SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation		
42 CFR 431.15 AT-79-29	4.1	Methods of Administration The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

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CITATION: 42 CFR 431.202 (AT-79-29 & AT-80-34)

4.2 Hearings For Applicants And Recipients

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

The Commissioner of the Department of Social Welfare may review an applicants complaint and determine whether or not the applicant is entitled to have the relief being sought throughout the fair hearing process

Citation	4.3	Safeguarding Information on Applicants and Recipients
42 CFR 431.301 AT-79-29		Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.
52 FR 5967		All other requirements of 42 CFR Part 431, Subpart F are met.

State/Territory: __Vermont____

Citation	4.4	Medicaid Quality Control
42 CFR 431.800(c) 50 FR 21839 1903(u)(l)(D) of the Act, P.L. 99-509 (Section 9407)	(a)	A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.
	(b)	The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h), (j) and (k).

☐ Yes.

☒ Not applicable. The State has an approved Medicaid Management Information System (MMIS).

State/ Territory: _____Vermont_____

4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

Citation

Section 1902(a)(80) of the Social Security Act, P.L. 111-148 (Section 6505)

___X___ The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

State/Territory: Vermont

Citation		
42 CFR 455.12 AT-78-90 48 FR 3742 52 FR 48817	4.5	Medicaid Agency Fraud Detection and Investigation Program The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

New: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: VERMONT

Citation		
Section 1 902(a)(64) of the Social Security Act P.L. 105-33	4.5a	Medicaid Agency Fraud Detection and Investigation Program The Medicaid agency has established a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title.

New: December 31, 2010

State: _____Vermont_____

4.5b Medicaid Recovery Audit Contractor Program

Citation

Section 1902(a)(42)(B)(i) of the Social Security Act

☐ The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.

☒ The State is seeking an exception to establishing such program for the following reasons:

More than 95% of Vermont's Medicaid beneficiaries are enrolled in managed care. The number of Vermont Medicaid beneficiaries and the associated claims expenditures in non-managed care programs is too low to attract a Recovery Audit Contractor compensated on a contingency fee basis.

Section 1902(a)(42)(B)(ii)(I) of the Act

This SPA will be in effect as long as the current GC Waiver is in effect. At the expiration of the waiver's renewal period, Vermont must submit to CMS either:

a) A new request for an exemption; or
b) A SPA establishing a Medicaid RAC program.

☐ The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.*

Place a check mark to provide assurance of the following:

Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act

☐ The State will make payments to the RAC(s) only from amounts recovered.

☐ The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.

The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):

☐ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.

☐ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 431.16 (AT-79-29)

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CRF 431.17 (AT-79-29)

4.7 Maintenance Of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the Plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 431.18(b) (AT-79-29)

4.8 Availability Of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State Office and in each local and District Office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

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TITLE XIX

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 433.37 (AT-78-90)

4.9 Reporting Provider Payments To Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by Social Security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the Plan.

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New: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: VERMONT

Citation	4.10 Free Choice of Providers
42 CFR 431.51 AT-78-90 46 FR 48524 48 FR 23212 1902(a)(23) of the Act P.L. 100-93 (Section 8(f)) P.L. 100-203 (Section 4113)	(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis. (b) Paragraph (a) does not apply to services furnished to an individual – (1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or (2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or (3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act, or
Section 1902(a)(23) of the Social Security Act P.L. 105-33	(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services. (c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1915(b)(1), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905(a)(4)(c).

CITATION: 42 CFR 431.610 (AT-78-90 & AT-80-34)

4.11 Relations With Standard-Setting And Survey Agencies

a. The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private and public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is the:

DEPARTMENT OF AGING AND DISABILITIES

b. The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are) the:

DEPARTMENT OF AGING AND DISABILITIES

c. ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

CITATION: 42 CFR 431.610 (AT-78-90 & AT-89-34)

4.11 Relations With Standard-Setting And Survey Agencies (continued)

d. The Department of Aging and Disabilities, which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements of participation in the Medicaid Program. The requirements in 42 CFR 431.610 (e), (f), and (g) are met.

Revision: HCFA-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 431.105(b) (AT-78-90)

4.12 Consultation To Medical Facilities

a. Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

b. Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

☐ Yes, as listed below:

☒ Not applicable. Similar services are not provided to other types of medical facilities.

