State of Vermont

Agency of Human Services

Global Commitment to Health
11-W-00194/1

Section 1115(e)
Demonstration Waiver Extension Request to CMS
(1/1/2017 – 12/31/2021)

Draft for Submission by 12/31/2015

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Vermont Application Certification Statement - Section 1115(e) Five Year Extension

This document, together with Appendices A through D, constitutes Vermont's application to the Centers for Medicare & Medicaid Services (CMS) to extend its demonstration entitled, Global Commitment to Health, Project Number 11-W-00194/1, without any programmatic changes pursuant to section 1115(e) of the Social Security Act. The state is requesting CMS' approval for a 5-year extension of the demonstration subject to the same approved Special Terms and Conditions (STCs), waivers, and expenditure authorities currently in effect for the period January 30, 2015, through December 31, 2016.

CMS' expedited review and assessment of the state's request to continue the demonstration without any substantive program changes is conditioned upon the state's submission and CMS' assessment of the below items that are necessary to ensure that the demonstration is operating in accordance with the objectives of title XIX and/or title XXI as originally approved. The state's application will only be considered complete for purposes of initiating federal review and federal-level public notice when the state provides the information as requested in the below appendices.

- **Appendix A:** A historical narrative summary of the demonstration project, which includes the objectives set forth at the time the demonstration was approved, evidence of how these objectives have or have not been met, and the future goals of the program.

- **Appendix B:** Budget neutrality assessment, and projections for the projected 5-year extension period. The state will present an analysis of budget/allotment neutrality for the current demonstration approval period, including status of budget/allotment neutrality to date based on the most recent expenditure and member month data, and projected through the end of the current approval period. CMS will also review the state's Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) expenditure reports to ensure that the demonstration has not exceeded the Federal expenditure limits established for the demonstration. The state's actual expenditures incurred over the period from initial approval through the current expiration date, together with the projected costs for the requested 5-year extension period, must comply with CMS budget/allotment neutrality requirements outlined in the STCs.

- **Appendix C:** Interim evaluation of the overall impact of the demonstration that includes evaluation activities and findings to date, in addition to plans for evaluation activities over the 5-year extension period. The interim evaluation should provide CMS with a clear analysis of the state's achievement in obtaining the outcomes expected as a direct effect of the demonstration program. The state's interim evaluation must meet all of the requirements outlined in the STCs.

- **Appendix D:** Summaries of External Quality Review Organization (EQRO) reports, managed care organization and state quality assurance monitoring, and any other documentation of the quality of and access to care provided under the demonstration.

- **Appendix E:** Documentation of the state's compliance with the public notice process set forth in 42 CFR 431.408 and 431.420.

The state attests that it has abided by all provisions of the approved STCs and will continuously operate the demonstration in accordance with the requirements outlined in the STCs.

Signature:_____ **Date:**_____

Governor Peter Shumlin

Appendix A: Historical Summary of the Demonstration

Background

For more than two decades, the State of Vermont has been a national leader in making affordable health care coverage available to low-income children and adults, and providing innovative system reforms to support enrollee choice and improved outcomes. Vermont was among the first states to expand coverage for children and pregnant women, accomplished in 1989 through the implementation of the state-funded Dr. Dynasaur program, which later in 1992 became part of the state-federal Medicaid program. When the federal government introduced the Children's Health Insurance Program (CHIP) in 1997, Vermont extended coverage to uninsured and under-insured children living in households with incomes below 300% of the Federal Poverty Level (FPL). Effective January 1, 2014, Vermont incorporated the CHIP program into its Medicaid State Plan, with the upper income limit expanded to 312% FPL (the MAGI-converted income limit).

In 1995, Vermont implemented a Section 1115(a) Demonstration, the Vermont Health Access Plan (VHAP). The primary goal was to expand access to comprehensive health care coverage through enrollment in managed care for uninsured adults with household incomes below 150% (later raised to 185% of the FPL for parents and caretaker relatives with dependent children in the home). VHAP also included a prescription drug benefit for low-income Medicare beneficiaries who did not otherwise qualify for Medicaid. Both Demonstration populations paid a modest premium on a sliding scale based on household income. The VHAP waiver also included a provision recognizing a public managed care framework for the provision of services to persons who have a serious and persistent mental illness, through Vermont's Community Rehabilitation and Treatment program.

While making progress in addressing the coverage needs of the uninsured through Dr. Dynasaur and VHAP, by 2004 it became apparent that Vermont's achievements were being jeopardized by the ever-escalating cost and complexity of the Medicaid program. Recognizing that it could not spend its way out of projected deficits, Vermont worked in partnership with CMS to develop two new innovative 1115 demonstration waiver programs, Global Commitment to Health (GC) and Choices for Care (CFC). As explained in more detail below, the GC and CFC Demonstrations have enabled the state to preserve and expand the affordable coverage gains made in the prior decade, provide program flexibility to more effectively deliver and manage public resources, and improve the health care system for all Vermonters.

Effective January 30, 2015, Vermont received CMS approval to consolidate the Global Commitment and Choices for Care Demonstrations into one 1115(a) Demonstration, the current Global Commitment to Health.

According to the GC's Special Terms and Conditions (STCs), Vermont operates its managed care model in accordance with federal managed care regulations found at 42 CFR 438. The Agency of Human Services (AHS), as Vermont's Single State Medicaid Agency, is responsible for oversight of the managed care model. The Department of Vermont Health Access (DVHA) operates the Medicaid program as if it were a Managed Care Organization in accordance with federal managed care regulations. Program requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. CMS reviews the IGA annually to ensure compliance with the Medicaid managed care model and the Demonstration Special Terms and Conditions. DVHA also has sub-agreements with the other state entities that provide specialty care for GC enrollees (e.g., mental health services,

developmental disability services, and specialized child and family services). As such, since the inception of the GC Demonstration, DVHA and its IGA partners have modified operations to meet Medicaid managed care requirements, including requirements related to network adequacy, access to care, beneficiary information, grievances, quality assurance, and quality improvement. Per the External Quality Review Organization's findings (see Appendix D), DVHA and its IGA partners have achieved exemplary compliance rates in meeting Medicaid managed care requirements.

Under the current waiver structure, the State has agreed to an aggregate budget neutrality limit. In addition, total annual funding for medical assistance is limited based on an actuarially determined, per member per month limits. AHS uses prospectively derived actuarial rates for the waiver year to draw federal funds and pay DVHA a per member per month (PMPM). This capitation payment reflects the monthly need for federal funds based on estimated GC expenditures. On a quarterly basis, AHS reconciles the federal claims from the underlying GC expenditures on the CMS-64 filing. As such, Vermont's payment mechanisms function similarly to those used by state Medicaid agencies that contract with private managed care organizations to manage some or all of the Medicaid benefits.

Historical Summary

Global Commitment to Health

The Global Commitment (GC) to Health Section 1115(a) Demonstration, implemented on October 1, 2005, continued VHAP and provided flexibility with regard to the financing and delivery of health care to promote access, improve quality, and control program costs. The majority of Vermont's Medicaid program currently operates under the GC Demonstration, with the exception of Vermont's Disproportionate Share Hospital (DSH) program.

An amendment to the Global Commitment (GC) to Health Demonstration approved by CMS on October 31, 2007, allowed Vermont to implement the Catamount Health Premium Assistance Program for individuals with incomes up to 200% of the Federal Poverty Level (FPL) who enrolled in a corresponding Catamount Health Plan. Created by state statute and implemented in October 2007, the Catamount Health Plan was a commercial health insurance product, initially offered by both Blue Cross Blue Shield of Vermont and MVP Health Care, which provided comprehensive, quality health coverage for uninsured Vermonters at a reasonable cost, regardless of income. CMS approved a second amendment on December 23, 2009, that expanded federal participation for the Catamount Health Premium Assistance Program up to 300% of the FPL. Additionally, this amendment allowed for the inclusion of Vermont's supplemental pharmaceutical assistance programs in the GC Demonstration.

Renewed on January 1, 2011, the GC Demonstration was subsequently amended twice, once on December 13, 2011, to include authority for a children's palliative care program, and on June 27, 2012, to update co-pay obligations. On October 2, 2013, CMS approved the extension of the GC demonstration through December 31, 2016; the extension included sun-setting the authorities for most of the 1115 Expansion Populations since they would be eligible for Affordable Care Act Marketplace coverage beginning January 1, 2014. The renewal also added the New Adult Group to the demonstration effective January 1, 2014. Finally, the renewal included premium subsidies for individuals enrolled in a qualified health plan and whose income is at or below 300% of the FPL.

On January 30, 2015, Vermont received approval from CMS to consolidate its Global Commitment and Choices for Care 1115 Demonstrations.

Choices for Care

Vermont's Choices for Care Section 1115(a) Demonstration, implemented on October 1, 2005, and renewed through September 30, 2015, addressed consumer choice and funding equity for low-income seniors and people with disabilities by providing an entitlement to both home- and community-based services (HCBS) and nursing home care. Vermont was the first state to create such a program and the first state to commit to a global cap ($1.2 billion over five years) on federal financing for long-term care services.

Vermont's overarching goal for Choices for Care is to support individual choice, thus improving access to HCBS. In supporting more people in their own homes and communities, Vermont has sought to increase the range and capacity of HCBS.

As stated above, on January 30, 2015, Vermont received approval from CMS to consolidate its Global Commitment and Choices for Care 1115 Demonstrations.

Global Commitment to Health Demonstration Objectives

Vermont's goal in implementing the Demonstration is to improve the health status of all Vermonters by:

- Increasing access to affordable and high-quality health care;
- Improving access to primary care;
- Improving the health care delivery for individuals with chronic care needs;
- Containing health care costs; and
- Allowing beneficiaries a choice in long-term services and supports and providing an array of home- and community-based alternatives recognized to be more cost effective than institutional-based supports.

