Global Commitment to Health Section 1115 Demonstration Renewal Request
Response to Public Comment Received 11/4/15 – 12/10/15

1. My comment is that the draft that will be submitted at the end of December should include a description of how the state plans to comply with Home & Community Services and how they tend to do that throughout the waiver and specifically how those rules, how their plan, would impact all of the community based settings.

> ***State Response:*** *Information about the State's compliance with federal HCBS regulations as required in the Global Commitment to Health Special Terms and Conditions are described in the State's Comprehensive Quality Strategy (CQS). The CQS, while a separate document from the Special Terms and Conditions, is a required component of Vermont's 1115 Demonstration and Public Managed Care Model. The CQS is where the Agency of Human Services (AHS) sets expectations for how the Public Managed Care Entity (e.g., DVHA, DAIL, DMH, DCF, VDH, AOE) will comply with federal regulations as described in the Special Terms and Conditions.*
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> *In response to requirements outlined by the AHS through the CQS, the Department of Vermont Health Access and its partners (e.g. the Department of Aging and Independent Living) have engaged in a separate public notice and stakeholder engagement process specific to the Home and Community Based Settings and Person-Centered Planning requirements as required in CQS. We will forward this comment to be included in the CQS public comment process.*

2. My comment is specific to the inner program evaluation, general approach to the evaluation that the state is pursuing in looking at whether its meeting its goals under Global Commitment. While this suggests a strong performance and probably meets the letter of the law in terms of requirements, I'm really concerned about the lack of specificity that this analysis has to medically underserved populations. Probably the largest medically underserved population in the United States is not officially named that by HRSA but that is people with disabilities, specifically even more people with developmental and intellectual disabilities. There is now a significant body of research nationally showing that people with developmental disabilities have higher rates of chronic illness, have lower rates of preventative routine screening, have higher emergency room rates, and in general die earlier than necessary not based on anything to do with their disability. This can also be demonstrated at least partially through Medicaid claims data specifically to Vermont. For example the rate of pulmonary disease is extremely high for people with IDD in Vermont. Emergency room use is very high. And this is regardless of whether people are on a home and community based waiver or not. Use of mammography is extremely low for women of the appropriate age range with intellectual and developmental disabilities. I am really campaigning to urge the state to think about segmenting its data analysis so it has some sensitivity to sub-populations. When the population is small enough it just doesn't have the statistical sort of noise to get noticed in the larger pool. I think we're really missing an opportunity to improve how we're caring for Vermont's most vulnerable people and we're not really noticing it in the kind of reports that we're delivering to CMS.

> ***State Response:*** *The State agrees with your observation; one of the key principles of the Comprehensive Quality Strategy (CQS) is performance measurement. AHS defines performance measurement as the ongoing monitoring and communicating of program accomplishments, particularly progress towards achieving predetermined goals.*

Annually, DVHA and its partners are required to measure and report performance using standard measures identified by AHS. The CQS is under review and revision. In addition to measures designed to assess plan-wide performance, AHS will require population-specific performance measures (e.g., those for children, pregnant women, beneficiaries with developmental and/or intellectual disabilities, etc.). By requiring population-specific measures, AHS hopes to maintain sensitivity to outcomes of these sub-populations that might otherwise be overlooked due to their smaller numbers. We will forward this comment to be included in the CQS public comment process.

3. I just wanted to make two points. One is I do think it's important to make clear on the linked website that people need to look at more than just the extension request. My second comment is with respect to Home and Community Based Service pools and specifically in the existing terms and conditions in the current waiver there's reference to Section 7 Long Term Services Support Protection for CFC. There's no mention for other long term services support to consumers. Within that section, that paragraph 32, the state's required to share compliance with the characteristics of home and community based settings found in accordance with 42 CFR 441.301 for those Choices for Care services that could be authorized under Section 1915i of the waiver, again there's no reference to the other long term care services for consumers and I think that should be made clear that those populations are covered requirements for adherence to home and community based services.

