



DEPARTMENT OF VERMONT HEALTH ACCESS
**Health Care Programs
Handbook**



GreenMountainCare
A HEALTHIER STATE OF LIVING

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Welcome to Your Green Mountain Care Program

The first part of this handbook has general program information that applies to all of our health care programs. Later sections give information about the program you have joined.

If you don't know what program you are in, or if you have any questions, call Green Mountain Care Member Services at 1-800-250-8427. Call Monday through Friday, from 7:45 a.m. to 4:30 p.m. (closed on holidays). The call is free. Our TDD line is 1-888-834-7898.

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

Program Names

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

Medicaid is a health care program for children, parents, caretakers, the elderly, and people with disabilities who meet program guidelines. Long-term care Medicaid is available for people who meet medical criteria (as determined by the Department of Disabilities, Aging, and Independent living) and the income and resource guidelines.

Dr. Dynasaur is a special Medicaid program for children and pregnant women.

VHAP (Vermont Health Access Plan) is a health care program for uninsured adults who don't qualify for Medicaid or Dr. Dynasaur.

VHAP-ESIA (Employer-Sponsored Insurance Assistance) is a health care program for adults who meet criteria for VHAP and have approved employer-sponsored insurance available.

Primary Care Plus (PC Plus) is a managed care plan that most members of Medicaid and Dr. Dynasaur, and all members of VHAP, must enroll in to continue accessing benefits.

If you are mailed an orange PC Plus enrollment form, you must contact Member Services by phone or mail to enroll.

Your Green Mountain Care Card

Your ID card will be mailed to your home. Please show it when you go for health care. If you don't get your new ID card within a month of getting this handbook, or if you lose your card, call Member Services and ask for a new one. If you have other health care insurance, show your provider both of your insurance ID cards.

Health Care and Referrals

Primary Care Provider (PCP)

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

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

After Hours Care

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

Your PCP’s office will have someone available 24 hours a day, seven days a week to help you. Please see page 10 of this handbook for more information about emergency and urgent care.

Specialists

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

If Your Doctor does not Accept Green Mountain Care

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

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

To arrange for a 60-day, extension, or to find out more about referrals and providers in our programs, call Member Services.

You can also see which providers accept Green Mountain Care by going to www.vtmedicaid.com, and clicking on Provider Look-up.

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

Waiting Times for Appointments

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

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

Most of the time, you should not have to wait in your provider's office for a scheduled appointment for longer than one hour.

Remember if you can't go to an appointment, it's your responsibility to call and cancel or reschedule.

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

Travel Time

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

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

Regular Checkups

It's always better to prevent health problems before they start. One way to do this is to have regular checkups with your PCP. Your doctor can help you decide how often to have checkups. The Vermont Health Department has this advice about checkups:

Routine Care	Newborn	1st Mo	2nd – 6th Mo Every other month	12th Mo	18th Mo	2-20 yrs Annually <i>except for years 7 and 9</i>	21-39 Yrs Every 3-5 yrs	40-49 Yrs Every 1-2 yrs	50+ Yrs Annually
Comprehensive Physical	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dental Screening	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dental Visits	First visit at 2-3 years, every 6 months following								
Hearing Screening	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hearing Test	Annually between 4 and 10 Years of age								
Vision Screening	✓	✓	✓	✓	✓	✓	✓	✓	✓
Vision Test	Annually between 4 and 10 Years of age, more if no tests are performed at school or there are problems								
Immunizations	Primary series of immunizations by 3 years, boosters as needed following								

Ask your primary care provider about specific health care screenings that you should have based on your age and individual risk factors.

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



Services

What Your Program Covers (Services You Can Get)

Most Green Mountain Care programs cover doctor visits, hospital care, prescriptions, and many other services with some rules and limits. To find out what your program covers, see pages 12 through 19.

What Your Program Does Not Cover

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

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

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

To find out more about this process, or to ask for an exception, call Member Services. The forms can also be found on our web site www.dvha.vermont.gov/for-consumers under the heading "Member Services."

Prior Approval

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

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

Drugs and Prior Approval

Green Mountain Care, along with other insurance companies, works to provide quality health coverage at an affordable cost. To help keep costs down, Vermont asks providers to prescribe medications from a list of preferred drugs. These are generic drugs or drugs that cost less money. They work the same way as more expensive drugs advertised by drug companies. Physicians and Pharmacists must prescribe or fill the lowest priced equivalent as medically necessary. If you refuse the substitution, your program will not cover the drug.

