

March 25, 2005

Mr. Joshua Slen, Director  
Enrollment & Member Services RFP  
Office of Vermont Health Access  
312 Hurricane Lane, Suite 201  
Williston, Vermont 05495

Dear Mr. Slen:

MAXIMUS is pleased to submit our proposal to continue to provide Enrollment, Benefits Counseling, and Member Services for the Office of Vermont Health Access (OVHA). We acknowledge receipt of the Answers to Questions, dated February 25, 2005, and we accept and agree to all of the terms and conditions contained in the RFP. We have carefully reviewed all requirements listed in the Request for Proposal (RFP) and its addendum, understand the scope of work, and are ready and willing to perform all of the services you have defined.

MAXIMUS has enjoyed serving as your partner since 1996, and we are eager to continue in this role. We offer OVHA a superior approach to enrollment, benefits counseling, and member services that includes a risk free transition of services, a full complement of staff who are in place and fully-trained, a management team with over 43 years experience supporting the Vermont project, the proven ability to meet or exceed contractual performance standards, and the proven commitment to remain flexible and respond to unanticipated needs.

As President of the Health Services Group, I am the person official authorized to bind MAXIMUS to the provisions of the RFP and proposal. I also serve as the primary contract for the State's Issuing Officer and can be reached by e-mail at [johnboyer@maximus.com](mailto:johnboyer@maximus.com) or at the following address and telephone number:

MAXIMUS, Inc.  
11419 Sunset Hills Road  
Reston, Virginia 20190  
Telephone: (703) 251-8500  
Facsimile: (703) 251-8240

MAXIMUS does not discriminate in its employment practices with regard to race, color, religion, age, sex, sexual orientation, marital status, political affiliation, national origin, or handicap, and complies with all applicable provisions of Public Law 101-336, Americans with

Disabilities Act. We agree to comply with all State and Federal requirements related to fair employment practices.

Thank you for considering our proposal to continue to provide Enrollment, Benefits Counseling, and Member Services in Vermont. We have enjoyed serving as the Vermont contractor for the past 9 years and look forward to continuing our partnership with OVHA into the future. If you have any questions or require additional information, please feel free to contact me at the above mentioned numbers or Ms. Susan Bauer at (802) 651-1577.

Sincerely,

John F. Boyer, Ph.D.  
President, Health Services Group



## PROPRIETARY INFORMATION

As required by the RFP, we have identified certain pages of our proposal as being proprietary. Each page is boldly stamped "**PROPRIETARY**" and contain information pertaining to one of the following categories.

- A. Personnel:** Disclosure of personnel names and positions shows the types of qualifications and responsibilities of key individuals and reveals information about a specific approach to service delivery that may be economically advantageous to a competitor.
- B. MAXIMUS Innovations:** Disclosure of the innovations developed by MAXIMUS would cause economic loss if disclosed to competitors in this and future procurements.
- C. Technology Approach:** Disclosure of the MAXIMUS technology approach including hardware, software, telephone systems, and the configurations of such would lead to economic loss if disclosed.
- D. Corporate Management, Business Practices, or Policies:** Disclosure of management principles and techniques, protected business practices, and corporate policies as applied to this proposal would create an economic loss for MAXIMUS if revealed.

MAXIMUS SECTION	PAGE NUMBER	REASON CODE
Section 3 – Executive Summary	Entire Section	A, B, C, D
Section 4 – Corporate Background and Experience	Pages 4-24 – 4-41	A, D
Section 6 – Responses to Questions (6.1 – 6.10)	Entire Section	A, B, C, D
Section 8 - Cost	Entire Section	A, B, C
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## 4. CORPORATE BACKGROUND AND EXPERIENCE

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- 4.1 Experience With Projects of a Similar Scope and Nature
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The Office of Vermont Health Access (OVHA) seeks a qualified contractor to provide benefits counseling, enrollment services, outreach and education, and member services to Vermont's health care beneficiaries. MAXIMUS brings unmatched experience in providing these services due to our long and successful role as your partner for this project since 1996, and our company-wide experience in operating projects of similar scope and scale across the country.

MAXIMUS has a long history of providing services in the State of Vermont, and specifically has served as a partner to the Office of Vermont Health Access (OVHA) since 1996 in operating the Vermont Health Access Member Services (VHAMS) Project. As your partner in administering the Vermont project, the array of services provided as well as our role and responsibilities has evolved and grown to accommodate changes in State policies and programs.

During the early implementation of Medicaid managed care in Vermont, MAXIMUS provided enrollment, education, and outreach activities for an estimated 60,000 beneficiaries enrolled in the program. In the spring of 1998, additional member services functions were added for Medicaid, Dr. Dynasaur and the VHAP and VHAP Pharmacy programs. With passage of the State Children's Health Insurance Program (SCHIP) and Vermont's inclusion of this population through a Medicaid expansion program, our role again expanded and we provided enrollment, outreach, and education services to an expanding population.



Other significant changes occurred within Vermont's managed care program, most notably, the movement from enrolling Medicaid beneficiaries into managed care health plans to exclusively enrolling in **Primary Care Plus**. MAXIMUS was an active participant and partner in helping State officials craft this new program. We also assisted OVHA in creating the State's new premium collection process. MAXIMUS currently provides services to an estimated 147,000 consumers of Vermont's health care programs, including an estimated 85,000 receiving Medicaid through **Primary Care Plus**.

*MAXIMUS currently provides services to an estimated 147,000 consumers of Vermont's health care programs, including an estimated 85,000 receiving Medicaid through Primary Care Plus.*

In addition to our role in administering the Vermont project, MAXIMUS has other experience in providing a broad array of services in Vermont. A summary of our recent presence within Vermont is shown in *Exhibit 4-1: MAXIMUS History in Vermont*.

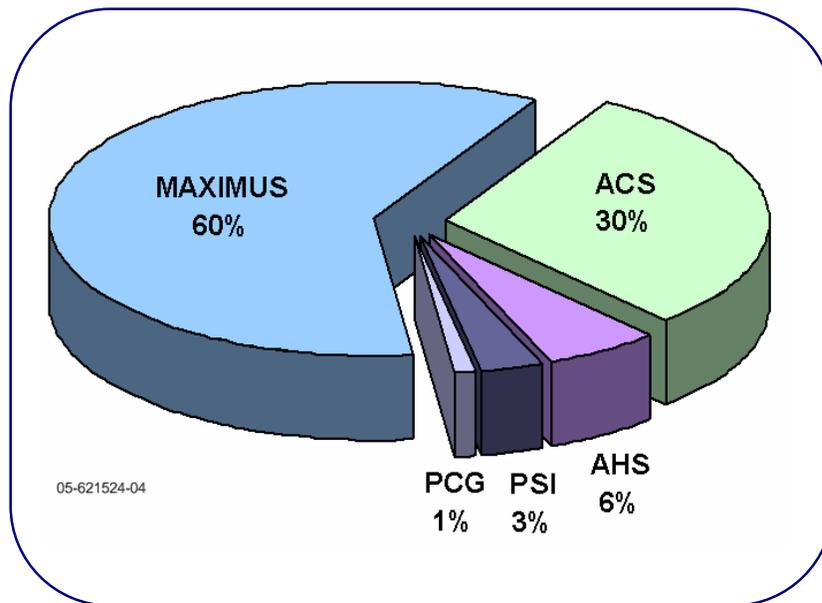


Agency Name	Project Name	Contract Term/Value	Description
Vermont AOT	Vermont FleetFocusM5™ Implementation	<b>Period of Performance:</b> February 2004 through October 2004  <b>Contract Amount:</b> \$252,000	The State of Vermont has contracted for the implementation of FleetFocusM5.
State of Vermont, Agency of Human Services; Department of Prevention, Transition, Assistance, and Health Access	Vermont Medicaid Family-Directed Personal Care Attendant (PCA) Services for Children Program	<b>Period of Performance:</b> January 2001 through June 2004  <b>Contract Amount:</b> \$890,478	MAXIMUS provided administrative services for the Consumer-Directed Personal Care Attendant (PCA) Services for Children program on behalf of the Office of Vermont Health Access. Under this program, families of children with special health care needs have the option of acting as the employer for personal care services for their children. MAXIMUS provided education, guidance, and ongoing support for families who opted to self-direct their PCA services.
Office of Vermont State Treasurer	Vermont Public Employee Retirement System (PERS)	<b>Period of Performance:</b> January 2004 through April 2004  <b>Contract Amount:</b> \$58,650	MAXIMUS provided services to the Retirement Operations Division of the Office of Vermont State Treasurer to assist the Retirement Division in reviewing business processes and procedures and assessing organization and operational areas of the Division.
Vermont Department of Social and Rehabilitation Services, Child Care Services Division (CCSD)	Child Care Information System (CCIS)	<b>Period of Performance:</b> December 2002 through March 2004  <b>Contract Amount:</b> \$1,677,000	MAXIMUS provided Vermont with a completely web-based Child Care Information System (CCIS), designed for security, scalability, performance, administration, and affordability.
University of Vermont	University of Vermont Comprehensive Rate Information System (CRIS) Project	<b>Period of Performance:</b> September 2002 through September 2003  <b>Contract Amount:</b> \$60,000	MAXIMUS prepared a Facilities and Administration (F&A) rate proposal and negotiate F&A rates for the University with the Department of Health & Human Services, its cognizant Federal agency.
University of Vermont	University of Vermont Comprehensive Rate Information System (CRIS) Project	<b>Period of Performance:</b> January 2001 through August 2002  <b>Contract Amount:</b> \$120,000	The University of Vermont purchased the MAXIMUS' CRIS Software through a sole-source purchase requisition. The University of Vermont needed a system that efficiently calculates, supports, and defends the Facilities and Administration (F&A) rate proposal.

**Exhibit 4-1: MAXIMUS History in Vermont.** *Our commitment to providing a variety of services in Vermont provides us with knowledge and understanding of State programs and the consumer populations served.*

#### 4.1 EXPERIENCE WITH PROJECTS OF A SIMILAR SCOPE AND NATURE

MAXIMUS is the leading contractor in the nation in implementing and managing Medicaid managed care enrollment and SCHIP eligibility. MAXIMUS is currently the Medicaid managed care enrollment broker in nine states serving more than 10.7 million individuals and the SCHIP administrative vendor in four states serving an estimated 850,000 persons. As shown in *Exhibit 4.1-1: U.S. Medicaid Managed Care Population Served*, MAXIMUS provides services to an estimated 4.7 million more Medicaid managed care beneficiaries than our closest competitor.



**Exhibit 4.1-1: U.S. Medicaid Managed Care Population Served.** MAXIMUS has the largest market share of providing Medicaid managed care services compared to any other firm providing similar services.

We operate projects that are similar in scope, scale, and nature to the Vermont project in Montana, Colorado, and Virginia. In each of these projects we serve enrollees living in rural areas and provide enrollment into a Primary Care Case Management (PCCM) program. In addition to these smaller scale projects, MAXIMUS also has large-scale projects that provide services to a large number of health care beneficiaries, many of whom live in urban areas and are culturally and ethnically diverse. Our California Health Care Options Project serves as a good example of a large-scale project providing services to a diverse population. This project is the largest Medicaid managed care enrollment broker operation in the country. In *Exhibit 4.1-2: Why MAXIMUS?* We highlight our experience, strengths, and capabilities that position us as the best choice for the continued operation of the Vermont project.



Key Factor Required	MAXIMUS Accomplishments
Understanding Vermont	<ul style="list-style-type: none"> <li>✓ Incumbent Contractor since 1996</li> <li>✓ Active participant in the Vermont Health Access Team workgroup</li> <li>✓ Worked collaboratively with the State in creating the <b>Primary Care Plus</b> program and the premium payment system</li> <li>✓ Understand intricacies of all of Vermont's health care programs</li> <li>✓ Proven flexible and responsive to changes in State policy and program requirements</li> </ul>
Experience with Medicaid Enrollment, Managed Care Enrollment and Managed Care Education	<ul style="list-style-type: none"> <li>✓ More than 90 program years of related program experience</li> <li>✓ Medicaid managed care education and enrollment contractor in 9 States currently serving more than 10.7 million individuals</li> <li>✓ Cumulative voluntary rate of 82 percent during the last 12 months across all MAXIMUS projects.</li> <li>✓ Provide PCCM enrollment services in Vermont, Colorado, Virginia, and Montana</li> <li>✓ Currently provide managed care education and/or enrollment through 14 separate customer service call centers</li> <li>✓ Operate general HelpLine services in Vermont, Massachusetts, and Michigan</li> </ul>
Consumer Relations and Outreach/Public Relations	<ul style="list-style-type: none"> <li>✓ The MAXIMUS New York Medicaid CHOICE project received nine national advertising and marketing awards</li> <li>✓ Awarded the "Center of Excellence" certification from Purdue University's Center for Customer Driven Quality for the MAXIMUS MassHealth Customer Service Call Center</li> <li>✓ Answered more than 39 million calls in our health care practice area</li> <li>✓ Conducted 687,582 public presentations, participated in 58,255 community events, and produced 432,947 newsletters across Medicaid, SCHIP, and EPSDT projects</li> <li>✓ Made more than 11.6 million outreach calls to consumers as part of our Medicaid, SCHIP, and EPSDT programs nationwide</li> <li>✓ The MAXIMUS Center for Health Literacy has created health education and outreach materials for more than 15 state programs (Medicaid, SCHIP or Medicare) and British Columbia</li> </ul>
Data Systems and Operations	<ul style="list-style-type: none"> <li>✓ Successfully designed and implemented sophisticated enrollment and eligibility systems for all our Medicaid managed care enrollment and SCHIP projects</li> </ul>
Depth of Organizational Resources	<ul style="list-style-type: none"> <li>✓ 5,500 Staff Nationwide, over 1,000 current contracts, and over 100 operational projects</li> </ul>
Corporate Financial Resources	<ul style="list-style-type: none"> <li>✓ Revenue of \$603.8 million in 2004</li> <li>✓ Profitable every year of operation</li> </ul>

**Exhibit 4.1-2: Why MAXIMUS?** *As the current contractor for the Vermont Health Access Member Services Project, MAXIMUS has direct experience in all required areas. This experience is supplemented by our operation of similar programs in other states around the country, and is supported through our strong organizational and financial stability and strength.*

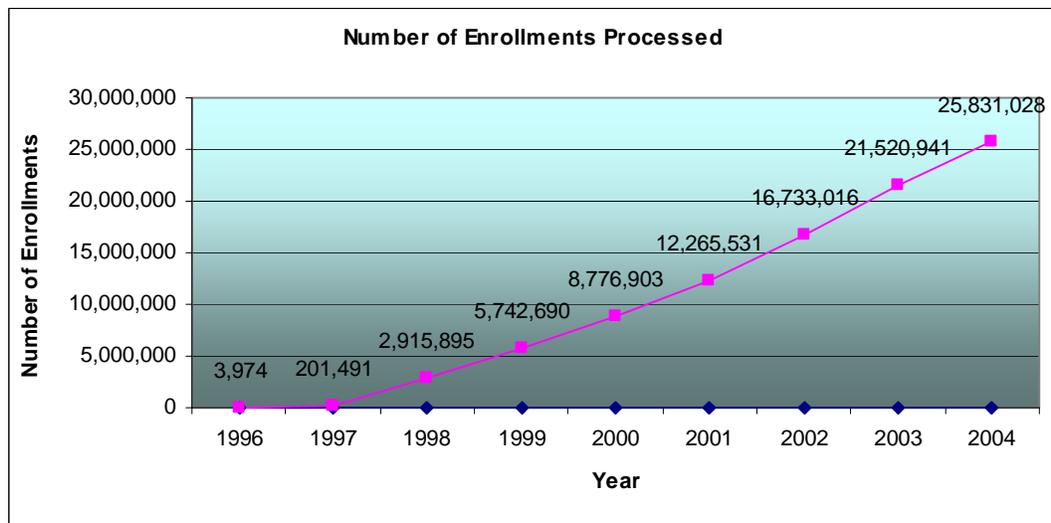


In the subsections that follow we provide a brief description for the areas listed below.

- Medicaid Enrollment and Managed Care Enrollment
- Managed Care Education
- Consumer Relations and Outreach/Public Relations
- Data Systems and Operations
- Descriptions of Relevant Projects

#### 4.1.1 Medicaid Enrollment and Managed Care Enrollment

Throughout our history of providing Medicaid managed care enrollment services we have processed 25.8 million enrollments. Our experience in this area is depicted in *Exhibit 4.1.1-1: MAXIMUS Managed Care Enrollment Experience*.



**Exhibit 4.1.1-1: MAXIMUS Managed Care Enrollment Experience.** Through November 2004, MAXIMUS reached a cumulative total of over 25.8 million enrollments.

During a recent 12-month period of operation MAXIMUS has maintained a project-wide voluntary choice rate of 82 and an impressive 88 percent voluntary choice rate for the Vermont project.

As part of the enrollment process MAXIMUS is responsible for ensuring appropriate handling of enrollment packets and other enrollment-related notices. We have mailed over 12 million enrollment packets across all of our Medicaid managed care enrollment broker projects.

While much of our experience in Medicaid enrollment and managed care enrollment stems from our Medicaid projects, our SCHIP projects also provide us with similar qualifications. Our SCHIP operations require us to identify individuals who are potentially eligible for Medicaid and refer them to the appropriate entity for services. We also conduct enrollment transactions into a managed care health plan once we have confirmed eligibility for services.

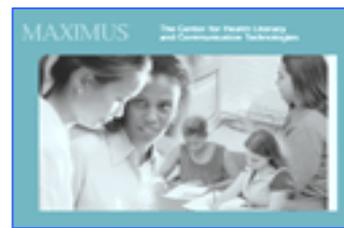
## 4.1.2 Managed Care Education

*An indicator of our success in providing appropriate managed care education is our ability to maintain a very high voluntary choice rate company wide of 82 percent during a recent 12 month period and 80 percent since we first began providing these services nine years ago.*

Managed care education is a critical component of both our Medicaid managed care enrollment and SCHIP eligibility projects. Within managed care, we assist Medicaid beneficiaries throughout the enrollment process with special attention towards providing comprehensive, accurate, and unbiased information about enrollment options. An indicator of our success in providing appropriate managed care education is our ability to maintain a very high voluntary choice rate company wide of 82 percent during a recent 12 month period and 80 percent since we first began providing these services nine years ago. Within our Vermont project, we have maintained a voluntary choice rate of 83 percent since we first started project operations in 1996.

Managed care education for both our Medicaid and SCHIP projects involves educating consumers about how to access and receive services, their rights and responsibilities in receiving services under managed care, and resources available in the community to assist with service delivery. Education is conducted primarily through the operation of 14 separate customer service centers for our Medicaid SCHIP, pharmacy benefit, and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) related projects. Our customer service centers in these areas have answered more than 39 million consumer calls.

The MAXIMUS Center for Health Literacy (The Center) is involved in project operations to create linguistically and culturally appropriate materials to further consumer education and outreach. The Center is a national leader in the development of print, web-based, and other media materials that are easy to read and tailored to low literate consumers. The Center studies how well consumers understand materials, and develops, designs, and translates low barrier materials. The Center writes and designs materials that explain the key components of managed care and educate consumers about how to access services. These materials also serve as additional advertising and marketing about managed care programs. The Center has created health education and outreach materials for more than 15 state programs (Medicaid, SCHIP, or Medicare) and British Columbia.

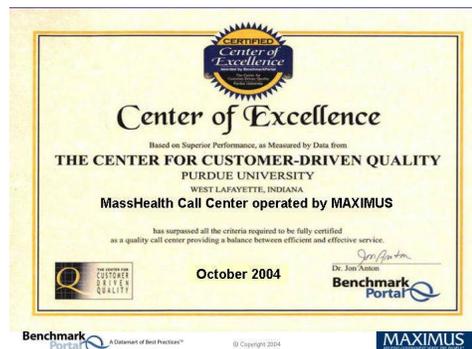


Recently The Center was awarded a contract with The Southern Institute on Children and Families (SICF). This entity is the National Program Office for Covering Kids & Families (CKF), an initiative funded by The Robert Wood Johnson Foundation, to address the need to reduce the number of uninsured children and adults who are eligible for public health care coverage programs but not enrolled. CKF is sponsoring a Process Improvement Collaborative over the next year, with 14 states as grantees. The Center is acting as a faculty member for the Collaborative, and will present at each of three learning sessions, offering strategies that help grantees simplify program materials and websites.

### 4.1.3 Consumer Relations and Outreach/Public Relations

*We recently were awarded the "Center of Excellence" certification from Purdue University's Center for Customer Driven Quality for call center operations in the Commonwealth of Massachusetts.*

The majority of our interactions with health care consumers occur within our customer service call centers. MAXIMUS provides customer service through call centers for all projects involving Medicaid enrollment, SCHIP, and EPSDT services. We recently were awarded the "Center of Excellence" certification from Purdue University's Center for Customer Driven Quality for call center operations in the Commonwealth of Massachusetts. The MAXIMUS MassHealth Customer Service Center ranks among the top ten percent of the 20,000 call centers evaluated by Purdue University.



In some of our projects, including Medicaid enrollment projects in Michigan and Massachusetts and our SCHIP project in California, we provide general HelpLine services that are similar to the member services functions we currently provide as part of the Vermont project. In Michigan, our consumer HelpLine provides answers to beneficiary questions about benefits and policies for various Department programs in addition to supporting the managed care enrollment related functions. In Massachusetts our customer call center provides HelpLine services to all MassHealth beneficiaries. The MAXIMUS California Healthy Families Project provides "Single Point of Entry" services for California's publicly funded health care programs.

*Our experience shows use of outbound dialer technology enables us to make 10 times more outreach calls with existing staff than without use of this tool.*

MAXIMUS currently operates the nation's largest EPSDT outreach and education effort in our Texas Health Steps project. Outreach and education services are provided to an estimated 1.7 million children who are eligible for EPSDT services. In addition to call center staff, we also use an outbound dialer to facilitate the delivery of important messages and information to families of eligible children. This project has made more than 7.5 million total education and outreach calls with more than 4.9 million calls made using the outbound dialer. MAXIMUS also uses outbound dialer technology in support of our California Healthy Families Project. Our experience shows use of outbound dialer technology enables us to make 10 times more outreach calls with existing staff than without use of this tool. Our data shows that three out of 10 calls made using the outbound dialer results in a call that reaches a live voice. Calls resulting in a live voice response can be immediately transferred to a customer service representative for a personalized outreach message.



In light of the many program changes proposed within the Governor's Global Commitment initiative, outbound dialer technology could prove to be a cost



effective tool for use in the Vermont project. The outbound dialer would enable us to greatly streamline and enhance outreach and education efforts and send mass messages quickly, efficiently, and for little cost. For example, the outbound dialer can be used to send messages, including the ability to leave standardized messages on voice mail recording and answering machines about general health issues or upcoming changes in programs or policies. Such messages also can be used to remind consumers that they need to select a PCP as part of their enrollment in managed care.

MAXIMUS uses call center performance data to monitor the quality of consumer relations. We strive to answer calls quickly thereby minimizing the call abandonment rate and the length of time required for consumers to speak to a live operator. Contractual performance standards vary from project to project, and often reflect the level of service required based on available State resources. MAXIMUS routinely meets call center contractual performance standards in our Medicaid managed care enrollment broker contracts and is one way we provide a high level of customer service and maintain strong consumer relations.

We interact directly with consumers during the conduct of outreach and education presentations. As part of our Medicaid managed care enrollment projects, we have made more than 680,000 group presentations to more than four million individual consumers. We also have conducted an estimated 700,000 individual client meetings.

Public relations and outreach are further conducted through MAXIMUS participation in community events. To date, MAXIMUS has participated in more than 6,400 individual community events as part of our Medicaid enrollment projects and another 51,413 in our Texas EPSDT project alone. Our Medicaid enrollment projects have also made almost 2,000 provider presentations to more than 8,200 individual providers.



*The New York Medicaid CHOICE project has received nine national advertising and marketing awards, including the Gold Award for "consumer decision-making" programs from the 2001 National Health Information Awards program.*

While many of our projects are proactive in consumer and public relations through outreach activities, our New York Medicaid CHOICE and California Health Care Options projects have noteworthy accomplishments. The New York Medicaid CHOICE project has received nine national advertising and marketing awards, including the Gold Award for "consumer decision-making" programs from the 2001 National Health Information Awards program. In 2001, the





MAXIMUS-New York project also was recognized by the American Publishers Association and awarded a Gold Award of Excellence, in recognition of its customer services and its written materials. The MAXIMUS California Health Care Options (HCO) Project employs 130 full- and part-time enrollment services representatives who make educational presentations throughout California in County Welfare Offices and in other space leased by MAXIMUS. Currently there are 115 California HCO locations where walk-in beneficiaries can receive assistance.

#### **4.1.4 Data Systems and Operations**

A critical component of our ability to provide enrollment, education, and other related services depends on the presence of a data system to support project operations. For our State clients who are not concerned about the use of proprietary software, we offer use of our MAXSTAR<sup>®</sup> system. MAXSTAR has been successfully used in many of our enrollment and eligibility projects. We have used MAXSTAR in Vermont to support call center tracking, reporting, and other related functions for the Vermont project since 1996. MAXSTAR continues to be used in many of our other Medicaid enrollment projects including those operated in California, Montana, New York, Michigan, Virginia, and Texas.

We also offer an Oracle, web-based system called MAXe<sup>2</sup> to provide a full suite of enrollment and eligibility functionality. We currently use MAXe<sup>2</sup> in SCHIP projects located in California and Kansas and we are implementing this same system for a new project in Canada, British Columbia providing Medical Service Plan (MSP) and PharmaCare enrollment, eligibility, information maintenance, and contact center services.

#### **4.1.5 Description of Relevant Projects**

We provide a listing of relevant projects and major functional activities conducted in each project in *Exhibit 4.1.5-1: MAXIMUS Projects Demonstrating Relevant Experience*. This exhibit is followed by a description of each project including the client name, contact person and phone number, duration of the project, the cumulative contract amount, and project components that are similar to the Vermont project.



Area of Experience MAXIMUS Project	Years Operated	Type of Project	Medicaid Enrollment	Managed Care Enrollment	Managed Care Education	Consumer Relations	Outreach/Public Relations	Data Systems and Operations	Call Center Operations	PCCM Education and Enrollment
<b>Vermont</b> Health Access and Member Services Project	9	MMC	✓	✓	✓	✓	✓	✓	✓	✓
<b>Montana</b> Enrollment Services Project	5.5	MMC	✓	✓	✓	✓	✓	✓	✓	✓
<b>Colorado</b> HealthColorado Project	7	MMC	✓	✓	✓	✓	✓	✓	✓	✓
<b>Virginia</b> Enrollment Broker Service Project	2	MMC	✓	✓	✓	✓	✓	✓	✓	✓
<b>Massachusetts</b> Health Benefits Management Project	7	MMC	✓	✓	✓	✓	✓	✓	✓	✓
<b>New York</b> Medicaid CHOICE Project	6.5	MMC	✓	✓	✓	✓	✓	✓	✓	
<b>Texas</b> Enrollment Broker Services Project	7.5	MMC	✓	✓	✓	✓	✓	✓	✓	
<b>California</b> Health Care Options Project	8.5	MMC	✓	✓	✓	✓	✓	✓	✓	
<b>Michigan</b> MI ENROLLS	7.5	MMC	✓	✓	✓	✓	✓	✓	✓	
<b>Missouri</b> Senior Rx Program	.5	Pharmacy Benefit				✓		✓	✓	
<b>Centers for Medicare and Medicaid Services</b> Medicare Drug Card Reconsideration Project	.5	Pharmacy Benefit				✓			✓	
<b>California</b> Healthy Families	2	SCHIP		✓	✓	✓	✓	✓	✓	
<b>Kansas</b> HealthWave Project	6.5	SCHIP		✓	✓	✓	✓	✓	✓	
<b>Michigan</b> MChild Project	7	SCHIP		✓	✓	✓	✓	✓	✓	
<b>Iowa</b> <i>hawk-i</i> Project	5	SCHIP		✓	✓	✓	✓	✓	✓	
<b>Texas</b> Health Steps Project	5.5	EPSDT			✓	✓	✓	✓	✓	
<b>Connecticut</b> Children's Health Project	7	EPSDT			✓	✓	✓	✓	✓	

**Exhibit 4.1.5-1: MAXIMUS Projects Demonstrating Relevant Experience.** MAXIMUS has extensive experience in all functional areas required to continue operating the Vermont project.

#### 4.1.5.1 Montana Enrollment Services Project

**Project Highlights:**

- ♦ Provides enrollment broker and outreach services to 65,000 beneficiaries
- ♦ Managed care provided through PCCM program

**Client Name:** Department of Public Health and Human Services

**Contact Person:** Mary Angela Collins

**Contact Phone Number:** 406-444-4146

**Contract Duration:** May 1999 – June 2006

**Cumulative Contract Amount:** \$ 5,003,664

**Similar Project Components:** Medicaid Enrollment, Managed Care Enrollment, Managed Care Education, Consumer Relations, Outreach/Public Relations, Data Systems and Operations, PCCM Enrollment

In 1999, MAXIMUS was awarded a seven-year contract to provide a variety of services in support of the Montana Medicaid managed care program. This program provides Medicaid benefits to some 65,000 residents of Montana, including a large population of Native Americans via a primary care case management (PCCM) program called PASSPORT To Health. MAXIMUS works closely with the State to operate a call center to respond to general Medicaid questions and to provide outreach and enrollment services for program consumers.

In addition to these ongoing activities, under the original contract, we performed several quality assurance functions that included developing a recipient complaint process, creating and administering a client satisfaction survey, analyzing health care utilization factors using HEDIS guidelines, and initiating several focused clinical studies. The focused clinical studies examined issues relevant to Montana's diverse populations and its frontier geography. MAXIMUS also oversaw the PCCM network including recruiting new providers into managed care, managing the contractual relationship between the network providers and the state, and maintaining the provider database. Related to these tasks, we developed a comprehensive communication system between providers and Montana Health Choices via written and personal communications with contracted PASSPORT providers. These communications included the conduct of follow-up calls by our provider coordinator to resolve billing issues or to discuss client enrollment problems or PASSPORT program questions. As part of our relationship with providers, MAXIMUS notified primary care providers when Medicaid consumers were due for well-child visits.

#### 4.1.5.2 HealthColorado Project

##### Project Highlights:

- Provides enrollment broker and outreach services to 360,000 beneficiaries
- Managed care provided through health plans and a PCCM program

**Client Name:** Colorado Department of Health Care Policy and Financing

**Contact Person:** Ms. Katie Brookler

**Contact Phone Number:** 303-866-2416

**Contract Duration:** February 1998 – June 2005

**Cumulative Contract Value:** \$9,647,501

**Similar Project Components:** Medicaid Enrollment, Managed Care Enrollment, Managed Care Education, Consumer Relations, Outreach/Public Relations, Data Systems and Operations, PCCM Enrollment



MAXIMUS was awarded an initial contract in 1998 and has won five subsequent one-year renewals from the Colorado Department of Health Care Policy and Financing to serve as the managed care education and enrollment services provider for Colorado's Medicaid program. Services are provided to 360,000 Medicaid consumers statewide. Under the original contract, the HealthColorado project processed enrollments and disenrollments into Medicaid health plans (HMOs) and the state's primary care case management (PCCM) program, and provided Medicaid beneficiaries with information about the mandatory nature of Medicaid managed care, health plan options, primary care provider participation, and beneficiary rights and responsibilities under managed care. Since December 2002, enrollment into managed care is no longer mandatory as the state offers enrollment into Medicaid HMOs and the PCCM program as a voluntary option.

Other key project activities include: implementing a mechanism to transmit and receive data files from Colorado's COIN and Medicaid Management Information System (MMIS) systems in a timely manner; utilizing our MAXSTAR system for processing enrollments, disenrollments, beneficiary tracking, data reporting, and generating forms, letters, and other correspondence materials; conducting plan and provider file maintenance; operating a toll free customer service call center to provide outreach, education, and enrollment services; and presenting education and enrollment material via mail, telephone, and limited face to face encounters.

#### 4.1.5.3 Virginia Enrollment Broker Services

##### Project Highlights:

- Provides enrollment broker and outreach services to 343,700 beneficiaries
- Managed care provided through health plans and a PCCM program
- Direct overflow calls to trained staff in our NY project to help with periodic call volume increases

**Client Name:** Virginia Department of Medical Assistance Services

**Contact Person:** Ms. Senthia Barlow

**Contact Phone Number:** 804-786-7336

**Contract Duration:** November 2002 – January 2007

**Cumulative Contract Amount:** \$6,018,425

**Similar Project Components:** Medicaid Enrollment, Managed Care Enrollment, Managed Care Education, Consumer Relations, Outreach/Public Relations, Data Systems and Operations, PCCM Enrollment



MAXIMUS was awarded a contract with the Virginia Department of Medical Assistance Services (DMAS) to provide Medicaid managed care enrollment broker services to 343,700 consumers statewide. DMAS provides managed care services through a primary care case management (PCCM) program called MEDALLION, and through managed care organizations (MCOs) under the MEDALLION II program. Program choices vary in each of the Commonwealth's 135 jurisdictions (counties and cities). The project staff performs customer service in the following areas: complaint resolution; health status assessments; exemptions from managed care; managed care education; telephone-based enrollment services; and fulfillments.

Enrollment Services Representatives undergo rigorous training regarding the MEDALLION (PCCM) and Medallion II (MCO) options offered throughout the Commonwealth of Virginia. Staff also receives detailed training related to Virginia Medicaid, customer service techniques, and other technical skills necessary to provide participants with exceptional service. Although the project's call center is located in Richmond, Virginia a distinguishing feature of the Virginia Enrollment Broker Project is the use of our call center in New York City as a standby location to handle overflow calls that occur. This approach is being used because of the periodic increases in call volumes that result from the Commonwealth's practice of large and periodic open enrollments. The MAXIMUS call center located in New York City houses the MAXIMUS New York Medicaid CHOICE, New York Physician Profile, and the Medicare Drug Card Reconsideration projects. MAXIMUS New York staff are fully trained to take calls from Virginia during periods of peak call volumes.

MAXIMUS works closely with the DMAS, their fiscal agent, and the MCOs to ensure the success of the Virginia Enrollment Broker Project. Program responsibilities are implemented in a cooperative and complimentary manner, consistent with the Commonwealth's goals and objectives. Frequent meetings take place regarding a variety of topics including systems interfaces, marketing materials, enrollment procedures, and provider file issues.

**Project Highlights:**

- ◆ Provides enrollment broker and outreach services to more than 925,000
- ◆ Responds to inquiries about benefits
- ◆ Authorizes non-emergency transportation services
- ◆ Provides Helpline service to the entire Massachusetts Medicaid population

**4.1.5.4 Massachusetts Health Benefits Management Project**

**Client Name:** MassHealth Operations

**Contact Person:** Mr. Bruce Pangburn

**Contact Phone Number:** 617-210-5326

**Contract Duration:** February 1998 – March 2005

**Cumulative Contract Amount:** \$75,000,000

**Similar Project Components:** Medicaid Enrollment, Managed Care Enrollment, Managed Care Education, Consumer Relations, Outreach/Public Relations, Data Systems and Operations, General HelpLine, PCCM Enrollment



MAXIMUS provides enrollment and outreach services for more than 925,000 MassHealth consumers, including persons with disabilities who are eligible for managed care. The MassHealth project has one of the largest Medicaid call centers in the country and has been recognized by the Center for Customer-



Driven Quality at Purdue University as a "Certified Center of Excellence," ranking it among the top ten percent of 20,000 call centers evaluated.

MAXIMUS also is responsible for authorizing non-emergency medical transportation services and reimbursement for transportation expenses for all qualified Medicaid customers.

To fully disseminate information about managed care, community outreach staff meets with consumers in person and develops community relationships within their regions. We participate in community events to reach out to targeted populations. Staff makes presentations to members and organizations who serve MassHealth members on such topics as available program benefits, general eligibility guidelines, the application process, and effective access to managed care upon eligibility determination. Outreach staff also contacts members who are assigned to a health plan to make sure they receive a complete education about MassHealth and their choices.

MAXIMUS conducts a quarterly transportation survey to track and measure customer satisfaction with its transportation services. In addition, MAXIMUS conducts an annual customer satisfaction survey that assesses the level of customer service provided to the member by the call center representatives.

In addition to information related to managed care, we provide customer service to the entire Massachusetts Medicaid population through a call center HelpLine. Project staff answers all of the Medicaid consumers' questions related to covered services, billing, applications, MassHealth card replacement, eligibility, third-party liability, prior authorization, and many other related topics. As the telephone number to call on the back of all MassHealth cards, our staff provides a one-stop service for many MassHealth customer service needs.

**Project Highlights:**

- Medicaid outreach, education, and enrollment to 1.6 million consumers
- Received nine National Marketing and Advertising and Health Program Awards including the Gold Awards for "Consumer Decision Making Programs."

**4.1.5.5 New York Medicaid CHOICE Project**

**Client Name:** New York State Department of Health

**Contact Person:** Mr. Christopher Parker

**Contact Phone Number:** 518-473-1134

**Contract Duration:** June 1998 – September 2006

**Cumulative Contract Amount:** \$185,600,000

**Similar Project Components:** Medicaid Enrollment, Managed Care Enrollment, Managed Care Education, Consumer Relations, Outreach/Public Relations, Data Systems and Operations

The primary objective of the New York Medicaid CHOICE Program is to enroll Medicaid consumers into a qualified health plan with the provider of their choice. The number of enrollment consumers served by this project is more than 1.6 million. Since the inception of the New York project in 1998, MAXIMUS has met or exceeded all contract requirements – supporting our consistent record in providing high levels of quality in all aspects of project operations.



As part of our operations, MAXIMUS: performs outreach to consumers and educates them on the concepts of managed care; provides accurate and complete

information on managed care choices and educates consumers on their rights and responsibilities under managed care; provides customer service through the toll-free call center in 13 languages; distributes educational materials that assist consumers in making managed care choices; conducts all health plan and provider enrollment and disenrollment activities and enrolls consumers in health plans and with the primary care physician of their choice; assigns mandatory Medicaid consumers who fail to make a timely health plan choice; and works closely with numerous community based organizations to communicate information about the managed care enrollment process.

