

State of Vermont

Agency of Human Services

**Global Commitment to Health
11-W-00194/1**

**Section 1115(a)
Demonstration Waiver Extension Request to CMS
(1/1/2014 – 12/31/2018)**

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I. Introduction and Summary of Demonstration Projects

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

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

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

Global Commitment to Health

Historical Summary

The Global Commitment (GC) to Health Section 1115(a) Demonstration, implemented on October 1, 2005, continued VHAP and also was designed to provide flexibility with regard to the financing and delivery of health care to promote access, improve quality and control program costs. The majority of Vermont's Medicaid program currently operates under the GC Demonstration, with the exception of its Children's Health Insurance Program (CHIP), individuals enrolled in Vermont's Section 1115 Long Term Care Demonstration (Choices for Care), and Vermont's Disproportionate Share Hospital (DSH) program. More than 95% of Vermont's Medicaid program participants are enrolled in the GC Demonstration.

According to the GC's Special Terms and Conditions (STCs), Vermont operates its managed care model in accordance with federal managed care regulations, found at 42 CFR 438. The Agency of Human Services (AHS), as Vermont's Single State Medicaid Agency, is responsible for oversight of the managed care model. The Department of Vermont Health Access (DVHA) operates the Medicaid program as if it were a Managed Care Organization in accordance with federal managed care regulations. Program

requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. CMS reviews and approves the IGA annually to ensure compliance with Medicaid Managed Care requirements. DVHA also has sub-agreements with the other State entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, and specialized child and family services). As such, since the inception of the GC Demonstration, DVHA has modified operations to meet Medicaid managed care requirements. This includes requirements related to network adequacy, access to care, beneficiary information, grievances, quality assurance and quality improvement. Per the External Quality Review Organization's findings (see section VII), DVHA has achieved exemplary compliance rates in meeting Medicaid managed care requirements. Additionally, in its role as the designated unit responsible for operation of the traditional Medicaid program (including long term care, SCHIP and DSH), DVHA is responsible for meeting requirements defined in federal regulations at 42 CFR 455 for those services excluded from the GC Demonstration.

Under the current waiver structure, AHS pays DVHA a per member per month (PMPM) estimate using prospectively derived actuarial rates for the waiver year. This capitation payment reflects the monthly need for federal funds based on estimated GC expenditures. On a quarterly basis, AHS reconciles the federal claims from the underlying GC expenditures on the CMS-64 filing. As such, Vermont's payment mechanisms function similarly to those used by state Medicaid agencies that contract with traditional managed care organizations to manage some or all of the Medicaid benefits.

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

Renewed on January 1, 2011, the current GC Demonstration has subsequently been amended twice; once on December 13, 2011 to include authority for a children's palliative care program, and most recently on June 27, 2012, to update co-pay obligations.

Global Commitment to Health Demonstration Objectives and Successes

The Global Commitment to Health (GC) 1115 Demonstration waiver was designed to test the hypothesis that greater Medicaid program and resource flexibility and the lessening of federal regulatory restrictions governing the operation of Vermont's Medicaid program would permit the State to better meet the needs of Vermont's publicly insured and uninsured populations for the same or a lower cost. Specifically, the GC Demonstration aimed to:

- Promote access to affordable health coverage.
- Develop public health approaches to meet the needs of individuals and families.
- Develop innovative, outcome- and quality-focused payment approaches.
- Enhance coordination of care across providers and service delivery systems.
- Control program cost growth.

Vermont has proven the Demonstration to be a success. With the flexibility granted by the GC Demonstration, Vermont has:

- Bent the curve on Medicaid costs. Vermont's actual spending over the 8.25 years of the Demonstration is projected to be \$8.2 billion – approximately \$650 million less in expenditures than projected without the waiver (i.e., Demonstration savings).
- Made steady progress in reducing the rate of uninsured, as evidenced by an overall 3 percent decrease in the uninsured rate for adults and 2.4 percent decrease for children during the course of the waiver (2007 to 2012). As of December 2012, Vermont's uninsured rates are estimated to be at 6.8 percent for adults and 2.5 percent for children.
- Developed multiple mechanisms to contain the costs of pharmaceuticals while also maintaining access (e.g., an emphasis on generic drug use where appropriate; implementation of a 340B Pharmacy program to decrease the pharmaceutical cost for patients served by Federal Qualified Health Centers).
- Development of new payment mechanisms and combined funding streams in targeted areas to improve efficiency, promote access to cost-effective services and move toward performance-based financing. Examples include bundled rate initiatives for serving individuals with serious mental illness, mental health crisis counseling and other support for runaway youth, integrated family services, and case management/care coordination for children with developmental service needs.

This has been achieved even while Vermont has been able to expand coverage by adding:

- The Catamount Health Premium Assistance Program for approximately 16,000 Vermonters.
- Pharmacy-only coverage for 13,000 low-income beneficiaries up to and including 225% FPL.
- Immediate, no-waiting coverage periods, for persons who lost health care coverage as a result of leaving relationships characterized by domestic violence.

Vermont has made significant investments to improve the health of Vermonters through several interrelated initiatives, including the Vermont Chronic Care Initiative (VCCI) and the Blueprint for Health:

Vermont Chronic Care Initiative (VCCI): The goal of the VCCI is to improve health outcomes for Medicaid beneficiaries by addressing the increasing prevalence of chronic illness. Specifically, VCCI is designed to identify and assist Medicaid beneficiaries with chronic health conditions by accessing clinically-appropriate health care information and services; coordinating the efficient delivery of health care by removing barriers, bridging gaps and avoiding duplication of services; and educating, encouraging and empowering beneficiaries to self-manage their chronic condition(s). VCCI utilizes Care Coordination teams who act as case managers for high-risk Medicaid beneficiaries with specific chronic conditions. Data for state fiscal year 2011 showed a 14% reduction for inpatient admissions and a 10% reduction in emergency room utilization over the baseline year of 2008 for VCCI beneficiaries. Additionally, when compared to beneficiaries who were not enrolled in VCCI, those receiving VCCI services demonstrated better adherence to evidence-based treatment (see next page).

Condition/Treatment Regime Measured	Percent adherence to treatment regime: VCCI Participants	Percent adherence to treatment regime: Non-VCCI Participants
Asthma (medication adherence)	53.2	33.8
COPD	75.8	58.9
Congestive Heart Failure (CHF) – ACE/ARB	65.3	42.4
CHF – Beta Blocker	70.5	45.7
CHF – Diuretic	65.3	41.2
Coronary Artery Disease (CAD) – Lipid test	67.0	56.6
CAD – Lipid lowering med	71.5	59.7
Depression – med 84 days	69.6	50.3
Depression – med 180 days	66.4	45.2
Diabetes – HbA1c test	86.3	67.4
Diabetes – Lipid test	69.6	55.7
Hyperlipidemia – 1 or more tests	67.8	56.8
Hypertension – 1 or more lipid tests	62.0	48.6
Kidney Disease – microalbuminuria screening	46.2	44.6
Kidney Disease – ACE/ARB	69.2	62.0

Vermont's Blueprint for Health has an emphasis on prevention, wellness and management of chronic conditions. The Blueprint is dedicated to achieving well-coordinated and seamless health services to improve the health of the population, enhance the patient experience of care (including quality, access, and reliability), and reduce, or at least control, the per capita cost of care. The model is based on advanced primary care practices (APCPs) that serve as medical homes for the patients they serve, with comprehensive support from Community Health Teams, Supports and Services at Home (SASH) teams, an integrated information technology infrastructure and multi-insurer payment reforms to drive quality improvement. Since its inception in 2008, the Blueprint has been financially supported by Vermont's three major commercial insurers and Medicaid. With Vermont's designation as one of eight states to be part of the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration through the Center for Medicare and Medicaid Innovation, Medicare now also is a fully-participating insurer. With both Medicare and Medicaid participating in the Blueprint multi-payer efforts, local teams have been able to connect the health and long term care systems statewide. SASH, mentioned above, is one such innovation that helps streamline access to the medical and non-medical services necessary to support vulnerable seniors living safely at home. As part of MAPCP grant and model, SASH efforts, working in tandem with Blueprint Community Health Teams, have moved from one pilot team in 2009 to 26 teams statewide as of 2013. Along these lines, as of the end of October 2012, the Blueprint included 100 Advanced Primary Care Practices, representing 435 primary care physicians serving over 67% of the State's population. Expansion is in progress to involve all willing providers statewide by October 2013.

Results of the statewide implementation experience will be published later in 2013, but evaluation of the initial pilots demonstrates the following encouraging trends:

- Between 2009 and 2010, growth rates for emergency room visits and inpatient hospital admissions in participating patients were favorable in spite of this group being older.
- During this period, overall expenditures per capita increased 22% in the Blueprint participants vs. 25% for the control population. In other words, the annual expenditures

increases are trending downwards when there was a projected significant increase for the same population (“bending the cost curve”).

Future goals of the Blueprint include:

- NCQA recognition of all willing primary care practices as patient-centered medical homes and serving an estimated 500,000 Vermonters by the end of 2013.
- Creating an environment where all Vermonters have access to seamless, effective and preventive health services that improve health care for individuals, improve the health of the population, and improve control of health care costs (the “Triple Aim”).
- Achieving community-wide transformation characterized by excellent communication and funding streams aligned with health-related goals, resulting in independent providers working together in ways they never have before.

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

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

Examples of services supported through this mechanism include respite services for families of children with disabilities; substance abuse treatment services for uninsured and underinsured Vermonters; tuition support for health professionals in short supply in Vermont, such as nurses, primary care physicians, and dentists; and support for development of standards and training for medical emergency care.

The managed care model also encourages inter-departmental collaboration and consistency across programs. Having all Medicaid initiatives, including three former 1915 (c) waivers, mental health and other specialty carve outs, under one regulatory structure has allowed for a more unified and streamlined approach to provider negotiations and coordination of services. This has included administrative flexibilities such as:

- Creation of one master grant agreement with the state’s network of developmental disabilities and mental health service providers to provide mental health, substance abuse, developmental disabilities and vocational services to the most vulnerable Medicaid beneficiaries.
- Creation of a single simplified reporting, budgeting and regulatory structure for all Medicaid programs related to federal and state reporting.
- Infrastructure efficiencies for mental health and developmental disability service providers by moving away from separate, and often conflicting, 1915(c) and Medicaid state plan regulatory structures to one cohesive Medicaid Managed Care regulatory framework.

- Medicaid participation in Vermont's multi-payer claims database to facilitate understanding of health care utilization, expenditures, and performance across all payers and services.

Additionally, programmatic service delivery changes have included:

- Collaboration between the State's division of Alcohol and Drug Abuse Programs, DVHA and Department of Mental Health with community providers to create a specialized health home program for a coordinated, systemic response to the complex issues of opioid and other addictions. This response has come to be known as the "*Hub and Spoke*" system and Medication Assisted Therapy (MAT). MAT is the use of medications (such as methadone and/or buprenorphine) in combination with counseling and behavioral therapies to provide a holistic approach to treatment. Under the *Hub and Spoke* model, each patient undergoing MAT will have an established, physician-led medical home, including a single MAT prescriber, a pharmacy home, access to existing Community Health Teams (CHTs), and access to the *Hub* (a specialty treatment center) or *Spoke* (ongoing community supports, nurses and clinicians) in their geographic area. Providers of opioid addiction treatment will have access to resources and support to effectively care for current patients as well as allow for additional care of new patients.
- Integration of separate and fragmented children and family programs. Specifically, children's Medicaid services are scattered across six departments. Programs historically developed separately and distinctly from each other with varying Medicaid waivers, procedures and rules for managing sub-specialty populations. These were the best approaches available at the time; however, the artifacts of this history are multiple and fragmented funding streams, policies and guidelines for work with children and families. Often the same provider and family will be captive to varied and conflicting procedures, reporting and eligibility requirements. With the inception of GC, the Agency of Human Services can look at one overarching regulatory structure (42 CFR 438) and one universal EPSDT screening, referral and treatment continuum. This also allows for efficiency and effective review for enhanced coordination and reduced redundancy with other federal mandates such as Title V, IDEA part B and C, Title IV-E, Federal early childhood programs and others.

The following are additional strategies developed through the GC Demonstration that have contributed to improved access and quality for beneficiaries as well as integration with the State's broader health care reform efforts:

- Rebranding of the Global Commitment and Dr. Dinosaur coverage programs under one name, Green Mountain Care, and aggressive outreach to increase enrollment including:
 - Targeting the hard-to-reach population of 18 to 26 year olds with information packets included in university mailings to students and parents, and co-sponsoring end-of-year music events for college-age students;
 - Attending a "welcome home" event for 500 returning veterans and their families to inform them of the availability of their health insurance options;
 - Partnering with the Department of Labor (DOL) to conduct outreach at job fairs and as part of the DOL rapid response team related to company layoffs across the state, reaching over 600 people with information about options for continued health care coverage; and
 - Implementation of an outreach tracking tool to assist enrollment efforts.

- Support for Wellness Recovery Action Plan (WRAP), a standardized group intervention for adults with mental illness using a set curriculum and implementation model.
- Providing financial and organizational support for Vermont's Blueprint for Health, Vermont's state-led multi-payer initiative to transform the way health care services are delivered.

Choices for Care

Historical Summary

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

Vermont's overarching goal for Choices for Care is to support individual choice, thus improving access to HCBS. In supporting more people in their own homes and communities, Vermont has sought to increase the range and capacity of HCBS. One measure of success is to compare utilization of HCBS to utilization of nursing homes. When Choices for Care began, 34% of people were using HCBS, and Vermont's initial goal was to increase HCBS utilization to 40%. That goal was reached in 2007, so Vermont set a new goal, to increase HCBS utilization to 50%. Current HCBS utilization in Choices for Care is nearly 49%, 15% higher than in 2005 and very close to the current goal of 50%.

This shift in the use of different settings has affected the use of Vermont's long term care financial resources. In 2005, about 19% of Choices for Care expenditures were for HCBS; in 2012, about 33% of expenditures were for HCBS.

Choices for Care Demonstration Objectives and Successes

Vermont's Choices for Care Demonstration has achieved success similar to the accomplishments of the Global Commitment Demonstration. The CFC Demonstration was designed to create fundamental changes in how long-term care services and supports are provided to low-income seniors and people with disabilities by increasing access to HCBS while reducing the use of nursing home services and controlling overall costs.

CFC participants are assigned into three groups based on level of need:

1. The "highest need" group is entitled to both nursing home and HCBS;
2. The "high need" group qualifies for nursing home and HCBS (as State resources permit); and
3. The "moderate need" group who do not yet meet the eligibility requirements for nursing home care but receive limited services (as State resources permit). The "moderate need" group was intended to test the theory that early interventions can be cost-effective by helping to prevent increased disability, and support people to live as independently as possible in community settings.

Currently, beneficiaries enrolled in CFC have a choice of using a home health agency or an Area Agency on Aging as their case management provider.

Vermont's progress over the past several years has positioned it to focus on one of the most challenging groups within CFC: longer-stay nursing home residents who desire to return home or to another community alternative. Although many former nursing home residents have returned to the community under CFC, there are longer-stay residents who face barriers to discharge due to lack of initial transition supports and other services necessary to address their complex needs. In 2011, Vermont received a *Money Follows the Person* (MFP) grant that has been targeted at removing these barriers to community choice. Participants in the MFP program are a subset of CFC beneficiaries. MFP participants have the support of transition coordinators, community development specialists, one-time set-up payment of up to \$2,500, and an adult family care living arrangement option.

