

## Acronyms Used in Attachment A

AAP	American Academy of Pediatrics
ACG	Adjusted Clinical Groups
ACO	Accountable Care Organization
AHS	Agency of Human Services
AIPBP	All-Inclusive Population-Based Payment
AY	Attribution Year
BY	Base Year
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Health Plans Survey
CANS	Child and Adolescent Needs and Strengths [Assessment Tool]
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHT	Community Health Team
CMP	Civil Money Penalty
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
CPA	Certified Public Accountant
CPT	Common Procedural Terminology
CY	Calendar Year
DA	Designated Agency
DME	Durable Medical Equipment
DRG	Diagnosis Related Grouping
DSH	Disproportionate Share Hospital Payment
DVHA	Department of Vermont Health Access
E&M	Evaluation & Management
EHR	Electronic Health Record
EOB	Explanation of Benefits
EPSDT	Early & Periodic Screening, Diagnosis & Treatment
FFS	Fee For Service
FQHC	Federally Qualified Health Center
GME	Graduate Medical Education
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data & Information Set
HHA	Home Health Agency
HIPAA	Health Insurance Portability & Accountability Act
HIT	Health Information Technology
HMO	Health Maintenance Organization
HPE	Hewlett Packard Enterprises
IBNR	Incurred But Not Reported
ICN	Internal Control Number
IRO	Independent Review Organization
IS	Information System
IVR	Interactive Voice Recording
LWIM	Living With Illness Measures

## Acronyms Used in Attachment A

MCHB	Maternal & Child Health Bureau
MFRAU	Medicaid Fraud and Residential Abuse Unit
MHPAEA	Mental Health Parity & Addiction Parity Act
MLR	Medical Loss Ratio
MMIS	Medicaid Management Information System
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
NF	Nursing Facility
NPI	National Provider Identifier
NPP	Non-Physician Practitioner
PCC	Parent Child Center
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PCMH	Patient Centered Medical Home
PHI	Protected Health Information
PI	Program Integrity
PMPM	Per Member Per Month
PY	Program Year
QEM	Qualified Evaluation & Management
RA	Remittance Advice
RFP	Request For Proposals
RHC	Rural Health Clinic
SSA	Specialized Service Agency
STFP	Secure File Transfer Protocol
SFY	State Fiscal Year
SIM	State Innovation Model
SIU	Special Investigation Unit
STC	Special Terms & Conditions
TDD	Telecommunications Device for the Deaf
TIN	Taxpayer Identification Number
TPL	Third Party Liability
TTY	Text Telephony
UID	Unique Identification Number
VCCI	Vermont Chronic Care Initiative
VHCURES	Vermont Health Care Uniform Reporting & Evaluation System
WHPP	Would Have Paid Provider
WIC	[Supplemental Food Program for] Women, Infants & Children

## **Technical Proposal Attachment A Scope of Work**

### **1.0 Attribution Methodology**

#### **1.1 Introduction and Overview**

This section describes the methods that will be used for attributing Department of Vermont Health Access (DVHA) members to the Accountable Care Organization (ACO). It also describes the expenditure data that will be used to set actuarial rates.

DVHA intends to follow the methodology set forth by the Centers for Medicare & Medicaid Services' (CMS) Next Generation methodology using the full risk capitation method. CMS refers to this at the All-Inclusive Population-Based Payment (AIPBP). One difference from the CMS Next Generation model is that DVHA is using a larger set of Evaluation and Management (E&M) codes used in the attribution process. In this Contract, DVHA will use the same E&M codes used in the State of Vermont's Blueprint for Health program and in DVHA's current Vermont Medicaid Shared Savings Program.

The capitation rates, or AIPBP, will be set based on the actual attributed lives to the Successful Bidder using the attribution methodology described in Section 1 of this Scope of Work. Preliminary rates are expected to be released in July 2016. Analytics will be completed by DVHA's actuary once it is known who the potential attributed members will be to the Contractor. It is anticipated that DVHA's actuary will present the methodology used to compute the proposed capitation rates to the Successful Bidder using the Bidder's projected attributed DVHA population as the basis for the analysis. In addition to the calculations using historical DVHA expenditures for these attributed members, the actuary will describe other analysis or information relevant for rate review. This includes, but is not limited to:

- Adjustments for policy related changes,
- Differences across entitlement categories,
- Geographic differences,
- Whether to employ truncation or capping of expenditures, and
- Risk adjustment.

Throughout this Section of the Scope of Work, the term "members" means Medicaid beneficiaries who are members of DVHA's public managed care organization. The term "attribution" is synonymous with the Next Generation term "alignment".

#### **1.2 Definitions**

This section defines certain terms that are used to describe the attribution process.

##### **1.2.1 Performance Year, Base Year, Attribution Years**

Performance Year (PY) refers to the first year of this Contract, in this case, Calendar Year 2017.

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Base Years (BYs) refers to those years of data used in establishing expenditure trends to inform the setting of capitation rates, in this case, Calendar Years 2013, 2014 and 2015.

Attribution Years (AYs) refers to those two historic years of data used to conduct the prospective attribution to each of the BYs and the PY. For example, the AYs used for the PY are the time periods representing State Fiscal Years 2014 and 2015.

The table below shows the time periods covered in the performance year, base years and attribution years.

Period	Period covered	Corresponding Attribution Years (AY)
Performance Year 2017 (PY)	01/01/2017 – 12/31/2017	AY1: 07/01/2014-6/30/2015 AY2: 07/01/2015-6/30/2016
Base Year 3 (BY3)	01/01/2015 – 12/31/2015	AY1: 07/01/2012-6/30/2013 AY2: 07/01/2013-6/30/2014
Base Year 2 (BY2)	01/01/2014 – 12/31/2014	AY1: 07/01/2011-6/30/2012 AY2: 07/01/2012-6/30/2013
Base Year 1 (BY1)	01/01/2013 – 12/31/2013	AY1: 07/01/2010-6/30/2011 AY2: 07/01/2011-6/30/2012

### 1.2.2 Attribution-eligible member

DVHA members must have at least one month of Medicaid enrollment in either of the two attribution years in order to be considered for attribution.

During the Performance Year, newborns (born or adopted) to mothers who have been prospectively attributed to the ACO will be automatically attributed to the ACO at the time of their birth.

A DVHA member is not eligible for attribution in the Performance Year if the member falls into any of the following categories during the corresponding Attribution Years:

- a. The DVHA member did not have any paid Qualified Evaluation and Management (QEM) service claims.
- b. The DVHA member is dually eligible for Medicare;
- c. The DVHA member had evidence of third party liability coverage;
- d. The DVHA member is eligible for enrollment in Vermont Medicaid but has obtained coverage through commercial insurers;

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- e. The DVHA member is enrolled in Vermont Medicaid but receives a limited benefit package; or
- f. The DVHA member is not enrolled as a DVHA member at the start of the Performance Year.

