CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

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

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

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

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

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

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

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

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

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

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

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

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

f. **Demonstration Population 9: Substance Use Disorder (SUD) Community Intervention and Treatment Group.** Individuals with a diagnosis of a substance use disorder (SUD) with income above 133 percent of the FPL up to and including 225 percent of the FPL. Individuals in this population are not eligible for full State Plan benefits.

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

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

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

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

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

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

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

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

8. **HCBW-like Services for State Plan Eligibles Who Meet Highest Need, High Need or Moderate Needs Clinical Criteria for Choices for Care (CFC).** Expenditures for HCBW-like services for State Plan eligibles who meet all State Plan eligibility requirements, who have the indicated level of clinical need for HCBW-like services. The Moderate Needs Group do not meet all the Choices for Care (CFC) clinical criteria for long-term services, but are at risk of institutionalization. These individuals demonstrate a clinical need that shows they would benefit from a subset of HCBW-like services.

9. **Other Choices for Care HCBW-like and Special Program Expenditures.**

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

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

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

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

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

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

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

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

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

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

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

14. **Supportive Housing Assistance Pilot**

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

    b. Expenditures for community transition services for enrollees in the state's Supportive Housing Assistance Pilot program who are moving to supportive housing from non-institutional, non-provider-operated living arrangements.

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

16. **Children's Personal Care Services (CPCS).** Expenditures for personal care services, as authorized and described under the Medicaid State Plan, provided by legally responsible individuals (which could be inclusive of legally responsible family caregivers) following a

reasonable assessment by the state that the caregiver is capable of rendering the services. At the conclusion of the COVID-19 PHE, the state will notify CMS of its readiness to effectuate this flexibility and this authority will be active as of the date of the notice. Providers of CPCS, including legally responsible relatives, must meet all existing requirements as described under the Medicaid State Plan, including EVV requirements.

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

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

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

19. Retroactive Eligibility — Section 1902(a)(34)

To enable the state to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance is made for expansion groups.

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

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

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

21. Freedom of Choice — Section 1902(a)(23)(A)

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

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

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

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

1. PREFACE

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

The STCs have been arranged into the following subject areas:

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

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

Attachment A. Preparing the Evaluation Design

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

2. PROGRAM DESCRIPTION AND OBJECTIVES

The demonstration was initiated in September 2005, and is designed to use a multi-disciplinary approach including the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, and program flexibility. Since 2005, the demonstration has helped reduce Vermont's uninsured rate from 11.4 percent in 2005 to approximately 3.1 percent in 2021 through expansion of eligibility. The demonstration has also enabled Vermont to address and eliminate the bias toward institutional care and offer cost-effective, community-based services. For example, the proportion of Choices for Care participants served in the community has passed fifty percent and continues to increase. In addition, Vermont no longer has a waiting list for individuals in the Highest and High Needs Groups under the Choices for Care component of the demonstration.

As of July 1, 2022, Vermont extended the demonstration to further promote delivery system and

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

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

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

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

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

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

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

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

The initial Global Commitment to Health and Choices for Care demonstrations were approved in September of 2005, effective October 1, 2005. The Global Commitment to Health demonstration was extended for 3 years, effective January 1, 2011, and again for 3 years, effective October 2, 2013. The Choices for Care demonstration was extended for 5 years, effective October 1, 2010, and became part of the Global Commitment to Health demonstration in January 2015. The Global Commitment to Health demonstration was extended for another 5 years effective January 1, 2017. The following amendments have been made to the Global Commitment to Health demonstration:

- 2007: A component of the Catamount Health program was added, enabling the state to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the FPL, and who did not have access to cost-effective employer-sponsored insurance, as determined by the state.
- 2009: The state extended Catamount Health coverage to Vermonters at or below 300 percent of the FPL.
- 2011: The state included a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life-limiting illness that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.
- 2012: CMS provided authority for the state to eliminate the $75 inpatient admission co-pay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid State Plan.
- 2013: CMS approved the extension of the Global Commitment to Health demonstration which included sun-setting the authorities for most of the Expansion Populations, including Catamount Health coverage, because these populations would be eligible for Marketplace coverage beginning January 1, 2014. The extension also added the Adult Group under the State Plan to the population affected by the demonstration effective January 1, 2014. Finally, the extension also included premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL.
- 2015: In January 2015, the Global Commitment to Health demonstration was amended to include authority for the former Choices for Care demonstration. In addition, the state received section 1115 authority to provide full Medicaid State Plan benefits to pregnant women who are determined presumptively eligible.
- 2017: In January 2017, CMS approved the extension of the Global Commitment to Health demonstration to further promote delivery system and payment reform to meet the goals of the state working with the Center for Medicaid and CHIP Services and the Center for Medicare and Medicaid Innovation (CMMI), consistent with Medicare's payment reform efforts in order to allow for alignment across public payers.
- 2018: CMS approved an amendment to permit the state to receive federal financial participation (FFP) for the continuum of services to treat addictions to opioids and other substances, including services provided to Medicaid enrollees with a substance use disorder (SUD) who are short-term residents in residential and inpatient treatment facilities that meet the definition of an Institution for Mental Diseases (IMD).
- 2019: CMS approved an amendment to enable Vermont to receive FFP for inpatient services provided to otherwise-eligible Medicaid beneficiaries while residing in IMDs for diagnoses of serious mental illness (SMI) and/or serious emotional disturbance (SED).
- 2020: The Global Commitment to Health demonstration was amended May 22, 2020 to add an Emergency Preparedness and Response Attachment R (now Attachment K) in order to respond to the COVID-19 pandemic. Additionally, the demonstration was amended December 3, 2020 to modify the requirement, at 42 CFR 438.406(b)(4), to allow beneficiaries to provide evidence and testimony "in person" to appeal an adverse benefit determination during the COVID-19 public health emergency. The STCs were amended to grant flexibility during public health emergencies where the Department of Vermont Health

Access (DVHA) must provide enrollees reasonable opportunity, in writing, telephonically, and video or virtual communication, to present evidence and testimony and make legal factual arguments.

