DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

**Center for Medicaid and CHIP Services**

June 27, 2012

Douglas A. Racine, Secretary
Vermont Agency of Human Services
208 Hurricane Lane, Suite 103
Williston, VT 05495

Dear Mr. Racine:

The Centers for Medicare & Medicaid Services (CMS) has approved an amendment for Vermont's section 1115 Demonstration, Global Commitment to Health (11-W-00194/1). The enclosed changes fully respond to the State's amendment request submitted on May 14, 2012. The State requested a August 1, 2012 effective date.

The amended section 1115 Demonstration provides Vermont with the authority to:

1. Eliminate the $75 inpatient admission co-pay; and,
2. Implement nominal co-payments for the Vermont Health Access Plan (VHAP) population as long as they do not exceed the co-payments charged to State plan populations under the Medicaid State plan.

CMS approval of this section 1115 Demonstration amendment is subject to the limitations specified in the approved waiver and expenditure authorities and not applicables list. The State may deviate from the Medicaid State plan requirements only to the extent those requirements have been specifically listed as waived or not applicable to the expenditure authorities. All requirements of the Medicaid program as expressed in law, regulation, and policy statement not expressly waived or identified as not applicable shall apply to the Global Commitment to Health Demonstration. No changes are being made to the list of waivers or expenditure authorities.

This approval is conditioned upon continued compliance with the enclosed Special Terms and Conditions (STCs) defining the nature, character, and extent of Federal involvement in this project. This approval is also conditioned upon written acceptance from the State that it agrees with the amendment, waivers, expenditure authorities, and STCs. This written acceptance is needed for our records within 30 days of the date of this letter.

Your contact for this Demonstration is Ms. Anne Chiang, who may be reached at (410) 786-5354 and through e-mail at Anne.Chiang@cms.hhs.gov. Ms. Chiang is available to answer any questions concerning the scope and implementation of the project. Communications regarding program matters and official correspondence concerning the Demonstration should be submitted to Ms. Chiang at the following address:

Centers for Medicare & Medicaid Services

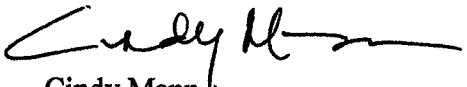
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850

Official communication regarding program matters should be sent simultaneously to Ms. Chiang and to Mr. Rich McGreal, Associate Regional Administrator in our Boston Regional Office. Mr. McGreal's contact information is as follows:

Centers for Medicare & Medicaid Services
JFK Federal Building, Room 2275
Boston, MA 02203-0003

If you have questions regarding this approval, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group, Center for Medicaid, and CHIP Services, at (410) 786-5647.

Sincerely,



Cindy Mann
Director

Enclosures

Cc: Rich McGreal, Associate Regional Administrator, Boston Regional Office
Robert Cruz, State Representative, Boston Regional Office
Anne Chiang, Project Officer, Center for Medicaid and CHIP Services

# CENTERS FOR MEDICARE & MEDICAID SERVICES
# WAIVER AUTHORITY

**NUMBER:** **11-W-00194/1**

**TITLE:** **Global Commitment to Health Section 1115 Demonstration**

**AWARDEE:** **Vermont Agency of Human Services (AHS)**

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the Demonstration project from January 1, 2011 through December 31, 2013. These waivers do not apply to the excluded populations of recipients of long term care services who are served under the Vermont LTC Section 1115 Demonstration other than community residential treatment.

Under the authority of section 1115(a)(1) of the Social Security Act (the Act) the following waivers shall enable Vermont to implement the Global Commitment to Health section 1115 Demonstration:

**1. Statewideness/Uniformity** **Section 1902(a)(1)**

To the extent necessary to enable Vermont to operate the program differently in different geographical areas of the State.

2. **Hearings and Appeals** **Section 1902(a)(3)**

To permit the State to offer an initial hearing on coverage denials through the Department of Vermont Health Access, with an opportunity to appeal to a Fair Hearing before the State Medicaid agency.

**2. Amount, Duration, Scope of Services** **Section 1902(a)(10)(B)**

To enable Vermont to vary the amount, duration and scope of services offered to various mandatory and optional categories of individuals eligible for Medical assistance under the Demonstration as long as the amount, duration and scope of covered services meets the minimum requirements under title XIX of the Act and the special terms and conditions.

**3. Financial Eligibility** **Section 1902(a)(10)(C)(i)(III)**

To allow the State to use institutional income rules (up to 300 percent of the Supplemental Security Income payment level) for medically needy enrollees electing home-based services in lieu of nursing facility or in lieu of other residential care services in licensed settings while allowing resource limits up to $10,000.

**4. Comparability** **Section 1902(a)(17)**

To the extent necessary to enable the State to use more liberal income and resource standards and methods for plan groups and individuals.

**5. Financial Responsibility/Deeming** **Section 1902(a)(17)(D)**

To the extent necessary to enable the State to use more liberal income and resource standards and methods for plan groups and individuals whose eligibility is determined under the more liberal standards and methods, resource standards, and requirements that differ from those required under title XIX. The waiver would specifically exempt the State from the limits under section 1902(a)(17)(D) on whose income and resources may be used to determine eligibility unless actually made available, and so that family income and resources may be used instead.

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

**6. Payment to Providers** **Sections 1902(a)(13)**
**1902(a)(30)**

To allow the State, through the Department of Vermont Health Access, to establish rates with providers on an individual or class basis without regard to the rates currently set forth in the approved State plan.

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

To enable the State to offer 1-month spend-downs for medically needy people receiving community-based services as an alternative to institutionalization, and non-institutionalized persons who are receiving personal care attendant services at the onset of waivers.

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

To enable the State to restrict freedom of choice of provider for the demonstration participants to the extent that beneficiaries will be restricted to providers enrolled in a provider network through the Department of Vermont Health Access for the type of service at issue, but may change providers among those enrolled providers.

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

**9. Premium Requirements** **Section 1902(a)(14)**
**Insofar as it incorporates Section 1916**

To permit Vermont to impose premiums in excess of statutory limits for optional populations as reflected in the special terms and conditions.

**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**EXPENDITURE AUTHORITY**

**NUMBER:** **11-W-00194/1**

**TITLE:** **Global Commitment to Health Section 1115 Demonstration**

**AWARDEE:** **Vermont Agency of Human Services (AHS)**

Under the authority of section 1115(a)(2) of the Social Security Act, expenditures made by Vermont for the items identified below (which are not otherwise included as expenditures under section 1903) shall, for the period of this Demonstration, January 1, 2011, through December 31, 2013, be regarded as expenditures under the State's Medicaid title XIX plan.

The following expenditure authorities shall enable Vermont to implement the Global Commitment to Health Section 1115 Demonstration.

## 1. Expenditures Related to Eligibility Expansion

Expenditures to provide Medical Assistance coverage, either in the form of payment for medical services under the State plan as affected by the waivers and expenditure authorities under this Demonstration, or in the form of premium assistance as specified in the Special Terms and Conditions, to the following Demonstration populations that are not covered under the Medicaid State plan and are enrolled in the Vermont Global Commitment to Health Demonstration:

***Vermont Health Access Plan (VHAP) Expansion Populations***

| | |
|---|---|
| **Demonstration Population 3:** | Underinsured children with income between 225 and up to and including 300 percent of the Federal poverty level (FPL) who are not otherwise eligible for Medicaid or the State Children's Health Insurance Program |
| **Demonstration Population 4:** | Adults with children with income between 150 and up to and including 185 percent of the FPL |
| **Demonstration Population 5:** | Childless Adults with income up to and including 150 percent of the FPL |
| **Demonstration Population 6:** | Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income at or below 150 percent of the FPL, not otherwise categorically eligible |
| **Demonstration Population 7:** | Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income above 150 percent and up to and including 225 percent of the FPL, not otherwise categorically eligible |

**Demonstration Population 8:** Individuals with persistent mental illness with income up to and including 150 percent of the FPL

***Premium Assistance Expansion Populations***

**Demonstration Population 9:** Employer-Sponsored Insurance Premium Assistance

a. Adults with children with incomes between 185 and including 300 percent of the FPL without adjustment (gross income)
b. Childless adults and non custodial parents with income between 150 and including 300 percent of the FPL without adjustment (gross income)
c. College students with income up to and including 300 percent of FPL who do not meet eligibility requirements for Demonstration Populations 4 & 5

**Demonstration Population 10:** Catamount Premium Assistance

a. Adults with children with incomes between 185 and including 300 percent of the FPL without adjustment (gross income)
b. Childless adults and non custodial parents with income between 150 and including 300 percent of the FPL without adjustment (gross income)
c. College students with income up to and including 300 percent of FPL who do not meet eligibility requirements for Demonstration Populations 4 & 5

**2. Expenditures Related to Additional Services**

Expenditures for additional health care related-services for the demonstration populations.

**3. Expenditures for Public Health Initiatives, Outreach, Infrastructure, and Services Related to State Plan, Demonstration, Uninsured and Underinsured Populations**

Subject to availability of funding within the per member per month limit, expenditures to reduce the rate of uninsured and/or underinsured in Vermont, increase the access to quality health care for uninsured, underinsured, and Medicaid beneficiaries, provide public health approaches and other innovative programs to improve the health outcomes and the quality of life for Medicaid-eligible individuals in Vermont; and encourage the formation and maintenance of public-private partnerships in health care.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to Demonstration Populations 5 through 11 beginning January 1, 2011, through December 31, 2013.

