

DEPARTMENT OF VERMONT HEALTH ACCESS

Health Care Programs Handbook



GreenMountainCare
A HEALTHIER STATE OF LIVING

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May 2015



**Vermont Health Connect and Green Mountain Care
Customer Support Center**

Questions: Call 1-800-250-8427 (TDD/TTY) 1-888-834-7898

You can also get free interpreter services and alternative formats.

Welcome to Your Green Mountain Care Program

The first part of this handbook has general program information that applies to all of our health care programs. Later sections give information about the program you have joined. If you don't know what program you are in, or if you have any questions, call the Vermont Health Connect & Green Mountain Care Customer Support Center at 1-800-250-8427. Call Monday through Friday, from 8:00 a.m. to 8:00 p.m., or Saturday, from 8:00 a.m. to 1:00 p.m. (closed on holidays).

Green Mountain Care encourages providers to offer quality, medically necessary covered services to all members, and does not encourage physicians to limit, deny or restrict medically necessary covered services. Green Mountain Care will not discriminate against you based on federally-prohibited conditions. More information about Green Mountain Care Programs is available by calling the Customer Support Center at 1-800-250-8427.

The Affordable Care Act states that all Americans are responsible for their own health insurance coverage, and provides options for choosing affordable health coverage. As part of the Affordable Care Act, everyone is required to either have health coverage or pay a shared responsibility fee.

If you wish to cancel your Green Mountain Care coverage, call the Vermont Health Connect and Green Mountain Care Customer Support Center at 1-800-250-8427. To cancel your coverage in writing, please mail your request to:

DCF/Economic Services Division
ADPC
103 South Main Street
Waterbury, VT 05671-1500

Program Names

The following healthcare programs in Vermont are run by the Department of Vermont Health Access (a managed care organization under the Global Commitment to Health Waiver).

Medicaid is a health care program for children, parents, caretakers, the elderly, people with disabilities who meet program guidelines and certain adults without children who meet certain eligibility requirements. Long-term care Medicaid is available for people who meet medical criteria (as determined by the Department of Disabilities, Aging, and Independent living) and the income and resource guidelines.

Dr. Dinosaur is a special Medicaid program for children and pregnant women. Primary Care Plus (*PC Plus*) is a managed care plan that most members of Medicaid and Dr. Dinosaur must enroll in to continue accessing benefits.



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Your Green Mountain Care Card

Your ID card will be mailed to your home. Please show it when you go for health care. If you don't get your new ID card within a month of getting this handbook, or if you lose your card, call the Customer Support Center at 1-800-250-8427 and ask for a new one. If you have other health care insurance, show your provider both of your insurance ID cards. It is against the law to share your Medicaid ID card.

Health Care and Referrals

Primary Care Provider (PCP)

The word "primary" means first. Your PCP is who you call first when you need medical care. Your PCP will see you for routine care and work with you to schedule specialty care when you need it.

See your PCP as needed, so he or she will get to know your health care needs. If your PCP is new to you, ask your old PCP to send your medical records to your new PCP. Call your new PCP to say that the records are coming.

After Hours Care

Try to take care of routine (not urgent) medical problems during regular office hours. If you have an urgent health care problem when your Primary Care Provider's (PCP) office is closed, you can call your PCP's office and ask for help or advice.

Your PCP's office will have someone available 24 hours a day, seven days a week to help you. Please see page 12 of this handbook for more information about emergency and urgent care.

Specialists

A specialist is someone who has extra training and works on certain kinds of health care problems. For example, if you have heart problems, your PCP will help you get an appointment with a heart specialist. This is called a "referral." In most cases, you must see your PCP before going to a specialist. He or she can help you decide if you need a specialist and help you choose which one to see. If you don't get a referral from your PCP before you go, you may have to pay for the visit. If you have to go to a specialist for many visits, you can ask your PCP for a "standing referral," so that you do not have to get a referral for each visit.



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If Your Doctor Does Not Accept Green Mountain Care

If you see a provider now who is not in your program, you may be able to keep going to that provider for up to 60 days after you join the program. This can only happen if:

- You have a life-threatening illness, **or**
- You have an illness that is disabling or degenerative, **or**
- You are more than three months pregnant, **and**
- The provider agrees to accept the program rates and follow the program's rules.

To arrange for a 60-day extension, or to find out more about referrals and providers in our programs, call the Customer Support Center at 1-800-250-8427. You can also see which providers accept Green Mountain Care by going to vtmedicaid.com, and clicking on Provider Look-up. Providers listed as "out of network" may not accept Green Mountain Care insurance.

Any doctors you see must accept Green Mountain Care. If they do not, they will not get paid by Green Mountain Care for treating you and you will have to pay for the services. If you have other health insurance that may pay for all or part of the treatment, your provider must accept both health insurance plans.

Waiting Times for Appointments

When you call your PCP's office, you should get an appointment:

- Within 24 hours if you have a problem where going without care for 24 hours might put your health in danger,
- Within 14 days for more minor problems, and
- Within 90 days for preventive care.

Most of the time, you should not have to wait in your provider's office for a scheduled appointment for longer than one hour. Remember: if you can't go to an appointment, it's your responsibility to call and cancel or reschedule.

If you have a problem that is a serious threat to your health if not treated right away, go to the nearest emergency room. Call your PCP as soon as you can after an emergency room visit.

