



VERMONT ASSOCIATION OF
HOSPITALS AND HEALTH SYSTEMS

March 22, 2013

Ashley Berliner
289 Hurricane Lane
Williston, VT 05495

RE: VAHHS comments on Global Commitment to Health 11-W-00194/1: Section 1115(a) Demonstration Waiver extension request

Dear Ms. Berliner:

On behalf of the Vermont Association of Hospitals and Health System (VAHHS), I am writing to comment on the Global Commitment to Health 11-W-00194/1: Section 1115(a) Demonstration Waiver extension request. The public notice for this waiver specifically includes the intention to consolidate a variety of programs and services, including the pending Dual Demonstration. We currently understand that Vermont's Department of Vermont Health Access (DVHA) does not now plan to include the Duals Demonstration as part of this waiver extension request. VAHHS agrees with DVHA's decision to exclude the Duals Demonstration.

Given the importance of health reform changes on the dually eligible population, these comments will still include our concerns regarding DVHA's current Duals Demonstration approach.

Overall, 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).

All these efforts share the same goals: improved health, higher quality and greater coordinated care. What's less clear is how these efforts align to create a more efficient, aligned delivery infrastructure to care for the Medicaid, Medicare and commercial populations. For example, under an ACO model, would DVHA still need to operate the

Vermont Chronic Care Initiative? In addition, how will the myriad provider requirements become more aligned and streamlined under pending changes for ACOs, the Duals Demonstration and other program changes contemplated by DVHA? If providers must meet more requirements and measure data for a multitude of performance goals, they will be less likely to provide more efficient care. Even within the Medicaid program, will program integration address care overlaps in existing programs such as the Vermont Blueprint for Health and the Core Care Model that would cover many of the same patients?

I. Due Process Concerns

Accompanying our concern about an overburden of new requirements stemming from the plethora of reform approaches, is growing provider frustration related to DVHA's inattention to due process procedures relating to (a) notice of policy/program changes and (b) establishing clear audit and appeals processes. The potential participation in the Duals Demonstration would exacerbate this problem.

A. Administrative Simplification/Notice: DVHA aims to achieve "efficiencies through a single integrated administrative approach." (DWER, p. 12) Unlike Medicare, DVHA's policy making is haphazard, unpredictable and does not adhere to any reasonable standards for advance public notice and an opportunity to comment. For example, the public notice for the State Plan Amendment 12-029 was published in the Burlington Free Press on Wednesday, September 26, 2012. The deadline for the receipt of comments was no later than 4:00 pm on September 28, 2012. While a two day notice requirement may technically not violate the public notice regulation it does not afford "providers, beneficiaries and their representatives, and other concerned State residents a reasonable opportunity for review and comment" as required by section 1902(a)(13) of the Social Security Act.

DVHA's request to extend and simplify the 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. The September 26 public notice included DVHA's frequently repeated admonition that the Global Commitment Waiver authorizes a great deal of flexibility in developing policies. DVHA's emphasis on the authorized flexibility has allowed it to avoid developing reasonable processes for communicating proposed policy changes and engaging providers in the policy making process.

B. Lack of Audit and Appeals Processes: Medicare's audit and appeals processes are highly regulated and administered with detailed requirements outlined in regulation, the Medicare Program Integrity Manual and contractor

Scope of Work requirements. These detailed requirements, including the five levels of administrative appeals, provide the fairness and consistency needed to address complex payment disputes. DVHA, conversely, has no established audit or provider appeals processes, which has resulted in prolonged, costly disputes. For example, in May 2011, two hospitals raised a concern regarding the lack of an administrative appeals process to address a payment dispute with DVHA. The hospitals were informed by DVHA that there was no right of appeal. Fourteen months later, the Commissioner of DVHA agreed to meet with the hospitals to discuss their concerns about the audit process and a lack of an administrative appeals process. On August 17, 2012, the Commissioner informed the two hospitals that DVHA was actively engaged in implementing an appeals process based on their review of appeals processes in other states and Medicare. Almost two years later, DVHA has not implemented an appeals process.

VAHHS recommends that DVHA's request to streamline the regulatory structures should be conditioned on the implementation of an appeals process that is similar to Medicare and other states' Medicaid appeals processes including the opportunity for an independent administrative hearing.

II. Concerns Stemming from Duals Demonstration

Pertaining more specifically to the concerns stemming from Duals Demonstration, our comments can be categorized into three groups: Reduction in the Scope of Services, Impact on Payment and Claims Processing.

