



## **Center for Medicaid and CHIP Services**

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June 27, 2012

Douglas A. Racine, Secretary  
Vermont Agency of Human Services  
208 Hurricane Lane, Suite 103  
Williston, VT 05495

Dear Mr. Racine:

The Centers for Medicare & Medicaid Services (CMS) has approved an amendment for Vermont's section 1115 Demonstration, Global Commitment to Health (11-W-00194/1). The enclosed changes fully respond to the State's amendment request submitted on May 14, 2012. The State requested a August 1, 2012 effective date.

The amended section 1115 Demonstration provides Vermont with the authority to:

1. Eliminate the \$75 inpatient admission co-pay; and,
2. Implement nominal co-payments for the Vermont Health Access Plan (VHAP) population as long as they do not exceed the co-payments charged to State plan populations under the Medicaid State plan.

CMS approval of this section 1115 Demonstration amendment is subject to the limitations specified in the approved waiver and expenditure authorities and not applicables list. The State may deviate from the Medicaid State plan requirements only to the extent those requirements have been specifically listed as waived or not applicable to the expenditure authorities. All requirements of the Medicaid program as expressed in law, regulation, and policy statement not expressly waived or identified as not applicable shall apply to the Global Commitment to Health Demonstration. No changes are being made to the list of waivers or expenditure authorities.

This approval is conditioned upon continued compliance with the enclosed Special Terms and Conditions (STCs) defining the nature, character, and extent of Federal involvement in this project. This approval is also conditioned upon written acceptance from the State that it agrees with the amendment, waivers, expenditure authorities, and STCs. This written acceptance is needed for our records within 30 days of the date of this letter.

Your contact for this Demonstration is Ms. Anne Chiang, who may be reached at (410) 786-5354 and through e-mail at [Anne.Chiang@cms.hhs.gov](mailto:Anne.Chiang@cms.hhs.gov). Ms. Chiang is available to answer any questions concerning the scope and implementation of the project. Communications regarding program matters and official correspondence concerning the Demonstration should be submitted to Ms. Chiang at the following address:

Centers for Medicare & Medicaid Services  
Center for Medicaid and CHIP Services

Dr. Racine – Page 2 of 2

7500 Security Boulevard, Mail Stop: S2-01-16  
Baltimore, MD 21244-1850

Official communication regarding program matters should be sent simultaneously to Ms. Chiang and to Mr. Rich McGreal, 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 approval, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group, Center for Medicaid, and CHIP Services, at (410) 786-5647.

Sincerely,

/Cindy Mann/

Cindy Mann  
Director

Enclosures

Cc: Rich McGreal, Associate Regional Administrator, Boston Regional Office  
Robert Cruz, State Representative, Boston Regional Office  
Anne Chiang, Project Officer, Center for Medicaid and CHIP Services

**CENTERS FOR MEDICARE & MEDICAID SERVICES  
WAIVER AUTHORITY**

**NUMBER:** 11-W-00194/1  
**TITLE:** Global Commitment to Health Section 1115 Demonstration  
**AWARDEE:** Vermont Agency of Human Services (AHS)

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the Demonstration project from January 1, 2011 through December 31, 2013. These waivers do not apply to the excluded populations of recipients of long term care services who are served under the Vermont LTC Section 1115 Demonstration other than community residential treatment.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act) the following waivers shall enable Vermont to implement the Global Commitment to Health section 1115 Demonstration:

**1. Statewideness/Uniformity** **Section 1902(a)(1)**

To the extent necessary to enable Vermont to operate the program differently in different geographical areas of the State.

**2. Hearings and Appeals** **Section 1902(a)(3)**

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

**2. Amount, Duration, Scope of Services** **Section 1902(a)(10)(B)**

To enable Vermont to vary the amount, duration and scope of services offered to various mandatory and optional categories of individuals eligible for Medical assistance under the Demonstration as long as the amount, duration and scope of covered services meets the minimum requirements under title XIX of the Act and the special terms and conditions.

**3. Financial Eligibility** **Section 1902(a)(10)(C)(i)(III)**

To allow the State to use institutional income rules (up to 300 percent of the Supplemental Security Income payment level) for medically needy enrollees electing home-based services in lieu of nursing facility or in lieu of other residential care services in licensed settings while allowing resource limits up to \$10,000.

**4. Comparability** **Section 1902(a)(17)**

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

**5. Financial Responsibility/Deeming** **Section 1902(a)(17)(D)**

To the extent necessary to enable the State to use more liberal income and resource standards and methods for plan groups and individuals whose eligibility is determined under the more liberal standards and methods, resource standards, and requirements that differ from those required under title XIX. The waiver would specifically exempt the State from the limits under section 1902(a)(17)(D) on whose income and resources may be used to determine eligibility unless actually made available, and so that family income and resources may be used instead.

To enable the State to disregard quarterly income totaling less than \$20 from the post-eligibility income determination.

**6. Payment to Providers** **Sections 1902(a)(13)  
1902(a)(30)**

To allow the State, through the Department of Vermont Health Access, to establish rates with providers on an individual or class basis without regard to the rates currently set forth in the approved State plan.

**7. Spend-Down** **Section 1902(a)(17)**

To enable the State to offer 1-month spend-downs for medically needy people receiving community-based services as an alternative to institutionalization, and non-institutionalized persons who are receiving personal care attendant services at the onset of waivers.

**8. Freedom of Choice** **Section 1902(a)(23)**

To enable the State to restrict freedom of choice of provider for the demonstration participants to the extent that beneficiaries will be restricted to providers enrolled in a provider network through the Department of Vermont Health Access for the type of service at issue, but may change providers among those enrolled providers.

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

**9. Premium Requirements** **Section 1902(a)(14)  
Insofar as it incorporates Section 1916**

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

**CENTERS FOR MEDICARE & MEDICAID SERVICES  
EXPENDITURE AUTHORITY**

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

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

**AWARDEE:** Vermont Agency of Human Services (AHS)

Under the authority of section 1115(a)(2) of the Social Security Act, expenditures made by Vermont for the items identified below (which are not otherwise included as expenditures under section 1903) shall, for the period of this Demonstration, January 1, 2011, through December 31, 2013, be regarded as expenditures under the State's Medicaid title XIX plan.

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

**1. Expenditures Related to Eligibility Expansion**

Expenditures to provide Medical Assistance coverage, either in the form of payment for medical services under the State plan as affected by the waivers and expenditure authorities under this Demonstration, or in the form of premium assistance as specified in the Special Terms and Conditions, to the following Demonstration populations that are not covered under the Medicaid State plan and are enrolled in the Vermont Global Commitment to Health Demonstration:

**Vermont Health Access Plan (VHAP) Expansion Populations**

- |                                    |   |
|------------------------------------|---|
| <b>Demonstration Population 3:</b> | Underinsured children with income between 225 and up to and including 300 percent of the Federal poverty level (FPL) who are not otherwise eligible for Medicaid or the State Children's Health Insurance Program     |
| <b>Demonstration Population 4:</b> | Adults with children with income between 150 and up to and including 185 percent of the FPL   |
| <b>Demonstration Population 5:</b> | Childless Adults with income up to and including 150 percent of the FPL   |
| <b>Demonstration Population 6:</b> | Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income at or below 150 percent of the FPL, not otherwise categorically eligible                               |
| <b>Demonstration Population 7:</b> | Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income above 150 percent and up to and including 225 percent of the FPL, not otherwise categorically eligible |

**Demonstration Population 8:** Individuals with persistent mental illness with income up to and including 150 percent of the FPL

**Premium Assistance Expansion Populations**

**Demonstration Population 9:** Employer-Sponsored Insurance Premium Assistance

- a. Adults with children with incomes between 185 and including 300 percent of the FPL without adjustment (gross income)
- b. Childless adults and non custodial parents with income between 150 and including 300 percent of the FPL without adjustment (gross income)
- c. College students with income up to and including 300 percent of FPL who do not meet eligibility requirements for Demonstration Populations 4 & 5

**Demonstration Population 10:** Catamount Premium Assistance

- a. Adults with children with incomes between 185 and including 300 percent of the FPL without adjustment (gross income)
- b. Childless adults and non custodial parents with income between 150 and including 300 percent of the FPL without adjustment (gross income)
- c. College students with income up to and including 300 percent of FPL who do not meet eligibility requirements for Demonstration Populations 4 & 5

**2. Expenditures Related to Additional Services**

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

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

Subject to availability of funding within the per member per month limit, expenditures to reduce the rate of uninsured and/or underinsured in Vermont, increase the access to quality health care for uninsured, underinsured, and Medicaid beneficiaries, provide public health approaches and other innovative programs to improve the health outcomes and the quality of life for Medicaid-eligible individuals in Vermont; and encourage the formation and maintenance of public-private partnerships in health care.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to Demonstration Populations 5 through 11 beginning January 1, 2011, through December 31, 2013.

**3. Retroactive Eligibility** **Section 1902(a)(34)**

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

**4. Reasonable Promptness and Simplicity of Administration** **Sections 1902(a)(3),  
Section 1902(a)(8), and  
Section 1902 (a)(19)**

To enable Vermont to implement policies intended to prevent substitution of public coverage for private coverage, including policies related to a waiting period prior to becoming eligible for the VHAP or Catamount expansion programs.

**5. Amount, Duration and Scope of Services** **Section 1902(a)(10)(B)**

To enable Vermont to offer different services to different expansion populations.

**6. Cost Sharing Requirements** **Section 1902(a)(14) insofar  
as it incorporates Section  
1916**

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

**7. Direct Provider Reimbursement** **Section 1902(a)(32)**

To enable Vermont to provide premium assistance to expansion populations for the purchase of employer-sponsored health insurance.

**CENTERS FOR MEDICARE & MEDICAID SERVICES  
AMENDED SPECIAL TERMS AND CONDITIONS**

**NUMBER:** 11-W-00194/1  
**TITLE:** Global Commitment to Health Section 1115 Demonstration  
**AWARDEE:** Vermont Agency of Human Services (AHS)

**I. PREFACE**

The following are the Special Terms and Conditions (STCs) for the Vermont Global Commitment to Health Section 1115(a) Medicaid Demonstration (hereinafter “Demonstration”). The parties to this agreement are the Vermont Agency of Human Services (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth limitations on the extent of the waivers and expenditure authorities that have been granted to further the Demonstration, which are enumerated in separate lists. The STCs also 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. The amended STCs are effective date of the approval letter through December 31, 2013 unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. The amended STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; General Reporting Requirements; Eligibility, Benefits, and Enrollment; Cost Sharing; Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; Use of Demonstration Funds; and Schedule of State Deliverables for the Demonstration Period.

Additionally, Attachment A has been included to provide supplemental information and guidance for the quarterly report content and format. Attachment B has been included to provide supplemental information on the Catamount Health Program

**II. PROGRAM DESCRIPTION AND OBJECTIVES**

The Global Commitment to Health Section 1115(a) Demonstration is designed to use a multi-disciplinary approach including the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, public-private partnership, an initiative in employer sponsored health insurance, and program flexibility. Specifically, Vermont expects to demonstrate its ability to achieve universal access to health care, cost containment, and improved quality of care. The initial Global Commitment to Health Demonstration was approved in September of 2005.

The State’s goal in implementing the Demonstration is to improve the health status of all Vermonters by:

- Increasing access to affordable and high quality health care;
- Improving access to primary care;
- Improving the health care delivery for individuals with chronic care needs; and
- Containing health care costs.

The State will employ four major elements in achieving the above goals:

1. **Program Flexibility:** Vermont has the flexibility to change benefits for the non-mandatory populations and invest in alternative services and programs designed to achieve the Demonstration's objectives;
2. **Managed Care Delivery System:** Under the Demonstration the AHS will enter into an agreement with the Department of Vermont Health Access (DVHA), which will operate using a managed care model;
3. **Aggregate Budget Neutrality Cap:** Vermont will be at risk for the caseload and the per capita program expenditures, as well as certain administrative costs. Vermont will have to manage this program within a total computable aggregate cap of \$8.9 billion over the approved eight and one quarter -year Demonstration period; and
4. **Premium assistance:** Vermont will increase access to affordable health care coverage by providing premium assistance to purchase private coverage via the Catamount Health Plan for the uninsured and by providing premium assistance to individuals with access to employer sponsored insurance (ESI).

In 2006, the State passed legislation establishing Catamount Health, a fully insured product available through private insurers in Vermont. The Catamount Health Assistance Program seeks to fill gaps in coverage for Vermonters by providing a health services delivery model for uninsured individuals.

In October 2007, a component of the Catamount program was added to the Demonstration enabling the State to provide a premium subsidy to Vermonters who have been without health insurance coverage for a year or more, have income at or below 200 percent of the Federal poverty level (FPL), and who do not have access to cost effective employer-sponsored insurance, as determined by the State. In December 2009, CMS processed an amendment allowing the State to extend coverage to Vermonters at or below 300 percent of the FPL.

In Fall 2011, Vermont implemented a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life limiting illnesses that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.

In June 2012, CMS processed a cost-sharing amendment to the Demonstration, providing the authority for the State to eliminate the \$75 inpatient admission co-pay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid State plan.

### **III. GENERAL PROGRAM REQUIREMENTS**

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it must 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, unless specified otherwise in the STCs, waiver list, or expenditure authorities or otherwise listed as non- applicable, must apply to

the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in the applicable law, regulation, or policy directive, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
  - a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified budget neutrality agreements would be effective upon the implementation of the change.
  - b. If mandated changes in the Federal law require State legislation, the changes must 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 is not required to submit title XIX State plan amendments for changes to Demonstration-eligible populations covered solely through the Demonstration. If a population covered through the Medicaid State plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State plan may be required, except as otherwise noted in these STCs. Reimbursement of providers will not be limited to reimbursement described in the State plan.
6. **Changes Subject to the Demonstration Amendment Process.** The State must 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 7, below.

The State has the authority to modify the Demonstration program design elements in accordance with the parameters specified below. Changes in eligibility or process in determining eligibility requires a Demonstration amendment.

**Mandatory State Plan Eligibles.** All changes in benefits (whether reductions or additions), including optional services, for federally mandated populations must be submitted as an amendment to the State plan.

**Non-Mandatory Eligibles.** All proposed changes (whether additions or reductions) in State plan benefits for optional groups must be submitted as an amendment to the State plan; all proposed changes in benefits (whether additions or reductions) for the expansion groups must be submitted as an amendment to the Demonstration by the amendment process outlined in paragraph 7. The State may change the benefit package for the non-mandatory eligible population so long as the State plan benefit changes and/or changes to benefits for the expansion groups result in no more than a 5-percent cumulative increase, or decrease each year of the total Medicaid expenditures for the corresponding Demonstration year, and comparison year and as long as the resulting benefit package is consistent with the requirements in paragraph 23 below. The following chart indicates the corresponding years:

<b>Demonstration Year (DY)</b>	<b>Comparison Year Expenditures</b>
DY 1	2004 Total Global Expenditures
DY2	2005 Total Global Expenditures
DY 3	2006 Total Global Expenditures
DY 4	2007 Total Global Expenditures
DY 5	2008 Total Global Expenditures
DY 6	2009 Total Global Expenditures
DY 7	2010 Total Global Expenditures
DY 8	2011 Total Global Expenditures
DY 9	2012 Total Global Expenditures

The State must offer benefit packages that, at a minimum, include inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, and well-baby, and well-child care, including age appropriate immunizations. However, this does not apply to Populations 6 through 10 as defined in paragraph 17.

For changes in the non-mandatory populations' benefit package, the State must notify CMS 60 days prior to any expected 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 an amendment to the State plan or an amendment to the Demonstration as outlined in paragraph 7. Should the State fail to notify within the time period or submit an amendment as requested, CMS has the right to withhold or disallow FFP.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the date of implementation of the change and may not be implemented until approved. Amendment requests will be reviewed by the Federal Review Team and must include, but are not 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 data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis must include current total computable “with waiver” and “without waiver” status on both a summary and detailed level though the approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;
  - c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
  - d. If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

8. **Frequency of Demonstration Amendments.** 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 must submit amendments pursuant to paragraph 6, and governed by the process outlined in paragraph 7 of this section. Any approved changes must be reflected in the annual rate-setting process for the upcoming year.
9. **Demonstration Phase-Out.** The State may only suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements.
  - a. **Notification of Suspension or Termination:** The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received, the State's response to the comment and how the State incorporated the received comment into a revised phase-out plan. \
  - b. The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.
  - c. **Phase-out Plan Requirements:** The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
  - d. **Phase-out Procedures:** The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
  - e. **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.
10. **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 that the State has materially failed to comply with the terms of the project. In addition, CMS reserves the right to withdraw expenditure authorities at any time it determines that

continuing the expenditure authorities would no longer be in the public interest. If an expenditure authority is withdrawn, CMS shall be liable for only normal close-out costs. CMS will promptly notify the State in writing of the determination and the reasons for suspension or termination of the Demonstration, or any withdrawal of an expenditure authority, together with the effective date.

11. **Finding of Non-Compliance.** The State does not relinquish either its rights to challenge the CMS finding that the State materially failed to comply, or to request reconsideration or appeal of any disallowance pursuant to section 1116(e) of the Act.
12. **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 or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.
13. **Adequacy of Infrastructure.** The State must 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 requirements; and reporting on financial and other Demonstration components.
14. **Public Notice and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and regulations that implement section 1115(d), as added by section 10201 of the Affordable Care Act.
15. **Compliance with Managed Care Regulations.** The State shall comply with all of the managed care regulations published at 42 CFR section 438 et. seq., except as expressly identified as not applicable in the STCs. The per member, per month fixed amount pursuant to paragraph 41 must be developed and certified as actuarially sound in accordance with 42 CFR 438.6. DHVA shall continue to serve as the unit designated by AHS (the Single State Agency) responsible for administration of the State Medicaid program and operates as a public managed care model solely to carry out the goals and purposes of the Demonstration. DVHA's role under the Demonstration as a public managed care model does not reduce or diminish its authority to operate as the designated Medicaid unit under the approved State plan, including its authority to implement program policies permissible under a State plan and establish provider participation requirements DVHA shall comply with federal program integrity and audit requirements as if it were a managed care organization for services and populations covered under the Demonstration.
16. **Federal Funds Participation (FFP).** No federal matching for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

## IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

The Global Demonstration includes four fundamental elements: program flexibility; a health care delivery system administered by the State but modeled after a managed care delivery system; an aggregate budget neutrality cap; and premium assistance.

17. **Eligibility.** Mandatory and optional State plan groups described below are subject to all applicable Medicaid laws and regulations, except as expressly waived in the award letter for this Demonstration.

Those non-Medicaid eligible groups described below who are made eligible for the Demonstration by virtue of the expenditure authorities expressly granted in this Demonstration are subject to Medicaid laws or regulations only as specified in the expenditure authorities for this Demonstration.

Only those Vermont Choice for Care (CfC) beneficiaries receiving Community Rehabilitation and Treatment (CRT) services under Global Commitment or moderate eligible services under CfC overlap with the Global Commitment to Health Demonstration. Except for the exclusion of participants covered solely under the Vermont CfC section 1115 Demonstration, the following populations listed in the tables below must be covered under the Global Commitment to Health Demonstration. Changes to the following, outside the parameters as outlined in paragraph 6, are pursuant to the amendment process as discussed in paragraphs 7 and 8 under section III, General Program Requirements.

To be eligible for premium assistance, adults not otherwise eligible for DVHA programs must have been uninsured for 12 months, subject to the exceptions noted in this paragraph, or six months if the State elects such shorter period and gives 30 days prior notice to CMS. Individuals must meet these requirements unless they lost coverage due to one of the following reasons: loss of employment; death of the principal insurance policyholder; divorce or dissolution of a civil union; domestic violence; no longer qualified as a dependent under the plan of a parent or caretaker relative; no longer qualifying for Consolidated Omnibus Budget Reconciliation Act (COBRA), Vermont Continuing Coverage Program (VIPER), or other state continuation coverage; or a college-sponsored insurance plan became unavailable because the individual graduated, took a leave of absence, or otherwise terminated studies.

