



Intergovernmental Agreement

Between

Agency of Human Services

and

Department of Vermont Health Access

For the Administration and Operation of the

***Global Commitment to Health Waiver
(Demonstration Program)***

October 1, 2011-September 30, 2012

Table of Contents

Article One: General Provisions

1.1	Purpose.....	1
1.2	Agreement Review and Renewal.....	1
1.3	Compliance.....	1
1.4	Prohibited Affiliations.....	1

Article Two: Department of Vermont Health Access (DVHA) Responsibilities

2.1	Administration and Management.....	2
2.2	Eligibility and Enrollment.....	3
2.3	Enrollee Outreach and Education.....	4
2.4	Network Development.....	8
2.5	Covered Services.....	10
2.6	Access to Services.....	12
2.7	Coordination of Services.....	16
2.8	Payment to Providers.....	17
2.9	Quality Assurance and Medical Management.....	17
2.10	Grievances and Appeals.....	20
2.11	Enrollee Records.....	28
2.12	Reporting Requirements.....	29
2.13	Fraud and Abuse.....	30
2.14	Records Retention.....	30
2.15	Disclosure Requirements.....	31

Article Three: Agency of Human Services (AHS) Responsibilities

3.1	Eligibility Determination.....	32
3.2	Capitation Rate Setting.....	32
3.3	Performance Evaluation.....	32
3.4	Access to, and Analysis of, Encounter Data.....	33
3.5	Centers for Medicare and Medicaid Services (CMS) Reporting.....	33
3.6	Ombudsman.....	33
3.8	Third Party Liability (TPL).....	33
3.9	Sanctions.....	34

Article Four: Payment Provisions

4.1	Capitation Payment between AHS and DVHA.....	36
4.2	Payments Between DVHA and IGA Partners.....	37
4.3	Use of Excess Funds.....	37

Attachment A: Acronyms

Attachment B: Description of Covered Benefits and Populations

IGA Signature Page

ARTICLE ONE: GENERAL PROVISIONS

1.1 Purpose

The purpose of this Inter-Governmental Agreement (IGA) is to specify the responsibilities of the Agency of Human Services (AHS) and the Department of Vermont Health Access (DVHA) pertinent to the *Global Commitment to Health Waiver* under United States Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS) approved Section 1115 Demonstration Waiver.

DVHA will serve as the Public Managed Care Entity (Public MCE) for all enrollees under the *Global Commitment to Health Waiver*. AHS, as the Single State Agency, will provide oversight of DVHA in that capacity.

1.2 Agreement Review and Renewal

This IGA represents a comprehensive understanding of each party's responsibilities as pertinent to the *Global Commitment to Health Waiver* and DVHA's role as the Public Managed Care Entity. This IGA shall be effective for the period from October 1, 2011 to September 30, 2012. This IGA shall be amended as necessary. In the event that a new agreement is not executed prior to the expiration date of the agreement, the pending agreement shall remain in effect until a successor agreement is signed.

1.3 Compliance

This IGA meets the requirements of 45 Code of Federal Regulations (CFR) Part 74, and DVHA meets the requirements of 42 CFR 434.6.

DVHA must also meet the requirements of all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

1.4 Prohibited Affiliations

DVHA shall not knowingly have a relationship with either of the following:

- An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

FFP is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for emergency services.

For purposes of this IGA, a prohibited relationship is an employment relationship that exists between a debarred, suspended, or otherwise excluded individual, or an affiliate, as described above, and a commissioner or deputy commissioner or officer of the Department or a person with an employment consulting or other business arrangement with the Department.

ARTICLE TWO: DVHA RESPONSIBILITIES

2.1 Administration and Management

DVHA must have an executive management function with clear authority over all administrative functions and must maintain sufficient administrative staff and organizational components to comply with all program standards. Staffing must be sufficient to perform services in an appropriate and timely manner.

DVHA shall designate a representative to act as liaison between DVHA and AHS for the duration of this IGA. The representative shall be responsible for:

- Representing DVHA on all matters pertaining to this IGA. Such a representative shall be authorized and empowered to represent DVHA regarding all aspects of this IGA;
- Monitoring DVHA's compliance with the terms of this IGA;
- Receiving and responding to all inquiries and requests made by AHS in the timeframes and format specified by AHS in this IGA;
- Meeting with the AHS representative on a periodic or as-needed basis to resolve issues which may arise;
- Coordinating requests from AHS to ensure that staff from DVHA with appropriate expertise in administration, operations, finance, management information systems, claims processing and payment, clinical service provision, quality management, utilization management, and network management is available to participate in AHS activities and respond to requests by AHS which may include, but not be limited to, requests to participate in training programs designated by AHS, requests to coordinate fraud and abuse activities with AHS, and requests to meet with other State of Vermont agency representatives or other parties;
- Making best efforts to resolve any issues identified either by DVHA or AHS that may arise in connection with this IGA;
- Meeting with AHS at the time and place requested by AHS, if AHS determines that DVHA is not in compliance with the requirements of this IGA;
- Ensuring that all reports, contracts, subcontracts, agreements and any other documents subject to prior review and approval by AHS are provided to AHS no less than 10 business days prior to execution or implementation, as applicable; and
- Submitting any requests for documents or any other information provided to DVHA by any individual or entity to AHS for its review; and submitting any proposed responses and responsive documents or other materials in connection with any such requests to AHS for its prior review and approval.

2.1.1 Management Information System

DVHA shall maintain a management information system that collects, analyzes, integrates and reports data. The system(s) must provide information on areas including, but not limited to, utilization,

grievances and appeals. The system(s) must collect data on enrollee and provider characteristics, as specified by AHS and on services as set forth under Section 2.12.1 of this IGA. DVHA must collect, retain and report encounter data, defined currently as a provider claim, in accordance with the *Global Commitment to Health Waiver's* Terms and Conditions. All collected data must be available to AHS and the CMS upon request.

2.2 Eligibility and Enrollment

2.2.1 Eligible Population

The following populations are eligible for enrollment in the *Global Commitment to Health Waiver*:

- Individuals who are eligible for medical assistance in accordance with the State of Vermont Medicaid plan;
- Individuals who are eligible for medical assistance in accordance with the 1115 Medicaid Waiver Demonstration as approved and/or amended by CMS;

2.2.2 Eligibility for the Global Commitment to Health Waiver

All individuals eligible for the State of Vermont's public insurance programs (Medicaid and VHAP), excluding the following persons:

- Individuals covered under the Vermont section 1115 Long Term Care Demonstration not receiving CRT services
- Unqualified aliens, and qualified aliens subject to the Special Terms and Conditions.
- SCHIP eligibles

will be enrolled in the *Global Commitment to Health Waiver*. Eligibility and enrollment are therefore synonymous for the purpose of this IGA.

DVHA shall be responsible for verification of the current status of an individual's Medicaid/VHAP eligibility with the Economic Services Division (ESD), within AHS Department for Children and Families (DCF), which makes these eligibility determinations.

DVHA and its IGA partners shall not discriminate, or use any policy or practice that has the effect of discriminating, against any individual's eligibility to enroll on the basis of race, color, religion, disability, sexual orientation or national origin. DVHA, the delegated AHS departments and providers will accept and serve all individuals eligible for, and enrolled in, the *Global Commitment to Health Waiver*.

2.2.3 Data Transfers

The Agency of Human Services (AHS) Economic Services Division's (ESD) eligibility determination system (ACCESS) and the Medicaid Management Information System (MMIS) shall continue to provide Medicaid eligibility functions under the *Global Commitment to Health Waiver*. A regular data transfer between the ACCESS and the MMIS shall ensure that identical information on Medicaid/VHAP eligibility status and the *Global Commitment to Health Waiver* enrollment status is available concurrently in both information systems to ensure data integrity for payment purposes. DVHA must have the capability to interface with the ACCESS and MMIS systems.

2.2.4 Loss of Eligibility/Disenrollment from the Demonstration

DVHA shall ensure that individuals who lose eligibility are disenrolled from the *Global Commitment to Health Waiver*. Loss of eligibility may occur due to:

- Death;
- Movement out of State of Vermont;
- Incarceration;
- No longer meeting the eligibility requirements for medical assistance under the *Global Commitment to Health Waiver*; and
- The enrollee's request to have his/her eligibility terminated and to be disenrolled from the program

DVHA shall compare, on at least a monthly basis, the active Global Commitment to Health enrollee list with the ESD's Medicaid/VHAP eligibility list to confirm Medicaid status for all Global Commitment to Health enrollees. DVHA shall not receive a capitation payment for any individual who is not eligible under the *Global Commitment to Health Waiver*.

2.2.5 Prohibitions

DVHA shall not disenroll any individual except those who have lost eligibility as specified under 2.2.4 of this IGA. This prohibition specifically precludes disenrollment on the basis of an adverse change in the enrollee's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

2.3 Enrollee Outreach and Education

2.3.1 New Enrollees

DVHA shall be responsible for educating individuals at the time of their enrollment into the *Global Commitment to Health Waiver*. Education activities may be conducted via mail, by telephone and/or through face-to-face meetings. DVHA may employ the services of an enrollment broker to assist in outreach and education activities.

DVHA shall provide information and assist enrollees in understanding all facets pertinent to their enrollment, including the following:

- What services are covered and how to access them
- Restrictions on freedom-of-choice
- Cost sharing
- Role and responsibilities of the primary care provider (PCP)
- Importance of selecting and building a relationship with a PCP
- Information about how to access a list of PCPs in geographic proximity to the enrollee and the availability of a complete network roster
- Enrollee rights, including appeal and Fair Hearing rights; confidentiality rights; availability of the Department of Health Care Ombudsman; and enrollee-initiated dis-enrollment

- Enrollee responsibilities, including making, keeping, canceling appointments with PCPs and specialists; necessity of obtaining prior authorization (PA) for certain services and proper utilization of the emergency room (ER)

2.3.2 Enrollee Handbook

DVHA and AHS shall coordinate the development of the *Global Commitment to Health Waiver* enrollee handbook, which shall help enrollees and potential enrollees understand the requirements and benefits of the various programs available through the *Global Commitment to Health Waiver*. DVHA shall mail the enrollee handbook to all new enrollee households within 45 business days of determination of eligibility for the *Global Commitment to Health Waiver*. Enrollees may request and obtain an enrollee handbook at any time.

The enrollee handbook must be specific to the *Global Commitment to Health Waiver* and be written in language that is clear and easily understood by an elementary-level reader. The enrollee handbook must include a comprehensive description of the *Global Commitment to Health Waiver*, including a description of covered benefits, how to access services in urgent and emergent situations, how to access services in other situations (including family planning services and providers not participating in the Vermont Medicaid program), complaint and grievance procedures, appeal procedures (for eligibility determinations or service denials), enrollee disenrollment rights, and advance directives.

With respect to information on grievance, appeal and Fair Hearing procedures and timeframes, the *Global Commitment to Health Waiver* enrollee handbook must include the following information:

- Right to a State of Vermont Fair Hearing, method for obtaining a hearing, timeframe for filing a request, and rules that govern representation at the hearing;
- Right to file grievances and appeals;
- Requirements and timeframes for filing a grievance or appeal;
- Availability of assistance in the filing process;
- Toll-free numbers that the enrollee can use to obtain assistance in filing a grievance or an appeal;
- The fact that, when requested by the enrollee, benefits will continue if the enrollee files an appeal or a request for a State of Vermont Fair Hearing within the timeframes specified for filing; and that the enrollee may be required to pay the cost of any services furnished while the appeal is pending if the denial is upheld;
- Any appeal rights that the State of Vermont makes available to providers to challenge the failure of DVHA to cover a service;
- Information about Advance Directives and the service providers' obligation to honor the terms of such directives;

The following additional information must be included in the enrollee handbook:

- Information on specialty referrals;
- Information on unrestricted access to family planning services;

- Information on accessing emergent and urgent care (including post-stabilization services and after-hours care);
- Information on enrollee disenrollment;
- Information on enrollee right to change providers;
- Information on restrictions to freedom of choice among network providers;
- Information on enrollee rights and protections, as specified in 42 CFR 438.100 and IGA Section 2.15;
- Information on enrollee cost sharing; and
- Additional information that is available upon request, including information on the structure of the *Global Commitment to Health Waiver* and any physician incentive plans.

