State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Quarterly Report
for the period
October 1, 2005 to December 31, 2005

Submitted on
March 9, 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 first quarterly report for the new waiver which began on October 1, 2005.

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.

Legislative Approval

On September 30, 2005, the Vermont Legislature, through its Joint Fiscal Committee, granted conditional approval for the State to begin implementation of the Global Commitment to Health Demonstration Waiver Program on October 1, 2005, with the following contingencies for final legislative final approval:

(1) *Complete demonstration provisions furnished*. That a complete and comprehensive listing and description of all the provisions of the Demonstration Waiver agreement be prepared and included in the letter of acceptance to CMS by the Office of Vermont Health Access (OVHA) and provided to the Joint Fiscal Committee, comparing the original proposal for the Demonstration Waiver Program with the outcome of the negotiations with CMS; and that the Joint Fiscal Committee finds that these final provisions are in accord with the terms and conditions presented to the Joint Fiscal Committee as the basis for its contingent approval.

(2) *Final premium amounts determined to be sufficient*. That OVHA present to the Joint Fiscal Committee the final premium amounts adopted by the Agency of Human Services (AHS) upon actuarial certification, and that the Joint Fiscal Committee finds that such amounts are sufficient to support the Demonstration Waiver Program including the state's current Medicaid and expansion programs.

(3) Agreement regarding future years' premiums. That AHS work with CMS regarding the criteria utilized in future waiver years in order to ensure that future premiums will not be negatively affected by successful cost savings efforts achieved by the state, and that OVHA report to the Joint Fiscal Committee and the Health Access Oversight Committee on the status and provisions of any agreement reached.

(4) MCO Savings Identified. That OVHA present to the Joint Fiscal Committee a list of criteria for MCO targeted health care investments.

(5) Attorney General Review. That the Attorney General review as to form the Special Terms and Conditions (STC), the Intergovernmental Agreement (IGA), and other legal documents regarding the demonstration waiver program.

During the first quarter of waiver implementation, the State spent a significant amount of time responding to legislative and other requests for information, and addressing the above contingencies. Satisfied that the contingencies had been met, the Legislature gave full approval for participation on the waiver on December, 13, 2005. A formal letter of acceptance was submitted from AHS Secretary Michael K. Smith to Dr. Mark B. McClellan, Administrator of the Centers for Medicare and Medicaid Services (CMS) on December 15, 2005 (Attachment A). As specified by the Vermont Legislature, this letter also included points of clarification regarding operational parameters of the waiver, and requested that CMS inform the state within thirty days if there were any concerns with the clarifications.

Since no concerns were raised by CMS within the thirty day timeframe, Vermont concludes that the clarifications were acceptable.

Financial Administration

Development of the financial aspects of the waiver received significant attention during the first quarter. The actuarial certification of the MCO premium ranges for the current fiscal year was completed in mid-December. The actuarially certified rate range was established at $60,115,350 - $66,747,894 per month for the nine months of Waiver Year 1 that fall in SFY 2006, and the monthly premium amount paid to the Office of Vermont Health Access during State Fiscal Year 2006 was established at $65,371,811, subject to modification, within the certified rate range, based on the Legislative Budget Adjustment Process (which occurs in January through March each year).

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.

During weekly calls between Vermont and CMS, we also have clarified the methodology for paying and matching administrative expenditures under the waiver. All MCO-related administrative expenditures will be included in the monthly premium payment from AHS to the MCO, and matched at the program rate.

Vermont also agreed that the IGA between AHS and the MCO would include a fixed, monthly sum to be paid by the Agency to the MCO. AHS will put in place a reconciliation process to validate the fixed monthly sum. The MCO also will monitor appropriate utilization of services via its quality assurance and improvement efforts.

MCO Requirements

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

Benefit Changes

A significant amount of time and effort has been 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 B.

No other benefit changes have occurred since implementation of the waiver. However, on February 24, 2005 OVHA did submit a request to the Vermont Legislature for consideration of participation in the CMS demonstration project regarding chiropractic care (see Attachment C). OVHA has not yet received a response from the Vermont Legislature.

Proposed Health Care Legislation

The 2006 Vermont Legislative session began in early January. Within the first weeks, Governor Jim Douglas unveiled a Health Care Reform Plan for Vermont. The Governor's Plan proposes to commit $28 million to fund a comprehensive Health Care Reform Plan with the following goals: (1) Universal access to health insurance for all Vermonters, with a comprehensive, seamless coverage system for low and moderate income uninsured Vermonters. (2) Improved quality and cost containment through long-term system improvements. (3) A healthier population through the promotion of healthy behaviors and disease prevention.

The Governor's Health Care Reform Plan includes common sense elements for which it is anticipated that consensus can be reached quickly, as well as health insurance access initiatives for which an extended discussion will be likely. Following is an outline of the Governor's Plan; a more complete description is in Attachment D.

