State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Quarterly Report
for the period
July 1, 2006 – September 30, 2006

Submitted Via Email on
November 28, 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 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 fourth quarterly report for the first waiver year, covering the period from July 1, 2006 to September 30, 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

Mary Day, MCO administrator has accepted another position within OVHA, she is expected to continue full time with the AHS through the calendar year. Her position is under recruitment and it is expected that a replacement will begin in the first quarter of FFY07. Mary will be available to train her replacement. Mary will be returning to OVHA as the Program Integrity Unit Director and be available within the AHS network to consult on global commitment waiver issues as relevant.

MCO Requirements

All work plan activities are progressing; several areas of work were completed in the 4th 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 October 31, 2006.

Benefit Changes

As previously reported the legislature included language in the FY07 Budget Act requiring OVHA to review all available literature and clinical findings related to chiropractic treatment and make a recommendation to the general assembly for the reinstatement of chiropractic services under the Medicaid program during the fiscal year 2008. Please see attachment B for the report to the legislature. In summary, OVHA is recommending we not reinstate the benefit at this time, but rather wait for the results of the CMS Chiropractic Demonstration Project to guide our decision making.

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.* Please see attachment C for descriptions from the 3rd quarter report.

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. We have begun informal discussion with CMS regional and central office staff, supplemental information will be submitted December 8th 2006. We look forward to January 2007 discussions with CMS regarding our request and its 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.

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 Work Plan (Attachment A). In addition, staff positions discussed in the 3rd quarter report to address unanticipated and ongoing case management needs associated with the Medicare Modernization Act (MMA) at OVHA were approved and are under recruitment.

AHS-wide cross departmental operations teams have been meeting in the four core areas identified last quarter (policy, operations, fiscal and quality improvement). In the operations area, AHS Deputies and Directors are in the process of identifying opportunities for programmatic flexibilities in two areas. First, program flexibilities within existing budgeted resources. For example, the integration of administrative structures for programs serving the same or similar populations. We are exploring whether we may be able to increase access to services while decreasing administrative burdens created by programs operating, (pre-waiver), under separate AHS administrative and Medicaid reimbursement structures. Second, this group is developing criteria for the review of requests for expansion of existing programs or new requests for Medicaid program support. 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, Quality Assurance/Performance Improvement Committee (QA/PI) meeting dates and membership was finalized. The group was created as one of the four operational groups mentioned in the 3rd quarter report and is charged with the development, integration, and maintenance of an AHS & OVHA quality strategy, generating AHS -wide quality standards for access to care, structure and operations, and quality measurement and improvement that comply with the Code of Federal Regulations 438.206 – 438.236. Additionally, this group will make recommendations to the Secretary's Office regarding the overall AHS direction related to quality and outcome measurement. The QA/PI Committee leverages the experience, expertise, and insight of AHS personnel whose job specification

include a special focus on Quality Assurance/Performance Improvement activities. As a result, the committee constitutes a cross-section of Quality Managers for all AHS Departments and Divisions. Responsibilities and activities of the Committee include, but are not limited to: reviewing Federal Quality Standards and establishing AHS-wide Quality Standards and procedures, identifying and defining medical and non-medical outcomes that will be monitored by AHS/MCO, defining and recommending AHS-wide Performance Measures, and providing suggestions and recommendations for AHS-wide Performance Improvement Projects. During this quarter, the AHS Quality Improvement Manager also worked with OVHA and its sub-contracted departments/divisions to begin development of an inventory of current Performance Measures and Quality Improvement activities. The results will help to identify agency-wide quality strengths and challenges, document gaps in performance measures and quality improvement projects and help inform the written Quality Strategy.

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

OVHA has created a Program Integrity Unit; position requests identified in the last report were approved. Mary Day has been selected as the Director, remaining positions are under recruitment. Staffing of a complete unit will 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 is scheduled for release in the first quarter of FFY07. It is anticipated that any vendor bidding on either of those projects will also be providing a decision support system that OVHA will be utilizing in its related care coordination projects.