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

If your provider thinks you need a drug that is not preferred or should not be for a 90-day supply, he or she may ask for approval for us to pay for that drug. If you would like a copy of the preferred drug list or the list of drugs that require a 90-day supply, call Member Services or go to www.dvha.vermont.gov.

Emergencies

An emergency is a sudden and unexpected illness, medical, or mental health condition, with symptoms that you believe could be a serious threat to your health or life if you don't get medical attention right away. Examples of emergencies are:

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

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

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

Urgent Care

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

When You Have to Pay

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

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

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

If You Get a Bill

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

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

If You Have Other Insurance

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

Our programs can only pay providers.

If you pay for a service, we cannot pay you back.

Medicaid and Dr. Dynasaur

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

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

Medicaid or Dr. Dynasaur Covered Services	Referral Needed
Inpatient Hospitalization	✓ Emergency admissions do not need a referral
Lab Tests	✓
Maternity Care (Obstetrics) including certified nurse midwives	
Medical Equipment and supplies Prescription or prior approval may be needed.	
Mental Health Services See page 31 for more information.	
Naturopathic physicians Covered services with PCP, with referral if naturopath is not the PCP	✓
Occupational, Physical, or Speech Therapy	✓
Outpatient Hospital Care	✓
Over-the-Counter Drugs Prescription needed	
Physicals When provided by your Primary Care Provider	
Podiatry Non-routine foot-care only	✓
Prescription Drugs Prescription needed. Some drugs need prior approval. Members eligible for both Medicare and Medicaid must also enroll in a Medicare Part D drug plan (PDP) for prescription coverage.	
Prosthetics Prescription or prior approval may be needed.	
Radiation and chemotherapy	✓
Routine Checkups	
Smoking Cessation Products Prescription needed.	
Surgery	✓
Transportation Go to www.dvha.vermont.gov/for-consumers and go to the Transportation box, or call Member Services at 1-800-250-8477	
X-rays	✓

Primary Care Plus

Most Medicaid or Dr. Dynasaur members must enroll in PC Plus to keep getting coverage. If you get an orange PC Plus enrollment form, call Member Services or mail back the form as soon as you can. The benefit package and costs for Medicaid and Dr. Dynasaur stay the same even after you enroll in PC Plus. Please see the section on PC Plus on page 19.

Copayments for Medicaid

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

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

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

Premiums

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

Automatic Payments

If you don't want to worry about paying your bill each month, you can sign up for automatic withdrawal where your payment is taken from your checking or savings account each month. If you want to set up automatic withdrawal, call Member Services.

VHAP (Vermont Health Access Plan)

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

VHAP Covered Services	Referral Needed
Alcohol and Substance Abuse Treatment	
Ambulance No referral needed for life or health threatening emergencies. Tell your PCP as soon as possible.	
Birth Control/Family Planning Includes birth control methods and counseling. You may go to your PCP, a gynecologist, or Planned Parenthood	
Chiropractic Services Spinal manipulations only. Prior approval for more than 10 visits per calendar year.	
Diabetic Supplies and Counseling Prescription needed.	✓ Referral needed for Counseling
Doctor Visits	
Emergency Services No referral needed for life or health-threatening emergencies. Call 911 or go to the emergency room right away.	
Eye Exams (Routine) Treatment of eye diseases or injuries needs a referral.	
Gynecologist (Women's Health Care)	
Home Health	✓
Hospice	✓
Immunizations	
Inpatient Hospitalization	✓ Emergency admissions do not need a referral
Lab Tests	✓
Maternity Care (Obstetrics) including certified nurse midwives	
Medical Equipment and supplies Prescription or prior approval may be needed.	
Mental Health Services See page 31 for more information.	
Naturopathic physicians Covered services with PCP, with referral if naturopath is not the PCP	✓

VHAP Covered Services	Referral Needed
Occupational, Physical, or Speech Therapy	✓
Outpatient Hospital Care	✓
Over-the-Counter Drugs Prescription needed	
Physicals When provided by your Primary Care Provider	
Podiatry Non-routine foot-care only	✓
Prescription Drugs Prescription needed. Some drugs need prior approval.	
Prosthetics Prescription needed.	
Radiation and chemotherapy	✓
Routine Checkups	
Smoking Cessation Products Prescription needed.	
Surgery	✓
X-rays	✓

Primary Care Plus

All VHAP members without access to employer-sponsored insurance must enroll in PC Plus to keep getting coverage. When you get an orange PC Plus enrollment form, call Member Services or mail back the form as soon as you can. Read about PC Plus on page 19.

Read about VHAP members with access to employer-sponsored insurance on page 18.