The following summary includes key elements and findings for the CFC Demonstration that have contributed to beneficiary choice, increased access to home and community-based services and improvements:

- Creation of a team of long-term care nurses serving as clinical coordinators to manage the clinical eligibility process and provide technical assistance to beneficiaries and stakeholders.
- Expansion of long-term care ombudsman services to include community-based beneficiaries.
- Implementation of a higher resource test for single individuals residing in their home, allowing the beneficiary more available funds to maintain their home in the community.
- Implementation of the Flexible Choices (Cash & Counseling) option, currently supporting approximately 100 people to purchase the services and supports they need to live in the community.
- Implementation of a policy to pay caregiver spouses to provide personal care.
- Development of a web-based registry for direct care workers to assist beneficiaries who self-manage their services and supports to find direct care staff.
- Policy briefs to inform decision making created for Vermont by the University of Massachusetts Medical School, Center for Health Policy and Research. Topics have included: Eligibility (2008), Enrollment and Wait List (2008), Quality Oversight (2009), Self-Direction (2010), Hospital Discharge Planning (2011) and Nonmedical Providers (2012).
- Completion of annual Consumer Satisfaction Surveys, the most recent of which, released in December 2011, states "*...the large majority of customers are satisfied with VT DAIL programs, satisfied with the services they receive, and consider the quality of these services to be excellent or good. The survey results are a clear indication that VT DAIL is in large part fulfilling its goal 'to make Vermont the best state in which to grow old or to live with a disability with dignity, respect and independence.'*"
- Findings of an independent evaluator in 2012 concluded, "*In this sixth year of the CFC program, DAIL met the needs of those Vermonters who need long-term support services. As with any far-reaching program, there are areas which can be improved. However, with an overwhelmingly high rate of consumer satisfaction, DAIL is well positioned to meet the current and future needs of Vermont's elders and adults with disabilities who use the CFC program.*"

Future Goals

Vermont Health Care Reform

The Global Commitment (GC) to Health Section 1115 Demonstration, initiated in 2005, has served as the foundation for Vermont's health reform model, providing the flexibility to improve access to health coverage and care based on individual and family needs. The GC Demonstration enables Vermont to operate as if it were a public managed care organization as the vehicle for achieving the following reform objectives:

- Promoting universal access to affordable health coverage.
- Developing public health approaches for meeting the needs of individuals and families.
- Developing innovative, outcome- and quality-focused payment approaches.
- Enhancing coordination of care across providers and service delivery systems.
- Controlling program cost growth.

Similarly, the Choices for Care (CFC) Section 1115 Demonstration has enabled Vermont to promote early intervention and prevention, equal access to nursing home and community-based services, and person-centered services for beneficiaries in need of long-term services and supports. It is crucial to maintain these foundations of health care delivery for Vermont's most vulnerable and lower-income citizens while moving towards the broader goals of state and federal reform.

In January 2011, Vermont Governor Shumlin announced his comprehensive plan for health reform, including the goal of implementing a single payer system of universal health coverage for Vermonters. In January of 2012, the Governor's Strategic Plan for Health Care Reform was released. Specific objectives of this plan are to: 1) reduce the growth of health care cost; 2) assure universal access to high quality health coverage; 3) improve the health of Vermonters; and 4) assure greater fairness in health care financing in Vermont. Core strategies of Governor Shumlin's Reform Plan include changing how care is delivered to Vermonters; moving from volume-based to value-based reimbursement; and moving from a fragmented and overly complex financing system to a unified system that supports integration of service delivery and payment reform.

Vermont Act 48 (2011) is the first step in this broader reform by providing legislative authority to create a health care system in which all Vermonters receive equitable coverage through universal health coverage. This included establishing Vermont's Health Benefit Exchange as per the Affordable Care Act (ACA) within DVHA as a unique integration of Medicaid and the Exchange in a single state department - the goal of which is to build on successes of the public programs, increase administrative efficiencies and begin the groundwork for a fully-integrated single payer system.

Act 48 also created the Green Mountain Care Board (GMCB) to oversee cost-containment and to approve the benefit design of Green Mountain Care, the comprehensive health care program that will provide coverage for the health care needs of Vermonters. Members of the GMCB are responsible for controlling the rate of growth in health care costs and improving the health of residents through a variety of regulatory and planning tools. Specifically, the GMCB is tasked with expanding health care payment and delivery system reforms by building on the Blueprint, and implementing policies that move away from a fee-for-service payment system to one that is based on quality and value and reduces (or eliminates) cost-shifting between the public and private sectors.

The GMCB currently is modeling and testing a range of payment reform models, including:

- Population-based payments to integrated health care delivery systems.
- Global physician/hospital budgets.
- Bundled payments for specific diagnoses and procedures.

These payment models provide clear steps toward development of a mixed payment model that would balance incentives for reduced utilization, improved access, high quality care and satisfaction, with adherence to an overall state health care budget.

The GMCB is working actively with health care providers to identify and define pilot sites related to the three models. The goal is to implement these models on an all-payer basis. As such, the GMCB anticipates seeking CMS demonstration authority to include Medicare in Vermont's payment reforms. In addition, the GMCB is working with DVHA to determine the applicability and impact of these models for Medicaid and how they interface with current payment streams and methodologies.

It is anticipated that Medicaid will actively participate in these payment reform efforts. These payment reforms will provide the framework within which the Medicaid program will provide seamless coverage for beneficiaries, improve access, and continue to increase the quality of care.

Affordable Care Act (ACA)

Vermont supports the goals of the ACA to enhance access to affordable coverage, improve service delivery and control program cost growth. Vermont is committed to collaborating with CMS to ensure that state and federal health reform activities are complementary and coordinated. To this end, Vermont has developed operational models, policies and infrastructure to meet CMS expectations, federal requirements under the ACA and support Vermont's health reform initiatives. Vermont plans to continue collaborating with CMS to implement programs under the ACA and secure the needed authorities to preserve and enhance coverage available under the current Demonstrations. Specifically, Vermont is planning for the seamless integration of the Health Benefits Exchange and a modernized Medicaid eligibility system. This integrated system, along with the payment reforms and service delivery flexibilities allowed under the consolidated GC Demonstration, will become the foundation for unifying health care coverage under an eventual single payer system.

As state and federal health reforms progress, Vermont is committed to building on the strengths of the current system and ensuring that the transition is seamless and transparent for beneficiaries to the maximum extent possible and does not result in any coverage interruptions.

Summary

In summary, Vermont has a history of successfully implementing its 1115 Demonstrations to help control health care costs, improve access to care and implement innovative health care reforms.

Vermont seeks renewal/extension of the GC Demonstration and consolidation of the CFC Demonstration into one waiver that includes CHIP, and furthers the State's goals:

- Building on the successes of both existing 1115 Demonstrations, using the current GC Demonstration model as the foundation.

- Advancing both federal and state health reform initiatives, including changes contemplated by the ACA and by Vermont Act 48 (2011).
- Ensuring a smooth transition for Vermonters whose health care coverage will change as a result of the ACA, and maintain affordability of the coverage options.
- Streamlining program administration, oversight and reporting.
- Managing, under one authority, all acute and long-term services and supports for people with developmental disabilities, traumatic brain injuries, physical disabilities and beneficiaries who are aging.
- Continuing to expand the availability of flexible services and supports to assist beneficiaries with complex needs.
- Seamlessly integrating Medicare payments for dually eligible Vermonters into the existing managed care structure and providing higher quality care for beneficiaries while achieving efficiencies through a single integrated administrative approach.

II. Proposed Health Delivery System

A. Continuation of Public MCO Model and Regulatory Structure

Vermont is requesting to preserve the public managed care model that has been the foundation of GC operations and is proposing to manage all programs under the new integrated GC Demonstration using the managed care model in accordance with federal managed care regulations found at 42 CFR 438. This includes continuation of all waiver authorities, the existing GC payment mechanisms between CMS and the State of Vermont, and the service delivery flexibilities afforded under these structures. Although this is not a change from the existing GC Demonstration, Vermont seeks CMS concurrence that this will be the guiding regulatory framework for the GC Demonstration extension, effective January 1, 2014. Additionally, the state would like to collaborate with CMS to create a simplified amendment and maintain the simplified fiscal reporting process currently in place for the State Plan and other services covered under the GC Demonstration. This includes confirmation of the state's efficient and flexible models for transportation brokers and other services, capitated rate setting, MCO payment flexibilities and fully utilizing the Medicaid managed care regulatory structure for federal oversight and auditing activities such as PERM.

B. Consolidation and Integration of 1115 Medicaid Demonstrations and Programs

Both the Global Commitment and Choices for Care Demonstrations represent first-in-the-country models of care and health care reform. Both have achieved success in balancing beneficiary choice and in containing costs while assuring high quality care. To achieve administrative efficiency and seamless coverage for low-income Vermonters and people with disabilities, the State is requesting extension and integration of both these waivers into one consolidated 1115 Demonstration project beginning January 1, 2014.

Furthermore, to achieve similar goals for low-income Vermont families, Vermont is requesting that the Children's Health Insurance Program (CHIP) also be integrated into the consolidated Demonstration with the appropriate adjustment in federal share. While the managed care model, health care reform initiatives and payment flexibilities afforded under GC Demonstration would extend to CHIP, Vermont seeks to preserve the existing funding approach and enhanced FMAP under Title XXI of the Social Security Act.

Additionally, all Vermonters who are dually eligible for Medicare and Medicaid are currently enrolled in either the Global Commitment or Choices for Care Demonstrations. Vermont currently is working with the Center for Medicare and Medicaid Innovation (CMMI) to develop a system of care that integrates Medicare and Medicaid benefits for these beneficiaries. On May 9, 2012, Vermont submitted a Capitated Financial Alignment Demonstration application to CMMI, which proposes to utilize DVHA's managed care model to serve the dual eligible population rather than contracting with one or more private Managed Care Organizations (MCO). As of the submission of this Renewal request, AHS is in the process of developing a Memorandum of Understanding with CMS to proceed with implementation. Expecting that the Dual Eligible Demonstration will become operational on January 1, 2014, Vermont seeks to utilize the GC Demonstration authorities and funding arrangements for the integrated Medicare and Medicaid model.

There are several immediate benefits to the consolidation of these Demonstrations. This includes the efficiency and clarity in using one regulatory framework (42 CFR 438) for all Medicaid operations. This is particularly important in applying payment and health care reform efforts statewide. The administrative burden in maintaining multiple and cumbersome regulatory frameworks and associated reporting and oversight structures is inefficient and costly to both the state and providers. Additionally, beneficiary protections and outreach and access standards provided for under 42 CFR 438 would extend to all beneficiaries and offer consistent standards for member rights and protections, outreach and education, access standards, grievance and appeals processes, and a unified quality oversight plan for both state and provider operations.

C. Continuation of Home and Community-Based Service Services (former 1915 (c) authorities)

Vermont is requesting continuation of all Home and Community Based services (HCBS) for beneficiaries who meet eligibility requirements for all former 1915(c) groups, including limited benefits to persons with moderate needs up to and including 300% of the FPL. Former waivers incorporated into the current GC Demonstration include services for persons with developmental disabilities, persons with traumatic brain injuries and children and adolescents who are experiencing severe emotional disturbances and their families. Vermont's array of HCBS has been considered exemplary in many external reviews. This consolidation request ensures that all authorities formerly provided and transferred into the Global Commitment and Choices for Care Demonstrations (for persons who are aging or who have certain disabilities) are maintained. These include, but are not limited to, continuation of:

- Adherence to person centered planning practices.
- Self-directed care options with consumer, surrogate or shared management options.
- Spouses as caregivers for long-term care beneficiaries.
- Level of care assessment and enrollment for long-term care beneficiaries in the highest, high and moderate groups.
- Allocation of cash allowances to beneficiaries for self-directed services (Cash and Counseling; Flexible Choices).
- Use of an array of community-based residential and habilitation options to provide care in the least restrictive setting and divert the need for higher levels of institutionalized care.

D. Continuation of Community Rehabilitation and Treatment Program (former 1115 authorities)

In August 2011, Tropical Storm Irene created major flooding throughout Vermont, including flooding the Vermont State Hospital. As a result, the State had to quickly find alternative placements in surrounding hospitals, and the State's commitment to replace the antiquated facility with more community-based options and specialized residential programs was significantly accelerated. The Department of Mental Health (DMH) is working with providers to assure that citizens have a variety of clinical and support services that focus on the recovery of the person experiencing the mental illness while supporting them to live in the community. These services will include, but are not limited to: peer services, housing with recovery-oriented supports, intensive residential services for people who need a more intensive and secure treatment environment yet do not need hospitalization including those who are not yet ready to live independently in the community. This continuum includes psychiatric inpatient services both for people who voluntarily present for that level of care and those involuntarily committed to that level of care. All of these services will be coordinated through a statewide care management system that is available to any person or family who present with manifestations of a mental illness or emotional disturbance.

Such services have been included in the former 1115(a) Demonstration authorized in 1999 and are currently included within the existing GC Demonstration for individuals enrolled in the Community Rehabilitation and Treatment (CRT) program. The CRT program is administered by the DMH in exchange for a capitated payment. The State of Vermont has used the flexibility afforded under the GC Demonstration's managed care model to develop a full array of community-based, residential and inpatient hospital services to serve Vermonters with intensive mental health treatment needs and includes the full array of services, regardless of provider type in rate development.

This request ensures the continuation and expansion of all authorities to support persons coping with all levels of mental illness and emotional disturbance who can clinically benefit from the innovative community based continuum, and small scale residential and psychiatric inpatient options afforded under Vermont's former and current 1115 Demonstrations.

III. Eligibility Groups & ACA Impact

Vermont has partnered with the federal government since 1996 to make coverage affordable and accessible to Vermonters. Uninsured and underinsured children with incomes up to 300% of the Federal Poverty Level (FPL) have access to coverage under the GC Demonstration and Vermont's CHIP. Uninsured adults with incomes up to 300% of the FPL have access to subsidized coverage under the GC Demonstration. Low-income adults with access to employer-sponsored insurance have direct access to a Medicaid expansion program or program subsidies to make private coverage more affordable. Finally, Vermont operates a number of prescription assistance programs to promote affordable access to prescription drugs. As a result of these efforts to make coverage affordable and accessible, Vermont has one of the lowest uninsured rates in the nation.

Starting January 1, 2014, the ACA consolidates some of the complex categorical eligibility groupings and extends Medicaid eligibility to all individuals under age 65 with income at or below 133% of the FPL and who meet certain non-financial eligibility criteria, such as citizenship or satisfactory immigration status. The ACA will impact Vermont's current eligibility groups as follows:

- **Vermont Health Access Plan (VHAP)** - An expansion program available to adults age 18 and older who do not meet the eligibility requirements for Medicaid, and who have income that is under 150% of the FPL for adults with no children, or 185% of the FPL for parents and caretaker relatives who have minor children in the home. There is no asset test but eligible applicants must have been uninsured for 12 months or more, with exceptions for people who recently lost their insurance because of a life change such as a divorce or loss of a job. VHAP provides a comprehensive package of benefits with nominal copayments and monthly premiums. Under the ACA:
 - Adults in VHAP with incomes at or below 133% of the FPL would transition to Medicaid;
 - Adults in VHAP with incomes above 133% of the FPL would be eligible for federal tax credits and cost-sharing subsidies for private plans offered through the Exchange. Vermont plans to collaborate with CMS to implement a premium and cost-sharing subsidy program for individuals up to 300% of the FPL to ensure coverage is affordable and accessible.

- **Catamount Health Premium Assistance (CHAP)** - Catamount Health is a private health insurance plan, offered in cooperation with the State. People who have been uninsured for 12 or more months, with some exceptions for loss of insurance due to a life change, and who have income less than or equal to 300% of the FPL may qualify for premium assistance based on a sliding scale. There is no asset test. Under the ACA:
 - Adults in Catamount Health premium assistance (CHAP) with income less than or equal to 133% of the FPL would transition to Medicaid;
 - Adults in CHAP with income above 133% of the FPL would be eligible for federal tax credits and cost-sharing subsidies for private plans offered through the Exchange, as long as they do not have access to an affordable Employer-Sponsored Insurance plan. Vermont plans to collaborate with CMS to implement a premium and cost-sharing subsidy program for individuals up to and including 300% of the FPL to ensure coverage is affordable and accessible.

- **Employer-Sponsored Insurance (ESI) Premium Assistance** - People who otherwise meet the eligibility criteria for VHAP or CHAP may receive premium assistance to enroll in their ESI plan if it is more cost-effective for the State than enrolling them in either VHAP or CHAP. Beneficiaries enrolled in ESI premium assistance pay a monthly premium equivalent to that paid by beneficiaries in VHAP or CHAP. Beneficiaries otherwise eligible for VHAP but enrolled in their ESI plan receive wrap-around coverage for cost-sharing required by their ESI plan. Beneficiaries otherwise eligible for CHAP but enrolled in their ESI plan receive wrap-around coverage for the prevention and maintenance of certain chronic conditions. Under the ACA:
 - Adults in VHAP-ESIA with income at or below 133% of the FPL would transition to Medicaid;
 - Adults in VHAP-ESIA with income above 133% of the FPL will not be eligible for federal premium tax and cost-sharing subsidies under the ACA unless the employer plan is unaffordable. Individuals employed by small employers may be able to buy through the Exchange, or if their employers drop coverage, will be eligible as individuals to buy through the Exchange.