#### 1.2.3 Monthly exclusion of members during the performance year

DVHA members will be prospectively attributed to the ACO at the start of the Performance Year (with the exception of the newborns who may be attributed during the year). Attribution-eligibility requirements will be applied during the Performance Year as part of a monthly exclusion process.

In the months beginning February 2017 through January 2018, DVHA's fiscal agent will exclude DVHA members from attribution who became ineligible for attribution in the previous month either due to one of the criteria stated in 1.2.2 or as a result of death of the member. If it is determined that capitation payments were unknowingly made in any month prior to the knowledge of one of these criteria, the capitation payments will be recouped and applied against a final year-end reconciliation for the Performance Year.

#### 1.2.4 Qualified Evaluation and Management (QEM) services

QEM services are identified by the combination of Healthcare Common Procedure Coding System (HCPCS) codes and physician specialty. The HCPCS codes used are listed in Attachment B, Table 1.

In the case of claims submitted by physician's practices and institutional providers, a QEM service must be provided by a physician specialty listed in Attachment B, Table 2 or Table 3.

#### 1.2.5 Primary care practitioners

A primary care practitioner is a physician or non-physician practitioner (NPP) whose principal specialty is included in Attachment B, Table 3.

For purposes of applying the 2-stage attribution algorithm described below in 1.3.2, the provider specialty will be determined based on the specialty associated with the QEM as described in Section 1.2.4.

#### 1.2.6 Participating provider

A participating provider is either a physician or a NPP who is a member of a participating practice or an institutional provider or a supplier that has entered into an agreement with the ACO.

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In the case of physician practices and institutional practices, participating providers are identified by a combination of:

- a. Taxpayer Identification Number (TIN)<sup>1</sup> and
- b. Medicaid provider identification numbers.

#### 1.2.7 Participating practice

A participating practice is identified by the TIN and may include the following:

- A physician practice;
- A Critical Access Hospital;
- A Federally Qualified Health Center; or a
- A Rural Health Clinic

#### 1.2.8 Participating practitioner

A participating practitioner is a physician or NPP identified by a Medicaid provider identifier, derived from the variable MC024 in the VHCURES data, who is a member of a participating practice.

#### 1.2.9 Legacy practices

A legacy practice is a TIN that was used by a participating practice to bill for services provided to Medicaid members in an Attribution year or for any of the Base years but not during the Performance Year.

Legacy practices may be used to conduct attribution only if:

- Merger, acquisition, or corporate reorganization has resulted in the consolidation or replacement of a TIN that appears on claims for QEMs provided during an attribution-year; and
- The TIN will not be used to bill for QEM services provided during the Performance Year.

#### 1.2.10 Expenditures used in the financial calculations

In general and subject to the exceptions discussed below, the expenditures incurred by an attribution-eligible member, for purposes of financial calculations for any performance or baseline period, is the sum of all Medicaid payments on claims for services covered by DVHA, subject to the adjustments described in this section, including:

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<sup>1</sup> DVHA is currently deriving TIN from a crosswalk produced by DVHA's fiscal agent that links Medicaid billing identification numbers to TIN since TIN is not captured in the data warehouse.

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1. Inpatient claims,
2. Outpatient claims,
3. Physician claims,
4. Home Health Agency (HHA) claims,
5. Durable Medical Equipment (DME) claims,
6. Hospice claims, and
7. Care coordination fees

Refer to Attachment C for a detailed listing of the codes that represent the services included or excluded from the financial calculations.

#### 1.2.11 Three-month run out

The expenditure that is used in financial calculations is the total amount paid to providers for services covered by DVHA that are incurred during the Base Year or Performance Year and paid within three months of the close of the Base Year or Performance Year.

#### 1.2.12 Care coordination fees

Some payments made under care coordination programs that are tied to coordination of services provided to identifiable members but are paid outside the standard claims systems will also be included in the calculation of the baseline and performance period expenditures. These financial transactions include:

- Primary care case management (PCCM) payments to attributed members
- Community Health Team (CHT) payments, which will include a pro rata portion of the payments currently made by DVHA based on the attributed members affiliated with the ACO as a percentage of all DVHA members covered by CHT payments

#### 1.2.13 Exclusion of certain provider payments

Within the scope of services defined in Section 1.2.10, further exclusions of certain provider payments from the calculation of medical expenses include:

- Graduate Medical Education (GME) payments
- Electronic Health Record (EHR) incentive payments
- Disproportionate Share Hospital (DSH) payments
- Any service funded through the Agency of Human Services outside of a DVHA fund source. The fund sources excluded are shown in Attachment B, Table 4.
- Nursing home payments

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### 1.3 Attribution of members

The members aligned with an ACO will be identified prospectively prior to the start of the Performance Year. Similarly, the members who are attributed in each Base Year are identified on the basis of each member's use of QEM services in the two-year attribution period ending prior to the start of the Base Year. Refer back to the table in 1.2.1 for the attribution time periods tied to each Base Year.

Attribution of the DVHA member is determined by comparing:

- The weighted paid claims for all QEM services that the member received from each ACO's participating providers;
- The weighted paid claims for all QEM services that the member received from each physician practice (including institutional providers) whose members are not participating in the ACO.

A member is aligned with the ACO or physician practice from which the member received the largest amount of QEM services during the two year attribution period.

Only claims that are identified as being provided by the primary care specialist listed in Attachment B, Table 2 and the non-primary care specialists listed in Attachment B, Table 3 will be used in the attribution calculations.

#### 1.3.1 Use of weighted paid claims in attribution

The payment amount on paid claims for services received during the two Attribution Years associated with each Base Year or Performance Year will be used to determine the ACO or physician practice from which the member received the most QEM services and is weighted as follows.

1. The payments for QEM services provided during the 1st (earlier) Attribution Year will be weighted by a factor of  $\frac{1}{3}$ .
2. The payments for QEM services provided during the 2nd (later or more recent) Attribution Year will be weighted by a factor of  $\frac{2}{3}$ .

The payments that will be used in attribution will be obtained from claims for QEM services that are:

1. Incurred in each Attribution Year as determined by the date of service on the claim line-item; and,
2. Paid within three months following the end of the 2nd Attribution Year as determined by the effective date of the claim.

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#### 1.3.2 The 2 stage attribution algorithm

Attribution for a Base Year or Performance Year uses a two-stage attribution algorithm:

1. *Attribution based on primary care services provided by primary care specialists.* If 10% or more of the payments incurred on QEM services received by a member during the two-year attribution period are obtained from physicians and practitioners with a primary care specialty as defined in Attachment B, Table 2, then attribution is based on the payments on QEM services provided by primary care specialists.
2. *Attribution based on primary care services provided by selected non-primary care specialties.* If less than 10% of the QEM service payments are received by a member during the two-year attribution period are provided by primary care providers (step 1 above), then attribution is based on the QEM services provided by physicians and practitioners with certain non-primary specialties as defined in Attachment B, Table 3.

