State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Quarterly Report
for the period
April 1, 2006 – June 30, 2006

Submitted Via Email on
August 31, 2006

Background and Introduction

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

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

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

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

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

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

One of the Terms and Conditions of the Global Commitment Waiver requires the State "to submit progress reports 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas." ***This is the third quarterly report for the new waiver, covering the period from April 1, 2006 to June 30, 2006.***

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

Staffing Changes

Staffing changes previously reported in the second quarter report (Jan-March 2006) targeted for June 2006, have taken place. Specifically, Susan Besio, former AHS lead for the demonstration, assumed her new responsibilities as Director of Health Care Reform Implementation within the Agency of Administration. Simultaneously, on June 5, 2006 Suzanne Santarcangelo, Ph.D. assumed her role as Principal Assistant in the AHS Secretary's Office and the lead role for AHS on the demonstration.

MCO Requirements

On-going operational needs of the Medicare Modernization Act continue to divert staff from the Demonstration project. Nonetheless, OVHA continues to make progress toward implementing the MCO requirements under 42 CFR section 438 (see Attachment A for updated work plan timelines and list of task completions through July 27, 2006).

Benefit Changes

As previously reported, the legislature included language in the FY07 Budget Act requiring OVHA to review all available literature and clinical findings related to chiropractic treatment and make a recommendation to the general assembly for the reinstatement of chiropractic services under the Medicaid program during the fiscal year 2008 budget. Work is underway and will be completed for inclusion in the fourth quarter report.

The Vermont FY07 Budget Act and the Vermont Health Care Affordability Act contain the following changes regarding cost-sharing amounts, eligibility and benefits:

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

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

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

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

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

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

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

Vermont expects to be submitting a waiver amendment request in September 2006 to operate those initiatives that require CMS approval within the framework of our approved Global Commitment to Health 1115(a) Demonstration. We will manage the program within the existing financial terms and conditions, so the request will only be for programmatic approval.

Financial Administration

No change has occurred this quarter. Consistent with 42 CFR section 438, in December 2005 Vermont submitted the actuarial certification report prepared by Milliman Consultants and Actuaries, Inc. to CMS for review. Vermont has not yet received formal feedback from CMS on the methodology used by the actuarial firm for the SFY2006 rates. Therefore, we continue to assume that the methodology is acceptable by CMS, and have extended the contract with Milliman Consultants and Actuaries, Inc. to develop the SFY2007 rates using the same methodology.

Health plan financial performance, including capitated revenue expenditures.

The state and CMS collaborated to develop reporting formats and supplemental documentation for the quarterly CMS-64 reports, as well as other financial reports required by the Demonstration's Special Terms and Conditions. We have submitted our CMS-64 reports using the formatting changes provided by CMS. Vermont remains flexible as we work through this process with CMS and reporting formats are finalized. We anticipate submission of our third quarter CMS-64 report in the near future.

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

See OVHA Work Plan (Attachment A). In addition, OVHA will be requesting several additional staff positions in order to address unanticipated and ongoing case management needs associated with the Medicare Modernization Act (MMA). If approved current staff workload will be eased, diversions in work assignments due to the MMA will cease and it is anticipated that there will be minimal to no disruptions in demonstration project work plan timelines as outlined in Attachment A.

The need for and AHS-wide cross departmental operations teams has been identified in at least four core areas. These include 1) Policy, 2) Operations, 3) Fiscal and 3) Quality Improvement. Meeting dates and membership is currently being finalized. Each team will be facilitated by an AHS and OVHA senior staff member and be composed of Deputy Commissioners and/or senior managers from departments and divisions impacted by Global Commitment. These teams will begin meeting in August and September and be responsible for ensuring that necessary changes in internal operations occur related to the OVHA/MCO work plan (Attachment A), IGA commitments and other relevant state and federal regulations.

We also are beginning to work on the details required to implement the changes identified in the Vermont Health Care Affordability Act outlined in section a) above. For, example, Attachment B represents a spreadsheet that begins to map the process for determining eligibility for the premium assistance programs.