Common Sense, Consensus Initiatives

I. Improving Quality and Containing Costs through Health Care System Reform
- The Vermont Blueprint for Health: the Chronic Care Initiative.
- The VITL Health Information Technology project.
- Multi-Payer Data Collection.
- Common Claims Administration.
- Consumer Price and Quality Information.
- Advanced directives.
- Adverse Event Reporting and Safe Apology Legislation.

II. Promoting healthy behaviors and disease prevention across the lifespan of the individual
- Fit and Healthy Kids.
- Healthy Aging.
- Healthy Choices Incentives.

III. Medicaid Enrollment and Cost Shift Initiatives
- Outreach and enrollment initiative.
- Medicaid cost shift initiative.

Universal Access Initiatives

IV. Universal Access to Affordable Health Insurance for All Vermonters
- Toll-free Health Insurance Assistance and Referral.
- Medicaid Initiatives.
- The Premium Assistance Program.
- The Basic Insurance Policy.
- Tort Reform.

Since the Governor unveiled his Plan, several competing Health Care Reform Plans have

been discussed within the legislature. For example, the Committee on Health Care in the House of Representatives has introduced a bill that would: 1) create the Catamount Health Plan, a private MCO, to offer comprehensive coverage to Vermonters without health insurance; 2) encourage enrollment in the current Medicaid program for those already eligible; 3) increase disease management; 4) develop statewide case management for chronic care; and 5) increase payments to physicians. (see Attachment E).

Similar bills are being developed within the Senate. Obviously, any of these bills that are passed by the legislature will have a significant impact on health care delivery under the Global Commitment to Health waiver, and many aspects would require CMS review and approval. At this point it is too early to predict which aspects of any of these plans will be included in a bill that would be passed by the full legislature before adjournment (most likely in May). Even if legislation is passed during the session, the Governor has ultimate authority to sign the bill into law. As the session proceeds, Vermont will notify CMS of any components of proposed legislation that seem likely to be passed into Vermont law.

Health plan financial performance, including capitated revenue expenditures.

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

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

See OVHA Work Plan (Attachment B)

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. Vermont is currently field testing a Fraud Abuse Detection Decision-Support System (FADS) that will interface with the EDS claims system to provide electronic data reports to the SURS Team for their analytical use. We expect this to be fully operational in April, 2006.

Secondly, we are currently finalizing a Request for Proposals 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 currently in the development phase. Final development work includes: performance improvement; data validity testing; new data source addition; migrating to Business Objects® XI; and new system installation. CSME is expected to be ready for implementation by Summer, 2006.

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

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

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

- **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**

See following Table.

Population	Age Limit	Oct-05	Nov-05	Dec-05
Optional	Under 21	41,205	40,907	40,838
Optional	21 and Over	15,183	15,298	15,257
Mandatory	Thru 18	14,871	14,963	14,954
Mandatory	Over 18	23,111	23,207	23,244
VHAP/Underinsured	Thru 18	1,672	1,644	1,650
VHAP/Underinsured	Over 18	20,723	20,750	20,637
Pharmacy Only/HVP	All	25,556	26,073	26,439
Total		142,321	142,842	143,019

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.

Because the Global Commitment to Health has just begun, Vermont does not have specific initiatives or data to report regarding progress towards these goals. However, the outcomes of the activities discussed in section a) of this report will have a significant impact on the state's future progress towards these demonstration 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 hopefully will be in the next two months (we held first interviews the week of February 27). (See Attachment F for the Quality Improvement Manager position description). In the meantime, the preliminary draft evaluation plan provides a starting point for ensuring that we are planning in the right direction.

Attachment A

Vermont Letter of Acceptance

WATERBURY OFFICE COMPLEX
103 SOUTH MAIN STREET
WATERBURY, VERMONT 05671-0204

OFFICE OF THE SECRETARY
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MICHAEL K. SMITH, SECRETARY

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

December 15, 2005

Dr. Mark B. McClellan, M.D., Ph.D
Administrator
Centers for Medicare and Medicaid Services
Mail Stop C5-11-24 – Central Building – Room C5-25-25
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Dr. McClellan:

I am writing to formally accept the Special Terms and Conditions (STCs) of the recently approved Global Commitment Section 1115 Demonstration, with an effective start date of October 1, 2005. We sincerely appreciate the time and dedication of the Centers for Medicare & Medicaid (CMS) staff in the development of this innovative program. We believe that the Demonstration will enable us to better serve Vermonters through more effective use of state and federal resources.

Under the Global Commitment to Health Waiver, Vermont will demonstrate its ability to promote universal access to health care. Subject to the availability of state funds, authorization of the Vermont legislature and compliance with the Demonstration's STCs, the Demonstration will enable the State to develop health care initiatives to improve the access to and quality of health care services received by uninsured and underinsured Vermonters.

Vermont's Demonstration Proposal, submitted April 15, 2005, identified the State's goals and objectives; described examples of innovative programs that might be implemented in order to more effectively and efficiently meet Vermonters' health needs; and provided assumptions regarding program design.