3. GENERAL PROGRAM REQUIREMENTS

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

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

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

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

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the State may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

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

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

3.6. **Changes Subject to the Amendment Process.** Demonstration changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration except as referenced in STCs 13.16 and 13.17 below. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS through an approved amendment to the Medicaid State Plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STCs 3.3, 13.16, and 13.17.

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

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

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

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

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

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

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

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

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

c. **Transition and Phase-out Plan Approval.** The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. **Transition and Phase-out Procedures.** The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for

Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

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

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

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

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

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

3.12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties**. The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the

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

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

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

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

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

requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

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

4. ELIGIBILITY, BENEFITS, AND ENROLLMENT

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

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

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

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

c. **Choices for Care Program Eligibility.** State Plan-eligible individuals who receive long-term services and supports under the Choices for Care program must meet State Plan financial rules, with the exception of waivers granted through this demonstration, and clinical eligibility criteria as defined by Vermont statutes, regulations, and policies and procedures. See Attachments C and D for a summary of eligibility definitions for the highest, high, and moderate needs groups, services, and policies. Non-State Plan eligible Choices for Care individuals are included in Populations 4, 5, and 6 in the tables below.

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

non-MAGI based methodologies, as appropriate, used to determine financial eligibility for expansion populations.

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

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

Demonstration Expansion Populations		
Population Number & Name	**Population Description**	**Benefits**
Population 4 CFC Highest Needs Group	Individuals age 65 and older and age 18 and older with disabilities, not otherwise eligible under the State Plan, who meet the clinical criteria for the highest need group for CFC, and who would have been Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR §435.217, in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under the demonstration would have been provided under an HCBS waiver granted to the state under section 1915(c) of the Act prior to 2014. This includes the application of the post eligibility rules specified at 42 CFR §435.726, and of the spousal impoverishment rules specified at 1924 of the Act. This demonstration allows for a resource standard of $10,000 for an unmarried individual who resides in and has an ownership interest in their principal place of residence.	Benefits as described in the Medicaid State Plan and HCBS benefits described in these STCs.
Population 5 CFC High Needs Group	Individuals age 65 and older and age 18 and older with disabilities, not otherwise eligible under the State Plan, who meet the clinical criteria for the high need group for CFC, and who would have been Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR §435.217, in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under the demonstration would have been provided under an HCBS waiver granted to the state under section 1915(c) of the Act prior to 2014. This includes the application of the post eligibility rules specified at 42 CFR 435.726, and of the spousal impoverishment rules specified at 1924 of the Act. This demonstration allows for a resource standard of $10,000 for an unmarried individual who resides in and has an ownership interest in their principal place of residence.	Benefits as described in the Medicaid State Plan and HCBS benefits described in these STCs.

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

Demonstration Expansion Populations		
Population Number & Name	**Population Description**	**Benefits**
Population 9 SUD Community Intervention and Treatment Group	Individuals with a diagnosis of a substance use disorder (SUD) with income above 133 percent of the FPL up to and including 225 percent of the FPL. The entry into SUD CIT is less stringent than inpatient hospital level of care. Vermont uses the American Society of Addiction Medicine (ASAM) criteria to determine medically appropriate intensity of services and level of need to best meet the needs for individuals with SUD. Individuals must have a substance use need, where an assessment using the ASAM criteria indicates that the individual meets at least ASAM 1.0.	Benefits as described in the Medicaid State Plan and as described in STC 4.4(d).

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

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

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

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

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

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

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

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

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

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

d. **SUD Community Intervention and Treatment (CIT).** SUD CIT services are provided to individuals with a diagnosis of SUD with income above 133 percent of the FPL up to and including 225 percent of the FPL. Individuals in this population are not eligible for full State Plan benefits. The clinical eligibility criteria for this program are listed in Attachment U.

i. **Benefits.** Individuals will have access to the following SUD treatment services covered under the Medicaid State Plan: case management, recovery supports, psychoeducation, peer supports (upon approval of a State Plan

amendment and promulgation of necessary Vermont administrative rules), residential treatment, withdrawal management, counseling, and skilled therapy services.

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

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

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

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

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

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

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

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

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

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

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

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

f. **Supportive Housing Assistance Pilot.** The Supportive Housing Assistance Pilot is for Medicaid enrollees age 18 and older eligible for full Medicaid State Plan benefits who meet the health needs-based and risk-based criteria defined by the state in Attachment I. This pilot will provide eligible individuals with access to pre-tenancy supports, tenancy sustaining services, and community transition services for enrollees moving to supportive housing that are in full alignment with services under 1915(c) and 1915(i) authorities, with the exception of community transition services, which may be provided to individuals moving to supportive housing from non-institutional, non-provider-operated living arrangements. Benefits are further described in Attachment I. The expenditure authority limit for the Community Transition Services authority is shown in the table below.