Copayments for VHAP Members

- VHAP members pay \$25.00 for each emergency room visit.
- VHAP members may pay \$1 \$2, or \$3 copays for prescriptions, depending on household income and the cost of the drug.
- VHAP members pay \$3 for each outpatient hospital visit.

Premiums

Some VHAP members may need to pay a monthly premium. Premium amounts per person depend on family size and income. If you owe a premium, you will get a premium bill each month. When you get your first bill, it is very important that you pay it right away so that your coverage can begin as soon as possible, and keep paying on time so that you do not lose coverage. If you lose your premium bill, call Member Services to find out how much you owe and how to pay.

Automatic Payments

If you don't want to worry about paying your bill each month, you can sign up for automatic withdrawal where your payment is taken from your checking or savings account each month. If you want to set up automatic withdrawal, call Member Services.

VHAP-ESIA

(Employer-Sponsored Insurance Assistance)

VHAP-ESIA is a health care program for uninsured adults who meet the eligibility criteria for VHAP and have approved employer-sponsored insurance available. The program helps pay the premium for that insurance. If you are on VHAP and have approved employer-sponsored insurance available, you may be required to join that plan. The state must first review and approved your employer-sponsored insurance. Call Member Services before signing up for your employer's plan.

Covered Services

Once you are enrolled in your employer-sponsored insurance plan, that plan will pay for most of your health care services. VHAP-ESIA will cover any services not covered by that plan that are normally covered by VHAP. Read about VHAP covered services on page 15.

If you have questions about covered services, call the customer service number on the back of your employer-sponsored insurance plan ID card and Green Mountain Care Member Services if needed.

Copayments

If VHAP-ESIA pays for an emergency room visit that your employer's insurance plan does not pay for, you must pay a \$25 copayment. You must pay a \$3 copayment for a hospital outpatient visit if VHAP-ESIA pays and if your employer's insurance does not pay. You will pay \$1, \$2 or \$3* for a prescription drug, depending on household income and the cost of the drug, if VHAP-ESIA pays because your employer-sponsored insurance plan does not (for example, while you have a deductible), or because you have an insurance copayment. Also, you may have to get the drug in a 90-day supply if VHAP-ESIA is the primary payer.

Premiums

Once you are enrolled in your employer-sponsored insurance plan, you will pay a premium to your employer for this coverage. This is usually paid through a payroll deduction. The month before your premium is due the state will pay you the amount of the premium you pay your employer minus what you owe for a VHAP-ESIA premium. VHAP-ESIA premium amounts per person depend on family size and income.

Automatic Payments

If you have a bank account, you will need to provide your savings account or checking account information so that the state can deposit your premium assistance money directly into your account each month. If you have not done so already, call Member Services with this information immediately.

Primary Care Plus (*PC Plus*) Program

VHAP Managed Care

All VHAP members must enroll in PC Plus to keep getting coverage. When you get an orange PC Plus enrollment form, call Member Services or mail back the form. Providers in PC Plus are paid to help manage members care. They do not get a financial incentive to reduce or limit a member's health care.

Medicaid or Dr. Dynasaur Managed Care

Medicaid and Dr. Dynasaur members without other insurance must enroll in PC Plus to keep getting coverage. When you get an orange PC Plus enrollment form, call Member Services or mail back the form.

Medicaid and Dr. Dynasaur members in PC Plus can choose a PCP who is within 30 minutes of their work or home. If there are not at least two PCPs within 30 minutes, you do not have to be in PC Plus. You will also be asked to choose a dentist for any children in your household that are 1-18 years old. Providers in PC Plus are paid to help manage member care. They do not get a financial incentive to reduce or limit a member's health care.

VHAP-ESIA

VHAP-ESIA members do not enroll in PC Plus.

Change Your Primary Care Provider (PCP)

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

Specialist as Your Primary Care Provider (PCP)

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

If you have questions about PC Plus, changing your PCP, or using a specialist as your PCP, call Member Services.

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

Disenrollment

Disenrollment means that a person is taken out of PC Plus. If you are disenrolled from PC Plus and have questions, call Member Services.

- You will be disenrolled from PC Plus if any of the following things happen:
- You get private health insurance,
- You get Medicare,
- You go into a nursing home or onto a home-based care waiver, or
- You have Medicaid or Dr. Dynasaur and move to an area of the state where you don't have a choice of at least two PCPs who are part of PC Plus (unless you decide you want to stay in PC Plus anyway).
- You could also be disenrolled from PC Plus or asked to change your PCP if you:
- Pose a threat to your providers or other members,
- Don't show up for appointments and don't call ahead to cancel, or
- Don't cooperate with treatment you and your doctor have agreed to.