During the course of extensive collaboration and negotiation with CMS, Vermont's goals and objectives for the Demonstration continued without change. Through collaboration with CMS, we refined the program design and operational parameters to better meet both state and federal policy and fiscal objectives. Therefore, the final parameters under which the State will operate are defined by the Special Terms and Conditions approved by CMS on September 27, 2005. Short of rewriting the April 15, 2005 application to reflect the approved and accepted STCs, the following points serve as clarification:

- The Vermont Legislature must approve changes to eligibility requirements and benefits for enrollees in the Global Commitment to Health Section 1115(a) Demonstration and they also may be subject to CMS approval as specified in the STCs.

- Per the STCs, should the State of Vermont elect to implement any of the innovative features outlined in its waiver proposal in accordance with any directive of the state legislature, the state will seek approval from CMS to do so through an amendment to the demonstration.

- The Office of Vermont Health Access (through the Agency of Human Services) will be serving as the public MCO for the demonstration program. OVHA will provide services in accordance with the managed care provisions set forth at 42 CFR part 438 and part 447 with respect to timely claims payment. The MCO premium rate will be based on covered benefits and eligibility, will be actuarially certified, and approved by CMS. The MCO will have broad operational authority, subject only to the limitations specified in section 40 of the Special Terms and Conditions, MCO payment restrictions identified in 42 CFR 438, and approval of the Vermont Legislature.

- Changes in eligibility criteria and the scope of benefits provided under the Vermont Medicaid program, including this demonstration, will be determined by the Vermont Legislature. Vermont does not plan to change mandatory services for mandatory populations or EPSDT services. Changes also must be approved by CMS if required by the Special Terms and Conditions. However, further health care initiatives for the purposes defined under section 40 of the STCs may be implemented without CMS approval.

- The payment rate in the Intergovernmental Agreement (IGA) between the AHS and MCO can be altered during the agreement year, as long as the revised rate is compliant with 42 CFR part 438 and is prior approved by CMS.

- As is consistent with the CMS capitation rate setting checklist for risk contracts and the actuary practice guidelines for Medicaid rate-setting, it is permissible for the actuary to make adjustments based on plan specific encounter and financial data to ensure that an efficiently run managed care plan is not penalized for its efficiencies.

- The budget neutrality terms rely on historical expenditures and current federal projections of program growth. The State may seek re-negotiation of the budget neutrality terms if an unforeseen event occurs during the course of the Waiver term, such as a major economic downturn or catastrophic event (e.g., epidemic, natural disaster or terrorist action).

- The specific details regarding “normal close-out costs” in Special Terms and Conditions #10 is determined on a case-by-case basis. However, at a minimum, this clause indicates that, in the event that the waiver is prematurely suspended or terminated, CMS will provide federal match for the administrative and service costs associated with transitioning the care of people enrolled in the demonstration, including non-state plan populations.

- Consistent with the Global Commitment Special Terms and Conditions, Vermont intends to continue to operate the Vermont Health Access Program (VHAP) through the MCO, including VHAP-Uninsured, VHAP Pharmacy, VScript and PCPlus Programs. However, such services will be provided under the authority of the Section 1115a Global Commitment waiver rather than the authority of the former Section 1115a VHAP waiver. Program eligibility criteria and benefits will remain unchanged unless directed by the Vermont Legislature and by CMS, as required by the Special Terms and Conditions.

- Existing federal authority and state administrative rules associated with all programs included under the 1115a Global Commitment waiver will remain in effect unless they are changed through the state's formal rule-making process.

- Vermont intends to continue to offer the following home and community based (HCBS) services under the Global Commitment Waiver for the following populations: people with developmental disabilities, children and adolescents with severe emotional disturbances, and people with traumatic brain injuries. However, such services will be provided under the authority of the 1115a Global Commitment waiver rather than the authority of Section 1915c waivers. HCBS program parameters, including eligibility criteria, under the former developmental services, severe emotional disturbance and traumatic brain injury waivers will remain unchanged unless modified through established state procedures associated with these programs. The operational parameters for these 1915c waiver programs will be defined in the Intergovernmental Agreements between the MCO and the departments that administer these programs. The State does not need to submit any additional reports to CMS for these 1915c waivers for services paid after September 30, 2005.

The Vermont Legislature, through its Joint Fiscal Committee, has given final approval for entering into the waiver program, in accordance with its September 30th contingent approval, and subsequent review and approval of the completion of these contingencies on December 13, 2005.

If you have any concerns with the above clarifications, please inform us within thirty days of receipt of this letter.

