LRB-1706

2001 DRAFTING REQUEST

Bill

Received: **12/29/2000**

Received By: **kenneda**

Wanted: **As time permits**

Identical to LRB:

For: **Administration-Budget 266-2214**

By/Representing: **Kraus**

This file may be shown to any legislator: **NO**

Drafter: **kenneda**

May Contact:

Alt. Drafters:

Subject: **Health - miscellaneous**

Extra Copies: **ISR, JTK, RAC**

Pre Topic:

DOA:......Kraus -

Topic:

Prescription drug assistance program

Instructions:

See Attached

Drafting History:

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/2	kenneda 01/13/2001	csicilia 01/14/2001	martykr 01/15/2001	_______ _______	lrb_docadmin 01/15/2001		S&L
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/1		/1 cjs 1/14/01	kfollet 01/10/2001	Kf	lrb_docadmin 01/10/2001		

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/?	kenneda	/1 1/10 jld	lcjf 1/10	lcjf/rs 1/10			S&L

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<END>

Kennedy, Debora

From: Kraus, Jennifer
Sent: Friday, December 29, 2000 3:43 PM
To: Kennedy, Debora
Cc: Pawasarat, Jane
Subject: Drafting request

Debora - Attached is a drafting request that I'm sending through Steve Miller by snail mail related to prescription drugs. I wanted to get it to you as soon as possible, though. Our Performance Evaluation Office has taken the lead on this issue but either Jane Pawasarat (PEO) or I would be happy to answer any questions that you may have. Thanks and sorry in advance for the latest of the request - we just got into the Governor yesterday and as you might guess things have been a bit unsettled over here... Jennifer

rx memo to lfb 12-29.doc

CORRESPONDENCE/ *Memorandum*

State of Wisconsin
Department of Administration
Performance Evaluation Office

Date: December 29, 2000

To: Stephen Miller
Legislative Reference Bureau

From: Jane Pawasarat, Deputy Director
Performance Evaluation Office

Subject: Prescription Drug Assistance Program for Seniors

The Department of Administration is requesting that the Legislative Reference Bureau draft language to implement a prescription assistance program and six additional healthcare-related initiatives as part of the Governor's biennial budget.

Prescription Drug Assistance Program for Seniors

Administration: The Department of Health and Family Services (DHFS) would administer the prescription assistance program.

Implementation: The program would begin July 1, 2002 unless either:

- the federal government creates a national prescription drug benefit program for seniors, which would make a state program unnecessary or would result in a need to modify the State's program design to ensure that Wisconsin provides no more state funding than needed; or
- Wisconsin does not receive a federal waiver to include the program as part of Medicaid. DHFS should be directed to apply for a waiver similar to the one obtained by Vermont that extends Medicaid discounts and rebates to its senior prescription assistance program and allows federal matching dollars to be drawn down. Part of pursuing a waiver would necessitate demonstrating cost neutrality for the Medicaid program.

Eligibility: Persons 65 and older with income below 185 percent of the federal poverty level that have not had prescription drug coverage for at least one year.

Enrollment Fee: $25 annually, which would be designated to partially fund DHFS' administrative costs.

Type: Because the program would be an expansion of Medicaid, some of the benefits of Medicaid's prescription drug coverage would be extended to the new program and its participants, including:

- participants would receive pharmacy discounts on drug purchases that are the same as those provided to Medicaid, which approximates 23 percent of the usual and customary pharmacy charges. In general, drug charges would be based on either a drug's average wholesale price minus a 10 percent discount (AWP – 10%) or the maximum allowed cost, plus a dispensing fee of $4.38;

- the state would receive the same manufacturers' rebates as provided to Medicaid, which are expected to approximate 17 percent of the amount charged by pharmacies during the first year of operation; and

- federal funds would be available to fund approximately 59 percent of drug costs and 50 percent of administrative costs not funded by enrollment fees.

Drugs Covered: Similar to drugs included in Medicaid.

Variable Deductible:
- $0 for participants with income less than 110% of the federal poverty level;
- $300 for participants with income of 110% to 130% of the federal poverty level;
- $600 for participants with income of 130% to 155% of the federal poverty level; and
- participants with income of 155% to 185% of the federal poverty level would pay the entire drug cost. Their benefit would be limited to the savings generated by receiving a pharmacy discount.

Co-payment: $10 for generic drugs and $20 for brand name drugs.

State Costs: $10.2 million, which would be offset by savings in Medicaid.
- Additionally, one-time costs of up to $750,000 could be incurred in fiscal year 2001-02 to modify the Medicaid claims processing system to accommodate the needs of a prescription assistance program.

Federal Costs: $14.5 million, which would be offset by savings in Medicaid.
- Additionally, one-time costs of up to $750,000 could be incurred in fiscal year 2001-02 to modify the Medicaid claims processing system to accommodate the needs of a prescription assistance program.

Medicaid Cost Saving Strategies: DHFS should be directed to generate sufficient savings in Medicaid to demonstrate budget neutrality, which is the primary criterion for obtaining a federal waiver. Consequently, in order to fully fund the program, traditional Medicaid costs would need to be reduced by a total of $24.7 million, which would represent a combination of the State's $10.2 million share and the Federal $14.5 million share. Implementation and continuation of the program should be contingent on the availability of sufficient State and Federal funding.

Appropriations: Modify thc languagc of s.20.435(4)(b), (4)(bm),(4)(o) and (4)(pa) to allow DHFS to expend funds from these appropriations for the purposes of administration and benefits of the prescription assistance program.

Bulk Purchasing Initiative

DHFS should be directed to work with the Department of Administration to contract with a private entity for the bulk purchase of drugs and medical supplies for Medicaid recipients with certain chronic conditions (diabetes, asthma, and hypertension). Medicaid recipients would not be compelled to join; participation would be voluntary. The program would operate at no cost to the State and would be expected to generate savings of at least $8.5 million in fiscal year 2002-03. The contractor would be

responsible for promoting and administering the mail order drug program, as well as phoning participants on a quarterly basis to provide an additional point of contact to check on participants' self-care. Because additional long-term savings are likely to be realized through a reduction in emergency room and hospital care, DHFS should also be required to conduct an annual evaluation of the hospital and emergency room costs of participants to determine the extent of any savings. No funds would be appropriated for this purpose.

- Immediate savings generated from lower-priced drugs and the longer-term savings associated with reduced hospital and emergency room care should be designated in the waiver application as an offset to the cost of a prescription assistance program.
- This program should be extended to include participants in a prescription assistance program who volunteer to participate. — the one under the waiver? (Yes)

Multi-state Purchasing Group

16.735

The Department of Administration should be directed to work in conjunction with DHFS to develop a multi-state purchasing group of sufficient size to negotiate directly with manufacturers to obtain larger Medicaid rebates. The objective would be to increase manufacturer rebates sufficiently to get Medicaid prices that are significantly closer to those paid by the federal departments of Defense and Veterans Affairs, which are approximately one-third less expensive. Organizational efforts could include contacting states individually or working through organizations, such as the National Governors Association. No funds would be appropriated for this purpose.

- To the extent savings occur within the first five years of a prescription assistance program, they should be designated in the waiver application as an offset to the cost of a prescription assistance program. In statute? JK: (No)

State Sponsored Drug Discount Program

16.736

The Department of Administration should be directed to contract with a private entity to operate a state-sponsored drug discount program that would be available to anyone regardless of age or income. The program should be similar to those being developed in Washington and Iowa. Drug discounts should be the same or greater than the pharmacy discounts provided to Medicaid. Participants would be expected to pay a nominal enrollment fee to join the program. The State would not provide financial support, but would select a program from those responding to a request-for-proposals, as well as lending its name as program sponsor. No funds would be appropriated for this purpose. — send me material

Promote Private Drug Assistance Plans

49.45 (49)

DHFS in conjunction with the Department of Administration should be directed to promote private drug assistance plans, including drug manufacturers' free or reduced-cost plans for specific drugs and private plans offering pharmacy discounts to members. Promotional efforts should be incorporated into existing health information programs and the State's Internet site. No funds would be appropriated for this purpose.

Utilize Federal Discount Drug

From Craig:
no age limit
no income limit
DOA consult w/ DHFS

Federal discount drug programs allow certain federal agencies, populations, and other entities to purchase drugs at prices that are substantially less expensive than what the states are charged for the same drugs used by Medicaid recipients. Federal discount drug program restrictions prohibit the extension of program benefits beyond eligible entities identified by law. In Wisconsin, eligible entities include tribal members and patients receiving medical care at Federally Qualified Health Centers (FQHC). The State may not be maximizing available federal funds that could help to control drug costs in Wisconsin. For instance, only four of the 15 non-tribal FQHCs access the 340B Drug Pricing Program, provided under the Public Health Service Act. DHFS should be directed to inform Wisconsin entities eligible for federal discount drug programs about the benefits of these programs and to provide technical assistance on how to apply for and implement them. No funds would be appropriated for this purpose.

Encourage the Development of Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are comprehensive primary care centers that provide health services to low income populations. Areas in the state that are "federally designated" as a medically underserved area, medically underserved populations, or health professional shortage area are eligible to apply for federal operating grants to establish FQHCs. As already noted FQHCs are eligible entities under the 340B Drug Pricing Program. In addition, FQHCs receive full cost reimbursement under Medicaid and 80 percent reimbursement of allowable Medicare costs. Currently, DHFS collects data and processes requests from local entities that are interested in receiving any of the above federal designations. DHFS does not analyze statewide data to target areas of the state that could be eligible for and benefit FQHC funding. In order to maximize available federal funds, DHFS should be directed to complete this analysis and to provide identified regions with information and technical assistance regarding the FQHC development. No funds would be appropriated for this purpose.

If you have any questions please contact me at 267-2743 or Jennifer Kraus at 266-2214.

Cc: Debora Kennedy, LRB
Jennifer Kraus, State Budget Office

Making Drugs More Affordable for Seniors

"Drug prices are going through the roof, and older Washington residents are suffering the most. My new program will allow them to buy prescription drugs at a significantly lower cost."
- Governor Gary Locke
August 29, 2000

THOUSANDS OF OLDER Washington residents are suffering under the weight of increasingly costly prescription drugs. Standard Medicare doesn't cover prescription drugs, and many insurance policies offer scant help.

Governor Gary Locke is taking a big step to ease the suffering, and at no cost to the taxpayer.

The Governor is creating a program, "A Washington Alliance to Reduce prescription-Drug Spending" (AWARDS), to offer significantly lower prescription drug costs for Washington residents aged 55 and older. The program may be expanded by the Legislature to include more Washington residents.

Seniors Save Money!

Suzy Que is a 56-year-old diabetic female with high cholesterol and high blood pressure who has just reached menopause. Her monthly medication costs are as follows:

Drug	Strength	Retail Price
Glucophage	500mg	$25.60
Prem-Pro	0.625mg/5gm	$30.26
Lipitor	20mg	$102.00
Accupril	20mg	$32.36
Total Monthly Cost		**$190.22**

By enrolling in the AWARDS program for seniors, Mrs. Que could save $37.27 per month or $447.25 per year at a retail pharmacy or $845.06 per year if she orders through the mail.*

Drug	Retail Price	AWARDS Discount Retail	AWARDS Mail Order Discount**
Glucophage	$25.60	$19.24	$15.02
Prem-Pro	$30.26	$25.31	$20.40
Lipitor	$102.00	$80.30	$69.84
Accupril	$32.36	$28.10	$14.55
Total Monthly Cost	**$190.22**	**$152.95**	**$119.81**
Annual Cost:	**$2,283**	**$1,835**	**$1,438**
Percent Savings:		*19.59%*	*37.02%*

*Does not include the $15.00 enrollment fee
**Price based on 90-day purchase

AWARDS Highlights:

- Starting in January, residents aged 55 and older will pay $15 per individual and $25 per family each year to join what amounts to a buyer's club. Their purchases at participating pharmacies will be piggy backed on the buying power of the state Uniform Medical Plan to buy drugs at significantly lower cost.
- AWARDS members can expect to pay from 12 percent to 30 percent less for prescriptions than the retail price. If members order from a mail service, they can expect discounts of from 20 to 49 percent. Discounts will vary depending on the array of drugs used by an individual and their current use of generics.
- State government will combine its purchasing power across agencies and join forces with a pharmacy benefit manager (PBM) to win additional savings on the $376 million spent by state government each year on prescription drugs, further benefiting seniors.
- The Governor and Legislature will explore how best to use some of the savings to help buy drugs for those in financial need. This longer time frame would allow the state to take into consideration any action at the federal level to provide drug coverage through Medicare.

