Global Commitment to Health Section 1115 Demonstration Amendment Application

State of Vermont
Agency of Human Services

DRAFT FOR PUBLIC COMMENT

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Section I. Program Description

Introduction

Vermont's Global Commitment to Health (Global Commitment) Section 1115 demonstration has served as the cornerstone of Vermont's Medicaid transformation efforts for almost 20 years. With nearly the entirety of Vermont's Medicaid program falling under the purview of the demonstration, it has played a pivotal role in broadening access to health care coverage, strengthening the State's public health and health-related services infrastructure, and driving reforms in health care payment and delivery. The results of Vermont's efforts are clear, with Vermont ranking fifth among all states on the Commonwealth Fund's 2023 Scorecard on State Health System Performance. Notably, Vermont ranks second nationwide on measures of income disparity, highlighting the success of Vermont's Medicaid program in producing strong health outcomes for the State's lower-income residents.

The Centers for Medicare and Medicaid Services (CMS) first approved the Global Commitment demonstration in 2005. Since then, Vermont has renewed its demonstration four times, with CMS approving the most recent 5.5-year renewal in June 2022. **Vermont's Agency of Human Services (AHS) is submitting this demonstration amendment request to catalyze its efforts to address the mental health, substance use, and housing crises in the State, in addition to enabling an innovative new payment methodology.**

Summary of Current Demonstration

Today, the Global Commitment demonstration governs Vermont's Medicaid program, which provides Medicaid services and supports to more than 200,000 Medicaid enrollees—nearly 30% of the State's population.[1] At its core, the demonstration authorizes the Department of Vermont Health Access (DVHA) to act as a public, non-risk-bearing prepaid inpatient health plan, a unique delivery system that enables the State to pursue many of the programmatic and payment flexibilities afforded to commercial managed care plans in operating its Medicaid program. The Global Commitment demonstration also supports vital investments in health-related functions, such as emergency medical services, health professional training, and public health. These investments have enabled Vermont to create a robust health ecosystem focused on improving health, reducing health care costs, and promoting health equity for all Vermonters, regardless of their insurance status. Other key features of the demonstration include:

- ***Eligibility Expansions.*** Vermont provides a range of benefits to individuals with incomes above Medicaid limits to promote overall health and to prevent them from becoming Medicaid-eligible in the future.
    - Through the **Community Rehabilitation and Treatment (CRT) Expansion Group**, individuals with incomes above Medicaid limits diagnosed with a severe mental illness (SMI) are able to access a range of community-based mental health services.
    - Individuals with a diagnosed substance use disorder (SUD) with incomes up to and including 225% of the federal poverty level (FPL) will be eligible for the **SUD Community**

[1] "Medicaid Program Enrollment and Expenditures Quarterly Report." Vermont Legislature, December 1, 2023. https://dvha.vermont.gov/sites/dvha/files/documents/SFY2024Q1_Medicaid_Program_EE_YTD.pdf

Intervention and Treatment (SUD CIT) group upon its launch in July 2025. Individuals in this group will have access to an array of benefits, including case management, recovery supports, psychoeducation, peer supports, residential treatment, withdrawal management, counseling, and skilled therapy services.

  - Under the **Choices for Care (CFC) Moderate Needs Group**, Vermonters with disabilities with incomes up to 300% of the Social Security Income Federal Benefit Rate who are at risk of needing nursing home care, and would not otherwise have been eligible for Medicaid, are able to access home and community-based services (HCBS).

- ***HCBS Programs for Individuals with Disabilities.*** Under the Global Commitment demonstration, Vermont operates HCBS programs for individuals with brain injury (Brain Injury Program), physical disabilities (Choices for Care), and developmental disabilities (Developmental Disabilities Services).
- ***Other Special Programs***. Vermont administers special programs that provide primarily rehabilitative benefits to individuals with SMI (CRT) and serious emotional disturbance (SED) (Mental Health Under 22). In January 2025, Vermont will launch a Supportive Housing Assistance Pilot that will provide pre-tenancy, tenancy sustaining, and community transition services to Medicaid enrollees in need of housing supports.
- ***Medicaid Data Aggregation and Access Program (MDAAP).*** Vermont is implementing the MDAAP to expand mental health, SUD, and long-term services and supports (LTSS) providers' health information technology (HIT) capabilities. With funding available under the demonstration, providers are able to purchase tools to capture and exchange data and use data meaningfully to improve population health.
- ***Treatment in Institutions for Mental Diseases (IMDs).*** Vermont obtains federal Medicaid matching funds for individuals ages 21 to 64 with short-term stays in IMDs for mental health and SUD treatment.
- ***Coverage of Maternal Health and Treatment Services.*** Vermont covers maternal health and treatment services offered at the Lund Home, an IMD that offers a unique mental health and SUD treatment model for pregnant and postpartum individuals and mothers.
- ***Marketplace Subsidies.*** Vermont provides subsidies to help Vermonters with incomes above Medicaid limits up to 300% FPL purchase coverage on the Marketplace.
- ***VPharm.*** Vermont assists individuals enrolled in Medicare Part D who have incomes up to 225% FPL, including those over age 65 and those with disabilities, with paying premiums and co-payments for prescription drugs.

Proposed Changes to Demonstration

To build upon these successes, Vermont is requesting to amend the Global Commitment demonstration to continue its efforts to strengthen access and quality of care, improve equity, and advance health care innovation. With this amendment, Vermont seeks to:

- **Expand access to care for Vermonters with mental health conditions and SUD.** Specifically, Vermont proposes to:
  - Transition benefits offered under the CRT and Mental Health Under 22 programs to the State Plan.
  - Provide Medicaid coverage of room and board for enrollees receiving treatment in residential mental health and SUD treatment facilities.

  - Close the coverage gap for the SUD CIT group to enable all individuals with a SUD whose income is above Medicaid limits up to and including 225% FPL to access SUD CIT services.
- **Provide housing and other supports to promote whole-person health** through:
  - Coverage of medical respite and rent/temporary housing under the Supportive Housing Assistance Pilot for individuals who have a history of homelessness, including if they are currently or formerly homeless, or are at-risk of homelessness in addition to having complex clinical or functional needs.
  - Adding a new environmental and assistive adaptations benefit to the Developmental Disabilities Services program.
- **Advance payment and delivery system reforms by instituting Medicaid hospital global payments.**

These proposed changes will enable Vermont's health care and social services providers and other critical partners to deliver comprehensive, person-centered care within a delivery system focused on innovation. Vermont's proposal is described in more detail in this application.