The state employs five major elements in achieving the above goals:

1. *Program Flexibility:* Vermont has the flexibility to invest in alternative services and programs designed to achieve the Demonstration's objectives (including the Marketplace subsidy program);
2. *Managed Care Delivery System:* Under the Demonstration AHS entered into an agreement with the Department of Vermont Health Access (DVHA), which operates using a managed care model;
3. *Removal of Institutional Bias:* Under the Demonstration, Vermont provides a choice of settings for delivery of services and supports to older adults, people with serious and persistent mental illness, people with physical disabilities, people with developmental disabilities, and people with traumatic brain injuries who meet program eligibility and level-of-care requirements.
4. *Aggregate Budget Neutrality Cap:* Vermont is at risk for the caseload and the per capita program expenditures, as well as certain administrative costs for all Demonstration populations. Effective January 1, 2014, the new adult group is not included in the total computable aggregate cap, but is subject to a separate per member per month (PMPM) budget neutrality limit; and
5. *Marketplace Subsidy Program:* To the extent it is consistent with Vermont's aggregate budget neutrality cap, effective January 1, 2014, Federal Financial Participation (FFP) is available for

state funds for a Designated State Health Program (DSHP) to provide a premium Marketplace subsidy program to individuals up to and including 300% of the FPL who purchase health care coverage in the Marketplace.

Each of the Demonstration goals has specific, measurable, achievable, realistic, and timed objectives that will assess and directly influence changes in access, cost, and quality during the life of the Demonstration.

Evidence of How the Goals Have Been Met

Vermont has proven the Demonstration to be a success. With the flexibility granted under the public managed care model, Vermont has achieved the Demonstration's goals and will continue to use innovative approaches to improve the health care delivery system and enhance positive health outcomes. A summary of Vermont's success in achieving the goals of the Demonstration is provided below.

Goal # 1: Increasing Access to Affordable and High-Quality Care, with an Emphasis on Increasing Access to Primary Care

The GC Demonstration has succeeded in increasing access to care for Vermont Medicaid beneficiaries as measured in the following areas:

- *Overall Enrollment:* Total enrollment grew by almost 36% between 2005 and 2014.

- *Number of Uninsured:* The 2014 Vermont Household Health Insurance Survey found that Vermont's uninsured rate was reduced by 46% from the 2012 uninsured rate. The 3.7% rate in 2014 put Vermont second in the nation in health insurance coverage. By November 1 of 2014, over 140,000 Vermonters had received coverage through Vermont Health Connect, including 32,237 enrolled in Qualified Health Plans.

- *HEDIS Measures:* Vermont demonstrated improvement in HEDIS access-to-care measures and in scores achieved by accredited Medicaid HMOs as reported in the NCQA 2014 *State of Health Care Quality Report.* Vermont achieved:

    - Significantly higher (14%) than the accredited Medicaid HMO average of 61.6% for the measure for Well Child Visits in the First 15 Months of Life;
    - High performance for the measure for Child and Adolescent Access to Primary Care Physician (PCP), with scores ranging from 93.9% to 98.6% across the childhood years; and
    - High scores related to the measure for Adult Access to Preventive and Ambulatory Care, 84.21% to 94.31% across the adult years.

- *Beneficiary Satisfaction:* According to the 2014 CAHPS, most respondents are getting needed care (86%), getting care quickly (83%), are satisfied with how doctors communicate (88%), and are satisfied with how care is coordinated (80%).

- *Access to Medicaid Assistance Treatment (MAT) for Opioid-Dependence:* AHS is collaborating with community partners to increase access to MAT for patients through the use of a Specialized Health Home program. CMS approved Specialized Health Home State Plan Amendments for

Vermont's Integrated Treatment for Opioid Dependence's "Hub and Spoke" Initiative in January and March of 2014. The initiative includes regional treatment centers (i.e., Hubs) along with community support (i.e., Spokes) integrated with the Blueprint for Health model and office-based practices statewide. The "Hubs," which began operations in late CY13, had caseloads of 2,542 statewide as of September 2014. Specialized statewide staff are also in more than 50 different practice settings, including OB-GYN, psychiatry, pain, and primary care specialties.

- *Access to Mental Health Treatment:* The abrupt closure of Vermont's only state-run psychiatric hospital, due to flooding from Tropical Storm Irene in 2011, resulted in significant legislative investments in the community mental health system. Vermont has continued to enhance the mental health system to reduce its reliance on institutional care. Small-scale psychiatric centers, enhanced mobile crisis teams, peer-run recovery options, and hospital diversion programs have been supported as the Department of Mental Health continues to promote a more person-centered, flexible, and community-based system of care.

Goal #2: Enhance Quality of Care and improve Health Care Delivery for Individuals with Chronic Care Needs

The GC Demonstration has succeeded in enhancing the quality of care for Vermont Medicaid beneficiaries; examples include:

- *Compliance with required Managed Care quality-of-care standards identified by AHS*: DVHA has consistently improved its compliance, scoring 100% compliant with all CMS measurement and improvement standards in 2014.
- *Performance Improvement Project (PIP):* In 2014 DVHA' s new PIP, *Follow-up after Hospitalization for Mental Illness,* received a score of 100% for all applicable evaluation elements scored as *Met*, a score of 100% for critical evaluation elements scored as *Met*, and an overall validation status of *Met.*
- *Vermont Chronic Care Initiative (VCCI):* The goal of the VCCI is to improve health outcomes for Medicaid beneficiaries by addressing the increasing prevalence of chronic illness. VCCI has made improvements in health outcomes for Vermont's highest-risk Medicaid beneficiaries. SFY13 utilization change offers further evidence of this strategy with documented reduction of Acute Ambulatory Care Sensitive Conditions inpatient admissions by 37%, 30-day hospital readmission rates by 34%, and an ED utilization decline of 15% for eligible VCCI members in the top 5% utilization category.

- *Blueprint for Health:* Medicaid is an active partner in Vermont's Blueprint for Health, described in Vermont statute as "*a program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management"* (18 VSA Chapter 13).

  In 2014 Blueprint participants had lower hospitalization rates and lower expenditures on pharmacy and specialty care. In spite of lower expenditures, the results for measures of effective and preventive care for Blueprint participants were either better for participants or similar for both Blueprint and comparison groups (cervical cancer screening, breast cancer

screening, imaging studies for low back pain, and five Special Medicaid Services (SMS), such as transportation, residential treatment, dental, and home and community based services).

- *Integrating Family Services Program (IFS):* Vermont has worked to integrate a variety of separate and discreet children and family services funded under the Medicaid program. Using a bundled payment approach to provider reimbursement, several disparate Medicaid programs were unified in a single payment model with clear provider expectations for treatment. In FFY14, the one AHS district with a fully implemented IFS program showed positive outcomes for clients and more efficient service delivery with the same level of funding providers received in previous years. In addition, there was a nearly 50% decrease in crisis interventions needed for children, since the community now has the flexibility to provide supports and services earlier than they were able to under the traditional fee-for-service model.

Goal #3: Contain Cost of Care

The GC Demonstration has contained spending relative to the absence of the Demonstration while adding significant quality and value to the health care system. The effectiveness of the GC cost containment efforts can be summarized as follows:

- *Decreased Expenditures:* The Demonstration generated a surplus associated with overall decreased expenditures relative to the aggregate budget neutrality limit (ABNL). Actual expenditures have been consistently below projected and the Demonstration surplus is projected to be $994 million at the end 2016.
- *VCCI Savings:* In state fiscal year (SFY) 2013, the Vermont Chronic Care Initiative (VCCI) documented net savings of $23.5 million over anticipated expense among the top 5% of eligible Medicaid members (high utilizers).
- *Blueprint for Health Savings:* Year-to-year growth in health care expenditures was lower for Blueprint participants, particularly from 2011 forward as more of the 126 practices underwent preparation, scoring, and began working with community health teams.

Goal #4: Allowing Beneficiaries a Choice in Long-Term Services and Supports and Providing an Array of Home- and Community-Based Alternatives Recognized to be more Cost-Effective than Institutional-Based Supports

- *Participation:* SFY2014 participation in Choices for Care increased 6.5% from the previous year.

- *Balance of Settings:* As of October 2014, approximately 52% of people enrolled in Choices for Care's Highest/High Needs groups were served in a home- or community-based setting, while 48% were served in a nursing facility.

- *No Waiting List:* In September 2005, 241 people were on waiting lists for high- and highest-needs home- and community-based services; at the end of SFY2014, the number was 0.

- *Controlled Cost:* In recent years Choices for Care spending has been under State appropriations. This has provided program stability, as well as created opportunities for the State to support

quality improvements as directive by the legislature. In SFY2014 Choices for Care expenditures were $5.6 million (3%) less than legislative appropriations.

The GC Demonstration has allowed Vermont to use any excess in the PMPM limit to support additional investments, provided that DVHA meets its contractual obligation to the populations covered under the Demonstration. These expenditures must meet one or more of the following four conditions:

1) Reduce the rate of uninsured and or underinsured in Vermont;
2) Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
3) Provide public health approaches and other innovative programs to improve the health outcomes, health status, and quality of life for uninsured, underinsured, and Medicaid beneficiaries in Vermont; or
4) Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

Examples of services supported through this mechanism include access to necessary substance abuse treatment services for uninsured and underinsured Vermonters; tuition support for health professionals in short supply in Vermont, such as nurses, primary care physicians, and dentists; support for Blueprint for Health provider practice transformation; healthy activity and prevention programs; and support for development of standards and training for medical emergency care.

