VERMONT GLOBAL COMMITMENT TO HEALTH
SECTION 1115 DEMONSTRATION
FACT SHEET

OCTOBER 2016

Program Name: Global Commitment to Health
Waiver Number: 11-W-00194/1
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Date of Implementation: October 1, 2005

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Date First Extension Implemented: December 31, 2013

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Second Extension Expiration: December 31, 2016

Date Third Extension Submitted: December 22, 2016
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Date Third Extension Implementation: January 1, 2017
Date of Expiration: December 31, 2021

SUMMARY

The Vermont Global Commitment to Health Medicaid section 1115(a) demonstration was originally approved on September 27, 2005, and implemented on October 1, 2005. The Global Commitment to Health section 1115(a) demonstration is designed to use a multi-disciplinary approach including the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, public-private partnership, and program flexibility.

In October 2007, a component of the Catamount program was added to the demonstration. The offering consisted of a premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the federal poverty level (FPL), and who do not have access to cost effective employer-sponsored insurance (ESI) as determined by the state.

In 2009, the state extended coverage to Vermonters at or below 300 percent of the FPL.

In 2011, the state included a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life limiting illnesses that would preclude them from reaching adulthood.

In 2012, an amendment was approved to eliminate the $75 inpatient admission co-pay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid state plan.

In 2013, CMS approved the extension of the Global Commitment to Health demonstration which included sun-setting the authorities for most of the 1115 Expansion Populations because they would be eligible for Marketplace coverage beginning January 1, 2014. The renewal also added the New Adult Group to the demonstration effective January 1, 2014. Finally, the renewal also included premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL.

On January 30, 2015, an amendment was approved to combine the Choices for Care and Global Commitment to Health section 1115 demonstrations.

On December, 22, 2016, Vermont submitted its extension request for the Global Commitment to Health section 1115(a) demonstration to CMS.

As of January 1, 2017, Vermont is extending the Global Commitment to Health demonstration to further promote delivery system and payment reform to meet the goals of the state working with the Center for Medicaid and CHIP Services and the Center for Medicare and Medicaid Innovation (CMMI) consistent with Medicare's payment reform efforts in order to allow for alignment across public payers. Specifically, Vermont expects to demonstrate its ability to achieve universal access to health care, cost containment, and improved quality of care.

Since 2005, the Global Commitment to Health demonstration has helped reduce Vermont's uninsured rate from 11.4 percent in 2005 to approximately 2.7 percent in 2015. The demonstration has also enabled Vermont to address and eliminate the bias toward institutional care and offer cost-effective, community-based services. For example, the proportion of Choices for Care participants served in the community has passed fifty percent and continues to increase. In addition, Vermont no longer has a waiting list for individuals in the Highest and High Need Groups under the Choices for Care component of the demonstration.

The state will employ four major elements in achieving the above goals:

1. *Program Flexibility:* Vermont has the flexibility to invest in certain specified alternative services and programs designed to achieve the demonstration's objectives (including the Marketplace subsidy program);

2. *Managed Care Delivery System:* Under the demonstration the Agency for Human Services (AHS) will enter into an agreement with the Department of Vermont Health Access (DVHA), which will deliver services through a managed care-like model, subject to the requirements that would be applicable to a non-risk pre-paid inpatient health plan (PIHP) as defined in STC 23;

3. *Removal of Institutional Bias:* Under the demonstration, Vermont will provide a choice of settings for delivery of services and supports to older adults, people with serious and persistent mental illness, people with physical

disabilities, people with developmental disabilities, and people with traumatic brain injuries who meet program eligibility and level of care requirements.

4. *Delivery System Reform*: Under the demonstration, Vermont will support systemic delivery reform efforts using the payment flexibility provided through the demonstration to create alignment across public and private payers.

ELIGIBILITY

The general categories of populations eligible under the demonstration are:

Mandatory and Optional State Plan Groups

Population 1: Mandatory state plan populations (except for the new adult group)
Population 2: Optional state plan populations
Population 3: Affordable Care Act new adult group

Demonstration Expansion Populations

Population 4: 217-like individuals receiving home and community based waiver (HCBW)-like services who meet the clinical standard of need in the Highest Need Group

Population 5: 217-like individuals receiving HCBW-like services who met the clinical standard for the High Need Group

Population 6: Individuals who are not otherwise eligible under the Medicaid state plan and who would not have been eligible had the state elected eligibility under 42 CFR 435.217, but are at risk for institutionalization and are in need of home and community-based services. They only receive a small subset of HCBW-like services as outlined in the Special Terms and Conditions (STCs).

