Global Commitment to Health
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*
Medicaid State Plan:
- Eligibility
- Covered Services
- Provider types & qualifications
- Reimbursement

Global Commitment Waiver:
- Specialized programs and services
- Managed Care Organization Investments (MCOI)
- Designated State Health Programs (VPA and CRT)
Model: Funding

**Global Commitment Waiver:**
- Specialized programs and services
- Managed Care Organization Investments (MCOI)
  - Medicaid eligible
  - Medicaid & Non-Medicaid

**Medicaid State Plan:**
- Eligibility
- Covered Services
- Provider types & qualifications
- Reimbursement
  - Medicaid eligible
  - Medicaid & Non-Medicaid

**FFP (federal financial participation) or “Medicaid Match”**
# GC Specialized Programs and Services

## Operations Unique to Global Commitment to Health Demonstration

<table>
<thead>
<tr>
<th>Department</th>
<th>Program</th>
<th>Authorities Supporting Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAIL</td>
<td>Developmental Disability</td>
<td>Non-State Plan Services Populations Payment Models Eligibility Rules</td>
</tr>
<tr>
<td></td>
<td>Traumatic Brain Injury</td>
<td>Non-State Plan Services Populations Payment Models Eligibility Rules</td>
</tr>
<tr>
<td></td>
<td>Choices for Care</td>
<td>Non-State Plan Services Populations Payment Models Eligibility Rules</td>
</tr>
<tr>
<td></td>
<td>Bridge Program</td>
<td>Payment Reform (Performance Based Monthly Bundle)</td>
</tr>
<tr>
<td>DMH</td>
<td>Children’s Enhanced Family Treatment</td>
<td>Non-State Plan Services Payment Model</td>
</tr>
<tr>
<td></td>
<td>Community Rehabilitation and Treatment</td>
<td>Non-State Plan Services Populations Payment Models Eligibility Rules Delivery system</td>
</tr>
<tr>
<td></td>
<td>Jump on Board for Success (JOBS)</td>
<td>Payment Reform (Performance Based Monthly Bundle)</td>
</tr>
<tr>
<td></td>
<td>Success Beyond Six Clinicians</td>
<td>Payment Reform (Performance Based Monthly Bundle)</td>
</tr>
</tbody>
</table>
## Operations Unique to Global Commitment to Health Demonstration

<table>
<thead>
<tr>
<th>Department</th>
<th>Program</th>
<th>Authorities Supporting Program</th>
<th>Section 1115</th>
<th>Managed Care Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>DVHA</td>
<td>VPharm</td>
<td></td>
<td></td>
<td>Non-State Plan Services Populations</td>
</tr>
<tr>
<td></td>
<td>Dental Dozen</td>
<td></td>
<td></td>
<td>Payment Reform (Supplemental Incentive)</td>
</tr>
<tr>
<td></td>
<td>Blueprint</td>
<td></td>
<td></td>
<td>Payment Reform (CHT payments and PCP quality Incentive)</td>
</tr>
<tr>
<td>DVHA/GMCB</td>
<td>Medicaid ACO</td>
<td></td>
<td></td>
<td>Alternative Delivery Model Payments</td>
</tr>
<tr>
<td>DVHA/VDH</td>
<td>Buprenorphine</td>
<td></td>
<td></td>
<td>Payment Reform (Case Rate and Incentive)</td>
</tr>
<tr>
<td></td>
<td>Children’s Palliative Care</td>
<td></td>
<td>Concurrent with Curative Care</td>
<td>Non-State Plan Rules Payment Model</td>
</tr>
<tr>
<td>DVHA/DAIL</td>
<td>Adult Hospice</td>
<td></td>
<td>Concurrent with Curative Care</td>
<td></td>
</tr>
<tr>
<td>DVHA/VHC</td>
<td>Premium Subsidies</td>
<td></td>
<td></td>
<td>Non-State Plan Expenditures</td>
</tr>
</tbody>
</table>
# GC Specialized Programs and Services

## Operations Unique to Global Commitment to Health Demonstration

<table>
<thead>
<tr>
<th>Department</th>
<th>Program</th>
<th>Authorities Supporting Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCF</td>
<td>Children’s Integrated Services</td>
<td>Payment Reform (Performance Based Monthly Bundle)</td>
</tr>
<tr>
<td></td>
<td>Woodside Rehabilitation Center</td>
<td>Delivery Model Monthly Payment</td>
</tr>
<tr>
<td></td>
<td>VT Coalition of Runaway and Homeless Youth Programs</td>
<td>Payment Reform (Performance Based Monthly Bundle)</td>
</tr>
<tr>
<td>AHS</td>
<td>AHS – Integrated Family Services</td>
<td>Payment Reform (Performance Based Monthly Bundle)</td>
</tr>
</tbody>
</table>
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.
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