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Al Gobeille, Secretary

December 31, 2018

Mary Mayhew, Director
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Center for Medicaid and CHIP Services
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Director Mayhew:

In my capacity as Secretary of Vermont's Agency of Human Services, I am submitting to the Centers for Medicare and Medicaid Services (CMS) a report to fulfill the requirement of Special Term and Condition (STC) 87 of Vermont's Global Commitment to Health 1115 Demonstration Waiver, which requires the submission of a phasedown plan for Vermont's psychiatric Institutions for Mental Disease (IMDs).

Sincerely,

Al Gobeille
Secretary

CC: Cory Gustafson, DVHA
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Vermont Global Commitment to Health Section 1115(a) Medicaid Demonstration 11-W-00194/1

Table of Contents

Introduction 2

I. Five-Year IMD Phasedown Schedule 3

II. Vermont Alternatives to IMDs 4

- a. *Pursue 1115 Mental Health IMD Opportunity* 4
- b. *Eliminate psychiatric IMDs in Vermont* 5
- c. *Contract with a Risk-Based Medicaid Managed Care Organization* 9

III. Post-IMD Phasedown Scenario 10

IV. The Value of IMDs for Vermont 12

V. Conclusion 14

Introduction

This report is submitted to fulfill the requirement of Special Term and Condition (STC) 87 of Vermont's Global Commitment to Health 1115 Demonstration Waiver, which states:

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

Vermont does not agree that Medicaid must phase down federal funding of Institutions for Mental Disease (IMDs). Psychiatric IMDs provide essential services to Vermont Medicaid beneficiaries, and it will require the full time allowed to 2026 to restructure and refinance the system in a way that avoids the most severe impacts to access and quality incurred by this loss elimination of federal funding.

STC 87 and the phasedown requirement was established under a different administration, and federal IMD policy at both the congressional and administration level has evolved drastically since this requirement was placed on the State in 2016. As evidence of the evolution in policy, in November 2018, CMS reversed its 2016 IMD position from which this phasedown requirement was predicated. With this recent advance in federal policy, and the mental health and opioid crises plaguing the nation at increasing severity, Vermont requests CMS to reconsider the requirement set forth in STC 87.

The following report is broken into four parts to provide a description of Vermont's IMD phasedown plan, including: (1) Five-year phasedown schedule, (2) Alternatives to IMDs in Vermont, (3) Post-IMD phasedown scenario, and (4) The value of IMDs for Vermont.

I. Five-Year IMD Phasedown Schedule

Vermont has amended its Global Commitment to Health 1115 Demonstration waiver to receive authority to pay for IMD treatment of primary substance use disorders. Therefore, the IMD phasedown of federal funds required by STC 87 of the State's 1115 waiver is limited to the following:

Facility	Type and Target Group(s)	Treatment Focus	# of Beds	SFY18 Gross Expenditure
Lund Home	Residential treatment for pregnant and parenting women with children under 5 years old	Psychiatric/SUD	26	$2,349,849
Brattleboro Retreat: Inpatient Psychiatric Hospital	Inpatient stabilization for adults	Psychiatric, Co-occurring SUD	89	$13,780,260
Vermont Psychiatric Care Hospital	Inpatient stabilization for adults under the care and custody of DMH	Psychiatric, Co-occurring SUD	25	$22,438,553

Per the requirements set forth in STC 87, the State is submitting the following phase-down schedule of Federal Medical Assistance Percentages (FMAP) for IMDs for the treatment of a primary mental health diagnosis:

2021: 95% of FMAP
2022: 90% of FMAP
2023: 85% of FMAP
2024: 80% of FMAP
2025: 75% of FMAP
2026: 0% of FMAP

Vermont understands the need to get to 0% FMAP by 2026. However, it is critical that the State have adequate time to adjust its system of care strategically in preparation for the complete elimination of federal funds. Vermont has spent over a decade building a comprehensive system of care, and the complete elimination of federal funding for these critical mental health services

is a drastic shift away from that effort. The full time allowed to 2026 is necessary to restructure and refinance the system in a way that prevents the most severe impacts to access and quality that would be caused by a loss of federal funding.

