

*Administrator*

Washington, DC 20201

OCT 31 2007

Ms. Cynthia D. LaWare
Secretary
Agency for Human Services
103 South Main Street
Waterbury, VT 05671-2301

Dear Ms. LaWare:

We are pleased to inform you that Vermont's September 11, 2006, employer sponsored insurance (ESI)/Catamount Health Program amendment application, has been approved. Under this approval, Vermont has the authority to provide premium assistance for adults with income up to 200 percent of the Federal poverty level (FPL). The Global Commitment continues as project number 11-W-00194/1 for a period of 5 years, beginning October 1, 2005, through September 30, 2010. This approval is under the authority of section 1115(a) of the Social Security Act.

Using a multi-disciplinary approach including the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, and flexibility under this demonstration, Vermont will continue to demonstrate its ability to promote universal access to health care, cost containment, and improved quality of care. Vermont will be required to conduct an evaluation of the impact of the demonstration program during the 5-year period.

The Centers for Medicare & Medicaid Services (CMS) is granting Vermont the authority to cover all adults with income up to 200 percent of the FPL, either through access to the current Vermont Health Access Plan (VHAP) or through premium assistance to purchase ESI or the Catamount Health Program. The approval of this demonstration does not include the State's proposal to expand premium assistance to individuals with income up to 300 percent of the FPL.

The existing expenditure authorities were updated to reflect the addition of five non-applicable sections of the statute: section 1902(a)(34) to enable the State to not provide retroactive eligibility for expansion populations, section 1902(a)(8) to enable the State to implement policies intended to reduce crowd out of private coverage, section 1902(a)(10)(B) to enable the State to offer different services to different expansion populations, section 1902(a)(14) to enable the State to impose premiums and other cost sharing requirements, and section 1902(a)(32) to enable Vermont to provide premium assistance to expansion populations for the purchase of employer-sponsored insurance.

Our approval of the Global Commitment to Health section 1115(a) demonstration, including the waivers and expenditures authorities provided thereunder, is conditioned upon compliance with the enclosed Special Terms and Conditions (STCs). All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the enclosed waiver and expenditure authority list, shall apply to the Global Commitment to Health demonstration. The award is subject to our receiving your written acceptance of the award within 30 days of the date of this letter.

On May 25, 2007, CMS placed a final rule, CMS-2258-FC (Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership), on display at the Office of the Federal Register. This rule, found at *72 Fed. Reg.* 29748 (May 29, 2007), would modify Medicaid reimbursement. Because of this regulation, some or all of the payments under this section of the STCs may no longer be allowable expenditures for Federal Medicaid matching funds. Public Law 110-28, enacted on May 25, 2007, instructed CMS to take no action to implement this final regulation for 1 year. CMS will abide by the time frames specified by the statute. These STCs do not relieve the State of its responsibility to comply with Federal laws and regulations, including the recent requirements related to children's health outlined in the August 17, 2007, State Health Official letter.

Your project officer is Ms. Jacqueline Roche. She is available to answer any questions concerning your section 1115 demonstration. Ms. Roche's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard
Mail stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-3420
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E-mail: jacqueline.roche@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Roche and to Mr. Richard McGreal, Acting Associate Regional Administrator in our Boston Regional Office.

Mr. McGreal's contact information is as follows:

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

If you have questions regarding this correspondence, please contact Ms. Jean Sheil, Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at (410) 786-5647.

We look forward to continuing to work with you and your staff on this significant health care reform demonstration.

Sincerely,



Kerry Weems
Acting Administrator

Enclosure

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cc: Richard McGreal, Acting ARA, Region I

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS
Amended October 2007**

NUMBER: 11-W-00194/1

TITLE: Global Commitment to Health Section 1115 Demonstration

AWARDEE: Vermont Agency of Human Services (AHS)

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Vermont Global Commitment to Health Section 1115(a) Medicaid Demonstration (hereinafter “Demonstration”). The parties to this agreement are the Agency of Human Services (State) and the Centers for Medicare & Medicaid Services (CMS). These terms and conditions have been modified to include an amendment Vermont submitted to CMS on September 11, 2006, which is annotated throughout. 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. The STCs are effective October 1, 2005, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration is approved from October 1, 2005, through September 30, 2010.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; General Reporting Requirements; Eligibility, Benefits, and Enrollment; Cost Sharing; Delivery Systems; General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; Capitated Revenue; and Schedule of State Deliverables for the Demonstration Period.

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

II. PROGRAM DESCRIPTION AND OBJECTIVES

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

In 2006, the State passed legislation regarding development of Catamount Health, a fully insured

product that will be available through private insurers in Vermont. The Catamount Health Assistance Program seeks to fill gaps in coverage for Vermonters by providing a health services delivery model for uninsured individuals.

In October 2007, a component of the Catamount program was added to the Demonstration. The offering consists of a premium subsidy to Vermonters who have been without health insurance coverage for a year or more, have income at or below 200 percent of the Federal poverty level (FPL), and who do not have access to cost effective employer-sponsored insurance as determined by the State.

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

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

The State will employ the following principles in achieving the above goals:

- Program Flexibility: Vermont has the flexibility to change benefits for the non-mandatory populations;
- Managed Care Delivery System: Under the Demonstration the AHS will contract with the Office of Vermont Health Access (OVHA), which will serve as a publicly sponsored managed care organization (MCO);
- Aggregate Budget Neutrality Cap: Vermont will be at risk for both the caseload and the per member per month Medicaid managed care payments, as well as certain administrative costs. Vermont will have to manage this program within a total computable aggregate cap of \$4.7 billion over the approved 5-year Demonstration period; and
- Premium assistance: Vermont seeks to increase access to affordable health care coverage by providing premium assistance to purchase private coverage via the Catamount Health Plan for the uninsured and by providing premium assistance to individuals with access to employer sponsored insurance (ESI).

