

State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Quarterly Report
for the period
January 1, 2006 to March 31, 2006

Submitted on
June 2, 2006

Background and Introduction

The Global Commitment to Health is a Demonstration Initiative operated under a Section 1115(a) waiver granted by the Centers for Medicare and Medicaid Services, within the Department of Health and Human Services.

The state of Vermont is a national leader in making affordable health care coverage available to low-income children and adults. Vermont was among the first states to expand coverage for children and pregnant women, through the implementation in 1989 of the state-funded Dr. Dynasaur program. In 1992, Dr. Dynasaur became part of the state-federal Medicaid program.

When the federal government introduced the State Children's Health Insurance Program (SCHIP) in 1997, Vermont extended coverage to uninsured and under-insured children living in households with incomes below 300 percent of the Federal Poverty Level (FPL).

In 1995, Vermont implemented an 1115(a) waiver program, the Vermont Health Access Plan (VHAP). That program's primary goal was to expand access to comprehensive health care coverage for uninsured adults with household incomes below 150 percent (later raised to 185 percent) of FPL, through enrollment in managed care. VHAP also included a prescription drug benefit for low-income Medicare beneficiaries who did not otherwise qualify for Medicaid. Both waiver populations pay a modest premium on a sliding scale based on household income.

The Global Commitment converts the Office of Vermont Health Access (OVHA), the state's Medicaid organization, to a public Managed Care Organization (MCO). AHS will pay the MCO a lump sum premium payment for the provision of all Medicaid services in the state (with the exception of the Long-Term Care Waiver, managed separately).

The Global Commitment provides the state with the ability to be more flexible in the way it uses its Medicaid resources. Examples of this flexibility include new payment mechanisms (e.g., case rates, capitation, combined funding streams) rather than fee-for-service, to pay for services not traditionally reimbursable through Medicaid (e.g., pediatric psychiatric consultation) and investments in programmatic innovations (e.g., the Vermont Blueprint for Health). The managed care model will also encourage inter-departmental collaboration and consistency across programs.

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit progress reports 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas." This is the second quarterly report for the new waiver, covering the period from January 1, 2006 to March 31, 2006.

- a) Events occurring during the quarter, or anticipated to occur in the near future, that affect health care delivery, enrollment, quality of care, and access that are relevant to the Demonstration, the benefit package, and other operational issues.**

Staffing Changes

Susan Besio, who has been the AHS lead for the demonstration, has been appointed as Director of Health Care Reform Implementation within the Agency of Administration, effective June 5, 2006. Given the close relationship between the new Health Care Reform Initiative (see description below) and the Global Commitment to Health Demonstration, Susan will continue to be closely involved with the demonstration.

The new demonstration project lead for AHS will be Suzanne Santarcangelo, Ph.D. who will start on June 5, 2006 as Principal Assistant to the AHS Secretary's Office. Suzanne has over 20 years of experience in the human services arena and a long history with AHS. She has served as Deputy Commissioner for DDMHS, Director of the Juvenile Justice Commission, Principal Assistant to the Secretary's office from 2004-2005, and she currently serves as Director of Policy Development for the Department of Corrections.

In addition, Shawn Skaflestad, Ph.D. has accepted the position of AHS Quality Improvement Manager, effective August 1, 2006. Shawn has extensive experience in quality improvement in both hospital and community health care settings. He will have primary responsibility for several aspects of the demonstration, including revising and implementing the five-year evaluation plan; developing and implementing a quality assessment and performance improvement plan for Medicaid services; and managing the external contracts for external quality review activities on quality, timeliness, and access to health care services for Medicaid recipients statewide.

MCO Requirements

OVHA has made significant progress toward implementing the MCO requirements under 42 CFR section 438 (see Attachment A for detailed work plan).

Benefit Changes

During the period from January 1 to March 31, 2006, a significant amount of time and effort was directed towards addressing the implementation issues that have arisen with the pharmacy changes under the Medicare Modernization Act. Within 48 hours after implementation of the federal program, Vermont recognized the need to re-instate the state program to ensure that beneficiaries received their medications in a timely manner. Because of the operational complexity of this program, OVHA staff and others within AHS have needed to spend significant amounts of time on this program, delaying work on some of the

operational issues identified in the MCO work plan. The delayed timeframes are reflected on the work plan in Attachment A.