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

To enable the State to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance is made for expansion groups.

**4. Reasonable Promptness and Simplicity of Administration** **Sections 1902(a)(3), Section 1902(a)(8), and Section 1902 (a)(19)**

To enable Vermont to implement policies intended to prevent substitution of public coverage for private coverage, including policies related to a waiting period prior to becoming eligible for the VHAP or Catamount expansion programs.

**5. Amount, Duration and Scope of Services** **Section 1902(a)(10)(B)**

To enable Vermont to offer different services to different expansion populations.

**6. Cost Sharing Requirements** **Section 1902(a)(14) insofar as it incorporates Section 1916**

To enable Vermont to impose premiums, enrollment fees, deductions, cost sharing and similar charges that exceed the statutory limitations.

**7. Direct Provider Reimbursement** **Section 1902(a)(32)**

To enable Vermont to provide premium assistance to expansion populations for the purchase of employer-sponsored health insurance.

# CENTERS FOR MEDICARE & MEDICAID SERVICES
# AMENDED SPECIAL TERMS AND CONDITIONS

**NUMBER:** **11-W-00194/1**

**TITLE:** **Global Commitment to Health Section 1115 Demonstration**

**AWARDEE:** **Vermont Agency of Human Services (AHS)**

## I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Vermont Global Commitment to Health Section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"). The parties to this agreement are the Vermont Agency of Human Services (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth limitations on the extent of the waivers and expenditure authorities that have been granted to further the Demonstration, which are enumerated in separate lists. The STCs also detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The amended STCs are effective date of the approval letter through December 31, 2013 unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. The amended STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; General Reporting Requirements; Eligibility, Benefits, and Enrollment; Cost Sharing; Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; Use of Demonstration Funds; and Schedule of State Deliverables for the Demonstration Period.

Additionally, Attachment A has been included to provide supplemental information and guidance for the quarterly report content and format. Attachment B has been included to provide supplemental information on the Catamount Health Program

## II. PROGRAM DESCRIPTION AND OBJECTIVES

The Global Commitment to Health Section 1115(a) Demonstration is designed to use a multi-disciplinary approach including the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, public-private partnership, an initiative in employer sponsored health insurance, and program flexibility. Specifically, Vermont expects to demonstrate its ability to achieve universal access to health care, cost containment, and improved quality of care. The initial Global Commitment to Health Demonstration was approved in September of 2005.

The State's goal in implementing the Demonstration is to improve the health status of all Vermonters by:

- Increasing access to affordable and high quality health care;
- Improving access to primary care;
- Improving the health care delivery for individuals with chronic care needs; and
- Containing health care costs.

The State will employ four major elements in achieving the above goals:

1. Program Flexibility: Vermont has the flexibility to change benefits for the non-mandatory populations and invest in alternative services and programs designed to achieve the Demonstration's objectives;
2. Managed Care Delivery System: Under the Demonstration the AHS will enter into an agreement with the Department of Vermont Health Access (DVHA), which will operate using a managed care model;
3. Aggregate Budget Neutrality Cap: Vermont will be at risk for the caseload and the per capita program expenditures, as well as certain administrative costs. Vermont will have to manage this program within a total computable aggregate cap of $8.9 billion over the approved eight and one quarter -year Demonstration period; and
4. Premium assistance: Vermont will increase access to affordable health care coverage by providing premium assistance to purchase private coverage via the Catamount Health Plan for the uninsured and by providing premium assistance to individuals with access to employer sponsored insurance (ESI).

In 2006, the State passed legislation establishing Catamount Health, a fully insured product available through private insurers in Vermont. The Catamount Health Assistance Program seeks to fill gaps in coverage for Vermonters by providing a health services delivery model for uninsured individuals.

In October 2007, a component of the Catamount program was added to the Demonstration enabling the State to provide a premium subsidy to Vermonters who have been without health insurance coverage for a year or more, have income at or below 200 percent of the Federal poverty level (FPL), and who do not have access to cost effective employer-sponsored insurance, as determined by the State. In December 2009, CMS processed an amendment allowing the State to extend coverage to Vermonters at or below 300 percent of the FPL.

In Fall 2011, Vermont implemented a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life limiting illnesses that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.

In June 2012, CMS processed a cost-sharing amendment to the Demonstration, providing the authority for the State to eliminate the $75 inpatient admission co-pay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid State plan.

## III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, unless specified otherwise in the STCs, waiver list, or expenditure authorities or otherwise listed as non- applicable, must apply to

the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in the applicable law, regulation, or policy directive, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
   a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified budget neutrality agreements would be effective upon the implementation of the change.

   b. If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State is not required to submit title XIX State plan amendments for changes to Demonstration-eligible populations covered solely through the Demonstration. If a population covered through the Medicaid State plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State plan may be required, except as otherwise noted in these STCs. Reimbursement of providers will not be limited to reimbursement described in the State plan.

6. **Changes Subject to the Demonstration Amendment Process.** The State must not implement changes to its program that require an amendment without prior approval by CMS, as discussed below. Amendments to the Demonstration are not retroactive, and FFP may not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7, below.

   The State has the authority to modify the Demonstration program design elements in accordance with the parameters specified below. Changes in eligibility or process in determining eligibility requires a Demonstration amendment.

   **Mandatory State Plan Eligibles**. All changes in benefits (whether reductions or additions), including optinal services, for federally mandated populations must be submitted as an amendment to the State plan.

   **Non-Mandatory Eligibles.** All proposed changes (whether additions or reductions) in State plan benefits for optional groups must be submitted as an amendment to the State plan; all proposed changes in benefits (whether additions or reductions) for the expansion groups must be submitted as an amendment to the Demonstration by the amendment process outlined in paragraph 7. The State may change the benefit package for the non-mandatory eligible population so long as the State plan benefit changes and/or changes to benefits for the expansion groups result in no more than a 5-percent cumulative increase, or decrease each year of the total Medicaid expenditures for the corresponding Demonstration year, and comparison year and as long as the resulting benefit package is consistent with the requirements in paragraph 23 below. The following chart indicates the corresponding years:

| Demonstration Year (DY) | Comparison Year Expenditures |
|---|---|
| DY 1 | 2004 Total Global Expenditures |
| DY2 | 2005 Total Global Expenditures |
| DY 3 | 2006 Total Global Expenditures |
| DY 4 | 2007 Total Global Expenditures |
| DY 5 | 2008 Total Global Expenditures |
| DY 6 | 2009 Total Global Expenditures |
| DY 7 | 2010 Total Global Expenditures |
| DY 8 | 2011 Total Global Expenditures |
| DY 9 | 2012 Total Global Expenditures |

The State must offer benefit packages that, at a minimum, include inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, and well-baby, and well-child care, including age appropriate immunizations. However, this does not apply to Populations 6 through 10 as defined in paragraph 17.

For changes in the non-mandatory populations' benefit package, the State must notify CMS 60 days prior to any expected change in the benefit package. After receipt of the written notification, CMS officials will notify the State if the request needs to be submitted as an amendment to the State plan or an amendment to the Demonstration as outlined in paragraph 7. Should the State fail to notify within the time period or submit an amendment as requested, CMS has the right to withhold or disallow FFP.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the date of implementation of the change and may not be implemented until approved. Amendment requests will be reviewed by the Federal Review Team and must include, but are not limited to, the following:

    a. An explanation of the public process used by the State to reach a decision regarding the requested amendment;

    b. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level though the approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;

    c. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

    d. If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

8. **Frequency of Demonstration Amendments**. Vermont's expectation is that changes to the Demonstration will occur at the same time of year each year, based on the outcomes of the legislative session. At the end of the legislative session, the State must submit amendments pursuant to paragraph 6, and governed by the process outlined in paragraph 7 of this section. Any approved changes must be reflected in the annual rate-setting process for the upcoming year.

9. **Demonstration Phase-Out.** The State may only suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements.

    a. Notification of Suspension or Termination: The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received, the State's response to the comment and how the State incorporated the received comment into a revised phase-out plan. \

    b. The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

    c. Phase-out Plan Requirements: The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

    d. Phase-out Procedures: The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

    e. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration (in whole or in part) at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. In addition, CMS reserves the right to withdraw expenditure authorities at any time it determines that

continuing the expenditure authorities would no longer be in the public interest. If an expenditure authority is withdrawn, CMS shall be liable for only normal close-out costs. CMS will promptly notify the State in writing of the determination and the reasons for suspension or termination of the Demonstration, or any withdrawal of an expenditure authority, together with the effective date.

11. **Finding of Non-Compliance.** The State does not relinquish either its rights to challenge the CMS finding that the State materially failed to comply, or to request reconsideration or appeal of any disallowance pursuant to section 1116(e) of the Act.

12. **Withdrawal of Waiver Authority**. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

14. **Public Notice and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and regulations that implement section 1115(d), as added by section 10201 of the Affordable Care Act.

15. **Compliance with Managed Care Regulations.** The State shall comply with all of the managed care regulations published at 42 CFR section 438 et. seq., except as expressly identified as not applicable in the STCs. The per member, per month fixed amount pursuant to paragraph 41 must be developed and certified as actuarially sound in accordance with 42 CFR 438.6. DHVA shall continue to serve as the unit designated by AHS (the Single State Agency) responsible for administration of the State Medicaid program and operates as a public managed care model solely to carry out the goals and purposes of the Demonstration. DVHA's role under the Demonstration as a public managed care model does not reduce or diminish its authority to operate as the designated Medicaid unit under the approved State plan, including its authority to implement program policies permissible under a State plan and establish provider participation requirements DVHA shall comply with federal program integrity and audit requirements as if it were a managed care organization for services and populations covered under the Demonstration.