III. 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, unless specified otherwise in the STCs, waiver list, or expenditure authorities or otherwise listed as non-

applicable, shall apply to the Demonstration.

3. **Compliance with the Deficit Reduction Act of 2005.** All applicable regulations and policies issued by CMS implementing the Deficit Reduction Act of 2005 (P.L. 109-171) DRA, including but not limited to the documentation of citizenship requirements set out at section 1903(x) of the Social Security Act (the Act) and the cost-sharing limitations in section 1916 of the Act, shall apply to the demonstration unless specified otherwise in these STCs.
4. **Changes in Medicaid Law, Regulation, and Policy.** The State shall, within the time frames specified in the applicable law, regulation, or policy directive, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid program that occur during this Demonstration approval period, unless the provision being changed is expressly waived.
5. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State shall adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration, as necessary, to comply with such change. The modified budget neutrality agreement would be effective upon the implementation of the change.
 - b) 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.
6. **State Plan Amendments.** The State shall not be required to submit title XIX State plan amendments for changes to Demonstration-eligible populations covered solely through the Demonstration. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required except as otherwise noted in these STCs. Reimbursement of providers by the MCO will not be limited to those described in the State plan.
7. **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 FFP may not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph eight, below.

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

Mandatory State Plan Eligibles. 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 Demonstrations 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 must 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. Should the State fail to notify within the time period or submit an amendment as requested, CMS has the right to withhold or disallow FFP.

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 eight below.

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

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

- b) A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level though the approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;
 - c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
 - d) If applicable, a description of how the evaluation design shall be modified to incorporate the amendment provisions.
9. **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.
10. **Extension of the Demonstration.** The following requirements will apply. The head of the single State agency must submit to CMS a written request to extend the demonstration at least 1 year prior to the expiration date of the current demonstration period. Since Vermont’s section 1115(a) demonstration expires on September 30, 2010, the extension request must be submitted no later than September 30, 2009. The State must also provide an interim evaluation report for the current period with the extension request pursuant to paragraph 54 of these STCs. Without the submission of a request to extend, Vermont must begin phase-down of the program 6 months prior to September 30, 2010.
11. **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 must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. 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 emergent 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.
12. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 10, during the last 6 months of the Demonstration, the enrollment of individuals who would not be eligible for Medicaid under the current Medicaid State plan shall not be permitted unless

the Demonstration is extended by CMS. Enrollment may be suspended if CMS notifies the State in writing that the demonstration will not be renewed.

13. **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.
14. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.
15. **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 is limited to normal closeout costs associated with terminating the demonstration, including services and administrative costs of disenrolling participants.
16. **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 requirements; and reporting on financial and other Demonstration components.
17. **Public Notice and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 FR 49249 (September 27, 1994) when any program changes to the Demonstration, including, but not limited to, those referenced in paragraph 6 are proposed by the State.
18. **Compliance with Managed Care Regulations.** The State must comply with the managed care regulations published at 42 CFR section 438 et. Seq., except as expressly identified as not applicable in the expenditure authorities incorporated into the STCs. Capitation rates must be developed and certified as actuarially sound in accordance with 42 CFR 438.6.
19. **Federal Funds Participation (FFP).** No Federal matching for expenditures for this Demonstration will take effect until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

The Global Demonstration includes four fundamental elements: program flexibility; a publicly sponsored managed care delivery system; an aggregate budget neutrality cap; and premium assistance. The State seeks to increase access to affordable health care coverage by enhancing private coverage via the Catamount Health Plan for the uninsured, providing premium assistance

to individuals with access to employer sponsored insurance (ESI) and by improving outreach to the uninsured.

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

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

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 7 and 8 under section II, General Program Requirements.

To be eligible for premium assistance, adults not otherwise eligible for OVHA programs must have been uninsured for at least 12 months, unless they lost coverage due to one of the following reasons: loss of employment; death of the principal insurance policyholder; divorce or dissolution of a civil union; no longer qualified as a dependent under the plan of a parent or caretaker relative; no longer qualifying for COBRA, VIPER, or other state continuation coverage; or a college-sponsored insurance plan became unavailable because the individual graduated, took a leave of absence, or otherwise terminated studies. The state intends to permit insurers to deny Catamount Health coverage to workers whose employer drops coverage solely for the purpose of enabling employees to enroll in Catamount.

The general categories of populations eligible under the Demonstration are:

Traditional Medicaid-eligible Populations

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

Vermont Health Access Plan (VHAP) Expansion Populations

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

- Demonstration Population 4:** Adults with children with income between 150 and including 185 percent of FPL
- Demonstration Population 5:** Childless Adults with income up to and including 150 percent of FPL
- Demonstration Population 6:** Medicare beneficiaries with income at or below 150 percent of the FPL, not otherwise categorically eligible
- Demonstration Population 7:** Medicare beneficiaries with income above 150 percent and less than 200 percent of FPL, not otherwise categorically eligible
- Demonstration Population 8:** Individuals with persistent mental illness with income up to 150 percent of FPL

Premium Assistance Expansion Populations

- Demonstration Population 9:** ESI Premium Assistance
- a. Adults with children with incomes between 185 and including 200 percent of the FPL
 - b. Childless adults and non custodial parents with income between 150 and including 200 percent of the FPL
- Demonstration Population 10:** Catamount Premium Assistance
- a. Adults with children with incomes between 185 and including 200 percent of the FPL
 - b. Childless adults and non custodial parents with income between 150 and including 200 percent of the FPL

