67. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the demonstration the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to the contractor or CMS as requested.

XIII. USE OF DEMONSTRATION FUNDS

68. **Use of Demonstration Funds.** Expenditures within the per member per month limit (calculated over the life of the demonstration) can include expenditures for the following purposes:
    a. Reduce the rate of uninsured and/or underinsured in Vermont;
    b. Increase the access to quality health care by uninsured, underinsured, and Medicaid beneficiaries;
    c. Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and

d. Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

XIV. MEASUREMENT OF QUALITY OF CARE AND ACCESS TO CARE

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

a. *CQS Elements*. The CQS must also address the following elements:

i. Goals. The state's goals for improvement, identified through claims and encounter data, quality metrics, and expenditure data. The goals should align with the three part aim but should be more specific in identifying pathways for the state to achieve these goals.

ii. Responsibilities. The CQS must identify Single State Agency and public managed care responsibilities. The Single State Agency retains ultimate authority and accountability for public managed care responsibilities and adherence to the CQS, including monitoring and evaluation of the public managed care model's compliance with requirements specific to the MLTSS assurances identified in STC 1(a)(vii)(2) below as well as the health and welfare of enrollees.

iii. Performance Improvement Projects (PIPs). The associated interventions for improvement in the goals. All PIP topics, tied to specific goals, must be included in the CQS.

iv. Performance Measures. The specific quality metrics for measuring improvement in the goals. The metrics should be aligned with the Medicaid and CHIP adult and child core measures, and should also align with other existing Medicare and Medicaid federal measure sets where possible and appropriate. The metrics should go beyond HEDIS and CAHPS data, and should reflect cost of care.

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

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

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

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

2. The CQS must include a special focus on MLTSS populations and address the following:
    a. A self-assessment of MLTSS adherence to state and federal standards of care to include:

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

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

    b. Person-Centered Planning and Integrated Care Settings

    c. Comprehensive and Integrated Service packages

    d. Qualifications of Providers

    e. Participant Protections

vi. Timeline. The CQS should include a timeline that considers metric development and specification, contract amendments, data submission and review, incentive disbursement (if available), and the re-basing of performance data.

vii. Monitoring and Evaluation. This should include specific plans for continuous quality improvement, which includes transparency of performance on metrics and structured learning, as well as a rigorous and independent evaluation of the demonstration, as described in STC 63. The

evaluation in STC 63 should reflect all the programs covered by the CQS as mentioned above.

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

b. *CQS Public Engagement*. The state must solicit for and obtain the input of beneficiaries, the Medical Care Advisory Committee (MCAC), and other stakeholders in the development of its CQS, and make the draft CQS, as well as any significant revisions, available for public comment prior to submission to CMS.

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

d. *CQS Development Timeline and Revision*. The state must revise (and submit to CMS for review) the CQS whenever this demonstration is renewed or materially amended, or when significant changes are made to the associated Medicaid programs and thus the content of the CQS. An outline and/or driver diagram for the revised CQS must be submitted to CMS with 90 days of approval of the demonstration renewal or material amendment. A draft of the revised CQS must be submitted to CMS for review within 180 days of approval of the demonstration renewal or material demonstration amendment.

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

ii. Any further revisions must be submitted accordingly:

1. Modifications to the CQS due to changes in the Medicaid operating authorities must be submitted concurrent with the proposed changes to the operating authority (e.g., state plan or waiver amendments or waiver renewals); and/or

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

iii. At a minimum, the CQS must be revised at least once every three years, but no more often than once per year (inclusive of any revisions per the requirements of STC 69(d)(i)).

e. *CQS Annual Reports*. Consistent with 42 CFR §438.202(e)(2), the state must submit to CMS regular reports on the implementation and effectiveness of the CQS. Pursuant to STC 44, Annual Report, the state must include information on the implementation and effectives of its CQS in its annual demonstration reports, which should include a discussion of the CQS as it impacts the demonstration.

