DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

June 28, 2022

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

Dear Secretary Samuelson:

The Centers for Medicare & Medicaid Services (CMS) is approving Vermont's request to extend the demonstration project entitled, "Global Commitment to Health" (GCH) (Project Number 11-W-00194/1), in accordance with section 1115(a) of the Social Security Act (the Act). Approval of the GCH extension request will enable the state to continue to test, monitor, and evaluate a managed care-like delivery system, home and community-based services (HCBS), and pilot programs, as well as pursue innovations within the Medicaid program to maintain high quality services and programs that are cost-effective. Approval of the extension request allows the state to modify existing demonstration programs as well as add additional programs to the longstanding demonstration. This approval is effective July 1, 2022 through December 31, 2027, upon which date, unless extended or otherwise amended, all authorities granted to operate this demonstration will expire.

The GCH demonstration extension advances several key priorities of the Biden-Harris Administration by leveraging Medicaid as a tool to help address the complex challenges facing Vermont's most vulnerable residents, such as behavioral health care access, prescription drug costs, and the health needs of individuals receiving HCBS. In this demonstration, Vermont is introducing new initiatives and investments to assist the state in improving health coverage, access, and equity for Medicaid beneficiaries and other low-income individuals in the state.

Over the past several years, Vermont has had higher rates of substance use disorders (SUDs) and illicit drug use disorders than the national average[1,2] and the state has been implementing initiatives to increase access to treatment services and improve health outcomes. Through this demonstration extension, Vermont will continue and expand efforts to provide community-based interventions and inpatient treatment services for individuals with a SUD or serious mental illness (SMI). New efforts in this extension include the creation of a new SUD Community

[1] "State Level Data National Survey on Drug Use and Health 2017-2018." Vermont Department of Health, December 2019. https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP-NSDUH-Summary-2017-2018.pdf.
[2] Vermont's 2018 GCH demonstration amendment application.

Intervention and Treatment (CIT) eligibility group that will provide benefits, such as service coordination, counseling, and residential treatment, for low and moderate-income Vermonters with a SUD. Vermont is also establishing a Maternal Health and Treatment Services initiative that provides a whole-person and family-centered care model for treating pregnant women and mothers with SUD and/or a mental health condition at the Lund Home facility. The Lund Home provides mental health and SUD treatment to pregnant women, postpartum women, and mothers with children up to age five in a setting that allows the family to stay and be treated together.

Vermont is continuing and expanding benefits for the VPharm premium assistance program authorized in the GCH demonstration. The VPharm program helps individuals enrolled in Medicare Part D, including those over 65 and those with disabilities, pay their monthly Part D premiums and lower the co-pays for many of their prescriptions. Currently, Vermont provides the same prescription coverage as under the Medicaid State Plan to eligible individuals with incomes up to 150 percent of the Federal Poverty Level (FPL), and maintenance drug-only coverage for eligible individuals with incomes between 150 percent and 225 percent FPL. In this demonstration extension, Vermont is extending state plan-equivalent prescription coverage to VPharm-eligible individuals at all income levels up to 225 percent FPL. This program supports the objectives of Medicaid by expanding premium assistance and access to affordable healthcare for low-income individuals.

Vermont is also maintaining and strengthening existing programs offering HCBS. For instance, Vermont is continuing the Developmental Disabilities Services program and adding an enhanced dental benefit in excess of the limitations set forth in the state plan, because individuals enrolled in the program may have more significant dental needs than other Medicaid enrollees (e.g., needing sedation for regular dental services).

Notable new programs include the Supportive Housing Assistance Pilot program, which will provide individuals with services to successfully transition into and maintain residency in close coordination and collaboration with agencies that provide rental assistance. Eligible individuals will have access to pre-tenancy supports, tenancy sustaining services, and community transition services for enrollees moving to supportive housing from any setting. Furthermore, Vermont is creating a new incentive-based program, titled Medicaid Data Aggregation and Access Program (MDAAP), that will provide health information technology (HIT) infrastructure support to Medicaid providers in order to increase HIT use and connectivity to the state's health information exchange. Eligible providers include mental health providers, SUD treatment providers, and long-term services and supports (LTSS) providers who meet the Medicaid patient volume criteria in the STCs.

CMS is also taking steps in this demonstration extension to reinforce and ensure the authorized programs offering HCBS comply with HCBS rules and regulations. Following a review of information and stakeholder feedback, CMS determined the state's five HCBS programs do not separate case management from the direct service providers; therefore, the state is out of compliance with 42 CFR section 441.730(b). CMS directed Vermont to submit a corrective action plan (CAP) that outlines the state's process to reach full compliance with conflict of interest regulations. On December 17, 2021, Vermont submitted the plan for CMS review, and

CMS and Vermont are working together to finalize the plan. Once approved, the CAP will be appended to the STCs as Attachment Q.

