FINAL

Intergovernmental Agreement

Between

Agency of Human Services

and

Office of Vermont Health Access

For the Administration and Operation of the

Global Commitment to Health Waiver
(Demonstration Program)

September 30, 2005

Table of Contents

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 Office of Vermont Health Access (OVHA) 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.

The OVHA will serve as the Public Managed Care Organization (Public MCO) for all enrollees under the *Global Commitment to Health Waiver*. The AHS, as the Single State Agency, will provide oversight of the OVHA 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 the OVHA's role as the Public MCO. This IGA shall be effective for the period from October 1, 2005 to September 30, 2006. This IGA shall be amended as necessary.

1.3 Compliance

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

The OVHA 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

The OVHA 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.

For purposes of this IGA, a relationship is defined as a director or officer of the OVHA or a person with an employment, consulting or other arrangement with the OVHA.

ARTICLE TWO: OVHA RESPONSIBILITIES

2.1 Administration and Management

The OVHA 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.

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

- Representing the OVHA on all matters pertaining to this IGA. Such a representative shall be authorized and empowered to represent the OVHA regarding all aspects of this IGA;
- Monitoring the OVHA's compliance with the terms of this IGA;
- Receiving and responding to all inquiries and requests made by the AHS in the timeframes and format specified by the 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 the AHS to ensure that staff from the OVHA 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 the AHS activities and respond to requests by the AHS which may include, but not be limited to, requests to participate in training programs designated by the AHS, requests to coordinate fraud and abuse activities with the 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 the OVHA or the AHS that may arise in connection with this IGA;
- Meeting with the AHS at the time and place requested by the AHS, if the AHS determines that the OVHA 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 the 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 the OVHA by any individual or entity to the AHS for its review; and submitting any proposed responses and responsive documents or other materials in connection with any such requests to the AHS for its prior review and approval.

2.1.1 Management Information System

The OVHA shall maintain a management information system that collects, analyzes, integrates and reports data. The system must provide information on areas including, but not limited to, service utilization, grievances, appeals and disenrollments for reasons other than loss of Medicaid eligibility. The system must collect data on enrollee and provider characteristics, as specified by the AHS and on services as set forth under Section 2.12.1 of this IGA. The OVHA must collect, retain and report encounter data in accordance with the *Global Commitment to Health Waiver*'s Terms and Conditions. All collected data must be available to the 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;

- Adults who meet the State of Vermont's clinical criteria for the Designated Agency Community Rehabilitation and Treatment (CRT) Program and who initially meet Medicaid/Vermont Health Access Plan (VHAP) eligibility requirements but who subsequently exceed the earned income and/or resources requirements. Increases in income after enrollment in the program will be disregarded, as long as the individual continues to meet the clinical criteria for participation in the CRT Program. These individuals will be remain eligible for all VHAP benefits, and will remain co-enrolled with the OVHA; and

- Individuals who are eligible for the CRT Program for Medicaid and Medicare (dual eligibles) and who meet the CRT clinical criteria are eligible for enrollment in the CRT Program. These individuals will continue to utilize their Medicare benefits on an unrestricted fee-for-service basis

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 those enrolled solely in the Vermont Long-Term Care (LTC) Waiver, will be enrolled in the *Global Commitment to Health Waiver*. Eligibility and enrollment are therefore synonymous for the purpose of this IGA.

The OVHA shall be responsible for verification of the current status of an individual's Medicaid/VHAP eligibility with the Economic Services Division (ESD), within the AHS Department for Children and Families (DCF), which makes these eligibility determinations. If an individual is not currently covered by Medicaid/VHAP, the OVHA shall refer such person to the ESD for an eligibility determination for these programs.

The OVHA shall also be responsible for assisting the ESD with the collection of information necessary for determination of eligibility for individuals who may not be eligible for the public insurance programs. Initial eligibility determination for these individuals may be delegated to other departments within the AHS [e.g., Department of Disabilities, Aging and Independent Living (DAIL), Department of Health (VDH), and Department for Children and Families (DCF)]. However, the OVHA shall retain responsibility for final eligibility determinations for the *Global Commitment to Health Waiver* populations.

The OVHA 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. The OVHA, 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 all three information systems to ensure data integrity for payment purposes. The OVHA must have the capability to interface with the ACCESS and MMIS systems.

2.2.4 Loss of Eligibility/Disenrollment from the Demonstration

The OVHA 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

The OVHA shall compare, on a monthly basis, the active Global Commitment to Health enrollee list (the roster) with the ESD's Medicaid/VHAP eligibility list to confirm

Medicaid/VHAP status for all Global Commitment to Health enrollees. The OVHA shall not receive a capitation payment for any individual who is not eligible under the *Global Commitment to Health Waiver*.

2.2.5 Prohibitions

The OVHA 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.

Upon request, information on dis-enrollments (by reason code) shall be available to the AHS for audit purposes.

2.3 Enrollee Outreach and Education

2.3.1 New Enrollees

The OVHA 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. The OVHA may employ the services of an enrollment broker to assist in outreach and education activities.

The OVHA 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 (described in greater detail below); confidentiality rights; availability of the Office 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

The OVHA and the 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*. The OVHA shall mail the enrollee handbook to all new enrollees within 45 business days of determination of eligibility for the *Global Commitment to Health Waiver*.