Sincerely,

Michael K. Smith, Secretary
Agency of Human Services

Attachment B

MCO Work Plan

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	Directory developed; being tested by Medicaid Advisory Board members during March ; directory on-line in April
	Survey providers on language capacity and open panel issues	Survey has been sent
	Develop process for periodic updates	web-based format will allow for immediate updates
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	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		
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
	Draft handbook	Completed
	Disseminate for input, finalize based on comments received	Completed
	Print a supply for initial distribution	Completed
	Develop and execute handbook distribution process on an ongoing basis	Began dissemination to new enrollees in February, 2006
	Post handbook on website	Completed
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- waiting for new forms for Vermont Ethics Network
	Obtain a supply of forms for distribution upon request	providers have been notified of link
	Post information on website	new state wide format being developed by Vermont Ethics Network
	Draft informational notice on Advance Directives and distribute for posting in physicians' offices (EDS Newsletter)	Link and info on 2/3/06 Banner page

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; under review by CMS
	Change □dministrative rules to reflect new policy	Rule-making process to begin April, 2006
	Draft notice to include appeal rights, information on the continuation of benefits, and how to request an expedited appeal	New policy implemented Fall, 2006
	Develop policies and procedures for processing requests	New policy implemented Fall, 2006
	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)	New policy implemented Fall, 2006
Acknowledgement of Appeal		
Grievances and appeals must be acknowledged in writing (typical standard is within five business days).	Develop notices	New policy implemented Fall, 2006
	Develop policies and procedures for ensuring notices are sent timely	New policy implemented Fall, 2006
	Develop process and assign staff to assist enrollees in filing grievances and appeals	New policy implemented Fall, 2006
	Assign staff to receive, date stamp and log in all grievances and appeals	New policy implemented Fall, 2006
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 Grievance – 45 days from date of*	Develop policies and procedures for the receipt, acknowledgement and resolution of grievances and appeals	New policy implemented Fall, 2006
	Develop a system for logging and tracking grievances and appeals (type, days to resolution, outcome)	New policy implemented Fall, 2006
	Develop a system for automated reporting on grievances and appeals	New policy implemented Fall, 2006
	Assign staff to process all grievances and appeals	New policy implemented Fall, 2006

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)]	Design resolution notices	New policy implemented Fall, 2006
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	New policy implemented Fall, 2006
	Develop a system for notifying enrollees at the time of the resolution of their grievance or appeal of their right to a fair hearing	New policy implemented Fall, 2006
	Develop reporting system to track number, types, timeliness and resolution of fair hearings	New policy implemented Fall, 2006
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI)		
QAPI Plan		
OVHA 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)]	Draft initial plan and strategy	Completed; under review by OVHA Director
	Submit final draft to CMS for review	April, 2006
Source of Primary Care		May, 2006
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 new beneficiaries not already participating through PCPLus	May, 2006
	Develop policies and procedures for the selection of a PCP by each Demonstration enrollee	May, 2006
	Design information system capacity to capture the PCP information for each enrollee	May, 2006
	Develop a mechanism for tracking PCP caseload	May, 2006
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		
OVHA 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)]	Establish QAPI oversight committee	New QAPI Plan will be operattionalized once QAPI Plan is approved by CMS (May, 2006)
	Identify key performance indicators	
	Develop baseline data on current status of selected indicators	
	Establish improvement goals	
	Collect and analyze performance data annually	
	Develop audit tools and processes for the biannual clinical care audits and program reviews	
	Develop report formats	
	Prepare annual performance report for CMS	
	Develop process and procedures for incorporating grievance and appeals information into the QAPI plan	
	Develop and maintain database for monitoring quality indicators	
	Develop process and policies for the establishment of annual QI goals	
	Develop Member Satisfaction Survey guide and submit to CMS for approval	
PROGRAM INTEGRITY		
Actuarial Certification of Capitation Rates		
OVHA 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	Completed for Year 1 rates
	Establish capitation rates by MEG	Completed for Year 1 rates
	Obtain written certification from qualified actuary	Completed for Year 1 rates
	Submit rates to CMS	Completed for Year 1 rates
	Develop process for periodic recertification of rates	TBD after CMS review of Actuarial methodology
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	Completed with ongoing activities
	Develop written compliance plan	Completed with ongoing activities
	Develop policies and procedures for program integrity	Completed with ongoing activities
	Develop written standards of conduct	Completed with ongoing activities
	Design staff training program	Completed with ongoing activities
	Conduct staff training	Completed with ongoing activities

