

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00194/1

TITLE: Global Commitment to Health Section 1115 Demonstration

AWARDEE: Vermont Agency of Human Services

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Vermont Global Commitment to Health section 1115(a) of the Social Security Act (The Act) Medicaid demonstration (the ‘Demonstration’). The parties to this agreement are the Agency of Human Services (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State’s obligations to CMS during the life of the Demonstration. This Demonstration is approved for the 5-year period from October 1, 2005, through September 30, 2010.

The STCs have been arranged into the following subject areas: General Program Requirements; General Reporting Requirements; Eligibility and Enrollment; Benefits and Coverage; Cost Sharing; Delivery Systems; Evaluation; General Financial Requirements under title XIX; and Monitoring Budget Neutrality.

II. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it shall comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the award letter of which these terms and conditions are part, shall apply to the Demonstration.
3. **Changes in Law.** The State shall, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the approval date of this demonstration.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.** To the extent that a change in Federal law impacts State Medicaid spending on program components included in the demonstration, CMS shall incorporate such changes into a modified budget neutrality expenditure cap for the Demonstration. The

modified budget neutrality expenditure cap would be effective upon implementation of the change in the Federal law. The growth rates for the budget neutrality baseline are not subject to this STC. If mandated changes in the Federal law require State legislation, the changes shall take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State shall not be required to submit title XIX State plan amendments for changes to any populations covered solely through the demonstration. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required. Reimbursement of providers by the managed care organization (MCO) will not be limited to those described in the State plan.

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

The State has the authority to modify the Demonstration program design elements in accordance with the parameters specified below.

Mandatory State Plan Eligibles. Eligibility criteria and cost-sharing requirements for federally mandated Medicaid eligibility groups, must be in compliance with Federal statutes and regulations. Reductions in benefits for federally mandated populations (including optional services) must be submitted as an amendment to the demonstration by the process outlined below in item seven. Subject to remaining in compliance with the Demonstration's terms and conditions, the State shall submit an amendment to the Demonstration to expand covered benefits to include health services not currently covered under the State plan.

Non-Mandatory Eligibles

Benefits

The State has the authority to change the benefit package for the non-mandatory eligible population so long as the changes result in no more than a 5-percent cumulative increase, or decrease, each year of the total Medicaid expenditures for the corresponding waiver year, and comparison year. The following chart indicates the corresponding years:

Waiver Year (WY)	Comparison Year Expenditures
WY 1	2004 Base Year Medicaid Expenditure
WY 2	2005 Total Global Expenditures
WY 3	2006 Total Global Expenditures
WY 4	2007 Total Global Expenditures
WY 5	2008 Total Global Expenditures

The State must offer benefit packages that meet or exceed Secretary-approved coverage, which include inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, and well-baby, and well-child care, including age appropriate immunizations.

The State shall notify CMS 60 days prior to any such change in the benefit package. After receipt of the written notification, CMS officials will notify the State if the request needs to be submitted as an amendment to the Demonstration as outlined in item seven below. Upon review, CMS has the right to withhold or disallow FFP.

If changes to the benefit package for the non-mandatory eligible population would result in more than a 5-percent increase or decrease of the corresponding year benefit expenditures, or would not be equivalent to the Secretary-approved coverage as described above, then the State will submit an amendment to the Demonstration as described by the process outlined in item seven below.

7. **Amendment Process.** Amendment requests must be submitted to CMS for approval no later than 90 days prior to the date of implementation, and may not be implemented until approved. Utilizing the standard review process, CMS will consult with the Federal review team. Amendment requests shall include, but not be limited to, the following:
 - a) An explanation of the public process used by the State to reach a decision regarding the requested amendment;
 - b) A current assessment of the impact the requested amendment shall have on budget neutrality;
 - c) A detailed description of the amendment, with sufficient supporting documentation; and
 - d) A description of how the evaluation design shall be modified to incorporate this amendment request.
8. **Global Commitment to Health Flexibility.** Vermont's expectation is that changes to the Demonstration will occur at the same time of year each year, based on the outcomes of the legislative session. At the end of the legislative session, the State shall submit amendments pursuant to item six, and governed by the process outlined in item seven of this section. Any approved changes shall be reflected in the annual rate-setting process for the upcoming year.
9. **Extension of the Demonstration.** If the State intends to extend the Demonstration beyond the period of approval granted under section 1115(a) of the Act, then the State is responsible for reviewing, complying, and adhering to the timeframes and reporting requirements, as stated in sections 1115(a), 1115(e) and 1115(f) of the Act.
10. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase-out the Demonstration, the State

shall submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. The State may also submit an extension plan on a timely basis in order to prevent disenrollment of demonstration enrollees. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by unexpected circumstances. The phase-out plan and extension plan are subject to CMS approval. If the project is terminated, or any relevant waivers suspended by the State, FFP shall be available for only normal close-out costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