***State Response**: Regarding clarity of the website, the State took action to update its website posting immediately after receiving this comment on 11/12/15.*

Regarding compliance with federal HCBS regulations, as required in the Global Commitment to Health Special Terms and Condition, these efforts are described in the State's Comprehensive Quality Strategy (CQS). The CQS, while a separate document from the Special Terms and Conditions, is a required component of Vermont's 1115 Demonstration and Public Managed Care Model.

Since 2005, the State has only operated one Long-Term Service and Support Demonstration, Choices for Care. That program was consolidated into the Global Commitment to Health Demonstration in January 2015. The Developmental Services Program is one of several programs that were recognized in 2005 as a Special Health Needs Population under the Global Commitment to Health Public Managed Care Demonstration. As such, the program is governed by Vermont rule and statutes. While the Special Terms and Conditions do not require the State to address HCBS assurances beyond Choices for Care, AHS, at its discretion, has set out requirements for the Public Managed Care Entity to engage in a full assessment of all special health needs programs under the Demonstration. In response, the Department of Vermont Health Access and its governmental partners have started a separate public notice and stakeholder engagement process specific to the Home and Community-Based Settings and Person-Centered Planning requirements as required in CQS. We will forward this comment to be included in the CQS public comment process.

4. I know that Global Commitment includes the developmental service program that was formerly a waiver. About $180 million is spent per year on it. It helps my son. But I don't see how this renewal describes those services and how the state is going to do that. And also, following up on other comments, how the new home and community based rule will be addressed by the state of Vermont because he certainly fits within this goal 4 but there's no indication that you're considering people with

developmental disabilities as beneficiaries of long term services and support. It should be easier for families, it should be easier for self-advocates to know that some very important thing is going to be renewed for five years and we should know really where we fit within it and what you're asking approval from the feds to be able to do. And to upgrade it with the home and community based services.

> ***State Response**: The Developmental Services Program is one of several programs that were recognized in 2005 as a Special Health Needs Population under the Global Commitment to Health Public Managed Care Demonstration. As such the program is governed by Vermont rule and statutes. While the Special Terms and Conditions do not require the State to address HCBS assurances beyond Choices for Care, AHS, at its discretion, has set out requirements for the Public Managed Care Entity to engage in a full assessment of all Special Health Needs programs under the Demonstration. In response, the Department of Vermont Health Access and its governmental partners have started a separate public notice and stakeholder engagement process specific to the Home and Community-Based Settings and Person-Centered Planning requirements as required in CQS. We will forward this comment to be included in the CQS public comment process.*

5. This may not be a good timeline? I am only referring to the fact 2017 is projected to be a dynamic year of uncertainties, and significant policy decisions, would be better if was 2018 to 2022? That doesn't mean it's possible, but this extension will be particularly rough to calculate in projections? State could indeed end up with significant expenses in those last two years?

> ***State Response:** The period for each Demonstration is set by the Center for Medicaid and CHIP Services (CMCS). In addition, the Social Security Act outlines the frequency and timelines a State must follow when it seeks to renew those Demonstrations. On 10/03/2013 CMCS approved the Global Commitment to Health Demonstration for a three-year extension through 12/31/2016. This end date requires the State of Vermont to submit a renewal request now (one year prior to its end date) with a proposed effective date of 1/1/2017.*

6. If it is agreed that risk-bearing responsibility should shift from the Department of Vermont Health Access to provider-led clinically-integrated networks, similar to efforts in Medicare and among private insurers, then it makes no sense to continue to require clinicians to engage with multiple quality improvement, utilization and care management entities or for the State to continue expansion of its medical cost management, clinical and quality improvement programming and infrastructure. In fact, continuing to do so could undermine the opportunity for true population health management and clinical transformation. Yet in the Extension Request it says, "Vermont's Medicaid goal is to maintain the public managed care model to ensure maximum ability to serve Vermont's most vulnerable and lower-income residents while moving towards broader state and federal health care reform goals." As such, would DVHA participate in a public/private partnership and transition those responsibilities to one or more ACOs?