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

Population Description	Statutory/Regulatory Citations	Standards and Methodologies	Benefit Package
Title XIX State Plan Groups			
Mandatory Categorically Needy (Demonstration Population 1)			
Section 1931 low-income families with children	§1902(a)(10)(A)(i)(I) §1931	AFDC standard and methodologies	Medicaid State plan benefit package
Children receiving IV-E payments (IV-E foster care or adoption assistance)	§1902(a)(10)(i)(I)	AFDC standard and methodologies	Medicaid State plan benefit package
Individuals who lose eligibility under §1931 due to employment	§1902(a)(10)(A)(i)(I) §402(a)(37) §1925	AFDC standard and methodologies	Medicaid State plan benefit package

Individuals who lose eligibility under §1931 because of child or spousal support	§1902(a)(10)(A)(i)(I) §406(h)	AFDC standard and methodologies	Medicaid State plan benefit package
Individuals participating in a work supplementation program who would otherwise be eligible under §1931	§1931 §1902(a)(10)(A)(i)(I) §482(e)(6)	AFDC standard and methodologies	Medicaid State plan benefit package
Individuals receiving SSI cash benefits	§1902(a)(10)(A)(i)(I)	SSI standard and methodologies	Medicaid State plan benefit package
Disabled children no longer eligible for SSI benefits because of a change in definition of disability	§1902(a)(10)(A)(i)(II)(aa)	SSI standard and methodologies	Medicaid State plan benefit package
Qualified severely impaired individuals (as defined in §1905(q))	§1902(a)(10)(A)(i)(II)(bb) §1905(q)	SSI standard and methodologies	Medicaid State plan benefit package
Individuals under age 21 eligible for Medicaid in the month they apply for SSI	§1902(a)(10)(A)(i)(II)(cc)	SSI standard and methodologies	Medicaid State plan benefit package
Qualified pregnant women	§1902(a)(10)(A)(i)(III) §1905(n)(1)	AFDC standard and methodologies	Medicaid State plan benefit package
Qualified children	§1902(a)(10)(A)(i)(III) §1905(n)(2)	AFDC standard and methodologies	Medicaid State plan benefit package
Poverty level pregnant women	§1902(a)(10)(A)(i)(IV) §1902(l)(1)(A)	Income less than or equal to 185 percent of the FPL	Medicaid State plan benefit package
Poverty level infants	§1902(a)(10)(A)(i)(IV) §1902(l)(1)(B)	Income less than or equal to 185 percent of the FPL	Medicaid State plan benefit package
Qualified family members	§1902(a)(10)(A)(i)(V) §1905(m)(1)	AFDC standard and methodologies	Medicaid State plan benefit package
Poverty level children under age six	§1902(a)(10)(A)(i)(VI) §1902(l)(1)(C)	Family income less than or equal to 133 percent of FPL	Medicaid State plan benefit package
Poverty level children under age 19, who are born after September 30, 1983 (or, at State option, after any earlier date)	§1902(a)(10)(A)(i)(VII) §1902(l)(1)(D)	Family income less than or equal to 100 percent of FPL	Medicaid State plan benefit package
Disabled individuals whose earnings exceed SSI substantial gainful activity level	§1619(a)	SSI standard and methodologies	Medicaid State plan benefit package
Disabled individuals whose earnings are too high to receive SSI cash benefits	§1619(b)	SSI standard and methodologies	Medicaid State plan benefit package
Pickle amendment:	§1939(a)(5)(E)	SSI standard and	Medicaid State plan

individuals who would be eligible for SSI if Title II COLAs were deducted from income (§503 of Public Law 94-566)		methodologies	benefit package
Disabled widows and widowers	§1634(b) §1939(a)(2)(C)	SSI standard and methodologies	Medicaid State plan benefit package
Disabled adult children	§1634(c) §1939(a)(2)(D)	SSI standard and methodologies	Medicaid State plan benefit package
Early widows/widowers	§1634(d) §1939(a)(2)(E)	SSI standard and methodologies	Medicaid State plan benefit package
Individuals who would be eligible for AFDC except for increased OASDI income under P.L. 92-336 (July 1, 1972)	42 CFR 435.114	AFDC standards and methodologies	Medicaid State plan benefit package
Individuals receiving mandatory State supplements	42 CFR 435.130	SSI standard and methodologies	Medicaid State plan benefit package
Individuals eligible as essential spouses in December 1973	42 CFR 435.131	SSI standard and methodologies	Medicaid State plan benefit package
Institutionalized individuals who were eligible in December 1973	42 CFR 435.132	SSI standard and methodologies	Medicaid State plan benefit package
Blind and disabled individuals eligible in December 1973	42 CFR 435.133	SSI standard and methodologies	Medicaid State plan benefit package
Individuals who would be eligible except for the increase in OASDI benefits under Pubic Law 92-336	42 CFR 435.134	SSI standard and methodologies	Medicaid State plan benefit package
Individuals who become eligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977	42 CFR 435.135	SSI standard and methodologies	Medicaid State plan benefit package
Individuals who become eligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977	42 CFR 435.135	SSI standard and methodologies	Medicaid State plan benefit package
Newborns deemed eligible for one year as long as mother remains eligible or would remain eligible if pregnant	§1902(e)(4)		Medicaid State plan benefit package

Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post partum services	§1902(e)(5)		Pregnancy related and post partum services under the State plan
Pregnant women losing eligibility because of a change in income remain eligible 60 days post partum	§1902(a)(10)(A)(i)(IV) §1902(e)(6)		Pregnancy related and post partum services under the State plan
Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay	§1902(e)(7)		Inpatient hospital services
Qualified Medicare Beneficiaries (QMBs)	§1902(a)(10)(E)(i) §1905(p)(1)	Medicare beneficiaries with income equal to 100 percent of the FPL	Payment of Medicare premiums, coinsurance, deductibles, and copayment except Part D copayment
Qualified disabled and working individuals	§1902(a)(10)(E)(ii) §1905(s)	Medicare beneficiaries with income equal to 200 percent of the FPL and not eligible for Medicaid	Payment of Medicare Part A premiums
Specified Low-Income Medicare Beneficiaries (SLMBs)	§1902(a)(10)(E)(iii)	Medicare beneficiaries with income between 100 and 120 percent of the FPL	Payment of Medicare Part B premiums
Qualifying individuals	§1902(a)(10)(E)(iv)	Medicare beneficiaries with income equal to 120 percent but less than 135 percent of the FPL and not eligible for Medicaid	Payment of Medicare Part B premiums

