The
GLOBAL COMMITMENT
Waiver

The
ALL-PAYER
ACCOUNTABLE CARE
ORGANIZATION (ACO) MODEL
Agreement

High-Level Overviews

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Context: Separate but Connected

While there is a strong relationship between the two, the **GLOBAL COMMITMENT WAIVER** and the **ALL-PAYER MODEL AGREEMENT** are two separate and very different agreements between the State of Vermont and the federal Government.

GLOBAL COMMITMENT

- Medicaid – 1115 Demonstration (Waiver)

All Payer Model Agreement

- Payers include Medicaid, Medicare and Commercial
- Goal: Move from Fee for Service to Value-Based payments within overall growth targets and outcomes.

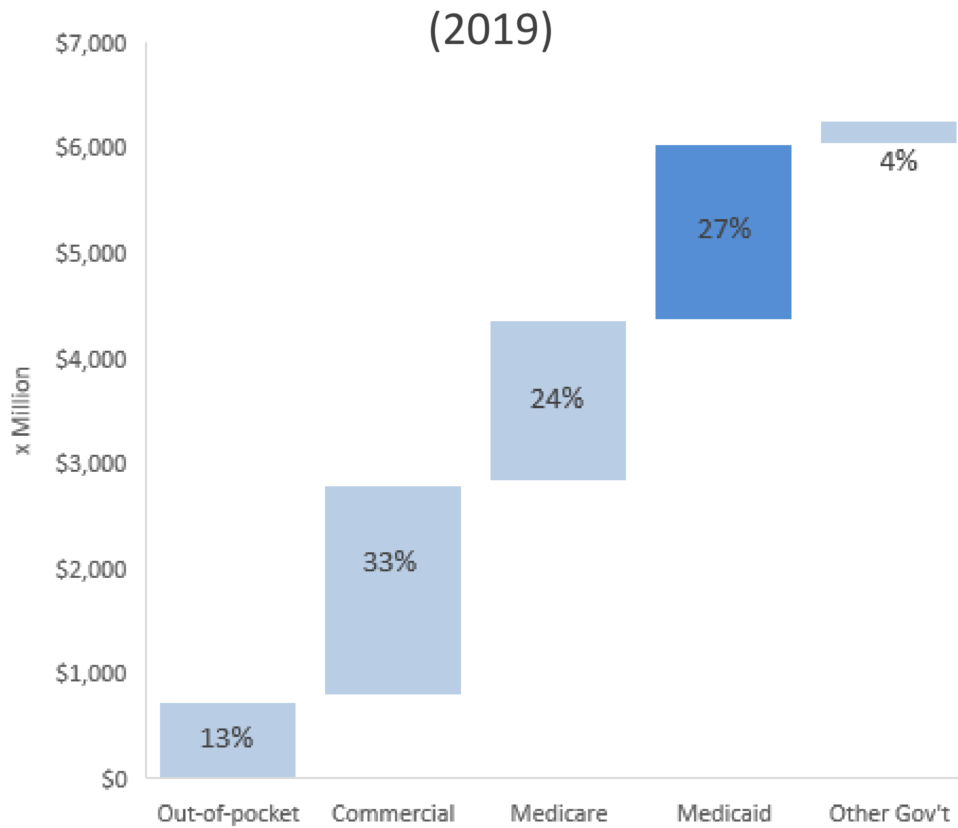
The goal of this presentation is to provide a high-level overview of each.

Part 1:

The
GLOBAL COMMITMENT
Waiver

Context: Overall Health Spending

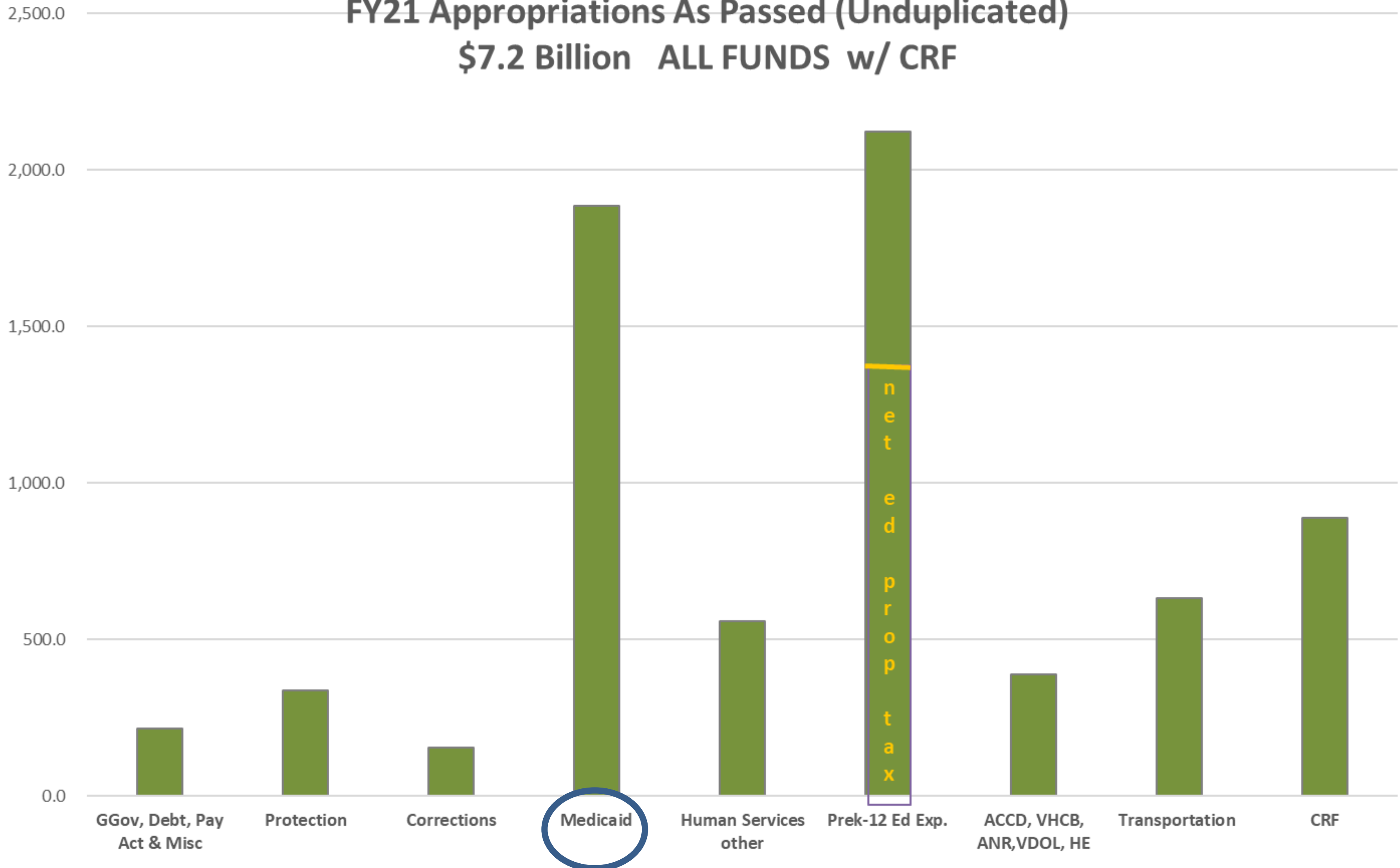
IN 2019, VERMONTERS SPENT $6.5 BILLION ON HEALTH CARE



- **Medicaid** accounted for **27%** of Vermonters' health spending
- Approx. 90% of Medicaid spending was/is through the Global Commitment (GC) Waiver
  - Non GC spending includes DSH, clawback, CHIP, Exchange cost-sharing subsidies, and state-only Rx.

Source: Green Mountain Care Board Expenditure Analysis

Context: State Budget



Global Commitment

- **GLOBAL COMMITMENT TO HEALTH ("Global Commitment")** is the name of the agreement between Vermont and the Centers for Medicare and Medicaid Services (CMS) that is used to administer the majority of Vermont's Medicaid program
  - Under GC most of Medicaid is operated through a managed care-like model. Vermont is unique in that DVHA is a public managed care entity.