The general categories of populations included under the Demonstration are:

### **Traditional Medicaid-eligible Mandatory and Optional Populations**

**Demonstration Population 1:** Mandatory Categorically Needy

**Demonstration Population 2:** Optional Categorically Needy

### **Vermont Health Access Plan (VHAP) Expansion Populations**

**Demonstration Population 3:** Underinsured children with income between 225 percent and up to and including 300 percent of the FPL who are not otherwise eligible for Medicaid or the Children's Health Insurance Program

**Demonstration Population 4:** Adults with children with income between 150 percent

and up to and including 185 percent of FPL

**Demonstration Population 5:** Childless Adults with income up to and including 150 percent of FPL

**Demonstration Population 6:** Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income at or below 150 percent of the FPL, not otherwise categorically eligible

**Demonstration Population 7:** Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income at or above 150 percent but less than and including 225 percent of FPL, not otherwise categorically eligible

**Demonstration Population 8:** Individuals with persistent mental illness with income up to and including 150 percent of FPL

**Premium Assistance Expansion Populations**

**Demonstration Population 9:** ESI Premium Assistance Expansion Population

- a. Adults with children with incomes between 185 percent and up to and including 300 percent of the FPL
- b. Childless adults and non custodial parents with income between 150 percent and up to and including 300 percent of the FPL
- c. College students with income up to and including 300 percent of FPL who do not meet eligibility requirements for Demonstration Populations 4 & 5

**Demonstration Population 10:** Catamount Premium Assistance Expansion Population

- a. Adults with children with incomes between 185 percent and up to and including 300 percent of the FPL
- b. Childless adults and non custodial parents with income between 150 percent and up to and including 300 percent of the FPL
- c. College students with income up to and including 300 percent of FPL who do not meet eligibility requirements for Demonstration Populations 4 & 5

The eligibility criteria for Global Commitment to Health Plan eligibility is as follows:

<b>Title XIX State Plan Groups</b>			
<b>Mandatory Categorically Needy (Demonstration Population 1)</b>			
<b>Population Description</b>	<b>Statutory/Regulatory Citations</b>	<b>Standards and Methodologies</b>	<b>Benefit Package</b>
Section 1931 low-income families with children	§1902(a)(10)(A)(i)(I) §1931	AFDC standard and methodologies	Medicaid State plan benefit package
Children receiving IV-E payments (IV-E foster care or adoption assistance)	§1902(a)(10)(i)(I)	AFDC standard and methodologies	Medicaid State plan benefit package
Individuals who lose eligibility under §1931 due to employment	§1902(a)(10)(A)(i)(I) §402(a)(37) §1925	AFDC standard and methodologies	Medicaid State plan benefit package
Individuals who lose eligibility under §1931 because of child or spousal support	§1902(a)(10)(A)(i)(I) §406(h)	AFDC standard and methodologies	Medicaid State plan benefit package
Individuals participating in a work supplementation program who would otherwise be eligible under §1931	§1931 §1902(a)(10)(A)(i)(I) §482(e)(6)	AFDC standard and methodologies	Medicaid State plan benefit package
Individuals receiving SSI cash benefits	§1902(a)(10)(A)(i)(I)	SSI standard and methodologies	Medicaid State plan benefit package
Disabled children no longer eligible for SSI benefits because of a change in definition of disability	§1902(a)(10)(A)(i)(II)(aa)	SSI standard and methodologies	Medicaid State plan benefit package
Qualified severely impaired individuals (as defined in §1905(q))	§1902(a)(10)(A)(i)(II)(bb) §1905(q)	SSI standard and methodologies	Medicaid State plan benefit package
Individuals under age 21 eligible for Medicaid in the month they apply for SSI	§1902(a)(10)(A)(i)(II)(cc)	SSI standard and methodologies	Medicaid State plan benefit package
Qualified pregnant women	§1902(a)(10)(A)(i)(III) §1905(n)(1)	AFDC standard and methodologies	Medicaid State plan benefit package
Qualified children	§1902(a)(10)(A)(i)(III) §1905(n)(2)	AFDC standard and methodologies	Medicaid State plan benefit package
Poverty level pregnant women	§1902(a)(10)(A)(i)(IV) §1902(l)(1)(A)	Income less than or equal to 185 percent of the FPL	Medicaid State plan benefit package

Poverty level infants	§1902(a)(10)(A)(i)(IV) §1902(l)(1)(B)	Income less than or equal to 185 percent of the FPL	Medicaid State plan benefit package
Qualified family members	§1902(a)(10)(A)(i)(V) §1905(m)(1)	AFDC standard and methodologies	Medicaid State plan benefit package
Poverty level children under age six	§1902(a)(10)(A)(i)(VI) §1902(l)(1)(C)	Family income less than or equal to 133 percent of FPL	Medicaid State plan benefit package
Poverty level children under age 19, who are born after September 30, 1983 (or, at State option, after any earlier date)	§1902(a)(10)(A)(i)(VII) §1902(l)(1)(D)	Family income less than or equal to 100 percent of FPL	Medicaid State plan benefit package
Disabled individuals whose earnings exceed SSI substantial gainful activity level	§1619(a)	SSI standard and methodologies	Medicaid State plan benefit package
Disabled individuals whose earnings are too high to receive SSI cash benefits	§1619(b)	SSI standard and methodologies	Medicaid State plan benefit package
Pickle amendment: individuals who would be eligible for SSI if Title II COLAs were deducted from income (§503 of Public Law 94-566)	§1939(a)(5)(E)	SSI standard and methodologies	Medicaid State plan benefit package
Disabled widows and widowers	§1634(b) §1939(a)(2)(C)	SSI standard and methodologies	Medicaid State plan benefit package
Disabled adult children	§1634(c) §1939(a)(2)(D)	SSI standard and methodologies	Medicaid State plan benefit package
Early widows/widowers	§1634(d) §1939(a)(2)(E)	SSI standard and methodologies	Medicaid State plan benefit package
Individuals who would be eligible for AFDC except for increased OASDI income under P.L. 92-336 (July 1, 1972)	42 CFR 435.114	AFDC standards and methodologies	Medicaid State plan benefit package
Individuals receiving mandatory State supplements	42 CFR 435.130	SSI standard and methodologies	Medicaid State plan benefit package
Individuals eligible as essential spouses in December 1973	42 CFR 435.131	SSI standard and methodologies	Medicaid State plan benefit package
Institutionalized individuals who were eligible in December 1973	42 CFR 435.132	SSI standard and methodologies	Medicaid State plan benefit package
Blind and disabled individuals eligible in December 1973	42 CFR 435.133	SSI standard and methodologies	Medicaid State plan benefit package
Individuals who would be eligible except for the increase in OASDI benefits under Public Law 92-336	42 CFR 435.134	SSI standard and methodologies	Medicaid State plan benefit package
Individuals who become eligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977	42 CFR 435.135	SSI standard and methodologies	Medicaid State plan benefit package

Individuals who become eligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977	42 CFR 435.135	SSI standard and methodologies	Medicaid State plan benefit package
Newborns deemed eligible for one year	§1902(e)(4)		Medicaid State plan benefit package
Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post partum services	§1902(e)(5)		Pregnancy related and post partum services under the State plan
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)		Pregnancy related and post partum services under the State plan
Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay	§1902(e)(7)		Inpatient hospital services
Qualified Medicare Beneficiaries (QMBs)	§1902(a)(10)(E)(i) §1905(p)(1)	Medicare beneficiaries with income equal to 100 percent of the FPL	Payment of Medicare premiums, coinsurance, deductibles, and copayment except Part D copayment
Qualified disabled and working individuals	§1902(a)(10)(E)(ii) §1905(s)	Medicare beneficiaries with income equal to 200 percent of the FPL and not eligible for Medicaid	Payment of Medicare Part A premiums
Specified Low-Income Medicare Beneficiaries (SLMBs)	§1902(a)(10)(E)(iii)	Medicare beneficiaries with income between 100 and 120 percent of the FPL	Payment of Medicare Part B premiums
Qualifying individuals	§1902(a)(10)(E)(iv)	Medicare beneficiaries with income equal to 120 percent but less than 135 percent of the FPL and not eligible for Medicaid	Payment of Medicare Part B premiums

This is not an exhaustive list of mandatory groups covered under the Vermont title XIX State plan. For a complete list, refer to the Vermont approved title XIX State plan.

<b>Optional Categorically Needy (Demonstration Population 2)</b>			
Individuals who are eligible for but not receiving IV-A, SSI or State supplement cash assistance	§1902(a)(10)(A)(ii)(I)		Medicaid State plan benefit package
Individuals who could be eligible for IV-A cash assistance if State did not subsidize child care	§1902(a)(10)(A)(ii)(II)		Medicaid State plan benefit package
Individuals who are eligible for Title IV-A if State AFDC plan were as broad as allowed	§1902(a)(10)(A)(ii)(II)		Medicaid State plan benefit package
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)		Medicaid State plan benefit package
<i>Special income level group</i> : 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)		Medicaid State plan benefit package
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)		Medicaid State plan benefit package
Children under 21 (or at State option 20, 19, or 18) who are under State adoption agreements	§1902(a)(10)(A)(ii)(VIII)		Medicaid State plan benefit package
Poverty level pregnant women not mandatorily eligible	§1902(a)(10)(A)(ii)(IX) §1902(l)(1)(A)		Medicaid State plan benefit package
Poverty level infants not mandatorily eligible	§1902(a)(10)(A)(ii)(IX) §1902(l)(1)(B)		Medicaid State plan benefit package
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)		Medicaid State plan benefit package
Katie Beckett children	§1902(e)(3)		Medicaid State plan benefit package
Individuals receiving HCBS who would only be eligible for Medicaid under the State Plan if they were in a medical institution; individuals who were previously covered under a separate 1915(c) Demonstration. 5. TBI (traumatic brain injury) 6. MI under 22 (Children's mental Health) 7. MR/DD (Mental Retardation/Developmental	§1902(a)(10)(A)(ii)(VI)		Medicaid State plan benefit package along with HCBS

Disabilities)			
Individuals under 18 who would be mandatorily categorically eligible except for income and resources	§1902(a)(10)(C)(ii)(I)		Medicaid State plan benefit package
Pregnant women who would be categorically eligible except for income and resources	§1902(a)(10)(C)(ii)(II)		Pregnancy-related and Post-Partum Services under the State plan
Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post partum services	§1902(a)(10)(C) §1905(e)(5)		Medicaid State plan benefit package
Blind and disabled individuals eligible in December 1973	42 CFR 435.340		Medicaid State plan benefit package
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)		Medicaid State plan benefit package
Specified relatives of dependent children who are ineligible as categorically needy	42 CFR 435.301(b)(2)(ii) 42 CFR 435.310 1902(a)(10)(c)		Medicaid State plan benefit package
Aged individuals who are ineligible as categorically needy	42 CFR 435.301(b)(2)(iii) 42 CFR 435.320 42 CFR 435.330		Medicaid State plan benefit package
Blind individuals who are ineligible as categorically needy but meet the categorically needy definition of blindness	1902(a)(10)(c) 42 CFR 435.301(b)(2)(iv)		Medicaid State plan benefit package
Disabled individuals who are ineligible as categorically needy that meet the categorically needy definition of blindness	§1902(a)(10)(C)		Medicaid State plan benefit package

This is not an exhaustive list of optional groups covered under the Vermont title XIX State plan. For a complete list, refer to the Vermont approved title XIX State plan.

<b>Expansion Populations</b>			
<b>VHAP Expansion Populations (Demonstration Populations 3-8)</b>			
Underinsured children with income between 225 percent and including 300 percent of FPL who are not eligible for Medicaid or CHIP		children with income between 225 percent and up to and including 300 percent of FPL	Same as Medicaid State plan benefit package
Adults with children with income between 150 percent and up to and including 185 percent of the FPL		income between 150 percent and up to and including 185 percent of the FPL	VHAP Limited/VHAP
Adults with income up to and including 150 percent of the FPL		income up to and including 150 percent of the FPL	VHAP Limited/VHAP PCPlus
Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income at or below 150 percent of the FPL		income at or below 150 percent of the FPL	Medicaid Prescriptions, eyeglasses and related eye exams
Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income above 150 percent and less than 225 percent of the FPL		income below 225 percent of the FPL	Maintenance Drugs
Individuals with persistent mental illness with income up to and including 150 percent of the FPL		income up to and including 150 percent of the FPL	Day services, diagnosis and evaluation services, emergency care, psychotherapy, group therapy, chemotherapy, specialized rehabilitative services
<b>Premium Assistance Expansion Populations** (Demonstration Population 9 and 10)</b>			
<b>ESI Premium Assistance</b>			
Adults with children with income between 185 percent and up to and including 300 percent of the FPL		Income between 185 percent and up to and including 300 percent of the FPL	Premium assistance to purchase ESI
Childless adults with income between 150 percent and up to and including 300 percent of the FPL		Income between 150 percent and up to and including 300 percent of the FPL	Premium assistance to purchase ESI
<b>Catamount Premium Assistance</b>			
Adults with children with income between 185 percent and up to and including 300 percent FPL		Income between 185 percent and up to and including 300 percent of the FPL	Premium assistance to purchase the Catamount Health
Childless adults with income between 150 percent and up to and including 300 percent of the FPL		Income between 150 percent and up to and including 300 percent of FPL	Premium assistance to purchase Catamount Health

\* VHAP Limited is the interim benefit package offered to enrollees before a primary care physician (PCP) is chosen. After the PCP is chosen, the enrollee is eligible for the full VHAP benefits package, referred to as VHAP PC Plus.

\*\* In order to qualify for premium assistance, the individual has to be currently uninsured during the prior 12 months. Refer to current Vermont rules and policies for the definition of “uninsured” and other crowd-out provisions related to premium assistance

Note: VHAP adults with access to cost-effective ESI are also eligible to receive premium assistance.

**Global Commitment to Health Eligibility Exclusions:** The following persons are excluded from the Global Commitment to Health Program:

Individuals covered under the Vermont section 1115 Choices for Care Demonstration not receiving CRT services
CHIP eligibles

18. **Optional and Expansion Eligibility Groups Expenditure and Enrollment Cap.** The State must seek approval to modify program eligibility via the Demonstration amendment process, as described in paragraphs 6, 7, and 8 of section III “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 mandatory populations over optional populations, and last priority will be given to expansion populations.

19. **Benefits.** All covered services may be subject to medical review and prior approval by DVHA based on medical appropriateness. A complete listing of covered services and limitations are contained in the Vermont approved title XIX State plan, Vermont statutes, regulations, and policies and procedures. The State has the authority to adjust the benefit package for the non-mandatory eligible populations without amendment per STC paragraph 6.

Services	State Plan	VHAP PC Plus (full VHAP Benefits package)	Limitations
Inpatient Hospital Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan program rules and policies

Services	State Plan	VHAP PC Plus (full VHAP Benefits package)	Limitations
			VHAP: Urgent and emergent admissions only
Outpatient Hospital Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
FQHC/RHC including ambulatory services offered by FQHCs	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Laboratory/X-ray Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
EPSDT for Individuals Under 21	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Family Planning Services and Supplies	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Physician Services and Medical and Surgical Services of a Dentist	X	X	State plan: any limitations on this service is described in the approved Title XIX State plan, program rules and policies
Home Health Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Nurse Midwife Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Pediatric/Family Nurse Practitioner	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Other Medical/Remedial Care Provided by Licensed Practitioners and Recognized under State Law (chiropractor, podiatrist, optometrist, chiropractor, licensed clinical social worker, licensed mental counselor or licensed marriage and family therapist, psychologist, optician, hi-tech nursing, nurse practitioner,	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies

Services	State Plan	VHAP PC Plus (full VHAP Benefits package)	Limitations
licensed lay midwife, chiropractor)			
Clinic Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Prescribed Drugs	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Diagnostic, Screening, Preventive, and Rehabilitative Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Private Duty Nursing Services	N/A	N/A	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Eyeglasses and Other Aids to Vision	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies Note: Eyeglasses are not covered. Covered services are limited to other aids to vision.
Dental Services	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Prosthetic Devices	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Physical and Occupational Therapies, and Services for Individuals with Speech, Hearing, and Language Disorders	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Inpatient Hospital/Nursing Facility/ ICF Services for Individuals 65 and Older in IMD	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
ICF/MR Services	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Inpatient Psychiatric Services for Individuals Under 21	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies

Services	State Plan	VHAP PC Plus (full VHAP Benefits package)	Limitations
Personal Care Services	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Case Management	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Respiratory Care for Ventilator Dependent Individuals	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
PCCM	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
PACE (covered under VT Choice for Care 1115 Demonstration)	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Hospice	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies
Transportation Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Services Provided in a Religious Non-Medical Health Care Institution	N/A	N/A	
Nursing Facility Services for Individuals Under Age 21	X		State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies. *covered for persons under 18 years old. 18 and older covered in the Choices for Care 1115 Demonstration.
Emergency Hospital Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies
Critical Access Hospital	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in the Vermont Rules and/or policies

Note: Please note that benefit limitations do not apply to children under age 21- in accordance with EPSDT requirements.

<b>Services provided to the State's different "Programs offered to individuals who were previously covered under a separate 1915(c) waiver or the State's prior 1115 Demonstration</b>		
<b>Program Name</b>	<b>Services</b>	<b>Limitations</b>
Traumatic Brain Injury (TBI)	HCBS waiver-like services including crisis/support services, psychological and counseling supports, case management, community supports, habilitation, respite care, supported employment, environmental and assistive technology and self-directed care.	Any limitation on this service defined by Vermont rules and policies
Mental Illness Under 22	HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, crisis and community supports	Any limitation on this service defined by Vermont rules and policies
Community Rehabilitation and Treatment	HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, crisis and community supports	Any limitation on this service defined by Vermont rules and policies
Developmental Services	HCBS waiver services, including service coordination, residential habilitation, day habilitation, supported employment, crisis services, clinical intervention, respite and self-directed care	Any limitation on this service defined by Vermont rules and policies

The VHAP adults are eligible for premium assistance to purchase ESI if deemed cost-effective by the State. The benefits offered by the plan must be substantially similar to the benefits offered by the typical benefit plans issued by the four health insurers with the greatest amount of covered individuals in the small group market. To ensure that individuals enrolled in VHAP ESI receive the same benefits as individuals in the VHAP program, the State will provide a wrap for services not covered under the ESI plan.

<b>Premium Assistance Catamount Health Plan Benefit Package (Refer to Attachment B)</b>
Comprehensive benefit as prescribed in Catamount State statute

<b>ESI Premium Assistance (Non-VHAP) Benefit Package</b>
The benefits covered by the plan must be substantially similar to the benefits offered by the Catamount Health Premium Assistance.

20. **Palliative Care Program.** The Palliative Care Program is for children under the age of 21 years in Demonstration populations 1, 2, and 3, who have been diagnosed with a life-limiting illness that is expected to be terminal before adulthood. The program will allow for children to receive palliative and curative services.

- a. **Participation.** Demonstration participants will be identified based diagnostic codes found on claims data and referrals from medical professionals.
  - i. Eligibility will be determined by the nurse care manager and/or DVHA Medical Director, based on the assessment tool and supplemental clinical information (as needed). Continued eligibility will be re-assessed at least annually.
  - ii. Care planning activities for children enrolled in the palliative care program will

meet the requirements specified in federal managed care regulations for enrollees with special health care needs.

- b. **Benefits.** In addition to State plan services, children enrolled in the palliative care program may also receive care and services that meet the definition of ‘medical assistance’ contained in section 1905(a) of the Act if determined to be medically appropriate in the child’s care plan
- i. **Care coordination.** Development and implementation of a family centered care plan that includes telephonic and home visits by a licensed nurse.
  - ii. **Respite care.** Short term relief for caretaker relatives from the demanding responsibilities for caring for a sick child.
  - iii. **Expressive Therapies.** Therapies provided by licensed therapist to provide support to the child to help the child to creatively and kinesthetically express their reaction to their illness. The palliative care program offers 52 hours of expressive therapies per year. Additional, expressive therapy may be authorized if medically appropriate.
  - iv. **Family Training.** Training to teach family members palliative care principles, medical treatment regimen, use of medical equipment, and how to provide in-home care.
  - v. **Bereavement Counseling.** Anticipatory counseling and up to 6 months after the child’s death for the family by a licensed professional trained in grief counseling. Payment for bereavement counseling services may be provided for on-going counseling to family members after the child’s death so long as such services were initiated prior to the child’s death.
- c. **Cost Sharing.** Cost sharing requirements as described in paragraph 22 will apply.

21. **Enrollment Process.** The State agrees to notify participants newly entering a section 1115 Demonstration within 30 days of their entry into the Global Commitment to Health Demonstration

## V. COST SHARING

22. **Premiums, Co-Payments, and Premium Assistance.** All cost-sharing for demonstration-eligible populations described in STC 17 shall be set forth in the approved Medicaid State plan. Such cost-sharing shall not exceed the nominal cost sharing levels as described in 42 CFR 447.54, etc. CMS publishes an annual update of nominal cost-sharing levels. As part of the State’s quarterly reports (specified in STC 37), the State must update CMS regarding any intended changes in the nominal cost-sharing articulated in the Medicaid State plan. Should the State seek to impose any cost-sharing that is more than nominal in amount, the State must submit and receive approval of an amendment to the Demonstration.

Cost-sharing for optional and expansion children eligible for Medicaid and adults whose coverage is mandated by Federal law must not exceed 5 percent of the family’s gross income. In addition, the State must not apply co-payment requirements to excluded populations (children under age 21, pregnant women or individuals in long-term care facilities) or for excluded services/supplies (*e.g.*, family planning).

Detailed cost-sharing and premium requirements are specified in Attachment C.

## VI. DELIVERY SYSTEMS

23. **Health Plans.** Benefits will be furnished by DVHA which will operate on a managed care model and will be responsible for the delivery of all Medicaid covered services. The DVHA must be authorized by State statute and must adhere to federal regulations at 42 CFR section 438 that would be applicable to a managed care entity unless specifically stated otherwise in the STCs.
24. **Premium Assistance.** There are three programs offering premium assistance under this Demonstration; VHAP-ESI, ESI premium assistance (non-VHAP), and Catamount premium assistance. As the Single State Agency for Medicaid, AHS will have authority and responsibility for eligibility determination related to these premium assistance programs. The role filled by AHS will be identical to that of Single State Agencies in other States. The AHS PMPM limits include these eligibility groups. The methodology for providing premium assistance for each of the three programs is described below:
- a. **VHAP-ESI.** AHS determines eligibility, processes enrollment and makes the determination that ESI is cost effective. DVHA transfers to the beneficiary an amount of premium assistance that does not exceed the amount that the employer withholds from the employee's wages for the employee premium share of employer-sponsored insurance.  
  
DVHA provides additional benefits to ensure that the beneficiary receives the full VHAP benefit package in the aggregate.
  - b. **ESI Premium Assistance.** AHS determines eligibility, processes enrollment, and makes the determination that the ESI is cost effective. DVHA transfers to the beneficiary an amount of premium assistance that does not exceed the amount that the employer withholds from the employee's wages for the employee premium share. There is a wraparound benefit for prevention and management services to treat certain chronic conditions.
  - c. **Catamount Premium Assistance.** AHS determines eligibility and processes enrollment in Catamount Premium Assistance. The beneficiary pays a premium contribution to AHS and DVHA pays the total premium for the beneficiary to enroll in a private Catamount Health plan. There is no additional wraparound benefit.
25. **Catamount Health.** The Catamount Health product will be offered by private health plans in the State as dictated by Vermont Statute Title 8, Chapter 107, and section 4084f. Catamount Health.
26. **Limitation of Freedom of Choice.** Freedom of choice is limited to the DVHA network of providers. However, populations must have freedom of choice when selecting enrolled providers within that network (when applicable, the provider must be enrolled in the specific specialty or subprogram applicable to the services at issue.)
- a. Specifically, Demonstration participants enrolled in a special service program such as, but not limited to specialized substance abuse and behavioral health services or a program for home and community-based services may only have access to the providers enrolled under that program, and will not have access to every Medicaid enrolled provider for services under that program. Such participants will have freedom of choice of providers enrolled in the special service program.
27. **Contracts and Provider Payments.** Payments to providers will be set by DVHA and will not be required to comply with the payment provisions in the approved State plan, or with federal

regulations pertaining to the upper payment limits for provider rates. The AHS will be responsible for oversight of DVHA, ensuring compliance with State and federal statutes, regulations, special terms and conditions, waiver, and expenditure authority. AHS shall be responsible for evaluation, interpretation and enforcement of findings issued by the external quality review organization.

Procurement of health care services by AHS (the Single State Agency) through selective contracting or similar processes, and the subsequent final contracts developed to implement selective contracting by the AHS with any provider group, must be subject to CMS regional office approval prior to implementation.

28. **Contracting with Federally Qualified Health Centers (FQHCs).** The State must maintain its existing agreements with FQHCs and rural health centers. Reimbursement for services provided to individuals enrolled in ESI/Premium Assistance programs must be based on requirements established by the Vermont Statute 2006 Health Care Affordability Act and the terms contained in the independent agreements reached between FQHCs/rural health centers and participating carriers.
29. **Data Sharing.** DVHA 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 section 1902(a)(7) of the Act. DVHA 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, DVHA is permitted to release enrollee-specific information to providers in order 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. Consent of the enrollee is required whenever release of enrollee information for a purpose directly connected with plan administration is sought by an outside source, except in an emergency. Release under these conditions is defined in federal regulations at 42 CFR section 431.306(d).

