

State of Vermont Global Commitment to Health

Program Summary

October, 2005

Prepared by Susan Besio, AHS Director of Planning

Presentation Goals

Provide Overviews of:

- Context for Waiver Agreement
- Global Commitment Waiver Financial Model
- Global Commitment Organizational Structure
- MCO Requirements
- Changes in Current Programs for Beneficiaries

Provide Opportunity to:

- Begin to see opportunities
- Identify and address questions and concerns

Summary of Global Commitment Benefits

- Provides the State with federal authority to continue VHAP-Uninsured, VHAP Pharmacy, VScript and PCPlus programs
- Provides the State with a framework to initiate program reforms approved by the legislature, but does not require program changes
- Provides the State with the opportunity to produce \$135 – \$165 million in state savings by investing in health care programs through the MCO model

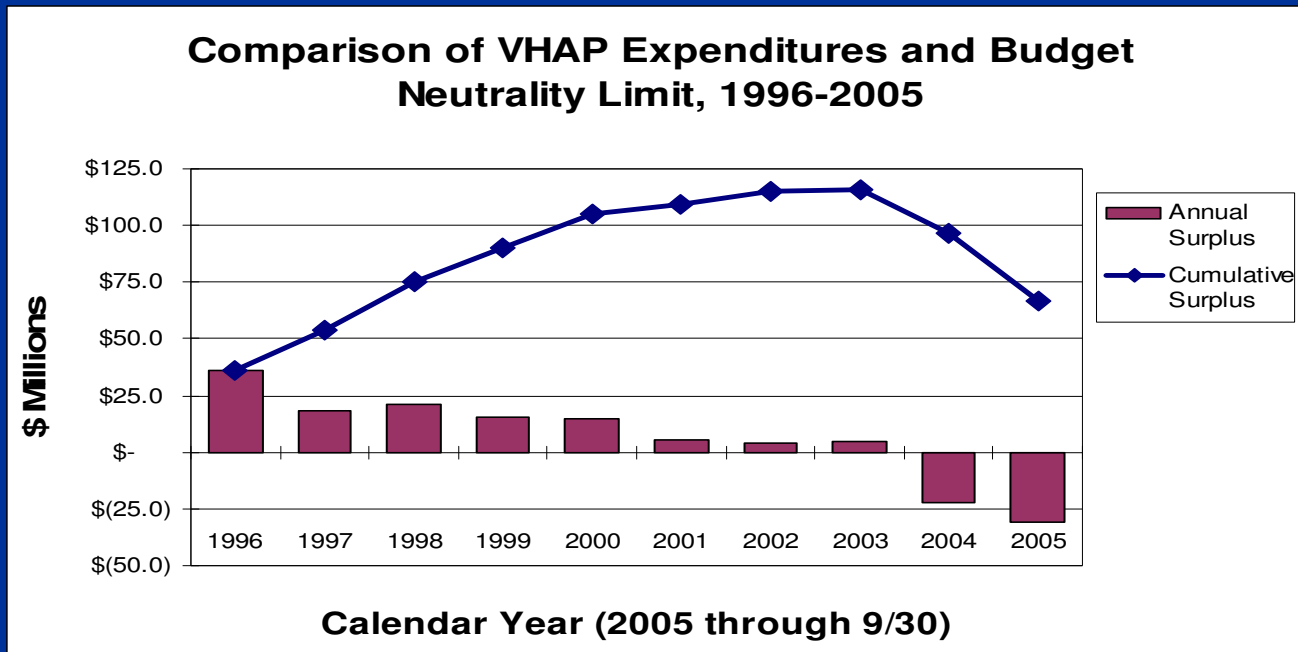
Context for Global Commitment:

Medicaid Expenditure Growth

- Current Projections include a deficit in Medicaid Expenditures (all Vermont programs) of:
 - \$60 million GF in FY07
 - \$370 million GF over next five years (cumulative)
- Projections based on:
 - Past growth trends for most line items
 - Slight decrease in OVHA growth rates
- Expenditures over next five years projected at \$4.18 billion (cumulative)
- Major Program Changes would be Needed to Address Deficit