Future Goals

Vermont remains at the forefront of state-based health care reform. Future goals envision the creation of an all-payer model of care. All-Payer efforts include the continued alignment of the Global Commitment (GC) to Health Section 1115 Demonstration and current State Innovation Model (SIM) work with the State's pursuit of related Medicare waivers. These efforts aim to increase value-based payments, accelerate payment reform, and put total health care spending on a more sustainable trajectory. Within the overall health reform framework, Vermont's Medicaid goal is to maintain the public managed care model to ensure maximum ability to serve Vermont's most vulnerable and lower-income residents while moving towards broader state and federal health care reform goals.

Act 48 of 2011, Vermont's landmark health care reform law, created the Green Mountain Care Board. The GMCB is an independent regulatory board charged with ensuring that changes in the health system improve quality while stabilizing costs. The Legislature assigned the GMCB three main health care responsibilities: regulation, innovation, and evaluation. The GMCB regulates health insurance rates, approves benefit plans for the Vermont Health Connect Benefit Marketplace, sets hospital budgets, and issues certificates of need for major hospital expenditures. The Board is the locus of payment and delivery system reform and a co-signatory of Vermont's SIM grant. Additionally, the GMCB acts as an important convener of the stakeholder community. Beyond these responsibilities, the Green Mountain Care Board is empowered by statute to:

- **Improve** the health of Vermonters;
- **Reduce** the rate of growth of Vermont's health care costs;
- **Enhance** the quality of care and experience of patients and providers;

- **Recruit** high-quality health care professionals to practice in Vermont; and
- **Simplify** and streamline administrative and claims processes to reduce overhead and enhance efficiency.

The GMCB is also charged with exploring the potential implementation of an All-Payer Model. Currently, the GMCB and the State are negotiating with CMMI regarding Medicare waivers to enable an All-Payer Model, including researching feasibility, developing analytics, and obtaining information to support APM negotiating team decision-making as needed to complete term sheet and waiver terms and conditions. SIM investments are contributing to analytics related to the all-payer model implementation design for the state, payers, and providers. These SIM investments are helping Vermont prepare for future success with both the GC Demonstration and the All-Payer Model.

Within an All-Payer Model, and through the GC Waiver, Vermont's goals are to move away from volume-based payments toward a payment system that reinforces efforts to improve the health of Vermonters, improve quality of care, and contain the rate of growth in health care costs. Vermont is testing systems on a pilot basis with willing providers and across all payers, including Medicaid and Medicare. The pilots will be evaluated to judge their applicability to broader populations of health professionals and patients.

One such pilot includes the Vermont Shared Savings Programs. In this effort, participating insurers and Medicaid collaborate with Vermont's Patient Centered Medical Home Project, the Blueprint for Health and with Vermont's Health Care Improvement Project to support Vermont's three Accountable Care Organizations (ACOs). More than 150,000 Vermonters were attributed to Commercial, Medicaid, or Medicare Shared Savings Program participating providers in 2014. GC Demonstration enrollees represent approximately one quarter of the pilot's beneficiaries.

The implementation of Shared Savings Programs, the collaboration between the Blueprint and the ACOs, and findings of other GMCB studies all set the stage for an all-payer system of payments to providers. Additionally, many of these pilots strengthen primary care and better integrate mental health and substance abuse treatment into the health care system as a whole. These programs give Vermont confidence that the alignment of federal waivers and an All-Payer Model will succeed. As progress continues, Vermont will maintain its longstanding commitment to maintain an open, transparent, stakeholder-driven process of health care reform and constant evaluation of whether and how Vermont is meeting its goals.

The GC Demonstration has served as a foundational tool in Vermont's health reform model. The current GC construct provides the flexibility to improve access to health coverage and care based on individual and family needs. Specifically, the Section 1115 Demonstration efforts and the public managed care model have supported:

- Increasing access to affordable and high-quality health care;
- Improving access to primary care;
- Improving the health care delivery for individuals with chronic care needs;
- Containing health care costs through payment reform and other activities; and
- Allowing beneficiaries a choice in where they receive long term services and supports.

It is crucial to maintain these foundations of health care delivery for Vermont's most vulnerable and lower-income citizens while aligning our shared federal and state priorities.

Appendix B: Budget Neutrality Assessment and Projections

Vermont's actual and projected expenditures and enrollment under the Demonstration are presented in a series of tables[1], as follows:

Table 1: Projected Expenditures without Waiver, Years 1 – 5
Table 2: Actual Caseloads with Waiver, Years 1 – 5
Table 3: Actual Expenditures per Member per Month, Years 1 – 5
Table 4: Actual Expenditures, Years 1 - 5
Table 5: Summary of Program Expenditures with and without Waiver, Years 1 - 5
Table 6: Projected Expenditures without Waiver, Years 6 - 11
Table 7: Actual and Projected Caseloads with Waiver, Years 6 - 11
Table 8: Actual and Projected Expenditures per Member per Month, Years 6 - 11
Table 9: Actual and Projected Expenditures, Years 6 - 11
Table 10: Summary of Program Expenditures with and Without Waiver, Years 6 - 11
Table 11: Projected Expenditures without Waiver, Years 12 - 16
Table 12: Projected Caseloads with Waiver, Years 12 - 16
Table 13: Projected Expenditures per Member per Month, Years 12 - 16
Table 14: Projected Expenditures, Years 12 -16
Table 15: Summary of Program Expenditures with and without Waiver, Years 12 -16

Tables 1 through 5 provide a summary of the expenditures and enrollment for the initial Demonstration period, from October 2005 through September 2010. Table 1 provides the projected expenditures absent the Demonstration, which represents the aggregate budget neutrality limit for the first five years of the Demonstration. The annual budget neutrality limits are included in the approved Special Terms and Conditions for the Demonstration (STCs). Tables 2 through 4 provide a summary of Vermont's actual enrollment and expenditures under the Demonstration. Table 5 provides a summary comparison of the budget neutrality limit and actual program expenditures under the Demonstration.

Tables 6 through 10 provide a summary of actual and projected expenditures and enrollment for Years 6 through 11 (October 2010 through December 2016). Table 6 presents the projected expenditures absent the Demonstration and reflects the annual budget neutrality limits as approved in the STCs. Tables 7 through 9 provide actual and estimated expenditures and enrollment through end of the approved Demonstration period (December 2016). Table 10 provides a summary of Vermont's projected expenditures relative to the budget neutrality limit over the life of the Demonstration. Beginning in Calendar Year 2014, a separate budget neutrality limit was established for medical expenditures on behalf of the New Adult Group; these expenditures are tracked separately and are not included in the aggregate budget neutrality ceiling. Expenditure and caseload information related to the New Adult Group is included in the tables.

Tables 11 through 15 present the projected expenditures and enrollment absent the Demonstration and under the Demonstration for a five-year extension period from January 2017 through December 2021. The projected budget neutrality limit presented in Table 11 reflects the trend rates and methodology that were used to develop the budget neutrality limit under which the Demonstration currently operates.

[1] Estimates to be Finalized Prior to CMS Submission.

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Table 1: Projected Expenditures Without Waiver, Years 1 - 5 (State and Federal)

	Waiver Year					Five-Year Total
	1 (Oct '05-Sept '06)	2 (Oct '06-Sept'07)	3 (Oct '07-Sept '08)	4 (Oct '08-Sept '09)	5 (Oct '09-Sept '10)	
Continuation of VHAP MEGs						
ANFC	$ 162,865,374	$ 180,391,545	$ 199,803,732	$ 221,304,891	$ 245,119,820	$ 1,009,485,362
ABD	$ 92,181,185	$ 98,000,805	$ 104,187,831	$ 110,765,458	$ 117,758,348	$ 522,893,626
Spend Down	$ 1,832,177	$ 1,947,847	$ 2,070,819	$ 2,201,555	$ 2,340,544	$ 10,392,943
Optional Expansion: Parent/Caretakers [1931(b) < 150% of FPL]	$ 32,343,864	$ 37,315,155	$ 43,050,539	$ 49,667,459	$ 57,301,407	$ 219,678,423
Optional Expansion: Parent/Caretakers [1931(b) 150 - 185% of FPL]	$ 7,779,307	$ 8,974,996	$ 10,354,463	$ 11,945,957	$ 13,782,065	$ 52,836,787
Optional Expansion: Children [1902(r)(2)]	$ 1,747,191	$ 1,938,773	$ 2,151,361	$ 2,387,261	$ 2,649,027	$ 10,873,612
Community Rehbabilitation and Treatment (CRT)	$ 29,345,283	$ 31,197,922	$ 33,167,521	$ 35,261,467	$ 37,487,608	$ 166,459,800
Community Rehbabilitation and Treatment (CRT) Duals	$ 138,411	$ 147,150	$ 156,440	$ 166,316	$ 176,816	$ 785,132
VHAP Surplus Carry-Forward	$ 66,605,297	$ -	$ -	$ -	$ -	$ 66,605,297
Subtotal	*$ 394,838,090*	*$ 359,914,191*	*$ 394,942,706*	*$ 433,700,363*	*$ 476,615,633*	*$ 2,060,010,982*
Additional Program Expenses Not Included Under VHAP	$ 372,800,747	$ 406,518,502	$ 443,439,549	$ 483,873,610	$ 528,160,809	$ 2,234,793,218
Program Administration	$ 73,627,826	$ 77,161,961	$ 80,865,735	$ 84,747,291	$ 88,815,161	$ 405,217,974
Total	**$ 841,266,663**	**$ 843,594,654**	**$ 919,247,991**	**$ 1,002,321,263**	**$ 1,093,591,603**	**$ 4,700,022,174**

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Table 2: Actual Caseloads with Waiver, Years 1 - 5