## VIII. GENERAL REPORTING REQUIREMENTS

30. **General Financial Requirements.** The State must comply with all general financial reporting requirements under title XIX set forth in section IX.
31. **Compliance with Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR 438 et. Seq., as if DVHA were a managed care entity except as expressly identified as not applicable in these STCs.
32. **Reporting Requirements Relating to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality set forth in section X.
33. **Reporting on Participants Receiving Community Rehabilitation and Treatment (CRT) Services.** The State agrees 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.
34. **Managed Care Data Requirements.** The DVHA must maintain an information system that

collects, analyzes, integrates, and reports data. The system must provide information that would be required from managed care entities as set forth in Federal regulations at 42 CFR section 438, 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 the AHS, and on services as set forth under the intergovernmental agreement. DVHA must collect, retain and report encounter data in accordance with the Demonstration terms and conditions. All collected data must be available to AHS, and to CMS, upon request. The State must have contractual provisions in place to impose sanctions on the DVHA if accurate data are not submitted in a timely fashion.

35. **Submission of Encounter Data.** The State will submit encounter data to the Medicaid Statistical Information System (MSIS) system, as is consistent with Federal law and section IX of this document. The State must assure that encounter data maintained at DVHA and provider level can be linked with eligibility files maintained by the State.
36. **Quarterly Calls.** CMS will schedule at least Quarterly 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, DVHA operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, DVHA 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 will 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) will jointly develop the agenda for the calls.
37. **Quarterly Reports.** The State must submit progress reports in the format specified in Attachment A no later than 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 must include, but not be limited to:
  - a. An updated budget neutrality monitoring spreadsheet;
  - b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; benefits; enrollment; grievances; quality of care; access; health plan financial performance that is relevant to the Demonstration; pertinent legislative activity; and other operational issues;
  - c. Action plans for addressing any policy and administrative issues identified;
  - d. A separate discussion of the State efforts related to the collection and verification of claims and encounter data;
  - e. Evaluation activities and interim findings and a description of State progress towards Demonstration goals;
  - f. Updates on any intended changes in the nominal cost-sharing as stated in the Medicaid State plan, if applicable; and
  - g. The State must report Demonstration program enrollment on a quarterly basis using the

quarterly report format in Attachment A.

Quarterly report for the quarter ending September 30 is due **November 30**

Quarterly report for the quarter ending December 31 is due **February 28**

Quarterly report for the quarter ending March 31 is due **May 31**

Quarterly report for the quarter ending June 30 is due **August 31**

38. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy and administrative difficulties in the operation of the Demonstration. The State must submit the draft annual report no later than April 1 after the close of each Demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted, and posted, to the CMS Web site with prior permission.
39. **Transition Plan.** On or before July 1, 2012, the State is required to prepare and incrementally revise a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in paragraphs 39 a-e. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan.
- a. **Seamless Transitions.** Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:
- i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.
  - ii. Identify Demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.
  - iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.
  - iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the State identifies that may be necessary to continue coverage for these individuals.
  - v. Develop a modified adjusted gross income (MAGI) calculation for program eligibility.

- b. Access to Care and Provider Payments and System Development or Remediation.** As necessary to meet the State’s priorities, the State should assure adequate provider supply for the State plan and Demonstration populations affected by the Demonstration on December 31, 2013. Additionally, the Transition Plan for the Demonstration is expected to expedite the State’s readiness for compliance with the requirements of the Affordable Care Act and other federal legislation.
- c. Pilot Programs.** Progress towards developing and testing, when feasible, pilot programs that support Affordable Care Act-defined “medical homes,” “accountable care organizations,” and / or “person-centered health homes” to allow for more efficient and effective management of the highest risk individuals.
- d. Progress Updates.** After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.
- e. Implementation.**
  - i. By July 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the Demonstration to coverage under the State plan, the State will not require these individuals to submit a new application.
  - ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

## **IX. GENERAL FINANCIAL REQUIREMENTS**

- 40. Aggregate Budget Neutrality Limit.** Federal funding will be limited to an aggregate amount of \$8,955,886,798 over the 8.25 year term of this Demonstration. In any year in which the State exceeds the annual target amount set forth in section X below, the State will develop a plan to ensure that the budget neutrality limit is not exceeded, pursuant to the process set forth in section X.
- 41. Per Member Per Month Limit:** In addition to the aggregate budget neutrality limit described in STC 40, total Federal funding for medical assistance will be limited over the life of the Demonstration extension to an aggregate spending limit based on the actuarially-determined, per member per month limits. Total allowable Demonstration expenditures will be reconciled against the aggregate budget neutrality limit described in STC 40 and the sum of the annual limits for the extension period (per member per month limits multiplied by actual caseload). The fixed per member per month amount, established in accordance with the requirements set forth under paragraph 15, shall be determined no more frequently than annually unless approved by CMS, and must meet the requirements for a rate paid to a managed care entity under 42 CFR 438.6 for the managed care entity expenses . The fixed per member per month amount may vary based upon rate cells that take into account different categories of individuals and benefits.
- 42. Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using the form CMS-64 to separately 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 will provide 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).

43. **Reporting Expenditures Subject to the Budget Neutrality Cap.** In order to track expenditures under this Demonstration, Vermont must report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System, following routines from CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All Demonstration expenditures subject to the budget neutrality cap must be reported each quarter 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 the expenditure was made). Reporting for expenditures made subsequent to termination of the Demonstration must indicate the Demonstration year in which services were rendered. Payment adjustments attributable to expenditures under the Demonstration must be recorded on the applicable Global Commitment prior quarter waiver form, identified as either CMS-64.9P Waiver (Medical Assistance Payments) or CMS-64.10P Waiver (Administrative Payments). When populated, these forms read into the CMS-64 Summary sheet, Line 7 for increasing adjustments and Line 10B for decreasing adjustments. Adjustments not attributable to this Demonstration should be reported on non-waiver forms, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined in paragraph 52."

- a. For each Demonstration Year five 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 from the separate reports will represent the expenditures subject to the budget neutrality cap (as defined in 40.b.). As needed and subject to CMS approval, the State will develop reasonable methods to allocate allowable *Demonstration* expenditures across Demonstration population reporting groups. The Vermont Global Medicaid eligibility groups, for reporting purposes, include *the* following names and definitions:

CMS 64 Reporting Name	Reporting name description	Corresponding Demonstration population number per the STCs	Population description
<u>“ABD”</u>	Report expenditures for individuals eligible as aged, blind, or disabled under the state plan	Demonstration Populations 1-2	<ul style="list-style-type: none"> <li>• Mandatory Categorically needy</li> <li>• Optional Categorically needy</li> </ul>
<u>“ANFC”</u>	Report the expenditures for all non-ABD children and adults in the State plan mandatory and optional categories	Demonstration Populations 1-2	<ul style="list-style-type: none"> <li>• Mandatory Categorically needy</li> <li>• Optional Categorically needy</li> </ul>
<u>“Optional Expansions”</u>	Report for all expenditures for all non-ABD children and adults in optional categories	Demonstration populations 2	<ul style="list-style-type: none"> <li>• Optional Categorically needy</li> </ul>

CMS 64 Reporting Name	Reporting name description	Corresponding Demonstration population number per the STCs	Population description
<b><u>“VT Global Rx”</u></b>	Report for all expenditures for individuals eligible as pharmacy-only expansions through VT Global (previously VHAP Rx)	Demonstration population 6  Demonstration Population 7	<ul style="list-style-type: none"> <li>• Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with disabilities with income at or below 150 percent of FPL</li> <li>• Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income between 150 percent and up to and including 225 percent of FPL</li> </ul>
<b><u>“VT Global Expansion”</u></b>	Report for all expenditures for individuals eligible as non-categorical health care expansions through VT global	Demonstration Population 3  Demonstration Population 4  Demonstration Population 5  Demonstration Population 9 and 10	<ul style="list-style-type: none"> <li>• Underinsured Children with income between 225 and up to and including 300 percent of the FPL who otherwise are ineligible for Medicaid or CHIP</li> <li>• Adults with children with income between 150 and up to and including 185 percent of the FPL</li> <li>• Childless adults with income up to and including 150 percent of the FPL</li> <li>• Premium assistance expansion groups (ESI or Catamount Health) <ul style="list-style-type: none"> <li>a) adults with children with incomes between 185 and 300 percent of the FPL)</li> <li>b) all adults with income between 150 and up to and including 300 percent of the FPL.</li> <li>c) college students with income up to and including 300 percent of FPL who do not meet the eligibility requirements for Demonstration Populations 4 &amp; 5</li> </ul> </li> </ul>

It is understood that Demonstration Population (CRT) is duplicative of other MEGs that are reported on the CMS-64. Reporting to CMS for Demonstration Population 8 will occur via a supplemental information report provided as backup to the CMS-64. This report will be submitted concurrently with the other CMS-64 backup documentation submitted every quarter.

- b. For purposes of this section, the term “expenditures subject to the budget neutrality cap” must include all Medicaid expenditures on behalf of the individuals who are enrolled in this Demonstration (as described in paragraph 40.a. 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 must be reported on line 49 of forms CMS-64.9 waiver and/or 64.9P waiver.
- c. Premiums and other applicable cost-sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration must be reported to CMS on the CMS-64 Summary Sheet, Line 9E “Miscellaneous.” In order to ensure that the Demonstration is properly credited with premium collections, please indicate in the CMS-64 Certification “Footnotes” section that Line 9E of the Summary Sheet is for Global Commitment Collections only.
- d. Administrative costs must 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 not included in the expenditures reported on line 49 of forms CMS-64.9 waiver and/or 64.9P waiver (described in 40.b of this section) must be identified on the forms CMS-64.10 waiver and/or 64.10P waiver.
- e. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all title XIX claims for services during the Demonstration period (including any cost settlements and claims incurred during the Demonstration but paid subsequent to the end date of the Demonstration) are considered allowable expenditures under the Demonstration and must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-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.
- f. At the end of the Demonstration, all MCO investment and administrative claims for expenditures subject to the budget neutrality cap (including any cost settlements and non-title XIX claims incurred during the Demonstration but paid subsequent to the end date of the Demonstration) must be made within 2 quarters (6 months) after the calendar quarter in which the State made the expenditures. During the latter 6 month 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.
- g. Disproportionate Share Hospital (DSH) payments are not counted as expenditures under the Demonstration.

- h. The Demonstration does not prohibit the State from requesting to implement special initiatives available, and taking advantage of enhanced Federal Medical Assistance Percentage (FMAP) for these initiatives, under ACA subject to the federal approval process established for these initiatives.
44. **Reporting Member Months.** 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 3 months contributes 3 eligible member/months to the total. Two individuals, who are eligible for 2 months, each contributes 2 eligible member months to the total, for a total of 4 eligible member/months
45. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. Vermont must estimate matchable Medicaid expenditures on the quarterly form CMS-37 based on the PMPM limit (or a percentage of the PMPM limit) and projected caseload for the quarter. 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 on the form CMS-37.12 for both the medical assistance program and administrative costs outside of the PMPM limit. CMS will make federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures, consistent with the definition of an expenditure in 45 C.F.R. 95.13, made in the quarter just ended. Intergovernmental transfers of the individual per member per month fixed amount from AHS to DVHA are not reportable expenditures, but provide funding for reportable DVHA expenditures. CMS will reconcile expenditures reported on the form CMS-64 with federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.
46. **Sources of Non-Federal Share.** The State certifies that matching the non-Federal share of funds for the Demonstration are State/local monies. The State further certifies that such funds must not be used to match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.
- a. CMS will review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program must require the State to provide information to CMS regarding all sources of the non-Federal share of funding.
47. **State Certification of Public Expenditures.** Nothing in these STCs concerning certification of public expenditures relieves the State of its responsibility to comply with federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements. The State must certify that the following conditions for non-federal share of Demonstration expenditures are met:
- a. Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-federal share of funds under the Demonstration.

- b. To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c. To the extent the State utilizes CPEs as the funding mechanism to claim federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.
- d. The State may use intergovernmental transfers as a source of non-Federal share to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment. Intergovernmental transfers are not themselves expenditures, but may be a source of funding for expenditures.

48. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

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

## **X. MONITORING BUDGET NEUTRALITY**

50. **Aggregate Limit on Title XIX Funding.** The State 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 aggregate budget neutrality limit over the life of the Demonstration is defined in STC 40. The per member per month budget neutrality expenditure limits are set on a yearly basis with a cumulative per member per month expenditure limit for the length of the entire Demonstration extension.

51. **Risk.** The State shall be at risk for the both the number of enrollees in the Demonstration as well as the per capita cost for Demonstration eligibles under the aggregate budget neutrality agreement as defined in STCs 40 and 52. The cumulative, per member per month limit will vary based on actual caseload.

52. **Budget Neutrality Aggregate Cap.** Budget neutrality is determined on an aggregate cap basis as shown below:

<b>DY/ FFY</b>	<b>Annual Budget Neutrality Cap (total computable)</b>
DY 1/ FFY 2006	\$ 841,266,663
DY 2/ FFY 2007	\$ 843,594,654
DY 3/ FFY 2008	\$ 919,247,991
DY 4/ FFY 2009	\$ 1,002,321,263
DY 5/ FFY 2010	\$ 1,093,591,603
<b>Total DY 1 to DY 5</b>	\$ 4,700,022,174
DY 6/ FFY 2011	\$ 1,165,191,563
DY 7/ FFY 2012	\$ 1,248,077,166
DY 8/ FFY 2013	\$ 1,337,393,583
DY 9/ 10/01/2013 – 12/31/2013	\$ 505,202,312
<b>Total for Extension Period</b>	\$ 4,255,864,623
<b>Cumulative Total (Initial 5 Years Plus Extension Period)</b>	\$ 8,955,886,798

53. **Impermissible DSH, Taxes or Donations.** The CMS reserves the right to adjust the budget neutrality ceiling in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or with policy interpretations implemented through letters, memoranda, or regulations. 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 section 1903(w) of the Social Security Act (the Act). Adjustments to annual budget targets will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.
54. **How the Limits will be Applied.** The limits calculated in paragraph 52 will apply to actual expenditures for the Demonstration including claims incurred during the Demonstration period but paid after the end of the 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 eight and a quarter-year period, the budget neutrality test will be pro-rated based on the time period through the termination date.
55. **Enforcement of Budget Neutrality.** CMS will enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval.
56. **Expenditure Review and Cumulative Target Calculation.** CMS will 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.

<u>Year</u>	<u>Cumulative Target</u> (Total Computable Cost)	<u>Cumulative Target</u> <u>Definition</u>	<u>Percentage</u>
Year 6	\$1,200,147,310	Year 6 budget estimate plus	3 percent
Year 7	\$2,449,467,760	Years 6 and 7 combined budget estimate plus	1.5 percent
Year 8	\$3,769,415,624	Years 6 through 8 combined budget estimate plus	0.5 percent
Year 9	\$4,255,864,624	Years 6 through 9 combined budget estimate plus	0 percent

## **XI. EVALUATION OF THE DEMONSTRATION**

57. **Submission of Draft Evaluation Design.** The State must submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after CMS’ approval of the Demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in section II of these STCs, as well as the specific hypotheses that are being tested, including those indicators that focus specifically on the target populations and the public health outcomes generated from the use of Demonstration funds. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval. It must 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 must be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.
58. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State’s request for each subsequent renewal.
59. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft evaluation design described in paragraph 57 within 60 days of receipt, and the State must submit a final design within 60 days after receipt of CMS comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after the expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.
60. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any

component of the Demonstration the State will cooperate fully with CMS or the independent evaluator selected by CMS. The State will submit the required data to the contractor or CMS as requested.

**XII. USE OF DEMONSTRATION FUNDS**

61. **Use of Demonstration Funds.** Expenditures within the per member per month limit (calculated over the life of the Demonstration) can include expenditures for the following purposes:
- a. Reduce the rate of uninsured and/or underinsured in Vermont;
  - b. Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
  - c. Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and
  - d. Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

**XIII. SCHEDULE OF THE STATE DELIVERABLES OF THE DEMONSTRATION PERIOD**

<b>Date Specific</b>	<b>Deliverable</b>	<b>STC Reference</b>
120 days after approval	Submit Draft Evaluation Plan	Section XI, paragraph 57
July 1, 2012	Draft ACA Transitional Plan	Section VIII, paragraph 39
October 1, 2012	Submit Final Evaluation Plan	Section XI, paragraph 59

	<b>Deliverable</b>	<b>STC Reference</b>
<b>Annually (by April 1<sup>st</sup>)</b>	Draft Annual Report	Section VIII, paragraph 38
<b>Quarterly</b>		
	Quarterly Operational Reports	Section VIII, paragraph 37
	CMS-64 Reports	Section IX, paragraph 42

## ATTACHMENT A: QUARTERLY REPORT CONTENT AND FORMAT

Under section VIII, paragraph 37, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

### **NARRATIVE REPORT FORMAT:**

**Title Line One** – Vermont Global Commitment to Health

**Title Line Two - Section 1115 Quarterly Report**

#### **Demonstration/Quarter Reporting Period:**

Example:

Demonstration Year: 6 (10/1/2010 – 9/30/2011)

Federal Fiscal Quarter: 1/2010 (10/01/2010 – 12/31/2010)

### **Introduction**

Information describing the goal of the Demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

### **Enrollment Information**

Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by “0”.

**Enrollment Counts Note:** Enrollment counts should be person counts, not member months.

<b>Demonstration Populations</b>	<b>Current Enrollees: last day of the quarter: xx/xx/xxxx</b>	<b>Previously reported enrollees last day of quarter: xx/xx/xxxx</b>	<b>Variance</b>
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**Demonstration Population 1:**

**Demonstration Population 2:**

**Demonstration Population 3:**

**Demonstration Population 4:**

**Demonstration Population 5:**

**Demonstration Population 6:**

**Demonstration Population 7:**

**Demonstration Population 8:**

**Demonstration Population 9:**

**Demonstration Population 10:**

**Outreach/Innovative Activities**

Summarize outreach activities and/or promising practices for the current quarter.

**Operational/Policy Developments/Issues**

Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

**Expenditure Containment Initiatives**

Identify all current activities, by program and or Demonstration population. Include items such as status, and impact to date as well as short and long term challenges, successes and goals.

**Financial/Budget Neutrality Development/Issues**

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State’s actions to address these issues.

**Member Month Reporting**

Enter the member months for each of the EGs for the quarter.

**A. For Use in Budget Neutrality Calculations**

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Demonstration Population 1:				
Demonstration Population 2:				
Demonstration Population 3:				
Demonstration Population 4:				
Demonstration Population 5:				
Demonstration Population 6:				
Demonstration Population 7:				
Demonstration Population 8:				
Demonstration Population 9:				
Demonstration Population 10:				

**Consumer Issues**

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also discuss feedback received from the other consumer groups.

**Quality Assurance/Monitoring Activity**

Identify any quality assurance/monitoring activity in current quarter.

**Demonstration Evaluation**

Discuss progress of evaluation design and planning.

**Enclosures/Attachments**

Identify by title any attachments along with a brief description of what information the document contains.

**State Contact(s)**

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

**Date Submitted to CMS**

## **ATTACHMENT B: SUMMARY OF CATAMOUNT HEALTH**

Catamount Health is a new fully insured product that will be available through private insurers in Vermont. The Catamount Health Assistance Program offers a subsidized insurance program to Vermont residents who have been without health insurance coverage for a year or more, have income at or below 300 percent of FPL, and who do not have access to employer-sponsored insurance that has been approved and is cost effective. The beneficiary's share of the premium is based on income.

### **Participating Carriers**

Insurers currently offering products in the small group market may offer Catamount Health. The benefits to be provided in the plan are set out in the legislation creating the program. Insurers offering Catamount Health are required to provide benefit plans that are actuarially equivalent to the following, which are modeled on a PPO plan:

- A \$500.00 annual deductible for an individual and a \$1000.00 deductible for a family for health services received in network;
- A \$1000.00 annual deductible for an individual and a \$2,000.00 deductible for a family for health services received out of network;
- 20 percent co-insurance, in and out of network;
- \$10.00 office co-payment;
- Prescription drug coverage without a deductible, \$10.00 co-payments for generic drugs, \$35.00 co-payments for drugs on the preferred drug list, and \$55.00 co-payments for non-preferred drugs;
- Out-of-pocket maximums of \$1,050.00 for an individual and \$2,100.00 for a family for in-network services and \$2,100.00 for an individual and \$4,000.00 for a family for out-of-network services; and
- A waiver of the deductible and other cost-sharing payments for chronic care for individuals participating in chronic care management and for preventive care.

## ATTACHMENT C: Premiums and Co-Payments for Demonstration Populations

Population	Premiums	Co-Payments	State Program Name
<b><i>Traditional Medicaid-eligible Mandatory and Optional Populations</i></b>			
<b>Demonstration Population 1:</b> Mandatory Categorically Needy	\$0 or as otherwise indicated in approved Medicaid State Plan	Medicaid State Plan	Medicaid/Dr. Dynasaur
<b>Demonstration Population 2:</b> Optional Categorically Needy	\$0 or as otherwise indicated in approved Medicaid State Plan	Medicaid State Plan	Medicaid/Dr. Dynasaur
<b><i>Vermont Health Access Plan (VHAP) Expansion Populations</i></b>			
<b>Demonstration Population 3:</b> Underinsured children with income between 225 percent and up to and including 300% of the FPL who are not otherwise eligible for Medicaid or the Children's Health Insurance Program	Premiums not to exceed the following:  186-225% FPL: \$15/month/family 226-300% FPL: \$20/month/family	Not to exceed the nominal co-payments specified in the Medicaid State plan	Dr. Dynasaur
<b>Demonstration Population 4:</b> Adults with children with income between 150 percent and up to and including 185 percent of FPL	Premiums not to exceed the following: 150-185% FPL: \$49/month	Not to exceed the nominal co-payments specified in the Medicaid State Plan plus \$25 per emergency room visit, with no charge if admitted to the hospital	VHAP
<b>Demonstration Population 5:</b> Adults with income up to and including 150 percent of FPL	Premiums not to exceed the following: 50-75% FPL: \$7/month 76-100% FPL: \$25/month 101-150% FPL: \$33/month	Not to exceed the nominal co-payments specified in the Medicaid State Plan plus \$25 per emergency room visit, with no charge if admitted to the hospital	VHAP
<b>Demonstration Population 6:</b> Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income at or below 150 percent of the FPL, not otherwise categorically eligible	Premiums not to exceed the following:  0-150% FPL: \$15/month/person	Not to exceed the nominal co-payments specified in the Medicaid State plan	VHAP Pharmacy/ VPharm1
<b>Demonstration Population 7:</b> Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income above 150 percent but less than and including 225 percent of the FPL, not otherwise categorically eligible	Premiums not to exceed the following:  151-175% FPL: \$20/month/person 176-225% FPL: \$50/month/person	Not to exceed the nominal co-payments specified in the Medicaid State plan	VScript/VPharm2 or VScript Expanded/ VPharm3
<b>Demonstration Population 8:</b> Individuals with persistent mental illness with income up to and including 150 percent of FPL	Premiums not to exceed the amounts indicated in the Medicaid State Plan	Not to exceed the nominal co-payments specified in the Medicaid State plan	VHAP
<b><i>Premium Assistance Expansion Populations</i></b>			
<b>Demonstration Population 9:</b> ESI Premium Assistance Expansion Population	Premiums not to exceed the following:  50-75% FPL: \$7/month 76-100% FPL: \$25/month 101-150% FPL: \$33/month 150-185% FPL: \$49/month	Not to exceed the nominal co-payments specified in the Medicaid State Plan plus \$25 per emergency room visit, with no charge if admitted to the hospital	VHAP-ESI
<b>Demonstration Population 10:</b> Catamount Health Premium Assistance Expansion Population	Based on lowest cost plan; premium amounts will be the same as Catamount  Based on lowest cost plan; amounts dictated by Vermont Legislation	N/A	Non-VHAP ESI or Catamount

\*Cost refers to the amount of reimbursement.