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, complaint and grievance procedures, appeal procedures (for eligibility determinations or service denials), enrollee dis-enrollment 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, timeframes for resolution of the Fair Hearing, 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 the OVHA to cover a service;

- Information about Advance Directives and the service providers' obligation to honor the terms of such directives; 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 OVHA shall notify its enrollees in writing of any change that the 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

The OVHA shall comply fully with the AHS policies for providing assistance to persons with Limited English Proficiency. The OVHA 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.

The OVHA shall make in-person or telephonic interpreter services available to any enrollee who requests them, regardless of the prevalence of the enrollee's language within the overall program. The AHS contracts with in-person and telephonic interpreter vendors, as well as written translation vendors on behalf of the OVHA and other departments under the AHS umbrella. The OVHA 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.

The OVHA 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

The OVHA shall comply with the requirements of 42 Code of Federal Regulations (CFR) 489.100 related to maintaining written policies and procedures respecting advance directives. The OVHA shall require all *Global Commitment to Health Waiver* providers, including its subcontracted Departments, 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 the OVHA 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

The OVHA shall conduct enrollee satisfaction surveys once every three years. The survey tool and methodology must be submitted to the AHS for review and approval at least 90 business days prior to implementation of the survey. The AHS will submit the survey tool to the CMS at least 60 business days prior to implementation of the survey. The OVHA agrees to make all appropriate modifications required by the AHS and/or the CMS.

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

2.4 Network Development

2.4.1 Subcontractors

The OVHA may subcontract with other Departments under the AHS umbrella 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) and the Department for Children and Families (DCF) - collectively referred to as the Departments). Prior to subcontracting with a Department, the OVHA shall evaluate each Department's ability to perform the activities covered under the proposed contract.

In addition to services available through the subcontracted Departments, 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 the OVHA's established credentialing requirements;
- Be willing to coordinate care with the OVHA or its designee, including sharing clinical information (with appropriate enrollee consent); and
- Accept the OVHA's fee schedule.

The OVHA and its subcontracted Departments 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.

All contracts and subcontracts for services pertinent to the *Global Commitment to Health Waiver* must be in writing and must provide that the 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 the OVHA to ensure that all activities under this IGA are carried out. The OVHA agrees to make available to the AHS and the CMS all subcontracts between the OVHA and the Departments.

2.4.2 Oversight Process for Subcontractors

The OVHA shall provide oversight for Medicaid enrollee services through the following:

- At least biennially, the OVHA will complete Minimum Standards and Clinical Care Audits. The OVHA will review an established percentage of enrollee records for emergency care, actions and appeal outcomes, service plan development and utilization review of reported service records; and
- Biennially, on alternating years with the Minimum Standards and Clinical Care Audit, the OVHA will conduct a Program Review which will evaluate access to services, its subcontractor Department practices, enrollee outcomes, operational management, and administrative structures.

The OVHA will maintain evaluation tools, reports, improvement plans, and reported service data profiles used in the service plan and utilization review monitoring activity. The OVHA shall also conduct ongoing monitoring of its Departmental subcontractors through the review of required reports and data submissions.

2.4.3 Provider Services

The OVHA 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
- Provider grievances and appeals, including appeals of enrollee eligibility.

2.4.4 Provider Contracting and Credentialing

The OVHA shall ensure that all providers participating in the *Global Commitment to Health Waiver* meet the credentialing requirements established by the AHS for the Medicaid program. At a minimum, the OVHA shall 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*. Providers may not furnish services that are subject to the Certificate of Need law when a Certificate has not been issued.

2.4.5 Provider Profiling

The OVHA shall conduct provider profiling activities, including producing monthly information on enrollment, service encounters, costs, reimbursements, and outcomes for all health services provided to *Global Commitment to Health Waiver* enrollees through its subcontracted Departments. Information used in provider profiling will include data from all providers of health services within the subcontracted Departments, and will provide for the development of standard comparison reports and ad hoc reports as needed. Standard and ad-hoc reports shall be made available to the subcontracted Departments.

2.4.6 Mainstreaming

The OVHA agrees to 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 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 the 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 the AHS to the OVHA, as the Public MCO, will include payment only for services covered under the *Global Commitment to Health Waiver*.

2.5.1.1 Medical Necessity

The OVHA 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. The OVHA 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. The OVHA 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.

Medically-necessary care, as defined in Rule 10 of the Vermont Division of Health Care Administration, 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 the OVHA in a manner that is no more restrictive than the State of Vermont Medicaid program. Ultimate authority in such determinations lies with the AHS, as the entity to which *Global Commitment to Health Waiver* enrollees have the right to appeal. The

AHS will arrange for independent medical review of appeals of medical necessity decisions by the OVHA as appropriate.

Within the limits of the benefit plan, the OVHA has the responsibility for establishing procedures for referrals and when prior authorization is required either by the OVHA or a subcontracted Department.

The capitated benefit package for the *Global Commitment to Health Waiver* is included in Attachment A of this IGA.