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
	Identify key areas for monitoring (e.g., inpatient days, emergency visits, etc)	Completed with ongoing activities
	Develop process and plan for periodic measurement using claims data	Completed with ongoing activities
	Establish thresholds for evaluating potentially inappropriately high or low levels of utilization by MEG	Completed with ongoing activities
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 accom-modations for the disabled in their offices) [438.242]	Develop system design for capturing selected characteristics	Completed with ongoing activities
	Develop a provider profiling plan that monitors and reports on enrollment, encounters, reimbursement and outcomes on a monthly basis	Completed with ongoing activities
	Execute plan for incorporating additional fields within the MMIS	Completed
	Develop report formats	Completed
Enrollee Rights		
Establish policies and procedures on enrollee rights consistent with the requirements of Part 438.100 of 42 CFR.	Draft policies and procedures	Completed with ongoing activities
	Develop staff training plan	Completed with ongoing activities
	Disseminate policies and conduct staff training as needed	Completed with ongoing activities
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 exisitng processes to include sub-contrated departments.	July, 2006
	Implement new Fraud and Abuse Detection Decision Support System	April, 2006
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	June, 2006
	Identify any existing gaps	June, 2006
	Recruit additional providers as needed	June, 2006 and on-going
	Develop process and procedures for provider site visits if warranted	June, 2006 and on-going
	Develop ongoing monitoring plan for the provider network	June, 2006 and on-going
	Design process for collecting info on providers with closed panels (no new patients accepted) and those with access/accommodations for the physically disabled	Survey distributed
	Develop contracts (IGAs) with other departments	Finalized in April 2006
	Establish policies and procedures to ensure compliance by subcapitated entities	On-going

	Develop a monitoring plan for oversight of these entities	On-going

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

Attachment C

Legislative Request from OVHA regarding Chiropractic Benefits

VERMONT

Office of Vermont Health *Agency of Human Services*
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To: House Appropriations Committee
House Health Care Committee
House Human Services Committee
Senate Appropriations Committee
Senate Health & Welfare Committee
Joint Fiscal Office

From: Joshua Slen, Director

Date: February 24, 2006

Re: Update - Act 71, Section 298, Chiropractic Benefits for Adults

An opportunity has arisen that addresses Act 71, Section 298, Chiropractic Benefits for Adults:

(a) *The Office of Vermont Health Access shall design a chiropractic trial to begin in state fiscal year 2007. This trial shall be predicated upon and will proceed only if federal financial participation can be secured for the trial. The trial shall include limited diagnoses where chiropractic services, identified by the Office of Vermont Health Access, shall be covered for the duration of the trial. The study period shall include an analysis of both the clinical efficacy of chiropractic treatment for the diagnoses identified along with a comparison to other treatment modalities for the same diagnoses and a financial analysis of the different treatment modalities. At the conclusion of the trial period and upon confirmation from the Centers for Medicare and Medicaid Services that federal financial participation would be available, a recommendation shall be made to the general assembly for reinstatement of chiropractic services where positive clinical outcomes and lower overall treatment costs have been shown. This recommendation may be limited by the scope and definitions of the trial.*

The Centers for Medicare and Medicaid Services (CMS), per section 651 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, is conducting a demonstration project which evaluates the feasibility and advisability of expanding coverage for the 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 study began in April 2005 and will continue through March 31, 2007.

CMS, like Vermont Medicaid, 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 CMS 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.

Act 71, Section 298 authorizes the OVHA to proceed with a chiropractic trial if federal financial participation can be secured. As an update to the legislation, the OVHA is recommending that the above-described CMS chiropractic demonstration project replace an OVHA-only trial and that the results of the CMS demonstration be used as the basis for determining whether or not to reinstate chiropractic services under the Medicaid umbrella.

The CMS demonstration offers several advantages over an OVHA-only trial:

1. Encompasses more individuals than the OVHA-only trial.
2. No state funds will be needed.
3. Broader analysis can occur because of the variety of state participants.
4. Already underway and will conclude March 31, 2007.

In conclusion, the OVHA offers the following recommendations for consideration:

1. The CMS chiropractic demonstration project replaces the OVHA chiropractic trial.
2. Amend Act 71, Section 298 to reflect the CMS chiropractic demonstration project.

Attachment D

Governor's Proposed Health Care Reform Plan: Overview

The Governor's Health Care Reform Plan

The Governor proposes to commit $28 million to fund a comprehensive Health Care Reform Plan with the following goals: (1) Universal access to health insurance for all Vermonters, with a comprehensive, seamless coverage system for low and moderate income uninsured Vermonters. (2) Improved quality and cost containment through long-term system improvements. (3) A healthier population through the promotion of healthy behavior and disease prevention.

The Governor's Health Care Reform Plan includes common sense elements concerning which it is anticipated that consensus can be reached quickly, as well as health insurance access initiatives concerning which an extended discussion may be warranted.

Common Sense, Consensus Initiatives

III. Improving Quality and Containing Costs through Health Care System Reform

- *The Vermont Blueprint for Health: the Chronic Care Initiative.* The Blueprint constitutes a major, long-term restructuring of Vermont's health care system designed to promote health improvement and improve cost-effectiveness in the treatment and management of chronic conditions, which account for over 80% of Vermont's health care costs. The Blueprint will accelerate the development and deployment of a state-wide chronic disease registry. Patient self-management program will be expanded from two to five communities. Best practice treatment protocols will be developed for additional chronic conditions.