No other benefit changes have occurred since implementation of the waiver. However, as reported in the first quarterly report, the Administration submitted a request in February to the Vermont Legislature for consideration of participation in the CMS demonstration project regarding chiropractic care. In response, the legislature included language in the FY07 Budget Act requiring OVHA to review all available literature and clinical findings related to chiropractic treatment that demonstrate positive clinical outcomes and lower overall treatment costs, and then make a recommendation to the general assembly for the reinstatement of chiropractic services under the Medicaid program during the fiscal year 2008 budget Submission (section 107c).

The FY07 Budget Act and the Health Care Reform Act contain multiple other changes affecting cost-sharing amounts, eligibility and benefits. These will be summarized for the 3rd quarter report (the quarter immediately proceeding July 1, 2006, the date when the bills take effect).

Financial Administration

Consistent with 42 CFR section 438, in December 2005 Vermont submitted the actuarial certification report prepared by Milliman Consultants and Actuaries, Inc. to CMS for review. Vermont has not yet received formal feedback from CMS on the methodology used by the actuarial firm for the SFY2006 rates. Therefore, we must assume that the methodology is acceptable by CMS, and have extended the contract with Milliman Consultants and Actuaries, Inc. to develop the SFY2007 rates using the same methodology.

Proposed Health Care Legislation

The 2006 Vermont Legislative session ended in mid-May, 2006. As reported in the first quarter report, health care reform was a major topic of debate during the session, with competing and somewhat conflicting proposals by the House, Senate and the Governor. However, shortly before final adjournment, an agreement was reached by all parties, and on May 25, 2006, the Governor signed into law H.861 and H.895- jointly referred to as the Vermont Health Care Affordability Act. The pair of laws will create Catamount Health, a health coverage program for Vermont's uninsured which will be offered by private insurance companies beginning in October, 2007, and authorizes implementation (with CMS approval) of an employer-sponsored insurance (ESI) program. The Act also promotes changes in treatment and management of chronic disease and access to immunizations, regardless of insurance coverage. Funding for the new health coverage and benefits is generated through a requirement that employers pay an assessment for employees that do not have access to health coverage and increased taxes on tobacco products. (A more detailed summary of the Act is in Attachment B).

Because these Bills have just been signed into law, we are still analyzing their impact on the Global Commitment to Health Waiver. We will submit a summary analysis to CMS with or before submission of the Third Quarter Report. Needless to say, however, these Bill will have a major impact on the health care system in Vermont.

Health plan financial performance, including capitated revenue expenditures.

The state and CMS collaborated to develop reporting formats and supplemental documentation for the quarterly CMS-64 reports, as well as other financial reports required by the Demonstration's Special Terms and Conditions. We have submitted our CMS-64 report for the 1st quarter of the demonstration using the agreed-upon format. We are waiting for CMS to provide access to the CMS 64 reporting system in order to electronically file the 2nd quarter report.

b) Action plans for addressing any policy and administrative issues identified.

See OVHA Work Plan (Attachment A). We also will include analyses of the policy and administrative issues related to the new Health Care Bill to CMS with or before submission of the Third Quarter Report.

c) State efforts related to the collection and verification of encounter data.

The State is initiating several different mechanisms to verify encounter data. First, the Medicaid Surveillance and Utilization Review System (SURS) Team within OVHA is charged with reviewing high utilization of Medicaid services by individuals and/or providers. This includes routine claims evaluation activities to identify unusual patterns in billing activity; routine provider performance review activities to identify administrative claims errors, misuse, and/or abuse; routine beneficiary reviews to identify overuse, underuse, and/or aberrant behavior; ad hoc provider specific auditing; ad hoc beneficiary specific utilization auditing; and annual reporting of findings and recommendations. A new Fraud Abuse Detection Decision-Support System (FADS) that interfaces with the EDS claims system to provide electronic data reports to the SURS Team for their analytical use is now fully operational.

