Global Commitment to Health Medicaid Waiver Renewal: October 25, 2016

Summary: The Agency of Human Services received approval on October 24, 2016 from the federal government to continue the Global Commitment to Health Medicaid Waiver. The waiver term is 5 years, starting 1/1/2017 and ending 12/31/2021. The negotiation focused on three primary goals:

- Continuing current Medicaid coverage of essential services for Vermont's most vulnerable populations.
- Promoting health care reform by ensuring Medicaid participation and alignment with the All-Payer Model by providing Vermont with additional financial capacity to invest in healthcare reform concurrent with the All-Payer Model.
- Continuing flexibility in using Medicaid dollars to invest in health care priorities. Without this authority, these investments would require new general fund appropriations or elimination.

There are several changes that impact how Vermont operates its waiver resulting from federal alignment of Section 1115 waivers across the country and new Medicaid Managed Care rules.

Changes required by CMCS include the following financial Impacts detailed below. This reflects an estimated $5.0 million GF need in FY17 and $6.2 million GF need in FY18.

- **MCO Investments -**
  - Vermont must phase down or seek alternative federal fund sources for certain investments. New guardrails and approval process will ensure investment funds are not spent on unallowable items, such as room and board, non-Medicaid school based services, bricks and mortar, Health Information Technology and Health Information Exchange (HIT/HIE), and Institutes for Mental Disease (IMD). The impact of phasing out current investments on unallowable items is estimated to be $64 million gross over the next 10 years, out of the total Medicaid budget of $1.6 billion.
  - Alternative investment fund sources include: Substance Use Disorder Demonstration Waiver and Implementation Advanced Planning Document.

    - There are new annual caps on investments that include capacity for payment reform and to maintain existing allowable investments. The state currently invests about $127 million in total funds under this authority.
    - The transition starts in FY18 – reflected in an estimated $600K state fund impact related to HIT.
- **Administrative Match Rate Change** - The administrative match rate will change so that some areas previously eligible for a program match rate of ~54% will now draw federal funds at the administrative match rate of 50%. On the positive side, Vermont will also now be eligible for enhance match rates such as 75% for Medicaid Management Information Systems (MMIS). The net financial impact is estimated at $3.4 million GF in FY17 and FY18.
- **Woodside -** based on new 2016 federal guidance which broadens the CMS interpretation of the definition of an "inmate of a public institution," approximately $4 million gross of treatment expenditures for youth at Woodside is no longer eligible for Medicaid match. AHS is currently working on options for future funding.

Conclusion: Overall, the benefits of maintaining the core flexibility of our current waiver and aligning the waiver with the All-Payer Model agreement far outweigh any new burden imposed by the waiver. The Global Commitment waiver renewal is a positive step forward for the state by maintaining Vermont's commitment to covering the most vulnerable Vermonters and ensuring the affordability of health insurance. In addition, Global Commitment remains one of the most flexible waivers in the country, allowing the state to pursue its health care coverage and delivery system reform goals.

Additional Detail:

Managed Care Model- Since 2005, Vermont's Medicaid delivery system has required AHS departments to adhere to federal Medicaid Managed Care rules in exchange for Medicaid Managed Care flexibilities. During Vermont's 2010 negotiations, CMS determined that a unit of state government may not legally be considered a Managed Care Entity and may not be at risk for loss of federal matching funds if Medicaid expenditures were to exceed the annually certified PMPM. In 2016, CMS has further expanded on this determination, in connection to newly promulgated Medicaid managed care rules. The result of this is that Vermont is now considered to have a "Public Managed Care-Like Model" and, with a few exceptions, Vermont must follow Medicaid Managed Care regulatory expectations as if it were a "non-risk pre-paid inpatient health plan (PIHP)".

Substance Use Disorder Demonstration Waiver Amendment- The federal government encouraged AHS to pursue a Substance Use Disorder Demonstration Waiver as an amendment to our Waiver. This closely aligns with Vermont's goals for the SUD continuum of care while formally aligning the state within current federal constructs for this work. AHS staff has already begun this next step.

Investments:

- New annual caps on investments that include capacity for payment reform. As noted in the chart below, the state currently invests about $127 Million in total funds under this authority.