	Waiver Year				
	1 (Oct '05-Sept '06)	2 (Oct '06-Sept'07)	3 (Oct '07-Sept '08)	4 (Oct '08-Sept '09)	5 (Oct '09-Sept '10)
ABD - Non-Medicare - Adult	180,954	182,711	143,469	153,096	161,974
ABD - Non-Medicare - Child	34,211	41,425	42,058	43,588	44,059
ABD - Dual	167,349	159,373	171,634	178,974	185,693
ANFC - Non-Medicare - Adult	125,441	111,976	112,489	120,450	126,544
ANFC - Non-Medicare - Child	612,860	609,295	611,127	634,843	655,412
Global Expansion (VHAP)	266,886	271,659	307,567	353,286	411,864
Global Rx	145,269	137,079	120,823	119,626	143,768
Optional Expansion (Underinsured)	14,875	13,886	14,005	14,253	14,348
VHAP ESI	-	-	5,365	10,659	11,270
ESIA	-	-	1,476	4,406	5,571
CHAP	-	-	21,278	62,457	82,765
ESIA Expansion - 200-300% of FPL	-	-	-	-	2,172
CHAP Expansion - 200-300% of FPL	-	-	-	-	23,541
Total	**1,547,845**	**1,527,404**	**1,551,291**	**1,695,638**	**1,868,981**

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Table 3: Actual Expenditures per Member per Month, Years 1 - 5 (State and Federal)

	Waiver Year				
	1 (Oct '05-Sept '06)	2 (Oct '06-Sept'07)	3 (Oct '07-Sept '08)	4 (Oct '08-Sept '09)	5 (Oct '09-Sept '10)
ABD - Non-Medicare - Adult	$ 1,125.37	$ 1,187.30	$ 1,324.11	$ 1,099.65	$ 1,106.66
ABD - Non-Medicare - Child	$ 1,780.10	$ 2,095.44	$ 2,343.40	$ 2,155.76	$ 2,152.63
ABD - Dual	$ 1,056.96	$ 851.74	$ 908.38	$ 1,270.88	$ 1,180.64
ANFC - Non-Medicare - Adult	$ 494.60	$ 501.49	$ 566.02	$ 502.58	$ 573.63
ANFC - Non-Medicare - Child	$ 301.09	$ 319.18	$ 354.39	$ 349.31	$ 364.72
Global Expansion (VHAP)	$ 343.40	$ 431.59	$ 488.96	$ 405.25	$ 413.76
Global Rx	$ 63.15	$ 3.74	$ 3.94	$ 15.97	$ 9.97
Optional Expansion (Underinsured)	$ 151.69	$ 190.84	$ 211.38	$ 177.70	$ 173.46
VHAP ESI	$ -	$ -	$ 234.15	$ 192.90	$ 224.80
ESIA	$ -	$ -	$ 178.38	$ 141.86	$ 177.43
CHAP	$ -	$ -	$ 407.94	$ 373.99	$ 427.96
ESIA Expansion - 200-300% of FPL	$ -	$ -	$ -	$ -	$ 176.87
CHAP Expansion - 200-300% of FPL	$ -	$ -	$ -	$ -	$ 432.52
Total	**$ 511.08**	**$ 530.65**	**$ 572.88**	**$ 557.74**	**$ 550.46**

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Table 4: Actual Expenditures, Years 1 - 5 (State and Federal)

	Waiver Year					Five-Year Total
	1 (Oct '05-Sept '06)	2 (Oct '06-Sept'07)	3 (Oct '07-Sept '08)	4 (Oct '08-Sept '09)	5 (Oct '09-Sept '10)	
Capitation Payments						
ABD - Non-Medicare - Adult	$ 203,640,203	$ 216,932,770	$ 189,968,738	$ 168,352,016	$ 179,249,891	$ 958,143,618
ABD - Non-Medicare - Child	$ 60,899,001	$ 86,803,602	$ 98,558,717	$ 93,965,267	$ 94,842,614	$ 435,069,201
ABD - Dual	$ 176,881,327	$ 135,744,359	$ 155,908,893	$ 227,454,477	$ 219,236,518	$ 915,225,575
ANFC - Non-Medicare - Adult	$ 62,043,119	$ 56,154,844	$ 63,671,024	$ 60,535,761	$ 72,589,220	$ 314,993,967
ANFC - Non-Medicare - Child	$ 184,526,017	$ 194,474,778	$ 216,577,298	$ 221,757,008	$ 239,043,470	$ 1,056,378,571
Global Expansion (VHAP)	$ 91,648,652	$ 117,245,308	$ 150,387,960	$ 143,169,152	$ 170,413,126	$ 672,864,198
Global Rx	$ 9,173,970	$ 512,594	$ 475,763	$ 1,911,020	$ 1,433,935	$ 13,507,282
Optional Expansion (Underinsured)	$ 2,256,389	$ 2,650,004	$ 2,960,377	$ 2,532,758	$ 2,488,843	$ 12,888,371
VHAP ESI	$ -	$ -	$ 1,256,215	$ 2,056,121	$ 2,533,498	$ 5,845,833
ESIA	$ -	$ -	$ 263,289	$ 625,035	$ 988,443	$ 1,876,767
CHAP	$ -	$ -	$ 8,680,147	$ 23,358,293	$ 35,420,469	$ 67,458,909
ESIA Expansion - 200-300% of FPL	$ -	$ -	$ -	$ -	$ 384,158	$ 384,158
CHAP Expansion - 200-300% of FPL	$ -	$ -	$ -	$ -	$ 10,181,948	$ 10,181,948
Subtotal Capitation Payments	*$ 791,068,678*	*$ 810,518,260*	*$ 888,708,420*	*$ 945,716,909*	*$ 1,028,806,133*	$ 4,464,818,400
Premium Offsets	$ (8,908,833)	$ (7,633,900)	$ (7,210,870)	$ (10,603,732)	$ (15,815,296)	$ (50,172,631)
Administrative Expenses Outside of Managed Care Model	$ 4,620,302	$ 6,464,439	$ 6,457,896	$ 5,495,618	$ 5,949,605	$ 28,987,860
Total	**$ 786,780,147**	**$ 809,348,799**	**$ 887,955,446**	**$ 940,608,795**	**$ 1,018,940,442**	**$ 4,443,633,629**

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Table 5: Summary of Program Expenditures With and Without Waiver, Years 1 - 5 (State and Federal)

	Waiver Year					Five-Year Total
	1 (Oct '05-Sept '06)	2 (Oct '06-Sept'07)	3 (Oct '07-Sept '08)	4 (Oct '08-Sept '09)	5 (Oct '09-Sept '10)	
Expenditures without Waiver (Aggregate Budget Neutrality Limit)	**$ 841,266,663**	**$ 843,594,654**	**$ 919,247,991**	**$ 1,002,321,263**	**$ 1,093,591,603**	**$ 4,700,022,174**
Expenditures with Waiver						
Capitation Payments	$ 791,068,678	$ 810,518,260	$ 888,708,420	$ 945,716,909	$ 1,028,806,133	$ 4,464,818,400
Premium Offsets	$ (8,908,833)	$ (7,633,900)	$ (7,210,870)	$ (10,603,732)	$ (15,815,296)	$ (50,172,631)
Admin. Expenses Outside Managed Care Model	$ 4,620,302	$ 6,464,439	$ 6,457,896	$ 5,495,618	$ 5,949,605	$ 28,987,860
Total	**$ 786,780,147**	**$ 809,348,799**	**$ 887,955,446**	**$ 940,608,795**	**$ 1,018,940,442**	**$ 4,443,633,629**
Annual Surplus (Deficit)	**$ 54,486,516**	**$ 34,245,856**	**$ 31,292,544**	**$ 61,712,468**	**$ 74,651,161**	**$ 256,388,545**
Cumulative Surplus (Deficit)	**$ 54,486,516**	**$ 88,732,372**	**$ 120,024,916**	**$ 181,737,384**	**$ 256,388,545**	**$ 256,388,545**

Table 6: Projected Expenditures Without Waiver, Years 6 Through 11 (State and Federal)

	Waiver Year							Total
	6 (Oct '10-Sept '11)	7 (Oct '11-Sept'12)	8 (Oct '12-Sept '13)	9a (Oct '13-Dec '13)	9b (Jan '14-Dec '14)	10 (est.) (Jan '15-Dec '15)	11 (est.) (Jan '16-Dec '16)	Oct '10 - Dec '16
Continuation of VHAP MEGs								
ANFC	$ 263,358,696	$ 286,864,302	$ 312,467,859	$ 119,576,169	$ 341,704,747	$ 363,900,356	$ 387,537,692	$ 2,075,409,820
ABD	$ 126,696,206	$ 134,694,842	$ 143,198,450	$ 53,760,496	$ 155,072,171	$ 428,178,047	$ 456,405,036	$ 1,498,005,248
Spend Down	$ 2,534,821	$ 2,694,851	$ 2,864,983	$ 1,075,591	$ 3,102,542	$ 3,306,694	$ 3,524,281	$ 19,103,763
Optional Expansion: Parent/Caretakers [1931(b) < 150% of FPL]	$ 61,507,444	$ 69,848,352	$ 79,320,354	$ 31,268,586	$ -	$ -	$ -	$ 241,944,737
Optional Expansion: Parent/Caretakers [1931(b) 150 - 185% of FPL]	$ 14,793,696	$ 16,799,841	$ 19,078,035	$ 7,520,682	$ -	$ -	$ -	$ 58,192,253
Optional Expansion: Children [1902(r)(2)]	$ 2,848,800	$ 3,105,970	$ 3,386,356	$ 1,296,821	$ -	$ -	$ -	$ 10,637,947
Community Rehbabilitation and Treatment (CRT)	$ 40,332,917	$ 42,879,231	$ 45,586,300	$ 17,114,306	$ 49,366,222	$ 52,614,606	$ 56,076,741	$ 303,970,322
Community Rehbabilitation and Treatment (CRT) Duals	$ 190,236	$ 202,246	$ 215,015	$ 80,722	$ 232,843	$ 248,165	$ 264,494	$ 1,433,721
Subtotal	*$ 512,262,817*	*$ 557,089,634*	*$ 606,117,352*	*$ 231,693,373*	*$ 549,478,524*	*$ 848,247,868*	*$ 903,808,244*	*$1,907,163,176*
Additional Program Expenses Not Included Under VHAP	$ 559,850,458	$ 593,441,485	$ 629,047,974	$ 235,588,296	$ 676,575,239	$ 717,169,754	$ 760,199,939	$ 4,171,873,145
Program Administration	$ 93,078,288	$ 97,546,046	$ 102,228,256	$ 37,920,643	$ 108,398,321	$ 113,601,441	$ 119,054,310	$ 671,827,307
Waiver Surplus (Deficit) Carry-Forward	$ 256,388,545	$ -	$ -	$ -	$ -	$ -	$ -	$ 256,388,545
Total	*$ 1,421,580,108*	*$ 1,248,077,166*	*$ 1,337,393,583*	*$ 505,202,312*	*$ 1,334,452,085*	*$ 1,679,019,063*	*$ 1,783,062,493*	*$ 9,308,786,808*
Supplemental Test: New Adult						*$ 262,901,853*	*$ 280,253,375*	*$ 543,155,227*
Budget Neutrality Limit, Net of Supplemental Test (eff. CY15)	**$ 1,421,580,108**	**$ 1,248,077,166**	**$ 1,337,393,583**	**$ 505,202,312**	**$ 1,334,452,085**	**$ 1,416,117,210**	**$ 1,502,809,118**	**$ 8,765,631,581**