XV. SCHEDULE OF THE STATE DELIVERABLES OF THE DEMONSTRATION PERIOD

Date Specific	Deliverable	STC Reference
120 days after approval	Submit Draft Evaluation Plan	Section XI, STC 63
September 1, 2014	Interim Evaluation of Marketplace Subsidy Program	Section XII, STC 64
April 30, 2017	Submit Final Evaluation Plan	Section XI, STC 66

Recurring Date	Deliverable	STC Reference
Not later than April 1st	Draft Annual Report	Section VIII, STC 44
	Interagency Agreement	Section VI, STC 23
	PMPM limit calculation	Section VI, STC 23
Quarterly		
	Quarterly Operational Reports	Section VIII, STC 43
	CMS-64 Reports	Section IX, STC 47

ATTACHMENT A: QUARTERLY REPORT CONTENT AND FORMAT

Under section VIII, STC 43, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

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

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

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

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

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

Enrollment Counts

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

Demonstration Populations	Current Enrollees: last day of the quarter: xx/xx/xxxx	Previously reported enrollees last day of quarter: xx/xx/xxxx	Variance
Demonstration Population 1:			
Demonstration Population 2:			
Demonstration Population 3:			
Demonstration Population 4:			
Demonstration Population 5:			
Demonstration Population 6:			

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

Operational/Policy Developments/Issues
Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

Expenditure Containment Initiatives
Identify all current activities, by program and or Demonstration population. Include items such as status, and impact to date as well as short and long term challenges, successes and goals.

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

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

A. For Use in Budget Neutrality Calculations

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

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

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

Demonstration Evaluation
Discuss progress of evaluation design and planning.

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

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

Date Submitted to CMS

ATTACHMENT B.
Summary of Choices for Care Eligibility Criteria

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

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

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

ATTACHMENT C
Choices for Care Services by Demonstration Group

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

Definitions of each service may be found in Attachment D.

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

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

ATTACHMENT D:
Choices for Care Long Term Services and Supports Definitions

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

Choices for Care
Adult day services: Community -based non-residential services that provide a range of professional health, social and therapeutic services delivered in a safe, supportive environment.
Assistive devices and home modifications: An "Assistive Device" is defined as an item which is used to increase, maintain, or improve functional capabilities. Such devices are intended to replace functional abilities lost to the individual because of his or her disability and must be used in performing Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL). A "Home Modification" is defined as a physical adaptation to the home which is necessary to allow safe access to and use of, the individual's primary living space, bathroom, kitchen, or main exit/entrance to the home.
Case management: Assistance to participants in gaining access to needed long-term care Medicaid services and other state plan and/or medical, social and community services. This includes comprehensive assessment and reassessments, treatment and support planning, obtaining and monitoring the provision of services included in the service care plan and assessing the quality, effectiveness and efficiency of CFC services.
Enhanced Residential Care Home Services: A package of services provided by an approved Level III Residential Care Home (RCH) or an Assisted Living Residence (ALR). In addition to services provided to all RCH/ALR residents, these residential settings also provide a Registered Nurse on-site, personal care services and daily social and recreational activity opportunities.
Adult Family Care: 24-hour care and support option in which participants live in and receive services from an Adult Family Care Home which is contracted by an Authorized Agency
Companion care: Non-medical supervision and socialization for participants who are unable to care for themselves.
Homemaker services: Assistance with activities that help to maintain a safe, healthy environment for individuals residing in their homes. Such services contribute to the prevention, delay, or reduction of risk of harm or hospital, nursing home, or other institutional care.
Personal care: Assistance with Activities of Daily Living (ADLs) like eating, dressing, walking, transferring, toileting and bathing and Instrumental Activities of Daily Living (IADLs) such as cooking, cleaning and shopping.
Personal Emergency Systems: Electronic devices which enable individuals at high risk to secure help in an emergency.
Respite care: Alternate care giving arrangements to facilitate planned short term and time limited breaks for unpaid care givers.
Flexible choices (Self Directed Care): Participant or surrogate directed home and community based option which converts a participant's Home Based Service Plan into a cash allowance. Working with a consultant, the participant develops a budget which details expenditure of the allowance and guides the participant's acquisition of services to meet their needs.

Nursing Facility: Health-related services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition that includes provision of or arranging, nursing or related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident.

ATTACHMENT E:
Global Commitment Specialized Program Service Definitions

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

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

determined to be necessary to improve functional independence.
Self-Directed Care: When an individual, their family or surrogate meets requirements and chooses to manage some or all of their TBI services, the person has the responsibility of hiring his or her own staff and overseeing the administrative responsibilities associated with receiving TBI funding, including contracting for services, developing a service plan, fulfilling the responsibilities of the employer, and planning for back-up support or respite in the case of an emergency.