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

Optional Categorically Needy (Demonstration Population 2)			
Individuals who are eligible for but not receiving IV-A, SSI or State supplement cash assistance	§1902(a)(10)(A)(ii)(I)		Medicaid State plan benefit package
Individuals who could be eligible for IV-A cash assistance if State did not subsidize child care	§1902(a)(10)(A)(ii)(II)		Medicaid State plan benefit package

Individuals who are eligible for Title IV-A if State AFDC plan were as broad as allowed	§1902(a)(10)(A)(ii)(II)		Medicaid State plan benefit package
Individuals who would have been eligible for IV-A cash assistance, SSI, or State supplement if not in a medical institution	§1902(a)(10)(A)(ii)(IV)		Medicaid State plan benefit package
<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)		Medicaid State plan benefit package
Individuals who are terminally ill, would be eligible if they were in a medical institution, and will receive hospice care	§1902(a)(10)(A)(ii)(VII)		Medicaid State plan benefit package
Children under 21 (or at State option 20, 19, or 18) who are under State adoption agreements	§1902(a)(10)(A)(ii)(VIII)		Medicaid State plan benefit package
Poverty level pregnant women not mandatorially eligible	§1902(a)(10)(A)(ii)(IX) §1902(l)(1)(A)		Medicaid State plan benefit package
Poverty level infants not mandatorially eligible	§1902(a)(10)(A)(ii)(IX) §1902(l)(1)(B)		Medicaid State plan benefit package
Poverty level children under six years not mandatorially eligible	§1902(a)(10)(A)(ii)(IX) §1902(l)(1)(C)		Medicaid State plan benefit package
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)		Medicaid State plan benefit package
Individuals receiving only an optional State supp. payment more restrictive than the criteria for an optional State supplement under title XVI	§1902(a)(10)(A)(ii)(XI)		Medicaid State plan benefit package
Katie Beckett children	§1902(e)(3)		Medicaid State plan benefit package

Uninsured women, under 65, who are screened for breast or cervical cancer under CDC program	§1902(a)(10)(A)(ii)(XVIII)	No income or asset test; must not have creditable coverage, not eligible for Medicaid under any other group, in need of active treatment,	Medicaid State plan benefit package
Individuals receiving HCBS who would only be eligible for Medicaid under the State Plan if they were in a medical institution; individuals who were previously covered under a separate 1915(c) demonstration. <ul style="list-style-type: none"> • TBI (traumatic brain injury) • MI under 22 (Children's mental Health) • MR/DD (Mental Retardation/Developmental Disabilities) 	§1902(a)(10)(A)(ii)(VI)		Medicaid State plan benefit package along with HCBS
Individuals under 18 who would be mandatorially categorically eligible except for income and resources	§1902(a)(10)(C)(ii)(I)		Medicaid State plan benefit package
Pregnant women who would be categorically eligible except for income and resources	§1902(a)(10)(C)(ii)(II)		Pregnancy-related and Post-Partum Services under the State plan
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)		Medicaid State plan benefit package
Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post partum services	§1902(a)(10)(C) §1905(e)(5)		Medicaid State plan benefit package
Blind and disabled individuals eligible in December 1973	42 CFR 435.340		Medicaid State plan benefit package

All individuals under 21 or at State option 20, 19, or 18 or reasonable classifications who would not be covered under mandatory medically needy group of individuals under 18	§1902(a)(10)(C) §1905(a)(i)		Medicaid State plan benefit package
Specified relatives of dependent children who are ineligible as categorically needy	42 CFR 435.301(b)(2)(ii) 42 CFR 435.310		Medicaid State plan benefit package
Aged individuals who are ineligible as categorically needy	1902(a)(10)(c) 42 CFR 435.301(b)(2)(iii) 42 CFR 435.320 42 CFR 435.330		Medicaid State plan benefit package
Blind individuals who are ineligible as categorically needy but meet the categorically needy definition of blindness	1902(a)(10)(c) 42 CFR 435.301(b)(2)(iv)		Medicaid State plan benefit package
Disabled individuals who are ineligible as categorically needy that meet the categorically needy definition of blindness	§1902(a)(10)(C)		Medicaid State plan benefit package

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

Expansion Populations			
VHAP Populations			
(Demonstration Populations 3-8)			
Underinsured children with income between 225 and including 300 percent of FPL who are not eligible for Medicaid or SCHIP		children with income between 225 and including 300 percent of FPL	Same as Medicaid State plan benefit package
Adults with children with income between 150 and including 185 percent of the FPL		income between 150 and including 185 percent of the FPL	VHAP Limited/VHAP PC Plus*
Adults with income up to and including 150 percent of the FPL		income up to and including 150 percent of the FPL	VHAP Limited/VHAP PCPlus
Medicare beneficiaries with income at or below 150 percent of the FPL		income at or below 150 percent of the FPL	Medicaid Prescriptions, eyeglasses and related eye exams

Medicare beneficiaries with income above 150 percent and less than 200 percent of the FPL		income below 175 percent of the FPL	Maintenance Drugs
Individuals with persistent mental illness with income up to 150 percent of FPL		income up to 150 percent of FPL	Day services, diagnosis and evaluation services, emergency care, psychotherapy, group therapy, chemotherapy, specialized rehabilitative services
Premium Assistance Populations** (Demonstration Population 9 and 10)			
ESI Premium Assistance			
Adults with children with income between 185 and including 200 percent of the FPL		Income between 185 percent and including 200 percent of FPL	Premium assistance to purchase ESI
Childless adults with income between 150 and including 200 percent of the FPL		Income between 150 percent and 200 percent of FPL	Premium assistance to purchase ESI
Catamount Premium Assistance			
Adults with children with income between 185 and including 200 percent of the FPL		Income between 185 percent and including 200 percent of FPL	Premium assistance to purchase the Catamount Health
Childless adults with income between 150 and including 200 percent of the FPL		Income between 150 percent and 200 percent of FPL	Premium assistance to purchase Catamount Health

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

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

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

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

Individuals covered under the Vermont section 1115 Long Term Care Demonstration not receiving CRT services
Unqualified aliens, both documented and undocumented
SCHIP eligibles

21. 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 paragraphs 6, 7, and 8 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 mandatory populations over optional populations, and last priority will be given to expansion populations.