Section II. Proposal Details

Demonstration Amendment Goals and Objectives

Given the vital role of the Global Commitment demonstration in Vermont's Medicaid program and the State's health care ecosystem as a whole, the current goals and objectives of the Global Commitment demonstration are expansive. They are:

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

Underlying all these goals and objectives is Vermont's commitment to leveraging its 1115 demonstration to advance health equity. This amendment aims to advance the State's efforts to achieve these goals and objectives, with a specific focus on Goals/Objectives 2, 4, and 5. Additionally, Vermont seeks to achieve one additional goal/objective: **addressing Vermonters' health-related social needs (HRSN) to improve health outcomes and promote whole-person health**. While the Global Commitment demonstration has historically authorized many initiatives targeting Vermonters' HRSN, such as the investments and Supportive Housing Assistance Pilot, with this amendment request, the State is articulating addressing HRSN as one of its top priorities. Table 1 displays how each of Vermont's new requests under this amendment application map to the demonstration goals and objectives.

Table 1. Alignment of Proposed New Demonstration Features with Demonstration Goals and Objectives

	Demonstration Goals/Objectives Advanced Through Request *All Goals/Objectives Seek to Advance Health Equity*					
	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**	**Accelerate payment reform**	**Address Vermonters' HRSN to improve health outcomes and promote whole-person health**
Cover room and board in residential settings		✓		✓		
Close coverage gap for SUD CIT group	✓		✓			
Provide medical respite and rent/temporary housing		✓	✓	✓		✓
Support for HRSN infrastructure		✓		✓		✓
Add a new environmental and assistive adaptations benefit for Developmental Disabilities Services program		✓	✓			✓
Implement Medicaid global payments		✓		✓	✓	

Proposed Demonstration Requests

Vermont's proposed requests fall into the following three categories: 1) expanding access to care for Vermonters with mental health conditions and SUD; 2) providing housing and other supports to promote whole-person health; and 3) advancing payment and delivery reforms. The State developed these requests in response to concerning trends unfolding in the State around mental health and SUD use, homelessness, timeliness and supports available at transitions between settings, and rising health care costs. Vermont believes that Medicaid can play a leading role in addressing these issues.

1. Expand Access to Care for Vermonters with Mental Health Conditions and SUD

Similar to other states across the nation, Vermont is in the midst of a mental health and substance use crisis. Approximately one-third of all Vermonters reported anxiety and depression symptoms and the growth in suicide rate is among the fastest in the country.[2] Among Vermonters ages 18-25, the average percentage of those with an SMI has more than doubled from 4.5% from 2008-2010 to 10.2% from 2017-2019.[3] Deaths related to substance use have also grown rapidly; for example, there was a 10% increase in opioid-related deaths among Vermonters from 2021 to 2022.[2]

Vermont's Medicaid program has played a critical role in responding to this crisis. Over the past several years, Vermont has:

- Instituted meaningful rate increases for mental health and SUD treatment providers, including 8% and 5% increases in 2022 and 2023, respectively, for Vermont's designated agencies (community-based mental health providers), 5% rate increases during both years for SUD Preferred Providers (SUD providers that achieve a specialized certification).
- Implemented a new mobile crisis benefit in alignment with Section 9813 of the American Rescue Plan Act (ARPA).
- Designed the SUD CIT program.
- Funded programming at designated agencies to provide alternatives to mental health crisis care in emergency departments (e.g., implementation of a multidisciplinary mobile response team to perform welfare checks in lieu of police intervention for individuals in crisis).
- Implemented a new residential eating disorder treatment benefit.
- Conducted planning to implement new peer supports and recovery supports State Plan benefits in July 2025.

As the need for mental health and SUD treatment remains high, Vermont is committed to building upon its efforts to ensure that individuals are able to access the full continuum of mental health and SUD treatment in settings that meet their needs, ranging from community-based to residential settings. As such, three of Vermont's requests for this amendment are targeted toward increasing access to mental health and SUD treatment.

[2] "Vermont Statewide Health Needs." Vermont Department of Health, 2023. https://www.healthvermont.gov/sites/default/files/document/Statewide data brief.pdf

[3] Substance Abuse and Mental Health Services Administration (SAMHSA). "Behavioral Health Barometer: Vermont, Volume 6: Indicators as measured through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services." HHS Publication No. SMA–20–Baro–19–VT, 2020. https://www.samhsa.gov/data/sites/default/files/reports/rpt32862/Vermont-BH-Barometer_Volume6.pdf

A. Transition CRT and Mental Health Under 22 Benefits to the Medicaid State Plan

Today, the Global Commitment demonstration authorizes the CRT and Mental Health Under 22 programs, which offer expanded, primarily rehabilitative mental health benefits to over 2400 individuals with SMI and SED. These programs enable individuals to remain in their homes and communities while receiving the care they need to successfully manage their conditions. Historically, Vermont has administered these programs through the Global Commitment demonstration. Given their critical importance to Vermonters with SMI and SED, **Vermont intends to establish CRT and Mental Health Under 22 program benefits as entitlements under the State Plan for individuals enrolled in Medicaid.**

With this demonstration amendment, Vermont requests to phase out authority for the CRT and Mental Health Under 22 benefits authorized under the 1115 demonstration as of December 31, 2024; the corresponding State Plan benefits will be effective on January 1, 2025. Accordingly, with the transition of services to the State Plan, the CRT and Mental Health Under 22 programs will no longer be "special programs" under the Global Commitment demonstration with one exception: Vermont will continue to use the 1115 demonstration to authorize the provision of CRT benefits to adults with SMI who have incomes above Medicaid limits (i.e., the CRT expansion group).[4]

This transition will make CRT and Mental Health Under 22 benefits more accessible to Medicaid enrollees with mental health needs. Individuals will no longer need to be determined eligible for the CRT or Mental Health Under 22 programs and will be able to access corresponding mental health benefits as long as they meet State-defined medical necessity criteria.

Vermont is committed to ensuring that individuals receiving services under the CRT and Mental Health Under 22 programs today do not experience disruptions or lapses in care with this transition. The State has determined that a vast majority of the benefits offered under the CRT and Mental Health Under 22 programs are coverable under Section 1905(a) authority, primarily under the rehabilitative services option or targeted case management. Vermont will submit State Plan Amendments to effectuate these transitions. Vermont will pay for select HCBS offered under CRT and Mental Health Under 22 that are not coverable under Section 1905(a) of the Social Security Act (e.g., respite for Mental Health Under 22 enrollees, certain components of supported employment) through state funds, meaning HCBS rules, and in particular, conflict-free case management rules will not apply. Services that are not being offered today or have not been utilized by program participants in recent years will not transition to the State Plan and will no longer be offered. For individuals who would have been eligible for CRT, an enhanced dental benefit will continue to be authorized under the 1115 demonstration. Table 2 below displays the planned future state for each benefit.