#### 1.3.3 Tie-breaker rule

In the case of a tie in the dollar amount of the weighted payments for QEM services, the member will be attributed to the provider from whom the member most recently obtained a QEM service.

#### 1.3.4 Voluntary attribution

DVHA will not use the CMS Next Generation voluntary attribution methodology in Performance Year 2017 but will consider this option in future performance years.

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### **2.0 Administrative Requirements**

#### **2.1 State Registration**

Prior to the Contract Award, the Contractor must be registered as a business with the Vermont Secretary of State.

#### **2.2 National Committee for Quality Assurance (NCQA) Accreditation**

By the start of the second year of this contract, the Contractor shall have Level 1 accreditation for Accountable Care Organizations (ACOs) by the NCQA. When accreditation standards conflict with the standards set forth in the Contract, the Contract shall prevail.

#### **2.3 Contractor Governance**

The Contractor must maintain an identifiable governing body that has responsibility for oversight and strategic direction that holds the Contractor's management accountable for its activities.

The Contractor must identify its board members, define their roles and describe the responsibilities of the board in writing to the State.

The Contractor's governing body must have a transparent governing process which includes the following:

1. Publishing the names and contact information for the governing body members, for example, on a website;
2. Devoting an allotted time at each in-person governing body meeting to allow comments from members of the public to be heard. Public participants must provide prior notice of intent to speak;
3. Providing updates to the Contractor's activities;
4. Making meeting minutes available to the Contractor's provider network upon request; and
5. Posting summaries of Contractor activities provided to the Contractor's consumer advisory board on its website.

The Contractor's governing body members shall have a fiduciary duty to the ACO and act consistently with that duty.

At least 75 percent of the voting membership of the Contractor's governing body must be held by or represent Contractor participants in order to provide for meaningful involvement of Contractor participants on the governing body. For the purpose of determining if this requirement is met, a "participant" shall mean an organization that:

1. Has a signed Participant Agreement and has programs designed to improve quality, patient experience, and manage costs.

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2. Of the 75% participant membership required on the governing body:
  - a. At least one seat must be held by a participant representative of the mental health and substance abuse community of providers; and
  - b. At least one seat must be held by a participant representative of the post-acute care (such as home health) or long term care services and supports community of providers.
  - c. Institutional and home-based long-term care providers, sub-specialty providers, mental health providers and substance abuse treatment providers are strongly encouraged to be invited to participate on ACO clinical advisory boards. This shall not be construed to create a right to participate or to be represented.
  - d. It is also strongly encouraged that ACO participant membership serving all ages of Medicaid members (pediatric and geriatric) be represented in governance and in clinical advisory roles. This shall not be construed to create a right to participate or to be represented.

Regardless of the number of payers with which the Contractor participates, there must be at least two consumer members on the Contractor governing body. At least one consumer member must be a Medicaid member. Consumer members shall have some prior personal, volunteer, or professional experience in advocating for consumers on health care issues. The Contractor's governing body shall consult with advocacy groups and organizational staff in the recruitment process for the consumer member.

The Contractor shall not be found to be in non-conformance with this provision if the Contractor has in good faith recruited the participation of qualified consumer representatives to its governing body on an ongoing basis and has not been successful.

The Contractor must have a regularly scheduled process for inviting and considering consumer input regarding ACO policy, including but not limited to a consumer advisory board with membership drawn from the community served by the Contractor, including patients, their families, and caregivers. The consumer advisory board must meet at least quarterly. Members of the Contractor's management and the governing body must regularly attend consumer advisory board meetings and report back to the Contractor's governing body following each meeting of the consumer advisory board. Other consumer input activities shall include but not be limited to hosting public forums and soliciting written comments. The results of other consumer input activities shall be reported to the ACO's governing body at least annually.

At any time during the period of this Contract, the Contractor must be willing to adjust the composition and responsibilities of its governing body as may be mandated by ACO Governance Standards set by the Green Mountain Care Board for all ACOs in the state.

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#### 2.4 Administrative and Organizational Structure

The Contractor shall maintain an administrative and organizational structure that supports effective and efficient delivery of integrated services to its members. The organizational structure shall demonstrate a coordinated approach to managing the delivery of health care services to its members. The Contractor's organizational structure shall support collection and integration of data from every aspect of its delivery system and its internal functional units to accurately report the Contractor's performance. The Contractor shall also have policies and procedures in place that support the integration of financial and performance data and comply with all applicable federal and state requirements.

The Contractor shall have in place sufficient administrative and clinical staff and organizational components to comply with all contract requirements and standards. The Contractor shall manage the functional linkage of the following major operational areas:

- Administrative and fiscal management
- Member services (but not Medicaid eligibility)
- Provider services (but not DVHA provider enrollment)
- Provider contracting (limited to contractual relationships between the Contractor and its provider network)
- Network development and management
- Quality management and improvement
- Utilization and care management
- Information systems
- Provider payments
- Performance data reporting and submission of provider payment transactions
- Member and provider grievances (state fair hearings will remain DVHA's responsibility)

#### 2.5 Staffing

The Contractor shall have in place sufficient administrative, clinical and organizational staffing to comply with all program requirements and standards. The Contractor shall maintain a high level of Contract performance and data reporting capabilities regardless of staff vacancies or turnover. The Contractor shall have an effective method to address and minimize staff turnover (e.g., cross training, use of temporary staff or consultants, etc.) as well as processes to solicit staff feedback to improve the work environment. These processes will be verified during the readiness review.

The Contractor shall have position descriptions for the positions discussed in this section that include the responsibilities and qualifications of the position such as, but not limited to: education (e.g., high school, college degree or graduate degree), professional credentials (e.g., licensure or certifications), work experience, membership in professional or community associations, etc.

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### 2.5.1 Key Staff

The Contractor shall employ the key staff members listed below. The Contractor shall have an office in the State of Vermont from which, at a minimum, key staff members physically perform the majority of their daily duties and responsibilities and a major portion of the Contractor's operations take place. The Contractor shall be responsible for all costs related to securing and maintaining this facility.

Upon award of the Contract, the Contractor shall deliver the final staffing plan, including all key staffing positions, within thirty (30) calendar days after notice of award.

The Contractor shall identify and disclose any staff or operational functions located outside the State of Vermont. If any staff or operational functions are located outside the State of Vermont, the Contractor shall ensure that these locations do not compromise the delivery of integrated services and the seamless experience for members and providers.

In the event of a vacancy of a key staff member for any reason, the Contractor shall notify DVHA in writing within five (5) business days of the vacancy and the Contractor's plan to fill the vacancy. As part of its annual and quarterly reporting, the Contractor must submit to DVHA an updated organizational chart including e-mail addresses and phone numbers for key staff.

