Response to Questions of Joint Legislative Medicaid Working Group
March 16, 2005

1. Global Commitment:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Premium Subsidies:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Nursing Homes:

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

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

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

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

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

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

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

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

Hospital	**$17,750,000**
Physicians	**$1,950,000***
Dental	**$800,000**
Home Health	**$2,000,000**

***This includes all CPT Code Billers**

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

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

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

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

Response: **To be provided.**

5. RX and Medicare Wrap:

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

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

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

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

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

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

Global Commitment to Health 1115a Waiver Concept Paper
SUMMARY of QUESTIONS / COMMENTS with RESPONSES

MAB = Medicaid Advisory Board Written Questions: March, 2005
JLMWG = Joint Legislative Medicaid Working Group Written Questions: March 16, 2005
PH = Public Hearings: March 15, 2005 – Rutland * March 16, 2005 – Burlington * March 17, 2005 - Vermont Interactive Television
WC = Formal Written Comments: March 23, 2005 - Final Submission Date

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

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

COMMENTS ABOUT THE OVERALL FINANCIAL IMPACT OF THE PROPOSED WAIVER

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

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

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

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

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

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

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

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

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

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

- *The proposed waiver limits Vermont to a fixed amount of funds to spend. How is the cap advantageous to Vermonters?* (PH)
- *How are financial and caseload predictions derived and how can the accuracy of these predictions be assured?* (PH)
- *What is the financial structure of the Global commitment going to be in practice? Will it work like the current waiver i.e. constrained by a five year trend line for federal cost or a block grant? Will all Medicaid match disappear or just some of the match?* (JLMWG)
- *Why is the state using 2004 rather than 2005 as the base year for spending and why is the state negotiating for a total budget cap without using the approach of a per capita amount that has been used in other waivers?* (WC)

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

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

Because of the large increase in the cost of healthcare, Vermont, as a state, has now exceeded its capacity to continue to fund our portion of the Medicaid program's cost and maintain all current benefits (of every 2 dollars spent on the Medicaid program, roughly 60 cents is federal and 40 cents comes from Vermont taxpayers). The challenge that we now face is how to manage the state's share of the cost of the program at a level we can sustain and also ensure that the current federal commitment is protected and continues to grow at the historical rate (approximately 10-12%). Under the *Global Commitment to Health,* we are working with the Federal Centers for Medicare and Medicaid Services (CMS) to negotiate an agreement that would provide us with an annual guarantee of federal funds each year for five years. This annual amount will be comprised of two parts: a "lump sum" payment that reflects federal expenditures in a base year (we are proposing to use SFY04 because it is the most complete recent fiscal year), and a trend rate applied to this base each year, which will be built on Vermont's historical expenditures and caseload growth. While we will need to manage within this total amount each year, we believe this is possible since the amount will be based on our past experience and growth rate.

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

- *The exit potential of the waiver is unclear. The concept paper says the state could "seek authority" to leave the waiver in the event of an emergency subject to CMS determination. Shouldn't the criteria of CMS approval of withdrawal be clear?* (JLMWG)
- *Vermont is locking itself into a financial arrangement and there is concern that something may be overlooked that will have a negative long-term negative impact.* (PH; WC – 5 submissions)
- *There is potential congressional action to provide Medicaid relief currently in congress. If this relief is forthcoming, how will Vermont's interest be protected?* (JLMWG)
- *Rage 25 of the concept paper states "…in the event of a national emergency… (such as an epidemic)" How is epidemic defined? What determines an epidemic*? (PH, WC - 2 submissions)
- *What contingencies will be included in the "force majeure" clause*? (MAB)

Response: The Global Commitment to Health Waiver agreement will include a number of protections for Vermont. Our proposal for the Waiver will include a clause in the Terms and Conditions of Approval that will require that any changes in Federal Law which would benefit State Medicaid spending in the absence of a waiver demonstration will be incorporated into a modified budget limit for the demonstration. In addition, the criteria for the State's ability to suspend the waiver in the event of a national or state emergency or catastrophic event will be clearly defined in the Terms and Conditions of Approval before the Waiver agreement is signed. In general, this term refers to a state or national health care crisis that is beyond the control of the state and which requires an unexpected and significant health care resource investment. Examples might be an outbreak of smallpox or a nuclear event.

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

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

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

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

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

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

- *What happens at the end of the five year term cited?* (PH; WC = 2 submissions)
- *Can the State return to the current system if the new waiver doesn't work?* (PH)
- *At the end of the 5 year period, what will be the status our existing waivers should we decide not to continue under the global commitment?* (JLMWG)

  <u>Response:</u> The exit strategy at the end of the five year term will depend entirely on where the state is vis a vis the national Medicaid program at that point in time. If desired, the state will negotiate the ability to extend the Waiver. If we decide that we do not want to extend the Waiver agreement, our existing waivers will no longer exist. However, there will be an "Extension or Phase-out Plan" clause in the Terms and Conditions of Approval

for the Global Commitment to Health Waiver. This will specify the timeframes and terms for negotiating an extension of the Waiver, or if so desired, phasing-out the waiver in a manner that protects existing beneficiaries and services. This is true for all federal demonstration projects.

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

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

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

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

- *What is the contingency plan?* (PH)
- *Please explain the administration's plan if the funding under the Global Commitment is not adequate to sustain eligibility and coverage in the current programs.* (MAB)
- *If final approval comes after July1, and the enhanced federal funding that the proposal relies on to be solvent for FY06 and beyond is not available or significantly lower than projected, how do you envision making these lost revenues up? For example the plan counts on the state receiving 100% of the premium payments.* (JLMWG)

Response: We are currently committed to the July 1, 2005 implementation timeline. To the extent that federal approval is received subsequent to that date, the state of Vermont will request retroactive authority back to July 1, 2005. If there is no Global Commitment to Health Waiver agreement, there will be an immediate and substantial fiscal issue that will need to be resolved for SFY06 and longer-term issues for future years.

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

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

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

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

approval. We will clearly define in our proposal and in the Terms and Conditions of Agreement the process that will be used in the state to make any changes in eligibility, benefits, or beneficiary payment requirements for Medicaid services. As is currently the case, any proposed changes in benefits and eligibility in the future would be vetted with stakeholders and the legislature, and would not be implemented without legislative approval. This is the same process that is in place today and will not change under the new Waiver agreement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMMENTS ABOUT THE PROCESS FOR DEVELOPING THE PROPOSAL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Governor has committed to a Medicare Wrap through his repeated statements that no Vermonter will be financially disadvantaged as a result of MMA. The Agency of Human Services has a Medicare Modernization Act Workgroup that is planning for the implementation of the MMA in Vermont. The administrative burden of having a wrap for MMA is part of the work of the AHS MMA workgroup. The proposed wrap program will amend the existing state law to allow for a pharmacy program that is secondary to Medicare's Part D Drug coverage beginning on 1/1/06. This program, VPharm, will provide for financial coverage for Medicare Part D Eligibles and continue to allow Medicaid only pharmacy eligibles to be covered in existing Medicaid or pharmacy only programs. In addition, Vermont's PDL and the generic drug law are two tools that over the past several years have allowed Vermont to substantially slow the rate of growth in pharmacy spending.

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

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

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

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

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

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

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

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