STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Medical Assistance Program

State/Territory: _____Vermont_____

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Revision: HCFA-PM-91-4 (BPD) OMB No. 0938-
August 1991

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: __VERMONT__

Citation	
	As a condition for receipt of Federal funds under title XIX of the Social Security Act, the
42 CFR 430.10	___AGENCY OF HUMAN SERVICES___ (Single State Agency)
	submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

==========

CITATION: 42 CFR 431.10 (AT-79-29)

SECTION 1 SINGLE STATE AGENCY ORGANIZATION

1.1 Designation and Authority

a. The AGENCY OF HUMAN SERVICES

is the single State agency designated to administer or supervise the administration of the Medicaid Program under Title XIX of the Social Security Act. (All references in this Plan to "the Medicaid agency" mean the agency named in this paragraph.)

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the Program.

==========

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

==========

CITATION: Section 1902 (a) of the Act

1.1 Designation And Authority (Continued)

b. The State agency that administered or supervised the administration of the Plan approved under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this Plan which relates to blind individuals.

☐ Yes. The State agency so designated is:

_____

_____

This agency has a separate Plan covering that portion of the State Plan under Title XIX for which it is responsible.

☒ Not applicable. The entire Plan under Title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

==========

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: Intergovernmental Cooperation Act of 1968

1.1 Designation And Authority (Continued)

c. Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

☐ Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.

☐ Not applicable. Waivers are no longer in effect.

☒ Not applicable. No waivers have ever been granted.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 431.10 (AT-79-29)

1.1 Designation And Authority (Continued)

d. ☐ The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for Medicaid under this Plan.

☒ Determinations of eligibility for Medicaid under this Plan are made by the agency(ies) specified in ATTACHMENT 2.2-A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this Plan. The agreement defines the relationships and respective responsibilities of the agencies.

==========

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

==========

CITATION: 42 CFR 431.10 (AT-79-29)

1.1 Designation and Authority (Continued)

e. All other provisions of this Plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under Title XI of the Act.

f. All other requirements of 42 CFR 431.10 are met.

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CITATION: 42 CFR 431.11

1.2 Organization for Administration

a. ATTACHMENT 1.2–A contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.
b. ATTACHMENT 1.2-B contains a description and organizational chart of the Department of Vermont Health Access (DVHA); DVHA has been designated as the medical assistance department.
c. ATTACHMENT 1.2-C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the Plan and their responsibilities.
d. Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1 (a).
ATTACHMENT 1.2-D contains a description of the staff designated to make such determinations and the functions they will perform.

[X] Not applicable. Only the staff of the agency named in paragraph 1.1 (a) make such determinations.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42CFR 431.50(b) (AT-79-29)

1.3 Statewide Operation

The Plan is in operation on a statewide basis in accordance with all requirements of 42 CFR 431.50.

☒ The Plan is State administered.

☐ The Plan is administered by the political subdivisions of the State and is mandatory on them.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 431.12(b) (AT-78-90)

1.4 State Medical Care Advisory Committee

There is an advisory committee to the Medicaid Agency Director On Health and Medical Care Services established in accordance with and meeting all the requirements of 42 CFR 431.12.

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Revision: HCFA-PM-94-3 (MB)
APRIL 1994
State/Territory: Vermont

Citation

1928 of the Act

1.5 Pediatric Immunization Program

1. The State has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

   a. The State program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

   b. The State will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

   c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have a limited ability to speak the English language, the State will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

   d. The State will instruct program-registered providers to determine eligibility in accordance with section 1928 (b) and (h) of the Social Security Act.

   e. The State will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The State will inform program-registered providers of the maximum fee for the administration of vaccines.

   f. The State will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

   g. Except as authorized under section 1915 (b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the State will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

Revision: HCFA-PM-94-3 (MB)
APRIL 1994
State/Territory: _____Vermont_____

Citation

1928 of the Act

2. The State has not modified or repealed any Immunization Law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The State Medicaid Agency has coordinated with the State Public Health Agency in the completion of this preprint page.

4. The State agency with overall responsibility for the implementation and enforcement of the provisions of the provisions of section 1928 is:

☐ State Medicaid Agency

☒ State Public Health Agency

State/Territory: VERMONT

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation
42 CFR 435.10 and Subpart J

2.1 Application, Determination of Eligibility and Furnishing Medicaid

(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

Revision: HCFA-PM-93-2 (MB)
March 1993

State: VERMONT

Citation				
42 CFR 435.914 1902 (a)(34) of the Act 1902(e)(8) and 1905(a) of the Act 1902(a)(47) and 1920 of the Act 42 CFR 434.20	2.1	(b)	(1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if the were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in ATTACHMENT 2.6-A.
			(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first determined to be a qualified Medicare beneficiary. ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.
			(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.
		(c)		The Medicaid agency elects to enter into a risk contract with an HMO that is--
			☒	Qualified under title XIII of the Public Health Service Act or is provisionally qualified as an HMO pursuant to section 1903(m)(3) of the Social Security Act.
			☒	Not Federally qualified, but meets the Requirements of 42 CFR 434.20(c) and is defined in ATTACHMENT 2.1-A.
			☐	Not applicable

Revision: HCFA-PM-91-6 (MB) OMB No.
September 1991

State/Territory: Vermont

Citation		
1902(a)(55) of the Act	2.1(d)	The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in §1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions.

Citation

42 CFR 435.10

2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

☐ Mandatory categorically needy and other required special groups only.

☐ Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.

☐ Mandatory categorically needy, other required special groups, and specified optional groups.

☒ Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(1) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

Citation	2.3 Residence
435.10 and 435.403, and 1902(b) of the Act, P.L. 99-272 (Section 9529) and P.L. 99-509 (Section 9405)	Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.

Citation	2.4 Blindness
42 CFR 435.530(b) 42 CFR 435.531 AT-78-90 AT-79-29	All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

Citation	2.5 Disability
42 CFR 435.121, 435.540(b) 435.541	All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of a disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b of ATTACHMENT 2.2-A of this plan.

Revision: HCFA-PM-92-1 (MB)
FEBRUARY 1992

State: VERMONT

Citation(s)	2.6	Financial Eligibility
42 CFR 435.10 and Subparts G & H 1902(a)(10)(A)(i)(III)(IV), (V), (VI), and (VII), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), 1902(a)(10)(C), 1902(f), 1902(l) and (m), 1905(p) and(s), 1902 (r)(2), and 1920		The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

Citation	2.6		
		(b)	Medically Needy
42 CFR Part 435, 435.10 and Subparts G & I, 46 FR 47976 and 1920 of the Act, P.L. 99-509 (Section 9407)			All requirements of 42 CFR Part 435, subparts G and I and Section 1920 of the Act are met with respect to the families and individuals to whom the requirements apply. The level of income and resources, expressed in total dollar amounts, that are used as a basis for establishing eligibility under the plan are described in ATTACHMENT 2.6-A. ☐ Not applicable. The medically needy are not included in the plan.
1902 (a)(10)(E) and 1905(p) of the Act, P.L. 99-509 (section 9403), P.L. 100-360, (section 301), P.L. 101-508 (section 4501)		(c)	Qualified Medicare Beneficiaries All requirements of section 1905(p) of the Act are met with respect to Qualified Medicare Beneficiaries. The level of income and resources, expressed in total dollar amounts, that are used as a basis for establishing eligibility under the plan are described in ATTACHMENT 2.6-A.
		(d)	Qualified Disabled and Working Individuals
1902(a)(10)(E) and 1905(s) of the Act, P.L. 101-239(section 6408(d))			All requirements of section 1905(s) of the Act are met with respect to Qualified Disabled and Working Individuals. The level of income and resources, expressed in total dollar amounts, that are used as a basis for establishing eligibility under the plan are described in ATTACHMENT 2.6-A.

State/Territory: VERMONT

Citation	2.7	Medicaid Furnished Out of State
431.52 and 1902(b) of the Act, P.L. 99-272 (Section 9529)		Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

Revision: HCFA-PM-94-5 (MB)
APRIL 1994

State/Territory: VERMONT

SECTION 3 - SERVICES: GENERAL PROVISIONS

Citation		
	3.1	Amount, Duration, and Scope of Services
42 CFR Part 440, Subpart B, 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act.	(a)	Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920, and 1925 of the Act

(1) Categorically needy.

Services for the categorically needy are described below and in ATTACHMENT 3.1-A. These services include:

(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 1905® and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

☐ Not applicable. Nurse-midwives are not authorized to practice in this State.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: VERMONT

Citation			Amount, Duration, and Scope of Services: Categorically Needy (Continued)
1902(e)(5) of the Act	3.1(a)(1)		
1902(a)(10), clause (VII) of the matter following (E) of the Act		(iii)	Pregnancy-related, including family planning services, and postpartum services for a 60 day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.
	☒	(iv)	Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.
		(v)	Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

Revision: HCFA-PM-92-7 (MB)
October 1992

State/Territory: VERMONT

Citation

3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1902(e)(7) of the Act

(vi) Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1(b) of this plan.

1902(e)(9) of the Act

(vii) Inpatient services that are being furnished to infants and children described in section 1902(1)(1)(B) through (D), or section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which inpatient services are furnished.

1902(a)(52) and 1925 of the Act

☐ (viii) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1 (h) of this plan.

1905(a)(23) and 1929

(ix) Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.

☐ (x) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

Citation	3.1	Amount, Duration, and Scope of Services (Cont'd)
42 CFR Part 440, Subpart B	(a)(2)	Medically needy.
		☒ This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.
		Services for the medically needy include:
1902(a)(10)(C)(iv) of the Act, 42 CFR 440.220		(i) If services in an institution for mental diseases (42 CFR 440.140 and .160) or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1) through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in sections 1902, 1905, and 1915 of the Act.
		☐ Not applicable with respect to nurse-mid-wife services under section 1905(a)(17). Nurse-midwives are not authorized to practice in this State.
1902(e)(5) of the Act		(ii) Prenatal care and delivery services for pregnant women.

Citation

3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

☒ (iv) Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

(v) Ambulatory services, as defined in ATTACHMENT 3.1-B for recipients under age 18 and recipients entitled to institutional services.

☐ Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services of the medically needy.

(vi) Home health services to recipients entitled to nursing facility services as indicated in item 3.1(b) of this plan.

42 CFR 440.140, 440.150, 440.160 Subpart B, 442.441 Subpart C, 1902 (a)(20) and (21) of the Act

☒ (vii) Services in an institution for mental diseases for individuals over 65.

☒ (viii) Services in an intermediate care facility for the mentally retarded.

☒ (ix) Inpatient psychiatric services for individuals under age 21.

Citation

1902(e) (9) of Act

1905(a) (23) and 1929 of the Act

3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

☐ (x) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1(h) of this plan.

☐ (xi) Home and Community care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

State: Vermont

Citation

3.1 Amount, Duration, and Scope of Services (Continued)

1902(a)(10)(E)(i) and clause (VIII) of the matter following (F), and 1905(p)(3) of the Act.

(a)(3) Other Required Special Groups: Qualified Medicare Beneficiaries

Medicare cost sharing for qualified Medicare beneficiaries described in section 1905(p) of the Act is provided only as indicated in item 3.2 of this plan.

1902(a)(10)(E)(ii) and 1905(s) of the Act.

(a)(4)(i) Other Required Special Groups: Qualified Disabled and Working Individuals

1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act

Medicare Part A premiums for qualified disabled and working individuals described in section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.

1902(a)(10)(E)(iv)(I), 1905(p)(3)(A)(ii), and 1933 of the Act.

(ii) Other Required Special Groups: Specified Low-Income Medicare Beneficiaries

Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902(a)(10)(E)(iii) of the Act are provided as indicated in item 3.2 of this plan.

(iii) Other Required Special Groups: Qualifying Individuals - 1

Medicare Part B premiums for qualifying individuals described in Section 1902(a)(10)(E)(iv)(I) and subject to section 1933 of the Act are provided as indicated in item 3.2 of this plan.

Revision: HCFA-PM-97-3 (CMS)
December 1997

State: Vermont

Citation

3.1 Amount, Duration, and Scope of Services (Continued)

1902(a)(10)(E)(iv)(II)
1905(p)(3)(A)(iv)(II),
1905(p)(3)of the Act

(iv) Other Required Special Groups: Qualifying Individuals - 2

The portion of the amount of increase to the Medicare Part B premium attributable to the Home Health provisions for qualifying individuals described in section 1902(A)(10)(E)(iv) (II) and subject to section 1933 of the Act are provided as indicated in item 3.2 of this plan.

1925 of the Act

(a)(5) Other Required Special Groups: Families Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

Citation 3.1 Amount, Duration, and Scope of Services (Continued)

Sec. 245A(h) of the Immigration and Nationality Act

(a)(6) Limited Coverage for Certain Aliens

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they--

(A) Are aged, blind or disabled individuals as defined in section 1614(a)(1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L. 96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

Citation	3.1 (a)(6)	Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (Continued)
1902(A) and 1903(v) of the Act		(iii) Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.
1905(a)(9) of the Act	(a)(7)	Homeless Individuals. Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
1902(a)(47) and 1920 of the Act	☐ (a)(8)	Presumptively Eligible Pregnant Women Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
42 CFR 441.55, 50 FR 43654, 1902(a)(43), 1905(a)(4)(B), and 1905(r)of the Act	(a)(9)	EPSDT Services The Medicaid agency meets the requirements of sections 1905(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

Citation		3.1 (a)(9) Amount, Duration, and Scope of Services: EPSDT Services (Continued)
42 CFR 441.60	☐	The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.
42CFR 440.240 and 440.250	(a)(10)	Comparability of Services
1902(a), 1902 (a)(10), 1902(A)(52), 1903(v), 1915(g), and 1925(b)(4) of the Act		Except for those items or services for which sections 1902(a) and 1902(a)(10), 1903(v), 1915 and 1925 of the Act, 42CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:
		(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person
		(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.
		(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.
	☒	(iv) Additional coverage for pregnancy-related services and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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Citation 42 CFR Part 440, Subpart B & 42 CFR 441.15 (AT-78-90 & AT-80-34)

3.1 Amount, Duration, and Scope of Services: EPSDT Services (Continued)

b. Home health services are provided in accordance with the requirements of 42 CFR 441.15.

1. Home health services are provided to all categorically needy individuals 21 years of age or over.

2. Home health services are provided to all categorically needy individuals under 21 years of age.

☒ Yes

☐ Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

3. Home health services are provided to the medically needy:

☒ Yes, to all

☐ Yes, to individuals age 21 or over; SNF services are provided

☐ Yes, to individuals under age 21; SNF services are provided.

☐ No; SNF services are not provided.

☐ Not applicable; the medically needy are not included under this Plan.

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Revision: HCFA-PM-93-8 (BPD)

State/Territory: VERMONT

Citation 3.1 Amount, Duration, and Scope of Services: (Continued)

42 CFR 431.53 (c)(1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.

42 CFR 483.10 (c)(2) Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c)(8)(i).

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 440.260 (AT-78-90)

3.1 Amount, Duration And Scope Of Services (Continued)

d. Methods And Standards To Assure Quality Of Services

The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.

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CITATION: 42 CFR 441.20 (AT-78-90)

3.1 Amount, Duration And Scope Of Services (Continued)

e. Family Planning Services

The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

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Citation		
	3.1 (f) (1)	Optometric Services
42 CFR 441.30 AT-78-90		Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist ☐ Yes. ☐ No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform. ☒ Not applicable. The conditions in the first sentence do not apply.
1903(i)(l) of the Act, P.L. 99-272 (Section 9507)	(2)	Organ Transplant Procedures Organ transplant procedures are provided. ☐ No. ☒ Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

* U.S. GOVERNMENT PRINTING OFFICE: 1987 - 1 8 1 - 2 7 0 / 6 0 1 7 4

Citation
42 CFR 431.110(b)
AT-78-90
1902(e)(9) of the Act,
P.L. 99-509 (Section
9408)

3.1 (g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902(e)(9)(C) of the Act, are provided under the plan to individuals who--

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of--

☐ 30 consecutive days;

☐ ___ days (the maximum number of inpatient days allowed under the State plan);

(3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

(4) Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at hone.

☐ Yes. The requirements of section 1902(e)(9) of the Act are met.

☒ Not applicable. These services are not included in the plan.

Revision: HCFA-PM-93-5 (MB)
MAY 1993

State: __Vermont__

Citation

1902(a)(10)(E)(i) and
l905(p)(l) of the Act

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-In agreement for:

☒ PartA ☒ Part B

☐ The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

Revision: HCFA-PM-97-3 (CMS)
December 1997

State: __Vermont__

Citation	3.1	Amount, Duration, and Scope of Services (Continued)
1902(a)(10)(E)(ii) and 1905(s) of the Act	(ii)	Qualified Disabled and Working Individual (QDWI) The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in ATTACHMENT 4.18-E, for individuals in the QDWI group defined in item A.26 of ATTACHMENT 2.2-A of this plan.
1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act	(iii)	Specified Low-Income Medicare Beneficiary (SLMB) The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of ATTACHMENT 2.2-A of this plan.
1902(a)(l0)(E)(iv)(I), 1905(p)(3)(A)(ii), and 1933 of the Act	(iv)	Qualifying Individual - 1 (QI-1) The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in section 1902(a)(10)(E)(iv)(I) and subject to section 1933 of the Act.
1902(a)(10)(E)(iv)(II), 1905(p)(3)(A)(ii), and 1933 of the Act	(v)	Qualifying Individual - 2 (QI-2) The Medicaid agency pays the portion of the amount of increase to the Medicare Pan B premium attributable to the Home Health Provision to the individuals described in section 1902(a)(10)(E)(iv) (II) and subject to section 1933 of the Act.

Revision: HCFA-PM-97-3 (CMS)
December 1997

State: __Vermont__

Citation

3.1 Amount, Duration, and Scope of Services (Continued)

1843(b) and 1905(a) of the Act and 42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

☒ All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); (b) receiving State supplements under title XVI; or (c) within a group listed at 42 CFR 431.625(d)(2).

☐ Individuals receiving title II or Railroad Retirement benefits.

☐ Medically needy individuals (FFP is not available for this group).

1902(a)(30) and 1905(a) of the Act

(2) Other Health Insurance

☒ The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

Revision: HCFA-PM-93-2 (MB)

State: VERMONT

Citation

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902(a)(30), 1902(n), 1905 (a), and 1916 of the Act

Supplement 1 to ATTACHMENT 4.19-B describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902 (a)(10)(E)(i) and 1905(p)(3) of the Act

(i) Qualified Medicare Beneficiaries (QMBs)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

1902(a)(10), 1902(a)(30), and 1905(a) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2(a)(1)(iv), payment is made as follows:

42 CFR 431.625

☒ For the entire range of services available under Medicare Part B.

☐ Only for the amount, duration, and scope of services otherwise available under this plan.

1902(a)(10), 1902(a)(30), 1905(a), and 1905(p) of the Act

(iii) Dual Eligibility--QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible as both QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

State/Territory: ___VERMONT___

Citation	Condition	or Requirement
1906 of the Act 1902(a)(10) (F) of the Act	(c)	Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans. When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22(h).
	(d) ☐	The Medicaid agency pays premiums for individuals described in item 19 of Attachment 2.2-A.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 441. 101 & 42 CFR 431.620(c) and (d) (AT-79-29)

3.3 Medicaid For Individuals Age 65 Or Over In Institutions For Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

☒ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620(c) and (d) are met.

☐ Not applicable. Medicaid is not provided to aged individuals in such institutions under this Plan.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 441.252 (AT-78-99)

3.4 Special Requirements Applicable To Sterilization Procedures

All requirements of 42 CPR Part 441, Subpart F are met.

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State: VERMONT

Citation
1902(a)(52) and 1925
of the Act

3.5 Families Receiving Extended Medicaid Benefits

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health, insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

☒ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

☐ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

☐ Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

☐ Medical or remedial care provided by licensed practitioners.

☐ Home health services.

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

- ☐ Private duty nursing services.
- ☐ Physical therapy and related services.
- ☐ Other diagnostic, screening, preventive, and rehabilitation services.
- ☐ Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.
- ☐ Intermediate care facility services for the mentally retarded.
- ☐ Inpatient psychiatric services for individuals under age 21.
- ☐ Hospice services.
- ☐ Respiratory care services,
- ☐ Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

State: VERMONT

Citation

3.5 Families Receiving Extended Medicaid Benefits (Continued)

(c) ☐ The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance--
☐ 1st 6 months ☐ 2nd 6 months

☐ The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.
☐ 1st 6 months ☐ 2nd 6 months

(d) ☐ (1) The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

☐ Enrollment in the family option of an employer's health plan.

☐ Enrollment in the family option of a State employee health plan.

☐ Enrollment in the State health plan for the uninsured.

☐ Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

State: ____VERMONT____

Citation

3.5 Families Receiving Extended Medicaid Benefits (Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

☐ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

State/Territory _____Vermont_____

☐ Enrollment in an eligible health maintenance organization (HMO) that has an enrollment of less than 50 percent of Medicaid recipients who are not recipients of extended Medicaid.

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency -

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

☐ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

Revision: HCFA – Region I
December 1990

State/Territory: _____Vermont_____

Sec 1905(o)(3) of the Act. (Sec 6408(c) of P.L. 101-239 and Sec 4705 of P.L. 101-508)

3.8 Additional Amounts for Nursing Facility Residents

When hospice care is furnished to an individual residing in a nursing facility, the hospice is paid an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility. The additional amount paid to the hospice on behalf of an individual residing in a nursing facility equals at least 95 percent of the per diem rate that would have been paid to the nursing facility for that individual in that facility under this State Plan.

Revision: HCFA - Region I
December 1991

State: _____Vermont_____

1902(a)(54)
1903(i)(10)
1927
P.L. 101-508
(s. 4401)

3.9 Reimbursement for Prescribed Drugs

The State meets all requirements applicable to reimbursement for prescribed drugs.

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation		
42 CFR 431.15 AT-79-29	4.1	Methods of Administration The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

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CITATION: 42 CFR 431.202 (AT-79-29 & AT-80-34)

4.2 Hearings For Applicants And Recipients

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

The Commissioner of the Department of Social Welfare may review an applicants complaint and determine whether or not the applicant is entitled to have the relief being sought throughout the fair hearing process

Citation	4.3	Safeguarding Information on Applicants and Recipients
42 CFR 431.301 AT-79-29		Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.
52 FR 5967		All other requirements of 42 CFR Part 431, Subpart F are met.

Citation	4.4	Medicaid Quality Control
42 CFR 431.800(c) 50 FR 21839 1903(u)(l)(D) of the Act, P.L. 99-509 (Section 9407)	(a)	A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.
	(b)	The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h), (j) and (k).

☐ Yes.

☒ Not applicable. The State has an approved Medicaid Management Information System (MMIS).

State/ Territory: _____Vermont_____

4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

Citation

Section 1902(a)(80) of the Social Security Act, P.L. 111-148 (Section 6505)

___X___ The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

Citation		
42 CFR 455.12 AT-78-90 48 FR 3742 52 FR 48817	4.5	Medicaid Agency Fraud Detection and Investigation Program The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

New: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: VERMONT

Citation	4.5a	Medicaid Agency Fraud Detection and Investigation Program
Section 1 902(a)(64) of the Social Security Act P.L. 105-33		The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

State: _____Vermont_____

4.5b Medicaid Recovery Audit Contractor Program

Citation

Section 1902(a)(42)(B)(i) of the Social Security Act

☐ The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.

☒ The State is seeking an exception to establishing such program for the following reasons:

More than 95 percent of Vermont's Medicaid beneficiaries are enrolled in a managed care model. Additionally, under the Global Commitment to Health Waiver, the Special Terms & Conditions (STC) 15 indicates that the Department of Vermont Health Access (DVHA) "shall comply with federal program integrity and audit requirements as if it were a managed care organization for services and populations covered under the demonstration."

This SPA will be in effect as long as the current GC Waiver is in effect. At the expiration of the waiver's renewal period (12/31/2016), Vermont must submit to CMS either:

a) A new request for an exemption; or
b) A SPA establishing a Medicaid RAC program.

Section 1902(a)(42)(B)(ii)(I) of the Act

☐ The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.*

Place a check mark to provide assurance of the following:

☐ The State will make payments to the RAC(s) only from amounts recovered.

☐ The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.

Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act

The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):

☐ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.

☐ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 431.16 (AT-79-29)

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CRF 431.17 (AT-79-29)

4.7 Maintenance Of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the Plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 431.18(b) (AT-79-29)

4.8 Availability Of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State Office and in each local and District Office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

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TITLE XIX

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 433.37 (AT-78-90)

4.9 Reporting Provider Payments To Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by Social Security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the Plan.

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New: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: VERMONT

Citation	4.10 Free Choice of Providers
42 CFR 431.51 AT-78-90 46 FR 48524 48 FR 23212 1902(a)(23) of the Act P.L. 100-93 (Section 8(f)) P.L. 100-203 (Section 4113)	(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis. (b) Paragraph (a) does not apply to services furnished to an individual – (1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or (2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or (3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act, or
Section 1902(a)(23) of the Social Security Act P.L. 105-33	(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services. (c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1915(b)(1), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).

CITATION: 42 CFR 431.610 (AT-78-90 & AT-80-34)

4.11 Relations With Standard-Setting And Survey Agencies

a. The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private and public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is the:

DEPARTMENT OF AGING AND DISABILITIES

b. The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are) the:

DEPARTMENT OF AGING AND DISABILITIES

c. ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

CITATION: 42 CFR 431.610 (AT-78-90 & AT-89-34)

4.11 Relations With Standard-Setting And Survey Agencies (continued)

d. The Department of Aging and Disabilities, which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements of participation in the Medicaid Program. The requirements in 42 CFR 431.610 (e), (f), and (g) are met.

Revision: HCFA-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 431.105(b) (AT-78-90)

4.12 Consultation To Medical Facilities

a. Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

b. Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

☐ Yes, as listed below:

☒ Not applicable. Similar services are not provided to other types of medical facilities.

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Citation

4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107

(a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

42 CFR Part 483, 1919 of the Act

(b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.

42 CFR Part 483, Subpart D

(c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.

1920 of the Act

(d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section l920(b)(2) and (c) are met.

☒ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

State/Territory: _____VERMONT_____

Citation
1902 (a)(58) 4.13 (e) For each provider receiving funds under the plan, all the requirements for advance directives of
1902(w) section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether

statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Health maintenance organizations at the time of enrollment of the individual with the organization.

(3) Attachment 4.34-A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

☐ Not applicable. No State law or court decision exist regarding advance directives.

State/Territory: Vermont

Citation

4.14 Utilization/Quality Control

42 CFR 431.60
42 CFR 456.2
50 FR 15312
1902(a)(30)(c) and
1902(d) of the Act,
P.L. 99-509
(Section 9431)

(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met.

☒ Directly

☐ By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO--

(1) Meets the requirements of §434.6(a);

(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;

(3) Identifies the services and providers subject to PRO review;

(4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and

(5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

☐ Quality review requirements described in section 1902(a)(30)(C) of the Act relating to services furnished by HMOs under contract are undertaken through contract with the PRO designed under 42 CFR Part 462.

1902(a)(30)(c) and
1902(d) of the Act,
P.L. 99-509
(section 9431)

☐ By undertaking quality review of services furnished under each contract with an HMO through a private accreditation body.

Citation
42CFR 456.2
50 FR 15312

4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part. 456, Subpart C, for control of the utilization of inpatient hospital services.

☐ Utilization and Medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

- ☐ All hospitals (other than mental hospitals).
- ☐ Those specified in the waiver.
- ☒ No waivers have been granted.

State/Territory: _____Vermont_____

Citation
42 CFR 456.2
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

☐ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

☐ All mental hospitals.

☐ Those specified in the waiver.

☒ No waivers have been granted.

☐ Not applicable. Inpatient services in mental hospitals are not provided under this plan.

Revision: HCFA-PM-85-3 (BERC)
MAY 1985

State: ____Vermont_____

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

☐ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

☐ All skilled nursing facilities.

☐ Those specified in the waiver.

☒ No waivers have been granted.

State: _____Vermont_____

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 ☒ (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

☐ Facility-based review.

☐ Direct review by personnel of the medical assistance unit of the State agency.

☐ Personnel under contract to the medical assistance unit of the State agency.

☐ Utilization and Quality Control Peer Review Organizations.

☐ Another method as described in ATTACHMENT 4.14-A.

☒ Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

☐ Not applicable. Intermediate care facility services are not provided under this plan.

Revision: HCFA-PM-91-10 (MB)
December 1991

State/Territory: _____Vermont_____

Citation

4.14 Utilization/Quality Control (Continued)

1902 (a) (30) and 1902(d) of the Act, P.L. 99-509 (Section 9431), P.L. 99-203 (section 4113)

(f) The Medicaid agency meets the requirements of section 1902(a)(30) of the Act for control of the assurance of quality furnished by each health maintenance organization under contract with the Medicaid agency. Independent, external quality reviews are performed annually by:

☐ A Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ A private accreditation body.

☐ An entity that meets the requirements of the Act, as determined by the Secretary.

The Medicaid agency certifies that the entity in the preceding subcategory under 4.14(f) is not an agency of the state.

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: _____Vermont_____

Citation	4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals
42 CFR Part 456 Subpart I, and 1902(a)(31) and 1903(g) of the Act	☐ The State has contracted with a Peer Review organization (PRO) to perform inspection of care for: ☐ ICFs/MR; ☐ Inpatient psychiatric facilities for recipients under age 21; and ☐ Mental Hospitals.
42 CFR Part 456 Subpart A and 1902(a)(30) of the Act	☒ All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services. ☐ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan. ☐ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan. ☐ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 431.615(c) (AT-78-90)

4.16 Relations with State Health And Vocational Rehabilitation Agencies And Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with Title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: VERMONT

Citation
42 CFR 433.36(c)
1902(a)(18) and
1917(a) and (b) of the
Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

☐ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c) - (g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

☐ The State imposes liens on real property on account of benefits incorrectly paid.

☐ The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

☐ The State imposes liens on both real and personal property of an individual after the individual's death.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____VERMONT_____

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36(h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

☐ Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917(a)(1)(B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

☐ In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State plan as listed below:

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____VERMONT_____

(b) Adjustments or Recoveries (Continued)

(3) Continued

Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____VERMONT_____

(4) ☐ The State disregards assets or resources for individuals who receive or are entitled to-receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, Supplement 8b.

☒ The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy - based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

☐ The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

☐ The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: VERMONT

(C) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h)-(i).

(1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) with respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: VERMONT

(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

(3) Defines the following terms:

- estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
- individual's home,
- equity interest in the home,
- residing in the home for at least 1 or 2 years,
- on a continuous basis,
- discharge from the medical institution and return home, and
- lawfully residing.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____VERMONT_____

(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustment or recovery is not cost-effective. Defines cost- effective and includes methodology or thresholds used to determine cost-effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

Citation

4.18 Recipient Cost Sharing and Similar Charges

42 CFR 447.51 through 447.58

(a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b) of the Act

(b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section l905(p)(l) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

☐ Age 19

☐ Age 20

☒ Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

Citation 4.18 (b)(2) (Continued)

42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women.

☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a health maintenance organization in which the individual is enrolled.

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

Citation

4.18 (b) (Continued)

42 CFR 447.51 through 447.58

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

☐ 18 or older

☐ 19 or older

☐ 20 or older

☒ 21 or older

☐ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

Citation
42 CFR 447.51 through
447.58

4.18 (b)(3) (Continued)

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

☐ Not applicable. There is no maximum.

Citation		
1916(c) of the Act	4.18 (b) (4) ☐	A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902(a)(52) and 1925(b) of the Act	4.l8 (b) (5) ☐	For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
1916(d) of the Act	4.18 (b) (6) ☐	A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section l902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.19-E specifies the method and standards the State uses for determining the premium.

Citation
42 CFR 447.51 through 447.58

4.18 (c) ☒ Individuals are covered as medically needy under the plan.

(1) ☐ An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through 447.58

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

☐ Age 19

☐ Age 20

☒ Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

Citation

4.18 (c)(2) (Continued)

42 CFR 447.51 through 447.58

1916 of the Act, P.L. 99—272 (Section 9505), 447.51 through 447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

(viii) Services provided by a health maintenance organization (MMD) to enrolled individuals.

☒ Not applicable. No such charges are imposed.

Citation 4.18 (c) (3) Unless a waiver under 42 CFR 431.55(g) applies; nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

☐ 18 or older

☐ 19 or older

☐ 20 or older

☒ 21 or older

Reasonable categories of individuals who are l8 years of age, but under 21, to whom charges apply are listed below, if applicable.

Citation

4.18 (c) (3) (Continued)

447.51 through 447.58

(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

☐ Not applicable. There is no maximum.

Citation 4.19 Payment for Services

42 CFR 447.252, 1902(a)(13), and 1923 of the Act

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

☒ Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

☐ Inappropriate level of care days are not covered.

Citation		
42 CFR 447.201, 42 CFR 447.302, 52 FR 28648, 1902(a)(13)(E), 1903(a)(1) and (n), 1920, and 1926 of the Act	4.19 (b)	In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements:
1902(a)(10), an 1902(a)(30) of the Act		(1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).
		(2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.
		ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.
		SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

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CITATION: 42 CFR 447.40 (AT-78-90)

4.19 Payment For Services (Continued)

c. Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

☒ Yes. The State's policy is described in ATTACHMENT 4.19-C.

☐ No.

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State/Territory: Vermont

Citation
42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141

4.19 (d)

☒ (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

(2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

☒ At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

☐ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

☐ Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

☒ At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

☐ At a rate established by the State, which meets the requirements of 42 CFR Part 441, Subpart C, as applicable.

☐ Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

☐ (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 447.45(c) (AT-79-50)

4.19 Payment For Services (Continued)

e. The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims.

ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

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Citation		
42 CFR 447.15, AT-78-90, AT-80-34, 48 FR 5730	4.19	(f) The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15. No provider participating under this plan may deny services to any individual eligible under the plan on account of the individuals inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 447.201 & 42 CFR 447.202 (AT-78-90)

4.19 Payment For Services (Continued)

g. The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

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Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State: VERMONT

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CITATION: 42 CFR 447.201 & 42 CFR 447.203 (AT-78-90)

4.19 Payment For Services (Continued)

h. The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 447.201 & 42 CFR 447.204 (AT-78-90)

4.19 Payment For Services (Continued)

i. The Medicaid agency's payments are sufficient to enlist enough providers so that services under the Plan are available to recipients at least to the extent that those services are available to the general population.

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Citation		
42 CFR 447.201 and 447.205	4.19	(j) The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(v) of the Act		(k) The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

Revision: HCFA-PM-92-7 (MB)
October, 1992

State/Territory: Vermont

Citation		
1903(i)(14) of the Act	4.19 (1)	The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

Revision: HCFA-PM-94-8 (MB)
OCTOBER 1994

State/Territory: Vermont

Citation | 4.19 (m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928(c)(2)(C)(ii) of the Act

(i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

☐ sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

☐ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

☐ sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

☒ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine: $6.00

1926 of the Act

(iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

Vermont is a Universal Purchase State.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 447.25(b) (AT-78-90)

4.20 Direct Payments To Certain Recipients For Physicians' Or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

☐ Yes, for:

☐ Physicians' services.

☐ Dentists' services.

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

☒ Not applicable. No direct payments are made to recipients.

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CITATION: 42 CFR 447.10(c) (AT-78-90) 46 FR 42699

4.21 Prohibition Against Reassignment Of Provider Claims

Payment for Medicaid services furnished by any provider under this Plan is made only in accordance with the requirements of 42 CFR 447.10.

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Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: _____Vermont_____

Citation	4.22 Third Party Liability
42 CFR 433.137	(a) The Medicaid agency meets all requirements of:
	(1) 42 CFR 433.138 and 433.139.
	(2) 42 CFR 433.145 through 433.148.
1902(a)(25)(H) and (I) of the Act	(3) 42 CFR 433.151 through 433.154.
	(4) Sections 1902(a)(25)(H) and (I) of the Act.
42 CFR 433.138(f)	(b) ATTACHMENT 4.22-A --
	(1) Specifies the frequency with which the data exchanges required in §433.138(d)(l), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;
42 CFR 433.138(g)(1)(ii) and (2)(ii)	(2) Describes the methods the agency uses for meeting the follow up requirements contained in §433.138(g)(1)(i) and (g)(2)(i);
42 CFR 433.138(g)(3)(i) and (iii)	(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources; and
42 CFR 433.138(g)(4)(i) through (iii)	(4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: Vermont

Citation	
42 CFR 433.139(b)(3)(ii)(A)	☐ (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
42 CFR 433.139(b)(3)(ii) (C) 42 CFR 433.139(f)(2) 42 CFR 433.139(f)(3) 42 CFR 447.20	(d) ATTACHMENT 4.22-B specifies the following: (1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C). (2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective. (3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
	(e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

State/Territory: Vermont

Citation 4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

☒ State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

☐ Other appropriate State agency(s) --

☐ Other appropriate agency(s) of another State

☐ Courts and law enforcement officials.

1902(a)(60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

☐ The Secretary's method as provided in the State Medicaid Manual, Section 3910.

☒ The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

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CITATION: 42 CFR Part 434.4 (48 FR 54013)

4.23 Use Of Contracts

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

☒ Not applicable. The State has no such contracts.

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Revision: HCFA-PM-94-2 (BPD)
APRIL 1994

State/Territory: _____Vermont_____

Citation		
42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 P.L 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826	4.24	Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met. ☐ Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 431.702 (AT-78-90)

4.25 Program For Licensing Administrators Of Nursing Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

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Revision: HCFA-PM- (MB)

State/Territory: _____Vermont_____

Citation	4.26 Drug Utilization Review Program
1927(g), 42 CFR 456.700	A. l. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.
1927(g)(l)(A)	2. The DUR program assures that prescriptions for outpatient drugs are: • Appropriate • Medically necessary • Are not likely to result in adverse medical results
1927(g)(1)(a), 42 CFR 456.705(b) and 456.709(b)	B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as: • Potential and actual adverse drug reactions • Therapeutic appropriateness • Overutilization and underutilization • Appropriate use of generic products • Therapeutic duplication • Drug disease contra-indications • Drug-drug interactions • Incorrect drug dosage or duration of drug treatment • Drug-allergy interactions • Clinical abuse/misuse
42 CFR 456.703 1927(g)(1)(B)(d) and (f)	C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia: • American Hospital Formulary Service Drug Information • United States Pharmacopeia – Drug Information • American Medical Association Drug Evaluations

Revision: HCFA-PM- (MB)

State/Territory: _____Vermont_____

Citation		
1927(g) (1) (D), 42 CFR 456.703(b)	D.	DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in: • Prospective DUR • Retrospective DUR.
1927 (g) (2) (A), 42 CFR 456.705(b)	E. 1	The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.
1927(g) (2) (A) (i), 42 CFR 456.705(b), (1)-(7)	2.	Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to: • Therapeutic duplication • Drug-disease contra-indications • Drug-drug interactions • Drug-interactions with non-prescript ion or over-the-counter drugs • Incorrect drug dosage or duration of drug treatment • Drug allergy interactions • Clinical abuse/misuse
1927(g) (2) (A) (ii), 42 CFR 456.705 (c) and (d)	3.	Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.
1927(g) (2) (B), 42 CFR 456.709(a)	F. 1.	The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify: • Patterns of fraud and abuse • Gross overuse • Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

Citation

1927(g)(2)(C), 42 CFR 456.709(b)

F. 2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug-disease contra-indications
- Drug-drug interactions
- Incorrect drug dosage/duration of drug treatment
- Clinical abuse/misuse

1927(g)(2)(D), 42 CFR 456.711

3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

G. 1. The State has established a State DUR Board either:

1927(g)(3)(A), 42 CFR 456.716(a)

☒ Directly, or
☐ Under contract with a private organization

1927(g)(3)(B), 42 CFR 456.716(A) and (B)

2. The DUR Board membership includes health professionals (at least one-third licensed actively practicing pharmacists and at least one-third but no more than one-half licensed and actively practicing physicians) appointed by the Commissioner of the Department of Vermont Health Access (DVHA) and approved by the Governor, with knowledge and experience in one or more of the following:

- Clinically appropriate prescribing of covered outpatient drugs.
- Clinically appropriate dispensing and monitoring of covered outpatient drugs.
- Drug use review, evaluation and intervention.
- Medical quality assurance.

1927(g)(3)(C), 42 CFR 456.716(d)

The board may include other members as proposed by the Commissioner of the DVHA and approved by the Governor. Members serving on the board as of September 8, 2010, shall be reappointed by the Commissioner to serve staggered one- and two-year terms. As of September 8, 2010, a board member having served the equivalent of two consecutive full terms on the date his or her term expires, shall not be eligible for re-appointment for a period of two years.

Effective September 8, 2010, new board members shall be appointed to staggered two-year terms and shall not serve more than two consecutive full terms. After serving for two consecutive full terms the member shall not be eligible for reappointment for a period of two years. The chair shall be elected by vote of the members.

3. DUR Board duties include:
   - Retrospective DUR,
   - Application of Standards as defined in section 1927(g)(2)(C)
   - Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.
   - Making recommendations to Commissioner for the adoption of the preferred drug list.
   - Board shall meet at least quarterly.
   - Board shall review all drug classes included in the preferred drug list at least every 12 months and may recommend that the Commissioner make additions to or deletions from the preferred drug list.

Citation		
1927(g)(3)(C), 42 CFR 456.711 (a)-(d)		G. 4. The interventions include in appropriate instances: – Information dissemination – Written, oral, and electronic reminders – Face-to-Face discussions – Intensified monitoring/review of prescribers/dispensers
1927(g)(3)(D), 42 CFR 456.712 (A) and (B)		H. The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.
1927(h)(l), 42 CFR 456.722	*☒	I. 1. The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line: – real time eligibility verification – claims data capture – adjudication of claims – assistance to pharmacists, etc. applying for and receiving payment.
1927(g)(2)(A)(i), 42 CFR 456.705(b)	*☒	2. Prospective DUR is performed using an electronic point of sale drug claims processing system.
l927(j)(2), 42 CFR 456.703(c)		J. Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

* effective 9/27/93

* U.S. G.P.O.: 1993-342-239:80043

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 431.115(c) (AT-78-90 & AT-79-74)

4.27 Disclosure Of Survey Information And Provider Or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

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State/Territory: Vermont

Citation	4.28 Appeals Process
42 CFR 431.152; AT-79-18 52 FR 22444; Secs. 1902(a)(28)(D)(i), and 1919(e)(7) of the Act; P.L.100-203 (Sec. 4211(c)).	(a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154. (b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

New: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: VERMONT

Citation	4.29 Conflict of Interest Provisions
1902(a)(4)(C) of the Social Security Act; P.L. 105-33	The Medicaid agency meets the requirements of section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.
1902(a)(4)(D) of the Social Security Act; P.L. 105-33	The Medicaid agency meets the requirements of section 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

State/Territory: Vermont

Citation
42 CFR 1002.203
AT-79-54
48 FR 3742
51 FR 34772

4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

☐ The agency, under the authority of State law, imposes broader sanctions.

State/Territory: Vermont

Citation

1902(p) of the Act,
P.L. 100-93 (secs. 7)

(b) The Medicaid agency meets the requirements of --

(1) Section 1902(p) of the Act by excluding from participation-

(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).

(B) Any HMO (as defined in section 1903(m) of the Act) or an entity furnishing services under a waiver approved under section 1915(b)(l) of the Act, that --

(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or

(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1l28(b)(8)(B) of the Act.

Citation:

1902(a)(39) of the Act; P. L. 100-93 (sec. 8(f))

1902(a)(41) of the Act; P.L. 96-272, (sec. 308(c))

1902(a)(49) of the Act; P.L. 100-93 (sec. 5(a)(4))

(2) Section 1902(a)(39) of the Act by --

(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and

(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of --

(1) Section 1902(a)(4l) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

Citation
455.103
44 FR 41644
1902(a)(38) of the Act
P.L. 100-93 (Sec. 8(f))

4.31 Disclosure of information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.

435.940 through 435.960
52 FR 5967

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960.

(b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

(c) ATTACHMENT 4.32-A describes in accordance with 42 CFR 435.948(a)(6) the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

Revision: HCFA-PM-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State/Territory: Vermont

Citation
1902(a)(48) of the Act,
P.L. 99-570 (Section 11005)
P.L. 100-93 (Sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless 1ndividuals.

Revision: HCFA-PM-88-10 (BERC) OMB No.: 0938-0193
SEPTEMBER 1988

State/Territory: Vermont

Citation	4.34	Systematic Alien Verification for Entitlements
1137 of the Act P.L. 99-603 (sec. 121)		The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

☐ The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

☐ The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

- ☐ Total waiver
- ☐ Alternative system
- ☐ Partial implementation

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: VERMONT

Citation

4.35 Enforcement of Compliance for Nursing Facilities

42 CFR §488.402(f)

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

(1) nature of noncompliance,
(2) which remedy is imposed,
(3) effective date of the remedy, and
(4) right to appeal the determination leading to the remedy.

42 CFR §488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR §488.402(f)(2)

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR §488.456(c)(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

42 CFR §488.404(b)(1)

(b) Factors to be Considered in Selecting Remedies

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b) (1) & (2).

☐ The State considers additional factors. Attachment 4.35-A describes the State's other factors.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: VERMONT

Citation	
	(c) Application of Remedies
42 CFR §488.410	(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF'S provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.
42CFR§488.417(b), §1919(h)(2)(C) of the Act.	(ii) The State imposes the denial: of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.
42 CFR§488.414, §1919(h)(2)(D) of the Act.	(iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.
42 CFR §488.408, §1919(h)(2)(A) of the Act.	(iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.
42 CFR §488.412(a)	(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.
42 CFR §488.406(b), §1919(h)(2)(A) of the Act	(d) Available Remedies
	(i) The State has established the remedies defined in 42 CFR 488.406(b).
	☒ (1) Termination ☒ (2) Temporary Management ☒ (3) Denial of Payment for New Admissions ☒ (4) Civil Money Penalties ☒ (5) Transfer of Residents; Transfer of Residents with Closure of Facility ☒ (6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: VERMONT

Citation
42 CFR §488.406(b)
§1919(h)(2)(B)(ii) of the Act.

42 CFR §488.303(b)
1910(h)(2)(F) of the Act

(ii) ☐ The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

☐ (1) Temporary Management
☐ (2) Denial of Payment for New Admissions
☐ (3) Civil Money Penalties
☐ (4) Transfer of Residents; Transfer of Residents with Closure of Facility
☐ (5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

(e) ☐ State Incentive Programs

☐ (1) Public Recognition of the Act.
☐ (2) Incentive Payments

Citation	4.36 Required Coordination Between the Medicaid and WIC Programs
1902(a)(11)(C)and 1902(a)(53) of the Act	The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

Revision: HCFA-PM-91-10 (BPD)
DECEMBER, 1991

State/Territory: Vermont

Citation

42 CFR 483.75;
42 CFR 483 Subpart D;
Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3));
P.L. 101-239 (Secs 6901(b)(3) and (4));
P.L. 101-508 (Sec. 4801(a)).

4.38 Nurse Aide Training and Competency Evaluation for Nursing Facilities

☐ (a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.

☒ (b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).

☒ (c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.

☐ (d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.

☐ (e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.

☒ (f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

Revision: HCFA-PM-91-10 (BPD)
DECEMBER 1991

State/Territory: _____Vermont_____

Citation

42 CFR 483.75;
42 CFR 483 Subpart D;
Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-03 (Sec. 4211(a)(3));
P.L. 101-39 (Secs. 6901(b)(3) and (4));
P.L. 101-508 (Sec. 4801(a)).

(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.

(h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.

(i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.

(j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.

(k) For program reviews other than the initial review, the State visits the entity providing the program.

(l) The State does not approve a nurse aide training and competency evaluation program or -competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.

(n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.

(o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).

(p) The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).

☒ (q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.

(r) The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

Citation

42 CFR 483.75;
42 CFR 483 Subpart D;
Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3));
P.L. 101-239 (Secs. 6901(b)(3) and(4));
P.L. 101-508 (Sec. 4801(a)).

(s) When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.

(t) The State permits students who have started training and competency evaluation program from which approval is withdrawn to finish the program.

(u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.

(v) The State provides, advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.

(w) Competency evaluation programs are administered by the State or by a state-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.

☐ (x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).

(y) The State has a standard for successful completion of competency evaluation programs.

Revision: HCFA-PM-91-10 (BPD)
DECEMBER 1991

State/Territory: Vermont

Citation		
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2) P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Sec. 6901(b)(3) and (4); P.L. 101-508 (Sec. 4801(a)).	(z)	The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
	☒ (aa)	The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
	(bb)	The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
	☐ (cc)	The State includes home health aides on the registry.
	☒ (dd)	The State contracts the operation of the registry to a non State entity.
	☐ (ee)	ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c),
	☐ (ff)	ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: _____Vermont_____

Citation
Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)); P.L. 101-508 (Sec. 4801(b)).

4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities

(a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 CFR 431.621(c).

(b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.

(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.

☒ (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: Vermont

4.39 (Continued)

(f) Except for residents identified in 42 CFR 483.118(c)(l), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

State/Territory: _____Vermont_____

Citation	4.40	Survey & Certification Process
Sect ions 1919(g)(1) thru (2) and 1919(g)(4) thru (5) of the Act; P.L. 100-203 (Sec. 4212(a))	(a)	The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act are met.
1919(g)(1)(B) of the Act	(b)	The State conducts periodic education programs for staff and residents (and their representatives). Attachment 4.40-A describes the survey and certification educational program.
1919(g)(1)(C) of the Act	(c)	The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. Attachment 4.40-B describes the State's process.
1919(g)(1)(C) of the Act	(d)	The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation, of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency? _____
1919(g)(1)(C) of the Act	(e)	The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.
1919(g)(1)(C) of the Act	(f)	The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

1919(g)(2)(A)(i) of the Act	(g)	The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. Attachment 4.40-C describes the State's procedures.
1919(g)(2)(A)(ii) of the Act	(h)	The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participations and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
1919(g)(2)(A)(iii)(I) of the Act	(i)	The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
1919(g)(2)(A)(iii)(II) of the Act	(j)	The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
1919(g)(2)(B) of the Act	(k)	The State conducts extended surveys immediately or, if not practicable, not later that 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
1919(g)(2)(C) of the Act	(l)	The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

1919(g) (2)(D) of the Act	(m)	The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. Attachment 4.40-D describes the State's programs.
1919(g) (2)(E)(i) of the Act	(n)	The State uses a multidisciplinary team of professionals including a registered professional nurse.
1919(g) (2)(E)(ii) of the Act	(o)	The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
1919(g) (2)(E)(iii) of the Act	(p)	The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
1919(g) (4) of the Act	(q)	The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. Attachment 4.40-E describes the State's complaint procedures
1919(g)(5)(A) of the Act	(r)	The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
1919(g)(5)(B) of the Act	(s)	The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
1919(g)(5)(C) of the Act	(t)	If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
1919(g)(5)(D) of the Act	(u)	The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: Vermont

Citation	4.41 Resident Assessment for Nursing Facilities
Sections 1919(b)(3), and 1919(e)(5) of the Act	(a) The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §19l9(b)(3)(A) of the Act
1919(e)(5)(A) of the Act	(b) The State is using:
1919(e)(5)(B) of the Act	☐ the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§19l9(e)(5)(A)]; or
	☒ a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§l919(e)(5)(B)].

Citation

1902(a)(68) of the Act,
P.L. 109-171 (section 6032)

4.42 Employee Education About False Claims Recoveries

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section l902(a)(63) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan amendment on 1/1/2007.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

State/Territory: _____Vermont_____

Citation	4.43 Cooperation with Medicaid Integrity Program Efforts.
1902(a)(69) of the Act, P.L. 109-171 (section 6034)	The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Vermont_____

4.46 Provider Screening and Enrollment

The State Medicaid agency gives the following assurances:

Citation
1902(a)(77)
1902(a)(39)
Adds 1902(kk);
P.L. 111-148
And P.L. 111-152

42 CFR 455 Subpart E	PROVIDER SCREENING __X__Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS __X__ Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq. __X__Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES __X__Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT __X__Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OF ENROLLMENT __X__Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.
42 CFR 455.420	REACTIVATION OF PROVIDER ENROLLMENT __X__Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422	APPEAL RIGHTS __X__Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.
42 CFR 455.432	SITE VISITS __X__Assures that pre-enrollment and post enrollment site visits of providers who are in “moderate” or “high risk” categories will occur.
42 CFR 455.434	CRIMINAL BACKGROUND CHECKS __X__Assures that providers as a condition of enrollment will be required to consent to criminal background checks including fingerprints if required to do so under State law or by the level of screening based on risk of fraud, waste or abuse for that category of provider.
42 CFR 455.436	FEDERAL DATABASE CHECKS __X__Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.
42 CFR 455.440	NATIONAL PROVIDER IDENTIFIER __X__Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.
42 CFR 455.450	SCREENING LEVELS FOR MEDICAID PROVIDERS __X__Assures that the State Medicaid agency complies with 1902(a)(77)and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.
42 CFR 455.460	APPLICATION FEE __X__Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.
42 CFR 455.470	TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS __X__Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries’ access to medical assistance.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 432.10(a) (AT-78-90, AT-79-23 & AT-80-34)

SECTION 5: PERSONNEL ADMINISTRATION

5.1 Standards Of Personnel Administration

a. The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

☐ The Plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

b. Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

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5.2 [Reserved]

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR Part 432 Subpart B (AT-78-90)

5.3 Training Programs; Subprofessional And Volunteer Programs

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 433.32 (AT-79-29)

SECTION 6: FINANCIAL ADMINISTRATION

6.1 Fiscal Policies And Accountability

The Medicaid agency and, where applicable, local agencies administering the Plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

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CITATION: 42 CFR 433.34 47 PR 17490

6.2 Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

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CITATION: 42 CFR 433.33 (AT-79-29 & AT-80-34)

6.3 State Financial Participation

a. State funds are used in both assistance and administration.

☒ State funds are used to pay all of the non-Federal share of total expenditures under the Plan.

☐ There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the Plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the Plan in any part of the State.

b. State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

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SECTION 7 - GENERAL PROVISIONS

Citation	7.1	Plan Amendments
42 CFR 430.12(c)		The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

Citation	7.2	Nondiscrimination
45 CFR Parts 80 and 84		In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap. The Medicaid agency has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in ATTACHMENT 7.2-A.

Citation 7.3 Maintenance of AFDC Efforts

RESERVED

Revision: HCFA-PM-91-4 (BPD)
January 2011

State/Territory: _____Vermont_____

Citation 7.4 State Governor's Review

42 CFR 430.12(b) The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget, and fiscal reports. Any comments made will be transmitted to the Centers for Medicare & Medicaid Services with such documents.

☐ Not applicable. The Governor:

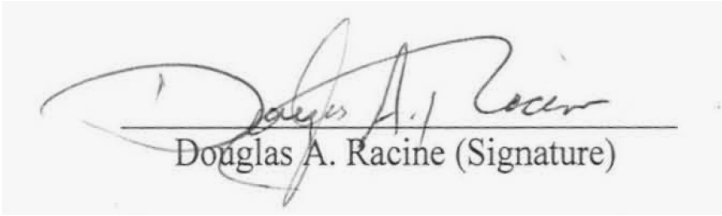
☐ does not wish to review any plan material.

☐ wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

_____The Agency of Human Services_____
(Designated Single State Agency)

Date: ____03/17/11____



Douglas A. Racine (Signature)

Secretary, Agency of Human Services
(Title)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of VERMONT

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

Agency of Human Services is the single State agency responsible for:

☒ Administering the plan.

The legal authority under which the agency administers the plan on a Statewide basis is

3 VSA Chapter 53
33 VSA Chapter 4, 19
(statutory citation)

☐ Supervising the administration of the plan by local political subdivisions.

The legal authority under which the agency supervises the administration of the plan on a Statewide basis is contained in

(statutory citation)

The agency's legal authority to make rules and regulations that are binding on the political subdivisions administering the plan is

(statutory citation)

June 25, 2013
Date

Signature

Assistant Attorney General
Title

ORGANIZATION AND FUNCTION OF STATE AGENCY

Function of the Department of Vermont Health Access (DVHA) is addressed in Attachment 1.2-B. The Department for Children and Families (DCF) is one of the major components of the Agency of Human Services (AHS). Within the DCF, the Economic Services Division (ESD) encompasses the functions regarding Medicaid eligibility. The DCF's principal functions and structure are outlined below:

Child Development Division (CDD)
CDD's goal is to increase accessibility to high-quality child care and child development services by working with programs within communities to coordinate and deliver services that meet families' needs. Direct services for children and families include regulating early childhood and afterschool programs; early intervention services; information, resource and referral for families; parent education and family support services. CDD provides technical assistance, professional development, and mentoring opportunities to Vermont's early childhood and afterschool workforce, and are involved in developing early childhood and afterschool systems in Vermont.

Disability Determination Services (DDS)
DDS determines the eligibility of Vermonters who apply for disability benefits under Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI); and determines the medical eligibility of Vermonters who apply for Medicaid based on having a disability.

Economic Services Division (ESD)
ESD's mission is to help Vermonters find a path to a better life. ESD administers programs which include assistance-to-work; supplemental nutrition assistance; fuel assistance; and health care.

Family Services Division (FSD)
FSD's mission is to protect children and strengthen families in partnership with families and communities. FSD services include child abuse/neglect intake, investigation and assessment; ongoing services to families at risk; care, treatment and permanency planning of children in state custody; probation and other restorative justice services for delinquent youth; post adoption supports and subsidy for children adopted through foster care; transition services for youth; and the Woodside Juvenile Rehabilitation Facility.

Office of Child Support (OCS)
OCS is responsible for establishing, collecting upon, enforcing, and modifying support orders for children who do not live with both parents, is responsible for helping Vermonters establish parentage; establish an order for child and medical support; modify or enforce an existing order for child and medical support; make support payments to the custodial parent; and locate a missing non-custodial parent.

Office of Economic Opportunity (OEO)
OEO's mission is to increase the self-sufficiency of Vermonters, strengthen Vermont communities, and eliminate the causes and symptoms of poverty. OEO manages programs and grants; identifies and develops resources; provides training and technical assistance; advocates for community-based organizations, and connects communities to resources within government and the private sector.

Within the Agency of Human Services, the Department of Disabilities, Aging and Independent Living (DAIL) assists older persons, children and adults with disabilities to live as independently as possible. The DAIL's principal functions and structure are as follows:

Licensing & Protection
Responsible for protecting vulnerable Vermonters through licensing health care providers, and investigating complaints and allegations of abuse, neglect and exploitation.

Advocacy & Independent Living
Responsible for helping elders and adults with disabilities to live as independently as possible in the community.

Blind & Visually Impaired
Responsible for helping Vermonters with blindness or visual impairment work and live independently.

Developmental Services
Responsible for helping children and adults with developmental disabilities and children with health impairments and/or physical disabilities to live as independently as possible within their family, home and community.

Vocational Rehabilitation
Responsible for helping Vermonters with disabilities prepare for and find employment.

The Department of Health is also a large component of the Agency of Human Services. Within the Department, the responsibilities of each division are outlined below:

Alcohol and Drug Abuse Programs Division
Responsible for helping Vermonters prevent and eliminate the problems caused by alcohol and other drug use. In partnership with other public and private organizations, the division plans, supports and evaluates a comprehensive system that provides education, prevention, intervention, treatment, recovery, and research services.

Mental Health Division
Responsible for providing services to people with a wide range of emotional, behavioral and other mental health problems. Assures timely delivery of effective prevention, early intervention, and behavioral health treatment and supports through a family-centered system of care for all children and families in Vermont. Operates the Vermont State Hospital which serves adults with serious and persistent mental illness who require a higher level of care.

Community Public Health
Responsible for providing essential health promotion and disease prevention services, working in partnership with local health care providers, voluntary agencies, schools, businesses and community organizations.

Health Protection
Responsible for the regulatory, forensic and risk assessment components of the department: including the inspection of ambulances and licensing of emergency services personnel.

Medical Practice Board
Responsible for licensing physicians and podiatrists and certifying physician assistants and anesthesiologist assistants. Investigates unprofessional conduct, issues reprimands, and revokes, suspends or places conditions on professional licenses and certifications where appropriate

The Department of Corrections, in partnership with the community, supports safe communities by providing leadership in crime prevention, repairing the harm done, addressing the needs of crime victims, ensuring offender accountability for criminal acts,

and managing the risk posed by offenders. Within the Department, responsibilities of each division are outlined below:

Administration
Responsible for central oversight and management of all divisions.

Facilities
Responsible for maintaining and operating nine incarcerative facilities and seventeen community-based facilities.

Program Services
Responsible for a variety of services to the community, the criminal justice system, and offenders. The services provided directly to the community focus on education/ information, victims, and reparative support. The services provided to the criminal justice system includes housing and supervision of offenders, sentencing options/reports, and intelligence information. Treatment programs are designed to meet the needs of sex offenders, violent offenders, substance use, and domestic violence issues.

Restorative and Community Justice
Responsible for involving victims and the community as central elements in a process whereby the focus is on the offender being as held accountable to the victim and community.

Placement Services
Responsible for providing offenders with assistance re-integrating into the community after a period of incarceration.

Field Services
Responsible for the ongoing supervision of offenders in the community and ensuring that offenders under supervision are in compliance with all applicable requirements and conditions of release.

The Office of the Secretary of the Agency of Human Services oversees several functions of the Agency under the direction of the Secretary and Deputy Secretary. Within the Secretary's Office, responsibilities of each division are outlined below:

Operations
The Operations Division includes the Rate Setting Unit which sets Medicaid payment rates for services provided in Vermont licensed nursing homes participating in the Medicaid program. The rates are set prospectively, based on nursing home costs which are annually reviewed by the Division's auditors for

allowability. Operations also includes the Fiscal Unit which advises the Secretary on fiscal policy and management issues, the Personnel Unit which advises the Secretary on personnel administration and the interpretation of policies and procedures, the Information Technology Unit which is responsible for executing the core technology vision to unify all Agency technology, the Training Unit which develops, implements, and evaluates agency-wide training programs, and the Internal Affairs Unit. The Secretary's Office also includes the Secretary's Senior Policy Advisor and the State Refugee Coordinator who is the state liaison with all resettlement service providers within the state.

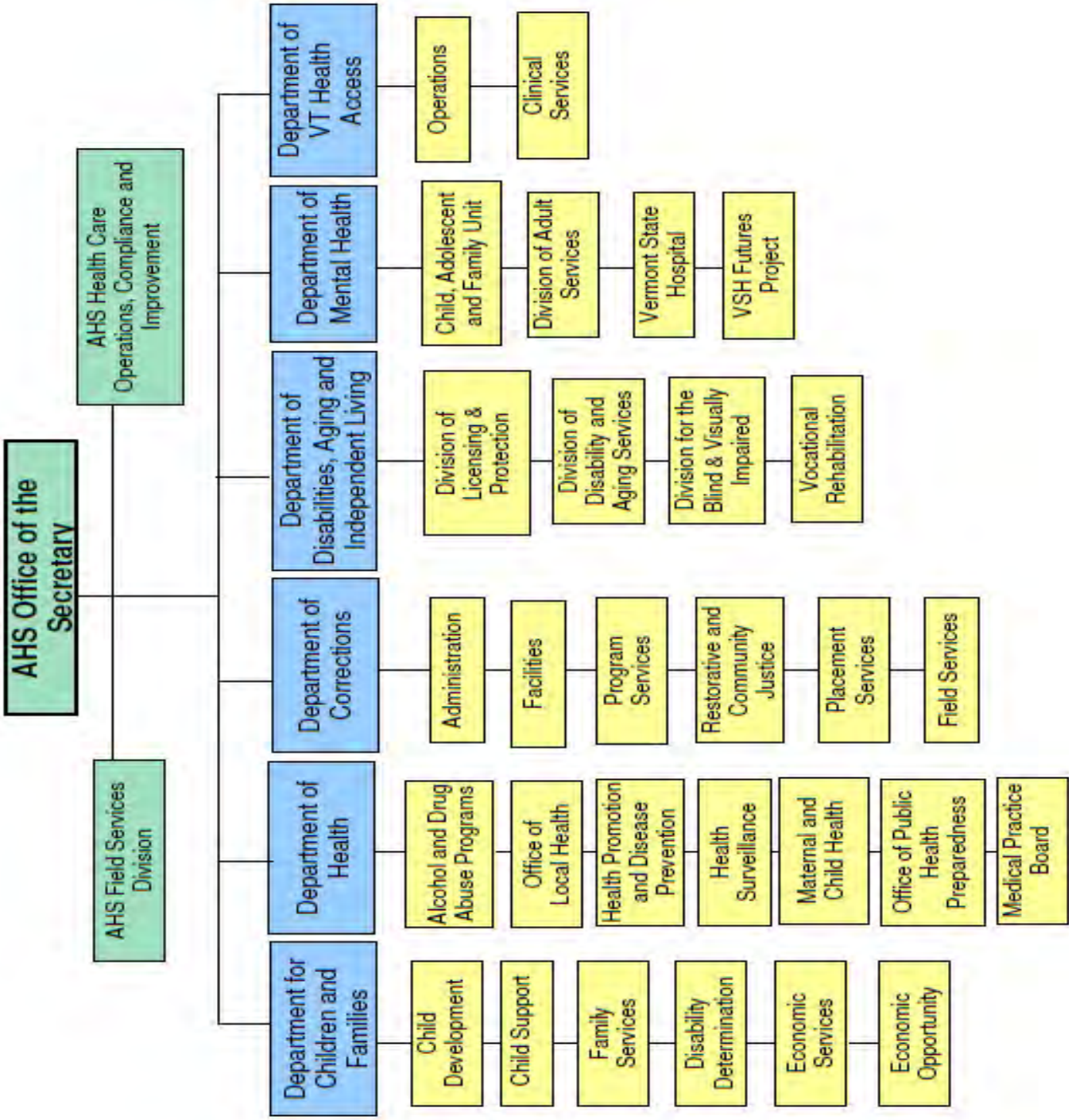
Planning Division
Responsible for advising the Secretary on the Agency's direction, priorities, and strategic planning in program and departmental development.