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

OVHA has created a Program Integrity Unit and will be requesting positions to fully staff the unit in the State fiscal year beginning July 1 2006. Staffing of a complete unit will bring together the Medicaid Surveillance and Utilization Review System (SURS) Team, the Fraud Abuse Detection Decision-Support System (FADS) reporting, overall OVHA and AHS utilization review and investigative functions.

The second quarter report noted OVHA's release of a Request for Information (RFI) for an on-line decision support system had been issued. Soon after the RFI release, a decision was made to table the project pending the release of a Request for Proposals to implement two pivotal initiatives; the Chronic Care Management Intervention Services and the Health Risk Assessment Administration. It is anticipated that any vendor bidding on either of those projects will also be providing a decision support system that OVHA will be utilizing in its related care coordination projects.

AHS continues work on developing the Coverage and Service Management Enhancement (CSME) Data Warehouse, recently renamed the "Central Source Measurement and Evaluation Data Warehouse". CSME data are structured to answer questions across departments for policy, planning, legislative and program review. "CSME Release 2" is scheduled for this fall and will allow policy analyst and AHS research staff continue data validity testing while work on the addition of new data source systems are prioritized and timelines developed and security tools are put into place.

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

No change has occurred this quarter. The state and CMS currently are collaborating with regard to development of budget neutrality monitoring formats. We anticipate that reporting procedures and formats will be finalized within the next 60 days.

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

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

- **a. Mandatory State Plan Adults**
- **b. Mandatory State Plan Children**
- **c. Optional State Plan Adults**
- **d. Optional State Plan Children**
- **e. VHAP Expansion Adults**

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

f. Pharmacy Program Beneficiaries (non-Duals)
g. Other Waiver Expansion Adults

Population	Age Limit	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06
Optional	Under 21	41,205	40,907	40,838	40,842	41,646	41,727	42,272	42,179	42,012
Optional	21 and Over	15,183	15,298	15,257	15,530	15,587	15,574	16,466	16,626	16,647
Mandatory	Thru 18	14,871	14,963	14,954	15,000	14,780	14,800	14,863	14,834	14,751
Mandatory	Over 18	23,111	23,207	23,244	23,307	23,237	23,300	23,613	23,713	23,655
VHAP/Underinsured	Thru 18	1,672	1,644	1,650	1,478	1,433	1,442	1,542	1,582	1,623
VHAP/Underinsured	Over 18	20,723	20,750	20,637	20,573	21,284	21,329	22,967	22,701	22,686
Pharmacy Only/HVP	All	25,556	26,073	26,439	25,718	25,776	26,213	27,356	25,007	24,964
SCHIP	All	3,187	3,250	3,294	3,252	2,977	3,006	3,058	3,012	3,109
QI1					10	39	52	81	122	116
TOTAL		145,508	146,092	146,313	145,710	146,759	147,443	152,218	149,776	149,563

f) State's progress toward the Demonstration goals.

The Global Commitment to Health Waiver has the following goals:

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

In preparation for the August 1st arrival of the AHS Quality Improvement Manager, meetings are being scheduled for August and September of 2006 to begin discussions related to quality and outcome indicators in keeping with our stated goals.

g) State's evaluation activities.

No changes in status this quarter. The State submitted a Draft Evaluation Plan to CMS on February 16, 2006. As noted in the correspondence accompanying the draft plan, we will want to refine the evaluation plan once we have filled the new AHS Quality Improvement Manager Position, which will occur on August 1, 2006. In addition, a noted above, the demonstration evaluation will need to be closely coordinated with the monitoring activities regarding progress towards the goals of the new Health Care Reform Act. In the meantime, the preliminary draft evaluation plan provides a starting point for ensuring that we are planning in the right direction.