- Global Commitment (GC) is a Medicaid Section 1115 Demonstration
  - Section 1115 of the federal Social Security Act allows the federal government to waive many, but not all, of the laws governing Medicaid, including those relating to eligible individuals and services
  - Section 1115 authority is intended to encourage state innovation in designing and improving state Medicaid programs
  - States can have more than one Section 1115 demonstration ("waiver") agreement with CMS at the same time
  - 40 states have at least one 1115 demonstration
  - Federal expenditures for a state's Medicaid program under the waiver cannot exceed the federal expenditures that would otherwise have been made

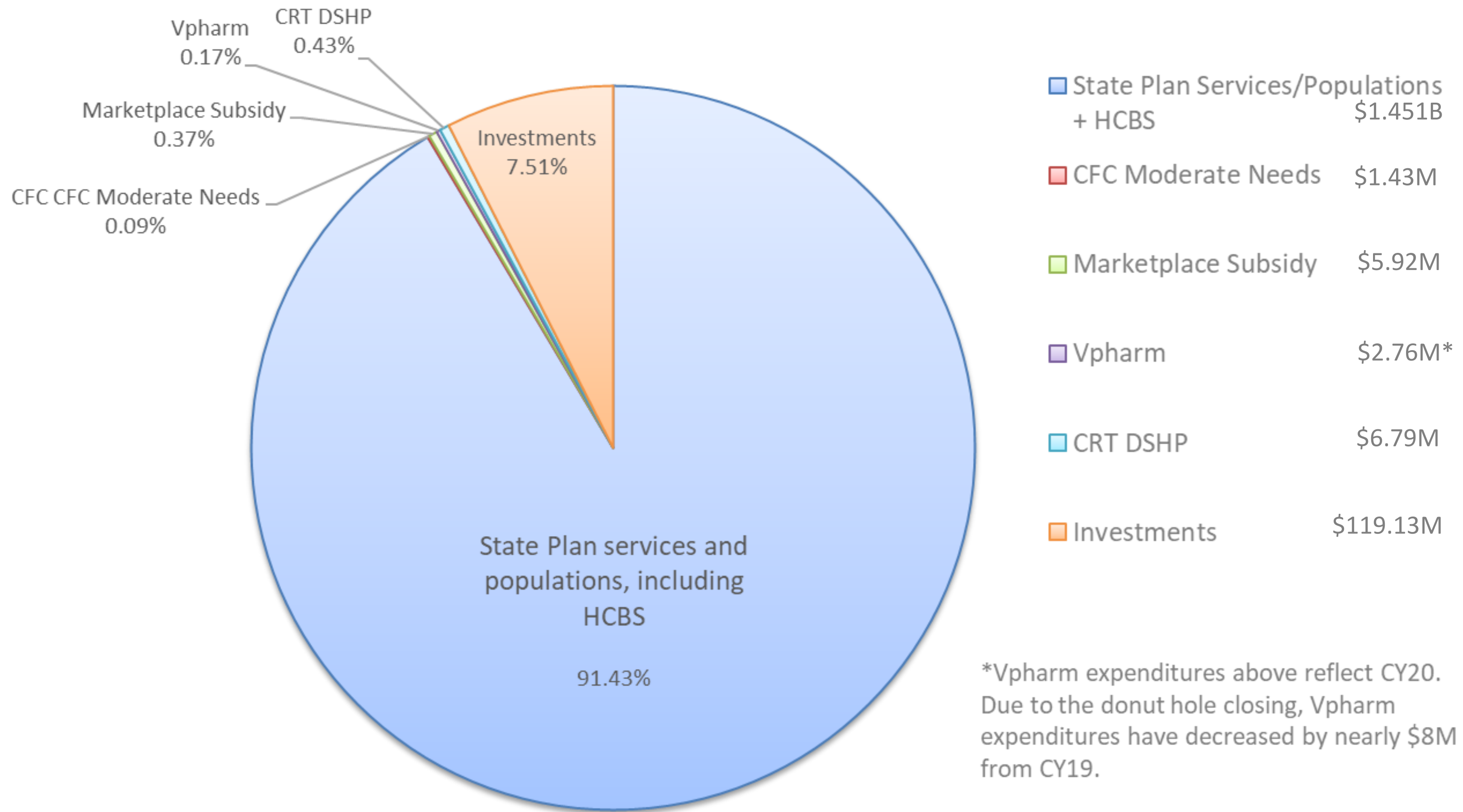
Global Commitment (cont.)