Significant administrative, facility, and geographic shifts in the delivery of mental health from the status-quo to a post-IMD model are necessary to avoid the most significant burdens this reduction in funding will place on Medicaid beneficiaries and the system of care. Vermont's phase down schedule considers the extensive amount of time and resources that will be necessary to adequately plan and implement such large-scale change.

II. Vermont Alternatives to IMDs

While efforts are ongoing to increase the strength of our community mental health system, Vermont, consistent with a comprehensive, accessible, and high-quality system of care, requires inpatient psychiatric beds to treat individuals with severe mental health challenges. High levels of wait times in emergency departments across the state reveal that there are not currently enough beds throughout our system of care. Options used in other states must be evaluated for monetary impacts, but also how it would align within the system that exists in Vermont. In planning for the elimination of federal funding to IMDs that primarily treat individuals with severe mental illness, the State is carefully exploring and considering possible treatment alternatives to IMDs or alternative funding mechanisms for existing IMDs. The State's preliminary examination of such alternatives raise serious political, philosophical, and financial issues that will require robust stakeholder engagement and considerable strategic planning by the State, providers, and the legislature to fully explore.

Vermont has evaluated below the following alternatives to its current IMD facilities and/or funding sources: (i) Pursue 1115 mental health IMD opportunity; (ii) Eliminate psychiatric IMDs in Vermont; (iii) Contract with a Risk-Based Medicaid Managed Care Organization.

a. Pursue 1115 Mental Health IMD Opportunity

Vermont intends to pursue an amendment to its Global Commitment to Health 1115 Demonstration waiver to receive authority to pay for short-term residential treatment services in

an IMD for individuals with severe mental illness. Similar to the Substance Use Disorder (SUD) IMD 1115 waiver opportunity, Vermont is already well-poised to take advantage of this change in federal policy.

Vermont is encouraged by the waiver opportunity, but concerns remain that the 30-day length of stay requirement will continue to cause funding challenges for IMDs. Although a 30-day length of stay limitation falls within evidence based best practice for the treatment of substance use disorders, and therefore is a rational guardrail for the SUD IMD 1115 demonstration, no such length of stay best practice exists for mental health treatment. The length of medically necessary inpatient stays appropriately varies based on the clinical complexity of the patient.

b. Eliminate psychiatric IMDs in Vermont

Noting the length-of-stay limitation of the recently announced 1115 mental health IMD waiver opportunity, and absent comprehensive system reform, both the Brattleboro Retreat and the Vermont Psychiatric Care Hospital (operating at current bed levels) would likely remain ineligible to receive federal funding for mental health treatment after the phase-down has been implemented, even if Vermont is granted new mental health IMD 1115 waiver authority.

Additionally, Vermont's Lund Home serves as a national model where pregnant women and parenting mothers can live with their young children while they participate in treatment for SUD and/or mental health issues. Lund Home is unique in that while providing quality, evidence-based mental health and SUD treatment services to pregnant women and new mothers, it also places an emphasis on family support and education. All children in Lund Home are screened and connected to appropriate services, as necessary. Lund's innovative model, which treats pregnant women throughout their pregnancy and allows mothers to continue receiving treatment while remaining with their children, necessarily extends beyond a 30-day stay.

Reducing the bed count at these three facilities from current levels to 16 beds per facility would result in a net loss of 82 acute adult inpatient psychiatric beds and 10 residential co-occuring SUD/mental health treatment beds for some of Medicaid's most vulnerable individuals, including pregnant and parenting women and their young children. Research shows that new

parenthood is apt for intervention, with promising return on investment if appropriate treatment can occur with pregnant and parenting women and their young children. Loss of such treatment capacity would place significant strain on Vermont's entire system of care, including emergency departments, community mental health providers, general inpatient hospitals, and the Department for Children and Families as they continue to deal with devasting results that the escalating opioid and mental health crises are wreaking on children.