The key staff positions include, but are not limited to:

- **Chief Executive Officer** – The Chief Executive Officer has full and final responsibility for management and compliance with all provisions of the Contract.
- **Chief Financial Officer** – The Chief Financial Officer shall oversee the budget and accounting systems of the Contractor for this contract. This Officer shall, at a minimum, be responsible for ensuring that the Contractor meets the State's requirements for financial performance and reporting.
- **Compliance Officer** – The Contractor shall employ a Compliance Officer who is accountable to the Contractor's executive leadership. This individual will be the primary liaison with the State (or its designees) to facilitate communications between DVHA, the State's contractors and the Contractor's executive leadership and staff. This individual shall maintain a current knowledge of federal and state legislation, legislative initiatives and regulations that may impact the program. It is the responsibility of the Compliance Officer to coordinate reporting to the State and to review the timeliness, accuracy and completeness of reports and data submissions to the State. The Compliance Officer has primary responsibility for ensuring

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all Contractor functions are performed in compliance with the terms of the Contract.

- **Data Compliance Manager** - The Contractor shall employ a Data Compliance Manager who will provide oversight to ensure the Contractor's information systems and data related to this Contract conforms to DVHA data standards and policies. The Data Compliance Manager must have extensive experience in managing data quality and data exchange processes, including data integration and data verification. The Data Compliance Manager must also be knowledgeable in health care data and health care data exchange standards. The Data Compliance Manager shall manage data quality, verification and delivery, change management and data exchanges with DVHA or its designee(s). The Data Compliance Manager shall coordinate with the State to implement data exchange requirements. The Data Compliance Manager is responsible for attendance at all Technical Meetings called by the State.
  
- **Medical Director** – The Contractor shall employ the services of a Medical Director who is a DVHA-enrolled physician and is dedicated full time to this Contract. The Medical Director shall oversee the development and implementation of the Contractor's disease management and care management programs; oversee the development of the Contractor's clinical practice guidelines; review any potential quality of care problems; oversee the Contractor's clinical management program and programs; serve as the Contractor's medical professional interface with the Contractor's primary care providers (PCPs) and specialty providers; and direct the Quality Management and Utilization Management programs, including, but not limited to, monitoring, corrective actions and other quality management, utilization management or program integrity activities. The Medical Director is responsible for ensuring that the medical management and quality management components of the Contractor's operations are in compliance with the terms of the Contract. The Medical Director will attend DVHA quality meetings, at DVHA's request, which are expected to occur on a quarterly basis. .
  
- **Member Services Manager** – The Contractor shall employ a Member Services Manager who shall, at a minimum, be responsible for directing the activities of the Contractor's member services, including, but not limited to member helpline telephone performance; member e-mail communications; member education; the member website; member outreach programs; and development, approval and distribution of member materials. The Member Services Manager manages the member grievance process and works closely with other managers (especially the Quality Manager, Utilization Manager and Medical Director) and departments to address and resolve member grievances.

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The Member Services Manager is responsible for ensuring that all of the Contractor's member services operations are in compliance with the terms of the Contract.

- **Provider Services Manager** – The Contractor shall employ a Provider Services Manager who shall, at a minimum, be responsible for the provider services helpline performance; provider recruitment; provider contracting with the ACO (but not with DVHA); facilitating the provider claims dispute process (for payments made by the ACO, but not claims paid by DVHA); developing and distributing provider education materials; and developing outreach programs. The Provider Services Manager oversees the process of providing information to the State regarding the Contractor's provider network. The Provider Services Manager is responsible for ensuring that all of the Contractor's provider services operations are in compliance with the terms of the Contract.
- **Quality Improvement Manager** – The Contractor shall employ a Quality Improvement Manager who shall, at a minimum, be responsible for directing the activities of the Contractor's quality management staff in monitoring and auditing the Contractor's health care delivery system, including, but not limited to internal processes and procedures; provider network; service quality; and clinical quality. The Quality Improvement Manager shall assist the Contractor's Compliance Officer in overseeing the activities of the Contractor's operations to meet the State's goal of providing health care services that improve the health status and health outcomes of its members.
- **Utilization Management Manager** – The Contractor shall employ a Utilization Management Manager who shall, at a minimum, be responsible for directing the activities of the utilization management staff. With direct supervision by the Medical Director, the Utilization Management Manager shall direct staff performance regarding prior authorization; medical necessity determinations; concurrent review; retrospective review; appropriate utilization of health care services; continuity of care; care coordination; and other clinical and medical management programs. The Utilization Management Manager shall assure matters requiring review or investigation are submitted within five (5) business days to DVHA's Program Integrity Unit or as otherwise directed by DVHA.

In future years of this contract, DVHA may define additional key staff depending upon negotiated additional functions or responsibilities that may be added to the Contract.

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### 2.5.2 Staff Positions

In addition to the required key staff described in Section 2.5.1, the Contractor may employ those additional staff necessary to ensure the Contractor's compliance with the State's performance requirements. Suggested staff include, but is not limited, to:

- **Compliance staff** to support the Compliance Officer and help ensure all Contractor functions is in compliance with state and federal laws and regulations, the State's policies and procedures and the terms of the Contract. This may include staff who will assist and interface with the DVHA Program Integrity Unit and help review and investigate Contractor's providers and members that are engaging in wasteful, abusive, or fraudulent billing or service utilization.
- **Member services representatives** to coordinate communications between the Contractor and its members; respond to member inquiries; and assist all members regarding issues such as the Contractor's policies, procedures, general operations, and benefit coverage.
- **Provider representatives** to develop the Contractor's network and coordinate communications between the Contractor and contracted and non-contracted providers.
- **Grievance and appeals staff** necessary to investigate and coordinate responses to address member and provider grievances and appeals against the Contractor and interface with the DVHA Member and Provider Services staff.
- **Quality management staff** dedicated to perform quality management and improvement activities, and participate in the Contractor's internal Quality Management and Improvement Committee.
- **Utilization and medical management** staff dedicated to perform utilization management and review activities.
- **Care managers** who provide care management, care coordination and utilization management for high-risk or high-cost members.
- **Technical support services staff** to ensure the timely and efficient maintenance of information technology support services, production of reports, processing of data requests and submission of timely, complete and accurate encounter data.
- **Website staff** to maintain and update the Contractor's member and provider websites and member portal.

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#### 2.5.3 Training

On an ongoing basis, the Contractor must ensure that each staff person, including subcontractor staff, has appropriate education and experience to fulfill the requirements of their positions, as well as ongoing training specific to their role in the organization. The Contractor must ensure that all staff are trained in the major components of the Vermont Medicaid program.

Additionally, utilization management staff shall receive ongoing training regarding interpretation and application of the Contractor's utilization management guidelines. The ongoing training shall, at minimum, be conducted on a quarterly basis and as changes to the Contractor's utilization management guidelines and policies and procedures occur.