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-01-16  
Baltimore, Maryland 21244-1850



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**Children and Adults Health Programs Group**

June 5, 2013

Mr. Mark Larson, Commissioner  
Department of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, VT 05495

Dear Mr. Larson:

Thank you for your recent request to extend Vermont's Global Commitment section 1115 demonstration (11-W-00194/1). The Centers for Medicare & Medicaid Services (CMS) received your extension request on May 21, 2013. We have completed a preliminary review of the application, and have determined that the state's application has met the requirements for a complete application as specified under section 42 CFR 431.412(a).

In accordance with section 42 CFR 431.416(a), CMS acknowledges receipt of the state's application. The 30-day federal comment period, as required under 42 CFR 431.416(b), begins on June 5, 2013 and ends on July 4, 2013. The state's application is available at <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>.

We look forward to working with you and your staff, and are available to provide technical assistance as you revise the state's application. If you have additional questions or concerns, please contact your project officer, Megan Renfrew, Division of State Demonstrations and Waivers, at (410) 786-0435, or at [megan.renfrew@cms.hhs.gov](mailto:megan.renfrew@cms.hhs.gov).

Sincerely,

/s/

Diane T. Gerrits  
Director  
Division of State Demonstration and Waivers

cc: Jen Ryan, CMCS  
Richard McGreal, ARA DMCHO, CMS Boston Regional Office  
Megan Renfrew, CMCS

PETER SHUMLIN  
Governor



State of Vermont  
OFFICE OF THE GOVERNOR

April 23, 2013

Secretary Kathleen Sebelius  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Dear Secretary Sebelius:

Through transmittal of this letter and its attachments, Vermont is requesting federal approval to renew its Section 1115 Demonstration, the Global Commitment to Health (11-W-00194/1) beyond the December 31, 2013 expiration date, and to consolidate Vermont's Choices for Care (long-term care) Section 1115 Demonstration and the Children's Health Insurance Program (CHIP) into the renewed Global Commitment Demonstration.

A single, consolidated Demonstration will enable Vermont to:

- Build on the successes of both waivers using the Global Commitment model as the foundation.
- Advance both federal and state health reform initiatives, including changes contemplated by the Affordable Care Act (ACA) and Vermont Act 48 (2011).
- Ensure a smooth transition for Vermonters whose health care coverage will change as a result of the ACA, and maintain affordability of the coverage options.
- Streamline program administration, oversight and reporting.
- Manage a seamless system for all acute and long term services and supports for people with developmental disabilities, traumatic brain injuries, and physical disabilities as well as for individuals who are aging.
- Continue to expand the availability of flexible services and supports to assist individuals with complex needs.
- Seamlessly integrate Medicare payments for dually eligible Vermonters into the existing managed care model and provide higher quality care for beneficiaries while achieving efficiencies through a single integrated administrative approach.

Since 1996, Vermont and CMS have partnered to reform health care delivery and financing to make coverage affordable and accessible for low and middle-income Vermonters. The Global Commitment to Health Section 1115 Demonstration and the Choices for Care Long Term Care 1115 Demonstration, both initiated in 2005, serve as the foundation for Vermont's health reform effort. Through these waivers Vermont is provided necessary flexibility to improve access to health coverage and care based on an individual's and family's needs. The Demonstrations have served as a vehicle for achieving the following reform objectives:

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

Vermont supports the goals of the Affordable Care Act (ACA) to enhance access to health care coverage, improve service delivery and control program cost growth. We are committed to collaborating with CMS to ensure that state and federal health reform activities are complementary and coordinated.

Please contact Stephanie Beck, Director of Health Care Operations (802-871-3265), in Agency of Human Services Secretary Douglas Racine's office to begin the detailed discussions necessary to ensure a successful 2014 renewal.

We look forward to working with you and your staff to continue and expand upon Vermont's successes.

Sincerely,



Peter Shumlin  
Governor

cc: Juliana Sharp, CMS  
Richard McGreal, CMS  
Stephen Mills, CMS  
Robert Cruz, CMS

Enclosures

# State of Vermont

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## *Agency of Human Services*

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

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

**Submitted: April 2013 Revised May 17, 2013**

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## I. Introduction and Summary of Demonstration Projects

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

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

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

### ***Global Commitment to Health***

#### Historical Summary

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

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

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

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

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

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

### **Global Commitment to Health Demonstration Objectives and Successes**

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

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

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

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

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

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

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

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

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

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

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

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

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

Future goals of the Blueprint include:

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

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

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

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

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

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

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

Additionally, programmatic service delivery changes have included:

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

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

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

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

## **Choices for Care**

### **Historical Summary**

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

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

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

### **Choices for Care Demonstration Objectives and Successes**

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

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

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

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

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

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

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

## ***Future Goals***

### **Vermont Health Care Reform**

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

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

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

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

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

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

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

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

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

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

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

### **Affordable Care Act (ACA)**

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

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

### **Summary**

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

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

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

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

## **II. Proposed Health Delivery System**

### ***A. Continuation of Public MCO Model and Regulatory Structure***

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

### ***B. Consolidation and Integration of 1115 Medicaid Demonstrations and Programs***

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

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

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

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

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

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

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

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

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

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

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

**III. Eligibility Groups & ACA Impact**

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

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

- **Vermont Health Access Plan (VHAP)** - An expansion program available to adults age 18 and older who do not meet the eligibility requirements for Medicaid, and who have income that is under 150% of the FPL for adults with no children, or 185% of the FPL for parents and caretaker relatives who have minor children in the home. There is no asset test but eligible applicants must have been uninsured for 12 months or more, with exceptions for people who recently lost their insurance because of a life change such as a divorce or loss of a job. VHAP provides a comprehensive package of benefits with nominal copayments and monthly premiums. Under the ACA:
  - Adults in VHAP with incomes at or below 133% of the FPL would transition to Medicaid;
  - Adults in VHAP with incomes above 133% of the FPL would be eligible for federal tax credits and cost-sharing subsidies for private plans offered through the Exchange. Vermont plans to collaborate with CMS to implement a premium and cost-sharing subsidy program for individuals up to 300% of the FPL to ensure coverage is affordable and accessible.
  
- **Catamount Health Premium Assistance (CHAP)** - Catamount Health is a private health insurance plan, offered in cooperation with the State. People who have been uninsured for 12 or more months, with some exceptions for loss of insurance due to a life change, and who have income less than or equal to 300% of the FPL may qualify for premium assistance based on a sliding scale. There is no asset test. Under the ACA:
  - Adults in Catamount Health premium assistance (CHAP) with income less than or equal to 133% of the FPL would transition to Medicaid;
  - Adults in CHAP with income above 133% of the FPL would be eligible for federal tax credits and cost-sharing subsidies for private plans offered through the Exchange, as long as they do not have access to an affordable Employer-Sponsored Insurance plan. Vermont plans to collaborate with CMS to implement a premium and cost-sharing subsidy program for individuals up to and including 300% of the FPL to ensure coverage is affordable and accessible.
  
- **Employer-Sponsored Insurance (ESI) Premium Assistance** - People who otherwise meet the eligibility criteria for VHAP or CHAP may receive premium assistance to enroll in their ESI plan if it is more cost-effective for the State than enrolling them in either VHAP or CHAP. Beneficiaries enrolled in ESI premium assistance pay a monthly premium equivalent to that paid by beneficiaries in VHAP or CHAP. Beneficiaries otherwise eligible for VHAP but enrolled in their ESI plan receive wrap-around coverage for cost-sharing required by their ESI plan. Beneficiaries otherwise eligible for CHAP but enrolled in their ESI plan receive wrap-around coverage for the prevention and maintenance of certain chronic conditions. Under the ACA:
  - Adults in VHAP-ESIA with income at or below 133% of the FPL would transition to Medicaid;
  - Adults in VHAP-ESIA with income above 133% of the FPL will not be eligible for federal premium tax and cost-sharing subsidies under the ACA unless the employer plan is unaffordable. Individuals employed by small employers may be able to buy through the Exchange, or if their employers drop coverage, will be eligible as individuals to buy through the Exchange.

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

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

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

#### **IV. Benefits and Cost Sharing**

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

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

#### **V. Proposed Demonstration Changes**

##### ***A. Use of consistent MAGI methodologies for Income Determination***

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

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

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

### ***B. Streamlined Eligibility Transition Process***

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

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

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

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

### ***C. Premium Subsidies and Cost Sharing For Exchange Participants***

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

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

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

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

<sup>2</sup> Updated to 2013

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

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

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

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

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

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

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

Note: Amounts include State and Federal share.

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

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

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

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

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

### Summary of Proposed Demonstration Changes

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

## **VI. Requested Waivers and Expenditure Authorities**

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

### **Statewideness/Uniformity**

**Section 1902(a)(1)**

To the extent necessary to enable Vermont to operate the program differently in different geographical areas of the State.

### **Hearing and Appeals**

**Section 1902(a)(3)**

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

### **Reasonable Promptness**

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

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

### **Amount, Duration, Scope of Services**

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

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

### **Financial Eligibility**

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

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

### **Comparability**

**Section 1902(a)(17)**

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

**Financial Responsibility/Deeming**

**Section 1902(a)(17)(D)**

To the extent necessary to enable the State to use more liberal income and resource standards and methods for plan groups and individuals whose eligibility is determined under the more liberal standards and methods, resource standards, and requirements that differ from those required under title XIX. The waiver would specifically exempt the State from the limits under section 1902(a)(17)(D) on whose income and resources may be used to determine eligibility unless actually made available, and so that family income and resources may be used instead.

To enable the State to disregard quarterly income totaling less than \$20 from the post-eligibility income determination.

**Payment to Providers**

**Sections 1902(a)(13), 1902(a)(30)**

To allow the State, through the Department of Vermont Health Access, to establish rates with providers on an individual or class basis without regard to the rates currently set forth in the approved State Plan.

**Spend-Down**

**Section 1902(a)(17)**

To offer one-month spend-downs for medically needy people receiving community-based services as an alternative to institutionalization, and non-institutionalized persons who are receiving personal care attendant services at the onset of waivers.

**Freedom of Choice**

**Section 1902(a)(23)**

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

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

**Premium Requirements**

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

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

**Retroactive Eligibility**

**Section 1902(a)(34)**

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

**Cost Sharing Requirements**

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

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

**Direct Provider Reimbursement**

**Section 1902(a)(32)**

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

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

**1. Expenditures Related to Eligibility Expansion**

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

**2. Expenditures Related to Additional Services**

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

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

Subject to availability of funding within the per member per month limit, expenditures to reduce the rate of uninsured and/or underinsured in Vermont, increase access to quality health care for uninsured, underinsured and Medicaid beneficiaries, provide public health approaches and other innovative programs to improve the health outcomes and quality of life for Medicaid beneficiaries; and encourage the formation and maintenance of public private partnerships in health care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## **VIII. Financial Data**

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

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

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

### **Budget Neutrality Status, Years 1 through 5**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Notes:

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

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

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

Notes:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## IX. Public Notice Process

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Public Comments and Associated Responses**

#### Public Hearing Comments:

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

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

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

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

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

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

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

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

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

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

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

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

1. The Support and Services At Home (SASH) project is a formal partner with DAIL, DVHA and the Blueprint Community Health Teams to provide proactive supports to seniors that will allow them to stay in their home and community settings as long as medically possible. Project staff asked that specific edits be made to the renewal narrative to describe the program.

A. The state has accepted a few edits that were submitted, however the state has many partners in success and to list all such projects in this narrative would be unrealistic. The state is proud of the many innovative community efforts in place across Vermont.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19. VLA Senior Law Project notes that ACA creates a “MAGI cliff” and requests that the state address this in its waiver request.
  - A. We will explore this issue further and work with CMS to determine if any proposed remedy is within the purview of the Global Commitment waiver.
  
20. VLA Senior law Projects requests no changes be made to medically needy spend down and deeming rules.
  - A. The state is not requesting changes to these rules.

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

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

**State of Vermont**

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

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

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

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

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**Table 4: Actual Expenditures, Years 1 - 5 (State and Federal)**

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

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Table 5: Summary of Program Expenditures With and Without Waiver, Years 1 - 5 (State and Federal)

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

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**Table 6: Projected Expenditures Without Waiver, Years 6 Through 9 (State and Federal)**

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

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

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

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

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

**State of Vermont  
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**Table 9: Actual and Projected Expenditures with Waiver, Years 6 Through 9 (State and Federal)**

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

State of Vermont  
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Table 10: Summary of Program Expenditures With and Without Waiver, Years 6 - 9 (State and Federal)

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

State of Vermont  
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Table 11: Projected Expenditures Without Waiver, Years 9 Through 13 (State and Federal)

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

Projected expenditures for CFC  
already approved through Sept '15

**State of Vermont  
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**Table 12a: Projected Expenditures with Waiver, Years 9 Through 13 (State and Federal) Without Reform**

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

**State of Vermont  
Global Commitment to Health**

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

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

State of Vermont  
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Table 13: Summary of Program Expenditures With and Without Waiver, Years 9 - 13 (State and Federal)

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

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Global Commitment to Health

Projected Caseloads with Waiver, Years 9 Through 13 (State and Federal) *Without Reform*

	Waiver Year									
	9 (Jan Dec '14)		10 (Jan Dec '15)		11 (Jan Dec '16)		12 (Jan Dec '17)		13 (Jan Dec '18)	
<b>Global Commitment</b>										
ABD - Non-Medicare - Adult	172,738		175,486		178,278		181,115		183,997	
ABD - Non-Medicare - Child	44,917		45,146		45,376		45,607		45,840	
ABD - Dual	214,950		223,943		233,314		243,076		253,247	
ANFC - Non-Medicare - Adult	152,394		162,010		172,232		183,099		185,921	
ANFC - Non-Medicare - Child	669,636		673,036		676,452		679,886		683,338	
Global Expansion (VHAP)										
Global Rx	150,739		150,249		149,761		149,274		148,789	
Optional Expansion (Underinsured)	11,837		11,277		10,743		10,235		9,750	
VHAP ESI										
ESIA										
CHAP										
ESIA Expansion - 200-300% of FPL										
CHAP Expansion - 200-300% of FPL										
New Adult	428,251		441,380		454,911		468,856		483,230	
<b>Total Global Commitment</b>	<b>1,845,462</b>		<b>1,882,526</b>		<b>1,921,067</b>		<b>1,961,148</b>		<b>1,994,111</b>	
<b>Choices for Care</b>										
Highest Level of Care	36,237		36,420		36,603		36,788		36,973	
High Level of Care	7,009		7,689		8,435		9,254		10,152	
Moderate Level of Care	11,196		11,892		12,632		13,417		14,251	
Program of All-Inclusive Care for the Elderly (PACE)										
Community Rehabilitation and Treatment (CRT)	1,549		1,603		1,660		1,718		1,779	
<b>Total Choices for Care</b>	<b>55,991</b>		<b>57,604</b>		<b>59,330</b>		<b>61,177</b>		<b>63,155</b>	
<b>Combined Total: Global Commitment &amp; Choices for Care</b>	<b>1,901,453</b>		<b>1,940,131</b>		<b>1,980,396</b>		<b>2,022,325</b>		<b>2,057,266</b>	

State of Vermont

Global Commitment to Health

Projected Expenditures per Member per Month with Waiver, Years 9 Through 13 (State and Federal) *Without Reform*

	Waiver Year									
	9		10		11		12		13	
	(Jan	Dec '14)	(Jan	Dec '15)	(Jan	Dec '16)	(Jan	Dec '17)	(Jan	Dec '18)
<b>Global Commitment</b>										
ABD - Non-Medicare - Adult	\$	1,191.43	\$	1,260.31	\$	1,333.16	\$	1,410.22	\$	1,491.74
ABD - Non-Medicare - Child	\$	2,303.36	\$	2,350.35	\$	2,398.30	\$	2,447.23	\$	2,497.16
ABD - Dual	\$	1,174.16	\$	1,193.66	\$	1,213.48	\$	1,233.62	\$	1,254.11
ANFC - Non-Medicare - Adult	\$	651.77	\$	691.64	\$	733.96	\$	778.87	\$	826.53
ANFC - Non-Medicare - Child	\$	396.79	\$	417.50	\$	439.30	\$	462.23	\$	486.35
Global Expansion (VHAP)										
Global Rx	\$	66.39	\$	73.59	\$	81.57	\$	90.41	\$	100.22
Optional Expansion (Underinsured)	\$	198.46	\$	208.59	\$	219.24	\$	230.43	\$	242.19
VHAP ESI										
ESIA										
CHAP										
ESIA Expansion - 200-300% of FPL										
CHAP Expansion - 200-300% of FPL										
New Adult	\$	498.59	\$	525.86	\$	554.61	\$	584.94	\$	616.92
<b>Total Global Commitment</b>	\$	<b>629.75</b>	\$	<b>660.49</b>	\$	<b>692.93</b>	\$	<b>727.07</b>	\$	<b>762.74</b>
<b>Choices for Care</b>										
Highest Level of Care	\$	4,035.27	\$	4,192.02	\$	4,354.86	\$	4,524.02	\$	4,699.75
High Level of Care	\$	3,050.50	\$	3,165.64	\$	3,285.14	\$	3,409.14	\$	3,537.83
Moderate Level of Care	\$	293.83	\$	307.75	\$	322.34	\$	337.62	\$	353.63
Program of All-Inclusive Care for the Elderly (PACE)										
Community Rehabilitation and Treatment (CRT)	\$	2,678.38	\$	2,661.67	\$	2,645.07	\$	2,628.57	\$	2,612.17
<b>Total Choices for Care</b>	\$	<b>3,126.31</b>	\$	<b>3,210.53</b>	\$	<b>3,296.39</b>	\$	<b>3,383.99</b>	\$	<b>3,473.44</b>
<b>Combined Total: Global Commitment &amp; Choices for Care</b>	\$	<b>706.55</b>	\$	<b>739.54</b>	\$	<b>774.32</b>	\$	<b>810.89</b>	\$	<b>849.46</b>

State of Vermont

Global Commitment to Health

Projected Caseloads with Waiver, Years 9 Through 13 (State and Federal) *With Reform*

	Waiver Year									
	9 (Jan Dec '14)		10 (Jan Dec '15)		11 (Jan Dec '16)		12 (Jan Dec '17)		13 (Jan Dec '18)	
<b>Global Commitment</b>										
ABD - Non-Medicare - Adult	172,738		175,486		178,278		181,115		183,997	
ABD - Non-Medicare - Child	44,917		45,146		45,376		45,607		45,840	
ABD - Dual	214,950		223,943		233,314		243,076		253,247	
ANFC - Non-Medicare - Adult	152,394		162,010		172,232		209,851		214,031	
ANFC - Non-Medicare - Child	669,636		673,036		676,452		679,886		683,338	
Global Expansion										
Global Rx	150,739		150,249		149,761		149,274		148,789	
Optional Expansion (Underinsured)	11,837		11,277		10,743		10,235		9,750	
VHAP ESI										
ESIA										
CHAP										
ESIA Expansion - 200-300% of FPL										
CHAP Expansion - 200-300% of FPL										
New Adult	428,251		441,380		454,911		555,953		567,180	
<b>Total Global Commitment</b>	<b>1,845,462</b>		<b>1,882,526</b>		<b>1,921,067</b>		<b>2,074,997</b>		<b>2,106,171</b>	
<b>Choices for Care</b>										
Highest Level of Care	36,237		36,420		36,603		36,788		36,973	
High Level of Care	7,009		7,689		8,435		9,254		10,152	
Moderate Level of Care	11,196		11,892		12,632		13,417		14,251	
Program of All-Inclusive Care for the Elderly (PACE)										
Community Rehabilitation and Treatment (CRT)	1,549		1,603		1,660		1,718		1,779	
<b>Total Choices for Care</b>	<b>55,991</b>		<b>57,604</b>		<b>59,330</b>		<b>61,177</b>		<b>63,155</b>	
<b>Combined Total: Global Commitment &amp; Choices for Care</b>	<b>1,901,453</b>		<b>1,940,131</b>		<b>1,980,396</b>		<b>2,136,174</b>		<b>2,169,325</b>	

State of Vermont

Global Commitment to Health

Projected Expenditures per Member per Month with Waiver, Years 9 Through 13 (State and Federal) *Reform*

	Waiver Year									
	9		10		11		12		13	
	(Jan	Dec '14)	(Jan	Dec '15)	(Jan	Dec '16)	(Jan	Dec '17)	(Jan	Dec '18)
<b>Global Commitment</b>										
ABD - Non-Medicare - Adult	\$	1,191.43	\$	1,260.31	\$	1,333.16	\$	1,752.48	\$	1,853.78
ABD - Non-Medicare - Child	\$	2,303.36	\$	2,350.35	\$	2,398.30	\$	2,658.73	\$	2,712.98
ABD - Dual	\$	1,174.16	\$	1,193.66	\$	1,213.48	\$	1,313.03	\$	1,334.83
ANFC - Non-Medicare - Adult	\$	651.77	\$	691.64	\$	733.96	\$	998.45	\$	1,059.54
ANFC - Non-Medicare - Child	\$	396.79	\$	417.50	\$	439.30	\$	545.53	\$	574.00
Global Expansion										
Global Rx	\$	66.39	\$	73.59	\$	81.57	\$	90.41	\$	100.22
Optional Expansion (Underinsured)	\$	198.46	\$	208.59	\$	219.24	\$	237.97	\$	250.12
VHAP ESI										
ESIA										
CHAP										
ESIA Expansion - 200-300% of FPL										
CHAP Expansion - 200-300% of FPL										
New Adult	\$	498.59	\$	525.86	\$	554.61	\$	761.39	\$	803.02
<b>Total Global Commitment</b>	\$	<b>633.13</b>	\$	<b>663.93</b>	\$	<b>696.43</b>	\$	<b>857.21</b>	\$	<b>900.51</b>
<b>Choices for Care</b>										
Highest Level of Care	\$	4,035.27	\$	4,192.02	\$	4,354.86	\$	4,681.42	\$	4,863.27
High Level of Care	\$	3,050.50	\$	3,165.64	\$	3,285.14	\$	3,505.21	\$	3,637.52
Moderate Level of Care	\$	293.83	\$	307.75	\$	322.34	\$	347.48	\$	363.96
Program of All-Inclusive Care for the Elderly (PACE)										
Community Rehabilitation and Treatment (CRT)	\$	2,678.38	\$	2,661.67	\$	2,645.07	\$	2,724.53	\$	2,707.54
<b>Total Choices for Care</b>	\$	<b>3,126.31</b>	\$	<b>3,210.53</b>	\$	<b>3,296.39</b>	\$	<b>3,498.03</b>	\$	<b>3,590.21</b>
<b>Combined Total: Global Commitment &amp; Choices for Care</b>	\$	<b>706.55</b>	\$	<b>739.54</b>	\$	<b>774.32</b>	\$	<b>932.84</b>	\$	<b>978.81</b>

**Assumptions for Budget Neutrality Projections (CY 2014 - 2018)**

MEG	Caseload Projections					PMPM Projections					
	Trends	Adjustments		Total	Adjustment WITHOUT REFORM	Adjustment WITH REFORM	Trends	Adjustments		Total	Adjustment WITH REFORM
	Oct '10 - Dec '13	Aging of Pop. (1)	Increased Access to Svcs. for Cognitive Impairments (2)	CY '14-'18	ACA Migration: Additional MM CY '18	ACA Migration: Additional MM CY '18	Oct '10 - Dec '13**	VT Hosp / ACA PCP	Prov Rate Increases / Increased Complexity of Needs	CY '14-'18	Cost Shift Increase CY '17'18
ABD - Non-Medicare - Adult	1.59%			1.59%			4.54%	1.24%		5.78%	\$ 342.26
ABD - Non-Medicare - Child	0.51%			0.51%			1.45%	0.59%		2.04%	\$ 211.50
ABD - Dual	4.18%			4.18%			0.68%	0.98%		1.66%	\$ 79.41
ANFC - Non-Medicare - Adult	3.82%			3.82%	17,793	28,110	4.58%	1.53%		6.12%	\$ 219.58
ANFC - Non-Medicare - Child	0.51%			0.51%			4.17%	1.05%		5.22%	\$ 83.30
Global Expansion (VHAP)	0.74%						4.17%	1.30%			
Global Rx	-0.33%			-0.33%			10.84%	0.00%		10.84%	\$ -
Optional Expansion (Underinsured)	-4.73%			-4.73%			4.87%	0.24%		5.10%	\$ 7.54
New Adult*	0.74%			0.74%	54,979	83,950	4.17%	1.30%		5.47%	\$ 176.45
Highest Level of Care	-3.50%	3.50%	0.50%	0.50%			0.79%	0.10%	3.00%	3.88%	\$ 157.41
High Level of Care	5.70%	3.50%	0.50%	9.70%			0.68%	0.10%	3.00%	3.77%	\$ 96.07
Moderate Level of Care	2.22%	3.50%	0.50%	6.22%			1.64%	0.10%	3.00%	4.74%	\$ 9.86
Program of All-Inclusive Care for the Elderly (PACE)	19.05%						-0.54%				
Community Rehabilitation and Treatment (CRT)	-0.48%	3.50%	0.50%	3.52%			-3.72%	0.10%	3.00%	-0.62%	\$ 95.96

\*New Adult trends assumed similar to eliminated VHAP MEG

1 - The State of Vermont expects an additional 3.50% annual growth in caseload for the Medicare-eligible population due to the increased aging of Vermont's over 65 population.