Faced with the complete elimination of federal funding to Brattleboro Retreat, the Vermont Psychiatric Care Hospital, and Lund Home, Vermont has explored the following scenarios aimed at preserving bed capacity:

Maintain Psychiatric Bed Capacity through Community Hospitals

As discussed above, there are currently 92 psychiatric beds across Vermont that are supported by federal IMD funding. Despite efforts to increase our community mental health system, Vermont continues to see a strong need for inpatient bed capacity. Therefore, we could expect, given our current identified needs, that approximately 92 new beds would need to be sited across the state to replace the loss of beds from the loss of federal IMD funding. Because of the IMD restrictions, these beds would necessarily have to be dispersed across existing community hospital settings or through the creation of new, free-standing psychiatric facilities of 16 beds or less. The feasibility of maintaining current capacity achieved through the three IMDs discussed above and placing those beds in a mix of community hospitals and/or standalone facilities would be exceedingly difficult given Vermont's small size, extremely limited work force, and the structure of the current mental health delivery system. Vermont's small population and rural nature presents additional delivery system and workforce barriers not present in more populous states.

Of Vermont's 14 community hospitals, four currently have designated psychiatric units and eight are small critical access hospitals (CAHs) of 25 beds or less. The small scale of these CAHs makes psychiatric expansion difficult and if undertaken, expansion in any given facility would be limited to 10 psychiatric beds or less due to federal IMD and CAH policy. Additionally, Vermont has been historically challenged by a shortage of psychiatric professionals (i.e., medical doctors, nurses, psychologists, licensed mental health counselors, and social workers) to staff

programs across the state. This already grave shortage in clinical professionals would only be exacerbated by relocating psychiatric beds from current centralized facilities in relatively populous towns to be diffused across Vermont's 14 community hospitals. Beyond the substantial workforce concerns, spreading existing psychiatric bed capacity across the State would present a myriad of other considerable challenges, including: financing the loss of economies of scale inherent in IMDs, capital construction costs, local zoning limitations, obtaining Certification of Needs, and federal and state regulatory licensing and certification requirements.

Maintain Psychiatric Bed Capacity through Creation of Several 16 Bed Facilities

To maintain federal IMD funding, Vermont's two acute psychiatric inpatient IMDs would need to separate into at least eight independently operated and administered facilities in order to maintain critical bed capacity. Vermont is a small state that is already experiencing recruitment and retention issues for clinical professions, particularly in the field of mental health. Consistent with the challenges presented in the community hospital bed model discussed above, the State's current workforce simply could not support the administrative and clinical redundancies that would be necessary for the effective operation of six additional facilities. Such a dispersion of care dramatically reduces the economy of scale enjoyed by larger facilities, as each small facility would require separate and sufficient executive leadership, medical staff, administrative support, and governance.

Furthermore, tens, if not hundreds, of millions in capital funding would need to be secured in order to develop and build the six new stand-alone inpatient psychiatric facilities necessary to maintain existing capacity achieved through Vermont's current IMDs. Any new facilities would be subject to Vermont's Certificate of Need regulations, a single process that takes approximately 270 days, at the present time. Notably, no money can be spent developing any new health care project until a Certificate of Need is granted. Therefore, even at an aggressive pace, the actual provision of care in any of these facilities is at least four years away. During the time it would take to plan, develop, and build new infrastructure, existing IMD capacity must be maintained so not to diminish Medicaid beneficiaries' access to essential psychiatric services.

Vermont has yet to find any evidence that restructuring the mental health system in this way would provide any benefits of increased access from present state nor improved quality for

Medicaid beneficiaries. This, combined with the obvious inefficiencies and increased cost inherent in a dispersed model, greatly limits the viability of such an alternative.

Merge IMDs with Larger, General Care Hospitals

Transforming Vermont's two inpatient IMDs by merging them with larger acute care facilities (such that the psychiatric beds are less than 50% of total bed capacity—as measured by average daily census) could theoretically allow continued federal financial participation for these necessary services without violating the IMD exclusion. There are several significant challenges with implementing such a solution, many already expressed in detail above.

First, transferring the assets of a state-run hospital (in the case of Vermont Psychiatric Care Hospital) or large non-profits (in the case of the Brattleboro Retreat and Lund Home) requires a robust operational transformation on the part of both the transferring and the receiving entities. Transactions of this magnitude, like the other scenarios explored above, would require a Certificate of Need. There is no guarantee that such certificates would be granted absent compelling arguments anticipating improved quality, of which the State finds no such evidence to support.

