CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

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

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

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

Under the authority of Section 1115(a)(1) of the Social Security Act (the Act) the following waivers are granted to enable Vermont to operate the Global Commitment to Health section 1115 demonstration. These waivers are effective beginning January 1, 2017 and are limited to the extent necessary to achieve the objectives below. These waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in the accompanying document.

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project for the period beginning January 1, 2017 through December 31, 2021.

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

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

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

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

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

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

To allow the state to provide nursing facility and home and community-based services based on relative need as part of the person-centered and options counseling process for new

applicants for Choices for Care services; to permit certain individuals, based on need, to receive demonstration services that are not available to categorically eligible individuals, or other individuals in the same eligibility group, under the Medicaid state plan; and to limit the amount, duration, and scope of services to those included in the participants' approved care plan.

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

To allow the state to use institutional income rules (up to 300 percent of the Supplemental Security Income payment level) for medically needy beneficiaries.

To allow the state to use institutional income and resource rules for the high and highest need groups of the medically needy in the same manner as it did for the terminated 1915(c) waiver programs that were subsumed under the Choices for Care demonstration in 2005.

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

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

To allow the state, through the Department of Vermont Health Access, to establish rates with providers on an individual or class basis without regard to the rates currently set forth in the approved state plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

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

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

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

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Vermont for the items identified below (which are not otherwise included as expenditures under section 1903 of the Act) shall, for the period of this demonstration extension, beginning January 1, 2017 through December 31, 2021, be regarded as expenditures under the state's Medicaid Title XIX plan. These expenditure authorities are granted to enable the state to operate its Global Commitment to Health Section 1115 demonstration and may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in the accompanying document.

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

These expenditure authorities promote the objectives of title XIX in the following ways:

1. Increase and strengthen overall coverage of low-income individuals in the state;
2. Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income individuals in the state;
3. Improve health outcomes for Medicaid and other low-income populations in the state; and
4. Increase efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

1. Expenditures Related to Eligibility Expansion

Expenditures to provide Medicaid coverage to the following demonstration populations that are not covered under the Medicaid state plan and are enrolled in the Vermont Global Commitment to Health demonstration. (Note: demonstration populations 1, 2, and 3, which are described in the demonstration's special terms and conditions, are covered under the Medicaid state plan.)

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

b. **Demonstration Population 5: High Need**: Expenditures for 217-like individuals receiving HCBW-like services in the High Need Group and PACE- like participants who meet the clinical standards for the High Need Group.

c. **Demonstration Population 6: Moderate Needs Group (Expansion Group)**: Expenditures for a small subset of HCBW- like services for individuals who are not otherwise eligible under the Medicaid state plan and who would not have been eligible had the state elected eligibility under 42 CFR 435.217, but are at risk for institutionalization and are in need of home and community-based services. Such individuals may have income up to 300 percent of the SSI/Federal Benefit Rate (FBR) and resources below $10,000. Individuals with income below the limit and with excess resources may apply excess resources to income, up to the income limit. These benefits do not meet the requirements of Minimum Essential Coverage.

d. **Demonstration Population 7:** Medicare beneficiaries with income at or below150 percent of the Federal poverty level (FPL), who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise eligible for full benefits.

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

2. **Expenditures Related to Additional Services.** Expenditures for additional health care related-services described in STC 19(c) for all populations affected by or eligible through the demonstration.

3. **Expenditures for Public Health Initiatives, Outreach, Infrastructure, and Services Related to State Plan, Demonstration, Uninsured, and Underinsured Populations.** Expenditures to support the goal of providing state-funded health care programs to improve the access and quality of health care services available to uninsured and underinsured individuals in Vermont subject to the terms and limitations set forward in STCs 79 and 80 and up to a maximum of the limits set in STC 81 (and which cannot be rolled over to the next demonstration year (DY)), to reduce the rate of uninsured and underinsured in Vermont, increase access to quality health care for uninsured, underinsured, and Medicaid beneficiaries, provide public health approaches and other innovative programs to improve the health outcomes and quality of life for Medicaid beneficiaries; and encourage the formation and maintenance of public-private partnerships in health care including initiatives to support and improve the health care delivery system and promote transformation to value-based and integrated models of care.

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

5. **Expenditures for the Marketplace Subsidy Program.** Expenditures for state funded subsidy programs that provide assistance to certain individuals who purchase health

insurance through the Marketplace.

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

7. **Expenditures for Mental Health Community Rehabilitation and Treatment (CRT) Services.** Expenditures for mental health community rehabilitation and treatment (CRT) services, as defined by Vermont rule and policy, provided through a state-funded program to individuals with severe and persistent mental illness who have incomes above 133 percent of the FPL and up to and including 185 percent of FPL who are not otherwise Medicaid enrolled.

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

9. **Other Choices for Care Expenditures:**

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

    b. Expenditures for personal care services provided by Choices for Care participants spouses; and

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

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

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

1. Retroactive Eligibility **Section 1902(a)(34)**

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

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

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

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

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Vermont Global Commitment to Health Section 1115(a) Medicaid demonstration (hereinafter "demonstration"). The parties to this agreement are the Vermont Agency of Human Services (AHS, state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth limitations on the extent of the waivers and expenditure authorities that have been granted to further the demonstration, which are enumerated in separate lists. The STCs also detail the nature, character, and extent of Federal involvement in the demonstration and the state's obligations to CMS during the life of the demonstration. These STC's are effective as of January 1, 2017 through December 31, 2021 unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below.

The amended STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility, Benefits, and Enrollment
V. Cost Sharing
VI. Delivery Systems
VII. Long Term Services and Supports Protections for Choices for Care
VIII. Designated State Health Programs
IX. Monitoring and Reporting Requirements
X. General Financial Requirements
XI. Monitoring Budget Neutrality for the Demonstration
XII. Evaluation of the Demonstration
XIII. Use of Demonstration Funds
XIV. Measurement of Quality of Care and Access to Care
XV. Schedule of State Deliverables for the Demonstration Period

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

Attachment A. Quarterly Report Content and Format
Attachment B. Summary of Choices for Care Eligibility Criteria

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Global Commitment to Health Section 1115(a) demonstration was initiated in September 2005, and is designed to use a multi-disciplinary approach including the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, public-private partnership, and program flexibility.

As of January 1, 2017, Vermont is extending the Global Commitment to Health demonstration to further promote delivery system and payment reform to meet the goals of the state working with the Center for Medicaid and CHIP Services and the Center for Medicare and Medicaid Innovation (CMMI) consistent with Medicare's payment reform efforts in order to allow for alignment across public payers. Specifically, Vermont expects to demonstrate its ability to achieve universal access to health care, cost containment, and improved quality of care.

Since 2005, the Global Commitment to Health demonstration has helped reduce Vermont's uninsured rate from 11.4 percent in 2005 to approximately 2.7 percent in 2015 through expansion of eligibility. The demonstration has also enabled Vermont to address and eliminate the bias toward institutional care and offer cost-effective, community-based services. For example, the proportion of Choices for Care participants served in the community has passed fifty percent and continues to increase. In addition, Vermont no longer has a waiting list for individuals in the Highest and High Need Groups under the Choices for Care component of the demonstration.

While expansion of eligibility is no longer the primary focus of the demonstration, in light of the expansion of eligibility under the state plan pursuant to the Affordable Care Act, the demonstration continues to promote delivery system reform and cost-effective community-based services as an alternative to institutional services. The state's goal in implementing the demonstration is to improve the health status of all Vermonters by:

- Promoting delivery system reform through value based payment models and alignment across public payers;

- Increasing access to affordable and high quality health care by assisting

lower-income individuals who can qualify for private insurance through the Marketplace;

- Improving access to primary care;
- Improving the health care delivery for individuals with chronic care needs; 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 will employ four major elements in achieving the above goals:

1. *Program Flexibility:* Vermont has the flexibility to invest in certain specified alternative services and programs designed to achieve the demonstration's objectives (including the Marketplace subsidy program);

2. *Managed Care Delivery System:* Under the demonstration the Agency for Human Services (AHS) will enter into an agreement with the Department of Vermont Health Access (DVHA), which will deliver services through a managed care-like model, subject to the requirements that would be applicable to a non-risk pre-paid inpatient health plan (PIHP) as defined in STC 23;

3. *Removal of Institutional Bias:* Under the demonstration, Vermont will provide 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; and

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

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

- 2007: A component of the Catamount Health program was added, enabling the state to provide a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the FPL, and who do not have access to cost effective employer-sponsored insurance, as

determined by the state.

- 2009: The state extended Catamount Health coverage to Vermonters at or below 300 percent of the FPL.

- 2011: The state included a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life-limiting illness that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.

- 2012: CMS provided authority for the state to eliminate the $75 inpatient admission co- pay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid state plan.

- 2013: CMS approved the extension of the Global Commitment to Health demonstration which included sun-setting the authorities for most of the Expansion Populations, including Catamount Health coverage, because these populations would be eligible for Marketplace coverage beginning January 1, 2014. The extension also added the New Adult Group under the state plan to the population affected by the demonstration effective January 1, 2014. Finally, the extension also included premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL.

- 2015: In January 2015, the Global Commitment to Health demonstration was amended to include authority for the former Choices for Care demonstration. In addition, the state received section 1115 authority to provide full Medicaid state plan benefits to pregnant women who are determined presumptively eligible.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state agrees that it must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in federal law, regulation, and policy statement, unless specified otherwise in the STCs, waiver list, or expenditure authorities or otherwise listed as non- applicable, must apply to the demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The state must, within the timeframes specified in the applicable federal law, regulation, or policy directive, come into compliance with any changes in federal law, regulation, or policy affecting the

Medicaid program that occur during this demonstration approval period, unless the provision being changed is expressly waived.

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

    a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified budget neutrality agreements would be effective upon the implementation of the change.

    b. If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the latest day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The state is not required to submit title XIX state plan amendments for changes to demonstration-eligible populations covered solely through the demonstration. If a population covered through the Medicaid state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan may be required, except as otherwise noted in these STCs. Reimbursement of providers will not be limited to reimbursement described in the state plan.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, and budget neutrality must be submitted to CMS as amendments to the demonstration (and as amendments to the state plan, if eligibility under the state plan is changed). All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Social Security Act (the Act). The state shall not implement changes to these elements of the amendment to the demonstration without prior approval by CMS. In certain instances, amendments to the Medicaid state plan may or may not require amendment to the demonstration as well. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the date of implementation of the change and may not be implemented until approved. Amendment requests will be reviewed by the Federal Review Team and must include, but are not limited to, the following:

    a. An explanation of the public process used by the state to reach a decision regarding the requested amendment;

    b. A data analysis which identifies the specific "with waiver" impact of the proposed

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

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

d. If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

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

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than five (5) months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a thirty (30) day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state plan amendment. Once the thirty (30) day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

b. The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than fourteen (14) days after CMS approval of the phase-out plan.

c. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

d. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the

date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

e. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

9. Extension of the Demonstration.

a. Should the state intend to request an extension of the demonstration under section 1115(a) or 1115(f), the state must submit an extension request no later than six (6) months prior to the expiration date of the demonstration. A request to extend an existing demonstration under 1115(e) must be submitted at least twelve (12) months prior to the expiration date of the demonstration. The chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of STC 8 of this section.

b. Compliance with Transparency Requirements of 42 CFR 431.412. As part of the demonstration extension requests, the state must provide documentation of compliance with the transparency requirements of 42 CFR 431.412 and the public notice and tribal consultation requirements outlined in STC 14 of this section regarding Public Notice, Tribal Consultation and Consultation with Interested Parties. The financial data described in 42 CFR 431.412(c)(2)(v) must include five years of recent historical expenditure and enrollment data for the Medicaid and demonstration populations that are to be included in the demonstration extension, and a proposed budget neutrality test for the extension period based on recent data.

10. CMS Right to Terminate or Suspend. CMS may suspend or terminate the demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. In addition, CMS reserves the right to withdraw expenditure authorities at any time it determines that continuing the expenditure authorities would no longer be in the public interest. If an expenditure authority is withdrawn, CMS shall be liable for only normal close-out costs. CMS will promptly notify the state in writing of the determination and the reasons for suspension or termination of the demonstration, or any withdrawal of an expenditure authority, together with the effective date.

11. Finding of Non-Compliance. The state does not relinquish either its rights to challenge the CMS finding that the state materially failed to comply, or to request reconsideration or appeal of any disallowance pursuant to section 1116(e) of the Act.

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

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

14. **Public Notice and Consultation with Interested Parties.** The state must continue to comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and regulations that implement section 1115(d), as added by section 10201 of the Affordable Care Act.

15. **Dual Role of Managed Care-Like Model and Compliance with Managed Care Regulations.** For purposes of the demonstration the state shall comply with all of the managed care regulations published at 42 CFR section Part 438 et. seq., except as expressly modified or identified as not applicable in the STCs. DVHA shall continue to serve as the unit designated by AHS (the Single State Agency) responsible for administration of the state Medicaid program and operates as a public managed care model solely to carry out the goals and purposes of the demonstration. DVHA's role under the demonstration as a public managed care model does not reduce or diminish its authority to operate as the designated Medicaid unit under the approved state plan, including its authority to implement program policies permissible under a state plan and establish provider participation requirements. DVHA shall comply with federal program integrity and audit requirements as if it were a non-risk pre-paid inpatient health plan (PIHP) for services and populations covered under the demonstration in accordance with STC 23.