The Contractor shall update its training materials on a regular basis to reflect program changes. The Contractor shall maintain documentation to confirm its internal staff training, curricula, schedules and attendance, and shall provide this information to DVHA upon request and during regular on-site visits. For its utilization management staff, the Contractor shall be prepared to provide a written training plan, which shall include dates and subject matter, as well as training materials, upon request by DVHA.

#### 2.5.4 Debarred Individuals

In accordance with 42 CFR 438.610, the Contractor must not knowingly have a relationship with the following:

- An individual who is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, which relates to debarment and suspension; or
- An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

For purposes of this prohibition, the term relationships include directors, officers or partners of the Contractor, persons with beneficial ownership of five percent (5%) or more of the Contractor's equity, or persons with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under the Contract.

In accordance with 42 CFR 438.610, if DVHA finds that the Contractor is in violation of this regulation, this shall be grounds for Contract termination.

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The Contractor shall have policies and procedures in place to routinely monitor staff positions and subcontractors for individuals debarred or excluded. As part of readiness review, the Contractor shall demonstrate to DVHA that it has mechanisms in place to monitor staff and subcontractors for individuals debarred by Federal agencies.

The Contractor shall be required to disclose to the DVHA Program Integrity Unit information required by 42 CFR 455.106 regarding the Contractor's staff and persons with an ownership/controlling interest in the Contractor that have been convicted of a criminal offense related to that person's involvement in the Medicare or Medicaid program.

#### 2.6 DVHA Meeting Requirements

The Contractor shall comply with all meeting requirements established by DVHA, and is expected to cooperate with DVHA and/or its contractors in preparing for and participating in these meetings. DVHA reserves the right to cancel any regularly scheduled meetings, change the meeting frequency or format or add meetings to the schedule as it deems necessary.

DVHA will meet at least annually with the Contractor's executive leadership to review the Contractor's performance, discuss the Contractor's outstanding or commendable contributions, identify areas for improvement and outline upcoming issues that may impact the Contractor or the Medicaid ACO program.

#### 2.7 Financial Stability

DVHA will monitor the Contractor's financial performance. DVHA shall be copied on required filings with the Green Mountain Care Board related to the Contractor's financial stability.

##### 2.7.1 Solvency

The Contractor shall provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its members will not be liable for the Contractor's debts if the entity becomes insolvent.

##### 2.7.2 Insurance

The Contractor shall be in compliance with all applicable insurance laws throughout the term of the Contract and those specified in the State's Customary Provisions for Contracts and Grants. In addition, the Contractor must provide a performance bond of standard commercial scope issued by a surety company registered with the Vermont Department of Financial Regulation, Insurance Division in the amount of \$5,000,000, or other evidence of financial responsibility as may be approved by the State to guarantee performance by the Contractor of its obligations under the Contract. The State reserves the right to increase the

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financial responsibility requirements set forth in this section if, in the State's judgment, attribution levels indicate the need to do so. In the event of a default by the Contractor, the State must, in addition to any other remedies it may have under the Contract, obtain payment under the performance bond or other arrangement for the purposes of the following:

- (i) Reimbursing the State for any expenses incurred by reason of a breach of the Contractor's obligations under the Contract, including, but not limited to, expenses incurred after termination of the Contract for reasons other than the convenience of the State.
- (ii) Reimbursing the State for costs incurred in procuring replacement services.

The performance bond, which is due within 10 calendar days after the execution of the contract, must be made payable to "State of Vermont" and must be in the form of an irrevocable letter of credit, certified check, cashier's check, a bond acquired from a surety company registered with the Vermont Department of Financial Regulation Insurance Division, or other evidence deemed acceptable by the State. The bond must remain in effect for the duration of the contract. Notwithstanding any other provisions relating to the beginning of the term, the contract shall not become effective until the performance bond required by the contract is delivered in the correct form and amount to DVHA.

No less than thirty (30) calendar days before the policy renewal effective date, the Contractor must submit to DVHA its certificate of insurance for each renewal period for review and approval.

#### **2.7.3 Financial Accounting Requirements**

The Contractor shall maintain separate accounting records for its Medicaid line of business that incorporates performance and financial data of subcontractors, as appropriate, particularly risk-bearing subcontractors.

The Contractor shall notify DVHA of any person or corporation with five percent (5%) or more of ownership or controlling interest in the Contractor and shall submit financial statements for these individuals or corporations.

Authorized representatives or agents of the State and the federal government shall have access to the Contractor's accounting records and the accounting records of its subcontractors upon reasonable notice and at reasonable times during the performance and/or retention period of the Contract for purposes of review, analysis, inspection, audit and/or reproduction.

Copies of any accounting records pertaining to the Contract shall be made available by the Contractor within ten (10) calendar days of receiving a written request from the State for specified records. DVHA and other state and federal

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agencies and their respective authorized representatives or agents shall have access to all accounting and financial records of any individual, partnership, firm or corporation insofar as they relate to transactions with any department, board, commission, institution or other state or federal agency connected with the Contract.

The Contractor shall maintain financial records pertaining to the Contract, including all claims records, for the period specified in the State's Customary Provisions for Contracts and Grants. However, accounting records pertaining to the Contract shall be retained until final resolution of all pending audit questions and for one (1) year following the termination of any litigation relating to the Contract.

DVHA will require Contractors to produce the information on the Contractor's financial condition at the close of its fiscal year and upon request by the DVHA Commissioner. Included with the financial information will be an opinion of an independent certified public accountant (CPA) on the financial statement of the Contractor. The CPA's certification shall represent whether the assets of the Contractor make adequate provision for any additional liability that may inure to the Contractor by virtue of its assumption of risk under a financial risk transfer agreement or any similar transaction. The amount and adequacy of any such liability shall be disclosed and commented upon by the CPA in its certification.

Any financial statement submitted to DVHA shall be sworn to under penalty of perjury by the Contractor's Chief Financial Officer. Information in the financial statement submission shall include, but not be limited to:

- A statement of revenues and expenses
- A balance sheet
- Cash flows and changes in equity/fund balance

At least annually, the Contractor shall provide to DVHA confirmation of appropriate insurance coverage for medical malpractice, general liability, property, workers' compensation and fidelity bond, in conformance with state and federal regulations.

DVHA may make an examination of the affairs of the Contractor as often as it deems prudent. The focus of the examination will be to ensure that the Contractor is not subject to adverse actions which in DVHA's determination have the potential to impact the Contractor's ability to meet its responsibilities with respect to its use of in-network capitation funds received from DVHA and the Contractor's compliance with the terms and conditions of any financial risk transfer agreement. Responses to DVHA requests shall fully disclose all financial or other information requested. Information designated as confidential may be not be disclosed by DVHA without the prior written consent of the Contractor except as required by law. If the Contractor believes the requested information is confidential and not to be disclosed to third parties, the Contractor shall provide a

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detailed legal analysis to DVHA setting forth the specific reasons why the information is confidential and describing the specific harm or injury that would result from disclosure.

