

JAMES H. DOUGLAS  
GOVERNOR



State of Vermont  
OFFICE OF THE GOVERNOR

April 15, 2005

Mike Leavitt, Secretary  
The U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, DC 20201

Dear Secretary Leavitt: *MIKE*

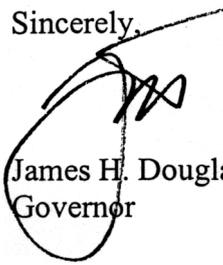
I am very pleased to submit to you *Vermont's Global Commitment to Health*, an 1115a Medicaid waiver proposal designed to reform our state Medicaid program.

This proposal describes an approach that will help both Vermont and the federal government manage its Medicaid expenditures at a sustainable level over the next five years, while also providing Vermont with the flexibility to determine how to use its health care resources to improve service effectiveness and efficiency. As you are aware, Vermont has been a national leader in many areas of health care, and we believe that this waiver is essential for us to continue in this direction.

We very much appreciate the assistance provided by your staff in the Centers for Medicare and Medicaid Services (CMS) as we developed this proposal. We look forward to working with them to successfully negotiate the terms and conditions of this waiver.

Thank you for your efforts to help address States' concerns and for your assistance with this proposal as it moves forward.

Sincerely,



James H. Douglas  
Governor

JHD/hkp

cc: Dennis Smith, Director, CMS Center for Medicaid and State Operations  
Bruce Greenstein, Director, CMS Division of Integrated Health Systems  
Maggie Grant, Office of Intergovernment Affairs, The White House  
Michael K. Smith, Secretary, Vermont Agency of Human Services  
Charles P. Smith, Secretary, Vermont Agency of Administration  
Joshua Slen, Director, Office of Vermont Health Access  
Jean Close, CMS Disabled and Elderly Health Program

# **Vermont Global Commitment to Health**



**A Proposal to the  
Centers for Medicare and Medicaid Services (CMS)**

**Submitted by**

**The Vermont Agency of Human Services  
Office of Vermont Health Access**

**April, 2005**

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- ◆ Summary of Questions / Comments with Responses

# Chapter 1: Background on Vermont's Current Medical Assistance Programs

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## *Introduction*

The state of Vermont has been a national leader in making affordable health coverage available to low income children and adults. Vermont was among the first states to expand health coverage for children and pregnant women, through implementation of the state-funded Dr. Dynasaur program in 1989. The Dr. Dynasaur program subsequently became part of the state-federal Medicaid program in 1992.

In 1995, Vermont implemented a section 1115a Demonstration waiver program known as the Vermont Health Access Plan (VHAP). The program's primary goal was to expand access to comprehensive health coverage for uninsured adults with household incomes below 150 percent of FPL (later raised to 185 percent) through enrollment in managed care. VHAP also included a prescription drug benefit for low-income Medicare beneficiaries who did not otherwise qualify for Medicaid.

When the federal government introduced the State Children's Health Insurance Program (SCHIP) in 1997, Vermont took full advantage by extending coverage to uninsured and underinsured children living in households with incomes up to 300 percent of the Federal Poverty Level (FPL).

In 2000, the VHAP waiver was further amended to add the Community Rehabilitation and Treatment (CRT) program which serves 3,000 low-income Vermonters with serious mental illnesses.

Vermont also has implemented a number of 1915(c) Home and Community Based Services (HCBS) waivers to provide services to persons with disabilities in non-institutional settings. Vermont was among the first states in the country to move its entire population of individuals with developmental service needs from institutional settings into the community.

Vermont has made enormous progress over the past fifteen years in reducing the number of uninsured in the state. Vermont's average uninsurance rate for the three-year period between 2001 and 2003 was 9.9 percent, sixth lowest in the nation. (Many of the remaining uninsured are low income working adults with incomes between 185 and 300 percent of FPL.) In State Fiscal Year 2004, there were approximately 36,000 persons enrolled in the VHAP managed care and prescription benefit programs and another 95,000 traditional Medicaid beneficiaries. The State today covers nearly one-in-four Vermonters through its public health insurance programs.

Recently, the State has been negotiating the terms of a new Demonstration Waiver with CMS for the Vermont Long Term Care program. That initiative will be carried forward under the *Global Commitment to Health* Demonstration, as later described in this Waiver proposal.

*The Problem*

Vermont's achievements have been substantial, but they are now being jeopardized by the ever escalating cost and complexity of the Medicaid program. While the state has consistently kept Medicaid expenditures within VHAP waiver budget neutrality limits, the Vermont Medicaid program today faces the prospect of large and deepening annual deficits<sup>1</sup>. Without program changes in fiscal year 2006, the Medicaid deficit will be approximately \$78 million.

Figure 1.1 below presents current revenue and expenditure projections for Vermont through SFY2010 for the OVHA Medicaid budget. As it shows, the cumulative deficit over the upcoming five fiscal years, if unaddressed, will be \$597 million.<sup>2</sup>

**Figure 1.1 - Projected Medicaid Deficit (see footnote 2 below)**

	SFY06	SFY07	SFY08	SFY09	SFY10
Revenues	\$ 592,427,900	\$ 624,763,101	\$ 661,943,534	\$ 706,523,987	\$ 750,624,192
Medicaid Cost	669,956,397	725,164,761	784,967,881	849,749,582	919,925,818
Net Revenue/(deficit)	(77,528,497)	(100,401,660)	(123,024,347)	(143,225,595)	(169,301,626)
Carry forward	<u>16,307,127</u>	<u>(61,221,370)</u>	<u>(161,623,030)</u>	<u>(284,647,377)</u>	<u>(427,872,972)</u>
Year-end balance	\$ (61,221,370)	\$ (161,623,030)	\$ (284,647,377)	\$ (427,872,972)	\$ (597,174,598)

In his SFY 2005 budget adjustment, Governor Douglas proposed that \$39.1 million of surplus general fund revenue be allocated to shore up Medicaid. The Governor also has recommended that an additional \$10 million in base dollars be appropriated to the Health Access Trust Fund (HATF) for SFY 2006. Together, these will add one-time and ongoing revenues of nearly \$50 million dollars, yet they will provide only temporary relief.

Vermont recognizes that it cannot tax its way out of the projected deficits. Taxes would have to be raised each year to keep pace with program growth. Figure 1.2 illustrates the impact of trying to fund the deficit, for only the part of the program in OVHA's budget, by increasing either the sales or personal income tax.

**Figure 1.2 - Scale of Medicaid Deficit Relative to Two Major Tax Sources (in millions)**

Scale of Projected Medicaid Deficit Relative to Two Major Tax Sources					
	Fiscal Year				
	2006	2007	2008	2009	2010
<b>Projected Annual Medicaid State Fund Deficit Unabated</b>	\$61.20	\$100.40	\$123.00	\$143.20	\$169.30
<b>Increase in Tax Revenues Necessary to Meet Deficit</b>					
Sales Tax: Cumulative Percentage Increase	21%	36%	44%	51%	60%
<b>-OR-</b>					
Income Tax: Cumulative Percentage Increase	12%	20%	23%	26%	29%

<sup>1</sup> Deficit as used here means a shortfall in state appropriations (and associated federal matching dollars) as compared to program needs, not a budget neutrality deficit.

<sup>2</sup> Due to a recently announced decrease in the federal participation rate for FY2007, the five year cumulative deficit for the OVHA Medicaid budget is now estimated to be \$656,803,489.

Vermont's Medicaid program needs fundamental, systemic change. The factors driving growth, including restrictive use of resources and growing program complexity, must be brought under control. Everyone, including beneficiaries and providers, needs to share equitably in the solution.

The nature of the problem was summarized by Governor Douglas in his inaugural address this past January. Governor Douglas also defined the principles which must guide the state's Medicaid reform efforts:

*"Today, we face at least a seventy million dollar deficit in Medicaid. Left unrestrained, the very next legislature, in the very next biennium, will confront a deficit of almost two hundred seventy million dollars – over a quarter of a billion dollars. That's an amount equivalent to twenty-five percent of our entire general fund budget.*

*"This deficit would be the largest in Vermont history. It threatens our fiscal stability, basic economic and health protections, and the already over-taxed Vermonter.*

*"To eliminate a deficit of this magnitude, the legislature would have to impose draconian tax hikes on working people: raising personal income taxes by over fifty percent or nearly doubling the sales tax or almost quadrupling the gas tax.*

*"These tax hikes would destroy the foundation of our economy. The fact is plain: we cannot, should not and must not tax our way out of this problem.*

*"It falls on us – all of us – to find a solution that will save Medicaid for future generations before it collapses under the burden of its own weight. Getting spending under control will require leadership, and I am prepared to provide it. A solution will require a commitment as well from you, the legislature, to make those tough decisions required to put a responsible bill on my desk.*

*"As you consider all of the other spending pressures you will surely face, including and especially additional health care spending, I ask you to tend to what we already have. I ask you to save Medicaid first...The plan that I (offer) is built around five fundamental principles to which any comprehensive plan must adhere.*

- ✓ *Real health care reform must lower the cost of care for those Vermonters who are struggling to keep up.*
- ✓ *Reform must be patient-centered and put decisions in the hands of patients and their doctors, not politicians and bureaucrats.*
- ✓ *Reform must increase choices and options of care.*
- ✓ *Reform must be affordable for Vermonters and sustainable for state government."*

The requirements of Medicaid law are lengthy and extremely complex. Currently, it takes months to change one small aspect of a waiver program even if the change is more customer-friendly, such as changing the wording in a consumer notice or revising eligibility criteria to be more inclusive. One of the major incentives for our proposal to CMS is to receive operational flexibility in administering the new *Global Commitment to*

*Health Waiver.* However, this does not mean that the State will have total flexibility – the State will still have negotiated terms and conditions that will identify core groups and services that will be covered. These terms will further require Vermont to adhere to existing consumer protections, such as federal rules regarding eligibility appeals and complaints and grievances. The State also will want to incorporate its existing waiver programs into the *Global Commitment to Health* demonstration waiver, as they have served Vermonters very well. However, the new Waiver will provide an overall financial agreement and additional flexibility that will be more beneficial to Vermont than the existing 1115a and 1915(c) waivers.

In the context of the *Global Commitment to Health*, the term “flexibility” means that Vermont as a state will be able to make policy decisions that are most appropriate for Vermont, without having to obtain federal approval. This proposal (and ultimately the Terms and Conditions that govern the operation of the Demonstration) ensure that changes in eligibility, benefits, or beneficiary payment requirements for Medicaid services in the future would be vetted with stakeholders, and would not be implemented without legislative approval. This is the same process that is in place today and will not change under the new Demonstration Waiver.

This application includes the specific statutory requirements that Vermont would like to have waived. The state is not requesting waivers for items related to consumer protections and the due process requirements in federal statutes and regulations.

Vermont is committed to preserving and building on the affordable coverage gains made over the past ten years by developing and implementing creative reforms to the existing program. These reforms, examples of which are described in the next Chapter, will require more flexibility from traditional Medicaid rules than is available under the current VHAP waiver. Vermont therefore proposes a new comprehensive waiver that includes the tools necessary for the state, in partnership with the federal government, to restructure the program and address future needs in a holistic, global manner.

## Chapter 2: Global Commitment Demonstration Design

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In accordance with the Vermont Administration's objectives, and direction provided by legislative leadership, the *Global Commitment to Health* Demonstration is built on the premise that health coverage needs to be comprehensive and continuous. Coverage for essential health services needs to be in place for all Vermonters throughout their lives. Access to health care should not be disrupted by life changes, such as a change in employer, or reaching adulthood. The demonstration proposed is specifically designed to put in place a series of health coverage options to achieve the goal of universal access to health care in Vermont. The program design is specifically responsive to the priorities of the Governor and state legislature. These priorities include universal access, cost containment, system accountability and quality of care.

Medicaid is a major source of health coverage in Vermont, with one in four of our residents covered through this program.<sup>3</sup> Accordingly, it is appropriate that Medicaid take a leadership role in developing and implementing innovative reforms that may serve as a model for other coverage programs in the state. In setting priorities for the proposed demonstration, several key concepts and legislative priorities remain at the forefront:

- High quality health care should be accessible to all Vermonters
- The health of the state's children should be promoted through broad availability of well child services, prevention efforts and education activities
- Appropriate prescription drugs should be available at a reasonable cost
- Health care coverage for the state's most vulnerable populations, including people living in poverty and people with disabilities, should be protected
- Aged and disabled Vermonters should be assisted in remaining as independent as possible in their homes and communities

The proposed Demonstration Design includes many innovative components that may be used in combination to ensure that these priorities can and will be addressed. These features are described below.

### **Innovative Features**

The *Global Commitment to Health* Demonstration is designed to provide Vermont with the flexibility necessary to administer the state's publicly supported health care programs in a member-centered and fiscally sustainable manner. The state intends to adopt a health care financing and delivery model which better addresses the complex and varying needs of its beneficiaries and which can be modified quickly in response to changing demographic and economic circumstances. Simply put, Vermont believes it can do a better job and serve more persons through the *Global Commitment to Health* than it can under the existing constraints of the federal Medicaid and SCHIP programs.

Specifically, Vermont is proposing to enter into an 1115a Medicaid Demonstration Waiver that would capitate the federal spending for all Medicaid services in Vermont for

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<sup>3</sup> And its companion program for children, known as SCHIP.

five years, based on a mutually agreed upon base year and trend rate. Vermont will be financially at risk for managing costs within this targeted amount, and will benefit from any savings accrued due to program efficiencies that are achieved.

Under this Demonstration, the Vermont Agency of Human Services (AHS) will contract with the Office of Vermont Health Access (OVHA), which will serve as a publicly sponsored managed care organization (MCO) and adhere to all federal MCO regulations. OVHA will then either directly administer programs, have intergovernmental agreements or subcontract with various entities to ensure an adequate network of services and providers are in place to deliver the full range of benefits to meet the health care needs of Vermonters, including:

- Primary care
- Acute care
- Long term care
- Home and Community-based services
- Mental health care
- Substance Abuse Treatment
- Pharmacy services
- Public Health initiatives
- Targeted initiatives (e.g., disease management or specialized services)

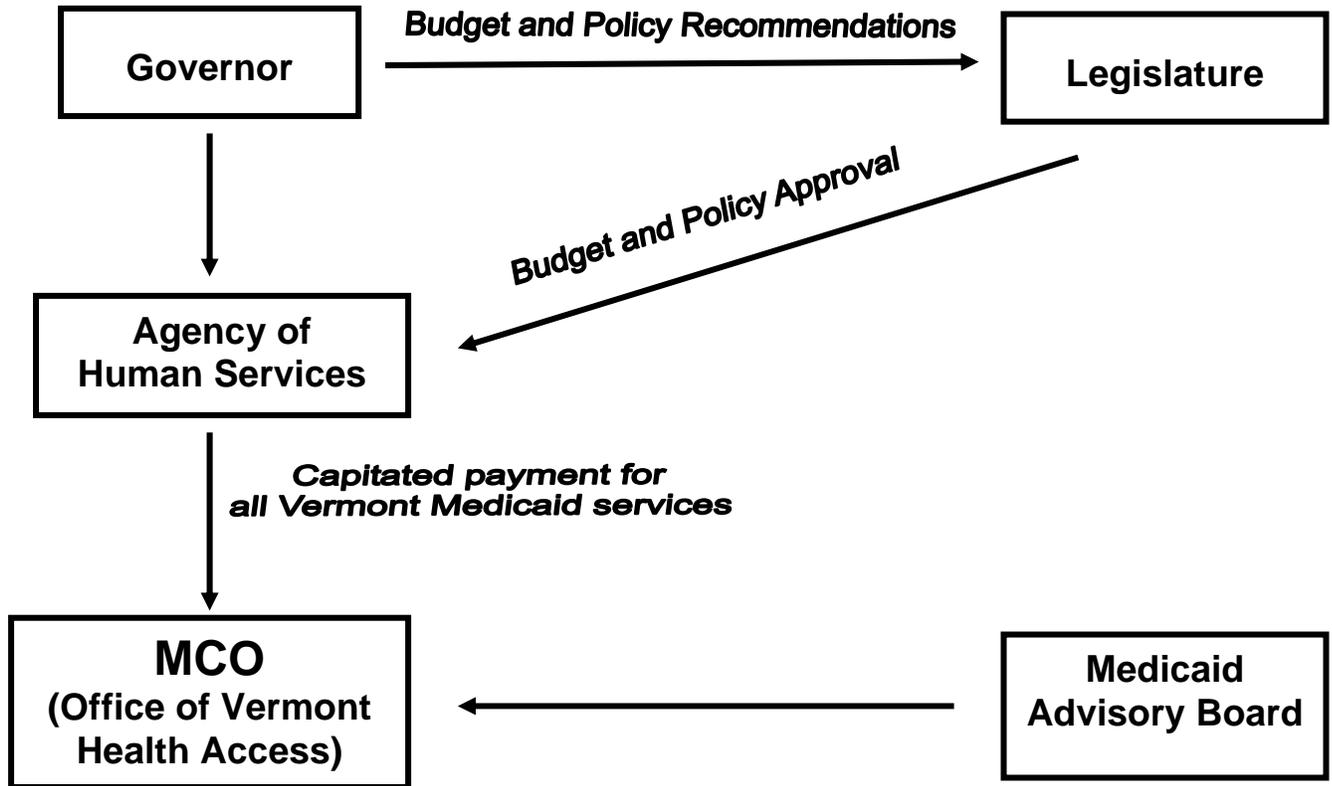
Vermont also will have the autonomy and flexibility to make decisions about changes to its Medicaid program, within the parameters of the Terms and Conditions that guarantee benefits to certain populations during the Waiver period. As is the case today, no policy or program changes that affect eligibility or benefits will be implemented without approval of the Vermont Legislature. Figure 2.1 provides an overview of the proposed MCO organizational structure.

Vermont will continue to serve federally mandated Medicaid populations through provision of a core service package that includes all mandatory Title XIX services. Subject to the availability of funding, the state also will maintain current eligibility standards and benefits for other persons already enrolled in the program.