16. **Federal Funds Participation (FFP)**. No federal matching for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

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

17. Populations Affected and Eligible under the Demonstration.

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

b. **State plan groups:** Coverage for mandatory and optional state plan groups described below are subject to all applicable Medicaid laws and regulations, except as expressly waived in these STCs and the waiver list and expenditure authority for this demonstration. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a modified adjusted gross income standard on January 1, 2014, will apply to this demonstration.

c. **Choices for Care Program Eligibility:** Individuals who receive long term services and supports under the Choices for Care program must meet state plan financial rules and clinical eligibility criteria as defined by state regulation in effect as of February, 9, 2009. These clinical eligibility determinations define highest, high, and moderate needs service groups. See Attachment A for a summary of eligibility definitions, services, and policies. Non-state plan eligible Choices for Care individuals are included in Populations 4, 5, and 6 in the table below.

d. **Other Demonstration Expansion Populations:** Coverage for these populations is subject to Medicaid laws or regulations only as specified in the expenditure authorities for this demonstration.

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

Mandatory and Optional State Plan Groups		
Population number	***Population description***	***Benefits***
Population 1	Mandatory state plan populations, except for the Affordable Care Act new adult group (included in population 3) and Medicare Savings Program beneficiaries (included in populations 7 and 8).	Benefits as described in the title XIX state plan and these STCs.
Population 2	Optional state plan populations (including medically needy)	Benefits as described in the title XIX state plan and these STCs.

Population 3	The new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119, pursuant to the approved state plan.	Benefits as described in approved alternative benefit plan state plan amendment and these STCs.

Demonstration Expansion Populations		
Demonstration population number	***Population description***	***Benefits***
Population 4	Individuals age 65 and older and age 21 and older with disabilities, not otherwise eligible under the state plan, who meet the clinical criteria for the highest need group, and who would have been Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR §435.217, in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under the demonstration would have been provided under an HCBS waiver granted to the state under section 1915(c) of the Act prior to 2014. This includes the application of the post eligibility rules specified at 42 CFR 435.726, and of the spousal impoverishment rules specified at 1924 of the Act, with a resource standard of $10,000. This only applies to unmarried individuals who have an ownership interest in their principal residence.	Benefits as described in the Medicaid state plan and HCBS benefits described in these STCs.

Demonstration Expansion Populations		
Demonstration population number	***Population description***	***Benefits***
Population 5	Individuals age 65 and older and age 21 and older with disabilities, not otherwise eligible under the state plan, who meet the clinical criteria for the high need group, and who would have been Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR §435.217, in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under the demonstration would have been provided under an HCBS waiver granted to the state under section 1915(c) of the Act prior to 2014. This includes the application of the post eligibility rules specified at 42 CFR 435.726, and of the spousal impoverishment rules specified at 1924 of the Act, and have a resource standard of $10,000. This only applies to unmarried individuals who have an ownership interest in their principal place of residence.	Benefits as described in the Medicaid state plan and HCBS benefits described in these STCs.

Demonstration Expansion Populations		
Demonstration population	***Population description***	***Benefits***
Population 6	Individuals who have incomes below 300 percent of the SSI Federal Benefit rate and would be described in Populations 4 or 5 except that they meet the clinical criteria for the moderate needs group and are at risk of institutionalization.	Limited HCBS including Adult Day Services, Case Management, and Homemaker services. This coverage does not meet the requirements of minimum essential coverage as communicated by CMS in its February 12, 2016 correspondence to the state.
Population 7	Medicare beneficiaries who are 65 years or older or have a disability with income at or below 150 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise categorically eligible for full benefits.	Medicaid Prescriptions, eyeglasses and related eye exams; MSP beneficiaries also receive benefits as described in the title XIX state plan.
Population 8	Medicare beneficiaries who are 65 years or older or have a disability with income above 150 percent and up to and including 225 percent of the FPL, who may be enrolled in the MSP, but are not otherwise categorically eligible for full benefits.	Maintenance Drugs (defined as a drug approved by the FDA for continuous use and prescribed to treat a chronic condition for a prolonged period of time of 30 days or longer, and includes insulin, an insulin syringe and an insulin needle). MSP beneficiaries also receive benefits as described in the title XIX state plan.

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

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

b. The state may maintain waiting list policies and procedures for home and community-based services through the Choices for Care Program including a description of how the state will manage wait lists, if and when waiting lists should occur. Waiting list management may include, but not be limited to consideration of clinical need, other risk factors, eligibility status, date of application, and any regulatory legislative mandates. A description of the wait list policy can be found in Attachment F.

19. Benefits.

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

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

b. **Individual Assessed Cost Effective Alternative Services.** Vermont may provide individuals with the option to receive cost-effective treatment as patients in in lieu of otherwise covered services in other settings. This option must be voluntary with the individual, and must be based on an assessment and determination that the service is a medically appropriate and cost effective substitute for the corresponding state plan service or setting. The state must not claim any expenditures under this expenditure authority that are otherwise not allowable including, but not limited to institution for mental diseases (IMD), inmates, or room and board.

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

Special Program Name	Services	Limitations
Traumatic Brain Injury (TBI)	HCBS waiver-like services including crisis/support services, psychological and counseling supports, case management, community supports, habilitation, respite care, supported employment, environmental and assistive technology and self-directed care.	Any limitation on this service is defined by Vermont rules and policies.
Mental Illness Under 22	HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, supported employment, and crisis and community supports.	Any limitation on this service is defined by Vermont rules and policies.
Community Rehabilitation and Treatment	HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, supported employment, and crisis and community supports.	Any limitation on this service is defined by Vermont rules and policies.
Developmental Disability Services	HCBS waiver-like services, including service coordination, residential habilitation, day habilitation, supported employment, crisis services, clinical intervention, respite and self-directed care.	Any limitation on this service is defined by Vermont rules and policies.

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

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

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

2. Care planning activities for children enrolled in the palliative care program will meet the requirements specified in federal managed care

regulations for enrollees with special health care needs.

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

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

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

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

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

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

iii. **Cost Sharing.** Cost sharing requirements as described in STC 20 will apply.

V. COST SHARING

20. Premiums and cost sharing

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

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

plan.

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

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

c. Premiums for children through age 18 with income above 195 percent of the FPL through 312 percent of the FPL are outlined in Attachment G.

VI. DELIVERY SYSTEMS

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

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

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

a. AHS shall develop a per member per month (PMPM) capitation rate consistent with the requirements for actuarial soundness, rate development, special contract provisions (as applicable), and rate certifications in 42 CFR 438.4 through 438.7;

b. The PMPM capitation rates shall not be used for determination of federal financial participation, rather the PMPM capitation rates and corresponding rate certification shall be used to determine that:

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

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

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

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

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

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

24. Capitation Rate Development. In addition to the requirements described in STC 23, the development of the capitation rate must:

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

b. Be developed for twelve (12) month periods (Note: The first contract under the extension STCs will be for the period April 1, 2017 through December 31, 2017 which is nine (9) months.);

c. Not include any administrative services and costs that are required to be incurred by AHS as the Single State Agency under federal law, regulation, or these STCs. Such administrative services and costs that cannot be part of the capitation rate include: eligibility determinations, Single State Agency Central Office and External Quality Review Organization (EQRO), administration of a State Fair Hearing system, the Beneficiary Support System in 42 CFR 438.71 and STC 30, and the provider screening and enrollment process under 42 CFR 438.602(b);

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

e. Not include any costs for "investments" as described in STC 79;

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

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

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

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

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

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

    iii. Any reimbursement arrangements between AHS or DVHA and providers that is not a fee-for-service style fee schedule shall be required to meet the prior approval requirements in 42 CFR 438.6(c)(2) for reimbursement arrangements described in 42 CFR 438.6(c)(1)(i) and (ii);

    iv. AHS is required to obtain prior approval under 42 CFR 438.6(c)(2) for all reimbursement methodologies that are not fee-for-service regardless of whether the reimbursement methodology is included explicitly in the interagency agreement or instituted at DVHA's discretion; and

    v. Fee-for-service (FFS) for the purposes of this STC means any payment system where:

        1. The provider's services are described in terms of "X units of services" where the units of the services are appropriate for the type of service and consistent with units prescribed in national coding standards.

        2. The provider's services are reimbursed at a specific reimbursement rate per unit of service, regardless of how the specific reimbursement rate is determined (e.g. fixed dollar amount, Diagnostic-Related Group (DRG), All Patients Refined Diagnostic Related-Group (APR-DRG), or Prospective Payment System (PPS) rates such as Federally Qualified Health Center (FQHC) or Indian Health Service (IHS) rates.

3. The total provider reimbursement is determined by multiplying:

    a. The provider's "X units of services" delivered to an enrollee; and

    b. The specific reimbursement rate per unit of service.

4. The payment is not for a "bundle of services."

5. For the purposes of distinguishing the concept of FFS in 42 CFR 438.6(c)(1)(iii) versus a "bundle of services" in 42 CFR 438.6(c)(1)(i), a payment is considered a "bundle of services" when the payment system:

    a. Pays a single payment for delivering a set of services, whenever the set of services includes covered services across multiple categories of services in §1905 of the Act.

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

26. Non-Application of 42 CFR 438.3(m). AHS and DVHA shall not be determined out of compliance with 42 CFR 438.3(m) if:

a. AHS and DVHA meet the financial reporting requirements, consistent with requirements in Section IX and X of these STCs, as well as, applicable federal and state accounting principles and controls.

27. Limitation of Freedom of Choice. Freedom of choice is limited to the DVHA network of providers. However, populations must have freedom of choice when selecting enrolled providers within that network (when applicable, the provider must be enrolled in the specific specialty or subprogram applicable to the services at issue). Specifically, demonstration participants enrolled in a special service program such as, but not limited to specialized substance abuse and behavioral health services or a program for home and community-based services may only have access to the providers enrolled under that program, and will not have access to every Medicaid enrolled provider for services under that program. Such participants will have freedom of choice of providers enrolled in the special service program. No restriction on freedom of choice of family planning provider may be imposed.

28. Contracts and Provider Payments. Payments to providers for Global Commitment will be set by DVHA and approved by AHS and will not be required to comply with the payment provisions in the approved state plan.

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

b. The state must not make any supplemental payments to providers under the Medicaid state plan.

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

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

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

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

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

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

33. **Data Sharing.** DVHA acting as a non-risk PIHP under a managed care-like model shall comply with all privacy and confidentiality requirements on PIHPs in 42 CFR 438. Nothing in this STC prohibits AHS from delegating data and information rights and responsibilities to DVHA consistent with federal law, including section 1902(a)(7) of the Act and 42 CFR 431.306(d). To the extent that DVHA has access to data and information under delegation

from AHS that may not otherwise be shared with a non-risk PIHP, AHS must establish administrative, managerial and, technical controls to prevent sharing the data with divisions of DVHA responsible for the managed care-like model acting as a non-risk PIHP.

VII. LONG TERM SERVICES AND SUPPORTS PROTECTIONS FOR CHOICES FOR CARE

34. Person Centered Planning. The state agrees to use person centered planning processes to identify participants' and applicants' long term service and support needs, the resources available to meet those needs, and to provide access to additional service and support options, such as the choice to use spouse caregivers, and access a prospective monthly cash payment. The state assures that person centered planning will be in compliance with the characteristics set out in 42 CFR 441.301(c)(1)-(3).

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

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

36. Participant/Applicant Waiting List Monitoring. The state agrees to report on the status of the waiting lists for Choices for Care services during regular progress calls between CMS and the state and in reports submitted to CMS by the state.

a. The state assures that it has a system as well as policies and procedures in place through which the providers must identify, report and investigate critical incidents that occur within the delivery of Choices for Care Long Term Services and Supports (LTSS). The state also has a system as well as policies and procedures in place through which to prevent, detect report, investigate, and remediate abuse, neglect, and exploitation. Providers and participants are educated about this system. Provider obligations include specific action steps that providers must take in the event of known or suspected abuse, neglect or exploitation. The Vermont policies and procedures are specified in Vermont Statute, 33 V.S.A. Chapter 69, available at: http://www.leg.state.vt.us/statutes/sections.cfm?Title=33&Chapter=069.

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

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

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

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

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

c. Assist with access to services and supports and help individuals understand their choices, resolve problems and address concerns that may arise between the individual and a provider or payer. The state will assure:
    i. Beneficiaries have support in the pre-enrollment stage, such as unbiased options counseling and general program-related information.

    ii. Beneficiaries have an access point for complaints and concerns about Choices for Care enrollment, access to services, and other related matters.
    iii. Enrollees understand the fair hearing, grievance, and appeal rights and processes within the Choices for Care program and assist them through the process if needed/requested.

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

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

delivered in a culturally competent manner and are accessible to individuals with limited English proficiency; and

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

VIII. DESIGNATED STATE HEALTH PROGRAMS

40. State-Funded Marketplace Subsidies Program. The state may claim as allowable expenditures under the demonstration the payments made through its state-funded program to provide premium subsidies for individuals up to and including 300 percent of the FPL who purchase health insurance through the Marketplace. Subsidies will be provided on behalf of individuals who: (1) are not Medicaid eligible; (2) are eligible for the advance premium tax credit (APTC); and (3) whose income is up to and including 300 percent of the FPL. Expenditures for this designated state health program (DSHP) must not include any expenditures listed in STC 82 ("Investment Approval Process"). The state must submit a claiming protocol for this DSHP and the protocol will become Attachment L.

a. Funding Limit. Expenditures for the subsidies are limited on an annual basis as follows (total computable):

	DY 12 CY 2017	DY 13 CY 2018	DY 14 CY 2019	DY 15 CY 2020	DY 16 CY 2021
DSHP – State Funded Exchange Subsidy	$6,520,640	$7,172,704	$7,889,974	$8,678,971	$9,546,869

b. Reporting. The state must provide data regarding the operation of this subsidy program in the annual report required per STC 49. This data must, at a minimum, include:
   i. The number of individuals served by the program;
   ii. The size of the subsidies; and
   iii. A comparison of projected costs with actual costs.

c. Budget Neutrality. This subsidy program will be subject to the budget neutrality limit.