2.6 Access to Services

2.6.1 General

Through its contracts with Medicaid providers and the subcontracted Departments, the OVHA 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, the OVHA must consider the following:

- Anticipated enrollment in the *Global Commitment to Health Waiver*;
- Expected utilization of services;
- 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.

2.6.1 Twenty-Four Hour Coverage

The OVHA 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 subcontracted Departments, but the OVHA must maintain procedures for monitoring coverage to ensure twenty-four hour availability.

The OVHA will collaborate with the AHS to develop a toll-free Nurse Advice Line, through which enrollees with urgent or emergent medical problems can obtain guidance twenty-four hours per day, seven days per week.

2.6.2 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 OVHA 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.

The OVHA 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 the OVHA or a subcontracted Department 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.

The OVHA or its subcontracted Departments may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. The OVHA and its subcontracted Departments 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 the OVHA of the enrollee's screening and treatment within 10 calendar days of the enrollee's presentation for emergency services. This shall not preclude the OVHA 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 (OVHA) responsible for coverage and payment.

2.6.3 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 the OVHA for all enrollees in the public insurance programs under the *Global Commitment to Health Waiver*. The OVHA may conduct concurrent review for post-stabilization services as soon as medically appropriate. However, the OVHA must pay for all inpatient post-stabilization care services that are pre-approved by the OVHA, 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 the OVHA 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:

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

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

- OVHA-contracted physician who has privileges at the treating hospital assumes responsibility for the enrollee's care;
- OVHA-contracted physician assumes responsibility for the enrollee's care through transfer;

- OVHA and the treating physician reach an agreement concerning the enrollee's care; or

- Enrollee is discharged.

2.6.4 Travel Time

The OVHA 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. The OVHA'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, the OVHA 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.

2.6.5 Appointment Availability

The OVHA shall ensure that in-office waiting times for appointments do not exceed one hour, except in areas where a longer waiting time is usual and customary. Exceptions to the one-hour standards must be justified and documented to the AHS on the basis of community standards.

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 five business days;

- Referral appointments for non-urgent care: Within 30 days or as clinically appropriate;

- Routine Care: Available in a timely manner consistent with the individual enrollee's plan of treatment.

2.6.6 Interpreter Services at Medical Sites

The OVHA shall ensure availability of interpreter services at medical delivery sites to enrollees who speak a language other than English as a first language, or who are hearing-impaired, and who request such assistance. Where reasonable and practicable, the OVHA shall make interpreters available in-person. Where this is not practicable, interpreters must be made available by telephone.

2.6.7 Cultural Considerations

The OVHA shall participate in the 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.

2.6.8 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.

2.6.9 Direct Access to Women's Health Specialist

The OVHA 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.

2.6.10 Alternative Treatment

The OVHA shall ensure that its subcontracted Departments do 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.

2.6.11 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, at no cost to the enrollee.

2.7 Coordination of Services

The OVHA shall assist in the coordination of services provided through its network of Medicaid providers and its subcontracted Departments. The OVHA shall require that each enrollee's record contains the name of his/her primary care provider.

2.8 Payment to Providers

2.8.1 General

The OVHA is responsible for ensuring timely payments to its contracted providers, including its subcontracted Departments.

The OVHA 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 for covered services for which the OVHA does not pay 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 the AHS provided the services directly.

2.8.2 Incentive Payments

The OVHA may make payments to its subcontracted Departments on a risk or incentive basis, provided such arrangements are in compliance with the AHS and Federal requirements and guidelines, and disclosed to the AHS. In making payments on an incentive basis, the OVHA 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)

The OVHA 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. In addition, they are paid a per member per month (PMPM) case management fee for providing care coordination and referral services to their enrollees.

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, as reflected in Attachment A of this IGA.

2.9 Quality Assurance and Medical Management

2.9.1 Quality Management Plan

The OVHA shall maintain a comprehensive 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 the AHS upon request.

The OVHA 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 the AHS as requested.

The CMS or the AHS may specify performance measures and topics for performance improvement projects. The OVHA shall conduct projects specified by the CMS or the AHS.

The OVHA shall require each of its subcontracted Departments to also develop and maintain an internal Quality Management/Quality Improvement program.

2.9.2 Utilization Management Plan

The OVHA shall develop and maintain a comprehensive Utilization Management Plan to identify potential over- and under-utilization of services. The Utilization Management Plan must conform to all applicable Federal and State regulations.

The OVHA shall adopt program 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. The OVHA shall disseminate the guidelines to its subcontracted Departments and shall require the Departments to disseminate the guidelines among all of their designated providers.

The OVHA 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.

The OVHA shall maintain, and shall require each of its subcontracted Department, to 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).

The OVHA 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. For inpatient admissions, specific review criteria for authorization decisions is identified and outlined in the Acute Care Management Program Description policies and procedures manual. The OVHA will ensure consistent application of review criteria for authorization decisions. Review Criteria shall be incorporated in the Utilization Management Plan as described above.

For standard authorization decisions, the subcontracted Departments 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 subcontracted Department justifies to the OVHA 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 subcontracted Department 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 subcontracted Department 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 subcontracted Department justifies to the OVHA 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.

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 Section 2.3.1.

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.