A Compelling Need to Help Older Citizens

Tens of thousands of older Washington citizens need one or more prescription drugs to stay healthy, and sometimes to stay alive. On average, those over 65 use four prescription drugs. Yet the costs of these drugs are going through the roof, and fewer and fewer older citizens can afford them.

Many older people have less than adequate health insurance, and some none at all. Seniors on Medicare get no prescription drug coverage, and 30,000 seniors lucky enough to have been on Medicare Plus coverage will lose it in January when insurers drop out of the program, unhappy with reimbursement rates paid by the federal government.

Advocates for the elderly say seniors are starting to cut back on food and housing to pay for medications, or to skip doses of needed medications in an effort to make ends meet.

Drug Costs: The Challenge of Affordability

This spring, the White House used data collected by the respected Washington D.C.-based organization, Families USA, to make its case to Congress, so far unsuccessfully, for prescription drug coverage for Medicare recipients. Among the findings:

- Average prices of prescription drugs common to seniors have soared 30 percent since 1994.
- Senior citizens 65 and older pay an average of $1,205 a year for prescriptions - up from $559 in 1992. They will pay an average of $2,810 apiece by 2010.
- The burden of paying for drugs falls disproportionately on older people. Americans 65 and older pay 42 cents of every dollar spent by the entire population on prescription drugs, although they account for just 13 percent of the population.

Time for Washington to Act

Congress and the administration continue to debate whether to provide drug benefits under Medicare. Meanwhile, seniors are left with a hard choice: buy the drugs at any price in order to stay well.

AWARDS Program: A Timely Tool

The state has limited options available. Purchasing in an aggressive, efficient and prudent fashion is one of the potent tools available. This program attempts to harness the state's purchasing power and put it to work for the citizens of this state.

Staff Contact: Ree Sailors, Governor's Executive Policy Office, 360-902-0655; Fax: 360-586-8380.

CORRESPONDENCE/ *Memorandum*

State of Wisconsin
Department of Administration
Performance Evaluation Office

Date: January 8, 2001

To: Debora Kennedy
Legislative Reference Bureau

From: Craig Barkelar

Subject: Prescription Drug Assistance Bill

Jennifer Kraus asked me to forward you some information related to the Governor's prescription assistance plan. I have included a copy of:

- two of Vermont's Medicaid waivers; and
- description of Washington's prescription assistance program;

Jennifer also said you wanted the site for:

- federal Medicaid waiver (**Section 1115 of the Social Security Act**); and
- identifying parties eligible for federal discount drug prices (**Section 340B(a)(5)(B) of the Public Health Service Act**).

Please contact me at 261-5056 with any other questions.

STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
PERFORMANCE EVALUATION OFFICE
DOA-5167 N(R06/95)

FACSIMILE COVER MESSAGE

THE FACSIMILE MACHINE COPIES ONE SIDE OF DOCUMENT

TO

Name		Facsimile Telephone Number
Debora Kennedy		608(264-8522)
Location	**Room Number**	**Telephone Number**
		608(

FROM (Sender)

Name	Number of Pages including Cover Sheet	Facsimile Telephone Number
Craig Barkelar	4	(608) 261-5058
Location		**Telephone Number**
101 East Wilson Street, 5th Floor, Madison, WI 53707		(608) 261-5056

COMMENTS / INSTRUCTIONS

I hope this helps!

Thanks

Craig

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INFORMATIONAL PAPER

Private Prescription Plans

As part of our evaluation of Wisconsin's pharmaceutical-purchasing practices, the Performance Evaluation Office reviewed private prescription plans that provide discounts on drugs purchased from most pharmacies throughout the State. Private prescription plans include a pharmacy discount that compares favorably to the discount received by the State's Medicaid program, which is 10 percent of the average wholesale price for brand name drugs. Private plans provide significantly larger discounts if drugs are ordered through the mail. Further, the fee paid to pharmacists for dispensing prescriptions typically is lower under private prescription plans than the $4.38 per prescription paid by the State's medical assistance program. Membership costs for private prescription plans vary from no charge to more than $300 per year. As the cost of membership increases so do the size of reported discounts, as well as the provision of other benefits, such as less expensive nonprescription drugs.

Based on a recent study completed by AARP, seniors without a prescription benefit could save, on average, approximately $200 a year by purchasing drugs through its prescription plan. A listing of more than 30 private prescription plans that we became aware of during our review is attached. Examples of private plans include:

- Rx Samaritan Prescription Drug Plan. Membership is free, although a fee of $3 per prescription is charged unless member savings are less than this amount. Membership is open to everyone. Brand name drugs reportedly cost 10 to 15 percent less than average wholesale prices and generic drugs reportedly receive substantially larger discounts.

- ComCare, Inc. Annual memberships cost $20 per person, plus a fee of $0.85 per prescription. Membership is open to everyone. Prescription prices reportedly average $13.51 less than retail drug prices.

- AARP Pharmacy Service is a prescription plan operated by Retired Persons Services, Inc. Annual memberships cost $25 per person ($15 for the prescription plan and $10 for enrollment in AARP, which provides other member benefits). Membership is limited to individuals over 50 years of age. This plan does not allow pharmacists to charge a dispensing fee. Brand name drugs reportedly cost, on average, $8.49 less than retail drug prices or about 15 percent less than the average wholesale prices.

- United Medical Claim Administration, Inc. Annual memberships cost $30 per family, and membership is open to everyone. This plan does not allow pharmacists to charge a dispensing fee. Brand name drugs reportedly cost up to 25 percent less average wholesale prices and generic drugs costs up to 40 percent less.

- Enhancedbenefits.com. Annual memberships cost $88 per family plus a one-time enrollment fee of $10. Membership is open to everyone. Prescription prices reportedly cost 10 percent less than the AARP plan's prices.

- American Family Benefits. Annual memberships cost $120 per person or $180 per family. Membership is open to everyone. Prescription prices reportedly cost 20 to 30 percent less than retail drug prices.

Individuals need only present their membership card when purchasing prescriptions to obtain discounts. Most chain and independent pharmacies honor a number of private prescription plans. For example, the plans noted above are accepted at more than 45,000 pharmacies nationwide. In Wisconsin, pharmacies, including Walgreen's, K-Mart, Osco, Shopko, Copps, Walmart, Coe Drug, and numerous independent pharmacies, participate in a large number of private prescription plans.

To ensure that state residents without a prescription benefit are aware of the savings associated with belonging to a private prescription plan, Wisconsin could publicize these plans. However, to avoid potential liability, state officials should consider not providing opinions on specific plans, but rather limiting the State's involvement to disseminating similar types of information for each plan, including membership cost, dispensing fee, reported discounts, and the number of participating pharmacies in Wisconsin. The State could provide informational brochures for distribution at pharmacies, medical facilities, public libraries, and senior citizen centers, as well as at state and local social services agencies. The State could also provide general program information on its Internet site, with links to other sites that provide more detailed information on individual plans.

Consideration should be given to including an initiative in the Governor's 2001-03 biennial budget to promote private prescription plans on the State's Internet site, through brochures, and by other methods that are intended to cost-effectively educate persons without a prescription benefit about the availability of prescription discounts through private plans.

Attachment A

Selected Private Prescription Plans

Name of Program	Annual Membership Costs	Claimed Savings	Contact Information
Kmart AmeriKind Pharmacy Network	no membership cost	up to 15% off retail	800-866-0086, http://userpages.chorus.net/
Rx Samaritan Prescription Drug Plan	no membership cost, $3 per prescription	10 to 15% off average wholesale cost	888-711-1182, http://home.att.net/~epa-ptm/
MemberHealth Inc., Criterion Plan	$10 per family	12% off wholesale, 40% off retail	888-868-5854, www.mhrx.com
MatureRx Prescription Drug Program	$10 per person	up to 65% off retail	800-511-1314, www.maturerx.com
AARP Pharmacy Service	$15 per person and $10 to join AARP	an average of $8.49 per prescription	800-456-2277, www.rpspharmacy.com
ComCare Inc.	$20 per family, plus $0.85 per prescription	$13.51 per prescription	888-209-7979, www.comcare.com
Prescription Services of America	$25 per family and $5 per prescription	pay wholesale acquisition cost rates	800-444-PSA4, http://all-biz.com/psa/benefit.htm
Value Rx	$29 per person, $55 per family	20% to 30% off retail	231-779-1079, www.healthcarebenefits.com/
United Medical Claim Administrator, Inc	$30 per family	25% to 40% off retail	708-798-7133, www.umca.ohgolly.com
Independent LifeStyle Association, Inc.	$30 per person	20% off retail	800-895-5535, www.senior-benefit-savings.com
Activ Savings Card	$35 per family	10% to 50% off retail	888-847-4787, www.getactiv.com
National Association of Mature Americans	$35 per person	12% off average wholesale cost	800-409-0983, www.namatx.com
RX Point Prescription Service	$35 per person	3% to 62% savings off retail	888-531-4793, www.rxpoint.com
Qdrug Pharmacy Plan (HealthPlus Network)	$49 per family	up to 60% off retail	888-715-4802, www.qdrug.com
RxValue USA	$49 per person	up to 60% off retail	800-444-1012, www.rxvalueusa.com
Pharmacy USA	$50 per family	10% to 50% off retail	877-745-2332, www.prescriptionplan.com
Prescription Discount Plus	$50 per person, $70 per family	up to 50% off retail	800-454-7321, www.prescriptiondiscount.com
Prescription Drugs Direct (RXSmart Card)	$50 per person	38% off retail	800-481-8405, www.rxsmartcard.com
SaveWell Discount Prescription Program	$52 per family	29% to 50% off retail	877-728-3935, www.savewell.com
Healthy Options Card	$69 per family	up to 50% off retail	888-825-9777, www.healthyoptionscard.com
Bodyguard Health Savings Card	$69 per person, $89 per family	17% off retail	800-991-0006, www.bodyguardcard.com
PlanPlus (associated with JCPenney)	$70 per family	up to 30% off retail	800-527-5583, www.planplus-discounts.com
MedPerks Card	$88 per family	9% to 85% off retail	800-475-0623, www.medperkscard.com
Ehancedbenefits.com	$88 per family and a one-time fee of $10	10% less than AARP prices	877-342-6233, www.ehancedbenefits.com
HealthSaver Club	$89 per person, $109 per family	10% to 60% off retail	877-479-1580, www.healthsaverclub.com
Select Care Benefits Plan	$96 per family	25% to 50% off retail	800-853-5582, www.moneymanual.com/sb
American Family Benefits	$120 per person, $180 per family	20% to 30% off retail	877-892-6407, www.americanfamilybenefits .com
AmeriPlan	$143 per person, $239 per family	25% to 50% off retail	800-647-8421, www.ameriplanusa.com
Discounted Prescription	$143 per person, $239 per family	up to 70% off retail	877-662-3942, www.trymybiz.com/cgi-bin/usa5/fairchild
ProCare Health Plan, family plan also covers	$191 per family and a one-time fee of $5	10% less than AARP prices	888-750-4565, www.procarecard.com
Senior Druggist Prescription Drug Co-op	$275 per person, $443 per family	up to 25% off retail for brand name	800-583-9323, www.seniordruggist.com
SeniorScrips Prescription Drug Co-op	$372 per person and $3 per prescription	30% to 50% off average wholesale cost	888-422-8482, www.seniorscrips.org

FAX TRANSMITTAL COVER SHEET

Agency of Human Services
Office of Vermont Health Access
103 South Main Street
Waterbury, VT 05671-1201

Voice: (802)241-2880 Fax: (802)241-2897

PAGE 1 of 41 PAGES

DATE: 11/14/00

TO:

NAME: Sherry Lloyd

LOCATION: State of Wisconsin - Pharmacy Assistance Program

FAX NUMBER: 608-261-5058

FROM:

NAME: Samantha Haley

TELEPHONE NUMBER: (802) 241 - 3984

COMMENTS: VHAP-PDP waiver amendment, approval letter and terms and conditions - also informational sheet

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Pharmacy Discount Program (PDP)

Program Background

Governor Dean, Agency of Human Services staff and the Legislature have wrestled with the issue of how to address the rising cost of prescription drugs. While several proposals have been introduced and analyzed, none have quickly produced the desired result of lower prices for Vermonters that do not have insurance that covers drugs.

