QUESTION NUMBER	Category	DATE ASKED	WHO ASKED	Who Was Asked	RESPONSE DATE	QUESTION	T&C	RESPONSE
1	Finances	9/12/05	Legislature	Secretary Charles Smith	9/14/05	The actual financial terms of the proposal and the likelihood of specific financial outcomes. We have seen proposed spreadsheets but we understand that you are still working with the federal government on final financial terms.		The Administration has worked with the Joint Fiscal Office on the financial modeling, and this work is current to date.
2	Actuarial certification	9/12/05	Legislature	Secretary Charles Smith	9/14/05	The actuarial involvement in the waiver raises a number of uncertainties. We are very interested in how the actuary will develop premium estimates throughout the waiver. We also need to know the relationship between the actuarial certification of premium, the state plan, and what services and populations are actually covered; and how much flexibility there is to provide a different mix of services from the basis of the actuary's calculations. We also need to know the process by which a new policy initiative such as a coverage expansion or limitation would be included in the waiver and how that would impact the actuary's analysis.		The actuary will establish a range for acceptable aggregate capitation payments based on Vermont-specific experience, as well as national health care trends. Annually, the policy making and legislative process will precede the actuarial certification process. Therefore, rate certification will be based on the eligibility criteria and scope of services authorized by the legislature and approved by CMS, as appropriate. The CMS guidelines for MCO rate certification indicate that the rates must be based on authorized services (i.e., services contained in the State Plan or authorized under the 1115 Waiver). When evaluating actual experience, however, the actuary is permitted to include other services which are cost-effective alternatives to authorized services. In the event that a new policy initiative expands or limits coverage, this initiative would be incorporated into the actuary's calculation of the appropriate capitation rate.
3	CNOM	9/12/05	Legislature	Secretary Charles Smith	9/14/05	How will the determination be made of what makes up "costs not otherwise matchable" (CNOM) that gets included in the premium and is matched? We clearly need to see the terms and conditions to understand this and hear what you think is covered and how you interpret the CNOM parameters.		The items that comprise the "costs not otherwise matchable" (CNOM) are being finalized by the AHS Business Managers in collaboration with the Commissioner of Finance and Management and his staff. Following are the parameters in the final Terms and Conditions: *18. Capitated Revenue Expenditures. Provided that OVHA's contractual obligation to the populations covered under the demonstration is met, any revenue from capitation payments related to the beneficiaries covered under this demonstration may be used for the following purposes:* *• Reduce the rate of uninsured and, or, underinsured in Vermont;* *• Increase the access of quality health care to uninsured, underinsured and Medicaid beneficiaries;* *• Provide public health approaches to improve the health outcomes and the quality of life for Medicaid-eligible individuals in Vermont; and* *• Encourage the formation and maintenance of public-private partnerships in health care.* The list of CNOMs meets these parameters.
4	Beneficiary rights and entitlements	9/12/05	Legislature	Secretary Charles Smith	9/14/05	Please describe the workings of the more flexible eligibility determination process that the waiver envisions. We will need to see how the terms and conditions address this issue. Will there be changes to current processes of eligibility determinations for Medicaid services?		The mention of developing a more flexible eligibility determination process is conceptual in nature, and is not anticipated to be implemented in the first year of the waiver. If and when such changes are made, it will be in concert with the departments, providers and advocacy organizations that can help inform a positive change for beneficiaries and program management.

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5	MCO	9/12/05	Legislature	Secretary Charles Smith	9/14/05	The MCO structure raises many questions. You have indicated this is a pass through entity which will not change current control of Medicaid programs throughout state government. Is this limited managed care function consistent with what the federal government is proposing? Is the MCO strictly a financial entity or does it impact service delivery? Will CMS be performing a readiness review prior to operation of the MCO which could push us into late October or beyond?		The managed care function we have outlined is consistent with the proposal of the federal government. Any changes in benefits and eligibility coverage will be approved by the legislature each year. Under the new MCO model, there will be improved coordination of activities across departments and providers (e.g., care management for people with chronic diseases), and consistent processes across all Medicaid providing departments regarding consumer rights and protections (e.g., the same complaints, grievance and appeals processes for Medicaid beneficiaries). CMS will not be performing a readiness review associated with this demonstration waiver.
6	Beneficiary rights and entitlements	9/12/05	Legislature	Secretary Charles Smith	9/14/05	What are rights of Vermonters and the specific entitlements that you are proposing to waive and how will current populations be assured that this will not impact their benefits?		We are not proposing to waive any rights or entitlements in the Global Commitment to Health Medicaid Waiver.