The Project has received accolades from many quarters for the media program that provides the basis of an extensive marketing and outreach effort. Nine national advertising and marketing awards have been received, including the Gold Award for "consumer decision-making" programs from the 2001 National Health Information Awards program. In 2001, the MAXIMUS-New York project also was recognized by the American Publishers Association and awarded a Gold Award of Excellence, in recognition of its customer services and its written materials.

**Project Highlights:**

- ♦ Provide Medicaid Managed Care Outreach, Education, and Enrollment for more than 1.1 million recipients
- ♦ Enroll STAR+Plus Eligibles into Medicaid Managed Care Pilot Program
- ♦ Enroll NorthSTAR Eligibles into Behavioral Health

#### 4.1.5.6 Texas Enrollment Broker Services Project

**Client Name:** Texas Health and Human Services Commission

**Contact Person:** Mr. Billy Millwee

**Contact Phone Number:** 512-491-1869

**Contract Duration:** October 1997 – April 2005

**Cumulative Contract Amount:** \$125,330,690

**Similar Project Components:** Medicaid Enrollment, Managed Care Enrollment, Managed Care Education, Consumer Relations, Outreach/Public Relations, Data Systems and Operations

Under the Texas Enrollment Broker Services Project, MAXIMUS educates and enrolls Medicaid recipients into the state's Medicaid managed care program known as the Texas STAR program. MAXIMUS began providing Medicaid managed care services in October 1997, and continues to enroll and educate approximately 1.1 million Texas STAR recipients.



As part of our efforts, MAXIMUS conducts extensive program outreach services throughout major urban centers within the state. A large portion of our outreach services target pregnant women as part of the Expedited Enrollment effort within the STAR program. Texas is an extremely culturally diverse state, and working with community partners that know and serve local populations is critical to a successful outreach program.

In addition to enrolling Medicaid recipients into the Texas STAR Program, the Texas Enrollment Broker Services Project also enrolls approximately 65,000 recipients into the STAR+PLUS program and an estimated 480,000 recipients into the NorthSTAR pilot program. The STAR+PLUS Program is a Texas Medicaid managed care pilot program in the Houston area for delivering both acute health care and long-term care services to persons eligible for Medicaid, based on age or disability. The NorthSTAR program requires enrollment into a

behavioral health organization for certain Medicaid recipients, as well as non-Medicaid clients who currently receive services from designated state agencies in the Dallas Metro Area.

Specific project services provided under the Texas Enrollment Broker Services Project includes: educating Medicaid recipients, providers, and other interested parties regarding the STAR, STAR+PLUS, and NorthSTAR programs; informing Medicaid recipients of managed care concepts and educating recipients about their enrollment options; providing assistance with their health plan selection and primary care provider selection; conducting extensive community outreach including presentations and home visits; assigning mandatory clients to a health plan if they fail to make a timely choice; furnishing an effective data-reporting system for enrollments, transfers, outreach activities, and the complaint and grievance process; having a systems interface with the State, the Medicaid claims processor, the Primary Care Case Management Network administrator, and the NorthSTAR system; and conducting statewide client satisfaction surveys.

**Project Highlights:**

- Largest Medicaid managed care enrollment broker operation in the country
- Staff of 130 full and part time enrollment services representatives who make presentations throughout the state
- Have 115 project locations for walk-in services
- First Medicaid managed care program to receive ISO 9001:2000 certification

#### 4.1.5.7 California Health Care Options (HCO) Project

**Client Name:** California Department of Health Services

**Contact Person:** Mr. Jerry Stanger

**Contact Phone Number:** 916-319-8010

**Contract Duration:** October 1996 – September 2007

**Cumulative Contract Amount:** \$367,000,000 (Note: Contract value includes funding for three options years, through September 2007)

**Similar Project Components:** Medicaid Enrollment, Managed Care Enrollment, Managed Care Education, Consumer Relations, Outreach/Public Relations, Data Systems and Operations



MAXIMUS serves as the enrollment broker for California's Medi-Cal (Medicaid) managed-care program, called California Health Care Options (CA HCO). This contract is the largest enrollment services contract in the nation. We provide managed health care education and enrollment services for 4.6 million Medi-Cal new eligibles and enrolled beneficiaries.

MAXIMUS operates a toll-free call center in Rancho Cordova, staffed by 86 full- and part-time customer service representatives, nine research analysts, and seven enrollment forms processors. Additionally, 130 full- and part-time enrollment services representatives make educational presentations throughout California in County Welfare Offices and in other space leased by MAXIMUS. Currently there are 115 California HCO locations where walk-in beneficiaries can receive assistance. We have placed our culturally and linguistically competent staff in offices where the heaviest concentrations of Medi-Cal beneficiaries reside. Our staff also conducts outreach activities and presentations in the more remote areas of the state.

MAXIMUS provides an array of services to ensure that beneficiaries receive accurate information regarding enrollment into medical and dental plans (health plans) serving their areas. Beneficiaries receive assistance in selecting health plans and providers, and are educated on how to access health plan services and



resolve problems should any arise. Enrollment and disenrollment services are consistently offered in a rapid and professionally appropriate manner.

We also conduct administrative reviews of Medical Exemption Requests (MERs) for the State of California. This process involves reviewing criteria qualifications, creating data records in the MAXSTAR enrollment data system, and submitting information to the Medi-Cal Managed Care Division (MMCD) for exemption review. Following MMCD approval for the MER, consumers with complex medical condition are able to access care outside the managed care programs and receive fee-for-service treatment from Medi-Cal providers.

The Health Care Options Project is certified under the ISO 9001:2000 guidelines. The ISO 9001:2000 quality standards, which have been adopted by more than 146 countries around the world, require companies to understand customer specifications, implement a document quality system, and deliver products that meet customer requirements. In addition, many ISO 9001:2000 registered organizations achieve considerable savings with reduction in rework, customer returns, and waste.

#### 4.1.5.8 Michigan ENROLLS

##### **Project Highlights:**

- ♦ Medicaid managed care education, outreach and enrollment services to more than 900,000 beneficiaries
- ♦ Operate the State's Beneficiary HelpLine for Medicaid and the Children's Special Health Care Program

**Client Name:** Michigan Department of Community Health

**Contact Person:** Ms. Rose Perry

**Contact Phone Number:** 517-335-5532

**Contract Duration:** July 1997– September 2005

**Cumulative Contract Amount:** \$63,498,000

**Similar Project Components:** Medicaid Enrollment, Managed Care Enrollment, Managed Care Education, Consumer Relations, Outreach/Public Relations, Data Systems and Operations, General HelpLine

MAXIMUS contracts with the Michigan Department of Community Health to provide managed care education and enrollment services for Michigan's Medicaid program. Enrollment



services are provided for more than 900,000 Medicaid beneficiaries statewide via a toll-free call center located in East Lansing, Michigan that is staffed with bilingual counselors and field enrollment counselors in subcontracted local offices. The project also operates Michigan's Beneficiary HelpLine that provides assistance to more than 1,400,000 Medicaid and Children's Special Health Care Program beneficiaries.

The project performs a number of tasks including: providing accurate, complete, and current information to Medicaid beneficiaries on managed care plans and their providers; maintaining electronic files of health plan provider networks; educating and informing beneficiaries of their rights and responsibilities under managed care, Medicaid, Children's Special Health Care, and other Department programs; informing clients of the voluntary or mandatory nature of the program; transmitting and receiving data files with Michigan's Medicaid Managed Care Information System (MMIS) and eligibility systems in a timely manner; conducting health plan and primary care physician enrollments and health plan



disenrollments; subcontracting with and overseeing a statewide network of local community agencies whose staff assist with enrollments and education; subcontracting with a mail house vendor to generate and mail enrollment and member notices; and providing outreach education and enrollment material in group or during individual sessions.

**Project Highlights:**

- ♦ Provides eligibility and enrollment services to 18,700 Seniors in the Rx program
- ♦ The MAXIMUS Center for Health Literacy redesigned the application and brochure to make information user friendly

#### 4.1.5.9 Missouri Senior Rx Program

**Client Name:** Department of Health and Senior Services

**Contact Person:** Mr. Jerry Simon

**Contact Phone Number:** 800-979-4662

**Contract Duration:** May 2004 – June 2005

**Cumulative Contract Amount:** \$1,353,184

**Similar Project Components:** Consumer Relation and Data Systems

MAXIMUS was awarded the contract to provide eligibility and enrollment services for the Missouri Senior Rx program. At present, more than 18,000 seniors are enrolled in the Missouri Senior Rx program. MAXIMUS successfully assumed operation of this program from another vendor within two months of the contract start date. This program involves providing seniors with discounted prices for prescription drugs after they pay a deductible based on income and marital status. The MAXIMUS Center for Health Literacy redesigned the application and brochure to make them more "user-friendly" for applicants, members, and community partners. A letter commending the center for its performance in Missouri is provided in *Attachment 1: Letters of Support*.

Specific program tasks include: operate a toll-free call center with bilingual counselors to provide program information and application assistance to Missouri seniors; process enrollment and re-enrollment applications during a two-month open enrollment period every January and February; process enrollment applications throughout the year for seniors who "age-in" during the program year; determine program eligibility; periodically match enrollment records with State Medicaid data to ensure members are not Medicaid eligible; collect and process enrollment fee payments from eligible seniors; generate and mail applicant and member notices and member ID cards using a subcontracted mail house; image all application and enrollment fee payment documents using a subcontracted vendor; and provide daily electronic files to Missouri's pharmacy benefit manager containing enrollment transactions, demographic and deductible information.

#### 4.1.5.10 Medicare Drug Card Reconsideration Project

**Project Highlights:**

- ♦ Administers appeals for those who apply for the Medicare drug card program
- ♦ Allow beneficiaries to initiate an appeal through a toll-free call center

**Client Name:** Centers for Medicare and Medicaid Services (CMS)

**Contact Person:** Ms. Barbara Rufo

**Contact Phone Number:** 410-786-5589

**Contract Duration:** February 2004 – December 2005

**Cumulative Contract Amount:** \$6,000,000

**Similar Project Components:** Consumer Relations

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established the Medicare Prescription Drug Discount Card and Transitional Assistance Program. The Program is a transitional program to provide immediate assistance with prescription drug costs to Medicare beneficiaries during 2004 and 2005 while preparations are made for the implementation of a full Medicare Drug Benefit (Medicare Part D) in 2006. Medicare beneficiaries without drug coverage are provided with access to discounts on prescription drugs through enrollment in card programs offered by "sponsors" endorsed by Medicare. Low-income enrollees may also qualify for \$600 of annual transitional assistance that they may apply directly to the cost of their prescription drugs.

Under this contract, MAXIMUS administers an appeal program for beneficiaries who apply for the drug card, but are determined ineligible for either the Drug Card or transitional assistance. Beneficiaries who are denied eligibility have a right to appeal to MAXIMUS in writing or through a MAXIMUS call center. MAXIMUS conducts a full reconsideration of the beneficiary's application and, based upon Medicare rules, either upholds or overturns the eligibility denial.

#### 4.1.5.11 California Healthy Families

##### Project Highlights:

- Serves as Administrative vendor for more than 700,000 children enrolled in the Healthy Families Program (HFP) and those enrolled in the Access for Infants and Mothers (AIM) program
- Provide call center Services for HFP, AIM, and Outreach
- Operate as the "Single Point of Entry" for consumers via the call center and through a web portal for consumers seeking information about health care programs

**Client Name:** Managed Risk Medical Insurance Board (MRMIB)

**Contact Person:** Ms. Janette Lopez

**Contact Phone Number:** 916-324-4752

**Contract Duration:** April 2003 – December 2008

**Cumulative Contract Amount:** \$418,407,294

**Similar Project Components:** Managed Care Enrollment, Managed Care Education, Consumer Relations, Outreach/Public Relations, Data Systems and Operations, General HelpLine

MAXIMUS was selected by California's Managed Risk Medical Insurance Board (MRMIB) as the Administrative Vendor for 700,000 children enrolled in the Healthy



Families Program (HFP), that state's Title XXI Children's Health Insurance Program and the Access for Infants and Mothers (AIM) Program. MAXIMUS receives and processes applications for both programs and performs a high-level income screening for potential Medi-Cal (Title XIX) eligibility. Under this contract, MAXIMUS also refers some applicants with incomes between 250 percent and 300 percent of the Federal Poverty Level (FPL) to counties that participant in a locally funded Title XXI expansion.

As the Administrative Vendor, MAXIMUS is performing a broad range of tasks including the following: screening applications and making referrals to county welfare departments, the Healthy Families Program, and counties participating in the Title XXI expansion; soliciting missing information for HFP applicants; making HFP eligibility determinations, processing eligibility appeals, and enrolling children into selected health plans; calculating capitation payments; training outreach workers and linking those workers with interested applicants; performing a wide range of call center services, including telephone application assistance; collecting premium payments made using lockbox, credit card, and

cash payment through a subcontractor; generating reports and posting report information through an online interface; producing and mailing a large variety of correspondence forms and letters; maintaining and enhancing the Health-e-App electronic application; and maintaining and improving the HFP website.

**Project Highlights:**

- *Serve as Administrative vendor for the State's SCHIP program, called Kansas HealthWave, providing eligibility and enrollment services*
- *Developed statewide marketing plan to enhance efforts by State outreach workers*

**4.1.5.12 Kansas HealthWave Project**



**Client Name:** *Department of Social and Rehabilitation Service, Health Care Policy Division/Medical Policy/Medicaid*

**Contact Person:** *Ms. Cristiane Swartz*

**Contact Phone Number:** *785-368-6296*

**Contract Duration:** *August 1998 – September 2006*

**Cumulative Contract Amount:** *\$54,858,967*

**Similar Project Components:** *Managed Care Enrollment, Managed Care Education, Consumer Relations, Outreach/Public Relations, Data Systems and Operations*

Under the existing Kansas HealthWave Project, MAXIMUS provides eligibility determination services for children eligible to participate in Title XXI and contract work for Title XIX benefits. In Kansas, this is known as HealthWave - moving forward with health care for Kansans. A customer service center is used to respond to consumer questions and direct consumers for needed information. Other project services include: conducting Title XXI eligibility determination and monitoring; performing on-going case maintenance, processing and collecting premiums; collecting various data and preparing reports and statistical analyses; conducting process improvement and training; and conducting program marketing.

The HealthWave Project received an enhanced role under its recent contract to provide marketing services for the program in an effort to continuously promote the program statewide and retain beneficiaries. While outreach efforts are the responsibility of the State of Kansas, MAXIMUS has developed a collaborative partnership with the State outreach coordinators to ensure that marketing efforts complement the statewide outreach activity. As part of program marketing for Kansas HealthWave, MAXIMUS developed a marketing plan that identifies comprehensive strategies for promoting the program through: media campaigns; production and distribution of TV and radio commercials; web enhancement and maintenance; production and distribution of brochures and fliers; direct appeals to families; use of indoor and outdoor advertising (billboards); creation of promotional materials; and use of surveys for measuring the availability and effectiveness of the HealthWave program in the community.

#### 4.1.5.13 Michigan MICHild Project

##### **Project Highlights:**

- ♦ Serve as Administrative vendor for the State's SCHIP program, MICHild, providing eligibility and enrollment services to an estimated 35,000 children
- ♦ Accept and process online applications for benefits

**Client Name:** Michigan Department of Community Health

**Contact Person:** Mr. David McLaury or Mr. Logan Dreasky

**Contact Phone Number:** 517-335-5182

**Contract Duration:** April 1998 – September 2005

**Cumulative Contract Amount:** \$23,447,731

**Similar Project Components:** Managed Care Enrollment, Managed Care Education, Consumer Relations, Outreach/Public Relations, Data Systems and Operations



MAXIMUS serves as the administrative services contractor for Michigan's State Children's Health Insurance Program known as MICHild. MAXIMUS operates a toll-free call center in East Lansing, Michigan that is staffed with bilingual counselors who provide information and services for the MICHild and Healthy Kids programs. Nearly 35,000 children are enrolled in MICHild. The program also serves as an outreach mechanism for Medicaid and resulted in the referral of more than 230,000 children to Medicaid since May 1998.

In conjunction with the Michigan Department of Community Health and eMichigan, the Project developed a web-based application, which was implemented statewide in May 2002. The web-based application allows individuals to enter all required data online and to receive an immediate eligibility decision. The integration of the web-based application, along with the call center, has been essential to developing an integrated customer contact center.

Other project tasks include: determining eligibility for MICHild and Medicaid (Healthy Kids) using MAXSTAR and screening for Medicaid eligibility; enrolling MICHild-eligible children in health and dental plans and community mental health and substance abuse agencies; maintaining the state MICHild database; generating and mailing notices to applicants and enrollees; generating plan capitation invoices; collecting and processing monthly premiums; conducting enrollee surveys, including a customer satisfaction survey; maintaining a web-based application that provides applicants with an immediate decision and prints notices and coupons at the website; performing monthly matches between the MICHild database and the Medicaid database to identify and disenroll children who have Medicaid.



**Project Highlights:**

- ♦ Serve as Administrative vendor for the State's SCHIP program, hawk-i, providing eligibility and enrollment services to an estimated 17,000 children
- ♦ Accept and process online applications for benefits
- ♦ Conduct and prepare quarterly network analysis report using geographic information systems (GIS) software
- ♦ Process encounter data

#### 4.1.5.14 Iowa hawk-i Project

**Client Name:** Department of Health  
**Contact Person:** Ms. Anita Smith  
**Contact Phone Number:** 515- 281-8791  
**Contract Duration:** June 2000 – June 2008  
**Cumulative Contract Amount:** \$9,895,000  
**Similar Project Components:** Managed Care Enrollment, Managed Care Education, Consumer Relations, Outreach/Public Relations, Data Systems and Operations

Under a contract with the State of Iowa, MAXIMUS serves as the third party administrator for the State's Children's Health Insurance Program known as **hawk-i**. MAXIMUS successfully began transition operations from an incumbent contractor in March 2000 assuming program operations in June 2000. MAXIMUS provides services to more than 17,000 enrollees.

As the SCHIP administrator, the project provides a number of services including: providing customer service and education via a toll-free call center; determining eligibility and screening for Medicaid eligibility using MAXSTAR; generating and mailing applicant and member notices and letters; enrolling program participants into participating health plans; generating health plan capitation payments; collecting and processing premium payments using subcontracted lockbox services with a local bank; administering a functional health survey to a sample of participants; collecting encounter data from participating health plans; accepting automated referrals from the Medicaid program; and providing the state with a quarterly network analysis on accessibility of providers for the program.

The project maintains a website for the **hawk-i** program that also allows applicants to apply for benefits on-line. The web site also provides links to participating health plans supplying provider directories and toll-free customer service telephone numbers.

**Project Highlights:**

- ♦ Outreach and education to 1.7 million eligibles
- ♦ One of the first to use outbound dialer in a social services setting
- ♦ Extensive outreach and education throughout the State
- ♦ Use of a Case Management Informing Unit to conduct outreach to target populations that are most likely to have special needs and require a referral to EPSDT case management providers

#### 4.1.5.15 Texas Health Steps Project

**Client Name:** Texas Department of Health and Human Services  
**Contact Person:** Mr. Billy Millwee  
**Contact Phone Number:** 512-491-186  
**Contract Duration:** September 1999 – April 2005  
**Cumulative Contract Amount:** \$71,835,471  
**Similar Project Components:** Managed Care Education, Consumer Relations, Outreach/Public Relations, Data Systems and Operations



MAXIMUS provides EPSDT outreach and education to the Medicaid population under the Texas Health Steps (THSteps) project. This project is the largest EPSDT outreach program in the nation. Under the initial contract, MAXIMUS provided EPSDT services in 194 counties representing more than 70 percent of the eligible children. Because of the success of the program, MAXIMUS expanded THSteps statewide in May 2004. Statewide implementation increased the number eligible for EPSDT services to 1.7 million children.



We were successful in securing the statewide contract because of our ability to provide effective outreach and education, and our ability to continue to provide these services during a significant increase in the Medicaid caseload. MAXIMUS responded to challenges of an increase in caseload and the resulting higher call volumes by increasing the number of staff, and by using outbound dialer technology. The outbound dialer technology facilitates more effective EPSDT outreach and education by automating outbound dialing. Automated calls can then be transferred to live call center staff when the call results in a successful contact with a live person. MAXIMUS became one of the first to use outbound dialer technology in a social services setting.

Other important activities conducted by the THSteps project include the following: operating a toll-free HelpLine for educating Medicaid consumers, providers, and others interested in services; conducting outreach services to newly certified or re-certified Medicaid consumers on the benefits of preventive health care via the HelpLine or in person; making face-to-face recipient presentations at various locations throughout the Public Health Regions; sending program mailings and reminder letters notifying Medicaid consumers of their eligibility for program services and to promote the importance of preventive health care for their children; and operating field offices staffed with trained outreach counselors who conduct home visits, organize health fairs, participate in health education activities, and make presentations throughout the community to promote THSteps and preventive health care for children.

MAXIMUS also contracts with or uses Memorandums of Understanding with community-based organizations to assist with conducting outreach and education at the grass roots level in each Public Health Region. Our project conducts quality assurance activities through customer/client surveys and real-time monitoring of phone calls and data entry.

The MAXIMUS project also operates a special referral unit called the Case Management Informing Unit. This unit conducts outreach to target populations that are most likely to have special needs and require a referral to EPSDT case management providers. Staff in the referral unit have specialized training and receive client referrals from the general call center staff as well as providers, and other agencies seeking more information and assistance linking these clients to case management services. MAXIMUS also assisted in designing the case management brochure used for this component and distributes brochures to consumers with special health care needs.

## 5. REFERENCES

We are pleased to offer you three references representing projects from our Medicaid enrollment broker as well as our pharmacy benefit practice areas. Our references can attest to our prior experience providing services, or services of similar scope and scale, to those required for the Vermont Project.

The Massachusetts Health Benefits Management Project provides Medicaid enrollment broker as well as general HelpLine services for the entire Massachusetts Medicaid population. The Virginia Enrollment Broker Services Project provides Medicaid managed care enrollment into health plans as well as the Commonwealth's PCCM program. The Missouri Senior Rx Program provides eligibility and enrollment services for the senior pharmacy program. In addition to the three required references listed below, MAXIMUS also includes letters of support from clients in *Attachment 1: Letters of Support*.

### 5.1 MASSACHUSETTS HEALTH BENEFITS MANAGEMENT PROJECT

*Name: MassHealth Operations*

*Address: 600 Washington Street, Boston, Massachusetts 02111*

*Telephone Number: 617-210-5326*

*Responsible Project Manager: Mr. Bruce Pangburn*

### 5.2 VIRGINIA ENROLLMENT BROKER SERVICES

*Name: Virginia Department of Medical Assistance Services*

*Address: 600 E. Broad Street, Suite 130, Richmond, Virginia 23219*

*Telephone Number: 804-786-7336*

*Responsible Project Manager: Ms. Senthia Barlow*

### 5.3 MISSOURI SENIOR RX PROGRAM

*Name: Department of Health and Senior Services, Office of Administration*

*Address: 205 Jefferson Street, Room 1310, PO Box 570, Jefferson City, Missouri 65102-0570*

*Telephone Number: 800-979-4662*

*Responsible Project Manager: Mr. Jerry Simon*



## 7. WORK PLAN

**As the Vermont Incumbent, we offer OVHA a risk-free plan for providing Enrollment, Benefits Counseling, and Member Services project requiring no real transition of services. To further improve the efficiency of our ongoing project operations, we offer OVHA several cost-effective innovations that can be implemented in a timeframe that best meets your needs.**

We look forward to serving as the Vermont contractor into the coming contract term. By selecting MAXIMUS, OVHA avoids any risk associated with transitioning services to a new contractor, as we require no actual transition activities. The only changes we propose are those innovations we identified as ways to further enhance our ability to support OVHA and our beneficiaries. *Exhibit 7-1: Features and Benefits of the Work Plan*, summarizes the benefits that MAXIMUS brings if selected to continue as the Vermont contractor.

MAXIMUS Features	Benefits
<ul style="list-style-type: none"> <li>▪ No transition of core operations needed</li> <li>▪ Proposed enhancements are cost-effective and proven to be effective in other MAXIMUS project locations</li> <li>▪ Onsite Management Team supported by Corporate Team with many years experience implementing project enhancements</li> <li>▪ Proposed Enhancements are cost-effective, requiring minimal effort, and be phased-in at a time that best meets your needs</li> </ul>	<ul style="list-style-type: none"> <li>▪ No risk to OVHA</li> <li>▪ Ensures MAXIMUS continues to meet all OVHA and beneficiary needs and identifies new and better ways to serve you</li> <li>▪ Experienced staff ensures smooth implementation of enhancements with no interruption of ongoing service to beneficiaries</li> <li>▪ Enhancements are deployed seamlessly with no disruption for OVHA or beneficiaries</li> </ul>

**Exhibit 7-1: Features and Benefits of the Work Plan.** *MAXIMUS proposes to phase-in our enhancements in a way that meets OVHA and beneficiary needs.*

*MAXIMUS ensures that all innovations are implemented without disruption to the ongoing project.*

### **Implementation Timeline**

To enhance our existing operation, we have identified some new innovations we propose to implement during the first year of the new contract. In addition, we present OVHA with some optional innovations for your consideration in *Section 6.10: Optional Innovations*.

We understand that the period of time between May and June is expected to be very hectic for OVHA and the Vermont contractor. Because of this, we propose to phase in our enhancements during a timeframe that works best for OVHA and Vermont program beneficiaries. We present our Implementation Timeline as *Exhibit 7-2: Implementation Timeline*. Since we have no real transition period or activities, we have assumed a start date of July 1, 2005 to implement our proposed enhancements for the new contract period. However, the commencement dates of these tasks can easily be adjusted as directed by OVHA.



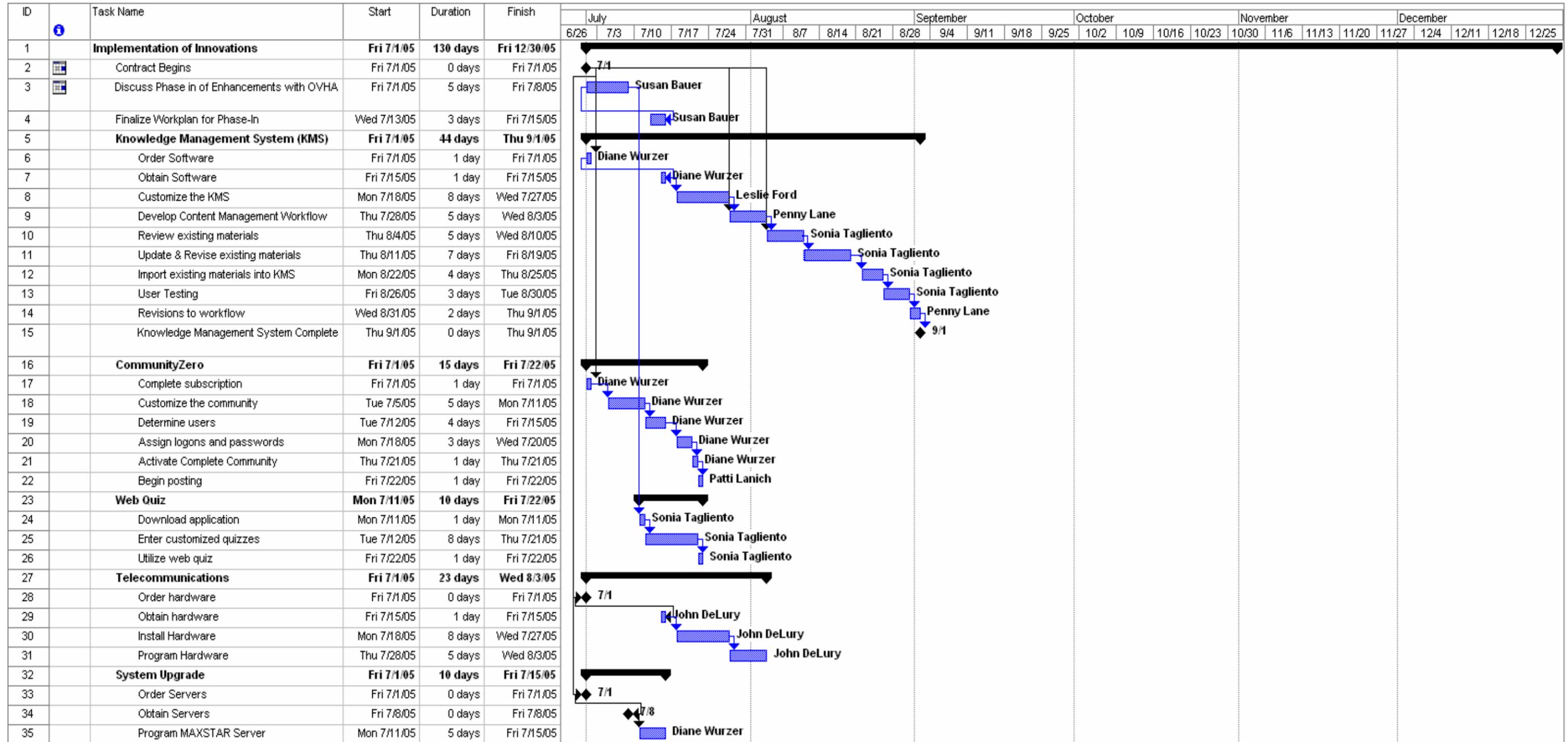
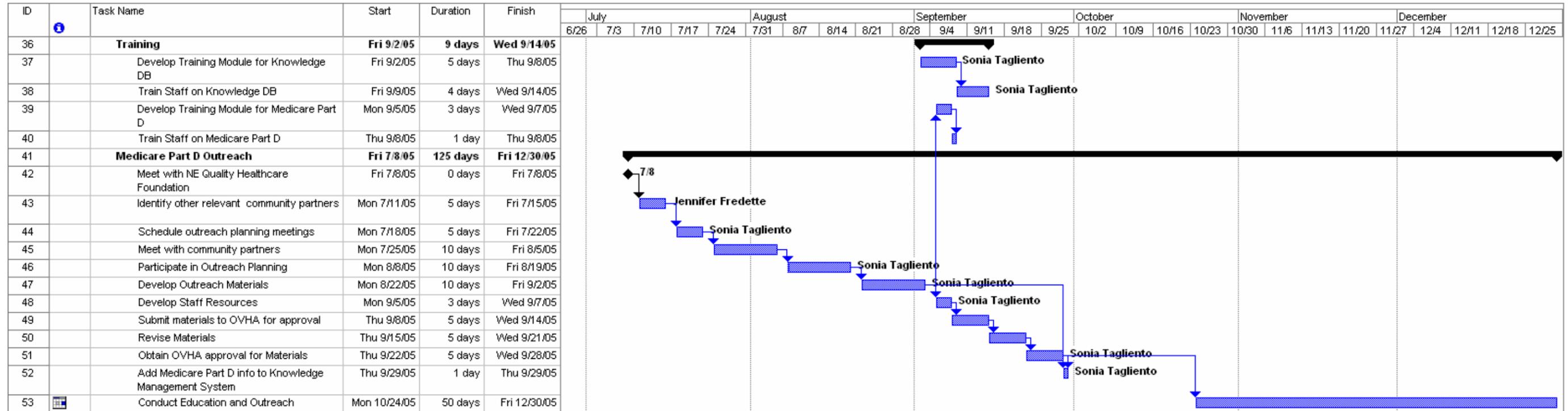


Exhibit 7-2: Implementation Timeline. We propose a timeline for implementing Vermont project enhancements intended to best meet OVHA and beneficiary needs.





**Exhibit 7-2: Implementation Timeline (continued).** We propose a timeline for implementing Vermont project enhancements intended to best meet OVHA and beneficiary needs.

ATTACHMENT C

CUSTOMARY STATE CONTRACT PROVISIONS

1. **Entire Agreement.** This contract represents the entire agreement between the parties on the subject matter. All prior agreements, representations, statements, negotiations, and understandings shall have no effect.
2. **Applicable Law.** This contract will be governed by the laws of the State of Vermont.
3. **Appropriations.** If this contract extends into more than one fiscal year of the state (July 1 to June 30), and if appropriations are insufficient to support this contract, the State may cancel at the end of the fiscal year, or otherwise upon the expiration of existing appropriations authority.
4. **No Employee Benefits for Contractors.** The Contractor understands that the State will not provide any individual retirement benefits, group life insurance, group health and dental insurance, vacation and sick leave, workers compensation or other benefits or services available to State employees, nor will the State withhold any federal or state taxes except as required under applicable tax laws, which shall be determined in advance of execution of the contract. The Contractor understands that all tax returns required by the Internal Revenue Code and the State of Vermont, including but not limited to income, withholding, sales and use, and rooms and meals, must be filed by the Contractor, and information as to contract income will be provided by the State of Vermont to the Internal Revenue Service and the Vermont Department of Taxes.
5. **Independence, Liability.** The Contractor will act in an independent capacity and not as officers or employees of the State. The Contractor shall indemnify, defend and hold harmless the State and its officers and employees from liability and any claims, suits, judgments, and damages arising as a result of the Contractor's acts and/or omissions in the performance of this contract. The Contractor shall notify its insurance company and the State within 10 days of receiving any claim for damages, notice of claims, pre-claims, or service of judgments or claims, for any act or omissions in the performance of this contract.
6. **Insurance.** Before commencing work on this contract the Contractor must provide certificates of insurance to show that the following minimum coverage are in effect. The Contractor must notify the State no more than 10 days after receiving cancellation notice of any required insurance policy. It is the responsibility of the Contractor to maintain current certificates of insurance on file with the State through the term of the contract. Failure to maintain the required insurance shall constitute a material breach of this contract.

**Workers Compensation:** With respect to all operations performed, the Contractor shall carry workers compensation insurance in accordance with the laws of the State of Vermont.

**General Liability and Property Damage:** With respect to all operations performed under the contract, the Contractor shall carry general liability insurance having all major divisions of coverage including, but not limited to:

Premises - Operations  
Independent Contractors' Protective  
Products and Completed Operations  
Personal Injury Liability  
Contractual Liability

The policy shall be on an occurrence form and limits shall not be less than:

\$1,000,000 Per Occurrence  
\$1,000,000 General Aggregate  
\$1,000,000 Products/Completed Operations Aggregate  
\$ 50,000 Fire Legal Liability

**Automotive Liability:** The Contractor shall carry automotive liability insurance covering all owned, non-owned and hired vehicles used in connection with the contract. Limits of coverage shall not be less than: \$1,000,000 Combined single limit.

**Professional Liability:** Before commencing work on this contract and throughout the term of this contract, the Contractor shall procure and maintain professional liability insurance for any and all services performed under this contract, with minimum coverage of \$     N/A     per occurrence.

No warranty is made that the coverage and limits listed herein are adequate to cover and protect the interests of the Contractor for the Contractor's operations. These are solely minimums that have been set to protect the interests of the State.

7. **Reliance by the State on Representations.** All payments by the State under this contract will be made in reliance upon the accuracy of all prior representations by the Contractor, including but not limited to bills, invoices, progress reports and other proofs of work.
8. **Records Available for Audit.** The Contractor will maintain all books, documents, payroll, papers, accounting records and other evidence pertaining to costs incurred under this agreement and make them available at reasonable times during the period of the contract and for three years thereafter for inspection by any authorized representatives of the State or Federal government. If any litigation, claim or audit is started before the expiration of the three year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved. The State, by any authorized representative, shall have the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed under this contract.

9. **Fair Employment Practices and Americans with Disabilities Act.** Contractor agrees to comply with the requirement of Title 21 V. S.A. Chapter 5, Subchapter 6, relating to fair employment practices, to the full extent applicable. Contractor shall also ensure, to the full extent required by the Americans with Disabilities Act of 1990, that qualified individuals with disabilities receive equitable access to the services, programs, and activities provided by the Contractor under this contract. Contractor further agrees to include this provision in all subcontracts.
10. **Set Off.** The State may set off any sums which the Contractor owes the State against any sums due the Contractor under this contract; provided, however, that any set off of amounts due the State of Vermont as taxes shall be in accordance with the procedures more specifically provided hereinafter.
11. **Taxes Due to the State.**
- a. Contractor understands and acknowledges responsibility, if applicable, for compliance with State tax laws, including income tax withholding for employees performing services within the State, payment of use tax on property used within the State, corporate and/or personal income tax on income earned within the State.
  - b. Contractor certifies under the pains and penalties of perjury that, as of the date the contract is signed, the Contractor is in good standing with respect to, or in full compliance with, a plan to pay any and all taxes due the State of Vermont.
  - c. Contractor understands that final payment under this contract may be withheld if the Commissioner of Taxes determines that the Contractor is not in good standing with respect to or in full compliance with a plan to pay any and all taxes due to the State of Vermont.
  - d. Contractor also understands the State may set off taxes (and related penalties, interest and fees) due to the State of Vermont, but only if the Contractor has failed to make an appeal within the time allowed by law, or an appeal has been taken and finally determined and the Contractor has no further legal resource to contest the amounts due.
12. **Child Support.** (Applicable if Contractor is a natural person, not a corporation or partnership.) Contractor states that, as of the date the contract is signed, he/she:
- a. is not under any obligation to pay child support; or
  - b. is under such an obligation and is in good standing with respect to that obligation; or
  - c. has agreed to a payment plan with the Vermont Office of Child Support Services and is in full compliance with that plan.
- Contractor makes this statement with regard to support owed to any and all children residing in Vermont. In addition, if the Contractor is a resident of Vermont, Contractor makes this statement with regard to support owed to any and all children residing in any other state or territory of the United States.

13. **Subcontractors.** The Contractor shall not assign or subcontract the performance of this agreement or any portion thereof to any other contractor without the prior written approval of the State. Contractor also agrees to include in all subcontract agreements a tax certification in accordance with paragraph II above.

Notwithstanding the foregoing, the State agrees that the Contractor may assign this contract, including all of the Contractor's rights and obligations hereunder, to any successor in interest to the Contractor arising out of the sale of or reorganization of the Contractor.