To partially address this problem, the administration proposed an innovative approach during the SFY2001 budget discussions. Implementation of this proposal required an amendment to the state's 1115 demonstration waiver to include an expansion of the Pharmacy Program of the Vermont Health Access Plan (VHAP). The federal Health Care Financing Administration (HCFA) approved the amendment to the state's VHAP waiver. This expansion is called the Pharmacy Discount Program (PDP).

PDP Eligibility

This program covers two groups:

- Any Medicare-covered individual with income above 150% of federal poverty level (FPL) without drug coverage. This would include drugs for acute conditions for these beneficiaries currently eligible for VScript (up to 225% FPL) who currently receive a benefit only for maintenance drugs.
- All individuals with incomes up to 300% FPL who do not have a benefit program that includes drug coverage. Currently, this translates to monthly income of $2088 for a household of one, $2813 for a household of two, and $3538 for a household of three.

PDP Benefits

The Medicaid payment and rebate structure will be extended to the above two groups of people. Beneficiaries will have the ability to purchase drugs at a price that is equivalent to the price that Medicaid pays net of the manufacturers' rebate available to the Medicaid program. This translates into a cost to the individual that is approximately 30 percent lower than what the person normally pays for the prescription.

For prescriptions at the Medicaid rate of $20 or more, a beneficiary's discount will be reduced by $3 for the first eight prescriptions to cover the $2[illegible] annual enrollment fee for this program. This fee will offset the state's cost of administrating this program, including the additional claims processing costs and staff to process enrollment into the program.

Population Served

Approximately 3[illegible],550 Medicare covered beneficiaries and an additional 31,350 individuals under 300% FPL will be eligible for this expansion. Projected calendar year-end enrollment is 20,600 for 2001, 2[illegible],375 for 2002, and 28,123 for 2003.

Implementation

Implementation begins January 1, 2001. Applications will be available on December 1, 2000. Call 1-800-25[illegible]-8427. Applications will also be included in the Vermont tax booklet, which is available at the end of January.

11/7/00

State of Vermont **AGENCY OF HUMAN SERVICES**

DEPARTMENT OF SOCIAL WELFARE
COMMISSIONER'S OFFICE
103 South Main Street
Waterbury, Vermont 05671-1201

Telephone: (802) 241-2852
Fax: (802) 241-2830

March 17, 2000

Timothy Westmoreland, Director
Center for Medicaid and State Operations
Health Care Financing Administration
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: 11-W-00051/1

Dear Mr. Westmoreland:

Vermont requests an amendment to its 1115 demonstration waiver to include in an expansion of the Pharmacy Program of the Vermont Health Access Plan (VHAP), the following:

- Any Medicare-covered individual with income above 150% of the Federal Poverty Level (FPL) without drug coverage. This would include drugs for acute conditions for those beneficiaries currently eligible for the pharmacy component of our demonstration waiver between 150% and 175% of the FPL who currently receive a benefit only for maintenance drugs.

- All individuals with incomes up to 300% of the FPL who do not have a benefit program that includes drug coverage.

For this purpose, drug coverage is any such coverage other than VHAP Pharmacy regardless of beneficiary cost-sharing for premiums, deductibles, coinsurance, or co-payments.

VHAP was created with the goal of improving the health status and access to needed health care for lower income Vermonters. Since the onset of the demonstration, one of the major areas of concern for all health consumers, in Vermont and nationally, has been the ever rising cost of essential pharmaceuticals.

Vermont proposes to extend the Medicaid payment and rebate structure to the above two groups of people who have not otherwise been eligible for full pharmaceutical coverage under VHAP programs. Beneficiaries would have the ability to purchase drugs at a price that is equivalent to the price that Medicaid pays net of the manufacturers' rebate available to the Medicaid program.

We believe that the waiver requiring amendment would be regarding amount, duration, and scope of services. Beneficiaries of this proposal would only receive a pharmacy benefit and then only upon payment of their share of the prescription or refill.

The program will work as follows:

1. For each year, an amount will be established to reflect the expected return to the state under the rebate provisions of the Omnibus Budget Reconciliation Act of 1990. This amount will be set as a percentage of total drug expenditures and will be the program subsidy. To illustrate, the current rebate is estimated to be 18% of gross pharmacy expenditures. Thus, 18% will be the subsidy amount.

2. An annual enrollment fee will be set to cover the administrative costs of the program. This will be collected at enrollment and annually thereafter as a condition of ongoing coverage.

3. An individual found eligible for the program will be enrolled and issued an identification card. Individuals eligible for VHAP Pharmacy over 150% of the FPL for maintenance drugs will use their existing cards to access coverage for their non-maintenance drugs.

4. The provider will swipe the card using the Point of Sale (POS) swipe boxes that are provided by Medicaid.

5. The provider will identify the script by NDC and indicate units.

6. The Medicaid Management Information System (MMIS) will verify eligibility, price the script at the Medicaid rate on file, and notify the provider of the results.

7. The provider will charge an eligible beneficiary the Medicaid rate less the established program subsidy; for example, with the subsidy set at 18% the beneficiary will be charged 82% of the Medicaid rate.

8. Upon payment, the provider will dispense the drug and submit a claim showing the beneficiary payment.

9. The provider will be reimbursed for the subsidy amount.

10. The State will bill the drug manufacturers to collect the rebate quarterly.

Rebates collected from manufacturers will be deposited into a revolving fund and used to pay the subsidy. Initially, State funds, which have been included in the House Appropriations bill, will be provided to meet the cash flow needs of the program.

Vermont anticipates that 37,550 Medicare covered beneficiaries and an additional 31,350 individuals under 300% of the FPL will be eligible for this expansion. The Department believes that this

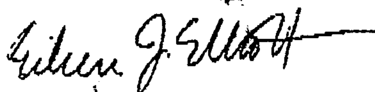
expansion will not impact on the budget neutrality of the demonstration since there will be no benefit cost to the program. As noted above, the Department plans to collect an enrollment fee to offset the cost of administering this program, particularly the additional claims processing costs and staff to process beneficiary enrollment and fee collection. Given the nature of this waiver amendment, we request an approval that will allow the state to retain 100% of the fees collected from beneficiaries. This will enable us to keep that amount low and encourage participation. Attached is an analysis of our anticipated enrollment.

We believe this is an opportunity for the Health Care Financing Administration to assess the drug utilization patterns of consumers, especially the Medicare population, using existing Medicaid service delivery systems and administrative structures. The information available through Vermont's MMIS will be invaluable in evaluating options for making medicines accessible to many Americans in need.

Vermont has been working closely with other states, particularly New Hampshire and Maine, on pharmacy cost containment and coverage expansion strategies. It is possible that under our demonstration, these two states might be willing to pilot options that parallel our proposal or join with Vermont as part of this proposal if that were feasible from HCFA's perspective. In that way a greater pool of eligibles would present a greater volume of drug utilization information for HCFA program purposes.

If you or your colleagues have any questions, please contact Ann Rugg, Managed Care Senior Administrator, at 802-241-2766. As always, we appreciate your continued assistance in support of our efforts to improve access, service coordination and quality care to our beneficiaries.

Sincerely,



Eileen I. Elliott
Commissioner

cc: Howard Dean, M.D., Governor
M. Jane Kitchel, Secretary, AHS
Ronald Preston, Ph.D., Associate Regional Administrator, HHS Region I
Paul Wallace-Brodeur, Director, OVHA

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State of Vermont: Extension of Pharmacy Benefits

Projected Enrollment

Eligible Group:	Adults		Medicare Beneficiaries		
Income as a Percentage of Federal Poverty Level (FPL):	Less than 225%	225 to 300%	150 to 225%	Greater than 225%	Total
Number of Individuals	160,327	73,431	18,863	44,082	296,702
Number Eligible for Medicaid/CHAMPUS Coverage	98,345	19,330	3,336	8,594	
Number of Individuals with Private Coverage	54,901	44,105	9,932	30,873	
Percentage of Private Policies without a Pharmacy Benefit	14.4%	14.4%	67%	67%	
Individuals with Private Coverage Only and No Pharmacy Benefit	7,906	6,351	6,655	20,685	
Individuals without Private Coverage and Ineligible for Medicaid/VHAP	7,080	9,996	5,594	[illegible]	
Total Individuals without Pharmacy Coverage	14,986	16,347	12,249	25,299	68,881
Projected Participation Rate					
CY 2001	20.0%	20.0%	55.0%	30.0%	
CY 2002	25.0%	25.0%	57.5%	37.5%	
CY 2003	30.0%	30.0%	60.0%	45.0%	
Projected Year-End Enrollment					
CY 2001	2,997	3,269	6,735	7,599	20,600
CY 2002	3,746	4,087	7,043	9,499	24,3[illegible]
CY 2003	4,496	4,904	7,349	11,385	28,134
Average Annual Enrollment					
CY 2001	1,499	1,635	3,367	3,799	10,300
CY 2002	3,372	[illegible]	6,889	[illegible]	22,488
CY 2003	4,121	4,496	7,196	10,442	26,255

Sources: Census Population Survey, 1998; Vermont Study of Medi-Gap coverage; and Tennessee study of inclusion of pharmacy benefit in private coverage policies

Office of the Administrator
Washington, D.C. 20201

NOV 3 2000

Ms. Eileen I. Elliott
Commissioner
Department of Social Welfare
103 South Main Street
Waterbury, Vermont 05671-1201

Dear Ms. Elliott:

We are pleased to inform you that your March 17, 2000, request to amend the current section 1115 demonstration, the Vermont Health Access Plan (VHAP) (11-W-00051/1), has been approved. This approval will permit Vermont to expand its pharmacy program to cover two new groups and will extend access to discounted prices for prescription drugs to them. The groups are Medicare beneficiaries with income above 150 percent of the Federal Poverty Level (FPL) who lack prescription drug coverage and other adults with income at or below 300 percent FPL who lack prescription drug coverage. This new program is known as the Pharmacy Discount Program (PDP).

The following expenditure authority is granted for PDP:

Under the authority of section 1115(a)([illegible]) of the Act, expenditures made by the State under VHAP for the item identified below (which are not otherwise included as expenditures under section 1903) shall, for the period of the demonstration, be regarded as expenditures under the State's title XIX plan:

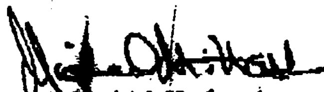
> Expenditures for extending pharmacy-only supplemental benefits to Medicare beneficiaries with income above 150 percent and at or below 175 percent of the FPL for non-maintenance medicines only, to Medicare beneficiaries with income above 175 percent of the FPL, and to all adults with income at or below 300 percent of the FPL as part of the Pharmacy Discount Program (PDP).

The demonstration authority approved in this letter is subject to compliance with the enclosed special terms and conditions. These terms and conditions have been revised, in consultation with your staff, to reflect approval of the PDP. The cumulative list of waivers and expenditure authorities for the VHAP demonstration is also attached. Written notification to our office of your acceptance of this award must be received within 30 days after you receive this letter.