2 - The State of Vermont is experiencing an increased need to serve individuals with cognitive impairments (e.g., dementia). The State will be continuing to build additional capacity to meet these needs, and therefore is projecting a modest 0.5% annual growth in caseload for the Choices for Care population.

\*\*CFC MEG trends include months Oct '05 - Dec '13

Reduction in GC Administrative Costs under Reform: 1.00% of total spending

## **CHOICES FOR CARE 1115 Long-term Care Medicaid Waiver Summary of Eligibility, Benefits, Cost Sharing and Delivery System: April 2013**

Vermont's Choices for Care Long Term Care Medicaid Demonstration provides long-term care services to elderly or physically disabled Vermont adults who are found both clinically and financially eligible. The primary goal of the Choices for Care Demonstration Waiver is to provide Vermonters with equal access to either nursing facility care or home and community-based services, consistent with their choice. The Choices for Care Demonstration is managed by the Vermont Department of Aging and Independent Living (DAIL).

The Choices for Care Demonstration is operated using the following principles and policies:

- Services are based on a person-centered planning process designed to ensure quality and protect the health and welfare of the individuals receiving services.
- Services are provided in a cost-effective and efficient manner, preventing duplication, unnecessary costs, and unnecessary administrative tasks.
- DAIL will use resources efficiently and ensure benefits and services are available to the greatest number of eligible individuals possible.

Eligibility for the Demonstration includes those individuals who meet long term care financial eligibility as:

- Categorically eligible individuals
- Medically needy individuals
- Medicaid Working Disabled

Eligibility for services includes persons who have a functional physical limitation resulting from a physical condition (including stroke, dementia, traumatic brain injury, and similar conditions) or associated with aging. Persons must be a Vermont resident aged 18 or older who meets both clinical and financial eligibility requirements. Individuals whose need for services is due solely to mental retardation, autism, or mental illness are not eligible for services.

Clinical Eligibility Criteria fall into three groups, Highest Needs, High Needs and Moderate Needs. Both clinical and financial eligibility must be met in order for an individual to be served in the Choices for Care Demonstration.

**Highest Needs Group:** Financial (Medicaid) eligibility standards for this group are determined according to the state's Supplemental Security Income (SSI-related) Medicaid regulations applicable to long-term care eligibility. Individuals who apply and meet any of the following clinical eligibility criteria are eligible for and enrolled in the Highest Needs group:

1. Individuals who require extensive or total assistance with at least one of the specified Activity of Daily Living (ADLs), toilet use, eating, bed mobility, or transfer -- and at *least* limited assistance with any other ADL.

2. Individuals who have a moderate to severe impairment with decision-making skills and one of the following behavioral symptoms or conditions which occurs frequently and is not easily altered:
  - a. Wandering Verbally Aggressive Behavior;
  - b. Resists Care Physically Aggressive Behavior;
  - c. Behavioral Symptoms.
  
3. Individuals who have at least one of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis:
  - a. Stage 3 or 4 Skin Ulcers Ventilator/ Respirator;
  - b. IV Medications Naso-gastric Tube Feeding;
  - c. End Stage Disease Parenteral Feedings;
  - d. 2nd or 3rd Degree Burns Suctioning.
  
4. Individuals who require daily skilled nursing assessment, monitoring and care for an unstable medical condition related, but not limited to, at least one of the following:
  - a. Dehydration or Internal Bleeding;
  - b. Aphasia Transfusions;
  - c. Vomiting or Wound Care;
  - d. Quadriplegia Aspirations;
  - e. Chemotherapy Oxygen;
  - f. Septicemia Pneumonia;
  - g. Cerebral Palsy Dialysis;
  - h. Respiratory Therapy Multiple Sclerosis;
  - i. Open Lesions Tracheotomy;
  - j. Radiation Therapy Gastric Tube Feeding.
  
5. An individual may also be enrolled in the Highest Needs group when DAIL determines that the individual has a critical need for long-term care services due to special circumstances that may adversely affect the individual's safety. DAIL may, with the consent of the individual, initiate such an action. An individual may also request such an action. Special circumstances may include:
  - a. Loss of primary caregiver (e.g. hospitalization of spouse, death of spouse);
  - b. Loss of living situation (e.g. fire, flood);
  - c. The individual's health and welfare is at imminent risk if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect); or
  - d. The individual's health condition would be at imminent risk or worsen if services are not provided or if services are discontinued (e.g. circumstances such as natural catastrophe, effects of abuse or neglect).

**High Needs Group:** Enrollment in the High Needs group is limited by the availability of funds. If funds are unavailable, the names of eligible applicants are put on a waiting list. Financial (Medicaid) eligibility standards for this group are determined according to the state's Supplemental Security Income (SSI-related) Medicaid regulations applicable to long-term care eligibility. Individuals who meet any of the following clinical eligibility criteria are eligible for and may be enrolled in the High Needs group:

1. Individuals who require extensive to total assistance on a daily basis with at least one of the following ADLs: bathing; dressing; eating; toilet use; physical assistance to walk;
2. Individuals who require skilled teaching on a daily basis to regain control of, or function with at least one of the following:
  - a. Gait Training or Speech;
  - b. Range of Motion, Bowel, or Bladder Training;
3. Individuals who have impaired judgment or impaired decision-making skills that require constant or frequent direction to perform at least one of the following:
  - a. Bathing or Dressing;
  - b. Eating or Toilet Use;
  - c. Transferring or Personal Hygiene;
4. Individuals who exhibit at least one of the following behaviors requiring a controlled environment to maintain safety for self:
  - a. Constant or Frequent Wandering;
  - b. Behavioral Symptoms;
  - c. Physically Aggressive Behavior;
  - d. Verbally Aggressive Behavior;
5. Individuals who have a condition or treatment that requires skilled nursing assessment, monitoring, and care on a less than daily basis including, but not limited to, the following conditions AND who require an aggregate of other services (personal care, nursing care, medical treatments or therapies) on a daily basis:
  - a. Wound Care Suctioning;
  - b. Medication Injections for End Stage Disease;
  - c. Parenteral Feedings for Severe Pain Management;
  - d. Tube Feedings
6. Individuals whose health condition will worsen if services are not provided or if services are discontinued;
7. Individuals whose health and welfare will be at imminent risk if services are not provided or if services are discontinued.

**Moderate Needs Group:** Enrollment in the Moderate Needs group is limited by the availability of program funds. Applicants who meet both the clinical criteria and the financial criteria for the Moderate Needs group may be enrolled in the program. If funds are unavailable, the names of any eligible applicants are put on a waiting list. Individuals are financially eligible for the Moderate Needs group if they meet DAIL's financial criteria below.

1. The income standard for the Moderate Needs group is met if the adjusted monthly income of the individual (and spouse, if any) is less than 300% of the supplemental security income (SSI) payment standard for one person (or couple) in the community after deducting recurring monthly medical expenses (including but not limited to prescriptions, medications, physician bills, hospital bills, health insurance premiums, health insurance co-pays, and medical equipment and supplies). Countable Income for the individual includes all sources of earned and unearned income, including Social Security, SSI, retirement, pension, interest, VA benefits, wages, salaries, earnings and rental income.
2. The resource standard for the Moderate Needs group is met if all resources of the individual are less than or equal to \$10,000. If the resources exceed \$10,000, the individual shall not be eligible. If there is a question about whether or not resources or income are countable under this section, DAIL shall apply the SSI-related community Medicaid financial eligibility rules. Countable resources includes cash, savings, checking, certificates of deposit, money markets, stocks, bonds and trusts that an individual (or couple) owns and could easily convert to cash to be used for his or her support and maintenance (trust resources are included even if the conversion results in the resource having a discounted value).
3. Post-eligibility rules related to transfer of assets and patient share do not apply to individuals enrolled in the Moderate Needs group.

Individuals are found to be eligible and may be enrolled in the Moderate Needs group if they meet any of the following clinical criteria:

1. Individuals who require supervision or any physical assistance three (3) or more times in seven (7) days with any single ADL or IADL, or any combination of ADLs and IADLs.
2. Individuals who have impaired judgment or decision making skills that require general supervision on a daily basis.
3. Individuals who require at least monthly monitoring for a chronic health condition.
4. Individuals whose health condition will worsen if services are not provided or if services are discontinued.

**The covered services and delivery of care for the Choices for Care need-based groups are as follows:**

### **Choices for Care Covered Services - Highest and High Needs Groups**

- Case Management (maximum of 48 hours/year)
- Personal Care (maximum of 4.5 hours/week of assistance for the following IADLs: phone use, money management, household maintenance, housekeeping, laundry, shopping, transportation, and care of adaptive equipment)
- Respite Care (maximum, including companion care, of 720 hours/year)
- Companion Care (maximum, including respite care, of 720 hours/year)
- Adult Day Services (maximum of 12 hours/day)
- Assistive Devices and Home Modifications (maximum of \$750/year)
- Personal Emergency Response Systems (PERS)
- Intermediary Services Organization (ISO)
- Enhanced Residential Care
- Nursing Facility
- Adult Family Care
- Flexible Choices
- Other services as defined by the Department

### **Choices for Care Covered Services - Moderate Needs Group**

- Case management (maximum of 12 hours/year)
- Adult day services (maximum of 50 hours/week)
- Homemaker (maximum of 6 hours/week)
- Other services as defined by the Department

### **Cost Sharing**

There are currently no costs sharing requirements under the Choices for Care Demonstration.

### **Delivery System**

Services under the Choices for Care Demonstration are provided by an array of home and community providers statewide. Beneficiaries may choose to receive services from a variety of provider types (listed below) or may choose to use self-directed care by hiring their own caregivers using a fee for model and a case manager for support or under Vermont's Flexible Choices option (cash and counseling) by developing a budget within a set allowance, with help from a consultant. Both self-directed care options use an intermediate service organization under contract with the state of Vermont. Hyperlinks below provide listings of providers based on geographic regions of Vermont.

- [\*\*Adult Day Centers\*\*](#) : Adult Day Centers provide an array of services to help older adults and adults with disabilities to remain as independent as possible in their own homes. Adult day services provide programs during the daytime. Programs include activities, social interaction, nutritious meals, health screening and monitoring, personal care, and transportation. Respite for family caregivers is also available. Adult Day Centers are certified by the state according to the Standards for Adult Day Services in Vermont

<http://www.ddas.vermont.gov/ddas-policies/policies-adult-day/policies-adult-day-documents/standards-for-adult-day-services-vt>).

- **[Area Agencies on Aging](#)** : Area Agencies on Aging provide support to people 60 and older in their efforts to remain active, healthy, financially secure, and in control of their own lives. Area Agencies on Aging are certified by the state according to the Case Management Standards & Certification Procedures for Older American's Act Programs & Choices for Care (2009).
- **[Assisted Living Facilities](#)** : Assisted Living Facilities are state licensed residences that combine housing, health and supportive services to support resident independence and aging in place. Assisted Living Facilities are licensed by the state according to the Assisted Living Residence Licensing Regulations ( <http://www.dail.vermont.gov/dail-statutes/statutes-dlp-documents/assisted-living-regs-final>).
- **[Home Health Agencies](#)** : Home Health Agencies provide health services in the home. Services include: nursing; personal care; physical therapy; homemaker services; hospice care, and social work services. Home Health Agencies are designated by the state according to the Regulations for the Designation and Operation of Home Health Agencies (<http://www.dail.vermont.gov/dail-statutes/statutes-dlp-documents/regs-designation-operation-home-health-agencies>). They are also certified to provide Choices for Care case management services according to the Case Management Standards & Certification Procedures for Older American's Act Programs & Choices for Care (2009).
- **[Nursing Facilities](#)** : Nursing homes provide nursing care and related services for people who need nursing, medical, rehabilitation, or other special services. They are licensed by the state according to the Licensing and Operating Rules for Nursing Homes and may be certified to participate in the Medicaid and/or Medicare programs. Certain nursing homes may also meet specific standards for sub-acute care or dementia care. (<http://www.dail.vermont.gov/dail-statutes/statutes-dlp-documents/nursing-home-regulations>).
- **[Residential Care Homes - Level III](#)** : Residential care homes are state licensed group living arrangements designed to meet the needs of people who cannot live independently and usually do not require the type of care provided in a nursing home. When needed, help is provided with daily activities such as eating, walking, toileting, bathing, and dressing. Residential care homes may provide nursing home level of care to residents under certain conditions. **Level III** homes provide nursing overview, but not full-time nursing care. (<http://www.dail.vermont.gov/dail-statutes/statutes-dlp-documents/rch-licensing-regulations>).
- **Personal Emergency Response Organizations:** Personal Emergency Response organizations provide an array of services to help older adults and adults with disabilities to remain as independent as possible in their own homes.
- **Adult Family Care Home:** (Currently under development. Implementation planned for mid-2013) Adult Family Care Homes are private homes designed to provide 24-hour services in a family-oriented home setting. Authorized Agencies will be approved by the state and receive a daily rate to match people with an approved home provider and to manage all of their long-term services and supports.

***PHPG***

**The Pacific Health Policy Group**



***INTERIM PROGRAM EVALUATION***

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**Global Commitment to Health**

*11-W-00194/1*

*On behalf of:*

**State of Vermont  
Agency of Human Services**

*Prepared by:*

**The Pacific Health Policy Group  
April 2013**

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# Introduction

## Purpose of Evaluation

In compliance with the Special Terms and Conditions, the State of Vermont submits to the Centers for Medicare and Medicaid Services (CMS) this Interim Program Evaluation with its request to renew the Global Commitment to Health (GC) Section 1115 Demonstration waiver for the five year period from January 1, 2014 through December 31, 2018. This Evaluation reports the Demonstration's progress toward accomplishing its three goals: 1) increasing access, 2) improving quality, and 3) controlling costs.

This Evaluation includes a compilation of Vermont's quality assessment and improvement activities, as well as emerging results from Vermont's innovative programs for Chronic Care Management and its Patient Centered Medical Home Initiative, Blueprint for Health. As part of its renewal request the State is requesting that the 1115 Long Term Care Demonstration waiver, Choices for Care (CFC), be consolidated into the GC Demonstration. To-date, evaluation activities of the two waivers have been separate. This evaluation focuses on GC Demonstration activities while the CFC Demonstration information will be reported separately. Additionally, the Agency of Human Services (AHS) will be working closely with the Green Mountain Care Board (GMCB) to craft a revised evaluation plan that continues to align and complement any new health care reform initiatives.

## Background on Health Care Reform in Vermont

The State of Vermont passed comprehensive health care reforms in 2006, augmented in 2007 and 2008, to expand access to coverage, improve the quality and performance of the health care system, and contain costs. The reforms encompass 11 bills with over 60 different initiatives including the availability of subsidized coverage options for low-income uninsured Vermonters, investments in health information technology, and the strategy to transform the health care delivery system through integration of prevention, chronic disease management, and provider payment reform.

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

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

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

Vermont's comprehensive package of health care reforms is based on the following design principles:

- It is the policy of the State of Vermont to ensure universal access to, and coverage for, essential health care services for all Vermonters.
- Health care coverage needs to be comprehensive and continuous.
- Vermont's health care delivery system must model continuous improvement of health care quality and safety.
- The financing of health care in Vermont must be sufficient, equitable, fair, and substantial.
- Built-in accountability for quality, cost, access, and participation must be the hallmark of Vermont's health care system.
- Vermonters must be engaged, to the best of their ability, to pursue healthy lifestyles, to focus on preventive care and wellness efforts, and to make informed use of all health care services throughout their lives.

Using these principles as a framework, Vermont's health care reforms are designed to simultaneously achieve the following three goals:

Increase access to affordable health insurance for all Vermonters;  
Improve quality of care across the lifespan; and,  
Contain health care costs.

The GC Demonstration has served as the foundation for Vermont's health reform model, providing the flexibility to improve access to health coverage and care based on individual and family needs. The GC

Demonstration enables Vermont to operate as if it were a (public) Medicaid Managed Care model for achieving the following reform objectives:

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

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

### Background on Global Commitment

In October, 2005, Vermont entered into a new five-year comprehensive 1115 federal Medicaid Demonstration waiver, Global Commitment (GC) designed to, 1) provide the State with financial and programmatic flexibility to help Vermont maintain its broad public health care coverage and provide more effective services, 2) continue to lead the nation in exploring new ways to reduce the number of uninsured, and 3) foster innovation in health care by focusing on health care outcomes.

The GC Demonstration consolidates funding for all of the State's Medicaid programs, except for the Choices for Care (CFC) long-term care Demonstration, the Children's Health Insurance Program (CHIP) and Disproportionate Share Hospital (DSH) payments for hospitals. It also converts the operations of the state's Medicaid organization to a (public) Medicaid Managed Care Organization. Under the GC Demonstration, Vermont has the flexibility to implement creative programs and reimbursement mechanisms to help curb costs and improve quality of care: new payment mechanisms such as case rates, capitation, and combined funding streams to pay for services not traditionally reimbursable through Medicaid and investments in programmatic innovations. The managed care regulatory framework and program model also encourages interdepartmental collaboration and consistency across programs.

The Special Terms and Conditions require Vermont's (public) managed care model, DVHA, to comply with the Medicaid managed care requirements contained in federal law and regulations, including requirements that improve information available to beneficiaries, promote access to care, and enhance accountability. DVHA has transformed its operations to comply with these laws and regulations. In exchange for the additional flexibility granted under the GC Demonstration, the State of Vermont and Federal government have agreed to an aggregate cumulative 8.25 year spending limit.

A GC Demonstration amendment approved by CMS on October 31, 2007 allowed Vermont to implement the Catamount Health Premium Assistance Program with the corresponding commercial Catamount Health Plan (implemented by State statute October 1, 2007) to reduce the number of uninsured Vermonters. The Catamount Health Plan is offered in cooperation with Blue Cross Blue Shield of Vermont and until recently MVP Health Care. On December 23, 2009 a second amendment was approved to extend eligibility for Catamount Health and Employer Sponsored Insurance subsidies from 200% to 300% of the Federal Poverty Level (FPL), to extend pharmacy benefits for Medicare beneficiaries from 175% of FPL to 225% of FPL and to waive the 12-month waiting period. Following renewal effective January 1, 2011, another amendment, approved December 7, 2011, allows the state to provide both palliative and curative care at the same time for children with a terminal illness who are not expected to survive into adulthood. The last amendment, finalized on June 27, 2012, adjusted co-pay levels as directed by the Vermont Legislature.

### Waiver Continuation

The State is in the final stage of submitting a letter of intent and draft request to CMS indicating its commitment to renew the GC Demonstration for the period January 1, 2014 to December 31, 2018.

### Contents of Evaluation

In accordance with the Special Terms and Conditions of the GC Demonstration, AHS contracted with the Pacific Health Policy Group (PHPG) to prepare an evaluation of the GC Demonstration and its performance relative to the goals set forth at implementation. Specifically, PHPG has been directed to assess the following goals as specified in the Revised Evaluation Plan submitted to CMS in December 2008:

Goal 1: Increase Access to Care	<ul style="list-style-type: none"><li>• Evaluation of Global Commitment’s ability to increase Medicaid beneficiary access to primary care</li></ul>
Goal 2: Enhance Quality of Care	<ul style="list-style-type: none"><li>• Evaluation of the extent to which Global Commitment has enhanced the quality of care for Medicaid beneficiaries</li></ul>
Goal 3: Control Cost of Care	<ul style="list-style-type: none"><li>• Evaluation of Global Commitment’s ability to contain (by maintaining or reducing) Medicaid spending in comparison to what would have been spent absent the waiver</li></ul>

This evaluation is organized according to the three goals specified previously. For each goal, a summary of goal accomplishments and a discussion of related data and initiatives is presented.