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Citation

4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107

(a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

42 CFR Part 483, 1919 of the Act

(b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.

42 CFR Part 483, Subpart D

(c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.

1920 of the Act

(d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section l920(b)(2) and (c) are met.

☒ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

Citation
1902 (a)(58)
1902(w)

4.13 (e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether

statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient.

(b) Nursing facilities when the individual is admitted as a resident.

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Health maintenance organizations at the time of enrollment of the individual with the organization.

(3) Attachment 4.34-A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

☐ Not applicable. No State law or court decision exist regarding advance directives.

State/Territory: _____Vermont_____

Citation

4.14 Utilization/Quality Control

42 CFR 431.60
42 CFR 456.2
50 FR 15312
1902(a)(30)(c) and
1902(d) of the Act,
P.L. 99-509
(Section 9431)

(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met.

☒ Directly

☐ By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO--

(1) Meets the requirements of §434.6(a);

(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;

(3) Identifies the services and providers subject to PRO review;

(4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and

(5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

☐ Quality review requirements described in section 1902(a)(30)(C) of the Act relating to services furnished by HMOs under contract are undertaken through contract with the PRO designed under 42 CFR Part 462.

1902(a)(30)(c) and
1902(d) of the Act,
P.L. 99-509
(section 9431)

☐ By undertaking quality review of services furnished under each contract with an HMO through a private accreditation body.

Citation
42CFR 456.2
50 FR 15312

4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part. 456, Subpart C, for control of the utilization of inpatient hospital services.

☐ Utilization and Medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

- ☐ All hospitals (other than mental hospitals).
- ☐ Those specified in the waiver.
- ☒ No waivers have been granted.

State/Territory: _____Vermont_____

Citation
42 CFR 456.2
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

☐ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

☐ All mental hospitals.

☐ Those specified in the waiver.

☒ No waivers have been granted.

☐ Not applicable. Inpatient services in mental hospitals are not provided under this plan.

State: ____Vermont_____

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

☐ Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

☐ All skilled nursing facilities.

☐ Those specified in the waiver.

☒ No waivers have been granted.

State: _____Vermont_____

OMB NO. 0938-0193

Citation
42 CFR 456.2
50 FR 15312

4.14 ☒ (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

☐ Facility-based review.

☐ Direct review by personnel of the medical assistance unit of the State agency.

☐ Personnel under contract to the medical assistance unit of the State agency.

☐ Utilization and Quality Control Peer Review Organizations.

☐ Another method as described in ATTACHMENT 4.14-A.

☒ Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

☐ Not applicable. Intermediate care facility services are not provided under this plan.

Revision: HCFA-PM-91-10 (MB)
December 1991

State/Territory: _____Vermont_____

Citation

1902 (a) (30) and 1902(d) of the Act, P.L. 99-509 (Section 9431), P.L. 99-203 (section 4113)

4.14 Utilization/Quality Control (Continued)

(f) The Medicaid agency meets the requirements of section 1902(a)(30) of the Act for control of the assurance of quality furnished by each health maintenance organization under contract with the Medicaid agency. Independent, external quality reviews are performed annually by:

☐ A Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☐ A private accreditation body.

☐ An entity that meets the requirements of the Act, as determined by the Secretary.

The Medicaid agency certifies that the entity in the preceding subcategory under 4.14(f) is not an agency of the state.

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: _____Vermont_____

Citation

4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part 456 Subpart I, and 1902(a)(31) and 1903(g) of the Act

☐ The State has contracted with a Peer Review organization (PRO) to perform inspection of care for:

- ☐ ICFs/MR;
- ☐ Inpatient psychiatric facilities for recipients under age 21; and
- ☐ Mental Hospitals.

42 CFR Part 456 Subpart A and 1902(a)(30) of the Act

☒ All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

☐ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.

☐ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.

☐ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 431.615(c) (AT-78-90)

4.16 Relations with State Health And Vocational Rehabilitation Agencies And Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with Title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: VERMONT

Citation
42 CFR 433.36(c)
1902(a)(18) and
1917(a) and (b) of the
Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

☐ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c) - (g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

☐ The State imposes liens on real property on account of benefits incorrectly paid.