Community Transition Services Expenditure Authority Limits						
	DY18	**DY19**	**DY20**	**DY21**	**DY22**	**DY23**
Annual PMPM Amount	N/A	N/A	$2,828.00	$2,963.74	$3,106.00	$3,255.09

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

5. COST SHARING

5.1. Premiums and Cost Sharing.

a. **Populations 1, 2, and 3.**

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

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

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

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

6. DELIVERY SYSTEMS

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

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

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

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

participation, rather the PMPM capitation rates and corresponding rate certification shall be used to determine that:

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

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

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

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

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

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

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

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

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

b. Be developed for 12-month periods;

c. Not include any administrative services and costs that are required to be incurred by AHS as the Single State Agency under federal law, regulation, or these STCs. Such administrative services and costs that cannot be part of the capitation rate include: eligibility determinations, Single State Agency Central Office and External Quality Review Organization (EQRO), administration of a State Fair Hearing system, the

Beneficiary Support System in 42 CFR 438.71 and STC 6.10, and the provider screening and enrollment process under 42 CFR 438.602(b);

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

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

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

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

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

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

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

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

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

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

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

6.7. **Limitation of Freedom of Choice.** Freedom of choice is limited to the DVHA network of providers. However, populations must have freedom of choice when selecting enrolled providers within that network (when applicable, the provider must be enrolled in the specific specialty or subprogram applicable to the services at issue). Specifically, demonstration participants enrolled in a special service program such as, but not limited

to, specialized substance use and mental health services, a special program as defined in STC 4.4(c), or the CIT program may only have access to the providers enrolled under that program, and will not have access to every Medicaid-enrolled provider for services under that program. Such participants will have freedom of choice of providers enrolled in the special service program in the appropriate geographic area. No restriction on freedom of choice of family planning provider may be imposed.

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

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

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

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

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

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

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

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

direct access to the information systems that maintain such data, documentation and information.

6.13. **Data Sharing.** DVHA acting as a non-risk PIHP under a managed care-like model shall comply with all privacy and confidentiality requirements on PIHPs in 42 CFR 438. Nothing in this STC prohibits AHS from delegating data and information rights and responsibilities to DVHA consistent with federal law, including section 1902(a)(7) of the Act and 42 CFR 431.306(d). To the extent that DVHA has access to data and information under delegation from AHS that may not otherwise be shared with a non-risk PIHP, AHS must establish administrative, managerial and, technical controls to prevent sharing the data with divisions of DVHA responsible for the managed care-like model acting as a non-risk PIHP.

6.14. **State Quality Strategy.** The state must meet the managed care quality strategy requirements at 42 CFR 438.340 and adopt and implement a comprehensive, dynamic, and holistic continuous quality improvement strategy that integrates all aspects of quality improvement programs, processes, and requirements across the state's Medicaid program. This quality strategy must address quality improvement for all components of the state's Medicaid State Plan and its section 1115 demonstration.

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

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

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

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

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

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

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

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

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

ix. Beginning with the DY 19 annual monitoring report, the state must report the deficiencies found during the monitoring and evaluation of the HCBS demonstration assurances and measures, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect,

exploitation and/or death, the actions taken regarding the incidents and how they were resolved. The DY19 annual report must also include this information for the months in DY 18 after which CMS has approved the performance measures.

7. LONG-TERM SERVICES AND SUPPORTS PROTECTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.6. **HCBS Electronic Visit Verification System.** The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care

services (PCS) by January 1, 2021 and home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act, unless the state has received a good faith effort exemption for up to one year from CMS.

7.7. **Conflict of Interest Protections.** Regulations at 42 CFR 441.301(c)(1)(vi) require that providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.

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

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

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

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

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

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

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

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

    ii. Describe safeguards that mitigate and address the potential problems that may arise, with the service providers' influence on the person-centered planning process (exercising free choice of providers, controlling the content of the

plan, including assessment of risk, services, frequency and duration, and informing the participant of their rights) including:

1. Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of HCBS, not just the services furnished by the entity that is responsible for the person-centered service plan development;
2. An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;
3. Direct oversight of the process or periodic evaluation by a state agency;
4. Restricting the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
5. Requiring the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

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

8. OTHER PROGRAMS

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

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

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

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

ii. The number of individuals served by the program;

iii. The size of the subsidies; and

iv. A comparison of projected costs with actual costs.

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

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

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

i. Individual, group, family therapy

ii. Medication assisted treatment

iii. Health screening, education, monitoring and referral

iv. Case management

v. NEMT

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

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

family-centered model contributes to achieving the goals of improved retention in treatment, lower child custody rates, and improved psychosocial outcomes for the family.

d. **Unallowable Expenditures.** Under no circumstances may the state receive FFP under expenditure authority approved for the Lund Home (or its successor) for room and board costs. Treatment for children receiving care within the Lund Home (or its successor) is not authorized by this STC and its associated expenditure authority. Instead, service expenditures associated with children receiving care within the Lund Home (or its successor) are authorized to the extent allowable under statute, the State Plan, and associated regulations.

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

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

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

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

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

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

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

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

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

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

9.2. **SUD Implementation Plan.** The state's SUD Implementation Plan, initially approved for the period from July 1, 2018 through December 31, 2021, remains in effect for the approval period from July 1, 2022 through December 31, 2027, and is affixed to the STCs as Attachment J. Any future modifications to the approved Implementation Plan will require CMS approval. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral. The approved SUD Implementation Plan describes the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of this SUD demonstration project:

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

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

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

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

e. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards

based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.6. **SUD Health Information Technology (Health IT).** The state will provide CMS with an assurance that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, and individual provider) to achieve the goals of the demonstration—or it will submit to CMS a plan to develop the infrastructure/capabilities.

