State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Quarterly Report
for the period
October 1, 2006 – December 31, 2006

Submitted Via Email on
February 20, 2007

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 pyschiatric 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 first quarterly report for the second waiver year, covering the period from October 1, 2006 to December 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

Ira Sollace, AHS Chief Fiscal Officer has accepted another position within AHS. He will remain the fiscal contact for Global Commitment activities until replacements for his and the MCO Financial Administrator positions are hired and trained.

MCO Requirements

All work plan activities are progressing; several areas of work were completed in the 1st quarter. OVHA and AHS continue to focus on ensuring requirements under 42 CFR sections 438. See Attachment A for updated work plan timelines and list of task completions through December 31, 2006.

Benefit Changes

The Vermont FY07 Budget Act and the Vermont Health Care Affordability Act contain changes regarding cost-sharing amounts, eligibility and benefits including, *VHAP-Employer Sponsored Insurance; Employer Sponsored Insurance Premium Assistance Program; Catamount Health Assistance Program*; *Revised Premium, Recertification & VHAP eligibility requirements*; and a *Chronic Care Management Program.*

Vermont submitted a waiver amendment request to CMS on September 11, 2006 to operate those initiatives that require CMS approval within the framework of our approved Global Commitment to Health 1115(a) Demonstration. We will manage the program within the existing financial terms and conditions, so the request is for programmatic approval. This request is an integral piece of a much larger Health Care Reform plan and critical to our state legislative and budgeting process.

An initial meeting with CMS Regional staff was held Nov 1st and 2nd. A Supplemental Information packet of information and clarification was forwarded to CMS (Boston and Baltimore Offices) on December 15th. We are planning a January 2007 face to face meeting to continue discussions with CMS regarding our request and how we might expedite its consideration and approval.

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 received feedback from CMS that the methodology used by the actuarial firm is acceptable. The contract with Milliman Consultants and Actuaries, Inc. has been extended to develop the SFY2007 rates using the same methodology. 2007 rates are still under development, it is expected that final rate ranges will be available late February of 2007.

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 reports using the formatting changes provided by CMS. Vermont remains flexible as we work through this process with CMS and reporting formats are finalized.

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

See OVHA/MCO Work Plan (Attachment A)

AHS-wide cross departmental operations teams have been meeting in the four core areas as identified last quarter (policy, operations, fiscal and quality improvement). In the operations area, criteria have been developed for the review of AHS requests for expansion of existing programs or new requests for Medicaid program support (see Attachment B).

AHS Deputies and Directors are in the process of identifying and reviewing opportunities for programmatic flexibilities within existing budgeted resources. These include the integration of administrative structures for programs serving the same or similar populations, and opportunities to increase access to services by decreasing administrative burdens created by programs operating, (pre-waiver), under separate AHS administrative and Medicaid reimbursement structures. Conceptual projects identified to date are included in the chart below.

Project Title	**Proposal in brief**	**Status**
Early Childhood "3 programs into 1" Project & Supportive Child Care	A streamlined administrative structure and unified plans of care for AHS programs delivering early childhood services.	Actively being pursued. Work began as part of AHS reorganization and may be enhanced by flexibilities afforded under global commitment wavier structure.
Children's Personal Care Services	Offering eligible families choice to receive traditional or flexible benefit package	Under Review
Unified Service Plans	Unifying service plans for individuals who receive high tech, developmental services and personal care services	Actively being pursued
Jump on Board for Success (MH services for target youth in order to increase stability of jobs, home and health status)	Capitated Performance Based Contract Option to replace fee for service billing.	Actively being pursued
Runaway and Homeless Youth (MH services for target youth in order to stabilize crisis and health status, reunify families and counsel youth)	Capitated Performance based Contract Option to replace fee for service billing.	Under Review

In addition to looking at AHS programming and opportunities under the waiver, this group continues to be responsible for ensuring that necessary changes in internal operations occur related to the OVHA/MCO work plan (Attachment A), IGA commitments and other relevant state and federal regulations.

During this quarter, the Quality Assurance/Performance Improvement Committee spent time reviewing Federal Quality Assessment and Performance Improvement Standards, outlining a draft Quality Framework, and reviewing current AHS-wide Performance Measures and Performance Improvement Projects. The AHS Quality Framework will draw its structure from the CMS HCBS Quality Framework, the Institute Of Medicine domains of quality (i.e., effectiveness, efficiency, equity, patient centeredness, safety, and timeliness) and Donabedian's aspects of care (i.e., structure, process, and outcome). During this quarter, the AHS also worked with OVHA and its sub-contracted departments/divisions to continue to inventory current Performance Measures and Performance Improvement activities. This inventory is expected to be complete in the second quarter of FFY07.