The Human Services Board
The Human Services Board is a citizen's panel consisting of seven members and was created by the Vermont legislature. Its duties are to act as a fair hearing board for appeals brought by individuals who are aggrieved by decisions or policies of the various departments and programs throughout the Agency of Human Services.

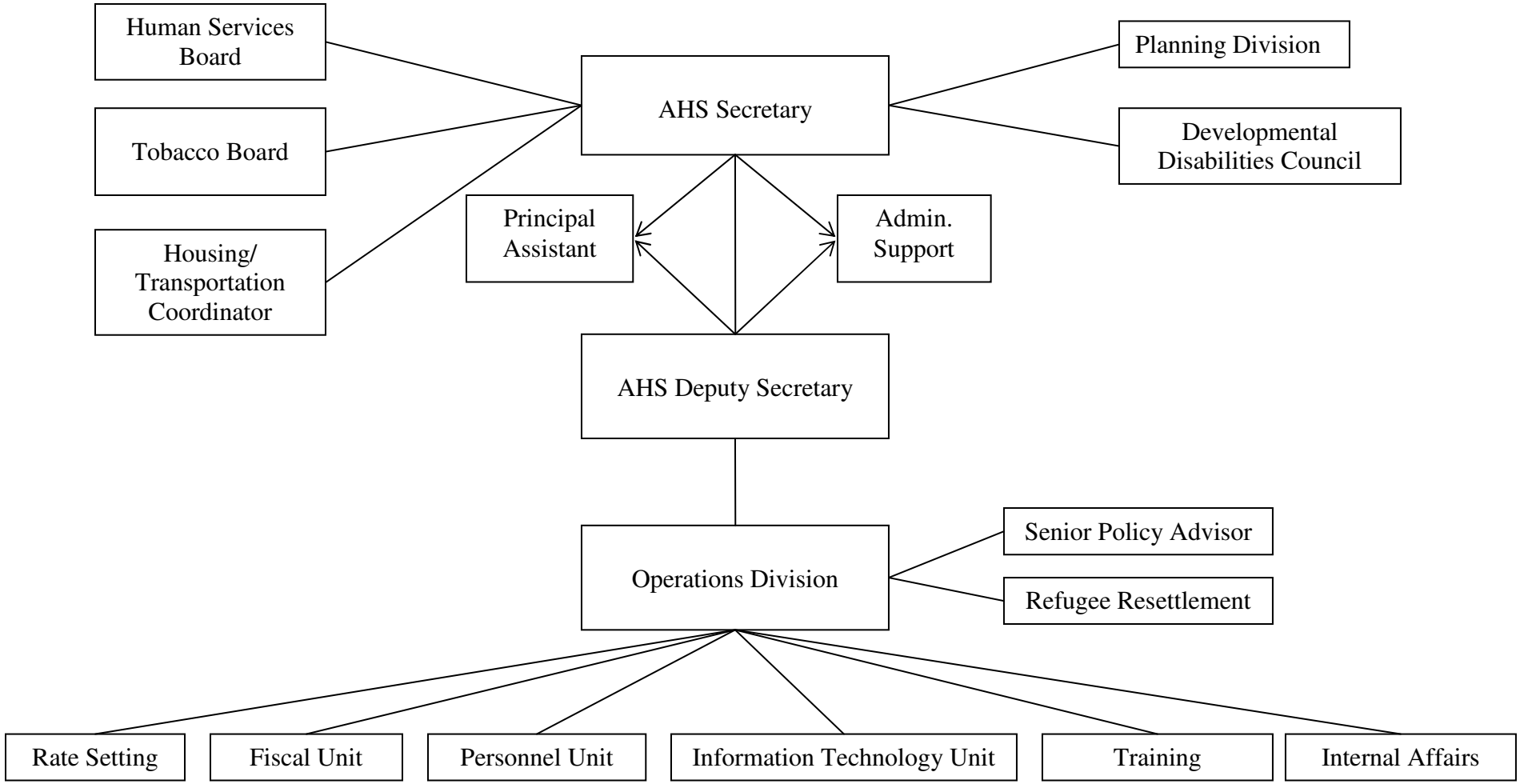
Tobacco Board
The Vermont Legislature established the Vermont Tobacco Evaluation and Review Board effective July 1, 2000 as an independent state board. It is located within, and receives administrative support front the Office of the Secretary of the Agency of Human Services. The Board works in partnership with the Agency and the Departments of Health and Education in establishing the annual budget, program criteria, and policy development, review and evaluation of the entire tobacco control program.

Developmental Disabilities Council
Responsible for supporting advocacy and improving services and supports for people with developmental disabilities. They fund activities to increase the availability of individual and family-centered supports to promote independence, self-determination and community inclusion. They work to increase pubic awareness of issues affecting people with disabilities and their families.

Housing/Transportation Coordinator
Responsible for the coordination of agency-wide housing and transportation initiatives and programs.


AHS Office of the Secretary
AHS Health Care Operations, Compliance and Improvement
AHS Field Services Division
Department of VT Health Access
Operations
Clinical Services
Department of Mental Health
Child, Adolescent and Family Unit
Division of Adult Services
Vermont State Hospital
VSH Futures Project
Department of Disabilities, Aging and Independent Living
Division of Licensing & Protection
Division of Disability and Aging Services
Division for the Blind & Visually Impaired
Vocational Rehabilitation
Department of Corrections
Administration
Facilities
Program Services
Restorative and Community Justice
Placement Services
Field Services
Department of Health
Alcohol and Drug Abuse Programs
Office of Local Health
Health Promotion and Disease Prevention
Health Surveillance
Maternal and Child Health
Office of Public Health Preparedness
Medical Practice Board
Department for Children and Families
Child Development
Child Support
Family Services
Disability Determination
Economic Services
Economic Opportunity

VERMONT AGENCY OF HUMAN SERVICES



FUNCTION OF THE DEPARTMENT OF VERMONT HEALTH ACCESS

The Department of Vermont Health Access (DVHA) is assigned program responsibility for medical assistance furnished eligible individuals under Title XIX of the Social Security Act. The DVHA has a Commissioner, a Director of Health Services and Managed Care, a Director of Health Care Reform, a Director of Medicaid Policy, Fiscal and Support Services, a Director of the Blueprint for Health Program, and a Medical Director. The DVHA is described below:

Blueprint for Health
Supports, monitors and manages the state's multi-insurer initiative designed to integrate a system of health care for patients, improve the health of the overall population, and improve control over health care costs by promoting health maintenance, prevention, and care coordination and management at the provider level.

Chronic Care
With nurses and social workers located throughout the state this unit identifies and assists Medicaid beneficiaries with chronic health conditions to access clinically appropriate health care information and services; coordinates the efficient delivery of health care to this population by addressing barriers to care, bridging care gaps, and avoiding duplication of services; and educates and empowers this population to self-manage their chronic conditions. This program is closely aligned with the care coordination efforts of the Blueprint for Health.

Clinical Operations
Monitors and evaluates the quality, appropriateness and effectiveness of health care services requested for beneficiaries. Ensures requests for services are reviewed and processed efficiently and within time frames outlined in Medicaid Rule. Identifies over- and under-utilization of health care services through the Prior Authorization (PA) review process and case tracking. Specific functions include developing clinical criteria and assuring correct coding for medical benefits; reviewing provider appeals; providing provider education related to specific medical procedures; and performing quality improvement activities to enhance medical benefits for beneficiaries.

Coordination of Benefits (COB)
Works with providers, beneficiaries, and other insurance companies to ensure that Medicaid is payer of last resort. COB also administers the premium assistance programs by performing analyses to ensure beneficiaries are placed in the most cost-effective program.

Data/Reimbursement
Provides Medicaid data to other state agencies, the legislature and other stakeholders. Provides data for mandatory federal reporting to the Centers for Medicare and Medicaid Services (CMS). Provides analyses for the budget development process. Reimbursement oversees the claims processing function of the Medicaid program and provides direction, guidance and interpretation of the state plan to our fiscal agent who processes the Medicaid claims. Develops projections, implements updates, and analyzes the impact of reimbursement methodologies.

Fiscal Operations
Supports, monitors, manages and reports all aspects of fiscal planning and responsibility. Functions include vendor payments, timesheets, expense reports, grants, contracts, purchasing, financial monitoring, budgeting and other relevant practices, procedures, and processes.

Health Care Reform
Responsible for providing oversight and coordination across state government, and with other public and private partners, to foster collaboration, inclusiveness, consistency, and effectiveness in state and federal health care reform. Leads on Health Information Technology (HIT) and Health Information Exchange (HIE) policy, planning and oversight.

Managed Care
Responsible for managing care arrangements for beneficiaries covered under the Medicaid Global Commitment to Health waiver, and works to develop new initiatives for DVHA which includes monitoring programs for compliance with quality standards to improve services for Medicaid beneficiaries.

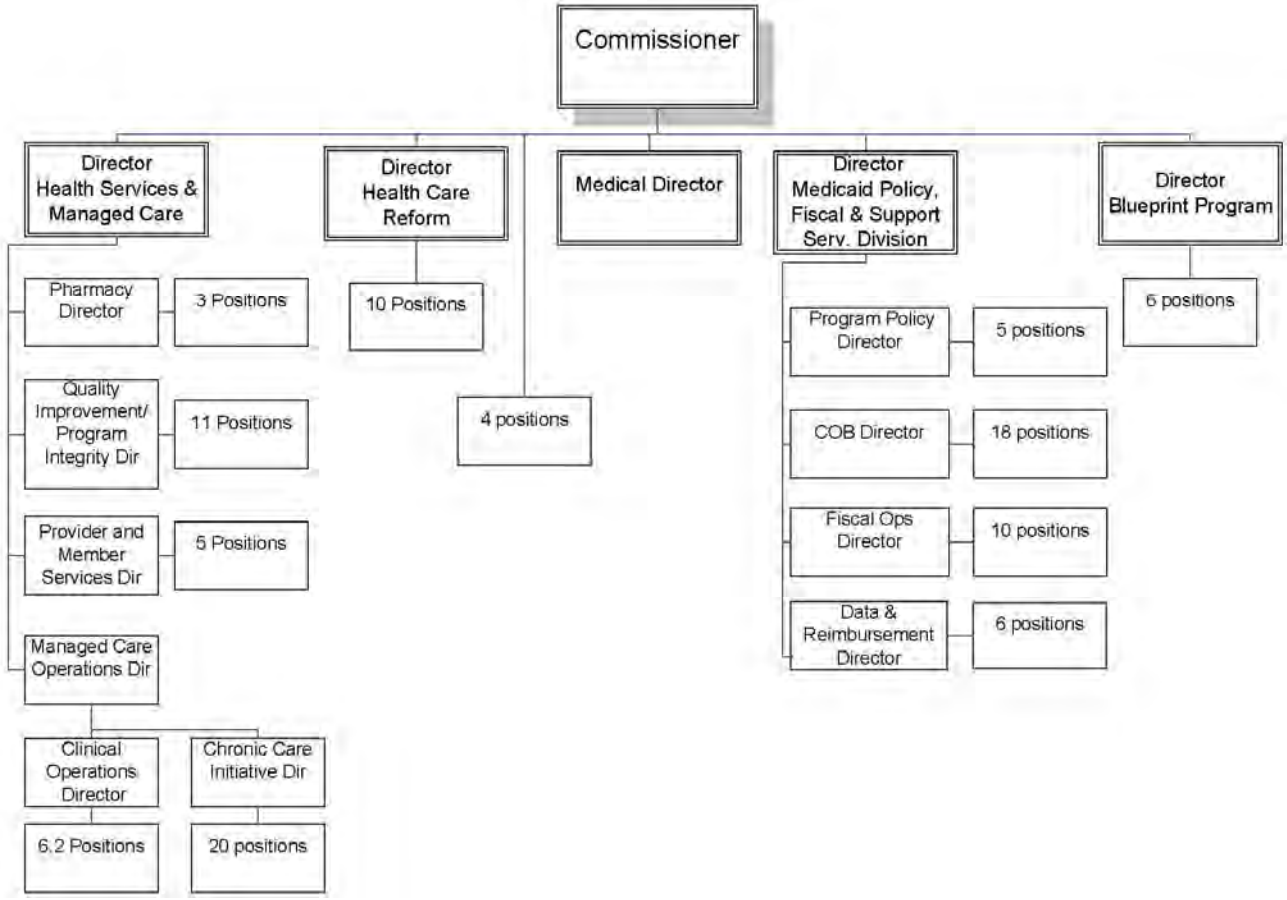
Pharmacy
Ensures beneficiaries receive medically necessary medications in the most cost-effective manner. Pharmacy Unit staff members and the contracted Prescription Benefit Manager (PBM) work with providers, pharmacies and beneficiaries on benefits issues, clinical criteria, claims processing and appeals related to pharmacy. Responsible for the Drug Utilization Review (DUR) Board.

Program Policy
Responsible for coverage rules, fair hearings, grievances and appeals, HIPAA compliance, legislative activities, public record requests, requests for non-covered services, State Plan Amendments, and the State Children's Health Insurance Program (SCHIP). Coordinates major initiatives resulting from federal health care reform and state legislative sessions. May serve as the primary liaison to legislators, Vermont's Congressional Delegation, the media and the Centers for Medicare and Medicaid Services (CMS).

Provider/Member Relations Unit
Communication/liaison activities that assist providers and beneficiaries in accessing clinically appropriate health services. Manages the Medicaid non-emergency transportation program, and other various provider contracts for services (such as the member services contract); interacts with groups/organizations that represent provider and member interests, such as the Medicaid Advisory Board; and maintains the DVHA web site.

Quality Improvement/Program Integrity
Responsible for activities to prevent, detect, and investigate Medicaid fraud, waste and abuse. Includes data mining and analysis; recoupment of provider overpayments; and lock-in programs for overutilization or abuse of the system. Educates providers for accurate billing, and refers cases of abuse to the Attorney General's office (provider fraud) and to DCF (eligibility fraud). Monitors Intergovernmental Agreements (IGAs) and collaborates with AHS partners that serve special health needs populations; prepares for annual external quality reviews for managed care organizations required by CMS, as well as for statewide and other quality audits: and provides concurrent review of psychiatric inpatient admissions.

Department of Vermont Health Access (DVHA) Organizational Chart



PROFESSIONAL MEDICAL PERSONNEL AND SUPPORTING STAFF

The Department of Vermont Health Access (DVHA) engages a physician as a full-time Medical Director and a nurse in a full-time position as the Director of Health Services and Managed Care. The Blueprint for Health employs two full-time physicians, including the Blueprint for Health Director. In Care Coordination, the Director is a nurse and there are 12 nurses who are employed as Nurse Case Managers. In Clinical Operations, the Director is a nurse and there are four Nurse Case Managers, and three dentists. The Pharmacy Director is a pharmacist. The DVHA also employees a Licensed Clinical Mental Health Counselor.

Reference Attachment 1.2-B for additional details.

When necessary for consultation on prior authorizations, fair hearings, or exception requests, the DVHA has contractual relationships with clinical specialists such as physicians, dentists, physical therapists, and contracts such as the pharmacy benefits manager (PBM) contract, provide access to other pertinent clinical expertise. Other medical personnel is available in other departments within the agency.

Definition of an HMO that is Not Federally Qualified

An HMO that is not federally qualified must be an entity that is licensed in Vermont as an HMO under provisions of 8 V.S.A. Chapter 139, as an insurer licensed to sell in Vermont under 8 V.S.A. Chapter 101, or a non-profit hospital or medical service corporation approved under 8 V.S.A. Chapters 123 and 125.

Additionally, the HMO must meet the following federal requirements:

- Be organized primarily for the purpose of providing health care services;
- Make the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration, and scope) as those services are to nonenrolled Medicaid recipients within the area served by the HMO;
- Make provision, satisfactory to the Medicaid agency, against the risk of insolvency, and assure that Medicaid enrollees will not be liable for the HMO's debts if it does become insolvent.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups	Covered

The following groups are covered under this plan.

42 CFR 435.110

42 CFR 435.115

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups

1. Recipients of AFDC

The approved State AFDC plan includes:

☒ Families with an unemployed parent for the mandatory 6-month period and an optional extension of ___* months. *There is no limit.

☒ Pregnant women with no other eligible children.

☒ AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement 1 of ATTACHMENT 2.6-A.

2. Deemed Recipients of AFDC

a. Individuals denied a title IV-A cash payment solely because the amount would be less than $10.

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
1902(a)(10) (A)(i)(I) of the Act		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)	
402(a)(22)(A) of the Act		2. Deemed Recipients of AFDC.	
406(h) and 1902(a)(10)(A)(i)(I) of the Act		b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.	
1902(a) of the Act		c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.	
		d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.	
		e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.	

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)	
	407(b), 1902(a)(10)(A)(i) and 1905(m)(1) of the Act	3. Qualified Family Members Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed. ☒ Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.	
	1902(a)(52) and 1925 of the Act	4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)	

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
42 CFR 435.113		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)	

5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:

   a. Families denied AFDC solely because of income and resources deemed to be available from--

      (1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;

      (2) Grandparents;

      (3) Legal guardians; and

      (4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);

   b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.

   c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
42 CFR 435.114 1902 (a)(10)(A)(i)(III) and 1905(n) of the Act		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued) 6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972. ☒ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan). ☒ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in the State's August 1972 plan). ☐ Not applicable with respect to intermediate care facilities; State did or does not cover this service. 7. Qualified Pregnant Women and Children a. A pregnant woman whose pregnancy has been medically verified who-- (1) Would be eligible for an AFDC cash payment if the child had been born and was living with her;	

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
1902(a)(10)(A)(i)(III) and 1905(n) of the Act		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued) 7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents program; or (3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan. b. Children born after September 30, 1983, who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan. ☒ Children who are under age 18 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.	

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(a)(10)(A)(i)(IV) and 1902(l)(1)(A) and (B) of the Act

8. Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A)(i)(IV) and 1902(l)(1)(A) and (B) of the Act. The income level for this group is specified in Supplement 1 to ATTACHMENT 2.6-A.

☒ The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.

9. Children:

1902(a)(10)(A)(i)(VI) and 1902(l)(1)(C) of the Act

a. who have attained 1 year of age but have not attainted 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.

1902(a)(10)(A)(i)(VII) and 1902(l)(1)(D) of the Act

b. born after September 30, 1983, who have attained 6 years of age but have not attainted 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Income levels for these groups are specified in Supplement 1 to ATTACHMENT 2.6A.

1902(e)(7)

Infants and children covered under items 7, 8, 9 and 12 below who are receiving inpatient services on the date they reach the maximum age for coverage under the approved plan will continue to be eligible for inpatient services until the end of the stay for which the inpatient services are furnished.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
1902(a)(10)(A)(i)(V) and 1905(m) of the Act		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)	
1902(e)(5) of the Act 1902(e)(6) of the Act		10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under section 407 of the Act if the State had not exercised the option under section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.	
		11. a. A woman who, while pregnant, was eligible for, applied for, and received Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.	
		b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.	

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
1902(e)(4)of the Act 42 CFR 435.120		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued) 12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother. 13. Aged, Blind and Disabled Individuals Receiving Cash Assistance ☒ a. Individuals receiving SSI. This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act. ☒ Aged ☒ Blind ☒ Disabled	

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
435.121 1619(b)(1) of the Act		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued) 13. ☐ b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.) ☐ Aged ☐ Blind ☐ Disabled The more restrictive categorical eligibility criteria are described below: (Financial criteria are described in ATTACHMENT 2.6-A).	

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)	
	1902(a)(10)(A)(i)(II) and 1905(q) of the Act	14. Qualified severely impaired blind and disabled individuals under age 65, who--	
		a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or	
		b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must--	
		(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;	
		(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;	
		(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;	

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

☐ Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
		A	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1619(b)(3) of the Act	☐	The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)	
	1634(c) of the Act	15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who--	
		a. Are at least 18 years of age;	
		b. Lose SSI eligibility because they become entitled to OASDI child's benefit under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.	
		☐ c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.	
		☐ d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.	
	42 CFR 435.122	16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.	
	42 CFR 435.130	17. Individuals receiving mandatory State supplements.	

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
42 CFR 435.131		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)	

18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

☒ In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

☒ Aged ☒ Blind ☒ Disabled

☐ Not Applicable. In December 1973, the essential spouse was not eligible for Medicaid.

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	42 CFR 435.132	19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they-- a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and b. Remain institutionalized; and c. Continue to need institutional care.
	42 CFR 435.133	20. Blind and disabled individuals who-- a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and b. Were eligible for Medicaid in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
42 CFR 435.134		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued) 21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972. ☒ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in the State's August 1972 plan). ☒ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution, nursing facility, or intermediate care facility/MR (this group was included in this State's August 1972 plan). ☐ Not applicable with respect to nursing facilities or intermediate care facilities/MR; the State did or does not cover this service.	

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)	
42 CFR 435.135		22. Individuals who--	
		a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and	
		b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.	
		☐ Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.	
		☐ Not applicable because the State applies more restrictive eligibility requirements than those under SSI.	
		☐ The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.	

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
1902(a)(10)(E)(ii)and 1905(s) of the Act		☐ Not applicable because the State applies more restrictive eligibility than those under SSI and the State chooses not to deduct any of the benefit increases caused by the elimination of the reduction factor, or subsequent cost-of-living increases. ☐ The State applies more restrictive eligibility requirements that those under SSI and part or all of the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.	
		20. Qualified disabled and working individuals - 1. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A; 2. Who are not otherwise eligible for medical assistance under the plan; 3. Whose income does not exceed 200 percent of the Federal non-farm income poverty line specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and 4. Whose resources do not exceed twice the maximum amount allowed-- ☒ Under SSI; or ☐ Under the State's medically needy level specified in ATTACHMENT 2.6-A (if the State has a medically needy program). Medical assistance for this group is limited to cost sharing as defined in section 1905(p)(3)(A)(i) of the Act.	

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)	
1634 of the Act		23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.	
		☐ Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.	
		☐ The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equaling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.	

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)	
1634(d) of the Act		24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.	
		☐ The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.	
		☐ In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in §1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.	
		☐ In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in §1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.6-A.	
		☐ In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in §1634(d)(1)(A) in determining the income of the individual.	

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)	
	1902(a)(10)(E)(i), 1905(p) and 1860D-14(a)(3)(D) of the Act	25. Qualified Medicare beneficiaries-- a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income does not exceed 100 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index. (Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)	
	1902(a)(10)(E)(ii), 1905(p), 1905(p)(3)(A)(i) and 1860D-14(a)(3)(D) of the Act	26. Qualified disabled and working individuals-- a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act; b. Whose income does not exceed 200 percent of the Federal poverty level; and c. Whose resources do not exceed two times SSI resource limit. d. Who are not otherwise eligible for medical assistance under Title XIX of the Act. (Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)	

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)	
	1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act	27. Specified low-income Medicare beneficiaries-- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index. (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)	
	1902(a)(10)(E)(iv), 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act	28. Qualifying Individuals-- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income is greater than 120 percent but less than 135 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.	

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
42 CFR 435.210, 1902(a)(10)(A)(ii) and 1905(a) of the Act 42 CFR 435.211		B. Optional Groups Other Than the Medically Needy ☒ 1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance. ☒ The plan covers all individuals as described above. ☐ The plan covers only the following group or groups of individuals: ☐ Aged ☐ Blind ☐ Disabled ☐ Caretaker relatives ☐ Pregnant women ☒ 2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.	

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
42 CFR 435.212 & 1902(e)(2) of the Act, P.L. 99-272 (section 9517), P.L. 101-508 (section 4732)		B. Optional Groups Other Than the Medically Needy (Continued) ☐ 3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act or while enrolled in an entity described in section 1903(m)(2)(B)(iii), (E) or (G) of the Act, or a Competitive Medical Plan (CMP) with a Medicare contract under section 1876 of the Act, but who have been enrolled in the HMO or entity for less than the minimum enrollment period listed below. The HMO or entity must have a risk contract as specified in 42 CFR 434.20(a). Coverage under this section is limited to HMO services and family planning services described in section 1905(a)(4)(C). ☐ The State elects not to guarantee eligibility. ☐ The State elects to guarantee eligibility. The minimum enrollment period is _____ months (not to exceed six). The State measures the minimum enrollment period from: ☐ The date beginning the period of enrollment in the HMO or other entity, without any intervening disenrollment, regardless of Medicaid eligibility. ☐ The date beginning the period of enrollment in the HMO as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment. ☐ The date beginning the last period of enrollment in the HMO as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment of periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section.)	

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
1903(m)(2)(F) of the Act, P.L. 98-369 (section 2364), P.L. 99-272 (section 9517), P.L. 101-508 (section 4732)		B. Optional Groups Other Than the Medically Needy (Continued) The Medicaid Agency may elect to restrict the disenrollment rights of Medicaid enrollees of certain Federally qualified HMOs, Competitive Medical Plans (CMPs) with Medicare contracts under section 1876 of the Act, and other organizations described in 42 CFR 434.27(d), in accordance with the regulations at 42 CFR 434.27. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible. ☐ Disenrollment rights are restricted for a period of _____ months (not to exceed 6 months). During the first month of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least twice per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment. ☐ No restrictions upon disenrollment rights.	
1903(m)(2)(H), 1902(a)(52) of the Act, P.L. 101-508 (section 4732)		In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an entity having a contract under section 1903(m) when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract. ☐ The agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost. ☐ The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.	

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
42 CFR 435.217		B. Optional Groups Other Than the Medically Needy (Continued)	
		☒ 4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.	

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
	1902(a)(10)(A)(ii)(VII) of the Act	B. Optional Groups Other Than the Medically Needy (Continued)	

☒ 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

☒ The State covers all individuals as described above.

☐ The State covers only the following group or groups of individuals:

- ☐ Aged
- ☐ Blind
- ☐ Disabled
- ☐ Individuals under the age of--
  - ☐ 21
  - ☐ 20
  - ☐ 19
  - ☐ 18
- ☐ Caretaker relatives
- ☐ Pregnant women

*Agency that determines eligibility for coverage.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.220

☒ 6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.

☒ The State covers all individuals as described above.

1902(a)(10)(A)(ii) and 1905(a) of the Act

☐ The State covers only the following group or groups of individuals:

☐ Individuals under the age of--
- ☐ 21
- ☐ 20
- ☐ 19
- ☐ 18

☐ Caretaker relatives
☐ Pregnant women

42 CFR 435.222, 1902(a)(10)(A)(ii) and 1905(a)(i) of the Act

☒ 7. a. All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are under the age of 21 as indicated below.
- ☐ 20
- ☐ 19
- ☐ 18

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered

42 CFR 435.222

B. Optional Groups Other Than the Medically Needy (Continued)

☐ b. Reasonable classifications of individuals described in (a) above, as follows:

☐ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

☐ (a) In foster homes (and are under the age of _____).

☐ (b) In private institutions (and are under the age of _____).

☐ (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of _____).

☐ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of _____).

☐ (3) Individuals in NFs (who are under the age of _____). NF services are provided under this plan.

☐ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of _____).

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered

B. Optional Groups Other Than the Medically Needy (Continued)

☐ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of _____). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

☐ (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(VIII) of the Act

☒ 8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement--

a. Was eligible for Medicaid under the State's approved Medicaid plan; or

b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The State covers individuals under the age of--
☒ 21
☐ 20
☐ 19
☐ 18

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
		B. Optional Groups Other Than the Medically Needy (Continued)	
	42 CFR 435.223	☒ 9. Individuals described below who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A:	
	1902(a)(10)(A)(ii) and1905(a) of the Act	☒ Individuals under the age of-- ☒ 21 ☐ 20 ☐ 19 ☐ 18 ☒ Caretaker relatives ☒ Pregnant women	

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.230

☒ 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in the State.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

☒ (1) All aged individuals.

☒ (2) All blind individuals.

☒ (3) All disabled individuals.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
42 CFR 435.230		B. Optional Groups Other Than the Medically Needy (Continued)	
		☐ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.	
		☐ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.	
		☐ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.	
		☐ (7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.	
		☐ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.	
		☐ (9) Individuals in additional classifications approved by the Secretary as follows:	

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
42 CFR 435.230		B. Optional Groups Other Than the Medically Needy (Continued)	

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

☐ Yes

☒ No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.230, 435.121, 1902(a)(10)(A)(ii)(XI) of the Act

☐ 11. Section 1902(f) States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is-

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement

c. Available to all individuals in each classification and available on a Statewide basis.

d. Paid to one or more of the classifications of individuals listed below:

☐ (1) All aged individuals.

☐ (2) All blind individuals.

☐ (3) All disabled individuals.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered

B. Optional Groups Other Than the Medically Needy (Continued)

☐ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

☐ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

☐ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

☐ (7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

☐ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

☐ (9) Individuals in additional classifications approved by the Secretary as follows:

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
		B. Optional Groups Other Than the Medically Needy (Continued)	
			The supplement varies in income standard by political subdivisions according to cost-of-living differences. ☐ Yes ☐ No The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.231, 1902(a)(10)(A)(ii)(V) of the Act

☒ 12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.

☒ The State covers all individuals as described above.

☐ The State covers only the following group or groups of individuals:

1902(a)(10)(A)(ii) and 1905(a) of the Act

- ☐ Aged
- ☐ Blind
- ☐ Disabled
- ☐ Individuals under the age of--
  - ☐ 21
  - ☐ 20
  - ☐ 19
  - ☐ 18
- ☐ Caretaker relatives
- ☐ Pregnant women

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
		B. Optional Groups Other Than the Medically Needy (Continued)	
	1902(e)(3) of the Act	☒ 13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act. Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.	
	1902(a)(10)(A)(ii)(IX) and 1902(l) of the Act	☒ 14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A: a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and b. Infants under one year of age.	

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
		B. Optional Groups Other Than the Medically Needy	
§§1902(a)(10)(A)(ii)(IX) and 1902(l)(1)(C) of the Act		☐ 15. The following individuals who are not mandatory categorically needy, who have attained age 1 but have not attained age 6, who have income that does not exceed the income level (established at an amount up to 133 percent of the Federal poverty level) specified in Supplement 1 of Attachment 2.6-A for a family of the same size.	
§§1902(a)(10)(A)(ii)(IX) and 1902(l)(1)(D) of the Act		☐ a. The following individuals who are not mandatory categorically needy, who are born after September 30, 1983 (or, at the option of a State, an earlier date), who have attained 6 years of age but have not attained 19 years of age and who have income that does not exceed the income level (established at an amount up to 100 percent of the Federal poverty level) specified in Supplement 1 of Attachment 2.6-A for a family of the same size. ☐ The State uses the September 30, 1983 born after date. ☐ The State uses an earlier born after date: _____.	

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)(ii)(X) and 1902(m)(1) and (3) of the Act

☐ 16. Individuals--

a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.

b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and

c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
		B. Optional Groups Other Than the Medically Needy (Continued)	
1902(a)(47) and 1920 of the Act		☐ 17. Pregnant women who are determined by a "qualified provider" (as defined in §1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with §1920 of the Act.	

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups Covered
1906 of the Act		B. Optional Groups Other Than the Medically Needy (Continued)
1902(a)(10)(F), and 1902(u)(1) of the Act		18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of 0 months.
		19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See Supplement 11 to ATTACHMENT 2.6-A.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
		B. Optional Coverage Other Than the Medically Needy (Continued)	
1902(a)(10)(A)(ii)(XVIII) of the Act		☒ 24. Women who: a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix; b. are not otherwise covered under creditable coverage, as defined in section 2701 (c) of the Public Health Service Act; c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and d. have not attained age 65.	
1920B of the Act		☐ 25. Women who are determined by a "qualified entity" (as defined in 1920B (b) based on preliminary information), to be a woman described in 1902 (aa) the Act related to certain breast and cervical cancer patients. The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.	

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
		B. Optional Groups Other Than the Medically Needy (Continued)	
	1902(a)(10)(A)(ii) (XIII) of the Act	☒ 23. BBA Work Incentives Eligibility Group - Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6-A	
	1902(a)(10)(A)(ii) (XV) of the Act	☐ 24. TWWIIA Basic Insurance Group - Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of Attachment 2.6-A.	
	1902(a)(10)(A)(ii) (XVI) of the Act	☐ 25. TWWIIA Medical Improvement Group - Employed individuals at least 16 but less than 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State. See page 12h of Attachment 2.6-A. NOTE: If the State elects to cover this group, it MUST also cover the Basic Insurance Group described in no. 21 above.	

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered

C. Optional Coverage of the Medically Needy

42 CFR 435.301

This plan includes the medically needy.

☐ No
☒ Yes, this plan covers:

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

1902(e) of the Act

2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

1902(a)(10)(C)(ii)(I) of the Act

3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered

C. Optional Coverage of Medically Needy (Continued)

1902(e)(4) of the Act

4. Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains eligible and the child is a member of the woman's household.

42 CFR 435.308

5. ☒ a. Financially eligible individuals who are not described in section C. 3. above and who are under the age of --
   - ☒ 21
   - ☐ 20
   - ☐ 19
   - ☐ 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training

   ☐ b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

   ☐ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

   ☐ (a) In foster homes (and are under the age of _____).

   ☐ (b) In private institutions (and are under the age of _____).

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered

C. Optional Coverage of Medically Needy (Continued)

☐ (c) In addition to the group under b. (1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of _____).

☐ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of _____).

☐ (3) Individuals in NFs (who are under the age of _____). NF services are provided under this plan.

☐ (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of _____).

☐ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of _____). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

☐ (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
		C. Optional Coverage of Medically Needy (Continued)	
42 CFR 435.310		☒ 6. Caretaker relatives.	
42 CFR 435.320 and 435.330		☒ 7. Aged individuals.	
42 CFR 435.322 and 435.330		☒ 8. Blind individuals.	
42 CFR 435.324 and 435.330		☒ 9. Disabled individuals.	
42 CFR 435.326		☐ 10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.	
42 CFR 435.340		11. Blind and disabled individuals who: a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; b. Were eligible as medically needy in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.	

State: VERMONT

COVERAGE AND CONDITIONS OF ELIGIBILITY

Agency*	Citation(s)	Groups	Covered
1906 of the Act		C. Optional Coverage of Medically Needy (Continued)	
		12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of 0 months.	

State: VERMONT

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency*	Citation(s)	Groups Covered
	1935(a) and 1902(a)(66) 42 CFR 423.774 and 423.904	The agency provides for making Medicare prescription drug Low-Income Subsidy determinations under Section 1935(a) of the Social Security Act. 1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act; 2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined; 3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER THE AGE OF 21, 20, 19, AND 18

Not applicable.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: VERMONT

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children at Home

1. The Medicaid Division makes a determination based on medical evidence that the child requires a level of care normally provided in a hospital or nursing facility.

2. The Medicaid Division makes a determination that the necessary resources and family support are available to enable the child to be cared for at home.

3. The Medicaid Division makes a determination that it is cost effective to care for the child at home based on the following cost comparison:

   Average monthly cost of hospital care at $710.83/day = $21,324.90.

   Average monthly cost of nursing facility care at $192.34/day = $5,770.20.

   Average monthly cost of home care based on expenditure and caseload information from 7/1/90 through 9/30/91 = $1,300.00.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Presumptive Eligibility by Hospitals — S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

◉ Yes ○ No

☑ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

■ A qualified hospital is a hospital that:

■ Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

■ Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

◉ Yes ○ No

■ The eligibility groups or populations for which hospitals determine eligibility presumptively are:

- ■ Pregnant Women
- ■ Infants and Children under Age 19
- ■ Parents and Other Caretaker Relatives
- ■ Adult Group, if covered by the state
- ■ Individuals above 133% FPL under Age 65, if covered by the state
- ■ Individuals Eligible for Family Planning Services, if covered by the state
- ■ Former Foster Care Children
- ■ Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state
- ☐ Other Family/Adult groups:
- ☐ Eligibility groups for individuals age 65 and over
- ☐ Eligibility groups for individuals who are blind
- ☐ Eligibility groups for individuals with disabilities
- ☐ Other Medicaid state plan eligibility groups
- ☐ Demonstration populations covered under section 1115

The state establishes standards for qualified hospitals making presumptive eligibility determinations.

Medicaid Eligibility

OFFICIAL

◉ Yes ○ No

Select one or both:

☒ The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards: The state will establish performance standards in this area after establishing baseline data for a period of 12 months. See complete list of performance areas below.

☒ The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Description of standards: For the first 12 months, the state will establish baseline data, and will require 100% compliance with data reporting, after which performance standards will be set in the following areas:
1) The number of PE applications submitted
2) The proportion of those individuals approved for PE that complete and submit an application for full ongoing coverage
3) The proportion of those individuals approved for PE and that complete and submit an application for full ongoing coverage who are determined eligible for full ongoing benefits
4) The accuracy of Hospitals' determination that applicants do not have coverage
5) The accuracy of Hospitals' determination that applicants do not have a prior period of PE in the preceding twelve month period

■ The presumptive period begins on the date the determination is made.

■ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

■ Periods of presumptive eligibility are limited as follows:

◉ No more than one period within a calendar year.

○ No more than one period within two calendar years.

○ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

○ Other reasonable limitation:

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

◉ Yes ○ No

○ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

◉ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

Medicaid Eligibility

An attachment is submitted.

☒ The presumptive eligibility determination is based on the following factors:

☒ The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

☒ Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☑ The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Click here for extra pages to Supplement 4 to 2.2-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	A. General Conditions of Eligibility
	Each individual covered under the plan:
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the applicable non-financial eligibility conditions.
	a. For the categorically needy:
	(i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
1902(1) of the Act	(iii) For financially eligible pregnant women, infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act, meets the non-financial criteria of section 1902(1) of the Act.
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

State: VERMONT

Citation(s)	Condition or Requirement
	b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.
1905 (p) of the Act	c. For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of the Act.
1905(s) of the Act	d. For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).
42 CFR 435.406	3. Is residing in the United States (U.S), and—
	a. Is a citizen or national of the United States;
	b. Is a qualified alien (QA) as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) as amended, and the QA's eligibility is required by section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended;
	c. Is a qualified alien subject to the 5-year bar as described in section 403 of PRWORA, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;
	d. Is a non-qualified alien, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;

State: VERMONT

Citation(s)	Condition	or Requirement

c. Is a QA whose eligibility is authorized under section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended.
X State covers all authorized QAs.
___ State does not cover authorized QAs.

d. State elects CHIPRA option to provide full Medicaid coverage to otherwise eligible pregnant women or children as specified below who are aliens lawfully residing in the United States; including the following:

1. A qualified alien as defined in section 431 of PRWORA (8 U.S.C. §1641);

2. An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;

3. An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

4. An alien who belongs to one of the following classes:

State: VERMONT

Citation(s)	Condition or Requirement
	(i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively); (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization; (iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24); (iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended; (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President; (vi) Aliens currently in deferred action status; or (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status; 1. A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;

State: VERMONT

Citation(s)	Condition	or Requirement

1. An alien who has been granted withholding of removal under the Convention Against Torture;

2. A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));

3. An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or

4. An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

X Elected for pregnant women.
X Elected for children under age 21.

g. X The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA section 214 option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

State: VERMONT

Citation	Condition or Requirement
42 CFR 435.403 Act	4. Is a resident of the State, regardless of whether or not the individual 1902(b) of the maintains the residence permanently or maintains it at a fixed address. ☐ State has interstate residency agreement with the following states: ☐ State has open agreement(s). ☐ Not applicable; no residency requirement.

State: VERMONT

Citation(s)	Condition or Requirement
	An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(l)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate. An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate. ☐ Assignment of rights is automatic because of State law.
42 CFR 435.910	7. Is required, as a condition of eligibility, to furnish his/her Social Security account number (or numbers, if he/she has more than one number).

State: VERMONT

Citation(s)	Condition or Requirement
435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include nursing facilities, intermediate care facilities/MRs, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008, 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. ☐ Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
433.145, 435.604, 1912 of the Act	6. Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment, to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order.)

State: VERMONT

Citation(s)	Condition or Requirement
1902(c)(2)	8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.
1902(e)(10)(A) and (B) of the Act	9. Is not required, as an individual child or pregnant woman, to meet requirements under section 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)

State: VERMONT

Citation(s)	Condition or Requirement
1906 of the Act	10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

State: VERMONT

Citation(s)	Condition or Requirement
	B. Post-eligibility Treatment of Institutionalized Individuals' Incomes
	1. The following items are not considered in the post-eligibility process:
1902(o) of the Act	a. SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.
Bondi v Sullivan (SSI)	b. Austrian Reparation Payments (pension (reparation) payments made under §500 - 506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.
1902(r)(1) of the Act	c. German Reparations Payments (reparation payments made by the Federal Republic of Germany).
105/206 of P. L. 100-383	d. Japanese and Aleutian Restitution Payments.
1. (a) of P.L. 103-286 10405 of P.L. 101-239	e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
6(h)(2) of P.L. 101-426	f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.)
12005 of P. L. 103-66	g. Radiation Exposure Compensation.
	h. VA pensions limited to $90 per month under 38 U.S.C. 5503.

State: VERMONT

Citation(s)	Condition or Requirement
1924 of the Act, 435.725, 435.733, 435.832	2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care: Personal Needs Allowance (PNA) of not less than $30 for Individuals and $60 For Couples For All Institutionalized Persons. a. Aged, blind, disabled: Individuals $ 47.66 Couples $ 95.33 For the following persons with greater need: Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. b. AFDC related: Children $ 47.66 Adults $ 47.66 For the following persons with greater need: Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. c. Individual under age 21 covered in the plan as specified in Item B. 7 of Attachment 2.2 -A. $ 47.66

State: VERMONT

Citation(s)	Condition or Requirement
1924 of the Act	For the following persons with greater need: Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. 3. In addition to the amounts under item 2., the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse: a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse' income. The maintenance needs standard cannot exceed the maximum prescribed in §1924 (d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance. ☒ The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level. ☐ The poverty level component is calculated using a percentage greater than the applicable percentage, equal to _____%, of the official poverty level (still subject to maximum maintenance needs standard). ☐ The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C). Vermont does allow the maximum community spouse allocation where a greater need is documented. Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.

State: VERMONT

Citation(s)	Condition or Requirement
	In determining any excess shelter allowance, utility expenses are calculated using: ☒ the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or ☐ the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges. b. The monthly income allowance for other dependent family members living with the community spouse is: ☒ one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924 (d)(3)(B)) exceeds the dependent family member's monthly income. ☐ a greater amounted calculated as follows: The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924(d)(1): N/A c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party: (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or co-payments. (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)

State: VERMONT

Citation(s)	Condition or Requirement
435.725, 435.733, 435.832	4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple: a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the: • AFDC level; or • Medically needy level: (Check one) ☐ AFDC levels in Supplement 1 ☒ Medically needy level in Supplement 1 ☐ Other: $ _____ b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party: (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or co-payments. (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to ATTACHMENT 2.6-A.)
	5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple:
435.725, 435.733, 435.832	A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period: ☐ No. ☒ Yes (the applicable amount is shown on page 5a.)

State: VERMONT

Citation(s)	Condition	or Requirement
		☒ Amount for maintenance of home is: $ 544.53.
		☐ Amount for maintenance of home is the actual maintenance costs not to exceed $ _____.
		☐ Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individuals' home and the community spouse's home are different.
		☒ Amount for maintenance of home is not deductible when countable income is determined under §1924 (d)(1) of the Act.

State: VERMONT

Citation(s)	Condition or Requirement
42 CFR 435.711, 435.721, 435.831	C. Financial Eligibility For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below. For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply. Supplement 1 to ATTACHMENT 2.6-A specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level - pregnant women and infants or children covered under sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act - and for mandatory groups of qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act.

State: VERMONT

Citation(s)	Condition	or Requirement
		☒ Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.
		☐ Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under §1902(f) of the Act.
		☐ Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under §1902(f) of the Act.
		☒ Supplement 6 to ATTACHMENT 2.6-A specifies the payment standards for optional state supplementary payments.
		☐ Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind, and disabled persons who are covered under requirements more restrictive than SSI.
		☒ Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under §1902(r)(2) of the Act.
		☒ Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under §1902(r)(2) of the Act.

State: VERMONT

Citation(s)	Condition or Requirement
	☒ Supplement 9a to ATTACHMENT 2.6-A specifies transfer of assets.
	☒ Supplement 10 to ATTACHMENT 2.6-A specifies undue hardship trust provisions.
	☒ Supplement 11 to ATTACHMENT 2.6-A specifies COBRA continuation.
	☒ Supplement 12 to ATTACHMENT 2.6-A specifies PNA variations and §1931 standards.
	☒ Supplement 13 to ATTACHMENT 2.6-A specifies §1924 treatment of income and resources.
	☐ Supplement 14 to ATTACHMENT 2.6-A specifies income levels used by States for determining eligibility of Tuberculosis-infected individuals whose eligibility is determined under §1902(z)(1) of the Act.

State: VERMONT

Citation(s)	Condition or Requirement
1902(r)(2) of the Act	1. Methods of Determining Income
1902(e)(6) of the Act	a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

(1) In determining countable income for AFDC-related individuals, the following methods are used:

☐ (a) The methods under the State's approved AFDC plan only; or

☒ (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.

State: VERMONT

Citation(s)	Condition or Requirement
42 CFR 435.721, 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	b. Aged individuals. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used: ☐ The methods of the SSI program only. ☒ The methods of the SSI program and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

State: VERMONT

Citation(s)	Condition or Requirement
	☐ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
	☒ For institutional couples, the methods specified under section 1611(e)(5) of the Act.
	☐ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.
	☐ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements--
	☐ SSI methods only.
	☐ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.
	☐ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.
	In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

State: VERMONT

Citation(s)	Condition or Requirement
42 CFR 435.721 and 435.831, 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	c. Blind individuals. In determining countable income for blind individuals, the following methods are used: ☐ The methods of the SSI program only ☒ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ☐ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ☒ For institutional couples, the methods specified under section 1611(e)(5) of the Act. ☐ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. ☐ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements: ☐ SSI methods only. ☐ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ☐ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

State: VERMONT

Citation(s)	Condition or Requirement
42 CFR 435.721, and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21. d. Disabled individuals - In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act, the following methods are used: ☐ The methods of the SSI program. ☒ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ☒ For institutional couples: The methods specified under section 1611(e)(5) of the Act. ☐ For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. ☐ For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

State: VERMONT

Citation(s)	Condition	or Requirement
		☐ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements: ☐ SSI methods only. ☐ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ☐ Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A. In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

State: VERMONT

Citation(s)	Condition or Requirement
1902(1)(3)(E) and 1902(r)(2) of the Act	e. Poverty level pregnant women, infants, and children. For pregnant women and infants or children covered under the provisions of sections 1902(a)(10)(A)(i)(IV), (VI), and (VII), and 1902(a)(10)(A)(ii)(IX) of the Act: (1) The following methods are used in determining countable income: ☐ The methods of the State's approved AFDC plan. ☐ The methods of the approved title IV-E plan. ☒ The methods of the approved AFDC State plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ☐ The methods of the approved title IV-E plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

State: VERMONT

Citation(s)	Condition or Requirement
	(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
1902(e)(6) of the Act	(3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.
1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act	f. Qualified Medicare beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used: ☐ The methods of the SSI program only. ☒ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ☒ For institutional couples, the methods specified under section 1611(e)(5) of the Act.

State: VERMONT

Citation(s)	Condition or Requirement
1905(s) of the Act 1905(p) of the Act	If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level. For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period. For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication. g. (1) Qualified disabled and working individuals In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used. (2) Specified low-income Medicare beneficiaries In determining countable income of specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.

State: VERMONT

Citation(s)	Condition or Requirement
1902(u) of the Act	(h) COBRA Continuation Beneficiaries In determining countable income for COBRA continuation beneficiaries, the following disregards are applied: ☐ The disregards of the SSI program; ☐ The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to ATTACHMENT 2.6-A. NOTE: For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).

State: VERMONT

Citation(s)	Condition or Requirement
1902(a)(10)(A)(ii)(XIII) of the Act	(i) Working Individuals with Disabilities - BBA In determining countable income and resources for working individuals with disabilities under the BBA, the following methodologies are applied: ☐ The methodologies of the SSI program. ☐ The agency uses methodologies for treatment of income and resources more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 (income) and/or Supplement 5 (resources) to Attachment 2.6-A. ☒ The agency uses more liberal income and/or resource methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.

State: VERMONT

Citation(s)	Condition or Requirement
1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act	Payment of Premiums or Other Cost Sharing Charges For individuals eligible under the BBA eligibility group described in No. 23 on page 23d of Attachment 2.2-A: ☐ The agency requires payment of premiums or other cost-sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied, are described below:

State: VERMONT

Citation(s)	Condition or Requirement
1902(k) of the Act	2. Medicaid Qualifying Trusts In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded. ☒ The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. Supplement 10 of ATTACHMENT 2.6-A specifies what constitutes an undue hardship.
1902(a)(10) of the Act	3. Medically needy income levels (MNILs) are based on family size. Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.

State: VERMONT

Citation(s)	Condition or Requirement
42 CFR 435.732, 435.831	4. Handling of Excess Income - Spend-down for the Medically Needy in All States and Categorically Needy in 1902(f) States Only a. Medically Needy (1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of either 6 (community) or 1 (long-term care) month(s) (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services. (2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order: (a) Health insurance premiums, deductibles and coinsurance charges. (b) Expenses for necessary medical and remedial care not included in the plan. (c) Expenses for necessary medical and remedial care included in the plan. ☐ Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.
1902(a)(17) of the Act	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

State: VERMONT

Citation(s)	Condition or Requirement
1903(f)(2) of the Act	a. Medically Needy (Continued) ☐ (3) If countable income exceeds the MNIL standard, the agency deducts spend-down payments made to the State by the individual.

State: VERMONT

Citation(s)	Condition or Requirement
42 CFR 435.732	b. Categorically Needy - Section 1902(f) States The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income: (1) Any SSI benefit received. (2) Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act. (3) Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section. (4) Other deductions from income described in this plan at Attachment 2.6-A, Supplement 4. (5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a)(17) of the Act, P.L. 100-203	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

State: VERMONT

Citation(s)	Condition or Requirement
1903(f)(2) of the Act	4.b. Categorically Needy - Section 1902(f) States Continued ☐ (6) Spend-down payments made to the State by the individual. NOTE: FFP will be reduced to the extent a State is paid a spend-down payment by the individual.

State: VERMONT

Citation(s)	Condition or Requirement

5. Methods for Determining Resources

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

(1) In determining countable resources for AFDC-related individuals, the following methods are used:

(a) The methods under the State's approved AFDC plan; and

☒ (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

(2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State: VERMONT

Citation(s)	Condition or Requirement
	5. Methods for Determining Resources
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act	b. Aged individuals. For aged individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources: ☐ The methods of the SSI program. ☒ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. ☐ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

State: VERMONT

Citation(s)	Condition or Requirement
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act	c. Blind individuals. For blind individuals the agency uses the following methods for treatment of resources: ☐ The methods of the SSI program. ☒ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. ☐ Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with the parents until the children become 21.

State: VERMONT

Citation(s)	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act	d. Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act. The agency uses the following methods for the treatment of resources: ☐ The methods of the SSI program. ☒ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. ☐ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(1)(3) and 1902(r)(2) of the Act	e. Poverty level pregnant women covered under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX)(A) of the Act. The agency uses the following methods in the treatment of resources. ☐ The methods of the SSI program only. ☐ The methods of the SSI program and/or any more liberal methods described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.

State: VERMONT

Citation(s)	Condition or Requirement
	☐ Methods that are more liberal than those of SSI. The more liberal methods are specified in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.
	☒ Not applicable. The agency does not consider resources in determining eligibility.
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(1)(3) and 1902(r)(2) of the Act	f. Poverty level infants covered under section 1902(a)(10)(A)(i)(IV) of the Act
	The agency uses the following methods for the treatment of resources:
	☐ The methods of the State's approved AFDC plan.
1902(1)(3)(C) of the Act	☐ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.
1902(r)(2) of the Act	☐ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.
	☒ Not applicable. The agency does not consider resources in determining eligibility.

State: VERMONT

Citation(s)	Condition or Requirement
1902(1)(3) and 1902(r)(2) of the Act	g. 1. Poverty level children covered under section 1902(a)(10)(A)(i)(VI) of the Act The agency uses the following methods for the treatment of resources: ☐ The methods of the State's approved AFDC plan.
1902(1)(3)(C) of the Act	☐ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.
1902(r)(2) of the Act	☐ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8b to ATTACHMENT 2.6-A.
	☒ Not applicable. The agency does not consider resources in determining eligibility. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State: VERMONT

Citation(s)	Condition or Requirement
1902(1)(3) and 1902(r)(2) of the Act 1902(1)(3)(C) of the Act 1902(r)(2) of the Act	g. 2. Poverty level children under section 1902(a)(10)(A)(i)(VII) The agency uses the following methods for the treatment of resources: ☐ The methods of the State's approved AFDC plan. ☐ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in Supplement 5a of ATTACHMENT 2.6-A. ☐ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8a to ATTACHMENT 2.6-A. ☒ Not applicable. The agency does not consider resources in determining eligibility. In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

State: VERMONT

Citation(s)	Condition or Requirement
1905(p)(1)(C) and (D) and 1902(r)(2) of the Act	5. h. For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act the agency uses the following methods for treatment of resources: ☐ The methods of the SSI program only. ☒ The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A.
1905(s) of the Act	i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.
1902(u) of the Act	j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources: ☐ The methods of the SSI program only. ☐ More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to ATTACHMENT 2.6-A.

State: VERMONT

Citation(s)	Condition or Requirement
1902(a)(10)(E)(iii) of the Act	k. Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act The agency uses the same method as in 5.h. of ATTACHMENT 2.6-A. 6. Resource Standard - Categorically Needy a. 1902 (f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals: ☐ Same as SSI resource standards. ☐ More restrictive. The resource standards for other individuals are the same as those in the related cash assistance program. b. Non-1902 (f) States (except as specified under items 6.c. and d. below) The resource standards are the same as those in the related cash assistance program. Supplement 8 to ATTACHMENT 2.6-A specifies for 1902 (f) States the categorically needy resource levels for all covered categorically needy groups.

State: VERMONT

Citation(s)	Condition or Requirement
1902(1)(3)(A), (B) and (C) of the Act	c. For pregnant women and infants covered under the provisions of section 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies a resource standard. ☐ Yes. Supplement 2 to ATTACHMENT 2.6-A specified the standard which, for pregnant women, is no more restrictive than the standard under the SSI program; and for infants is no more restrictive than the standard applied in the State's approved AFDC plan. ☒ No. The agency does not apply a resource standard to these individuals.
1902(1)(3)(A) and (C) of the Act	d. For children covered under the provisions of section 1902(a)(10)(A)(i)(VI) of the Act, the agency applies a resource standard. ☐ Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan. ☒ No. The agency does not apply a resource standard to these individuals.

State: VERMONT

Citation(s)	Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	e. For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is: ☐ Same as SSI resource standards. ☐ Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy). Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.

State: VERMONT

Citation(s)	Condition or Requirement
	7. Resource Standard - Medically Needy
	a. Resource standards are based on family size.
1902(a)(10)(C)(i) of the Act	b. A single standard is employed in determining resource eligibility for all groups.
	☐ c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for: ☐ Aged ☐ Blind ☐ Disabled Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 to ATTACHMENT 2.6-A so indicates.
1902(a)(10)(E), 1905(p)(1)(D), 1905(p)(2)(B), and 1860D-14(a)(3)(D) of the Act	8. Resource Standard - Qualified Medicare Beneficiaries and Specified Low -Income Medicare Beneficiaries and Qualifying Individuals For qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low -Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals covered under section 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually since 1996 by the increase in the consumer price index.
1902(a)(10)(E)(ii), 1905(s), and 1860-D14(A)(3)(D) of the Act	9. Resource Standard - Qualified Disabled and Working Individuals For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is twice the SSI resource standard.

State: VERMONT

Citation(s)	Condition or Requirement
1902(u) of the Act	9.1 For COBRA continuation beneficiaries, the resource standard is: ☐ Twice the SSI resource standard for an individual. ☐ More restrictive standard as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.

State: VERMONT

Citation(s)	Condition or Requirement
1902(u) of the Act	10. Excess Resources a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries Any excess resources make the individual ineligible. b. Categorically Needy Only ☒ This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources. c. Medically Needy Any excess resources make the individual ineligible.

State: VERMONT

Citation(s)	Condition or Requirement
42 CFR § 435.914	11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

☒ Aged, blind, disabled.
☒ AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

☐ Aged, blind, disabled.
☐ AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

☐ Aged, blind, disabled.
☐ AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied.

☒ Aged, blind, disabled.
☒ AFDC-related.

State: VERMONT

Citation(s)	Condition or Requirement
1920(b)(1) of the Act 1902(e)(8) and 1905(a) of the Act	☐ (3) For a presumptive eligibility for pregnant women only. Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day. ☒ b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for: ☒ 12 months ☐ 6 months ☐ ___ months (no less than 6 months and no more than 12 months)

State: VERMONT

Citation(s)	Condition or Requirement
1902(a)(18) and 1902(f) of the Act	12. Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources. Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to Attachment 2.6-A.
1917(c)	13. Transfer of Assets - All eligibility groups The agency complies with the provisions of section 1917(c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets. Disposal of assets at less than fair market value affects eligibility for certain services as detailed in Supplement 9(a) to ATTACHMENT 2.6-A, except in instances where the agency determines that the transfer rules would work an undue hardship.
1917(d)	14. Treatment of Trusts - All eligibility groups The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA 93, with regard to trusts. ☐ The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts; ☐ The agency meets the requirements in section 1917(d)(f)(B) of the Act for use of Miller trusts. The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in Supplement 10 to ATTACHMENT 2.6-A.

State: VERMONT

Citation(s)	Condition or Requirement
1924 of the Act	15. The agency complies with the provisions of §1924 with respect to income and resource eligibility and post-eligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community. When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is: ☒ the maximum standard permitted by law; ☐ the minimum standard permitted by law; or ☐ a standard that is an amount between the minimum and the maximum ($_____).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

Note: CC - Chittenden County and OCC - Outside Chittenden County

1. AFDC-Related Groups Other Than Poverty Level Pregnant Women and Infants:

Family Size	Need Standard		Payment Standard	Maximum Payment Amounts	
	CC	OCC	(ratable reduction)	CC	OCC
1	803	730	54.3%	436	396
2	988	915	54.3%	536	496
3	1173	1100	54.3%	636	597
4	1318	1245	54.3%	715	676
5	1477	1404	54.3%	802	762

2. Pregnant Women and Infants under Section 1902(a)(10)(A)(i)(IV) of the Act:

Based on the following percent of the official Federal income poverty level--

☐ 133 percent ☒ 185 percent (no more than 185 percent)
(specify)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

INCOME ELIGIBILITY LEVELS (Continued)

A. MANDATORY CATEGORICALLY NEEDY (Continued)

3. Children under Section 1902(a)(10)(A)(i)(VI) of the Act who have attained age 1 but not attained age 6:

Based on 133 percent of the official Federal income poverty level.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

INCOME ELIGIBILITY LEVELS (Continued)

A. MANDATORY CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

4. Children who have attained age 6 but have not attained age 19

The levels for determining income eligibility for children born after September 30, 1983, (or, at the option of a State, after any earlier date), who have attained 6 years of age but have not attained 19 years of age under the provisions of §1902(a)(10)(A)(i)(VII) of the Act are as follows:

Based on 100 percent (no more than 100 percent) of the official Federal income poverty line:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women and Infants*

The levels for determining income eligibility for optional groups of pregnant women and infants under the provisions of sections 1902(a)(10)(A)(ii)(IX) and 1902(1)(2) of the Act are as follows:

Based on _185_ percent of the official Federal income poverty level (no less than 133 percent and no more than 185 percent).

NOTE: Please note we are mandated to be at 185 percent under 1902(a)(10)(A)(i)(IV) of the Act.

* (1) Pregnant women are eligible under §1902(a)(10)(A)(ii)(IX) of the Social Security Act (the Act), based on a disregard specified in Supplement 8a to Attachment 2.6-A of net countable income between 185 percent and 200 percent of the FPL; and

(2) Infants are eligible under §1902(a)(10)(A)(ii)(IX) of the Act, based on a disregard specified in Supplement 8a to Attachment 2.6-A of net countable income between 185 percent and 225 percent of the FPL.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL (Continued)

2. Reserved for future use.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL (Continued)

2. Reserved for future use.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL (Continued)

3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1903(m)(1) of the Act are as follows:

Based on _____ percent of the official Federal income poverty line.

Family Size	Income Level
1	$ _____
2	$ _____
3	$ _____
4	$ _____
5	$ _____

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication

N/A - Vermont does not cover this optional coverage group.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

INCOME ELIGIBILITY LEVELS (Continued)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

INCOME ELIGIBILITY LEVELS (Continued)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

INCOME ELIGIBILITY LEVELS (Continued)

D. MEDICALLY NEEDY

☐ Applicable to all groups. ☐ Applicable to all groups except those specified below.
Excepted group income levels are also listed on an attached page 3.

(1) Family Size	(2) Net income level protected for maintenance for 1 month ☒ Urban only ☐ Urban & rural	(3 Amount by which Column (2) exceeds limits specified in 42 CFR § 435.1007[1/]	(4) Net income level for persons living in rural areas for 1 month	(5) Amount by which Column (2) exceeds limits specified in 42 CFR § 435.1007[1/]
1	$ 741	$0	$ 683	$0
2	$ 741	$0	$ 683	$0
3	$ 875	$0	$ 825	$0
4	$ 991	$0	$ 933	$0
5	$1,108	$0	$1,050	$0
6	$1,183	$0	$1,125	$0
7	$1,316	$0	$1,258	$0
8	$1,433	$0	$1,375	$0
9	$1,533	$0	$1,483	$0
10	$1,641	$0	$1,583	$0
For each additional person add:	$ 100	$0	$ 100	$0

1/ The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

** See Supplement 8a to Attachment 2.6-A, Page 3 for additional income disregards applied by the agency pursuant to §1902(r)(2).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

INCOME ELIGIBILITY LEVELS (Continued)

E. INSTITUTIONAL INCOME LEVEL

300 percent of the SSI benefit amount payable under section 1611(b)(1) of the Act to an individual in his or her own home who has no income.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women

a. Mandatory Groups

☐ Same as SSI resources levels.

☐ Less restrictive than SSI resource levels and is as follows:

Family Size	Resource Level
1	$ _____
2	$ _____

b. Optional Groups

☐ Same as SSI resources levels.

☐ Less restrictive than SSI resource levels and is as follows:

Family Size	Resource Level
1	$ _____
2	$ _____

No resource level used as permitted in 1902(1)(3) of the Social Security Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

RESOURCE LEVELS (Continued)

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL (Continued)

2. Infants

a. Mandatory Group of Infants

☐ Same as resource levels in the State's approved AFDC plan.

☐ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	$ _____
2	$ _____
3	$ _____
4	$ _____
5	$ _____
6	$ _____
7	$ _____
8	$ _____
9	$ _____
10	$ _____

No resource level used as permitted in 1902(1)(3) of the Social Security Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

RESOURCE LEVELS (Continued)

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL (Continued)

2. Infants

b. Optional Group of Infants

☐ Same as resource levels in the State's approved AFDC plan.

☐ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	$ _____
2	$ _____
3	$ _____
4	$ _____
5	$ _____
6	$ _____
7	$ _____
8	$ _____
9	$ _____
10	$ _____

No resource level used as permitted in 1902(1)(3) of the Social Security Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

RESOURCE LEVELS (Continued)

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL (Continued)

3. Children

a. Mandatory Group of Children under Section 1902(a)(10)(i)(VI) of the Act. (Children who have attained age 1 but have not attained age 6.)

☐ Same as resource levels in the State's approved AFDC plan.

☒* Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	$ _____
2	$ _____
3	$ _____
4	$ _____
5	$ _____
6	$ _____
7	$ _____
8	$ _____
9	$ _____
10	$ _____

* There is no resource test for this group.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

RESOURCE LEVELS (Continued)

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL (Continued)

3. Children

b. Mandatory Group of Children under Section 1902(a)(10)(i)(VII) of the Act. (Children born after September 30, 1983 who have attained age 6 but have not attained age 19.)

☐ Same as resource levels in the State's approved AFDC plan.

☐ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	$ _____
2	$ _____
3	$ _____
4	$ _____
5	$ _____
6	$ _____
7	$ _____
8	$ _____
9	$ _____
10	$ _____

No resource test for this group.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

RESOURCE LEVELS (Continued)

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL (Continued)

4. Aged and Disabled Individuals

☐ Same as SSI resource levels.

☐ Less restrictive than the SSI levels and are as follows:

Family Size	Resource Level
1	$ _____
2	$ _____
3	$ _____
4	$ _____
5	$ _____

☐ Same as medically needy resource levels (applicable only if state has a medically needy program).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups -

☐ Except those specified below under the provisions of section 1902(f) of the Act.