Table 2. Future State for CRT and Mental Health Under 22 Benefits

Future State	Current CRT and Mental Health Under 22 Benefits
Benefits to be transitioned to the State Plan under Section 1905(a)	• Case management • Community supports (individual or group) • Flexible support • Skilled therapy services

[4] Note: With this amendment, Vermont seeks to clarify that eligibility for the CRT expansion group starts when an individual's income is above Medicaid limits, recognizing that the Medicaid income limit varies by eligibility group.

Future State	Current CRT and Mental Health Under 22 Benefits
	• Residential treatment • Crisis support • Counseling • Peer supports (CRT only; service has not yet been implemented) • Components of supported employment that help individuals manage their behavior in the work environment, develop strategies for resolving workplace issues, and address their symptoms while at work
Benefits to be covered through state funds	• Respite (Mental Health Under 22 only) • Remaining components of supported employment not coverable under Section 1905(a)
Benefits to no longer be offered	• Environmental safety devices (not used today) • Respite (CRT only) (not used today)
Benefits to continue to be authorized under the 1115 demonstration	• Enhanced dental (CRT only)

B. Cover the Totality of Costs for Residential Treatment

As the country's largest payer of mental health and substance use services,[5] Medicaid is critical to covering life-saving residential treatment services for low-income individuals. However, current rules prohibit Medicaid from covering room and board for stays at these residential facilities, except for stays at IMDs for individuals ages 65 and over and stays at psychiatric residential treatment facilities and inpatient settings for youth under age 21. Vermont's Medicaid program covers an expansive set of residential mental health and SUD benefits, including clinically managed low- and high-intensity residential services, medically monitored intensive inpatient services, withdrawal management services, crisis beds, and eating disorder treatment.

In combatting the mental health and substance use crisis, Vermont is hindered by Medicaid's treatment of room and board. By definition, an individual cannot obtain residential treatment without residing in a facility, meaning that coverage of their treatment depends on the availability of state funds. As a result, while Medicaid enrollees are entitled to the clinical component of residential treatment, the entitlement does not extend to the totality of the service. This is particularly concerning given residential treatment is generally for those with significant needs who require round-the-clock care, such as individuals who have a co-occurring mental health condition and SUD.

Through the HRSN framework, CMS has recently permitted states to use Medicaid funds to cover up to six months' room and board, including rent/temporary housing, in community-based settings. As described below, Vermont is pursuing this opportunity through this demonstration amendment. Vermont requests to extend this flexibility **to cover room and board for the duration of medically**

[5] Guth, Madeline, Heather Saunders, Lauren Niles, Bergefurd Angela, Kathleen Gifford, and Roxanne Kennedy. "How do States Deliver, Administer, and Integrate Behavioral Health Care? Findings from a Survey of State Medicaid Programs." KFF, May 25, 2023. https://www.kff.org/mental-health/issue-brief/how-do-states-deliver-administer-and-integrate-behavioral-health-care-findings-from-a-survey-of-state-medicaid-programs/

necessary treatment at residential mental health and SUD facilities, excluding IMDs.[6] With this authority, Vermont will be able to provide equitable coverage of room and board across residential settings.

C. Closing the Coverage Gap for SUD CIT Expansion Group

Vermont intends to launch the SUD CIT expansion group in July 2025. Today, the Global Commitment demonstration authorizes eligibility for the SUD CIT expansion group for individuals with a SUD whose income is above 133% FPL up to and including 225% FPL. In creating the SUD CIT expansion group, the State intended for all Vermonters with incomes above Medicaid limits up to and including 225% FPL to have access to this important program. Vermont's Medicaid income limit for its aged, blind, and disabled (MABD) population is capped at the medically needy income level (MNIL), meaning that there is an eligibility gap for some individuals with incomes from roughly 100% to 133% FPL (i.e., individuals who fall into the medically needy eligibility group). **Vermont is seeking to implement a technical correction to modify eligibility for the SUD CIT expansion group so that an individual is eligible when their income is above the applicable Medicaid limit** (MNIL for MABD, 133% FPL for other eligibility groups) up to and including 225% FPL.

2. Providing Housing and Other Supports to Promote Whole-Person Health

Research shows that access to stable housing is associated with positive health outcomes, including better management of chronic diseases, improved mental health, healthy emotional and behavioral development among young children, and better self-reported health.[7,8,9] By the same token, housing instability translates to a range of negative health outcomes. For example, chronic health conditions such as anemia, asthma, diabetes, heart disease, and lung disease are significantly more prevalent among individuals with a history of homelessness compared to individuals with stable housing.[10] Mental health conditions, such as depression and schizophrenia, and substance use are also more common among this group.[11] In Vermont, there are substantial differences in the rate of homelessness across racial groups; Black Vermonters comprise 1.4% of the State's total population, but represented 6.0% of

[6] With the exception of IMD stays for individuals ages 65 and over, in which case Medicaid match for room and board is already permissible.

[7] Maqbool, Nabihah, Janet Viveiros, and Mindy Ault. "The Impacts of Affordable Housing on Health: A Research Summary." Center for Housing Policy, April 2015. https://nhc.org/wp-content/uploads/2017/03/The-Impacts-of-Affordable-Housing-on-Health-A-Research-Summary.pdf

[8] "Affordable Housing, Eviction, and Health" Office of Policy Development and Research (PD&R), 2021. https://www.huduser.gov/portal/periodicals/em/Summer21/highlight1.html

[9] Pollack, Craig Evan, Beth Ann Griffin, and Julia Lynch. "Housing Affordability and Health Among Homeowners and Renters." American Journal of Preventative Medicine, Volume 39 Issue 6, November 15, 2010. https://doi.org/10.1016/j.amepre.2010.08.002

[10] Sutherland, Harper, Mir M. Ali, and Emily Rosenoff. "Health Conditions Among Individuals with a History of Homelessness" January 2021. https://aspe.hhs.gov/reports/health-conditions-among-individuals-history-homelessness-research-brief-0

[11] Substance Abuse and Mental Health Services Administration (SAMHSA). "Expanding Access to and Use of Behavioral Health Services for People Experiencing Homelessness." SAMHSA Publication No. PEP22-06- 02-003, National Mental Health and Substance Use Policy Laboratory, 2023. https://store.samhsa.gov/sites/default/files/pep22-06-02-003.pdf

the homeless population statewide in 2022.[12] As a result, addressing homelessness is a significant health equity issue.