This "SUD Health IT Plan," or assurance is included as a section of the state's approved "Implementation Plan" (see STC 9.2), which remains in effect for the approval period from July 1, 2022 through December 31, 2027, and is affixed to the STCs as Attachment J. The SUD Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of SUD health IT ecosystem improvement.

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

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

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

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

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

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

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

[2] *Ibid*.

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

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

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

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

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

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

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

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

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

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

9.7. **Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones.** Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plan and the required

performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

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

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

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

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

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

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

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

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

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

        1. Participating hospitals must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and be either: a) certified by the state agency as being in compliance with those conditions through a state agency survey, or b) deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.

        2. Participating residential treatment providers must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.

        3. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating psychiatric hospitals and residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;

        4. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

h. Components of the Health IT Plan include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Elements of the mid-point assessment include:

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

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

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

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

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

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

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

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

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

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

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

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

11. USE OF DEMONSTRATION FUNDS

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

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

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

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

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

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

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

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

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

iv. Non-emergency health-related transportation.

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

vi. Parenting support programs.

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

viii. Alternative pain management treatments.

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

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

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

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

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

iv. Self-management and tobacco cessation initiatives.

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

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

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

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

ix. Contingency management.

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

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

xii. Lead and other environmental health remediation.

xiii. Water fluoridization.

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

xv. Screening for unmet social needs.

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

xvii. Weatherization activities that promote health and safety.

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

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

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

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

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

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

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

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

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

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

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

iii. Programs that support family caregivers.

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

v. Mobile Response Program for mental health crisis care.

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

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

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

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

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

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

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

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

b. Room and board;

c. Animal shelters and vaccines;

d. Provider or beneficiary debt relief and restructuring;

e. Sheltered workshops;

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

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

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

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

j. Facility closures;

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

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

m. Unspecified projects.

11.6. **New Investment Notification.** The state must notify CMS of any new investments. Investments must meet the criteria in STC 11.1 and must not include any of the activities listed in STC 11.5 above. The state must submit information regarding new investments following the template in Attachment S for CMS review and approval. The state must use the Investment Framework (Attachment R) to ensure investments meet the goals in STC 11.1. The state must notify CMS at least 30 days prior to implementing any of the proposed new investments. CMS will not approve a new investment if it includes unallowable activities. If CMS notifies the state with concerns or questions within 30 calendar days, the proposed investment will be considered under review as outlined in STC 11.7 below.

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

11.8. **Investment Monitoring and Evaluation**.

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

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

c. The state's monitoring and evaluation should accommodate data collection and analyses stratified by key subpopulations of interest (e.g., race and ethnicity, income

level, and regional population density) to inform a fuller understanding of existing disparities in access and health outcomes, and how the investments might support bridging any such inequities. To that end, the state should collect and submit to CMS stratified data on: rates of uninsured and underinsured in Vermont, enrollment in each of its investment programs, changes in health outcomes for individuals enrolled in investment programs, and outreach efforts to increase enrollment, especially any outreach that targets populations with existing health disparities. Monitoring reports should also incorporate successes and challenges encountered during program implementation.

12. MONITORING AND REPORTING REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Monitoring Protocol requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Disparities Sensitive Measure Set, and outlining the corresponding data sources and reporting timelines, as applicable to the demonstration initiatives and populations. If needed, the state may submit an amendment to the Monitoring Protocol within 150 days after the receipt of the final Disparities Sensitive Measure Set from CMS. This set of measures consists of metrics known to be important for addressing disparities in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e. social) drivers. The Monitoring Protocol must also outline the state's planned approaches and

parameters to track implementation progress and performance relative to the goals and milestones including relevant transitional, non-service expenditures investments, as captured in these STCs, or other applicable implementation and operations protocols.

In addition, the state must describe in the Monitoring Protocol methods and the timeline to collect and analyze relevant non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include but are not limited to data related to carceral status, Medicaid eligibility, and the health care needs of individuals who are incarcerated and returning to the community. Across data sources, the state must make efforts to consult with relevant non-Medicaid agencies to collect and use data in ways that support analyses of data on demonstration beneficiaries and subgroups of beneficiaries, in accordance with all applicable requirements concerning privacy and the protection of personal information.

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

12.8. **Monitoring Reports.** The state must submit three Quarterly Monitoring Reports and one compiled Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 days following the end of each demonstration quarter. The compiled Annual Monitoring Report (including the fourth quarter information) is due no later than 90 days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428. and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

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

include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

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

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

Specifically, the state must undertake standardized reporting on categories of metrics for demonstration components outlined in STC 12.8(b)(i), including, but not limited to: beneficiary participation in demonstration components, primary and specialist provider participation, utilization of services, quality of care, and health outcomes. The reporting of metrics focused on quality of care and health outcomes must be aligned with the demonstration's policies and objectives populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, sexual orientation and gender identity, and geography), and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities.

i. The state's selection and reporting of quality of care and health outcome metrics outlined above must also accommodate the Reentry Demonstration Initiative. In addition, the state is required to report on metrics aligned with tracking progress with implementation and toward meeting the milestones of the Reentry Demonstration Initiative. CMS expects such metrics to include, but not be limited to: utilization of applicable pre-release and post-release services as defined in STC 16.4, provision of health or social service referrals pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the

state's Reentry Initiative Implementation Plan, the state must also provide in its Monitoring Reports narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

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

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

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

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

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

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

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

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

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

12.9. **Compliance with Managed Care, Network Adequacy, Quality Strategy and EQR Reporting Requirements**. The state must comply with all managed care reporting

regulations at 42 CFR Part 438 et. seq., except as expressly identified as not applicable in the expenditure authorities incorporated into these STCs.