11. **Enrollment Limitation.** During the last 6 months of the Demonstration, the enrollment of individuals who would not be eligible for Medicaid under the current State plan shall not be permitted unless the Demonstration is extended by CMS.
12. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing, that the State has materially failed to comply with the terms of the project. CMS shall promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.
13. **Finding of Non-Compliance.** The State waives none of its rights to challenge CMS' finding that the State materially failed to comply.
14. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers, or expenditure authorities, at any time it determines that continuing the waivers, or expenditure authorities, would no longer be in the public interest or would promote the objectives of title XIX. If a waiver or expenditure authority is withdrawn, FFP shall be available only for normal close-out costs associated with terminating the demonstration, including services and administrative costs of disenrolling participants.
15. **Adequacy of Infrastructure.** The State shall ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing; and reporting on financial and other demonstration components.
16. **Public Notice and Consultation with Interested Parties.** The State shall comply with the State notice procedures set forth in 59 Fed. Reg. 49249 (1994) when any program changes to the Demonstration are proposed by the State.
17. **Managed Care Requirements.** The State must comply with the managed care regulations published at 42 CFR section 438.

III. GENERAL REPORTING REQUIREMENTS

18. **General Financial Reporting Requirements.** The State shall comply with all general financial reporting requirements set forth in section IX, “General Reporting Requirements under title XIX.”
19. **Reporting Requirements Relating to Budget Neutrality.** The State shall comply with all reporting requirements for monitoring budget neutrality set forth in section X, “Monitoring Budget Neutrality.”
20. **Reporting on Participants Receiving Community Rehabilitation and Treatment (CRT) Services.** The State agrees to develop systems to track and report expenditures for CRT services to participants with severe and persistent mental illness. Expenditures for CRT mental health services will be included under the budget neutrality agreement for the Vermont Global Commitment to Health section 1115 demonstration.
21. **Managed Care Data Requirements.** The Office of Vermont Health Access (OVHA) shall maintain an information system that collects, analyzes, integrates, and reports data. The system must provide information as set forth in Federal regulations at 42 CFR 438, on program elements including, but not limited to, service utilization, grievances, appeals, and disenrollments for reasons other than loss of Medicaid eligibility. The management information system must collect data on member and provider characteristics, as specified by the Agency of Human Services (AHS), and on services as set forth under section 2.12.1 of the intergovernmental agreement. OVHA must collect, retain and report encounter data in accordance with the demonstration terms and conditions. All collected data must be available to AHS, and to CMS, upon request. The State shall have contractual provisions in place to impose sanctions on the OVHA if accurate data are not submitted in a timely fashion.
22. **Submission of Encounter Data.** The State will submit encounter data to the Medicaid Statistical Information System (MSIS) system, as is consistent with Federal law and section IX of this document. The State must assure that encounter data maintained at the MCO and provider level can be linked with eligibility files maintained by the State.
23. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual, or anticipated, developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any demonstration amendments, concept papers, or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review, as well as on Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the project officer and the regional office) shall jointly develop the agenda for the calls.
24. **Quarterly Reports.** The State will submit progress reports 60 days following the end of

each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports shall include, but are not limited to, the following:

- a) A discussion of events occurring during the quarter, or anticipated to occur in the near future, that affect health care delivery, enrollment, quality of care, access, health plan financial performance; including capitated revenue expenditures that are relevant to the Demonstration, the benefit package, and other operational issues.
- b) Action plans for addressing any policy and administrative issues identified.
- c) A separate discussion of the State efforts related to the collection and verification of encounter data.
- d) The quarterly reports will include enrollment data, member month data, budget neutrality monitoring tables in the attached format, etc.
- e) The state shall report demonstration program enrollment on a quarterly basis. The format of the report shall be specified by CMS. Average monthly enrollment will be reported for each of the following eligibility groups:
 - a. Mandatory State Plan Adults
 - b. Mandatory State Plan Children
 - c. Optional State Plan Adults
 - d. Optional State Plan Children
 - e. VHAP Expansion Adults
 - f. Pharmacy Program Beneficiaries (non-Duals)
 - g. Other Waiver Expansion Adults
- f) A discussion of the State's progress toward the Demonstration goals.
- g) A discussion of the State's evaluation activities.

25. **Annual Report.** The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The annual report shall also include a section that identifies how capitated revenue is spent. The State shall submit the draft annual report no later than 120 days after the end of each operational year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted, and posted, to the CMS Website with prior permission.

