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

State Demonstrations Group

June 2, 2025

Jenney Samuelson
Secretary
Vermont Agency of Human Services
280 State Drive
Waterbury, VT 05671

Dear Secretary Samuelson:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Vermont's Final Report for the Reasonable Opportunity Period (ROP) Extension COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled, "Global Commitment to Health" (Project No: 11-W-00194/1). This report covers the demonstration period from March 1, 2020 through the end of the PHE. CMS determined that the Final Report, submitted on May 10, 2024, is in alignment with the CMS-approved Evaluation Design, and therefore, approves the state's Final Report.

The approved Final Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Final Report on Medicaid.gov.

We sincerely appreciate the state's commitment to evaluating the COVID-19 PHE demonstration under these extraordinary circumstances. We look forward to our continued partnership on Vermont's section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S
Digitally signed by DANIELLE DALY -S
Date: 2025.06.02 04:59:28 -04'00'

Danielle Daly
Director
Division of Demonstration
Monitoring and Evaluation

cc: Gilson DaSilva, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

NORC at the University of Chicago

FINAL EVALUATION REPORT

May 2024

COVID-19 Public Health Emergency Medicaid Section 1115 Demonstration

Presented by:
NORC at the University of Chicago

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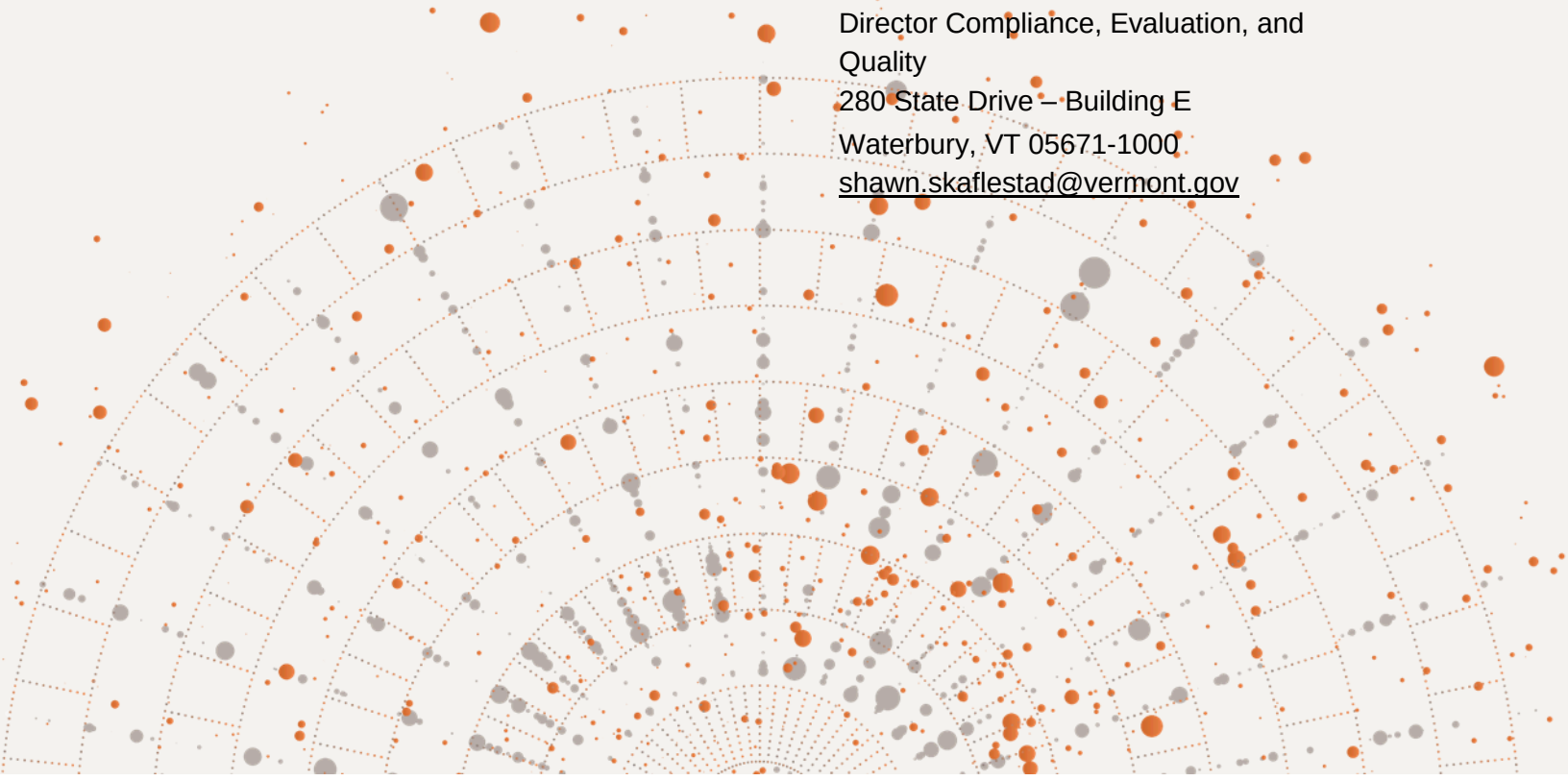

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Executive Summary

The Department of Vermont Health Access (DVHA), which administers Vermont's Medicaid program, is required to have an internal grievance and appeal process for resolving service disagreements, including denial of a particular service; failure to provide services in a timely manner or of a sufficient quantity, and denial of a request for mental health services. The goals of the grievance and appeal system are to resolve disputes fairly and ensure that members' rights are upheld. Under usual circumstances, members are required to provide testimony of their appeal in-person or in-writing. Due to the COVID-19 public health emergency (PHE), CMS waived the requirement of the in-person testimony of appeals under 42 CFR 438.406(b)(4) Handling of Grievances and Appeals.

Relative to the baseline period, we observed a decrease in the number of appeals filed in the waiver period. However, waiver of in-person testimonies due to the PHE did not appear to significantly impact the appeals process for members, nor affect the outcome of these appeals. Though the overall number of appeals decreased significantly before and after implementation of the PHE waiver, this should be interpreted in light of the decrease in service utilization during the PHE.

Background

The Vermont Global Commitment to Health Medicaid Section 1115(a) demonstration is an arrangement between the Vermont Agency of Human Services (AHS) and the Centers for Medicare & Medicaid Services (CMS) to advance care delivery and payment reform to improve the health of all Vermonters. The Department of Vermont Health Access (DVHA) is required under 42 CFR Part 438, Subpart F[i] to maintain an internal grievance and appeal process for resolving service disagreements between members and representatives of the Medicaid Program, such as Designated Agencies (DAs) and Specialized Service Agencies (SSAs) for mental health services.