The OVHA or its subcontracted Departments 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 the OVHA or the subcontracted Department has taken or intends to take; the reasons for the action; the enrollee's right to a second opinion regarding the service decision, or at least, a clinical program director not involved in the service decision; 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 the OVHA/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 the OVHA/AHS.

2.9.3 State of Vermont and Federal Reviews

The OVHA must make available to the State of Vermont and/or outside reviewers, on a periodic basis, medical 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. The OVHA 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 the AHS External Quality Review Organization.

2.10 Grievances and Appeals

2.10.1 Grievance Systems

2.10.1.1 Definitions and General Requirements

The terms "action", "grievance" and "appeal" are used as follows to describe the *Global Commitment to Health Waiver* grievance system:

'Action' means

- The denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension or termination of a previously authorized service;
- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner; or
- Failure of the OVHA or one of its subcontracted Departments to act within the established timeframes for grievances and appeals.

'Grievance' means an expression of dissatisfaction about any matter other than an action, such as the quality of a service provided or aspects of interpersonal relationships, such as rudeness. Enrollees can file grievances with the OVHA or one of its subcontracted Departments.

'Appeal' means a request for a review of an action.

The OVHA or its subcontracted Departments shall be responsible for processing all enrollee grievances, and shall serve as the initial point of response for appeals, with the exception of appeals pertaining to Medicaid and the *Global Commitment to Health Waiver* eligibility determinations. Appeals with respect to medical necessity determinations made by the OVHA or its subcontracted Departments may be sent directly to the AHS by the enrollee without going through the OVHA process.

The Department for Children and Families (DCF) will retain responsibility for appeals pertaining to Medicaid/VHAP eligibility determinations. Similarly, if an enrollee files an appeal pertaining to Medicaid/VHAP eligibility determinations, the OVHA or its subcontracted Departments shall immediately forward the issue to the DCF and shall notify the enrollee in writing that the issue will be resolved by the DCF.

For grievances and appeals not related to eligibility for the Medicaid or VHAP programs, the OVHA shall ensure that each of its subcontracted Department develops and maintains comprehensive grievance and appeal procedures that include a grievance process, an appeal process, and access to the State of Vermont's Fair Hearing system at any time, even if an appeal has not yet been adjudicated.

The OVHA must review and approve each of its subcontracted Department's grievance and appeals procedures. The OVHA shall ensure that each of its subcontracted Departments informs the enrollees it is serving and its providers of the grievance and appeals procedures. Grievance and appeals procedures shall be distributed to enrollees and providers in written format at least annually, and upon request. Information shall include enrollee rights with respect to filing grievances, appeals, and requests for Fair Hearing at any time, even if an appeal ha not yet been adjudicated; the process for doing so; the applicable timeframes for filing; the availability of assistance (including interpretation services); and the toll-free numbers for filing oral grievances and appeals.

2.10.1.2 Grievance Procedures

Grievance procedures must comply with the following requirements:

- Clearly articulated and easily accessible for people with disabilities;
- Clear description of who can initiate a grievance and the process for doing so. Grievances must be accepted orally and in writing. Enrollees may elect whether to file the grievance orally or in writing and may not be required to do both;
- Clearly defined steps for the process of resolving grievances;
- Include a process for impartial hearing of the grievance by individuals not involved in any prior level of decision-making on the issue. Grievances regarding denials of expedited resolutions of appeals, or involving clinical issues must be reviewed by a health care professional with expertise in treating the enrollee's condition or disease;
- Grievances are logged and tracked;

- Protection of confidentiality and from retribution for initiating a grievance;

- Assistance is available to enrollees and family members throughout the grievance process. Including assistance in completing forms and other procedural steps not limited to providing interpreter services and toll-free numbers with Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capability.

In addition to the above requirements, the OVHA and its subcontracted Department grievance procedures must comply with the following timeframes and requirements:

- All grievances must be acknowledged in writing within five days;

- Grievances must be resolved within 45 days of receipt. If a grievance cannot be resolved within 45 days, the OVHA or its subcontracted Departments must contact the enrollee to inform him/her of the status of the grievance and the reason for the delay. Any extension in the timeline for processing the grievance shall not exceed an additional 45 days;

- The OVHA or its subcontracted Departments must send written notices of resolution for all grievances. The written notice must include a brief summary of the grievance, the steps taken on the enrollee's behalf, and the resolution.

2.10.1.3 Appeal Procedures

Appeal procedures must comply with the following minimum requirements:

- Clearly articulated and easily accessible for people with disabilities;

- Clear description of who can initiate an appeal and the process for doing so. *Global Commitment to Health Waiver* enrollees may file appeals directly with AHS. Providers may file appeals when they are acting on behalf of an enrollee and have the enrollee's written consent to do so. Appeals may be submitted either orally or in writing. Oral appeals, except for an oral appeal where expedited resolution is requested, must be followed with a written, signed appeal;

- Procedures allow enrollees the opportunity to present evidence and allegations of fact or law, in person as well as in writing, and provide the enrollee and/or his/her representative the opportunity to examine the case file, including medical records and other documents or records. In expedited appeals, enrollees are informed of the limited time available for presentation of evidence and allegations of fact or law;

- Clearly defined steps for the process of resolving appeals;

- Include a process for impartial hearing of the appeal by individuals with appropriate clinical expertise who were not involved in any prior level of decision-making on the issue;