- **Prescription Assistance** - Vermont has several Prescription Assistance programs under the GC Demonstration to help uninsured Vermonters and those enrolled in Medicare pay for prescription drugs based on income, disability status and age. These programs include:
 - **VPharm** assists Vermonters who are enrolled in Medicare Part D with paying for prescription drugs. This includes people age 65 and older as well as people of all ages with disabilities.
 - **VHAP-Pharmacy** helps Vermonters age 65 and older and people with disabilities that are not enrolled in Medicare pay for eye exams and prescription drugs for short-term and long-term medical problems.
 - **VScript** and **VScript Expanded** help Vermonters age 65 and older and people of all ages with disabilities that are not enrolled in Medicare and who have incomes up to and including 225% of FPL, pay for prescription and over-the-counter maintenance drugs for long-term medical problems.

Under the ACA, non-Medicare beneficiaries in pharmacy-only programs (VHAP-Pharmacy, VScript, VScript Expanded) would be afforded pharmacy benefits as part of new essential health benefits required by the ACA, therefore these programs would be eliminated from the GC Demonstration. Vermont's program for Medicare beneficiaries (VPharm) would continue.

In general, a beneficiary enrolled in programs other than those described above would not experience any eligibility changes in 2014 as a result of ACA. This includes beneficiaries currently participating in Dr. Dynasaur and the Choices for Care Demonstration; individuals with Medicare coverage; individuals with both Medicare and Medicaid ("dual eligible") coverage; individuals in the state based discount drug program ("Healthy Vermonters") and individuals enrolled in other eligibility categories where existing Title XIX authority continues.

IV. Benefits and Cost Sharing

Vermont intends to continue all current Medicaid coverage policies and cost sharing commitments. Any future benefit or cost sharing changes must be authorized by the Vermont legislature. VHAP beneficiaries with incomes at or below 133% of FPL will be afforded increased benefits as a function of moving out of the Global Commitment expansion population and into a traditional Medicaid eligibility group.

Additionally, the Vermont legislature has requested that the state seek authority for an enhanced hospice benefit that will allow the state to expand the definition of "terminal illness" from six months to twelve months life expectancy and allow all participants access to hospice without being required to discontinue curative therapy.

V. Proposed Demonstration Changes

A. Use of consistent MAGI methodologies for Income Determination

Beginning on January 1, 2014, eligibility for Medicaid for most individuals, as well as for CHIP, will be determined using methodologies that are based on modified adjusted gross income (MAGI) as defined

in the Internal Revenue Code of 1986 (IRC). The ACA also eliminates the current resource test for individuals whose income eligibility is based on MAGI.

Vermont is pursuing a fully-integrated, automated eligibility system that will determine financial eligibility for all of Vermont's health care programs. Further, it will employ common income methodologies and aligned rules to evaluate eligibility for Medicaid, CHIP and the Exchange. Vermont is requesting authority to transition to the MAGI rules for income determination for all GC Demonstration populations, with the exception of long-term care Medicaid benefits. This would extend the methodology to the proposed GC Demonstration population #4, (pharmacy-only beneficiaries). Vermont would request flexibility to pursue this alignment if extending the methodology proves no adverse impact on any optional or expansion groups, such as SSI-related populations.

B. Streamlined Eligibility Transition Process

Vermont is committed to making the transition for current beneficiaries as seamless as possible. Vermont shares CMS' concerns regarding the potential adverse impacts on beneficiaries due to the breadth and complexity of forthcoming system, policy and operational changes and the relatively aggressive timeline. Although Vermont is working toward implementation in accordance with the ACA timelines, Vermont seeks authority to extend current coverage policies, as necessary, through a transition period to ensure that:

- 1) Coverage is seamless and there is no disruption in coverage for current beneficiaries.
- 2) Little to no additional burden is placed on current beneficiaries due to ACA changes.
- 3) Adequate resources are available to enroll new beneficiaries.

Vermont plans to work with CMS to develop a flexible, phased approach that meets the above-stated principles. Vermont is proposing a "safe harbor" approach whereby all beneficiaries in the mandatory and optional categories of eligibility who are due for eligibility recertification in the first three months of 2014 will be deferred for review and distributed throughout the remainder of the calendar year, and all beneficiaries due for review be held harmless until March 31, 2014 or their review date, whichever is later.

Vermont is also proposing that the new MAGI rules be applied at all review dates. This would have the functional effect of all current beneficiaries being converted to MAGI-related determination by December 31, 2014. This would enable the majority of current beneficiaries to continue coverage during the transition period, without the need to submit additional information. Under this approach, Vermont is requesting approval from CMS to identify program eligibility groups whose current income levels are at or below 133% of the FPL and continue coverage until their scheduled eligibility recertification date. Effective January 1, 2014, eligibility for all new applicants would be determined in accordance with the MAGI income standards.

C. Premium Subsidies and Cost Sharing For Exchange Participants

In a preliminary analysis of current out-of-pocket obligations, Vermont found that in many instances ACA out-of-pocket is substantially higher than current obligations (see table on following page). For example, many Vermonters over 133% of the FPL will have to pay higher premiums under the ACA than what is currently charged for Vermont's Catamount Health product under the current GC

Demonstration. Furthermore, the ACA out-of-pocket maximum is almost six times higher than Vermont's current out-of-pocket maximum for Vermonters up to and including 300% of the FPL.

FPL Range	ACA Required Premium	Current Premium Levels in VHAP & CHAP	ACA Out-of-Pocket Maximum	Current VHAP/CHAP Annual Out-of-Pocket Maximum
0-50%	\$0	\$0	N/A	N/A ¹
50-75%	\$0	\$7	N/A	N/A
75-100%	\$0	\$25	N/A	N/A
100-133%	\$19-\$38	\$33	N/A	N/A
133%-150%	\$38-57	\$33	\$2250	N/A
150-185%	\$57-\$100	\$49	\$2250	\$1,050 ³
185-200%	\$100-\$121	\$60	\$2250	\$1,050
200-225%	\$121-\$154	\$124	\$5,200	\$1,050
225-250%	\$154-\$193	\$152	\$5,200	\$1,050
250-275%	\$193-\$230	\$180	\$6,400	\$1,050
275-300%	\$230-\$273	\$208	\$6,400	\$1,050

¹ People enrolled in VHAP have minimal cost-sharing: \$1 and \$2 pharmacy co-pays and a \$25 co-pay for emergency room visits

² Updated to 2013

³ Parents of minor children are eligible for VHAP if their income is less than 185% of the FPL, thus liable for VHAP-level cost-sharing only

As a result, implementation of the ACA may pose a serious financial challenge for those currently eligible through VHAP and Catamount Health which may result in a decrease in the percentage of Vermonters who have health coverage. Vermont has made significant progress in developing programs to make coverage affordable and accessible to low- and middle-income Vermonters, and this increased cost sharing may negate this progress.

To address this concern, Vermont proposes to build on the federal premium tax credits to create affordability by additionally subsidizing monthly premiums by 1% of income for individuals to ensure affordability for low- and middle-income Vermonters up to and including 300% of the FPL. Therefore, Vermont is seeking authority to implement a premium subsidy for which it requests federal financial participation for Vermonters up to and including 300% of the FPL, as currently authorized by the GC Demonstration. The Governor and his administration have presented a proposal on premium assistance up to 300% FPL, expected to be a CMS/State partnership, to the Vermont Legislature. The budget impact of that proposal is presented in the table below. Legislative committee hearings and public testimony on this aspect of the administration's proposal is ongoing and final approved proposal will be part of the State's final waiver renewal application.

In addition to the population described above and despite available assistance, there are a small number of people who do not qualify for either premium-free Part A or any Medicare Savings program due to their unique circumstances. In 2009 approximately 57 Vermonters who fell under

such circumstances elected to pay the Part A premium on their own while an unknown number of people elected not to pay the Part A premiums (and go without Medicare). According to the 2009 Vermont Household Insurance Survey, there were 60 people who were 65 and over, uninsured and less than 150% of the federal poverty level (FPL), half of which would likely be eligible for the Medicare savings program (QMB) highlighted above. Of the 30 individuals not eligible for the Medicare savings program, we do not know for sure how many would be eligible for premium-free Part A, but we will use them as a proxy to estimate the number of Medicare eligible individuals not currently enrolled.

The AHS has been directed by the legislature to ask CMS for consideration of “wrapping” or subsidizing Medicare coverage for individuals who are not eligible for any type of free-premium or premium assistance programs. Should the state chose to fully cover their Part A coverage, the annualized state costs (using 2012 premiums) could range from \$390,000 to \$615,000. This does not include any form of cost sharing for these individuals, which the legislature may want to consider should it choose to pursue this. For instance the state currently provides a Medicare Part D wrap through the VPharm program. Beneficiary premiums for the VPharm program range from \$15 to \$50 per person per month depending on income. There are also \$1 and \$2 prescription co-pays.

	SFY 2014 (6 months)	SFY 2015 (12 months)
Budget Impact of Premium Assistance Subsidies (not including any Part A or B subsidy)	\$4,391,058	\$9,221,221
Budget Impact of Part A Subsidies	\$307,500	\$615,000
Total Budget Impact of Premium Assistance and Part A Subsidies	\$4,698,558	\$9,836,221

Note: Amounts include State and Federal share.

D. Expansion of Services to Moderate Needs Group and Other Needs-Based Populations

Long Term Support and Service Recipients: Currently, individuals enrolled in the Choices for Care Moderate Needs Group have access to case management, homemaker, and adult day services. Within available resources, Vermont proposes to expand the service options for the Moderate Needs Group, based on individual need, to include a variety of home and community services, such as: case management, homemaker/home health aide, personal care, life skills aide, adult day health, habilitation, and respite care for elderly and disabled populations.

Other Needs-Based Populations: The Global Commitment public managed care model provides the flexibility to offer an array of services in lieu of traditionally covered services. In many instances, alternative services have proven to be more clinically appropriate, less restrictive and/or less costly. Vermont intends to continue to use the flexibility afforded by the managed care model to best meet the needs of program participants.

Vermont currently is exploring service delivery options for Medicaid participants who have complex needs and who could benefit from home and community services, but do not meet institutional level of

care requirements. By extending certain, less-restrictive home and community services to certain individuals based on need, Vermont believes that more costly interventions could be delayed or eliminated, thereby reducing expenditure growth trends.

Summary of Proposed Demonstration Changes

Area	Proposed Change	Impact	Hypothesis
Eligibility Expansions	Eliminate VHAP, Catamount Health and ESI Expansion Populations and VScript, Vscript expanded and VHAP pharmacy programs.	Persons under 133% will move to traditional Medicaid and receive a fuller benefit package; persons over 133% will move into commercial products through the Exchange.	Vermont will retain a high rate of insured Vermonters; transition to Affordable Care Act rules will not diminish coverage rates.
ACA Transition	Adopting a “safe harbor” approach to transitioning current Medicaid beneficiaries: those who are due for eligibility recertification in the first three months of 2014 will be deferred for review and distributed throughout the remainder of the calendar year, and all beneficiaries due for review will be held harmless until March 31, 2014 or their review date, whichever is later.	Current Medicaid beneficiaries would not be required to submit any new information until their anniversary date.	Vermont will minimize coverage gaps, and limited to no new administrative burden will be placed on current beneficiaries.
Modified Adjusted Gross Income	Use new MAGI rules for all eligibility determinations as long as it does not adversely impact optional or expansion populations.	Administrative efficiency in eligibility determinations.	Streamlined and standardized rules will result in easier to understand information requests and timelier processing of health care program applications.
Benefits	Within state budget restrictions, expand the current menu of services offered in the Long Term Care Moderate Needs Group. Enhance Hospice Benefits for persons within 12 months of end of life and allow delivery of both palliative and curative care.	Additional flexibility for current long term care service beneficiaries in available service options.	Long term care beneficiaries will remain in their homes longer and delay the need for nursing facility care.
Affordability	Include a state based, sliding scale premium subsidy for persons purchasing on the Exchange up to 300% FPL. Including Medicare premium subsidies for certain individuals who are low income.	To maintain affordability of Vermont programs at a level of expense substantially similar to former VHAP, Catamount and ESI programs.	Vermont will retain a high rate of insured Vermonters; transition to the Affordable Care Act rules will not diminish coverage rates.
Demonstration Consolidation	Consolidate Choices for Care, Dual Eligible Demonstrations and CHIP into GC under one demonstration.	Administrative simplification in the use of one federal regulatory structure for state and provider network.	Administrative efficiencies will be achieved.
Administrative	Streamline CMS reporting, state plan amendment, auditing and other processes as much as possible under the 42 CFR 438 regulatory structures.	Administrative simplification in the use of one federal regulatory structure for state and provider network.	Administrative efficiencies will be achieved.

VI. Requested Waivers and Expenditure Authorities

Under the authority of Section 1115(a)(1) of the Social Security Act (the Act), Vermont is requesting continuation of all waivers granted under the current Global Commitment to Health and Choices for Care Long Term Care section 1115 Demonstrations. Additionally, the State will collaborate with CMS to identify any other waivers needed to carry out the operations of the program. Vermont's preliminary list of current waivers includes:

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.

Hearing and Appeals

Section 1902(a)(3)

To permit the State to offer an initial hearing on coverage denials through the Department of Vermont Health Access, with opportunity to appeal to a Fair Hearing before the State Medicaid Agency.

Reasonable Promptness

**Sections 1902(a)(3), 1902(a)(8), and
1902(a)(19)**

To permit the State to maintain a waiting list for high and moderate need individuals applying for long term care services and supports. To allow the State to require applicants for long term care services to complete a person centered assessment and options counseling process.

Amount, Duration, Scope of Services

**Sections 1902(a)(10), 1902(a)(10)(b), and
1902(a)(10)(B)**

To enable the State to vary the amount, duration and scope of services offered to various mandatory and optional categories of individuals eligible for Medical assistance under the Demonstration. To allow the State to provide non-state plan services to demonstration populations. To enable the State to offer different services to different expansion populations.

Financial Eligibility

Section 1902(a)(10)(C)(i)(III)

To allow the State to use institutional income rules (up to 300% of the SSI payment level) for medically needy beneficiaries electing home-based services in lieu of nursing facility or in lieu of other residential care services in licensed settings while allowing resource limits up to \$10,000 for single individuals who own and reside in their own homes.

Comparability

Section 1902(a)(17)

To the extent necessary to enable the State to use more liberal income and resource standards and methods for plan groups and individuals.

Financial Responsibility/Deeming

Section 1902(a)(17)(D)

To the extent necessary to enable the State to use more liberal income and resource standards and methods for plan groups and individuals whose eligibility is determined under the more liberal standards and methods, resource standards, and requirements that differ from those required under title XIX. The waiver would specifically 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.

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.

Spend-Down

Section 1902(a)(17)

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.

Freedom of Choice

Section 1902(a)(23)

To enable the State to restrict freedom of choice of provider for the demonstration participants. Participants will be restricted to a single plan and may change providers within the plan.

Some demonstration waiver participants may only have access to the providers participating in those programs, and will not have access to every Medicaid enrolled provider in the State.

Premium Requirements

**Section 1902(a)(14)
insofar as it incorporates Section 1916**

To permit Vermont to impose premiums in excess of statutory limits for optional populations and cost sharing on certain services as reflected in the special terms and conditions.

Retroactive Eligibility

Section 1902(a)(34)

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

Cost Sharing Requirements

**Section 1902(a)(14)
insofar as it incorporates Section 1916**

To enable Vermont to impose premiums, enrollment fees, deductions, cost sharing and similar charges that exceed the statutory limitations.

Direct Provider Reimbursement

Section 1902(a)(32)

To enable Vermont to provide premium assistance subsidies to former Global Commitment expansion populations (pre-January 1, 2014) now insured under ACA and the Health Benefits Exchange to continue a reasonably similar level of affordability of health care coverage for low and middle income Vermonters.

The following expenditure authorities shall enable Vermont to implement the revised Global Commitment to Health Section 1115 Demonstration.

1. Expenditures Related to Eligibility Expansion

Expenditures to provide Medical Assistance coverage to the following Demonstration populations that are not covered under the Medicaid State Plan and are enrolled in the Global Commitment to Health Demonstration.

2. Expenditures Related to Additional Services

Expenditures for additional health care related-services for the Demonstration populations.

3. Expenditures for Public Health Initiatives, Outreach, Infrastructure, and Services Related to State Plan, Demonstration, Uninsured and Underinsured Populations.

Subject to availability of funding within the per member per month limit, expenditures to reduce the rate of uninsured and/or 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.

4. Expenditures to provide home and community-based services to individuals who would not otherwise be eligible for Medicaid, because they are not at immediate risk of institutionalization absent the provision of the home and community based services. Including:

- a. Expenditures for home and community based services for elderly and disabled adults, with income up to 300% of Supplemental Security Income payment level, who do not meet the Demonstration's clinical criteria for long term care services, but are at risk for institutionalization;
- b. Expenditures for home and community based services for participants with resources exceeding current limits, who are single, own and reside in their own homes, and select

home based care rather than a nursing facility care, to allow them to retain resources to remain in the community;

- c. Expenditures for personal care services provided by participant's spouses;
- d. Expenditures for incidental purchases paid in cash allowances to participants who are self-directing their services prior to service delivery.