16. **Federal Funds Participation (FFP).** No federal matching for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

## IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

The Global Demonstration includes four fundamental elements: program flexibility; a health care delivery system administered by the State but modeled after a managed care delivery system; an aggregate budget neutrality cap; and premium assistance.

17. **Eligibility.** Mandatory and optional State plan groups described below are subject to all applicable Medicaid laws and regulations, except as expressly waived in the award letter for this Demonstration.

    Those non-Medicaid eligible groups described below who are made eligible for the Demonstration by virtue of the expenditure authorities expressly granted in this Demonstration are subject to Medicaid laws or regulations only as specified in the expenditure authorities for this Demonstration.

    Only those Vermont Choice for Care (CfC) beneficiaries receiving Community Rehabilitation and Treatment (CRT) services under Global Commitment or moderate eligible services under CfC overlap with the Global Commitment to Health Demonstration. Except for the exclusion of participants covered solely under the Vermont CfC section 1115 Demonstration, the following populations listed in the tables below must be covered under the Global Commitment to Health Demonstration. Changes to the following, outside the parameters as outlined in paragraph 6, are pursuant to the amendment process as discussed in paragraphs 7 and 8 under section III, General Program Requirements.

    To be eligible for premium assistance, adults not otherwise eligible for DVHA programs must have been uninsured for 12 months, subject to the exceptions noted in this paragraph, or six months if the State elects such shorter period and gives 30 days prior notice to CMS. Individuals must meet these requirements unless they lost coverage due to one of the following reasons: loss of employment; death of the principal insurance policyholder; divorce or dissolution of a civil union; domestic violence; no longer qualified as a dependent under the plan of a parent or caretaker relative; no longer qualifying for Consolidated Omnibus Budget Reconciliation Act (COBRA), Vermont Continuing Coverage Program (VIPER), or other state continuation coverage; or a college-sponsored insurance plan became unavailable because the individual graduated, took a leave of absence, or otherwise terminated studies.

    The general categories of populations included under the Demonstration are:

    ***Traditional Medicaid-eligible Mandatory and Optional Populations***

    **Demonstration Population 1:** Mandatory Categorically Needy
    **Demonstration Population 2:** Optional Categorically Needy

    ***Vermont Health Access Plan (VHAP) Expansion Populations***

    **Demonstration Population 3:** Underinsured children with income between 225 percent and up to and including 300 percent of the FPL who are not otherwise eligible for Medicaid or the Children's Health Insurance Program

    **Demonstration Population 4:** Adults with children with income between 150 percent

and up to and including 185 percent of FPL

**Demonstration Population 5:** Childless Adults with income up to and including 150 percent of FPL

**Demonstration Population 6:** Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income at or below 150 percent of the FPL, not otherwise categorically eligible

**Demonstration Population 7:** Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income at or above 150 percent but less than and including 225 percent of FPL, not otherwise categorically eligible

**Demonstration Population 8:** Individuals with persistent mental illness with income up to and including 150 percent of FPL

***Premium Assistance Expansion Populations***

**Demonstration Population 9:** ESI Premium Assistance Expansion Population

a. Adults with children with incomes between 185 percent and up to and including 300 percent of the FPL

b. Childless adults and non custodial parents with income between 150 percent and up to and including 300 percent of the FPL

c. College students with income up to and including 300 percent of FPL who do not meet eligibility requirements for Demonstration Populations 4 & 5

**Demonstration Population 10:** Catamount Premium Assistance Expansion Population

a. Adults with children with incomes between 185 percent and up to and including 300 percent of the FPL

b. Childless adults and non custodial parents with income between 150 percent and up to and including 300 percent of the FPL

c. College students with income up to and including 300 percent of FPL who do not meet eligibility requirements for Demonstration Populations 4 & 5.

The eligibility criteria for Global Commitment to Health Plan eligibility is as follows:

| Title XIX State Plan Groups | | | |
|---|---|---|---|
| Mandatory Categorically Needy (Demonstration Population 1) | | | |
| **Population Description** | **Statutory/Regulatory Citations** | **Standards and Methodologies** | **Benefit Package** |
| Section 1931 low-income families with children | §1902(a)(10)(A)(i)(I) §1931 | AFDC standard and methodologies | Medicaid State plan benefit package |
| Children receiving IV-E payments (IV-E foster care or adoption assistance) | §1902(a)(10)(i)(I) | AFDC standard and methodologies | Medicaid State plan benefit package |
| Individuals who lose eligibility under §1931 due to employment | §1902(a)(10)(A)(i)(I)<br>§402(a)(37)<br>§1925 | AFDC standard and methodologies | Medicaid State plan benefit package |
| Individuals who lose eligibility under §1931 because of child or spousal support | §1902(a)(10)(A)(i)(I)<br>§406(h) | AFDC standard and methodologies | Medicaid State plan benefit package |
| Individuals participating in a work supplementation program who would otherwise be eligible under §1931 | §1931 §1902(a)(10)(A)(i)(I)<br>§482(e)(6) | AFDC standard and methodologies | Medicaid State plan benefit package |
| Individuals receiving SSI cash benefits | §1902(a)(10)(A)(i)(I) | SSI standard and methodologies | Medicaid State plan benefit package |
| Disabled children no longer eligible for SSI benefits because of a change in definition of disability | §1902(a)(10)(A)(i)(II)(aa) | SSI standard and methodologies | Medicaid State plan benefit package |
| Qualified severely impaired individuals (as defined in §1905(q)) | §1902(a)(10)(A)(i)(II)(bb)<br>§1905(q) | SSI standard and methodologies | Medicaid State plan benefit package |
| Individuals under age 21 eligible for Medicaid in the month they apply for SSI | §1902(a)(10)(A)(i)(II)(cc) | SSI standard and methodologies | Medicaid State plan benefit package |
| Qualified pregnant women | §1902(a)(10)(A)(i)(III)<br>§1905(n)(1) | AFDC standard and methodologies | Medicaid State plan benefit package |
| Qualified children | §1902(a)(10)(A)(i)(III)<br>§1905(n)(2) | AFDC standard and methodologies | Medicaid State plan benefit package |
| Poverty level pregnant women | §1902(a)(10)(A)(i)(IV)<br>§1902(l)(1)(A) | Income less than or equal to 185 percent of the FPL | Medicaid State plan benefit package |

| | | | |
|---|---|---|---|
| Poverty level infants | §1902(a)(10)(A)(i)(IV)<br>§1902(l)(1)(B) | Income less than or equal to 185 percent of the FPL | Medicaid State plan benefit package |
| Qualified family members | §1902(a)(10)(A)(i)(V)<br>§1905(m)(1) | AFDC standard and methodologies | Medicaid State plan benefit package |
| Poverty level children under age six | §1902(a)(10)(A)(i)(VI)<br>§1902(l)(1)(C) | Family income less than or equal to 133 percent of FPL | Medicaid State plan benefit package |
| Poverty level children under age 19, who are born after September 30, 1983 (or, at State option, after any earlier date) | §1902(a)(10)(A)(i)(VII)<br>§1902(l)(1)(D) | Family income less than or equal to 100 percent of FPL | Medicaid State plan benefit package |
| Disabled individuals whose earnings exceed SSI substantial gainful activity level | §1619(a) | SSI standard and methodologies | Medicaid State plan benefit package |
| Disabled individuals whose earnings are too high to receive SSI cash benefits | §1619(b) | SSI standard and methodologies | Medicaid State plan benefit package |
| Pickle amendment: individuals who would be eligible for SSI if Title II COLAs were deducted from income (§503 of Public Law 94-566) | §1939(a)(5)(E) | SSI standard and methodologies | Medicaid State plan benefit package |
| Disabled widows and widowers | §1634(b)<br>§1939(a)(2)(C) | SSI standard and methodologies | Medicaid State plan benefit package |
| Disabled adult children | §1634(c)<br>§1939(a)(2)(D) | SSI standard and methodologies | Medicaid State plan benefit package |
| Early widows/widowers | §1634(d)<br>§1939(a)(2)(E) | SSI standard and methodologies | Medicaid State plan benefit package |
| Individuals who would be eligible for AFDC except for increased OASDI income under P.L. 92-336 (July 1, 1972) | 42 CFR 435.114 | AFDC standards and methodologies | Medicaid State plan benefit package |
| Individuals receiving mandatory State supplements | 42 CFR 435.130 | SSI standard and methodologies | Medicaid State plan benefit package |
| Individuals eligible as essential spouses in December 1973 | 42 CFR 435.131 | SSI standard and methodologies | Medicaid State plan benefit package |
| Institutionalized individuals who were eligible in December 1973 | 42 CFR 435.132 | SSI standard and methodologies | Medicaid State plan benefit package |
| Blind and disabled individuals eligible in December 1973 | 42 CFR 435.133 | SSI standard and methodologies | Medicaid State plan benefit package |
| Individuals who would be eligible except for the increase in OASDI benefits under Public Law 92-336 | 42 CFR 435.134 | SSI standard and methodologies | Medicaid State plan benefit package |
| Individuals who become eligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977 | 42 CFR 435.135 | SSI standard and methodologies | Medicaid State plan benefit package |