The MCE provides to its enrollees information on providers which, at a minimum, includes primary care physicians, specialists, and hospitals. The information:

- Includes provider names, locations, and telephone numbers,
- Identifies providers that speak any non-English languages.
- Information on specialty referrals.
- Identifies providers that are not accepting new patients.

DVHA shall notify its enrollees in writing of any change that AHS defines as significant to the information in the *Global Commitment to Health Waiver* enrollee handbook at least 30 business days before the intended effective date of the change.

2.3.3 Languages other than English

DVHA shall comply fully with AHS policies for providing assistance to persons with Limited English Proficiency. DVHA shall develop appropriate methods of communicating with its enrollees who do not speak English as a first language, as well as enrollees who are visually and hearing impaired, and accommodating enrollees with physical disabilities and different learning styles and capacities. Enrollee materials, including the enrollee handbook, shall be made available in all prevalent non-English languages. A prevalent non-English language shall mean any language spoken as a first language by five percent or more of the total statewide *Global Commitment to Health Waiver* enrollment.

DVHA shall ensure in-person or telephonic interpreter services are available to any enrollee who requests them, regardless of the prevalence of the enrollee's language within the overall program. AHS contracts with in-person and telephonic interpreter vendors, as well as written translation vendors on behalf of DVHA and other departments under AHS umbrella. DVHA and its IGA partners will use these vendors as necessary and will bear the cost of their services, as well as the costs associated with making American Sign Language (ASL) interpreters and Braille materials available to hearing- and vision-impaired enrollees.

DVHA shall include information in the enrollee handbook on the availability of oral interpreter services, translated written materials, and materials in alternative formats. The *Global Commitment to Health* enrollee handbook shall also include information on how to access such services.

2.3.4 Advance Directives

DVHA and its IGA partners shall comply with the requirements of 42 Code of Federal Regulations (CFR) 422.128 and 489, Subpart I related to maintaining written policies and procedures respecting advance directives. DVHA shall require all *Global Commitment to Health Waiver* providers to comply with these provisions.

This requirement includes:

- Maintaining written policies and procedures that meet requirements for advance directives in Subpart I of part 489;
- Maintaining written policy and procedures concerning advance directives with respect to all adult individuals receiving medical care or assistance by or through DVHA or one of its Departments;
- Providing written information to those individuals with respect to the following:
 - A description of State of Vermont law and their rights under State of Vermont law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Such information must reflect changes in State of Vermont law as soon as possible, but not later than 90 business days after the effective date of the State law.
 - Policies respecting implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.
- Informing enrollees that any complaints concerning noncompliance with the advance directive requirements may be filed with the State of Vermont survey and certification agency.

2.3.5 Satisfaction Surveys

DVHA and its IGA partners shall conduct enrollee satisfaction surveys. Any changes in the survey tools and methodology must be submitted to AHS for review and approval at least 90 business days prior to implementation of the survey. AHS will submit any proposed changes to the survey tool to the CMS at least 60 business days prior to implementation of the survey. DVHA agrees to make all appropriate modifications required by AHS and/or the CMS.

DVHA may delegate the execution of a satisfaction survey to a subcontractor as long as the subcontractor uses a survey tool and methodology approved by AHS.

To the extent that they are available, the results of the DVHA and/or its IGA partner's enrollee satisfaction surveys will be made available to potential or current enrollees via posting on the DVHA or appropriate IGA partner website.

2.3.6 Enrollee Notification: Provider Termination

DVHA shall make a good faith effort to give written notice of termination of the contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

2.3.7 Marketing

2.3.7.1 Terminology

Cold Call Marketing means any unsolicited personal contact by the MCE with a potential enrollee for the purpose of marketing as defined in this paragraph.

Marketing means any communication, from an MCE to a Medicaid recipient who is not enrolled in that entity, that can reasonably be interpreted as intended to influence the recipient to enroll in that particular MCO's Medicaid product, or either to not enroll in, or to disenroll from, another MCO's Medicaid product.

Marketing Materials means materials that are produced in any medium, by or on behalf of an MCE can reasonably be interpreted as intended to market to potential enrollees

2.3.7.2 State Approval of Marketing Materials

DVHA shall not distribute any marketing materials without first obtaining approval of such materials from AHS.

2.3.8 Enrollee Services

DVHA, through its enrollment subcontractor (currently Maximus), shall provide an enrollee helpline function for *Global Commitment to Health Waiver* enrollees. DVHA shall make available to its enrollment subcontractor an up-to-date provider listing, including names, telephone numbers, office hours, and other relevant information, for use by the helpline operators.

DVHA shall require each of its IGA partners to identify a liaison to respond to inquiries from the helpline operators and to assist in resolution of enrollee issues.

2.4 Network Development

2.4.1 Subcontractors

DVHA may subcontract with other Departments in state government to provide certain covered *Global Commitment to Health Waiver* services that are relevant to the programs they administer, including the Department for Disabilities, Aging and Independent Living (DAIL), Department of Health (VDH), Department of Education (DOE), the Department for Children and Families (DCF) and the Department of Mental Health (DMH) – (collectively referred to as the Departments).

In addition to services available through the IGA partners, enrollees may access health and mental health services from licensed Medicaid-enrolled providers.

Licensed and enrolled Medicaid providers must:

- Meet the requirements set forth in 42 CFR 431.107;
- Meet DVHA's established enrollment requirements;

- Be willing to coordinate care with DVHA or its designee, including sharing clinical information (with appropriate enrollee consent); and
- Accept DVHA’s fee schedule.

Unless authorized by State or federal statute or regulation, DVHA and the IGA partners shall be prohibited from discriminating with respect to the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State of Vermont law, solely on the basis of that license or certification. The MCE must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. This provision does not prohibit DVHA and the IGA partners from limiting network participation based on quality, cost or other reasonable business purposes as permitted under federal laws and regulations. If a provider is denied enrollment in the Medicaid program the MCE must provide written notice of its reason(s) for denying enrollment.

All contracts and subcontracts for services pertinent to the *Global Commitment to Health Waiver* must be in writing and must provide that AHS and the United States Department of Health and Human Services (DHHS) may:

- Evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed; and
- Inspect and audit any financial records of such contractor/subcontractor.

Written contracts must specify the activities and reporting responsibilities of the contractor or subcontractor and provide for revoking delegation or imposing other sanctions if the contractor or subcontractor’s performance is inadequate.

No subcontract terminates the responsibility of AHS and DVHA to ensure that all activities under this IGA are carried out. In the event of non-compliance, AHS (as the Single State Agency) will determine the appropriate course of action to ensure compliance. DVHA agrees to make available to AHS and CMS all subcontracts between DVHA and the Departments.

2.4.2 Oversight Process for Subcontractors

The MCE oversees and is accountable for any functions and responsibilities that it delegates to any subcontractors. Before any delegation can take place, the MCE must evaluate the prospective subcontractor’s ability to perform the activities to be delegated. The MCE monitors the subcontractor’s performance via a formal review according to a periodic schedule established by the State, consistent with industry standards or State MCE laws and regulations. If the MCE identifies deficiencies or areas for improvement, the MCE will follow its operating procedures for initiating corrective action.

2.4.3 Provider Services

DVHA shall maintain a provider services function that operates during normal business hours. Functions shall include:

- Assistance with development of procedures for determining enrollee eligibility;
- Assistance with the submittal of claims for services rendered,

- Assistance with preparation and submittal of monthly encounter data; and

2.4.4 Provider Contracting and Enrollment

The MCE implements written policies, procedures, or operating principles for selection and retention of providers, and those policies, procedures, or operating principles include, at a minimum, the requirements of 42 CFR 438.214(a). DVHA shall ensure that all providers participating in the *Global Commitment to Health Waiver* meet the enrollment requirements established by AHS for the Medicaid program. Upon change in statute and/or pertinent Vermont State licensing standards DVHA shall work with EDS to ensure that the current provider enrollment processes are up to date and are reflective of the necessary changes. Upon approval from DVHA, EDS will enter provider information into the MMIS and program necessary automated edit and audit checks to ensure that all *Global Commitment to Health Waiver* providers are licensed and/or certified where required, and are acting within the scope of that license and/or certification, or Federal authority, including Federal Clinical Laboratory Improvements Amendments (CLIA) requirements. Providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act are prohibited from participation in the *Global Commitment to Health Waiver*. Each physician must have a unique identifier. DVHA must provide information to providers at the time of contracting related to DVHA's Grievance, Appeal, and State Fair Hearing process and provider's obligation to comply with advanced directive requirements.

2.4.5 Provider Profiling

DVHA in collaboration with its IGA partners shall conduct periodic provider profiling activities, including producing information on enrollment, service claims, costs, reimbursements, and outcomes for all health services provided to *Global Commitment to Health Waiver* enrollees. Information used in provider profiling will include data from all providers of health services within the IGA partner Departments.

2.4.6 Mainstreaming

DVHA's policies and procedures will ensure that network providers do not intentionally discriminate against *Global Commitment to Health Waiver* enrollees in the acceptance of patients into provider panels, or intentionally segregate *Global Commitment to Health Waiver* enrollees in any way from other individuals receiving services.

2.5 Covered Services

2.5.1 General

The *Global Commitment to Health Waiver* includes a comprehensive health care services benefit package. The covered services will include all services that AHS requires be made available through its public insurance programs to enrollees in the *Global Commitment to Health Waiver* including all State of Vermont plan services in the following categories:

- Acute health care services
- Preventative health services
- Behavioral health services, including substance abuse treatment
- Specialized mental health services for adults and children
- Developmental services

- Pharmacy services
- School-based services

The monthly capitation amount paid by AHS to DVHA, as the Public MCE, will include payment only for services covered under the *Global Commitment to Health Waiver*.

2.5.1.1 Medical Necessity

DVHA agrees to make available the benefits covered under the *Global Commitment to Health Waiver* to groups of individuals eligible for coverage through its public health insurance programs. DVHA further agrees, at a minimum, to provide the services that are covered based on medical/clinical necessity. Services shall be sufficient in amount, duration or scope to reasonably achieve the purpose for which the services are furnished. DVHA shall not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition. DVHA may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

Medically-necessary care, as defined in Medicaid Regulation Rule 107, means health care services including diagnostic testing, preventive services and aftercare appropriate, in terms of type, amount, frequency, level, setting, and duration to the enrollee's diagnosis or condition. Medically-necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition; and 1) help restore or maintain the enrollee's health; 2) prevent deterioration of or palliate the enrollee's condition; and 3) prevent the reasonably likely onset of a health problem or detect an incipient problem.

Medical/clinical necessity determinations will be made by the Medical Director of DVHA. Ultimate authority in such determinations lies with AHS, as the entity to which *Global Commitment to Health Waiver* enrollees have the right to appeal. AHS will arrange for independent medical review of appeals of medical necessity decisions by DVHA as appropriate.

Within the limits of the benefit plan, DVHA and IGA partners have the responsibility for establishing procedures for referrals and when prior authorization is required either by DVHA or IGA partners.

The capitated benefit package for the *Global Commitment to Health Waiver* is defined in the Demonstration's Special Terms and Conditions, dated October 31, 2007.