VII. Summary of Documentation of Quality and Access to Care and Demonstration Evaluation Efforts

Since 2007, the Vermont Agency of Human Services (AHS) has contracted with Health Services Advisory Group, Inc. (HSAG), an External Quality Review Organization (EQRO), to review the performance of DVHA in the three CMS required activities (i.e., Compliance with Medicaid Managed Care Regulations, Validation of Performance Improvement Projects, and Validation of Performance Measures), and to prepare the EQR annual technical report which consolidates the results from the activities it conducted.

Over the past five years, HSAG has observed tremendous growth, maturity, and substantively improved performance results across all three activities. Vermont's Medicaid Managed Care Model has achieved the following scores relative to the three mandatory areas of EQR:

1. Average Overall Percentage of Compliance Score of **93.8%**;
2. Average Performance Improvement Validation scores for Evaluation Elements Met of **98.4%**, Critical Elements Met of **100%**, and an Overall Validation Status of **Met** for each year - indicating high confidence in the reported results; and
3. Performance Measures Validation finding of **Fully Compliant** and a determination that measures were valid and accurate for reporting for each year.

In addition, with each successive EQRO contract year, HSAG has found that DVHA has increasingly followed up on HSAG's prior year recommendations and has initiated numerous additional improvement initiatives. For example, they found that Vermont's Medicaid Managed Care Model regularly conducts self-assessments and, as applicable, makes changes to its internal organizational structure and key positions to more effectively align staff skills, competencies, and strengths with the work required and unique challenges associated with each operating unit within the organization.

HSAG also said that DVHA's continuous quality improvement focus and activities, and steady improvements over the five years have been substantive and have led to demonstrated performance improvements, notable strengths, and commendable and impressive outcomes across multiple areas and performance indicators. Finally, HSAG has concluded that DVHA has demonstrated incremental and substantive growth and maturity which has led to its current role and functioning as a strong, goal-oriented, innovative, continuously improving Medicaid managed care organization model.

This growth is also evidenced in evaluation efforts as reflected by the 2012 CAHPS survey data on "Overall Rating of Health Plan": the percentage of beneficiaries that rated the health plan 8 out of 10 or higher improved from 68.1% in 2009 to 81.3% in 2012.

DVHA beneficiaries also have experienced increased access and quality of care under the Global Commitment to Health 1115(a) Demonstration. Overall, Vermont's Medicaid Managed Care model

showed strong performance (greater than the 75th percentile) across three measures related to access in 2012:

- DVHA significantly exceeded the national average for Annual Dental Visits in 2011 (**by 17.4%**).
- DVHA exceeded the national average for Children's and Adolescents' Access to Primary Care Practitioners in 2011 (**by an average of 4.2%**).
- DVHA was significantly higher than the national average for 2011 for Antidepressant Medication Management: Acute and Continuation Phase (**by 17.3%** and **20.1%** respectively).

In addition, according to the 2012 CAHPS data, most respondents are satisfied with provider punctuality, availability (in both urgent and non-urgent situations), attentiveness, and coordination of care. Overall, Vermont's Medicaid Managed Care model showed strong performance across two composite CAHPS measures related to access:

- Getting Needed Care - The percentage of beneficiaries that responded that they were "Always" or "Usually" able to get care when attempting to do so improved from **79.9%** in 2009 to **84.9%** in 2012.
- Getting Care Quickly – percentage of beneficiaries that responded that they were "Always" or "Usually" able to receive care or advice in a reasonable time, including office waiting room experiences improved from **81.6%** in 2009 to **83.3%** in 2012.

DVHA in cooperation with the Vermont Department of Health (VDH), the Division of Alcohol and Drug Abuse Programs (ADAP), the Department of Corrections (DOC), and the commercial insurers, is increasing access for patients to buprenorphine services and the number of physicians in Vermont licensed to prescribe buprenorphine. At the end of FFY 2011, the program successfully increased access and providers who were in the program consistently increased their patient loads incrementally each month.

Examples of DVHA's success in enhancing the quality of care for beneficiaries during the GC Demonstration include the following data:

- DVHA had above-average performance (greater than the national HEDIS 75th percentile) in 2012 for the following HEDIS measures that also relate to quality of care: Antidepressant Medication Management—Effective Acute Phase Treatment; Antidepressant Medication Management—Effective Continuation Phase Treatment; Well-Child Visits in the First 15 Months of Life—Six or More Visits; Children's and Adolescents' Access to Primary Care Practitioners (all indicators); and the Annual Dental Visits measure, which involve distinct provider specialties.
- Vermont's Medicaid Managed Care Model's most recent Performance Improvement Project (PIP), Increasing Adherence to Evidence-Based Pharmacy Guidelines for Members Diagnosed with Congestive Heart Failure, received a score of **96%** for all applicable evaluation elements, a score of **100%** for critical evaluation elements and an overall validation status of **Met** indicating a finding of high confidence in the reported baseline and re-measurement results.

Vermont's Chronic Care Initiative (VCCI) as reported earlier in this document is also yielding positive results. Data for State Fiscal Year 2011, showed a 14% reduction for inpatient admissions and a 10% reduction in emergency room utilization over the baseline year of 2008 for VCCI beneficiaries. Additionally, when compared to similar beneficiaries who were not enrolled in VCCI, those receiving VCCI service demonstrated better adherence to evidence based treatment.

The GC Demonstration has contained spending relative to the absence of the Demonstration over the first 7.5 years of the waiver.

Vermont plans to continue the central hypothesis of the Demonstration throughout the extension period; that greater flexibility in service delivery and payment models promoting holistic population approaches to health will result in better outcomes, higher quality and increased access to services, while containing costs.

VIII. Financial Data

Note: Historical and projected caseload data subject to validation and revision prior to final submission to CMS.

The following tables present the historical spending by Demonstration year and population as measured against the budget neutrality ceilings.

Over the first eight years of the Global Commitment and Choices for Care Demonstrations (FFY 2006 through December 31, 2013), total spending absent the waivers for these populations was projected to reach nearly \$11.8 billion; actual spending is projected to be approximately 18.6% less, representing a savings of \$2.2 billion.

Budget Neutrality Status, Years 1 through 5

Tables 1 through 5 present the calculations underlying the waiver limits and actual program performance for the initial five-year period of the Global Commitment and Choices for Care Demonstrations, as follows:

Table 1: Projected Expenditures without Waiver, Years 1 – 5 (State and Federal)

Global Commitment: This table presents the line item expenses used to establish the budget neutrality ceiling for the initial five-year period. The budget ceiling is based on the continuation of the Medicaid Eligibility Groups (MEGs) that were established for Vermont’s previous Section 1115 Demonstration, the Vermont Health Access Plan (VHAP). Because Global Commitment is more comprehensive than the previous Demonstration in terms of included populations and services, the limit includes costs for additional programs and populations. These “additional program expenses not included under VHAP” include populations not enrolled under VHAP (e.g., Dual eligibles) and additional program costs (e.g., program expenditures for individuals with developmental disabilities and the Vermont State Hospital Futures project).

Choices for Care: The table provides the projected expenditures without implementation of the waiver for eligibility groups by type of long-term care setting: nursing home, home and community-based services (HCBS), and enhanced residential care (ERC). Expenditures with and without adjustments made by the Medicare Modernization Act (MMA) also are included.

Table 2: Actual Caseloads with Waiver, Years 1 – 5 (State and Federal)

Global Commitment: Table 2 presents actual caseload, in accordance with the MEGs specified in the Demonstration’s Special Terms and Conditions. As indicated by the presented data, there was some fluctuation in reported member months, particularly during the early stages of the project. These fluctuations resulted from modifications to the methodology for tracking and reporting program participants. However, the fluctuations represent only a reporting issue and do not impact expenditures. The table presents the average annual growth in caseload, by MEG, for years 1 through 5 and years 3 through 5.

Choices for Care: The table presents the average annual growth in caseload for the waiver-participating eligibility groups: Highest Need, High Need, Moderate Need, PACE, and Community Rehabilitation and Treatment (CRT). There was some fluctuation in reported member months, particularly during the early stages of the project. After implementation of the Demonstration, the State reassessed participants for the Highest and High Need Group criteria. The State subsequently transitioned individuals from the Highest Need to High Need Group as appropriate. In order to provide a more representative depiction of PMPM expenditures, the presented data includes redistribution in year 1 of 10% of the Highest Needs to the High Need Group. However, these fluctuations represent only a reporting issue and do not impact expenditures in the aggregate. A uniform methodology was applied to calculate member months.

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

This table presents actual program expenditures per member per month (PMPM), by MEG (Global Commitment) and long-term care setting (Choices for Care) based on Tables 1 and 2.

Table 4: Actual Expenditures with Waiver, Years 1 – 5 (State and Federal)

This table presents total program expenditures, including Global Commitment capitation payments, member premium collections and administrative expenses that are outside of the capitation payments. Expenditures reported for Choices for Care include Quality Awards awarded in year 5 of the Demonstration, and do not include third party liability (TPL) or estate recovery, which are both reported separately from the Demonstration.

Table 5: Summary of Program Expenditures with and without Waiver, Years 1 – 5 (State and Federal)

Table 5 provides a summary of Demonstration spending relative to the aggregate waiver ceilings. In summary, total program spending fell below the ceiling for both programs, and combined aggregate waiver savings for the initial five-year period for Global Commitment and Choices for Care was approximately \$489 million.

Budget Neutrality Status, Years 6 through 9 (ending 12/31/2013)

Tables 6 through 10 present the projected waiver ceiling and actual and estimated program expenditures for the first renewal period, with an ending date of December 31, 2013, as follows:

Table 6: Projected Expenditures without Waiver, Years 6 – 9 (State and Federal)

Global Commitment: Table 6 provides the projected budget neutrality ceiling for first renewal period. The projected expenditures without the waiver represent a continuation of baseline expenditures from the initial five-year period, using the same caseload and per capita trend rates that were applied to the initial five-year projection. The net impact of the individual trend rates is an aggregate annual growth rate that is around 7% for program caseload and costs combined.

As is the case with the ceiling for the initial five-year period, the limit is based only on costs for participants and services that are covered by Medicaid under traditional federal laws and regulations. The estimated budget neutrality limit for the first renewal period includes a carry-forward of waiver savings for the first five years of the Demonstration.

Choices for Care: The projected expenditures without the waiver represent a continuation of baseline expenditures, using the same caseload and cost per eligible trend rates that were applied to the initial five-year projection, which results in a net impact on total expenditures of 11%.

Table 7: Actual and Projected Caseloads with Waiver, Years 6 – 9 (State and Federal)

Table 7 presents the actual caseload through year 7 and estimated caseload for year 8 through December 31, 2013, by MEG (Global Commitment) and level of care (Choices for Care). The table presents average annual growth from year 6 through December 31, 2013.

Table 8: Actual and Projected Expenditures per Member per Month with Waiver, Years 6 – 9 (State and Federal)

Table 8 presents actual PMPM expenditures for years 6 and 7, and estimated PMPM expenditures for year 8 through December 31, 2013 based on PMPM trends established by DVHA for the period, presented by MEG (Global Commitment) and level of care (Choices for Care). The table presents average annual growth from year 6 through December 31, 2013.

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

Table 9 presents actual expenditures for years 6 and 7, and projected expenditures for year 8 through December 13, 2013 based on the caseload and per member per month expenditure data presented in Tables 8 and 9.

Table 10: Summary of Program Expenditures with and without Waiver, Years 6 – 9 (State and Federal)

Table 10 provides a summary of Demonstration actual and projected spending relative to the aggregate waiver ceilings. Vermont estimates that spending will fall under the ceilings for both Global Commitment and Choices for Care Demonstrations, with combined aggregate savings through December 31, 2013 totaling \$1.7 billion.

Budget Neutrality Status, Years 9 through 13 (01/01/2014 through 12/31/2018)

Tables 11 through 13 present the projected waiver ceilings and projected program expenditures for the extension period, as follows:

Table 11: Projected Expenditures without Waiver, Years 9 – 13 (State and Federal)

Table 11 provides the projected budget neutrality ceiling for the extension period. The projected expenditures without the waiver represent a continuation of the current baseline expenditures, using the same caseload and per capita trend rates that were applied to previous without waiver projections. The net impact of the individual trend rates is an aggregate annual growth rate, for program caseload and costs combined, that is equal to about 9 percent.

As is the case with the current ceiling, the limit is based only on costs for participants and services that are covered by Medicaid under traditional federal laws and regulations. The estimated budget neutrality limit for the extension period includes a carry-forward of estimated waiver savings for the 9 years (through December 31, 2013) of the Demonstration.

Note: Expenditures for the Children's Health Insurance Program (CHIP) are not categorized under either of the current Demonstrations but are included in the table, as these members will be included under the proposed Demonstration. Although Vermont proposes to include CHIP under the Demonstration for programmatic purposes, Vermont proposes to exclude CHIP funding from the budget neutrality ceiling and calculation as CHIP allotments are established by federal law. In the event that Title XXI funding is exhausted or unavailable, Vermont seeks authority to access funding available under the Demonstration for individuals eligible under the current CHIP program.

**Table 12: Projected Expenditures with Waiver, Years 9 – 13 (State and Federal)
(12a) Without and (12b) With Reform**

Tables 12a and 12b present Vermont's estimate of projected program expenditures for the renewal period with and without the 2017 implementation of the State's single payer reform called for in Vermont's Act 48 of the 2011 legislative session.

Table 12a presents Vermont's estimate of projected program expenditures for all Demonstration-eligible populations without the single payer reform. The table includes the caseload and per capita trends that were applied to each MEG and line item.

Notes:

- *ACA Caseload Impact:* The table reflects the elimination of VHAP, Catamount Health and ESI Expansion populations. Also, existing PACE caseload was redistributed equally in CY 2014 to the Choices for Care Highest Needs and High Needs groups to account for the elimination of the program. The table also reflects the addition of a "New Adult" population as defined in the ACA. The caseload and PMPM growth rates for the "New Adult" population were assumed similar to the eliminated VHAP population.
- *Enhanced Hospice Benefits:* The table does not reflect the fiscal impact of the proposed Enhanced Hospice Benefits for persons within 12 months of end of life and delivery of both palliative and curative care. Further analysis will be completed once eligibility parameters are established by the Department of Disabilities, Aging and Independent Living (DAIL).
- *Choices for Care PMPM and Caseload Growth:* The caseload and PMPM growth rates for each population were based on the historical growth rates observed during the previous renewal period. However, Vermont assumed an additional 4% caseload growth and an overall 3% PMPM growth for the Choices for Care populations, because:
 - (a) The State of Vermont expects an additional 3.50% annual growth in caseload for the Medicare-eligible population due to the increased aging of Vermont's over 65 population.
 - (b) The State of Vermont is experiencing an increased need to serve individuals with cognitive impairments (e.g., dementia). The State will be continuing to build additional capacity to meet these needs, and therefore is projecting a modest 0.5% annual growth in caseload for the Choices for Care population.

- (c) Although historical trends exhibit a decrease in PMPM expenditures, Vermont expects to see modest growth during the renewal period due to increasing complexity of needs of those enrolled, as well as provider rate increases.

Table 12b represents Vermont's estimates of projected program expenditures with single payer reform and uses the methodology created in the State of Vermont Health Care Financing Plan Beginning Calendar Year 2017 prepared by University of Massachusetts Medical School, Center for Law and Economics. Medicaid assumptions used in that plan include but are not limited to: approximately 3% of large group members in 2017 being eligible for Medicaid; a slight caseload increase for those persons who remain uninsured prior to 2017; an increase in Medicaid rates to 105% of Medicare (to eliminate historical cost shifting); and a decrease in Medicaid administrative costs under single payer reform.

Notes:

- Medicaid rate changes were assumed to only apply to the medical component of the costs, thus current 2017 reform models do not include rate changes for long term care services and support, prescription drug, dental or vision services.

Table 13: Summary of Program Expenditures with and without Waiver, Years 9 – 13 (State and Federal)

Table 13 provides a summary of Demonstration actual and projected spending relative to the aggregate waiver ceilings. Vermont estimates that spending will fall under the ceilings for both Global Commitment and Choices for Care Demonstrations, with combined aggregate savings through December 31, 2013 totaling \$5.4 billion without reform, and \$4.8 billion with reform.