A. Reduction in Scope of Services

DVHA has not indicated how it will preserve certain components of the Medicare benefit that are either not covered or where the scope of services is more limited, such as scope of swing-bed services for hospital based extended care services covered in certain rural hospitals. Vermont Medicaid does not allow as many hospitals to participate in the swing bed program as Medicare does.

B. Concerns about the impact on payment

DVHA has repeatedly insisted that demonstration savings will not come from reduced provider payments. While provider rates may not change, providers will certainly experience adverse payment impacts when Vermont's Medicare beneficiaries decrease by thirty percent. The formula-driven adverse impacts, which include inputs such as the number of Medicare discharges or days, will include:

- Medicare provider based reimbursement

- Medicare Meaningful Use where the payment calculation is based on Medicare discharges
- Sole community hospital payments
- Critical access hospital payment
- Medicare co-insurance payments
- Medicare capital payments per discharge
- Medicaid 340b Drug Pricing

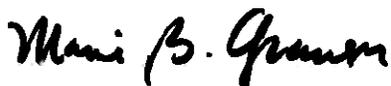
Looking ahead, DVHA envisions some sharing of savings and performance incentives, but currently no details exist on these potential distributions or which providers would be eligible to receive them. For example, it currently appears that distributions would only be available to providers that become Integrated Care Providers (ICP) or ICP-PLUS.

C. Claims Processing

DVHA intends that the enrollment process for dual eligibles would be automatic, with a monthly opt-out opportunity. This process may result in patients shifting in and out of Medicare coverage in a short period of time. As the two programs have differences in coverage, prior authorization requirements, coding, and certification requirements (e.g., face to face visits for home health certifications), providers may not have real-time knowledge as to what program provides coverage which dates, and which set of rules to comply with for these various regulatory requirements. There is also a higher risk of claims being directed to the wrong program and a resulting delay in payments. In addition, providers may need to seek prior authorization for services to now-Medicaid patients where they were not required to seek it previously. Medicaid pre-authorization (and difficulty or failure to obtain it) is currently a particularly troublesome issue.

On behalf of our member hospitals, we appreciate the opportunity to provide these comments and would be happy to provide additional detail or answer any questions.

Sincerely,



M. Beatrice Grause, RN, JD, FACHE
President and CEO

Vermont Association of Hospitals and Health Systems



*Healthy Homes
Caring Communities
Positive Aging*

Mark Larson, Commissioner
Department of Vermont Health Access
312 Hurricane Lane
Williston, Vermont 05495

SENT VIA EMAIL

Dear Mark,

Thank you for the opportunity to comment on the draft Section 1115(a) Demonstration Waiver Extension Request (1/1/2014 – 12/31/2018).

Cathedral Square Corporation (CSC) supports the state's renewal goals:

- To consolidate the existing 1115 Demonstrations;
- To expand the current menu of services offered to the Moderate Needs Group; and
- To enhance Hospice benefits by expanding the benefit to 12 months, allowing more and different types of care under this benefit. This will really allow Vermonters to age at home.

Through the Memorandum of Understanding between DVHA and CSC, we have made great strides together in bringing the Support And Services at Home (SASH) initiative to hundreds of low income Vermonters. As of May 1, 2013, SASH will be operating in every Health Service Area in the state at approximately 80 affordable housing locations. Nearly 20% of SASH participants are Dual Eligible or Medicaid only. SASH is also a recipient of MCO funds through the Department of Disabilities, Aging and Independent Living (DAIL). For those reasons, we believe that SASH should be reflected in the waiver extension request.

SASH has served to advance the aims of the Global Commitment Demonstration:

- (1) Promote access to affordable health coverage: through team work between VNAs, Area Agencies on Aging, designated mental health agencies and nonprofit housing providers SASH has increased access to health services and coverage.
- (2) Develop public health approaches to meet the needs of individuals and families: SASH has entered into a grant agreement with the Vermont Department of Health to reduce tobacco usage and reduce hypertension among the non elderly in the Northeast Kingdom and Rutland



412 Farrell Street, Suite 100, South Burlington, VT 05403
P (802) 863-2224 • F (802) 863-6661 • TTY/TTD (800) 253-0191

www.cathedralsquare.org

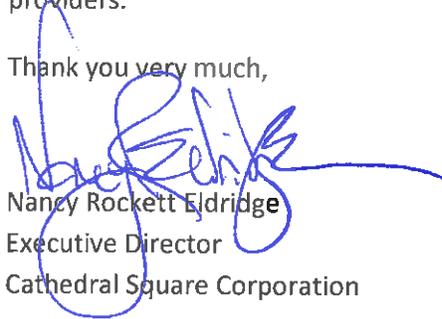


County. SASH was recently recognized by the Centers for Disease Control (CDC) for its “systems-level approach.”