14. **No Gifts or Gratuities.** Contractor shall not give title or possession of any thing of substantial value (including property, currency, travel and/or education programs) to any officer or employee of the State during the term of this contract.
15. **Copies.** All written reports prepared under this contract will be printed using both sides of the paper.
16. **Access to Information.** The Contractor agrees to comply with the requirements of AHS Rule No. 96-23 concerning access to information. The Contractor shall require all of its employees performing services under this contract to sign the AHS affirmation of understanding or an equivalent statement.
17. **Suspension and Debarment.** Non-federal entities are prohibited by Executive Orders 12549 and 12689 from contracting with or making sub-awards under covered transactions to parties that are suspended or debarred or whose principals are suspended or debarred. Covered transactions include procurement contracts for goods or services equal to or in excess of \$25,000 and all non-procurement transactions (sub-awards to sub-recipients). By signing this contract, current Contractor certifies as applicable, that the contracting organization and its principals are not suspended or debarred by GSA from federal procurement and non-procurement programs.
18. **Health Insurance Portability & Accountability Act (HIPAA).** The confidentiality of any health care information acquired by or provided to the independent contractor shall be maintained in compliance with any applicable state or federal laws or regulations.
19. **Abuse Registry.** The Contractor agrees not to employ any individual, or use any volunteer, to provide for the care, custody, treatment, or supervision of children or vulnerable adults if there is a substantiation of abuse or neglect or exploitation against that individual. The Contractor will check the Adult Abuse Registry in the Department of Aging and Independent Living. Unless the Contractor holds a valid childcare license or registration from the Division of Child Development, Department for Children and Families, the Contractor shall also check the Central Child Abuse Registry. (See 33 V.S.A. §4919 & 33 V.S.A. §6911).
20. **Voter Registration.** When designated by the Secretary of State, the Contractor agrees to become a voter registration agency as defined by 17 V.S.A. §2103 (41), and to comply with the requirements of State and Federal law pertaining to such agencies.

21. **Non-Discrimination Based on National Origin as evidenced by Limited English Proficiency.** The Contractor agrees to comply with the non-discrimination requirements of Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, et seq., and with the federal guidelines promulgated pursuant to Executive Order 13166 of 2000, which require that contractors and sub-grantees receiving federal funds must assure that persons with limited English proficiency can meaningfully access services. To the extent the Contractor provides assistance to individuals with limited English proficiency through the use of oral or written translation or interpretive services in compliance with this requirement, such individuals cannot be required to pay for such services.

**ATTACHMENT E**  
**BUSINESS ASSOCIATE AGREEMENT**

This Business Associate Agreement (“Agreement”) is entered into by and between **the State of Vermont, Agency of Human Services, operating by and through its Department, Office, or Division of Office of Vermont Health Access** (“Covered Entities”) and **MAXIMUS, Inc.** (“Business Associate”), as of **July 1, 2005** (“Effective Date”).

**Preliminary Statement.** Covered Entity and Business Associate have entered into the Contract to which this Business Associate Agreement is an attachment pursuant to which Business Associate provides to Covered Entity certain services (“Services”) which may require the use and/or disclosure of health information. For the avoidance of any doubt, “Services” includes all work performed by the Business Associate for or on behalf of Covered Entity. This Agreement supplements and is made a part of the Contract.

The parties enter into this Agreement to comply with standards promulgated under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), including the Standards for the Privacy of Individually Identifiable Health Information, at 45 CFR Parts 160 and 164 (“Privacy Rule”), and the Security Standards, at 45 CFR Parts 160 and 164 (“Security Rule”).

**Agreement.** In consideration of the foregoing, and in consideration of the desire of Covered Entity to continue receiving Services, and of Business Associate to continue providing Services, the parties agree as follows:

1. **Definitions.** All capitalized terms in this Agreement have the meanings identified in this Agreement, 45 CFR Part 160, or 45 CFR Part 164. The term “Individual” includes a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g). All references to PHI mean Protected Health Information. All references to Electronic PHI mean Electronic Protected Health Information.
2. **Permitted and Required Uses/Disclosures of PHI.**
  - 2.1 Except as limited in this Agreement, Business Associate may use or disclose PHI to perform the Services, provided that any use or disclosure would not violate the minimum necessary policies and procedures of Covered Entity. Business Associate shall not use or disclose PHI in any manner that would constitute a violation of the Privacy Rule if used or disclosed by Covered Entity in that manner. Business Associate may not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law.
  - 2.2 Business Associate may make PHI available to its employees who need access to provide Services (provided that Business Associate makes such employees aware of the use and disclosure restrictions in this Agreement and binds them to comply with such restrictions). Business Associate may only disclose PHI for the purposes authorized by this Agreement: (a) to its agents (including subcontractors), in accordance with Sections 6 and 14; or (b) as otherwise permitted by Section 3.

3. **Business Activities.** Business Associate may use PHI received in its capacity as a “Business Associate” to Covered Entity, if necessary, for its proper management and administration or to carry out its legal responsibilities. In addition, Business Associate may disclose PHI received in its capacity as “Business Associate” to Covered Entity, for its proper management and administration or to carry out its legal responsibilities, if a disclosure is Required by Law, or: (a) Business Associate obtains reasonable written assurances (via a written contract) from the person to whom the information is to be disclosed that the PHI shall remain confidential and be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person; and (b) the person promptly notifies Business Associate (who in turn will promptly notify Covered Entity) in writing of any instances of which it is aware in which the confidentiality of the PHI has been breached. All uses and disclosures of PHI for the purposes identified above must be of the minimum amount of PHI necessary to accomplish such purposes.
4. **Safeguards.** Business Associate shall implement and use appropriate safeguards to prevent the use or disclosure of PHI, other than as provided for by this Agreement. Business Associate shall identify in writing, upon request from Covered Entity, all of the safeguards that it uses to prevent impermissible uses or disclosures of PHI.
5. **Reporting.** Business Associate shall report in writing to Covered Entity any use or disclosure of PHI in violation of this Agreement by Business Associate or its agents (including subcontractors). Business Associate shall provide such written report promptly after it becomes aware of any such use or disclosure. Business Associate shall provide Covered Entity with the information necessary for Covered Entity to investigate any such use or disclosure. Business Associate may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 CFR 164.502(j)(1).
6. **Agreements by Third Parties.** Business Associate shall ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate on behalf of, Covered Entity, agrees in a written contract to the same restrictions and conditions that apply through this Agreement to Business Associate, with respect to such PHI. By way of example, the written contract must include those restrictions and conditions set forth in Section 12. Business Associate must enter into the written contract before any use or disclosure of PHI by such agent, and such written contract must identify Covered Entity as a direct and intended third party beneficiary, with the right to enforce any breach of the contract concerning the use or disclosure of PHI. Business Associate shall provide a copy of the written contract to Covered Entity upon request. Business Associate may not make any disclosure of PHI to any agent without the prior written consent of Covered Entity.
7. **Access to PHI.** Business Associate shall provide access to PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual, to meet the requirements under 45 CFR 164.524. Business Associate shall provide such access in the time and manner reasonably designated by Covered Entity. Business Associate shall promptly forward to Covered Entity for handling any request for access to PHI that Business Associate directly receives from an Individual.

8. **Amendment of PHI.** Business Associate shall make any amendments to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR 164.526, whether at the request of Covered Entity or an Individual. Business Associate shall make such amendments in the time and manner reasonably designated by Covered Entity. Business Associate shall promptly forward to Covered Entity for handling any request for amendment to PHI that Business Associate directly receives from an Individual.
9. **Accounting of Disclosures.** Business Associate shall document disclosures of PHI and all information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528. Business Associate shall provide such information to Covered Entity, or as directed by Covered Entity, to an Individual, to permit Covered Entity to respond to an accounting request. Business Associate shall provide such information in the time and manner reasonably designated by Covered Entity. Business Associate shall promptly forward to Covered Entity for handling any accounting request that Business Associate directly receives from an Individual.
10. **Books and Records.** Subject to the attorney-client and other applicable legal privileges, Business Associate shall make its internal practices, books, and records (including policies and procedures and PHI) relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary in the time and manner designated by the Secretary. Business Associate shall make the same information available to Covered Entity (without regard to the attorney-client or other applicable legal privileges), upon request, in the time and manner reasonably designated by Covered Entity, so that Covered Entity may determine whether Business Associate is in compliance with this Agreement.
11. **Termination.**
  - 11.1 This Agreement commences on the Effective Date and shall remain in effect until terminated by Covered Entity, or until all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, subject to Section 15.12.
  - 11.2 If Business Associate breaches any material term of this Agreement, Covered Entity may either: (a) provide an opportunity for Business Associate to cure the breach, and Covered Entity may terminate each Services Agreement, without liability or penalty, if Business Associate does not cure the breach within the time specified by Covered Entity; or (b) immediately terminate each Services Agreement, without liability or penalty, if Covered Entity believes that cure is not reasonably possible; or (c) if neither termination nor cure are feasible, Covered Entity shall report the breach to the Secretary. Covered Entity has the right to seek to cure any breach by Business Associate and this right, regardless of whether Covered Entity cures such breach, does not lessen any right or remedy available to Covered Entity at law, in equity, or under this Agreement or any Services Agreement, nor does it lessen Business Associate's

responsibility for such breach or its duty to cure such breach.

12. **Return/Destruction of PHI.**

12.1 Business Associate shall, in connection with the expiration or termination of a Services Agreement, return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, and pertaining to that Services Agreement, that Business Associate still maintains in any form or medium (including electronic), within thirty (30) days after such expiration or termination. Business Associate shall not retain any copies of such PHI. Business Associate shall certify for Covered Entity, in writing, when all PHI has been returned or destroyed, and that Business Associate does not continue to maintain any PHI, with such certification to be provided during such thirty (30) day period.

12.2 Business Associate shall provide to Covered Entity notification of any conditions that Business Associate believes make the return or destruction of PHI infeasible. If Covered Entity agrees that return or destruction is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

13. **Notice/Training.** Business Associate understands that: (a) there may be civil or criminal penalties for misuse or misappropriation of PHI; and (b) violations of this Agreement may result in notification by Covered Entity to law enforcement officials and regulatory, accreditation, and licensure organizations. If requested by Covered Entity, Business Associate shall participate in information security awareness training regarding the use, confidentiality, and security of PHI.

14. **Security Rule Obligations.** The following provisions of this Section 14 apply to the extent that Business Associate creates, receives, maintains or transmits Electronic PHI on behalf of Covered Entity.

14.1 Business Associate shall implement and use administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate shall identify in writing, upon request from Covered Entity, all of the safeguards that it uses to protect such Electronic PHI.

14.2 Business Associate shall ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees in a written contract to implement and use administrative, physical, and technical safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI. Business Associate must enter into the written contract before any use or disclosure of Electronic PHI by such agent, and such written contract must identify Covered Entity as a direct and intended third party beneficiary, with the right to enforce any breach of the contract concerning the use or disclosure of Electronic PHI. Business Associate shall provide a

copy of the written contract to Covered Entity upon request. Business Associate may not make any disclosure of Electronic PHI to any agent without the prior written consent of Covered Entity.

14.3 Business Associate shall report in writing to Covered Entity any Security Incident pertaining to such Electronic PHI (whether involving Business Associate or an agent, including a subcontractor). Business Associate shall provide such written report promptly after it becomes aware of any such Security Incident. Business Associate shall provide Covered Entity with the information necessary for Covered Entity to investigate any such Security Incident.

14.4 Business Associate shall comply with any reasonable policies and procedures Covered Entity implements to obtain compliance under the Security Rule.

**15. Miscellaneous.**

15.1 Notwithstanding anything to the contrary in any Services Agreement, in no event shall any provision limiting Business Associate's liability to Covered Entity, including, but not limited to, provisions creating a cap on damages, excluding certain types of damages, limiting available remedies, or shortening a statute of limitations, present in any Services Agreement, apply with respect to any breach by Business Associate of any term of this Agreement.

15.2 In the event of any conflict or inconsistency between the terms of this Agreement and the terms of any Services Agreement, the terms of this Agreement shall govern, with respect to its subject matter. Otherwise, the terms of each Services Agreement continue in effect.

15.3 Any reference to "promptly" in this Agreement shall mean no more than seven (7) business days after the circumstance or event at issue has transpired. A reference in this Agreement to a section in the Privacy Rule or Security Rule means the section as in effect or as amended or renumbered.

15.4 Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to it of a use or disclosure of PHI in violation of any provision of this Agreement.

15.5 Business Associate shall cooperate with Covered Entity to amend this Agreement from time to time as is necessary for Covered Entity to comply with the Privacy Rule, the Security Rule, or any other standards promulgated under HIPAA.

15.6 Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule, Security Rule, or any other standards promulgated under HIPAA.

- 15.7 In addition to applicable state law, the parties shall rely on applicable federal law (e.g., HIPAA, the Privacy Rule and Security Rule) in construing the meaning and effect of this Agreement.
- 15.8 This Agreement may be amended or modified, and any right under this Agreement may be waived, only by a writing signed by an authorized representative of each party.
- 15.9 Nothing express or implied in this Agreement is intended to confer, upon any person other than the parties hereto, any rights, remedies, obligations or liabilities whatsoever. Notwithstanding the foregoing, the Covered Entity in this Agreement is the Agency of Human Services, operating by and through its Department, Office, or Division of (**Office of Vermont Health Access**). Covered Entity and Business Associate agree that the term “Covered Entity”, as used in this Agreement, also means any other Department, Division or Office of the Agency of Human Services, to the extent that such other Department, Division, or Office has a relationship with Business Associate that would require, pursuant to the Privacy or Security Rules, entry into an agreement of this type.
- 15.10 As between Business Associate and Covered Entity, Covered Entity owns all PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity.
- 15.11 Business Associate shall abide by the terms and conditions of this Agreement with respect to all PHI it receives from Covered Entity, or creates or receives on behalf of Covered Entity, even if some of that information relates to specific Services for which Business Associate may not be a “Business Associate” of Covered Entity under the Privacy Rule.
- 15.12 The provisions of this Agreement that by their terms encompass continuing rights or responsibilities shall survive the expiration or termination of this Agreement. For example: (a) the provisions of this Agreement shall continue to apply if Covered Entity determines that it would be infeasible for Business Associate to return or destroy PHI, as provided in Section 12.2; and (b) the obligation of Business Associate to provide an accounting of disclosures, as set forth in Section 9, survives the expiration or termination of this Agreement, with respect to accounting requests (if any) made after such expiration or termination.
- 15.13 This Agreement constitutes the entire agreement of the parties with respect to its subject matter, superseding all prior oral and written agreements between the parties in such respect.

Attachment C

Customary State Contract Provisions

MAXIMUS agrees to comply with all provisions contained within the Customary State Contract Provisions (Rev. AHS – 11/9/04) including all statements associated with provisions as attached.

**ATTACHMENT F**

**Agency of Human Services Rule # 96-23  
Final Adopted Rule for  
Access to Information**

**Definition.**

“Agency” means the Agency of Human Services or any of the offices, departments or programs that comprise the Agency.

“AHS” means the Vermont Agency of Human Services.

“Client” means an individual or family who is voluntarily served by a department, office, program, Contractor or grantee of the Agency of Human Services.

“Contractor” means an individual or entity with whom the Agency or any of its departments, offices, or programs has a contract to provide personal services.

“Employee” means any person who works in a full-time, part-time, temporary or contractual position for the Agency or any of its departments, offices, or programs.

1.6 “Grantee” means an individual or entity with whom the Agency or any part thereof has a grant to provide personal services.

1.7 “Program” means a set of services, (such as determining and processing ANFC benefits, verifying and setting up delivery for WIC foods) for which the Agency bears fiscal responsibility.

1.8 “Administrative Obligations” means activities pursuant to federal or state laws or regulations (such as verification of eligibility, verification of service delivery, detection of fraud, monitoring of quality assurance, audit of expenditure reports) which provide for accountability in the use of public funds.

**Basic Principles** Presumption of Confidentiality

All information specific to, and identifying of, individuals and families is presumed to be confidential and subject to these standards. Employees shall not disclose the information unless a specific exception to the presumption applies or the disclosure is authorized by the client, a court or as otherwise authorized by law or rule.

Existing Statutes

These rules are not intended to expand or diminish current provisions in law relating to disclosure of confidential information.

**AHS Rule 96-23**

Information Collection

Employees shall collect and record only that information needed to fulfill the goal of serving the client and meeting administrative or legal obligations.

Informing Clients

At the initial meeting with each client, or within two weeks, employees shall review and offer to provide the rules for access to information to the client.

**Permissible Disclosures**

Client consent

No information about a client shall be released without prior consent from the client, unless directly connected with the administration of a program or necessary for compliance with federal or state laws or regulations.

Sharing “Non-identifiable” Information

Information that does not identify a client may be used for statistical research, forecasting program needs, or other such purposes.

Public Information

Information defined as public by 1 VSA & 317 or other applicable statute is available to the public. The procedures in the public records statute shall be followed before public information is released.

Information Sharing for Administrative Purposes

Employees may share information which is necessary to satisfy the Agency’s administrative obligations. Departments will develop written agreements limiting the kinds of information to be shared when programs are jointly administered by different Departments. No information shall be released to a person or entity that is out of state, unless directly connected with the administration of a program or necessary for compliance with federal or state laws or regulations.

Disclosure Without Consent in Limited Circumstances

Employees must release sufficient information to comply with mandatory reporting requirements for cases involving the abuse, neglect, or exploitation of children and persons who are elderly or who have disabilities. Information may be released without consent when Vermont law creates a duty to warn identified individuals of potential harm to their person or property, in response to court orders, or to investigate or report criminal activity as required by federal or state law or regulation. Only information relevant to the situation shall be disclosed. The employee shall document the date, purpose and content of the report, the name, address and affiliation of the person to whom the information was released, and shall notify the client that the information was disclosed.

**AHS Rule 96-23**

**Procedures Related to Consent**

Obtaining Informed Consent

Prior to releasing confidential information the Agency shall obtain the client's informed consent. This includes providing information about consent in a language and format understandable to the client. Reasonable accommodations shall be made for special needs based on the individual or family's education, culture, or disability. Employees shall inform clients that granting consent is not a pre-requisite for receiving services, and shall explain that they may apply for services separately.

Consent of Minors to Release of Information

Employees shall obtain the consent of a minor client to release information concerning treatment for which parental consent is not required.

Format for Consent to Share Information

Consent for the sharing or release of information shall ordinarily be in writing. If an emergency situation requires granting of verbal consent, written consent shall be obtained at the next office visit or within thirty days, whichever comes sooner. Required information will include:

1. Names of the people about whom information may be shared.
2. A checklist of the kinds of information to be shared.
3. A checklist of the departments within the Agency to receive the information.
4. A statement or date covering expiration of consent.
5. A statement about procedures for revoking consent.
6. Signature of individuals covered by the consent, or their parents or guardians.
7. Signature of the individual explaining the consent process with their position and job title.
8. A space to provide individualized instructions.

A copy of the consent form shall be provided to

all signatories. Client Access to Records

Unless prohibited by federal or state law or regulation, clients shall be permitted to view and obtain copies of their records. Each department within the Agency shall have written procedures which permit clients to verify personal information they have provided for accuracy and completeness and for placing amendments to the information in their files. Employees shall take reasonable steps to present records in a form accessible to the client, including but not limited to large type format or verbal review. A fee not to exceed the actual cost of copying may be charged for records exceeding 10 pages. This fee shall be waived if it would prohibit access.

**AHS Rule 96-23**

**Procedures to Protect**

**Confidentiality Staff Training**

All AHS employees and all AHS volunteers and interns, shall be instructed in these rules. AHS shall train their Contractors and grantees who shall, in turn, provide the same instruction for their employees, interns, and volunteers.

**Response to Requests for Information**

An employee shall not respond to requests from outside the Agency for information about clients even to acknowledge that the person is a client, unless authorized. If a client has consented to or requests that information be released, the employee shall comply with the request.

**Designated Individual**

Each agency or department shall appoint one or more trained staff members to be responsible for responding to all requests for client information when there is no written consent to release, and no statutory or administrative authority permitting release of the requested information. These individuals shall be specially trained in maintaining confidentiality. A list of the designated individuals for each department and office shall be maintained in the Attorney General's Office, Human Services Division.

**Affirmation of Understanding**

Employees shall sign an affirmation that they will comply with these rules. This affirmation shall be part of their personnel files. Supervisors shall review this affirmation during annual evaluations. Violation of these rules shall result in disciplinary action.

**Written Agreements with Grantees or Contractors**

The following assurance, or one similar to it, will be included in all AHS grants/contracts signed after these rules have been approved:

[Grantee/Contractor] agrees to comply with the requirements of AHS Rule No. 96-23 concerning access to information. The Contractor shall require all of its employees to sign the AHS Affirmation of Understanding or an equivalent statement.

**Client Referrals**

When referring a client to another agency for services, if the referral does not meet the criteria for permissible disclosures under Section 3.4, the initial agency shall obtain the consent of the client for the referral and alert the receiving agency that confidential client information accompanies the referral.

**AHS Rule 96-23**

Documentation of

Disclosure

Requests for disclosures of client information shall be maintained in the client's file if the request does not meet the definition of a permissible disclosure under Section 3.4. Employees shall document in writing any information actually disclosed, along with the name of the person/agency to whom it was disclosed and the date of the disclosure. When permissible disclosures are made under Section 3.4, documentation may be limited to the name of the department/agency/program to whom the disclosure was made.

**Information Systems**

Computerized Information

When developing a computerized data system, the Agency shall:

1. Develop security procedures consistent with the rule;
2. Instruct staff in the security procedures;
3. Inform clients if a computerized system is being used;
4. Establish written agreements with participating agencies outlining procedures for sharing and protecting information.
5. Develop security procedures in relation to the transmission of information.

Security Procedures

The Agency shall develop a protocol which is consistent with the requirements of this rule to safeguard confidential client information. Contractors and grantees shall also develop a protocol or shall adopt the protocol of the Agency. The protocol shall be designed to safeguard written information, data in computer systems, and verbal exchange of information. The protocol shall prohibit unauthorized access to records and include an appropriate disciplinary process for violations of the security rules.

Procedures

Written procedures for implementing these rules shall be used as the basis for employee instruction and shall be available for review in the Agency Central Office.

**AGENCY OF HUMAN SERVICES  
103 South Main Street  
Waterbury, Vermont 05676**

**AFFIRMATION OF UNDERSTANDING STATEMENT**

**As a Contractor for the State of Vermont, I affirm that I have read the Agency of Human Services (AHS) Rule No. 96-23 concerning Access to Information, and that I agree to comply with the requirements of AHS Rule No. 96-23.**

**I shall require all of my employees performing services under this contract, to sign an affirmation of understanding statement. Employee statements need not be sent to the State. However, they shall remain in Contractor's personnel records. The State can request copies of such documents if necessary.**

\_\_\_\_\_  
**Name of Company (Print or type)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Authorized Signature**

\_\_\_\_\_  
**Title**

**COVERED SERVICES – VT MEDICAID PROGRAMS**

**\*\*All Providers Must Be Participating in Medicaid\*\***

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Abortions	<p>If deemed <i>medically necessary</i> to ensure mother’s emotional or physical well being, or federally mandated (rape, incest) and performed by a Medicaid Provider. A physician’s certification form stating medical necessity required (consent form/waiting period not required).</p> <p><u>(Medicaid does not pay for abortions if they are court ordered.</u> C.O. abortions are denied in our system and forwarded to admin services for payment by General Assistance.)</p> <p>No prior authorization (PA) required for general anesthesia. No PA required for ectopic pregnancy. Covered as any other medical condition.</p> <p>Abortion Pill Covered.</p> <p><b>Abortion Pill Name:</b> RU-486, Mifepristone, Mifeprex</p> <p>If hospital inpatient \$75 per admission* If hospital outpatient \$3 per visit*</p> <p>* Co-pays do not apply to children under 21, pregnant women, or patients in long term care facilities. Exception – co-pays do apply to SSI-related beneficiaries age 18, 19, and 20 if in a hospital setting.</p>	<p>See Medicaid FFS column. Covered as any other medical condition.</p> <p>No co-pay Abortion Pill Covered.</p> <p><b>Abortion Pill Name:</b> RU-486 Mifepristone Mifeprex</p>	<p>Covered for members if medically necessary. See FFS column. Covered as any other medical condition. Abortion Pill Covered.</p> <p><b>Abortion Pill Name:</b> RU-486 Mifepristone Mifeprex</p> <p>If hospital inpatient \$75 per admission* If hospital outpatient \$3 per visit*</p> <p>* Co-pays do not apply to children under age 21 pregnant women, or patients in long term care facilities. Exception – co-pays apply to SSI-related beneficiaries’ age 18, 19, and 20 if in a hospital setting.</p>	<p>Same as Medicaid managed care. See previous column. Covered for members if medically necessary. Covered as any other medical condition. No co-pay . Abortion Pill Covered.</p> <p><b>Abortion Pill Name:</b> RU-486 Mifepristone Mifeprex</p>
Acupuncture	Not Covered	Not Covered	Not Covered	Not Covered
ADHD – ADD Learning Disabilities	Treatment/assessment of medical conditions covered if provided by a Medicaid provider. Testing sometimes arranged through a child’s school using a Medicaid provider.	See Medicaid FFS column. No co-pay	Covered; See FFS column. Referral from PCP required. Must be Medicaid provider.	Covered; See FFS column. Referral from PCP required. Must be Medicaid provider. No co-pay
Administrative Assessments	Not covered if required for administrative reasons only.	See Medicaid FFS column.	Not covered if required for administrative reasons only.	Not covered if required for administrative reasons only.
Adult Day Health Rehab Services	Covered with PA from Dept of Aging and Independent Living (DAIL). Interested providers should contact EDS for info on billing. Interested clients should call Camille George at DAIL, at 241-2427.	Not Covered.	Same as FFS.	Not Covered.

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Ambulance	PA required in transport from facilities not participating in Vermont Medicaid. Includes from home/nursing home to hospital for admission, therapy, diagnostic services and back home. Also from one hospital to another when services not available at first. Also to hospital based renal dialysis facility. From accident scene to facility. If transport to the VA, VA pays. <u>Must be medically necessary</u> to transport.	Emergency transport only	Referral by PCP needed in non-emergency situations. Emergency transportation covered 100%. Client needs to notify PCP of emergency occurrence as soon as possible.	Referral by PCP needed in non-emergency situations. Emergency transportation covered 100%. Client needs to notify PCP of emergency occurrence as soon as possible.
Anesthesia (General)	Yes when determined medically necessary by a doctor.	Yes when determined medically necessary by a doctor.	Yes when determined medically necessary by a doctor.	Yes when determined medically necessary by a doctor.
Anti-embolism Stockings	Medical supply. Prescription required. Covered w/o PA. Restricted to 3 or 6 pairs every 365 days, depending on the type of stocking.	Covered only if provided in Dr. office.	See FFS	See FFS
Audiology Services	Audiological examinations, hearing screening and assessments, diagnostic tests, fitting/orientation, checking of hearing aids and ear molds. Usually requires doctor referral to another Medicaid provider.	Only if ordered by a doctor to diagnose a condition other than hearing loss. Such as a brain tumor or neurological defect.	Covered for all Medicaid clients. See FFS. Referral by PCP needed.	Only if ordered by a doctor to diagnose a condition other than hearing loss. Such as a brain tumor or neurological defect. Referral by PCP needed.
Augmentative Communication Devices	Covered for qualified Medicaid clients. PA required.  Includes non-powered devices, battery-powered systems like specialized communication devices; typewriters; electro larynges, portable speech devices, hand-held computers and memo pads, typewriter-style communication aid with LCD and/or synthesized speech, electronic memo writers with key or membrane pad, customized assisted keyboards, scanning devices, laptop or micro computers and software.  Modification or adaptation of Medicaid-purchased devices is available if provided by qualified Medicaid participating speech/language providers.  Repairs or servicing of Medicaid –purchased items after one year, when provided by qualified Medicaid vendors. All devices must carry a one-year warranty. See <i>Speaking Devices</i> , M842.  Not covered: environmental control devices like switches, control boxes or battery interrupters	No	Medicaid/Dr. Dynasaur only. Referral by PCP needed if to a specialist. Devices require Rx and PA.  See <i>hearing aids</i> .	No

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Blood Draw	Blood typing. If ordered by a Medicaid provider.	Blood typing. If ordered by a Medicaid provider.	Blood typing. If ordered by a Medicaid provider.	Blood typing. If ordered by a Medicaid provider.
Birth Control/ Family Planning	All services to prevent or delay pregnancy, preg testing, screening for STDs and HIV. Sterilization/vasectomy for adults 21+ w/ a consent form (from EDS) signed 30 days prior to procedure. See Sterilization. Reversals and Infertility treatments not covered. Cloning is not covered. Birth control pills/patches covered 100% and can get up to a 3-month supply at one time. No co-pay but need prescription. Norplant, IUDs, and DEP shots covered 100% as in-office procedures. Male & Female Condoms, Specific Brands. Have pharmacy contact First Health for assistance with billing. See below.	Same as Medicaid FFS <b>except</b> Birth control pills/patches covered. No co-pay but need a prescription. See previous column. Male & Female Condoms, Specific Brands, see below.	All family planning services provided to members as FFS. See Medicaid FFS column. Treatment of abnormal pap smears and complications assoc. w/ birth control are covered, no referral needed. No referral needed for GYN care. No co-pay. Male & Female Condoms, Specific Brands, see below.	All family planning services provided to members as FFS. See Medicaid FFS column. Treatment of abnormal pap smears and complications assoc. w/ birth control are covered, no referral needed. Birth control pills/patches covered 100% and can get up to a 3-month supply at one time. No co-pay but need prescription. No referral needed for GYN care. <b>No Rx co-insurance.</b> Male & Female Condoms, Specific Brands, see below.
Condoms	Male & Female Condoms, Specific Brands. Female condoms sold under the name Reality. Have pharmacy contact First Health for assistance with billing. Requires a prescription. Covered 100%.	Male & Female Condoms, Specific Brands. Requires a prescription. Covered 100%	Same as FFS	Same as FFS
Diaphragms	Covered, if obtained through an in-office procedure, prescription is covered 100%.	Requires a prescription., covered 100%	Covered, if prescription obtained through an in-office procedure, prescription is covered 100%.	Covered, if prescription obtained through an in-office procedure, prescription is covered 100%
Bone Marrow Transplant	Yes. Medicaid will pay for the costs associated with the harvesting of transplant organs if the recipient of the transfer is on Medicaid. If the donor has TPL, the claims must be first sent to and denied by the TPL carrier in order to have Medicaid pay. If the donor (non-Medicaid person) develops complications, Medicaid will not cover those expenses.  If the donor is the Medicaid client, and the recipient is the non-Medicaid client, Medicaid would not pay towards harvest.  PA required.	Yes. See previous column. This would have to be billed as urgent/emergent. PA required.	Yes. Referral by PCP required if through a specialist. See Medicaid FFS column. PA required.	Yes. Referral by PCP required if through a specialist. See Medicaid FFS column. PA required.

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
<p>Brattleboro Retreat (mental health and substance abuse facility)</p>	<p>Yes – PA required from OVHA for substance abuse admissions. Recommend referral by PCP but not required Outpatient and inpatient. Inpatient details below; <b><u>Inpatient Psychiatric Admission</u></b> <u>Under 18:</u> All inpatient minors admitted to the Retreat are funded by VDH ADAP and are subject to VDH ADAP guidelines. VDH ADAP will not pay for methadone. OVHA does not pay for inpatient minors. <u>Age 18-21:</u> Medicaid FFS covers for CRT patients only. <u>Age 22-64:</u> Medicaid FFS covers for CRT patients only. <u>Age 65+:</u> Medicaid FFS covers non-CRT, if CRT go through DDMHS.</p> <p><b><u>Inpatient Acute Medical Detoxification Using Methadone</u></b> <u>Under 18:</u> Refer to OADAP, Retreat <u>not</u> covered by OVHA. <u>Age 18 up to age 22:</u> Refer CRT patients to VDH ADAP. Refer Non-CRT to OADAP providers. <u>Age 22 up to age 65:</u> Refer CRT patients to VDH ADAP. Refer non-CRT to OADAP providers. <u>Age 65 and over:</u> Covers non-CRT patients <u>only</u> with an OADAP provider. Refer CRT patients to VDH ADAP</p> <p><u>Note:</u> <b>CRT</b> is Community Rehabilitation and Treatment. A program run by VDH ADAP. See <a href="http://www.ddmhs.state.vt.us">http://www.ddmhs.state.vt.us</a> for more info. <b>OADAP</b> is Office of Alcohol and Drug Abuse Programs. Approves provider participation. <b>DDHMS</b> is the Department of Developmental and Mental Health Services now handled through the VDH <b>VDH ADAP</b> is the Vermont Dept. of Health Division of Alcohol &amp; Drug Abuse Programs <b>OVHA</b> is the Office of Vermont Health Access</p>	<p>PA required from OVHA for substance abuse admissions. Outpatient and inpatient treatment, only for those over age 18. Note: Elective inpatient admission not covered under the retreat’s hospital provider number. (Depends upon the services provided. The client must work with retreat staff to ensure coverage.)</p> <p><b><u>Inpatient Psychiatric Admission</u></b> <u>Age 18-21:</u> Medicaid FFS covers for CRT patients only. <u>Age 22-64:</u> Medicaid FFS covers for CRT patients only. <u>Age 65+:</u> Medicaid FFS covers non-CRT, if CRT go through VDH ADAP.</p> <p><u>Note:</u> Authorization for early enrollment into PC+ for the purpose of admission into the retreat must be medically necessary. See Exception Request document.</p>	<p>Yes – PA required from OVHA for substance abuse admissions. Recommend referral by PCP but not required. Outpatient and inpatient. Inpatient details below; <b><u>Inpatient Psychiatric Admission</u></b> <u>Under 18:</u> Covered: all inpatient minors admitted to the Retreat are funded by VDH ADAP and are subject to guidelines. VDH ADAP will not pay for methadone. OVHA <u>does not</u> pay for inpatient minors. <u>Age 18-21:</u> Medicaid MC covers. <u>Age 22-64:</u> Medicaid MC covers for all patients. <u>Age 65+:</u> Medicaid MC covers <u>non-</u> CRT , if CRT go through VDH ADAP.</p> <p><b><u>Inpatient Acute Medical Detoxification Using Methadone</u></b> <u>Under 18:</u> Refer to OADAP, Retreat <u>not</u> covered by OVHA. <u>Age 18 up to age 22:</u> Refer CRT patients to VDH ADAP. Refer non-CRT to OADAP providers. <u>Age 22 up to age 65:</u> Covers non-CRT patients <u>only</u>. Refer CRT patients to VDH ADAP <u>Age 65 and over:</u> Covers non-CRT patients <u>only</u>. Refer CRT patients to VDH ADAP</p> <p><u>Note:</u> <b>CRT</b> is Community Rehabilitation and Treatment. A program run by VDH ADAP. See <a href="http://www.ddmhs.state.vt.us">http://www.ddmhs.state.vt.us</a> for more info. <b>OADAP</b> is Office of Alcohol and Drug Abuse Programs. Approves provider participation. <b>VDH ADAP</b> is the Vermont Dept. of Health Division of Alcohol &amp; Drug Abuse Programs <b>OVHA</b> is the Office of Vermont Health Access</p>	<p>Yes-PA required from OVHA for substance abuse admissions. Recommend referral by PCP but not required – Outpatient. and inpatient. Inpatient details below; Note: Elective inpatient admission not covered under the retreat. (Depends upon services provided. The client must work with retreat staff to ensure coverage.) <b><u>Inpatient Psychiatric Admission</u></b> <u>Under 18:</u> Shouldn’t be VHAP <u>Age 18-21:</u> VHAP MC covers. <u>Age 22-64:</u> VHAP MC covers for CRT patients <u>only</u>. <u>Age 65+:</u> VHAP MC covers those <u>not</u> in CRT, if CRT go through VDH ADAP.</p> <p><b><u>Inpatient Acute Medical Detoxification Using Methadone</u></b> <u>Under 18:</u> Refer to OADAP, Retreat <u>not</u> covered by OVHA. <u>Age 18 up to age 22:</u> Covers non-CRT patients. Refer CRT patients to VDH ADAP <u>Age 22 up to age 65:</u> Covers non-CRT patients <u>only</u>. Refer CRT patients to VDH ADAP <u>Age 65 and over:</u> Covers non-CRT patients <u>only</u>. Refer CRT patients to VDH ADAP</p> <p><u>Note:</u> <b>CRT</b> is Community Rehabilitation and Treatment. A program run by VDH ADAP. See <a href="http://www.ddmhs.state.vt.us">http://www.ddmhs.state.vt.us</a> for more <b>OADAP</b> is Office of Alcohol and Drug Abuse Programs <b>DDHMS</b> is the Department of Developmental and Mental Health Services now handled through the VDH <b>VDH ADAP</b> is the Vermont Dept. of Health Division of Alcohol &amp; Drug Abuse Programs <b>OVHA</b> is the Office of Vermont Health Access</p>

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Burial Benefit	Possibly through General Assistance fund through local DCF office.	Not a covered service. See <b>FFS</b> column.	Not a covered service. See <b>FFS</b> column.	Not a covered service. See <b>FFS</b> column.
Catheter and related equip	Doctor fills out medical necessity form, and the vendor fills the order. If the amount or type needed is outside of normal guidelines, the vendor (not the Dr.) requests a PA.	No.	Same as <b>FFS</b> column. If patient goes to a specialist requires a referral.	Same as <b>FFS</b> and Med MC. If seen by specialist, requires a referral.
Chemotherapy	Yes, if prescribed by a doctor. Usually in the treatment of cancer. Note: This term also applies to medication for people with mental illnesses.	Yes, on an outpatient basis	Yes. Drugs administered <b>during</b> a hospital stay are covered in-patient. Since a specialist administers chemo, client should have a <b>referral</b> from PCP for original/ongoing treatment.	Yes. Drugs administered <b>during</b> a hospital stay are covered in-patient. Since a specialist administers chemo, client should have a <b>referral</b> from PCP for original/ongoing treatment.
<b>Childbirth</b>	Yes from a Medicaid provider. Childbirth classes are covered if accessed through the Healthy Babies program at the VDH. Refer to VDH. “Mother Boarder” program is not covered, but mom may arrange close lodging if they live far away through transportation broker. Baby hugger or LSO covered as DME. Breast Pumps covered w/ PA from OVHA. Prenatal vitamins with an RX for Pregnant women. Dr.D Women get 60 days post-partum without regard to income changes; newborns get 2 months w/o regard to income. (Policy m302.28) <i>Those <b>not</b> on Dr. D and post-partum, may apply for 3 months retro coverage (up to the birth only)</i> Dr.D women who miscarry get 60 days post-partum coverage. <i>Those <b>not</b> on Dr. D who miscarry may apply for 3 months retro coverage during time of pregnancy.</i>	Outpatient charges only. Childbirth classes are not covered. “Mother Boarder” program is not covered. Pregnant women should be on Medicaid or Dr. Dynasaur.	Referral required. Childbirth classes are covered if accessed through the Healthy Babies program at the VDH. Refer to VDH. “Mother Boarder” program is not covered, but mom may arrange close lodging if they live far away through transportation broker (FFS). Baby hugger or LSO covered as DME w/ PA. If a PCP specializes in OB/GYN client may use the PCP as an OB specialist. Prenatal vitamins with an RX for pregnant women. Dr.D Women get 60 days post-partum without regard to income changes; newborns get 2 months w/o regard to income. (Policy m302.28) <i>Those <b>not</b> on Dr. D and post-partum, may apply for 3 months retro coverage (up to the birth only)</i> Dr.D women who miscarry get 60 days post-partum coverage. <i>Those <b>not</b> on Dr. D who miscarry may apply for 3 months retro coverage during time of pregnancy.</i>	Same as Medicaid managed care except that lodging via transportation broker is not available. See previous column. Pregnant women should be on Medicaid or Dr. Dynasaur.
Licensed & Certified Nurse Midwife	<b>Yes for Certified Midwives/Certified Nurse Midwives. Home births are covered without a PA if the Medicaid provider is present.</b> <b>Licensed Midwives(LM) services are covered as of 1/1/02. Includes obstetric care prior to delivery, home birth, vaginal delivery, and some follow-up care. Please have providers contact EDS for coverage/billing details.</b> No Lay Midwives are covered.	Same as Medicaid FFS. See previous column.	<b>Yes for Certified Midwives/Certified Nurse Midwives. Home births are covered without a PA if the Medicaid provider is present. No referrals required.</b> <b>Licensed Midwives(LM) services are covered as of 1/1/02. Includes obstetric care prior to delivery, home birth, vaginal delivery, and some follow-up care. Please have providers contact EDS for coverage/billing details.</b> No Lay Midwives are covered.	Same as Medicaid managed care. No referrals required. See previous column.