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

	Waiver Year					Five-Year Total
	1 (Oct '05-Sept '06)	2 (Oct '06-Sept '07)	3 (Oct '07-Sept '08)	4 (Oct '08-Sept '09)	5 (Oct '09-Sept '10)	
Global Commitment						
Continuation of VHAP MEGs						
ANFC	\$ 162,865,374	\$ 180,391,545	\$ 199,803,732	\$ 221,304,891	\$ 245,119,820	\$ 1,009,485,362
ABD	\$ 92,181,185	\$ 98,000,805	\$ 104,187,831	\$ 110,765,458	\$ 117,758,348	\$ 522,893,626
Spend Down	\$ 1,832,177	\$ 1,947,847	\$ 2,070,819	\$ 2,201,555	\$ 2,340,544	\$ 10,392,943
Optional Expansion: Parent/Caretakers [1931(b) < 150% of FPL]	\$ 32,343,864	\$ 37,315,155	\$ 43,050,539	\$ 49,667,459	\$ 57,301,407	\$ 219,678,423
Optional Expansion: Parent/Caretakers [1931(b) 150 - 185% of FPL]	\$ 7,779,307	\$ 8,974,996	\$ 10,354,463	\$ 11,945,957	\$ 13,782,065	\$ 52,836,787
Optional Expansion: Children [1902(r)(2)]	\$ 1,747,191	\$ 1,938,773	\$ 2,151,361	\$ 2,387,261	\$ 2,649,027	\$ 10,873,612
Community Rehabilitation and Treatment (CRT)	\$ 29,345,283	\$ 31,197,922	\$ 33,167,521	\$ 35,261,467	\$ 37,487,608	\$ 166,459,800
Community Rehabilitation and Treatment (CRT) Duals	\$ 138,411	\$ 147,150	\$ 156,440	\$ 166,316	\$ 176,816	\$ 785,132
VHAP Surplus Carry-Forward	\$ 66,605,297	\$ -	\$ -	\$ -	\$ -	\$ 66,605,297
<i>Subtotal</i>	\$ 394,838,090	\$ 359,914,191	\$ 394,942,706	\$ 433,700,363	\$ 476,615,633	\$ 2,060,010,982
Additional Program Expenses Not Included Under VHAP	\$ 372,800,747	\$ 406,518,502	\$ 443,439,549	\$ 483,873,610	\$ 528,160,809	\$ 2,234,793,218
Program Administration	\$ 73,627,826	\$ 77,161,961	\$ 80,865,735	\$ 84,747,291	\$ 88,815,161	\$ 405,217,974
Total Global Commitment	\$ 841,266,663	\$ 843,594,654	\$ 919,247,991	\$ 1,002,321,263	\$ 1,093,591,603	\$ 4,700,022,174
Choices for Care						
Nursing Facility	\$ 138,958,676	\$ 154,262,673	\$ 171,252,152	\$ 190,112,741	\$ 211,050,511	\$ 865,636,753
Home and Community-Based Services	\$ 43,260,502	\$ 48,024,929	\$ 53,314,080	\$ 59,185,743	\$ 65,704,073	\$ 269,489,327
Enhanced Residential Care	\$ 4,599,244	\$ 5,105,774	\$ 5,668,091	\$ 6,292,337	\$ 6,985,334	\$ 28,650,781
<i>Subtotal</i>	\$ 186,818,422	\$ 207,393,377	\$ 230,234,323	\$ 255,590,821	\$ 283,739,918	\$ 1,163,776,861
MMA Adjustment	\$ 2,897,635					\$ 2,897,635
Total Choices for Care	\$ 189,716,057	\$ 207,393,377	\$ 230,234,323	\$ 255,590,821	\$ 283,739,918	\$ 1,166,674,496
Combined Total: Global Commitment & Choices for Care	\$ 1,030,982,720	\$ 1,050,988,031	\$ 1,149,482,314	\$ 1,257,912,084	\$ 1,377,331,521	\$ 5,866,696,670

Table 2: Actual Caseloads with Waiver, Years 1 – 5 (State and Federal)

	Waiver Year				
	1 (Oct '05-Sept '06)	2 (Oct '06-Sept '07)	3 (Oct '07-Sept '08)	4 (Oct '08-Sept '09)	5 (Oct '09-Sept '10)
Global Commitment					
ABD - Non-Medicare - Adult	180,954	182,711	143,469	153,096	161,974
ABD - Non-Medicare - Child	34,211	41,425	42,058	43,588	44,059
ABD - Dual	167,349	159,373	171,634	178,974	185,693
ANFC - Non-Medicare - Adult	125,441	111,976	112,489	120,450	126,544
ANFC - Non-Medicare - Child	612,860	609,295	611,127	634,843	655,412
Global Expansion (VHAP)	266,886	271,659	307,567	353,286	411,864
Global Rx	145,269	137,079	120,823	119,626	143,768
Optional Expansion (Underinsured)	14,875	13,886	14,005	14,253	14,348
VHAP ESI	-	-	5,365	10,659	11,270
ESIA	-	-	1,476	4,406	5,571
CHAP	-	-	21,278	62,457	82,765
ESIA Expansion - 200-300% of FPL	-	-	-	-	2,172
CHAP Expansion - 200-300% of FPL	-	-	-	-	23,541
Total Global Commitment	1,547,845	1,527,404	1,551,291	1,695,638	1,868,981
Choices for Care					
Highest Level of Care	39,970	43,156	41,348	39,932	39,489
High Level of Care	4,716	2,198	6,022	5,575	4,939
Moderate Level of Care	4,782	6,870	11,910	13,724	12,777
Program of All-Inclusive Care for the Elderly (PACE)	-	45	356	575	885
Community Rehabilitation and Treatment (CRT)	1,198	1,387	1,776	1,764	1,744
Total Choices for Care	50,666	53,656	61,412	61,570	59,834
Combined Total: Global Commitment & Choices for Care	1,598,511	1,581,060	1,612,703	1,757,208	1,928,815

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

	Waiver Year				
	1 (Oct '05-Sept '06)	2 (Oct '06-Sept '07)	3 (Oct '07-Sept '08)	4 (Oct '08-Sept '09)	5 (Oct '09-Sept '10)
Global Commitment					
ABD - Non-Medicare - Adult	\$ 1,125.37	\$ 1,187.30	\$ 1,324.11	\$ 1,099.65	\$ 1,106.66
ABD - Non-Medicare - Child	\$ 1,780.10	\$ 2,095.44	\$ 2,343.40	\$ 2,155.76	\$ 2,152.63
ABD - Dual	\$ 1,056.96	\$ 851.74	\$ 908.38	\$ 1,270.88	\$ 1,180.64
ANFC - Non-Medicare - Adult	\$ 494.60	\$ 501.49	\$ 566.02	\$ 502.58	\$ 573.63
ANFC - Non-Medicare - Child	\$ 301.09	\$ 319.18	\$ 354.39	\$ 349.31	\$ 364.72
Global Expansion (VHAP)	\$ 343.40	\$ 431.59	\$ 488.96	\$ 405.25	\$ 413.76
Global Rx	\$ 63.15	\$ 3.74	\$ 3.94	\$ 15.97	\$ 9.97
Optional Expansion (Underinsured)	\$ 151.69	\$ 190.84	\$ 211.38	\$ 177.70	\$ 173.46
VHAP ESI	\$ -	\$ -	\$ 234.15	\$ 192.90	\$ 224.80
ESIA	\$ -	\$ -	\$ 178.38	\$ 141.86	\$ 177.43
CHAP	\$ -	\$ -	\$ 407.94	\$ 373.99	\$ 427.96
ESIA Expansion - 200-300% of FPL	\$ -	\$ -	\$ -	\$ -	\$ 176.87
CHAP Expansion - 200-300% of FPL	\$ -	\$ -	\$ -	\$ -	\$ 432.52
Total Global Commitment	\$ 511.08	\$ 530.65	\$ 572.88	\$ 557.74	\$ 550.46
Choices for Care					
Highest Level of Care	\$ 3,776.18	\$ 3,835.56	\$ 4,037.35	\$ 4,169.69	\$ 4,217.90
High Level of Care	\$ 2,878.02	\$ 2,761.04	\$ 2,945.11	\$ 3,154.04	\$ 3,286.57
Moderate Level of Care	\$ 258.08	\$ 232.07	\$ 255.15	\$ 294.11	\$ 290.29
Program of All-Inclusive Care for the Elderly (PACE)	\$ -	\$ 3,729.42	\$ 3,818.94	\$ 5,183.39	\$ 4,140.11
Community Rehabilitation and Treatment (CRT)	\$ 3,531.46	\$ 3,802.08	\$ 3,016.22	\$ 2,537.61	\$ 2,811.24
Total Choices for Care	\$ 3,354.74	\$ 3,329.21	\$ 3,165.95	\$ 3,176.56	\$ 3,262.26
Combined Total: Global Commitment & Choices for Care	\$ 598.53	\$ 624.88	\$ 671.16	\$ 646.59	\$ 629.47

Table 4: Actual Expenditures with Waiver, Years 1 – 5 (State and Federal)

	Waiver Year					Five-Year Total
	1 (Oct '05-Sept '06)	2 (Oct '06-Sept'07)	3 (Oct '07-Sept '08)	4 (Oct '08-Sept '09)	5 (Oct '09-Sept '10)	
Global Commitment						
Capitation Payments						
ABD - Non-Medicare - Adult	\$ 203,640,203	\$ 216,932,770	\$ 189,968,738	\$ 168,352,016	\$ 179,249,891	\$ 958,143,618
ABD - Non-Medicare - Child	\$ 60,899,001	\$ 86,803,602	\$ 98,558,717	\$ 93,965,267	\$ 94,842,614	\$ 435,069,201
ABD - Dual	\$ 176,881,327	\$ 135,744,359	\$ 155,908,893	\$ 227,454,477	\$ 219,236,518	\$ 915,225,575
ANFC - Non-Medicare - Adult	\$ 62,043,119	\$ 56,154,844	\$ 63,671,024	\$ 60,535,761	\$ 72,589,220	\$ 314,993,967
ANFC - Non-Medicare - Child	\$ 184,526,017	\$ 194,474,778	\$ 216,577,298	\$ 221,757,008	\$ 239,043,470	\$ 1,056,378,571
Global Expansion (VHAP)	\$ 91,648,652	\$ 117,245,308	\$ 150,387,960	\$ 143,169,152	\$ 170,413,126	\$ 672,864,198
Global Rx	\$ 9,173,970	\$ 512,594	\$ 475,763	\$ 1,911,020	\$ 1,433,935	\$ 13,507,282
Optional Expansion (Underinsured)	\$ 2,256,389	\$ 2,650,004	\$ 2,960,377	\$ 2,532,758	\$ 2,488,843	\$ 12,888,371
VHAP ESI	\$ -	\$ -	\$ 1,256,215	\$ 2,056,121	\$ 2,533,498	\$ 5,845,833
ESIA	\$ -	\$ -	\$ 263,289	\$ 625,035	\$ 988,443	\$ 1,876,767
CHAP	\$ -	\$ -	\$ 8,680,147	\$ 23,358,293	\$ 35,420,469	\$ 67,458,909
ESIA Expansion - 200-300% of FPL	\$ -	\$ -	\$ -	\$ -	\$ 384,158	\$ 384,158
CHAP Expansion - 200-300% of FPL	\$ -	\$ -	\$ -	\$ -	\$ 10,181,948	\$ 10,181,948
<i>Subtotal Capitation Payments</i>	<i>\$ 791,068,678</i>	<i>\$ 810,518,260</i>	<i>\$ 888,708,420</i>	<i>\$ 945,716,909</i>	<i>\$ 1,028,806,133</i>	<i>\$ 4,464,818,400</i>
Premium Offsets	\$ (8,908,833)	\$ (7,633,900)	\$ (7,210,870)	\$ (10,603,732)	\$ (15,815,296)	\$ (50,172,631)
Administrative Expenses Outside of Managed Care Model	\$ 4,620,302	\$ 6,464,439	\$ 6,457,896	\$ 5,495,618	\$ 5,949,605	\$ 28,987,860
Total Global Commitment	\$ 786,780,147	\$ 809,348,799	\$ 887,955,446	\$ 940,608,795	\$ 1,018,940,442	\$ 4,443,633,629
Choices for Care						
Highest Level of Care	\$ 150,933,576	\$ 165,527,483	\$ 166,936,530	\$ 166,504,079	\$ 166,560,641	\$ 816,462,309
High Level of Care	\$ 13,573,034	\$ 6,068,773	\$ 17,735,428	\$ 17,583,792	\$ 16,232,367	\$ 71,193,394
Moderate Level of Care	\$ 1,234,143	\$ 1,594,289	\$ 3,038,873	\$ 4,036,304	\$ 3,709,079	\$ 13,612,688
Program of All-Inclusive Care for the Elderly (PACE)	\$ -	\$ 167,824	\$ 1,359,544	\$ 2,980,450	\$ 3,663,997	\$ 8,171,815
Community Rehabilitation and Treatment (CRT)	\$ 4,230,692	\$ 5,273,482	\$ 5,356,808	\$ 4,476,350	\$ 4,902,804	\$ 24,240,136
Quality Awards					\$ 125,000	\$ 125,000
Total Choices for Care	\$ 169,971,445	\$ 178,631,852	\$ 194,427,182	\$ 195,580,976	\$ 195,193,889	\$ 933,805,343
Combined Total: Global Commitment & Choices for Care	\$ 956,751,592	\$ 987,980,650	\$ 1,082,382,629	\$ 1,136,189,770	\$ 1,214,134,331	\$ 5,377,438,972

Table 5: Summary of Program Expenditures with and without Waiver, Years 1 – 5 (State and Federal)

	Waiver Year					Five-Year Total
	1 (Oct '05-Sept '06)	2 (Oct '06-Sept '07)	3 (Oct '07-Sept '08)	4 (Oct '08-Sept '09)	5 (Oct '09-Sept '10)	
Expenditures without Waiver (Aggregate Budget Neutrality Limit)						
Global Commitment	\$ 841,266,663	\$ 843,594,654	\$ 919,247,991	\$ 1,002,321,263	\$ 1,093,591,603	\$ 4,700,022,174
Choices for Care	\$ 189,716,057	\$ 207,393,377	\$ 230,234,323	\$ 255,590,821	\$ 283,739,918	\$ 1,166,674,496
Total	\$ 1,030,982,720	\$ 1,050,988,031	\$ 1,149,482,314	\$ 1,257,912,084	\$ 1,377,331,521	\$ 5,866,696,670
Expenditures with Waiver						
Global Commitment						
<i>Capitation Payments</i>	\$ 791,068,678	\$ 810,518,260	\$ 888,708,420	\$ 945,716,909	\$ 1,028,806,133	\$ 4,464,818,400
<i>Premium Offsets</i>	\$ (8,908,833)	\$ (7,633,900)	\$ (7,210,870)	\$ (10,603,732)	\$ (15,815,296)	\$ (50,172,631)
<i>Admin. Expenses Outside Managed Care Model</i>	\$ 4,620,302	\$ 6,464,439	\$ 6,457,896	\$ 5,495,618	\$ 5,949,605	\$ 28,987,860
Subtotal Global Commitment	\$ 786,780,147	\$ 809,348,799	\$ 887,955,446	\$ 940,608,795	\$ 1,018,940,442	\$ 4,443,633,629
Choices for Care	\$ 169,971,445	\$ 178,631,852	\$ 194,427,182	\$ 195,580,976	\$ 195,193,889	\$ 933,805,343
Total	\$ 956,751,592	\$ 987,980,650	\$ 1,082,382,629	\$ 1,136,189,770	\$ 1,214,134,331	\$ 5,377,438,972
Annual Surplus (Deficit)						
Global Commitment	\$ 54,486,516	\$ 34,245,856	\$ 31,292,544	\$ 61,712,468	\$ 74,651,161	\$ 256,388,545
Choices for Care	\$ 19,744,612	\$ 28,761,526	\$ 35,807,141	\$ 60,009,846	\$ 88,546,029	\$ 232,869,153
Total	\$ 74,231,128	\$ 63,007,381	\$ 67,099,685	\$ 121,722,314	\$ 163,197,190	\$ 489,257,698
Cumulative Surplus (Deficit)						
Global Commitment	\$ 54,486,516	\$ 88,732,372	\$ 120,024,916	\$ 181,737,384	\$ 256,388,545	\$ 256,388,545
Choices for Care	\$ 19,744,612	\$ 48,506,138	\$ 84,313,279	\$ 144,323,124	\$ 232,869,153	\$ 232,869,153
Total	\$ 74,231,128	\$ 137,238,510	\$ 204,338,195	\$ 326,060,508	\$ 489,257,698	\$ 489,257,698