In recognition of housing as a key driver of health, Vermont has used the Global Commitment demonstration as a lever to promote housing stability. Under its Global Commitment investments, the State has funded transitional housing programs for individuals who were formerly justice-involved, as well as those with mental illness and SUD. These investments have enabled these groups to receive mental health and SUD treatment, intensive case management, and other social supports in a safe and supportive community. Additionally, in the most recent demonstration renewal, Vermont received approval to implement a Supportive Housing Assistance Pilot to provide pre-tenancy supports, tenancy sustaining services, and community transition services to Medicaid enrollees with significant clinical needs and other risk factors; the State plans to launch this program in January 2025. Even with these investments, there are still significant gaps in the continuum of services available to Vermont's Medicaid population. Facilitating successful hospital discharges for individuals experiencing homelessness has been a persistent challenge for Vermont's hospitals and homeless shelters. State survey data and residents' experiences on the ground show that health care facilities are forced to delay discharges because of the lack of supportive settings available, transition these individuals to settings that do not have the necessary clinical and social supports, or to "discharge to homelessness."[13,14] In 2023, at times, there were over 150 subacute patients waiting in Vermont hospitals per day to be discharged or transferred to an appropriate level of care. These critical gaps in discharge settings for individuals experiencing homelessness lead to poorer health outcomes, increased utilization of care, and higher health care costs.[15]

In addition, Vermont, like many other states, continues to grapple with a housing crisis and skyrocketing rates of homelessness. A report from the US Department of Housing and Urban Development (HUD) found that Vermont had the second highest homelessness rate in the country—with 51 out of every 10,000 Vermonters experiencing homelessness at a point-in-time count.[16] In response to rising rates of homelessness, Vermont has taken a multi-pronged approach to promote housing stability, including through the passage of the HOME Act to create more affordable housing and provision of significant state funding for grants to increase the capacity of emergency shelters and transitional housing programs for justice-involved individuals re-entering the community, among others. Access to

[12] "2022 Vermont's Annual Point-in-Time Count of Those Experiencing Homelessness." Vermont Coalition to End Homelessness and Chittenden County Homeless Alliance, May 19, 2022. https://helpingtohousevt.org/wp-content/uploads/2022/05/2022-Vermont-Point-in-Time-Report.pdf

[13] "Homelessness Study: Vermont Roadmap to End Homelessness." Vermont Legislature, January 15, 2017. https://legislature.vermont.gov/assets/Legislative-Reports/Homelessness-Study.pdf

[14] Whitcomb, Keith. "Where do Vermont's Homeless People go when they Leave the Hospital?" The Argus Times, August 30, 2023. https://www.timesargus.com/news/local/where-do-vermonts-homeless-people-go-when-they-leave-the-hospital/article_941d4a03-bccc-5fbd-87c9-9ce1dd9f3452.html

[15] Jenkinson, Jesse, Adam Wheeler, Claudia Wong, and Louisa Mussells Pires. "Hospital Discharge Planning for People Experiencing Homelessness Leaving Acute Care: A Neglected Issue." National Library of Medicine, August 16, 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7435079/

[16] De Sousa, Tanya, Alyssa Andrichik, Ed Prestera, Katherine Rush, Colette Tano, and Micaiah Wheeler. "The 2023 Annual Homelessness Assessment Report (AHAR) to Congress" The U.S. Department of Housing and Urban Development, December 2023. https://www.huduser.gov/portal/sites/default/files/pdf/2023-AHAR-Part-1.pdf

affordable housing is also an equity issue in Vermont, with Vermonters of color more likely than their White counterparts to experience housing problems, including being cost burdened, where monthly housing costs (including utilities) exceed 30% of monthly income. While existing initiatives are making an impact in increasing the availability of housing, there is still further work to be done. Vermont is looking to leverage every tool available, including Medicaid, to create more housing and housing supports in the State, while promoting equity in the process.

A. Provide Medical Respite and Rent/Temporary Housing Under the Supportive Housing Assistance Pilot

Since the most recent renewal of the Global Commitment demonstration in June 2022, CMS has released its HRSN framework, which enables states to obtain Medicaid match for a wide array of services impacting enrollees' HRSNs. Vermont intends to pursue this opportunity to expand the scope of housing supports that it offers to Medicaid enrollees. **Specifically, Vermont will create a new "tier" of the Supportive Housing Assistance Pilot to offer up to six months of medical respite and rent/temporary housing benefits** to eligible individuals. Vermont is defining medical respite as a residential, sub-acute setting, where a range of rehabilitative services and supports are provided to an individual after discharge from an acute hospital setting to address individuals' physical, psychosocial, behavioral, and other needs. Studies have shown that use of medical respite is associated with reduced hospital readmission rates, improved quality of life, and increased continuity of care.[17] By providing medical respite, Vermont aims to improve Medicaid enrollees' overall health and well-being, particularly among Vermonters of color who are more likely to experience housing instability and homelessness. Research has also shown that the provision of rental assistance is linked to positive outcomes. For example, studies have shown that rental assistance is associated with reduced homelessness, housing instability, and unnecessary institutionalization among individuals with disabilities; improved self-management of diabetes; and reduced likelihood of poor mental health.[18,19] Through the provision of a rent/temporary housing benefit, Vermont will be able to promote housing stability and improve health outcomes among these populations with significant clinical and functional needs.

These benefits will be available to Medicaid enrollees ages 18+ receiving full State Plan benefits who have a history of homelessness (including people who are currently or formerly homeless) or are at-risk of homelessness **and** meet at least one of the needs-based criteria for the Supportive Housing Assistance Pilot:

- A mental health or substance use need, which is defined as one or more of the following criteria:

[17] National Institute for Medical Respite Care. (2021). *Medical Respite Literature Review: An Update on the Evidence for Medical Respite Care.* https://nimrc.org/wp-content/uploads/2021/08/NIMRC_Medical-Respite-Literature-Review.pdf

[18] Bailey, A., De La Huerga, R. and Gartland, E. (July 6, 2021). *More Housing Vouchers Needed to Help People with Disabilities Afford Stable Homes in the Community.* Center on Budget and Policy Priorities. https://www.cbpp.org/sites/default/files/7-6-21hous.pdf

[19] Keene, D. E., Henry, M., Gormley, C., & Ndumele, C. (2018). 'Then I Found Housing and Everything Changed': Transitions to Rent-Assisted Housing and Diabetes Self-Management. *Cityscape (Washington, D.C.)*, *20*(2), 107–118. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6690624/pdf/nihms-1032057.pdf

  - A mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of an SMI; and/or
  - A substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) criteria indicates that the individual meets at least an ASAM level 1.0, indicating the need for outpatient SUD treatment.
- Assistance with one or more activities of daily living (ADLs), instrumental activities of daily living (IADLs), or other daily life skills, resulting from the presence of an acquired brain injury.
- Assessed to have a need for assistance, demonstrated by the need for assistance with two or more ADLs; or hands-on assistance with one or more ADLs.
- Assessed to have a complex physical health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support), resulting from the presence of a continuing, progressive, or indefinite physical condition, development or cognitive disability, or an emotional medical condition.
- Assessed to have measurable delays in cognitive development and significant observable and measurable delays in at least two of the following areas of adaptive behavior: communication, social/emotional development, motor development, daily living skills.