IV. ELIGIBILITY, ENROLLMENT, AND BENEFITS

26. **Mandatory Eligibles.** The State agrees that the eligibility criteria for mandatory eligible individuals fully served under the demonstration shall not change from the base year of the Demonstration.
27. **Demonstration Populations.** Except for the exclusion of participants covered under the Vermont Long-Term Care (LTC) section 1115 demonstration not receiving Community Residential Treatment (CRT) services, the following populations listed in the tables below shall be covered under the Global Commitment to Health demonstration. Only those Vermont LTC beneficiaries receiving CRT services shall overlap with the Global Commitment to Health demonstration beneficiaries. Changes to the following, outside

the parameters as outlined in paragraph 6, are pursuant to the amendment process as discussed in items 6 and 7 under section II, General Program Requirements.

28. **Vermont Populations and Services.** The following charts list the general categories of populations that are served under the Global Commitment to Health demonstration. The services listed below are only some of the services covered under the demonstration. For a complete list of services covered under the Demonstration please refer to the Vermont State plan.

The general categories of populations are:

Mandatory Categorically Needy;
Mandatory Medically Needy;
Mandatory Special Coverage Groups;
Optional Categorically Needy;
Optional Medically Needy;
1915(c) Waiver Populations; and
VHAP demonstration populations.

AID GROUP	SERVICES (SEE LIST BELOW)
<i>Mandatory Categorically Needy</i>	
1 1931 low-income families with children (1902(a)(10)(A)(i)(I)) (1931)	Some Listed
2 Children receiving IV-E payments (IV-E foster care or adoption assistance) (1902(a)(10)(i)(I))	Some Listed
3 Individuals who lose eligibility under 1931 due to employment (1902(a)(10)(A)(i)(I)) (402(a)(37)) (1925)	Some Listed
4 Individuals who lose eligibility under 1931 because of child or spousal support (1902(a)(10)(A)(i)(I))(406(h))	Some Listed
5 Individuals participating in a work supplementation program who would otherwise be eligible under 1931 (1902(a)(10)(A)(i)(I)) (482(e)(6))	Some Listed
6 Individuals receiving SSI cash benefits (does not apply to 209(b) States) (1902(a)(10)(A)(i)(I))	Some Listed
7 Disabled children no longer eligible for SSI benefits because of a change in definition of disability (1902(a)(10)(A)(i)(II))	Some Listed
8 Qualified pregnant women (1902(a)(10)(A)(i)(III)) (1905(n)(1))	Some Listed
9 Qualified children (1902(a)(10)(A)(i)(III)) (1905(n)(2))	Some Listed
10 Poverty level pregnant women (1902(a)(10)(A)(i)(IV)) (1902(l)(1)(A))	Some Listed
11 Poverty level infants (1902(a)(10)(A)(i)(IV)) (1902(l)(1)(B))	Some Listed
12 Qualified family members (1902(a)(10)(A)(i)(V)) (1905(m)(1))	Some Listed
13 Poverty level children under age six (1902(a)(10)(i)(VI)) (1902(l)(1)(C))	Some Listed
14 Poverty level children under age 19, who are born after September 30, 1983 (or, at State option, after any earlier date) (1902(a)(10)(i)(VII)) (1902(l)(1)(D))	Some Listed
15 Disabled individuals whose earnings exceed SSI substantial gainful activity level (1619(a))	Some Listed
16 Disabled individuals whose earnings are too high to receive SSI cash benefits (1619b))	Some Listed
17 Disabled individuals whose earnings are too high to receive SSI cash benefits (1902(a)(10)(i)(II)) (1905(q))	Some Listed
18 Pickle amendment: individuals who would be eligible for SSI if Title II COLAs were deducted from income (section 503 of P.L. 94-566) (1935(a)(5)(E))	Some Listed
19 Disabled widows and widowers (1634(b)) (1935 (a)(2)(C))	Some Listed
20 Disabled adult children (1634(c)) (1935(a)(2)(D))	Some Listed
21 Early widows/widowers (1634(d)) (1935)	Some Listed
22 Individuals who would be eligible for AFDC except for increased OASDI income under P.L. 92-336 (July 1, 1972) (42 CFR 435.114)	Some Listed
23 Individuals receiving mandatory State supplements (42 CFR 435.130)	Some Listed
24 Individuals eligible as essential spouses in December 1973 (42 CFR 435.131)	Some Listed
25 Institutionalized individuals who were eligible in December 1973 (42 CFR 435.132)	Some Listed
26 Blind and disabled individuals eligible in December 1973 (42 CFR 435.133)	Some Listed
27 Individuals who would be eligible except for the increase in OASDI benefits under Pubic Law 92-336 (42 CFR 435.134)	Some Listed
28 Individuals who become eligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977 (42 CFR 435.135)	Some Listed
29 Individuals who would be eligible except for the increase in OASDI benefits under Pubic Law 92-336 (42 CFR 435.134)	Some Listed
30 Individuals who become eligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977 (42 CFR 435.135)	Some Listed