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

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

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

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

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

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

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

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement

with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 15.6 and 15.7, respectively.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13. GENERAL FINANCIAL REQUIREMENTS

13.1. **Allowable Expenditures.** This demonstration project is approved for expenditures applicable to services rendered during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.[4]

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

[4] For a description of CMS's current policies related to budget neutrality for Medicaid demonstration projects authorized under section 1115(a) of the Act, see State Medicaid Director Letter #18-009.

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

13.3. **Sources of Non-Federal Share**. As a condition of demonstration approval, the state certifies that the non-federal share is obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that such funds must not be used to match any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, CMS reserves the right to prohibit the use of any sources of non-federal share funding that it determines impermissible.

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

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

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

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

a. Units of state or local government, including health care providers that are units of state or local government, certify that state or local monies have been expended as the non-federal share of funds under the demonstration.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the state share of title XIX payments, including expenditures authorized under a section 1115 demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for expenditures under the demonstration, governmental entities to which

general revenue funds are appropriated must certify to the state the amount of such state or local monies that are allowable under 42 CFR 433.51 to satisfy demonstration expenditures. If the CPE is claimed under a Medicaid authority, the federal matching funds received cannot be used as the non-federal share needed to receive other federal matching funds under 42 CFR 433.51(c). The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers (IGT) to the extent that such funds are derived from state or local revenues and are transferred by units of government within the state. Any transfers from units of government for purposes of Title XIX must be made in an amount not to exceed the non-federal share of title XIX payments and any payment derived from a proper IGT is not contingent upon receipt of the IGT.

e. Under all circumstances, health care providers must retain 100 percent of the reimbursement for claimed expenditures. Moreover, consistent with 42 CFR 447.10, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments to return and/or redirect to the state any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

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

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

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments comply with all requirements on payments in 42 CFR §438, including 438.6(b)(2), 438.6(c), 438.6(d), 438.60 and/or 438.74.

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

a. All health care-related taxes as defined by Section 1903 (w)(3)(A) of the Social Security Act and 42 CFR § 433.55 are broad-based as defined by Section 1903 (w)(3)(B) of the Social Security Act and 42 CFR § 433.68 (c).

b. All health care-related taxes are uniform as defined by Section 1903 (w)(3)(C) of the Social Security Act and 42 CFR § 433.68 (d).

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

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

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

13.7. **State Monitoring of Non-federal Share.** No later than 60 days after demonstration approval, the state must provide a report to CMS regarding payments under the demonstration specifying that payments under the demonstration are funded all or in part by a locality tax, if the state operates any locality taxes that constitute any non-federal share for the demonstration. This requirement also applies, effective upon initiation of a locality tax, if the state initiates a new locality tax for non-federal share of the demonstration. This report must include:

a. Any agreement written or otherwise regarding the arrangement among the providers with counties, the state or other entities for each locality tax;

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

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

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

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

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

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

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

This deliverable is subject to the deferral as described in STC 12.5.

13.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the

applicable federal matching rate for the demonstration as a whole for the following, subject to the budget neutrality expenditure limits described in section 14:

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

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

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

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

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

Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Aged, Blind, and Disabled (ABD) Non-Medicare Adult	Main	X		X	Expenditures for aged, blind, and disabled (ABD) adults without Medicare.
ABD Non-Medicare Child	Main	X		X	Expenditures for ABD children without Medicare.
ABD Dual	Main	X		X	Expenditures for ABD with Medicare.
Non-ABD, Non-	Main	X		X	Expenditures for non-ABD adults who are not in the Affordable Care

Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Medicare Adult					Act adult group described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119.
Non-ABD, Non-Medicare Child	Main	X		X	Expenditures for non-ABD children.
New Adults	Hypo 1	X		X	Medical expenditures for the Affordable Care Act adult group described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119.
Investments	Main			X	Expenditures for investments as described in STC 11.1, as well as HCBS Investments.
SUD IMD ABD	Hypo 2	X		X	Expenditures for costs of medical assistance that could be covered for ABD individuals without Medicare, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.
SUD IMD ABD Duals	Hypo 2	X		X	Expenditures for costs of medical assistance that could be covered for ABD individuals with Medicare, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.
SUD IMD Non-ABD	Hypo 2	X		X	Expenditures for costs of medical assistance that could be covered for non-

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

Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
					during a month in an IMD.
SMI IMD non-ABD	Hypo 3	X		X	Expenditures for costs of medical assistance that could be covered for non-ABD individuals without Medicare, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.
SMI IMD New Adult	Hypo 3	X		X	Expenditures for costs of medical assistance that could be covered for the Affordable Care Act adult group described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119, were it not for the IMD prohibition under the State Plan, provided to otherwise eligible individuals during a month in an IMD.
Supportive Housing Assistance Pilot	Hypo 4	X		X	Expenditures for housing supportive services provided to enrollees in the state's Supportive Housing Assistance Pilot.
Maternal Health and Treatment Services	Hypo 5	X		X	Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD or SMI and who are

Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
					residents at the Lund Home facility.
CRT	Hypo 6	X		X	Expenditures for individuals receiving CRT services.
SUD CIT	Hypo 7	X		X	Expenditures for individuals eligible as part of the SUD CIT group (Demonstration Population 9).
VT Global Rx	Hypo 8	X		X	Expenditures for individuals eligible for VPharm cost sharing assistance (Demonstration Populations 7 and 8).
Moderate Needs	Hypo 9	X		X	Expenditures for individuals eligible as part of the CFC Moderate Needs group (Demonstration Population 6).
Marketplace Subsidy	Hypo 10	X		X	Expenditures for the state-funded Marketplace Subsidy Program for individuals at or below 300 percent of the FPL who purchase health care in the Marketplace.
MDAAP	Main			X	Expenditures to conduct MDAAP activities in accordance with the requirements in STC 8.3.
IMD Investments	Main			X	Expenditures for IMD investments phasing down in accordance with STC 11.3.
ADM	N/A				Administrative costs that are directly attributable to the demonstration.

Master MEG Chart					
MEG	**To Which BN Test Does This Apply?**	**WOW Per Capita**	**WOW Aggregate**	**WW**	**Brief Description**
Community Transition Services	Main			X	Expenditures for community transition services for enrollees in the state's Supportive Housing Assistance Pilot program who are moving to supportive housing from non-institutional, non-provider-operated living arrangements.
Ind Cost Eff Serv	Main			X	Individually cost-effective services as assessed by the state.
Reentry Services	Hypo 11	X		X	Expenditures for targeted services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 90 days immediately prior to the expected date of release from participating state correctional facilities
Reentry Non-Services	Hypo 11		X	X	Expenditures for planning and supporting the reentry demonstration initiative

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

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

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

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

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

e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in section 12, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible

for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

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

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

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

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

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

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

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

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

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

MEG Detail for Expenditure and Member Month Reporting								
MEG (Waiver Name)	**Detailed Description**	**Exclusions**	**CMS-64.9 or 64.10 Line(s) To Use**	**How Expend. Are Assigned to DY**	**MAP or ADM**	**Report Member Months (Y/N)**	**MEG Start Date**	**MEG End Date**
ADM	Administrative costs that are directly attributable to the demonstration.	N/A	Follow standard CMS-64.10 Category of Service Definitions	Date of payment	ADM	N	7/1/22	12/31/27
Community Transition Services	Report expenditures for community transition services for enrollees in the state's Supportive Housing Assistance Pilot program who are moving to supportive housing from non-institutional, non-provider-operated living arrangements.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	N	1/1/24	12/31/27
Ind Cost Eff Serv	Report expenditures for individually assessed cost effective alternative services.	N/A	Follow standard CMS-64.9 Category of Service Definitions	Date of payment	MAP	N	1/1/23	12/31/27

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

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

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

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

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

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

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

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

13.16. **Budget Neutrality Adjustments.** To the extent that there are any changes to the federal Section 1115 demonstration budget neutrality approach during the demonstration period, the state has the opportunity to submit an adjustment aligning with these changes, along with detailed data to justify this, for CMS review without submitting an amendment pursuant to STC 3.7. All changes in budget neutrality would apply retroactively to the date of the federal policy changes.

13.17. **Budget Neutrality Adjustments for Increased Provider Rates.** The state may submit an adjustment to its budget neutrality for CMS review, upon receiving an appropriation for provider rate increases, without submitting an amendment pursuant to STC 3.7. All changes to budget neutrality would apply on the state's effective date for the increase.

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

14. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

14.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The limit may consist of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. CMS' assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

14.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis. If the per capita method is used, the state is at risk for the per capita cost of State Plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita

costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

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

14.4. **Main Budget Neutrality Test.** The Main Budget Neutrality Test allows the state to show that demonstration waivers granted have not resulted in increased costs to Medicaid, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Main Budget Neutrality Test										
MEG	**PC or Agg***	**WOW Only, WW Only, or BOTH**	**Base Year**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**
ABD Non-Medicare Adult	PC	Both	2019	4.7%	$2,404.76	$2,489.04	$2,606.02	$2,728.51	$2,856.75	$2,991.01
ABD Non-Medicare Child	PC	Both	2019	2.8%	$2,668.61	$2,724.65	$2,801.21	$2,879.93	$2,960.85	$3,044.05
ABD Dual	PC	Both	2019	3.8%	$2,119.20	$2,178.84	$2,260.98	$2,346.22	$2,434.68	$2,526.46
Non-ABD, Non-Medicare Adult	PC	Both	2019	6.3%	$787.20	$824.11	$876.03	$931.22	$989.88	$1,052.24
Non-ABD, Non-Medicare Child	PC	Both	2019	5.8%	$598.55	$624.40	$660.62	$698.93	$739.47	$782.36
Investments	Agg	WW Only	2019	5%	N/A	N/A	N/A	N/A	N/A	N/A
MDAAP	Agg	WW Only	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Main Budget Neutrality Test										
MEG	**PC or Agg***	**WOW Only, WW Only, or BOTH**	**Base Year**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**
Community Transition Services	Agg	WW Only	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Individually Assessed Cost Effective Alternative Services	Agg	WW Only	2020	N/A	N/A	N/A	N/A	N/A	N/A	N/A