The AHS "Central Source Measurement and Evaluation Data Warehouse" – release 2 is on schedule for the first quarter of FFY07. CSME data are structured to answer questions across departments for policy, planning, legislative and program review. New source systems have been prioritized for addition in calendar year 2007. Work continues on security protocols tools.

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
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	Apr-06	May-06	Jun-06	Jul-06	Aug-06	Sep-06
Optional	Under 21	41,205	40,907	40,838	40,842	41,646	41,727	42,272	42,179	42,012	41,778	41,627	41,465
Optional	21 and Over	15,183	15,298	15,257	15,530	15,587	15,574	16,466	16,626	16,647	17,074	17,028	16,983
Mandatory	Thru 18	14,871	14,963	14,954	15,000	14,780	14,800	14,863	14,834	14,751	14,848	15,079	15,055
Mandatory	Over 18	23,111	23,207	23,244	23,307	23,237	23,300	23,613	23,713	23,655	23,743	23,869	23,834
VHAP/Underinsured	Thru 18	1,672	1,644	1,650	1,478	1,433	1,442	1,542	1,582	1,623	1,572	1,544	1,514
VHAP/Underinsured	Over 18	20,723	20,750	20,637	20,573	21,284	21,329	22,967	22,701	22,686	22,389	22,322	22,415
Pharmacy Only/HVP	All	25,556	26,073	26,439	25,718	25,776	26,213	27,356	25,007	24,964	20,917	21,249	21,805
SCHIP	All	3,187	3,250	3,294	3,252	2,977	3,006	3,058	3,012	3,109	3,104	3,162	3,171
QI1					10	39	52	81	122	116	88	129	106
TOTAL		145,508	146,092	146,313	145,710	146,759	147,443	152,218	149,776	149,563	145,513	146,009	146,348

e) State's progress toward the Demonstration goals.

External Quality Review: During this quarter, the Agency of Human Services Quality Improvement Manager reviewed the current External Quality Review Organization (EQRO) contract. This review included meetings with the OVHA contract manager, current EQRO staff, and phone conversations with our CMS technical assistance staff. We also participated in the audio conference sponsored by the CMS Division of Quality, Evaluation & Health Outcomes to obtain technical assistance regarding mandatory and optional EQRO activities. As a result of the new Global Commitment (GC) to Health Waiver, and after discussion with CMS, Division of Mental Health (DMH), and Office of Vermont Health Access (OVHA), the focus of the EQRO will be broadened to include all Medicaid recipients. Modifications will be made to deliverable three (focus on GC quality strategy and waiver evaluation) in order to facilitate the transition from the original CRT population based EQRO to the new broader MCO focused EQRO. EQRO staff provided AHS and OVHA with updates on current activities, as well as, discussed issues or barrier that might impact proposed timelines. The EQRO contract will be formally transferred from OVHA to AHS and will be managed by the AHS Quality Improvement Manager.

Quality Strategy: CFR section 438.202 Subpart D outlines five State responsibilities for a Quality Strategy. One of the five requirements is a written strategy for assessing and improving

[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.

the quality of managed care services. During this quarter, the CMS Quality Strategy Tool Kit was reviewed giving special attention to the recommended structure and required QI components. In addition, the AHS Quality Improvement Manager reviewed the CMS standards for access, structure and organization, and measurement and outcome, as well as, CMS approved Quality Strategies from various states. In addition to promoting appropriate, safe, effective care aimed at optimum health outcomes, the AHS Quality Strategy will require input of recipients and ensure plan compliance with standards for quality of care. Finally, the AHS Quality Improvement Manager participated in an audio conference sponsored by the CMS Division of Quality, Evaluation & Health Outcomes regarding the development of a written Quality Strategy.

f) State's evaluation activities.