- The 1115 waiver should align delegation of population-level financial risk and health management risk to health care providers with steps being taken by other payers. The State has the opportunity in the 1115 waiver to shift financial risk-bearing responsibility for utilization changes from the Department of Vermont Health Access to provider-led clinically-integrated networks, similar to efforts in Medicare and among private insurers. This would allow for the fullest shift from volume-based care to outcomes-based care. OneCare Vermont is a national pioneer in its willingness and readiness to take on risk-based

payments to improve care. This model would represent a logical next step from the current VMSSP, which ends after 2016. The first-year success of the VMSSP in generating savings against the state's projected spend gives us confidence in the accountable provider network model.

State Response: *The Global Commitment Demonstration affords the State with great flexibility to transform the health care system. If Vermont is able to retain the current flexibilities under the Demonstration, we will be able to partner with other payers and providers to develop reforms that are best for the State. The Vermont Medicaid program currently has the federal authority to engage providers in an Accountable Care Organization and/or other models that that enable the State to engage in payment reform that transitions payment from volume based to quality based. If these flexibilities are compromised as part of the federal approval process, Vermont may need to pursue alternative authorities under the Demonstration to permit it to move forward with health reform.*

Any substantive change in the Global Commitment to Health model or approaches used in the Medicaid program would also require legislative approval.

7. Will the State work with community organizations and risk-bearing health care organizations (such as OneCare Vermont) to achieve common aims for improving patient outcomes, and help identify clear financial incentives for collaboration in order to reduce clinical and payment fragmentation?

- The 1115 waiver should include incentives for provider-community collaboration. Federally Qualified Health Centers, Behavioral health organizations, community organizations and social services agencies are essential to providing the highest-quality care to Medicaid patients. The State has the opportunity in the 1115 waiver to offer these groups clear financial incentives to collaborate with risk-bearing health care organizations to achieve common aims for improving patient outcomes. Reducing clinical and payment fragmentation through shared responsibility for outcomes would bring considerable lasting benefit to Vermont's health care system.

State Response: *The current Demonstration provides Vermont with the flexibility to create incentives for collaboration and investment in programs designed to increase integration. Any use of funds to support such initiatives in our public system must be approved by the Vermont Legislature through the budget process.*

8. Will the State pursue new federal funds for population health infrastructure and/ or agree to work with ACO's on using the GC Waiver to obtain and provide additional support for community and provider led efforts?

- The 1115 waiver should increase investments in population health infrastructure. In recent 1115 waivers, most notably in New York, the federal government has invested substantial sums in supporting provider networks as they develop the capacity to improve population health outcomes. Risk-based payments could be coupled with supplementary programs to reward utilization and quality outcomes with funds to support the infrastructure required for ongoing transformation. Clinical infrastructure could include embedded case managers in primary care offices and community based organizations, interdisciplinary teams visiting patients at home after discharge, co-located behavioral health and primary care services,

and other proven interventions. It is important to acknowledge that OneCare Vermont does not simply seek to have delegated responsibility to replicate more centralized managed care organization models as they currently exist, but to build a balanced model of central technology, support capabilities and process definition with a model which enables approaches embedded in day-to-day care processes delivered in local communities as close to the patient as possible. We hope that the flexibility and additional spending capacity under a GC waiver, that DVHA would work with OneCare Vermont to provide additional resources to enable our efforts beyond the care delivery cost targets under fixed revenue risk. We also encourage investigation of the Delivery System Reform Incentive Payment (DSRIP) program or other programs available to Vermont, as a way to obtain new federal funds for forward-thinking providers to improve care through ACOs in deploying resources as close to the patient-provider interaction as possible.