In response to the COVID-19 public health emergency (PHE), Vermont applied for a new section 1115(a) demonstration flexibility requesting CMS approval for waiver and expenditure authorities to facilitate the delivery of effective care and to allow the state to focus operations on addressing the PHE. Specifically, the state requested to waive the requirement 42 CFR 438.406(b)(4) Handling of Grievances and Appeals, which allows beneficiaries to provide evidence and testimony "in person" to appeal an adverse benefit determination during the PHE. This application was approved by CMS on December 3, 2020.[ii]

Grievances and Appeals Process

The formal grievance and appeal process ensures that Medicaid members are informed about adverse benefit determinations and can challenge decisions without retaliation. According to DVHA, the overall goals of the grievance and appeal system are to resolve disputes fairly; to enhance member and public confidence in the equity and integrity of the service system; to ensure members access to medically necessary, covered, benefits; and to allow for the independent review of Medicaid Program staff decisions concerning appealable actions.

Appeals are defined by the Health Care Administrative Rule 8.100 as adverse benefit determinations made by the Managed Care Model,[1] that are subject to an internal appeal.[iii] These actions include:

- Denial or limitation of authorization of a requested covered service or eligibility for service, including the type, scope or level of service; reduction, suspension or termination of a previously authorized covered service or a service plan;
- Denial, in whole or in part, of payment for a covered service; failure to provide a clinically indicated, covered service, when the managed care provider is a DA/SSA;
- Failure to act in a timely manner when required by state rule; and

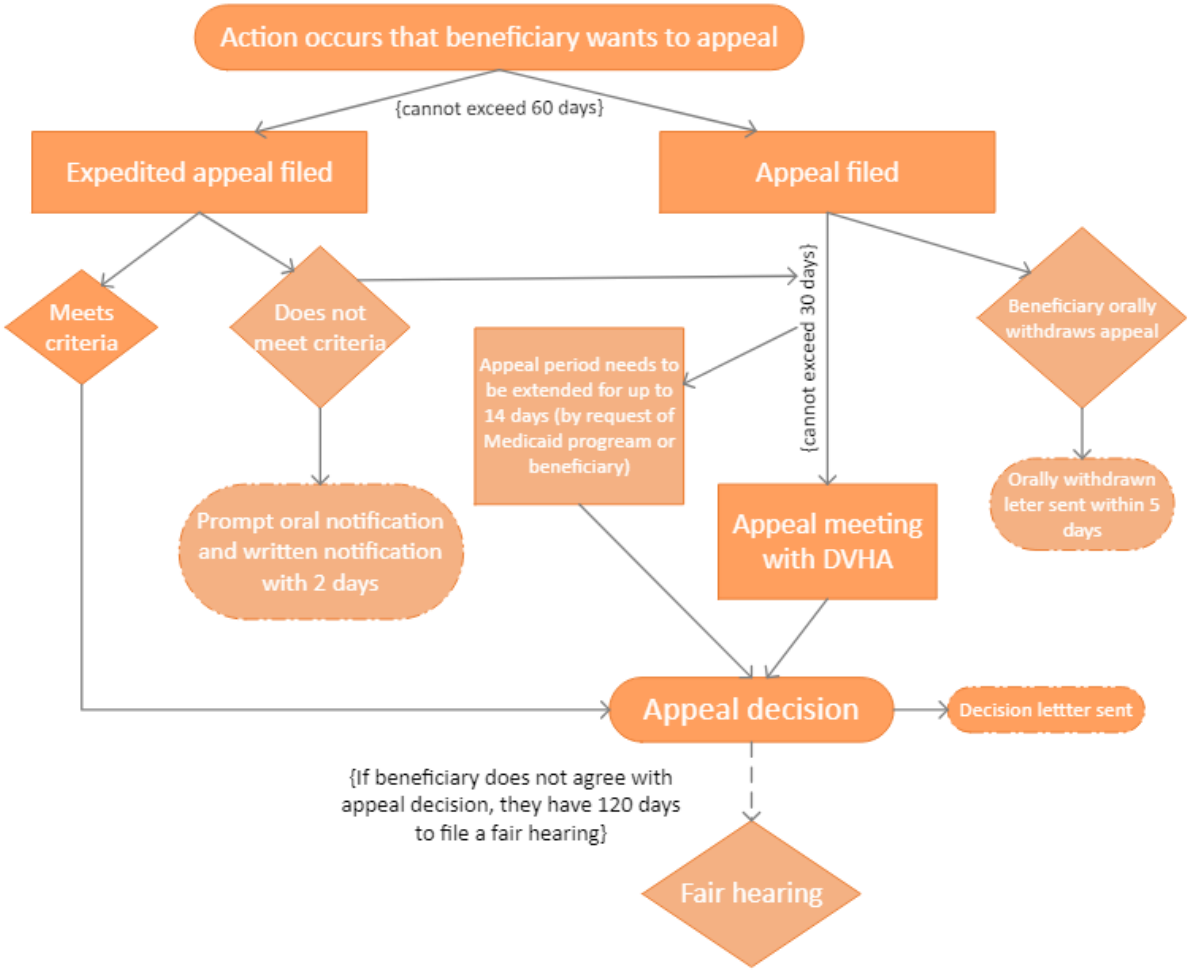
[1] The Medicaid Managed Care Model is composed of various administrative areas within the Agency of Human Services (AHS). These include: the Department of Vermont Health Access (DVHA), the Department for Children and Families (DCF), the Department of Mental Health (DMH), the Department of Disabilities, Aging and Independent Living (DAIL), and the Department of Health (VDH). Also, included in the Medicaid Managed Care Model are the Designated Agencies (DA) and Specialized Service Agencies (SSA) that provide service authorizations for DMH and DAIL.

- Denial of a member's request to obtain covered services outside the network.

As part of this process, DVHA is required to offer members the opportunity to provide their testimony for appeal in-person with Medicaid staff; Vermont members are also given the option to provide their testimony in writing or virtually via telephone or video.

Written acknowledgement of a grievance or appeal must be sent within five days of receipt and must reach a conclusion or an appeal within 30 days. If the appeal is denied, members must complete the full internal appeals process before a hearing. See **Exhibit 1** for an illustration of the appeals process.

Exhibit 1. DVHA Appeals Process Flowchart



SOURCE: Medicaid Program Grievance and Appeals Technical Assistance Manual (Attachment 3.F)

Waiver of In-Person Requirement for Grievances and Appeals

On December 3, 2020, CMS approved the PHE waiver for the State of Vermont, removing the requirement (42 CFR 438.406(b)(4))[i] to offer in-person testimony to appeal an adverse benefit determination during the PHE. CMS amended the Global Commitment to Health Special Terms and Conditions (STCs) to state that DVHA must provide members reasonable opportunity, in writing, telephonically, and video or virtual communication, to present evidence and testimony and make legal factual arguments. A key goal of this waiver was to limit in-person contact during the COVID-19 PHE.

This flexibility was authorized retroactively from March 1, 2020, through 60 days after the end of the PHE, which expired on May 11, 2023.[iv]

Evaluation Questions and Hypotheses

This evaluation uses a mixed-methods approach involving both primary and secondary data sources to assess how the waiver of in-person appeals (referred to henceforth as the "PHE waiver") affected the appeals process and members' rights. The State submitted the final evaluation design plan for this evaluation to CMS on February 12, 2021[v]; the evaluation design was approved by CMS on March 29, 2021.[vi] Research questions, dependent variables and corresponding hypotheses as presented in the evaluation design are summarized in **Exhibit 2**.