41. State-funded Mental Health Community Rehabilitation and Treatment (CRT) Services.

a. The state may claim as allowable expenditures under the demonstration payments through a state funded program for CRT services, as defined by Vermont rule and policy, provided to individuals with severe and persistent mental illness who have

incomes above 133 percent of the FPL and up to and including 185 percent of FPL who are not Medicaid enrolled. This program will be subject to the budget neutrality limit. A description of the services can be found in Attachment E: Global Commitment Specialized Program Service Definitions. Expenditures for this DSHP must not include any expenditures listed in STC 82 ("Investment Approval Process"). The state must submit a claiming protocol for this DSHP and the protocol will become Attachment L.

IX. MONITIORING AND REPORTING REQUIREMENTS

42. Monitoring Calls. CMS will convene periodic conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration, including planning for future changes in the program. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS will jointly develop the agenda prior to the calls. Areas to be addressed during the monitoring call include, but are not limited to:

Operations and performance;

a. Transition and implementation activities;
b. Stakeholder concerns;
c. Enrollment;
d. Cost sharing;
e. Quality of care;
f. Beneficiary access;
g. Benefit package and wrap around benefits;
h. Audits;
i. Lawsuits;
j. Financial reporting and budget neutrality issues;
k. Progress on evaluation activities and contracts;
l. Related legislative developments in the state; and
m. Any demonstration changes or amendments the state is considering such as the state's section 1115 SUD demonstration amendment.

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

44. **Submission of Post-approval Deliverables.** The state shall submit all required analyses, reports, design documents, presentations, and other items specified in these STCs ("deliverables"). The state shall use the processes stipulated by CMS and within the timeframes outlined within these STCs.

45. **Compliance with Federal Systems Innovation**. As federal systems continue to evolve and incorporate 1115 waiver reporting and analytics, the state shall work with CMS to revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems. The state will submit the monitoring reports and evaluation reports to the appropriate system as directed by CMS.

46. **Deferral for Failure to Submit Timely Demonstration Deliverables.** The state agrees that CMS may issue deferrals in the amount of $5,000,000 (federal share) when deliverables are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS.

    a) Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

    b) For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Should CMS agree to the state's request, a corresponding extension of the deferral process described below can be provided.

        i. CMS may agree to a corrective action as an interim step before applying the deferral, if requested by the state.

    c) The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

    d) When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.

    e) As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

    f) CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example the structure of the state request for an extension, what quarter the deferral applies to, and how the deferral is released.

47. **Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), should CMS undertake a federal evaluation of the demonstration or any component of the demonstration,

the state shall cooperate fully and timely with CMS and its contractors' evaluation activities. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required by the state under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in Section IX, STC 46.

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

49. Quarterly and Annual Progress Reports.

a. The state must submit three (3) Quarterly Reports and one (1) compiled Annual Report each DY. The Quarterly Reports are due no later than sixty (60) days following the end of each demonstration quarter. The compiled Annual Report is due no later than ninety (90) days following the end of the DY.

b. The Quarterly and Annual Reports shall provide sufficient information for CMS to understand implementation progress of the demonstration including the reports documenting key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The reports will include all required elements and should not direct readers to links outside the report. (Additional links not referenced in the document may be listed in a Reference/Bibliography section).

c. The Quarterly and Annual Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

    i. Operational Updates - The reports shall provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held.

    ii. Performance Metrics – Progress any required monitoring and performance metrics must be included in writing in the Quarterly and Annual Reports.

Information in the reports will follow the framework provided by CMS and be provided in a structured manner that supports federal tracking and analysis.

iii. Budget Neutrality and Financial Reporting Requirements – The state must provide an updated budget neutrality workbook with every Quarterly and Annual Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.

iv. Evaluation Activities and Interim Findings. The state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed. The state shall specify for CMS approval a set of performance and outcome metrics and network adequacy, including their specifications, reporting cycles, level of reporting (e.g., the state, health plan and provider level, and segmentation by population) to support rapid cycles assessment in trends for monitoring and evaluation of the demonstration.

v. The Annual Report must include all items outlined in STC 49. In addition, the Annual Report must at a minimum include the requirements outlined below:

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

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

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

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

50. Compliance with Managed Care, Network Adequacy, Quality Strategy and EQR Reporting Requirements. The state must comply with all managed care reporting regulations at 42 CFR Part §438 et. seq., except as expressly identified as not applicable in the expenditure authorities incorporated into these STCs.

51. State Data Collection.

1. The state must collect data and information necessary to oversee service utilization and rate setting by provider/plan, comply with the Core Set of Children's Health Care

Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP, obtain NCQA and other accreditations that the state may seek, and comply with other existing federal measure sets.

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

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

4. The raw and edited data will be made available to CMS within thirty (30) days of a written request.

X. GENERAL FINANCIAL REQUIREMENTS

52. Quarterly Expenditure Reports. The state must provide quarterly expenditure reports using the form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XI (Monitoring Budget Neutrality).

53. Reporting Expenditures Subject to the Budget Neutrality Cap. In order to track expenditures under this demonstration, Vermont must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System, following routines from CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures subject to the budget neutrality cap must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which the expenditure was made). Reporting for expenditures made subsequent to termination of the demonstration must indicate the demonstration year in which services were rendered. Payment adjustments attributable to expenditures under the demonstration must be recorded on the applicable Global Commitment prior quarter waiver form, identified as either CMS-64.9P Waiver (Medical Assistance Payments) or CMS-64.10P Waiver (Administrative Payments). When populated, these forms read into the CMS-64 Summary sheet, Line 7 for increasing adjustments and Line 10B for decreasing adjustments. Adjustments not attributable to this demonstration should be reported on non-waiver forms, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined in subparagraph (b) below.

a. For each demonstration year, separate form CMS-64.9 waiver and/or 64.9P waiver reports must be submitted reporting expenditures subject to the budget neutrality cap.

All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported. The sum of the expenditures from the separate reports will represent the expenditures subject to the budget neutrality cap (as defined in subparagraph (c) below) Medical expenditures for the new adult group, as described below, are not subject to the demonstration's budget neutrality cap, but they are subject to Supplemental Budget Neutrality Test 1, as defined in STC 64. The Vermont Global Medicaid eligibility groups, for reporting purposes, include the names and definitions described in the table below.

Corresponding Population number per STC 17	Reporting name description	CMS 64 Reporting Name
Populations 1-2	Report expenditures for individuals eligible as aged, blind, or disabled under the state plan.	**"ABD"**
	Report the expenditures for all non-ABD children and adults in the state plan mandatory and optional categories, with the exception of adults eligible under population 3.	**"non-ABD"**
	Report for all expenditures for all non-ABD children and adults in optional categories.	
Population 3	Report for all medical expenditures for the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119.	**"New Adult Group Medical"**
Population 4	Report for all expenditures for individuals eligible as part of the Highest Need Group.	**"ABD"**
Population 5	Report for all expenditures for individuals eligible as part of the High Need Group.	**"ABD"**

Corresponding Population number per STC 17	Reporting name description	CMS 64 Reporting Name
Population 6	Report for all expenditures for individuals eligible as part of the Moderate Needs Group.	**"Moderate Needs"**
Population 7 Population 8	Report for all expenditures for individuals eligible as pharmacy-only expansions through VT Global (previously VHAP Rx).	**"VT Global Rx"**
Investments	Report for all expenditures labeled investments as described in STC 79, except for DSR investments.	**"Investments (formerly referred to as "MCO Investments")**
Delivery System Reform (DSR) Investments	Report for all expenditures labeled DSR investments as described in STC 83.	**"DSR Investments"**
Individually Assessed Cost Effective Services	Report for all expenditures labeled individually assessed cost effective services described in STC 19(b).	**"Ind Cost Eff Serv"**
Designated State Health Programs	Report for designated state health program expenditures for the state-funded Marketplace subsidy program for individuals at or below 300 percent of the FPL who purchase health care coverage in the Marketplace.	**"Marketplace Subsidy"**
Designated State Health Programs	Report for designated state health program expenditures for individuals receiving CRT services who are not Medicaid enrolled.	**"CRT DSHP"**

b. It is understood that individuals receiving Community Rehabilitation and Treatment (CRT) Services are included in MEGs that are reported on the CMS-64. Reporting to CMS will occur via a supplemental information report provided as backup to the CMS-64. This report will be submitted concurrently with the other CMS-64 backup documentation submitted every quarter.

c. For purposes of this section, the term "expenditures subject to the budget neutrality cap" must include all Medicaid expenditures on behalf of the individuals who are enrolled in this demonstration (as described in subparagraph (a) of this section) and who are receiving the services subject to the budget neutrality cap. All Global Commitment to Health program expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and must be reported on line 49 of forms CMS-64.9 waiver and/or 64.9P waiver. The state must continue to report Choices for Care program (nursing facility and HCBS) expenditures on the appropriate service line on the CMS-64.

c. Premiums and other applicable cost-sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS on the CMS-64 Summary Sheet, Line 9D "Other." In order to ensure that the demonstration is properly credited with premium collections, please indicate in the CMS- 64 Certification "Footnotes" section that Line 9D of the Summary Sheet is for Global Commitment Collections only.

d. Administrative costs are not included in the budget neutrality agreement. The state must report administrative costs on the appropriate CMS-64 reporting line. Administrative costs associated with investments that are strictly administrative in nature are subject to the budget neutrality limit and are reported on the "Investments" or "DSR investments" waiver forms. All other administrative costs must be identified on the Forms CMS-64.10 waiver and/or 64.10P Waiver.

e. MBES/CBES Schedule C Reporting Adjustments. The state must submit prior period adjustments subsequent to the routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual to report actual expenditures incurred for demonstration services in DY9 (CY 2014) through DY11 (CY 2016). The state shall complete these reporting adjustments within twelve (12) months of the date of CMS' approval of this extension and provide written certification of the accuracy of the adjusted expenditures upon completion. The state must provide an update on the progress of these adjustments during the CMS monitoring calls described in STC 42.

f. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within two (2) years after the calendar quarter in which the state made the expenditures. Furthermore, all title XIX claims for services during the demonstration period (including any cost settlements and claims incurred during the demonstration but paid subsequent to the end date of the

demonstration) are considered allowable expenditures under the demonstration and must be made within two (2) years after the conclusion or termination of the demonstration. During the latter two (2)-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

g. At the end of the demonstration, all investment claims (as defined in STC 79) for expenditures subject to the budget neutrality cap (including any cost settlements and non-title XIX claims incurred during the demonstration but paid subsequent to the end date of the demonstration) must be made within two (2) quarters (six (6) months) after the calendar quarter in which the state made the expenditures. During the latter six (6) month period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

h. Disproportionate Share Hospital (DSH) payments are not counted as expenditures under the demonstration.

54. Reporting Member Months. The following describes the reporting of member months for demonstration populations.

a. For the purpose of calculating the budget neutrality expenditure limit and for other purposes, the state must provide to CMS, as part of the Quarterly Report required under STC 49, the actual eligible member months for each of the EGs described above. The state must submit a statement accompanying the Quarterly Report, which certifies the accuracy of this information. To permit full recognition of "in process" eligibility, reported counts of member months may be subject to revision.

b. The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three (3) months contributes three (3) eligible member/months to the total. Two (2) individuals, who are eligible for two (2) months, each contributes two (2) eligible member months to the total, for a total of four (4) eligible member/months.

55. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. Vermont must estimate matchable Medicaid expenditures on the quarterly form CMS-37 based on the PMPM limit (or a percentage of the PMPM limit) and projected caseload for the quarter. In addition, the estimate of matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality cap must be separately reported by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administrative costs (ADM) outside of the PMPM limit. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within thirty (30) days after the end of each quarter, the state must submit

the form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures, consistent with the definition of an expenditure in 45 C.F.R. 95.13, made in the quarter just ended.

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

56. Sources of Non-Federal Share. The state certifies that the source of the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used as the non-Federal share for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. CMS will review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

57. State Certification of Public Expenditures. Nothing in these STCs concerning certification of public expenditures relieves the state of its responsibility to comply with federal laws and regulations, and to ensure that claims for federal funding are consistent with all applicable requirements. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

a. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

b. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. The state must receive prior approval from CMS before implementing any CPEs. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

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

revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

d. The state may use intergovernmental transfers as a source of non-federal share to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the payment for the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment. Intergovernmental transfers are not themselves expenditures, but may be a source of funding for expenditures.

58. Monitoring the Demonstration. The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

59. Program Integrity. The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

60. Limit on Title XIX Funding. Vermont will be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit will consist of two parts, Medicaid Eligibility Groups defined in these Terms and Conditions and the New Adult Group, and are determined by using a per capita cost method. The Supplemental Test 1 for the New Adult Group is described in STC 64. Actual expenditures subject to the budget neutrality expenditure limit must be reported by Vermont using the procedures described in the section for General Financial Requirements under title XIX. The data supplied by the state to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the Medicaid Budget and Expenditure System/ Children's Health Insurance Budget and Expenditure System (MBES/CBES). As described in STC 9(b), when the state submits its extension request, it must include five years of recent historical expenditure and enrollment data for the Medicaid and demonstration populations that are to be included in the demonstration extension, and a proposed budget neutrality test for the

extension period based on recent data.