Travel Time

We try to make sure that we have providers for you within these travel times:

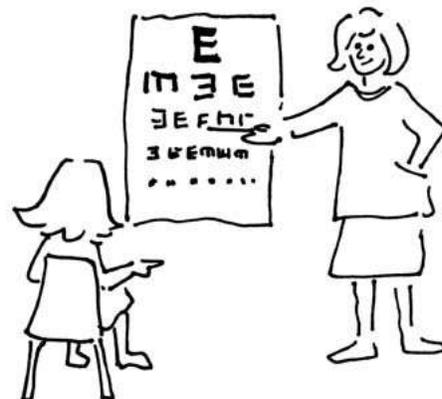
- 30 minutes to a Primary Care Provider (PCP),
- 30 minutes to hospitals,
- 60 minutes for care such as lab, x-ray, pharmacy, general optometry, inpatient psychiatric, MRI and inpatient medical rehab services.



Regular Checkups

It's always better to prevent health problems before they start. One way to do this is to have regular checkups with your PCP. Your doctor can help you decide how often to have checkups. Ask your primary care provider about specific health care screenings that you should have based on your age and individual risk factors.

The Vermont Department of Health has advice about checkups. For more information, call the Vermont Department of Health at 1-800-464-4343, or visit the website at www.healthvermont.gov.



Services

What Your Program Covers (Services You Can Get)

Most Green Mountain Care programs cover doctor visits, hospital care, prescriptions, and many other services with some rules and limits. To find out what your program covers, see pages 13 and 14.

What Your Program Does Not Cover

- Work-related injuries that should be covered by Worker's Compensation,
- Costs for court-ordered services unless they are also medically necessary,
- Services that are experimental or investigational,
- Cosmetic services (services to improve how you look),
- Services that are not medically necessary,
- Acupuncture, acupressure, or massage therapy,
- Fertility treatment (services that help you get pregnant),
- Personal health and comfort items, such as air conditioners, humidifiers, or exercise equipment,
- Modifications to your home,
- Health club memberships,
- Care in foreign countries, and
- Prescription drugs that are made by companies that are not part of the federal drug rebate program.

Getting Services Covered in Medicaid and Dr. Dynasaur Programs (Exceptions)

When a service is not covered by Medicaid or Dr. Dynasaur, you can ask to have the service covered for you. The Customer Support Center can help you submit this request. You and your provider will be asked to give information to the Department of Vermont Health Access about the service and why you need it. We will send you an answer by mail in about 30 days.

To find out more about this process, or to ask for an exception, call the Customer Support Center. The forms can also be found online at www.greenmountaincare.org/member_information/forms.

Prior Authorization

Green Mountain Care works with doctors, nurses and other professionals to make sure that the health care you get is medically necessary. Some services and drugs need authorization before you can get them. Your providers know what those services and drugs are, and they will ask for the authorization for you.

Decisions about prior authorization are made within three days after we get the information we need. Both you and your provider will get a letter telling you the decision.

Durable Medical Equipment (DME)

Durable Medical Equipment (DME) is something you can use in your home to help make life with your medical condition easier. Wheelchairs and hospital beds are examples of DME.

I have Medicaid and I need DME. How do I get it?

1. Your provider will refer you to an evaluator for an assessment.

- Most evaluators are physical or occupational therapists. The evaluator will set up an assessment with you. You might have to wait for the assessment if the evaluator is very busy. You might also have to wait if the DME vendor needs to help you try the equipment. The DME vendor is the company that provides the equipment.
- *Note:* If the DME that you need is simple, you might not need an assessment. If your provider says you do not need an assessment, skip to step 2.
- The evaluator will decide what kind of DME you need and send an assessment form to your provider.

2. Your provider will write a prescription.

- Your provider will sign the assessment form and send a prescription for the DME to the vendor.

3. The DME vendor will ask Medicaid for prior authorization.



If you do NOT need prior authorization, skip to step 5.

- If you need prior authorization for the DME, the vendor will send information about you and the DME you need to Medicaid. Prior authorization means that Medicaid has to say it is okay before you can get the equipment.
- A clinical reviewer will review your information. The reviewer will decide if you have a medical need for the equipment.
- The clinical reviewer might need more information to decide if you have a medical need for the equipment. If the reviewer needs more information, Medicaid will ask the DME vendor to send it. The vendor must send the information within 12 days. Once Medicaid has all the information, the reviewer must make a decision within 3 business days.

4. Medicaid will send you a Notice of Decision

- Medicaid will tell you the decision by sending you a letter called a Notice of Decision. Medicaid will also send the letter to your provider and the DME vendor. In Vermont, the Department of Vermont Health Access (DVHA) runs Medicaid, so the letters will be from DVHA.

5. The DME vendor will get the DME for you.

If Medicaid approves, the DME vendor will give you the DME or order it for you.

If Medicaid does NOT approve, you can appeal the decision. To appeal, call the Customer Support Center at 1-800-250-8427. Medicaid has worked hard to shorten the amount of time it takes to approve a request for DME in Vermont. For complex wheelchairs, it takes about 9 days. That is shorter than the amount of time Medicaid rules require. It is also shorter than the national average. For simple equipment, the amount of time is shorter. If you have Medicaid and Medicare or another insurance plan, this process may take longer.