- *The VITL Health Information Technology project.* During the 2005 Session, the Legislature and the Governor approved the creation of the Health Information Technology project, under the leadership of the Vermont Information Technology Leaders (VITL) and BISHCA. The project is designed to provide Vermont with a modern health care information and communications system. Two key elements of the project include the development of a patient-centered health information technology plan and the implementation of an electronic medical records system. Beginning in July 2006, a pilot project involving at least two hospitals will start. VITL will be asked to explore the potential for a patient-centered "problem knowledge coupler"-type tool in an electronic patient medical records system. Additional resources for VITL will remove existing barriers to comprehensive implementation of this project.

- *Multi-Payer Data Collection.* BISHCA has been charged with developing a system for collecting health care data from public and private health insurance plans, and from hospitals, doctors and other health care providers. Additional funding for program development and start up will help to create a comprehensive, population-based information system, enabling all participants in Vermont's health care system to improve the quality and cost-effectiveness of the delivery system, and to restructure the provider payment system for Medicaid and other health insurers.

- *Common Claims Administration.* Vermonters are concerned about the complexity of the health care system, and the time and resources needed for claims administration. Hospitals and doctors are burdened with time spent on claims administration that could be directed toward direct patient care. Additional funding for the Common Claims Administration project will help to simplify and standardize the claims administration process, and thereby reduce health care administrative costs.

- *Consumer Price and Quality Information.* Patients need more and much better information about the price of health care, and the quality and outcomes of health care services in order to make wise health care choices. BISHCA will create a consumer price and quality information system, after consultation with individual and business payers, physicians, hospitals and other providers, health insurance plans, and other elements of the health care system. The system will start by assuring that consumers have good information about the cost of, and provider experience in the ten most common in-patient and out-patient procedures or services.

- *Advanced directives.* During the 2005 Session the modernization of Vermont's advanced directives law was approved. The Department of Health will enlist partner agencies to serve as "deposit sites" where trained staff will be available to assist individuals with the technical aspects of advance directives forms. A central registry administrator would receive advance directives forms, and provide information to individuals concerning

advanced directives. This will be accompanied by a public education campaign to encourage all Vermonters to talk with family members about medical decision-making, and to take steps to approve a formal advance directive.

- *Adverse Event Reporting and Safe Apology Legislation.* An adverse event reporting system will be established for hospitals, to improve quality of care and lower health care costs. The Governor Plan will include safe apology legislation to exclude statements of apology from medical malpractice litigation.

IV. **Promoting healthy behaviors and disease prevention across the lifespan of the individual**

- *Fit and Healthy Kids.* The Fit and Healthy Kids program addresses the root causes of the prevalence of overweight and obesity among Vermonters by working to increase physical activity and healthy nutrition among our children and youth. The program will be expanded for grants to four communities designed to support healthy eating and physical activity among community members. The program will also expand the Run Girl Run program from 20 to 30 middle school sites and the after school SPARK program (Sports Play and Active Recreation for Kids) from 9 to 14 sites. Funding of the Governor's Daylight Savings Challenge, engaging elementary school children in fun physical and nutritional activities and for the nutritional expertise and program oversight in the Department of Health will also be continued.

- *Healthy Aging.* Vermonters use more health care services as they grow older, and the greatest number of chronic conditions occurs among seniors. Vermonters with developmental disabilities are aging and have a greater incidence of obesity, a known risk factor in many chronic conditions. As our population ages, health care costs will increase dramatically unless lifestyle changes can be encouraged. The Department of Disabilities, Aging and Independent Living will provide funds to the Area Agencies on Aging to fund Healthy Aging initiatives through grants to Senior Centers and appropriate programs such as RSVP to stimulate physical activity programs for this demographic.

- *Healthy Choices Incentives.* Vermonters with health insurance in the small group or non-group market should be eligible for premium discounts if they make healthy choices in addressing personal health issues such as smoking and obesity, and if they engage in approved self-management programs for chronic conditions such as diabetes or heart disease. Standards should be established by BISHCA to ensure that healthy choices premium discount plans offer appropriate protections for Vermonters with disabilities.

V. **Medicaid Enrollment and Cost Shift Initiatives**

- *Outreach and enrollment initiative.* Vermont is a national leader in providing health insurance coverage for low and moderate income Vermonters, but despite Vermont's efforts 45% of the uninsured could be eligible for coverage under Medicaid or another public health insurance program (based on an estimate of uninsured Vermonters' household income), but are either unwilling or unable to enroll. The Governor's plan to ensure universal access to health insurance for all Vermonters will include aggressive outreach and enrollment initiatives.

- *Medicaid cost shift initiative.* This initiative will increase annual Medicaid reimbursement levels for doctors and other providers by $5 million. Reasonable reimbursements will assure continued access to providers, and reduce the Medicaid cost shift. Future reimbursement level increases will be contingent upon implementation of "pay for performance" and chronic care payment reform strategies, which reward hospitals, doctors and other health care providers for adherence to quality and cost-effectiveness standards. Any increases in Medicaid reimbursement levels should be accompanied by reductions in commercial health insurance premiums.