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
"Mother Boarder" program <i>mom stays at hosp. w/ child</i>	No, but mom may arrange close lodging if they live far away through transportation broker.	No	No, but mom may arrange close lodging if they live far away through Medicaid transportation broker.	No
Chiropractic	<b>Under age 21 only.</b> Self-referral More than 10 visits per year require PA Members <b>under age 12</b> require PA and a "Primary Practitioner Referral Form" (per OVHA) . Limited to spinal adjustments for subluxation <b>ONLY</b> . Client pmt. for initial consult may be necessary. Providers should clear with EDS. No X-rays covered, although member's PCP can provide them in some instances. No co-pay.	No	<b>Under age 21 only.</b> Self-referral More than 10 visits per year require PA See <b>FFS</b> column. Members <b>under age 12</b> requires a PA and a Primary Practitioner Referral Form (per OVHA).	No
Circumcision	Yes, no PA required for a child. An adult would need a PA.	Same as <b>FFS</b> . An adult would need PA.	Same as FFS.	Yes. An adult would need a PCP referral (to a specialist) and PA.
Contact Lenses	<b>&lt;21 years of age:</b> Yes <b>Age 21 years old and older:</b> Suspended Indefinitely Only if medically necessary for certain diagnosed conditions. PA for Medical Necessity.	No	See FFS.	No
Cosmetic or Reconstructive Surgeries	PA required (assumed inpatient). Procedures to include: Breast augmentation, reconstruction or repair; rhinoplasty, blepharoplasty, lipectomy, abrasions/tattoo removal. Must be medically necessary.  If hospital inpatient \$75 per admission* If hospital outpatient \$3 per visit* * Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities. Exception – co-pays do apply to SSI-related beneficiaries age 18, 19, and 20 if in a hospital setting.	No	Only with PA (assumed inpatient) and medical necessity. See FFS. Referral to Specialist for <b>PC Plus</b> .  If hospital inpatient \$75 per admission* If hospital outpatient \$3 per visit* * Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities. Exception – co-pays do apply to SSI-related beneficiaries age 18, 19, and 20 if in a hospital setting..	Only with PA (assumed inpatient) and medical necessity. See FFS. Referral to Specialist for <b>PC Plus</b> . No co-pay.
Court Ordered Treatment	Not covered (for administrative purposes). Only if medically necessary.	Not covered (for administrative purposes). Only if medically necessary.	Not covered (for administrative purposes). Only if medically necessary. PCP referral if through a specialist, PA might be required.	Not covered (for administrative purposes). Only if medically necessary. PCP referral if through a specialist, PA might be required.

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
CPR training	No	No	No	No
Dental <b>-under 21 years</b> Medicaid/Dr. D only	<p>Cleanings and periodic exams (every 180 days), sealants (on teeth # 02, 03, 14, 15, 18, 19, 30 and 31), fillings, crowns, root canals, and extractions. No co-pays*. Treatment of “baby bottle tooth decay” is covered. Fluoride pills (w/ or w/o vitamins) are covered with PA. Mouth guards to prevent teeth grinding covered w/ PA- not athletic guards.</p> <p>*Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities.</p>	<p><b>Not covered.</b> May be able to get GA from the local DCF in emergency situations (pain, bleeding, or infection). Refer to free clinics/UVM for sliding fee scale programs. See Resource Guide.</p> <p><u>Note:</u> (Per P-4005 B(3)(b), Oral surgery may is only covered as treatment for an accidental injury, TMJ or to correct a gross deformity. No coverage for periodontal care.</p>	<p>Covered; See <b>FFS</b> column. No co-pays*. <b>Accident related injuries</b> to jaw, teeth, mouth, and face <b>are covered.</b> Referrals and PAs apply if treated through a specialist, or depending on procedure. May call the Dental Division at 1-800-464-4343 ext. 7341.</p> <p>*Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities.</p>	<p><b>Not covered.</b> May be able to get GA from the local DCF in emergency situations (pain, bleeding, or infection). Refer to free clinics/UVM for sliding fee scale programs. See Resource Guide.</p> <p><u>Note:</u> (Per P-4005 B(3)(b), Oral surgery is only covered as treatment for an accidental injury, TMJ or to correct a gross deformity. No coverage for periodontal care.</p>
Dental/Adult <b>-over 21 years</b> Medicaid/Dr.D only	<p><b>\$3 co-pay per visit. \$475 max/yr</b> (even w/ PA for additional service). Cleanings and periodic exams (every 180 days), fillings, root canals (max. 3 per lifetime), extractions. Oral exams, cancer screening, radiography, testing, amalgam/composite restorations, root planing/scaling, abscess drainage, oral prophylaxis. PA required for the extraction of more than one wisdom tooth per year. PA required for Oral Surgery/Inpatient Dental. Some Prefabricated (temporary or used as spacers) crowns covered, Cast crowns not covered No permanent crowns. Clients may apply for GA at their local DCF in cases of pain, bleeding or infection. Dental Division PA ph# 1-800-464-4343 Xt.7341</p>	<p><b>Not covered.</b> May be able to get GA from the local DCF in emergency situations (pain, bleeding, or infection). Refer to free clinics/UVM for sliding fee scale programs. See Resource Guide.</p> <p><u>Note:</u> (Per P-4005 B(3)(b), Oral surgery is only covered as treatment for an accidental injury, TMJ or to correct a gross deformity. No coverage for periodontal care.</p>	<p>Covered; See <b>FFS</b> column. <b>Accident related injuries</b> to jaw, teeth, mouth, and face <b>are covered.</b> Referrals and PAs apply if treated through a specialist, or depending on procedure. May call the Dental Division at 1-800-464-4343 ext. 7341. <b>\$3 co-pay per visit</b></p>	<p><b>Not covered.</b> May be able to get GA from the local DCF in emergency situations (pain, bleeding, or infection). Refer to free clinics/UVM for sliding fee scale programs. See Resource Guide.</p> <p><u>Note:</u> (Per P-4005 B(3)(b), Oral surgery is only covered as treatment for an accidental injury, TMJ or to correct a gross deformity. No coverage for periodontal care.</p>

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Dentures	<p>No</p> <p><u>Note:</u> Reach Up participant’s only.....</p> <p>Denture Services may be obtained through the Reach Up program, <u>only</u> upon recommendation by a Case Manager who determines a participant’s oral health is a barrier to their employment. Reach Up funds used! <b>Refer callers to the Reach Up Case Manager in their local DCF office for details.</b></p> <p>Participants receive a denture referral form and a PA request form which they bring to a dental provider. The provider submits the forms to: Dental Consultant, VT Dept. of Health, 108 Cherry Street, P.O. Box 70, Drawer 28, Burlington, VT 05402 for review. Upon review the Dental Consultant notifies both provider and participant whether or not approved.</p> <p>Used for obtaining an oral evaluation, new dentures or for replacing ones that are broken, lost or stolen complete and partial dentures.</p>	No	No See FFS Note	No
<b>Diabetic Supplies for VHAPRx, VScript &amp; VScript Expanded, HVP</b>	<p><b>VHAPRx:</b> Insulin as well as diabetic supplies, including glucose strips, tablets needles and syringes are covered with a prescription at the pharmacy.</p> <p><b>No –co-pay</b></p> <p>Also covered as DME.</p>		<p><b>VScript &amp; VScript Expanded:</b> Diabetic Supplies like syringes and needles are all covered as well as <u>Diabetic Drugs</u> like pills and insulin.</p> <p>Requires a prescription. <b>No co-pay.</b></p> <p><i>Diabetic lancets, strips, tracers, and glucose tablets may be covered under VScript if billable (having NDC code) to First Health.</i></p> <p><b>VScript: No co-pay..</b></p> <p><b>VScript Expanded: No co-pay.</b></p> <p><b>HVP:</b> Syringes and insulin are covered with a prescription, Medicaid rate applies.</p>	
<b>Diabetic Supplies</b>	See diabetic matrix			
Syringes	<p>Prescription needed. Covered 100% from pharmacy only.</p> <p>Also covered as DME.</p>	<p>Prescription needed. Covered 100% from pharmacy only.</p>	Covered; See <b>FFS</b> column.	Covered; See <b>FFS</b> column.
Lancets, glucose strips/tablets	<p>Prescription needed. Covered 100% from pharmacy only.</p> <p>Also covered as DME.</p>	<p>Prescription needed. Covered 100% from pharmacy only.</p>	Covered with prescription. See <b>FFS</b> column.	Covered with prescription. See <b>FFS</b> column.

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Insulin, prescription pills	Prescription needed. May be \$1,\$2, or \$3 co-pay, from pharmacy only*. PA required over \$100.  *Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities.	Prescription needed. No co-pay.	Covered; See FFS column.	Covered; See FFS column.
Diabetic Counseling	12 sessions/year by a certified diabetic counselor, membership in ADA (1/lifetime), or diabetic counseling provided as hospital sponsored outpatient course (1 course of 10-12 sessions per lifetime). PA required to exceed 12 visits.	Yes. Same as Medicaid FFS.	Same as FFS. Referral needed.	Yes. Same as Medicaid FFS. Referral needed.
Glucose Monitors	Covered as a DME. Over \$65 requires PA from OVHA. Prescription/med necessity form and PA required. <u>Covered if medically appropriate.</u>	Not covered.	Covered as a DME. Prescription/med Necessity form and PA required, see FFS column. See FFS column for glucose monitor batteries too.	Covered as a DME. Prescription/med Necessity form and PA required, see FFS column. See FFS column for glucose monitor batteries too.
Doctor Visits	Covered, limited to 5 visits per month. <b>After 5 visits an attending physician must show that it was necessary for additional visits and send their claim to OVHA (Att: CSU), with a written explanation for signature and forwarding for payment.</b>	See Medicaid FFS column. <b>No co-pay.</b>	Limited to 5 visits per month. Visits to specialists require PCP referral. OVHA approval required for more than 5 general visits – see FFS column.	Limited to 5 visits per month. Visits to specialists require PCP referral. OVHA approval required for more than 5 general visits – see FFS column. No co-pay.
Dressings  Note: Not covered under pharmacy programs.	Yes, with Rx.	See Medicaid FFS. <b>No co-pay.</b>	Yes, with Rx. See FFS column.	Yes, with Rx. See FFS column. No co-pay
Durable Medical Equipment	Prescription or medical necessity form needed. DME covered 100%. Example: leg or arm brace, pressure pumps, mattresses, monitors, protective helmets, bathtub seats, hospital beds, mattresses, commodes and diabetic supplies/equipment. Some items require a PA. PA by vendor, not provider. Baby hugger covered as DME. See med. regs. M840.3 & M840.4.	No	Prescription/med Necessity form needed. DME covered 100%. Example: leg or arm brace, pressure pumps, mattresses, monitors, protective helmets, bathtub seats, hospital beds, mattresses, commodes and diabetic supplies/equipment. Baby hugger covered as DME. Some items require a PA. PA by vendor, not provider. See med. regs. M840.3 & M840.4.	Prescription/med Necessity form needed. DME covered 100%. Example: leg or arm brace, pressure pumps, mattresses, monitors, protective helmets, bathtub seats, hospital beds, mattresses, commodes and diabetic supplies/equipment. Some items require a PA. PA by vendor, not provider. See med. regs. M840.3 & M840.4.

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Educational Summer Programs for Learning Disabled Kids	No. May be covered through local Dept of Education. For example, Pine Ridge School.	N/A	No. May be covered through local Dept of Education. For example, Pine Ridge School.	N/A
ER Services	Covered for emergency medical conditions.	\$25 co-pay per visit.	Referral by PCP needed unless during a health emergency. Client should contact PCP after a health emergency.	\$25 co-pay per visit Referral by PCP needed unless during a health emergency. Client should contact PCP after a health emergency.
Eyeglasses	<p><b>Age 21 years old and older:</b> <u>Not Covered.</u> General Assistance (GA) may be available, refer to local DCF office.</p> <p><b>&lt;21 years of age:</b> Yes One pair of glasses from the Medicaid approved selection every 2 years. Glasses repaired as needed. Glasses can be replaced in cases where they are lost, broken beyond repair, extensively scratched, or in cases where vision has significantly changed. Tri-focals/contacts require PA. Medicaid providers must prescribe glasses. (Provider should contact EDS for billing instructions).</p> <p>Note: There is no limitation on the frequency of repairs, as long as the dispensing provider decides the glasses are broken beyond repair or visual acuity is compromised. Refer providers to EDS with questions. <i>(per Nicole Brothers at OVHA 12/8/04)</i></p>	No	See FFS column.	No
Eyeglasses & Eye Care – VHAP RX Program	<p><u>Not Covered:</u> eyeglass frames, lenses, contacts, special lenses and repairs. General Assistance (GA) may be available, refer to local DCF office.</p> <p>Covers one comprehensive eye exam and 1 interim exam every 2 years at optometrist or ophthalmologist. Refraction exams covered (determines the curve on the lenses needed to correct your vision). Historical procedure codes normally covered: A9030, V2035, W1000, 92340,92342, 92352, 92353, 92370 &amp; 92371.</p>			

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Eye Care	<p><b>Age 21 years old and older:</b> Yes One comprehensive eye exam and 1 interim exam every 2 years at optometrist or ophthalmologist. Specialty eye care as needed The following are not covered for Dr. Dynasaur/Medicaid adults: eyeglass frames, lenses, contacts, special lenses and repairs.</p> <p><b>&lt;21 years of age:</b> Yes One comprehensive eye exam and 1 interim exam every 2 years at optometrist or ophthalmologist. Specialty eye care as needed. Other aids to vision (i.e. telescope lenses, cc TV) as determined appropriate and require a PA. Cataract Surgery requires PA inpatient. See Eyeglasses.</p>	Only if ordered by a doctor to diagnose a condition other than routine vision issues. For example, brain tumor or neurological defect.	See FFS	See Medicaid FFS
Feeding Protocol	Defined as training to learn to eat by the mouth (provided to clients currently with G tubes). Is covered if provided through the home health benefit.	Defined as training to learn to eat by the mouth (provided to clients currently w/ G tubes). Is covered if provided through the home health benefit.	Yes. Home health requires a PCP referral. Enteral nutritional products require a prescription and PA. Formula and foods for metabolic disorders require a prescription and PA.	Yes. Home health requires a PCP referral. Enteral nutritional products require a prescription and PA. Formula and foods for metabolic disorders require a prescription and PA.
Flu Shots	Must be medically necessary and obtained from VT Medicaid Provider as an in-office immunization.	Must be medically necessary and obtained from VT Medicaid Provider as an in-office immunization.	Must be medically necessary and obtained from PCP as an in-office immunization.	Must be medically necessary and obtained from PCP as an in-office immunization.
Genetic Testing	Covered if medically necessary with provider referral, unless related to fertility or paternity.	Covered if medically necessary w/ provider referral, unless related to fertility or paternity.	Covered if medically necessary w/ PCP provider referral, unless related to fertility or paternity.	Covered if medically necessary w/ PCP provider referral, unless related to fertility or paternity.
Haponal (Rx)	Not covered (“Desi” drug ).	No - See Medicaid <b>FFS</b> .	No - See <b>FFS</b> column.	No - See <b>FFS</b> column.

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Hearing Aids  Analog and Digital	<p>Yes, Analog and digital hearing aids for all members.</p> <p>Do not require a medical necessity form but <b>do require an RX</b> from the prescribing Audiologist.</p> <p>PA required for more than 1 hearing aid repair per year or any repair &gt;\$100. See med. Regs. 650.</p> <p>Ear molds covered. Canal aids and loaners not covered. Batteries: do require an Rx. Clients can get 1 pkg containing 4-6 batteries per month at any pharmacy who is a Medicaid billable provider.</p> <p><i>As of July 1, 2003 digital hearing aids covered for all ages. Previous coverage was for kids only.</i></p>	<p><b>No.</b> May be able to get an assist through HEAR NOW, 1-800-328-8602. (They offer analog hearing aids only. Call to request an application.)</p>	<p>See FFS column.</p>	<p><b>No.</b> May be able to get an assist through HEAR NOW, 1-800-328-8602. (They offer analog hearing aids only. Call to request an application.)</p>
High Tech Program	<p>A program for clients dependent on high tech equipment that also includes skilled nursing care and DME. Callers should be referred to Gary Boyce at DAIL 1-802-241-4639.</p>	<p>No</p>	<p>Members in the High Tech program are not eligible to participate in managed care.</p>	<p>Members in the High Tech program are not eligible to participate in managed care.</p>
HIV Testing	<p>Covered as medically indicated.</p> <p>Note: People <u>not covered</u> seeking HIV drugs may be able to get help through AMAP, 800-244-7639; or 802-863-7253</p>	<p>Covered as medically indicated.</p>	<p>Covered as medically indicated. Lab tests require a referral from PCP.</p>	<p>Covered as medically indicated. Lab tests require a referral from PCP.</p>
Home Health (includes in-home hospice care)	<p>Upon doctor certification/referral. Must use Medicaid providers.</p> <p>Only PT/OT/ST requires PA after 4 months. Nursing Home Health Aid visits do not require PA.</p>	<p>Upon doctor certification/referral. No coverage for Chronic Conditions.</p>	<p>Must use Medicaid providers and requires referral from PCP.</p>	<p>Must use Medicaid providers and requires referral from PCP. No coverage for Chronic Conditions.</p>
Humidifiers	<p>Heated and unheated covered as part of respiratory equipment. Prescription needed. DME covered 100%. PA must be submitted by vendor.</p>	<p>No</p>	<p>See FFS</p>	<p>See FFS</p>
Hydro-therapy	<p>See physical therapy.</p>	<p>See physical therapy.</p>	<p>See physical therapy.</p>	<p>See physical therapy.</p>

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service ( <b>FFS</b> )	VHAP-Limited ( <b>FFS</b> )	Medicaid/Dr. Dynasaur Managed Care – <b>PC Plus</b>	VHAP Managed Care - <b>PC Plus</b>
Infant Formula (only if not available through WIC or CSHN)	Only for treatment of inherited metabolic diseases such as Biotinidase Deficiency, Hypothyroidism, Galactosemia, Homocytinuria, Maple Syrup Urine Disease, Phenylketonuria, and Sickle Cell Disease.	No	Only for treatment of inherited metabolic diseases such as Biotinidase Deficiency, Hypothyroidism, Galactosemia, Homocytinuria, Maple Syrup Urine Disease, Phenylketonuria, and Sickle Cell Disease. Formulas and foods require a prescription and PA. Testing by specialists requires a referral.	No
Interpreter Services	Yes. Dental providers should contact James Lasaponara at the Dental Health Office @863-7341 to obtain a PA. No other interpreter services require PA. Refugee Resettlement Center in Burlington can help their clients in person. All others: client or provider can arrange an interpreter. The Medicaid provider must pay the interpreter and then bill Medicaid. Reimbursement rate is \$59.50 per visit, regardless of actual cost. The provider may also set up an account with the AT&T Language line and utilize in the same manner.	Yes. We offer AT&T Language line. Refugee Resettlement Center in Burlington can help their clients in person. All others: client or provider can arrange an interpreter. The Medicaid provider must pay the interpreter and then bill Medicaid. Reimbursement rate is \$59.50 per visit, regardless of actual cost.	Yes. See FFS	Yes. We offer AT&T Language line. Refugee Resettlement Center in Burlington can help their clients in person. All others: client or provider can arrange an interpreter. The Medicaid provider must pay the interpreter and then bill Medicaid. Reimbursement rate is \$59.50 per visit, regardless of actual cost.
Immunization	Yes. RX co-pay of \$1,\$2 or \$3 if client goes to pharmacy to secure vaccine.*  *Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities.	Yes. No co-pay.	Yes, when administered by member’s PCP. RX co-pay of \$1,\$2 or \$3 if client goes to pharmacy to secure vaccine.*  *Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities.	When administered by member’s PCP. No co-pay
Impotence Medications	6 tablets or injections/month for max of 3 months for males over 18. Dr. required to fill out PA form obtained from First Health. Co-pays apply of \$1,\$2 or \$3.*  *Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities.	Same as Medicaid <b>FFS</b> . See previous column. No co-pay	Covered. See Medicaid <b>FFS</b> column. PA required. Co-pays apply of \$1,\$2 or \$3.*  *Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities.	Covered. See Medicaid <b>FFS</b> column. PA required. No co-pay

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service ( <b>FFS</b> )	VHAP-Limited ( <b>FFS</b> )	Medicaid/Dr. Dynasaur Managed Care – <b>PC Plus</b>	VHAP Managed Care - <b>PC Plus</b>
Independent Lab or X-ray	<p>Some diagnostic imaging requires PA, some “routine” x-rays do not need PA.</p> <p><u>Note:</u> As of 12/1/04 the following diagnostic codes do not need PA: 72125-72133 (CT Scans) G0044-G0253 (PET Scans) 78459 (PET Scans) <i>(Per Roger Tremblay, OVHA 11/17/04)</i></p>	<p>Referral by PCP or from specialist to whom patient has been referred, or OB/GYN needed. Some diagnostic imaging requires PA, some “routine” x-rays do not need PA. No co-pay</p> <p><u>Note:</u> As of 12/1/04 the following diagnostic codes do not need PA: 72125-72133 (CT Scans) G0044-G0253 (PET Scans) 78459 (PET Scans) <i>(Per Roger Tremblay, OVHA 11/17/04)</i></p>	<p>Referral by PCP or from specialist to whom patient has been referred, or OB/GYN needed. Some diagnostic imaging requires PA, some “routine” x-rays do not need PA.</p> <p><u>Note:</u> As of 12/1/04 the following diagnostic codes do not need PA: 72125-72133 (CT Scans) G0044-G0253 (PET Scans) 78459 (PET Scans) <i>(Per Roger Tremblay, OVHA 11/17/04)</i></p>	<p>Referral by PCP or from specialist to whom patient has been referred, or OB/GYN needed. Some diagnostic imaging requires PA, some “routine” x-rays do not need PA.</p> <p><u>Note:</u> As of 12/1/04 the following diagnostic codes do not need PA: 72125-72133 (CT Scans) G0044-G0253 (PET Scans) 78459 (PET Scans) <i>(Per Roger Tremblay, OVHA 11/17/04)</i></p>

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service ( <b>FFS</b> )	VHAP-Limited ( <b>FFS</b> )	Medicaid/Dr. Dynasaur Managed Care – <b>PC Plus</b>	VHAP Managed Care - <b>PC Plus</b>
<p>Inpatient Hospitalization</p>	<p>\$75 co-pay per urgent admission*. Semi private room only. Will not pay for any portion of private room. No PA required.</p> <p>* Co-pays do not apply to children under age 21, pregnant women, women in 60-day post partum period or patients in long term care facilities.</p> <p>*Exception – co-pays do apply to SSI-related beneficiaries’ age 18, 19, and 20.</p> <p>*No co-pays for family planning admissions or any emergent admissions.</p> <p>To exempt co-pay requirements for Family planning on inpatient and outpatient claims, provider should bill with A4 in the condition code field. This is the way the system was set up in the original co-pay design.</p> <p>There are other exemptions for co-pay such as a specific list of diagnosis codes (63000 - 67694, V2200 - V2420, V2700 - V2890, V6160, V6170, V7240, V2220, V30, V3921) , admit code 1 for emergency, NH recipient, etc.</p>	<p>Yes, if it is on an <b>emergent or urgent</b> care basis only. No co-pays.</p> <p><b>Elective inpatient hospital stays are <u>not</u> covered.</b> The admitting physician determines if an admission is emergent, urgent or elective.</p>	<p>Admissions require PCP referral if through a specialist. No PA required. \$75 co-pay per admission*.</p> <p>* Co-pays do not apply to children under age 21, pregnant women, women in 60-day post partum period or patients in long term care facilities.</p> <p>*Exception – co-pays do apply to SSI-related beneficiaries’ age 18, 19, and 20.</p> <p>*No co-pays for family planning admissions or any emergent admissions. To exempt co-pay requirements for Family planning on inpatient and outpatient claims, provider should bill with A4 in the condition code field. This is the way the system was set up in the original co-pay design.</p> <p>There are other exemptions for co-pay such as a specific list of diagnosis codes (63000 - 67694, V2200 - V2420, V2700 - V2890, V6160, V6170, V7240, V2220, V30, V3921) , admit code 1 for emergency, NH recipient, etc.</p>	<p>Yes, if it is on an <b>emergent or urgent</b> care basis only. Admissions require PCP referral if through a specialist. No PA required. No co-pay</p> <p><b>Elective inpatient hospital stays are <u>not</u> covered.</b> The admitting physician determines if an admission is emergent, urgent or elective.</p>
<p>Intensive Family Based Services (CWYJ)</p>	<p>Intensive intervention for families in crisis including counseling services and parent education and support services. Administered by the Child Welfare &amp; Youth Justice Division (CWYJD). Refer to local CWYJ office (see R drive).</p>	<p>N/A</p>	<p>See Medicaid <b>FFS</b> column.</p>	<p>N/A</p>
<p>IV Therapy (Infusion Therapy)</p>	<p>Covered as DME and provided by home health provider.</p>	<p>Possibly through home health. Does <b>not</b> cover home infusion therapy. No co-pay for medications</p>	<p>If through high-tech program, client should not be in managed care. Possibly through home health.</p>	<p>If through high-tech program, client should not be in managed care. Possibly through home health. No co-pay for medications</p>
<p>Lamaze Classes</p>	<p>See childbirth classes.</p>	<p>N/A – Pregnant Women should be in Dr. Dynasaur.</p>	<p>See childbirth classes.</p>	<p>N/A – Pregnant Women should be in Dr. Dynasaur.</p>

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
LifeLine Program or Link-Up	LifeLine provides a <u>discounted phone bill</u> and/or phone with special features. <u>Not covered by Medicaid</u> . Clients should contact phone company or LifeLine office at 1-800-287-0589.  LifeLine as an <u>emergency medical response</u> service is a covered benefit for <u>Waiver clients only</u> who have this service in their plan of care.  If non-Waiver clients wish to find out about the emergency response program, refer to local Area Agency on Aging or Senior Helpline at 800-642-5119.  For Link-Up call local DCF office.	No. See <b>FFS</b> column.	No. See <b>FFS</b> column.	No. See <b>FFS</b> column.
Long Term Care Facility (also known as skilled nursing facilities)	Must meet admittance criteria of facility. Facility must be a Medicaid provider. Family can get a private room vs. a semi- private and pay the difference.	No	Skilled nursing facility only upon PCP referral; 30 days per episode of illness. After 30 days, member is disenrolled from managed care and returns to <b>FFS</b> .	Same as Medicaid managed care. See previous column. After 30 days, member is no longer eligible for VHAP. If the stay is likely to be more than 30 days, should apply for Medicaid.
Mammography	Yes – See Radiology Services. No PA required for Mammography.	Yes – See Radiology Services. No PA required for Mammography.	Yes - See Radiology Services. No PA required for Mammography.	Yes - See Radiology Services. No PA required for Mammography.
Marijuana (Medical Use)	No	No	No	No
Marriage Counseling	Medicaid provider needs to bill under one individual's number and code the session as an individual session w/ family.	Same as FFS.	Yes. Provider bills under one member and must be a <b>PC Plus</b> provider.	Yes. Provider bills under one member and must be a <b>PC Plus</b> provider.
Massage Therapy	Not Covered	Not Covered	Not Covered	Not Covered
Maxillofacial Surgery (non-cosmetic)	Includes surgery to the face or the jaw. Some procedures require PA.	Same as Medicaid FFS. See previous column. No-co-pay per visit	Referral and PA by PCP needed.	Referral and PA by PCP needed. No co-pay per visit
Medical Alert Bracelet	Not covered.	Not covered.	Not covered.	Not covered.

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service ( <b>FFS</b> )	VHAP-Limited ( <b>FFS</b> )	Medicaid/Dr. Dynasaur Managed Care – <b>PC Plus</b>	VHAP Managed Care - <b>PC Plus</b>
Medical Supplies	Prescription/medical necessity form needed. Example: Vaporizers, diabetic supplies; ostomy supplies; disposable supplies; tape, cotton; respiratory supplies; tracheotomy supplies; and incontinent supplies (disposable under pads, diapers, pants or liners). More than 300 disposable adult diapers per month require a PA. Also, diapers for children under 3 require a PA to establish an extraordinary need. Tracheotomy care <u>kits</u> not covered- can get bulk supplies. Some items require a PA and some items have imposed limits. See Sanitary Napkins below.	Coverage is limited to supplies furnished by the physician during an office visit. See Sanitary Napkins below.	Same as <b>FFS</b> . Prescription/medical necessity form needed. Example: diapers for older children and adults; catheter and related equip; diabetic supplies; ostomy supplies (need PA); dressings for wounds; disposable supplies. Some items require a PA and some items have imposed limits. See Sanitary Napkins below.	Same as <b>FFS</b> . Prescription/medical necessity form needed. Example: diapers for older children and adults; catheter and related equip; diabetic supplies; ostomy supplies (need PA); Vaporizers, dressings for wounds; and disposable supplies. Some items require a PA and some items have imposed limits. See Sanitary Napkins below.
<b>Mental Health</b> Center (DMH/MR), or Community Mental Health Center	Yes. No referral needed..	Yes, through CMHC with no co-pay. See previous FFS column.	No PCP referral needed. Member may self-refer to a mental health provider.	Same as Medicaid managed care. See previous column. No co-pay.
Court Ordered Treatment	Only if medically necessary. Then, other MH rules apply.	Only if medically necessary. Then, other MH rules apply.	If medically necessary, client gets the treatment they need through <b>PC Plus</b> , but may not fulfill court ordered requirements.	If medically necessary, client gets the treatment they need through <b>PC Plus</b> , but may not fulfill court ordered requirements.
Outpt Rehab Facilities	\$3 co-pay.*  * Co-pays do not apply to children under age 21, pregnant women, women in 60-day post partum period or patients in long term care facilities. *Exception – co-pays do apply to SSI-related beneficiaries age 18, 19, and 20 if in a hospital setting.	No co-pay. Seneca House is covered as an outpatient partial hospitalization.	Referral by PCP needed. \$3 co-pay*.  * Co-pays do not apply to children under age 21, pregnant women, women in 60-day post partum period or patients in long term care facilities. *Exception – co-pays do apply to SSI-related beneficiaries age 18, 19, and 20 if in a hospital setting.	Referral by PCP needed. No co-pay.
Psychiatrist	Must be a Medicaid provider.	See Medicaid FFS	No PCP referral needed. Member may self-refer to a <b>PC Plus</b> mental health provider.	Same as Medicaid managed care. See previous column. No co-pay

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – <i>PC Plus</i>	VHAP Managed Care - <i>PC Plus</i>
Psychiatric Hospital	Covered for recipients under 21 only. Adults can be admitted to the psychiatric ward of a general hospital. 30 days/episode, 60 days/year.  PA not required for any in-state admissions. PA <b>is</b> required for all out-of-state admissions.	No, although members may be admitted for residential treatment at a mental health or OADAP substance abuse facility.	Members can be admitted to psychiatric facilities or the psychiatric ward of a hospital at the provider's discretion. 30 days/episode, 60 days/year. Facility must accept <i>PC Plus</i> . PA not required for any in-state admissions. PA <b>is</b> required for all out-of-state admissions.	Same as Medicaid managed care. See previous column.
Psychologist	Must be a Medicaid provider.	See Medicaid FFS	No PCP referral needed. Member may self-refer to a <i>PC Plus</i> mental health provider.	Same as Medicaid managed care. See previous column. No co-pay.
Meridia (Diet drug)	Yes, covered with PA and Rx. Co-pays apply.* * Co-pays do not apply to children under age 21, pregnant women, women in 60-day post partum period or patients in long term care facilities.	See Medicaid <b>FFS</b> . No co-pay	Covered; See Medicaid <b>FFS</b> column. Co-pays apply.* * Co-pays do not apply to children under age 21, pregnant women, women in 60-day post partum period or patients in long term care facilities.	Covered; See Medicaid <b>FFS</b> column. No co-pay.
Methadone	Requires PA. Methadone as a drug acquired at a pharmacy is only covered for pain. Needs PA & RX. Co-pays may apply Methadone as part of a detoxification program is part of the substance abuse treatment claim and can not be picked up at the pharmacy. See Substance abuse.	See FFS	See FFS	See Medicaid FFS
Nebulizers/ Vaporizers	Yes, covered with medical necessity form.	No.	Yes, covered with medical necessity form.	Yes, covered with medical necessity form, covered as DME – no co-pay.
Nursing	Coordinated through the High Tech program.	No. All nursing care is provided by home health agencies.	High tech beneficiaries do not qualify for managed care.	High tech beneficiaries do not qualify for managed care.

