

1. Global Commitment:

- a. How critical are the specific (particularly the Employer subsidy) policy recommendations you made to the waiver? To what degree does the enhanced federal funding depend on these i.e. your specific policy initiatives?

**Response:** The funding agreement we are trying to reach with the federal government does not depend on any of the specific policy initiatives in the Governor's Saving Medicaid Plan (January 19, 2005) or that are described in the February *Global Commitment to Health* concept paper. However, the Employer-Sponsored Initiative (ESI) does require approval via a waiver or other mechanism.

The state is seeking to enter into an 1115a waiver. There is no explicit request for "enhanced" federal funding.

- b. The exit potential of the waiver is unclear. The concept paper says the state could "seek authority" to leave the waiver in the event of an emergency subject to CMS determination. Shouldn't the criteria of CMS approval of withdrawal be clear?

**Response:** The criteria for the State's ability to suspend the waiver in the event of a national emergency or catastrophic event will be clearly defined in the Terms and Conditions of Approval before the Waiver agreement is signed. The exit strategy at the end of the five year term will depend entirely on where the state is vis a vis the national Medicaid program at that point in time. The state will negotiate the ability to extend the waiver concept. Beyond that the waivers, as with all demonstrations, could be terminated at the end of the five year term.

- c. What is the financial structure of the Global commitment going to be in practice? Will it work like the current waiver i.e. constrained by a five year trend line for federal cost or a block grant? Will all Medicaid match disappear or just some of the match?

**Response:** The Waiver we are seeking will function differently than the existing 1115a waiver. The *Global Commitment to Health* waiver agreement would provide us with an annual guarantee of federal funds each year for five years. This annual amount will be comprised of two parts: a "lump sum" payment that reflects federal expenditures in a base year (we are proposing to use SFY04), and a trend rate applied to this base each year, which will be built on Vermont's historical expenditures and caseload growth. We will need to manage within this total amount each year.

**The State will agree to guarantee to provide benefits to specific populations (e.g., ABD) with the understanding that we will have to continue to use state funds in order to financially afford these services under the agreement. In addition, we will clearly define (in our proposal and in the Terms and Conditions of Agreement) the process that will be used in the state to make any changes in eligibility, benefits, or beneficiary payment requirements for Medicaid services. Of course, legislative approval is at the core of this process. No policy changes will be made without legislative approval.**

- d. The concept paper includes all Medicaid spending in the state. The financial summary provided so far only shows the impact in the Health Access Trust Fund portion of the total Medicaid program. Please provide a detailed five year financial projection with and without the Global Commitment for all other Medicaid funded areas – VDH – MH – Substance Abuse – DAIL – DS- DCF – School Based Services etc.

**Response: A detailed funding analysis is currently under development and will be provided as soon as it is available.**

- e. If final approval comes after July 1, and the enhanced federal funding that the proposal relies on to be solvent for FY06 and beyond is not available or significantly lower than projected, how do you envision making these lost revenues up? For example the plan counts on the state receiving 100% of the premium payments.

**Response: We are currently committed to the July 1, 2005 implementation timeline. To the extent that federal approval is received subsequent to that date, the state of Vermont will request retroactive authority back to July 1, 2005.**

- f. There is potential congressional action to provide Medicaid relief currently in congress. If this relief is forthcoming, how will Vermont's interest be protected?

**Response: Our proposal for the Waiver will include a clause in the Terms and Conditions of Approval that states; “any changes in Federal Law which would benefit State Medicaid spending in the absence of a waiver demonstration will be incorporated into a modified budget limit for the demonstration.”**

- g. At the end of the 5 year period, what will be the status our existing waivers should we decide not to continue under the global commitment?

**Response: Our existing waivers will no longer exist. However, there will be an “Extension or Phase-out Plan” clause in the Terms and Conditions of Approval for the Global Commitment to Health Waiver. This will specify the timeframes and terms for negotiating an extension of the Waiver, or if so desired, phasing-out the waiver in a manner that protects existing beneficiaries and services. This is true for all demonstration projects.**

2. Premium Subsidies:

- a. You propose uninsured parents and caretakers with incomes between 150 and 185% of poverty to only be eligible for premium subsidies. What about those where no health insurance option exists? Doesn't this create two classes of parent/caretaker?