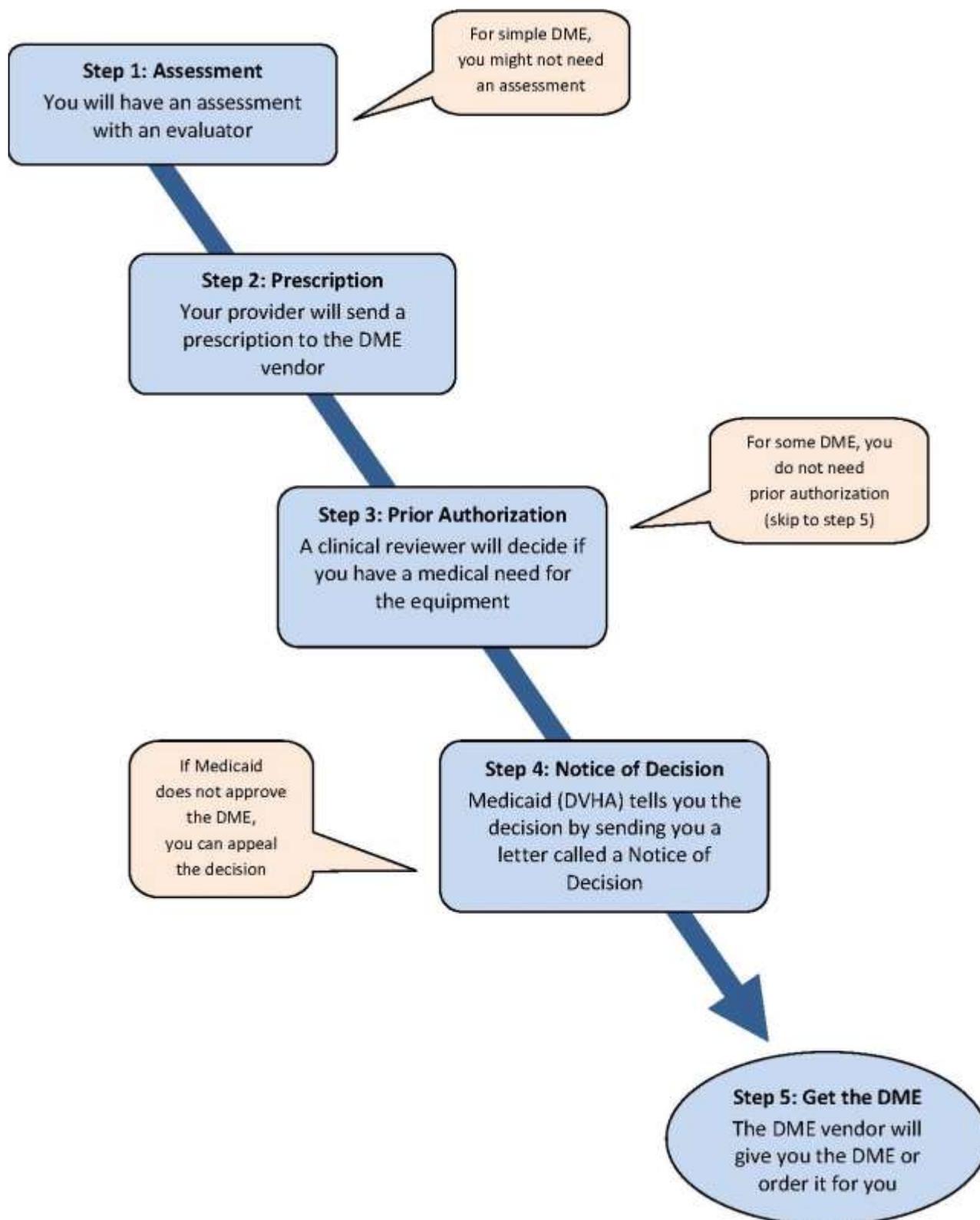


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How to Get Durable Medical Equipment (DME) through Vermont Medicaid



Drugs and Prior Authorization

Green Mountain Care, along with other insurance companies, works to provide quality health coverage at an affordable cost. To help keep costs down, Green Mountain Care asks providers to prescribe medications from a list of preferred drugs. Some drugs on the Preferred Drug list are generics that cost less. They work the same way as more expensive drugs advertised by drug companies. Physicians should prescribe and pharmacists must fill the lowest priced equivalent drug that is medically appropriate. If you refuse the substitution, your program may not cover the non-preferred drug.

Drugs for certain long-term treatments must be given to you in 90-day supplies. These are drugs taken routinely to manage select health issues. They depend on the person's situation and include, but are not limited to, drugs to manage high blood pressure, cholesterol and diabetes. The first time you try the drug, it can be for a shorter period of time while you and your provider decide if it is right for you. After that, you will get a 90-day supply.

If your provider thinks you need a drug that is not preferred or should not be for a 90-day supply, he or she may ask for authorization for us to pay for that drug. If you would like a copy of the preferred drug list or the list of drugs that require a 90-day supply, call the Customer Support Center or go to <http://dvha.vermont.gov/for-providers/preferred-drug-list-clinical-criteria>.

Emergencies

An emergency is a sudden and unexpected illness, medical condition, or mental health condition, with symptoms that you believe could be a serious threat to your health or life if you don't get medical attention right away. These are some examples, but emergencies are not limited to this list:

- Chest pain
- Broken bones
- Convulsions or seizures
- Severe bleeding
- Severe burns
- Severe pain
- Mental health crisis

Post-emergency services to make sure that your health is stable after an emergency are also covered.

Emergency medical services to keep you from getting worse or to help you get better, such as stitches, compresses, x-rays, or other procedures, are also covered.

If you have an emergency, call 911 or go to the nearest emergency room or hospital for emergency care right away. You do not need a referral from your PCP for emergency care, but call your PCP to let him or her know what happened as soon as you can.



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If you require emergency care when out-of-state or out-of-network, Green Mountain Care will make every effort to outreach the provider so we can pay the bill. Report information and any bill received to the Customer Support Center at 1-800-250-8427.