Second, and not withstanding any other complications, the average daily censuses for the two hospitals most poised (due to both size and physical proximity) to merge with Vermont's existing hospital IMDs are not high enough to absorb the full psychiatric IMD bed capacity without becoming IMDs themselves. Central Vermont Medical Center, already co-located with the Vermont Psychiatric Care Hospital, estimates it could safely take on 20 psychiatric beds without facing IMD characterization concerns, already reducing level-one inpatient psychiatric treatment capacity by five beds. Although the Brattleboro Retreat has explored several options for partnering with acute care hospitals, only Brattleboro Memorial Hospital presented any viability for merger. Even still, though Brattleboro Memorial has 61 licensed inpatient beds, its average daily census is only 20. These low numbers are adequate to absorb only 10 of the Brattleboro Retreat's 89 existing adult inpatient beds.

Merging IMDs with larger general hospitals would serve to mitigate some of the lost capacity incurred from complete closure of psychiatric IMDs, but it would present the same difficult-to-overcome capital funding, regulatory, and workforce challenges described above. This plan

would destabilize Vermont's mental health system and significantly decrease access to psychiatric care, particularly for Medicaid beneficiaries.

c. Contract with a Risk-Based Medicaid Managed Care Organization

Under current regulation, risk-bearing managed care organizations (MCO) are eligible to receive FFP for stays in IMDs that are less than 15 days in a single month[1]. As with the new 1115 mental health demonstration opportunity, this would not completely address Vermont's full Medicaid funding need for psychiatric IMD stays. While the average length of stay for Vermont Medicaid beneficiaries at the Brattleboro Retreat is less than 15 days, there are a significant number of patients with treatment-refractory disorders that require longer hospital-based interventions, or patients with complicated step-down needs for whom discharge planning is a challenge. Furthermore, the patient mix at the Vermont Psychiatric Care Hospital exclusively consists of acute level-one, involuntary psychiatric inpatient stays, which often necessitates more clinically complex, longer treatment. Additionally, such limited managed care flexibility does nothing to alleviate any of the phase-down pressure for the longer-term treatment targeted to pregnant women and new mothers at Lund Home. It is important to note that long inpatient stays are not a result of poor care. Vermont has a robust, collaborative utilization review and management process carried out by the Medicaid Agency that closely monitors stays in excess of 15 days.

Vermont has operated its Medicaid program through a public managed care-like model, and in adherence to managed care regulations since 2005. CMS has repeatedly asserted that Vermont is not authorized to leverage managed care IMD flexibility described above because its public model is not risk-bearing. The State continues to disagree with CMS on this point, and respectively requests CMS take additional consideration in light of its significant policy shifts on IMDs since the State's 2016 renegotiation of its 1115 demonstration.

Absent reconsideration allowing Vermont to utilize the IMD flexibility codified in managed care regulation, it is unlikely, given its very small size, Medicaid could find a willing partner to enter into a managed agreement for behavioral health. Even still, assuming an MCO was willing to take on Vermont Medicaid's very small market and stringent insurance regulation, transitioning

[1] 42 CFR §438.6(e)

from the current public model to a risk-based MCO would require significant policy, operational, and system changes, and would require large upfront investment of time and funds.

Unless CMS changes its position that the Department of Vermont Health Access (DVHA) can follow the managed care regulations that authorize IMD payments for up to 15 days per month, this is not a realistic solution to Vermont's IMD federal funding issue.

III. Post-IMD Phasedown Scenario

Vermont is a small, rural state. The IMD settings are an integral part of the overall mental health treatment continuum that supports integrated care in the most clinically appropriate, least restrictive setting possible. The most intensive treatment services (inpatient and residential) are provided through a combination of IMD and non-IMD settings.

The loss of IMD funding will negatively impact Vermont's efforts to provide appropriate and timely care in systems already stressed with increased demand for mental health services. As stated above, there is not adequate capacity in the Vermont community hospital system to absorb the number of beds necessary to maintain the capacity currently provided by IMDs.