- Clearly defined process for expedited review of appeals when a provider indicates, or the OVHA or its subcontracted Departments determine, that the timeframe for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. Expedited appeals can be filed orally or in writing. There is no requirement to file a written appeal following an oral request for an expedited appeal;

- Appeals are logged and tracked;

- There is protection of confidentiality and from retribution for initiating an appeal or from requesting or supporting a request for an expedited resolution of an appeal;

- Assistance is available to enrollees and family members throughout the appeal process, including assistance in completing forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability;

In addition to the above requirements, the OVHA and its subcontracted Departments appeal procedures must comply with the following timeframes and requirements:

- Enrollees must be allowed at least 10 days from the initial determination to file an appeal;

- All appeals must be acknowledged in writing within five days;

- Appeals must be resolved, and notice provided, as expeditiously as the enrollee's health condition requires and not later than 45 days from the date of receipt. If an appeal cannot be resolved within 45 days, the OVHA or its subcontracted Departments must contact the enrollee and inform him/her of the status of the appeal and the reason for the delay. The extension shall not exceed an additional 14 days. An extension may also be granted at the request of the enrollee;

- Expedited appeals must be resolved, and notice provided, as expeditiously as the enrollee's health condition requires and no later than three working days after receipt of the appeal. The timeframe may be extended by up to 14 calendar days if the enrollee requests the extension or the subcontracted Department demonstrates, and the OVHA agrees, that the extension is in the enrollee's interest. If the extension is not requested by the enrollee, the subcontracted Department must provide written notice of the reason for the delay;

- If a request for an expedited appeal resolution is denied, the OVHA or its subcontracted Departments must transfer the appeal to the standard timeframe (no longer than 45 days from receipt of the request) and must provide prompt oral notice of the denial to the enrollee. Written notice of the denial must be given within two calendar days. The notice must explain the reason for the denial of an expedited

resolution and information on the enrollee's right to file a grievance and the process for doing so;

- The OVHA or its subcontracted Departments must send written notices of resolution for all appeals. Reasonable efforts to provide oral notice must also be made. The written notice must include the results and date of the appeal resolution and, for decisions not wholly in the enrollee's favor when the enrollee is a beneficiary of the *Global Commitment to Health Waiver*'s public insurance programs --
  - The right to request a State of Vermont Fair Hearing for up to 30 days from the date of the appeal decision;
  - How to request a Fair Hearing;
  - The right to continue to receive benefits pending a hearing;
  - How to request continuation of benefits; and
  - If the OVHA or the subcontracted Department's action is upheld during a hearing, the enrollee's liability for the cost of any continued benefits.

- For decisions not wholly in the enrollee's favor when the enrollee is not a beneficiary of the *Global Commitment to Health Waiver*'s public insurance programs, or has filed an appeal pertaining to a service not covered by Medicaid, the written notice shall include information on the enrollee's right to file an appeal and how to file such an appeal.

2.11 Enrollee Records

The OVHA shall ensure (and require its subcontracted Departments to ensure) that each enrollee served under the *Global Commitment to Health Waiver* has a comprehensive medical record. The OVHA and its subcontracted Departments shall ensure compliance with all State and Federal legal requirements as they pertain to medical records and in particular, to confidentiality of records. At a minimum, all medical records shall:

- Be maintained in a manner that is current, detailed, and organized such that it permits effective patient care and quality review as documented in the Minimum Standards and Clinical Care Audit;

- Include sufficient information to identify the patient, date of encounter and pertinent information which documents the type and frequency of services provided;

- Include an annual review of treatment and service plan determinations (as appropriate and applicable); and

- Describe the enrollee's diagnosis and appropriateness of the treatments/services, the course and results of the treatment/services, and shall illustrate how the provider facilitates continuity and coordination of care as evidenced by:

  - Presence of a comprehensive health evaluation;
  - Functional assessment completed biennially (if appropriate);
  - History and Physical;

- Annual service plan derived from clinically assessed needs and enrollee preference, if applicable;
- Quarterly updates to the service plan, if applicable;
- Monthly evaluative summary of treatment and service needs, if applicable;
- As appropriate, medication evaluation, prescription and management of drug therapies.

2.12 Reporting Requirements

2.12.1 Encounter Data

The OVHA shall maintain claims history data for all *Global Commitment to Health Waiver* enrollees through contractual arrangements with its Fiscal Agent. The OVHA shall also require its subcontracted Departments to submit encounter reports for all services rendered to Global Commitment to Health Waiver enrollees, when such services are provided through a sub-capitation arrangement with the Department. Reporting shall be in accordance with the CMS Special Terms and Conditions of the 1115 Medicaid Waiver Demonstration. The OVHA shall make such claims and encounter data available to the AHS and the CMS upon request.

2.12.1.1 Data Validation

Encounter data submitted to the OVHA by its subcontracted Departments will be edited by the OVHA for accuracy, timeliness, correctness, and completeness. Any encounter data failing edits will be rejected and must be re-submitted. Encounter data must represent services provided to *Global Commitment to Health Waiver* enrollees only.

