Vermont Medicaid
Access Plan – Family Planning
Eligibility Group

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

Table of Contents

SECTION 1 INTRODUCTION **3**

1.1 Background 3

1.2 Population Served by Access Plan 3

1.3 Coverage Review 3

1.4 Retrospective Review 4

SECTION 2 ACCESS PLAN BENEFIT PROVIDER GUIDANCE **5**

2.1 Presumptive Eligibility 5

2.2 Provider Requirements for presumptive eligibility 5

2.3 Training 5

2.4 Steps to Determine Eligibility 5

SECTION 3 POLICY REFERENCES **7**

Section 1 Introduction

This manual is designed as a supplement to and does not replace the Vermont Medicaid General Provider Manual which can be found at https://vtmedicaid.com/#/manuals.

This supplement describes processes to be followed by Vermont Medicaid enrolled providers electing to presumptively determine eligibility for Access Plan and deliver family planning / family planning related services to those recipients of the Access Plan.

Vermont Medicaid only pays for healthcare services that are medically necessary. Per Health Care Administrative Rules 4.101 Medical Necessity for Covered Services, medically necessary is defined as healthcare services that are appropriate, in terms of type, amount, frequency, level, setting and duration to the member's diagnosis or condition. It must conform to generally accepted practice parameters recognized by healthcare providers in the same or similar general specialty who typically treat or manage the diagnosis or condition.

1.1 Background

Access Plan is an eligibility group that differs from other Medicaid category groups in that individuals in this group are covered only for family planning and family planning related services.

Family planning related services are medical, diagnostic, and treatment services provided pursuant to a family planning visit that address an individual's medical condition and may be provided for a variety of reasons, including but not limited to: treatment of medical conditions routinely diagnosed during a family planning visit, such as treatment of urinary tract infections or sexually transmitted infection; preventive services routinely provided during a family planning visit, such as the HPV vaccine; or treatment of a major medical complication resulting from a family planning visit.

For a list of billing codes covered under this eligibility group, visit the DVHA webpage Access Plan, under What does Access Plan Cover?

1.2 Population Served by Access Plan

To be eligible for Access Plan a person must:

- Be a United States citizen or a have Medicaid eligible immigration status
- Be a Vermont resident
- Be a person of child-bearing age
- Have income under 208% FPL
- Not have Medicaid or other comprehensive health insurance that covers family planning/family planning related services

1.3 Coverage Review

The Department of Vermont Health Access (DVHA) conducts code reviews on a quarterly or annual basis depending on the type of services that are being requested for consideration. This means that a newly released procedure code may not be available until the next quarterly or annual code review as applicable to the type of specific procedure code.

For additional information, please see the General Billing and Forms Manual, Section 2.2 Coverage Review, https://vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.pdf.

1.4 Retrospective Review

The DVHA will not perform retrospective reviews for the purpose of reviewing authorization decisions and recoupment of payments except in the case of material misrepresentation or fraud. For additional information, please see the General Provider Manual, Section 6 Special Investigations Unit. https://vtmedicaid.com/#/manuals

Section 2 Access Plan Benefit Provider Guidance

2.1 Presumptive Eligibility

Presumptive eligibility allows a qualified entity, as deemed by the State, to determine a person's eligibility for Access Plan based on preliminary information they attest to on behalf of the State.

2.2 Provider Requirements for presumptive eligibility

Provider participation in presumptive eligibility for Access Plan is optional. To apply to be a qualified entity providers must:

- Be enrolled as a Medicaid provider (for more information visit https://vtmedicaid.com/#/provEnrollDataMaint)
- Agree with the policies and procedures of the State in a Memorandum of Understanding

Any qualified employee of the qualified entity who is properly trained is able to determine eligibility. Any contract workers or vendors can assist with application completion but cannot make the determinations.

2.3 Training

Qualified entities must have staff successfully complete training for eligibility determinations. DVHA staff will provide Presumptive Eligibility training for provider training staff.

2.4 Steps to Determine Eligibility

1. Staff must walk through with the applicant the eligibility questions on the screening tool to ensure completeness. Visit the DVHA Access Plan webpage for the Access Plan Provider Screening tool.

   In order for an applicant to be determined eligible they must attest that they meet the following criteria:

   - Have a valid Social Security Number (SSN)
   - US Citizen or lawfully present
   - Person of child-bearing age
   - Vermont resident
   - Not receiving Medicaid or other comprehensive health coverage that includes family planning/related services
   - Their income is < 208%FPL (For qualified entity's ease, the screening tool will have the maximum income/month allowable on it)
2. Once attestations are recorded on the screening tool, providers can determine if the applicant meets all of the qualifications for the program.

Note: The screening tool must include who determined the eligibility and the date the screening occurred/determination completed.

If the applicant has been determined eligible for Access Plan, the qualified entity must upload the screening tool through the online uploader (https://my.vermont.gov/) so that DVHA can enter the member's information for claims billing.

Note: If eligibility is approved and the visit concludes with a prescription to be filled by a pharmacy, please e-mail the screening tool to AHS.DVHAAccessPlan@vermont.gov as soon as possible to expedite processing.

3. Once eligibility has been determined, the qualified entity must give the applicant an Access Plan Decision letter with the decision documented.

If the applicant has been determined eligible, family planning/related services delivered during the visit will be covered. If the applicant is determined not to be eligible, services will not be covered.

Section 3 Policy References

Health Benefits Eligibility and Enrollment Rule

Health Care Administrative Rules 4.101 Medical Necessity for Covered Services