- Global Commitment terms and conditions set forth how the program will be administered, including who and what is covered.

- A state identifies ways to save Medicaid funds and is permitted to use those savings for identified priorities/goals.
  - Some goals are written into the demonstration's terms and conditions; others are achieved through "investments."
  - In FY2020, Vermont had 69 investments worth approx. $124M (with federal match). Without the waiver, these would all require State funds to pay for the service or the service could be defunded/eliminated.
    - Initially known as *costs not otherwise matchable* or *CNOM.*
  - A list of investments can be found at this link: https://legislature.vermont.gov/assets/Legislative-Reports/Annual-Report-on-the-Global-Commitment-Investments-10.1.20-Final.pdf

Global Commitment - Spending

Vermont's waiver currently supports traditional State Plan services and HCBS benefits at a cost of $1.451B gross, as well as $136.03M gross in additional funding for investments and expansions.



Source: Agency of Human Services (with JFO Modifications)

History

- **2005 – 2010 – Initial Term**
  - Most of Medicaid operated through a managed care-like model.
  - AHS paid DHVA (then called "OVHA") a per-member, per month capitation rate to cover Medicaid expenditures.
  - If DVHA kept expenditures within capitation rate, State accrued savings that could be used to make expenditures for the following purposes:
    - Reduce rate of uninsured/underinsured
    - Increase access to quality health care
    - Implement public health programs to improve health outcomes and quality of life for Medicaid-eligible individuals
    - Encourage formation and maintenance of public-private partnerships
  - Global Spending Cap was for the whole duration period (and not annual)
  - Expanded access to Medicaid coverage
  - 2007 – waiver amendment allowed for implementation of premium assistance program for eligible individuals enrolled in Catamount Health
    - Initially for individuals ≤ 200% FPL; increased to ≤ 300% FPL in 2009

History (cont.)

- **2011 – 2013**
  - Minor changes to managed care model, but retained ability to use savings to make investments based on existing categories
  - Fiscal Change to the draw of federal match tied back to actual expenditures instead capitated PMPM. GC PMPMs still projected and reported

- **2014 – 2016**
  - Many amendments based on coverage changes from Affordable Care Act (ACA):
    - Effective 2014 – Eliminated provisions related to VHAP and Catamount
    - Effective 2014 – Added “New Adult” Medicaid eligibility group
    - Effective 2014 – Added Vermont premium subsidies for eligible individuals (income ≤ 300% FPL) who purchase qualified health plans (QHPs) through Vermont Health Connect
  - 2015 – Choices for Care (which was separate 1115 waiver) consolidated into Global Commitment

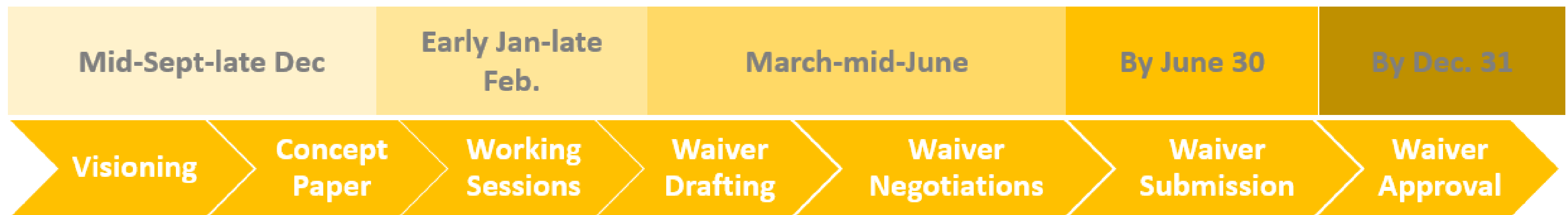
History (cont.)