During this quarter, the AHS Quality Improvement Manager reviewed the draft evaluation plan previously submitted to CMS to ensure: hypotheses were linked to objectives, goals had baseline and performance targets, sources for collection of data were identified, methods for ensuring statistical rigor or limitations for not doing so had been identified, timelines for accomplishing goals were clear, and interventions in the demonstration were well specified. The overall purpose of the evaluation is to measure the degree to which identified performance measures changed as a result of the demonstration. As a result, the evaluation will answer the following questions: to what degree did the demonstration achieve its purpose, aims, objectives, goals and quantified performance targets, what lessons were learned as a result of the demonstration, in what ways were outcomes for enrollees, providers, and payers changed as a result of the demonstration, and did the reallocation of resources in the demonstration generate greater "value" for the state's program expenditures. CMS approved waiver evaluation plans from other states were reviewed and the AHS Quality Improvement Manager obtained technical assistance regarding 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 1st and 2nd quarter of FFY07, the AHS Quality Improvement Manager will work with the QAPI Committee, the EQRO, and other appropriate parties to modify the current Evaluation Plan and submit a finalized plan to CMS for review.

4th Quarter Report: MCO Work Plan (revised 10/31/06) **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 August 2006:
	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	1st quarter FFY'07
	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	Formal Legislative Rule-making begun October 2006 (on schedule)
	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 of care) [438.400(b)]. Resolution Timeframes: Standard*	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	

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; 2) Summarize into comprehensive QAPI Plan for CMS review	1st Quarter , FFY07 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 professionals. [438.236(b)]	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
	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;	1st Quarter , FFY07
	Develop workgroup to identify new priorities;	
	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-utilization is identified, OVHA shall develop a Corrective Action Plan (CAP) for review by the AHS. [438.240(b)(3)]	Develop an overall utilization management plan for the Demonstration	Completed with ongoing activities through new Program Integrity Unit 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		
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	1st Quarter, FFY'07
	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 financial statements; 6) All reports and data necessary to support waiver reporting requirements [IGA 2.12.2]	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		
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

4th Quarter Report
Attachment B

LEGISLATIVE REPORT

CHIROPRACTIC REVIEW OF LITERATURE; OVHA RECOMMENDATION
ACT 215
Sec. 107c.

THE OFFICE OF VERMONT HEALTH ACCESS

October 24, 2006

CONTENTS

LEGISLATIVE CHARGE

Act 215
Sec. 107c. *Review of Chiropractic Literature; OVHA Recommendation*

(a) The Office of Vermont Health Access shall review available literature and clinical findings related to clinical outcomes and overall treatment costs associated with chiropractic treatment. The Office shall make a recommendation to the General Assembly regarding the reinstatement of chiropractic services under the Medicaid Program during the fiscal year 2008 budget submission.

BACKGROUND

As a part of Act 71, the OVHA was mandated to design a chiropractic trial to study the clinical outcome and cost of chiropractic treatment in comparison to other treatment modalities, if federal financial participation was available. At the end of the study, the OVHA would then make a recommendation to the General Assembly regarding reinstatement of coverage for chiropractic services for adults.

As a result of collaboration with members of the Vermont Chiropractic Association (VCA), the OVHA concluded that adequate resources to conduct this type of comprehensive study within the time frame desired by the VCA were not available. An alternate proposal was to monitor the Centers for Medicaid and Medicaid Services (CMS) Demonstration Project *Expansion of Medicare Coverage for Chiropractic Services (Sec. 651 of the Medicare Modernization Act of 2003)* and consider their recommendations following their reported results and analysis.

The OVHA's memo to the Legislature, dated February 24, 2006, recommended that the CMS Demonstration Project replace the Act 71 study. Two major concerns were voiced by the chiropractic community to this recommendation: (1) relying on the outcome of the CMS Demonstration Project would unnecessarily delay the reinstatement of chiropractic coverage for Vermont's Medicaid (adult) population; and (2) the CMS Demonstration Project is limited in scope for expanding chiropractic services for neuromuscular conditions.

The current Legislative mandate for the OVHA attempts to address these concerns by reviewing the available literature and making a recommendation to the General Assembly based on this review.

LITERATURE REVIEW

A focused literature review was performed by the OVHA after soliciting references from the chiropractic community, the VCA and sources cited in the CMS Demonstration Project. The literature reviewed, herein, includes original research, editorials and position papers in both full text and abstract formats. A Systematic Review by the Research Commission of the Council on Chiropractic Guidelines and Practice Parameters, *Chiropractic Best Practices,* currently in draft form, was reviewed, but was excluded from this report because of a disclaimer, 'not for distribution or for attribution' pending stakeholder comments. While the review process encompassed many more sources than cited below, it is representative of the most current literature.

