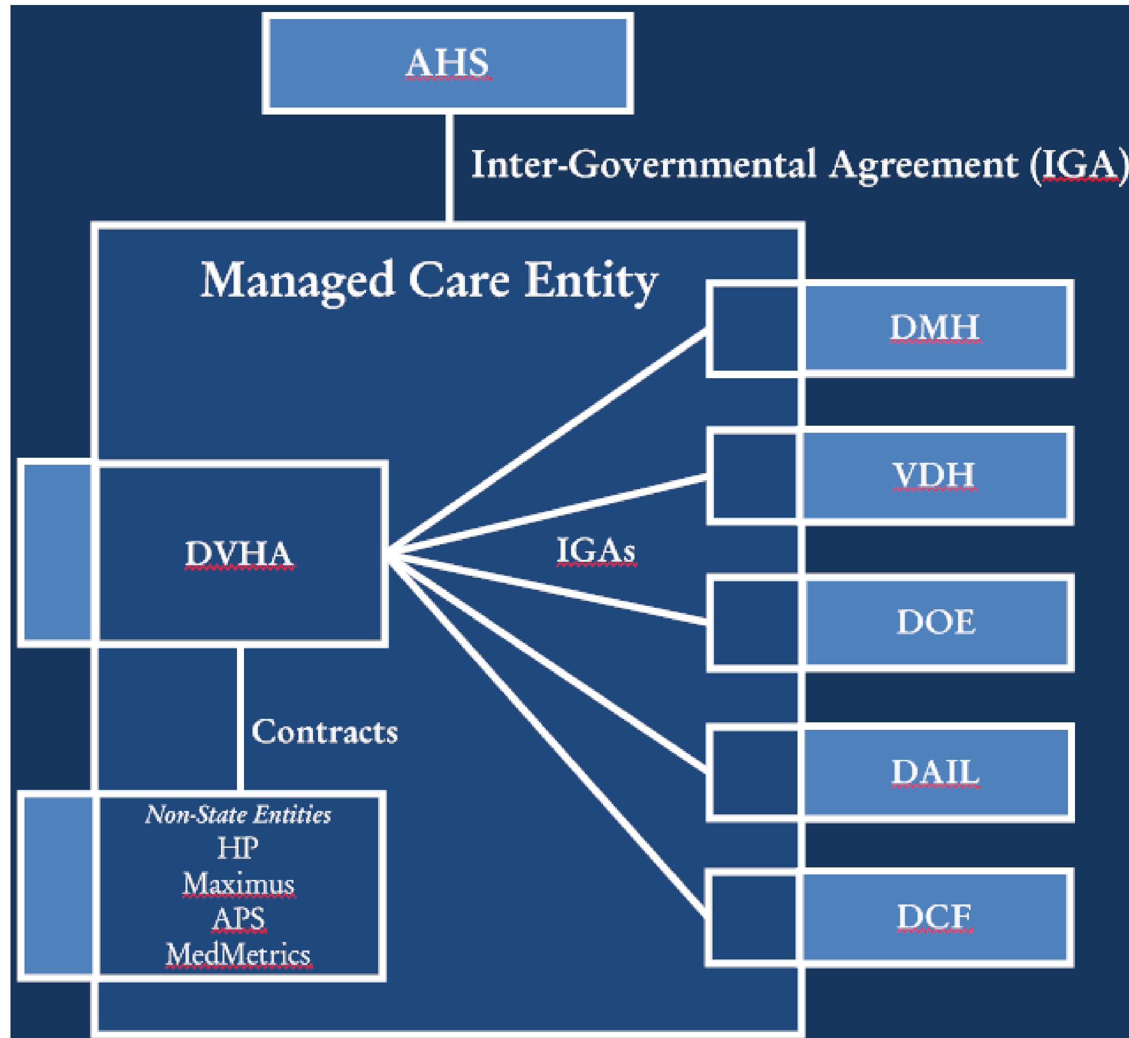
Global Commitment to Health

August 2015

Presentation Agenda

- Global Commitment to Health Overview:
  - Model
  - Programs
  - Funding
  - Comprehensive Quality Strategy

Model: Organizational Structure



Model: Waiver and State Plan

Global Commitment Waiver
Waivers of State Plan requirements
Establishes a Public Managed Care Model including concept of Managed Care Investments
Establishes Specialized programs and services

Adherence to Medicaid Managed Care Regulations (42 CFR 438 et. seq.)