Table 6: Projected Expenditures without Waiver, Years 6 – 9 (State and Federal)

	Waiver Year				Total Oct '10 - Dec '13
	6 (Oct '10-Sept '11)	7 (Oct '11-Sept '12)	8 (Oct '12-Sept '13)	9 (Oct '13-Dec '13)	
Global Commitment					
Continuation of VHAP MEGs					
ANFC	\$ 263,358,696	\$ 286,864,302	\$ 312,467,859	\$ 119,576,169	\$ 982,267,026
ABD	\$ 126,696,206	\$ 134,694,842	\$ 143,198,450	\$ 53,760,496	\$ 458,349,995
Spend Down	\$ 2,534,821	\$ 2,694,851	\$ 2,864,983	\$ 1,075,591	\$ 9,170,246
Optional Expansion: Parent/Caretakers [1931(b) < 150% of FPL]	\$ 61,507,444	\$ 69,848,352	\$ 79,320,354	\$ 31,268,586	\$ 241,944,737
Optional Expansion: Parent/Caretakers [1931(b) 150 - 185% of FPL]	\$ 14,793,696	\$ 16,799,841	\$ 19,078,035	\$ 7,520,682	\$ 58,192,253
Optional Expansion: Children [1902(r)(2)]	\$ 2,848,800	\$ 3,105,970	\$ 3,386,356	\$ 1,296,821	\$ 10,637,947
Community Rehabilitation and Treatment (CRT)	\$ 40,332,917	\$ 42,879,231	\$ 45,586,300	\$ 17,114,306	\$ 145,912,753
Community Rehabilitation and Treatment (CRT) Duals	\$ 190,236	\$ 202,246	\$ 215,015	\$ 80,722	\$ 688,219
<i>Subtotal</i>	<i>\$ 512,262,817</i>	<i>\$ 557,089,634</i>	<i>\$ 606,117,352</i>	<i>\$ 231,693,373</i>	<i>\$ 1,907,163,176</i>
Additional Program Expenses Not Included Under VHAP	\$ 559,850,458	\$ 593,441,485	\$ 629,047,974	\$ 235,588,296	\$ 2,017,928,213
Program Administration	\$ 93,078,288	\$ 97,546,046	\$ 102,228,256	\$ 37,920,643	\$ 330,773,234
Waiver Surplus (Deficit) Carry-Forward	\$ 256,388,545				\$ 256,388,545
Total Global Commitment	\$ 1,421,580,108	\$ 1,248,077,166	\$ 1,337,393,583	\$ 505,202,312	\$ 4,512,253,169
Choices for Care					
Nursing Facility	\$ 234,294,230	\$ 260,097,859	\$ 288,743,331	\$ 80,135,907	\$ 863,271,327
Home and Community-Based Services	\$ 72,940,288	\$ 80,973,453	\$ 89,891,338	\$ 24,947,845	\$ 268,752,925
Enhanced Residential Care	\$ 7,754,653	\$ 8,608,700	\$ 9,556,805	\$ 2,652,332	\$ 28,572,490
<i>Subtotal</i>	<i>\$ 314,989,171</i>	<i>\$ 349,680,012</i>	<i>\$ 388,191,474</i>	<i>\$ 107,736,084</i>	<i>\$ 1,160,596,741</i>
Waiver Surplus (Deficit) Carry-Forward	\$ 232,869,153				\$ 232,869,153
Total Choices for Care	\$ 547,858,324	\$ 349,680,012	\$ 388,191,474	\$ 107,736,084	\$ 1,393,465,894
Combined Total: Global Commitment & Choices for Care	\$ 1,969,438,432	\$ 1,597,757,178	\$ 1,725,585,057	\$ 612,938,396	\$ 5,905,719,063

Table 7: Actual and Projected Caseloads with Waiver, Years 6 – 9 (State and Federal)

	Waiver Year				Annual Growth Oct '10 - Dec '13
	6 (Oct '10-Sept '11)	7 (Oct '11-Sept'12)	8 - <i>est'd</i> (Oct '12-Sept '13)	9 - <i>est'd</i> (Oct '13-Dec '13)	
Global Commitment					
ABD - Non-Medicare - Adult	166,049	168,369	170,700	43,013	1.59%
ABD - Non-Medicare - Child	44,349	44,615	44,742	11,215	0.51%
ABD - Dual	193,983	201,872	208,337	53,181	4.18%
ANFC - Non-Medicare - Adult	131,746	136,059	140,534	35,837	3.82%
ANFC - Non-Medicare - Child	661,211	664,307	666,982	167,197	0.51%
Global Expansion (VHAP)	444,056	444,653	449,336	112,882	0.74%
Global Rx	151,971	151,266	151,209	37,715	-0.33%
Optional Expansion (Underinsured)	13,360	12,604	12,301	2,995	-4.73%
VHAP ESI	10,554	9,877	9,604	2,361	-4.81%
ESIA	5,952	5,606	6,011	1,512	0.71%
CHAP	86,965	92,730	98,904	25,590	7.51%
ESIA Expansion - 200-300% of FPL	3,171	2,899	3,393	855	3.42%
CHAP Expansion - 200-300% of FPL	34,078	38,474	42,847	11,325	13.48%
Total Global Commitment	1,947,445	1,973,331	2,004,899	505,678	1.70%
Choices for Care					
Highest Level of Care	38,276	36,395	35,619	8,833	-3.50%
High Level of Care	5,362	6,681	6,047	1,519	5.70%
Moderate Level of Care	10,494	11,806	11,111	2,756	2.22%
Program of All-Inclusive Care for the Elderly (PACE)	1,164	1,373	1,658	431	19.05%
Community Rehabilitation and Treatment (CRT)	1,552	1,637	1,548	384	-0.48%
Total Choices for Care	56,848	57,892	55,983	13,922	-0.91%
Combined Total: Global Commitment & Choices for Care	2,004,293	2,031,223	2,060,882	519,600	1.63%

Table 8: Actual and Projected Expenditures per Member per Month with Waiver, Years 6 – 9 (State and Federal)

	Waiver Year				Annual Growth Oct '10 - Dec '13
	6 (Oct '10-Sept '11)	7 (Oct '11-Sept'12)	8 - est'd (Oct '12-Sept '13)	9 - est'd (Oct '13-Dec '13)	
Global Commitment					
ABD - Non-Medicare - Adult	\$ 1,063.14	\$ 1,128.89	\$ 1,165.39	\$ 1,174.81	4.54%
ABD - Non-Medicare - Child	\$ 2,218.64	\$ 2,273.13	\$ 2,288.02	\$ 2,291.76	1.45%
ABD - Dual	\$ 1,151.67	\$ 1,127.52	\$ 1,160.78	\$ 1,169.34	0.68%
ANFC - Non-Medicare - Adult	\$ 580.55	\$ 615.66	\$ 636.72	\$ 642.16	4.58%
ANFC - Non-Medicare - Child	\$ 357.34	\$ 381.72	\$ 389.73	\$ 391.78	4.17%
Global Expansion (VHAP)	\$ 406.08	\$ 425.64	\$ 441.13	\$ 445.14	4.17%
Global Rx	\$ 51.33	\$ 62.46	\$ 64.25	\$ 64.71	10.84%
Optional Expansion (Underinsured)	\$ 176.14	\$ 196.15	\$ 196.04	\$ 196.01	4.87%
VHAP ESI	\$ 181.73	\$ 162.66	\$ 164.73	\$ 165.26	-4.14%
ESIA	\$ 144.81	\$ 144.17	\$ 144.50	\$ 144.58	-0.07%
CHAP	\$ 462.38	\$ 425.92	\$ 441.73	\$ 445.83	-1.61%
ESIA Expansion - 200-300% of FPL	\$ 94.27	\$ 77.92	\$ 77.96	\$ 77.97	-8.09%
CHAP Expansion - 200-300% of FPL	\$ 536.32	\$ 508.93	\$ 508.88	\$ 508.87	-2.31%
Total Global Commitment	\$ 545.91	\$ 568.43	\$ 584.12	\$ 589.43	3.47%
Choices for Care					
Highest Level of Care	\$ 4,302.65	\$ 4,065.21	\$ 4,030.96	\$ 3,997.01	-3.22%
High Level of Care	\$ 3,287.50	\$ 3,074.37	\$ 3,048.26	\$ 3,022.37	-3.67%
Moderate Level of Care	\$ 302.84	\$ 291.90	\$ 291.17	\$ 290.44	-1.84%
Program of All-Inclusive Care for the Elderly (PACE)	\$ 3,998.67	\$ 4,169.58	\$ 3,877.80	\$ 3,606.44	-4.48%
Community Rehabilitation and Treatment (CRT)	\$ 2,941.38	\$ 2,623.62	\$ 2,652.93	\$ 2,682.57	-4.01%
Total Choices for Care	\$ 3,427.35	\$ 3,143.08	\$ 3,139.95	\$ 3,108.56	-4.25%
Combined Total: Global Commitment & Choices for Care	\$ 621.79	\$ 635.79	\$ 647.64	\$ 651.08	2.07%

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

	Waiver Year				Total Oct '10 - Dec '13
	6 (Oct '10-Sept '11)	7 (Oct '11-Sept'12)	8 - est'd (Oct '12-Sept '13)	9 - est'd (Oct '13-Dec '13)	
Global Commitment					
Capitation Payments					
ABD - Non-Medicare - Adult	\$ 176,533,399	\$ 190,519,365	\$ 198,932,837	\$ 50,532,576	\$ 616,518,178
ABD - Non-Medicare - Child	\$ 98,394,413	\$ 101,488,090	\$ 102,370,372	\$ 25,701,760	\$ 327,954,634
ABD - Dual	\$ 223,405,119	\$ 227,781,883	\$ 241,833,573	\$ 62,186,840	\$ 755,207,415
ANFC - Non-Medicare - Adult	\$ 76,485,557	\$ 83,964,229	\$ 89,480,354	\$ 23,013,400	\$ 272,943,540
ANFC - Non-Medicare - Child	\$ 236,275,561	\$ 254,203,807	\$ 259,943,958	\$ 65,503,705	\$ 815,927,031
Global Expansion (VHAP)	\$ 180,323,161	\$ 189,841,022	\$ 198,215,113	\$ 50,248,461	\$ 618,627,756
Global Rx	\$ 7,800,694	\$ 9,482,604	\$ 9,714,687	\$ 2,440,456	\$ 29,438,441
Optional Expansion (Underinsured)	\$ 2,353,179	\$ 2,473,802	\$ 2,411,403	\$ 586,997	\$ 7,825,380
VHAP ESI	\$ 1,917,977	\$ 1,607,347	\$ 1,582,128	\$ 390,214	\$ 5,497,666
ESIA	\$ 861,905	\$ 817,498	\$ 868,591	\$ 218,606	\$ 2,766,600
CHAP	\$ 40,210,581	\$ 39,644,962	\$ 43,688,746	\$ 11,408,575	\$ 134,952,863
ESIA Expansion - 200-300% of FPL	\$ 298,915	\$ 227,184	\$ 264,521	\$ 66,665	\$ 857,285
CHAP Expansion - 200-300% of FPL	\$ 18,276,728	\$ 19,640,320	\$ 21,804,072	\$ 5,762,807	\$ 65,483,927
<i>Subtotal Capitation Payments</i>	<i>\$ 1,063,137,188</i>	<i>\$ 1,121,692,114</i>	<i>\$ 1,171,110,351</i>	<i>\$ 298,061,063</i>	<i>\$ 3,654,000,716</i>
Premium Offsets	\$ (17,794,216)	\$ (17,971,216)	\$ (18,149,977)	\$ (4,582,629)	\$ (58,498,037)
Administrative Expenses Outside of Managed Care Model	\$ 6,071,553	\$ 5,751,066	\$ 5,964,783	\$ 1,546,611	\$ 19,334,013
Total Global Commitment	\$ 1,051,414,525	\$ 1,109,471,964	\$ 1,158,925,158	\$ 295,025,045	\$ 3,614,836,691
Choices for Care					
Highest Level of Care	\$ 164,688,089	\$ 147,953,219	\$ 143,580,541	\$ 35,303,944	\$ 491,525,794
High Level of Care	\$ 17,627,596	\$ 20,539,841	\$ 18,433,724	\$ 4,590,167	\$ 61,191,328
Moderate Level of Care	\$ 3,178,030	\$ 3,446,205	\$ 3,235,158	\$ 800,524	\$ 10,659,917
Program of All-Inclusive Care for the Elderly (PACE)	\$ 4,654,451	\$ 5,724,838	\$ 6,427,456	\$ 1,553,541	\$ 18,360,286
Community Rehabilitation and Treatment (CRT)	\$ 4,565,023	\$ 4,294,866	\$ 4,105,677	\$ 1,029,671	\$ 13,995,237
Quality Awards	\$ 125,000				\$ 125,000
Total Choices for Care	\$ 194,838,188	\$ 181,958,969	\$ 175,782,557	\$ 43,277,848	\$ 595,857,561
Combined Total: Global Commitment & Choices for Care	\$ 1,246,252,713	\$ 1,291,430,933	\$ 1,334,707,715	\$ 338,302,892	\$ 4,210,694,253

Table 10: Summary of Program Expenditures with and without Waiver, Years 6 – 9 (State and Federal)

	Waiver Year				Total Oct '10 - Dec '13
	6 (Oct '10-Sept '11)	7 (Oct '11-Sept '12)	8 - est'd (Oct '12-Sept '13)	9 - est'd (Oct '13-Dec '13)	
Expenditures without Waiver (Aggregate Budget Neutrality Limit)					
Global Commitment	\$ 1,421,580,108	\$ 1,248,077,166	\$ 1,337,393,583	\$ 505,202,312	\$ 4,512,253,169
Choices for Care	\$ 547,858,324	\$ 349,680,012	\$ 388,191,474	\$ 107,736,084	\$ 1,393,465,894
Total	\$ 1,969,438,432	\$ 1,597,757,178	\$ 1,725,585,057	\$ 612,938,396	\$ 5,905,719,063
Expenditures with Waiver					
Global Commitment					
<i>Capitation Payments</i>	\$ 1,063,137,188	\$ 1,121,692,114	\$ 1,171,110,351	\$ 298,061,063	\$ 3,654,000,716
<i>Premium Offsets</i>	\$ (17,794,216)	\$ (17,971,216)	\$ (18,149,977)	\$ (4,582,629)	\$ (58,498,037)
<i>Admin. Expenses Outside Managed Care Model</i>	\$ 6,071,553	\$ 5,751,066	\$ 5,964,783	\$ 1,546,611	\$ 19,334,013
Subtotal Global Commitment	\$ 1,051,414,525	\$ 1,109,471,964	\$ 1,158,925,158	\$ 295,025,045	\$ 3,614,836,691
Choices for Care	\$ 194,838,188	\$ 181,958,969	\$ 175,782,557	\$ 43,277,848	\$ 595,857,561
Total	\$ 1,246,252,713	\$ 1,291,430,933	\$ 1,334,707,715	\$ 338,302,892	\$ 4,210,694,253
Annual Surplus (Deficit)					
Global Commitment	\$ 370,165,583	\$ 138,605,202	\$ 178,468,425	\$ 210,177,267	\$ 897,416,477
Choices for Care	\$ 353,020,136	\$ 167,721,043	\$ 212,408,918	\$ 64,458,237	\$ 797,608,333
Total	\$ 723,185,719	\$ 306,326,245	\$ 390,877,342	\$ 274,635,504	\$ 1,695,024,810
Cumulative Surplus (Deficit)					
Global Commitment	\$ 370,165,583	\$ 508,770,785	\$ 687,239,210	\$ 897,416,477	\$ 897,416,477
Choices for Care	\$ 353,020,136	\$ 520,741,179	\$ 733,150,096	\$ 797,608,333	\$ 797,608,333
Total	\$ 723,185,719	\$ 1,029,511,964	\$ 1,420,389,306	\$ 1,695,024,810	\$ 1,695,024,810

Table 11: Projected Expenditures without Waiver, Years 9 – 13 (State and Federal)