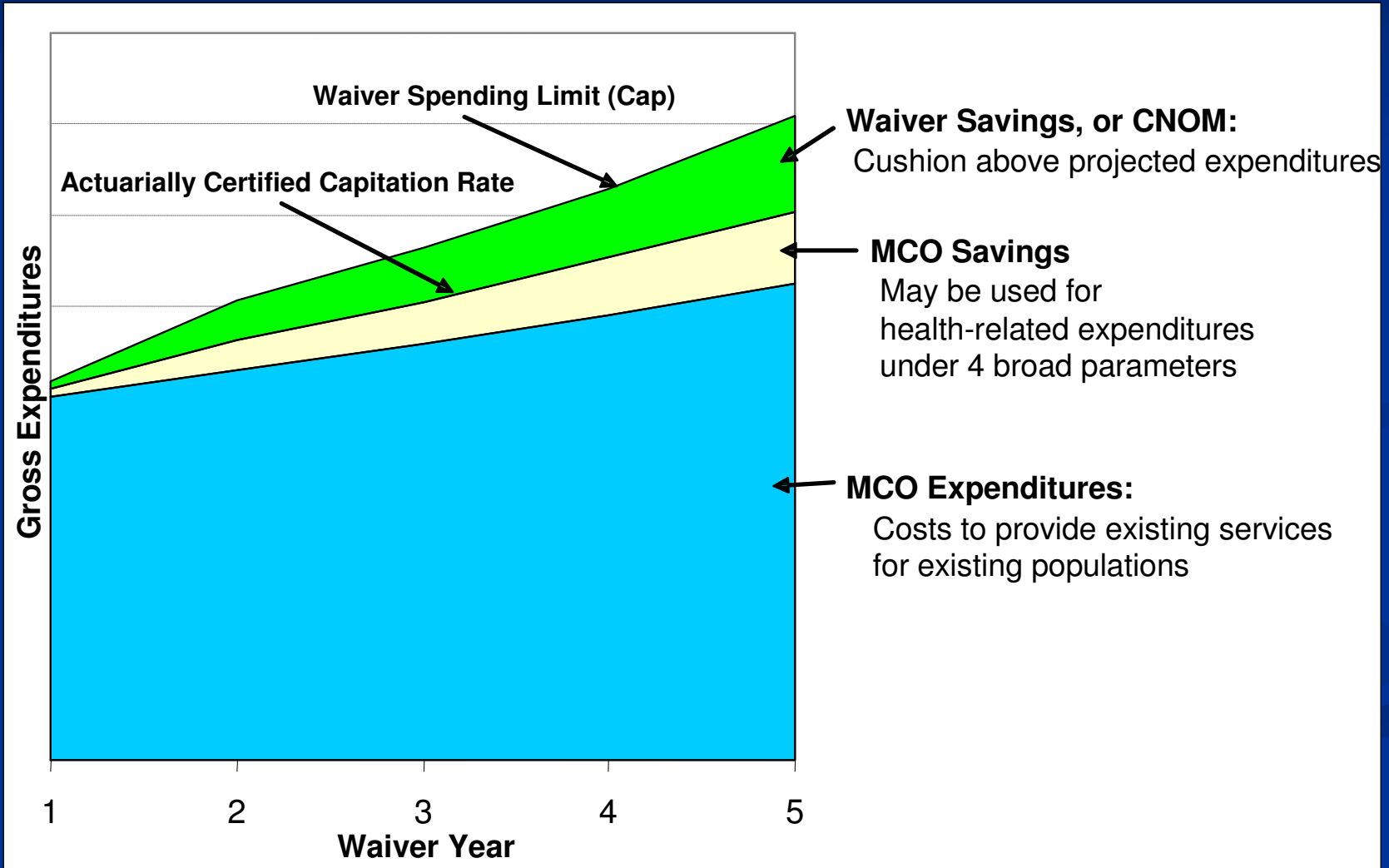
Context for Global Commitment: Existing VHAP Waiver

- Current 1115 VHAP Waiver expires December, 2006
- Budget neutrality surpluses are diminishing, meaning that an alternative approach is needed to continue federal funding for the expansion populations



Global Commitment to Health Financial Model

Summary of Global Commitment Financial Model



Global Commitment Financial Model

Budget Neutrality Ceiling

- Vermont Medicaid will operate under a 5-year budget neutrality ceiling (i.e., Waiver Spending Limit, Cap)
- Ceiling based on FY04 expenditures (plus DS waiting list) trended forward at 9% each year → \$4.7 billion cumulative over five years (gross dollars -state and federal)
- The VHAP surplus (\$66m) as of 9/30/05 was “rolled forward” into the Global Commitment Budget Neutrality agreement
- Administrative costs are in the ceiling; however, traditional federal claiming rules will be used for administrative costs (still under consideration by CMS)
- LTC Waiver, VPharm Wrap, DSH and SCHIP are excluded from the ceiling