Mandatory Medically Needed	
31 Individuals under 18 who would be mandatorially categorically eligible except for income and resources (1902(a)(10)(C)(ii)(I))	Some Listed
32 Pregnant women who would be categorically eligible except for income and resources (1902(a)(10)(C)(ii)(II))	Some Listed
33 Newborns, except for income and resources would be eligible as categorically needy, for one year as long as mother remains eligible or would if pregnant (1902(a)(10)(C)) (1902(e)(4))	Some Listed
34 Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post partum services (1902(a)(10)(C)) (1905(e)(5))	Some Listed
35 Blind and disabled individuals eligible in December 1973 (42 CFR 435.340)	Some Listed
Mandatory Special Coverage Groups	
36 Newborns deemed eligible for one year as long as mother remains eligible or would remain eligible if pregnant (1902(e)(4))	Some Listed
37 Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post partum services (1902(e)(5))	Pregnancy/Post Partum Svcs
38 Pregnant women losing eligibility because of a change in income remain eligible 60 days post partum (1902(a)(10)(A)(i)(IV)) (1902(e)(6))	Some Listed
39 Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay (1902(e)(7))	Some Listed
40 Qualified Medicare Beneficiaries (QMBs) (1902(a)(10)(E)(i) (1905(p)(1))	Part A/B, Coinsurance/Deductible
41 Qualified disabled and working individuals (1902(a)(10)(E)(ii) (1905(s))	Part A
42 Specified Low-Income Medicare Beneficiaries (SLMBs) (1902(a)(10)(E)(iii))	Part B
43 Qualifying individuals (1902(a)(10)(E)(iv)(I))	Part B

For a complete list of covered services refer to the State Plan. The following are some of the covered services.

Covered Services (subject to medical necessity determination)

- ✓ Ambulance
- ✓ Case management/targeted case management
- ✓ Clinic services (psychotherapy, group therapy, day hospital, chemotherapy, diagnosis and evaluation, emergency care)
- ✓ CMHC
- ✓ Day health rehabilitation
- ✓ Dental (subject to limitations for adults)
- ✓ Developmental Therapy
- ✓ EPSDT services for individuals under 21
- ✓ Extended services for pregnant women for a 60-day post partum
- ✓ Eyeglasses (for children under 21)
- ✓ Family Planning
- ✓ Hi-Tech Nursing
- ✓ Home health for those entitled to NF services
- ✓ Hospice
- ✓ ICF/MR
- ✓ IMD services (age 65 and over)

- ✓ Inpatient hospital
- ✓ Inpatient psychiatric under 22 years of age
- ✓ Laboratory/X-Ray
- ✓ Licensed Clinical Social Worker
- ✓ Medical and surgical services of a dentist
- ✓ Nurse and lay midwife services
- ✓ Nursing facility
- ✓ Optician
- ✓ Optometry
- ✓ Organ transplants
- ✓ Outpatient hospital
- ✓ Pediatric/Family Nurse Practitioner
- ✓ Personal care for children under 21
- ✓ Physician services
- ✓ PNMI (*child care services, assistive community care services, therapeutic substance abuse treatment*)
- ✓ Podiatry
- ✓ Prescription drugs
- ✓ Preventive/screening/diagnostic services
- ✓ Primary care case management
- ✓ Private duty nursing (EPSDT only)
- ✓ Prosthetic devices
- ✓ Psychologist
- ✓ PT/OT/Speech-Language Therapy
- ✓ Respiratory care
- ✓ RHC/FQHC
- ✓ School-based services (children only)
- ✓ Substance abuse
- ✓ Transportation