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|---|---|---|---|
| Individuals who become eligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977 | 42 CFR 435.135 | SSI standard and methodologies | Medicaid State plan benefit package |
| Newborns deemed eligible for one year | §1902(e)(4) | | Medicaid State plan benefit package |
| Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post partum services | §1902(e)(5) | | Pregnancy related and post partum services under the State plan |
| 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) | | Pregnancy related and post partum services under the State plan |
| Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay | §1902(e)(7) | | Inpatient hospital services |
| Qualified Medicare Beneficiaries (QMBs) | §1902(a)(10)(E)(i) §1905(p)(1) | Medicare beneficiaries with income equal to 100 percent of the FPL | Payment of Medicare premiums, coinsurance, deductibles, and copayment except Part D copayment |
| Qualified disabled and working individuals | §1902(a)(10)(E)(ii) §1905(s) | Medicare beneficiaries with income equal to 200 percent of the FPL and not eligible for Medicaid | Payment of Medicare Part A premiums |
| Specified Low-Income Medicare Beneficiaries (SLMBs) | §1902(a)(10)(E)(iii) | Medicare beneficiaries with income between 100 and 120 percent of the FPL | Payment of Medicare Part B premiums |
| Qualifying individuals | §1902(a)(10)(E)(iv) | Medicare beneficiaries with income equal to 120 percent but less than 135 percent of the FPL and not eligible for Medicaid | Payment of Medicare Part B premiums |

This is not an exhaustive list of mandatory groups covered under the Vermont title XIX State plan. For a complete list, refer to the Vermont approved title XIX State plan.

| Optional Categorically Needy (Demonstration Population 2) | | | |
|---|---|---|---|
| Individuals who are eligible for but not receiving IV-A, SSI or State supplement cash assistance | §1902)(a)(10)(A)(ii)(I) | | Medicaid State plan benefit package |
| Individuals who could be eligible for IV-A cash assistance if State did not subsidize child care | §1902(a)(10)(A)(ii)(II) | | Medicaid State plan benefit package |
| Individuals who are eligible for Title IV-A if State AFDC plan were as broad as allowed | §1902(a)(10)(A(ii)(II) | | Medicaid State plan benefit package |
| 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) | | Medicaid State plan benefit package |
| *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 state-specified standard | §1902(a)(10)(A)(ii)(V) | | Medicaid State plan benefit package |
| 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) | | Medicaid State plan benefit package |
| Children under 21 (or at State option 20, 19, or 18) who are under State adoption agreements | §1902(a)(10)(A)(ii)(VIII) | | Medicaid State plan benefit package |
| Poverty level pregnant women not mandatorily eligible | §1902(a)(10)(A)(ii)(IX)<br>§1902(l)(1)(A) | | Medicaid State plan benefit package |
| Poverty level infants not mandatorily eligible | §1902(a)(10)(A)(ii)(IX)<br>§1902(l)(1)(B) | | Medicaid State plan benefit package |
| Individuals receiving only an optional State supp. payment more restrictive than the criteria for an optional State supplement under title XVI | §1902(a)(10)(A(ii)(XI) | | Medicaid State plan benefit package |
| Katie Beckett children | §1902(e)(3) | | Medicaid State plan benefit package |
| Individuals receiving HCBS who would only be eligible for Medicaid under the State Plan if they were in a medical institution; individuals who were previously covered under a separate 1915(c) Demonstration.<br>5. TBI (traumatic brain injury)<br>6. MI under 22 (Children's mental Health)<br>7. MR/DD (Mental Retardation/Developmental | §1902(a)(10)(A)(ii)(VI) | | Medicaid State plan benefit package along with HCBS |

| | | | |
|---|---|---|---|
| Disabilities) | | | |
| Individuals under 18 who would be mandatorily categorically eligible except for income and resources | §1902(a)(10)(C)(ii)(I) | | Medicaid State plan benefit package |
| Pregnant women who would be categorically eligible except for income and resources | §1902(a)(10)(C)(ii)(II) | | Pregnancy-related and Post-Partum Services under the State plan |
| Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post partum services | §1902(a)(10)(C)<br>§1905(e)(5) | | Medicaid State plan benefit package |
| Blind and disabled individuals eligible in December 1973 | 42 CFR 435.340 | | Medicaid State plan benefit package |
| 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)<br>§1905(a)(i) | | Medicaid State plan benefit package |
| Specified relatives of dependent children who are ineligible as categorically needy | 42 CFR 435.301(b)(2)(ii)<br>42 CFR 435.310<br>1902(a)(10)(c) | | Medicaid State plan benefit package |
| Aged individuals who are ineligible as categorically needy | 42 CFR 435.301(b)(2)(iii)<br>42 CFR 435.320<br>42 CFR 435.330 | | Medicaid State plan benefit package |
| Blind individuals who are ineligible as categorically needy but meet the categorically needy definition of blindness | 1902(a)(10)(c)<br>42 CFR 435.301(b)(2)(iv) | | Medicaid State plan benefit package |
| Disabled individuals who are ineligible as categorically needy that meet the categorically needy definition of blindness | §1902(a)(10)(C) | | Medicaid State plan benefit package |

This is not an exhaustive list of optional groups covered under the Vermont title XIX State plan. For a complete list, refer to the Vermont approved title XIX State plan.

| Expansion Populations | | | |
|---|---|---|---|
| **VHAP Expansion Populations (Demonstration Populations 3-8)** | | | |
| Underinsured children with income between 225 percent and including 300 percent of FPL who are not eligible for Medicaid or CHIP | | children with income between 225 percent and up to and including 300 percent of FPL | Same as Medicaid State plan benefit package |
| Adults with children with income between 150 percent and up to and including 185 percent of the FPL | | income between 150 percent and up to and including 185 percent of the FPL | VHAP Limited/VHAP |
| Adults with income up to and including 150 percent of the FPL | | income up to and including 150 percent of the FPL | VHAP Limited/VHAP PCPlus |
| Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income at or below 150 percent of the FPL | | income at or below 150 percent of the FPL | Medicaid Prescriptions, eyeglasses and related eye exams |
| Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income above 150 percent and less than 225 percent of the FPL | | income below 225 percent of the FPL | Maintenance Drugs |
| Individuals with persistent mental illness with income up to and including 150 percent of the FPL | | income up to and including 150 percent of the FPL | Day services, diagnosis and evaluation services, emergency care, psychotherapy, group therapy, chemotherapy, specialized rehabilitative services |
| **Premium Assistance Expansion Populations** (Demonstration Population 9 and 10) | | | |
| **ESI Premium Assistance** | | | |
| Adults with children with income between 185 percent and up to and including 300 percent of the FPL | | Income between 185 percent and up to and including 300 percent of the FPL | Premium assistance to purchase ESI |
| Childless adults with income between 150 percent and up to and including 300 percent of the FPL | | Income between 150 percent and up to and including 300 percent of the FPL | Premium assistance to purchase ESI |
| **Catamount Premium Assistance** | | | |
| Adults with children with income between 185 percent and up to and including 300 percent FPL | | Income between 185 percent and up to and including 300 percent of the FPL | Premium assistance to purchase the Catamount Health |
| Childless adults with income between 150 percent and up to and including 300 percent of the FPL | | Income between 150 percent and up to and including 300 percent of FPL | Premium assistance to purchase Catamount Health |

* VHAP Limited is the interim benefit package offered to enrollees before a primary care physician (PCP) is chosen. After the PCP is chosen, the enrollee is eligible for the full VHAP benefits package, referred to as VHAP PC Plus.

** In order to qualify for premium assistance, the individual has to be currently uninsured during the prior 12 months. Refer to current Vermont rules and policies for the definition of "uninsured" and other crowd-out provisions related to premium assistance

Note: VHAP adults with access to cost-effective ESI are also eligible to receive premium assistance.

**Global Commitment to Health Eligibility Exclusions:** The following persons are excluded from the Global Commitment to Health Program:

| |
|---|
| Individuals covered under the Vermont section 1115 Choices for Care Demonstration not receiving CRT services |
| CHIP eligibles |

18. **Optional and Expansion Eligibility Groups Expenditure and Enrollment Cap.** The State must seek approval to modify program eligibility via the Demonstration amendment process, as described in paragraphs 6, 7, and 8 of section III "General Program Requirements." Regardless of any extension of eligibility, the State will be limited to federal funding reflected in the budget neutrality requirements set forth in these STCs.

If program eligibility is expanded or reduced, the State must give priority to extension or continuation of eligibility for optional populations prior to extension or continuation of eligibility for expansion groups. In the event of any reduction in eligibility for expansion and optional populations, the State may continue eligibility for all individuals already enrolled in the program. If the State establishes a waiting list for eligibility or services, priority will be given to State plan mandatory populations over optional populations, and last priority will be given to expansion populations.