22. Benefits

All covered services are subject to medical necessity review. A complete listings of covered services and limitations are contained in the Vermont approved title XIX State plan, Vermont statutes, regulations, and policies and procedures. The State has the authority to change the benefit package for the non-mandatory eligible populations without amendment per STC paragraph 6.

Services	State Plan	VHAP PC Plus (full VHAP Benefits package)	Limitations
Inpatient Hospital Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan VHAP: Urgent and emergent admissions only

Outpatient Hospital Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan VHAP: any limitations defined in Vermont rules and/or policies
FQHC/RHC including ambulatory services offered by FQHCs	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan VHAP: any limitations defined in Vermont rules and/or policies
Laboratory/X-ray Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan VHAP: any limitations defined in Vermont rules and/or policies
Nursing Facilities Services for Individuals 21 Years or Older	X		State plan: any limitations on this service are described in the approved Title XIX State plan
EDSPT for Individuals Under 21	X		State plan: any limitations on this service are described in the approved Title XIX State plan
Family Planning Services and Supplies	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan
Physician Services and Medical and Surgical Services of a Dentist	X	X	State plan: any limitations on this service is described in the approved Title XIX State plan
Home Health Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan VHAP: any limitations defined in Vermont rules and/or policies
Nurse Midwife Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan State plan: any limitations on this service are described in the approved Title XIX State plan VHAP: any limitations defined in Vermont rules and/or policies
Pediatric/Family Nurse Practitioner	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan VHAP: any limitations defined in Vermont rules and/or policies

Other Medical/Remedial Care Provided by Licensed Practitioners and Recognized under State Law (podiatrist, optometrist, chiropractor, licensed clinical social worker, licensed mental counselor or licensed marriage and family therapist, psychologist, optician, hi-tech nursing, nurse practitioner, licensed lay midwife, chiropractor)	X	X	State plan: Chiropractic services are not covered. State plan: any limitations on this service are described in the approved Title XIX State plan VHAP: chiropractor services not covered; any limitations defined in Vermont rules and/or policies
Clinic Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan VHAP: any limitations defined in Vermont rules and/or policies
Prescribed Drugs	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan VHAP: any limitations defined in Vermont rules and/or policies
Diagnostic, Screening, Preventive, and Rehabilitative Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan VHAP: any limitations defined in Vermont rules and/or policies
Private Duty Nursing Services	X		State plan: any limitations on this service are described in the approved Title XIX State plan
Eyeglasses	X		State plan: any limitations on this service are described in the approved Title XIX State plan
Dental Services	X		State plan: any limitations on this service are described in the approved Title XIX State plan
Prosthetic Devices	X		State plan: any limitations on this service are described in the approved Title XIX State plan
Physical and Occupational Therapies, and Services for Individuals with Speech, Hearing, and Language Disorders	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan VHAP: any limitations defined in Vermont rules and/or policies

Inpatient Hospital/Nursing Facility/ ICF Services for Individuals 65 and Older in IMD	X		State plan: any limitations on this service are described in the approved Title XIX State plan VHAP: any limitations defined in Vermont rules and/or policies
ICF/MR Services	X		State plan: any limitations on this service are described in the approved Title XIX State plan
Inpatient Psychiatric Services for Individuals Under 21	X		State plan: any limitations on this service are described in the approved Title XIX State plan
Personal Care Services	X		State plan: any limitations on this service are described in the approved Title XIX State plan
Case Management	X		State plan: any limitations on this service are described in the approved Title XIX State plan
Respiratory Care for Ventilator Dependent Individuals	X		State plan: any limitations on this service are described in the approved Title XIX State plan
PCCM	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan VHAP: any limitations defined in Vermont rules and/or policies
PACE	X		State plan: any limitations on this service are described in the approved Title XIX State plan
Hospice	X		State plan: any limitations on this service are described in the approved Title XIX State plan
Transportation Services	X		State plan: any limitations on this service are described in the approved Title XIX State plan
Services Provided in a Religious Non-Medical Health Care Institution			
Nursing Facility Services for Individuals Under Age 21			
Emergency Hospital Services	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan VHAP: any limitations defined in Vermont rules and/or policies

Critical Access Hospital	X	X	State plan: any limitations on this service are described in the approved Title XIX State plan VHAP: any limitations defined in Vermont rules and/or policies
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Services Provided by the State’s Different “Home and Community Based Services” Programs offered to individuals who were previously covered under a separate 1915(c) demonstration.

Program Name	Services	Limitations
Traumatic Brain Injury (TBI)	Crisis/support services, psychological and counseling supports, case management, community supports, habilitation, respite care, supported employment, environmental and assistive technology	Any limitation on this service are defined by Vermont rules and policies
Mental Illness Under 22	Service coordination, flexible support, skilled therapy services, environmental safety devices	Any limitation on this service are defined by Vermont rules and policies
MRDD	Case management, residential habilitation, day rehabilitation, supported employment, crisis services, clinical intervention, respite	Any limitation on this service are defined by Vermont rules and policies

VHAP ESI

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

Premium Assistance Catamount Health Plan Benefit Package (Refer to Attachment B)

Comprehensive benefit as prescribed in Catamount State statute

ESI Premium Assistance (Non-VHAP) Benefit Package

The benefits covered by the plan must be substantially similar to the benefits offered by the Catamount Health Premium Assistance.