Medicaid State Plan:
Eligibility
Covered Services
Provider types & qualifications
Reimbursement

Adherence to traditional Medicaid regulations

Model: Eligibility

Medicaid State Plan:
Eligibility
Covered Services
Provider types & qualifications
Reimbursement

Medicaid eligible

Global Commitment Waiver:

Specialized programs and services

Medicaid eligible

Managed Care Organization Investments (MCOI)

Medicaid & Non-Medicaid

Designated State Health Programs (VPA and CRT)

Non-Medicaid

Model: Funding

FFP (federal financial participation) or "Medicaid Match"

Medicaid State Plan:
Eligibility
Covered Services
Provider types & qualifications
Reimbursement

Medicaid eligible

Global Commitment Waiver:

Specialized programs and services

Medicaid eligible

Managed Care Organization Investments (MCOI)

Medicaid & Non-Medicaid

Designated State Health Programs (VPA and CRT)

Non-Medicaid

GC Specialized Programs and Services

Operations Unique to Global Commitment to Health Demonstration			
		Authorities Supporting Program	
Department	**Program**	**Section 1115**	**Managed Care Model**
DAIL	Developmental Disability	Non-State Plan Services Populations Payment Models Eligibility Rules	
	Traumatic Brain Injury	Non-State Plan Services	
	Choices for Care	Non-State Plan Services Populations Payment Models Eligibility Rules	
	Bridge Program		Payment Reform (Performance Based Monthly Bundle)
DMH	Children's Enhanced Family Treatment	Non-State Plan Services Payment Model	
	Community Rehabilitation and Treatment		Non-State Plan Services Populations Payment Models Eligibility Rules Delivery system
	Jump on Board for Success (JOBS)		Payment Reform (Performance Based Monthly Bundle)
	Success Beyond Six Clinicians		Payment Reform (Performance Based Monthly Bundle)

GC Specialized Programs and Services

Operations Unique to Global Commitment to Health Demonstration			
		Authorities Supporting Program	
Department	**Program**	**Section 1115**	**Managed Care Model**
DVHA	VPharm		Non-State Plan Services Populations
	Dental Dozen		Payment Reform (Supplemental Incentive)
	Blueprint		Payment Reform (CHT payments and PCP quality Incentive)
DVHA/GMCB	Medicaid ACO		Alternative Delivery Model Payments
DVHA/VDH	Buprenorphine		Payment Reform (Case Rate and Incentive)
	Children's Palliative Care	Concurrent with Curative Care	Non-State Plan Rules Payment Model
DVHA/DAIL	Adult Hospice	Concurrent with Curative Care	
DVHA/VHC	Premium Subsidies	Non-State Plan Expenditures	