Vermont already has the ability to institute an enrollment cap and waitlist for the Supportive Housing Assistance Pilot and requests to extend this flexibility, including the ability to prioritize individuals seeking these benefits, to this new Pilot tier.

As required under the HRSN framework, the State will ensure that all individuals assessed to need medical respite or rent/temporary housing are engaged in a person-centered planning process to identify their needs and strategies and interventions for meeting those needs. Recognizing that individuals may need additional supports to maintain stable housing upon discharge from medical respite or the conclusion of six months' rent/temporary housing, individuals will also have the option to access pre-tenancy, tenancy sustaining, and community transition services under the Supporting Housing Assistance Pilot if determined to be clinically appropriate. Additionally, with this demonstration amendment, Vermont is seeking to shift authority for the community transition services benefit to be under the HRSN framework upon the launch of the medical respite and rent/temporary housing benefits.

B. Building HRSN Infrastructure

Vermont requests $10.4 million in federal Medicaid matching funds for investments in HRSN infrastructure to support capacity building among community-based organizations, social services providers, and other community partners that will enhance their ability to successfully deliver medical respite, rent/temporary housing, and community transition services to eligible Medicaid enrollees. These organizations are typically under-resourced and would benefit from infrastructure investments that will enable them to work with health care partners to identify Medicaid enrollees in need of medical respite and rent/temporary housing services and to deliver them effectively.

Eligible providers may use HRSN infrastructure funding for the following activities, among others:

- **Improvements in technology**, such as developing and implementing functionalities to facilitate data sharing, tracking referrals, updating accounting and billing systems, and monitoring and reporting data.
- **Funds to support outreach, education, and stakeholder convening,** which may include development of outreach and education materials for eligible Medicaid enrollees, soliciting stakeholder input, and forming partnerships with health care providers.
- **Investments to promote workforce development,** including recruiting, hiring, and onboarding staff to deliver housing services and providing trainings on relevant topics (e.g., cultural competency).
- **Funds to support development of business or operational practices,** such as procurement and planning, development of policies and workflows (e.g., referral management, quality improvement, member navigation).

Vermont also seeks HRSN infrastructure funding to support statewide capacity to enable delivery of housing services under Medicaid. Vermont may use funds to provide technical assistance to community organizations (e.g., trainings on Medicaid processes and policies), offer capacity building grants to providers, and develop strong partnerships with participating organizations, among others.

C. Adding a New Benefit to the Developmental Disabilities Services Program

Vermont is seeking to expand the benefit package for the Developmental Disabilities Services program to include an environmental and assistive adaptations service. The service will cover physical adaptations, devices, or technology necessary to ensure the health and safety of the individual or to enable greater independence.

3. Advancing Payment and Delivery Reforms

A. Ability to Implement Medicaid Hospital Global Payments

Vermont is a national leader in health care payment and delivery reform. The State, in partnership with CMS, has successfully implemented complex, multi-payer reforms, such as the State's current integrated health services and advanced primary care program, Blueprint for Health, and the Vermont All-Payer Accountable Care Organization Model (VTAPM).

To continue the State's trajectory towards health care payment and delivery reform, Vermont is pursuing participation in CMS's States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. Hospitals participating in the AHEAD Model will be reimbursed for services rendered to Medicare fee-for-service enrollees through fixed prospective global budgets. The AHEAD Model will also require that Vermont develop a parallel global budget methodology for Medicaid payments to participating hospitals. To do so, Vermont requests the ability to institute Medicaid hospital global payments without being required to reconcile the payments against actual utilization. Under the VTAPM, Vermont has been able to approximate unreconciled global payments for Medicaid services for hospitals via the State's accountable care organization (ACO) for ACO-attributed Medicaid members. Under AHEAD, Vermont would like to make similar fixed global budget payments directly to hospitals, or through a third-party administrative services organization procured by the State, and needs expenditure authority to do so. The State seeks this flexibility to continue advancing its payment and delivery system transformation goals.

Section III. Eligibility, Benefits, Delivery System, and Cost-Sharing

Eligibility

The State is not proposing any changes to Vermont Medicaid eligibility requirements for State Plan populations. Vermont is requesting the following clarifications to eligibility for expansion groups under the demonstration:

- **CRT expansion group eligibility criteria:** Individuals not eligible for Medicaid with severe and persistent mental illness who have incomes above Medicaid limits.
- **SUD CIT expansion group eligibility criteria:** Individuals with a diagnosis of a SUD with incomes above Medicaid limits up to and including 225% FPL.

Benefits

The State is proposing to modify covered benefits as follows:

- Provide Medicaid coverage of room and board for Medicaid enrollees' treatment in residential mental health and SUD treatment facilities, excluding IMDs, if determined to be medically appropriate.
- Add up to six months of medical respite and up to six months of rent/temporary housing as Supportive Housing Assistance Pilot benefits for eligible Medicaid enrollees.
- Add an environmental and assistive adaptations benefit to the Developmental Disabilities Services program benefit package.

Delivery System

Under the Global Commitment demonstration, DVHA is authorized to act as a public, non-risk-bearing prepaid inpatient health plan. The State is not proposing any changes to the Medicaid delivery system with this amendment.

Cost-Sharing

The State is not proposing any changes to cost-sharing under the Vermont Medicaid program.

Section IV. Requested Waiver and Expenditure Authorities

In addition to the approved demonstration authorities, Vermont is requesting the new and amended expenditure authorities outlined in Table 3 below. To the extent that CMS advises the State that additional authorities are necessary to implement the programmatic vision and operational details described in this amendment, the State is requesting such waiver or expenditure authority, as applicable. Vermont's negotiations with the federal government, as well as State legislative and budget changes, could lead to refinements in these lists as we work with CMS to move these requests forward.