Attachment A

MCO Work Plan

(revised July 27, 2006)

3rd Quarterly Report Attachment A: MCO Work Plan (revised July 27, 2006)

AREA/ DESCRIPTION	TASKS	TIMELINE
MEMBER SERVICES		
Interpreter Services		
Oral interpreter services must be provided free of charge to non-English speaking enrollees who request assistance. [438.10(c)(4)]	Arrange for vendor to provide services as needed	Completed
Provider Directory		
A directory must be compiled and maintained. The directory must list the name, location and telephone numbers for all primary care and specialist providers and hospitals participating in the Medicaid program. The directory must also identify any languages other than English spoken by the provider and must include an indicator to identify those who are accepting new patients. [438.10(e)(2)(ii)(D)]	Develop web-based directory with ability to search by address, provider type, etc.	On-line directory is available and being used by Maximus to assist enrollees and providers for updates; will be available on-line to enrollees by August
	Survey providers on language capacity and open panel issues	Survey completed; used to populate new on-line directory
	Develop process for periodic updates	web-based format allows for immediate updates
Notification of Terminating Providers		
OVHA must notify an enrollee whose PCP terminates their participation in Medicaid within 15 days of the provider's notice to the state. Enrollees who are regularly seeing a provider who is not their PCP must also be similarly noticed. [438.10(f)(5)]	Develop process for identification of terminating providers	An existing requirement of provider enrollment agreement
	Draft notice to enrollees	Completed
	Identify process for determining which enrollees have been "regularly treated" by any terminating provider	4th Quarter, FFY'06
	Print and mail notices within 15 days to affected enrollees	Completed
Enrollee Handbook		
Develop and maintain a current enrollee handbook which covers how to access care, enrollee rights and responsibilities, procedures for obtaining benefits, what to do in a medical emergency and how to file a grievance or appeal. Handbooks must be distributed to new enrollees within 45 days of enrollment. Handbooks must be available in languages other than English if five (5) percent or more of Demonstration enrollees speak that language. [438.10]	Assess need for languages other than English (documentation for CMS)	Completed for PCP and CRT enrollees; available for all enrollees by Spring 2007
	Draft handbook	
	Disseminate for input, finalize based on comments received	
	Print a supply for initial distribution	
	Develop and execute handbook distribution process on an ongoing basis	
	Post handbook on website	
Advance Directives		
OVHA must prepare and make available information on Advance Directives. [438.6(h)(2)(i)]	Identify materials related to new 2005 state statute regarding Advance Directives	Link to new statewide information on EDS and OVHA web-page; Providers have been notified of link. Maximus will send to
	Obtain a supply of forms for distribution upon request	
	Post information on website	

	Draft informational notice on Advance Directives and distribute for posting in physicians' offices (EDS Newsletter)	enrollees that request it.

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

prescribed timeframes. ***An Appeal means –*** *Any request for a review of an action.* ***A Grievance is –*** *An expression of dissatisfaction with any matter other than an action (e.g., quality of care) [438.400(b)]. Resolution Timeframes: Standard Grievance – 45 days from date of receipt ([438.408(b)(1)] =90days); Standard Appeal – 45 days from date of receipt [438.408(b)(2)]; Expedited Appeal – Three (3) business days from date of receipt [438.408(b)(3)]*	Design resolution notices	
Fair Hearings		
OVHA must ensure that enrollees have the right to request a fair hearing within no less than 20 days or more than 90 days from the date of the notice of resolution of the grievance or appeal. [438.408(f)]. AHS, as the oversight entity, must ensure that the fair hearing is conducted in accordance with all applicable state and federal regulations including timeframes for the conduct of the hearing and the enrollee's due process rights.	Develop policies and procedures for coordinating between the Grievance and Appeals process and the state Fair Hearing process	New policy implemented Spring, 2007
	Develop a system for notifying enrollees at the time of the resolution of their grievance or appeal of their right to a fair hearing	
	Develop reporting system to track number, types, timeliness and resolution of fair hearings	
QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI)		
QAPI Plan		
AHS must develop a strategy and plan which incorporates procedures that: 1) Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees, including those with special health care needs [438.204(b)(1)]; 2) Identify the race, ethnicity and primary language spoken by each Demonstration enrollee [438.204(b)(2)]; 3) Provide for an annual, external independent review of the quality outcomes and timeliness of, and access to, the covered services under the Demonstration [438.204(d)]	1) Develop inventory of all QA/QI activities currently underway within OVHA and sub-contracted departments; Develop workgroup to identify new priorities; 2) Summarize into comprehensive QAPI Plan for CMS review	1st Quarter , FFY07 2nd Quarter FFY07
	3) Ensure that information is available in ACCESS eligibly system	December, 2007
	4) Expand EQRO focus beyond CRT program	4th Quarter, FFY06
Source of Primary Care		
OVHA must ensure that each Demonstration enrollee has an ongoing source of primary care. [438.208(b)(1)] It must further implement mechanisms to identify persons with special health care needs. [438.208(b)(4)(c)] The quality strategy must specify these mechanisms. [438.208(b)(4)(c)(i)]	Identification of beneficiaries not already participating through PCPLus	March 2007
	Develop policies and procedures for the selection of a PCP by each Demonstration enrollee	Completed for current PCPlus
	Design information system capacity to capture the PCP information for each enrollee	Completed
	Develop a mechanism for tracking PCP caseload	Completed
Practice Guidelines		