Page 2 – Ms. Eileen I. Elliott

Your project officer continues to be Ms. Joan Peterson, who may be reached at (410) 786-0621. We look forward to the continued success of the VHAP demonstration in extending health care coverage to uninsured and underinsured Vermonters.

Sincerely,



Michael M. Hash
Acting Administrator

Enclosures

TOTAL P.03

HEALTH CARE FINANCING ADMINISTRATION
SPECIAL TERMS AND CONDITIONS
(Effective January 1, 2001)

NUMBER: 11-W-00051/1

TITLE: The Vermont Health Access Plan

AWARDEE: Vermont Agency of Human Services

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I. PREFACE

The following are terms and conditions for the award of the Vermont Health Access Plan (VHAP) demonstration waiver request. The terms and conditions have been arranged into three broad subject areas: General Conditions for Approval, Legislation, and Program Design/ Operational Plan.

In addition, specific requirements are attached, entitled: Requirements for Federal Financial Participation/ Cost Control/ Fiscal Administration (Attachment A); General Administrative Requirements (Attachment B); General Reporting Requirements (Attachment C); Monitoring of Budget Neutrality (Attachment D); Access Standards (Attachment E); Outline for Operational Protocol (Attachment F); and Recommended Minimum Data Set (Attachment G).

Note: DDMHS refers to the Vermont Department of Developmental and Mental Health Services, which is a prepaid health plan (PHP) as defined in 42 CFR 434.2.

II. GENERAL CONDITIONS

1. All special terms and conditions prefaced with an asterisk (*) contain requirements that must be approved by the Health Care Financing Administration (HCFA) prior to marketing, enrollment, or implementation. No Federal Financial Participation (FFP) will be provided for marketing, enrollment or implementation until HCFA has approved these requirements. FFP will be available for project development and implementation, and for compliance with terms and conditions, the readiness review, etc. Unless otherwise specified where the State is required to obtain HCFA approval of a submission, HCFA will make every effort to respond to the submission in writing within 30 days of receipt of the submission. HCFA and the State will make every effort to ensure that each submission is approved within sixty days from the date of HCFA's receipt of the original submission.

*2. Within 60 days of award, the State will submit a pre-implementation workplan for approval by the HCFA project officer. The workplan will specify timeframes for major tasks and related subtasks for managed care expansion.

*3. The State shall prepare one protocol document that represents and provides a single source for the policy and operating procedures applicable to this demonstration which have been agreed to by the State and HCFA during the course of the waiver negotiation and approval process. The protocol must be submitted to the HCFA project officer no later than 70 days prior to the implementation date of the program (implementation defined as the first date when beneficiaries select a health plan). HCFA will respond within 30 days of receipt of the protocol regarding any issues or areas it believes require clarification. HCFA and the State will make every effort to ensure that the protocol is approved within 60 days from the date of its original submission. During the demonstration, subsequent changes to the protocol which are the result of major changes in policy or operating procedures should be submitted no later than 60 days prior to the date of implementation of the change(s) for approval by HCFA. The Special Terms and Conditions and Attachments include requirements that should be included in the protocol. Attachment F is an outline of areas that should be included in the protocol. Where not specified in the protocol, the State's original waiver proposal, as modified or clarified in written responses to HCFA questions, shall govern.

4. a. The State will submit a phase-out plan of the demonstration to HCFA six months prior to initiating normal phase-out activities and, if desired by the State, an extension plan on a timely basis to prevent disenrollment of VHAP members if the waiver is extended by HCFA. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than six months when such action is necessitated by emergent circumstances. The phase-out plan is subject to HCFA review and approval.

   b. During the last 6 months of the demonstration, eligibility determination of individuals who would not be eligible for Medicaid under the current State plan will not be permitted unless the waiver is extended by HCFA.

5. HCFA may suspend or terminate any project in whole or in part at any time before the date of expiration, whenever it determines that the awardee has materially failed to comply with the terms of the project. HCFA will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights to challenge HCFA's finding that the State materially failed to comply. HCFA reserves the right to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, HCFA will be liable for only normal close-out costs.

6. The State will comply with:

   a. Requirements for Federal Financial Participation/ Cost Control/ Fiscal Administration (Attachment A)
   b. General Administrative Requirements (Attachment B)
   c. General Reporting Requirements (Attachment C)
   d. Monitoring of Budget Neutrality (Attachment D)
   e. Access Standards (Attachment E)
   f. Outline for Operational Protocol (Attachment F)

III. LEGISLATION

1. a. All requirements of the Medicaid program expressed in law not expressly waived or identified as not applicable in the award letter of which these terms and conditions are part, shall apply to VHAP. To the extent the enforcement of such laws through regulations and official policy statements issued by a Bureau director and/or Associate Regional Administrator or higher would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, HCFA shall incorporate such effects into a modified budget limit for VHAP. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. HCFA will have two years after the waiver award date to notify the State that it intends to take action. The growth rates for the budget neutrality baseline, as described in Attachment D, are not subject to this special term and condition. If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the VHAP demonstration (e.g., all disallowances involving provider taxes or donations), and if HCFA and the State working in good faith to ensure State flexibility in deciding where the appropriate modifications should occur, do not agree within 90 days to establish an alternative methodology for revising the without waiver baseline, the effect of enforcement on the State's budget limit shall be proportional to the size of the VHAP demonstration in comparison to its entire Medicaid program (as measured in aggregate medical assistance payments).

b. The State shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after July 31, 1995. To the extent that a change in Federal law which does not exempt State section 1115 demonstrations, would affect State Medicaid spending in the absence of the waiver, HCFA shall incorporate such changes into a modified budget limit for VHAP. The modified budget limit would be effective upon implementation of the change in Federal law, as specified in law. If the new law cannot be linked specifically with program components that are or are not affected by the VHAP demonstration (e.g., laws affecting sources of Medicaid funding), the State shall submit its methodology to HCFA for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in Vermont, HCFA would approve the methodology. Should HCFA and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent

with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments shall be made according to the method applied in non-waiver States.

c. The State may submit to HCFA an amendment to the program to request exemption from changes in law occurring after July 31, 1995. The cost to the Federal government of such an amendment must be offset to ensure that total projected expenditures under the modified VHAP program do not exceed projected expenditures in the absence of VHAP (assuming full compliance with the change in law).

IV. PROGRAM DESIGN/OPERATIONAL PLAN

A. Eligibility Review

1. The State will continue to maintain a Medicaid Eligibility Quality Control (MEQC) program for traditional eligibles. The expanded eligibility group shall be incorporated into the Income Eligibility Verification System (IEVS), which verifies income. This data combined with other information shall be used to implement control mechanisms. Control mechanisms to be implemented shall be included in the protocol.

2. The State will cooperate with HCFA in its monitoring activities related to the accuracy of coding cases as (1) eligible under previous Medicaid criteria or (2) eligible only under VHAP criteria.

B. Capitation Rates

1. The State will submit to HCFA for review and approval all capitation rates, and the fee-for-service upper payment limits from which they are derived, for the Managed Care Plans (MCPs) and DDMHS throughout the demonstration. Also, the State will submit the methodology for determining the fee-for-service upper payment limits for services.

C. Managed Care Plan Contracting

1. The State will use a Request for Proposal (RFP) process to select contracting MCPs. This process will be open to all MCPs that meet VHAP participation standards, including minority-owned plans.

2. Before issuing the solicitation for MCPs, the State shall submit the RFP for review by the HCFA project officer. HCFA will have 21 days to provide comments to the State.

3. The State shall submit to HCFA, for its review and comment, the RFP for the Benefits Counseling Contractor at least 21 days prior to its issuance.

4. The State will provide HCFA with 30 days to review and approve the executed contract prior to its use. No FFP will be available for contracts using a contract which has not been approved by HCFA in advance of the effective dates of the contracts.

D. Managed Care Plan and DDMHS Contracting

1. a. The State will notify the HCFA project officer of significant changes to any provider network which affect access and quality of care, and the State shall define within its protocol contingency plans for assuring continued access to care for enrollees in the case of an MCP or PHP-DDMHS contract termination and/or insolvency, or in case of significant disruptions in the provider network for the CRT Program.

b. HCFA reserves the right to review and approve individual subcontracts with MCPs or with DDMHS in accordance with the same requirements as those imposed by these Special Terms and Conditions on MCPs and DDMHS. Copies of subcontracts or individual provider agreements with managed care organizations or DDMHS shall be provided to HCFA upon request.

c. The State shall establish a process by which it receives, reviews, and approves all marketing material prior to their use by health plans or by DDMHS.

d. In the protocol, the State shall describe how homeless populations will access health care services under the demonstration. The protocol will include a description of how providers of care to this population will be incorporated in the managed care model and reimbursed for their services to this population.

2. a. The State must provide the methodology it will use to determine whether each MCP and DDMHS has an adequate provider network in relation to the geographic location of Medicaid beneficiaries. For MCPs, this methodology will be incorporated under the plan evaluation and selection process.

b. The State must provide the methodology it is using to determine whether each region in the State (as defined by the State) has sufficient MCP provider capacity to justify mandatory managed care enrollment. This should consider both the incidence of providers enrolled with multiple MCPs and the percentage of provider caseloads open to Medicaid clients in relation to the geographic location of Medicaid beneficiaries.

c. The State must provide the HCFA Regional Office (RO) with an annually updated listing of all providers (primary and specialty) participating in the demonstration.

d. In the protocol, the State will provide assurances to HCFA that the fee-for-service system is being maintained in areas where provider capacity is determined to be insufficient.

*3. The State must meet the usual Medicaid disclosure requirements at 42 CFR 455, Subpart B, for contracting with MCPs prior to the start date of the demonstration, and for contracting with DDMHS prior to the start date of the CRT Program. Such requirements include disclosure of ownership and completion of the standard HCFA disclosure form.

E. Family Planning

*1. In the protocol, the State should provide HCFA with a description of available family planning services and assurances that access to these services is not restricted by the VHAP demonstration.

2. The State will provide HCFA with any amendments to the Title X provider agreements which occur as a result of the demonstration.

F. Federally Qualified Health Centers (FQHCs)

1. a. For FQHCs that are established prior to the start date of the demonstration, the State will assure (except as specified in 1b below) that health plans within the FQHC's service area contract with the FQHCs. If an FQHC forms its own MCP, health plans will not have to contract with the FQHC.

b. For any health plan that requests relief from the requirement, the State shall submit to HCFA a report with the following information at least 30 days prior to submission of the final HMO contract for the RO approval:

1) The FQHCs in the health plan's service area, and a description of the demonstration populations served and the services provided by the FQHCs prior to the demonstration.

2) An analysis that the health plan has sufficient provider capacity to serve the demonstration populations currently receiving services at the FQHC. The analysis should include, but not be limited to, a listing of providers aligned with the MCP, capacity of each provider to take on additional Medicaid patients, geographic location of providers, and description of accessibility for Medicaid patients to

these providers. The health plan must inform the State if any of this information or data changes over the course of the demonstration.

3) An analysis that the health plan will provide a comparable level of Medicaid services as the FQHC (as covered in the approved State plan and actually provided by the FQHC under the fee-for-service program), including covered outreach, social support services, and the availability of culturally sensitive services, such as translators and training for medical and administrative staff. The analysis should describe the proximity of providers, and range of services as it relates to FQHC patients.

2. For FQHCs/RHCs which are established prior to the start date of the demonstration, the State will use, over the term of the demonstration, a year-end reconciliation process to assess revenues received through payment from the plans compared to reasonable allowable costs; if revenues are below 100 percent of reasonable allowed costs, the State will reimburse those FQHCs/RHCs the difference. FQHCs/RHCs may elect to permanently waive the cost reconciliation process for the duration of the waiver.