Global Commitment Financial Model

Budget Neutrality Ceiling Protections

- Expenditure projections for the five-year period are significantly below the five-year ceiling (\$4.18 versus \$4.7 billion) → \$522 million cushion for program growth
 - We need GF to match any of this \$522 million cushion
 - And we currently have a \$360 million gap in needed GF to support existing programs
- The Terms and Conditions do not have a specific clause protecting Vermont from the fiscal impact of a catastrophic event
 - CMS works with states to ensure that Medicaid beneficiaries receive necessary services (i.e., CMS issued waivers to 8 states in 10 days after Hurricane Katrina to indemnify home and host states for Medicaid costs of evacuees)
 - Other federal agencies cover a majority of state costs for disaster relief (e.g., FEMA, Homeland Security, HHS Health Services)

Global Commitment Financial Model

MCO Capitation (Premium) Payment

- AHS will pay the MCO (OVHA) a lump sum premium each month to provide all necessary services under the Waiver
- Pursuant to federal managed care rules, AHS must obtain actuarial certification of the capitation rate (premium)
 - It will be based on Vermont's actual experience and regional experience, where appropriate
 - The actuary will certify a range of rates, based on the benefits authorized and appropriated by the Legislature each year
 - The State can establish the actual premium payment amount within the certified range
- Each year, state savings will depend on difference between the actual program expenditures and the premium amount

Global Commitment Financial Model

MCO Savings

- MCO Savings Can be used for expenditures in the Following Categories:
 - 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 to improve the health outcomes and the quality of life for Medicaid-eligible individuals in Vermont; and
 - Encourage the formation and maintenance of public-private partnerships in health care.

Global Commitment Financial Model

MCO Savings

- Using these parameters, the MCO can invest in current GF-only health-related programs, such as:
 - Respite programs
 - Tobacco Cessation
 - Emergency Mental Health Services
 - Newborn Screening
 - Substance Abuse Services
- This will free-up the GF supporting these programs which can then be used as state match for Medicaid Plan services
- Over the five years, this will result in \$135 to \$165 million of additional federal funds to support Vermont services

Global Commitment Financial Model

CNOMs

- CNOM = Costs not Otherwise Matchable under traditional Medicaid Rules that CMS grants the state authority to receive FFP for under a waiver agreement (e.g., VHAP)
- MCO Savings investments are not CNOMs (they will not be matched with FFP)
- Use of Waiver Savings (the cushion between the ceiling and the MCO Premium Payment = CNOMs (e.g., new expansion populations, programs)
- These will require CMS approval to implement

Comparison with the Current VHAP Program

- Like GC, the VHAP Waiver has operated under a Budget Neutrality Ceiling for nearly over ten years
- For both, the budget neutrality calculation is cumulative, over the life of the Waiver
- Neither waiver has a catastrophic event clause
- Like GC, the VHAP Waiver enabled the State to secure federal funding for populations otherwise not eligible for Medicaid (Costs Not Otherwise Matchable, or CNOM)
- The VHAP Waiver has operated under Special Terms and Conditions (STCs) very similar to those approved for the Global Commitment Waiver
- The specific federal rules waived under VHAP are very similar to those waived for Global Commitment