Please note that Green Mountain Care cannot guarantee that out-of-state or out-of-network providers will choose to accept your Green Mountain Care insurance and you may have to pay for services yourself.

Urgent Care

A problem is urgent if going without care for 24 hours might put your health in danger. If you have an urgent problem, call your PCP. Your PCP is on call 24 hours a day, seven days a week. He or she will make sure you are seen within 24 hours.

When You Have to Pay

If you don't follow program rules, you may have to pay for services yourself. Examples of when this can happen are:

- If the service needs a referral or prior authorization and you don't get it before you get the service,
- If you choose to go to a provider who does not accept Green Mountain Care,
- If your provider tells you the service is not covered, or he or she will not bill the program for it, and you decide to have it anyway.

Follow your program rules if you do not want to get bills for your medical care.

If You Get a Bill

If you follow your program rules, you should not get bills for medical services that are covered, except for any copays you may have. If you do get a bill, follow these steps:

- Open the bill right away,
- Call the provider and make sure he or she knows you are on Green Mountain Care, and
- Call the Customer Support Center for help.

If You Have Other Insurance

If you have other insurance, it is important that you always follow the rules of your insurance plan. Go to providers who are in your insurance plan and in our programs. Your provider will bill your other insurance first. Our programs may help to cover what your other insurance does not.

Our programs can only pay providers. If you pay for a service, we cannot pay you back.



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Medicaid and Dr. Dynasaur

The table below shows the services covered by Medicaid and Dr. Dynasaur. You should see your primary care provider first before making appointments for services that need a referral. Your provider should contact Provider Services to be sure that the service is covered for you before he or she provides the service. If you have a question about a service that is not listed, call the Customer Support Center.

Medicaid or Dr. Dynasaur Covered Services	Referral Needed
Alcohol and Substance Abuse Treatment	
Ambulance No referral needed for life or health threatening emergencies. Tell your PCP as soon as possible.	
Birth Control/Family Planning Includes birth control methods and counseling. You may go to your PCP, a gynecologist, or Planned Parenthood	
Chiropractic Services Spinal manipulations only. Prior authorization for more than 10 visits per calendar year and for all children under 12.	
Dental Adult benefits have a \$\$ limit each calendar year. There are no \$\$ limits for children, pregnant women or 60 days post-partum	
Dentures Covered only for members under 21.	
Diabetic Supplies and Counseling Prescription needed.	✓ Referral needed for Counseling
Doctor Visits	
Emergency Services No referral needed for life or health-threatening emergencies. Call 911 or go to the emergency room right away.	
Eye Exams (Routine) Treatment of eye diseases or injuries needs a referral.	
Eyeglasses Covered only for members under 21.	
Gynecologist (Women's Health Care)	
Hearing Aids	
Home Health	✓
Hospice	✓
Immunizations	



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Medicaid or Dr. Dynasaur Covered Services	Referral Needed
Inpatient Hospitalization	✓ Emergency admissions do not need a referral
Lab Tests	✓
Maternity Care (Obstetrics) including certified nurse midwives	
Medical Equipment and Supplies Prescription or prior authorization may be needed. See page 8.	
Mental Health Services See page 24 for more information.	
Naturopathic physicians Services that are normally covered can be covered with a naturopathic PCP; requires referral if naturopath is not the PCP.	✓
Occupational, Physical, or Speech Therapy	✓
Outpatient Hospital Care	✓
Over-the-Counter Drugs Prescription needed.	
Physicals When provided by your Primary Care Provider.	
Podiatry Non-routine foot-care only.	✓
Prescription Drugs Prescription needed. Some drugs need prior authorization. Customers eligible for both Medicare and Medicaid must also enroll in a Medicare Part D prescription drug plan (PDP) for prescription coverage.	
Prosthetics Prescription or prior approval may be needed.	
Radiation and Chemotherapy	✓
Routine Checkups	
Smoking Cessation Products Prescription needed.	
Surgery	✓
Transportation Go to: http://www.greenmountaincare.org/health_plans/medicaid#More Information or call the Customer Support Center at 1-800-250-8427.	
X-rays	✓



Primary Care Plus

Most Medicaid or Dr. Dynasaur customers must enroll in *PC Plus* to keep getting coverage. If you get a *PC Plus* enrollment form, call the Customer Support Center or mail back the form as soon as you can. The benefit package and costs for Medicaid and Dr. Dynasaur stay the same even after you enroll in *PC Plus*.

Copayments for Medicaid

- Medicaid customers pay \$3 for each dentist visit.
- Medicaid customers pay \$1, \$2 or \$3 for prescriptions.
- Medicaid customers pay \$3 per hospital outpatient visit.

Some services provided at an office outside of the hospital are still considered hospital outpatient services. Ask your provider if a service will be billed as hospital outpatient visit. If it is, your copay will be \$3.

Most children, pregnant women, and people in nursing homes do not have to pay copays.

Premiums

Some Dr. Dynasaur members may need to pay a monthly premium. Household premium amounts depend on family income, size, and health insurance status. When you get your first bill, it is important to pay it right away so that your coverage can begin. Keep paying on time so that you do not lose coverage. If you lose your premium bill, call the Customer Support Center to find out how much you owe and how to pay.

Primary Care Plus (*PC Plus*) Program

Medicaid or Dr. Dynasaur Managed Care

Medicaid and Dr. Dynasaur members without other insurance must enroll in *PC Plus* to keep getting coverage. When you get a *PC Plus* enrollment form, call the Customer Support Center or mail back the form.