3. FQHCs/RHCs which are established after the start date of the demonstration will not be entitled to retroactive Medicaid cost reimbursement, unless it is determined by the appropriate State entities, with the advice of health plans, that this reimbursement is necessary to provide primary care access for enrollees in the geographic area served by the practice. If cost based reimbursement is used, it will be limited to the mean cost for FQHCs or free standing RHCs.

G. Encounter Data Requirements

1. a. The State shall define a minimum data set (which at least includes inpatient and physician services) and require all providers to submit these data. The recommended minimum data set is attached. The State must perform periodic reviews, including validation studies, in order to ensure compliance, and shall have provisions in its contract with the managed care organizations and with DDMHS to provide the data and be authorized to impose financial penalties if accurate data are not submitted in a timely fashion. The State shall submit the proposed minimum data set and a workplan showing how collection of plan encounter data will be implemented and monitored, and how the State will use the encounter data to monitor implementation of the project and feed findings directly into

program change on a timely basis. If the State fails to provide reasonably accurate and complete encounter data for any MCP or for DDMHS, it will be responsible for providing to the designated HCFA evaluator data abstracted from medical records comparable to the data which would be available from encounter reporting requirements.

b. The State, in collaboration with MCPs, DDMHS, and other appropriate parties, will develop a detailed plan, submitted to HCFA, for using encounter data to pursue health care quality improvement. At a minimum, the plan shall include: how the baseline for comparison will be developed; what indicators of quality will be used to determine if the desired outcomes are achieved; where the data will be stored; how data will be validated and how monitoring will occur; and what penalties will be incurred if information is not provided.

c. At a minimum, the State's plan for using encounter data to pursue health care quality improvement must focus on the following priority areas:

childhood immunizations;
prenatal care and birth outcomes;
pediatric asthma;
serious and persistent mental illness; and
two additional clinical conditions to be determined by the State based upon the population(s) served.

d. The State shall conduct annual validity studies to determine the completeness and accuracy of the encounter data collected. The State shall submit a plan for HCFA approval describing how it will validate the completeness and accuracy of the encounter data.

H. Quality Assurance Requirements

*1. In the protocol, the State shall provide its overall quality assurance monitoring plan for the managed care organizations and for DDMHS. The State shall develop quality audits to be conducted by the State and an external review agency to monitor the performance of the plans and DDMHS under VHAP. At a minimum, the State shall monitor the financial performance and quality assurance activities of each plan and DDMHS and its subcontractors. In the protocol, the State shall provide detailed criteria for monitoring the financial performance and quality assurance of each plan and DDMHS and its subcontractors. Upon request from HCFA, the State shall submit to the Center for Medicaid and State Operations (CMSO) and

the [illegible]O copies of all financial audits of participating managed care organizations and quality assessment reviews of these plans and DDMHS.

2. a. Within 15 months of implementation, the State shall conduct a survey of each managed care organization. The survey, which shall be described in the protocol, will measure satisfaction and, for MCPs, include: measures of out-of-plan use, to include use of emergency rooms; average waiting time for appointments, including physician office visits; average time and distance to reach providers; access to special providers; the number and causes of disenrollments; and coordination with other health programs. The survey for DDMHS shall measure satisfaction, shall be described in the protocol, and shall be submitted to HCFA for approval 60 days prior to use. Results of the surveys must be provided to HCFA by the 18th month of project implementation. Thereafter, the State shall conduct beneficiary surveys during each year of the demonstration as part of its quality improvement and performance monitoring process. Such surveys shall be designed to produce statistically valid results.

b. The State shall establish a quality improvement process for bringing managed care organizations, and DDMHS, which score below the State's benchmarks for specific and overall beneficiary satisfaction measures up to an acceptable level. The State will specify the benchmarks in the protocol.

3. Vermont shall collect and review quarterly reports on grievances received by each managed care organization and by DDMHS which describe the resolution of each formal grievance. Quarterly reports must also include an analysis of logs of informal complaints (which may be verbally reported to customer service personnel) as well as descriptions of how formal (written) grievances and appeals were handled.

4. Guidelines for State Monitoring of MCPs and DDMHS

a. The State will require, by contract, that MCPs and DDMHS meet certain State specified standards for Internal Quality Assurance Programs (QAPs) as required in 42 CFR 434.

b. The State will monitor, on a periodic or continuous basis (but no less often than every 12 months), MCP's and DDMHS adherence to these standards, through the following mechanisms: review of each plan's written QAP; review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes; and on-site monitoring of the implementation of the QAP standards.

5. Guidelines for MCP and DDMHS Monitoring of Providers
MCPs and DDMHS will require, by contract, that providers meet specified standards as required by the State contract. MCPs will monitor, on a periodic or continuous basis, providers' adherence to these standards, and recipient access to care.

6. MCPs will satisfy access and solvency requirements in 1903(m)(1)(A)(i)(ii); MCPs and DDMHS shall meet requirements in 1902(w).

I. Management Information Systems

*1. The State will develop a Detailed Implementation Schedule (DIS) addressing the State's approach to achieving changes, modifications and enhancements to its Medicaid Management Information System (MMIS), Eligibility System (ACCESS) and other systems capability to ensure the State's readiness to:

a. Collect, process, and maintain recipient eligibility information necessary to support recipient enrollment;

b. Collect, process, and maintain health plan and DDMHS information necessary to support plan and DDMHS enrollment;

c. Process and pay capitation fees and other required compensation to participating plans and DDMHS;

d. Collect, validate and use encounter data from participating plans and DDMHS.

The DIS should include the components set forth in State Medicaid Manual (SMM) section 11237.

*2. Prior to enrollment of beneficiaries, the State must submit evidence to the HCFA RO that a management information system is in place which meets the minimum standards of performance or the functional equivalent required of the State's current management information system.

J. Medicare Pharmacy Benefit

*1. The protocol must contain a complete description of how the pharmacy benefit for low income Medicare beneficiaries will operate. This discussion

should include but not be limited to the following: delivery system; quality management and cost containment activities; utilization review; and monitoring and fiscal tracking of the benefit. In addition, the protocol must contain a description of any coinsurance or cost-sharing requirements imposed on beneficiaries receiving the Medicare pharmacy benefit.

K. CRT Program Protocol and Fiscal Accountability

*1. The protocol must contain a complete description of how the CRT Program will operate, as well as revisions that reflect changes associated with the CRT Program. The description of the CRT Program and the revisions should include items required by these terms and conditions, and should include but not be limited to the following: eligibility; delivery system; payment mechanism; financial management; information systems; quality management and cost containment activities; utilization review; coordination of care with MCPs, including a description of the process for exchanging patient specific information while protecting the confidentiality of the patient; grievance and complaint process; and monitoring and fiscal tracking of the Program.

2. OVHA will monitor and ensure on an annual basis that DDMHS has provided the appropriate State match necessary to draw down the FMAP for title XIX services provided to persons eligible for the CRT Program through this demonstration. OVHA will certify that such matching funds will not be used as matching funds for any other federal grant or contract, except as permitted by federal law.

3. OVHA must ensure that DDMHS maintains separate fiscal accountability for Medicaid funding, including Federal share and State match, under the CRT Program, apart from behavioral health funds provided by State, county, and/or other Federal programs.

4. The contract between OVHA and DDMHS should specify the permissible use of any excess funds, including the requirement that excess funds may be used only for activities related to services provided to CRT Program enrollees eligible through this demonstration. The protocol will describe how OVHA will monitor the compliance of DDMHS with the contract.

L. Pharmacy Discount Program (PDP)

1. The protocol must contain a complete description of how the Pharmacy Discount Program will operate for (1) Medicare-covered individuals with

incomes above 150 percent of the Federal Poverty Level (FPL) without drug coverage, and (2) all adults with incomes at or below 300 percent FPL who do not have a benefit program that includes drug coverage. This discussion should include, but not be limited to, the following: eligibility; delivery system; quality management and cost containment activities; utilization review; and monitoring and tracking of the benefit. In addition, the protocol must contain a description of any coinsurance or cost-sharing requirements imposed on beneficiaries receiving the PDP benefit.

2. For the purpose of this demonstration, subsidy is defined as the amount of money the State pays to the pharmacy on behalf of PDP enrollees, thereby reducing the cost of prescriptions to the enrollees. The rebate is the amount of money paid by drug manufacturers to the State under section 1927 of the Social Security Act (the Act) as an offset to benefit expenditures.

3. The State will perform an annual reconciliation of prescription drug costs and rebates under the State's Medicaid program to determine the percentage of drug rebate and the amount of subsidy to be paid to the pharmacy and to establish the estimated rebate percentage for the following year. The basis for calculating the rebate percentage will be total Medicaid expenditures for pharmaceuticals and total rebate amounts collected. The State will describe this process in the operational protocol.

4. There will be no net Federal benefit cost to the Medicaid program due to the PDP on an annual basis. Specifically, the pharmacy subsidies for one demonstration year will be compared to the PDP rebates subsequently received for that same year.

5. In the event that manufacturers' rebates are not available on a timely basis, the State will be allowed to limit its liabilities by: a) ceasing to enroll new applicants in the PDP; or b) modifying or suspending the subsidy amount for current or new enrollees following written notice to HCFA. Any such cessation of enrollment or modification or suspension of subsidy amounts will apply equally to all PDP enrollees or applicants.

Attachment A

Requirements for Federal Financial Participation/ Cost Control/ Fiscal Administration

Those items prefaced with an asterisk (*) contain requirements that must be approved by the HCFA prior to marketing, enrollment, or implementation.

1. a. The State will report net expenditures in the same manner as is done under the current Medicaid program. The State shall provide quarterly expenditure reports using the form HCFA-64 to separately report expenditures for those receiving services under the Medicaid program and those participating in VHAP under section 1115 authority. HCFA will provide Federal Financial Participation (FFP) only for allowable VHAP expenditures that do not exceed the pre-defined limits as specified in Attachment D.

b. Vermont will report VHAP expenditures through the MBES, following routine HCFA-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. In this regard, VHAP expenditures will be differentiated from other Medicaid expenditures by identifying on forms HCFA-64.9 and/or 64.9p the demonstration project number assigned by HCFA. Because expenditures are reported on the HCFA-64 by date of payment, Vermont must also submit along with each HCFA-64 quarterly report a supplemental schedule that details services and reported waiver expenditures according to the waiver year in which the services were provided. The procedure related to under this reporting process must be approved by HCFA as part of the protocol referenced in Section II.3 of these Special Terms and Conditions.

c. All claims for VHAP services provided during the demonstration period (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. During the period following the conclusion or termination of the demonstration, the State must continue to separately identify VHAP waiver expenditures using the procedures addressed above.

d. In addition to the form HCFA-64, the State shall provide to HCFA on an annual basis (related to the period for which the expenditure limit is established) the actual caseloads for each traditional and hypothetical Medicaid eligibility group (i.e., Aid to Needy Families and Children; Aged, Blind, and Disabled, Spend-Down Medically Needy, 1902(r)(2), 1931(b)-

Full VHAP Benefit, CRT, and MH-Duals). This information should be provided to HCFA 90 days after the end of the year.

2. The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Vermont Medicaid and VHAP expenditures on the quarterly form HCFA-37. The State must provide supplemental schedules that clearly distinguish between waiver expenditure estimates (by major component) and non-waiver Medicaid expenditure estimates. HCFA will make Federal funds available each quarter based upon the State's estimates, as approved by HCFA. Within 30 days after the end of each quarter, the State must submit the form HCFA-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. HCFA will reconcile expenditures reported on the Form HCFA-64 with Federal funding previously made available to the State for that quarter, and include the reconciling adjustment in a separate grant award to the State.

