FINAL AGENDA

Joint Fiscal Committee
September 28, 2005
10:00 a.m.
Room 11, State House

10:00 a.m. Call to order

10:05 1. Global Commitment Presentation
Health Management Associates
Eileen Ellis
Theresa Sachs

11:30 2. Question and Answer Session – Global Commitment Administration
Joshua Slen, Director of Office of Vermont Health Access
Scott Wittman, Pacific Health Policy Group
Health Management Associates
Eileen Ellis
Theresa Sachs
Joint Fiscal Office
Steve Kappel

12:00 * Recess for lunch

1:00 p.m. 3. Continued Question & Answers and Committ

2:00 4. Conference Call with AHS contracted actu

3:00 5. Committee Discussion

4:00 Adjourn

Ret'n. file JFC 9.28.05

Next Meeting
Friday September 30, 2005 – 2:00 pm
Global Commitment – Committee Action

Global Commitment Materials Book
September 26, 2005

Prepared for the:
Health Access Oversight Committee of September 27th 12:00 PM
Legislative Briefing of September 27th 6:30 PM
Legislative Joint Fiscal Committee of September 28th 10 AM

Contents

1. Meeting Schedules
    a. Overview of work
    b. Meetings summary
2. Administration Materials
    a. Global Commitment - Terms and Conditions with addendums
    b. Intergovernmental agreement – AHS and OVHA – September 2005
3. Global Commitment questions - Administration answers
    a. Organized by category
4. Joint Fiscal Materials
    a. Power Point Legislative Meeting of September 7th
    b. Vermont's Medicaid Global Commitment Proposal Summary (Sept 2005)
    c. Deficit projections-
        i. summary
        ii. detailed presentations
5. Other Submissions
    a. Vermont Children's Forum, September 22
    b. Families USA, September 23, 2005
    c. AARP Vermont Group E Mail September 18,2005
    d. Recent Articles
        i. Sunday Free Press – Global commitment
        ii. Sunday Times Argus – Editorial

Global Commitment Legislative Review Schedule
Week of September 26th

Act 71, Section 250 calls for the consideration of Global Commitment to be by the Joint Fiscal Committee based on the recommendation of the Health Access Oversight Committee. As you may imagine the tight timelines due to the administration's desire to have Global Commitment in place by October 1, have created scheduling issues for legislative committees. In order to allow the Health Access Oversight Committee and the Joint Fiscal Committee time for information gathering and deliberation we have in place the following schedule.

September 27th Health Access Oversight Committee

The Health Access Oversight Committee will meet in the afternoon to hear from the legislative consultants on the proposed Global Commitment waiver. They will take any other testimony that they see fit to consider.

- Based on this meeting, the Health Access Oversight Committee will consider making a recommendation at that time.
- If the Health Access Oversight Committee makes a recommendation it shall forward it to the Joint Fiscal Committee.
- If it can not make a recommendation without further deliberation, it will schedule another meeting for Friday morning, September 30th.

September 28th Joint Fiscal Committee

The Joint Fiscal Committee will meet to consider the Global Commitment waiver on September 28th. They will hear from the legislative consultants and hear of any recommendation from the Health Access Oversight Committee.

- If the Health Access Oversight Committee has made a recommendation the Joint Fiscal Committee will plan to make a final recommendation on the 28th.
- If Health Access Oversight has not been able to finalize its recommendation:
  - The Fiscal Committee will postpone a final deliberation and vote until Friday afternoon, September 30th at one p.m. At that time it will hear the Health Access Oversight Committee recommendation.
  - The Fiscal Committee may decide that it needs more information for its own action and postpone decision making until October. In that case the Health Access Oversight Committee meeting on the 30th will likely be postponed.

September 30th Health Access Oversight Committee/Joint Fiscal Committee – If necessary – To be held as follows:

- If the Joint Fiscal Committee is ready for a decision but the Health Access Committee needs to finalize its recommendation. The Health Access Oversight Committee will meet at 10:00 AM
- If the Joint Fiscal Committee meets it will meet at 1 P.M. to hear from the Health Access Oversight Committee their recommendation, discuss the recommendation and take a formal vote.

1. b

Legislative Committee meetings and briefings on Global Commitment to Health since July 1, 2005.

Commission on Health Care Reform
- July 19 - OVHA update
- September 20 – JFO update

Joint Fiscal Committee
- July 14 – OVHA update
- September 15 – OVHA update
- September 28 – OVHA, JFO, consultants, advocates
- September 30 -

Health Access Oversight Committee
- July 19 – OVHA update
- August 30 – update
- September 13 – update
- September 19 – update
- September 27 – OVHA, consultants, advocates

General Legislative briefings
- September 7 – State House 6:30 PM JFO presentation
- September 27 – State House 6:30 PM

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00194/1**

TITLE: **Global Commitment to Health Section 1115 Demonstration**

AWARDEE: **Vermont Agency for Human Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Vermont Global Commitment to Health Section 1115(a) Medicaid demonstration (hereinafter "Demonstration"). The parties to this agreement are the Agency for Human Services (State) and the Centers for Medicare & Medicaid Services (CMS). These STCs set forth below and the lists of waivers and expenditure authorities are incorporated in their entirety into the letter approving the Demonstration. The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. This Demonstration is approved for the five-year period, from October 1, 2005 through September 30, 2010.

The STCs have been arranged into the following subject areas: General Program Requirements; General Reporting Requirements; Eligibility and Enrollment; Benefits and Coverage; Cost Sharing; Delivery Systems; Evaluation; General Financial Requirements under Title XIX; and Monitoring Budget Neutrality.

II. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it shall comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the award letter of which these terms and conditions are part, shall apply to the Demonstration.

3. **Changes in Law**. The State shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the approval date of this Demonstration.

4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy**

Statements. To the extent that a change in Federal law impacts State Medicaid spending on program components included in the Demonstration, CMS shall incorporate such changes into a modified budget neutrality expenditure cap for the demonstration. The modified budget neutrality expenditure cap would be effective upon implementation of the change in the Federal law. The growth rates for the budget neutrality baseline are not subject to this STC. If mandated changes in the Federal law require State legislation, the changes shall take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State shall not be required to submit Title XIX State plan amendments for changes to any populations covered solely through the Demonstration. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required. Reimbursement of providers by the MCO will not be limited to those described in the State Plan.

6. **Changes Subject to the Demonstration Amendment Process.** The state shall not implement changes to its program that require an amendment without prior approval by CMS as discussed below. Amendments to the Demonstration are not retroactive and FFP may not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph seven, below.

   The State has the authority to modify the demonstration program design elements in accordance with the parameters specified below.

   Mandatory State Plan Eligibles. Eligibility criteria and cost sharing requirements for federally mandated Medicaid eligibility groups must be in compliance with federal statutes and regulations. Reductions in benefits for federally mandated populations (including optional services) must be submitted as an amendment to the demonstration by the process outlined below in item seven. Subject to remaining in compliance with the demonstrations terms and conditions, the State shall submit an amendment to the demonstration to expand covered benefits to include health services not currently covered under the State plan.

   Benefits

   The State has the authority to change the benefit package for the non-mandatory eligible population so long as the changes result in no more than a five percent cumulative increase or decrease each year of the total Medicaid expenditures for the corresponding waiver year and comparison year. The following chart indicates the corresponding years:

Waiver Year (WY)	Comparison Year Expenditures
WY 1	2004 Base Year Medicaid Expenditure
WY 2	2005 Total Global Expenditures
WY 3	2006 Total Global Expenditures
WY 4	2007 Total Global Expenditures
WY 5	2008 Total Global Expenditures

The State must offer benefit packages that meet or exceed "Secretary approved coverage" as defined under the HIFA guidelines.

The State shall notify CMS 60 days prior to any such change in the benefit package. After receipt of the written notification CMS officials will notify the State if the request needs to be submitted as a formal amendment to the demonstration. To clarify, the formal amendment process is outlined in item seven below. Upon review, CMS has the right to withhold or disallow federal financial participation (FFP).

If changes to the benefit package for the non-mandatory eligible population would result in more than a five percent increase or decrease of the corresponding year benefit expenditures or would not be equivalent to the "Secretary approved coverage" as defined under the HIFA guidelines then the State will submit an amendment to the demonstration as described by the process outlined in item seven below.

7. **Amendment Process.** Amendment requests must be submitted to CMS for approval no later than 90 days prior to the date of implementation and may not be implemented until approved. Utilizing the standard review process CMS will consult with the federal review team. Amendment requests shall include but not be limited to the following:

   a) An explanation of the public process used by the State to reach a decision regarding the requested amendment;
   b) A current assessment of the impact the requested amendment shall have on budget neutrality;
   c) A detailed description of the amendment, with sufficient supporting documentation; and
   d) A description of how the evaluation design shall be modified to incorporate this amendment request.

8. **Global Commitment to Health Flexibility**: Vermont's expectation is that changes to the demonstration will occur at the same time of year each year, based on the outcomes of the legislative session. At the end of the legislative session the state shall submit amendments pursuant to item six governed by the process outlined in item seven of this section. Any approved changes shall be reflected in the annual rate setting process for the upcoming year.

9. **Extension of the Demonstration.** If the State intends to extend the Demonstration beyond the period of approval granted under section 1115(a), the requirements in section 1115(e) shall apply. During the six-month period ending one year before the date the Demonstration would otherwise expire, the Chief Executive Officer of the State that is operating the Demonstration may submit to the Secretary of the Department of Health and Human Services (DHHS) a written request to extend the Demonstration for up to three years. If the Secretary fails to respond to the request within six months after the date it is submitted, the request is deemed to have been granted. The extension of a

Demonstration shall be on the same terms and conditions that applied to the Demonstration before it was extended. If an original condition of approval of a Demonstration was that it be budget neutral, the Secretary shall take such steps as may be necessary to ensure that in the extension of the Demonstration, such condition continues.

10. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase-out the Demonstration, the State shall submit a phase-out plan to CMS at least six months prior to initiating phase-out activities. The State may also submit an extension plan on a timely basis to prevent disenrollment of Demonstration enrollees. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than six months when such action is necessitated by emergent circumstances. The phase-out plan and extension plan are subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be available for only normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

11. **Enrollment Limitation.** During the last six months of the Demonstration, the enrollment of individuals who would not be eligible for Medicaid under the current State plan shall not be permitted unless the waiver is extended by CMS.

12. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing at which it has been determined that the State has materially failed to comply with the terms of the project. CMS shall promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

13. **Finding of Non-Compliance.** The State waives none of its rights to challenge CMS's finding that the State materially failed to comply.

14. **Withdrawal of Waiver Authority**. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest. If a waiver or expenditure authority is withdrawn, FFP shall be available for only normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

15. **Adequacy of Infrastructure.** The State shall ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing; and reporting on financial and other Demonstration components.

16. **Public Notice and Consultation with Interested Parties.** The State shall continue to

comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (1994) when any program changes to the Demonstration are proposed by the State.

17. **Quality Assurance Strategy Plan**. The State must comply with the managed care regulations published at 42 CFR 438.

III. GENERAL REPORTING REQUIREMENTS

18. **General Financial Requirements.** The State shall comply with all general financial requirements under Title XIX set forth in Section IX, General Reporting Requirements under Title XIX.

19. **Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality set forth in Section X, Monitoring Budget Neutrality for the Vermont Global Commitment to Health Demonstration.

20. **Reporting on Participants Receiving Community Rehabilitation and Treatment (CRT) Services.** The State agrees to develop systems to track and report expenditures for CRT Services to participants with severe and persistent mental illness. Expenditures for CRT mental health services will be included under the budget neutrality agreement for the Vermont Global Commitment to Health Section 1115 demonstration.

21. **Encounter Data.** OVHA shall maintain an information system that collects, analyzes, integrates and reports data. The system must provide information on program elements including, but not limited to, service utilization, grievances, appeals and disenrollments for reasons other than loss of Medicaid eligibility. The management information system must collect data on member and provider characteristics, as specified by AHS, and on services as set forth under Section 2.12.1 of the Intergovernmental Agreement. OVHA must collect, retain and report encounter data in accordance with the Demonstration's Terms and Conditions. All collected data must be available to AHS and to CMS upon request. The State shall have contractual provisions in place to impose sanctions on the MCO if accurate data are not submitted in a timely fashion.

22. **Encounter Data Validation Study for New MCOs or PIHPs.** If the State contracts with new MCOs or PIHPs, the State shall conduct a validation study six months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study shall include validation through a sample of medical records of Demonstration enrollees.

23. **Submission of Encounter Data.** The State shall submit encounter data to the MSIS system as is consistent with Federal law and Section IX of this document. The State must assure that encounter data maintained at the MCO and provider level can be linked with eligibility files maintained at the State.

24. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments

affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review as well as federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.

25. **Quarterly Reports.** The State shall submit progress reports 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports shall include:

    a) A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, health plan financial performance that is relevant to the Demonstration, the benefit package, and other operational issues.
    b) Action plans for addressing any policy and administrative issues identified.
    c) A separate discussion of the State efforts related to the collection and verification of encounter data.
    d) The quarterly reports will include enrollment data, member month data, budget neutrality monitoring tables in the attached format, etc.
    e) The state shall report Demonstration program enrollment on a quarterly basis. The format of the report shall be specified by CMS. Average monthly enrollment will be reported for each of the following eligibility groups:
        a. Mandatory State Plan Adults
        b. Mandatory State Plan Children
        c. Optional State Plan Adults
        d. Optional State Plan Children
        e. VHAP Expansion Adults
        f. Pharmacy Program Beneficiaries (non-Duals)
        g. Other Waiver Expansion Adults
    f) A discussion of the State's progress toward the demonstration goals.
    g) A discussion of the State's evaluation activities.

26. **Annual Report.** The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The annual report shall also include a section that identifies how capitated revenue is spent. The State shall submit the draft annual report no later than 120 days after the end of each operational year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted.

IV. ELIGIBILITY, ENROLLMENT, AND BENEFITS

27. **Maintenance of Effort.** The State agrees that the eligibility criteria for mandatory eligible individuals fully served under the demonstration shall not change from the base year of the demonstration.

Demonstration Populations. Except for the exclusion of participants covered under the Vermont Long Term Care (LTC) Section 1115 demonstration not receiving Community Residential Treatment (CRT) Services, the following populations listed in the tables below shall be covered under the Global Commitment to Health Demonstration. Only, those Vermont LTC beneficiaries receiving CRT services shall overlap with the Global Commitment to Health demonstration beneficiaries. Changes to the following, outside the parameters as outlined in paragraph six, are pursuant to the amendment process as discussed in item six and seven under Section II, General Program Requirements.

Vermont Mandatory Populations and Services

AID GROUP	SERVICES (SEE LIST BELOW)
Mandatory Categorically Needy	
1 1931 low-income families with children (1902(a)(10)(A)(i)(I)) (1931)	Some Listed
2 Children receiving IV-E payments (IV-E foster care or adoption assistance) (1902(a)(10)(i)(I))	Some Listed
3 Individuals who lose eligibility under 1931 due to employment (1902(a)(10)(A)(i)(I)) (402(a)(37)) (1925)	Some Listed
4 Individuals who lose eligibility under 1931 because of child or spousal support (1902(a)(10(A)(i)(I))(406(h))	Some Listed
5 Individuals participating in a work supplementation program who would otherwise be eligible under 1931 (1902(a)(10(A)(i)(I)) (482(e)(6))	Some Listed
6 Individuals receiving SSI cash benefits (does not apply to 209(b) States) (1902(a)(10)(A)(i)(I))	Some Listed
7 Disabled children no longer eligible for SSI benefits because of a change in definition of disability (1902(a)(10)(A)(i)(II))	Some Listed
8 Qualified pregnant women (1902(a)(10)(A)(i)(III)) (1905(n)(1))	Some Listed
9 Qualified children (1902(a)(10)(A)(i)(III)) (1905(n)(2))	Some Listed
10 Poverty level pregnant women (1902(a)(10)(A)(i)(IV)) (1902(l)(1)(A))	Some Listed
11 Poverty level infants (1902(a)(10)(A)(i)(IV)) (1902(l)(1)(B))	Some Listed
12 Qualified family members (1902(a)(10)(A(i)(V)) (1905(m)(1))	Some Listed
13 Poverty level children under age six (1902(a)(10(i)(VI)) (1902(l)(1)(C))	Some Listed
14 Poverty level children under age 19, who are born after September 30, 1983 (or, at State option, after any earlier date) (1902(a)(10(i)(VII)) (1902(l)(1)(D))	Some Listed
15 Disabled individuals whose earnings exceed SSI substantial gainful activity level (1619(a))	Some Listed
16 Disabled individuals whose earnings are too high to receive SSI cash benefits (1619b))	Some Listed
17 Disabled individuals whose earnings are too high to receive SSI cash benefits (1902(a)(10)(i)(II)) (1905(q))	Some Listed
18 Pickle amendment: individuals who would be eligible for SSI if Title II COLAs were deducted from income (section 503 of P.L. 94-566) (1935(a)(5)(E))	Some Listed
19 Disabled widows and widowers (1634(b)) (1935 (a)(2)(C))	Some Listed
20 Disabled adult children (1634(c)) (1935(a)(2)(D))	Some Listed
21 Early widows/widowers (1634(d)) (1935)	Some Listed
22 Individuals who would be eligible for AFDC except for increased OASDI income under P.L. 92-336 (July 1, 1972) (42 CFR 435.114)	Some Listed
23 Individuals receiving mandatory State supplements (42 CFR 435.130)	Some Listed
24 Individuals eligible as essential spouses in December 1973 (42 CFR 435.131)	Some Listed
25 Institutionalized individuals who were eligible in December 1973 (42 CFR 435.132)	Some Listed
26 Blind and disabled individuals eligible in December 1973 (42 CFR 435.133)	Some Listed
27 Individuals who would be eligible except for the increase in OASDI benefits under Pubic Law 92-336 (42 CFR 435.134)	Some Listed
28 Individuals who become eligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977 (42 CFR 435.135)	Some Listed
29 Individuals who would be eligible except for the increase in OASDI benefits under Pubic Law 92-336 (42 CFR 435.134)	Some Listed
30 Individuals who become eligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977 (42 CFR 435.135)	Some Listed

Mandatory Medically Needy	
31 Individuals under 18 who would be mandatorially categorically eligible except for income and resources (1902(a)(10)(C)(ii)(I))	Some Listed
32 Pregnant women who would be categorically eligible except for income and resources (1902(a)(10)(C)(ii)(II))	Some Listed
33 Newborns, except for income and resources would be eligible as categorically needy, for one year as long as mother remains eligible or would if pregnant (1902(a)(10)(C)) (1902(e)(4))	Some Listed
34 Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post partum services (1902(a)(10)(C)) (1905)(e)(5))	Some Listed
35 Blind and disabled individuals eligible in December 1973 (42 CFR 435.340)	Some Listed
Mandatory Special Coverage Groups	
36 Newborns deemed eligible for one year as long as mother remains eligible or would remain eligible if pregnant (1902(e)(4))	Some Listed
37 Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post partum services (1902(e)(5))	Pregnancy/Post Partum Svcs
38 Pregnant women losing eligibility because of a change in income remain eligible 60 days post partum (1902(a)(10)(A)(i)(IV)) (1902(e)(6))	Some Listed
39 Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay (1902(e)(7))	Some Listed
40 Qualified Medicare Beneficiaries (QMBs) (1902(a)(10)(E)(i) (1905(p)(1))	Part A/B, Coinsurance/Deductble
41 Qualified disabled and working individuals (1902(a)(10)(E)(ii) (1905(s))	Part A
42 Specified Low-Income Medicare Beneficiaries (SLMBs) (1902(a)(10)(E)(iii))	Part B
43 Qualifying individuals (1902(a)(10)(E)(iv)(I))	Part B

For a complete list of covered services refer to the State Plan. The following are some of the covered services.

Covered Services (subject to medical necessity determination)

- ✓ Ambulance
- ✓ Case management/targeted case management
- ✓ Clinic services *(psychotherapy, group therapy, day hospital, chemotherapy, diagnosis and evaluation, emergency care)*
- ✓ CMHC
- ✓ Day health rehabilitation
- ✓ Dental (subject to limitations for adults)
- ✓ Developmental Therapy
- ✓ EPSDT services for individuals under 21
- ✓ Extended services for pregnant women for a 60-day post partum
- ✓ Eyeglasses (for children under 21)
- ✓ Family Planning
- ✓ Hi-Tech Nursing
- ✓ Home health for those entitled to NF services
- ✓ Hospice
- ✓ ICF/MR
- ✓ IMD services (age 65 and over)

- ✓ Inpatient hospital
- ✓ Inpatient psychiatric under 22 years of age
- ✓ Laboratory/X-Ray
- ✓ Licensed Clinical Social Worker
- ✓ Medical and surgical services of a dentist
- ✓ Nurse and lay midwife services
- ✓ Nursing facility
- ✓ Optician
- ✓ Optometry
- ✓ Organ transplants
- ✓ Outpatient hospital
- ✓ Pediatric/Family Nurse Practitioner
- ✓ Personal care for children under 21
- ✓ Physician services
- ✓ PNMI *(child care services, assistive community care services, therapeutic substance abuse treatment)*
- ✓ Podiatry
- ✓ Prescription drugs
- ✓ Preventive/screening/diagnostic services
- ✓ Primary care case management
- ✓ Private duty nursing (EPSDT only)
- ✓ Prosthetic devices
- ✓ Psychologist
- ✓ PT/OT/Speech-Language Therapy
- ✓ Respiratory care
- ✓ RHC/FQHC
- ✓ School-based services (children only)
- ✓ Substance abuse
- ✓ Transportation

Vermont Optional Populations and Services

AID GROUP	SERVICES (SEE LIST BELOW)
Optional Categorically Needy	
1 Individuals who are eligible for but not receiving IV-A, SSI or State supplement cash assistance (1902)(a)(10)(A)(ii)(I))	Some Listed
2 Individuals who could be eligible for IV-A cash assistance if State did not subsidize child care (1902(a)(10)(A)(ii)(II))	Some Listed
3 Individuals who are eligible for Title IV-A if State AFDC plan were as broad as allowed (1902(a)(10)(A(ii)(II))	Some Listed
4 Individuals who would have been eligible for IV-A cash assistance, SSI, or State supplement if not in a medical institution (1902(a)(10)(A)(ii)(IV))	Some Listed
5 *Special income level group*: individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard, or state-specified standard (1902(a)(10)(A)(ii)(V))	Some Listed
6 Disabled children no longer eligible for SSI benefits because of a change in definition of disability (1902(a)(10)(A)(i)(II))	Some Listed
7 Individuals who are terminally ill, would be eligible if they were in a medical institution, and will receive hospice care (1902(a)(10)(A)(ii)(VII)	Some Listed
8 Children under 21 (or at State option 20, 19, or 18) who are under State adoption agreements (1902(a)(10)(A)(ii)(VIII))	Some Listed
9 Poverty level pregnant women not mandatorially eligible (1902(a)(10)(A)(ii)(IX)) (1902(l)(1)(A))	Some Listed
10 Poverty level infants not mandatorially eligible (1902(a)(10)(A)(ii)(IX)) (1902(l)(1)(B))	Some Listed
11 Poverty level children under six years not mandatorially eligible (1902(a)(10)(A)(ii)(IX)) (1902(l)(1)(C))	Some Listed
12 poverty level children under 19, who are born after September 30, 1983 not mandatorially eligible (1902(a)(10)(A)(ii)(IX)) (1902(l)(1(D))	Some Listed
13 Individuals receiving only an optional State supp. payment more restrictive than the criteria for an optional State supplement under title XVI (1902(a)(10)(A(ii)(XI))	Some Listed
14 Katie Beckett children (1902(e)(3))	Some Listed
15 Uninsured women, under 65, who are screened for breast or cervical cancer under CDC program (1902(a)(10)(A)(ii)(XVIII))	Some Listed
16 Individuals receiving HCBS who would only be eligible for Medicaid under the State Plan if they were in a medical institution (1902(a)(10)(A)(ii)(VI)	Some Listed
Optional Medically Needy	
17 All individuals under 21 or at State option 20, 19, or 18 or reasonable classifications who would not be covered under mandatory medically needy group of individuals under 18 (1902(a)(10)(C)) (1905(a)(i))	Some Listed
18 Specified relatives of dependent children who are ineligible as categorically needy (42 CFR 435.301(b)(2)(ii)) (42 CFR 435.310)	Some Listed
19 Aged individuals who are ineligible as categorically needy (42 CFR 435.301(b)(2)(iii)) (42 CFR 435.320) (42 CFR 435.330)	Some Listed
20 Blind individuals who are ineligible as categorically needy but meet the categorically needy definition of blindness (42 CFR 435.301(b)(2)(iv))	Some Listed
21 Disabled individuals who are ineligible as categorically needy that meet the categorically needy definition of blindness (1902(a)(10)(C))	Some Listed

For a complete list of covered services refer to the State Plan. The following are some of the covered services.

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- ✓ CMHC

- ✓ Day health rehabilitation
- ✓ Dental (subject to limitations for adults)
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- ✓ Extended services for pregnant women for a 60-day post partum
- ✓ Eyeglasses (children only)
- ✓ Family Planning
- ✓ Hi-Tech Nursing
- ✓ Home health for those entitled to NF services
- ✓ Hospice
- ✓ ICF/MR
- ✓ IMD services (age 65 and over)
- ✓ Inpatient hospital
- ✓ Inpatient psychiatric
- ✓ Laboratory/X-Ray
- ✓ Licensed Clinical Social Worker
- ✓ Medical and surgical services of a dentist
- ✓ Nurse and lay midwife services
- ✓ Nursing facility
- ✓ Optician
- ✓ Optometry
- ✓ Organ transplants
- ✓ Outpatient hospital
- ✓ Pediatric/Family Nurse Practitioner
- ✓ Personal care (services for children under 21)
- ✓ Physician services
- ✓ PNMI *(child care services, assistive community care services, therapeutic substance abuse treatment)*
- ✓ Podiatry
- ✓ Prescription drugs
- ✓ Preventive/screening/diagnostic services
- ✓ Primary care case management
- ✓ Private duty nursing (EPSDT only)
- ✓ Prosthetic devices
- ✓ Psychologist

- ✓ PT/OT/Speech-Language Therapy
- ✓ Respiratory care
- ✓ RHC/FQHC
- ✓ School-based services (children only)
- ✓ Substance abuse
- ✓ Transportation

Demonstration Eligible Populations

AID GROUP	SERVICES
1915c Waivers	
1 TBI (Traumatic Brain Injury)	Crisis/support services, psychological and counseling supports, case management, community supports, habilitation, respite care, supported employment, environmental and assistive technology
2 MI under 22 (Children's Mental Health Waiver)	Service coordination, flexible support, skilled therapy services, environmental safety devices
3 MR/DD (Mental Retardation/Developmental Disabilities)	Case management, residential habilitation, day rehabilitation, supported employment, crisis services, clinical intervention, respite
VHAP Waivers	
1 Under-insured children with income between 225 and including 300 percent of FPL	All State Plan Services (see Mandatory/Optional Lists)
2 Adults with children with income between 150 and including 185 percent of the FPL	VHAP-Limited or PCPlus VHAP Benefit Package
3 Adults with income up to and including 150 percent of the FPL	VHAP-Limited or PCPlus VHAP Benefit Package
4 Medicare beneficiaries and individuals with disabilities with income at or below 150 percent of the FPL	Medicaid Prescriptions
5 Medicare beneficiaries and individuals with disabilities with income above 150 percent and less than 175 percent of the FPL	Maintenance Drugs
6 Individuals with persistent mental illness with income up to 150 percent of FPL	Day services, diagnosis and evaluation services, emergency care, psychotherapy, group therapy, chemotherapy, specialized rehabilitative services

1915c Waivers

VHAP Benefit Package: Covered Services (subject to medical necessity determination)

- ✓ MI under 22 (Children's Mental Health Waiver) — Service coordination, flexible support, skilled therapy services, environmental safety devices
- ✓ MR/DD (Mental Retardation/Developmental Disabilities)
- ✓ CMHC
- ✓ Family Planning
- ✓ Hospice

- ✓ Inpatient hospital (urgent and emergent admissions)
- ✓ Inpatient psychiatric in an IMD (30 days per episode; 60 days per calendar year)
- ✓ Laboratory/X-Ray
- ✓ Licensed Clinical Social Worker
- ✓ Licensed Marital Counselor/Marriage and Family Therapy
- ✓ Medical and surgical services of a dentist
- ✓ Nurse and lay midwife services
- ✓ Nursing facility (30 days per episode)
- ✓ Organ transplants
- ✓ Outpatient hospital
- ✓ Pediatric/Family Nurse Practitioner
- ✓ Physician services
- ✓ Podiatry
- ✓ Prescription drugs (OTCs for PCPlus VHAP only)
- ✓ Primary care case management (PCPlus VHAP only)
- ✓ Prosthetic devices (PCPlus VHAP only)
- ✓ Psychologist
- ✓ PT/OT/Speech-Language Therapy
- ✓ Respiratory care (PCPlus VHAP only)
- ✓ RHC/FQHC
- ✓ Substance abuse

28. **Optional and Expansion Eligibility Groups Expenditure and Enrollment Cap**

The State is not obligated under this demonstration to extend eligibility to population groups listed above as optional or expansion populations, but may do so. The State must seek approval to modify program eligibility via the waiver amendment process as described in number six and seven of Section II General Program Requirements. Regardless of any extension of eligibility, the State will be limited to federal funding reflected in the budget neutrality requirements set forth in these STCs.

If program eligibility is expanded or reduced, the State must give priority to extension or continuation of eligibility for optional populations prior to extension or continuation of eligibility for expansion groups. In the event of any reduction in eligibility for expansion and optional populations, the State may continue eligibility for all individuals already enrolled in the program. If the State establishes a waiting list for eligibility or services, priority will be given to State plan populations over optional populations and last priority will be given to expansion populations.

29. **Enrollment Process.** The State agrees to notify demonstration participants regarding eligibility changes to be implemented under the Global Commitment to Health demonstration, including, but not limited to their enrollment into a Section 1115 research and demonstration program. The notification to participants must meet the provisions of 42 CFR 431.210. Participants will be notified no later than 30-days prior to their transition to the Global Commitment to Health demonstration.

VI. COST SHARING

30. The State agrees to maintain the State Plan co-payments and premium provisions for the mandatory population.

Approved premiums and co-payments will be included in the annual report. Listed below are the approved premium and co-payment requirements by population for demonstration year 1.

Population	Premiums	Deductibles	Co-Payments
Children Dr. Dynasaur 100-185% FPL[1] Dr. Dynasaur 186-225% FPL Underinsured 226-300% FPL	 $30/month $30/month $40/month		
Population	**Premiums**	**Deductibles**	**Co-Payments**

[1] This does not include Mandatory Medicaid eligibles

Adults VHAP 50-75% FPL VHAP 76-100% FPL VHAP 101-150% FPL	 $11/month $39/month $50/month		$25-ER
VHAP 150-185% FPL	$75/month		

The State aggress that the annual aggregate cost-sharing limits for optional and expansion populations may not exceed five percent of the annual household income.

VI. DELIVERY SYSTEMS

31. **Health Plans.** The Vermont Agency of Human Services will contract with the Office of Vermont Health Access (OVHA) as a public MCO, on a capitated basis, for the delivery of all Medicaid-eligible services. The OVHA must be authorized by state statute and must adhere to 42 CFR 438.

32. **Limitation of Freedom of Choice.** Freedom of choice shall be limited for the Managed Care entity. However, populations enrolled in the Global Commitment to Health shall have freedom of choice when selecting participating Medicaid MCO providers.

33. **Contracts.** The Agency for Human Services will be responsible for oversight of the public MCO, ensuring its compliance with state and federal statutes, regulations, special terms and conditions, waiver and cost not otherwise matchable authority.

    To further clarify the MCO requirements published at 42 CFR 438 the actuary shall not be employed by the state for purposes of certifying actuarially sound rates.

    Procurement and the subsequent final contracts developed to implement selective contracting by the State with any provider group shall be subject to CMS Regional Office approval prior to implementation.

    In the future, should OVHA contract with a behavioral health organization (BHO) to cover individuals previously served at the Vermont State Hospital (VSH) then the aggregate cap at the time of the BHO implementation would need to be adjusted to reflect the current alternative costs to VSH under the aggregate cap.

34. **Contracting with Federally Qualified Health Centers (FQHCs).** The State shall maintain its existing agreements with FQHCs and Rural Health Centers (RHCs).

35. **Data Sharing**. The MCO as a state agency may share enrollee data with other state agencies if the use or release of such data is for a purpose directly connected with administration of the plan as defined in Federal regulations at 42 CFR 431.302. The MCO is authorized to use or release de-identified data, as defined in Federal privacy regulations, to enable participation in statewide program studies. As a purpose directly connected with plan administration, the MCO is permitted to release enrollee specific

information to providers to enable the provider to seek payment for services rendered under the plan. Any other release of enrollee specific information for a purpose not directly connected with plan administration is prohibited. Whenever, release of enrollee information for a purpose directly connected with plan administration is sought by an outside source consent of the enrollee is required except in an emergency. Release under these conditions is defined in 42 CFR 431.306(d).

VII. EVALUATION

36. **Submission of Draft Evaluation Design.** The State shall submit to CMS for approval within 120 days from the award of the Demonstration a draft evaluation design. At a minimum, the draft design shall include a discussion of the goals, objectives and specific hypotheses that are being tested, including those that focus specifically on the target population for the Demonstration. The draft design shall discuss the outcome measures that shall be used in evaluating the impact of the demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design shall identify whether the State shall conduct the evaluation, or select an outside contractor for the evaluation.

37. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State shall submit a final design within 60 days of receipt of CMS comments. The State shall implement the evaluation design, and submit to CMS a draft of the evaluation report 120 days after the expiration of the current demonstration period (September 30, 2010). CMS shall provide comments within 60 days of receipt of the report. The State shall submit the final evaluation report for this demonstration period by May 31, 2011.

38. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the Demonstration, the State must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the Demonstration.

VIII. ASSURANCES

Acceptance of the Special Terms and Conditions of Approval constitutes the State's assurance of the following:

39. **Capitated Revenue Expenditures.** Provided that OVHA's contractual obligation to the populations covered under the demonstration is met, any revenue from capitation payments related to the beneficiaries covered under this demonstration may be used for the following purposes:
    - Reduce the rate of uninsured and, or, underinsured in Vermont;

- Increase the access of quality health care to uninsured, underinsured and Medicaid beneficiaries;
- Provide public health approaches to improve the health outcomes and the quality of life for the uninsured, underinsured Medicaid-eligible individuals in Vermont; and
- Encourage the formation and maintenance of public-private partnerships in health care.

As described in Section III General Reporting Requirements, the State shall include in the Annual report a section on how capitated revenue was spent.

40. **Changes Resulting from Implementation of the Medicare Modernization Act (MMA).** CMS has used trend rates from the President's Budget 2006 that fully account for Part D adjustment for budget neutrality. Federal funds are not available as of January 1, 2006 for drugs covered by the Medicare Prescription Drug Program for any Part D eligible individual or for any cost sharing for such drugs.

IX GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

41. The State shall 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. CMS shall provide Federal Financial Participation (FFP) for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section X (Monitoring Budget Neutrality for the Demonstration).

42. The following describes the reporting of expenditures subject to the budget neutrality cap:

    a) In order to track expenditures under this Demonstration, Vermont shall report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap shall be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which service or capitation payments were made). Corrections for any incorrectly reported demonstration expenditures for previous demonstration years must be input within three months of the beginning of the Demonstration. For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 42.c.

b) For each demonstration year at least seven separate Form CMS-64.9 WAIVER and/or 64.9P WAIVER reports must be submitted reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 42.c.). The Vermont Global Medicaid eligibility groups (MEGs), for reporting purposes, include the following names and definitions:

- ABD – report expenditures for individuals eligible as aged, blind or disabled under the state plan;
- ANFC – report the expenditures for all non-ABD children and adults in state plan mandatory and optional categories;
- Optional Expansions – report all expenditures for individuals eligible as children or adults through optional expansions under VT Global
- VT Global Expansion - report all expenditures for individuals eligible as non-categorical health care expansions through VT Global (previously VHAP Expansion);
- Administrative expenditures;
- VT Global Rx - report all expenditures for individuals eligible as pharmacy-only expansions through VT Global (previously VHAP Rx); and
- CRT Group - report expenditures for individuals receiving CRT services this includes CRT expenditures for participants with severe, persistent mental illness covered under the Long-Term Care Plan 1115 demonstration.

c) For purposes of this section, the term "expenditures subject to the budget neutrality cap" shall include all Medicaid expenditures on behalf of the individuals who are enrolled in this Demonstration (as described in item 42.b.of this section) and who are receiving the services subject to the budget neutrality cap. All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and shall be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

d) Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration shall be reported to CMS on Form CMS-64.9 Waiver, Line 18.E. in order to assure that the Demonstration is properly credited with premium collections.

e) Administrative costs shall be included in the budget neutrality limit. Vermont will not be at risk for expenditures related to systems enhancements including any new procurements related to claims processing, program management and eligibility. All administrative costs shall be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

f) All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within two years after the calendar quarter in which the

State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the Demonstration. During the latter two-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

43. The following describes the reporting of member months subject to the budget neutrality cap:

a) The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member/months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member/months.

b) The term "Demonstration eligibles" refers to the following categories of enrollees:
- ABD – report expenditures for individuals eligible as aged, blind or disabled under the state plan;
- ANFC – report the expenditures for all non-ABD children and adults in state plan mandatory and optional categories;
- Optional Expansions – report all expenditures for individuals eligible as children or adults through optional expansions under VT Global
- VT Global Expansion - report all expenditures for individuals eligible as non-categorical health care expansions through VT Global (previously VHAP Expansion);
- Administrative expenditures;
- VT Global Rx - report all expenditures for individuals eligible as pharmacy-only expansions through VT Global (previously VHAP Rx); and
- CRT Group - report expenditures for individuals receiving CRT services includes CRT expenditures for participants with severe, persistent mental illness covered under the Long-Term Care Plan 1115 demonstration.

c) The term "Demonstration eligibles" excludes unqualified aliens, including unqualified aliens from the Compact of Free Association countries.

d) For the purpose of monitoring the budget neutrality expenditure cap described in Section X, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the demonstration eligibles as defined above. This information should be provided to CMS in conjunction with the quarterly progress report referred to in number 25 of Section III. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.)

44. The standard Medicaid funding process shall 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 and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year (FFY) on the Form CMS-37.12 for both the Medical Assistance Program (MAP) and Administrative Costs (ADM). CMS shall 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 must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall 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.

45. Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in Section X:

    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 with dates of service during the operation of the Demonstration.

46. The State shall certify State/local monies used as matching funds for the Demonstration and shall further certify that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of the non-federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

47. The State shall submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards. The State shall ensure, within 120 days of the approval of the Demonstration, that all prior reports are accurate and timely.

X MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

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 43.c. of Section IX of this document. The budget neutrality cap will be for the Federal share of the total computable cost of $4.7 billion for the 5-year demonstration. The cap places the State at risk for enrollment and for Per Participant Per Month (PPPM) cost trends.

48. 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.

49. Vermont shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, and budget targets are set on a yearly basis with a cumulative budget limit for the length of the entire Demonstration.

50. Vermont shall be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles in the seven Medicaid Eligibility Groups (MEGs) under this budget neutrality agreement, and for the number of Medicaid eligibles in each of the groups. By providing Federal Financial Participation for all eligibles in the specified MEGs, Vermont shall be at risk for changing economic conditions that impact enrollment levels. By placing Vermont at risk for the per capita costs for Medicaid eligibles in each of the MEGs under this agreement, CMS assures that Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

51. **How the Limit will be Applied:** The limit calculated above will apply to actual expenditures for demonstration, as reported by the State under Section IX. 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.

52. **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, they must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved corrective action plan.

Year	Cumulative Target (Total Computable Cost)	Cumulative Target Definition	Percentage
Year 1	$1,015,000,000	Year 1 budget estimate plus	8 percent
Year 2	$1,936,000,000	Years 1 and 2 combined budget estimate plus	3 percent
Year 3	$2,848,000,000	Years 1 through 3 combined budget estimate plus	1 percent
Year 4	$3,779,000,000	Years 1 through 4 combined budget estimate plus	0.5 percent
Year 5	$4,700,000,000	Years 1 through 5 combined budget estimate plus	0 percent

Addendum

CHANGES TO GLOBAL COMMITMENT TO HEALTH 1115 WAIVER SEPTEMBER 13, 2005 FINAL TERMS AND CONDITIONS

(as of September 15, 2005)

After reviewing the Terms and Conditions, Vermont and CMS have agreed to the following changes:

➢ *29. Enrollment Process. The State agrees to notify demonstration participants regarding eligibility changes to be implemented under the Global Commitment to Health demonstration, including, but not limited to their enrollment into a Section 1115 research and demonstration program. The notification to participants must meet the provisions of 42 CFR 431.210. Participants will be notified no later than 30-days prior to their transition to the Global Commitment to Health demonstration.*

This section has been revised to read: *The State agrees to notify demonstration participants newly entering a Section 1115 research and demonstration program within 30 days of their enrollment into the Global Commitment to Health demonstration.*

➢ *30. The State agrees to maintain the State Plan co-payments and premium provisions for the mandatory population.*

Approved premiums and co-payments will be included in the annual report. Listed below are the approved premium and co-payment requirements by population for demonstration year 1.

Population	*Premiums*	*Deductibles*	*Co-Payments*
Children			
Dr. Dynasaur 100-185% FPL[2]	*$30/month*		
Dr. Dynasaur 186-225% FPL	*$30/month*		
Underinsured 226-300% FPL	*$40/month*		
Adults			*$25-ER*
VHAP 50-75% FPL	*$11/month*		
VHAP 76-100% FPL	*$39/month*		
VHAP 101-150% FPL	*$50/month*		
VHAP 150-185% FPL	*$75/month*		

The State aggress that the annual aggregate cost-sharing limits for optional and expansion populations may not exceed five percent of the annual household income.

- **The $30/month premium in the chart was an error and has been deleted.**
- **The $25 – ER Co-payment has been moved down one line to reflect that this only applies to adults enrolled in VHPA programs.**
- **The last sentence has been changed to read: "The State agrees that cost sharing for optional and expansion children eligible for Medicaid should not exceed five percent of the family's gross income. " This also will apply to eligible pregnant women.**

[2] This does not include Mandatory Medicaid eligibles

- *45. Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in Section X:*
  ... c) Net medical assistance expenditures made with dates of service during the operation of the Demonstration.

  The phrase "dates of service" is being changed to "dates of payment" to be consistent with the remainder of the STCs.

- The following additional typographical errors are being corrected:

  page 1 AWARDEE line: Vermont Agency of Human Services (**replace "for" with "of"**)

  page 1 line 3: Vermont Agency of Human Services (**replace "for" with "of"**)

  page 7 line Demonstration Populations. Line 4: **delete the comma after "Only"**

d. b

REVISED DRAFT

Intergovernmental Agreement

between

Agency of Human Services

and

Office of Vermont Health Access

For the Administration and Operation of the

Global Commitment to Health
Demonstration Waiver Program

September 2005

Table of Contents

Article One: General Provisions

1.1 Purpose 1
1.2 Agreement Review and Renewal 1
1.3 Compliance 1
1.4 Prohibited Affiliations 1

Article Two: OVHA Responsibilities

2.1 Administration and Management 2
2.2 Demonstration Program Eligibility and Enrollment 3
2.3 Member Outreach and Education 5
2.4 Network Development 8
2.5 Covered Services 10
2.6 Access to Services 12
2.7 Coordination of Services 17
2.8 Payment to Providers 17
2.9 Quality Assurance and Medical Management 18
2.10 Grievances and Appeals 21
2.11 Client Records 25
2.12 Reporting Requirements 25
2.13 Fraud and Abuse 27
2.14 Records Retention 27
2.15 Disclosure Requirements 28

Article Three: AHS Responsibilities

3.1 Eligibility Determination 30
3.2 Capitation Rate Setting 30
3.3 Performance Evaluation 30
3.4 Receipt and Analysis of Encounter Data 32
3.5 CMS Reporting 32
3.6 Fair Hearing Process 32
3.7 Member Services 33
3.8 Ombudsman 33
3.9 Third Party Liability 33

Article Four: Payment Provisions

4.1 Capitation Payment Between AHS and OVHA 34
4.2 Payment Arrangements Between OVHA and Subcontracted Departments 34
4.3 Restrictions on Use of Excess Funds 34

Attachment A: Description of Covered Benefits and Populations

IGA Signature Page

ARTICLE ONE: STANDARD REQUIREMENTS

1.1 Purpose

The purpose of this Inter-Governmental Agreement (IGA) is to specify the responsibilities of the Agency of Human Services (AHS) and the Office of Vermont Health Access (OVHA) relative to the Global Commitment Demonstration program under HHS's Centers for Medicare and Medicaid Services (CMS) approved Section 1115 Demonstration Waiver. OVHA will serve as the Public Managed Care Organization (Public MCO) for all enrollees under the Global Commitment Demonstration. AHS, as the Single State Agency, will provide the oversight of OVHA in that capacity.