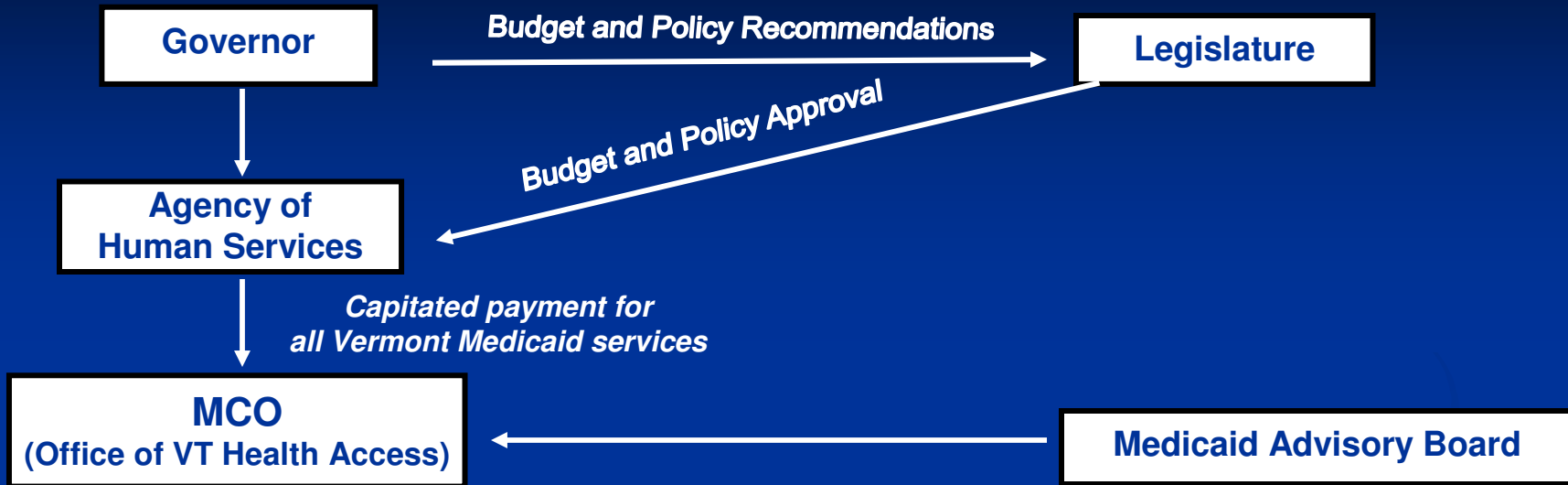
Global Commitment versus Block Grants

Block Grants	Global Commitment
<ul style="list-style-type: none">■ A defined amount of funding, often less than traditionally spent in exchange for total flexibility■ Funds are not tied to amount of services provided■ Bush Block Grant: automatically decreased federal support to states over time■ Amount can be increased or decreased at any time	<ul style="list-style-type: none">■ A ceiling amount available for reimbursement based on historical expenditure growth■ Funds based on program expenditures and costs■ Waiver ceiling increases annually based on 9% inflationary trend■ Ceiling is permanent for 5 year term of agreement■ Additional, but limited flexibility to operate program

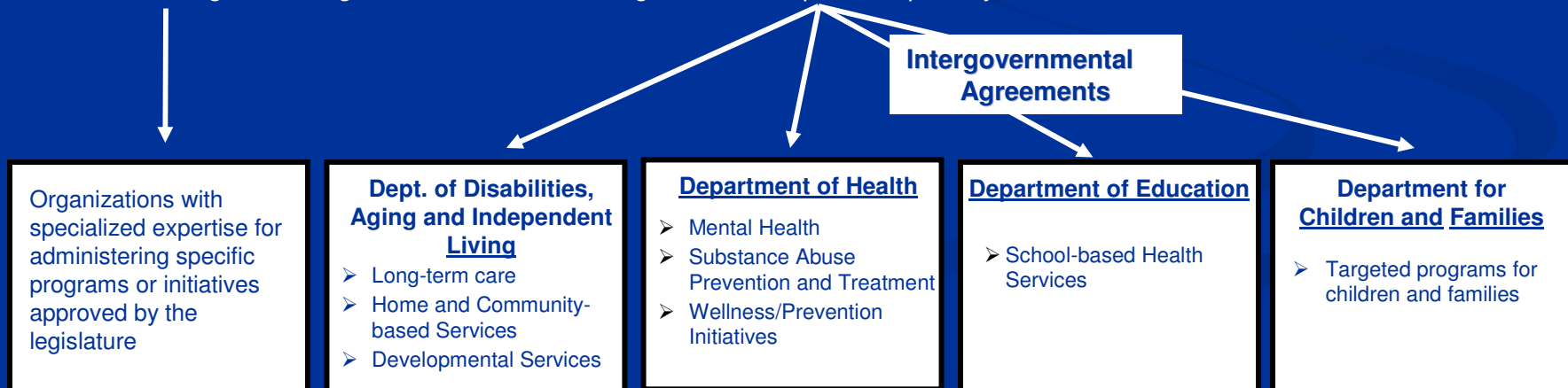
Organizational Structure

GLOBAL COMMITMENT TO HEALTH

Organizational Structure



- Manages all Vermont Medicaid expenditures under capitated agreement
- Oversees implementation of all approved policy and program changes
- Adheres to all BBA MCO requirements and the terms and conditions of the 1115a Waiver
- Administers the public health insurance programs (Medicaid, VHAP, Dr. Dynasaur) and pharmacy benefits
- Through formal agreements, funds other organizations to provide specialty benefits