2.5.1.2 Premium Assistance Programs

DVHA shall make premium assistance payments for individuals enrolled in the following programs:

- VHAP ESI
- Catamount Health ESI
- Catamount Health Premium Assistance

DVHA shall provide the following wraparound coverage to individuals enrolled in premium assistance programs:

- VHAP ESI – VHAP benefit package

- Catamount Health ESI – enrollee cost sharing obligations for chronic care services as identified in Vermont rules
- Catamount Health Premium Assistance – no wraparound coverage

2.5.1.3 Limitations on Coverage for Abortion

The MCE may only provide for abortions in the following situations:

- If the pregnancy is the result of an act of rape or incest; or
- In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

No other abortions can be covered under this IGA.

2.6 Access to Services

2.6.1 General

Through its contracts with Medicaid providers and the IGA partners, DVHA must ensure that a network of appropriate providers is maintained to furnish adequate access to all covered *Global Commitment to Health Waiver* services. In establishing and maintaining this network, DVHA must consider the following:

- Anticipated enrollment in the *Global Commitment to Health Waiver*;
- Expected utilization of services, taking into consideration the characteristics and health care needs of the population served;
- That services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
- Number and types of providers required to furnish the contracted services;
- Number of providers who are not accepting new patients; and
- Geographic location of providers and *Global Commitment to Health Waiver* enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location(s) provide physical access for enrollees with disabilities.

2.6.2 Twenty-Four Hour Coverage

DVHA must ensure that coverage is available to enrollees on a twenty-four hour per day, seven day per week basis. Coverage may be delegated to the IGA partners, but DVHA must maintain procedures for monitoring coverage to ensure twenty-four hour availability.

2.6.3 Emergency Services

“Emergency medical condition” means a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy;
- Serious impairment to such person's bodily functions; and
- Serious dysfunction of any bodily organ or part of such person.

“Emergency services” means covered inpatient and outpatient services that are as follows:

- Furnished by a qualified provider; and
- Needed to evaluate or stabilize an emergency medical condition.

The MCE provides the following information to all enrollees:

- The fact that prior authorization is not required for emergency services
- The process and procedures for the use of the 911 telephone system or its local equivalent
- The location of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the waiver
- The fact that the enrollee has the right to use any hospital or other setting for emergency care

DVHA is responsible for coverage and payment of emergency services for all enrollees served through the *Global Commitment to Health Waiver*. Payment for these services shall be made in accordance with the Medicaid fee schedule.

DVHA must cover and pay for emergency services regardless of whether the provider who furnishes the services has a contract with the Medicaid program, and may not deny payment for treatment obtained whenever an enrollee has an emergency medical condition (according to the prudent layperson standard) or is instructed by a representative of DVHA or an IGA partner to seek emergency services, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition.

DVHA or its IGA partner may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. DVHA and its IGA partner may further not refuse to cover emergency services based on a failure on the part of the emergency room provider, hospital or fiscal agent to notify the enrollee's provider, the responsible Department, or DVHA of the enrollee's screening and treatment within 10 calendar days of the enrollee's presentation for emergency services. This shall not preclude DVHA from refusing to cover non-emergency services that do not meet medically necessity criteria, or refusing payment for non-emergency services in cases where a provider does not provide notice within the 10-day timeframe.

A *Global Commitment to Health Waiver* enrollee receiving services through the public insurance programs who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entity (DVHA) responsible for coverage and payment.

2.6.4 Post-Stabilization Care Services

“Post-stabilization care services” means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the enrollee’s condition.

Post-stabilization care services provided on an inpatient hospital basis are paid for by DVHA for all enrollees in the public insurance programs under the *Global Commitment to Health Waiver*. DVHA may conduct concurrent review for post-stabilization services as soon as medically appropriate. However, DVHA must pay for all inpatient post-stabilization care services that are pre-approved by DVHA, all post-stabilization services that are not pre-approved but are administered to maintain the enrollee’s stabilized condition within one hour of a request to DVHA for pre-approval, and all services that are not pre-approved but are administered to maintain, improve or resolve an enrollee’s stabilized condition if the:

- DVHA does not respond to a request for pre-approval within one hour;
- DVHA cannot be contacted; or
- DVHA’s representative and the treating physician cannot agree concerning the enrollee’s treatment and DVHA does not have a physician available for consultation. In this situation, DVHA must allow the treating physician to continue with care of the enrollee until DVHA physician is reached or the enrollee is discharged.

DVHA’s financial responsibility for post-stabilization services for services it has not pre-approved ends when any of the following conditions is met the:

- DVHA-contracted physician who has privileges at the treating hospital assumes responsibility for the enrollee’s care;
- DVHA-contracted physician assumes responsibility for the enrollee’s care through transfer;
- DVHA and the treating physician reach an agreement concerning the enrollee’s care; or
- Enrollee is discharged.

2.6.5 Travel Time

DVHA shall ensure that travel time to services does not exceed the limits described below:

Primary Care – No more than 30 miles or 30 minutes for all enrollees from residence or place of business unless the usual and customary standard in an area is greater, due to an absence of providers. DVHA’s network will include all Medicaid participating providers, which equates to nearly all providers in the State of Vermont. However, if the travel time standard is exceeded in an area which contains a non-participating provider, DVHA will work aggressively to bring that provider into the network.

Hospitals – Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater, mental health services where access to specialty care may require longer transport time, and for physical rehabilitative services where access is not to exceed 60 minutes.

General Optometry – Transport time will be the usual and customary, not to exceed one hour, except in areas where community standards will apply.

Lab and X-Ray – Transport time will be the usual and customary, not to exceed one hour, except in areas where community access standards will apply.

All Other Services – All services not specified above shall meet the usual and customary standards for the community.

2.6.6 Appointment Availability

Appointment availability shall meet the usual and customary standards for the community, and shall comply with the following:

- Urgent care: Within twenty-four hours;
- Non-urgent, non-emergent conditions: Within 14 days;
- Preventive Care: Within 90 days.

Network providers must offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

DVHA must establish mechanisms to ensure that network providers comply with the timely access requirements; monitor regularly to determine compliance; and take corrective action if there is a failure to comply.

2.6.7 Interpreter Services at Medical Sites

DVHA and the IGA partners shall ensure availability of interpreter services by offering reimbursement. Medical delivery sites will be allowed to seek reimbursement for in person interpreter services provided to enrollees who speak a language other than English as a first language, or who are hearing-impaired, and who request such assistance.

2.6.8 Cultural Considerations

DVHA shall participate in AHS's efforts to promote the delivery of services in a culturally competent manner to all *Global Commitment to Health Waiver* enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

2.6.9 Choice of Health Professional

Per 42 CFR 438.6(m), *Global Commitment to Health* enrollees will have choice of health professional within the network of Medicaid providers to the extent possible and appropriate.

DVHA shall not impose any restrictions on the choice of the provider from whom the person may receive family planning services and supplies.

2.6.10 Direct Access to Women’s Health Specialist

DVHA must provide female enrollees with direct access to a women’s health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a woman's health specialist.

2.6.11 Alternative Treatment

DVHA and the IGA partners shall not prohibit, or otherwise restrict a health care professional acting within the lawful scope of practice, from the following actions:

- Advising or advocating on behalf of an enrollee who is his or her patient for the enrollee’s health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- Providing information to the enrollee as necessary for the enrollee to decide among all relevant treatment options;
- Advising or advocating on behalf of a enrollee for the risks, benefits, and consequences of treatment or non-treatment;
- Advising or advocating on behalf of the enrollee for the enrollee’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

2.6.12 Second Opinion

Global Commitment to Health enrollees served through the public insurance programs shall have the right to obtain a second opinion from a qualified health care professional, within the network of enrolled Medicaid providers, or arrange for the ability of the enrollee to obtain a second opinion by enrolling a qualified provider in the program, at no cost to the enrollee.

2.6.12 Other State Plan Benefits

The MCE informs beneficiaries about how and where to access any benefits that are available under the State plan but are not covered under the AHS/DVHA agreement, including how transportation may be provided to those services.

2.7 Coordination of Services

DVHA shall assist in the coordination of services provided through its network of Medicaid providers and its IGA partners. DVHA will document name of primary care provider for each enrollee. DVHA shall maintain mechanisms for enrolling specialists as primary care providers, as appropriate for the enrollee’s condition and identified needs.

DVHA and IGA partners shall maintain mechanisms to assess each enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The following individuals are identified by the state as having special health care needs:

- Developmental Services and Traumatic Brain Injury (DAIL)
- Community Rehabilitation and Treatment (CRT) and Children with a Severe Emotional Disturbance (DMH)

The assessment mechanisms must use appropriate health care professionals. When treatment plans are required, the treatment plan must be developed with the participation of the enrollees' primary care provider and enrollee, in consultation with any specialists caring for the enrollee. When appropriate, DVHA and its IGA partners will create a unified plan to prevent enrollees with special health care needs from receiving duplicative case management/care coordination activities. DVHA and its IGA partners will ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that there are applicable. The treatment plan must be approved by DVHA or IGA partner in a timely manner, if approval is required. The treatment plan must identify specialist services that may be accessed directly by the enrollee as appropriate for that enrollee's condition and identified needs. The treatment plan must conform to the State's quality assurance and utilization review standards.

If the contracted network is unable to provide necessary medical services covered under the contract to a particular enrollee, DVHA must adequately and timely cover these services out of network for the enrollee, for as long as the entity is unable to provide them.

2.8 Payment to Providers

2.8.1 General

DVHA and the IGA partners are responsible for ensuring timely payments to contracted providers.

DVHA shall ensure that all enrollees enrolled in the *Global Commitment to Health Waiver* are assigned a unique enrollee identification number, and a Medicaid eligibility classification as applicable.

Medicaid or VHAP enrollees will not be held liable when DVHA denies a claim from the health care provider who furnished the services. Medicaid or VHAP enrollees are further not liable for payments for covered services furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount that the enrollee would owe if AHS provided the services directly.

2.8.2 Incentive Payments

DVHA and IGA partners may make payments to providers on a risk or incentive basis, provided such arrangements are in compliance with AHS and Federal requirements and guidelines, and disclosed to AHS. In making payments on an incentive basis, DVHA (and IGA partners) shall comply as applicable with the requirements set forth in 422.208 and 422.210 regarding Physician Incentive Plans.

2.8.3 Payments to Primary Care Providers (PCP)

DVHA will ensure that each enrollee enrolled in the public insurance programs, for which the public insurance programs serve as the primary payor, has a primary care provider (PCP). PCPs are paid on a fee-for-service basis in accordance with the Medicaid fee schedule.

2.8.4 Enrollee Cost-Sharing

Enrollee cost sharing shall be in accordance with the premium and co-payment provisions of the program as established by the State of Vermont Legislature each year.

2.9 Quality Assurance and Medical Management

2.9.1 Quality Management Plan

DVHA in collaboration with its IGA partners shall maintain a comprehensive MCE Quality Management Plan for the *Global Commitment to Health Waiver*. The Quality Management Plan shall conform to all applicable Federal and State regulations. The Quality Management Plan shall be available to AHS upon request.

DVHA and its IGA partners shall maintain an ongoing program of performance improvement projects that focuses on clinical and non-clinical areas, and that involves the following:

- Measurement of performance using objective quality indicators;
- Implementation of system interventions to achieve improvements in quality;
- Evaluation of the effectiveness of the interventions;
- Planning and initiation of activities for increasing or sustaining improvement; and
- Reporting of the status and results of each project to AHS as requested and in a timely manner.

DVHA and as applicable, its IGA partners, completes each PIP in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality care every year. The CMS or AHS may specify performance measures and topics for performance improvement projects. DVHA and its IGA partners shall conduct projects specified by the CMS or AHS.

2.9.2 Utilization Management Plan

DVHA must have in effect mechanisms to detect both underutilization and over utilization of services and to assess the quality and appropriateness of care furnished to enrollees with special health care needs. DVHA has delegated the function of assessing the quality and appropriateness of care furnished to beneficiaries with special health care needs to the Department of Aging and Independent Living (DAIL) and the Department of Mental Health (DMH).