Exhibit 2. Quantitative Evaluation Research Questions and Hypotheses

Research Question	Hypothesis
How did the implementation of the PHE waiver affect the number of appeals filed?	There will be no difference in the number of appeals filed before and after the PHE waiver.
How did the implementation of the PHE waiver affect the percent of appeals meeting the 30-day appeal resolution timeframe?	There will be no difference in the percent of appeals meeting 30-day appeal resolution timeframe before and after the PHE waiver.
How did the implementation of the PHE waiver affect the number of appeals reversed?	There will be no difference in number and percent of appeals reversed before and after the PHE waiver
How did the implementation of the PHE waiver affect the number of appeals for services under the Department of Mental Health (DMH)?	There will be no difference in number and percent of DMH appeals before and after the PHE waiver
How did the implementation of the PHE waiver affect the number of transportation appeals?	There will be no difference in number and percent of transportation appeals before and after the PHE waiver

In addition, the evaluation will assess the following research questions qualitatively to provide context for quantitative findings:

1. What were the principal challenges associated with engagement with Medicaid beneficiaries during this public health emergency?
2. What strategies did states pursue to address those challenges?

3. What policies and procedures were most helpful to states and providers in leveraging flexibilities to reduce barriers and ensure access to care, including accessing medical supplies and equipment?
4. What population groups were principally affected by this demonstration?
5. What were the unresolved or ongoing challenges related to implementation of the demonstration flexibilities?

Methodology

We used both quantitative and qualitative data and approaches to assess how the PHE waiver of the in-person requirement for appeals and grievances may have affected members' rights to appeal Medicaid service coverage decisions. This section outlines the target population, evaluation period, quantitative and qualitative data sources and outcomes, analytic methods, and methodological limitations.

Target Population

We assessed whether the PHE waiver affected appeals filed by Medicaid members in the state of Vermont. We included all Medicaid members enrolled with full benefits and Medicaid as their primary payer during the measurement periods in our analyses.

Evaluation Period

This evaluation includes appeals filed by Vermont Medicaid members between March 2019 and February 2021. The PHE waiver was implemented on March 1, 2020; the pre-PHE waiver period is defined as the 12 months before the PHE waiver implementation (March 2019-February 2020), and the post-waiver period is defined as the 12 months after implementation (March 2020-February 2021). **Exhibit 3** summarizes the allowed modes of addressing grievances and appeals for the pre- and post-waiver periods used in this evaluation.

Exhibit 3. Summary of Appeals Process in the Pre- and Post-Waiver Periods

	Pre-Waiver	**Post-Waiver**
Measurement Period	March 1, 2019 – February 29, 2020	March 1, 2020 – February 28, 2021
Appeals Process	The state must offer opportunities to handle grievances and appeals **in person and in writing**.	The state must offer opportunities to handle grievances and appeals **in writing, by telephone, and by video or virtual communication.**

Data Sources and Measures

Quantitative Data. The quantitative data presented in this report are derived from the DVHA grievance and appeals database. For each appeal, the database contains the applicable department, division, program, service category, resolution,[2] relevant dates (including date the appeal was received and date it was resolved), and information on fair hearing (if applicable). **Exhibit 4** displays the five outcomes that are included in this evaluation.

Exhibit 4. Quantitative Outcomes for Evaluation of the PHE Waiver

Outcome	Definition
Appeals filed	Number of appeals filed with AHS
Appeals resolved within 30 days	Number and percent of appeals for which 30 days or fewer passed between the date of resolution and the date an appeal was received by AHS
Appeals that result in decision reversal	Number and percent of appeals for which the result was having the original appeal decision reversed
Appeals for Department of Mental Health (DMH) services	Number and percent of appeals filed for DMH services
Appeals for transportation services	Number and percent of appeals filed for transportation services

NOTE: DVHA advised that the resolutions "decision reversed" and "approved by department" are essentially the same result, given that an appeal being approved by a department is necessary for the appeal decision to be reversed. Therefore, both resolution statuses are counted toward the "percent of appeals reversed" outcome.

[2] Departments include Department for Children and Families (DCF); Department of Disabilities, Aging, and Independent Living (DAIL); Department of Health (VDH); and Department of Mental Health (DMH) with which DVHA enters into an agreement delegating its managed care functions. Divisions are more specialized units within these departments (e.g., Developmental Disabilities Service Division) within DAIL). Services are any clinical or non-clinical benefit a member utilizes, and is categorized by use-case, e.g. long-term care, personal care services, transportation, home health care, etc. Resolutions, or decisions on the appeals filed, are decided and written notice sent to the member within 30 days of receipt of the appeal. The resolution can result in the appeal decision being reversed, upheld, withdrawn, modified, or dismissed due to the time frame within which the member could file an appeal expiring.

Qualitative Data. NORC interviewed a DVHA staff member to gain a better understanding of the implementation approach and effects of the waiver on Medicaid enrollees in Vermont. The semi-structured interview questions focused on the challenges faced engaging Medicaid members during the PHE, facilitators of the state's ability to leverage this flexibility, and the impact that this flexibility had on increasing access to care for the Medicaid population.

Analytic Methods

We conducted descriptive trend analyses to assess the monthly total number of appeals filed, as well as the number and percent of appeals meeting the four criteria of interest over the evaluation period. Due to small sample sizes in the post-waiver period, data are aggregated in 3-month increments.[3]

To assess the significance of the differences in outcomes between the pre- and post-waiver periods, we compared the average number of appeals per month before and after the PHE waiver implementation using the Mann-Whitney (M-W) U test, also known as the Wilcoxon rank sum test,[4] a non-parametric, two-sided (nondirectional) test that assumes no specific underlying distribution.[vii] Using the M-W test, we test whether the means for the appeals outcomes in the pre- and post-waiver periods differ at a 5% significance level. All analyses were conducted using SAS Enterprise Guide version 8.3.8.206.

Methodological Limitations

We were unable to link appeals data from the DVHA database to claims data in the Medicaid Management Information System (MMIS) given that the appeals data available for analysis do not contain unique identifiers (e.g., Medicaid ID numbers). As a result, we are unable to explore Medicaid spending, utilization, and/or quality of care outcomes for members filing appeals. In lieu of this information, we contextualize the trends in appeals filed during the PHE and trends in service utilization in Vermont over the same period.

The appeals database does not contain information on the format in which members provide testimony (e.g., in-person, in writing, virtually), which limits our ability to make a statement regarding the cause of changes between the pre- and post-waiver periods due to the waiver of the in-person requirement. Further, some in-person appeal meetings resumed before the end of the federal COVID-19 PHE in May of 2023 based on enrollee need; however, we are unable to identify those appeals in the data. Similarly, Vermont permitted testimony to be presented virtually prior to the PHE, a provision which DVHA established to provide flexibility to Medicaid enrollees.

[3] Because the waiver flexibility began on March 1, 2020, the 3-month increments do not align with calendar quarters.

[4] The State initially proposed the use of a one-sample Poisson test at a 5% significance level; however, the data do not reflect a Poisson distribution which is a key assumption of the Poisson test.