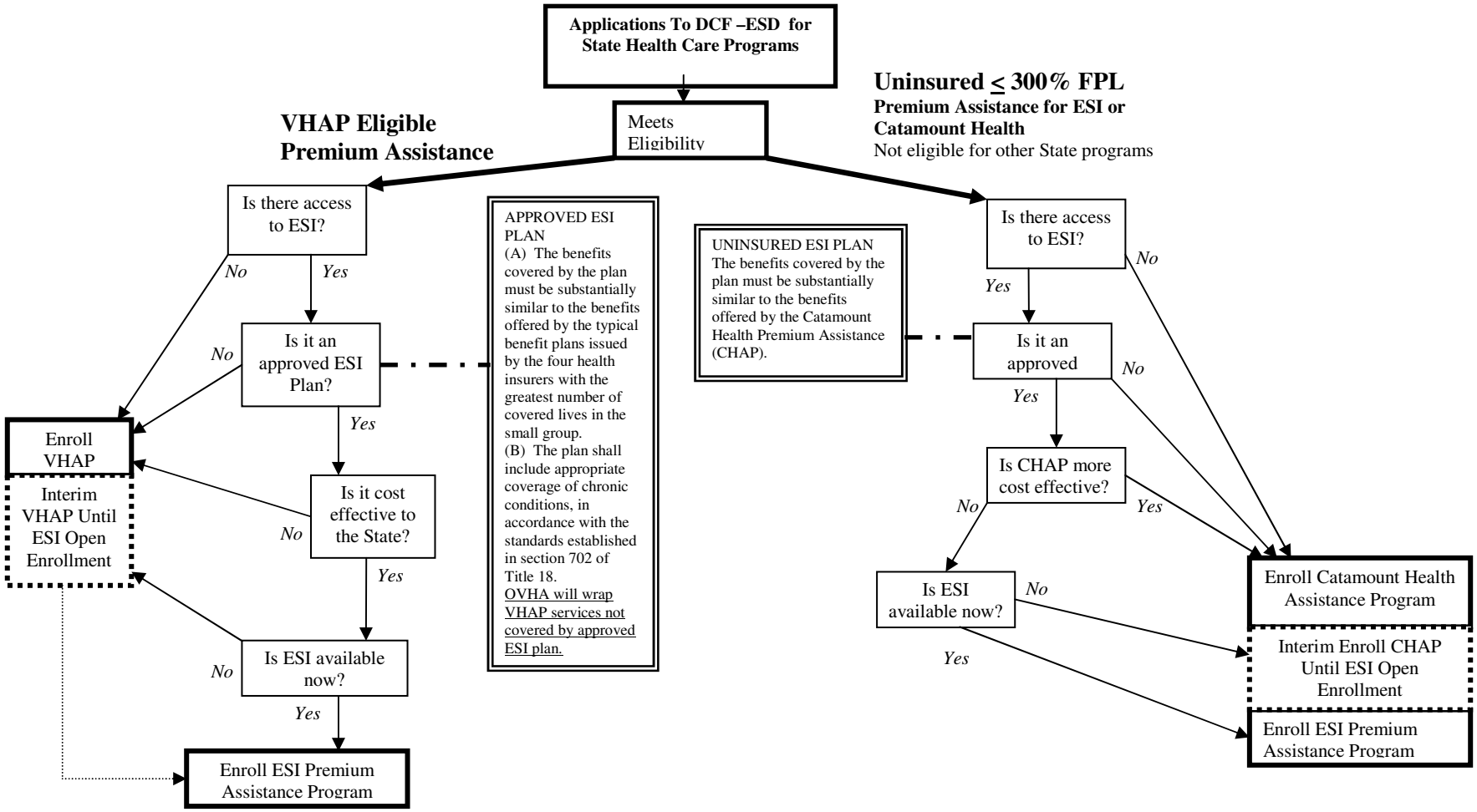
OVHA must adopt practice guidelines that are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field, and which are adopted in consultation with contracting health care professionals. [438.236(b)]	Establish a medical advisory task force of contracting professionals to provide consultation on the guidelines to be adopted for physical health issues	Completed
	Select key areas where guidelines are to be developed	Completed
	Research evidence-based guidelines and protocols for each of the key areas	Completed
	Adopt the appropriate guidelines after consultation with the task force	Completed for existing guidelines; on-going identification of new national practice guidelines
	Distribute guidelines to appropriate network providers	Completed
Measuring Performance Improvement		
AHS must operate its QAPI program on an ongoing basis and conduct performance improvement projects designed to achieve, through ongoing measurement and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Procedures must be in place to collect and use performance measurement data and to detect both under- and over-utilization of services. Mechanisms must also be in place to assess the quality and appropriateness of care furnished to enrollees with special health care needs. [438.240(a), (b), (c), & (d)]	Develop inventory of all QA/QI activities currently underway within OVHA and sub-contracted departments;	1st Quarter , FFY07 2nd Quarter FFY07
	Develop workgroup to identify new priorities;	
	Summarize into comprehensive QAPI Plan for CMS review	
PROGRAM INTEGRITY		
Actuarial Certification of Capitation Rates		
AHS must provide CMS with an actuarial certification of the capitation rates that will be used as the basis of payment of Medicaid funds to the health plan. The rates must be certified by an actuary who meets the standards established by the American Academy of Actuaries. [438.6(c)(4)(i)]	Develop database for actuaries	In process for Year 2 rates
	Establish capitation rates by MEG	
	Obtain written certification from qualified actuary	
	Submit rates to CMS	
Compliance Plan		
OVHA must also have administrative and management arrangements and/or procedures, including a mandatory compliance plan, that is designed to guard against fraud and abuse. This includes written policies, procedures and standards of conduct. A compliance officer must be designated and a compliance committee formed that is accountable to senior management. An effective training and education program must be developed and implemented for the compliance officer and other VHAP employees. [438.608(a) &(b)]	Appoint compliance officer	In substantial compliance with major expansion of activities planned
	Develop written compliance plan	
	Develop policies and procedures for program integrity	
	Develop written standards of conduct	
	Design staff training program	
	Conduct staff training	