DVHA and its IGA partners, when applicable, shall adopt practice guidelines that are based on valid clinical evidence, or based on the consensus of health care professionals, consideration of the needs of the enrollees, and consultation with health care professionals who participate in the *Global Commitment to Health Waiver* and other program stakeholders. Program guidelines shall be reviewed and updated periodically as appropriate. DVHA shall disseminate guidelines in collaboration with its

IGA partners and shall require the Departments to disseminate the guidelines among all of their designated providers.

DVHA and its IGA partners make decision with regard to the following areas that are consistent with the practice guidelines: utilization management; enrollee education; coverage of services; and other areas to which the guidelines apply.

DVHA shall not structure compensation for any entity that conducts utilization management services in such a way as to provide incentives for the denial, limitation or discontinuation of medically necessary services to any enrollee.

2.9.2.1 Authorization of Services

The term “service authorization request” means a *Global Commitment to Health Waiver* enrollee’s request for the provision of a service, or a request by the enrollee’s provider.

DVHA and each of the IGA partners shall maintain and follow written policies and procedures for processing requests for initial and continuing authorization of medically necessary, covered services. The policies and procedures must conform to all applicable Federal and State regulations, including specifically 42 CFR 438.210(b).

DVHA and each of the IGA partners may require pre-authorization for certain covered services including, but not limited to, inpatient hospital admissions, home and community based services, and certain pharmaceutical products. Should DVHA or its IGA partners exercise the prior authorization option, review criteria for authorization decisions will be identified for providers. DVHA or its IGA partners will ensure consistent application of review criteria for authorization decisions.

- For standard authorization decisions, the IGA partners must reach a decision and provide notice as expeditiously as the enrollee’s health condition requires and no later than 14 calendar days from receipt of the request for service, with a possible extension of up to 14 additional calendar days if the enrollee or provider requests the extension; or the IGA partner justifies to DVHA a need for additional information and how the extension is in the enrollee’s best interest.
- For cases in which a provider indicates, or the IGA partner determines, that following the standard timeframe could seriously jeopardize the enrollee’s life or health or ability to attain, maintain or regain maximum function, the IGA partner must make an expedited authorization decision and provide notice as expeditiously as the enrollee’s health condition requires and no later than three working days after receipt of the request for service. The three days may be extended by up to 14 additional calendar days if the enrollee requests the extension, or if the IGA partner justifies to DVHA a need for additional information and how the extension is in the enrollee’s interest.

Any case where a decision is not reached within the referenced timeframes constitutes a denial. Written notice must then be issued to the enrollee on the date that the timeframe for the authorization expires. Untimely service authorizations constitute a denial and are thus adverse actions.

Planned services will be identified by the authorized clinician working with the enrollee and under the direct supervision of a prescribing provider. Any decision to deny, reduce the range, or suspend covered services, or a failure to approve a service that requires pre-authorization, will constitute

grounds for noticing the enrollee. Any disagreement identified by the enrollee at any interval of evaluation, will also be subject to notice requirements.

Notices must meet language and format requirements set forth in 42 CFR §438.404

Notice must be given within the timeframes set forth above, except that notice may be given on the date of action under the following circumstances:

- Signed written enrollee statement requesting service termination;
- Signed written enrollee statement requesting new service or range increase;
- A enrollee's admission to an institution where he or she is ineligible for further services;
- A enrollee's address is unknown and mail directed to him or her has no forwarding address;
- The enrollee's physician prescribes the change in the range of clinical need.

DVHA or its IGA partners shall notify the requesting provider and issue written notices to enrollees for any decision to deny a service, or to authorize a service in an amount, scope or duration less than that requested and clinically prescribed in the service plan. Notices must explain the action DVHA or the IGA partner has taken or intends to take; the reasons for the action; the enrollee's right to file an appeal and procedures for doing so; circumstances under which an expedited resolution is available and how to request one; the enrollee's right at any time to request a Fair Hearing for covered services and how to request that covered services be extended; the enrollee's right to request external review by DVHA/AHS for covered services (as applicable to Medicaid eligibility) or alternate services; and the circumstances under which the enrollee may be required to pay the costs of those services pending the outcome of a Fair Hearing or external review by DVHA/AHS.

2.9.3 State of Vermont and Federal Reviews

DVHA must make available to the State of Vermont and/or outside reviewers, on a periodic basis, medical, financial and other records for review of quality of care and access issues.

The CMS also will designate an outside review agency to conduct an evaluation of the *Global Commitment to Health Waiver* and its progress toward achieving program goals. DVHA must agree to make available to the CMS outside review agency medical and other records (subject to confidentiality constraints) for review as requested. This shall include AHS External Quality Review Organization.

2.10 Grievances and Appeals

DVHA and IGA partners shall adhere to uniform Grievance and Appeals rules. AHS shall review and approve any proposed change in Grievance and Appeals rules and policies. AHS shall be responsible for ensuring grievance and appeals rules, policies and practices comply with the federal statutes and regulations, including provisions applicable to MCE operations. For purposes of the Grievance and Appeals process, Designated Agencies (DA) and Specialized Services Agencies (SSA) are contracted agents of DVHA and/or its IGA partners who act within the delegated authority of the MCE for the DS and MH special populations. Therefore, any decisions these entities make that fall under the definition of "action" as defined at 42 CFR 438.400 are subject to the MCE's appeal process. MCEs must maintain records of grievances and appeals.

Grievance is defined as an expression of dissatisfaction about any matter other than an “action.” An appeal is defined as a request for review of an “action.”

Action is defined to include:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service or service plan;
- Denial, in whole or in part, of payment for a service;
- Failure to provide a clinically indicated, covered service with the MCE provider is a DA/SSA;
- Failure of to act in a timely manner when required by state rule; or
- Denial of an enrollee’s request to obtain services outside the network:

The MCE provides information about the MCE’s beneficiary appeal and State fair hearing requirements and processes to all providers and subcontractors at the time they enter into a contract with the MCE.

2.10.1 Right to Appeal

Any Medicaid applicant or beneficiary has a right to appeal any decision about his or her amount of coverage and/or to request a fair hearing before the Human Services Board.

Regarding issues of coverage MCE appeals must be filed within 90 days of the date the notice of action was mailed by the MCE, or if no mailing, within 90 days after the action occurred. A request for a fair hearing challenging an MCE decision must be made within 90 days of the date the notice of action was mailed by the MCE or within thirty (30) days of the date the notice of the MCE decision being appealed was mailed.

Medicaid beneficiaries also have the right to file grievances using the provisions of the Global Commitment for Health 1115 waiver internal grievance process. Beneficiaries (or duly appointed representatives) may file grievances orally or in writing.

2.10.2 Continued Benefits During Appeal or Fair Hearing

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice.

If the MCE or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal or State fair hearing was pending, the MCE authorizes or provides the disputed services promptly and as expeditiously as the beneficiary’s health condition requires.

Beneficiaries may waive their right to continued benefits. If they do so and are successful on an appeal, benefits will be paid retroactively.

If the MCE or the State fair hearing officer reverses a decision to deny, limit, or delay services and the beneficiary received the disputed services while the appeal and/or State fair hearing processes were pending, the MCE pays for those services.

The DVHA may recover from the beneficiary the value of any continued benefits paid during the appeal period when the beneficiary withdraws the appeal before the relevant MCE or fair hearing

decision is made, or following a final disposition of the matter in favor of the MCE. Beneficiary liability will occur only if an MCE appeal, fair hearing decision, Secretary's reversal and/or judicial opinion upholds the adverse determination, and the MCE also determines that the beneficiary should be held liable for service costs.

An issue of law or policy means that the person is questioning the legality of a law or rule rather than the facts used or DVHA's judgment in applying the rules to make the decision being appealed.

2.10.3 MCE Appeal and Fair Hearing Rules

Medicaid coverage appeals are processed in accordance with applicable MCE Appeals Rules and fair hearing rules, as promulgated separately by the Human Services Board pursuant to 3 V.S.A. 3091 (d). A copy of the Human Services Board fair hearing rules is in the All Programs Procedures Manual available at humanservices.vt.gov/boards-committees/HSB/Fair-Hearing-Rule

2.10.4 Beneficiary Appeals

A. Right to Appeal

Beneficiaries may request an internal MCE appeal of an MCE action, and a subsequent fair hearing before the Human Services Board.

MCE actions are considered preliminary decisions subject to appeal. If no appeal is filed within the 90-day time frame set out in these rules, the original or reconsidered decision is considered the final MCE decision. If an appeal is filed, the decision rendered as a result of the appeal is the final MCE decision.

Nothing in the MCE appeals procedures should preclude reconsideration of a decision by the MCE staff member or entity that made the original decision. A request for reconsideration may be made orally or in writing by the beneficiary, provider or designated representative. A request may be accompanied by any additional information that supplements or clarifies material that was previously submitted and is likely to materially affect the decision. A request for reconsideration does not suspend the 90-day time frame for filing of appeals. In addition, a request for reconsideration does not suspend the 45-day time frame for an MCE to make a decision on an appeal.

B. Request for Non Covered Services

An MCE appeal may only be filed regarding the denial of a service that is covered under Medicaid. Any request for a non-covered service must be directed to DVHA. A subsequent DVHA denial to cover such service cannot be appealed using the internal MCE process, but may be appealed through the fair hearing process.

C. Medicaid Financial Eligibility and Premium Determinations

If a beneficiary files an MCE appeal regarding only a Medicaid financial eligibility or premium determination, the entity that receives the appeal will forward it to the Department for Children and Families ("DCF"), Economic Services Division. They will then notify the beneficiary in writing that the issue has been forwarded to and will be resolved by DCF. These appeals will not be addressed through the MCE appeal process and will be considered a request for fair hearing as of the date the MCE received it.

D. Filing of Appeals

Beneficiaries may file appeals orally or in writing for any MCE action. Oral inquiries to appeal an action are treated as appeals to establish the earliest possible filing date. Providers and representatives of the beneficiary may initiate appeals only after a clear determination that the third-party involvement is being initiated at the beneficiary's request. Appeals of actions must be filed with the MCE within 90 days of the date of the MCE notice of action. The date of the appeal, if mailed, is the postmark date.

The MCE appeal process will include assistance by staff members of the MCE, as needed, to the beneficiary to initiate and participate in the appeal. Beneficiaries will not be subject to retribution or retaliation for appealing an MCE action.

E. Written Acknowledgment

Written acknowledgment of the appeal shall be mailed within five calendar days of receipt by the part of the MCE that receives the appeal.

If a beneficiary files an appeal with the wrong entity, that entity will notify the beneficiary in writing in order to acknowledge the appeal. This written acknowledgment shall explain that the issue has been forwarded to the correct division within the MCE, identify the division to which it has been forwarded, and explain that the appeal will be addressed by that division. This does not extend the deadline by which appeals must be determined.

F. Withdrawal of Appeals

Beneficiaries or designated representatives may withdraw appeals orally or in writing at any time. If an appeal is withdrawn orally, the withdrawal will be acknowledged by the MCE in writing within five calendar days.

G. Beneficiary Participation in Appeals

The beneficiary, designated representative, or the beneficiary's treating provider, if requested by the beneficiary, has the right to participate in person, by phone or in writing in the meeting in which the MCE is considering the final decision regarding their appeal. If the appeal involves a DA/SSA decision, a representative of the DA/SSA may also participate in the meeting. Beneficiaries, their designated representative, or treating provider may submit additional information that supplements or clarifies information that was previously submitted and is likely to materially affect the decision. They will also be provided the opportunity to examine the case file, including medical records and other documents or records, prior to the meeting.

Upon request, the MCE shall provide the beneficiary or their designated representative with all the information in its possession or control relevant to the appeal process and the subject of the appeal, including applicable policies or procedures and (to the extent applicable) copies of all necessary and relevant medical records. The department will not charge the beneficiary for copies of any records or other documents necessary to resolve the appeal.