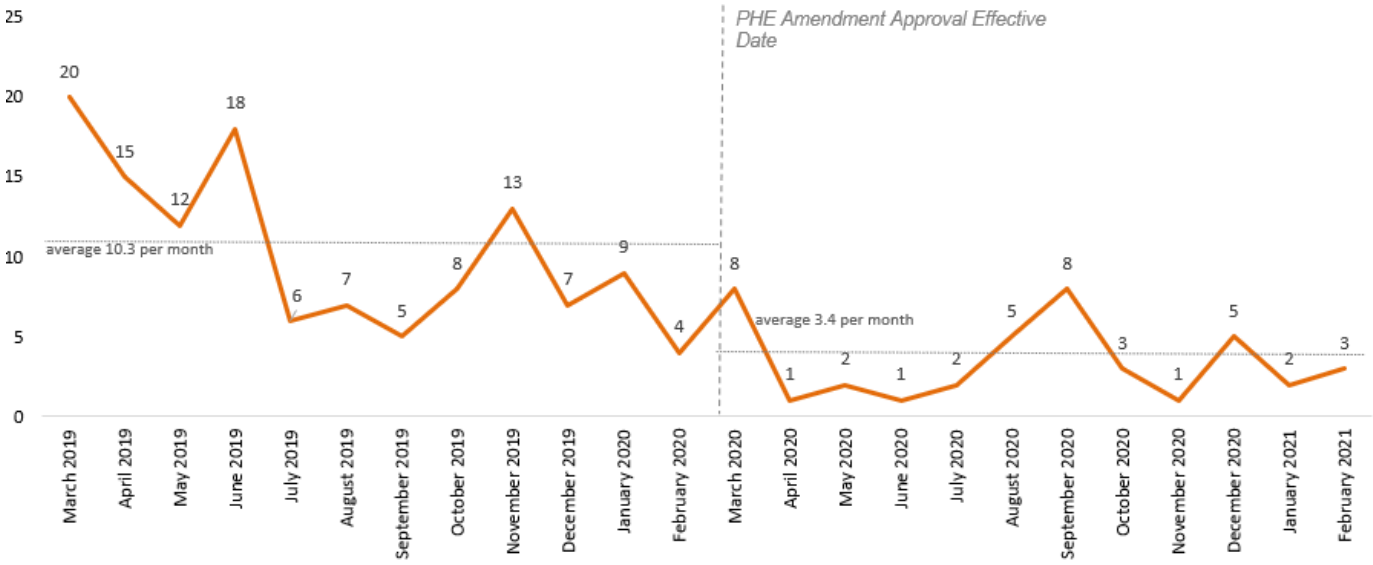
Results

Overall, our results indicate that the PHE waiver of the in-person requirement for appeals maintained members' right to appeal while upholding social distancing practices for the benefit of Medicaid members and state staff. Due to existing policies that allowed for flexibility in handling grievances and appeals, DHVA reported that the appeals process did not change significantly due to the PHE waiver flexibilities. Prior to the pandemic, Medicaid members were already given the option to conduct appeal meetings and fair hearings virtually or in-person; with the introduction of the PHE waiver, the State was no longer required to offer an in-person option. At the beginning of the PHE, DVHA began administering all services, including those related to grievances and appeals, virtually.

Appeals Filed

The total number of appeals filed decreased across in the post-waiver period relative to the pre-waiver period (**Exhibit 5**). The pre-waiver period had a total of 124 appeals filed (average of 10.3 appeals per month), and the post-waiver period had 41 total appeals filed (average of 3.4 appeals per month). The difference in monthly average was significant ($p<0.01$) across the pre- and post-waiver periods; however, we hypothesize that a decline in the utilization of Medicaid services was driving the decline in appeals filed. According to Vermont Agency of Human Services (AHS) reporting, both acute care services and preventative services declined meaningfully between 2019 and 2021, likely due to the COVID-19 PHE.[viii,ix]

Exhibit 5. Total Number of Appeals Filed over the 24-Month Evaluation Period

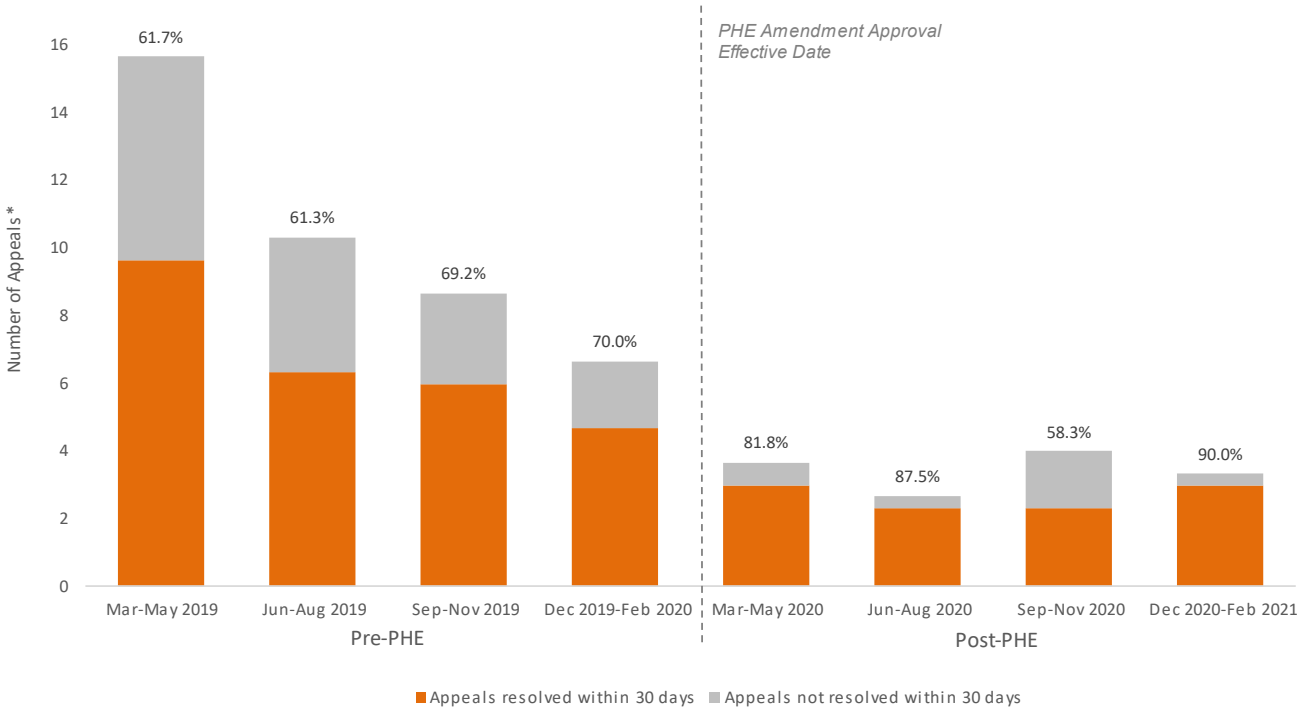


NOTE: The vertical dotted line indicates the retroactive effective date of the PHE waiver of required in-person appeals (March 1st, 2020).