Medicaid and Dr. Dynasaur members in *PC Plus* can choose a PCP who is within 30 minutes of their work or home. If there are not at least two PCPs within 30 minutes, you do not have to be in *PC Plus*. You will also be asked to choose a dentist for any children in your household who are under 18 years old. Providers in *PC Plus* are paid to help manage member care. They do not get a financial incentive to reduce or limit a member's health care.

Change Your Primary Care Provider (PCP)

You can contact the Customer Support Center to change your PCP at any time. The change will start on the 1st of the month after you make the request.

Specialist as Your Primary Care Provider (PCP)

If you have a life-threatening condition, disease, or a disability that requires special care over a long period of time, you may be able to have your specialist be your PCP. The specialist must agree and you need approval from the Department of Vermont Health Access (DVHA) medical director.



If you have questions about PC Plus, changing your PCP, or using a specialist as your PCP, call the Customer Support Center.

You can search for doctors accepting Green Mountain Care and Primary Care Plus by going to www.vtmedicaid.com and clicking on Provider Look-up.

Disenrollment

Disenrollment means that a person is taken out of PC Plus. If you are disenrolled from *PC Plus* and have questions, call the Customer Support Center.

You will be disenrolled from *PC Plus* if any of the following things happen:

- You get private health insurance;
- You get Medicare;
- You go into a nursing home or onto a home-based care waiver;
- You have Medicaid or Dr. Dynasaur and move to an area of the state where you don't have a choice of at least two PCPs who are part of *PC Plus* (unless you decide you want to stay in *PC Plus* anyway).
- To continue with your *PC Plus*, always:
 - » Cooperate and be polite, never threatening;
 - » Cooperate with treatment you and your doctor have agreed to;
 - » Show up for appointments or;
 - » always call ahead to cancel.

If you are disenrolled from *PC Plus*, you will be placed back on Medicaid if you are eligible.

Your Rights and Responsibilities

You have the right to

- Be treated with respect and courtesy,
- Be treated with thoughtfulness,
- Choose and change your providers,
- Get facts about your program services and providers,
- Get complete, current information about your health in terms you can understand,
- Be involved in decisions about your health care, including having your questions answered and the right to refuse treatment,
- Ask for and get a copy of your medical records and ask for changes to be made to them when you believe the information is wrong,
- When you believe the information in them is wrong, get a second opinion from a qualified provider who is enrolled in Vermont Medicaid,
- Complain about your program or your health care (see page 20 for more information),



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- Be free from any form of restraint or seclusion used as a means of bullying, discipline, convenience, or retaliation, and
- Ask for an appeal if you have been denied services you think you need. See page 20 for more information.

You have the responsibility to take care of your health by:

- Telling your provider about your symptoms and health history;
- Asking questions when you need more information or don't understand something;
- Following the treatment plans you and your provider have agreed to;
- Keeping your appointments or calling ahead to cancel if you can't make it;
- Learning about your program rules so that you can make the best use of the services that you can get;
- Making sure you have referrals from your PCP (when needed) before going to other providers;
- Paying premiums and copays when they are required;
- Calling to cancel or reschedule if you can't go to an appointment.

Living Wills and Advance Directives

Here is a general summary of the Vermont Advance Directive law (found in Title 18, Chapter 231) and what it means to a patient:

An “advance directive” is a written record which may say who you choose to act on your behalf, who your primary care provider is, and your instructions on your health care desires or treatment goals. It may be a durable power of attorney for health care or a terminal care document. Advance directives are free of charge.

An adult may use an advance directive to name one or more people and alternates who have the authority to make health care decisions for you. You may describe how much authority the person has, what type of health care you want or don't want, and say how you want personal issues handled, such as funeral arrangements. The advance directive may also be used to name one or more persons to serve as a guardian if one is needed, or identify persons that you do not want to make decisions.

If your condition means that you cannot direct your own health care, and it is not an emergency, health care providers cannot provide health care to you without first trying to find out if you have an advance directive. Health care providers who know that you have an advance directive must follow the instructions of the person who has the authority to make health care decisions for you, or follow the instructions in the advance directive.

A health care provider can refuse to follow the instructions in your advance directive based on a moral, ethical, or other conflict with the instructions. However, if a health care provider does refuse, the provider must tell you, if possible, and whomever you have named to act



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on your behalf about the conflict; help to transfer your 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 your 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 to ensure that all patients' advance directives are handled in a way that strictly follows all state laws and regulations.

You may call the Division of Licensing and Protection at 1-800-564-1612 or go online to file a complaint about someone who is not following the law. You may submit a written complaint to:

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671

You may get information about the state law, advance directives and living wills by calling the Vermont Ethics Network at 802-828-2909, or going to their website at www.vtethicsnetwork.org.

Title 18 is available at www.leg.state.vt.us/statutes/sections.cfm?Title=18&Chapter=231. You can get the forms you need or more information by going to the websites listed, talking to your provider, or calling the Customer Support Center.

Organ Donation

You may be interested in donating your organs when you die. One donor can help many people. If you would like to learn more about this, call 1-888-ASK-HRSA for free information.

Sharing Information with Your Primary Care Provider (PCP)

To help your PCP make sure that you get the health care you should have, your name may be on a list that we give to him or her. Some of these lists may be about:

- Patients who have diabetes who have not had their eyes examined in the last year,
- Women who have not had a pap test or mammogram recently,
- Children who aren't up to date on their immunizations,
- Drugs patients are on to help avoid bad reactions from drugs that don't mix, and
- Children who are behind on their routine exams.