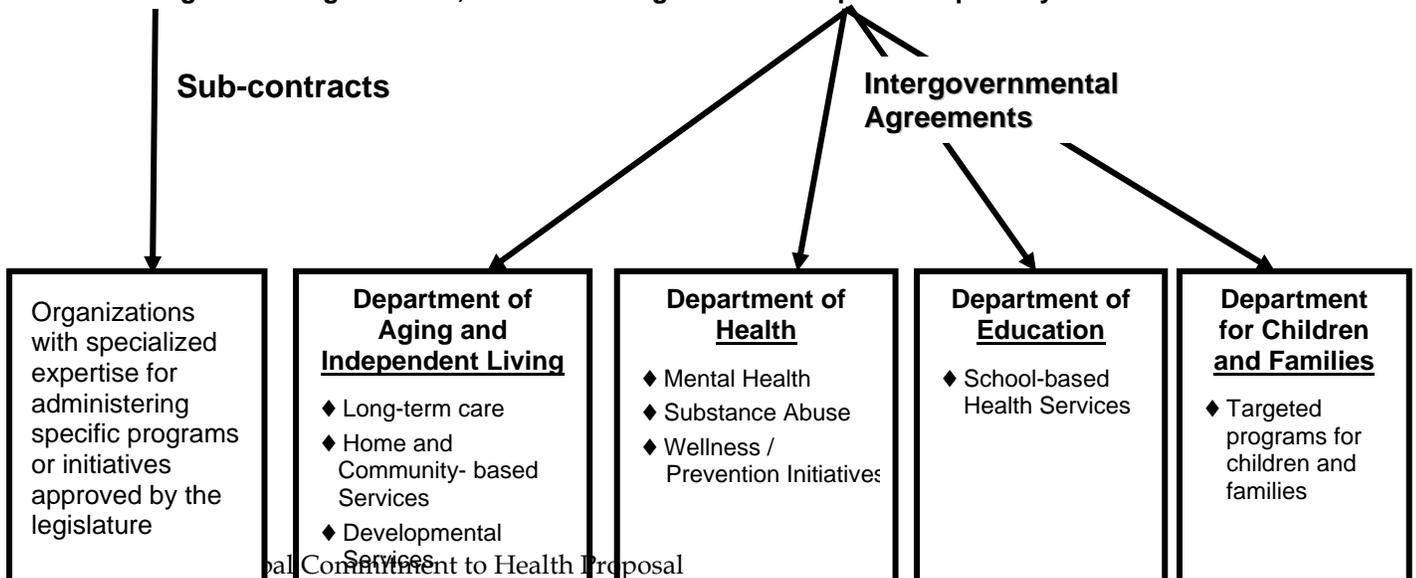
The state will draw from a broad array of options for providing and funding health coverage, although the majority of services will be provided through the public health insurance programs. Specifically, the following programs are proposed for implementation or are under consideration by the State:

- *Public Health Insurance Programs*: The state will continue to operate public programs of health coverage, including the Vermont Health Access Plan (VHAP), Dr. Dynasaur and the traditional Medicaid program covering acute, long term care, mental health and developmental services. The populations served will include all mandatory Title XIX eligibility categories as well as various optional Medicaid groups. Covered services will include all mandatory Title XIX benefits plus many optional services.
- *Premium Subsidies for the Purchase of Employer-Sponsored Health Insurance (ESI)*: With legislative approval, the state may elect to provide premium subsidies to certain eligible uninsured persons who have access to employer-sponsored health coverage. Subsidies would vary based on income and household composition. For eligible individuals and families who do not have access to employer-sponsored health coverage, the state would maintain access to the public health insurance plan.

**Figure 2..1  
OVERVIEW OF VERMONT GLOBAL COMMITMENT TO HEALTH  
MCO ORGANIZATIONAL STRUCTURE**



- ◆ Manages all Vermont Medicaid expenditures under capitated agreement
- ◆ Oversees implementation of all approved policy and program changes
- ◆ Adheres to all BBA MCO requirements and the terms and conditions of the 1115a Waiver
- ◆ Administers the public health insurance programs (Medicaid, VHAP, Dr. Dynasaur) and pharmacy benefits
- ◆ Through formal agreements, funds other organizations to provide specialty benefits



- *Health Savings Accounts (HSAs)*: Eligible persons may have the option to open health savings accounts, with the state making contributions to those accounts on their behalf. Beneficiaries would be required to make a contribution of their own funds in an amount at least equal to what their premium obligation would have been if they were enrolled in VHAP. Participants would also be required to purchase a high deductible health insurance plan, in accordance with federal requirements governing the tax deductibility of HSA contributions.
- *Pharmacy Benefit Plans*: The state intends to offer pharmacy benefit programs to supplement or add coverage for prescription drugs for some populations. The pharmacy benefit design will be established by the state. Cost sharing will vary based on an individual's category of eligibility, and the brand or generic status of the drug prescribed.
- *Home and Community-Based Services Plan*: Vermont will provide home and community based services for lower income residents with long term care needs to the greatest extent possible. Service delivery will be in accordance with the State's long term care waiver, which is currently pending with CMS and the Vermont PACE model currently under development.
- *Specialized Mental Health Programs*: Vermont will continue to provide specialized mental health services to Medicaid eligible persons as it currently does under its Community, Rehabilitation and Treatment (CRT) and Children's Mental Health waiver programs.
- *Community Supported Substance Abuse Treatment*: Vermont may develop community based substance abuse treatment programs for persons in need of treatment, but who are uninsured or underinsured (i.e., their health insurance does not provide adequate coverage for substance abuse treatment).
- *Developmental Services Programs*: Vermont will continue to provide an array of State Plan services to its developmentally disabled residents through its public health coverage program (traditional Medicaid). Expanded services (traditional HCBS waiver services) will be provided based on the beneficiaries' assessed needs and the funding priorities established by the state. The establishment of funding priorities will continue in a manner similar to what occurs in Vermont today.
- *School-based Health Services*: Vermont will continue to fund school-based services for children who meet the eligibility standards developed for those programs. Currently, all children eligible for Dr. Dynasaur are potentially eligible for medically necessary school-based health services. Eligibility standards may expand over the course of the demonstration, but children in mandatory Medicaid eligibility categories will not be affected.
- *Public Health Initiatives*: The state may elect to develop other types of public health programs which support the statewide Chronic Care Model described later in the proposal. The Chronic Care Model may include an array of disease management initiatives and the use of evidence-based clinical practice guidelines. The state may also elect to expand funding for community clinics to enhance the availability of primary care.

- *Beneficiary Cost Sharing (premiums, deductibles, co-payments)*: As a part of its cost containment strategy, and to encourage responsible use of health care services, Vermont may require varying levels and types of enrollee cost sharing. Decisions with respect to cost sharing will be made annually through the legislative process and beneficiaries will be informed in advance of any changes from the prior year's requirements.

The precise combination of programs adopted during the five years of the Demonstration will be determined as the program evolves and will be dependent on available funding and legislative approval. The overall construct will be designed to address, to the extent possible, the differing needs of various population groups, including:

- Ensuring access to health care for uninsured individuals or families with very low incomes
- Ensuring access to care for persons with specialized service needs (e.g., children with emotional disturbances or specialized health needs, adults with serious mental illness, and people with developmental or physical disabilities)
- Developing specialized programs for persons who have chronic conditions that can benefit from case and disease management
- Improving choices for persons by developing alternative coverage options, such as health savings accounts
- Enhancing access for lower-income elderly persons who need home and community based services to avoid being institutionalized in a nursing home

Under the proposed *Global Commitment to Health Waiver*, Vermont as a state will be able to make policy decisions without having to obtain federal approval. However, the Waiver will include terms and conditions that will identify core groups and services that must be covered, consumer protections regarding complaints and grievances, etc., in a manner similar to the existing waivers in Vermont. The State also will want to maintain most aspects of its existing waivers, as they have served Vermonters very well. The Terms and Conditions under which the Demonstration will operate will clearly define the process that will be used in the state to make any changes in eligibility, benefits, or beneficiary payment requirements for Medicaid services. As is currently the case, any proposed changes in benefits and eligibility in the future would be vetted with stakeholders and the legislature, and would not be implemented without legislative approval. This is the same process that is in place today and will not change under the new Demonstration Waiver.

The remaining sections of this Chapter describe the programs in greater detail, including eligibility requirements and benefit provisions. This discussion will provide CMS with a sense of the state's intentions with respect to program development. However, the actual programs and implementation schedules may vary based on when the Waiver is approved, the state's financial position and the outcome of the public policy development process described in Chapter 5 of this application.

## Eligibility Requirements, Benefits and Services by Program

### *Public Health Coverage (Acute care component of Medicaid benefit package)*

Under the *Global Commitment to Health* Waiver, Vermont will guarantee the provision of all mandatory Medicaid benefits to those in the mandatory Medicaid eligibility categories. Vermont intends to retain its traditional Medicaid, VHAP and Dr. Dynasaur programs for low income persons enrolled at the time the *Global Commitment to Health* program is implemented<sup>4</sup>. That is, the state intends to continue to cover current beneficiaries under these programs as long as they continue to meet the eligibility requirements in place prior to the *Global Commitment to Health* program and have no lapse in enrollment.

As such, the transition to the *Global Commitment to Health* program will be essentially transparent to most enrollees in the Medicaid, VHAP and SCHIP programs, as well as for individuals served under the CRT waiver or included in any of the state's HCBS waiver programs. There will be no change in the manner in which these individuals receive their health care, the providers they currently use, or their covered benefits.

During the years of the Demonstration, however, fiscal realities may dictate that either eligibility or benefits, or both, be modified to some degree for non-mandatory populations. While Vermont would prefer not to take these steps, it reserves the right to do so under the Waiver using the public input and legislative approval processes identified in Chapter 5.

For example, due to current fiscal constraints, the Legislature is considering a proposal by the Governor to introduce premiums for children living in households with incomes between 100 and 185 percent of FPL who are enrolled in Dr. Dynasaur, and to increase premiums for higher income Dr. Dynasaur enrollees and for adult waiver populations.

Figure 2.2 below shows the various eligibility groups and the existing premium levels versus what is being proposed by the Governor for FY2006.

**Figure 2.2 Enrollee Premiums: Current and Proposed**

Eligibility Group/Income	Current		Proposed	
	Premium	As Pct of HH Income	Premium	As Pct of HH Income
Children (Dr. Dynasaur)				
Dr. Dynasaur 100 - 185% FPL	\$ -	0.0%	\$ 20.00	1.0%
Dr. Dynasaur 186 - 225% FPL	\$ 25.00	1.1%	\$ 35.00	1.5%
Underinsured Children 226 - 300% FPL	\$ 35.00	1.1%	\$ 50.00	1.6%
Uninsured Children 226 - 300% FPL	\$ 70.00	2.2%	\$ 90.00	2.8%
Adults (VHAP Waiver)				
VHAP 50 - 75% FPL	\$ 10.00	1.3%	\$ 25.00	3.1%
VHAP 76 - 100% FPL	\$ 35.00	3.3%	\$ 40.00	3.8%
VHAP 101 - 150% FPL	\$ 45.00	2.8%	\$ 60.00	3.8%
Weighted Average Based on Enrollment	\$ 20.47	1.0%	\$ 30.84	1.5%

<sup>4</sup> Eligibility for uninsured parents and caretakers with income between 150-185% of FPL is proposed to be eliminated in the SFY2006 budget, subject to legislative approval.

### *Employer Sponsored Health Insurance (ESI)*

Vermont may elect to implement an employer-sponsored insurance option through which the state would provide premium subsidies to persons with access to such coverage. Those individuals would receive the benefits included in their private coverage. The state would only elect to fund the ESI option for certain eligibility groups that are not federally mandated. The twin objectives of offering a premium subsidy option to these groups would be to:

- 1) make the employer coverage more affordable to the individual or family, and
- 2) support the employer sponsored system of health coverage by reducing incentives for lower income workers to elect public vs. private coverage.

In the ESI model currently under consideration, adult applicants (who do not meet the traditional Medicaid eligibility criteria) with incomes below 50 percent of FPL would continue to enroll in VHAP. However, the state may elect to require adults with incomes at or above 50 percent of FPL, who have access to employer sponsored health insurance, to access that coverage option. The State would provide a premium subsidy to assist those individuals in purchasing their employer sponsored coverage. Adults who do not have access to employer sponsored coverage would continue to be eligible for the existing VHAP program.

Similarly, children in households with income at or above 100 percent of the federal poverty level (who qualify for the optional Dr. Dynasaur program) would be required to access employer-sponsored coverage if it is available to them through their parents. If employer-sponsored coverage is not available, the children would be eligible for enrollment in Dr. Dynasaur at premium levels that vary based upon income.

Additionally, and based on available funding, the state may elect to offer premium subsidies to uninsured workers with household income between 150 – 300 percent of FPL. The subsidy level would vary by income level, and would be based on a percentage of the cost of a high deductible health plan.

Because enrollment in the ESI program would apply only to newly eligible individuals with access to ESI, the anticipated shift between the public programs and the employer-sponsored plans would be gradual.

If an ESI program is implemented, Vermont intends to use available SCHIP funds in the *Global Commitment to Health* to fund family coverage when there are children residing in an eligible household. This would preserve the family as a unit in terms of their health coverage and provide further incentives for employers to offer coverage for dependents.

Vermont would not specify a minimum benefit package for the ESI program, other than a basic requirement that the plans cover hospital and physician services. While many employer plans in the state provide a much richer benefit package than the floor established for this premium subsidy initiative, when states mandate a lengthy list of benefits, premiums rise accordingly.

In addition, to protect benefits for the state's most vulnerable children and offset potential increased future costs within Vermont's health care system, the state will explore options to ensure that children and adults with specialized health needs continue to receive needed services and supports that may not typically be covered by private insurers.

### *Health Savings Accounts*

An option currently under discussion is to allow Vermonters who are not inclined to purchase “first-dollar” health coverage – either from a public or private program – to open health savings accounts. These accounts, which would be coupled with a catastrophic, high deductible health plan, should encourage some currently uninsured persons in the state to take steps to plan for routine medical needs and protect themselves and their families financially in the event of a serious illness or injury.

If implemented, Vermont would follow federal guidelines governing HSAs, including the requirement that individuals purchase high deductible health insurance policies, as a minimum. The State would also follow federal guidelines governing maximum contribution levels and the roll-forward of unexpended funds. Distributions from the HSA which are used for expenses other than qualified medical expenses would be subject to income taxes and applicable penalties.

Persons eligible for a premium subsidy could also elect to use the subsidy to fund an HSA. In that case, individuals and families would be required to make a personal contribution at least equal to the premium share they would have paid for VHAP coverage had they been eligible for and enrolled in that program (monthly amounts will range from \$20 - \$90 for each child in the family and \$25 - \$60 for each adult, depending on income). HSA holders would be permitted to contribute additional amounts on a voluntary basis, up to the level of the deductible of their companion High Deductible Health Plan, with a maximum contribution of \$2,650 for individuals and \$5,250 for families<sup>5</sup>. Funds would be available to pay for a full range of health care services, including dental and vision care.

The accounts would operate on a calendar year cycle. Any balances left in accounts at year end would be rolled over into the following year. Contributions made to the account using the state premium subsidy funds would not be taxable to the individual.

Persons who are eligible for ESI premium subsidies, but who are precluded from enrolling until the next open enrollment cycle for the group plan, may elect to deposit their premium subsidies into HSAs. Once they become enrolled in the ESI plan, their premium subsidy would transfer to the employer plan. Any unused funds remaining in the HSA could be used to pay for health care services that are not covered by their ESI. These individuals would not be required to purchase high deductible health plans during the interim period.

### *Pharmacy Benefit Programs*

Dually eligible (Medicare/Medicaid) beneficiaries will have a Medicare Part D Pharmacy Plan as their primary source of coverage for prescription drugs. Under the *Global Commitment to Health* and with legislative approval, Vermont would continue to offer a pharmacy benefit program as a wrap-around to the new Medicare Part D program. This supplemental program for the dually eligible could potentially cover certain categories of drugs excluded from Part D coverage, as well as over-the-counter medications.

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<sup>5</sup> These are the maximum contribution levels for 2005 and will be indexed each year by the federal government.

Vermont will continue to provide a pharmacy benefit program through its public plans (Medicaid, VHAP and Dr. Dynasaur). Generic substitution will generally be mandatory and prescription drugs will be provided based on a preferred drug list. Prior authorization of some drugs or quantities may be required.

The Pharmacy Benefit provided through the public programs (Medicaid, VHAP and Dr. Dynasaur) may also incorporate a number of features designed to better manage drug utilization and costs. These may include:

- Gaining more rapid compliance with the Preferred Drug List (PDL) by bringing major classes of drugs under the PDL that have been exempt
- Providing financial incentives to beneficiaries who switch from brand to generic drugs
- Increasing the number of days of medication a patient with a maintenance drug need can obtain
- Using mail order to pay for certain categories of drugs and supplies
- Offering a maintenance drug benefit that is more consistent with the accepted practices of other health insurers

The State also will continue to offer a pharmacy benefit program for other low income residents who do not have prescription drug coverage. The level of any subsidy will be based on available funding.

#### *Mental Health Programs*

Vermont is a rural state with a shortage of mental health professionals, particularly child psychiatrists. In many cases, children with mental health conditions are treated by primary care providers who may lack the time or expertise to properly diagnose and treat without the assistance of a mental health professional.

Physician-to-physician consults offer one method for stretching scarce mental health resources in a cost-effective manner. Psychiatrists often can provide valuable assistance to primary care providers by telephone in lieu of seeing a patient themselves, but are reluctant to do so without compensation. Under the *Global Commitment to Health*, Vermont will explore reimbursing psychiatrists for this service.

The Vermont community mental health system serves a vital role in meeting community needs. Vermont is a national leader in providing community-based care for individuals with mental health, substance abuse treatment and developmental service needs. In recent years, community providers have faced increasing fiscal challenges as demand for services has exceeded public resources.

Vermont will further rely on the community system as part of its comprehensive plan to close the Vermont State Hospital. Consistent with the state's general philosophy to treat individuals in the community, the State intends to develop community resources to help serve individuals previously admitted to the State Hospital. While initial expenditures for development of alternatives to the State Hospital will be more costly, the State anticipates that the revised system will produce better treatment outcomes and prove cost effective over the long term.

Another challenge facing the community system is balancing the enhanced need for emergency services with available funding streams. Community providers are responsible for providing emergency mental health services in their geographic areas, on a 24-hour/7 days per week basis, for both individuals in crisis and in response to community-wide crises (e.g., violent community events). However, the nature of the service makes it difficult to receive adequate reimbursement on a fee-for-service basis. Under the *Global Commitment to Health*, the state intends to evaluate a service-specific, presumptive funding process for financing community-based emergency services.

The state currently operates its Community Rehabilitation and Treatment (CRT) program for individuals with serious mental health needs under the VHAP 1115 waiver. The state intends to continue to administer the CRT program under the *Global Commitment to Health* demonstration as it currently operates. The state also intends to explore initiatives to identify at-risk individuals to facilitate early treatment. Similarly, the state intends to continue the administration of the children's mental health waiver and develop strategies to efficiently manage the benefits of those enrolled. The state also will continue to provide service and supports for children with mental health needs and their families to help avert crisis and the need for more intensive services and hospitalization.

In addition, individuals entering the correctional system possess a disproportionate need for mental health treatment. The Department of Corrections recently developed a Comprehensive Mental Health Plan to address the growing need for mental health services. Vermont also intends to develop strategies to enhance the continuum of care for mental health services provided to individuals under correctional custody and during their transition back to the community. Through improved coordination, the State expects to improve treatment outcomes, while reducing the incarceration recidivism rate, and improving the overall health of this population.

#### *Programs for Elderly Persons and Individuals with Physical Disabilities*

The Department of Aging and Independent Living (DAIL) is responsible for managing services for individuals with physical and developmental disabilities. DAIL is implementing major reforms of the Vermont long term care system under the aegis of a Section 1115a waiver currently being negotiated with CMS. These reforms would continue under the *Global Commitment to Health* Demonstration.

The Waiver seeks to restructure the long-term care system for individuals receiving nursing facility services, individuals enrolled in the two 1915(c) waivers (Home and Community-Based Services [HCBS] and Enhanced Residential Care [ERC] waivers), and individuals in need of other long-term care services. The waiver is designed to give the state the tools it needs to more effectively manage resources as it faces an increasing demand for long term care by its aging population.

DAIL is also responsible for administration of the 1915(c) Waiver for individuals with traumatic brain injuries (TBI). The state would continue to administer this Waiver program under the *Global Commitment to Health* Demonstration as it does today.

DAIL may seek to undertake additional reforms designed to ensure the cost-effective use of dollars for institutional care, such as introducing selective contracting, or competitive bidding, for nursing facility bed days. At the same time, DAIL will seek to maintain and reinforce the greatest possible array of community-based service options, including attendant services, adult day health, respite care, homemaker services,

supportive housing arrangements, mobility training and other services for the frail elderly.

The state is undertaking other initiatives to better serve individuals with physical disabilities, including implementation of a PACE program. The state anticipates that two PACE sites may be operational within the next twelve to eighteen months. Also, with the support of a Real Choices grant, the state is evaluating alternative delivery systems to integrate acute/primary care with long-term care services. The state believes that alternative systems may present the opportunity to improve consumer choice and outcomes while controlling program costs.