H. MCE Appeals Reviewer

The individual who hears the appeal shall not have made the decision subject to appeal and shall not be a subordinate of the individual that made the original decision. Appeals shall be

decided by individual(s) designated by the entity responsible for the services that are the subject of the appeal who, when deciding an appeal of a denial that is based on medical necessity or an appeal that involves clinical issues, possess(es) the requisite expertise, as determined by the state, in treating the beneficiary's condition or disease.

I. Resolution

The beneficiary shall be notified as soon as the meeting is scheduled. Meetings will be held during normal business hours and, if necessary, the meeting will be rescheduled to accommodate individuals wishing to participate. If a scheduling or rescheduling results in exceeding the 45-day limit, an automatic 14-day time extension is effective. [For clarification, the 14-day extension will only be made if requested by the enrollee or the MCE shows that there is a need for additional information and the delay is in the enrollee's interest]. If a meeting cannot be scheduled within the 45-day time limit and 14-day extension, a decision will be rendered by the MCE without a meeting with the beneficiary, their designated representative, or treating provider.

Appeals shall be decided and written notice sent to the beneficiary within 45 days of receipt of the appeal. The 45 day period begins with the receipt of the appeal, and includes any review at the level of the DA/SSA. If an appeal cannot be resolved within 45 days, the time frame may be extended up to an additional 14 days by request of the beneficiary, or by the MCE, if the MCE demonstrates that the extension is in the best interest of the beneficiary. If the extension is at the request of the MCE, it must give the beneficiary written notice of the reason for the delay. The maximum total time period for the resolution of an appeal, including any extension requested either by the beneficiary or the MCE, is 59 days.

2.10.4.1 Expedited Appeal Requests

Expedited appeals may be requested in emergent situations in which the beneficiary or the treating provider (in making the request on the beneficiary's behalf or supporting the beneficiary's request) indicates that taking the time for a standard resolution could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function. Requests for expedited appeals may be made orally or in writing with the MCE for any MCE actions subject to appeal. The MCE will not take any punitive action against a provider who requests an expedited resolution or supports a beneficiary's appeal.

If the request for an expedited appeal does not meet the criteria and is denied, the MCE will inform the beneficiary that the request does not meet the criteria for expedited resolution and that the appeal will be processed within the standard 45 day time frame. Notice of the denial for an expedited appeal must be communicated orally to the beneficiary promptly and followed up within two calendar days with a written notice.

If the expedited appeal request meets the criteria for such appeals, it must be resolved within three working days. The written notice for any expedited appeal determination shall include a brief summary of the appeal, the resolution, the basis for the resolution, and the beneficiary's right to request a fair hearing.

2.10.4.2 Participating Provider Decisions

With the exception of a DA/SSA, provider decisions shall not be considered MCE actions and are not subject to appeal using this process. A state agency shall be considered a provider if it provides a service that is:

1. Claimed at the Medicaid service matching rate;
2. Based on medical or clinical necessity; and
3. Not prior authorized.

2.10.4.3 Notices, Continuation of Services, Beneficiary Liability for Service Costs

A. Beneficiary Notice

The division of the MCE issuing a service decision must provide the beneficiary with written notice of its decision. In cases involving a termination or reduction of service(s), such notice of decision must be mailed at least eleven (10) days before the change will take effect. Where the division's decision was adverse to the beneficiary, the notice must inform the beneficiary when and how to file an appeal. In addition, the notice must inform the beneficiary that he or she has a right to request a fair hearing; how to request a fair hearing; may request that covered services be continued without change as well as the circumstances under which the beneficiary may be required to pay the costs of those services pending the outcome of any MCE appeal or fair hearing. Service authorization decisions must be made within the time frames specified in Section 2.9.2.1 of this agreement.

Timeframes for notice of action: Termination, suspension or reduction of services - DVHA gives notice at least 10 days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services, except:

- When the period of advanced notice is shortened to 5 days if probable recipient fraud has been verified
- death of a recipient;
- DVHA receives a signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he or she understands that this must be the result of supplying that information);
- the recipient is admitted to an institution where he or she is ineligible for further services;
- when the recipient's address is unknown and mail directed to him or her has no forwarding address;
- when the recipient has been accepted for Medicaid services by another state;
- when the recipient's physician prescribes the change in the level of medical care;
- when an adverse determination is made with regard to the preadmission screening requirements for Nursing Facility (NF) admissions on or after January 1, 1989; or the safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 days (applies only to adverse actions for NF transfers).

Timeframes for notice of action: Denial of payment – DVHA gives notice on the date of action when the action is a denial of payment.

B. Continuation of Services

1. If requested by the beneficiary, services must be continued during an appeal regarding a Medicaid-covered health service termination or reduction under the following circumstances:
 - a. The MCE appeal was filed in a timely manner, meaning before the effective date of the action or within 10 days of DVHA mailing the notice of action.
 - b. The beneficiary has paid any required premiums in full;
 - c. The appeal involves the termination, suspension or reduction of a previously authorized course of treatment or service plan;
 - d. The services were ordered by an authorized provider and the original period covered by the authorization has not expired.
2. Where properly requested, a service must be continued until any one of the following occurs:
 - a. The beneficiary withdraws the appeal;
 - b. Any limits on the cost, scope or level of service, as stated in law or rule, have been reached;
 - c. The MCE issues an appeal decision adverse to the beneficiary, and the beneficiary does not request a fair hearing within the applicable time frame;
 - d. A fair hearing is conducted and the Human Services Board issues a decision adverse to the beneficiary; or
 - e. The original service period ordered by an authorized provider has expired.

Beneficiaries may waive their right to receive continued benefits pending appeal.

C. Change in Law

Continuation of benefits without change does not apply when the appeal is based solely on a reduction or elimination of a benefit required by federal or state law affecting some or all beneficiaries, or when the decision does not require the minimum advance notice.

D. Beneficiary Liability for Cost of Services

A beneficiary may be liable for the cost of any services provided after the effective date of the reduction or termination of service or the date of the timely appeal, whichever is later.

The MCE may recover from the beneficiary the value of any continued benefits paid during the appeal period when the beneficiary withdraws the appeal before the relevant MCE or fair hearing decision is made, or following a final disposition of the matter in favor of the MCE. Beneficiary liability will occur only if an MCE appeal, fair hearing decision, Secretary's reversal and/or judicial opinion upholds the adverse determination, and the MCE also determines that the beneficiary should be held liable for service costs.

If the provider notifies the beneficiary that a service may not be covered by Medicaid, the beneficiary can agree to assume financial responsibility for the service. If the provider fails to inform the beneficiary that a service may not be covered by Medicaid, the beneficiary is not

liable for payment. Benefits will be paid retroactively for beneficiaries that assume financial responsibility for a service and who are successful on such service coverage appeal.

E. Appeals Regarding Proposed Services

If an appeal is filed regarding a denial of service eligibility, the MCE is not required to initiate service delivery.

The MCE is not required to provide a new service or a health service that is not a Medicaid-covered service while an appeal or fair hearing determination is pending.

F. Non-English Notices

Written notices must be translated for the individuals who speak prevalent non-English languages (as defined by the State per 42 CFR 438.10(c)). Notices must include language clarifying that oral interpretation is available for all prevalent languages and how to access it. Written materials must use easily understood language and format, be available in alternative formats, and in an appropriate manner that takes into consideration those with special needs. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

2.10.5 Fair Hearing

A beneficiary who wishes to obtain a fair hearing must request it within 90 days of the date the notice of action was mailed by the MCE or if no mailing, within 90 days after the action occurred. A request for a fair hearing challenging an MCE appeal decision must be made within 90 days of the date the original notice of the MCE decision being appealed was mailed, or within 30 days of the date the notice of the MCE decision being appealed was made. If the beneficiary's original request for an MCE appeal was filed before the effective date of the adverse action and the beneficiary has paid in full any required premiums, the beneficiary's services will continue.

MCE beneficiaries have the right to file requests for fair hearings related to eligibility and premium determinations. DCF shall retain responsibility for representing the State in any fair hearings pertaining to such eligibility and premium determinations. Hearing descriptions must be included in enrollee and provider information within the MCE contract. A provider who is an authorized representative may request a State fair hearing.

- If the MCE takes action and the enrollee requests a State Fair Hearing, the State (not the MCE) must grant the enrollee a State Fair Hearing. The right to a state fair hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the enrollee and provider by the MCE (if they have delegated authority) or by the State (if the State has not delegated that authority).

2.10.6 School-Based Health Services

The State uses the School-Based Health Services Program to obtain Medicaid reimbursement for medical services provided by schools to eligible students. To be eligible, the students must be enrolled in Medicaid, receiving special education services, and receiving Medicaid-billable services. School districts can claim reimbursement under the Program only for those students on an individualized education program ("IEP") and not for students on 504 plans. A release of protected health information for each eligible student is required before any claims can be processed. The parent or guardian has

the right to refuse to give consent to such a release. In such case, the school district cannot claim Medicaid reimbursement for any services provided to that student. Additionally, a physician or a nurse practitioner must sign a physician authorization form, establishing that the IEP services are medically necessary.

Federal Individuals with Disabilities Education Improvement Act (“IDEA”) statutes and regulations govern the process for assessing needs and developing the IEP. Separate Department of Education due process and appeals procedures apply when there is a disagreement concerning the services included in the IEP. Parents of a child receiving special education services who disagree with decisions made by the school regarding a child’s identification, eligibility, evaluation, IEP or placement have three options available under the DOE procedures for resolving disputes with the school: mediation, a due process hearing and/or an administrative complaint. The Department of Education due process and appeals procedures also apply to Global Commitment services authorized under Part C of IDEA.

2.10.7 Beneficiary Grievances

2.10.7.1 Filing Grievances

A grievance may be expressed orally or in writing by the enrollee and/or their representative. A beneficiary or his or her designated representative must file any grievance within 60 days of the pertinent issue in order for the grievance to be considered. Staff members will assist a beneficiary if the beneficiary or his or her representative requests such assistance. The MCE must have a process to ensure that the individuals who make decisions on grievances are individuals who:

- Were not involved in any previous level of review or decision-making
- Are health care professionals who have the appropriate clinical expertise in treating the beneficiary’s condition or disease, if deciding a grievance regarding the denial of expedited resolution of an appeal, or a grievance that involves a clinical issue.

2.10.7.2 Written Acknowledgment

Written acknowledgment of the grievance must be mailed within five calendar days of receipt by the MCE. The acknowledgment must be made by the part of the MCE responsible for the service area that is the subject of the grievance. If the MCE decides the issue within the five day time frame, it need not send separate notices of acknowledgment and decision. The decision notice is sufficient in such cases.

2.10.7.3 Withdrawal of Grievances

Beneficiaries or designated representatives may withdraw grievances orally or in writing at any time. If a grievance is withdrawn orally, the withdrawal will be acknowledged by the MCE in writing within five calendar days.

2.10.7.4 Disposition

All grievances shall be addressed within 90 calendar days of receipt. The decision maker must provide the beneficiary with written notice of the disposition. The written notice shall include a brief summary of the grievance, information considered in making the decision, and the disposition. If the response is adverse to the beneficiary, the notice must also inform the beneficiary of his or her right to initiate a grievance review with the MCE, as well as information on how to initiate such review. If the grievance decision constitutes an action adverse to the beneficiary, then the beneficiary shall be entitled to all fair hearing rights.

2.10.7.5 MCE Grievance Review

A. Initiating a Grievance Review

If a grievance is decided in a manner adverse to the beneficiary, the beneficiary may request a review by the MCE within 10 calendar days of the decision. The review will be conducted by an individual who was not involved in deciding the grievance under review and is not a subordinate of the individual who decided the original grievance. [For clarification, a grievance is defined as an expression of dissatisfaction where there is no action. If the grievance decision constitutes an action adverse to the beneficiary, the grievance review process shall not delay or inhibit an enrollee's ability to request a fair hearing.]