Secondly, we have issued a Request for Information (RFI) for an on-line decision support system to be used by the new Care Coordination Team within OVHA that will also support verification of encounter data.

In addition, AHS is developing the Coverage and Service Management Enhancement (CSME) Data Warehouse, a new tool bringing together substantial amounts of AHS data into a central "data warehouse" and making it available for decision-making and analytic purposes. For the first time, CSME will provide AHS with an unduplicated, aggregate view

of AHS individuals served and benefits received by department, program and region to better understand and manage service provision. CSME data are structured to answer questions across departments for policy, planning, legislative and program review. The tool is also designed to maximize statistical analysis and longitudinal studies to find patterns of behavior and trends.

CSME is in the final development phase, and is expected to be ready for implementation by fall, 2006. Outstanding work includes: performance improvement; data validity testing; new data source addition; migrating to Business Objects® XI; and new system installation.

d) Enrollment data, member month data and budget neutrality monitoring tables

The state and CMS currently are collaborating with regard to development of budget neutrality monitoring formats. We anticipate that reporting procedures and formats will be finalized within the next 60 days.

Enrollment and member month data are in section e) below.

e) Demonstration program average monthly enrollment for each of the following eligibility groups:¹

- a. Mandatory State Plan Adults**
- b. Mandatory State Plan Children**
- c. Optional State Plan Adults**
- d. Optional State Plan Children**
- e. VHAP Expansion Adults**
- f. Pharmacy Program Beneficiaries (non-Duals)**
- g. Other Waiver Expansion Adults**

Population	Age Limit	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06
Optional	Under 21	41,205	40,907	40,838	40,842	41,646	41,727
Optional	21 and Over	15,183	15,298	15,257	15,530	15,587	15,574
Mandatory	Thru 18	14,871	14,963	14,954	15,000	14,780	14,800
Mandatory	Over 18	23,111	23,207	23,244	23,307	23,237	23,300
VHAP/Underinsured	Thru 18	1,672	1,644	1,650	1,478	1,433	1,442
VHAP/Underinsured	Over 18	20,723	20,750	20,637	20,573	21,284	21,329
Pharmacy Only/HVP	All	25,556	26,073	26,439	25,718	25,776	26,213
SCHIP	All	3,187	3,250	3,294	3,252	2,977	3,006
QI1					10	39	52
TOTAL		145,508	146,092	146,313	145,710	146,759	147,443

¹ Note: CMS and AHS have agreed that the eligibility groups should be reported as identified in the table rather than in the initial Special Terms and Conditions.

f) State's progress toward the Demonstration goals.

The Global Commitment to Health Waiver has the following goals:

1. Promote access to health care
2. Improve quality of care
3. Improve health care outcomes
4. Contain health-care costs

The State also intends to rely on the flexibility granted by the waiver to form public-private partnerships in order to facilitate the goals listed above.

Obviously, the new Health Care Reform Bills will have a significant impact on our progress in meeting the Global Commitment to Health Demonstration goals. The Health Care Reform Act requires substantial monitoring towards its goals and this monitoring will be closely coordinated with the monitoring of progress towards the Global Commitment goals.

g) State's evaluation activities.

The State submitted a Draft Evaluation Plan to CMS on February 16, 2006. As noted in the correspondence accompanying the draft plan, we will want to refine the evaluation plan once we have filled the new AHS Quality Improvement Manager Position, which will occur on August 1, 2006. In addition, as noted above, the demonstration evaluation will need to be closely coordinated with the monitoring activities regarding progress towards the goals of the new Health Care Reform Act. In the meantime, the preliminary draft evaluation plan provides a starting point for ensuring that we are planning in the right direction.