As a practical matter, the elimination of IMD federal funding required by STC 87 will result in bed closures. Vermont does not have the infrastructure, staff resources, or geographic attributes needed to further decentralize its systems of care. Vermont's mental health and substance use systems of care need to be stabilized and enhanced in order to impact high emergency room utilization for mental health, pervasive opioid use, adverse childhood events and trauma, and suicide rates. Eliminating federal funding to IMDs will do exactly the opposite. Even if Vermont and its private partners could somehow effectively implement *all* of the alternatives outlined above in a responsible time frame and manner, the net result would still be far-reaching negative impacts on access, quality, cost, and outcomes for all Vermonters, but none more than Vermont Medicaid beneficiaries seeking mental health care.

Negative Impact on Robust Inpatient Capacity

As of this report, there are 199 psychiatric adult inpatient beds across Vermont's hospital system. A majority (57%) of these beds are within IMDs. Psychiatric IMDs accept over 50% of all adult psychiatric inpatient admissions in any given year and account for 67% of all adult psychiatric inpatient bed days[2].

Even with federal funding still available, the current psychiatric bed capacity is not adequate to meet the demand. A September 2016 policy brief, compiled by the Treatment Advocacy Center, suggests that the most commonly cited bed target is 40-60 psychiatric beds per every 100,000 residents. Using this range, Vermont's adult inpatient bed target would be between approximately 200 and 300 beds statewide.[3] At the low end of this range, Vermont faces significant challenges in emergency department wait times for inpatient care, and bed occupancy rates are 5-10% above the practice standard of 85%. To further reduce bed capacity would result in substantial reductions in timely access and leave Vermont without a system to adequately serve people in psychiatric crisis.

Negative Impacts of Reduced Bed Capacity on Emergency Room Utilization

- Loss of beds will further exacerbate emergency department wait times statewide.
- Longer wait times delay access to treatment and recovery.
- Long waits in emergency departments with no psychiatrist on call exacerbate patients' conditions.
- Vermont's All Payer Model waiver requires the state to reduce mental health/SUD emergency department visits; Vermont cannot be successful in this measure if psychiatric bed capacity is diminished.

Negative Impacts of Reduced Bed Capacity on Timely Access to Care

- Loss of beds will result in longer wait times for essential treatment.
- Medicaid beneficiaries will be disproportionately affected.

Negative Impacts of Reduced Bed Capacity on Workforce Retention and Recruitment

[2] Vermont Association of Hospitals and Health Systems Mental Health White Paper (2018) draft.
[3] Psychiatric Bed Supply Need Per Capita, The Treatment Advocacy Center, September 2016, retrieved Feb. 28, 2018 http://www.treatmentadvocacycenter.org/evidence-and-research/learn-more-about/3696

- Vermont Psychiatric Care Hospital and Brattleboro Retreat are facilities with skilled staff experienced in working with patients with severe mental health challenges. This staffing infrastructure is heavily jeopardized if staff needs to be dispersed to serve smaller facilities across Vermont.
- Loss in the IMD economy of scale will result in more staff needed to serve smaller, separate facilities (i.e., hospital staff needed to staff eight small facilities is greater than the hospital staff needed to staff two large facilities with the same bed capacity).
- Vermont is already experiencing an extreme shortage of providers for both inpatient care and community-based healthcare. The phase down of IMDs will place further stress on the existing workforce.
- Vermont's aging and shrinking demographics make new workforce recruitment and retention extremely difficult.

Negative Impacts of Reduced Bed Capacity on Core Capacity for Children's Inpatient Care

- An IMD phase down will negatively impact children's services as well as adult services. The Brattleboro Retreat, the only facility in Vermont for children's inpatient needs, will be financially de-stabilized and will struggle to maintain core service capacity.

IV. The Value of IMDs for Vermont

IMDs are an essential and high-quality component of Vermont's psychiatric system of care. Evidence of lower emergency department utilization post discharge, low readmission rates, and high rates for follow-up post placement, including initiation and engagement in SUD treatment post discharge, suggest that the IMD programs are successful in linking Medicaid beneficiaries to essential care as they transition out of the IMD setting.[4] Evidence also supports Vermont's hypothesis that elimination of IMDs would have significant impacts to the system of care. The following outlines findings from Vermont's Global Commitment 1115 Demonstration Interim Evaluation Report:

IMD Services Result in Improved Quality of Care and Community Integration

[4] Page 79 of Global Commitment 1115 Demonstration Interim Evaluation Report 4/2/2018: http://dvha.vermont.gov/administration/vt-gc-1115-demo-interim-eval-report-final-apr2-18.pdf

Vermont's psychiatric system of care employs nationally recognized placement and concurrent review criteria for inpatient treatment. Data suggests that Vermont's current psychiatric care system is of high quality and relies on both small scale IMD settings to stabilize and treat persons in acute psychiatric crisis and an extensive community-based system for mental health care that includes mobile crisis supports, integrated physical health care, and community based psychiatric placement.