MONITORING		
Utilization		
OVHA must monitor the program to identify potential areas of over- and under-utilization. Where such over- or under-utilization is identified, OVHA shall develop a Corrective Action Plan (CAP) for review by the AHS. [438.240(b)(3)]	Develop an overall utilization management plan for the Demonstration	Completed with ongoing activities through new Program Integrity Unit and FADS
	Identify key areas for monitoring (e.g., inpatient days, emergency visits, etc)	
	Establish thresholds for evaluating potentially inappropriately high or low levels of utilization by MEG	
Provider and Enrollee Characteristics		
OVHA's health information system must track certain characteristics of its network providers and enrollees (e.g., enrollees with special health care needs; providers with accommodations for the disabled in their offices) [438.242]	Identify outstanding issues in ACCESS and/other systems related to capturing required enrollee characteristics	4th Quarter, FFY'06
	Ensure that Provider survey captures required information and is in on-line directory	
Enrollee Rights		
Establish policies and procedures on enrollee rights consistent with the requirements of Part 438.100 of 42 CFR.	Expand existing PCP and CRT policies and procedures	Completed for PCP and CRT enrollees; available through enrollee handbook for all enrollees by September, 2007
Encounter Data Validation		
OVHA must put in place a process for validating encounter data and for reporting information on encounters/ claims by category of service. [438.242]	Expand existing processes to include sub-contracted departments.	Completed
	Implement new Fraud and Abuse Detection Decision Support System (FADS)	
ENROLLEE ACCESS & PROVIDER NETWORK		
Availability of Services		
OVHA must ensure that an adequate network of providers to provide access to all covered services is under contract to the state. This includes an assessment of geographic location of providers, considering distance and travel time, the means of transportation ordinarily used by Medicaid enrollees and whether the location provides for physical access for enrollees with disabilities. The assessment must also consider the number of network providers who are NOT accepting new Medicaid patients. OVHA must also ensure that network providers offer hours of operation that are no less than those offered to other patients. OVHA must also subcontract with other selected AHS departments that will provide services to Demonstration enrollees. [438.206]	Conduct geo-access analysis of current network	September 2006 and on-going
	Identify any existing gaps	
	Recruit additional providers as needed	
	Develop process and procedures for provider site visits if warranted	
	Develop ongoing monitoring plan for the provider network	
	Design process for collecting info on providers with closed panels (no new patients accepted) and those with access/accommodations for the physically disabled	Survey completed; information available in on-line provider directory
	Develop contracts (IGAs) with other departments	Finalized by September 2006
CMS REPORTING		
General Financial Requirements		