Authority for OVHA as a MCO

- The Vermont FY 2006 Budget Bill:
 - Approved the creation of OVHA as a Public MCO for purposes of the Global Commitment to Health Waiver
 - Exempted the new MCO (OVHA) from BISHCA MCO requirements
- The GC Waiver Approval authorizes AHS to Contract with OVHA to serve as a publicly sponsored MCO
 - OVHA must comply with the federal MCO requirements

Vermont Experience with Public MCOs

- The VHAP Waiver operates under a managed care model
 - OVHA contracted with private health plans from October, 1996 through April, 2000
 - OVHA transitioned to a Primary Care Case Management (PCCM) model, known as PCPlus
 - OVHA has operated under federal managed care rules for PCCM programs
 - Because OVHA has been operating PCPlus, many managed care requirements already are met

Vermont Experience with Public MCOs

- The CRT program operates under a Public MCO model
 - VHAP Waiver was amended in April, 1999 to create the CRT MCO model
 - AHS makes actuarially certified capitated payments to VDH
 - VDH must comply with federal managed care rules
 - VDH is at risk for costs in excess of the capitation rate
 - In exchange for assuming risk, VDH has greater flexibility regarding payment approaches and covered services
 - VDH has used MCO savings to provide mental health services to individuals not eligible for Medicaid

MCO Requirements:

Member Services

- **Interpreter Services** available free upon request
- **A Provider Directory**, including languages spoken and if accepting new patients
- **Notification of Terminating Providers** to enrollees whose PCP or regularly seen provider terminates Medicaid participation within 15 days of the provider's notice to the state.
- **Enrollee Handbook**: how to access care, enrollee rights and responsibilities, procedures for obtaining benefits, what to do in a medical emergency and how to file a grievance or appeal.
 - Handbooks must be available in languages other than English if five (5) percent or more of Demonstration enrollees speak that language.
- **Advance Directives** information must be made available.
- **Toll Free Member Helpline** must be available during normal business hours to answer enrollee inquiries and to accept verbal grievances or appeals.

MCO Requirements:

Grievances and Appeals: Definitions

- An Action means:
 - The denial or limited authorization of a requested service, including the type or level of services;
 - The reduction, suspension or termination of a previously authorized service;
 - The denial, in whole or in part, of payment for a service;
 - The failure to provide services in a timely manner (as defined by the state);
 - The failure of the public MCO to act within prescribed timeframes.
- An Appeal means: Any request for a review of an action.
- A Grievance is: an expression of dissatisfaction with any matter other than an action (e.g., quality of care)

MCO Requirements:

Grievances and Appeals: Requirements

- OVHA must have a formal process for resolving all grievances and appeals.
- Grievances and appeals must be acknowledged in writing (typical standard is within five business days).
- Resolution Timeframes:
 - Standard Grievance – 45 days from date of receipt
 - Standard Appeal – 45 days from date of receipt
 - Expedited Appeal – Three (3) business days from date of receipt
- Enrollees have the right to request a fair hearing within no less than 20 days or more than 90 days from the date of the notice of resolution of the grievance or appeal.

MCO Requirements:

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT

- **QAPI Plan** which incorporates procedures that:
 - Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees, including those with special health care needs
 - Identify the race, ethnicity and primary language spoken by each Demonstration enrollee
 - Provide for an annual, external independent review of the quality outcomes and timeliness of, and access to, the covered services under the Demonstration
- **Source of Primary Care** must be assured for each Demonstration enrollee. It must further implement mechanisms to identify persons with special health care needs.
- **Practice Guidelines** must be adopted that are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field
- **Measuring Performance Improvement:** through projects designed to:
 - Achieve significant sustained improvement in clinical care and non-clinical care
 - Detect both under- and over-utilization of services
 - Assess the quality and appropriateness of care furnished to enrollees with special health care needs.