	Waiver Year					Five-Year Total
	9 (Jan - Dec '14)	10 (Jan - Dec '15)	11 (Jan - Dec '16)	12 (Jan - Dec '17)	13 (Jan - Dec '18)	
Global Commitment						
Continuation of VHAP MEGs						
ANFC	\$ 351,024,060	\$ 385,267,268	\$ 422,850,979	\$ 464,101,067	\$ 509,375,197	\$ 2,132,618,571
ABD	\$ 154,916,731	\$ 164,978,112	\$ 175,692,949	\$ 187,103,683	\$ 199,255,511	\$ 881,946,985
Spend Down	\$ 3,103,077	\$ 3,307,721	\$ 3,525,862	\$ 3,758,388	\$ 4,006,250	\$ 17,701,298
Optional Expansion: Parent/Caretakers [1931(b) < 150% of FPL]	\$ 93,101,093	\$ 105,830,509	\$ 120,300,377	\$ 136,748,665	\$ 155,445,875	\$ 611,426,518
Optional Expansion: Parent/Caretakers [1931(b) 150 - 185% of FPL]	\$ 22,392,561	\$ 25,454,225	\$ 28,934,500	\$ 32,890,622	\$ 37,387,652	\$ 147,059,562
Optional Expansion: Children [1902(r)(2)]	\$ 3,811,120	\$ 4,188,984	\$ 4,604,312	\$ 5,060,818	\$ 5,562,586	\$ 23,227,820
Community Rehabilitation and Treatment (CRT)	\$ 49,316,738	\$ 52,519,714	\$ 55,930,713	\$ 59,563,246	\$ 63,431,702	\$ 280,762,113
Community Rehabilitation and Treatment (CRT) Duals	\$ 232,610	\$ 247,717	\$ 263,806	\$ 280,939	\$ 299,185	\$ 1,324,256
<i>Subtotal</i>	\$ 677,897,990	\$ 741,794,249	\$ 812,103,497	\$ 889,507,429	\$ 974,763,958	\$ 4,096,067,123
Additional Program Expenses Not Included Under VHAP	\$ 690,647,503	\$ 744,242,707	\$ 801,996,974	\$ 864,233,052	\$ 931,298,736	\$ 4,032,418,972
Program Administration	\$ 108,398,321	\$ 113,601,441	\$ 119,054,310	\$ 124,768,917	\$ 130,757,825	\$ 596,580,814
Waiver Surplus (Deficit) Carry-Forward	\$ 897,416,477					\$ 897,416,477
Total Global Commitment	\$ 2,374,360,292	\$ 1,599,638,397	\$ 1,733,154,781	\$ 1,878,509,399	\$ 2,036,820,519	\$ 9,622,483,387
Choices for Care						
Nursing Facility	\$ 329,369,271	\$ 365,643,841	\$ 405,913,455	\$ 450,618,101	\$ 500,246,222	\$ 2,051,790,890
Home and Community-Based Services	\$ 102,538,972	\$ 113,831,942	\$ 126,368,645	\$ 140,286,059	\$ 155,736,245	\$ 638,761,864
Enhanced Residential Care	\$ 10,901,439	\$ 12,102,053	\$ 13,434,893	\$ 14,914,524	\$ 16,557,112	\$ 67,910,022
<i>Subtotal</i>	\$ 442,809,682	\$ 491,577,836	\$ 545,716,994	\$ 605,818,684	\$ 672,539,580	\$ 2,758,462,776
Waiver Surplus (Deficit) Carry-Forward	\$ 797,608,333					\$ 797,608,333
Total Choices for Care	\$ 1,240,418,015	\$ 491,577,836	\$ 545,716,994	\$ 605,818,684	\$ 672,539,580	\$ 3,556,071,109
Combined Total: Global Commitment & Choices for Care	\$ 3,614,778,307	\$ 2,091,216,233	\$ 2,278,871,775	\$ 2,484,328,082	\$ 2,709,360,099	\$ 13,178,554,496
Children's Health Insurance Program	\$ 10,362,010	\$ 11,160,921	\$ 12,021,428	\$ 12,948,280	\$ 13,946,593	\$ 60,439,232

*Projected expenditures for CFC already
 approved through Sept '15*

Table 12a: Projected Expenditures with Waiver, Years 9 – 13 (State and Federal) Without Reform

	Waiver Year					Five-Year Total
	9 (Jan - Dec '14)	10 (Jan - Dec '15)	11 (Jan - Dec '16)	12 (Jan - Dec '17)	13 (Jan - Dec '18)	
Global Commitment						
Capitation Payments						
ABD - Non-Medicare - Adult	\$ 205,805,528	\$ 221,166,199	\$ 237,673,342	\$ 255,412,526	\$ 274,475,706	\$ 1,194,533,301
ABD - Non-Medicare - Child	\$ 103,459,113	\$ 106,107,996	\$ 108,824,699	\$ 111,610,959	\$ 114,468,555	\$ 544,471,322
ABD - Dual	\$ 252,386,215	\$ 267,312,165	\$ 283,120,825	\$ 299,864,399	\$ 317,598,176	\$ 1,420,281,780
ANFC - Non-Medicare - Adult	\$ 99,325,538	\$ 112,053,203	\$ 126,411,803	\$ 142,610,327	\$ 153,668,560	\$ 634,069,431
ANFC - Non-Medicare - Child	\$ 265,705,829	\$ 280,994,496	\$ 297,162,869	\$ 314,261,568	\$ 332,344,123	\$ 1,490,468,885
Global Expansion						
Global Rx	\$ 10,008,138	\$ 11,057,097	\$ 12,215,999	\$ 13,496,365	\$ 14,910,928	\$ 61,688,527
Optional Expansion (Underinsured)	\$ 2,349,260	\$ 2,352,293	\$ 2,355,331	\$ 2,358,372	\$ 2,361,416	\$ 11,776,672
VHAP ESI						
ESIA						
CHAP						
ESIA Expansion - 200-300% of FPL						
CHAP Expansion - 200-300% of FPL						
Premium Assistance Subsidies	\$ 9,616,669	\$ 10,247,721	\$ 11,105,152	\$ 12,034,324	\$ 13,041,240	\$ 56,045,105
New Adult	\$ 213,522,717	\$ 232,101,847	\$ 252,297,592	\$ 274,250,618	\$ 298,113,831	\$ 1,270,286,604
<i>Subtotal Capitation Payments</i>	<i>\$ 1,162,179,006</i>	<i>\$ 1,243,393,017</i>	<i>\$ 1,331,167,612</i>	<i>\$ 1,425,899,457</i>	<i>\$ 1,520,982,535</i>	<i>\$ 6,683,621,627</i>
Administrative Expenses Outside of Managed Care Model	\$ 6,243,917	\$ 6,475,950	\$ 6,716,605	\$ 6,966,203	\$ 7,225,077	\$ 33,627,751
Total Global Commitment	\$ 1,168,422,924	\$ 1,249,868,967	\$ 1,337,884,216	\$ 1,432,865,660	\$ 1,528,207,612	\$ 6,717,249,379
Choices for Care						
Highest Level of Care	\$ 146,227,956	\$ 152,672,874	\$ 159,401,848	\$ 166,427,398	\$ 173,762,596	\$ 798,492,672
High Level of Care	\$ 21,379,758	\$ 24,339,997	\$ 27,710,109	\$ 31,546,848	\$ 35,914,820	\$ 140,891,532
Moderate Level of Care	\$ 3,289,740	\$ 3,659,917	\$ 4,071,748	\$ 4,529,920	\$ 5,039,647	\$ 20,590,972
Program of All-Inclusive Care for the Elderly (PACE)						
Community Rehabilitation and Treatment (CRT)	\$ 4,148,454	\$ 4,267,764	\$ 4,390,506	\$ 4,516,778	\$ 4,646,682	\$ 21,970,185
Total Choices for Care	\$ 175,045,908	\$ 184,940,552	\$ 195,574,212	\$ 207,020,944	\$ 219,363,745	\$ 981,945,360
Combined Total: Global Commitment & Choices for Care	\$ 1,343,468,831	\$ 1,434,809,519	\$ 1,533,458,428	\$ 1,639,886,604	\$ 1,747,571,357	\$ 7,699,194,739
Children's Health Insurance Program	\$ 10,051,150	\$ 10,826,093	\$ 11,660,785	\$ 12,559,832	\$ 13,528,195	\$ 58,626,055

Table 12b: Projected Expenditures with Waiver, Years 9 – 13 (State and Federal) *With Reform*

	Waiver Year					Five-Year Total
	9 (Jan - Dec '14)	10 (Jan - Dec '15)	11 (Jan - Dec '16)	12 (Jan - Dec '17)	13 (Jan - Dec '18)	
Global Commitment						
Capitation Payments						
ABD - Non-Medicare - Adult	\$ 205,805,528	\$ 221,166,199	\$ 237,673,342	\$ 314,227,237	\$ 337,680,161	\$ 1,316,552,467
ABD - Non-Medicare - Child	\$ 103,459,113	\$ 106,107,996	\$ 108,824,699	\$ 120,044,430	\$ 123,117,951	\$ 561,554,190
ABD - Dual	\$ 252,386,215	\$ 267,312,165	\$ 283,120,825	\$ 315,975,233	\$ 334,661,794	\$ 1,453,456,232
ANFC - Non-Medicare - Adult	\$ 99,325,538	\$ 112,053,203	\$ 126,411,803	\$ 207,430,734	\$ 224,506,814	\$ 769,728,092
ANFC - Non-Medicare - Child	\$ 265,705,829	\$ 280,994,496	\$ 297,162,869	\$ 367,187,678	\$ 388,315,591	\$ 1,599,366,463
Global Expansion						
Global Rx	\$ 10,008,138	\$ 11,057,097	\$ 12,215,999	\$ 13,361,402	\$ 14,761,818	\$ 61,404,454
Optional Expansion (Underinsured)	\$ 2,349,260	\$ 2,352,293	\$ 2,355,331	\$ 2,411,174	\$ 2,414,287	\$ 11,882,346
VHAP ESI						
ESIA						
CHAP						
ESIA Expansion - 200-300% of FPL						
CHAP Expansion - 200-300% of FPL						
Premium Assistance Subsidies	\$ 9,616,669	\$ 10,247,721	\$ 11,105,152	\$ 12,034,324	\$ 13,041,240	\$ 56,045,105
New Adult	\$ 213,522,717	\$ 232,101,847	\$ 252,297,592	\$ 419,061,914	\$ 450,901,449	\$ 1,567,885,519
<i>Subtotal Capitation Payments</i>	<i>\$ 1,162,179,006</i>	<i>\$ 1,243,393,017</i>	<i>\$ 1,331,167,612</i>	<i>\$ 1,771,734,126</i>	<i>\$ 1,889,401,106</i>	<i>\$ 7,397,874,867</i>
Administrative Expenses Outside of Managed Care Model	\$ 6,243,917	\$ 6,475,950	\$ 6,716,605	\$ 6,966,203	\$ 7,225,077	\$ 33,627,751
Total Global Commitment	\$ 1,168,422,924	\$ 1,249,868,967	\$ 1,337,884,216	\$ 1,778,700,329	\$ 1,896,626,182	\$ 7,431,502,618
Choices for Care						
Highest Level of Care	\$ 146,227,956	\$ 152,672,874	\$ 159,401,848	\$ 172,217,958	\$ 179,808,371	\$ 810,329,007
High Level of Care	\$ 21,379,758	\$ 24,339,997	\$ 27,710,109	\$ 32,435,807	\$ 36,926,864	\$ 142,792,535
Moderate Level of Care	\$ 3,289,740	\$ 3,659,917	\$ 4,071,748	\$ 4,662,233	\$ 5,186,849	\$ 20,870,486
Program of All-Inclusive Care for the Elderly (PACE)						
Community Rehabilitation and Treatment (CRT)	\$ 4,148,454	\$ 4,267,764	\$ 4,390,506	\$ 4,681,675	\$ 4,816,321	\$ 22,304,720
Total Choices for Care	\$ 175,045,908	\$ 184,940,552	\$ 195,574,212	\$ 213,997,672	\$ 226,738,405	\$ 996,296,748
Combined Total: Global Commitment & Choices for Care	\$ 1,343,468,831	\$ 1,434,809,519	\$ 1,533,458,428	\$ 1,992,698,001	\$ 2,123,364,588	\$ 8,427,799,366
Children's Health Insurance Program	\$ 10,051,150	\$ 10,826,093	\$ 11,660,785	\$ 14,823,319	\$ 15,966,197	\$ 63,327,544

Table 13: Summary of Program Expenditures with and without Waiver, Years 9 – 13 (State and Federal)

	Waiver Year					Five-Year Total
	9 (Jan - Dec '14)	10 (Jan - Dec '15)	11 (Jan - Dec '16)	12 (Jan - Dec '17)	13 (Jan - Dec '18)	
Expenditures without Waiver (Aggregate Budget Neutrality Limit)						
Global Commitment	\$ 1,476,943,814	\$ 1,599,638,397	\$ 1,733,154,781	\$ 1,878,509,399	\$ 2,036,820,519	\$ 8,725,066,910
Choices for Care	\$ 442,809,682	\$ 491,577,836	\$ 545,716,994	\$ 605,818,684	\$ 672,539,580	\$ 2,758,462,776
Total	\$ 1,919,753,497	\$ 2,091,216,233	\$ 2,278,871,775	\$ 2,484,328,082	\$ 2,709,360,099	\$ 11,483,529,685
Without Reform						
Expenditures with Waiver						
Global Commitment	\$ 1,168,422,924	\$ 1,249,868,967	\$ 1,337,884,216	\$ 1,432,865,660	\$ 1,528,207,612	\$ 6,717,249,379
Choices for Care	\$ 175,045,908	\$ 184,940,552	\$ 195,574,212	\$ 207,020,944	\$ 219,363,745	\$ 981,945,360
Total	\$ 1,343,468,831	\$ 1,434,809,519	\$ 1,533,458,428	\$ 1,639,886,604	\$ 1,747,571,357	\$ 7,699,194,739
Annual Surplus (Deficit)	\$ 576,284,666	\$ 656,406,714	\$ 745,413,347	\$ 844,441,478	\$ 961,788,742	\$ 3,784,334,947
Waiver Surplus Carry-Forward: Years 1 - 9 (Dec '13)	\$ 1,695,024,810					\$ 1,695,024,810
Cumulative Surplus (Deficit)	\$ 2,271,309,476	\$ 2,927,716,190	\$ 3,673,129,537	\$ 4,517,571,015	\$ 5,479,359,757	\$ 5,479,359,757
With Reform						
Expenditures with Waiver						
Global Commitment	\$ 1,168,422,924	\$ 1,249,868,967	\$ 1,337,884,216	\$ 1,778,700,329	\$ 1,896,626,182	\$ 7,431,502,618
Choices for Care	\$ 175,045,908	\$ 184,940,552	\$ 195,574,212	\$ 213,997,672	\$ 226,738,405	\$ 996,296,748
Total	\$ 1,343,468,831	\$ 1,434,809,519	\$ 1,533,458,428	\$ 1,992,698,001	\$ 2,123,364,588	\$ 8,427,799,366
Annual Surplus (Deficit)	\$ 576,284,666	\$ 656,406,714	\$ 745,413,347	\$ 491,630,081	\$ 585,995,511	\$ 3,055,730,319
Waiver Surplus Carry-Forward: Years 1 - 9 (Dec '13)	\$ 1,695,024,810					\$ 1,695,024,810
Cumulative Surplus (Deficit)	\$ 2,271,309,476	\$ 2,927,716,190	\$ 3,673,129,537	\$ 4,164,759,618	\$ 4,750,755,129	\$ 4,750,755,129

IX. Public Notice Process

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

Public Comment Period: The CFR requires a 30 day comment period. The State's public comment period on the Global Commitment to Health 1115 Waiver Renewal request was from February 14 through March 22, 2013.

Public notice of the application: On February 13, the draft *Global Commitment to Health* Waiver Renewal Request, the public notice, and executive summary of the draft, were posted online. Materials were available on the following websites: DVHA, the Agency of Human Services, the Agency of Administration Health Care Reform home pages. All *Global Commitment to Health* Waiver documents, including renewal information are available year-round at <http://dvha.vermont.gov/administration/2013-global-commitment>.

On February 14, a public notice was published in the Burlington Free Press noticing the availability of the draft renewal request, two public hearing dates, the online website, and the deadline for submission of written comments with contact information. Additionally, all district offices of the Department for Children and Families' Economic Services Division, the division responsible for health care eligibility had notice posted and proposal copies available, if requested. The Burlington Free Press is the state's newspaper with the largest statewide distribution and paid subscriptions. Between February 16-20th, additional public notices were published in Vermont's other newspapers of record, including the Valley News, The Caledonian Record, St. Albans Messenger, Addison Independent, The Bennington Banner, Newport Daily Express, The Islander, Herald of Randolph, and the News and Citizen. This distribution list represents all geographic regions of the state.

On March 1, a public notice and link to the renewal documents was included on the banner page for Vermont's Medicaid provider network.