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Table 7: Actual and Projected Caseloads with Waiver, Years 6 Through 11

	Waiver Year							Annual Growth Oct '10 - Dec '13
	6 (Oct '10-Sept '11)	7 (Oct '11-Sept'12)	8 (Oct '12-Sept '13)	9a (Oct '13-Dec '13)	9b (Jan '14-Dec '14)	10 (est.) (Jan '15-Dec '15)	11 (est.) (Jan '16-Dec '16)	
ABD - Non-Medicare - Adult	166,049	168,306	171,716	43,359	193,529	197,309	201,163	1.95%
ABD - Non-Medicare - Child	44,349	44,619	44,203	10,815	44,778	45,226	45,678	-1.10%
ABD - Dual	193,983	202,000	205,960	52,041	212,732	219,509	226,501	3.19%
ANFC - Non-Medicare - Adult	131,746	136,075	135,532	33,133	187,670	191,423	195,252	0.26%
ANFC - Non-Medicare - Child	661,211	664,341	663,820	165,296	706,727	727,929	749,767	0.00%
Global Expansion (VHAP)	444,056	444,652	449,364	109,808	10,150	-	-	-0.48%
Global Rx	151,971	151,240	151,759	38,096	148,291	148,470	148,649	0.12%
Optional Expansion (Underinsured)	13,360	12,606	11,397	2,615	11,759	-	-	-10.31%
VHAP ESI	10,554	9,870	9,318	2,171	940	-	-	-8.30%
ESIA	5,952	5,609	5,961	1,381	1,831	-	-	-3.26%
CHAP	86,965	92,725	101,961	28,516	22,553	-	-	12.81%
ESIA Expansion - 200-300% of FPL	3,171	2,898	2,991	765	-	-	-	-1.57%
CHAP Expansion - 200-300% of FPL	34,078	38,467	40,104	11,450	-	-	-	14.04%
Total	**1,947,445**	**1,973,408**	**1,994,086**	**499,446**	**1,540,960**	**1,529,866**	**1,567,010**	**1.14%**

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Table 8: Actual and Projected Expenditures per Member per Month with Waiver, Years 6 Through 11 (State and Federal)

	Waiver Year							Annual Growth Oct '10 - Dec '13
	6 (Oct '10-Sept '11)	7 (Oct '11-Sept'12)	8 (Oct '12-Sept '13)	9a (Oct '13-Dec '13)	9b (Jan '14-Dec '14)	10 (est.) (Jan '15-Dec '15)	11 (est.) (Jan '16-Dec '16)	
ABD - Non-Medicare - Adult	$ 1,063.14	$ 1,167.43	$ 1,236.30	$ 1,255.98	$ 1,282.17	$ 1,365.62	$ 1,446.62	7.69%
ABD - Non-Medicare - Child	$ 2,218.64	$ 2,330.19	$ 2,281.04	$ 2,530.69	$ 2,785.04	$ 2,994.31	$ 3,201.83	6.02%
ABD - Dual	$ 1,151.67	$ 1,164.80	$ 1,226.49	$ 1,290.35	$ 1,438.30	$ 2,478.75	$ 2,594.40	5.18%
ANFC - Non-Medicare - Adult	$ 580.55	$ 633.24	$ 687.47	$ 740.71	$ 595.86	$ 634.35	$ 671.67	11.44%
ANFC - Non-Medicare - Child	$ 357.34	$ 388.40	$ 400.61	$ 425.41	$ 453.37	$ 477.97	$ 501.17	8.06%
Global Expansion (VHAP)	$ 406.08	$ 441.33	$ 462.38	$ 492.27	$ 536.24	$ -	$ -	8.93%
Global Rx	$ 51.33	$ 64.81	$ 70.07	$ 69.78	$ 79.98	$ 91.68	$ 105.08	14.62%
Optional Expansion (Underinsured)	$ 176.14	$ 201.69	$ 202.26	$ 212.97	$ -	$ -	$ -	8.81%
VHAP ESI	$ 181.73	$ 168.20	$ 127.63	$ 179.31	$ -	$ -	$ -	-0.59%
ESIA	$ 144.81	$ 150.50	$ 131.77	$ 135.71	$ -	$ -	$ -	-2.84%
CHAP	$ 462.38	$ 441.60	$ 450.78	$ 530.76	$ -	$ -	$ -	6.32%
ESIA Expansion - 200-300% of FPL	$ 94.27	$ 80.96	$ 40.06	$ 85.93	$ -	$ -	$ -	-4.03%
CHAP Expansion - 200-300% of FPL	$ 536.32	$ 527.40	$ 644.49	$ 648.23	$ -	$ -	$ -	8.79%
Total	**$ 539.89**	**$ 577.82**	**$ 604.86**	**$ 642.99**	**$ 722.69**	**$ 922.92**	**$ 974.02**	**8.08%**
Supplemental Test: New Adult					*$ 360.40*	*$ 404.77*	*$ 423.17*	

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Table 9: Actual and Projected Expenditures with Waiver, Years 6 Through11 (State and Federal)

	Waiver Year							Total
	6 (Oct '10-Sept '11)	7 (Oct '11-Sept'12)	8 (Oct '12-Sept '13)	9a (Oct '13-Dec '13)	9b (Jan '14-Dec '14)	10 (est.) (Jan '15-Dec '15)	11 (est.) (Jan '16-Dec '16)	Oct '10 - Dec '16
Capitation Payments								
ABD - Non-Medicare - Adult	$ 176,533,340.07	$ 196,485,337	$ 212,291,903	$ 54,457,994	$ 248,137,034.05	$ 269,450,031.54	$ 291,006,034.06	$ 1,448,361,673
ABD - Non-Medicare - Child	$ 98,394,380	$ 103,970,781	$ 100,828,815	$ 27,369,420	$ 124,708,354.98	$ 135,419,810.72	$ 146,253,395.57	$ 736,944,958
ABD - Dual	$ 223,405,044	$ 235,290,439	$ 252,607,145	$ 67,151,116	$ 305,973,058.95	$ 544,106,199.85	$ 587,634,695.84	$ 2,216,167,698
ANFC - Non-Medicare - Adult	$ 76,485,531	$ 86,167,567	$ 93,174,370	$ 24,541,959	$ 111,825,070.71	$ 121,429,954.81	$ 131,144,351.19	$ 644,768,804
ANFC - Non-Medicare - Child	$ 236,275,482	$ 258,028,089	$ 265,930,690	$ 70,319,232	$ 320,408,530.40	$ 347,929,074.55	$ 375,763,400.52	$ 1,874,654,498
Global Expansion (VHAP)	$ 180,323,101	$ 196,237,736	$ 207,777,299	$ 54,055,470	$ 5,442,816.10	$ -	$ -	$ 643,836,422
Global Rx	$ 7,800,691	$ 9,801,310	$ 10,633,937	$ 2,658,330	$ 11,860,804.42	$ 13,611,556.24	$ 14,700,480.74	$ 71,067,110
Optional Expansion (Underinsured)	$ 2,353,178	$ 2,542,533	$ 2,305,144	$ 556,908	$ -	$ -	$ -	$ 7,757,763
VHAP ESI	$ 1,917,976	$ 1,660,128	$ 1,189,221	$ 389,290	$ -	$ -	$ -	$ 5,156,615
ESIA	$ 861,905	$ 844,135	$ 785,505	$ 187,419	$ -	$ -	$ -	$ 2,678,964
CHAP	$ 40,210,567	$ 40,947,623	$ 45,962,054	$ 15,135,122	$ -	$ -	$ -	$ 142,255,366
ESIA Expansion - 200-300% of FPL	$ 298,915	$ 234,632	$ 119,805	$ 65,738	$ -	$ -	$ -	$ 719,090
CHAP Expansion - 200-300% of FPL	$ 18,276,722	$ 20,287,457	$ 25,846,789	$ 7,422,225	$ -	$ -	$ -	$ 71,833,192
Subtotal Capitation Payments	*$ 1,063,136,831*	*$ 1,152,497,766*	*$ 1,219,452,678*	*$ 324,310,224*	*$ 1,128,355,670*	*$ 1,431,946,628*	*$ 1,546,502,358*	*$ 7,866,202,155*
Premium Offsets	$ (17,794,216)	$ (17,971,216)	$ (19,565,123)	$ (4,388,444)	$ (19,808,694)	$ (20,005,731)	$ (20,204,729)	$ (119,738,153)
Administrative Expenses Outside of Managed Care Model	$ 6,071,553	$ 5,751,066	$ 6,260,794	$ 1,214,631	$ 5,086,126	$ -	$ -	$ 24,384,170
Total	**$ 1,051,414,168**	**$ 1,140,277,616**	**$ 1,206,148,349**	**$ 321,136,411**	**$ 1,113,633,102**	**$ 1,411,940,896**	**$ 1,526,297,629**	**$ 7,770,848,171**