61. Risk. Vermont will be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, Vermont will not be at risk for changing economic conditions which impact enrollment levels. However, by placing Vermont at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

62. Budget Neutrality Annual Expenditure Limit. For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each Eligibility Group (EG) described as follows:

a. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state for that EG under the section entitled General Reporting Requirements, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (b) below.

b. The PMPMs for each EG used to calculate the annual budget neutrality expenditure limit for this demonstration is specified below.

Medicaid Eligibility Group	Trend Rate	DY 12 PMPM CY 2017	DY 13 PMPM CY 2018	DY 14 PMPM CY 2019	DY 15 PMPM CY 2020	DY 16 PMPM CY 2021
ABD - Non-Medicare – Adult	3.70%	$1,509.69	$1,565.54	$1,623.47	$1,683.54	$1,745.83
ABD - Non-Medicare – Child	3.70%	$2,957.18	$3,066.60	$3,180.06	$3,297.72	$3,419.74
ABD – Dual	3.70%	$2,599.65	$2,695.84	$2,795.58	$2,899.02	$3,006.28
ANFC - Non-Medicare – Adult	4.90%	$644.18	$675.75	$708.86	$743.60	$780.03
ANFC - Non-Medicare – Child	4.60%	$537.35	$562.07	$587.93	$614.97	$643.26

c. Each DY, the net variance between the without-waiver cost and actual with-waiver cost will be reduced. The reduced variance, to be calculated as a percentage of the total variance, will be used in place of the total variance to determine overall budget neutrality for the demonstration. (Equivalently, the difference between the total variance and reduced variance could be subtracted from the without-waiver cost estimate.) The formula for calculating the reduced variance is, reduced variance equals total variance times applicable percentage. The percentages for each EG and DY are determined based on how long the associated population has been enrolled in managed care subject to this demonstration; lower percentages are for longer

established managed care populations. In the Vermont demonstration, the percentages below apply to all EGs in the same manner.

	DY 12 CY 2017	DY 13 CY 2018	DY 14 CY 2019	DY15 CY 2020	DY 16 CY 2021
Savings Percentage	30%	25%	25%	25%	25%

63. Impermissible DSH, Taxes or Donations. The CMS reserves the right to adjust the budget neutrality terms in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new federal statutes, or with policy interpretations implemented through letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality terms if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.

64. Monitoring of New Adult Group Spending and the Opportunity to Adjust Projections. For each DY, a separate annual budget limit for the new adult group will be calculated as product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the state under the guidelines set forth in STC 54. The trend rates and per capita cost estimates for the new adult group are listed in the table below.

Medicaid Eligibility Group	Trend Rate	DY 12 PMPM CY 2017	DY 13 PMPM CY 2018	DY 14 PMPM CY 2019	DY 15 PMPM CY 2020	DY 16 PMPM CY 2021
New Adult Group	4.20%	$518.26	$540.03	$562.71	$586.34	$610.97

a. If the state's experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above may underestimate the actual costs of medical assistance for the new adult group, the state has the opportunity to submit an adjustment to the PMPM limit, along with detailed expenditure data to justify this, for CMS review without submitting an amendment pursuant to STC 7. In order to ensure timely adjustments to the PMPM limit for a demonstration year, the revised projection must be submitted to CMS by no later than the end of the third quarter of the demonstration year for which the adjustment would take effect. Additional adjustments to the PMPM limit may be made pursuant to the process outlined in (d) below.

b. The budget limit for the new adult group is calculated by taking the PMPM cost projection for the above group in each DY, times the number of eligible member months for that group and DY, and adding the products together across DYs. The federal share of the budget neutrality cap is obtained by multiplying the total computable budget neutrality cap by the federal share.

c. The state will not be allowed to obtain budget neutrality "savings" from this population.

d. If total FFP reported by the state for the new adult group should exceed the federal share of FFP for the budget limit for the new adult group by more than 3 percent following each demonstration year, the state must submit a corrective action plan to CMS for approval.

65. Composite Federal Share Ratios. The federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite Federal Share Ratio. The Composite Federal Share is the ratio calculated by dividing the sum total of federal financial participation (FFP) received by the state on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections and pharmacy rebates, by total computable demonstration expenditures for the same period as reported on the same forms.

66. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. The budget neutrality test for the demonstration extension will incorporate net savings from the immediately prior demonstration period of October 1, 2011 through December 31, 2016, but not from any earlier approval period.

67. Exceeding Budget Neutrality. If the budget neutrality expenditure limit defined in STC 62, at the end of this demonstration period, the overall budget neutrality expenditure cap has been exceeded, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

68. Expenditure Review and Cumulative Target Calculation. CMS will enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the state under budget neutrality. Using the schedule below as a guide, if the state exceeds the cumulative target, they must submit a CAP to CMS for approval within thirty (30) days of notification from CMS. The state will subsequently implement the approved corrective action plan.

Year	Cumulative Target Definition	Percentage
Year 12	Year 12 budget estimate plus	3 percent
Year 13	Years 12 and 13 combined budget estimate plus	3 percent
Year 14	Years 12 through 14 combined budget estimate plus	3 percent
Year 15	Years 12 through 15 combined budget estimate plus	1.5 percent
Year 16	Years 12 through 16 combined budget estimate plus	0 percent

XII. EVALUATION OF THE DEMONSTRATION

69. Independent Evaluator. At the beginning of the demonstration period, the state must acquire an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in accord with the CMS-approved, draft evaluation plan. For scientific integrity, every effort should be made to follow the approved methodology, but requests for changes may be made in advance of running any data or due to mid-course changes in the operation of the demonstration.

70. Evaluation Design and Implementation. The state shall submit a draft evaluation design for the Global Commitment to Health demonstration to CMS no later than 120 days after the award of the Demonstration extension. Such revisions to the evaluation design and the STCs shall not affect previously established timelines for report submission for the insert old demo name, if applicable. The state must submit a final evaluation design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the evaluation design, the state must implement the evaluation design and submit their evaluation implementation progress in each of the quarterly and annual progress reports, including the rapid cycle assessments as outlined in the Monitoring Section of these STCs. The final evaluation design will be included as Attachment K to the STCs. Per 42 CFR 431.424(c), the state will publish the approved evaluation design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit their evaluation implementation progress in each of the Quarterly and Annual Reports as outlined in STC 54.

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

72. Evaluation Requirements.

a. The demonstration evaluation will meet the prevailing standards of scientific evaluation and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings.

    i. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

    ii. The state shall acquire an independent entity to conduct the evaluation. The evaluation design shall discuss the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications the entity must possess, how the state will assure no conflict of interest, and a budget for evaluation activities.

b. The state shall also conduct an evaluation pursuant to STC 86 which shall include an investigation of the impact of providing Medicaid reimbursement for IMD services on the following outcomes among beneficiaries in need of acute mental health or substance use disorder treatment:

    i. Emergency room utilization;
    ii. Lengths of stay in emergency rooms;
    iii. Access to acute inpatient treatment for mental health and substance use disorders;
    iv. Lengths of stay in acute inpatient settings for treatment for those conditions;
    v. Quality of acute mental health or substance use disorder treatment;
    vi. Quality of discharge planning in making effective linkages to community-based care;
    vii. Readmissions for inpatient treatment;
    viii. Cost of treatment for acute mental health or substance use disorder conditions;
    ix. Access to care for co-morbid physical health conditions;
    x. Quality of care for co-morbid physical health conditions; and
    xi. Overall cost of care for mental health and substance use disorders and co-morbid physical conditions combined.

73. Evaluation Design Requirements. The Evaluation Design shall include the following core components to be approved by CMS:

a. Research questions and hypotheses: This includes a statement of the specific research questions and testable hypotheses that address the goals of the demonstration. The state's design must include research questions and testable hypotheses that address the impact of providing Medicaid payment for IMD services including the impacts on the outcomes of interest listed above in STC 72(b). At a minimum, the research questions shall address the goals of the demonstration such as improving access, improving quality of care thereby leading to enhanced health outcomes, and lowering costs. The research questions will have appropriate comparison groups and may be studied in a time series. The analyses of these research questions will provide the basis for robust assessment of cost effectiveness. The following are among the hypotheses to be considered in development of the evaluation design and will be included in the design as appropriate:

   i. The demonstration will result in improved access to care;
   ii. The demonstration will result in improved quality of care;
   iii. Value-based payment models will promote appropriate use of resources;
   iv. Improved access to preventive care will result in lower overall costs for the healthcare delivery system;
   v. Improved access to primary care will result in positive health outcomes; and
   vi. Enhanced care coordination will promote timely access to needed care.

   These hypotheses should be addressed in the demonstration reporting described in STC 49 with regard to progress towards the expected outcomes.

b. Study Design: The design will include a description of the quantitative and qualitative study design to be used (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.), as well as a rationale for the methodologies selected. The discussion will include a proposed baseline and approach to comparison; examples to be considered as appropriate include the definition of control and/or comparison groups or within-subjects design and difference in differences design to a discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time. The former will address how the effects of the demonstration will be isolated from those other changes occurring in the state at the same time through the use of comparison or control groups to identify the impact of significant aspects of the demonstration. The discussion will include approach to benchmarking, and should consider applicability of national and state standards. The application of sensitivity analyses as appropriate shall be considered;

c. Study Population: This includes a clear description of the populations impacted by each hypothesis, as well as the comparison population, if applicable. The design shall include, for purposes of the investigation of the impact of providing Medicaid

payment for IMDs, a discussion of the feasibility of making comparisons between beneficiaries in need of acute mental health or substance use disorder treatment who reside within the catchment areas in the state for IMDs receiving Medicaid reimbursement and beneficiaries in need of acute mental health or substance use disorder treatment who reside in the state but outside of those catchment areas. The design shall also discuss the feasibility of constructing a comparison group of beneficiaries in need of acute mental health or substance use disorder treatment in another state that does not provide Medicaid payment to IMDs. The design shall also make a recommendation as to which comparison group would be preferable. The discussion may include the sampling methodology for the selected population, as well as support that a statistically reliable sample size is available;

d. Access, Service Delivery Improvement, Health Outcome, Satisfaction and Cost Measures: This includes identification, for each hypothesis, of quantitative and/or qualitative process and/or outcome measures that adequately assess the impact on the outcomes of interest listed in STC 72 above. Nationally recognized measures should be used where appropriate. Measures will be clearly stated and described, with the numerator and denominator clearly defined. To the extent possible, the State will incorporate comparisons to national data and/or measure sets. A broad set of performance metrics will be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation, for meaningful use under Health Information Technology (HIT), core measure sets developed by the Core Quality Measures Collaborative, measures identified for the certified community behavioral health clinics (CCBHC) demonstration), and from the CMS Child and Adult Core Measure Sets for Medicaid and CHIP. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care;

e. Data: This discussion shall include: a description of the data sources including a definition/description of the sources and the baseline values for metrics/measures, the frequency and timing of data collection and the method of data collection. The following shall be considered and included as appropriate: i. Medicaid encounter and claims data, ii. Enrollment data, iii. provider network data, iv. consumer and provider surveys, and v. other data needed to support performance measurement relative to access and quality metrics;

f. Assurances Needed to Obtain Data: The design report will discuss the state's arrangements to assure needed data to support the evaluation design are available, including from health plans;

g. Data Analysis: This includes a detailed discussion of the method of data evaluation, including appropriate statistical methods that will allow for the effects of the demonstration to be isolated from other initiatives occurring in the state. The level of analysis may be at the beneficiary, provider, and program level, as appropriate, and shall include population stratifications, for further depth. Sensitivity analyses shall be

used when appropriate. Qualitative analysis methods shall also be described, if applicable;

h. Timeline: This includes a timeline for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables outline in this section. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the final summative evaluation report is due;

i. Evaluator: This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess; how the state will assure no conflict of interest, and a budget for evaluation activities; and

j. State additions: The state may provide to CMS any other information pertinent to the state's research on the policy operations of the demonstration operations. The state and CMS may discuss the scope of information necessary to clarify what is pertinent to the state's research.

74. Evaluation Standards. The demonstration evaluation will meet the prevailing standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation, including standards for the evaluation design, conduct, and interpretation and reporting of findings. The demonstration evaluation will use the best available data; use controls and adjustments for and reporting of the limitations of data and their effects on results; and discuss the generalizability of results.

75. Interim Evaluation Report.

a. The state is required to submit a draft Interim Evaluation Report 90 days following completion of year one (1) of the demonstration extension (April 1, 2018). The interim evaluation shall include an assessment of the impact of providing Medicaid payment for IMD services on the research questions included in the final evaluation design including the outcomes of interest listed above in STC 72 for the four (4) year period preceding the start of this demonstration. The Interim Evaluation Report shall include the same core components as identified in STC 76 for the Summative Evaluation Report and should be in accordance with the CMS approved evaluation design. The state shall submit the final Interim Evaluation Report within thirty (30) days after receipt of CMS' comments. The interim evaluation will inform the state's IMD phase-down plan which is due December 31, 2018.

b. The state is also required to submit a draft interim evaluation report for the completed years of the demonstration, as outlined in 432 CFR 431.412(c)(2) (vi) one year prior to the current expiration date of the demonstration. The state will submit the final interim evaluation report thirty (30) days after receiving CMS comments.
    i. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.

ii. For demonstration authority that expires prior to the overall demonstration's expiration date, the interim evaluation report must include an evaluation of the authority as approved by CMS.
iii. If the state requests changes to the demonstration, it must identify research questions and hypotheses related to the changes requested and an evaluation design for addressing the revisions.