#### 2.7.4 Medical Loss Ratio

On an annual basis, the Contractor shall maintain, at minimum, a Medical Loss Ratio (MLR) of eighty-five (85%) percent for its Medicaid line of business. DVHA reserves the right to recoup excess capitation paid to the Contractor in the event the Contractor's MLR, as verified by DVHA on an annual basis, is less than eighty-five (85%) percent for the Medicaid line of business. DVHA shall retain the authority to determine how the MLR is defined and calculated.

#### 2.8 Reporting Transactions with Parties of Interest

The Contractor shall disclose to DVHA information on certain types of transactions they have with a "party in interest" defined as:

- Any director, officer, partner or employee responsible for management or administration of an ACO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the ACO; any person who is the beneficial owner of a mortgage, deed of trust, note or other interest secured by, and valuing more than five percent (5%) of the ACO; and, in the case of an ACO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable state corporation law;
- Any entity in which a person described in the paragraph above is director or officer; is a partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the ACO; or has a mortgage, deed of trust, note or other interest valuing more than five percent (5%) of the assets of the ACO;
- Any person directly or indirectly controlling, controlled by or under common control of the ACO; and
- Any spouse, child or parent of an individual described above.

Business transactions which shall be disclosed include:

- Any sale, exchange or lease of any property between the ACO and a party in interest;
- Any lending of money or other extension of credit between the ACO and a party in interest; and
- Any furnishing for consideration of goods, services (including management services) or facilities between the ACO and the party in interest. This does not

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include salaries paid to employees for services provided in the normal course of their employment.

The information which must be disclosed in the transactions between the Contractor and a party in interest listed above includes:

- The name of the party in interest for each transaction;
- A description of each transaction and the quantity or units involved;
- The accrued dollar value of each transaction during the fiscal year; and
- Justification of the reasonableness of each transaction.

In addition to the above information on business transactions, the Contractor may be required to submit a consolidated financial statement for the Contractor and the party in interest.

#### **2.9 Subcontracts**

The term “subcontract(s)” includes contractual agreements between the Contractor and any entity that performs delegated activities related to the Contract or any administrative entities not involved in the actual delivery of medical care. Medicaid approved providers are excluded from the requirements and oversight of Section 2.9.

The Contractor is responsible for the performance of any obligations that may result from the Contract. Subcontractor agreements do not terminate the legal responsibility of the Contractor to the State to ensure that all activities under the Contract are carried out. The Contractor shall oversee subcontractor activities and submit an annual report on its subcontractors’ compliance, corrective actions and outcomes of the Contractor’s monitoring activities. The Contractor shall be held accountable for any functions and responsibilities that it delegates.

The Contractor shall provide that all subcontracts indemnify and hold harmless the State of Vermont, its officers and employees from all claims and suits, including court costs, attorney’s fees and other expenses, brought because of injuries or damage received or sustained by any person, persons or property that is caused by an act or omission of the Contractor and/or the subcontractors. This indemnification requirement does not extend to the contractual obligations and agreements between the Contractor and health care providers or other ancillary medical providers that have contracted with the Contractor.

The subcontracts shall further provide that the State shall not provide such indemnification to the subcontractor.

Contractor shall monitor the financial stability of subcontractor(s) whose payments are equal to or greater than five percent (5%) of DVHA capitation payments to the Contractor.

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At least annually, the Contractor must obtain the following information from the subcontractor and use this information to monitor the subcontractor's performance: audited financial statements including statement of revenues and expenses, balance sheet, cash flows and changes in equity/fund balance. The Contractor shall make these documents available to DVHA upon request and DVHA shall have the right to review these documents during Contractor site visits.

The Contractor shall comply with 42 CFR 438.230 and the following subcontracting requirements:

- The Contractor shall obtain the approval of DVHA before subcontracting any portion of the project's requirements. The Contractor shall give DVHA a written request and submit a Subcontractor Compliance Form at least sixty (60) calendar days prior to the use of a subcontractor. The State will insure that the proposed subcontractor (1) does not appear on the State's debarment list, and (2) that the work to be performed by the subcontractor is appropriate and in accordance with the scope and terms of the agreement. If the Contractor makes subsequent changes to the duties included in the subcontractor contract, it shall notify DVHA sixty (60) calendar days prior to the revised contract effective date and submit an updated Subcontractor Compliance Form for review and approval. DVHA must approve changes in vendors for any previously approved subcontracts.
- The Contract shall insure the subcontractor is in full compliance with Attachment C regarding fair employment practices and the Americans with Disabilities Act, taxes due the State, child support orders (if applicable) and debarment.
- The State will not approve a subcontract involving offshore services.
- The Contractor shall evaluate prospective subcontractors' abilities to perform delegated activities prior to contracting with the subcontractor to perform services associated with the Medicaid ACO program.
- The Contractor shall have a written agreement with each subcontractor in place that specifies the subcontractor's responsibilities and provides an option for revoking delegation or imposing other sanctions if performance is inadequate. The written agreement shall be in compliance with the State of Vermont statutes and federal laws and will be subject to the provisions thereof.
- The Contractor shall collect performance data from its subcontractors and monitor delegated performance on an ongoing basis and conduct formal, periodic and random reviews. The Contractor shall incorporate all subcontractors' data into the Contractor's performance and financial data for a comprehensive evaluation of the Contractor's performance compliance and identify areas for its subcontractors' improvement when appropriate. The Contractor shall take corrective action if deficiencies are identified during the review.

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- All subcontractors shall fulfill all state and federal requirements appropriate to the services or activities delegated under the subcontract. In addition, all subcontractors shall fulfill the requirements of the Contract (and any relevant amendments) that apply to any service or activity delegated under the subcontract.
- The Contractor shall submit a plan to the state on how the subcontractor will be monitored for debarred employees.
- The Contractor shall assure the fulfillment of the requirements of 42 CFR 434.6, which addresses general requirements for all Medicaid contracts and subcontracts.

The Contractor must have policies and procedures addressing auditing and monitoring subcontractors' data, data submissions and performance. The Contractor must integrate subcontractors' performance data (when applicable) into the Contractor's information system to accurately and completely report Contractor performance and confirm contract compliance.

DVHA shall have the right to audit the Contractor's subcontractors' self-reported data and change reporting requirements at any time with reasonable notice. DVHA may require corrective actions and will assess liquidated damages for non-compliance with reporting requirements and performance standards.

If the Contractor uses subcontractors to provide direct services to members, the subcontractors shall meet the same requirements as the Contractor, and the Contractor shall demonstrate that the subcontractors are in compliance with these requirements. The Contractor shall require subcontractors providing direct services to have quality improvement goals and performance improvement activities specific to the types of services provided by the subcontractors.