In Vermont's demonstration extension application, the state requested to transition the Department of Vermont Health Access (DVHA) from a non-risk prepaid inpatient health plan (PIHP) to a full-risk bearing MCO subject to the Medicaid managed care requirements under 42 CFR 438. CMS is not approving this request, and instead, the state will maintain the current managed care-like model that was approved in the 2016 demonstration extension. The Agency for Human Services (AHS) will continue the interagency agreement with the DVHA to deliver services through a managed care-like model, subject to the requirements that would be applicable to a non-risk PIHP. As a part of the state's unique model, Vermont has authority to pay for services and fund programs, referred to as investments, that improve public health, reduce the rate of uninsured and/or underinsured, increase access to care, and support the health care delivery system. In this extension, Vermont will maintain this authority but with a new investment framework and updated investment goals that include investments in social determinants of health, HCBS, and supports to increase community living for individuals at risk of needing facility-based care.

CMS is authorizing Vermont's request to extend a COVID-19 public health emergency (PHE) flexibility for Children's Personal Care Services that permits the state to reimburse legally responsible individuals, which could be inclusive of legally responsible family caregivers, for personal care services following a reasonable assessment by the state that the caregiver is capable of rendering the service. This flexibility will be active at the conclusion of the COVID-19 PHE and after Vermont notifies CMS of its readiness to effectuate the flexibility.

Components of the Proposal Still Under Review

CMS and Vermont are continuing discussions regarding the state's pending requests, which are key components of the state's strategy to improve equitable access and outcomes for individuals enrolled in Medicaid: services and supports for justice-involved adults to stabilize health pre-release, ensure continuity of coverage through Medicaid pre-release enrollment strategies, increase mental health services for inmates, and support re-entry into the community. CMS is supportive of increasing prerelease services for justice involved populations and we will work with the state on its prerelease initiatives in the coming year. CMS is also continuing to review the state's request pertaining to in-lieu of services that would be authorized under the state's managed care plan-like framework.

Monitoring and Evaluation

Vermont conducted and submitted to CMS an Interim Evaluation Report that covered calendar years 2016 to 2019 of the Global Commitment to Health demonstration.[3] This evaluation report found that the demonstration was associated with an overall improvement in beneficiaries' access to care. Specifically, there was an increase in access to ambulatory and preventive care visits, well-child visits, and dental care during the evaluation period. In addition, while there were mixed findings on a range of quality of care outcome measures, the report found that the demonstration improved initiation and engagement in SUD treatment, and improved self-

[3] The Pacific Health Policy Group. State of Vermont: Global Commitment to Health Section 1115 Medicaid Demonstration 11-W-00194/1. December 21, 2020. Draft Interim Evaluation Report submitted for CMS review.

reported health status for enrollees with LTSS needs. The report also showed that the ACO model improved diabetes and hypertension control, increased engagement of eligible beneficiaries over time, and improved access to mental health care and SUD treatment. Furthermore, the demonstration reduced overall Medicaid spending and total per capita risk-adjusted expenditures for enrollees who were between 1 and 64 years old.

Consistent with CMS requirements for section 1115 demonstrations, and as outlined in the demonstration extension special terms and conditions (STCs), the state is required to conduct systematic monitoring of the various demonstration components, per applicable CMS guidance and technical assistance. Such monitoring will support tracking the state's progress with the demonstration components towards their corresponding milestones and/or goals. Furthermore, in alignment with CMS guidance and STC requirements, Vermont will develop a rigorous Evaluation Design using robust data sources and analytic approaches that will support a comprehensive evaluation of the demonstration to assess whether the demonstration initiatives are effective in producing the desired outcomes for its beneficiaries and providers, as well as for the state's overall Medicaid program. The evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact on beneficiary coverage, access to and quality of care, and health outcomes, as well as its effectiveness in achieving the policy goals and objectives. For example, the evaluation must assess the likelihood of enrollment and enrollment continuity and beneficiary financial status in the context of the waiver of retroactive eligibility. Likewise, as another example, the evaluation of the SUD demonstration component should assess initiation and compliance with treatment, utilization of health services in appropriate care settings, and reductions in key outcomes, such as deaths due to overdose. CMS underscores the importance of the state undertaking a well-designed beneficiary survey to assess, for instance, beneficiary understanding of the various demonstration policy components, including the waiver of retroactive eligibility, beneficiary experiences with access to and quality of care, as well as the incidence and extent of beneficiary medical debt. The state must also investigate cost outcomes for the demonstration as a whole, including but not limited to, uncompensated care costs. In addition, the state must revisit and revise the Evaluation Design, if necessary, each time a new investment is approved by CMS to ensure the state is evaluating the effectiveness of each investment opportunity.

The state's monitoring and evaluation should accommodate data collection and analyses stratified by key subpopulations of interest to inform a fuller understanding of existing disparities in access and health outcomes, and how the demonstration's various policies might support bridging any such inequities.

Consideration of Public Comments

To increase the transparency of demonstration projects, section 1115(d)(1) and (2) of the Act direct the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 demonstration that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application, and the second comment period occurs at the federal level after the application is received by the Secretary.