Attachment A

MCO Work Plan

(revised May 26, 2006)

AREA/ DESCRIPTION	TASKS	TIMELINE
MEMBER SERVICES		
Interpreter Services		
<i>Oral interpreter services must be provided free of charge to non-English speaking enrollees who request assistance. [438.10(c)(4)]</i>	Arrange for vendor to provide services as needed	Completed
Provider Directory		
<i>A directory must be compiled and maintained. The directory must list the name, location and telephone numbers for all primary care and specialist providers and hospitals participating in the Medicaid program. The directory must also identify any languages other than English spoken by the provider and must include an indicator to identify those who are accepting new patients. [438.10(e)(2)(ii)(D)]</i>	Develop web-based directory with ability to search by address, provider type, etc.	On-line directory is available and being used by Maximus to assist enrollees and providers for updates; will be available on-line to enrollees by August
	Survey providers on language capacity and open panel issues	Survey completed; used to populate new on-line directory
	Develop process for periodic updates	web-based format allows for immediate updates
Notification of Terminating Providers		
<i>OVHA must notify an enrollee whose PCP terminates their participation in Medicaid within 15 days of the provider's notice to the state. Enrollees who are regularly seeing a provider who is not their PCP must also be similarly noticed. [438.10(f)(5)]</i>	Develop process for identification of terminating providers	An existing requirement of provider enrollment agreement
	Draft notice to enrollees	3rd Quarter, FFY'06
	Identify process for determining which enrollees have been "regularly treated" by any terminating provider	3rd Quarter, FFY'06
	Print and mail notices within 15 days to affected enrollees	3rd Quarter, FFY'06
Enrollee Handbook		
<i>Develop and maintain a current enrollee handbook which covers 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 distributed to new enrollees within 45 days of enrollment. Handbooks must be available in languages other than English if five (5) percent or more of Demonstration enrollees speak that language. [438.10]</i>	Assess need for languages other than English (documentation for CMS)	Completed for PCP and CRT enrollees; available for all enrollees by September, 2006
	Draft handbook	
	Disseminate for input, finalize based on comments received	
	Print a supply for initial distribution	
	Develop and execute handbook distribution process on an ongoing basis	
Post handbook on website		
Advance Directives		
<i>OVHA must prepare and make available information on Advance Directives. [438.6(h)(2)(i)]</i>	Identify materials related to new 2005 state statute regarding Advance Directives	Link to new statewide information on OVHA web-page; Providers have been notified of link
	Obtain a supply of forms for distribution upon request	
	Post information on website	
	Draft informational notice on Advance Directives and distribute for posting in physicians' offices (EDS Newsletter)	

Member Helpline		
<i>OVHA must maintain a toll-free member hotline during normal business hours to answer enrollee inquiries and to accept verbal grievances or appeals. [438.406(a)(1)]</i>		Completed
GRIEVANCES & APPEALS		
Notice of Adverse Action		
<i>OVHA must provide a written Notice of Adverse Action to each enrollee and their requesting provider of any decision to deny a services authorization request or to authorize a service in an amount, duration or scope that is less than requested. The notice must be sent within 14 days of the receipt of the request for services, unless that timeframe might, in the opinion of the requesting provider, seriously jeopardize the enrollee's health. In the latter event, the notice must be sent within three (3) business days of the request. [438.210I]</i>	Develop one Agency Policy for all GC enrollees	New policy drafted; finalized and approved by CMS
	Change administrative rules to reflect new policy	Rule-making process to begin August, 2006
	Draft notice to include appeal rights, information on the continuation of benefits, and how to request an expedited appeal	New policy implemented Spring, 2007
	Develop policies and procedures for processing requests	
	Design notice inserts that describe the various reasons for the denial or reduction in services (e.g., not medically necessary, not a covered service, etc)	
Acknowledgement of Appeal		
<i>Grievances and appeals must be acknowledged in writing (typical standard is within five business days).</i>	Develop notices	New policy implemented Spring, 2007
	Develop policies and procedures for ensuring notices are sent timely	
	Develop process and assign staff to assist enrollees in filing grievances and appeals	
	Assign staff to receive, date stamp and log in all grievances and appeals	
Resolution of Grievances and Appeals		
<i>OVHA must have a formal process for resolving all grievances and appeals. Providers must be permitted to file grievances or appeals on behalf of their patients if so requested. The following definitions apply: An Action means – 1) The denial or limited authorization of a requested service, including the type or level of services; 2) The reduction, suspension or termination of a previously authorized service; 3) The denial, in whole or in part, of payment for a service; 4) The failure to provide services in a timely manner (as defined by the state); 5) 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) [438.400(b)]. Resolution Timeframes: Standard Grievance – 45 days from date of receipt ([438.408(b)(1)] =90days); Standard Appeal – 45 days from date of receipt [438.408(b)(2)]; Expedited Appeal – Three (3) business days from date of receipt [438.408(b)(3)]</i>	Develop policies and procedures for the receipt, acknowledgement and resolution of grievances and appeals	New policy implemented Spring, 2007
	Develop a system for logging and tracking grievances and appeals (type, days to resolution, outcome)	
	Develop a system for automated reporting on grievances and appeals	
	Assign staff to process all grievances and appeals	
	Design resolution notices	