Appeals Resolved Within 30 Days

Throughout the pre-waiver and post-waiver periods, most appeals were resolved within 30 days of being filed, which meets AHS' statutory requirements for the appeal resolution timeframe (**Exhibit 6**). In the pre-waiver period, 64.5% of appeals were resolved within 30 days, compared to 77.5% of appeals in the post-waiver period; this difference was not significant. DVHA reported that the increase in the percentage of appeals resolved within 30 days of filing may be due in part to a reduced burden on the DHVA appeals team, given the lower number of appeals filed during that time.

Exhibit 6. Number and Percent of Appeals Resolved within 30 Days of Filing

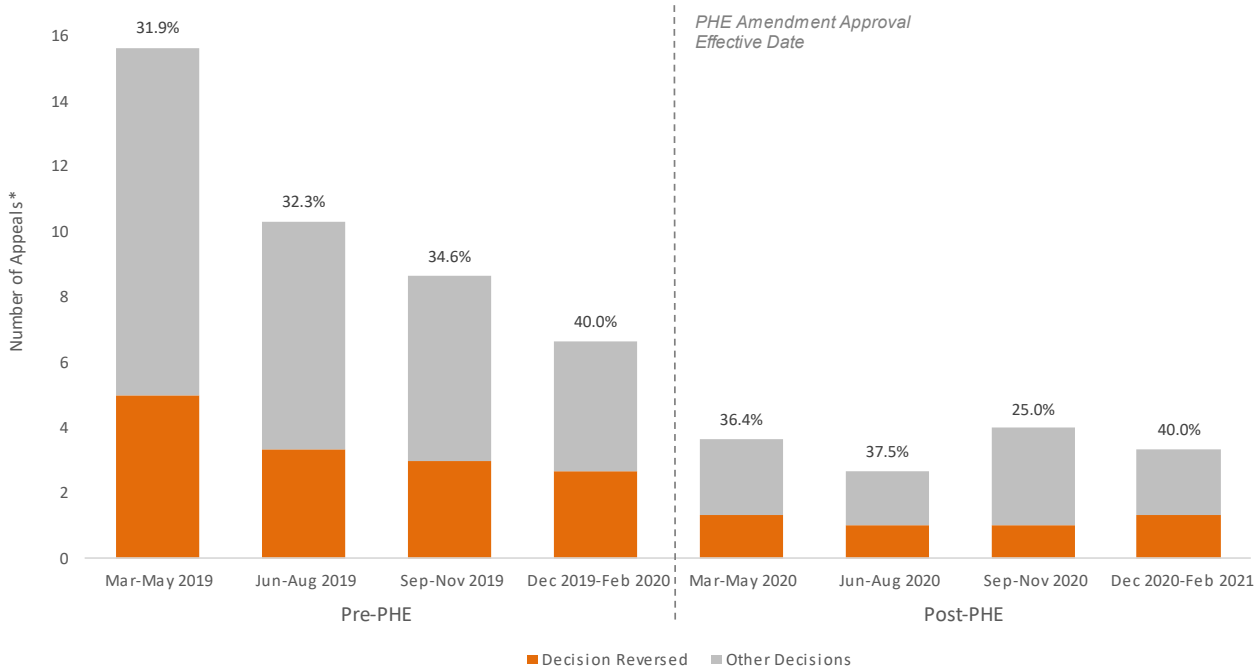


NOTE: The vertical dotted line indicates the retroactive effective date of the PHE waiver of required in-person appeals (March 1st, 2020). Percentages for each quarter are calculated as the average number of appeals resolved in 30 days in each month, over the average number of appeals for those months. One appeal in the post-waiver period contained a date of resolution that was before the date received by DVHA and was excluded from this exhibit.

Appeals That Result in Decision Reversal

The number of appeals that resulted in a decision reversal remained relatively steady over the pre-waiver and post-waiver periods. The pre-waiver period had a total of 42 decisions reversed on appeal (33.9% of total appeals), compared to the post-waiver period which had 18 reversals (43.9%); this difference was not significant (**Exhibit 7**).

Exhibit 7. Number and Percent of Appeals Filed for which the Decision was Reversed

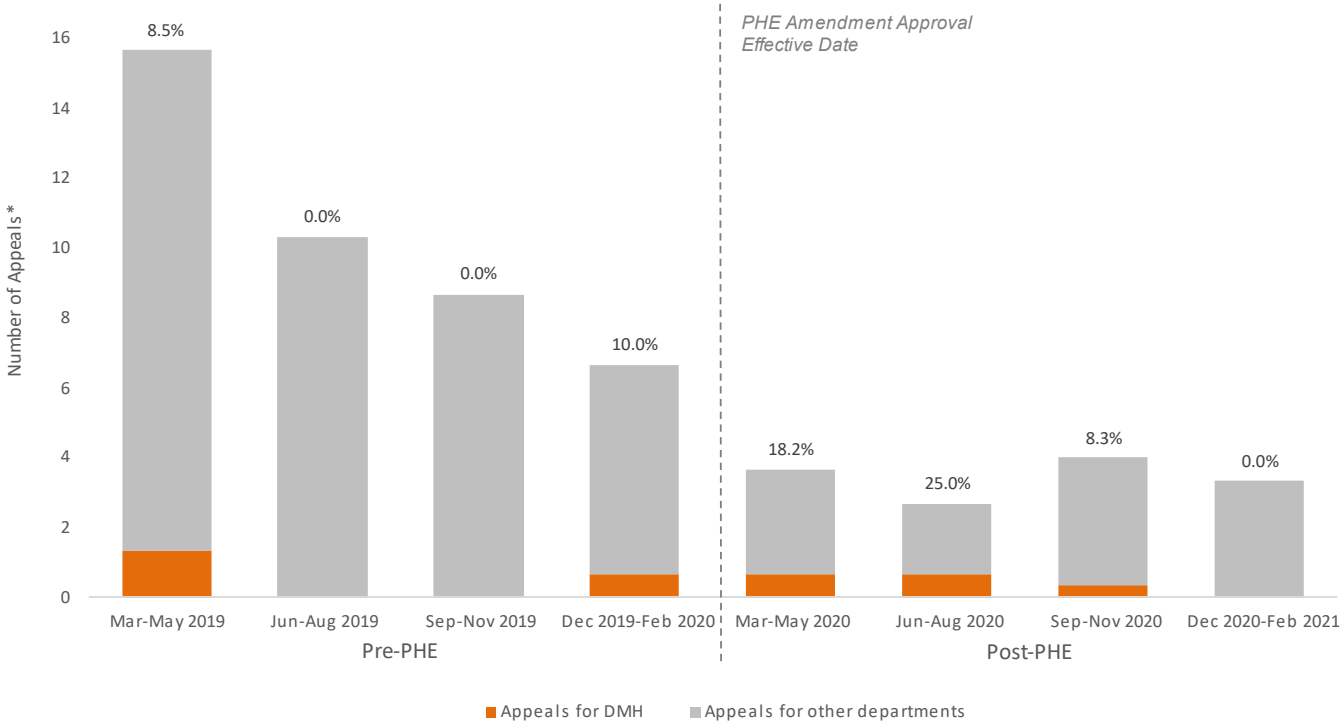


NOTE: The vertical dotted line indicates the retroactive effective date of the PHE waiver of required in-person appeals (March 1st, 2020). Percentages for each quarter are calculated as the average number of appeals for which the appeal decision was reversed in each month, over the average number of appeals for those months.