3. HCFA will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Attachment D:

a. Administrative costs associated with the administration of VHAP. Enrollment fees collected under the PDP will be reported to HCFA on the HCFA-64 Summary Sheet on line 9.D. This will allow HCFA to share in the collection of such fees. The State will also separately identify these fees on the narrative form of the HCFA-64.

b. Net expenditures and prior period adjustments of the Medicaid program which are paid in accordance with the approved State plan. HCFA will provide FFP for medical assistance payments with dates of service prior to and during the operation of the section 1115 waiver. Under PDP, HCFA will not provide FFP to the extent that the subsidies paid to pharmacies exceed the related rebates received from the manufacturers. If, in any quarter, the State believes subsidies are likely to exceed rebates collected, the State will not request FFP for the estimated difference between subsidies paid and anticipated rebates collected. The State will perform an annual reconciliation of subsidies paid and rebates received 180 days after the end of each demonstration year. The State will return to HCFA the Federal share of any subsidies claimed in excess of applicable rebates. Rebates collected in excess of subsidies paid to pharmacies in any given year will be considered in the calculation of the pharmacy subsidy percentage for the next demonstration year.

c. The State will certify State/local monies used as matching funds for VHAP purposes and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

4. Guidelines for Financial Monitoring of Participating Providers

a. The State shall provide to HCFA, upon request, copies of all financial statements filed by insurers and HMOs with the Vermont Department of Banking, Insurance and Securities.

b. The State shall provide to HCFA, upon request, copies of any Department of Insurance documents related to their monitoring of the financial stability of insurers and HMOs.

c. The State shall provide to HCFA, upon request, copies of all audits conducted by the State under the Federal Single Audit Act.

Attachment B

General Administrative Requirements

Those items prefaced with an asterisk (*) contain requirements that must be approved by the HCFA prior to marketing, enrollment, or implementation.

1. Vermont will request modifications to the demonstration by submitting revisions to the protocol (see Special Term and Condition section II.3) for HCFA approval. These modifications will include significant changes in policy and procedures. The State shall not submit amendments to the approved State plan relating to the new eligibles.

2. Substantive changes to the demonstration design (i.e., employer buy-in program and participation of the Veterans Administration [VA]) will require submission of a formal amendment to the proposal and advance HCFA approval. The State will work with HCFA in amending the waiver application in the later stages of the demonstration program. However, with respect to the VA, the requirement of a formal amendment will not apply if the VA meets the terms of a participating health plan with respect to Medicaid-eligible veterans or becomes a participating provider within another health plan. HCFA must approve the payment methodology to VA facilities who participate in VHAP either as a participating plan or provider.

3. By April 1 of each year, the State will submit Form HCFA-416, EPSDT program reports for the previous Federal fiscal year. These reports will follow the format specified in section 2700.4 of the <u>State Medicaid Manual</u>, with data for each line item arrayed by age group and basis of eligibility. Copies should be submitted simultaneously to HCFA's Boston Regional Office and to the HCFA Central Office address contained in section 2700.4 of the <u>State Medicaid Manual</u>. All data reported must be supported by documentation consistent with the general requirements of these terms and conditions.

4. All contracts and subcontracts for services related to the VHAP must provide that the State agency and the U.S. Department of Health and Human Services may: (1) evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed; and (2) inspect and audit any financial records of such contractor/subcontractors. This includes contracts with MCPs, Third Party Administrators (TPAs), and DDMHS.

*5. Vermont must implement procedures so that hospitals will be able to distinguish individuals who would be eligible for Medicaid in the absence of the demonstration from all other individuals. These procedures must be in place and operational on the implementation date of the waiver so that hospitals can calculate traditional Medicaid days throughout the life of the waiver. Correct accounting for Medicaid days is required for calculating a hospital's Medicare disproportionate share hospital (DSH) payments. The proposed procedure must be submitted to HCFA in the protocol.

Attachment C

General Reporting Requirements

Those items prefaced with an asterisk (*) contain requirements that must be approved by the HCFA prior to marketing, enrollment, or implementation.

1. a. Through the first six months after implementation, including implementation of the CRT Program, the State will report on its progress in a series of monthly conference calls with the HCFA project officer, and will develop a detailed agenda prior to each call. Subsequently, the State will submit quarterly progress reports (including grievances), which are due 60 days after the end of each quarter.

   b. The reports should include a brief narrative of events occurring during the quarter that will affect access to health care, enrollment, quality of care (including statistics on grievances), MCO financial viability or other key operational areas. The report should include a separate discussion of State efforts related to the collection and verification of encounter data and provide summary utilization statistics (beginning in the third quarter). The report should also include proposals for addressing any significant problem areas.

2. The State will submit a draft annual report, documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties no later than 120 days after the end of its operational year. Within [illegible] days of receipt of comments from the Center for Medicaid and State Operations (CMSO), a final annual report will be submitted.

3. At the end of the demonstration, a draft final report should be submitted to the HCFA project officer for comments. HCFA's comments should be taken into consideration by the awardee for incorporation into the final report. The awardee should use the HCFA, ORD's Author's Guidelines: Grants and Contracts Final Reports (copy attached) in the preparation of the final report. The final report is due no later than 90 days after the termination of the project.

4. The State shall submit a continuation application by May 31 of each year (beginning in 1996).

Attachment D

Monitoring Budget Neutrality for the Vermont Health Access Plan (VHAP)

The following describes the method by which budget neutrality will be assured under the VHAP demonstration. Vermont will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the waiver period. The limit will be determined using a per capita cost method. In this way, Vermont will be at risk for the per capita cost (as determined by the method described below) for current eligibles, but not at risk for the number of current eligibles. By providing FFP for all current eligibles, HCFA will not place Vermont at risk for changing economic conditions. However, by placing Vermont at risk for the per capita costs of current eligibles, HCFA assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year, on a Federal fiscal year (FFY) basis. These annual estimates will then be added together to obtain an expenditure estimate for the entire waiver period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 8-year waiver period (January 1, 1996, through December 31, 2003) for the types of Medicaid expenditures described below. For each FFY, the Federal share will be calculated using the FMAP rate for that year.

Each yearly budget estimate will be the sum of separate cost projections for each of seven Medicaid enrollment groups (MEG) of beneficiaries and for Disproportionate Share Hospital (DSH) expenditures. The enrollee groups are (A) Aid to Needy Families and Children (ANFC); (B) Aged, Blind, and Disabled (ABD); © Spend-Down/Medically Needy (SD); (D) 1902(r)(2) Children (1902); (E) 1931(b) Full VHAP Benefit; (F) [illegible]RT; and (G) Mental Health -- Dual Eligibles (MH-Duals). The yearly cost projection for each MEG will be the product of the projected per capita cost for that MEG times the actual number of enrollee/months in that group, as reported to HCFA by the State under Attachment A, Special Term and Condition #1(d), including eligibles counted as categorical, where the method for counting eligibles, including any factoring of the duration of eligibility, is consistent with the counting method used in the calculation of base year per capita costs and VHAP capitation payments.

RECEIVE STOP

FAX TRANSMITTAL COVER SHEET

Agency of Human Services
Office of Vermont Health Access
103 South Main Street
Waterbury, VT 05671-1201

Voice: (802)241-2880 Fax: (802)241-2897

DATE: 11/14/00

PAGE 1 of 41 PAGES

TO:

NAME: Sherry Moyd

LOCATION: State of Wisconsin - Pharmacy Assistance Program

FAX NUMBER: 608-261-5058

FROM:

NAME: Samantha Haley

TELEPHONE NUMBER: (802) 241 - 3984

COMMENTS: VHAP-PDP waiver amendment, approval letter and terms and Conditions - also informational sheet

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Projected Per Capita Cost The State shall submit to HCFA a base year per capita cost for each MEG, subject to the approval of the project officer. These should reflect all expenditures related to services performed during State fiscal year (SFY) 1994 (i.e., expenditures should be totaled on a date of service basis) in the enrollee groups, except for: (1) the 1902 MEG; (2) the 1931(b)-Full VHAP Benefit MEG; (3) the CRT MEG; and (4) the MH-Duals MEG. The base year cost for the 1902 group is $39.63, which is the PMPM cost of under-insured Dr. Dynasaur children from SFY 1997. The base year cost for the 1931(b) group is $152.59, which is the SFY 1997 PMPM cost for VHAP expansion adults who are parents or caretaker relatives of Medicaid-eligible children, and who receive the full VHAP benefit.

The base year cost estimate for the 1902 group is estimated from actual experience for children eligible during 1997, since claims experience does not exist for the 225-300% FPL expansion group. The baseline will be adjusted to reflect actual experience if expenditures for the 225-300% 1902(r)(2) eligibles in their first year of demonstration eligibility are more than 10 percent above or below the trended baseline for that time period.

The reporting period for 1931(b) adults with family income up to 150% of the FPL begins on October 1, 1997. The reporting period for 1931(b) adults with family income between 150 and 185% of the FPL begins on March 1, 1999.

The base year cost for the CRT group is the PMPM cost for CRT services for traditional Medicaid eligibles (i.e., ANFC, ABD, S-D, 1931(b), eligibles with Medicare, eligibles with commercial insurance). The base year cost for the MH-Duals group is the PMPM cost for psychiatrist, psychologist, outpatient hospital psychiatric, and inpatient hospital psychiatric services for traditional Medicaid eligibles with Medicare or with commercial insurance, who were previously excluded from the demonstration. Upper limits for the base year PMPM for the CRT MEG and the base year PMPM for the MH-Duals MEG amendment will be calculated according to the following formula:

$$\frac{\text{Expenditures 4/1/98 through 2/28/99}}{\text{Member months 4/1/98 through 2/28/99}}(11/12) + \frac{\text{Expenditures 1/1/99 through 2/28/99}}{\text{Member months 1/1/99 through 2/28/99}}(1/12)$$

Vermont will submit expenditure and member month data for the period April 1, 1998 through March 31, 1999 by November 1, 1999. The base year PMPM for the CRT MEG will be the lower of upper limit PMPM for the CRT MEG and the PMPM for the CRT MEG calculated using data for the entire period. The base year PMPM for the MH-Duals MEG will be the lower of upper limit PMPM for

the MH-Duals MEG and the PMPM for the MH-Duals MEG calculated using data for the entire period.

Per capita costs for all MEGs for SFY 1995 and beyond will be derived by inflating the base year per capita costs, using the rates of increase listed below.

Per Capita Growth Rates for the Vermont Health Access Plan

SFY	ANFC	ABD	S-D	1902	1931(b)	CRT	MH-Duals
1995	9.53%	10.70%	21.60%				
1996	19.95%*	14.50%*	24.51%				
1997	8.02%	10.[illegible]0%	13.19%				
1998	6.51%	10.70%	4.78%	6.5[illegible]%	4.77%		
1999	6.51%	5.86%	4.[illegible]8%	6.5[illegible]%	4.77%	3.27%	3.27%
2000	6.51%	5.86%	4.[illegible]	6.[illegible]%	4.77%	3.27%	3.27%
2001**	6.51%	5.86%	4.[illegible]	6[illegible]%	4.77%	3.27%	3.27%

Footnote: * The rates of increase for SFY 1996 include the Medicaid physician and dental fee increases enacted by the State in April 1995.

** The six month period from July 1, 2000 through December 31, 2000, will be trended at the same rate as SFY 2000 in order to continue budget neutrality through year five of the demonstration.

Projected DSH Expenditures The projected yearly DSH expenditures for the demonstration will be calculated using a base year figure grown at a predetermined growth rate. The base for DSH will be the lower of the State's total DSH expenditures for FFY 1995 or $29,081,000, which is the State's final allotment for FFY 1995. The base amount will be grown up to and during the waiver at 6.94 percent annually. However, after October 1, 1997, the Federal share of the trended amount will be limited to the lower of either the trended amount or the State's DSH allotment.

Projected PDP Expenditures The projected Federal expenditures under PDP without the VHAP waiver are zero ($0). PDP expenditures are approved as costs not otherwise matchable under section 1115(a)([illegible]), therefore costs for this population in the absence of the VHAP waiver are zero ($0).