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – <i>PC Plus</i>	VHAP Managed Care - <i>PC Plus</i>
Nursing Facility-- Mental Retardation (NF-MR)	<p>Facility where services are provided to clients with mental retardation. Administered by the Dept of Health, although some services are billed to Medicaid.</p> <p>Many clients would instead be on Community Waiver program. Only 2 facilities left in Vermont. One in Barre, one in Rutland. 6 residents each only. Contact: DAIL, 241-2400.</p>	No	Members in an NF-MR are not eligible to participate in managed care and would return to a FFS model.	Members in an NF-MR are not eligible to participate in managed care and need to apply for Medicaid benefits upon disenrollment from VHAP.
Nutritional Counseling	<p>Yes, if medically necessary, Hospital outpatient nutritional counseling services when ordered by a physician [policy M520] In a clinic setting when incidental to a physician’s services [M720]</p> <p><u>Note:</u> Dieticians are not enrolled as Medicaid providers, so must occur as a hospital outpatient counseling or in a clinic setting per above.</p> <p>Nutrition counseling by a state certified dietician can be billed as a school health service when part of an IEP or IFSP for special ed students. Requires prescription by a physician or other licensed practitioner.</p>	Same as Medicaid FFS.	<p>Same as Medicaid FFS with referral.</p> <p><b>Pregnant women and children under five ONLY</b> -Covered through WIC, refer to 1-800-464-4343.</p>	<p>Same as Medicaid FFS with referral.</p> <p><b>Pregnant women and children under five ONLY</b> -Covered through WIC, refer to 1-800-464-4343.</p>

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Occupational Therapy	<p>Services are limited to home health agency, outpatient hospital/rehab facility and <u>independent</u> provider types. \$3 co-pay per visit for outpatient under FFS for adults.*</p> <p>* Co-pays do not apply to children under age 21, pregnant women, women in 60-day post partum period or patients in long term care facilities.</p> <p>*Exception – co-pays do apply to SSI-related beneficiaries age 18, 19, and 20 if in a hospital setting.</p> <p>No co-pay if under a home health heading. <u>Services beyond 4 months require PA</u> if they are classified as Home Health Services.</p> <p>Services discontinued after one year, but may continue if immediate and predictable deterioration or resume if deterioration of condition occurs. Have provider contact EDS if questions. PA needed for services beyond 1 year.</p> <p><b>See M710.5</b></p> <p><u>Note:</u> Other types of HH Visits = no PA: Physician’s referral for Home Health Aide Services, no PA (even after 4 months). Physician’s referral for Nursing Visits, no PA (even after 4 months).</p>	<p>Same as Medicaid <b>FFS</b>. See previous column. Does not include supplies or equip.</p> <p>No co-pays</p>	<p>Referral by PCP needed. Must be a Medicaid provider. Can be an <u>independent</u> provider. <u>PA needed beyond 4 months</u>. Services discontinued after one year, but may continue if immediate and predictable deterioration or resume if deterioration of condition occurs. PA needed for services beyond 1 year.</p> <p>Services are limited to home health agency, outpatient hospital/rehab facility and <u>independent</u> provider types. \$3 co-pay per visit for outpatient for adults.*</p> <p>* Co-pays do not apply to children under age 21, pregnant women, women in 60-day post partum period or patients in long term care facilities.</p> <p>*Exception – co-pays do apply to SSI-related beneficiaries age 18, 19, and 20 if in a hospital setting.</p> <p><u>Note:</u> Other types of HH Visits = no PA: Physician’s referral for Home Health Aide Services, no PA (even after 4 months). Physician’s referral for Nursing Visits, no PA (even after 4 months).</p>	<p>Referral by PCP needed. Must be a Medicaid provider. Can be an <u>independent</u> provider. <u>PA needed beyond 4 months</u>. Services discontinued after one year, but may continue if immediate and predictable deterioration or resume if deterioration of condition occurs.</p> <p>No co-pays</p> <p><u>Note:</u> Other types of HH Visits =no PA: Physician’s referral for Aide Services, no PA. (even after 4 months). Physician’s referral for Nursing Visits, no PA (even after 4 months).</p>

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Optometrist & Ophthalmologist	<p><b>Age 21 years old and older: Yes</b>                      The following are not covered for Dr. Dynasaur/Medicaid adults.                      : eyeglass frames, lenses, contacts, special lenses and repairs.                      Routine eye care is covered for one comprehensive eye exam and 1 interim exam every 2 years at an optometrist or ophthalmologist. Specialty eye care as needed for diagnosis and treatment of diseases of the eye.</p> <p><b>&lt;21 years of age: Yes</b>                      One comprehensive eye exam and 1 interim exam every 2 years at optometrist or ophthalmologist. Specialty eye care as needed. Other aids to vision (i.e. telescope lenses, cc TV) as determined appropriate and require a PA. Cataract Surgery requires PA inpatient.</p>	<p>Coverage is limited to diagnosis and treatment of diseases of the eye, visual analysis. No co-pay</p> <p>Eyeglasses are not covered.</p>	See FFS column	<p>The following are not covered for VHAP clients: eyeglass frames, lenses, contacts, special lenses and repairs.</p> <p>Routine eye care is covered for one comprehensive eye exam and 1 interim exam every 2 years at an optometrist or ophthalmologist. Specialty eye care as needed for diagnosis and treatment of diseases of the eye. No co-pay</p> <p>Diagnosis and treatment of diseases of the eye requires a referral from PCP.</p>
Optometrist & Ophthalmologist <b>VHAP Rx</b>	<p>The following are <u>not covered</u> for VHAP RX clients: eyeglass frames, lenses, contacts, special lenses and repairs. Covers one comprehensive eye exam and 1 interim exam every 2 years at an optometrist or ophthalmologist.</p> <p>Historical procedure codes normally covered: A9030, V2035, W1000, 92340, 92342, 92352, 92353, 92370 &amp; 92371.</p>			
Oral Surgery	<p>Covered. Requires referral from dentist. Some services are counted against \$475 annual maximum. More than 1 extraction requires PA. Anesthesia/intravenous sedation is covered w/o PA (Is counted against \$475). On a inpatient basis, need PA and referral from PCP.</p>	No	See FFS column.	<p>Some services are covered, i.e. treatment for accidental injury; surgery to correct gross deformity; surgery for TMJ.</p>
Organ Transplants (see also Bone Marrow)	<p>Yes. Covered if procedure is no longer considered experimental or investigational. PA required.</p>	<p>Yes. Urgent or emergent. Covered if procedure is no longer considered experimental or investigational.</p>	<p>Referral by PCP to specialist. Surgical PA needed.</p> <p>Covered if procedure is no longer considered experimental or investigational.</p>	<p>Referral by PCP to specialist. Surgical PA needed.</p> <p>Covered if procedure is no longer considered experimental or investigational.</p>

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Orthodontics (braces) <b>Under 21 years Medicaid/Dr. D only</b>	Initial orthodontic examination covered, including exam, treatment planning, radiography, diagnostic models and photographs. <b>Dentist will screen for basic eligibility and submit PA request ONLY IF CRITERIA MET.</b> Must have one major or two minor malocclusions or comparable degree of severity. Provider is under no obligation to submit PA if criteria not established. Interceptive or comprehensive services provided as a result of the initial exam <u>require prior approval</u> from the Dental Health Division (1-800-464-4343 ext. 7341). Each provider allowed 1 comprehensive oral exam per patient per lifetime. Patient can receive comp. Exam from several different providers. Retro Orthodontia ONLY IF CERTAIN CRITERIA MET. Doc should call Dental Division.	No	Covered. See FFS column.	No
Orthotics	Braces, trusses, shoes affixed to leg brace or other devices used for the purpose of supporting a weak or deformed body member. Excludes garter belts and may require a PA.	No	Referral/med. Necessity/prescription form by PCP needed. Braces, trusses shoes affixed to leg brace or other devices used for the purpose of supporting a weak or deformed body member. Excludes garter belts and arch supports. Vendor secures PA when needed in some cases. PA often required.	Same as Medicaid managed care. See previous column. No co-pay.
Out-of-state Health Care Services	Within the US, only emergency care if the facility is willing to become a VT Medicaid provider. Inpatient out-of-country care is not covered unless an emergency happened in the US, but a Canadian facility is the closest. These rules do not apply to those “border” providers who are VT Medicaid providers.	Same as Medicaid FFS. See previous column. \$25 co-pay may apply for ER services	Within the US only emergency care if the facility is willing to become a VT Medicaid provider. Inpatient out-of-country care is not covered unless an emergency happened in the US, but a Canadian facility is the closest. These rules do not apply to those “border” providers who are in plan network.	Same as Medicaid managed care. See previous column. \$25 co-pay may apply for ER services.
Outpatient Hospital Services	Covered services, some require PA. \$3 co-pay.* * Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities. Exception – co-pays do apply to SSI-related beneficiaries’ age 18, 19, and 20.	Some services require PA	Referral by PCP needed. Some services require PA. \$3 co-pay.*  * Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities. Exception – co-pays do apply to SSI-related beneficiaries’ age 18, 19, and 20.	Referral by PCP needed. Some services require PA.
Outpt Rehab Facilities	Covered services, some require PA.	Some services need PA.	Referral by PCP needed. PA may be required depending on service.	Referral by PCP needed. Some services require PA

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Over the Counter Drugs	<p>Selected OTC drugs covered with Rx. Refer Providers to First Health for confirmation of coverage. Co-pays apply.*</p> <p>(Generally <b>NOT covered by VHAP RX, VSCRIPTS or HVP</b>)</p> <p><b>Exceptions:</b>                      (OTC coverage is limited to Loratidine &amp; Prilosec for VHAP Limited, VHAP Pharmacy, VScript &amp; VScript Exp.)                      (OTC is limited to Non-steroidal Anti-inflammatory analgesics for VHAP Limited and VHAP Pharmacy.)</p> <p>* Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities.</p>	<p>No</p> <p><b>Exception: (OTC coverage is limited to Loratidine, Prilosec and Non-steroidal Anti-inflammatory analgesics for VHAP Limited)</b></p>	Covered. See <b>FFS</b> column.	Covered. See <b>FFS</b> column. No co-pay
Oxygen	<p>The State has a contract with several hi-tech suppliers to provide oxygen. (Apria, Merriam-Graves, Life Plus, Keene Medical, The Medical Store).</p> <p>Covered as DME 100% with Rx, no co-pay. NOTE: Prescription (no PA) needed.</p>	No	Referral by PCP may be required if through a specialist. See DME and <b>FFS</b> column. Covered with Rx through approved suppliers.	See previous column. Same as Medicaid managed care. Covered with Rx through approved suppliers at 100%, no co-payment.
PAP Smears	Yes, OB/GYN lab work.	<p>See Medicaid <b>FFS</b> column.</p> <p>No co-pay.</p>	Yes. Routine lab work covered without PA.	Yes. Routine lab work covered without PA. No co-pay
Paternity Test	No, must apply @ Child Support Office 1-800-786-3214.	No, must apply @ Child Support Office 1-800-786-3214.	No, must apply @ Child Support Office 1-800-786-3214.	No, must apply @ Child Support Office 1-800-786-3214.

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service ( <b>FFS</b> )	VHAP-Limited ( <b>FFS</b> )	Medicaid/Dr. Dynasaur Managed Care – <b>PC Plus</b>	VHAP Managed Care - <b>PC Plus</b>
Patient Record Charges	Unless, there is another agreement in place that forbids such a charge. Vermont law, 18 V.S.A. 9419(b), says that a physician "may charge an individual a fee, reasonably related to the associated costs, for providing copies" of such records.	Unless, there is another agreement in place that forbids such a charge. Vermont law, 18 V.S.A. 9419(b), says that a physician "may charge an individual a fee, reasonably related to the associated costs, for providing copies" of such records.	PCP switch under PC+– no charge  Specialists: Unless, there is another agreement in place that forbids such a charge. Vermont law, 18 V.S.A. 9419(b), says that a physician "may charge an individual a fee, reasonably related to the associated costs, for providing copies" of such records.	PCP switch under PC+– no charge  Specialists: Unless, there is another agreement in place that forbids such a charge. Vermont law, 18 V.S.A. 9419(b), says that a physician "may charge an individual a fee, reasonably related to the associated costs, for providing copies" of such records.
Peak Flow Meter	DME. Covered.	No	See Medicaid <b>FFS</b> .	See Medicaid <b>FFS</b> .
Penile Implant	Medically necessary. Requires PA.	Out patient services only. See <b>FFS</b> column. Requires PA.	See <b>FFS</b> column. Referral by PCP if through specialist and PA for surgery. Must be medically necessary.	See <b>FFS</b> column. Referral by PCP if through specialist and PA for surgery. Must be medically necessary.
Personal Care. Covered for <b>Children under 21only</b> .  (For adult personal care see community resources)	Hands-on assistance related to a person’s physical requirements. Services enable a person to remain in the home/community, maintain health status, and prevent/delay/minimize deterioration. Must be prescribed by a Doctor and requires a PA. Longer term than similar services provided under home health benefit. <b>PCA Self-Directed option</b> for families prior approved for benefits. DAIL Case Manager outreaches families for assistance with consumer-directed program.	No	Covered. See <b>FFS</b> column. Covered for kids under 21 with PA.	No
Pharmacy Programs.	VHAP Rx, VScript, VScript Expanded & HVP People living in Nursing Homes can apply for pharmacy programs.			

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Physical Therapy	<p>Services are limited to home health agency, and outpatient hospital/rehab facility and <u>independent</u> provider types. \$3 co-pay per visit for outpatient under FFS for adults.*</p> <p>No co-pay if under a home health heading. <u>Services beyond 4 months require PA if they are classified as Home Health Services.</u></p> <p>* Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities. Exception – co-pays do apply to SSI-related beneficiaries age 18, 19, and 20 if in a hospital setting.</p> <p>Services discontinued after one year, but may continue if immediate and predictable deterioration or resume if deterioration of condition occurs. Have provider contact EDS if questions. PA needed for services beyond 1 year.</p> <p><b>See M710.5</b></p> <p><u>Note:</u> Other types of HH Visits = no PA: Physician’s referral for Home Health Aide Services, no PA (even after 4 months). Physician’s referral for Nursing Visits, no PA (even after 4 months).</p>	<p>Same as Medicaid <b>FFS</b>. See previous column. Does not include supplies or equip.</p> <p>No co-pays.</p>	<p>Referral by PCP needed. Must be a Medicaid provider. Can be an <u>independent</u> provider. PA needed after 4 months. Services discontinued after one year, but may continue if immediate and predictable deterioration or resume if deterioration of condition occurs. Have provider contact EDS if questions. PA needed for services beyond 1 year.</p> <p>\$3 co-pay per visit for outpatient for adults.*</p> <p><u>Note:</u> Other types of HH Visits = no PA: Physician’s referral for Home Health Aide Services, no PA (even after 4 months). Physician’s referral for Nursing Visits, no PA (even after 4 months).</p> <p>* Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities. Exception – co-pays do apply to SSI-related beneficiaries age 18, 19, and 20 if in a hospital setting.</p>	<p>Referral by PCP needed. Must be a Medicaid provider. Can be an <u>independent</u> provider. PA needed beyond 4 months. Services discontinued after one year, but may continue if immediate and predictable deterioration or resume if deterioration of condition occurs. Have provider contact EDS if questions.</p> <p>No co-pays</p> <p><u>Note:</u> Other types of HH Visits = no PA: Physician’s referral for Home Health Aide Services, no PA (even after 4 months). Physician’s referral for Nursing Visits, no PA (even after 4 months).</p>
Physicals	<p>One routine physical per year by a Medicaid provider. Physicals for administrative or employment physicals are not covered. (May be covered by Reach Up).</p>	<p>Same as Medicaid <b>FFS</b>. See previous column.</p> <p>No co-pay per visit</p>	<p>One routine physical per year by PCP. Physicals for administrative or employment physicals are not covered. (May be covered by Reach Up).</p>	<p>One routine physical per year by PCP. Physicals for administrative or employment physicals are not covered. No co-pay per visit</p>
Physician Services	<p>Yes</p>	<p>Yes. No co-pay</p>	<p>Covered at office of PCP. Referral by PCP needed for specialty care (exceptions: one routine eye exam every two years and OB/GYN services).</p>	<p>Same as Medicaid managed care. See previous column. No co-pay.</p>
Private Non-Med institution (CWYJ, DAIL)	<p>Group Homes - Administered by CWYJ.</p>	<p>No</p>	<p>Group Homes – Administered by CWYJ. Covered for children under 21.</p>	<p>No</p>

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Podiatry	Non-routine care is covered (i.e. diabetic related care, infections). Routine care is not covered (i.e., corns, calluses).	Same as Medicaid FFS. See previous column. No co-pay	Referral by PCP needed. Non-routine care is covered (i.e. Diabetic related care, infections). Routine care is not covered (i.e., corns, calluses).	Referral by PCP required. Same as Medicaid managed care. See previous column. No co-pay
<b>Prescriptions RX</b>  (VHAP-Pharmacy, & both VScripts do not generally cover OTCs, see OTC for exceptions).  GA for VHAP Pharmacy, VScript see FFS column.  GA for VScript Expanded co-insurance and HVP may be obtained. Refer to DCF	\$1 co-pay for drugs \$29.99 or less. \$2 co-pay for drugs \$30.00 to \$49.99. \$3 co-pay for drugs \$50.00 or more.*  * Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities.  Prescribing doctor must be "enrolled in the system". DESI drugs are not covered. Some drugs require PA. Prescribed multi-source vitamins require PA.  Refer to PDL for drugs requiring PA.  Pharmacists should call First Health with problems or questions. Drugs administered during a hospital stay are covered. No co-pay.  <b>Birth Control</b> – SEE Birth Control Section.  GA for co-pay may be obtained for emergency medical needs. Refer to DCF. Pharmacies can not turn away for non-payment of co-pay. May however refuse future service. Client will be billed co-pay from pharmacy.  Medicaid is a 2 <sup>nd</sup> payer to Medicare Part B covered medications.	No co-pay See previous column on DESI drugs. Prescribing doctor must be "enrolled in the system".	Covered. See FFS column.  GA for co-pay may be obtained for emergency medical needs. Refer to DCF. Pharmacies can not turn away for non-payment of co-pay. May however refuse future service. Client will be billed co-pay from pharmacy.	Covered. See FFS column. No co-pay
Prenatal Vitamins	Covered for pregnant women with Rx. Generic brand for pregnant or lactating women. No co-pay.	NA - Pregnant women should be in Dr.D, see FFS.	Covered, See Medicaid FFS.	NA - Pregnant women should be in Dr.D, see FFS Medicaid column.
Prosthetics	Rx required. Some items require PA. Variety of artificial limbs, eyes, larynx, shoes, braces, and orthopedic supports. See med. regs. M843.	No	Referral/medical Necessity form by PCP needed. PA for some items. See FFS column.	Referral/medical Necessity form by PCP needed. PA for some items. See FFS column.
Psychiatrist	Covered.	No co-pay	No PCP referral needed. Member may self-refer to a Medicaid mental health provider.	Same as Medicaid managed care. See previous column. No co-pay

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Psychiatric Hospital	Covered for recipients under 21 only. Adults can be admitted to the psychiatric ward of a general hospital. PA not required for any in-state admissions. PA <b>is</b> required for all out-of-state admissions.	No, although members may be admitted for residential treatment at a mental health or approved substance abuse facility.	Members can be admitted to psychiatric facilities or the psychiatric ward of a hospital at the plan and the provider’s discretion. PA not required for any in-state admissions. PA <b>is</b> required for all out-of-state admissions. Facility must accept Medicaid. 30 days/episode, 60 days/year.	Same as Medicaid managed care. See previous column.
Psychologist	Covered.	See Medicaid FFS	No PCP referral needed. Member may self-refer to a Medicaid mental health provider.	Same as Medicaid managed care. See previous column. No co-pay
Radiation Therapy	Yes, if prescribed by a doctor. Usually in the treatment of cancer.	Yes, on an out-patient basis	Presumed client has PCP referral to specialist.	Presumed client has PCP referral to specialist.
Radiology Services	Yes. X-rays, MRIs, CAT scans, Mammography, etc. Some require PA.  As of 9/1/02 no PA needed for MRI of the knee  <u>Note:</u> As of 12/1/04 the following diagnostic codes do not need PA: 72125-72133 (CT Scans) G0044-G0253 (PET Scans) 78459 (PET Scans) (Per Roger Tremblay, OVHA 11/17/04)	Same as <b>FFS</b> if done on an out patient basis. No co-pay As of 9/1/02 no PA needed for MRI of the knee  <u>Note:</u> As of 12/1/04 the following diagnostic codes do not need PA: 72125-72133 (CT Scans) G0044-G0253 (PET Scans) 78459 (PET Scans) (Per Roger Tremblay, OVHA 11/17/04)	Yes, needs referral from PCP.  As of 9/1/02 no PA needed for MRI of the knee  <u>Note:</u> As of 12/1/04 the following diagnostic codes do not need PA: 72125-72133 (CT Scans) G0044-G0253 (PET Scans) 78459 (PET Scans) (Per Roger Tremblay, OVHA 11/17/04)	Yes, needs referral from PCP. Some services require PA. No co-pay As of 9/1/02 no PA needed for MRI of the knee  <u>Note:</u> As of 12/1/04 the following diagnostic codes do not need PA: 72125-72133 (CT Scans) G0044-G0253 (PET Scans) 78459 (PET Scans) (Per Roger Tremblay, OVHA 11/17/04)
Respiratory Therapy	Services are limited to home health agency, and outpatient hospital/rehab facility provider types. \$3 co-pay per visit for outpatient under FFS. No co-pay if under a home health heading.* Have provider contact EDS if questions. See M710.5  * Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities. Exception – co-pays do apply to SSI-related beneficiaries age 18, 19, and 20 if in a hospital setting.	Same as Medicaid <b>FFS</b> . See previous column. Does not include supplies or equip. No co-pay	Referral by PCP needed. Must be a Medicaid provider. PA required beyond 4 months. Services discontinued after one year, but may continue if immediate and predictable deterioration or resume if deterioration of condition occurs.	Referral by PCP needed. See Medicaid Managed Care column. No co-pay

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Sanitary Napkins	<p>Medical necessity form needed. Covered up to a quantity of 200. Med. necessity form needs to be on file only for incontinence or drainage. Billable code is <b>W1677</b>.</p> <p>Quantities over 200 require PA from OVHA and Med. necessity form on file. PA requests should come from supplying provider with physician’s Med. Necessity form attached. (old billing code W1670-do not use)</p>	Coverage is limited to supplies furnished by the physician during an office visit.	See FFS	See Medicaid FFS
Seasonal Depression	Yes, covered under Mental Health. S.D. is a diagnosis.	Yes, covered under Mental Health. S.D. is a diagnosis	Must be a Medicaid provider. Yes, covered under Mental Health. S.D. is a diagnosis	Same as Medicaid managed care. See previous column..
Second Opinions	Yes, from a Medicaid provider	Yes, from a Medicaid provider	A PCP may refer the member to another PCP or a second specialist for a second opinion. Must be a Medicaid provider.	Same as Medicaid managed care. See previous column..
Sexual Abuse, Offender Treatment	Program administered by the CWYJ covered for children under 21.	No	Program administered by the CWYJ for children under 21.	No
Sleep Studies	If provided by a Medicaid provider.	Covered if Outpatient.	Referral by PCP needed. Must be a Medicaid provider.	Referral by PCP needed. Must be a Medicaid provider.
Smoking Cessation Treatment	<p>Over-the-counter and prescription products covered with a limit of 2 treatment regimens per calendar year. Needs a prescription. No PA needed except for Zyban (same drug as Wellbutrin).</p> <p><b>VHAP Rx:</b> no OTC, prescription only. (except for OTC drugs like Zyban and Nicotrol inhaler. Covered) <b>VScript &amp; HVP:</b> no OTC, prescription only.</p>	Over-the-counter and prescription products covered with a limit of 2 treatment regimens per calendar year. Needs a prescription. No PA needed except for Zyban. No co-pay	Covered like <b>FFS. Needs a Rx.</b>	Covered like <b>FFS. Needs a Rx.</b> No co-pay

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – <i>PC Plus</i>	VHAP Managed Care - <i>PC Plus</i>
Special Needs	<p>DCF offices work with clients to accommodate special needs. See Interpreters, High Tech program, etc. Refer to CSHN if appropriate. Some special services for Waiver clients administered through Dept. of Mental Health through VDH.</p> <p>Car seats: for special needs older kids who are unable to sit safely without a car seat in a vehicle. PA required through OVHA.</p>	<p>DCF offices work with clients to accommodate special needs.</p>	<p>DCF offices work with clients to accommodate special needs. <i>PC Plus</i> can provide information in alternative formats including Braille, TTY, and audiocassette. M&amp;O counselors are available for home visits in some circumstances.</p> <p>Car seats: for special needs older kids who are unable to sit safely without a car seat in a vehicle. PA required through OVHA.</p>	<p>Same as Medicaid managed care. See previous column.</p>
Speech Therapy	<p>Services are limited to home health agency, and outpatient hospital/rehab facility provider types. \$3 co-pay per visit for outpatient under FFS for adults.*</p> <p>* Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities. Exception – co-pays do apply to SSI-related beneficiaries age 18, 19, and 20 if in a hospital setting.</p> <p>No co-pay if under a home health heading. <u>Services beyond 4 months require PA</u> if they are classified as Home Health Services.</p> <p>Services discontinued after one year, but may continue if immediate and predictable deterioration or resume if deterioration of condition occurs. Have provider contact EDS if questions. PA needed for services beyond 1 year.</p> <p><b>See M710.5</b></p> <p><u>Note:</u> Other types of HH Visits = no PA: Physician’s referral for Home Health Aide Services, no PA (even after 4 months). Physician’s referral for Nursing Visits, no PA (even after 4 months). Speech Therapists are not enrolled as Medicaid providers.</p>	<p>Same as Medicaid FFS. See previous column. Does not include supplies or equip. No co-pay</p>	<p>Referral by PCP needed to a specialist. Must be a Medicaid provider. PA required beyond 4 months. Services discontinued after one year, but may continue if immediate and predictable deterioration or resume if deterioration of condition occurs. Have provider contact EDS if questions. PA needed for services beyond 1 year.</p> <p>\$3 co-pay per visit for outpatient under FFS for adults.*</p> <p>* Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities. Exception – co-pays do apply to SSI-related beneficiaries age 18, 19, and 20 if in a hospital setting.</p> <p><u>Note:</u> Other types of HH Visits = no PA: Physician’s referral for Home Health Aide Services, no PA (even after 4 months). Physician’s referral for Nursing Visits, no PA (even after 4 months). Speech Therapists are not enrolled as Medicaid providers.</p>	<p>Referral by PCP needed. See Medicaid managed care column. No co-pay</p> <p><u>Note:</u> Other types of HH Visits = no PA: Physician’s referral for Home Health Aide Services, no PA (even after 4 months). Physician’s referral for Nursing Visits, no PA (even after 4 months). No services beyond one year. Speech Therapists are not enrolled as Medicaid providers.</p>

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Sterilization Procedures	<p>Yes. Tubal Ligation, Vasectomy, Hysterectomy. All require 30 day waiting period with a signed consent form and client must be 21 years or older on the day the form is signed. These are Federal Guidelines that must be adhered to.</p> <p><b>Hysterectomy is not</b> covered if sole purpose is sterilization. Hysterectomy must be pre-authorized by OVHA.</p> <p>No PA needed for tubals or vasectomies.</p>	<p>Yes, see previous column. VHAP Ltd., outpatient coverage only, unless inpatient care is needed for urgent or emergent reasons.</p>	<p>Yes, see Medicaid FFS column.</p>	<p>Yes, see Medicaid FFS column.</p>
Substance Abuse Treatment	<p>Yes, no PA required for outpatient. Seneca House (substance abuse facility) covered as an out patient partial hospitalization. See other Mental Health Guidelines. PA may be required depending on type/duration of treatment.</p> <p>Must be VDH/OADAP facility.</p> <p>Methadone – requires a PA. Methadone as a drug acquired at a pharmacy is only covered for pain. Methadone as part of a detox program is part of the substance abuse treatment claim and can not be picked up at the pharmacy.</p> <p>Transportation to out-of-state facilities may be available. Refer to broker.</p> <p>*Independent Clinicians (LICSW, LMHC, LMFC) who are Medicaid providers <b>and</b> Licensed Drug &amp; Alcohol Counselors <b>and</b> have extensive experience with adolescents may apply to provide substance abuse treatment to adolescents’ age 0-20. Clinicians bill using “W” codes.</p> <p><i>In EDS shows as Provider Type T38 (Certified ADAP Adolescent Counselor) and Specialty Type 079 (Addiction Medicine).</i></p>	<p>Yes, substance abuse counseling is a covered service. Residential treatment <u>is</u> covered, but not in-patient hospital treatment. Seneca House covered as an out patient partial hospitalization.</p> <p>* See Medicaid FFS column for special substance abuse treatment providers for adolescents.</p>	<p>Yes, SA is covered. See Mental Health section. Specific facilities/programs must accept Medicaid, <b>and be VDH/OADAP affiliated</b>. PA may be required depending on type/duration of treatment.</p> <p>* See Medicaid FFS column for special substance abuse treatment providers for adolescents.</p>	<p>Yes, SA is covered. See Mental Health section. Specific facilities/programs must accept Medicaid, <b>and be VDH/OADAP affiliated</b>. PA may be required depending on type/duration of treatment.</p> <p>* See Medicaid FFS column for special substance abuse treatment providers for adolescents.</p>
Surgery	<p>On an inpatient /outpatient basis. Have Medicaid provider contact EDS for confirmation of coverage. If covered may require PA.</p> <p><u>As of 9/1/02: No PA needed for:</u></p> <p>*<b>Cholecystectomies (gall bladder surgery)</b>-done by laparoscopic or open procedures.</p> <p>*<b>Laminectomies and Spinal Fusions</b></p> <p>*<b>Vein Stripping and Ligation</b></p>	<p>Outpatient only, unless urgent or emergent.</p>	<p>Same as FFS.</p>	<p>Same as FFS.</p>

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
<b>TBI Waiver Program</b>	Yes – Contact DAIL, Division of Vocational Rehab @ 802-241-3186 TBI- Traumatic Brain Injury TBI Program Coordinator e-mail: <a href="mailto:Wargo@dad.state.vt.us">Wargo@dad.state.vt.us</a>	<b>For TBI Waiver Program Must Be On Medicaid.</b>	<b>Same as FFS</b>	<b>For TBI Waiver Program Must Be On Medicaid.</b>
TMJ (Dental)	Diagnostic services are counted against \$475 max, but most treatments are not. PA is required for appliances (splint guard) but not for evaluation, radiographs, molds, etc.	No	Covered; See Medicaid <b>FFS</b> column. Referral to oral surgeon needed.	TMJ treatment is covered; See Medicaid <b>FFS</b> column.
Translation Services	See Interpreter Services.	See Interpreter Services	See Interpreter Services	See Interpreter Services
Transportation	To and from medical visits, \$ for transportation, meals, lodging when out-of-state for care, mileage \$ for prolonged outpatient therapy (radiation/chemo), and transportation for family members in some cases. Does not pay for transportation to a facility for the purpose of experimental procedures or clinical trials. <b>Member should call transportation broker in their area.</b> See broker list and Transportation Guide for more details.  <u>Note:</u> Long Term Care (LTC) Medicaid codes (i.e. nursing home clients) are not generally eligible for this benefit as the code denotes residency in a long-term care facility and should not need transportation benefit listed above. For billing issues or ACCESS/EDS discrepancies contact Computer Services Division (CSD).	No.	Covered; See Medicaid <b>FFS</b> column.	No.

Type of Service	Medicaid/Dr. Dynasaur Fee-for-service (FFS)	VHAP-Limited (FFS)	Medicaid/Dr. Dynasaur Managed Care – PC Plus	VHAP Managed Care - PC Plus
Vaccines	<p>All vaccines are covered. No PA (including Hepatitis A &amp; B) if it is <i>medically</i> necessary, not administratively required (i.e. job requirements). Must also be medically necessary.</p> <p>Clients may be required to pick up some vaccines from a pharmacy and bring it to the doctor to be administered. Co-pays apply in this instance.* Rx, like malaria pills, might not be covered. Vaccinations required by schools are covered through Dr. Dynasaur as medically necessary.</p> <p>See flu shots.</p> <p>* Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities.</p>	<p>Same as Medicaid FFS. See previous column.</p> <p>No co-pay</p>	Covered; See Medicaid FFS column.	Covered; See Medicaid FFS column. No co-pay
Vitamins	See Over-the-Counter.	See Over-the-Counter	See Over-the-Counter	See Over-the-Counter
Wart Removal	Yes, as in-office procedure. For removal of a wart from the foot, it must be a “non-routine” procedure.	See FFS	See FFS	See FFS
Walkers	DME; Rx needed; PA required for other than basic models.	No	Same as FFS.	Same as FFS.
Weight Loss	Services provided by doctor.	Covered as FFS. See FFS column. No co-pay for rx	Services provided by doctor. Referral required for visit to a specialist.	Same as Medicaid managed care. No co-pay for rx
Wheelchairs	Covered like other DME. Client takes a medical necessity form to a vendor. Vendor submits a PA as required. PA required for all rentals over 3 months or purchase of custom or electric chairs. See med. regs. M841	No	Same as FFS.	Same as FFS.
Wigs	NO. Wigs, hair, cranial prosthetics NOT COVERED. Refer to American Cancer Society	Same as FFS.	Same as FFS.	Same as FFS.

Outstanding Issues:

Awaiting clarification from OVHA. Last email from Esther was 10/21/04. Question remains should the following be under 18 or 21? Last info from Esther was we should follow the rule which says under 21.

January 10, 2005

MAXIMUS

\* Co-pays do not apply to children under age 21, pregnant women, or patients in long term care facilities. Exception – co-pays do apply to SSI-related beneficiaries age 18, 19, and 20 if in a hospital setting.

**Health Care Programs Eligibility Matrix 2005**

Program	Age	Category	Citizenship/Residency	Monthly Income as of 1/1/05		Allowable Deductions to Income	Resource Test	Premiums And/Or TPL		Co-pay
<b>Medicaid &amp; "Reach Up" Medicaid (RUFA formerly ANFC)</b>	No age limits <b>IF</b> client meets other elig. requirements.	Participating Reach-Up Client, <Age 21, Pregnant, Under PIL Limits	U.S. citizen or eligible alien status, VT resident	<b>PILS Out of Chitt Co</b> HH of 1: \$800 HH of 2: \$800 HH of 3: \$966 HH of 4: \$1,091 HH of 5: \$1,233 HH of 6: \$1,325 HH of 7: \$1,475	<b>Inside Chitt Co</b> \$866 \$866 \$1,033 \$1,158 \$1,300 \$1,383 \$1,541	Reach-Up/Related is \$90 per working adult H.H.member for Wages/Self Employment	Excludes home, auto (2 autos in 2 parent HH), rental property,cash value of whole life insurance. Resource Info: \$2,000 - 1 person \$3,000 - 2 people (+\$150/person) Resources from Earned Income are allowed, and are not counted.	N/A		(FFS & Managed Care) <b>\$3 dental or outpt hospital per visit</b> <b>\$75 per inpt hospital admission</b> <b>\$1,\$2 or \$3 Rx</b> (no co-pay for children under 21, pregnant women, women in the 60-day post-pregnancy period or people in long-term-care facilities.) (Exception: co-pays do apply to SSI-related beneficiaries age 18-20 if in a hopital setting.)
<b>Dr. Dynasaur (Medicaid)</b>	Pregnant woman or child up to 18 years old	Pregnant woman or child up to 18 years old	U.S. citizen or eligible alien status, VT resident	<b>300% FPL for kids</b> HH of 1: \$2,380 HH of 2: \$3,195 HH of 3: \$4,010 HH of 4: \$4,825 HH of 5: \$5,640 HH of 6: \$6,455 HH of 7: \$7,270	<b>200% FPL for preg women</b> n/a \$2,130 \$2,674 \$3,217 \$3,760 \$4,304 \$4,847	\$90/month per working household member; all allowable business deductions for the self-employed. *Childcare (per child deduction) & Dependent Care Expenses: Up To \$175 Per Month Per Incapacitated Adult Or Child Age Two Or Older; Up To \$200 Per Month Per Child Under Age Two	N/A	<b>Per Family</b> > 185% 185%-225% 225%-250% w. TPL 225%-250% wo TPL  Based on FPL%	<b>Monthly</b> <b>\$0</b> <b>\$25</b> <b>\$35</b> <b>\$70</b>	N/A
<b>Medicaid DCHC (Katie Beckett)</b>	18 years old or younger	Disabled & require care normally provided in an institution	U.S. citizen or eligible alien status, VT resident	Only child's income is counted. Child may qualify for Medicaid/Dr. D. In the interim. See Medicaid info		See Medicaid info	Only child's resources are counted. See Medicaid info	None. Elig determination may take up to 90 days. May be on Medicaid/Dr. D in the interim		N/A
<b>Medicaid SSI/AABD Aged, Blind, or Disabled</b>	No age limits	Disabled, over age 65, or blind	U.S. citizen or eligible alien status, VT resident	<b>SSI/AABD Payment Levels: Independent Living</b> Individual: \$631.04 Couple: \$967.88 * Workers use this payment level as the income limit only if higher than the PILS inside/outside Chitt county. ** If more than two in the HH, refer to RUFA(ANFC) Medicaid PILS. <b>SSI/AABD Payment Levels: Living in HH of another</b> Individual: \$425.30 Couple: \$627.64  <b>Working Disabled 250% FPL</b> HH of 1: \$1,984 HH of 4: \$4,021 HH of 2: \$2,663 HH of 5: \$4,700 HH of 3: \$3,342 HH of 6: \$5,380		SSI/AABD \$65 plus 1/2 of remaining income & One \$20 disregard per H.H. from any source of income. **If over income limits, lower PILS are used to calculate spenddowns. **Also, Working Disabled eligibility has special disregards and net incomes are compared to the 250% FPL. Working Disabled have a \$500 disregard of SSDI benefits.	Resource Test: excludes residence, auto, rental property and some life insurance. See previous column.	N/A		(FFS & Managed Care) <b>\$3 dental or outpt hospital per visit</b> <b>\$75 per inpt hospital admission</b> <b>\$1,\$2 or \$3 Rx</b> (no co-pay for children under 21, pregnant women or people in long-term-care facilities.) (Exception: co-pays do apply to SSI-related beneficiaries age 18-20 if in a hopital setting.)

**Health Care Programs Eligibility Matrix 2005**

Program	Age	Category	Citizenship/Residency	Monthly Income as of 1/1/05		Allowable Deductions to Income	Resource Test	Premiums And/Or TPL		Co-pay
<b>VHAP Limited</b>	18 years of age or older	w/o hosp & doc coverage for the past 12 mth or involuntary loss of coverage-waived if < 75% FPL. VA benefits do not count.	U.S. citizen or eligible alien status, VT resident	<b>150% FPL no kids</b> HH of 1: \$1,190 HH of 2: \$1,598 HH of 3: \$2,005 HH of 4: \$2,413 HH of 5: \$2,820 HH of 6: \$3,228	<b>185% FPL w. kids &lt; 21</b> n/a \$1,971 \$2,473 \$2,976 \$3,478 \$3,981	\$90/month per working household member; all allowable business deductions for the self-employed. Depreciation DOES NOT count for VHAP eligibility for self-employed. *Childcare (per child deduction) & Dependent Care Expenses: Up To \$175 Per Month Per Incapacitated Adult Or Child Age Two Or Older; Up To \$200 Per Month Per Child Under Age Two.	N/A	<b>Per Person Monthly</b> < 50% 50%-75% 75%-100% 100%-150% 150%-185%	<b>Monthly</b> <b>\$0</b> <b>\$10</b> <b>\$35</b> <b>\$45</b> <b>\$65</b>	<b>\$25/Emergency Room visit</b>
<b>VHAP Rx</b>	65 years old +; or Disabled	Disabled and receiving SSA payments OR have Medicare; or receiving Railroad Retirement benefits w/Medicare.	U.S. citizen or eligible alien status, VT resident	<b>150% FPL</b> HH of 1: \$1,190 HH of 2: \$1,598 HH of 3: \$2,005 HH of 4: \$2,413 HH of 5: \$2,820 HH of 6: \$3,228		\$90/month per working household member; all allowable business deductions for the self-employed. *Childcare (per child deduction) & Dependent Care Expenses: Up To \$175 Per Month Per Incapacitated Adult Or Child Age Two Or Older; Up To \$200 Per Month Per Child Under Age Two.	N/A	<b>\$13 Monthly Per Person</b> Can not have other Rx coverage at the time of application. Discounted Rx programs (AARP) do not qualify as Rx coverage.		<b>None</b> <b>Covers: Acute/Maintenance drugs, eye exam</b>
<b>V-Script</b>	65 years old +; or Disabled	See VHAP Rx above	U.S. citizen or eligible alien status, VT resident	<b>175% FPL</b> HH of 1: \$1,389 HH of 2: \$1,864 HH of 3: \$2,340 HH of 4: \$2,815		See VHAP Rx above	N/A	<b>\$17 Monthly Per Person</b> Can not have other Rx coverage at the time of application. Discounted Rx programs (AARP) do not qualify as Rx coverage.		<b>\$0 = Maintenance drugs</b> <b>Medicaid Rate= Acute drugs</b> <b>Covers: Maintenance drugs, HVP for Acute Rx</b>
<b>V-Script Expanded</b>	65 years old +; or Disabled	See VHAP Rx above	U.S. citizen or eligible alien status, VT resident	<b>225% FPL</b> HH of 1: \$1,785 HH of 2: \$2,397 HH of 3: \$3,008 HH of 4: \$3,619		See VHAP Rx above	N/A	<b>\$35 Monthly Per Person</b> Can not have other Rx coverage at the time of application. Discounted Rx programs (AARP) do not qualify as Rx coverage.		<b>\$0 = Maintenance drugs</b> <b>Medicaid Rate= Acute drugs</b> <b>Covers: Maintenance drugs, HVP for Acute Rx.</b>
<b>HVP- Healthy Vermonters Program</b>	N/A	Age 65 years or older, disabled and have Medicare or receive SSA benefits. OR Others: Capped or no prescription coverage	U.S. citizen or eligible alien status, VT resident	<b>400% FPL for 65+/disabled</b> HH of 1: \$3,174 HH of 2: \$4,260 HH of 3: \$5,347 HH of 4: \$6,434	<b>300% FPL for all others</b> \$2,380 \$3,195 \$4,010 \$4,825	See VHAP Rx above	N/A	<b>None.</b> May have VScript or VScript Expanded. Must be uninsured or have reached annual limit on Rx TPL policy		Purchase drugs at the Medicaid Rate.  Provides Acute Rx to VScript and VScript Expanded.  PDL and PA requirements do not apply.