Family Size	Resource Level
1	$ 2,000
2	$ 3,000
3	$ 3,150
4	$ 3,300
5	$ 3,450
6	$ 3,600
7	$ 3,750
8	$ 3,900
9	$ 4,050
10	$ 4,200
For each additional person	$ 150

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

Section 1902(r)(1)(A)(ii) of the Social Security Act	The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r) (2) of the Act. Use Supplement 8a for section 1902 (r) (2) methods.)

Not Applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

MORE RESTRICTIVE METHODS OF TREATING RESOURCES THAN THOSE OF THE SSI PROGRAM - Section 1902 (f) States only

Not Applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

Not applicable. There is no resource test for groups related to federal poverty levels.

Standards for Optional State Supplementary Payments

Payment Category *(Reasonable Classification)*	Administered by		Payment Level (Monthly)*	
	Federal	State	One person with gross income ≤ $1,911 per month	Couple with gross income ≤ $3,822 per month
Independent Living Outside Chittenden County	X		$689.04	$1054.88
Independent Living Chittenden County	X		$689.04	$1054.88
Another's Household	X		$463.97	$685.65
Licensed Residential Care Level III *(Limited Nursing Care)*		X	$904.13	$1,559.69
Licensed Residential Care Level III *(Assistive Community Care)*	X		$685.38	$1,052.77
Licensed Residential Care Care Level IV	X		$860.94	$1,518.06
Custodial Care Family Home	X		$735.69	$1,288.82
Long-Term Care *(Medicaid Payment)*	X		$47.66	$95.33

*Vermont applies federal SSI program eligibility criteria, income disregards, and resource limitations.

42 CFR 435.1005
42 CFR 435.1006

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

INCOME LEVELS FOR 1902 (f) STATES - CATEGORICALLY NEEDY WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

Not applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

Not Applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT*

☐ Section 1902 (f) ☒ Non-Section 1902 (f) State

The following items were formerly included as supplement 5, effective 10/1/87 and approved 1/25/88 (SPA 87-16).

SSI-related Medicaid

- Infrequent or irregular voluntary cash contributions or gifts are excluded.

- Lump Sum receipt of earnings such as sale of crops or livestock are averaged over the six-month accounting period.

- Countable income of an ineligible spouse is added to the countable income of an eligible individual and compared, after deductions, to the Medically Needy Income Level for two.

** The following items apply only to pregnant women and children under subsection 1902(a)(10)(A)(i)III, IV, VI, VII and 1902 (a)(10)(A)(ii)(IX) which includes those with income under the applicable poverty line income test:

** Depreciation is deducted as a business expense.

** In-kind assistance from others is excluded.

* More liberal methods may not result in exceeding gross income limitations under section 1903(f).

** These items are contained in SPA 89-6.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT*

☐ Section 1902 (f) ☒ Non-Section 1902 (f) State

From January 1 until April 1, the Department will disregard the difference between its estimated Federal poverty levels (FPLs) and the currently approved FPLs as published in the Federal Register. Effective April 1, the Department will issue a second increase if the actual FPLs exceed its estimate. If the department's estimated FPLs issued January 1 are higher than the actual FPLs, the department will continue to disregard the difference between its estimated FPLs and the ones published in the Federal Register.

For pregnant women eligible (at 185 percent of the poverty guideline) under 1902(a)(10)(A)(ii)(IX) and 1902(a)(l)(1)(A):

(1) Disregard income in the amount of 15 percent of the federal poverty level for the size family involved as revised annually in the Federal Register.

For infants eligible (at 185 percent of the poverty guideline) under 1902(a)(10)(A)(ii)(IX) and 1902(a)(l)(1)(B):

(1) Disregard income in the amount of 40 percent of the federal poverty level for the size family involved as revised annually in the Federal Register.

For children ages one through five eligible (at 133 percent of the poverty guideline) under 1902(a)(10)(A)(i)(VI):

(1) Disregard income in the amount of 92 percent of the federal poverty level for the size family involved as revised annually in the Federal Register.

For children age six or more, born after September 30, 1983, eligible (at 100 percent of the poverty guideline) under 1902(a)(10(A)(i)(VII):

(1) Disregard income in the amount of 125 percent of the federal poverty level for the size family involved as revised annually in the Federal Register.

For qualified children eligible (using AFDC income requirements) under 1902(a)(10)(A)(i)(III):

(1) Disregard income in the amount of the difference between 100 percent of the AFDC payment standard and 225 percent of the federal poverty level for the size family involved as revised annually in the Federal Register.

For working disabled individuals eligible (at 250 percent of the poverty guideline) under 1902(a)(10)(A)(ii)(XIII):

(1) Disregard all Social Security Disability Insurance benefits.

(2) Disregard all veteran's disability benefits.

*More liberal methods may not result in exceeding gross income limitations under section 1903(f).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT*

☐ Section 1902 (f) ☒ Non-Section 1902 (f) State

For medically needy individuals under 1902(a)(10)(C):

(1) Disregard income in the amount of the difference between the percentage increase in the CPI-U (between July 16, 1996 and September of the last month in the most recently completed FFY) and the MNIL in effect on July 16, 1996.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT*

☐ Section 1902 (f) ☒ Non-Section 1902 (f) State

Wages paid by the Census Bureau for temporary employment related to census activities are excluded for the following eligibility groups:

- Poverty level pregnant women and infants described at §1902(a)(10)(A)(i)(IV)
- Poverty level children under age 6 described at §1902(a)(10(i)(VI)
- Poverty level children under age 19, who are born after September 30, 1983 (or, at State option, after any earlier date) described at §1902(a)(10)(A)(i)(VII)
- Qualified pregnant women described at §§1902(a)(10)(A)(i)(III) and 1905(n)(1)
- Qualified children described at §1902(a)(10)(A)(i)(III)
- Qualified Medicare Beneficiaries described at §§1902(a)(10)(E)(i) and 1905(p)
- Specified Low Income Medicare Beneficiaries described at §1902(a)(10)(E)(iii)
- Qualifying individuals described at §1902(a)(10)(E)(iv)
- Individuals who are eligible for but not receiving IV-A, SSI or State supplement cash assistance described at §1902(a)(10)(A)(ii)(I)
- Individuals who could be eligible for IV-A cash assistance if State did not subsidize child care described at §1902(a)(10)(A)(ii)(II)
- Individuals who would have been eligible for IV-A cash assistance, SSI, or State Supplement if not in a medical institution described at §1902(a)(10)(A)(ii)(IV)
- Children under 21 (or at State option 20, 19, or 18) who are under State adoption agreements described at §1902(a)(10)(A)(ii)(VIII)
- Optional poverty level pregnant women described at §§1902(a)(10)(A)(ii)(IX) and 1902(l)(1)(A)
- Optional poverty level infants described at §§1902(a)(10)(A)(ii)(IX) and 1902(l)(1)(B)
- Individuals receiving only an optional State supplement payment which may be more restrictive than the criteria for an optional State supplement under title XVI described at §1902(a)(10)(A(ii)(XI)
- Uninsured women, under 65, who are screened for breast or cervical cancer under CDC program described at §1902(a)(10)(A)(ii)(XVIII)
- Working disabled individuals who buy in to Medicaid (BBA working disabled group) described at §1902(a)(10)(A)(ii)(XIII)
- Aged medically needy individuals described at §§1902(a)(10)(C) and 1905(a)(iii)
- Blind medically needy individuals described at §§1902(a)(10)(C) and 1905(a)(iv)
- Disabled medically needy individuals described at §§1902(a)(10)(C) and 1905(a)(v)
- Individuals who would be eligible if State AFDC plan were as broad as permitted described at 1902(a)(10)(A)(ii)(III)
- Medically needy parents/caretaker relatives described at §§1902(a)(10)(C) and 1905(a)(ii)
- Medically needy children younger than age 21 described at §§1902(a)(10)(C) and 1905(a)(i)
- Medically needy pregnant women described at §§1092(a)(10)(C) and 1905(a)(viii).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

MORE LIBERAL METHODS OF TREATING RESOURCES UNDER SECTION 1902(r)(2) OF THE ACT

☐ Section 1902 (f) ☒ Non-Section 1902 (f) State

The following items were formerly included as Supplement 5 or 5a, effective 10/1/87 and approved 1/25/88 (SPA 87-16).

SSI-Related Medicaid and Pregnant Women Eligibility

1. Resources of couple, where one member has been admitted to a long-term care facility are combined for 6 months if this is to the advantage of the couple.

2. Resources may be spent-down to the applicable Resource Maximum if used for medical or maintenance expenses.

3. Real property is excluded if the income it produces is significant to meeting living expenses and consistent with its fair market value.

4. Savings from excluded income are excluded.

5. Vermont does not use the first moment of the first day of the month in counting resources. If the applicant(s) is under resources at any time during the month, Medicaid is granted for the entire month if all other eligibility criteria are met.

ANFC-Related Medicaid

1. Savings which can be demonstrated are solely from excluded income are not counted as a resource.

2. The equity value of one operable motor vehicle per assistance group with one adult and of two operable motor vehicles per assistance group with more than one adult is excluded as a resource.

3. Assets accumulated with the earnings of families participating in Reach Up shall be excluded as a resource.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

MORE LIBERAL METHODS OF TREATING RESOURCES UNDER SECTION 1902(r)(2) OF THE ACT

* SSI-related Medicaid. (aged, blind and disabled individuals including individuals who are described at 1902(a)(10)(A)(ii), 1902(a)(10)(C)(i)(III) and 1905(p) of the Social Security Act who are not receiving SSI/AABD cash assistance or deemed to be cash assistance recipients.

1. Non exempt real property which is up for sale is excluded as long as owners verify that they are making reasonable efforts to sell it.
2. Automobiles of any value are excluded.
3. No limit is placed on the equity value of property used to produce goods for home consumption.
4. Life estates in real property are excluded when the owner does not retain the power to sell the real property.
5. Separately identifiable burial funds designated for burial expenses, either singly or in combination, are exempt in an amount not to exceed $10,000. The burial funds must be designated by the title of the fund or by sworn statement provided to the department. The burial funds in conjunction with the irrevocable burial trust referenced in Supplement 10 to Attachment 2.6-A, page 1, last paragraph, cannot exceed $10,000 in total.
6. Annuities, promissory notes, and similar resources that produce income are exempt resources if they would otherwise be countable by SSI as long as they meet the following criteria.

   (i) Annuities are not a countable resource if they: have no beneficiary other than an individual requesting Medicaid or his or her spouse; and provide for payments to applicants or their spouses in equal intervals and equal amounts; and do not exceed the life expectancy of the applicants or their spouses, as determined by the department; and return to the beneficiary at least the amount used to establish the contract and any additional payments plus any earnings, as specified in the contract; and do not pay anyone other than the applicant, the applicant's spouse, even if the applicant or spouse dies before the payment period ends. The department will also consider an annuity to meet the requirements above, if the owner of the annuity elects to designate Vermont Medicaid as the primary beneficiary up to the amount of long-term care payments it made, and names a contingent beneficiary other than the applicant or spouse to receive any surplus after Vermont Medicaid is paid.

   (ii) Promissory notes and similar resources that produce income are not a countable resource if: (1) they meet the requirements in subsection (i) above, or (2) the individual owned a nonnegotiable or nonassignable promissory note executed before September 1, 2005 and the individual or spouse can expect to receive the full fair market value of the resource within the expected lifetime of the individual or spouse, as determined by the department.
7. Resources set aside in a separate bank account in the name of the Medicaid beneficiary are exempt in an amount not to exceed $30,000. The funds may only be spent on medical care, assistive technology devices or home modifications not covered by Medicare, private insurance or Medicaid. They must be found to be reasonable and necessary to assist an individual in achieving or maintaining independent living. Up to $500 per month of these resources may be spent for medical care and assistive technology devices. A one time expenditure of up to $7,500 of these resources may be spent for home modifications.

*For qualified children eligible (using AFDC income and asset requirements) under 1902(a)(10)(A)(i)(III)
1. Disregard all assets.

*BBA Work Incentive Eligibility Group (1902(a)(10)(A)(ii)(XIII)):
1. Savings from excluded income are excluded.
2. An additional $3,000 in resources is disregarded for individuals; $4,000 for couples.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

MORE LIBERAL METHODS OF TREATING RESOURCES UNDER SECTION 1902(r)(2) OF THE ACT

Medicare Savings Program individuals who are described at §§1902(a)(10)(E)(i) and 1905(p)(1) – Qualified Medicare Beneficiaries; §1902(a)(10)(E)(iii) – Specified Low-Income Medicare beneficiaries; and §1902(a)(10)(E)(iv) – Qualified Individuals.

1. Disregard all resources.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

TRANSFER OF ASSETS

1917(c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

   The agency withholds payment to institutionalized individuals for the following services:

   Payments based on a level of care in a nursing facility;

   Payments based on a nursing facility level of care in a medical institution;

   Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

   ☐ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

   The agency withholds payment to non-institutionalized individuals for the following services:

   Home health services (section 1905(a)(7));

   Home and community care for functionally disabled and elderly adults (section 1905(a)(22));

   Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

   ☐ The following other long-term care services for which medical assistance is otherwise under the agency plan:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

TRANSFER OF ASSETS

3. Penalty Date –

The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

☐ the first day of the month in which the asset was transferred;

☒ the first day of the month following the month of transfer;

4. Penalty Period - Institutionalized Individuals

In determining the penalty for an institutionalized individual, the agency uses:

☒ the average monthly cost to a private patient of nursing facility services in the state;

☐ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

5. Penalty Period- Non-institutionalized Individuals-

The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

☐ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care-

a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:

☐ does not impose a penalty;

☒ imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.

b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:

☐ does not impose a penalty;

☒ imposes a series of penalties, each for less than a full month.

7. Transfers made so that penalty periods would overlap-
The agency:

☐ totals the value of all assets transferred to produce a single penalty period;

☒ calculates the individual penalty periods and imposes them sequentially.

8. Transfers made so that penalty periods would not overlap-
The agency:

☒ assigns each transfer its own penalty period;

☐ uses the method outlined below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

TRANSFER OF ASSETS

9. Penalty periods- transfer by a spouse that results in a penalty period for the individual -

a. The agency apportions any existing penalty period between the spouse using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

- If married couple admitted to Institution at same time, the uncompensated value of the transferred assets are divided by 2 before determining penalty period for each person.

- If married couple not admitted to Institution at same time, the uncompensated value for which no penalty period has yet been served, is divided by 2 before determining penalty period for each person.

b. If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset-
When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

☐ The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

☐ For transfers of individual income payments, the agency will impose partial month penalty periods.

☒ For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

☐ The agency uses an alternate method to calculate penalty periods, as described below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

TRANSFER OF ASSETS

11. Imposition of a penalty would work an undue hardship

The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

- recipients are notified in brochures that a penalty may be applied for transfers of assets; and
- if a transfer has occurred, staff notify the individual of a penalty period, if any, and explain the undue hardship provisions; and
- a waiver request is acted upon promptly and the individual is told about the appeal process if undue hardship is not found.

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

- Application of the transfer of assets provisions would deprive the individual of necessary institutional level care.
- Undue hardship exists if funds can be made available for medical care only if assets are sold, and these assets are the sole source of income for the individual's immediate family. Such income-producing assets include a family farm or other family business. Immediate family is defined as spouse, parents, children or siblings.
- Undue hardship also exists if sale of the income-producing assets would result in the immediate family seeking public assistance.
- Undue hardship may be found at a similar degree of impact in other circumstances as well, upon the agreement of the District Director.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

TRANSFER OF ASSETS

1917(c) FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006, the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

   The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

   Nursing facility services;

   Nursing facility level of care provided in a medical institution;

   Home and community-based services under a 1915(c) or (d) waiver.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

TRANSFER OF ASSETS

2. Non-institutionalized individuals:

☐ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

☐ The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

TRANSFER OF ASSETS

3. Penalty Date -- The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

- the first day of a month during or after which assets have been transferred for less than fair market value;

  ☐ The State uses the first day of the month in which the assets were transferred

  ☒ The State uses the first day of the month after the month in which the assets were transferred

or

- the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid;

AND

which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

TRANSFER OF ASSETS

4. Penalty Period - Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:

☒ the average monthly cost to a private patient of nursing facility services in the State at the time of application;

☐ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

5. Penalty Period - Non-institutionalized Individuals--
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

☐ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. Penalty period for amounts of transfer less than cost of nursing facility care--

☒ Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

☒ The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

TRANSFER OF ASSETS

7. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

(a) The agency apportions any existing penalty period between the spouses provided the spouse is eligible for Medicaid. The method for apportions the penalty is as follows, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

The existing penalty period is divided in half and apportioned evenly between spouses.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

8. Treatment of a transfer of income—

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

☒ For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in #6 above.

☒ For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

TRANSFER OF ASSETS

9. Imposition of a penalty would work an undue hardship--

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

(a) Of medical care such that the individual's health or life would be endangered; or

(b) Of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

(a) Notice to a recipient subject to a penalty that an undue hardship exception exists;

(b) A timely process for determining whether an undue hardship waiver will be granted; and

(c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

TRANSFER OF ASSETS

11. Bed Hold Waivers For Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

☐ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed _____ days (may not be greater than 30).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

The agency does not apply the trust provisions in any case in which the agency determines that such an application would work an undue hardship.

The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardship:

Undue hardship includes situations where the individual would be forced to go without life-sustaining services because the trust funds could not be made available to pay for the services.

Undue hardship also exists if funds can be made available for medical care only if assets are sold, and these assets are the sole source of income for the individual's immediate family. Such income-producing assets include a family farm or other family business. Immediate family is defined as spouse, parents, children, or siblings.

Undue hardship also exists if sale of the income-producing assets would result in the immediate family seeking public assistance.

Undue hardship also includes situations where a trust has been established with awards paid to disabled children under the Zebley decision.

Undue hardship may be found at a similar degree of impact in other circumstances as well, upon the agreement of the District Director.

Under the state's undue hardship provisions, the agency exempts the funds in an irrevocable burial trust. A maximum value of the exemption for an irrevocable burial trust, established prior to July 1, 2002, is not limited. Irrevocable burial trusts established on or after July 1, 2002 are exempt up to $10,000. This language is to be read in conjunction with Supplement 8b to Attachment 2.6-A, page 2, paragraph 6 and it is not intended to provide an additional exemption beyond $10,000.

State: _____VERMONT_____

Citation(s)	Condition or Requirement
1902 (u) of the Act	COST EFFECTIVENESS METHODOLOGY FOR COBRA CONTINUATION BENEFICIARIES Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods: ☐ The methodology as described in SMM section 3598. ☐ Another cost-effective methodology as described below.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

Not applicable.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under section 1931 of the Act.

The following groups were included in the AFDC State plan effective July 16, 1996:

☒ Pregnant women with no other eligible children *will receive AFDC benefits as long as it has been medically verified that her expected delivery date falls within the next 30 days or, if she is either a minor or is unable to work due to a high-risk pregnancy, within the three-month period following the month of application, and it has been determined that the child would be eligible for ANFC if he or she were born.*

☒ AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

☒ In determining eligibility for Medicaid, the agency uses the AFDC standards in effect as of July 16, 1996 without modification.

Household Size	ANFC Payment Level on July 16, 1996 (Within Chittenden County)	(Outside Chittenden County)
1	$436	$396
2	$536	$496
3	$636	$597
4	$715	$676
5	$802	$762
6	$857	$818
7	$954	$914
8	$1,036	$996

☐ In determining eligibility for Medicaid, the agency uses the AFDC standards in effect as of July 16, 1996, with the following modifications:

☐ The agency applies lower income standards which are no lower than the AFDC standards in effect on May 1, 1988, as follows:

☐ The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

☐ The agency applies higher resource standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

☒ The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

For individuals who qualify for the categorically needy coverage group by meeting ANFC eligibility criteria, we exclude an amount equal to the difference between the Reach Up payment level currently in effect and the ANFC payment level in effect on July 16, 1996.

The equity value of one operable motor vehicle per assistance group with one adult and two operable motor vehicles per assistance group with more than one adult is excluded as a resource.

The department disregards earned income from wages for 24 months following receipt, if this income would otherwise cause loss of section 1931 eligibility.

The department disregards $150 plus 25% of the remainder from earnings per month. During the first four months of earnings the department disregards $90 plus $30 plus 1/3 of the remainder or $150 plus 25% of the remainder, whichever is more generous.

The department excludes wages paid by the Census Bureau for temporary employment related to census activities.

The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

All income considered for ANFC eligibility was considered for the purposes of categorically needy coverage.

The equity value of up to $1500 for one vehicle used as a primary means of transportation per assistance group was excluded as a resource.

Under ANFC, earned income after allowable disregards was counted.

For ANFC, $90 was deducted from the gross earnings and a disregard of $30 plus 1/3 of the remainder was given for the first four months of employment. Then $90 plus $30 was disregarded for the next eight months. After that, only $90 was disregarded from earned income. The remainder was counted in determining eligibility.

Under ANFC, wages paid by the Census Bureau for temporary employment related to census activities were counted.

☐ The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

☒ The agency continues to apply the following waivers of provisions of Part A of title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997: The Department of Health and Human Services' Administration for Children and Families authorized waivers of various provisions of the AFDC section of the Social Security Act for Vermont's Welfare Restructuring Project (WRP).

The following waiver provisions are carried forward from the WRP and apply to Section 1931 coverage group:

100-hour Rule: The department provides benefits for families in which the principal earner works 100 or more hours per month.

The department disregards assets accumulated from earnings.

Vermont follows section 1924 for treatment of income and resources for certain institutionalized spouses as follows:

The MMMNA as set out at 1924(d)(3)(A) is 150 percent of 1/12 of the income official poverty line for a family unit of 2 members plus an excess shelter allowance. The amount is subject to the cap at 1924(d)(3)(C).

The CSRA as set out at 1924(f)(2) is the maximum allowed at 1924(f)(2)(A)(ii)(2) for use at 1924(f)(2)(A)(i).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

INCOME AND RESOURCE REQUIREMENTS FOR TUBERCULOSIS (TB) INFECTED INDIVIDUALS

For TB infected individuals under §1902 (z) (1) of the Act, the income and resource eligibility levels are as follows:

Not applicable.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____Vermont_____

ASSET VERIFICATION SYSTEM

1940(a) of the Act

1. The agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.

A. The request and response system must be electronic:

(1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
(2) The system cannot be based on mailing paper-based requests.
(3) The system must have the capability to accept responses electronically.

B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).

C. The system must establish and maintain a database of FIs that participate in the agency's AVS.

D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or redetermine the individual's eligibility.

E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____Vermont_____

ASSET VERIFICATION SYSTEM

2. System Development

☐ A. The agency itself will develop an AVS.

In 3 below, provide any additional information the agency wants to include.

☒ B. The agency will hire a contractor to develop an AVS.

In 3 below provide any additional information the agency wants to include.

☐ C. The agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

☐ D. The agency already has a system in place that meets the requirements for an acceptable AVS.

In 3 below, describe how the existing system meets the requirements in Section 1.

☐ E. Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____Vermont_____

ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include.

Vermont has prepared an RFP and will be reviewing bids during the months of May and June, 2010. The vendor will be required to implement the AVS system as of October 1, 2010.

The vendor selected will have a system that meets the requirements of Supplement 16 to Attachment 2.6-A, page 1.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____VERMONT_____

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

☒ $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

☐ An amount that exceeds $500,000 but does not exceed $750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

The amount chosen by the State is _____.

☐ This higher standard applies statewide.

☐ This higher standard does not apply statewide. It only applies in the following areas of the State:

☐ This higher standard applies to all eligibility groups.

☐ This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.

State Plan Under Title XIX of the Social Security Act

State: Vermont

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 01/28/2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	**Relevant Population Group Income Standard** For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	**Resource Proxy**	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	Attachment A, Column C, Line 1 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Disabled Persons, non-institutionalized	Attachment A, Column C, Line 2 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Disabled Persons, institutionalized	Attachment A, Column C, Line 3 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Children Age 19 or 20	Attachment A, Column C, Line 4 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Childless Adults	Attachment A, Column C, Line 5 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

   ☐ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   ■ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

   Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

   The state:

   ☐ Applies existing state data from periods before January 1, 2014.

   ☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

   Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. ☐ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

   ■ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

   ☐ Yes. The combined enrollment cap adjustment is described in Attachment C

   ☐ No.

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:

   ☐ Applies a special circumstances adjustment(s).

   ■ Does not apply a special circumstances adjustment.

2. The state:

   ☐ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).

   ■ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

☒ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

☐ The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

☐ Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)

☒ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated 06/18/2013.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

☐ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

☒ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated 06/18/2013. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- ☒ Attachment A – Conversion Plan Standards Referenced in Table 1
- ☐ Attachment B – Resource Criteria Proxy Methodology
- ☐ Attachment C – Enrollment Cap Methodology
- ☐ Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- ☒ Attachment E – Transition Methodologies

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 4 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Attachment A. Most Recent Updated Summary Information for Part 2 of the Modified Adjusted Gross Income (MAGI) Conversion Plan*

Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan

VERMONT

1/6/2014

	Population Group	Net standard as of 12/1/09	Converted standard for FMAP claiming	Same as converted eligibilty standard? (yes, no, or n/a)	Source of information in Column C (New SIPP conversion or Part 1 of approved state MAGI conversion plan)	Data source for Conversion (SIPP or state data)
	A	B	C	D	E	F
Conversions for FMAP Claiming Purposes						
1	**Parents/Caretaker Relatives** FPL %	185%	195%	yes	Part 1 of approved state MAGI conversion plan	SIPP
2	**Noninstitutionalized Disabled Persons** Dollar standards Single Couple	 * *	 $956 $956	no	new SIPP conversion	SIPP
3	**Institutionalized Disabled Persons** SSI FBR%	300%	300%	n/a	ABD conversion template	n/a
4	**Children Age 19-20** Dollar standards by family size 1 2 3 4 add-on	 * * * * n/a	 $997 $1,021 $1,229 $1,383 n/a	no	new SIPP conversion	SIPP
5	**Childless Adults** FPL % (VHAP)	150%	157%	yes	Part 1 of approved state MAGI conversion plan	SIPP

n/a: Not applicable.

* Converted standards are a weighted average of separate standards for inside and outside Chittenden County.

***The numbers in this summary chart will be updated automatically in the case of modification in the CMS approved MAGI Conversion Plan.**

Attachment E: Transition Methodologies

Vermont is an expansion state with no newly eligibles, and as such will be claiming enhanced FMAP only for non-pregnant, childless adults in the new adult group.

Vermont's 1115 waiver demonstration groups cover non-pregnant, childless adults, some of whom have current incomes below 133% FPL. Specifically, those programs are the Vermont Health Access Plan (VHAP), the Employer-sponsored insurance premium assistance program (ESIA), and the Catamount Health premium assistance program (CHAP). The non-MAGI income limits for these groups in effect as of December 1, 2009, were as follows:

- VHAP: 150% FPL for childless adults and 185% for parents
- ESIA: 300% FPL
- CHAP: 300% FPL

As of January 1, 2014, adults in these programs with income at or below the 133% threshold for the adult group have been assigned a Medicaid category code; non-pregnant, childless adults, as a subgroup, will be identifiable by this code. Adults who have been assigned a Medicaid category code are being held temporarily in the legacy system, ACCESS, and will be transitioned to the new eligibility system, OneGate, at the time of their first annual review in 2014, at which point a full determination of their eligibility based on MAGI methodologies, including the use of the streamlined application form and verification through electronic data sources, will be completed. Vermont estimates that approximately 32,000 individuals enrolled in 1115 expansion groups were assigned Medicaid category codes as a result of this transition. A portion of these individuals are parents and therefore not eligible for enhanced FMAP claims.

A more detailed description of the transition plan for all groups under the state plan and the 1115 waiver is contained in our approved transition matrix (attached).

In addition to the transition matrix, Vermont has requested and received several waivers under 1902(e)(14)(A) authority to augment its transition plan. They are as follows:

- Annual redeterminations scheduled for January through March 2014 for Individuals eligible for Medicaid as of 12/31/13 and subject to MAGI methodologies in 2014 were rescheduled for the months of April through December 2014.
- Individuals enrolled in Medicaid as of 12/31/13 and subject to MAGI methodologies in 2014 will have income increases disregarded until their first annual redetermination in 2014.
- Adults under age 65 enrolled in an 1115 expansion group as of 12/31/13 and whose income is at or below 133% were transitioned to the new adult group without a formal redetermination of eligibility based on MAGI methodologies.

State: VERMONT

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: ☒ No limitations ☐ With limitations*

2. a. Outpatient hospital services.

   Provided: ☐ No limitations ☒ With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic which are otherwise provided in the state plan.

   ☒ Provided: ☐ No limitations ☒ With limitations*
   ☐ Not provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   ☒ Provided: ☐ No limitations ☒ With limitations*

3. Other laboratory and x-ray services.

   Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

ITEM 1. INPATIENT HOSPITAL:

No limitations

ITEM 2.a. OUTPATIENT HOSPITAL SERVICES

Emergency Care

Emergency Care shall be administered in accordance with 42 CFR 447.53(b)(4).

Rehabilitative Therapies

Physical, occupational and speech/language therapies are described on page 4e of Attachment 3.1-A.

Diagnostic Testing

Diagnostic testing is limited to those tests ordered by a physician for determining the nature and severity of an illness or medical condition. Administratively necessary or court ordered tests are not covered, unless they are medically necessary.

Psychiatric Partial Hospitalization

Psychiatric partial hospitalization is covered as a hospital service for those programs which have received and meet the conditions of a Certificate of Need for the Vermont Health Care Authority.

ITEM 2.b. RURAL HEALTH CLINIC SERVICES AND OTHER AMBULATORY SERVICES FURNISHED BY A RURAL HEALTH CLINIC

Limitations on rural health clinics are:

1) no more than 5 visits (encounters) per month.

2) no more than 1 visit (encounter) per day.

3) any exceptions to the above by prior authorization only.

ITEM 2.c. LIMITATIONS ON FEDERALLY QUALIFIED HEALTH CENTERS ARE:

1) no more than 5 visits (encounters) per month.

2) no more than 1 visit (encounter) per day.

3) any exceptions to the above by prior authorization only.

ITEM 3. OTHER LABORATORY AND X-RAY SERVICES:

Covered laboratory and radiology services include the following:

- Microbiological, serological, hematological and pathological examinations; and
- Diagnostic and therapeutic imaging services; and
- Electro-encephalograms, electrocardiograms, basal metabolism readings, respiratory and cardiac evaluations.

Limitations:

The following outpatient high-tech imaging services require prior authorization:

- computed tomography (CT) (previously referred to as CAT scan);
- computed tomographic angiography (CTA);
- magnetic resonance imaging (MRI);
- magnetic resonance angiography (MRA);
- positron emission tomography (PET); and
- positron emission tomography-computed tomography (PET/CT).

The following imaging services do not require prior authorization:

- those provided during an inpatient admission;
- those provided as part of an emergency room visit;
- x-rays, including dual x-ray absorptiometry (DXA) images;
- ultrasounds; or
- mammograms.

Laboratory services for urine drug testing is limited to eight (8) tests per calendar month. This limitation applies to tests provided by professionals, independent labs and hospital labs for outpatients. Exceptions to this limitation must be prior approved.

State: VERMONT

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ☐ No limitations ☒ With limitations*

4. b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4. c. Family planning services and supplies for individuals of child-bearing age.

Provided: ☐ No limitations ☒ With limitations*

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: ☐ No limitations ☒ With limitations*

5. b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ☐ No limitations ☒ With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

ITEM 4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older: Coverage for nursing facility services is based on a physician's order with documentation of medical necessity for treatment of illness or injury.

All specialized out-of-state nursing facility stays require prior authorization.

ITEM 4.b. EPSDT for individuals under 21 years of age:

EPSDT services are provided to all Medicaid eligibles under age 21 in accordance with Sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Social Security Act.

Coverage is provided for all medically necessary diagnosis and treatment services including the following services not otherwise provided under the State Plan:

- Dentures (Item #12b)
- Eyeglasses (Item #12d)
- Personal care in home (Item #24f)
- Personal care services (Item #26)

Christian Science nursing and Christian Science sanatoria services (Items #24b and #24c) are not currently available in Vermont.

Coverage and service limitations described in this State Plan do not apply to medically necessary EPSDT services, although some services may be subject to prior authorization requirements.

ITEM 4.c. Family planning services and supplies for individuals of child-bearing age: provided, with limitations.

Reversals of sterilization are not covered.

4. D 1) Face-to-Face Tobacco Cessation Counseling Services provided (by**):**

☒ (i) By or under supervision of a physician;

☒ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services; * or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: ☐ No limitations ☒ With limitations*

Face-to-face smoking cessation counseling is covered for pregnant Vermont Medicaid beneficiaries. The maximum number of visits allowed per calendar year is 16.

ITEM 5.a. PHYSICIAN'S SERVICES WHETHER FURNISHED IN THE OFFICE, A PATIENT'S HOME, A HOSPITAL, A NURSING FACILITY, OR ELSEWHERE

Physician's services are limited in the following ways:

A. Physician visits:
- Office visits - up to five visits per month
- Home visits - up to five visits per month
- Nursing facilities visits - up to one visit per week
- Hospital visits - up to one admission visit per patient per diagnosis per month, and up to one visit per day for acute care.

B. Services requiring prior authorization:
1) Visits in excess of those listed above,
2) Concurrent care by more than one physician,
3) Certain reconstructive surgical procedures,
4) New procedures of unproven value,
5) Procedures of questionable medical efficacy,
6) Procedures which tend to be redundant when performed in combination with other procedures,
7) Organ transplants,
8) Psychotherapy.

C. Services which require special reporting under Federal regulations:
1) Sterilization: signed consent within stipulated time frames on the approved HCFA Sterilization Consent form required
2) Hysterectomy: physician certification and patient signed consent required.
3) Abortion: physician certification required.

D. No reimbursement will be made for the following services:
1) Cosmetic surgery
2) Ineffective or unproven procedures
3) Unnecessary testing
4) Experimental procedures
5) Services provided without required consent

ITEM 5.b. MEDICAL AND SURGICAL SERVICES FURNISHED BY A DENTIST

See item 5a. Also, some dental services may require prior authorization.

ITEM 6. MEDICAL CARE AND ANY OTHER TYPE OF REMEDIAL CARE RECOGNIZED UNDER STATE LAW, FURNISHED BY LICENSED PRACTITIONERS WITHIN THE SCOPE OF THEIR PRACTICE AS DEFINED BY STATE LAW

A. Podiatrist's Services

Podiatrists' services are limited to non-routine foot care.

The following are routine foot care services and are excluded, regardless of who performs them:

1. Treatment of flat foot conditions and supportive devices used in such treatment.

2. Treatment of subluxations of the foot (structural misalignments of the joints of the feet) not requiring surgical procedures (i.e., treatment by strapping, electrical therapy, manipulations: massage, etc.)

3. Cutting or removal of corns or calluses, trimming of nails and preventative or hygienic care of the feet.

The fact that an individual is unable, due to physical disability, to perform routine foot care services for himself does not change the character of the services and make them "non-routine".

State: VERMONT

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

b. Optometrists' services.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Chiropractors' services.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Other practitioners' services.
☒ Provided: Identified on attached sheet with description of limitations, if any.
☐ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Home health aide services provided by a home health agency.

☒ Provided: ☐ No limitations ☒ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

State: _____VERMONT_____

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

7. Home health services.

d. Physical therapy, occupational therapy, or speed pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

8. Private duty nursing services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

ITEM 6. MEDICAL CARE AND ANY OTHER OF REMEDIAL CARE RECOGNIZED UNDER STATE LAW, FURNISHED BY LICENSED PRACTITIONERS WITHIN THE SCOPE OF THEIR PRACTICE AS DEFINED BY STATE LAW (continued)

B. Optometrists' Services

Vision care services are limited to the following* (when provided by a licensed physician or optometrist approved to participate in Medicaid):

- One complete visual analysis including refraction once every two years per eligible beneficiary.
- One interim diagnostic eye exam once every two years per eligible beneficiary.
- Contact lenses/special lenses with prior authorization.
- Other aids to vision, such as closed circuit television, when the beneficiary is legally blind and when providing the aid to vision would foster independence by improving at least one activity of daily living (ADL or IADL).

* With the exception of services authorized for coverage via the procedure for requesting Medicaid coverage of a service or item (M108) found at Attachment 3.1-A Page 6o.

ITEM 6. MEDICAL CARE AND ANY OTHER OF REMEDIAL CARE RECOGNIZED UNDER STATE LAW, FURNISHED BY LICENSED PRACTITIONERS WITHIN THE SCOPE OF THEIR PRACTICE AS DEFINED BY STATE LAW (continued)

C. Chiropractic Services

Chiropractic services are limited to treatment by means of manual manipulation of the spine for the correction of a misalignment of the spine.

Coverage is limited to ten (10) treatments per calendar year per beneficiary. Treatments beyond ten per year require prior authorization.

Treatments for children under 12 years of age require prior authorization.

ITEM 6. MEDICAL CARE AND ANY OTHER OF REMEDIAL CARE RECOGNIZED UNDER STATE LAW, FURNISHED BY LICENSED PRACTITIONERS WITHIN THE SCOPE OF THEIR PRACTICE AS DEFINED BY STATE LAW (continued)

D. Other Practitioners' Services

1. Behavioral Health Services:
The services of a licensed psychologist, licensed clinical social worker, licensed mental health counselor or licensed marriage and family therapist practicing independently are covered for psychotherapy.

No reimbursement for this state plan service is allowed if the beneficiary is an inpatient or outpatient of a general hospital, resident in a mental hospital or a patient concurrently receiving services at a community mental health clinic.

2. Opticians' Services:
Vision care services are limited to the coverage of eyeglass-dispensing services.

3. High-Tech Nursing Services:
High-tech nursing services are nursing services furnished by licensed registered nurses and licensed practical nurses and are limited to technology-dependent beneficiaries who are receiving care through the Medicaid "High-Tech Program". All services must be prior authorized by the Medicaid Division.

4. Licensed Lay Midwife Services:
Services are limited to those specified in protocols for licensure and reviewed and accepted by the State of Vermont, Director of the Office of Professional Regulation.

5. Naturopathic Physician Services:
Services are limited to those specified in protocols for licensure and reviewed and accepted by the State of Vermont, Director of the Office of Professional Regulation, and are services covered by Medicaid.

ITEM 7. HOME HEALTH SERVICES

Home health services are listed to those required on an intermittent basis. Covered home health services under this Plan are those that are provided by the staff of a Medicare certified and Medicare participating home health agency or visiting nurse association.

A. Intermittent or part-time nursing ordered by and included in the Plan of treatment established by the physician.

An initial visit by a registered nurse or appropriate therapist for the assessment of the need for home health services by observation and evaluation of function may be covered either in the community or the hospital. If nursing care is ordered and provided during the visit, only one service (either the initial visit or the care) will be covered.

B. Home health aide services must be documented in the Plan of treatment and supervised by the appropriate therapist or the registered nurse. Personal care services may be performed by the aide when they are incidental to the medical care being provided.

C. Medical supplies are limited to those required to perform the services ordered by the physician. Routine small cost items (eg. cotton balls, tongue depressors, etc.) are covered in the visit or hourly rate paid to the agency. Agencies owning equipment may be reimbursed a rental fee for the loan of such equipment as meets the needs of the beneficiary as documented in the plan of treatment. Medicaid will not pay the agency for the purchase of equipment.

D. Therapy services whether occupational therapy, physical therapy or speech pathology services, are limited to four months, after which prior authorization must be requested of and granted by the DVHA for reimbursement to be made. Unless, the service may not be reasonably provided by the patient's support person(s) and the patient undergoes another acute care episode or injury, or experiences increased loss of function, or deterioration of the patient's condition requiring therapy is imminent and predictable, authorization will not be granted for more than one year from the start of treatment. Services requiring treatment which cannot be brought into the home, will be covered provided the agency has met the certifying standards for that service under their participation agreement with Medicare. Physical, occupational and speech/language therapist, assistant and aide qualifications are described on page 4f of Attachment 3.1-A.

ITEM 8. PRIVATE DUTY NURSING SERVICES

Private duty nursing services are provided to Medicaid eligible individuals only. All services require prior authorization. Services are provided in the home and community. The community setting refers to normal life activities outside of the home.

Private duty nursing services are provided in accordance with 42 CFR §440.80.

State: VERMONT

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

10. Dental services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Occupational therapy.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist)

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

ITEM 9. CLINIC SERVICES

a) Services of medical care clinics, physician group practices or Indian health services are limited in accordance with the limits to Physicians' Services set forth in this plan.

b) Mental Health clinic services are those services provided by mental health clinics which are facilities, not a part of a hospital, established for the purpose of providing mental health care and services to outpatients. A mental health clinic eligible for participation under the Plan must meet all of the following conditions:

(1) Be an incorporated, non-profit clinic governed by an elected board of directors, who reside in the catchment area of the facility;

(2) Have an organized, multi-disciplinary professional staff;

(3) Be a clinic which renders services without regard to the patient's ability to pay; and

(4) Be a clinic which conforms to the standards for mental health clinics published by the Commissioner of the Department of Mental Health.

Services eligible for reimbursement under the Plan shall be provided according to an individualized patient treatment plan which shall be prescribed by a physician or formulated with physician participation. The treatment plan or the process of treatment shall be regularly reviewed by the physician. Services shall be provided by the physician or by a qualified mental health professional on the staff of the clinic or other participating home and community based providers considered by the prescribing physician to be a competent therapist or practitioner.

c. Comprehensive service clinics operated by the Vermont Department of Health may provide all the services of medical care clinics, physician group practices, physical therapy and related services, and any other outpatient service covered in the state plan. All services provided are limited in amount, duration and scope, and qualified provider as set forth in this plan.

All patients of the comprehensive service clinics shall have an individualized patient treatment plan prescribed by a physician or formulated with physician participation. The treatment plan or the process of treatment shall be regularly reviewed by the physician. Clinic services shall be provided by a physician or by another qualified provider. All health care providers used by the clinic that are not enrolled in the Medicaid program must be credentialed by the Vermont Department of Health.

ITEM 9. CLINIC SERVICES (Continued)

1) Psychotherapy:

A method of treatment of mental disorders using the interaction between a therapist and a patient to promote emotional or psychological change to alleviate mental disorder. Psychotherapy also includes family therapy when only one family is being treated. Psychotherapy may be provided in any setting except skilled nursing or intermediate care facilities or the facilities of the Vermont State Hospital or the Brandon Training School.

2. Group Therapy:

A method of treatment of mental disorders, using the interaction between a therapist and two or more patients to promote emotional or psychological change to alleviate mental disorders. Group therapy may, in addition, focus on the patient's adaptational skills involving social interaction and emotional reactions to reality situations. Group therapy may be provided in any setting except skilled nursing or intermediate care facilities or the facilities of the Vermont State Hospital or the Brandon Training School.

3) Day Hospital:

Day Hospital is an intensive service provided in clinic facilities that provides active treatment which can reasonably be expected to lead to full or partial recovery of the patient (client). Day Hospital services are provided as an alternative to inpatient care for clients with mental illness of an acute and/or episodic nature. A variety of treatment modalities is available, including individual, group and family therapy, chemotherapy and treatment-related activity programs.

4) Chemotherapy (Med-Check):

Prescription of psychoactive drugs to favorably influence or prevent mental illness by a physician, physician's assistant, or nurse performing within the scope of their license. Chemotherapy also includes the monitoring and assessment of patient reaction to prescribed drugs. Chemotherapy may be provided in any setting except skilled nursing or intermediate care facilities, or the facilities of the Vermont State Hospital or the Brandon Training School.

ITEM 9. CLINIC SERVICES (Continued)

5) Diagnosis and Evaluation

A service related to identifying the extent of a patient's (client's) condition. It may take the form of a psychiatric and/or psychological and/or developmental and/or social assessment, including the administration and interpretation of psychometric tests. It may include: an evaluation of the client s attitudes, behavior, emotional state, personality characteristics, motivation, intellectual functioning, memory and orientation; an evaluation of the client's social situation relating to family background, family interaction and current living situation; an evaluation of the client's social performance, community living skills, self-care skills and prevocational skills; and/or an evaluation of strategies, goals and objectives included in the development of a treatment plan, program plan of care consistent with the assessment findings as a whole.

6) Emergency Care

A method of care provided for persons experiencing an acute mental health crisis is evidenced by (1) a sudden change in behavior with negative consequences for wellbeing; (2) a loss of usual coping mechanisms, or (3) presenting a danger to self or others. Emergency care includes diagnostic and psychotherapeutic services such as evaluation of the client and the circumstances leading to the crisis, crisis counseling, screening for hospitalization, referral and follow-up. Emergency services are intensive, time-limited and are intended to resolve or stabilize the immediate crisis through direct treatment, support services to significant others, or arrangement of other more appropriate resources.

ITEM 10. DENTAL SERVICES

Coverage of non-surgical treatment of temporomandibular joint disorders is limited to the fabrication of an occlusal orthotic appliance (TMJ splint). Coverage of prophylaxis is limited to once every six months, except more frequent treatments are authorized by the DVHA's dental consultant. Prior authorization is required for most special dental procedures.

For beneficiaries age 21 and older, excluding pregnant and postpartum women, the dental benefit is limited to $510.00 per beneficiary per calendar year. Non-covered services for beneficiaries age 21 and older, excluding pregnant and postpartum women, include; cosmetic procedures; and certain elective procedures, including but not limited to: bonding, sealants, periodontal surgery, comprehensive periodontal care, orthodontic treatment, processed or cast crowns and bridges.

ITEM 11. PHYSICAL THERAPY AND RELATED SERVICES

A, B, & C Physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders are covered as follows:

For beneficiaries under age 21, prior authorization is required beyond eight therapy visits per discipline (physical, occupational, or speech therapy).

For beneficiaries age 21 and older, thirty (30) therapy visits per calendar year and include any combination of physical therapy, occupational therapy and speech/language therapy. Exceptions to this limitation must be prior approved.

All therapy providers meet the provider qualification described in 42 CFR 440.110

PT, OT, and ST for an inpatient of the nursing facility are covered in the nursing facility per diem.

Analog or Digital hearing aids are limited to one hearing aid per ear every three years for specified degrees of hearing loss outlined below. Prior authorization is required for more frequent requests for a hearing aid. Hearing aid repairs are limited to one repair/modification per aid per year. Prior authorization is required when a second or subsequent repair/modification is requested within 365 days of a previous repair/modification. Hearing loss will have to meet one of the following conditions or if otherwise necessary under EPSDT; prior authorization is required for other degrees of hearing loss:

a. Hearing loss in the better ear is greater than 30dB based on an average taken at 500, 1000, and 2000Hz.

b. Unilateral hearing loss is greater than 30dB, based on an average taken at 500, 1000, and 2000Hz.

c. Hearing loss in the better ear is greater than 40dB base on an average taken at 2000, 3000, and 4000Hz, or word recognition is poorer than 72 percent.

(Continued)

All licensed therapy providers must meet the provider qualification described in 42 CFR 440.110. A physical therapist, occupational therapist, and speech language pathologist shall provide all of the therapeutic intervention that requires the expertise of a licensed therapist and shall determine the use of physical or occupational therapist assistants or therapy aides who provide for the delivery of care that is safe, effective and efficient, provided the assigned acts, tasks, or procedures do not exceed the person's education or training and provided:

1) Physical and occupational assistants are graduates of an accredited program and are licensed to practice in the state of Vermont. A physical therapist assistant shall work under a physical therapist's supervision; an occupational therapist assistant shall work under an occupational therapist's supervision. A physical therapist or occupational assistant may document care pursuant to an existing treatment plan from the supervising therapist. A speech language pathologist assistant is not a graduate of an accredited program and is not licensed in the state of Vermont, therefore is considered an aide.

2) A licensed therapist may use aides for designated routine tasks, which do not include skilled therapy services. An aide shall work under the on-site supervision of a licensed therapist who is continuously on site and present at the facility, who is immediately available to assist the person being supervised in the services being performed, and who maintains continued involvement in appropriate aspects of each treatment session in which a component of treatment is assigned. The supervision by the licensed therapist may extend to off-site supervision of the aide only when the aide is accompanying and working directly with a physical or occupational assistant with a specific patient or when performing nonpatient-related tasks.

Speech therapy assistants and any other person regardless of discipline working under the supervision of a licensed therapist (for example, a massage therapist, an athletic trainer, an exercise physiologist, a kinesiotherapist) shall be considered an aide and is subject to the above supervision requirements. All aides are defined as individuals, trained under the direction of a licensed therapist, who performs designated and supervised routine tasks.

3) Students enrolled in accredited therapist/physical or occupational therapist assistant programs, while engaged in completing a clinical requirement for graduation must work under the direct line-of-sight supervision and direction of a licensed therapist.

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12. Prescribed drugs, dentures, and prosthetic devices; eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed drugs.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Dentures.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Eyeglasses.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than provided elsewhere in the plan.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

ITEM 12. PRESCRIBED DRUGS, DENTURES, AND PROSTHETIC DEVICES; EYEGLASSES PRESCRIBED BY A PHYSICIAN SKILLED IN DISEASES OF THE EYE OR BY AN OPTOMETRIST

A. Prescribed Drugs

1. Drugs listed by the FDA as less than effective are not covered by Medicaid, nor are the generic equivalents of the listed drugs covered.
2. Physicians and Pharmacists are required to conform to Act 127 (18 VSA Chapter 91), otherwise known as the Vermont Generic Drug Law. In those cases where the Generic Drug Law permits substitution, only the lowest priced equivalent in stock at the pharmacy shall be considered medically necessary. Medicaid will not pay if the recipient refuses the substitution required by law.
3. A pharmacist must fill prescriptions in quantities of between 30 and 90 days supply for all drugs prescribed for continued regular use. The physician may prescribe for particular patients or conditions in lesser amounts and in these instances the pharmacist is required to fill as directed. Effective July 15, 2009, when the DVHA is the primary payer, pharmacies will be required to dispense designated classes of maintenance drugs in 90-day supplies after the first fill. The first fill allows prescribers to test for therapeutic effectiveness and patient tolerance.
4. Coverage for certain other drugs is limited to specific conditions, e.g. amphetamines for the treatment of narcolepsy cataplexy syndrome only.
5. Generic over-the-counter (OTC) drugs are covered when medically necessary; without the option of prior authorization for brand products; prescribed by a qualified Medicaid provider; and a federal rebate agreement with the manufacturer is in force. Some OTC medications already managed on the Preferred Drug list (PDL) may have additional restrictions. The PDL can be found at http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria.
6. Contraceptive drugs are covered and claimed at the increased Federal match under Family Planning.
7. No coverage is provided for items such as:
   - topical antiseptics
   - rubbing alcohol
8. [Reserved]

ITEM 12. PRESCRIBED DRUGS, DENTURES, AND PROSTHETIC DEVICES; EYEGLASSES PRESCRIBED BY A PHYSICIAN SKILLED IN DISEASES OF THE EYE OR BY AN OPTOMETRIST (Continued)

A. Prescribed Drugs (Continued)

9. Medicaid Program: Requirements Relating To Covered Outpatient Drugs For The Categorically Needy

Citation (s)	Provision (s)
1935(d)(I)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.
1927(d)(2) and 1935(d)(2)	The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare prescription Drug Benefit –Part D.

The Medicaid agency will cover the following classes of excluded drugs as listed below:

☒ (a) Drugs for anorexia, weight loss, or weight gain: Some drug categories covered under the drug class:

Hormone therapy is covered when used for anorexia or weight gain.

No drugs are covered for weight loss.

☒ (b) Some prescription vitamins and mineral products, except prenatal vitamins and fluoride:

Single vitamins or minerals when prescribed for the treatment of a specific vitamin deficiency or disease related to a vitamin deficiency;

☒ (c) Nonprescription Drugs: Some drug categories covered under the drug class:

analgesics; antacids; antihistamines; decongestants; cough suppressants; dermatological agents; gastrointestinal agents; non-steroidal anti-inflammatory drugs; ophthalmics; and otics.

ITEM 12. PRESCRIBED DRUGS, DENTURES, AND PROSTHETIC DEVICES; EYEGLASSES PRESCRIBED BY A PHYSICIAN SKILLED IN DISEASES OF THE EYE OR BY AN OPTOMETRIST (Continued)

A. Prescribed Drugs (Continued)

9. Medicaid Program: Requirements Relating To Covered Outpatient Drugs For The Categorically Needy (Continued)

☒ Some drugs when used for the symptomatic relief of coughs and colds
- Decongestants
- Antihistamines
- Cough suppressants

☐ Drugs when used for cosmetic purposes or hair growth

☐ Drugs when used to promote fertility

These services provided are identical in the amount, duration and scope of services as provided to the medically needy for prescription drugs.

ITEM 12. PRESCRIBED DRUGS, DENTURES, AND PROSTHETIC DEVICES; EYEGLASSES PRESCRIBED BY A PHYSICIAN SKILLED IN DISEASES OF THE EYE OR BY AN OPTOMETRIST (Continued)

A. Prescribed Drugs (Continued)

10. Supplemental Rebate Agreements: Certain covered products in accordance with Section 1927 of the Social Security Act may not be among the baseline preferred drugs identified by the State of Vermont's Drug Utilization Review (DUR) Board and/or the Pharmacy and Therapeutics (P & T) Committee for various therapeutic classes. The state may negotiate supplemental rebate agreements that would reclassify any drug not designated as preferred in the baseline listing for as long as the agreement is in effect.

    In addition the State has the following policies for the supplemental rebate program for the Medicaid population:

    - Supplemental rebate agreements are unique to each state. The supplemental rebate agreement submitted to CMS on December 4, 2012 amends the June 6, 2009 version of the "Vermont Supplemental Drug Rebate Agreement" authorized under Transmittal 09-007. CMS has authorized this amended version of the "Vermont Supplemental Drug Rebate Agreement." The addendum to this agreement, approved by CMS, entitled "Sovereign States Drug Consortium, Addendum to Member States Agreements" is not changed by this amendment. The January 1, 2013 supplemental rebate agreement and the approved SSDC Addendum apply to drugs dispensed beginning January 1, 2013.
    - Funds received from supplemental rebate agreements will be reported to CMS. The state will remit the federal portion of any supplemental rebates collected.
    - Manufacturers with supplemental rebate agreements are allowed to audit utilization data.
    - The unit rebate amount is confidential and cannot be disclosed in accordance with Section 1927(b)(3)(D) of the Social Security Act.
    - The Department of Vermont Health Access (DVHA) may require prior authorization for covered outpatient drugs. Non-preferred drugs are available with prior authorization.
    - The prior authorization process for covered outpatient drugs will conform to the provisions of section 1927(d)(5) of the Social Security Act.

11. The DVHA covers select active pharmaceutical ingredients (API) and excipients used in extemporaneously compounded prescriptions when dispensed by a participating pharmacy provider and issued by a licensed prescriber following state and federal laws. Select APIs are published at http://dvha.vermont.gov/for-providers.

ITEM 12. PRESCRIBED DRUGS, DENTURES, AND PROSTHETIC DEVICES; EYEGLASSES PRESCRIBED BY A PHYSICIAN SKILLED IN DISEASES OF THE EYE OR BY AN OPTOMETRIST (Continued)

B. Dentures

Dentures are covered for EPSDT only.

C. Prosthetic Devices

Prosthetic devices are covered only by prior authorization except for breast prostheses, trusses, and prosthetic socks which require only a physician's order.

Augmentative communication devices are covered for all beneficiaries when medically necessary, with prior authorization.

Wheelchairs are covered, with limitations.

D. Eyeglasses and Other Aids to Vision

Eyeglasses are covered for EPSDT only.

ITEM 13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN.

Additional diagnostic, screening, preventive or rehabilitative services provided to EPSDT eligible recipients may require medical necessity review.

1. Diagnostic Services

Diagnostic services provided by state and/or local education agencies are covered when provided pursuant to the development of an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) for special education students as defined under Part B or Part H of the Individuals with Disabilities Education Act.

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13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than provided elsewhere in the plan. (Continued)

b. Screening services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Preventive services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Rehabilitation services;

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

14. Services for individual age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

b. Skilled nursing facility services.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

c. Intermediate care facility services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

*Description provided on attachment.

ITEM 13. OTHER DIAGNOSTIC, SCREENING PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

2. Substance Abuse Services

Covered substance abuse services include detoxification and rehabilitation services provided in a residential treatment facility approved by the Vermont Office of Alcohol and Drug Abuse Programs. These services may be provided by a physician, psychologist or by a substance abuse counselor certified by the Vermont Office of Alcohol and Drug Abuse Programs.

Professional services provided to residents of approved treatment centers who are in need of detoxification is limited to seven days of service per acute episode.

Professional services provided to residents in need of post-detoxification services is limited to thirty days of service per calendar year.

Professional services provided to residents in need of extended post-detoxification services is available to eligible beneficiaries, as determined by the Office of Alcohol and Drug Abuse Programs, and is limited to 183 days per calendar year.

Professional services provided to non-residents is limited to ninety hours of counseling per episode.

3. Community Mental Health Center Services

Covered services include rehabilitation services provided by qualified professional staff in a community mental health center designated by the Department of Developmental and Mental Health Services. These services may be provided by physicians, psychologists, MSWs, psychiatric nurses, and qualified mental health professionals carrying out a plan of care approved by a licensed physician or licensed psychologist. Services may be provided in any setting; however, services will not be duplicated.

Beneficiaries receiving Community Rehabilitation and Treatment (CRT) services under the 1115 waiver are ineligible for this State Plan service.

ITEM 13. OTHER DIAGNOSTIC, SCREENING PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

A. Reserved

B. Diagnosis and Evaluation

A service related to identifying the extent of a patient's (client's) condition. It may take the form of a psychiatric and/or psychological and/or developmental and/or social assessment, including the administration and interpretation of psychometric tests. It may include: an evaluation of the client's attitudes, behavior, emotional state, personality characteristics, motivation, intellectual functioning, memory and orientation; an evaluation of the client's social situation relating to the family background, family interaction and current living situation; an evaluation of the client's social performance, community living skills, self-care skills and prevocational skills; and/or an evaluation of strategies, goals and objectives included in the development of a treatment plan, program plan of care consistent with the assessment findings as a whole.

ITEM 13. OTHER DIAGNOSTIC, SCREENING PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

C. Emergency Care

A method of care provided for persons experiencing an acute mental health crisis as evidenced by (1) a sudden change in behavior with negative consequences for wellbeing; (2) a loss of usual coping mechanisms, or (3) presenting a danger to self or others. Emergency care includes diagnostic and psychotherapeutic services such as evaluation of the client and the circumstances leading to the crisis, crisis counseling, screening for hospitalization, referral and follow-up. Emergency services are intensive, time-limited and are intended to resolve or stabilize the immediate crisis through direct treatment, support services to significant others, or arrangement of other more appropriate resources.

D. Psychotherapy

A method of treatment of mental disorders using the interaction between a therapist and a patient to promote emotional or psychological change to alleviate mental disorder. Psychotherapy also includes client-centered family therapy.

E. Chemotherapy (Med-Check)

Prescription of psychoactive drugs to favorably influence or prevent mental illness by a physician, physician's assistant, or nurse performing within the scope of their license. Chemotherapy also includes the monitoring and assessment of patient reaction to prescribed drugs.

ITEM 13. OTHER DIAGNOSTIC, SCREENING PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

F. Group Therapy

A method of treatment of mental disorders, using the interaction between a therapist and two or more patients to promote emotional or psychological change to alleviate mental disorders. Group therapy may, in addition, focus on the patient's adaptational skills involving social interaction and emotional reactions to reality situations.

G. Specialized Rehabilitative Services

- Basic Living Skills

  Restoration of those basic skills necessary to independently function in the community, including food planning and preparation, maintenance of living environment, community awareness and mobility skills.

- Social Skills

  Redevelopment of those skills necessary to enable and maintain independent living in the community, including communication and socialization skills and techniques.

- Counseling

  Counseling services directed toward the elimination of psychosocial barriers that impede the development or modification of skills necessary for independent functioning in the community.

ITEM 13. OTHER DIAGNOSTIC, SCREENING PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

G. Specialized Rehabilitative Services (Continued)

- Collateral Contact

  Meeting, counseling, training or consultation to family, legal guardian, or significant others to ensure effective treatment of the recipient. These services are only provided to, or directed exclusively toward, the treatment of the Medicaid eligible person.

ITEM 13. OTHER DIAGNOSTIC, SCREENING PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

4. Private Non Medical Institutions

A. Child Care Services

Covered services are child care services provided by qualified staff to recipients who are in residential child care facilities. These services are psychiatric/psychological services, counseling services, nursing services, physical, occupational, and speech therapy services, and care coordination services.

A residential child care facility is defined as a facility that is maintained and operated for the provision of child care services, as defined in 33VSA 306, and is licensed by the Department of Social and Rehabilitation Services under the "Licensing Regulations for Residential Child Care Facilities".

Services may be provided by physicians, psychologists, R.N.s, L.P.N.s, speech therapists, occupational therapists, physical therapists, licensed substance abuse counselors, Masters degree social workers, and other qualified residential child care facility staff carrying out a plan of care. Such plans of care, or initial assessments of the need for services, must be prescribed by a physician, psychologist, or other licensed practitioner of the healing arts, within the scope of his/her practice under State Law. Covered services also include administrative costs related to the provision of direct services covered by the Medicaid Program.

B. Assistive Community Care Services

Assistive Community Care Services are provided to adults with functional impairments or cognitive disabilities. Services are provided in licensed level III facilities. Services provided to beneficiaries are case management, assistance with the performance of activities of daily living, medication assistance monitoring and administration, 24-hour on-site assistive therapy, restorative nursing, nursing, assessment, health monitoring, and routine nursing tasks. Any services that constitute the practice of nursing under the Vermont Nurse Practice Act will be provided by a licensed registered nurse or will be delegated by a licensed registered nurse in accordance with the procedures of the Board of Nursing.

Individual plans of care are reviewed at least annually by the Department of Aging and Disabilities. The services are furnished by providers who are licensed by and meet the qualifications established by the Department of Aging and Disabilities.

ITEM 13 OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN (Continued)

4. Private Non Medical Institutions (Continued)

C. Therapeutic Substance Abuse Treatment Services (TSATS)

Therapeutic Substance Abuse Treatment Services are provided to individuals, who have a history and primary diagnosis of substance abuse and who meet the placement and medical necessity criteria established by the Agency of Human Services. In this program, participation is voluntary but participants must be willing to enroll for a period of at least six and no more than twelve months.

Services provided to beneficiaries are 24-hour on site assistive therapy; medication assistance, monitoring and administration; health monitoring; primary care coordination; random substance screenings; and individual and group therapy services provided on-site.

Individual plans of care are written upon admittance to the program and are adhered to for the duration of the participant's stay in the program. Individual plans of care may be modified with the agreement of the beneficiary and the program director. Services are provided by providers who are licensed by the state of Vermont and/or meet the qualifications established by the Agency of Human Services.

ITEM 13 OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN (Continued)

5. School Health Services

School health services are ordered by an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP) for special education students as defined under Part B or Part C of the Individuals with Disabilities Education Act (IDEA). Services are administered by state agencies, or state or local education agencies and must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law. Covered services may be provided by employees of the state or local education agencies or by the health professionals under contract with the education agencies, or providers who meet applicable state licensure or certification requirements.

A. Assessment and Evaluation

Included are services for the assessment and evaluation of an existing IEP/IFSP. Services provided for the purposes of evaluating an individual's treatment needs may include medical, psychiatric, psychological, developmental and/or behavioral assessment, including the administration and interpretation of psychological tests. It may be performed by one or more of the following providers: physician, psychiatrist, psychologist, clinical social worker, school nurse, specialized therapist or a licensed or certified mental health practitioner.

B. Medical Consultation

Services provided by a licensed physician whose opinion or advice is requested in the evaluation or treatment of an individual's problem or disability.

C. Durable Medical Equipment

Items of durable medical equipment provided pursuant to an IEP may be covered subject to prior authorization requirements established by the Office of Vermont Health Access.

D. Vision Care Services

Covered services include visual analysis with refraction, and diagnostic and treatment services for diseases of the visual system.

ITEM 13 OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN (Continued)

5. School Health Services (Continued)

E. Nutrition Services

Evaluation and treatment services related to a child's nutritional needs, as allowed by 42 CFR 440.130(d). Nutrition services are child specific and must be medically necessary to treat and correct problems such as eating disorders, food intake deficits, and excessive weight gain or loss which result from other medical problems, psychological issues, metabolic diseases, etc. The service includes assistance with assessments and care plan development. More specifically, it includes modification of child-specific food menus and counseling so as to provide the maximum reduction of physical and/or mental disability and the restoration of the child to his/her best possible functional level. Services do not include coverage of general nutritional services such as those provided by a school's hot lunch program.

Services must be furnished by dieticians who meet state certification requirements.

F. Physical Therapy

Evaluation and treatment services for the purpose of preventing, restoring, or alleviating a lost or impaired physical function. Services are performed by or under the direction of a qualified physical therapist. A qualified physical therapist is an individual who is a graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent, and is licensed by the State of Vermont.