High Quality Discharge Planning

Vermont IMD settings are providing high quality targeted treatment services as evidenced by lower emergency department utilization post discharge, low readmission rates, and high rates for follow-up in the community post-placement, including initiation and engagement in SUD treatment post-discharge. Results for IMD settings on HEDIS® measures for seven and 30-day follow-up after hospitalization for mental illness outperformed the general Vermont Medicaid results and the national HEDIS® benchmark. Results indicate that IMD settings are achieving high quality discharge planning and making effective linkages to community-based settings.

Quality of discharge planning in making effective linkages to community-based care	*HEDIS® 50th Percentile*	*VT Medicaid*	*VT IMD*
Percent of enrollees with follow-up after hospitalization for mental illness 7-days (HEDIS® FUH)	45.00%	57.00%	65.00%
Percent of enrollees with follow-up after hospitalization for mental illness 30-days HEDIS® FUH)	66.00%	74.00%	85.00%
Percent of SUD IMD enrollees who initiate treatment for alcohol and other drug dependence (HEDIS® IET)	38.00%	43.00%	74.00%
Percent of SUD IMD enrollees who engage in treatment for alcohol and other drug dependence (HEDIS® IET)	11.00%	17.00%	23.00%

High Quality of Care for Comorbid Physical Health Conditions

Vermont IMDs also performed well on measures of quality of care for comorbid physical health conditions. Vermont outperformed rates published in the NCQA report card for Medicaid programs for diabetes screenings for persons with co-morbid psychiatric conditions and who use antipsychotic medications, with 89% of Vermont recipients screened in 2016. Psychiatric cohorts averaged 52% of persons who had a primary care visit within 30-days of discharge across the four-year study period. Vermont's 1115 Demonstration has been actively supporting the integration of physical and behavioral health care since its inception in 2005. Vermont Medicaid

has supported active partnerships between Federally Qualified Health Centers (FQHCs), local primary care practices, and designated mental health providers to ensure collaboration and integration in care planning and service delivery.

Lower Readmission Rates

Length of stay was important when readmissions to the same setting type were examined. In all settings, readmission rates were lower for lengths of stay between 16 – 29 days and dropped to near zero for lengths of stay over 29 days. These results suggest that psychiatric stabilization often warrant stays over 15 and even 30 days and should be considered related to the federal policy that allows MCOs to receive payments for IMD stays of 15 days or less and the recent demonstration opportunity allowing statewide average stays of 30 days or less.

Findings also suggest the IMD authority appears to be integral to the overall system of care by supporting community integration and high treatment initiation and engagement rates for recipients. In the psychiatric IMD cohort, readmission rates were low for both the 30 and 180 days, with a four-year average of 8% for the 30-day measure and 17% for the 180-day measure. The four-year average for psychiatric general hospital setting showed 9% and 20%.

Emergency Room Utilization

Emergency room utilization showed the greatest reductions in visits post discharge in IMD settings for psychiatric cohorts, with IMD psychiatric settings seeing declines that ranged from 23% to 44% across the study years. These results support the State's assertion that the elimination of inpatient treatment in the IMD settings will increase emergency room utilization.

V. Conclusion

Federal and state priorities for treating mental health and substance use disorder have evolved dramatically since 2016. Rather than supporting those priorities, STC 87's requirement to completely phase down IMD expenditures will have catastrophic effects on one of Vermont's most vulnerable populations of Medicaid beneficiaries. The phase-down plan proposed herein allows Vermont the time necessary to evaluate and carefully prepare for the elimination of IMD

funding as contemplated by STC 87. It will also provide Vermont more time to study and continue to implement the most effective care-delivery models to serve these populations.