State Response: *The Section 1115 Demonstration process does not automatically grant the State access to new federal funds, nor does it exclude the State from pursuing additional federal monies that may become available. Any new federal funds would be secured using the process identified for the relevant fund. Any new or redistributed State funds in support of population health infrastructure in the provider community would need to be approved by the legislature through the budget process.*

The current Demonstration enables the State to make managed care investments to fund the same types of activities that are funded by DSRIPs. Vermont has the flexibility to invest in public-private partnerships, public health approaches, and alternative services and programs designed to improve access to care and enhance quality of care. Other states have obtained similar flexibility through DSRIPs. However, DSRIP programs tend to be more narrowly defined as compared to Vermont's model, and recently approved DSRIP programs have become more prescriptive. The DSRIP programs must define the types of programs and providers to be funded, describe a detailed funding approval process, and define federal reporting requirements. Also, the waiver terms stipulate that federal support for a DSRIP program is discontinued if pre-defined performance targets are not met. DSRIP funds would still require State match and would need to be approved by the Legislature through the budget process.

9. Will AHS partner with ACO's for Quality Measurement and Improvement?

- In order to evaluate quality and impact in our health care systems, OneCare Vermont is investing heavily in data analytics and quality improvement processes. We believe that we could be helpful in showing the value of the Global Commitment investments. Rigorous application of analytics to those investments would go a long way toward addressing the opportunities raised in the Pacific Health Policy Group and Vermont State Auditor reports.

State Response: *The Global Commitment to Health Section 1115 Demonstration requires the development of a Comprehensive Quality Strategy and includes requirements for Performance Improvement Projects. In addition, the AHS is aggressively pursuing a modernization of our Health Service Enterprise and Information Technology platforms. Aligning these efforts with our ACO and Health Care Reform efforts is essential to streamlining data collection, improving data quality, and ultimately improving the State's ability to support meaningful performance measurement across all of our programs.*

10. We have been assured in previous communications by AHS Secretary Cohen and DVHA Commissioner Costantino that all of these provisions are within the scope of the application to renew the 1115 waiver and that the AHS and DVHA agree that these steps are necessary and desirable for implementation to be successful. Secretary Cohen wrote, "We are committed to ensuring we retain all the flexibility required to undertake the initiatives enumerated in your white paper. We are partnering closely with the Agency of Administration and the GMCB to make sure that the Medicaid program is well positioned to take part in Vermont's All-Payer health care reform initiative." We would request that the waiver extension should explicitly and transparently embrace the vision that we are collectively pursuing.

At OneCare Vermont believes that our population health model and willingness to lead will be assets to the State as it negotiates with the federal government. Few other states can count on a major clinical organization ready to accept the responsibility of improving health and controlling cost. We hope that our commitment will serve to strengthen Vermont's application and serve to accelerate change and make our state a model for health care in the United States.

> **State Response:** *If Vermont is able to retain the current flexibilities under the Demonstration, we will be able to partner with other payers and providers to develop reforms that are best for the State. The Vermont Medicaid program currently has the federal authority to engage providers in an Accountable Care Organization and/or other models that that enable the State to engage in payment reform that transitions payment from volume based to quality based. If these flexibilities are compromised as part of the federal approval process, Vermont may need to pursue alternative authorities under the Demonstration to permit it to move forward with health reform.*
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> *The State has included a discussion of our future goals in the Global Commitment Extension Request. As final health care reform models and the details of Vermont's provider agreements are defined, we will assess whether the design requires additional State and Federal approval. Pursuit of any substantive change in the Global Commitment to Health model or approaches used in the Medicaid program would also require legislative approval.*

11. The 1115 waiver should align delegation of risk to health care providers with steps being taken by other payers. The State has the opportunity in the 1115 waiver to shift financial risk-bearing responsibility from DVHA to provider-led clinically-integrated networks, similar to efforts in Medicare and among private insurers. This would allow for the fullest shift from volume-based care to outcomes-based care and allow for the reduction in duplicative capacity and infrastructure.

> ***State Response****: Please see the State's response to Question #6*

12. Changing payment models is simply not possible through existing shared-savings constructs that provide bonuses but do not change basic revenue models. Moreover, prolonging a system that requires clinicians to engage with multiple care management entities undermines the opportunity for true clinical transformation.