To measure the performance of the GC Demonstration, PHPG has compiled data from a variety of applicable projects and reports made available by AHS and nationally. The following resources were used:

- Global Commitment to Health Enrollment 2006-2012
- Vermont Department of Financial Regulation, formerly Department of Banking Insurance Securities and Health Care Administration (BISHCA), Vermont Health Insurance Coverage Survey (2001-2006, 2008, 2012)
- 2007-2012 External Quality Review Organization (EQRO) Technical Reports
- 2011-2012 HEDIS Measures
- 2011 and 2012 Consumer Assessment of Health Provider and Systems (CAHPS) Survey
- 2012 Blueprint for Health Annual Report
- 2012 Global Commitment to Health Demonstration Annual and Quarterly Reports to CMS
- NCQA, State of Health Care Quality 2012

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## Goal 1: Increase Access to Care

All Vermont Medicaid beneficiaries must have access to comprehensive care, including financial, geographic, physical, and communicative access. This means having health coverage, with appropriate providers, timely access to services, and culturally sensitive services.

### Goal 1: Highlights:

The GC Demonstration has succeeded at increasing access to care for Vermont Medicaid beneficiaries over the first eight years of the waiver as measured in the following areas:

- *Average Enrollment:* average enrollment grew by 16.3% between 2009 and 2012, for an overall increase of 27.5% since 2006.
- *Number of Uninsured:* uninsured rate in Vermont decreased from 7.6% in 2009 to 6.8% in 2012, well below the national rate of 15.7% in 2011 (most recent U.S. Census data available).
- *HEDIS Measures:* improvement in standing relative to HEDIS access to care measures and as related to scores achieved by accredited Medicaid HMO's as reported in the NCQA 2012 *State of Health Care Quality Report*.
  - Significantly higher (10%) than the accredited Medicaid HMO average of 63% for Well Child Visits in the First 15 months of Life.
  - High performance for Child and Adolescent access to primary care physician (PCP) with scores ranging from 92% to 98% across the childhood years.
  - High scores related to Adult Access to Preventive and Ambulatory Care, 80% to 83.5% across the adult years.
- *Beneficiary Satisfaction:* According to the 2012 CAHPS, most respondents are satisfied with provider availability with 84.8% reporting they received the care needed and 84% reporting they received needed care quickly. Overall, respondents were satisfied with provider access.
- *Access to Buprenorphine:* DVHA, in cooperation with the Vermont Department of Health (VDH)/Division of Alcohol and Drug Abuse Programs (VDH/ADAP), the Department of Corrections (DOC), and the commercial insurers, is increasing access for patients to Buprenorphine services and increasing the number of physicians licensed to prescribe Buprenorphine. At the end of FFY 2012, the program successfully increased provider access for beneficiaries to receive treatment. In addition, providers who were enrolled in the program consistently increased their patient loads incrementally each month.

- *Blueprint for Health, Patient Centered Medical Home:* Starting in 2011 and continuing in 2012 there was accelerated growth in the number of primary care practices engaged in Vermont’s multi-payer patient centered medical home activities. Having moved from pilot to implementation, the Blueprint is now in all 14 Health Service Areas. As of December 31, 2012, 106 primary care practices serving approximately 422,000 Vermonters have successfully undergone the national recognition process, with several more scheduled for scoring in each month of 2013.

**Goal 1: Data and Related Initiatives**

Global Commitment Enrollment for 2006-2012

The GC Demonstration covers a significant portion of the total Vermont population, and its potential impact extends beyond those directly enrolled. As part of the Revised Evaluation Plan, the AHS must show that the GC Demonstration continues to enroll Medicaid beneficiaries. Data in Table 1-1 show the total lives (member months divided by 12) enrolled in the GC Demonstration from FFY 2006 through FFY 2012.

**Table 1-1: Global Commitment Average Number of Enrollees**

<i>Federal Fiscal Year (FFY):</i>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Total Lives (Member Months / 12)	128,987	127,284	129,274	141,323	154,855	162,287	164,414
<i>Percent Change from Previous Year</i>		-1.3%	1.6%	9.3%	9.6%	4.8%	1.3%

Enrollments presented in Table 1-1 are summarized as follows:

- Enrollment was essentially flat during the first three years of the waiver.
- Average enrollment increased by over 9% in 2009 and 2010 before falling to more modest rates in 2011 and 2012.
- Average enrollment increased 27.5% from 2006 to 2012.

Department of Financial Regulation (formerly BISHCA) Health Insurance Coverage Survey (2001-2006; 2008, 2012)

According to the Health Insurance Group Profile of Vermont Residents, 2001-2006, and the 2008 and 2012 Vermont Household Health Insurance Survey, Table 1-2 summarizes the number of Vermonters insured under the private market, government, and uninsured from 2005 to 2012.

**Table 1-2: Vermont Health Insurance Coverage 2000-2012**

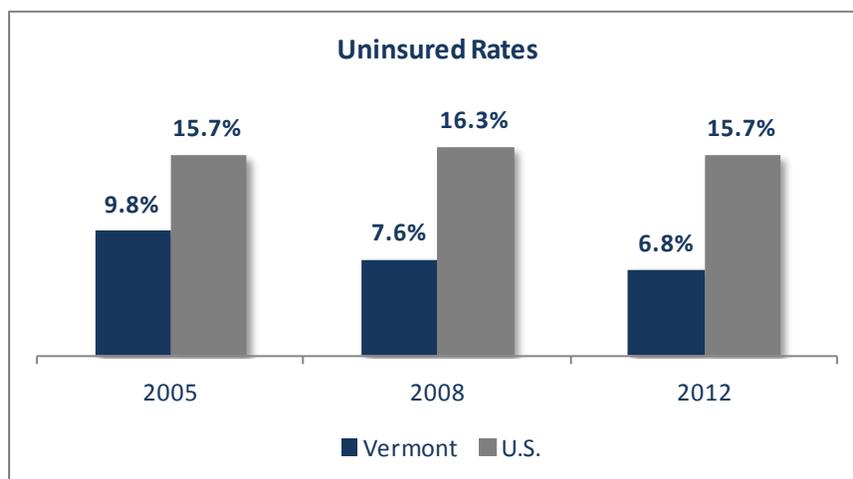
	2000	2005	2008	2009	2012	2000	2005	2008	2009	2012
	<b>Rate</b>					<b>Count</b>				
Private Insurance*	60.1%	59.4%	59.9%	57.2%	56.8%	366,213	369,348	370,981	355,358	355,857
Medicaid	16.1%	14.7%	16.0%	17.6%	17.9%	97,664	91,126	99,159	109,353	111,833
Medicare	14.4%	14.5%	14.3%	15.3%	16.0%	87,937	90,110	88,915	95,182	100,505
Military	0.9%	1.6%	2.4%	2.2%	2.5%	5,626	9,754	14,910	13,917	15,477
Uninsured	8.4%	9.8%	7.6%	7.6%	6.8%	51,390	61,057	47,286	47,460	42,760

**Notes:**

- Data sources: 2000, 2005, 2008, 2009, 2012 Vermont Household Health Insurance Survey, Dept. Financial Regulation
- Private Insurance includes Catamount Health Program
- Medicaid excludes enrollees dually eligible for Medicare, Catamount Health Program, and Employer-Sponsored Insurance (ESI) Programs, which are included in the enrollment figures in Table 1-1.

Table 1-2 can be summarized as follows:

- The number of Vermonters enrolled in Medicaid as their primary coverage increased by 2.3% between 2009 and 2012, for a total of 22.7% since before the GC Demonstration.
- The number of uninsured Vermonters has decreased by 10.5% as a percent of the population between 2009 and 2012, for a total decrease of 30.6% since before the GC Demonstration.
- The uninsured rate in Vermont has been consistently below the national rate throughout the life of the GC Demonstration, most recently in 2012, 6.8% compared to 15.7% (2011 for national rate, the most recent U.S. Census data available).



2012 HEDIS Measures

Table 1-3 shows four HEDIS measures used to evaluate access to primary care for 2011 and 2012. Where available, data are displayed with comparisons made to NCQA reported averages for accredited Medicaid HMO scores for 2012. GC Demonstration measures for children and adolescents include Annual Dental Visits, Well-Child Visits in the First 15 Months of Life (6 or more visits), Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, and Adolescent Well-Care.

**Table 1-3: Global Commitment Access to Care Child/Adolescent HEDIS Measures**

HEDIS Measure	VT EQRO Year		VT Average: 2011-2012	NCQA Accredited Medicaid HMO Average	VT vs. NCQA HMO Average
	2011	2012			
Well Child Visits 1 <sup>st</sup> 15 Months (6 or more)	72.18%	73.91%	73.05%	63.2%	9.85%
Well Child 3 <sup>rd</sup> , 4 <sup>th</sup> , 5 <sup>th</sup> , 6 <sup>th</sup> year	69.02%	69.70%	69.36%	72.8%	-3.44%
Adolescent Well Care	46.25%	46.17%	46.21%	50.8%	-4.59%
Annual Dental Combined <21 yo*	68.13%	68.10%	68.12%	n/a	
Child/Adolescent Access to PCP					
12-24months	98.18%	98.34%	98.26%	96.3%	1.96%
25months-6 yrs	91.56%	92.18%	91.87%	88.5%	3.37%
7-11 yrs	94.05%	94.54%	94.30%	90.1%	4.19%
12-19 yrs	93.52%	93.56%	93.54%	88.3%	5.24%

\*n/a – not available

Well-Child Visits in the First 15 months of Life was significantly higher than the accredited Medicaid HMO scores for 2012 (10%). Well-Child Visits in the First 15 months of Life is defined as the percentage of enrolled members who turned 15 months during the measurement year, and who had 6 or more well-child visits with a primary care practitioner during their first 15 months of life.

Well-Child Visits (ages 3 -6 years) exceeded the accreditation Medicaid HMO scores by 3% in 2012. Well Child Visits represents the percentage of children (ages 3 – 6 years) who received one or more well-child visits with a primary care practitioner during the measurement year.

Child and Adolescent Access to a PCP scores were consistently higher than accredited Medicaid HMO scores for all age ranges.

**Table 1-4 Adult Access Measures**

Measure	VT EQRO Year		NCQA Accredited Medicaid HMO Average
	2011	2012	
Adult Access to Preventative/Ambulatory Care			
20-44 years	83.09%	81.39%	n/a
45-64 years	84.88%	83.59%	n/a
65 and over	82.09%	79.49%	n/a
Total	83.56%	81.92%	n/a
Anti-Depressant Medication Mgt			
Effective Acute phase Treatment	66.98%	68.42%	50.9%
Continuation Phase Treatment	51.38%	54.54%	34.5%

n/a: not available

For most adult access measures, NCQA comparison scores for accredited Medicaid HMOs were not available. However, the state’s contracted External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), notes that overall, Vermont showed strong performance (greater than the 75th percentile) across three measures related to access in 2012:

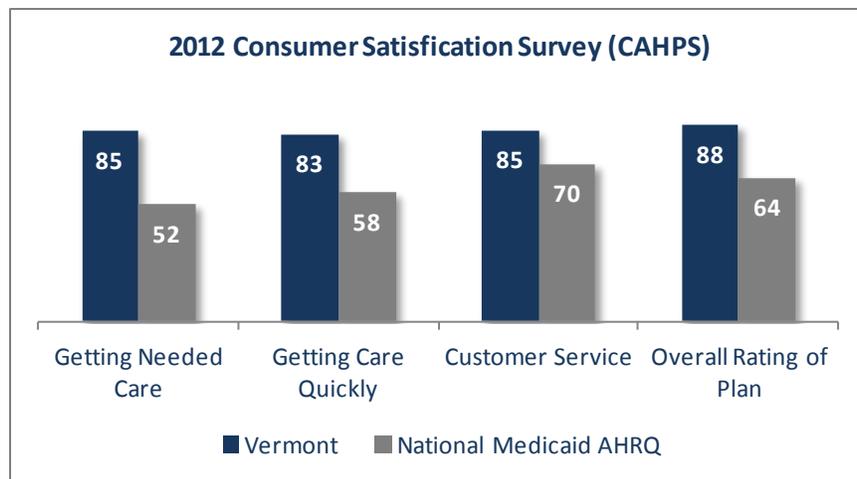
- Significantly exceeded the national average for Annual Dental Visits in 2011 (by 17.4%).
- Exceeded the national average for Children’s and Adolescents’ Access to Primary Care Practitioners in 2011 (by an average of 4.2%).
- Significantly higher than the national average for 2011 for Antidepressant Medication Management: Acute and Continuation Phase (by 18% and 20% respectively).

2012 Customer Assessment of Health Care Providers and Systems (CAHPS) Survey

The DVHA contracted with a private vendor, WB&A Market Research, who assisted in the administration and scoring of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan 4.0 Adult Medicaid survey. The CAHPS Health Plan 4.0 Adult Medicaid survey includes 39 questions; DVHA added questions from the CAHPS Health Plan 4.0 Supplemental Items for a total of 55 questions. The survey was administered to 600 beneficiaries enrolled in the GC Demonstration in the six months prior to the fielding of the survey. A multi-modal (using both telephone and mail) approach was used to increase the response rate. Beneficiaries received an introductory mailing, a survey mailing, and a follow up reminder postcard after which beneficiaries are contacted by phone. The survey was administered in the spring of 2012. The 2012 overall response rate was 54.3% which was an increase over the 2009 response rate. 80% of beneficiaries responded by mail, while 20% responded by telephone. The mail response rate increased 3% over 2009.

According to the survey results, respondents overall were satisfied in their experiences with provider access, customer service and their plan.

- 84% of Vermont beneficiaries report satisfaction with access to care, as compared to 52% of Medicaid beneficiaries nationally.
- 83.4% of Vermont beneficiaries report satisfaction in getting needed care quickly as compared to 57.5% of Medicaid beneficiaries nationally.
- 85% of Vermont beneficiaries report satisfaction with customer service as compared to 70% of Medicaid beneficiaries nationally.
- 87.5% of Vermont beneficiaries report satisfaction with their health plan as compared to 64% of Medicaid beneficiaries nationally.



In addition, according to the 2012 CAHPS data, most respondents are satisfied with provider punctuality, availability (in both urgent and non-urgent situations), attentiveness, and coordination of care. Overall, Vermont’s Medicaid Managed Care model showed strong performance across two composite CAHPS measures related to access as compared to 2009 scores:

- Getting Needed Care - percentage of beneficiaries that responded they were “Always” or “Usually” able to get care when attempting to do so improved from 79.9% in 2009 to 84.8% in 2012.
- Getting Care Quickly – percentage of beneficiaries that responded that they were “Always” or “Usually” able to receive care or advice in a reasonable time, including office waiting room experiences, improved from 81.6% in 2009 to 83.4% in 2012.

AHS and DVHA must comply with the access to care standards as required by CMS. The Quality Assurance/Performance Improvement Committee (QAPI) produced the 2008 Medicaid Managed Care Quality Strategy (Quality Strategy) which implements a written strategy for assessing and improving all aspects of managed care services. The 2010 EQRO report shows an overall compliance score of 97%

with 42 CFR 438 standards related to enrollee and access. Specifically standards and associated scores contributing to the 97% overall score include:

- ✓ Availability of Services (100% or 13 of 13 elements met).
- ✓ Furnishing of Services (93% or 12 of 14 elements met and two partially met).
- ✓ Cultural Competence (100% or 4 of 4 elements met).
- ✓ Coordination and Continuity of Care (100% or 8 of 8 elements met).
- ✓ Coverage and Authorization of Services (95% or 19 of 21 elements met and 2 partially met).
- ✓ Emergency and Post Stabilization Services (100% or 13 of 13 elements met)
- ✓ Enrollment and Disenrollment (83% or 2 of 3 elements met and 1 partially met)

### Catamount Health and Green Mountain Care

To increase access to care, the State made available in October of 2007 the Catamount Health Plan, a separate insurance pool for uninsured Vermonters. Since its launch in November 2007, the State has insured over 10,000 individuals under the plan. The success of the plan can be attributed to its lower premium costs versus comparable plans on the individual market – the State also offers premium assistance under the plan to those with incomes under 300% of the Federal Poverty Level (FPL).

With the launch of the Catamount Health Plan, all public health care programs were rebranded under the umbrella name “Green Mountain Care” with the tag line, “A Healthier State of Living.” Promotional materials, a web site, logo and an advertising campaign helped achieve 69% brand recognition for Green Mountain Care within three months of launching.

The legislature passed a provision providing amnesty for the pre-existing condition exclusion under the Catamount Health Plan. This created the need to educate the public about this time-limited offer to have all conditions covered without waiting periods if they applied before November 1, 2008. This was done through press releases, trainings, LISTSERVs, State government emails, a mailing in partnership with the Vermont Department of Labor to all 22,000 private sector employers in Vermont, and by updating the image of the web button link which existed on over 20 partnering websites.

Simultaneous with the Amnesty Campaign was a successful “Senior Campaign” to reach college graduates and their parents. Public and private colleges showed support by marketing directly to 6,250 college seniors and 3,600 faculty and staff.

The State also provides subsidies through its Employer-Sponsored Insurance (ESI) Premium Assistance Program to complement the Catamount Health Plan and limit the possibility of “crowd-out” from employer-based coverage. Finally, the State determines the cost-effectiveness of enrolling an individual in a certain program versus another, and makes the appropriate decision.

Enrollment in the Catamount Health premium assistance program grew steadily in the past few years but began to slow in 2012 with an average monthly enrollment of 10,716 individuals. Enrollment in the

Employer-Sponsored Insurance (ESI) program decreased for 2012 with only 1553 individuals enrolled (including those eligible for VHAP-ESI). On average 824 individuals enrolled in VHAP-ESI and on average 729 individuals enrolled in ESI. Most recent decreases in ESI enrollment is partially due to the fact that employers continue to increase the deductibles in their plans in an effort to control the cost of premiums. Vermont's ESI premium assistance program is not permitted, by law, to approve an ESI plan if the deductible is greater than \$500.

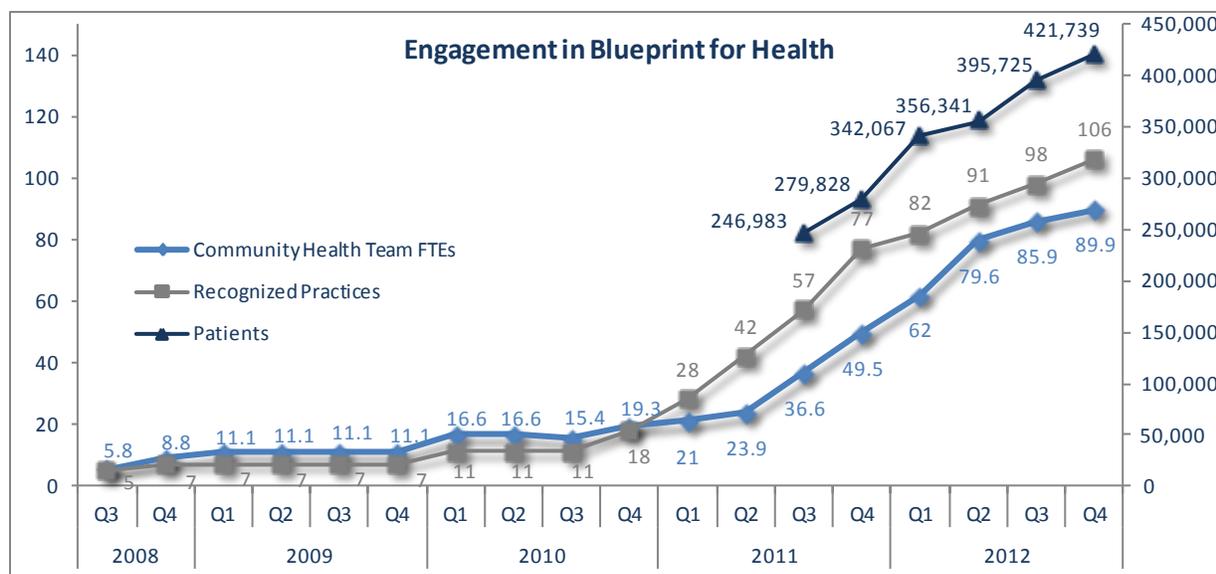
Green Mountain Care outreach has become an increasingly integral part of the Vermont Department of Labor's (DOL)'s response to layoffs. The DVHA and DOL have also developed a training curriculum for employers that explains everything an employer needs to know from paying the Catamount assessment to the health benefits available to uninsured Vermonters who qualify. As DVHA prepares for the transition to ACA in 2014, the Health Benefit Exchange team has begun aggressive work on the comprehensive outreach and education plan for Vermont's January 2014 transition.

### Blueprint for Health

Vermont's Blueprint for Health (Blueprint) is a multi-payer patient centered medical home initiative that employs a multi-payer advanced primary care practice (APCP) model. Practices are supported by Community Health Teams (CHTs) comprised of nurse coordinators, clinician case managers, social workers and other professionals who extend the capacity of primary care practices to provide multidisciplinary care and support. This model has enabled Vermont to provide high quality primary care with embedded multidisciplinary support services, better coordination and transitions of care, and more seamless linkages among diverse community partners. The Blueprint includes the following components:

- Multi-insurer payment reforms that support APCPs and CHTs;
- Statewide health information architecture to support coordination across a wide range of providers of health and human services; and
- Evaluation and quality improvement infrastructure to support a Learning Health System which continuously refines and improves itself.

Starting in 2011 and continuing through 2012, there was extraordinary growth in the number of primary care practices engaged in patient centered medical home activities. Having moved from pilot to program phase, the Blueprint now has a solid presence in all 14 Health Service Areas.



### Buprenorphine Program

DVHA in cooperation with the Vermont Department of Health - Alcohol & Drug Abuse Program (VDH-ADAP), the Department of Corrections (DOC), and commercial insurers, increased access for patients to Buprenorphine services, increased the number of physicians in Vermont licensed who prescribe Buprenorphine, and added support practices which care for the opiate-dependent population. In 2006, DVHA was appropriated funding by the legislature to implement the Buprenorphine Program.

Throughout FFY 2007 and FFY2008, DVHA in collaboration with VDH/ADAP, utilized the funding to establish and maintain the capitated payment program: reimbursement is tiered to increase reimbursement to physicians in a step-wise manner depending on the number of patients treated by the enrolled physician. Many physicians limit the number of opiate-dependent patients because of difficulties in caring for the population (i.e., missed appointments, diversion, time spent by office staff), and as a result, most physicians see fewer patients than they could.

In November 2007, despite a reduction in funding, DVHA and VDH-ADAP continued to collaborate to ensure that enrolled providers continued to receive support in the management of patients being treated with Buprenorphine for opioid dependence. At the end of FFY 2012, the program successfully increased provider access for beneficiaries to receive treatment. Enrolled providers consistently increased their patient loads incrementally each month. Additionally, Vermont’s Chronic Care Initiative (VCCI) staff provides direct care coordination in several pilot areas for beneficiaries in the Buprenorphine program.

As a result of this program DVHA, including the Blueprint for Health, VDH-ADAP and other AHS Departments have partnered on the creation of the “Hub and Spoke” model of medical home care for persons who are addicted to opioids (describe later in this report).

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## Goal 2: Enhance Quality of Care

The second goal of Global Commitment (GC) Demonstration is to enhance the quality of care to all Vermont Medicaid beneficiaries.