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

If you are on VHAP and are disenrolled from PC Plus, your coverage on VHAP will end. If you have access to employer-sponsored insurance, you may be able to enroll in VHAP-ESIA.

Your Rights and Responsibilities

You have the right to

- Be treated with respect and courtesy,
- Be treated with thoughtfulness
- Choose and change your providers,
- Get facts about your program services and providers,
- Get complete, current information about your health in terms you can understand,
- Be involved in decisions about your health care, including having your questions answered and the right to refuse treatment,
- Ask for and get a copy of your medical records and ask for changes to be made to them when you believe the information is wrong,
- When you believe the information in them is wrong, get a second opinion from a qualified provider who is enrolled in Vermont Medicaid,
- Complain about your program or your health care (see page 24 for more information),
- Be free from any form of restraint or seclusion used as a means of bullying, discipline, convenience, or retaliation, and
- Ask for an appeal if you have been denied services you think you need. See page 24 for more information.

You also have the responsibility to

Take care of your health by:

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

Living Wills and Advance Directives

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

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

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

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

A health care provider can refuse to follow the instructions in your advance directive based on a moral, ethical, or other conflict with the instructions. However, if a health care provider does refuse, the provider must tell you, if possible, and whomever you have named to act on your behalf about the conflict; help to transfer your care to another provider who is willing to honor the instructions; provide ongoing health care until a new provider has been found to provide the services; and document in your medical record the conflict, the steps taken to resolve the conflict, and the resolution of the conflict.

Every health care provider, health care facility, and residential facility shall develop protocols to ensure that all patients' advance directives are handled in a way that strictly follows all state laws and regulations.

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

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

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

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

Organ Donation

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

Sharing Information with Your Primary Care Provider (PCP)

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

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

Notice of Privacy Practices

When you were determined eligible for our programs, you received a letter stating that you were eligible and a copy of our Notice of Privacy Practices. The federal law, the Health Insurance Portability and Accountability Act (HIPAA), requires that we give you the notice. The notice tells you about your privacy rights and about how your health information may be used or shared. If you need another copy of the notice you can call Member Services and ask for a copy.

Quality Assurance Program

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

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

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

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

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

You can get information about the quality of care given by hospitals, nursing homes, home health care providers, or a copy of clinical best practice guidelines by going to the Department of Vermont Health Access web site www.dvha.vermont.gov/for-consumers or by calling Member Services.

When You Don't Agree with an Action

An “action” is one of the following:

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

If you don't agree with an action, you may ask for that action to be reviewed. If the Department of Vermont Health Access made the decision, you can ask Member Services for your appeal or fair hearing (described below) by calling 1-800-250-8427, or writing to the address below. Call the customer service number on the back of your employer-sponsored insurance plan ID card for information about how to appeal a decision made by that plan.

Green Mountain Care Member Services
Department of Vermont Health Access
101 Cherry Street, Suite 320
Burlington, VT 05401

Appeal

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

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

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

Fair Hearing

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

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

Continuation of Benefits

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

- You must ask for a continuation of benefits within 10 days of when you requested an appeal or fair hearing,
- You may ask for the benefit to continue until your appeal or hearing is decided.
- If you paid for your benefits, you will be paid back the amount you paid if the appeal or hearing is decided in your favor.
- If the state paid for the continuing benefits and the denial is upheld, you may have to pay the cost of any benefits you got while the appeal was pending.
- You can ask for continuing benefits at the same time you request the appeal or fair hearing from member services (phone number and address on page 24).
- The service cannot continue if your appeal or hearing is about a benefit that has ended or been reduced because of a change in federal or state law.
- If your fair hearing is about your premium, you must pay your premium by the premium due date or your coverage will end. You will be paid back the amount you over paid if the appeal or hearing is decided in your favor.

Grievances

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

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

Neither you nor your provider shall be subject to retribution or retaliation for filing a grievance or an appeal with Green Mountain Care. If you need help with any part of the grievance or appeal process, staff members of Green Mountain Care can help you – just ask. You can ask a family member, a friend, or another person (such as a provider) to help you request an appeal or a fair hearing, or to file a grievance. You will need to tell the State that you want this person to act on your behalf. That person can also represent you during the process. If you do not know what to do for any of these requests, or for help with any of the steps, please call Member Services at 1-800-250-8427 for help. You can also call the Office of Health Care Ombudsman at 1-800-917-7787 for help.