Appeals for DMH Services

The percent of appeals filed for DMH services was low in the pre-waiver period and remained low in the post-waiver period, with many months in both periods having no appeals filed for DMH services. In the pre-waiver period, a total of six appeals were filed for DMH services (4.0% of all appeals); in the post-waiver period, five appeals were filed (14.6% of all appeals; **Exhibit 8**); this difference was not significant. While the decline in overall appeals in the post-waiver period means that a higher percentage of appeals were filed for DMH services, the sample sizes are too small to draw any meaningful conclusions.

Exhibit 8. Number and Percent of Appeals Filed for DMH-Related Services



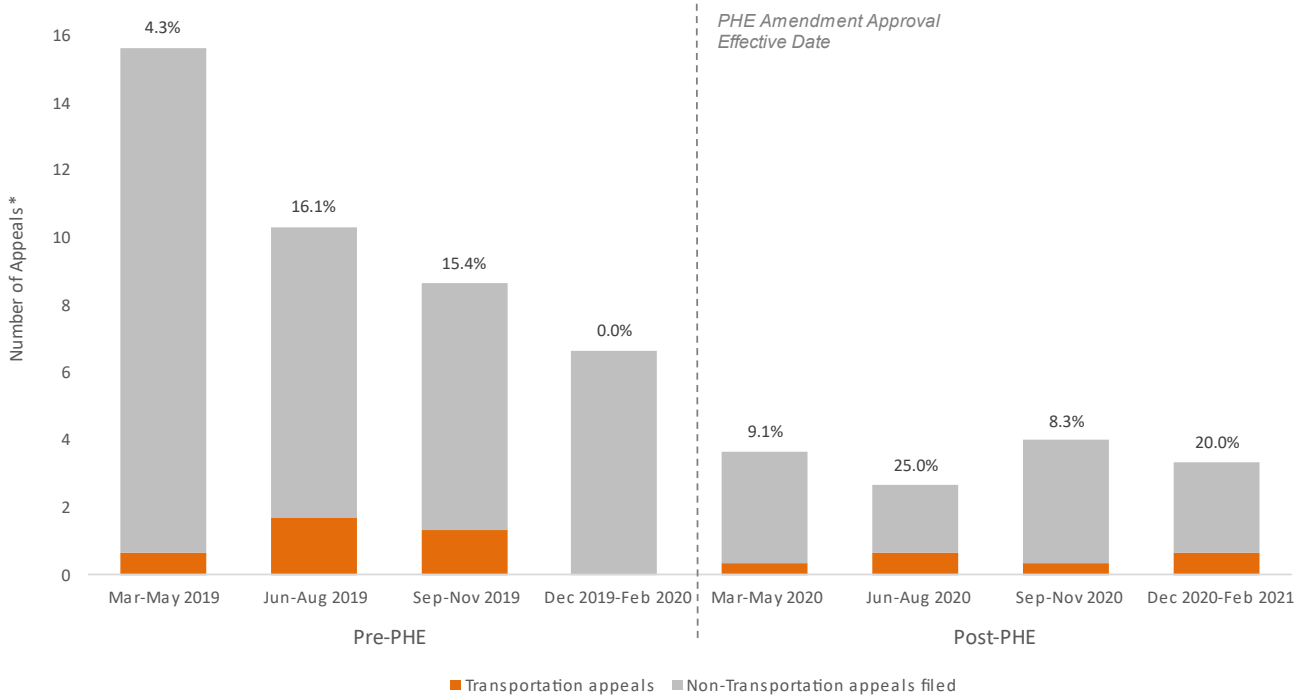
NOTE: The vertical dotted line indicates the retroactive effective date of the PHE waiver of required in-person appeals (March 1st, 2020). Percentages for each quarter are calculated as the average number of appeals for DMH services in each month, over the average number of appeals for those months.

Appeals for Transportation Services

Appeals for Medicaid-covered transportation services were low in both the pre- and post-waiver periods, with no statistically significant difference between the two.[5] There were eleven total appeals for transportation services filed in the pre-waiver period (8.9% of all appeals), compared to six appeals in the post-waiver period (14.6% of all appeals; **Exhibit 9**).

[5] DVHA covers non-emergency medical transportation (NEMT) to receive services billable to Medicaid by a Medicaid-enrolled provider. For more information on what types of NEMT are covered, see the Medicaid Non-Emergency Medical Transportation (NEMT) Procedure Manual.

Exhibit 9. Number and Percent of Appeals Filed for Transportation-related Services



NOTE: The vertical dotted line indicates the retroactive effective date of the PHE waiver of required in-person appeals (March 1st, 2020). Percentages for each quarter are calculated as the average number of appeals for transportation services in each month, over the average number of appeals for those months.

Conclusions, Interpretations, and Policy Implications

Overall, we observed a decrease in the number of appeals filed in the post-waiver period. However, these results cannot be interpreted causally. DVHA reported there were no meaningful changes to the appeals and grievances process due to the waiver of the in-person requirement, suggesting that the decrease in appeals may instead be driven primarily by other factors and should be interpreted in the context of the broader reductions in service use. Lower rates of overall service utilization in Vermont would provide fewer opportunities for denials of service, resulting in fewer appeals filed.

It is important to note that this flexibility was one of many affecting the appeals process during the evaluation period, and findings we report here should be also interpreted in the context of other federal and state PHE-related regulatory and policy changes. For example, the Families First Coronavirus Response Act, which was enacted into law by Congress on March 18, 2020, was a nationwide requirement for Medicaid programs to keep persons continuously enrolled in throughout the entirety of the PHE. With no Medicaid eligibility redetermination reviews, no appeals for eligibility redetermination

decisions were filed in the post-waiver period, as compared to the 9 appeals filed for eligibility redetermination which were filed before the PHE waiver (8% of total appeals in the pre-waiver period).

Further, as part of its pandemic response, Vermont removed prior authorization requirements for imaging services, durable medical equipment, and dental services. The state also extended pre-existing prior authorizations for certain clinical services and drugs approved prior to the PHE for six months, resulting in fewer denials of service and likely fewer appeals.[x] Finally, DVHA reported that the flexibility to extend the period for individuals to file appeals, which was enacted under a Section 1135 wavier flexibility under 42 C.F.R. §438.408(f)(2), and extended the timeframe for Medicaid members to exercise their appeal rights to allow an additional 120 days to request a fair hearing, had a positive impact on the appeals process.[xi]

This demonstration amendment was intended to promote the objectives of the Vermont Medicaid program by allowing the state to furnish medical assistance in a manner intended to protect the health, safety, and welfare of individuals and providers affected by COVID-19. Importantly, the PHE waiver achieved these goals and afforded flexibilities which safeguarded both Medicaid members and staff during the height of the PHE when social distancing was an important safety measure, while also maintaining members' rights to access to the appeal process.