☐ The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

☐ The State imposes liens on both real and personal property of an individual after the individual's death.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____VERMONT_____

(b) Adjustments or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36(h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

☐ Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917(a)(1)(B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

☐ In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State plan as listed below:

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____VERMONT_____

(b) Adjustments or Recoveries (Continued)

(3) Continued

Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____VERMONT_____

(4) ☐ The State disregards assets or resources for individuals who receive or are entitled to-receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, Supplement 8b.

☒ The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy - based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)

☐ The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

☐ The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: VERMONT

(C) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR §433.36(h)-(i).

(1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) with respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

Revision: HCFA-PM-95-3 (MB)
MAY 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____VERMONT_____

(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

(3) Defines the following terms:

- estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
- individual's home,
- equity interest in the home,
- residing in the home for at least 1 or 2 years,
- on a continuous basis,
- discharge from the medical institution and return home, and
- lawfully residing.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____VERMONT_____

(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustment or recovery is not cost-effective. Defines cost- effective and includes methodology or thresholds used to determine cost-effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

Citation 4.18 Recipient Cost Sharing and Similar Charges

42 CFR 447.51 through 447.58

(a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b) of the Act

(b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section l905(p)(l) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

☐ Age 19

☐ Age 20

☒ Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

Citation

4.18 (b)(2) (Continued)

42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women.

☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a health maintenance organization in which the individual is enrolled.

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

Citation 4.18 (b) (Continued)

42 CFR 447.51 through 447.58

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

☐ 18 or older

☐ 19 or older

☐ 20 or older

☒ 21 or older

☐ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

Citation
42 CFR 447.51 through
447.58

4.18 (b)(3) (Continued)

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

☐ Not applicable. There is no maximum.

Citation		
1916(c) of the Act	4.18 (b) (4) ☐	A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902(a)(52) and 1925(b) of the Act	4.l8 (b) (5) ☐	For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
1916(d) of the Act	4.18 (b) (6) ☐	A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section l902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.19-E specifies the method and standards the State uses for determining the premium.

State/Territory: __VERMONT__

Citation		
42 CFR 447.51 through 447.58	4.18 (c)	☒ Individuals are covered as medically needy under the plan.
	(1)	☐ An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.
447.51 through 447.58	(2)	No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:
	(i)	Services to individuals under age 18, or under--
		☐ Age 19
		☐ Age 20
		☒ Age 21
		Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

Revision: HHCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: ____VERMONT_____

Citation

42 CFR 447.51 through 447.58

1916 of the Act, P.L. 99—272 (Section 9505), 447.51 through 447.58

4.18 (c)(2) (Continued)

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

(viii) Services provided by a health maintenance organization (MMD) to enrolled individuals.

☒ Not applicable. No such charges are imposed.

State/Territory: _____VERMONT_____

Citation 4.18 (c) (3) Unless a waiver under 42 CFR 431.55(g) applies; nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

☐ 18 or older

☐ 19 or older

☐ 20 or older

☒ 21 or older

Reasonable categories of individuals who are l8 years of age, but under 21, to whom charges apply are listed below, if applicable.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: _____VERMONT_____

Citation

4.18 (c) (3) (Continued)

447.51 through 447.58

(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

☐ Not applicable. There is no maximum.

Citation

42 CFR 447.252, 1902(a)(13), and 1923 of the Act

4.19 Payment for Services

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

☒ Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

☐ Inappropriate level of care days are not covered.

Citation		
42 CFR 447.201, 42 CFR 447.302, 52 FR 28648, 1902(a)(13)(E), 1903(a)(1) and (n), 1920, and 1926 of the Act	4.19 (b)	In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements:
		(1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).
1902(a)(10), an 1902(a)(30) of the Act		(2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.
		ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.
		SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 447.40 (AT-78-90)

4.19 Payment For Services (Continued)

c. Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

☒ Yes. The State's policy is described in ATTACHMENT 4.19-C.

☐ No.

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State/Territory: Vermont

Citation
42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141

4.19 (d)

☒ (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

(2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

☒ At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

☐ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

☐ Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

☒ At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

☐ At a rate established by the State, which meets the requirements of 42 CFR Part 441, Subpart C, as applicable.

☐ Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

☐ (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

Revision: HCFA-AT-80-38(BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 447.45(c) (AT-79-50)

4.19 Payment For Services (Continued)

e. The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims.

ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

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Citation		
42 CFR 447.15, AT-78-90, AT-80-34, 48 FR 5730	4.19	(f) The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15. No provider participating under this plan may deny services to any individual eligible under the plan on account of the individuals inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 447.201 & 42 CFR 447.202 (AT-78-90)

4.19 Payment For Services (Continued)

g. The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

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Revision: HCFA-AT-80-60 (BPP)
August 12, 1980

State: VERMONT

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CITATION: 42 CFR 447.201 & 42 CFR 447.203 (AT-78-90)

4.19 Payment For Services (Continued)

h. The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

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Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 447.201 & 42 CFR 447.204 (AT-78-90)

4.19 Payment For Services (Continued)

i. The Medicaid agency's payments are sufficient to enlist enough providers so that services under the Plan are available to recipients at least to the extent that those services are available to the general population.

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Citation		
42 CFR 447.201 and 447.205	4.19	(j) The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(v) of the Act		(k) The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

Revision: HCFA-PM-92-7 (MB)
October, 1992

State/Territory: Vermont

Citation		
1903(i)(14) of the Act	4.19 (1)	The Medicaid agency meets the requirements of section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

Revision: HCFA-PM-94-8 (MB)
OCTOBER 1994

State/Territory: _____Vermont_____

Citation | 4.19 (m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928(c)(2)(C)(ii) of the Act

(i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

☐ sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

☐ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

☐ sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

☒ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine: __$6.00__

1926 of the Act

(iii) Medicaid beneficiary access to immunizations is assured through the following methodology:

Vermont is a Universal Purchase State.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 447.25(b) (AT-78-90)

4.20 Direct Payments To Certain Recipients For Physicians' Or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

☐ Yes, for:

☐ Physicians' services.

☐ Dentists' services.

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

☒ Not applicable. No direct payments are made to recipients.

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Revision: HCFA-AT-81-34 (BPP)
October 1981

State: VERMONT

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CITATION: 42 CFR 447.10(c) (AT-78-90) 46 FR 42699

4.21 Prohibition Against Reassignment Of Provider Claims

Payment for Medicaid services furnished by any provider under this Plan is made only in accordance with the requirements of 42 CFR 447.10.

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Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: _____Vermont_____

Citation		
	4.22	Third Party Liability
42 CFR 433.137	(a)	The Medicaid agency meets all requirements of:
		(1) 42 CFR 433.138 and 433.139.
		(2) 42 CFR 433.145 through 433.148.
1902(a)(25)(H) and (I) of the Act		(3) 42 CFR 433.151 through 433.154.
		(4) Sections 1902(a)(25)(H) and (I) of the Act.
42 CFR 433.138(f)	(b)	ATTACHMENT 4.22-A --
		(1) Specifies the frequency with which the data exchanges required in §433.138(d)(l), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;
42 CFR 433.138(g)(1)(ii) and (2)(ii)		(2) Describes the methods the agency uses for meeting the follow up requirements contained in §433.138(g)(1)(i) and (g)(2)(i);
42 CFR 433.138(g)(3)(i) and (iii)		(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources; and
42 CFR 433.138(g)(4)(i) through (iii)		(4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow up that identifies legally liable third party resources.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: _____Vermont_____

Citation	
42 CFR 433.139(b)(3)(ii)(A)	☐ (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
42 CFR 433.139(b)(3)(ii) (C) 42 CFR 433.139(f)(2) 42 CFR 433.139(f)(3) 42 CFR 447.20	(d) ATTACHMENT 4.22-B specifies the following: (1) The method used in determining a provider's compliance with the third party billing requirements at §433.139(b)(3)(ii)(C). (2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective. (3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
	(e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

State/Territory: _____Vermont_____

Citation | 4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

☒ State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

☐ Other appropriate State agency(s) --
_____
_____

☐ Other appropriate agency(s) of another State
_____
_____

☐ Courts and law enforcement officials.

1902(a)(60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

☐ The Secretary's method as provided in the State Medicaid Manual, Section 3910.

☒ The State provides methods for determining cost effectiveness on ATTACHMENT 4.22-C.

Revision: HCFA-AT-84-2 (BERC)
01-84

State: VERMONT

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CITATION: 42 CFR Part 434.4 (48 FR 54013)

4.23 Use Of Contracts

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

☒ Not applicable. The State has no such contracts.

