# Global Commitment Waiver Renewal Request

General Overview

March 2013

# Section 1115 Demonstration Waivers

- Federal government can “waive” many, but not all, of the laws governing Medicaid, including eligible people and services
- Section 1115 waiver authority is intended to encourage state innovation in the Medicaid program
- Often, states identify ways to save Medicaid funds and are permitted to use the savings to expand coverage
- The Federal government approves Section 1115 Demonstrations for five-year terms, but Demonstrations can be extended

# Global Commitment 1115 Waiver

- The Global Commitment Demonstration provides Vermont with flexibility, by applying managed care concepts, to increase access to care, improve quality of care and control program costs
- Vermont's Global Commitment to Health Demonstration began October 1, 2005; the initial term ended December 31, 2010, but it has been extended through December 31, 2013
- This request will extend the Global Commitment Demonstration through 2018 (5 years)

# Global Commitment Model

- The State must adhere to Medicaid managed care regulations (42 CFR 438 et. seq.) for all GC-funded programs and activities
- Vermont's Medicaid program currently has a "dual role" in that the State must also adhere to traditional Medicaid regulations, as approved in the Vermont Medicaid State Plan for programs funded by Choices for Care, the State's current long term care Demonstration, and the Children's Health Insurance Program (CHIP)
- Greater flexibility in what can be reimbursed (cost effective alternatives and managed care investments)
- A holistic approach to serving individuals and families
- Better communication and collaborative planning when more than one service is being provided to a single consumer or family (Chronic Care, Community Health Teams, Integrated Family Services, etc.)