7	Beneficiary rights and entitlements	9/16/05	Legislature	Josh Slen	9/20/05	Does the state have to do a new state plan to reflect the waiver? If so, are the references to the “state plan” in the terms and conditions the current (9/05) or the future state plan? If a new state plan is required, what is the time frame? Can implementation be done prior to the approval of the new state plan (if any)?		The state does not have to revise the State Plan to implement the Waiver.
8	Eligibility	9/16/05	Legislature	Josh Slen	9/20/05	Please clarify what is meant by a “population solely covered through the Demonstration.”	5	Populations solely covered through the Demonstration include eligibility groups the state is authorized to cover by virtue of the granted 1115 Waiver authority.
9	Beneficiary rights and entitlements	9/16/05	Legislature	Josh Slen	9/20/05	When a new population obtains coverage through the waiver, does this mean that there will be a new eligibility process for this population (the example of substance abuse treatment in the application). What is the population for potential CNOM services such as legislative analysis or HCA regulation?		If there is a new expansion eligibility group approved and funded by the legislature, there will be a new eligibility process for this group. However, for the example provided, substance abuse treatment, the state sought broad authority to fund services that may not necessarily be tied directly to eligible populations. The other examples, legislative analysis and HCA regulation, would not be eligible for funding "outside the premium" (in the yellow area), but potentially could be funded through any savings realized by the MCO.
10	Operations	9/16/05	Legislature	Josh Slen	9/20/05	What is your interpretation of “The State shall notify CMS 60 days prior to any such change in the benefit package” ? Does this mean only such changes resulting in a 5% increase/decrease or any change in benefit package?	6	We will notify CMS of any changes in the benefit package.
11	Beneficiary rights and entitlements	9/16/05	Legislature	Josh Slen	9/20/05	Please explain how Medicare beneficiaries will be eligible for drug coverage as a demonstration population. Is this just for the period of operation prior to January 1, 2006? Which pharmacy programs are or are not included as a waiver population after 1/1/06 & where in the terms and conditions is this reflected?		Existing 1115 Waiver authority will continue for Medicare beneficiaries until the implementation of Medicare Part D. Pharmacy programs will continue for eligible individuals who do not have Medicare coverage in accordance with existing eligibility rules. These groups are listed on the Table contained on Page 13 of the Terms and Conditions, under VHAP Waivers, #4 & #5. Item #40 on Page 18 of the Terms and Conditions limits the availability of FFP for Medicare beneficiaries as of 1/1/06.
12	Actuarial certification	9/15/05	Legislature	Josh Slen	9/20/05	Please explain what “the actuary shall not be employed by the state for purposes of certifying actuarially sound rates” means. Who actually contracts with the actuary?	33	This means that the actuary can not be a state employee.

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13	MCO	9/16/05	Legislature	Josh Slen	9/20/05	What will the approval process be for the contract between AHS and OVHA? Will operations begin before the contract is finalized?	33	CMS regional office has already reviewed and approved the Intergovernmental Agreement between AHS and the MCO.
14	Operations	9/16/05	Legislature	Josh Slen	9/20/05	Is there adequate statutory authorization for OVHA? Is the language in Act 71 sufficient?	33	The language in Act 71 is sufficient.
15	Operations	9/16/05	Legislature	Josh Slen	9/20/05	What is the status of the operational protocol or Attachment C? When will a copy be available?		CMS is not requiring an operational protocol for this demonstration waiver. The reference to an Attachment C is not pertinent to this Waiver.
16		9/16/05	Legislature	Josh Slen	9/20/05	What is meant by a "public-private partnership"?	39	This provision in the Terms and Conditions was inserted specifically to allow funding for the Vermont Blueprint to Health and will provide flexibility to fund future public-private partnerships as Vermont moves forward.
17		9/16/05	Legislature	Josh Slen	9/20/05	What is "VT Global Rx (previously VHAP Expansion)"?	42	VT Global Expansion includes populations currently defined as VHAP Expansion eligibles; VT Global Rx includes populations currently defined as VHAP-Rx and Vscript, which would be limited to non-Medicare beneficiaries upon implementation of Medicare Part D.
18	Operations	9/16/05	Legislature	Josh Slen	9/20/05	Are there different match rates for administration and for services ("applicable federal match rates")	45	There are different match rates for program expenditures and administrative expenditures. However, under the MCO model, the actuarially certified rate will include an administrative allowance for administration. Capitation rates are subject to the program match rate. All administrative expenses will be included in the capitation rate, with the exception of eligible AHS Central Office and MMIS expenses.