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Revision: HCFA-PM-94-2 (BPD)
APRIL 1994

State/Territory: _____Vermont_____

Citation		
42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 P.L 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826	4.24	Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met. ☐ Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 431.702 (AT-78-90)

4.25 Program For Licensing Administrators Of Nursing Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

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Revision: HCFA-PM- (MB)

State/Territory: _____Vermont_____

Citation	4.26 Drug Utilization Review Program
1927(g), 42 CFR 456.700	A. l. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.
1927(g)(l)(A)	2. The DUR program assures that prescriptions for outpatient drugs are: • Appropriate • Medically necessary • Are not likely to result in adverse medical results
1927(g)(1)(a), 42 CFR 456.705(b) and 456.709(b)	B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as: • Potential and actual adverse drug reactions • Therapeutic appropriateness • Overutilization and underutilization • Appropriate use of generic products • Therapeutic duplication • Drug disease contra-indications • Drug-drug interactions • Incorrect drug dosage or duration of drug treatment • Drug-allergy interactions • Clinical abuse/misuse
42 CFR 456.703 1927(g)(1)(B)(d) and (f)	C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia: • American Hospital Formulary Service Drug Information • United States Pharmacopeia – Drug Information • American Medical Association Drug Evaluations

Revision: HCFA-PM- (MB)

State/Territory: _____Vermont_____

Citation		
1927(g) (1) (D), 42 CFR 456.703(b)	D.	DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in: • Prospective DUR • Retrospective DUR.
1927 (g) (2) (A), 42 CFR 456.705(b)	E. 1	The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.
1927(g) (2) (A) (i), 42 CFR 456.705(b), (1)-(7)	2.	Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to: • Therapeutic duplication • Drug-disease contra-indications • Drug-drug interactions • Drug-interactions with non-prescript ion or over-the-counter drugs • Incorrect drug dosage or duration of drug treatment • Drug allergy interactions • Clinical abuse/misuse
1927(g) (2) (A) (ii), 42 CFR 456.705 (c) and (d)	3.	Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.
1927(g) (2) (B), 42 CFR 456.709(a)	F. 1.	The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify: • Patterns of fraud and abuse • Gross overuse • Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

Citation

1927(g)(2)(C), 42 CFR 456.709(b)

F. 2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug-disease contra-indications
- Drug-drug interactions
- Incorrect drug dosage/duration of drug treatment
- Clinical abuse/misuse

1927(g)(2)(D), 42 CFR 456.711

3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

G. l. The State has established a State DUR Board either:

1927(g)(3)(A), 42 CFR 456.716(a)

☒ Directly, or
☐ Under contract with a private organization

1927(g)(3)(B), 42 CFR 456.716(A) and (B)

2. The DUR Board membership includes health professionals (at least one-third licensed actively practicing pharmacists and at least one-third but no more than one-half licensed and actively practicing physicians) appointed by the Commissioner of the Department of Vermont Health Access (DVHA) and approved by the Governor, with knowledge and experience in one or more of the following:

- Clinically appropriate prescribing of covered outpatient drugs.
- Clinically appropriate dispensing and monitoring of covered outpatient drugs.
- Drug use review, evaluation and intervention.
- Medical quality assurance.

1927(g)(3)(C), 42 CFR 456.716(d)

The board may include other members as proposed by the Commissioner of the DVHA and approved by the Governor. Members serving on the board as of September 8, 2010, shall be reappointed by the Commissioner to serve staggered one- and two-year terms. As of September 8, 2010, a board member having served the equivalent of two consecutive full terms on the date his or her term expires, shall not be eligible for re-appointment for a period of two years.

Effective September 8, 2010, new board members shall be appointed to staggered two-year terms and shall not serve more than two consecutive full terms. After serving for two consecutive full terms the member shall not be eligible for reappointment for a period of two years. The chair shall be elected by vote of the members.

3. DUR Board duties include:
   - Retrospective DUR,
   - Application of Standards as defined in section 1927(g)(2)(C)
   - Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.
   - Making recommendations to Commissioner for the adoption of the preferred drug list.
   - Board shall meet at least quarterly.
   - Board shall review all drug classes included in the preferred drug list at least every 12 months and may recommend that the Commissioner make additions to or deletions from the preferred drug list.