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

OVHA continues assembling the Program Integrity Unit to bring together the Medicaid Surveillance and Utilization Review System (SURS) Team, the Fraud Abuse Detection Decision-Support System (FADS) reporting, overall OVHA and AHS utilization review and investigative functions.

The Request for Proposals to implement two pivotal initiatives; the Chronic Care Management Intervention Services and the Health Risk Assessment Administration was released on October 5, 2006. We received 19 letters of intent to bid, and 30 individuals attended the bidders' conference on November 9. 11 proposals were received by the December bid deadline. All Vendors provided proposals including a decision support system. Once a final vendor is selected OVHA will be utilizing the system in its related care coordination projects.

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

No change has occurred this quarter. The state and CMS currently are collaborating with regard to development of budget neutrality monitoring formats. Enrollment and member month data are in section e) below.

d) Demonstration program average monthly enrollment for each of the following eligibility groups:[1]

a. Mandatory State Plan Adults

b. Mandatory State Plan Children

[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.

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-06	Nov-06	Dec-06
Optional	Under 21	41,180	40,685	40,256
Optional	21 and Over	16,974	16,691	16,464
Mandatory	Thru 18	15,078	15,140	15,112
Mandatory	Over 18	23,981	23,954	23,963
VHAP/Underinsured	Thru 18	1,550	1,552	1,523
VHAP/Underinsured	Over 18	22,196	22,124	21,958
Pharmacy Only/HVP	All	22,030	22,160	22,378
SCHIP	All	3,283	3,301	3,240
TOTAL		146,272	145,607	144,894

e) State's progress toward the Demonstration goals.

External Quality Review: The AHS finalized modifications to the External Quality Review Organization (EQRO) grant agreement. Beginning January 2, 2007, Cathleen Gent within the AHS quality improvement unit will assume the management responsibilities of the EQRO contract. As a final step, the original grant agreement and approved modifications will be submitted to CMS. Also during this quarter, the EQRO submitted their annual technical report to AHS for review. This report will be examined by AHS and forwarded to OVHA for their comment. Finally, a quarterly update meeting with AHS and the EQRO has been scheduled to ensure that grant agreement deliverables remain on track.

f) State's evaluation activities.

During this quarter, AHS staff and the Director of Evaluative Sciences from the Vermont Program for Quality in Health Care worked to modify the evaluation framework for the GC waiver. Activities included work in drafting a formative and summative evaluation plan, developing a timeline, identifying goals, objectives, hypotheses, and performance measures and targets, determining the method, procedures, and instruments, as well as, identifying the data analysis plans and report writing requirements. Also during this quarter, AHS examined CMS approved waiver evaluation plans from other states and obtained technical assistance re: general information on evaluations, the broader context of evaluations in terms of CMS policies, general guidelines for evaluations, the relationships between evaluations of demonstrations and other program functions, including evaluation of program quality, and recommended components of a state evaluation plan and of state evaluation reports. During the next quarter, a draft evaluation plan will be reviewed internally prior to its submission and finalization with CMS.

ATTACHMENT A

MCO WORKPLAN
UPDATED 12/31/2006

MCO Work Plan (revised 12/31/06) **AREA/ DESCRIPTION**	**TASKS**	**TIMELINE**
MEMBER SERVICES		
Interpreter Services		
Oral interpreter services must be provided free of charge to non-English speaking enrollees who request assistance. [438.10(c)(4)]	Arrange for vendor to provide services as needed	Completed
Provider Directory		
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)]	Develop web-based directory with ability to search by address, provider type, etc.	Completed:
	Survey providers on language capacity and open panel issues	Completed
	Develop process for periodic updates (web-based format allows for immediate updates).	Completed
Notification of Terminating Providers		
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)]	Develop process for identification of terminating providers	Completed
	Draft notice to enrollees	Completed
	Identify process for determining which enrollees have been "regularly treated" by any terminating provider	Completed
	Print and mail notices within 15 days to affected enrollees	Completed
Enrollee Handbook		
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]	Assess need for languages other than English (documentation for CMS)	Completed for PCP and CRT enrollees AHS-wide work group established and meeting for all other enrollees Target date for completion: Spring 2007 (on schedule)
	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		
OVHA must prepare and make available information on Advance Directives. [438.6(h)(2)(i)]	Identify materials related to new 2005 state statute regarding Advance Directives	Completed: Link to new statewide information on EDS and OVHA web-page; Providers notified, also sent to enrollees on request.
	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		
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)]		Completed
GRIEVANCES & APPEALS		
Notice of Adverse Action		
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]	Develop one Agency Policy for all GC enrollees	New policy drafted; finalized and approved by CMS
	Change administrative rules to reflect new policy	Rulemaking not initiated; alternative process under consideration
	Draft notice to include appeal rights, information on the continuation of benefits, and how to request an expedited appeal	In process: 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		
Grievances and appeals must be acknowledged in writing (typical standard is within five business days).	Develop notices	In process: 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		
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*	Develop policies and procedures for the receipt, acknowledgement and resolution of grievances and appeals	In process: 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	