Sample Calculation Suppose the base year per capita cost for the ABD MEG is $381.[illegible]. Using the rates of increase in the above table, the projected per capita cost for this category in SFY 1997 is $535.[illegible]. Suppose further that during SFY 1997, the State reports 83,6[illegible]0 enrollee/months. The resulting budget estimate for ABD MEG in SFY 1997 is $535.[illegible]8 X 83,[illegible]0 = $44,825,702. Since the budget

estimate is on a SFY, weighing adjustments will need to be completed to align the SFY budget estimates with the FFY. For example, using the ABD category and assuming that the State reports 87,504 enrollee/months for SFY 1998, for FFY 1997 the following adjustment will be made:

SFY 1997: $44,825,702 x .75	= $33,619,277
SFY 1998: $535.68 x 1.1070 x 87,504 x .25	= $12,972,419
FFY 1997 ABD MEG estimate	= $46,591,696

The same calculation is repeated for the other six MEGs, and the seven MEG estimates and the FFY DSH estimate are added together to obtain a budget estimate for the year.

The limit calculated above will apply to actual expenditures, as reported by the State under Attachment A, Special Term and Condition #1(c), #3(b), and #3(c). If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to HCFA. No new limit is placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

Expenditure Review

HCFA shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than six months after the end of an individual waiver year, the State will calculate annual expenditure targets for the completed year for each of the two components: benefits (using actual categorical eligibles) and DSH. The annual component targets will be summed to calculate a target annual spending limit. This amount should be compared with the actual claimed FFP for Medicaid. Using the below schedule as a guide, if the State exceeds these cumulative targets they shall submit a corrective action plan to HCFA for approval.

- Year 1 target spending limit	+8 percent
- Years 1 to 2 combined target spending limit	+6 percent
- Years 1 to 3 combined target spending limit	+4 percent
- Years 1 to 4 combined target spending limit	+2 percent
- Years 1 to 5 combined target spending limit	+0 percent

Attachment E

Access Standards

Contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied and paramedical personnel for the provision of all covered services on an emergency basis, 24-hour-a-day, 7-day-a-week basis. At a minimum, unless Vermont can demonstrate otherwise, this shall include:

Primary Care Delivery Site:

a) Distance/Time: No more than 30 miles or 30 minutes for all enrollees from residence or place of employment.

b) Patient Load: A VHAP patient/primary care physician ratio to be determined by Vermont and approved by the HCFA project officer 30 days prior to implementation of the program.

c) Appointment/Waiting Times: Usual and customary practice not to exceed 30 days from date of a patient's request for routine and preventive office visits and 48 hours for urgent care.

d) Documentation/Tracking requirements:

+ Documentation - MCPs must have a system in place to document appointment scheduling times. Vermont must utilize statistically valid sampling methods for monitoring compliance with appointment/waiting time standards as part of the required beneficiary survey.

+ Tracking - MCPs must have a system in place to document the exchange of client information with the primary care provider if a school-based health center, not serving as the primary care provider, provides health care.

Specialty Care and Emergency Care: Referral appointments to specialists, except for specialists providing mental health and substance abuse services, (e.g., specialty physician services, hospice care, home health care, and certain rehabilitation services, etc.) shall not exceed 30 days for routine care

or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contracts.

Hospitals: Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater and for mental health and physical rehabilitative services where access is not to exceed 60 minutes. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to Vermont on the basis of community standards.

General Optometry Services:

a) Transport time will be the usual and customary, not to exceed one hour, except in areas where community standards and documentation shall apply.

b) Appointment/Waiting Times: Usual and customary not to exceed 30 days for regular appointments and 48 hours for urgent care.

Pharmacy Services:

a) Transport time will be the usual and customary, not to exceed one hour, except in areas where community access standards and documentation will apply.

Lab and X-Ray Services:

a) Transport time will be the usual and customary, not to exceed one hour, except in areas where community access standards and documentation will apply.

b) Appointment/Waiting Times: Usual and customary not to exceed 30 days for regular appointments and 48 hours for urgent care.

All other services not specified here shall meet the usual and customary standards for the community.

Definition of "Usual and Customary": access that is equal to or greater than the currently existing practice in the fee-for-service system.

Attachment F

Outline for Operational Protocol

Vermont will be responsible for developing a detailed protocol describing the VHAP demonstration. The protocol is a stand alone document that reflects the operating policies and administrative guidelines of the demonstration. The State shall assure and monitor compliance with the protocol. Areas that should be addressed in the document include:

1. organizational and structural configuration of the demonstration arrangements
2. organization of managed care networks, and procedures for determining adequate managed care provider capacity by region
3. payment mechanism
4. benefit package
5. Medicaid eligibility process
6. marketing and outreach strategy (i.e., a) State-initiated marketing and recipient education activities; and (b) oversight of plan-initiated marketing activities)
7. enrollment process
8. eligibility simplification
9. quality assurance and utilization review system
10. administrative and management system
11. encounter data
12. federally qualified health centers
13. family planning services
14. pharmacy benefit for low income Medicare beneficiaries

15. financial reporting, including procedures for addressing insolvency issues

16. recipient grievance and appeal process

17. VHAP-Limited Fee-for-Service (Acute) Benefit, Uninsured

18. CRT Program

HCFA review and approval of the protocol will be consistent with the waivers granted and the proposal, as amended by the questions and answers submitted by the State.

Waivers and Expenditure Authorities
Updated to Reflect Approval of the Pharmacy Discount Program

The following lists of waivers and expenditure authorities have been updated to incorporate all amendments that have been approved since VHAP was originally approved on July 28, 1995. In addition, some provisions have been deleted to conform to changes made by the BBA. None of the changes affects the operation of the program.

The following waivers of provisions of the Act remain in effect to enable Vermont to carry out the VHAP demonstration under the authority of section 1115 (A)(1) of the Act:

1. Amount Duration and Scope of Services — 1902(a)(10)(B)

   To the extent that the State may offer a different benefit package to the newly eligible VHAP demonstration participants than is being offered to the traditional Medicaid population.

2. Statewideness — 1902(a)(1)

   To the extent that the State may offer different benefits to the newly eligible VHAP participants than the ones being offered to the current Medicaid population, and that the type of managed care plans available under the demonstration may vary by geographical area of the State.

3. Payment of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) — 1902(a)(10) and 1902(a)(13)(E)

   To the extent that the State may provide FQHC and RHC services through managed care providers, and not require payment to those FQHCs and RHCs in accordance with Medicare cost-based reimbursement.

4. Freedom-of-Choice — 1902(a)(23)

   To the extent the State may restrict freedom-of-choice of provider for the VHAP participants. Participants will be restricted to a single plan of choice for one year.

5. Retroactive Eligibility — 1902(a)(34)

   To the extent that the State need not provide retroactive eligibility for newly eligible individuals under the expanded eligibility provisions of the program.

6. Upper Payment Limits for Capitation Contract Requirements — 1902(a)(30)(A) as implemented by 42 CFR 447.361 and 447.362

   To the extent that the State may set capitation rates for the VHAP that would exceed the costs to Medicaid on a fee-for-services basis.

7. Disproportionate Share Hospital (DSH) Payments — Section 1902(a)(13)(A) insofar as it incorporates 1923(c)(1)

   To remove the obligation that the State make DSH payments to hospitals under the mandatory provisions of section 1923(c)(1).

8. Premiums — Section 1902(a)(14)

   To enable the State to impose a $10 monthly premium on families between 185 percent and 225 percent of the Federal Poverty Level (FPL), and impose a $12 monthly premium on families between 225 percent and 300 percent FPL.

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State under VHAP for the items identified below (which are not otherwise included as expenditures under section 1903) shall, for the period of this extension, be regarded as expenditures under the State's title XIX plan. In these items, unless specified, VHAP does not refer to Pharmacy Discount Program (PDP):

1. Expenditures for extending health insurance coverage to non-Medicare-eligible adults and children with incomes up to 150 percent of the FPL, who are not otherwise eligible for Medicaid.

2. Expenditures for extending pharmacy-only supplemental benefits to Medicare beneficiaries with income at or below 150 percent of the FPL for all drugs and for Medicare beneficiaries with income above 150 percent and at or below 175 percent of the FPL for maintenance medicines only as part of the VHAP Pharmacy Program.

3. Expenditures to provide Medicaid coverage for VHAP participants who would otherwise be excluded by virtue of enrollment in managed care delivery systems which do not meet the requirements in section 1903(m) specified below. Vermont's managed care plans participating in the VHAP demonstration will have to meet all the requirements of 1903(m) except the following:

   -- 1903(m)(2)(A)(vi) insofar as it conditions Federal financial participation in contracts for comprehensive services on a prepaid or other risk basis, unless such contracts are with entities that permit all Medicaid members to disenroll without cause during the first 90 days of enrollment with a managed care organization.

   - Under VHAP, members instead will be offered only a 30 day period within which they can disenroll without cause, and will then be allowed to change the selection of their health plan every 12 months after enrollment.

4. Expenditures that might otherwise be disallowed under 1903(f); 42 CFR 435.100 et. seq. insofar as they restrict payment to a State for eligibles whose income is no more than 133 1/3 percent of the AFDC eligibility level.

5. Expenditures for services to a VHAP enrollee residing in an Institution for Mental Disease for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days.

6. Expenditures to provide Medicaid to individuals who have been guaranteed 6 months of Medicaid eligibility at the time they are enrolled in VHAP, who were eligible for VHAP when they enrolled, and who ceased to be eligible during the 6-month period.

7. Expenditures to provide Medicaid coverage to children with income between 225 and 300 percent of the FPL, and who are covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).

8. Expenditures to expand eligibility to parents and caretaker relatives of Medicaid-eligible children with family income between 150 percent and 185 percent of the FPL, and implement a 1931(b) pass-through for parents and caretaker relatives of Medicaid-eligible children with family income up to 150 percent of the FPL.

9. Expenditures for extending health insurance coverage to adults enrolled in the Community Rehabilitation and Treatment (CRT) Program whose income exceeds

150 percent of the FPL due to employment income, who are not otherwise eligible for Medicaid.

10. Expenditures for extending pharmacy-only supplemental benefits to Medicare beneficiaries with income above 150 percent and at or below 175 percent of the FPL for non-maintenance medicines only, to Medicare beneficiaries with income above 175 percent of the FPL, and to all adults with income at or below 300 percent of the FPL as part of the PDP.

State of Wisconsin
2001 – 2002 LEGISLATURE

LRB–1706/1
DAK.......

DOA:......Kraus – Prescription drug assistance program

FOR 2001–03 BUDGET — NOT READY FOR INTRODUCTION

1 AN ACT ...; **relating to:** the budget.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

MEDICAL ASSISTANCE

Under current state law, pharmacies and pharmacists that are certified providers of medical assistance (MA) services are reimbursed, at a rate established by the department of health and family services (DHFS), for providing certain prescription drugs to MA recipients. Under current federal law, persons entitled to coverage under part B of medicare do not receive coverage for prescription drugs for outpatient care as a benefit.

Under the bill, DHFS must request from the secretary of the federal department of health and human services a waiver of federal medicaid laws to permit DHFS to conduct a project to expand MA eligibility for persons who are aged at least 65, who have not had outpatient prescription drug coverage from any source for 12 months, and whose annual household incomes do not exceed 185% of the federal poverty line for a family the size of the persons' eligible families. Under the waiver, the expanded MA eligibility would entitle an eligible person, after paying a $25 annual enrollment fee and after paying specified deductible amounts at the MA rate amounts, to purchase a prescription drug for a copayment, as specified in the bill, for that prescription drug; however, the benefit for persons with household incomes over 155% but less than 186% of the federal poverty line would be limited to their

eligibility to purchase prescription drugs at the MA rate amounts. The pharmacy or pharmacist who sells the drug at this reduced price receives reimbursement for the difference between the copayment and the medical assistance reimbursement amount from DHFS, from moneys received by DHFS under rebate agreements with drug manufacturers.

This bill requires that DOA and DHFS together work to develop, in conjunction with states other than Wisconsin and with associations, a multistate purchasing group for the negotiation with prescription drug manufacturers of prescription drug rebate agreements that result in lower MA costs for prescription drugs. Under the bill, DOA must also contract with a private entity to administer a discount program for the purchase of prescription drugs.