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Table 10: Summary of Program Expenditures With and Without Waiver, Years 6 -11 (State and Federal)

	Waiver Year							Total
	6 (Oct '10-Sept '11)	7 (Oct '11-Sept'12)	8 (Oct '12-Sept '13)	9a (Oct '13-Dec '13)	9b (Jan '14-Dec '14)	10 (est.) (Jan '15-Dec '15)	11 (est.) (Jan '16-Dec '16)	Oct '10 - Dec '16
Expenditures without Waiver (Aggregate Budget Neutrality Limit)	**$ 1,421,580,108**	**$ 1,248,077,166**	**$ 1,337,393,583**	**$ 505,202,312**	**$ 1,334,452,085**	**$ 1,416,117,210**	**$ 1,502,809,118**	**$ 8,765,631,581**
Expenditures with Waiver								
Capitation Payments	$ 1,063,136,831	$ 1,152,497,766	$ 1,219,452,678	$ 324,310,224	$ 1,128,355,670	$ 1,431,946,628	$ 1,546,502,358	$ 7,866,202,155
Premium Offsets	$ (17,794,216)	$ (17,971,216)	$ (19,565,123)	$ (4,388,444)	$ (19,808,694)	$ (20,005,731)	$ (20,204,729)	$ (119,738,153)
Admin. Expenses Outside Managed Care Model	$ 6,071,553	$ 5,751,066	$ 6,260,794	$ 1,214,631	$ 5,086,126	$ -	$ -	$ 24,384,170
Total	**$ 1,051,414,168**	**$ 1,140,277,616**	**$ 1,206,148,349**	**$ 321,136,411**	**$ 1,113,633,102**	**$ 1,411,940,896**	**$ 1,526,297,629**	**$ 7,770,848,171**
Annual Surplus (Deficit)	$ 370,165,940	$ 107,799,549	$ 131,245,234	$ 184,065,901	$ 220,818,983	$ 4,176,314	$ (23,488,511)	$ 994,783,410
Cumulative Surplus (Deficit)	**$ 370,165,940**	**$ 477,965,489**	**$ 609,210,723**	**$ 793,276,624**	**$ 1,014,095,607**	**$ 1,018,271,921**	**$ 994,783,410**	**$ 994,783,410**
Supplemental Test: New Adult								
Limit					*$ 254,774,669*	*$ 319,420,696*	*$ 367,879,124*	*$ 942,074,489*
Actual					*$ 202,373,001*	*$ 272,170,226*	*$ 312,995,760*	*$ 787,538,987*
Annual Surplus (Deficit)					*$ 52,401,668*	*$ 47,250,470*	*$ 54,883,364*	*$ 154,535,502*

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Table 11: Projected Expenditures Without Waiver, Years 12 Through 16 (State and Federal)

	Waiver Year					Total
	12 (Jan '17-Dec '17)	13 (Oct '18-Sept'18)	14 (Oct '19-Sept '19)	15 (Oct '20-Dec '20)	16 (Jan '21-Dec '21)	Jan '17 - Dec '21
Continuation of VHAP MEGs						
ANFC	$ 412,710,404	$ 439,518,222	$ 468,067,356	$ 498,470,913	$ 530,849,350	$ 2,349,616,245
ABD	$ 486,437,296	$ 518,445,733	$ 552,560,381	$ 588,919,834	$ 627,671,804	$ 2,774,035,049
Spend Down	$ 3,756,185	$ 4,003,348	$ 4,266,776	$ 4,547,537	$ 4,846,773	$ 21,420,619
Community Rehbabilitation and Treatment (CRT)	$ 59,766,690	$ 63,699,444	$ 67,890,980	$ 72,358,327	$ 77,119,633	$ 340,835,075
Community Rehbabilitation and Treatment (CRT) Duals	$ 281,898	$ 300,448	$ 320,218	$ 341,289	$ 363,746	$ 1,607,599
Subtotal	*$ 962,952,473*	*$ 1,025,967,195*	*$ 1,093,105,711*	*$ 1,164,637,901*	*$ 1,240,851,306*	*$ 4,246,663,280*
Additional Program Expenses Not Included Under VHAP	$ 805,811,935	$ 854,160,651	$ 905,410,290	$ 959,734,908	$ 1,017,319,002	$ 4,542,436,787
Program Administration	$ 124,768,917	$ 130,757,825	$ 137,034,201	$ 143,611,842	$ 150,505,211	$ 686,677,995
Waiver Surplus (Deficit) Carry-Forward	$ 994,783,410	$ -	$ -	$ -		$ 994,783,410
Total	**$ 2,888,316,735**	**$ 2,010,885,671**	**$ 2,135,550,202**	**$ 2,267,984,651**	**$ 2,408,675,519**	**$ 11,711,412,778**

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Table 12: Projected Caseloads with Waiver, Years 12 Through 16

	Waiver Year					Trend Rate
	12 (Jan '17-Dec '17)	13 (Oct '18-Sept'18)	14 (Oct '19-Sept '19)	15 (Oct '20-Dec '20)	16 (Jan '21-Dec '21)	
ABD - Non-Medicare - Adult	205,093	209,099	213,183	217,347	221,593	1.95%
ABD - Non-Medicare - Child	46,135	46,596	47,062	47,533	48,008	1.00%
ABD - Dual	233,716	241,161	248,843	256,770	264,950	3.19%
ANFC - Non-Medicare - Adult	197,204	199,176	201,168	203,180	205,212	1.00%
ANFC - Non-Medicare - Child	757,264	764,837	772,485	780,210	788,012	1.00%
Global Rx	148,829	149,008	149,188	149,368	149,548	0.12%
Total	**1,588,241**	**1,609,878**	**1,631,930**	**1,654,408**	**1,677,323**	**1.37%**
Supplemental Test: New Adult	*776,631*	*815,463*	*856,236*	*899,048*	*944,000*	5.00%

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Table 13: Projected Expenditures per Member per Month with Waiver, Years 12 Through 16 (State and Federal)

	Waiver Year					PMPM Trend
	12 (Jan '17-Dec '17)	13 (Oct '18-Sept'18)	14 (Oct '19-Sept '19)	15 (Oct '20-Dec '20)	16 (Jan '21-Dec '21)	
ABD - Non-Medicare - Adult	$ 1,557.86	$ 1,677.65	$ 1,806.66	$ 1,945.58	$ 2,095.19	7.69%
ABD - Non-Medicare - Child	$ 3,394.69	$ 3,599.16	$ 3,815.94	$ 4,045.79	$ 4,289.47	6.02%
ABD - Dual	$ 2,728.87	$ 2,870.31	$ 3,019.08	$ 3,175.56	$ 3,340.15	5.18%
ANFC - Non-Medicare - Adult	$ 748.48	$ 834.07	$ 929.46	$ 1,035.75	$ 1,154.20	11.44%
ANFC - Non-Medicare - Child	$ 541.56	$ 585.20	$ 632.36	$ 683.32	$ 738.39	8.06%
Global Rx	$ 120.45	$ 138.06	$ 158.25	$ 181.39	$ 207.92	14.62%
Total	**$ 1,049.78**	**$ 1,130.86**	**$ 1,218.31**	**$ 1,312.65**	**$ 1,414.43**	**10.44%**
Supplemental Test: New Adult	*$ 455.71*	*$ 490.75*	*$ 528.49*	*$ 569.13*	*$ 612.89*	*7.69%*

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Table 14: Projected Expenditures with Waiver, Years 12 Through16 (State and Federal)

	Waiver Year					Total
	12 (Jan '17-Dec '17)	13 (Oct '18-Sept'18)	14 (Oct '19-Sept '19)	15 (Oct '20-Dec '20)	16 (Jan '21-Dec '21)	Jan '17 - Dec '21
Capitation Payments						
ABD - Non-Medicare - Adult	$ 319,504,836	$ 350,794,582	$ 385,148,596	$ 422,866,966	$ 464,279,173	$ 1,942,594,153
ABD - Non-Medicare - Child	$ 156,613,224	$ 167,706,888	$ 179,586,370	$ 192,307,333	$ 205,929,382	$ 902,143,197
ABD - Dual	$ 637,781,508	$ 692,207,684	$ 751,278,411	$ 815,390,040	$ 884,972,744	$ 3,781,630,388
ANFC - Non-Medicare - Adult	$ 147,603,299	$ 166,127,885	$ 186,977,355	$ 210,443,485	$ 236,854,674	$ 948,006,697
ANFC - Non-Medicare - Child	$ 410,104,921	$ 447,584,960	$ 488,490,349	$ 533,134,137	$ 581,857,980	$ 2,461,172,346
Global Rx	$ 17,926,481	$ 20,572,577	$ 23,609,258	$ 27,094,177	$ 31,093,500	$ 120,295,993
Subtotal Capitation Payments	*$ 1,689,534,269*	*$ 1,844,994,577*	*$ 2,015,090,339*	*$ 2,201,236,138*	*$ 2,404,987,452*	*$10,155,842,774*
Premium Offsets	$ (22,225,202)	$ (24,447,722)	$ (26,892,494)	$ (29,581,744)	$ (32,539,918)	$ (135,687,081)
Administrative Expenses Outside of Managed Care Model	$ -	$ -	$ -	$ -	$ -	$ -
Total	**$ 1,667,309,067**	**$ 1,820,546,854**	**$ 1,988,197,844**	**$ 2,171,654,394**	**$ 2,372,447,534**	**$ 10,020,155,693**