References

[i] Subpart F—Grievance and Appeal System. National Archives Code of Federal Regulations. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-F

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[vii] Mann, H. B., & Whitney, D. R. (1947). On a test of whether one of two random variables is stochastically larger than the other. Annals of Mathematical Statistics, 18, 50–60.

[viii] Annual Report for Demonstration Year 2021 for Global Commitment to Health Waiver. State of Vermont Agency of Human Services. https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/2021-VT-GC-Annual-Report-Resubmission-4.25.2022-web.pdf

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[xi] Section 1135 Waiver Flexibilities - Vermont Coronavirus Disease 2019. Medicaid.gov. https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/entry/54091

Attachment 1: CMS-Approved Evaluation Design

NORC at the University of Chicago

EVALUATION DESIGN PLAN

September 2023

Reasonable Opportunity Period Extension COVID-19 Public Health Emergency

Presented by:
NORC at the University of Chicago

Presented to:
The Vermont Agency of Human Services

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Demonstration Purpose

Vermont's Global Commitment to Health Demonstration ("the Demonstration") is an agreement between the Vermont Agency of Human Services (AHS) and the Centers for Medicare and Medicaid Services (CMS) that is designed to use principles of public health, effective administration of a Medicaid managed care delivery system, and programmatic flexibilities to improve the health and welfare of Vermonters.[xii,xiii] The Demonstration was first implemented in October 2005 and is currently in its fourth renewal period, effective from July 2022 through December 2027.[xiv]

The COVID-19 public health emergency (PHE) caused significant disruptions to programs and initiatives covered under the Demonstration. To mitigate the effects of such disruptions, the State of Vermont applied for a new section 1115(a) demonstration opportunity providing an exemption from the statutory prohibition in 1902(ee)(1)(B)(ii)(II) of the Social Security Act. Vermont's request was approved as an amendment under the Demonstration. Under this statutory requirement, if an individual declares U.S. citizenship or nationality, but either lacks the required documentation or the verification cannot be completed using administrative data, the State must provide coverage during a reasonable opportunity period (ROP) of 90 days. The current waiver amendment provides expenditure authority for the state to extend the ROP window for individuals to verify their citizenship and resolve data inconsistencies around their citizenship status during the Medicaid unwinding period (HBEE 54.05(a)(1)(ii)). Under this ROP extension, the State sent another notice to individuals with pending citizenship verification at the end of the COVID-19 PHE continuous coverage period, and individuals are then given an additional three months to verify their citizenship status to retain their Medicaid benefits.

Vermont began the unwinding period on April 1, 2023, and the ROP extension extends expenditure authority for 15 months after the start of the unwinding period, so the ROP extension period will end on July 1, 2024.[xv] These 15 months include the 12-month unwinding period plus an additional three months for the State to complete the verification process for cases that are submitted in the twelfth month of the unwinding period. The ability for the State to extend the ROP for any individual will terminate three months following the initiation of trathe verification process.

The ROP extension amendment will assist the State in processing eligibility and enrollment during the unwinding period by providing additional time to complete outstanding verifications of citizenship and aims to facilitate continuity of coverage during the PHE unwinding period. The amendment also enables the State to assist individuals in obtaining documents needed to verify their status and help individuals understand what is required of them to establish their eligibility. To this end, the ROP amendment aims to facilitate equitable access to care and continuity of coverage, thereby supporting the goals of the Demonstration's fourth renewal period.[xvi]

Demonstration Population

The state projects that the ROP demonstration amendment will affect roughly 200 Vermonters who have declared U.S. citizenship[6] but are awaiting verification of their citizenship status, or those whose status is inconsistent with available data sources.[xvii] These individuals are required to provide documentation to verify their status to the State to continue Medicaid coverage beyond the ROP extension period.[xviii] We will focus evaluation activities on Vermonters who have declared U.S. citizenship but whose verification of their citizenship status is pending, or those whose status is inconsistent with available information, subsequently referred to as the "ROP demonstration population."

Evaluation Questions

To support the aims of the broader Global Commitment to Health Demonstration, the evaluation questions for the ROP demonstration are aligned with the overall goal of advancing the state towards population-wide comprehensive coverage by facilitating continuity of coverage during the PHE unwinding period. Specifically, the evaluation questions and hypotheses will investigate whether the expenditure authority to provide coverage beyond the statutorily limited 90-day ROP will support state's management of workload, promotes continuity of coverage, and reduces barriers to care.

To this end, we will investigate the following research questions:

1. What policies, strategies, or flexibilities did the state implement for this demonstration?
    a. What factors and data were considered to inform implementation decisions?

2. What successes did the state achieve with the implementation of the demonstration flexibilities?
    a. To what extent did the policies, strategies, or flexibilities reduce procedural terminations of coverage during the unwinding period?
    b. In what ways did the ROP extension help add or modify the state's administrative capacity for processing redeterminations, including eligibility verifications, for Medicaid members?
    c. To what extent did these flexibilities allow the state to overcome problems they would have otherwise faced absent these flexibilities?

[6] Satisfactory immigration status includes lawful permanent residents, asylees, refuges, Cuban/Haitian entrants, those who are paroled into the U.S. for at least one year, those who have been grated conditional entry before 1980, battered non-citizens, spouses, children, or parents, victims of trafficking and his or her spouse, child, sibling, or parent or individuals with a pending application for a victim of trafficking visa, granted withholding of deportation, member of a federally recognized Indian tribe or American Indian person born in Canada, or citizens of the Marshall Islands, Micronesia, and Palau who are living in Vermont. (https://www.healthcare.gov/immigrants/lawfully-present-immigrants/)

3. How many Vermonters were served and impacted by this demonstration?
    a. Who are the populations (e.g., age, sex, race/ethnicity) served and affected by this demonstration?

4. How did the demonstration affect member health coverage?
    a. How many individuals in the ROP demonstration population retained their coverage throughout the demonstration period?
    b. Did the retention of coverage vary by demographic characteristics, such as by age, sex, or race/ethnicity?

5. What were the principal challenges in implementing the ROP Extension demonstration?
    a. What actions did the state take to address challenges presented by the implementation of ROP extension?
    b. To what extent were mitigation strategies successful in the context of the PHE?

6. What were the principal applicable lessons learned for any future PHEs in implementing the demonstration flexibilities?

Exhibit 1 displays the research questions we will answer through these analyses, and the measures and methods we will use to complete them (described in more detail in the following sections). The target population for all research questions will be the ROP demonstration population as described in the previous section.

