

June 4, 2021

Medicaid Policy Unit  
280 State Drive  
NOB 1 South Waterbury, VT 05671-1010 3  
Re: 1115 Renewal Public Comment

**Via Email**

[AHS.MedicaidPolicy@vermont.gov](mailto:AHS.MedicaidPolicy@vermont.gov)

To Whom it May Concern:

Thank you for the opportunity to comment on [Global Commitment Register \(GCR\) proposed policy 21-033](#), and for making senior policy officials available to answer our questions. The provider organizations listed below have considered this proposal and together offer the following comments:

**Transition to a Risk-bearing MCO**

- (1) Our understanding is that the AHS policy team believes the transition to an MCO structure is the path that will afford Vermont the most flexibility and the best chance at favorable spending caps. Our coalition supports those goals. At the same time, we are aware that in some states, Medicaid MCOs have created substantial administrative burdens for providers and barriers to care for patients, which of course we could not support.
- (2) If Vermont transitions to an MCO model, we think it's important that the MCO work from a clear regulatory framework. Working from the federal Medicaid MCO rules as proposed is a step in the right direction, but we think it's important that the MCO also adhere to the standards laid out in Department of Financial Regulation [Reg. H-2009-03](#) so there is consistency across all payers.
- (3) We recognize the State's interest in being able to provide *in lieu of services* as it affords opportunities for addressing the social determinants of health. For example, many states utilize *in lieu of services* to provide programs like medically-tailored meals. Our understanding of 42 CFR 438.3(e)(e)(2) is that an MCO may cover, for enrollees, services or settings that are *in lieu of* the services and settings covered under the State plan. These flexibilities must meet four criteria, which are enumerated in the regulation (subsections (e)(2)(i-iv)). Given that the State of Vermont is proposing a non-traditional MCO arrangement, we request the State ensure that these criteria are met through a transparent process that allows for stakeholder input. We are

happy to work with you to create a process that is not cumbersome and meets our mutual goal of ensuring Vermonters receive optimal services. We look forward to working with the State to identify other services that meet similar federal statutory definitions. We are interested in working with you to identify ways to provide the appropriate services, utilizing *in lieu of services* or other mechanisms should that not be the best solution, through the 1115 waiver for Vermont's Medicaid beneficiaries.

- (4) The AHS policy team reported to our coalition that the State will only agree with a renegotiated Global Commitment Waiver cap and PMPM rates that are generous enough to allow the State to meet all of the goals contained in the draft renewal application, including new waiver requests, flexibility to fund workforce and public health initiatives and all core services, without service, benefit, or rate cuts; Our coalition supports the waiver request assuming an adequate cap to meet these goals.
- (5) Our coalition supports the goal of using an MCO model to continue as an "anchor participant in the State's All-Payer ACO Model Agreement" rather than pursuing fragmented payment reform goals, especially at time when health care providers and facilities have faced unprecedented regulatory fatigue during the COVID-19 pandemic.

## **Comments on Goals**

### Goal 1

- (1) Home health Agencies and Adult Day centers have different views on the changes to the moderate needs criteria and will submit individual comments on that issue. Both groups would be glad to work collaboratively to develop a model that makes sense for both settings.
- (2) We support filling coverage gaps by extending Medicaid coverage to inmates 90 days prior to release from prison and creating an SUD Community Intervention and Treatment benefit that includes, among other services, "medication evaluation, management, and consultation with primary care and other medical providers."

### Goal 2

- (1) We support the continued inclusion of an enhanced hospice benefit and children's palliative care program in Vermont's waiver.
- (2) We are generally support the proposal to provide reimbursement to parents of a minor child, legal guardians, and spouses providing the newly defined "life skills aide" services and community supports (including shared living) to individuals enrolled in the Brain Injury

Program. That said, we have questions about reimbursement to parents, legal guardians and spouses for life skills and community supports. How will the state ensure accountability for services provided? How will services be documented? What will the oversight mechanism be?