<u>Universal Access Initiatives</u>

VI. Universal Access to Affordable Health Insurance for All Vermonters

The Governor's universal access initiatives are designed to address the diverse needs of all Vermonters. 45% of the uninsured are potentially eligible for Medicaid, but are not enrolled in the Medicaid program. Strategies for this lower income group should focus on Medicaid outreach and enrollment efforts. 34% of the uninsured have low or moderate income, and may need financial assistance to purchase health insurance. 21% of the uninsured have income greater than 300% of the Federal Poverty Level. These higher income individuals should be encouraged to participate in the health care system, but they do not need financial assistance.

- *Toll-free Health Insurance Assistance and Referral.* By calling a toll free number, uninsured individuals and businesses will be given simple directions for enrolling in public and private health insurance programs designed to ensure universal access to affordable health insurance for all Vermonters. Depending upon their circumstances and

income, callers will have a choice of Medicaid, the Premium Assistance Plan, and the Basic Insurance Plan, and other insurance options.

- *Medicaid Initiatives.* These initiatives will include the outreach and enrollment and Medicaid cost shift initiatives described above in the Common Sense, Consensus Initiatives. If current VHAP beneficiaries who have access to employer-sponsored insurance were to participate in the employers' offer of coverage, the Medicaid program achieve significant savings. A public subsidy will be paid to VHAP beneficiaries to maintain access to affordable, comprehensive health insurance at no additional cost to the beneficiary.

- *The Premium Assistance Program.* Uninsured individuals with household income between 150% - 300% of the Federal Poverty Level will receive the financial assistance necessary to purchase an affordable health insurance policy. The Program will require adherence to chronic care management procedures and treatment protocols. Basic Insurance Policies purchased through the Premium Assistance Program by uninsured individuals will be in a separately rated pool. Estimated enrollment in the Program after start up will be about 13,000.

- *The Basic Insurance Policy.* Uninsured Vermonters need a low-cost, basic insurance policy in order to be able to afford health care coverage. The Basic Insurance Policy will be a Health Savings Account-type health insurance plan. The deductible amount (typically $2,500 per person per year) will ensure that premiums will be affordable, and will ensure that the policy is eligible for federal tax savings. Preventive care expenses will not be subject to the deductible amount. Major medical health care expenses, such as hospital expenses, will be covered above the deductible amount. The Basic Insurance Policy will require adherence to chronic care management procedures and treatment protocols.

- *Tort Reform.* Steps should be taken to reform the system of adjudicating medical malpractice claims, including the following items from the Medical Malpractice Study Committee Report: (a) establishing caps on on-economic damages such as "pain and suffering"; (b) safe apology legislation to exclude statements of apology from medical malpractice litigation; (c) revision of the collateral source rule; (d) establish a pre-trial screening panel minimize frivolous lawsuits; and (e) amending the statute of limitations as applied to minors, reducing uncertainty and long-term insurance costs.

Attachment E

Burlington Free Press Article describing Health Care Reform Legislation by House Committee on Health Care

Burlington Free Press
burlingtonfreepress.com | A Local Custom

Health reform bill begins political journey

By Nancy Remsen
Free Press Staff Writer

February 17, 2006

MONTPELIER -- Like a ski racer in the Winter Olympics, the House Health Committee's health care reform bill blasted out of the starting gate Thursday and headed down a course full of political obstacles.

Seven Democrats and two Republicans voted to recommend a package of reforms the committee has worked on for seven weeks, while two Republicans voted against the bill.

"This is a significant first step," declared Committee Chairman John Tracy, D-Burlington.

The bill would create a comprehensive health program for the uninsured called Catamount Health and promote initiatives that would transform the way care is provided to Vermonters with chronic conditions.

"I wasn't holding out a lot of hope we could do anything significant," said Rep. Lucy Leriche, D-Hardwick, "but what we are doing is huge. We are creating a system out of so many parts."

Leriche's initial pessimism grew from the committee's experience last year. The panel had recommended a grander plan for health reform that never made it to the finish line because Gov. Jim Douglas disagreed with the state-financed health system the committee envisioned. He also rejected a payroll tax as a way to finance the first phases of the plan.

Douglas doesn't embrace the House committee's new plan, but he and his staff were careful Thursday to leave open the possibility for compromise.

"We feel the state can't afford what Catamount Health is going to cost," said John Crowley, commissioner of banking, insurance, securities and health care administration, "but we're still hopeful things can be worked out going forward."

Tension built throughout Thursday as the time neared for the committee to vote. Several Republican lawmakers huddled and struggled to decide how to vote.

Rep. Francis "Topper" McFaun, R-Barre, said the bill fell short of helping Vermonters with insurance get immediate reductions in health care costs. He chose to vote for the bill anyway.