19. **Benefits**. All covered services may be subject to medical review and prior approval by DVHA based on medical appropriateness. A complete listing of covered services and limitations are contained in the Vermont approved title XIX State plan, Vermont statutes, regulations, and policies and procedures. The State has the authority to adjust the benefit package for the non-mandatory eligible populations without amendment per STC paragraph 6.

| Services | State Plan | VHAP PC Plus (full VHAP Benefits package) | Limitations |
|---|---|---|---|
| Inpatient Hospital Services | X | X | State plan: any limitations on this service are described in the approved Title XIX State plan program rules and policies |

| Services | State Plan | VHAP PC Plus (full VHAP Benefits package) | Limitations |
|---|---|---|---|
| | | | VHAP: Urgent and emergent admissions only |
| Outpatient Hospital Services | X | X | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies |
| FQHC/RHC including ambulatory services offered by FQHCs | X | X | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies |
| Laboratory/X-ray Services | X | X | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies |
| EPSDT for Individuals Under 21 | X | | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies |
| Family Planning Services and Supplies | X | X | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies |
| Physician Services and Medical and Surgical Services of a Dentist | X | X | State plan: any limitations on this service is described in the approved Title XIX State plan, program rules and policies |
| Home Health Services | X | X | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies |
| Nurse Midwife Services | X | X | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies |
| Pediatric/Family Nurse Practitioner | X | X | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies |
| Other Medical/Remedial Care Provided by Licensed Practitioners and Recognized under State Law (chiropractor, podiatrist, optometrist, chiropractor, licensed clinical social worker, licensed mental counselor or licensed marriage and family therapist, psychologist, optician, hi-tech nursing, nurse practitioner, | X | X | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies |

| Services | State Plan | VHAP PC Plus (full VHAP Benefits package) | Limitations |
|---|---|---|---|
| licensed lay midwife, chiropractor) | | | |
| Clinic Services | X | X | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies |
| Prescribed Drugs | X | X | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies |
| Diagnostic, Screening, Preventive, and Rehabilitative Services | X | X | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies |
| Private Duty Nursing Services | N/A | N/A | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies |
| Eyeglasses and Other Aids to Vision | X | | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies<br>Note: Eyeglasses are not covered. Covered services are limited to other aids to vision. |
| Dental Services | X | | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies |
| Prosthetic Devices | X | | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies |
| Physical and Occupational Therapies, and Services for Individuals with Speech, Hearing, and Language Disorders | X | X | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies |
| Inpatient Hospital/Nursing Facility/ ICF Services for Individuals 65 and Older in IMD | X | | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies |
| ICF/MR Services | X | | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies |
| Inpatient Psychiatric Services for Individuals Under 21 | X | | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies |

| Services | State Plan | VHAP PC Plus (full VHAP Benefits package) | Limitations |
|---|---|---|---|
| Personal Care Services | X | | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies |
| Case Management | X | | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies |
| Respiratory Care for Ventilator Dependent Individuals | X | | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies |
| PCCM | X | X | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies |
| PACE (covered under VT Choice for Care 1115 Demonstration) | X | | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies |
| Hospice | X | | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies |
| Transportation Services | X | X | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies<br>VHAP: any limitations defined in Vermont rules and/or policies |
| Services Provided in a Religious Non-Medical Health Care Institution | N/A | N/A | |
| Nursing Facility Services for Individuals Under Age 21 | X | | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies. *covered for persons under 18 years old. 18 and older covered in the Choices for Care 1115 Demonstration. |
| Emergency Hospital Services | X | X | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in Vermont rules and/or policies |
| Critical Access Hospital | X | X | State plan: any limitations on this service are described in the approved Title XIX State plan, program rules and policies VHAP: any limitations defined in the Vermont Rules and/or policies |

Note: Please note that benefit limitations do not apply to children under age 21- in accordance with EPSDT requirements.

| Services provided to the State's different "Programs offered to individuals who were previously covered under a separate 1915(c) waiver or the State's prior 1115 Demonstration | | |
|---|---|---|
| **Program Name** | **Services** | **Limitations** |
| Traumatic Brain Injury (TBI) | HCBS waiver-like services including crisis/support services, psychological and counseling supports, case management, community supports, habilitation, respite care, supported employment, environmental and assistive technology and self-directed care. | Any limitation on this service defined by Vermont rules and policies |
| Mental Illness Under 22 | HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, crisis and community supports | Any limitation on this service defined by Vermont rules and policies |
| Community Rehabilitation and Treatment | HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, crisis and community supports | Any limitation on this service defined by Vermont rules and policies |
| Developmental Services | HCBS waiver services, including service coordination, residential habilitation, day habilitation, supported employment, crisis services, clinical intervention, respite and self-directed care | Any limitation on this service defined by Vermont rules and policies |

The VHAP adults are eligible for premium assistance to purchase ESI if deemed cost-effective by the State. The benefits offered by the plan must be substantially similar to the benefits offered by the typical benefit plans issued by the four health insurers with the greatest amount of covered individuals in the small group market. To ensure that individuals enrolled in VHAP ESI receive the same benefits as individuals in the VHAP program, the State will provide a wrap for services not covered under the ESI plan.

| Premium Assistance Catamount Health Plan Benefit Package (Refer to Attachment B) |
|---|
| Comprehensive benefit as prescribed in Catamount State statute |

| ESI Premium Assistance (Non-VHAP) Benefit Package |
|---|
| The benefits covered by the plan must be substantially similar to the benefits offered by the Catamount Health Premium Assistance. |

20. **Palliative Care Program.** The Palliative Care Program is for children under the age of 21 years in Demonstration populations 1, 2, and 3, who have been diagnosed with a life-limiting illness that is expected to be terminal before adulthood. The program will allow for children to receive palliative and curative services.
    a. **Participation.** Demonstration participants will be identified based diagnostic codes found on claims data and referrals from medical professionals.
        i. Eligibility will be determined by the nurse care manager and/or DVHA Medical Director, based on the assessment tool and supplemental clinical information (as needed). Continued eligibility will be re-assessed at least annually.
        ii. Care planning activities for children enrolled in the palliative care program will

meet the requirements specified in federal managed care regulations for enrollees with special health care needs.

b. **Benefits.** In addition to State plan services, children enrolled in the palliative care program may also receive care and services that meet the definition of 'medical assistance' contained in section 1905(a) of the Act if determined to be medically appropriate in the child's care plan
   i. **Care coordination.** Development and implementation of a family centered care plan that includes telephonic and home visits by a licensed nurse.
   ii. **Respite care.** Short term relief for caretaker relatives from the demanding responsibilities for caring for a sick child.
   iii. **Expressive Therapies.** Therapies provided by licensed therapist to provide support to the child to help the child to creatively and kinesthetically express their reaction to their illness. The palliative care program offers 52 hours of expressive therapies per year. Additional, expressive therapy may be authorized if medically appropriate.
   iv. **Family Training.** Training to teach family members palliative care principles, medical treatment regimen, use of medical equipment, and how to provide in-home care.
   v. **Bereavement Counseling.** Anticipatory counseling and up to 6 months after the child's death for the family by a licensed professional trained in grief counseling. Payment for bereavement counseling services may be provided for on-going counseling to family members after the child's death so long as such services were initiated prior to the child's death.

c. **Cost Sharing.** Cost sharing requirements as described in paragraph 22 will apply.

21. **Enrollment Process**. The State agrees to notify participants newly entering a section 1115 Demonstration within 30 days of their entry into the Global Commitment to Health Demonstration

## V. COST SHARING

22. **Premiums, Co-Payments, and Premium Assistance.** All cost-sharing for demonstration-eligible populations described in STC 17 shall be set forth in the approved Medicaid State plan. Such cost-sharing shall not exceed the nominal cost sharing levels as described in 42 CFR 447.54, etc. CMS publishes an annual update of nominal cost-sharing levels. As part of the State's quarterly reports (specified in STC 37), the State must update CMS regarding any intended changes in the nominal cost-sharing articulated in the Medicaid State plan. Should the State seek to impose any cost-sharing that is more than nominal in amount, the State must submit and receive approval of an amendment to the Demonstration.

    Cost-sharing for optional and expansion children eligible for Medicaid and adults whose coverage is mandated by Federal law must not exceed 5 percent of the family's gross income. In addition, the State must not apply co-payment requirements to excluded populations (children under age 21, pregnant women or individuals in long-term care facilities) or for excluded services/supplies (*e.g.,* family planning).

    Detailed cost-sharing and premium requirements are specified in Attachment C.

## VI. DELIVERY SYSTEMS

23. **Health Plans.** Benefits will be furnished by DVHA which will operate on a managed care model and will be responsible for the delivery of all Medicaid covered services. The DVHA must be authorized by State statute and must adhere to federal regulations at 42 CFR section 438 that would be applicable to a managed care entity unless specifically stated otherwise in the STCs.

24. **Premium Assistance.** There are three programs offering premium assistance under this Demonstration; VHAP-ESI, ESI premium assistance (non-VHAP), and Catamount premium assistance. As the Single State Agency for Medicaid, AHS will have authority and responsibility for eligibility determination related to these premium assistance programs. The role filled by AHS will be identical to that of Single State Agencies in other States. The AHS PMPM limits include these eligibility groups. The methodology for providing premium assistance for each of the three programs is described below:

    a. **VHAP-ESI.** AHS determines eligibility, processes enrollment and makes the determination that ESI is cost effective. DVHA transfers to the beneficiary an amount of premium assistance that does not exceed the amount that the employer withholds from the employee's wages for the employee premium share of employer-sponsored insurance.

       DVHA provides additional benefits to ensure that the beneficiary receives the full VHAP benefit package in the aggregate.

    b. **ESI Premium Assistance**. AHS determines eligibility, processes enrollment, and makes the determination that the ESI is cost effective. DVHA transfers to the beneficiary an amount of premium assistance that does not exceed the amount that the employer withholds from the employee's wages for the employee premium share. There is a wraparound benefit for prevention and management services to treat certain chronic conditions.

    c. **Catamount Premium Assistance**. AHS determines eligibility and processes enrollment in Catamount Premium Assistance. The beneficiary pays a premium contribution to AHS and DVHA pays the total premium for the beneficiary to enroll in a private Catamount Health plan. There is no additional wraparound benefit.