Enrollment Process. The State agrees to notify participants newly entering a section 1115

demonstration within 30 days of their entry into the Global Commitment to Health Demonstration.

V. COST SHARING

23. **Premiums, Co-Payments, and Premium Assistance.** 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 and adults whose coverage is mandated by Federal law must not exceed 5 percent of the family's gross income. The following chart provides details regarding cost sharing for Demonstration expansion populations (Demonstration Populations 4-12):

A. Premiums and Co-payments for the Expansion Populations

Population	Premiums	Deductibles	Co-Payments*
Underinsured children not otherwise eligible for Medicaid and SCHIP 186-225% FPL 226-300% FPL	\$15/month/family \$20/month/family	\$0	\$0
Adults Pregnant Women 186-200% VHAP 50-75% FPL VHAP 76-100% FPL VHAP 101-150% FPL VHAP 150-185% FPL	\$15/month/family \$7/month \$25/month \$33/month \$49/month	\$0	Traditional Medicaid populations: Nominal co-payments Prescriptions: <ul style="list-style-type: none"> • \$1.00: for prescriptions \$29.99 or less • \$2.00: for prescriptions between \$30.00 to \$49.99 • \$3.00: for prescriptions \$50.00 or more \$3.00 per dental visit \$3.00 per day per hospital for outpatient services** \$75.00 per inpatient hospital admission** VHAP populations \$25/emergency room visit; no charge if admitted
HCBS (TBI, MI under 22, and MR/DD)	\$0	\$0	\$0

Medicare beneficiaries income at or below 150 percent of the FPL, not otherwise categorically eligible	\$15/month	\$0	\$0
Medicare beneficiaries with income above 150 percent and less than 200 percent of the FPL not otherwise categorically eligible	\$20/month	\$0	\$0
Individuals with persistent mental illness with income up to 150 percent of FPL	\$0	\$0	\$0

* Co-payments do not apply to children under age 21, pregnant women or individuals in long-term care facilities

** These copays also apply to SSI-related beneficiaries ages 18, 19 & 20

B. Premium Assistance for VHAP, ESI and Catamount Populations is as follows:

Population	Premiums
VHAP/ESI VHAP 50-75% FPL VHAP 76-100% FPL VHAP 101-150% FPL VHAP 151-185% FPL	\$7/month \$25/month \$33/month \$49/month
Non VHAP/ESI Childless adults 151-200% FPL All adults 186-200% FPL	\$60/month \$60/month Based on lowest cost plan; premium amounts will be the same as Catamount
Catamount Childless adults 150-200% All adults 185-200%	\$60/month \$60/month Based on lowest cost plan; amounts dictated in the Vermont legislation

All cost sharing related to chronic care will be waived for persons enrolled in a chronic care management program.

VI. DELIVERY SYSTEMS

24. **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.
25. **Premium Assistance.** There are three programs offering premium assistance under this demonstration; VHAP-ESI, ESI premium assistance (non-VHAP), and Catamount premium assistance. As the Single State Agency for Medicaid, AHS will have authority and responsibility for eligibility determination related to these premium assistance programs. The role filled by AHS will be identical to that of Single State Agencies in other States. The methodology for providing premium assistance for each of the three programs is described below:
 - a. **VHAP-ESI.** AHS determines eligibility, processes enrollment and makes the determination that the ESI is cost effective. AHS makes a capitation payment to OVHA for premium assistance and wraparound benefits. OVHA transfers the premium assistance to the beneficiary and the employer withholds the employee premium share. The employer pays the full insurance benefit.
 - b. **ESI Premium Assistance.** AHS determines eligibility, processes enrollment, and makes the determination that the ESI is cost effective. AHS makes a capitation payment to OVHA for premium assistance. OVHA transfers the premium assistance to the beneficiary and the employer withholds the employee premium share. The employer pays the full insurance benefit. There is no additional wraparound benefit, however all cost sharing for chronic care services are waived for those enrolled in a chronic care management program.
 - c. **Catamount Premium Assistance.** AHS determines eligibility and processes enrollment in Catamount Premium Assistance. AHS makes a capitation payment to OVHA. The beneficiary pays a premium contribution to AHS and OVHA pays the total premium for the beneficiary to enroll in Catamount Health. There is no additional wraparound benefit, however all cost sharing for chronic care services are waived for those enrolled in a chronic care management program.
26. **Catamount Health.** The Catamount Health product will be offered by private health plans in the State as dictated by Title 8, Chapter 107, section 4084f. Catamount Health.
27. **Limitation of Freedom of Choice.** Freedom of choice shall be limited to the OVHA managed care entity. However, populations enrolled in the Global Commitment to Health shall have freedom of choice when selecting participating Medicaid MCO providers.
28. **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 expenditure authority.

To further clarify the MCO requirements published in Federal regulations at 42 CFR section 438, the actuary shall not be a State employee 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.

29. **Contracting with Federally Qualified Health Centers (FQHCs).** The State shall maintain its existing agreements with FQHCs and rural health centers. Reimbursement for services provided to individuals enrolled in ESI/Premium Assistance programs shall be based on requirements established by the Vermont 2006 Health Care Affordability Act and the terms contained in the independent agreements reached between FQHCs/rural health centers and participating carriers.
30. **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).

VIII. GENERAL REPORTING REQUIREMENTS

31. **General Financial Requirements.** The State must comply with all general financial reporting requirements under title XIX set forth in section IX.
32. **Compliance with Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR 438 et. Seq., except as expressly identified as not applicable in the expenditure authorities incorporated into these STCs.
33. **Reporting Requirements Relating to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality set forth in section X.
34. **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.