**Health Care Programs Eligibility Matrix 2005**

Program	Age	Category	Citizenship/Residency	Monthly Income as of 1/1/05	Allowable Deductions to Income	Resource Test	Premiums And/Or TPL	Co-pay
<b>QMB Qualified Medicare Beneficiary</b>	65 years old +; <b>or</b> Disabled	Medicare Beneficiary	U.S. citizen or eligible alien status, VT resident	<b>100% FPL</b> <b>HH of 1:</b> \$794 <b>HH of 2:</b> \$1,065	Pays Medicare premiums, deduct., co-insurance and co-pays. Most are eligible for Medicaid as 2nd payer. Those with JUST coverage for the Medicare benefits are "pure QMB's"	H.H.of 1:\$4000 H.H of 2:\$6000	None. Use the 202Med form to apply	Those eligible for Medicaid as 2nd payer, incur Medicaid Co-pays. See Medicaid.
<b>SLMB</b>	65 years old +; <b>or</b> Disabled	Medicare Beneficiary	U.S. citizen or eligible alien status, VT resident	<b>120% FPL</b> <b>HH of 1:</b> \$952 <b>HH of 2:</b> \$1,278	Pays only Medicare part B premiums (\$78.20). Many are also eligible for Medicaid as a secondary payer. 3 mo retro possible. 2-3 mo to process.	H.H.of 1:\$4000 H.H of 2:\$6000	None. Use the 202Med form to apply	Those eligible for Medicaid as 2nd payer, incur Medicaid Co-pays. See Medicaid.
<b>QDWI Disabled &amp; Working Beneficiaries</b>	65 years old +; <b>or</b> Disabled	Medicare Beneficiary	U.S. citizen or eligible alien status, VT resident	<b>200% FPL</b> <b>HH of 1:</b> \$1,587 <b>HH of 2:</b> \$2,130	Pays only Medicare part A (hospital) premiums for those otherwise ineligible for Medicaid. Very few QDWI's in VT, 3 mo retro possible.	H.H.of 1:\$4000 H.H of 2:\$6000	None. Use the 202Med form to apply	N/A
<b>QI-1</b>	65 years old +; <b>or</b> Disabled	Medicare Beneficiary who <b>does not</b> have Medicaid	U.S. citizen or eligible alien status, VT resident	<b>135% FPL</b> <b>HH of 1:</b> \$1,071 <b>HH of 2:</b> \$1,438	Pays <u>only</u> Medicare part B (doctor) premiums (\$78.20) directly to the SSA for those otherwise ineligible	H.H.of 1:\$4000 H.H of 2:\$6000	None. Cannot be on any other state programs	N/A

### Health Care Programs Eligibility Matrix 2005

Program	Age	Category	Citizenship/Residency	Monthly Income as of 1/1/05	Allowable Deductions to Income	Resource Test	Premiums And/Or TPL	Co-pay
<b>AMAP - AIDs Medication Assistance Program</b>	No age limits	Confirmed HIV diagnosis	U.S. citizen or eligible alien status, VT resident	<b>200% FPL Net Income</b> <b>HH of 1:</b> \$1,587 <b>HH of 2:</b> \$2,130 <b>HH of 3:</b> \$2,674 <b>HH of 4:</b> \$3,217	Numerous deductions allowed. Program Coordinator Contact: Moretti 802-863-7253	N/A	None- may have private or state funded insurance Note: People at risk of losing their insurance due to HIV/AIDS, see (ICAP) in community resources	May be a co-pay
<b>Dental Care Assistance Program- DCAP</b>	No age limits	Confirmed HIV diagnosis	U.S. citizen or eligible alien status, VT resident	<b>200% FPL Net Income</b> <b>HH of 1:</b> \$1,587 <b>HH of 2:</b> \$2,130 <b>HH of 3:</b> \$2,674 <b>HH of 4:</b> \$3,217	Numerous deductions allowed. Program Coordinator Contact: Moretti 802-863-7253	N/A	Acts as secondary insurance. Doesn't cover crowns, bridges, braces Other: People at risk of losing their insurance due to HIV/AIDS, see (ICAP) in community resources	No annual limit. May be a co-pay
<b>BCCT-Breast &amp; Cervical Cancer Treatment Program</b>	Ages 40-60	Confirmed breast or cervical cancer diagnosis. Must be screened by Ladies First.	U.S. citizen or eligible alien status, VT resident	<b>250% FPL</b> <b>HH of 1:</b> \$1,984 <b>HH of 2:</b> \$2,663 <b>HH of 3:</b> \$3,342 <b>HH of 4:</b> \$4,021	Contact Ladies First for screening through DOH at:1-800-508-2222. Eligibility handled by Amy Tucker & Vikki Monroe at HAEU. <b>Refer callers to HAEU.</b> Health Care Ombudsman can help with eligibility questions, call 1-800-917-7787 or 863-2316, or TTY: 1-888-884-1955	N/A	Cannot have other creditable insurance. Covered under full Medicaid while eligible.	May be a co-pay
<b>ACCS- Assisted Community Care Services, Level III</b>	No age limits	Must be eligible for Medicaid & require residential care in a level III community care home	U.S. citizen or eligible alien status, VT resident	<b>Individual:</b> \$627 <b>Couple:</b> \$966	Client? re: eligibility for ACCS services are directed to eligibility worker. HAEU cases are referred to their local PATH office. For lists of care homes contact DAIL (formerly DAD) at 802-241-2400. Providers contact Karin Hammer-Williamson @ 802-241-1286, Dept. of Aging & Independant Living.	Similar to Medicaid. Spend-downs may be calculated.	Must qualify for Medicaid first, then ACCS. These are facilities some clients live in. ACCS facilities are not nursing homes or long term care facilities. They are residential care homes.	Not applicable

**Note: When determining HH size for unmarried people with children there are varying eligibility rules.**

**\*\*\*\*\* If the program is Medicaid and the couple has a child in common we look at them as if they are married when determining the child's eligibility: his income counts for kids but not for her, hers counts for the kids but not for him.**

**\*\*\*\*\*If the program is VHAP and the couple has a child in common, income counts for everyone (including any income from the kids). If there are no children in common then each would be considered their own HH, under their own Social Security number. For pregnant women the dad's income counts after the baby is born and only for himself and the baby, unless they marry.**

**FPL** - Federal Poverty Level

**PIL** - Protected Income Level

**RUFA** - Reach Up financial Assistance

**ANFC** - Aid to Needy Families With Children (formerly TANF but now known as Reach Up)

**Reach Up** - DCF program offering case mgmt., transitional cash assistance, work support and health insurance for families with children.

**DCHC**- Disabled Childrens Health Care

**AABD**- Aid to the Aged, Blind and Disabled.

**SSI**- Supplemental Security Income.

**Co-pay**- An amount of money paid at the time of service or for a particular item.

**Premium**- An amount paid monthly to continue insurance benefits.

**ACCS**- Residential care homes providing assistive community care or limited nursing care. Categorized as level 3 or 4.

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**VERMONT HEALTH ACCESS MEMBER SERVICES PROJECT  
TREND ANALYSIS  
January 2003 - December 2003**

The Vermont Health Access Member Services Project (VHAMS) has been operational since January 1, 1996. Originally operating primarily as a managed care enrollment project, the contract was amended to provide member services functions for state funded health care programs in April of 1998. This amendment resulted in a substantial increase in staff and the scope of services provided by the staff. The contract was further amended in the Fall of 1999 to include providing member service functions specific to the primary care case management program, *Primary Care Plus*, newly created by the state of Vermont.

This report is divided into the following sections:

- o Section A: Overview
- o Section B: Call Statistics
- o Section C: HelpLine Activity
- o Section D: Enrollment Outreach Activity
- o Section E: Enrollment Activity
- o Section F: Disenrollment Activity
- o Section G: Primary Care Plus Member Services Activities
- o Section H: Marketing and Outreach Activity
- o Section I: Mail House Functions
- o Section J: Third Party Liability
- o Section K: Billing Resolution
- o Section L: Fair Hearings
- o Section M: Complaints
- o Section N: Summary of Events
- o Section O: Conclusion

**A. OVERVIEW**

The following report analyzes our HelpLine and enrollment activities during 2003, the eighth full year of our operations. Please see *VHAP Trend Analysis Report: January-July 1996*, *Office of Vermont Health Access Benefits Counseling Services Trend Analysis Report: August 1996-February 1997*, *Office of Vermont Health Access Benefits Counseling Services Project HelpLine Trend Analysis: January 1997-December 1997*, *Vermont Health Access Member Services Project Trend Analysis: Two Years, January 1998-December 1999*, and *Vermont Health Access Member Services Project Trend Analysis* for years 2000, 2001, and 2002 for a comprehensive accounting of previous operations.

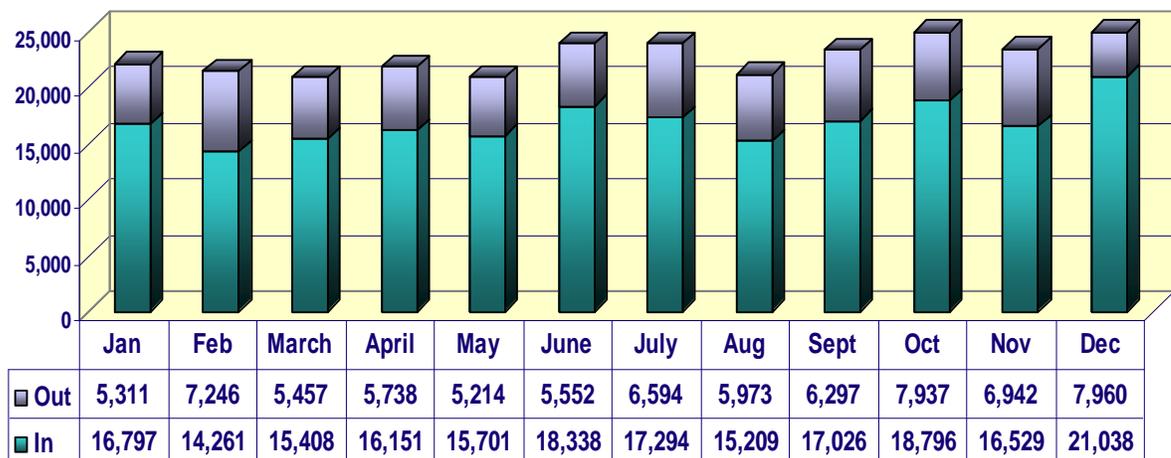
For the purpose of this report, the Vermont Health Access Member Services Project will henceforth be referred to as VHAMS or MAXIMUS.

As VHAMS, staff provides assistance with:

- o managed care enrollment, transfers, and education,
- o applications and general eligibility questions,
- o entering changes to member cases,
- o requesting replacement of *AIM* and *PC Plus* cards,
- o questions regarding covered services,
- o questions about program fees,
- o billing problems,
- o finding providers,
- o understanding notices,
- o handling and tracking complaints,
- o questions about prior authorization for services,
- o fair hearing requests,
- o transportation to medical appointments,
- o and information and referrals.

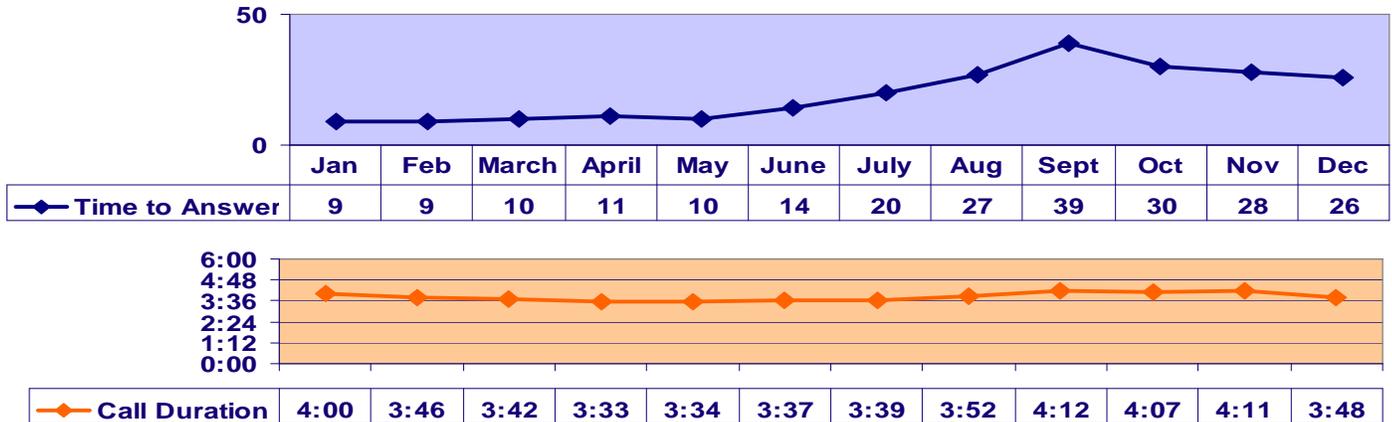
**B. CALL STATISTICS**

*Exhibit 1: Incoming and Outgoing Calls 2003* displays the number of calls handled by Member Services Representatives (MSRs) in 2003, broken down into incoming and outgoing calls. Incoming call volumes averaged 16,879 per month in 2003, compared to 15,578 per month in 2002. Calls increased dramatically in December due to client response to several premium-related mailings. Outgoing calls averaged 6,352 per month in 2003, compared to 5,397 per month in 2002. As Exhibit 1 displays, months with a lower volume of incoming calls resulted in higher outgoing call volume. While outreach calls are an important means of maintaining a low auto-assignment rate and high rate of successful welcome calls, incoming calls are always first priority. In total, MAXIMUS handled 278,769 calls in 2003, an average of approximately 1,162 calls per day.



**Exhibit 1: Incoming and Outgoing Calls 2003.** Shows fluctuation of call volumes throughout 2003.

*Exhibit 2: Call Statistics 2003* shows the average time to answer calls and average call duration during 2003. The average time to answer was 19 seconds. This rate factors in higher time to answer rates in the latter months of 2003 as a result of client response to changes in program premiums and the premium collection process. The average call duration during 2003 was fairly constant, fluctuating between 3 minutes, 33 seconds and 4 minutes, 12 seconds. Again, longer call durations in the latter months of the year contributed to higher time to answer rates for those months as well.



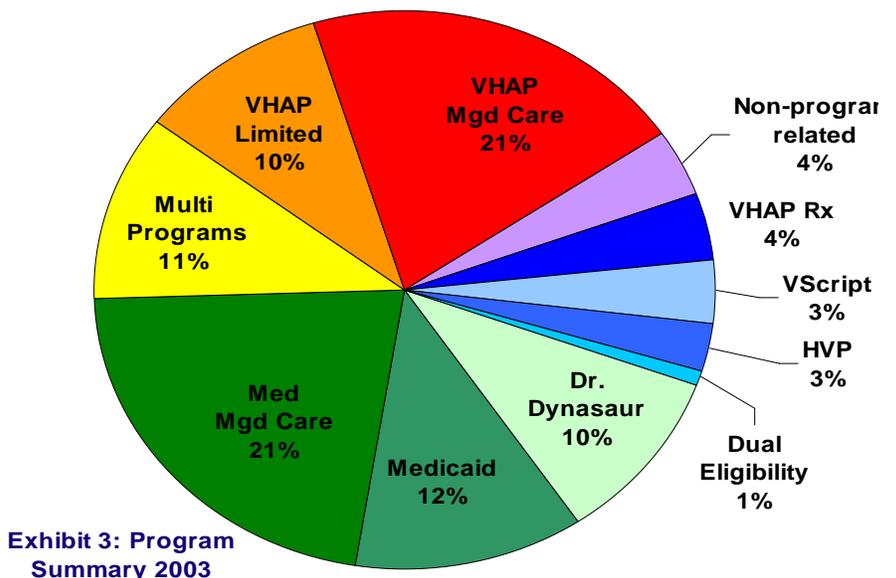
**Exhibit 2: Call Statistics 2003.** Shows increased call durations and time to answer in the latter months of 2003 due to program premium changes.

**C. HELPLINE ACTIVITY**

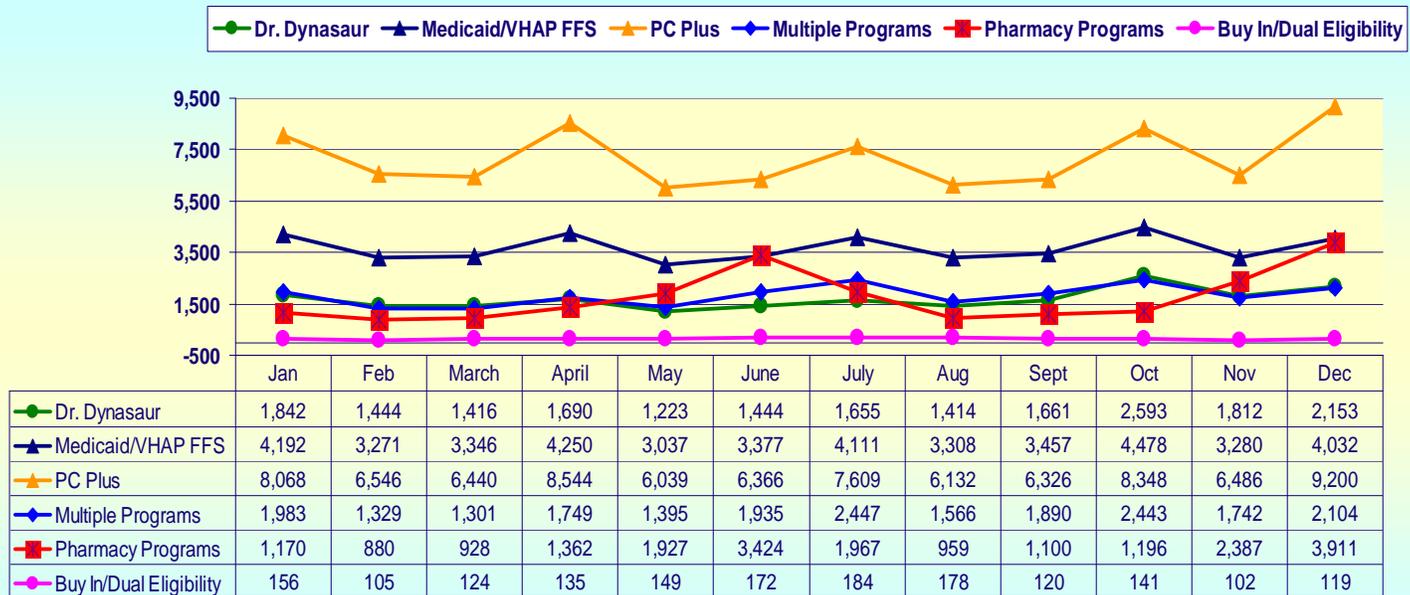
In addition to reporting on call statistics, MAXIMUS also reports on what the calls are about, where the callers are calling from, how calls are handled, and how the callers are referred to the HelpLine. Management information on these business requirements follows.

**1. PROGRAM**

*Exhibit 3: Program Summary 2003* displays the percentage of calls by program on a yearly basis. As you can see, the managed care programs accounted for 42% of all calls received in 2003. Fee-for-service Medicaid and Dr. Dynasaur calls accounted for 22% of all calls. Calls regarding VHAP Limited and the pharmacy programs each accounted for 10% of all calls.



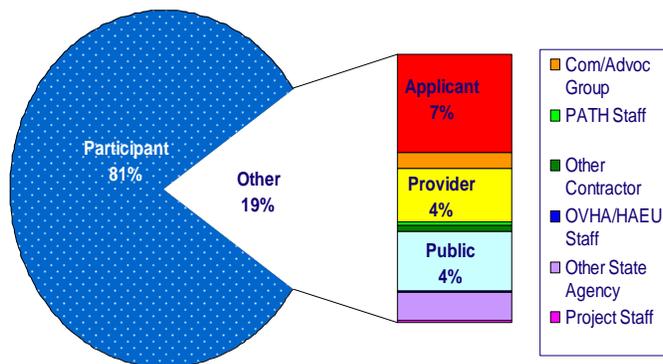
*Exhibit 4: Program Summary by Month 2003* displays the number of calls by program by month. As you can see, PC Plus managed care calls accounted for the highest volume of calls in 2003. As in past years, calls regarding pharmacy programs peaked in May, June, and July in response to year-end review and closure notices for these programs. Client notification of changes in program premiums and the premium collection process prompted call increases for programs impacted by premiums in April, July, and October. The annual pharmacy review process, as well as the implementation of premiums for pharmacy programs, prompted an increase in pharmacy calls in June, November and December.



**Exhibit 4: Program Summary by Month 2003.** *The flow of incoming calls by program type in 2003.*

**2. CALLER TYPE**

*Exhibit 5: Caller Type by Year 2003* displays the type of caller in 2003. As you might expect, the vast majority of calls to the HelpLine were from participants in state funded health care programs. The percentage of calls from potential applicants to state funded health care



**Exhibit 5: Caller Type by Year 2003.** *Demonstrates that the vast majority of HelpLine encounters are with program beneficiaries.*

programs continued to decrease from 8% in 2002 to 7% in 2003. We attribute this continued but slight decline to much publicized changes in program premiums. Eight percent of calls were again from providers or the general public. The remaining calls were from social work professionals, advocates, and other contractors or state agencies, each accounting for less than two percent of total calls received.

### 3. CALL TOPIC

*Exhibit 6: Call Topic Summary*, reports on the “business processes” the caller conducts during the call. Questions regarding client status and eligibility were consistently rated as the top call topics in 2003. Extensive outreach regarding changes to program premiums, as well as the changes themselves, prompted a dramatic increase in premium related and client status calls in the last three months of the year. Calls related to premiums ranged from 520 in March to 5,731 in December.

2003	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Totals
Eligibility Question	5,775	4,524	5,401	6,062	5,046	6,502	6,759	5,112	5,540	6,024	4,107	4,907	65,759
Client Status Question	2,933	2,298	1,715	2,229	1,793	2,858	2,741	1,584	1,810	2,764	2,010	3,394	28,129
Managed Care Question	1,630	1,158	1,324	3,018	1,222	1,288	1,454	1,306	1,228	1,554	1,083	1,121	17,386
Premiums	812	743	520	668	538	730	718	536	709	2,000	3,108	5,731	16,813
Change Member Info	1,334	995	878	1,317	1,056	1,278	1,568	1,098	1,195	1,636	1,450	1,840	15,645
Enr/Disenrollment	1,312	1,080	808	1,220	797	847	987	679	719	951	653	799	10,852
Misc Question	778	595	621	758	516	576	759	582	614	878	682	870	8,229
FFS Benefits/Providers	723	487	541	873	553	654	830	646	516	814	543	635	7,815
Billing Issues	746	545	593	772	514	551	763	679	604	904	631	607	7,909
Change PCP	615	455	660	1,045	618	573	669	579	629	719	634	772	7,968
Application Assistance	75	77	233	408	636	398	440	534	615	725	602	544	5,287
Replacement Card	431	351	324	442	316	288	393	325	325	387	315	299	4,196
TPL	521	384	389	452	356	355	401	310	254	393	267	296	4,378
Prior Authorization	444	303	317	416	228	319	386	268	332	432	278	292	4,015
Self-Directed PCA Program	202	156	174	281	189	187	200	189	145	168	201	330	2,422
Complaints/Fraud	27	22	30	22	20	27	29	31	39	23	37	19	326
<b>Totals for 2003</b>	<b>18,358</b>	<b>14,173</b>	<b>14,528</b>	<b>19,983</b>	<b>14,398</b>	<b>17,431</b>	<b>19,097</b>	<b>14,458</b>	<b>15,274</b>	<b>20,372</b>	<b>16,601</b>	<b>22,456</b>	<b>207,129</b>

Exhibit 6: Call Topic Summary

### 4. RESOLUTION

*Exhibit 7: Call Resolution Summary 2003* reports on the business processes the MSRs use to address and resolve the call topic. The majority of calls (48%) were resolved by answering a question or providing a thorough overview to the caller. MSRs entered changes to participant information or forwarded information to eligibility workers on the behalf of 30,944 participants in 2003. In addition, MAXIMUS staff assisted 5,177 callers with billing and TPL issues, complaints, and fair hearing requests. While these calls accounted for just 3% of total call volume, they were by far the most labor-intensive resolutions to calls. A designated TPL Coordinator, Fair Hearing Coordinator, and a Billing Resolution Coordinator processed and reported TPL, fair hearing, and billing resolution activities throughout 2003. These activities are described in more detail later in this report. Enrollment related resolutions (such as enrollment, transfers, provider recruitment, and requests for in-person presentations) accounted for 8% of incoming calls in 2003.

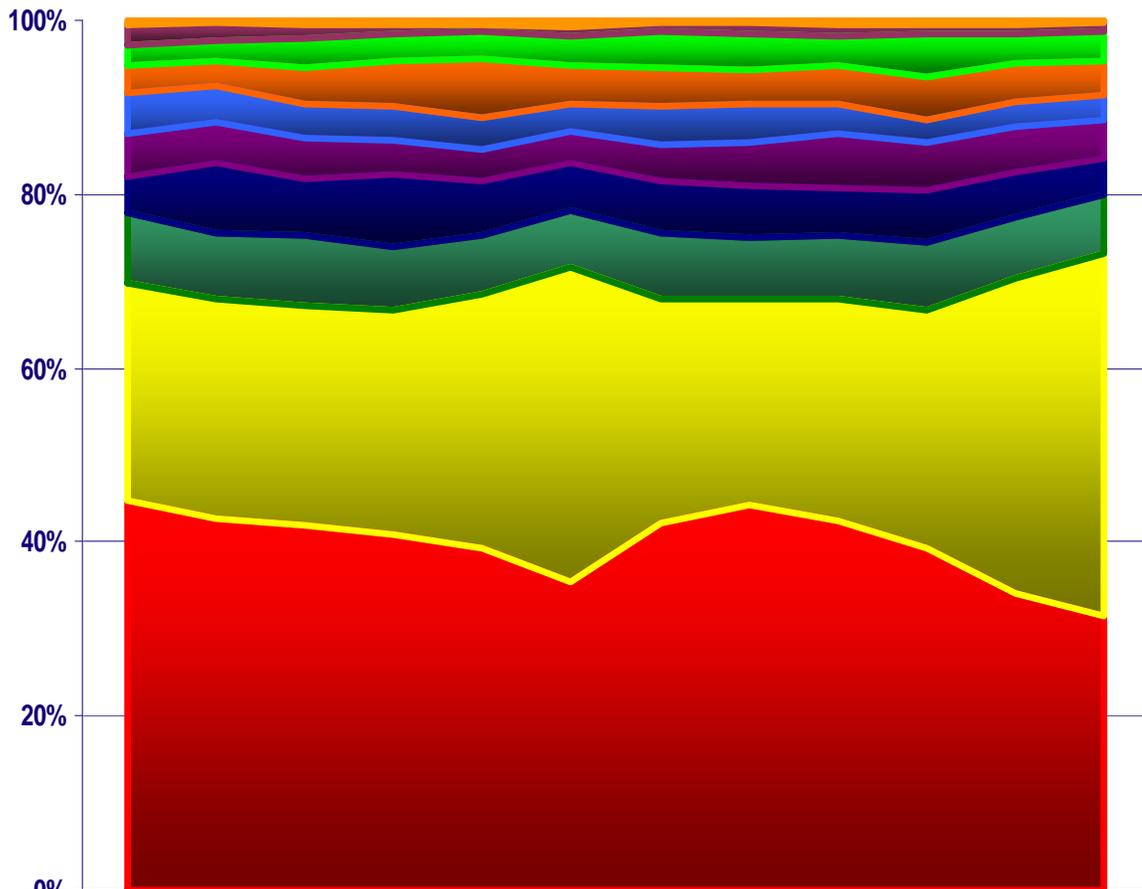
2003	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Totals
Answer Question or Provided Overview	8,959	6,839	6,624	8,585	6,723	8,300	8,091	6,263	6,867	10,109	8,345	12,324	98,029
Enter Change or CATN-DO Case	2,499	2,003	2,150	2,886	2,373	2,937	3,235	2,192	2,357	2,830	2,499	2,983	30,944
Mailed Application/Info	2,587	1,740	1,661	2,167	1,878	2,455	2,604	2,151	2,152	2,461	2,005	2,711	26,572
Referred Outside MAXIMUS	1,171	986	1,450	1,748	1,269	1,519	2,215	1,785	2,060	2,445	1,698	2,241	20,587
Enroll Customer	1,077	1,074	774	1,209	802	829	983	674	695	923	674	811	10,525
TPL or Billing Issues	659	450	426	550	361	412	528	327	315	497	352	300	5,177
Change PCP or Submit PCP Recruit	551	410	436	653	381	351	425	330	413	442	349	359	5,100
Referred to PCA or M&O	200	152	180	277	184	188	201	194	13	186	214	19	2,008
Issue Card	287	229	227	293	220	211	278	230	238	260	235	235	2,943
Disenroll and Exemption Requests	6	1	0	1	0	0	0	1	2	7	2	0	20
Complaints or Fair Hearing Requests	57	45	37	43	28	48	53	35	41	43	49	63	542
<b>Totals for 2003</b>	<b>18,053</b>	<b>13,929</b>	<b>13,965</b>	<b>18,412</b>	<b>14,219</b>	<b>17,250</b>	<b>18,613</b>	<b>14,182</b>	<b>15,153</b>	<b>20,203</b>	<b>16,422</b>	<b>22,046</b>	<b>202,447</b>

#### Exhibit 7: Call Resolution Summary

MAXIMUS staff screened callers for program eligibility and subsequently mailed information and applications to 26,572 households in 2003, slightly up from 24,567 households in 2002. If MAXIMUS staff was unable to provide the information the caller was seeking, the caller was referred to another state agency, vendor, or other resources using the community resources guide developed in-house by staff. MAXIMUS changed client's PCPs in the PC Plus program in response to 5,100 client requests via the HelpLine, as well as a monthly average of 123 PCP changes requested via mail or fax.

#### 5. REFERRAL SOURCE

*Exhibit 8: Call Referral Summary 2003* reports on how the caller obtained the HelpLine telephone number. As you can see, the primary source of referral to the HelpLine was the back of the AIM/PC *Plus* card and PATH or OVHA notices. These sources again prompted 69% of HelpLine calls for the year. As in previous years, calls generated by a PATH or OVHA notice increased in May and June as a result of the annual review process for clients on pharmacy programs. Calls generated by OVHA notices, brochures/posters, providers, state agencies, and MAXIMUS increased in the latter three months of the year, reflecting client response to extensive outreach efforts regarding changes in the premium process beginning January 2004. Calls in response to MAXIMUS mailings and phone outreach efforts accounted for 6% of all calls received. Callers referred by providers accounted for 7% of call volumes.



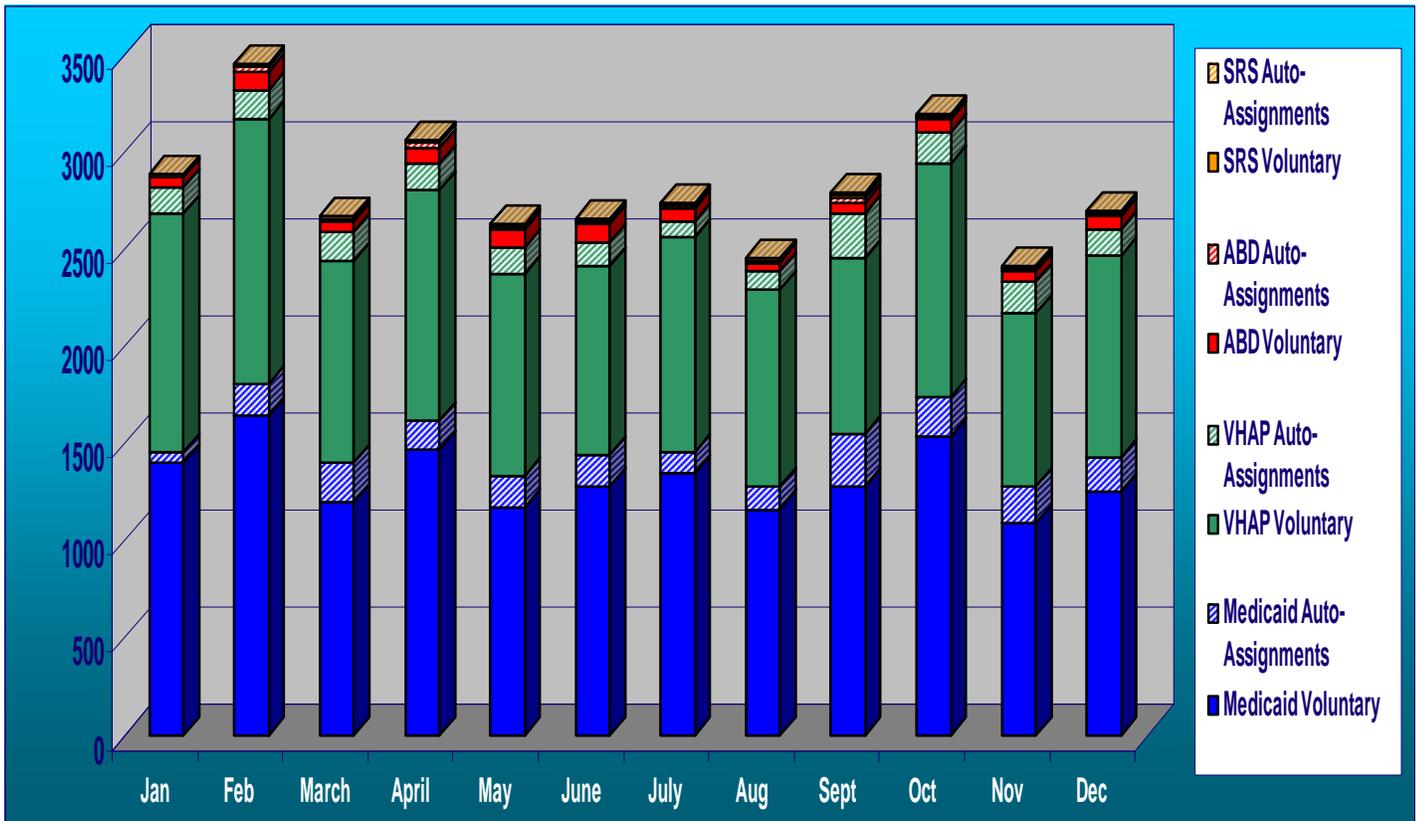
	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Media/Special Initiative	82	50	62	106	73	113	64	50	69	95	72	78
Comm Based Org	410	290	222	184	122	200	166	165	194	235	165	189
State Agency/Contractor	408	305	497	588	442	596	793	585	514	984	591	789
Brochure/Poster	554	400	567	961	936	766	832	591	680	990	699	845
Friend/Relative	853	618	570	677	524	539	792	608	523	541	500	643
Phone Book	849	649	654	750	539	611	778	721	931	1,092	850	1,016
MAXIMUS Outreach	767	1,134	927	1,506	872	954	1,154	830	827	1,195	844	875
Providers/Pharmacy	1,408	1,082	1,121	1,382	958	1,105	1,379	1,013	1,099	1,609	1,165	1,511
OVHA/PATH Mailing	4,402	3,535	3,562	4,729	4,147	6,226	4,819	3,385	3,884	5,504	5,900	9,318
Back of Card	7,891	6,016	5,938	7,517	5,592	6,118	7,839	6,314	6,423	7,920	5,602	6,993

**Exhibit 8: Call Referral Summary 2003.** Shows the majority of calls are generated by the back of the card of OVHA/PATH mailings

**D. ENROLLMENT OUTREACH ACTIVITY**

As part of the managed care enrollment process, MAXIMUS staff makes repeated attempts to outreach participants targeted for enrollment in a given month. The goal of these efforts is to maximize the participant’s opportunity to choose a provider, thus minimizing auto-assignment to a provider. The OVHA provides MAXIMUS with a monthly report listing participants who are currently eligible for enrollment into managed care but have not yet reported a choice of primary care provider (PCP). MSRs make three attempts to contact the households by telephone. For households without phones or households who fail to respond to telephone outreach attempts, staff mails a series of three flyers urging a response. In 2003 MAXIMUS staff made 76,221 outbound calls and mailed 13,616 flyers. In addition to minimizing auto-assignment rates, these outreach attempts provide further opportunity to educate the participant about managed care and to identify potential exemption situations such as Third Party Liability.

MAXIMUS staff placed an emphasis on outreaching SRS clients and ABD clients for enrollment into managed care. A designated staff member makes additional attempts to reach clients identified as aged, blind, or disabled. Marketing and Outreach staff makes routine visits to SRS offices and outreach extensively via e-mail.



**Exhibit 9: Enrollment Summary 2003.** Shows the vast majority of enrollments across all programs were voluntary

**E. ENROLLMENT ACTIVITY**

MAXIMUS staff enrolled eligible participants into managed care via HelpLine conversations, in-person interviews, or as a result of enrollment forms returned through the mail. Managed care enrollment was mandatory for all of the population targeted for enrollment during this reporting period. A small percentage of participants were granted deferrals of enrollment by the OVHA.

