

S O C I A L W E L F A R E

BULLETIN NO. 00-06P

FROM Eileen I. Elliott, Commissioner
for the Secretary

DATE

SUBJECT VHAP Changes and Program Updates

CHANGES ADOPTED EFFECTIVE 5/1/00

Instructions

Maintain Manual - See instructions below.

MANUAL REFERENCE(S)

Proposed Regulation - Retain bulletin and attachments until
you receive Manual Maintenance Bulletin 00-06F

4003

Information or Instructions - Retain until

This bulletin proposes to revise the VHAP managed care policy to clarify the rights and responsibilities of beneficiaries enrolled in the PCCM program. The bulletin proposes for the VHAP managed care policy to adopt the rules governing the PCCM program and the other managed health care programs found at M103. The policy at M103 that was adopted on clearly explains the department's adoption of the Department of Banking, Insurance, Securities, Health Care and Administration's Rule 10 managed health care consumer protection standards.

Specific Changes to the Existing Policy Pages

4003 Removes references to wrap-around services

4003.1 Lists services available to VHAP-Limited beneficiaries and services available to VHAP Managed Care beneficiaries. Removed references to referrals, self-referrals, and wrap-around benefits because the procedures for obtaining benefits will be outlined in the VHAP Managed Care procedures.

4003.2- Delete these sections as the policy M103 supercedes it.
4003.22

A public hearing is scheduled on February 14, 2000, at 1:30 p.m. in the Skylight Conference Room, State Office Complex, Waterbury, Vermont.

Written comments may be submitted by 4:30 p.m., on February 22, 2000, to Samantha Haley, Office of Vermont Health Access, Department of Social Welfare, 103 South Main Street, Waterbury, VT 05671-1201.

Vertical lines in the left margin indicate significant changes. Changes to clarify, rearrange, correct references, etc., without changing regulation content are indicated by dotted lines at the left.

5/1/00

Bulletin No. 00-06

4003

4003 Benefit Delivery Systems

While enrollment in a managed health care plan will be mandatory for VHAP participants, covered services for eligible beneficiaries may be provided using a fee-for-service payment system until adequate managed care capacity is developed.

As managed care capacity becomes available in a given area VHAP participants will be transferred into available managed care slots.

For beneficiaries required to enroll in managed health care plans, no payment will be made for services obtained outside the plan.

The policy that governs the enrollment of VHAP beneficiaries into a managed health care system is found at M103.

4003.1 Benefits

The VHAP-Limited benefit packages (limited and managed care) are described in procedures found at P-4003.

VHAP-Limited beneficiaries can access the following services:

- emergency inpatient hospitalization
- outpatient services in a general hospital, including lab tests, radiology procedures and treatments, or ambulatory surgical center services;
- physician and mid-level practitioner services, including services provided by rural health centers and federally qualified health centers, routine gynecological exams and related diagnostic services, family planning services, and prenatal and maternity care until the individual is enrolled in traditional Medicaid;
- home health care;
- hospice services furnished by a Medicare-certified hospice provider;
- Outpatient therapy services (occupational, physical, speech and nutrition therapy)
- emergency ambulance services;
- outpatient mental health and chemical dependency services;
- podiatry services; and
- prescription drugs.

VHAP beneficiaries enrolled in a managed health care plan can access the following services:

- inpatient hospital care;
- outpatient services in a general hospital or ambulatory surgical center;
- physician services;
- maxillofacial surgery;
- cornea, kidney, heart, heart-lung, liver and bone marrow transplants, including expenses related to providing the organ or doing a donor search;

5/1/00

Bulletin No. 00-06

4003.1

4003.1 Benefits (Continued)

- home health care;
- hospice services by a Medicare-certified hospice provider;
- outpatient therapy services (home infusion therapies and occupational, physical, speech and nutrition therapy);
- prenatal and maternity care;
- ambulance services;
- medical equipment and supplies;
- skilled nursing facility services for up to 30 days length of stay per episode;
 - mental health and chemical dependency services;
NOTE: services are limited to 30 days per episode and 60 days per calendar year.
 - podiatry services;
 - prescription drugs and over-the-counter drugs prescribed by a physician for a specific disease or medical condition.
 - annual gynecological exams and related diagnostic services;
 - mental health and chemical dependency visits
 - one routine eye examination every 24 months
 - limited dental services for adults, excluding dentures, up to an annual benefit maximum of \$475;
 - eyeglasses furnished through the Department of Social Welfare's sole source contractor;
 - chiropractic services;
 - family planning services (defined as those services that either prevent or delay pregnancy).

4003.2 Accessing Benefits

The procedures explaining how beneficiaries may access benefits are found at P-4003 for VHAP-Limited beneficiaries and at P-4004 for VHAP-managed care beneficiaries.