### Goal 2: Highlights

The GC Demonstration has succeeded at enhancing the quality of care for Vermont Medicaid beneficiaries over the eight years of the waiver as measured in the following areas:

- Compliance with required Managed Care quality of care standards identified by AHS. DVHA has consistently improved its compliance, scoring 100% compliant with all CMS measurement and improvement standards in 2012.
- DVHA has engaged in two Performance Improvement Projects (PIP) related to clinical care and received a score of 100% for all evaluation and critical evaluation elements met and an overall final validation status of 'Met' for both.
- The Vermont Chronic Care Initiative (VCCI) has made improvements in health outcomes for Vermont's highest risk Medicaid beneficiaries. Data for SFY 2011 showed a 14% reduction in inpatient admissions and a 10% reduction for emergency room utilization over the baseline year of 2008 for enrolled beneficiaries.
- Beneficiaries enrolled in VCCI showed better adherence to evidenced-based treatments than those not enrolled.
- Medicaid is an active partner in Vermont's Patient Centered Medical Home initiative, the Blueprint for Health. Emerging data from this multi-payer effort is beginning to show decreased utilization of emergency rooms and inpatient stays, and increased statewide access to quality care. Additionally, the Blueprint has partnered with Seniors Aging Safely at Home (SASH) and Medicare to implement a statewide effort to provide care coordination, nursing and other services to seniors directly within their community housing.
- In SFY 2008, DVHA began distributing \$292,836 annually to recognize and reward dentists serving high volumes of Medicaid beneficiaries. For SFY 2009, a distribution of \$146,418 was made in October 2008 and another distribution of \$146,418 was made in the spring of 2009, for an annual total of \$292,836. The initiative has continued on the same cycle and same dollar amount. Typically, 35-40 dentists qualify for semiannual payouts each year.
- Following Tropical Storm Irene's abrupt closure of the only state psychiatric hospital in August of 2011, the Department of Mental Health (DMH) implemented significant enhancements to the home and community based service system. This includes several new community-based crisis

stabilization and rehabilitation treatment services, increased community based psychiatric inpatient services, partnerships with law enforcement and greater step-down and hospital diversion capacity.

- Global Commitment has allowed the AHS to look at one overarching regulatory structure (42 CFR 438) and one universal EPSDT screening, referral and treatment continuum for services that were once the purview of several separate and distinct 1915(c)waivers and Medicaid state plan options. The Integrated Family Services Initiative seeks to bring all agency children, youth and family services together in an integrated and consistent continuum of services for families, regardless of federal funding stream (Title V, Title XIX, IDEA part B and C, Title IV-E, etc.). This universal care coordination should reduce duplication and close gaps in the system, especially at pivotal transition times. The premise being that giving a family early support, education and intervention will produce more favorable health outcomes at a lower cost than the current practice of *waiting until circumstances are bad enough* to access funding. Several pilot efforts are underway and include: performance based reimbursement projects, capitated annual budgets with caseload and shared savings incentives and flexible choices for self-managed services.

### Goal 2: Data and Related Initiatives

#### 2012 Medicaid Managed Care Quality Strategy

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

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

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

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

HSAG also indicated that DVHA's continuous quality improvement focus and activities, and steady improvements over the five years have been substantive and have led to demonstrated performance improvements, notable strengths, and commendable and impressive outcomes across multiple areas and performance indicators.

Finally, HSAG concluded that DVHA has demonstrated incremental and substantive growth and maturity which has led to its current role and functioning as a strong, goal-oriented, innovative, continuously improving Medicaid Managed Care model.

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

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

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

Vermont Chronic Care Initiative

The goal of the Vermont Chronic Care Initiative (VCCI) is to improve health outcomes of Medicaid beneficiaries through addressing the increasing prevalence of chronic illness. Specifically, the VCCI is designed to identify and assist Medicaid beneficiaries with chronic health conditions in accessing clinically appropriate health care information and services; coordinate the efficient delivery of health care by attempting to remove barriers, bridge gaps, and avoid duplication of services; and educate, encourage and empower these beneficiaries to eventually self-manage their chronic conditions.

The VCCI uses a holistic approach of evaluating both the physical and behavioral conditions, as well as the socioeconomic issues, that often are barriers to health improvement. The VCCI emphasizes evidence-based, planned, integrated and collaborative care for beneficiaries who exhibit high-prevalence chronic disease states, high-expense utilization, high medication utilization, and/or high emergency room and inpatient utilization. Ultimately, the VCCI aims to improve health outcomes by supporting better self-care and lowering health care expenditures through appropriate utilization of health care services. By targeting predicted high-cost beneficiaries, resources can be allocated where there is the greatest cost savings opportunity. The VCCI focuses on helping beneficiaries understand the health risks of their conditions; engage in changing their own behavior, and by facilitating effective communication with their primary care provider. The intention ultimately is to support the person in taking charge of his or her own health care.

The VCCI supports and aligns with other State health care reform efforts, including the Blueprint for Health APCPs and CHTs. The VCCI has now expanded its services to include all age groups and prioritize their outreach activities to target beneficiaries with the greatest need based on the highest acuity population (defined as the top 5%) with an ability to impact their conditions and/or utilization patterns. The VCCI is expanding both service scope as well as partnerships. A Pediatric Palliative Care Program was added in 2012 and in July 2010, the VCCI started embedding nursing and licensed social workers in primary care practices with high volume Medicaid populations and hospitals with high volume ambulatory sensitive emergency room and inpatient admissions.

Emerging data for VCCI is yielding positive results: data for State Fiscal Year 2011 showed a 14% reduction for inpatient admissions and a 10% reduction in emergency room utilization over the baseline year of 2008. Additionally, when compared to similar beneficiaries who were not enrolled in VCCI, those receiving VCCI service demonstrated better adherence to evidence based treatment.

Condition/Treatment Regime Measured	Percent adherence to treatment regime: <i>VCCI Participants</i>	Percent adherence to treatment regime: <i>Non-VCCI Participants</i>	VCCI vs. Non-VCCI Participants
Asthma (medication adherence)	53.2	33.8	19.4
COPD	75.8	58.9	16.9
Congestive Heart Failure (CHF) – ACE/ARB	65.3	42.4	22.9
CHF – Beta Blocker	70.5	45.7	24.8
CHF – Diuretic	65.3	41.2	24.1
Coronary Artery Disease (CAD) – Lipid test	67.0	56.6	10.4
CAD – Lipid lowering med	71.5	59.7	11.8
Depression – med 84 days	69.6	50.3	19.3
Depression – med 180 days	66.4	45.2	21.2
Diabetes – HbA1c test	86.3	67.4	18.9
Diabetes – Lipid test	69.6	55.7	13.9
Hyperlipidemia – 1 or more tests	67.8	56.8	11.0
Hypertension – 1 or more lipid tests	62.0	48.6	13.4
Kidney Disease – microalbuminuria screening	46.2	44.6	1.6
Kidney Disease – ACE/ARB	69.2	62.0	7.2

### Blueprint for Health

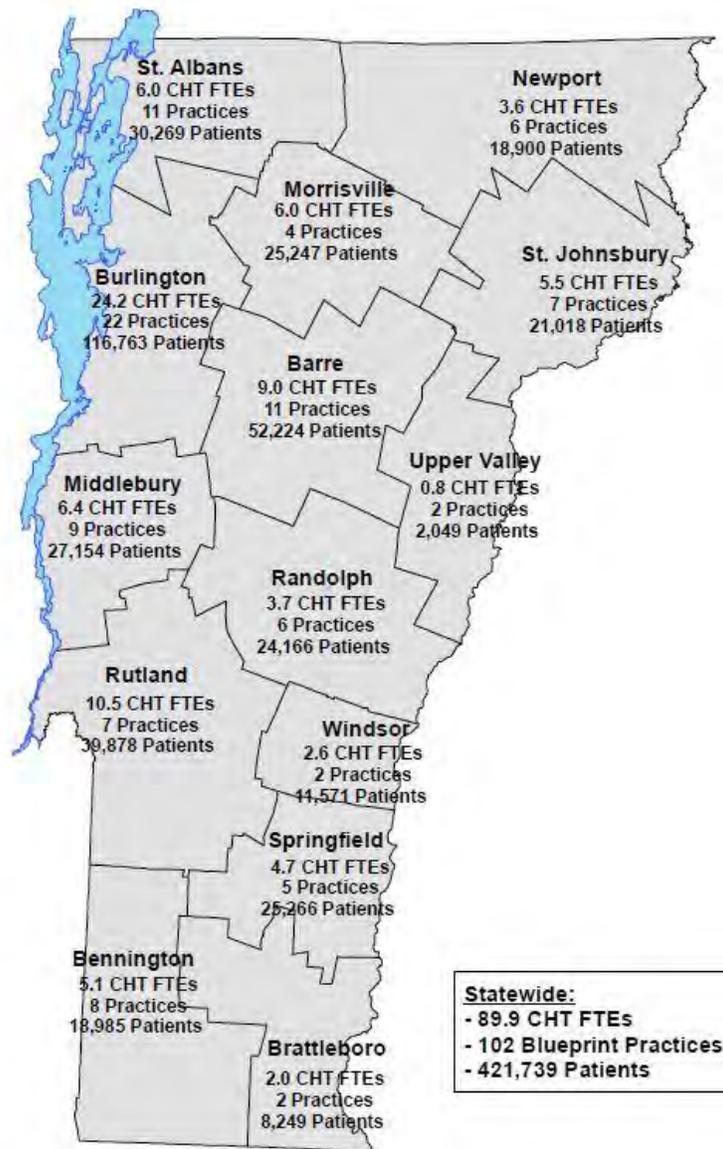
A critical component to the Blueprint for Health systems change strategy is financial incentives to reward quality. As part of the Blueprint, practices which undergo national accreditation through the NCQA and which are independently scored on their adherence to quality are given a PMPM incentive payment based on their quality scores. As of December 31, 2012, 106 primary care practices serving approximately 422,000 patients have successfully undergone the national recognition process (see previous chart on page 14), with several more scheduled for scoring in each month of 2013.

Perhaps the most important innovation in the Blueprint is the Community Health Team (CHT) concept. Recognizing that, for many patients, support and coordination services have not been well integrated into the primary care setting, and have even not been readily available to the general population. These multi-disciplinary locally based teams, funded through targeted Blueprint payment reform, are designed and hired at the community level. Local leadership convenes a planning group to determine the most appropriate use of these positions, which can vary depending upon the demographics of the community and upon identified gaps in available services. This could include personnel from the following disciplines: nursing, social work, nutrition science, psychology, pharmacy, administrative support, and others. CHT job titles include but are not limited to Care Coordinator, Case Manager, Certified Diabetic Educator, Community Health Worker, Health Educator, Mental Health Clinician, Substance Abuse Treatment Clinician, Nutrition Specialist, Social Worker, CHT Manager and CHT Administrator.

The CHT effectively expands the capacity of the primary care practices by providing patients with direct access to an enhanced range of services, and with closer and more individualized follow up. Barriers to care are minimized since there is no charge (no co-payments, prior authorizations, or billing for CHT services) to patients or practices. Importantly, CHT services are available to all patients in the primary care practices they support, regardless of whether these patients have health insurance of any kind or are uninsured.

The dollar amount accessible to an individual community is proportional to the population served by the recognized and engaged primary care practices in the Health Service Area. Currently this is set at \$350,000 per year for a general population of 20,000 served by the practices (\$17,500 per year for every 1000 patients). Again, the way this money is spent, and specifically what types of staff are hired, is decided at the community level. This has resulted in enhanced ownership and pride in the local CHT as well as anecdotally improving working relationships locally. CHTs are now established in every health services area of the state.

Blueprint Engagement by Service Area



FTEs = Full Time Equivalents

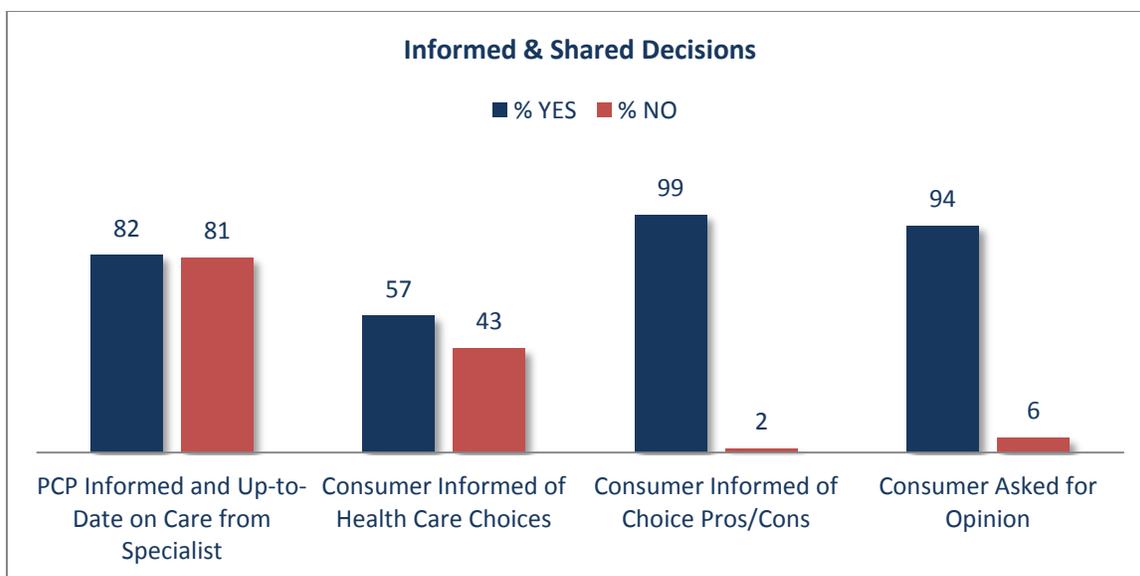
2012 HEDIS Measures

HEDIS measures for quality of care are summarized below. Comprehensive Diabetes Care scores have remained stable, although lower than NCQA accredited Medicaid HMO scores; this is an area noted for improvement in both the 2011 and 2012 EQRO report. Appropriate Medication for Asthma 5-11 years old and 12-18 years old as well as total scores remain at or above the NCQA average while improvement is needed in both the 19-50 and 51-64 age ranges. As noted earlier, scores related to Antidepressant Medication Management continue to be well above the national averages for both years.

HEDIS Measure	VT EQRO Year		VT Average: 2011-2012	NCQA Medicaid Accredited HMO's Average	VT vs. NCQA HMO Average
	2011	2012			
Comprehensive Diabetes Care					
HbA1c testing	62.02%	63.84%	62.93%	82.80%	-19.87%
Eye Exams	45.18%	45.69%	45.44%	54.10%	-8.67%
LDL-C Screens	47.24%	46.70%	46.97%	75.10%	-28.13%
Medical Attention for Nephropathy	59.21%	59.72%	59.47%	78.20%	-18.74%
Appropriate Medication for Asthma					
5-11 yrs	93.68%	92.72%	93.20%	90.90%	2.30%
12-18 yrs		87.57%	87.57%	87.30%	0.27%
19-50		79.10%	79.10%	73.70%	5.40%
51-64		81.62%	81.62%	71.50%	10.12%
Total	86.60%	85.34%	85.97%	85.50%	0.47%
Anti-Depressant Medication Management					
Effective Acute Phase Treatment	66.98%	68.42%	67.70%	50.90%	16.80%
Continuation Phase Treatment	51.38%	54.54%	52.96%	34.50%	18.46%

2009 Global Commitment to Health Beneficiary Survey

Informed and shared decision making is an underlying tenet of Vermont's system of care. Person centered and self-directed care have been at the forefront of home and community based service planning for decades and are key elements in the medical home and chronic care initiatives. A review of CAHPS questions related to this key principle shows that Vermont scores remain high and indicate that actual practice embodies these values.



Integrated Treatment for Opioid Dependence: *Hub and Spoke* Initiative

The Agency of Human Services (AHS) is collaborating with community providers to create a coordinated, systemic response to the complex issues of opioid addictions in Vermont, referred to as the *Hub and Spoke* initiative. This initiative is focused on beneficiaries receiving Medication Assisted Therapy (MAT) for opioid addiction. MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a holistic approach to the treatment of substance use disorders. Overall health care costs are approximately three times higher among MAT patients than the general Medicaid population, not only from costs directly associated with MAT, but also due to high rates of co-occurring mental health and other health issues, and high use of emergency rooms, pharmacy benefits, and other health care services.

The *Hub and Spoke* initiative creates a framework for integrating treatment services for opioid addiction into the Blueprint for Health (Blueprint) model, which includes patient-centered medical homes, multi-disciplinary Community Health Teams (CHTs), and payment reforms. Initially focused on primary care, its goals include improving individual and overall population health, and controlling health care costs by promoting health maintenance, prevention, and care management and coordination.

The two primary medications used to treat opioid dependence are methadone and buprenorphine, with the majority of MAT patients receiving office-based opioid treatment (OBOT) with buprenorphine prescribed by specially licensed physicians in a medical office setting. These physicians generally are not well-integrated with behavioral and social support resources. In contrast, methadone is a highly regulated treatment provided only in specialty opioid treatment programs (OTPs) that provide comprehensive addiction treatment but are not well integrated into the larger health and mental health care systems. To address this service fragmentation, AHS submitted a State Plan Amendment (SPA) to provide Health Home services to the MAT population under section 2703 of the Affordable Care Act.

Health Home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. State-supported nurses and licensed clinicians will provide the health home services and ongoing support to both OTP and OBOT providers.

The comprehensive *Hub and Spoke* initiative builds on the strengths of the specialty OTPs, the physicians who prescribe buprenorphine in office-based (OBOT) settings, and the local Blueprint patient-centered medical home and Community Health Team (CHT) infrastructure. Each MAT patient will have an established physician-led medical home, a single MAT prescriber, a pharmacy home, access to existing Blueprint CHTs, and access to *Hub* or *Spoke* nurses and clinicians for health home services.

The five planned regional *Hubs* build upon the existing methadone OTPs and also will provide buprenorphine treatment to a subset of clinically complex patients. Working in partnership with primary care providers and Blueprint CHTs, *Hubs* will replace episodic care based exclusively on addictions illness with comprehensive health care and continuity of services.

*Spokes* include a physician prescribing buprenorphine in an OBOT and the collaborating health and addiction professionals who monitor adherence to treatment, coordinate access to recovery supports and community services, and provide counseling, contingency management, care coordination and case management services. Support will be provided by the nurses and licensed addiction/mental health clinicians, who will be added to the existing Blueprint CHTs. Accomplishments for 2012 include, but are not limited to:

- Planning Guidance was sent to all buprenorphine providers and the entities that manage the local Blueprint CHTs to assist with *Spoke* network development and staffing estimates.
- Two *Hub and Spoke* learning collaboratives with multidisciplinary provider teams were established; they are provided through a partnership of the Blueprint, the Vermont Department of Health, and the Dartmouth Psychiatric Research Center.
- Two western Vermont regional *Hubs* began developing their infrastructure for implementation in 2013, while proposals for remaining regional *Hubs* are under review.
- The Health Home SPA was submitted to CMS.

### Mental Health System of Care

The abrupt closure of Vermont's single state psychiatric hospital due to Tropical Storm Irene resulted in an immediate shift of state funds. Funding previously spent on the physical plant and infrastructure of an antiquated hospital was used to enhance community-based support and mental health treatment services. Act 79, passed in the 2001-2012 legislative session, marked a historic investment of funds into the home and community based system of mental health care. Twenty-eight new community based inpatient beds were authorized while the legislature approved the development of a new replacement state psychiatric hospital no larger than 25 beds. Care management is being expanded to coordinate all

involuntary mental health inpatient services and facilitate coordination of treatment services between the community and inpatient provider. Designated Agencies (DA's) for mental health services throughout the state were provided resources to enhance emergency outreach and crisis support services at the local level. Mobile response capability and improved collaborations with local law enforcement are developing. GC Demonstration resources are targeting additional crisis bed capacity to divert unnecessary inpatient hospitalization where clinically appropriate and step-down individuals who are ready to transition from inpatient care back to community support services. Act 79 also supported the investment of GC Demonstration resources into intensive residential recovery support programs.

The realities of a rural state, with remote or geographic distance between points of service, require that transportation also be a consideration for access of any crisis stabilization, residential, or inpatient treatment capacities established. Trauma sensitive and the least restrictive transportation options, consistent with safety, are being enhanced. Collaboration with law enforcement and training in alternative transport options, when clinically appropriate, have already had a positive influence on reducing the use of hard restraints for acute emergency mental health transports.

Act 79 also provided for new investment in housing and coordinated treatment supports to provide greater stabilization in the community for individuals at higher risk for homelessness. The pairing of both treatment and stable housing resources increases the likelihood of individuals with mental health needs remaining more engaged with services and less likely to destabilize requiring acute inpatient treatment. Augmenting these formal support services with peer support services is also being promoted. Investments in peer services to broaden the array and options for recovery supports to individuals with mental illness are being made and a statewide peer "warmline" is in development as an alternative for individuals needing active listening and problem-solving support from peers.

### Dental Dozen

The Dental Dozen are 12 targeted initiatives that DVHA (in partnership with VDH-Office of Oral Health) is undertaking to improve oral health, and to remedy existing delivery system issues. Key highlights include: A collaboration between the VDH, DVHA, and the Department of Education to reinforce school outreach efforts and encourage preventive care; reimbursement of Primary Care Physicians for Oral Health Risk Assessments; selection/assignment of a dental home for children; loan repayment incentives to dentists in return for a commitment to practice in Vermont and serve low income populations; scholarships, administered through the Vermont Student Assistance Corporation, have been awarded to encourage new dentists to practice in Vermont; and supplemental payment incentives to recognize and reward dentists serving high volumes of Medicaid beneficiaries.

---

## Goal 3: Contain Cost of Care

Cost effectiveness takes into consideration the costs associated with providing services and interventions to the Vermont Medicaid population. For the GC Demonstration, this is measured at the eligibility group and aggregate program levels. The final goal of GC Demonstration is to contain Medicaid spending in comparison to what would have been spent absent the Demonstration. AHS assumes that the impact of the Demonstration will be “cost neutral.”

### Goal 3: Summary

The GC Demonstration has contained spending relative to the absence of the Demonstration over the eight years of the waiver and the reallocation of resources generated greater “value” for program expenditures. The cost-effectiveness of the GC Demonstration can be summarized as follows:

- Generated a significant surplus associated with overall decreased expenditures relative to the aggregate budget neutrality limit (ABNL).
- Overall, since the inception of the GC Demonstration in October 2005 through FFY 2012, a surplus has accrued for each year at an average of 9.6% of ABNL.
- Total cumulative surplus at time of renewal (January 1, 2014) is projected to be \$980 million.

### Goal 3: Data

The following measures were used to illustrate the cost-effectiveness of the GC Demonstration in containing spending relative to the absence of the Demonstration:

- Total Capitated Revenue Spending per MEG.
- Summary of Global Commitment Expenditures: With and Without Demonstration (relative to the ABNL).