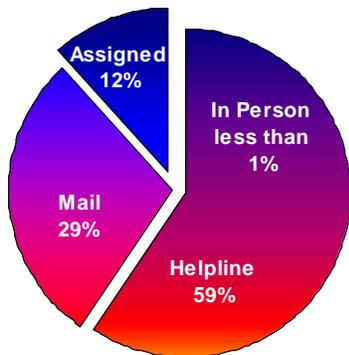


Exhibit 10: Enrollment Method 2003

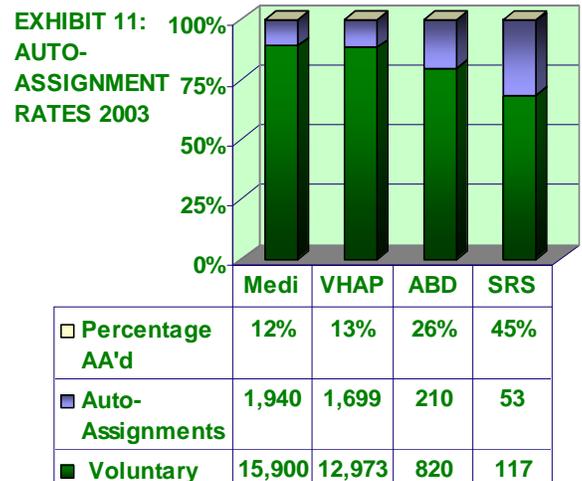
*Exhibit 9: Enrollment Summary 2003* represents program participants actively involved in the enrollment process, as well as those who were automatically enrolled and assigned to a primary care provider (PCP). MAXIMUS enrolled 33,712 participants into managed care in 2003. The size of the monthly enrollment cohort ranged from 3,457 in February to 2,413 in November, averaging 2,809 per month. Participants in Medicaid account for 52% of enrollments and VHAP accounted for 44% of enrollments. Three percent of enrollments involved the ABD population, while the remaining 1% were children in state custody. As you can see in *Exhibit 10: Enrollment Method*, 59% of

enrollments were accomplished via the HelpLine, 29% were via a mailed enrollment form, and 12% of participants were auto-assigned. Eleven participants (less than one percent) enrolled via a one-on-one encounter with MAXIMUS Marketing and Outreach staff. These numbers compare very closely to enrollment method numbers in 2002. In addition, 46,273 participants were reinstated to *PC Plus* in 2003 by the OVHA, compared to 33,914 in 2002. MAXIMUS attributes this increase to client confusion surrounding the premium collection process, resulting in a larger number of inadvertent closures and reinstatements.

**2. AUTOMATIC-ASSIGNMENT**

In the event that a participant who is part of a mandatory enrollment group chooses not to respond to our outreach efforts and remains eligible for state health care benefits, that participant is automatically enrolled in *PC Plus* and assigned to a primary care provider (PCP). As mentioned previously, MAXIMUS devotes a substantial amount of time and resources toward minimizing the percentage of enrollments by auto-assignment.

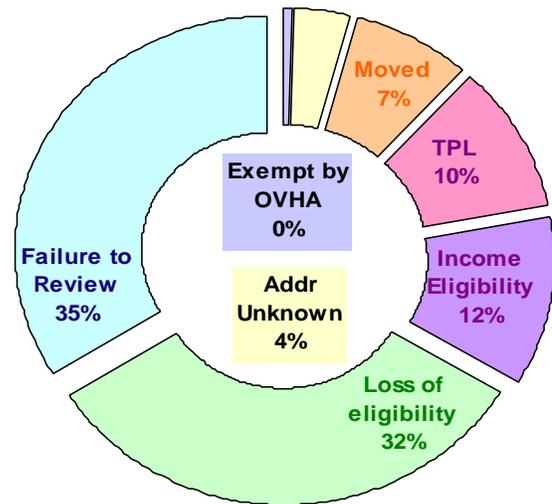
*Exhibit 9: Enrollment Summary 2003* shows the rate of voluntary and auto-assignment enrollments by aide category. *Exhibit 11: Auto-Assignment Rates 2003* also provides information regarding



auto-assignment rates. The overall auto-assignment rate across categories for year 2003 was 12%. VHAP and Medicaid participants had auto-assignment rates of 13% and 12% respectively. ABD Medicaid participants were auto-assigned at a rate of 26%, representing a population that is historically difficult to enroll. SRS clients were enrolled with an auto-assignment rate of 45%. MAXIMUS is not permitted to contact SRS participants (or caregivers) directly, so must outreach to designated SRS liaisons from each SRS district. The SRS liaisons are responsible for responding with enrollment information for each SRS participant targeted for enrollment in a given month. Due to discrepancies between OVHA SRS enrollment reporting and MAXIMUS SRS enrollment tracking, the SRS auto-assignment rate is not used in the calculation of the overall auto-assignment rate.

**F. DISENROLLMENT ACTIVITY**

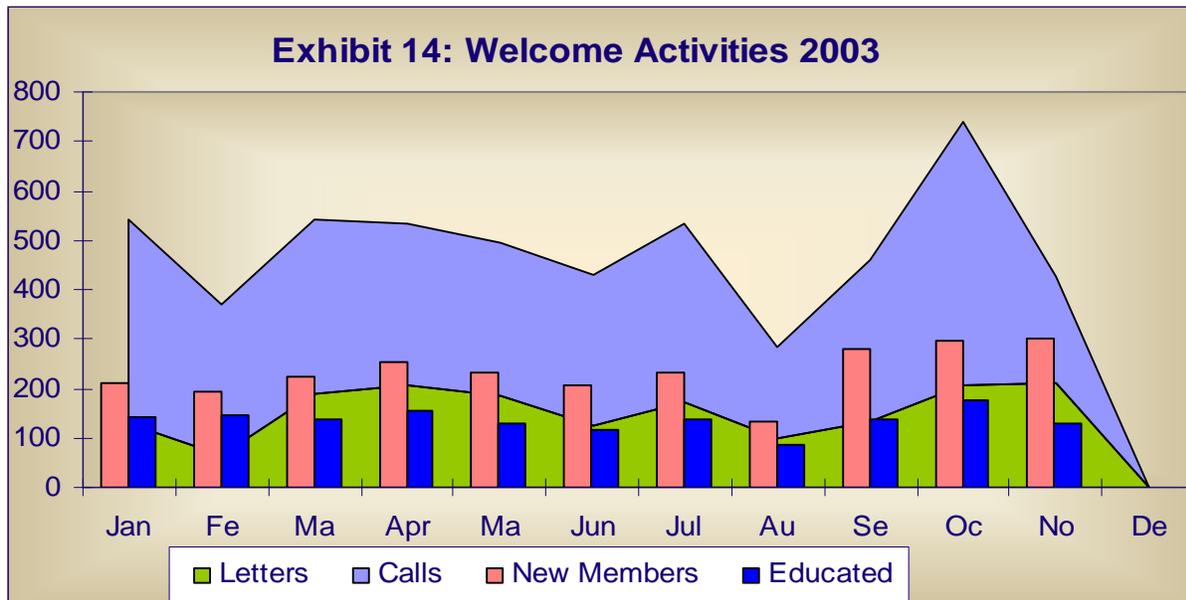
*Exhibit 12: PC Plus Disenrollment Summary 2003* displays disenrollments from **PC Plus** by reason. Disenrollments from **PC Plus** for 2003 totaled 12,433. The prevailing reason for disenrollment was a failure to review. These disenrollments were highest in August and may reflect client’s failure to respond to review outreach due to vacations and other summer activities. Only 54 members were disenrolled after being granted an exemption from enrollment into managed care by the OVHA in 2003, compared to 152 members in 2002.



**Exhibit 12: PC Plus Disenrollment Summary 2003.** *The majority of disenrollments were due to failure to review and loss of eligibility.*

**G. PRIMARY CARE PLUS MEMBER SERVICES ACTIVITIES**

As the member services unit for the **PC Plus** program, MAXIMUS staff attempts to educate new program members about their benefits by way of welcome calls. Each month, the OVHA provides MAXIMUS with a list of new members of **PC Plus** who have not previously been educated regarding managed care. MAXIMUS makes several attempts to contact each new member by mail or by telephone. There were 2,562 households in 2003 requiring a welcome call. Over the course of the year, MAXIMUS staff mailed 1,724 fliers and made 3,631 phone calls in attempts to contact these households. MAXIMUS was able to contact and welcome 1,491 households. This reflects a 58% rate of success overall. *Exhibit 13: Welcome Activities 2003* graphically displays this information. Of note, response from households without phones is significantly lower. Approximately 544 out of 605 households did not respond to outreach efforts via mail. This indicates a response rate of 10% for households outreached by mail and an adjusted response rate of approximately 73% for households outreached via the phone.



In addition, MAXIMUS is responsible for transferring *PC Plus* members to a new primary care provider (PCP) if their designated PCP is incorrect or becomes unavailable. In year 2003, MAXIMUS outreached 312 members to assist in the transfer to a new PCP. Outreach activities were initiated per the provider’s request or a request from the OVHA. The number of members outreached per month ranged from 3 to 208. Of the 312 members, 221 members were successfully outreached and transferred to the PCP of their choice. This is a 71% success rate. The remaining 91 members were ultimately assigned to a provider. MAXIMUS staff devoted 3,160 minutes (53 hours) to these activities during 2003.

**H. MARKETING AND OUTREACH ACTIVITY**

MAXIMUS employs two Marketing and Outreach Counselors who travel the entire State of Vermont. One of our main objectives is to ensure participants understand their health care options within the various VHAP programs. The Marketing and Outreach Counselors work to achieve that objective by providing education about VHAP programs to health care professionals, social services professionals, community based organizations, and advocacy groups in the form of presentations, meetings, training sessions, and one on one encounters. They maintain regularly scheduled and publicized hours at local Department of Prevention, Assistance, Transition, and Health Care Offices and Women, Infants, and Children Clinics, as well as participating in health fairs, conferences, and committees. In addition, they are also available to meet with individual participants in their homes or in a mutually agreed upon setting by request. During their travels they also distribute program posters and brochures to community gathering places.

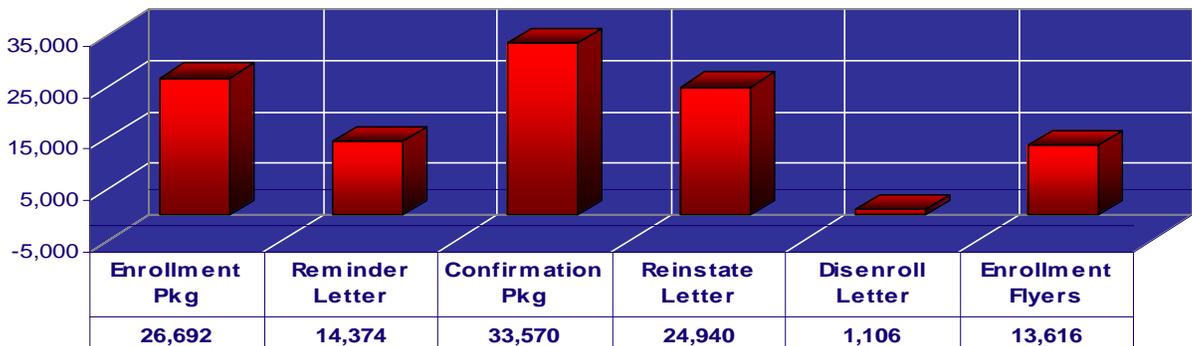
During 2003, Marketing and Outreach Counselors presented information at 875 locations throughout the state, making contact with 18,508 individuals. *Exhibit 14: Marketing and Outreach Venues 2003* provides a sample of locations and events attended.

Location	Summary	Frequency
All District PATH Offices	Provide program information to PATH staff and clients	Monthly
All District Women, Infants, & Children Clinics	Provide program information to DOH staff and clients	Monthly
Commodities Food Drop	Provide program information to Commodities clients (elderly)	Monthly
District Department of Health Offices	Provide program information to DOH staff	Frequently
District SRS Offices	Provide program information to SRS staff, troubleshoot individual SRS client problems	Regularly
Community Senior Citizen Centers	Provide pharmacy program information to members	Regularly
Senior Citizen Action Groups	Provide pharmacy program information to members	Regularly
Area Health Fairs	Distribute program materials and provide information to attendees	Regularly
Area Health Care Clinics	Provide program information to staff and assist patients in applying for benefits	Regularly
Medicare Meetings	Discuss Medicare issues and how they impact the dual eligible population and pharmacy program clients	Regularly
Success by Six Programs	Provide program information to staff and clients	Occasionally
School Nurses Offices	Provide program information to staff and troubleshoot individual client problems	Occasionally
Homeless Shelters	Provide program information to staff and assist residents in applying for benefits	Occasionally
Retired Seniors Volunteer Program	Provide pharmacy program information to members	Occasionally
Area Salvation Army Offices	Provide program information to staff and distribute program materials	Occasionally
Community Food Shelves	Provide program information to staff and distribute program materials	Occasionally
Planned Parenthood Offices	Provide program information to staff and assist patients in applying for benefits	As needed
NorthEast Kingdom Community Action	Provide program information to staff	As needed
Area Agency on Aging Offices	Provide program information to staff	As needed
WACT	Provide program information to staff	As needed
AARP Offices	Provide program information to staff	As needed
Community Meals on Wheels Programs	Provide program information to staff and distribute program materials	As needed
United Way Offices	Provide program information to staff and distribute program materials	As needed
Aids Medication Assistance Program	Provide program information to staff	As needed

**Exhibit 14: Marketing and Outreach Venues 2003.** *Two staff are available on request to conduct presentations, in-home client visits, and attend meetings or informational gatherings.*

**I. MAILHOUSE FUNCTIONS**

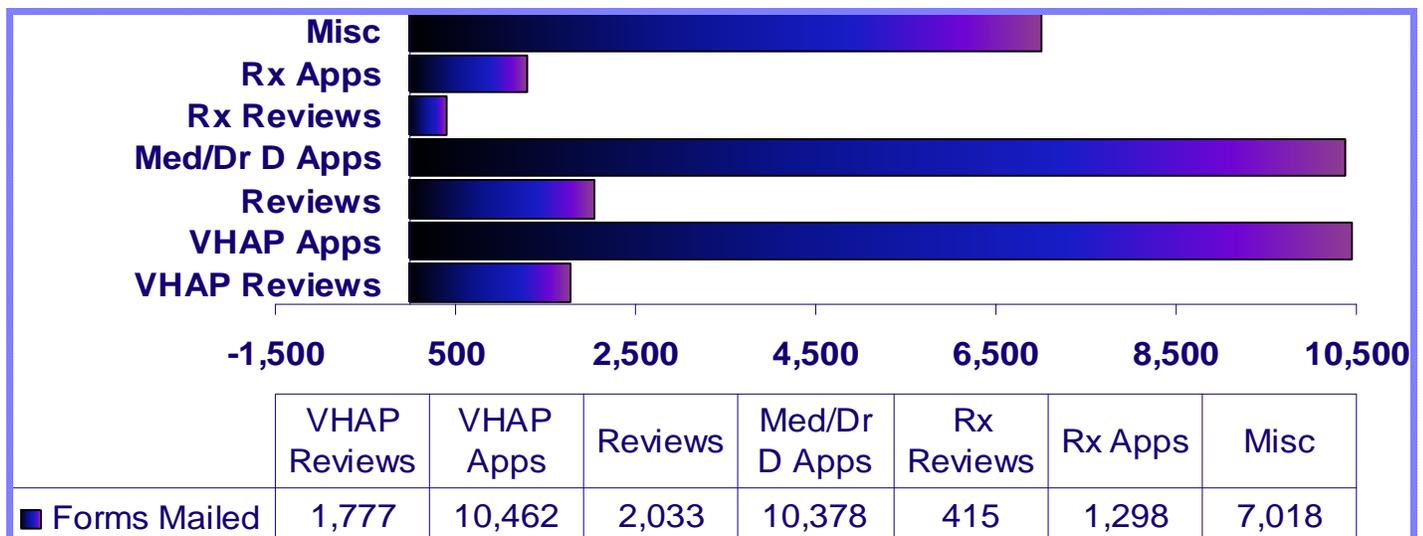
In 2003, MAXIMUS mailed 148,263 pieces of mail. Of these, 115,017 were *PC Plus* related. *Exhibit 15: PC Plus-Related Mailings 2003* displays mail activity related to *PC Plus*. You will note that confirmation packages mailed slightly exceeded enrollment packages mailed in 2003, as a change in a client’s PCP also results in the mailing of a confirmation package. A total of 13,616 flyers were mailed to clients to prompt a response to the enrollment package mailings and minimize auto-assignment rates.



**Exhibit 15: PC Plus Related Mailings 2003.** *PC Plus related mailings accounted for 78% of all mailings in 2003.*

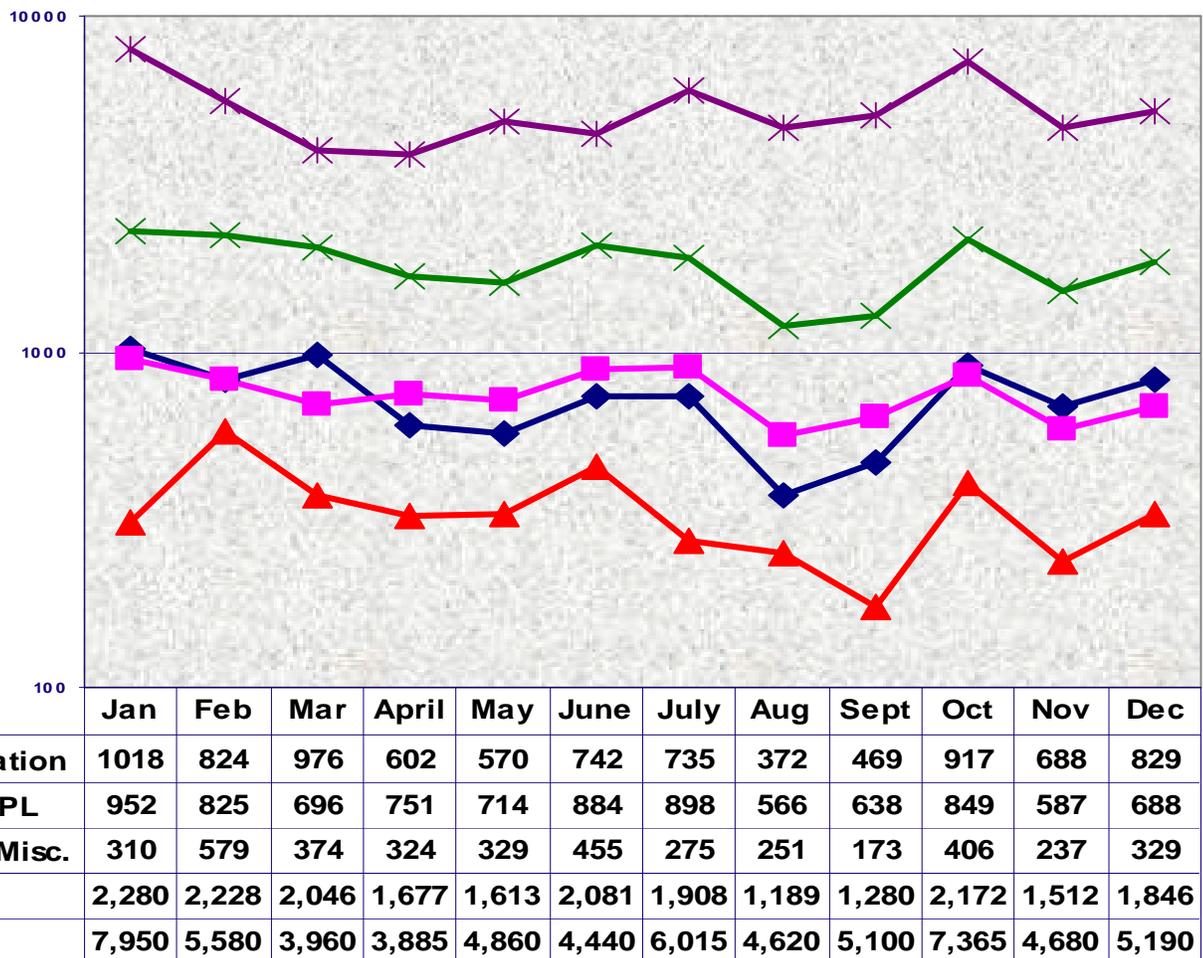
MAXIMUS mailed applications and/or program information to 33,246 households in 2003, an averages of 2,771 households per month. This information is displayed in *Exhibit 16: Applications and Information Summary 2003*.

**Exhibit 16: Applications and Information Mailings 2003.** *MAXIMUS mailed applications and brochures to individuals interested in applying for programs, as well as applications to replace review paperwork lost by program participants.*



**J. THIRD PARTY LIABILITY IDENTIFICATION**

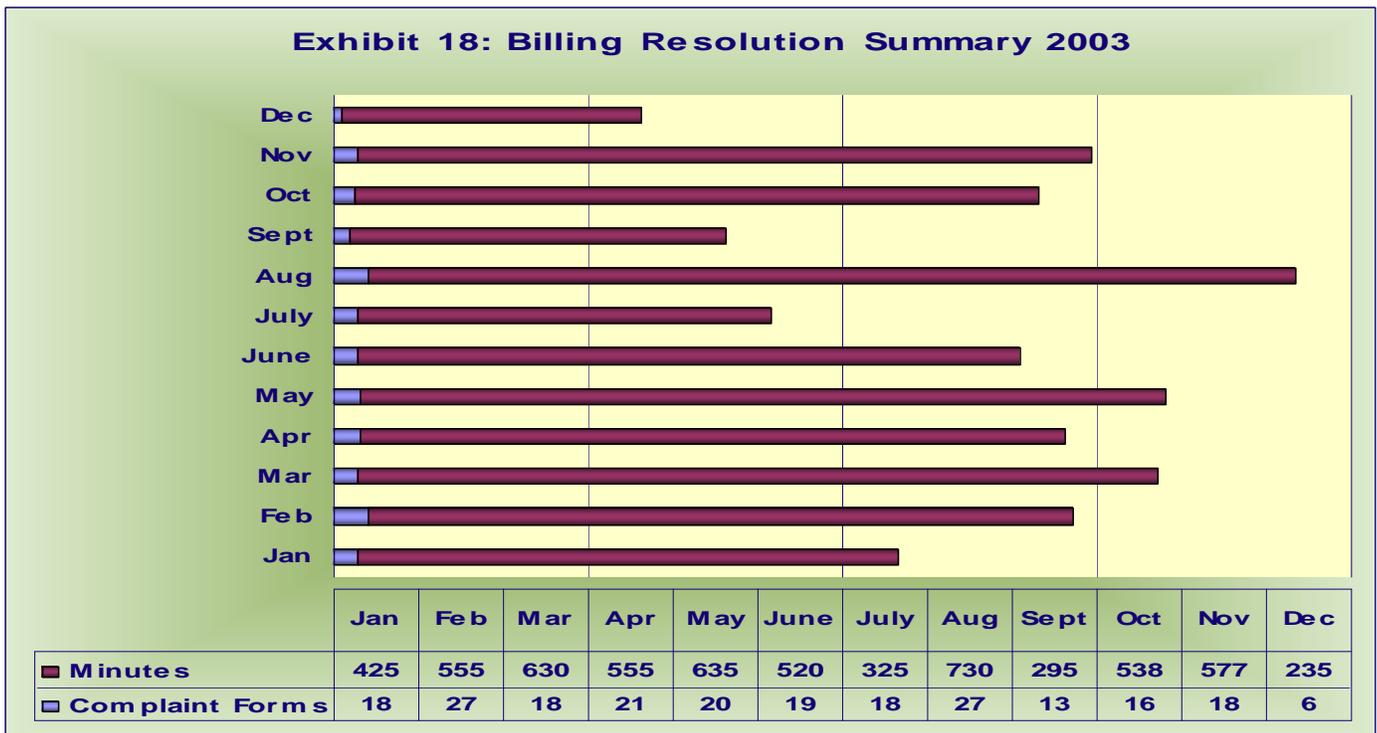
All TPL information reported to MAXIMUS or gathered during the enrollment process is verified and entered into the ACCESS system by a designated TPL Coordinator. In 2003, the TPL coordinator took action in 21,832 TPL cases. This is an average of 1,819 cases per month in 2003, compared to an average of 1,082 cases per month in 2002-an increase of approximately 41%. Of the cases handled, 40% involved confirming and entering new information. Closing existing TPL panels accounted for 41% of the cases. The remaining 19% of the cases required the correction of information on existing panels. The TPL Coordinator made 5,137 telephone calls and mailed 1,990 letters regarding TPL matters in 2003. TPL activities required a total of 63,660 minutes (1,061 hours) in 2003. This is an average of 5,305 minutes per month. *Exhibit 17: TPL Activity 2003*, is a graphical representation of this data by month.



**Exhibit 17: TPL Activity 2003.** Reports of TPL increased in July and October, coinciding with client notification of increases and changes to premiums. TPL activity was at the highest level in January as clients reported changes in health insurance carriers for the new year.

**K. BILLING RESOLUTION**

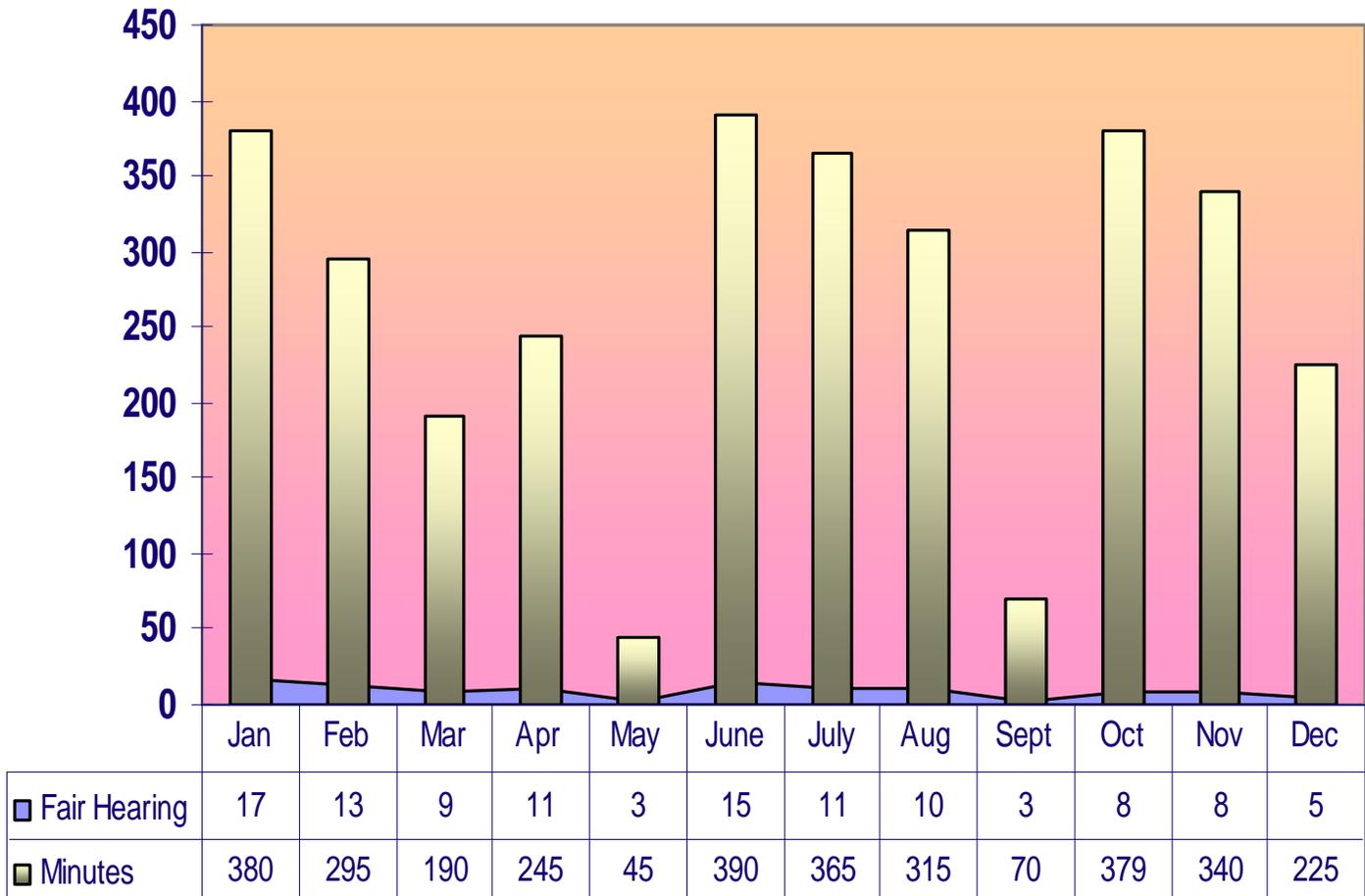
A designated Billing Coordinator addresses, resolves, and tracks all billing problems received at MAXIMUS via the mail. Individual MSRs continue to address billing problems reported via the HelpLine. In 2003, the Billing Coordinator spent 6,020 minutes (100 hours) researching and resolving 221 billing problems received in the mail. *Exhibit 18: Billing Resolution Summary 2003*, is a graphical representation of this data. As you can see, the amount of time spent resolving billing problems in any month is not directly tied to the number of billing problems received in that month. This reflects the fact that some problems are significantly more complex and time consuming than other problems.



**L. FAIR HEARINGS**

A designated Fair Hearing Coordinator responds to client requests for fair hearings. MSRs forward information regarding the request from the client to the Coordinator. The Coordinator researches as needed and creates documents that are forwarded to both the AAG’s office and the Human Services Board. Requests for fair hearings are occasionally forwarded to MAXIMUS from the OVHA as well. MSRs continue to forward appeals of eligibility decisions directly to the eligibility worker. In 2003, MAXIMUS staff spent 3,239 minutes (54 hours) initiating fair hearing requests on the behalf of 113 clients. *Exhibit 19: Fair Hearings*, is a graphical representation of fair hearing activity. As you can see, the number of fair hearings processed does not necessarily correlate with the number of minutes to process. Some requests require additional time to gather details and clarify information.

**Exhibit 19: Fair Hearings 2003**



**M. COMPLAINTS**

MAXIMUS staff submits weekly reports to the OVHA chronicling weekly call volumes and issues or complaints raised by clients. MAXIMUS staff does not attempt to verify or validate the client’s complaint, but makes every effort to resolve the client’s problem. There were 456 complaints/issues reported to OVHA in 2003. *Exhibit 20: Complaint Summary 2003* details the most common types of complaints and resolutions. As you can see, complaints against PATH workers accounted for the largest percentage (31%) of complaints, with another 23% of complaints lodged against providers. Of the 23 complaints made against MAXIMUS, project management staff was able to validate 8 incidents of error. The balance of complaints were determined to be unfounded, or were complaints against policy rather than MAXIMUS performance.

<b>Exhibit 20: Complaint Summary 2003</b>		
<b>Complaint</b>	<b>Resolution</b>	<b>% of Total Complaints</b>
<b>PATH Staff</b>	Attempted to answer the client's questions and/or referred the client to PATH management staff.	31%
<b>Provider</b>	Assisted the client in identifying an alternative provider and/or mailed a provider complaint form.	23%
<b>Program Fees</b>	Reviewed income and program fee information in ACCESS, contacting the client's PATH worker or the Administrative Services Unit to facilitate a resolution to the problem when appropriate.	7%
<b>OVHA Policies</b>	Documented the complaint and/or referred the client to the Governor's Action Hotline.	6%
<b>Del Marva/EDS</b>	Documented the complaint and/or referred the caller to the appropriate party.	5%
<b>MAXIMUS</b>	Attempted to resolve the issue to the client's satisfaction. Reviewed all call records/documentation and followed up with staff involved if appropriate.	5%
<b>Billing Issues</b>	Reviewed client eligibility and claims information, contacting the client's PATH worker, a provider, or EDS to facilitate a resolution to the problem when appropriate.	5%
<b>Co-Pays, PAs, Benefits, and Eligibility</b>	Documented the complaint and/or referred the caller to the appropriate party.	Less than 5% each

**N. SUMMARY OF EVENTS**

Programs administered by the OVHA were impacted by several changes in 2003. A summary of changes, events, or issues are listed by month in the table below:

January	o Implementation of deductions and out-of-pocket maximums.
February	o Continued client feedback regarding program changes.
March	o Complaints regarding the preferred drug list and other pharmacy limitations. o Complaints regarding physical therapy co-payments.
April	o Working People with Disabilities clients incorrectly billed due to field limitations in ACCESS. o Client response to OVHA letter outlining July 1 changes. o Client complaints regarding pharmacy costs.
May	o Client complaints regarding pharmacy costs.
June	o Training for implementation of the new notice process in ACCESS. o MAXIMUS provided client feedback regarding new notice design to OVHA, as well as identified apparent glitches.

	<ul style="list-style-type: none"> <li>○ Complaints of HAEU notices mailed to incorrect households.</li> <li>○ Client response to HIPAA and July 1 Changes notices.</li> <li>○ Incidents of program fee problems, ultimately identified as due to isolated systems and personnel errors.</li> <li>○ Verified TPL information creating errors as requested by the OVHA.</li> </ul>
July	<ul style="list-style-type: none"> <li>○ MAXIMUS staff determined that some pharmacy deductible and yearly out-of-pocket maximum tallies failed to reset July 1 and alerted First Health.</li> <li>○ Complaints of an incorrect fax number on HAEU notices. MAXIMUS staff alerted the OVHA.</li> </ul>
August	<ul style="list-style-type: none"> <li>○ Problems with pharmacy deductible and yearly out-of-pocket maximum tallies at First Health.</li> </ul>
September	<ul style="list-style-type: none"> <li>○ Problems with pharmacy deductible and yearly out-of-pocket maximum tallies at First Health.</li> <li>○ Erroneous information in PATH notices.</li> <li>○ Back log of review paperwork in HAEU resulting in clients receiving closure notices for failure to review.</li> </ul>
October	<ul style="list-style-type: none"> <li>○ Premium bills with incorrect fee amounts.</li> <li>○ Complaints regarding increased Dr. Dynasaur premiums.</li> <li>○ Complaints regarding backlog of application processing in the Springfield PATH office.</li> </ul>
November	<ul style="list-style-type: none"> <li>○ Problems with pharmacy deductible and yearly out-of-pocket maximum tallies at First Health.</li> <li>○ Confusion regarding the staggered billing schedule for Fall 2003.</li> <li>○ Back log of review paperwork in HAEU resulting in clients receiving closure notices for failure to review.</li> </ul>
December	<ul style="list-style-type: none"> <li>○ Multiple mailings regarding changes in the premium billing process.</li> <li>○ Confusion regarding the application of premiums.</li> <li>○ Back log of review paperwork in HAEU resulting in clients receiving closure notices for failure to review.</li> </ul>

**O. CONCLUSION**

Throughout 2003, MAXIMUS was committed to providing an exemplary level of customer service while implementing many changes in our operations to remain responsive to the changing needs of the OVHA and other state and community agencies. We continued to explore new and improved ways to perform our contracted responsibilities in a way that achieved the goals identified by the Office of Vermont Health Access and best meets the needs of our customers. We look forward to continued success and new challenges in the year to come.

# MAXIMUS

December 6, 2004

Ms. Esther Perelman  
Director of Policy and Reports  
Agency of Human Services  
Office of Vermont Health Access  
103 South Main Street  
Waterbury, Vermont 05671-1201

Dear Ms. Perelman:

MAXIMUS is pleased to submit this weekly report to the Office of Vermont Health Access (OVHA) for your review. This report documents our call statistics, as well as client complaints and feedback, for the week of November 29, 2004 through December 3, 2004. Upon your review, please let us know if you have any comments or questions.

## **A. CALL STATISTICS**

The Vermont Health Access Member Services (VHAMS) Project was operational for five days last week. MAXIMUS staff handled a total of 5,484 calls during this reporting period. The project answered a total of 4,659 incoming Help Line calls and placed 825 outgoing calls. This means that on average MAXIMUS staff handled 1,097 calls per day. Additional calls made in relation to PCP gone and TPL activities are not reflected in this report. Resources devoted to these activities are reported in the monthly report. This week, the average time to answer a call was 10 seconds. The average talk time per call was 4 minutes and 10 seconds.

## **B. INCIDENTS AND FEEDBACK**

MAXIMUS documented three complaints this week. Please note that some complaints may not be reflected in the monthly HelpLine reports, as the complaint was not the primary topic of the call. The details of these complaints are documented in *Exhibit 1: Weekly Complaint Log*.

## **C. PREMIUM RELATED STATISTICS**

MAXIMUS documented 600 calls relating specifically to premiums during this reporting period. There were zero callers requesting closure or indicating that they would not pay their premium.

# MAXIMUS

## D. CONCLUSION

Operations for the Vermont Health Access Member Services Project continue to run smoothly as MAXIMUS strives to meet the needs of the Office of Vermont Health Access, the Department for Children and Families, Agency of Human Services, and our clients.

Sincerely,

Susan Bauer  
Project Director

## EXHIBIT 1: COMPLAINT LOG

Client Program	Type of Issue	Complaint	Resolution
Medicaid MC	Transportation Broker RCT	The client complains that Rural Community Transportation in Essex county has given her poor care and has refused her services.	HelpLine staff referred her to the Vermont Public Transportation Association along with mailing her a provider complaint form. The MSR filed a complaint per the client's request.
Medicaid MC	Transportation Broker GMARC	The client complains that Green Mountain American Red Cross in Bennington has caused her to be late for several doctor's appointments, and parks too far from her home.	HelpLine staff filed a complaint per client request, and sent a provider complaint form. The MSR also referred the client to the Vermont Transportation Association.
VHAP MC	Eligibility Worker ZDO	The client complains that she sent in a new application in October with her husband in the same household. Her husband was closed in another household for non-payment.	HelpLine staff verified that her husband was in the wrong household. Transferred call to her eligibility worker per client's request.