**Response: The Governor's Premium Assistance Plan would provide subsidies to assist individuals in the purchase of health insurance. There would be no Medicaid coverage for individuals currently enrolled in the caretaker relative program. Individuals who do not have access to employer-based coverage have access to the individual market. BCBSVT and MVP offer options in this market and both premium and deductible subsidies would be available through the Governor's Health Care Plan in H. 102 for this coverage.**

- b. Based on your premium subsidy approach to caretakers and VHAP program entrants, how many more uninsured to you expect will result from these and other elements of your plan?

**Response: If the Governor's Premium Assistance Plan were enacted along with all aspects of the Governor's ESI, the net impact on insured status is estimated to be a gain in the number of lives covered. HCA worked with an independent research organization to project participation rates for the various components of the Governor's Health Care Plan. Research included focus groups and interviews with 200 small employers in Vermont and 300 uninsured individuals. At the end of the first full year, it is projected that there would be 9,750 newly enrolled individuals through the Premium Assistance program in small businesses and another 2,300 through the premium assistance in the Individual Market, for a total of 12,050 newly insured Vermonters.**

- c. Is subsidizing individuals to participate in employer plans that would otherwise be eligible for Medicaid a cost shift to Vermont's employers?

**Response:** By providing access to existing private coverage options Vermont would strengthen the overall health care financing system and provide coverage to more Vermonters. Yes, ESI would shift some individuals from solely taxpayer supported health care to existing employer based health coverage.

Under the Plan in H 102, small employers not currently offering insurance and those that are currently offering who meet certain financial criteria, will benefit from a refundable tax credit. The program does not cost shift to employers for several reasons:

- Attracting younger healthier individuals to the private insurance market improves the risk pool by spreading the cost of medical claims across a larger base.
- Reducing the number of Vermonters on Medicaid, reducing the number of uninsured Vermonters and increasing the number of Vermonters with private insurance where reimbursement to providers is higher, overall reduces the amount that providers need to make up in uncompensated care.

- d. Are the premium subsidies for the expansion to 300% FPL in the governors H. 102 proposal funded through the premium tax alone? Won't this tax just be pushed back onto other parts of the system? How will the language intended to avoid such a cost shift be effective? Is there any federal participation anticipated for this expansion - in the base setting for the global commitment? how much? If no federal financial participation is anticipated why is it a part of the waiver?

**Response:** Yes, federal financial participation will be requested at the regular match rate as part of the rate. The H 102 subsidy is funded by the expansion of the premium tax to all insurers in Vermont. For reasons noted above, a cost shift is not anticipated. BISHCA, in its review of insurance rates and hospital budgets will be responsible to ensure that providers and hospitals do not cost-shift absent a showing of significant financial hardship.

- e. Is the \$2.326 million that is to be saved from under 150% VHAP new enrollees who are otherwise eligible for private insurance, a net savings number with the premium subsidy already deducted out? Or, is \$150,000 to cover all administrative expenses and the subsidy?

**Response:** Yes, the \$2.326 million is a net figure. The \$150,000 is for the administration only.

- f. How will the new VHAP subsidy program be administered? Arguably there could be considerable negotiations required as the state subsidizes premiums as it will impact employer's payroll and payment systems. As employer changes in cost or coverage occur how will the system be designed to respond in a way that meets participant's needs?

**Response:** The administration of the program would be coordinated with the Governor's Premium Assistance Plan and managed out of the Office of Vermont Health Access (OVHA). The details regarding the subsidy are a matter of policy for the legislature to establish.

3. Nursing Homes:

- a. Raising nursing home occupancy thresholds is designed to save \$1.02 million. It penalizes nursing homes that have been participants in efforts toward nursing home alternatives thereby lowering bed counts. How will this change of reimbursement impact our goals of home health care?

**Response:** This proposal is not designed to penalize facilities that have helped reduce beds. It is designed to create higher efficiency in the nursing home system. Otherwise, the state Medicaid program is in the position of paying more for empty beds, which reduces the funds available for expanding home based services. Due to this proposal nursing homes with low occupancy will have an incentive to negotiate a reduction in beds. As some homes with chronic low occupancy right-size, the rest of the facilities should see improved occupancy and the whole system will be healthier. In some cases, the state will be able to use savings from reduced beds to cover the downsized facility's fixed costs and still have funds for increased community services. Overall this proposal is designed to result in greater efficiency and stabilization of the nursing home system.