> ***State Response****: Please see the State's response to Question #6*

13. The 1115 waiver should include incentives for provider/community collaboration. Federally Qualified Health Centers, behavioral health organizations, home health agencies and social services agencies are

essential to providing the highest-quality care to Medicaid patients. The State has the opportunity to offer these groups clear financial incentives to collaborate with risk-bearing health care organizations to achieve common aims for improving patient outcomes. Reducing clinical and payment fragmentation through shared responsibility for outcomes would bring considerable lasting benefit to Vermont's health care system.

State Response*: Please see the State's response to Question #7*

14. The 1115 waiver should increase investments in population health infrastructure. Risk-based payments could be coupled with supplementary programs to reward utilization and quality outcomes with funds to support the infrastructure required for ongoing transformation.

State Response*: Please see the State's response to Question #8*

15. Clinical infrastructure could include embedded case managers in primary care offices, interdisciplinary teams visiting patients at home after discharge, co-located behavioral health and primary care services, and other proven interventions. Whether through a Delivery System Reform Incentive Payment (DSRIP)-type program or a concept unique to Vermont, the State should pursue new federal funds to improve care through supporting ACOs in deploying resources as close to the patient-provider interaction as possible.

State Response: *Please see the State's response to Question #8*

16. The 1115 waiver request should articulate the importance of the strategic integration of the Blueprint of Health with the anticipated statewide ACO, in order to avoid having separate programs to address chronic disease.

State Response: *Please see the State's response to Question #6*

17. The all-payer model being negotiated by the State of Vermont would require the participation of the Medicaid program, as well as Medicare and commercial insurers, in creating value-based payment models and establishing more standardized approaches to care delivery, care management, and performance measurement. We recommend that the 1115(e) waiver be explicit on the importance of alignment between the 1115 waiver and all-payer waiver. Most importantly, in order to constrain the cost shift, the State must develop a responsible funding model for the expansion of Medicaid that ends the cost shift to employers and insurers.

State Response: *Please see the State's response to Question #10*

18. We recommend that the 1115(e) extension request indicate planned changes to DVHA's current population health management (PHM) infrastructure and capabilities if they are duplicative of those needed by a single statewide private-sector health care provider network (ACO) that is assuming fixed revenue risk for the Medicaid population. If they are duplicative of those needed by a single statewide ACO or similar organization, reducing DVHA's current population health management infrastructure and capabilities could provide significant savings and help reduce the administrative cost of Vermont's Medicaid program.

State Response: *Please see the State's response to Question #10*

19. I submit these comments on behalf of Planned Parenthood of Northern New England. At this time it is our understanding the State of Vermont has voluntarily chosen not to accept the federal 90/10 match for family planning services. The Social Security Act section 1903(a)(5) requires the federal government to supply each state a 90 percent match for family planning services, without exception. There is also no legal avenue by which a state could waive this federal match. Indeed, Congress drafted the 90/10 match provision, as well as other, related protections for family planning services, to ensure that individuals would have robust coverage of family planning services and supplies and would be able to receive family planning care in a timely manner.

While it is uncertain how Vermont could forego the 90 percent match, it is disconcerting to hear that the state may not be receiving the federal funds it is entitled to for family planning supplies and services. Without drawing down the match the state is losing the opportunity to save hundreds of thousands of dollars for critical women's health and reproductive health services such as family planning counseling services and patient education, well-woman exams, testing and treatment for sexually transmitted infections, laboratory examinations and tests, and medically approved family planning methods, procedures, pharmaceutical supplies, and devices to prevent conception and infertility. As DVHA moves forward to finalize this waiver extension proposal, we strongly urge the state to make clear that family planning services and supplies require a 90/10 match and that the state is not forfeiting its ability to claim the 90 percent match for such services.

State Response: *The Global Commitment to Health Demonstration operates using a Medicaid Managed Care financial model; however that does not preclude the State from seeking enhanced match in certain circumstances. We are currently analyzing our options in preparation for our discussions with CMS.*