Services for Children and Youth under 21 Experiencing Severe Emotional Disturbance/ Mental Illness and Their Families
Service Coordination: Case management and assistance to individuals and families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of medical, social, educational and other services and supports, including discharge planning, advocacy, monitoring and supporting them to make and assess their own decisions.
Community Supports (Individual or Group): Specific, individualized and goal-oriented services which assist individuals in developing skills and social supports necessary to promote growth.
Skilled Therapy Services: Services provided by or under the direction of licensed practitioners that include, but may not be limited to: clinical assessment; medication and psychiatric consultation; individual, family and group therapy or specialized behavioral and health services.
Residential Treatment: Out of home treatment services that include: • *Transitional Living*: Short-term out of home care for adolescents requiring intensive supports in order to transition to independent living. • *Therapeutic Foster Care*: Short-term out-of-home care to assist in skill development and remediation of intensive mental health issues to support a return to the family. • *Residential Treatment:* Intensive out of home care for mental health treatment, skill building, family reintegration and/or specialized assessment services to assist recovery and skill building that supports return to the family home.
Flexible Support: • *Family Education*: In home support and treatment for the purpose of enhancing the family's ability to meet their child's emotional needs. • *Specialized Rehabilitation or Treatment Plan Services*: Services, supports or devices used to increase, maintain, or improve functional capabilities or health outcomes identified as the result of an approved assessment, treatment plan and/or prior approval.
Counseling: Services directed toward the development and restoration of skills or the elimination of psychosocial or barriers that impede the development or modification of skills necessary for independent functioning in the community. Services may include approved peer supported and recovery services.
Respite: Alternative care giving arrangements to facilitate planned short term and time limited breaks for care givers.
Supported Employment: Job coaching, on and off site support, and consultation with employers to support competitive employment in integrated community work settings.
Crisis Supports: Time limited services and supports that assist an individual to resolve a severe behavioral, psychological or emotional crisis safely in their community. This includes 247

availability, one to one support, and case management, hospital diversion programs, mobile outreach, community crisis placements and/or intensive in home support.
Environmental Safety Devices: Devices or technology necessary to ensure health and safety or to enable independence. This does not include structurally permanent modifications.
Community Rehabilitation and Treatment
Service Coordination: Case management and assistance to individuals and families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of medical, social, educational and other services and supports, including discharge planning, advocacy, monitoring and supporting them to make and assess their own decisions.
Community Supports: (Individual or Group): Specific, individualized and goal-oriented services which assist individuals in developing skills and social supports necessary to promote growth.
Flexible Support: • *Day Recovery/Psychoeducation, Including Recovery Education:* Group recovery activities in a milieu that promotes wellness, empowerment, a sense of community, personal responsibility, self-esteem and hope. These activities are consumer-centered; they provide socialization, daily skills development, crisis support, and promotion of self-advocacy. • *Family Psychoeducation and Support for Families and Significant Others*: To support recovery and assist individual in managing their symptoms
Skilled Therapy Services: Services provided by or under the direction of licensed practitioners that include, but may not be limited to: clinical assessment; individual, group, and family therapy or diagnosis-specific practices; medication evaluation, management and consultation with Primary Care; inpatient behavioral health services; partial hospitalization.
Residential Treatment • *Residential Treatment:* Intensive mental health treatment, skill building, community reintegration and/or specialized assessment services to assist recovery and skill building to support community living, but not provided in institutions for mental disease (IMD). Treatment may include the use of approved peer supported and peer run alternatives. • *Housing and Home Supports*: Mental Health services and supports based on the clinical needs of individuals in and around their residences. This may include support to a person in his or her own home; a family home; sharing a home with others (e.g., in an apartment, group home, shared living arrangement).
Crisis Support: Time limited services and supports that assist individuals to resolve a severe behavioral, psychological or emotional crisis safely in their community. This includes 24-hour 7 day week availability, one to one support, case management, hospital diversion programs, mobile outreach, community crisis placements and/or intensive in home support.
Environmental Safety Devices: Devices or technology necessary to ensure health and safety or to enable independence. This does not include structurally permanent modifications.
Counseling: Services directed toward the development and restoration of skills or the elimination of psychosocial or barriers that impede the development or modification of skills necessary for independent functioning in the community. May include approved peer supported

and/or peer run recovery services.
Respite: Alternative care giving arrangements to facilitate planned short term and time limited breaks for care givers.
Supported Employment: Job coaching, on and off site support, and consultation with employers to support competitive employment in integrated community work settings.