Section 1115(d)(2)(A) and (C) of the Act further specify that comment periods should be "sufficient to ensure a meaningful level of public input," but the statute imposed no additional requirement on the states or the Secretary to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline, but will not necessarily provide written responses to all public comments (42 CFR 431.416(d)(2)). The federal comment period opened on July 9, 2021, and closed on August 8, 2021. There were five public comments received during the federal comment period; however, two of these comments did not contain any feedback or information about the commenter, therefore they were not considered. One commenter supported Vermont's proposed supportive housing pilot and recommended it for approval. One commenter supported the demonstration, in particular the innovative care models such as family-focused residential mental health and SUD treatment.

One commenter raised several concerns with some of the state's extension proposals and did not recommend approval. The commenter opposed the IMD provisions of the demonstration for various reasons, including that the IMD exclusion cannot be waived. CMS is approving the expenditures associated with SMI IMD section 1115(a)(2) of the Act. Section 1115(a)(2) of the Act grants the Secretary the authority, in the context of a demonstration project under section 1115(a), to provide federal matching of state expenditures that would not otherwise be federally matchable under the terms of section 1903. Specifically, with respect to state expenditures under a section 1115 "demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of [Medicaid]," expenditures that would "not otherwise" be matchable under section 1903 may "be regarded as expenditures under the State plan or plans approved under such title, or for administration of such State plan or plans . . . as may be appropriate." This "expenditure authority" has been exercised by the Secretary for decades to conduct demonstration projects that provide coverage for individuals or services that could not otherwise be covered under a State's Medicaid State plan. This has allowed the Secretary to expand eligibility for benefits to individuals who would not otherwise be eligible, and for services that would not otherwise be covered. This interpretation has been upheld in court as a valid exercise of the Secretary's demonstration authority under section 1115. For example, federal courts have upheld demonstration projects that covered individuals under section 1115(a)(2) who would not otherwise be eligible for coverage. Spry v. Thompson, 487 F.3d 1272 (9th Cir. 2007); Wood v. Betlach, No. CV-12-08098, 2013 WL 3871414 (D. Ariz. July 26, 2013).

Additionally, the commenter shared concerns that it does not view receiving FFP as a valid experiment. CMS has determined that Vermont's request serves a research and demonstration purpose as outlined in the SMDL #18-011. As noted above, testing the benefits of covering individuals and services that could not otherwise be covered promotes the coverage objective of Medicaid, and helps states and CMS gather information to inform any potential future legislation CMS believes that this authority will yield useful data as this demonstration includes robust monitoring and evaluation requirements.

The commenter said that, "Should CMS grant this extension, it should at least reject Vermont's request to modify the STCs to permit FFP for IMD stays over 60 days." CMS agrees and has not included this in the state's extension.

The commenter also raises concerns with Vermont's request to continue its waiver to impose premiums per month on children under 18 with household incomes above 195% FPL, because section 1115 authority cannot be used to allow Vermont to charge premiums; premiums are not experimental and conflict with Medicaid objectives.

CMS has determined states can be authorized to set premiums for optional populations, including those at a higher household income (e.g., above 195% FPL). Therefore, Vermont is permitted to continue setting premiums for these optional populations.

Finally, the commenter states there is nothing experimental about Vermont's proposal to extend its waiver for eliminating retroactive coverage because states have been permitted to waive it since at least the 1990s. The commenter also argued that waiving retroactive coverage doesn't promote Medicaid objectives and evidence suggests it reduces access to coverage and care among low income individuals, leaving them with unmet needs and/or medical debt. They note that this could cause significant hardship for individuals and Vermont doesn't justify its request and why it's experimental in its extension application.

We appreciate the concerns raised regarding waiving retroactive eligibility and CMS is examining this further, with plans to share additional guidance regarding its limitations. The three populations that Vermont has a waiver of retroactive eligibility for (CFC Moderate Needs, VPharm, and VPharm Expansion) are optional demonstration populations that do not receive full Medicaid benefits, and Vermont can continue to apply this waiver.

After carefully reviewing the public comments submitted during the federal comment period and information received from the state public comment period, CMS has concluded that the demonstration is likely to assist in promoting the objectives of Medicaid.

Other Information

CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached waiver and expenditure authorities, STCs, and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from Medicaid state plan requirements only to the extent those requirements have been specifically listed as waived or not applicable under the demonstration.

The award is subject to CMS receiving written acceptance of this award within 30 days of the date of this approval letter. Your project officer is Ms. Rabia Khan. Ms. Khan is available to answer any questions concerning implementation of the state's section 1115(a) demonstration and her contact information is as follows:

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We appreciate your state's commitment to improving the health of people in Vermont, and we look forward to our continued partnership on the GCH section 1115(a) demonstration. If you have any questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

Daniel Tsai
Deputy Administrator and Director

Enclosure

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