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)]		
Fair Hearings		
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.	Develop policies and procedures for coordinating between the Grievance and Appeals process and the state Fair Hearing process	In process: new policy implemented Spring, 2007
	Develop a system for notifying enrollees at the time of the resolution of their grievance or appeal of their right to a fair hearing	
	Develop reporting system to track number, types, timeliness and resolution of fair hearings	
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI)		
QAPI Plan		
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)]	1) Develop inventory of all QA/QI activities currently underway within OVHA and sub-contracted departments; Develop workgroup to identify new priorities;	2nd Quarter FFY07
	2) Summarize into comprehensive QAPI Plan for CMS review	2nd Quarter FFY07
	3) Ensure that information is available in ACCESS eligibly system	December, 2007
	4) Expand EQRO focus beyond CRT program	Completed
Source of Primary Care		
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)]	Identification of beneficiaries not already participating through PCPLus	March 2007
	Develop policies and procedures for the selection of a PCP by each Demonstration enrollee	Completed for current PCPlus
	Design information system capacity to capture the PCP information for each enrollee	Completed
	Develop a mechanism for tracking PCP caseload	Completed
Practice Guidelines		
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	Establish a medical advisory task force of contracting professionals to provide consultation on the guidelines to be adopted for physical health issues	Completed
	Select key areas where guidelines are to be developed	Completed

professionals. [438.236(b)]	Research evidence-based guidelines and protocols for each of the key areas	Completed
	Adopt the appropriate guidelines after consultation with the task force	Completed for existing guidelines; on-going identification of new national practice guidelines
	Distribute guidelines to appropriate network providers	Completed
Measuring Performance Improvement		
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)]	Develop inventory of all QA/QI activities currently underway within OVHA and sub-contracted departments;	In Process
	Develop workgroup to identify new priorities;	Completed
	Summarize into comprehensive QAPI Plan for CMS review	2nd Quarter FFY07
PROGRAM INTEGRITY		
Actuarial Certification of Capitation Rates		
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)]	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		
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)]	Appoint compliance officer	In substantial compliance with major expansion of activities planned
	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		
OVHA must monitor the program to identify potential areas of over- and under-utilization. Where such over- or under-	Develop an overall utilization management plan for the Demonstration	Completed with ongoing activities through new Program Integrity

utilization is identified, OVHA shall develop a Corrective Action Plan (CAP) for review by the AHS. [438.240(b)(3)]	Identify key areas for monitoring (e.g., inpatient days, emergency visits, etc)	Unit and FADS
	Establish thresholds for evaluating potentially inappropriately high or low levels of utilization by MEG	
Provider and Enrollee Characteristics		
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]	Identify outstanding issues in ACCESS and/other systems related to capturing required enrollee characteristics	Completed
	Ensure that Provider survey captures required information and is in on-line directory	
Enrollee Rights		
Establish policies and procedures on enrollee rights consistent with the requirements of Part 438.100 of 42 CFR.	Expand existing PCP and CRT policies and procedures	Completed for PCP and CRT enrollees; available through enrollee handbook for all enrollees by September, 2007
Encounter Data Validation		
OVHA must put in place a process for validating encounter data and for reporting information on encounters/ claims by category of service. [438.242]	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		
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]	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	
	Design process for collecting info on providers with closed panels (no new patients accepted) and those with access/accommodations for the physically disabled	Survey completed; information available in on-line provider directory
	Develop contracts (IGAs) with other departments	Completed.
CMS REPORTING		
General Financial Requirements		
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	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

financial statements; 6) All reports and data necessary to support waiver reporting requirements [IGA 2.12.2]		
Budget Neutrality Reporting		
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]	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

Global Commitment Proposal Process & Form v. 12/19/06

1. Talk to your OVHA liaison and fiscal office ASAP (if you do not know your OVHA liaison, contact Brendan Hogan, Director of Health Programs Integration Unit, 879-5928, brendanh@ahs.state.vt.us.

   Your OVHA liaison will help you determine if the proposal falls within the scope of the Medicaid program, whether it is a change AHS can make internally, or whether it is a change that needs legislative approval and what process you should follow to move forward.

   Your fiscal office will help you determine if your proposal is within existing budget allocations or if it will require a budget adjustment or is a "new" or expanded fiscal obligation.

   Review the considerations on the back side of this page and submit any relevant information with your proposal.