19	Finances	9/16/05	Legislature	Josh Slen	9/20/05	Where do the cumulative target numbers come from? What years do they refer to (Is Year 1 October 1 through September 30)?	52	The cumulative target numbers were derived from the "Without Waiver" budget neutrality projections by CMS. The years refer to Waiver Years (10/1 - 9/30).
20	Finances	9/16/05	Legislature	Josh Slen	9/20/05	Please describe how spending will be allocated between this waiver and the LTC waiver. Are the caps additive? Where are administrative costs for the LTC waiver?		Spending will be allocated in accordance with the Terms and Conditions of the two Demonstration Waivers. The LTC Waiver includes all long-term care expenditures as well as the acute care costs for those eligible for Medicaid under the State Plan and enrolled in the LTC Waiver. All administrative costs, including LTC administrative costs, are included in the Global Commitment budget neutrality ceiling.
21	Finances	9/16/05	Legislature	Josh Slen	9/20/05	Are there any issues with Global Commitment being treated as an IGT (intergovernmental transfer), particularly as regards cost limits?		Throughout the discussions with CMS policy and legal staff regarding the MCO model, this was not raised as an issue. There are no known issues with regard to cost limits.
22	Beneficiary rights and entitlements	9/16/05	Legislature	Josh Slen	9/20/05	Is it true that under GC, optional service benefit changes for mandatory populations will require an amendment to the waiver, rather than a change in state plan?	6	Yes, although a conforming state plan amendment may be required by CMS.
23	Finances	9/16/05	Legislature	Josh Slen	9/20/05	How does the 5% window operate? It appears that the 5% standard will be measured against actual spending from two years before. Does this mean that the spending in the comparison period will be adjusted to reflect the benefit change, and then compared to the unadjusted spend?	6	If a proposed benefit change would have impacted total spending by less than five percent in the comparison year, then the change does not require prior approval by CMS.

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24	CNOM	9/16/05	Legislature	Josh Slen	9/20/05	Why didn't the state include certain programs as demonstration populations, such as VScript Expanded? What is the benefits and risks of including a population as a demonstration population v. an allowable expense/CNOM?		The State previously was unsuccessful in its efforts to add Vscript Expanded as a demonstration population under the existing 1115 Waiver. The benefit of including an eligibility group as a demonstration population is that the expenditures are added to the base in calculating the actuarially certified rate.
25	Beneficiary rights and entitlements	9/16/05	Legislature	Josh Slen	9/20/05	It appears from the terms and conditions that the state may remove eligibility for Medicaid optional & expanded (eg VHAP) populations without need for CMS approval – is this any accurate reading?		No, if the legislature approves changes in eligible populations, the State will need to receive approval from CMS.
26	Beneficiary rights and entitlements	9/16/05	Legislature	Josh Slen	9/20/05	From the email addendum to the terms and conditions, you expect term #29 to be deleted or modified. Is this because you do not think that moving people into the waiver does not require a notice?	29	This section has been revised to read: *The State agrees to notify demonstration participants newly entering a Section 1115 research and demonstration program within 30 days of their enrollment into the Global Commitment to Health demonstration.*
27	Operations	9/16/05	Legislature	Josh Slen	9/20/05	What is the process for contracting with providers?	32	The same process that exists now,
28	Beneficiary rights and entitlements	9/16/05	Legislature	Josh Slen	9/20/05	Is term 43(c) a change in eligibility for some populations? For example, some legal immigrants are eligible for VHAP but would not be eligible for Medicaid as a "qualified alien."	43	No, this is not a change.
29	Beneficiary rights and entitlements	9/16/05	Legislature	Josh Slen	9/20/05	If the terms and conditions require us to cover current services for Medicaid mandatory populations, why is the state asking to waive amount, duration & scope requirements for this population? Why aren't we asking to waive these requirements for the expansion populations?		A waiver of "Amount, Duration and Scope" typically is provided for 1115 Waivers which include the transition to an MCO model. The State does not believe it needs this waiver authority as the program is currently designed, but may require it in the future to implement legislated initiatives. The waiver is not required for non-State Plan populations, as the federal requirement applies only to traditional eligibility groups.
30	Beneficiary rights and entitlements	9/16/05	Legislature	Josh Slen	9/20/05	Is the waiver of financial eligibility rules (#5) necessary since this is now covered in the Choices for Care waiver?		No , this waiver is not currently necessary for the GC demonstration project; however, it is included in case it is needed in future years.
31		9/16/05	Legislature	Josh Slen	9/20/05	What proposed policy changes require waiving financial responsibility/deeming & spend down rules?		There are no policy changes requiring waiver of these rules; however, this waiver is included in case it is needed in future years.