35. **Managed Care Data Requirements.** The 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 section 438, on program elements including, but not limited to, service utilization, grievances, appeals, and disenrollments for reasons other than loss of Medicaid eligibility. The management information system must collect data on member and provider characteristics, as specified by the AHS, and on services as set forth under 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.
36. **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.
37. **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, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, MCO 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 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.
38. **Quarterly Reports.** The State must submit progress reports in the format specified in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include, but not be limited to:
 - a) An updated budget neutrality monitoring spreadsheet;
 - b) Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: approval and contracting with new plans; benefits; enrollment; grievances; quality of care; access; health plan financial performance that is relevant to the Demonstration; pertinent legislative activity; and other operational issues;
 - c) Action plans for addressing any policy and administrative issues identified;

- d) A separate discussion of the State efforts related to the collection and verification of encounter data;
- e) Evaluation activities and interim findings and a description of State progress towards demonstration goals; and
- f) 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:

Traditional Medicaid-eligible Populations

Demonstration Population 1: Mandatory Categorically Needy

Demonstration Population 2: Optional Categorically Needy

Vermont Health Access Plan (VHAP) Expansion Populations

Demonstration Population 3: Underinsured children with income between 225 and 300 percent of FPL who are not otherwise eligible for Medicaid or SCHIP

Demonstration Population 4: Adults with children with income between 150 and including 185 percent of FPL

Demonstration Population 5: Childless Adults with income up to and including 150 percent of FPL, not otherwise categorically eligible

Demonstration Population 6: Medicare beneficiaries with income at or below 150 percent of the FPL, not otherwise categorically eligible

Demonstration Population 7: Medicare beneficiaries with income above 150 percent and less than 200 percent of FPL

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

Premium Assistance Expansion Populations

Demonstration Population 9: ESI Premium Assistance

a. Adults with children with incomes between 185 and including 200 percent of the FPL

c. Childless adults and non custodial parents with income between 150 and including 200 percent of the FPL

Demonstration Population 10: Catamount Premium Assistance

a. Adults with children with incomes between 185 and including 200 percent of the FPL

- c. Childless adults and non custodial parents with income between 150 and including 200 percent of the FPL

Quarterly report for the quarter ending September 30 is due **November 30**

Quarterly report for the quarter ending December 31 is due **February 28**

Quarterly report for the quarter ending March 31 is due **May 31**

Quarterly report for the quarter ending June 30 is due **August 31**

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

IX. GENERAL FINANCIAL REQUIREMENTS

- 40. **Changes Resulting from Implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.** 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.
- 41. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using the form CMS-64 to separately report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS 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).
- 42. **Reporting Expenditures Subject to the Budget Neutrality Cap.** In order to track expenditures under this Demonstration, Vermont must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System, following routine from CMS-64 reporting instructions outlined in section 2500 and section 2115 of the State Medicaid Manual. All Demonstration expenditures subject to the budget neutrality cap must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the Demonstration year in which services were rendered or for which capitation payments were made). 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 41.b.

a) 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 41.b.). The Vermont Global Medicaid eligibility groups, for reporting purposes, include the following names and definitions:

CMS 64 Reporting Name	Reporting name description	Corresponding Demonstration population number per the STCs	Population description
<u>“ABD”</u>	Report expenditures for individuals eligible as aged, blind, or disabled under the state plan	Demonstration Populations 1-2	<ul style="list-style-type: none"> • Mandatory Categorically needy • Optional Categorically needy
<u>“ANFC”</u>	Report the expenditures for all non-ABD children and adults in the State plan mandatory and optional categories	Demonstration Populations 1-2	<ul style="list-style-type: none"> • Mandatory Categorically needy • Optional Categorically needy
<u>“Optional Expansions”</u>	Report for all expenditures for all non-ABD children and adults in optional categories	Demonstration populations 2	<ul style="list-style-type: none"> • Optional Categorically needy
<u>“VT Global Rx”</u>	Report for all expenditures for individuals eligible as pharmacy-only expansions through VT Global (previously VHAP Rx)	Demonstration population 6	<ul style="list-style-type: none"> • Medicare beneficiaries and individuals with disabilities with income at or below 150 percent of FPL

		Demonstration population 7	<ul style="list-style-type: none"> • Medicare beneficiaries and individuals with disabilities with income above 150 percent and less than 200 percent of FPL
<u>“Administrative expenditures”</u>	All administrative expenditures under the Global Commitment to Health		
<u>“VT Global Expansion”</u>	Report for all expenditures for individuals eligible as non-categorical health care expansions through VT global	<p>Demonstration Population 3</p> <p>Demonstration Population 4</p> <p>Demonstration Population 5</p> <p>Demonstration Population 9 and 10</p>	<ul style="list-style-type: none"> • Underinsured Children with income between 225 and 300 who otherwise are ineligible for Medicaid or SCHIP • Adults with children with income between 150 and 185 percent of the FPL • Childless adults with income up to and including 150 percent of the FPL • Premium assistance expansion groups (ESI or Catamount Health)

			<p>a) adults with children with incomes between 185 and 200 percent of the FPL)</p> <p>b) all adults with income between 150 and 200 percent of the FPL</p>
<u>“CRT Group”</u>	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	Demonstration Population 8	<ul style="list-style-type: none"> • Individuals with persistent mental illness with income up to 150 percent of FPL

- b) 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 42.a.of this section) and who are receiving the services subject to the budget neutrality cap. All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and shall be reported on forms CMS-64.9 waiver and/or 64.9P waiver.
- c) Premiums and other applicable cost-sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration must be reported to CMS on form CMS-64.9 waiver, Line 18.E. in order to ensure that the Demonstration is properly credited with premium collections.
- d) 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.
- e) All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all 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.

f) Disproportionate Share Hospital (DSH) payments and any programs financed by 100 percent federal funding are not counted as expenditures under the Demonstration.