Mills MW, Henley CE, et al (2003), *The Use of Osteopathic Manipulative Treatment as Adjuvant Therapy in Children with Recurrent Acute Otitis* Media, Archives of Pediatric Adolescent Medicine 2003; 157:861-866

This study was published in 2003 based on claims data dating back to 1999 with a total of 57 patients. There was no placebo group to account for whether patients would have improved with any perceived intervention. This is an exceptionally important factor because the parents were advised of the nature of the intervention being administered to their child and therefore introduced the potential for biased results. Thus the most the authors could conclude was that "the results of the study suggest a potential benefit" in the treatment of acute otitis media, but that a larger study was indicated.

The Chiropractic Report 2004; Vol. 18; No. 6

This newsletter provides an overview of the cost-effectiveness discussion in the medical/chiropractic community, drawing on past articles by Manga and Angus; Stano and Smith; Jarvis, Phillips, et al; Mosely and Cohen; as well as the large American Specialty Health Plans research study headed by Legorreta, et al from the School of Public Health at UCLA. Key statistics regarding back pain and the treatment thereof, including costs and percentage of patients who go onto long term disability, are duly noted. Concerns by payors such as whether the addition of chiropractic care will be an "add-on" cost, or rather reduce costs spent elsewhere, are also recognized as important issues in this debate.

The flaw in the estimated 'cost-savings', however, rests in the comparison with 'traditional' medical treatment which in the past ten years has undergone a complete revision. Non-surgical interventions are being recommended by the medical community in radically increased numbers, which affects any purported cost savings therein. The UCLA study was based on claims data from as far back as 1997. Many of the other studies are even older, and the first Manga work and the Jarvis study were published 13 and 15 years ago, which means the data analyzed was 2-3 years older still.

Manga P, Angus D et al (1993), The Effectiveness and Cost Effectiveness of Chiropractic Management of Low Back Pain, Pran Manga and Associates, University of Ottawa, Ottawa, Ontario

This literature review is one of the original papers documenting the enhanced cost effectiveness of chiropractic treatment for low back pain. The strength of having a health economist perform the study is ameliorated by the fact that retrospective reviews are inherently less convincing than controlled studies especially when 13+ year old data is involved.

Manga P, Angus D et al (1998), Enhanced Chiropractic Coverage Under OHIP as a Means of Reducing Health Outcomes and Achieving Equitable Access to Select Health Services, Ontario Chiropractic Association, Toronto

This study is similar in design to the one noted above except it is broader in scope and more comprehensive in its cost-effectiveness analysis. This was accomplished by trying to capture all associated costs including direct costs, costs arising from harm from treatment and compensation costs for disability. Similar concerns regarding the design and age of this study are present. Interestingly enough chiropractic services were eliminated as a covered benefit in 2004 by the Ontario Government who called chiropractic "one of the least important services" despite their own study-and Dr. Manga-a Professor of Economics-recommending otherwise.

Legorreta AP, Metz RD, Nelson CF et al (2004), Comparative Analysis of Individuals With and Without Chiropractic Coverage, Patient Characteristics, Utilization and Costs, Arch Intern Med 164:1985-1992

This sizeable retrospective claims study, done over 4 years, compared individuals with chiropractic coverage to those without in a California managed care plan dating back to 1997. Total annual health costs and number of x-rays, hospitalizations and MRI's were all decreased in the chiropractic group. However, as noted in the editorial cited below, there were a number of weaknesses in the study.