Vermont Optional Populations and Services

AID GROUP	SERVICES (SEE LIST BELOW)
Optional Categorically Needy	
1 Individuals who are eligible for but not receiving IV-A, SSI or State supplement cash assistance (1902)(a)(10)(A)(ii)(I))	Some Listed
2 Individuals who could be eligible for IV-A cash assistance if State did not subsidize child care (1902)(a)(10)(A)(ii)(II))	Some Listed
3 Individuals who are eligible for Title IV-A if State AFDC plan were as broad as allowed (1902)(a)(10)(A)(ii)(III))	Some Listed
4 Individuals who would have been eligible for IV-A cash assistance, SSI, or State supplement if not in a medical institution (1902)(a)(10)(A)(ii)(IV))	Some Listed
5 <i>Special income level group</i> : individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard, or state-specified standard (1902)(a)(10)(A)(ii)(V))	Some Listed
6 Disabled children no longer eligible for SSI benefits because of a change in definition of disability (1902)(a)(10)(A)(i)(II))	Some Listed
7 Individuals who are terminally ill, would be eligible if they were in a medical institution, and will receive hospice care (1902)(a)(10)(A)(ii)(VII))	Some Listed
8 Children under 21 (or at State option 20, 19, or 18) who are under State adoption agreements (1902)(a)(10)(A)(ii)(VIII))	Some Listed
9 Poverty level pregnant women not mandatorially eligible (1902)(a)(10)(A)(ii)(IX)) (1902(l)(1)(A))	Some Listed
10 Poverty level infants not mandatorially eligible (1902)(a)(10)(A)(ii)(IX)) (1902(l)(1)(B))	Some Listed
11 Poverty level children under six years not mandatorially eligible (1902)(a)(10)(A)(ii)(IX)) (1902(l)(1)(C))	Some Listed
12 poverty level children under 19, who are born after September 30, 1983 not mandatorially eligible (1902)(a)(10)(A)(ii)(IX)) (1902(l)(1)(D))	Some Listed
13 Individuals receiving only an optional State supp. payment more restrictive than the criteria for an optional State supplement under title XVI (1902)(a)(10)(A)(ii)(XI))	Some Listed
14 Katie Beckett children (1902)(e)(3))	Some Listed
15 Uninsured women, under 65, who are screened for breast or cervical cancer under CDC program (1902)(a)(10)(A)(ii)(XVIII))	Some Listed
16 Individuals receiving HCBS who would only be eligible for Medicaid under the State Plan if they were in a medical institution (1902)(a)(10)(A)(ii)(VI))	Some Listed
Optional Medically Needy	
17 All individuals under 21 or at State option 20, 19, or 18 or reasonable classifications who would not be covered under mandatory medically needy group of individuals under 18 (1902)(a)(10)(C)) (1905)(a)(i))	Some Listed
18 Specified relatives of dependent children who are ineligible as categorically needy (42 CFR 435.301(b)(2)(ii)) (42 CFR 435.310)	Some Listed
19 Aged individuals who are ineligible as categorically needy (42 CFR 435.301(b)(2)(iii)) (42 CFR 435.320) (42 CFR 435.330)	Some Listed
20 Blind individuals who are ineligible as categorically needy but meet the categorically needy definition of blindness (42 CFR 435.301(b)(2)(iv))	Some Listed
21 Disabled individuals who are ineligible as categorically needy that meet the categorically needy definition of blindness (1902)(a)(10)(C))	Some Listed

For a complete list of covered services refer to the State Plan. The following are some of the covered services.

Covered Services (subject to medical necessity determination)

- ✓ Ambulance
- ✓ Case management/targeted case management
- ✓ Clinic services (*psychotherapy, group therapy, day hospital, chemotherapy, diagnosis and evaluation, emergency care*)

- ✓ CMHC
- ✓ Day health rehabilitation
- ✓ Dental (subject to limitations for adults)
- ✓ Developmental Therapy
- ✓ EPSDT services for individuals under 21
- ✓ Extended services for pregnant women for a 60-day post partum
- ✓ Eyeglasses (children only)
- ✓ Family Planning
- ✓ Hi-Tech Nursing
- ✓ Home health for those entitled to NF services
- ✓ Hospice
- ✓ ICF/MR
- ✓ IMD services (age 65 and over)
- ✓ Inpatient hospital
- ✓ Inpatient psychiatric
- ✓ Laboratory/X-Ray
- ✓ Licensed Clinical Social Worker
- ✓ Medical and surgical services of a dentist
- ✓ Nurse and lay midwife services
- ✓ Nursing facility
- ✓ Optician
- ✓ Optometry
- ✓ Organ transplants
- ✓ Outpatient hospital
- ✓ Pediatric/Family Nurse Practitioner
- ✓ Personal care (services for children under 21)
- ✓ Physician services
- ✓ PNMI (*child care services, assistive community care services, therapeutic substance abuse treatment*)
- ✓ Podiatry
- ✓ Prescription drugs
- ✓ Preventive/screening/diagnostic services
- ✓ Primary care case management
- ✓ Private duty nursing (EPSDT only)
- ✓ Prosthetic devices

- ✓ Psychologist
- ✓ PT/OT/Speech-Language Therapy
- ✓ Respiratory care
- ✓ RHC/FQHC
- ✓ School-based services (children only)
- ✓ Substance abuse
- ✓ Transportation