B. Written Acknowledgment

The MCE will acknowledge grievance review requests within five calendar days of receipt.

C. Disposition

The grievance review will assess the merits of the grievance issue(s), the process employed in reviewing the issue(s), and the information considered in making a final determination. The primary purpose of the review shall be to ensure that the grievance process has functioned in an impartial manner and that the response was consistent with the issues and/or facts presented. The beneficiary will be notified in writing of the findings of the grievance review, which is considered final.

2.10.7.6 MCE Components with Responsibility for Addressing Grievances

The MCE and any part of the MCE receiving funds for the provision of services under the Global Commitment to Health shall be responsible for resolving grievances initiated under these rules.

2.11 Enrollee Records

DVHA and its member departments shall guard the confidentiality and privacy of individually identifiable health information contained in enrollee records in a manner consistent with 45 CFR parts 160 and 164 (Health Insurance Portability and Accountability Act) to the extent that these requirements are applicable. Specific requirements include the following: policies and procedures for protecting enrollee information; procedures for authorizing access to enrollee information; physical security procedures; and information system security procedures." Enrollee records must include all recipient information required for utilization review as specified in 42 CFR 456.

2.12 Reporting Requirements

2.12.1 Encounter Data

The state has defined an encounter as a claim. DVHA shall maintain claims history data for all *Global Commitment to Health Waiver* enrollees through contractual arrangements with its Fiscal Agent. Reporting shall be in accordance with the CMS Special Terms and Conditions of the 1115 Medicaid Waiver Demonstration. DVHA shall make such claims/encounter data available to AHS and CMS upon request.

2.12.1.1 Data Validation

Encounter data is currently defined by the AHS as a “claim”. All claims for payments are currently submitted to EDS undergo a series of automated edits and audits to ensure accuracy, timeliness, correctness, and completeness. Any claim failing edits will be rejected and must be re-submitted. Claims must represent services provided to *Global Commitment to Health Waiver* enrollees only. DVHA will perform validation on a random sample of all claims to ensure that services were actually provided.

2.12.2 Financial Reporting

DVHA, IGA partners and AHS shall collaborate to generate and maintain the following financial information and records:

- Quarterly comparisons of projected vs. actual expenditures;
- Quarterly report of DVHA revenues and expenses for the *Global Commitment to Health Waiver*;
- Quarterly analysis of expenditures by service type; and
- All reports and data necessary to support waiver reporting requirements.

AHS, the U.S. Department of Health and Human Services and the U.S. Government Accountability Office shall have the right to inspect and audit any financial records of DVHA and IGA partners.

2.12.3 Network Reporting

AHS shall review variable definitions used by DVHA and any relevant reporting by DVHA’s contractors relative to beneficiary access to services to ensure that providers enrolled in the Vermont Medicaid Program offers an appropriate range of covered services adequate for the anticipated number of enrollees for a given service area; and that it the network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the enrollees in the service area.

DVHA in collaboration with its IGA partners will update network capacity data any time there has been a significant change in operations that would affect adequate capacity or services, including changes in services, benefits, payments or enrollment of a new population.

2.13 Fraud and Abuse

DVHA in collaboration with its IGA partners must have both administrative and management procedures, and a mandatory compliance plan, to guard against fraud and abuse. The procedures and compliance plan must include the following:

- Written policies, procedures and standards of conduct that articulate a commitment to comply with all applicable Federal and State standards;
- Designation of a compliance officer and a compliance committee that are accountable to senior management;
- Effective training and education for the compliance officer and all of DVHA’s employees;
- Effective lines of communication between the compliance officer and employees;
- Enforcement of standards through well-publicized disciplinary guidelines;

- Provision for internal monitoring and auditing; and
- Provision for prompt response to detected offenses, and for development of corrective action initiatives.

DVHA must further require any employees, contractors, and grantees that provide goods or services for the *Global Commitment to Health Waiver* to furnish, upon reasonable request, to DVHA, the Vermont Attorney General, and the United States DHHS, any record, document, or other information necessary for a review, audit, or investigation of program fraud or abuse, and shall establish procedures to report all suspected fraud and abuse to AHS and the Vermont Attorney General. For each case of suspected fraud and abuse reported, DVHA shall supply (as applicable) the name and identification number; source of the complaint or issue; type of provider; nature of the complaint or issue; the approximate dollars involved; and the legal and administrative disposition of the case. DVHA must provide access to both original documents and provide free copies of requested documents on a reasonable basis. Such access may not be limited by confidentiality provisions of the plan or its contractors.

2.14 Records Retention

2.14.1 General

DVHA must maintain books and records relating to the *Global Commitment to Health Waiver* services and expenditures, including reports to the State and source information used in preparation of these reports. These records include but are not limited to financial statements, records relating to quality of care, medical records, and prescription files. DVHA also agrees to comply with all standards for record keeping specified by AHS. In addition DVHA agrees to permit inspection of its records.

2.14.2 Confidentiality of Information

DVHA agrees that all information, records, and data collected in connection with the agreement shall be protected from unauthorized disclosures. In accordance with section 1902(a) (7) of the Social Security Act, DVHA agrees to provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan. In addition, DVHA agrees to guard the confidentiality of recipient information, in a manner consistent with the confidentiality requirements in 45 CFR parts 160 and 164. Access to recipient identifying information shall be limited by DVHA to persons or agencies which require the information in order to perform their duties in accordance with the agreement, including AHS, the United States DHHS, and other individuals or entities as may be required by the State of Vermont.

Any other party may be granted access to confidential information only after complying with the requirements of State and Federal laws and regulations, including 42 CFR 431, Subpart F pertaining to such access. AHS shall have absolute authority to determine if and when any other party shall have access to this confidential information. Nothing herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals.

Nothing in this section shall be construed to limit or deny access by enrollees or their duly authorized representatives to medical records or information compiled regarding their case, or coverage, treatment or other relevant determinations regarding their care, as mandated by State and/or Federal laws and regulations.

2.15 Disclosure Requirements

DVHA must comply with any applicable Federal and State of Vermont laws that pertain to enrollee rights, and must ensure that its staff and affiliated providers take enrollee rights into account when furnishing services to enrollees. DVHA must have a written policy on *Global Commitment to Health Waiver* enrollee rights that addresses the enrollee's right to:

- Be treated with respect, dignity, and privacy;
- Be provided with information about the Demonstration Program, its services, practitioners, and enrollee rights and responsibilities;
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand;
- Be able to choose health care providers within the limits of DVHA network;
- Participate in decision-making regarding their health care;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;
- Voice grievances about the program or care received;
- Formulate advance directives; and
- Have access to copies of his/her medical record and to request that the medical record be amended or corrected.

DVHA must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way DVHA or its providers treat the enrollee.

DVHA must comply with disclosure requirements in 1902(a)(7) of the Social Security Act and 42 CFR 431, Subpart F, and 42 CFR 455, Subpart B. DVHA also must inform *Global Commitment to Health Waiver* enrollees about:

- Rights and responsibilities, including rights to terminate enrollment;
- Policies on advance directives;
- Provisions for after-hours coverage; and
- Procedures for DVHA-approved disenrollments.

ARTICLE THREE: AHS RESPONSIBILITIES

3.1 Eligibility Determination

The Agency of Human Services (AHS) shall maintain sole responsibility for the establishment of eligibility requirements and standards for Medicaid or VHAP, as well as any other eligibility requirements for expansion populations under the *Global Commitment to Health Waiver*.

3.2 Capitation Rate Setting

AHS shall establish fixed rates for monthly payments for *Global Commitment to Health Waiver* enrollees. The capitation payments will be based on the fee-for-service equivalent cost for the package of services that are to be administered through DVHA. The methodology for capitation rate setting will be subject to approval of the CMS.

3.3 Performance Evaluation

AHS shall, at its discretion, do the following:

- Define measurable performance standards for DVHA and its subcontractors in all of the following areas:
 - Service Accessibility
 - Enrollee Satisfaction
 - Quality Assurance & Medical Management
 - Grievance & Appeal Resolution
 - Reporting
- Monitor and evaluate DVHA’s compliance with the terms of this IGA, including performance standards;
- Meet with DVHA a minimum of twice a year to assess the performance of its Quality Assurance Program;
- Review reports submitted by DVHA, including specifically quarterly reports on grievances and appeals received by DVHA and its IGA partners;
- Request additional reports that AHS deems necessary for purposes of monitoring and evaluating the performance of DVHA under this IGA;
- Engage in audit activities performed by AHS staff and/or its sub-contracted EQRO designed to determine if DVHA and its IGA partners are in compliance with standards established by AHS for access to care, structure and operations, and, quality measurement and improvement.
- Perform periodic financial reviews of DVHA’s performance of responsibilities. This may include, but is not limited to a review of the following:
 - Administration
 - Operations
 - Financial performance

- Provide DVHA and/or its IGA partners prior notice of any on-site visit by AHS or its agents to conduct an audit, and further notify DVHA of any records that must be made available for review;
- Inform DVHA and/or its IGA partners of the results of any performance evaluations conducted by AHS or its agents;
- Develop Corrective Action Plans (CAP) to address any areas of non-compliance or poor performance identified as part of the evaluation process. In the event a CAP is issued to DVHA or one of its IGA partners, DVHA will be required to file a formal response within the time period specified in the CAP. AHS will review and approve or modify the response, as appropriate. AHS will monitor implementation of the CAP response through progress reports and interim audits until it is satisfied that the deficiency has been corrected.

The EQRO shall perform an annual, external independent review of the quality outcomes, timeliness of, and access to, the services covered under this IGA. AHS shall contract with an External Quality Review Organization (EQRO) in order to obtain independent monitoring of DVHA's Quality Management Program.

3.4 Access to, and Analysis of Encounter Data

AHS shall have access to the claims data as reported by DVHA or IGA partners. AHS may, at its discretion, conduct an evaluation of the claims to identify any changes from historical utilization rates, areas of potential over- or under-utilization, and any other issues that may affect the success of the program.

3.5 Centers for Medicare and Medicaid Services (CMS) Reporting

AHS shall retain sole responsibility for production and submission of reports to the CMS, including all fiscal reports. DVHA agrees to cooperate with AHS in the preparation of any required reports, including providing any necessary data and analysis, preparation of materials for submission to the CMS, and assisting in the preparation of responses to any questions or issues the CMS may raise with respect to the reports.

3.6 Ombudsman

DVHA shall coordinate with the State of Vermont Health Care Ombudsman and provide information necessary to support this function. AHS shall ensure that DVHA provides for an Ombudsman function.

3.7 Third Party Liability (TPL)

DVHA will be responsible for identifying and pursuing accident insurance and estate recovery; and all other sources of third party liability (TPL). AHS shall monitor DVHA's experience in identifying sources of third party liability or coverage and in collecting funds due to it through these sources.

3.8 Sanctions

The Department of Vermont Health Access (DVHA) may be subject to sanctions by the Agency of Human Services (AHS) if AHS determines that DVHA acted or failed to act as follows:

1. DVHA fails substantially to provide medically necessary services, required by law or contract, to an enrollee covered under the contract;
2. DVHA imposes on enrollees premiums or charges that exceed Medicaid limits;
3. DVHA discriminates among enrollees on the basis of their health care status or need for health care services;
4. DVHA misrepresents or falsifies information that it furnished to CMS or AHS;
5. DVHA misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or health care provider;
6. DVHA fails to comply with the requirements for physician incentive plans;
7. DVHA provides marketing materials that are unapproved by AHS or that contain false or intentionally misleading information;
8. DVHA has violated federal law or regulations, including the applicable sections of sections 1903(m) or 1932 of the Social Security Act and any implementing regulations.

3.8.1 Sanctions by CMS

DVHA acknowledges that payments for new enrollees under this contract will be denied when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements of 42 CFR 438.730.

