# Managed Care in Vermont

This profile reflects state managed care program information as of August 2014. This profile only includes information on active federal operating authorities, and as such, the program start date may not reflect the earliest date that a program enrolled beneficiaries and provided services. Some states report populations and services available to program participants under the federal authority (e.g. Section 1115 waiver), so these features cannot be easily distinguished for each program.

## Overview of Current Managed Care Programs

In July 2011, nearly 60 percent of Medicaid beneficiaries in Vermont were enrolled in managed care. Vermont first implemented managed care in 1995 through the Vermont Health Access Plan, which enrolled low-income uninsured adults into managed care plans. That same year, the state also introduced a "public managed care" framework to provide behavioral health services for individuals with serious and persistent mental illness as part of the Community Rehabilitation and Treatment program. Building on its experience expanding Medicaid coverage through managed care and operating a public managed care model, Vermont launched the **Global Commitment to Health (GCH) Demonstration program,** also known as Green Mountain Care, in 2005 as part of extensive reforms to the state's health care system. The program uses a public managed care model in which the Vermont Agency for Human Services (AHS), the state Medicaid agency, oversees the state's Department of Vermont Health Access (DVHA), which serves as the state's sole managed care organization. Green Mountain Care is mandatory for most beneficiaries in the state and covers most Medicaid services, except long-term services and supports which are provided on a fee-for-service basis through a separate **Choices for Care** program. DVHA contracts with and pays providers for all Medicaid benefits and has agreements with other state entities to provide specialty care, such as behavioral health services, developmental disability services, and specialized child and family services. In addition, as part of its Care Coordination Program, DVHA contracts with health care teams located in eight geographic districts covering the state, to provide enhanced case management for the highest risk Medicaid beneficiaries. The state also introduced a **Program for All-Inclusive Care for the Elderly (PACE)** in 2007 to cover the full range of Medicare and Medicaid services for individuals over age 55 who meet a nursing home level of care and live in certain regions, but this program was closed in March 2013.

The state sought approval to renew Global Commitment to Health, as well as consolidate Vermont's Choices for Care and the state's Children's Health Insurance Program (CHIP) into the renewed demonstration program, which would streamline program administration, oversight, and reporting, and provide a more seamless system of primary, acute and long term services and supports for beneficiaries with complex needs. The state has also been expanding its **Blueprint for Health** program, which, as of 2013, provides the majority of Medicaid beneficiaries, along with nearly all state residents, access to medical homes with community health teams and additional support services for those with complex conditions.

In April 2014 its formal proposal for the Global Commitment to Health Section 1115(a) demonstration to CMS was approved. The Global Commitment to Health Section 1115(a) Demonstration is designed to use a multi-disciplinary approach. Under the Demonstration the AHS will contract with the Department of Vermont Health Access (DVHA), which will serve as a publicly sponsored managed care service delivery model. This is not managed care.

Vermont operates a unique "managed care" model authorized in their 1115 demonstration. The STCs indicate the state will comply with all 42 CFR 438. (managed Care) Regulations with very few reservations. Functionally, the Agency of Human Services (AHS) is responsible for administering the Medicaid managed care program. AHS has enlisted DVHA (a sub-department) as the managed care entity. Through intergovernmental agreements DVHA "contracts" with other AHS departments to provide admin and service management functions common to a managed care organization but does not provide any direct clinical services on its own. CMS sees the payment process as Fee-For-Service, with the funding flowing through DVAH and AHS to providers that receive funding through "value-based payment methodologies" that encourage quality and cost improvements

## Participating Plans, Plan Selection, and Rate Setting

In Vermont, the state Department of Vermont Health Access serves as the managed care entity, and must adhere to both state and federal Medicaid managed care regulations. The state, therefore, does not contract directly with plans to manage care. AHS pays DVHA a capitated per member per month rate similar to the way other state Medicaid agencies pay managed care organizations. Rates are set prospectively using an actuarial process for the waiver year.

For Medicaid, DVHA will “contract” with two ACOs (OneCare Vermont and Community Health Accountable Care). Green Mountain is a commercial plan that is for Medicare. All three will be a part of a Shared Savings plan with savings generated through the “value-based payment methodologies”.

## Quality and Performance Incentives

The state uses a number of quality metrics, including HEDIS and CAHPS, to assess performance on measures in a number of health care focus areas. The state also requires DVHA to conduct performance improvement projects to increase performance on specific measures, including preventive care and oral health. Through the Care Coordination Program, Vermont makes incentive payments to providers to encourage participation and effective care management.

## Table: Managed Care Program Features, as of July 2011

| Program Name | Vermont Global Commitment to Health | |
|---|---|---|
| **Program Type** | MCO | |
| **Program Start Date** | October 2005 | |
| **Statutory Authorities** | 1115(a) | |
| **Geographic Reach of Program** | Statewide | |
| **Populations Enrolled** *(Exceptions may apply for certain individuals in each group)* | | |
| *Aged* | X | |
| *Disabled Children & Adults* | X | |
| *Children* | X | |
| *Low-Income Adults* | X | |
| *Medicare-Medicaid Eligibles ("duals")* | X | |
| *Foster Care Children* | X | |
| *American Indians/Alaska Natives* | X | |
| **Mandatory or Voluntary enrollment?** | Mandatory | |
| **Medicaid Services Covered in Capitation** (*Specialized services other than those listed may be covered. Services not marked with an X are excluded or "carved out" of the benefit package.)* | | |
| *Inpatient hospital* | X | |
| *Primary Care and Outpatient services* | X | |
| *Pharmacy* | X | |
| *Institutional LTC* | | |
| *Personal Care/HCBS* | X | |
| *Inpatient Behavioral Health Services* | X | |
| *Outpatient Behavioral Health Services* | X | |
| *Dental* | X | |
| *Transportation* | X | |
| **Participating Plans** | 1. Global Commitment to Health operated by the Division of Vermont Health Access (DVHA) | 1. |
| **Uses HEDIS Measures or Similar** | X | |
| **Uses CAHPS Measures or Similar** | X | |
| **State requires MCOs to submit HEDIS or CAHPS data to NCQA** | | |

| Program Name | Vermont Global Commitment to Health | |
|---|---|---|
| **State Requires MCO Accreditation** | | |
| **External Quality Review Organization** | Health Services Advisory Group | |
| **State Publically Releases Quality Reports** | Yes | |

Sources: Centers for Medicare and Medicaid Services (CMS), National Summary of State Medicaid Managed Care Programs as of July 1, 2011.

Kaiser Commission on Medicaid and the Uninsured. Profile of Medicaid Managed Care Programs in 2010. September 2011.

National Committee on Quality Assurance. NCQA Medicaid Managed Care Toolkit 2012 Health Plan Accreditation Standards. State Use of Accreditation as of February 2012.

Notes: Managed Care Organization (MCO); Prepaid Inpatient Health Plans (PIHP); Prepaid Ambulatory Health Plan (PAHP); Mental Health/Substance Use Disorder (MH/SUD); Healthcare Effectiveness Data and Information Set (HEDIS); Consumer Assessment of Healthcare Providers and Systems (CAHPS).

Primary Care and Outpatient Services include physician services, hospice, laboratory, imaging, FQHC, and other specialty services delivered in outpatient offices and clinics. Institutional Long Term Care (LTC) includes Skilled Nursing Facilities (SNF) and/or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDD).

External Quality Review Organization activities are only required for MCOs, PIHPs, PAHPs, and other applicable entities with comprehensive risk contracts.

* According to the PACE Vermont website, the PACE program was closed as of March 31, 2013. See http://www.pacevt.org/.