- (3) Develop innovative, outcome and quality focused payment approaches: SASH is a population based approach to serving Vermonters across the spectrum of health needs. Medicare funding was dependent on projecting a net savings as a result of evidence based practices.
- (4) Enhance coordination of care across providers and service delivery systems: ten hospitals have entered into the SASH MOU which includes a commitment to collaborate on discharge protocols and transitions planning. SASH enters all assessments into the Central Clinical Registry through DocSite – setting the stage for accurate and timely information sharing between SASH teams on the ground and medical homes.
- (5) Control program cost growth: by providing affordable housing and assisted living options for low income seniors, SASH housing providers provide an affordable alternative to nursing homes.

We ask that the attached “track changes” language be added to the waiver extension request. Thank you for the many ways DVHA and DAIL has supported SASH. The effectiveness of the program would not be possible without your support and the incredible nurses, case managers, elder care clinicians, Community Health Teams, medical homes and discharge planners working in collaboration with housing providers.

Thank you very much,



Nancy Rockett Eldridge
Executive Director
Cathedral Square Corporation

Cc: Dr. Craig Jones
Dr. Susan Wehry
Christine Hart
Eileen Peltier
John Broderick
Kevin Loso
Merten Bangemann-Johnson
Molly Dugan

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, [Support 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. 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.

[Support And Services at Home \(SASH\) brings a caring partnership together to support aging at home. It connects the health and long-term care systems to and for Medicare beneficiaries statewide. Together, these systems are facilitating streamlined access to the medical and non-medical services necessary for this vulnerable population to remain living safely at home. SASH is funded by Medicaid through a grant agreement with DAIL and the Centers for Medicare and Medicaid Innovation Center \(CMMI\) Multi-payer Advanced Primary Care Practice Demonstration, awarded to the Vermont Blueprint for Health in 2011. This leveraging of federal funds complements the targeted payment reforms already part of the Blueprint. SASH has transitioned from its pilot single team in Burlington in 2009 to 26.5 teams in most areas of the state as of January 2013.](#)

[The SASH model includes an organized, person-centered presence in the community, with a](#)

SASH Coordinator and Wellness Nurse serving a panel of 100 participants. These participants may live in subsidized housing or out in the community, as the program is designed to serve all Medicare beneficiaries as needed. Staff members focus their efforts around three areas of intervention that have proven most effective in reducing unnecessary Medicare expenditures: transition support after a hospital or rehabilitation facility stay, Self-Management education and coaching, and care coordination.

The SASH Coordinator and Wellness Nurse are part of a larger team of representatives of local Home Health Agencies, Area Agencies on Aging, mental health providers and others. The roles and responsibilities of the team members are formalized through a Memorandum of Understanding (MOU) between all partner organizations. The team meets regularly to facilitate an individual and population based approach to care management. Individual Healthy Aging Plans are developed for each participant. The SASH staff provides the tools to help the participant meet those goals. Based on the cumulative and common goals identified, a Community Healthy Living Plan is created. This addresses specific interventions from a directory of evidence based programs organized around the following five key areas:

- Falls
- Medication management
- Control of chronic conditions
- Lifestyle barriers
- Cognitive and mental health issues

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.
- Build on the Blueprint by fully integrating home and community based service providers with primary and acute care delivery and payment systems.

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; [care management at home by SASH teams embedded in the community](#); 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

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VERMONT LEGAL AID, INC.

264 NORTH WINOOSKI AVENUE, P.O. BOX 1367

BURLINGTON, VERMONT

802-863-5620 (VOICE AND TTY)

802-863-7152 FAX

By email to ashley.berliner@state.vt.us

March 22, 2013

Department of Vermont Health Access
289 Hurricane Lane
Williston, VT 05495

Re: Draft Section 1115(a) Demonstration Waiver Extension Request

These comments are submitted by the Office of Health Care Ombudsman, the Vermont Long Term Care Ombudsman, the Poverty Law Project, and the Disability Law Project of Vermont Legal Aid, in response to the Agency of Human Services' draft Section 1115(a) demonstration waiver extension request. Page references are to the draft waiver extension request, unless otherwise specified.

In general, we support the expansion of health care eligibility and services that has been possible through the Global Commitment to Health waiver. We applaud the state for its commitment to universal coverage and its proactive approach to health care reform. We support the seamless integration of the Health Benefits Exchange and the Medicaid eligibility system. Better-integrated services will benefit consumers and beneficiaries, and improve access to health care.