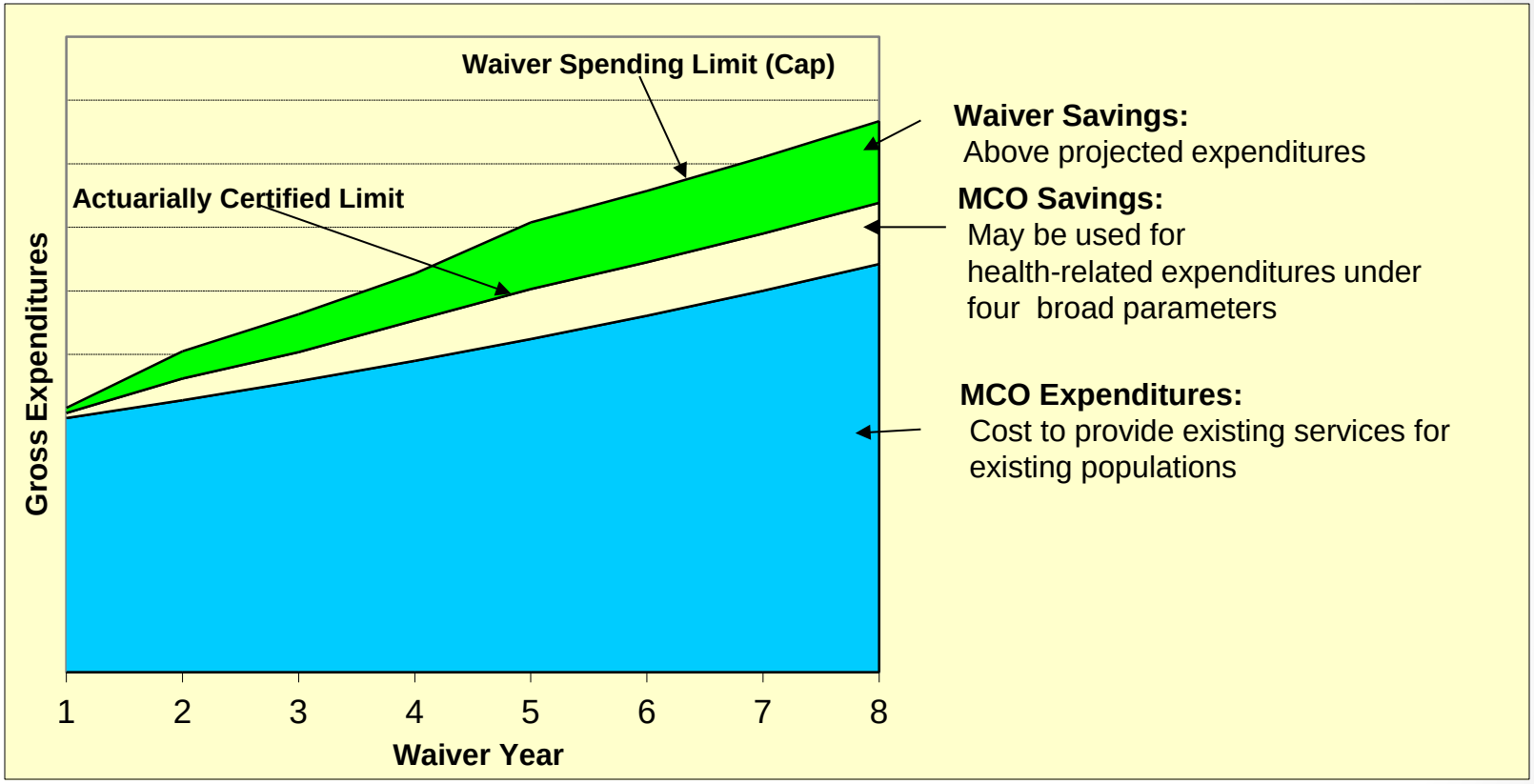
# Global Commitment Financing

- Section 1115 Demonstrations must be budget neutral (i.e., the Demonstration cannot cost the federal government more than what would have otherwise been spent absent the Demonstration)
  - Special Terms and Conditions establish aggregate spending limit (currently $8.96 Billion over 8.25 years)

- Managed care model design incorporates second spending limit
  - Program spending limited to Per Member, Per Month (PMPM) limits, established in accordance with federal managed care rate setting requirements

- Expenditures within the per member per month limit (calculated over the life of the Demonstration) can include expenditures for the following purposes:
  - *Reduce the rate of uninsured and or underinsured in Vermont;*
  - *Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;*
  - *Provide public health approaches 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*
  - *Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system*

# Global Commitment




- The Current Waiver Spending Limit excludes:
  - Choices for Care (Long-term care) Demonstration
  - CHIP (uninsured children with incomes between 225 and 300 percent of the Federal Poverty Level)
  - Disproportionate Share Hospital (DSH) Payments
  - Enhanced FFP for IT Infrastructure, Affordable Care Act initiatives

# Renewal Request

- Continuation of current public MCO model and regulatory structure
- Consolidation of all federal healthcare programs under one demonstration waiver (Choices for Care; CHIP)
- Continuation of all home and community services , including enhancements to Mental Health authorities to allow for federal participation in intensive services whether acute (hospitalization) or chronic (CRT)

# Summary of Proposed Demonstration Changes

| Area | Proposed Change | Impact |
|---|---|---|
| **Eligibility Expansions** | Eliminate VHAP, Catamount Health and ESI Expansion Populations and VScript, VScript Expanded and VHAP Pharmacy programs. | Persons under 133% will move to traditional Medicaid and receive a fuller benefit package; persons over 133% will move into commercial products through the Exchange |
| **ACA Transition** | Adopting a "safe harbor" approach to transitioning current Medicaid beneficiaries: those who are due for eligibility recertification in the first three months of 2014 will be deferred for review and distributed throughout the remainder of the calendar year, and all beneficiaries due for review be held harmless until March 31, 2014 or their review date, whichever is later. | Current Medicaid beneficiaries would not be required to submit any new information until their anniversary date. |
| **Modified Adjusted Gross Income** | Use new MAGI rules for all eligibility determinations as long as it does not adversely impact optional or expansion populations. | Administrative efficiency in eligibility determinations. |
| **Benefits** | Within state budget restrictions, expand the current menu of services offered in the Long Term Care Moderate Needs Group.<br><br>Enhance Hospice Benefits for persons within 12 month of end of life and allow delivery of both palliative and curative care. | Additional Flexibility for current long term care service beneficiaries in available service options. |