1.2 Agreement Review and Renewal

This Agreement shall be amended as necessary, and shall be reviewed (and amended if necessary) at least annually. In the event the annual review does not result in amendments, the most current executed version shall remain in effect.

1.3 Compliance

This Agreement meets the requirements of 45 CFR Part 74, and the Office of Vermont Health Access (OVHA) meets the requirements of 42 CFR 434.6.

OVHA must also meet the requirements of all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

1.4 Prohibited Affiliations

OVHA shall not knowingly have a relationship with either of the following:

- An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

- An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

For purposes of this agreement, a relationship is defined as a director or officer within OVHA or a person with an employment, consulting or other arrangement with OVHA.

ARTICLE TWO: OVHA's RESPONSIBILITIES

2.1 Administration and Management

OVHA must have an executive management function with clear authority over all administrative functions and must maintain sufficient administrative staff and organizational components to comply with all program standards. Staffing must be sufficient to perform services in an appropriate and timely manner.

OVHA shall designate a representative to act as liaison between OVHA and AHS for the duration of this Agreement. The representative shall be responsible for:

- Representing OVHA on all matters pertaining to the Agreement. Such a representative shall be authorized and empowered to represent OVHA regarding all aspects of the Agreement;
- Monitoring OVHA's compliance with the terms of the Agreement;
- Receiving and responding to all inquiries and requests made by AHS in the timeframes and format specified by AHS in this Agreement;
- Meeting with AHS's representative on a periodic or as-needed basis to resolve issues which may arise;
- Coordinating requests from AHS to ensure that OVHA staff with appropriate expertise in administration, operations, finance, management information systems, claims processing and payment, clinical service provision, quality management, utilization management, and network management is available to participate in AHS activities and respond to requests by AHS which may include, but not be limited to, requests to participate in AHS training programs, requests to coordinate fraud and abuse activities with AHS, and requests to meet with other State agency representatives or other parties;
- Making best efforts to resolve any issues identified either by OVHA or AHS that may arise in connection with this Agreement;
- Meeting with AHS at the time and place requested by AHS, if AHS determines that OVHA is not in compliance with the requirements of this Agreement;
- Ensuring that all reports, contracts, subcontracts, agreements and any other documents subject to AHS's prior review and approval are provided to AHS no less than ten business days prior to execution or implementation, as applicable; and
- Submitting any requests for documents or any other information provided to OVHA by any individual or entity to AHS for its review; and submitting any proposed responses and responsive documents or other materials in connection with any such requests to AHS for its prior review and approval.

2.1.1 Management Information System

OVHA shall maintain an information system that collects, analyzes, integrates and reports data. The system must provide information on areas including, but not limited to, service utilization, grievances, appeals and disenrollments for reasons other than loss of Medicaid eligibility. The management information system must collect data on member and provider characteristics, as specified by AHS, and on services as set forth under Section 2.12.1 of this Agreement. OVHA must collect, retain and report encounter data in accordance with the Demonstration's Terms and Conditions. All collected data must be available to AHS and to CMS upon request.

2.2 Program Eligibility and Enrollment

2.2.1 Eligible Population

The following populations are eligible for enrollment in the Global Commitment to Health Demonstration Program:

- Individuals who are eligible for medical assistance in accordance with the State Medicaid plan;

- Individuals who are eligible for medical assistance in accordance with the 1115 Medicaid Waiver Demonstration;

- Adults who meet the State's clinical criteria for Designated Agency CRT services and who initially meet Medicaid/VHAP eligibility requirements but who subsequently exceed the earned income and/or resources requirements. Increases in income after enrollment in the program will be disregarded, as long as the individual continues to meet the clinical criteria for participation in the CRT Program. These individuals will be remain eligible for all VHAP benefits, and will remain co-enrolled with OVHA and

- Individuals who are eligible for the CRT Program for Medicaid and Medicare (dual eligibles) and who meet the CRT clinical criteria are eligible for enrollment in the CRT Program. These individuals will continue to utilize their Medicare benefits on an unrestricted fee-for-service basis;

2.2.2 Eligibility for Global Commitment Demonstration Program

All individuals eligible for the state's public insurance programs (Medicaid and VHAP) will be enrolled in the Demonstration. Eligibility and enrollment are therefore synonymous for the purpose of this IGA.

OVHA shall be responsible for verification of the current status of a person's Medicaid/VHAP eligibility with the Economic Services Division (within the Agency of Human Services Department for Children and Families), which makes these eligibility

determinations. If an individual is not currently covered by Medicaid/VHAP, OVHA shall refer such person to ESD for an eligibility determination for these programs.

OVHA shall also be responsible for assisting ESD with the collection of information necessary for determination of eligibility for individuals who may not be eligible for the public insurance programs (e.g., premium subsidy program eligibles, those eligible for specialized programs such as substance abuse treatment). Initial eligibility determination for these groups may be delegated to other departments within AHS (Department of Aging and Independent Living, Department of Health, Department of Mental Health and Department for Children and Families); however, OVHA shall retain responsibility for final eligibility determinations for these Demonstration Waiver populations.

OVHA shall not discriminate, or use any policy or practice that has the effect of discriminating, against any individuals eligible to enroll on the basis of race, color, religion, disability, sexual orientation or national origin. OVHA and the subcontracted Departments and providers will accept and serve all people eligible for and enrolled in the Demonstration Program.

2.2.3 Data Transfers

The Agency of Human Services' Economic Services Division's (ESD) eligibility determination system (ACCESS) and the EDS Medicaid Management Information System (MMIS) shall continue to provide Medicaid eligibility functions under the Demonstration Program. A regular data transfer between the OVHA managed care information system, ACCESS and EDS shall ensure that identical information on Medicaid/VHAP eligibility status and Demonstration Program enrollment status is available concurrently in all three information systems to ensure data integrity for payment purposes. OVHA must have the capability to interface with the ACCESS and EDS MMIS systems.

2.2.4 Loss of Eligibility/Disenrollment from the Demonstration

OVHA shall ensure that members who lose eligibility are disenrolled from the Demonstration Program. Loss of eligibility may occur due to:

- Death;
- Movement out of state;
- Incarceration;
- No longer meeting the eligibility requirements for medical assistance under the Demonstration; and
- The member's request to have his/her eligibility terminated and to be disenrolled from the program

Monthly, OVHA shall compare the active Demonstration enrollee list (the roster) against ESD's Medicaid/VHAP Eligibility list to confirm Medicaid/VHAP status for all Demonstration Program enrollees. OVHA shall not receive a capitation payment for any client who is not eligible under the Demonstration.

2.2.5 Prohibitions

OVHA shall not disenroll any members except those who have lost eligibility as specified under 2.2.4. This prohibition specifically precludes disenrollment on the basis of an adverse change in the enrollee's health status, the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

Information on disenrollments (by reason code) shall be available to AHS for audit purposes upon request.

2.3 Member Outreach and Education

2.3.1 New Enrollees

OVHA shall be responsible for educating newly eligible persons at the time of their enrollment into the program. Education activities may be conducted via mail, by telephone and/or through face-to-face meetings. OVHA may employ the services of an Enrollment Broker to assist in outreach and education activities.

OVHA shall provide information and assist enrollees in understanding all facets of the program, including the following:

- What services are covered and how to access them
- Restrictions on freedom-of-choice
- Cost sharing
- The role and responsibilities of the primary care provider
- The importance of selecting and building a relationship with a primary care provider
- Information about how to access a list of PCPs in geographic proximity to the enrollee, as well as the availability of a complete network roster
- Enrollee rights, including appeal and fair hearing rights (described in greater detail below); confidentiality rights; availability of the Office of Health Care Ombudsman; and member-initiated disenrollment
- Enrollee responsibilities, including making, keeping, canceling appointments with PCP and specialists; necessity of obtaining prior authorization for certain services and proper utilization of the emergency room.

2.3.2 Member Handbook

OVHA and AHS shall coordinate the development of a Demonstration Program member handbook, which shall help members and potential members understand the requirements and benefits of the various programs available through the Demonstration. OVHA shall

mail the member handbook to all new members within forty-five (45) days of determination of eligibility for the Demonstration Program.

The member handbook must be specific to the Demonstration Program and must be written in language that is clear and easily understood by an elementary-level reader. Member handbooks must contain a comprehensive description of the Demonstration program, including a description of covered benefits, how to access services in urgent and emergent situations, how to access services in other situations, complaint and grievance procedures, appeal procedures (for eligibility determinations or service denials), member disenrollment rights, and advance directives.

With respect to information on grievance, appeal and fair hearing procedures and timeframes, the Demonstration Program member handbook must contain the following information:

- The right to a State fair hearing, method for obtaining a hearing, timeframe for filing a request, timeframes for resolution of the fair hearing, and rules that govern representation at the hearing;
- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The toll-free numbers that the enrollee can use to obtain assistance in filing a grievance or an appeal;
- The fact that, when requested by the member, benefits will continue if the member files an appeal or a request for State fair hearing within the timeframes specified for filing; and that the member may be required to pay the cost of any services furnished while the appeal is pending if the denial is upheld;
- Any appeal rights that the State makes available to providers to challenge the failure of OVHA to cover a service;
- Information about Advance Directives and the service providers' obligation to honor the terms of such directives; and
- Additional information that is available upon request, including information on the structure of OVHA's Demonstration Program and any physician incentive plans.

OVHA shall notify its members in writing of any change that AHS defines as significant to the information in the Demonstration Program member handbook at least thirty days before the intended effective date of the change.

2.3.3 Languages other than English

OVHA shall comply fully with AHS policies for providing assistance to persons with Limited English Proficiency. OVHA shall develop appropriate methods of communicating with its members who do not speak English as a first language, as well as its visually and hearing impaired members, and accommodating members with physical disabilities and different learning styles and capacities. Member materials, including the member handbook, shall be made available in all prevalent non-English languages. A prevalent non-English language shall mean any language spoken as a first language by five percent or more of the total statewide Demonstration program enrollment.

OVHA shall make in-person or telephonic interpreter services available to any enrollee who requests them, regardless of the prevalence of the enrollee's language within the overall program. AHS contracts with in-person and telephonic interpreter vendors, as well as written translation vendors on behalf of OVHA and other AHS departments. OVHA will use these vendors as necessary and will bear the cost of their services, as well as the costs associated with making ASL interpreters and Braille materials available to hearing- and vision-impaired enrollees.

OVHA shall include information in the member handbook on the availability of oral interpreter services, translated written materials, and materials in alternative formats. The Demonstration Program member handbook shall also contain information on how to access such services.

2.3.4 Advance Directives

OVHA shall comply with the requirements of 42 CFR 489.100 related to maintaining written policies and procedures respecting advance directives. OVHA shall require all Demonstration Program providers, including its subcontracted Departments, to comply with these provisions.

This requirement includes:

- Maintaining written policies and procedures that meet requirements for advance directives in Subpart I of part 489;

- Maintaining written policy and procedures concerning advance directives with respect to all adult individuals receiving medical care or assistance by or through OVHA or one of its sister Departments;

- Providing written information to those individuals with respect to the following:

  - A description of State law and their rights under State law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Such

information must reflect changes in State law as soon as possible, but not later than ninety days after the effective date of the State law.
  - The organizations' policies respecting implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.

- Informing clients that any complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.

2.3.5 Satisfaction Surveys

OVHA shall conduct member satisfaction surveys once every three years. The survey tool and methodology must be submitted to AHS for review and approval at least 90 days prior to implementation of the survey. AHS will submit the survey tool to CMS at least 60 days prior to implementation of the survey. OVHA agrees to make all appropriate modifications required by AHS and/or CMS.

OVHA may delegate the execution of a satisfaction survey to a subcontractor as long as the sub-contractor uses a survey tool and methodology approved by OVHA.

2.4 Network Development

2.4.1 Subcontractors

OVHA may subcontract with other Departments to provide certain covered Demonstration Program services that are relevant to the programs they administer, including DAIL, DOH, DOE and DCF (collectively referred to as the Departments). Prior to subcontracting with a Department, OVHA shall evaluate the Department's ability to perform the activities covered under the proposed contract.

In addition to services available through the subcontracted Departments, members may access health and mental health services from licensed Medicaid-enrolled providers.

Licensed and enrolled Medicaid providers must:

- Meet the requirements set forth in 42 CFR 431.107;

- Meet OVHA's established credentialing requirements;

- Be willing to coordinate care with OVHA or its designee, including sharing clinical information (with appropriate client consent); and

- Accept OVHA's fee schedule.

OVHA and the subcontracted Departments shall be prohibited from discriminating with respect to the participation, reimbursement or indemnification of any provider who is

acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

All contracts and subcontracts for services related to the Demonstration Program must be in writing and must provide that AHS and the U.S. Department of Health and Human Services may:

- Evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed; and

- Inspect and audit any financial records of such contractor/subcontractor.

Written contracts must specify the activities and reporting responsibilities of the contractor or subcontractor and provide for revoking delegation or imposing other sanctions if the contractor or subcontractor's performance is inadequate.

No subcontract terminates the responsibility of OVHA to ensure that all activities under this Agreement are carried out. OVHA agrees to make available to AHS and CMS all subcontracts between OVHA and the Departments.

2.4.2 Oversight Process for Subcontractors

OVHA shall provide oversight for Medicaid enrollee services through the following:

- At least biennially, OVHA will complete Minimum Standards and Clinical Care Audits. OVHA will review an established percentage of client records for emergency care, actions and appeal outcomes, service plan development and utilization review of reported service records; and

- Biennially, on alternating years with the Minimum Standards and Clinical Care Audit, OVHA will conduct a Program Review. Program Reviews will evaluate access to services, Department practices, member outcomes, operational management, and administrative structures.

OVHA will maintain evaluation tools, reports, improvement plans, and reported service data profiles used in the service plan and utilization review monitoring activity. OVHA shall also conduct ongoing monitoring of its Departmental subcontractors through the review of required reports and data submissions.

2.4.3 Provider Services

OVHA shall maintain a provider services function that operates during normal business hours. Functions shall include:

- Assistance with development of procedures for determining client eligibility;
- Assistance with the submittal of claims for services rendered,

- Assistance with preparation and submittal of monthly encounter data; and
- Provider grievances and appeals, including appeals of member eligibility.

2.4.4 Provider Contracting and Credentialing

OVHA shall ensure that all providers participating in the Demonstration Program meet the credentialing requirements established by the AHS for the Medicaid program. At a minimum, OVHA shall ensure that all Demonstration Program providers are licensed and/or certified where required, and are acting within the scope of that license and/or certification, or federal authority, including federal CLIA requirements. Providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act are prohibited from participation in the Demonstration Program. Providers may not furnish services that are subject to the Certificate of Need law when a Certificate has not been issued.

2.4.5 Provider Profiling

OVHA, through its managed care information system, shall conduct provider profiling activities, including producing monthly information on enrollment, service encounters, costs, reimbursements, and outcomes for all health services provided to Demonstration enrollees through the subcontracted departments. Information used in provider profiling will include data from all providers of health services within the subcontracted Departments, and will provide for the development of standard comparison reports and ad hoc reports as needed. Standard and ad hoc reports shall be made available to Departments.

2.4.6 Mainstreaming

OVHA agrees to ensure that network providers do not intentionally discriminate against Demonstration enrollees in the acceptance of patients into provider panels, or intentionally segregate Demonstration enrollees in any way from other persons receiving services.

2.5 Covered Services

2.5.1 General

The OVHA Demonstration Program includes a comprehensive health care services benefit package. The covered services will include all services that AHS requires to be made available through its public insurance programs to enrollees in the Demonstration including all state plan services in the following categories:

Acute health care services
Preventative health services
Behavioral health services, including substance abuse treatment
Specialized mental health services for adults and children

Developmental services
Pharmacy services
School-based services

The monthly capitation amount paid by the Agency of Human Services (AHS) to OVHA, as the Managed Care Organization, will include payment only for services covered under the Demonstration.

2.5.1.1 Medical Necessity

OVHA agrees to make available the benefits covered under the Demonstration to groups of individuals eligible for coverage through its public health insurance programs. OVHA further agrees, at a minimum, to provide the services that are covered based on medical/clinical necessity. Services shall be sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished. OVHA shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition.

Medically-necessary care, as defined in Rule 10 of the Vermont Division of Health Care Administration, means health care services including diagnostic testing, preventive services and aftercare appropriate, in terms of type, amount, frequency, level, setting, and duration to the member's diagnosis or condition. Medically-necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition; and 1) help restore or maintain the member's health; 2) prevent deterioration of or palliate the member's condition; and 3) prevent the reasonably likely onset of a health problem or detect an incipient problem.

Medical/clinical necessity determinations will be made by the medical director of OVHA in a manner that is no more restrictive than the State Medicaid program. Ultimate authority in such determinations lies with AHS, as the entity to which Demonstration enrollees have the right to appeal. AHS will arrange for independent medical review of appeals of medical necessity decisions by OVHA as appropriate.

Within the limits of the benefit plan, OVHA has the responsibility for establishing procedures for referrals and when prior authorization is required either by OVHA or a subcontracting Department.

The capitated benefit package for the Demonstration Program is included in Attachment A to this Agreement.

2.6 Access to Services

2.6.1 General

Through its contracts with Medicaid providers and the subcontracted Departments, OVHA must ensure that a network of appropriate providers is maintained to furnish adequate access to all covered Demonstration Program services. In establishing and maintaining this network, OVHA must consider the following:

- The anticipated enrollment in the Demonstration Program;
- The expected utilization of services;
- The number and types of providers required to furnish the contracted services;
- The numbers of providers who are not accepting new patients; and
- The geographic location of providers and Demonstration Program clients, considering distance, travel time, the means of transportation ordinarily used by Demonstration enrollees, and whether the location(s) provide physical access for clients with disabilities.

2.6.1 Twenty-Four Hour Coverage

OVHA must ensure that coverage is available to members on a twenty-four hours per day, seven days a week basis. Coverage may be delegated to the subcontracted Departments, but OVHA must maintain procedures for monitoring coverage to ensure twenty-four hour availability.

OVHA will collaborate with AHS to develop a toll-free Nurse Advice Line, through which enrollees with urgent or emergent medical problems can obtain guidance twenty-four hours per day, seven days a week.

2.6.2 Emergency Services

"Emergency medical condition" means a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy;
- Serious impairment to such person's bodily functions; and
- Serious dysfunction of any bodily organ or part of such person.

"Emergency services" means covered inpatient and outpatient services that are as follows:

- Furnished by a qualified provider; and
- Needed to evaluate or stabilize an emergency medical condition.

OVHA is responsible for coverage and payment of emergency services for all enrollees served through the Demonstration's public health insurance programs. Payment for these services shall be made in accordance with the Medicaid fee schedule.

OVHA must cover and pay for emergency services regardless of whether the provider who furnishes the services has a contract with the Medicaid program, and may not deny payment for treatment obtained whenever an enrollee has an emergency medical condition (according to the prudent layperson standard) or is instructed by a representative of OVHA or a subcontracted Department to seek emergency services, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition.

OVHA or its subcontracted Departments may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. OVHA and the Departments may further not refuse to cover emergency services based on a failure on the part of the emergency room provider, hospital or fiscal agent to notify the member's provider, the responsible Department, or OVHA of the member's screening and treatment within ten calendar days of the client's presentation for emergency services. This shall not preclude OVHA from refusing to cover non-emergency services that do not meet medically necessity criteria, or refusing payment for non-emergency services in cases where a provider does not provide notice within the ten-day timeframe.

A Demonstration enrollee receiving services through the public insurance programs who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

The attending emergency physician, or the provider actually treating the client, is responsible for determining when the client is sufficiently stabilized for transfer or discharge, and that determination is binding on the entity (OVHA) responsible for coverage and payment.

2.6.3 Post-Stabilization Care Services

"Post-stabilization care services" means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the client's condition.

Post-stabilization care services provided on an inpatient hospital basis are paid for by OVHA for all enrollees in the public insurance programs under the Demonstration. OVHA may conduct concurrent review for post-stabilization services as soon as medically appropriate. However, OVHA must pay for all inpatient post-stabilization care services that are pre-approved by OVHA, all post-stabilization services that are not pre-approved but are administered to maintain the client's stabilized condition within one hour of a request to OVHA for pre-approval, and all services that are not pre-approved but are administered to maintain, improve or resolve an client's stabilized condition if:

- OVHA does not respond to a request for pre-approval within one hour;
- OVHA cannot be contacted; or
- OVHA's representative and the treating physician cannot agree concerning the client's treatment and OVHA does not have a physician available for consultation. In this situation, OVHA must allow the treating physician to continue with care of the enrollee until an OVHA physician is reached or the enrollee is discharged.

OVHA's financial responsibility for post-stabilization services for services it has not pre-approved ends when any of the following conditions is met:

- A OVHA-contracted physician who has privileges at the treating hospital assumes responsibility for the client's care;
- A OVHA-contracted physician assumes responsibility for the client's care through transfer;
- OVHA and the treating physician reach an agreement concerning the client's care; or
- The client is discharged.

2.6.4 Travel Time

OVHA shall ensure that travel time to services does not exceed the limits described below:

- Primary Care – No more than 30 miles or 30 minutes for all enrollees from residence or place of business unless the usual and customary standard in an area is greater, due to an absence of providers. OVHA's network will include all Medicaid participating providers, which equates to nearly all providers in the State. However, if the travel time standard is exceeded in an area which contains a non-participating provider, OVHA will work aggressively to bring that provider into the network.
- Hospitals – Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater, mental health

services where access to specialty care may require longer transport time, and for physical rehabilitative services where access is not to exceed 60 minutes.

- General Optometry – Transport time will be the usual and customary, not to exceed one hour, except in areas where community standards will apply.

- Lab and X-Ray – Transport time will be the usual and customary, not to exceed one hour, except in areas where community access standards will apply.

- All Other Services – All services not specified above shall meet the usual and customary standards for the community.

2.6.5 Appointment Availability

OVHA shall ensure that in-office waiting times for appointments do not exceed one hour, except in areas where a longer waiting time is usual and customary. Exceptions to the one-hour standards must be justified and documented to AHS on the basis of community standards.

Appointment availability shall meet the usual and customary standards for the community, and shall comply with the following:

- Urgent care: Within twenty-four hours;

- Non-urgent, non-emergent conditions: Within five business days;

- Referral appointments for non-urgent care: Within thirty days or as clinically appropriate;

- Routine Care: Available in a timely manner consistent with the individual client's plan of treatment.

2.6.6 Interpreter Services at Medical Sites

OVHA shall ensure availability of interpreter services at medical delivery sites to members who speak a language other than English as a first language, or who are hearing-impaired, and who request such assistance. Where reasonable and practicable, OVHA shall make interpreters available in-person. Where this is not practicable, interpreters must be made available by telephone.

2.6.7 Cultural Considerations

OVHA shall participate in AHS's efforts to promote the delivery of services in a culturally competent manner to all Demonstration Program enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

2.6.8 Choice of Health Professional

As per 42 CFR 438.6(m), Demonstration enrollees will have choice of health professional within the network of Medicaid providers to the extent possible and appropriate.

2.6.9 Direct Access to Women's Health Specialist

OVHA must provide female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a woman's health specialist.

2.6.10 Alternative Treatment

OVHA shall ensure that its subcontracted Departments do not prohibit, or otherwise restrict a health care professional acting within the lawful scope of practice, from the following actions:

- Advising or advocating on behalf of an client who is his or her patient for the client's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Providing information to the client as necessary for the client to decide among all relevant treatment options;
- Advising or advocating on behalf of a client for the risks, benefits, and consequences of treatment or non-treatment;
- Advising or advocating on behalf of the client for the client's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

2.6.11 Second Opinion

Demonstration Program enrollees served through the public insurance programs shall have the right to obtain a second opinion from a qualified health care professional, within the network of enrolled Medicaid providers, at no cost to the enrollee.

2.7 Coordination of Services

OVHA shall assist in the coordination of services provided through its network of Medicaid providers and its subcontracted Departments.

OVHA shall require that each member's record contains the name of his/her primary care provider.

2.8 Payment to Providers

2.8.1 General

OVHA is responsible for ensuring timely payments to its contracted providers, including its subcontracted Departments.

OVHA shall ensure that all members enrolled in the Demonstration Program are assigned a unique client identification number, and a Medicaid eligibility classification as applicable.

Medicaid or VHAP enrollees will not be held liable for covered services for which OVHA does not pay the health care provider who furnished the services. Medicaid or VHAP enrollees are further not liable for payments for covered services furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount that the enrollee would owe if AHS provided the services directly.

2.8.2 Incentive Payments

OVHA may make payments to its subcontracted Departments on a risk or incentive basis, provided such arrangements are in compliance with AHS and Federal requirements and guidelines, and disclosed to AHS. In making payments on an incentive basis, OVHA shall comply as applicable with the requirements set forth in 422.208 and 422.210 regarding Physician Incentive Plans.

2.8.3 Payments to Primary Care Providers

OVHA will ensure that each member enrolled in the public insurance programs, for which the public insurance programs serve as the primary payor, has a primary care provider. Primary care providers are paid on a fee-for-service basis in accordance with the Medicaid fee schedule. In addition, they are paid a per member per month case management fee for providing care coordination and referral services to their members.

2.8.4 Member Cost-Sharing

Member cost sharing shall be in accordance with the premium and copayment provisions of the program as established by the Vermont State Legislature each year, as reflected in Attachment A of this IGA.

2.9 Quality Assurance and Medical Management

2.9.1 Quality Management Plan

OVHA shall maintain a comprehensive Quality Management Plan for the Demonstration Program. The Quality Management Plan shall conform to all applicable federal and State regulations. The Quality Management Plan shall be available to AHS upon request.

OVHA shall maintain an ongoing program of performance improvement projects that focuses on clinical and non-clinical areas, and that involves the following:

- Measurement of performance using objective quality indicators;
- Implementation of system interventions to achieve improvements in quality;
- Evaluation of the effectiveness of the interventions;
- Planning and initiation of activities for increasing or sustaining improvement; and
- Reporting of the status and results of each project to AHS as requested.

CMS or AHS may specify performance measures and topics for performance improvement projects. OVHA shall conduct projects specified by CMS or AHS.

OVHA shall require each subcontracted Department to also develop and maintain an internal Quality Management/Quality Improvement program.

2.9.2 Utilization Management Plan

OVHA shall develop and maintain a comprehensive Utilization Management Plan to identify potential over- and under-utilization of services. The Utilization Management Plan must conform to all applicable federal and State regulations.

OVHA shall adopt program guidelines that are based on valid clinical evidence, or based on the consensus of health care professionals, consideration of the needs of the enrollees, and consultation with health care professionals who participate in the Demonstration Program and other program stakeholders. Program guidelines shall be reviewed and updated periodically as appropriate. OVHA shall disseminate the guidelines to subcontracted Departments and shall require the Departments to disseminate the guidelines among all of their designated providers.

OVHA shall not structure compensation for any entity that conducts utilization management services in such a way as to provide incentives for the denial, limitation or discontinuation of medically necessary services to any client.

2.9.2.1 Authorization of Services

The term "service authorization request" means a Demonstration Program member's request for the provision of a service, or a request by the member's provider.

OVHA shall maintain, and shall require each subcontracted Department, to maintain and follow written policies and procedures for processing requests for initial and continuing authorization of medically necessary, covered services. The policies and procedures

must conform to all applicable federal and State regulations, including specifically 42 CFR 438.210(b).

OVHA may require pre-authorization for certain covered services including, but not limited to, inpatient hospital admissions, home and community based services, and certain pharmaceutical products. For inpatient admissions, specific review criteria for authorization decisions is identified and outlined in the Acute Care Management Program Description policies and procedures manual. OVHA will ensure consistent application of review criteria for authorization decisions. Review Criteria shall be incorporated in the Utilization Management Plan as described above.

For standard authorization decisions, the subcontracted Departments must reach a decision and provide notice as expeditiously as the client's health condition requires and no later than 14 calendar days from receipt of the request for service, with a possible extension of up to 14 additional calendar days if the enrollee or provider requests the extension; or the Department justifies to OVHA a need for additional information and how the extension is in the client's best interest.

For cases in which a provider indicates, or the Department determines, that following the standard timeframe could seriously jeopardize the client's life or health or ability to attain, maintain or regain maximum function, the Department must make an expedited authorization decision and provide notice as expeditiously as the client's health condition requires and no later than three working days after receipt of the request for service. The three days may be extended by up to 14 additional calendar days if the enrollee requests the extension, or if the Department justifies to OVHA a need for additional information and how the extension is in the client's interest.

Any case where a decision is not reached within the referenced timeframes constitutes a denial. Written notice must then be issued to the enrollee on the date that the timeframe for the authorization expires.

Planned services will be identified by the authorized clinician working with the enrollee and under the direct supervision of a prescribing provider. Any decision to deny, reduce the range, or suspend covered services, or a failure to approve a service that requires pre-authorization, will constitute grounds for noticing the enrollee. Any disagreement identified by the enrollee at any interval of evaluation, will also be subject to notice requirements.

Notices must meet language and format requirements set forth in Section 2.3.1.

Notice must be given within the timeframes set forth above, except that notice may be given on the date of action under the following circumstances:

- Signed written client statement requesting service termination;
- Signed written client statement requesting new service or range increase;

- A client's admission to an institution where he or she is ineligible for further services;
- A client's address is unknown and mail directed to him or her has no forwarding address;
- The client's physician prescribes the change in the range of clinical need.

OVHA or its subcontracted Departments shall notify the requesting provider and issue written notices to enrollees for any decision to deny a service, or to authorize a service in an amount, scope or duration less than that requested and clinically prescribed in the service plan. Notices must explain the action OVHA or the Department has taken or intends to take; the reasons for the action; the client's right to a second opinion regarding the service decision, or at least, a clinical program director not involved in the service decision; the client's right to file an appeal and procedures for doing so; circumstances under which an expedited resolution is available and how to request one; the client's right at any time to request a Fair Hearing for covered services and how to request that covered services be extended; the client's right to request external review by OVHA/AHS for covered services (as applicable to Medicaid eligibility) or alternate services; and the circumstances under which the enrollee may be required to pay the costs of those services pending the outcome of a Fair Hearing or external OVHA/AHS review.

2.9.3 State and Federal Reviews

OVHA must make available to the State and/or outside reviewers, on a periodic basis, medical and other records for review of quality of care and access issues.

CMS also will designate an outside review agency to conduct an evaluation of the Global Commitment Demonstration and its progress toward achieving program goals. OVHA must agree to make available to CMS's outside review agency medical and other records (subject to confidentiality constraints) for review as requested. This shall include the AHS's External Quality Review Organization.

2.10 Grievances and Appeals

2.10.1 Grievance Systems

2.10.1.1 Definitions and General Requirements

The terms "action", "grievance" and "appeal" are used as follows to describe the Demonstration Program grievance system:

'Action' means

- The denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner; or
- Failure of OVHA or a subcontracted Department to act within the established timeframes for grievances and appeals.

'Grievance' means an expression of dissatisfaction about any matter other than an action, such as the quality of a service provided or aspects of interpersonal relationships, such as rudeness. Enrollees can file grievances with OVHA or a subcontracted Department.

'Appeal' means a request for a review of an action.

OVHA or its subcontracted Departments shall be responsible for processing all enrollee grievances, and shall serve as the initial point of response for appeals, with the exception of appeals pertaining to Medicaid and Demonstration Program eligibility determinations. Appeals with respect to medical necessity determinations made by OVHA or its subcontracted Departments may be sent directly to the AHS by the member without going through the OVHA process.

DCF will retain responsibility for appeals pertaining to Medicaid/VHAP eligibility determinations. Similarly, if a member files an appeal pertaining to Medicaid/VHAP eligibility determinations, OVHA or its subcontracted Departments shall immediately forward the issue to DCF and shall notify the member in writing that the issue will be resolved by DCF.

For grievances and appeals not related to eligibility for the Medicaid or VHAP programs, OVHA shall ensure that each subcontracted Department develops and maintains comprehensive grievance and appeal procedures that include a grievance process, an appeal process, and access to the State's fair hearing system at any time, even if an appeal has not yet been adjudicated.

OVHA must review and approve each subcontracted Department's grievance and appeals procedures. OVHA shall ensure that each Department informs the members it is serving and its providers of the grievance and appeals procedures. Grievance and appeals procedures shall be distributed to members and providers in written format at least annually, and upon request. Information shall include enrollee rights with respect to filing grievances, appeals, and requests for fair hearing at any time, even if an appeal ha not yet been adjudicated; the process for doing so; the applicable timeframes for filing;

the availability of assistance (including interpretation services); and the toll-free numbers for filing oral grievances and appeals.

2.10.1.2 Grievance Procedures

Grievance procedures must comply with the following requirements:

- Procedures are clearly articulated and easily accessible for people with disabilities;
- There is a clear description of who can initiate a grievance and the process for doing so. Grievances must be accepted orally and in writing. Enrollees may elect whether to file the grievance orally or in writing and may not be required to do both;
- There are clearly defined steps for the process of resolving grievances;
- There is a process for impartial hearing of the grievance by individuals not involved in any prior level of decision-making on the issue. Grievances regarding denials of expedited resolutions of appeals, or involving clinical issues must be reviewed by a health care professional with expertise in treating the client's condition or disease;
- Grievances are logged and tracked;
- There is protection of confidentiality and from retribution for initiating a grievance;
- Assistance is available to consumers and family members throughout the grievance process. Including assistance in completing forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

In addition to the above requirements, the OVHA and subcontracted Department grievance procedures must comply with the following timeframes and requirements:

- All grievances must be acknowledged in writing within five days;
- Grievances must be resolved within 45 days of receipt. If a grievance cannot be resolved within 45 days, OVHA or the subcontracted Department must contact the member, inform him/her of the status of the grievance and the reason for the delay. Any extension in the timeline for processing the grievance shall not exceed an additional 45 days;
- OVHA or its subcontracted Departments must send written notices of resolution for all grievances. The written notice must include a brief summary of the grievance, the steps taken on the member's behalf, and the resolution.

2.10.1.3 Appeal Procedures

Appeal procedures must comply with the following minimum requirements:

- Procedures are clearly articulated and easily accessible for people with disabilities;

- There is a clear description of who can initiate an appeal and the process for doing so. Demonstration members may file appeals directly with AHS. Providers may file appeals when they are acting on behalf of an enrollee and have the client's written consent to do so. Appeals may be submitted either orally or in writing. Oral appeals, except for an oral appeal where expedited resolution is requested, must be followed with a written, signed appeal;

- Procedures allow members the opportunity to present evidence and allegations of fact or law, in person as well as in writing, and provide the client and/or his/her representative the opportunity to examine the case file, including medical records and other documents or records. In expedited appeals, clients are informed of the limited time available for presentation of evidence and allegations of fact or law;

- There are clearly defined steps for the process of resolving appeals;

- There is a process for impartial hearing of the appeal by individuals with appropriate clinical expertise who were not involved in any prior level of decision-making on the issue;

- There is a clearly defined process for expedited review of appeals when a provider indicates, or OVHA or its subcontracted Departments determine, that the timeframe for a standard resolution could seriously jeopardize the client's life or health or ability to attain, maintain or regain maximum function. Expedited appeals can be filed orally or in writing. There is no requirement to file a written appeal following an oral request for an expedited appeal;

- Appeals are logged and tracked;

- There is protection of confidentiality and from retribution for initiating an appeal or from requesting or supporting a request for an expedited resolution of an appeal;

- Assistance is available to consumers and family members throughout the appeal process, including assistance in completing forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability;

In addition to the above requirements, OVHA and Department appeal procedures must comply with the following timeframes and requirements:

- Enrollees must be allowed at least ten days from the initial determination to file an appeal;

- All appeals must be acknowledged in writing within five days;

- Appeals must be resolved, and notice provided, as expeditiously as the client's health condition requires and not later than 45 days from the date of receipt. If an appeal

cannot be resolved within 45 days, OVHA or the subcontracted Department must contact the client and inform him/her of the status of the appeal and the reason for the delay. The extension shall not exceed an additional 14 days. An extension may also be granted at the request of the client;

- Expedited appeals must be resolved, and notice provided, as expeditiously as the client's health condition requires and no later than three working days after receipt of the appeal. The timeframe may be extended by up to 14 calendar days if the client requests the extension or the subcontracted Department demonstrates, and OVHA agrees, that the extension is in the client's interest. If the extension is not requested by the client, the Department must provide written notice of the reason for the delay;

- If a request for an expedited appeal resolution is denied, OVHA or the subcontracted Department must transfer the appeal to the standard timeframe (no longer than 45 days from receipt of the request) and must provide prompt oral notice of the denial to the enrollee. Written notice of the denial must be given within two calendar days. The notice must explain the reason for the denial of an expedited resolution and information on the client's right to file a grievance and the process for doing so;

- OVHA or its subcontracted Department must send written notices of resolution for all appeals. Reasonable efforts to provide oral notice must also be made. The written notice must include the results and date of the appeal resolution and, for decisions not wholly in the client's favor when the client is a beneficiary of the Demonstration's public insurance programs --
  - The right to request a State fair hearing for up to 30 days from the date of the appeal decision;
  - How to request a fair hearing;
  - The right to continue to receive benefits pending a hearing;
  - How to request continuation of benefits; and
  - If OVHA or the subcontracted Department's action is upheld during a hearing, the client's liability for the cost of any continued benefits.

- For decisions not wholly in the client's favor when the client is not a beneficiary of the Demonstration's public insurance programs, or has filed an appeal pertaining to a service not covered by Medicaid, the written notice shall include information on the client's right to file an appeal and how to file such an appeal.

2.11 Client Records

OVHA shall ensure (and require its subcontracted Departments to ensure) that each client served under the Demonstration Program has a comprehensive medical record. OVHA and its subcontracted Departments shall ensure compliance with all state and federal legal requirements as they pertain to medical records and in particular, to confidentiality of records. At a minimum, all medical records shall:

- Be maintained in a manner that is current, detailed, and organized such that it permits effective patient care and quality review as documented in the Minimum

Standards and Clinical Care Audit;

- Include sufficient information to identify the patient, date of encounter and pertinent information which documents the type and frequency of services provided;

- Include an annual review of treatment and service plan determinations (as appropriate and applicable); and

- Describe the client's diagnosis and appropriateness of the treatments/services, the course and results of the treatment/services, and shall illustrate how the provider facilitates continuity and coordination of care as evidenced by:

  - Presence of a comprehensive health evaluation;
  - Functional assessment completed biennially (if appropriate);
  - History and Physical;
  - Annual service plan derived from clinically assessed needs and client preference, if applicable;
  - Quarterly updates to the service plan, if applicable;
  - Monthly evaluative summary of treatment and service needs, if applicable;
  - As appropriate, medication evaluation, prescription and management of drug therapies.

2.12 Reporting Requirements

2.12.1 Encounter Data

OVHA shall maintain claims history data for all Demonstration enrollees through contractual arrangements with its Fiscal Agent. OVHA shall also require its subcontracted Departments to submit encounter reports for all services rendered to Demonstration Program clients, when such services are provided through a sub-capitation arrangement with the Department. Reporting shall be in accordance with the CMS Special Terms and Conditions of the 1115 Medicaid Waiver Demonstration. OVHA shall make such claims and encounter data available to AHS and CMS upon request.

2.12.1.1 Data Validation

Encounter data submitted to OVHA by its subcontracted Departments will be edited by OVHA for accuracy, timeliness, correctness, and completeness. Any encounter data failing edits will be rejected and must be re-submitted. Encounter data must represent services provided to enrolled Demonstration Program clients only.

Biennially, AHS or its designee will perform medical record reviews for purposes of comparing submitted claims and encounter data to the medical record to assess correctness, completeness and to review for omissions in encounters or claims.

2.12.2 Financial Reporting

OVHA shall maintain the following financial information and records, and shall make such information available to AHS upon request, in the format specified by AHS. Financial records shall include the following:

- Monthly comparisons of projected vs. actual expenditures;
- Monthly report of OVHA revenues and expenses for Demonstration Program;
- Monthly comparisons of projected vs. actual case load;
- Quarterly analysis of expenditures by service type;
- Monthly financial statements; and
- All reports and data necessary to support waiver reporting requirements.

AHS reserves the right to modify the financial reporting requirements. AHS will consult with OVHA prior to modification of reporting requirements.

2.12.3 Network Reporting

AHS shall provide report formats and variable definitions for OVHA to use in providing network capacity data to demonstrate that it offers an appropriate range of covered services adequate for the anticipated number of enrollees for the service area; and that it maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

Network capacity documentation shall be submitted annually and at any time there has been a significant change in OVHA's operations that would affect adequate capacity or services, including changes in services, benefits, payments or enrollment of a new population.

Monthly reports are due within thirty days following the end of the month. Annual and quarterly reports are due within forty-five days following the end of the reporting period.

2.13 Fraud and Abuse

OVHA must have both administrative and management procedures, and a mandatory compliance plan, to guard against fraud and abuse. The procedures and compliance plan must include the following:

- Written policies, procedures and standards of conduct that articulate OVHA's commitment to comply with all applicable Federal and State standards;
- Designation of a compliance officer and a compliance committee that are

accountable to senior management;
- Effective training and education for the compliance officer and all OVHA employees;
- Effective lines of communication between the compliance officer and employees;
- Enforcement of standards through well-publicized disciplinary guidelines;
- Provision for internal monitoring and auditing; and
- Provision for prompt response to detected offenses, and for development of corrective action initiatives.

OVHA must further require any employees, contractors, and grantees that provide goods or services for the Demonstration Program to furnish, upon reasonable request, to the Vermont Office of Health Access, the Vermont Attorney General, and the federal Department of Health and Human Services, any record, document, or other information necessary for a review, audit, or investigation of program fraud or abuse, and shall establish procedures to report all suspected fraud and abuse to AHS and the Vermont Attorney General. For each case of suspected fraud and abuse reported, OVHA shall supply (as applicable) the name and identification number; source of the complaint or issue; type of provider; nature of the complaint or issue; the approximate dollars involved; and the legal and administrative disposition of the case. OVHA must provide access to both original documents and provide free copies of requested documents on a reasonable basis. Such access may not be limited by confidentiality provisions of the plan or its contractors.

2.14 Records Retention

2.14.1 General

OVHA must maintain books and records relating to Demonstration Program services and expenditures, including reports to the State and source information used in preparation of these reports. These records include but are not limited to financial statements, records relating to quality of care, medical records, and prescription files. OVHA also agrees to comply with all standards for record keeping specified by AHS. In addition OVHA agrees to permit inspection of its records.

2.14.2 Confidentiality of Information

OVHA agrees that all information, records, and data collected in connection with the agreement shall be protected from unauthorized disclosures. In accordance with section 1902(a)(7) of the Social Security Act, OVHA agrees to provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan. In addition, OVHA agrees to guard the confidentiality of recipient information, in a manner consistent with the confidentiality requirements in 45 CFR parts 160 and 164. Access to recipient

identifying information shall be limited by OVHA to persons or agencies which require the information in order to perform their duties in accordance with the agreement, including AHS, the U.S. Department of Health and Human Services, and other individuals or entities as may be required by the State.

Any other party may be granted access to confidential information only after complying with the requirements of State and Federal laws and regulations, including 42 CFR 431, Subpart F pertaining to such access. AHS shall have absolute authority to determine if and when any other party shall have access to this confidential information. Nothing herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals.

Nothing in this section shall be construed to limit or deny access by clients or their duly authorized representatives to medical records or information compiled regarding their case, or coverage, treatment or other relevant determinations regarding their care, as mandated by either state and/or federal laws and regulations.