Biennially, the AHS or its designee will perform medical record reviews for purposes of comparing submitted claims and encounter data to the medical record to assess correctness, completeness and to review for omissions in encounters or claims.

2.12.2 Financial Reporting

The OVHA shall maintain the following financial information and records, and shall make such information available to the AHS upon request, in the format specified by the AHS. Financial records shall include the following:

- Monthly comparisons of projected vs. actual expenditures;
- Monthly report of the OVHA revenues and expenses for the *Global Commitment to Health Waiver*;
- Monthly comparisons of projected vs. actual case load;
- Quarterly analysis of expenditures by service type;
- Monthly financial statements; and

- All reports and data necessary to support waiver reporting requirements.

The AHS reserves the right to modify the financial reporting requirements. The AHS will consult with the OVHA prior to modification of reporting requirements.

2.12.3 Network Reporting

The AHS shall provide report formats and variable definitions for the OVHA to use in providing network capacity data to demonstrate that it offers an appropriate range of covered services adequate for the anticipated number of enrollees for the service area; and that it maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

Network capacity documentation shall be submitted annually and at any time there has been a significant change in the OVHA's operations that would affect adequate capacity or services, including changes in services, benefits, payments or enrollment of a new population.

Monthly reports are due within 30 days following the end of the month. Annual and quarterly reports are due within 45 days following the end of the reporting period.

2.13 Fraud and Abuse

The OVHA 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 the OVHA's 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 the OVHA'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.

The OVHA 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 the OVHA, 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 the AHS and the Vermont Attorney General. For each case of suspected fraud and abuse reported, the OVHA 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. The OVHA 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

The OVHA 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. The OVHA also agrees to comply with all standards for record keeping specified by the AHS. In addition the OVHA agrees to permit inspection of its records.

2.14.2 Confidentiality of Information

The OVHA 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, the OVHA 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, the OVHA 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 the OVHA to persons or agencies which require the information in order to perform their duties in accordance with the agreement, including the 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. The 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 either State and/or Federal laws and regulations.

2.15 Disclosure Requirements

The OVHA 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. The OVHA 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 the OVHA 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.

The OVHA 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 the OVHA or its providers treat the enrollee.

The OVHA must comply with disclosure requirements in 42 CFR 455, Subpart B. The OVHA 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 the OVHA-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

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

The AHS shall pay the OVHA the appropriate monthly Capitation Rate for each *Global Commitment to Health Waiver* enrollee. The OVHA will submit a monthly report to the AHS listing all enrollees who meet the *Global Commitment to Health Waiver* eligibility criteria. This roster of *Global Commitment to Health Waiver* enrollees will be used to determine the total capitation payment due to the OVHA for that month.

The OVHA will ensure that the enrollee roster submitted to the AHS has been certified by the Director or an individual who has delegated authority to sign for, and reports directly to, the Director. The certification must attest to the accuracy, completeness and truthfulness of the documents and data. The certification must be submitted concurrently with the enrollee roster.

3.3 Performance Evaluation

The AHS shall annually, or more frequently at its discretion, do the following:

- Define measurable performance standards for the OVHA and its subcontractors in all of the following areas:
  - Service Accessibility
  - Enrollee Satisfaction
  - Quality Assurance & Medical Management
  - Grievance & Appeal Resolution
  - Reporting
- Monitor and evaluate the OVHA's compliance with the terms of this IGA, including performance standards;
- Meet with the OVHA a minimum of twice a year to assess the performance of its

Quality Assurance Program, as set forth in the Protocol;

- Review reports submitted by the OVHA, including specifically quarterly reports on grievances and appeals received by the OVHA and its subcontracted Departments;

- Request additional reports that the AHS deems necessary for purposes of monitoring and evaluating the performance of the OVHA under this IGA;

- Perform periodic programmatic and financial reviews of the OVHA's performance of responsibilities. This may include, but is not limited to, on-site inspections and audits of the OVHA's and/or its subcontracted Department's records and audits. The on-site inspections and audits may, at a minimum, include a review of the following:

  - Administration
  - Operations
  - Financial performance
  - Staff/provider qualifications and training
  - Enrollee access
  - Enrollee services
  - Provider services
  - Individual medical records
  - Quality Assurance Program
  - Utilization Management functions
  - Grievances and appeals
  - Enrollee satisfaction

- Provide the OVHA and/or its subcontracted Departments prior notice of any on-site visit by the AHS or its agents to conduct an audit, and further notify the OVHA of any records that must be made available for review;

- Inform the OVHA and/or its subcontracted Departments of the results of any performance evaluations conducted by the 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 the OVHA or one of its subcontracted Departments, the OVHA will be required to file a formal response within the time period specified in the CAP. The AHS will review and approve or modify the response, as appropriate. The AHS will monitor implementation of the CAP response through progress reports and interim audits until it is satisfied that the deficiency has been corrected.

- Perform medical audits at least annually as required by 42 CFR 434.63; and

The AHS shall contract with an External Quality Review Organization (EQRO) for purposes of independently monitoring the OVHA's Quality Management Program.