G. Speech. Hearing and Language Services

Evaluation and treatment services related to speech, hearing or language disorders which result in communication disabilities. Services are performed by or under the direction of a speech-language pathologist or audiologist who has a certificate of clinical competence from the American Speech and Hearing Association, or who has the equivalent education and work experience, or who has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

ITEM 13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

5. School Health Services (Continued)

H. Occupational Therapy

Evaluation and treatment services to implement a program of purposeful activities to develop or maintain adaptive skills necessary to achieve the maximal physical and mental functioning of the individual in daily pursuits. Services are performed by or under the direction of a qualified occupational therapist who is registered by the American Occupational Therapy Association or who is a graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and is engaged in the supplemental clinical experience required before registration by the AOTA.

I. Mental Health Counseling

Evaluation and treatment services involving mental, emotional or behavioral problems, disturbances and dysfunctions. Services are individual, group, or family counseling when provided by a psychiatrist, psychologist, clinical social worker, or other licensed or certified mental health practitioner.

J. Rehabilitative Nursing Services

Services provided by a licensed nurse including medical monitoring and provision of other medical rehabilitative services.

K. Developmental and Assistive Therapy

Services provided in order to promote normal development by correcting deficits in the child's affective, cognitive, behavioral, or psychomotor/fine motor skills development, when such services are identified in the IEP/IFSP. Services include application of techniques and methods designed to overcome disabilities, improve cognitive skills, and modify behavior. Services are furnished by or under the direction of licensed professionals who meet qualifications established by the LEA, or who meet applicable state licensure or certification requirements.

ITEM 13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

5. School Health Services (Continued)

L. Personal Care

Services related to a child's physical or behavioral requirements, including assistance with eating, dressing, personal hygiene, activities of daily living, bladder and bowel requirements, use of adaptive equipment, ambulation and exercise, behavior modification, and other remedial services necessary to promote a child's ability to participate in, and benefit from, the educational setting. Services are furnished by providers who have satisfactorily completed a training program for home-health aides/nursing assistants, or other equivalent training, or who have appropriate background and experience in the provision of personal care or related services for individuals with a need for assistance due to physical or behavioral conditions and meet qualifications established by the LEA. Person Care providers must be employed by a school, school district or Supervisory Union. Personal care services are not covered when provided to recipients by their parents, including natural, adoptive and step-parents.

M. Case Management

Services designed to assist children in gaining access to, and coordinating the delivery of, medical services, including interaction with providers, monitoring treatment and interaction with parents and guardians. Services are furnished by qualified providers who based on their education, training and experience, have been designated as such by either the Agency of Human Services, Department of Education or LEA.

N. Medical Transportation

Transportation services to or from necessary medical care. Services are furnished by providers who meet the qualifications established by the LEA.

ITEM 13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

6. Child Sexual Abuse and Juvenile Sex Offender Treatment Services

Child Sexual Abuse and Juvenile Sex Offender treatment services are individual, group and client-centered family counseling; care coordination; and clinical review and consultation services provided to children who have been sexually abused or who are sexual offenders. Services must be authorized by the Department of Social and Rehabilitation Services.

These services are not available to inmates of public institutions and/or prisons. Also, reimbursement by Medicaid is non-duplicative of other public or private funding sources.

ITEM 13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

7. Intensive Family Based Services

Intensive Family Based Services are family-focused, in-home treatment services for children that include crisis intervention, individual and family counseling, basic living skills and care coordination. Services are authorized by the Department of Social and Rehabilitation Services or the Department of Mental Health and Mental Retardation and are furnished by providers who meet qualifications specified by the Department of Social and Rehabilitation Services.

Reimbursement for Intensive Family Based Services will not duplicate reimbursement from other State Plan, other public, or other private funding sources.

ITEM 13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

8. Developmental Therapy

Evaluation and treatment services provided to a child in order to promote normal development by correcting deficits in the child's affective, cognitive and psychomotor development. Services must be specified in a child's Individualized Family Service Plan (IFSP) under Part H of the Individuals with Disabilities Education Act (IDEA) and must be furnished by providers who meet applicable state licensure or certification requirements.

ITEM 13. OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

9. Day Health Rehabilitation Services

Day Health Rehabilitation Services are provided to individuals with physical or cognitive impairments who are not residing in a nursing home, nor receiving enhanced residential care services or other similar services. Day Health Rehabilitation Services are intended to maintain optimal functioning and prevent or delay the need for the level of services provided in a nursing facility. The services provided at a Day Health Rehabilitation Center are health assessment and screening, health monitoring and education, nursing, personal care, physical therapy, occupational therapy, speech therapy, social work, and nutrition counseling/services. Beneficiaries are determined eligible for Day Health Rehabilitation Services by the Department of Aging and Disabilities. The intensity of services provided to each individual is in accordance with the individual's plan of care and is provided under the supervision of a registered nurse.

The services are furnished by providers who meet the qualifications specified by the Department of Aging and Disabilities. Prior authorization of this service is required from the Department of Aging and Disabilities.

Reimbursement for Day Health Rehabilitation Services will not duplicate reimbursement from other State Plan, public or private funding sources.

ITEM 13. OTHER DIAGNOSTIC, SCREENING PREVENTIVE AND REHABILITATIVE SERVICES, I.E., OTHER THAN THOSE PROVIDED ELSEWHERE IN THE PLAN. (Continued)

This page describes the WAM M108 procedure (which went through public notice) for requesting services or items to be approved for Medicaid beneficiaries in addition to those services or items on a pre-approved list. For services or items in Attachment 3.1-A with pre-approved lists the service or item description includes a reference to this page (6o) of the State Plan.

Procedure for Requesting Medicaid Coverage of a Service or Item

This procedure provides a way for beneficiaries to seek Medicaid coverage for medically-necessary items or services that are not already listed as pre-approved for coverage in Vermont's current Medicaid regulations. The procedure requires that a beneficiary's situation must be unique and that serious detrimental health consequences will result if the service or item is not approved for coverage, then the item or services may be approved for coverage.

Beneficiaries send a request for coverage to the department, accompanied by their physician's written recommendation for the service or item. The department reviews the request, seeks additional information as necessary, and endeavors to make the coverage decision within 30 days from the date of the request. The department evaluates each request using 10 criteria.

Each decision results in one of four outcomes. The four possible outcomes are: (1) the commissioner approves coverage of the service or item for the individual and adds it to a list of pre-approved services or items; (2) the commissioner approves coverage of the service or item for the individual and does not add it to a list of pre-approved services or items; (3) the commissioner does not approve coverage of the service or item for the individual and adds it to a list of pre-approved services or items; or (4) the commissioner does not approve coverage of the service or item for the individual and does not add it to a list of pre-approved services or items.

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15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with §1902(a)(31)(A) of the Act, to be in need of such care.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

17. Nurse-midwife services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

18. Hospice care (in accordance with §1905 (o) of the Act).

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided. ☒ Provided in accordance with section 2302 of the Affordable Care Act.

*Description provided on attachment.

ITEM 15.a. INTERMEDIATE CARE FACILITY SERVICES (OTHER THAN SUCH SERVICES IN AN INSTITUTION FOR MENTAL DISEASES) FOR PERSONS DETERMINED, IN ACCORDANCE WITH SECTION 1902(A)(31)(A) OF THE ACT, TO BE IN NEED OF SUCH SERVICES.

Provided: No Limitations.

ITEM 15.b. INCLUDING SUCH SERVICES IN A PUBLIC INSTITUTION (OR DISTINCT PART THEREOF) FOR THE MENTALLY RETARDED OR PERSONS WITH RELATED CONDITIONS.

Provided: No Limitations

ITEM 16. INPATIENT PSYCHIATRIC FACILITY SERVICES FOR INDIVIDUALS UNDER 22 YEARS OF AGE.

Provided: No Limitations.

ITEM 18. HOSPICE CARE

Provided: No Limitations.

Hospice services to terminally ill recipients are covered in accordance with Section 1905(o) of the Social Security Act and must comply with the requirement in section 4305 of the State Medicaid Manual. A physician must certify that the eligible person is within the last six (6) months of life. These services may be provided on a 24 hour, continuous basis. Coverage is available for an unlimited duration. All services must be performed by appropriately qualified personnel, for the nature of service being provided.

State: VERMONT

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case Management Services and Tuberculosis Related Services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2) (F) of the Act.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

☒ Additional coverage **

b. Services for any other medical conditions that may complicate pregnancy.

☐ Additional coverage **

** Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

State: _____VERMONT_____

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

22. Respiratory care services (in accordance with section l902(e)(9)(A) through (C) of the Act).

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

23. Certified pediatric or family nurse practitioners' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

ITEM 20. EXTENDED SERVICES TO PREGNANT WOMEN

Personal care services, home visits, and health education are included as extended services to pregnant and postpartum women when prior authorized by the Title V agency as part of the Healthy Babies Program.

ITEM 23. PEDIATRIC OR FAMILY NURSE PRACTITIONERS' SERVICES

Services are limited pursuant to Item 5a of the State Plan.

State: VERMONT

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Services provided in Religious Nonmedical Health Care Institutions.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

c. Reserved

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

e. Emergency hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on attachment.

ITEM 24. ANY OTHER MEDICAL CARE AND ANY TYPE OF REMEDIAL CARE RECOGNIZED UNER STATE LAW, SPECIFIED BY THE SECRETARY

A. Transportation

Ambulance

Ambulance service coverage is limited to:

- Medicaid certified and participating ambulance providers;
- instances where other methods of transportation are medically contraindicated; and
- service is ordered by a physician or certified by the receiving facility physician as medically necessary;
- where the patient is transported to the nearest appropriate facility for admission or emergency outpatient treatment; or
- an inpatient is transported home from a hospital or nursing facility; or
- an inpatient is transported to another hospital and returned for specialized diagnostic or therapeutic services not available at the first hospital.

Prior authorization is required for coverage of ambulance service to an out-of-state hospital. Transport to a border hospital does not require prior authorization.

Non-Emergency Services

Coverage for transportation to and from medical service providers is provided when no other means of transportation is available. Coverage for transporting a beneficiary and a medically necessary escort to and out-of-state appointment with appropriate meals and lodging is outlined at: http://dvha.vermont.gov/for-providers. See Attachment 3.1-D.

Prescription Drug Services for full-benefit Dual Eligibles

Transportation is provided for full-benefit dual-eligible beneficiaries to and from pharmacies in order to obtain Medicare Part D prescription drugs if no other means of transportation is available.

ITEM 24. ANY OTHER MEDICAL CARE AND ANY TYPE OF REMEDIAL CARE RECOGNIZED UNER STATE LAW, SPECIFIED BY THE SECRETARY (Continued)

B. Services of Christian Science nurses: not available in Vermont.

C. Care and services provided in Christian Science Sanitoria: not available in Vermont.

D. Nursing facility services for patients under 21 years of age: Rehabilitation Center services provided in nursing facilities located outside Vermont for the severely disabled such as head injured or ventilator dependent people require authorization prior to admission from the Medicaid director or a designee. Coverage of this care is limited to one year.

E. Emergency Hospital Services: Medicaid will cover services provided on an emergency basis by a hospital that does not participate in Medicare but services must be reviewed and approved prior to payment.

F. Personal care services in a recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse: provided to EPSDT eligible recipients only. Some services may require medical necessity review.

State: VERMONT

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

☒ Provided: ☒ State Approved (Not Physician) Service Plan Allowed
☒ Services Outside the Home Also Allowed
☒ Limitations Described on Attachment
☐ Not provided.

ITEM 26: PERSONAL CARE SERVICES

A. EPSDT Personal Care Services

EPSDT Personal care services are defined as services related to a beneficiary's physical requirements, such as assistance with eating, bathing, dressing, personal hygiene, activities of daily living, bladder and bowel requirements, and taking medications.

EPSDT personal care services are provided only to eligible beneficiaries under age 21 when they are determined to be medically necessary pursuant to §1905(r)(5) of the Social Security Act.

B. Participant-Directed Attendant Care Services

Participant-Directed Attendant Care Services are services which provide physical assistance with activities of daily living and instrumental activities of daily living.

Participant directed attendant care services are covered when the individual requires physical assistance with a minimum of two activities of daily living due to a chronic physical condition, and has the personal capacity to obtain and direct attendant care services (including serving as an employer to hire, train, schedule, supervise, and fire attendants.)

Participant-Directed Attendant Care Services will be reviewed and prior authorized at least annually.

State: _____VERMONT_____

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

PACE State Plan Amendment Pre-Print

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 2 to Attachment 3.1-A.

☐ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

☒ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

State: VERMONT

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. Free Standing Birth Center Services

a. Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ☐ No limitations ☐ With limitations ☒ None licensed or approved

Please describe any limitations:

b. Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ☐ No limitations ☐ With limitations (please describe below)

☒ Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

Please check all that apply:

☐ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: VERMONT

CASE MANAGEMENT SERVICES

A. Target Group:

Persons with developmental disabilities who are unable to access needed medical, social, educational and other services because of adaptive deficits due to their level of disability, or who lack the active assistance of a family member or other interested person to assist them in accessing needed services. These individuals may reside with their natural families, in individualized residential settings, or licensed and unlicensed community care homes, which do not receive funding from Medicaid.

B. Areas of the State in which Services will be Provided:

X Entire State

_ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

C. Comparability of Services:

_ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration and scope.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: VERMONT

CASE MANAGEMENT SERVICES (Continued)

D. Definition of Services: Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:

- taking client history;
- identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- is based on the information collected through the assessment;
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- to help an eligible individual obtain needed services including activities that help link an individual with
  - medical, social, educational providers or
  - other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: VERMONT

CASE MANAGEMENT SERVICES (Continued)

E. Qualifications of Providers:

Providers serving individuals with developmental disabilities who are unable to access needed medical, social, educational, and other services because of adaptive deficits due to their level of disability must be at least eighteen years of age and possess a high school degree or equivalent. Additionally, these providers must complete the local designated agency's training and are supervised by managers at local designated agencies.

Providers serving individuals with developmental disabilities who lack assistance of a family member or other interested person to assist them in accessing needed services must possess a minimum a Bachelor's degree and must have knowledge and skills related to identification and resolution of issues encountered by individuals with developmental service needs, community resources, and needs assessment. Qualifications have been established to ensure that service needs are met and case management services are accessible to the target group.

F. Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception:

X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: VERMONT

CASE MANAGEMENT SERVICES (Continued)

G. Access to Services:

The State assures that case management services will not be used to restrict an individual's access to other services under the plan.

The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

The State assures that providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

H. Payment:

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

I. Limitations:

Case Management does not include the following:

- Case management activities that are an integral component of another covered Medicaid service;
- The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred;
- Services to individuals who are incarcerated;
- Services to individuals who reside in an institution for mental disease;
- Activities for which third parties are liable to pay.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

CASE MANAGEMENT SERVICES (Continued)

A. Target Group:

Children who receive special education and related services pursuant to an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) as described in the Individuals with Disabilities Education Act.

B. Areas of the State in Which Services Will Be Provided:

☒ Entire State

☐ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide.)

C. Comparability of Services:

☐ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

CASE MANAGEMENT SERVICES (Continued)

D. Definition of Services:

Purpose - The purpose of case management is to assist individuals in gaining access to needed medical, social, educational, and other services.

Services -

1. Intake/assessment: Identifying the child's medical, social, educational, and other conditions and needs through in-person contact with the child and his/her family, and where appropriate, consultation with educational and medical service providers.
2. IEP/IFSP Development: Developing with the child, his/her family, and appropriate service providers an individualized plan which describes the services identified through the assessment process and sets out a plan to provide these services.
3. Coordination/Advocacy: Facilitating the child's access to the services identified in the IEP/IFSP. The case manager may advocate on behalf of the child for appropriate community resources and coordinate the multiple providers of social, educational, and health services defined in the IEF/IFSP.
4. Monitoring: Ensuring that the child's IEF/IFSP is implemented and assessing the child's progress towards meeting its objectives.
5. Evaluation: Determining whether the care plan is appropriate, whether a new or revised plan is necessary, or whether services should be terminated.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

CASE MANAGEMENT SERVICES (Continued)

E. Qualifications of Providers:

Qualified case managers are those providers who, based on their education, training and experience, have been designated as such by either the Agency of Human Services or the Department of Education.

F. Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the Plan.

G. Duplication of Payments:

Payment for case management services under the Plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

CASE MANAGEMENT SERVICES (Continued)

A. Target Group:

1) Families whose children are abused or neglected or suspected of being at imminent risk thereof;
2) Children and adolescents who are in the care or custody of the Department of Social and Rehabilitation Services or of an agency in another state and placed in Vermont; and,
3) Families of children receiving post adoption assistance.

B. Areas of the State in Which Services Will Be Provided:

☒ Entire State

☐ Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide.)

C. Comparability of Services:

☐ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

CASE MANAGEMENT SERVICES (Continued)

D. Definition of Services:

Purpose - The purpose of case management is to assist individuals in gaining access to needed medical, social, educational, and other services.

Services -

1. Case study and assessment: to facilitate the collection and assessment of information regarding the child, family and other relevant individuals, to determine the nature of the individual and family problems and to identify the services required to resolve/alleviate the problems.
2. Case Plan Development and Implementation: to facilitate the development of a case plan including medical and mental health components in accordance with the policy, procedure and regulation of the Department of Social and Rehabilitation Services and consistent with Medicaid requirements.
3. Case Supervision: to monitor the implementation of the case plan, to arrange for support services to maintain individuals in their home or in substitute care and to monitor the child and families' progress toward the goals and objectives established in the case plan.
4. Advocacy: to negotiate and coordinate activities on behalf of children and families to enable them to obtain otherwise inaccessible or unavailable medical, social, educational or other necessary services.
5. Placement: to facilitate the assessment of client placement needs, the selection of appropriate placement, preparation of client and family, coordination and accomplishment of placement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

CASE MANAGEMENT SERVICES (Continued)

E. Qualified Provider:

Qualified case managers are those providers who, based on their education, training and experiences have been designated as such by either the Agency of Human Services or the Department of Social and Rehabilitation Services.

F. Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the Plan.

G. Duplication of Payments:

Payment for case management services under the Plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

1. The payment rate for this service will be established in accordance with the methodology identified in the approved cost allocation plan and will not duplicate payment from any other State Plan section. Additionally, payment for this service is not available for inmates of public institutions or prisons.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

CASE MANAGEMENT SERVICES (Continued)

Target Group:

Pregnant and postpartum women and infants through twelve months of age enrolled in the Vermont Department for Children and Families, Healthy Babies, Kids, and Families Program.

Areas of state in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount duration and scope.

Definition of services: Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include

- taking client history;
- identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- is based on the information collected through the assessment;
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

CASE MANAGEMENT SERVICES (Continued)

Referral and related activities:

- to help an eligible individual obtain needed services including activities that help link an individual with
  - medical, social, educational providers or
  - other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

Qualifications of providers:

Eligible providers must have a minimum of a bachelor's degree and must possess knowledge and skills in one or more of the following areas: assessment and evaluation; prenatal, postpartum and child development; anticipatory guidance; cultural competence, life skills and/or community resources. These qualifications enable providers to identify service needs and assist individuals with accessing and coordinating needed services.

Freedom of Choice:
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

CASE MANAGEMENT SERVICES (Continued)

Freedom of Choice Exception:

☐ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services:
The State assures that case management services will not be used to restrict an individual's access to other services under the plan.

The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

The State assures that providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment:
Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case management providers are paid on a per-visit, unit-of-service basis. A detailed description of the reimbursement methodology identifying the data used to develop the rate, is included in Attachment 4.19-B.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

CASE MANAGEMENT SERVICES (Continued)

Limitations:
Case Management does not include the following:

- Case management activities that are an integral component of another covered Medicaid service;
- The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.
- Activities integral to the administration of foster care programs;
- Services to individuals who are incarcerated;
- Services to individuals who reside in an institution for mental disease;
- Activities for which third parties are liable to pay.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

CASE MANAGEMENT SERVICES (Continued)

Target Group:

The target group is comprised of children, ages one to five years, who have been identified by a health professional or community program who are at risk of inappropriate health care service utilization, medical complications, neglect, and or abuse. A medical provider verifies the medical necessity of the service.

Areas of state in which services will be provided:

☒ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☒ Services are not comparable in amount duration and scope.

Definition of services: Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include

- taking client history;
- identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- is based on the information collected through the assessment;
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

CASE MANAGEMENT SERVICES (Continued)

Referral and related activities:

- to help an eligible individual obtain needed services including activities that help link an individual with
  - medical, social, educational providers or
  - other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

Qualifications of providers:

Eligible providers must have a minimum of a bachelor's degree and must possess knowledge and skills in one or more of the following areas: assessment and evaluation; child development; anticipatory guidance; cultural competence, life skills and/or community resources. These qualifications enable providers to identify service needs and assist individuals with accessing and coordinating needed services.

Freedom of choice:
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1) Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
2) Eligible recipients will have free choice of the providers of other medical care under the plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

CASE MANAGEMENT SERVICES (Continued)

Freedom of Choice Exception:

☐ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services:
The State assures that case management services will not be used to restrict an individual's access to other services under the plan.

The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

The State assures that providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment:
Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case management providers are paid on a per-visit, unit-of-service basis. A detailed description of the reimbursement methodology identifying the data used to develop the rate, is included in Attachment 4.19-B.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

CASE MANAGEMENT SERVICES (Continued)

Limitations:
Case Management does not include the following:

- Case management activities that are an integral component of another covered Medicaid service;
- The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred;
- Activities integral to the administration of foster care programs;
- Services to individuals who are incarcerated;
- Activities for which third parties are liable to pay;
- Visits which are not medically necessary.

State/Territory: Vermont

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S): _____

The following ambulatory services are provided.

Services provided to the medically needy are identical in the amount, duration and scope of services as provided to the categorically needy described in Attachment 3.1-A.

*Description provided on attachment.

State: _____Vermont_____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Standards and Methods of Assuring High Quality Care

The following is a listing of the methods that will be used to assure that the medical and remedial care and services are of high quality:

- Periodic medical review including on-site visits to skilled nursing homes, mental hospitals, and mental health clinics.
- Licensing and certification of participating facilities.
- Surveillance and Utilization Review (part of Medicaid management information system).
- Patient reviews in Intermediate Care Facilities and Mental Health Clinics.
- Professional staff and consultants employed by the Department.
- Fair Hearings.
- Maintenance of records and ad hoc reports.
- Licensing of administrators of skilled nursing facilities.
- Reasonable fees in payment to providers for medical services.
- Use of non-institutional providers appropriately licensed or certified by state agencies.
- Regulation of participating mental health clinics.
- Limiting approval for reimbursement to providers who can meet published State standards for coordinated care to high-technology dependent recipients whose quality of care depends upon the coordinated provision and monitoring of benefits available under the Plan. Assurance is made that no barrier is placed on free choice of providers.

STATE OF VERMONT
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECUTIRY ACT
==========

Methods of Providing Transportation

DVHA provides Non- Emergency Medical Transportation (NEMT) to Medicaid beneficiaries through a statewide network of transportation brokers. Each of these brokers is responsible for the provision of NEMT services for beneficiaries living in the broker's defined geographical area. This network covers the entire geography of the state and has no gaps in coverage area.

All transportation requests must be fulfilled by the brokers as long as: the member is eligible for Medicaid; the member does not have access to another means of transportation; the medical service is covered by Medicaid and provided by a Medicaid provider; and the request for transportation is made with enough advance notice to schedule the ride (at least 48 hours in advance of the appointment).

The following limitations on coverage shall apply:

1. Prior authorization is required. (Exceptions may be granted in a case of a medical emergency.)
2. Transportation is not otherwise available to the Medicaid recipient.
3. Transportation is to and from medical services which are necessary and covered by the recipient's Medicaid plan.
4. The Medical Service is generally available to and used by other members of the community or locality in which the recipient is located. A recipient's freedom of access to health care does not require Medicaid to cover transportation at unusual or exceptional cost in order to meet a recipient s personal choice of provider.
5. Payment is made for the least expensive means of transportation and suitable to the medical needs of the recipient. The available modes of transportation include: buses, vans, wheelchair vans, taxis, sedans and volunteer drivers. NEMT brokers shall not submit claims for volunteer mileage for miles driven without the Medicaid recipient in the vehicle.
6. Reimbursement for the service is limited to enrolled transportation providers.
7. Reimbursement is subject to utilization control and review in accordance with the requirements of Title XIX.
8. Any Medicaid-eligible recipient who believes that his or her request for transportation has been improperly denied may request a fair hearing.
9. Payment for transportation other than that covered in the Ambulance paragraph in Attachment 4.19-B page 7 is made through a negotiated per member, per-month payment methodology which was put into place on 07/01/12 and is effective for services on or after that date. These payments will be made to the existing network of NEMT brokers. All rates are published in individual contracts, which are available at http://dvha.vermont.gov/administration/contracts. Except as otherwise noted in the Plan, State-developed fee schedule rates are the same for both governmental and private providers.

Ambulance Services: See Attachment 3.1-A Page 9a for Ambulance transportation.

State/Territory: Vermont

STANDARDS FOR THE COVERAGE OF ORGAN AND TISSUE TRANSPLANT SERVICES

The following organ transplantation services are covered subject to the conditions contained in this section:

- Cornea
- Kidney
- Heart
- Heart-Lung (single procedure)
- Liver
- Bone Marrow

Reimbursement will be made for medically necessary health care services provided to an eligible recipient, live donor, and the harvesting, preservation and transportation of cadaver organs.

Prior Authorization

Authorization prior to the initiation of services must be obtained from the Medicaid Division Director and the designated review authority.

This requirement is administered to assure consistent disposition of organ transplant requests; that similarly situated recipients are treated alike; that any restriction on the facilities or practitioners which may provide service is consistent with the accessibility of high quality care to eligible recipients; and that services for which reimbursement will be made are sufficient in amount, duration, and scope to achieve their purpose.

Standards for Coverage

The Medicaid Director and the designated review authority must receive from the recipient's attending or referring physician and the transplant center physician the following assurances:

1. The Medicaid recipient has a condition for which organ transplantation is the appropriate treatment.

2. All other medically feasible forms of medical and/or surgical treatment have been considered and the most effective and appropriate medically indicated alternative for the recipient is organ transplantation.

State/Territory: _____Vermont_____

STANDARDS FOR THE COVERAGE OF ORGAN AND TISSUE TRANSPLANT SERVICES (Continued)

3. The Medicaid recipient meets all medical criteria for the proposed type of organ transplantation based upon the prevailing standards and current practices. These would include, but are not limited to:

   a. Test lab results which are within identified limits to assure successful transplantation and recovery.

   b. Diagnostic evaluations of the recipient's medical and mental conditions which indicate there will be no significant adverse effect upon the outcome of the transplantation.

   c. Assessment of other relevant factors which might affect the clinical outcome or adherence to an immunosuppressive regimen and rehabilitation program following the transplant.

   d. The recipient or the recipient's parent or guardian or spouse has been fully informed of the risks and benefits of the proposed transplant including the risks of complications and continuing care requirements and the expected quality of life after the procedure.

4. The transplant center meets the following criteria:

   a. Fully certified as a transplant center by applicable state and federal agencies.

   b. Is in compliance with all applicable state and federal laws which apply to organ acquisition and transplantation including equal access and non-discrimination.

   c. Has an interdisciplinary team to determine the suitability of candidates for transplantation on an equitable basis.

   d. Provides surgeons who have a minimum of one year of training and experience appropriate to the organ being transplanted which includes experience in transplant surgery, post-operative care and management of an immunosuppressive regimen.

   e. At the time Medicaid coverage is requested the center must have performed at least ten transplants of the type requested during the previous twelve months and must provide current documentation that it provides high quality care relative to other transplant centers.

State/Territory: _____Vermont_____

STANDARDS FOR THE COVERAGE OF ORGAN AND TISSUE TRANSPLANT SERVICES (Continued)

f. Provides all medically necessary services required including management of complications of the transplantation and late infection and rejection episodes. Failure of the transplant is considered a complication and re-transplantation is available at the center.

Liability of Other Parties

Medicaid is always the payer of last resort. Medicare and other insurance coverage for which a Medicaid recipient is eligible must discharge liability before a claim for payment will be accepted. Co-insurance and deductible amounts will be paid in an amount not to exceed the Medicaid rate for the service.

Any additional charges made to a recipient or recipient's family after payment by Medicaid is supplementation and is prohibited.

Providers of health care services which have been specifically funded by research or grant monies may not make claim for payment.

The State elects to offer Health Homes services to individuals with:

☐ **Two or more chronic conditions**

Specify the conditions included:

- ☐ **Mental Health Condition**
- ☐ **Substance Abuse Disorder**
- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Heart Disease**
- ☐ **BMI over 25**

Other Chronic Conditions	

Additional description of other chronic conditions:

☑ **One chronic condition and the risk of developing another**

Specify the conditions included:

- ☐ **Mental Health Condition**
- ☐ **Substance Abuse Disorder**
- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Heart Disease**
- ☐ **BMI over 25**

Other Chronic Conditions	
Opioid Addiction as defined by the DSM-IV-TR criteria	

Specify the criteria for at risk of developing another chronic condition:
Vermont Medicaid data are consistent with national data that has found this population to be at high risk of having or developing other substance abuse disorders and co-occuring mental health conditions, especially depression and anxiety. Research shows that individuals with a dependency on drugs are much more likely to drink alcohol, and individuals with an alcohol dependency are far more likely than the general population to use other drugs (HHS, NIH, NIAAA. Alcohol Alert 76, 2008). Among opiate dependent patients the lifetime prevalence of affective disorders has been reported to be 85.4% in women and 70.0% in men (Rounsaville. Arch Gen Psychiatry, 1982), with a current prevalence of major depression of 15.8% (Brooner. Arch Gen Psychiatry, 1997). The lifetime prevalence of anxiety disorders was reported to be 13.2% in women and 24.5% in men (Rounsaville. Arch Gen Psychiatry, 1982). Post-traumatic stress disorder (PTSD) is also common, though patients may deny a PTSD history until they feel confident in their treating clinician. Villagomez (Substance Abuse Treatment, 1995) reported a lifetime prevalence of PTSD of 20% in women and 11% in men.

Additional description of other chronic conditions:

One or more serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition:

Geographic Limitations

Health Homes services will be available statewide

If no, specify the geographic limitations:

By county

Specify which counties:

Effective 7/1/13: Addison, Chittenden, Franklin, Grand Isle, Washington, Lamoille, Orange, Windham, and Windsor counties.

Effective 1/1/14: Bennington, Rutland, Essex, Orleans and Caledonia counties

By region

Specify which regions and the make-up of each region:

By city/municipality

Specify which cities/municipalities:

Other geographic area

Describe the area(s):

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the State will use to enroll eligible Medicaid individuals into a Health Home:

Opt-In to Health Homes provider

Describe the process used:

Automatic Assignment with Opt-Out of Health Homes provider

Describe the process used:
MAT patients are automatically enrolled in Health Homes. All Health Home services are available at all times to enrolled participants. The Health Home Teams at the Hub Designated Provider provides all six Health Home Services and the Spoke RN and Clinician Case Manager teams also provide all six Health Home services. Individual beneficiaries may choose to decline a specific Health Home service based on their individual Plan of Care, but all six services remain available to them at any time these services are desired or needed.

Current MAT patients will be informed about Health Homes services via letter and follow-up communications, including telephone and face-to-face contact when the beneficiary visits the MAT prescriber's office for treatment or for a prescription refill. Potential Health Home participants will be identified through provider, community partner and judicial referrals, MAT prior authorizations, Vermont Chronic Care Initiative risk stratification, claims and utilization data. The majority will be identified through providers, clinical assessment, the prior authorization process for buprenorphine prescriptions and enrollment in methadone treatment.

☑ **The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

Other

Describe:

☑ **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**

☑ **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**

☑ **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**

☑ **The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes**

Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.

The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

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Attachment 3.1-H Page Number:

Health Homes Providers

Types of Health Homes Providers

Designated Providers

Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:

Physicians

Describe the Provider Qualifications and Standards:

Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards:

Rural Health Clinics

Describe the Provider Qualifications and Standards:

Community Health Centers

Describe the Provider Qualifications and Standards:

Community Mental Health Centers

Describe the Provider Qualifications and Standards:

Home Health Agencies

Describe the Provider Qualifications and Standards:

Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:

Case Management Agencies

Describe the Provider Qualifications and Standards:

Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards:

The Controlled Substances Act requires that any program dispensing opioid drugs for the treatment of opioid addiction must meet Federal Opioid Treatment standards established by SAMHSA. An OTP must have a current, valid certification from SAMHSA to be qualified to dispense drugs for opioid addiction and meet the federal opioid treatment standards. Highlights of the certification and treatment standards include:

Administrative and organizational structure to ensure quality of patient care and meet all local, state, and federal standards; A program sponsor and a medical director responsible for overseeing all care; A system of continuous quality improvement including annual reviews of program policies and procedures, and patient outcomes; Staff credentials, education, training, and experience to perform assigned duties and to comply with the credentialing requirements of their respective professions; Initial physical exam performed by a physician; Preparation of a treatment plan and periodic reassessment; Drug abuse testing services; System to ensure that patients are enrolled in only one OTP program at a time; Systems for medication administration, dispensing, and use including dosage ranges, witnessed dosing, protocols for take home medication; Security systems to assure safety of the medications.

The Division of Alcohol and Drug Abuse Programs (ADAP) in Vermont is the single state entity charged with oversight and certification of OTP. The Hubs in the region supported by the SPA have a current, valid certification from SAMHSA, meets the ADAP requirements and is also accredited by CARF as an OTP.

Registered nurses and master's level licensed clinician case managers (e.g., LADC, LCSW, LMHC), overseen by a program director who typically is also a clinician, will primarily be responsible for providing the Health Home services. The Hubs have agreed contractually to provide services in accordance with CMS' standards for the 11 core functional components.

Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards:

☐ Other (Specify)

☑ **Teams of Health Care Professionals**

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

☑ **Physicians**

Describe the Provider Qualifications and Standards:
Buprenorphine prescribers must have completed the federally required training and hold the appropriate X-DEA license to prescribe buprenorphine in an office-based setting. They are required to adhere to Vermont's Buprenorphine Clinical Practice Guidelines and the Vermont Department of Health Medication Assisted Therapy for Opioid Dependence Rules. These are the Spoke physician prescribers.

☑ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:
Registered Nurses with expertise in addictions treatment. These professionals will work under the Spoke model, supervised by prescribing physician.

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☑ **Social Workers**

Describe the Provider Qualifications and Standards:
Licensed master's level social workers with experience in addictions treatment. These professionals will work under the Spoke model, supervised by prescribing physician.

☑ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:
The Health Home behavioral health professionals in this proposed SPA include the professionals currently credentialed as licensed providers in Vermont's Medicaid program. These are: Licensed Alcohol and Drug Abuse Counselors, Licensed Clinical Social Workers, Licensed Mental Health Counselors, Licensed Psychologists, and Licensed Marriage and Family Therapists. These professionals will work under the Spoke model, supervised by prescribing physician.

☐ **Other (Specify)**

☐ **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

Nurses
Describe the Provider Qualifications and Standards:

Pharmacists
Describe the Provider Qualifications and Standards:

Nutritionists
Describe the Provider Qualifications and Standards:

Dieticians
Describe the Provider Qualifications and Standards:

Social Workers
Describe the Provider Qualifications and Standards:

Behavioral Health Specialists
Describe the Provider Qualifications and Standards:

Doctors of Chiropractic
Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**
Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**
Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers
Describe the methods by which the State will support providers of Health Homes services in addressing the following components:

1. **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,**
2. **Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,**
3. **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,**
4. **Coordinate and provide access to mental health and substance abuse services,**
5. **Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,**
6. **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,**
7. **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,**
8. **Coordinate and provide access to long-term care supports and services,**
9. **Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services:**
10. **Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:**
11. **Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.**

Description:
Current OTPs and OBOTs are supported in transforming into Hub and Spoke Health Homes through participation in regional and statewide learning activities, including learning collaboratives and trainings sponsored by the Department of Health/Division of Alcohol and Drug Abuse Programs and the Blueprint. Three types of learning collaboratives are planned or in progress: regional OBOT collaboratives, a state-wide Hub program collaborative, and a state-wide Spoke Staff learning community. Participation in the collaboratives is voluntary. The collaborative content is planned by clinical and scientific leaders in Vermont familiar with current programming and national practice standards. Led by a team from Dartmouth-Hitchcock Medical Center with expertise in addictions treatment, each meeting includes didactic learning, reports on quality performance measures,

description of PDSA cycles undertaken to improve performance and lessons learned. Two regional OBOT collaboratives are underway and the statewide Hub and Spoke staff collaboratives are also underway.
The State is providing the Health Home providers with the same HIT architecture as is used among all Primary Care Patient-Centered Medical Homes. An opioid treatment measures set is being developed as an addition to Vermont's central clinical registry, Covisint DocSite, which ultimately will be developed into an integrated health record for use by both health care and Health Home teams. The registry will contain consistent assessment criteria, protocols, treatment plans, and continuity of care mechanisms across the health care system, including substance abuse and mental health treatment providers. Health Home staff will document their clinical work with patients in the EMR used by each host program site to promote consistent access and documentation.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

The two primary pharmacological treatments for opioid dependence, methadone and buprenorphine, are governed by separate federal regulations that have resulted in two distinct provider types, programs, and funding streams. The majority of Vermont MAT patients receive OBOT with buprenorphine prescribed by specially licensed physicians in their offices. In contrast, methadone treatment is highly regulated and can only be provided through specialty OTPs that offer comprehensive addictions services. Methadone OTPs and physicians prescribing buprenorphine in OBOTs have worked in relative isolation from each other and with limited interface with the primary health and mental health care systems.

Vermont's new integrated MAT system of care, referred to as the Hub and Spoke, will provide Health Home services to MAT patients. It builds on strengths of the specialty OTPs, OBOT buprenorphine prescribing physicians, and the local Blueprint PCMH and CHT infrastructure. The Hub (OTP) is a regional specialty addictions treatment center that provides methadone MAT, buprenorphine for clinically complex patients, and addictions consultation. Spokes are buprenorphine prescribers supported by RN and Master's level clinician case managers who assist MAT patients with care coordination, counseling, enhanced self-management, education, and care transitions. Spoke staff are administratively managed by the administrative agent (AA) in each HSA that oversees the Blueprint CHTs. Enhanced Hub and Spoke staffing provide Health Home services specifically to Medicaid beneficiaries receiving MAT. Under this approach, each patient undergoing MAT will have a physician -led medical home and CHT, a single MAT prescriber, a pharmacy home, and access to Hub or Spoke Health Home nurses and clinicians.

The administrative agent for each of the 14 HSAs that oversees Spoke staff also provides the following services: administers the payment processes for CHTs and PCMH provider PMPMs; plans and operates the CHTs (hires, supervises or subcontracts for the CHT staff); recruits primary care providers to the Blueprint and supports work to become NCQA recognized as patient-centered medical homes; convenes the working teams to assure the exchange of health information from practice-based EMRs through the Health Information Exchange to the Blueprint Central Clinical Registry (DocSite); convenes and supports learning health system activities, including development and dissemination of performance reports, learning collaboratives, and training events, and; plans and implements initiatives including the health homes.

The lead AAs are health care organizations with strong fiduciary and administrative capabilities, are Medicaid enrolled providers, and are recognized health care leaders in their communities. Examples include hospitals, FQHCs, and/or community mental health centers. The Department of Vermont Health Access /Blueprint executes performance-based contracts with each lead AA for these services. The AAs do not provide any Health Home services.

Each HUB and Spoke system has its own RNs and licensed clinicians. HUB staff is employed by the HUB. Spoke staff employed by the lead administrative agents in each HSA as are members of the Blueprint Community Health Teams (CHTs). Health Home staff of HUBs and Spokes are planned and deployed in concert with local CHTs and participate in regional learning activities to build integration and coordination of care among PCMHs, addictions providers and community services providers.

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:

As the sole entity providing methadone treatment, the Hub must fulfill all federal requirements as an Opioid Treatment Program (OTP). It also must serve as the regional consultant/subject matter expert to Spoke providers on opioid dependence and treatment, and must provide buprenorphine to clinically complex patients. The Hubs will work under a performance-based contract with the State of Vermont that was developed to be consistent with the 11 required components for delivering Health Home services.

Spoke buprenorphine prescribers must have completed the federally required training and hold the appropriate X-DEA license to prescribe buprenorphine in an office-based setting. They are required to adhere to Vermont's Buprenorphine Clinical Practice Guidelines. Spoke RN care managers and clinician case managers are hired by the local Blueprint administrative agent (AA) that oversees the other CHT staff within the same Health Services Area. Nurse care managers are licensed nurses with experience working with individuals with substance abuse and/or mental health conditions. Clinician case managers are licensed in a behavioral health field (e.g., LADC, LCSW, LMHC). The AAs work under performance-based contracts with the State of Vermont that include the 11 required components for delivering Health Home services. The AAs will be responsible for establishing and monitoring staff performance expectations that also include the 11 required components.

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Health Homes Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services:

☐ **Fee for Service**
☐ **PCCM**

PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.

The PCCMs will be a designated provider or part of a team of health care professionals.

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**
Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

☐ **Risk Based Managed Care**

The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:

☐ **The current capitation rate will be reduced.**

☐ **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

Provide a summary of the contract language for the additional requirements:

☐ **Other**

Describe:

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.

Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

Yes

The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.

The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.

No

Indicate which payment methodology the State will use to pay its plans:

Fee for Service

Alternative Model of Payment (describe in Payment Methodology section)

Other

Description:

Other Service Delivery System:

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:
Spoke RNs and clinicians are part of a team of health care professionals. Payment for Spoke Health Home services will be made to the administrative agents (AAs) that oversee the Blueprint Community Health Teams (CHTs) so they can hire and support 1 RN care manager and 1 clinician case manager for every 100 buprenorphine patients served within the Health Services Area (HSA). Payments are based on the average monthly number of unique patients for which Medicaid paid a buprenorphine pharmacy claim during the most recent 3-month period. Payments will be added to DVHA's existing monthly payment to the AA for CHT services, which are covered by contracts the Blueprint already executes with the AAs to cover Blueprint administration and CHT payments. The additional CHT Spoke staff will provide the Health Home services and

will be fully funded by DVHA. Spoke staff resources will be deployed to the prescribing practices proportionate to the number of patients served by each practice. Spoke physicians will continue to bill fee-for-service for all typical treatment services currently reimbursed by DVHA.

Hubs are designated providers. Hub payments will be a single monthly rate per patient, with a percentage of the total payment linked directly to provision of Health Home services. The Hubs may initiate a claim through the MMIS on behalf of a patient for whom it can document 2 services during that month: 1 face-to-face typical treatment encounter (e.g. assessment, counseling, observed dosing), and 1 Health Home service. Only the HH service (30% of the total) will be paid using the enhanced funding match.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

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Health Homes Payment Methodologies

The State's Health Homes payment methodology will contain the following features:

☐ **Fee for Service**

☐ **Fee for Service Rates based on:**

☐ **Severity of each individual's chronic conditions**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Other: Describe below.**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

Per Member, Per Month Rates

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

Incentive payment reimbursement

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

PCCM Managed Care (description included in Service Delivery section)

Risk Based Managed Care (description included in Service Delivery section)

Alternative models of payment, other than Fee for Service or PM/PM payments (describe below)

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☑ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.
The funding methodology for Hub & Spokes is based on staff costs to provide health home services. The Hub methodology is based on the cost to employ key health professionals (salary and fringe benefits) to provide the Health Home services. The staffing enhancements are based on a model of 6 FTEs for every 400 MAT patients served. The enhanced staffing model represents a 43% increase over the current average rate for methadone treatment as usual.

The agency's fee schedule rate was set as of July 1, 2013, is effective for services provided on or after that date, and are the same for both private and public providers. All rates for both Hub and Spoke payments are published on the DVHA website: http://dvha.vermont.gov/for-providers/claims-processing-1.

The Hub payment is a monthly, bundled rate per patient. The Hub program makes a monthly claim with a Health Home modifier for each Medicaid Health Home member who receives at least one Health Home service in the month. The Health Home service is documented in the clinical chart of the Hub program. This documentation is auditable. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of addictions treatment services for patients receiving Medication Assisted Therapy (MAT).

Payment for Spoke Health Home services is based on the costs to employ 1 FTE RN and 1 FTE licensed clinician case manager for every 100 MAT patients across multiple providers. The patient count to determine the Spoke payment is based on the average monthly number of unique patients in each Health Services Area (HSA) for whom Medicaid paid a buprenorphine pharmacy claim during the most recent three-month period, in increments of 25 patients. Spoke staff resources are deployed to the prescribing practices proportionate to the number of patients served by each practice. Payments will be made to the lead Blueprint administrative agent in each HSA when staff provides at least one Health Home service per month to each Medicaid beneficiary on the Spoke Health Home caseload. Health Home services are documented in the clinical record of the prescribing physician's practice. This documentation is auditable.

The State will review service utilization rates annually to ensure that rates are economic and efficient based on analysis of care management costs and services provided by the team of health care professionals and its components for both the Hub and the Spoke programs.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.
The Hub program and the Spoke program make a monthly claim with a Health Home modifier for each Medicaid Health Home member who receives at least one Health Home service in the month.

The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule

The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.

Transmittal Number: VT 13-001 Supersedes Transmittal Number: VT 13-001 Approved Effective Date: Jul 1, 2013 Approval Date: Mar 4, 2014

Transmittal Number: VT 13-001 Supersedes Transmittal Number: VT 13-001 Approved Effective Date: Jul 1, 2013 Approval Date: Mar 4, 2014
Attachment 3.1-H Page Number:

Submission - Categories of Individuals and Populations Provided Health Homes Services

The State will make Health Homes services available to the following categories of Medicaid participants:

Categorically Needy eligibility groups

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive Care Management

Definition:
Activities involve identifying patients for MAT, conducting initial assessments, and formulating individual plans of care. Specific activities include: identifying potential MAT patients and conducting outreach, assessing preliminary service needs, treatment plan development and goal setting in conjunction with the patient, assigning Health Home team roles and responsibilities, developing treatment guidelines and protocols, monitoring the patient's health status and treatment progress, developing QI activities to improve care, and linkages with long term care services and supports.

Health Home Staff providing Comprehensive Care Management: Spoke Nurse and Spoke Clinician Care Manager; Hub Health Home Program Director, Hub supervising MD, Hub RN Supervisor, Hub Consulting Psychiatrist.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Treatment information will be documented in the EMR and communicated through the central clinical registry Covisint DocSite, which contains clinical information as well as documentation and tracking of self management goals and action plans. If Covisint DocSite usage is not yet operational, Covisint ProviderLink may be used to transmit patient information. Covisint ProviderLink is an electronic provider communication tool that supports case management by enabling providers to securely transmit and receive information directly to their EMR system or directly through their fax line.

Scope of benefit/service

The benefit/service can only be provided by certain provider types.

Behavioral Health Professionals or Specialists

Description
The Hub Health Home Program Director, who typically is also a clinician, is involved in these activities, especially in developing the overall plan of care (POC). Hub and Spoke Master's level clinician case managers, who frequently are behavioral health professionals, are involved in developing and implementing comprehensive care management activities.

Nurse Care Coordinators

Description
Spoke RN care coordinators will be involved in developing and monitoring these activities.

Nurses

Description

Medical Specialists

Description

Physicians

Description
Hub supervising physicians, consulting psychiatrists and Spoke prescribing physicians are actively involved in comprehensive care management activities and provide oversight and monitoring of the plan of care. PCPs also are involved in developing the plan of care, as needed.

Physicians' Assistants

Description

Pharmacists

Description

Social Workers

Description
Licensed master's level social workers may be Spoke clinician case managers and as such, will be involved in developing and implementing comprehensive care management activities.

Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

Dieticians

Description

Nutritionists

Description

Other (specify):

Name

Description

Care Coordination

Definition:
Care coordination activities involve implementing the Plan of Care through appropriate linkages, referrals, coordination and follow-up across treatment and human services settings and providers (medical, social, mental health and substance use, long-term care, corrections, education, and vocational).

The Spoke Nurses and clinician care managers share responsibility for all Health Home services and the staffing ratio for providing all Health Home services in the Spokes is 2 FTE for every 100 MAT members. The Health Home Care Coordination functions are shared across four Health Home staff at the Hubs (the supervising MD, the consulting psychiatrist, the addictions counselors, and the clinician case managers).

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Information will be shared through the central clinical registry Covisint DocSite as well as through existing information sharing technologies and Electronic Medical Records (EMRs). DocSite is a web-based registry that receives feeds of guideline-based data elements from practices and hospitals. Data sources include EMRs, hospital data systems, practice management systems, and direct data entry. Data from these sources is sent to the registry through Vermont's Health Information Exchange infrastructure run by Vermont Information Technology Leaders (VITL). In addition to patient care and population management, the registry supports flexible performance reporting with measures derived from national guidelines on health care quality and outcomes.

Scope of benefit/service

The benefit/service can only be provided by certain provider types.

Behavioral Health Professionals or Specialists

Description
HUB Clinician case managers, who often are behavioral health professionals, are key staff in providing care coordination services.

Nurse Care Coordinators

Description
Spoke RN care coordinators are key staff in providing these services.

Nurses

Description

Medical Specialists

Description

Physicians

Description
Hub supervising physicians, consulting psychiatrists and Spoke prescribing physicians are actively involved in comprehensive care management activities and provide oversight and monitoring of the plan of care. PCPs also are involved in developing the plan of care, as needed.

Physicians' Assistants

Description

Pharmacists

Description

Social Workers

Description
Licensed master's level social workers may be Hub clinician case managers and would be key staff in providing care coordination services.

Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

Dieticians

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Health Promotion

Definition:
Health promotion activities promote patient activation and empowerment and support healthy behaviors and self management of health, mental health, and substance abuse conditions. They include: health education specific to opioid dependence and treatment; health education regarding a patient's other chronic conditions; development of self-management plans; behavioral techniques (e.g., motivational interviewing) to engage patients in healthy lifestyles; supports for managing chronic pain, smoking cessation and reduction in use of alcohol and other drugs; promoting healthy lifestyle interventions such as nutritional counseling, obesity reduction, and increased physical activities; support for developing skills for emotional regulation and parenting; and support for improving social networks.

Health Home staffs providing Health Promotion Activities are the Spoke Nurse and Spoke Clinician Care Manager, and the Hub MA Addictions Counselors and the MA Clinician Case Managers.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Information will be shared through the central clinical registry Covisint DocSite as well as through existing information sharing technologies and Electronic Medical Records (EMRs). DocSite is a web-based registry that receives feeds of guideline-based data elements from practices and hospitals. Data sources include EMRs, hospital data systems, practice management systems, and direct data entry. Data from these sources is sent to the registry through Vermont's Health Information Exchange infrastructure run by Vermont Information Technology Leaders (VITL). In addition to patient care and population management, the registry supports flexible performance reporting with measures derived from national guidelines on health care quality and outcomes.

Scope of benefit/service

The benefit/service can only be provided by certain provider types.

Behavioral Health Professionals or Specialists

Description
Hub MA Addictions Counselors and the HUB and Spoke MA Clinician Case Managers are particularly involved with health education specific to opioid dependence and treatment, other substance issues, and with related behavioral interventions.

Nurse Care Coordinators

Description
Spoke RN nurse care coordinators are involved with health promotion regarding all health issues, particularly with health education regarding other chronic conditions and promoting healthy lifestyle interventions such as nutritional counseling, obesity reduction, and increased physical activities.

Nurses

Description

Medical Specialists

Description

Physicians

Description

Physicians' Assistants

Description

Pharmacists

Description

Social Workers

Description
HUB social workers are particularly involved with education and promotion of behavioral techniques and support for developing skills for emotional regulation, parenting, and improving social networks.

Doctors of Chiropractic

Description

Licensed Complementary and Alternative Medicine Practitioners

Description

Dieticians

Description

Nutritionists

Description
Spoke nutritionists are involved in education regarding healthy diets, weight reduction, and specific cooccurring chronic conditions (such as diabetes).

Other (specify):

Name

Description

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Definition:
Comprehensive transitional care focuses on streamlining movement of patients from one treatment setting to another, between levels of care, and between health, substance abuse and mental health service providers. These activities include developing collaborative relations between Health Home providers and hospital ERs, discharge planners, long-term care, corrections, probation and parole staff, residential treatment programs, primary care and specialty mental health and substance abuse treatment services. Care managers work with discharge planners to schedule follow-up appointments with primary or specialty care providers within seven days of discharge, and work with patients to help ensure attendance at scheduled appointments.

Spoke Nurse, the Hub Health Home Director, the Hub Supervising MD, the Hub RN Supervisor, and the Hub MA Clinician Case Managers will be involved with transitional care.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Concurrent review of hospital stays requires that Vermont Medicaid be notified when admissions occur. The State is developing automated procedures with hospital emergency departments and inpatient discharge planners, as well as CHTs, to receive daily feeds on Medicaid patients. Residential substance abuse providers also will be included in the procedures developed.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Especially involved in care transitions from inpatient stays for behavioral health issues, residential treatment programs, primary care and specialty mental health and substance abuse treatment services.

☑ **Nurse Care Coordinators**

Description
Especially involved in transitions involving hospital settings and nursing facilities. Activities include developing collaborative relations between Health Home providers and hospital ERs and discharge planners to schedule follow up appointments with primary or specialty care providers and work with patients to ensure attendance at scheduled appointments.

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☑ **Physicians**

Description
Specifically assists with patient education about health conditions and recommended treatments and facilitating ongoing revisions to individual plans of care.

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Especially involved in transitions involving corrections, probation and parole staff, and establishing supports and services in the community to facilitate successful transitions.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

Dieticians

Description

Nutritionists

Description

Other (specify):

Name

Description

Individual and family support, which includes authorized representatives

Definition:
These services promote recovery by supporting participation in treatment, reducing barriers to access to care, and supporting age and gender appropriate adult role functioning. Activities include advocacy, assessing individual and family strengths and needs, providing information about services and education about health conditions, assistance with navigating the health and human services systems, support and outreach to key caregivers, and assistance with adhering to treatment plans.

Spoke Registered Nurse, Spoke Licensed Clinician Case Manager, the Hub Supervising MD, the Hub MA Addictions Counselors, and the Hub MA Clinician Case Managers will be involved with individual and family support.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Covisint DocSite can make specific information related to a patient's care available for reference in Individual and Family Support Services.

Scope of benefit/service

The benefit/service can only be provided by certain provider types.

Behavioral Health Professionals or Specialists

Description
Especially involved with assessing individual and family strengths and needs,and linking individuals and families with appropriate supports and services.

Nurse Care Coordinators

Description
Especially involved with providing information and education to family and other support persons on ways they can support the patient in establishing healthy behaviors, particularly around chronic health conditions.

Nurses

Description

Medical Specialists

Description

Physicians

Description
Especially involved with advocacy, assessing individual and family strengths and needs, providing information about services and assistance with navigating the health and human services systems, and providing support and outreach to key caregivers.

Physicians' Assistants

Description

Pharmacists

Description

☑ **Social Workers**

Description
Especially involved with advocacy, assessing individual and family strengths and needs, providing information about services and assistance with navigating the health and human services systems, and providing support and outreach to key caregivers.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Referral to community and social support services, if relevant

Definition:
Activities include developing information about formal and informal resources including peer and community based programs, assistance with accessing resources based on patient needs and goals, and supporting patients in obtaining supports and entitlements for which they are eligible (e.g., income, housing, food assistance, vocational and employment services to promote self-sufficiency).

The Spoke Registered Nurse and Spoke Licensed Clinician Case Manager will be responsible for appropriate referrals to community and social support services.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
Covisint ProviderLink secure electronic fax functions may be used with all providers, including community and social support service agencies, to transmit and share appropriate patient information.

Scope of benefit/service

The benefit/service can only be provided by certain provider types.

Behavioral Health Professionals or Specialists

Description
Licensed clinician case managers, including behavioral health professionals, are the primary Health Home staff providing these services.

Nurse Care Coordinators

Description
RN Care Coordinators are involved with identifying and coordinating with community services, especially those pertaining to chronic health conditions and healthy behaviors.

Nurses

Description

Medical Specialists

Description

Physicians

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Licensed clinician case managers, including licensed master's level social workers, are the primary Health Home staff providing these services, especially with helping clients obtain supports and entitlement for which they are eligible.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

Other (specify):

Name

Description

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:
Members who are treated with buprenorphine can receive care in either a Spoke or Hub. The decision about which site is the most appropriate is a clinical one. In general, the Hub setting provides more intensive
structure and has the capacity to see members on a daily basis. Typical Spoke OBOT providers see patients twice a month and as frequently as three times a week but can rarely sustain daily contact over time. Therefore, a patient receiving buprenorphine care that is relatively stable can be well supported in a Spoke. If the patient is experiencing relapse or acute exacerbation of other mental health or health conditions, they can be
treated in a Hub. The Hub and Spoke Health Home supports movement of members
based on clinical needs between both types of providers.

By federal regulation, any member receiving methadone for the management of opioid dependence can only be served in an OTP Hub program.

Medically Needy eligibility groups

All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.

Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.

All Medically Needy receive the same services.

There is more than one benefit structure for Medically Needy eligibility groups.

Transmittal Number: VT 13-001 Supersedes Transmittal Number: VT 13-001 Approved Effective Date: Jul 1, 2013 Approval Date: Mar 4, 2014
Attachment 3.1-H Page Number:

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
Vermont will use the HEDIS method to calculate the number of inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days.

Data Source: Claims

Numerator: Number of hospital stays with a readmission within 30 days.

Denominator: Number of hospital stays.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
Vermont will annually assess cost savings using a pre/post comparison approach adapted from the Blueprint cost modeling framework. DVHA identified annual Medicaid total costs of care across major health care categories (health, mental health, and substance abuse treatment) for beneficiaries who received treatment for opioid dependence during state fiscal years 2010, 2011 and 2012 to establish a projected cost trend for subsequent years (without Health Homes) that is adjusted for projected inflation rates provided by Vermont's Department of Financial Regulation. Actual costs after Health Homes implementation for the same population and health care categories will be compared with the projected costs in the absence of Health Homes for SFY 2013 and subsequent post-implementation SFYs. Savings will be the difference between projected and actual costs in each post-implementation year net of new Health Home investments [cost of Health Home staffing at Hubs (30%) and Spokes (100%)].
Data source: claims.
Measure: Total Medicaid expenditures in the selected cost categories for the target population.

Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).
The Hub & Spoke system will build on the Blueprint's Health Information architecture, which includes a central clinical registry (Covisint DocSite), use of the Vermont Health Information Exchange, and a communication tool (ProviderLink) that facilitates the secure transmission of clinical information between health providers. This health information architecture supports guideline-based preventive healthcare, coordinated health services, an integrated health record across services and organizations, and flexible reporting. The Hub & Spoke initiative will be the first expansion of this capacity to specialty addictions treatment providers. An opioid treatment measures set is being developed for DocSite for visit planning and documentation. Hub and Spoke Health Home staff will document directly in the practice EMR. The goal is to have information on day-to-day provisions of care documented in practice EMRs, hospital data systems, and practice management systems and then transmitted via interfaces to the Health Information Exchange (VHIE) and then into the Covisint DocSite Clinical Registry. DocSite is web-based and receives data feeds of guideline -based data elements from practices and hospitals. Data sources include EMRs, hospital data systems, practice management systems, and direct data entry. To facilitate concurrent review of hospital stays for better transitional care planning, the State is developing automated procedures with hospial ERs and inpatient discharge planners, as well as CHTs, to receive daily feeds on Medicaid patients. Residential substance abuse service providers also will be included in the procedures developed.

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure: Admissions per 1000 member months for any diagnosis among Hub/Spoke clients. Measure Specification, including a description of the numerator and denominator. Numerator: All Hub & Spoke enrollees in the geographic area with a hosptial stay during the measurement year. Denominator: All Hub & Spoke enrollees in the geographic area during the measurement year. Data Sources: Claims Note: Claims are continuously collected. Admission rates will be calculated annually. Frequency of Data Collection: **Monthly** **Quarterly** **Annually** **Continuously** **Other**	

Emergency Room Visits

Measure: ER visits per 1000 member months for any diagnosis among Hub/Spoke clients. Measure Specification, including a description of the numerator and denominator. Numerator: All Hub & Spoke enrollees in the geographic area with an ER visit during the measurement year. Denominator: All Hub & Spoke enrollees in the geographic area during the measurement year. Data Sources: Claims Note: Claims are collected continuously but ER rates will be calculated annually. Frequency of Data Collection: **Monthly** **Quarterly** **Annually** **Continuously**	

Other	

Skilled Nursing Facility Admissions

Measure: Admissions per 1000 member months for any diagnosis among Hub/Spoke clients. Measure Specification, including a description of the numerator and denominator. Numerator: All Hub & Spoke enrollees in the geographic area with a skilled nursing facility admission during the measurement year. Denominator: All Hub & Spoke enrollees in the geographic area during the measurement year. Data Sources: Claims. Note: Claims are collected continuously but ER rates will be calculated annually. Frequency of Data Collection: **Monthly** **Quarterly** **Annually** ○ **Continuously** **Other**	

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates
This information is available through analysis of Vermont's Medicaid claims data. Hospital admissions rates for Health Home enrollees in the implementation region can be compared pre/post Health Homes implementation as well as with rates for the opioid dependent population in regions where Health Homes have not yet been implemented.

Chronic Disease Management
The Vermont Department of Health (VDH) maintains a number of databases and registries that can be used for modeling patterns at a population level and tracking change over time. The Blueprint team has worked closely with the VDH Center for Health Statistics to assemble an array of measures from these data sources that can be used to track changes in Vermont that may be influenced by the Blueprint Integrated Health Services model of payment reforms and Patient-Centered Medical Homes supported by Community Health Teams. Data sources for these measures include Vermont's Uniform Hospital Discharge Data Set, the Behavioral Risk Factor Surveillance System (BRFSS), the Youth Risk Behavior Survey (YRBS), the Adult Tobacco Survey, the Vermont Physician Survey, and United States Census Data. The VDH team has used these disparate data sources to construct integrated views on patterns of health, hospital based healthcare, and risk factors in the state. Results are presented for common chronic conditions and each Health Service Area. The analyses establish a basis for tracking change over time. The Hubs/Spokes initiative will build upon the resources available through the Blueprint. In addition, Vermont's Medicaid Chronic Care Initiative targets a variety of chronic diseases at both the population and individual levels and evaluates evidence-based care and health outcomes.

Coordination of Care for Individuals with Chronic Conditions
Each Health Home enrollee will have an established medical home, a single MAT prescriber, a pharmacy home, Hub or Spoke nurses and clinicians, and access to CHTs, if appropriate, all of which will be documented in the Plan of Care to ensure coordination and follow up among team members and with the patient. Existing Vermont CHTs already have established relationships and extensive experience coordinating with a wide range of community supports and services. The Hub and Spoke nurse and clinician case managers will become members of these existing CHTs and will share coordination protocols already established by the CHTs. The CHT measures sets maintained in Covisint DocSite (Vermont's clinical registry) already provide the ability to track the number and type of referrals to community and social services. Providers who do not yet have access to Covisint DocSite will receive information through Covisint ProviderLink, an electronic provider communication tool that supports case management by enabling providers to receive information to their electronic medical record or directly through their fax line. Vermont will use claims, encounter, and clinical registry data to collect information on patients' coordination of care, including post-inpatient discharge continuation of care.

Assessment of Program Implementation
Vermont will monitor implementation in several ways. The State will meet with personnel and provider representatives on a regular basis to assess implementation status and develop work groups, as necessary. Data and reports about progress will be shared with Hub/Spoke Health Homes staff and participating providers. Hubs and Blueprint administrative agents that oversee CHT staff, including new Spoke Health Home staff, work under performance-based contracts that will be monitored for fulfilling contract requirements. The requirements include the 11 CMS elements for Health Home performance. Efforts have begun to develop a consistent consumer survey to evaluate patient satisfaction.

Processes and Lessons Learned
The State regularly elicits feedback from providers and patients to understand any operational barriers to implementing Hub/Spoke Health Homes services. This is be especially important as it will inform implementation statewide. The Blueprint Assistant Director and other staff meet regularly with both Hub and Spoke service providers.