Exhibit 1. Evaluation Design Table

RQ#	Research Question	Outcome Measures	Data Source(s)	Analytic Methods
1	What policies, strategies, or flexibilities did the state implement for this demonstration?	Qualitative data	Key informant interviews	Thematic analysis
1a	What factors and data were considered to inform implementation decisions?	Qualitative data	Key informant interviews	Thematic analysis
2	What successes did the state achieve with the implementation of the demonstration flexibilities?	Monthly number and rate of terminations of coverage; qualitative data	MMIS; key informant interviews	Descriptive; thematic analysis
2a	To what extent did the policies, strategies, or flexibilities reduce procedural terminations of coverage during the unwinding period?	Monthly number and rate of terminations of coverage; qualitative data	MMIS; key informant interviews	Descriptive; thematic analysis
2b	In what ways did the ROP extension help add or modify the state's administrative capacity for processing redeterminations, including eligibility verifications, for Medicaid beneficiaries?	Qualitative data	Key informant interviews	Thematic analysis
2c	To what extent did these flexibilities allow the state to overcome problems they would have otherwise faced absent these flexibilities?	Qualitative data	Key informant interviews	Thematic analysis

3	How many Vermonters were served and impacted by this demonstration?	Number of Medicaid members who attested to U.S. citizenship/immigration status pending verification	Other Medicaid program data	Descriptive
3a	Who are the populations (e.g., age, sex, race/ethnicity) served and affected by this demonstration?	Age, sex, and race/ethnicity distribution of Medicaid members with pending status verification	MMIS; Other Medicaid program data	Descriptive
4	How did the demonstration affect beneficiary health coverage?	Number of Medicaid members retaining coverage during the demonstration period	MMIS; Other Medicaid program data	Descriptive
4a	How many individuals who attested to U.S. citizenship pending verification retained their coverage throughout the demonstration period	Number of Medicaid members retaining coverage during the demonstration period	MMIS; Other Medicaid program data	Descriptive
4b	Did retention of coverage vary by demographic characteristics, such as by age, sex, or race/ethnicity?	Demographic characteristics of members retaining coverage during the demonstration period	MMIS; Other Medicaid program data	Descriptive
5	What were the principal challenges in implementing the ROP Extension Demonstration?	Qualitative data	Key informant interviews	Thematic analysis
5a	What actions did the state take to address challenges presented by the implementation of ROP extension?	Qualitative data	Key informant interviews	Thematic analysis
5b	To what extent were mitigation strategies successful in the context of the PHE?	Qualitative data	Key informant interviews	Thematic analysis
6	What were the principal applicable lessons learned for any future PHEs in implementing the demonstration flexibilities?	Qualitative data	Key informant interviews	Thematic analysis

Data Sources

We plan to use the data sources described below to contextualize and respond to the evaluation questions, as well as inform best practices for similar situations in the future.

Qualitative Data Sources

- **Key Informant Interviews.** NORC will conduct semi-structured interviews with one to three Medicaid staff members to help better understand the populations affected by the demonstration and the policies and procedures to reduce barriers to care. We will work closely with AHS and DVHA to identify the most relevant perspectives and contacts for the interviews. To reduce

burden, we will align and coordinate the interviews with any interviews needed to address evaluation hypotheses relevant to the overall waiver evaluation, such as the SUD and SMI/SED Mid-Point Assessments.

- **Document Review.** We will conduct a thorough review of all relevant documentation, including the expenditure authority and other internal and public documentation provided by AHS and DVHA.

Quantitative Data Sources

- **ROP data and documents from AHS.** We anticipate that data needed to evaluate the ROP demonstration will include a list of individuals in the ROP demonstration population. These data will be linked to Medicaid enrollment data using UIDs. These data may also include member responses provided on their Medicaid application; we will assess the quality and relevancy of this data to determine whether and how we will use it in the evaluation.
- **Medicaid enrollment data.** NORC will utilize Medicaid enrollment data to gather information about the number and characteristics of individuals in the ROP demonstration population over the demonstration period. We will use these data to analyze trends in enrollments, changes to enrollments, demographics, and Medicaid program qualifications.

For each data source, we will conduct data quality and availability checks, including assessment for missingness, systematic errors, and any unexpected outliers.

Analytic Approach

We will conduct a mixed-methods analyinsis to understand how the ROP amendment meets the goals of the Demonstration to ensure high-value care for the residents of Vermont, integrating both quantitative and qualitative methods to draw on the strengths of each and make full use of existing and emerging primary data sources. These analyses will provide a detailed and nuanced understanding of whether, how, and why the demonstration goals are achieved.

Through this analysis, NORC will review primary and secondary data sources to gain a better understanding of:

- Populations affected by the expenditure authority under this amendment.
- Relevant policies and procedures that would support reducing barriers to care.
- Challenges associated with implementing the amendment and engaging with individuals the ROP demonstration population.
- Mechanisms and experiences overcoming these challenges, as applicable.
- Principal lessons learned.

Evaluation Period

The evaluation will include the entire duration of the ROP demonstration. The authority for Vermont lasts for up to 15 months starting from the first day of the first month of the state's unwinding period (April 1, 2023, to July 1, 2024). These 15 months include the state's 12-month unwinding period, plus three months for the state to complete the verification of U.S. citizenship for an individual whose case comes up for renewal in month 12 of the unwinding period. For all individuals, the authority to extend the ROP will terminate 3 months after the state initiates a renewal (or other eligibility action) for the individual.

Qualitative Analysis

NORC will conduct a qualitative analysis to gain a full understanding of the ROP extension, its barriers and facilitators, and the impact of the amendment on the state of Vermont.

We will first review all qualitative and primary data collected through the interviews and document review. We will then develop an initial coding frame and by systematically applying a reliable code list. Using an inductive and deductive approach to create the qualitative codebook, we will pilot test and refine codes and revisit refinements over the evaluation period. To organize program documents and interview transcripts for coding, we will use NVivo software (QSR International Pty Ltd., Melbourne, Australia). Whenever possible, coders will have been involved in primary data collection, to leverage their insights gained through first-hand experience. We will employ a thematic analysis to analyze qualitative data, guided by the Demonstration goals and evaluation questions. We will begin analysis of existing and emergent themes during the coding process and continue throughout the analysis phase. Existing themes are topics derived from the study's research questions and categories, while emergent themes arise out of the coding process. Early identification of emergent themes will help inform future primary data collection instruments.

Quantitative Analysis

Due to the limited sample size and lack of appropriate comparison populations, we will conduct descriptive analysis, including counts, frequency distributions and rates to address evaluation questions. We will present the results in tables and visuals, and where available, we will also present descriptive findings alongside benchmarks at the national level or from other states.

Limitations

We are cognizant of several challenges will likely arise in implementing mixed-methods in this evaluation, largely as a result of the limitations in data availability. **Exhibit 2** summarizes a summary of

the challenges we anticipate with our evaluation approach, and the corresponding steps we will take the mitigate the effects of the limitations.

Exhibit 2. Anticipated Challenges & Mitigation Strategies

Challenge	Mitigation strategy
Limited state staff available for key informant interviews	Begin with a target of one to three interviews We may potentially consider small group interviews, as needed, for saturation.
Lack of comparison group limits the ability to draw causal inferences	We will use qualitative data to supplement our interpretation of descriptive analyses
Absence of data indicating reason for coverage termination (inability to verify citizenship/vs. other)	We will determine the total number of coverage terminations to provide an upper bound for terminations that are potentially due to citizenship/. Additionally, we may be able to rely on dates of coverage onset and coverage termination to draw inferences on reason for termination and produce more nuanced estimates.
Small sample size limits the ability to conduct formal statistical testing to evaluate differences across age, sex, groups.	We will use qualitative data to supplement our interpretation of descriptive analyses.

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