Vermont will also evaluate ways to encourage individuals to purchase long-term care insurance as a way to help reduce health care costs. Vermont is in the process of completing its long-term care insurance regulations. DAIL will work with the long-term care insurance industry, the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), and other interested parties to research methods that encourage the purchase of long-term care insurance. The state will explore financial incentives such as State tax credits or income deductions. The state will also develop a public information initiative to inform consumers about long-term care insurance.

#### *Developmental Services*

Vermont has been successful in offering home- and community-based service options for its developmentally disabled population; as a result, the state's only institution for people with developmental disabilities closed over a decade ago. Under the *Global Commitment to Health* program, the state will continue to provide home and community based services for people with developmental disabilities in a manner similar to how the program operates today.

The program does face long term challenges resulting from the lengthening life spans of people with developmental disabilities and the growing number of aging caregivers (usually parents). To strengthen the system in the face of this changing demography, Vermont intends to explore opportunities for enhancing existing caregiver respite programs.

### **Other Initiatives and Programs**

The State of Vermont has identified a number of other programs and initiatives it may implement under the *Global Commitment to Health* Demonstration. These are briefly described below. In each case, the state will establish standards for participation and the level of participant cost sharing, if any, as part of the final program design.

#### *Chronic Care Initiative*

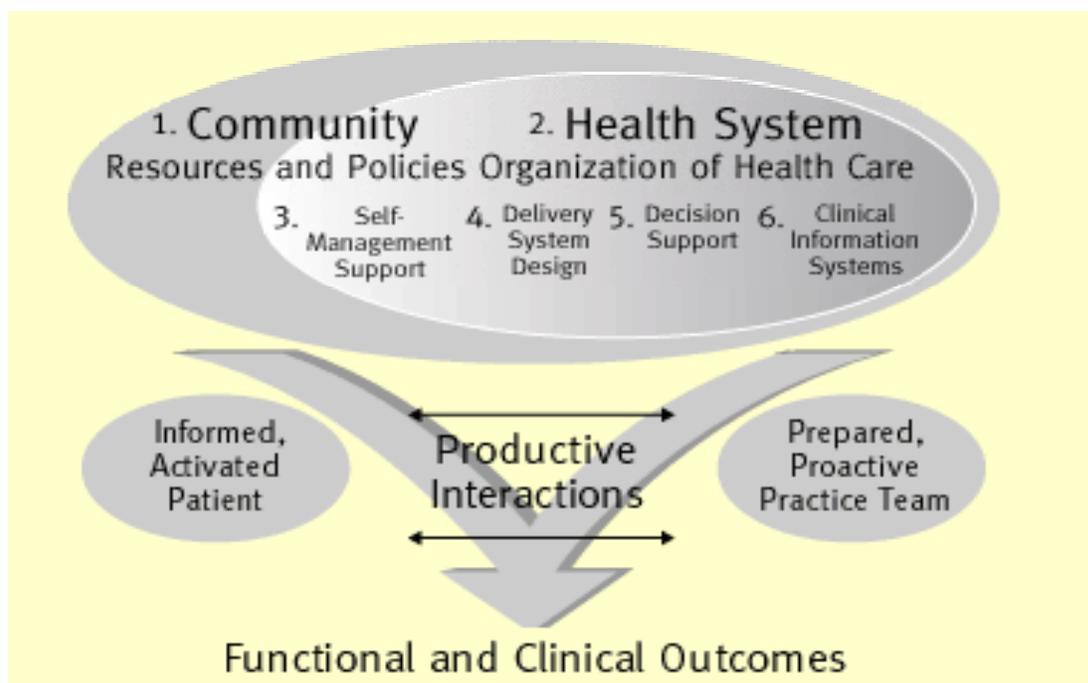
Vermont is poised to become the first state in the country to unveil multiple projects aimed at implementing its statewide Chronic Care Model. Staff at the MacColl Institute for Healthcare Innovation in Washington State developed the model, drawing on available literature about promising strategies for chronic illness management, and organizing that literature in a new, more accessible way.

The model was further refined during a nine-month planning project supported by The Robert Wood Johnson Foundation, and revised based on input from a large panel of national experts. It was then used to collect data and analyze innovative programs recommended by experts. RWJF then funded the MacColl Institute to test the model nationally across varied health care settings: the national program being “Improving Chronic Illness Care” (ICIC).

The Chronic Care Model identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. The model can be applied to a variety of chronic illnesses, health care settings and target populations. The bottom line is healthier patients, more satisfied providers, and cost savings.

Figure 2.3 below summarizes the major components of the model<sup>6</sup>.

**Figure 2.3 – Chronic Care Model**



In Vermont, the Chronic Care Model would be implemented under the auspices of the *Global Commitment to Health Waiver*. The model will have three objectives that support, and complement, the state’s overall waiver goals:

1. Implement a statewide system of care that enables Vermonters with, and at risk for, chronic disease to lead healthier lives.
2. Develop a system of care that is financially sustainable.
3. Forge a public-private partnership to develop and sustain the new system of care.

<sup>6</sup> Source: MacColl Institute

In furtherance of these above goals, the *Global Commitment to Health*, as conceptualized by the state, would provide the necessary flexibility to allow all of Vermont's current Medicaid recipients to be involved in evidence-based best practices as implemented utilizing the Chronic Care Model, without regard to their eligibility category.

The effect of chronic conditions on the health of Americans and health care costs is staggering. Individuals with chronic conditions account for 72 percent of all visits to physicians, 76 percent of hospital admissions, and overall, 84 percent of all health care expenditures. In Vermont, 51 percent of all adults have one or more chronic conditions. In the population from 45 to 64 years old, 68 percent of individuals have chronic conditions, and in the population 65 years and over, the rate is 88 percent, with 20 percent of this population having at least four chronic conditions. Thirty percent of the population with a chronic condition have their daily activity limited by the condition, which impacts productivity in the workplace.

Just one common chronic condition – cardiovascular disease – accounts for 20 percent of all hospital admissions, or more than 47,000 patient days per year, at an expense of over \$47 million. It is a leading cause of permanent, premature disability, and drives up disability premiums. It is the leading cause of death in Vermont, accounting for 27 percent of all deaths. Cardiovascular disease is largely preventable, and once obtained, is largely controllable. It is one of the chronic conditions that would be addressed through the Blueprint for Health.

The prevalence of chronic conditions has increased in our society due to unhealthy behaviors, including excessive caloric intake, lack of physical activity and smoking. However, our system of care has not changed, and the system, designed for acute care problems, is ill equipped to deal with chronic conditions.

According to the Institute of Medicine, more than 50 percent of individuals with chronic conditions such as diabetes, cardiovascular disease, and asthma are inadequately managed. In other words, they do not get appropriate care to minimize the impact of their condition on their health, quality of life and ability to be productive members of our community. This results in the exacerbation of their condition, the development of related medical problems and increased use of health care resources.

“The Vermont Blueprint for Health: The Chronic Care Initiative” is a public-private partnership formed to address the increasing burden of chronic care on individuals, the health care system, businesses and government programs such as Medicaid. The initiative envisions a future in Vermont where informed, activated patients interact with prepared, proactive practice teams, with the results being effective encounters with the health care system, improved health outcomes and decreased utilization of the health care system.

The Blueprint includes active roles for individuals, communities and providers. This would be assisted by information systems, such as a patient registry, that will facilitate proactive care management by providers and patients by furnishing them with the information they need when they need it. It would allow us to move from a system of reactive care to one of planned care, which will slow disease progression, reduce the number of hospitalizations for complications associated with chronic conditions (e.g., amputations due to diabetes) and decrease the number of premature deaths, while allowing Vermonters to lead productive lives.

### *Targeted Public Health Initiatives*

In conjunction with the overall chronic care initiative, Vermont may implement or expand targeted initiatives meant to address specific public health concerns. One area that may be expanded is Vermont's Tobacco Control Program, which includes telephone and face-to-face counseling services and nicotine replacement therapies. Tobacco is a leading cause of preventable death in Vermont, causing about 800 deaths each year and costing \$182 million in health care dollars, nearly a third of which are Medicaid.

Another is "Fit and Healthy Kids", which is a coordinated comprehensive approach to reduce the prevalence of obesity among children and youth. There are a growing number of youth who are at an increased risk for chronic diseases such as diabetes, cardiovascular disease and hypertension due to poor nutrition and being overweight. The direct medical costs attributable to obesity in adults are estimated to be as high as \$92 billion nationally in 2002 dollars, with approximately half financed by Medicaid and Medicare.

Projects developed under the Fit and Healthy Kids initiative provide a direct service to children, families and communities with the objective of reducing the disease risk associated with overweight and obesity. Based on lessons learned from the tobacco program, strategies to improve nutrition and increase physical fitness include individual behavior changes (e.g., increasing physical activity to at least 20 min per day); community wide response (e.g. increasing opportunities for physical activity, limiting access to soft drinks in schools); and public policy (e.g., promote implementation of school nutrition policies).

### *Substance Abuse Services*

Alcohol abuse and dependence are major public health problems, resulting in 100,000 deaths per year in the United States and costing the healthcare system billions of dollars annually. Excessive alcohol use is a major cause of injuries, lost productivity at work and school, family and social problems, and disease.

Vermont's ability to operate screening and early intervention programs is limited by the current eligibility process. Many times an uninsured person is brought to a hospital emergency room, treated and discharged before the eligibility determination process can even begin. Under the *Global Commitment to Health*, Vermont may explore establishing a diagnosis/service-specific presumptive funding process to facilitate early access to treatment. If it proves successful, this concept may be expanded to other, carefully selected diagnoses/services as needs are identified.

The link between criminal activity and substance abuse has been well-established. The Vermont correctional system currently faces a financial crisis as the need for additional prison beds continues to grow. Nearly seventy-five percent of individuals entering the Vermont correctional system are in need of substance abuse treatment.

In addition, it is clear from national and state data that individuals with co-occurring psychiatric and substance use disorders are sufficiently prevalent in all mental health, substance abuse and correctional settings that they can be considered an expectation, rather than an exception. However, categorical barriers have hindered effective service delivery for individuals with these co-occurring disorders, resulting in poorer outcomes than necessary and over-utilization of other resources in the broader health care system.

Our desire is to have integrated treatment systems and state level policies and practices so that anyone who has both of these disorders can access timely, effective treatment regardless of the service door they enter.

As part of the effort to develop strategies to enhance the continuum of care for people with co-occurring disorders, Vermont intends to address the need for substance abuse services provided to individuals under correctional custody and during their transition back to the community. Under the *Global Commitment to Health*, Vermont will not fund treatment services provided to individuals who are incarcerated. However, the state will seek to enhance care coordination and discharge planning activities for these individuals.

#### *School-based Health Services*

The State of Vermont currently operates a program for Medicaid reimbursement of school-based health services. The need for specialized health services continues to grow for a number of reasons, including more effective methods for identifying children with special health needs. While the Medicaid program provides some funding for these programs, the amount of paperwork necessary to collect Medicaid monies requires professional staff time that could be better spent serving children. Under the *Global Commitment to Health Waiver*, Vermont intends to streamline the funding process for this program in order to reduce administrative costs while continuing to equitably reimburse schools for health services.

Many children who would benefit from Individualized Education Plans (IEPs) and special education services fail to meet one of the qualifying criteria and instead are served in accordance with alternate, “504 plans”. Those with 504 plans also include children moving off of IEPs who still need some level of assistance to prevent a relapse. Under the *Global Commitment to Health* approach, Vermont would remove artificial barriers that hinder appropriate funding of health services for low-income children.

#### *Children’s Services*

The Department for Children and Families (DCF) is responsible for the social, emotional, physical and economic well being and the safety of many of Vermont’s children and families. This is done through the provision of protective, developmental, therapeutic, probation, economic, and other support services for children and families in partnership with schools, businesses, community leaders, service providers, families, and youths statewide. Medicaid funds currently support a number of programs and services administered by DCF, including respite care, treatment services and targeted case management. Currently, eligibility and program funding requirements vary. The State intends to evaluate these programs in order to identify strategies to steer individuals to appropriate care systems and to streamline the eligibility/assessment process to assist beneficiaries to more easily access services and reduce administrative burden. In addition, Vermont intends to continue to provide access to services as required under EPSDT for all mandatory eligibility groups and any changes to covered services for optional groups would only be implemented in future years with legislative approval.

## Eligibility Determination and Enrollment Process

### *Approach*

Vermont will initially use a two-pronged approach for eligibility determination, one for the public health insurance and premium subsidy programs and another for targeted programs. For the traditional public programs (Medicaid, VHAP and Dr. Dynasaur) the current eligibility processes will continue during the early stages of the Waiver. Changes will be made to reflect the requirement that some individuals currently eligible for VHAP or Dr. Dynasaur may elect instead to receive an ESI premium subsidy.

For specialized or targeted programs, such as substance abuse treatment and certain children's programs (such as Success by Six), individuals may be found eligible solely for those programs. That is, an individual might apply for a subsidized drug treatment program only and might not otherwise qualify for, or enroll in, the Medicaid, VHAP or a premium subsidy program. Others may seek mental health services of a type and scope not covered under their private health insurance, but which they cannot otherwise afford to pay for solely on their own.

The state may also sponsor Disease Management programs that residents can participate in free of charge or for a small fee. The goal is to target resources toward specific needs in ways that cannot be done with Medicaid funds today. Not all parents need the full Dr. Dynasaur benefit plan for their children because they have group health insurance, but they may need access to specialized services many commercial plans do not cover (e.g., personal care and durable medical equipment).

The state may also address its shortage of child psychiatrists by developing programs to provide educational and consultative services to primary care pediatricians to help them better serve children and adolescents with behavioral disorders.

Incarcerated individuals being released into the community may not qualify for VHAP or even a premium subsidy (or be able to afford their share of the cost even if they are eligible) but they need access to ongoing substance abuse or mental health treatment. These individuals could enroll in a subsidized treatment program with copays based on a sliding scale.

The state will establish a much simplified eligibility determination process for these targeted programs. Programs may include cost sharing in the form of copays, which will vary based on income. Assets and resources will probably not be considered when determining income.

### *Longer Term Strategic Plan for Streamlining the Eligibility Process*

The Economic Services Division (ESD) within the Department for Children and Families has responsibility for processing applications and making financial eligibility determinations for mandatory and optional coverage groups. Under the current system, ESD manages over 200 discrete coverage groups, each with its own set of eligibility criteria. The complexity of the system forces inordinate resources to be devoted to identifying the right "slot" for each applicant – resources that could be better used elsewhere. The current system also creates confusion on the part of program applicants.

Vermont plans to explore making major reforms to the eligibility determination process, ultimately collapsing the 200 existing categories reported to our federal partners into as few as ten. Concurrent with this change, the state may adopt a common financial screen for all applicants, possibly based on gross income, to further simplify and rationalize the process. Individuals enrolled in the program at the time the changes in the eligibility process are made will be “grandfathered” into the program. While these changes will require an investment of resources to convert existing technologies and procedural systems, the resulting simplification should create long-term administrative efficiencies and simplicity for beneficiaries.

Vermont also intends to evaluate and possibly implement a standardized, clinical assessment process as part of its eligibility reform initiative. Through standardized clinical assessment based on functional need, the state could more effectively allocate needed health care resources. The state already has considerable experience and expertise in the use of clinical assessment tools for those in need of long term care, mental health, and developmental services.

Vermont also seeks to evaluate options to limit resource exclusions for certain new applicants requesting long-term care Medicaid. Vermont would like to test the feasibility of curbing long-term care financial eligibility abuses by applying more stringent resource rules to these applicants. Current law permits states to completely eliminate optional coverage groups. However, wholesale elimination of optional groups would harm many people who are not taking advantage of the system and would deprive truly financially needy individuals from receiving long-term care. Transfer of assets is another prevalent practice of “Medicaid estate planning” that prevents dwindling governmental resources from being dedicated to those citizens most in need of access to health care. We would like to explore options to allow the State to avoid incurring costs of providing long-term care for persons who improperly transfer assets in order to achieve eligibility for Medicaid services.

## **Chapter 3: Program Funding and Global Federal Budget Commitment (Budget Neutrality)**

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Vermont believes that the innovative strategies described in this document will enable the state to effectively manage public resources while preserving and enhancing access to health care services in the state.

The state proposes a capitated model, whereby the Agency of Human Services, as the Medicaid Single State Agency, will make a capitation payment to the Office of Vermont Health Access (OVHA), serving as a publicly-operated managed care organization (MCO). OVHA will be responsible for overall management of the health care delivery system. The capitation payment will be based on the reasonable cost of purchasing all Medicaid services on behalf of eligible populations.

The MCO will be responsible for reimbursement of all eligible services and managing the health care delivery system. The state will assume risk for expenditure and caseload growth. In the event that the MCO is able to realize savings through implementation of the various initiatives, the MCO may use these savings to expand program benefits, expand program eligibility and support other Vermont health care programs, subject to specific restrictions. The MCO will be restricted from using program savings as follows:

- Program savings may not be used as state match in subsequent years
- Providing funds to the Vermont State Hospital
- Financing Institute for Mental Disease (IMD) services for individuals between the ages of 18 and 64
- Financing health care services provided to individuals incarcerated in correctional facilities, with the exception of discharge planning for inmates with health care needs who have established Medicaid eligibility
- Financing health care services covered under the Vermont State Employee Health Benefit Plan

Administrative costs will continue to be matched in accordance with current Medicaid rules and will be excluded from the Global Commitment budget neutrality agreement.

Premiums may be required for certain enrolled populations, as determined by the Vermont Legislature. While premium revenues may be used to offset the MCO's expenses, premium revenues will not be used as state match.

The state is seeking authority to access federal matching funds at the level projected to occur in the absence of the Waiver. Projected expenditures are based on historical program growth, adjusted to reflect demographic and programmatic trends not reflected by historical growth rates. Actual federal funding will be dependent on the availability of state funds and the federal matching rate within each waiver year.

The state seeks assurances of fiscal relief if any of the following events occur during the course of the five-year waiver period:

- The incidence of an epidemic or catastrophe that substantially impacts program funding requirements
- A major and prolonged economic downturn that impacts the demand for publicly funded health care services
- Federal legislation that provides fiscal relief to state Medicaid programs

The tables at the end of this chapter present the historical program expenditures and caseload, projected expenditures in the absence of the Waiver, and projected expenditures under the Waiver.

The state proposes to include the SCHIP program under the *Global Commitment to Health Waiver*. Given the distinct federal funding mechanisms under Title XXI, however, the state is prepared to separately track and report SCHIP expenditures. In order to facilitate the review of the budget neutrality projections, SCHIP caseload and expenditures are separately identified on the tables.

A description of the data sources and calculations contained in each table is provided below.

**Table 3.1 Historical Program Expenditures, by Eligibility Group (State and Federal)**

Table 3.1 presents historical program expenditures for the Vermont Medicaid program. Expenditures are based on dollars paid within each State Fiscal Year (July 1 – June 30), as reported to the federal government of the CMS-64 report.

The report presents expenditures by eligibility group, including Aged, Blind and Disabled; Families; SCHIP; VHAP (uninsured adults); and Pharmacy Programs (VHAP-Rx and VScript programs).

**Table 3.2 Historical Program Caseload, by Eligibility Group**

Historical caseload is derived from the average annual enrollment within each fiscal year. Average annual enrollment is calculated from the monthly caseload report generated by the Vermont eligibility system.

**Table 3.3 Historical Program Expenditures per Enrollee, by Eligibility Group (State and Federal)**

Program expenditures per eligible are calculated by dividing total reported program expenditures by the average annual caseload.