2.15 Disclosure Requirements

OVHA must comply with any applicable Federal and State laws that pertain to enrollee rights, and must ensure that its staff and affiliated providers take enrollee rights into account when furnishing services to enrollees. OVHA must have a written policy on Demonstration enrollee rights that addresses the member's right:

- To be treated with respect, dignity, and privacy;
- To be provided with information about the Demonstration Program, its services, practitioners, and member rights and responsibilities;
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the client's condition and ability to understand;
- To be able to choose health care providers within the limits of the OVHA network;
- To participate in decision-making regarding their health care;
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;
- To voice grievances about the program or care received;
- To formulate advance directives; and
- To have access to copies of his/her medical record and to request that the medical record be amended or corrected.

OVHA must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way OVHA or its providers treat the enrollee.

OVHA must comply with disclosure requirements in 42 CFR 455, Subpart B. OVHA also must inform Demonstration Program enrollees about:

- Rights and responsibilities, including rights to terminate enrollment;
- Policies on advance directives;
- Provisions for after-hours coverage; and
- Procedures for OVHA-approved disenrollments.

ARTICLE THREE: AHS RESPONSIBILITIES

3.1 Eligibility Determination

AHS shall maintain sole responsibility for the establishment of eligibility requirements and standards for Medicaid or VHAP, as well as any other eligibility requirements for expansion populations under the Global Commitment Demonstration.

3.2 Capitation Rate Setting

AHS shall establish fixed rates for monthly per capita payments for Demonstration Program enrollees. The capitation payments will be equal to the fee-for-service equivalent cost for the package of services that are to be administered through OVHA. The methodology for capitation rate setting will be subject to approval of the Center for Medicare and Medicaid Services.

AHS shall pay OVHA the appropriate monthly Capitation Rate for each Demonstration enrollee in the Global Commitment Program. OVHA will submit a monthly report to AHS listing all enrollees who meet the Demonstration eligibility criteria. This roster of Demonstration enrollees will be used to determine the total capitation payment due to OVHA for that month.

OVHA will ensure that the member roster submitted to AHS has been certified by the Director or an individual who has delegated authority to sign for, and reports directly to, the Director. The certification must attest to the accuracy, completeness and truthfulness of the documents and data. The certification must be submitted concurrently with the member roster.

3.3 Performance Evaluation

AHS shall annually, or more frequently at its discretion, do the following:

- Define measurable performance standards for OVHA and its subcontractors in all of the following areas:
  - Service Accessibility
  - Enrollee Satisfaction
  - Quality Assurance & Medical Management
  - Grievance & Appeal Resolution
  - Reporting
- Monitor and evaluate OVHA's compliance with the terms of this Agreement, including performance standards;
- Meet with OVHA a minimum of twice a year to assess the performance of its Quality Assurance Program, as set forth in the Protocol;

- Review reports submitted by OVHA, including specifically quarterly reports on grievances and appeals received by OVHA and its subcontracted Departments;

- Request additional reports that AHS deems necessary for purposes of monitoring and evaluating the performance of OVHA under this Agreement;

- Perform periodic programmatic and financial reviews of OVHA's performance of responsibilities. This may include, but is not limited to, on-site inspections and audits of OVHA's and/or its subcontracted Department's records and audits. The on-site inspections and audits may, at a minimum, include a review of the following:

  - Administration
  - Operations
  - Financial performance
  - Staff/provider qualifications and training
  - Client access
  - Member services
  - Provider services
  - Individual medical records
  - Quality Assurance Program
  - Utilization Management functions
  - Grievances and appeals
  - Member satisfaction

- Give OVHA and/or its subcontracted Departments prior notice of any on-site visit by AHS or its agents to conduct an audit, and further notify OVHA of any records that must be made available for review;

- Inform OVHA and/or its subcontracted Departments of the results of any performance evaluations conducted by AHS or its agents;

- Develop Corrective Action Plans to address any areas of non-compliance or poor performance identified as part of the evaluation process. In the event a Corrective Action Plan is issued to OVHA or one of its subcontractors, OVHA will be required to file a formal response within the time period specified in the CAP. AHS will review and approve or modify the response, as appropriate. AHS will monitor implementation of the CAP response through progress reports and interim audits until it is satisfied that the deficiency has been corrected.

- Perform medical audits at least annually as required by 42 CFR 434.63; and

AHS shall contract with an External Quality Review Organization (EQRO) for purposes of independently monitoring OVHA's Quality Management Program. The EQRO will report solely to AHS.

3.4 Receipt and Analysis of Encounter Data

AHS shall receive the claims and encounter data as reported by OVHA. AHS shall, at least annually, conduct an evaluation of the claims and validated encounter data to identify any changes from historical utilization rates, areas of potential over- or under-utilization, and any other issues that may affect the success of the program.

3.5 CMS Reporting

AHS shall retain sole responsibility for production and submission of reports to CMS, including all fiscal reports. OVHA agrees to cooperate with AHS in the preparation of any required reports, including providing any necessary data and analysis, preparation of materials for submission to CMS, and assisting in the preparation of responses to any questions or issues CMS may raise with respect to the reports.

3.6 Fair Hearing Process

The Human Services Board shall retain responsibility for conducting fair hearings. AHS shall retain responsibility for representing the State in any fair hearings pertaining to eligibility determinations other than Medicaid or VHAP (which is the responsibility of the Economic Services Division) or service denials. In the event of a request for a fair hearing regarding Demonstration Program eligibility or service denials, the decision of OVHA or its contracted Departments shall be reviewed by AHS. OVHA agrees to cooperate with AHS in any fair hearing proceedings, including preparation and submission of any client medical records or other documentation pertinent to the proceedings. OVHA further agrees that its legal staff shall assist the State in any fair hearings pertaining to service denials. OVHA must provide covered services promptly and as expeditiously as the client's health condition requires if such services are determined medically/clinically necessary by the AHS Medical Reviewer, or if the enrollee prevails in the fair hearing. Where possible, the AHS Medical Reviewer shall apply existing definitions and guidelines in making determinations of medical/clinical necessity.

Enrollee services must be continued during the Fair Hearing process under the following circumstances:

- The appeal was filed timely, meaning on or before the tenth day after the notice of action was mailed or by the intended effective date of the proposed action;
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The authorization period has not expired; or
- The enrollee requests extension of benefits.

If benefits are continued or reinstated, the benefits must be continued until one of the following occurs:

- The enrollee withdraws the appeal;
- The enrollee does not request a fair hearing within ten days from the date of mailing of the adverse decision;
- A State fair hearing decision adverse to the enrollee is made; or
- The authorization expires or service authorization limits are met.

If the final resolution of the appeal upholds OVHA's decision (or that of one of its subcontracted Departments), the enrollee is liable for the cost of services furnished while the appeal is pending.

OVHA must pay for disputed services, in accordance with State policy and regulations, if the State fair hearing officer reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending.

Parties to the State fair hearing include OVHA, the subcontracted Department (if applicable), the enrollee and his or her representative or the representative of a deceased member's estate.

3.7 Member Services

OVHA, through its enrollment subcontractor (currently Maximus), shall provide an enrollee helpline function for the Demonstration Program clients. OVHA shall make available to its enrollment subcontractor an up-to-date provider listing, including names, telephone numbers, office hours, and other relevant information, for use by the helpline operators. AHS shall ensure that the Member Services functions are appropriately carried out by OVHA.

OVHA shall require each subcontracted Department to identify a liaison to respond to inquiries from the helpline operators and to assist in resolution of client issues.

3.8 Ombudsman

OVHA shall coordinate with the State Health Care Ombudsman and provide information necessary to support this function. AHS shall ensure that OVHA provides for an Ombudsman function.

3.9 Third Party Liability

OVHA will be responsible for identifying and pursuing accident insurance and estate recovery; and all other sources of third party liability (TPL). AHS shall monitor OVHA's experience in identifying sources of third party liability or coverage and in collecting funds due to it through these sources.

ARTICLE FOUR: PAYMENT PROVISIONS

4.1 Capitation Payment between AHS and OVHA

OVHA shall be paid federal Medicaid matching funds based on eligible Demonstration Waiver enrollees at the capitated monthly amounts approved by AHS and CMS under the Waiver Terms and Conditions. The capitation rates provided under the Demonstration will comply with the actuarial certification requirements of the BBA. Administrative costs shall not be part of the capitation and shall be reported in accordance with existing federal regulations.

Capitation payments serve as full compensation for the provision of covered health care services to Demonstration enrollees. With the exception of the capitation payments specified herein, Medicaid funding will not be made available to reimburse services covered under this agreement.

OVHA shall be at risk for the provision of all covered health services required by Demonstration enrollees. Third-party collections shall be the responsibility of, and retained by, OVHA.

Monthly capitation rates for the period October 1, 2005 to September 30, 2006 shall be as follows:

TO BE DEVELOPED

4.2 Payments between OVHA and its Subcontracted Departments

OVHA will pay the subcontracted Departments using reimbursement methodologies based on the cost of delivering eligible services to individuals covered under the Demonstration.

4.3 Restrictions on Use of Excess Funds

Should OVHA have any excess funds after making all payments to its providers, including its subcontracted Departments, for Demonstration enrollees, those excess funds may be used to support health initiatives in the State. Restrictions on the use of excess funds are as follows:

- Funds may not be used as state match in subsequent years
- 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 Demonstration eligibility
- Financing health care services covered under the Vermont State Employee Benefit Plan

AHS will collect detailed information annually on how excess funds are spent.

Attachment A
Description of Covered Benefits and Populations

The MCO must provide for all the listed services and populations currently covered unless otherwise authorized by the Vermont Legislature and AHS.

Mandatory Categorically Needy Groups[1]	Mandatory Special Coverage Groups	Optional Categorically Needy Groups[2]	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
1931 low income families with children (1902(a)(10)(A)(i)(I)) (1931)	newborns deemed eligible for 1 year as long as mother remains eligible or would remain eligible if pregnant (1902(e)(4))	individuals who are eligible for but not receiving IV-A, SSI or State supplement cash assistance (1902)(a)(10)(A)(ii)(I)) **COVERED**	individuals under 18 who would be mandatorially categorically eligible except for income and resources (1902(a)(10)(C)(ii)(I))	all individuals under 21 or at State option 20, 19, or 18 or reasonable classifications who would not be covered under mandatory medically needy group of individuals under 18 (1902(a)(10)(C)) (1905(a)(i)) **COVERED**	inpatient hospital services	care furnished by State licensed practitioners (*podiatrist, optometrist, chiropractor, licensed clinical social worker, licensed mental counselor or licensed marriage and family therapist, psychologist, optician, hi-tech nursing, nurse practitioner, licensed lay midwife*) **COVERED excepted for chiropractor**
children receiving IV-E payments (IV-E foster care or adoption assistance) (1902(a)(10)(i)(I))	pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post partum services[3] (1902(e)(5))	individuals who could be eligible for IV-A cash assistance if State did not subsidize child care (1902(a)(10)(A)(ii)(II)) **COVERED**	pregnant women who would be categorically eligible except for income and resources (1902(a)(10)(C)(ii)(II))	specified relatives of dependent children who are ineligible as categorically needy (42 CFR 435.301(b)(2)(ii)) (42 CFR 435.310) **COVERED**	outpatient hospital, RHC, and FQHC services including ambulatory services offered by FQHCs	private duty nursing services **COVERED**

Mandatory Categorically Needy Groups[1]	Mandatory Special Coverage Groups	Optional Categorically Needy Groups[2]	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
individuals who lose eligibility under 1931 due to employment (1902(a)(10)(A)(i)(I)) (402(a)(37)) (1925)	pregnant women losing eligibility because of a change in income remain eligible 60 days post partum (1902(a)(10)(A)(i)(IV)) (1902(e)(6))	individuals who are eligible for Title IV-A if State AFDC plan were as broad as allowed (1902(a)(10)(A(ii)(II)) **COVERED**	newborns, who except for income and resources would be eligible as categorically needy, deemed eligible for 1 year as long as mother remains eligible or would remain eligible if pregnant (1902(a)(10)(C)) (1902(e)(4))	aged individuals who are ineligible as categorically needy (42 CFR 435.301(b)(2)(iii)) (42 CFR 435.320) (42 CFR 435.330) **COVERED**	X-rays services and other laboratory services	dental services **COVERED**
individuals who lose eligibility under 1931 because of child or spousal support (1902(a)(10(A)(i)(I)) (406(h))	poverty level infants and children who while receiving inpatient services loses eligibility because of age must be covered through an inpatient stay (1902(e)(7))	individuals who would have been eligible for IV-A cash assistance, SSI, or State supplement if not in a medical institution (1902(a)(10)(A)(ii)(IV)) **COVERED**	pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post partum services (1902(a)(10)(C)) (1905)(e)(5))	blind individuals who are ineligible as categorically needy but meet the categorically needy definition of blindness (42 CFR 435.301(b)(2)(iv)) (42 CFR 435.324) (42 CFR 435.330) **COVERED**	nursing facility services for individuals over 21	physical therapy; occupational therapy; speech, hearing, and language disorders services **COVERED**
individuals participating in a work supplementation program who would otherwise be eligible under 1931 (1902(a)(10(A)(i)(I)) (482(e)(6))	Qualified Medicare Beneficiaries (QMBs)[4] (1902(a)(10)(E)(i) (1905(p)(1))	*special income level group*: individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard or a separate standard specified by the State that does not exceed 300% of FPL (1902(a)(10)(A)(ii)(V)) **COVERED**	blind and disabled individuals eligible in December 1973 (42 CFR 435.340)	disabled individuals who are ineligible as categorically needy that meet the categorically needy definition of blindness (1902(a)(10)(C)) **COVERED**	EPSDT services for individuals under 21	prescribed drugs **COVERED**

Mandatory Categorically Needy Groups[1]	Mandatory Special Coverage Groups	Optional Categorically Needy Groups[2]	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
individuals receiving SSI cash benefits (does not apply to 209(b) States) (1902(a)(10)(A)(i)(I))	qualified disabled and working individuals[5] (1902(a)(10)(E)(ii) (1905(s))	individuals receiving home and community-based wavier services who would only be eligible for Medicaid under the State plan if they were in a medical institution (1902(a)(10)(A)(ii)(VI)) **COVERED**		individuals who would have been ineligible if they were not enrolled in a MCO[12] (1902(a)(10(C)) ((1902(e)(2)) **NOT COVERED**	physician services	dentures **NOT COVERED**
disabled children no longer eligible for SSI benefits because of a change in definition of disability (1902(a)(10)(A)(i)(II))	Specified Low Income Medicare Beneficiaries (SLMBs)[6] (1902(a)(10)(E)(iii))	individuals who are terminally ill, would be eligible if they were in a medical institution, and will receive hospice care (1902(a)(10)(A)(ii)(VII) **COVERED**			medical and surgical services of a dentist	prosthetic devices **COVERED**
qualified pregnant women (1902(a)(10)(A)(i)(III)) (1905(n)(1))	qualifying individuals[7,8] (QI-1s) (1902(a)(10)(E)(iv)(I))	children under 21(or at State option 20, 19, or 18) who are under State adoption agreements (1902(a)(10)(A)(ii)(VIII)) **COVERED**			nurse-midwife services	eyeglasses **NOT COVERED**
qualified children (1902(a)(10)(A)(i)(III)) (1905(n)(2))	qualifying individuals[7,9] (QI-2s) (1902(a)(10)(E)(iv)(II))	poverty level pregnant women not mandatorially eligible (1902(a)(10)(A)(ii)(IX)) (1902(l)(1)(A)) **COVERED**			pediatric nurse practitioner/ family nurse practitioner services	diagnostic services **COVERED**
poverty level pregnant women (1902(a)(10)(A)(i)(IV)) (1902(l)(1)(A))		poverty level infants not mandatorially eligible (1902(a)(10)(A)(ii)(IX)) (1902(l)(1)(B)) **COVERED**			family planning services and supplies	preventive services and screening services **COVERED**

Mandatory Categorically Needy Groups[1]	Mandatory Special Coverage Groups	Optional Categorically Needy Groups[2]	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
poverty level infants (1902(a)(10)(A)(i)(IV)) (1902(l)(1)(B))		poverty level children under 6 not mandatorially eligible (1902(a)(10)(A)(ii)(IX)) (1902(l)(1)(C)) **COVERED**			home health for those entitled to NF services	rehabilitative services recommended by a physician or other practitioners or the healing arts (*substance abuse, community mental health center, PNMI (child care services, assistive community care services, therapeutic substance abuse treatment), school health services, child sexual abuse and juvenile sex offender treatment, intensive family based, developmental therapy, day health rehab*) **COVERED**
qualified family members (1902(a)(10)(A(i)(V)) (1905(m)(1))		poverty level children under 19, who are born after September 30, 1983 (or, at State option, after any earlier date) not mandatorially eligible (1902(a)(10)(A)(ii)(IX)) (1902(l)(1(D)) **COVERED**			clinic services (*psychotherapy, group therapy, day hospital, chemotherapy, diagnosis and evaluation, emergency care*) **COVERED**	inpatient hospital, nursing facility, and services in IMDs for over 65 **COVERED**

Mandatory Categorically Needy Groups[1]	Mandatory Special Coverage Groups	Optional Categorically Needy Groups[2]	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
poverty level children under age 6 (1902(a)(10(i)(VI)) (1902(l)(1)(C))		aged or disabled individuals whose SSI income does not exceed 100% of FPL (1902(a)(10)(A)(ii)(X)) (1902(m)(1)) **NOT COVERED**				ICF/MR services **COVERED**
poverty level children under age 19, who are born after September 30, 1983 (or, at State option, after any earlier date) (1902(a)(10(i)(VII)) (1902(l)(1)(D))		individuals receiving only an optional State supplement payment which may be more restrictive than the criteria for an optional State supplement under title XVI (1902(a)(10)(A(ii)(XI)) **COVERED**			Extended services for pregnant women for a 60-day postpartum	inpatient psychiatric hospital services for under 21 **COVERED**
disabled individuals whose earnings exceed SSI substantial gainful activity level (1619(a))		TB infected individuals[10] (1902(a)(10)(A)(ii)(XII) (1902(z)(1)) **NOT COVERED**				hospice care services **COVERED**
disabled individuals whose earnings are too high to receive SSI cash benefits (1619b))		working disabled individuals who buy in to Medicaid (BBA working disabled group) (1902(a)(10)(A)(ii)(XIII)) **COVERED**				case management services **COVERED**
disabled individuals whose earnings are too high to receive SSI cash benefits (1902(a)(10)(i)(II)) (1905(q))		targeted low income children (1902(a)(10)(A)(ii)(XIV)) (1905(u)(2)) **NOT COVERED**				targeted case management services **COVERED**

Mandatory Categorically Needy Groups[1]	Mandatory Special Coverage Groups	Optional Categorically Needy Groups[2]	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
Pickle amendment: individuals who would be eligible for SSI if Title II COLAs were deducted from income (section 503 of P.L. 94-566) (1935(a)(5)(E))		working disabled individuals, at least 16 and no more than 65 years of age, who buy into Medicaid under TWWIIA basic coverage group (1902(a)(10)(A)(ii)(XV)) **NOT COVERED**				TB related services **NOT COVERED**
disabled widows and widowers (1634(b)) (1935 (a)(2)(C))		employed medically improved individuals, at least 16 and no more than 65 years of age, who buy into Medicaid under TWWIIA Medical Improvement Group[11] (1902(a)(10)(A)(ii)(XVI)) (1905(a)(xi)) **NOT COVERED**				respiratory care services **COVERED**
disabled adult children (1634(c)) (1935(a)(2)(D))		independent foster care adolescents (1902(a)(10)(ii)(XVII)) (1905(w)(i)) **NOT COVERED**				home and community care (to the extent allowed and as defined in section 1929) for functionally disabled elderly individuals **NOT COVERED**
early widows/widowers (1634(d)) (1935)		individuals with COBRA continuation coverage whom the State determine that the savings exceed the COBRA premium payment (1902(a)(10)(F)) (1902(u)) **NOT COVERED**				community supported living arrangement services **NOT COVERED**

Mandatory Categorically Needy Groups[1]	Mandatory Special Coverage Groups	Optional Categorically Needy Groups[2]	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
209(b) States: State uses more restrictive criteria to determine eligibility than are used by the SSI program (1902(f))		Katie Beckett: disabled individuals age 18 or under who require an institutional level of care; care can be provided outside institution; estimated amount for home care can be no more than estimated amount for institutional care (1902(e)(3)) **COVERED**				personal care services **COVERED**
individuals who would be eligible for AFDC except for increased OASDI income under P.L. 92-336 (July 1, 1972) (42 CFR 435.114)		uninsured women, under 65, who are screened for breast or cervical cancer under CDC program (1902(a)(10)(A)(ii)(XVIII)) **COVERED**				primary care case management services **COVERED**
individuals receiving mandatory State supplements (42 CFR 435.130)		individuals who would have been ineligible if they were not enrolled in a MCO[12] (1902(e)(2)) **NOT COVERED**				PACE program services **COVERED**
individuals eligible as essential spouses in December 1973 (42 CFR 435.131)		individuals under 21 or at State option 20, 19, 18, or reasonable classification (1905(A)(i)) **NOT COVERED**				Ambulatory prenatal care for pregnant worm furnished during a presumptive eligibility period **NOT COVERED**

Mandatory Categorically Needy Groups[1]	Mandatory Special Coverage Groups	Optional Categorically Needy Groups[2]	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
institutionalized individuals who were eligible in December 1973 (42 CFR 435.132)		presumptive eligibility for pregnant women[13] (1920) **NOT COVERED**				organ transplant services
blind and disabled individuals eligible in December 1973 (42 CFR 435.133)		presumptive eligibility for children[14] (1920A) **NOT COVERED**				other medical and remedial care specified by the Secretary
Individuals who would be eligible except for the increase in OASDI benefits under Pubic Law 92-336 (42 CFR 435.134)		presumptive eligibility for women who are screened for breast or cervical cancer under CDC program (1920B) **NOT COVERED**				religious non-medical health care institution services[15] **NOT COVERED**
Individuals who become eligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977 (42 CFR 435.135)						transportation services[15] **COVERED**
Individuals who would be eligible except for the increase in OASDI benefits under Pubic Law 92-336 (42 CFR 435.134)		presumptive eligibility for women who are screened for breast or cervical cancer under CDC program (1920B) **NOT COVERED**				nursing facility services for individuals under 21[15] **COVERED**

Mandatory Categorically Needy Groups[1]	Mandatory Special Coverage Groups	Optional Categorically Needy Groups[2]	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
Individuals who become eligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977 (42 CFR 435.135)						emergency hospital services[15] **COVERED**
						critical access hospital services[15]

Footnotes:

1. Must receive at least the mandatory services.
2. The mandatory and optional categorically needy are considered a group. To meet comparability requirements, the amount, duration, and scope of medical services must be the same for all groups. Further, if the State opts to cover a medically needy group, they are not authorized to provide the covered medically needy group more services.
3. Coverage for pregnancy related and post partum care only.
4. State pays Part A, Part B, coinsurance, and deductible.
5. State pays Part A premium
6. State pays Part B premium
7. These individuals are not otherwise eligible for Medicaid
8. State pays Part B premium
9. State pays for the difference in amount of the cost shift of home health services from Part A to Part B.
10. Services provided to this group are limited to TB-related services.
11. States electing to cover the medical improvement group under TWWIIA must also cover the basic coverage group under TWWIIA.
12. Coverage under this section is limited to MCO services and family planning services described in 1905(a)(4)(C).
13. Services provided to presumptive eligible women are limited to ambulatory prenatal care services.
14. Services provided to presumptive eligible children include all services covered under the State Plan including EPSDT services.
15. These services derived from the authority under 1905(a)(27) of the Social Security Act for the Secretary to specify other medical and remedial care.

IGA Signature Page

Agreed to:

_____	_____
Michael K. Smith, Secretary Agency of Human Services (AHS)	Joshua Slen, Director Office of Vermont Health Access
Date:_____	Date:_____

Global Commitment - Question and Response - Sorted By Category

Question Number	Category	Question	T&C	Answer
2	Actuarial certification	The actuarial involvement in the waiver raises a number of uncertainties. We are very interested in how the actuary will develop premium estimates throughout the waiver. We also need to know the relationship between the actuarial certification of premium, the state plan, and what services and populations are actually covered; and how much flexibility there is to provide a different mix of services from the basis of the actuary's calculations. We also need to know the process by which a new policy initiative such as a coverage expansion or limitation would be included in the waiver and how that would impact the actuary's analysis.		The actuary will establish a range for acceptable aggregate capitation payments based on Vermont-specific experience, as well as national health care trends. Annually, the policy making and legislative process will precede the actuarial certification process. Therefore, rate certification will be based on the eligibility criteria and scope of services authorized by the legislature and approved by CMS, as appropriate. The CMS guidelines for MCO rate certification indicate that the rates must be based on authorized services (i.e., services contained in the State Plan or authorized under the 1115 Waiver). When evaluating actual experience, however, the actuary is permitted to include other services which are cost-effective alternatives to authorized services. In the event that a new policy initiative expands or limits coverage, this initiative would be incorporated into the actuary's calculation of the appropriate capitation rate.
12	Actuarial certification	Please explain what "the actuary shall not be employed by the state for purposes of certifying actuarially sound rates" means. Who actually contracts with the actuary?	33	This means that the actuary can not be a state employee.
4	Beneficiary rights and entitlements	Please describe the workings of the more flexible eligibility determination process that the waiver envisions. We will need to see how the terms and conditions address this issue. Will there be changes to current processes of eligibility determinations for Medicaid services?		The mention of developing a more flexible eligibility determination process is conceptual in nature, and is not anticipated to be implemented in the first year of the waiver. If and when such changes are made, it will be in concert with the departments, providers and advocacy organizations that can help inform a positive change for beneficiaries and program management.
6	Beneficiary rights and entitlements	What are rights of Vermonters and the specific entitlements that you are proposing to waive and how will current populations be assured that this will not impact their benefits?		We are not proposing to waive any rights or entitlements in the Global Commitment to Health Medicaid Waiver.
7	Beneficiary rights and entitlements	Does the state have to do a new state plan to reflect the waiver? If so, are the references to the "state plan" in the terms and conditions the current (9/05) or the future state plan? If a new state plan is required, what is the time frame? Can implementation be		The state does not have to revise the State Plan to implement the Waiver.

9	Beneficiary rights and entitlements	When a new population obtains coverage through the waiver, does this mean that there will be a new eligibility process for this population (the example of substance abuse treatment in the application). What is the population for potentail CNOM services such as legislative analysis or HCA regulation?		If there is a new expansion eligibility group approved and funded by the legislature, there will be a new eligibility process for this group. However, for the example provided, substance abuse treatment, the state sought broad authority to fund services that may not necessarily be tied directly to eligible populations. The other examples, legislative analysis and HCA regulation, would not be eligible for funding "outside the premium" (in the yellow area), but potentially could be funded through any savings realized by the MCO.
11	Beneficiary rights and entitlements	Please explain how Medicare beneficiaries will be eligible for drug coverage as a demonstration population. Is this just for the period of operation prior to January 1, 2006? Which pharmacy programs are or are not included as a waiver population after 1/1/06 & where in the terms and conditions is this reflected?		Existing 1115 Waiver authority will continue for Medicare beneficiaries until the implementation of Medicare Part D. Pharmacy programs will continue for eligible individuals who do not have Medicare coverage in accordance with existing eligibility rules. These groups are listed on the Table contained on Page 13 of the Terms and Conditions, under VHAP Waivers, #4 & #5. Item #40 on Page 18 of the Terms and Conditions limits the availability of FFP for Medicare beneficiaries as of 1/1/06.
22	Beneficiary rights and entitlements	Is it true that under GC, optional service benefit changes for mandatory populations will require an amendment to the waiver, rather than a change in state plan?	6	Yes, although a conforming state plan amendment may be required by CMS.
25	Beneficiary rights and entitlements	It appears from the terms and conditions that the state may remove eligibility for Medicaid optional & expanded (eg VHAP) populations without need for CMS approval – is this any accurate reading?		No, if the legislature approves changes in eligible populations, the State will need to receive approval from CMS.
26	Beneficiary rights and entitlements	From the email addendum to the terms and conditions, you expect term #29 to be deleted or modified. Is this because you do not think that moving people into the waiver does not require a notice?	29	This section has been revised to read: *The State agrees to notify demonstration participants newly entering a Section 1115 research and demonstration program within 30 days of their enrollment into the Global Commitment to Health demonstration.*
28	Beneficiary rights and entitlements	Is term 43(c) a change in eligibility for some populations? For example, some legal immigrants are eligible for VHAP but would not be eligible for Medicaid as a "qualified alien."	43	No, this is not a change.

29	Beneficiary rights and entitlements	If the terms and conditions require us to cover current services for Medicaid mandatory populations, why is the state asking to waive amount, duration & scope requirements for this population? Why aren't we asking to waive these requirements for the expansion populations?		A waiver of "Amount, Duration and Scope" typically is provided for 1115 Waivers which include the transition to an MCO model. The State does not believe it needs this waiver authority as the program is currently designed, but may require it in the future to implement legislated initiatives. The waiver is not required for non-State Plan populations, as the federal requirement applies only to traditional eligibility groups.
30	Beneficiary rights and entitlements	Is the waiver of financial eligibility rules (#5) necessary since this is now covered in the Choices for Care waiver?		No , this waiver is not currently necessary for the GC demonstration project; however, it is included in case it is needed in future years.
50	Beneficiary rights and entitlements	Does the 5% limit apply to expansion populations?	6	The authority to change the benefit package for non-mandatory eligible populations within a five percent corridor applies to aggregate expenditures for optional and expansion populations.
51	Beneficiary rights and entitlements	Is an amendment to the state plan necessary for optional populations?	6	Vermont is prepared to file a state plan amendment should it be required. The Terms and Conditions provide CMS with the discretion to require state plan amendments for optional populations.
52	Beneficiary rights and entitlements	How will you provide services to dual eligibles and children under 19 on SSI (for example) who do not choose to be enrolled in the MCO? 42 CFR 438.50(d) does not allow the state to require these groups to participate in an MCO & this provision does not appear to be waived.		This condition of 42 CFR does not apply to this 1115 Demonstration waiver. 42CFR 438.50 states: State Plan requirements. (a) General rule. A State plan that requires Medicaid recipients to enroll in managed care entities must comply with the provisions of this section, except when the State imposes the requirement-- (1) As part of a demonstration project under section 1115 of the Act; As such, (d) does not apply to this 1115 waiver.
53	Beneficiary rights and entitlements	What current populations will need to receive notice that they will be included in a waiver? (Duals were excluded by the Vhap waiver, for instance).	29	Everyone who is included in the Global Commitment Waiver who is not currently enrolled in VHAP, PC Plus, and Expansion pharmacy programs will receive notices within 30 days after implementation of the new waiver.
56	Beneficiary rights and entitlements	Does the following new langauge related to cost-sharing also apply to eligible pregnant women: "The State agrees that cost sharing for optional and expansion children eligible for Medicaid should not exceed five percent of the family's gross income. " ?		Yes, this also will apply to eligible pregnant women

3	CNOM	How will the determination be made of what makes up "costs not otherwise matchable" (CNOM) that gets included in the premium and is matched? We clearly need to see the terms and conditions to understand this and hear what you think is covered and how you interpret the CNOM parameters.		The items that comprise the "costs not otherwise matchable" (CNOM) are being finalized by the AHS Business Managers in collaboration with the Commissioner of Finance and Management and his staff. Following are the parameters in the final Terms and Conditions: *18. Capitated Revenue Expenditures. Provided that OVHA's contractual obligation to the populations covered under the demonstration is met, any revenue from capitation payments related to the beneficiaries covered under this demonstration may be used for the following purposes:* *• Reduce the rate of uninsured and, or, underinsured in Vermont;* *• Increase the access of quality health care to uninsured, underinsured and Medicaid beneficiaries;* *• Provide public health approaches to improve the health outcomes and the quality of life for Medicaid-eligible individuals in Vermont; and* *• Encourage the formation and maintenance of public-private partnerships in health care.* The list of CNOMs meets these parameters.
24	CNOM	Why didn't the state include certain programs as demonstration populations, such as VScript Expanded? What is the benefits and risks of including a population as a demonstration population v. an allowable expense/CNOM?		The State previously was unsuccessful in its efforts to add Vscript Expanded as a demonstration population under the existing 1115 Waiver. The benefit of including an eligibility group as a demonstration population is that the expenditures are added to the base in calculating the actuarially certified rate.
32	CNOM	Do you expect to do rulemaking for any of the items in the CNOM list?		No.

34	CNOM	What are the mechanics of drawing match for the CNOM spend?		Vermont currently draws matching funds for "Costs Not Otherwise Matchable" under the existing VHAP waiver. The State must report expenditures authorized as CNOM in order to draw federal matching funds. Under the MCO model, actuarially certified capitation payments are matched with federal funds. In the event that the MCO realizes program savings, the MCO is permitted to spend these funds in accordance with the guidelines defined in the Waiver's Terms and Conditions. There have been discussions of two different types of CNOM; 1) the traditional type being the VHAP eligibles and other expansion and optional populations and services included in the Waiver, and 2) MCO savings where expenditures on items other than eligible services for eligible populations are allowable as defined in the Terms and Conditions.
8	Eligibility	Please clarify what is meant by a "population solely covered through the Demonstration."	5	Populations solely covered through the Demonstration include eligibility groups the state is authorized to cover by virtue of the granted 1115 Waiver authority.
1	Finances	The actual financial terms of the proposal and the likelihood of specific financial outcomes. We have seen proposed spreadsheets but we understand that you are still working with the federal government on final financial terms.		The Administration has worked with the Joint Fiscal Office on the financial modeling, and this work is current to date.
19	Finances	Where do the cumulative target numbers come from? What years do they refer to (Is Year 1 October 1 through September 30)?	52	The cumulative target numbers were derived from the "Without Waiver" budget neutrality projections by CMS. The years refer to Waiver Years (10/1 - 9/30).
20	Finances	Please describe how spending will be allocated between this waiver and the LTC waiver. Are the caps additive? Where are administrative costs for the LTC waiver?		Spending will be allocated in accordance with the Terms and Conditions of the two Demonstration Waivers. The LTC Waiver includes all long-term care expenditures as well as the acute care costs for those eligible for Medicaid under the State Plan and enrolled in the LTC Waiver. All administrative costs, including LTC administrative costs, are included in the Global Commitment budget neutrality ceiling.
21	Finances	Are there any issues with Global Commitment being treated as an IGT (intergovernmental transfer), particularly as regards cost limits?		Throughout the discussions with CMS policy and legal staff regarding the MCO model, this was not raised as an issue. There are no known issues with regard to cost limits.

23	Finances	How does the 5% window operate? It appears that the 5% standard will be measured against actual spending from two years before. Does this mean that the spending in the comparison period will be adjusted to reflect the benefit change, and then compared to the unadjusted spend?	6	If a proposed benefit change would have impacted total spending by less than five percent in the comparison year, then the change does not require prior approval by CMS.
33	Finances	How do you anticipate the appropriations and actuarial certification processes to interact? Will certification incorporate the budget as passed?		The appropriations process will precede the rate certification process. Any legislation that redefines the scope of benefits and covered populations will be used to adjust the base for actuarial rate development. Certification will potentially include historical trend analysis, any approved expansions through the waiver amendment process, national trends, and state specific circumstances.
35	Finances	Can the state provide matchable services OUTSIDE the premium? ("yellow money") If so, what is the process?		Yes, the State can provide matchable services outside the premium using the processes identified in Terms and Conditions items 6, 7, and 8.
36	Finances	Where is the CRT population? Are they covered under both the LTC waiver and the GC waiver?		Most people enrolled in the CRT program will be in the GC Waiver. However, there are a very few individuals enrolled in CRT that also will receive LTC services. In this case, their LTC expenses will be covered under the LTC waiver.
38	Finances	What is the source of the cost of the VSH alternative?		The cost projections were derived from the Vermont State Hospital Futures Plan Report to AHS Secretary Charles Smith, prepared by the Department of Health, Division of Mental Health, February 4, 2005.
42	Finances	It is our understanding that there are two ways that new populations can be covered under this waiver - 1) within the funds provided by the premium and 2) above the premium if there is any room between the premium and the cap. Scenario 1 would not require any approval from CMS, but scenario 2 would require an amendment to the waiver. Is this correct?		Yes, this is correct.

47	Finances	What does "CMS will calculate an annual expenditure target for the completed year" mean? Is there a methodology available for this calculation?	52	Number 52 in the Terms and Conditions is Titled "Expenditure Review" and the preceding sentence to the one referenced in the question reads "The CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis." The next sentence then reads in part "...CMS will calculate an annual expenditure target for the completed year." The "calculation" refers to a comparison of actual state expenditures to the Waiver ceiling as identified in the table under number 52 in the Terms and Conditions. The state will report to CMS, as identified in the reporting sections of the Terms and Conditions, actual waiver expenditures. CMS will then compare those expenditures to the ceiling figures identified in the table on page 23 (number 52) in the Terms and Conditions.
48	Finances	How will the actual premium be structured - lump sum or specific to eligibility categories?		The premium will be an aggregate payment amount. The actuary will rely on historical expenditure and enrollment data, based on eligibility groups and age, as the basis for calculating the premium.
49	Finances	Do you intend to implement a $30 premium for Dr. Dynasuar 100%-185% FPL? Is this revenue included in financial models?		No, this was not approved by the legislature last year and it is not included in the financial modeling.
54	Finances	Confirm that October 1, 2005 is the planned effective date. What are the risks (e.g.,financial) of delay?		Yes, October 1st is the planned effective date. The cost of delay is estimated by the Joint Fiscal Office at $2.5 million per month. The OVHA has estimated the cost of delay to be as high as $1 million per week. Therefore a realistic range is between $625,000 and $1 million per week.
55	Finances	If the GC is not effective for October 1, 2005 what are the other date options?		Any start date can be chosen. However, for the simplicity of financial reporting and budgeting the start of a month or of a quarter is usually chosen.

5	MCO	The MCO structure raises many questions. You have indicated this is a pass through entity which will not change current control of Medicaid programs throughout state government. Is this limited managed care function consistent with what the federal government is proposing? Is the MCO strictly a financial entity or does it impact service delivery? Will CMS be performing a readiness review prior to operation of the MCO which could push us into late October or beyond?		The managed care function we have outlined is consistent with the proposal of the federal government. Any changes in benefits and eligibility coverage will be approved by the legislature each year. Under the new MCO model, there will be improved coordination of activities across departments and providers (e.g., care management for people with chronic diseases), and consistent processes across all Medicaid providing departments regarding consumer rights and protections (e.g., the same complaints, grievance and appeals processes for Medicaid beneficiaries). CMS will not be performing a readiness review associated with this demonstration waiver.
13	MCO	What will the approval process be for the contract between AHS and OVHA? Will operations begin before the contract is finalized?	33	CMS regional office has already reviewed and approved the Intergovernmental Agreement between AHS and the MCO.
37	MCO	Are the AHS administrative costs of managing the MCO contract outside the premium?		Yes, AHS Central Office costs are outside the premium but subject to the Waiver budget neutrality ceiling.
10	Operations	What is your interpretation of "The State shall notify CMS 60 days prior to any such change in the benefit package" ? Does this mean only such changes resulting in a 5% increase/decrease or any change in benefit package?	6	We will notify CMS of any changes in the benefit package.
14	Operations	Is there adequate statutory authorization for OVHA? Is the language in Act 71 sufficient?	33	The language in Act 71 is sufficient.
15	Operations	What is the status of the operational protocol or Attachment C? When will a copy be available?		CMS is not requiring an operational protocol for this demonstration waiver. The reference to an Attachment C is not pertinent to this Waiver.
18	Operations	Are there different match rates for administration and for services ("applicable federal match rates")	45	There are different match rates for program expenditures and administrative expenditures. However, under the MCO model, the actuarially certified rate will include an administrative allowance for administration. Capitation rates are subject to the program match rate. All administrative expenses will be included in the capitation rate, with the exception of eligible AHS Central Office and MMIS expenses.
27	Operations	What is the process for contracting with providers?	32	The same process that exists now,
39	Operations	Is it possible to get a tracking sheet that reflects changes in the proposal over time?		Vermont only submitted one formal proposal to CMS on April 15, 2005. All future discussions with CMS focused on developing Terms and Conditions.

40	Operations	Is it possible to get a tracking sheet that reflects changes in the Terms and Consitions over time?		There is not one document that reflects changes over the past months to the Terms and Conditions because there were several different versions with different authors (including internal CMS versions) and many changes were made via verbal discussions.
41	Operations	Please send a copy of the work plan that was shared with the Medicaid Advisory Committee		We have posted this on the AHS and OVHA web-sties
46	Operations	Where are the protections in case of disaster or other catastrophe outside our control?		As noted above, Term #10 explicitly states that "The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration." This includes catastophic situations, and is standard language used by CMS in all Demonstration waivers. Regarding this issue, CMS notes that the Medicaid program is a federal - state partnership and their willingness to enter into a demonstration with Vermont is an indication that they work in good faith with states to achieve common goals for the Medicaid program. As evidenced by recent economic and natural disaster events in other states, CMS has worked with them to continue services for beneficiaries.
16		What is meant by a "public-private partnership"?	39	This provision in the Terms and Conditions was inserted specifically to allow funding for the Vermont Blueprint to Health and will provide flexibility to fund future public-private partnerships as Vermont moves forward.
17		What is "VT Global Rx (previously VHAP Expansion)"?	42	VT Global Expansion includes populations currently defined as VHAP Expansion eligibles; VT Global Rx includes populations currently defined as VHAP-Rx and Vscript, which would be limited to non-Medicare beneficiaries upon implementation of Medicare Part D.
31		What proposed policy changes require waiving financial responsibility/deeming & spend down rules?		There are no policy changes requiring waiver of these rules; however, this waiver is included in case it is needed in future years.
43		Is the new Medicaid plan likely to save money, given the risks? If so, how much money?		Yes, it is expected to save between $135 and $165 million over five years.

44		How will Medicaid recipients be affected by the change?		Medicaid recipients will not experience any changes as a result of the implementation of this waiver demonstration project. Any changes to Vermont's programs will be driven by Legislative decision making in future sessions of the Vermont Legislature not by this Waiver.
45		Can the state bow out of the agreement if the plan fails to meet its objectives/		Yes, the Terms and Conditions explicitly state that: "The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration." (#10)

4. a

Medicaid "Global Commitment" Proposal Update

September 7th

Joint Fiscal Office

Global Commitment History

- January 10, 2005:
  - Medicaid Deficit Estimated at $597 million over five years
  - Administration proposes
    - Program reductions and
    - a "Global Commitment" Block grant to save Vermont $295 million in state funds.
- April 4, 2005:
  - Administration submits revised Global Commitment "waiver" proposal to save state $183 million in state funds.

Global Commitment History ...

- June 2005
  - Legislature makes program changes reducing five year deficit to $357M assuming 5% state fund growth
  - Global Commitment waiver re-estimated by administration and legislative analysts to save $165M
- July 2005
  - Emergency Board revises several Medicaid cost categories
- August 2005
  - New baseline estimates indicate a $439M five year shortfall assuming 3.5% state fund growth (4% general fund growth)
  - GC waiver preliminary value estimated at $135M - $165M based on estimates of current state spending that could be "matched." The maximum value could be higher if additional state expenditures could be "matched" within the waiver.

5 Year Medicaid Baseline

	FY06	FY07	FY08	FY09	FY10	
Medicaid	949.94	1027.98	1074.38	1153.28	1238.72	
State $s Req	400.22	457.16	484.73	525.98	570.84	
State $s Avail	395.63	380.99	393.86	407.40	21.65	
Deficit	(4.59)	(76.17)	(90.87)	(118.58)	(149.19)	*(439)*

Preliminary Estimate of Remaining Deficit After Global Commitment

	FY07	FY08	FY09	FY10	
	$30m to $33m	*$55m to $62m*	*$80m to $90m*	*$110m to $120m*	*($275)* *($305)*

How is Global Commitment Structured?