32	CNOM	9/16/05	Legislature	Josh Slen	9/20/05	Do you expect to do rulemaking for any of the items in the CNOM list?		No.
33	Finances	9/16/05	Legislature	Josh Slen	9/20/05	How do you anticipate the appropriations and actuarial certification processes to interact? Will certification incorporate the budget as passed?		The appropriations process will precede the rate certification process. Any legislation that redefines the scope of benefits and covered populations will be used to adjust the base for actuarial rate development. Certification will potentially include historical trend analysis, any approved expansions through the waiver amendment process, national trends, and state specific circumstances.

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34	CNOM	9/16/05	Legislature	Josh Slen	9/20/05	What are the mechanics of drawing match for the CNOM spend?		Vermont currently draws matching funds for "Costs Not Otherwise Matchable" under the existing VHAP waiver. The State must report expenditures authorized as CNOM in order to draw federal matching funds. Under the MCO model, actuarially certified capitation payments are matched with federal funds. In the event that the MCO realizes program savings, the MCO is permitted to spend these funds in accordance with the guidelines defined in the Waiver's Terms and Conditions. There have been discussions of two different types of CNOM; 1) the traditional type being the VHAP eligibles and other expansion and optional populations and services included in the Waiver, and 2) MCO savings where expenditures on items other than eligible services for eligible populations are allowable as defined in the Terms and Conditions.
35	Finances	9/16/05	Legislature	Josh Slen	9/20/05	Can the state provide matchable services OUTSIDE the premium? ("yellow money") If so, what is the process?		Yes, the State can provide matchable services outside the premium using the processes identified in Terms and Conditions items 6, 7, and 8.
36	Finances	9/16/05	Legislature	Josh Slen	9/20/05	Where is the CRT population? Are they covered under both the LTC waiver and the GC waiver?		Most people enrolled in the CRT program will be in the GC Waiver. However, there are a very few individuals enrolled in CRT that also will receive LTC services. In this case, their LTC expenses will be covered under the LTC waiver.
37	MCO	9/16/05	Legislature	Josh Slen	9/20/05	Are the AHS administrative costs of managing the MCO contract outside the premium?		Yes, AHS Central Office costs are outside the premium but subject to the Waiver budget neutrality ceiling.
38	Finances	9/16/05	Legislature	Josh Slen	9/20/05	What is the source of the cost of the VSH alternative?		The cost projections were derived from the Vermont State Hospital Futures Plan Report to AHS Secretary Charles Smith, prepared by the Department of Health, Division of Mental Health, February 4, 2005.
39	Operations	9/16/05	Legislature	Josh Slen	9/20/05	Is it possible to get a tracking sheet that reflects changes in the proposal over time?		Vermont only submitted one formal proposal to CMS on April 15, 2005. All future discussions with CMS focused on developing Terms and Conditions.
40	Operations	9/16/05	Legislature	Josh Slen	9/20/05	Is it possible to get a tracking sheet that reflects changes in the Terms and Conditions over time?		There is not one document that reflects changes over the past months to the Terms and Conditions because there were several different versions with different authors (including internal CMS versions) and many changes were made via verbal discussions.
41	Operations	9/16/05	Legislature	Josh Slen	9/20/05	Please send a copy of the work plan that was shared with the Medicaid Advisory		We have posted this on the AHS and OVHA web-sties
42	Finances	9/16/05	Legislature	Josh Slen	9/20/05	It is our understanding that there are two ways that new populations can be covered under this waiver - 1) within the funds provided by the premium and 2) above the premium if there is any room between the premium and the cap. Scenario 1 would not require any approval from CMS, but scenario 2 would require an amendment to the waiver. Is this correct?		Yes, this is correct.
43	Finances	9/17/05	Burlington Free Press editorial	Administration	9/20/05	Is the new Medicaid plan likely to save money, given the risks? If so, how much money?		Yes, it is expected to save between $135 and $165 million over five years.

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44	Beneficiary rights and entitlements	9/17/05	Burlington Free Press editorial	Administration	9/20/05	How will Medicaid recipients be affected by the change?		Medicaid recipients will not experience any changes as a result of the implementation of this waiver demonstration project. Any changes to Vermont's programs will be driven by Legislative decision making in future sessions of the Vermont Legislature not by this Waiver.