Table 3. Expenditure Authority Requests

Expenditure Authority	Use for Authority
New Requests	
1. Room and board in residential settings	Expenditures to cover room and board for medically necessary treatment for Medicaid enrollees receiving treatment at residential mental health and SUD facilities, excluding IMDs.

Expenditure Authority	Use for Authority
2. HRSN services offered under Supportive Housing Assistance Pilot	Expenditures for HRSN services offered under the Supportive Housing Assistance Pilot that are not otherwise covered—specifically, medical respite, rent/temporary housing, and community transition services—to qualifying individuals. The State will institute annual enrollment limits for this Pilot program and may maintain a waiting list.
3. HRSN infrastructure funding	Expenditures to permit the State to receive Medicaid matching funds for allowable infrastructure expenditures related to HRSN services.
4. Enhanced dental benefits	Expenditures to cover enhanced dental benefits for Medicaid enrolled individuals with severe and persistent mental illness as defined by Vermont rule and policy.
5. Medicaid hospital global payments	Expenditures to enable the State to make unreconciled Medicaid hospital global payments to hospitals and other participating providers.
Amended Requests (amended text is underlined)	
6. Mental Health CRT Services	Expenditures for mental health CRT services, as defined by Vermont rule and policy, provided through a program to individuals not eligible for Medicaid with severe and persistent mental illness who have incomes above Medicaid limits.
7. SUD CIT Group	Individuals with a diagnosis of a SUD with incomes above Medicaid limits up to and including 225% FPL. Individuals in this population are not eligible for full State Plan benefits.

Section V. Demonstration Financing and Budget Neutrality

Expected Enrollment

Table 4 provides historical data on Member Months and estimated person counts for the Global Commitment 1115 demonstration populations from DY15 (CY2020) – DY20 (CY2024). Since 2024 is not complete, DY20 is a projection based on Vermont's June 2022 CMS-approved waiver projections and may not reflect actual enrollment once 2024 data is complete. Member Months increased from DY 15 through the combined period of DY17 and DY18 due to the COVID-19 pandemic and suspension of redeterminations during the public health emergency period. Person counts are estimated based on an average enrollment period of 10 months per member.

Table 4. Historical Member Months and Person Counts

Medicaid Expenditure Group		Historical Member Months and Person Counts					
		DY15	DY16	DY17	DY18	DY19	DY20[1]
		Jan - Dec 2020	Jan - Dec 2021	Jan - Jun 2022	Jul - Dec 2022	Jan - Dec 2023	Jan - Dec 2024
ABD - Non-Medicare - Adult	Member Months	79,935	79,738	39,101	38,226	88,873	77,596
	Person Count	7,994	7,974	3,910	3,823	8,887	7,760

Medicaid Expenditure Group		Historical Member Months and Person Counts					
		DY15	DY16	DY17	DY18	DY19	DY20[1]
		Jan - Dec 2020	Jan - Dec 2021	Jan - Jun 2022	Jul - Dec 2022	Jan - Dec 2023	Jan - Dec 2024
ABD - Non-Medicare - Child	Member Months	19,982	19,037	9,026	8,739	22,314	23,485
	Person Count	1,998	1,904	903	874	2,231	2,349
ABD - Dual	Member Months	259,965	265,553	133,548	136,650	274,281	267,177
	Person Count	25,997	26,555	13,355	13,665	27,428	26,718
Non ABD - Non-Medicare - Adult	Member Months	111,956	153,446	101,522	112,369	204,771	101,384
	Person Count	11,196	15,345	10,152	11,237	20,477	10,138
Non ABD - Non-Medicare - Child	Member Months	713,975	744,876	375,258	378,139	732,572	696,098
	Person Count	71,398	74,488	37,526	37,814	73,257	69,610
Total Medicaid Population	**Member Months**	**1,185,813**	**1,262,650**	**658,455**	**674,123**	**1,322,811**	**1,165,741**
	Person Count	**118,581**	**126,265**	**65,846**	**67,412**	**132,281**	**116,574**
Hypothetical Populations							
New Adult	Member Months	720,942	856,556	443,332	454,502	873,307	630,845
	Person Count	72,094	85,656	44,333	45,450	87,331	63,084
SUD IMD ABD	Member Months	106	71	48	51	136	69
	Person Count	11	7	5	5	14	7
SUD IMD ABD Dual	Member Months	136	121	69	70	146	118
	Person Count	14	12	7	7	15	12
SUD IMD Non-ABD	Member Months	161	145	171	121	190	143
	Person Count	16	15	17	12	19	14
SUD IMD New Adult	Member Months	1,366	1,191	691	623	1,555	1,163

Medicaid Expenditure Group		Historical Member Months and Person Counts					
		DY15	DY16	DY17	DY18	DY19	DY20[1]
		Jan - Dec 2020	Jan - Dec 2021	Jan - Jun 2022	Jul - Dec 2022	Jan - Dec 2023	Jan - Dec 2024
	Person Count	137	119	69	62	156	116
SMI IMD ABD	Member Months	68	66	76	55	127	64
	Person Count	7	7	8	6	13	6
SMI IMD ABD Dual	Member Months	7	26	30	10	28	25
	Person Count	1	3	3	1	3	3
SMI IMD Non-ABD	Member Months	24	24	34	20	173	24
	Person Count	2	2	3	2	17	2
SMI IMD New Adult	Member Months	253	256	214	174	350	250
	Person Count	25	26	21	17	35	25
SUD CIT	Member Months	---	---	---	---	---	---
	Person Count	---	---	---	---	---	---
Maternal Health and Treatment	Member Months	---	---	---	114	343	388
	Person Count	---	---	---	11	34	39
CRT	Member Months	---	---	---	1,213	2,437	1,304
	Person Count	---	---	---	121	244	130
VT Global Rx	Member Months	119,707	117,683	57,177	55,178	108,990	110,371
	Person Count	11,971	11,768	5,718	5,518	10,899	11,037
Moderate Needs	Member Months	1,991	1,697	852	731	1,391	2,157
	Person Count	199	170	85	73	139	216

Medicaid Expenditure Group		Historical Member Months and Person Counts					
		DY15	DY16	DY17	DY18	DY19	DY20[1]
		Jan - Dec 2020	Jan - Dec 2021	Jan - Jun 2022	Jul - Dec 2022	Jan - Dec 2023	Jan - Dec 2024
Total Hypothetical Population	**Member Months**	**723,063**	**858,456**	**444,665**	**512,862**	**989,173**	**746,919**
	Person Count	**72,306**	**85,846**	**44,467**	**51,286**	**98,917**	**74,692**
Total Other Population[2]	**Member Months**	**121,698**	**119,380**	**58,029**	**0**	**0**	**0**
	Person Count	**12,170**	**11,938**	**5,803**	**0**	**0**	**0**

[1] DY20 projected member months and person counts are based on the June 2022 budget neutrality projections as approved by CMS
[2] The "Other Population" for DY15-DY17 includes the VPharm and Moderate Needs groups that are now considered a hypothetical population in DY18 – DY23.