*PC = Per Capita, Agg = Aggregate

14.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid State Plan or other title XIX authority (such as a waiver under section 1915 of the Act), CMS considers these expenditures to be "hypothetical;" that is, the expenditures would have been eligible to receive FFP elsewhere in the Medicaid program. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid State Plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the otherwise allowable services. This approach reflects CMS's current view that states should not have to "pay for," with demonstration savings, costs that could have been otherwise eligible for FFP under a Medicaid State Plan or other title XIX authority; however, when evaluating budget neutrality, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures. That is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

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

Hypothetical Budget Neutrality Test 1										
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**
New Adult Group	PC	Both	2019	5.7%	$575.03	$599.44	$633.61	$669.72	$707.90	$748.25

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

Hypothetical Budget Neutrality Test 2										
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**

SUD IMD ABD	PC	Both	2021	4.3%	$3,064.94	$3,163.27	$3,299.29	$3,441.16	$3,589.13	$3,743.46
SUD IMD ABD Duals	PC	Both	2021	4.0%	$1,856.56	$1,911.98	$1,988.46	$2,068.00	$2,150.72	$2,236.75
SUD IMD Non-ABD	PC	Both	2021	4.5%	$2,833.69	$2,928.80	$3,060.59	$3,198.32	$3,342.24	$3,492.64
SUD IMD New Adult	PC	Both	2021	5.7%	$3,116.58	$3,248.89	$3,434.07	$3,629.81	$3,836.71	$4,055.41

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

Hypothetical Budget Neutrality Test 3										
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**
SMI IMD ABD	PC	Both	2021	4.3%	$55,828.51	$57,619.47	$60,097.11	$62,681.28	$65,376.58	$68,187.77

SMI IMD ABD Duals	PC	Both	2021	4.0%	$35,743.20	$36,810.22	$38,282.63	$39,813.93	$41,406.49	$43,062.75
SMI IMD Non-ABD	PC	Both	2021	4.5%	$36,335.77	$37,555.33	$39,245.32	$41,011.36	$42,856.87	$44,785.43
SMI IMD New Adult	PC	Both	2021	5.7%	$40,968.11	$42,707.31	$45,141.62	$47,714.69	$50,434.43	$53,309.19

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

Hypothetical Budget Neutrality Test 4										
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**
Supportive Housing Assistance	PC	Both	2024	4.8%	N/A	N/A	$424.95	$445.35	$466.72	$489.13

14.10. **Hypothetical Budget Neutrality Test 5: Maternal Health and Treatment Services.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 5. MEGs that are designated "WOW Only" or "Both" are the components

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

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

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

Hypothetical Budget Neutrality Test 6										
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**

CRT Services	PC	Both	2019	4.7%	$5,069.88	$5,247.56	$5,494.19	$5,752.42	$6,022.79	$6,305.86

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

Hypothetical Budget Neutrality Test 7										
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend Rate**	**DY 18 PMPM**	**DY 19 PMPM**	**DY 20 PMPM**	**DY 21 PMPM**	**DY 22 PMPM**	**DY 23 PMPM**
SUD CIT	PC	Both	2025	4.8%	N/A	N/A	N/A	$757.51	$793.11	$830.39

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

Hypothetical Budget Neutrality Test 8

MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 18 PMPM	DY 19 PMPM	DY 20 PMPM	DY 21 PMPM	DY 22 PMPM	DY 23 PMPM
VT Global Rx	PC	Both	2019	0%	$89.32	$89.32	$89.32	$89.32	$89.32	$89.32

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

Hypothetical Budget Neutrality Test 9										
MEG	PC or Agg	WOW Only, WW Only, or Both	Base Year	Trend Rate	DY 18 PMPM	DY 19 PMPM	DY 20 PMPM	DY 21 PMPM	DY 22 PMPM	DY 23 PMPM
Moderate Needs Group	PC	Both	2019	4.7%	$833.78	$863.00	$903.56	$946.03	$990.49	$1,037.05

14.15. **Hypothetical Budget Neutrality Test 10: Marketplace Subsidy.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 10. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is

calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

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

14.16. **Hypothetical Budget Neutrality Test 11: Reentry Demonstration Initiative Expenditures.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 11. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 11 are counted as WW expenditures under the Main Budget Neutrality Test.

Hypothetical Budget Neutrality Test 11										
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Base Year**	**Trend Rate**	**DY 18**	**DY 19**	**DY 20**	**DY 21**	**DY 22**	**DY 23**

Reentry Services	PC	Both	2022	6.3%	N/A	N/A	N/A	N/A	$1,247.82	$1,326.43
Reentry Non-Services	Agg	Both	N/A	$0	N/A	N/A	$750,539	$2,251,617	$0	$0

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

14.18. **Exceeding Budget Neutrality.** CMS will enforce budget neutrality agreement over the life of the demonstration, which extends from July 1, 2022 to December 31, 2027. If at the end of the demonstration approval period the budget neutrality limit has been exceeded, the excess federal funds will be returned to CMS. If the demonstration is eliminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

14.19. **Mid-Course Correction** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan (CAP) for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Budget Neutrality Test Mid-Course Correction Calculation		
Demonstration Year	**Cumulative Target Definition**	**Percentage**

DY 18	Cumulative budget neutrality limit plus:	2.0 percent
DY 18 through DY 19	Cumulative budget neutrality limit plus:	1.5 percent
DY 18 through DY 20	Cumulative budget neutrality limit plus:	1.0 percent
DY 18 through DY 21	Cumulative budget neutrality limit plus:	0.5 percent
DY 18 through DY 22	Cumulative budget neutrality limit plus:	0.0 percent
DY 18 through DY 23	Cumulative budget neutrality limit plus:	0.0 percent

15. EVALUATION OF THE DEMONSTRATION

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

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

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

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

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

amended Evaluation Design must also be reflected in the state's Interim (as applicable) and Summative Evaluation Reports, described below.

