

**WAIVER AND EXPENDITURE AUTHORITIES FOR VERMONT'S GLOBAL  
COMMITMENT TO HEALTH SECTION 1115 DEMONSTRATION**

**NUMBER:** 11-W-00194/1  
**TITLE:** Global Commitment to Health Section 1115 Demonstration  
**AWARDEE:** Vermont Agency of Human Services

**Title XIX Waivers**

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning October 1, 2005, through September 30, 2010.

1. **Statewideness/Uniformity** Section 1902(a)(1)  
  
To enable Vermont to provide managed care plans or certain types of managed care plans, only in certain geographical areas of the State.
  
3. **Amount, Duration, Scope of Services** Section 1902(a)(10)(B)  
  
To enable Vermont to vary the amount, duration and scope of services offered to various mandatory, and optional categories of individuals eligible for Medical assistance under the demonstration.
  
4. **Premium Requirements** Section 1902(a)(14)  
insofar as it incorporates Section 1916  
  
To permit Vermont to impose premiums in excess of statutory limits for optional and expansion populations as reflected in the special terms and conditions.
  
5. **Financial Eligibility** Section 1902(a)(10)(C)(i)(III)  
  
To allow the State to use institutional income rules (up to 300% of the SSI payment level) for categorically and medically needy enrollees electing home-based services in lieu of nursing facility or in lieu of other residential care services in licensed settings while allowing resource limits up to \$10,000.
  
6. **Financial Responsibility/Deeming** Section 1902(a)(17)(D)  
  
To enable the State to use for plan groups and individuals whose eligibility is determined under the more liberal standards and methods, eligibility standards, and requirements that differ from those required under title XIX. The waiver would

specifically exempt the State from the limits under section 1902(a)(17)(D) on whose income and resources may be used to determine eligibility unless actually made available, and so that family income and resources may be used instead.

To enable the State to disregard quarterly income totaling less than \$20 from the post-eligibility income determination.

**7. Spend-Down** Section 1902(a)(17)

To enable the State to provide coverage to the medically needy without offering a spend-down for pregnant women, parents, children ages 0-18, and the disabled, and to offer 1-month spend-downs for people receiving community-based services as an alternative to institutionalization, and non-institutionalized persons who are receiving personal care attendant services at the onset of waivers.

**8. Freedom of Choice** Section 1902(a)(23)

To enable the State to restrict freedom of choice of provider for the demonstration participants. Participants will be restricted to a single plan and may change providers within the plan.

Some demonstration waiver participants may only have access to the providers participating in those programs, and will not have access to every Medicaid enrolled provider in the State.

**9. Retroactive Eligibility** Section 1902(a)(34)

To enable the State to waive the requirement to provide medical assistance for up to three months prior to the date that an application for assistance is made for expansion groups.

**10. MCO Credentialing Requirements** Section 1902(a)(4)

To enable the State to waive the requirement from the provider credentialing requirements applicable to managed care plans under these regulations, since a State agency, the Office of Vermont Health Access (OVHA), will serve as the program's MCO. OVHA will continue to use its current process for qualifying and enrolling Medicaid participating providers. At a minimum, OVHA shall ensure that all Medicaid participating 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 CLIA requirements. Providers excluded from participation in Federal health care programs under either section 1128, or section 1128(a), of the Social Security Act are prohibited from participation in the demonstration program. Providers may not furnish services that are subject to the certificate of need law when a certificate has not been issued.

### **Costs Not Otherwise Matchable**

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State for the items identified below (which are not otherwise included as expenditures under section 1903) shall, for the period of this demonstration October 1, 2005, through September 30, 2010, be regarded as expenditures under the State's title XIX plan.

1. Expenditures to provide Global Commitment to Health coverage to individuals, subject to any approved enrollment cap, who would not otherwise be eligible for Medicaid, including expenditures for VHAP, medically needy individuals in families who, under streamlined eligibility procedures and expansions, have incomes which exceed the statutory limit.
2. Expenditures to provide pharmacy benefits to low-income individuals who are elderly or disabled. Expenditures include coverage for individuals who are covered by Medicare, until such time as Medicare Part D coverage replaces the existing pharmacy coverage.
3. Expenditures for additional health care related-services for the demonstration populations.
4. Expenditures for capitation payments provided to MCOs which restrict enrollees' rights to disenroll within 90-days of enrollment into a new MCO, as designated under sections 1903(m)(2)(A)(vi) and 1932(a)(4).
5. Expenditures for capitation payments provided to MCOs, which do not meet the contract requirements under section 1903(m)(2)(a)(xi) as specified under section 1932(a)(3).