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

ATTACHMENT F:
Choices for Care Wait List Procedure Description

Choices for Care - Waiting List Procedures High Needs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Choices for Care Moderate Needs Waiting List

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ATTACHMENT G:
Premiums and Co-Payments for Demonstration Populations

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

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

Population	Premiums	Co-Payments	State Program Name
Demonstration Population 7: Medicare beneficiaries with income at or below 150 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise categorically eligible for full benefits.	Premiums not to exceed the following: 0-150% FPL: $15/month/person	Not to exceed the nominal co-payments specified in the Medicaid State plan	VHAP Pharmacy/ VPharm1
Demonstration Population 8: Medicare beneficiaries with income above 150 percent and up to and including 225 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP), but are not otherwise categorically eligible.	Premiums not to exceed the following: 151-175% FPL: $20/month/person 176-225% FPL: $50/month/person	Not to exceed the nominal co-payments specified in the Medicaid State plan	VScript/VPharm2 or VScript Expanded/ VPharm3

ATTACHMENT H
Choices for Care Companion Aide Pilot Project and Payment Methodology

Purpose

The purpose of the Companion Aide Pilot Project is to provide assistance to nursing facilities in advancing culture change with a focus on person-centered dementia care. The goal of the pilot is to provide financial assistance to interested and eligible facilities that are committed to person-centered dementia care through a dedicated "Companion Aide." The Companion Aide is a trained licensed nursing assistant (LNA) who will champion person-centered dementia care with the goal of improving the lives of people with dementia, as evidenced by positive changes such as a reduction of the use of psychotropic drugs, incidence of resident to resident altercations, and improved staff satisfaction.

The pilot allows the state to provide funding to nursing facilities to hire additional LNA staff who will be specialized "Companion Aides."

Pilot Development

According to the Alzheimer's Association, 69 percent of nursing home residents have some degree of cognitive impairment; 45 percent have moderate to severe cognitive impairment (*U.S. Department of Health and Human Services, Centers for Medicare &Medicaid Services. Nursing Home Data Compendium, 2010 Edition*). In 2012, CMS commenced a national partnership to improve dementia care to reduce inappropriate medication use. Vermont is participating in this partnership.

With the increasing number of Vermonters diagnosed with Alzheimer's disease and related disorders (ADRD), one of the state's priorities is to continually seek ways to improve the system of care for people with ADRD. In 2013, the Department of Disabilities, Aging and Independent Living (DAIL) identified several problems:

- Vermont hospitals reported difficulty finding nursing facility options for people with cognitive impairment;
- Division of Licensing and Protection reports a significant increase in resident to resident incidents involving residents with dementia;
- Residents with dementia are at increased risk for involuntary discharge;
- Residents with dementia are at increased risk for receiving inappropriate medications;
- Facilities reported needing additional support to manage care for people with dementia.

The state underwent significant public notice regarding the project as shown in the timeline below:

- September 2013 - August 2014: Workgroup and Stakeholder Meetings
- October 2013: Choices for Care System Gap Analysis
- January 2014: Legislative Testimony on pilot in SFY15 Budget
- May 2014: SFY 15 Budget passed
- August 2014: Draft regulations
- September 2014: DAIL advisory board update
- September 8, 2014: ICAR approval

- November 20, 2014: Medicaid Exchange and Advisory Board
- September 18, November 14, December 22, 2014: Notice of proposed rulemaking to interested parties
- September 18 - November 4, 2014: Written comments accepted
- October 2, 2014: Presentation at Vermont Health Care Association (VHCA) Conference
- October 24, 2014: Public hearing
- November 20, 2014: Final rules filed
- December 4, 2014: Legislative Committee on Administrative Rules (LCAR) hearing
- December 22, 2014: LCAR approval
- March 1, 2015: Projected Start Date

Pilot Description

The pilot provides funding of approximately $479,000 per year over a period of approximately 2 years to provide financial assistance to interested and eligible facilities that are committed to person-centered dementia care through a dedicated "Companion Aide." The Companion Aide is a trained LNA who will champion person-centered dementia care and be a supportive resource for the resident and co-workers.

Eligible nursing facilities are committed to furthering advances in long term care collectively known as *culture change* with a focus on person-centered dementia care. This is evidenced by routinely providing training such as "Hand in Hand" or other CMS approved curriculum related to culture change for all staff and by making other changes to assist residents to exercise their preferences in various situations. The facility must collect data and complete the Artifacts of Culture Change Tool, Care Practice and Environment sections (Developed by the Centers for Medicare & Medicare Services and Edu-Catering, LLP) to evaluate the success of this enhancement to dementia care (See Reporting Requirements). Expenditures for the Companion Aides are contingent on the Companion Aides meeting the requirements outlined in the job description. Companion Aides must also be part of an overall facility wide effort to improve the lives of residents with various forms of dementia.

