VT Public Policy

Colleen Wieck

From: Judy Solomon [solomon@cbpp.org]
Sent: Thursday, October 20, 2005 4:48 PM
To: Judy Solomon
Subject: Recent state waiver activity

Hi all,

Most of you have probably already heard about Medicaid waivers that have recently been approved in Vermont and Florida. Both waivers make unprecedented and alarming changes in Medicaid. This e-mail describes some of the key features of both waivers, and provides some additional background materials. Over the next few weeks, we will be preparing some materials to help you in discussions with policymakers in your states as we understand that many of you are being asked about the waivers or are hearing that your state is interested in these approaches to the Medicaid program.

Vermont

The key features of the Vermont waiver, called the "Global Commitment" are the financing and the unprecedented flexibility given to the state to change eligibility, benefits, and cost-sharing:

- Over the five-year period of the waiver, Vermont will be limited to a fixed allotment of federal funds. While the state still has to provide state matching funds, the cap limits the total amount of federal funds that the state can draw down over the waiver period.
- Because of the global cap on federal funds, Vermont could lose the ability to draw down federal matching funds once the cap is reached. Under the cap, Vermont is at risk for unanticipated increases in both health care costs and enrollment. Declining economic conditions, a natural disaster like Hurricane Katrina, a new disease or epidemic like the avian flu, or new medical advances could all drive expenditures up above the cap. At that point, the state would have to meet all additional expenses with state funds or cut eligibility, benefits or provider payments.
- Under the waiver, Medicaid beneficiaries in optional coverage groups lose any guarantee of eligibility and benefits. They can lose even mandatory benefits and can be placed on waiting lists if the state decides to establish enrollment caps
- While beneficiaries in mandatory coverage groups cannot lose eligibility under the waiver, they can lose both optional and mandatory benefits.
- Because mandatory benefits can be limited for all beneficiaries, children no longer have an entitlement to the protections of the EPSDT program.
- Optional beneficiaries can be charged premiums and co-payments. The only limit on cost-sharing is a cap equal to five percent of family income
- While the Vermont legislature has no immediate plans to use the flexibility it has under the waiver to cut eligibility or benefits or to increase cost-sharing, the capped funding could force the state into a situation where such changes have to be made.

Attached to this e-mail is testimony delivered to the VT Health Access Oversight Committee last month. Please note that the testimony states that mandatory coverage groups *are* entitled to mandatory benefits. A closer read of the terms and conditions shows that this is not the case and these beneficiaries can in fact lose mandatory benefits. The terms and conditions and other information on the VT waiver can be found at http://www.ovha.state.vt.us/globalhome.cfm and http://www.leg.state.vt.us/JFO/default.htm In addition, I have pasted a column from yesterday's Wall Street Journal regarding the Vermont waiver at the bottom of this e-mail.

Florida

The Florida waiver was approved on October 19, 16 days after it was submitted. A summary of the waiver proposal prepared by Joan Alker, Center for Children and Families, Georgetown University Health Policy

Institute, on the Florida plan can be found at www.wphf.org. There do not appear to be changes in the waiver as approved, so the summary is still an excellent source of background on the waiver. The terms and conditions of the Florida waiver and other information is at http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/waiver/index.shtml

Key features of the Florida waiver:

- The program will be phased in beginning in two counties, Duval (Jacksonville) and Broward (Fort Lauderdale).
- In the two counties, most children, all parents, pregnant women with income below 23 percent of the poverty line, and most SSI beneficiaries who are not enrolled in Medicare, will have to enroll in the demonstration program in the first phase.
- The state will establish risk adjusted premiums for all participants.
- All participants will have to choose a health plan, either a managed care plan or a provider network that will receive the premium assigned to the individual. In the alternative families can choose to receive a voucher to purchase private coverage that does not have to meet federal benefit or cost-sharing standards even for children.
- For adults, including people with disabilities, there will be a maximum dollar amount of coverage each year per person. While the state claims that few individuals will hit the cap, those with the greatest need are the most likely to hit their benefit cap and be left without coverage.
- Adults, including people with disabilities and pregnant women who are required to participate, are subject to limits in benefits set by the plans. Plans have to provide mandatory benefits, but they can vary the amount, duration, or scope of mandatory benefits. Plans can choose not to provide optional benefits at all. The only standard is that the benefit package must be actuarially equivalent to the value of the current Medicaid benefit package for an *average* member of the population. Again, people with disabilities are at particular risk that the benefits they need will not be offered.
- Children will continue to receive EPSDT benefits.
- Beneficiaries who engage in "healthy behaviors," such as annual check-ups, gym memberships or signing a living will, receive points that are deposited in "enhanced benefits accounts" that can be used for non-covered services or for private insurance when Medicaid eligibility ends.

Look for more information over the coming weeks, but feel free to call if you have questions or need more information.

Judy

From Wall Street Journal, 10/19/05

Not So Deaniac

BURLINGTON, Vt. -- Vermont is about the last place you'd expect to see free-market health care ideas take hold, but it may well become a laboratory for some bold medical reform experiments if popular Republican Governor Jim Douglas gets his way.