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

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

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

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as likelihood of enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care

Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP; Consumer Assessment of Health Care Providers and Systems (CAHPS); the Behavioral Risk Factor Surveillance System (BRFSS) survey; and/or measures endorsed by National Quality Forum (NQF).

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

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

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

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

estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

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

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

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

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

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

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

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

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

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

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

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

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

15.8. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid,

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

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

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

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

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

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

16. REENTRY DEMONSTRATION INITIATIVE

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

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

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

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

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

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

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

e. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs;

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

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

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

i. Lower rates of recidivism;

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

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

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

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

b. Be enrolled in Medicaid; and

c. Have a post-adjudication disposition.

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

a. The covered pre-release services are:

i. Case management to assess and address physical and behavioral health needs;

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

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

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

v. Peer support services;

vi. Treatment for Hepatitis C; and

vii. Screening for common health conditions.

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

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

16.6. **Participating Providers**.

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

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

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

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

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

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

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

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

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

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

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

d. Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to, physical and behavioral health community-based providers and the state Medicaid agency.

e. Appropriate reentry planning, pre-release case management, and assistance with care transitions to the community, including connecting individuals to physical and

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

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

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

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

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

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

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

CMS will provide the state with a template to support developing and obtaining approval of the Implementation Plan. Contingent upon CMS's approval of the state's Implementation Plan, the state may begin claiming FFP for services provided through the

Reentry Demonstration Initiative starting from the date of inclusion of the Implementation Plan as an attachment to these STCs.

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

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

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

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

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

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

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

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

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

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

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

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

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

i. **Technology and IT Services.** Expenditures for the purchase of technology for Qualified Applicants that are to be used for assisting the Reentry Demonstration Initiative population with Medicaid application and enrollment for demonstration coverage. This includes the development of electronic

interfaces for Qualified Applicants listed in STC 16.12(d). to communicate with Medicaid IT systems to support Medicaid enrollment and suspension/unsuspension and modifications. This also includes support to modify and enhance existing IT systems to create and improve data exchange and linkages with Qualified Applicants listed in STC 16.12(d), in order to support the provision of pre-release services delivered in the period up to 90 days immediately prior to the expected date of release and reentry planning.

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

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

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

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

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

vii. **Planning**. Expenditures for planning to focus on developing processes and information sharing protocols to: (1) identifying individuals who are potentially eligible for Medicaid; (2) assisting with the completion of a Medicaid application; (3) submitting the Medicaid application to the state Medicaid agency or coordinating suspension/unsuspension; (4) screening for eligibility for pre-release services and reentry planning in a period for up to 90 days immediately prior to the expected date of release; (5) delivering necessary services to eligible individuals in a period for up to 90 days immediately prior to the expected date of release and care coordination to support reentry; and (6) establishing on-going oversight and monitoring process upon implementation.

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

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

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

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

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

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

17. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION PERIOD

Due Date	Deliverable	STC Reference
30 calendar days after approval date[5]	Written acknowledgement of the award letter and acceptance of the STCs	N/A; see Approval letter

[5] Approval date refers to the date marked on the approval letter for this demonstration.

Due Date	Deliverable	STC Reference
150 calendar days after approval date	SUD Monitoring Protocol	STC 9.3
150 calendar days after approval date	SMI/SED Monitoring Protocol	STC 10.5
180 calendar days after the demonstration's implementation and annually thereafter	Post Award Forum	STC 12.2
180 days after demonstration approval	Draft Evaluation Design	STC 15.3
90 days after approval of demonstration extension	HCBS Quality Measures	STC 6.14(a)(vii)
June 30, 2025	SUD Mid-Point Assessment	STC 9.4
June 30, 2024	SMI/SED Mid-Point Assessment	STC 10.8
The end of the third year of implementation of the Reentry Demonstration Initiative	Reentry Mid-Point Assessment	STC 12.13
One year prior to current expiration date (December 31, 2026), or with extension application	Draft Interim Evaluation Report	STC 15.5
Within 18 months of the end of the demonstration period	Draft Summative Evaluation Report	STC 15.6
30 calendar days after CMS approval	Approved Final Summative Evaluation Report published to state's website	STC 15.6
Within 30 days of CMS written request	State Data Collection	STC 12.9

Due Date	Deliverable	STC Reference
21 months before the end of the demonstration period, in accordance with the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers	HCBS Quality Improvement Strategy Evidentiary Report	STC 6.14(a)(viii)
120 calendar days after approval date of the Reentry Demonstration Initiative	Reentry Demonstration Initiative Implementation Plan	STC 16.10
6 months after approval date of the Reentry Demonstration Initiative	Reentry Demonstration Initiative Reinvestment Plan	STC 16.11

Recurring Date	Deliverable	STC Reference
No later than 60 days after the end of the quarter (except Q4)	Quarterly Monitoring Reports	STC 12.7
No later than 90 days after the end of the Demonstration Year	Annual Monitoring Reports	STC 12.7
Updated every three years in accordance with 42 CFR 438.340 (c)	State Quality Strategy	STC 6.14
Not later than 90 days prior to the effective date	Interagency Agreement and Rate Certification	STC 6.2
No later than 30 days after the end of the quarter	CMS-64 Expenditure Reports	STCs 13.2 & 13.11