**Table 3.4 Without Waiver Projections, Caseload**

Projected caseload for the five-year waiver term (State Fiscal Years 2006 through 2010) is based on historical caseload trends, subject to minor adjustments to account for demographic trends not addressed by historical growth rates. Specific adjustments to historical data include the following:

*ABD Caseload* – Base Year (SFY04) average annual caseload has been increased by a total of 220, reflecting the impact of restricted HCBS waiver caseloads during the base period. The caseload trend rate during the Waiver is estimated to equal 3.52 percent annually. While the five-year historical caseload growth rate is 1.52 percent, more recent experience demonstrates higher growth (2.27 percent annually between SFY02 and SFY04). Additionally, Vermont-specific demographic studies demonstrate higher demand for long-term care and developmental services over the next ten years.

*SCHIP Caseload* – Average annual growth for the period between SFY00 and SFY04 is 16.2 percent. However, the program experienced little or no program growth between SFY02 and SFY04. Program enrollment during the Waiver period is projected to remain constant.

*VHAP Caseload* – Average annual growth in the VHAP caseload is 4.93 percent. However, historical growth was tempered by increases in program premiums. Additionally, at any given point, a large number of individuals enrolled in VHAP are awaiting disability determination; demographic trends related to growth in the number of individuals with disabilities therefore is likely to impact VHAP program growth. The state expects program growth to be modestly higher than historical levels, equal to 6.43 percent.

*Pharmacy Programs Caseload* – The historical caseload trend (2.69 percent) for the pharmacy programs is impacted by increases in enrollee cost sharing requirements. The projected trend has been increased to 3.69 percent to account for the impact of prior programmatic changes on caseload and Vermont’s aging demographics.

**Table 3.5 Without Waiver Projections, Expenditures per Eligible (State and Federal)**

Projected expenditures per member are based on historical expenditures and trend rates. The following adjustments were made to account for programmatic changes not reflected by historical data:

*ABD Expenditures per Eligible* – Base Year expenditures were adjusted to reflect the impact of the state’s transition of services from the Vermont State Hospital. The state estimates that Medicaid-eligible

services provided in alternative settings will increase ABD expenditures by approximately two percent. This increase represents additional expenditures above base year expenditures for the Vermont State Hospital. The Vermont State Hospital will not be funded under the *Global Commitment to Health Waiver*.

*SCHIP Expenditures per Eligible* – Base Year expenditures were increased by \$800,000 to reflect the unspent portion of the SFY04 SCHIP allotment.

**Table 3.6 Without Waiver Projections, Total Expenditures (State and Federal)**

Projected aggregate (State and Federal) expenditures in the absence of the Waiver are the product of projected enrollment (Table 3.4) and projected expenditures per eligible (Table 3.5).

**Table 3.7 With Waiver Projections, Caseload**

Projected caseload under the Waiver is equal to projected caseload in the absence of the Waiver. While the state may undertake program changes that impact enrollment under the Waiver, these changes are subject to legislative authority and the availability of state funds.

**Table 3.8 With Waiver Projections, Expenditures per Eligible (State and Federal)**

The state anticipates that program initiatives allowed under the *Global Commitment to Health* will produce program savings and will serve to bring program growth to a sustainable level. Targeted savings and changes in growth trend rates are as follows:

*Projected Program Savings During Waiver Year 1* – Program initiatives currently before the legislature are estimated to reduce program expenditures per eligible by two percent, across all eligibility groups.

*Growth Rates* – Program initiatives are expected to reduce program growth as follows:

Eligibility Group	Annual Growth Without Waiver	Annual Growth With Waiver
ABD	5.18%	4.68%
Families	10.36%	8.86%
SCHIP	3.06%	2.06%
VHAP	17.55%	12.55%
Pharmacy Programs	12.94%	10.94%

**Table 3.9 With Waiver Projections, Total Expenditures (State and Federal)**

Projected aggregate (State and Federal) expenditures under the Waiver are the product of projected enrolment (Table 3.7) and projected expenditures per eligible (Table 3.8).

**Table 3.10 Summary of Program Expenditures With and Without the Waiver (State and Federal)**

This table provides a summary of projected aggregate (State and Federal) expenditures with and without the Waiver, as well as estimated Waiver program savings.

**Table 3.11 Summary of Program Expenditures With and Without the Waiver (Federal Expenditures)**

This table provides a summary of projected Federal expenditures with and without the Waiver, as well as estimated Federal savings under the Waiver. The summary of “Total Program Expenditures, Excluding SCHIP” reflects an adjusted federal match to account for the impact of the enhanced match rate available under SCHIP.

**State of Vermont**  
**Global Commitment to Health**

**Table 3.1 Historical Program Expenditures, by Eligibility Group (State and Federal)**

	State Fiscal Year					Average Annual Trend
	2000	2001	2002	2003	2004	
<b>Current Law Populations</b>						
Aged, Blind and Disabled	\$ 334,969,887	\$ 346,882,857	\$ 373,094,858	\$ 406,871,358	\$ 435,470,170	6.78%
Families	\$ 143,670,836	\$ 168,902,467	\$ 206,617,694	\$ 213,372,718	\$ 230,621,213	12.56%
SCHIP	\$ 1,408,272	\$ 2,185,757	\$ 2,672,606	\$ 3,239,936	\$ 2,896,225	19.75%
<i>Current Law Subtotal</i>	<i>\$ 480,048,995</i>	<i>\$ 517,971,082</i>	<i>\$ 582,385,159</i>	<i>\$ 623,484,012</i>	<i>\$ 668,987,608</i>	<i>8.65%</i>
<i>Current Law, Excluding SCHIP</i>	<i>\$ 478,640,723</i>	<i>\$ 515,785,324</i>	<i>\$ 579,712,553</i>	<i>\$ 620,244,076</i>	<i>\$ 666,091,383</i>	<i>8.61%</i>
<b>Expansion Groups</b>						
VHAP	\$ 30,409,315	\$ 39,328,840	\$ 45,641,552	\$ 49,253,626	\$ 70,380,189	23.34%
Pharmacy Programs	\$ 13,666,967	\$ 16,979,550	\$ 17,575,257	\$ 17,665,013	\$ 21,800,379	12.38%
<i>Expansion Subtotal</i>	<i>\$ 44,076,282</i>	<i>\$ 56,308,390</i>	<i>\$ 63,216,809</i>	<i>\$ 66,918,639</i>	<i>\$ 92,180,568</i>	<i>20.26%</i>
<b>Total Program</b>	<b>\$ 524,125,277</b>	<b>\$ 574,279,472</b>	<b>\$ 645,601,968</b>	<b>\$ 690,402,651</b>	<b>\$ 761,168,176</b>	<b>9.78%</b>
<b>Total Program, Excluding SCHIP</b>	<b>\$ 522,717,005</b>	<b>\$ 572,093,715</b>	<b>\$ 642,929,362</b>	<b>\$ 687,162,715</b>	<b>\$ 758,271,951</b>	<b>9.75%</b>

**State of Vermont**  
***Global Commitment to Health***

**Table 3.2 Historical Program Caseload, by Eligibility Group**

	State Fiscal Year					Average Annual Trend
	2000	2001	2002	2003	2004	
<b>Current Law Populations</b>						
Aged, Blind and Disabled	21,732	21,812	22,070	22,636	23,083	1.52%
Families	66,681	68,267	70,576	71,828	72,162	1.99%
SCHIP	1,604	2,437	2,924	3,094	2,924	16.20%
<i>Current Law Subtotal</i>	<i>90,017</i>	<i>92,516</i>	<i>95,570</i>	<i>97,558</i>	<i>98,169</i>	<i>2.19%</i>
<i>Current Law, Excluding SCHIP</i>	<i>88,413</i>	<i>90,079</i>	<i>92,647</i>	<i>94,464</i>	<i>95,245</i>	<i>1.88%</i>
<b>Expansion Groups</b>						
VHAP	17,934	19,147	20,207	21,010	21,739	4.93%
Pharmacy Programs	10,228	11,121	11,561	11,655	11,372	2.69%
<i>Expansion Subtotal</i>	<i>28,162</i>	<i>30,268</i>	<i>31,768</i>	<i>32,665</i>	<i>33,111</i>	<i>4.13%</i>
<b>Total Program</b>	<b>118,179</b>	<b>122,784</b>	<b>127,338</b>	<b>130,224</b>	<b>131,280</b>	<b>2.66%</b>
<b>Total Program, Excluding SCHIP</b>	<b>116,576</b>	<b>120,347</b>	<b>124,415</b>	<b>127,130</b>	<b>128,356</b>	<b>2.44%</b>

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**Table 3.3 Historical Program Expenditures per Enrollee, by Eligibility Group (State and Federal)**

	State Fiscal Year					Average Annual Trend
	2000	2001	2002	2003	2004	
<b>Current Law Populations</b>						
Aged, Blind and Disabled	\$ 15,413	\$ 15,903	\$ 16,905	\$ 17,975	\$ 18,865	5.18%
Families	\$ 2,155	\$ 2,474	\$ 2,928	\$ 2,971	\$ 3,196	10.36%
SCHIP	\$ 878	\$ 897	\$ 914	\$ 1,047	\$ 991	3.06%
<i>Current Law Subtotal</i>	\$ 5,333	\$ 5,599	\$ 6,094	\$ 6,391	\$ 6,815	6.32%
<i>Current Law, Excluding SCHIP</i>	\$ 5,414	\$ 5,726	\$ 6,257	\$ 6,566	\$ 6,993	6.61%
<b>Expansion Groups</b>						
VHAP	\$ 1,696	\$ 2,054	\$ 2,259	\$ 2,344	\$ 3,238	17.55%
Pharmacy Programs	\$ 1,336	\$ 1,527	\$ 1,520	\$ 1,516	\$ 1,917	9.44%
<i>Expansion Subtotal</i>	\$ 1,565	\$ 1,860	\$ 1,990	\$ 2,049	\$ 2,784	15.49%
<b>Total Program</b>	\$ 4,435	\$ 4,677	\$ 5,070	\$ 5,302	\$ 5,798	6.93%
<b>Total Program, Excluding SCHIP</b>	\$ 4,484	\$ 4,754	\$ 5,168	\$ 5,405	\$ 5,908	7.14%

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**Table 3.4 Without Waiver Projections, Caseload**

	Base Year (SFY04) - Adjusted	Annual Trend Rate	Waiver Year				
			1 (SFY06)	2 (SFY07)	3 (SFY08)	4 (SFY09)	5 (SFY10)
<b>Current Law Populations</b>							
Aged, Blind and Disabled	23,303	3.52%	24,972	25,851	26,761	27,703	28,678
Families	72,162	1.99%	75,069	76,566	78,093	79,650	81,239
SCHIP	2,924	0.00%	2,924	2,924	2,924	2,924	2,924
<i>Current Law Subtotal</i>	<i>98,389</i>	<i>2.32%</i>	<i>102,965</i>	<i>105,341</i>	<i>107,778</i>	<i>110,278</i>	<i>112,841</i>
<i>Current Law, Excluding SCHIP</i>	<i>95,465</i>	<i>2.38%</i>	<i>100,041</i>	<i>102,417</i>	<i>104,854</i>	<i>107,354</i>	<i>109,917</i>
<b>Expansion Groups</b>							
VHAP	21,739	6.43%	24,623	26,206	27,891	29,684	31,592
Pharmacy Programs	11,372	3.69%	12,226	12,677	13,144	13,629	14,131
<i>Expansion Subtotal</i>	<i>33,111</i>	<i>5.54%</i>	<i>36,850</i>	<i>38,883</i>	<i>41,035</i>	<i>43,312</i>	<i>45,723</i>
<b>Total Program</b>	<b>131,500</b>	<b>3.20%</b>	<b>139,815</b>	<b>144,224</b>	<b>148,813</b>	<b>153,590</b>	<b>158,564</b>
<b>Total Program, Excluding SCHIP</b>	<b>128,576</b>	<b>3.26%</b>	<b>136,891</b>	<b>141,300</b>	<b>145,889</b>	<b>150,666</b>	<b>155,640</b>

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**Table 3.5 Without Waiver Projections, Expenditures per Eligible (State and Federal)**

	Base Year (SFY04) - Adjusted	Annual Trend Rate	Waiver Year					
			1 (SFY06)	2 (SFY07)	3 (SFY08)	4 (SFY09)	5 (SFY10)	
<b>Current Law Populations</b>								
Aged, Blind and Disabled	\$ 19,329	5.18%	\$ 21,384	\$ 22,492	\$ 23,658	\$ 24,884	\$ 26,174	
Families	\$ 3,196	10.36%	\$ 3,892	\$ 4,295	\$ 4,740	\$ 5,231	\$ 5,773	
SCHIP	\$ 1,264	3.06%	\$ 1,343	\$ 1,384	\$ 1,426	\$ 1,469	\$ 1,514	
<i>Current Law Subtotal</i>	\$ 6,815	7.70%	\$ 8,062	\$ 8,680	\$ 9,348	\$ 10,069	\$ 10,848	
<i>Current Law, Excluding SCHIP</i>	\$ 6,993	7.63%	\$ 8,259	\$ 8,889	\$ 9,569	\$ 10,303	\$ 11,096	
<b>Expansion Groups</b>								
VHAP	\$ 3,238	17.55%	\$ 4,474	\$ 5,259	\$ 6,181	\$ 7,266	\$ 8,541	
Pharmacy Programs	\$ 1,917	12.94%	\$ 2,445	\$ 2,762	\$ 3,119	\$ 3,523	\$ 3,979	
<i>Expansion Subtotal</i>	\$ 2,784	16.94%	\$ 3,801	\$ 4,445	\$ 5,201	\$ 6,088	\$ 7,131	
<b>Total Program</b>	\$ 5,798	8.64%	\$ 6,939	\$ 7,538	\$ 8,204	\$ 8,946	\$ 9,776	
<b>Total Program, Excluding SCHIP</b>	\$ 5,908	8.60%	\$ 7,059	\$ 7,666	\$ 8,340	\$ 9,091	\$ 9,931	

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**Table 3.6 Without Waiver Projections, Total Expenditures (State and Federal)**

	Waiver Year					Five-Year Total
	1 (SFY06)	2 (SFY07)	3 (SFY08)	4 (SFY09)	5 (SFY10)	
<b>Current Law Populations</b>						
Aged, Blind and Disabled	\$ 534,012,887	\$ 581,458,196	\$ 633,118,867	\$ 689,369,420	\$ 750,617,652	\$ 3,188,577,022
Families	\$ 292,189,476	\$ 328,887,394	\$ 370,194,435	\$ 416,689,488	\$ 469,024,148	\$ 1,876,984,941
SCHIP	\$ 3,925,543	\$ 4,045,483	\$ 4,169,087	\$ 4,296,468	\$ 4,427,742	\$ 20,864,323
<i>Current Law Subtotal</i>	<i>\$ 830,127,905</i>	<i>\$ 914,391,073</i>	<i>\$ 1,007,482,389</i>	<i>\$ 1,110,355,377</i>	<i>\$ 1,224,069,542</i>	<i>\$ 5,086,426,286</i>
<i>Current Law, Excluding SCHIP</i>	<i>\$ 826,202,363</i>	<i>\$ 910,345,590</i>	<i>\$ 1,003,313,302</i>	<i>\$ 1,106,058,908</i>	<i>\$ 1,219,641,800</i>	<i>\$ 5,065,561,963</i>
<b>Expansion Groups</b>						\$ -
VHAP	\$ 110,154,271	\$ 137,808,751	\$ 172,405,952	\$ 215,688,858	\$ 269,838,037	\$ 905,895,870
Pharmacy Programs	\$ 29,896,513	\$ 35,010,538	\$ 40,999,355	\$ 48,012,605	\$ 56,225,524	\$ 210,144,534
<i>Expansion Subtotal</i>	<i>\$ 140,050,784</i>	<i>\$ 172,819,289</i>	<i>\$ 213,405,307</i>	<i>\$ 263,701,463</i>	<i>\$ 326,063,561</i>	<i>\$ 1,116,040,404</i>
<b>Total Program</b>	<b>\$ 970,178,689</b>	<b>\$ 1,087,210,362</b>	<b>\$ 1,220,887,696</b>	<b>\$ 1,374,056,840</b>	<b>\$ 1,550,133,103</b>	<b>\$ 6,202,466,690</b>
<b>Total Program, Excluding SCHIP</b>	<b>\$ 966,253,147</b>	<b>\$ 1,083,164,879</b>	<b>\$ 1,216,718,609</b>	<b>\$ 1,369,760,372</b>	<b>\$ 1,545,705,361</b>	<b>\$ 6,181,602,368</b>

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**Table 3.7 With Waiver Projections, Caseload**

	Annual Trend Rate	Waiver Year				
		1 (SFY06)	2 (SFY07)	3 (SFY08)	4 (SFY09)	5 (SFY10)
<b>Current Law Populations</b>						
Aged, Blind and Disabled	3.52%	24,972	25,851	26,761	27,703	28,678
Families	1.99%	75,069	76,566	78,093	79,650	81,239
SCHIP	0.00%	2,924	2,924	2,924	2,924	2,924
<i>Current Law Subtotal</i>	<i>2.32%</i>	<i>102,965</i>	<i>105,341</i>	<i>107,778</i>	<i>110,278</i>	<i>112,841</i>
<i>Current Law, Excluding SCHIP</i>	<i>2.38%</i>	<i>100,041</i>	<i>102,417</i>	<i>104,854</i>	<i>107,354</i>	<i>109,917</i>
<b>Expansion Groups</b>						
VHAP	6.43%	24,623	26,206	27,891	29,684	31,592
Pharmacy Programs	3.69%	12,226	12,677	13,144	13,629	14,131
<i>Expansion Subtotal</i>	<i>5.54%</i>	<i>36,850</i>	<i>38,883</i>	<i>41,035</i>	<i>43,312</i>	<i>45,723</i>
<b>Total Program</b>	<b>3.20%</b>	<b>139,815</b>	<b>144,224</b>	<b>148,813</b>	<b>153,590</b>	<b>158,564</b>
<b>Total Program, Excluding SCHIP</b>	<b>3.26%</b>	<b>136,891</b>	<b>141,300</b>	<b>145,889</b>	<b>150,666</b>	<b>155,640</b>

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**Table 3.8 With Waiver Projections, Expenditures per Eligible (State and Federal)**

	Annual Trend Rate	Waiver Year				
		1 (SFY06)	2 (SFY07)	3 (SFY08)	4 (SFY09)	5 (SFY10)
<b>Current Law Populations</b>						
Aged, Blind and Disabled	4.68%	\$ 20,957	\$ 21,938	\$ 22,965	\$ 24,040	\$ 25,166
Families	8.86%	\$ 3,814	\$ 4,152	\$ 4,520	\$ 4,921	\$ 5,357
SCHIP	2.06%	\$ 1,316	\$ 1,343	\$ 1,370	\$ 1,398	\$ 1,427
<i>Current Law Subtotal</i>	<i>6.83%</i>	<i>\$ 7,901</i>	<i>\$ 8,439</i>	<i>\$ 9,015</i>	<i>\$ 9,630</i>	<i>\$ 10,289</i>
<i>Current Law, Excluding SCHIP</i>	<i>6.77%</i>	<i>\$ 8,093</i>	<i>\$ 8,642</i>	<i>\$ 9,228</i>	<i>\$ 9,855</i>	<i>\$ 10,525</i>
<b>Expansion Groups</b>						
VHAP	12.55%	\$ 4,384	\$ 4,934	\$ 5,553	\$ 6,250	\$ 7,035
Pharmacy Programs	10.94%	\$ 2,396	\$ 2,659	\$ 2,949	\$ 3,272	\$ 3,630
<i>Expansion Subtotal</i>	<i>12.56%</i>	<i>\$ 3,725</i>	<i>\$ 4,192</i>	<i>\$ 4,719</i>	<i>\$ 5,313</i>	<i>\$ 5,983</i>
<b>Total Program</b>	<b>7.40%</b>	<b>\$ 6,924</b>	<b>\$ 7,436</b>	<b>\$ 7,994</b>	<b>\$ 8,602</b>	<b>\$ 7,322</b>
<b>Total Program, Excluding SCHIP</b>	<b>7.37%</b>	<b>\$ 7,043</b>	<b>\$ 7,562</b>	<b>\$ 8,127</b>	<b>\$ 8,741</b>	<b>\$ 7,433</b>