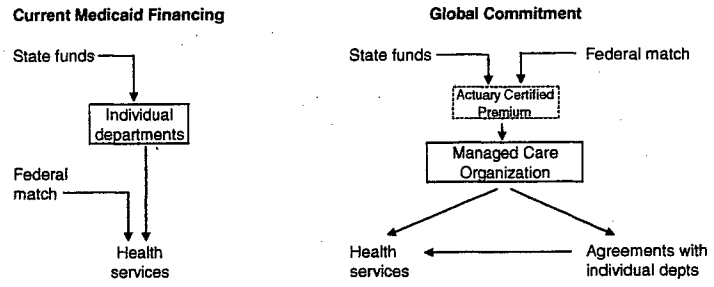
- Traditionally, states seek greater Medicaid program flexibility in a waiver by agreeing to manage the program under a budget neutrality cap for the waiver term. The cap is set by establishing a base year that is trended forward at a set rate.
- The Global Commitment "GC" waiver differs from traditional waivers in several significant ways.
  - Most waivers are per member, under GC the cap is aggregate so the state will bear the risk of increased enrollment.
  - In this respect it is more like a block grant – however the match element remains.
  - GC financial flow is different than the current Medicaid financial structure.

How is Global Commitment Structured?

Global Commitment Waiver:

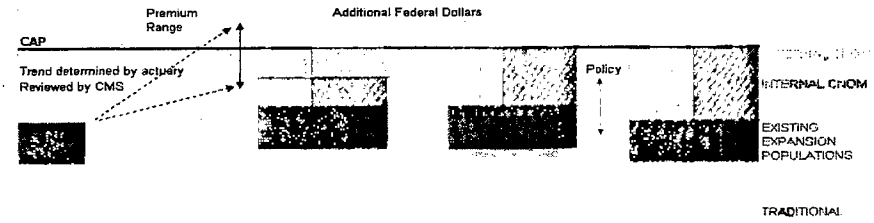
- Design requires most of the VT Medicaid program be administered by a public "MCO" Managed Care Organization. The Office of Vermont Health Access becomes the MCO.
- MCOs are typically private sector entities that are paid an actuary set premium to provide services.
- A public MCO is unique.
  - Operational and structural issues need to be identified.
  - What are the risks or impacts associated with these issues?

Current v. New



How it works Chart

Global Commitment - Financial Components - First Year



TRADITIONAL MEDICAID - spending on mandatory and optional populations and services that does not require a waiver
EXISTING EXPANSION POPULATIONS - spending on populations or services that requires a waiver
Internal CNOM - spending WITHIN the premium other than traditional Medicaid
Includes expansion populations
Includes other health-related services
[illegible] - spending above the premium, but below the cap.
PREMIUM is based on historical spending, trended forward
Savings - the difference between premium and spending for traditional and expansion populations

Legislative Review Process

- All-legislator briefing on Global Commitment September 7th...the State House.
- Presentations by legislative staff & Administration to Health Access Oversight & JFC the week of September 12th.
- A possible independent review by national health consulting firm.
- Follow up briefings the week of September 19th.
- Final JFC meeting and vote on September 28th.
- Target implementation date is October 1.

Questions to be addressed

- The financial implications to Vermonters - how the financial system, caps and premium would operate?
- What will be the remaining deficit be and what are the implications of various strategies to address it?
- How does this Global Commitment affect proposals for health care reform?
- What are the implications of the cap on Medicaid and how will that impact Vermont's flexibility or level of risk for program operation?
- How will Vermont's costs and obligations be impacted with or without the waiver?
- What flexibility will the waiver provide?
- How will it impact the legislative role in policy changes such as benefits and eligibility?
- Other questions...

4.b

Vermont's Medicaid "Global Commitment" Proposal

Vermont is currently negotiating a major 1115 waiver with the federal government that would restructure the way Medicaid is financed in the state. Key changes include:

- Creation of a public managed care organization (MCO)
- Federal matching of the "premium" paid to the MCO, rather than payment for individual health services
- Increased flexibility in determination of eligibility and benefits for all but mandatory populations
- Opportunities for using managed care savings to pay for additional services or to fund future year shortfalls
- Increased flexibility to obtain match for services not normally considered matchable under Medicaid (CNOM)

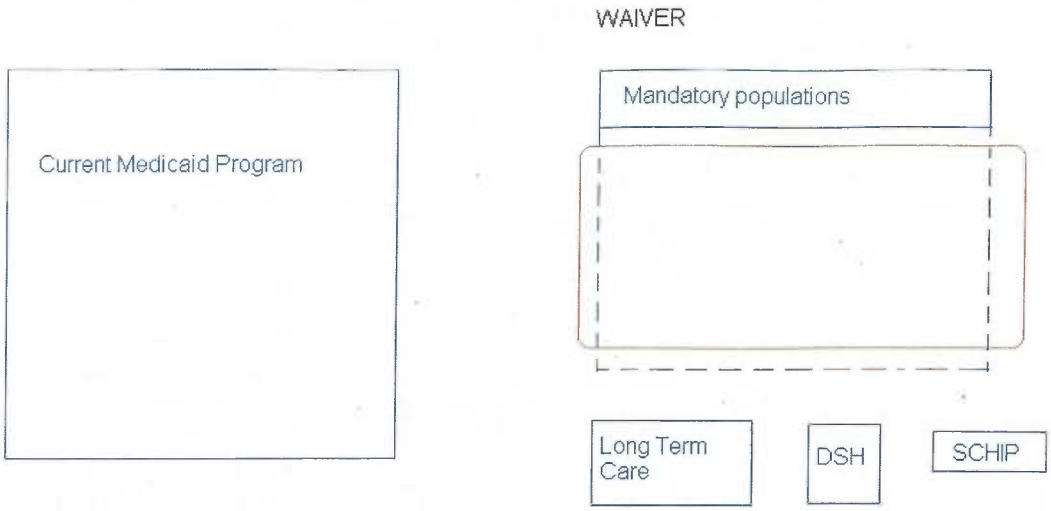
The proposal is built on the creation of a public MCO, which will be financed by a premium paid by the state. This premium will be the spending against which federal matching funds are paid. The premium will be certified by an actuary as being the appropriate amount to spend, based on historical state spending and local and national Medicaid cost trends. The MCO assumes risk for any spending above the premium, likely without federal match.

In addition, as in any 1115 waiver, there will be a budget neutrality cap, intended to ensure that the federal government spends no more under the waiver than it would have otherwise. The cap parameters (initial year base, growth) are being negotiated by the state and federal governments, but if the five year total premium payment exceeds the aggregate cap, any additional spending does not draw federal match.

Analogous to the way private MCOs operate under Medicaid, the public MCO will be accountable for quality and appropriateness of services provided to beneficiaries, but will have substantial flexibility in the mix of services purchased. This provides an opportunity, <u>within the premium</u>, to obtain matching funds for state public health spending that does not currently qualify for federal matching. Also analogous to private MCOs, the public MCO may reserve some of its premium revenue to assist with future costs.

The Vermont legislature has the authority to accept or reject the proposed waiver. Among the issues being examined are:

- What will be the cap parameters – base and trend?
- How will actuarial certification occur?
- How will the MCO be organized and managed?
- How will the MCO be financed, including any changes to the appropriations process?
- How will state costs and obligations compare with and without the waiver?
- What level of flexibility will the waiver grant the state, under what obligations?
- What will the legislature's role in policy changes such as benefits or eligibility be?



The waiver will not include:

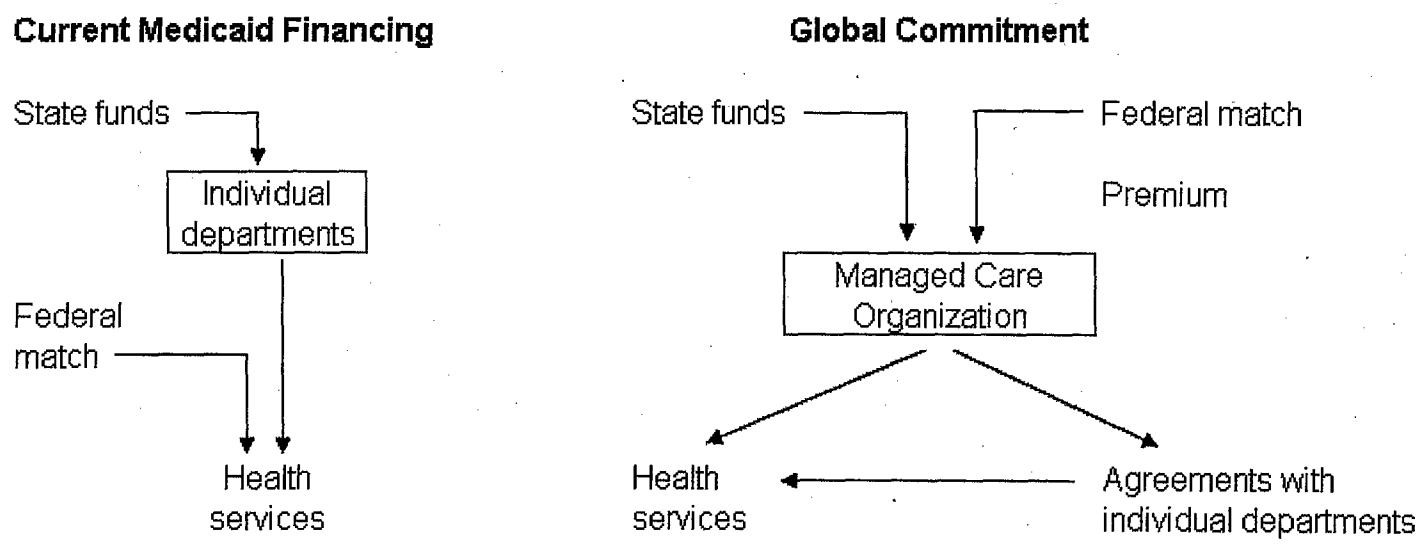
- Those beneficiaries in the recently-granted long term care waiver, including their other costs
- The Disproportionate Share Hospital (DSH) program
- The State Children's Health Insurance Program (SCHIP)

No change in eligibility for mandatory populations will be permitted. Changes in benefits for mandatory populations will require an amendment to the waiver.

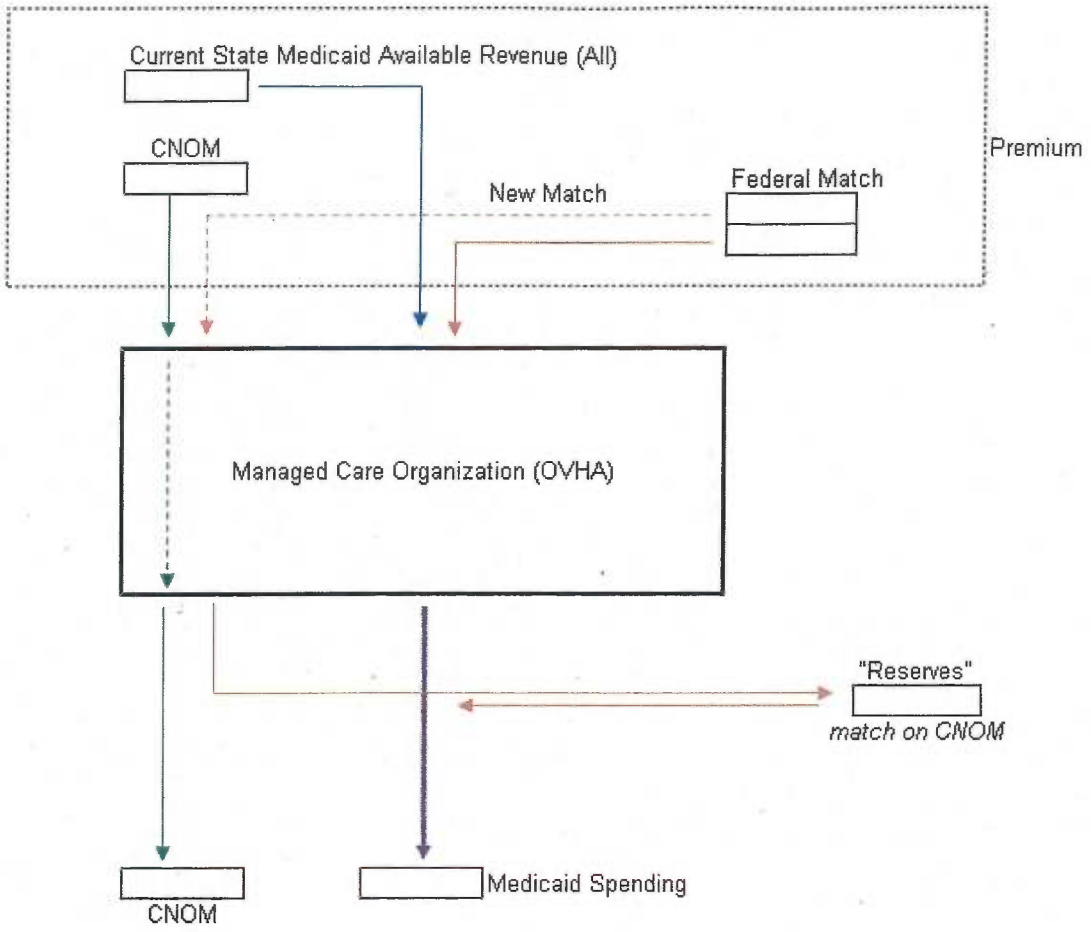
There is increased flexibility in determination of both benefits for all optional beneficiaries. Any changes which alter spending by less than 5 percent can be made at the state's discretion. Larger changes will require an amendment to the waiver.

It is unclear whether an amendment would be necessary to make changes in eligibility for optional populations.

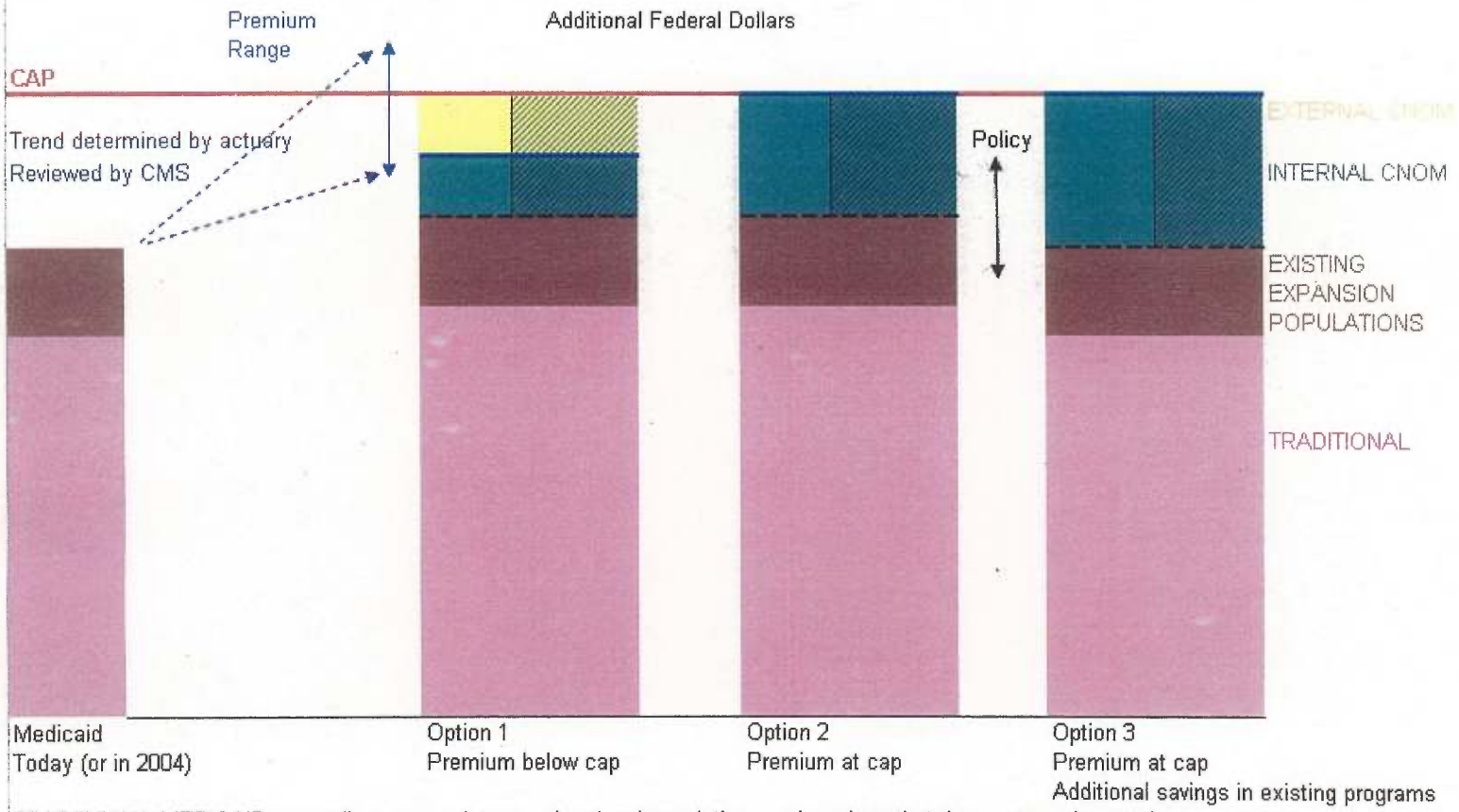
Comparison of Traditional Medicaid Financing and Vermont's Global Commitment



Vermont Medicaid Global Commitment - Conceptual Diagram



Global Commitment - Financial Components - First Year



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Vermont Medicaid Expenditures and Revenues - State Funds

	2006 Appropriated	2006 Updated	2006 Adjusted	2007	2008	2009	2010
Expenditures							
AHS - CO	$924,809	$924,809	$924,809	$985,866	$1,043,512	$1,105,132	$1,170,425
DCF	$14,979,707	$14,979,707	$14,979,707	$16,605,487	$17,930,031	$19,385,399	$20,948,551
DAIL	$47,801,830	$47,801,830	$47,801,830	$53,514,110	$58,062,615	$63,083,299	$68,487,696
VDH	$50,945,838	$50,945,838	$50,945,838	$56,709,458	$62,205,176	$67,219,719	$72,604,776
DOE	$14,460,593	$14,460,593	$14,460,593	$16,090,018	$16,834,720	$17,637,496	$18,463,697
OVHA	$257,888,722	$258,676,435	$271,103,423	$313,258,538	$328,651,500	$357,547,152	$389,163,643
TOTAL	$387,001,499	$387,789,211	$400,216,199	$457,163,477	$484,727,555	$525,978,197	$570,838,788
Revenue							
General Fund	$204,014,462	$210,838,462	$210,838,462	$197,254,160	$205,144,327	$213,350,100	$221,884,104
Provider Taxes	$62,701,307	$75,412,148	$75,412,148	$79,521,719	$83,906,281	$88,584,925	$93,578,079
Tobacco Taxes	$47,400,000	$47,400,000	$47,400,000	$46,600,000	$45,800,000	$45,000,000	$44,200,000
Tobacco Settlement	$18,850,277	$18,850,277	$18,850,277	$18,850,277	$18,850,277	$18,850,277	$18,850,277
All Other	$37,735,024	$37,735,024	$37,735,024	$38,764,005	$40,159,288	$41,615,180	$43,134,527
2005 HATF Balance	$16,307,127	$5,394,231	$5,394,231				
TOTAL	$387,008,197	$395,630,142	$395,630,142	$380,990,162	$393,860,173	$407,400,482	$421,646,987
(Deficit) / Surplus	$6,698	$7,840,931	($4,586,057)	($76,173,315)	($90,867,381)	($118,577,715)	($149,191,801)
Cumulative (Deficit) / Surplus				($80,759,372)	($171,626,753)	($290,204,469)	($439,396,270)

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Medicaid Current Law 5yr Projection
August 25, 2005

		Appropriated As Passed Act 71 SFY 2006		Projected SFY 2010			
		Gross Funds	State Fur	Gross Funds		State Funds	
Administration Expenses							
OVHA	*OVHA*	$ 27,944,458	$ 11,0	$ 33,966,663	5.0%	$ 13,430,219	5.0%
Non OVHA	*AHS-CO*	$ 1,443,642	$ 7	$ 1,754,756	5.0%	$ 877,378	5.0%
	DCF - Map History	$ 4,706,452	$ 2,3	$ 5,720,722	5.0%	$ 2,860,361	5.0%
	DCF - HATF (not on map hist)	$ 862,030	$ 4	$ 1,047,803	5.0%	$ 523,901	5.0%
	DCF/OCS- HATF (not on map hist)	$ 367,778	$ 1	$ 447,036	5.0%	$ 223,518	5.0%
	DAIL-OTH	$ 4,579,470	$ 2,2	$ 5,566,374	5.0%	$ 2,783,187	5.0%
	VDH-OTH	$ 21,612,334	$ 9,5	$ 26,269,927	5.0%	$ 13,134,964	5.0%
	DOE	$ 599,286	$ 2	$ 728,436	5.0%	$ 364,218	5.0%
	Sub-Total	$ 62,115,450	$ 26,8	$ 75,501,718	5.0%	$ 34,197,746	5.0%
Program Expenditures							
	Regular FMAP					*0.444*	
	Enhanced FMAP					*0.268*	
Non OVHA	*AHS-CO*	$ 493,887	$ 2	$ 659,571	7.5%	$ 293,047	8.7%
	DCF	$ 29,225,249	$ 12,0	$ 39,029,418	7.5%	$ 17,340,770	8.7%
	DAIL-DS	$ 100,621,960	$ 41,3	$ 134,377,522	7.5%	$ 59,703,933	8.7%
	DAIL-OTH	$ 10,113,064	$ 4,1	$ 13,505,685	7.5%	$ 6,000,576	8.7%
	VDH-MH (VSH futures?)	$ 80,551,549	$ 33,1	$ 107,574,108	7.5%	$ 47,795,176	8.7%
	VDH-OTH	$ 19,423,033	$ 8,1	$ 25,938,861	7.5%	$ 11,524,636	8.7%
	VDH- Hlth Imprv - (not on map hist)	$ 150,000	$ 1	$ 150,000		$ 150,000	
	DOE	$ 35,500,000	$ 14,1	$ 40,737,067	3.5%	$ 18,099,479	4.7%
	Sub-Total	$ 276,078,742	$ 113,3	$ 361,972,232	7.0%	$ 160,907,618	8.2%
OVHA	*ABD*	$ 166,960,545	$ 68,6				
	MMA Impact	$ (24,913,788)	$ (10,2				
	SLMB/QMB 1/2 yr cost	$ 5,824,812	$ 2,3				
	ABD Adjusted	$ 147,871,569	$ 60,7	$ 167,691,116	6.1%	$ 74,505,163	7.3%
	Families	$ 138,524,716	$ 56,9	$ 186,475,278	5.4%	$ 82,850,966	6.6%
	Ladies First	$ 1,231,006	$ 3	$ 2,053,645	9.1%	$ 549,863	7%
	SCHIP	$ 3,928,372	$ 1,1	$ 7,179,528	14.1%	$ 1,922,319	12.0%
	Underinsured Children	$ 1,296,036	$ 5	$ 3,494,008	20.0%	$ 1,552,388	21.4%
	Caretakers	$ 5,138,500	$ 2,1	$ 8,450,261	10.0%	$ 3,754,451	11.3%
	VHAP	$ 60,341,115	$ 24,8	$ 115,943,315	13.5%	$ 51,513,615	14.8%
	LTC	$ 141,883,758	$ 58,3	$ 200,207,006	9.0%	$ 88,951,973	10.2%
	Buy In	$ 13,241,683	$ 5,4	$ 28,381,898	7.3%	$ 12,610,077	8.5%
	SLMB/QMB 1/2 cost	$ 4,296,600	$ 1,7				
	DSH	$ 36,619,917	$ 15,0	$ 37,500,000		$ 16,661,250	
	Legal Aid	$ 384,375	$ 1	$ 550,585	9.4%	$ 275,293	9.4%
	Rate Setting	$ 620,468	$ 3	$ 754,183	5.0%	$ 377,091	5.0%
	Lund Center	$ 625,000	$ 2	$ 759,691	5.0%	$ 337,531	6.2%
	VHAP Rx	$ 10,251,339	$ 4,2	$ -		$ -	
	Vscript	$ 3,027,203	$ 1,2	$ -		$ -	
	VScript Expanded	$ 2,844,011	$ 2,8	$ -		$ -	
FY06 Rx is half yr	*Clawback*	$ 10,427,803	$ 10,4	$ 29,116,622		$ 29,116,622	8.7%
	V-Pharm - Part D Wrap	$ 7,957,095	$ 7,0	$ 11,232,186	11.4%	$ 10,108,968	12.7%
	SLMB/QMB 1/2 savings	$ (6,059,900)	$ (6,0				
	VT Rx	$ 471,942	$ 1	$ 1,453,647	11.4%	$ 645,855	12.7%
	Sec. 311 adj (Pfizer)	$ (2,433,090)	$ (1,0				
	Sub-Total	$ 582,489,519	$ 246,8	$ 801,242,970	7.8%	$ 375,733,425	9.0%
Total		$ 920,683,711	$ 387,0	$ 1,238,716,920	7.4%	$ 570,838,788	8.5%
Revenue			$ 387,0	$ 14,246,505	3.50%	$ 421,646,987	
HATF	End Yr Fund Balance		$ 16,3			$ -	
	GF Onetime		$ 14,3			$ -	
	GF Base		$ 96,1			$ 112,474,498	4.0%
	Tob Settlement		$ 17,2			$ 17,250,000	0.0%
	Tob Taxes		$ 47,4			$ 44,200,000	-1.8%
	Rx $0.10 per script		$ 1,2			$ 1,389,026	3.0%
	NH/HH/ICF-MR Provider Tax		$ 17,6			$ 18,400,579	1.0%
	VSH/Retreat Provider tax		$ 9			$ 1,022,531	1.0%
	Hosp Provider Taxes (Base)		$ 42,8			$ 60,153,179	7.0%
	Bump to 6% on Hospitals		$			$ 12,612,764	7.0%
	State Share premiums		$ 6,1			$ 6,638,430	2.0%
	Other		$ 1			$ 150,000	0.0%
NON OVHA	GF Base		$ 93,5			$ 109,409,606	4.0%
	Tobacco Settlement		$ 1,6			$ 1,600,277	0.0%
	DOE - LEAs Special Ed Services		$ 14,1			$ 16,250,016	3.5%
	VDH - UVM VCHIP - LEAs EPSDT		$ 2,9			$ 3,396,553	3.5%
	MH -Valley Vista ITs/ LEAs SBSix / MH ITs		$ 10,9			$ 13,667,755	5.6%
	SF Early Childhood - Spec Ed Med Admin SF		$ 9			$ 975,015	0.0%
	DAIL Other IT/SF		$ 1,7			$ 1,706,758	0.0%
	VDH Admin -RWJ Oral/ LEAs EPSDT/Misc		$ 6			$ 350,000	0.0%
DEFICIT /SURPLUS			$			$ *(149,191,801)*	
						$ *(439,396,270)*	

5. a

Vermont Children's Forum

Concerns about Medicaid Global Commitment
September 22, 2005

The administration is asking for legislative approval for one of the biggest changes ever to Vermont's Medicaid program. While everyone is working hard to find a way out of the serious deficit in available state funds for Medicaid, this high risk strategy may not be the right solution.

This is too big a decision to be made so quickly with so many unanswered questions.
The administration is pressuring for a decision to be made in only 15 days from the unveiling of the details of the proposal and, in fact, all of the final details are not yet known.

Unanswered questions / Potential problems

How much is the state actually going to get each year?

The state would be agreeing to take a fixed amount from Washington for all Medicaid reimbursement. There is still doubt about whether that amount will be enough to warrant going ahead with a very risky plan.

The process of determining that annual fixed amount is complicated and not at all understood at this time (see Actuary Process question below.)

CMS (Federal Government) has a review each year of the annual fixed amount. It is still not clear that they won't shrink that amount if Vermont is successful in reducing Medicaid spending.

The Bush administration and Congress have an agenda to reduce federal Medicaid spending. Even though the promised global cap may be high enough to provide more federal Medicaid dollars than VT gets now, it appears from Terms and Conditions number 4 (Impact on Demonstration of changes in federal law…) that we are not getting a guarantee that CMS will keep the same funding level throughout the five years.

Where are the guarantees that the promised "new money" is real?

Although the administration is assuring the legislature that certain expenditures will be able to draw down what would be "new" money to cover some of the deficit, the exact amount of that new money has been declining since this proposal originated and is completely dependent on a process that has not yet been completed. This process - an independent actuary setting payments following certain guidelines has to be approved by CMS each year and despite assurances that we can trust Washington, there needs to be more clarity about both the process and Washington's commitment to funding Vermont's Medicaid plans.

PO Box 261 Montpelier, VT 05601 Phone: 802.229.6377 Fax: 802.229.4929 email: vtkids@childrensforum.org

How can we be sure the actuary process will serve Vermont and maximize draw-down of federal dollars?

Although the administration has been successful in negotiating a fairly high overall "cap" for Medicaid spending, the global cap does not tell the whole story. Because the actual amount of Medicaid spending that will be approved will be set by an annual process where an actuary follows certain formulas, the annual capitation rate (called the premium) could be significantly lower than the amount predicted. If this happens, Vermont will not realize the promised savings.

There is still not enough clarity about the actuary process. The $135 - $165M figure that is stated as the amount of new money created by GC is based on assumptions that so far have not been guaranteed. To get these amounts over the five years the actuary would have to arrive at a premium amount (capitation payment) that is significantly over current Medicaid spending. The difference can then be used to obtain additional federal match for health services that presently are paid for with 100% state funds, after approval each year by CMS. So far there is only the administration assurances that CMS will allow those services to be matched. Can we be sure that we can trust CMS? Is there a way to procure additional guarantees in the Terms and Conditions?

How will the completely new Managed Care Organization (MCO) work for Vermont.

Basic to the GC is an entirely new system for delivering Medicaid services, gathering them all under one managed care organization which will have power over many policy decisions. There has not been time to have a thorough review of the contract and terms setting up this MCO. Nor is it clear how the appropriations process would work and how the legislature will maintain authority over appropriations policies.

MCO practices can sometimes be detrimental to patients as they create obstacles to people who need services in an effort to "manage" their costs. It is not clear how this MCO will manage costs in an environment of troublesome deficits and how the legislature can make sure that it can protect the priorities of the people of Vermont.

The Vermont Children's Forum joins others concerned about the health and well-being of our children and vulnerable citizens and strongly urges the legislature to take the time necessary to fully assess this monumental change in our health care system.

5.b

FamiliesUSA
The Voice for Health Care Consumers

Statement of Ron Pollack
Executive Director
Families USA

Submitted to

The Joint Fiscal Committee
Vermont General Assembly

September 23, 2005

I respectfully submit this statement to the members of the Joint Fiscal Committee of the Vermont General Assembly. Thank you for extending this opportunity to Families USA.

My name is Ron Pollack, and I am the Executive Director of Families USA, a national, nonprofit health care consumer advocacy organization based in Washington, D.C. Our mission is to bring the voices of health care consumers to policy debates at both the state and federal levels. An important focus of our work is ensuring that low-income people have access to affordable, comprehensive health care coverage.

We are dismayed by the proposed "Global Commitment" Medicaid waiver. I want to emphasize to you that our concern does not arise from inflexible ideology or preconceived notions about the "best" way to provide health coverage and health care to low-income people. We have one—and only one—test to evaluate Medicaid proposals: Will this proposal help or hurt low-income people? Our evaluation of the Vermont Global Commitment Medicaid waiver concludes that the waiver poses a serious threat to the people who must rely on Medicaid for health care coverage. It is, in fact, the most dangerous and far-reaching change to a state Medicaid program that we have seen emerge from *any* state.

Many questions about the Global Commitment proposal remain unanswered and many details are not yet known. Rather than discussing all of them, I want to focus my comments on the issue of financial risk and the undermining of the financial partnership that now exists between Vermont and the federal government. While it is understandable that the administration and the General Assembly would look for ways to save money and to operate Medicaid efficiently in Vermont, you should be aware that the Global Commitment waiver serves the federal government's financial interests—***not*** Vermont's.

The five year global cap in the proposed waiver is insurance for the federal government—in essence, it transfers financial risk from the federal government to the state of Vermont. If you go down this road, you are betting that nothing unforeseen will happen to affect your Medicaid program over the next five years: There will be no recession, no rise in unemployment, no unexpected increase in health care costs, no epidemic or other public health crisis. Is this a smart bet? Is it a bet you need to make at all? I would strongly encourage the Joint Fiscal Committee to carefully consider all aspects of the Global Commitment Medicaid waiver and to take the time to

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E-mail: info@familiesusa.org * Web site: www.familiesusa.org

know exactly what bargain you would be making with the federal government. You may find that the deck is stacked against you.

I don't have a crystal ball that will give us a clear picture of the next five years. I can offer you a couple examples of unpredictable events that could drive up the cost of your Medicaid program. Today, the obvious example is the Hurricane Katrina catastrophe. Besides the obvious, heart-wrenching effects on survivors, Katrina threatens to drive up oil prices (gas, heating fuel) and put enormous strains on every state's economy. The federal government's spending patterns and decisions about the 2006 federal budget in the wake of Katrina will also affect every state.

Here is another example. Like me, you have probably been reading news coverage discussing the very real threat of an influenza epidemic in the near future. Experts predict that a flu epidemic of only mid-level severity could result in 147,245 flu cases in Vermont, with 1,185 additional deaths and 5,213 additional hospitalizations.1 What would this mean for Vermont's Medicaid spending levels? Under the Global Commitment spending caps, it would mean that you would be "all alone and on your own" as you struggled to pay for the added cost of the epidemic—the federal government would not be a financial partner and would not match state spending to help cover the added costs.

As you look at the Global Commitment proposal, ask yourselves, "What is the federal government trying to accomplish? What will the federal government get out of the deal— and at what cost to Vermont?" Can Vermont secure its goals without the financial risk of federal funding caps? Obviously, the state wants to find savings in the Medicaid program. A core element of the waiver proposal is the shift to an increased level of managed care penetration in your Medicaid program. This shift could be tried without linking it to the drastic step of accepting absolute federal funding caps. Linking managed care and funding caps is dangerous: while you may realize savings in your Medicaid spending from managed care, the dollar amount of these savings will be hard to predict before you have at least a year or two of experience and a chance to "tweak" the details.

If you do decide to seek a managed care waiver, I hope you will take the time to carefully examine the intergovernmental agreement that is, in essence, a contract between two state agencies, the AHS and the OVHA. Although this is a unique situation, and it differs from other managed care arrangements in which states contract with outside entities, you may want to consider incorporating the kinds of criteria that other states have used to ensure that reasonable protections for both patients and providers are built in. (It is my understanding that as of today, September 23, 2005, that the Joint Fiscal Committee has not seen the specifics of the Intergovernmental Agreement—which is specifically referenced in item 21, page 5, of the Special Terms and Conditions, dated September 13, 2005.)

The Vermont Global Commitment Medicaid is the equivalent of someone putting himself into a straight-jacket, then finding that he can't use his hands to break a fall. At the federal level, this

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1 Projections are based on the federal Centers for Disease Control and Prevention FluAid 2.0 program. The FluAid program is built using U.S. Census data gathered in 1999. If current population estimates were used, the numbers would be higher for all impact measures.

concept of "block granting," or constricting the federal financial support to state Medicaid

programs, was rejected by the National Governors Association in 2003. After thorough examination, vetting, and debate (and in spite of some broad initial support), the governors rejected the concept of federal dollar caps.

I would respectfully ask you only this: Would it not be prudent for the Joint Fiscal Committee to also allow for adequate time to thoroughly examine and debate the merits of the Vermont Global Commitment Medicaid waiver proposal? This is a bet with high stakes. At risk are the lives of Vermont's most vulnerable residents, who will, in the end, pay the price if Vermont's bargain with the federal government leaves the state coming up short.

Thank you.

1201 New York Avenue, NW, Suite 1100 * Washington, DC 20005 * 202-628-3030 * Fax: 202-347-2417
E-mail: info@familiesusa.org * Web site: www.familiesusa.org

5.c

From: Steve Kappel
To: Klein, Steve
Date: 9/26/2005 10:45:34 AM
Subject: Fwd: Global Commitment Concerns

>>> "Taormina, Philene" <PTaormina@aarp.org> 9/19/2005 3:22 PM >>>
September 18, 2005

Dear Members of the Vermont Health Access Oversight and Joint Fiscal Committees:

The organizations listed below are writing to express deep concerns about the Administration's proposal to change the Medicaid system and implement the "Global Commitment" §1115 waiver on October 1, 2005. We urge the Legislature to take the time necessary, and to give the public the time, to analyze the details of the final offer from the federal government released on Tuesday September 13. More specifically, we ask that the Heath Access Oversight and Joint Fiscal Committees not implement the "Global Commitment" until the full General Assembly has the opportunity to review the waiver in January 2006.

It is very important that we all take more time to fully understand the details and potential risks of this proposal before it is approved for implementation. The unexpected tragedy of hurricane Katrina has shown us all just how fragile our families living in poverty are throughout this country. If we have learned anything from the past several weeks, it is that Medicaid is absolutely crucial in providing essential health services to our most vulnerable citizens and must be maintained.

The Vermont General Assembly has a long history of involvement in waiver requests related to Medicaid, especially when broad changes to the structure of the program and services are being proposed. The most recent example of legislative involvement in waiver requests are the two laws passed directing the negotiation of the terms and implementation of the home and community based long-term care waiver. We ask that the same careful consideration be given here.

We strongly support the decision of the Legislature to hire an outside analyst to assess the plan. There are a number of questions that need to be answered in order to assist legislators in making the most responsible decision possible so that vulnerable Medicaid recipients will have their needs met. Attached, you will find this list of questions.

While there is much in the Global Commitment about which we are individually concerned, our chief concern is the implication of a cap on federal funds, and how it would place the state at risk for unanticipated growth in expenditures and caseload. The effects of a cap are likely to be felt by beneficiaries, hospitals, nursing homes, and physicians throughout the state health care system. It is therefore essential that the terms and conditions of this proposal be carefully and deliberately scrutinized, so that the potential impact and effects can be understood by the legislature and the public. All we ask is that the legislature and people of Vermont be given more time to review the massive proposed changes to our state's largest health care system.

Thank you for your thoughtful consideration of this very important issue. If you have any further questions, please contact Sheila Reed at the Vermont Children's Forum 802-592-3318 or 802-229-6377 or sreed@childrensforum.org <mailto:sreed@childrensforum.org> .

AARP Vermont

Vermont Children's Forum

Vermont Coalition for Disability Rights

Vermont Health Care Ombudsman

March of Dimes Vermont Chapter

Vermont Commission on Women

Community of Vermont Elders (COVE)

Vermont Low-Income Advocacy Council

Planned Parenthood of Northern New England

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Lawmakers weigh ground-breaking Medicaid deal

Published: Sunday, September 25, 2005
By Nancy Remsen
Free Press Staff Writer

Ten state legislators decide this week whether Vermont becomes the first state to make a new pact with the federal government on how to pay for health care for the state's poor and disabled.

The proposal, involving a capped amount of federal dollars for five years, would fundamentally change the way the Vermont and the U.S. governments share responsibility for the cost of Medicaid, a program that pays medical expenses for 122,000 Vermonters -- one fifth of the state's population.

The ground-breaking plan was finalized just two weeks ago, but the Douglas administration is pressing for its speedy approval. Advocacy groups for elderly, disabled and low-income residents have scrambled to analyze the plan's impact. Many advocates want lawmakers to delay their decision until January.

"Change is scary," admits Rep. Martha Heath, D-Westford, head of the Joint Fiscal Committee charged with accepting or rejecting the agreement. "We want to be cautious about making this decision," she said, but noted that delaying the deal would cost the state money -- $1 million a week by the administration's estimate.

Until now, the federal government has been responsible for a share of

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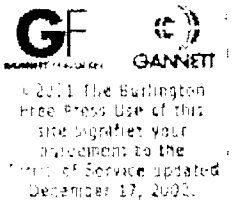

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the cost of providing health care to Vermonters who qualify for Medicaid coverage. When costs rose, or the number of eligible people increased, both the federal and state governments paid more.

Under the deal reached between the Douglas administration and the federal Centers for Medicare and Medicaid Services, the federal government would share the financial burden for spending up to $4.7 billion over five years. The state would be on its own to cover expenses if program costs exceeded $4.7 billion during that period.

State officials project program costs will total $4.2 billion over the next five years, giving the state a $500 million cushion for the unexpected.

In exchange for limiting the federal government's financial liability through Sept. 30, 2010, Vermont would gain greater flexibility in how it could use federal dollars and would be able to pocket all the savings from operating the program more efficiently, explained Joshua Slen.

As director of the Office of Vermont Health Access -- Vermont's Medicaid program -- Slen was one of the chief architects of the agreement.

With this waiver agreement, Slen said, "we don't have to say, 'Mother, may I,' to the federal government."

Troubled finances

The Medicaid program has serious money problems in Vermont and other states. Year after year, the growth in tax revenues fails to keep pace with the escalating cost of medical care, forcing states to scale back Medicaid coverage, pare other state programs to free up dollars, or approve new taxes.

Vermont faces an $80 million gap between projected state revenues and Medicaid expenses for the budget year beginning next summer.

Against this backdrop, the Douglas administration set out last winter to negotiate a new way to cover Medicaid expenses that would leverage more federal dollars. The deal, dubbed "Global Commitment to Health," won't make up for the total shortfall in state dollars available to pay for Medicaid, Slen stressed, but it will help.

Over the five years of the agreement, Slen estimates the state could save between $135 million and $165 million without making drastic cuts in the benefits provided to financially and medically vulnerable Vermonters.

If lawmakers approve the agreement before Oct. 1, Slen projects $20 million in savings by next summer and $27 million in the following year -- all of which would ease the $80 million deficit. Delaying the deal delays the savings, he said.

So many unknowns

The global commitment deal is all about moving and matching Medicaid money, state officials say. "It makes no changes in services," Slen said, "it makes no changes in eligibility."

If benefit or eligibility changes are needed to keep the program afloat, he continued, the Legislature will have to debate and approve them.

Still, advocates for Medicaid beneficiaries worry the deal, with its cap on federal funding, could reduce the Legislature's options. With so little time to study the terms

and conditions, they worry, too, about unforeseen consequences.

Nine organizations asked lawmakers to put off the decision until the Legislature returns in January.

Alicia Weiss, executive director of the Vermont Coalition for Disability Rights, explained one of her concerns with the cap. Limits have been placed on services to the disabled, yet the need is increasing, she said, noting, for example, the growing number of children with autism.

"It's difficult to figure out how this proposal will keep pace with growing demand," Weiss said.

Sheila Reed of Vermont Children's Forum said her organization has two pages of questions about the deal. She worried about the federal government's power to review its contribution level annually. Reed said, "It's still not clear that they won't shrink that amount if Vermont is successful in reducing Medicaid spending."

"This may be an OK idea in the end," said Drew Hudson of the Vermont Public Interest Research Group, citing the deal's goal of leveraging more federal dollars. He said he remained mystified about the meaning of numerous conditions in the agreement. "The biggest problem is what we don't know."

Even national organizations have concerns about the precedent of giving a state the liability for Medicaid growth.

Judith Solomon, senior fellow with the Center on Budget and Policy Priorities, argues the risks of a cap are clear. The state won't get any help if costs increase unexpectedly, she said. The unanswered question is whether the benefit of greater flexibility outweighs this risk.

Solomon has joined the chorus of Vermont advocates calling for delay. The state would still get all the money due it under the deal if it were implemented later, she said. "There doesn't appear to be anything lost by slowing down."
Finding answers

Heath and other legislators charged with deciding the fate of this agreement will likely give significant weight to the analysis conducted by two independent consultants hired last week by the Legislature.

Theresa Sachs and Eileen Ellis of Health Management Associates present their report Tuesday to the Health Access Oversight Committee and again Wednesday to the Joint Fiscal Committee.

"We have hired consultants with lots of expertise," Heath said. "We just want to be sure we aren't doing anything that puts our Medicaid population at any greater risk."