Comprehensive description of the proposed waiver extension: The State posted a comprehensive description of the proposed waiver request on February 13, 2013 on the above-cited websites. The document included: program description, goals and objectives; a description of the beneficiary groups that will be impacted by the demonstration; the proposed health delivery system and benefit and cost-sharing requirements impacted by the demonstration; estimated increases or decreases in enrollment and in expenditures; the hypothesis and evaluation parameters of the proposal; and the specific waiver and expenditure authorities it is seeking. In addition to the draft posted for public comment, an Executive Summary and the PowerPoint presentation used during each public hearing was also posted to the same state websites noted above.

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

On February 19 from 3:30 p.m.-5:30 p.m., a public hearing was held using videoconferencing at Vermont Interactive Television (VIT) sites in Bennington, Brattleboro, Johnson, Lyndonville,

Middlebury, Newport, Randolph Center, Rutland, Springfield, St. Albans, White River Junction, Montpelier, and originating in Williston.

On March 11 from 11:00 a.m.-1:00 p.m., a public hearing was held during the Medicaid and Exchange Advisory Board meeting in Winooski, with teleconferencing available for individuals who could not attend in person.

On March 14, an informational presentation (with a question/answer period), of the Global Commitment to Health Waiver Renewal request was given at the Department of Disabilities, Aging, and Independent Living (DAIL) Advisory Board meeting in Berlin, Vermont.

Use of an electronic mailing list to notify the public: On February 13, the Draft *Global Commitment to Health Waiver Renewal Request* was distributed simultaneously to the Medicaid and Exchange Advisory Board, the committees of jurisdiction in the Vermont legislature, the DAIL Advisory Board, Department of Children and Families (DCF) District Offices, Dual Eligible Demonstration Stakeholders, DMH, VDH and other external stakeholders as well as internal management teams from across AHS.

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

Public Comments and Associated Responses

Public Hearing Comments:

Q. Several Stakeholders asked if the Dual Eligible Demonstration would be included in this waiver request.

A. No. The state continues to negotiate and work with CMS regarding the duals demonstration; the state currently manages the Medicaid portion of care related to dual Medicaid and Medicare beneficiaries as part of both the GC and the Choices for Care waiver. Should the state finalize a demonstration project with CMS we would seek maximum alignment of policy and rules, and look to CMS to provide guidance regarding any needed changes. Any demonstration agreement and formal MOU would be outside of this current waiver request.

Q. Will the Governor's proposed 3% cost of living increase for provider rates be included in assumptions? What accounts for the jump in projected Medicaid spending in 2016 and 2017?

A. The projections in the draft posted for comment do not carry forward the proposed increase in reimbursement rates. However before a final request is submitted to CMS all financial projections will be adjusted to reflect the annual inflationary rate increase as well as any other financial driver that was not known at the time the draft was written.

The projected increases in 2016 and 2017 represent provider rate increases to 105% of Medicare for acute care services managed by DVHA and the enrollment projections that were outlined in the UMASS Single Payer Finance Report.

Q. Is Choices for Care currently operated as a Managed Care Organization? If Choices for Care becomes part of Global Commitment to Health Waiver, will it become part of the MCO and if so can a PMPM type of provider reimbursement methodology be used for Choices for Care providers?

A. Choice for Care is not currently operating using a formal MCO model. The state may request modifications to traditional Medicaid payment models under any 1115 demonstration. If the waivers are consolidated the Choice for Care delivery system would have the same flexibility to explore various provider payment models as used in Global Commitment Demonstration. This could include a sub-capitated PMPM model for provider payments.

Q. The Global Commitment Waiver Renewal Summary mentioned that MAGI might be applied for other Medicaid groups, but aren't we using MAGI for everyone anyways?

A. Vermont's pharmacy only benefit programs currently use the same eligibility rules as VHAP. With the state's elimination of the VHAP program we would like to align all demonstration populations (with the exception of long term care) under the same eligibility structure. In doing so the state is requesting the flexibility to extend MAGI to SSI-related Medicaid determinations as well. Final implementation of such an option would be based on legislative direction following a full review of impact.

Q. Please explain the request for enhancement to the home and community based services benefit currently provided to CRT consumers in DMH.

A. Prior to the 2005 Global Commitment waiver, the state had an 1115 demonstration waiver that allowed the DMH to operate using a Medicaid Managed Care framework for the CRT program. This included establishing a PMPM payment methodology that took into account the provision of ALL services regardless of whether they provided in home, community, residential and/or inpatient settings. This methodology also allowed the DMH to establish and pay for a full continuum of services including those not traditionally found in a Medicaid State plan. While it was acknowledged that all former 1915 (c) and 1115 delivery system enhancements were "rolled into" the 2005 Global Commitment waiver, the state would like to clearly establish this allowance and extend it to any Medicaid beneficiary needing intensive mental health interventions regardless of the setting.

Written Comments and Questions: All written comments and questions are attached. Summarized below are the state's responses including modifications, if any, that the state made to the final proposal as a result of the input. Several stakeholders made comments related to the Dual Eligible Demonstration, however, because the Duals is a separate CMS negotiation and ultimately a separate agreement, those comments will not be addressed in this summary or renewal request

1. The Support and Services At Home (SASH) project is a formal partner with DAIL, DVHA and the Blueprint Community Health Teams to provide proactive supports to seniors that will allow them to stay in their home and community settings as long as medically possible. Project staff asked that specific edits be made to the renewal narrative to describe the program.
 - A. The state has accepted a few edits that were submitted, however the state has many partners in success and to list all such projects in this narrative would be unrealistic. The state is proud of the many innovative community efforts in place across Vermont.

2. The Vermont Association of Hospital and Health Systems (VAHHS) noted that this waiver extension request fails to clarify how the state plans to “begin the groundwork for a fully-integrated single payer system” and concurrently participate in the recently awarded State Innovation Model (SIM) grant, which builds upon the recent CMS approved Medicare Shared Savings Program Accountable Care Organization (ACO). They asked for clarity in how these efforts align to create a more efficient, aligned delivery infrastructure to care for the Medicaid, Medicare and commercial populations. Many specific questions were asked about related health care reform and programmatic efforts.
 - A. The state appreciates the complexity of the health care reform tasks ahead. However, we do not see these projects as mutually exclusive. The Global Commitment waiver renewal gives us the flexibility to continue many of the current reforms while the State Innovative Model grant provides us the opportunity to do the planning and dialogue necessary to answer many of the programmatic and performance measurement questions outlined in this comment letter. It will allow us to implement a pilot that will inform the state’s future efforts.

This waiver is not intended to answer questions about Vermont’s transition to a single payer health system other than acknowledging the financial impact of that transition for Medicaid enrollment and expenditures. This is intended to allow the state to continue the reforms already in place and build on them as we move forward. Alignment with the final single payer plan, as approved by the Vermont Legislature, will likely require an amendment to the waiver in future years. Such an amendment would be sought at the direction of and as defined by the legislature at that time.

3. The VAHHS also noted frustration with what they characterized as DVHA’s incomplete attention to due process and notice of changes specifically related to state plan and other policy changes and provider audit and appeals process. VAHHS suggests that DVHA’s request to simplify the state plan amendment and reporting process should be conditioned on the requirement that a coverage or payment policy is not effective unless it has had at least a 30-day public notice and comment period. Additionally VAHHS recommends that DVHA’s request to streamline the regulatory structures should be conditioned on the implementation of a provider appeals process that is similar to Medicare and other states’ Medicaid appeals processes including the opportunity for an independent administrative hearing.
 - A. The state agrees that a clear and consistent public engagement, notice and provider audit and appeals process is desirable for policies and changes. The implementation of a state provider review process is outside the purview of the Global Commitment waiver; however DVHA is actively working with providers to adopt state specific processes that meet these needs.

4. The Vermont Legal Aid (VLA) raised concerns that the state should not restrict benefits for existing beneficiaries and in particular mandatory eligible and children's EPSDT benefits.
 - A. Benefit restrictions on the mandatory populations would need to be approved by the legislature. We are not requesting a waiver from EPSDT regulations; the waivers that we are requesting are included in the draft.
5. The VLA and its Senior Law Project have separately asked that the waiver include specific references to state statutes related to Choices for Care reinvestments and home and community services.
 - A. This is redundant with state authority and legislative process. Where no federal requirements exist the waiver states that these programs are governed by state policy and rule. We feel this is sufficient and allows policy decisions to remain the purview of the state's executive and legislative branches.
6. The VLA and its Senior Law Project separately requested retention of the Choices for Care STC which states that "funding equivalent to 100 slots be added each year to expand the home and community based services".
 - A. We agree that the goal of the Demonstration is to serve more people, not fewer. We do include language that notes that this is accomplished through the flexible, cost effective investment in long-term service and support innovations such as expanding community-based housing options and health promotion. The reference to 'slots' is antiquated and unnecessarily restrictive.
7. The VLA Senior Law Project has requested that waiver terms define a methodology for calculating savings and require reinvestment in home and community based services (and not nursing facility or institutions).
 - A. This is a state decision and policy, and should remain the purview of the Legislature.
8. The Vermont Legal Aid Senior Law Project requests that the Moderate Needs Groups under Choices for Care be administered by DVHA and be unrestricted in enrollment and funding. The VLA asks that funds be distributed to consumers rather than as limited allocations to local providers.
 - A. While admirable, this is an unrealistic request. The state does not have the funding or staffing to expand these waiver services to beneficiaries.
9. The VLA Senior Law Project requests more detail related to administrative streamlining and how that will change the long term services and DAIL's oversight.
 - A. The intention of the state is to streamline how the state reports to CMS and the CMS approval processes for services. Specifically, to use the more simplified quarterly reporting formats developed under Global Commitment, to adopt one regulatory structure, 42 CFR 438 for all populations and programs, and streamline the state plan process. Additionally, many of the innovations the state has adopted

while in state statute, rules or guidelines, are not found in the state plan (home and community based services) nor do they employ traditional provider payments. As the state moves further into health care reform, service delivery approaches will become more flexible and unique to Vermont. Thus the state is requesting an alternative to the state plan amendment process. As noted earlier, the state would like the flexibility to adopt a legislatively approved public engagement process that does not rely on CMS action for payment reforms, the use of non-traditional health care strategies and population based health improvements.

The state has no intention of changing the DAIL oversight model or to restrict the programs and benefits currently operated under the Choices for Care waiver

10. The VLA requests that the state guarantee that beneficiaries and applicants continue to have access to advocates by including this advocacy system in the renewal request. Independent advocacy is an integral part of any effective health care delivery system.
 - A. The state agrees that beneficiaries and applicants continue to have access to independent advocates and does not plan to eliminate this aspect of our model.
11. The VLA requests that ESI Premium Assistance be added to the narrative as a 'state only program'.
 - A. The reference is indicating that the Vermont Health Connect allows qualified employees or their dependents to enroll in or change from one QHP to another as a result of various triggering events. One of those events is the qualified employee or dependent becoming eligible for premium assistance with a small employer plan under the Health Insurance Premium Payment (HIPP) program or other such Medicaid or CHIP option.
12. The VLA notes that Section 34(b)(8) of Act 171 requires the waiver request to "ensure affordable coverage for individuals who are eligible for Medicare but who are responsible for paying the full cost of Medicare coverage due to inadequate work history or for another reason." The draft waiver proposal does not mention this population, or explain how the state intends to comply with the statutory mandate. We urge you to remedy this omission.
 - A. We will add this request to the premium assistance section in the waiver narrative.
13. The VLA requests that any use of MAGI rules for SSI related Medicaid be prohibited if it is adverse to any individual consumer.
 - A. The state is requesting the flexibility to extend MAGI to other eligibility groups (except long term care); this could include SSI-related Medicaid determinations. Any final implementation of such an option would be based on Legislative direction following a full review of impact.
14. The VLA is requesting that beneficiaries whose spend down period ends before March 1, 2014 have their Medicaid coverage continued until the extended safe harbor review date.

- A. Our transition plan calls for structuring spend downs in the latter part of 2013 such that there will be no medically needy in MAGI-based coverage on January 1, 2014. The plan is currently before CMS's Eligibility Division for their review and approval. There are no changes currently planned for implementation in SSI-related medically needy coverage.

15. The VLA has asked that more specificity be added related to waiver authorities.

- A. These authorities and their associated descriptions are written by CMS. After full discussion of the request and the intended goals, CMS reviews and identifies what waivers are necessary for the state to carry out its program. CMS has ultimate authority in what is granted and for what purpose. The waivers listed in this proposal have been in existence since 2005 and 2007 (for Catamount/ESI programs) the state is asking for continuation of all and will CMS determine which ones no longer apply. A brief overview of how they have been used and responses to certain VLA concerns is provided below.
 - i. *Hearings and Appeals* – This waiver allows the state to use the exhaustion of administrative appeals process if it desires; the state rules currently do not require exhaustion of administrative appeal as allowed by the MCO rules. The state has had this option since 2005. Whether or not to implement this option is a state decision and the state should retain the flexibility.
 - ii. *Reasonable Promptness* – This waiver has been in place since 2005 and allows the state to implement Choices for Care waiting list, if needed, due to budget constraints.
 - iii. *Amount, Scope and Duration* – This waiver has been in effect since 2005 and allows the state to: offer limited benefits such as VHAP to expansion populations; offer 1915 (c) like services in DAIL and DMH; create pilots to test new and innovative service approaches; and provide expanded services to consumers. This waiver as written by CMS does not allow the state to create restrictions that would be out of compliance with federal EPSDT or federally mandated benefits. The state should retain the flexibility to provide all home and community based services that it has had since 2005 under GC and for several decades prior to 2005 in the 1915 (c) waivers.
 - iv. *Financial Responsibility/Deeming* – The state is not seeking authority to change, restrict or expand current eligibility requirements.
 - v. *Spend Down* - The state is not seeking authority to change or expand long term care eligibility requirements. We will look to CMS for guidance on any changes necessary to implement the requested expansion of the hospice benefit.
 - vi. *Freedom of Choice* – This waiver has been in place since 2005 and for decades prior related to all former 1915 (c) service recipients. Using specialty providers in a variety of circumstances (transportation brokers) and as required in Vermont statute (Designated Agencies, Home Health

Agencies, Area Agencies on Aging, etc.) it is a key aspect of Vermont programs and we wish to retain all current and long standing flexibilities.

- vii. *Premium Requirements* – This is a continuation of current authorities, CMS will determine if it is needed to address premium cost sharing as proposed in this renewal request.
- viii. *Retroactive Eligibility* – This is a continuation of current authorities, the state plans no change to the current system.
- ix. *Cost Sharing* – This is a continuation of current authorities, CMS will determine if it is needed.
- x. *Direct Provider Reimbursement* - This is a continuation of current authorities, CMS will determine if it is needed.

16. The VLA Senior Law Project expressed concern that consolidation of the two waivers would cause erosion of the long term care program and have requested STC's that require all programs to remain the same, and current beneficiaries to be grandfathered in to any new system. Additionally, they request that beneficiary protections and beneficiary notice requirements also be listed in the STC's.

- A. The state does not intend to change current programs, benefits or eligibility requirements; any such changes in underlying structure would require state legislative changes and as such would be fully vetted with the public.

The beneficiary protections currently outlined in the Choices for Care waiver are addressed in the Medicaid regulations related to MCO operations. One overarching goal of the federal Medicaid Managed Care regulation is to ensure that beneficiaries have robust protections from HMO's and commercial insurers who may be inclined to restrict services in order to increase profits. All of these protections and notice requirements are in federal regulation and will extend to Choices for Care population if the waivers are consolidated, and should provide the same or greater due process, notice, grievance, appeal, member education and outreach than are currently outlined for Choices For Care.

17. VLA Senior Law Project requests the elimination of the authority to have a waiting list for High Needs groups.

- A. The state, as you noted, has been successful in reducing and eliminating the waiting list whenever possible. However, it is fiscally prudent to have this mechanism available should economic conditions warrant budget rescissions or reductions.

18. VLA Senior Law Project comments that long term care application processing is insufficient and should be simplified; they also request that presumptive eligibility be expanded in this waiver request.

- A. The state can implement presumptive eligibility without waiver authority and has been doing so based on availability of legislative appropriations. Expansion is a legislative budget item and not a federal waiver provision.

19. VLA Senior Law Project notes that ACA creates a “MAGI cliff” and requests that the state address this in its waiver request.
 - A. We will explore this issue further and work with CMS to determine if any proposed remedy is within the purview of the Global Commitment waiver.

20. VLA Senior law Projects requests no changes be made to medically needy spend down and deeming rules.
 - A. The state is not requesting changes to these rules.