25. **Catamount Health.** The Catamount Health product will be offered by private health plans in the State as dictated by Vermont Statute Title 8, Chapter 107, and section 4084f. Catamount Health.

26. **Limitation of Freedom of Choice.** Freedom of choice is limited to the DVHA network of providers. However, populations must have freedom of choice when selecting enrolled providers within that network (when applicable, the provider must be enrolled in the specific specialty or subprogram applicable to the services at issue.)

    a. Specifically, Demonstration participants enrolled in a special service program such as, but not limited to specialized substance abuse and behavioral health services or a program for home and community-based services may only have access to the providers enrolled under that program, and will not have access to every Medicaid enrolled provider for services under that program. Such participants will have freedom of choice of providers enrolled in the special service program.

27. **Contracts and Provider Payments.** Payments to providers will be set by DVHA and will not be required to comply with the payment provisions in the approved State plan, or with federal

regulations pertaining to the upper payment limits for provider rates. The AHS will be responsible for oversight of DVHA, ensuring compliance with State and federal statutes, regulations, special terms and conditions, waiver, and expenditure authority. AHS shall be responsible for evaluation, interpretation and enforcement of findings issued by the external quality review organization.

Procurement of health care services by AHS (the Single State Agency) through selective contracting or similar processes, and the subsequent final contracts developed to implement selective contracting by the AHS with any provider group, must be subject to CMS regional office approval prior to implementation.

28. **Contracting with Federally Qualified Health Centers (FQHCs).** The State must maintain its existing agreements with FQHCs and rural health centers. Reimbursement for services provided to individuals enrolled in ESI/Premium Assistance programs must be based on requirements established by the Vermont Statute 2006 Health Care Affordability Act and the terms contained in the independent agreements reached between FQHCs/rural health centers and participating carriers.

29. **Data Sharing**. DVHA as a State agency may share enrollee data with other State agencies if the use or release of such data is for a purpose directly connected with administration of the plan as defined in section 1902(a)(7) of the Act. DVHA is authorized to use or release de-identified data, as defined in Federal privacy regulations, to enable participation in statewide program studies. As a purpose directly connected with plan administration, DVHA is permitted to release enrollee-specific information to providers in order to enable the provider to seek payment for services rendered under the plan. Any other release of enrollee-specific information for a purpose not directly connected with plan administration is prohibited. Consent of the enrollee is required whenever release of enrollee information for a purpose directly connected with plan administration is sought by an outside source, except in an emergency. Release under these conditions is defined in federal regulations at 42 CFR section 431.306(d).

## VIII. GENERAL REPORTING REQUIREMENTS

30. **General Financial Requirements.** The State must comply with all general financial reporting requirements under title XIX set forth in section IX.

31. **Compliance with Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR 438 et. Seq., as if DVHA were a managed care entity except as expressly identified as not applicable in these STCs.

32. **Reporting Requirements Relating to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality set forth in section X.

33. **Reporting on Participants Receiving Community Rehabilitation and Treatment (CRT) Services.** The State agrees to track and report expenditures for CRT services to participants with severe and persistent mental illness. Expenditures for CRT mental health services will be included under the budget neutrality agreement for the Vermont Global Commitment to Health section 1115 Demonstration.

34. **Managed Care Data Requirements.** The DVHA must maintain an information system that

collects, analyzes, integrates, and reports data. The system must provide information that would be required from managed care entities as set forth in Federal regulations at 42 CFR section 438, on program elements including, but not limited to, service utilization, grievances, appeals, and disenrollments for reasons other than loss of Medicaid eligibility. The management information system must collect data on member and provider characteristics, as specified by the AHS, and on services as set forth under the intergovernmental agreement. DVHA must collect, retain and report encounter data in accordance with the Demonstration terms and conditions. All collected data must be available to AHS, and to CMS, upon request. The State must have contractual provisions in place to impose sanctions on the DVHA if accurate data are not submitted in a timely fashion.

35. **Submission of Encounter Data.** The State will submit encounter data to the Medicaid Statistical Information System (MSIS) system, as is consistent with Federal law and section IX of this document. The State must assure that encounter data maintained at DVHA and provider level can be linked with eligibility files maintained by the State.

36. **Quarterly Calls.** CMS will schedule at least Quarterly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, DVHA operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, DVHA financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or State plan amendments the State is considering submitting. CMS will update the State on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the project officer and the regional office) will jointly develop the agenda for the calls.

37. **Quarterly Reports.** The State must submit progress reports in the format specified in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:

    a. An updated budget neutrality monitoring spreadsheet;

    b. Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; benefits; enrollment; grievances; quality of care; access; health plan financial performance that is relevant to the Demonstration; pertinent legislative activity; and other operational issues;

    c. Action plans for addressing any policy and administrative issues identified;

    d. A separate discussion of the State efforts related to the collection and verification of claims and encounter data;

    e. Evaluation activities and interim findings and a description of State progress towards Demonstration goals;

    f. Updates on any intended changes in the nominal cost-sharing as stated in the Medicaid State plan, if applicable; and

    g. The State must report Demonstration program enrollment on a quarterly basis using the

quarterly report format in Attachment A.

Quarterly report for the quarter ending September 30 is due **November 30**
Quarterly report for the quarter ending December 31 is due **February 28**
Quarterly report for the quarter ending March 31 is due **May 31**
Quarterly report for the quarter ending June 30 is due **August 31**

38. **Annual Report.** The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, progress on implementing cost containment initiatives and policy and administrative difficulties in the operation of the Demonstration. The State must submit the draft annual report no later than April 1 after the close of each Demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted, and posted, to the CMS Web site with prior permission.

39. **Transition Plan.** On or before July 1, 2012, the State is required to prepare and incrementally revise a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in paragraphs 39 a-e. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan.

    a. **Seamless Transitions**. Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:

        i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.

        ii. Identify Demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.

        iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.

        iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the State identifies that may be necessary to continue coverage for these individuals.

        v. Develop a modified adjusted gross income (MAGI) calculation for program eligibility.

b. **Access to Care and Provider Payments and System Development or Remediation.** As necessary to meet the State's priorities, the State should assure adequate provider supply for the State plan and Demonstration populations affected by the Demonstration on December 31, 2013. Additionally, the Transition Plan for the Demonstration is expected to expedite the State's readiness for compliance with the requirements of the Affordable Care Act and other federal legislation.

c. **Pilot Programs.** Progress towards developing and testing, when feasible, pilot programs that support Affordable Care Act-defined "medical homes," "accountable care organizations," and / or "person-centered health homes" to allow for more efficient and effective management of the highest risk individuals.

d. **Progress Updates.** After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

e. **Implementation.**

i. By July 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the Demonstration to coverage under the State plan, the State will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

## IX. GENERAL FINANCIAL REQUIREMENTS

40. **Aggregate Budget Neutrality Limit.** Federal funding will be limited to an aggregate amount of $8,955,886,798 over the 8.25 year term of this Demonstration. In any year in which the State exceeds the annual target amount set forth in section X below, the State will develop a plan to ensure that the budget neutrality limit is not exceeded, pursuant to the process set forth in section X.

41. **Per Member Per Month Limit**: In addition to the aggregate budget neutrality limit described in STC 40, total Federal funding for medical assistance will be limited over the life of the Demonstration extension to an aggregate spending limit based on the actuarially-determined, per member per month limits. Total allowable Demonstration expenditures will be reconciled against the aggregate budget neutrality limit described in STC 40 and the sum of the annual limits for the extension period (per member per month limits multiplied by actual caseload). The fixed per member per month amount, established in accordance with the requirements set forth under paragraph 15, shall be determined no more frequently than annually unless approved by CMS, and must meet the requirements for a rate paid to a managed care entity under 42 CFR 438.6 for the managed care entity expenses . The fixed per member per month amount may vary based upon rate cells that take into account different categories of individuals and benefits.

42. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using the form CMS-64 to separately report total expenditures for services provided under the Medicaid

program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS will provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section X (Monitoring Budget Neutrality).