Assessment of Quality Improvements and Clinical Outcomes
The State will utilize quality process and outcome measures to assess quality improvements and clinical outcomes. As the Hubs/Spokes Health Homes program progresses, Vermont anticipates implementing additional quality improvement and clinical outcome measures for patients receiving MAT, including but not limited to:
- Reducing rates of arrest and incarceration
- Increasing rates of employment/wages earned
- Increasing housing stability
- Reducing rates of positive urine drug screenings
- Engaging patients in Community Self-Management Programs
- Engaging patients in documenting self-management goals and written self-management plans
- Reducing smoking rates
- Increasing rates of continuous health insurance
- Developing patient experience of care survey instruments
- Reducing use of high cost/high use health care categories such as pharmacy, inpatient hospitalization, emergency room, lab, and residential treatment

Estimates of Cost Savings
__ **The State will use the same method as that described in the Monitoring section.**
If no, describe how cost-savings will be estimated.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 80 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: New Adult Group

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130724

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐

OMB Expiration date: 10/31/2014

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act	**ABP2a**
The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.	Yes

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

Vermont is an expansion state that will not have newly eligible groups under ACA. However, the state will recognize the New Adult group in the state plan and will use the Medicaid State Plan as the benefits plan for the New Adult Group. The Medicaid state plan is more comprehensive than the state's Benchmark plan selected for the Health Benefits Exchange, the BCBS 'Vermont Health Plan, LLC' supplemented with the CHIP and FEDVIP plans. In Vermont the CHIP plan mirrors the Medicaid State Plan for Children.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐

OMB Expiration date: 10/31/2014

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

Select one of the following:

- (●) The state/territory is amending one existing benefit package for the population defined in Section 1.
- ( ) The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Medicaid State Plan

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- (●) Benchmark Benefit Package.
- ( ) Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ( ) The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ( ) State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ( ) A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- (●) Secretary-Approved Coverage.
  - (●) The state/territory offers benefits based on the approved state plan.
  - ( ) The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
    - (●) The state/territory offers the benefits provided in the approved state plan.
    - ( ) Benefits include all those provided in the approved state plan plus additional benefits.
    - ( ) Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
    - ( ) The state/territory offers only a partial list of benefits provided in the approved state plan.
    - ( ) The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

N/A

Selection of Base Benchmark Plan

Alternative Benefit Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. Yes

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

1. The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.
2. The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130801

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Alternative Benefit Plan Cost-Sharing	ABP4

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. ☐

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Benefits Description	ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Blue Care, Vermont Health Plan, LLC, CDHP

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

Alternative Benefit Plan

■ Essential Health Benefit 1: Ambulatory patient services — Collapse All ☐

Benefit Provided: Outpatient Hospital
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Rural Health Clinic
Source: State Plan 1905(a)
Remove

Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan

Amount Limit: 5 visits per month; 1 visit per day
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Federally Qualified Health Center
Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan

Amount Limit: 5 visits per month; 1 visit per day
Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Physician Services in all settings

Source: State Plan 1905(a)

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: See other information below

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Home & Office - 5 visits per month; Nursing Facility - up to 1 visit per week; Hospital - up to 1 admission visit per patient per diagnosis per month and up to one visit per day for acute care. Excludes solely cosmetic surgery; ineffective or unproven procedures; unnecessary testing; experimental; services provided without consent. Prior authorizations apply for certain circumstances and procedures. Limits may be exceeded based on medical necessity.

Benefit Provided: Family Planning

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Reversal of sterilizations not covered

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Medical & Surgical furnished by Dentist

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit: None

Duration Limit: None

Remove

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: OLP: Chiropractic

Source: State Plan 1905(a)

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: 10 visits per year

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: OLP: Podiatry

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Non-routine foot care only; Excludes flat foot; subluxations of foot not requiring surgery; corns, calluses, nail trimming preventative hygiene

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Non-Emergency Transportation

Source: State Plan 1905(a)

Alternative Benefit Plan

Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Remove

Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Hospice
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

6 months prior to end of life.

Benefit Provided: OLP: Pediatric or Family Nurse Practitioners
Source: State Plan 1905(a)

Authorization: Other
Provider Qualifications: Medicaid State Plan

Amount Limit: See other information below
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Home & Office - 5 visits per month; Nursing Facility - up to 1 visit per week; Hospital - up to 1 admission visit per patient per diagnosis per month and up to one visit per day for acute care. Excludes solely cosmetic surgery; ineffective or unproven procedures; unnecessary testing; experimental; services provided without consent. Prior authorizations apply for certain circumstances and procedures. Limits may be

Alternative Benefit Plan

exceeded based on medical necessity.

Remove

Add

Alternative Benefit Plan

■ Essential Health Benefit 2: Emergency services — Collapse All ☐

Benefit Provided: Outpatient Hospital: Emergency Care
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Transportation: Ambulance
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For emergency services. Prior authorization is required for coverage of ambulance service to an out-of-state hospital. Transport to a border hospital does not require prior authorization.

Add

Alternative Benefit Plan

Essential Health Benefit 3: Hospitalization — Collapse All

Benefit Provided: Inpatient Hospital
Source: State Plan 1905(a) — Remove
Authorization: Concurrent Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Substance Abuse Detox is performed in an inpatient hospital setting.

Benefit Provided: Inpatient Psychiatric Hospital
Source: State Plan 1905(a) — Remove
Authorization: Concurrent Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Not Institutions for Mental Disease (IMD).

Add

Alternative Benefit Plan

■ Essential Health Benefit 4: Maternity and newborn care — Collapse All ☐

Benefit Provided: OLP: Licensed Lay Midwife
Source: State Plan 1905(a) — Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Nurse Midwife
Source: State Plan 1905(a) — Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Physician Services: Maternity Care
Source: State Plan 1905(a)
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Inpatient Hospital: Maternity Care

Source: State Plan 1905(a)

Remove

Authorization: Concurrent Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Current Authorization on the 13th day of stay.

Add

Alternative Benefit Plan

Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment

Collapse All

Benefit Provided: Clinic Services - Mental Health Clinic

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Includes group therapy, individual psychotherapy, day hospital, diagnosis and evaluation, emergency care, and chemotherapy.

Benefit Provided: OLP: Behavioral Health

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Not covered if resident of inpatient hospital or mental health hospital, or concurrently receiving mental health clinic services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Vermont has five designated hospitals that provided psychiatric services in the general hospital setting with wings of 8 beds or less and are not Institutions for Mental Disease (IMD).

Benefit Provided: Rehab: Substance Abuse Services Residential Treat

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Not Institutions for Mental Disease (IMD).

Benefit Provided:

Rehab: Substance Abuse Residential Detoxification

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

7 days per acute episode

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Not Institutions for Mental Disease (IMD).

Benefit Provided:

Rehab: Substance Abuse Residential Post Detox Serv

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

30 days per year

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Not Institutions for Mental Disease (IMD).

Benefit Provided:

Rehab: Substance Abuse Resid. Extended Post Detox

Source:

State Plan 1905(a)

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Alternative Benefit Plan

Amount Limit:
183 days per year

Duration Limit:
None

Remove

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Not Institutions for Mental Disease (IMD).

Benefit Provided:
Rehab:Substance Abuse Non-residential professional

Source:
State Plan 1905(a)

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
90 hours counseling per episode

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

☒ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The State of Vermont's ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs.

Alternative Benefit Plan

Essential Health Benefit 7: Rehabilitative and habilitative services and devices — Collapse All

Benefit Provided: Outpatient Hospital - Rehabilitative therapies

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: OT/PT/SLP

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Both rehabilitative and habilitative

Benefit Provided: OT/PT/SLP (non-hospital based)

Source: State Plan 1905(a)

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: Under 21, 8 visits; over 21, 30 visits/year combin

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Under 21, prior authorization after 8 visits; over 21, prior authorization for over 30 visits per year of any type. Both rehabilitative and habilitative.

Benefit Provided: Physical Therapies & Related Service: Hearing Aids

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: Every three years

Duration Limit: None

Scope Limit: Hearing loss has to meet certain conditions. Prior authorization is required for other degrees of hearing loss.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Prosthetic Devices

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Physician order is required for breast prostheses, trusses and socks ; all others require prior authorization.

Benefit Provided: Nursing Facility 21 and older; rehab care

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Requires a physician order; Out of state requires prior authorization.

Benefit Provided: Home Health Intermittent Part Time Nursing

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Requires physician order and plan of care.

Benefit Provided: Home Health Aide

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Requires plan of care and supervision by OT/PT/SLP or nurse.

Benefit Provided: Home Health: Medical Supplies, Equip. and Applianc

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Requires physician order.

Benefit Provided: Home Health PT/OT/SLP

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit: None

Duration Limit: four month limit

Remove

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Home Health: Private Duty Nursing

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

Essential Health Benefit 8: Laboratory services

Collapse All

Benefit Provided:

Other Laboratory and X-Ray Services

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Urine drug test limited to 8 per month

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Exceptions to the urine drug test limitation must be prior approved. Diagnostic imaging requires prior authorization for high-tech (CT, CTA, MRI, MRA, PET, PET/CA) unless provided as part of ER or inpatient visit.

Add

Alternative Benefit Plan

■ Essential Health Benefit 9: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Clinic Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: OLP: Naturopathic Physician

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Other diagnostic, screening, preventative and reha

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

■ Essential Health Benefit 10: Pediatric services including oral and vision care — Collapse All ☐

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source: State Plan 1905(a) — Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

All federally required services in accordance CFR and Statute.

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source: State Plan 1905(a) — Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Nursing facility under 21. Rehabilitation Center services provided in nursing facilities located outside of Vermont for the severely disabled such as head injured or ventilator dependent people require authorization prior to admission from the Medicaid Director or a designee. Coverage of this care is limited to one year

Add

Alternative Benefit Plan

☐ Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

☒ Base Benchmark Benefits Not Covered due to Substitution or Duplication — Collapse All ☐

Base Benchmark Benefit that was Substituted: Family Planning: Reversal of Sterilization

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substitution - Non-Emergency Transportation was substituted in the ambulatory care EHB category. The Medicaid State Plan does not cover reversal of sterilization and the state seeks an identical benefit plan for this former 1115 expansion, now state plan, group in the Medicaid program.

Base benchmark benefit limitation(s): One attempt at reversal of sterilization covered.

Base Benchmark Benefit that was Substituted: Infertility Drugs with natural conception

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Generic and Brand Name Drug benefit services includes Hormone treatments and were used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

Base benchmark benefit limitation(s): Infertility Drugs up to 4 months per year for natural conception.

This benefit maps to EHB 6: Prescription Drugs.

Base Benchmark Benefit that was Substituted: Outpatient Hospital Fee

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Outpatient Hospital service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Outpatient Surgery Physician/Surgical Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Outpatient Hospital service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Urgent Care Centers or Facilities

Source: Base Benchmark

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Remove

Duplication - The Medicaid State Plan Other Ambulatory Services - Rural Health Clinic and FQHC's and Physician Services In all settings service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program. Certain clinics provide urgent care, however Vermont does not have stand alone urgent care center providers who are not affiliated with a health clinic or hospital.

This benefit maps to EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted:

Primary Care Visit to Treat an Injury or Illness

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Physician Services In all settings service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted:

Dental Services (not Routine)

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Medical & Surgical furnished by dentist service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

Base benchmark benefit limitation(s): Prior approval required.

This benefit maps to EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted:

Chiropractic Care

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Chiropractic service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

Base benchmark benefit limitation(s): Prior Approval is required after the 12th visit.

This benefit maps to EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted:

OLP: Routine Foot Care for diabetics only

Source:
Base Benchmark

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Remove

Duplication - The Medicaid State Plan Podiatry service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

Base benchmark benefit limitation(s): Covered for Diabetics only; excluded for all other members.

This benefit maps to EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted: Emergency Room Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Outpatient Hospital Emergency Care service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 2: Emergency Services.

Base Benchmark Benefit that was Substituted: Emergency Transportation/ Ambulance

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Transportation: Ambulance service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 2: Emergency Services.

Base Benchmark Benefit that was Substituted: Inpatient Hospital Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Inpatient Hospital, Physician Services In all settings was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 3: Hospitalization.

Base Benchmark Benefit that was Substituted: Inpatient Physician and Surgical Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Inpatient Hospital, Physician Services In all settings was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 3: Hospitalization and EHB 1: Ambulatory Care.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:

Substance Abuse Disorder Inpatient Services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Inpatient Hospital, Physician Services In all settings was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 3: Hospitalization and EHB 1: Ambulatory Care.

Base benchmark benefit limitation(s): Excludes services provided by non-participating providers or facilities, treatment without concurrent review, non-traditional or alternative therapies, services that focus on education or socialization or delinquency, custodial care that is not medically necessary and biofeedback, pain management, stress reduction classes or pastoral counseling.

Prior Approval is required for all non-Emergency Inpatient or partial-Inpatient substance abuse services.

Base Benchmark Benefit that was Substituted:

Cosmetic Surgery if reconstructive

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Inpatient Hospital, Physician Services In all settings was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 3: Hospitalization and EHB 1: Ambulatory Care.

Base Benchmark Benefit that was Substituted:

Bariatric Surgery

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Inpatient Hospital, Physician Services In all settings was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 3: Hospitalization and EHB 1: Ambulatory Care.

Base Benchmark Benefit that was Substituted:

Transplant-deceased donor

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Inpatient Hospital, Physician Services In all settings was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 3: Hospitalization and EHB 1: Ambulatory Care.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:

Transplant live donor

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Inpatient Hospital, Physician Services In all settings was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 3: Hospitalization and EHB 1: Ambulatory Care.

Base Benchmark Benefit that was Substituted:

Mental/Behavioral Health Inpatient Services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Inpatient psychiatric Hospital service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 3: Hospitalization.

Base benchmark benefit limitation(s): Excludes services provided by non-participating providers or facilities, treatment without concurrent review, non-traditional or alternative therapies, services that focus on education or socialization or delinquency, custodial care that is not medically necessary and biofeedback, pain management, stress reduction classes or pastoral counseling.

Prior Approval is required for all non-Emergency Inpatient or partial-Inpatient Mental Health services.

Base Benchmark Benefit that was Substituted:

Other Practitioner Office Visit (Nurse, Physician

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Pediatric or Family Nurse Practitioners' Services was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 1: Ambulatory Patient Services.

Base Benchmark Benefit that was Substituted:

Prenatal and Postnatal Care

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Licensed Lay Midwife, Physician Services: Maternity Care services were used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 4: Maternity and Newborn Care.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:

Delivery and All Inpatient Services for Maternity

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Nurse Mid Wife, Physician Services: Maternity Care, Inpatient Hospital: Maternity Care was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 4: Maternity and Newborn Care.

Base Benchmark Benefit that was Substituted:

Diagnostic Test (Lab Work)

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Other Laboratory and X-Ray Services was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 8: Laboratory Services.

Base Benchmark Benefit that was Substituted:

Diagnostic Tests and Imaging

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Other Laboratory and X-Ray Services was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 8: Laboratory Services.

Base Benchmark Benefit that was Substituted:

Preventive Care

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Physician Services In all settings, Clinic Services, and Other diagnostic, screening, preventative and rehab services were used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 9: Preventive and Wellness Services and Chronic Disease Management and EHB 1: Ambulatory Care.

Base Benchmark Benefit that was Substituted:

Nutritional Counseling

Source:
Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Naturopathic Physician and Physician Services were used in order to

Alternative Benefit Plan

ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 9: Preventive and Wellness Services and Chronic Disease Management and EHB 1: Ambulatory Care.

Remove

Base Benchmark Benefit that was Substituted: Generic Drugs

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Generic drug benefit was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 6: Prescription Drugs.

Base Benchmark Benefit that was Substituted: Preferred brand, non-pref. brand, & specialty drug

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Brand Name drug benefit was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 6: Prescription Drugs.

Base Benchmark Benefit that was Substituted: Nutritional Formulae

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Generic, Brand Name and OTC drug benefit was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 6: Prescription Drugs.

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health Outpatient Services

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Clinic Services - Mental Health Clinic (group therapy; individual psychotherapy; day hospital; diagnosis and evaluation; emergency care; chemotherapy) and OLP: Behavioral Health services were used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 5: Mental Health and Substance Use Disorder Services Including Behavioral Health Treatment.

Base benchmark benefit limitation(s): Prior authorization is required for psychological testing, electro-

Alternative Benefit Plan

shock therapy; and intensive outpatient mental health services. For all other outpatient services, there is a 10 visit limit per plan year without prior approval. If more than 10 visits are required for outpatient mental health services, prior approval is required beginning with the 11th visit.

Remove

Base Benchmark Benefit that was Substituted:

Neuropsychological Testing

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Clinic Services - Mental Health Clinic (group therapy; individual psychotherapy; day hospital; diagnosis and evaluation; emergency care; chemotherapy) service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 5: Mental Health and Substance Use Disorder Services Including Behavioral Health Treatment.

Base Benchmark Benefit that was Substituted:

Substance Abuse Disorder Outpatient Services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Substance Abuse Services Residential Treatment .
Substance Abuse Services Residential Detoxification, Substance Abuse Services Residential Post Detox Services, Substance Abuse Services Residential Extended post detox, and
Substance Abuse Services Non-residential professional services were used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 5: Mental Health and Substance Use Disorder Services Including Behavioral Health Treatment.

Base benchmark benefit limitation(s): Prior authorization is required for psychological testing, electro-shock therapy; and intensive outpatient substance abuse services. For all other outpatient services, there is a 10 visit limit per plan year without prior approval. If more than 10 visits are required for outpatient substance abuse services, prior approval is required beginning with the 11th visit.

Base Benchmark Benefit that was Substituted:

Outpatient Rehabilitation Services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Outpatient Hospital - Rehabilitative therapies (OT/PT/SLP) service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 7: Rehabilitative and Habilitative Services and Devices.

Base Benchmark Benefit that was Substituted:

Outpatient physical, speech and occupational thera

Source:
Base Benchmark

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Remove

Duplication - The Medicaid State Plan OT/PT/SLP (non-hospital based)service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

Base benchmark benefit limitation(s): Covered up to 30 visits combined per plan year.

This benefit maps to EHB 7: Rehabilitative and Habilitative Services and Devices.

Base Benchmark Benefit that was Substituted:

Durable Medical Equipment

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Communication Devices, Wheelchair, Physical Therapies & Related Services: Hearing Aids, Prosthetic Devices, Home Health: Medical Supplies, Equipment and Appliances were used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

Base benchmark benefit limitation(s): Some durable medical equipment and supplies require prior approval. Includes supplies and equipment necessary for administration, orthotics (if approved), prosthetics, and devices. Threshold applies.

This benefit maps to EHB 7: Rehabilitative and Habilitative Services and Devices.

Base Benchmark Benefit that was Substituted:

Skilled Nursing Facility

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Nursing Facility 21 and older was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

Base benchmark benefit limitation(s): Covered by participating facility only for Acute Care.

This benefit maps to EHB 7: Rehabilitative and Habilitative Services and Devices.

Base Benchmark Benefit that was Substituted:

Home Health Care Services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Home Health Aide and Home Health PT/OT and SLP Services were used in order to ensure identical benefits for all beneficiaries in the Medicaid program.7a. Home Health Intermittent part time nursing.

This benefit maps to EHB 7: Rehabilitative and Habilitative Services and Devices.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:

Private-Duty Nursing

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Home Health: Private Duty Nursing service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

Base benchmark benefit limitation(s): Covered up to $2,000 per plan year; Requires prior approval and recertification of treatment plan every 60 days.

This benefit maps to EHB 7: Rehabilitative and Habilitative Services and Devices.

Base Benchmark Benefit that was Substituted:

Hospice Services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Hospice service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

Base benchmark benefit limitation(s): 100 hours per month.

This benefit maps to EHB 1: Ambulatory Services.

Base Benchmark Benefit that was Substituted:

Home Health Aide

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Home Health Aide was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

Base benchmark benefit limitation(s): 100 hours per month.

This benefit maps to EHB 7: Rehabilitative and Habilitative Services and Devices.

Base Benchmark Benefit that was Substituted:

Habilitation Autism

Source:
Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan EPSDT service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

VT requires private insurers to cover services to children up to the age of 21 who have an ASD regardless of whether they are gaining a new skill or recovering a lost skill. This is the same coverage that EPSDT provides e.g. to ameliorate, or prevent from worsening or promote healthy development.

Alternative Benefit Plan

This benefit maps to EHB 10: Pediatric services including oral and vision care.

Remove

Base Benchmark Benefit that was Substituted:

Preventive Care/ Screening/ Immunization

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan EPSDT and Physician Services in All Settings was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 1: Ambulatory Patient Services and EHB 10: Pediatric Services including Oral and Vision Care.

Base Benchmark Benefit that was Substituted:

Eye Glasses for Children

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan EPSDT service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 10: Pediatric Services Including Oral and Vision Care.

Base Benchmark Benefit that was Substituted:

Dental Check-Up for Children

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan EPSDT service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 10: Pediatric Services Including Oral and Vision Care.

Base Benchmark Benefit that was Substituted:

Family Planning: All Other Services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication - The Medicaid State Plan Family Planning service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

This benefit maps to EHB 1: Ambulatory Patient Services.

Add

Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered

Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Routine Eye Exam (Adult)

Source:
Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

Routine adult eye exams are not considered an EHB.

The Medicaid State Plan Optometry service was used in order to ensure identical benefits for all beneficiaries in the Medicaid program.

Base benchmark benefit limitation(s): 1 routine eye exam per calendar year; Does not cover the evaluation and fitting of contact lenses or other supplemental tests, routine eye care, eye exercises or visual training.

Add

Alternative Benefit Plan

☒ Other 1937 Covered Benefits that are not Essential Health Benefits — Collapse All ☐

Other 1937 Benefit Provided: Dental- Prophylaxis

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: 1 visit every 6 months; $510 per year

Duration Limit: None

Scope Limit: Excludes cosmetic; elective; TMJ treatment except TMJ splint fabrication.

Other:

Other 1937 Benefit Provided: ICF/IID

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other:

Other 1937 Benefit Provided: OLP: High Tech Nursing

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other:

Alternative Benefit Plan

Remove

Other 1937 Benefit Provided:
Extended Services (home visits) for Pregnant Women

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:

Other 1937 Benefit Provided:
OLP: Opticians

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Limited to eye glass dispensing only.

Other:
No authorization requirement.

Other 1937 Benefit Provided:
Face-to-Face Tobacco cessation for pregnant women

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
16 visits per calendar year.

Alternative Benefit Plan

Other:

No authorization requirement.

Remove

Other 1937 Benefit Provided:

Case Management for TB related services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

No authorization requirement.

Other 1937 Benefit Provided:

Outpatient Hospital - Partial Hospitalization

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

No authorization requirement.

Other 1937 Benefit Provided:

Therapeutic Substance Abuse Services (PNMI)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Alternative Benefit Plan

Scope Limit:

None

Remove

Other:

No authorization requirement.

Other 1937 Benefit Provided:

Community Mental Health Center Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

No authorization requirement.

Diagnosis and evaluation; emergency care; psychotherapy; chemotherapy; group therapy; specialized rehabilitation services provided by Mental Health Designated Providers authorized by DMH and required by state law. The benefit category in Vermont's State plan is "Other Diagnostic, Screening, Preventive and Rehabilitative Services."

Other 1937 Benefit Provided:

Assertive Community Care Services (PNMI)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Persons with functional impairments and/or cognitive disabilities.

Other:

No authorization requirement.

Other 1937 Benefit Provided:

Day Health Rehabilitation - Center based

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Alternative Benefit Plan

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Remove

Amount Limit: None

Duration Limit: None

Scope Limit: Excludes residents of nursing home or enhanced residential care facilities.

Other:

Other 1937 Benefit Provided: Targeted Case Management (3 targeted groups)

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other: No authorization requirement.

Three target groups for persons over 18 years old: (1) Persons with developmental disabilities who are unable to access needed medical, social, educational and other services because of adaptive deficits due to their level of disability, or who lack the active assistance of a family member or other interested person to assist them in accessing needed services; (2) Families whose children are abused or neglected or suspected of being at imminent risk thereof and Families of children receiving post adoption assistance; (3) Pregnant and postpartum women and infants through twelve months of age enrolled in the Vermont Department for Children and Families, Healthy Babies, Kids, and Families Program.

Other 1937 Benefit Provided: Respiratory Care Services

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

Other:

No authorization requirement.

Remove

Other 1937 Benefit Provided:

Personal Care Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Other 1937 Benefit Provided:

Nursing Facility 21 and older; custodial care

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Requires a physician order; Out of state requires prior authorization.

Other 1937 Benefit Provided:

OLP: Optometry

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Routine exam 1/2 years; diagnostic exam 1/2 years

Duration Limit:

None

Alternative Benefit Plan

Scope Limit:

None

Remove

Other:

Contact Lens prior authorization; Aids to vision approved when legally blind and will improve at least one ADL or IADL.

Other 1937 Benefit Provided:

Inpatient Psych. Services for Individuals Under 22

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

No authorization requirement.

Add

Alternative Benefit Plan

☐ Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130814

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/ territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

- (●) Through an Alternative Benefit Plan.
- ( ) Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

Alternative Benefit Plan

- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☐ Managed care.

☒ Fee-for-service.

☒ Other service delivery system.

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

◉ Traditional state-managed fee-for-service

○ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

Choices for Care 1115 Long Term Care (Control #11-W-00191/6) and CHIP beneficiaries receive all state plan services using all state plan approved payment methodologies including a variety of bundled rate options.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

Other Service Delivery Model

Name of service delivery system:

Global Commitment to Health (MCO) model (Control # 11-W-001941) and Choices for Care 1115 (Control #11-W-00191/6) Demonstration Waivers

Provide a narrative description of the model:

The state operates its Medicaid Program under two 1115 Demonstration waivers. One for long term care (Control #11-W-00191/6) and one using a managed care model and adhering to the MCO regulatory structure and 42 CFR 438 as per the STC's (Control # 11-W-001941/1). The new adult is moving from an 'expansion population' in the Global Commitment to Health (MCO) waiver to a state plan group under the same waiver. For Global Commitment populations, Medicaid eligibility is considered synonymous with MCO enrollment under the model. Current beneficiaries will be converted from 'expansion' population to 'state plan' as part of the state's CMS approved transition plan. Other members will move seamlessly into their new ACA group during annual recertification reviews. As of January 1, 2014 new members will be enrolled directly into the new adult group upon eligibility determination for the Medicaid program. Members who qualify for Long Term Care Medicaid will receive all state plan and any approved demonstration services under the state's long term care waiver Choices for Care. Former 1915 Home and Community Based Waivers and former 1115 (b) Demonstrations are incorporated into the 1115 Demonstration for individuals with a Developmental Disability, Traumatic Brain Injury, Severe and Persistent Mental Illness and Children with a severe emotional disturbance and their families. The state has a several networks of designated specialty providers for the behavioral health and disability related carve outs under the current 1115 Demonstration. All former 1915 services for the elderly have been incorporated into the 1115 Choices for Care, Long Term Care waiver.

Alternative Benefit Plan

PRA Disclosure Statement

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V.20130718

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- ☐

OMB Expiration date: 10/31/2014

General Assurances	ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/ territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L-

Employer Sponsored Insurance and Payment of Premiums	ABP9
The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.	Yes

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

The state assures that ESI coverage is established in sections 3.2 and 4.22(h) of the state's approved Medicaid state plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

The state/territory otherwise provides for payment of premiums.	No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

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Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Payment Methodology	ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____Vermont_____

COORDINATION OF TITLE XIX WITH PART B OF TITLE XVIII

==========

The following method is used to provide the entire range of benefits under Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

☒ A: Buy-in agreements with the Secretary of HHS. This agreement covers:

1. ☐ Individuals receiving SSI under title XVI or State supplementation who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:
   ☐ Yes ☐ No

2. ☒ Individuals receiving SSI under title XVI, State supplementation or a money payment under the State's approved title IV-A plan, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:
   ☒ Yes ☐ No

3. ☐ All individuals eligible under the State's approved title XIX plan.

☐ B. Group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

☒ C. Payment of deductible and coinsurance costs. Such payments are made in behalf of the following groups: Categorically and Medically Needy

This relates only to comparability of devices - benefits under XVIII to what groups - not how XIX pays. …if State has buy-in (which covers premium), it does not check #3 for same group- only if it does #3 for another group, e.g. does #1 for money payment receipts and #3 for non-$- receipts. How it handles deductibles and coinsurance for money payment receipts is a matter for reimbursement attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: VERMONT

==========

Standards for Institutions

1. Hospitals

For an institution to be eligible to participate as a hospital under this plan it must meet the statutory requirements of Section 1861(e) of the Social Security Act and there must be a finding of substantial compliance on the part of the institution with all the other conditions for participation in Title XVIII. These conditions, set forth in 42 CFR Sections 405.1020 through 405.1040, relate to the quality of care and the adequacy of essential functions to be performed by the institution.

2. Institution for Mental Diseases

For an institution to be eligible to participate as an institution for mental diseases it must meet the requirements of Section 1861(f) of the Social Security Act as a psychiatric hospital and be accredited by the Joint Commission on Accreditation of Hospitals. In addition, it must be in substantial compliance with the conditions of participation contained in 42 CFR Sections 405.1037 and 405.1038 relating to special medical records and special staffing requirements for psychiatric hospitals.

3. Skilled Nursing Facilities

For an institution to be eligible to participate as a skilled nursing facility under this plan it must meet the statutory requirements of Section 1861(j) of the Social Security Act and there must be a finding of substantial compliance on the part of the institution with all the other conditions for participation in Title XVIII. These conditions, which include both the statutory requirements and the additional health and safety requirements prescribed by the Secretary of HEW, are set forth in 42 CFR Sections 405.1120 through 405.1137. Whenever the Secretary of HEW certifies an institution to be qualified as a skilled nursing facility under Medicare, that institution is deemed to meet the standards for certification as a skilled nursing facility under Medicaid.

Vermont Statutes for Licensure

- of hospitals is contained in Title 18, Vermont Statutes Annotated, Chapter 43
- of nursing homes is contained in Title 18, Vermont Statutes Annotated, Chapter 45
- of institution for mental diseases is contained in Title 18, Vermont Statutes Annotated, Chapter 43.

UTILIZATION CONTROL — INTERMEDIATE CARE FACILITY SERVICES

Utilization review in intermediate care facilities is performed under an agreement with the Vermont Department of Aging and Disabilities.

The review activities meet all requirements of 42 CFR Part 456, subpart F.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE __VERMONT__

==========

Cooperative Arrangements With the State Health and State Vocational Rehabilitation Agencies and With Title V Grantees

1. The State agency will make cooperative arrangements with State Health and State vocational rehabilitation agencies (including agencies which administer or supervise health or vocational rehabilitation services) directed toward maximum utilization of such services in the provision of medical assistance under the plan. Attached are descriptions of the cooperative arrangements.

2. The State agency will make cooperative arrangements with grantees under Title V of the Social Security Act to provide for utilizing such grantee agencies in furnishing, to medical assistance recipients, care and services which are available under Title V plans or projects and are included in the State plan for Title XIX. Such arrangements will include, where requested by the Title V grantee, provision for reimbursing the Title V grantee for care or services furnished by or through such grantee to individuals eligible therefore under the Title XIX plan, and will be in writing.

3. The arrangements with State health and State vocational rehabilitation agencies, and with Title V grantees that request provision for reimbursement will include a description, as appropriate, of the items specified in 45 CFR 251.10(a)(3).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE __VERMONT__

==========

Description of Cooperative Arrangements

The agreement between the XIX agency and the rehabilitation agency will include the following: definition of factors of eligibility in each of the programs; identification of the basic responsibility of each program and the precedence assigned; and delineation of the objective of the agreement which shall be directed towards pooling the resources of both agencies to the fullest advantage to recipients.

The agreement will provide for a reciprocal referral service; an exchange of reports of services to mutual recipients; coordination of plans for individuals; joint periodic evaluation of policies affecting the points of cooperation; joint planning for needed changes to achieve identified mutual goals; a system of continuous liaison between agencies; and incorporation of staff training for each agency by means of manual releases and other appropriate channels.

Arrangements with the Title V agency will assure the strengthening of services to crippled children by permitting a broader scope and greater amount of medical services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____VERMONT_____

Liens and Adjustments or Recoveries

---

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

   N/A--liens are not placed on property.

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR §433.36(f):

   A signed and dated written statement is accepted as documentation and verification of the facts in the case.

3. The State defines the terms below as follows:

   - estate

     An estate shall include all real and personal property and other assets which are included in the estate when it is filed in the probate court.

   - individual's home

     A home includes contiguous land and any other buildings located on the land.

   - equity interest in the home

     Equity value is the price the home can be reasonably expected to sell for on the local open market minus any encumbrances. In the case of shared ownership, only the applicant's/recipient's share is his/her interest in the home.

   - residing in the home for at least one or two years on a continuous basis, and an individual has been continuously residing in a home if he/she has had no other legal or mailing address during the period of time.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: VERMONT

Liens and Adjustments or Recoveries (Continued)

- lawfully residing.

  An individual is lawfully residing in a home if the home is his/her legal residence.

4. The State defines undue hardship as follows:

Undue hardship exists when any of the following conditions are met:

A. A sibling has been living in the home for at least one year immediately before (and on a continuous basis since) the date of the individual's admission to long-term care.

B. A son or daughter has been living in the home for at least two years immediately before (and on a continuous basis since) the date of the individual's admission to long-term care and establishes to the Department's satisfaction that he or she provided care to the individual which permitted the individual to reside at home rather than in a long-term care living arrangement.

C. One or more siblings or direct descendents of the deceased person (lineal heir(s), such as children and grandchildren) will inherit the homestead of the deceased Medicaid recipient, provided that the conditions in either subsection (1) or (2) are met.

(1) Each sibling or lineal heir inheriting the homestead has family income below 300 percent of the federal poverty level; or

"Family" means that the department will consider each heir separately. Heirs will not be aggregated into one family unless the heirs are minor children who are siblings. In the case of an adult heir, his or her family will be limited to the heir, the heir's spouse, the heir's minor (younger than 18) children, and the spouse's minor children residing in the household. In the case of an heir who is a minor, the heir's family will be the heir, his or her parent(s) or stepparent residing in the household, and the heir's minor siblings residing in the household, including half-, step-, and adoptive siblings.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: VERMONT

Liens and Adjustments or Recoveries (Continued)

"300 percent of the federal poverty level" is a gross income test; no exclusions or deductions are allowed.

(2) The sibling(s) or lineal heir(s) inheriting the homestead can demonstrate that significant services or financial support they provided to the deceased Medicaid recipient delayed or avoided the decedent's placement in a nursing home. "Significant" means when the deceased Medicaid recipient's admission to a nursing home was delayed by at least six months, or avoided entirely, as a result of either:

(a) Medical or remedial care or support services that was:
   i) medically necessary,
   ii) provided directly by one or more of the lineal heirs or siblings, or their spouses, without compensation, or purchased with their own funds, and
   iii) provided while the person required medical care and services consistent with the level of care standard for level III residential care homes at a frequency averaging no fewer than three times per week or, if provided less frequently, constituting the equivalent expenditure of time or money.

Such services may have been provided in combination with services provided by governmental or other private entities. If the care or services provided or purchased were in addition to those the deceased person received from governmental or private sources (and were paid for by other sources), then the care or services provided or purchased must have been medically necessary.

or

(b) Other services or financial support that was of equal or greater significance as the care or services described in criterion (a) above.

When there are multiple heirs and not all heirs qualify for the hardship waiver, only that percentage of the homestead that corresponds to the qualifying heir or heirs' share of the homestead will be exempt from Medicaid recovery.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____VERMONT_____

Liens and Adjustments or Recoveries (Continued)

D. The assets were treated as a transfer of assets and the assigned penalty period for the transfer was served.

E. The funds can be recovered from the estate only if assets are sold, and these assets are the sole source of income for the individual's immediate family.

NOTE: Such income-producing assets include a family farm or other family business. Immediate family is defined as spouse, parents, children or siblings.

F. The sale of the income-producing assets would result in the immediate family seeking public assistance.

5. The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective.

Recovery is waived when it would cause undue hardship (see above). Recovery is waived as being not cost-effective in cases where the estate consists only of personal property, such as home furnishings, apparel, personal effects and household goods, which do not exceed $2,000 in value, based on information filed with the probate court.

6. The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness):

Recovery is considered cost-effective in cases where the estate includes liquid resources, such as cash, bank accounts, stocks, bonds, Certificates of Deposit, IRAs, or real property. There is no minimum threshold, excepted that described in #5.

7. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: VERMONT

Liens and Adjustments or Recoveries (Continued)

A. All applicants for long-term care Medicaid are advised in writing about the Department's estate recovery policy at the time of application, via the DSW 204REC form. This form outlines the circumstances under which the Department will file a claim, describes what constitutes undue hardship, and specifies which Medicaid payments the Department will seek to recover.

B. The Probate Courts report all estate openings to the Department. A claim is then filed against the estate of any deceased individual who was a Medicaid recipient meeting the criteria for estate recovery. Notice is given to both the administrator and the Probate Court, and includes a copy of the Department's regulations on estate recovery and instructions for requesting a hardship waiver.

C. If a waiver is requested and denied, the administrator is notified in writing and provided with information on appeals procedures.

D. If the Department is advised that the estate consists only of personal property as described in #5, collection is waived as not cost-effective.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____Vermont_____

A. The following charges are imposed on the categorically needy for services, in accordance with section 1916 of the Social Security Act and 42 CFR 447.50 – 447.60:

Service	**Type of Charge**			**Amount/Basis for Determination**
	Deductible	Coinsurance	Copayment	
Pharmacy			X	$1.00 for prescription drugs costing* less than $30.00. Copayment is based on average state payment of $12.62 per claim (as of 06/12).
			X	$2.00 for prescription drugs costing* $30.00 or more but less than $50.00.
			X	$3.00 for prescription drugs costing* $50.00 or more.
Outpatient			X	$3 per day per hospital. Copayment is based on average state payment of $243.64 per outpatient claim (as of 12/11).
Dental			X	$3.00 per provider per date of service. Copayment is based on average state payment of $138.29 per claim (as of 12/11)

*Cost refers to the amount of reimbursement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____Vermont_____

B. The method used to col1ect cost sharing charges for categorically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for a service and collects the cost sharing charges for individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Pursuant to Section 1916(c) of the Act, the State permits the provider, in the absence of know1edge or indications to the contrary, to accept the Medicaid recipient's assertion that he or she is unable to pay.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 1916(a)(2) and (j) of the Social Security Act and 42 CFR 447.53(b) are described below:

The co-payment is deducted from the Medicaid payment unless the provider indicates an excluded category as contained on the claim form.

Vermont implements and enforces the federally required exclusions from co-payment by programming edits into the claims processing system which checks each claim for entries in date of birth, address, diagnosis, procedure code, emergency, and family planning indicator fields. Claims lacking information in any of these fields are denied. Correctly completed claims are edited against the copayment exclusion information in the system to determine whether or not a copayment is required.

American Indians/Alaska Natives (AI/AN) who currently or have previously received services by the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U), or through a referral under contract health services in any State are exempt from co-payments.

Vermont will accept documentation from Indian Health Providers and Urban Indian Organizations, such as the IHS active or previous user letter, which indicates that the individual has received a service from an I/T/U, and the State will then provide an edit in the system exempting the individual from cost sharing.

E. Cumulative maximums on charges:

☐ State policy does not provide for cumulative maximums.

☒ Cumulative maximums have been established as described below:

The Department of Vermont Health Access's (DVHA's) fiscal agent performs a calculation and produces a report, within thirty (30) days after the end of each quarter, indicating if any Medicaid beneficiaries have exceeded the 5% of the family's gross income for cost sharing. 5% of the family's gross income will not be exceeded in any quarter. The amount above the 5% cap is refunded to the beneficiary.

MEDICALLY NEEDY - PREMIUM

Not applicable.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____Vermont_____

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge Deduct.	Coins.	Copay.	Amount and Basis for Determination
Pharmacy			X	$1.00 for prescription drugs costing* less than $30.00. Copayment is based on average state payment of $12.62 per claim (as of 06/12).
			X	$2 00 for prescription drugs costing* $30.00 or more but less than $50.00.
			X	$3.00 for prescription drugs costing* $50.00 or more.
Outpatient			X	$3 per day per hospital. Copayment is based on average state payment of $243.64 per outpatient claim (as of 12/11).
Dental			X	$3.00 per provider per date of service. Copayment is based on average state payment of $138.29 per claim (as of 12/11)
				*Cost refers to the amount of reimbursement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____Vermont_____

B. The method used to collect cost sharing charges for medically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

See Attachment 4.18-A, Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____Vermont_____

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 1916(a)(2) and (j) of the Social Security Act and 42 CFR 447.53 (b) are described below:

The co-payment is deducted from the Medicaid payment unless the provider indicates an excluded category as contained in 42 CFR 447.53(b) on the claim form.

Vermont implements and enforces the federally required exclusions from co-payment by programming edits into the claims processing system which checks each claim for entries in date of birth, address, diagnosis, procedure code, emergency, and family planning indicator fields. Claims lacking information in any of these fields are denied. Correctly completed claims are edited against the copayment exclusion information in the system to determine whether or not a copayment is required.

American Indians/Alaska Natives (AI/AN) who currently or have previously received services by the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U), or through a referral under contract health services in any State are exempt from co-payments.

Vermont will accept documentation from Indian Health Providers and Urban Indian Organizations, such as the IHS active or previous user letter, which indicates that the individual has received a service from an I/T/U, and the State will then provide an edit in the system exempting the individual from cost sharing.

E. Cumulative maximums on charges:

☐ State policy does not provide for cumulative maximums.

☒ Cumulative maximums have been established as described below:

The Department of Vermont Health Access's (DVHA's) fiscal agent performs a calculation and produces a report, within thirty (30) days after the end of each quarter, indicating if any Medicaid beneficiaries have exceeded the 5% of the family's gross income for cost sharing. 5% of the family's gross income will not be exceeded in any quarter. The amount above the 5% cap is refunded to the beneficiary.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____Vermont_____

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

N/A

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____Vermont_____

Premiums Imposed on Low Income Pregnant Women and Infants (Continued)

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☐ No

N/A

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

N/A

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

Optional Sliding Scale Premiums Imposed on Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

N/A

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

N/A

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

Optional Sliding Scale Premiums Imposed on Qualified Disabled and Working Individuals
(Continued)

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☐ No

N/A

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

N/A

*Description provided on attachment.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -INPATIENT HOSPITAL CARE

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A) of this State plan.

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (A) of this State plan.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
____ Additional Other Provider-Preventable Conditions identified below:

In compliance with 42 CFR 447.26(c), the DVHA assures that:

1. No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
2. Reductions in provider payment may be limited to the extent that the following apply:
    a. The identified PPC would otherwise result in an increase in payment.
    b. The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the PPC.
3. Non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

In order to determine the non-payment amount, for services paid under Section 4.19 (A) of this State plan, the DVHA will utilize the diagnoses and present on admission indicator submitted by providers on claims. The DVHA utilizes the MS-DRG grouper in its methodology to pay for inpatient hospital services. As such, the MS-DRG grouper will identify the amount of non-payment for inpatient hospital services when a PPC is reported that was not present on admission. In the event of a Deep Vein Thrombosis diagnosis, DVHA will review and make an individual adjustment to the case.

This provision applies to all providers contracted with the DVHA.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES

Effective with dates of admission on or after October 1, 2012, the Department of Vermont Health Access (DVHA) will reimburse qualified providers for inpatient hospital services under the prospective payment system as set forth in this plan.

I. Participating Hospitals

All in-state and out-of-state hospitals will be included in this payment methodology, regardless of any designation provided by Medicare. Hospitals may be eligible for special payment provisions in addition to payments made under this methodology as discussed in Section IV below.

II. Data Sources and Preparation of Data for Computation of Prospective Rates

A. Introduction

The calculation of prospective rates requires the use of claims data and cost report data. The historical claims data is obtained from a chosen base period and the cost for these claims is derived from Medicare cost report data for the corresponding period. Claim costs are adjusted to the year in which the rates are in effect to account for inflation. Claims are grouped together into a diagnostic related group (DRG) based upon the diagnoses present on the claim.

B. Data Sources- Initial Period

For the rate setting period effective October 1, 2012, hospital cost report data from all in-state Medicaid providers plus Dartmouth-Hitchcock Medical Center for the fiscal years ending 2009 and 2010 were used to assign cost values to claims used in the rate development process. All hospitals included in the analysis have a fiscal year end of September 30 with the exception of one hospital (Retreat Health Care) which has a fiscal year end of December 31. The claims used to assign relative weight values and to develop base rates were from the same hospitals for which cost data was collected and were from the hospital fiscal years ending 2009, 2010 and 2011.

C. Data Sources- Subsequent Periods

More recent cost report and claims data will be used to develop new base rates and relative weights no less than once every four fiscal years.

(Continued)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

III. Payment for Inpatient Hospital Services

A. Payment Formulas

1. Non-Outlier DRG Payment Per Case = (Base Rate Assigned to Hospital x DRG Relative Weight)

2. Outlier DRG Payment Per Case = (Cost of Case – Outlier Threshold) x Outlier Payment Percentage

   where

   Cost of Case = Allowable Charges x Hospital-specific Cost to Charge Ratio and Outlier Threshold = (Base Rate x DRG Relative Weight) + Fixed Outlier Value

3. Psychiatric DRG Payment Per Case = (Base Per Diem Rate Assigned to Hospital x DRG Relative Weight x Factor Representing Length of Stay)

   where

   Factor Representing Length of Stay = The factors assigned by the Medicare Inpatient Psychiatric Facilities Prospective Payment System effective October 1, 2012

(Continued)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

III. Payments Inpatient Hospital Services (Continued)

B. Discussion of Payment Components

1. Base Rates

The in-state Base Rate effective October 1, 2012 is based on claims with dates of discharge from October 1, 2008 to September 30, 2011 from all in-state hospitals plus Dartmouth-Hitchcock Medical Center. The cost values were assigned to each hospital claim on a claim-by-claim basis using data from each hospital's Medicare Cost Report (MCR). The cost report used to assign the cost for each claim was based on the discharge date of the claim. Claims with dates of discharge from October 1, 2008 to September 30, 2009 were assigned costs using the hospital's 2009 fiscal year end MCR. Claims with dates of discharge from October 1, 2009 to September 30, 2011 were assigned costs using the hospital's 2010 fiscal year end MCR.

Allowed charges on each detail line of the inpatient claim were multiplied by a hospital-specific cost to charge ratio (CCR). The CCR assigned to each detail line is based on the revenue code billed for the detail line. The mapping of revenue codes to CCRs followed the principles that were described in the Medicare Inpatient Prospective Payment System (IPPS) Final Rule for 2007 published in the Federal Register on August 18, 2006, with the following exceptions. The Medicare IPPS group for Routine Days was split into two groups—Adults & Peds and Nursery. The Medicare IPPS group for Intensive Days was split into three groups—ICU, Surgical ICU and NICU. The Medicare IPPS group for Other Services was split into four groups—Emergency Room, Clinic, Observation and Other Services.

The cost value of the claim is adjusted for inflation using Global Insight's Health Care Cost Review New CMS Hospital Prospective Reimbursement Market Basket moving average factors. Claim costs are inflated to the mid-point of the rate year.

The in-state base rate was derived by first computing the average inflated cost per case across all claims in the base period. This value is $8,682. Because of funding limits imposed by the Vermont Legislature, the in-state Base Rate effective November 1, 2013 for non-psychiatric DRGs is $7,611.45.

(Continued)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

III. Payments Inpatient Hospital Services (Continued)

2. Relative Weights

Relative weights were assigned to each DRG in the CMS MS-DRG Grouper Version 29.0 based on Vermont hospital costs. The relative weight is the average cost of the claims grouped into the DRG divided by the average cost of all claims in the base period.

Before calculating the relative weight for a DRG, tests were conducted to ensure that there was sufficient volume and conformity among the cases in the DRG to set a stable relative weight. A DRG was found to have sufficient sample size to compute a relative weight if: (a) There was a minimum of 10 claims across the two years of data; and (b) There were sufficient claims to pass this statistical test: The standard error of the claims' costs is within 25% of the mean with a 90% level of confidence.

Before running the statistical test, low-cost and high-cost outliers were removed from each DRG, which are defined as any claim that was outside +/- two standard deviations from the geometric mean cost of the DRG.

This test yielded 228 stable DRGs, 403 unstable DRGs, and 119 empty DRGs (no Vermont claims volume in the base period utilized). The 522 unstable and empty DRGs were then collapsed into 12 tier groups based on the Medicare relative weight for each DRG. After the claims were collapsed into these categories, a new average cost was computed for the claims in each tier and a relative weight was set.

Effective with dates of admission on or after October 1, 2012, all DRGs that were collapsed into a tier will share the same relative weight.

(Continued)

IV. Special Payment Provisions

A. Rehabilitation DRG

In-state hospitals with a claim that groups into the Rehabilitation DRGs (DRGs 945 and 946 in MS-DRG Grouper Version 30.0) will be paid an additional $300 per diem for the entire length of the patient's stay for the single episode of care. Border Teaching Hospitals will be paid an additional $200 per diem. This payment is in addition to the Non-Outlier and Outlier DRG Payments per Case.

The Rehabilitation DRGs paid under this methodology are those Rehabilitation DRGs as assigned by the Grouper being utilized by DVHA. Effective October 1, 2012, this included the following DRGs:
DRG 945: Rehabilitation W CC/MCC
DRG 946: Rehabilitation W/O CC/MCC

B. Neonate DRGs

In-state hospitals that do not serve a disproportionate number of neonate cases that have a claim that groups into a Neonate DRG will be paid an additional $300 per diem for the entire length of the patient's stay for the single episode of care. Border Teaching Hospitals will be paid an additional $200 per diem. This payment is in addition to the Non-Outlier and Outlier DRG Payments per Case.

In-state hospitals that do serve a disproportionate number of neonate cases that have a claim that groups into a Neonate DRG will be paid an additional $400 per diem for the entire length of the patient's stay for the single episode of care. This payment is in addition to the Non-Outlier and Outlier DRG Payments per Case. A hospital with a disproportionate share of neonate cases is a hospital that had more than 50% of all of the neonate DRG cases in the rate setting claims period.

The Neonate DRGs paid under this methodology are those Neonate DRGs as assigned by the Grouper being utilized by DVHA. Effective October 13, 2012, this included the following DRGs:

DRG 789: Neonates, Died or Transferred to another Acute Care Facility
DRG 790: Extreme Immaturity or Respiratory Distress Syndrome, Neonate
DRG 791: Prematurity with Major Problems
DRG 792: Prematurity without Major Problems
DRG 793: Full Term Neonate with Major Problems
DRG 794: Neonate with Other Significant Problems

(Continued)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

IV. Special Payment Provisions (Continued)

C. Psychiatric DRG Cases Provided by In-State Hospitals

In-state hospitals will be paid for psychiatric cases under a DRG per diem methodology instead of a DRG per case methodology using the formula shown in III.A above.

The Psychiatric DRGs paid under this methodology are those Psychiatric DRGs as assigned by the Grouper being utilized by DVHA. Effective October 1, 2012, this included the following DRGs:

DRG 56: Degenerative Nervous System Disorders w MCC
DRG 57: Degenerative Nervous System Disorders w/o MCC
DRG 80: Nontraumatic Stupor and Coma w MCC
DRG 81: Nontraumatic Stupor and Coma w/o MCC
DRG 876: O.R. Procedure with Principal Diagnosis of Mental Illness
DRG 880: Acute Adjustment Reaction & Psychosocial Dysfunction
DRG 881: Depressive Neuroses
DRG 882: Neuroses Except Depressive
DRG 883: Disorders of Personality & Impulse Control
DRG 884: Organic Disturbances & Mental Retardation
DRG 885: Psychoses
DRG 886: Behavioral & Developmental Disorders
DRG 887: Other Mental Disorder Diagnoses
DRG 894: Alcohol/Drug Abuse or Dependence, Left AMA
DRG 895: Alcohol/Drug Abuse or Depend. with Rehabilitation Therapy
DRG 896: Alcohol/Drug Abuse or Depend. w/o Rehabilitation Therapy w MCC
DRG 897: Alcohol/Drug Abuse or Depend. w/o Rehabilitation Therapy w/o MCC

On an ongoing basis, the factors applied representing the length of stay will be the same as those utilized by Medicare in its Inpatient Psychiatric Prospective Payment System. The factors applied are additive by length of stay.

The psychiatric base per diem rate was set to ensure that there is sufficient access to services for Medicaid beneficiaries in the state. Effective November 1, 2013, the Base Per Diem Rate for in-state hospitals is $1,104.60 per diem.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

IV. Special Payment Provisions (Continued)

D. One-Day Stays

Claims for patients admitted as an inpatient but for which the length of stay is not overnight are paid as the lesser of the cost of the case or the Non-Outlier DRG Payment Per Case. The exception is if the patient is classified as a Normal Newborn (DRG 795). In this case, payment will always be the Non-Outlier DRG Payment.

E. Transfer Cases

For claims in which the patient is transferred from one inpatient general acute care facility to another, the payment to the transferring hospital is the lesser of the cost of the case or the DRG Payment Per Case, including any outlier payment or DRG Add-on payment, if applicable. Payment to the receiving hospital will follow the payment guidelines of non-transfer cases.

F. Sub-acute Care

Swing bed, awaiting placement and inappropriate level of care days are reimbursed at a per diem rate established by the Division of Rate Setting equal to the average statewide rate per patient day paid for services furnished in nursing facilities during the previous calendar year.

(Continued)

IV. Special Payment Provisions (Continued)

G. Out of State Facilities

Out-of-state facilities will receive payments using the same payment formulas as stated in III.A.1 and III.A.2. However, the values of components of the formulas differ from those used to pay in-state hospitals.

1. A Base Rate will be assigned to each participating out-of-state hospital based upon its peer group.

   a. Border Teaching Hospitals: Defined as hospitals within 10 miles of the Vermont border that operate post-graduate training programs. For payments on or after November 1, 2013, the base rate will equal $5,224.80.
   b. Non-Border Teaching Hospitals: Defined as hospitals greater than 10 miles of the Vermont border that operate post-graduate training programs. For payments on or after November 1, 2013, the base rate will equal $3,122.70.
   c. Other Out-of-State Hospitals: Defined as hospitals not meeting the criteria of G.1.a or G.1.b. For payments on or after November 1, 2013, the base rate will equal $2,882.25.

H. Outlier Payments

Using the formula for outlier payments described in III.A.2, a Fixed Outlier Value, an Outlier Payment Percentage, and a Cost to Charge Ratio will be assigned to each participating hospital based upon its peer group.

1. Fixed Outlier Value
   a. In-state Hospitals: $24,000
   b. Border Teaching Hospitals: $40,000
   c. Non-Border Teaching Hospitals: $50,000
   d. Other Out-of-State Hospitals: $50,000

2. Outlier Payment Percentage
   a. In-state Hospitals: 80%
   b. Border Teaching Hospitals: 50%
   c. Non-Border Teaching Hospitals: 50%
   d. Other Out-of-State Hospitals: 50%

Hospitals that are eligible for payment under the per diem methodology for psychiatric stays are not eligible to receive an outlier payment for cases in the psychiatric DRGs listed in IV.C.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

IV. Special Payment Provisions (Continued)

3. The Cost to Charge Ratio (CCR) to be applied for calculating the outlier cost of the case will be assigned to each participating in-state hospital specifically on an annual basis based on a recently filed MCR. Each out-of-state hospitals will be assigned a CCR based upon its peer group.

   a. Border Teaching Hospitals: The CCR to apply will be assigned to each participating hospital specifically on an annual basis based on a recently filed MCR for each hospital in the peer group.
   b. Non-Border Teaching Hospitals: The CCR that will be assigned will be the average CCR of all in-state hospitals.
   c. Other Out-of-State Hospitals: The CCR that will be assigned will be the average CCR of all in-state hospitals.

I. Extraordinary Access Issues

In order to ensure access to non-Vermont hospitals providing unusual and highly complex services, the DVHA has the authority to establish rates on a case by case basis or by hospital.

J. New Facilities

New facilities under the DRG system will receive payments using the same payment formulas as stated in III.A.1 and III.A.2. If the new facility is an in-state hospital, it will receive the same base rate as other in-state hospitals and all other payment policies for in-state hospitals will apply. If it is an out-of-state hospital, it will receive a base rate based upon the out-of-state peer group it is assigned to. All other payment provisions will follow the policies for the out-of-state hospital peer group to which it is assigned or the authority as outlined in IV.G and IV.H above.

K. New Medicaid Providers

Prospective payment rates for established facilities which had not been an OVHA participating provider prior to October 1, 2012 will receive payments based on the same provisions that apply to new facilities as described in IV.J.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

V. Ongoing Maintenance

As a part of ongoing maintenance of the payment system, the DVHA will change the following rate setting components either separately or in combination:

A. Annually
   1. The DRG Grouper used to group claims. If a new DRG grouper includes a new DRG for which the OVHA does not have a relative weight assigned, the DVHA will use the Medicare relative weight to assign the DRG to a Vermont tier weight until such time as all DRG relative weights are updated.
   2. The factors representing length of stay in payments for psychiatric cases made to eligible hospitals.
   3. The Cost to Charge Ratio assigned to each hospital for use in establishing claim outlier status

B. At least once every four years
   1. The base period of claims and Medicare Cost Report(s) used to establish DRG relative weight values
   2. The DRG Relative Weight Values
   3. The inflation factor used to best represent current costs
   4. The Fixed Outlier Value
   5. The Outlier Payment Percentage

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES (CONTINUED)

V. Ongoing Maintenance

As a part of ongoing maintenance of the payment system, the OVHA will change the following rate setting components either separately or in combination:

A. Annually
   1. The DRG Grouper used to group claims. If a new DRG grouper includes a new DRG for which the OVHA does not have a relative weight assigned, the OVHA will use the Medicare relative weight until such time as all DRG relative weights are updated.
   2. The factors representing length of stay in payments for psychiatric cases made to eligible hospitals.
   3. The Cost to Charge Ratio assigned to each hospital for use in establishing claim outlier status

B. At least once every four years
   1. The base period of claims and Medicare Cost Report(s) used to establish DRG relative weight values
   2. The DRG Relative Weight Values
   3. The inflation factor used to best represent current costs
   4. The Fixed Outlier Value
   5. The Outlier Payment Percentage

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES (CONTINUED)

Methods and Standards for Payment Adjustments to Hospitals Qualifying as Disproportionate Share Hospitals

Effective October 1, 2009, the Office of Vermont Health Access (OVHA) will make disproportionate share payments to hospitals as set forth in this plan.

VI. Eligible Hospitals

A. Minimum Requirements

In order to be eligible for disproportionate share payment, a hospital must:

1. Have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the Medicaid state plan. For hospitals outside of the Burlington-South Burlington Core Based Statistical Area (CBSA), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

   The above obstetric-related criteria do not apply to hospitals in which the inpatients are predominantly individuals under 18 years of age, or to hospitals which did not offer non-emergency obstetric services as of December 21, 1987.

2. Have a Medicaid inpatient utilization rate of at least one percent. The Medicaid inpatient utilization rate is defined as a hospital's total Medicaid inpatient days (including managed care days) divided by the total number of inpatient days.

(Continued)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES (CONTINUED)

VI. Eligible Hospitals (Continued)

B. Federally Deemed Hospitals

Additionally, the OVHA recognizes those hospitals deemed by federal law to be disproportionate share hospitals. The OVHA deems a hospital to be a disproportionate share hospital if:

1. The hospital has a Medicaid inpatient utilization rate that is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the state (herein named DSH Eligibility Group #1); or

2. The hospital has a low income utilization rate exceeding 25 percent (herein named DSH Eligibility Group #2).

C. State-Defined Criteria

Hospitals that meet the minimum requirements in VI.A. but do not meet the criteria for VI.B will still qualify for disproportionate share payments based on:

1. The hospital's status as an in-state post-graduate teaching facility (herein named DSH Eligibility Group #3); or

2. The hospital's proportion of statewide Medicaid inpatient days (herein named DSH Eligibility Group #4).

(Continued)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES (CONTINUED)

VII. Data Sources for Computation of Disproportionate Share Payments

A Base Year is established each year for collecting the data used to set disproportionate share payments in each State Plan Year (SPY). For payments in SPY 2015 (effective October 1, 2014), the Base Year used is the fiscal year ending September 30, 2012. The Base Year will advance one year for each subsequent SPY. Data sources, and the data that will be used from them, include the following:

A. From the State's Medicaid Management Information System (MMIS)
   1. Vermont Medicaid inpatient and outpatient hospital charges
   2. Vermont Medicaid inpatient days - Excluded from this figure are Title XXI days and days attributable to Medicaid patients between 21 and 65 years of age in Institutions for Mental Disease (IMD).
   3. Vermont Medicaid payments

B. Hospital Medicare Cost Reports
   1. Hospital cost-to-charge ratios
   2. Total hospital inpatient days and total Medicaid inpatient days
   3. Medicaid inpatient accommodation per diem costs

C. Hospital Attestation. Federal statute, specifically 42 CFR 447 and 455 requires that hospitals provider certain information for the DSH calculation. The Department of Vermont Health Access (DVHA) collects this federally required information in the form of an attestation from hospitals. Hospitals are required to complete this attestation each year to allow the DVHA the ability to collect data that is not available from any other sources. The DVHA will establish the due date for hospitals to complete this attestation each year and will provide hospitals at least 60 calendar days to complete the attestation. The due date will be on or before May 1. Hospitals who do not submit a completed attestation by the due date waives its right to be eligible for a DSH payment for that DSH plan year.

   1. Attestation of federal obstetrical requirement.
   2 Total state and local cash subsidies for inpatient and outpatient services
   3. Disproportionate share payments from other states and Section 1011 payments
   4. Inpatient days for Medicare/Medicaid dual eligibles, out of state Medicaid beneficiaries, and individuals with no third party coverage
   5. Inpatient and outpatient hospital charges for Medicare/Medicaid dual eligibles, out of state Medicaid beneficiaries, and individuals with no third party coverage
   6. Payments for claims from Medicare/Medicaid dual eligibles, out of state Medicaid beneficiaries, and individuals with no third party coverage

D. Green Mountain Care Board's Payer Revenue by Hospital (former Report 5)
   1. Net Medicaid and Net All Payer patient services revenue
   2. Gross Inpatient Charges

E. Audited hospital financial statements and hospital accounting records.
   1. Total revenue for hospital patient services, including inpatient and outpatient services and services by sub provider

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES (CONTINUED)

VIII. Disproportionate Share Payments (DSH)

Each year of the program, DVHA will determine the DSH Eligibility Group that each hospital is eligible for before calculating payments. If a hospital is eligible for more than one DSH Eligibility Group, for the purposes of computing the funding for each DSH group, the hospital will be placed in the DSH Eligibility Group that maximizes the hospital's DSH payment.

Within a DSH Eligibility Group, funds will be assigned to each hospital using the formulas described in VIII.A. Hospitals may only receive funds from one DSH Eligibility Group each year.

The Total DSH Funding for the DSH State Plan Year 2015 is $37,448,781. At the time that DSH payments are disbursed, DVHA will publish the funding for each DSH Eligibility Group and a schedule showing the DSH payment made to each eligible hospital.

A. Payment Formulas

Before the calculation of funding by DSH Eligibility Group occurs, the calculation of each Hospital Specific Limit is completed as described in VIII.B. Funding for each Group is then completed as follows:

1. Funding for DSH Group #3 is done first. The amount funded for Group #3 is the lesser of 50% of the of the Total DSH Funding for the DSH SPY or 76% of the combined Hospital Specific Limit for all hospitals in the Group.

2. Subtract the amount funded for DSH Group #3 from the Total DSH Funding for the DSH SPY to derive the remaining amount to be allocated between DSH Groups #1, #2 and #4.

3. Calculate for each hospital its percentage of Title XIX statewide days in the Base Year.

(Continued)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES (CONTINUED)

VIII. Disproportionate Share Payments (DSH) (Continued)

A. Payment Formulas (Continued)

a. The total statewide days value used in the calculation excludes the Title XIX days for any hospitals in DSH Group #3.

b. The total statewide days does not include days from any in-state hospitals that were paid for Title XIX days in the Base Year if they are not eligible for a DSH payment, or if they waived participation from the DSH program.

4. Sum the percentage of statewide days in the DSH Group.

5. Calculate the DSH Allotment by DSH Eligibility Group using the following formula:

*Total Remaining DSH Funding Available (computed in Step 2) **
Total Percentage of Statewide Days in the DSH Group (computed in Step 4)

6. The DSH payments to each hospital in DSH Groups #1, #2 and #4 are made using the following methodology:

a. For each DSH Group, compute an Aggregate Hospital Limit that is the sum of the individual Hospital Specific Limits within the DSH Group for hospitals that are eligible for a DSH payment, excluding any hospital that waived participation from the DSH program.

b. Determine each hospital's limit as a percentage of the Aggregate Hospital Limit.

c. Multiply the percentage computed in (b) by the DSH Group Allotment in VIII.A.5.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL SERVICES (CONTINUED)

VIII. Disproportionate Share Payments (Continued)

B. Payment Limitations

The Omnibus Budget Reconciliation Act of 1993 established rules limiting the total disproportionate share payment that a hospital can receive. Disproportionate share payments are limited to no more than the cost of providing hospital services to patients who are either eligible for medical assistance under a state plan or have no health insurance for the services provided, less payments received under Title XIX (other than DSH payment adjustments).

When all cost reports are available, the State will recalculate each hospital's specific payment limit starting with Medicaid State Plan Year (SPY) FY 2011 using audited Medicare Cost Reports. The State will then compare the hospital specific limit against DSH payments made for the SPY to determine if any hospital was paid in excess of its specific limit. The same procedure will occur in subsequent SPYs.

If the recalculated hospital specific limits show that the State made a payment to a hospital in excess of its hospital specific limit, the State will recoup any excess payment and redistribute the funds to other hospitals using the payment formula set forth in VIII.A using the applicable DSH State Plan for the year of the overpayment.

Furthermore, if the State's DSH auditor has findings demonstrating that DSH payments made for SPY 2011 or subsequent years exceed the documented hospital specific limits, the State will recoup and redistribute to other hospitals using the payment formula set forth in VIII.A that was in place for the applicable DSH state plan year under audit.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -INPATIENT HOSPITAL CARE

Citation
42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions (PPCs).

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (B) of this State plan.