Further, we support expansion of the services offered in the Long Term Care Moderate Needs Group, enhanced hospice benefits, and continuation of Community Treatment and Rehabilitation (CRT) and Home and Community Based Services (HCBS).

We have two broad concerns with the waiver proposal. First, the Agency of Human Services (AHS) should clarify that the intent of the waiver is not to restrict benefits for existing Medicaid beneficiaries or those who would be eligible under traditional Medicaid or Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The demonstration waiver should only expand eligibility and services, which is consistent with existing statutory restrictions and legislative intent.

The Vermont legislature has stated that the Global Commitment Waiver approval was not intended to restrict eligibility, or override the state's responsibilities under EPSDT. "The general assembly did not grant approval for the implementation of any changes in the eligibility or benefits in this approval, including any waiver of amount, duration, and scope requirements or the provision of early periodic screening, diagnosis, and treatment services for children." Fiscal Year 2007 Appropriations Act, Sec. 311. Similar clarifying language should be incorporated into the current waiver proposal.

Second, AHS must be more specific in its proposal, especially in the enumeration of requested waivers (pp. 20 - 22). The waivers must be narrowly tailored to their purpose, so that important rights under federal law are not waived unless there is good reason to do so. Specific examples are listed below.

1. Proposed Health Delivery System

Act 171 of 2012 sets out a number of requirements for any future Medicaid or Medicare waiver request. The present proposal must comply with the provisions of this Act.

First, Section 33(b)(1) of Act 171 requires that any future modification or consolidation of the Choices for Care (CFC) waiver comply with the prior requirements of Act 56 of 2005, the enabling legislation for CFC. The clear intent of the legislature in Act 171 is to maintain the requirements of CFC, including the terms and conditions of the waiver, in any consolidation of CFC into Global Commitment (GC).

One of the central requirements of the original CFC waiver is that any savings resulting from the waiver be reinvested in home and community based services, rather than being diverted to other budgetary purposes (Act 56, Sec. 1(g)). The current terms and conditions of the CFC waiver further require that funding equivalent to a minimum of 100 “slots” be added each year to expand home and community based services (2010 CMS approval document, Term 24, p. 8). In order to comply with the mandate of the Vermont legislature, it is vital that these budgetary protections for CFC be maintained in the current waiver proposal. By subsuming CFC into the broader GC waiver, there is a significant danger that any savings accrued by the program will be diverted to other budgetary demands, and that CFC will be forced to compete for expansion funds with other GC programs. Given the current unmet need for home and community based services, and the proposed request to continue to allow waiting lists under CFC, the loss of these protections would further harm this vulnerable population and be contrary to the mandate of the Vermont legislature. The proposal should further specify that the long-term care services covered by the waiver include the broad scope of home and community based services enumerated in Act 56, Sec. 1(h), to ensure that these budgetary protections apply to the full range of covered services.

Second, Section 34(b)(8) of Act 171 requires the waiver request to “[e]nsure 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.

Finally, the proposed health delivery system must include access to independent advocacy. The CFC Special Terms and Conditions gave beneficiaries and applicants access to an advocacy system that includes legal services, the health care ombudsman and the long term care ombudsman. The state should 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

2. ESI Premium Assistance

Although individuals with employer-sponsored insurance will generally not be eligible for federal subsidies, the Vermont legislature could potentially extend state premium and cost-sharing subsidies to such individuals. This possibility is currently recognized in section 10.00(a)(8)(ii) of the Vermont small employer health benefits program rules, draft version 5, dated 3/15/13. (Obtained from Erick Carrera, Erick.Carrera@state.vt.us). This possibility should be noted in the waiver request.

3. Use of MAGI methodologies

In theory, it makes sense to simplify income-determination methodologies as much as possible. However, we are concerned that SSI-related populations, or subsets of them, would be adversely affected by a transition to the MAGI rules. SSI-related Medicaid rules currently disregard a substantial part of earned income. This is important for some beneficiaries' eligibility. We believe that your intent is that everyone who is eligible for SSI-Related Medicaid under the current rules would be eligible after the transition to the new methodology. This needs to be explicitly stated.

At the March 11, 2013 public hearing on this draft, Department of Vermont Health Access (DVHA) Commissioner Mark Larson stated that the state would look at the effects on a population as a whole when considering whether to expand MAGI methodologies. We object to any interpretation of the waiver that allows even a single person who currently qualifies for SSI-related Medicaid to be rendered ineligible as the result of a transition to MAGI methodology.