3.8.2 Types of Sanctions

AHS reserves the right to impose the following sanctions if it determines that DVHA has violated any of the items enumerated in Section 3.8:

- Appointment of temporary management as provided in 42 CFR 438.706;
- Granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;
- Suspension of all new enrollment, including default enrollment, after the effective date of the sanction;
- Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or AHS is satisfied that the reason for the imposition of the sanction no longer exists and is not likely to recur.

3.8.3 Temporary Management

AHS may impose temporary management if it finds that:

- There is continued egregious behavior by DVHA, including, but not limited to behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Act; or
- There is substantial risk to enrollees' health; or
- The sanction is necessary to ensure the health of DVHA's enrollees while improvements are made to remedy violations under 438.700 or until there is an orderly contract termination or reorganization of DVHA.

Nothing in this subpart should be construed as requiring AHS to impose temporary management in these situations. However, AHS will impose temporary management if it finds that DVHA has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Social Security Act. AHS will also grant enrollees the right to terminate enrollment without cause and will notify affected enrollees of their right to terminate. AHS will not delay imposition of temporary management to provide a hearing before imposing this sanction. AHS will not terminate temporary management unit it determines that DVHA can ensure that the sanctioned behavior will not reoccur.

3.8.4 Termination of the Contract

AHS may terminate its contract with DVHA and provide enrollee benefits through other options included in the State plan if AHS determines that DVHA has failed to:

- Carry out the substantive terms of its contract.
- Meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Act.

3.8.5 Due Process

AHS will notify DVHA prior to the imposition of sanctions through a written notice that explains:

- The basis and nature of the sanction.
- The right to a pre-termination hearing.

Prior to terminating DVHA's contract under 42 CFR 438.708, AHS will provide DVHA with a pre-termination hearing. AHS will:

- Give DVHA written notice of AHS' intent to terminate, the reason for termination, and the time and place of the hearing.
- Give DVHA (after the hearing) written notice of the decision affirming or reversing the proposed termination of the contract, and for an affirming decision, the effective date of termination; and
- For an affirming decision, give DVHA enrollees notice of the termination and information, consistent with 438.10, on their options for receiving Medicaid services following the effective date of termination.

During the disenrollment process, and after AHS notifies DVHA of its intent to terminate the contract, AHS may:

- Give DVHA enrollees written notice of the AHS' intent to terminate the contract.
- Allow enrollees to disenroll immediately without cause.

ARTICLE FOUR: PAYMENT PROVISIONS

4.1 Capitation Payment between AHS and DVHA

DVHA shall be paid Federal Medicaid matching funds based on eligible *Global Commitment to Health Waiver* enrollees at the capitated monthly amounts approved by AHS and CMS under the *Global Commitment to Health Waiver* Terms and Conditions. The capitation rates provided under the *Global Commitment to Health Waiver* will comply with the actuarial certification requirements of the Balanced Budget Act (BBA).

Administrative costs related to operation of the managed care entity shall be reimbursed as part of the monthly capitation payment. The following administrative functions shall not be reimbursed as part of the capitation and shall be reported in accordance with the Special Terms and Conditions and existing Federal regulations:

- Administration of the long-term care program
- Agency of Human Services/Central Office functions
- Systems enhancements

Capitation payments serve as full compensation for the provision of covered health care services to *Global Commitment to Health Waiver* enrollees. AHS will reconcile the estimated capitation payments against actual expenditures (Administrative, Program, and MCE Investments) under the *Global Commitment to Health Waiver*, upon filing the quarterly CMS-64 report.

DVHA shall be at risk for the provision of all covered health services required by *Global Commitment to Health Waiver* enrollees. Third-party collections shall be the responsibility of and retained by DVHA, the IGA partners, or providers, pursuant to the Inter-Departmental IGAs or provider agreements.

Capitated payment rates for the period from October 1, 2011 through September 30, 2012 are as follows:

Rate Category	Monthly Capitation Rate
ABD, Non-Dual, Adult	\$1,188.00
ABD, Non-Dual, Child	\$2,504.86
ABD, Dual	\$1,303.12
ANFC, Adult	\$751.19
ANFC, Child	\$411.61
Global Expansion (VHAP)	\$456.77
Global Rx, Dual	\$20.45
Global Rx, Non-Dual	\$36.76
Optional Expansion	\$169.24
VHAP ESI	\$241.39
ESI Premium Assistance	\$178.53
Catamount Premium Assistance	\$424.28

4.2 Payments Between DVHA and IGA Partners

DVHA shall authorize funding from the MCE capitation fund based on the cost of delivering eligible services to individuals covered under the *Global Commitment to Health Demonstration* as identified in the IGAs. Payments from the MCE capitation fund must be permissible under Vermont law.

4.3 Use of Excess Funds

Should the *Global Commitment Fund* have any excess funds following payment of all providers, including IGA partners, for *Global Commitment to Health* enrollees, those excess funds may be used to support health initiatives in the State of Vermont.

Pursuant to Item #40 of the Global Commitment to Health Special Terms and Conditions, any revenue from capitation payments related to the beneficiaries covered under this demonstration may only be used for the following purposes:

- Reduce the rate of uninsured and/or underinsured in Vermont;
- Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
- Provide public health approaches to improve the health outcomes and the quality of life for Medicaid-eligible individuals in Vermont; and
- Encourage the formation and maintenance of public-private partnerships in health care.

Restrictions on the use of excess funds are as follows:

- Funds may not be used as State match in subsequent years
- Funds may not be used to purchase health care services provided to individuals incarcerated in correctional facilities, with the exception of discharge planning for inmates with health care needs who have established *Global Commitment to Health Waiver* eligibility
- Funds may not be used to purchase health care services covered under the Vermont State Employee Benefit Plan

AHS will collect and report to CMS detailed information annually on how excess funds are spent.

4.4 American Recovery & Reinvestment Act

The funds used to support this agreement in full or in part, are provided through the federal American Recovery and Reinvestment Act (ARRA or the Act); this agreement therefore is subject to payment criteria and specific reporting requirements mandated by the Act. A periodic report, certified by an authorized agent of the DVHA, utilizing the form provided by the State of Vermont, shall be submitted as required. Failure to submit timely accurate and fully executed reports will result in a mandate to return state funds already disbursed under this agreement or a withholding of current and future payments under this agreement until such a time as the reporting irregularities are resolved to the State's satisfaction.

The parties to this agreement are further bound by the Act that they shall promptly refer to an appropriate federal inspector general any credible evidence that a principle, employee, agent, contractor, sub-recipient, or other person has submitted a false claim under the False Claims Act or has committed a criminal or civil violation of laws pertaining to fraud, conflict of interest, bribery, gratuity, or similar misconduct involving the ARRA funds used to support this agreement.

Attachment A Acronyms

ACCESS	The computer software system for eligibility used to track program information
AHS	Agency of Human Services
ASL	American Sign Language
BBA	Balanced Budget Act
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CLIA	Clinical Laboratory Improvements Amendments
CRT	Community Rehabilitation and Treatment
DAIL	Department of Disabilities, Aging and Independent Living
DCF	Department for Children and Families
DOE	Department of Education
DHHS	Department of Health and Human Services (United States)
ER	Emergency Room
ESD	Economic Services Division (of the Department for Children and Families)
IGA	Intergovernmental Agreement
LTC	Long-Term Care
MCE	Managed Care Organization (Public MCE)
MMIS	Medicaid Management Information System
DVHA	Department of Vermont Health Access
PA	Prior Authorization
PCP	Primary Care Provider
PMPM	Per Member Per Month
SUBCONTRACTORS	Vendors, organizations, health care excluding an IGA partner
TPL	Third Party Liability
TTY/TTD	Teletypewriter/Telecommunications Device for the Deaf
VDH/DOH	Vermont Department of Health
VHAP	Vermont Health Access Plan

Attachment B
Description of Covered Benefits and Populations

The Managed Care Organization (MCE) must provide for all the listed services and populations currently covered unless otherwise authorized by the Vermont Legislature and the Agency of Human Services (AHS).

Mandatory Categorically Needy Groups ¹	Mandatory Special Coverage Groups	Optional Categorically Needy Groups ²	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
1931 low income families with children (1902(a)(10)(A)(i)(I)) (1931)	newborns deemed eligible for 1 year as long as mother remains eligible or would remain eligible if pregnant (1902(e)(4))	individuals who are eligible for but not receiving IV-A, SSI or State supplement cash assistance (1902(a)(10)(A)(ii)(I)) COVERED	individuals under 18 who would be mandatorially categorically eligible except for income and resources (1902(a)(10)(C)(ii)(I))	all individuals under 21 or at State option 20, 19, or 18 or reasonable classifications who would not be covered under mandatory medically needy group of individuals under 18 (1902(a)(10)(C)) (1905(a)(i)) COVERED	inpatient hospital services	care furnished by State licensed practitioners (<i>podiatrist, optometrist, chiropractor, licensed clinical social worker, licensed mental counselor or licensed marriage and family therapist, psychologist, optician, hi-tech nursing, nurse practitioner, licensed lay midwife</i>) COVERED; CHIROPRACTIC NOT COVERED FOR ADULTS
children receiving IV-E payments (IV-E foster care or adoption assistance) (1902(a)(10)(i)(I))	pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post partum services ³ (1902(e)(5))	individuals who could be eligible for IV-A cash assistance if State did not subsidize child care (1902(a)(10)(A)(ii)(II)) COVERED	pregnant women who would be categorically eligible except for income and resources (1902(a)(10)(C)(ii)(II))	specified relatives of dependent children who are ineligible as categorically needy (42 CFR 435.301(b)(2)(ii)) (42 CFR 435.310) COVERED	outpatient hospital, RHC, and FQHC services including ambulatory services offered by FQHCs	private duty nursing services COVERED

Mandatory Categorically Needy Groups ¹	Mandatory Special Coverage Groups	Optional Categorically Needy Groups ²	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
<p>individuals who lose eligibility under 1931 due to employment (1902(a)(10)(A)(i)(I)) (402(a)(37)) (1925)</p>	<p>pregnant women losing eligibility because of a change in income remain eligible 60 days post partum (1902(a)(10)(A)(i)(IV)) (1902(e)(6))</p>	<p>individuals who are eligible for Title IV-A if State AFDC plan were as broad as allowed (1902(a)(10)(A)(ii)(II)) COVERED</p>	<p>newborns, who except for income and resources would be eligible as categorically needy, deemed eligible for 1 year as long as mother remains eligible or would remain eligible if pregnant (1902(a)(10)(C)) (1902(e)(4))</p>	<p>aged individuals who are ineligible as categorically needy (42 CFR 435.301(b)(2)(iii)) (42 CFR 435.320) (42 CFR 435.330) COVERED</p>	<p>X-rays services and other laboratory services</p>	<p>dental services COVERED</p>
<p>individuals who lose eligibility under 1931 because of child or spousal support (1902(a)(10)(A)(i)(I)) (406(h))</p>	<p>poverty level infants and children who while receiving inpatient services loses eligibility because of age must be covered through an inpatient stay (1902(e)(7))</p>	<p>individuals who would have been eligible for IV-A cash assistance, SSI, or State supplement if not in a medical institution (1902(a)(10)(A)(ii)(IV)) COVERED</p>	<p>pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post partum services (1902(a)(10)(C)) (1905)(e)(5))</p>	<p>blind individuals who are ineligible as categorically needy but meet the definition of blindness (42 CFR 435.301(b)(2)(iv)) (42 CFR 435.324) (42 CFR 435.330) COVERED</p>	<p>nursing facility services for individuals over 21</p>	<p>physical therapy; occupational therapy; speech, hearing, and language disorders services COVERED</p>