   Determine if your department leadership is in support of the proposal

2. Create a brief written summary **using the attached format** which includes:
   a. What you want to explore;
   b. Who is or will be involved in the discussion;
   c. What you to hope to gain regarding:
      i. Access to services;
      ii. Outcomes;
      iii. Fiscal, staff or other savings or efficiencies;
   d. If the proposal is for increased use of Medicaid beyond your departments allocation
      i. What is the source of general fund?
      ii. Is it one time or on-going funding commitment?
      iii. What will happen if the program is not funded using Medicaid receipts?

3. Forward the summary to your Deputy or GC operations representation, your OVHA liaison and to Suzanne Santarcangelo at suzannes@ahs.state.vt.us .

4. Your Deputy or GC operations representative should be prepared to

   a. Present the proposal at the next GC operations team and
   b. Confirm that this a Departmental Priority
   c. Speak to what other departmental priorities may be put on hold or slowed down in order to accommodate this proposal
   d. Describe how other divisions, departments or offices will be involved

5. Operations meetings occur on a monthly basis. This group will recommend priorities for action to the AHS Secretary's office.

6. The AHS Secretary will make the final decision to approve a proposal that involves any increased use of Medicaid.

Key Points for Consideration

- There is **no "new" money** outside of that already appropriated.
- We have a "cap" or "ceiling" on **ALL** Medicaid expenditures including administrative claiming. This is both an annual cap and an overall 5-year cap.
- The opportunities and flexibilities under Global Commitment come from our ability to work differently within our existing Medicaid allocations.
- We have the flexibility to waive some federal regulations (not all), at the same time we must be in compliance with a new set of regulations related to OVHA's new role as a Managed Care Organization (MCO).

Opportunities

Opportunities can be created to the extent that you can find innovative approaches for:

1. New or more efficient funding mechanisms (case, bundled or capitated rates; pay for performance structures, etc) within the existing program budget allocation;
2. New or more efficient approaches to program monitoring or reporting requirements that may free up existing staff or current fiscal resources;
3. Elimination of redundant business processes across programs, division or departments that may free up existing staff or current fiscal resources.

Cautions

Opportunities that fall into the following two categories:

1. Finance or program strategies that will involve increased use of Medicaid dollars (administrative or service);
2. Finance or program strategies that will require new state match dollars.

Must be approved prior to exploration and may be considered for development ***only if they hold either considerable promise or have empirical evidence for:***

- Bending the curve on health care expenditures;
- Increasing well-being and decreasing reliance on public sector services;
- Increasing independence and decreasing reliance on intensive service provision;

There are already projects approved by the legislature that will take priority for development in FY07. It is unlikely that any additional projects will be approved until we have more details on the fiscal & program impact of existing legislative and AHS priorities.

Time Lines

Discussions regarding flexibilities within existing budget can occur at anytime
Discussions regarding new or expanded use of Medicaid or state funds must occur prior to the state budget development process (September/October).

Elements that will be considered in Proposal Review

What is the evidence for

- Bending the curve on health care expenditures;
- Increasing well-being and decreasing reliance on public sector services;
- Increasing independence and decreasing reliance on intensive service provision;

Does it constitute an administrative simplification for AHS, our consumers and/or our community partners?
Is it a strategic investment (i.e., will it further one or more of AHS outcomes/initiatives)?
Does it support the goal of AHS acting as one agency and/or the four key practices?
Is the proposed change achievable in the next 12-24 months?
Can outcomes of the change be measured during the remainder of the demonstration wavier?

Program:	
Description	
Lead Department/Other Departments	
New Spending Initiative (Yes/No)	
Outcomes & Objectives	
Service Delivery: ▪ How will the initiative affect care delivery as it relates to **quality, access, prevention, treatment, outcomes and coordination?** ▪ **What results are expected?** ▪ How will we measure & evaluate success? ▪ What will we learn that is transferable to other programs?	
Administrative: ▪ How will the initiative affect program administration, including: – State staffing, oversight and inter-departmental coordination? – Provider data collection and reporting, billing processes? IT issues? ▪ What will we learn that is transferable to other programs?	
Fiscal Impact: ▪ How will the initiative impact program spending? ▪ Does this initiative require new funding or changes in existing funding patterns? ▪ **How will the initiative help to "bend the curve" for overall health care growth?** ▪ How will we measure success?	
Implementation Issues	
Major Activities/Timeline: ▪ What are the major tasks associated with program development and implementation? ▪ What is the timeline for program development and implementation? ▪ Is this actively under development?	
State Staff/Other Resources: ▪ What staff will/should be involved in development and implementation? ▪ How much staff time will be required? ▪ Will the initiative require regulatory/contractual changes? ▪ What level of systems modification is needed (IT or other)?	
Providers: ▪ Who are the affected providers? ▪ Will the initiative require billing/systems, or IT changes? ▪ How does the initiative relate to other initiatives affecting the same provider group?	
Clients: ▪ What education and outreach activities need to occur to ensure that clients are informed? ▪ Who will be affected? ▪ What will clients need to know?	