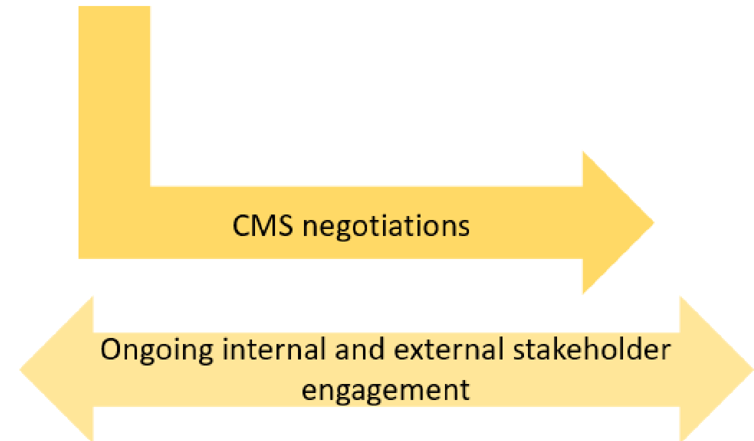
- **2017 – 2021** (Current term)
  - Managed care-like model remains largely same as in previous periods
    - CMS designated DHVA as a pre-paid inpatient health plan (PIHP) for services and populations covered under the waiver, which is a Medicaid managed care designation for how the state will be regulated and rules, requirements, and standards the state must adhere to.
  - New, stricter requirements regarding spending on investments
    - State can only spend investment dollars on specific programs and services approved by CMS
    - Total amount of permitted investments gradually reduces each year over the 5-year period
  - Allows for delivery system-related investments to support implementation of All-Payer ACO Model
  - 2018 and 2019 – amendments to waive institution for mental diseases (IMD) exclusion for short-term residential and inpatient treatment services for substance use disorder (SUD) and serious mental illness

Waiver Renewal

- In May, AHS released a draft of its request for another 5-year renewal for public comment, with the goal of formally submitting a renewal application to CMS by June 30, 2021.

Waiver Development Process





Link to 2022 Waiver Documents:
https://humanservices.vermont.gov/about-us/medicaid-administration/global-commitment-health-1115-waiver/1115-waiver-documents/2022

Legislative Role

- AHS administers Vermont’s Medicaid program
  - State law: AHS duty pursuant to 33 V.S.A. § 1901
  - Federal law: AHS is single state agency pursuant to 42 U.S.C. § 1396a
- 33 V.S.A. §1901(a)(2) requires AHS Secretary or designee to seek approval from General Assembly prior to applying for and implementing Medicaid/SCHIP waiver or waiver amendment
- Sec. E.301.1 of Act 74 of 2021 authorizes the AHS Secretary to seek to extend or renew the Global Commitment demonstration set to expire on December 31, 2021
  - AHS must “strive to maintain or increase the State’s flexibility to use Global Commitment investment dollars to increase access to care and coverage, improve health outcomes, strengthen health care delivery, and promote transformation to value-based and integrated models of care.”
- General Assembly provides oversight, appropriates State funds for Medicaid, and directs AHS to seek waiver amendments as needed to implement legislative policy decisions

PART 2:

The ALL-PAYER ACCOUNTABLE CARE ORGANIZATION (ACO) MODEL Agreement

All-Payer ACO Model

Legislative history

- Act 54 of 2015 required Secretary of Administration and Green Mountain Care Board (GMCB) to jointly explore an all-payer model.
- Act 113 of 2016 allowed GMCB and Agency of Administration (AoA) to enter into agreement with CMS for a Medicare waiver only if the agreement:
  - Is consistent with the Act 48 principles
  - Preserves Medicare consumer protections
  - Allows providers to choose whether to participate in ACOs
  - Allows Medicare patients to choose any Medicare-participating provider
  - Includes outcomes for population health
  - Continues to provide Medicare payments directly to providers/ACOs (no State control of Medicare funds)