43. **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:

Traditional Medicaid-eligible Populations

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

Vermont Health Access Plan (VHAP) Expansion Populations

Demonstration Population 3: Underinsured children with income between 225 and 300 percent of FPL who are not otherwise eligible for Medicaid or SCHIP
Demonstration Population 4: Adults with children with income between 150 and including 185 percent of FPL
Demonstration Population 5: Childless Adults with income up to and including 150 percent of FPL, not otherwise categorically eligible
Demonstration Population 6: Medicare beneficiaries with income at or below 150 percent of the FPL, not otherwise categorically eligible
Demonstration Population 7: Medicare beneficiaries with income above 150 percent and less than 200 percent of FPL
Demonstration Population 8: Individuals with persistent mental illness with income up to 150 percent of FPL

Premium Assistance Expansion Populations

Demonstration Population 9: ESI Premium Assistance

- a. Adults with children with incomes between 185 and including 200 percent of the FPL
- d. Childless adults and non custodial parents with income between 150 and including 200 percent of the FPL

Demonstration Population 10: Catamount Premium Assistance

- a. Adults with children with incomes between 185 and including 200 percent of the FPL
- d. Childless adults and non custodial parents with income between 150 and including 200 percent of the FPL

And report administrative expenditures

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. 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.)

44. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. Vermont must estimate matchable Medicaid expenditures on the quarterly form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year on the form CMS-37.12 for both the medical assistance program and administrative costs outside of the MCO capitation payment. 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.

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

non-Federal share of funding are subject to CMS approval.

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

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

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

Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

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

49. **Impermissible DSH, Taxes or Donations.** The CMS reserves the right to adjust the budget neutrality ceiling in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or with policy interpretations implemented through letters, memoranda, or regulations. CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act (the Act). Adjustments to annual budget targets will reflect the phase-out of impermissible provider payments by law or regulation, where applicable.
50. **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.
51. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State's expenditures exceed the calculated cumulative budget neutrality expenditure cap by the percentage

identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval.

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 (Total Computable Cost)</u>	<u>Cumulative Target 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

XI. EVALUATION OF THE DEMONSTRATION

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

The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

54. **Interim Evaluation Reports.** In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.
55. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft evaluation design described in paragraph 51 within 60 days of receipt, and the State must submit a final design within 60 days after receipt of CMS comments. The State must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The State must submit to CMS a draft of the evaluation report within 120 days after the expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.
56. **Cooperation with CMS Evaluators.** Should CMS conduct an independent evaluation of any component of the Demonstration the State will cooperate fully with CMS or the independent evaluator selected by CMS. The State will submit the required data to the contractor or CMS as requested.

XII. CAPITATED REVENUE

57. **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.
58. **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.

XIII. SCHEDULE OF THE STATE DELIVERABLES OF THE DEMONSTRATION PERIOD

Date - Specific	Deliverable	STC Reference
120 days after original approval	Submit Draft Evaluation Plan	Section XI, paragraph 53
6/1/2008	Submit Final Evaluation Plan	Section XI, paragraph 55
2/1/2011	Submit Draft Evaluation Report, including preliminary analysis and recommendations	Section XI, paragraph 55
6/1/2011	Submit Final Evaluation Report	Section XI, paragraph 55

	Deliverable	STC Reference
Annually (by April 1st)	Draft Annual Report	Section VIII, paragraph 39
Quarterly		
	Quarterly Operational Reports	Section VIII, paragraph 38
	CMS-64 Reports	Section IX, paragraph 41

ATTACHMENT A: QUARTERLY REPORT CONTENT AND FORMAT

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

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

NARRATIVE REPORT FORMAT:

Title Line One – Vermont Global Commitment to Health

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 3 (10/1/2007 – 9/30/2008)

Federal Fiscal Quarter: 1/2008 (10/01/2007 – 12/31/2007)

Introduction

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

Enrollment Information

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

Enrollment Counts

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

Demonstration Populations	Current Enrollees (to date)	Disenrolled in Current Quarter
Demonstration Population 1:		
Demonstration Population 2:		
Demonstration Population 3:		
Demonstration Population 4:		
Demonstration Population 5:		
Demonstration Population 6:		

Demonstration Population 7:		
Demonstration Population 8:		
Demonstration Population 9:		
Demonstration Population 10:		

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues

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

Expenditure Containment Initiatives

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

Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State’s actions to address these issues.

Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

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

Consumer Issues

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions

taken or to be taken to prevent other occurrences. Also discuss feedback received from the other consumer groups.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Reported 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.

Enclosures/Attachments

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

State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT B: SUMMARY OF CATAMOUNT HEALTH

Catamount Health is a new fully insured product that will be available through private insurers in Vermont. The Catamount Health Assistance Program offers a subsidized insurance program to Vermont residents who have been without health insurance coverage for a year or more, have income at or below 200 percent of FPL, and who do not have access to employer-sponsored insurance that has been approved and is cost effective. The beneficiary's share of the premium is based on income.

Participating Carriers

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

- A \$250.00 annual deductible for an individual and a \$500.00 deductible for a family for health services received in network;
- A \$500.00 annual deductible for an individual and a \$1,000.00 deductible for a family for health services received out of network;
- 20 percent co-insurance, in and out of network;
- \$10.00 office co-payment;
- Prescription drug coverage without a deductible, \$10.00 co-payments for generic drugs, \$30.00 co-payments for drugs on the preferred drug list, and \$50.00 co-payments for non-preferred drugs;
- Out-of-pocket maximums of \$800.00 for an individual and \$1,600.00 for a family for in-network services and \$1,500.00 for an individual and \$3,000.00 for a family for out-of-network services; and
- A waiver of the deductible and other cost-sharing payments for chronic care for individuals participating in chronic care management and for preventive care.