3.4 Receipt and Analysis of Encounter Data

The AHS shall receive the claims and encounter data as reported by the OVHA. The AHS shall, at least annually, conduct an evaluation of the claims and validated encounter data 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

The AHS shall retain sole responsibility for production and submission of reports to the CMS, including all fiscal reports. The OVHA agrees to cooperate with the 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 Fair Hearing Process

The Human Services Board shall retain responsibility for conducting Fair Hearings. The AHS shall retain responsibility for representing the State of Vermont in any Fair Hearings pertaining to eligibility determinations other than Medicaid or VHAP (which is the responsibility of the Economic Services Division) or service denials. In the event of a request for a Fair Hearing regarding *Global Commitment to Health Waiver* eligibility or service denials, the decision of the OVHA or its contracted Departments shall be reviewed by the AHS. The OVHA agrees to cooperate with the AHS in any Fair Hearing proceedings, including preparation and submission of any enrollee medical records or other documentation pertinent to the proceedings. The OVHA further agrees that its legal staff shall assist the State of Vermont in any Fair Hearings pertaining to service denials. The OVHA must provide covered services promptly and as expeditiously as the enrollee's health condition requires if such services are determined medically/clinically necessary by the AHS Medical Reviewer, or if the enrollee prevails in the Fair Hearing. Where possible, the AHS Medical Reviewer shall apply existing definitions and guidelines in making determinations of medical/clinical necessity.

Enrollee services must be continued during the Fair Hearing process under the following circumstances:

- Appeal was filed timely, meaning on or before the tenth day after the notice of action was mailed or by the intended effective date of the proposed action;
- Appeal involves the termination, suspension or reduction of a previously authorized course of treatment;
- Services were ordered by an authorized provider;
- Authorization period has not expired; or

- Enrollee requests extension of benefits.

If benefits are continued or reinstated, the benefits must be continued until one of the following occurs:

- Enrollee withdraws the appeal;
- Enrollee does not request a Fair Hearing within 10 days from the date of mailing of the adverse decision;
- State of Vermont Fair Hearing decision adverse to the enrollee is made; or
- Authorization expires or service authorization limits are met.

If the final resolution of the appeal upholds the OVHA's decision (or that of one of its subcontracted Departments), the enrollee is liable for the cost of services furnished while the appeal is pending.

The OVHA must pay for disputed services, in accordance with State of Vermont policy and regulations, if the State of Vermont Fair Hearing officer reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending.

Parties to the State of Vermont Fair Hearing include the OVHA, the subcontracted Department (if applicable), the enrollee and his or her representative or the representative of a deceased enrollee's estate.

3.7 Enrollee Services

The OVHA, through its enrollment subcontractor (currently Maximus), shall provide an enrollee helpline function for *Global Commitment to Health Waiver* enrollees. The OVHA 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. The AHS shall ensure that the Enrollee Services functions are appropriately carried out by the OVHA.

The OVHA shall require each of its subcontracted Departments to identify a liaison to respond to inquiries from the helpline operators and to assist in resolution of enrollee issues.

3.8 Ombudsman

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

3.9 Third Party Liability (TPL)

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

ARTICLE FOUR: PAYMENT PROVISIONS

4.1 Capitation Payment between AHS and OVHA

The OVHA shall be paid Federal Medicaid matching funds based on eligible *Global Commitment to Health Waiver* enrollees at the capitated monthly amounts approved by the AHS and the 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 shall not be part of the capitation and shall be reported in accordance with existing Federal regulations.~~ *(Note: this sentence is incorrect, and will be permanently deleted in the revised version once the Premium amounts are defined. 10/04/05)*

Capitation payments serve as full compensation for the provision of covered health care services to *Global Commitment to Health Waiver* enrollees. With the exception of the capitation payments specified herein, Medicaid funding will not be made available to reimburse services covered under this IGA.

The OVHA 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, the OVHA.

The AHS shall pay an interim monthly rate to the OVHA until such time as the actuarially certified rate has been developed and approved by the CMS. The interim monthly capitation rate shall be $65,371,811.

Upon completion of the actuarial certification process and the CMS approval, the capitation rate shall be adjusted and paid in accordance with the approved rate.

As necessary, the AHS shall make a retroactive adjustment to reflect the difference between interim capitation payments made by the AHS and the rate that has been actuarially certified and approved by the CMS. The AHS shall submit to the CMS sufficient documentation to support the calculation of the retroactive rate adjustment.

4.2 Payments between OVHA and its Subcontracted Departments

The OVHA will pay its subcontracted Departments using reimbursement methodologies based on the cost of delivering eligible services to individuals covered under the *Global Commitment to Health Waiver*.

4.3 Restrictions on Use of Excess Funds

Should the OVHA have any excess funds after making all payments to its providers, including its subcontracted Departments, for Global Commitment to Health enrollees,

those excess funds may be used to support health initiatives in the State of Vermont restrictions on the use of excess funds are as follows:

- Funds may not be used as State match in subsequent years
- Financing 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
- Financing health care services covered under the Vermont State Employee Benefit Plan

The AHS will collect detailed information annually on how excess funds are spent.