Neither you nor your provider shall be subject to retribution or retaliation for filing a grievance or an appeal with the MCO. If you need help with any part of the grievance or appeal process, staff members of the MCO can help you – just ask. You can ask a family member, a friend, or another person (such as a provider) to help you request an appeal or a fair hearing, or to file a grievance. You will need to tell the State that you want this person to act on your behalf. That person can also represent you during the process. If you do not know what to do for any of these requests or for help with any of the steps, please call Member Services at 1-800-250-8427 for help. You can also call the Office of Health Care Ombudsman at 1-800-917-7787 for help.

Need Help?

Green Mountain Care Member Services

Green Mountain Care Member Services is there to help you. They can answer questions about your program, help you choose or change your PCP, and help you if you have problems getting health care.

Member Services staff are available from 7:45 a.m. to 4:30 p.m., Monday through Friday (closed holidays) at 1-800-250-8427 or TDD 1-888-834-7898.

Report changes within 10 days of the change:

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

The Office of the Health Care Ombudsman

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

Additional Information

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

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

You can also find out about program eligibility and benefits on the web at www.dvha.vermont.gov.

Other Programs

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

Attendant Services Program

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

Adult Day Services

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

Children's Personal Care Services

This program is designed to help families with the extra care needs of children under the age of 21 who have disabilities or serious health problems. Hours of support may be used flexibly and can be provided in a variety of settings. Families hire their own staff. For more information, call the Division of Disability and Aging Services (DDAS) at 1-800-660-4427 or go to www.ddas.vermont.gov.

Children with Special Health Needs (CSHN) Clinics

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

Special Clinics

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

Special Services

CSHN nurses or medical social workers who are based in regional Health Department district offices provide assistance with access to and coordination of specialized health care not available through CSHN direct service clinics.

Financial Assistance Program

A voluntary program which can help families with the after-insurance costs of their child's health care when the services have been prescribed or pre-authorized through a CSHN clinical program.

Hearing Outreach Program

Audiologists provide screening and referral for diagnostic services at 14 sites statewide. For more information about any of these programs, please call 1-800-537-0076 or go to www.healthvermont.gov/family/hearing/index.aspx.

Choices for Care

Choices for Care is a long-term care program to pay for care and support for older Vermonters and people with physical disabilities. The program assists people with everyday activities at home, in an enhanced residential care setting, or in a nursing facility. Providers are Adult Day Centers, Area Agencies on Aging, Assisted Living Residences, Home Health Agencies, Nursing Facilities, and Residential Care Homes. For more information, call the Division of Disability and Aging Services (DDAS)/Individual Supports Unit at 802-871-3069 or go to www.ddas.vermont.gov

Developmental Disability Services

Developmental disability services help keep individuals of any age who have developmental disabilities living at home with their families. Services include case management, employment services, community supports, and respite. Providers must be developmental services providers or Intermediary Service Organizations for people who self-manage services. For more information, call the Division of Disability and Aging Services (DDAS) at 802-871-3064 or 802-786-5081 or go to www.ddas.vermont.gov

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

This is a special program for children under age 3 who have disabilities or developmental delays. Provides infants, toddlers and families with early intervention services. For more information, call Vermont Family Network at 1-800-870-6758.

Flexible Family Funding

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

Healthy Babies

This is a program for pregnant women and infants who have Medicaid or Dr. Dynasaur. It offers home visiting and other support services from public health nurses, home health agencies and parent-child centers. For more information, call the Vermont Department of Health at 1-800-464-4343 or go to www.healthvermont.gov.

High Technology Home Care

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

Homemaker Services

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

Mental Health

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

A) Adult Outpatient Services

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

B) Child, Adolescent, and Family Services

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

C) Community Rehabilitation and Treatment

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

D) Emergency Services

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

Traumatic Brain Injury Program

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

Women, Infants, and Children Program (WIC)

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

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

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

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

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

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

**သတိပြုရန်! မိတ်ဆွေသည် သင့်ဘာသာစကားဖြင့် အကူအညီ လိုပါက၊
ကျေးဇူးပြုပြီး 1-800-250-8427 ကိုခေါ်ပါ။**

**ध्यान दिनुहोस्! तपाईंलाई आफ्नो भाषामा मद्दत चाहिएको छ भने कृपया
1-800-250-8427-मा फोन गर्नुहोस्।**

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

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

Green Mountain Care Member Services

For questions call: 1-800-250-8427(TDD/TTY) 1-888-834-7898
Call for free interpreter services or alternate formats.
Open 7:45 a.m. to 4:30 p.m. Monday through Friday
(except for State of Vermont holidays)