All-Payer ACO Model

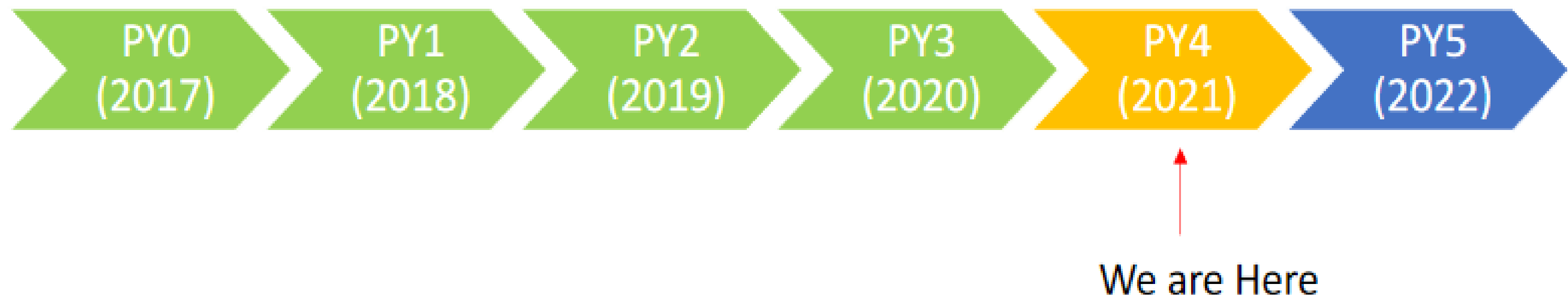
Legislative history (cont.)

- Act 113 enacted 18 V.S.A. § 9551, codifying parameters that GMCB and AoA must ensure all-payer model meets, including:
  - Consistency with Act 48 principles
  - Maximizes alignment among payers
  - Strengthens and invests in primary care
  - Incorporates social determinants of health
  - Provides process for integration of community-based providers
  - Allows providers to choose whether to participate in ACOs
  - Evaluates access to care, quality of care, patient outcomes, and social determinants of health
- Act 113 also created framework for GMCB oversight of ACOs through annual certification and budget review in 18 V.S.A. § 9382
  - Several amendments since 2016

All-Payer ACO Model

High level Summary

- All-Payer ACO Model signatories – Governor, Secretary of the Agency of Human Services, and GMCB Chair
- Performance Years (PYs) - 12 month periods between Jan. 1 and Dec. 31



- Start-up funding – Included $9.5M for start-up funding in CY2017

- ***Link to agreement*** - https://gmcboard.vermont.gov/sites/gmcb/files/files/payment-reform/All%20Payer%20Model%20ACO%20Agreement.pdf

All-Payer ACO Model

High level Summary

- Goal: Shift from fee-for-service system to value-based reimbursement model, with targets for spending growth, population health, and care quality:
  - Spending growth target - No more than 3.5% average per capita per year across all payers between 2018-2022.
    - Ceiling capped at 4.3% per capital per year
    - Medicare – 0.2% below national projections
  - Scale Targets: Annual attribution targets, with goal of 70% population enrolled into model (90% for Medicare) by 2022

Percent (%)	By end of PY1 (2018)	By end of PY2 (2019)	By end of PY3 (2020)	By end of PY4 (2021)	By end of PY5 (2022)
Vermont All-Payer Scale Target Beneficiaries	36%	50%	58%	62%	70%
Vermont Medicare Beneficiaries	60%	75%	79%	83%	90%

  - Improve health outcomes – reduce drug overdose deaths, lower suicide rate, reduce incidence of chronic disease, and increase access to primary care