#### Total Capitated Revenue Spending per MEG

Table 3-1 shows total capitated revenue spending for Global Commitment per MEG from 2006-2012. Also included in Table 3-1 is the average annual percent change during the previous (2006 to 2008) and current (2009 to 2012) interim evaluation periods.

**Table 3-1: Global Commitment Capitated Revenue Spending per MEG from 2006-2012**

MEG	Federal Fiscal Year					Average Annual Percent Change:	
	2006	2009	2010	2011	2012	2006-2009	2009-2012
ABD - Non-Medicare - Adult	\$203,640,203	\$168,352,016	\$179,249,891	\$176,533,399	\$190,519,365	-6.1%	4.2%
ABD - Non-Medicare - Child	\$60,899,001	\$93,965,267	\$94,842,614	\$98,394,413	\$101,488,090	15.6%	2.6%
ABD – Dual	\$176,881,327	\$227,454,477	\$219,236,518	\$223,405,119	\$227,781,883	8.7%	0.0%
ANFC - Non-Medicare - Adult	\$62,043,119	\$60,535,761	\$72,589,220	\$76,485,557	\$83,964,229	-0.8%	11.5%
ANFC - Non-Medicare - Child	\$184,526,017	\$221,757,008	\$239,043,470	\$236,275,561	\$254,203,807	6.3%	4.7%
Global Expansion (VHAP)	\$91,648,652	\$143,169,152	\$170,413,126	\$180,323,161	\$189,841,022	16.0%	9.9%
Global Rx	\$9,173,970	\$1,911,020	\$1,433,935	\$7,800,694	\$9,482,604	-40.7%	70.6%
Optional Expansion (Underinsured)	\$2,256,389	\$2,532,758	\$2,488,843	\$2,353,179	\$2,473,802	3.9%	-0.8%
VHAP ESI	n/a	\$2,056,121	\$2,533,498	\$1,917,977	\$1,607,347	n/a	-7.9%
ESIA	n/a	\$625,035	\$988,443	\$861,905	\$817,498	n/a	9.4%
CHAP	n/a	\$23,358,293	\$35,420,469	\$40,210,581	\$39,644,962	n/a	19.3%
ESIA Expansion - 200-300% of FPL	n/a	n/a	\$384,158	\$298,915	\$227,184	n/a	-23.1%
CHAP Expansion - 200-300% of FPL	n/a	n/a	\$10,181,948	\$18,276,728	\$19,640,320	n/a	38.9%
<b>Total Capitated Spending</b>	<b>\$791,068,678</b>	<b>\$945,716,909</b>	<b>\$1,028,806,133</b>	<b>\$1,063,137,188</b>	<b>\$1,121,692,114</b>	<b>6.1%</b>	<b>5.9%</b>

n/a: not available

The capitated amounts presented in Table 3-1 are summarized as follows:

- ✓ Overall, capitated spending has grown consistently at an average annual rate of approximately 6% from 2006 to 2012, on par with national Medicaid spending over the same period. (Source: The Henry J. Kaiser Family Foundation)
- ✓ ABD Adult capitated spending decreased about 6% per year from 2006 to 2009 (due to decreasing enrollment), while increasing 4% annually from 2009 to 2012.
- ✓ Capitated spending for ABD Children grew more modestly per year between 2009 to 2012 (2.6%) compared to 2006 to 2009 (15.6%)
- ✓ While growing nearly 9% per year between 2006 and 2009, ABD Dual capitated spending has remained essentially flat since 2009.
- ✓ ANFC Adults capitated spending remained level in the first few years before growing over 11% annually between 2009 and 2012
- ✓ Capitated spending for ANFC Children has consistently grown on average between 4% and 6% each year since 2006.
- ✓ Global Expansion (VHAP) capitated spending grew 16% annually from 2006 to 2009, slowing down modestly to 10% between 2009 and 2012.
- ✓ After implementation of Medicare Part D, capitated spending for Global Pharmacy (Duals, Non-Duals, and Expansion) has grown from \$513,000 in 2007 to \$9.5 million in 2012, due mostly to the Duals Expansion population created in 2010.
- ✓ After growing approximately 4% per year between 2006 and 2009, capitated spending for Optional Expansion (Underinsured) has remained essentially level as of 2012.

*Note: The following MEGs will be eliminated as of January 1, 2014 because of the Affordable Care Act (ACA).*

- ✓ Since inception in 2008, Vermont has made an average of \$3.1 million in capitated expenditures each year from 2009 to 2012 for Employer-Sponsored Insurance (ESI) programs (VHAP ESI, ESIA, and ESIA Expansion).
- ✓ Capitated spending for Catamount Health with Premium Assistance (CHAP) ramped up to \$59 million in the first four years after implementation (2008 to 2011) before leveling off in 2012.

#### Global Commitment Expenditures: With and Without Demonstration Relative to ABNL

CMS guidelines state that Section 1115 waivers are required to be budget neutral, i.e., do not increase federal funding over what would have been spent without the waiver. To evaluate budget neutrality, actual expenditures are measured against projections on what otherwise would have spent, based on the State's historical experience for the years prior to implementation of the waiver (e.g., enrollment, benefits, utilization, and cost of care). The cumulative spending projections are referred to as the aggregate budget neutrality limit, or ABNL. Table 3-2 on the following page summarizes actual ("with Demonstration") and projected ("without Demonstration") expenditures through December 2013, including the federal share of any surpluses or deficits.

**Table 3-2: Total Global Commitment Expenditures including Premium Offsets and Administrative Costs, with and without Demonstration 2006-2012**

	Federal Fiscal Year						
	Subtotal: 2006-2008	2009	2010	2011	2012	Estimated: Oct '12-Dec '13	TOTAL: 2006-Dec '13
Total Capitated Spending	\$2,490,295,359	\$945,716,909	\$1,028,806,133	\$1,063,137,188	\$1,121,692,114	\$1,469,171,414	\$8,118,819,116
Premium Offsets	(\$23,753,603)	(\$10,603,732)	(\$15,815,296)	(\$17,794,216)	(\$17,971,216)	(\$22,732,605)	(\$108,670,668)
Administrative Costs	<u>\$17,542,637</u>	<u>\$5,495,618</u>	<u>\$5,949,605</u>	<u>\$6,071,553</u>	<u>\$5,751,066</u>	<u>\$7,511,394</u>	<u>\$48,321,873</u>
<b>Total GC Expenditures</b>	<b>\$2,484,084,392</b>	<b>\$940,608,795</b>	<b>\$1,018,940,442</b>	<b>\$1,051,414,525</b>	<b>\$1,109,471,964</b>	<b>\$1,453,950,203</b>	<b>\$8,058,470,320</b>
ABNL	\$2,604,109,308	\$1,002,321,263	\$1,093,591,603	\$1,165,191,563	\$1,248,077,166	\$1,842,595,895	\$8,955,886,798
<b>Surplus (Deficit)</b>	<b>\$120,024,916</b>	<b>\$61,712,468</b>	<b>\$74,651,161</b>	<b>\$113,777,038</b>	<b>\$138,605,202</b>	<b>\$388,645,692</b>	<b>\$897,416,477</b>
Surplus (Deficit), % of ABNL	4.6%	6.2%	6.8%	9.8%	11.1%	21.1%	10.0%
<b>Federal Share of Surplus (Deficit)</b>	<b>\$70,522,235</b>	<b>\$43,174,043</b>	<b>\$52,225,952</b>	<b>\$66,798,499</b>	<b>\$79,808,875</b>	<b>\$217,797,046</b>	<b>\$530,326,650</b>

Actual expenditures for Oct '12 – Dec '13 are estimated.

Federal Share of Surplus/(Deficit) based on predominant FMAP.

The totals presented in Table 3-2 are summarized as follows:

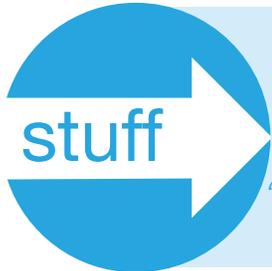
- ✓ During the first three years of the waiver surpluses averaged 4.6%, for a total of \$120 million.
- ✓ Between 2009 and 2012, surpluses increased to an average of 8.6%, for a four-year aggregate of \$389 million.
- ✓ An additional surplus of \$389 million is estimated for the period October 2012 to December 2013, or 21.1% of the ABNL.
- ✓ Annual surpluses have been steadily increasing; most recently in 2012 with a surplus of \$139 million, of over 11% of the ABNL.
- ✓ By the end of December 2013, GC is estimated to have achieved aggregate surplus through 2012 of \$897 million, or 10% of the ABNL.
- ✓ The aggregate federal share of the surplus through December 2013 is estimated at \$530 million.

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**Legal Notices**

**NOTICE OF PUBLICATION  
NOTICE OF DISSOLUTION OF  
NORTHGROUP SPONSORED  
CAPTIVE INSURANCE, INC.**

Pursuant to Title 11A, Section 14.07 of the laws of the State of Vermont, notice is hereby given that the Articles of Dissolution of Northgroup Sponsored Captive Insurance, Inc. (the "Company") have been filed with the office of the Secretary of State for the State of Vermont.

Notice is hereby given that all unknown creditors of and claimants against the Company are required to present their claims within five (5) years of publication of this notice. The claim will be barred unless a proceeding to enforce the claim is commenced within five (5) years of publication of this notice.

Notice is further given that all claimants with contingent claims or claims contingent upon the occurrence or nonoccurrence of a future event or otherwise conditional or un-matured, against the Company are required to present their respective claims in writing to the address below within five (5) years of this notice. Any such claim will be barred unless a proceeding to enforce the claim is commenced within five (5) years of this notice.

Notice is further given that all claims must be in writing and sent to the dissolved Company's principal office:

Northgroup Sponsored Captive Insurance, Inc.  
c/o Downs Rachlin Martin PLLC  
199 Main Street, 6th Floor  
P.O. Box 190  
Burlington, VT 05402-0190

Published February 14, 2013

STATE OF VERMONT

**SUPERIOR COURT CIVIL  
DIVISION  
CHITENDEN UNITDOCKET NO:  
50329-12 Cnc**

**BANK OF AMERICA, N.A., AS  
SUCCESSOR BY  
MERGER TO BAC HOME LOAN  
SERVICING, LP  
F/K/A COUNTRYWIDE HOME  
LOANS SERVICING, LP  
Plaintiff**

**ORRIN W. LONGBOTHUM;  
MILLYARD CONDOMINIUM ASSOCIATION;**

**Defendants**

**NOTICE OF SALE**

By virtue and in execution of the Power of Sale contained in a certain mortgage given by Orrin W. Longbothum to Mortgage Electronic Registration Systems, Inc., as nominee for Countrywide Home Loans, Inc. dated May 25, 2006 and recorded in Book 174 at Page 187 of the City/Town of Winooski Land Records, of which mortgage the undersigned is the present holder by Assignment of Mortgage recorded on July 30, 2009 in Book 201 at Page 136, for breach of the conditions of said mortgage and for the purpose of foreclosing the same will be sold at Public Auction at 10:00 a.m. on March 5, 2013 at 100 West Canal Street, designated as Apt. 2H of the Millyard Condominium, Winooski, VT 05404 all and singular the premises described in said mortgage.

**To Wit:**

Being Apartment No. 2H of the Millyard Condominium as numbered and further described and depicted in the Declaration dated September 1, 1984, recorded in Volume 58, Pages 368-379, together with an undivided interest in the Common Areas and Facilities as set forth in the Declaration.

Being the same premises conveyed to the herein named mortgage(s) by deed recorded with the Winooski, Town Office-Land Records in Book 168, Page 126.

Plaintiff may adjourn this Public Auction one or more times for a total time not exceeding 30 days, without further court order, and without publication or service of a new notice of sale, by announcement of the new sale date to those present at each adjournment. Terms of Sale: \$10,000.00 to be paid in cash or by certified check by the purchaser at the time of sale, with the balance due at closing. Proof of financing for the balance of the purchase to be provided at the time of sale. The sale is subject to taxes due and owing to the Town of Winooski.

The Mortgagor is entitled to redeem the premises at any time prior to the sale by paying the full amount due under the mortgage, including the costs and expenses of the sale.

Other terms to be announced at the sale.

Bank of America, N.A., as successor by merger to BAC Home Loan Servicing, LP f/k/a Countrywide Home Loans Servicing, LP, Richard J. Volpe, Esq., Shechtman, Halperin, Savage, LLP, 1080 Main Street, Pawcatuck, RI 02860, 877-575-1400, Attorney for Plaintiff

(5502844)(Longbothum)(02-07-13, 02-14-13, 02-21-13)(295746)

February 7th, 14th & 21st, 2013.

The State of Vermont, Agency of Human Services (AHS), plans to submit an extension request for the period from 1/1/2014 to 12/31/2018, to the Centers for Medicare and Medicaid Services (CMS) for its Section 1115(a) Demonstration Waiver: Global Commit-

ment (GC) to Health. The GC Demonstration was designed to test the hypothesis that greater program flexibility in the use of Medicaid resources and the lessening of federal restrictions on Medicaid services would permit the State to better meet the needs of Vermont's uninsured, underinsured and Medicaid beneficiaries for the same or lower cost. Specifically, the GC Demonstration aims to: 1) promote access to affordable health coverage, 2) develop public health approaches for meeting the needs of individuals and families, 3) develop innovative, outcome- and quality-focused payment approaches, 4) enhance coordination of care across health care providers and service delivery systems, and 5) control program cost growth.

**Summary of Extension Proposal for effective date of January 1, 2014**

- Continuation of the current public Medicaid managed care model and all current payment and service system flexibilities;
- Consolidation of the Choices for Care and GC waivers and the Children's Health Insurance Program (CHIP) (authorized under Title XXI of the Social Security Act) into one 1115 Demonstration Waiver;
- Inclusion of any necessary authorities for the Dual Eligible integrated Medicare and Medicaid model, once approved;
- Revisions to eligibility groups due to the Affordable Care Act;
- Use of Modified Adjusted Gross Income methodologies for income determination;
- Premium subsidies for individuals with incomes up to and including 300% of FPL who purchase insurance through the Health Benefit Exchange;
- Continue coverage of existing home and community-based programs;
- Continue coverage of specialized mental health services through continuation and expansion of the Community Rehabilitation and Treatment Program benefit;
- Expand service options for persons in the 'moderate needs group';
- Add an enhanced hospice benefit for persons with terminal illness; and
- Continue authorities and preserve choice for Long Term Support and Service beneficiaries.

The complete description of changes and draft extension request, including financial data (preliminary budget neutrality data from 2014 through 2018 and potential Medicaid impacts as they align with the Governor's single payer financial plan), can be found at: <http://doha.vermont.gov/administratio/n/2013-global-commitment>.

Public Hearings will be held on 2/19/13 from 3:30pm-5:30pm at Vermont Interactive Television (VIT) sites in Bennington, Brattleboro, Johnson, Lyndonville, Middlebury, Newport, Randolph Center, Rutland, Springfield, St. Albans, White River Junction, Montpelier, originating in Williston, and on 3/11/13 from 11:00am-1:00pm at the VSAC Building, 1st floor Community Conference Room, 10 East Allen Street, Winooski (call in number: 213-289-0155, Conference room #4238242). Written comments on the draft are due 3/22/13 by 4:30pm. Written comments should be sent via email to [ashley.berliner@state.vt.us](mailto:ashley.berliner@state.vt.us) or mailed to Ashley Berliner, DVHA, 289 Hurricane Lane, Williston, VT 05495. Comments received will be posted to the DVHA website for viewing by 4:30pm on 3/27/13. Copies of the draft extension request are available at: <http://doha.vermont.gov/administratio/n/2013-global-commitment>, or can be requested from local Department for

Children and Families (DCF) offices or from DVHA at (802) 879-5603.

**If you need special accommodations to participate in the public hearing, please notify Ashley Berliner at (802) 879-5603.**

February 14th, 2013.

**Personals**

FY6286748J- I hear you Call me!

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**State of Vermont**  
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*Secretary*

Office of the Secretary

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Williston, VT 05495

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*Douglas A. Racine,*

[phone] 802-871-3009

[fax] 802-871-3001

May 14, 2012

Cindy Mann, Director Center for Medicaid and State Operations  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244

Re: 11-W-0019411

Dear Ms. Mann:

As you are aware, Vermont's Global Commitment to Health Section 1115 Demonstration has proven to be an integral component to Vermont's health reform initiative, providing Vermont with the flexibility to enhance access to care, improve quality and control program costs.

As part of the Act authorizing State Fiscal Year 2013 Appropriations, the Vermont Legislature made modest modifications to cost sharing obligations for individuals participating in the Global Commitment Demonstration under the Medicaid and VHAP populations. The intent of these changes is to ensure that individuals continue to have affordable access to coverage and bring copayment obligations into alignment across eligibility groups.

Vermont proposes to eliminate the current copayment requirement of \$75.00 per inpatient hospital admission. In an effort to offset the program costs associated with elimination of the inpatient hospital copayment requirement and contain overall program costs, Vermont intends to introduce nominal copayment for a limited number of services. (The proposed co-payment structure is expected to reduce expenditures by approximately \$337,000 [State and Federal] during the period from July 1, 2012 to June 30, 2013.)

Modifications to Vermont's current cost sharing requirements include the following:

- Eliminate the Medicaid \$75.00 inpatient admission co-pay;
- Implement a \$3.00 co-pay for the VHAP waiver expansion population for outpatient hospital services (thus aligning copayment requirements with copayment requirements for individuals enrolled in traditional Medicaid eligibility groups);
- Implement a \$3.00 co-pay for the VHAP waiver expansion population for prescriptions costing \$50.00 or more (thus aligning copayment requirements with copayment requirements for individuals enrolled in traditional Medicaid eligibility groups); and
- Implement nominal co-pay requirements for Durable Medical Equipment (DME) and medical supplies for both traditional Medicaid and VHAP.

The current Special Terms and Conditions (STCs) include a waiver of federal, statutory cost sharing requirements, and Vermont is seeking federal approval to amend the Demonstration, effective July 1, 2012. Vermont seeks to modify and move the table contained in Paragraph 22 of the STCs to reflect the proposed changes. Attached, please find a copy of the current cost sharing table contained in the STCs, with the proposed changes highlighted. Vermont proposes to incorporate the modified table as Attachment C to the STCs. Removing the table from its current location in Paragraph 22 of the STCs will enable Vermont to update cost sharing obligations when necessary and facilitate this process more expeditiously.

The current STCs require public notice and consultation of interested parties as set forth in Paragraph 13 of the STCs. Vermont provides for a public process that includes participation in the legislative process, consultation with the State Medicaid Advisory Board and Vermonters. Vermont's Administrative Procedures Act governs the process by which administrative rules are to be adopted by State agencies, including the Vermont Agency of Human Services, and provides for notification in newspapers of record and online notice publication with opportunities for public commentary. When Vermont develops its rules there will be a public hearing process.

Thank you for your consideration of Vermont's proposed amendment. Suzanne Santarcangelo, Director of AHS Health Care Operations, Compliance and Improvement will serve as the point of contact for this amendment request. Please let us know if you require additional information or if you would like to arrange a conference call to discuss this material.

Sincerely,

/Douglas A. Racine/

Douglas A. Racine, Secretary  
Vermont Agency of Human Services

Cc: Mark Larson, Commissioner, DVHA  
Suzanne Santarcangelo, AHS  
Stephanie Beck, DVHA  
Richard McGreal, CMS  
Annie Chang, CMS

**Proposed Modifications to Cost Sharing Table in Paragraph 22 of the STCs**

**ATTACHMENT C: Premiums and Co-payments for the **Waiver Expansion** Populations**

<b>Population</b>	<b>Premiums</b>	<b>Deductibles</b>	<b>Co-Payments*</b>
Underinsured children not otherwise eligible for Medicaid 186-225% FPL 226-300% FPL		\$0	\$0
	\$15/month/family		
	\$20/month/family		
<del>Adults</del>			<del>Traditional Medicaid populations: Nominal co-payments</del>
Pregnant Women 186-200%	\$15/month/family	\$0	<b>\$0</b>
<p align="center"><b>Adults</b></p> <p align="center">VHAP 50-75% FPL VHAP 76-100% FPL VHAP 101-150% FPL VHAP 150-185% FPL</p>	<p align="center"><b>\$0</b></p> <p align="center">\$7/month \$25/month \$33/month \$49/month</p>		<p>Prescriptions*, <b>Durable Medical Equipment and Medical Supplies</b>:*</p> <ul style="list-style-type: none"> <li>• \$1.00: for prescriptions <del>\$29.99 or less</del> <b>less than \$30.00</b></li> <li>• \$2.00: for prescriptions between \$30.00 to \$49.99 <b>\$30.00 or more but less than \$50.00</b></li> <li>• \$3.00: for prescriptions \$50.00 or more</li> </ul> <p>\$3.00 per dental visit**</p> <p>\$3.00 per day per hospital for outpatient services</p> <p><del>\$75 per inpatient hospital admission</del></p> <p>VHAP population: \$25/emergency room visit; no charge if admitted</p> <p><del>VHAP at or above 100% of FPL</del></p> <ul style="list-style-type: none"> <li>• <del>\$1.00 for prescriptions \$29.99 or less</del></li> <li>• <del>\$2.00 for prescriptions above \$30.00</del></li> </ul> <p><b>*not applicable for VHAP below 100 percent of FPL</b></p> <p><b>**dental is not a VHAP covered service</b></p>
<p align="center">HCBS (TBI, MI under 22, and MR/DD)</p>	\$0	\$0	\$0

Population	Premiums	Deductibles	Co-Payments*
Medicare beneficiaries income at or below 150 percent of the FPL, not otherwise categorically eligible and non-Medicare individuals who are 65 years or older or have a disability	\$15/month	\$0	\$0 Prescriptions, <ul style="list-style-type: none"> <li>• \$1.00: less than \$30.00</li> <li>• \$2.00: \$30.00 or more</li> </ul>
Medicare beneficiaries with income above 150 percent and at or below 175 percent of the FPL not otherwise categorically eligible and non-Medicare individuals who are 65 years or older or have a disability	\$20/month	\$0	\$0 Prescriptions, <ul style="list-style-type: none"> <li>• \$1.00: less than \$30.00</li> <li>• \$2.00: \$30.00 or more</li> </ul>
Medicare beneficiaries with income above 175 percent and at or below 225 percent of the FPL not otherwise categorically eligible and non-Medicare individuals who are 65 years or older or have a disability	\$50/month	\$0	\$0 Prescriptions, <ul style="list-style-type: none"> <li>• \$1.00: less than \$30.00</li> <li>• \$2.00: \$30.00 or more</li> </ul>
Individuals with persistent mental illness with income up to 150 percent of FPL	\$0	\$0	\$0

Co-payments do not apply to **excluded populations** (e.g., children under age 21, pregnant women or individuals in long-term care facilities) or **excluded services/supplies** (e.g., family planning).

For the most current listing of cost sharing obligations, please refer to the Vermont approved title XIX State plan and Vermont rules and policies.