The bill requires that DHFS work with DOA to contract with a private entity for the bulk mail order purchase of prescription drugs for MA recipients who voluntarily participate in the program and who have chronic conditions. Further, DHFS must promote, on its Internet site and in health information, private prescription drug assistance plans that offer prescription drug discounts to members. DHFS must inform those entities, including tribes and federally qualified health centers (as defined in the bill), that are eligible for a federal prescription drug discount program about the eligibility and provide technical assistance to the entities in applying for and implementing benefits under the program. Lastly, DHFS must analyze health care data in Wisconsin so as to identify areas that could be eligible for and benefit from establishment of federally qualified health centers and shall provide interested entities in those areas with information about and technical assistance in developing the centers.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

1 **SECTION 1.** 16.735 of the statutes is created to read:

2 **16.735 Multistate purchasing of prescription drugs. (1)** In this section,
3 "prescription drug" means a prescription drug, as defined in s. 450.01 (20), that is
4 included in the drugs specified under s. 49.46 (2) (b) 6. h.

5 **(2)** The department and the department of health and family services shall
6 together work to develop, in conjunction with states other than this state and with
7 associations, a multistate purchasing group for the direct negotiation with
8 prescription drug manufacturers of rebates that are modeled on the rebate

1 agreement specified under 42 USC 1396r–8 and that result in significantly lower
2 costs for the purchase of prescription drugs under the medical assistance program
3 under subch. IV of ch. 49 in comparison with those costs in effect on the effective date
4 of this subsection [revisor inserts date].

5 **SECTION 2.** 16.736 of the statutes is created to read:

6 **16.736 Prescription drug discount program. (1)** In this section,
7 "prescription drug" means a prescription drug, as defined in s. 450.01 (20), that is
8 included in the drugs specified under s. 49.46 (2) (b) 6. h. DELETE BOLDING

9 **(2)** After first consulting with the department of health and family services, the
10 department of administration shall contract with a private entity to administer a discount program for
11 purchase of prescription drugs by persons of any age or income who pay to the entity
12 nominal fees.

13 **SECTION 3.** 20.435 (4) (jd) of the statutes is created to read:

14 20.435 **(4)** (jd) *Prescription drug assistance project; enrollment fees.* All moneys
15 received from payment of enrollment fees under s. 49.477 (4) (a), to be used for
16 administration of the program under s. 49.477. This paragraph applies only if s.
17 49.477 (7) (a) applies and if s. 49.477 (7) (b) does not apply.

****NOTE: This SECTION involves a change in an appropriation that must be reflected in the revised schedule in s. 20.005, stats.

18 **SECTION 4.** 49.45 (48) of the statutes is created to read:

19 49.45 **(48)** BULK MAIL ORDER PURCHASE OF PRESCRIPTION DRUGS. (a) In this
20 subsection, "prescription drug" means a prescription drug, as defined in s. 450.01
21 (20), that is included in the drugs specified under s. 49.46 (2) (b) 6. h.

22 (b) The department shall work with the department of administration to
23 contract with a private entity for the bulk mail order purchase of prescription drugs

1 and medical supplies for persons who meet eligibility requirements under s. 49.46
2 (1), 49.468, 49.47 (4), or 49.472, or, if a waiver is granted, under s. 49.477, and who
3 have chronic conditions, including diabetes, asthma, and hypertension.
4 Participation by an eligible person under this subsection is voluntary. If the
5 department contracts under this subsection, the private entity with which the
6 department contracts shall administer and promote the bulk mail order purchase of
7 prescription drugs and shall, each 3 months, telephone participants to ascertain
8 their progress in administering self–care.

9 (c) Annually, the department shall evaluate hospital and emergency room costs
10 of participants under par. (b) to determine the extent of savings, if any, achieved by
11 their participation in the bulk mail order purchase of prescription drugs.

12 **SECTION 5.** 49.45 (49) of the statutes is created to read:

13 49.45 **(49)** PROMOTION OF PRESCRIPTION DRUG ASSISTANCE PLANS. (a) In this
14 subsection, "prescription drug" means a prescription drug, as defined in s. 450.01
15 (20), that is included in the drugs specified under s. 49.46 (2) (b) 6. h.

16 (b) After first consulting with the department of administration, the
17 department shall promote, in health information and on the department's Internet
18 site, private prescription drug assistance plans, including offers by prescription drug
19 manufacturers of specific no–cost or reduced–cost prescription drugs and private
20 plans that offer prescription drug discounts to members.

21 **SECTION 6.** 49.45 (50) of the statutes is created to read:

22 49.45 **(50)** FEDERAL DISCOUNT DRUG PROGRAM. (a) In this subsection, "federally
23 qualified health center" has the meaning specified in 42 USC 1396d (L) (2) (B).

24 (b) The department shall inform those entities, including tribes and federally
25 qualified health centers, that are eligible for the federal prescription drug discount

about their eligibility and

1 program under 42 USC 256b about the benefits of the program and shall provide
2 technical assistance to the entities in applying for and implementing benefits under
3 the program.

4 **SECTION 7.** 49.45 (51) of the statutes is created to read:

5 49.45 **(51)** FEDERALLY QUALIFIED HEALTH CENTERS. (a) In this subsection,
6 "federally qualified health center" has the meaning specified in 42 USC 1396 (L) (2)
7 (B).

8 (b) The department shall analyze health care data in the state so as to identify
9 areas that could be eligible for and benefit from establishment of federally qualified
10 health centers and shall provide interested entities in the identified areas with
11 information about and technical assistance in developing federally qualified health
12 centers.

13 **SECTION 8.** 49.477 of the statutes is created to read:

14 **49.477 Prescription drug assistance project. (1)** In this section:

15 (a) "Medicare" means coverage under part A or part B of Title XVIII of the
16 federal Social Security Act, 42 USC 1395 to 1395y.

17 (b) "Poverty line" means the nonfarm federal poverty line for the continental
18 United States, as defined by the federal department of labor under 42 USC 9902 (2).

19 (c) "Prescription drug" means a prescription drug, as defined in s. 450.01 (20),
20 that is included in the drugs specified under s. 49.46 (2) (b) 6. h. and that is
21 manufactured by a manufacturer that enters into a rebate agreement in force under
22 sub. (4).

23 (d) "Prescription order" has the meaning given in s. 450.01 (21).

24 **(2)** The department shall request from the secretary of the federal department
25 of health and human services a waiver, under 42 USC 1315 (a), of federal medicaid

1 laws necessary to permit the department to conduct, beginning July 1, 2002, a project
2 to expand eligibility for medical assistance to include individuals who meet the
3 requirements specified under sub. (3). Eligibility for medical assistance under this
4 subsection entitles an individual only to a benefit related to prescription drugs as
5 specified under sub. (3).

6 **(3)** Notwithstanding ss. 49.46 (1) and 49.47 (4), a person who is a resident, as
7 defined in s. 27.02 (10) (a), of this state, who is at least 65 years of age, who is
8 otherwise ineligible for medical assistance, whose annual household income, as
9 determined by the department, does not exceed 185% of the poverty line for a family
10 the size of the individual's eligible family, who has not had available outpatient
11 prescription drug coverage from any source for 12 months, and who pays the project
12 enrollment fee specified in sub. (4) (a) is eligible for medical assistance for purposes
13 of purchasing a prescription drug by paying the amounts specified in sub. (4). The
14 person may apply to the department, on a form provided by the department together
15 with program enrollment fee payment, for a determination of eligibility and issuance
16 of a prescription drug card for purchase of prescription drugs under this section.

17 **(4)** Project participants shall pay all of the following:

18 (a) For each 12–month benefit period, a project enrollment fee of $25.

19 (b) For each 12–month benefit period, a deductible that equals one of the
20 following, except that an individual with an annual household income, as specified
21 in sub. (3), that does not exceed 110% of the federal poverty line pays no deductible:

22 1. For an individual with an annual household income, as specified in sub. (3),
23 that exceeds 110% but does not exceed 130% of the federal poverty line, $300.

24 2. For an individual with an annual household income, as specified in sub. (3),
25 that exceeds 130% but does not exceed 155% of the federal poverty line, $600.

1 3. For an individual with an annual household income, as specified in sub. (3),
2 that exceeds 155% but does not exceed 185% of the federal poverty line, a deductible
3 that equals, for each prescription drug, the medical assistance reimbursement
4 amount for the drug, as determined by the department.

5 (c) For an individual with an annual household income, as specified in sub. (3)
6 that is less than 110% of the federal poverty line and, after payment of the deductible
7 under par (b), for the individuals specified in par. (b) 1. and 2., all of the following:

8 1. A copayment of $10 for each prescription drug that bears only a generic
9 name.

10 2. A copayment of $20 for each prescription drug that does not bear only a
11 generic name.

12 **(5)** Under the project under sub. (2), as a condition of participation by a
13 pharmacy or pharmacist in the program under s. 49.45, 49.46, or 49.47, the
14 pharmacy or pharmacist may not charge an individual who is eligible for medical
15 assistance under sub. (2) and who presents a valid prescription order an amount for
16 a prescription drug under the order that exceeds the amounts specified in sub. (4) (b)
17 and (c).

18 **(6)** From the appropriations under s. 20.435 (4) (b) and (o), the department
19 shall pay the pharmacy or pharmacist for a prescription drug purchased as specified
20 under sub. (5) the medical assistance reimbursement rate amount for the drug.

21 **(7)** (a) The department may not implement the project under this section
22 unless all of the following applies:

23 1. A waiver that is consistent with all of the provisions of this section is granted
24 and in effect. If the department receives the waiver, at the end of the period during

1 which the waiver remains in effect the department shall request any available
2 extension of the waiver.
3 2. Sufficient state and federal funds for the project are available.
4 (b) The department may not implement the project under this section if a
5 national prescription drug benefit program for seniors is created that renders the
6 project unnecessary.
7 **(END)**

1/12/01 From Jane Pawasarat 7-2743 -1706/1

(1) Pharmacists charge their rate (AWP - 10% or mac, whichever is lower), plus a dispensing fee

Define Pharmacy discount ~~amount~~ rate
change p. 7, ll 3+4 to refer to ↑

✓(2) Anal: Make clear that MA eligibility will be expanded for purpose of op drugs only

✓(3) Anal: Make clear that waiver requires cost-neutrality

✓(4) Anal: bulk purchase + mail order delivery p. 3, l. 21, p. 4, l. 9

✓(5) Analysis - add "free and reduced price drugs"

✓(6) p. 3, l. 8 - DOA shall contract

✓(7) p. 4, l. 14 - DHFS shall together with DOA, promote

✓(8) p. 4, l. 15 ~~add "at state"~~ change to "state's internet site"

✓(9) p. 6, ~~l. 1~~ l. 10 - except m—a—.

✓(10) Re Maintenance of effort question: direct DHFS to pursue waiver, effective on bill passage; if waiver is approved, require DHFS to receive approval from DOA + jt fin. to implement, unless feds have approved something in interim

1/12/01 -1706/1

Questions of Jane Pawasarat + Craig Barkelar

✓ ① Does the ^requirement^ DOA + Jt. fin. approval eliminate the July 1, 2002, start date for the waiver program?
ⓐ July 1, 2002 unless approval not secured or fed program? (eliminate July 1, 2002 date)

what they took out was incorrect?

✓ ② ~~How do the pharmacists get reimbursed for costs (and at what rate) for those below~~ 185% ~~100%~~ ~~who pay no deductible, or some deductible, plus copayments?~~ At what rate do they pay the deductible? (pharmacy discount rate)

✓ ⓑ (6) needs to be fixed – less copays + deductibles

✓ ③ Question re rebate negotiations – 16.735
Necessary? Does DHFS do now? No
yes

④ 16.736 JTK's suggestion: "Requirements of 16.75 (3t)(c) + 16.752 (12)(a) do not apply to this section."