Mandatory Categorically Needy Groups ¹	Mandatory Special Coverage Groups	Optional Categorically Needy Groups ²	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
<p>individuals participating in a work supplementation program who would otherwise be eligible under 1931 (1902(a)(10)(A)(i)(I)) (482(e)(6))</p>	<p>Qualified Medicare Beneficiaries (QMBs)⁴ (1902(a)(10)(E)(i)) (1905(p)(1))</p>	<p><i>special income level group:</i> individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard or a separate standard specified by the State that does not exceed 300% of FPL (1902(a)(10)(A)(ii)(V)) COVERED</p>	<p>blind and disabled individuals eligible in December 1973 (42 CFR 435.340)</p>	<p>disabled individuals who are ineligible as categorically needy that meet the categorically needy definition of blindness (1902(a)(10)(C)) COVERED</p>	<p>EPSDT services for individuals under 21</p>	<p>prescribed drugs COVERED</p>
<p>individuals receiving SSI cash benefits (does not apply to 209(b) States) (1902(a)(10)(A)(i)(I))</p>	<p>qualified disabled and working individuals⁵ (1902(a)(10)(E)(ii)) (1905(s))</p>	<p>individuals receiving home and community-based wavier services who would only be eligible for Medicaid under the State plan if they were in a medical institution (1902(a)(10)(A)(ii)(VI)) COVERED</p>		<p>individuals who would have been ineligible if they were not enrolled in a MCE¹¹ (1902(a)(10)(C)) ((1902(e)(2)) NOT COVERED</p>	<p>physician services</p>	<p>dentures NOT COVERED</p>
<p>disabled children no longer eligible for SSI benefits because of a change in definition of disability (1902(a)(10)(A)(i)(II))</p>	<p>Specified Low Income Medicare Beneficiaries (SLMBs)⁶ (1902(a)(10)(E)(iii))</p>	<p>individuals who are terminally ill, would be eligible if they were in a medical institution, and will receive hospice care (1902(a)(10)(A)(ii)(VII)) COVERED</p>			<p>medical and surgical services of a dentist</p>	<p>prosthetic devices COVERED</p>

Mandatory Categorically Needy Groups ¹	Mandatory Special Coverage Groups	Optional Categorically Needy Groups ²	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
qualified pregnant women (1902(a)(10)(A)(i)(III)) (1905(n)(1))	qualifying individuals ^{7,8} (QIs) (1902(a)(10)(E)(iv)(I))	children under 21(or at State option 20, 19, or 18) who are under State adoption agreements (1902(a)(10)(A)(ii)(VIII)) COVERED			nurse-midwife services	eyeglasses COVERED FOR CHILDREN ONLY
qualified children (1902(a)(10)(A)(i)(III)) (1905(n)(2))		poverty level pregnant women not mandatorially eligible (1902(a)(10)(A)(ii)(IX)) (1902(l)(1)(A)) COVERED			pediatric nurse practitioner/ family nurse practitioner services	diagnostic services COVERED
poverty level pregnant women (1902(a)(10)(A)(i)(IV)) (1902(l)(1)(A))		poverty level infants not mandatorially eligible (1902(a)(10)(A)(ii)(IX)) (1902(l)(1)(B)) COVERED			family planning services and supplies	preventive services and screening services COVERED

Mandatory Categorically Needy Groups ¹	Mandatory Special Coverage Groups	Optional Categorically Needy Groups ²	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
poverty level infants (1902(a)(10)(A)(i)(IV)) (1902(l)(1)(B))		poverty level children under 6 not mandatorially eligible (1902(a)(10)(A)(ii)(IX)) (1902(l)(1)(C)) COVERED			home health for those entitled to NF services	rehabilitative services recommended by a physician or other practitioners or the healing arts (<i>substance abuse, community mental health center, PNMI (child care services, assistive community care services, therapeutic substance abuse treatment), school health services, child sexual abuse and juvenile sex offender treatment, intensive family based, developmental therapy, day health rehab</i>) COVERED
qualified family members (1902(a)(10)(A)(i)(V)) (1905(m)(1))		poverty level children under 19, who are born after September 30, 1983 (or, at State option, after any earlier date) not mandatorially eligible (1902(a)(10)(A)(ii)(IX)) (1902(l)(1)(D)) COVERED			clinic services (<i>psychotherapy, group therapy, day hospital, chemotherapy, diagnosis and evaluation, emergency care</i>) COVERED	inpatient hospital, nursing facility, and services in IMDs for over 65 COVERED

Mandatory Categorically Needy Groups ¹	Mandatory Special Coverage Groups	Optional Categorically Needy Groups ²	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
poverty level children under age 6 (1902(a)(10)(i)(VI)) (1902(l)(1)(C))		aged or disabled individuals whose SSI income does not exceed 100% of FPL (1902(a)(10)(A)(ii)(X)) (1902(m)(1)) NOT COVERED				ICF/MR services COVERED
poverty level children under age 19, who are born after September 30, 1983 (or, at State option, after any earlier date) (1902(a)(10)(i)(VII)) (1902(l)(1)(D))		individuals receiving only an optional State supplement payment which may be more restrictive than the criteria for an optional State supplement under title XVI (1902(a)(10)(A)(ii)(XI)) COVERED			Extended services for pregnant women for a 60-day postpartum	inpatient psychiatric hospital services for under 21 COVERED
disabled individuals whose earnings exceed SSI substantial gainful activity level (1619(a))		TB infected individuals ⁹ (1902(a)(10)(A)(ii)(XII)) (1902(z)(1)) NOT COVERED				hospice care services COVERED
disabled individuals whose earnings are too high to receive SSI cash benefits (1619b))		working disabled individuals who buy in to Medicaid (BBA working disabled group) (1902(a)(10)(A)(ii)(XIII)) COVERED				case management services COVERED

Mandatory Categorically Needy Groups ¹	Mandatory Special Coverage Groups	Optional Categorically Needy Groups ²	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
disabled individuals whose earnings are too high to receive SSI cash benefits (1902(a)(10)(i)(II)) (1905(q))		targeted low income children (1902(a)(10)(A)(ii)(XIV)) (1905(u)(2)) NOT COVERED				targeted case management services COVERED
Pickle amendment: individuals who would be eligible for SSI if Title II COLAs were deducted from income (section 503 of P.L. 94-566) (1935(a)(5)(E))		working disabled individuals, at least 16 and no more than 65 years of age, who buy into Medicaid under TWWIIA basic coverage group (1902(a)(10)(A)(ii)(XV)) NOT COVERED				TB related services NOT COVERED
disabled widows and widowers (1634(b)) (1935 (a)(2)(C))		employed medically improved individuals, at least 16 and no more than 65 years of age, who buy into Medicaid under TWWIIA Medical Improvement Group ¹⁰ (1902(a)(10)(A)(ii)(XVI)) (1905(a)(xi)) NOT COVERED				respiratory care services COVERED
disabled adult children (1634(c)) (1935(a)(2)(D))		independent foster care adolescents (1902(a)(10)(ii)(XVII)) (1905(w)(i)) NOT COVERED				home and community care (to the extent allowed and as defined in section 1929) for functionally disabled elderly individuals NOT COVERED

Mandatory Categorically Needy Groups ¹	Mandatory Special Coverage Groups	Optional Categorically Needy Groups ²	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
<p>early widows/widowers (1634(d)) (1935)</p>		<p>individuals with COBRA continuation coverage whom the State determine that the savings exceed the COBRA premium payment (1902(a)(10)(F)) (1902(u)) NOT COVERED</p>				<p>community supported living arrangement services NOT COVERED</p>
<p>209(b) States: State uses more restrictive criteria to determine eligibility than are used by the SSI program (1902(f))</p>		<p>Katie Beckett: disabled individuals age 18 or under who require an institutional level of care; care can be provided outside institution; estimated amount for home care can be no more than estimated amount for institutional care (1902(e)(3)) COVERED</p>				<p>personal care services COVERED</p>
<p>individuals who would be eligible for AFDC except for increased OASDI income under P.L. 92-336 (July 1, 1972) (42 CFR 435.114)</p>		<p>uninsured women, under 65, who are screened for breast or cervical cancer under CDC program (1902(a)(10)(A)(ii)(XVIII)) COVERED</p>				<p>primary care case management services COVERED</p>

Mandatory Categorically Needy Groups ¹	Mandatory Special Coverage Groups	Optional Categorically Needy Groups ²	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
individuals receiving mandatory State supplements (42 CFR 435.130)		individuals who would have been ineligible if they were not enrolled in a MCE ¹¹ (1902(e)(2)) NOT COVERED				PACE program services COVERED
individuals eligible as essential spouses in December 1973 (42 CFR 435.131)		individuals under 21 or at State option 20, 19, 18, or reasonable classification (1905(A)(i)) NOT COVERED				Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period NOT COVERED
institutionalized individuals who were eligible in December 1973 (42 CFR 435.132)		presumptive eligibility for pregnant women ¹² (1920) NOT COVERED				organ transplant services COVERED
blind and disabled individuals eligible in December 1973 (42 CFR 435.133)		presumptive eligibility for children ¹³ (1920A) NOT COVERED				other medical and remedial care specified by the Secretary
Individuals who would be eligible except for the increase in OASDI benefits under Pubic Law 92-336 (42 CFR 435.134)		presumptive eligibility for women who are screened for breast or cervical cancer under CDC program (1920B) NOT COVERED				religious non-medical health care institution services ¹⁴ NOT COVERED

Mandatory Categorically Needy Groups ¹	Mandatory Special Coverage Groups	Optional Categorically Needy Groups ²	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
Individuals who become eligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977 (42 CFR 435.135)						transportation services ¹⁴ COVERED
Individuals who would be eligible except for the increase in OASDI benefits under Public Law 92-336 (42 CFR 435.134)						nursing facility services for individuals under 21 ¹⁴ COVERED
Individuals who become eligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977 (42 CFR 435.135)						emergency hospital services ¹⁴ COVERED
						critical access hospital services ¹⁴ COVERED

Footnotes:

1. Must receive at least the mandatory services.
2. The mandatory and optional categorically needy are considered a group. To meet comparability requirements, the amount, duration, and scope of medical services must be the same for all groups. Further, if the State opts to cover a medically needy group, they are not authorized to provide the covered medically needy group more services.
3. Coverage for pregnancy related and post partum care only.
4. State pays Part A, Part B, coinsurance, and deductible.

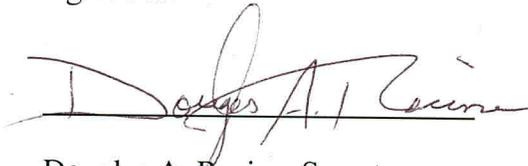
Mandatory Categorically Needy Groups¹	Mandatory Special Coverage Groups	Optional Categorically Needy Groups²	Mandatory Medically Needy Groups	Optional Medically Needy Groups	Mandatory Services	Optional Services
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5. State pays Part A premium
6. State pays Part B premium
7. These individuals are not otherwise eligible for Medicaid
8. State pays Part B premium
9. Services provided to this group are limited to TB-related services.
10. States electing to cover the medical improvement group under TWWIIA must also cover the basic coverage group under TWWIIA.
11. Coverage under this section is limited to MCE services and family planning services described in 1905(a)(4)(C).
12. Services provided to presumptive eligible women are limited to ambulatory prenatal care services.
13. Services provided to presumptive eligible children include all services covered under the State Plan including EPSDT services.
14. These services derived from the authority under 1905(a)(27) of the Social Security Act for the Secretary to specify other medical and remedial care.

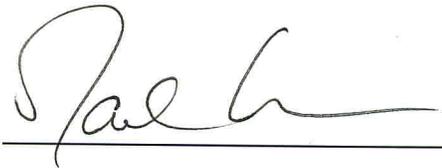
Intergovernmental Agreement between Agency of Human Services and Department of Vermont Health Access for the Administration and Operation of the Global Commitment to Health Waiver October 1, 2011 – September 30, 2012.

Signature Page

Agreed to:



Douglas A. Racine, Secretary
Agency of Human Services (AHS)



Mark Larson, Commissioner
Department of Vermont Health Access (DVHA)

Date: 8-23-11

Date: 8.23.11