76. Summative Evaluation Reports. The state shall provide the summative evaluation reports described below to capture the demonstration period covered by this renewal. The summative evaluation shall include an assessment the impact of providing Medicaid payment for IMD services on the research questions included in the summative evaluation design including the outcomes of interest listed above in STC 72(b) for the period from year one through year four of this demonstration extension. The IMD summative evaluation is due ninety (90) days after the completion of DY 4 of the extension period, therefore by April 1, 2021. The state shall provide a Summative Evaluation Report for the demonstration period starting January 1, 2017 through December 31, 2021.

The state is required to submit a preliminary report within ninety (90) days of year four (4) of the demonstration period, therefore by April 1, 2021. This report should include documentation of outstanding assessments due to data lags to complete the interim evaluation.

The second of these is due within eighteen (18) months of the end of the demonstration period, (June 30, 2022). The state shall respond to CMS comments and submit the Final Summative Evaluation Report within thirty (30) days after receipt of CMS' comments. The Summative Evaluation Report shall include the following core components:

a. Executive Summary. This includes a concise summary of the goals of the demonstration; the evaluation questions and hypotheses tested; and key findings including whether the evaluators find the demonstration to be budget neutral, what impact the demonstration has on health outcomes, and any policy implications.

b. Demonstration Description. This includes a description of the demonstration programmatic goals and strategies.

c. Study Design. This includes a discussion of the evaluation design employed including research questions and hypotheses; type of study design; impacted populations and stakeholders; data sources; and data collection; analysis techniques, including controls or adjustments for differences in comparison groups, controls for other interventions in the state and any sensitivity analyses, and limitations of the study.

d. Discussion of Findings and Conclusions. This includes a summary of the key findings and outcomes, particularly a discussion of cost effectiveness, as well as implementation successes, challenges, and lessons learned.

e. Policy Implications. This includes an interpretation of the conclusions; the impact of the

demonstration within the health delivery system in the state; the implications for state and federal health policy; and the potential for successful demonstration strategies to be replicated in other state Medicaid programs.

f. Interactions with Other State Initiatives. This includes a discussion of this demonstration within an overall Medicaid context and long range planning, and includes interrelations of the demonstration with other aspects of the state's Medicaid program, and interactions with other Medicaid waivers, the SIM award and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This final report shall include a detailed description of Medicaid payment for mental health and substance use disorder services in the state including payment for inpatient and community-based services each year from 2009 through year three (3) of the demonstration extension.

77. State Presentations for CMS. The state will present to and participate in a discussion with CMS on the final design plan, post approval, in conjunction with STC 73. The state shall present on its interim evaluation in conjunction with STC 75. The state shall present on its summative evaluation in conjunction with STC 76.

78. Public Access. The state shall post the final approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report on the State Medicaid website within thirty (30) days of approval by CMS.

a. For a period of twenty-four (24) months following CMS approval of the Summative Evaluation Report, CMS will be notified prior to the public release or presentation of these reports and related journal articles, by the State, contractor or any other third party directly connected to the demonstration. Prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. CMS will be given thirty (30) days to review and comment on journal articles before they are released. CMS may choose to decline some or all of these notifications and reviews.

XIII. USE OF DEMONSTRATION FUNDS

79. Use of Demonstration Funds. Since 2005, the state has been able to make expenditures previously referred to as "Managed Care Organization" (MCO) investments. As part of the 2017 extension these expenditures will be referred to as "investments." The demonstration provides authority for expenditures within the annual limits specified in STC 81 below and can include expenditures within the following areas:

a. Reduce the rate of uninsured and/or underinsured in Vermont;
b. Increase the access to quality health care by uninsured, underinsured, and Medicaid beneficiaries;
c. Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and

d. Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system and promote transformation to value-based and integrated models of care.

80. Phase-Down of Investments. The state must follow the phase-down schedule below for the following investments. The percentages note how much of the SFY 2016 amount the state has authority to spend for DY 1 through DY 5 of the extension period.

	DY 1 of the extension CY 2017 DY 12	DY 2 of the extension CY 2018 DY 13	DY 3 of the extension CY 2019 DY 14	DY 4 of the extension CY 2020 DY 15	DY 5 of the extension CY 2021 DY 16
Vermont Psychiatric Care Hospital, Brattleboro Retreat, Valley Vista, Maple Leaf, Serenity House, and Lund Home (IMD)	100%	100%	100%	100%	Amount to be determined per the phase-down schedule in STC 87
HIT	100%	50%	0%	0%	0%
Non-state plan Related Education Fund Investments, Room and Board, and Physician Training Program not tied to serving in an underserved area	100%	100%	67%	33%	0%

81. Investment Annual Limits. The table below shows the specific annual limits. These amounts cannot be rolled over from DY to DY.

	DY 1 of the extension	DY 2 of the extension	DY 3 of the extension	DY 4 of the extension	DY 5 of the extension	Total
	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	
Annual Investment Limit	$142.5M	$148.5M	$138.5M	$136.5M	$136.5M	$702.5M

82. Investment Approval Process. The state may spend up to the amounts listed in the above "Investment Annual Limits" STC 81 on approved investments during each DY. See Appendix H for a list of approved investments. The state must submit an Investment Claiming Protocol for all current and new investments. This protocol will become attachment M. The annual limits cannot be rolled-over to the next DY. If the state chooses to add a new investment, it must meet the criteria specified in STC 79 "Use of Demonstration Funds" and must not supplant other federal involvement (including meeting a maintenance of effort requirement for any federal grant program) and must not include the following, including other activities CMS determines are unallowable:

i. Construction costs (bricks and mortar);
ii. Room and board;
iii. Animal Shelters and Vaccines;
iv. Provider or Beneficiary Debt Relief and Restructuring;
v. Sheltered Workshops;
vi. Research expenditures;
vii. Rent and/or Utility Subsidies that are normally funded by the United States Department of Housing and Urban Development;
viii. Prisons, correctional Facilities or services for people who are civilly committed and unable to leave an institutional setting;
ix. Services provided to individuals who are not lawfully present in the United States or are undocumented;
x. Facility closures;
xi. Unspecified projects; and
xii. School based programs for children.

83. Accountable Care Organization (ACO) and Medicaid Community Provider Integration Program ("Medicaid Pathway") Investments.

CMS is making one-time funding available under the above investment structure for the state to assist the Accountable Care Organization (ACO) and Medicaid community providers in one-time, developmental start-up funding. STC 84 establishes that Vermont shall notify CMS of delivery system-related investments that fall within the following categories which requires that the state notify CMS ninety (90) days prior to claiming for any of the proposed new investments. If CMS

finds that the proposed investment does not meet the criteria outlined in STC 79 and 84, it must notify Vermont of this finding within forty-five (45) days. For investments that do not fall within the categories below, Vermont must follow the notification and CMS review procedures as described in STC 85. The state must not include any costs listed in STC 82 above.

a. Delivery System Related Investment Categories
The goal of the delivery system-related investments is to support implementation of Vermont's All Payer Accountable Care Organization (ACO) model.

- Category #1 projects consists of funding to the Accountable Care Organization(s). Funding under category #1 is limited to development costs only.
- Category #2 projects consist of funding to providers.

b. Vermont may select time-limited, start-up delivery system investments in DY one (1) through DY four (4) of the extension period and maintenance investments in DY five (5) of the renewal period. These are time-limited investments that are expected to phase down and out at the end of five (5) years. There may not be start-up investments in DY five (5) of the extension period.

c. A project plan is required for each project and shall include an explanation of how the project will provide a return on investment over the demonstration extension period and how the project could be sustainably funded or phased out by the completion of the five (5) year demonstration extension period. The state must include metrics for all projects and the metrics are required for all years that the project receives funding. Detailed requirements are listed in Appendix I.

d. Vermont may include one-time, development start-up funding for its ACO and "Medicaid Pathways" program as an investment as long as the projects meet the criteria in Appendix. For such projects, Vermont will follow the new investment notification requirements in STC 84 below.

84. New Investment Notification. The state must notify CMS of any new investments. Investments must meet the criteria in STC 79 above and must not include any of the activities listed in STC 82 above. The state must submit information regarding new investments following the template in Attachment J. The state may also choose from a menu of time-limited, start-up, one-time delivery system activities listed in Appendix I and must indicate if the proposed investment is strictly administrative in nature. The state must notify CMS ninety (90) days prior to claiming for any of the proposed new investments. CMS reserves the right to not approve new investments if they do not meet the criteria above or if CMS and the state cannot agree to a phase-down schedule for the Vermont Psychiatric Care Hospital and other IMD costs. If CMS finds that the proposed investment does not meet the criteria above, it must notify Vermont of this finding within forty-five (45) days. If CMS notifies the state with concerns, the proposed investment will be considered under review as outlined in STC 85 below.

85. Requirement for Approval of Investments That Do Not Meet Criteria. The state may request to add an investment that that does not meet the requirements of STC 83 or the menu of delivery system projects in Attachment I. In this instance, the state must submit a letter to CMS at least 120 days prior to the proposed implementation explaining the investment and providing justification for the investment, including how the investment advances the goals of the Medicaid program and demonstration. CMS will review the investment and will issue a disapproval or approval within sixty (60) days of receipt of the state's letter.

86. IMD Evaluation Requirements. CMS is continuing time-limited expenditure authority for costs not otherwise matchable, subject to the cap described in STC 87 for costs of care to eligible individuals at a specific group of facilities (listed in STC 80) that are IMDs. Furthermore, the state anticipates seeking to amend the demonstration to take advantage of the SUD demonstration opportunity outlined in CMS' July 2015 guidance, entitled "New Service Delivery Opportunities for Individuals with a Substance Use Disorder." Given this unique previously approved authority, CMS is asking the state to perform an extensive evaluation of the IMD expenditure authority (in addition to the evaluation that will be part of a future SUD demonstration opportunity) on individuals with serious mental illness as well as individuals in need of acute mental health and substance use disorder services in the context of system-wide service, payment, and delivery system reforms. The evaluation will help inform broader policy discussions about Medicaid funding for IMD services.

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

88. Application Process for Use of Demonstration Funds. AHS will use a standardized approach to evaluate new investment applications. Documentation of new and proposed investments will be posted on the state's Global Commitment to Health register website. Where specific program statistics for Medicaid, uninsured, or underinsured members are not available, the state will apply a proxy percentage for allowable expenditures based on the most recent reliable and valid state survey information such as the Vermont Household Health Insurance Survey. Monitoring and evaluation of approved investments will be performed and submitted to CMS in the quarterly and annual reports to ensure that expenditures advance the goals of the demonstration and the Medicaid program and do not violate the restrictions listed in STC 82.

89. Administrative Investments. The state may only receive the 50 percent administrative matching rate for investments that are strictly administrative in nature. The following investments have been found to be strictly administrative in nature:

a. Green Mountain Care Board;

b. Health Research and Statistics;
c. Patient Safety Adverse Events; and
d. Area Health Education Centers (AHEC).

XIV. MEASUREMENT OF QUALITY OF CARE AND ACCESS TO CARE

90. Comprehensive State Quality Strategy (CQS). The state shall expand upon the managed care quality strategy requirements at 42 CFR 438.340 and adopt and implement a comprehensive, dynamic, and holistic continuous quality improvement strategy that integrates all aspects of quality improvement programs, processes, and requirements across the state's Medicaid program. This comprehensive quality strategy (CQS) must address quality improvement for all components of the state's Medicaid state plan and its section 1115 demonstration. The CQS must meet all the requirements of 42 CFR 438 and must include LTSS and HCBS quality components.

a. *CQS Elements*. The CQS must also address the following elements , as well as those identified in 42 CFR 438.340(b):

i. Goals. Building on the requirements at 42 CFR 438.340(b)(2), the state's goals for improvement, identified through claims and encounter data, quality metrics, and expenditure data. The goals should align with the three-part aim but should be more specific in identifying pathways for the state to achieve these goals.

ii. Responsibilities. The CQS must identify Single State Agency and public managed care responsibilities. The Single State Agency retains ultimate authority and accountability for public managed care responsibilities and adherence to the CQS, including monitoring and evaluation of the public managed care model's compliance with requirements specific to the MLTSS assurances identified in STC 90(a)(v)(2) below as well as the health and welfare of enrollees.

iii. Performance Improvement Projects (PIPs). Building on the requirements at 42 CFR 438.340(b)(3)(ii), the associated interventions for improvement in the goals. All performance improvement project (PIP) topics, tied to specific goals, must be included in the CQS.

iv. Performance Measures. Building on the requirements at 42 CFR 438.340(b)(3)(i), the specific quality metrics for measuring improvement in the goals. The metrics should be aligned with the CMS Child and Adult Core Measure Sets for Medicaid and CHIP, and should also align with other existing Medicare and Medicaid federal measure sets where possible and appropriate. The metrics should go beyond Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, and should reflect cost of care.

1. Levels of Aggregation. Metrics should be measured at the following levels of aggregation: the state Medicaid agency, specific health care program (such as Choices for Care), if applicable, and potentially at each direct health services provider. The state will work with CMS to further define metrics, as appropriate, for collection.

2. Benchmarks and Targets. The specific methodology for determining benchmark and target performance on these metrics.

v. Populations. Specific metrics related to each population covered by the Medicaid program, including children, pregnant women, non-disabled adults (including parents), individuals receiving HCBS services, and individuals receiving LTSS.

1. HCBS performance measures in the areas of: level of care determinations, person-centered service planning process, outcome of person-centered goals, health and welfare, outcomes, quality of life, effectives process, community integration, and assuring there are qualified providers and appropriate HCBS settings.