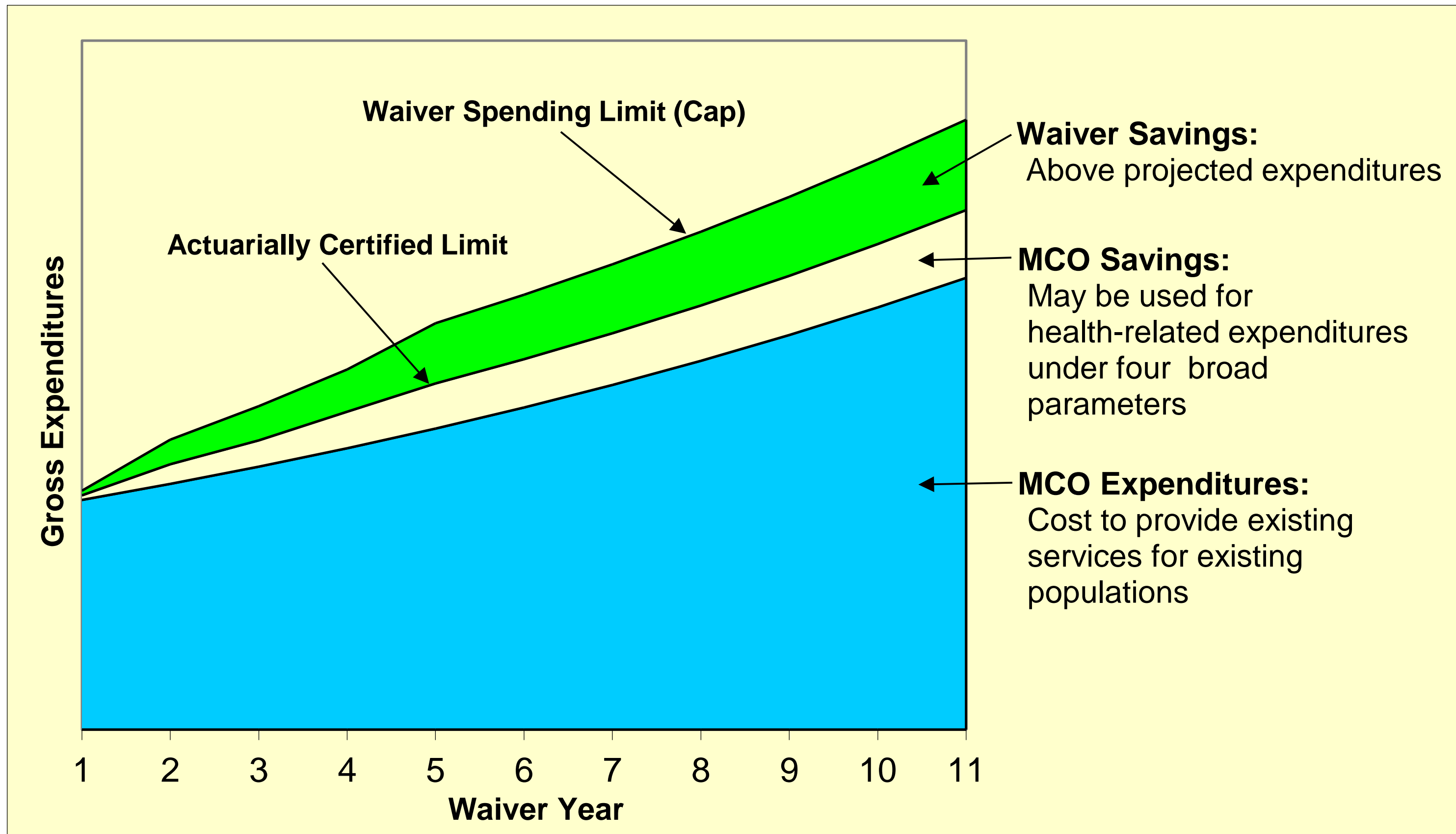
GC Specialized Programs and Services

Operations Unique to Global Commitment to Health Demonstration			
		Authorities Supporting Program	
Department	**Program**	**Section 1115**	**Managed Care Model**
DCF	Children's Integrated Services		Payment Reform (Performance Based Monthly Bundle)
	Woodside Rehabilitation Center		Delivery Model Monthly Payment
	VT Coalition of Runaway and Homeless Youth Programs		Payment Reform (Performance Based Monthly Bundle)
AHS	AHS – Integrated Family Services		Payment Reform (Performance Based Monthly Bundle)

Funding

- Global Commitment expenditures must be budget neutral compared to what the State would have spent without the waiver.
  - Special Terms and Conditions establish an aggregate spending limit over the lifetime of the waiver (currently $13.8 billion over 11.25 years)
- The managed care model design incorporates a second annual per member per month (PMPM) spending limit
  - Program spending is limited to the annual PMPM limit, established in accordance with federal requirements by an independent actuary across several rate categories, based on a CMS-approved methodology

Funding



- The Current Waiver Spending Limit excludes:
  - CHIP
  - Disproportionate Share Hospital (DSH) Payments for uninsured clients
  - Enhanced FFP for IT Infrastructure, Affordable Care Act initiatives

Managed Care Organization Investments

Vermont has expenditure authority under the GCW to invest in health related services and activities, and draw federal receipts, for costs that would not otherwise be Medicaid matchable. These initiatives are known as "MCO Investments".

CMS has approved four broad categories of expenditure as allowable under the demonstration:

a. Reduce the rate of uninsured and/or underinsured in Vermont;
b. Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
c. Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and
d. Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

Medicaid Managed Care Requirement

- As per Global Commitment (GC) Waiver Special Terms and Conditions (STC #14), DVHA and the Departments must adhere to Medicaid Managed Care Regulations for all GC funded programs and activities (42 CFR 438)
- 42 CFR 438.202(e), requires states implementing Medicaid Managed Care to develop and maintain a Comprehensive Quality Strategy (CQS)

CQS: Purpose

- The Comprehensive Quality Strategy (CQS) is intended to serve as a blueprint or road map for Vermont and its contracted Medicaid health plan in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement.
- As approved by CMS, the CQS will be the vehicle for Vermont's compliance with the HCBS regulations- comparable to 'transition plans' in other states.

CQS: Critical Elements

- Compliance with State & Federal Standards
  - Corrective Action Plans
  - External Quality Review
- Performance Measures
  - Population Specific
- Performance Improvement Projects
  - Population Specific

CQS: Content

- Medicaid Managed Care Regulations
  - Access, Structure & Operations, and Measurement & Improvement Standards
- New HCBS Regulations
  - Setting Requirements
  - Person Centered Planning (e.g., conflict free case management)
- Other MLTSS Requirements
  - Comprehensive and Integrated Service packages
  - Qualifications of Providers
  - Participant Protections