4. Streamlined Eligibility Transition Process

It is unclear how the extension of review dates impacts Medicaid beneficiaries with spend-down requirements. For beneficiaries whose spend-down periods end before March 1, 2014, Medicaid coverage should be continued until the extended review date.

5. Premium Subsidies and Cost-Sharing for Exchange Participants

We support maximizing the state's additional subsidies. We appreciate the state's support of health care affordability. We understand that the specific subsidies approved by the Vermont legislature will be included in the waiver proposal.

6. Requested Waiver – Hearings and Appeals

The waiver request should be clarified to state that any initial Managed Care Organization (MCO) internal review offered through DVHA will not be mandatory. The current language suggests that this will be the case, but it is somewhat ambiguous.

To ensure compliance with state and federal due process rights, the internal process for review should not be an impediment or barrier to the formal Human Services Board process for requesting an appeal through an independent fair hearing. We believe that the basic structure of

the current fair hearing process should be maintained. The waiver request should clarify the state's intention in this regard.

7. Requested Waiver – Reasonable Promptness

We urge you not to waive the reasonable promptness requirements for anyone, including highest needs long term care applicants. While we have no problem with a “person centered assessment and options counseling process” in concept, we have not seen specific descriptions of what it would entail. Participation in “options counseling” should not be an eligibility requirement for long term care. Assessment and counseling should not delay provision of long term care services, particularly for highest needs individuals.

Vermont has consistently failed to process applications for Medicaid in accordance with federally-mandated requirements. Applications for long term care Medicaid currently take many months to process. This is a significant burden on beneficiaries. Presumptive eligibility determinations should be expanded. The waiver extension should require the State to have an adequate infrastructure to timely process all Medicaid applications.

8. Amount, Duration, and Scope of Services

We strongly urge you to narrow the requested waiver of federal “amount, duration and scope” requirements. Federal “amount, duration and scope” requirements mean that when Vermont provides a medical service, Vermont has to provide that service in sufficient quantity to meet the federal purpose of that service. This beneficiary protection assures that when services are provided, they are in sufficient quantity to meet the medical need for which the service is designed.

We recognize that the waiver of “amount, duration and scope” requirements allows the State to provide some expanded services to current and new populations. However, the Global Commitment Waiver should not restrict Medicaid beneficiaries' access to the current level of Medicaid-funded services. Waiving federal “amount, duration and scope” requirements in effect eliminates the promise that current Medicaid beneficiaries will receive the same level of traditional Medicaid-funded services. This waiver should be narrowed. The state should clarify that it is not seeking to reduce or limit any existing services beyond what is currently provided under the existing waivers. Medicaid beneficiaries should remain entitled to the same level of care that they are receiving now.

In approving the Global Commitment Waiver, the Legislature expressly disapproved waiving “amount, duration and scope” requirements. “The General Assembly did not grant approval for the implementation of any changes in the eligibility or benefits in this approval, including any waiver of amount, duration, and scope requirements or the provision of early periodic screening diagnosis, and treatment services for children.” Sec. 311 Global Commitment Approval, SFY 2007 Appropriations Bill.

Vermont has successfully operated its traditional Medicaid program under the federal “amount, duration and scope requirements” for decades. There is no reason that these requirements should

be waived for traditional Medicaid services. It would be a serious roll-back of beneficiary protections to increase access to new populations and non-traditional Medicaid-funded services through Global Commitment, while eliminating federal assurances that the amount of traditional Medicaid-funded services will be adequate.

9. Financial Responsibility/Deeming

Family income and resources should only be used in conjunction with more liberal income and resource standards. Any change in methodology should not result in the disqualification of current beneficiaries. We object to any interpretation that allows even a single person who currently qualifies for SSI-related Medicaid to be rendered ineligible as the result of a transition to MAGI methodology.

There is no exception for long-term care Medicaid at page 21. On page 16, however, the State does not seek authority to extend MAGI methodologies to the long-term care population. The waiver request on page 21 should be narrowed.

10. Spend-Down

In general, we support the continued inclusion of the one-month spend-down option to allow expanded financial eligibility for long-term care Medicaid services. To the extent that the proposed waiver tracks the current CFC waiver for financial spend-down eligibility, or broadens its scope, we support this proposal. In particular, it is important to be clear that this spend-down waiver provision encompasses financial eligibility determinations for all of the current long-term care services currently specified in Medicaid Rule 4412, along with any expansions included in the new waiver proposal. We would object to any interpretation of this waiver language that might have the effect of terminating eligibility for any person currently deemed financially eligible for long-term care services.