All-Payer ACO Model

High level Summary

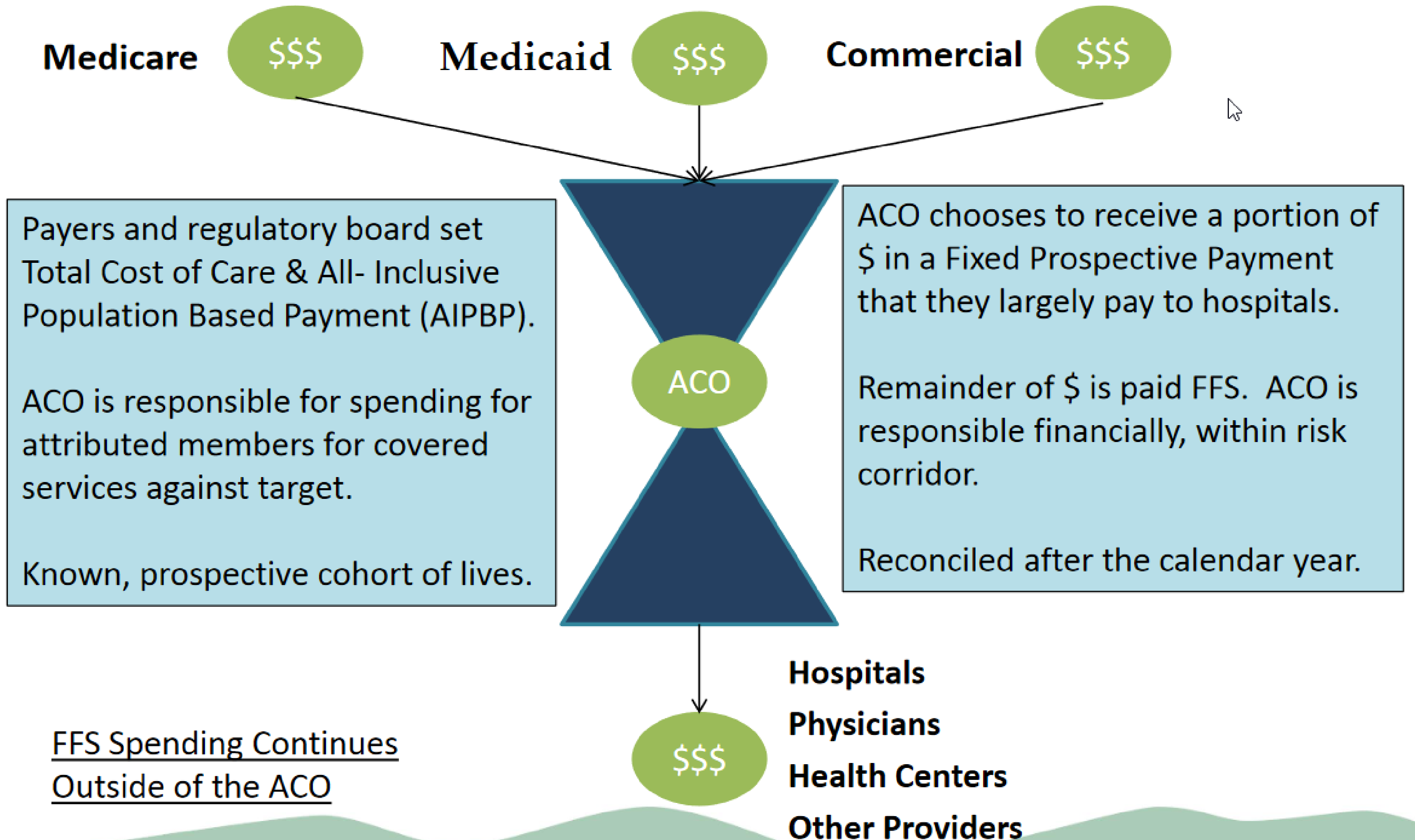
Data and Reporting

Agreement Requirement	Data Sources
All-Payer and Medicare Total Cost of Care per Beneficiary Growth Targets	APCD, Medicare data, Medicaid data, non-claims cost growth information for commercial and Medicaid payers
Scale Targets for Vermonters aligned to an ACO	APCD, ACO attribution data, payer attribution data, insurer data, federal program data
Statewide Health Outcomes and Quality of Care Targets	APCD, clinical data, survey data

APCD = All-payer claims data base (also known as VHCURES)

Source: Green Mountain Care Board

All-Payer ACO Model



Source: Green Mountain Care Board