45	Operations	9/17/05	Burlington Free Press editorial	Administration	9/20/05	Can the state bow out of the agreement if the plan fails to meet its objectives/		Yes, the Terms and Conditions explicitly state that: "The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration." (#10)
46	Operations	9/21/05	Legislature	Josh Slen	9/22/05	Where are the protections in case of disaster or other catastrophe outside our control?		As noted above, Term #10 explicitly states that "The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration." This includes catastophic situations, and is standard language used by CMS in all Demonstration waivers. Regarding this issue, CMS notes that the Medicaid program is a federal - state partnership and their willingness to enter into a demonstration with Vermont is an indication that they work in good faith with states to achieve common goals for the Medicaid program. As evidenced by recent economic and natural disaster events in other states, CMS has worked with them to continue services for beneficiaries.
47	Finances	9/21/05	Legislature	Josh Slen	9/22/05	What does "CMS will calculate an annual expenditure target for the completed year" mean? Is there a methodology available for this calculation?	52	Number 52 in the Terms and Conditions is Titled "Expenditure Review" and the preceding sentence to the one referenced in the question reads "The CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis." The next sentence then reads in part "...CMS will calculate an annual expenditure target for the completed year." The "calculation" refers to a comparison of actual state expenditures to the Waiver ceiling as identified in the table under number 52 in the Terms and Conditions. The state will report to CMS, as identified in the reporting sections of the Terms and Conditions, actual waiver expenditures. CMS will then compare those expenditures to the ceiling figures identified in the table on page 23 (number 52) in the Terms and Conditions.
48	Finances	9/21/05	Legislature	Josh Slen	9/22/05	How will the actual premium be structured - lump sum or specific to eligibility categories?		The premium will be an aggregate payment amount. The actuary will rely on historical expenditure and enrollment data, based on eligibility groups and age, as the basis for calculating the premium.
49	Finances	9/21/05	Legislature	Josh Slen	9/22/05	Do you intend to implement a $30 premium for Dr. Dynasuar 100%-185% FPL? Is this revenue included in financial models?		No, this was not approved by the legislature last year and it is not included in the financial modeling.
50	Beneficiary rights and entitlements	9/21/05	Legislature	Josh Slen	9/22/05	Does the 5% limit apply to expansion populations?	6	The authority to change the benefit package for non-mandatory eligible populations within a five percent corridor applies to aggregate expenditures for optional and expansion populations.

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51	Beneficiary rights and entitlements	9/21/05	Legislature	Josh Slen	9/22/05	Is an amendment to the state plan necessary for optional populations?	6	Vermont is prepared to file a state plan amendment should it be required. The Terms and Conditions provide CMS with the discretion to require state plan amendments for optional populations.
52	Beneficiary rights and entitlements	9/21/05	Legislature	Josh Slen	9/22/05	How will you provide services to dual eligibles and children under 19 on SSI (for example) who do not choose to be enrolled in the MCO? 42 CFR 438.50(d) does not allow the state to require these groups to participate in an MCO & this provision does not appear to be waived.		This condition of 42 CFR does not apply to this 1115 Demonstration waiver. 42CFR 438.50 states: State Plan requirements. (a) General rule. A State plan that requires Medicaid recipients to enroll in managed care entities must comply with the provisions of this section, except when the State imposes the requirement-- (1) As part of a demonstration project under section 1115 of the Act; As such, (d) does not apply to this 1115 waiver.
53	Beneficiary rights and entitlements	9/21/05	Legislature	Josh Slen	9/22/05	What current populations will need to receive notice that they will be included in a waiver? (Duals were excluded by the Vhap waiver, for instance).	29	Everyone who is included in the Global Commitment Waiver who is not currently enrolled in VHAP, PC Plus, and Expansion pharmacy programs will receive notices within 30 days after implementation of the new waiver.
54	Finances	9/23/05	AARP	OVHA	9/23/05	Confirm that October 1, 2005 is the planned effective date. What are the risks (e.g., financial) of delay?		Yes, October 1st is the planned effective date. The cost of delay is estimated by the Joint Fiscal Office at $2.5 million per month. The OVHA has estimated the cost of delay to be as high as $1 million per week. Therefore a realistic range is between $625,000 and $1 million per week.
55	Finances	9/23/05	AARP	OVHA	9/23/05	If the GC is not effective for October 1, 2005 what are the other date options?		Any start date can be chosen. However, for the simplicity of financial reporting and budgeting the start of a month or of a quarter is usually chosen.
56	Beneficiary rights and entitlements	9/23/05	VCDR	OVHA	9/23/05	Does the following new langauge related to cost-sharing also apply to eligible pregnant women: "The State agrees that cost sharing for optional and expansion children eligible for Medicaid should not exceed five percent of the family's gross income. " ?		Yes, this also will apply to eligible pregnant women