Ness J, Nisly N (2004), Cracking the Problem of Back Pain: Is Chiropractic the Answer? Arch Intern Med 164:1953-1954

Although the study above was widely recognized as one of the most substantial analysis done to date, the editors of the Archives of Internal Medicine noted "the study design does not permit the definite determination of a cause and effect relationship between access to chiropractic and a more budget-effective approach to muscular care, pointing rather to the coexistence of the two phenomena in a managed care population. Furthermore, the lack of a random element in defining the populations with and without access to chiropractic care may have partly compromised the validity of the results." In addition, "The favorable health profile of the 'chiropractically insured' is of particular concern. They comprise a younger and healthier population and thus are likely to have better outcomes and fewer health expenses." Ultimately, they conclude that "critical questions remain regarding which subsets of patients could derive the most benefit from chiropractic care and yet incur fewer health expenditures." They caution that "extensive research in this area is warranted" and "careful scrutiny should be applied in future research".

Livermore GA, Stapleton DC (2005) Medicare Chiropractic Services Demonstration: Final Design Report, Cornell University Institute for Policy Research

This paper was prepared for CMS as the basis for their Demonstration Project described below. Prepared by the Cornell University Institute for Policy Research under subcontract to the Medstat Group as recently as a year ago, it represents one of the most impressive compilations of scientific literature concerning chiropractic care. It notes at the very beginning that "previous research on the cost effectiveness of chiropractic care is inconclusive" despite acknowledging studies by the chiropractic community attesting to the contrary. The basic premise for this conclusion, as noted repeatedly above, is the presence of selection bias in many of the studies. This concern is the primary underpinning of the study design they recommended to CMS, which CMS elected to follow verbatim in rolling out their Demonstration Project in April 2005.

DEMONSTRATION PROJECTS

U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Medicare Program: Demonstration of Coverage of Chiropractic Services under Medicare: Notice (1/8/05)

CMS, per sec. 651 of the Medicare Modernization Act of 2003 is conducting a Demonstration Project evaluating the feasibility and advisability of expanding coverage for scope of services that chiropractors are permitted to provide. This Demonstration Project will operate for two years and must be budget neutral. The project sites are the State of Maine; State of New Mexico; 26 Illinois Counties; Scott County in Iowa, and 17 Virginia Counties. The Demonstration Project began in April 2005 and will continue through March 31 2007.

CMS currently reimburses chiropractors for treatment limited to manual spinal manipulation to correct subluxations related to neuromuscular conditions with reasonable expectation of recovery or functional improvement. At the close of the Demonstration Project, an independent evaluation will be conducted to assess costs and other impacts of demonstration. An interim report will be submitted to Congress in spring 2008 with a final report due in late 2009. (Reference attached power point).

U.S. Department of Health and Human Services, Health Resources and Services Administration, Elderly Back pain: Comparing Chiropractic to Medical Care (2005)

As abstracted from the researchers' application presentation:

Organization Name: Palmer Chiropractic University
Project Title: Elderly Back Pain: Comparing Chiropractic to Medical Care
Grant Number: R18HP01423
Project Period: 9/1/03 – 8/31/06
FY 2005 Award Amount: $369,572

Low back pain (LBP) in the elderly is a significant public health problem with prevalence ranging from 13-49%. Despite significant impact on elderly quality of life, there are no randomized clinical trials (RCT) examining medical and chiropractic treatment options.

We propose a prospective (RCT) of 250 elderly patients with subacute or chronic LBP. Patients will be randomized to one of three treatment conditions: 1) chiropractic care consisting of high-velocity low amplitude (HVLA) spinal adjustments (manipulation), 2) chiropractic care consisting of low-velocity variable amplitude (LVVA) spinal mobilization (flexion-distraction) and 3) standard medical care.

The study is statistically powered for two separate primary comparisons: 1) chiropractic care versus medical care and 2) HVLA manipulation versus LVVA mobilization. The two primary analyses have the potential to inform and improve medical and chiropractic clinical practice.

The Palmer Center for Chiropractic Research (PCCR) has developed a considerable infrastructure to conduct RCTs, and investigators at PCCR have significant experience conducting both clinical and biomechanical research. The PCCR is the largest and most comprehensive chiropractic research effort in the U.S., and it is well-positioned and highly experienced at medical/chiropractic collaboration. PCCR is partnering with community-based medical physicians and the Departments of Internal Medicine and Biomechanical Engineering at the University of Iowa to conduct this study.