MCO Requirements:

Other Miscellaneous Requirements

- **Enrollee Rights:** Establish policies and procedures on enrollee rights consistent with the requirements of Part 438.100 of 42 CFR.
- **Availability of Services:** Ensure an adequate network of providers, including
 - an assessment of geographic location and whether the location provides for physical access for enrollees with disabilities.
 - Consideration of the number of network providers who are NOT accepting new Medicaid patients.\
 - Subcontracts with other selected AHS departments that will provide services to Demonstration enrollees.

Program Operations

Impact of Global Commitment on Program Design and Operations

- The Global Commitment Waiver provides the State with greater flexibility with regard to program design and operations
- Program benefits in SFY06 (and subsequent years) would continue as authorized by the Legislature

Impact of Global Commitment on Program Design and Operations

- Departments will continue to receive appropriations through the existing budget and legislative process
- New Flexibilities will be available to:
 - Cover health services not available under Title XIX
 - Explore alternative reimbursement approaches (e.g., case rates)
 - Invest funds in programs designed to improve health outcomes
 - Encourage inter-departmental collaboration and consistency across programs
- Decisions about implementation of new flexibilities will be made collaboratively with AHS leadership and the MCO

Impact of Global Commitment for Beneficiaries

- Federal managed care requirements enhance beneficiary protections beyond those required by Title XIX
- The Global Commitment does not authorize Vermont to change benefits for mandatory populations and mandatory benefits
- There is a 5% corridor for the State to make changes to the benefits provided to optional and expansion populations, if authorized by the Vermont Legislature
- Program reforms approved by the Vermont Legislature that significantly increase or decrease program benefits or eligibility would require federal approval
- Some individuals previously not participating in PCPlus will be required to select a 'medical home' or Primary Care Provider, pursuant to federal managed care requirements

Global Commitment Waiver Protections

- Continuation
 - Vermont may elect to renew the waiver at the end of the five year term
- Termination
 - The State and CMS may elect to terminate the waiver at any time during the five year term
- Disaster Relief
 - CMS works with states to ensure that Medicaid beneficiaries receive necessary services (i.e., CMS has issued waiver to 8 states in the past 10 days to indemnify home and host states for Medicaid costs of evacuees)
 - Other federal agencies cover a majority of state costs for disaster relief (e.g., FEMA, Homeland Security, HHS Health Services)
- Federal Program Changes
 - Traditionally, CMS has allowed states that have implemented innovative programs to continue these programs even when new federal regulations are implemented (e.g., Vermont's Welfare Reform waiver was allowed to continue even with the subsequent federal welfare reform legislation)
- Vermont legislature must approve any changes affecting beneficiary eligibility or benefits

Implementation Timelines

- By October 1, 2005:
 - Vermont Legislative approval (preliminary or full) to begin waiver implementation
 - Notification by CMS of Interim Premium Rates to be used until actuarial certification is completed and a rate is chosen by the State (November)
 - Intergovernmental Agreement signed by AHS and OVHA
 - Fiscal systems in place to draw federal funds under new arrangement
- November 17, 2005
 - Joint Fiscal Committee meets to Vote on Final Approval
 - Letter of Acceptance from State to CMS
- By January 30, 2006
 - MCO requirements fully in place (Grievance and Appeals process may need additional time for any needed regulatory changes and implementation)
 - Intergovernmental agreements signed between MCO and Departments
 - Evaluation plan submitted to CMS

Joint Fiscal Committee Approval Contingencies

- (1) *Complete demonstration provisions furnished.* That a letter of acceptance to CMS be drafted and approved by JFC that identifies and clarifies changes between the original proposal and the final terms and Conditions
- (2) *Final premium amounts determined to be sufficient.* That the JFC be provided the final actuarially certified premium amounts, and that the JFC finds that such amounts are sufficient to support the Demonstration Waiver Program including the state's current Medicaid and expansion programs.
- (3) *Agreement regarding future years' premiums.* That AHS work with CMS regarding the criteria utilized in future waiver years to ensure that future premiums will not be negatively affected by successful cost savings efforts achieved by the state.
- (4) *MCO Savings Identified.* That OVHA present to the JFC a list of criteria and an updated list of MCO targeted health care investments which support the administration's recommendation that the financial value of the Waiver is within the range of \$135 million to \$165 million.
- (5) *Attorney General Review.* That the Attorney General review as to form the Special Terms and Conditions (STC), the Intergovernmental Agreement (IGA), and other legal documents regarding the demonstration waiver program.

Other Issues

- TBD