AHS/OVHA shall comply with all general financial requirements under Title XIX. AHS must maintain financial records, including the following: 1) Monthly comparisons of projected vs actual expenditures; 2) Monthly report of OVHA revenues and expenses for Demonstration program; 3) Monthly comparisons of projected vs actual caseload, 4) Quarterly analysis of expenditures by service type; 5) Monthly financial statements; 6) All reports and data necessary to support waiver reporting requirements [IGA 2.12.2]	Document any modifications to current report formats that will be required	On-going
	Assign staff responsible for the production and submission of the required reports	Completed
Budget Neutrality Reporting		
For the purpose of monitoring budget neutrality, within 60 days after the end of each quarter, the state shall provide to CMS a report identifying actual expenditures under the Demonstration. [STC pg. 20]	Obtain report format from CMS	Still under discussion
	Make any necessary changes to reporting processes and procedures to accommodate the CMS-specified report formats	Still under discussion
	Assign staff responsible for the production of the reports	Completed
	Develop policies and procedures for the development of corrective action plans if actual expenditures exceed the levels permissible under the Demonstration STCs (by year)	Under development

Attachment B

Flow Chart for eligibility determinations For premium assistance programs Under Vermont Health Care Affordability Act


Applications To DCF –ESD for State Health Care Programs
Meets Eligibility
VHAP Eligible
Premium Assistance
Uninsured ≤ 300% FPL
Premium Assistance for ESI or Catamount Health
Not eligible for other State programs
Is there access to ESI?
No
Yes
Is it an approved ESI Plan?
No
Yes
Enroll VHAP
Interim VHAP Until ESI Open Enrollment
Is it cost effective to the State?
No
Yes
Is ESI available now?
No
Yes
Enroll ESI Premium Assistance Program
APPROVED ESI PLAN
(A) The benefits covered by the plan must be substantially similar to the benefits offered by the typical benefit plans issued by the four health insurers with the greatest number of covered lives in the small group.
(B) The plan shall include appropriate coverage of chronic conditions, in accordance with the standards established in section 702 of Title 18.
OVHA will wrap VHAP services not covered by approved ESI plan.
UNINSURED ESI PLAN
The benefits covered by the plan must be substantially similar to the benefits offered by the Catamount Health Premium Assistance (CHAP).
Is there access to ESI?
No
Yes
Is it an approved
No
Yes
Is CHAP more cost effective?
No
Yes
Is ESI available now?
No
Yes
Enroll Catamount Health Assistance Program
Interim Enroll CHAP Until ESI Open Enrollment
Enroll ESI Premium Assistance Program