The waiver proposal should, for purposes of clarity, also specify the availability of the one-month spend-down option for eligibility for hospice services.

The language regarding “the onset of waivers” is unclear. It is unclear whether this phrase refers only to personal care attendant services or to the entire waiver request. It is also unclear exactly what the word “onset” refers to. In any case, the language is unnecessarily limiting, since the spend-down requirements for financial eligibility are ongoing.

We propose to shorten the final sentence, and end the sentence with, “persons who are receiving personal care attendant services.” This change would clarify that all persons receiving long-term care services, including personal care attendant services, have the flexibility of the one-month spend-down option on an ongoing basis. This change would ensure the maximum number of beneficiaries who could qualify for services under the long-term care Medicaid rules.

11. Freedom of Choice

The breadth and ambiguity of this request to restrict freedom of choice of provider is troubling. The state must specify its intentions, and enumerate the populations and programs that could be affected.

We understand that beneficiaries purchasing a Qualified Health Plan through the Exchange will necessarily be limited to their plan's network of providers. There may be other specific programs for which this waiver is prudent or necessary. However, we object to an across-the-board restriction in choice of providers. The draft request is not sufficiently detailed to enable us to evaluate it.

12. Premium Requirements

This request is vague. We urge you to specify which populations could be affected. It is not clear why a waiver is sought for "optional" populations but not "expansion" populations. The phrase, "as reflected in the special terms and conditions" should be clarified. Does this refer to the special terms and conditions currently in effect for the Global Commitment waiver? There were no draft special terms and conditions made available for public comment.

13. Retroactive Eligibility

AHS must specify what populations will be considered "expansion groups" under the new waiver. It is unclear who would be affected by this waiver provision.

We understand that retroactive eligibility is not available for beneficiaries purchasing a Qualified Health Plan through the Exchange, with the assistance of federal and Vermont subsidies. However, the waiver request is not clearly limited to that population. All populations of beneficiaries who currently have retroactive eligibility should maintain it.

14. Cost Sharing Requirements

We encourage the State to note here, as was done on page 16 in Section IV, that any cost-sharing requirements, or changes to cost-sharing requirements, must be approved by the Vermont Legislature under Vermont law.

15. Direct provider reimbursement

We are puzzled by the title of this section. Vermont premium subsidies do not appear to involve direct provider reimbursements. Rather, the subsidy would go to the Qualified Health Plan insurer.

We strongly agree with the necessity of continuing a similar level of affordability of health care coverage for those beneficiaries moving from VHAP and Catamount to the Health Benefits Exchange. This is crucial for many of our clients, and for the success of health care reform.

Conclusion

Thank you for your consideration of these comments. We applaud the expansion of health care eligibility and services that has been possible through the Global Commitment to Health waiver, and the State's commitment to universal coverage and health care reform. However, we do have concerns about the breadth of the waivers of important federal protections that are designed to ensure that Medicaid benefits are provided and administered equitably. We look forward to meeting with you to discuss this further.

Sincerely,

Sam Abel-Palmer
Staff Attorney, Disability Law Project

Trinka Kerr
Vermont State Health Care Ombudsman

Kaili Kuiper
Staff Attorney, Office of Health Care Ombudsman

Jackie Majoros
Vermont State Long Term Care Ombudsman

Barbara Prine
Staff Attorney, Disability Law Project

Lila Richardson
Staff Attorney, Office of Health Care Ombudsman

Christine Speidel
Staff Attorney, Poverty Law Project

VERMONT LEGAL AID, INC.

SENIOR CITIZENS LAW PROJECT

264 NORTH WINOOSKI AVE.
BURLINGTON, VERMONT 05402
(802) 863-5620 (VOICE AND TTY)
FAX (802) 863-7152
(800) 747-5022

OFFICES:

BURLINGTON
RUTLAND
ST JOHNSBURY

OFFICES:

MONTPELIER
SPRINGFIELD

March 22, 2013

Ashley Berliner
Department of Vermont Health Access
289 Hurricane Lane, Williston, VT 05495

Re: Comments on Section 1115(a) Global Commitment Extension Request

Dear Ms. Berliner:

We submit these comments behalf of the Community of Vermont Elders and the Senior Citizens Law Project of Vermont Legal Aid. In contrast to the public input process involving the Duals Demonstration waiver, there has been little public input about these proposed changes, and the draft waiver extension proposal provides only cursory details. This is particularly true about any programmatic or administrative changes to Choices for Care (CFC), and how that would impact long term care in Vermont.