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**Table 3.9 With Waiver Projections, Total Expenditures (State and Federal)**

	Waiver Year					Five-Year Total
	1 (SFY06)	2 (SFY07)	3 (SFY08)	4 (SFY09)	5 (SFY10)	
<b>Current Law Populations</b>						
Aged, Blind and Disabled	\$ 523,332,629	\$ 567,120,262	\$ 614,571,640	\$ 665,993,310	\$ 721,717,469	\$ 3,092,735,310
Families	\$ 286,345,686	\$ 317,928,798	\$ 352,995,438	\$ 391,929,828	\$ 435,158,569	\$ 1,784,358,320
SCHIP	\$ 3,847,032	\$ 3,926,103	\$ 4,006,799	\$ 4,089,153	\$ 4,173,201	\$ 20,042,287
<i>Current Law Subtotal</i>	<i>\$ 813,525,347</i>	<i>\$ 888,975,164</i>	<i>\$ 971,573,877</i>	<i>\$ 1,062,012,291</i>	<i>\$ 1,161,049,239</i>	<i>\$ 4,897,135,917</i>
<i>Current Law, Excluding SCHIP</i>	<i>\$ 809,678,315</i>	<i>\$ 885,049,061</i>	<i>\$ 967,567,078</i>	<i>\$ 1,057,923,137</i>	<i>\$ 1,156,876,038</i>	<i>\$ 4,877,093,630</i>
<b>Expansion Groups</b>						\$ -
VHAP	\$ 107,951,186	\$ 129,308,065	\$ 154,890,152	\$ 185,533,357	\$ 222,238,960	\$ 799,921,720
Pharmacy Programs	\$ 29,298,583	\$ 33,702,755	\$ 38,768,965	\$ 44,596,728	\$ 51,300,523	\$ 197,667,554
<i>Expansion Subtotal</i>	<i>\$ 137,249,768</i>	<i>\$ 163,010,820</i>	<i>\$ 193,659,117</i>	<i>\$ 230,130,085</i>	<i>\$ 273,539,483</i>	<i>\$ 997,589,274</i>
<b>Total Program</b>	<b>\$ 950,775,116</b>	<b>\$ 1,051,985,984</b>	<b>\$ 1,165,232,993</b>	<b>\$ 1,292,142,375</b>	<b>\$ 1,434,588,723</b>	<b>\$ 5,894,725,191</b>
<b>Total Program, Excluding SCHIP</b>	<b>\$ 946,928,084</b>	<b>\$ 1,048,059,881</b>	<b>\$ 1,161,226,195</b>	<b>\$ 1,288,053,222</b>	<b>\$ 1,430,415,522</b>	<b>\$ 5,874,682,903</b>

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**Table 3.10 Summary of Program Expenditures With and Without the Waiver (State and Federal)**

	Waiver Year					Five-Year Total
	1 (SFY06)	2 (SFY07)	3 (SFY08)	4 (SFY09)	5 (SFY10)	
<b>Total Program Expenditures</b>						
Without Waiver	\$ 970,178,689	\$ 1,087,210,362	\$ 1,220,887,696	\$ 1,374,056,840	\$ 1,550,133,103	\$ 6,202,466,690
Annual Growth		12.1%	12.3%	12.5%	12.8%	12.4%
With Waiver	\$ 950,775,116	\$ 1,051,985,984	\$ 1,165,232,993	\$ 1,292,142,375	\$ 1,434,588,723	\$ 5,894,725,191
Annual Growth		10.6%	10.8%	10.9%	11.0%	10.8%
<b>Waiver Savings</b>	\$ 19,403,574	\$ 35,224,378	\$ 55,654,703	\$ 81,914,465	\$ 115,544,380	\$ 307,741,500
Cumulative Savings	\$ 19,403,574	\$ 54,627,952	\$ 110,282,655	\$ 192,197,119	\$ 307,741,500	\$ 307,741,500
Percent Savings	2.00%	3.24%	4.56%	5.96%	7.45%	4.96%
<b>Total Program Expenditures, Excluding SCHIP</b>						
Without Waiver	\$ 966,253,147	\$ 1,083,164,879	\$ 1,216,718,609	\$ 1,369,760,372	\$ 1,545,705,361	\$ 6,181,602,368
Annual Growth		12.1%	12.3%	12.6%	12.8%	12.5%
With Waiver	\$ 946,928,084	\$ 1,048,059,881	\$ 1,161,226,195	\$ 1,288,053,222	\$ 1,430,415,522	\$ 5,874,682,903
Annual Growth		10.7%	10.8%	10.9%	11.1%	10.9%
<b>Waiver Savings</b>	\$ 19,325,063	\$ 35,104,998	\$ 55,492,414	\$ 81,707,150	\$ 115,289,839	\$ 306,919,464
Cumulative Savings	\$ 19,325,063	\$ 54,430,061	\$ 109,922,475	\$ 191,629,625	\$ 306,919,464	\$ 306,919,464
Percent Savings	2.00%	3.24%	4.56%	5.97%	7.46%	4.97%

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**Table 3.11 Summary of Program Expenditures With and Without the Waiver (Federal Expenditures)**

	Waiver Year					Five-Year Total
	1 (SFY06)	2 (SFY07)	3 (SFY08)	4 (SFY09)	5 (SFY10)	
<b>Total Program Expenditures</b>						
Effective Federal Match Rate (Est.)	59.65%	59.65%	59.65%	59.65%	59.65%	
Without Waiver	\$ 578,711,588	\$ 648,520,981	\$ 728,259,511	\$ 819,624,905	\$ 924,654,396	\$ 3,699,771,381
Annual Growth		12.1%	12.3%	12.5%	12.8%	12.4%
With Waiver	\$ 567,137,356	\$ 627,509,639	\$ 695,061,481	\$ 770,762,927	\$ 855,732,173	\$ 3,516,203,576
Annual Growth		10.6%	10.8%	10.9%	11.0%	10.8%
<b>Waiver Savings</b>	\$ 11,574,232	\$ 21,011,342	\$ 33,198,030	\$ 48,861,978	\$ 68,922,223	\$ 183,567,804
Cumulative Savings	\$ 11,574,232	\$ 32,585,573	\$ 65,783,604	\$ 114,645,582	\$ 183,567,804	\$ 183,567,804
Percent Savings	2.00%	3.24%	4.56%	5.96%	7.45%	4.96%
<b>Total Program Expenditures, Excluding SCHIP</b>						
Effective Federal Match Rate (Est.)	59.60%	59.60%	59.60%	59.60%	59.60%	
Without Waiver	\$ 576,370,002	\$ 646,107,850	\$ 725,772,650	\$ 817,062,062	\$ 922,013,248	\$ 3,687,325,812
Annual Growth		12.1%	12.3%	12.6%	12.8%	12.5%
With Waiver	\$ 564,842,602	\$ 625,167,719	\$ 692,671,425	\$ 768,323,747	\$ 853,242,859	\$ 3,504,248,352
Annual Growth		10.7%	10.8%	10.9%	11.1%	10.9%
<b>Waiver Savings</b>	\$ 11,527,400	\$ 20,940,131	\$ 33,101,225	\$ 48,738,315	\$ 68,770,389	\$ 183,077,461
Cumulative Savings	\$ 11,527,400	\$ 32,467,532	\$ 65,568,757	\$ 114,307,071	\$ 183,077,461	\$ 183,077,461
Percent Savings	2.00%	3.24%	4.56%	5.97%	7.46%	4.97%

## Chapter 4: Beneficiary Protections

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Vermont will continue to provide beneficiary protections and guarantee the rights of enrollees in its public health coverage programs under the *Global Commitment to Health* Demonstration. That is, Vermont is not seeking to waive any existing protections and rights. In fact, under the MCO model within the *Global Commitment to Health*, beneficiaries will have additional protections as required by the Balanced Budget Act of 1997. These protections and rights fall into one of two categories: 1) Due Process Protections with respect to eligibility determinations and fair hearings (in accordance with regulations found in 42CFR Sections 431.200-.250 and 435.911-920); and 2) Consumer rights with respect to their treatment as a patient receiving health care services through programs operated under the *Global Commitment to Health* program.

In addition, Vermont will ensure that the public's interest in the Quality Assurance and Performance Improvement (QAPI) aspects of the demonstration is represented. Specifically, the state will present its QAPI plan to the Medicaid Advisory Board on an annual basis and obtain their input on its design.

The protections and rights being retained are briefly described below.

### **Due Process Protections**

*Right to apply* – All Vermont residents will retain the right to apply for Medical Assistance under the new program without delay. The state will make available written information on the eligibility requirements for the various public health coverage programs available under the *Global Commitment to Health* Demonstration, and the services or subsidies available for each program separately.

*Written application* – All applications must be made in writing to the eligibility determination unit of the Agency of Human Services. Applicants may be assisted in the process by an individual(s) of their choice.

*Automatic enrollment following a determination of eligibility under other programs* – Vermont will continue to provide for automatic enrollment in Medicaid by individuals found eligible for Temporary Assistance to Needy Families (TANF) or Supplemental Security Income (SSI).

*Timely determination of eligibility* – Vermont will continue to adhere to the federally established timeframes for determining eligibility and informing applicants of what those timeframes are (90 days for applicants who apply on the basis of disability and 45 days for all other applications).

*Notice of decision concerning eligibility* – Vermont will send each applicant a written notice of the agency's decision on their application. If the application is denied the notice will include the reasons for the denial and an explanation of the applicant's right to a fair hearing.

*Case documentation* – The state will maintain a case record for each applicant that documents the facts that support the eligibility determination or denial.

*Effective date* – For applicants eligible for Medical Assistance through the Title XIX or XXI programs (Medicaid/SCHIP), the effective date of coverage will be consistent with existing rules for each program.

*Timely and adequate notice concerning adverse actions* – Vermont will continue to give Medicaid recipients timely and adequate notice of proposed actions to terminate, discontinue or suspend their eligibility or to reduce or discontinue services they may be receiving under Medicaid. Notices regarding the reduction or discontinuance of services will not be provided to individuals enrolled in Employer Sponsored Insurance or the Health Savings Account program.

*Fair hearings* – Vermont will continue to operate its fair hearing system for all applicants and enrollees in the Medicaid, VHAP or Dr. Dynasaur programs. The system will provide for a hearing before the agency, or a local evidentiary hearing at the local level, with a right of appeal to the state agency. The hearing system will meet federal due process standards.

*Notice of Hearing decisions* – Vermont will notify beneficiaries following the hearing of the state's decision and their options for further appeal, if any.

## **Consumer Protections**

In addition to the due process protections outlined above, Vermont will ensure that other consumer protections are incorporated into the Demonstration. These are briefly discussed below:

*Access to emergency services* – All beneficiaries will have access to emergency services in accordance with the federal prudent layperson standard.

*Timely access to services* – Vermont shall ensure that access to services is provided consistent with state standards, as required under the Balanced Budget Act.

*Direct Access to a Women's Health Specialist* – Consistent with the requirements of the Balanced Budget Act, Vermont will ensure that female beneficiaries have direct access to a women's health specialist for routine and preventive services.

*Access to a Second Opinion* – Vermont will ensure that beneficiaries have access to a second opinion from a network provider.

*Participation in treatment decisions* – Beneficiaries have the right to obtain from their treating physician complete and current information concerning their diagnosis, treatment plan, and any known prognosis. The beneficiary has the right to participate in decisions regarding the treatment recommended by their clinicians, and to refuse treatment to the extent allowed under law.

*Respect and nondiscrimination* – Program providers may not discriminate against any beneficiary based on race, creed, color, religion, disability, or sexual preference. Beneficiaries have the right to considerate and respectful care at all times and under all circumstances with recognition of his or her personal dignity.

*Confidentiality of health information* – Program providers are required to ensure the confidentiality of personal health information in accordance with the requirements of

Health Insurance Portability and Accountability Act (HIPAA) and state and federal laws and regulations.

*Appeals of disputed claims* – Beneficiaries and program providers will have the right to appeal the denial of any claim for covered health services. The appeal process will be specified by the state for the public program and by private sector health plans for the ESI program.

In addition, program enrollees who receive services in a hospital or nursing home within the state of Vermont have additional rights as specified in Vermont's Patient Bill of Rights for hospital or nursing facility patients.

## Chapter 5: Public Process

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The need for Medicaid reform has been a well-discussed topic over the past months in Vermont. This has been the focus of multiple legislative hearings and testimony, meetings of the Health Access Oversight Committee (a ten member legislative committee that meets when the Legislature is not in session), monthly meetings of the Medicaid Advisory Board (a statutorily defined stakeholder group to advise the Agency of Human Services on the Medicaid program), and consistent coverage by the media. All of these forums have acknowledged that health care reform must be a priority in Vermont. As such, through the winter of 2005, the Governor's Office and the Vermont Agency of Human Services, along with its consultants – The Pacific Health Policy Group – have worked collaboratively to develop the *Global Commitment to Health* concept paper, which was distributed for public input in February, and this proposal which was shaped by the public input gathered through these forums.

### A. Background

The Governor's Budget address in January, 2005, unveiled his "*Saving Medicaid Plan*", which included the following elements:

- Program restraints and modifications (e.g., pharmacy management mechanisms, long-term care reform, changes in eligibility for some VHAP categories; investments in quality improvement initiatives)
- Premium increases
- Provider savings
- Premium subsidies for conversion from public to private coverage (the Employer-Sponsored Initiative)
- Malpractice insurance reform
- Full implementation of the Governor's "Chronic Care" initiative, known as the "Blueprint for Health"
- Additional state general fund revenues dedicated to the Health Access Trust Fund
- A proposed new relationship with the federal government called the "Global Commitment to Health"

Prior to the unveiling of the Governor's Plan, an initial meeting was held in December to discuss possible methods for creating a new state-federal Medicaid relationship. As a result, the Governor's *Saving Medicaid Plan* provided a general framework for the *Global Commitment to Health*, including the following core elements:

- The state and federal government enter into a 5-year agreement;
- The federal government commits to an acceptable, annual funding growth rate that is less than its growth rate in recent years;
- The state commits to controlling the cost growth of the Medicaid program at a rate equal to or less than the federal trend rate commitment;
- The federal government allows Vermont to operate the Medicaid program with much more flexibility to innovate.

The following potential flexibilities were noted:

- For 18 months, we have been negotiating a long-term care “1115 waiver”, to equalize the Medicaid entitlement between home health and nursing home services. Going forward, we would not need to engage in these excruciatingly slow, detailed negotiations to accomplish a sensible, cost-effective change.
- We could strategically engage in chronic disease management, to reduce future demand for expensive care.
- We could use funds to be more innovative in coordinating mental and physical health, and substance abuse services.
- We could fund premium subsidies to encourage VHAP participants (i.e., non-traditional, employed Medicaid recipients) and uninsured Vermonters up to 300% of poverty, to buy into private employer plans.
- We could fund employer health plan incentives.
- We could potentially offer “healthy choice” discounts or incentives within the Medicaid program.

During the months of January and February, the State continued to flesh out the concepts for the *Global Commitment to Health* as identified in the Saving Medicaid Plan, including the identification of additional flexibilities that might be pursued under such an agreement. These ideas were summarized in the *Global Commitment to Health* Concept Paper which was widely disseminated on February 24, 2005.

## **B. Overview of Process for Gathering Input**

### **Legislative Activities**

Almost all of the initiatives in the Governor’s *Saving Medicaid Plan* require Legislative approval and are being vetted through many hearings held by the three House Committees and two Senate Committees of jurisdiction. In addition, a special Joint Legislative Medicaid Working Group (comprised of key leaders from the House and Senate) was formed early in the session to meet weekly with the Administration to discuss the Governor’s proposed solutions as well as generate new ideas for reform. *Global Commitment to Health* has been a key element of all these legislative activities.

### **Solicitation of Public and Stakeholder Input**

Following is a chronology of the events that provided input into the design of this proposal:

- On February 4, the State received a list of questions concerning the *Global Commitment to Health* from the Medicaid Advisory Group.
- On February 24, the *Global Commitment to Health* Concept Paper was distributed simultaneously to the Medicaid Advisory Board, the Vermont legislature, and AHS Policy Executives, and was posted on the AHS home web-page and the OVHA home web-page.

- On February 25, Public Announcements were placed on the OVHA website and the Vermont State Government website and published in the Burlington Free Press and Rutland Herald (the State's two primary newspapers) noticing the availability of the concept paper, three Public Hearings dates, and the deadline for submission of Written Comments.
- On March 4, public notice was published a second time in both the Burlington Free Press and Rutland Herald newspapers.
- On March 9, responses to questions submitted by the Medicaid Advisory Board regarding the *Global Commitment to Health* were posted on the OVHA web-site and distributed to the Medicaid Advisory Board.
- On March 11, the State received a list of questions concerning the *Global Commitment to Health* from the Joint Legislative Medicaid Working Group
- On March 14, AHS Secretary Michael Smith sent a memo to the Joint Legislative Medicaid Working Group clarifying that the *Global Commitment to Health* is not intended to be a vehicle for circumventing Legislative authority regarding approval of Medicaid policy and programmatic changes<sup>7</sup>; this document as also posted on the OVHA website.
- On March 15, a Public Hearing was held in Rutland, Vermont.
- On March 16, a Public Hearing was held in Burlington, Vermont.
- On March 16, responses to questions submitted by the Joint Legislative Medicaid Working Group regarding the *Global Commitment to Health*, were posted on the OVHA web-site and distributed to the Legislative Working Group members.
- On March 17, a Public Hearing was held via Vermont Interactive Television at nine sites around the state.
- March 23 was the deadline for written comments. Fifty-six (56) written comments were submitted by the deadline.
- On March 24, the *Summary of Questions / Comments with Responses* was posted on the OVHA web-site and distributed to the Medicaid Advisory Board. This document contained a compilation of the questions / comments submitted to the State by the Medicaid Advisory Board on February 4, the Joint Legislative Medicaid Working Group on March 11, and the written comments submitted by the public on or before March 23. (See Appendix 1 for the Summary of Comments and Responses).

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<sup>7</sup> Because the Global Commitment to Health was included as a component of the Governor's Saving Medicaid Plan, most stakeholders have assumed that the Global Commitment to Health Waiver is the Administration's vehicle for implementing other cost-reduction parts of the proposal. Since identifying this confusion, we have tried to be very clear in every communication that the waiver is a vehicle for allowing Vermont to make decisions about how to use its healthcare resources, but that any proposed changes in benefits and eligibility in the future would be vetted with stakeholders and the legislature, and would not be implemented without legislative approval.

- On March 28, a special meeting of the Medicaid Advisory Board (MAB) was held to hear a summary of the feedback on the Concept Paper gathered at the public hearings and in writing, and for the Board to provide its feedback on the concept paper
- On April 4, the Medicaid Advisory Board was sent a draft of the *Global Commitment to Health* proposal, which incorporated the feedback received by the state through the above processes.
- On April 7, a special meeting of the Medicaid Advisory Board (MAB) was held to provide feedback on the draft proposal. During the April 7 MAB meeting, members provided recommendations which were incorporated into this final proposal for submission to CMS. The board, however, expressed strong concerns about specific aspects of the proposal, and passed the following motion by a majority vote:

*“The Medicaid Advisory Board (MAB) advises the State that it does not support the Global Commitment Waiver draft as of 4/4/05. While the idea of a waiver giving flexibility to the State to use Medicaid dollars more effectively has merit, we have severe reservations regarding this proposal because of: 1) Lack of specifics as to the potential changes in programs and the effect on vulnerable populations; 2) Specific suggestions such as ESI and HSAs raise significant public policy issues; 3) Lack of a comprehensive plan that encompasses new funding sources; and 4) An unrealistic time frame provided to review the proposal. The MAB, however, is committed to continuing to work with the administration to explore waiver options and proposals. “*

As to points 1) and 2) above, the State understands the fears of many of the Board members regarding entering into the proposed waiver agreement. Unlike waivers of the past, this waiver is much broader in scope and is not targeted towards a specific population or target group. The waiver proposal does, however, provide specifics about the public process that will be followed before any future changes in eligibility or benefits are enacted. The proposal and all other written and verbal communications have explicitly stated that any changes to eligibility or benefits would continue to be discussed among stakeholders and approved by the legislature. The Legislature is in effect, the Managed Care Governing Body. MAB members, however, expressed fear that the new waiver would allow the administration to make sweeping changes without public input and legislative approval. The State again affirms that the proposed waiver does not give the State administration authority to implement any changes in eligibility or benefits without legislative approval.