Revision: HCFA-PM- (MB) OMB No.
State/Territory: Vermont

Citation		
1927(g)(3)(C), 42 CFR 456.711 (a)-(d)		G. 4. The interventions include in appropriate instances: – Information dissemination – Written, oral, and electronic reminders – Face-to-Face discussions – Intensified monitoring/review of prescribers/dispensers
1927(g)(3)(D), 42 CFR 456.712 (A) and (B)		H. The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.
1927(h)(l), 42 CFR 456.722	*☒	I. 1. The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line: – real time eligibility verification – claims data capture – adjudication of claims – assistance to pharmacists, etc. applying for and receiving payment.
1927(g)(2)(A)(i), 42 CFR 456.705(b)	*☒	2. Prospective DUR is performed using an electronic point of sale drug claims processing system.
l927(j)(2), 42 CFR 456.703(c)		J. Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

* effective 9/27/93

* U.S. G.P.O.: 1993-342-239:80043

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: VERMONT

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CITATION: 42 CFR 431.115(c) (AT-78-90 & AT-79-74)

4.27 Disclosure Of Survey Information And Provider Or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

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State/Territory: _____Vermont_____

Citation		
	4.28	Appeals Process
42 CFR 431.152; AT-79-18 52 FR 22444; Secs. 1902(a)(28)(D)(i), and 1919(e)(7) of the Act; P.L.100-203 (Sec. 4211(c)).	(a)	The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154.
	(b)	The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

New: HCFA-PM-99-3 (CMSO)
JUNE 1999

State: _____VERMONT_____

Citation	4.29	Conflict of Interest Provisions
1902(a)(4)(C) of the Social Security Act; P.L. 105-33		The Medicaid agency meets the requirements of section 1902(a)(4)(C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.
1902(a)(4)(D) of the Social Security Act; P.L. 105-33		The Medicaid agency meets the requirements of section 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

State/Territory: Vermont

Citation		
42 CFR 1002.203 AT-79-54 48 FR 3742 51 FR 34772	4.30	Exclusion of Providers and Suspension of Practitioners and Other Individuals

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

☐ The agency, under the authority of State law, imposes broader sanctions.

State/Territory: _____Vermont_____

Citation	
	(b) The Medicaid agency meets the requirements of --
1902(p) of the Act, P.L. 100-93 (secs. 7)	(1) Section 1902(p) of the Act by excluding from participation-
	(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).
	(B) Any HMO (as defined in section 1903(m) of the Act) or an entity furnishing services under a waiver approved under section 1915(b)(l) of the Act, that --
	(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or
	(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1l28(b)(8)(B) of the Act.

State/Territory: _____Vermont_____

Citation:

1902(a)(39) of the Act; P. L. 100-93 (sec. 8(f))

1902(a)(41) of the Act; P.L. 96-272, (sec. 308(c))

1902(a)(49) of the Act; P.L. 100-93 (sec. 5(a)(4))

(2) Section 1902(a)(39) of the Act by --

(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and

(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of --

(1) Section 1902(a)(4l) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

Citation
455.103
44 FR 41644
1902(a)(38) of the Act
P.L. 100-93 (Sec. 8(f))

4.31 Disclosure of information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b)(9) and 1902(a)(38) of the Act.

435.940 through 435.960
52 FR 5967

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960.

(b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

(c) ATTACHMENT 4.32-A describes in accordance with 42 CFR 435.948(a)(6) the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

Revision: HCFA-PM-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Vermont

Citation
1902(a)(48) of the Act,
P.L. 99-570 (Section 11005)
P.L. 100-93 (Sec. 5(a)(3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless 1ndividuals.

Revision: HCFA-PM-88-10 (BERC)
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: Vermont

Citation		
	4.34	Systematic Alien Verification for Entitlements
1137 of the Act P.L. 99-603 (sec. 121)		The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

☐ The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

☐ The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

- ☐ Total waiver
- ☐ Alternative system
- ☐ Partial implementation

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: VERMONT

Citation

4.35 Enforcement of Compliance for Nursing Facilities

42 CFR §488.402(f)

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

(1) nature of noncompliance,
(2) which remedy is imposed,
(3) effective date of the remedy, and
(4) right to appeal the determination leading to the remedy.

42 CFR §488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR §488.402(f)(2)

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR §488.456(c)(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

42 CFR §488.404(b)(1)

(b) Factors to be Considered in Selecting Remedies

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b) (1) & (2).