2. The CQS must include a special focus on MLTSS populations and address the following:

a. A self-assessment of MLTSS adherence to state and federal standards of care to include:

i. Assessment of existing initiatives designed to improve the delivery of MLTSS, including performance measures or PIPs directed to this population.

ii. Examination of processes to identify any potential corrective action steps toward improving the MLTSS system.

b. Person-Centered Planning and Integrated Care Settings

c. Comprehensive and Integrated Service packages

d. Qualifications of Providers

e. Participant Protections

vi. Timeline. The CQS should include a timeline that considers metric development and specification, contract amendments, data submission and

review, incentive disbursement (if available), and the re-basing of performance data.

vii. Monitoring and Evaluation. This should include specific plans for continuous quality improvement, which includes transparency of performance on metrics and structured learning, as well as a rigorous and independent evaluation of the demonstration, as described in STC 74. The evaluation in STC 74 should reflect all the programs covered by the CQS as mentioned above.

viii. Performance improvement accountability. The state must include in its CQS a determination of how plans for financial incentives, if available, adequately align with the specific goals and performance improvement targets, and whether enhancements to these incentives are necessary (increased or restructured financial incentives, in-kind incentives, contract management, etc.).

b. *State and Provider Responsibilities*. The CQS must include state Medicaid agency and any contracted service providers' responsibilities, including managed care entities, and providers enrolled in the state's FFS program. The state Medicaid agency must retain ultimate authority and accountability for ensuring the quality of and overseeing the operations of the program. The CQS must include distinctive components for discovery, remediation, and improvement.

c. *CQS Development, Evaluation, and Revision*. The state must comply with the requirements at 42 CFR 438.340(c) regarding the development, evaluation, and revision of the CQS. This includes the requirements at 42 CFR 438.340(c)(1) regarding public engagement. The state must revise (and submit to CMS for review) the CQS whenever this demonstration is renewed or materially amended, or when significant changes are made to the associated Medicaid programs and thus the content of the CQS. An outline and/or driver diagram for the revised CQS must be submitted to CMS with ninety (90) days of approval of the demonstration extension or material amendment. A draft of the revised CQS must be submitted to CMS for review within 180 days of approval of the demonstration extension or material demonstration amendment.

i. A material amendment to the demonstration is one that makes changes to the populations that participate in managed care; changes the services included in the managed care program; changes how the managed care program operates; brings an existing program into the demonstration, or otherwise substantially impacts a component of the CQS.

ii. Any further revisions must be submitted accordingly:

1. Modifications to the CQS due to changes in the Medicaid operating authorities must be submitted concurrent with the

proposed changes to the operating authority (e.g., state plan or waiver amendments or waiver extensions); and/or

2. Changes to an existing CQS due to fundamental changes to the CQS must be submitted for review to CMS no later than sixty (60) days prior to the contractual implementation of such changes. If the changes to the CQS do not impact any provider contracts, the revisions to the CQS may be submitted to CMS no later than sixty (60) days following the changes.

iii. At a minimum, the CQS must be revised at least once every three (3) years (pursuant to 42 CFR 438.340(c)(2)), but no more often than once per year (inclusive of any revisions per the requirements of STC 49.

d. *CQS Annual Reports*. Pursuant to STC 49, Annual Report, the state must include information on the implementation and effectives of its CQS in its annual demonstration reports, which should include a discussion of the CQS as it impacts the demonstration.

e. *Availability*. Consistent with 42 CFR 438.340(d), the state must make the CQS available on the Web site required under 42 CFR 438.10(c)(3).

XV. SCHEDULE OF THE STATE DELIVERABLES OF THE DEMONSTRATION PERIOD

Date Specific	Deliverable	STC Reference
Within six (6) months of the demonstration's implementation and annually thereafter.	Post Award Forum	Section IX, STC 43
120 days after approval (~Feb. 14, 2017)	Submit Draft Evaluation Design	Section XII, STC 70
Within sixty (60) days of receipt of CMS comments.	Submit Final Evaluation Design	Section XII, STC 70
90 days following the completion of DY 1 of the extension period, April 1, 2018	Interim Evaluation Report of IMD Expenditures	Section XIII, STC 75(a)

90 days after the completion of DY 4 of the extension period, April 1, 2021	Preliminary Summative Evaluation Report of IMD Expenditures	Section XII, STC 76
One year prior to current expiration date, December 31, 2020	Draft Interim Evaluation Report	Section XII, STC 75(b)
90 days after the completion of DY 4 of the extension period, April 1, 2021	Preliminary IMD Summative Evaluation Report	Section XII, STC 76
Within 18 months of the end of the demonstration period (June 30, 2022)	Summative Evaluation Report	Section XII, STC 76
120 days prior to proposed Implementation	Approval of Investments That Do Not Meet Criteria	Section XIII, STC 85
Ninety (90) days prior to claiming for any of the proposed new investments.	New Investment Notification	Section XIII, STC 84
Within 30 days of CMS written request.	State Data Collected	Section IX, STC 51
No later than December 31, 2018	Phase-Down Plan for Vermont Psychiatric Care Hospital and IMD-expenditures	Section XIII, STC 87

Recurring Date	Deliverable	STC Reference
Not later than April 1st	Draft Annual Report	Section IX, STC 49
Not later than 90 days prior to the effective date.	Interagency Agreement and Rate Certification	Section VI, STC 22

Not later than October 1 of the demonstration year for which the adjustment would take effect.	PMPM limit calculation	Section XI, STC 64(a)
Quarterly	Quarterly Operational Reports	Section IX, STC 49
Quarterly	CMS-64 Expenditure Reports	Section X, STCs 52 & 53
Annually (included in annual report submission)	Comprehensive State Quality Strategy	Section XIV, STC 90

ATTACHMENT A: QUARTERLY REPORT CONTENT AND FORMAT

Under section IX, STC 49, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS sixty (60) days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:
Title Line One – Vermont Global Commitment to Health
Title Line Two – Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 6 (10/1/2010 – 9/30/2011)
Federal Fiscal Quarter: 1/2010 (10/01/2010 – 12/31/2010)

Introduction
Information describing the goal of the demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information
Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

Enrollment Counts

Note: Enrollment counts should be person counts, not member months.

Demonstration Populations	Current Enrollees: last day of the quarter: xx/xx/xxxx	Previously reported enrollees last day of quarter: xx/xx/xxxx	Variance

Demonstration Population 1:
Demonstration Population 2:
Demonstration Population 3:
Demonstration Population 4:
Demonstration Population 5:
Demonstration Population 6:
Demonstration Population 8:

Outreach/Innovative Activities
Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues
Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity. The state must also report on whether any of the HCBW-like programs have waiting lists and an update on the progress of enrolling individuals on the waiting list.

Financial/Budget Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the state's actions to address these issues.

Member Month Reporting
Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Population 1:				
Population 2:				
Population 3:				
Population 4:				
Population 5:				
Population 6:				
Population 7:				
Population 8:				

Consumer Issues
A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also discuss feedback received from the other consumer groups.

Quality Assurance/Monitoring Activity
Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation
Discuss progress of evaluation design and planning.

Enclosures/Attachments
Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT B
Summary of Choices for Care Eligibility Criteria

Choices for Care Eligibility Group	Choices for Care Clinical Eligibility Categories*			
	Need for Assistance with Activities of Daily Living	**Physical Health Needs**	**Behavioral Health Needs/Needs Due to Impaired Decision-Making**	**Unique Circumstances**
Highest	Extensive or total assistance daily with eating, toileting, bed mobility or transfer and limited assistance with any other activity of daily living.	Skilled nursing care on a daily basis for a specific condition/treatment or unstable medical condition.	Severe impairment with decision-making or moderate impairment with behavioral symptoms (e.g., wandering, aggression, resistance to care) that occur frequently and are not easily altered.	Loss of primary caregiver; loss of living situation; health and welfare at imminent risk without services; health condition would be at imminent risk or
High	Extensive or total assistance daily with bathing, dressing, eating, toileting, and mobility.	Skilled nursing care, assessment and monitoring of care on less than daily basis but require an aggregate of personal care, nursing care, therapies and/or medical treatments on a daily basis; skilled teaching to regain or maintain certain skills/control.	Impaired judgment or loss of decision-making that: • Requires controlled environment to maintain safety due to behavioral conditions (e.g., wandering, aggression), • Requires constant or frequent direction to perform certain ADLs.	Health and welfare at imminent risk without services; health condition would worsen without services.

Moderate	Supervision or assistance 3 or more times in 7 days with one ADL or combination of ADL and IADL's.	Chronic condition that requires monitoring at least monthly.	Impaired judgment or decision-making that requires general supervision on a daily basis.	Worsening health condition without services.

*Persons must meet both clinical and financial eligibility requirements detailed in Vermont rule and policy.

ATTACHMENT C

Choices for Care Services by Demonstration Group

All covered services are subject to medical necessity review. A complete description of covered services and limitations is contained in the Vermont approved title XIX State plan, the Choices for Care Operational Protocol, Vermont statutes, regulations, and policies and procedures.

Definitions of each service may be found in Attachment D.

Home and Community-Based Services						
Type of HCBS Service	**Highest Need**	**High Need**	**Moderate Need**	**CRT**	**PACE**	**Limitations**
Adult Day Services	X	X	X	X		Any limitation on this service are defined by Vermont rules and policies.
Assistive Devices and Home Modifications	X	X		X		
Case Management	X	X	X	X		
Companion	X	X		X		Limited in combination with Respite Service.
Homemaker	X	X	X	X		Excluded if participant receives Personal Care services since homemaker activities are included among Personal Care services.
Incidental purchases paid out of cash allotments to participants who are self-directing their services	X	X				Limited to Flexible Choices participants who are self-directing their services.
Nursing Overview	X	X				Limited to participants residing in Enhanced Residential Care.

Type of HCBS Service	Highest Need	High Need	Moderate Need	CRT	PACE	Limitations
Personal Care	X	X		X		Includes assistance with ADLs and limited IADLs; laundry, meal preparation; medication management and non-medical transportation.
Personal Emergency Response System	X	X		X		
Respite Care	X	X		X		Limited in combination with Companion Service for individuals residing at home.
Social and Recreational Activities	X	X				Limited to participants residing in Enhanced Residential Care.
Supervision	X	X				Limited to participants residing in Enhanced Residential Care.
Transportation Services	X	X		X		Non-medical transportation. Limited to participants residing in Enhanced Residential Care. Included in Personal Care for individuals residing at home.

ATTACHMENT D
Choices for Care Long Term Services and Supports Definitions

Long Term Services and Supports Service Definitions & Waiting List Procedures
Comprehensive descriptions and coverage policies, prior authorization, applicant rules and limitations are defined by the Medicaid State Plan, Vermont statutes and rules and program policies.

Choices for Care
Adult day services: Community -based non-residential services that provide a range of professional health, social and therapeutic services delivered in a safe, supportive environment.
Assistive devices and home modifications: An "Assistive Device" is defined as an item which is used to increase, maintain, or improve functional capabilities. Such devices are intended to replace functional abilities lost to the individual because of his or her disability and must be used in performing Activities of Daily Living (ADL) or Instrumental Activities of Daily Living (IADL). A "Home Modification" is defined as a physical adaptation to the home which is necessary to allow safe access to and use of, the individual's primary living space, bathroom, kitchen, or main exit/entrance to the home.
Case management: Assistance to participants in gaining access to needed long-term care Medicaid services and other state plan and/or medical, social and community services. This includes comprehensive assessment and reassessments, treatment and support planning, obtaining and monitoring the provision of services included in the service care plan and assessing the quality, effectiveness and efficiency of CFC services.
Enhanced Residential Care Home Services: A package of services provided by an approved Level III Residential Care Home (RCH) or an Assisted Living Residence (ALR). In addition to services provided to all RCH/ALR residents, these residential settings also provide a Registered Nurse on-site, personal care services and daily social and recreational activity opportunities.
Adult Family Care: 24-hour care and support option in which participants live in and receive services from an Adult Family Care Home which is contracted by an Authorized Agency
Companion care: Non-medical supervision and socialization for participants who are unable to care for themselves.
Homemaker services: Assistance with activities that help to maintain a safe, healthy environment for individuals residing in their homes. Such services contribute to the prevention, delay, or reduction of risk of harm or hospital, nursing home, or other institutional care.

Personal care: Assistance with Activities of Daily Living (ADLs) like eating, dressing, walking, transferring, toileting and bathing and Instrumental Activities of Daily Living (IADLs) such as cooking, cleaning and shopping.
Personal Emergency Systems: Electronic devices which enable individuals at high risk to secure help in an emergency.
Respite care: Alternate care giving arrangements to facilitate planned short term and time limited breaks for unpaid care givers.
Flexible choices (Self Directed Care): Participant or surrogate directed home and community based option which converts a participant's Home Based Service Plan into a cash allowance. Working with a consultant, the participant develops a budget which details expenditure of the allowance and guides the participant's acquisition of services to meet their needs.
Nursing Facility: Health-related services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition that includes provision of or arranging, nursing or related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident.

ATTACHMENT E
Global Commitment Specialized Program Service Definitions

Vermont's specialized programs rely on person centered planning to develop individualized plans of care. Specialized programs support a continuum of care from short term crisis or family support to intensive 24/7 home and community based wraparound services. These programs include both State Plan recognized and specialized non-State Plan services and providers to support enrollees in home and/or community settings. The state may require: additional provider agreements, certifications or training not found in the State plan; specific assessment tools, level of care or other planning processes; and/or prior authorizations to support these programs. This attachment is for summary purposes only, complete service definitions, approved provider types, applicant rules, prior authorizations, limitations and exclusions can be found in Vermont statute, rule and policy.