- (3) We are concerned about the proposal to remove respite services from the CRT program. We need to understand the plan in greater detail before we can comment about its impact. For example, we understand that respite services under the CRT program are underutilized, but before eliminating them, we recommend exploring whether respite services could be used to reduce emergency department visits and wait times. Vermont Care Partners may submit additional comments if they are able to obtain more detailed information in time.
- (4) We support removing the prohibition on FFP for patient stays at IMDs for longer than 60 days. We would like to understand the impact on applying the inpatient exception to inmate exclusion for IMDs to the 30- day average length of stay.

### Goal 3

- (1) We strongly support moving investments in workforce to “expenditure authority under the demonstration” outside the per member per month capitation rate. As we understand it, doing so will allow those programs to be funded under the total Medicaid cap, rather than be subject to the availability of “savings” under the “investment” program. In addition, we would support incorporating funding within the expenditure authority for workforce development investments consistent with the Healthcare Workforce Development Strategic Plan required by Act 155 (2020), to the extent appropriate. We expect the Act 155 plan to address a broader spectrum of workforce needs than the existing “investment” program.
- (2) For similar reasons, we support moving public health infrastructure investments to “expenditure authority” and continuing to fund Vermont’s core prevention programs that minimize downstream healthcare costs, including tobacco cessation services, immunization programs and lead poisoning prevention.

### Goal 4

- (1) Our understanding is that Goal 4, “Advancing Integration in Care Coordination” signals Vermont’s intent to re-examine care coordination, the Blueprint and strategies to better align Blueprint programs and various case management services without committing to specific policy changes. Further work is necessary to fully utilize existing care management resources and coordinate care management efforts. The proposed approach appears to allow time for

AHS to work with stakeholders on specific proposals. Assuming our understanding is correct, and assuming that the overall negotiated waiver cap allows adequate funding for care coordination services, we support the inclusion of Goal 4.

- (2) We share your goal of strengthening providers' ability to participate in health information exchange. Transitioning to electronic health records has been a substantial expense for health care providers; payer support, has been limited and inconsistent between provider types. Any adjustments providers need to make to electronic health record vendors in service of Vermont's health care reform goals require state support; they are often expensive, and it can be difficult to get buy-in from vendors. Vermont should seek to eliminate duplicative record keeping for initiatives like care coordination and state-mandated reporting systems like SAMS that exist outside electronic health records.

#### Goal 5

Our top Medicaid policy priority is adequate Medicaid reimbursement to support the services we provide. Budget-neutral "payment reform" and payment models that have no routine rate schedule update will not adequately support the health care delivery system. To that end:

- (1) We urge the agency to ensure that Medicaid reimbursement rates at a minimum match Medicare fee schedules for core services where a Medicare fee schedule exists. Where no Medicare fee schedule exists, Vermont should identify other mechanisms for regular rate schedule updates.
- (2) We would like more information on how using the Medicaid risk-bearing model for *Medicare*-covered Vermonters impacts the All-Payer ACO Model. While we support the overall goal of integrating a risk-bearing MCO model with the All-Payer Model, we do not have adequate information to assess how these two risk-bearing models will work together at the statewide or individual provider level. We would not support efforts that make implementation of payment reform for providers more administratively complex or ask providers to take on additional financial risk.
- (3) Goal 5 references AHS' intent to consider payment reform for Vermont's successful LTSS initiatives. LTSS "reform" must include increasing total reimbursement for the services. Vermont's successful LTSS programs across the continuum are eroding because Vermont has failed to adequately invest in them – almost since their inception. Absent new dollars to adequately fund LTSS programs, new payment models will not improve Vermont's ability to deliver LTSS. Planning must also account for the need to increase capacity because of

increasing demand. Too often, Vermont has budgeted only for caseload increases, without reimbursement increases.

Jessa Barnard  
Vermont Medical Society

Devon Green  
Vermont Association of Hospitals and Health Systems

Georgia Maheras  
Bi-State Primary Care Association

Jill Mazza Olson  
VNAs of Vermont

Laura Pelosi, on behalf of  
Vermont Health Care Association  
BAYADA Home Health Care

Virginia Renfrew, on behalf of  
Vermont Association of Area Agencies on Aging

Susan Ridzon  
HealthFirst Independent Practice Association

Julie Tessler  
Vermont Care Partners: VT Council

Stephanie Winters  
Vermont Academy of Family Physicians  
American Academy of Pediatrics – Vermont Chapter