As to point 3) above, many MAB members have been advocates for comprehensive health care reform funded through increased state revenues such as taxes. As such, point 3) reflects their concern that the *Global Commitment to Health* is only focused on Medicaid and not the entire health care system in Vermont, and that it does not advocate for increased state revenues to support a broad health care system. The State acknowledges this, and thinks it is appropriate that the proposal submitted to CMS only focus on the health care funding for which CMS has authority.

Regarding point 4) above, the State acknowledges that the timeframe for this project has been aggressive. We also believe that the public input process (as described in this section) has been diligent and that the feedback attained through this process has been vital to informing the content of the final proposal.

- During the months of April and May, we also anticipate that there will continue to be testimony regarding the *Global Commitment to Health* before key legislative committees, as well as meetings held with various stakeholder groups throughout Vermont.

### **C. Oversight and Involvement under *Global Commitment to Health* Demonstration**

#### **Legislative Review and Approval**

As noted throughout this document, the Vermont Legislature will have ultimate authority for approving any policy or programmatic changes to the Medicaid program that are implemented under the *Global Commitment to Health*. This will occur through the normal legislative process when in session (January through April / May of each year), and vetted by standing legislative committees outside of the session. This will include formal testimony before legislative committees, as well as participation in any public forums concerning the Medicaid Program or health care convened by the legislature.

#### **Public and Program Participant Involvement**

The Medicaid Advisory Board will continue in its role of providing input into policy and programmatic changes as a key component of the Public Input process for any proposed changes under the *Global Commitment to Health* demonstration. In addition, the State will conduct public hearings on changes which the State Legislature advises are significant enough to require additional input from the broader public. The feedback from these public hearings will be provided to the Medicaid Advisory Board and the Vermont Legislature to help inform policy or programmatic changes, and also will be posted on the OVHA web-site for broad public review.

Under the *Global Commitment to Health*, the State of Vermont will convene focus groups of beneficiaries and of providers on a quarterly basis to help us identify possible program changes and efficiencies from these participants' points of view. These focus groups will be linked with the MCO Quality Assurance / Quality Improvement efforts (see Chapter 7, Section III). In addition, the content of these focus group discussions will be summarized for the Medicaid Advisory Board for their discussion of the implications of potential program or policy changes on program effectiveness.

## Chapter 6: Program Administration and Reporting

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### Overview of Program Administration

The *Global Commitment to Health Demonstration* will be operated as a managed care program. The Agency of Human Services will capitate the Office of Vermont Health Access (OVHA) for the provision of all covered health care services and programs for all eligible populations. OVHA will be responsible for ensuring that services are delivered and the program is administered consistent with the requirements of the Balanced Budget Act of 1997 (BBA) and the terms and conditions of the federal demonstration waiver (see Figure 2.1 in Chapter 2)

OVHA will perform the functions of a managed care organization, including the following:

*Enrollment* – OVHA will ensure the enrollees who are eligible for PC Plus are enrolled in the PCCM program and have a Primary Care Provider (PCP).

*Case Management* – OVHA will arrange with other AHS departments for comprehensive case management services for children with special health care needs, children and adults with serious mental health disorders, people with developmental and physical disabilities, and the frail elderly.

*Utilization Management* – OVHA may require prior authorization for some services and will monitor utilization to ensure appropriate levels of service use.

*Quality Management* – OVHA will provide quality oversight for the demonstration program. The state's External Quality Review Organization (EQRO) will also conduct monitoring activities.

*Provider Network* – OVHA, in conjunction with other AHS departments will ensure that an adequate network of Medicaid certified providers is accessible to all public program enrollees.

*Member Services* – OVHA will ensure the provision of traditional member services functions, including handling telephone inquiries, supporting the PCP enrollment function, and the provision of certain member informational materials. OVHA will be assisted in these activities by its enrollment broker.

*Claims Processing* – OVHA, through its contract with EDS for MMIS services will provide a claims system for the receipt, processing and adjudication of all enrollee claims for services.

*Service Delivery* - OVHA will enter into a series of Inter-Governmental Agreements (IGAs) with other state departments to provide, or arrange for the provision of, services and to manage programs. Specifically, OVHA expects the following departments will be responsible for these services and programs:

Dept of Aging & Independent Living: Long-term care  
Home- and Community-based Services  
Developmental services

Department of Health:	Substance abuse prevention / treatment Public health initiatives Adult mental health Children's mental health Community Rehabilitation and Treatment Emergency mental health
Department of Education:	School-based health services
Department for Children and Families	Targeted programs for children

Through the Inter-Governmental Agreements, OVHA will make payments to these departments to finance the programs and services for which they are responsible. The state does not anticipate using any Inter-Governmental Transfers (IGTs) or Certified Public Expenditures (CPE) to finance the *Global Commitment to Health* Demonstration.

OVHA will retain responsibility for the public health insurance programs (Medicaid, VAHP and Dr. Dynasaur), and if implemented, the premium subsidy program and the Health Savings Accounts. OVHA will also administer the pharmacy benefit programs.

The state will establish the overall eligibility requirements for its programs and the level of beneficiary cost sharing and premium subsidies through its legislative and budget process. OVHA will be responsible for ensuring each department administers its programs consistent with the requirements of the Demonstration's terms and conditions, and BBA regulations.

The State's contracted EQRO will conduct quality reviews of each program area. The reviews will focus on quality outcomes, timeliness of, and access to, the services provided in each department and within OVHA.

Enrollees in the PC Plus program (approximately two-thirds of the Medicaid, VHAP and SCHIP enrollment) are all assigned to a Primary Care Provider. OVHA will ensure that primary care services are available throughout the state, by contracting with the twelve existing primary care clinics and other primary care providers.

As previously noted, the transition to the *Global Commitment to Health* program will be essentially transparent to most enrollees in the Medicaid, VHAP and SCHIP programs, as well as for individuals served under the CRT waiver or included in any of the state's HCBS waiver programs. There will be no change in the way these individuals receive their health care or the providers they currently use. Over time, beneficiaries may see more programs and options added under the Demonstration. Whenever new programs are contemplated, the state will provide information on those initiatives to the general public, public program enrollees, providers and other interested parties such as advocacy organizations.

OVHA, in conjunction with the departments, will ensure that an adequate number of providers are available to serve the enrolled population across all of the programs administered under the demonstration. All providers will be required to meet the MCO's participation requirements. OVHA will delegate to each department the responsibility for ensuring quality oversight of the providers delivering care and services to demonstration eligibles.

For example, the Department of Health will be responsible for oversight of substance abuse treatment programs and entities providing services through the chronic care initiative. Similarly, DAIL will be responsible for the oversight of nursing facilities, HCBS and developmental services providers (the Designated Agencies and Specialized Services Agencies).

AHS will retain responsibility for the grievance and appeals process for both eligibility and services, as well as the Fair Hearing process. Under the demonstration, Vermont will continue to follow the due process requirements (notices and hearings) specified in federal statutes and regulations for Medicaid. OVHA will ensure that consumer protections are afforded to demonstration enrollees (see Chapter 4).

The *Global Commitment to Health Waiver Demonstration Terms and Conditions* must include certain key protections for Vermont. This would include any changes in Federal law which would benefit state Medicaid spending. Those statutory changes must be incorporated into a modified budget limit for the demonstration.

In addition, the State's ability to suspend the Waiver in the event of a national or state emergency or catastrophic event must be clearly defined in the Terms and Conditions governing the Demonstration. Specifically, in the event of a state or national health care crisis that is beyond Vermont's control and which requires an unexpected and significant health care resource investment, the state must be protected. Examples might be an outbreak of smallpox or a nuclear or "dirty-bomb" event.

The Terms and Conditions will also specify the State's options with respect to the extension or termination of the Waiver at the end of the five year demonstration period. If the Waiver is to be phased out at the end of the five year period, this must be accomplished in a manner that protects existing beneficiaries and services.

### *Reporting*

All claims for services will be processed through the state Medicaid Management Information System (MMIS). Accordingly, OVHA will retain all claims history and paid claims information to facilitate analysis and reporting of utilization and expenditures under the demonstration. All prior authorization activities will be centralized within OVHA and executed through MMIS functionality.

Vermont will continue to file the federally mandated reports in accordance with the timeframes required in the Terms and Conditions governing this demonstration. This includes all required expenditure reports.

The CMS-64 Report will continue to be provided on a quarterly basis, and will establish the basis for determination of Federal Financial Participation. The state will provide information regarding capitation payments and administrative expenses on the CMS-64 Report; additional information, such as capitation payments by eligibility group, will be provided as specified in the Waiver Terms and Conditions.

If a premium subsidy program is implemented, Vermont will report on the number of participants and the total amount of premium subsidies provided. If a Health Savings Account program is implemented, Vermont will report on the number of individuals who open accounts and the total amount of contributions made to those accounts by the State.

### *Provision of Services*

Demonstration enrollees in public health insurance programs (Medicaid, VHAP and Dr. Dynasaur) will be eligible for all state plan services based on medical necessity. Seriously mentally ill adults will continue to receive services as they do today under the CRT amendment to the state's existing 1115a waiver. Individuals currently enrolled in HCBS waiver programs will continue to receive services based on their assessed needs and the funding priorities established by the state. This is consistent with the current process and procedures.

Enrollees who are only eligible for certain targeted or specialized services (e.g., substance abuse treatment, disease management, etc.) will receive the services specified under those programs based on their assessed needs. Program providers will conduct the assessments which will be reviewed by the sponsoring departments (e.g., Department of Health) before the services are authorized.

### *Clinical Assessments*

Some services provided to demonstration enrollees with serious mental illness, developmental or physical disabilities, or for the frail elderly, are based on a clinical assessment of their needs. This is the process currently used in Vermont. Clinical assessment tools are used by several departments, particularly the Department of Aging and Independent Living and the Department of Mental Health.

In the general acute care program, primary care providers are responsible for conducting assessments of their patients and determining the care and treatment they require, sometimes in consultation with specialty providers.

## Chapter 7: Proposed Model Terms and Conditions

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While Vermont acknowledges that CMS will present the State with its proposed Terms and Conditions under which the Demonstration will operate, the State has included with this application the model terms it would like to see included. These terms are based on those already proposed for Vermont's Long Term Care Demonstration Waiver, which is currently pending.

### SECTION I. GENERAL PROGRAM REQUIREMENTS

**Extension or Phase-out Plan.** The State will discuss demonstration extension plans with CMS at least 18 months prior to demonstration expiration and requests for extensions are due to CMS no later than 12 months prior to the expiration of the demonstration. If the State does not request an extension, it must submit a phase-out plan, which includes provisions for cessation of enrollment, to CMS no later than 12 months prior to the expiration of the demonstration. The phase-out plan must be submitted to CMS to review and consider for approval.

**CMS Right to Suspend or Preclude the Demonstration Implementation.** The CMS may suspend or preclude Federal Financial Participation (FFP) for State demonstration implementation and/or service provision to demonstration enrollees whenever it determines that the State has materially failed to comply with the terms of the project, and/or if the implementation of the project does not further the goals of the Medicaid program.

**State Right to Terminate or Suspend Demonstration.** The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State will promptly notify CMS in writing of the reasons for suspension or termination, together with the effective date. If the demonstration project is terminated by the State, CMS will be liable for only normal closeout costs. The State will submit a phase-out plan for CMS to review and consider for approval.

**CMS Right to Terminate or Suspend the Demonstration Operation.** During demonstration operation, CMS may suspend or terminate FFP for any project in whole or in part at any time before the date of expiration, whenever it determines that the State has materially failed to comply with any of the terms of the project. The CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination. The effective date of such action shall not be fewer than 45 days from the date of notice. The State waives none of its rights to challenge CMS' finding that the State materially failed to comply. The CMS reserves the right to withhold waivers and authority for pending FFP for costs not otherwise matchable or to withdraw waivers or authority for costs not otherwise matchable at any time if it determines, after good faith consultation with the State, that granting or continuing the waivers or authority for costs not otherwise matchable would no longer be in the public interest. If the Waiver or authority for costs not otherwise matchable is withdrawn, CMS will be liable only for normal closeout costs.

**Suspension based on Catastrophic Event.** Should the state find it necessary to suspend the Demonstration due to a state/national emergency or other catastrophic event, it is agreed that the two parties shall work collaboratively to ensure that program

beneficiaries are protected and the state has available adequate fiscal resources to respond to the event and protect the health and lives of its residents.

**Monthly Progress Calls.** During the first 6 months of operation, CMS and the State will hold monthly calls to discuss demonstration progress. After 6 months of operation, CMS and the State will determine the appropriate frequency of progress calls.

**Quarterly & Annual Progress Reports.** The State will submit quarterly progress reports that are due 60 days after the end of each quarter. The fourth quarterly report of every calendar year will include an overview of the past year as well as the last quarter, and will serve as the annual progress report. The CMS reserves the right to request the annual report in draft. The reports will address, at a minimum:

- a discussion of events occurring during the quarter (including enrollment numbers, lessons learned, and a summary of expenditures);
- notable accomplishments; and
- problems/issues that were identified and how they were solved.

**Final Demonstration and Evaluation Report.** At the end of the demonstration period, a draft final report will be submitted to CMS for comments. CMS' comments shall be taken into consideration by the State for incorporation into the final report. The final report with CMS' comments is due no later than 180 days after the termination of the project.

## **SECTION II: LEGISLATION**

**Changes in the Enforcement of Laws, Regulations, and Policy Statements.** All requirements of the Medicaid program expressed in Federal laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter, will apply to the demonstration. To the extent that changes in the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS will incorporate such effects into a modified budget limit for the demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement.

If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

**Changes in Federal Law Affecting Medicaid.** The State will, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the demonstration award date. To the extent that a change in Federal law, which does not exempt State section 1115 demonstrations, would affect State Medicaid spending in the absence of the demonstration, CMS will incorporate such changes into a modified budget limit for the demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law.

If the new law cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., laws affecting sources of Medicaid funding), the State will submit its methodology to CMS for complying with the change in law. If the

methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in the State, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop (within 90 days) a methodology to revise the without-waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration states.

**Amending the Demonstration.** The State may submit an amendment for CMS consideration requesting exemption from changes in law occurring after the demonstration award date. The cost to the Federal Government of such an amendment must be offset to ensure that total projected expenditures under a modified demonstration program do not exceed projected expenditures in the absence of the demonstration (assuming full compliance with the change in law).

### **SECTION III: ASSURANCES**

**Adequacy of Infrastructure.** Adequate resources for implementation, monitoring activities, and compliance to the Special Terms and Conditions of the demonstration will be provided by the State.

**Quality Assurance and Quality Improvement (QA/QI).** The Office of Vermont Health Access (OVHA) will design and implement an overall QA/QI plan that effectively assures the health and welfare of program participants and continuous improvement in the demonstration program. The system will be operational on the day the program is implemented.

The QA/QI plan developed by OVHA will, at a minimum, include a plan for discovery, remediation, and improvement; a protocol for reviews and data collection; and a monitoring and implementation plan. Monitoring activities will include, but are not limited to reviewing reports and corrective action plans, and auditing the QA/QI systems and plans. In addition, separate quarterly focus groups with providers and with beneficiaries will be convened to help identify areas for improved program efficiencies and effectiveness. The summaries of these focus groups will be used internally for program improvements and to help inform public policy via the Medicaid Advisory Board and the Legislature.

The Medicaid Advisory Board will also provide input on the Quality Assurance and Performance Improvement Plan for the demonstration. OVHA will present its proposed plan design to the Board on an annual basis for their review and suggestions.

**Cost sharing/Co-payments.** The state will implement cost sharing and co-payment provisions as approved by the state legislature.

**Reporting on Participants Receiving Services under the Demonstration.** The State agrees to develop systems to track and report expenditures for all participants in the demonstration.

**Evaluation and Monitoring Design.** The State will conduct an evaluation of the impact of the *Global Commitment to Health* Demonstration on participants. The State acknowledges the importance to CMS of an evaluation to the operation, quality

improvement and possible modifications to innovative demonstration initiatives. The evaluation will, at a minimum:

- Determine the cost effectiveness of the overall program as compared to the former Medicaid program
- Assess the effect of the demonstration on the number of uninsured in the state
- Determine the effect of the demonstration and its policies on participant satisfaction;
- Determine the effect of the demonstration and its policies on the array and amount of services available in the community;

**Independent Evaluation.** The State agrees to fully cooperate with Federal evaluators and their contractor's efforts to conduct an independent Federally-funded evaluation of the demonstration program.

**Budget Neutrality.** The cost of services provided during the demonstration will be no more than 100 percent of the cost to provide Medicaid services without the demonstration.

**Public Notice Requirements.** The demonstration complies with public notice requirements as published in the *Federal Register*, Vol. 59, No. 186 dated September 29, 1994, (Document number 94-23960) and Centers for Medicare & Medicaid Services (CMS) requirements regarding Native American Tribe consultation.

#### **SECTION IV: GENERAL FINANCIAL REQUIREMENTS**

**Expenditure Reports.** The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in the "Monitoring Budget Neutrality" section.

**Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration.

The standard Medicaid funding process will be used during the demonstration. Vermont must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable demonstration expenditures (total computable/Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year on the Form CMS-37.12 for both the Medical Assistance Program (MAP) and Administrative Costs (ADM). As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality cap defined in these Terms and Conditions. The CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State will submit the Form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

The CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in the Budget Neutrality section of the Terms and Conditions.

- a. Administrative costs, including those associated with the administration of the demonstration.
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State Plan.
- c. Net medical assistance expenditures made under Section 1115 demonstration authority, including those made in conjunction with the demonstration.

The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

## **SECTION V: MONITORING BUDGET NEUTRALITY**

The following describes the method by which budget neutrality will be assured under the demonstration. The demonstration will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. The Special Terms and Conditions specify the aggregate financial cap on the amount of Federal Title XIX funding that the State may receive on expenditures subject to the budget neutrality cap as defined in this document.

The budget neutrality cap will be for the Federal share of the total computable cost for the 5-year demonstration. The cap places the State at risk for enrollment and for Per Participant Per Month (PPPM) cost trends.

**Impermissible DSH, Taxes or Donations.** The CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda or regulations. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

**How the Limit will be Applied.** The limit calculated above will apply to actual expenditures under the demonstration, as reported by the State. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

**Expenditure Review.** The CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State

exceeds the cumulative target, the State must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

<u>Year</u>	<u>Cumulative Target Definition</u>	<u>Percentage</u>
Year 1	Year 1 budget estimate plus	8 percent
Year 2	Years 1 and 2 combined budget estimate plus	3 percent
Year 3	Years 1 through 3 combined budget estimate plus	1 percent
Year 4	Years 1 through 4 combined budget estimate plus	0.5 percent
Year 5	Years 1 through 5 combined budget estimate plus	0 percent

## Chapter 8: Waivers and Approvals Requested

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To operate the *Global Commitment to Health Demonstration* as described in this proposal, the State of Vermont needs to have certain statutory and regulatory requirements of the federal Medicaid program waived. In addition, the State needs the Secretary, through his authority under Section 1115(a) of the Social Security Act, to authorize the provision of federal Medicaid matching funds for certain expenditures on behalf of individuals not eligible for Medical Assistance under Titles XIX or XXI of the Social Security Act, and for services and programs not included in the Vermont State Plan for Medical Assistance.