Population 7: Medicare beneficiaries who are 65 years or older or have a disability with income at or below 150 percent of the FPL, who may be enrolled in the Medicare Savings Program (MSP) but are not otherwise eligible for full benefits.

Population 8: Medicare beneficiaries who are 65 years or older or have a disability with income above 150 percent and up to and including 225 percent of the FPL, who may be enrolled in the MSP, but are not otherwise eligible for full benefits.

BENEFITS

State Plan Benefits

The demonstration provides at a minimum, the benefits and services covered under the title XIX state plan to individuals in populations 1 and 2 and benefits for individuals in population 3 shall

be specified in an approved Alternative Benefit plan under the state plan. All covered services may be subject to medical review and prior approval by DVHA based on medical appropriateness. A complete listing of covered services and limitations are contained in the Vermont approved title XIX state plan, Vermont statutes, regulations, and policies and procedures.

Special programs

Special Program Name	**Services**	**Limitations**
Traumatic Brain Injury (TBI)	HCBS waiver-like services including crisis/support services, psychological and counseling supports, case management, community supports, habilitation, respite care, supported employment, environmental and assistive technology and self-directed care.	Any limitation on this service defined by Vermont rules and policies
Mental Illness Under 22	HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, supported employment, crisis and community supports	Any limitation on this service defined by Vermont rules and policies
Community Rehabilitation and Treatment	HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, supported employment, crisis and community supports	Any limitation on this service defined by Vermont rules and policies
Developmental Disability Services	HCBS waiver-like services, including service coordination, residential habilitation, day habilitation, supported employment, crisis services, clinical intervention, respite and self-directed care	Any limitation on this service defined by Vermont rules and policies

Other Programs

Program Name	Services	Limitations
Palliative Care Program	Care coordination, respite care, expressive therapies, family training, and bereavement counseling	For children under the age of 21 years in populations 1, 2, and 3 who have been diagnosed with a life-limiting illness that is expected to be terminal before adulthood.

Hospice
Vermont will provide hospice services concurrently with curative therapy to adults in populations 1, 2, and 3.

Benefits for expansion populations

Population 4: Benefits as described in the Medicaid state plan and HCBS benefits described in the STCs.

Population 5: Benefits as described in the Medicaid state plan and HCBS benefits described in the STCs.

Population 6: Limited HCBS including Adult Day Services, Case Management, and Homemaker services.

Population 7: Medicaid Prescriptions, eyeglasses and related eye exams; MSP beneficiaries also receive benefits as described in the title XIX state plan.

Population 8: Maintenance Drugs; MSP beneficiaries also receive benefits as described in the title XIX state plan.

DELIVERY SYSTEM

The costs of all Medicaid covered services provided through the Global Commitment to Health demonstration will be covered by DVHA and may be furnished through contracts with providers, through interagency agreements with governmental partners. Contracts with providers may include capitated contracts that meet the requirements of 42 CFR Part 438. In addition, DVHA will, operate on a managed care-like model applying utilization controls and care management. The managed care-like model shall comply with federal regulations at 42 CFR part 438 that would be applicable to a non-risk PIHP, including beneficiary rights and appeal/grievance procedures (unless specifically stated otherwise in the STCs). Requirements under the demonstration shall be documented through an interagency agreement between AHS and DVHA.

COST-SHARING

Premiums and Cost Sharing: Premiums for populations 1, 2, and 3, must be in compliance with Medicaid requirements that are set forth in statute, regulation and policy. Premiums may be charged for this population in accordance with the approved state plan. Cost sharing for populations 1, 2, and 3, must be in compliance with Medicaid requirements that are set forth in statute, regulation and policies. Standard Medicaid exemptions from cost-sharing set forth in 42 CFR 447(b) applies to the demonstration. Detailed cost-sharing and premium requirements for Populations 7 and 8 are included in Attachment G. The state must not apply co-payment requirements to excluded populations (children under age 21, pregnant women or individuals in long-term care facilities) or for excluded services/supplies (e.g., family planning). Premiums for children through age 18 with income above 195 percent of the FPL through 312 percent of the FPL are outlined in Attachment G.

DESIGNATED STATE HEALTH PROGRAMS

The state implemented designated state health programs on January 1, 2014 to provide the following:

- Subsidies for premiums for individuals with incomes at or below 300 percent of the federal poverty level in Marketplace; and

- Community rehabilitation and treatment benefits to individuals with severe and persistent mental illness with incomes between 133 and 150 percent of the federal poverty level.

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