Notice of Privacy Practices

When you were determined eligible for our programs, you received a letter stating that you were eligible and a copy of our Notice of Privacy Practices. The federal law, the Health Insurance Portability and Accountability Act (HIPAA), requires that we give you the notice. The notice tells you about your privacy rights and about how your health information may



be used or shared. If you need another copy of the notice you can call the Customer Support Center and ask for a copy. This notice may also be viewed electronically by visiting www.humanservices.vermont.gov/privacy-documents.

If you feel that your privacy rights have been violated, please contact the AHS Privacy Officer at 802-241-2234 or visit www.humanservices.vermont.gov/policy-legislation/hipaa/hipaa-info-beneficiaries/health-information-complaints/

Quality Assurance Program

Green Mountain Care has a quality assurance program to make sure that you get quality health care from your providers and good service from your health care program.

Some of the things we look at to help measure the quality of health care are:

- How much medication patients use,
- How many members get routine preventive care,
- How many members use the emergency room when they don't have an emergency,
- How physical health care providers and mental health care providers coordinate care, and
- How satisfied members and providers are with our programs.

We have adopted clinical best practice guidelines for certain chronic illnesses that we encourage providers to follow in order to improve health outcomes.

If you would like to suggest ways that we can improve our programs and make yours work better for you, call the Customer Support Center. Your comments will be made part of our quality assurance review.

You can get information about the quality of care given by hospitals, nursing homes, home health care providers, or a copy of clinical best practice guidelines by going to www.greenmountaincare.org/member_information/other_resources or by calling the Customer Support Center.

When You Don't Agree with an Action

An "action" is one of the following:

- Denial or limit of a covered service or eligibility for service, including the type, scope or level of service;
- Reduction, suspension or termination of a previously approved covered service or a service plan;
- Denial, in whole or in part, of payment for a covered service;
- Failure to provide a clinically-indicated covered service, by any provider;
- Failure to act in a timely manner when required by state rule;
- Denial of your request to obtain covered services from a provider who is not enrolled in Medicaid (note that the provider who is not enrolled in Medicaid cannot be reimbursed by Medicaid).



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If you don't agree with an action, you may ask for that action to be reviewed. If the Department of Vermont Health Access made the decision, you can ask the Customer Support Center for your appeal or fair hearing (described below) by calling 1-800-250-8427, or writing to the address below.

Vermont Health Connect & Green Mountain Care Customer Support Center
101 Cherry Street, Suite 320
Burlington, VT 05401

Appeal

Appeals are heard by a qualified person who did not make the original decision. You have 90 days from the decision date to ask the department that made the decision for an appeal. Your provider may ask for the appeal if you wish. In most cases we try to make a decision in 30 days; however, it can take up to 45 days. You and the State can also request up to 14 more days but only if it might help you (for example, your provider needs more time to send information or you can't get to a meeting or appointment in the original time frame). The longest it will ever take is 59 days for a decision to be made.

If your need for the denied benefit is an emergency, you may ask for an expedited appeal. If it is decided that your appeal is an emergency, you will get a decision within three working days.

If you are told your benefit is changed because of a change in a federal or State law, you may not ask for an appeal, but may ask for a fair hearing.

Fair Hearing

If you disagree with the decision from the appeal, you may ask the department that made the decision for a fair hearing. You have 90 days from the date of the original notice of decision or action, or 30 days from the date of an appeal decision to ask for a fair hearing. At a fair hearing, you may represent yourself or ask a lawyer, a relative, a friend, or other spokesperson to represent you. You may ask for both an appeal and a fair hearing at the same time, just an appeal, or just a fair hearing.

When a fair hearing is requested, the first hearing will be scheduled within 7 to 30 days. Federal rules say that your fair hearing will be resolved within 90 days of the date you asked for an appeal or for a fair hearing, whichever comes first. However, this timeframe is often longer in order to get more information or review new information. Fair hearings generally end up taking several months.

Continuation of Benefits

If a benefit has been ended or reduced based on your individual situation and you have asked for an appeal or a fair hearing:

- If you choose to request continuation of benefits, you must request it within 10 days of when you requested an appeal or fair hearing.
- You may ask for the benefit to continue until your appeal or hearing is decided.
- If you paid for your benefits, you will be paid back the amount you paid if the appeal or hearing is decided in your favor.



- If the state paid for the continuing benefits and the denial is upheld, you may have to pay the cost of any benefits you got while the appeal was pending.
- You can ask for continuing benefits at the same time you request the appeal or fair hearing from the Customer Support Center.
- The service cannot continue if your appeal or hearing is about a benefit that has ended or been reduced because of a change in federal or state law.
- If your fair hearing is about your premium, you must pay your premium by the premium due date or your coverage will end. You will be paid back the amount you over paid if the appeal or hearing is decided in your favor.

Grievances

A Grievance is a complaint about things other than actions, like the location or convenience of visiting your health care provider, the quality of the health care provided, or being adversely affected after exercising your rights. If you can't work out your differences with your provider and it is within 60 days of the problem, you may file a grievance by calling the Customer Support Center or the department that is responsible for the provider or the quality of the service. That department will send you a letter about how they can address it within 90 days.

If you filed a grievance and are not happy with the way it was addressed, you may ask for a Grievance Review. A neutral person will review your grievance to be sure that the grievance process was handled fairly. You will get a letter with the results of the review.

Neither you nor your provider shall be subject to retribution or retaliation for filing a grievance or an appeal with Green Mountain Care. If you need help with any part of the grievance or appeal process, staff members of Green Mountain Care can help you – just ask.