Fair Hearings		
<p><i>OVHA must ensure that 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. [438.408(f)]. AHS, as the oversight entity, must ensure that the fair hearing is conducted in accordance with all applicable state and federal regulations including timeframes for the conduct of the hearing and the enrollee's due process rights.</i></p>	<p>Develop policies and procedures for coordinating between the Grievance and Appeals process and the state Fair Hearing process</p>	<p>New policy implemented Spring, 2007</p>
	<p>Develop a system for notifying enrollees at the time of the resolution of their grievance or appeal of their right to a fair hearing</p>	
	<p>Develop reporting system to track number, types, timeliness and resolution of fair hearings</p>	
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI)		
QAPI Plan		
<p><i>AHS must develop a strategy and plan which incorporates procedures that: 1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees, including those with special health care needs [438.204(b)(1)]; 2) Identify the race, ethnicity and primary language spoken by each Demonstration enrollee [438.204(b)(2)]; 3) Provide for an annual, external independent review of the quality outcomes and timeliness of, and access to, the covered services under the Demonstration [438.204(d)]</i></p>	<p>1) Develop inventory of all QA/QI activities currently underway within OVHA and sub-contracted departments; Develop workgroup to identify new priorities; Summarize into comprehensive QAPI Plan for CMS review</p>	<p>4th Quarter , FFY06</p>
	<p>2) Ensure that information is available in ACCESS eligibly system</p>	<p>June, 2006</p>
	<p>3) Expand EQRO focus beyond CRT program</p>	<p>4th Quarter, FFY06</p>
Source of Primary Care		
<p><i>OVHA must ensure that each Demonstration enrollee has an ongoing source of primary care. [438.208(b)(1)] It must further implement mechanisms to identify persons with special health care needs. [438.208(b)(4)(c)] The quality strategy must specify these mechanisms. [438.208(b)(4)(c)(i)]</i></p>	<p>Identification of new beneficiaries not already participating through PCPLus</p>	<p>3rd Quarter, FFY'06</p>
	<p>Develop policies and procedures for the selection of a PCP by each Demonstration enrollee</p>	
	<p>Design information system capacity to capture the PCP information for each enrollee</p>	
	<p>Develop a mechanism for tracking PCP caseload</p>	
Practice Guidelines		
<p><i>OVHA must adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field, and which are adopted in consultation with contracting health care professionals. [438.236(b)]</i></p>	<p>Establish a medical advisory task force of contracting professionals to provide consultation on the guidelines to be adopted for physical health issues</p>	<p>Completed</p>
	<p>Select key areas where guidelines are to be developed</p>	<p>Completed</p>
	<p>Research evidence-based guidelines and protocols for each of the key areas</p>	<p>Completed</p>
	<p>Adopt the appropriate guidelines after consultation with the task force</p>	<p>Completed for existing guidelines; on-going identification of new national practice guidelines</p>
	<p>Distribute guidelines to appropriate network providers</p>	<p>Completed</p>