Therefore, we have concerns that Medicaid beneficiaries will be adversely affected as a result of the extension of the Global Commitment waiver and the consolidation of Choices for Care under Global Commitment. We are concerned that this waiver will depart from current methodologies, standards, eligibility criteria and coverage provisions and diminish rather than expand eligibility and services. We would request that any approval of this waiver extension include terms and conditions to ensure that current beneficiaries are grandfathered into this new program, and that eligibility and covered services are only expanded and not reduced from the current waiver programs.

Given these uncertainties, we cannot support including Choices for Care in Global Commitment, separately from the Duals Demonstration, without additional assurances regarding the scope and nature of those changes to CFC, and without ensuring substantial protections for beneficiaries.

I. Choices for Care Savings and Budgeting

A core aspect of the CFC waiver was for the State of Vermont to reinvest savings back into the program in order to further expand home and community based service options for beneficiaries. Instead, savings have been consistently diverted away from CFC. The terms and conditions for the CFC waiver require Vermont to add resources to the system equivalent to a minimum of an additional 100 Home and Community Based "slots" per year. Although the program grew in the

initial two years, enrollment and spending on Home and Community Based Services has been flat or declining since approximately February 2008, more than 5 years total. Any consolidation of the CFC waiver into Global Commitment should clearly specify the methodology for calculating savings from CFC and require that the savings be reinvested in home and community based services. The terms and conditions of the extension waiver should explicitly continue the CFC requirement to expand services by a minimum of 100 “slots” per year.

Elimination of the High Needs Waiting List

CFC has been very successful for the State of Vermont in terms of achieving overall savings. Those savings from CFC should be reinvested in the program. Currently, as a result of the savings in CFC, there is no “high needs” waitlist. Clinical eligibility for CFC at the “highest needs” level is significantly more restrictive than the federal Medicaid criteria. The high needs group includes individuals in nursing facilities, residential care homes and in the community who would qualify as nursing home level of care under federal law but can be denied participation in CFC. A CFC waitlist for nursing home care and for home and community based services is inconsistent with the stated health care reform goals for Vermont as set out in this waiver extension. Proper reinvestment of the savings achieved should ensure that a waitlist for essential services is no longer necessary.

Moderate Needs Group

We strongly support the proposed expansion of services available to the moderate needs group. Although those services are limited, our clients appreciate the services offered and have found the assistance to be valuable. In addition to expanding the range and scope of services, the waiver should also continue to expand enrollment and reduce barriers to eligibility. Enrollment, eligibility, and the waitlist for the moderate needs group should be administered centrally by DVHA under Global Commitment, like any other aspect of Medicaid, and should not be distributed as limited funds to local providers.

II. CFC and Medicaid Administration and Processing

One of the stated goals is to achieve administrative simplification by consolidating administration of all health care programs, including CFC, into one unified waiver. The extension waiver request does not explain how these programs would be restructured, and does not explain what role the Department of Disabilities, Aging, and Independent Living would continue to have, if any, for CFC. The waiver should specify how the programs will be administered and how that will impact beneficiaries.

Application Processing

The current Medicaid application process creates barriers to access and delays in financial eligibility determinations. This is true both for community Medicaid and for long term care Medicaid under CFC. Vermont has consistently failed to process applications for Medicaid in accordance with the Federally mandated requirements, and applications for long term care Medicaid can take months to process. The application process should be simplified and

streamlined as part of the administrative consolidation of CFC. Presumptive eligibility determinations should be expanded. The waiver extension should require the State to have an adequate infrastructure to process all Medicaid applications in a timely way, including providing assistance to those applicants who need accommodation.

Notices

The notices currently provided to deny CFC or to reduce long-term care services are inadequate. Specifically, CFC notices provide general information but not the factual and legal basis for the decision in a manner that can be reasonably understood by beneficiaries. The SCLP regularly reviews CFC notices, and even though we specialize in Medicaid law, we are often unclear on why the Department is taking the action set out in the notice. Proper notice is an essential aspect of the right to a fair hearing process. As CFC is incorporated into the managed care framework of global commitment, beneficiaries are entitled to clear and specific notices about their eligibility and level of services. These protections should be set out in the terms of the waiver.

III. Revised Income Eligibility Standards

We support the transition to MAGI based income eligibility for TANF-related Medicaid. We support increasing the resource limit to \$10,000 for long term care Medicaid. We support more liberal income and resource eligibility standards generally. However, we do have some concerns about how these changes may impact seniors and persons with disabilities now and in the future.