#### 2.10 Confidentiality of Member Medical Records and Other Information

The Contractor shall ensure that member medical records as well as any other health and enrollment information that contains individually identifiable health information is used, stored/maintained and disclosed in accordance with the privacy requirements set forth in DVHA's Business Associate Agreement.

#### 2.11 Response to State Inquiries

DVHA may directly receive inquiries and complaints from external entities, including but not limited to providers, members, legislators or other constituents which the Contractor will be required to research, respond to and resolve in the timeframe specified by DVHA.

#### 2.12 Dissemination of Information

Upon the request of DVHA, the Contractor shall distribute information prepared by DVHA, its designee, or the Federal Government to its members.

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#### 2.13 Maintenance of Records

The Contractor shall maintain records that fully disclose the extent of services provided to individuals under this program for a period of six (6) years in accordance with 42 CFR part 455 and 45 CFR 164.530(j)(2), or for the duration of contested case proceedings, whichever is longer.

#### 2.14 Maintenance of Written Policies and Procedures

The Contractor shall develop and maintain written policies and procedures for each functional area in compliance with the Code of Federal Regulations, Vermont Statutes, DVHA Rules applicable to this Contract, ACO Operations Manual and the Contract. Written guidelines shall be maintained for developing, reviewing and approving all policies and procedures. The Contractor shall review all policies and procedures at least annually to ensure they reflect current practice and shall update them as necessary. Reviewed policies shall be signed and dated. All medical and quality management policies shall be reviewed and approved by the Contractor's Medical Director. DVHA has the right to review all Contractor policies and procedures. Should DVHA determine a policy requires revision, the Contractor shall work with DVHA to revise within the timeframes specified by the State. If DVHA determines the Contractor lacks a policy or process required to fulfill the terms of the Contract, the Contractor must adopt a policy or procedure as directed by DVHA.

#### 2.15 Participation in Readiness Review

The Contractor must pass a readiness review process and be ready to assume responsibility for contracted services before the Contract effective date. After the Contract has been ratified, the Contractor will be required to maintain a detailed implementation plan to be approved by DVHA which identifies the elements for implementing the proposed services. In addition to submitting the implementation plan with the proposal, the Contractor may be required to submit a revised implementation plan for review as part of the readiness review. The readiness review will be conducted by DVHA or its designee and will begin no later than 45 days prior to the start date of the Contract.

If DVHA determines at the conclusion of the readiness review that a functional area or areas are not ready, DVHA may, in its discretion, conduct a re-review at a later date. The re-review may occur prior to or after the start date of the Contract and will continue until the Contractor has passed DVHA's certification of readiness.

In preparation for planned onsite reviews, the Contractor shall cooperate with DVHA by forwarding in advance policies, procedures, job descriptions, contracts, reports, records, logs, and other material upon request. Documents not requested in advance shall be made available during the course of the review. Contractor personnel shall be available at all times during review activities.

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#### 2.16 DVHA Ongoing Monitoring

DVHA shall conduct ongoing monitoring of the Contractor to ensure compliance with Contract requirements and performance standards. The method and frequency of monitoring is at the discretion of DVHA and may include, but is not limited to, both scheduled and unannounced site visits, review of policies and procedures, and performance reporting.

In support of ongoing monitoring, DVHA is in the process of creating two guidance documents that will be effective upon execution of the contract:

- The ACO Reporting Manual will contain a catalog of the reports that will be required to be submitted by the Contractor to DVHA and the periodicity schedule of each report submission. For every report, DVHA will provide both a report template and instructions for how to complete each report.
- The ACO Operations Manual will contain written procedures that will be created for each functional area, as needed, that pertain to the notifications, reporting, or file exchanges between the Contractor and DVHA.

The ACO is bound to ACO Reporting Manual and ACO Operations Manual changes. Both the ACO Reporting Manual and ACO Operations Manual will be considered “living” documents and will be updated, as needed, throughout the course of the contract. The first version of each document is intended to be delivered to the Contractor upon notification of award. It is DVHA’s intention to conduct a thorough walk through of both the ACO Reporting Manual and ACO Operations Manual with the Contractor to allow for clarifications and input from the Contractor before DVHA finalizes both documents prior to Contract start date.

#### 2.17 Material Change

A material change to operations is any change in overall business operations, such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of the Contractor’s membership or provider network.

Prior to implementing a material change in operation, the Contractor shall submit a request to DVHA for review and approval at least sixty (60) calendar days in advance of the effective date of the change. The request shall contain, at minimum, information regarding the nature of the change, the rationale for the change, and the proposed effective date. Contractor may be required, at the direction of DVHA, to communicate material changes to members or providers at least thirty (30) days prior to the effective date of the change.

No change will alter the capitation payments agreed to.

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2.18 Future Program Guidance

In addition to complying with the ACO Operations Manual and ACO Reporting Manual, the Contractor shall operate in compliance with all future program manuals, guidance and policies and procedures, as well as any amendments thereto. Future modifications that have a significant impact on the Contractor's responsibilities, as set forth in this Scope of Work, will be made through the Contract amendment process.

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#### **3.0 Covered Services**

##### **3.1 Medical Necessity**

The Contractor shall provide to its attributed Medicaid members, at a minimum, all benefits and services deemed “medically necessary” that are covered by Medicaid and included in the Contract with the State. Medical necessity is defined in the State’s Medicaid Covered Services Rules as follows:

“Medically necessary” means health care services, including diagnostic testing, preventive services, and aftercare, that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the beneficiary's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition, and

- A. help restore or maintain the beneficiary's health; or
- B. prevent deterioration or palliate the beneficiary's condition; or
- C. prevent the reasonably likely onset of a health problem or detect an incipient problem.

The Contractor shall deliver covered services sufficient in amount, duration or scope to reasonably expect that provision of such services would achieve the purpose of the furnished services. Coverage may not be arbitrarily denied or reduced and is subject to certain limitations in accordance with 42 CFR 438.210(a)(3)(iii), which specifies when Contractors may place appropriate limits on services:

- On the basis of criteria applied under the State Plan, such as medical necessity; or
- For the purpose of utilization control, provided the services furnished are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.

##### **3.2 Services Covered in the ACO Capitation Payment**

The risk-based capitated payment to the Contractor includes payment for the following categories of services.