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Table 15: Summary of Program Expenditures With and Without Waiver, Years 12 -16 (State and Federal)

	Waiver Year					Total
	12 (Jan '17-Dec '17)	13 (Oct '18-Sept'18)	14 (Oct '19-Sept '19)	15 (Oct '20-Dec '20)	16 (Jan '21-Dec '21)	Jan '17 - Dec '21
Expenditures without Waiver (Aggregate Budget Neutrality Limit)	**$ 2,888,316,735**	**$ 2,010,885,671**	**$ 2,135,550,202**	**$ 2,267,984,651**	**$ 2,408,675,519**	**$ 11,711,412,778**
Expenditures with Waiver						
Capitation Payments	$ 1,689,534,269	$ 1,844,994,577	$ 2,015,090,339	$ 2,201,236,138	$ 2,404,987,452	$ 10,155,842,774
Premium Offsets	$ (22,225,202)	$ (24,447,722)	$ (26,892,494)	$ (29,581,744)	$ (32,539,918)	$ (135,687,081)
Admin. Expenses Outside Managed Care Model	$ -	$ -	$ -	$ -	$ -	$ -
Total	**$ 1,667,309,067**	**$ 1,820,546,854**	**$ 1,988,197,844**	**$ 2,171,654,394**	**$ 2,372,447,534**	**$ 10,020,155,693**
Annual Surplus (Deficit)	**$ 1,221,007,668**	**$ 190,338,817**	**$ 147,352,358**	**$ 96,330,257**	**$ 36,227,986**	**$ 1,691,257,085**
Cumulative Surplus (Deficit)	**$ 1,221,007,668**	**$ 1,411,346,485**	**$ 1,558,698,843**	**$ 1,655,029,099**	**$ 1,691,257,085**	**$ 1,691,257,085**
Supplemental Test: New Adult						
Limit	*$ 404,427,915*	*$ 444,607,828*	*$ 488,779,616*	*$ 537,339,870*	*$ 590,724,587*	*$ 2,465,879,815*
Actual	*$ 353,917,363*	*$ 400,189,125*	*$ 452,510,538*	*$ 511,672,541*	*$ 578,569,487*	*$ 2,296,859,054*
Annual Surplus (Deficit)	*$ 50,510,552*	*$ 44,418,703*	*$ 36,269,078*	*$ 25,667,329*	*$ 12,155,100*	*$ 169,020,761*

Appendix C: Interim Evaluation of the Overall Impact of the Demonstration

Background

In April 2013 Vermont submitted to CMS its Interim Program Evaluation with its request to renew the Global Commitment to Health (GC) Section 1115 Demonstration waiver. The evaluation reported the Demonstration's progress toward accomplishing its three goals: 1) increasing access, 2) improving quality, and 3) controlling costs.

The evaluation included a compilation of Vermont's quality assessment and improvement activities, as well as emerging results from Vermont's innovative programs for Chronic Care Management and its Blueprint for Health initiative. As part of the 2013 and 2014 CMS discussions, the state requested and ultimately received approval to incorporate the 1115 Long-Term Care Demonstration waiver, Choices for Care (CFC), into the GC Demonstration. Prior to January 30, 2015, evaluation activities of the two waivers had been separate. An updated evaluation plan for the consolidated waiver is currently under review with CMS.

2015 Interim Program Evaluation Report

In accordance with the Special Terms and Conditions of the GC Demonstration, AHS contracted with the Pacific Health Policy Group (PHPG) to prepare an interim evaluation of the GC Demonstration and its performance relative its goals. Specifically, PHPG was directed to compile findings related to:

- Increasing access to affordable and high-quality health care, with an emphasis on primary care;
- Improving the health care delivery for individuals with chronic care needs;
- Containing health care costs; and
- Allowing beneficiaries a choice in long-term services and supports and providing an array of home- and community-based alternatives recognized to be more cost-effective than institutional-based supports.

To measure the performance of the GC Demonstration, data was reviewed from a variety of applicable projects and reports made available by AHS and nationally. The following resources were used:

- Global Commitment to Health Enrollment 2008-2014
- Vermont Department of Financial Regulation, formerly Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA), Vermont Health Insurance Coverage Survey (2001-2006, 2008, 2012, and 2014)
- 2012-2015 External Quality Review Organization (EQRO) Technical Reports
- 2013-2014 HEDIS Measures
- 2012 and 2014 Consumer Assessment of Health Provider and Systems (CAHPS) Survey
- 2014 Blueprint for Health Annual Report
- 2014 Global Commitment to Health Demonstration Annual and Quarterly Reports to CMS
- NCQA, State of Health Care Quality 2014.

Based on current evaluation efforts, the GC Demonstration has succeeded at achieving all four goals as demonstrated by multiple measures detailed in the report. The link to the full report is here.

Vermont Premium Assistance Program Evaluation

As Vermont prepared for the transition to the Affordable Care Act (ACA) in 2013, a preliminary comparison of cost-sharing obligations between existing Vermont Medicaid coverage groups and the ACA found that in some instances ACA cost sharing would be substantially higher than the state's existing Medicaid waiver programs, such as Vermont Health Access Plan (VHAP) and Catamount Health.

Concerned that the ACA could result in a financial challenge for those currently with health care coverage through VHAP and Catamount Health, Vermont sought CMS guidance on supplementing the federal subsidies under the ACA for premiums and out-of-pocket expenses. In October of 2013, Vermont received approval effective January 1, 2014, to further subsidize monthly premiums to ensure greater affordability for low- and middle-income Vermonters.

Specifically, the state may claim Marketplace premium subsidies as allowable expenditures under the GC Section 1115 Demonstration waiver for individuals with incomes up to and including 300% of the Federal Poverty Level (FPL). Vermont provides subsidies on behalf of individuals who are not Medicaid eligible, are eligible for the advance premium tax credit (APTC), and who have household income up to and including 300% of FPL.

CMS has set annual limits for gross expenditures for which federal financial participation is available. During the transition to ACA, Vermont estimated that approximately 19,222 individuals would move from Medicaid waiver expansion programs into the Marketplace. An interim study of the marketplace subsidy program was conducted in 2014. Based on Vermont Health Connect (VHC) data at the time of the evaluation report, approximately 90%, or 17,377 covered persons who may have otherwise been part of this former group were benefiting from the VPA program.

Preliminary VHC data suggest that the program is attracting persons in income categories above 133% who may have otherwise applied for VHAP, Catamount, or Employer-Sponsored Premium Assistance pre-January 1, 2014. As of the fourth quarter of 2015, enrollment in VPA was 16,906.

Draft Demonstration Evaluation Design

Following the consolidation of Choices for Care under the Global Commitment to Health Demonstration, Vermont submitted a revised Draft Demonstration Evaluation Design to CMS. This revised evaluation plan includes:

- Background information on the Demonstration and its principles, goals, and objectives;
- Detailed evaluation design; and
- Information on the evaluation reports to be provided to CMS during the lifetime of the Demonstration and at its conclusion.

Vermont will select an independent contractor to conduct the evaluation. The contractor's work will be overseen by the Quality Improvement team within the Agency of Human Services (AHS), Vermont's Single State Agency for Medicaid.

This Evaluation Plan addresses all of the required elements outlined in the Special Terms and Conditions and is designed to answer four fundamental questions:

1. To what degree did the Demonstration achieve its goals and objectives?
2. What lessons were learned as a result of the Demonstration, and what would Vermont recommend to other states that may be interested in implementing a similar Demonstration?
3. In what ways, and to what extent, were outcomes for enrollees, providers, and payers changed as a result of the Demonstration?
4. Did the reallocation of resources in the Demonstration generate greater value for the state's program expenditures?

The information learned from the evaluation will be used to guide and inform both current and future planning. The evaluation is separate from, but linked to, the state's other quality assessment and improvement activities. It goes beyond quality assurance, quality measurement, and performance improvement by evaluating areas of the Demonstration other than those specified in the Quality Strategy.

AHS is interested in using the evaluation to identify both successes and opportunities for improvement. In addition, the evaluation incorporates different types of measures (e.g., financial, clinical, and program) and different targets (e.g., population groups, payers, and providers).

The state plans to use the results of the evaluation to inform its future policy decisions with respect to the evolution of its health care system and policy planning efforts. In addition to the hypotheses being tested as part of this Evaluation Plan, the state will continue to monitor the program for its impact in relation to the Healthy Vermonters 2020 goals. While the above questions cannot be conclusively answered until the end of the Demonstration, the Evaluation Plan includes ongoing information collection on the incremental progress of the Demonstration; it is designed to measure changes before, during, and after the Demonstration.

Appendix D: Summary of EQRO Reports and Quality Assurance Monitoring

External Quality Review Organization Reports

As a Managed Care model, DVHA adheres to federal rules contained in 42 CFR 438. Since 2007 AHS has contracted with the Health Services Advisory Group (HSAG) to conduct an external independent review of the quality outcomes and timeliness of—and access to—care furnished by DVHA to its Medicaid enrollees. These audits are known as External Quality Review Organization (EQRO) audits. The audits have three major areas of review:

- Performance Measures Validation;
- Monitoring Compliance with Standards; and
- Performance Improvement Projects Validation.

EQRO Report 2012 – 2013

Performance Measures Evaluation

HSAG validated a set of nine AHS-required performance measures as calculated by DVHA. The nine measures included 35 clinical indicators (or rates). The performance measurement period was calendar year 2011. AHS selected the nine measures from the 2013 HEDIS measures. HSAG determined that all nine measures were fully compliant with HEDIS specifications and were valid and accurate for reporting. All measures received a validation finding of Fully Compliant. DVHA implemented many of HSAG's recommendations from the previous years to reinforce support and commitment to the performance measure reporting process. This was evident through the participation of many DVHA staff members in HSAG's current year audit and the thorough completion of the audit documentation.