You can ask a family member, a friend, or another person (such as a provider) to help you request an appeal or a fair hearing, or to file a grievance. You will need to tell the State that you want this person to act on your behalf. That person can also represent you during the process. If you do not know what to do for any of these requests or for help with any of the steps, please call the Customer Support Center at 1-800-250-8427 for help. You can also call the Office of Health Care Advocate at 1-800-917-7787 for help.

Need Help?

Vermont Health Connect & Green Mountain Care Customer Support Center

Vermont Health Connect & Green Mountain Care Customer Support Center is there to help you. They can answer questions about your program, help you choose or change your PCP, and help you if you have problems getting health care.

Customer Support Center staff is available from 8:00 a.m. to 8:00 p.m., Monday through Friday, and 8:00 a.m. to 1:00 p.m. Saturday (closed holidays) at 1-800-250-8427 or TDD 1-888-834-7898.



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Report changes within 10 days of the change:

- Changes in your income or household,
- Address changes,
- The birth or adoption of children,
- Deaths, and
- Other health insurance that you get.

The Office of the Health Care Advocate (HCA)

The Office of the Health Care Advocate is available to help you with problems about your health care or your benefits. The Office of the Health Care Advocate can also help you with grievances, appeals, and fair hearings. You can call the HCA office at 1-800-917-7787.

Additional Information

We are happy to provide information to members about our programs, services and providers. In addition to what's in this handbook, you can also get information such as:

- A list of providers in your area who participate in our programs,
- Program rules and regulations,
- Our quality improvement plan, and
- More detailed information about covered services.

You can also find out about program eligibility and benefits on the web at www.greenmountaincare.org.

Other Programs

There are other programs and services available for children, adults, and families. Transportation to these services may be available depending upon what program you are enrolled in. For more information on transportation eligibility, call the Customer Support Center. Some of these programs have additional eligibility requirements. If you have questions or want to know if you are eligible, call the number for the specific program listed below.

Adult Day Services

Adult Day Services provide an array of services to help older adults and adults with disabilities remain as independent as possible in their own homes. Adult Day Services are provided in community-based, non-residential day centers creating a safe, supportive environment in which people can access both health and social services. For more information, call the Division of Disability and Aging Services (DDAS) at 802-871-3217 or go to www.ddas.vermont.gov.



Attendant Services Program

This program supports independent living for adults with disabilities who need physical assistance with daily activities. Program participants hire, train, supervise, and schedule their personal care attendant (s). For more information, call the Division of Disability and Aging Services (DDAS) at 802-871-3043 or go to www.ddas.vermont.gov.

Children’s Integrated Services (CIS)

CIS is a resource for pregnant or postpartum women and families with children from birth to age six. Teams have expertise in social work and family support; maternal/child health and nursing; child development and early intervention; early childhood and family mental health; child care; and other specialties (e.g., nutrition, speech and language therapy). For more information, contact the Department for Children and Families Child Development Division at 1-800-649-2642.

Children’s Integrated Services - Early Intervention (CIS-EI)

This is a special program for children under age 3 who have disabilities or developmental delays. Provides infants, toddlers and families with early intervention services. For more information, call Vermont Family Network at 1-800-800-4005.

Children’s Personal Care Services

Children’s Personal Care Services is a direct care service within Children with Special Health Needs (CSHN) – is a Medicaid service available to individuals under the age of 21 who have a significant, long-term disability or health condition which substantially impacts their age-appropriate development and ability to carry out activities of daily living (ADL). The goal of Children’s Personal Care Services (CPCS) is to provide supplemental assistance with personal care for the child. For more information, contact the Administrator at 802-865-1395 or the specialist at 802-951-5169 or go to <http://healthvermont.gov/family/childrenspersonalcareservices.aspx>.

Children with Special Health Needs (CSHN) Clinics

This program offers clinics and care coordination services for children who have special health needs. They also help with some health care costs that aren’t covered by health insurance or Dr. Dynasaur. Call the Vermont Department of Health at 1-800-464-4343 or go to www.healthvermont.gov.

Choices for Care

Choices for Care is a long-term care program to pay for care and support for older Vermonters and people with physical disabilities. The program assists people with everyday activities at home, in an enhanced residential care setting, or in a nursing facility. Providers are Adult Day Centers, Area Agencies on Aging, Assisted Living Residences, Home Health Agencies, Nursing Facilities, and Residential Care Homes. For more information, call the Senior Help Line at 1-800-642-5119 or go to http://dcf.vermont.gov/esd/health_insurance/ltc_medicaid.

Developmental Disability Services

Developmental disability services help keep individuals of any age who have developmental disabilities living at home with their families. Services include case management, employment services, community supports, and respite. Providers must be developmental



services providers or Intermediary Service Organizations for people who self-manage services. For more information, call the Division of Disability and Aging Services (DDAS) at 802-871-3064 or go to www.ddas.vermont.gov.

Financial Assistance Program

A voluntary program which can help families with the after-insurance costs of their child's health care when the services have been prescribed or pre-authorized through a CSHN clinical program. Call the Vermont Department of Health at 1-800-464-4343 or go to www.healthvermont.gov.

Flexible Family Funding

Flexible Family Funding is for people of any age who have a developmental disability and live with family, or for families who live with and support a family member with a developmental disability. The program acknowledges that families as caregivers offer the most natural and nurturing home for children and for many adults with developmental disabilities. Funds provided may be used at the discretion of the family for services and supports to benefit the individual and family. Providers of services are developmental services providers (Designated Agencies). For more information, call the Division of Disability and Aging Services (DDAS) at 802-786-5081 or go to www.ddas.vermont.gov.