Measuring Performance Improvement		
<p><i>AHS must operate its QAPI program on an ongoing basis and conduct performance improvement projects designed to achieve, through ongoing measurement and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Procedures must be in place to collect and use performance measurement data and to detect both under- and over-utilization of services. Mechanisms must also be in place to assess the quality and appropriateness of care furnished to enrollees with special health care needs. [438.240(a), (b), (c), & (d)]</i></p>	Develop inventory of all QA/QI activities currently underway within OVHA and sub-contracted departments;	4 th Quarter , FFY06
	Develop workgroup to identify new priorities;	
	Summarize into comprehensive QAPI Plan for CMS review	
PROGRAM INTEGRITY		
Actuarial Certification of Capitation Rates		
<p><i>AHS must provide CMS with an actuarial certification of the capitation rates that will be used as the basis of payment of Medicaid funds to the health plan. The rates must be certified by an actuary who meets the standards established by the American Academy of Actuaries. [438.6(c)(4)(i)]</i></p>	Develop database for actuaries	In process for Year 2 rates
	Establish capitation rates by MEG	
	Obtain written certification from qualified actuary	
	Submit rates to CMS	
Compliance Plan		
<p><i>OVHA must also have administrative and management arrangements and/or procedures, including a mandatory compliance plan, that is designed to guard against fraud and abuse. This includes written policies, procedures and standards of conduct. A compliance officer must be designated and a compliance committee formed that is accountable to senior management. An effective training and education program must be developed and implemented for the compliance officer and other VHAP employees. [438.608(a) & (b)]</i></p>	Appoint compliance officer	Completed with ongoing activities through new SURS and FADS
	Develop written compliance plan	
	Develop policies and procedures for program integrity	
	Develop written standards of conduct	
	Design staff training program	
	Conduct staff training	
MONITORING		
Utilization		
<p><i>OVHA must monitor the program to identify potential areas of over- and under-utilization. Where such over- or under-utilization is identified, OVHA shall develop a Corrective Action Plan (CAP) for review by the AHS. [438.240(b)(3)]</i></p>	Develop an overall utilization management plan for the Demonstration	Completed with ongoing activities through new SURS and FADS
	Identify key areas for monitoring (e.g., inpatient days, emergency visits, etc)	
	Establish thresholds for evaluating potentially inappropriately high or low levels of utilization by MEG	
Provider and Enrollee Characteristics		
<p><i>OVHA's health information system must track certain characteristics of its network providers and enrollees (e.g., enrollees with special health care needs; providers with accommodations for the disabled in their offices) [438.242]</i></p>	Ensure that ACCESS and/or other systems capture required enrollee characteristics	3rd Quarter, FFY'06
	Ensure that Provider survey captures required information and is in on-line directory	

Enrollee Rights		
<i>Establish policies and procedures on enrollee rights consistent with the requirements of Part 438.100 of 42 CFR.</i>	Expand existing PCP and CRT policies and procedures	Completed for PCP and CRT enrollees; available through enrollee handbook for all enrollees by September, 2006
Encounter Data Validation		
<i>OVHA must put in place a process for validating encounter data and for reporting information on encounters/ claims by category of service. [438.242]</i>	Expand existing processes to include sub-contracted departments.	Completed
	Implement new Fraud and Abuse Detection Decision Support System (FADS)	
ENROLLEE ACCESS & PROVIDER NETWORK		
Availability of Services		
<i>OVHA must ensure that an adequate network of providers to provide access to all covered services is under contract to the state. This includes an assessment of geographic location of providers, considering distance and travel time, the means of transportation ordinarily used by Medicaid enrollees and whether the location provides for physical access for enrollees with disabilities. The assessment must also consider the number of network providers who are NOT accepting new Medicaid patients. OVHA must also ensure that network providers offer hours of operation that are no less than those offered to other patients. OVHA must also subcontract with other selected AHS departments that will provide services to Demonstration enrollees. [438.206]</i>	Conduct geo-access analysis of current network	September, 2006 and on-going
	Identify any existing gaps	
	Recruit additional providers as needed	
	Develop process and procedures for provider site visits if warranted	
	Develop ongoing monitoring plan for the provider network	Survey completed; information available in on-line provider directory
	Design process for collecting info on providers with closed panels (no new patients accepted) and those with access/accommodations for the physically disabled	
Develop contracts (IGAs) with other departments	Finalized in June 2006	
CMS REPORTING		
General Financial Requirements		
<i>AHS/OVHA shall comply with all general financial requirements under Title XIX. AHS must maintain financial records, including the following: 1) Monthly comparisons of projected vs actual expenditures; 2) Monthly report of OVHA revenues and expenses for Demonstration program; 3) Monthly comparisons of projected vs actual caseload, 4) Quarterly analysis of expenditures by service type; 5) Monthly financial statements; 6) All reports and data necessary to support waiver reporting requirements [IGA 2.12.2]</i>	Document any modifications to current report formats that will be required	On-going
	Assign staff responsible for the production and submission of the required reports	Completed
Budget Neutrality Reporting		
<i>For the purpose of monitoring budget neutrality, within 60 days after the end of each quarter, the state shall provide to CMS a report identifying actual expenditures under the Demonstration. [STC pg. 20]</i>	Obtain report format from CMS	Still under discussion
	Make any necessary changes to reporting processes and procedures to accommodate the CMS-specified report formats	Still under discussion
	Assign staff responsible for the production of the reports	Completed
	Develop policies and procedures for the development of corrective action plans if actual expenditures exceed the levels permissible under the Demonstration STCs (by year)	Under development