Attachment A
Description of Covered Benefits and Populations

The Managed Care Organization (MCO) 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 (*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*) **COVERED excepted for chiropractor**
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**
individuals who lose eligibility under 1931 due to employment (1902(a)(10)(A)(i)(I)) (402(a)(37)) (1925)	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))	individuals who are eligible for Title IV-A if State AFDC plan were as broad as allowed (1902(a)(10)(A(ii)(II)) **COVERED**	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))	aged individuals who are ineligible as categorically needy (42 CFR 435.301(b)(2)(iii)) (42 CFR 435.320) (42 CFR 435.330) **COVERED**	X-rays services and other laboratory services	dental services **COVERED**
individuals who lose eligibility under 1931 because of child or spousal support (1902(a)(10(A)(i)(I)) (406(h))	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))	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**	pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post partum services (1902(a)(10)(C)) (1905)(e)(5))	blind individuals who are ineligible as categorically needy but meet the categorically needy definition of blindness (42 CFR 435.301(b)(2)(iv)) (42 CFR 435.324) (42 CFR 435.330) **COVERED**	nursing facility services for individuals over 21	physical therapy; occupational therapy; speech, hearing, and language disorders services **COVERED**
individuals participating in a work supplementation program who would otherwise be eligible under 1931 (1902(a)(10(A)(i)(I)) (482(e)(6))	Qualified Medicare Beneficiaries (QMBs)[4] (1902(a)(10)(E)(i) (1905(p)(1))	*special income level group*: 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**	blind and disabled individuals eligible in December 1973 (42 CFR 435.340)	disabled individuals who are ineligible as categorically needy that meet the categorically needy definition of blindness (1902(a)(10)(C)) **COVERED**	EPSDT services for individuals under 21	prescribed drugs **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 receiving SSI cash benefits (does not apply to 209(b) States) (1902(a)(10)(A)(i)(I))	qualified disabled and working individuals[5] (1902(a)(10)(E)(ii) (1905(s))	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**		individuals who would have been ineligible if they were not enrolled in a MCO[12] (1902(a)(10(C)) ((1902(e)(2)) **NOT COVERED**	physician services	dentures **NOT COVERED**
disabled children no longer eligible for SSI benefits because of a change in definition of disability (1902(a)(10)(A)(i)(II))	Specified Low Income Medicare Beneficiaries (SLMBs)[6] (1902(a)(10)(E)(iii))	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**			medical and surgical services of a dentist	prosthetic devices **COVERED**
qualified pregnant women (1902(a)(10)(A)(i)(III)) (1905(n)(1))	qualifying individuals[7,8] (QI-1s) (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 **NOT COVERED**
qualified children (1902(a)(10)(A)(i)(III)) (1905(n)(2))	qualifying individuals[7,9] (QI-2s) (1902(a)(10)(E)(iv)(II))	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 (*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)* **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 *(psychotherapy, group therapy, day hospital, chemotherapy, diagnosis and evaluation, emergency care*) **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[10] (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**
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**

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**
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[11] (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**
early widows/widowers (1634(d)) (1935)		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**				community supported living arrangement services **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**
209(b) States: State uses more restrictive criteria to determine eligibility than are used by the SSI program (1902(f))		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**				personal care services **COVERED**
individuals who would be eligible for AFDC except for increased OASDI income under P.L. 92-336 (July 1, 1972) (42 CFR 435.114)		uninsured women, under 65, who are screened for breast or cervical cancer under CDC program (1902(a)(10)(A)(ii)(XVIII)) **COVERED**				primary care case management services **COVERED**
individuals receiving mandatory State supplements (42 CFR 435.130)		individuals who would have been ineligible if they were not enrolled in a MCO[12] (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 worm furnished during a presumptive eligibility period **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**
institutionalized individuals who were eligible in December 1973 (42 CFR 435.132)		presumptive eligibility for pregnant women[13] (1920) **NOT COVERED**				organ transplant services
blind and disabled individuals eligible in December 1973 (42 CFR 435.133)		presumptive eligibility for children[14] (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[15] **NOT 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)						transportation services[15] **COVERED**
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**				nursing facility services for individuals under 21[15] **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)						emergency hospital services[15] **COVERED**
						critical access hospital services[15]

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.
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. State pays for the difference in amount of the cost shift of home health services from Part A to Part B.
10. Services provided to this group are limited to TB-related services.
11. States electing to cover the medical improvement group under TWWIIA must also cover the basic coverage group under TWWIIA.
12. Coverage under this section is limited to MCO services and family planning services described in 1905(a)(4)(C).
13. Services provided to presumptive eligible women are limited to ambulatory prenatal care services.
14. Services provided to presumptive eligible children include all services covered under the State Plan including EPSDT services.
15. 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.

Attachment B
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
MCO	Managed Care Organization (Public MCO)
MMIS	Medicaid Management Information System
OVHA	Office of Vermont Health Access
PA	Prior Authorization
PCP	Primary Care Provider
PMPM	Per Member Per Month
TPL	Third Party Liability
TTY/TTD	Teletypewriter/Telecommunications Device for the Deaf
VDH/DOH	Vermont Department of Health
VHAP	Vermont Health Access Plan

Draft AHS-MCO IGA – revised 29Sept05

IGA Signature Page

Agreed to:

Michael K. Smith, Secretary
Agency of Human Services (AHS)

Date: 9-30-05

Joshua Slen, Director
Office of Vermont Health Access (OVHA)

Date: 9-30-2005