Demonstration Eligible Populations

AID GROUP	SERVICES
1915c Waivers	
1 TBI (Traumatic Brain Injury)	Crisis/support services, psychological and counseling supports, case management, community supports, habilitation, respite care, supported employment, environmental and assistive technology
2 MI under 22 (Children's Mental Health Waiver)	Service coordination, flexible support, skilled therapy services, environmental safety devices
3 MR/DD (Mental Retardation/Developmental Disabilities)	Case management, residential habilitation, day rehabilitation, supported employment, crisis services, clinical intervention, respite
VHAP Waivers	
1 Under-insured children with income between 225 and including 300 percent of FPL	All State Plan Services (see Mandatory/Optional Lists)
2 Adults with children with income between 150 and including 185 percent of the FPL	VHAP-Limited or PCPlus VHAP Benefit Package
3 Adults with income up to and including 150 percent of the FPL	VHAP-Limited or PCPlus VHAP Benefit Package
4 Medicare beneficiaries and individuals with disabilities with income at or below 150 percent of the FPL	Medicaid Prescriptions
5 Medicare beneficiaries and individuals with disabilities with income above 150 percent and less than 175 percent of the FPL	Maintenance Drugs
6 Individuals with persistent mental illness with income up to 150 percent of FPL	Day services, diagnosis and evaluation services, emergency care, psychotherapy, group therapy, chemotherapy, specialized rehabilitative services

Individuals who are eligible for prescription drug benefits under Medicare Part D (at such time that benefits are made available) shall be excluded from the VHAP waiver.

VHAP Benefit Package: Covered Services (subject to medical necessity determination)

- ✓ MI under 22 (Children's Mental Health Waiver)
- ✓ MR/DD (Mental Retardation/Developmental Disabilities)
- ✓ CMHC
- ✓ Family Planning
- ✓ Hospice
- ✓ Inpatient hospital (urgent and emergent admissions)
- ✓ Inpatient psychiatric in an IMD (30 days per episode; 60 days per calendar year)
- ✓ Laboratory/X-Ray
- ✓ Licensed Clinical Social Worker
- ✓ Licensed Marital Counselor/Marriage and Family Therapy
- ✓ Medical and surgical services of a dentist
- ✓ Nurse and lay midwife services
- ✓ Nursing facility (30 days per episode)
- ✓ Organ transplants
- ✓ Outpatient hospital
- ✓ Pediatric/Family Nurse Practitioner
- ✓ Physician services
- ✓ Podiatry
- ✓ Prescription drugs (OTCs for PCPlus VHAP only)
- ✓ Primary care case management (PCPlus VHAP only)
- ✓ Prosthetic devices (PCPlus VHAP only)
- ✓ Psychologist
- ✓ PT/OT/Speech-Language Therapy
- ✓ Respiratory care (PCPlus VHAP only)
- ✓ RHC/FQHC
- ✓ Substance abuse

29. **Optional and Expansion Eligibility Groups Expenditure and Enrollment Cap.** The State is not obligated under this demonstration to extend eligibility to population groups listed above as optional or expansion populations, but may do so. The State must seek approval to modify program eligibility via the waiver amendment process, as described in numbers 6 and 7 of section II “General Program Requirements.” Regardless of any extension of eligibility, the State will be limited to Federal funding reflected in the budget neutrality requirements set forth in these STCs.

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

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

VI. COST SHARING

31. **Premiums and Co-Payments.** The State agrees to maintain the State plan co-payments and premium provisions for the mandatory population. The State agrees that cost sharing for optional and expansion children eligible for Medicaid shall not exceed 5 percent of the family’s gross income.

**Premium & Co-Payment Requirements by Population for
October 1, 2005-September 30, 2006.**

Population	Premiums	Deductibles	Co-Payments
Children			
Dr. Dynasaur 100-185% FPL ¹	\$0/month		
Dr. Dynasaur 186-225% FPL	\$30/month		
Underinsured 226-300% FPL	\$40/month		
Adults			
VHAP 50-75% FPL	\$11/month		
VHAP 76-100% FPL	\$39/month		\$25-ER
VHAP 101-150% FPL	\$50/month		No charge if
VHAP 150-185% FPL	\$75/month		admitted

Note. Approved premiums and co-payments will be included in the annual report.

¹ This does not include Mandatory Medicaid eligibles

VI. DELIVERY SYSTEMS

32. **Health Plans.** The Vermont AHS will contract with the OVHA as a public MCO, on a capitated basis, for the delivery of all Medicaid-eligible services. The OVHA must be authorized by State statute and must adhere to Federal regulations at 42 CFR section 438.
33. **Limitation of Freedom of Choice.** Freedom of choice shall be limited for the managed care entity. However, populations enrolled in the Global Commitment to Health shall have freedom of choice when selecting participating Medicaid MCO providers.
34. **Contracts.** The AHS will be responsible for oversight of the public MCO, ensuring compliance with State and Federal statutes, regulations, special terms and conditions, waiver, and cost not otherwise matchable authority.

To further clarify the MCO requirements published in Federal regulations at 42 CFR section 438, the actuary shall not be employed by the State for purposes of certifying actuarially sound rates.

Procurement, and the subsequent final contracts developed to implement selective contracting by the State with any provider group, shall be subject to CMS regional office approval prior to implementation.