# Summary of Proposed Demonstration Changes (cont.)

| Area | Proposed Change | Impact |
|---|---|---|
| **Affordability** | Include a state based, sliding scale premium subsidy for persons purchasing on the Exchange up to 300% FPL. | To maintain affordability of Vermont programs at a level of expense substantially similar to former VHAP, Catamount and ESI programs. |
| **Demonstration Consolidation** | Consolidate Choices for Care, Dual Eligible Demonstrations and CHIP into GC under one demonstration. | Administrative simplification in the use of one federal regulatory structure for state and provider network. |
| **Administrative** | Streamline CMS reporting, state plan amendment, auditing and other processes as much as possible under the 42 CFR 438 regulatory structures. | Administrative simplification in the use of one federal regulatory structure for state and provider network. |

# Projected Fiscal Trends

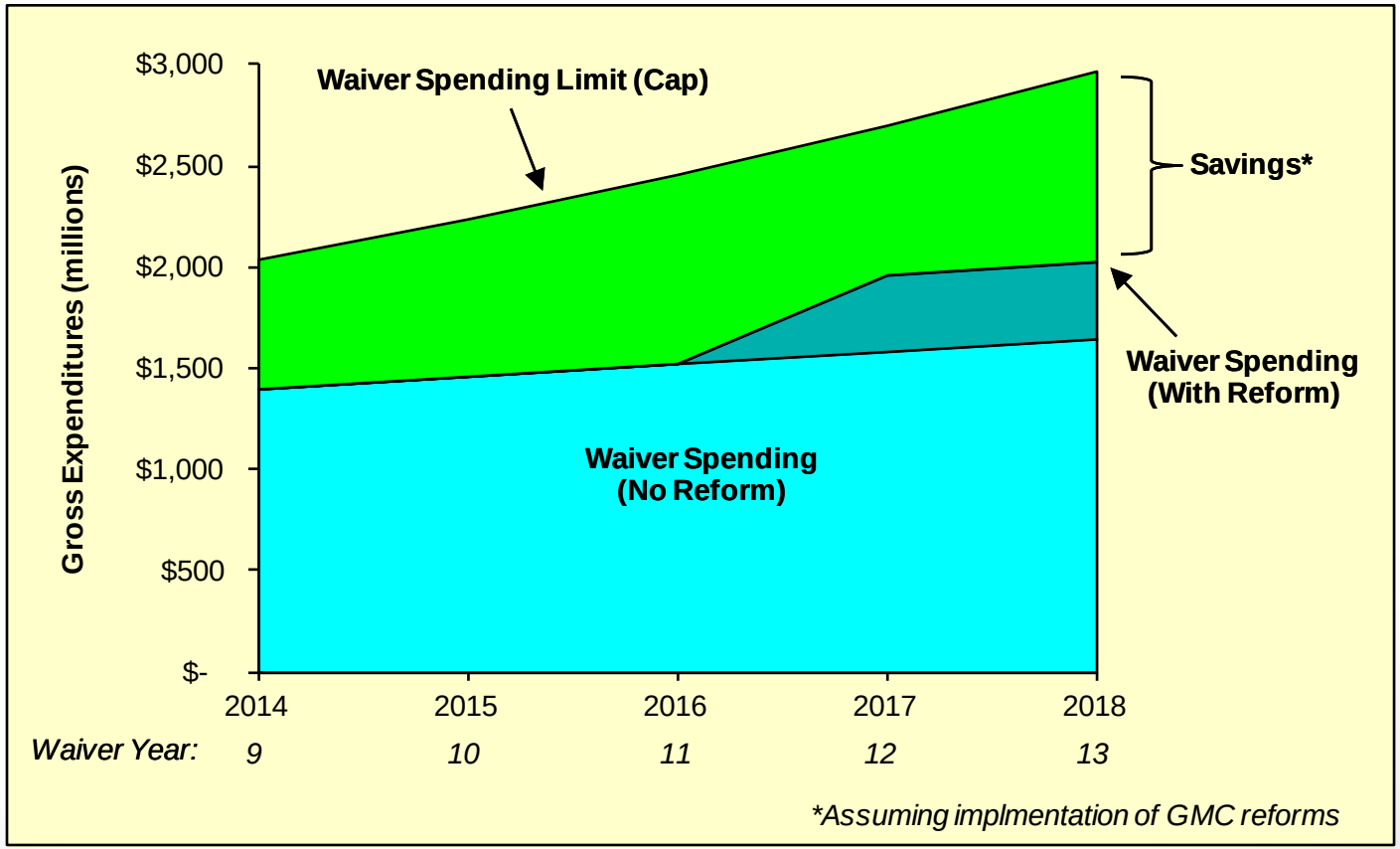
- Expenditures subject to budget neutrality for the extension period will include all Vermont Medicaid expenditures, except for:
  - *Disproportionate Share Hospital payments (DSH)*
  - *Children's Health Insurance Program (CHIP)*
  - *Medicaid Management Information System (MMIS) Enhancements*
- Projected spending without waiver
  - Continuation of pre-2005 eligibility groups and provision of traditional Medicaid services
  - Spending in the absence of Global Commitment is estimated to grow at nearly 10 percent per year, totaling $12.4 billion over the five-year extension period