Monitoring Compliance with Standards

Under its EQRO contract, AHS requested that HSAG continue to review one of the three sets of CMS standards applicable to Medicaid managed care organizations during each EQRO contract year. For contract year 2012–2013, AHS requested that HSAG conduct a review of the CMS Access Standards.

HSAG reviewed DVHA's performance related to 72 elements across the seven Access standards. Of the 71 applicable requirements, DVHA obtained a score of Met for 69 of the requirements and a score of Partially Met for two elements. As a result, DVHA obtained a total percentage-of-compliance score of 98.59% across the applicable elements, for a rounded score of 99.0% compliant.

Performance Improvement Validation

HSAG conducted a validation of the continuing annual submission of the DVHA PIP, *Increasing Adherence to Evidence-Based Pharmacy Guidelines for Members Diagnosed with Congestive Heart Failure*. The purpose of the study was to improve the appropriate use of medications for the treatment of congestive heart failure (CHF). DVHA's *Increasing Adherence to Evidence-Based*

Pharmacy Guidelines for Members Diagnosed with Congestive Heart Failure PIP received a score of 96% for all applicable evaluation elements scored as *Met*, a score of 100% for critical evaluation elements scored as *Met*, and an overall validation status of *Met.*

EQRO Report 2014-2015

Performance Measures Validation

The EQRO conducted the validation of 13 performance measures for 2014 (CY 2013). The auditors identified several aspects in the calculation of performance measures as crucial to the validation process. These include data integration, data control, and documentation of performance measure calculations. DVHA received a passing score on all of these aspects. There was a recommendation that DVHA staff conduct additional root cause analysis on performance measures and incorporate national/regional benchmarks to manage rates.

HSAG evaluated eligibility system data and claims processing data and found no areas requiring corrective action.

Performance Measure Specific Findings:
DVHA contracted with a software vendor to assist in producing the performance measures. HSAG conducted primary source verification for each required performance measure and identified no errors. All member eligibility strings matched the Hewlett-Packard (HP) Medicaid Management Information System (MMIS) and the Verisk performance measure software vendor system's numerators.

The auditors identified a potential for underreporting of some lab-related measures due to case rates and minimal monitoring of data submitted by DVHA's Federally Qualified Health Centers (FQHCs). HSAG recommended that DVHA conduct further investigation on this data.

Monitoring Compliance with Standards

The EQRO also reviewed DVHA's compliance with the Managed Care performance requirements described in 42 CFR §438, as well as state-specific requirements contained in the AHS/DVHA IGA. The performance audit focused on the following eight standards:

- Provider Selection;
- Credentialing and Re-Credentialing of Providers;
- Beneficiary Information;
- Beneficiary Rights;
- Confidentiality;
- Grievance System—Beneficiary Grievances;
- Grievance System—Beneficiary Appeals and State Fair Hearings ; and
- Subcontractual Relationships and Delegation.

DVHA's overall compliance score for this set of standards improved from 90% three years ago (the last time these standards were measured) to 92% this year. All programs either *Met* or *Partially Met* the required compliance standards. No programs were graded as having *Not Met* a required standard.

In their final report, the auditors noted that:

"It was clear from the review of DVHA's documentation, organizational structure, and staff responses during the interviews that DVHA staff members were passionate about providing quality, accessible, timely care and services to members and regularly went well beyond the minimum required to ensure that they took care of the members and adequately responded to their needs, while complying with the applicable CMS and AHS requirements related to this year's compliance review activity. It was also clear that, during the year, AHS and DVHA initiated numerous new, or enhanced existing projects and programs, designed to both improve member care and access to quality, accessible, and timely services."

Performance Improvement Validation

The PIP validation audit focused on DVHA's newest PIP, *Follow-up after Hospitalization for Mental Illness* and evaluated the technical methods of the PIP (i.e., the study design and implementation/evaluation). The PIP received an overall *Met* validation status when submitted.

The *Follow-up after Hospitalization for Mental Illness* PIP received a *Met* score for 100% of critical evaluation elements and 100% of overall evaluation elements in the Study Design, Implementation, and Evaluation stages.

Quality Assurance and Performance Improvement Activities

The DVHA Quality Improvement (QI) and Clinical Integrity Unit monitors, evaluates, and improves the quality of care to our Vermont Medicaid beneficiaries by improving internal processes, identifying performance improvement projects, and performing utilization management. Efforts are aligned across the Agency of Human Services as well as with community providers.

The Quality Committee focused during the Demonstration period on the CMS core performance measures for adults and children, evaluating DVHA's performance and receiving updates on performance improvement projects related to the measures. The committee agreed to structure its work around the triple aims of health care: improving the patient experience, improving the health of populations, and reducing the per capita cost of health care.

In 2014 the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys were completed. DVHA's contracted vendor, WBA Research, distributed and collated both the Adult and Children's Medicaid CAHPS 5.0H surveys.

Throughout the Demonstration period DVHA worked on developing the internal capacity to complete hybrid Healthcare Effectiveness Data and Information Set (HEDIS) chart reviews for a limited number of measures. Training was delivered via the online web portal of DVHA's HEDIS vendor for medical record abstractions.

During the Demonstration period the AHS Performance Accountability Committee (PAC) recommended performance measures for the GC Waiver and for the Medicaid/Shared Savings Program (ACO). During the process, members of the committee reviewed/considered performance measures associated with the following AHS-sponsored/supported initiatives: Blueprint for Health, Healthy Vermonters 2020, AHS Strategic Plan, and the CMS Adult/Child core measure sets. Now that the Choices for Care waiver has

been consolidated with the Global Commitment waiver, the group has added long-term services and supports (LTSS) measures to the Global Commitment measure set. The committee also supported the planning/design aspects of the AHS Results Scorecard. This is an electronic scorecard/dashboard that graphically displays AHS performance/accountability data relative to a number of population-based indicators of health and well-being. In addition to the tool, the group will continue their work to align measures associated with the Global Commitment waiver with those found in the AHS Strategic Plan/Results Scorecard.

The AHS Quality Improvement Manager engaged members of the PAC in a review of the Quality Strategy based on the findings of the final EQRO Annual Technical Report. In addition, the group has reviewed the CMS Quality Strategy resource documents. To accommodate the quality assessment and improvement activities associated with the Choices for Care 1115 Waiver, which was consolidated with the GC waiver effective January 30, 2015, an updated version of the strategy was reviewed by the AHS Integrated Operations and Planning Team (IOPT) and AHS Executive Committee, and made available for public comment. The final document was forwarded to CMS for review/approval.

Appendix E: Compliance with Public Notice Process

(To be completed following the formal public comment period)

Outlined below is a summary of 42 CFR 431.408 public process requirements and how the state has complied with federal regulations. Also included are comments received, the state's response, and any changes to the waiver that were made as a result of the public process.

Public Comment Period: The CFR requires a 30-day comment period. The state's public comment period on the Global Commitment to Health 1115 Waiver Extension request was from November 4 through December 10, 2015.

Public notice of the application: On October 30, 2015, the draft *Global Commitment to Health* Waiver Renewal Request, the public notice, and executive summary of the draft were posted online. Materials were available on the following websites: DVHA, the Agency of Human Services, and the Agency of Administration Health Care Reform home pages. All *Global Commitment to Health* Waiver documents, including extension information, are available year-round on DVHA's website.

On 11/1/15, a public notice was published in the *Burlington Free Press* announcing the availability of the draft renewal request, two public hearing dates, the online website, and the deadline for submission of written comments with contact information. Additionally, all district offices of the Department for Children and Families' Economic Services Division, the division responsible for health care eligibility, posted the notice and had proposal copies available, if requested. The *Burlington Free Press* is the state's newspaper with the largest statewide distribution and paid subscriptions.

On 11/13/15, a public notice and link to the renewal documents were included on the banner page for Vermont's Medicaid provider network.

Comprehensive description of the proposed waiver extension: The state posted a comprehensive description of the proposed waiver request on October 30, 2015, on the above-cited websites. The document included: program description, goals and objectives; a description of the beneficiary groups that will be impacted by the demonstration; the proposed health delivery system and benefit and cost-sharing requirements impacted by the demonstration; estimated increases or decreases in enrollment and in expenditures; the hypothesis and evaluation parameters of the proposal; and the specific waiver and expenditure authorities it is seeking. In addition to the draft posted for public comment, an Executive Summary and the PowerPoint presentation used during each public hearing was also posted to the same state websites noted above

Public Hearings: The state convened to two public hearing on the Global Commitment to Health 1115 Waiver renewal request.

On November 12, 2015, from 2:00 to 2:30 PM, a public hearing was held during the Department of Disabilities, Aging, and Independent Living (DAIL) Advisory Board meeting in Montpelier, Vermont.

On November 23, 2015, from 3:00 to 3:30 PM., a public hearing was held during the Medicaid and Exchange Advisory Board meeting in Winooski

Both hearings offered teleconferencing for individuals who could not attend in person.

Use of an electronic mailing list to notify the public: On 10/30/15, the Draft *Global Commitment to Health* Waiver Extension Request was distributed simultaneously to the Medicaid and Exchange Advisory Board, the committees of jurisdiction in the Vermont legislature, the DAIL Advisory Board, Department of Children and Families (DCF) District Offices, State Innovation Model Stakeholders, DAIL, DMH, VDH, and other external stakeholders as well as internal management teams from across AHS.

Tribal Government Notification: The State of Vermont has no federally recognized Indian tribes or groups.

Public Comments and Associated Responses

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