_X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below:

In compliance with 42 CFR 447.26(c), the DVHA assures that:

1. No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.
2. Reductions in provider payment may be limited to the extent that the following apply:
    a. The identified PPC would otherwise result in an increase in payment.
    b. The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the PPC.
3. Non-payment for PPCs does not prevent access to services for Medicaid beneficiaries.

In order to determine the non-payment amount, for services paid under Section 4.19 (B) of this State plan, the DVHA will utilize modifiers that are self-reported by providers on claims that indicate if an OPPC occurred. When one of the OPPC modifiers is present on the claim, the DVHA will calculate a non-payment amount to ensure that the services rendered which the OPPC pertains to are not paid for by DVHA.

This provision applies to all providers contracted with the DVHA.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE

2. a. Outpatient Hospital Services

2. Effective with dates of service on or after May 1, 2008, the Department of Vermont Health Access (DVHA) will reimburse qualified providers for outpatient hospital services under a prospective fee schedule as set forth in this plan. The majority of services will be paid using the Medicare Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classification (APC) fee schedule as its basis. Covered services that are delivered in an outpatient setting that are not payable in Medicare's OPPS will be paid using a fee that has been set on DVHA's professional fee schedule. The majority of the services on DVHA's professional fee schedule are derived from Medicare's Resource Based Relative Value Scale (RBRVS) relative value units (RVUs). Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of January 1, 2014 and is effective for services provided on or after that date. All rates are published at http://dvha.vermont.gov/for-providers/claims-processing-1.

i. Participating Hospitals

All in-state and out-of-state hospitals will be included in this payment methodology, regardless of any designation provided by Medicare.

ii. Discussion of Pricing Methodology

A. APC Rates

The DVHA will follow the Medicare OPPS pricing methodology with respect to how each CPT/HCPCS will be treated in the Medicare OPPS, with the exception that the DVHA will not utilize Medicare OPPS composite pricing logic. The DVHA will use the status indicator that the Medicare OPPS assigns to each CPT/HCPCS to set pricing methodology. Additionally, the DVHA will follow Medicare's methodology with respect to packaging items into the payment with the primary service.

Effective with dates of service on or after January 1, 2014, the rate paid for each service payable in DVHA's OPPS will be set as follows:

- For in-state hospitals that have a Medicare classification of either sole community hospital (SCH) or critical access hospital (CAH): 105.30% of the Medicare 2014 OPPS national median rate without local adjustment.
- For in-state hospitals that do not have a Medicare classification of either SCH or CAH: 98.30% of the Medicare 2014 OPPS national median rate without local adjustment.
- For Dartmouth-Hitchcock Medical Center: 84.80% of the Medicare 2014 OPPS national median rate without local adjustment.
- For out-of-state hospitals other than Dartmouth-Hitchcock Medical Center: 79.20% of the Medicare 2014 OPPS national median rate without local adjustment.

The DVHA will not pay any transitional outpatient payments (TOPs) made by Medicare to SCHs or to rural hospitals with 100 or fewer beds that are not SCHs as defined by Section 1886(d)(5)(D)(iii) of the Social Security Act.

The DVHA will update the APC rates, the status indicators, the packaging methodology, and the outlier payment methodology annually based upon the Medicare OPPS Final Rule set each year.

B. Outlier Payments

The DVHA will follow the Medicare OPPS pricing methodology with respect to identifying claims eligible as high-cost outliers and for the outlier payment calculation for these claims.

(Continued)

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

2. a. 2. Outpatient Hospital Services (Continued)

iii. Special Payment Provisions

A. Clinical Diagnostic Laboratory Services

Clinical diagnostic laboratory services performed for outpatients and nonhospital patients are reimbursed at the lesser of the submitted charges or the Medicare maximum allowable rate for the date of service.

B. Outpatient Hospital Services Paid at Cost

If the participating hospital is an in-state hospital, the Cost to Charge Ratio is applied to determine the payment, which is derived from the hospital's most recent filed Medicare Cost Report. If the participating hospital is an out-of-state hospital, the Cost to Charge Ratio is applied to determine the payment, which is the average in-state hospital Cost to Charge Ratio. The Cost to Charge Ratio is the total hospital cost to charge ratio, which includes inpatient and outpatient. The Cost to Charge Ratio is applied only to detailed lines on a claim in which: (1) the service is a covered service by DVHA and (2) it is not a packaged service in Medicare's OPPS and (3) it does not have a rate on the Medicare OPPS, the Medicare Lab Fee Schedule, or DVHA's professional fee schedule.

C. Covered Outpatient Services Not Paid Under the Medicare OPPS Payment Methodology

In addition to clinical diagnostic laboratory services, other services that DVHA covers in an outpatient hospital setting do not have a set fee under the Medicare OPPS Fee Schedule. These include, but are not limited to, physical, occupational, and speech therapy; routine dialysis services; screening and diagnostic mammography services; vaccines; non-implantable prosthetic and orthotic devices; some rehabilitative therapies; and non-implantable durable medical equipment. The full list of covered outpatient services paid outside of DVHA's OPPS payment methodology can be found at http://dvha.vermont.gov/for-providers/claims-processing-1. These services will be paid either on a prospective fee schedule or using a Cost to Charge Ratio methodology not to exceed cost as defined by the Medicare Cost Report. For items paid by fee schedule, the fee applied will be defined by the DVHA but fees for specific services will not exceed the fee established by Medicare.

D. Observation Services

The DVHA will follow the Medicare OPPS payment methodology for observation services when it is accompanied by a primary procedure. Additionally, if a provider bills for observation in the absence of a primary procedure, the DVHA will pay for units of observation service (1 hr = 1 unit) at a rate of $35.00/hour up to a maximum of 24 units ($840.00).

(Continued)

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

2. a. 2. Outpatient Hospital Services (Continued)

iii. Special Payment Provisions (Continued)

E. Medicare Crossover Claims

Effective with dates of service on or after May 1, 2008, the OVHA will limit payment on outpatient Medicare crossover claims to the allowable deductible and coinsurance amount.

F. Hospital-based Physician Services

Hospital-based physician services will not be reimbursed if billed by the hospital on the UB-04 claim form. These services must be billed to the physician program in order to be reimbursed by the OVHA.

G. New Facilities

New facilities under the APC system will receive payments using the same payment methodology as stated in 2.ii.A and 2.ii.B. The Cost to Charge Ratio that will be used in the initial year for the purposes of calculating outlier payments will be the average in-state Cost to Charge Ratio. If the new provider is an in-state hospital, the Cost to Charge Ratio that will be used for calculating outlier payments after the first year will be the hospital's Cost to Charge Ratio calculated from its Medicare Cost Report. If the new provider is an out-of-state hospital, the Cost to Charge Ratio after the first year will continue to be the average in-state Cost to Charge Ratio.

(Continued)

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

2. a. 2. Outpatient Hospital Services (Continued)

iii. Special Payment Provisions (Continued)

H. New Medicaid Providers

New Medicaid providers will receive payments using the same payment methodology as stated in 2.ii.A and 2.ii.B. The Cost to Charge Ratio that will be used in the initial year for the purposes of calculating outlier payments will be the average in-state Cost to Charge Ratio. If the new provider is an in-state hospital, the Cost to Charge Ratio that will be used for calculating outlier payments after the first year will be the hospital's Cost to Charge Ratio calculated from its Medicare Cost Report. If the new provider is an out-of-state hospital, the Cost to Charge Ratio after the first year will continue to be the average in-state Cost to Charge Ratio.

I. Other Rate Adjustments

There may be some situations where a fee has not been established by the Medicare OPPS or by the OVHA for a covered outpatient service. Payment for these services will be allowed charges multiplied by the Cost to Charge Ratio assigned to the hospital as defined in 2.iii.c.

iv. Ongoing Maintenance

As a part of ongoing maintenance of the payment system, the OVHA may change the following on a periodic basis either separately or in combination:

A. The Medicare Cost Report values used to establish outlier payment status

B. The inflation factor used to best represent current costs

C. The Medicare OPPS APC fee schedule

D. The Fixed Outlier Value

E. The Outlier Percentage

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

2. b. Rural Health Clinic Services/Federally Qualified Health Centers

☒ The payment methodology for FQHCs/RHCs will conform to section 702 of the BIPA 2000 legislation.

☒ The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements Prospective Payment System (PPS).

☒ The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:

1. Is agreed to by the State and the center or clinic; and
2. Results in payment to the center or clinic of an amount which is at least equal to the PPS payment rate.

Effective in the center's fiscal year beginning January 1, 2002, or later, payment to RHC's and FQHC's will be made at the greater of the federal PPS payment level with any adjustment for changes in scope, or allowable costs up to the Medicaid upper limit. For RHC's subject to the Medicare upper limit, the interim payment shall be calculated at 110% of the Medicare amount for services provided on or after November 1, 2013. For services provided by FQHC's on or after November 1, 2013, the interim payment shall be calculated at 130% of the Medicare upper limit for that year. For RHC's not subject to Medicare upper limit, the Medicaid upper limit shall be 125% of the non-urban FQHC Medicare upper limit from each calendar year. Effective on and after October 1, 2014, for RHC's not subject to the Medicare upper limit, the Medicaid upper limit shall be 130% of the non-urban FQHC Medicare upper limit for that year. The Commissioner may waive the application of the upper limit, in part or in whole, for good cause shown.

Thirty days prior to a fiscal year the DVHA shall set the interim payment for the next year at the greater of the PPS rate or the rate derived from the most recent adjudicated cost report up to the Medicaid upper limit. If the entity submits a timely cost report, the DVHA will settle on the basis of reasonable costs up to the limit. If the entity does not file a timely cost report and the interim payment was based on the costs, the DVHA will settle the interim payments at the PPS levels.

If a facility elects to be paid by the PPS system, it need not file a Medicaid cost report for that year. If a center elects to be paid by the cost-based system, it must include a declaration of agreement to use the cost-based alternative with its cost report.

3. Other Laboratory and X-Ray Services

Payment is limited to laboratories and laboratory services certified by Medicare.
Reimbursement is made at the lower of the provider's charge or the Medicaid rate on file.
The Agency's rates were set as of July 1, 2009 and are effective for services on for after that date. All rates are published on http://dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

4. a. Nursing Facility Services

The Division of Rate Setting of the Agency of Human Services, pursuant to 33 VSA §193, certifies to the Commissioner of Social Welfare prospective per diem rates to be utilized in reimbursing for care in each participating nursing facility.

Payment for authorized care furnished to a Vermont Medicaid recipient by a certified out-of-state nursing facility will be made at the per diem rate established by the state's single state agency for Medicaid. No retroactive adjustments are made in payments to an out-of-state facility.

A prospective per diem rate for the purpose of reimbursing for nursing facility care furnished in Vermont general hospitals will be established by the Division of Rate Setting at the beginning of each fiscal year.

See ATTACHMENT 4.19-C for additional methods and standards governing payment during temporary absences from the facility.

Payment for Rehabilitation Center services provided in nursing facilities located outside Vermont for the severely disabled such as head injured or ventilator dependent people will be made at the lowest of:

1) the amount charged; or
2) a negotiated rate: or
3) the Medicaid rate as paid by at least one other state Medicaid agency in the Boston region.

Payment for rehabilitation center services which have not been authorized by the Medicaid Director or a designee will be made at the nursing facility (non rehabilitation center) rate established by Medicaid in the state in which the center is located.

b. Early and Periodic Screening, Diagnosis and Treatment

All providers are reimbursed in accordance with the methods and standards described within this state plan for each specific service.

Personal care services, home visiting, and health education are paid at the lower of the actual charge or the Medicaid rate on file.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

4. c. Family Planning Services

Family planning services are reimbursed in accordance with the methods and standards described within this State Plan for each specific service. The agency's rates were set as of 07/01/09 and are effective for services on or after that date. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

5. Physician's Services

Payment for a service rendered by a physician (M.D or D.O.) is made at the lower of the actual charge for the service or the Medicaid rate on file. Most rates were set using the Medicare Resource Based Relative Value Scale payment methodology. This methodology was updated for dates of service effective on or after January 1, 2014. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

a. Supplemental Payments for Qualified Teaching Professionals

a. Notwithstanding other provisions of this Attachment 4.19-B, effective 7/1/2011, supplemental payment will be paid according to this subsection for professional services performed by Qualified Teaching Physicians (QTPs). The purpose of the supplemental payment is to ensure access to essential professional services for Medicaid beneficiaries through the care provided by teaching physicians on the faculty of the University of Vermont (UVM) College of Medicine.

   QTPs include those physicians who are:
   1. Licensed by the State of Vermont, where applicable;
   2. Enrolled as a State of Vermont Medicaid provider; and
   3. Hold salaried appointments on the faculty of the UVM College of Medicine and are employed by UVM Medical Group.

b. A supplemental payment will be made for services provided by QTPs in an amount equal to the difference between the Medicaid payments otherwise made for the services and payments at the Average Commercial Rate. Only the professional component of a procedure is eligible for a supplemental payment. Payment will be made quarterly and will not be made prior to the delivery of services.

(Continued)

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

c. The Average Commercial Rate to be paid to QTPs is determined as follows:

1. Compute the Average Commercial Fee Schedule: For the most recently completed calendar year, compute the average commercial payment rate per procedure code, including patient share amounts, paid by the top five commercial third party payers as determined by total billed charges reported for all QTPs. The average rate for each procedure code will be a straight average among all QTPs for which a rate is available.

2. Calculate the Average Commercial Payment Ceiling: For the most recently completed calendar year, multiply the Average Commercial Fee Schedule rate for each procedure code as determined above by the number of times each procedure code was paid to QTPs on behalf of Medicaid beneficiaries as reported from the Medicaid Management Information System (MMIS). The sum of the product for all procedure codes subject to enhanced payment represents the Average Commercial Payment Ceiling.

3. Calculate the Medicaid Payment Amount. Using the same data as in 11A.(c)(2), multiply the units for each procedure code by the most recent Medicaid rate on file for the procedure code.

d. The Medicaid Supplemental Payment to QTPs is equal to 95% of the difference between the Average Commercial Payment Ceiling for the year and the total Medicaid Payment Amount for the year.

e. The calculated supplemental payment amount is equal to 95% of the ACR as calculated and made available by the State for the calendar year.

6. a. Podiatrist's Services
Payment is made at the lower of the actual charge or the Medicaid rate on file. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

b. Optometrist's Services
Payment is made at the lower of the actual charge or the Medicaid rate on file. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

c. Chiropractors
Payment is made at the lower of the actual charge or the Medicaid rate on file. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE
(Continued)

6. d. Other Practitioners Services

1. Behavioral Health Services

Payment is made at the lower of the actual charge or the Medicaid rate on file. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment.4.19-B. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

2. Opticians' Services

Payment is made at the lower of the actual charge or the Medicaid rate on file. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

3. High-Tech Nursing Services

Payment is made at the lower of the actual charge or the Medicaid rate on file. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B . All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

4. Licensed Lay Midwife Services

Payment is made at the lower of the actual charge or the Medicaid rate on file. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B . All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

5. Naturopathic Physician Services

Payment is made at the lower of actual charge for the service or the Medicaid rate on file. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

7. Home Health Services

Payment is made at the lower of the actual charge of the Medicaid rate. The agency's rates were set as of 07/01/09 and are effective for services on or after that date. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

8. Private Duty Nursing

Payment is made at the lower of the actual charge of the Medicaid rate. The agency's rates were set as of 07/01/09 and are effective for services on or after that date. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

9. Clinic Services
   a. Payment for clinic services other than a mental health clinic, comprehensive service clinics and Free Standing Dialysis Centers is made at the lower of the actual charge or the Medicaid rate. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.
   b. Payment for mental health clinic services is made at the lower of the actual charge or the Medicaid rate. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.
   c. Payment for comprehensive service clinics is made at the lower of the actual charge or the Medicaid rate. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.
   d. Free Standing Dialysis Centers Payment is made at the lower of the actual charge or the Medicaid rate. The agency's rates were set as of 10/12/08 and are effective for services on or after that date. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

10. Dental Services
    Payment is made at the lower of the actual charge or the Medicaid rate. The agency's rates were set as of 1/1/14 and are effective for services on or after that date. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

11. Physical Therapy and Related Services
    Payment is made at the lower of the actual charge or the Medicaid rate. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

12 a. Prescribed Drugs

(1) "Multiple Source" drugs are paid, as of 7/15/09, at the lowest of:
- (a) AWP-14.2% + dispensing fee;
- (b) CMS Federal Upper Limit (FUL) + dispensing fee;
- (c) State Maximum Allowable Cost (MAC) + dispensing fee; or
- (d) the Usual and Customary (U&C) (includes dispensing fee).

(2) "Single-source" drugs are paid, as of 07/15/09, at the lower of:
- (a) AWP-14.2% + dispensing fee; or
- (b) Usual and Customary (U&C) (includes dispensing fee).

(3) "Physician Certified as Brand Necessary" are paid, as of 07/15/09, at the lower of:
- (a) AWP-14.2% + dispensing fee; or
- (b) the Usual and Customary (U&C) (includes dispensing fee).

(4) All compounded prescriptions must contain more than one ingredient, and:
- (a) As of 07/15/09, ingredients will be priced at the lesser of AWP – 14.2%, the MAC, or the FUL (plus a dispensing fee).
- (b) The ingredients' costs will be totaled and priced at the lesser of the calculated cost in (a) or the claim's U&C cost.

(5) Drugs dispensed by limited distribution pharmacies are paid, at the lower of
- (a) "Multiple Source" drugs are paid, at the lowest of:
  - AWP-16.5% + dispensing fee;
  - CMS Federal Upper Limit (FUL) + dispensing fee;
  - State Maximum Allowable Cost (MAC) + dispensing fee; or
  - the Usual and Customary (U&C) (includes dispensing fee).
- (b) "Single-source" drugs are paid, at the lower of:
  - AWP-16.5% + dispensing fee; or
  - Usual and Customary (U&C) (includes dispensing fee)

Effective July 1, 2009, the dispensing fee for all fills and refills will be:

a. $ 4.75 for Vermont pharmacies,
b. $19.75 for compounded prescriptions at Vermont pharmacies,
c. $2.50 for out-of-state pharmacies, and
d. $17.50 for compounded prescriptions at out-of-state pharmacies.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

'MAC' is a commonly utilized acronym in prescription drug management, translating to 'maximum allowable cost'. MAC represents the highest price a pharmacy will be reimbursed for the dispensing of a specific dose and formulation of a generic medication when that medication is available from multiple manufacturers. The goal of MAC pricing is to establish a fair and equitable level of reimbursement for all pharmacies, while simultaneously assuring that our clients are paying the lowest possible cost for such drug products. For a MAC price to be established on any given product, there needs to be a minimum of three suppliers. This generally consists of the originator brand and at least two generic sources. MAC pricing is established through an in-depth review of the prices paid by a typical pharmacy for the generic sources of the product. From there, a MAC price is established using a formula that ensures an adequate balance of low cost to our clients, yet a reasonable profit for the dispensing pharmacy.

Our MAC list is fully updated on a quarterly basis, with mid-quarter changes routinely taking place when significant pricing changes arise or when new generics enter the market from multiple generic manufacturers. We also commit to a more expeditious and aggressive updating of our MAC list when the generic exclusivity period expires on key products. This helps to avoid any substantial lost savings opportunity that may result from delays in MAC list updating.

Limited Distribution Pharmacies dispense medications that may have special requirements for dosing or close lab monitoring. Because of these special requirements, drug manufacturers sometimes choose to limit the distribution of their drugs to only one or a few select pharmacies or, as part of the drug approval process, the Food and Drug Administration (FDA) may recommend this type of distribution. This type of restricted distribution allows the manufacturer to properly control the inventory of the drug; educating dispensing pharmacists about appropriate patient education and monitoring required; and ensure that any risks associated with the medication are minimized.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

12. b. Dentures
Reimbursement is made at the lower of the actual charge or the Medicaid rate on file.

c. Prosthetic Devises
Reimbursement is made at the lower of the actual charge or the Medicaid rate on file.

d. Eyeglasses
Payment is made at the negotiated contract price for lenses and frames. With prior approval, payment may be made to local dispensers at actual costs of lenses and frames.

13. Other Diagnostic, Screening, Preventive and Rehabilitative Services

Reimbursement is made at the lower of the actual charge or the Medicaid rate on file or as specified below:

Substance Abuse Services: payment is made at the lower of the usual and customary rate charged to the general public or the Medicaid rate on file. Assurance is made that no reimbursement is made for residential (room and board) charges.

Community Mental Health Center Services: payment is made at the lower of the usual and customary rate charged to the general public or the Medicaid rate on file.

Private Non Medical Institutions (PNMI) for Child Care Services: payment is made via capitation rates as described in the PNMI section of the Medicaid Division Practices and Procedures Manual. Assurance is made that no reimbursement is made for residential (room and board) charges.

School Health Services: services provided for the development of an initial IEP/IFSP will not be reimbursed. Reimbursement for services ordered by an IFSP are paid fee-for-service. Services ordered by an IEP are reimbursed via a case rate system, with the exception of the following services that will be paid fee-for-service; assessment and evaluation, medical consultation, durable medical equipment, vision care services and nutrition services.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

13. Other Diagnostic, Screening, Preventive and Rehabilitative Services (Continued)

Intensive Family Based Services: Payment is made at per diem rates, paid weekly, which are based on the average costs of services delivered within the program.

Developmental Therapy: Payment is made at the lower of the actual charge or the Medicaid reimbursement rate on file.

Day Health Rehabilitation Services: Payment is made per hourly rates rounded to the nearest quarter hour, paid weekly.

Assistive Community Care Services: Payment is made at a uniform per diem rate, paid monthly. No reimbursement will be made for room and board.

Therapeutic Substance Abuse Treatment Services (TSATS): Payment is made at a uniform per diem rate paid monthly. No reimbursement will be made for room, board, transportation to non-medical appointments, vocational activities, and services and therapies not eligible for traditional Medicaid reimbursement.

14. Services for Individuals 65 or Older in Institutions for Mental Disease

a. See Inpatient Psychiatric Hospital Services – 4.19-A

b. Skilled nursing facility services – not covered.

c. Intermediate care facility services – see 4.19-C and 4.19-D.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

15. a. Intermediate Care Facility Services (Nursing Facilities)
See Attachments 4.1 9-C and 4.1 9-D.

b. Intermediate Care Facilities for the Mentally Retarded
See Attachment 4.1 9-D.

16. Inpatient Psychiatric Facility Services for Individuals Under Age 22
See Attachment 4.19-A.

17. Nurse-Midwife Services
Covered nurse-midwife services are reimbursed at the lower of the actual charge or the Medicaid rate on file for a physician providing the same service. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B. All rates are published at www.dvha.vermont.gov/for-providers.

18. Hospice Care
Payment for hospice services is at a per diem rate, based on Medicare rates which are adjusted for Medicaid and published annually and established in accordance with Medicare regulations at 42 CFR 418, subpart G. Fee schedule will be updated concurrently with Medicare updates. Hospice payments for inpatient care are limited and paid in accordance with 42 CFR 418.302(g). Acquired Immunodeficiency Syndrome cases are included in the limitation calculation. The State does not apply the optional cap limitation on payments. The agency's rates were set as of 10/01/10 and are effective for services on or after that date. All rates are published at http://dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

19. Case Management Services

Payment for Targeted Case Management Services provided to a child pursuant to an IFSP is made at a rate established on the basis of periodic time studies furnished by the service provider.*

Payment for Targeted Case Management Services provided to a child pursuant to an IEP is included in payment made under the case rate system.*

Payment for Targeted Case Management services provided by the Department of Social and Rehabilitation Services is developed from direct staff salaries, benefits and operating expenses (including indirect costs) which will be rebased periodically.

Payment for Targeted Case Management services furnished as part of the Healthy Babies Program is made at the lesser of the provider's charge or the Medicaid rate on file.

Payment for Targeted Case Management services provided to At-Risk Children Ages 1 to 5 years is made at the lesser of the provider's charge or the Medicaid Rate on file.

*Per approved state plan amendment 98-6 (School Health Services) effective 2/22/98.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

Payment rates for Targeted Case Management services for persons with developmental disabilities who are unable to access needed medical, social, educational and other services because of adaptive deficits due to their level of disability, provided by the Department of Disabilities, Aging, and Independent Living, are developed from direct staff salaries, benefits and operating expenses (including indirect costs) which will be rebased periodically. The State established payment rates based on an analysis of the provider cost structure and has periodically updated the rates to assure access to high quality care while maintaining economy and efficiency. Rates are established at levels necessary to assure access to the service for the target population. Rates are based on a unit of service equal to 15 minutes.

Payment rates for Targeted Case Management services for individuals who lack assistance of a family member or other interested person to assist them in accessing needed services are based on program costs. The State allocates costs to the program in accordance with its approved allocation plan. Costs include salaries, fringe benefits and indirect costs. Payment rates are based on the skill level of the provider. Separate rates have been established for each of two skill levels. Separate rates enable the agency to recognize differences in salary costs. The rate is based on a unit of service equal to one week.

Reimbursement is made at the lesser of the provider's charge or the Medicaid rate on file.

The rates were set as of June 28, 2008 and are effective for services on or after that date. All rates are published at http://dvha.vermont.gov/for-providers.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

Payment for Target Case Management services provided to pregnant and postpartum women and infants through twelve months of age enrolled in the Vermont Department of Children and Families, Healthy Babies, Kids, and Families Program is based on a market-based rate.

The agency established payment rates based on an analysis of the provider cost structure and has periodically been updated to assure access to high quality care while maintaining economy and efficiency. Rates are established at levels necessary to assure access to the service for the target population.

Payment rates are based on the skill level of the provider. Separate rates have been established for each of three skill levels: Registered Nurse, Master's Degree and Bachelor's Degree. Separate rates enable the agency to recognize differences in salary costs.

The established rates are paid based on a unit of service defined as a visit. While the duration of visits can vary depending on the needs of the individual, a visit typically represents one hour of service.

Reimbursement is made at the lesser of the provider's charge or the Medicaid rate on file. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

The agency's rates were set as of June 28, 2008 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers .

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

Payment for Targeted Case Management services provided to children, ages one to five years, who have been identified by a health professional or community program who are at risk of inappropriate health care service utilization, medical complications, neglect, and or abuse and who do not have another case management provider whose responsibility is to provide or coordinate the interventions included in this service is made at the lesser of the provider's charge or the Medicaid rate on file.

The agency established payment rates based on an analysis of the provider cost structure and has periodically been updated to assure access to high quality care while maintaining economy and efficiency. Rates are established at levels necessary to assure access to the service for the target population.

The established rates are paid based on a unit of service defined as a visit. While the duration of visits can vary depending on the needs of the individual, a visit typically represents one hour of service.

Reimbursement is made at the lesser of the provider's charge or the Medicaid rate on file. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

The agency's rates were set as of June 28, 2008 and are effective for services on or after that date. All rates are published at www.ovha.vermont.gov/for-providers .

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

20. Extended Services to Pregnant Women
Payment is made at the lower of the usual and customary charge to the general public or the Medicaid rate on file for the particular service. The agency's rates were set as of 10/01/10 and are effective for services on or after that date. All rates are published at http://dvha.vermont.gov/for-providers/claims-processing-1. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

21. Ambulatory Prenatal Care For Pregnant Women During a Presumptive Eligibi1ity Period
Not provided.

22. Respiratory Care
Payment is made at the lower of the actual charge or the Medicaid rate on file. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. This methodology was updated for dates of service effective on or after the date specified in the RBRVS section (26) of this attachment.. All rates are published at http://dvha.vermont.gov/for-providers/claims-processing-1. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

23. Certified Pediatric and Family Nurse Practitioners
Payment is made at the lower of the actual charge or the Medicaid rate on file for a physician providing the same service. For services payable in Medicare's Resource Based Relative Values Scale payment methodology, the DVHA is utilizing the Medicare RBRVS RVUs, the Medicare GPCIs and State determined conversion factors as specified in Section 26. The RBRVS methodology was updated for dates of service effective as specified in Section 26 of Attachment 4.19-B . All rates are published at http://dvha.vermont.gov/for-providers/claims-processing-1. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

24. Any Other Medical Care And Any Other Type Of Remedial Care Recognized Under State Law, Specified By The Secretary

a. Transportation

Ambulance: Payment for ambulance services is made at the lower of the actual charge or the Medicaid rate on file. The agency's rates were set as of 07/01/08 and are effective for services on or after that date. All rates are published at http://dvha.vermont.gov/for-providers/claims-processing-1. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private providers.

Non-Emergency: Payment for transportation other than that covered in the Ambulance paragraph above is made at negotiated rates under the terms of a provider agreement. The agency's rates were set as of 01/11/11 and are effective for services on or after that date. All rates are published at http://dvha.vermont.gov/for-providers/claims-processing-1. Except as otherwise noted in the Plan, State-developed fee schedule rates are the same for both governmental and private providers.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

24. Any Other Medical Care And Any Other Type Of Remedial Care Recognized Under State Law, Specified By The Secretary (Continued)

b. Christian Science Nurses:
Not available in Vermont.

c. Christian Science Sanatoria:
Not available in Vermont.

d. Skilled Nursing Facility for Persons Under 21
Payment for skilled nursing facility services for persons under age 21 is made as outlined in Attachment 4.19-B, item 4.a.

e. Emergency Hospital Services (In Hospitals Not Participating in Title XVIII)
The Department will apply the same standards, cost reporting period, cost reimbursement principles and methods of cost apportionment as currently used in computing reimbursement for emergency hospital services in non-participating hospitals under Title XVIII of the Social Security Act.

f. Personal Services:
Payment is made at the lower of the actual charge or the Medicaid rate on file.

g. Services to Aliens:
The method and standard employed is that each type of service as contained in Section 4.19-B of the Vermont State Plan.

25. Telemedicine

Telemedicine is defined as the practice of health care delivery by a provider who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, consultation, or treatment that requires the use of advanced telecommunications technology. Telephone conversations, chart reviews, electronic mail messages, and facsimile transmissions are not considered telemedicine.

The distant site provider uses telemedicine to provide a service to the patient at the patient site.

The applicable provider types are as follows:

1. Community Mental Health Clinics
2. Designated Agencies
3. Federally Qualified Health Centers
4. Rural Health Clinics
5. Physicians
6. Naturopathic Physicians

Qualifying distant site providers are reimbursed in accordance with the standard Medicaid reimbursement methodology.

Qualifying patient sites are reimbursed a facility fee. The fee is set at 80% of the current Medicare rate and is effective for services on or after 7/01/10; all rates are published at http://dvha.vermont.gov/for-providers. Payment is made at the lower of the actual charge or the Medicaid rate on file. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

26. Resource Based Relative Value Scale (RBRVS)

Effective for dates of service on or after January 1, 2014, the DVHA will reimburse qualified providers who deliver services that are covered by the DVHA and have a Relative Value Unit (RVU) listed on Medicare's RBRVS schedule by using the RVU listed on Medicare's RBRVS schedule in developing the DVHA's rate. There may be situations where the DVHA covers a service that is not payable in Medicare's RBRVS but a RVU is available. The DVHA will utilize the available RVU in this instance. There may be other situations where the DVHA covers a service that is not payable in Medicare's RBRVS and a RVU is not available. The DVHA will utilize the rate on file for this service as defined in Sections 5 through 25 above.

The components used to develop rates in the DVHA RBRVS payment methodology include the RVUs published by Medicare, the Geographic Practice Cost Indices (GPCIs) published by Medicare, and Conversion Factors which are specific to the DVHA fee schedule.

(Continued)

Effective for dates of service on or after January 1, 2014, the RVUs used are the Medicare RBRVS values published by the Centers for Medicare and Medicaid on its website in the file RVU13A.zip. The DVHA will utilize the Non-Facility values for services provided in the physician office and facility RVUs to providers when place of service is an inpatient hospital, outpatient hospital, emergency room, ambulatory surgical center, inpatient psychiatric facility, nursing facility or skilled nursing center. The DVHA will follow Medicare's payment logic of using the lesser of the RBRVS or OPPS RVU values for those select procedures subject to the policy.

The GPCIs used are 1.000 for Work, 1.006 for Practice Expense and 0.618 for Malpractice Insurance.

The DVHA will use one conversion factor for DVHA covered services payable in the RBRVS methodology except in cases described in Attachment 4.19-B pages 21-23. For providers who deliver evaluation and management and immunization services who do not meet criteria set forth by the Centers for Medicare and Medicaid, the DVHA will pay for these services using a conversion factor of $28.71 multiplied by the RVU value on file with DVHA as referenced in the first paragraph on this page. For all other covered services payable in the RBRVS methodology, a conversion factor of $28.71 is used.

Depending upon the provider billing the service, DVHA modifier pricing logic may also apply.

27. Anesthesia

Payment is made at the lower of the actual charge or the Medicaid rate on file. Effective for dates of service on or after January 1, 2012, the DVHA will reimburse qualified providers who administer anesthesia services covered by the DVHA using the Medicare payment formula of (time units of service + base unit) multiplied by a conversion factor. The units of service billed are based on Medicare billing requirements. The base unit values used by DVHA are those put in place by Medicare effective January 1, 2012. The DVHA will follow Medicare's changes to the base unit values by updating the base units each January.

1. The DVHA will not use Medicare's conversion factor for Vermont, but rather a conversion factor of $18.15.

All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

METHODS AND STANDARDS OF ESTABLISHING PAYMENT RATES - OTHER MEDICAL CARE (Continued)

27. Tobacco Cessation Counseling for Pregnant Women

Tobacco Cessation Counseling for Pregnant Women is defined as diagnostic, therapy, counseling services, and pharmacotherapy for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use; by or under supervision of a physician; or by any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services.

Qualifying providers are reimbursed in accordance with the standard Medicaid reimbursement methodology.

Payment is made at the lower of the actual charge or the Medicaid rate. The agency's rates were set as of 02/10/12 and are effective for services on or after that date. All rates are published at www.dvha.vermont.gov/for-providers. Except as otherwise noted in the plan, State developed fee schedule rates are the same for both governmental and private.

ADEQUACY OF ACCESS - OBSTETRICAL AND PEDIATRIC STANDARDS

Standard: c. Other

The Department of Social Welfare through the twelve district offices around the State of Vermont operates an action referral program to assure that Medicaid recipients have access to all covered health care, including obstetrical and pediatric care.

This program provides immediate and direct responses to recipients reporting difficulty in securing access to a Medicaid-covered service. Recipients may also call the toll free "hotline" maintained at the DSW State Office in Waterbury.

Under the direct supervision at the State Medicaid Director, a Medicaid staff member is designated to handle access problems which have not been resolved at the local or district office level.

The State practice outlined above and the almost negligible record of non-participation among pediatric and obstetrical providers assures the State of Vermont that the Medicaid fee-for-service rates are adequate to assure access.

There are currently approximately 215 family practitioners, 101 obstetricians, 112 pediatricians, and 16 certified nurse midwives enrolled in Vermont Medicaid, representing nearly 100 percent participation.

HMO Obstetrical and Pediatric Services

There are two Medicaid enrolled HMO's currently operating in Vermont, Community Health Plan (CHP) and Blue Cross Blue Shield. CHP began serving Title XIX recipients on 10/1/96 and BC/BS began serving recipients on 1/1/97.

Counseling regarding enrolled providers and services is available to all recipients required to enroll in managed care. As of 3/21/97, 6865 traditional Medicaid recipients are enrolled in managed care plans.

INCREASED PRIMARY CARE SERVICE PAYMENT 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☒ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: There is a single GPCI for VT so no calculation is necessary.

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405, 447.410, and 447.415.

Supplemental payment is made: ☐ monthly ☐ quarterly ☐semi-annually ☐annually

Primary Care Services Affected by this Payment Methodology

☒ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes). 99288, 99297, 99351 – 99353, 99358 - 99360, 99363, 99364, 99366 - 99368, 99374 – 99380, 99411, 99412, 99429, 99441 – 99444, 99455, 99456, 99499

INCREASED PRIMARY CARE SERVICE PAYMENT (Continued)

(Primary Care Services Affected by this Payment Methodology – continued)

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added). 99406 (10/01/10), 99407 (10/01/10), 99408 (01/01/12), 99409 (01/01/12)

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☒ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: $6.87.

☐ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: _____.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:_____.

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

INCREASED PRIMARY CARE SERVICE PAYMENT (Continued)

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at http://dvha.vermont.gov/.

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at http://dvha.vermont.gov/.

Fee Schedule Development
The fee schedule was developed by the State and uses the January 2013 release in conjunction with the 2009 conversion factor to set the rates. The State will not adjust the fee schedule to account for Medicare rate changes throughout the year. Rather, the State will make an annual adjustment effective with services beginning January 1 of each year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Vermont_____

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item __ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item __ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item __ of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Vermont

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare part A and Part B Deductible/Coinsurance

QMBs:	Part A	MR Deductibles	MR Coinsurance
	Part B	MR Deductibles	MR Coinsurance
Other Medicaid Recipients	Part A	MR Deductibles	MR Coinsurance
	Part B	MR Deductibles	MR Coinsurance
Dual Eligible (QMB Plus)	Part A	MR Deductibles	MR Coinsurance
	Part B	MR Deductibles	MR Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Vermont

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare part A and Part B Deductible/Coinsurance

N/A

OTHER METHODS AND STANDARDS OF PAYMENT DURING TEMPORARY ABSENCES

1. FROM AN INPATIENT NURSING FACILITY

Payment to a nursing home on behalf of an eligible Medicaid recipient is continued during an absence for the purpose of a "home visit" for up to 24 home visit days in a calendar year. Such absences must be included in the patient's plan of care. No payment will be made for home visit days beyond 24 in a calendar year.

Each home visit day is counted as a patient day for cost reporting purposes.

Payment to a nursing home on behalf of an eligible Medicaid recipient is continued during an absence for the purpose of an inpatient stay in a hospital for up to six successive days for each hospital admission provided that the nursing home would otherwise be at its maximum licensed occupancy if the bed were not obligated to be held open. Each day is counted as a patient day for cost reporting purposes.

OTHER METHODS AND STANDARDS OF PAYMENT DURING TEMPORARY ABSENCES (Continued)

2. FROM AN INPATIENT INTERMEDIATE CARE FACILITY/MENTALLY RETARDED

Requirements for payment to an Intermediate Care Facility/Mentally Retarded leave of absence include:

a. Any day for which the facility is paid to hold a bed open must be counted as a patient day and the revenue must be accounted for as a patient revenue.

b. The day of departure shall be counted as one day of leave and the day of return shall be counted as one day of inpatient care.

c. The facility shall hold the bed vacant during leave.

d. The beneficiary's return from leave shall not be followed by discharge within 24 hours.

e. Form DSW 289A, Leave Of Absence Report, shall identify the inclusive dates of leave.

f. Leave shall be terminated on the day of death.

Payments to an Intermediate Care Facility/Mentally Retarded on behalf of an eligible recipient is continued for an absence of up to fifteen (15) days per quarter or sixty (60) days per year for the purpose of "home visit" providing it is consistent with and part of the resident's current habilitation plan. Approval for an absence for the purpose of a "home visit" in excess of fifteen (15) days per quarter or sixty (60) days per annum shall be obtained in advance from the Commissioner of Mental Health.

The Department of Mental Health shall withhold such approval if:

a. The resident's habilitation plan does not specifically provide for the amount of absence requested.

b. The extent of absence suggests that continued Intermediate Care Facility/Mentally Retarded is inappropriate.

c. The resident's habilitation plan is not current or has not been reviewed in accordance with Federal regulations.

There will be no Medicaid payments made for leave of absences in mental hospitals or psychiatric facilities.

STATE OF VERMONT

AGENCY OF HUMAN SERVICES

DIVISION OF RATE SETTING

METHODS, STANDARDS AND PRINCIPLES FOR ESTABLISHING MEDICAID PAYMENT RATES FOR LONG-TERM CARE FACILITIES

July 1, 2013

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I. INTRODUCTION

(a) The purpose of this plan is to implement state and federal reimbursement policy with respect to all nursing facilities providing services to Medicaid residents, Long-term care services in swing-bed hospitals, and Intermediate Care Facilities for the Mentally Retarded.

(b) The methods, standards, and principles of rate setting established herein reflect the objectives for nursing facility reimbursement set out in 33 V.S.A. §901 and balance the competing policy objectives of access, quality, cost containment and administrative feasibility. Rates set under this payment system are consistent with efficiency, economy, and quality of care necessary to provide services in conformity with state and federal laws, regulations, quality and safety standards.

(c) This plan complies with the requirements of 33 V.S.A. Chapter 9, §1902 (a) (13) (A) of the SSA.

(d) The State has in place a public process which complies with the requirements of Section 1902 (a) (13) (A) of the Social Security Act. The Division shall make rules and issue practices and procedures pursuant to the Vermont Administrative Procedures Act, 3 V.S.A. §836 *et seq.* to carry out the provisions of this plan.

(e) The Division shall, according to this Plan, establish and certify to the Department of Vermont Health Access for payment per diem rates for providers of long term care services on behalf of residents eligible for assistance under Title XIX of the SSA.

II. ACCOUNTING REQUIREMENTS AND FINANCIAL REPORTING

(a) All financial and statistical reports shall be prepared on an accrual basis in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied. The Division may prescribe rules and practices and procedures relating to variations in accounting principles, cost allocation, record keeping and retention, and related matters. (See Addendum A §2.)

(b) Each nursing facility and Intermediate Care Facility for the Mentally Retarded in Vermont shall annually submit a uniform cost report on forms prescribed by the

Division, according to rules and practices and procedures adopted by the Division. (See Addendum A §3.2)

(c) The Division will review the cost reports, will perform periodic audits, and will settle the cost reports, as required by its rules, practices and procedures, and 42 C.F.R. §447.253 (e). (See Addendum A §§3.4-3.5.)

III. DETERMINATION OF ALLOWABLE COSTS FOR NURSING FACILITIES

(a) In determining the allowability or reasonableness of costs or the treatment of any reimbursement issue, not addressed in this plan, the Division shall apply its own rules and appropriate provisions of the Medicare Provider Reimbursement Manual (HCFA Publication 15). (See Addendum A §4.1.)

(b) The Division will adopt rules for the transfer of ownership of depreciable assets. In no case shall the change in basis, as applied in the aggregate to facilities which have undergone a change of ownership, be greater than the lesser of the (1) the fair market value of the assets, (2) the acquisition cost of the asset to the buyer, (3) the amount determined by the revaluation of the asset. An asset is revalued by increasing the basis of the asset to the seller by an annual percentage rate, limited to the lower of: one-half the percentage increase in the Consumer Price Index (CPI) for All Urban Consumers (United States City Average) or one-half the percentage change in an appropriate construction cost index as determined by the Division of Rate Setting, which change shall not be greater than one-half of the percentage increase in the Dodge Construction index (or reasonable proxy thereof) for the same period. (See Addendum A §4.7)

IV. CASE-MIX REIMBURSEMENT STANDARDS

(a) Rates set under this plan are intended to provide incentives to control costs and Medicaid outlays, while promoting access to services and quality of care. This case-mix reimbursement system takes into account the fact that some residents are more costly to care for than others.

(b) Case-mix rates shall be adjusted based on resident assessments made pursuant to 42 C.F.R §483.20, according to the resources utilized to care for the residents of each facility. (See Addendum A §5.1.) Case-mix adjustments may be limited to Medicaid residents only. Thus the system requires:

(1) the assessment of residents on a form prescribed by the Director of the Division of Licensing and Protection,
(2) a means to classify residents into groups which are similar in costs, known as RUG IV (48 group version); and
(3) a weighting system which quantifies the relative costliness of caring for different classes of residents to determine the average case-mix score for each facility. (See Addendum A §7.2)

(c) Per diem rates shall be prospectively determined for the rate year, based on the allowable operating costs of a facility in a Base Year plus property and related and ancillary costs from the most recently settled cost report. (See Addendum A §7.8).

(d) A Base Year shall be a calendar year, January through December. The Director shall determine the frequency of rebasing and shall select the Base Year. However, rebasing for Nursing Care costs shall occur no less frequently than once every two years and for other costs no less frequently than once every four years. (See Addendum A §5.6.)

(e) In the case-mix system of reimbursement, allowable costs are grouped into cost categories. The accounts to be used for each cost category shall be prescribed by the Director. (See Addendum A §6.) The Base Year costs shall be grouped into the following cost categories: Nursing Care Costs, Resident Care Costs, Indirect Costs, Director of Nursing, Property and Related, and Ancillaries. Nursing Care costs shall be adjusted quarterly for changes in each facility's case-mix score. (See Addendum A §9.7)

(f) The following cost limits shall be applied:

(1) Nursing Care Component – 90th percentile cost per case-mix point.

(2) Resident Care component – median cost for all facilities plus 5 percent.

(3) Indirect component – median cost for all privately owned nursing facilities plus 5 percent, except for special hospital-based facilities for which the limit is 137 percent of the median. (See Addendum A §§7.2-7.4)

(g) The Division shall by rule establish a method for determining the appropriate number of resident days to be used in calculating per diem rates and shall prescribe a minimum occupancy level (not lower than 90 percent of the certified beds in each facility) to be used for the purpose of calculating per diem costs and rates, which may be waived by rule for certain cost categories and certain types of facilities, including, but not limited to, those with 20 or fewer beds or terminating facilities. (See Addendum A §5.7.)

(h) The Division shall by rule prescribe methods to be used for adjusting costs for projected economic conditions during the rate period. The Division may use inflation factors based on the Health Care Cost Service (HCCS) Nursing Home Market Basket (NHMB) and/or the NECPI or similar indexes. Different inflation factors are used to adjust different rate components. Subcomponents of each inflation factor are weighted in proportion to the percentage of average actual costs incurred by Vermont facilities for specific subcomponents of the relevant cost components. (See Addendum A §5.8) The indexes that are used for calculating the inflation factors are as follows:

(1) Nursing Care – wages and salaries portion of HCCS NHMB and employee benefits portion of HCCS NHMB. An additional adjustment of one percentage point shall be made for every 12 month period prorated for fractions thereof, from the midpoint of the base year to the midpoint of the rate year.
(2) Resident Care – wages and salaries portion of HCCS NHMB, employee benefits portion of HCCS NHMB, utilities portion of the HCCS NHMB, and the food portion of the HCCS NHMB;
(3) Indirect – wages and salaries portion of HCCS NHMB, employee benefits portion of HCCS NHMB, and the NECPI-U (all items);
(4) Director of Nursing – wages and salaries portion of HCCS NHMB and employee benefits portion of HCCS NHMB;

(i) Special rate provisions or exemptions may be adopted by rule for state nursing facilities and for facilities operating under unique or special circumstances, including but not limited to new facilities, facilities providing special services to populations with distinct characteristics, terminating facilities, facilities in receivership or facilities qualifying for extraordinary financial relief. Payment supplements may be prescribed by rule for increases in the cost of wages. (See Addendum A §§5.9, 5.10, 10 and 14.)

(j) Prospective adjustments may be made to rates set under this plan for certain circumstances, prescribed by rule, which may include, but are not limited to, changes in services, changes in law, facilities in receivership, efficiency measures, changes in interest rates, emergencies and unforeseeable circumstances. (See Addendum A §8.)

(k) The total per diem rate in effect for any nursing facility shall be the sum of the rates calculated for all components, limited by the caps (as set out in Addendum A) adjusted in accordance with the Inflation Factors (calculated as described in Addendum A) and all adjustments. These rates may be adjusted periodically, according to rule, for changes in case-mix. (See Addendum A §9.)

(l) The Division may retroactively revise a rate under certain circumstances, specified by rule, which may include, but are not limited to, finalizing interim rates, responding to an order of the Secretary or a court of competent jurisdiction, or in settlement of an appeal, for terminating facilities or for facilities in receivership, for the recovery of over- or underpayments, or to pass the upper limits test. (See Addendum A §5.2)

(m) Payments to nursing facilities pursuant to this plan shall not exceed the limits established for such payment in 42 C.F.R. §447.272. Notwithstanding any other provision of this plan, the Division may adopt rules limiting reimbursement to facilities, if the Division determines that this limit is likely to be exceeded. (See Addendum A §§5.5 & 9.4.) Neither shall the Medicaid per diem rate paid to any provider exceed that provider's average customary charges to the general public for its nursing facility services. (See Addendum a §5.3.)

(n) Additional quality incentive payments may be made to nursing facilities providing a superior quality of care in an efficient and effective manner. (See Addendum A §9.5.)

V. PAYMENT FOR OUT-OF-STATE PROVIDERS

(a) Payment for services, other than Rehabilitation Center services, provided to Vermont Medicaid residents in long-term care facilities in another state shall be at the per diem rate established for Medicaid payment by the appropriate agency in that state. Payment of the per diem rate shall constitute full and final payment, and no retroactive settlements will be made. (See Addendum A §11.1.)

(b) Payment for Rehabilitation Center services provided in nursing facilities located outside Vermont for the severely disabled, such as head injured or ventilator dependent people, will be made at the lowest of the amount charged or the Medicaid rate, including ancillaries as paid by at least one other state agency in CMS Region 1. (See Addendum A §11.2.)

(c) Payment for Rehabilitation Center services which have not been authorized by the Medicaid Director or a designee will be made according to Subsection (a).

(d) Payment for pediatric care in out-of-state facilities requires the prior authorization of the Director of Vermont Health Access.

VI. RATES FOR ICF/MRS

(a) Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are paid according to Medicaid principles of reimbursement, pursuant to the *Regulations Governing the Operation of Intermediate Care Facilities for the Mentally Retarded* adopted by the Agency for the Department of Developmental and Mental Health Services. (See Addendum A §12 and Addendum B.)

(b) ICF/MRs are reimbursed under a retrospective payment system. Interim rates are paid with retroactive adjustments and final settlements after audit of costs. Allowability of costs is determined in accordance with the Provider Reimbursement Manual (HCFA-15) requirements.

VII. RATES FOR SWING BEDS

Payment for swing-bed nursing facility services provided by hospitals, pursuant to §1913 (a) of the SSA, shall be made at a rate equal to the average rate per diem during the previous calendar year under the State Plan to nursing facilities located in the State of Vermont. (See Addendum A §13.)

VIII. ADMINISTRATIVE REVIEW AND APPEALS

(a) As required by 42 C.F.R. 447.253 (c), the Division shall by rule prescribe procedures for prompt administrative review and appeals of cost report findings and such other matters as the Division finds appropriate, in addition to such other appeals as are prescribed by Vermont statue at 33 V.S.A. §909. These procedures shall offer individual providers an opportunity to submit additional evidence. (See Addendum A §15.)

(b) The Division or the Agency may agree to settle all such reviews and appeals or litigation arising from the work of the Division on such reasonable terms as the Division or Agency may deem appropriate to the circumstances of the case. (See Addendum A §15.8.)

IX. DEFINITIONS AND TERMS

For the purpose of this plan the following definitions and terms are used:

Accrual Basis of Accounting: an accounting system in which revenues are reported in the period in which they are earned, regardless of when they are collected, and expenses are reported in the period in which they are paid.

Agency: the Agency of Human Services.

AICPA: American Institute of Certified Public Accountants.

Allowable Costs or Expenses: costs or expenses that are recognized as reasonable and related to resident care in accordance with this plan and the Division's rules.

Ancillary Services: therapy services and therapy supplies, including oxygen, whether or not separate charges are customarily made. Other medical items or services identifiable to a specific resident furnished at the

direction of a physician and for which charges are customarily made in addition to the per diem charge.

Base Year: a calendar year for which the allowable costs are the basis for the case-mix prospective per diem rate.

Case-mix Weight: a relative evaluation of the nursing resources used in the care of a given class of residents.

Centers for Medicare and Medicaid Services (CMS): (formerly called the Health Care Financing Administration (HCFA)): Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.

Cost Report: a report prepared by a provider on forms prescribed by the Division.

Director: the Director of Rate Setting.

Division: the Division of Rate Setting, Agency of Human Services.

Facility or nursing facility: a nursing home facility licensed and certified for participation in the Medicaid Program by the State of Vermont.

FASB: Financial Accounting Standards Board.

Generally Accepted Accounting Principles (GAAP): those accounting principles with substantial authoritative support. In order of authority the following documents are considered GAAP: (1) FASB Standards and Interpretations, (2) APB Opinions and Interpretations, (3) CAP Accounting Research Bulletins, (4) AICPA Statements of Position, (5) AICPA Industry Accounting and Auditing Guides, (6) FASB Technical Bulletins, (7) FASB Concepts Statements, (8) AICPA Issues Papers and Practice Bulletins, and other pronouncements of the AICPA or FASB.

Generally Accepted Auditing Standards (GAAS): the auditing standards that are most widely recognized in the public accounting profession.

Health Care Cost Service: publication, by Global Insight, Inc., of national forecasts of hospital, nursing home (NHMB), and home health agency market baskets and regional forecasts of CPI (All Urban) for food and commercial power and CPIU-All Items.

Incremental Cost: the added cost incurred in alternative choices.

Inflation Factor: a factor that takes into account the actual or projected rate of inflation or deflation as expressed in indicators such as the New England Consumer Price Index.

Interim Rate: a prospective Case-Mix rate paid to nursing

facilities on a temporary basis.

New England Consumer Price Index (NECPI-U): the consumer price index for all urban consumers as published by the Health Care Cost Service.

OBRA 1987: the Omnibus Budget Reconciliation Act of 1987.

Occupancy Level: the number of paid days, including hold days, as a percentage of the licensed bed capacity.

Per Diem Cost: the cost for one day of resident care.

Prospective Case-Mix Reimbursement System: a method of paying health care providers rates that are established in advance. These rates take into account the fact that some residents are more costly to care for than others.

Provider Reimbursement Manual, CMS -15: a manual published by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, used by the Medicare Program to determine allowable costs.

Rate year: the State's fiscal year ending June 30.

Resident day: any day of service for which the facility is paid. For example, a paid hold day is counted as a resident day.

RUG IV: A systematic classification of residents in nursing facilities based upon a broad study of nursing care time required by groups of residents exhibiting similar needs.

Rules: as used in this state plan Attachment 4.19D, refers to Addendum A.

Secretary: the Secretary of the Agency of Human Services.

State nursing facilities: facilities owned and/or operated by the State of Vermont.

Swing-bed: a hospital bed used to provide nursing facility services.

STATE OF VERMONT
AGENCY OF HUMAN SERVICES
DIVISION OF RATE SETTING

METHODS, STANDARDS AND PRINCIPLES FOR ESTABLISHING MEDICAID PAYMENT RATES FOR LONG-TERM CARE FACILITIES

JULY 2013

GENERAL PROVISIONS

1.1 Purpose

The purpose of these rules is to implement state and federal reimbursement policy with respect to nursing facilities providing services to Medicaid eligible persons. The methods, standards, and principles of rate setting established herein reflect the objectives set out in 33 V.S.A. §901 and balance the competing policy objectives of access, quality, cost containment and administrative feasibility. Rates set under this payment system are consistent with the efficiency, economy, and quality of care necessary to provide services in conformity with state and federal laws, regulations, quality and safety standards, and meet the requirements of 42 U.S.C. §1396a(a)(13)(A).

1.2 Scope

These rules apply to all privately owned nursing facilities and state nursing facilities providing services to Medicaid residents. Long-term care services in swing-bed hospitals, and Intermediate Care Facilities for the Mentally Retarded are reimbursed under different methods and standards. Swing-bed hospitals are reimbursed pursuant to 42 U.S.C. §1396l(b)(1). Intermediate Care Facilities for the Mentally Retarded are reimbursed pursuant to the *Regulations Governing the Operation of Intermediate Care Facilities for the Mentally Retarded* adopted by the Agency and are subject to the Division's Accounting Requirements (Section 2) and Financial Reporting (Section 3).

1.3 Authority

These rules are promulgated pursuant to 33 V.S.A. §§904(a) and 908(c) to meet the requirements of 33 V.S.A. Chapter 9, 42 U.S.C. §§1396a(a)(13)(A) and §1396a(a)(30).

1.4 General Description of the Rate Setting System

A prospective case-mix payment system for nursing facilities is established by these rules in which the payment rate for services is set in advance of the actual provision of those services. A per diem rate is set for each facility based on the historic allowable costs of that facility. The costs are divided into certain designated cost categories, some of which are subject to limits. The basis for reimbursement within the Nursing Care cost category is a resident classification system that groups residents into classes according to their assessed conditions and the resources required to care for them. The costs in some categories are adjusted to reflect economic trends and conditions, and the payment rate for each facility is based on the per diem costs for each category.

1.5 Requirements for Participation in Medicaid Program

(a) Nursing facilities must satisfy all of the following prerequisites in order to participate in the Medicaid program:

(1) be licensed by the Agency, pursuant to 33 V.S.A. §7103(b),

(2) be certified by the Secretary of Health and Human Services pursuant to 42 C.F.R. Part 442, Subpart C, and

(3) have executed a Provider Agreement with the Agency, as required by 42 C.F.R. Part 442, Subpart B.

(b) To the extent economically and operationally feasible, providers are encouraged, but not required, to be certified for participation in the Medicare program, pursuant to 42 C.F.R. §488.3.

(c) Medicaid payments shall not be made to any facility that fails to meet all the requirements of Subsection 1.5(a).

1.6 Responsibilities of Owners

The owner of a nursing facility shall prudently manage and operate a residential health care program of adequate quality to meet its residents' needs. Neither the issuance of a per diem rate, nor final orders made by the Director or a duly authorized representative shall in any way relieve the owner of a nursing facility from full responsibility for compliance with the requirements and standards of the Agency of Human Services.

1.7 Duties of the Owner

The owner of a nursing facility, or a duly authorized representative shall:

(a) Comply with the provisions of Subsections 1.5 and 1.6 setting forth the requirements for participation in the Medicaid Program.

(b) Submit cost reports in accordance with the provisions of subsections 3.2 and 3.3 of these rules.

(c) Maintain adequate financial and statistical records and make them available at reasonable times for inspection by an authorized representative of the Division, the state, or the federal government.

(d) Assure that an annual audit is performed in conformance with Generally Accepted Auditing Standards (GAAS).

(e) Assure that the construction of buildings and the maintenance and operation of premises and programs comply with all applicable health and safety standards.

(f) Notwithstanding any other provision of these rules, any provider that fails to make a complete cost report filing within the time prescribed in subsection 3.3(a) or fails to file any other materials requested by the Division within the time prescribed shall receive no increase to its Medicaid rate until the first day of the calendar quarter after a complete cost report or the requested materials are filed, unless within an extension of time previously approved by the Division.

1.8 Powers and Duties of the Division and the Director

(a) The Division shall establish and certify to the Department of Vermont Health Access per diem rates for payment to providers of nursing facility services on behalf of residents eligible for assistance under Title XIX of the Social Security Act.

(b) The Division may request any nursing facility or related party or organization to file such relevant and appropriate data, statistics, schedules or information as the Division finds necessary to enable it to carry out its function.

(c) The Division may examine books and accounts of any nursing facility and related parties or organizations, subpoena witnesses and documents, administer oaths to witnesses and examine them on all matters over which the Division has jurisdiction.

(d) From time to time, the Director may issue notices of practices and procedures employed by the Division in carrying out its functions under these rules.

(e) The Director shall prescribe the forms required by these rules and instructions for their completion.

(f) Copies of each notice of practice and procedure, form, or set of instructions shall be sent to each nursing facility participating in the Medicaid program at the time it is issued. A compilation of all such documents currently in force shall be maintained at the Division, pursuant to 3 V.S.A. §835, and shall be available to the public.

(g) Neither the issuance of final per diem rates nor Final Orders of the Division which fail, in any one or more instances, to enforce the performance of any of the terms or conditions of these rules shall be construed as

a waiver of the Division's future performance of the right. The obligations of the provider with respect to performance shall continue, and the Division shall not be estopped from requiring such future performance.

1.9 Powers and Duties of the Department of Disabilities, Aging and Independent Living's Division of Licensing and Protection as Regards Reimbursement

(a) The Division of Licensing and Protection of the Department of Disabilities, Aging and Independent Living shall receive from providers resident assessments on forms it specifies. The Department of Disabilities, Aging and Independent Living shall process this information and shall periodically, but no less frequently than quarterly, provide the Division of Rate Setting with the average case-mix scores of each facility based upon the federal RUG IV classification system (48 group version). This score will be used in the quarterly determination of the Nursing Care portion of the rate.

(b) The management of the resident assessment process used in the determination of case-mix scores shall be the duty of the Division of Licensing and Protection of the Department of Disabilities, Aging and Independent Living. Any disagreements between the facility's assessment of a resident and the assessment of that same resident by the audit staff of Licensing and Protection shall be resolved with the Division of Licensing and Protection and shall not involve the Division of Rate Setting. As the final rates are prospective and adjusted on a quarterly basis to reflect the most current data, the Division of Rate Setting will not make retroactive rate adjustments as a result of audits or successfully appealed individual case-mix scores.

1.10 Computation of and Enlargement of Time; Filing and Service of Documents

(a) In computing any period of time prescribed or allowed by these rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a state or federal legal holiday, in which event the period runs until the end of the next day which is not a Saturday, a Sunday, or a state or federal legal holiday.

(b) For the purposes of any provision of these rules in which time is computed from the receipt of a notice or other document issued by the Division or other relevant administrative officer, the addressee of the notice shall be rebuttably presumed to have received the notice or other document three days after the date on the document.

(c) When by these rules or by a notice given thereunder, an act is required or allowed to be done at or within a specified time, the relevant administrative officer, for just cause shown, may at any time in her or his discretion, with or without motion or notice, order the period enlarged. This subsection shall not apply to the time limits for appeals to the Vermont Supreme Court or Superior Court from Final Orders of the Division or Final Determinations of the Secretary, which are governed by the Vermont Rules of Appellate Procedure and the Vermont Rules of Civil Procedure respectively.

(d) Filing shall be deemed to have occurred when a document is received and date-stamped as received at the office of the Division or in the case of a document directed to be filed under this rule other than at the office of the Division, when it is received and stamped as received at the appropriate office. Filings with the Division may be made by telefacsimile (FAX), but the sender bears the risk of a communications failure from any cause. Filings with the Division may also be made electronically, but the sender bears the risk of a communications failure from any cause, including, but not limited to, filings blocked due to size.

(e) Service of any document required to be served by this rule shall be made by delivering a copy of the document to the person or entity required to be served or to his or her representative or by sending a copy by prepaid first class mail to the official service address. Service by mail is complete upon mailing.

1.11 Representation in All Matters before the Division

(a) A facility may be represented in any matter under this rule by the owner (in the case of a corporation, partnership, trust, or other entity created by law, through a duly authorized agent), the nursing facility administrator, or by a licensed attorney or an independent public accountant.

(b) The provider shall file written notification of the name and address of its representative for each matter before the Division. Thereafter, on that matter, all correspondence from the Division will be addressed to that representative. The representative of a provider failing to so file shall not be entitled to notice or service of any document in connection with such matter, whether required to be made by the Division or any other person, but instead service shall be made directly on the provider.

1.12 Severability

If any part of these rules or their application is held invalid, the invalidity does not affect other provisions or applications which can be given effect without the invalid provision or application, and to this end the provisions of these rules are severable.

1.13 Effective Date

(a) These rules are effective from January 29, 1992, (as amended June 18, 1993, July 1, 1994, January 4, 1995, January 1, 1996, January 1, 1997, July 1, 1998, May 1, 1999, July 1, 1999, August 1, 1999, July 1, 2001, November 1, 2002, May 1, 2004, July 1, 2004, July 1, 2005, July 1, 2006, October 1, 2007, July 1, 2008, July 1, 2009, July 1, 2010, April 1, 2011 and July 1, 2013).

(b) Application of Rule: Amended provisions of this rule shall apply to:

(1) all cost reports draft findings issued on or after the effective date of the most recent amendment, and

(2) all rates set on or after the effective date of the most recent amendment.

(c) With respect to any administrative proceeding pending on the effective date of the most recent amendment the Director or the Secretary may apply any provision of such prior rules where the failure to do so would work an injustice or substantial inconvenience.

2 ACCOUNTING REQUIREMENTS

2.1 Accounting Principles

(a) All financial and statistical reports shall be prepared in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied, unless these rules authorize specific variations in such principles.

(b) The provider shall establish and maintain a financial management system which provides for adequate internal control assuring the accuracy of financial data, safeguarding of assets and operational efficiency.

(c) The provider shall report on an accrual basis. The provider whose records are not maintained on an accrual basis shall develop accrual data for reports on the basis of an analysis of the available documentation. In such a case, the provider's accounting process shall provide sufficient information to compile data to satisfy the accrued expenditure reporting requirements and to demonstrate the link between the accrual data reports and the non-accrual fiscal accounts.

The provider shall retain all such documentation for audit purposes.

2.2 Procurement Standards

(a) Providers shall establish and maintain a code of standards to govern the performance of its employees engaged in purchasing goods and services. Such standards shall provide, to the maximum extent practical, open and free competition among vendors. Providers should participate in group purchasing plans when feasible.

(b) If a provider pays more than a competitive bid for a good or service, any amount over the lower bid which cannot be demonstrated to be a reasonable and necessary expenditure that satisfies the prudent buyer principle is a nonallowable cost.