# Projected Fiscal Trends

- Estimated actual spending under the waiver
  - Projections were developed using actual spending under Global Commitment in previous waiver years
    - Caseload and per member, per month expenditures are estimated to grow modestly at annual rates of 0.6% and 3.6%, respectively
      - Caseload projections account for the impact of changes related to the Affordable Care Act (ACA), including the elimination of certain eligibility groups and the addition of a "New Adult" group, as defined in the ACA
  - Projections were developed with and without the implementation of Green Mountain Care (GMC) Reforms in 2017
    - Assumptions underlying the fiscal impact of GMC reforms include but are not limited to:
      - Approximately 3% of large group members in 2017 being eligible for Medicaid
      - Slight caseload increase for those persons who remain uninsured prior to 2017
      - Increase in Medicaid rates to 105% of Medicare (to eliminate historical cost shifting)
      - Decrease in Medicaid administrative costs under single payer reform
    - Additional spending due to GMC reforms is estimated at $380 million per year in 2017 and 2018

# Projected Fiscal Trends

- With the implementation of GMC reforms in 2017, total spending during the five-year extension period is estimated at $8.4 billion, resulting in cumulative savings over the extension period of $4.8 billion; when savings from prior waiver years are included, savings over the life of the waiver is estimated to reach $5.8 billion



# GOALS

- Building on the successes of both existing 1115 Demonstrations, using the current GC Demonstration model as the foundation.
- Advancing both federal and state health reform initiatives, including changes contemplated by the ACA and by Vermont Act 48 (2011).
- Ensuring a smooth transition for Vermonters whose health care coverage will change as a result of the ACA, and maintain affordability of the coverage options.
- Streamlining program administration, oversight and reporting.
- Managing, under one authority, all acute and long-term services and supports for people with developmental disabilities, traumatic brain injuries, physical disabilities and beneficiaries who are aging.
- Continuing to expand the availability of flexible services and supports to assist beneficiaries with complex needs.
- Seamlessly integrating Medicare payments for dually eligible Vermonters into the existing managed care structure and providing higher quality care for beneficiaries while achieving efficiencies through a single integrated administrative approach.

# Public Comment

- **Written comments by 3/22/13:**

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