### ***Specific Waivers Requested:***

1902(a)(1) – The state requests a waiver of the statewideness requirements set forth in this section to permit it to offer different types of services and programs in different geographic regions of the State.

1902(a)(10) – The state requests a waiver to enable it to provide non-Medicaid State Plan services to the Demonstration population (e.g., disease management)

1902(a)(10)(B) – The state requests a waiver of the comparability requirements set forth in this Section which requires that the amount, duration and scope of services be equally available to categorically and medically needy recipients. This waiver will allow the state to provide different types of services to various optional categories of individuals eligible for medical assistance under the Demonstration. It will also allow Vermont to pilot programs to test their effectiveness prior to implementing them across the entire Demonstration population.

1902 (a)(14) - The state requests this waiver to allow it to employ various types of cost sharing for program enrollees approved by the state's legislature , including premiums and point-of-service co-payments, at levels other than those specified in Section 1916.

1902 (a)(17) The state requests a waiver of this section to enable it to consider only the individual's or couple's income and resources when applying for assistance under the long term care program. Additionally, this waiver will permit the State to disregard quarterly income totaling less than \$20 from the post-eligibility income determination.

1902(a)(10) – The state is requesting waivers of certain provisions of this section to permit it to implement streamlined eligibility standards, process and procedures.

1902(a)(34) and 42 CFR 935.14 requires states to retroactively provide medical assistance for the three month period prior to the date the application for medical assistance is made. Vermont seeks a waiver of this provision for VHAP eligibles (consistent with the existing 1115a waiver) and demonstration participants receiving premium assistance to purchase employer-sponsored coverage or fund a Health Savings Account (HSA).

1902(a)(23) – The state requests a waiver of the freedom of choice provisions of this section. Some demonstration waiver participants may be only be eligible for certain

programs and have access to the providers participating in those programs, and will not have access to every Medicaid enrolled provider in the state.

1902(a)(10)(C)(i)(III) The state requests a waiver of this section to use institutional income and resource rules for the categorically and medically needy, with resource limits up to \$10,000 for enrollees electing home-based services in lieu of nursing facility or other residential care services in licensed settings.

42 CFR 431.800-.822 – The state is requesting waivers of relevant sections of these regulations to the extent necessary to employ a Medicaid Eligibility and Quality Control System that accommodates the programs, services and eligibility groups covered under the Demonstration.

42 CFR 438.206(b)(6) – The state requests to be waived from the provider credentialing requirements applicable to managed care plans under these regulations, since a state department (OVHA) will serve as the program’s Managed Care Organization. OVHA will continue to use its current process for qualifying and enrolling Medicaid participating providers.

42 CFR 431.201, 438.400(b), and 438.52(b)(2)(ii) and 438.56(f)(2) – The state requests a waiver of these requirements with respect to service authorizations and notices of action, but only for Demonstration eligibles receiving premium assistance and who are covered under employer-sponsored insurance plans (if applicable).

### ***Other Approvals Needed***

For purposes of the Demonstration, Vermont requests that expenditures made through the *Global Commitment to Health* program be treated as expenditures made under the State’s Title XIX or XXI programs, up to the Budget Neutrality limits established for the Demonstration, as follows:

- Expenditures for services provided by caregiver spouses approved by the State to provide care on a compensated basis for enrollees in the Long Term Care program
- Expenditures for services provided during a period of presumptive eligibility
- Expenditures for bed hold days in Enhanced Residential Care Homes for enrollees in the Long Term Care program
- All other expenditures made under the Demonstration program except the following:
  - o services rendered to inmates of correctional facilities, except discharge planning services for those who have established eligibility for a public program under the demonstration
  - o services provided by an IMD to individuals between the age of 18 and 64 years
  - o services provided by the Vermont State Hospital
  - o services covered under the Vermont State Employee Health Benefit Plan

Finally, the State asks to be explicitly waived from the requirements of the Balanced Budget Act as described in 42 CFR 438.6(c) with respect to the conduct of an actuarial certification of the capitated program rate paid to the Office of Vermont Health Access (OVHA) by the Agency of Human Services. The Global Commitment demonstration

fundamentally changes the financing mechanism for medical assistance in the State of Vermont. Accordingly, Vermont does not believe that the type of actuarial certification called for under the BBA is applicable to this demonstration. Because of the nature of the demonstration design, per member per month expenditures across all programs and recipients are not tracked in a manner that would lend itself to such a certification. For example, the MCO may invest in statewide initiatives that reduce health care service costs for enrolled populations over the long term. The waiver ceiling establishes the maximum permissible capitation payment under the demonstration, and was derived in consultation with CMS.

If there are any other waivers or approvals the Secretary or Administrator deems necessary to the operation of the Demonstration, we also request that those be granted.

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This document reflects the questions and comments received during the Public Comment period regarding the *Global Commitment to Health* Concept Paper which was distributed in February, 2005. It includes the specific questions submitted to the State by the Medicaid Advisory Board and the Joint Legislative Medicaid Working Group. It also includes a compilation of the comments and questions received at the three public hearings and the 56 written comments submitted to the State as of 4:30 PM on March 23, the end of the formal written comment period. The source of each question / comment is provided in parentheses at the end of the question / comment. The questions/comments have been categorized into five primary themes. Under each theme, we have grouped similar comments/ questions raised through these multiple processes, and have been provided a single response. Many of the comments submitted in writing were very similar in nature. In these situations, we have provided one comment that reflects the intent, and have indicated in parentheses the number of written comments that raised this issue.

Some of the questions and comments received through this process were related to the Governor's proposed budgetary changes to the Medicaid program for SFY 2006, including premium increases, provider reductions, increased pharmaceutical management, and premium subsidies through an Employer Sponsored Initiative (ESI). These are described in the January 19, 2005 Saving Medicaid document and the Office of Vermont Health Access SFY2006 Proposed Budget document and are under discussion in the Vermont legislature. However, only one of these initiatives – the provision of premium subsidies through an Employer-Sponsored Initiative – requires a new Federal waiver such as the *Global Commitment to Health*. All other proposed budgetary changes can be implemented, if approved by the legislature, without the *Global Commitment to Health* federal waiver. However, because many of our comments were specifically about these issues, we have included some of the comments / questions we received and have provided brief responses to clarify their relationship to the *Global Commitment to Health* federal waiver. More detailed information on the administration's SFY2006 Medicaid Budget proposal, including additional questions and answers, will be posted on the OVHA web-site at <http://www.ovha.state.vt.us/>.

**COMMENTS ABOUT THE OVERALL FINANCIAL IMPACT OF THE PROPOSED WAIVER**

- *Is this Global Commitment concept a Medicaid waiver? If so, under what federal law authority? If the Global Commitment is not a waiver, under what federal law authority will the plan be approved by CMS and implemented? (MAB)*

**Response: *The Global Commitment to Health will be an 1115a federal demonstration waiver.***

- *Currently, approximately 2/3 of Medicaid is included in the Health Access Trust Fund (HATF). 1/3 of Medicaid remains out of the HATF. It is my understanding that the HATF represents that portion of Medicaid administered by OVHA. Which Medicaid expenditures and programs are*

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*outside the trust fund? What are the funding sources for those services? How is the administration proposing to include them in the Global Commitment? How does the administration plan to incorporate money needed for the Vermont State Hospital and other mental health services into the Global Commitment? (MAB)*

**Response: Medicaid programs that are funded outside the HATF include the following:**

- **Department of Children and Families (DCF) programs – early development, Success by Six**
- **Vermont Department of Health (VDH) programs - mental health, substance abuse, EPSDT outreach**
- **Department of Aging and Independent Living - developmental services, assistive community care**
- **Department of Education - school-based health services**

**The state share for these programs primarily is part of each department’s General Fund appropriation. In some cases, the state share is provided through local education dollars, including Success Beyond Six and school-based health services.**

**The *Global Commitment to Health* waiver will include all programs that currently draw Federal Medicaid dollars. Funding for alternative services to the Vermont State Hospital and other mental health services will be included under the *Global Commitment to Health* waiver.**

- *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. (JLMWG)*

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

- *The proposed waiver limits Vermont to a fixed amount of funds to spend. How is the cap advantageous to Vermonters? (PH)*
- *How are financial and caseload predictions derived and how can the accuracy of these predictions be assured? (PH)*
- *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? (JLMWG)*
- *Why is the state using 2004 rather than 2005 as the base year for spending and why is the state negotiating for a total budget cap without using the approach of a per capita amount that has been used in other waivers? (WC)*

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- *The federal government should pay its share of the Medicaid costs. (WC – 6 submissions)*
- *What is the commitment to the entire health care system? The problem is not the services and programs but the cost of health care (e.g., pharmaceuticals). Health care costs are not just a Medicaid problem and solutions should be pursued in the context of the entire health care system. (PH; WC – 13 submissions)*
- *We need a comprehensive health care plan for Vermont. We see health care as a right for all, not a privilege for some. (PH; WC – 13 Submissions)*

**Response: Over the past decade, Vermont has been a national leader in expansion of Medicaid coverage for its citizens, securing one of the early Section 1115a Demonstration Waivers from the federal government (which has been in place in Vermont since 1996). This existing 1115a Waiver agreement has two major components: 1) it has allowed the state to access federal Medicaid funds to cover groups of individuals that do not meet the traditional Title XIX requirements (uninsured single adults with incomes up to 150% of the Federal Poverty Level (FPL), parents and caretaker relatives up to 185% of the FPL, pregnant women up to 200% of the FPL, and children up to 300% of the FPL); and 2) in exchange for this waiver to expand coverage to new people, Vermont agreed to not exceed a capped amount of spending each year for its overall program. This 1115a Waiver agreement has enabled the State to implement Dr. Dynasaur, VHAP, VHAP-Pharmacy, VScript, VScript Expanded, and Healthy Vermonters. As a result, Medicaid is now the insurance carrier for 25% of Vermont’s population. As such, addressing the Medicaid issue is addressing a major aspect of the health care delivery system in Vermont.**

Because of the large increase in the cost of healthcare, Vermont, as a state, has now exceeded its capacity to continue to fund our portion of the Medicaid program’s cost and maintain all current benefits (of every 2 dollars spent on the Medicaid program, roughly 60 cents is federal and 40 cents comes from Vermont taxpayers). The challenge that we now face is how to manage the state’s share of the cost of the program at a level we can sustain and also ensure that the current federal commitment is protected and continues to grow at the historical rate (approximately 10-12%). Under the *Global Commitment to Health*, we are working with the Federal Centers for Medicare and Medicaid Services (CMS) to negotiate an agreement that 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 because it is the most complete recent fiscal year), and a trend rate applied to this base each year, which will be built on Vermont’s historical expenditures and caseload growth. While we will need to manage within this total amount each year, we believe this is possible since the amount will be based on our past experience and growth rate.

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**And as noted above, Vermont has significant experience in developing financial and caseload projections for federal Waiver agreements. In addition, as with any waiver, the federal government will review in detail the financial assumptions behind our proposal and the agreed upon base and trend rates.**

- *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? (JLMWG)*
- *Vermont is locking itself into a financial arrangement and there is concern that something may be overlooked that will have a negative long-term negative impact. (PH; WC – 5 submissions)*
- *There is potential congressional action to provide Medicaid relief currently in congress. If this relief is forthcoming, how will Vermont’s interest be protected? (JLMWG)*
- *Page 25 of the concept paper states “...in the event of a national emergency... (such as an epidemic)” How is epidemic defined? What determines an epidemic? (PH, WC - 2 submissions)*
- *What contingencies will be included in the “force majeure” clause? (MAB)*

**Response: The *Global Commitment to Health* Waiver agreement will include a number of protections for Vermont. Our proposal for the Waiver will include a clause in the Terms and Conditions of Approval that will require that 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. In addition, the criteria for the State’s ability to suspend the waiver in the event of a national or state emergency or catastrophic event will be clearly defined in the Terms and Conditions of Approval before the Waiver agreement is signed. In general, this term refers to a state or national health care crisis that is beyond the control of the state and which requires an unexpected and significant health care resource investment. Examples might be an outbreak of smallpox or a nuclear event.**

- *The *Global Commitment to Health* is a block grant and historically, block grants have not benefited states. Block grants almost always go down in succeeding years while costs almost always go up. (PH; WC – 10 submissions)*
- *A block grant approach eliminates the federal entitlements to Medicaid. It means the state can put a cap on program enrollment and make drastic cuts and other program changes without federal oversight. (WC – 10 submissions)*
- *Is this a block grant where the money is a federal loan and then the money has to be repaid over the term of the waiver? (WC)*

**Response: The *Global Commitment to Health* proposal is very different than the block grant proposals of the past. Those initiatives were vetted and rejected by the states because they did not provide adequate protection against growth in program costs, in terms of both medical inflation and enrollment growth. As noted above, our waiver**

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would have a trend that goes up each year. We will not entertain an agreement unless it ensures that our program is fiscally sustainable.

It is true that under the proposed *Global Commitment to Health* waiver, Vermont as a state will be able to make policy decisions without having to obtain federal approval. However, the waiver will include terms and conditions that will identify core groups and services that must be covered, consumer protections regarding complaints and grievances, etc., - very similar to the existing waivers in Vermont. The State also will want to maintain most aspects of the existing waivers, as they have served Vermonters very well. The Terms and Conditions of Agreement also will clearly define the process that will be used in the state to make any changes in eligibility, benefits, or beneficiary payment requirements for Medicaid services. As is currently the case, any proposed changes in benefits and eligibility in the future would be vetted with stakeholders and the legislature, and would not be implemented without legislative approval. This is the same process that is in place today and will not change under the new Waiver agreement.

- *What is the plan for the pending §1115 Long Term Care Waiver and other existing Medicaid waivers? Will the state continue to pursue the Long Term Care waiver or will it be rolled into the Global Commitment? What about other existing Medicaid waivers? (MAB; WC – 2 submissions)*

**Response:** We are continuing to pursue the 1115a Long-term Care Waiver, as this agreement with CMS is close to being finalized. However, our plan is to replace the existing 1115a Waiver (which includes VHAP and the CRT Amendment) with the new Global 1115a waiver, which will also subsume the new Long-term Care Waiver and the existing 1915 waivers within AHS (Traumatic Brain Injury, Developmental Services, Children with Severe Emotional Disturbances, DAIL Home and Community-Based Waiver for people with physical disabilities). This will enable the Agency to have more non-categorical flexibility across these waiver programs while still maintaining our commitment to serving vulnerable populations.

- *What happens at the end of the five year term cited? (PH; WC = 2 submissions)*
- *Can the State return to the current system if the new waiver doesn't work? (PH)*
- *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? (JLMWG)*

**Response:** 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. If desired, the state will negotiate the ability to extend the Waiver. If we decide that we do not want to extend the Waiver agreement, 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

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**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 federal demonstration projects.**

- *What assurances are there that the Feds will meet their obligations and financial commitment under the new waiver? They haven't met their financial commitment for Temporary Assistance to Needy Families (TANF) and the Individuals with Disabilities in Education Act (IDEA) where despite a mandate to fund schools at 40% of special education costs, the percentage federal share is far lower than initially pledged and continues to decrease. Why is this different? (PH; WC- 3 submission)*
- *Comments about not trusting that the federal government would enter into an agreement that protects Vermont's interest. (WC – 3 submissions)*

**Response: The federal waiver agreement is a binding document between the state and federal government. As noted above, the terms and conditions will clearly spell out how and when either party can end their participation in the waiver agreement. On the other hand, the IDEA was a federal mandate that was passed by the United States Congress, separate from the federal budgeting process needed to support it.**

- *Vermont should consider new or additional taxes instead of pursuing the new waiver. (PH; WC – 6 submissions)*

**Response: By 2010, the state income tax would have to rise 29% over today's level, or the sales tax would need to increase by 60%, to keep up with the growth in current Medicaid program costs. The impact of such tax increases would be detrimental to Vermont's economy and would have repercussions well beyond health care.**

- *What is the contingency plan? (PH)*
- *Please explain the administration's plan if the funding under the Global Commitment is not adequate to sustain eligibility and coverage in the current programs. (MAB)*
- *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. (JLMWG)*

**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. If there is no *Global Commitment to Health Waiver* agreement, there will be an immediate and substantial fiscal issue that will need to be resolved for SFY06 and longer-term issues for future years.**

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**COMMENTS ABOUT HOW POLICY CHANGES TO THE EXISTING MEDICAID PROGRAM WILL BE IMPLEMENTED UNDER THE PROPOSED WAIVER**

- *“Flexibility” is a euphemism for cutting people off the program (WC); it is another term for the state being able to cut benefits without oversight. (PH)*
- *While the State may find a minimal number of federal rules and oversight desirable, there are reasons that current federal rules and oversight exist. We are concerned that these federal protections will no longer be in place. (PH; WC = 4 submissions)*
- *What are the checks, balances, and oversight that ensure that the services and programs won’t be eroded? (PH)*
- *What is meant by Legislative approval? How can the public be assured that the Legislative process is followed and that the full Global Commitment to Health process is transparent? (PH; WC – 2 submissions)*
- *Concern that the Global Commitment to Health will limit the State’s options. (PH)*
- *What specific requirements of Medicaid law will be waived under the Global Commitment? What provisions of existing waivers would be changed? (MAB)*
- *I consider the response on the OVHA website to Question #7 of the MAB to be unresponsive as it does not specify statutory questions to be waived. I am therefore repeating the question and would like to see an answer with statutory cites. (WC)*
- *We need a deal that lets the Vermont Legislature decide about our health care in a way that takes into account our local concerns and rural nature. (WC)*
- *We wish to be clearly understood that we support the goals of the Global Commitment proposal to maximize decision-making in Vermont – Vermont has clearly done a better job administering this program both programmatically and fiscally. (WC)*

**Response:** The requirements of Medicaid law are lengthy, complex and often byzantine. Often, it takes months to change one small aspect of a waiver program even if we believe it is more customer-friendly, such as changing the wording in a consumer notice or revising eligibility criteria to be more inclusive. One of the major incentives for our proposal to CMS is to receive operational flexibility in administering the new *Global Commitment to Health Waiver*. However, this does not mean that the State will have totally flexibility – the State will still have negotiated terms and conditions that will identify core groups and services that will be covered, consumer protections regarding complaints and grievances, etc. The State will also want to maintain most aspects of the existing waivers, as they have served Vermonters very well. However, the new waiver will provide an overall financial agreement and more flexibility that will be more beneficial to Vermont than the existing 1115a waiver.