2.3 Cost Allocation Plans and Changes in Accounting Principles

With respect to the allocation of costs to the nursing facility and within the nursing facility, the following rules shall apply:

(a) [Repealed]

(b) Providers that have costs allocated from related entities included in their cost reports shall include, as a part of their cost report submission, a summary of the allocated costs, including a reconciliation of the allocated costs to the entity's financial statements, which must also be submitted with the Medicaid cost report. In the case of a home office or related management company, this would include a completed Home Office Cost Statement. The provider shall submit this reconciliation with the Medicaid cost report.

(c) The Division reserves the right not to recognize changes in accounting principles or methods or basis of cost allocation made for the purpose or having the likely effect of increasing a facility's Medicaid payments.

(d) [Repealed]

(e) [Repealed]

(f) Each provider shall notify the Division of changes in statistical allocations or record keeping required by the Medicare Intermediary.

(g) Preferred statistical methods of allocation are as follows:

(1) Nursing salaries and supplies - direct cost,

(2) Plant operations - square footage,

(3) Utilities - square footage,

(4) Laundry - pounds of laundry,

(5) Dietary -resident days,

(6) Administrative and General - accumulated costs,

(7) [Repealed]

(8) Property and Related - square footage,

(9) Fringe Benefits - direct allocation/gross salaries.

(h) Food costs included in allocated dietary costs are calculated by dividing the facility's allocated dietary costs by total organization dietary costs, both of which include allocated overhead, and multiplying the result by the total organization food costs.

(i) Utility costs included in allocated plant operation and maintenance costs are calculated by dividing the facility's plant operation and maintenance costs by total organization plant operation and maintenance cost, both of which include allocated overhead, and multiplying the result by the total organization utility costs.

(j) All administrative and general costs, including home office and management

company costs, allocated to a facility shall be included in the Indirect Cost category.

(k) The capital component of goods or services purchased or allocated from a related or unrelated party, such as plant operation and maintenance, utilities, dietary, laundry, housekeeping, and all others, whether or not acquired from a related party, shall be considered as costs for that particular good or service and not classified as Property and Related costs of the nursing facility.

(l) Costs allocated to the nursing facility shall be reasonable, as determined by the Division pursuant to these rules.

2.4 Substance Over Form

The cost effect of transactions that have the effect of circumventing the intention of these rules may be adjusted by the Division on the principle that the substance of the transaction shall prevail over the form.

2.5 Record Keeping and Retention of Records

(a) Each provider must maintain complete documentation, including accurate financial and statistical records, to substantiate the data reported on the uniform financial and statistical report (cost report), and must, upon request, make these records available to the Division of Rate Setting, or the U. S. Department of Health and Human Services, and the authorized representatives of both agencies.

(b) Complete documentation means clear and compelling evidence of all of the financial transactions of the provider and affiliated entities, including but not limited to census data, ledgers, books, invoices, bank statements, canceled checks, payroll records, copies of governmental filings, time records, time cards, purchase requisitions, purchase orders, inventory records, basis of apportioning costs, matters of provider ownership and organization, resident service schedule and amounts of income received by service, or any other record which is necessary to provide the Director with the highest degree of confidence in the reliability of the claim for reimbursement. For purposes of this definition, affiliated entities shall extend to realty, management and other entities for which any reimbursement is directly or indirectly claimed whether or not they fall within the definition of related parties.

(c) The provider shall maintain all such records for at least six years from the date of filing, or the date upon which the fiscal and statistical records were to be filed, whichever is the later. The Division shall keep all cost reports, supporting documentation submitted by the provider, correspondence, workpapers and other analyses supporting Summaries of Findings for six years. In the event of litigation or appeal involving rates established under these regulations, the provider and Division shall retain all records which are in any way related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.

(d) Pursuant to 33 V.S.A. §908(a), all documents and other materials filed with the Division are public information, except for individually identifiable health information protected by law or the policies, practices, and procedures of the Agency of Human Services. With the exception of the administrator's salary, the salaries and wages of individual employees shall not be made public.

3 FINANCIAL REPORTING

3.1 [Repealed]

3.2 Uniform Cost Reports

(a) Each long-term care facility participating in the Vermont Medicaid program shall annually submit a uniform financial and statistical report (cost report) on forms prescribed by the Division. The inclusive dates of the reporting year shall be the 12

month period of each provider's fiscal year, unless advance authorization to submit a report for a greater or lesser period has been granted by the Division.

(1) The Division may require providers to file special cost reports for periods other than a facility's fiscal year.

(2) The Division may require providers to file budget cost reports. Such cost reports may be used *inter alia* as the basis for new facilities' rates or for rate adjustments.

(b) The cost report must include the certification page signed by the owner, or its representative, if authorized in writing by the owner.

(c) The original and one copy of the cost report must be submitted to the Division. All documents must bear original signatures.

(d) The following supporting documentation is required to be submitted with the cost report:

(1) Audited financial statements (except that at the discretion of the Director, this requirement may be waived),

(2) Most recently filed Medicare Cost Report with the required supplemental data on CMS Form 339 (if a participant in the Medicare Program), which for hospital-based nursing homes shall be the Medicare cost report for the same fiscal year as the Medicaid cost report,

(3) Independent auditor's adjusting entries and reconciliation of the audited financial statements to the cost report.

(e) A provider must also submit, upon request during the desk review or audit process, such data, statistics, schedules or other information which the Division requires in order to carry out its function. If, before the draft findings are issued, the facility has been specifically requested to provide certain information or materials and has failed to do so, such information or materials will not be admissible in any subsequent appeal taken pursuant to Section 15, provided the Division has notified the provider of such failure and afforded the provider a final opportunity to cure.

(f) Providers shall follow the cost report instructions prescribed by the Director in completing the cost report. The chart of accounts prescribed by the Director, shall be used as a guideline providing the titles, and description for type of transactions recorded in each asset, liability, equity, income, and expense account.

3.3 Adequacy and Timeliness of Filing

(a) With the exception of hospital-based nursing homes, an acceptable cost report filing shall be made on or before the last day of the fifth month following the close of the period covered by the report.

(1) Hospital-based nursing homes shall file their Medicaid cost-reports within five days after filing their Medicare cost report for the same cost reporting period with CMS.

(2) If a hospital-based Medicaid nursing home's cost report is not filed on or before June 30 following the end of the facility's fiscal year, the Division may require the facility to provide certain data or to file a draft cost report.

(b) The Division may reject any filing which does not comply with these regulations and/or the cost reporting instructions. In such case, the report shall be deemed not filed, until refiled and in compliance.

(c) Extensions for filing of the cost report beyond the prescribed deadline must be requested as follows:

(1) All Requests for Extension of Time to File Cost Report must be in writing, on a form prescribed by the Director, and must be received by the Division of Rate Setting prior to the due date. The provider must

clearly explain the reason for the request and specify the date on which the Division will receive the report.

(2) Notwithstanding any previous practice, the Division will not grant automatic extensions. Such extensions will be granted for good cause only, at the Director's sole discretion, based on the merits of each request. A "good cause" is one that supplies a substantial reason, one that affords a legal excuse for the delay or an intervening action beyond the provider's control. The following are not considered "good cause": ignorance of the rule, inconvenience, or a cost report preparer engaged in other work.

(d) Notwithstanding any other provision of these rules, any provider that fails to make a complete cost report filing within the time prescribed in subsection 3.3(a) or within an extension of time approved by the Division, shall be subject to the provisions of subsection 1.7(f).

3.4 Review of Cost Reports by Division

(a) Uniform Desk Review

(1) The Division shall perform a uniform desk review on each cost report submitted.

(2) The uniform desk review is an analysis of the provider's cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded thereon, allowable costs and a summary of the results of the review for the purpose of either settling the cost report without an on-site audit or determining the extent to which an on-site audit verification is required.

(3) Uniform desk reviews shall be completed within an average of 18 months after receipt of an acceptable cost report filing, except in unusual situations, including but not limited to, delays in obtaining necessary information from a provider. Notwithstanding this subdivision, the Division shall have an additional six months to complete its review or audits of facilities' base year cost reports.

(4) Unless the Division schedules an on-site audit, it shall issue a written summary report of its findings and adjustments upon completion of the uniform desk review.

(b) On-site Audit

(1) The Division will perform on-site audits, as considered appropriate, of the provider's financial and statistical records and systems in accordance with the relevant provisions of the *Medicare Intermediary Manual - Audits-Reimbursement Program Administration*, CMS Publication 13-2 (CMS-13).

(2) The Division will base its selection of a facility for an on-site audit on factors such as length of time since last audit, changes in facility ownership, management, or organizational structure, evidence or official complaints of financial irregularities, questions raised in the uniform desk review, failure to file a timely cost report without a satisfactory explanation, and prior experience.

(3) The audit scope will be limited so as to avoid duplication of work performed by an independent public accountant, provided such work is adequate to meet the Division's audit requirements.

(4) Upon completion of an audit, the Division shall review its draft findings and adjustments with the provider and issue a written summary report of such findings.

(c) The procedure for issuing and reviewing Summaries of Findings is set out in Subsections 15.1, 15.2 and 15.3.

3.5 Settlement of Cost Reports

(a) A cost report is settled if there is no request for reconsideration of the Division's findings or, if such request was made, the

Division has issued a final order pursuant to Subsection 15.3 of these rules.

(b) Cost report determinations and decisions, otherwise final, may be reopened and corrected when the specific requirements set out below are met. The Division's decision to reopen will be based on new and material evidence submitted by the provider, evidence of a clear and obvious material error, or a determination by the Secretary or a court of competent jurisdiction that the determination is inconsistent with applicable law, regulations and rulings, or general instructions.

(c) Reopening means an affirmative action taken by the Division to re-examine the correctness of a determination or decision otherwise final. Such action may be taken:

(1) On the initiative of appropriate authority within the applicable time period set out in paragraph (f), or

(2) In response to a written request of the provider or other relevant entity, filed with the Division within the applicable time period set out in subsection (f), and

(3) When the reopening has a material effect (more than one percent) on the provider's Medicaid rate payments.

(d) A correction is a revision (adjustment) in the Division's determination or Secretary's decision, otherwise final, which is made after a proper re-opening.

(e) A correction may be made by the Division, or the provider may be required to file an amended cost report. If the cost report is reopened by an order of the Secretary or a court of competent jurisdiction, the correction shall be made by the Division.

(f) A determination or decision may be reopened within three years from the date of the notice containing the Division's determination, or the date of a decision by the Secretary or a court.

(g) The Division may also require or allow an amended cost report to correct material errors detected subsequent to the filing of the original cost report or to comply with applicable standards and regulations. Once a cost report is filed, the provider is bound by its elections. The Division shall not accept an amended cost report to avail the provider of an option it did not originally elect.

4 DETERMINATION OF ALLOWABLE COSTS FOR NURSING FACILITIES

4.1 Provider Reimbursement Manual and GAAP

In determining the allowability or reasonableness of costs or treatment of any reimbursement issue, not addressed in these rules, the Division shall apply the appropriate provisions of the Medicare Provider Reimbursement Manual (CMS-15, formerly known as HCFA or HIM-15). If neither these regulations nor CMS-15 specifically addresses a particular issue, the determination of allowability will be made in accordance with Generally Accepted Accounting Principles (GAAP). The Division reserves the right, consistent with applicable law, to determine the allowability and reasonableness of costs in any case not specifically covered in the sources referenced in this subsection.

4.2 General Cost Principles

For rate setting purposes, a cost must satisfy criteria, including, but not limited to, the following:

(a) The cost must be ordinary, reasonable, necessary, related to the care of residents, and actually incurred.

(b) The cost adheres to the prudent buyer principle.

(c) The cost is related to goods and/or services actually provided in the nursing facility.

4.3 Non-Recurring Costs

(a) Non-recurring costs shall include:

(1) any reasonable and resident-related cost that exceeds $10,000, which is not expected to recur on an annual basis in the ordinary operation of the facility, may be designated by the Division as a "Non-Recurring Cost" subject to any limits on the cost category into which the type of cost would otherwise be assigned,

(2) litigation expenses of $10,000 or more, recognized pursuant to subsection 4.20.

(3) allowable lump-sum costs of $2,000 or more per cost reporting period for recruitment and legal fees or similar expenses associated with the hiring of registered nurses from countries outside the United States on condition that such fees or expenses shall be allowable only in respect of such nurses who are paid at least the prevailing salary/wage and benefits for employed nurses of similar qualifications and experience in the geographic area in which the facility is located or tuition expenses for nurse aide training reimbursed pursuant to 42 C.F.R. §483.152(c)(2).

(b) A non-recurring cost shall be capitalized and amortized and carried as an on-going adjustment beginning with the first quarterly rate change after the settlement of the cost report for a period of three years.

4.4 Interest Expense

(a) Necessary and proper interest is an allowable cost.

(b) “Necessary requires that:

(1) The interest be incurred on a loan made to satisfy a financial need of the provider.

(2) A financial need does not exist if the provider has cash and/or cash equivalents of more than 60 days cash needs.

(3) Cash and cash equivalents include:

(i) monetary investments, including unrestricted grants and gifts,

(ii) non-monetary investments not related to resident care that can readily be converted to cash net of any related liability,

(iii) receivables from (net of any payables to) officers, owners, partners, parent organizations, brother/sister organizations, or other related parties, excluding education loans to employees.

(iv) receivables that result from transactions not related to resident care.

(4) Cash and cash equivalents exclude:

(i) funded depreciation recognized by the Division,

(ii) restricted grants and gifts.

(5) Interest income offset.

(i) Interest expense shall be reduced by realized investment income, except where such income is from:

(A) funded depreciation recognized by the Division pursuant to CMS-15,

(B) grants and gifts, whether restricted or unrestricted.

(ii) Only working capital interest expense shall be offset by interest income derived from working capital.

(6) The provider must have a legal obligation to pay the interest.

(c) "Proper" requires that:

(1) Interest be incurred at a rate not in excess of what a prudent buyer would have

had to pay in the money market existing at the time the loan was made.

(2) Interest must be paid to a lender that is not a related party of the borrowing organization except as provided in paragraph (k).

(d) Interest expense shall be included in property costs if the interest is necessary and proper and if it is incurred as a result of financing the acquisition of fixed assets related to resident care.

(e) The date of such financing must be within 60 days of the date the asset is put in use, except for assets approved through the Certificate of Need process or approved by the Division under Subsection 4.11 of this rule. Allowable interest, on loans financed more than 60 days before or after the asset is put in use, will be included in Indirect Costs for the entire term of the loan.

(f) Borrowings to finance asset additions cannot exceed the sum of the basis of the asset(s), determined in accordance with Subsections 4.5 and 4.7, and other costs allowed pursuant to paragraph (g) related to the borrowing. The limit on borrowings related to fixed assets is determined as follows:

Basis of the assets recognized by the Division, plus a proportionate share of other costs allowed pursuant to paragraph (g), or

the principal amount of the loan, whichever is the lower:

Less: The provider's cash and cash equivalents in excess of 60 days needs, per subparagraph (b)(2) of this subsection.

Equals: The limits on borrowings related to fixed assets.

(g) Other costs related to the acquisition of the assets may be included in loans where the interest is recognized by the Division. These costs include bank finance charges, points and costs for legal and accounting fees, and discounts on debentures and letters of credit.

(h) Necessary and proper interest expense on debt incurred other than for the acquisition of assets shall be recognized as working capital interest expense and included in Indirect Costs.

(i) Application of Principal Payments.

(1) For loans entered into before a facility's 1998 fiscal year, principal payments shall be applied first to loan balances on allowable borrowings and second to non-allowable loan balances.

(2) For loans entered into during or after a facility's 1998 fiscal year, principal payments shall be applied to allowable and non-allowable loan balances on the ratio of each to the total amount of the loan.

(j) Refinancing of indebtedness.

(1) The provider must demonstrate to the Division that the costs of refinancing will be less than the allowable costs of the current financing.

(2) Costs of refinancing must include accounting fees, legal fees and debt acquisition costs related to the refinancing.

(3) Material interest expense related to the original loan's unpaid interest charges, to the extent that it is included in the refinanced loan's principal, shall not be allowed.

(4) A principal balance in excess of the sum of the principal balance of the previous financing plus accounting fees, legal fees and debt acquisition costs shall be considered a working capital loan, subject to the cash needs test in subsection 4.4(b)(2), unless the provider demonstrates to the Division that the excess was for the

acquisition of assets as set forth in (a) through (g).

(k) Interest expense incurred as a result of transactions with a related party (or related parties) will be recognized if the expense would otherwise be allowable and if the following conditions are met:

(1) The interest expense relates to a first and/or second mortgage or to assets leased from a related party where the costs to the related party are recognized in lieu of rent.

(2) The interest rate is no higher than the rate charged by lending institutions at the inception of the loan.

(l) Interest is not allowable with respect to any capital expenditure in property, plant and equipment related to resident care which requires approval, if the necessary approval has not been granted.

(m) Interest on loans that do not include reasonable and ordinary principle repayments in the debt service payments shall not be allowable except to the extent that it would have been incurred pursuant to a standard amortization schedule for a term equivalent to the useful life of the asset.

4.5 Basis of Property, Plant and Equipment

(a) The basis of a donated asset is the fair market value.

(b) The basis of other assets that are owned by a provider and used in providing resident care shall generally be the lower of cost or fair market value. Specific exceptions are addressed elsewhere in this rule. Cost includes:

(1) purchase price,

(2) sales tax,

(3) costs to prepare the asset for its intended use, such as, but not limited to, costs of shipping, handling, installation, architectural fees, consulting and legal fees.

(c) The basis of assets constructed by the provider to provide resident care shall be determined from the construction costs which include:

(1) all direct costs, including, but not limited to, salaries and wages, the related payroll taxes and fringe benefits, purchase price of materials, sales tax, costs of shipping, handling and installation, costs for permits, architectural fees, consulting fees and legal fees.

(2) indirect costs related to the construction of the asset.

(3) interest costs related to capital indebtedness used to finance the construction of the asset and prepare it for its intended use.

(d) The basis of betterments or improvements, if they extend the useful life of an asset two or more years or significantly increase the productivity of an asset are costs as set forth in paragraphs (b) and (c) above.

(e) Any asset that has a basis of $2,000 or more and an estimated useful life of two or more years must be capitalized and depreciated in accordance with Subsection 4.6. Groups of assets with the majority of assets in the group valued at $300 or more and a useful life of two years or more must also be capitalized and depreciated in accordance with Subsection 4.6. Assets or groups of assets with a basis lower than $2,000 may be expensed or depreciated at the provider's election.

(f) The gain on a transfer of an asset to a related party shall be calculated as follows: the fair market value of the asset, less the net book value will be the gain irrespective of the of the amount paid to the facility for the asset. This gain will be offset against property and related costs.

4.6 Depreciation and Amortization of Property, Plant and Equipment

(a) Costs for depreciation and amortization must be based on property records sufficient in detail to identify specific assets.

(b) Depreciation and amortization must be computed on the straight-line method.

(c) The depreciable basis of an asset shall be the basis established according to Subsections 4.5 and 4.7, net of any salvage value.

(d) The estimated useful life of an asset shall be determined by the Division as follows:

(1) The recommended useful life is the number of years listed in the most recent edition of Estimated Useful Lives of Depreciable Hospital Assets, published by the American Hospital Association.

(2) Leasehold improvements may be amortized over the term of an arms-length lease, including renewal period, if such a lease term is shorter than the estimated useful life of the asset.

4.7 Change in Ownership of Depreciable Assets - Sales of Facilities

(a) A change of ownership will be recognized when the following criteria have been met:

(1) The change of ownership did not occur between related parties, except for transactions that meet the criteria in subparagraph (2).

(2) The transaction takes place between family members and meets the following conditions:

(i) The Division shall be notified at least two years before the sale. The notice shall include a description of the terms and conditions of the sale and be accompanied by a current appraisal of the facility being sold.

(ii) The buyer shall demonstrate the capacity to manage and/or administer the facility; or if the buyer is to be an absentee owner, the buyer shall demonstrate that there will be sufficient capable staff to operate the facility according to standards prescribed by state and federal law.

(iii) The seller shall not maintain full time employment with the facility, except for a transition period which shall not be longer than one year during which the seller may provide reasonable consultation to assure a smooth transition.

(iv) A sale of the facility shall not have occurred between any members of the same family within the previous 12 years.

(v) For the purposes of this subsection, family members shall include spouses, parents, grandparents, children, grandchildren, brothers, sisters, spouses of parents, grandparents, children, grandchildren, brothers and sisters, aunts, uncles, nieces and nephews, or such other familial relationships as the Director may reasonably approve in the circumstances of the transaction.

(3) The change of ownership was made for reasonable consideration.

(4) The change of ownership was a bona fide transfer of all the powers and indicia of ownership.

(5) The change in ownership is in substance the sale of the assets or stock of the facility and not a method of financing.

(i) If the transferor and the transferee enter into a financing agreement, the agreement must be constructed to effect a complete change of ownership. The Division shall determine if the agreement does in substance effect a complete change of ownership and the Division shall monitor the compliance with the agreement.

(ii) Where, subsequent to a change of ownership, the transferor forgives or reduces the debt of the transferee, the amount of the forgiveness or reduction shall be retroactively applied to the acquisition or basis of the asset as determined by the Division.

(6) The buyer shall demonstrate to the satisfaction of the Division that all obligations to the State of Vermont arising out of the transaction have been satisfied.

(7) For rate setting purposes, the transfer of stock or shares shall not be recognized as a change in ownership in the following circumstances:

(i) the transferred stock or shares are those of a publicly traded corporation.

(ii) the transfer was made solely as a method of financing (not as a method of transferring management or control) and the number of shares transferred does not exceed 25 percent of the total number of shares in any one class of stock.

(b) Where the Division recognizes the change in ownership of an asset, the basis of the assets for the new owner shall be determined as follows:

(1) If the seller did not own the assets during the entire twelve year period immediately preceding the change in ownership or if the seller's facility did not receive Vermont Medicaid reimbursement during the entire twelve year period immediately preceding the change in ownership, the depreciable cost basis of the transferred asset for the new owner shall be the lowest of:

(i) the fair market value of the assets,

(ii) the acquisition cost of the asset to the buyer,

(iii) the original basis of the asset to the seller as recognized by the Division, less accumulated depreciation.

(2) If the seller owned the assets during the entire twelve year period immediately preceding the change in ownership and if the seller's facility received Vermont Medicaid reimbursement during the entire twelve year period immediately preceding the change in ownership, the depreciable cost basis of the transferred fixed equipment and building improvements for individual assets having an original useful life of at least 20 years in agreement with the useful life assigned in the American Hospital Association guidelines, the depreciable cost basis of land improvements, the depreciable cost basis of buildings and the cost basis of land for the new owner shall be the lowest of:

(i) the fair market value of the assets,

(ii) the acquisition cost of the asset to the buyer,

(iii) the amount determined by the revaluation of the asset. An asset is revalued by increasing the original basis of the asset to the seller, as recognized by the Division, by an annual percentage rate. The annual percentage rate will be limited to the lower of:

(A) One-half the percentage increase in the Consumer Price Index (CPI) for All Urban consumers (United States City Average).

(B) One-half the percentage change in an appropriate construction cost index as determined by the Division of Rate Setting, which change shall not be greater than one-half of the percentage increase in the Dodge Construction index (or a reasonable proxy therefor) for the same period.

(3) If the seller owned the assets during the entire twelve year period immediately

preceding the change in ownership and if the seller's facility received Vermont Medicaid reimbursement during the entire twelve year period immediately preceding the change in ownership, the depreciable cost basis of individual assets categorized as building improvements and fixed equipment with an original useful life of less than 20 years, in agreement with the useful life assigned in the American Hospital Association guidelines, shall be the seller's net book value and shall be depreciated over a useful life of seven years.

(4) If the seller owned the assets during the entire twelve year period immediately preceding the change in ownership and if the seller's facility received Vermont Medicaid reimbursement during the entire twelve year period immediately preceding the change in ownership,, the depreciable cost basis of moveable equipment and vehicles shall be the seller's net book value and shall be depreciated over a useful life of ten years.

4.8 [Repealed]

4.9 Leasing Arrangements for Property, Plant and Equipment

Leasing arrangements for property, plant and equipment must meet the following conditions:

(a) Rent expense on facilities and equipment leased from a related organization will be limited to the Medicaid allowable interest, depreciation, insurance and taxes incurred for the year under review, or the price of comparable services or facilities purchased elsewhere, whichever is lower.

(b) Rental or leasing charges, including sale and leaseback agreements for property, plant and equipment to be included in allowable costs cannot exceed the amount which the provider would have included in allowable costs had it purchased or retained legal title to the asset, such as interest on mortgage, taxes, insurance and depreciation.

4.10 Funding of Depreciation

(a) Funding of depreciation is not required, but it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciable assets, and coordinate their planning of capital expenditures with area-wide planning of community and state agencies. As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense.

(b) To the extent that the provider fails to retain sufficient working capital or sufficient resources to support operations, before making deposits in a funded depreciation account, the deposits will not be recognized as funded depreciation.

(c) To the extent that funded depreciation in the cost reporting period under consideration is used for purposes other than nursing facility asset acquisition, interest income on those sums will be offset against interest expense not only in the current period, but the Division may reopen settled cost reports for previous periods to revise funded depreciation and allowable interest expense. However, with the prior approval of the Division, under appropriate conditions, some or all of a provider's funded depreciation may be used as follows without triggering an interest income offset:

(1) to convert existing nursing home beds to residential care or assisted living, or

(2) when more economic, for new construction of residential care or assisted living units with a reduction in licensed nursing home beds.

(d) All relevant provisions of CMS-15 shall be followed, except as noted below:

(1) Replacement reserves. Some lending institutions require funds to be set aside periodically for replacement of fixed assets. The periodic amounts set aside for this purpose are not allowable costs in the period expended, but will be allowed when withdrawn and utilized either through depreciation or expense after considering the usage of these funds. Since the replacement reserves are essentially the same as funded depreciation the same regulations regarding interest will apply.

(2) If a facility is leased from an unrelated party and the ownership of the reserve rests with the lessor, then the replacement reserve payment becomes part of the lease payment and is considered an allowable cost in the year expended. If the lessee is allowed to use this replacement reserve for the replacement of the lessee's assets, lessee shall not be allowed to depreciate the assets purchased.

(e) The provider must maintain appropriate documentation to support the funded depreciation account and income earned thereon to be eligible for relief from the investment income offset.

4.11 Adjustments for Large Asset Acquisitions and Changes of Ownership

(a) Large Asset Acquisitions

(1) A provider may apply to the Division for an adjustment to the property and related component of the rate for *individual* capital expenditures determined to be necessary and reasonable. No application for a rate adjustment should be made if the change to the rate would be smaller than one half of one percent of the facility's rate in effect at the time the application is made. Interest expense related to these assets, provided it is necessary and reasonable, shall be included in calculating the adjustment.

(2) In the event that approval is granted by the Division, the adjustment will be made effective from the first day of the quarter after the filing date of the written notice, following the date of the final order on the application, or following the date the asset is actually put into service, whichever is the latest.

(b) Changes of Ownership

(1) Application shall also be made under this subsection, no later than 30 days after the execution of a purchase and sale agreement or other binding contract, or the receipt of a Certificate of Need pursuant to 18 V.S.A. §9434, for changes in basis resulting from a change in ownership of depreciable assets recognized by the Division pursuant to Subsection 4.7. The Division may make related adjustments to the Property and Related rate component.

(2) Adjustments to the Property and Related rate component resulting from a change in ownership of depreciable assets shall be effective from the first day of the month following the date of sale.

(c) Except in circumstances determined by the Division to constitute an emergency precluding a 60 day notice period, a provider applying for an adjustment pursuant to this subsection is required to give 60 days written notice to the Division prior to the purchase of the asset. Such applications shall be exempt from the materiality test set out in subsection 8.7(b), but are subject to the other provisions of subsection 8.7. The burden is on the provider to document all information applicable to this adjustment and to demonstrate that any costs to be incurred are necessary and reasonable. When applicable, such documentation shall include the Certificate of Need application and all supporting financial information. The Division shall review the application and issue draft findings approving, denying, or proposing modifications to the adjustment applied for within 60 days of receipt of all information required.

4.12 [Repealed]

4.13 Advertising Expenses

The reasonable and necessary expense of newspaper or other public media advertisement for the purpose of securing necessary employees is an allowable cost. No other advertising expenses are allowed.

4.14 Barber and Beauty Service Costs

The direct costs of barber and beauty services are not allowable for purposes of Medicaid reimbursement. However, the fixed costs for space and equipment related to providing these services and overhead associated with billing for these services are allowable.

4.15 Bad Debt, Charity and Courtesy Allowances

Bad debts, charity and courtesy allowances are deductions from revenues and are not to be included in allowable costs.

4.16 Child Day Care

Reasonable and necessary costs incurred for the provision of day care services to children of employees performing resident related functions will be allowable. Costs will be adjusted by any revenues received for the provision of care provided to employees' children. The direct and indirect expenses related to providing these services to non-employee children are not an allowable expense. Costs must be accumulated in a separate cost center. Revenues earned from providing day care must be identified for employees and non-employees in a separate account.

4.17 Community Service Activities

As an incentive for nursing home providers to furnish needed services (i.e., meals-on-wheels, adult day and certain respite care, etc.) to local communities, with the prior permission of the Division, only direct identifiable incremental costs will be adjusted (i.e., food, direct labor and fringe benefits, transportation). Overhead costs will not be apportioned for adjustment unless there is a significant expansion to a program resulting from community service involvement. The provider must maintain auditable records for all incremental direct costs associated with providing a community service.

4.18 Dental Services

Costs incurred for services performed in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth will not be allowed for the purposes of calculating the per diem rate. Dental services for Medicaid eligible individuals are covered as of February 1, 2006 pursuant to the *Medicaid Covered Services Rules*. However, the fixed costs for space and equipment related to providing these services and overhead associated with billing for these services may be allowable.

4.19 Legal Costs

Necessary, ordinary, and reasonable legal fees incurred for resident-related activities will be allowable.

4.20 Litigation and Settlement Costs

(a) Civil and criminal litigation -

(1) General Rule. Attorney fees and other expenses incurred in conjunction with litigation will be recognized only to the extent that the costs are related to resident care, that the provider prevails, and that the costs are not covered by insurance.

(2) Settlements. In instances, where a matter is settled before judgment (whether or not a lawsuit has been commenced), one half the costs, including attorney fees, settlement award, and other expenses, relating to the matter will be recognized to the extent that the costs are related to resident care and are not covered by insurance.

(3) Costs related to criminal or professional practice matters are not allowable.

(b) Challenges to decisions of the Division - Attorney fees and other expenses incurred by a provider in challenging decisions of the Division will be allowed based on the extent to which the provider prevails as determined on the ratio of total dollars at issue in the case to the total dollars awarded to the provider.

(c) All costs recognized pursuant to this subsection shall be subject to the non-recurring costs provision in subsection 4.3(a)(2) or subsection 6.4.

4.21 Motor Vehicle Allowance

Cost of operation of a motor vehicle necessary to meet the facility needs is an allowable cost. Where the vehicle is used for personal and business purposes, the portion of vehicle costs associated with personal use will not be allowed. If the provider does not document personal use and business use under a pre-approved method, DRS reserves the right to disallow all vehicle costs in question. All costs in excess of the cost of a similar size mid-price vehicle are not allowable.

4.22 Non-Competition Agreement Costs

Amounts paid to the seller of an on-going facility by the purchaser for an agreement not to compete are considered capital expenditures. The amortized costs for such agreements are not allowable.

4.23 Compensation of Owners, Operators, or their Relatives

(a) Facilities which have a full-time (40 hours per week minimum) administrator and/or assistant administrator, will not be allowed compensation for owners, operators, or their relatives who claim to provide some or all of the administrative functions required to operate the facility efficiently except in limited and special circumstances such as those listed in paragraph (b) of this subsection.

(b) The factors to be evaluated by the Division in determining the amount allowable for owner's compensation shall include, but not limited to the following:

(1) All applicable Medicare policies identified in CMS-15.

(2) The unduplicated functions actually performed, as described by the provider on the Medicaid cost report.

(3) The hours actually worked and the number of employees supervised, as reported on the cost report.

(c) For any facility fiscal year, the maximum allowable salary for an owner administrator shall be equal to 110 percent of the average of all reported administrator salaries for Vermont nursing facilities participating in the Medicaid program for that facility fiscal year.

4.24 Management Fees and Home Office Costs

(a) Management fees, home office costs and other costs incurred by a nursing facility for similar services provided by other entities shall be included in the Indirect Cost category. These costs are subject to the provisions for allowable costs, allocation of costs and related party transactions contained in these rules and shall include property and related costs incurred for the management company. These costs are allowable only if such costs would be allowable if a nursing facility provided the services for itself.

(b) Allowable costs shall be limited to five percent of the total net allowable costs less reported management fees, home office, or other costs, as defined in this subsection.

4.25 Membership Dues

Reasonable and necessary membership dues, including any portions used for lobbying

activities, shall be considered Medicaid allowable costs, provided the organization's function and purpose are directly related to providing resident care.

4.26 Post-Retirement Benefits

The allowability of costs of certain benefits which may be available to retired personnel shall be governed by CMS-15, except that all such costs shall be included in fringe benefits and shall be allocated accordingly.

4.27 Public Relations

Costs incurred for services, activities and events that are determined by the Division to be for public relations purposes will not be allowed.

4.28 Related Party

Expenses otherwise allowable shall not be included for purposes of determining a prospective rate where such expenses are paid to a related party unless the provider identifies any such related party and the expenses attributable to it and demonstrates that such expenses do not exceed the lower of the cost to the related party or the price of comparable services, facilities or supplies that could be purchased elsewhere. The Division may request either the provider or the related party, or both, to submit information, books and records relating to such expenses for the purpose of determining their allowability.

4.29 Revenues

Where a facility reports operating and non-operating revenues related to goods or services, the costs to which the revenues correspond are not allowable. If the specific costs cannot be identified, the revenues shall be deducted from the most appropriate costs. If the revenues are more than such costs, the deduction shall be equal to such costs.

4.30 Travel/Entertainment Costs

Only reasonable and necessary costs of meals, lodging, transportation and incidentals incurred for purposes related to resident care will be allowed. All costs determined to be for the pleasure and convenience of the provider or providers' representatives will not be allowed.

4.31 Transportation Costs

(a) Costs of transportation incurred, other than ambulance services for emergency transportation or transportation home from a nursing facility covered as of October 2, 1984 pursuant to the *Medicaid Covered Services Rules*, that are necessary and reasonable for the care of residents are allowable. Such costs shall include depreciation of utility vehicles, mileage reimbursement to employees for the use of their vehicles to provide transportation for residents, and any contractual arrangements for providing such transportation. Such costs shall not be separately billed for individual residents.

(b) Transportation costs related to residents receiving kidney dialysis shall be reported in the Ancillary cost category, pursuant to subsection 6.7(a)(5).

4.32 Services Directly Billable

Allowable costs shall not include the cost of services to individual residents which are ordinarily billable directly to Medicaid irrespective of whether such costs are payable by Medicaid.

5 REIMBURSEMENT STANDARDS

5.1 Prospective Case-Mix Reimbursement System

(a) In general, these rules set out incentives to control costs and Medicaid outlays, while promoting access to services and quality of care.

(b) Case-mix reimbursement takes into account the fact that some residents are more costly to care for than others. Thus the system requires:

(1) the assessment of residents on a form prescribed by the Director of the Division of Licensing and Protection;

(2) a means to classify residents into groups which are similar in costs, known as RUG IV (48 group version) and

(3) a weighting system which quantifies the relative costliness of caring for different classes of residents to determine the average case-mix score.

(c) Per diem rates shall be prospectively determined for the rate year based on the allowable operating costs of a facility in a Base Year, plus property and related and ancillary costs from the most recently settled cost report, calculated as described in Subsection 9.2.

5.2 Retroactive Adjustments to Prospective Rates

(a) In general, a final rate may not be adjusted retroactively.

(b) The Division may retroactively revise a final rate under the following conditions:

(1) as an adjustment pursuant to Sections 8 and 10;

(2) in response to a decision by the Secretary pursuant to Subsection 15.5 or to an order of a court of competent jurisdiction, whether or not that order is the result of a decision on the merits, or as the result of a settlement pursuant to Subsection 15.8;

(3) for mechanical computation or typographical errors;

(4) for a terminating facility or a facility in receivership, pursuant to Subsections 5.10, 8.3, and 10.2;

(5) as a result of revised findings resulting from the reopening of a settled cost report pursuant to Subsection 3.5;

(6) in those cases where a rate includes payment for Ancillary services and the provider subsequently arranges for another Medicaid provider to provide and bill directly for these services;

(7) recovery of overpayments, or other adjustments as required by law or duly promulgated regulation;

(8) when a special rate is revised pursuant to subsection 14.1(e)(2) or

(9) when revisions of final rates are necessary to pass the upper limits test in 42 C.F.R. §447.272.

5.3 Lower of Rate or Charges

(a) At no time shall a facility's Medicaid per diem rate exceed the provider's average customary charges to the general public for nursing facility services in semi-private rooms at the beginning of the calendar quarter. In this subsection, "charges" shall mean the amount actually required to be paid by or on behalf of a resident (other than by Medicaid, Medicare Part A or the Department of Veterans Affairs) and shall take into account any discounts or contractual allowances.

(b) It is the duty of the provider to notify the Division within 10 days of any change in its charges.

(c) Rates limited pursuant to paragraph (a) shall be revised to reflect changes in the provider's average customary charges to the general public effective on the latest of the following:

(1) the first day of the month in which the change to the provider's charges is made if the changes is effective on the first day of the month,

(2) the first day of the quarter after the effective date of the change to the provider's charges if the change to the provider's charges is not effective on the first day of the quarter, or

(3) the first day of the following quarter after the receipt by the Division of notification of the change pursuant to paragraph (b).

5.4 Interim Rates

(a) The Division may set interim rates for any or all facilities. The notice of an interim rate is not a final order of the Division and is not subject to review or appeal pursuant to any provision of these rules or 33 V.S.A. §909.

(b) Any overpayments or underpayments resulting from the difference between the interim and final rates will be either refunded by the provider or paid to the provider.

5.5 Upper Payment Limits

(a) Aggregate payments to nursing facilities pursuant to these rules may not exceed the limits established for such payment in 42 C.F.R. §447.272.

(b) If the Division projects that Medicaid payments to nursing facilities in the aggregate will exceed the Medicare upper limit, the Division shall adopt a rule limiting some or all of the payments to providers to the level that would reduce the aggregate payments to the Medicare upper limit.

5.6 Base Year

(a) A Base Year shall be a calendar year, January through December.

(b) All costs shall be rebased on July 1, 2007. Subsequent rebasing for Nursing Care costs shall occur two years after the last rebase of such costs. All costs shall be rebased no less frequently than every four years.

(c) For the purposes of rebasing, the Director may require individual facilities to file special cost reports covering the calendar year when this is not the facility's fiscal year or the Division may use the facility's fiscal year cost report adjusted by the inflation factors in subsection 5.8 to the Base Year. The Director may require audited financial statements for the special cost reporting period. The costs of preparing the special cost report and audited financial statements are the responsibility of the provider, without special reimbursement; however, for reporting purposes, these costs are allowable.

(d) The determination of a Base Year shall be subject of a notice of practices and procedures pursuant to Subsection 1.8(d) of these rules.

5.7 Occupancy Level

(a) A facility should maintain an annual average level of occupancy at a minimum of 90 percent of the licensed bed capacity.

(b) For facilities with less than 90 percent occupancy, the number of total resident days at 90 percent of licensed capacity shall be used, pursuant to section 7, in determining the per diem rate for all categories except the Nursing Care and Ancillary categories.

(c) The 90 percent minimum occupancy provision in paragraph (b) shall be waived for facilities with 20 or fewer beds or terminating facilities pursuant to Subsection 5.10, and when appropriate, for facilities operating under a receivership pursuant to Subsection 8.3.

(d) Decreasing the Number of Licensed Beds – For any facility that operated at less than 90 percent occupancy during the period used as the cost basis for any rate component subject

to subsection (b) which subsequently reduces the number of licensed beds, the minimum occupancy shall be calculated based on the number of the facility's licensed beds on the first day of the quarter after the facility notifies the Division of such reduction.

5.8 Inflation Factors

The Director shall use the most recent publication of the Health Care Cost Service available June 1 in the calculation of inflation factors, whether for rebase inflation calculations or annual inflation calculations. Different inflation factors are used to adjust different rate components. Subcomponents of each inflation factor are weighted in proportion to the percentage of actual allowable costs incurred by Vermont facilities for specific subcomponents of the relevant cost component. For example, if a cost in the Nursing Care cost component is 83.4 percent attributable to salaries and wages and 16.6 percent attributable to employee benefits, the weights for the two subcomponents of the Nursing Care inflation factor shall be 0.834 and 0.166 respectively. The weights for each inflation factor shall be recalculated no less frequently than each time the relevant cost category is rebased.

(a) The Nursing Care rate component shall be adjusted by an inflation factor that uses two price indexes to account for estimated economic trends with respect to two subcomponents of nursing costs: wages and salaries, and benefits. The price indexes for each subcomponent are the wages and salaries portion of the Health-Care Cost Service NHMB, and the employee benefits portion of the NHMB, respectively. An additional adjustment of one percentage point shall be made for every 12 month period, prorated for fractions thereof, from the midpoint of the base year to the midpoint of the rate year.

(b) The Resident Care Rate Component shall be adjusted by an inflation factor that uses four price indexes to account for estimated economic trends with respect to the subcomponents of Resident Care costs: wages and salaries, employee benefits, utilities, and food and all other Resident care costs. The price indexes for each subcomponent are: the wages and salaries portion of the Health-Care Cost Service NHMB, the employee benefits portion of the NHMB, the utilities portion of the NHMB, and the food portion of the NHMB respectively.

(c) The Indirect rate component shall be adjusted by an inflation factor that uses three price indexes to account for estimated economic trends with respect to three subcomponents of Indirect costs: wages and salaries, employee benefits, and all other indirect costs. The price indexes for each subcomponent are: the wages and salaries portion of the Health-Care Cost Service NHMB, the employee benefits portion of the NHMB and the NECPI-U (all items), respectively.

(d) The Director of Nursing rate component shall be adjusted by an inflation factor that uses two price indexes to account for estimated economic trends with respect to two subcomponents of Director of Nursing costs: wages and salaries and employee benefits. The price indexes for each subcomponent are: the wages and salaries portion of the Health-Care Cost Service NHMB, and the employee benefits portion of the NHMB, respectively.

(e) Pursuant to Subsection 1.8(d), the Division shall issue a description of the practices and procedures used to calculate and apply the Inflation Factors.

5.9 Costs for New Facilities

(a) For facilities that are newly constructed, newly operated as nursing facilities, or new to the Medicaid program, the prospective case-mix rate shall be determined based on budget cost reports submitted to the Division and the greater of the estimated resident days for the rate year or the resident days equal to 90 percent occupancy of all beds used or

intended to be used for resident care at any time within the budget cost reporting period. This rate shall remain in effect no longer than one year from the effective date of the new rate. The principles on allowability of costs and existing limits in Sections 4 and 7 shall apply.

(b) The costs reported in the budget cost report shall not exceed reasonable budget projections (adjusted for inflation and changes in interest rates as necessary) submitted in connection with the Certificate of Need.

(c) Property and related costs included in the rate shall be consistent with the property and related costs in the approved Certificate of Need.

(d) At the end of the first year of operation, the prospective case-mix rate shall be revised based on the provider's actual allowable costs as reported in its annual cost report filed pursuant to subsection 3.2 for its first full fiscal year of operation.

5.10 Costs for Terminating Facilities

(a) When a nursing facility plans to discontinue all or part of its operation, the Division may adjust its rate so as to ensure the protection of the residents of the facility.

(b) A facility applying for an adjustment to its rate pursuant to this subsection must have a transfer plan approved by the Department of Disabilities, Aging and Independent Living, a copy of which shall be supplied to the Division.

(c) An application under this subsection shall be made on a form prescribed by the Director and shall be accompanied by a financial plan demonstrating how the provider will meet its obligations set out in the approved transfer plan.

(d) In approving such an application the Division may waive the minimum occupancy requirements in Subsection 5.7, the limitations on costs in Section 7, or make such other reasonable adjustments to the facility's reimbursement rate as shall be appropriate in the circumstances. The adjustments made under this subsection shall remain in effect for a period not to exceed six months.

6 BASE YEAR COST CATEGORIES FOR NURSING FACILITIES

6.1 General

In the case-mix system of reimbursement, allowable costs are grouped into cost categories. The accounts to be used for each cost category shall be prescribed by the Director. The Base Year costs shall be grouped into the following cost categories:

6.2 Nursing Care Costs

(a) Allowable costs for the Nursing Care component of the rate shall include actual costs of licensed personnel providing direct resident care, which are required to meet federal and state laws as follows:

(1) registered nurses,
(2) licensed practical nurses,
(3) certified or licensed nurse aides, including wages related to initial and on-going nurse aide training as required by OBRA,
(4) contract nursing,
(5) the MDS coordinator,
(6) fringe benefits, including child day care.

(b) Costs of bedmakers, geriatric aides, transportation aides, paid feeding/dining assistants, ward clerks, medical records librarians and other unlicensed staff will not be considered nursing costs. The salary and related benefits of the position of Director of Nursing shall be excluded from the calculation of allowable nursing costs and shall be reimbursed separately.

6.3 Resident Care Costs

Allowable costs for the Resident Care component of the rate shall include reasonable costs associated with expenses related to direct care. The following are Resident Care costs:

(a) food, vitamins and food supplements,
(b) utilities, including heat, electricity, sewer and water, garbage and liquid propane gas,
(c) activities personnel, including recreational therapy and direct activity supplies,
(d) Medical Director, Pharmacy Consultant, Geriatric Consultant, and Psychological/psychiatric Consultant,
(e) counseling personnel, chaplains, art therapists and volunteer stipends,
(f) social service worker,
(g) employee physicals,
(h) wages for paid feeding/dining assistants only for those hours that they are actually engaged in assisting residents with eating,
(i) fringe benefits, including child day care,
(j) such other items as the Director may prescribe by a practice and procedure issued pursuant to subsection 1.8(d).

6.4 Indirect Costs

(a) Allowable costs for the indirect component of the rate shall include costs reported in the following functional cost centers on the facility's cost report, including those extracted from a facility's cost report or the cost report of an affiliated hospital or institution.

(1) fiscal services,
(2) administrative services and professional fees,
(3) plant operation and maintenance,
(4) grounds,
(5) security,
(6) laundry and linen,
(7) housekeeping,
(8) medical records,
(9) cafeteria,
(10) seminars, conferences and other in-service training (except tuition for college credit in a discipline related to the individual staff member's employment or costs of obtaining a GED which shall be treated as fringe benefits),
(11) dietary excluding food,
(12) motor vehicle,
(13) clerical, including ward clerks,
(14) transportation (excluding depreciation),
(15) insurances (director and officer liability, comprehensive liability, bond indemnity, malpractice, premise liability, motor vehicle, and any other costs of insurance incurred or required in the care of residents that has not been specifically addressed elsewhere),
(16) office supplies/telephone,
(17) conventions and meetings,
(18) EDP bookkeeping/payroll,
(19) fringe benefits including child day care.

(b) All expenses not specified for inclusion in another cost category pursuant to these rules shall be included in the Indirect Costs category, unless the Director at her/his discretion specifies otherwise in the instructions to the cost report, the chart of accounts, or by the issuance of a practice and procedure. For nursing facility rate setting, the costs of prescription drugs are not allowable.

6.5 Director of Nursing

Allowable costs associated with the position of Director of Nursing shall include reasonable salary for one position and associated fringe benefits, including child day care.

6.6 Property and Related

(a) The following are Property and Related costs:

(1) depreciation on buildings and fixed equipment, major movable equipment, minor equipment, computers, motor

vehicle, land improvements, and amortization of leasehold improvements and capital leases,
(2) interest on capital indebtedness,
(3) real estate leases and rents,
(4) real estate/property taxes,
(5) all equipment irrespective of whether it is capitalized, expensed, or rented,
(6) fire and casualty insurance,
(7) amortization of mortgage acquisition costs.

(b) For a change in services, facility, or a new health care project with projected property and related costs of $250,000 or more, providers shall give written notice to the Division no less than 60 days before the commencement of the project. Such notice shall include a detailed description of the project and detailed estimates of the costs.

6.7 Ancillaries

(a) The following are ancillary costs:

(1) All physical, speech, occupational, respiratory, and IV therapy services and therapy supplies (excluding oxygen) shall be considered ancillaries. Medicaid allowable costs shall be based on the cost-to-charge ratio for these services. These therapy services shall not be allowable for Medicaid reimbursement pursuant to this subsection unless:

(i) the services are provided pursuant to a physician's order,

(ii) the services are provided by a licensed therapist or other State certified or registered therapy assistant, or qualified IV professional, or other therapy aides,

(iii) the services are not reimbursable by the Medicare program, and

(iv) the provider records charges by payor class for all units of these services.

(2) Medical supplies, whether or not the provider customarily records charges.

(i) Medical supplies shall include, but are not limited to: oxygen, disposable catheters, catheters, colostomy bags, drainage equipment, trays and tubing.

(ii) Medical supplies shall not include rented or purchased equipment, with the exception of rented or purchased oxygen concentrators, which shall be included in medical supplies.

(3) Over-the-counter drugs. All drug costs will be disallowed for providers commingling the costs of prescription drugs (which are not allowable) and over-the-counter drugs.

(4) Incontinent Supplies and Personal Care Items: including adult diapers, chux and other disposable pads, personal care items, such as toothpaste, shampoo, body powder, combs, brushes, etc.

(5) Dialysis Transportation. The costs of transportation for Medicaid residents receiving kidney dialysis shall be included in the ancillary cost category. Allowable costs may include contract or other costs, but shall not include employee salaries or wages or cost associated with the use of provider-owned vehicles.

(6) Overhead costs related to ancillary services and supplies are included in ancillary costs.

(b) [Repealed]

7 CALCULATION OF COSTS, LIMITS AND RATE COMPONENTS FOR NURSING FACILITIES

Base year costs, rates, and category limits are calculated pursuant to this section. The Medicaid per diem payment rate for each facility is calculated pursuant to Section 9.

7.1 Calculation of Per Diem Costs

Per diem costs for each cost category, excluding the Nursing Care and Ancillary

cost categories, are calculated by dividing allowable costs for each case-mix category by the greater of actual bed days of service rendered, including revenue generating hold/reserve days, or the number of resident days computed using the minimum occupancy at 90 percent of the licensed bed capacity during the cost period under review calculated pursuant to subsection 5.7.

7.2 Nursing Care Component

(a) Case-Mix Weights.

There are 48 case-mix resident classes. Each case-mix class has a specific case-mix weight as follows:

Group Code	Case-Mix Weight	Description
ES3	3.00	Extensive Services
ES2	2.23	Extensive Services
ES1	2.22	Extensive Services
RAE	1.65	Rehabilitation
RAD	1.58	Rehabilitation
RAC	1.36	Rehabilitation
RAB	1.10	Rehabilitation
RAA	0.82	Rehabilitation
HE2	1.88	Special Care High
HE1	1.47	Special Care High
HD2	1.69	Special Care High
HD1	1.33	Special Care High
HC2	1.57	Special Care High
HC1	1.23	Special Care High
HB2	1.55	Special Care High
HB1	1.22	Special Care High
LE2	1.61	Special Care Low
LE1	1.26	Special Care Low
LD2	1.54	Special Care Low
LD1	1.21	Special Care Low
LC2	1.30	Special Care Low
LC1	1.02	Special Care Low
LB2	1.21	Special Care Low
LB1	0.95	Special Care Low
CE2	1.39	Clinically Complex
CE1	1.25	Clinically Complex
CD2	1.29	Clinically Complex
CD1	1.15	Clinically Complex
CC2	1.08	Clinically Complex
CC1	0.96	Clinically Complex
CB2	0.95	Clinically Complex
CB1	0.85	Clinically Complex
CA2	0.73	Clinically Complex
CA1	0.65	Clinically Complex
BB2	0.81	Behavioral Symptoms Plus Cognitive Performance
BB1	0.75	Behavioral Symptoms Plus Cognitive Performance
BA2	0.58	Behavioral Symptoms Plus Cognitive Performance
BA1	0.53	Behavioral Symptoms Plus Cognitive Performance
PE2	1.25	Reduced Physical Function
PE1	1.17	Reduced Physical Function
PD2	1.15	Reduced Physical Function
PD1	1.06	Reduced Physical Function
PC2	0.91	Reduced Physical Function
PC1	0.85	Reduced Physical Function
PB2	0.70	Reduced Physical Function
PB1	0.65	Reduced Physical Function
PA2	0.49	Reduced Physical Function
PA1	0.45	Reduced Physical Function

(b) Average case-mix score

The Department of Disabilities, Aging and Independent Living's Division of Licensing and Protection shall compute each facility's average case-mix score.

(1) The Division of Licensing and Protection shall periodically, but no less frequently than quarterly, certify to the Division of Rate Setting the average case-mix score for those residents of each facility whose room and board (excluding resident share) is paid for solely by the Medicaid program.

(2) For the Base Year, the Division of Licensing and Protection shall certify the average case-mix score for all residents.

(c) Nursing Care cost per case-mix point.

Each facility's Nursing Care cost per case-mix point will be calculated as follows:

(1) Using each facility's Base Year cost report, the total allowable Nursing Care costs shall be determined in accordance with Subsection 6.2.

(2) Each facility's Standardized Resident Days shall be computed by multiplying total Base Year resident days by that facility's average case-mix score for all residents for the four quarters of the cost reporting period under review.

(3) The per diem nursing care cost per case-mix point shall be computed by dividing total Nursing Care costs by the Base Year Standardized Resident Days for that Base Year.

(d) Per diem limits on the Base Year allowable Nursing Care rate per case-mix point:

(1) The Division shall array all nursing care facilities' allowable Base Year per diem Nursing Care costs per case-mix point, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high. These costs shall be limited to the cost at the ninetieth percentile, calculated using the percentile spreadsheet function.

(2) Each facility's Base Year Nursing Care rate per case-mix point shall be the lesser of the limit in subparagraph (1) or the facility's allowable Nursing Care cost per case-mix point.

7.3 Resident Care Base Year Rate

Resident Care Base Year rates shall be computed as follows:

(a) Using each facility's Base Year cost report, the provider's Base Year total allowable Resident Care costs shall be determined in accordance with Subsection 6.3.

(b) The Base Year per diem allowable Resident Care costs for each facility shall be calculated by dividing the Base Year total allowable Resident Care costs by total Base Year resident days.

(c) The Division shall array all nursing facilities' Base Year per diem allowable Resident Care costs, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high and identify the median.

(d) The per diem limit shall be the median plus five percent.

(e) Each facility's Base Year Resident Care per diem rate shall be the lesser of the limit set in paragraph (d) or the facility's Base Year per diem allowable Resident Care costs.

7.4 Indirect Base Year Rate

Indirect Base Year rates shall be computed as follows:

(a) Using each facility's Base Year cost report, each provider's Base Year total allowable Indirect costs shall be determined in accordance with Subsection 6.4.

(b) The Base Year per diem allowable Indirect costs for each facility shall be calculated by dividing the Base Year total allowable Indirect costs by total Base Year resident days.

(c) The Division shall array all nursing facilities' Base Year per diem allowable Indirect costs, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high and identify the median.

(d) The per diem limit shall be set as follows:

(1) For special hospital-based nursing facilities, the limit shall be 137 percent of the median.

(2) For all other privately-owned nursing facilities, the limit shall be the median plus five percent.

(e) Each provider's Base Year Indirect per diem rate shall be the lesser of the limit in paragraph (d) or the facility's Base Year per diem allowable Indirect costs.

7.5 Director of Nursing Base Year Rate

The Director of Nursing Base Year per diem rates shall be computed as follows:

(a) Using each facility's Base Year cost report, total allowable Base Year Director of Nursing costs shall be determined in accordance with Subsection 6.5.

(b) Each facility's Base Year per diem allowable Director of Nursing costs shall be calculated by dividing the Base Year total allowable Director of Nursing costs by total Base Year resident days.

(c) The Director of Nursing per diem rate shall be the facility's Base Year per diem allowable Director of Nursing costs calculated pursuant to this subsection.

7.6 Ancillary Services Rate

(a) The Ancillary per diem rate shall be computed as follows:

(1) Medicaid Ancillary costs shall be determined in accordance with subsection 6.7.

(2) Using each facility's most recently settled cost report, the per diem Ancillary rate shall be the sum of the following per diem costs calculated as follows:

(i) Costs for therapy services per diem, including IV therapy, shall be calculated by dividing allowable Medicaid costs by the number of related Medicaid resident days less Medicaid hold days.

(ii) Dialysis transportation costs per diem shall be calculated by dividing the allowable costs for Vermont Medicaid residents by the number of Vermont Medicaid resident days less Vermont Medicaid hold days.

(iii) Costs for medical supplies, over-the-counter drugs, and incontinent supplies and personal care items per diem shall be calculated by dividing allowable costs, by total resident days less hold days.

(b) Any change to the Ancillary per diem rate shall be implemented at the time of the first quarterly case-mix rate recalculation after the cost report is settled.

7.7 Property and Related Per Diem

The Property and Related per diem rate shall be computed as follows:

(a) Using each facility's most recently settled annual cost report, total allowable Property and Related costs shall be determined in accordance with Subsection 6.6.

(b) Using each facility's most recently settled cost report, the per diem property and related costs shall be calculated by dividing allowable property and related costs by total resident days. Any change to the property and related per diem rate shall be implemented at the time of the first quarterly case-mix rate recalculation after the cost report is settled.

7.8 Limits Final

Once a final order has been issued for all facilities' Base Year cost reports, notwithstanding any subsequent changes to the cost report findings, resulting from a reopening, appeal, or other reason, the limits set pursuant to subsections 7.2(d)(2), 7.3(d), and 7.4(d) will not change until nursing home costs are rebased pursuant to 5.6(b),

except for annual adjustment by the inflation factors or a change in law necessitating such a change.

8 ADJUSTMENTS TO RATES

8.1 Change in Services

The Division, on application by a provider, may make an adjustment to the prospective case-mix rate for additional costs which are directly related to:

(a) a new health care project previously approved under the provisions of 18 V.S.A. §9434. Costs greater than those approved in the Certificate of Need (as adjusted for inflation) will not be considered when calculating such an adjustment,

(b) a change in services, facility, or new health care project not covered under the provisions of 18 V.S.A. §9434, if such a change has previously been approved by the Division, or

(c) with the prior approval of the Division, a reduction in the number of licensed beds.

8.2 Change in Law

The Division may make or a provider may apply for an adjustment to a facility's prospective case-mix rate for additional costs that are a necessary result of complying with changes in applicable federal and state laws, and regulations, or the orders of a State agency that specifically requires an increase in staff or other expenditures.

8.3 Facilities in Receivership

(a) The Division, on application by a receiver appointed pursuant to state or federal law, may make an adjustment to the prospective case-mix rate of a facility in receivership for the reasonable and necessary additional costs to the facility incurred during the receivership.

(b) On the termination of the receivership, the Division shall recalculate the prospective case-mix rate to eliminate this adjustment.

8.4 Efficiency Measures

The Division, on application by a provider, may make an adjustment to a prospective case-mix rate for additional costs which are directly related to the installation of energy conservation devices or the implementation of other efficiency measures, if they have been previously approved by the Division.

8.5 Interest Rates

(a) A provider may apply for an adjustment to the Property and Related rate, or the Division may initiate an adjustment if there are cumulative interest rate increases or decreases of more than one-half of one percentage point because of existing financing agreements with a balloon payment or a refinancing clause that forces a mortgage to be refinanced at a different interest rate, or because of a variable rate of adjustable rate mortgages.

(b) A provider with an interest rate adjustment shall notify the Division of any change in the interest rate within 10 days of its receipt of notice of that change. The Division may rescind all interest rate adjustments of any facility failing to file a timely notification pursuant to this subsection for a period of up to two years.

8.6 Emergencies and Unforeseeable Circumstances

(a) The Division, on application by a provider, may make an adjustment to the prospective case-mix rate under emergencies and unforeseeable circumstances, such as damage from fire or flood.

(b) Providers must carry sufficient insurance to address adequately such circumstances.

8.7 Procedures and Requirements for Rate Adjustments

(a) Application for a rate adjustment pursuant to this section should be made as follows. Approval of any application for a rate adjustment under this section is at the sole discretion of the Director.

(b) Except for applications made pursuant to subsection 4.11, no application for a rate adjustment should be made if the change to the rate would be smaller than one percent of the rate in effect at the time.

(c) Application for a Rate Adjustment shall be made on a form prescribed by the Director and filed with the Division and shall be accompanied by all documents and proofs determined necessary for the Division to make a decision.

(d) The burden of proof is at all times on the provider to show that the costs for which the adjustment has been requested are reasonable, necessary and related to resident care.

(e) The Division may grant or deny the Application, or make an adjustment modifying the provider's proposal. If the materials filed by the provider are inadequate to serve as a basis for a reasonable decision, the Division shall deny the Application, unless additional proofs are submitted.

(f) The Division shall not be bound in considering other Applications, or in determining the allowability of reported costs, by any prior decision made on any Application under this section. Such decisions shall have no precedential value either for the applicant facility or for any other facility. Principles and decisions of general applicability shall be issued as a Division practice or procedure, pursuant to Section 1.8(d).

(g) For adjustments requiring prior approval of the Division, such approval should be sought before the provider makes any commitment to expenditures. An Application for Prior Approval is subject to the same requirements as an Application for a Rate Adjustment under this section.

(h) Rate adjustments made under this section shall be effective from the first day of the quarter following the date of the final order on the application or following the date the assets are actually put into service, whichever is the later, and may be continued, at the discretion of the Division, notwithstanding a general rebase of costs. Costs which are the basis for a continuing rate adjustment shall not be included in the cost categories used as the basis for the other rate components.

(i) The Division may require an applicant for a rate adjustment under this section or under subsection 4.11 to file a budget cost report in support of its application.

(j) When determined to be appropriate by the Division, a budget rate may be set for the facility according to the procedures in and subject to the provisions of subsection 5.9. Appropriate cases may include, but are not limited to, changes in the number of beds, an addition to the facility, or the replacement of existing property.

(k) In calculating an adjustment under this section and subsection 4.11, the Division may take into account the effect of such changes on all the cost categories of the facility.

(l) A revision may be made prospectively to a rate adjustment under this section and subsection 4.11 based on a "look-back" which will be computed based on a provider's actual allowable costs.

(m) In this subsection "additional costs" means the incremental costs of providing resident care directly and proximately caused by one of the events listed in this section or subsection 4.11. Increases in costs resulting from other causes will not be recognized. It is not intended that this section be used to effect a general rebase in a facility's costs.

8.8 Limitation on Availability of Rate Adjustments

Providers may not apply for a rate adjustment under this section for the sole reason that actual costs incurred by the facility exceed the rate of payment.

9 PRIVATE NURSING FACILITY AND STATE NURSING FACILITY RATES

The Medicaid per diem payment rates for nursing home services are calculated according to this section as follows:

9.1 Nursing Facility Rate Components

The per diem rate of reimbursement consists of the following rate components:

(a) Nursing Care
(b) Resident Care
(c) Indirect
(d) Director of Nursing
(e) Property and Related
(f) Ancillaries
(g) Adjustments (if any)

9.2 Calculation of the Total Rate

The total per diem rate in effect for any nursing facility shall be the sum of the rates calculated for the components listed in Subsection 9.1, adjusted in accordance with the Inflation Factors, as described in Subsection 5.8.

9.3 Updating Rates for a Change in the Average Case-Mix Score

(a) The Nursing Care rate component shall be updated quarterly, on the first day of January, April, July and October, for changes in the average case-mix score of the facility's Medicaid residents.

(b) The Nursing Care rate component and any part of a Section 8 adjustment that reimburses nursing costs are updated for a change in the average case-mix score for the facility's Medicaid residents. The update is calculated as follows:

(1) The Nursing Care rate component (or rate adjustment) in the current rate of reimbursement for a facility is divided by the average case-mix score used to determine the current Nursing Care rate component. This quotient is the current Nursing Care rate per case-mix point.

(2) The current Nursing Care rate component (or rate adjustment) per case-mix point is multiplied by the new average case-mix score. This product is the new Nursing Care rate component (or rate adjustment).

9.4 State Nursing Facilities

(a) Notwithstanding any other provisions of these rules, payment rates for state nursing facilities shall be determined retrospectively by the Division based on the reasonable and necessary costs of providing those services as determined using the cost reporting and cost finding principles set out in sections 3 and 4 of these rules.

(b) Until such time as the cost report is settled, the Division shall set an interim rate based on an estimate of the facility's costs and census for the rate year.

(c) After reviewing the facility's cost report, the Division shall set a final rate for the fiscal year based on the facility's allowable costs. If there has been an under payment for the period the difference shall be paid to the facility. If there has been an overpayment the excess payments shall be recouped.

(d) At no time shall the final rates paid to State nursing facilities exceed the upper limits established in 42 C.F.R. §447.272.

9.5 Quality Incentives

Certain awards shall be made annually to facilities that provide a superior quality of care in an efficient and effective manner.

(a) These payments will be based on:

(1) objective standards of quality, which shall include resident satisfaction surveys, to be determined by the Department of Disabilities, Aging and Independent Living, and

(2) objective standards of cost efficiency determined by the Division.