43. **Reporting Expenditures Subject to the Budget Neutrality Cap.** In order to track expenditures under this Demonstration, Vermont must report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System, following routines from CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All Demonstration expenditures subject to the budget neutrality cap must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the *Demonstration* project number assigned by CMS (including the project number extension, which indicates the Demonstration year in which the expenditure was made). Reporting for expenditures made subsequent to termination of the Demonstration must indicate the Demonstration year in which services were rendered. Payment adjustments attributable to expenditures under the Demonstration must be recorded on the applicable Global Commitment prior quarter waiver form, identified as either CMS-64.9P Waiver (Medical Assistance Payments) or CMS-64.10P Waiver (Administrative Payments). When populated, these forms read into the CMS-64 Summary sheet, Line 7 for increasing adjustments and Line 10B for decreasing adjustments. Adjustments not attributable to this Demonstration should be reported on non-waiver forms, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined in paragraph 52."

a. For each Demonstration Year five separate form CMS-64.9 waiver and/or 64.9P waiver reports must be submitted reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for Demonstration eligibles must be reported. The sum of the expenditures from the separate reports will represent the expenditures subject to the budget neutrality cap (as defined in 40.b.). As needed and subject to CMS approval, the State will develop reasonable methods to allocate allowable *Demonstration* expenditures across Demonstration population reporting groups. The Vermont Global Medicaid eligibility groups, for reporting purposes, include *the* following names and definitions:

| CMS 64 Reporting Name | Reporting name description | Corresponding Demonstration population number per the STCs | Population description |
|---|---|---|---|
| **"ABD"** | Report expenditures for individuals eligible as aged, blind, or disabled under the state plan | Demonstration Populations 1-2 | • Mandatory Categorically needy<br>• Optional Categorically needy |
| **"ANFC"** | Report the expenditures for all non-ABD children and adults in the State plan mandatory and optional categories | Demonstration Populations 1-2 | • Mandatory Categorically needy<br>• Optional Categorically needy |
| **"Optional Expansions"** | Report for all expenditures for all non-ABD children and adults in optional categories | Demonstration populations 2 | • Optional Categorically needy |

| CMS 64 Reporting Name | Reporting name description | Corresponding Demonstration population number per the STCs | Population description |
|---|---|---|---|
| **"VT Global Rx"** | Report for all expenditures for individuals eligible as pharmacy-only expansions through VT Global (previously VHAP Rx) | Demonstration population 6<br><br>Demonstration Population 7 | • Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with disabilities with income at or below 150 percent of FPL<br><br>• Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income between 150 percent and up to and including 225 percent of FPL |
| **"VT Global Expansion"** | Report for all expenditures for individuals eligible as non-categorical health care expansions through VT global | Demonstration Population 3<br><br>Demonstration Population 4<br><br>Demonstration Population 5<br><br>Demonstration Population 9 and 10 | • Underinsured Children with income between 225 and up to and including 300 percent of the FPL who otherwise are ineligible for Medicaid or CHIP<br>• Adults with children with income between 150 and up to and including 185 percent of the FPL<br>• Childless adults with income up to and including 150 percent of the FPL<br>• Premium assistance expansion groups (ESI or Catamount Health)<br>a) adults with children with incomes between 185 and 300 percent of the FPL)<br>b) all adults with income between 150 and up to and including 300 percent of the FPL.<br>c) college students with income up to and including 300 percent of FPL who do not meet the eligibility requirements for Demonstration Populations 4 & 5 |

It is understood that Demonstration Population (CRT) is duplicative of other MEGs that are reported on the CMS-64. Reporting to CMS for Demonstration Population 8 will occur via a supplemental information report provided as backup to the CMS-64. This report will be submitted concurrently with the other CMS-64 backup documentation submitted every quarter.

b. For purposes of this section, the term "expenditures subject to the budget neutrality cap" must include all Medicaid expenditures on behalf of the individuals who are enrolled in this Demonstration (as described in paragraph 40.a.of this section) and who are receiving the services subject to the budget neutrality cap. All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and must be reported on line 49 of forms CMS-64.9 waiver and/or 64.9P waiver.

c. Premiums and other applicable cost-sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration must be reported to CMS on the CMS-64 Summary Sheet, Line 9E "Miscellaneous." In order to ensure that the Demonstration is properly credited with premium collections, please indicate in the CMS-64 Certification "Footnotes" section that Line 9E of the Summary Sheet is for Global Commitment Collections only.

d. Administrative costs must be included in the budget neutrality limit. Vermont will not be at risk for expenditures related to systems enhancements, including any new procurements related to claims processing, program management, and eligibility. All administrative costs not included in the expenditures reported on line 49 of forms CMS-64.9 waiver and/or 64.9 waiver (described in 40.b of this section) must be identified on the forms CMS-64.10 waiver and/or 64.10P waiver.

e. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all title XIX claims for services during the Demonstration period (including any cost settlements and claims incurred during the Demonstration but paid subsequent to the end date of the Demonstration) are considered allowable expenditures under the Demonstration and must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

f. At the end of the Demonstration, all MCO investment and administrative claims for expenditures subject to the budget neutrality cap (including any cost settlements and non-title XIX claims incurred during the Demonstration but paid subsequent to the end date of the Demonstration) must be made within 2 quarters (6 months) after the calendar quarter in which the State made the expenditures. During the latter 6 month period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

g. Disproportionate Share Hospital (DSH) payments are not counted as expenditures under the Demonstration.

h. The Demonstration does not prohibit the State from requesting to implement special initiatives available, and taking advantage of enhanced Federal Medical Assistance Percentage (FMAP) for these initiatives, under ACA subject to the federal approval process established for these initiatives.

44. **Reporting Member Months.** The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member/months to the total. Two individuals, who are eligible for 2 months, each contributes 2 eligible member months to the total, for a total of 4 eligible member/months

45. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. Vermont must estimate matchable Medicaid expenditures on the quarterly form CMS-37 based on the PMPM limit (or a percentage of the PMPM limit) and projected caseload for the quarter. In addition, the estimate of matchable Demonstration expenditures (total computable and federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year on the form CMS-37.12 for both the medical assistance program and administrative costs outside of the PMPM limit. CMS will make federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures, consistent with the definition of an expenditure in 45 C.F.R. 95.13, made in the quarter just ended. Intergovernmental transfers of the individual per member per month fixed amount from AHS to DVHA are not reportable expenditures, but provide funding for reportable DVHA expenditures. CMS will reconcile expenditures reported on the form CMS-64 with federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

46. **Sources of Non-Federal Share.** The State certifies that matching the non-Federal share of funds for the Demonstration are State/local monies. The State further certifies that such funds must not be used to match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    a. CMS will review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.

    b. Any amendments that impact the financial status of the program must require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

47. **State Certification of Public Expenditures.** Nothing in these STCs concerning certification of public expenditures relieves the State of its responsibility to comply with federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements. The State must certify that the following conditions for non-federal share of Demonstration expenditures are met:

    a. Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-federal share of funds under the Demonstration.

b. To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
c. To the extent the State utilizes CPEs as the funding mechanism to claim federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.
d. The State may use intergovernmental transfers as a source of non-Federal share to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment. Intergovernmental transfers are not themselves expenditures, but may be a source of funding for expenditures.

48. **Monitoring the Demonstration.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

49. **MSIS Data Submission.** The State must submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards. The State must ensure, within 120 days of the approval of the Demonstration, that all prior reports are accurate and timely.

## X. MONITORING BUDGET NEUTRALITY

50. **Aggregate Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The aggregate budget neutrality limit over the life of the Demonstration is defined in STC 40. The per member per month budget neutrality expenditure limits are set on a yearly basis with a cumulative per member per month expenditure limit for the length of the entire Demonstration extension.

51. **Risk.** The State shall be at risk for the both the number of enrollees in the Demonstration as well as the per capita cost for Demonstration eligibles under the aggregate budget neutrality agreement as defined in STCs 40 and 52 The cumulative, per member per month limit will vary based on actual caseload.

52. **Budget Neutrality Aggregate Cap.** Budget neutrality is determined on an aggregate cap basis as shown below:

| DY/ FFY | Annual Budget Neutrality Cap (total computable) |
|---|---|
| DY 1/ FFY 2006 | $ 841,266,663 |
| DY 2/ FFY 2007 | $ 843,594,654 |
| DY 3/ FFY 2008 | $ 919,247,991 |
| DY 4/ FFY 2009 | $ 1,002,321,263 |
| DY 5/ FFY 2010 | $ 1,093,591,603 |
| **Total DY 1 to DY 5** | $ 4,700,022,174 |
| DY 6/ FFY 2011 | $ 1,165,191,563 |
| DY 7/ FFY 2012 | $ 1,248,077,166 |
| DY 8/ FFY 2013 | $ 1,337,393,583 |
| DY 9/ 10/01/2013 – 12/31/2013 | $ 505,202,312 |
| **Total for Extension Period** | $ 4,255,864,623 |
| **Cumulative Total (Initial 5 Years Plus Extension Period)** | $ 8,955,886,798 |

53. **Impermissible DSH, Taxes or Donations**. The CMS reserves the right to adjust the budget neutrality ceiling in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or with policy interpretations implemented through letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act (the Act). Adjustments to annual budget targets will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.

54. **How the Limits will be Applied.** The limits calculated in paragraph 52 will apply to actual expenditures for the Demonstration including claims incurred during the Demonstration period but paid after the end of the Demonstration, as reported by the State under section IX. If at the end of the Demonstration period the budget neutrality provision has been exceeded, the excess federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the Demonstration is terminated prior to the eight and a quarter-year period, the budget neutrality test will be pro-rated based on the time period through the termination date.

55. **Enforcement of Budget Neutrality.** CMS will enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval.

56. **Expenditure Review and Cumulative Target Calculation.** CMS will enforce budget neutrality over the life of the Demonstration, rather than on an annual basis. However, no later than 6 months after the end of each Demonstration year, CMS will calculate an annual expenditure target for the

completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, they must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved corrective action plan.

| Year | Cumulative Target (Total Computable Cost) | Cumulative Target Definition | Percentage |
|---|---|---|---|
| Year 6 | $1,200,147,310 | Year 6 budget estimate plus | 3 percent |
| Year 7 | $2,449,467,760 | Years 6 and 7 combined budget estimate plus | 1.5 percent |
| Year 8 | $3,769,415,624 | Years 6 through 8 combined budget estimate plus | 0.5 percent |
| Year 9 | $4,255,864,624 | Years 6 through 9 combined budget estimate plus | 0 percent |

## XI. EVALUATION OF THE DEMONSTRATION

57. **Submission of Draft Evaluation Design.** The State must submit to CMS for approval a draft evaluation design for an overall evaluation of the Demonstration no later than 120 days after CMS' approval of the Demonstration. At a minimum, the draft design must include a discussion of the goals and objectives set forth in section II of these STCs, as well as the specific hypotheses that are being tested, including those indicators that focus specifically on the target populations and the public health outcomes generated from the use of Demonstration funds. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration must be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

58. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

59. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft evaluation design described in paragraph 57 within 60 days of receipt, and the State must submit a final design within 60 days after receipt of CMS comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after the expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.

60. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any

component of the Demonstration the State will cooperate fully with CMS or the independent evaluator selected by CMS. The State will submit the required data to the contractor or CMS as requested.

## XII. USE OF DEMONSTRATION FUNDS

61. **Use of Demonstration Funds.** Expenditures within the per member per month limit (calculated over the life of the Demonstration) can include expenditures for the following purposes:
    a. Reduce the rate of uninsured and/or underinsured in Vermont;
    b. Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
    c. Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and
    d. Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system.

## XIII. SCHEDULE OF THE STATE DELIVERABLES OF THE DEMONSTRATION PERIOD

| Date Specific | Deliverable | STC Reference |
|---|---|---|
| 120 days after approval | Submit Draft Evaluation Plan | Section XI, paragraph 57 |
| July 1, 2012 | Draft ACA Transitional Plan | Section VIII, paragraph 39 |
| October 1, 2012 | Submit Final Evaluation Plan | Section XI, paragraph 59 |

| | Deliverable | STC Reference |
|---|---|---|
| **Annually (by April 1st)** | Draft Annual Report | Section VIII, paragraph 38 |
| **Quarterly** | | |
| | Quarterly Operational Reports | Section VIII, paragraph 37 |
| | CMS-64 Reports | Section IX, paragraph 42 |

## ATTACHMENT A: QUARTERLY REPORT CONTENT AND FORMAT

Under section VIII, paragraph 37, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

### NARRATIVE REPORT FORMAT:

**Title Line One** – Vermont Global Commitment to Health

**Title Line Two - Section 1115 Quarterly Report**

**Demonstration/Quarter Reporting Period:**

Example:
Demonstration Year: 6 (10/1/2010 – 9/30/2011)
Federal Fiscal Quarter: 1/2010 (10/01/2010 – 12/31/2010)

### Introduction

Information describing the goal of the Demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

### Enrollment Information

Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by "0".

**Enrollment Counts Note:** Enrollment counts should be person counts, not member months.

| Demonstration Populations | Current Enrollees: last day of the quarter: xx/xx/xxxx | Previously reported enrollees last day of quarter: xx/xx/xxxx | Variance |
|---|---|---|---|
| **Demonstration Population 1:** | | | |
| **Demonstration Population 2:** | | | |
| **Demonstration Population 3:** | | | |
| **Demonstration Population 4:** | | | |
| **Demonstration Population 5:** | | | |
| **Demonstration Population 6:** | | | |
| **Demonstration Population 7:** | | | |
| **Demonstration Population 8:** | | | |
| **Demonstration Population 9:** | | | |

**Demonstration Population 10:**

**Outreach/Innovative Activities**
Summarize outreach activities and/or promising practices for the current quarter.

**Operational/Policy Developments/Issues**
Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

**Expenditure Containment Initiatives**
Identify all current activities, by program and or Demonstration population. Include items such as status, and impact to date as well as short and long term challenges, successes and goals.

**Financial/Budget Neutrality Development/Issues**
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues.

**Member Month Reporting**
Enter the member months for each of the EGs for the quarter.

**A. For Use in Budget Neutrality Calculations**

| Eligibility Group | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|---|---|---|---|---|
| Demonstration Population 1: | | | | |
| Demonstration Population 2: | | | | |
| Demonstration Population 3: | | | | |
| Demonstration Population 4: | | | | |
| Demonstration Population 5: | | | | |
| Demonstration Population 6: | | | | |
| Demonstration Population 7: | | | | |
| Demonstration Population 8: | | | | |
| Demonstration Population 9: | | | | |
| Demonstration Population 10: | | | | |

**Consumer Issues**
A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also discuss feedback received from the other consumer groups.

**Quality Assurance/Monitoring Activity**
Identify any quality assurance/monitoring activity in current quarter.

**Demonstration Evaluation**
Discuss progress of evaluation design and planning.

**Enclosures/Attachments**
Identify by title any attachments along with a brief description of what information the document contains.

**State Contact(s)**
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

**Date Submitted to CMS**

## ATTACHMENT B: SUMMARY OF CATAMOUNT HEALTH

Catamount Health is a new fully insured product that will be available through private insurers in Vermont. The Catamount Health Assistance Program offers a subsidized insurance program to Vermont residents who have been without health insurance coverage for a year or more, have income at or below 300 percent of FPL, and who do not have access to employer-sponsored insurance that has been approved and is cost effective. The beneficiary's share of the premium is based on income.

**Participating Carriers**

Insurers currently offering products in the small group market may offer Catamount Health. The benefits to be provided in the plan are set out in the legislation creating the program. Insurers offering Catamount Health are required to provide benefit plans that are actuarially equivalent to the following, which are modeled on a PPO plan:

- A $500.00 annual deductible for an individual and a $1000.00 deductible for a family for health services received in network;
- A $1000.00 annual deductible for an individual and a $2,000.00 deductible for a family for health services received out of network;
- 20 percent co-insurance, in and out of network;
- $10.00 office co-payment;
- Prescription drug coverage without a deductible, $10.00 co-payments for generic drugs, $35.00 co-payments for drugs on the preferred drug list, and $55.00 co-payments for non- preferred drugs;
- Out-of-pocket maximums of $1,050.00 for an individual and $2,100.00 for a family for in-network services and $2,100.00 for an individual and $4,000.00 for a family for out- of-network services; and
- A waiver of the deductible and other cost-sharing payments for chronic care for individuals participating in chronic care management and for preventive care.

# ATTACHMENT C: Premiums and Co-Payments for Demonstration Populations

| Population | Premiums | Co-Payments | State Program Name |
|---|---|---|---|
| ***Traditional Medicaid-eligible Mandatory and Optional Populations*** | | | |
| **Demonstration Population 1:** Mandatory Categorically Needy | $0 or as otherwise indicated in approved Medicaid State Plan | Medicaid State Plan | Medicaid/Dr. Dynasaur |
| **Demonstration Population 2:** Optional Categorically Needy | $0 or as otherwise indicated in approved Medicaid State Plan | Medicaid State Plan | Medicaid/Dr. Dynasaur |
| ***Vermont Health Access Plan (VHAP) Expansion Populations*** | | | |
| **Demonstration Population 3:** Underinsured children with income between 225 percent and up to and including 300% of the FPL who are not otherwise eligible for Medicaid or the Children's Health Insurance Program | Premiums not to exceed the following:<br><br>186-225% FPL: $15/month/family<br>226-300% FPL: $20/month/family | Not to exceed the nominal co-payments specified in the Medicaid State plan | Dr. Dynasaur |
| **Demonstration Population 4:** Adults with children with income between 150 percent and up to and including 185 percent of FPL | Premiums not to exceed the following:<br>150-185% FPL: $49/month | Not to exceed the nominal co-payments specified in the Medicaid State Plan plus $25 per emergency room visit, with no charge if admitted to the hospital | VHAP |
| **Demonstration Population 5:** Adults with income up to and including 150 percent of FPL | Premiums not to exceed the following:<br><br>50-75% FPL: $7/month<br>76-100% FPL: $25/month<br>101-150% FPL: $33/month | Not to exceed the nominal co-payments specified in the Medicaid State Plan plus $25 per emergency room visit, with no charge if admitted to the hospital | VHAP |
| **Demonstration Population 6:** Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income at or below 150 percent of the FPL, not otherwise categorically eligible | Premiums not to exceed the following:<br><br>0-150% FPL: $15/month/person | Not to exceed the nominal co-payments specified in the Medicaid State plan | VHAP Pharmacy/ VPharm1 |
| **Demonstration Population 7:** Medicare beneficiaries and non-Medicare individuals who are 65 years or older or have a disability with income above 150 percent but less than and including 225 percent of the FPL, not otherwise categorically eligible | Premiums not to exceed the following:<br><br>151-175% FPL: $20/month/person<br>176-225% FPL: $50/month/person | Not to exceed the nominal co-payments specified in the Medicaid State plan | VScript/VPharm2 or VScript Expanded/ VPharm3 |
| **Demonstration Population 8:** Individuals with persistent mental illness with income up to and including 150 percent of FPL | Premiums not to exceed the amounts indicated in the Medicaid State Plan | Not to exceed the nominal co-payments specified in the Medicaid State plan | VHAP |
| ***Premium Assistance Expansion Populations*** | | | |
| **Demonstration Population 9:** ESI Premium Assistance Expansion Population | Premiums not to exceed the following:<br><br>50-75% FPL: $7/month<br>76-100% FPL: $25/month<br>101-150% FPL: $33/month<br>150-185% FPL: $49/month | Not to exceed the nominal co-payments specified in the Medicaid State Plan plus $25 per emergency room visit, with no charge if admitted to the hospital | VHAP-ESI |
| **Demonstration Population 10:** Catamount Health Premium Assistance Expansion Population | Based on lowest cost plan; premium amounts will be the same as Catamount<br><br>Based on lowest cost plan; amounts dictated by Vermont Legislation | N/A | Non-VHAP ESI or Catamount |

*Cost refers to the amount of reimbursement.