**In the context of the *Global Commitment to Health*, the term “flexibility” means that Vermont as a state will be able to make policy decisions without having to obtain federal**

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**approval. 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. As is currently the case, any proposed changes in benefits and eligibility in the future would be vetted with stakeholders and the legislature, and would not be implemented without legislative approval. This is the same process that is in place today and will not change under the new Waiver agreement.**

**The draft proposal will include any specific statutory requirements that we would like to be waived. The Medicaid Advisory Board has scheduled a special meeting to review the draft proposal before it is submitted to CMS, and it will also be provided to the legislature. We will not request waivers for items related to consumer protections.**

- *What are the daily (financial, administration, program and service) implications of the new waiver if it is implemented? (PH)*
- *How will administrative costs and procedures change under the new waiver? (PH; WC)*
- *What administrative costs will be attributable to the Global Commitment? (MAB)*
- *I also consider the response on the OVHA website to Question #7 of the MAB to be unresponsive and would like a response that actually estimates costs instead of saying that there will be no need for new resources because of off-setting efficiencies. (WC)*

**Response: There will most likely be administrative adjustments that will need to be made to manage the new Waiver. Many of these administrative adjustments cannot be estimated because they will depend on what changes Vermont chooses to implement in upcoming year under the new Waiver. However, we believe that the efficiencies we will gain from the new flexibilities will enable us to make these administrative changes without the need for additional resources. We also may exclude administrative costs from the capped arrangement to protect against unexpected needs and to continue to benefit from enhanced federal support for certain administrative costs experienced by states (e.g., the implementation of new information systems).**

**COMMENTS ABOUT THE POTENTIAL IMPACT ON CURRENT BENEFICIARIES AND SERVICES, INCLUDING PEOPLE WITH DISABILITIES:**

- *Cutting programs and services doesn't eliminate the demand for them. Medicaid is cost effective compared to alternatives. (PH)*
- *The waiver pits one group against another for a limited amount of funding. (PH)*
- *The waiver places intervention and prevention services and programs at risk. (PH; WC – 4 submissions)*

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- *The waiver erodes a system of services and programs that Vermont has built up over years and is desirable. (PH)*

**Response:** The State agrees that Medicaid is very cost effective for meeting the health needs of Vermonters who have low incomes or who are disabled or elderly. The *Global Commitment to Health* is an effort to obtain a guarantee of federal funding that will help us to sustain the services and programs that we have developed over the years. Without this agreement, the amount of available funding will be more limited, and prevention and early intervention will be more at risk.

- *The proposed waiver appears to waive eligibility protections and allow states to change eligibility and benefits whenever it is deemed necessary. (PH; WC – 5 submissions)*
- *Do not cut funding, eligibility and services for those that do not have other options. (WC- 11 submissions)*
- *Will mandatory and optional services be maintained under the proposed waiver? (PH)*
- *Provide a list of groups with their benefits and how these groups and benefits will change under the proposed waiver and the five-year period. (PH)*
- *What changes in benefits and eligibility will the state make under the Global Commitment? (MAB)*

**Response:** The only specific changes in benefits and eligibility currently under discussion are those aspects that relate to the Governor’s “Saving Medicaid Plan”, only one of which requires the *Global Commitment to Health* for implementation: freezing the VHAP enrollment for certain populations and instead converting to a Premium Assistance Plan through an Employer-Sponsored Initiative. Under the *Global Commitment to Health* Waiver, existing people enrolled under the current Medicaid/VHAP program, including traditional Medicaid, Dr Dynasaur, 1915 waiver enrollees, VHAP waiver beneficiaries and VHAP-Pharmacy beneficiaries, would be transitioned to the new program - there would be no other immediate impact on benefits as a result of the transition. In addition, as is currently the case, any proposed changes in benefits and eligibility in the future would be vetted with stakeholders and the legislature, and would not be implemented without legislative approval. Again, this is the same process that is in place today and will not change under the new Waiver agreement.

- *It is not clear how children’s mental health services will be funded under the waiver. (PH)*
- *How will the health care needs of children continue to be met under the proposed waiver? There have been many improvements in health care for children under Medicaid which focus on prevention and have resulted in positive outcomes. The proposed waiver will adversely affect health care for children. (PH; WC – 8 submissions)*
- *How is EPSDT going to be protected under the new waiver? (PH; WC -3 submissions)*

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- *Families of children with special health care issues need the assurance that their children will continue to be able to receive medically necessary treatment for their health conditions. (WC – 6 submissions)*

**Response: The *Global Commitment to Health Waiver* does not propose changes to children’s health and mental health services or programs. Instead, it would provide the State with the financial resources to be able to sustain the services and supports that have been implemented over the past decade. If any changes in services or programs were proposed in the future, they would be vetted with stakeholders and the legislature, and would not be implemented without legislative approval. Again, this is the same process that is in place today and will not change under the new Waiver agreement.**

- *Community resources are already struggling. They are already having difficulty finding staff and have budget concerns. It appears that an even greater reliance will be placed on the community system and resources. (PH)*
- *Page 20 of the *Global Commitment to Health* concept paper states “The Vermont community mental health system... In recent years, community providers have faced increasing fiscal challenges as demand has exceeded public resources.” The community mental health system is at risk. What assurances are there that the system will remain intact and not be placed in jeopardy? (PH)*
- *If reimbursements to health care providers are reduced, more of those providers will stop serving Medicaid clients. (WC- 11 submissions)*

**Response: The *Global Commitment to Health Waiver* does not propose cuts to services, programs, or providers. (Proposed reductions are being discussed in the Legislature as part of the Administration’s plan to address the Current Medicaid budget, but these are not part of the proposed federal waiver agreement.) Actually, the *Global Commitment to Health* waiver would provide the State with the financial resources to help sustain the services and supports that have been implemented over the past decade. Any proposed changes in services or programs in the future would be vetted with stakeholders and the legislature, and would not be implemented without legislative approval. Again, this is the same process that is in place today and will not change under the new Waiver agreement.**

- *Page 14 of the *Global Commitment to Health* concept paper states “Vermont believes that market-based approaches...” But the types of market-based plans under the proposed waiver often exclude people with disabilities. (PH)*
- *As a mom of a teenage son with developmental disabilities, I can say that families like mine are living lives that are relentlessly challenging. These cuts would dramatically compromise our ability to provide the care for our family members. (WC)*
- *Page 23 of the *Global Commitment to Health* concept paper states “...the program is facing long term challenges resulting from the lengthening life spans of the developmentally disabled*

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*and the growing number of aging caregivers (usually parents).” How does the proposed waiver affect people with developmental disabilities and impact services? (PH)*

- *The proposed waiver appears to indicate that it will not adversely affect low income Vermonters with disabilities. How is that possible? (PH)*
- *There appears to be no support for mildly and moderately autistic persons after they leave school. A job and part-time support person would be much more cost effective. (WC)*
- *Concern that reductions will cause people with disabilities to not be able to access needed supports, such as medications, therapy, personal cares services, transportation to medical appointments, etc. (WC- 12 submissions)*
- *Explain the impact of the proposed waiver on the Olmstead decision. Does it ensure the funding and benefits that are guaranteed under the Olmstead decision? (PH)*

**Response:** The State is committed to continuing to provide services for its most vulnerable citizens. Under the *Global Commitment to Health Waiver*, the State will agree to continue to guarantee benefits for core Medicaid groups (low-income individuals and individuals with specialized needs) and continue to ensure access to medically necessary treatment for children, as required by EPSDT. In fact, that is one of the primary reasons for pursuing the *Global Commitment to Health* agreement – to develop a financial arrangement with the federal government that will enable us to preserve these services and also provide us with flexibilities that could augment service administration and delivery. Examples of potential flexibilities that may be possible under the *Global Commitment to Health* waiver include expanding the SCHIP program to extend coverage to low-income families; expanding consumer choices and promoting early intervention for individuals with long-term care needs; enhancing existing caregiver respite programs; continuing coverage initiatives for working individuals with disabilities and exploring options to enhance benefits; improving access to services for children through integration of early childhood development and health services, and strengthening the integration of community-based systems for mental health and substance abuse treatment. Any proposed changes in services or programs in the future would be vetted with stakeholders and the legislature, and would not be implemented without legislative approval. Again, this is the same process that is in place today and will not change under the new Waiver agreement.

**COMMENTS ABOUT THE PROCESS FOR DEVELOPING THE PROPOSAL**

- *The Global Commitment waiver is being “fast-tracked”. What is the purpose of proceeding so quickly? Is the State budget crisis propelling it? It is important to proceed cautiously and leave time to explore all options and implications. Can the waiver be implemented for July 1<sup>st</sup>? (PH; WC)*

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- *Please explain in more detail the time table for approval and implementation of the Global Commitment, including the rule making time table. Please include detail on how does the administration expects to meet such an aggressive time table that assumes approval by CMS of the Global Commitment by March 31, 2005, and legislative approval of all regulatory changes by July 1, 2005. (MAB)*

**Response:** The Agency plans to submit the formal proposal to the Centers for Medicare and Medicaid (CMS) for the *Global Commitment to Health* by the middle of April and still hope to achieve agreement with CMS by July 1, 2005. The Agency acknowledges that this timeline is very aggressive, but also recognizes that both Vermont and the federal government would benefit from an expeditious review and agreement to this new arrangement. Draft statutory language specifying that the State will get legislative approval before finalizing the agreement with CMS has been proposed in the legislature, and is supported by the administration. Any new rules necessary as individual portions of the Global Commitment are further developed will be promulgated in accordance with state law. Any proposed changes in services or programs in the future would be vetted with stakeholders and the legislature, and would not be implemented without legislative approval. Again, this is the same process that is in place today and will not change under the new Waiver agreement.

- *What public process will the administration use to receive comments and feedback about the plan? (MAB)*
- *Thank you for having the Public Hearings to enable us to provide our comments. (PH; WC – 4 submissions)*
- *Are the public hearings a ploy? Will comments really be taken into consideration? What impact will the public hearings have on the waiver proposal? (PH)*
- *The details provided about the proposed plan, the opportunity for public input and the timing of the process for seeking approval have not been adequate. The public cannot evaluate the proposal if it does not know which groups or programs are going to be most affected. (WC – 4 submissions)*
- *The administration has made it clear that it is already seeking a response to its waiver request from the Centers on Medicaid and Medicare Services before all public comment has been received. (WC – 2 submissions)*

**Response:** On February 24, the Concept Paper which describes the *Global Commitment to Health* was distributed simultaneously to the Medicaid Advisory Board, the Vermont legislature, and AHS Policy Executives, and was posted on the web on the AHS home page and the OVHA home page ([www.ovha.state.vt.us](http://www.ovha.state.vt.us)). February 25, the following day, Public Announcements were published in the Burlington Free Press and Rutland Herald noticing Public Hearings and the availability of the concept paper. On March 4, public notice was

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**published a second time in both the Burlington Free Press and Rutland Herald newspapers.**

**Public hearings were held on March 15 in Rutland, March 16 in Burlington and on March 17 via nine Vermont Interactive Television sites. Notices of these public hearings were posted on the OVHA website and the Vermont State Government website. March 23 is the deadline for written comments. In addition, two special meetings of the Medicaid Advisory Board (MAB) have been scheduled: March 28 - to hear a summary of the feedback on the Concept Paper gathered at the public hearings and in writing, and for the Board to provide its feedback on the concept paper; and April 7 - to provide feedback on the draft proposal that will be sent to the MAB prior to the meeting. During the months of March and April, we also anticipate that there will be testimony regarding the *Global Commitment to Health* before key legislative committees, as well as meetings held with various stakeholder groups throughout Vermont.**

**The Administration has been very open about the fact that there have been discussions with the federal government about the concept of the *Global Commitment to Health*, including how the financing might be structured. This is common practice when States are considering a waiver submission, and is prudent for the State. We would not want to develop a proposal to the federal government if we did not have some indication that it would be considered. However, we do not have any formal agreement, and will not until after we submit the proposal in mid-April. The questions/comments provided through the public hearings and written comment process have been very helpful for understanding the issues of concern to Vermont citizens. These questions/comments are being used to inform the proposal that will be submitted to CMS in mid-April. As previously noted throughout this document, there are no proposed changes to the Medicaid program other than those in the Governor's proposed budget for SFY 2006, and these have been the focus of intense discussions during the legislative session. The only aspect of the Governor's proposal that would need the *Global Commitment to Health* is the Employer-Sponsored Insurance program, which has been a part of these discussions.**

- *The Global Commitment to Health Concept Paper appears to be a product of State government. To what extent were all of the "players" (e.g., providers, community mental health organizations) involved in the developing the concept?* (PH)

**Response: The concept paper was developed by the State to provide the Vermont legislature, providers and Vermont citizens with a set of ideas to enable them to provide feedback to help inform the formal proposal to CMS.**

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**COMMENTS ABOUT PREMIUMS, PHARMACY AND OTHER PROPOSED CHANGES AS THEY RELATE TO THE GLOBAL COMMITMENT TO HEALTH WAIVER**

During the Public Comment process for the *Global Commitment to Health* concept paper, we received several questions about specific financial implications of the Governor's proposed Medicaid budget initiatives as they relate to specific eligibility categories. More detailed information on the administration's SFY2006 Medicaid Budget proposal, including responses to these questions, will be posted on the OVHA web-site at <http://www.ovha.state.vt.us/>.

- *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? (JLMWG)*
- *What will be the impact on the Global Commitment if the Premium Assistance Plan does not pass the legislature? What changes will the administration make to the Global Commitment? (MAB)*
- *Concern that subsidy levels will jeopardize coverage. (PH; WC – 9 submissions)*
- *Concern that premium increases will shift costs to schools, providers, and to other payers. (WC- 9 submissions)*
- *Concern that premium increases will result in coverage losses. (PH; WC – 16 submissions)*
- *Low income families are already struggling, paying increased premiums is something they cannot do, and they will simply not engage in health care in a timely way and will require show up in the emergency room. This will especially affect children and prevention efforts that are successful in saving money in the future. (WC – 15 submissions)*
- *If a 60% subsidy is not sufficient to enable low income working families to purchase employer-based coverage, we recommend that the state establish a pathway into the Dr. Dynasaur program, or make sure they have access to the services not covered by private insurance programs. (WC – 3 submissions)*
- *I believe everyone who can afford something at all should pay into Medicaid. We would have no affordable access to basic health care at all without Medicaid. If we all pay in what we can afford, it would help the present system a lot. Offering a discount or rebate just doesn't help with the day-to-day financial issues of people living on the edge. (WC- 2 submissions)*
- *We don't mind an increase in the premium, nor do we mind having to provide a co-pay for our daughter's care. But please, let us earn more to cover the costs without taking it out of our paychecks. (WC)*

**Response:** The proposed Employer-sponsored Insurance program and premium increases are part of the Governor's proposed budgetary changes to the Medicaid program for SFY 2006 as a way to address part of the projected Medicaid budget deficit. We understand that there is concern about these changes and its impact on enrollment and coverage. These changes will only be implemented if they are approved by the

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**Legislature this year. We would only need the *Global Commitment to Health* waiver to be able to implement the Employer-sponsored Insurance proposal (if approved by the legislature); that is, the state can increase premiums under our existing waiver authority with approval from the federal government. Again, any changes in premiums must be approved by the Vermont Legislature.**

**There will be no impact on the *Global Commitment to Health* Waiver if the ESI, Premium Assistance Plan, or the premium increases do not pass the Legislature. However, there will be a SFY 2006 budget shortfall that the legislature will have to deal with should these proposals be unacceptable to the Legislature. On the other hand, the new Waiver would enable the state to have flexibility in the way we choose to provide health care benefits, such as providing additional coverage to meet specialized needs of children enrolled in private insurance plans.**

- *Are the pharmacy programs included in the Global Commitment? If so, why. The state is losing federal match for the pharmacy programs that are part of the §1115 waiver effective January 1, 2006. (MAB)*
- *Is VHAP–pharmacy and Vscript included in the 2004 base year amount being negotiated? (WC)*
- *Should pharmacy be excluded from the waiver? (PH)*
- *Is pharmacy the largest expenditure? What is the impact of Part D on pharmacy? (PH)*
- *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? (JLMWG)*
- *I am supportive of controlling Medicaid costs by utilization review programs, but do not support the restriction of drug availability for the treatment of serious and persistent mental illness. (WC)*
- *What assumptions and projections are built into the Global Commitment to Health waiver regarding the impact of the implementation of Medicare Part D on the state health care programs? (MAB)*
- *How will the wrap proposed meet the State pharmacy assistance program requirements of the Medicare Modernization Act? (JLMWG)*
- *How is the cost sharing that will be part of Part D for some beneficiaries (premiums, coinsurance, co-payments) accounted for in the Global Commitment plan? (MAB)*
- *Why have the PDL and generic drug requirements previously enacted not yielded better results in slowing drug expenditures in Medicaid? (JLMWG)*

**Response: Pharmacy costs are one of the major areas of increasing expenditures within the overall Medicaid program. We cannot afford to exclude them from the *Global Commitment to Health* Waiver agreement and we must manage the benefit to be able to afford it in the future. As such, the financial analyses for the proposed Waiver include the**

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**implications of the Medicare Modernization Act / Medicare Part D, and VHAP–pharmacy and VScript expenditures.**

**Under the *Global Commitment to Health*, how Vermont chooses to provide pharmacy coverage will be a Vermont decision and will not be subject to federal scrutiny. Any proposed changes in the pharmacy program will be vetted with stakeholders and the legislature, and will not be implemented without legislative approval.**

**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. 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. In addition, 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.**

- *I would like to suggest that a component of Medicaid reform be a pilot program testing “Health Savings Accounts.” (WC)*
- *The potential use of Health Savings Accounts for low income individuals is disturbing. Individuals with disabilities who require regular medical care are likely to forego care if they have significant deductibles. (WC)*

**Response: Health Savings Accounts is one of many options that could be considered by Vermont if we successfully receive the *Global Commitment to Health Waiver*. Any proposed changes in the Medicaid program in the future, such as Health Savings Accounts, will be vetted with stakeholders and the legislature, and will not be implemented without legislative approval. Again, this is the same process that is in place today and will not change under the new Waiver agreement.**

- *There are numerous efficiencies that could be implemented within the existing program, including implementing a residency requirement, including co-pays as part of every service rendered, extending Dr. Dynasaur eligibility to age 18, implementing a policy of pay before you get coverage, and streamlining communication with providers and beneficiaries to have more clarity about application, information sharing, review and billing processes. (WC)*
- *Some ideas for cost saving: better manage the need for well check-up visits, encourage assisted living arrangements to reduce hospital and nursing home stays, reduce the ability to protect*

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*assets, ration care by age and by medical condition, strive for more adequate mental health care, and save money by better managing prescription and non-prescription drugs.. (WC)*

- *Efforts to ensure the continued success of the Medicaid program for low-income families should include: implementation of quality performance measures that address access to care, utilization and effectiveness; establishment of appropriate incentives fro both Medicaid plans and providers to deliver high quality services. (WC)*
- *Funds are needed to plan for improved clinical practices and the resources to support them; make our rehabilitation centers accessible so people can really learn wellness and independent living skills; train our hospitals to work with people with complex health conditions and diverse disabilities; and work with the regional medical schools, the Area Health Education Centers, consumer groups and others to build models of health care that pay for themselves through greater citizen health and civic engagement. (WC)*

**Response:** We appreciate specific suggestions about how to make our existing programs more efficient. To gather more ideas like these routinely, we plan to hold several focus groups of beneficiaries each year to elicit their ideas for how to improve services. The flexibility provided through the *Global Commitment to Health* will enable us to implement such changes as they are identified rather than going a lengthy process of negotiating each change with the federal government. However, as previously noted, any proposed changes in Medicaid services or programs in the future would be vetted with stakeholders and the legislature, and would not be implemented without legislative approval. This is the same process that is in place today and will not change under the new Waiver agreement.

- *I have been disappointed at the Governor's Medicaid reform proposal. Any proposal that fails to address chronic illness and end of life care ignores the two leading causes for our out of control health costs. What is needed is a full-blown, aggressive pubic health initiative to deal with chronic care problems. (WC)*
- *Comments in support of the Governor's initiatives under the Chronic Care model. (WC – 6 submissions)*
- *We need to keep nutrition at the table when discussing health care reform. (WC)*

**Response:** Vermont is poised to become the first state in the country to unveil multiple projects aimed at implementing its statewide Chronic Care Model. For more information about these efforts, please refer to pages 16 through 19 of the *Global Commitment to Health* Concept paper and visit the following Vermont Department of Health website:  
**<http://www.healthyvermonters.info/hi/chronic/chroniccare.shtml>**