☐ The State considers additional factors. Attachment 4.35-A describes the State's other factors.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: _____VERMONT_____

Citation	
	(c) Application of Remedies
42 CFR §488.410	(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF'S provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.
42CFR§488.417(b), §1919(h)(2)(C) of the Act.	(ii) The State imposes the denial: of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.
42 CFR§488.414, §1919(h)(2)(D) of the Act.	(iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.
42 CFR §488.408, §1919(h)(2)(A) of the Act.	(iv) The State follows the criteria specified at 42 CFR §488.408(c)(2), §488.408(d)(2), and §488.408(e)(2), when it imposes remedies in place of or in addition to termination.
42 CFR §488.412(a)	(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.
42 CFR §488.406(b), §1919(h)(2)(A) of the Act	(d) Available Remedies
	(i) The State has established the remedies defined in 42 CFR 488.406(b).
	☒ (1) Termination ☒ (2) Temporary Management ☒ (3) Denial of Payment for New Admissions ☒ (4) Civil Money Penalties ☒ (5) Transfer of Residents; Transfer of Residents with Closure of Facility ☒ (6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: _____VERMONT_____

Citation
42 CFR §488.406(b)
§1919(h)(2)(B)(ii) of the Act.

42 CFR §488.303(b)
1910(h)(2)(F) of the Act

(ii) ☐ The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

☐ (1) Temporary Management
☐ (2) Denial of Payment for New Admissions
☐ (3) Civil Money Penalties
☐ (4) Transfer of Residents; Transfer of Residents with Closure of Facility
☐ (5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

(e) ☐ State Incentive Programs

☐ (1) Public Recognition of the Act.
☐ (2) Incentive Payments

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: VERMONT

Citation	4.36	Required Coordination Between the Medicaid and WIC Programs
1902(a)(11)(C)and 1902(a)(53) of the Act		The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

Revision: HCFA-PM-91-10 (BPD)
DECEMBER, 1991

State/Territory: Vermont

Citation	4.38 Nurse Aide Training and Competency Evaluation for Nursing Facilities
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).	☐ (a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.
	☒ (b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).
	☒ (c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.
	☐ (d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.
	☐ (e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.
	☒ (f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

Revision: HCFA-PM-91-10 (BPD)
DECEMBER 1991

State/Territory: _____Vermont_____

Citation

42 CFR 483.75;
42 CFR 483 Subpart D;
Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-03 (Sec. 4211(a)(3));
P.L. 101-39 (Secs. 6901(b)(3) and (4));
P.L. 101-508 (Sec. 4801(a)).

(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.

(h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.

(i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.

(j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.

(k) For program reviews other than the initial review, the State visits the entity providing the program.

(l) The State does not approve a nurse aide training and competency evaluation program or -competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

Citation
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

(m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.

(n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.

(o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).

(p) The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).

☒ (q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.

(r) The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

Citation

42 CFR 483.75;
42 CFR 483 Subpart D;
Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3));
P.L. 101-239 (Secs. 6901(b)(3) and(4));
P.L. 101-508 (Sec. 4801(a)).

(s) When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.

(t) The State permits students who have started training and competency evaluation program from which approval is withdrawn to finish the program.

(u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.

(v) The State provides, advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.

(w) Competency evaluation programs are administered by the State or by a state-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.

☐ (x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).

(y) The State has a standard for successful completion of competency evaluation programs.

Revision: HCFA-PM-91-10 (BPD)
DECEMBER 1991

State/Territory: _____Vermont_____

Citation		
42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2) P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Sec. 6901(b)(3) and (4); P.L. 101-508 (Sec. 4801(a)).	(z)	The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.
	☒ (aa)	The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).
	(bb)	The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.
	☐ (cc)	The State includes home health aides on the registry.
	☒ (dd)	The State contracts the operation of the registry to a non State entity.
	☐ (ee)	ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c),
	☐ (ff)	ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: Vermont

Citation
Secs. 1902(a)(28)(D)(i) and 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)); P.L. 101-508 (Sec. 4801(b)).

4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities

(a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 CFR 431.621(c).

(b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.

(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.