High Technology Home Care

This is an intensive home care program for people over the age of 20 who are dependent on technology to survive. The goals are to support the transition from the hospital or other institutional care to the home and to prevent institutional placement. Providers are home health agencies and medical equipment vendors. For more information, call the Division of Disability and Aging Services (DDAS)/Clinical Services Unit at 802-871-3044 or go to www.ddas.vermont.gov.

Homemaker Services

The Vermont Homemaker Program helps people age 18 and over with disabilities that need help with personal needs or household chores to live at home. Services include shopping, cleaning, and laundry. The services help people live at home independently in a healthy and safe environment. Providers are Home Health Agencies. For more information, call the Division of Disability and Aging Services (DDAS)/Individual Supports Unit at 802-871-3069 or go to www.ddas.vermont.gov.

Special Clinics

These are multidisciplinary, pediatric clinics, managed by or enhanced by nursing and medical social work staff, creating a comprehensive, family-centered, care-coordinated system of direct services. These clinics specialize in Cardiology; Child Development; Craniofacial/Cleft Lip and Palate; Cystic Fibrosis; Epilepsy/Neurology; Hand; Juvenile Rheumatoid Arthritis; Metabolic; Myelomeningocele; Muscular Dystrophy; Orthopedic; Rhizotomy, and other conditions. Call the Vermont Department of Health at 1-800-464-4343 or go to www.healthvermont.gov.

Special Services

CSHN nurses or medical social workers who are based in regional Health Department district offices provide assistance with access to and coordination of specialized health care



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not available through CSHN direct service clinics. Call the Vermont Department of Health at 1-800-464-4343 or go to www.healthvermont.gov.

The Pediatric High Technology Home Care Program

The Pediatric High Technology Home Care program is an intensive home care program that coordinates medical supplies, sophisticated medical equipment and provides shift care nursing for technology-dependent medically fragile Medicaid members. The program is overseen by the Office of Children with Special Health Needs for individuals under the age of 21. For information, contact the Pediatric High Technology Home Care Nurse Manager at 802-865-1327 or go to <http://healthvermont.gov/family/cshn/pedihitech.aspx>.

Vermont Early Hearing Detection and Intervention Program

Audiologists provide screening and referral for diagnostic services for children at 12 sites statewide. For more information about any of these programs, please call 1-800-537-0076 or go to www.healthvermont.gov/family/hearing/index.aspx.

Mental Health

The State of Vermont contracts with designated agencies across the state to provide an array of mental health services to individuals and families experiencing high emotional distress, mental illness, or behavioral difficulties severe enough to disrupt their lives. Services vary from agency to agency, but core programs are available at all designated agencies. Intake coordinators at each site work with individuals to determine programs and services that are available to meet the individual's needs. In addition, designated agencies provide access as needed to several state wide services for intensive residential care, emergency or hospital diversion beds, and hospital inpatient care. To contact the Department of Mental Health, call 1-888-212-4677 or 802-828-3824 or visit www.mentalhealth.vermont.gov.

Adult Outpatient Services

This program provides services that vary from agency to agency, and waiting lists are common. Services may include evaluation, counseling, medication prescription and monitoring, as well as services for individuals sixty and over with mental health care needs. Some services are available through private providers, and some individuals may be referred to them.

Child, Adolescent, and Family Services

This program provides treatment services and supports to families so children and adolescents with mental health issues can live, learn, and grow up healthy in their school, and community. These services include screening, prevention services, social supports, treatment, counseling, and crisis response.

Community Rehabilitation and Treatment

This program provides community-based mental health services to enable individuals to live with maximum independence in their communities among family, friends, and neighbors. The comprehensive CRT services are only available to adults with severe and persistent mental illness with qualifying diagnoses who meet additional eligibility criteria including service utilization and hospitalization history, severity of disability, and functional impairments.



Emergency Services

This program provides mental health emergency services twenty-four hours a day, seven days a week to individuals, organizations, and communities. Essential emergency services may include telephone support, face-to-face assessment, referral, and consultation.

Traumatic Brain Injury Program

This program assists Vermonters age 16 or older diagnosed with a moderate to severe brain injury. It diverts or returns people from hospitals and facilities to a community-based setting. This is a rehabilitation-based, choice-driven program intended to support individuals to achieve their optimum independence and help them return to work. For more information, call the Division of Disability and Aging Services (DDAS)/Individual Supports Unit at 802-871-3069 or go to www.ddas.vermont.gov.

Women, Infants, and Children Program (WIC)

WIC is a program that helps mothers and young children eat well and stay healthy by providing information and food items. You may go to one of 62 sites around the state to see if you are eligible. Benefits may include a nutrition newsletter, cooking classes, Farm to Family coupons, as well as individual food packages. For more information, call your local Vermont Department of Health Office; 1-800-649-4357, or go to www.healthvermont.gov

More information about resources in your community can be found at www.vermont211.org.



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**Attention! If you need help in your language,
please call 1-800-250-8427**

Attention ! Si vous avez besoin d'assistance dans votre langue, appelez le : 1-800-250-8427

¡Atención! Si necesita ayuda en su idioma, por favor llame al 1-800-250-8427

Pažnja! Ako vam je potrebna pomoć na vašem jeziku, pozovite 1-800-250-8427

Ogow! Haddii aad u baahan tahay in lagugu caawiyo luqaddada, fadlan wac 1-800-250-8427

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1-800-250-8427-मा फोन गर्नुहोस्।

Muhimu! Kama wahitaji usaidizi kwa lugha yako, tafadhali piga simu 1-800-250-8427



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