(b) Supplemental payments will not be available under this subsection for any facility that does not participate in the statewide resident satisfaction survey program.

(c) Supplemental payments shall be expended by the provider to enhance the quality of care provided to Medicaid eligible residents. In determining the nature of these expenditures, the provider shall consult with the facility's Resident Council.

(d) The amount and method of distribution of the quality incentive payments shall be as follows:

(1) The quality incentive payments shall be made from a pool. The annual size of the pool shall be based on the amount of $25,000 times the number of facilities meeting the award criteria, up to a maximum of five.

(2) The pool shall be distributed among the qualifying facilities, awarding each qualifying facility a share of the pool based on the ratio of its Medicaid days to the total Medicaid days for all the qualifying facilities.

(e) Award Criteria

The following criteria will be applied to facility data up to March 31 each year to determine eligibility for the award to be presented in May. In order to be eligible for the award, a facility must participate in the Vermont Medicaid program and meet all of the following criteria. All eligible facilities will be ranked according to their quality of care by the Department of Disabilities, Aging and Independent Living based on these basic quality criteria. The five facilities with the highest quality of care will receive an award. If, based on the basic criteria, there are ties which would cause more than five facilities to be equally qualified, the tied facilities will be ranked according to the efficiency criteria set out below in paragraph (6), to determine those facilities that will receive an award.

(1) The most recent health survey report resulted in a score of five or less, no deficiency with a scope and severity greater than "D" level, with no more than two "D" level deficiencies in the general categories of Quality of Care, Quality of Life, or Resident Rights.

(2) No substantiated complaints since the most recent survey and prior full health survey related to quality of care, quality of life, or residents' rights.

(3) Participation in Advancing Excellence in America's Nursing Homes campaign.

(4) Resident satisfaction survey results above the statewide average.

(5) Fire Safety deficiency score of 5 or less with scope and severity less than "E" in the most recent full survey.

(6) The efficiency rankings shall be based upon the allowable costs per day from each facility's most recently settled Medicaid cost report. Cost per day will be calculated using actual resident days for the same fiscal period.

10 EXTRAORDINARY FINANCIAL RELIEF

10.1 Objective

In order to protect Medicaid recipients from the closing of a nursing facility in which they reside, this section establishes a process by which nursing homes that are in immediate

danger of failure may seek extraordinary financial relief. This process does not create any entitlement to rates in excess of those required by 33 V.S.A. Chapter 9 or to any other form of relief.

10.2 Nature of the Relief

(a) Based on the individual circumstances of each case, the Director may recommend any of the following on such financial, managerial, quality, operational or other conditions as she or he shall find appropriate: a rate adjustment, an advance of Medicaid payments, other relief appropriate to the circumstances of the applicant, or no relief.

(b) The Director's Recommendation shall be in writing and shall state the reasons for the Recommendation. The Recommendation shall be a public record.

(c) The Recommendation shall be reviewed by the Secretary who shall make a Final Decision, which shall not be subject to administrative or judicial review.

(d) In those cases where the Division determines that financial relief may be appropriate, such relief may be implemented on an interim basis pending a Final Decision by the Secretary. The interim financial relief shall be taken into account in the Division's Recommendation to the Secretary and in the Secretary's Final Decision.

10.3 Criteria to be Considered by the Division

(a) Before a provider may apply for extraordinary financial relief, its financial condition must be such that there is a substantial likelihood that it will be unable to continue in existence in the immediate future.

(b) The following factors will be considered by the Director in making the Recommendation to the Secretary:

(1) the likelihood of the facility's closing without financial assistance,

(2) the inability of the applicant to pay bona fide debts,

(3) the potential availability of funds from related parties, parent corporations, or any other source,

(4) the ability to borrow funds on reasonable terms,

(5) the existence of payments or transfers for less than adequate consideration,

(6) the extent to which the applicant's financial distress is beyond the applicant's control,

(7) the extent to which the applicant can demonstrate that assistance would prevent, not merely postpone the closing of the facility,

(8) the extent to which the applicant's financial distress has been caused by a related party or organization,

(9) the quality of care provided at the facility,

(10) the continuing need for the facility's beds,

(11) the age and condition of the facility,

(12) other factors found by the Director to be material to the particular circumstances of the facility, and

(13) the ratio of individuals receiving care in a nursing facility to individuals receiving home- and community-based services in the county in which the facility is located.

10.4 Procedure for Application

(a) An Application for Extraordinary Financial Relief shall be filed with the

Division according to procedures to be prescribed by the Director.

(b) The Application shall be in writing and shall be accompanied by such documentation and proofs as the Director may prescribe. The burden of proof is at all times on the provider. If the materials filed by the provider are inadequate to serve as a basis for a reasoned recommendation, the Division shall deny the Application, unless additional proofs are submitted.

(c) The Secretary shall not be bound in considering other Applications by any prior decision made on any Application under this section. Such decisions shall have no precedential value either for the applicant facility or for any other facility.

11 PAYMENT FOR OUT-OF-STATE PROVIDERS

11.1 Long-Term Care Facilities Other Than Rehabilitation Centers

Payment for services, other than Rehabilitation Center services, provided to Vermont Medicaid residents in long-term care facilities in another state shall be at the per diem rate established for Medicaid payment by the appropriate agency in that state. Payment of the per diem rate shall constitute full and final payment, and no retroactive settlements will be made.

11.2 Rehabilitation Centers

(a) Payment for prior-authorized Rehabilitation Center services provided in nursing facilities located outside Vermont for the severely disabled, such as head injured or ventilator dependent people, will be made at the lowest of:

(1) the amount charged; or

(2) the Medicaid rate, including ancillaries as paid by at least one other state agency in CMS Region I.

(b) Payment for Rehabilitation Center services which have not been prior authorized by the Commissioner of the Department of Vermont Health Access or a designee will be made according to Subsection 11.1.

11.3 Pediatric Care

No Medicaid payments will be made for services provided to Vermont pediatric residents in out-of-state long-term care facilities without the prior authorization of the Commissioner of the Department of Vermont Health Access.

12 RATES FOR ICF/MRS

12.1 Reasonable Cost Reimbursement

Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are paid according to Medicaid principles of reimbursement, pursuant to the *Regulations Governing the Operation of Intermediate Care Facilities for the Mentally Retarded* adopted by the Agency.

12.2 Application of these Rules to ICF/MRS

The Division's Accounting Requirements (Section 2) and Financial Reporting (Section 3) shall apply to this program.

13 RATES FOR SWING BEDS AND OTHER LONG-TERM CARE SERVICES IN HOSPITALS

Payment for swing-bed and other long-term care services provided by hospitals, pursuant to 42 U.S.C. §1396l(a), shall be made at a rate equal to the average rate per diem during the previous calendar year under the State Plan to nursing facilities located in the State of Vermont. Supplemental payments made pursuant to section 14 and subsection 9.5 shall not be included in the calculation of swing-bed rates.

14 SPECIAL RATES FOR CERTAIN INDIVIDUAL RESIDENTS

14.1 Availability of Special Rates for Individuals with Unique Physical Conditions

(a) In rare and exceptional circumstances, a special rate shall be available for the care of an individual eligible for the Vermont Medicaid program whose unique physical conditions makes it otherwise extremely difficult to obtain appropriate long-term care.

(b) A special rate under this subsection is available subject to the conditions set out below.

(c) Required Findings. Before a rate is payable under this section:

(1) the Commissioner of the Department of Vermont Health Access, in consultation with the Department's Medical Director, and the Director of Licensing and Protection, must make a written finding that the individual's care needs meet the requirements of this section and that the proposed placement is appropriate for that individual's needs; and

(2) the Division of Rate Setting, in consultation with the Commissioner of the Department of Vermont Health Access and the Commissioner of the Department of Disabilities, Aging and Independent Living, must determine that the special rate, calculated pursuant to paragraph (e) of this subsection, is reasonable for the services provided.

(d) Plan of Care:

(1) Before an individual can be placed with any facility and a rate established, pursuant to this subsection, a plan of care for that person must be approved by the Director of Licensing and Protection and the Medical Director of the Department of Vermont Health Access.

(2) The facility shall submit the resident's assessment and plan of care for review by the Director of Licensing and Protection and the Medical Director of the Department of Vermont Health Access whenever there is a significant change in the resident's condition, but in no case less frequently than every six months. This review shall form the basis for a determination that the payment of the special rate should be continued or revised pursuant to 14.1(e)(2).

(e) Calculation of the Special Rate:

(1) A per diem rate shall be set by the Division based on the budgeted allowable costs for the individual's plan of care. The rate shall be exempt from the limits in section 7 of these rules.

(2) From time to time the special rate may be revised to reflect significant changes in the resident's assessment, care plan, and costs of providing care. The Division may adjust the special rate retroactively based on the actual allowable costs of providing care to the resident.

(3) Special rates set under this section shall not affect the facility's normal per diem rate. The case-mix weight of any resident on whose behalf a special rate is paid shall not be included in the calculation of the facility's average case-mix score pursuant to subsection 7.2(b), but the days of care shall be included in the facility's Medicaid days and total resident days. The provider shall track the total costs of providing care to the resident and shall self-disallow the incremental cost of such care on cost reports covering the period during which the facility receives Medicaid payments for services to the resident.

14.2 Special Rates for Certain Former Patients of the Vermont State Hospital

(a) A special rate is available for nursing home services to patients transferred directly from the Vermont State Hospital or to such other similarly situated individuals as the

Commissioner of Mental Health shall approve. The rate shall be prospective and shall be set before admission of the individual to the facility.

(1) The special rate payable for each individual shall consist of the current per diem rate for the receiving facility as calculated pursuant to Sections 5 to 9 of these rules and a monthly supplemental incentive payment. Three levels of supplemental payments are available for the care of residents meeting the eligibility criteria in this subsection based on the severity of the resident's condition and the resources needed to provide care.

(2) The supplemental payment will continue to be paid as long as the criteria in paragraph (c) are satisfied.

(b) To be eligible for a special rate, the receiving facility must have in place a plan of care developed in conjunction with and approved by the Commissioner of Mental Health and the Division of Licensing and Protection.

(c) Criteria for continuation of supplemental payments:

(i) The transferred person continues to reside at the receiving facility.

(ii) The facility documents to the satisfaction of the Division of Licensing and Protection that the transferred person continues to present significant behavior management problems by exhibiting behaviors that are significantly more challenging than those of the general nursing facility population.

(d) Any advance payments for days during which the transferred person is not resident or ceases to be eligible for the special transitional rate will be treated as overpayments and subject to refund by deductions from the provider's Medicaid payments.

14.3 Special Rates for Medicaid Eligible Furloughees of the Department of Corrections

A special rate equal to 150 percent of a nursing facility's ordinary Medicaid rate shall be paid for care provided to Medicaid eligible furloughees of the Department of Corrections.

15 ADMINISTRATIVE REVIEW AND APPEALS

15.1 Draft Findings and Decisions

(a) Before issuing findings on any Desk Review, Audit of a Cost Report, or decision on any application for a rate adjustment, the Division shall serve a draft of such findings or decision on the affected provider. If the Division makes no adjustment to a facility's reported costs or application for a rate adjustment, the Division's findings shall be final and shall not be subject to appeal under this section.

(b) The provider shall review the draft upon receipt. If it desires to review the Division's work papers, it shall file, within 10 days, a written Request for Work Papers on a form prescribed by the Director.

15.2 Request for an Informal Conference on Draft Findings and Decisions

(a) Within 15 days of receipt of either the draft findings or decision or requested work papers, whichever is the later, a provider that is dissatisfied with the draft findings or decision issued pursuant to Subsection 15.1(a) may file a written Request for an Informal Conference with the Division's staff on a form prescribed by the Director.

(b) Within 10 days of the receipt of the Request, the Division shall contact the provider to arrange a mutually convenient time for the informal conference, which shall be held within 45 days of the receipt of the Request at the Division. The informal conference may be held by telephone. At the

conference, if necessary, a date certain shall be fixed by which the provider may file written submissions or other additional necessary information. Within 20 days thereafter, the Division shall issue its official agency action.

(c) A Request for an Informal Conference must be pursued before a Request for Reconsideration can be filed pursuant to Subsection 15.3. Issues not raised in the Request for Informal Conference shall not be raised at the informal conference or in any subsequent proceeding arising from the same action of the Division, including appeals pursuant to 33 V.S.A. §909.

(d) Should no timely Request for an Informal Conference be filed within the time period specified in Subsection 15.2(a), the Division's draft findings and/or decision are final and no longer subject to administrative review or judicial appeal.

15.3 Request for Reconsideration

(a) A provider that is aggrieved by an official action issued pursuant to Subsection 15.2(b) may file a Request for Reconsideration.

(b) A Request for Reconsideration must be pursued before an appeal can be taken pursuant to 33 V.S.A. 909(a).

(c) The Request for Reconsideration must be in writing, on a form prescribed by the Director, and filed within 30 days of the provider's receipt of the official action.
(d) Within 10 days of the filing of a Request for Reconsideration, the provider must file the following:

(1) A request for a hearing, if desired;

(2) A clear statement of the alleged errors in the Division's action and of the remedy requested including: a description of the facts on which the Request is based, a memorandum stating the support for the requested relief in this rule, CMS-15, or other authority for the requested relief and the rationale for the requested remedy; and

(3) If no hearing is requested, evidence necessary to bear the provider's burden of proof, including, if applicable, a proposed revision of the Division's calculations, with supporting work papers.

(e) Issues not raised in the Request for Reconsideration shall not be raised later in this proceeding or in any subsequent proceeding arising from the same action of the Division, including appeals pursuant to 33 V.S.A. §909.

(f) If a hearing is requested, within 10 days of the receipt of the Request for Reconsideration, the Division shall contact the provider to arrange a mutually agreeable time.

(g) The hearing shall be conducted by the Director or her or his designee. The testimony shall be under oath and shall be recorded either stenographically or on tape. If the provider so requests, the Division staff involved in the official action appealed shall appear and testify. The Director, or her or his designee, may hold the record open to a date certain for the receipt of additional materials.

(h) The Director shall issue a Final Order on Request for Reconsideration no later than 30 days after the record closes. Pending the issuance of a final order, the official action issued pursuant to subsection 15.2(b) shall be used as the basis for setting an interim rate from the first day of the calendar quarter following its issuance. Final orders shall be effective from the effective date of the official action.

(i) Proceedings under this section are not subject to the requirements of 3 V.S.A. Chapter 25.

15.4 Appeals from Final Orders of the Division

(a) Within 30 days of the date thereof, a nursing facility aggrieved by a Final Order of the Division may file an appeal pursuant to 33 V.S.A. §909(a) and Subsections 15.5, 15.6, and 15.7 of this rule.

(b) Within 30 days of the date thereof, a ICF/MR aggrieved by a Final Order of the Division may file an appeal using the following procedures. Proceedings under this paragraph are not subject to the requirements of 3 V.S.A. Chapter 25.

(1) Request for Administrative Review by the Commissioner of Mental Health. The Commissioner or a designee shall review a final order of the Division of Rate Setting if a timely request is filed with the Director of the Division.

(i) Within 10 days of the receipt of the Request, the Director shall forward to the Commissioner a copy of the Request for Administrative Review and the materials that represent the documentary record of the Division's action.

(ii) The Commissioner or the designee shall review the record of the appeal and may request such additional materials as they shall deem appropriate, and shall, if requested by the provider, convene a hearing on no less than 10 days written notice to the provider and the Division. Within 45 days after the close of the record, the Commissioner or the designee shall issue a decision which shall be served on the provider and the Division.

(2) Appeal to the Secretary of Human Services. Within 20 days of the date of the date of issuance, an ICF/MR aggrieved by the Commissioner's decision, may appeal to the Secretary.

(i) The Notice of Appeal shall be filed with the Commissioner, who, within 10 days of the receipt of the Notice, shall forward to the Secretary a copy of the Notice and the record of the Administrative Review.

(ii) The Secretary or his designee shall review the record of the Administrative Review and may, within their sole discretion, hold a hearing, request more documentary information, or take such other steps to review the Commissioner's decision as shall seem appropriate.

(iii) Within 60 days of the filing of the Notice of Appeal or the closing of the record, whichever is the later, the Secretary or the designee shall issue a Final Determination.

(3) Further review of the Final Determination is available only pursuant to Rule 75 of the Vermont Rules of Civil Procedure.

15.5 Request for Administrative Review to the Secretary of Human Services pursuant to 33 V.S.A. §909(a)(3)

(a) No appeal may be taken under this section when the remedy requested is retrospective relief from the operation of a provision of this rule or such other relief as may be outside the power of the Secretary to order. Such relief may be pursued by an appeal to the Vermont Supreme Court or Superior Court pursuant to 33 V.S.A. §909(a)(1) and (2), or prospectively by a request for rulemaking pursuant 3 V.S.A. §806.

(b) Appeals under this section shall be governed by the relevant provisions of the Administrative Procedures Act, 3 V.S.A. §§809-815.

(c) Proceedings under this section shall be initiated by filing two copies of a written Request for Administrative Review with the Division, on forms prescribed therefor.

(d) Within 5 days of receipt of the Request, the Director shall forward one copy to the

Secretary. Within 10 days thereafter, the Secretary shall designate an independent appeals officer who shall be a registered or certified public accountant. The Letter of Designation shall be served on all parties to the appeal. All documents filed thereafter shall be filed directly with the independent appeals officer and copies served on all parties.

(e) Within 10 days of the designation of an independent appeals officer, the Division shall forward to him or her those materials that represent the documentary record of the Division's action.

(f) Within 30 days thereafter, the independent appeals officer shall, on reasonable notice to the parties, convene a prehearing conference (which may be held by telephone) to consider such matters as may aid in the efficient disposition of the case, including but not limited to:

(1) the simplification of the issues,

(2) the possibility of obtaining stipulations of fact and/or admissions of documents which will avoid unnecessary proof,

(3) the appropriateness of prefiled testimony,

(4) a schedule for the future conduct of the case.

The independent appeals officer shall make an order which recites the action taken at the conference, including any agreements made by the parties.

(g) The independent appeals officer shall hold a hearing, pursuant to 3 V.S.A. §809, on no less than 10 days written notice to the parties, according to the schedule determined at the prehearing conference. The independent appeals officer shall have the power to subpoena witnesses and documents and administer oaths. Testimony shall be under oath and shall be recorded either stenographically or on tape. Prefiled testimony, if admitted into evidence, shall be included in the transcript, if any, as though given orally at the hearing. Evidentiary matters shall be governed by 3 V.S.A. §810.

(h) The independent appeals officer may allow or require each party to file Proposed Findings of Fact which shall contain a citation to the specific part or parts of the record containing the evidence upon which the proposed finding is based. The Proposed Findings shall be accompanied by a Memorandum of Law which shall address each matter at issue.

(i) Within 60 days after the date of the hearing, or after the filing of Proposed Findings of Fact, whichever is the later, the independent appeals officer shall file with the Secretary a Recommendation for Decision, a copy of which shall be served on each of the parties. The Recommendation for Decision shall include numbered findings of fact and conclusions of law, separately stated, and a proposed order. If a party has submitted Proposed Findings of Fact, the Recommendation for Decision shall include a ruling upon each proposed finding. Each party's Proposed Findings and Memorandum of Law shall accompany the Recommendation.

(j) At the time the independent appeals officer makes her or his Recommendation, she or he shall transmit the docket file to the Secretary. The Secretary shall retain the file for a period of at least one year from the date of the Final Determination in the docket. In the event of an appeal of the Secretary's Final Determination to the Vermont Supreme Court or to Superior Court, the Secretary shall make disposition of the file as required by the applicable rules of civil and appellate procedure.

(k) Any party aggrieved by the Recommendation for Decision may file Exceptions, Briefs, and if desired, a written Request for Oral Argument before the Secretary. These submissions shall be filed with the Secretary within 15 days of the date

of the receipt of a copy of the Recommendation and copies served on all other parties.

(l) If oral argument is requested, within 20 days of the receipt of the Request for Oral Argument, the Secretary shall arrange with the parties a mutually convenient time for a hearing.

(m) Within 45 days of the receipt of the Recommendation or the hearing on oral argument, whichever is the later, the Secretary shall issue a Final Determination which shall be served on the parties.

(n) A party aggrieved by a Final Determination of the Secretary may obtain judicial review pursuant to 33 V.S.A. §909(a)(1) and (2) and Subsections 15.6 and 15.7 of this Rule.

15.6 Appeal to Vermont Supreme Court pursuant to 33 V.S.A. §909(a)(1)

Proceedings under this section shall be initiated, pursuant to the Vermont Rules of Appellate Procedure, as follows:

(a) by filing a Notice of Appeal from a Final Order with the Division; or

(b) by filing a Notice of Appeal from a Final Determination with the Secretary.

15.7 Appeal to Superior Court pursuant to 33 V.S.A. §909(a)(2)

De novo review is available in the Superior Court of the county where the nursing facility is located. Such proceedings shall be initiated, pursuant to Rule 74 of the Vermont Rules of Civil Procedure, as follows:

(a) by filing a Notice of Appeal from a Final Order with the Division; or

(b) by filing a Notice of Appeal from a Final Determination with the Secretary.

15.8 Settlement Agreements

The Director may agree to settle reviews and appeals taken pursuant to Subsections 15.3 and 15.5, and, with the approval of the Secretary, may agree to settle other appeals taken pursuant to 33 V.S.A. §909 and any other litigation involving the Division on such reasonable terms as she or he may deem appropriate to the circumstances of the case.

16 DEFINITIONS AND TERMS

For the purposes of these rules the following definitions and terms are used:

Accrual Basis of Accounting: an accounting system in which revenues are reported in the period in which they are earned, regardless of when they are collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

Agency: the Agency of Human Services.

AICPA: American Institute of Certified Public Accountants.

Allowable Costs or Expenses: costs or expenses that are recognized as reasonable and related to resident care in accordance with these rules.

Base Year: a calendar year for which the allowable costs are the basis for the case-mix prospective per diem rate.

Case-Mix Weight: a relative evaluation of the nursing resources used in the care of a given class of residents.

Centers for Medicare and Medicaid Services(CMS) (formerly called the Health Care Financing Administration (HCFA)): Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.

Certificate of Need (CON): certificate of approval for a new institutional health service, issued pursuant to 18 V.S.A. §2403.

Certified Rate: the rate certified by the Division of Rate Setting to the Department of Vermont Health Access.

Common Control: where an individual or organization has the power to influence or direct the actions or policies of both a provider and an organization or institution serving the provider, or to influence or direct the transactions between a provider and an organization serving the provider. The term includes direct or indirect control, whether or not it is legally enforceable.

Common Ownership: where an individual or organization owns or has equity in both a facility and an institution or organization providing services to the facility.

Cost Finding: the process of segregating direct costs by cost centers and allocating indirect costs to determine the cost of services provided.

Cost Report: a report prepared by a provider on forms prescribed by the Division.

Direct Costs: costs which are directly identifiable with a specific activity, service or product of the program.

Director: the Director of Rate Setting.

Division: the Division of Rate Setting, Agency of Human Services.

Donated Asset: an asset acquired without making any payment in the form of cash, property or services.

Facility or nursing facility: a nursing home facility licensed and certified for participation in the Medicaid Program by the State of Vermont.

Fair Market Value: the price an asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.

FASB: Financial Accounting Standards Board.

Final Order of the Division: an action of the Division which is not subject to change by the Division, for which no review or appeal is available from the Division, or for which the review or appeal period has passed.

Free standing facility: a facility that is not hospital-affiliated.

Funded Depreciation: funds that are restricted by a facility's governing body for purposes of acquiring assets to be used in rendering resident care or servicing long term debt.

Fringe Benefits: shall include payroll taxes, workers' compensation, pension, group health, dental and life insurances, profit sharing, cafeteria plans and flexible spending plans, child care for employees, employee parties, and gifts shared by all staff. Fringe benefits may include tuition for college credit in a discipline related to the individual staff member's employment or costs of obtaining a GED.

Generally Accepted Accounting Principles (GAAP): those accounting principles with substantial authoritative support. In order of authority the following documents are considered GAAP: (1) FASB Standards and Interpretations, (2) APB Opinions and Interpretations, (3) CAP Accounting Research Bulletins, (4) AICPA Statements of Position, (5) AICPA Industry Accounting and Auditing Guides, (6) FASB Technical Bulletins, (7) FASB Concepts Statements, (8) AICPA Issues Papers and Practice Bulletins, and other pronouncements of the AICPA or FASB.

Generally Accepted Auditing Standards (GAAS): the auditing standards that are most

widely recognized in the public accounting profession.

Health Care Cost Service: publication, by Global Insight, Inc., of national forecasts of hospital, nursing home (NHMB), and home health agency market baskets and regional forecasts of CPI (All Urban) for food and commercial power and CPIU-All Items.

Hold Day: a day for which the provider is paid to hold a bed open is counted as a resident day.

Hospital-affiliated facility: a facility that is a distinct part of a hospital provider, located either at the hospital site or within a reasonable proximity to the hospital.

Incremental Cost: the added cost incurred in alternative choices.

Independent Public Accountant: a Certified Public Accountant or Registered Public Accountant not employed by the provider.

Indirect Costs: costs which cannot be directly identified with a particular activity, service or product of the program. Indirect costs are apportioned among the program's services using a rational statistical basis.

Inflation Factor: a factor that takes into account the actual or projected rate of inflation or deflation as expressed in indicators such as the New England Consumer Price Index.

Interim Rate: a prospective Case-Mix rate paid to nursing facilities on a temporary basis.

Look-back: a review of a facility's actual costs for a previous period prescribed by the Division.

Medicaid Resident: a nursing home resident for whom the primary payor for room and board is the Medicaid program.

New England Consumer Price Index (NECPI-U): the New England consumer price index for all urban consumers as published by the Health Care Cost Service.

New Health Care Project: A project requiring a certificate of need (CON) pursuant to 18 V.S.A.§9434(a) or projects which would require a CON except that their costs are lower than those required for CON jurisdiction pursuant 18 V.S.A.§ 9434(a).

OBRA 1987: the Omnibus Budget Reconciliation Act of 1987.

Occupancy Level: the number of paid days, including hold days, as a percentage of the licensed bed capacity.

Paid feeding/dining assistants: persons (other than the facility's administrator, registered nurses, licensed practical nurses, certified or licensed nurse aides) who are qualified under state law pursuant to 42 C.F.R. §§483.35(h)(2), 483.160 and 488.301 and who are paid to assist in the feeding of residents.

Per Diem Cost: the cost for one day of resident care.

Prescription Drugs: drugs for which a physician's prescription is required by state or federal law.

Prospective Case-Mix Reimbursement System: a method of paying health care providers rates that are established in advance. These rates take into account the fact that some residents are more costly to care for than others.

Provider Reimbursement Manual, CMS-15: a manual published by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, used by the Medicare Program to determine allowable costs.

Rate year: the State's fiscal year ending June 30.

Related organization or related party: an individual or entity that is directly or indirectly under common ownership or control or is related by family or other business association with the provider. Related organizations include but are not restricted to entities in which an individual who directly or indirectly receives or expects to receive compensation in any form is also an owner, partner, officer, director, key employee, or lender, with respect to the provider, or is related by family to such persons.

Resident Assessment Form: Vermont version of a federal form, which captures data on a resident's condition and which is used to predict the resource use level needed to care for the resident.

Resident Day: any day of services for which the facility is paid. For example, a paid hold day is counted as a resident day.

Restricted Funds and Revenue: funds and investment income earned from funds restricted for specific purposes by donors, excluding funds restricted or designated by an organization's governing body.

RUG IV: A systematic classification of residents in nursing facilities based upon a broad study of nursing care time required by groups of residents exhibiting similar needs.

Secretary: the Secretary of the Agency of Human Services.

Special hospital-based nursing facility: a facility that meets the following criteria: (a) is physically integrated as part of a hospital building with at least one common wall and a direct internal access between the hospital and the nursing home; (b) is part of a single corporation that governs both the hospital and the nursing facility; and (c) files one Medicare cost report for both the hospital and the nursing home.

Standardized Resident Days: Base Year resident days multiplied by the facility's average Case-Mix score for the base year.

State nursing facilities: facilities owned and/or operated by the State of Vermont.

Swing-Bed: a hospital bed used to provide nursing facility services.

17 TRANSITIONAL PROVISIONS

[Repealed]

REGULATIONS GOVERNING

THE OPERATION OF

INTERMEDIATE CARE FACILITIES FOR THE

MENTALLY RETARDED

Agency of Human Services
Department of Mental Health
Division of Community Mental Retardation Programs

FINANCIAL STANDARDS

7.1 Allowable Costs - Allowable costs are defined as those necessary and ordinary costs related to resident care. They must be costs that prudent and cost-conscious management would pay for a given item or service. It should be noted, however, that allowable costs will not be considered for inclusion in reimbursement rate determination unless they have undergone prior budgetary review and have been approved by the Administrative Agency. The following, although not intended as an all-inclusive listing, are presented as specifics to clarify some anticipated areas of misunderstanding.

7.1.1 Depreciation - Depreciation will be an allowable cost when the following guidelines are followed:

a. Method: straight line.

b. Minimum asset life for new facilities and equipment:
   1. Buildings -25 years.
   2. Building improvement - remaining life of building but not less than 15 years.
   3. Equipment - 5 years.
   4. Vehicles - 3 years.
   5. Land improvement - 25 years.
   6. Leasehold improvements - the useful life of the improvement or the remaining term of the lease, whichever is shorter.

c. Asset life for used facilities and equipment: reasonable life expectancy.

d. Basis when purchased new: actual cost (which includes legal fees, shipping charges, etc.).

e. Basis when purchased used: actual cost.

f. Basis limitations: all assets with a life expectancy in excess of one year and an individual cost in excess of $500 must be capitalized and depreciated.

7.1.2 Gains and Losses on Disposition of Equipment - Gains and losses on the sale or abandonment of equipment are includable in computing allowable costs. A gain shall be an offset to depreciation expense to the extent that such gain resulted from depreciation reimbursed under these regulations. Gains or losses on trade-ins should be reflected in the basis of the acquired asset.

7.1.3 Costs of Residency - The costs of residence in the facility for administrators and key staff are allowable costs if such costs together with other compensation, are reasonable.

7.1.4 Cost of Purchases from Related Organizations - The cost of purchases from related organizations are allowable to the extent that they do not exceed the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere, whichever is lower.

7.1.5 Employee Training and Education Costs - Employee training and education costs pertaining to providing or improving patient care are allowable.

7.1.6 One Time, Pre-opening Costs of New Facilities - One time, pre-opening costs of new facilities incurred more than seven days prior to admittance of residents are allowable, but must be capitalized and amortized over a period of no less than 35 consecutive months beginning with the month in which the first resident is admitted for care. Examples of these costs are wages paid for services rendered prior to the opening of the facility. Costs related directly to the purchase, construction, or renovation of the building must be depreciated over the life of the building.

7.1.7 Facility Rental Costs - Facility rental costs under sale and lease-back agreements, lease with option to buy arrangements, or agreements with related organizations will be allowable for the lesser of the actual cost or the cost that would have been allowed if the provider owned the facility.

7.1.8 Indirect Costs - Indirect costs which are distributed from other facility cost centers, or, in the case of state owned facilities, from other state agencies and other cost centers of the facility itself, are allowable costs when the basis for such distribution have a statistical basis and have been approved as part of the budgetary process.

7.1.9 Return on Capital Investment - A reasonable rate of return on capital investment will be considered as an allowable cost for proprietary providers. In addition to the budgetary constraints, return on capital will be further limited to a maximum rate per annum as determined by the Administering Agency and applied to that portion of the owner's equity which is used to serve medical assistance residents.

7.2 Non-allowable Costs - Non-allowable costs may be identified in three areas: cost for services not chargeable to the medical assistance program, cost for expenses not related to patient care or costs not actually incurred, and costs that are judged unreasonable by the Administering Agency.

7.2.1 Services Not Chargeable to ICF/MR Medical Assistance Program - Services not chargeable to the ICF/MR Medical Assistance Program include, but are not limited to, the following list (if in establishing a new service, the facility is unable to find the requirement for such service, the Administering Agency should be contacted for an opinion):

a. Education services.

b. Vocational services.

c. Medical services billable under other provisions of the Medical Assistance Program.

d. Services that are specifically funded directly through other sources at least to the extent to which they are funded.

7.2.2 Cost for Expenses not Related to Patient Care - Cost for expenses not related to patient care or costs not actually Incurred include, but are not limited to, the following:

a. Depreciation for noted assets.

b. Amortization on intangible assets.

c. Bad debts arising from uncollectable resident accounts.

d. Fund raising.

e. Charitable contributions.

f. Entertainment.

7.2.3 Disallowance - The Administering Agency shall have the right to disallow any costs that relate to management inefficiency and/or unnecessary care of facilities. The cost effect of transactions that are conceived for the purpose of circumventing the regulations contained in this publication will be disallowed under the principle that the substance of the transaction shall prevail over form.

7.3 Rate Limitations - Notwithstanding any other provisions of these regulations, the actual cost rate for residential services will not exceed the provider's normal rate charged private residents of comparable residential services.

7.4 Acceptance of Medical Assistance Rate - The provider must accept the actual cost rates as full and final payment for ICF/MR services delivered to the Medical Assistance client.

7.5 Rate Determination

7.5.1 Budgetary Process

a. Each provider will submit, at least two days prior to the first day of its fiscal year, a budget for the ensuing fiscal year, in the format prescribed by the Administering Agency. This budget will contain line items of expense based on prior year's expenses and allowances for known cost changes as described in Paragraph e. of this section. Each line item must be justified by a concise narrative. For personnel costs, position titles and job descriptions must be used. All projected costs included in the budget which do not meet the criteria of allowable costs as defined in the Allowable Costs section of these regulations, must be deducted in the calculation of net cost.

b. This budget will be reviewed by the Administering Agency, adjusted if necessary, and when approved, will serve as a basis for the service payment rate and the calculation of the actual cost rate. Providers will be required to adhere to their approved budget. Expenditures which are in excess of allowable budgetary limits will be reimbursable. Allowable budgetary limits are defined as the approved line item amount plus 10% or $500.00, whichever is greater. Under no circumstances, however, will the total of allowable costs exceed the approved total net cost. If a provider foresees costs exceeding allowable budgetary limits, he may apply to the Administering Agency for a budget amendment. Such request must state justification for the change. Costs, in excess of the allowable budgetary limits, incurred prior to approval by the Administering Agency will not be reimbursable.

c. The service payment rate will be determined by dividing the net cost by the estimated patient days. The provider must indicate the number of certified beds and must estimate patient days based on past experience and known changes, but in no case may estimated patient days indicate an occupancy of less than 85%.

7.5.2 Exceptions to the Budgetary Process

a. State Agencies - State agencies which operate ICF/MR facilities and submit biennial budgets for legislative approval shall be exempt from the budgetary process. For these providers, the service payment rate will be calculated in accordance with the budget as approved by the Legislature. The actual cost rate will be determined in accordance with Paragraph c. of the above section of these regulations, except that budgetary constraints will not be imposed.

b. New Facilities - New facilities will be subject to Paragraph c., above, with the exception that budgets will be derived only from projections of operations for the ensuing fiscal year. New facilities will have the option of having the service payment rate adjusted quarterly if they can substantiate that the service payment race is not within 10% of the actual cost rate. New facilities are defined as those which have not completed one full fiscal year of operation.

c. Loss or Abandonment - Loss on the sale or abandonment of fixed assets may be submitted for consideration after incurrence, but such submission must be within ten days of determination of loss.

7.5.3 Allowance for Known Cost Changes - Future cost increases or decreases, known as of the budget filing date, must be taken into consideration in the budget preparation process. Cost increases will be considered only when they meet the criteria for allowability as defined in the Allowable Costs section of these regulations, and the following requirements:

a. Salary and wage changes must be based on changes in effect at the end of the current period and/or future changes substantiated by labor contracts, board resolutions, written policies, or minimum wage laws.

b. Changes in facility costs will be based on changes in effect at the end of the current period and/or future changes substantiated in the budget narrative.

c. The cost effects based on the need to change program services must be accompanied by justification of, and need for, such change.

d. Cost changes may be justified by references to pertinent Federal, State, or local laws and regulations.

e. Cost changes in all line items not specifically outlined above must be justified by referring to cost changes during the last completed fiscal quarter prior to the budget submission date plus consideration of reasonable increases expected to occur during the budget period.

7.5.4 Written Notification - The Administering Agency will provide written notification of the proposed service payment rate or the actual cost rate within ten days of its determination of such rate. Notification will include the method used in determining such rates and the method of submitting comments from the public to the Administering Agency. The posted, or an adjusted rate, shall become final on the tenth day following the date posted in the notification for receipt of comment.

7.6 Payment Mechanisms - Payments are made to providers from the Department of Mental Health. Providers must submit a properly completed form to:

Department of Social Welfare
Medical Services Division
Waterbury Office Complex
Waterbury, VT 05676

A copy of this form and instructions for completion are attached. Providers should expect payment for verified services within four weeks of mailing completed forms. Providers will receive a form listing any adjustments made to the billings. Information regarding the processing of any claims may be obtained from the Department of Mental Health at 241-2600. The provider will be reimbursed on a monthly basis during its fiscal year at the service payment rate, but no payment will be initiated prior to receipt of required reports. Reimbursement adjustments based on the actual cost rate will be determined within thirty days of receipt of an acceptable audit. If the determination requires a payment to the provider, payment shall be initiated within thirty days after the date of final determination. If the determination requires a repayment from the provider, the provider must make such repayment within ninety days of the final determination.

7.7 Service Payment Rate - The service payment rate will be based upon the total net costs of the approved budget, divided by the estimated resident days. The Administering Agency reserves the right to revise this rate at any time if the rate seems substantially inconsistent with the actual allowable costs.

7.8 Actual Cost Rate - The actual cost rate will be calculated by dividing the allowable costs for the fiscal year, in accordance with the budgetary provisions of the Rate Determination section of these regulations, actual resident days, except if actual resident days are 85% or less of maximum occupancy, 85% occupancy will be used to calculate the actual cost rate. Furthermore, the Administering Agency will require an annual audit (by a qualified person or firm, not connected with the provider), to determine the fairness of the actual cost rate. The Administering Agency may, at its option, provide said audit.

7.9 Record Keeping

7.9.1 All providers receiving Medical Assistance payments for ICF/MR's must meet the following financial accountability requirements:

a. All records must be maintained on a full accrual basis, excepting State agencies shall use a modified cash system approved by the Commissioner of Finance.

b. All non-allowable costs under the services provision in the Non-allowable Costs section of these regulations must be physically segregated (i.e., a separate set of financial records) from allowable costs, or if intermixed with allowable costs, must be readily identifiable for audit purposes. Costs eligible under the provisions of Part H of the Allowable Costs section of these regulations, that readily identify the basis for distribution, meet this condition.

c. All financial records must be maintained in accordance with generally accepted accounting principles and must provide a clear audit trail.

d. All reports required in the Reports section of these regulations will be subjected to a desk audit and may be subjected to a field examination of supporting records and compliance with regulations. If such audits reveal inadequacies in provider record keeping and accounting practices, the Administering Agency may require that the provider engage competent professional assistance to properly prepare the required reports.

e. Clinical records must be maintained in the manner prescribed in the ICF/MR Operating Regulations, and must provide a means of readily identifying the number of resident days. All records and reports pertaining to financial transactions must be maintained by the provider for not less than three years from the date of the submission of an approved audit for the period to which the material pertains.

7.10 Reports

7.10.1 Required Reports - In order to receive reimbursement at the service payment rate, the provider must submit a monthly report, in the format prescribed by the Administering Agency. The report must include cumulative revenue and expenditures according to budgetary line items, an invoice for the units of service rendered, and/or any other data relevant to justification or support of the Medical Assistance rate as deemed necessary by the Administering Agency.

7.10.2 Report Deadlines - All provider reports shall be submitted no later than the 30th of the month following the month being reported. Reports received after this date, and reports received in unacceptable condition, will be subject to at least a thirty day payment delay.

7.10.3 Report Certification - Reports must be certified, in the place indicated, by signature of the operating executive.

7.10.4 False Reports - False information knowingly supplied by the provider on a required report will result in termination of the provider's contractual agreement and/or prosecution under the applicable Federal and State statutes.

7.10.5 Amended Reports - Providers must file amended reports immediately upon discovery of any errors in the number of units of service billed. If an error is discovered in the financial reporting, appropriate adjustments must be made the succeeding month.

7.10.6 Audits - An audit will be conducted annually in accordance with provisions of the Actual Cost Rate section of these regulations. Reports will be submitted to the Administering Agency not more than five months after completion of the fiscal year.

7.11 Absence from Facility - Notwithstanding any other provision of these regulations, nothing herein shall be interpreted as an impediment to having ICF/MR residents: a) visit with family, friends, or other significant persons; or, b) be away from the facility for social, recreational, or related purposes, provided that all visitations and/or absences for which Title XIX reimbursement is sought are consistent with, and part of, the resident's current habilitation plan.

There shall be no limit to the number of such visitation/absent days per year. However, in the event that a resident's habilitation plan provides for visitations/absences in excess of fifteen (15) days per quarter or sixty (60) days per annum, approval for such excess days shall be obtained in advance from the Commissioner of Mental Health.

The Department shall not withhold such approval unless:

a. The resident's habilitation plan does not specifically provide for the amount of visitation/absence requested.

b. The extent of visitation/absence suggests that continued ICF/MR placement is inappropriate.

c. The resident's habilitation plan is not current or has not been reviewed in accordance with facility policy.

7.12 Appeal Procedures

7.12.1 Scope of Appeal Procedure - These procedures describe the manner by which unresolved individual provider disputes concerning application of these regulations shall be settled. Unresolved disputes are defined as those disagreements that cannot be resolved between the provider and the Administering Agency. Such disputes may be appealed by the provider.

7.12.2 Appeal Procedure - An appeal shall be submitted in writing to the Vermont Human Services Board and shall include facts, arguments, and other pertinent data. Appeals shall be heard by the Appeals Examiner who shall be an impartial party designated by the Board.

7.12.3 Time Limit - The provider has thirty days from the date of the Administering Agency's final determination of the matter disputed to initiate formal appeal.

7.12.4 Settlement Mechanism - If the appeal is related to a change in the provider's rate, the amount in dispute will not be adjusted until final determination according to the appeal procedure is made. If the appeal determination requires a payment to the provider, payment shall be initiated within thirty days after the date of final determination. If the appeal determination requires repayment from the provider, the provider must make such repayment within ninety days of the final determination.

7.12.5 Findings and Conclusions - Any findings, conclusions, or opinions of the Appeals Examiner about any appeal will be made available to the provider and to the Administering Agency.

TIMELY CLAIMS PAYMENT — DEFINITION OF A CLAIM

The definition of a claim to be used in meeting requirements for timely claims payment is as follows by type of service:

A. Pharmacy

Each line item on a billing invoice equals a claim.

B. Independent Laboratory

Each line item on a billing invoice equals a claim.

C. Long-Term Care Facility

Each line item on the turnaround document equals a claim.

D. All Other Services

Each billing invoice equals a claim.

For HCFA required reports #120 and #2082, every line item is a claim regardless of type of service as defined above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Vermont

Requirements for Third Party Liability -
Identifying Liable Resources

1. SWICA Employment Data Exchanges are run quarterly on all Medicaid recipients and exchanges on new Medicaid recipients are run monthly. SWICA Health Insurance information is not available. See attached letter Supplement 1, Page 1 to Attachment 4.22-A. SSA Data Exchanges are run twice per month. Data exchanges with the IV-A Agency are instantaneous via Shared Automated System. Data exchange with State Workmen's Compensation unavailable due to lack of automated system at this State Agency. Data exchange from State Motor Vehicle accident agency is currently under development. See attached letters Supplement 1, Page 2 and 3 to Attachment 4.22-A. Diagnosis and Trauma code edits are conducted weekly on each claims payment cycle.

2. Automated file maintenance of eligibility case files establishes existence of Third Party Resources and prints on the Medicaid Identification Card at monthly issuance and for weekly claims filing. Health Insurance information upon initial application and redetermination is obtained and incorporated into the eligibility case file and Third Party Recovery Unit within 30 days. Workmen's Compensation Data Exchanges not available per (1) above.

3. Not available per (1) above.

4. The Automated Claims Processing System produces monthly reports on paid claims with Diagnosis and Trauma codes having potential Third Party Recovery. Threshold amounts for other Diagnosis codes is set at $100.00. Third Party Recovery unit follows within 30 days to identify all related potential accident recoveries.

STATE OF VERMONT
DEPARTMENT OF EMPLOYMENT & TRAINING
P. 0. BOX 488
MONTPELIER., VERMONT 05602-0488
802-229-0311

Septem ber 23, 1987

Elmo Sassorossi, Director
Medicaid Division
VT Dept. of Social Welfare
Waterbury, VT 05676

Dear Mr. Sassorossi:

I'm writing to confirm my conversation of yesterday with Betsy Forrest of your Department.

Employment and Training is not collecting data from employers regarding health insurance they may have in effect for employees.

Yours truly

Ernest R. Tomasi, Director
Administrative Services

ERT /eg.

cc S. Soule, Commissioner

STATE OF VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF SOCIAL WELFARE
103 SOUTH MAIN STREET
WATERBURY, VERMONT 05678

MEMO TO: William H. Conway, Jr., Commissioner, Department of Motor Vehicles

FROM: Veronica H. Celani, Commissioner, Department of Social Welfare

DATE: August 27, 1987

RE: Computer Match

I appreciate your willingness to cooperate in helping this Department comply with our federal regulations as expressed in your letter of August 25 to Jim Barre.

Your understanding of our need is accurate. I anticipate that the file match would be performed no more often than quarterly - perhaps semi-annually. I also understand the fact that the match will only be more or less accurate because of name changes and other idiosyncrasies. If you're willing, I would propose that you copy the appropriate file to tape and we'll take care of the necessary programming. Of course, the Department will reimburse you for any costs involved.

I would suggest that you designate someone on your staff to meet with Mr. Barre and someone from our Computer Services Division to explore this effort further. If you have questions, please don't hesitate to call Jim or me.

VHC/jbp

STATE OF VERMONT

AGENCY OF TRANSPORTATION

DEPARTMENT OF MOTOR VEHICLES

120 State Street, Montpelier, Vermont 05603-0001

August 25, 1987

James Barre
Deputy Medicaid Director
Agency of Human Services
Dept. of Social Welfare
103 So. Main Street
Waterbury, VT 05676

Re: The request contained in your memo of August 21, 1987.

Dear Mr. Barre:

It has been the policy of the Department of Motor Vehicles to cooperate with units of government in sharing information. We will, of course, continue that cooperation with regard to your current request. We will not, however, do anything with social security numbers as we have a long-standing agreement with the courts that we are not to use these numbers for other than Department of Motor Vehicles work.

If what you are seeking is simply to match names and addresses by name and date of birth and select off those names of persons who currently have accident records on file, it would be possible to have computer programs written to do that. You must recognize, of course, that computer matching on names will not assure 100% match due to variations in spelling. It is not clear to us how you would associate the fact that someone has an accident record with one of your clients.

If you wish to pursue this request, please have your Commissioner write to me setting forth the specifics. Any cost incurred in cooperation with your department would have to be borne by your department.

Sincerely yours,

William H. Conway, Jr.
Commissioner

WHC: lac
cc: Veronica Celani, Commissioner of Social Welfare

STAFF PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: VERMONT

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE, ELIGIBILITY, AND CLAIMS DATA

1902(a)(25)(l)	The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(l) of the Social Security Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Vermont

Requirements for Third Party Liability
Payments of Claims

(1) Compliance with the requirement that providers wait 30 days from the date of furnishing a service to bill Medicaid, if they have billed a third party, is determined by manual review of claims with hard copy documentation attached during claims processing by a claims resolution specia1ist.

(2) The threshold amount for instituting recovery from a potentially liable third party is $100.00 in Medicaid payments made on behalf of an individual recipient within one year from date of service.

The threshold amount for instituting recovery from a potential third party payer in automobile casualty cases is $200.00 for Medicaid payments made on behalf of an individual recipient within one year from date of service unless such recovery effort is deemed not cost effective. Where a determination is made that a casualty case exceeding the $200.00 threshold is not cost-effective to pursue, the file will be annotated to show the basis for the determination.

These threshold amounts are set at amounts determined to be cost-effective after review and study of recovery cases.

(3) Claims less than the threshold amount are accumulated and submitted with claims of $100.00 or over in Medicaid payments. The TPL Unit pursues recovery of paid claims from third parties for up to one year from the date of service.

The method of assuring provider compliance with 447.20 is:

1. The Medicaid Provider Agreement requires it.

2. Providers have been given specific notice.

3. The Complaint Department receives and resolves recipient complaints relating to provider collections.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Vermont

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer-Based Group Health Plans

Cost Effectiveness

An individual's enrollment in a group health plan is cost effective when the amount paid for premiums, deductibles, and coinsurance plus the State's administrative costs are likely to be less than Medicaid's expenditures for an equivalent set of services.

Cost Effectiveness Methodology

1. Obtain information on the group health plan available to the recipient, including effective date, exclusions to enrollment, covered services, and amounts of premiums, deductibles, coinsurance, and premiums for non-Medicaid family members if applicable.

2. Obtain the average annual cost to the Medicaid program for similar services for persons like the applicant based on MMIS data.

3. Add the State administrative cost* for processing the group health insurance information to the amount determined in Step 1.

4. Compare the results of Steps 2 and 3. If the amount determined in Step 3 is less than that of Step 2, the cost effectiveness test is met, and Medicaid may pick up the cost of the group health plan.

5. If the amount determined in Step 3 is more than that of Step 2, the recipient's specific health-related circumstances may be considered, i.e. if the recipient has a medical condition which will likely increase his/her medical expenses above the average, a determination that paying for the group health plan will be cost effective may be made.

* Administrative costs are those costs related to gathering and processing the group health insurance and other information necessary to make a determination, including staffing, postage and telephone expenses, payment issuance, and other miscellaneous administrative expenses.

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

Description of Existing Vermont Matches

SDX and Bendex

SDX tapes are received approximately six times per month and are run against the database, which contains both applicants and recipients. DSW accretes new applicants to Bendex on a monthly basis, and receives Bendex tapes in return two to four times per month.

SDX and Bendex tapes are processed as they are received. If a discrepancy is found, an on-line edit message is generated and a message is produced on the next morning's Worker Daily Report. Both the edit message and the daily report message will remain until the eligibility worker resolves the discrepancy.

As a tracking mechanism, edits which are not resolved within a ten-day period are listed on a Supervisor's Report, which district supervisors will then use to concentrate on problem areas. This tracking mechanism is also used for all the matches described below.

UC Interface

As for SDX and Bendex, both applicants and recipients are matched with UC data from Department of Employment and Training (DET). The weekly tape that DSW receives contains records for all UC recipients in the state.

The database is updated and eligibility is automatically recomputed if a change in UC benefits has occurred. The eligibility worker is required to approve the new eligibility result if the benefit amount has changed.

As the edit messages, required approvals appear on the Supervisor's Report after a fixed amount of time has elapsed.

SSA Wage Data Exchange

Wage data tapes are processed as soon as they are received from SSA. Information from the tapes is displayed on line and discrepancies are reported to the eligibility worker via on-line edits.

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES (Continued)

Description of Existing Vermont Matches (Continued)

Enumeration

A standard form was given to all AFDC and Food Stamp applicants which they are required to have signed at the local Social Security Office and return to DSW as verification that an application for SSN has been made. The local SSA office inputs each household member's temporary SSN (assigned by DSW), and when the permanent SSN has been assigned, includes a record for that number on the next enumeration tape sent to DSW. These tapes are run as they are received, and are automatically updated with the new SSN.

Numident

The Numident verification process is in place and is run on a monthly basis. SSN discrepancies are reported to eligibility workers via an on-line edit.

Medicaid Long Term Care Bank Match

A match has been completed of all Medicaid Long Term Care recipients with the thirty-five member banks of the Vermont Bankers Association. A file was created containing all the match data furnished by the banks, and this file was then matched against the database. Reports on all discrepancies were generated to the district offices, and eligibility workers followed up on the data.

It is anticipated that this match will be run once or twice per year on an ongoing basis.

IRS

The IRS unearned income match is in the process of being developed.

SWICA Wage Exchange

Vermont is not currently a wage-reporting state, but will become one prior to the 10/1/88 deadline.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Vermont_____

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

Homeless individuals who are not also receiving Food Stamps may designate a mailing address. It is expected that the choice will usually be either the Department of Social Welfare District Office or the U. S. Post Office, c/o General Delivery, whichever is most convenient for the individual.

Individuals who are also receiving Food Stamps may designate any mailing address other than the U. S. Post Office, c/o General Delivery.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: VERMONT

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable, States should include definitions of living will, durable power of attorney for healthcare, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a healthcare provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

Vermont law provides that "Advance directive" means a written record pursuant to Section 1902(w)(4) of the Social Security Act and 18 VSA, Chapter 231, Section 9703, which may include but is not limited to appointment of an agent, identification of a preferred primary care clinician, and instructions on health care desires or treatment goals. The legal definition of "Advance directive" (18 VSA, Chapter 231, Section 9701) includes documents designated under prior law as a durable power of attorney for health care or a terminal care document. (The Terminal Care Document applies only when the individual is terminally ill and has no hope of recovery and states that the individual does not want his/her life prolonged by extraordinary measures. The Durable Power of Attorney for Health Care allows an individual to specify the desired kind of care and/or treatment to be administered in a variety of medical situations in which the individual is incapable of making decisions for him/herself.

Pursuant to 18 VSA, Chapter 231, Section 9702, an adult, referred to as a principal in the law, may use an Advance directive to appoint one or more agents and alternate agents to whom authority to make health care decisions is delegated. An adult in an Advance directive may specify the scope and extent of authority of the appointed agent(s), and may direct the type of health care desired or not desired, for example, a "do-not-resuscitate order", and may direct decisions regarding personal circumstances, for example, relating to disposition of remains and funeral arrangements. (18 VSA, Chapter 231, Section 9702). The Advance directive may also be used to select a preferred primary care clinician, nominate one or more persons to serve as a guardian should one be needed, or identify persons whom the principal does not want to serve as a decision-maker.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: VERMONT

A health care provider, health care facility, and residential facility must not, except on an emergency basis, provide health care to a patient without capacity without first attempting to ascertain whether the patient has an advance directive in effect (18 VSA, Chapter 231, Section 9707). Exceptions are outlined in 18 VSA, Chapter 231, Section 9707.

A health care provider, health care facility, and residential facility having knowledge that a principal's advance directive is in effect shall follow the instructions of the person, whether agent or guardian, who has the authority to make health care decisions for the principal, or the instructions contained in the Advance directive. (18 VSA, Chapter 231, Section 9707).

A health care provider can refuse to follow the instructions contained in an individual's advance directive based on moral, ethical, or other conflict with the instructions (18 VSA, Section 9707(b)(3)). However, if a health care provider does refuse to follow the instructions contained in an individual's advance directive, the provider shall promptly:

> Inform the individual, if possible, and any appointed agent and guardian of the conflict; assist the individual, agent or guardian in the transfer of care to another provider who is willing to honor the instructions; provide ongoing health care until a new provider has been found to provide the services; and document in the individual's medical record the conflict, the steps taken to resolve the conflict, and the resolution of the conflict.

Every health care provider, health care facility, and residential facility shall develop protocols pursuant to 42 CFR, Part 489, Subpart I and 18 VSA, Chapter 231, Section 9709 to ensure that all patients' advance directives are handled, administered, and implemented in a manner that strictly adheres to all applicable state laws and regulations.

The Vermont Ethics Network, under the direction of the Health Policy Council, has developed a summary describing this State law, as well as a comprehensive Advance Directive form, both of which are available to medical providers and the general public in Vermont.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Vermont_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The state uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Vermont_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy

(will use the criteria and notice requirements
specified in the regulation.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Vermont_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy

(will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Vermont_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy

(will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Vermont_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy

(will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Vermont_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy

(will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Vermont_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy

(will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Vermont_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____VERMONT_____

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

None

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____VERMONT_____

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

None

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____VERMONT_____

DEFINITION OF SPECIALIZED SERVICES

For persons with mental illness, specialized services must be provided in 24 hour inpatient psychiatric units. Services would typically include individual, family and group therapy, medication management, activities and milieu therapy, as well as all other services provided in a hospital setting.

Services are provided by an interdisciplinary team including: psychiatrists, nursing staff, social workers, psychologists, activities therapists, etc.

For persons with mental retardation or related conditions, specialized services are those services that are needed to address an individual's specific needs when they:

- are related to his/her mental retardation/developmental delay and;
- require ongoing intensive intervention by trained Mental Retardation staff and/or;
- are beyond the scope of services which are required of nursing facilities, particularly when they are not "practicable" due to their intensity.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: VERMONT

CATEGORICAL DETERMINATIONS

The state uses no categorical determinations. Every person who needs a level II evaluation is evaluated individually.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: VERMONT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

Vermont has held in-service educational programs routinely for nursing facilities since the early stages of implementation of OBRA. The educational program includes four in-service trainings per year.

During SFY 1992, the following in-service programs have been conducted:

(1) a pair of in-services in November for all certified providers, including nursing facilities, on the Patient Self Determination Act.

(2) a series of four in-services for all nursing facilities on the final long-term care regulations.

(3) a three day conference, sponsored in conjunction with the Vermont Health Care Association, on care and treatment of residents with dementia.

(4) a series of five in-services for all nursing facilities on MDS+ and care planning.

The Office of the Long-Term Care Ombudsman is invited to all in-service educational programs. We believe this offers the best opportunity for residents to be informed, since Vermont has an active Ombudsman Program.

Finally, the Division of Licensing & Protection is instituting a periodic educational newsletter which will be sent to all providers and Resident Councils in the nursing facilities to update them on current regulations, procedures, and policies.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: VERMONT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facil1ty or by another individual used by the facility in providing services to such a resident.

The Survey and Certification Agency maintains the following process for investigation of allegations of neglect, abuse, or exploitation of nursing facility residents. Under Vermont law, such allegations must be investigated within 72 hours of receipt of the report.

1. An incident report, including the following information is completed, logged, and assigned a number:
   * facility data
   * information related to the complainant if he/the is willing to reveal it
   * name, position, and shift of alleged perpetrator
   * name, room number or location of alleged victim
   * names, addresses of any witnesses or others who may have direct knowledge of the incident
   * summary of incident

2. Case is assigned to surveyor for investigation including:
   * visit to the facility where the alleged incident occurred unless convincing evidence exists without such a visit
   * interview of the involved resident if possible
   * review of all pertinent records
   * interviews of involved staff or witnesses

3. If a finding of abuse, neglect, or exploitation is made, the perpetrator is notified by certified mail and advised of his/her right to appeal the finding to the Human Services Board.

4. Any finding of abuse, neglect, or exploitation against a nurse aid is documented in the Nurse Assistant Registry within 10 days of the finding, and remains there permanently unless the finding was made in error, or the individual is found not guilty in a court of law. Additionally, the nurse aid is advised that he/she has a right to enter a statement into the Registry disputing the finding.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: VERMONT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The state has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

Vermont has taken steps to avoid giving notice through scheduling procedures and the conduct of the surveys.

For example, the fire/safety portion of the survey is conducted at the same time as the rest of the survey.

For example, the ombudsman is called by the surveyors once the surveyors are on site at the nursing facility. (Ombudsmen are called early after the entrance conference to let them know the survey is in progress, to ask if the ombudsman has any information to share with the surveyors, etc.)

However, until very recently, the Division of Licensing & Protection was informed by HCFA that time limited agreements of one year still needed to be issued until enforcement regulations were implemented. Such a system clearly gives providers a fairly good idea when their survey will occur. As a result of this state plan preprint, we are beginning to implement the 9-15 month schedule for surveys called for under OBRA '87, which we believe to be the correct approach under the law, regardless of other regulations.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: VERMONT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

Vermont has a system of supervisory review by several individuals, including the surveyor supervisor, Assistant Division Director and the Division Director of Licensing & Protection. These individuals meet on a weekly basis as well to review issues such as those related to survey consistency. The state agency also holds monthly surveyor staff meetings, the agenda of which includes a review of survey issues and interpretation of rules and survey procedures. The state also has fostered an open process with the provider community for discussion of survey findings. Several times this fiscal year, deficiency statements have been revised or removed due to discussions with providers. The survey teams have varying membership, so all surveyors work with all other surveyors, and all surveyors take turns as team leaders. We believe this combination of systems and process produces a high level of consistency, as evidenced by the fact there has not been one formal appeal of a deficiency finding in Vermont in the past two years.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: VERMONT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be it compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

1. A complaint report, including the following information, is completed, logged, and assigned a number:
   - facility data
   - information related to the complainant if he/she is willing to reveal it
   - name, addresses of any witnesses or others who may have direct knowledge of the complaint
   - summary of the complaint

2. Case is assigned to surveyor for investigation.

3. A letter of acknowledgement is sent to the complainant within three working days.

4. Notification is made to HCFA Regional Office within three working days for the following types of complaints:
   - federally certified facilities
   - civil rights violations
   - Medicare/Medicaid fraud

5. Referral is made to the Attorney General if the compliant may result in criminal prosecution.

6. Investigation is completed including site and/or office review of pertinent information and interviews with staff, witnesses, and/or the local ombudsman.

7. Upon completion of the investigation, the surveyor issues deficiencies as deemed necessary and prepares a narrative report of the investigation.

8. A HCFA Form 562 is completed and sent to HCFA Regional Office for any complaint involving a federally certified facility when an on site visit was made or a deficiency was cited.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Citation	Compliance Oversight of the False Claims Act
1902(a)(68) of the Act, P.L. 109-171 (section 6032)	The Vermont Medicaid program shall ensure that all entities (as defined in the State plan, 4.42) comply with the requirements of the False Claims Act mandating Employee Education About False Claims Recoveries. Beginning August 1 of 2007, the Vermont Medicaid program shall identify each entity through an annual review of all U.S. Department of Treasury Forms 1099-MISC that it has issued to its providers. All entities shall be notified by letter. All entities shall be requested to provide Vermont Medicaid with a copy of their policy regarding their compliance with the False Claims Act to include their specific plans for employee education of the False Claims Act by October 1 of 2007. On an annual basis in the month of April a randomly selected pool of entities shall be subject to an audit to review their False Claims Act compliance procedures. It shall be made known to all entities that as a Condition of Participation, as outlined in the Vermont Medicaid Provider Agreement (Attachment A, 1) that the entity must comply with said requirements, and that failure to comply with said requirements shall result in termination of the Provider Agreement. An entity shall be permitted a timeframe of 90 days (from receipt of notification) to provide Vermont Medicaid with said proof of compliance.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE __VERMONT__

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Citations of State Laws, Rules, Regulations and Policy Statements Providing Assurance of Conformity to Federal Merit System Standards

Title 3, Vermont Statutes Annotated
Chapter 11, 262-263 (State Officers and Employees)
Chapter 13 (Classification of State Personnel)
Chapter 27 (State Employees Labor Relations Act)

Rules and Regulations for Personnel Administration (1968) as amended

Attorney General's Opinion No. 1, dated 7/23/62 in re: 3-VSA-306(11) Temporary Employees

Assurances regarding the Administration of the Personnel Rules and Regulations, approved by the State Personnel Board on 8/27/69

Assurance regarding administration of 3-VSA-Chapter 13:
Section 306(10) - Engagement under retainer or contract

Letter of assurance of compliance with the U.S. Civil Service Standards as of 6/8/76 (see Attach 5.1-A page1-a)

Note: The single state agency responsible for the administration of the Title XIX program is not responsible for the administration of personnel. The Department of Personnel is in the Agency of Administration and all other state agencies are bound by the Department of Personnel's rules and regulations.

AGENCY OF ADMINISTRATION

DEPARTMENT OF PERSONNEL

MEMORANDUM

To: Donald Pfister, Policies & Procedures Consultant, Dept of Social Welfare

From: Margaret M. Kane, Special Manpower Programs Chief

Date: June 8, 1976

Subject: Standards for a Merit System of Personnel Administration

Several weeks ago, we discussed the above referenced standards to which agencies administering several HEW, Labor and Defense grant-in-aid programs are subject, and you inquired as to whether or not the State of Vermont's merit system conforms to these standards.

As you may know, the U.S. Civil Service Commission assumed responsibility for assuring compliance with those standards when the old Office of Merit System Standards within HEW was incorporated into the USCSC's Bureau of Intergovernmental Personnel Programs. The State's system of personnel administration was accepted at that time by the U.S. Civil Service Commission as meeting the federal standards and been subject to on-going Civil Service review ever since.

According to the State's representative from USCSC's Boston regional office, Mr. Stephen Craine, the State would be notified in writing only if and when the on-going review process revealed some violation of merit system standards; since this Department has received nothing alleging violation, it is assumed that our system meets merit system standards.

If you or any federal representatives require additional information on this matter, Mr. Craine suggested that you contact Thomas McCarthy, Assistant Chief, Intergovernmental Personnel Programs Division, USCSC office in Boston (telephone 617-223-6835). If I can be of further assistance, please let me know.

MMK/mb

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: VERMONT

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Methods of Administration - Civil Rights

Methods of administration are on file at the Civil Rights Administration Office.