Contact Nancy Remsen at 229-9141 or nremsen@bfp.burlingtonfree press.com
Proposed plan
The federal government and the Douglas administration have agreed on a new way to pay for Medicaid -- a health care program jointly subsidized by federal and state governments.
WHAT IS IT CALLED? Global Commitment to Health.
WHAT'S DIFFERENT?: Vermont would become the first state to agree to a block-grant framework to fund its Medicaid program. Under the agreement, federal funds paid to Vermont over the next five years for Medicaid would be capped at $4.7 billion. Currently the federal government is responsible for a share (roughly 60 percent) of whatever it costs to provide health care to eligible low-income and disabled Vermonters.
WHAT DOES VERMONT GAIN?: Under the agreement, Vermont would have greater

flexibility in how it spent federal Medicaid dollars. If the state ran the program for less than projected, it could keep the savings. State officials predict they would free up $135 million or more in state money over the five years of the contract.
WHO IS ON MEDICAID?: 122,348 Vermonters were receiving subsidized health care under an array of Medicaid programs on Sept. 3.
WHO DECIDES IF THE DEAL GOES AHEAD? The Legislature's Joint Fiscal Committee -- five House members and five Senators -- must agree to the new Medicaid plan. The Douglas administration wants a vote of approval this week, so the agreement can take effect Oct. 1. The committee meets Wednesday.

Respond to this story in a Letter to the Editor

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Article published Sep 25, 2005

The full implications

Gov. James Douglas is proposing a central role for Vermont state government in designing and managing health care for nearly a quarter of Vermonters. That is the upshot of Douglas' plan to transform the state's Medicaid program.

In a sense he is proposing to do with Medicaid what others are proposing to do with health care as a whole. Health care reformers in the Legislature envision a system where the government establishes a global budget for the health care system and provides services to Vermonters within that budget.

Douglas' proposal is the fruit of protracted negotiations with the federal government which has agreed to change Medicaid for Vermonters from an entitlement program to what amounts to a block grant program. Medicaid, which is the federal-state program providing health care for the poor, pays for medical services as claims are made by patients. The Bush administration has agreed to provide Vermont with a block of money over five years to cover Medicaid needs, and it would be up to Vermont officials to design and manage the program. That is no small task. In recent years Vermont has expanded Medicaid so it covers many more people than the low-income people for whom it was designed, including the working poor and children.

Douglas is urging the Joint Fiscal Committee of the Legislature to sign off on the global commitment program by Sept. 28 so that the new system can begin by Oct. 1. Legislators are wary of moving so quickly. Douglas' proposal may make sense, but members of the Legislature would be abdicating their responsibility if they were to approve the program before they understood its full implications.

Vermont's Medicaid program faces a towering deficit in the next few years, and Douglas' global commitment program would erase part of the deficit. Legislators are interested in looking at the rest of Douglas' program for addressing the Medicaid deficit. They want to know what Vermont will do if the state's health needs exceed the money provided by the federal government. What if the state is hit with a health disaster that no one foresees? There is palpable distrust of the federal government among legislators in Montpelier, particularly since it has been an aim of the Bush administration to cut health care spending.

Members of the Legislature have worked over the summer to study reform ideas that they hope will take them forward when they convene in January. Their special commission on health care has been slow getting started, in part because the Legislature lacks the staff resources available to the executive branch. But the Legislature remains deeply involved in the health care discussion, and it is not about to nod compliantly with a transformation of health care for a quarter of Vermonters without giving the plan a thorough look.

The commitment of money from Washington may allow the Douglas administration to make many of the important reforms needed to improve care and control costs. Money must be spent to improve chronic care and to establish information technology. But will there be

enough money to do that and care for Vermont's children and working poor? If there isn't, Vermonters might face a crisis dwarfing the one they are facing at present.

Douglas criticized the Legislature for moving too quickly to impose radical changes on the health care system last winter and spring. The Legislature can hardly be faulted for wanting to devote more than two weeks to looking at the major transformation Douglas is proposing for Vermont's health care system.

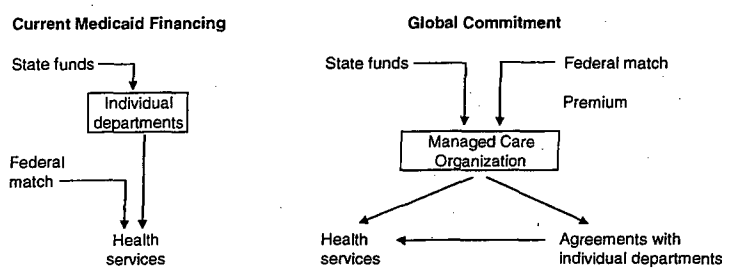
Introduction to Global Commitment

Steve Kappel
Joint Fiscal Office

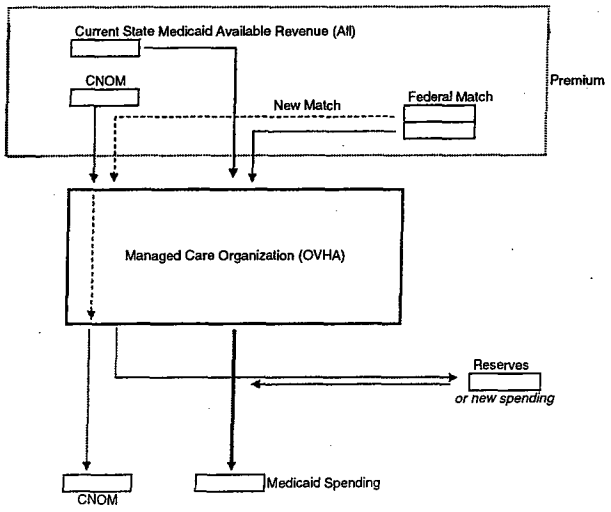
Key Components of GC

- Public Managed Care Organization (MCO)
- Change in how federal match operates
  - Match is based on premium paid by AHS to OVHA
  - Premium range is certified by actuary
- Opportunity to draw additional federal funds that can be used for a variety of purposes
- Increased program flexibility (benefits)

Comparison of Traditional Medicaid Financing and Vermont's Global Commitment



Vermont Medicaid Global Commitment - Conceptual Diagram



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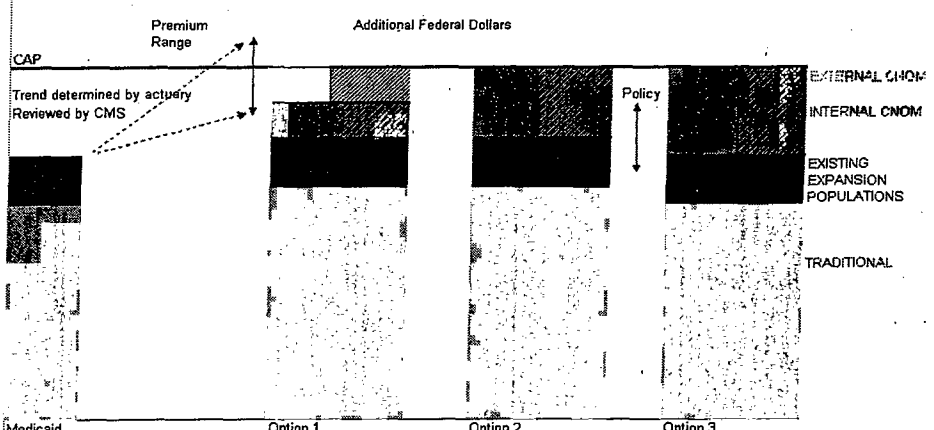
Global Commitment - Financial Components - First Year



TRADITIONAL MEDICAID - spending on mandatory and optional populations and services that does not require a waiver.
EXISTING EXPANSION POPULATIONS - spending on populations or services that requires a waiver
Internal CNOM - spending WITHIN the premium other than traditional Medicaid
Includes expansion populations
Includes other health-related services
EXTERNAL CNOM - spending above the premium, but below the cap.
PREMIUM is based on historical spending, trended forward
Savings - the difference between premium and spending for traditional and expansion populations

Legislative Joint Fiscal Office

Global Commitment - Funding Example

	Assume	40% match rate	
Now	Program	$1,000	
	Federal	$600	
	State	$400	
	Chronic Care Initiative (CCI)	$40	not matched
Waiver	Premium	$1,100	<actuary / appropriation
Savings	Federal	$660	
Version	State	$440	
	Current dollars		*$400*
	CCI funds to MCO		*$40*
	Available	$1,100	
	To fund current program	$1,000	
	To CCI	$40	
	New funds	**$60**	Can be spent by MCO on variety of services. See T&C #39
	State funds that would have been necessary to produce $60	$24	(Savings)

How Savings work

Program	$1,060
Federal	$636
State	$424

Global Commitment - Summary Analysis

$millions

Current Law		2006	2007	2008	2009	2010	TOTAL	Notes
All Spending	Total	$949.9	$1,028.0	$1,074.4	$1,153.3	$1,238.7	$5,444.3	1
(Projected)	State	$400.2	$457.2	$484.7	$526.0	$570.8	$2,438.9	1
Revenue	State	$395.6	$381.0	$393.9	$407.4	$421.6	$1,999.5	1
Supportable Spending	Total	$962.6	$887.4	$907.5	$927.4	$949.0	$4,633.9	2
		$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	
Shortfall	State	($4.6)	($76.2)	($90.9)	($118.6)	($149.2)	($439.4)	3
Waiver								
Cap	Total	$834.4	$870.2	$930.4	$996.8	$1,068.3	$4,700.0	4
Waiver Spending	Total	$730.4	$761.6	$814.3	$872.5	$935.0	$4,113.8	5
	State	$301.1	$327.3	$354.4	$383.9	$415.7	$1,782.3	5
Non-Waiver Spending	Total	$219.6	$266.3	$260.0	$280.8	$303.7	$1,330.5	6
	State	$99.1	$129.9	$130.3	$142.1	$155.2	$656.6	6
Available Revenue		$296.5	$251.1	$263.6	$265.3	$266.5	$1,342.9	7
Supportable Spending		$721.4	$584.8	$607.3	$603.9	$599.8	$3,117.2	2
Estimated available premium	Total	$111.2	$111.8	$116.1	$120.5	$125.1	$0.0	8
Additional Available Funds	Total	$65.5	$63.8	$65.7	$67.5	$69.5	$332.1	9
State Funds Saved	State	$26.9	$27.4	$28.5	$29.7	$30.9	$143.4	10
		$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	
State match available	State	$323.4	$278.5	$292.1	$295.0	$297.4	$1,486.3	11
Estimated Premium	Total	$786.9	$648.6	$673.0	$671.5	$669.3	$3,449.3	12
Shortfall	State	$22.3	($48.8)	($62.3)	($88.9)	($118.3)	($296.0)	13
FMAP		0.411	0.42935	0.434	0.4393	0.4443	See over for notes	

NOTES

1 Consensus Projection
2 Amount of total spending based on available revenue
3 Difference between consensus spending projection and supportable spending based on revenue
4 Waiver Special Terms and Conditions, reallocated to individual years based on waiver spending
5 OVHA Estimate. Consensus total spending minus costs excluded from waiver. NOTE: Based on 5 state fiscal years. Will need to be adjusted based on final waiver schedule.
6 Spending outside the Global Commitment waiver (primarily long term care, DSH, SCHIP)
7 Total available revenue minus non-waiver spending (assumes other spending is fully funded)
8 Estimated as gross funds supported by CNOM list
9 Amount of new funds that will be available.
10 Amount of state funds that will not need to be spent because of additional funds ("savings")
11 Available revenue, including CNOM savings
12 Estimated based on available revenue
13 Difference between projected spending under waiver and supportable spending based on premium

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Joint Fiscal Office

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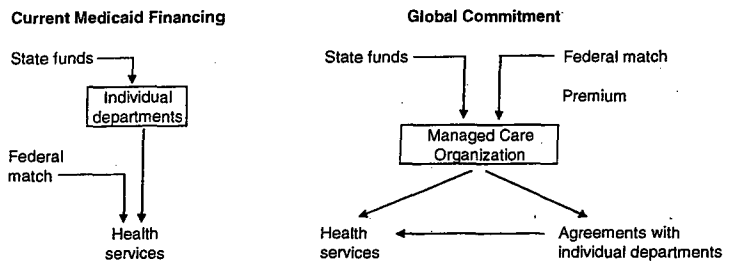

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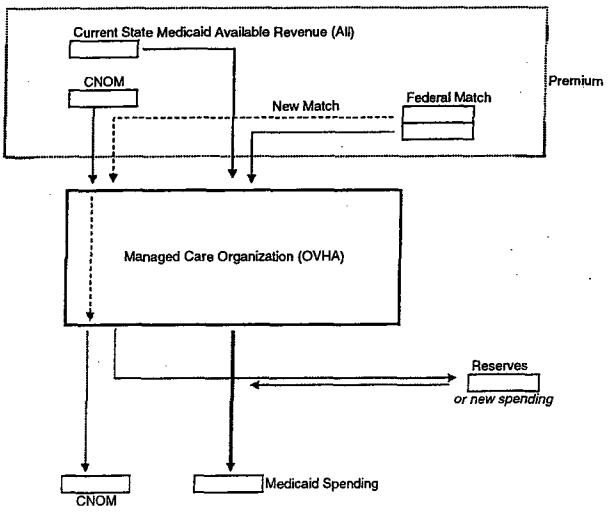
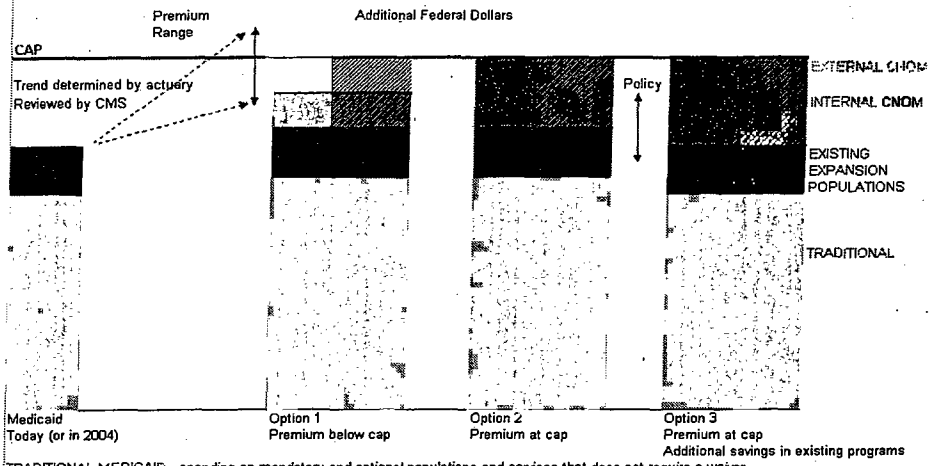


Legislative Joint Fiscal Office

Global Commitment - Financial Components - First Year



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3 Difference between consensus spending projection and supportable spending based on revenue
4 Waiver Special Terms and Conditions, reallocated to individual years based on waiver spending
5 OVHA Estimate. Consensus total spending minus costs excluded from waiver. NOTE: Based on 5 state fiscal years.
Will need to be adjusted based on final waiver schedule.
6 Spending outside the Global Commitment waiver (primarily long term care, DSH, SCHIP)
7 Total available revenue minus non-waiver spending (assumes other spending is fully funded)
8 Estimated as gross funds supported by CNOM list
9 Amount of new funds that will be available.
10 Amount of state funds that will not need to be spent because of additional funds ("savings")
11 Available revenue, including CNOM savings
12 Estimated based on available revenue
13 Difference between projected spending under waiver and supportable spending based on premium

Vermont Global Commitment

Health Access Oversight Committee
& Joint Fiscal Committee

September 27 & 28, 2005
Montpelier, VT

Theresa Sachs, Principal
Eileen Ellis, Principal
Health Management Associates

Presentation Overview

- HMA review process
- Waiver concept
- Programmatic issues
- Financing issues

HMA Review Process

- Joint Fiscal Office contracted with Health Management Associates
- Review team: Eileen Ellis and Theresa Sachs
- Our background:
  - State Medicaid Agency experience, including:
    - Extensive experience in program financing and fiscal analysis
  - CMS experience, including:
    - Medicaid reform and Health Insurance Flexibility and Accountability initiative
- Our charge:
  - Independent review, risk analysis of Global Commitment

HMA Review Process *(cont.)*

- What we did:
  - Review of documents
  - Interviews of staff and consultants
- Our work products:
  - Presentations
  - Written recommendations

Waiver Concept

- Global cap
- Public managed care organization (MCO)
- Financing flexibility
- Benefit flexibility
- Protection of mandatory eligibles

Unique Feature of the Waiver – Public MCO Receives Premiums

- VAHS pays premiums to OVHA
- Because of Global Cap, federal funds will match premiums for **ALL** enrolled waiver populations, including VHAP expansion adults & other waiver expansion adults
- OVHA pays for direct care services and distributes funds to other state agencies pursuant to contractual agreements
- OVHA can also distribute its savings to other agencies to fund **allowable** health-related programs for low-income populations
  - Discussed in more detail later. These are "Costs Not Otherwise Matchable" or CNOM

Programmatic Discussion

Issues Related to Meeting MCO Requirements

- The OVHA would have to meet all managed care requirements specified in federal regulation
- The only requirement being waived is the provider credentialing process
- The intergovernmental agreement between VAHS and OVHA has been reviewed by CMS as an MCO agreement and has met with preliminary approval

Issues Related to Documentation of Demonstration Provisions

- Demonstration documentation:
  - Special terms and conditions (STCs) are the only documentation of what is being approved
  - The original demonstration proposal has not been updated
  - No operational protocol will be required
  - No "Attachment C" of the STCs will be required

Documentation: Risk and Recommendation

- Demonstration documentation (cont.)
  - *Risk*: Future disagreements over operational elements of the demonstration
  - *HMA recommendation*: Written documentation of all understandings between the Agency for Human Services and CMS
  - This can be done via a letter from VAHS to CMS; CMS would have to respond in writing to correct any misunderstandings

Financing Discussion

Topics Regarding Financing the Global Commitment Waiver

- Parallels to financing of the Vermont Health Access Plan (VHAP)
- Global Cap – How calculated; what are the risks
- Premiums – How established; what are the risks
- Use of "Savings" to cover "Costs Not Otherwise Matchable" (CNOM)
  - "Internal CNOM"
  - "External CNOM"

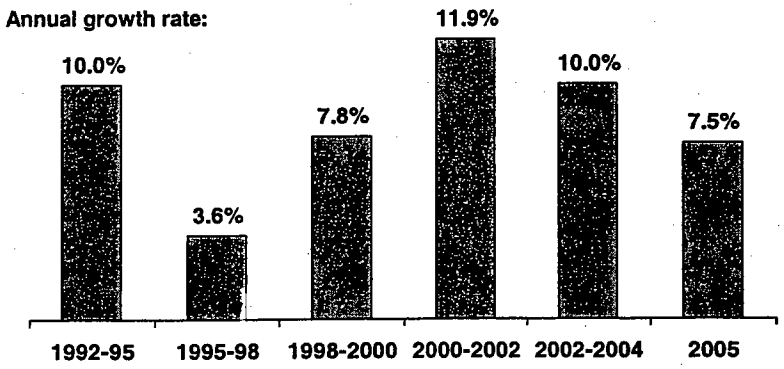
Parallels to VHAP

- VHAP waiver used some of the same concepts as Global Commitment
  - "Without Waiver" budget: traditional Medicaid populations with generous trend rate
  - "With Waiver" costs budget: traditional populations and expansion populations
  - VT used "savings" on traditional populations to fund VHAP expansion
- As a result Vermont has more generous eligibility than almost every other state
- Surplus of $66.6 million from VHAP

How was $4.7 B. Cap developed?

- Projected costs - mandatory & optional Medicaid
  - Trend rates:
    - Average over 10% for mandatory and optional waiver populations
    - Over 9.25% for non-waiver families & ABD
    - Developmental services waiver 9.92% per year
  - Since MCO Model, allowance of 9% for administrative costs
- Includes $66.6 million VHAP Surplus
- Allowance of $10.8 million per year for Vermont State Hospital (VSH) alternatives
- Excludes costs of "expansion" groups (such as VHAP adults who are not parents or caretakers)

Average Annual Growth Rates: Total Medicaid Spending, 1992 - 2005



SOURCE: For 1992-2002: Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64); For 2003, 2004 and 2005: Health Management Associates estimates based on information provided by state officials.

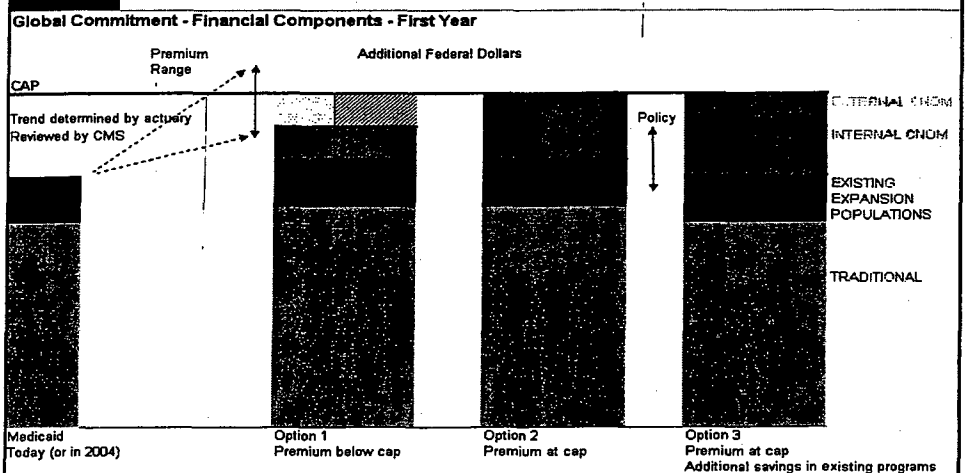
How was the Cap developed?

Included Waiver Groups	Annual Caseload Trend	PMPM Cost Trend
Aid to Needy Families & Children	1.99%	8.60%
ABD, Spend Down, Community Residential Treatment, MH-Duals	2.52%	3.70%
Parents to 150% & from 150% to 185% FPL	6.43%	8.40%
1902(r)(2) (Kids 225 – 300% with Insurance)	1.99%	8.80%

Premiums

- Actuarially sound premium **RANGE** to be set by an external actuary for each population in the waiver
- Will use historical medical costs, the funds for the VSH alternatives and an actuarial trend rate
- The premium includes an allowance of 9% of premium for administrative costs (total of $405 million over five years)
- CMS guidelines allow for risk, contingency & profit in MCO rate setting
- **The premiums have not yet been calculated**

w it works Chart – Joint Fiscal Office



TRADITIONAL MEDICAID - spending on mandatory and optional populations and services that does not require a waiver.
EXISTING EXPANSION POPULATIONS - spending on populations or services that requires a waiver
Internal CNOM - spending WITHIN the premium other than traditional Medicaid
Includes expansion populations
Includes other health-related services
External CNOM - spending above the premium, but below the cap.
PREMIUM is based on historical spending, trended forward
Savings - the difference between premium and spending for traditional and expansion populations

Scenario A: Premiums above Cap

- Actuary sets premium RANGE – hopefully part of range is below cap and VAHS pays at lower end of the range
- If premiums too high, federal share limited by the cap
- VT does not appear to have sufficient **state** funds to support $4.7 billion anyway, so program reductions are required with or without waiver if spending is at that level.
- Federal CMS 64 reports of amounts expended still required
  - Can't carry excess federal funds forward to use as match
  - Would need to return any excess federal funds

Note: Global cap is cumulative – can be exceeded in a given year – within STC thresholds, and if VT has sufficient state funds

Scenario B: Premiums at Cap

- Staff (administration and JFO) estimates imply that if the product of premiums and enrollment is $4.438 billion, it would match current program estimates, including matchable CNOM. This is less than the $4.7 billion cap.
- If total premiums are at the Cap:
  - If due to higher than anticipated caseload, VT would need to find additional state funds or reduce programs.
  - If due to high premium rates, would need to identify additional CNOM for use of savings or try to reduce the premiums.

Scenario C: Premiums below Cap

- If premiums payments are below the cap, but at $4.428 billion or above, projected 5 year savings are attainable (staff estimate of $135 million in "internal CNOM")
  - Some have suggested funding of "external CNOM" between cap and premiums.
    - Would require a waiver amendment.
    - While possible, this seems unlikely
- If premiums are below $4.428 billion:
  - If due to lower than expected caseload, state will share in savings
  - If due to lower per capita premium rates, less ability to fund CNOM through savings hurts state budget.

How "internal CNOM" is funded

- Premium rates may exceed costs pmpm if:
  - Administration costs less than 9% (highly probably)
  - Benefit costs less than rate due to favorable trend in premium
  - Medical management or provider rate negotiations reduce cost trends
- OVHA may "spend" the savings
  - Generates federal matching funds for existing state funded programs
  - Only for specified activities related to the uninsured, underinsured, and Medicaid populations

Uses for premium "savings"

- Per waiver Special Terms & Conditions (STC), savings can be used for programs to:
  - Reduce the rate of uninsured and, or underinsured in Vermont;
  - Increase the access of quality health care uninsured, underinsured and Medicaid beneficiaries;
  - Provide public health approaches to improve the health outcome and the quality of like for the uninsured, underinsured Medicaid-eligible individuals in Vermont; and
  - Encourage the formation and maintenance of public-private partnerships in health care.
- Clarification is needed regarding this indirect funding of CNOM and waiver list (which may be only restrictions on direct use of waiver funds for CNOM).

Is the Cap Sufficient –What are the Risks?

- September 9/07/05 staff document shows forecast of total expenditures subject to the cap < $4.2 billion over 5 years.
- Result is cushion of $518 million
- Staff estimate opportunity to use $255.8 million of waiver authority for other programs.
  - This part SAVES state funds ($135 million) since these programs would otherwise have been funded with 100% state dollars
- Still gross waiver authorization cushion of $262.3 million
- If costs within waiver exceed $4.182 billion forecast, would need state funds for matching purposes
  - Absent additional state funds, would need to cut programs, with or without the waiver

Risks To Vermont Related to the GC Premiums

- Initial premiums haven't been set – may be too low or high
- Rates will be set annually
  - Current documents discuss interface with legislative decisions. Staff indicate that initial trends will be used by the actuary, but modified for any legislative changes in coverage
    - Existing documents don't fully explain this.
- *HMA recommendation*:
  - Initial premiums should be available before the waiver is approved by the legislature and implemented by VAHS and OVHA.
  - The process for annual changes should be further specified.
- Also a concern that CMS or HHS Inspector General might review rates and discount some of the "savings" for year three or beyond.

Risks of Global Commitment Waiver to the State

- Apparent risk if cost increases exceed an average of 9% to 10% per year due to caseload or medical cost increases. Due to $4.7 billion cap, VT would be at risk to spend 100% state funds.
  - However, existing data indicates VT doesn't have state funds to even reach the cap without "savings" for CNOM
- Premiums unknown
  - Could be too low or too high for viability
  - Need assurance that there isn't going to be a "rebasing" in the middle of the waiver period.

Risks of Global Commitment Waiver to Beneficiaries

- Assertion: Under GC, OVHA has an incentive to reduce costs by limiting amount of care for waiver enrollees to increase "savings" for other programs
  - Observation: While perhaps waiver increases this incentive (because savings can be used for CNOM), the state already has this incentive due to budget deficits.
- Assertion: Due to waiver cap, OVHA may not be able to pay for all eligible individuals
  - Observation: The waiver lets VT fund more individuals with less state funding. If total program cost were to exceed $4.7 million, VT would need significant additional state revenues.

Risks of Global Commitment Waiver to Providers

- Assertion: Under Global Commitment, OVHA has an incentive to reduce costs by reducing provider payment rates or limiting increases
  - Observation: While the waiver may increase this incentive (because savings can be used for CNOM), the state already has this incentive due to budget deficits.
  - Observation: This is an issue without waivers in almost every state*.

*On October 19 our latest report on Medicaid budgets will be released by the Kaiser Foundation at www.kff.org.

Some Advantages of Global Commitment Waiver

- Vermont can continue funding VHAP expansion groups
- Vermont is able to carry-forward VHAP authorization surplus ($66.6 million)
- Federal funding is included for alternative services to Vermont State Hospital
- Generous cap allows direct federal funding in premiums for VHAP expansion populations and new expansion populations (expansions don't require other "savings" to fund them)

Additional Advantages of GC

- If service costs can be kept less than premium assumptions, funds are available for CNOM
- Because OVHA is an MCO, premiums can include 9% administrative component
  - Expected much lower spending on administration =savings $$ for CNOM
- CNOM = Potential to draw $135 million (or more) in federal matching funds over waiver period for currently 100 % state programs

Wrap-Up

- Federal perspective
  - Key benefits:
    - Predictable spending growth
    - Ability to claim savings inside the cap if Vermont does not draw down full amount
    - Ability to test Medicaid reform principles
  - Key risks:
    - No major risks seen

Wrap-Up

- State perspective
  - Key benefits:
    - Generous cap
    - Flexibility with respect to financing, benefits, eligibility
  - Key risks:
    - Scant documentation may lead to future misunderstandings
    - The actual premium has not been set

Wrap-up

- Beneficiary perspective
  - Key benefits:
    - More stable financial support for some existing state-funded programs
    - Potential to lower uninsurance rate
  - Key risks:
    - No major risks seen that would not also exist without the waiver

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TESTIMONY OF JUDITH SOLOMON
SENIOR FELLOW, CENTER ON BUDGET AND POLICY PRIORITIES
HEALTH ACCESS OVERSIGHT COMMITTEE
STATE OF VERMONT
SEPTEMBER 27, 2005

My name is Judith Solomon. Thank you for the opportunity to testify before you this afternoon. I hope I can be of assistance to you as you consider how the Global Commitment waiver would affect the state of Vermont.

Background on the Center on Budget and Policy Priorities

Since 1981, the non-profit, non-partisan Center on Budget and Policy Priorities has worked at both the federal and state levels on fiscal policy and public programs that affect low- and moderate-income families and individuals. The Center conducts research and analysis to inform public debates over proposed budget and tax policies and to help ensure that the needs of low-income families and individuals are considered in these debates. The Center promotes fiscally responsible budgets at the state and federal levels, and is regarded as one of Washington's leading budget watchdog groups.

I am a Senior Fellow at the Center and work primarily on state Medicaid policy issues. Prior to coming to the Center, I directed a project that was funded by the Connecticut General Assembly to provide independent oversight of Connecticut's Medicaid managed care program for children and families. I also taught a course on Medicaid at the Yale University School of Epidemiology and Public Health. My colleague, Leighton Ku, PhD, also a Senior Fellow at the Center, helped prepare this testimony. Dr. Ku has provided economic analyses for Vermont in the past on issues relating to premiums for VHAP. He is also an adjunct professor of public policy at George Washington University and earlier in his career co-directed a multi-million dollar federal evaluation of Medicaid waivers in several states and was a principal researcher at the Urban Institute. Together we have extensive experience with Section 1115 Medicaid waivers granted in the past 15 years. For this testimony, we focused on the legal and fiscal issues surrounding the proposed Global Commitment waiver and the issues that would also affect beneficiaries and health care providers in Vermont.

Introduction

I am here today out of concern about the impact of this waiver on Vermont residents and on the Medicaid program as a whole. The waiver proposes to limit, or cap, the federal contribution to Medicaid in Vermont. The nation's Governors have already rejected the Bush Administration's efforts in 2003 to impose a cap on federal funding through a block grant for all states. Because of

the fiscal risks to states posed by a federal funding cap, as well as the likely harmful consequences for beneficiaries and health care providers, the nation's Governors did not agree to the Administration proposal, and have continued bipartisan efforts to oppose caps on federal Medicaid funding. Many members of Congress also opposed this proposal. The National Conference on State Legislatures has also opposed block granting Medicaid. Stymied by the states and Congress, the Administration has instead tried to establish federal Medicaid funding caps on a state-by-state basis through waivers. Vermont would be the first state to accept a block grant.

The waiver presents substantial risks for Vermont:

- The state's projections of growth in health care expenditures for Vermont's Medicaid program are well below the average growth in Medicaid costs that Vermont has experienced over the last five years. Projections of health care spending often prove wrong, because health costs are unpredictable. Declining economic conditions, a natural disaster like Hurricane Katrina, a new disease or epidemic like the avian flu, or new medical advances all can drive health care expenditures up. None of these factors are within a state's control. If Vermont experiences growth just two percentage points above what it experienced in the last five years, its costs would go above the federal cap. At that point, the state would have to meet any additional expenses with state funds or cut eligibility, benefits or provider payments.

- Even if Vermont is able to stay within the cap on federal spending, there is no guarantee that the state will realize any savings. Because of the unpredictable nature of health care expenses, there may not be "room" under the cap to draw down additional federal funds. In other words, all or most of the federal funds may be needed to provide health care to beneficiaries enrolled in the program.

- No good explanation has been provided as to how the state can save money through its new public managed care organization given that federal law requires that capitation payments must be actuarially sound. Capitation rates must be based on the current number of beneficiaries and the current amount and price of services that they use.

The Global Commitment Waiver Could Undermine Vermont's Outstanding Progress in Providing Health Coverage to its Residents by Limiting the Federal Funds it Needs.

Vermont has good reason to be proud of its health care coverage. In 2004, according to the Center on Budget's analysis of Census Bureau data, 13.7 percent of all low-income Vermonters (those with income below two times the poverty line) were uninsured compared to 26.8 percent for the nation as a whole. For children, the rate was 5.2 percent compared to the national rate of 18.2 percent. For both these groups, Vermont had the lowest percentage of low-income uninsured state residents. In 2001, Vermont had the lowest rate of preterm births in the United States and the state ranks near the top of all states in ensuring that pregnant women get prenatal care and children get immunized. Moreover, Vermont has achieved these gains while maintaining a relatively efficient and low-cost program. *It has the lowest Medicaid costs per enrollee among New England states.* (Figure 1)

Vermont's accomplishments are due in large part to the health coverage that it has provided through Medicaid and the Vermont Health Access Plan (VHAP), its existing Medicaid demonstration project. The Global Commitment waiver would fundamentally change the financing of Vermont's Medicaid program, including the financing of coverage for those eligible under the

VHAP waiver. Instead of the current federal-state partnership that responds to the needs of beneficiaries and the state, the state would be limited to a capped allotment of federal funds that could leave the state short of federal funds to cover health care services for Vermont residents. Under the existing federal-state financial partnership, the federal government pays for almost 60 percent of Vermont's Medicaid costs, no matter what those costs are. Under the waiver, federal funds would be limited to no more than the federal share of Vermont's Medicaid expenditures up to $4.7 billion over the five-year period of the waiver from October 1, 2005 to September 30, 2010. The limit would apply even if Vermont would have qualified for additional federal funding under the current open-ended matching system.

As we have seen so vividly in the last few weeks, unexpected events can put a huge strain on a state's health care system. Hurricane Katrina has dramatically increased the number of low-income people in need of health care; these needs are now severely straining the health care safety net in several Gulf Coast states.

One of the biggest virtues of the current federal Medicaid matching system is that it provides states with flexible federal support to meet the health care needs of its most vulnerable residents. Under the current system, federal payments are guaranteed to states on an as-needed basis. Uncapped federal financing allows states to guarantee coverage to all low-income people who meet the eligibility criteria the state has established. Federal Medicaid matching payments to states are based on actual state costs. (Figure 2) This ensures that federal Medicaid support is available to fund a share of Vermont's Medicaid expenditures, regardless of the many unpredictable factors that can cause those expenditures to change without warning, including:

- Changing economic factors leading to a recession;
- A new disease or epidemic, such as the avian flu;
- Medical advances such as new drugs or technology;
- Higher than projected health care inflation; and
- Increases in the number of employers dropping health care coverage.

Each of these factors is beyond the control of a small state like Vermont to control.

The federal matching system is important not only from the standpoint of providing health coverage, but is also central to how the federal government provides fiscal support to states. Nationally, Medicaid is by far the single largest source of federal grant support to states. In Vermont, federal spending on Medicaid in the state accounts for more than half of all federal funds that come to the state. (Figure 3) Over the past several years, federal spending on Medicaid for Vermont has been growing rapidly, as the state's spending on Medicaid has increased. Federal contributions to Medicaid are a critical source of support for hospitals, physicians, clinics and other providers in the state. Nationally, Medicaid accounts for $1 in every $5 spent for health care services.

In contrast, the Global Commitment waiver would cap future federal funding at a set amount, leaving the state at risk if factors like health care costs and demographic changes increase the cost of providing Medicaid services above the level of the cap. If Vermont's costs end up exceeding the fixed federal cap because of higher-than-projected health care inflation, higher enrollment due to a recession, a natural disaster like Hurricane Katrina or a flu epidemic, the state would not receive any

federal funding in excess of the cap. Within the cap, Medicaid remains a matching program — the $4.7 billion five-year cap is a limit on the payments the federal government will make to match expenditures made by the state.

The cap in the Global Commitment waiver that puts Vermont at risk for growth in both costs and enrollment is far different from the cap that Vermont has in its VHAP waiver. The terms and conditions for the VHAP waiver explicitly state that Vermont is not at risk for growth in enrollment, and the state is therefore not at risk for changing economic conditions. In contrast, the terms and conditions for the Global Commitment waiver clearly state Vermont "shall be at risk for changing economic conditions that impact enrollment levels," such as a recession or erosion in employer-based coverage. Moreover, the risk of the cap is compounded in Vermont, because it recently accepted a waiver with a global cap for all Vermont Medicaid beneficiaries needing long-term care services. If the Global Commitment waiver is approved, federal funds for Vermont's entire Medicaid program would be capped without any safety valve for unanticipated growth in health care costs or enrollment.

Spending on health care is by its nature very difficult to predict. Many variables contribute to changes in the growth rate of spending — economic changes can affect enrollment, health care inflation frequently exceeds expectations, new drugs and technologies can increase spending, and changes in employment, like the loss of a big employer in the state, can increase the demand for publicly funded health care without warning. For this reason, states' own projections of what they will spend tend to change frequently. As demonstrated in Figure 4, states that had low growth in Medicaid costs the mid-1990s had very high growth rates five years later, and vice versa.

Even the best national projections, made by the highly regarded Congressional Budget Office, which employs highly sophisticated models based on the best available economic, demographic, and cost data, frequently fail to predict actual growth in Medicaid spending. As Figure 5 shows, CBO's 1998 projections of federal Medicaid spending in seven subsequent years underestimated the amount the federal government would spend by $19 billion, or ten percent. Had the federal government decided in 1998 to cap federal funding at the funding levels CBO predicted at the time, federal support to states for Medicaid costs would have been nearly $20 billion, or ten percent, below what it was without such caps.

This same unpredictability is as true in Vermont as it is elsewhere. Even over the past few months, as the waiver has been under discussion, the state's forecast of what it will spend on Medicaid over the next five years has changed substantially. The waiver proposal submitted in April forecast that increases in the state's expenditures over the next five years would average 12.5% without the waiver and 10.9% with the waiver. Current state budget projections show that the growth rate will only average about 7%. The cap on federal funds in the Global Commitment is set at the amount that Vermont projected it would need in the absence of the waiver, so it is above the amount that Vermont now projects it will need over the next five years with the waiver. (Figure 6) But these are projections, and they could prove to be wrong due to factors outside the state's control. Figure 7 shows that if Vermont's Medicaid costs grow just two percentage points above the rate that they have grown over the last five years due to an unforeseen event such as a recession, natural disaster or flu outbreak, the cap would be exceeded.

Given the unpredictability of health care expenses, the risks of a block grant for beneficiaries, health care providers, and the state are substantial. (Figure 8) As you decide whether to approve the

Global Commitment waiver, the critical question is whether the risks of accepting a block grant in place of the current guarantee of federal matching funds are outweighed by any potential benefits that the waiver would bring the state.

The Waiver Gives the State Unprecedented Flexibility to Cut Eligibility or Benefits to Stay within the Cap on Federal Funds.

The terms and conditions of the waiver issued by the Centers for Medicare and Medicaid Services on September 13 explicitly state that "the cap places the State at risk for enrollment and for Per Participant Per Month cost trends." There is absolutely no doubt that the waiver places the state at risk for unanticipated growth in both expenditures and caseload. In fact, in its waiver proposal the state asked CMS to provide assurances of fiscal relief if an epidemic, catastrophe, or major and prolonged economic downturn occurred. However, the terms and conditions do *not* include any such assurances.

Recognizing that the cap on federal funds could force the state to cut back spending on health coverage, CMS has granted the state broad discretion to make significant changes in eligibility and benefits for Medicaid beneficiaries in Vermont. In the description of the process for amending the waiver, the terms and conditions anticipate that *in each of the five years year the waiver is in effect*, the legislature will make changes in eligibility and benefits. Presumably, CMS anticipates that the state may need to make reductions in coverage and benefits to stay under the cap on federal funds. The state might choose to reduce eligibility, or the benefits available to eligible recipients, or both. Reductions in eligibility would likely increase the number of uninsured Vermonters, a result in direct opposition to the state's longstanding goal to decrease the number of uninsured state residents, and reducing benefits would limit their beneficiaries' access to necessary health care services, likely increasing the number of underinsured Vermonters. The state is also likely to consider reductions in payments to providers to stay within the cap.

Under the waiver, Vermont would have wide discretion in reducing eligibility and benefits. All beneficiaries other than those in "mandatory" Medicaid coverage groups lose any guarantee of eligibility and benefits. Even beneficiaries in mandatory coverage groups are only guaranteed the benefits that are considered mandatory under Medicaid. In Medicaid, using the terms "mandatory" and "optional" to describe beneficiaries and benefits can be misleading.

- "Mandatory" refers to eligibility groups and benefits the federal government requires states that participate in the Medicaid program to cover; "optional" eligibility and benefits are offered at a state's discretion.

- "Optional beneficiaries" include many low-income and vulnerable individuals in Vermont such as seniors and people with disabilities with income just slightly over 74 percent of the poverty line, pregnant women and children up to age six with income over 133 percent of poverty, and children over the age of six in families with income just above poverty. (Figure 9)

- "Optional services" include prescription drugs, prosthetic and orthotic devices and durable medical equipment. (Figure 10)

- States do not have to provide "optional services" even for beneficiaries in mandatory coverage groups.

- *In Vermont, more than half of current beneficiaries are in optional coverage groups and two-thirds of Medicaid expenditures are for optional beneficiaries or services.* (Figure 11)

Coverage for the beneficiaries described below would be classified as "optional" in Vermont under current law:

- An elderly nursing facility resident with an annual income of about $7,200 a year;
- A parent of two children who works three days a week at minimum wage in a service sector job without health insurance;
- A 50-year old with multiple sclerosis whose physician and drug costs are so large that he "spends down" to Medicaid coverage — that is, his income after medical expenses are subtracted is below the Medicaid eligibility cutoff.[1]

The waiver would give the Vermont the discretion to change eligibility levels and covered benefits for these "optional" beneficiaries. In particular:

- The waiver would allow the state to cap enrollment for these low-income beneficiaries for the first time. Currently, the Medicaid program guarantees coverage to all individuals who meet eligibility criteria. An enrollment cap would allow the state to stop offering coverage to needy, eligible individuals after a certain number of individuals are enrolled. Other low-income individuals could be placed on a waiting list even if they had a greater need for health care services than those who already had coverage.

- Children with special health care needs would be at special risk under this proposal, because they could lose benefits under Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Under EPSDT, children receive regular preventive health care and all necessary follow-up diagnostic and treatment services without any limitations, including services that may not otherwise be covered by a state's Medicaid program for adults. EPSDT is of critical importance for children in Medicaid because they tend to be in poorer health than children with private coverage.[2] Under the waiver, Vermont could be the first state where children lose EPSDT benefits.

- All beneficiaries, except children in mandatory coverage groups, could lose dental and vision services, wheelchairs, prosthetic devices, some mental health care, and other important health care services.

- Beneficiaries in optional coverage groups could be charged premiums and co-payments far above current Medicaid standards that prohibit the collection of premiums from most beneficiaries and limit co-payments to nominal amounts. The only limit on cost-sharing would be a cap equal to five percent of household income. There is a substantial body of research

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[1]These examples are taken from "Medicaid: An Overview of Spending on 'Mandatory" and 'Optional' Populations and Services, Kaiser Commission on Medicaid and the Uninsured, June 2005. A copy of this report is attached to this testimony. This report includes additional examples of the types of people who could lose services and the services that could be lost under the flexibility allowed in the Global Commitment waiver.