RECOMMENDATION

Reinstating chiropractic services under the Medicaid program for the adult population, as children are already covered, can be conceptually divided into three distinct groups: services provided for the treatment of back conditions; services provided for the treatment of back and neuromuscular disorders;

and services provided for the treatment of conditions unrelated to back or neuromuscular conditions. Definitive literature regarding the latter is lacking, although preliminary studies offer glimpses into possible benefits in ways the medical community has heretofore dismissed. Clearly, there is literature supporting the efficacy of chiropractic care in treating back conditions, but as to the supposed cost-effectiveness there is an honest open debate, that in the minds of the medical community, as noted above, is still unresolved.

Although less studied, the efficacy of extending chiropractic services to neuromuscular conditions is noted with some of the same flaws in study design as others. The CMS Demonstration Project attempts to answer that question among others. In the meanwhile, OVHA provides for the treatment of back, neuromuscular and other conditions within chiropractors' scope of expertise through conventional medical modalities. These medical modalities have undergone an evolution toward non-surgical interventions in greater numbers and will continue to evolve as more studies are done.

However, as to how cost effective chiropractic care might be as an additional benefit in the State of Vermont remains to be determined. At this time, of greater interest to OVHA is the result of the CMS Chiropractic Demonstration Project, which is due to have preliminary results in a year. The well designed methodology being employed and the applicability to Vermont's Medicaid population will more accurately answer questions regarding clinical and cost efficacy for chiropractic services. Pending the results of the Demonstration Project (and the HSRA's Palmer College of Chiropractic Project), however, there is not enough data to support reinstatement of services at this time.

Attachment C

Summary of Benefit Changes Contained in The Vermont FY07 Budget Act and The Vermont Health Care Affordability Act

VHAP-ESI – The new laws propose to implement an Employer Sponsored Insurance (ESI) program for both existing and new VHAP enrollees. Beneficiaries will be held harmless in terms of cost and benefits compared to the regular VHAP program. The savings generated by this initiative will be used to finance coverage for additional low-income, uninsured Vermonters.

ESI Premium Assistance Program – Vermont intends to make coverage more affordable for uninsured individuals with incomes up to 300 percent of FPL. Individuals who have access to coverage through their employers will have the opportunity to participate in the ESI Premium Assistance Program. Public subsidies will be available under this program to help cover the employee share of monthly premiums for employer-sponsored coverage.

Catamount Health Assistance Program – Catamount Health is a broad initiative designed to make affordable commercial coverage accessible to individuals unable to obtain coverage through their employers. Covered benefits will be defined by the State and provided through commercial carriers. Catamount Health will be available to all Vermonters, regardless of income. The Catamount Health Assistance Program would provide for public subsidies toward the premiums paid under Catamount Health. The Catamount Health Assistance Program will be available to low-income uninsured Vermonters with incomes up to 300% of the FPL, who do not have access to employer-sponsored insurance that is more cost-effective for the State.

Recertification Requirements – Vermont currently recertifies eligibility for certain groups at six-month intervals, while recertification occurs every twelve months for other eligibility groups. Vermont intends to modify the program requirements for VHAP, Dr. Dynasaur and other eligibility groups to require recertification every twelve months. This modification also helps to offset the operational resource demands resulting from the new citizenship verification requirements.

VHAP Eligibility Requirements – Vermont intends to modify existing rules in order to extend eligibility to Vermont residents who are college students and have taken medical leave.

Enrollee Premiums – In order to promote access to affordable health coverage, the law requires that VHAP premiums be reduced by 35% and Dr. Dynasaur premiums be reduced by 50% beginning July 1, 2007.

Chronic Care Management – The centerpiece of Vermont's efforts to reengineer the health care delivery system, improve quality and lower costs is to create a statewide system of care for individuals with chronic conditions—conditions that constitute more than 75% of our total health care spending. There are multiple approaches within the new laws that converge to achieve this statewide chronic care system, including expansion of the state's Blueprint for Health, a requirement that the Catamount Health Plans have a chronic care management program consistent with the Blueprint, and a chronic care management system to manage the chronic conditions of individuals enrolled in Medicaid, VHAP and Dr. Dynasaur.