CY2016	126,882,102
CY2017	142,500,000
CY2018	148,500,000
CY2019	138,500,000
CY2020	136,500,000
CY2021	136,500,000

Vermont Medicaid Capacity for System Transformation

	2017	2018	2019	2020	2021	NEW WAIVER 2022	TOTAL
Advance Consumer Health Engagement	$ 1,000,000	$ 5,000,000	$ 4,000,000	$ 3,000,000	$ 3,000,000	$ 3,000,000	$ 19,000,000
Advanced Community Care/Case Management	$3,000,000	$ 5,000,000	$5,000,000	$ 4,000,000	$ 3,000,000	$2,000,000	$22,000,000
Community Primary and Secondary Prevention	$ 2,000,000	$ 7,000,000	$7,000,000	$ 5,000,000	$ 3,000,000	$ 3,000,000	$27,000,000
Information Infrastructure	$15,000,000	$ 9,000,000	$6,000,000	$ 4,000,000	$ 4,000,000	$4,000,000	$42,000,000
Community based services-Medicaid Pathway	$15,000,000	$ 12,000,000	$ 10,000,000	$ 8,000,000	$ 6,000,000	$ 4,000,000	$55,000,000
Quality and PHM Measurement and Improvement	$ 3,000,000	$ 8,000,000	$ 6,000,000	$ 4,000,000	$ 2,000,000	$ 0	$23,000,000
Socio-Economic Risk and Mitigation	$2,000,000	$ 5,000,000	$5,000,000	$ 4,000,000	$ 3,000,000	$2,000,000	$21,000,000
Total	**$41,000,000**	**$51,000,000**	**$43,000,000**	**$ 32,000,000**	**$ 24,000,000**	**$18,000,000**	**$209,000,000**

- These represent potential expenditures in Medicaid Programs, Administration and Technology. All require some level of state dollars in order to draw down federal match.
- Spending would focus on building AHS, GMCB, community service provider, and ACO capacity for reform.

- Investments that must phase down- Vermont asked for and received adequate time to adjust course and seek alternative funding to mitigate any potential financial impacts, which are more heavily weighted toward the later years of the Waiver. AHS will be working with departments and affected partners to manage these transitions over the next 5 years of the GC Waiver. There is minimal impact in FY18 – only one investment must begin transition. The impact of phasing out current investments on unallowable items is estimated to be $64 million gross over the next 10 years, out of the total Medicaid budget of $1.6 billion gross.
- The following chart shows the yearly percentage of allowable spending on the investments that are required to be phased out over time. The percentages note how much of the SFY 2016 amount the state has authority to spend:

	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Vermont Psychiatric Care Hospital, Brattleboro Retreat, Valley Vista, Maple Leaf, Serenity House, and Lund Home (IMD)	100%	100%	100%	100%	Amount to be determined per the phase-down schedule in STC 87
HIT	100%	50%	0%	0%	0%
Non-state plan Related Education Fund Investments, Room and Board, and Physician Training Program not tied to serving in an underserved area	100%	100%	67%	33%	0%

  - The first category of investments includes facilities that qualify as an IMD under federal law, which is a facility primarily for mental health or substance use disorder treatment that has over 16 beds for individuals over 21 and under 65. This category constitutes $34.5 million gross in expenditures for the Vermont State Psychiatric Hospital and mental health payments to Brattleboro Retreat. Because IMDs are not covered in other states, CMCS has required a transition of the funding for these facilities beginning in the final year of this demonstration 2021 and continuing over 6 years. The timeframe allows the state time to plan appropriately for needed capacity, which could include downsizing these existing facilities so they are not over the bed limit, adding capacity elsewhere, or developing new facilities.

- In addition, by seeking a Substance Use Disorder waiver amendment, the state will be able to transition $9.7 million gross in expenditures for substance use disorder services from investments to an allowable program expense in a budget neutral manner. AHS is begun working on this waiver amendment.
- ~$.9M federal of investments for HIT/HIE can continue to be matched by changing the source from Investments to an advance planning document (APD) for HIT/HIE. AHS has begun working on this new authority.
- The financial impact in FY18 from the transition of HIT is $600K state funds.

<u>Other changes:</u>

- CMCS is requiring additional federal approvals and compliance with the new Medicaid Managed Care Rules. These approvals will impact the effective dates for some rate changes and for some program changes, including any new investments over time. Prior to 2010, AHS and DVHA reduced staff related to federal compliance as these activities were not required under the initial GC waiver. The Agency is determining appropriate staff and contract needs in order to comply with the enhanced federal oversight. It's important to note that all other states are required to do these types of compliance activities, so Vermont became an outlier over the course of GC due to the reduced need for compliance staff. Examples of approvals include:
  - Submitting PMPM rates for approval as was previously required prior to 2010. This is required for private Medicaid managed care plans. The PMPM will no longer have a connection to the investment capacity, which has been defined by the amounts listed above.
  - Submitting certain rates for approval to the managed care group at CMCS, which requires a minimum 90-day time period and prior approval before implementation. This will not impact all rate changes.
  - 90-day notice prior to implementation of new investments, including delivery reform investments.