[2] Leighton Ku and Sashi Nimalendran, "Improving Children's Health: A Chartbook About the Roles of Medicaid and SCHIP," (Washington, DC, Center on Budget and Policy Priorities, January 2004).

that convincingly demonstrates that significant co-payments and premiums prevent substantial numbers of Medicaid beneficiaries from using essential health care services and can worsen their health status. The research shows that for many beneficiaries, even co-payments that appear to be modest would deter their use of some lifesaving services, and that premiums would prevent many from enrolling in coverage at all. These research findings demonstrate that premiums and co-payments well below the level of five percent of family income have an impact on enrollment and use of services. At the same time, research in states that have increased co-payments and premiums has shown that increases in use of hospitals and emergency rooms as a result of the cost sharing largely negate whatever savings the increased cost-sharing produces.

Does the Global Commitment Provide Benefits to Vermont that Outweigh the Risk of a Block Grant?

The risks of the waiver to Vermont and its low-income residents are clear, but the benefits are not. While there appears to be a perception that this waiver would help Vermont achieve savings in the short term, that may or may not prove to be the case.

According to the Office of Vermont Health Access, the waiver could bring up to $145 million in additional federal funds to Vermont over the five-year waiver period. This estimate is based on some tenuous assumptions.

The waiver contemplates creating a new, public managed care organization (MCO) for all the Medicaid beneficiaries covered under the waiver. OVHA will receive monthly capitation payments to cover the health care needs of all Vermont Medicaid beneficiaries, who will now be enrolled in the MCO.

There are some ways that transforming Medicaid into a large managed care pool could save money, but they are far from certain. But in evaluating the probability of savings, a couple of key facts have to be kept in mind.

- First, federal regulations governing Medicaid managed care programs require that managed care payment rates must be based on the current cost of providing services covered under a state's Medicaid plan to eligible beneficiaries. In other words, the capitation payments that will be paid to OVHA will be based on the current number of beneficiaries and the current amount and price of services that they use. These rates must be certified by an independent actuary. There will also be independent federal oversight of whether the rates meet the requirements of federal law[3]

- Second, Vermont will not be getting a lump sum from the federal government to spend as it pleases. The $4.7 billion 5-year cap is an upper bound of the payments the federal government

[3]For example, the Office of Inspector-General of the Department of Health and Human Services has announced plans to review administrative costs included in capitation payments, citing the requirement of "actuarially sound capitation rates based on costs and utilization of Medicaid State plan services." *HHS/OIG Fiscal Year 2005 Work Plan – Centers for Medicare and Medicaid Services.*, p. 37.

will make to match expenditures made by the state. Within the federal cap, Medicaid remains a matching program. So Vermont must spend money on services in order to receive the federal funding. For the past several years, CMS has been increasing its scrutiny of how states have been funding the state share of their Medicaid spending. Because of the lack of clarity regarding what expenses Vermont expects to match, CMS can be expected to carefully review how the state funds its share. The terms and conditions contain no assurances from CMS to the state in this regard.

Sometimes when states transform some or all of their Medicaid programs to managed care, they are attempting to reap efficiency savings. Savings sometimes can be achieved if the managed care plan can find ways of reducing costs or decreasing utilization of care. While managed care plans can achieve savings in a number of ways, including the establishment of exclusive provider networks to reduce provider costs and care management strategies to redirect or limit utilization, it does not appear that the Global Commitment contemplates the use of these types of managed care techniques by the new public MCO. This does not seem to be where the state is heading, and in any event managed care does not require a waiver like the Global Commitment.

Since the state cannot set capitation rates higher than the normal price of services and the federal government only will match the reasonable capitation rates, the state has to do something else to make the claimed $145 to $165 million in "profit" that it wants to use to reduce the deficit or cover other populations. The only way it can draw down the extra federal funds is to re-characterize some state spending as eligible for a Medicaid match. In other words, it needs to make eligible for a federal matching payment certain services that currently are funded with state dollars alone.

In its initial waiver proposal, the Administration suggested that the state would draw down additional federal funds by incorporating certain state public or mental health expenditures — such as smoking cessation or certain mental health services — in the capitation payments. These expenditures would receive federal matching funds for the first time. However, these savings are *completely speculative.* The final waiver includes no description of the services Vermont would be able to refinance under the waiver. No list is enumerated in the federal terms and conditions or in the draft intergovernmental agreement that creates the MCO. Without further information, it is not possible to know how much might be saved or what the implications are for these services and for those who currently receive or provide the services. Therefore, it is not possible to know whether the savings that are being promoted as the benefit of the Global Commitment waiver will be generated.

The amount of the capitation rates has not yet been made public, yet they are a critical factor in evaluating the waiver. As noted above, these rates must be certified by an independent actuary. It is not possible to assess the fiscal implications of the Global Commitment waiver without knowing what these rates are or how they will change in the future. The Administration's budget estimates rely on a tenuous assumption that the total capitation level will be high enough to fund additional, unspecified state-financed health services, worth about $241 million over five years in order to generate $145 million in new federal funds, but still stay below the federal budget cap.

However, if the total capitation level is too low, there would not be enough money available within that amount to cover the cost of these unspecified health services and to maintain the current level of services in Medicaid. In that case, either the state would save much less than expected from these other services — dramatically reducing the savings from the expected level — or it would have

to cut core Medicaid services.

Similarly, if the total capitation level is too high, then it might exceed the federal budget cap if enrollment rises. In that case, the budget cap will limit the ability of the state to have savings from the other unspecified health services. Without knowing the capitation level and more about the other health services that the Administration plans to fund under Global Commitment, any fiscal analysis is incomplete.[4]

Does the Legislature have to Act by October 1?

Under the terms and conditions, the waiver would start on October 1, 2005. However, there is no clear reason the waiver has to start on that date. In fact, it appears to be impossible for the state to operate its program or to generate any potential savings until the capitated MCO arrangement is operational and OVHA begins receiving capitation payments. There are months of work to be done before the new public MCO is ready to enroll beneficiaries. This is clear from the work plan posted on the OVHA website.[5] To the extent that any savings are actually possible through the operation of the new public MCO, nothing can happen until the MCO is ready to enroll beneficiaries, because the new capitation payment structure will not begin until then.

Are there Alternatives to the Global Commitment Block Grants to Contain Medicaid Costs?

Vermont is not alone among states seeking to reduce the costs of its Medicaid program. Many states are dealing with growing health care costs, increased enrollment due to the erosion of employer-based coverage and increases in the number of low-income people, and the increasing costs and use of services by the elderly and disabled. (Figure 12) However, it is important to understand that Medicaid costs are growing because health care costs are growing. A recent study by Urban Institute researchers for the Kaiser Family Foundation found that Medicaid's cost per beneficiary is actually lower than that of private insurance.[6] A separate study by Urban Institute researchers finds that Medicaid's per-beneficiary costs have been rising more slowly than those of private insurance in recent years.[7]
(Figures 13 and 14)

There are ways states can save money by maximizing their receipt of federal funds, by becoming better purchasers of health care services, and by better coordination and management of care, particularly for beneficiaries with chronic illnesses. None of these initiatives require acceptance of a

---

[4]Moreover, the funding arrangement anticipated by the Global Commitment sets up a direct competition between these other health services and core Medicaid services because they both will be financed from the same pot of funds. If external circumstances such as an economic downturn, a disaster, or higher than expected health care inflation push costs to and beyond the limit of the block grant, then funding for one set of services must come at the expense of another service.

[5] The work plan and other documents relating to the waiver are at http://www.ovha.state.vt.us/globalhome.cfm.

[6] Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry,* 40 (2003/2004): 323-42.

[7] John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs* web exclusive, January 26, 2005

block grant in place of Medicaid's current federal matching system. *Moreover*, some of the initiatives described in the Global Commitment waiver proposal that could save money including the chronic care initiatives and efforts to decrease smoking and obesity, can be implemented *without* the Global Commitment waiver. Indeed, Vermont is already implementing some of these projects.

It is also possible that Vermont could increase federal funding for some state-funded public health activities without agreeing to a block grant by incorporating these services into its existing Medicaid program. Taking more time to analyze the risks and potential benefits along with any alternatives is a much better course for the state than hasty approval of the Global Commitment waiver, especially when it does not appear that the state will lose anything by taking the time for more deliberate review.

We understand that the state is looking for ways to reduce costs. But while the risks associated with this proposal are quite clear, the benefits are not. Accepting a risky new proposal that lacks key details and allows the federal government to limit arbitrarily its financial contribution to the program without addressing the underlying factors, such as increased costs of prescription drugs, that are causing increases in health care costs in public and private coverage programs alike is not a solution to the problem Vermont is facing. As the legislature moves forward, we would be happy to work with you to try to identify reasonable cost containment measures that do not require the risk to the state and to low-income people that is associated with the "Global Commitment."

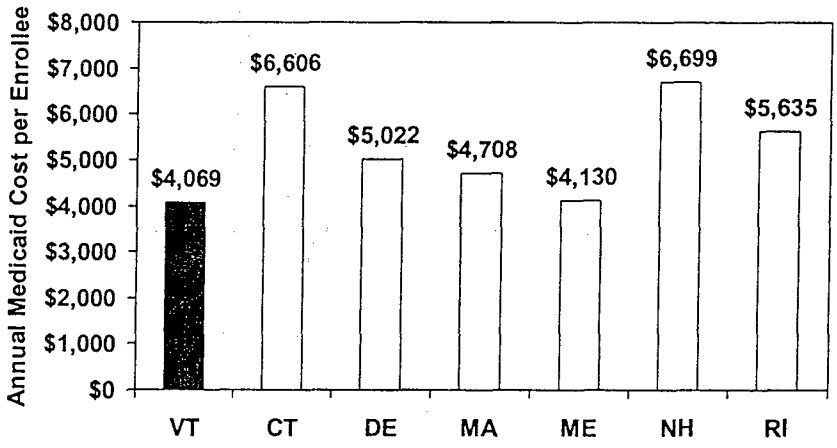
Thank you for the opportunity to comment. I would be happy to answer any questions you may have today or in the future.

Attachments to Testimony

Judith Solomon
Center on Budget and Policy Priorities

Figure 1

Vermont Already Has Lowest Average Medicaid Costs Per Enrollee in New England



Source: Analyses of FY 2002 Medicaid Statistical Information System data, adjusted for caseload differences (most recent data available)

Figure 2

Medicaid Financing: Key Features

Current Medicaid Program

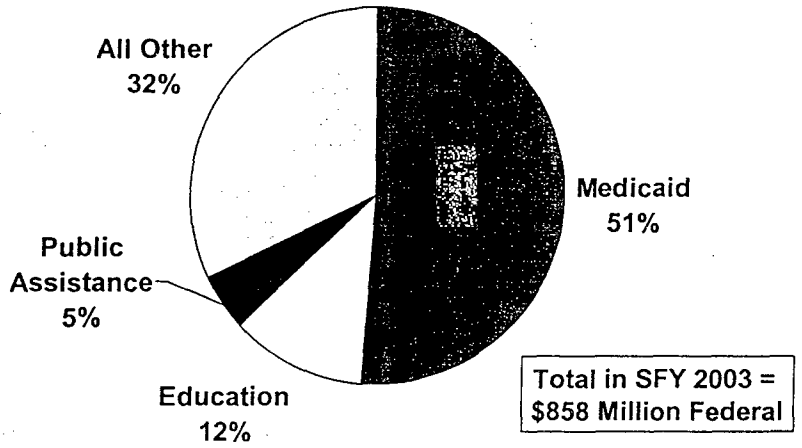
- ✓ Federal funding provided on an "as needed" basis
- ✓ Eligible people are guaranteed coverage
- ✓ Federal funds paid to states are based on actual costs

Capped Federal Funding

- ✓ Federal funding is capped at a set amount
- ✓ No federal guarantee of coverage (for some or all people)
- ✓ Federal funds paid to states are based on a pre-set amount or formula

Figure 3

Medicaid Provides More Than Half of All Federal Revenue for Vermont



Source: National Assn. of State Budget Officers

Figure 4

A state's historical Medicaid growth rate is not always a good predictor of future growth.

States with Lowest Growth Rates in 1997-2000		*Ranking Re: Growth Rates in 2000-2004*	
51. Louisiana	0.3%	37. Louisiana	9.6%
50. Texas	3.1%	17. Texas	12.4%
49. New Hampshire	3.2%	21. New Hampshire	12.0%
48. Wyoming	3.5%	22. Wyoming	11.9%
47. New Jersey	3.6%	45. New Jersey	8.5%

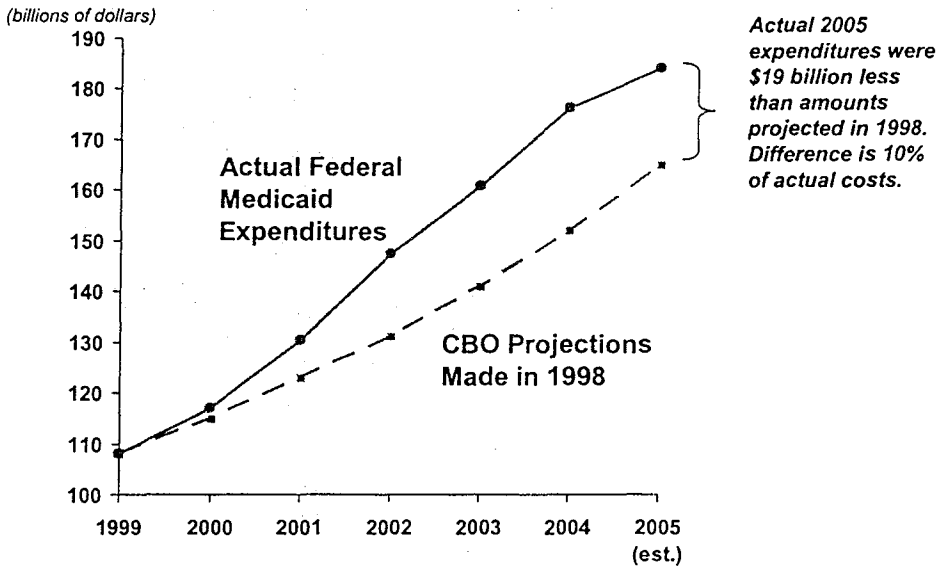
States with Highest Growth Rates in 1997-2000		*Ranking Re: Growth Rates in 2000-2004*	
1. Alaska	16.8%	4. Alaska	16.6%
2. Idaho	13.6%	10. Idaho	13.9%
3. Vermont	**12.9%**	**24. Vermont**	**11.4%**
4. Nebraska	12.8%	43. Nebraska	9.0%
5. Kansas	12.2%	46. Kansas	7.8%

Note: Both Alaska and the District of Columbia had their Medicaid matching rates increased by legislation after 1997, providing extra growth in federal payments in the 1997-2000 period.

Source: Data are net Medicaid expenditures as reported in CMS-64 reports. FFY2004 data are projections made by states as of August 2004, in CMS-37 reports. Includes DSH but not administrative expenditures.

Figure 5

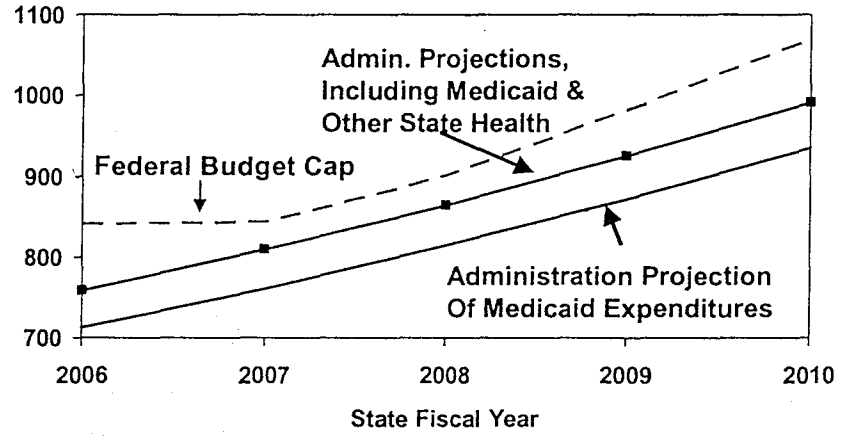
Projections Can Miss the Mark: CBO's National Medicaid Projections vs. Actual Levels



Source: Congressional Budget Office Medicaid Baselines, 1998-2004.

Figure 6

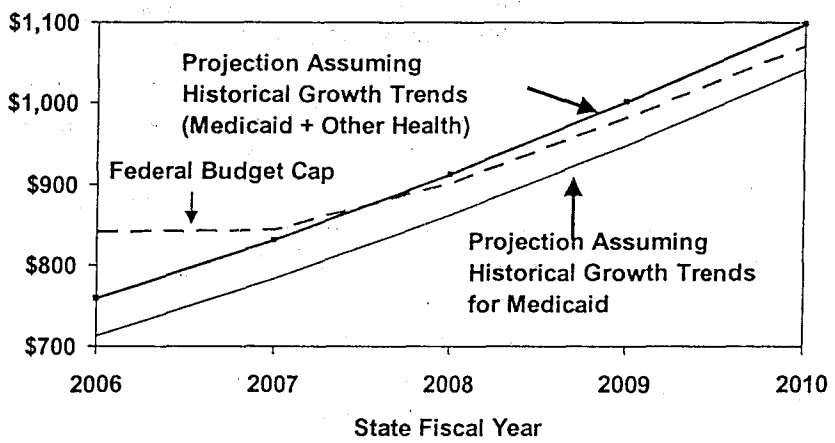
Administration Claims Global Commitment Expenditures (Medicaid Plus Other Health) Are Below Federal Cap, But Relies on Rosy Growth Estimates.....



Note: Federal cap and administration's budget estimate are based on data from Joint Fiscal Office based on OVHA data and are annualized.

Figure 7

But If Medicaid Instead Follows Historical Growth Rates, Global Commitment Expenditures Would Hit the Federal Cap Quickly, Forcing Cuts



Note: Historical trend is based on average growth of Medicaid and VHPA from 2000 to 2005, according to federal Medicaid data. Growth of other health expenditures is based on state projections.

Figure 8

Factors that Drive Need for Medicaid Coverage in Vermont (and other states)

How is Vermont changing, in terms of...

- Overall population?
- Low-income population?
- Economy?
- Expected growth in number of seniors?
- Change in number of people with disabilities?
- Health care costs?
- Rates of Uninsured? Changes in employer coverage?
- Incidence of new diseases?
- New medical technologies?

Figure 9

Medicaid Beneficiary Groups in Vermont

"Mandatory" Groups

•Children under age 6 and pregnant women ≤133% FPL
• Children age 6 and older ≤100% FPL
•Parents with incomes below state-established minimums (VT = 49% FPL)
•Disabled SSI beneficiaries (incomes ≤ 74% FPL)
•Elderly SSI beneficiaries (incomes ≤ 74% FPL)
• Low-income Medicare groups (QMB, SLMB, QI-1, QI-2)

"Optional" Groups

•Children above federal minimum income levels (100% or 133% FPL)
•Parents above minimum requirements
•Childless adults < 150% FPL
•Pregnant women > 133% FPL
•Disabled and elderly people > 74% FPL
•Disabled people serviced under Home and Community Based waivers
•Certain working disabled people
•Elderly and disabled nursing home residents > 74% FPL
•Women needing treatment for breast and cervical cancer
• Medicare beneficiaries and disabled >100% FPL, Px Drugs

Figure 10

Medicaid Benefits in Vermont

"Mandatory" Benefits

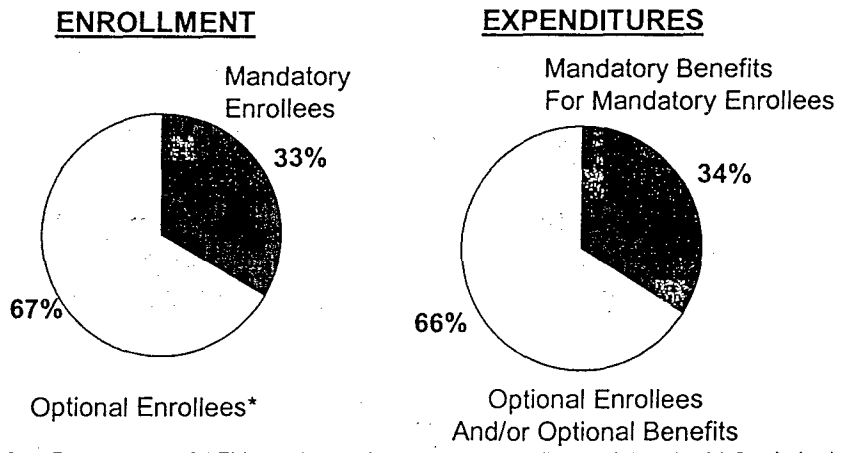
- Inpatient/ outpatient hospital services
- Lab and x-ray services
- Family planning services
- EPSDT
- Physician services
- Nursing facility services
- Rural health care services
- Services administered at an FQHC

"Optional" Benefits

- Case management services
- Dental services
- Prescription drugs
- Hospice care
- Physical and occupational therapy
- Intermediate care facility services
- Substance abuse treatment
- Personal care services
- Podiatry services
- Optometry services
- Services administered by a licensed social worker
- Inpatient psychiatric services for children

Figure 11

About Two-thirds of Vermont's Enrollment and Expenditures Are Optional



Source: CBPP analyses of SFY 2004 enrollment data and FY 2002 Medicaid Statistical Information System expenditure data. Optional enrollees also include expansion groups under existing waivers (roughly half of the group).

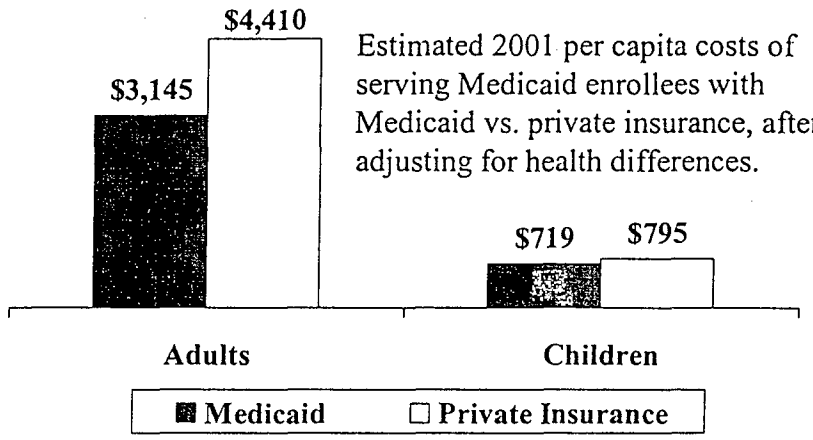
Figure 12

Why Are Medicaid Costs Rising ?

- Rising health care costs (public and private sector)
- Recent enrollment gains due to erosion in employer-based coverage
- Cost shift from federal government (Medicare) to states (Medicaid) – "dual eligibles"

Figure 13

Medicaid Costs 30% Less Than Private Health Insurance (Adults)

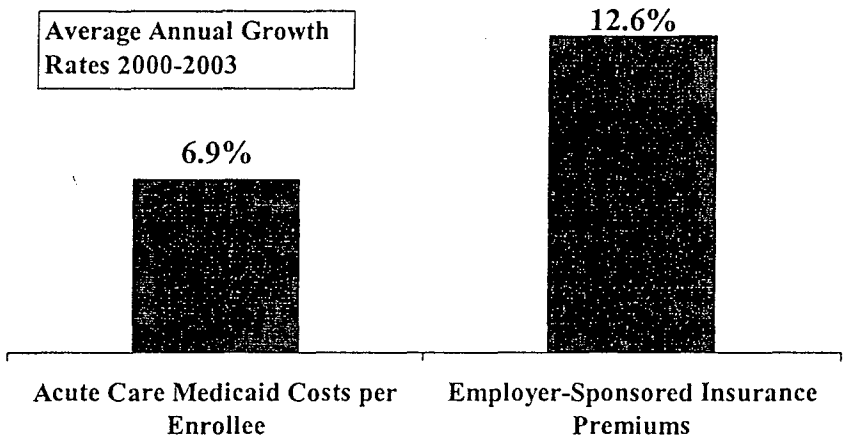


Estimated 2001 per capita costs of serving Medicaid enrollees with Medicaid vs. private insurance, after adjusting for health differences.

Source: Hadley and Holahan, Inquiry, 2004

Figure 14

Medicaid Expenditures Per Person Have Grown More Slowly Than Private Insurance Costs



Source: Holahan and Ghosh 2005 and Kaiser-HRET Surveys 2004

Kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

June 2005

Medicaid: An Overview of Spending on "Mandatory" vs. "Optional" Populations and Services

Medicaid is a federal-state program that provides health and long-term care services to 52 million low-income Americans. Federal Medicaid matching funds for the costs of these services are available to states that elect to participate in the program. As a condition of participation, states must cover certain populations (e.g., elderly poor receiving Supplemental Security Income) and certain services (e.g., hospital care). These are referred to as "mandatory" eligibility groups and "mandatory" services.

Participating states may also receive federal matching funds for the costs of covering other populations (e.g., elderly poor not eligible for SSI) and services (e.g., prescription drugs). These are known as "optional" eligibility groups and "optional" services. The use of the term "optional" is completely unrelated to whether a particular population or service is somehow less worthy or necessary than another. Instead, the term simply reflects whether, under federal Medicaid rules, a state may receive federal matching funds for the costs of covering a specific population group or service. Coverage of these "optional" eligibility groups and "optional" services is not required by federal law.

Medicaid reform discussions have often focused around giving states greater flexibility with respect to coverage of "optional" populations and services. To inform this debate, this issue brief provides an overview of Medicaid's optional beneficiaries and services. It draws on an analysis conducted for the Kaiser Commission on Medicaid and the Uninsured by the Urban Institute based on data collected by the Centers for Medicare and Medicaid Services (CMS). This work demonstrates that although "optional" populations account for only 29 percent of Medicaid enrollment, 60 percent of all Medicaid expenditures for both "mandatory" and "optional" populations are "optional," and the majority of these (86%) pay for services provided to the elderly and disabled. Some of the sickest and poorest Medicaid beneficiaries are considered "optional," and many "optional" benefits provided under Medicaid, such as prescription drugs, often are integral to appropriate care and functioning.

Medicaid Eligibility Groups

States that receive federal Medicaid matching funds must cover certain "mandatory" groups of beneficiaries (Figure 1). In general, Medicaid provides coverage of three basic groups of low-income Americans: children and parents, the elderly, and people

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Website: www.kff.org

Figure 1

Medicaid Beneficiary Groups

Mandatory Populations

- Children age 6 and older below 100% FPL ($15,670 a year for a family of 3)
- Children under age 6 below 133% FPL ($20,841 a year for a family of 3)
- Parents below state's AFDC cutoffs from July 1996 (median = 42% FPL)
- Pregnant women ≤133% FPL
- Elderly and disabled SSI beneficiaries with income ≤ 74% FPL ($6,768 a year for an individual).
- Certain working disabled
- Medicare Buy-In groups (QMB, SLMB, QI)

Optional Populations

- Low-income children above 100% FPL who are not mandatory by age (see column on left).
- Low-income parents with income above state's 1996 AFDC level.
- Pregnant women >133% FPL
- Disabled and elderly below 100% FPL ($9,310 a year for an individual), but above SSI level.
- Nursing home residents above SSI levels, but below 300% of SSI ($1,692 a month).
- Individuals at risk of needing nursing facility or ICF-MR care (under HCBS waiver)
- Certain working disabled (>SSI levels)
- Medically needy

with disabilities. The designation of some groups as "mandatory" and others as "optional" is to a large extent an artifact of Medicaid's origins as a health care program for traditional welfare populations. These populations historically eligible for cash-assistance programs are "mandatory" under Medicaid law, while most populations not eligible for cash assistance were made eligible for the program through new laws enacted over the program's 40-year history. As new eligibility pathways were created, most were offered as an option each state could decide whether to adopt.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, commonly known as "welfare reform," severed the historical link between Medicaid and cash assistance and furthered the evolution of Medicaid into a health insurance and long-term care financing program rather than a welfare program. However, one of the many legacies of this link is the continued designation of populations with incomes below historical cash assistance income eligibility levels as "mandatory," while others are "optional." "Mandatory" populations include pregnant women and children under age 6 with family income below 133 percent of poverty ($21,400 a year for a family of 3 in 2005) and older children with family income below 100 percent of poverty ($16,090 a year for a family of 3 in 2005); most persons with disabilities and elderly people receiving assistance through the Supplemental Security Income (SSI) program ($7,082 a year for an individual in 2005); and parents with income and resources below states' welfare eligibility levels as of July 1996, often below 50% of the federal poverty line.

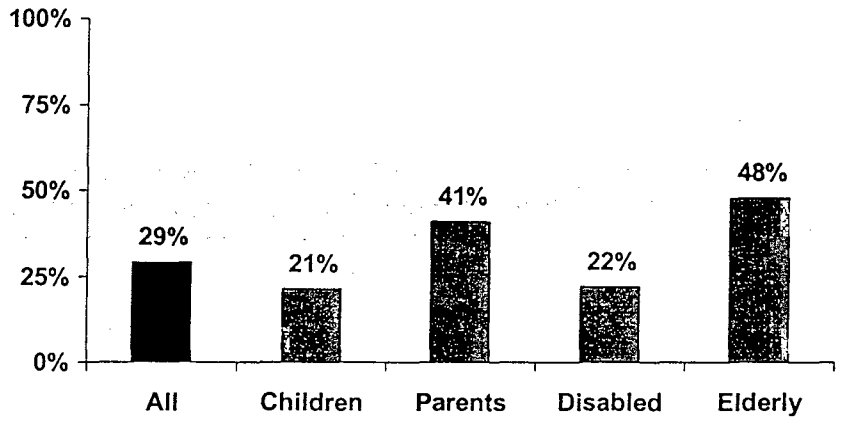
Beyond these federal minimums, states have substantial flexibility to cover additional "optional" population groups (Figure 1). "Optional" eligibility categories include children and parents above mandatory coverage limits; persons with disabilities and the elderly up to 100 percent of poverty ($9,570 a year for an individual in 2005); persons residing

in nursing facilities with income less than 300 percent of SSI standards ($1,770 a month for an individual in 2005); and individuals who have high recurring health expenses that "spend-down" to a state's medically needy income limit.

Overall, 29 percent of Medicaid beneficiaries qualify on the basis of an "optional" eligibility group. The likelihood of qualifying for Medicaid on the basis of a "mandatory" or "optional" group varies substantially by group (Figure 2). Most children (79%) qualify on the basis of "mandatory" coverage, reflecting Congressional legislative changes that have raised the minimum income eligibility threshold above cash assistance levels. In contrast, nearly half (48%) of the elderly qualify through "optional" eligibility groups, reflecting state decisions to extend coverage to nursing home residents and the medically needy population who have incomes above SSI eligibility levels.

Figure 2

Percent of Medicaid Beneficiaries with Optional Eligibility, 2001



SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

Many individuals who qualify as an "optional" beneficiary are poor and have extensive health and long-term care needs, especially the elderly and persons with disabilities. "Optional" coverage allows states to provide health insurance to children and their parents, low-income working parents who can not obtain health insurance in the workforce, and people with disabilities who are excluded from private coverage due to their disabilities. Without Medicaid, many of these individuals would not have health insurance.

The opportunity to obtain help from Medicaid after "spending down" income and resources due to health care expenses is particularly important to elderly individuals in nursing facilities and children and adults with disabilities who live in the community and incur high prescription drug, medical equipment, or other health care expenses.

Examples of "Optional" Beneficiaries

- An elderly nursing facility resident whose annual income ($7,184) is just above SSI standards (74% of poverty) but below 100% of poverty ($9,570 in 2005).
- A parent of two children who works full-time at a minimum wage level in a service sector job that does not provide health insurance coverage.
- A pregnant woman who has a part-time job, which does not offer health insurance, and earns more than $12,728/year (133% of poverty in 2005).
- A 68 year-old widow with multiple conditions, such as fibrosis of the lungs, rheumatoid arthritis, and high blood pressure, whose income ($8,400) is too high to qualify for SSI (74% of poverty or $7,082 in 2005) but qualifies for Medicaid home and community-based services, allowing her to remain in the community.
- A 7 year-old boy with autism living with his parents whose income is 110% of poverty ($17,699 in 2005) and qualifies through a home and community-based service waiver.
- A woman with disabilities who earns less than $23,925/year (250% of poverty in 2005), whose employer does not over coverage and needs Medicaid's coverage of physician services, personal care services, and prescription drugs.
- An 85-year old with Alzheimer's disease with a monthly income of $1,472 (less than 300% of SSI) qualifies for nursing facility care. She is allowed to keep $30 a month for personal needs, and the remainder of her income goes to the nursing facility to cover her medical and support needs.
- A 50 year-old man who has multiple sclerosis with recurring drug and physician costs that average $750/month "spends down" to Medicaid medically needy eligibility levels (median is 55% of poverty).

Medicaid Benefits

When extending coverage to a Medicaid beneficiary, states must provide physician services, hospital care, nursing facility care, and a range of other "mandatory" services, but they also can provide an array of "optional" services (Figures 3 & 4). Services offered at state option include prescription drugs and a broad range of disability-related services, such as, case management, rehabilitative services, personal care services, and home and community-based services. Many of these "optional" benefits provide important benefits for both Medicaid "mandatory" and "optional" beneficiaries and are particularly important for persons with disabilities and the elderly. These services

Figure 3

Medicaid Acute Care Benefits

"Mandatory" Items and Services	"Optional" Items and Services*
• Physicians services	• Prescription drugs
• Laboratory and x-ray services	• Medical care or remedial care furnished by other licensed practitioners
• Inpatient hospital services	• Rehabilitation and other therapies
• Outpatient hospital services	• Clinic services
• Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21	• Dental services, dentures
• Family planning and supplies	• Prosthetic devices, eyeglasses, durable medical equipment
• Federally-qualified health center (FQHC) services	• Primary care case management
• Rural health clinic services	• TB-related services
• Nurse midwife services	• Other specialist medical or remedial care
• Certified pediatric and family nurse practitioner services	

*These benefits are treated as mandatory for children under 21 through EPSDT in this analysis.

Figure 4

Medicaid Long-Term Care Benefits

"Mandatory" Items and Services	"Optional" Items and Services*
Institutional Services	
• Nursing facility (NF) services for individuals 21 or over	• Intermediate care facility services for the mentally retarded (ICF/MR)
	• Inpatient/nursing facility services for individuals 65 and over in an institution for mental diseases (IMD)
	• Inpatient psychiatric hospital services for individuals under age 21
Home & Community-Based Services	
• Home health care services (for individuals entitled to nursing facility care)	• Home- and community-based waiver services
	• Other home health care
	• Targeted case management
	• Respiratory care services for ventilator-dependent individuals
	• Personal care services
	• Hospice services
	• Services furnished under a PACE program

*These benefits are treated as mandatory for children under 21 through EPSDT in this analysis, with the exception of Home and Community-based waiver services

enable many persons with disabilities to remain in the community or recover from a serious illness or accident. Many of the "optional" services, such as case management, prosthetics, physical therapy, and hospice care are components of medically-appropriate care.

Examples of "Optional" Services

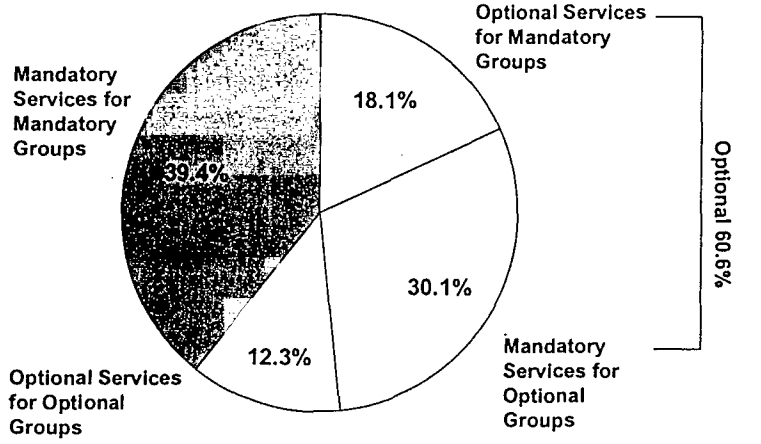
- A 22 year-old male with autism relies on the speech and occupational therapy and home based therapeutic services to learn basic life skills, such as how to dress, how to make his bed, and how to interact with other people.
- A 40 year-old woman with mental illness takes 4 prescription drugs a day to manage her bipolar disorder.
- A 32 year-old male with cerebral palsy relies on a personal care assistant who helps him bath, dress, eat, and essentially "have a normal life."
- A 51 year-old woman relies on Medicaid's prescription drug coverage for her twice daily dose of medications that include 10 different prescriptions to help manage her HIV disease.

Medicaid Spending on Optional Groups and Services

If a state decides to extend Medicaid coverage to an "optional" population, it must generally offer the same benefits package that it makes available to its "mandatory" populations. In every state, this benefits package includes both "mandatory" and "optional" services. Thus, the optional populations that a state includes in its Medicaid program will generally have coverage for both "mandatory" and "optional" services. As shown in Figure 5, sixty percent of total Medicaid spending is "optional." "Optional" populations account for about 42 percent of all Medicaid spending; of this spending, 70

Figure 5

Medicaid Expenditures by Eligibility Group and Type of Service, 2001



Total = $203.8 billion

Mandatory
Optional

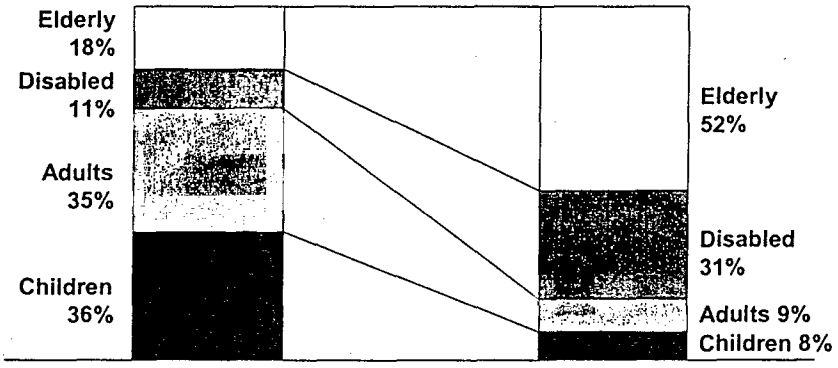
NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

percent is for "mandatory" services and 30 percent is for "optional" services. Spending is not evenly distributed among the "optional" populations. As shown in Figure 6, the elderly and disabled represent 29 percent of the "optional" populations but account for 83 percent of Medicaid spending on these populations. Conversely, children and their parents account for 71 percent of the "optional" populations but only 17 percent of Medicaid spending on these populations.

Figure 6

Medicaid Optional Enrollees and Their Expenditures, by Group, 2001



"Optional" Enrollees

Total = 13.8 million

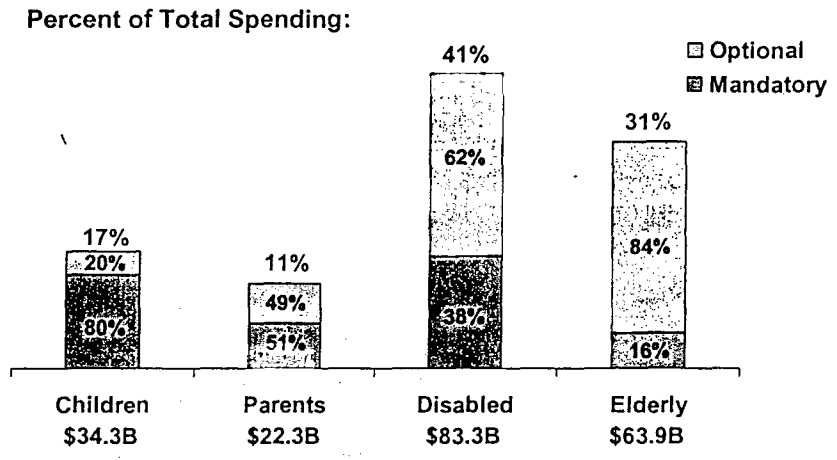
Expenditures for "Optional" Enrollees

Total = $86.5 billion

Although three fifths of total Medicaid spending is "optional," the share of spending that is "mandatory" or "optional" varies substantially across beneficiary groups (Figure 7).

Figure 7

Medicaid Expenditures by Eligibility Category and Type of Service



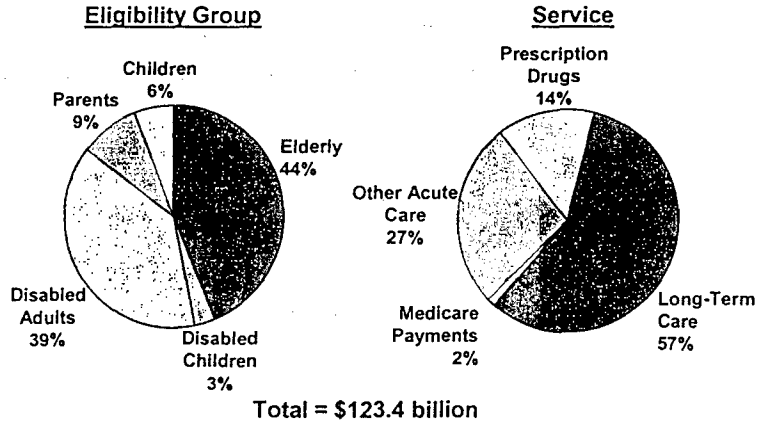
NOTE: Optional services for mandatory groups are counted as "optional" spending.

SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

For example, only 20 percent of spending on children is "optional," while 84 percent of spending on the elderly is "optional." Overall, the majority of "optional" spending is on persons with disabilities and elderly individuals needing nursing facility care. "Optional" spending is driven in large part by coverage of long-term care services for the elderly and persons with disabilities for nursing facility care, ICF/MR services, and home and community-based services. As a result of state decisions to cover these services, over half (57%) of total "optional" spending is for long-term care services (Figure 8).

Figure 8

Medicaid Optional Spending by Eligibility Group and Service, 2001



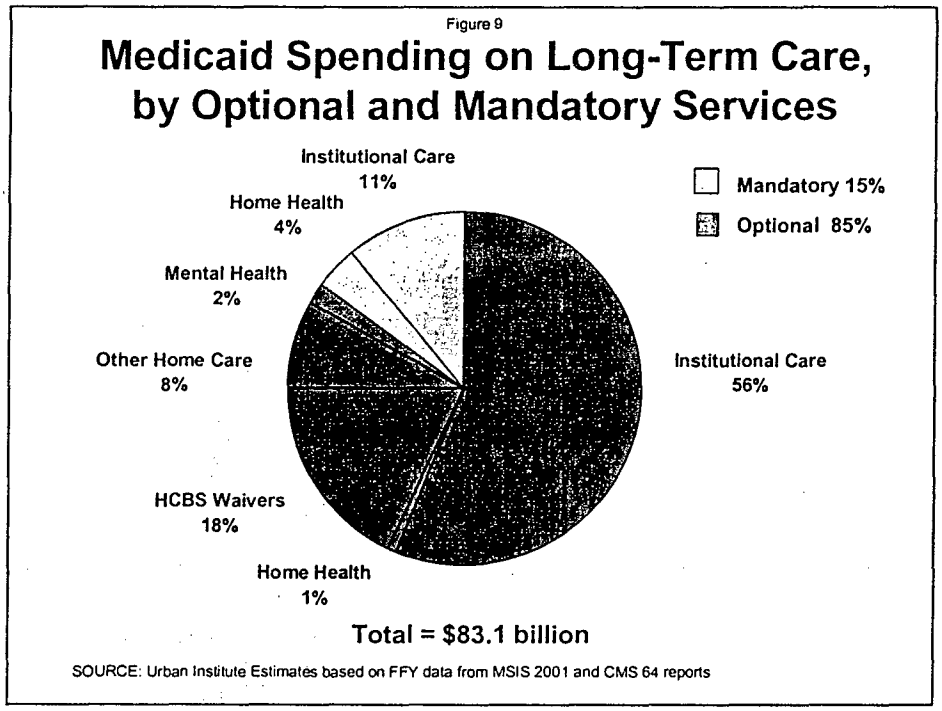
NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports

Coverage of prescription drugs is "optional" for all eligibility groups other than children (prescription drug coverage is required

under EPSDT). However, all states have chosen to include prescription drugs in their Medicaid benefits. Spending for prescription drugs comprised only 14 percent of all "optional" spending, with the majority of prescription drug spending (54%) for persons with disabilities.