Table 5 provides the estimated enrollment for DY21 through DY23. Projected member months are identical to those in the June 2022 CMS-approved projection.

Table 5. Projected Member Months and Person Counts

Medicaid Expenditure Group		Projected Member Months		
		DY21[2]	DY22[2]	DY23[2]
		Jan - Dec 2025	Jan - Dec 2026	Jan - Dec 2027
ABD - Non-Medicare - Adult	Member Months	76,877	76,165	75,459
	Person Count	7,688	7,616	7,546
ABD - Non-Medicare - Child	Member Months	23,412	23,339	23,266
	Person Count	2,341	2,334	2,327
ABD - Dual	Member Months	269,080	270,995	272,925
	Person Count	26,908	27,100	27,292
Non ABD - Non-Medicare - Adult	Member Months	100,840	100,298	99,760
	Person Count	10,084	10,030	9,976
Non ABD - Non-Medicare - Child	Member Months	694,537	692,979	691,424
	Person Count	69,454	69,298	69,142
Total Medicaid Population	**Member Months**	**1,164,745**	**1,163,776**	**1,162,835**
	Person Count	**116,475**	**116,378**	**116,283**
Hypothetical Populations				
New Adult	Member Months	625,846	620,887	615,967
	Person Count	62,585	62,089	61,597
SUD IMD ABD	Member Months	68	68	67
	Person Count	7	7	7
SUD IMD ABD Dual	Member Months	117	115	114
	Person Count	12	12	11

Medicaid Expenditure Group		Projected Member Months		
		DY21[2]	DY22[2]	DY23[2]
		Jan - Dec 2025	Jan - Dec 2026	Jan - Dec 2027
SUD IMD Non-ABD	Member Months	142	141	140
	Person Count	14	14	14
SUD IMD New Adult	Member Months	1,154	1,145	1,135
	Person Count	115	114	114
SMI IMD ABD	Member Months	64	63	62
	Person Count	6	6	6
SMI IMD ABD Dual	Member Months	25	25	25
	Person Count	3	2	2
SMI IMD Non-ABD	Member Months	23	23	23
	Person Count	2	2	2
SMI IMD New Adult	Member Months	248	246	244
	Person Count	25	25	24
SUD CIT	Member Months	11,223	11,223	11,223
	Person Count	1,122	1,122	1,122
Maternal Health and Treatment	Member Months	393	398	403
	Person Count	39	40	40
CRT	Member Months	1,343	1,383	1,425
	Person Count	134	138	142
VT Global Rx	Member Months	108,593	106,843	105,122
	Person Count	10,859	10,684	10,512
Moderate Needs	Member Months	2,192	2,227	2,263
	Person Count	219	223	226
Total Hypothetical Population	**Member Months**	**751,430**	**744,788**	**738,215**
	Person Count	**75,143**	**74,479**	**73,821**

Projected Expenditures

Table 6 provides historical data on the total expenditures for the Global Commitment 1115 demonstration services and populations from DY15 to DY20. The total expenditures of the Global Commitment 1115 demonstration are reported in millions and reconcile to the CMS-64 reports that are submitted to CMS on a quarterly basis for federal claiming. Since 2024 is not yet complete, DY20 is the projection from the June 2022 CMS approved application.

Table 6. Historical Expenditures

	Historical Expenditures (millions)					
	DY15	DY16	DY17	DY18	DY19	DY20[3]
Historical Expenditures	**Jan - Dec 2020**	**Jan - Dec 2021**	**Jan - Jun 2022**	**Jul - Dec 2022**	**Jan - Dec 2023**	**Jan - Dec 2024**
ABD - Non-Medicare - Adult	$177.9	$183.5	$94.8	$95.3	$217.9	$202.2
ABD - Non-Medicare - Child	$55.4	$57.1	$26.5	$20.4	$61.1	$65.8
ABD - Dual	$476.2	$491.3	$254.5	$283.8	$616.4	$604.1
Non ABD - Non-Medicare - Adult	$70.0	$72.2	$48.2	$56.5	$100.1	$88.8
Non ABD - Non-Medicare - Child	$334.4	$345.0	$205.1	$173.7	$385.8	$459.9
Investments	$114.9	$105.9	$52.4	$73.4	$111.4	$185.9
MDAAP	$0.0	$0.0	$0.0	$0.0	$0.0	$6.6
Community Transition Services	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Hypothetical Expenditures						
New Adult	$368.2	$368.2	$236.6	$222.9	$445.8	$399.7
SUD IMD ABD	$0.4	$0.4	$0.1	$0.2	$0.5	$0.2
SUD IMD ABD Dual	$0.4	$0.4	$0.2	$0.2	$0.5	$0.2
SUD IMD Non-ABD	$0.5	$0.5	$0.3	$0.4	$0.7	$0.4
SUD IMD New Adult	$4.3	$4.3	$1.7	$2.1	$4.9	$4.0
SMI IMD ABD	$1.7	$1.7	$3.0	$1.6	$5.2	$3.9
SMI IMD ABD Dual	$0.2	$0.2	$0.6	$0.5	$1.2	$1.0
SMI IMD Non-ABD	$0.7	$0.7	$1.0	$0.7	$1.6	$0.9
SMI IMD New Adult	$5.3	$5.3	$8.6	$5.5	$13.1	$11.3
Maternal Health and Treatment Services	$0.0	$0.0	$0.0	$1.2	$3.2	$3.9
CRT	$0.0	$0.0	$0.0	$4.7	$11.5	$7.2
VT Global Rx	$3.5	$3.6	$2.6	$5.7	$12.6	$9.9
Moderate Needs	$0.7	$0.7	$0.4	$0.4	$0.9	$1.9
Supportive Housing Assistance Pilot	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Marketplace Subsidy	$5.9	$6.0	$2.1	$2.0	$4.6	$7.5
Total Expenditures	**$1,620.3**	**$1,647.0**	**$938.4**	**$951.1**	**$1,998.9**	**$2,065.2**

[3] DY20 projected expenditures are based on the per member per month projections in the June 2022 budget neutrality submission as approved by CMS.