SSI Related Medicaid “MAGI” Cliff

As we understand the transition to the new methodology, individuals that are not eligible for Medicare will be eligible under MAGI. However, as those same individuals reach age 65, or qualify for Medicare after 2 years of disability, they will then transition to SSI related Medicaid. We are concerned that some individuals may lose Medicaid eligibility based on resources or based on the lower income standard of the PIL. As part of implementing health care reform through this waiver, this eligibility cliff should be eliminated or minimized. The waiver extension does not discuss changes to the Medicare Savings Plans, but expanded eligibility for an MSP may be the most effective and seamless way to ensure continuous health care coverage for this needy population. This could be achieved by increasing disregards, or aligning the MSP eligibility with the MAGI formula.

Medically Needy Eligibility

It is unclear if the waiver extension intends to change eligibility standards for spending down in either community Medicaid or for long term care Medicaid. We oppose any change to the spend down methodologies that are more restrictive than current standards.

Deeming

It is unclear if any changes to the deeming rules apply to the SSI-related Medicaid rules. We oppose any change to financial eligibility, including family responsibility and deeming rules, that restrict eligibility.

IV. Beneficiary Protections

To the extent the terms of either waiver are modified or changed, the purpose of those changes should only be to expand services or eligibility or protection of the beneficiary. The CFC terms and conditions set out a variety of protections for the beneficiary. If the CFC waiver is consolidated into Global Commitment, all of the provisions protecting beneficiaries' rights should be incorporated into the extension waiver. This includes explicitly requiring that beneficiaries and applicants have access to ombudsman and advocacy services as part of the waiver.

Thank you for consideration of these comments.

Sincerely,

Michael Benvenuto
Project Director

cc: Gini Milkey, Community of Vermont Elders
Michael Sirotkin, Esq.

Bi-State is a private nonprofit organization with a broad membership of thirty-two organizations that provide and/or support community-based primary care services. A ‘voice’ for the medically underserved, Bi-State members include Community Health Centers, Rural Health Clinics, private and hospital-supported primary care practices, Community Action Program, health care for the homeless programs, Area Health Education Centers, clinics for the uninsured, and social service agencies. Bi-State works with federal, state and regional health policy organizations and policymakers, foundations and payers to develop strategies, policies and programs that promote and sustain community-based, primary health care services. The mission of Bi-State is to foster the delivery of primary and preventive health services to the people of Vermont and New Hampshire with special emphasis on the medically underserved.

Bi-State’s VT members include all eight VT FQHCs, the majority of VT’s Rural Health Clinics, free clinics, women’s health services, hospital-based primary care practices, and Area Health Education Centers; collectively these organizations provided primary care for more than 190,000 in 2011 or (1 in 4 Vermonters). Bi-State encourages DVHA to follow the principles for Health Care Reform stated in Act 48, “Primary care must be preserved and enhanced so that Vermonters have care available to them, preferably within their own communities”.

Please see Bi-State’s comments on the Global Commitment Waiver Renewal listed below.

Page 11:

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.

Bi-State and their members have been active partners in payment reform. Bi-State members and all eight FQHCs are Blueprint practices. Members of Bi-State are also participants in the St. Johnsbury Oncology/Palliative Care Pilot from the GMCB. The VT FQHCs and our members are willing to put policy into practice and participate in payment reform pilot programs.

Page 17:

Streamlined Eligibility Transition Process and Premium Subsidies:

Providing a “safe harbor” approach will allow for less disruption of insurance coverage and the ability to 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.

Bi-State supports the efforts to maintain insurance coverage for Medicaid beneficiaries and provide a “safe harbor” approach to those who are due for eligibility recertification. With the implementation of the Exchange the concern is that there will be “churn”, patients falling off of insurance coverage. Bi-State supports the efforts to address this issue so that our patients can maintain access to affordable, high quality, primary care.

Page 17:

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.

Bi-State supports the efforts to provide funding to patients who will see an increase in their co-pays and /or out of pocket expenses under the ACA. The ability for patients to maintain health insurance coverage that is affordable is essential to providing adequate access to primary care.

Page 20:

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.

If additional waivers are sought, will there be a public notice and opportunity to comment on these additional waivers from CMS?

Please do not hesitate to contact me with any questions.

Best,

Susan Barrett, J.D.
Director of Vermont Public Policy
61 Elm St.
Montpelier, VT 05601
802-229-0002 ext. 218 office
802-238-3992 cell