Rep. Joseph Baker, R-West Rutland, held out hope the committee could reach agreement with the administration. Few on the committee welcomed a last-minute amendment from the Douglas administration, however, which Baker put on the table.

The proposed amendment, taken almost verbatim from the governor's health reform bill, would mandate that anyone who qualified for state subsidized health coverage under existing or new

programs but who could obtain coverage at work, had to take the employer's plan. The state would help workers pay their share of the premiums.

"That this comes in now at this point really frosts me," Tracy said. He explained he has met regularly with the administration concerning the bill and noted, too, that the committee had moved significantly from its advocacy of state-financed health care toward changes the administration could embrace.

"This to me says my way or the highway," said Rep. Virginia Milkey, D-Brattleboro.

Rep. Steve Maier, D-Middlebury, added that the governor's proposal would push $40 million or more in health insurance expenses onto businesses.

Tracy called for a break, and when the committee reconvened, Baker withdrew the amendment.

Lobbyists had crowded the committee room for much of the day, hungry for the final details of the bill. After the vote, many advocates said they weren't yet ready to comment.

Beatrice Grause, president of the Vermont Association of Hospitals and Health Systems, wasn't bashful, though. She criticized the bill's proposed reliance on federal dollars available under the state's new five-year Global Commitment for Health with the federal government. "I just don't think relying on Global Commitment is reliable funding."

Democratic House Speaker Gaye Symington called a news conference to praise the bill as making "solid progress" toward "quality health care that is affordable for all Vermonters."

She said she remained optimistic the Legislature and the governor could find common ground. "I had a conversation with the governor this morning," she said. "We have conversations left to have."

Attachment F

AHS Quality Improvement Manager Job Description

Specs for AHS Manager of Quality Improvement

Class Definition:
Managerial, administrative, and policy development work for the Agency of Human Services involving the development and implementation of a coordinated Quality Management program for cross-functional performance improvement. A primary focus area is implementation of the Global Commitment to Health Medicaid waiver demonstration project under which the State of Vermont will operate as a Managed Care Organization. Duties include development, integration and maintenance of an accurate, expansive system of evaluation, including process and outcome analysis, and preparation of reports measuring quality and consistency of human services programs, partnerships and operations. Supervision is exercised over a small number of professional staff; functional supervision is exercised over quality assurance partners. Work is performed under the general direction of the Agency Planning Director with significant latitude for independent initiative.

Examples of work:

Directs and supervises the planning, development, implementation, and administration of a comprehensive and coordinated quality improvement system for the delivery of human services statewide. Designs and implements a federally-mandated five-year evaluation of the overall goals of the statewide Global Commitment to Health Program. Designs and implements a statewide quality assessment and performance improvement plan for Medicaid services. Develops, procures and manages an external contract for federally-required external quality review activities on quality, timeliness, and access to health care services for Medicaid recipients statewide. Monitors compliance of the state's Medicaid Program with federal standards regarding access, structure and operations, and measurement and improvement. Oversees implementation and integration of AHS Central Office resources and activities related to quality improvement, including assessing customer satisfaction and managing responses to complaints from centralized sources such as the Governor's Hotline. Develops strategies and processes to optimize the use of existing data, resources and quality assurance / improvement activities within state government (e.g., AHS Central Office, AHS Departments, DOE, BISHCA) and external stakeholders (e.g., contracted provider organizations, private insurance companies, Vermont Association of Hospital and Health Care Services; Vermont Research Partnership; Area Health Education Councils).

Environmental Factors:

There may be need for travel around the state, so private means of transportation is required. Considerable work outside of normal working hours may be required. Significant amounts of tact and diplomacy are needed to reconcile a variety of differences of opinion. Substantial pressure from deadlines may be experienced.

Minimum Qualifications:

<u>Knowledge, Skills and Abilities</u>

Considerable knowledge of quality improvement principles and practices

Considerable knowledge of research evaluation and design methodology

Knowledge of health care practices and service systems

Familiarity with contract management

Ability to work with multiple levels of staff and external stakeholders to facilitate cooperative and integrated working relationshps and products

Ability to develop and apply program evaluation tools and use data to improve performance

Ability to design and integrate multiple projects and priorities at an agency-wide level,

Ability to identify and prioritize the most important aspects of health care for quality improvement focus

Ability to communicate effectively both orally and in writing in a variety of venues and formats

Education and Experience

Education: Bachelor's Degree
Experience: Six years of experience as a program administrator in human services or health services where the activities included at least two of the following: program evaluation, quality improvement projects, project management and data analysis.
OR
Education: Master's Degree
Experience: Four years of experience as a program administrator in human services or health services where the activities included at least two of the following: program evaluation, quality improvement projects, project management and data analysis.
OR
Education: Doctoral Degree
Experience: Two years of experience as a program administrator in human services or health services where the activities included at least two of the following: program evaluation, quality improvement projects, project management and data analysis.

Preference will be given to applicants with supervisory experience.