Traumatic Brain Injury Program (TBI) Services
Crisis Support Services: Time limited services and supports that assist an individual to resolve a severe behavioral, psychological or emotional crisis safely in their community. This includes 24/7 availability, one to one support and case management, hospital diversion programs, mobile outreach, community crisis placements and/or intensive in home support.
Psychological and Counseling Supports: Services provided by or under the direction of licensed practitioners that include, but may not be limited to: clinical assessment; medication and psychiatric consultation; individual, family and group therapy or specialized behavioral or health services.
Case Management: Assistance to enrollees in gaining access to needed waiver, medical, social, educational and other services regardless of the funding source for the services to which access is gained. Case management includes comprehensive assessment; treatment planning and plan of care development, service coordination, monitoring and collateral contacts with persons involved and/or designated by the enrollee.
Community Supports: Individualized support services that may be provided in a family setting, group home, supervised apartment, other community residential setting or in the individual's own apartment/home. Support may include 24-hour care and supervision as part of authorized treatment plan goals and objectives.
Habilitation: Comprehensive and integrated one to one training and support by authorized Life Skills Aides (LSA) to provide training in specific activities of daily living identified in the treatment plan designed to promote independent living and community re-integration.
Respite Care: Alternative caregiving arrangements to facilitate planned short term and time limited breaks for caregivers.

Supported Employment: Job coaching, on and off site support, and consultation with employers to support competitive employment in integrated community work settings.
Environmental and Assistive Technology: Physical adaptations, devices or technology in the home necessary to ensure health and safety or to enable greater independence. Eligible items may include, but are not limited to: durable medical equipment; safety devices; physical endurance equipment prescribed by a licensed health professional; accessibility devices and equipment. This may include services/supports, deposits, rentals or other items which are determined to be necessary to improve functional independence.
Self-Directed Care: When an individual, their family or surrogate meets requirements and chooses to manage some or all of their TBI services, the person has the responsibility of hiring his or her own staff and overseeing the administrative responsibilities associated with receiving TBI funding, including contracting for services, developing a service plan, fulfilling the responsibilities of the employer, and planning for back-up support or respite in the case of an emergency.

Services for Children and Youth under 21 Experiencing Severe Emotional Disturbance/ Mental Illness and Their Families
Service Coordination: Case management and assistance to individuals and families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of medical, social, educational and other services and supports, including discharge planning, advocacy, monitoring and supporting them to make and assess their own decisions.
Community Supports (Individual or Group): Specific, individualized and goal-oriented services which assist individuals in developing skills and social supports necessary to promote growth.
Skilled Therapy Services: Services provided by or under the direction of licensed practitioners that include, but may not be limited to: clinical assessment; medication and psychiatric consultation; individual, family and group therapy or specialized behavioral and health services.
Residential Treatment: Out of home treatment services that include: • *Transitional Living*: Short-term out of home care for adolescents requiring intensive supports in order to transition to independent living. • *Therapeutic Foster Care*: Short-term out-of-home care to assist in skill development and remediation of intensive mental health issues to support a return to the family. • *Residential Treatment:* Intensive out of home care for mental health treatment, skill building, family reintegration and/or specialized assessment services to assist recovery and skill building that supports return to the family home.
Flexible Support: • *Family Education*: In home support and treatment for the purpose of enhancing the family's ability to meet their child's emotional needs. • *Specialized Rehabilitation or Treatment Plan Services*: Services, supports or devices used to increase, maintain, or improve functional capabilities or health outcomes identified as the result of an approved assessment, treatment plan and/or prior approval.
Counseling: Services directed toward the development and restoration of skills or the elimination of psychosocial or barriers that impede the development or modification of skills necessary for independent functioning in the community. Services may include approved peer supported and recovery services.
Respite: Alternative care giving arrangements to facilitate planned short term and time limited breaks for care givers.
Supported Employment: Job coaching, on and off site support, and consultation with employers to support competitive employment in integrated community work settings.
Crisis Supports: Time limited services and supports that assist an individual to resolve a severe behavioral, psychological or emotional crisis safely in their community. This includes 24/7

Availability, one to one support, and case management, hospital diversion programs, mobile outreach, community crisis placements and/or intensive in home support.
Environmental Safety Devices: Devices or technology necessary to ensure health and safety or to enable independence. This does not include structurally permanent modifications.

Community Rehabilitation and Treatment
Service Coordination: Case management and assistance to individuals and families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of medical, social, educational and other services and supports, including discharge planning, advocacy, monitoring and supporting them to make and assess their own decisions.
Community Supports: (Individual or Group): Specific, individualized and goal-oriented services which assist individuals in developing skills and social supports necessary to promote growth.
Flexible Support: • *Day Recovery/Psychoeducation, Including Recovery Education:* Group recovery activities in a milieu that promotes wellness, empowerment, a sense of community, personal responsibility, self-esteem and hope. These activities are consumer-centered; they provide socialization, daily skills development, crisis support, and promotion of self-advocacy. • *Family Psychoeducation and Support for Families and Significant Others*: To support recovery and assist individual in managing their symptoms
Skilled Therapy Services: Services provided by or under the direction of licensed practitioners that include, but may not be limited to: clinical assessment; individual, group, and family therapy or diagnosis-specific practices; medication evaluation, management and consultation with Primary Care; inpatient behavioral health services; partial hospitalization.
Residential Treatment • *Residential Treatment:* Intensive mental health treatment, skill building, community reintegration and/or specialized assessment services to assist recovery and skill building to support community living, but not provided in institutions for mental disease (IMD). Treatment may include the use of approved peer supported and peer run alternatives. • *Housing and Home Supports*: Mental Health services and supports based on the clinical needs of individuals in and around their residences. This may include support to a person in his or her own home; a family home; sharing a home with others (e.g., in an apartment, group home, shared living arrangement).

Crisis Support: Time limited services and supports that assist individuals to resolve a severe behavioral, psychological or emotional crisis safely in their community. This includes 24-hour/ 7 day a week availability, one to one support, case management, hospital diversion programs, mobile outreach, community crisis placements and/or intensive in home support.
Environmental Safety Devices: Devices or technology necessary to ensure health and safety or to enable independence. This does not include structurally permanent modifications.
Counseling: Services directed toward the development and restoration of skills or the elimination of psychosocial or barriers that impede the development or modification of skills necessary for independent functioning in the community. May include approved peer supported and/or peer run recovery services.
Respite: Alternative care giving arrangements to facilitate planned short term and time limited breaks for care givers.
Supported Employment: Job coaching, on and off site support, and consultation with employers to support competitive employment in integrated community work settings.

Developmental Disability Services
Service Coordination: Case management and assistance to individuals and families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of medical, social, educational and other services and supports, including planning, advocacy, monitoring and supporting them to make and assess their own decisions.
Residential Habilitation: Home supports, services and supervision to an individual in and around their residence up to 24 hours a day. This may include support to a person in his or her own home; sharing a home with others (e.g., in an apartment, group home, shared living arrangement); or who lives with his or her family.
Day Habilitation: Community supports that are specific individualized and goal oriented services which assist individuals in developing skills and social supports necessary to promote positive growth. This may also include support for persons to prevent them from entering more restrictive levels of care such as: • *Flexible Family Funding:* One time support to assist a family not receiving other specialized services in maintaining their family member in home and diverting the use of more costly home and community based services or restrictive levels of care. • *Specialized Treatment Plan Services:* Services, supports or devices used to increase, maintain, or improve functional capabilities or health outcomes identified as the result of an approved assessment, plan of care and/or prior approval.
Supported Employment: Job coaching, on and off site support, and consultation with employers to support competitive employment in integrated community work settings.
Crisis Services: Time limited intensive services and supports that assist individuals to resolve a severe behavioral, psychological or emotional crisis safely in their community. This includes 24/7 availability, case management, hospital diversion programs, mobile outreach, community crisis placements and/or intensive in home support.
Clinical Interventions: Assessment, therapeutic, medication or medical services provided by clinical or medical staff.
Respite: Alternative care giving arrangements to facilitate planned short term and time limited breaks for care givers.
Self-Directed Care: When an individual, their family or surrogate meets requirements and chooses to manage some or all of their developmental services, the person has the responsibility of hiring his or her own staff and overseeing the administrative responsibilities associated with receiving developmental services funding, including contracting for services, developing a service plan, fulfilling the responsibilities of the employer, and planning for back-up support or respite in the case of an emergency.

ATTACHMENT F
Choices for Care Wait List Procedure Description

Choices for Care - Waiting List Procedures High Needs

Active participants who meet the "High Needs" clinical criteria at reassessment will not be terminated from services as long as they continue to meet all other CFC eligibility criteria.

New CFC applicants who meet the "High Needs" clinical criteria may be placed on a waiting list if state funds are not available at the time of referral, using the following procedures:

1. If funds are not available at time of application, Department of Disabilities, Aging and Independent Living (DAIL) staff will complete a High Needs Wait List Score Sheet.

2. A score will be generated based on the individuals Activities of Daily Living (ADL), Cognition, Behavior, Medical Conditions/Treatments and Risk Factors.

3. DAIL staff will then place the individual on a waiting list in order of score.

4. DAIL staff will notify the individual in writing that they have been found clinically eligible for the High Needs Group and have been placed on a wait list. The case management agency that the applicant chose on the application will be in contact with them. Appeal rights will also be included in the notice.

5. DAIL staff will forward a copy of the CFC program application and Wait List Score Sheet to the Case Management (CM) agency indicated on the application. The application will not be sent if the CM agency assisted in completing the application.

6. The case manager/agency will make contact individuals on the "High Needs" wait list on a monthly basis to monitor if they have had a change in their health or functional needs and complete the High Needs Waiting List Monthly Follow-Up Sheet. The initial contact will occur no later than 14 days after receiving the referral.

7. If the individual has had a significant health or functional status change the case manager will contact DAIL staff. DAIL staff shall reassess for clinical eligibility determination and/or rescore for wait list. Agencies are encouraged to use the Triggers for High Needs Wait List Referral for Clinical Review as a guide to determine if another clinical assessment is warranted.

8. DAIL staff and providers will review the wait list with the CFC waiver team at monthly meetings.

9. Each case management agency designee (determined by the CM agency) will ensure that a copy of the follow-up sheet for all applicants on the High Needs wait list monitored by their agency and send to DAIL Waterbury by the 5th of each month.

10. DAIL staff will follow up with the CM agency if any High Needs Waiting List Monthly Follow-up Sheets are missing.

11. Applicants on a waiting list shall be admitted to the Choices for Care waiver as funds become available, according to procedures established by the Department and implemented by regional Choices for Care waiver teams. The Choices for Care waiver teams shall use professional judgment in managing admissions to the Choices for Care waiver, admitting individuals with the most pressing needs. The teams shall consider the following factors:
    a. Unmet needs for ADL assistance;
    b. Unmet needs for IADL assistance;
    c. Behavioral symptoms;
    d. Cognitive functioning;
    e. Formal support services;
    f. Informal supports;
    g. Date of application;
    h. Need for admission to or continued stay in a nursing facility;
    i. Other risk factors, including evidence of emergency need; and
    j. Priority score.

12. When funding is allocated to an individual, DAIL staff will notify the individual and continue the CFC application process.

Choices for Care Moderate Needs Waiting List

Moderate Needs applicants may be placed on a waiting list if funds are not available or capacity at Adult Day is not available at the time of application, using the following procedures:

1. If funding, or capacity at Adult Day, is not available at time of application, the case manager (CM) will notify the individual in writing and will send a copy of the notice and application to the requested Service Providers.

2. The Homemaker Agency or Adult Day provider (Moderate Needs Providers) will place the individual on their waiting list.

3. Applicants on Community Medicaid are considered first priority, then chronological order by date of application.

4. Participants who are already active on Moderate Needs and wish to add a second service will be put on the wait list according to their original Moderate Needs application date

5. The wait list should contain only those people who are still waiting for funding on the last day of the reporting month.

6. The wait list shall not contain the names of people who have an active Moderate Needs service authorization and are waiting for staffing or additional hours.

7. The Moderate Needs Providers must forward a copy of the wait list to DAIL by the 15th of the month following the reporting month. *For example, the January report is due at DAIL by February 15th and must contain everyone waiting for funding as of January 31st.*

8. Providers who have no wait list must either send a blank wait list or send an email to DAIL by the 15th of the month stating they have no wait list.

9. When funding is allocated to an applicant the Moderate Needs Providers will indicate such date on the wait list and notify the Moderate Needs case manager.

10. The CM will notify the applicant when funding becomes available and continue the eligibility process. The CM shall put the date the applicant came off the wait list on the Moderate Needs application.

11. If the individual is already receiving other Moderate Needs services, the CM will complete a Moderate Needs Group Change Form and send to the Moderate Needs Coordinator. The Moderate Needs Coordinator will complete and send a new Service Authorization to the individual, case manager and provider(s).

12. The effective date of the service will be the date the individual was taken off the wait list or a later date as requested by the CM.

13. The DAIL Moderate Needs Coordinator will review the provider's wait list upon receiving a new Moderate Needs application to ensure that Medicaid applicants are served before non-Medicaid applicants.

14. Providers must assure that all people listed on their wait list are still waiting for funding to be served. This is accomplished contacting people on the wait list at least once every six months.