The projected expenditures include the impact from the new programs for which the State is requesting expenditure authority under the 1115 demonstration amendment. Table 7 provides the projected expenditures for DY21 to DY23. Projected expenditures include the following program changes:

- HRSN infrastructure expenditures are based on the needs of community-based organizations, social services providers, and other community partners and will be no greater than 15% of total HRSN spending.
- HRSN community transition services reflect an increase to the total member months as a result of the State intending to expand enrollment in the Supportive Housing Assistance Pilot.
- HRSN rental assistance reflect $20 million of expenditures per DY starting with DY22.
- HRSN medical respite reflects an assumed 90-day coverage period for eligible members.
- Room and board for residential treatment reflect non-IMD-related expenditures.

Vermont believes these projections accurately reflect ongoing efforts to ensure adequate access to health coverage while also controlling health care costs statewide. Vermont will continue to work with CMS on these projections to ensure they align adequately to the approved programs and meet the goals of budget neutrality.

Table 7. Projected Expenditures

	Projected Expenditures (millions)		
	DY21	**DY22**	**DY23**
With Waiver Expenditures	**Jan - Dec 2025**	**Jan - Dec 2026**	**Jan - Dec 2027**
ABD - Non-Medicare - Adult	$209.8	$217.6	$225.7
ABD - Non-Medicare - Child	$67.4	$69.1	$70.8
ABD - Dual	$631.3	$659.8	$689.5
Non ABD - Non-Medicare - Adult	$93.9	$99.3	$105.0
Non ABD - Non-Medicare - Child	$485.4	$512.4	$540.9
Investments	$185.9	$185.9	$185.9
MDAAP	$6.6	$1.7	$0.0
Community Transition Services	$3.6	$0.0	$0.0
Hypothetical Expenditures			
New Adult	$419.1	$439.5	$460.9
SUD IMD ABD	$0.2	$0.2	$0.3
SUD IMD ABD Dual	$0.2	$0.2	$0.3
SUD IMD Non-ABD	$0.5	$0.5	$0.5
SUD IMD New Adult	$4.2	$4.4	$4.6
SMI IMD ABD	$4.0	$4.1	$4.3
SMI IMD ABD Dual	$1.0	$1.0	$1.1
SMI IMD Non-ABD	$1.0	$1.0	$1.0
SMI IMD New Adult	$11.8	$12.4	$13.0
Maternal Health and Treatment Services	$4.0	$4.1	$4.2

	Projected Expenditures (millions)		
	DY21	DY22	DY23
With Waiver Expenditures	**Jan - Dec 2025**	**Jan - Dec 2026**	**Jan - Dec 2027**
SUD CIT	$8.5	$8.9	$9.3
CRT	$7.7	$8.3	$9.0
VT Global Rx	$9.7	$9.5	$9.4
Moderate Needs	$2.1	$2.2	$2.3
Supportive Housing Assistance Pilot	$8.6	$9.0	$9.4
Marketplace Subsidy	$7.9	$8.3	$8.7
HRSN Infrastructure	$5.2	$5.2	$0.0
HRSN	$0.0	$34.3	$35.0
Room and Board for Residential Treatment	$10.1	$12.4	$15.3
Total Expenditures	**$2,189.7**	**$2,311.3**	**$2,406.3**

Section VI. Evaluation Design

Table 8 below provides new hypotheses to evaluate the amendment and its achievement of the following goals and objectives:

- Implement innovative care models across the continuum that produce value;
- Strengthen care coordination and population health management capabilities to encompass the full spectrum of health-related services and supports;
- Accelerate payment reform; and
- Address Vermonters' HRSN to improve health outcomes and promote whole-person health.

These hypotheses and plan are subject to change and will be further defined as Vermont works with CMS to develop an evaluation design consistent with the special terms and conditions and CMS policy. Evaluation of these initiatives will be added to Global Commitment evaluation design and incorporated into the full evaluation.

Table 8. Proposed New Evaluation Hypotheses

Goal/Objective	Research Question	New Hypotheses	Variables	Analytical Methods	Data Sources
Implement innovative care models across the continuum that produce value	Will the amendment result in innovative care models across the continuum that produce value?	The amendment will result in improved access to comprehensive care for individuals who have co-occurring mental health and SUDs.	Analyze the number or percentage of Medicaid enrollees receiving treatment in residential mental health and SUD treatment facilities before and after the demonstration amendment.	Pre-post analyses; qualitative analysis to inform interpretation of quantitative findings	Medicaid Management Information System (MMIS); interviews with providers and provider organizations
Strengthen care coordination and population health management capabilities to encompass the full spectrum of health-related services and supports	Will the amendment strengthen care coordination and population health management capabilities to encompass the full spectrum of health-related services and supports?	The amendment will result in more integrated care coordination. The amendment will increase Medicaid providers' ability to participate in the Vermont Health Information Exchange (VHIE).	Analyze the percentage of patients with unplanned readmissions or admissions for preventable conditions. Analyze the number of Medicaid providers connected to the VHIE before and after the demonstration amendment.	Interrupted time-series; qualitative analysis to inform interpretation of quantitative findings Pre-post analyses; qualitative analysis to inform interpretation of quantitative findings	MMIS; interviews with providers and provider organizations VHIE data; interviews with providers and provider organizations

Goal/Objective	Research Question	New Hypotheses	Variables	Analytical Methods	Data Sources
Accelerate payment reform	Will the amendment accelerate payment innovation?	The amendment will result in new value-based payments for hospitals.	Analyze the percentage of hospitals that are subject to Medicaid hospital global payments. Analyze the percentage of hospital payments that are Medicaid hospital global payments.	Descriptive analysis; pre-post analyses Descriptive analysis; pre-post analyses	Program documents and data MMIS; program documents and data
Address Vermonters' HRSN to improve health outcomes and promote whole person health	Will the amendment address Vermonter's HRSN to improve health outcomes and promote whole person health?	The amendment will result in improved health outcomes for individuals who have a history of homelessness (including people who are currently or formerly homeless) or are at-risk of homelessness.	Analyze HEDIS rates (health and well-being) for individuals receiving medical respite OR rent/temporary housing.	Interrupted time-series; comparative interrupted time series analyses; qualitative analysis to inform interpretation of quantitative findings	Program documents and data; interviews with providers and members; MMIS

Section VII. Public Notice Process

A description of the public notice process will be added after the public comment period has been closed.

Section VIII. Public Comment Summary

Public comments and the State's responses will be added after the public comment period has been closed.