Attachment B

Summary of Health Care Affordability Act

SUMMARY OF H.861 AN ACT RELATING TO HEALTH CARE AFFORDABILITY FOR VERMONTERS

Purpose and Intent

- All Vermonters should receive affordable and appropriate health care.
- Health care costs must be contained over time.
Strategies:
 - Prevention and management of chronic conditions
 - Coverage of uninsured through Catamount Health
 - Minimum prevention services starting with immunizations for everyone
- Reduction in cost shift to private insurance should be returned to consumers by slowing the rate of growth of health care premiums.

Health Care System Reform

The Secretary of Administration will coordinate agencies, departments, and offices in implementing health care system reform, including the chronic care program through the Blueprint for Health, various health care technology projects, Medicaid and other publicly funded health care programs, employer-sponsored insurance, Catamount Health, and uniform hospital uncompensated care policies. The Secretary will provide a five-year strategic plan by 12/1/06 and will report monthly to the new Joint Legislative Commission on Health Care Reform and to various other legislative committees and commissions on an annual basis beginning 1/1/07 on progress on reform initiatives.

Prevention and Chronic Care Management

The Secretary of Administration and Commissioner of Health will develop and implement a Blueprint for Health, including a five-year strategic plan, for a statewide system of chronic care and prevention. Statewide participation in the new system of care will be achieved no later than 1/1/09.

The Secretary of Administration will create a chronic care management program, which shall be administered by a private entity, for people on Medicaid, VHAP, or Dr. Dynasaur, and who have one or more chronic conditions. The program will include a process for coordinating care and increasing communication among health care professionals, educational and clinical management protocols, process and outcome measures, payment methodologies that create incentives and rewards for professionals, penalties to the care management organization if it does not reduce costs to the state, and a requirement that data on enrollees be shared. The contract for the chronic care program will be awarded through an RFP process.

No later than 1/1/07, AHS will develop an implementation plan for prevention of chronic conditions and for chronic care management. The Commissioner of Human Resources will consider chronic care management programs in any RFP process for state employees' health care plans, and determine how and when to align the state employees' benefit plans with the Blueprint for Health.

Medicaid Reimbursement

OVHA will raise Medicaid reimbursement rates over time according to priorities set forth in the bill. After 2007, increases in rates will be tied to standards and quality or performance measures included in the Blueprint for Health.

VHAP and Dr. Dynasaur Premium Reductions

As of 7/1/07, VHAP and Dr. Dynasaur premiums will be significantly reduced. VHAP premiums will be reduced by approximately a third, and Dr. D. premiums by half.

Employer-Sponsored Insurance

On 10/1/07, subject to CMS approval, AHS will establish a premium assistance program for people on VHAP and uninsured people with incomes under 300% of the federal poverty level. AHS must determine whether to include children on Dr. Dynasaur. AHS shall not mandate participation of children in employer-sponsored insurance.

For people on VHAP who have access to employer-sponsored insurance, the Agency will subsidize the premiums or cost-sharing so the individual is not paying more than the VHAP premium amount. The premium assistance program will also provide supplemental benefit coverage equivalent to the benefits of VHAP.