Eighty-five percent of Medicaid spending on long-term care is "optional" (Figure 9). Two thirds of all "optional" long-term care spending is for institutional care. While 32 percent of "optional" spending is for home and community-based waiver services and other home care, only 4 percent of total long-term care spending is for "mandatory" home health services.



Conclusion

Although federal Medicaid law distinguishes between certain classes of eligible individuals and benefits as "mandatory" or "optional," these distinctions may not reflect the practical alternatives states face within today's policy environment. While fewer than 30% of Medicaid enrollees fall into "optional" categories, spending that occurs because of state's choices to cover "optional" services or "optional" populations makes up the majority (60.6%) of all Medicaid spending. Furthermore, the health delivery system in the past forty years has evolved toward greater continuity of care, care coordination, and away from institutionalized care, placing a greater relevance on a set of services currently considered "optional." Thus, the legal distinction of services by "mandatory" and "optional" classes imposed by federal statute may not provide a useful roadmap for distinguishing populations and services that are central to Medicaid's role.

This brief publication draws on Sommers, Ghosh, and Rousseau, *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories* (publication #7332), prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, June 2005.

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ISSUE PAPER

June 2005

Medicaid: An Overview of Spending on "Mandatory" vs. "Optional" Populations and Services

Medicaid is a federal-state program that provides health and long-term care services to 52 million low-income Americans. Federal Medicaid matching funds for the costs of these services are available to states that elect to participate in the program. As a condition of participation, states must cover certain populations (e.g., elderly poor receiving Supplemental Security Income) and certain services (e.g., hospital care). These are referred to as "mandatory" eligibility groups and "mandatory" services.

Participating states may also receive federal matching funds for the costs of covering other populations (e.g., elderly poor not eligible for SSI) and services (e.g., prescription drugs). These are known as "optional" eligibility groups and "optional" services. The use of the term "optional" is completely unrelated to whether a particular population or service is somehow less worthy or necessary than another. Instead, the term simply reflects whether, under federal Medicaid rules, a state may receive federal matching funds for the costs of covering a specific population group or service. Coverage of these "optional" eligibility groups and "optional" services is not required by federal law.

Medicaid reform discussions have often focused around giving states greater flexibility with respect to coverage of "optional" populations and services. To inform this debate, this issue brief provides an overview of Medicaid's optional beneficiaries and services. It draws on an analysis conducted for the Kaiser Commission on Medicaid and the Uninsured by the Urban Institute based on data collected by the Centers for Medicare and Medicaid Services (CMS). This work demonstrates that although "optional" populations account for only 29 percent of Medicaid enrollment, 60 percent of all Medicaid expenditures for both "mandatory" and "optional" populations are "optional," and the majority of these (86%) pay for services provided to the elderly and disabled. Some of the sickest and poorest Medicaid beneficiaries are considered "optional," and many "optional" benefits provided under Medicaid, such as prescription drugs, often are integral to appropriate care and functioning.

Medicaid Eligibility Groups

States that receive federal Medicaid matching funds must cover certain "mandatory" groups of beneficiaries (Figure 1). In general, Medicaid provides coverage of three basic groups of low-income Americans: children and parents, the elderly, and people

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Figure 1

Medicaid Beneficiary Groups

Mandatory Populations

- Children age 6 and older below 100% FPL ($15,670 a year for a family of 3)
- Children under age 6 below 133% FPL ($20,841 a year for a family of 3)
- Parents below state's AFDC cutoffs from July 1996 (median = 42% FPL)
- Pregnant women ≤133% FPL
- Elderly and disabled SSI beneficiaries with income ≤ 74% FPL ($6,768 a year for an individual).
- Certain working disabled
- Medicare Buy-In groups (QMB, SLMB, QI)

Optional Populations

- Low-income children above 100% FPL who are not mandatory by age (see column on left).
- Low-income parents with income above state's 1996 AFDC level.
- Pregnant women >133% FPL
- Disabled and elderly below 100% FPL ($9,310 a year for an individual), but above SSI level.
- Nursing home residents above SSI levels, but below 300% of SSI ($1,692 a month).
- Individuals at risk of needing nursing facility or ICF-MR care (under HCBS waiver)
- Certain working disabled (>SSI levels)
- Medically needy

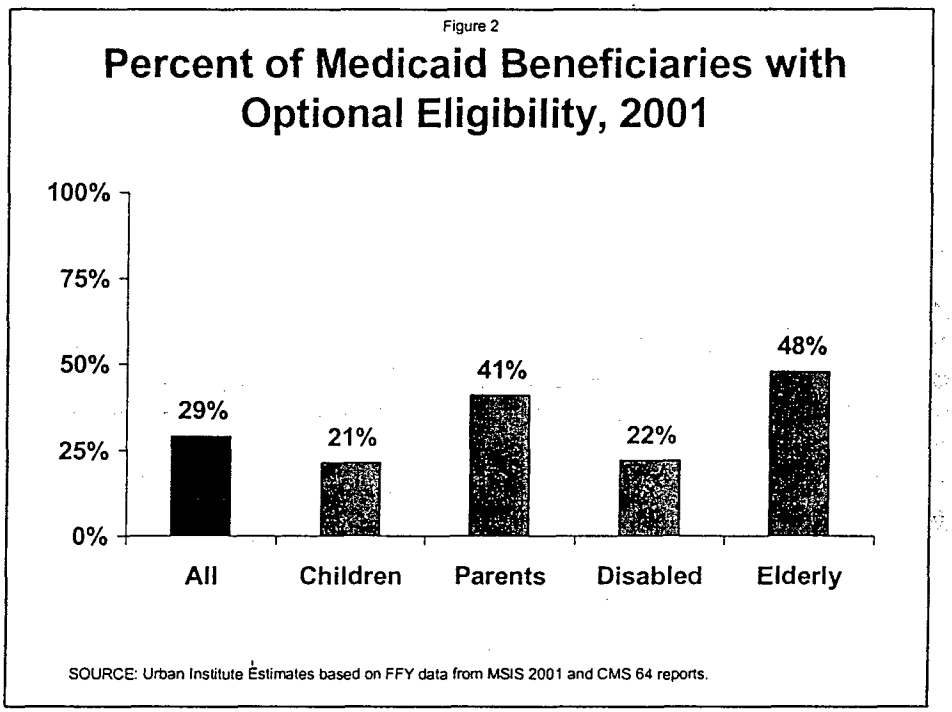
with disabilities. The designation of some groups as "mandatory" and others as "optional" is to a large extent an artifact of Medicaid's origins as a health care program for traditional welfare populations. These populations historically eligible for cash-assistance programs are "mandatory" under Medicaid law, while most populations not eligible for cash assistance were made eligible for the program through new laws enacted over the program's 40-year history. As new eligibility pathways were created, most were offered as an option each state could decide whether to adopt.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, commonly known as "welfare reform," severed the historical link between Medicaid and cash assistance and furthered the evolution of Medicaid into a health insurance and long-term care financing program rather than a welfare program. However, one of the many legacies of this link is the continued designation of populations with incomes below historical cash assistance income eligibility levels as "mandatory," while others are "optional." "Mandatory" populations include pregnant women and children under age 6 with family income below 133 percent of poverty ($21,400 a year for a family of 3 in 2005) and older children with family income below 100 percent of poverty ($16,090 a year for a family of 3 in 2005); most persons with disabilities and elderly people receiving assistance through the Supplemental Security Income (SSI) program ($7,082 a year for an individual in 2005); and parents with income and resources below states' welfare eligibility levels as of July 1996, often below 50% of the federal poverty line.

Beyond these federal minimums, states have substantial flexibility to cover additional "optional" population groups (Figure 1). "Optional" eligibility categories include children and parents above mandatory coverage limits; persons with disabilities and the elderly up to 100 percent of poverty ($9,570 a year for an individual in 2005); persons residing

in nursing facilities with income less than 300 percent of SSI standards ($1,770 a month for an individual in 2005); and individuals who have high recurring health expenses that "spend-down" to a state's medically needy income limit.

Overall, 29 percent of Medicaid beneficiaries qualify on the basis of an "optional" eligibility group. The likelihood of qualifying for Medicaid on the basis of a "mandatory" or "optional" group varies substantially by group (Figure 2). Most children (79%) qualify on the basis of "mandatory" coverage, reflecting Congressional legislative changes that have raised the minimum income eligibility threshold above cash assistance levels. In contrast, nearly half (48%) of the elderly qualify through "optional" eligibility groups, reflecting state decisions to extend coverage to nursing home residents and the medically needy population who have incomes above SSI eligibility levels.



Many individuals who qualify as an "optional" beneficiary are poor and have extensive health and long-term care needs, especially the elderly and persons with disabilities. "Optional" coverage allows states to provide health insurance to children and their parents, low-income working parents who can not obtain health insurance in the workforce, and people with disabilities who are excluded from private coverage due to their disabilities. Without Medicaid, many of these individuals would not have health insurance.

The opportunity to obtain help from Medicaid after "spending down" income and resources due to health care expenses is particularly important to elderly individuals in nursing facilities and children and adults with disabilities who live in the community and incur high prescription drug, medical equipment, or other health care expenses.

Examples of "Optional" Beneficiaries

- An elderly nursing facility resident whose annual income ($7,184) is just above SSI standards (74% of poverty) but below 100% of poverty ($9,570 in 2005).
- A parent of two children who works full-time at a minimum wage level in a service sector job that does not provide health insurance coverage.
- A pregnant woman who has a part-time job, which does not offer health insurance, and earns more than $12,728/year (133% of poverty in 2005).
- A 68 year-old widow with multiple conditions, such as fibrosis of the lungs, rheumatoid arthritis, and high blood pressure, whose income ($8,400) is too high to qualify for SSI (74% of poverty or $7,082 in 2005) but qualifies for Medicaid home and community-based services, allowing her to remain in the community.
- A 7 year-old boy with autism living with his parents whose income is 110% of poverty ($17,699 in 2005) and qualifies through a home and community-based service waiver.
- A woman with disabilities who earns less than $23,925/year (250% of poverty in 2005), whose employer does not over coverage and needs Medicaid's coverage of physician services, personal care services, and prescription drugs.
- An 85-year old with Alzheimer's disease with a monthly income of $1,472 (less than 300% of SSI) qualifies for nursing facility care. She is allowed to keep $30 a month for personal needs, and the remainder of her income goes to the nursing facility to cover her medical and support needs.
- A 50 year-old man who has multiple sclerosis with recurring drug and physician costs that average $750/month "spends down" to Medicaid medically needy eligibility levels (median is 55% of poverty).

Medicaid Benefits

When extending coverage to a Medicaid beneficiary, states must provide physician services, hospital care, nursing facility care, and a range of other "mandatory" services, but they also can provide an array of "optional" services (Figures 3 & 4). Services offered at state option include prescription drugs and a broad range of disability-related services, such as, case management, rehabilitative services, personal care services, and home and community-based services. Many of these "optional" benefits provide important benefits for both Medicaid "mandatory" and "optional" beneficiaries and are particularly important for persons with disabilities and the elderly. These services

Figure 3

Medicaid Acute Care Benefits

"Mandatory" Items and Services	"Optional" Items and Services*
• Physicians services	• Prescription drugs
• Laboratory and x-ray services	• Medical care or remedial care furnished by other licensed practitioners
• Inpatient hospital services	• Rehabilitation and other therapies
• Outpatient hospital services	• Clinic services
• Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21	• Dental services, dentures
• Family planning and supplies	• Prosthetic devices, eyeglasses, durable medical equipment
• Federally-qualified health center (FQHC) services	• Primary care case management
• Rural health clinic services	• TB-related services
• Nurse midwife services	• Other specialist medical or remedial care
• Certified pediatric and family nurse practitioner services	

*These benefits are treated as mandatory for children under 21 through EPSDT in this analysis.

Figure 4

Medicaid Long-Term Care Benefits

"Mandatory" Items and Services	"Optional" Items and Services*
Institutional Services	
• Nursing facility (NF) services for individuals 21 or over	• Intermediate care facility services for the mentally retarded (ICF/MR)
	• Inpatient/nursing facility services for individuals 65 and over in an institution for mental diseases (IMD)
	• Inpatient psychiatric hospital services for individuals under age 21
Home & Community-Based Services	
• Home health care services (for individuals entitled to nursing facility care)	• Home- and community-based waiver services
	• Other home health care
	• Targeted case management
	• Respiratory care services for ventilator-dependent individuals
	• Personal care services
	• Hospice services
	• Services furnished under a PACE program

*These benefits are treated as mandatory for children under 21 through EPSDT in this analysis, with the exception of Home and Community-based waiver services

enable many persons with disabilities to remain in the community or recover from a serious illness or accident. Many of the "optional" services, such as case management, prosthetics, physical therapy, and hospice care are components of medically-appropriate care.

Examples of "Optional" Services

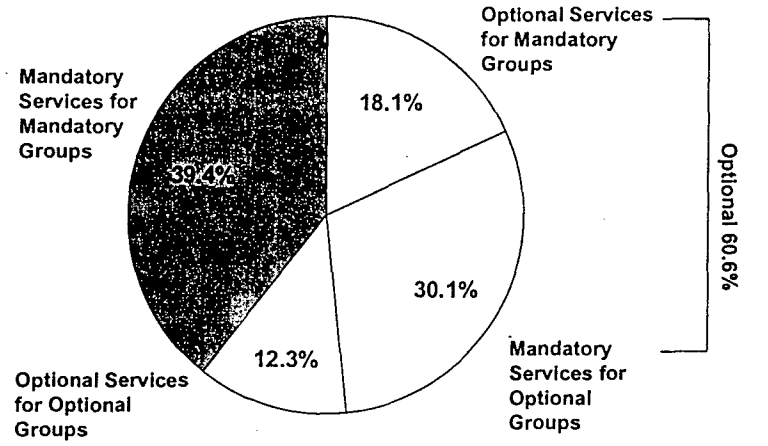
- A 22 year-old male with autism relies on the speech and occupational therapy and home based therapeutic services to learn basic life skills, such as how to dress, how to make his bed, and how to interact with other people.
- A 40 year-old woman with mental illness takes 4 prescription drugs a day to manage her bipolar disorder.
- A 32 year-old male with cerebral palsy relies on a personal care assistant who helps him bath, dress, eat, and essentially "have a normal life."
- A 51 year-old woman relies on Medicaid's prescription drug coverage for her twice daily dose of medications that include 10 different prescriptions to help manage her HIV disease.

Medicaid Spending on Optional Groups and Services

If a state decides to extend Medicaid coverage to an "optional" population, it must generally offer the same benefits package that it makes available to its "mandatory" populations. In every state, this benefits package includes both "mandatory" and "optional" services. Thus, the optional populations that a state includes in its Medicaid program will generally have coverage for both "mandatory" and "optional" services. As shown in Figure 5, sixty percent of total Medicaid spending is "optional." "Optional" populations account for about 42 percent of all Medicaid spending; of this spending, 70

Figure 5

Medicaid Expenditures by Eligibility Group and Type of Service, 2001



Total = $203.8 billion

Mandatory
Optional

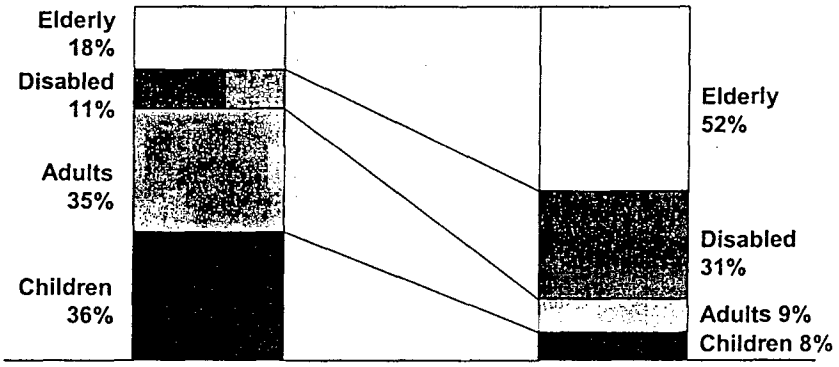
NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

percent is for "mandatory" services and 30 percent is for "optional" services. Spending is not evenly distributed among the "optional" populations. As shown in Figure 6, the elderly and disabled represent 29 percent of the "optional" populations but account for 83 percent of Medicaid spending on these populations. Conversely, children and their parents account for 71 percent of the "optional" populations but only 17 percent of Medicaid spending on these populations.

Figure 6

Medicaid Optional Enrollees and Their Expenditures, by Group, 2001



"Optional" Enrollees

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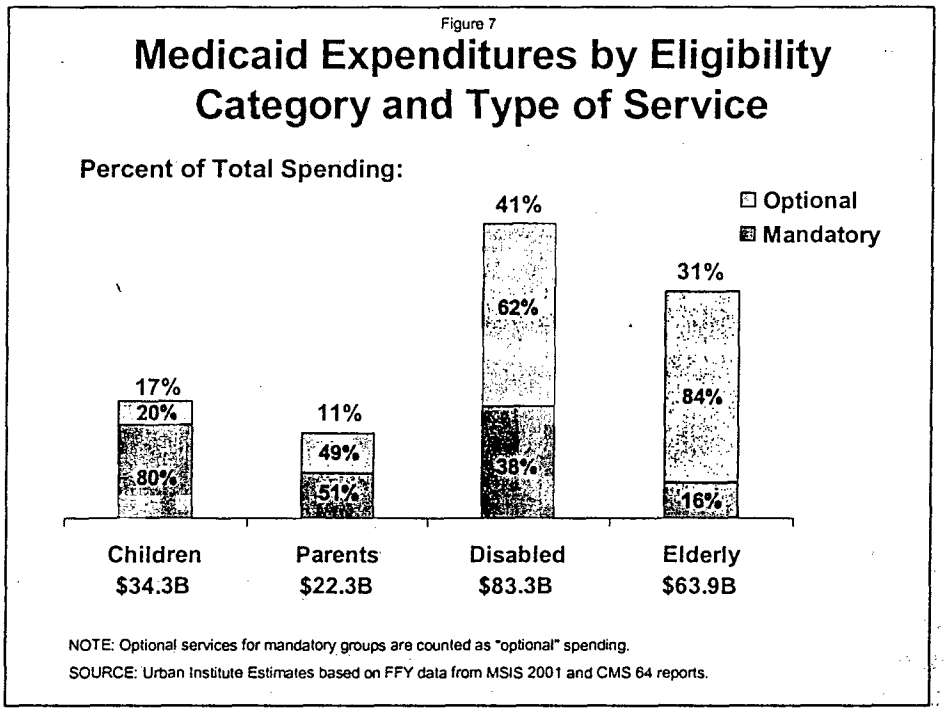
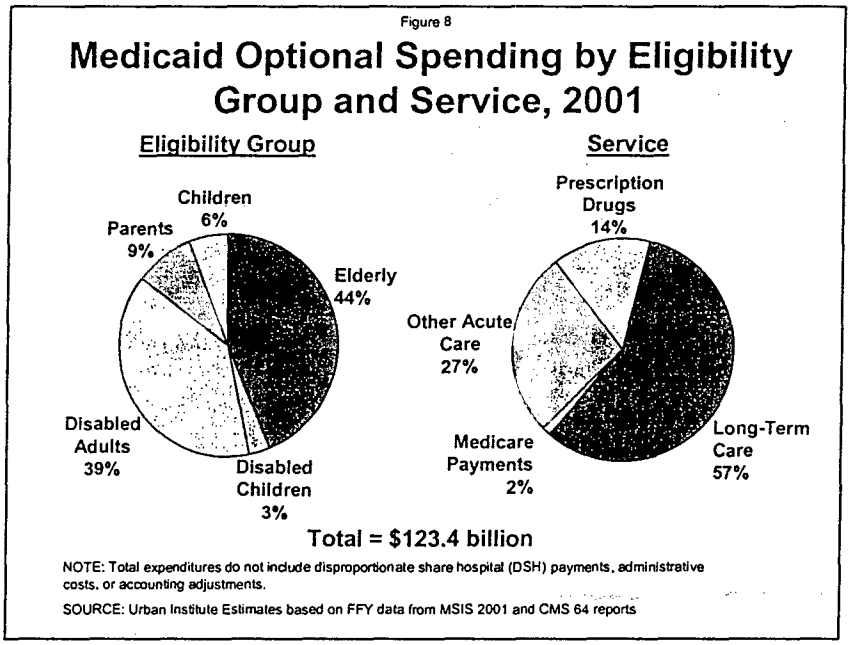
Expenditures for "Optional" Enrollees

Total = $86.5 billion

Although three fifths of total Medicaid spending is "optional," the share of spending that is "mandatory" or "optional" varies substantially across beneficiary groups (Figure 7).



For example, only 20 percent of spending on children is "optional," while 84 percent of spending on the elderly is "optional." Overall, the majority of "optional" spending is on persons with disabilities and elderly individuals needing nursing facility care. "Optional" spending is driven in large part by coverage of long-term care services for the elderly and persons with disabilities for nursing facility care, ICF/MR services, and home and community-based services. As a result of state decisions to cover these services, over half (57%) of total "optional" spending is for long-term care services (Figure 8).



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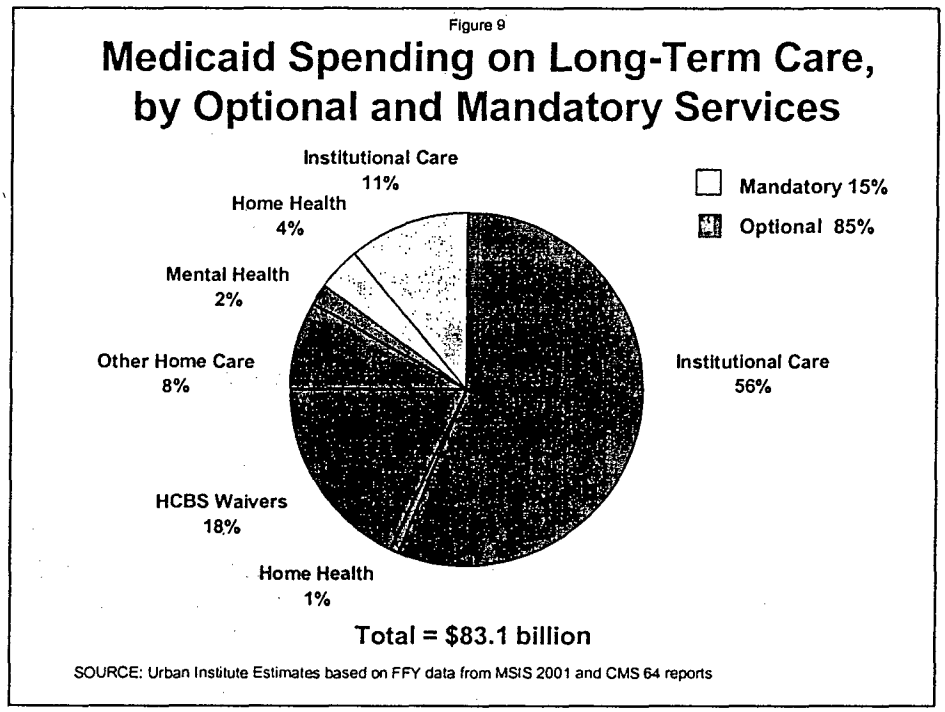

Conclusion

Although federal Medicaid law distinguishes between certain classes of eligible individuals and benefits as "mandatory" or "optional," these distinctions may not reflect the practical alternatives states face within today's policy environment. While fewer than 30% of Medicaid enrollees fall into "optional" categories, spending that occurs because of state's choices to cover "optional" services or "optional" populations makes up the majority (60.6%) of all Medicaid spending. Furthermore, the health delivery system in the past forty years has evolved toward greater continuity of care, care coordination, and away from institutionalized care, placing a greater relevance on a set of services currently considered "optional." Thus, the legal distinction of services by "mandatory" and "optional" classes imposed by federal statute may not provide a useful roadmap for distinguishing populations and services that are central to Medicaid's role.

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AARP Global Commitment Testimony
Health Access Oversight Committee
September 27, 2005

I am Veronica Celani, human services consultant, representing AARP of Vermont. I am pleased to have the opportunity to testify on behalf of AARP's 118,000 Vermont members regarding the terms and conditions being offered by the Centers for Medicare and Medicaid Services (CMS) to Vermont for its Global Commitment to Health demonstration proposal. If Vermont chooses to embark on this journey and assumes total risk for future Medicaid expenditures above a predetermined federal cap over the next five years, it will be laying the blueprint for the most momentous change in the Medicaid program since its inception. This waiver gives the federal government the wherewithal to proceed with recasting the long established contract for shared risk between the states and itself for unanticipated Medicaid expenditures due to higher than projected health care expenditures or enrollment

The Global commitment waiver would fundamentally alter Vermont's Medicaid program where now the federal government pays close to 60% of Vermont's Medicaid costs to one where the federal funding would be capped over the five year period from October 1, 2005 to September 30, 2010. Vermont would be the first state to accept a Medicaid block grant to limit the federal government's responsibility towards the health care needs of this country's most vulnerable populations.

Such a fundamental decision deserves careful consideration and a careful weighing of risks versus benefits. AARP is concerned about any hasty agreement to the Terms and Conditions without attempting to negotiate more assurances of relief (such as the state initially proposed) as well as obtaining a clearer understanding of what would happen if changes were made to Medicaid or Medicare that would impact on the state financially. AARP has observed other states' waivers where federal funding appears adequate at the time the waiver is negotiated but is insufficient in subsequent years. Tennessee's Tenncare Medicaid funded program experienced unanticipated growth rates forcing the state to remove about 230,000 people, about 20 percent, from its Medicaid rolls.

Vermont's Medicaid program is in the forefront of the nation, reported to have reduced the number of uninsured low income Vermonters to 13.7 percent. For children that rate was 5.2 percent, again the lowest in the nation. The question is whether this waiver will provide sufficient federal funds to permit Vermont to continue its programs to cover the health care needs of its most vulnerable populations and not compromise future efforts at health care reform. In order to minimize the risks involved and attempt to deal with the uncertainties that increase into the out years, Vermont needs to obtain the best possible terms and conditions for its waiver.

From the federal government's point of view, this demonstration is intended to provide it with de facto evidence of the viability of block grants in order to cap federal financial responsibility for a program that continues to grow. Such a substantial "gift" deserves to be reciprocated by reasonable concessions to Vermont's requests to alleviate some of the unacceptable risks inherent in block grants. Vermont had asked CMS to provide fiscal relief in the event of an epidemic, catastrophe or major and prolonged economic downturn. This was not granted and Number 50 in the Terms and Conditions explicitly states that, "Vermont shall be at risk for changing economic conditions that impact enrollment levels." For example, the federal Medicaid response to hurricane Katrina victims' acute need for health care is that states accepting evacuees should request a Medicaid waiver instead of relying on CMS to provide automatic Medicaid eligibility. Unfortunately this response does not raise confidence in fair or timely treatment.

If indeed Vermont will get more federal money under this proposal than is currently projected then it could receive support. However, it is difficult to understand how this squares with the requirement for federal budget neutrality that is a condition of all Section 1115 waivers. Furthermore, if any cuts are to be made AARP recognizes that there is more flexibility under this waiver. Assuming that the most vulnerable are protected, this gives the state greater decision-making power than currently if it is less hampered by some of the more arcane federal rules and regulations. Nevertheless this also assumes that no unanticipated events will occur and the terms and conditions are inadequate in this regard. There needs to be more federal assistance in the event of termination of the waiver prior to the end of the fifth year. AARP does not underestimate the major changes that would accompany the implementation of this waiver nor the costs of undoing it.

AARP has done an analysis of the Terms and Conditions and can provide some observations and suggestions which might help the committee in its

deliberations. The basic question is whether this waiver is good for Vermont and its people. Since the document provides little fiscal information, AARP is relying on assurances from the administration that the federal funds promised under the waiver will exceed what Vermont projects its federal funding would be under the current system.

It is our understanding the waiver would allow Vermont to reduce its projected five-year $439 million Medicaid deficit by approximately $135 to $165 million. Most optimistically, this reduction would still leave a $274 million deficit that would have to be addressed by cuts in benefits, eligibility, provider reimbursements or with additional funding. This also assumes that there will be no recessions or catastrophes over the next five years nor will the poverty populations grow, nor will the cost of services increase beyond a modest amount.

The Global Commitment makes an assumption that health care costs will be reduced by reconfiguring eligibility and cost sharing requirements, redefining coverage and forming private public partnerships for treating chronic and debilitating conditions. AARP is concerned that higher premiums and co-payments will ultimately increase the number of uninsured and prevent access to needed care. AARP urges great caution in consideration of increasing co-payments and imposing additional premiums.

Kaiser's "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences" (May 2005) study documented the problems that have arisen in states that have taken these approaches. The Kaiser study found that new or increased premiums made Medicaid unaffordable and substantially increased the number of uninsured individuals. In OR, a $6-20 Medicaid premium caused 49% of the covered population to leave the program. In the first three months following the program changes, emergency room use by uninsured patients increased by 17%. In RI, a $43-$58 monthly premium resulted in an 18% disenrollment rate during the first 3 months. Increased co-payments resulted in unmet medical care needs. In OR, 39% did not obtain needed medical care after co-payments ($3 to $250) were imposed. Inability to fill prescriptions was a particular problem. In 2004 these co-payments were eliminated.

The Kaiser study concluded:

- Cost sharing led to unmet medical need and financial stress, even when amounts were nominal or modest.
- Coverage losses and affordability problems stemming from increased out-of-pocket costs led to increased pressures on providers and the health care safety-net.

□ Increases in beneficiary costs may have created savings for states, but they may accrue more from reduced coverage and utilization rather than increased revenue.

To put a Vermont face on the burden of health care cost sharing, the increasing costs of heating fuel this season as well as at the gas pump will force fixed and low income Vermonter's to struggle with which bills they will pay first and what they will do without. Going to the doctor may take a back seat to paying the electric bill.

Under the Global Commitment the Office of Vermont Health Access (OVHA) will become a managed care organization (MCO) that will enroll eligible individuals and manage a premium with contractual arrangements with providers of services and other parts of the Agency of Human Services that now receive Medicaid funds. It is anticipated that this new organizational structure will generate savings that can be used to fund programs that are not currently matchable. A lack of MCO experience on the part of OVHA and specifics on how this will be achieved creates skepticism and distrust about the effects this waiver will have on individuals who are currently covered or would be covered under the present Medicaid program. Furthermore, historically MCOs have been unable to achieve more than one time savings and Vermont's Medicaid experience with MCOs ended in failure, raising questions about relying on the MCO model to achieve savings.

Ultimately it will be the administration and legislature that will determine the design of the program within the dollars they are willing to spend. The legislature can also enact legislation that provides guidelines defining covered benefits and populations providing a framework for future decisions. Without clear indication that there will be some protections for eligible individuals under the current system, AARP is hard pressed to support this waiver demonstration.

AARP also questions how this waiver will fit into future healthcare initiatives being explored by the legislature. While that is generally unanswerable until proposals emerge, however one can anticipate that employer contributions would most likely be considered. To the extant that those employer contributions are not matchable with federal funds presents a problem. Under the Global Commitment it is a problem because the federal dollars are capped. Absent the Global Commitment employer contributions might be matchable as an amendment to the current VHAP waiver to help cover more uninsured or underinsured individuals as part of Vermont's health care reform initiative. It is suggested that the state negotiate with CMS to include employer contributions as the state share

to be matched for proposals to cover the employed uninsured or under-insured population.

Vermont needs an opportunity to opt out of the waiver without assuming yet more substantial burdens. In the Terms and Conditions document Number 10. **Demonstration Phase Out** mentions "emergent circumstances" but gives no examples. There are no funds provided for anything but "normal closeout costs," which are undefined. The costs of "emergent circumstances" such as the hurricane Katrina example should be covered outside of the waiver cap along with the costs of returning to the current system.

Some other parts of the Terms and Conditions raise a red flag. Currently the state uses a variety of state matching funds, some from provider taxes, as well as foundation and nonprofit and governmental organization funds. The waiver permits CMS to revisit the legality of any of these funds that are in the FY2004 budget and disallow them even though they have been previously approved (See number 46 and 48).

Number 40 appears to disallow any federal funds in the capped budget for the current pharmacy waiver. In essence it appears from the Terms and Conditions that Vermont cannot fold the federal share of the pharmacy waiver into the federal share of the global budget.

The Waiver List number 6 proposes that family income and resources may be used to determine eligibility. Does that include income of parents of children with developmental disabilities? If so what will happen to those children? How will they get coverage when private insurance is unavailable or unaffordable?

Number 8 restricts plan participants to providers within a plan. Hopefully there can be exceptions when it is clear that the providers in the plan are not able to provide the care that is needed.

Under the Waiver List "**Costs not Otherwise Matchable**" there should be a number 6 "Emergency medical care for individuals impacted by catastrophic events."

Recommendations:

AARP hopes that the Health Care Oversight Committee conditions its approval by the following actions:

Request that the administration return to the negotiating table with CMS to obtain the changes to the Terms and Conditions that will provide the state with the protections outlined above.

Request that the administration give an outline of the eligibility and benefit changes it intends to make in order to achieve savings.

Request the administration to answer how consumers can appeal a decision or receive relief with a state operated MCO if they are denied care or otherwise ill treated.

Request the administration to explain how OVHA will obtain the expertise needed to become a MCO and how it intends to utilize the actuarially determined premium to achieve savings.

Request the administration to explain which savings initiatives, such as the chronic care partnership could be implemented without a Section 1115 waiver. In the event a waiver is needed, there are less comprehensive waivers available.

Request a five year waiver budget projection broken down by populations covered and by services to be provided.

Request the administration to provide all stakeholders with the actuarial recommendations on the Global Commitment and the breakdown of the components of the premium that the actuary develops.

AARP appreciates this opportunity to provide input to this difficult decision making process. We stand ready to provide assistance to the Committee should it so desire.

Kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

June 2005

Medicaid: An Overview of Spending on "Mandatory" vs. "Optional" Populations and Services

Medicaid is a federal-state program that provides health and long-term care services to 52 million low-income Americans. Federal Medicaid matching funds for the costs of these services are available to states that elect to participate in the program. As a condition of participation, states must cover certain populations (e.g., elderly poor receiving Supplemental Security Income) and certain services (e.g., hospital care). These are referred to as "mandatory" eligibility groups and "mandatory" services.

Participating states may also receive federal matching funds for the costs of covering other populations (e.g., elderly poor not eligible for SSI) and services (e.g., prescription drugs). These are known as "optional" eligibility groups and "optional" services. The use of the term "optional" is completely unrelated to whether a particular population or service is somehow less worthy or necessary than another. Instead, the term simply reflects whether, under federal Medicaid rules, a state may receive federal matching funds for the costs of covering a specific population group or service. Coverage of these "optional" eligibility groups and "optional" services is not required by federal law.

Medicaid reform discussions have often focused around giving states greater flexibility with respect to coverage of "optional" populations and services. To inform this debate, this issue brief provides an overview of Medicaid's optional beneficiaries and services. It draws on an analysis conducted for the Kaiser Commission on Medicaid and the Uninsured by the Urban Institute based on data collected by the Centers for Medicare and Medicaid Services (CMS). This work demonstrates that although "optional" populations account for only 29 percent of Medicaid enrollment, 60 percent of all Medicaid expenditures for both "mandatory" and "optional" populations are "optional," and the majority of these (86%) pay for services provided to the elderly and disabled. Some of the sickest and poorest Medicaid beneficiaries are considered "optional," and many "optional" benefits provided under Medicaid, such as prescription drugs, often are integral to appropriate care and functioning.

Medicaid Eligibility Groups

States that receive federal Medicaid matching funds must cover certain "mandatory" groups of beneficiaries (Figure 1). In general, Medicaid provides coverage of three basic groups of low-income Americans: children and parents, the elderly, and people

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Figure 1

Medicaid Beneficiary Groups

Mandatory Populations

- Children age 6 and older below 100% FPL ($15,670 a year for a family of 3)
- Children under age 6 below 133% FPL ($20,841 a year for a family of 3)
- Parents below state's AFDC cutoffs from July 1996 (median = 42% FPL)
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- Certain working disabled
- Medicare Buy-In groups (QMB, SLMB, QI)

Optional Populations

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- Low-income parents with income above state's 1996 AFDC level.
- Pregnant women >133% FPL
- Disabled and elderly below 100% FPL ($9,310 a year for an individual), but above SSI level.
- Nursing home residents above SSI levels, but below 300% of SSI ($1,692 a month).
- Individuals at risk of needing nursing facility or ICF-MR care (under HCBS waiver)
- Certain working disabled (>SSI levels)
- Medically needy

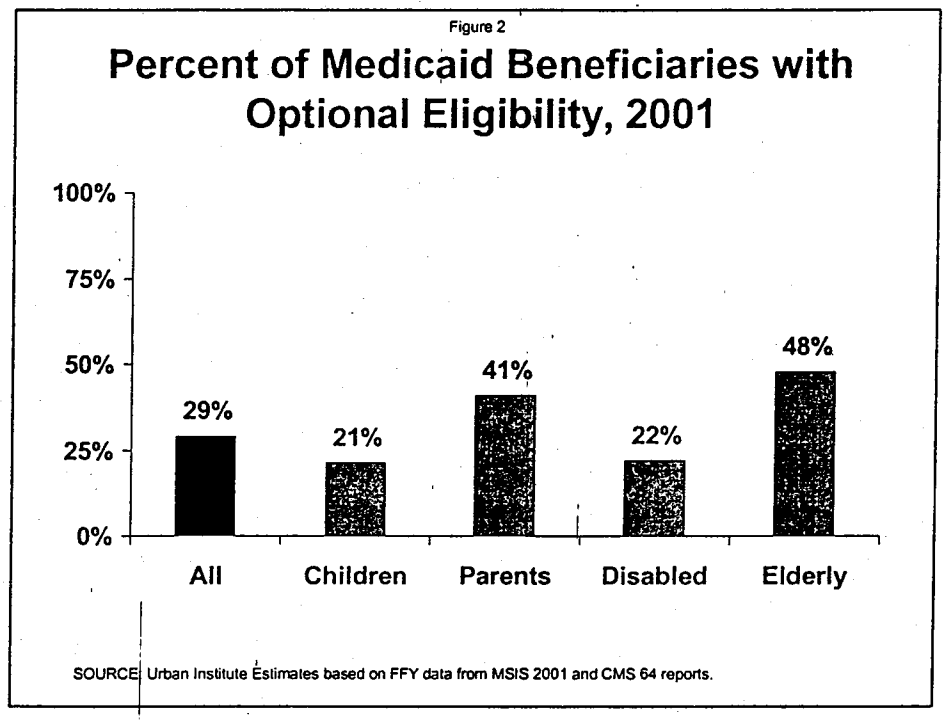
with disabilities. The designation of some groups as "mandatory" and others as "optional" is to a large extent an artifact of Medicaid's origins as a health care program for traditional welfare populations. These populations historically eligible for cash-assistance programs are "mandatory" under Medicaid law, while most populations not eligible for cash assistance were made eligible for the program through new laws enacted over the program's 40-year history. As new eligibility pathways were created, most were offered as an option each state could decide whether to adopt.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, commonly known as "welfare reform," severed the historical link between Medicaid and cash assistance and furthered the evolution of Medicaid into a health insurance and long-term care financing program rather than a welfare program. However, one of the many legacies of this link is the continued designation of populations with incomes below historical cash assistance income eligibility levels as "mandatory," while others are "optional." "Mandatory" populations include pregnant women and children under age 6 with family income below 133 percent of poverty ($21,400 a year for a family of 3 in 2005) and older children with family income below 100 percent of poverty ($16,090 a year for a family of 3 in 2005); most persons with disabilities and elderly people receiving assistance through the Supplemental Security Income (SSI) program ($7,082 a year for an individual in 2005); and parents with income and resources below states' welfare eligibility levels as of July 1996, often below 50% of the federal poverty line.

Beyond these federal minimums, states have substantial flexibility to cover additional "optional" population groups (Figure 1). "Optional" eligibility categories include children and parents above mandatory coverage limits; persons with disabilities and the elderly up to 100 percent of poverty ($9,570 a year for an individual in 2005); persons residing

in nursing facilities with income less than 300 percent of SSI standards ($1,770 a month for an individual in 2005); and individuals who have high recurring health expenses that "spend-down" to a state's medically needy income limit.

Overall, 29 percent of Medicaid beneficiaries qualify on the basis of an "optional" eligibility group. The likelihood of qualifying for Medicaid on the basis of a "mandatory" or "optional" group varies substantially by group (Figure 2). Most children (79%) qualify on the basis of "mandatory" coverage, reflecting Congressional legislative changes that have raised the minimum income eligibility threshold above cash assistance levels. In contrast, nearly half (48%) of the elderly qualify through "optional" eligibility groups, reflecting state decisions to extend coverage to nursing home residents and the medically needy population who have incomes above SSI eligibility levels.



Many individuals who qualify as an "optional" beneficiary are poor and have extensive health and long-term care needs, especially the elderly and persons with disabilities. "Optional" coverage allows states to provide health insurance to children and their parents, low-income working parents who can not obtain health insurance in the workforce, and people with disabilities who are excluded from private coverage due to their disabilities. Without Medicaid, many of these individuals would not have health insurance.

The opportunity to obtain help from Medicaid after "spending down" income and resources due to health care expenses is particularly important to elderly individuals in nursing facilities and children and adults with disabilities who live in the community and incur high prescription drug, medical equipment, or other health care expenses.

Examples of "Optional" Beneficiaries

- An elderly nursing facility resident whose annual income ($7,184) is just above SSI standards (74% of poverty) but below 100% of poverty ($9,570 in 2005).
- A parent of two children who works full-time at a minimum wage level in a service sector job that does not provide health insurance coverage.
- A pregnant woman who has a part-time job, which does not offer health insurance, and earns more than $12,728/year (133% of poverty in 2005).
- A 68 year-old widow with multiple conditions, such as fibrosis of the lungs, rheumatoid arthritis, and high blood pressure, whose income ($8,400) is too high to qualify for SSI (74% of poverty or $7,082 in 2005) but qualifies for Medicaid home and community-based services, allowing her to remain in the community.
- A 7 year-old boy with autism living with his parents whose income is 110% of poverty ($17,699 in 2005) and qualifies through a home and community-based service waiver.
- A woman with disabilities who earns less than $23,925/year (250% of poverty in 2005), whose employer does not over coverage and needs Medicaid's coverage of physician services, personal care services, and prescription drugs.
- An 85-year old with Alzheimer's disease with a monthly income of $1,472 (less than 300% of SSI) qualifies for nursing facility care. She is allowed to keep $30 a month for personal needs, and the remainder of her income goes to the nursing facility to cover her medical and support needs.
- A 50 year-old man who has multiple sclerosis with recurring drug and physician costs that average $750/month "spends down" to Medicaid medically needy eligibility levels (median is 55% of poverty).

Medicaid Benefits

When extending coverage to a Medicaid beneficiary, states must provide physician services, hospital care, nursing facility care, and a range of other "mandatory" services, but they also can provide an array of "optional" services (Figures 3 & 4). Services offered at state option include prescription drugs and a broad range of disability-related services, such as, case management, rehabilitative services, personal care services, and home and community-based services. Many of these "optional" benefits provide important benefits for both Medicaid "mandatory" and "optional" beneficiaries and are particularly important for persons with disabilities and the elderly. These services

Figure 3

Medicaid Acute Care Benefits

"Mandatory" Items and Services	"Optional" Items and Services*
• Physicians services	• Prescription drugs
• Laboratory and x-ray services	• Medical care or remedial care furnished by other licensed practitioners
• Inpatient hospital services	• Rehabilitation and other therapies
• Outpatient hospital services	• Clinic services
• Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21	• Dental services, dentures
• Family planning and supplies	• Prosthetic devices, eyeglasses, durable medical equipment
• Federally-qualified health center (FQHC) services	• Primary care case management
• Rural health clinic services	• TB-related services
• Nurse midwife services	• Other specialist medical or remedial care
• Certified pediatric and family nurse practitioner services	

*These benefits are treated as mandatory for children under 21 through EPSDT in this analysis.