☒ (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

4.39 (Continued)

(f) Except for residents identified in 42 CFR 483.118(c)(l), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

Citation	4.40	Survey & Certification Process
Sect ions 1919(g)(1) thru (2) and 1919(g)(4) thru (5) of the Act; P.L. 100-203 (Sec. 4212(a))	(a)	The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act are met.
1919(g)(1)(B) of the Act	(b)	The State conducts periodic education programs for staff and residents (and their representatives). Attachment 4.40-A describes the survey and certification educational program.
1919(g)(1)(C) of the Act	(c)	The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. Attachment 4.40-B describes the State's process.
1919(g)(1)(C) of the Act	(d)	The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation, of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency? _____
1919(g)(1)(C) of the Act	(e)	The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.
1919(g)(1)(C) of the Act	(f)	The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

1919(g)(2)(A)(i) of the Act	(g)	The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. Attachment 4.40-C describes the State's procedures.
1919(g)(2)(A)(ii) of the Act	(h)	The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participations and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
1919(g)(2)(A)(iii)(I) of the Act	(i)	The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
1919(g)(2)(A)(iii)(II) of the Act	(j)	The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
1919(g)(2)(B) of the Act	(k)	The State conducts extended surveys immediately or, if not practicable, not later that 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
1919(g)(2)(C) of the Act	(l)	The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

1919(g) (2)(D) of the Act	(m)	The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. Attachment 4.40-D describes the State's programs.
1919(g) (2)(E)(i) of the Act	(n)	The State uses a multidisciplinary team of professionals including a registered professional nurse.
1919(g) (2)(E)(ii) of the Act	(o)	The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
1919(g) (2)(E)(iii) of the Act	(p)	The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
1919(g) (4) of the Act	(q)	The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. Attachment 4.40-E describes the State's complaint procedures
1919(g)(5)(A) of the Act	(r)	The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
1919(g)(5)(B) of the Act	(s)	The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
1919(g)(5)(C) of the Act	(t)	If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
1919(g)(5)(D) of the Act	(u)	The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

Revision: HCFA-PM-92-2 (HSQB)
MARCH 1992

State/Territory: _____Vermont_____

Citation	4.41	Resident Assessment for Nursing Facilities
Sections 1919(b)(3), and 1919(e)(5) of the Act	(a)	The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §19l9(b)(3)(A) of the Act
1919(e)(5)(A) of the Act	(b)	The State is using:
1919(e)(5)(B) of the Act	☐	the resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [§19l9(e)(5)(A)]; or
	☒	a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [§l919(e)(5)(B)].

Citation

1902(a)(68) of the Act,
P.L. 109-171 (section 6032)

4.42 Employee Education About False Claims Recoveries

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section l902(a)(63) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan amendment on 1/1/2007.

(b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

State/Territory: _____Vermont_____

Citation	4.43	Cooperation with Medicaid Integrity Program Efforts.
1902(a)(69) of the Act, P.L. 109-171 (section 6034)		The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Vermont_____

4.46 Provider Screening and Enrollment

The State Medicaid agency gives the following assurances:

Citation
1902(a)(77)
1902(a)(39)
Adds 1902(kk);
P.L. 111-148
And P.L. 111-152

42 CFR 455 Subpart E	PROVIDER SCREENING __X__Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS __X__ Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq. __X__Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES __X__Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT __X__Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OF ENROLLMENT __X__Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.
42 CFR 455.420	REACTIVATION OF PROVIDER ENROLLMENT __X__Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422	APPEAL RIGHTS __X__Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.
42 CFR 455.432	SITE VISITS __X__Assures that pre-enrollment and post enrollment site visits of providers who are in “moderate” or “high risk” categories will occur.
42 CFR 455.434	CRIMINAL BACKGROUND CHECKS __X__Assures that providers as a condition of enrollment will be required to consent to criminal background checks including fingerprints if required to do so under State law or by the level of screening based on risk of fraud, waste or abuse for that category of provider.
42 CFR 455.436	FEDERAL DATABASE CHECKS __X__Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.
42 CFR 455.440	NATIONAL PROVIDER IDENTIFIER __X__Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.
42 CFR 455.450	SCREENING LEVELS FOR MEDICAID PROVIDERS __X__Assures that the State Medicaid agency complies with 1902(a)(77)and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.
42 CFR 455.460	APPLICATION FEE __X__Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.
42 CFR 455.470	TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS __X__Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries’ access to medical assistance.