Vermont is a blue-state, socialistic stronghold in America, having delivered 62% of the vote for John Kerry in the 2004 elections, his second largest vote percentage in any state. But Gov. Douglas is one of a four-pack of Republican governors in the New England states, and these blue state CEOs have become a check and balance on the excessive regulatory and tax policies of overwhelmingly liberal legislatures. Case in point: Earlier this year Mr. Douglas vetoed a single-payer health care contraption that had passed the Democratic legislature by big margins. He publicly belittled the Democratic plan as the "single payer, taxpayer funded, government rationed health care deform plan."

But now Mr. Douglas is the first governor to receive a waiver from the federal government to restructure its Medicaid system. The entire Medicaid system is in crisis in Vermont. One Vermonter in four relies on taxpayer-provided health care, compared to one in twelve in neighboring New Hampshire. The costs are growing at a 13% annual rate and eligibility reaches up to 300 percent of the poverty level. As Mr. Douglas puts it: "We have a single payer system called Medicaid for one-quarter of our population and it's a financial disaster. Why would we

want to put 100% of Vermonters under such a program?"

Mr. Douglas wants to use the federal waiver to put a global cap on Medicaid spending over five years, though this "cap" would only cut the growth rate to slightly less than 10%. He also wants to experiment with choice-based plans such as medical savings accounts to cap costs and put the patient back in the equation. The conservative think tank here, the Ethan Allen Institute, is the prime intellectual force behind the MSAs and their analysis shows that this approach would have a huge impact in reducing the cost inflation of the system.

Bottom line: The state that gave America Dr. Howard Dean, Ben & Jerry's community activism, socialist Rep. Bernie Sanders and Sen. Pat Leahy has been flirting with socialized medicine for most of the past 18 years under a succession of Democratic governors. The failure of this approach is now evident and Vermont is about to become the nation's pioneer in implementing market-based reforms in Medicaid. If they can succeed in Vermont, these ideas will sell anywhere.

-- Stephen Moore

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Article published Nov 17, 2005

Medicaid reform moving slowly

MONTPELIER — As expected, a powerful legislative committee today will give the Douglas administration another two weeks to finalize the financial details of its plan to shore up the state's ailing Medicaid program.

The members of the Joint Fiscal Committee already knew that officials in the administration of Gov. James Douglas would not have answers to some key details for today's meeting. The meeting was originally scheduled in order to give final approval to the governor's Global Commitment to Health plan — a $4.7 billion, five-year Medicaid reform effort.

Instead, the 10 lawmakers will listen to updates from the state's Medicaid numbers-crunchers. They will also learn about how the state has gone about changing its health care bureaucracy to accommodate the new approach to a public health program affecting more than a quarter of the state's population.

The key missing piece to the global commitment puzzle is what Medicaid officials call a premium payment. That payment represents the monthly amount of state and federal money available for use on the state's Medicaid programs, and it is based on a per-beneficiary amount determined by the federal government.

The federal government has approved of a tentative monthly premium of $65 million for October and November. The final number will make or break Douglas' plan, officials said.

At least two private consultants are working on that question, according to Joshua Slen, director of the Office of Vermont Health Access. One of the consultants — Pacific Health Policy Group Inc. of California — has been working on the state's Medicaid programs since the Dean administration.

Slen said he believes that the final number will be within roughly 5 percent of the interim level the state has been granted over the last two months — a difference of nearly $3.3 million a month.

"I think that it will work out for us," he said.

When the Joint Fiscal Committee gave Douglas' plan preliminary approval in September, they were told that the state had to let the federal Centers for Medicare and Medicaid know they approved of the Medicaid rescue plan within 30 days. That day has come and gone, but Slen is not worried.

"They have had acceptance letters sent months and months later, and I don't think they are all that worried about an arbitrary deadline," Slen said.

Douglas' approach to Medicaid was approved by federal health officials in September after nearly a year of negotiations.

The program, which caps Medicaid spending in the state at $4.7 billion between now and 2010, is an innovative approach to the four-decades-old public health program that is paid for mostly by the federal government.

In exchange for the cap on total Medicaid spending, the state was given unprecedented flexibility in managing a program that, left in its current form, would generate a cumulative deficit of about $600 million by 2010.

Global commitment allows Vermont to set up a state-run managed care organization that would administer public health to the poor, disabled, blind and working poor. Vermont's Medicaid system provides more benefits than most other states' programs, and it is the explosive growth in these services that is driving Douglas and lawmakers toward a radical solution.

Indeed, no other state has proposed putting all of its public health programs under the umbrella of a single, government-run entity.

Slen said his office has begun to make the change "from an ATM to a managed-care organization."

He said that implementing global commitment would probably mean that at least four full-time people will have to be added to his office's employment rolls. When all changes to the state's public health care services are in place, Slen predicted that a total of as many as 25 full-time positions will have to be added.

Right now, the Office of Vermont Health Access employs about 70 people.

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