Figure 4

Medicaid Long-Term Care Benefits

"Mandatory" Items and Services	"Optional" Items and Services*
Institutional Services	
• Nursing facility (NF) services for individuals 21 or over	• Intermediate care facility services for the mentally retarded (ICF/MR)
	• Inpatient/nursing facility services for individuals 65 and over in an institution for mental diseases (IMD)
	• Inpatient psychiatric hospital services for individuals under age 21
Home & Community-Based Services	
• Home health care services (for individuals entitled to nursing facility care)	• Home- and community-based waiver services
	• Other home health care
	• Targeted case management
	• Respiratory care services for ventilator-dependent individuals
	• Personal care services
	• Hospice services
	• Services furnished under a PACE program

*These benefits are treated as mandatory for children under 21 through EPSDT in this analysis, with the exception of Home and Community-based waiver services.

enable many persons with disabilities to remain in the community or recover from a serious illness or accident. Many of the "optional" services, such as case management, prosthetics, physical therapy, and hospice care are components of medically-appropriate care.

Examples of "Optional" Services

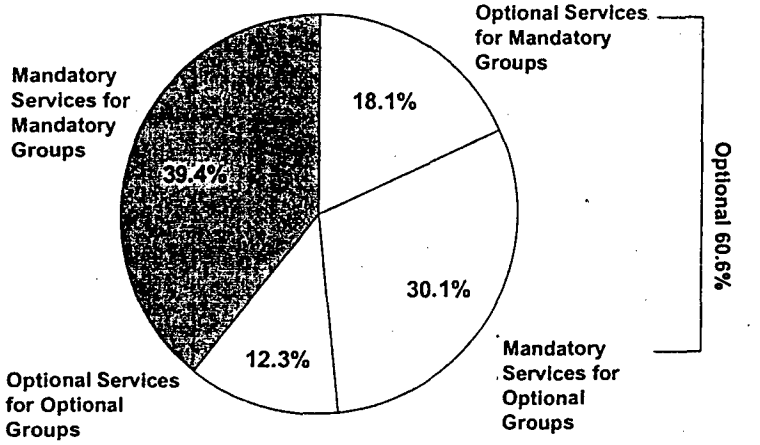
- A 22 year-old male with autism relies on the speech and occupational therapy and home based therapeutic services to learn basic life skills, such as how to dress, how to make his bed, and how to interact with other people.
- A 40 year-old woman with mental illness takes 4 prescription drugs a day to manage her bipolar disorder.
- A 32 year-old male with cerebral palsy relies on a personal care assistant who helps him bath, dress, eat, and essentially "have a normal life."
- A 51 year-old woman relies on Medicaid's prescription drug coverage for her twice daily dose of medications that include 10 different prescriptions to help manage her HIV disease.

Medicaid Spending on Optional Groups and Services

If a state decides to extend Medicaid coverage to an "optional" population, it must generally offer the same benefits package that it makes available to its "mandatory" populations. In every state, this benefits package includes both "mandatory" and "optional" services. Thus, the optional populations that a state includes in its Medicaid program will generally have coverage for both "mandatory" and "optional" services. As shown in Figure 5, sixty percent of total Medicaid spending is "optional." "Optional" populations account for about 42 percent of all Medicaid spending; of this spending, 70

Figure 5

Medicaid Expenditures by Eligibility Group and Type of Service, 2001



Total = $203.8 billion

Mandatory
Optional

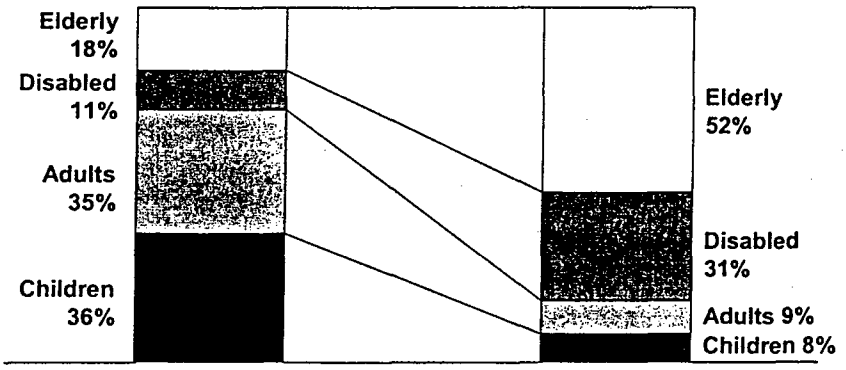
NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

percent is for "mandatory" services and 30 percent is for "optional" services. Spending is not evenly distributed among the "optional" populations. As shown in Figure 6, the elderly and disabled represent 29 percent of the "optional" populations but account for 83 percent of Medicaid spending on these populations. Conversely, children and their parents account for 71 percent of the "optional" populations but only 17 percent of Medicaid spending on these populations.

Figure 6

Medicaid Optional Enrollees and Their Expenditures, by Group, 2001



"Optional" Enrollees

Total = 13.8 million

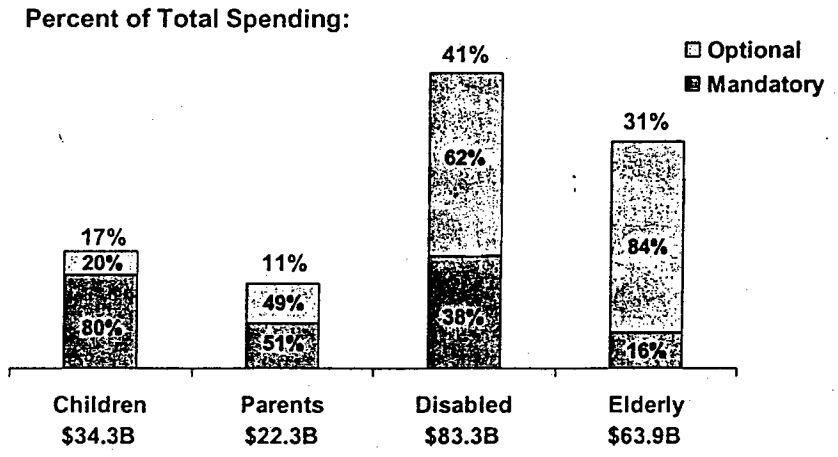
Expenditures for "Optional" Enrollees

Total = $86.5 billion

Although three fifths of total Medicaid spending is "optional," the share of spending that is "mandatory" or "optional" varies substantially across beneficiary groups (Figure 7).

Figure 7

Medicaid Expenditures by Eligibility Category and Type of Service



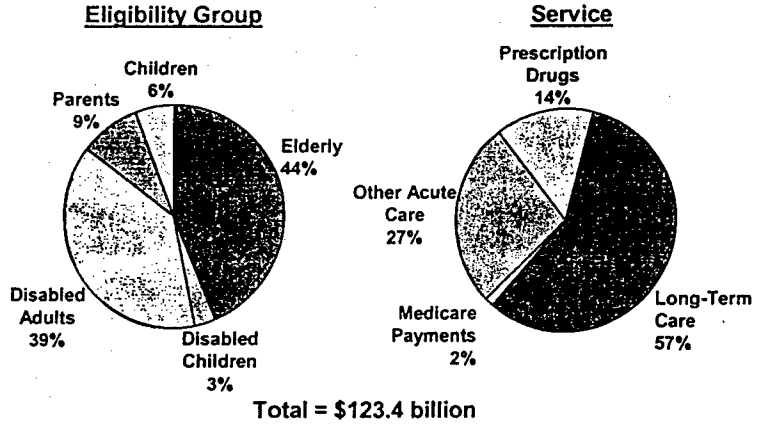
NOTE: Optional services for mandatory groups are counted as "optional" spending.

SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

For example, only 20 percent of spending on children is "optional," while 84 percent of spending on the elderly is "optional." Overall, the majority of "optional" spending is on persons with disabilities and elderly individuals needing nursing facility care. "Optional" spending is driven in large part by coverage of long-term care services for the elderly and persons with disabilities for nursing facility care, ICF/MR services, and home and community-based services. As a result of state decisions to cover these services, over half (57%) of total "optional" spending is for long-term care services (Figure 8).

Figure 8

Medicaid Optional Spending by Eligibility Group and Service, 2001



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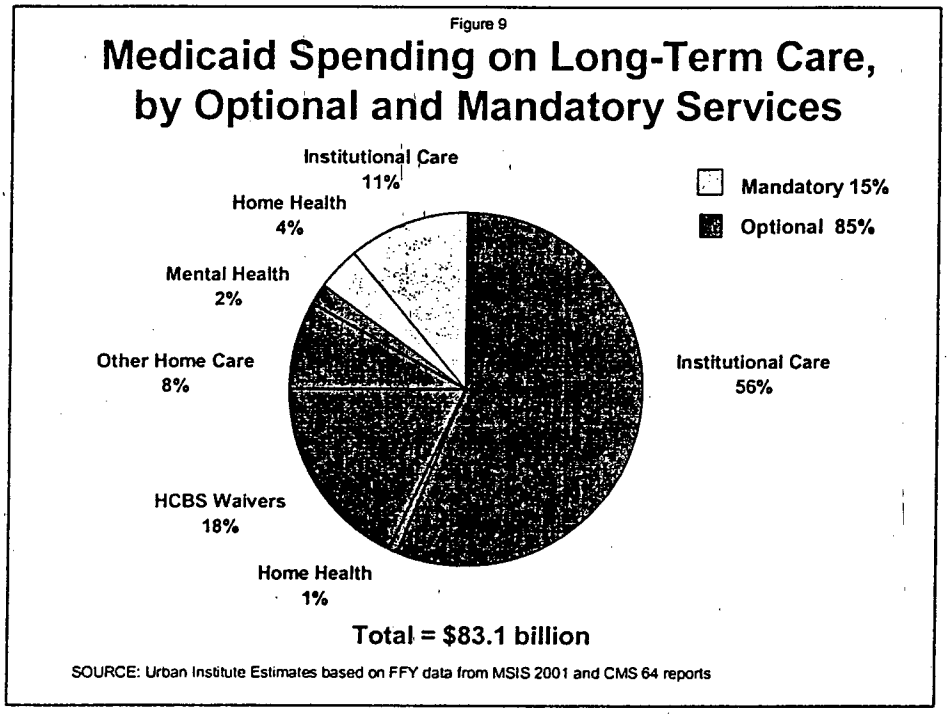
Coverage of prescription drugs is "optional" for all eligibility groups other than children (prescription drug coverage is required

under EPSDT). However, all states have chosen to include prescription drugs in their Medicaid benefits. Spending for prescription drugs comprised only 14 percent of all "optional" spending, with the majority of prescription drug spending (54%) for persons with disabilities.

Eighty-five percent of Medicaid spending on long-term care is "optional" (Figure 9). Two thirds of all "optional" long-term care spending is for institutional care. While 32 percent of "optional" spending is for home and community-based waiver services and other home care, only 4 percent of total long-term care spending is for "mandatory" home health services.



Conclusion

Although federal Medicaid law distinguishes between certain classes of eligible individuals and benefits as "mandatory" or "optional," these distinctions may not reflect the practical alternatives states face within today's policy environment. While fewer than 30% of Medicaid enrollees fall into "optional" categories, spending that occurs because of state's choices to cover "optional" services or "optional" populations makes up the majority (60.6%) of all Medicaid spending. Furthermore, the health delivery system in the past forty years has evolved toward greater continuity of care, care coordination, and away from institutionalized care, placing a greater relevance on a set of services currently considered "optional." Thus, the legal distinction of services by "mandatory" and "optional" classes imposed by federal statute may not provide a useful roadmap for distinguishing populations and services that are central to Medicaid's role.

This brief publication draws on Sommers, Ghosh, and Rousseau, *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories* (publication #7332), prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, June 2005.

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ISSUE PAPER

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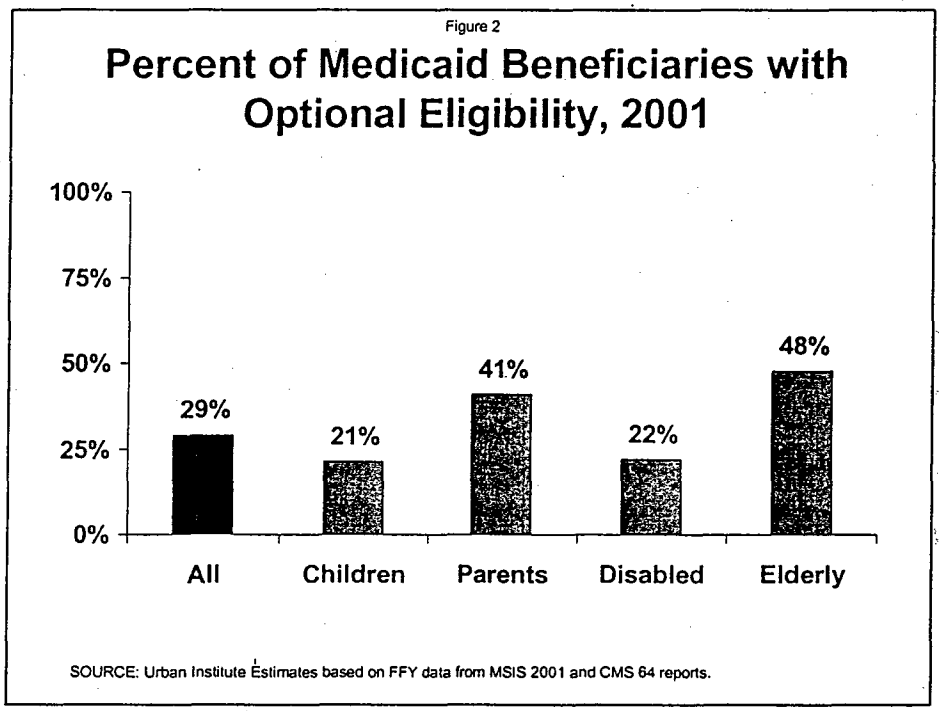

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• Federally-qualified health center (FQHC) services	• Primary care case management
• Rural health clinic services	• TB-related services
• Nurse midwife services	• Other specialist medical or remedial care
• Certified pediatric and family nurse practitioner services	

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Figure 4

Medicaid Long-Term Care Benefits

"Mandatory" Items and Services	"Optional" Items and Services*
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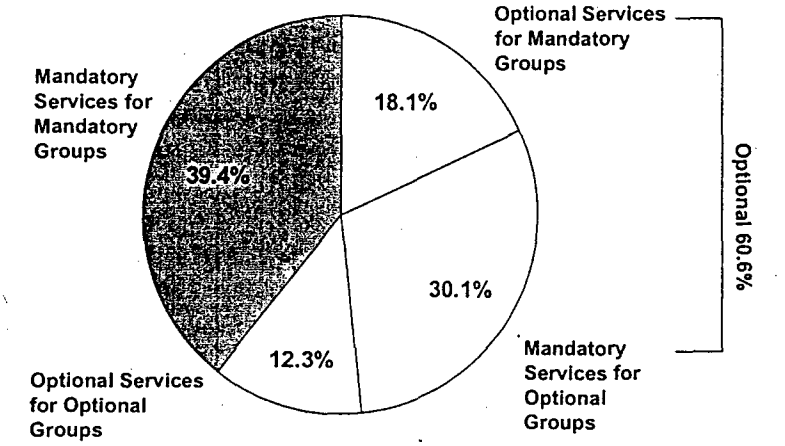
- A 40 year-old woman with mental illness takes 4 prescription drugs a day to manage her bipolar disorder.
- A 32 year-old male with cerebral palsy relies on a personal care assistant who helps him bath, dress, eat, and essentially "have a normal life."
- A 51 year-old woman relies on Medicaid's prescription drug coverage for her twice daily dose of medications that include 10 different prescriptions to help manage her HIV disease.

Medicaid Spending on Optional Groups and Services

If a state decides to extend Medicaid coverage to an "optional" population, it must generally offer the same benefits package that it makes available to its "mandatory" populations. In every state, this benefits package includes both "mandatory" and "optional" services. Thus, the optional populations that a state includes in its Medicaid program will generally have coverage for both "mandatory" and "optional" services. As shown in Figure 5, sixty percent of total Medicaid spending is "optional." "Optional" populations account for about 42 percent of all Medicaid spending; of this spending, 70

Figure 5

Medicaid Expenditures by Eligibility Group and Type of Service, 2001



Total = $203.8 billion

Mandatory
Optional

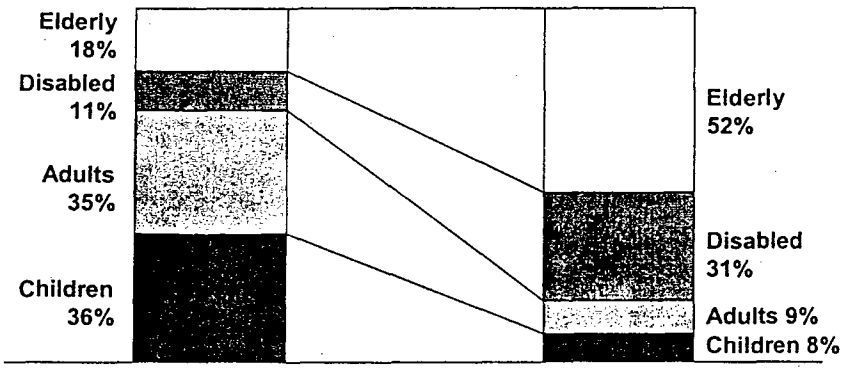
NOTE: Total expenditures do not include disproportionate share hospital (DSH) payments, administrative costs, or accounting adjustments.

SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports.

percent is for "mandatory" services and 30 percent is for "optional" services. Spending is not evenly distributed among the "optional" populations. As shown in Figure 6, the elderly and disabled represent 29 percent of the "optional" populations but account for 83 percent of Medicaid spending on these populations. Conversely, children and their parents account for 71 percent of the "optional" populations but only 17 percent of Medicaid spending on these populations.

Figure 6

Medicaid Optional Enrollees and Their Expenditures, by Group, 2001



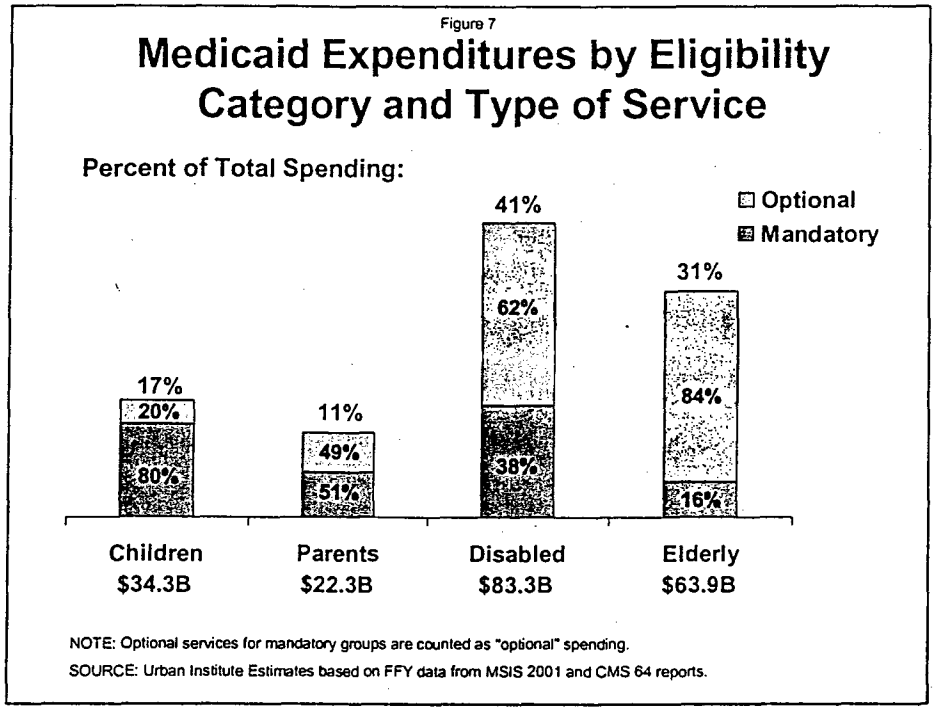
"Optional" Enrollees

Total = 13.8 million

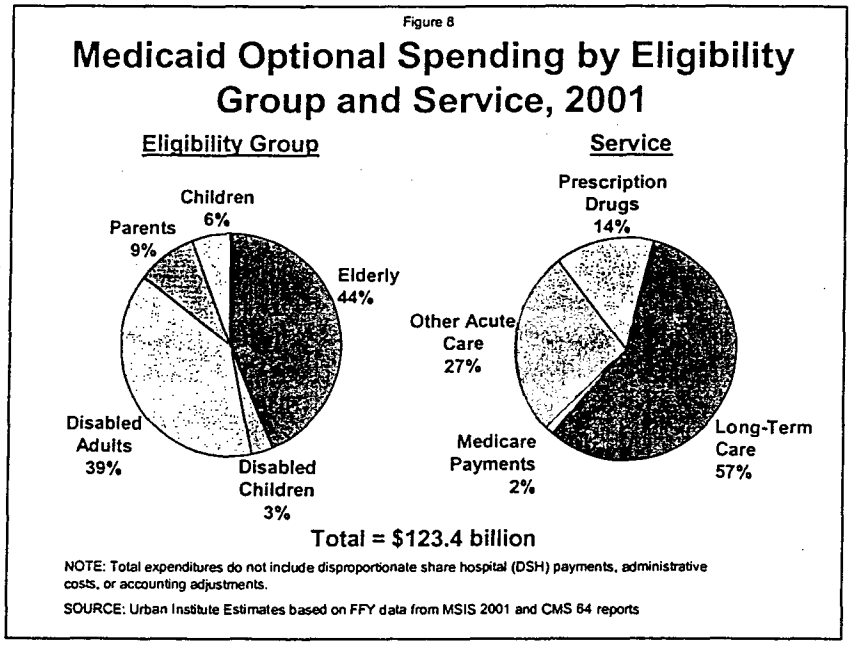
Expenditures for "Optional" Enrollees

Total = $86.5 billion

Although three fifths of total Medicaid spending is "optional," the share of spending that is "mandatory" or "optional" varies substantially across beneficiary groups (Figure 7).



For example, only 20 percent of spending on children is "optional," while 84 percent of spending on the elderly is "optional." Overall, the majority of "optional" spending is on persons with disabilities and elderly individuals needing nursing facility care. "Optional" spending is driven in large part by coverage of long-term care services for the elderly and persons with disabilities for nursing facility care, ICF/MR services, and home and community-based services. As a result of state decisions to cover these services, over half (57%) of total "optional" spending is for long-term care services (Figure 8).



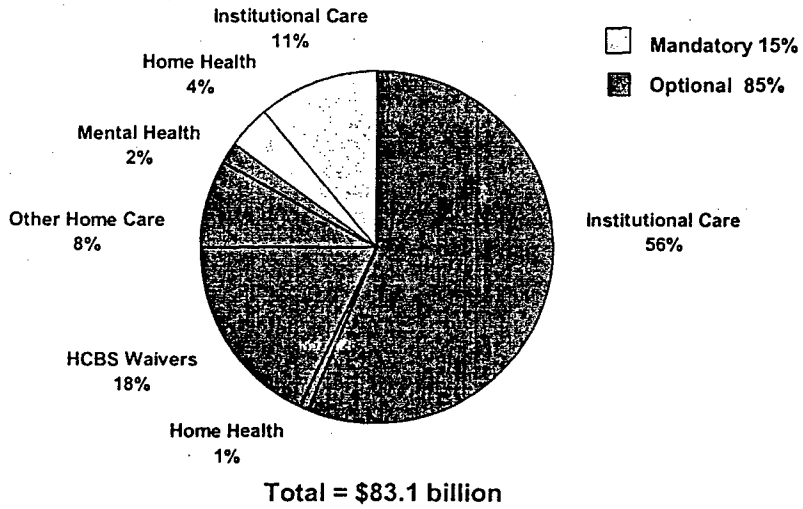
Coverage of prescription drugs is "optional" for all eligibility groups other than children (prescription drug coverage is required

under EPSDT). However, all states have chosen to include prescription drugs in their Medicaid benefits. Spending for prescription drugs comprised only 14 percent of all "optional" spending, with the majority of prescription drug spending (54%) for persons with disabilities.

Eighty-five percent of Medicaid spending on long-term care is "optional" (Figure 9). Two thirds of all "optional" long-term care spending is for institutional care. While 32 percent of "optional" spending is for home and community-based waiver services and other home care, only 4 percent of total long-term care spending is for "mandatory" home health services.

Figure 9

Medicaid Spending on Long-Term Care, by Optional and Mandatory Services



SOURCE: Urban Institute Estimates based on FFY data from MSIS 2001 and CMS 64 reports

Conclusion

Although federal Medicaid law distinguishes between certain classes of eligible individuals and benefits as "mandatory" or "optional," these distinctions may not reflect the practical alternatives states face within today's policy environment. While fewer than 30% of Medicaid enrollees fall into "optional" categories, spending that occurs because of state's choices to cover "optional" services or "optional" populations makes up the majority (60.6%) of all Medicaid spending. Furthermore, the health delivery system in the past forty years has evolved toward greater continuity of care, care coordination, and away from institutionalized care, placing a greater relevance on a set of services currently considered "optional." Thus, the legal distinction of services by "mandatory" and "optional" classes imposed by federal statute may not provide a useful roadmap for distinguishing populations and services that are central to Medicaid's role.

This brief publication draws on Sommers, Ghosh, and Rousseau, *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories* (publication #7332), prepared by the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, June 2005.

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THE HENRY J. KAISER FAMILY FOUNDATION

MINUTES

Joint Fiscal Committee
Meeting of September 28, 2005

Representative Martha Heath, Chair, called the meeting of the Joint Fiscal Committee to order at 10:05 a.m. in Room 11, State House.

Also present: Representatives Obuchowski, Perry, Severance and Westman
Senators Bartlett, Cummings, Sears, Snelling and Welch

Others attending the meeting included Joint Fiscal Office and Legislative Council staff; Administration officials; Theresa Sachs and Eileen Ellis from the firm of Health Management Associates; representatives of various advocacy groups; and the news media.

GLOBAL COMMITMENT MEDICAID WAIVER:

The purpose of the meeting was to consider the agreement negotiated by the State with the federal government to transform the current method of funding Vermont's Medicaid program to a system of federal participation, known as the Global Commitment Medicaid reform waiver. Act 71 of 2005 (fiscal year 2006 appropriations), Section 250(c) provided that, if the General Assembly is not in session, any such agreement is conditional upon a majority vote of the Joint Fiscal Committee, upon recommendation of the Health Access Oversight Committee.

At the outset of the meeting, Chairperson Heath outlined the process that she envisioned for this meeting and the one scheduled for Friday, September 30. Today's session she planned to devote to taking testimony from outside consultants and Committee and Administration staff and asking questions of those individuals; conferring via telephone with an actuary retained by the Administration to develop actuarial rates on which premium rates will be based; and further discussing the Global Commitment proposal presented at the September 15 meeting.

The Health Access Committee is to meet on Friday morning, September 30, followed by an afternoon meeting of this Committee at which time the Chair expected to consider the recommendation of the other committee and take formal action. She said that members unable to travel to Montpelier for what she anticipated would be a relatively short meeting could participate in Friday's discussion via telephone.

Members then heard testimony from Theresa Sachs and Eileen Ellis, principals with the firm Health Management Associates (HMA). That firm was retained by the Joint Fiscal Office, with the advance authorization of the Chair and Vice Chair of the Fiscal Committee, to provide an independent review of Global Commitment financial and programmatic documents. *[Note: Hard copies of the PowerPoint presentations from HMA were distributed at the meeting. They, along with numerous documents provided by the Administration and the Joint Fiscal Office as well as newspaper articles and written statements from several organizations which were collated by the staff into a "Global Commitment Materials Book," are on file in the Joint Fiscal Office.]*

A principal issue raised by the consultants and addressed intermittently during the discussion was that the Special Terms and Conditions (distributed to Committee members at their September 15 meeting) are the only documentation of the Global Commitment agreement between the Agency of Human Services (AHS) and the Centers for Medicare and Medicaid Services (CMS). In the absence of an operational protocol, Ms. Sachs and Ms. Ellis recommended that all understandings between the two parties should be in writing, such as a letter from AHS to CMS setting forth all agreements beyond the Special Terms and Conditions.

The fact that initial premiums have not been set was also a concern of the consultants, who recommended that these should be available before the waiver is approved and implemented. This subject was discussed periodically during the meeting, as reflected elsewhere in these minutes.

Members had an opportunity during and after Ms. Sachs' and Ms. Ellis' presentations to ask questions about their findings.

The Committee also heard from with Steve Kappel of the Joint Fiscal Office; Joshua Slen, Director of the Office of Vermont Health Access (OVHA); Susan Besio, Director of Planning, Agency of Human Services; and Scott Wittman from Pacific Health Policy Group. Mr. Wittman has been working for the Administration on financial modeling and has participated in its negotiations with the federal Centers for Medicare & Medicaid Services (CMS) on Global Commitment.

The Committee adjourned for lunch at 12:00 noon and reconvened at 1:05 p.m.

Susan Besio started off the afternoon portion of the meeting, describing process and timing aspects of Global Commitment. In response to the many questions posed by Committee members about the monetary consequences of postponing action until late in November or even the 2006 legislative session, she estimated the cost to the State for each week of delay beyond the planned October 1 start date would be between $500,000 and $1,000,000 a week.

Pointing out that Global Commitment represents negotiations between Vermont and CMS, and that the Joint Fiscal Committee is being asked essentially to approve those negotiations, Representative Obuchowski proposed that the State request a delay in the October 1 date.

On the question of Committee approval of the waiver pending establishment of premiums from the actuary, Ms. Besio and Mr. Slen gave assurance that interim rates would be set, basically based on FY 2006 budget assumptions, and then adjusted once the actuary produces rates. She also observed that implementation on a starting basis that does not coincide with the start of a fiscal quarter would entail extensive staff time in adjusting Federal and State reports.

Later in the meeting, the Chair received confirmation from Mr. Slen that if the final premium rates should be unacceptable, the State can terminate the waiver agreement.

Upon request of several members, Mr. Slen provided copies of CMS's letter of approval of the Global Commitment demonstration project. *[That letter is on file in the Joint Fiscal Office.]* He also agreed later to provide electronically to the Fiscal Office by the September 30 meeting the CMS letter agreeing to interim rates.

The Chair suggested that the Committee consider preliminary approval of the waiver contingent upon three conditions: (a) learning the amounts of the initial premiums and whether the staff and consultants consider them reasonable to accomplish the State's desired goals; (b) submission of a letter from AHS to CMS relating to understandings not explicitly covered in the Special Terms and Conditions which it approved; and (c) the opportunity for legislative clarification on the actuarial process and premiums.

In the course of the deliberations, Senator Snelling referred to a letter sent to Committee members from a prominent national organization representing children's interests, voicing strong concern over the Global Commitment proposal. The Senator expressed the hope that at some point the members will be provided with a statement that can be used as a response to such letters and to correct misinterpretations of the impact of the waiver.

Representative Obuchowski at the outset of the meeting had expressed concern over a press report that a "deal" had been brokered with the Administration over conditional approval of the Medicaid waiver. The implication was that the Joint Fiscal Committee already had established a position, contrary to the provision in Act 71 that the Committee vote shall follow a recommendation of the Health Access Oversight Committee. Senator Bartlett later responded to Representative Obuchowski concerns, describing her recent conversations with the Governor and senior Administration officials, and also with Joint Fiscal Office

staff, as seeking answers to questions. She made clear that no commitments were made on behalf of this Committee.

At 2:30 p.m. the Committee conversed via speaker telephone with William Finch from the Milliman consulting firm, which has been retained by the Administration to undertake the actuarial studies.

After providing a brief overview of what it means to set actuarial rates, Mr. Finch answered questions from the members on such wide-ranging topics as the firm's work for other states, its responsibilities to both Vermont and CMS in this endeavor, and details about elements that will be assessed in relationship to Global Commitment. He advised that his firm has just received most of the data required and needs sufficient time to analyze it. Replying to an inquiry, he said he did not expect a draft report to be ready within the next two weeks.

Upon conclusion of the conversation with Mr. Finch, the Committee resumed its deliberations, including receiving a presentation from Mr. Kappel of a summary analysis he had prepared on Global Commitment.

The Chair reiterated that there would be another meeting on this subject on Friday, September 30, at 2:00 p.m. That meeting will take place regardless of whether the Health Access Oversight Committee has a recommendation, although she did not think the Joint Fiscal Committee can take action if there is not a recommendation.

Chief Legislative Council William Russell then advised that, in his opinion, it can act on this matter without a recommendation from the other committee.

The Chair restated her view that approval of Global Commitment should be contingent upon CMS's approval in writing to understandings between it and the State not explicitly covered in the Special Terms and Conditions.

Representative Obuchowski was highly complimentary of the Chair for the manner in which she has guided the Committee through the process of consideration of Global Commitment. Senator Welch echoed this praise.

The meeting was adjourned at 3:35 p.m.

Respectfully submitted:

Virginia F. Catone

Virginia F. Catone
Joint Fiscal Office

COPY

Children's Defense Fund ®

September 27, 2005

The Honorable Susan Bartlett
Vermont State House
115 State Street
Montpelier, VT 05633

Dear Senator Bartlett:

I am writing to express the Children's Defense Fund's profound concern over the assault on Vermont's Medicaid program, a vital safety net for Vermont's most vulnerable children. Almost 12% of Vermont's children are living in poverty, and over 68,000 of its children rely upon the health coverage provided to them by the State's Medicaid program.

The action being considered by the Vermont legislature to create a "Global Commitment to Health" is directly contrary to Vermont's history as a model for the nation in providing generous health care coverage to those most in need. This legislation will in fact block grant the State's Medicaid funds and will ultimately severely restrict coverage and benefits to poor children and working families. Such legislation will have significant adverse effects on tens of thousands of Vermont's children and, potentially, on 6 to 25 million poor children throughout the United States if similar legislation is adopted in other states. At a time when 9 million American children are still without health coverage despite Medicaid and the State Children's Health Insurance Program (SCHIP), it is time for us to join together to extend coverage to every child – not go backwards.

Children are not the cause of Medicaid's escalating costs and are in fact its most cost effective enrollees. Per capita costs for children are the lowest among eligible Medicaid groups. Although children represent almost 44% of the enrollees in the State's Medicaid program, they represent only 31% of the costs of the program. While your concern about the rising costs of health care is valid and understandable, the national policy challenge of rising health care costs and an aging population is not an excuse for balancing budgets on the backs of poor children. Other solutions can be found that are morally and fiscally responsible. Hurting children is neither.

Block granting the Vermont Medicaid program for a short-term infusion of funds will jeopardize the health and health care for one in five Vermonters. Children, in particular, will likely face critical program changes that will seriously compromise access to health care services, such as reduced benefits, new premiums and co-payments, and changes in

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cdfinfo@childrensdefense.org
Internet
www.childrensdefense.org

eligibility that could result in waiting lists for the first time in the program's history. Although the Vermont legislature has stated its intention to maintain eligibility and benefits for beneficiaries, this will likely prove impossible as program costs continue to rise while federal funding increases shrink. The comprehensive and preventive benefits children receive under the Medicaid program, known as EPSDT (Early and Periodic Screening, Diagnostic, and Treatment), were created by Congress in response to clear evidence that disadvantaged children were suffering from disabling conditions that could have been reduced or completely eliminated with prevention and timely treatment. Tampering with these services will almost certainly result in higher – not lower – health and social costs in both the short and long term. Additionally, any increase in cost sharing or reduction in income eligibility for Medicaid will lead to poorer health for Vermont's most vulnerable children and will ultimately increase costs.

Approving Vermont's proposed "Global Commitment to Health" is the wrong choice for all Vermonters – especially its children. Vermont's most vulnerable children whose futures we hold in trust should not be put at risk. Vermont should not allow itself to set such a harmful precedent that other states may adopt in some form that would put hundreds of thousands of our poorest children at risk. The Children's Defense Fund urges you to exercise your responsibility to reject legislation that is contrary to the Medicaid program's purposes and, instead, exercise your leadership to prevent the harmful effects on children that Vermont is proposing. We urge you to do what is right and just.

Sincerely yours,

Marian Wright Edelman
CEO and Founder

Children's Defense Fund ®

September 27, 2005

The Honorable Gaye Symington
Vermont State House
115 State Street
Montpelier, VT 05633

Dear Madam Speaker:

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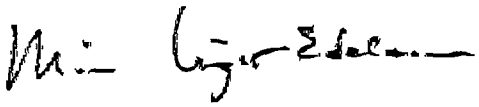

Marian Wright Edelman
CEO and Founder

OFFICE OF HEALTH CARE OMBUDSMAN

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Testimony of Donna Sutton Fay
State Health Care Ombudsman

September 27, 2005
Health Access Oversight Committee

Global Commitment

I regret that I am not able to testify in person before the Committee. I have a number concerns about the rapid pace with which the Health Access Oversight and Joint Fiscal Committees are being asked to approve the Global Commitment as outlined in the Special Terms and Conditions from CMS dated September 13, 2005. While the Administration has been negotiating the Global Commitment for several months, it is only in the last two weeks that the Terms and Conditions have been approved and made public. I urge you to take the time necessary to understand both the specific terms and the implications of Global Commitment before approving it.

The Health Care Ombudsman Office assists over 1000 Vermonters a year who rely on the state health care programs for their health insurance. We have assisted over 7000 beneficiaries since the inception of the program. I am keenly aware of the critical importance of Medicaid, VHAP, and the pharmacy programs in the lives of these Vermonters. In fact, approximately one-quarter of all Vermonters rely on the state health care programs for their access to health care. Global Commitment represents significant changes in the manner in which these programs are financed and administered; it is critically important that the legislature fully understand the implications of Global Commitment before it is approved. Two weeks simply is not enough time to understand and realize the implications of a fundamental restructuring of Medicaid programs.

I want to make sure that the Committee understands that I am just as aware of the projected Medicaid deficit and the potential impact it has on beneficiaries. The impact of the projected deficit on beneficiaries cannot be ignored. Nevertheless, it is important that the legislature fully understand Global Commitment before it approves it. Global Commitment, if it works as has been explained, will only be a solution to about one-third of the projected Medicaid deficit.

Global Commitment Caps Federal Funding for Vermont's Health Care Programs

One of the fundamental questions that must be answered in deciding whether or not to approve Global Commitment is the financial risk to Vermont. Under Global Commitment, Vermont assumes the entire risk if costs exceed the cap. "Vermont shall be at risk for the per capita cost...for Medicaid eligibles...., and for the number of Medicaid eligibles in each of the groups. ... Vermont shall be at risk for changing economic conditions that impact enrollment levels." #50, Terms and Conditions.

This financing mechanism is different than the current VHAP waiver. Under the current VHAP waiver, the budget neutrality limit is determined using a per capita cost method. According to the CMS web site, the terms and conditions for the current VHAP waiver state that " In this way, Vermont will be at risk for the per capita cost... for current eligibles but not at risk for the number of current eligibles. ... HCFA [now CMS] will not place Vermont at risk for changing economic conditions."

The Legislature needs to fully evaluate the risk to the state and its most vulnerable citizens if it agrees to a cap in federal funding for Medicaid programs.

What does implementation of Global Commitment on October 1 mean?
It is not clear what an approval by the Joint Fiscal and Health Access Oversight Committees of Global Commitment by October 1 means. There has been no explanation of how the state will lose $1 million per week if Global Commitment is not approved. Clearly, the terms of the Interagency Agreement between AHS and OVHA will not be implemented on October 1, nor will the 23 implementation tasks OVHA has identified for the MCO.

What does OVHA becoming a Managed Care Organization mean?
The legislature needs to take time to fully analyze and understand the implications of OVHA becoming a managed care organization (MCO). Under Global Commitment, OHVA becomes a MCO responsible for paying for and providing all Medicaid services. The Legislature should be satisfied that OVHA has the expertise and necessary levels of staffing to undertake this. OHVA as a MCO will be exempt from all the oversight that other MCOs in Vermont are subject to. It will not have to comply with consumer protections and quality assurance by an independent part of state government that all other MCOs in Vermont are subject to. The Legislature must insure that there will be adequate monitoring and evaluation of the MCO. It must understand how the parent agency of the MCO can objectively provide this level of oversight when both AHS and the MCO are part of the same agency within the executive branch.

The Interagency Agreement between AHS and OVHA must be carefully analyzed.
This interagency agreement is an extremely important document. It contains much of the detail about how the MCO will work and provide services. It contains enormous detail about the provision of services, prior authorization of services, appeals and grievances, payments to providers and quality assurance. The draft agreement was not available publicly until September 22. There are significant sections in the agreement that depart from current Medicaid law, and need detailed analysis. Prior authorization of services and appeals are two examples. There has been no public review of the agreement and no explanation of how and when the terms of the agreement will be implemented. There simply is not sufficient time to fully analyze and comprehend the implications of the terms of this agreement by October 1.

Policy Implications
Global Commitment gives the state enormous flexibility to change eligibility and covered services, beyond what is currently allowed by federal Medicaid law. The Terms and Conditions allow for reductions in benefits for mandatory populations.(#6). Only eligibility criteria for mandatory eligible individuals are protected in the terms and conditions (#27). The list of waivers granted include: waiver of the basic Medicaid concept of "amount, duration and scope

of services"; eliminating the "spend down" provisions of Medicaid for some pregnant women, parents and children; imposing premiums in excess of current federal statutory limits; allowing different levels of services by geographic area of the state. These waivers, if implemented, would change Vermont Medicaid programs in ways that cannot be fully understood and analyzed by October 1.

Given that Global Commitment has the potential to be a solution to only one-third of the projected Medicaid deficit over the next 5 years, these waivers pose a very real threat to the continued provision of health care services to poor, elderly and disabled Vermonters.

cc: Joint Fiscal Committee

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

SEP 27 2005

Mr. Michael Smith
Secretary
Agency for Human Services
103 South Main Street
Waterbury, VT 05671-2301

Dear Mr. Smith:

We are pleased to inform you that Vermont's April 15, 2005, application, "The Global Commitment to Health" section 1115 demonstration, has been approved as project number 11-W-00194/1, for a period of 5 years, beginning with the enrollment of the first demonstration participant, but no later than January 1, 2006. This approval is under the authority of section 1115(a) of the Social Security Act.

Using a multi-disciplinary approach including the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, and flexibility under this demonstration, Vermont will demonstrate its ability to promote universal access to health care, cost containment, and improved quality of care. Vermont will be required to conduct an evaluation of the impact of the demonstration program during the 5-year period.

The Vermont Agency for Human Services will contract with the Office of Vermont Health Access to serve as a publicly sponsored managed care organization. The Federal regulations published at 42 CFR Part 438 shall govern the provision of Medicaid services through managed care. Furthermore, the State will be financially at risk for managing costs within a targeted amount. Vermont will have to manage its program within the aggregate amount of $4.7 billion over the approved 5-year demonstration period.

Our approval of the Global Commitment to Health section 1115(a) demonstration, including the waivers and expenditures authorities provided thereunder, is conditioned upon compliance with the enclosed Special Terms and Conditions. All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the enclosed waiver and expenditure authority list, shall apply to the Global Commitment to Health demonstration. The award is subject to our receiving your written acceptance of the award within 30 days of the date of this letter.

As a follow-up to the State Medicaid Directors letter published on June 3, 2005, Federal funds are not available as of January 1, 2006, for drugs covered by the Medicare prescription drug program for any Part D-eligible individual or for any cost sharing for such drugs.

The approval of this demonstration does not include the State's proposal to expand the availability of Employer Sponsored Insurance through premium assistance, nor the approach to streamline eligibility determination. However, we are committed to working with you to further develop both of these proposals for future approval.

Your project officer is Ms. Angela Garner. She is available to answer any questions concerning your section 1115 demonstration. Ms. Garner's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard, Mailstop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-1074
Facsimile: (410) 786-5882
E-mail: angela.garner@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Garner and to Mr. Richard McGreal, Acting Associate Regional Administrator in our Boston Regional Office.

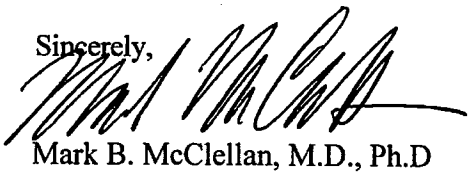
Mr. McGreal's contact information is as follows:

Centers for Medicare & Medicaid Services
JFK Federal Building, Room 2275
Boston, MA 02203-0003

If you have questions regarding this correspondence, please contact Ms. Jean Sheil, Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,



Mark B. McClellan, M.D., Ph.D

Enclosures