# MAXIMUS

March 15, 2005

Ms. Esther Perelman  
Director of Policy and Reports  
Agency of Human Services  
Office of Vermont Health Access  
103 South Main Street  
Waterbury, Vermont 05671-1201

Dear Ms. Perelman:

MAXIMUS is pleased to submit this monthly report to the Office of Vermont Health Access (OVHA) for your review. The following narrative and accompanying exhibits detail member services and enrollment activities performed through the HelpLine and mail for the month of February 2005. Upon your review, please let us know whether you have any questions or recommendations for modifications to the report format.

## **A. OVERVIEW**

We define this reporting period as having four full weeks, January 31, 2005 through February 28, 2005. The office was closed Monday, February 21, to observe the Presidents' Day holiday.

## **B. CALL STATISTICS**

The information in *Exhibit 1: Call Statistics* reflects the information gathered by the ACD February 1, 2005 through February 28, 2005. This month we answered 16,964 incoming calls, a decrease of 2,186 calls from last month. We placed 4,039 outgoing calls, a decrease of 88 calls from last month. On average, MAXIMUS staff handled 893 calls per day in February compared to 958 calls per day in January. *Exhibit 1* shows that the average time to answer a call for the month was 12 seconds. One-hundred percent of incoming calls were answered within four minutes and 99% were answered within two minutes. Abandoned calls amounted to 1% of incoming calls for the month.

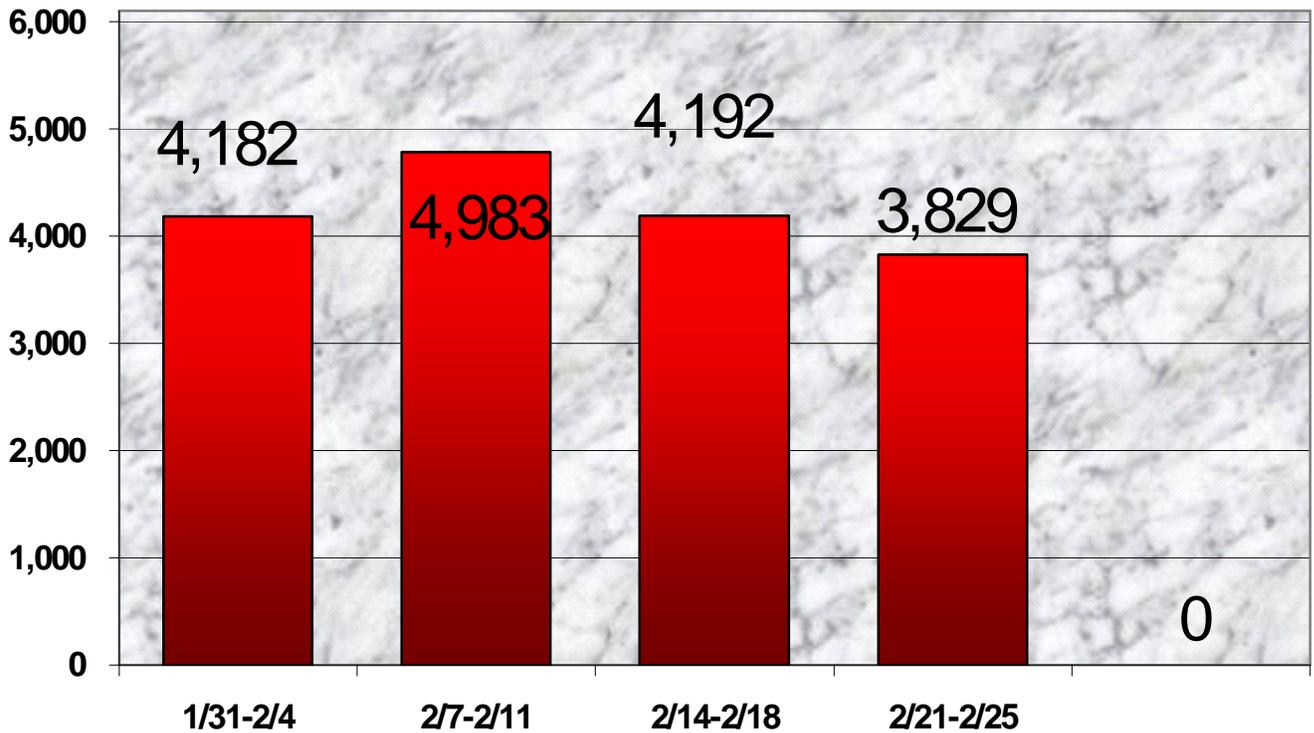
**Exhibit 1: Call Statistics**

	Recvd	Answrd	Abandon	Delay	Length	in 4 Mins	in 2 Mins	CALLS
2/1/2005	829	814	1.8%	19	211	99%	97%	117
2/2/2005	840	827	1.5%	10	212	100%	99%	129
2/3/2005	799	796	0.4%	6	214	100%	100%	77
2/4/2005	689	686	0.4%	11	207	100%	99%	145
2/7/2005	1107	1096	1.0%	9	191	100%	99%	152
2/8/2005	912	908	0.4%	9	192	100%	99%	95
2/9/2005	1032	1019	1.3%	11	201	100%	99%	447
2/10/2005	916	913	0.3%	9	205	100%	99%	621
2/11/2005	875	844	3.5%	27	206	99%	95%	131
2/14/2005	1003	993	1.0%	14	210	100%	99%	398
2/15/2005	910	907	0.3%	7	196	100%	100%	248
2/16/2005	876	868	0.9%	12	204	100%	99%	395
2/17/2005	696	694	0.3%	9	206	100%	99%	237
2/18/2005	745	745	0.0%	6	206	100%	100%	231
2/21/2005								
2/22/2005	1323	1304	1.4%	17	187	100%	98%	200
2/23/2005	1005	984	2.1%	17	212	100%	99%	97
2/24/2005	832	831	0.1%	6	206	100%	100%	94
2/25/2005	732	724	1.1%	16	221	100%	97%	102
2/28/2005	1018	1011	0.7%	10	197	100%	99%	123
MonthTotal	17,139	16,964	1.0%	12	204	100%	99%	4,039

In addition to call activity reported via the ACD report, MAXIMUS spent 30 minutes related to PCP gone activities as well as 3,120 minutes fulfilling Third Party Liability (TPL) related duties. MAXIMUS staff devoted approximately 360 minutes investigating and resolving 12 Medicaid Complaint forms. The Fair Hearing Coordinator spent 300 minutes forwarding requests for fair hearings to the OVHA, the Assistant Attorney General's Office (AAG) and the Human Services Board on the behalf of 12 clients. Further details regarding these processes are provided in later sections of this report.

*Exhibit 2: Calls by Week* displays graphically the volume of incoming calls this month.

### Exhibit 2: Calls by Week



#### HELPLINE ACTIVITY

MAXIMUS also reports on what the calls are about, where the customers are calling from, how calls are handled, and how the customer is referred to the HelpLine. Management information on these business requirements follows.

##### 1. Caller Type

In *Exhibit 3: Caller Type Summary*, we report on the category a caller to the HelpLine falls into. As you can see, the vast majority (85.2%) of callers continue to be recipients of state funded health care benefits. Individuals wishing to apply for state funded health care benefits accounted for 3.7% of total calls received. Provider calls to the HelpLine numbered 533 this month, and accounted for 3.1% of total calls received.

## Exhibit 3

Caller Type Summary --  
FEBRUARY 2005

CALLER TYPE	1/31/2005 THRU 2/4/2005	2/7/2005 THRU 2/11/2005	2/14/2005 THRU 2/18/2005	2/21/2005 THRU 2/25/2005	FOR MONTH	
					TOTAL	PERCENT
Applicant	155	180	148	151	634	3.7%
Community/Advocacy Org	48	27	40	49	164	1.0%
Care Provider	138	147	125	123	533	3.1%
DCF Staff	15	17	26	15	73	0.4%
Other Contractor	1	3	5	4	13	0.1%
Public	183	194	208	172	757	4.5%
Recipient	3,531	4,120	3,564	3,261	14,476	85.2%
OVHA Staff	1	0	0	0	1	0.0%
HAEU Staff	0	0	0	0	0	0.0%
Other Agency	99	75	60	44	278	1.6%
Ombudsman	9	16	7	4	36	0.2%
Project Staff	2	4	9	6	21	0.1%
<b>TOTAL</b>	<b>4,182</b>	<b>4,783</b>	<b>4,192</b>	<b>3,829</b>	<b>16,986</b>	<b>100.0%</b>

## Exhibit 4

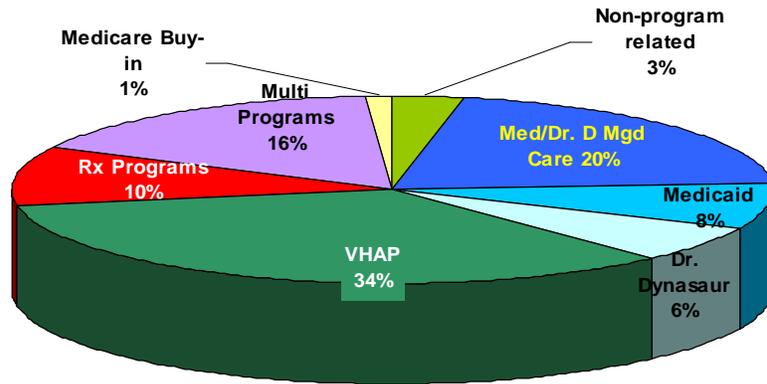
Number of Incoming Calls by Program  
FEBRUARY 2005

PROGRAM	1/31/2005 THRU 2/4/2005	2/7/2005 THRU 2/11/2005	2/14/2005 THRU 2/18/2005	2/21/2005 THRU 2/25/2005	FOR MONTH	
					TOTAL	PERCENT
Medicaid/DrD Managed Care	893	1,010	911	724	3,538	20.8%
Medicaid	311	384	336	280	1,311	7.7%
Dr Dynasaur	302	289	244	260	1,095	6.4%
VHAP Managed Care	994	1,218	1,038	928	4,178	24.6%
VHAP Limited	416	427	418	327	1,588	9.3%
Multiple Programs	632	776	647	712	2,767	16.3%
VHAP-Rx	174	209	165	180	728	4.3%
V-Script	56	78	48	62	244	1.4%
V-Script Expanded	49	56	52	50	207	1.2%
Healthy Vermonters	157	155	145	126	583	3.4%
Medicare/Medicaid (duals)	57	52	61	39	209	1.2%
Non-program Related	141	129	127	141	538	3.2%
<b>TOTAL</b>	<b>4,182</b>	<b>4,783</b>	<b>4,192</b>	<b>3,829</b>	<b>16,986</b>	<b>100.0%</b>

**2. Program**

In *Exhibit 4: Number of Incoming Calls by Program*, we report the number of calls received by OVHA programs. *Exhibit 5: Percent of Calls by Program* displays graphically the percent of HelpLine calls received by program. Pharmacy calls accounted for 10% of calls this month. Of the pharmacy calls, the majority (728) were from VHAP Pharmacy participants.

**Exhibit 5: Calls by Program**



**3. Call Topic**

*Exhibit 6: Number of Incoming Calls by Topic* reports on the "business process" the customer conducts during the call. Questions regarding premiums accounted for 12.6% of the calls received this month compared to 12.4% of calls last month. Thirty-two and one half percent of callers had questions regarding their eligibility. Callers with questions about managed care made up 6.9% of all calls. Calls regarding enrollment into managed care accounted for 5.2% of calls. There were 8 complaints against providers. There were an additional 13 complaints against OVHA/PATH, MAXIMUS, PC Plus, First Health, policy, or EDS this month. These complaints are documented in detail as they occur in the weekly complaint logs submitted to OVHA.

**4. Call Resolution**

*Exhibit 7: Call Resolutions* reports on the "business processes" the MSR conducted to resolve the call. MSRs provided an overview for 7,539 callers (44.1% of all calls) this month. MAXIMUS enrolled 848 households into managed care via the HelpLine. MAXIMUS mailed applications or information to 1,859 households this month. MSRs resolved billing issues for 62 callers this month, as well as 16 Medicaid complaint forms forwarded by local DCF offices or received in the mail. In addition, MAXIMUS staff helped file a complaint or fair hearing request on behalf of 26 clients. MSRs entered changes to cases or forwarded the information to district office workers on the behalf of 2,736 clients. MSRs processed 418 PCP changes requested via the HelpLine and 176 PCP changes requested fax machine for *PC Plus* members this month.

Exhibit 6 Number of Incoming Calls by Topic  
FEBRUARY 2005

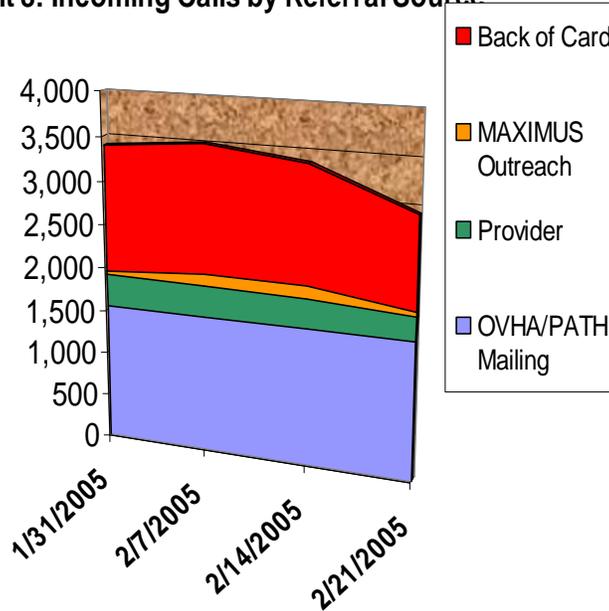
CALL TOPIC	1/31/2005 THRU 2/4/2005	2/7/2005 THRU 2/11/2005	2/14/2005 THRU 2/18/2005	2/21/2005 THRU 2/25/2005	FOR MONTH	
					TOTAL	PERCENT
? - Eligibility	1337	1552	1364	1292	5,545	32.6%
? - Client Status	474	720	418	417	2,029	11.9%
? - FFS Benefits/Providers	123	90	97	73	383	2.3%
? - MC Benefits/Providers	284	294	329	226	1,133	6.7%
? - MC Referral Process	9	12	10	6	37	0.2%
Enrollment	209	256	279	137	881	5.2%
Change PCP	134	111	150	115	510	3.0%
Application Assistance	94	104	117	114	429	2.5%
Change to Member Information	422	429	350	303	1,504	8.8%
Program Fee	421	609	485	633	2,148	12.6%
Replacement Card	105	88	97	56	346	2.0%
TPL	114	71	78	70	333	2.0%
Billing Notice	187	198	180	161	726	4.3%
Prior Authorization	70	74	66	51	261	1.5%
Complaint -- OVHA/DCF	2	2	3	2	9	0.1%
Complaint -- MAXIMUS	0	0	0	0	0	0.0%
Complaint -- Policy	1	0	1	1	3	0.0%
Complaint -- First Health	0	0	0	0	0	0.0%
Complaint -- EDS/DelMarva	0	0	0	1	1	0.0%
Complaint -- Provider	4	2	1	1	8	0.0%
Complaint -- PC Plus/MC	0	0	0	0	0	0.0%
Fraud	2	1	2	3	8	0.0%
PCA Program	4	2	4	2	12	0.1%
M&O	4	1	2	2	9	0.1%
Question	186	169	163	165	683	4.0%
<b>TOTAL</b>	<b>4,186</b>	<b>4,785</b>	<b>4,196</b>	<b>3,831</b>	<b>16,998</b>	<b>100.0%</b>

CALL RESOLUTION	1/31/2005 THRU 2/4/2005	2/7/2005 THRU 2/11/2005	2/14/2005 THRU 2/18/2005	2/21/2005 THRU 2/25/2005	FOR MONTH	
					TOTAL	PERCENT
Answer Question	73	80	74	85	312	1.8%
Provide Overview	1,717	2,211	1,737	1,874	7,539	44.1%
Mail Application	397	450	403	367	1,617	9.5%
Mail Information	67	61	52	62	242	1.4%
Enroll Customer	199	256	268	125	848	5.0%
Change PCP	111	99	121	87	418	2.4%
Submit Exception Request	0	0	0	0	0	0.0%
Reorder ZDO Premium Hierarchy	3	3	0	2	8	0.0%
Reorder DO Premium Hierarchy	0	1	0	0	1	0.0%
Close/Not Pay due to fee increase	1	2	0	1	4	0.0%
Help File Complaint/Fair Hearing	4	5	10	7	26	0.2%
CATN Case	375	425	406	295	1,501	8.8%
Enter Change	352	344	285	254	1,235	7.2%
Update TPL	55	55	47	49	206	1.2%
Resolve Billing/System Issue	20	19	8	15	62	0.4%
Issue Card	67	61	61	40	229	1.3%
Refer to M&O	0	0	1	1	2	0.0%
Refer to OVHA	19	16	27	15	77	0.5%
Refer to Eligibility Worker	251	266	258	217	992	5.8%
Refer to PCA/AIL	7	3	9	5	24	0.1%
Refer to EDS	58	44	40	32	174	1.0%
Refer to First Health	10	18	4	8	40	0.2%
Refer to PA Unit	0	0	0	0	0	0.0%
Refer to Provider	226	211	232	164	833	4.9%
Refer to other Resource/Agency	170	153	149	124	596	3.5%
<b>TOTAL</b>	<b>4,182</b>	<b>4,815</b>	<b>4,174</b>	<b>3,921</b>	<b>17,092</b>	<b>100.0%</b>

**5. Referral Source**

*Exhibit 8: Incoming Calls by Referral Source* is a graphical representation of some of the sources of calls received. *Exhibit 9: Number of Calls by How Referred* reflects all sources generating calls to the HelpLine telephone number. DCF and OVHA mailings generated 36% of the calls this month. The back of the AIM card prompted 31% of calls. Five percent of calls were in response to MAXIMUS outreach efforts via mail, phone, or Marketing and Outreach staff.

**Exhibit 8: Incoming Calls by Referral Source**



**Exhibit 9 Referral Source Summary -- FEBRUARY 2005**

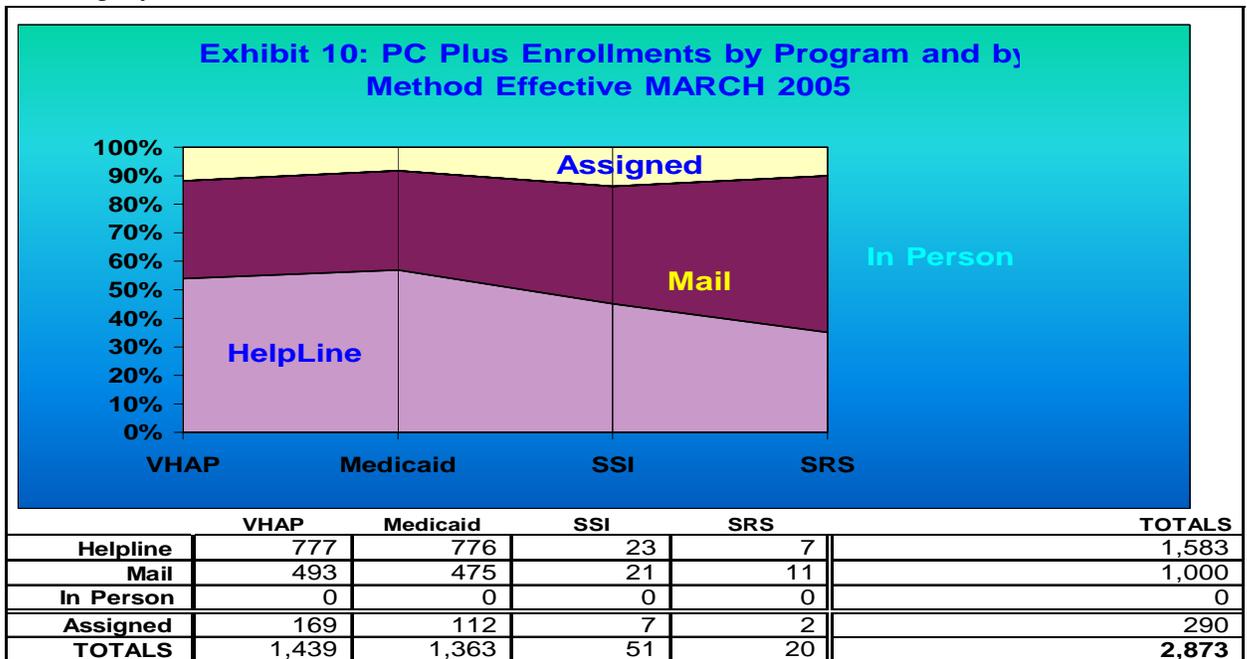
HOW REFERRED to HELPLINE	1/31/2005 THRU 2/4/2005	2/7/2005 THRU 2/11/2005	2/14/2005 THRU 2/18/2005	2/21/2005 THRU 2/25/2005	FOR MONTH	
					TOTAL	PERCENT
Medicaid/VHAP Card	1,438	1,470	1,318	1,051	5,277	30.5%
DCF/OVHA Mailing	1,550	1,550	1,550	1,550	6,200	35.8%
Provider	363	362	342	280	1,347	7.8%
Pharmacy	101	82	87	66	336	1.9%
MAXIMUS Mailing	152	137	151	100	540	3.1%
MAXIMUS Outreach	39	119	154	47	359	2.1%
M&O	2	3	7	0	12	0.1%
Friend/Relative	141	143	125	129	538	3.1%
Phone Book	229	236	200	227	892	5.2%
Brochure/Poster/App	191	195	173	152	711	4.1%
Media	1	2	0	0	3	0.0%
Community-based Organization	40	21	31	25	117	0.7%
Other Agency	259	198	244	177	878	5.1%
Ombudsman	6	12	7	4	29	0.2%
EDS	0	0	1	0	1	0.0%
Internet	16	16	14	24	70	0.4%
Special Mailing/Initiative	3	0	0	0	3	0.0%
<b>TOTAL</b>	<b>4,531</b>	<b>4,546</b>	<b>4,404</b>	<b>3,832</b>	<b>17,313</b>	<b>100.0%</b>

**D. ENROLLMENT ACTIVITY**

During the month of February, MSRs enrolled Medicaid and VHAP-Limited customers through HelpLine conversations, or as a result of enrollment forms returned by mail. Specific details on these activities follow.

**1. Managed Care Confirmed Enrollment by Individuals**

Confirmed enrollments represent individuals who enrolled via the HelpLine, in-person, or mailed in an enrollment form and remained program eligible through the effective date of the enrollment. Confirmed enrollments also include individuals in a mandatory enrollment group who did not respond to MAXIMUS outreach efforts and were auto-assigned to a plan. **For a March 1, 2005 effective date, MAXIMUS enrolled 1,363 Medicaid individuals, 1,439 VHAP individuals, 20 SRS individuals, and 51 SSI individuals for a total of 2,873 enrollments.** There were 5,042 members reinstated to *PC Plus* for a March 1, 2005 effective date. *Exhibit 10: Confirmed Enrollments* displays confirmed *PC Plus* enrollments by method and aid category.



Ninety-two percent of RUFA Medicaid individuals chose a PCP, while 8% were auto-assigned. Eighty-eight percent of VHAP individuals chose a PCP and 12% were auto-assigned. Eighty-six percent of SSI individuals also actively participated in the enrollment process. Two of 18 SRS individuals were auto-assigned for the month. Due to discrepancies between OVHA SRS enrollment reporting and MAXIMUS SRS enrollment tracking, the SRS auto-assignment rate is not used in the calculation of the overall auto-assignment rate. The overall auto-assignment rate for March 1, 2005 enrollments is 17.2%.

**2. Disenrollments**

Exhibit 11: Reasons for Disenrollment FEBRUARY 2005

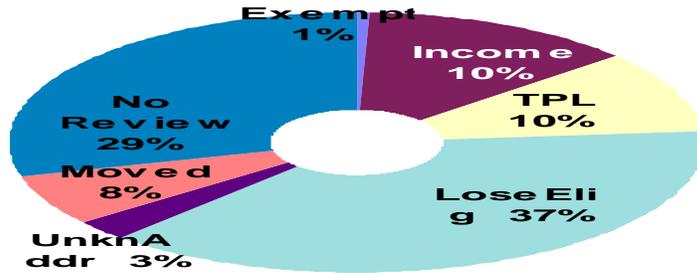


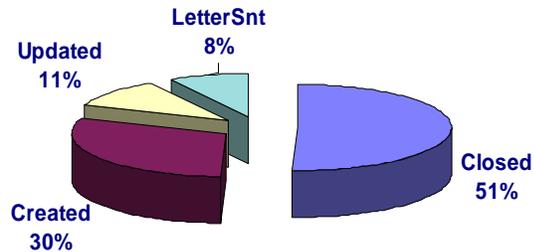
Exhibit 11: Reasons for Disenrollment displays disenrollment activity for the month by reason. A total of 797 individuals were disenrolled by the OVHA this month, compared to 828 disenrollments last month.

E. THIRD PARTY

LIABILITY IDENTIFICATION

All TPL information gathered by MSRs is verified and entered into the ACCESS system by designated TPL Coordinators. During this reporting period, TPL Coordinators took action in 524 TPL cases, compared to 1,683 TPL cases last month. These actions included closing, correcting, and creating INSU panels. Exhibit 12: TPL Activity is a graphical representation of this data. Overall, the TPL Coordinator mailed 43 letters, and devoted 3,120 minutes to TPL-related activities this month.

EXHIBIT 12: TPL ACTIVITY



F. MARKETING AND OUTREACH

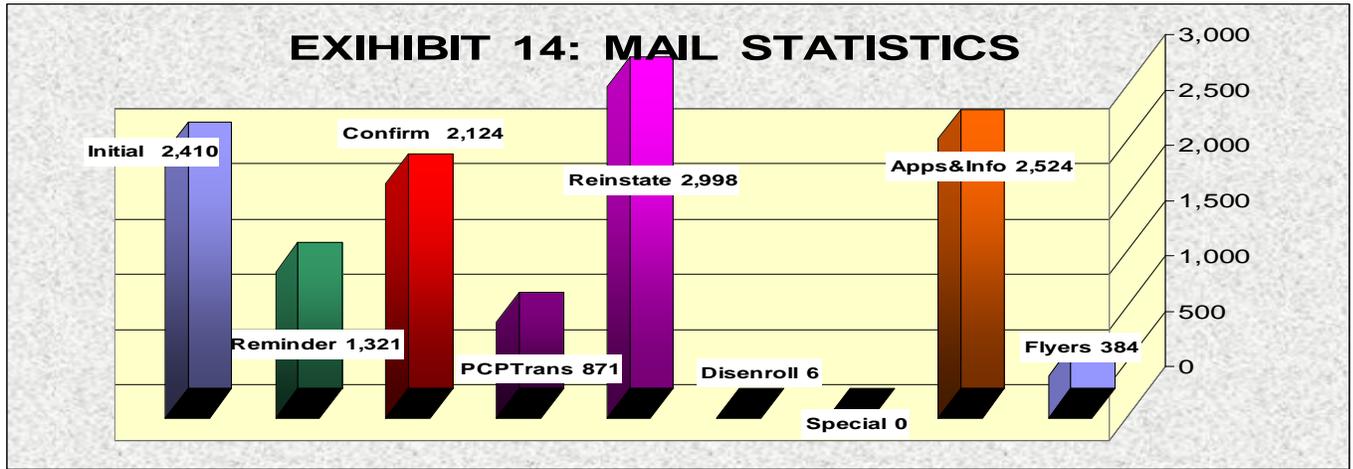
Marketing and Outreach Counselors conducted 60 presentations for a total of 1,861 individuals at locations throughout the State of Vermont in this reporting period. There were no enrollments into managed care processed by Marketing and Outreach staff this month. MAXIMUS staff provided in-person assistance to 11 clients in our Burlington office. One of our primary marketing and outreach objectives is to ensure that individuals understand their health care options within the various VHAP programs. Exhibit 13: Marketing and Outreach Activities details the time and effort spent in accomplishing this objective.

Exhibit 13: Marketing and Outreach Activities

TYPE	DISTRICT	#OF VISITS	PRESENT TIME	#IN ATTENDANCE	#OF CLIENTS ENROLLED	ACTIVITY SUMMARY
DOH/WIC/PATH	Barre	3	7.5	41	0	Updated DOH staff on program information
	Bennington	3	7	50	0	Updated PATH staff and made outreach calls.
	Brattleboro	3	8	41	0	
	Hartford	4	7.5	41	0	Assisted clients with questions and applications
	Springfield	3	8	39	0	Provided managed care overview to clients
	Rutland	2	6	33	0	Addressed accessibility issues for client care
	Burlington	5	11	37	0	Provided applications and brochures on state health care programs
	Morrisville	6	17	58	0	
	Middlebury	4	9.5	24	0	
	Newport	5	14	36	0	
	St. Johnsbury	5	15	42	0	
	St. Albans	4	10.5	43	0	
Presentations	SOLO	1	1	1	0	Spoke about the different state health programs
	Bugbee Senior Center	1	1	20	0	
Comm/food shelf	St. Albans food shelf	1	2	5	0	
	Morrisville food shelf	1	2.5	13	0	
	Middlebury comm	1	1	38	0	
	Barton comm	1	2	90	0	
Home Visits	Bennington	1	1	1	0	helped fill out insurance paperwork
Health Fairs	Vt. Maturity	1	6	2800	0	Spoke about the state health programs, and Dr. Dinosaur
	Dartmouth Med.	1	5	200	0	
Walk-ins/	Burlington	11	5	11	0	One on one encounters with clients
<b>Totals</b>		<b>67</b>	<b>147.5</b>	<b>3,664</b>	<b>0</b>	

**MAILHOUSE FUNCTIONS**

This month on-site project staff processed 12,638 pieces of mail. This mail consisted of 2,410 enrollment packages, 1,321 reminder letters, 2,124 confirmation packages, 2,998 reinstatement notices, 6 disenrollment notices, and 2,524 applications and brochures. In addition, MAXIMUS mailed 384 flyers to promote managed care enrollment. The MSU also received and data entered 888 enrollment forms. *Exhibit 14: Mail Statistics* graphically displays this information.



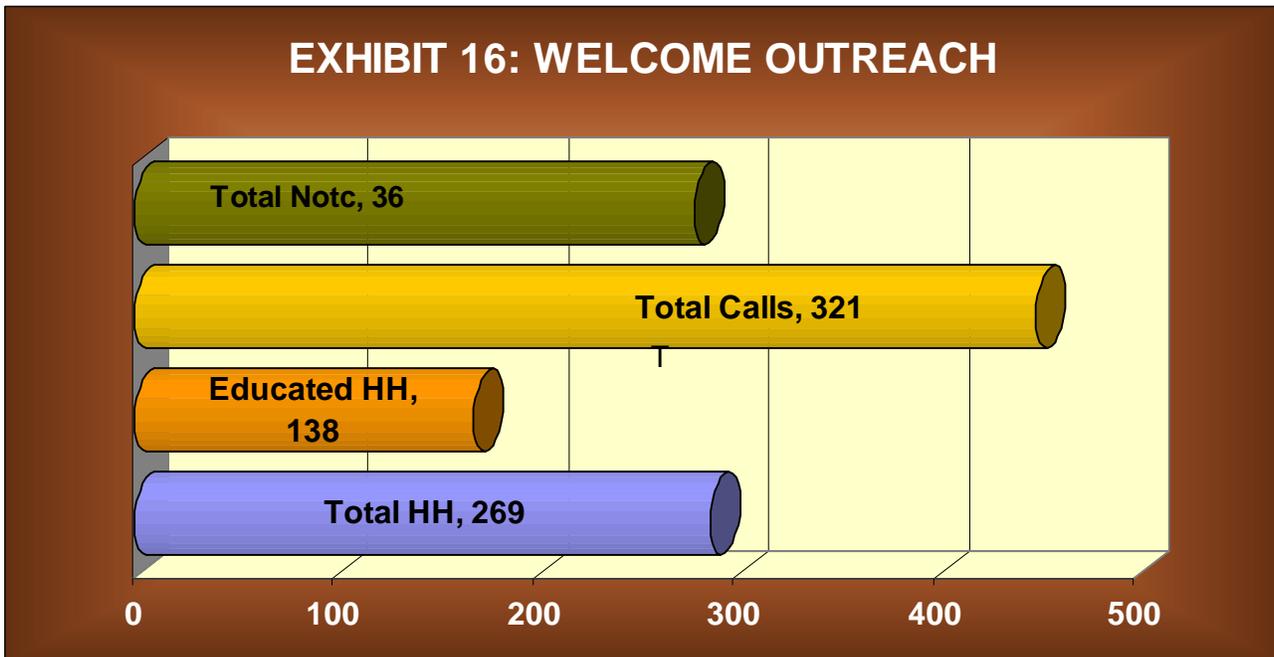
**Exhibit 15: Applications by Program**

Exhibit 15: Applications by Program is a graphical representation of the type applications mailed during this reporting period. Of the 686 initial applications for the Medicaid/Dr. Dynasaur programs mailed, 16 were as a result of an outreach effort sponsored by the VT Department of Health. MAXIMUS also began responding to district-based client requests for Medicaid applications or review forms, mailing these forms to 42 clients in the month of February. MAXIMUS previously referred these requests to the appropriate DCF office. Of note, MAXIMUS received 15 HCFA billing forms from providers in error this month. MAXIMUS returned the bills to the sender with instructions to mail to EDS for processing.

DATE	VHAP		MED		Dr. D			All Pharmacy		TAPE	PATH 202	Forms			All Others	REMAINS				daily TOTAL	Flyers
	REV	APP	REV	APP	REV	APP	REV	APP	Blind	ACH		MIC									
2/1/2005	5	57	1	13	2	23	0	2	0	0	4	6	0	35	1	0	3	0	152	0	
2/2/2005	2	34	2	17	0	24	1	0	0	0	4	6	0	34	1	0	0	0	125	0	
2/3/2005	2	43	0	21	0	21	0	5	0	0	2	4	0	30	1	0	0	0	129	0	
2/4/2005	4	47	1	23	1	21	0	2	0	0	3	4	0	27	1	0	0	0	134	0	
2/7/2005	4	37	3	16	0	15	0	2	0	0	2	6	0	28	1	0	6	1	121	0	
2/8/2005	6	36	4	29	3	23	0	3	0	0	4	3	0	28	1	0	0	0	140	0	
2/9/2005	5	40	0	15	3	16	0	1	0	0	0	3	0	23	0	0	1	4	111	0	
2/10/2005	3	30	0	0	2	10	0	2	0	0	1	9	0	22	0	0	1	0	80	0	
2/11/2005	6	36	1	17	1	17	0	8	0	0	1	6	0	24	1	0	0	2	120	150	
2/14/2005	4	38	1	28	1	11	0	4	0	0	1	6	0	27	0	0	2	4	127	32	
2/15/2005	3	52	2	14	0	13	0	9	0	0	4	6	0	28	1	0	1	3	136	90	
2/16/2005	3	48	0	21	3	19	0	3	0	0	4	4	0	23	0	0	0	0	128	23	
2/17/2005	5	54	0	16	1	18	0	2	0	0	2	6	0	23	0	0	1	0	128	72	
2/18/2005	2	27	1	7	0	11	0	3	0	0	0	4	0	138	0	0	0	1	194	7	
2/21/2005	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
2/22/2005	0	43	0	18	2	21	0	7	0	0	5	6	0	25	0	0	4	3	134	7	
2/23/2005	4	62	1	20	0	20	0	6	0	0	2	9	0	40	0	0	1	1	166	3	
2/24/2005	1	54	2	27	0	27	0	2	0	0	0	6	1	36	0	0	0	0	156	0	
2/25/2005	4	40	2	25	1	14	0	3	0	0	2	9	0	26	0	0	1	0	127	0	
2/28/2005	2	36	1	21	0	14	0	5	0	0	1	5	0	26	2	0	3	0	116	0	
<b>FEBRUARY</b>																					
<b>MoTOTAL</b>	<b>65</b>	<b>814</b>	<b>22</b>	<b>348</b>	<b>20</b>	<b>338</b>	<b>1</b>	<b>69</b>	<b>0</b>	<b>42</b>	<b>108</b>	<b>1</b>	<b>643</b>	<b>10</b>	<b>0</b>	<b>24</b>	<b>19</b>	<b>2524</b>	<b>384</b>		

**G. PRIMARY CARE PLUS MEMBER SERVICES ACTIVITIES**

As the member services unit for the *PC Plus* program, MAXIMUS staff attempts to educate new program members about their benefits by way of welcome calls. Each month, the OVHA provides MAXIMUS with a list of new members of *PC Plus* who have not previously been educated regarding managed care. MAXIMUS makes several attempts to contact each new member by mail or by telephone. There were 269 households in February requiring a welcome call, compared to 287 households in January. Over the course of the month, MAXIMUS staff mailed 36 fliers, and made 321 calls in an attempt to contact these households. MAXIMUS was able to contact and educate 138 households. *Exhibit 16: Welcome Calls* graphically displays this information. This reflects a 51% rate of success overall. Of note, of the 37 households that did not have phones, zero responded to outreach efforts via mail. This indicates a response rate of 0% for households outreached by mail and a response rate of approximately 59% for households outreached via the phone.



In addition, MAXIMUS is responsible for transferring *PC Plus* members to a new primary care provider (PCP) if their designated PCP is incorrect or becomes unavailable. This month, MAXIMUS outreached six members to assist in the transfer to a new PCP as a result of being discharged by the current provider. Three members were successfully transferred to the PCP of their choice for a choice rate of 50%. MAXIMUS staff devoted 30 minutes to PCP gone activities this month.

**I. ISSUES/ACTIVITIES**

The following summarizes various issues or projects identified via the weekly complaint report or project management observation during this reporting period.

- Letters sent to providers postponing changes to therapies and PA's.
- Eligibility approvals delayed to First Health.
- February 16<sup>th</sup> mailings to pharmacies and prescribes.
- PCP change issues from EDS.
- Changes to TPL co-pays and deductibles.
- Press concerning mail order prescriptions.

**J. CONCLUSION**

Operations for the Vermont Health Access Member Services Project continue to run smoothly as MAXIMUS modifies procedures on an ongoing basis to better meet the needs of the Agency of Human Services, Office of Vermont Health Access, and our clients.

Sincerely,

Susan Bauer  
Project Director

cc: Tom McGraw