ATTACHMENT G
Premiums and Co-Payments for Demonstration Populations

Premiums for children age 0 through age 18 in Population 1 are charged according to the following chart:

Group	Premiums
Children with income > 195% percent through 237% of the FPL	$15/month/family
Underinsured Children with income > 237% through 312% FPL	$20/month/family
Uninsured Children with income > 237% through 312% of the FPL	$60/month/family

Population	Premiums	Co-Payments	State Program Name
Demonstration Population 7: Medicare beneficiaries with income at or below 150 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise categorically eligible for full benefits.	Premiums not to exceed the following: 0-150% FPL: $15/month/person	Not to exceed the nominal co-payments specified in the Medicaid State plan.	VHAP Pharmacy/ VPharm1
Demonstration Population 8: Medicare beneficiaries with income above 150 percent and up to and including 225 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP), but are not otherwise categorically eligible.	Premiums not to exceed the following: 151-175% FPL: $20/month/person 176-225% FPL: $50/month/person	Not to exceed the nominal co-payments specified in the Medicaid State plan.	VScript/VPharm2 or VScript Expanded/ VPharm3

ATTACHMENT H

List of Approved Investments

No.	Investment Name
1.	Residential Care for Youth/Substitute Care
2.	Lund Home: IMD
3.	Institution for Mental Disease Services: DMH
4.	Return House
5.	Northern Lights
6.	Pathways to Housing
7.	Institution for Mental Disease Services: DVHA
8.	Vermont Information Technology LeadersHIT/HIE/HCR
9.	Addison Helping Overcome Poverty's Effects (HOPE) (Challenges for Change)
10.	Vermont Physician Training
11.	Non-state plan Related Education Fund Investments
12.	Mental Health Children's Community Services
13.	Acute Psychiatric Inpatient Services
14.	St. Albans and United Counseling Service Transitional Housing (Challenges for Change)
15.	Northeast Kingdom Community Action
16.	Mental Health CRT Community Support Services
17.	Recovery Centers
18.	Patient Safety Net Services
19.	Emergency Medical Services
20.	Vermont Veterans Home
21.	Area Health Education Centers (AHEC)
22.	Emergency Support Fund
23.	Public Inebriate Program (Challenges for Change)
24.	CHIP Vaccines
25.	Physician/Dentist Loan Repayment Program
26.	Strengthening Families
27.	Flexible Family/Respite Funding
28.	Special Payments for Treatment Plan Services
29.	Emergency Mental Health for Children and Adults
30.	Substance Use Disorder Treatment
31.	Health Laboratory
32.	Health Professional Training
33.	Prevent Child Abuse Vermont: Shaken Baby
34.	Prevent Child Abuse Vermont: Nurturing Parent
35.	Building Bright Futures
36.	Agriculture Public Health Initiatives
37.	WIC Coverage
38.	Fluoride Treatment
39.	Health Research and Statistics
40.	Epidemiology

No.	Investment Name
41.	United Ways 2-1-1
42.	Quality Review of Home Health Agencies
43.	Support and Services at Home (SASH)
44.	Vermont Blueprint for Health
45.	Green Mountain Care Board
46.	Immunization
47.	Patient Safety - Adverse Events
48.	Poison Control
49.	Healthy Homes and Lead Poisoning Prevention Program
50.	Tobacco Cessation: Community Coalitions
51.	Vermont Blueprint for Health
52.	Buy-In
53.	HIV Drug Coverage
54.	Designated Agency Underinsured Services
55.	Medical Services
56.	Aid to the Aged, Blind and Disabled CCL Level III
57.	Aid to the Aged, Blind and Disabled Res Care Level III
58.	Aid to the Aged, Blind and Disabled Res Care Level IV
59.	Essential Person Program
60.	GA Medical Expenses
61.	Therapeutic Child Care
62.	Lamoille Valley Community Justice Project
63.	Mobility Training/Other Services.-Elderly Visually Impaired
64.	DS Special Payments for Medical Services
65.	Seriously Functionally Impaired: DAIL
66.	MH Outpatient Services for Adults
67.	Respite Services for Youth with SED and their Families
68.	Seriously Functionally Impaired: DMH
69.	Intensive Substance Abuse Program (ISAP)
70.	Intensive Domestic Violence Program
71.	Community Rehabilitative Care
72.	Family Supports
73.	Renal Disease
74.	TB Medical Services
75.	Family Planning
76.	Statewide Tobacco Cessation
77.	Home Sharing
78.	Self-Neglect Initiative
79.	Mental Health Consumer Support Programs
80.	Intensive Sexual Abuse Program

ATTACHMENT I

Menu of Approvable Delivery System Investments

As described in STC 83, Vermont has a unique investment authority under the Global Commitment to Health demonstration to spend up to annual limits on expenditures for the following purposes:

a) Reduce the rate of uninsured and/or underinsured in Vermont;
b) Increase the access to quality health care by uninsured, underinsured, and Medicaid beneficiaries;
c) Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and
d) Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

CMS is making funding available under the above investment structure for the state to assist the Accountable Care Organization (ACO) and providers in one-time, developmental start-up funding, as defined in STC 83. STC 84 establishes that Vermont shall notify CMS of delivery system-related investments that fall within the following categories. For investments that do not fall within the categories below, Vermont must follow the notification and CMS review procedures as described in STC 85.

Delivery System Related Investment Categories
The goal of the delivery system-related investments is to support implementation of Vermont's All Payer Accountable Care Organization (ACO) model.

- Category #1 projects consists of funding to Accountable Care Organization(s). Funding under category #1 is limited to development costs only.
- Category #2 projects consist of funding to providers.

Vermont may select time-limited, start-up delivery system investments in demonstration year (DY) 1 through 4 of the extension period and maintenance investments in DY 5 of the extension period. These are time-limited investments that are expected to phase down and be completed at the end of five years. There may not be start-up investments in DY 5 of the extension period.

A project plan is required for each project and shall include an explanation of how the project will provide a return on investment over the demonstration extension period and how the project could be sustainably funded through the ACO over the five-year demonstration. The state must include metrics for all projects and the metrics are required for all years that the project receives funding.

Category #1: ***Accountable Care Organization (ACO) Infrastructure Improvement Program***

Project funding under category #1 is limited to development costs only. Category #1 projects are only allowed from demonstration year 1 through demonstration year 3 of the extension period. The state must submit a project plan to CMS at the time the state notifies CMS of the proposed project that includes a phasedown of demonstration funding no later than DY 5 of the extension period.

Eligibility: To be eligible to receive any funding under category #1, the ACO must meet the following criteria:

- Once the Green Mountain Care Board full certification and budget review process is implemented (expected by January 1, 2018), meet the state certification standards set by the Green Mountain Care Board under Vermont Act 113 (2016);
- Sign an agreement with the state consistent with the state's All Payer Model Accountable Care Organization agreement with the Centers for Medicare & Medicaid Services; and
- Sign an agreement with at least one other payer consistent with the state's All Payer Model Accountable Care Organization agreement.

Objectives: The ACO must submit a project plan to the state that describes how the funding would help the ACO achieve one or more of the following objectives:

- Develop governance, skills, and capacity to perform under a Medicaid risk-based contract designed to be an integrated part of an all payer approach;
- Manage enrollees' care across Medicaid providers in a manner consistent with unified processes across payers; and
- Successfully operate without decreased access or quality under population-level spending targets set to prospectively provide affordable per-person spending to the payers, programs and employers covering Vermont residents.

Metrics: Project metrics may include, but are not limited to:

- ACO quality measures included in the contract between DVHA and the ACO;
- Improvement in the ACO quality measures included in the contract between DVHA and the ACO; and
- Increase in the number of community providers participating in the ACO network and level of access to Medicaid enrollees.

Eligible Project Categories: Projects may fall under one or more of the categories of projects identified below in category #1(a) through category #1(b)(4).

***Category #1(a). Quality and Health Management Measurement Improvement Projects*:** The purpose of these projects is to provide funding for quality and health improvement information development and dissemination for participating providers of the ACO. Projects under this category must include one or more of the following:

- Learning collaboratives for provider communities to share best practices for using data to support health improvement for Medicaid beneficiaries;
- Technical assistance to providers in setting quality improvement targets for their specific panel of Medicaid patients in order to meet the ACO quality measures or to support the measures in the APM agreement; and
- Technical assistance in testing payment models which reward communities (and their providers across the continuum of care and services) who demonstrate high quality and/or improvement by working together.

Project metrics may include, but are not limited to:

- Yearly participation targets for learning collaboratives which demonstrate greater participation by number or type of provider;

- Quality improvement in one or more of the ACO quality measures (http://dvha.vermont.gov/administration/vermont-medicaid-shared-savings-progam-vmssp);and
- Number of ACO communities who achieve high overall results across a full measure scorecard, or targets identified in the state's Quality Improvement Plan (http://dvha.vermont.gov/global-commitment-to-health/1vt-gc-cqs-september-15-2015-cms-submission.pdf).

Category #1(b): Community-Based Population Health Projects*:*

The goal of this category of projects is to improve the integration of care for Medicaid beneficiaries by improving relationships between Medicaid's community providers and local hospitals. Projects must be designed, at the local/regional level, to promote integration across all types of care and service providers and targeted to the overall goals, including measures agreed to by the state in the All-Payer ACO Model Agreement or in the state's Quality Improvement Plan. The APM measures include:

- Reducing deaths of Vermont residents related to drug overdose;
- Reducing the number of deaths due to suicide;
- Not increase the prevalence of COPD, diabetes and hypertension for Vermont residents;
- Increasing the level and consistency in screening, access, and follow-up for mental health and substance abuse issues; and
- Ensuring most Vermonters have a usual primary care physician.

Projects must include one or more of the types of projects described in category #1(b)(1) through #1(b)(4).

Category #1(b)(1) Primary and Secondary Prevention Development projects, including:

- Expanding disease-specific programs to slow or reverse existing disease state and related co-morbidities at the community or local level;
- Building a statewide, community-focused health and wellness program; and
- Tailoring existing prevention programs to specific characteristics of Medicaid beneficiaries, the uninsured or the underinsured.

Metrics may include, but are not limited to: 1) disease-specific improvement targets, 2) an increase of prevention activities in a specific community, and/or 3) number of participants engaged.

Category #1(b)(2) Community-Based Provider Capacity projects to build integration between essential community providers, such as those who provide mental health, substance use disorder, developmental services, and long term services and supports, and ACO, to ensure community-based providers have the capacity to participate in quality improvement and health management projects with the ACO, and to ensure that Medicaid community providers are able to participate in the other ACO projects funded by investments.

Metrics include, but are not limited to: 1) an increase in the number of participating community-based providers in the ACO's network or in specific ACO projects.

Category #1(b)(3) Socio-Economic Risk and Mitigation projects to develop a screening profile for socio-economic, environmental, and behavior risks for low income Vermonters that builds on the Screening, Brief Intervention Referral to Treatment (SBIRT) program. These projects will ensure that individuals' unique needs and challenges are incorporated in care planning and that coordination is expanded beyond medical providers and Medicaid community providers. The purpose is to develop projects promoting a whole-person approach to care that takes into consideration the socio-economic needs of specific individuals.

Metrics may include, but are not limited to: 1) the number of individuals with unique care plans that include addressing socio-economic needs or 2) the number of providers who have integrated the tool into their work flow or electronic medical record.

Category #1(b)(4) Advanced Community Care Coordination projects would organize and expand upon current care management programs to create an efficient and effective approach, eliminating duplication in this arena. The project would include development of capacity to identify individuals needing supplemental coordination and management through risk scoring and other methods. This will involve codifying more standardized levels of care coordination, and developing programs and plans to best deliver the services based on existing capacity and community approaches. For example, projects would develop formats for shared care plans for complex (high risk scoring) patients and enhancement of existing community-based care management programs where necessary to meet the population health measures.

Metrics include, but are not limited to: 1) patients under active management, 2) percentage of patients engaged out of those who meet the criteria, and 3) the utilization and quality outcomes for patients under the more coordinated and advanced coordinated care management system.

Category #2: Medicaid Community Provider Integration Program ("Medicaid Pathway")

Goal: The goal of these projects is to assist Vermont's Medicaid community-based service providers to be able to manage population health for Medicaid beneficiaries and be able to participate in the All Payer model, including being able to accept value-based and risk-based payments.

Target: The following providers will propose projects under this category: Medicaid community-based providers, including designated mental health, disability support, substance use disorder providers and long term services and support providers.

Metrics include, but are not limited to: 1) targets identified in the Agency's comprehensive quality strategy, 2) the ACO measures included in the Medicaid contract, or 3) the APM measures included in the APM agreement with CMS.

ATTACHMENT J
Investment Application Template

During the extension negotiations, CMS reviewed the current 80 investments. For each new investment, the state must submit the following information to CMS as described in STC 84.

Date	
Investment Title	
Estimated Amount	
Time Period	
Department	
Category	
Project Objective (Must be time-limited)	
Project Description, including Phasedown Strategy	
Project Outcomes	
Project Specific Measurements (include measures and targets for each measure)	
How does the state ensure there is no duplication of federal funding?	
Source of non-federal share	
How does the project provide a return on investment?	
How does the state ensure that the investment does not include any activities listed in STC #82 (Investment Approval Process)?	
Performance Monitoring Plan	
The state assures that in reporting cost, the state and providers must adhere to 45 CFR §75 Uniform Administration Requirements, Cost Principles, and Audit Requirements for Health and Human Services (HHS) Awards and 42 CFR §413 Principles of Reasonable Cost Reimbursement. Pursuant to 45 CFR §75.302(a) the state must have proper fiscal control and accounting procedures in place to permit the tracing of funds to a level of expenditures adequate to establish that such funds have not been used in violation of applicable statutes. Costs must be supported by adequate source documentation.	

ATTACHMENT K
Evaluation Design [RESERVED]

ATTACHMENT L
DSHP Claiming Protocol [RESERVED]

ATTACHMENT M
Investment Claiming Protocol [RESERVED]