- b. Eliminating the automatic COLA saves \$1.2 million in your proposal. Together these two proposals threaten survival of institutions which will become increasingly important as the population ages. This is a greater concern where there is one such facility in a geographic region. How will we preserve a system which will be important to us in the future?

**Response:** The AHS recognizes the need for nursing home beds. However, consumers strongly prefer alternatives, whether staying at home or in assisted living. This will become even more the case as the baby boomers age. The AHS does not believe there will be a need for all of the nursing home beds available currently, even as the population ages. It is likely that as the AHS expands home care options, there will be some downsizing of nursing

**homes and 1-2 may actually close. The AHS recognizes the importance of having the proper number of nursing home beds for every region of the state. The AHS has taken steps in the past, and will in the future, to ensure that proper level of service.**

**The AHS is discussing with the nursing homes alternative ways to arrive at the nursing home system's share of the provider reductions, which now stands at \$4.4 million. One proposal has to do with contracting for a certain number of nursing home days of care. This proposal would permit the AHS to better target the impact of the reductions. If we are unable to get approval from CMS or agreement from the nursing homes to pursue this option, the AHS will have to resort to reducing or eliminating inflation.**

4. Provider Discussions:

- a. Two months ago you developed a proposal that counts on \$21 million in savings from providers. What is the current status of these discussions and do you now have \$21 million of recommendations to put forward?

**Response: The discussions continue. Below, please find the Administration's recommendation for the distribution of the \$21 million across provider types.**

<b>Hospital</b>	<b>\$17,750,000</b>
<b>Physicians</b>	<b>\$1,950,000*</b>
<b>Dental</b>	<b>\$800,000</b>
<b>Home Health</b>	<b>\$2,000,000</b>

**\*This includes all CPT Code Billers**

**The new total adds \$1.5 million to the total reduction of \$21 million in order to reduce the impact on nursing homes in the original list of 23 items. The original nursing home impact in the 23 items (not counting the \$21 million in provider reductions listed above) was \$5.9 million. With the \$22.5 million reflected above, the total impact on nursing homes is able to be reduced to \$4.4 million. (Please see answer 3b for more information)**

- b. In January, you have suggested: rebalancing the system using methods employed by health plans; adopting inpatient rates that reflect utilization; shifting to cost based reimbursement; requiring increased use of prior authorization, group visits, phone and email consults. Are these proposals still on the table? If so, can you explain them?

**Response:** There are a number of proposals on the table for modernizing and rationalizing the payment system. However, none of these proposals are able to be implemented in a timeframe to allow for utilization within SFY 2006. The Administration would be pleased to engage in conversations on the subject over the course of the next 6-9 months.

- c. You claimed that these \$21 million in savings “must be made without adding to the insurance burden of other insured Vermonters through costs shift.” Can you explain how you would prevent a resulting cost shift?

**Response:** To be provided.

5. RX and Medicare Wrap:

- a. You proposed a complete wrap for pharmacy recipients. Administratively this is fairly complex and costly. Have you committed to such a course? How are you handling the resultant administrative burden?

**Response:** The Governor has committed to a Medicare Wrap through his repeated statements that no Vermonter will be financially disadvantaged as a result of MMA. The Agency of Human Services has a Medicare Modernization Act Workgroup that is planning for the implementation of the MMA in Vermont. The administrative burden of having a wrap for MMA is part of the work of the AHS MMA workgroup.

- b. How will the wrap proposed meet the State pharmacy assistance program requirements of the Medicare modernization act?

**Response:** The proposed wrap program will amend the existing state law to allow for a pharmacy program that is secondary to Medicare’s Part D Drug coverage beginning on 1/1/06. This program, VPharm, will provide for financial coverage for Medicare Part D Eligibles and continue to allow Medicaid only pharmacy eligibles to be covered in existing Medicaid or pharmacy only programs.

- c. Why have the PDL and generic drug requirements previously enacted not yielded better results in slowing drug expenditures in Medicaid? Please provide the information previously requested on the brand v. generic utilization experience in the Medicaid program.

**Response:** Vermont’s PDL and the generic drug law are two tools that over the past several years have allowed Vermont to substantially slow the rate of growth in pharmacy spending.