Companion Aides must be a respected agent for promoting culture change in each facility selected to participate in the pilot. The hours worked by Companion Aides during calendar 2015 will match the number of Full Time Equivalents (2,080 hours per FTE) as calculated on the Agency of Human Services Division of Rate-Setting Budget Form submitted with the nursing facility's application. The Companion Aide's monthly hours can be utilized for general LNA duties in the following limited instances: an event that results from the occurrence of natural causes that could not have been prevented by the exercise of foresight or caution; an inevitable accident (i.e., snow storms or floods) so that other LNAs on a large scale cannot make it into work; or for short-term assistance in emergency situations (when a resident has fallen or needs immediate assistance). The facility must track how many hours a Companion Aide works in his/her Companion Aide role. The time when a Companion Aide is reassigned for general LNA work must be tracked separately.

DAIL will offer guidance and support to the facilities to assist them in empowering staff by identifying tools to help them better understand and care for people with dementia and identify approaches that are person-centered to improve quality of care and life for people with dementia.

The pilot is projected to run from March 1, 2015, through the end of the current demonstration period—December 31, 2016. If the Global Commitment to Health demonstration is renewed past December 31, 2016, the state expects to continue funding the pilot through June 30, 2017.

Application and Selection Process

All Vermont nursing facilities received an invitation to apply for the Companion Pilot project. The invitation included the following:

- Companion Aide Pilot Project Description;
- Companion Aide Job Description;
- Application Form;
- Budget Form;
- Artifact of Culture Change Form (Care Practice and Environment sections); and
- Ongoing Reporting Requirements Form.

Applications contained facility specific data including:

- Total residents as of June 15, 2014;
- Total residents with Alzheimer's or Dementia as a primary diagnosis based on data reported on the Minimum Data Set (MDS) forms on June 15, 2014;
- Total residents with a positive response for the uses of antipsychotic medications on the MDS forms for the picture date of June 15, 2014 (Q2 2014);
- Number of resident to resident incidents which occurred in the six months from January 1, 2014 to June 30, 2014;
- LNA Turnover; and
- Number of involuntary discharges due to behavioral issues over the last 12 months.

One nursing facility from each of five geographical regions of the state was selected to participate in the pilot. In each geographical region, the nursing facility whose application showed the highest proportion of residents with diagnoses of dementia or Alzheimer's was selected to participate in the pilot. The state's goal was to increase the number of LNAs in the facilities that had the highest proportion of residents with diagnoses of dementia or Alzheimer's. These facilities would benefit the most from the dedicated Companion Aides.

Reporting Requirements

Each facility must submit an annual report by November 10, 2015, and November 10, 2016, with the following information:

- Number of resident to resident incidents in a prescribed six month period;
- Number of residents with use of antipsychotic medications, as reported on the MDS forms;
- LNA Turnover;
- Number of involuntary discharges based on behavioral issues;
- Most recent resident and employee satisfaction surveys;
- Number of hours Companion Aides paid for the last calendar year;
- Number of different individuals who were staffed as Companion Aides over the last calendar year;
- Average length of service of the Companion Aides;

- Description of specialized training provided to Companion Aides; and,
- Artifact of Culture Change form (Care Practice and Environment sections).

Companion Aide Job Functions

Each facility is responsible for ensuring the Companion Aides are trained to perform the specific duties listed below.

Specific duties to be performed for residents with dementia:

- Get to know who the resident is and communicate the "who" to the care team;
- Interact with family and resident to get information on the resident's life and preferred daily routine;
- Be present and listen to the resident;
- Help identify unmet needs and help to meet them;
- Attend the resident's care planning meetings and use the "who" and observations of unmet needs to help drive care;
- Create and monitor use of the Music and Memory intervention;
- Accompany the resident on walks (indoors and out of doors);
- Identify preferences and engage the resident in individualized and small group activities;
- Support participation in the resident's preferred activities that enhance quality of life; this could include, but need not be limited to, creative, recreational, spiritual, and social activities;
- Encourage residents to eat or take nourishments; and
- Assist the staff development coordinator or OASIS trainer with "just-in-time" trainings on person-centered dementia care as able.

Each Companion Aide will assist the staff development coordinator or OASIS trainer with trainings on person-centered dementia care and participate in quality improvement initiatives in the facility as able.