In the future should OVHA contract with a behavioral health organization (BHO) to cover individuals previously served at the Vermont State hospital (VSH), then the aggregate cap at the time of the BHO implementation would need to be adjusted to reflect the current alternative costs to VSH under the aggregate cap.

35. **Contracting with Federally Qualified Health Centers (FQHCs).** The State shall maintain its existing agreements with FQHCs and rural health centers.
36. **Data Sharing.** The MCO as a State agency may share enrollee data with other State agencies if the use or release of such data is for a purpose directly connected with administration of the plan as defined in Federal regulations at 42 CFR 431.302. The MCO is authorized to use or release de-identified data, as defined in Federal privacy regulations, to enable participation in statewide program studies. As a purpose directly connected with plan administration, the MCO is permitted to release enrollee-specific information to providers in order to enable the provider to seek payment for services rendered under the plan. Any other release of enrollee-specific information for a purpose not directly connected with plan administration is prohibited. Consent of the enrollee is required whenever release of enrollee information for a purpose directly connected with plan administration is sought by an outside source, except in an emergency. Release under these conditions is defined in Federal regulations at 42 CFR section 431.306(d).

VII. EVALUATION

37. **Submission of Draft Evaluation Design.** The State shall submit to CMS for approval, within 120 days from the award of the demonstration, a draft evaluation design. At a minimum, the draft design shall include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target population and capitated revenue expenditures for the demonstration. The draft design shall discuss the outcome measures that shall be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design shall identify whether the State shall conduct the evaluation, or select an outside contractor for the evaluation.
38. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft design within 60 days of receipt, and the State shall submit a final design within 60 days of receipt of CMS' comments. The State shall implement the evaluation design, and as stated in section III, "General Reporting Requirements," submit its progress in the quarterly reports. The State shall submit to CMS a draft of the evaluation report 120 days after the expiration of the current demonstration period (September 30, 2010). CMS shall provide comments within 60 days of receipt of the report. The State shall submit the final evaluation report for this demonstration period by May 31, 2011.
39. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the Demonstration, the State must fully cooperate with Federal evaluators', and their contractors', efforts to conduct an independent federally funded evaluation of the Demonstration.

VIII. CAPITATED REVENUE

40. **Purposes for Capitated Revenue Expenditures.** Provided that OVHA's contractual obligation to the populations covered under the Demonstration is met, any revenue from capitation payments related to the beneficiaries covered under this demonstration may only be used for the following purposes:
- Reduce the rate of uninsured and/or underinsured in Vermont;
 - Increase the access of quality health care to uninsured, underinsured, and Medicaid beneficiaries;
 - Provide public health approaches to improve the health outcomes and the quality of life for Medicaid-eligible individuals in Vermont; and
 - Encourage the formation and maintenance of public-private partnerships in health care.
41. **Reporting Capitated Revenue Expenditures.** As described in section III, "General Reporting Requirements," the State shall include in the quarterly and annual report a section on how capitated revenue was spent.

IX. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

42. **Changes Resulting from Implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).** CMS has used trend rates from the President's Budget for 2006 that fully account for Part D adjustment for budget neutrality. Federal funds are not available as of January 1, 2006, for drugs covered by the Medicare Prescription Drug Program for any Part D-eligible individual or for any cost sharing for such drugs.
43. **Quarterly Expenditure Reports.** The State shall provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in section X (Monitoring Budget Neutrality for the Demonstration).
44. **Reporting Expenditures Subject to the Budget Neutrality Cap.** The following describes the reporting of expenditures subject to the budget neutrality cap:
 - a) In order to track expenditures under this Demonstration, Vermont shall report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System, following routine from CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap shall be reported on separate forms CMS-64.9 waiver and/or 64.9P waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which service or capitation payments were made). Corrections for any incorrectly reported demonstration expenditures for previous demonstration years must be submitted within 3 months of the beginning of the demonstration. For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 44.c.
 - b) For each demonstration year at least seven separate form CMS-64.9 waiver and/or 64.9P waiver reports must be submitted reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for Demonstration eligibles must be reported. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 44.c.). The Vermont Global Medicaid eligibility groups, for reporting purposes, include the following names and definitions:

- ABD – report expenditures for individuals eligible as aged, blind, or disabled under the State plan;
 - ANFC – report the expenditures for all non-ABD children and adults in State plan mandatory and optional categories;
 - Optional Expansions – report all expenditures for individuals eligible as children or adults through optional expansions under VT Global;
 - VT Global Expansion - report all expenditures for individuals eligible as non-categorical health care expansions through VT Global (previously VHAP expansion);
 - Administrative expenditures;
 - VT Global Rx - report all expenditures for individuals eligible as pharmacy-only expansions through VT Global (previously VHAP Rx); and
 - CRT Group - report expenditures for individuals receiving CRT services. This includes CRT expenditures for participants with severe, persistent mental illness covered under the Long-Term Care Plan 1115 demonstration.
- c) For purposes of this section, the term “expenditures subject to the budget neutrality cap” shall include all Medicaid expenditures on behalf of the individuals who are enrolled in this Demonstration (as described in item 44.b.of this section) and who are receiving the services subject to the budget neutrality cap. All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and shall be reported on forms CMS-64.9 waiver and/or 64.9P waiver.
- d) Premiums and other applicable cost-sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration shall be reported to CMS on form CMS-64.9 waiver, Line 18.E. in order to ensure that the Demonstration is properly credited with premium collections.
- e) Administrative costs shall be included in the budget neutrality limit. Vermont will not be at risk for expenditures related to systems enhancements, including any new procurements related to claims processing, program management, and eligibility. All administrative costs shall be identified on the forms CMS-64.10 waiver and/or 64.10P waiver.
- f) All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

45. **Reporting Member Months.** The following describes the reporting of member months subject to the budget neutrality cap:

- a) The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member/months to the total. Two individuals, who are eligible for 2 months, each contributes 2 eligible member months to the total, for a total of 4 eligible member/months.
- b) The term "demonstration eligibles" excludes unqualified aliens, and refers to the following categories of enrollees:
 - ABD – report expenditures for individuals eligible as aged, blind, or disabled under the State plan;
 - ANFC – report the expenditures for all non-ABD children and adults in State plan mandatory and optional categories;
 - Optional Expansions – report all expenditures for individuals eligible as children or adults through optional expansions under VT Global;
 - VT Global Expansion - report all expenditures for individuals eligible as non-categorical health care expansions through VT Global (previously VHAP expansion);
 - Administrative expenditures;
 - VT Global Rx - report all expenditures for individuals eligible as pharmacy-only expansions through VT Global (previously VHAP Rx); and
 - CRT Group - report expenditures for individuals receiving CRT services includes CRT expenditures for participants with severe, persistent mental illness covered under the Long-Term Care Plan 1115 demonstration.
- c) For the purpose of monitoring the budget neutrality expenditure cap described in Section X, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the Demonstration eligibles as defined above. This information should be provided to CMS in conjunction with the quarterly progress report referred to in number 25 of section III. If a quarter overlaps the end of 1 demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.)

46. **Standard Medicaid Funding Process.** The standard Medicaid funding process shall be used during the demonstration. Vermont must estimate matchable Medicaid expenditures on the quarterly form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year (FFY) on the form CMS-37.12 for both the medical assistance program and administrative costs. CMS shall make Federal funds available based upon the State's estimate, as approved by CMS.

Within 30 days after the end of each quarter, the State must submit the form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

47. **Non-Federal Share of Funding Conditions.** Subject to CMS' approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in section X:
 - a) Administrative costs, including those associated with the administration of the Demonstration;
 - b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan;
 - c) Net medical assistance expenditures made with dates of payment during the operation of the Demonstration.

48. **State Certification of Funding.** The State shall certify State/local monies used as matching funds for the Demonstration, and shall further certify that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of the non-Federal share of funding and distribution of monies involving Federal match are subject to CMS' approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

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

X. MONITORING BUDGET NEUTRALITY

The following describes the method by which budget neutrality will be assured under the Demonstration. The Demonstration will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. The STCs specify the aggregate financial cap on the amount of Federal title XIX funding that the State may receive on expenditures subject to the budget neutrality cap as defined in 44.c. of section IX of this document. The budget neutrality cap will be for the Federal share of the total computable cost of \$4.7 billion for the 5-year demonstration. The cap places the State at risk for enrollment and for per participant per month cost trends.

50. **Impermissible DSH, Taxes or Donations.** The CMS reserves the right to adjust the budget neutrality ceiling in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or with policy interpretations implemented through letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.
51. **How the Limit will be Applied.** The limit calculated above will apply to actual expenditures for the Demonstration, as reported by the State under section IX. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

52. **Expenditure Review and Cumulative Target Calculation.** CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, they must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved corrective action plan.

<u>Year</u>	<u>Cumulative Target</u> (Total Computable Cost)	<u>Cumulative Target</u> <u>Definition</u>	<u>Percentage</u>
Year 1	\$1,015,000,000	Year 1 budget estimate plus	8 percent
Year 2	\$1,936,000,000	Years 1 and 2 combined budget estimate plus	3 percent
Year 3	\$2,848,000,000	Years 1 through 3 combined budget estimate plus	1 percent
Year 4	\$3,779,000,000	Years 1 through 4 combined budget estimate plus	0.5 percent
Year 5	\$4,700,000,000	Years 1 through 5 combined budget estimate plus	0 percent