AHS will consult with BISHCA to develop criteria for approving employer-sponsored health care plans to ensure the plans provide comprehensive and affordable health insurance when combined with the premium assistance program.

If AHS determines it is cost-effective for someone to enroll in employer-sponsored insurance, the person will be required to enroll as a condition of continued assistance under VHAP.

Uninsured individuals who have not had private insurance within 12 months of application (with certain exceptions) may also qualify for the premium assistance program if they have income under 300% of FPL. Individuals in Catamount Health will be required to enroll in employer-sponsored insurance, instead of Catamount Health, if AHS determines it is cost-effective.

The Emergency Board will suspend enrollment in this program if appropriated funds are insufficient to meet demand.

Catamount Health

Catamount Health is a plan for coverage of primary care, preventive care, chronic care, acute episodic care, and hospital services through a health insurance policy, a nonprofit hospital or medical service corporation service contract, or a health maintenance organization subscriber contract. The plan will be available to uninsured individuals (individuals not qualifying for Medicare, Medicaid, VHAP, or Dr. Dynasaur and who have not had private insurance during the 12 months prior to application, with some exceptions).

The benefits for Catamount Health will be a preferred provider organization plan with deductibles, co-insurance, and out-of-pocket maximums defined in the bill.

Catamount Health will reimburse providers at the rate of 110% of the Medicare reimbursement levels in 2006.

Catamount Health will be considered an individual health insurance plan, health benefit plan, health insurance contract, and health insurance policy for purposes of Vermont law.

Catamount Health shall not be sold prior to 10/1/07.

Insurers and carriers in the private market will be given the opportunity to offer Catamount Health with the assumption of risk. If no insurers or carriers elect to offer Catamount Health, insurers and carriers will be required to provide Catamount Health. On 10/1/09 the commission on health care reform will evaluate whether the market is a cost-effective way of providing coverage; if not, the Agency of Administration will issue an RFP for the administration of Catamount Health, with the state assuming the risk.

Catamount Health Assistance Program

AHS will subsidize Catamount Health premiums for individuals with income under 300% of FPL. Individuals with income over 300% will pay the actual cost of Catamount Health coverage.

The Emergency Board will suspend enrollment in this program if appropriated funds are insufficient to meet demand.

Catamount Fund

The Catamount fund is established as a special fund in the treasury. Going into the fund are revenue from employer health care premium contributions, a percentage of the cigarette tax, premiums paid by Catamount enrollees, and other grants and contributions.

Joint Legislative Commission on Health Care Reform

This commission is established and membership is defined in the law. The commission will monitor the development, implementation, and ongoing operation of health care reform initiatives. The commission will have other roles as well, such as determining strategies for extending universal coverage and reducing the cost of health insurance.

Immunizations

The Secretary of Administration shall study methods to ensure that all Vermonters have access to immunizations through Catamount Health.

Cost Shift Task Force

The bill assumes that decreasing the number of uninsured people in Vermont, increasing Medicaid reimbursement rates, and providing preventive services through Catamount Health will reduce the cost shift. BISHCA will convene a task force to ensure that reductions in the cost shift will be reflected in a reduction or slower rate of growth in hospital and provider charges and in private health insurance premiums. The task force will make recommendations no later than 12/1/06.

Nongroup Market Security Trust

BISHCA will establish the nongroup security trust for the purpose of lowering the cost of, and thereby increasing access to, health care coverage in the individual or nongroup health insurance market.

Hospital Uncompensated Care

BISHCA shall review the uncompensated care and bad debt policies of Vermont's hospitals and recommend a standard statewide policy.

Employers' Health Care Premium Contribution

Beginning 4/1/07 employers will have to pay a quarterly health care premium contribution for full-time employees who are not covered by an insurance plan. Revenues generated go into the Catamount fund. The Dept. of Labor will assess and collect these payments.

Healthy Lifestyle Discounts

Insurance carriers will be permitted to offer discounts or financial rewards for individuals who adhere to health promotion and disease prevention programs.