Companion Aide Qualifications and Training

Each facility is responsible for ensuring the Companion Aides meet the qualification and training outlined below.

Companion Aides must have the following qualifications:

- Licensed Nursing Assistant (LNA) through the Vermont Secretary of State Office of Professional Regulation following the training and competency standards prescribed by the Vermont State Board of Nursing (https://www.sec.state.vt.us/professional-regulation/professions/nursing/licensed-nursing-assistants.aspx);
- Have prior training in dementia care with at least two years of experience working in a nursing home setting; and
- The staff person must attest that the role is chosen, not assigned. To qualify, the employee must want to do this.

Companion Aides must demonstrate satisfactory completion of the following Person-Centered dementia care training in the first year:

a. The facility's basic dementia care program (as provided by the Alzheimer's Association). This must be evidenced by a passing score on an examination or a certificate of completion;
b. Basic dementia care training (as provided by the Alzheimer's Association and others),
c. Basic TBI training (on-line Michigan course); and
d. Hand and Hand or other approved CMS trainings and pass core competencies at the end of each module.

Each Companion Aide must take an annual refresher on person-centered dementia care using an approved curriculum by DAIL in year two of the pilot. Each Companion Aide must be in good standing with the facility as evidenced by at least one satisfactory performance evaluation during the previous rating period.

Rate Adjustment Calculations

Vermont currently utilizes a case-mix payment system for nursing facilities which is established in state regulation. A per diem rate is set for each facility based on the historic allowable costs of that facility. Allowable costs include salary and fringe benefits of LNA staff at wage rates set by each facility. For details on Vermont's rate-setting methodology, please refer to *Methods, Standards and Principles for Establishing Medicaid Payment Rates for Long-Term Care Facilities* found at http://humanservices.vermont.gov/departments/office-of-the-secretary/ahs-drs/nursing-homes/.

The nursing facility rate adjustment for the pilot will include only the salary and fringe benefit costs for the approved number of Companion Aides at the selected facilities. The hourly salaries and fringe benefit rates will be reported on the Companion Aide application and reviewed by the Division of Rate Setting.

The selected facilities will be funded at a ratio of five Companion Aides per 100 total filled beds. As of December 2014, the average number of filled beds in a Vermont facility is 74. The calculated number of Companion Aides shall be rounded up or down to determine the number of Companion Aide Full Time Equivalents at 40 hours per week (40 hours/week X 52 weeks/year = 2,080 hours/year). The resulting number of aides to be funded will vary with the number of total filled beds at the selected facilities.

The number of total beds filled shall equal the total number of residents reported on the June 15, 2014 MDS picture date (Q2 2014) summary report supplied to the Division of Licensing and Protection.

The original per diem adjustment for Companion Aides will be inflated on July 1, 2015, and July 1, 2016, using the same methodology as detailed in Subsection 5.8 of the rate-setting regulations. http://humanservices.vermont.gov/departments/office-of-the-secretary/ahs-drs/nursing-homes/.

Evaluation

The goal of the pilot is to improve the lives of people with dementia as evidenced by positive change such as a reduction in the use of psychotropic drugs, incident of resident to resident altercations, and improved staff satisfaction.
An evaluation of the pilot will utilize the reports submitted by the facilities with the following targets:

- **Target #1**: Reduction in resident to resident incidences by 10 percent the first year, an additional 25 percent in second year for a total of 35 percent reduction from baseline by end of year two;
- **Target #2**: Reduction in antipsychotic use to at least five percent below the state average by the end of the pilot;
- **Target #3**: Ten percent reduction in LNA turnover each year;
- **Target #4**: Reduce involuntary discharges based on behavioral issues to zero by the end of the pilot;
- **Target #5**: Maintain or improve overall satisfaction of residents and employees by the end of the pilot;
- **Target #6**: Increase Care Practice Artifact score by the end of the pilot; and
- **Target #7**: Increase Family & Community Artifact Target score by the end of the pilot

DAIL will provide oversight in the following areas:

- Number of hours Companion Aides paid for the last calendar year;
- Number of different individuals who were staffed as Companion Aides over the last calendar year;
- Average length of service of the Companion Aides; and
- Specialized training provided to Companion Aides.

The state must evaluate the data and generate a summary evaluation report for each year of the pilot. The state must submit plans to evaluate the pilot in the revised draft evaluation design. The state must also submit updates on the pilot in each quarterly report.