- Inpatient hospital services
- Outpatient hospital services
- Physician services, primary care and specialty
- Nurse practitioner services
- Ambulatory surgical center services
- Federally Qualified Health Center and Rural Health Clinic services

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- Home health services
- Hospice services
- Physical, occupational and speech therapy services
- Chiropractor services
- Audiology services
- Podiatrist services
- Optometrist and optician services
- Independent laboratory services
- Mental health and substance abuse services funded by DVHA and not funded by other State Departments; *however, H0001 – H2037 are always excluded*
- Ambulance transport – emergent/non-emergent
- Durable medical equipment, prosthetics and orthotics (except eyewear)
- Medical supplies
- Dialysis facility services
- Preventive services

A detailed listing, by CPT/HCPCS, of services covered in the ACO capitation payment appears in Attachment C. Specific benefits/services and the limitations for these benefits/services are described in Vermont Medicaid Rules. The detailed listing in Attachment C represents national coding conventions at the time of the release of this RFP. Coding conventions are periodically updated. DVHA will update Attachment C on a periodic basis (no more frequently than quarterly), as necessary, and will include it as part of the ACO Operations Manual.

### 3.3 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

EPSDT is a federally-mandated preventive health care program that provides early and periodic screening and diagnosis of eligible Medicaid beneficiaries under age 21 to ascertain physical and mental defects and to provide treatment to correct or ameliorate defects and chronic conditions found. The Contractor must provide all medically necessary covered EPSDT services under Section 3.2 of the Scope of Work in accordance with Federal law.

For covered EPSDT services, the Contractor shall comply with the requirements of 42 U.S.C. § 1396a (a) (43) and 42 U.S.C. § 1396d (r). These citations require the Vermont Medicaid Program to follow an immunization schedule recommended by the American Pediatric Association; it requires vision, dental, and hearing screenings at regular intervals; and it requires treatment of conditions found during screenings to correct or ameliorate those conditions.

Additionally, the contractor shall educate pregnant woman and work with prenatal clinics and other providers to educate pregnant woman about the importance of EPSDT screenings and encourage them to schedule preventive visits for their infants. The contractor shall educate parents of children under 21 years of age regarding preventive screenings.

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#### 3.4 Emergency Care and Post Stabilization

The Contractor shall cover emergency services without the need for prior authorization or the existence of a contract with the emergency care provider in accordance with and as defined in 42 CFR 438.114.

The Contractor shall cover post-stabilization services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or to improve or resolve the member's condition in accordance with and as described in 42 CFR 438.114(e).

#### 3.5 Self-referral Services

The Contractor shall provide female members attributed to the ACO with direct access to women's health specialists in accordance with 42 CFR § 438.206(b)(2).

The Contractor shall provide members attributed to the ACO with direct access to specialists for members in special healthcare needs populations as defined in Section 4.2.2 of this Scope of Work.

#### 3.6 Services Not Covered in the ACO Capitation Payment

The following services are paid for by DVHA but are not included in the Contractor's capitated monthly rate:

- Pharmacy
- Nursing facility care
- Psychiatric treatment in a state psychiatric hospital
- Level 1 (involuntary placement) inpatient psychiatric stays in any hospital when paid for by DVHA
- Dental services
- Non-emergency transportation (ambulance transportation is not part of this category)
- Smoking cessation services

Additionally, other services offered to Medicaid members but paid for by State Departments other than DVHA are not covered in the Contractor's capitated monthly rate, such as:

- Services delivered through Designated Agencies (DAs), Specialized Service Agencies (SSAs) and Parent Child Centers (PCCs) paid for by State Agencies other than DVHA
- Other services administered and paid for by the Vermont Department of Mental Health

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- Services administered and paid for by the Vermont Division of Alcohol and Drug Abuse Programs through a preferred provider network
- Services administered by the Vermont Department of Disabilities, Aging and Independent Living
- Services administered and paid for by the Vermont Agency of Education
- Services administered and paid for by the Vermont Department of Health, including smoking cessation services

#### **3.7 Continuity of Care**

The Contractor shall implement mechanisms to ensure the continuity of care and coordination of medically necessary health care services for its members. The Contractor shall honor previous authorizations of services made by DVHA for a minimum of thirty (30) calendar days from the member's attribution with the Contractor. Contractor shall establish policies and procedures for identifying outstanding prior authorization decisions at the time of the member's attribution.

Additionally, when a member transitions out of the ACO, the Contractor shall be responsible for providing to DVHA, upon request, with information on any current service authorizations, utilization data and other applicable clinical information such as disease management, case management or care management notes.

If an ACO attributed member leaves the ACO during an inpatient stay, the Contractor will remain financially responsible for the hospital payment until the member is discharged from the hospital or the member's eligibility in Medicaid terminates.

#### **3.8 Enhanced Services**

The State encourages the Contractor to cover programs that enhance the general health and well-being of its members, including programs that address preventive health, risk factors or personal responsibility.

Any enhanced services shall comply with the member incentives guidelines set forth in Section 8 of this Scope of Work and other relevant state and federal regulations regarding inducements. All enhanced services offered by the Contractor must be approved by DVHA prior to initiating such services.

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#### **4.0 Member Services**

##### **4.1 Marketing and Outreach**

In accordance with 42 CFR 438.104, and the requirements outlined in Section 4.5, the Contractor may market itself to Medicaid members. However, if the Contractor chooses to conduct marketing activities, the Contractor shall obtain State approval for all marketing and outreach materials at least thirty (30) calendar days prior to distribution.

The Contractor may market by mail, mass media advertising (e.g., radio, television and billboards) and community-oriented marketing directed at potential members. The contractor shall not design their marketing efforts in such a way that the marketing materials target groups with favorable demographics or healthcare needs.

Any outreach and marketing activities (written and oral) shall be presented and conducted in an easily understood manner and format and at a sixth grade reading level. The Contractor shall not engage in marketing activities that mislead, confuse or defraud members or the State. Statements considered inaccurate, false, or misleading include, but are not limited to, any assertion or written or oral statement that:

- The member or potential member must join the Contractor's ACO to obtain benefits or to avoid losing benefits;
- The Contractor is endorsed by CMS, the federal or state government or a similar entity; or
- The Contractor's ACO plan is the only opportunity to obtain benefits under the State of Vermont's Medicaid program.

##### **4.2 Member Attribution to the ACO**

The attribution of DVHA members to an ACO will be prospective and will be based on the individual's prior utilization with either a Primary Care Provider (PCP) or selected specialist providers. The Contractor shall not, on the basis of health status or need for health care services, discriminate against individuals eligible to attribute to the ACO. Additionally, the Contractor shall not discriminate against individuals eligible to attribute on the basis of race, color, national origin, or sexual orientation and will not use any policy or practice that has the effect of discriminating in such manner.

###### **4.2.1 PCP Selection**

Medicaid members have the option to select their Primary Care Provider (PCP) at the time of enrollment with Medicaid. The member has the option to change their PCP selection at any time. The Contractor shall have written policies and procedures for allowing members to select a new PCP and provide information on options for selecting a new PCP when it has been determined that a PCP is non-compliant with provider standards (i.e. quality of care) and is terminated from the

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ACO, or when a PCP change is ordered as part of the resolution to a grievance proceeding. The ACO shall allow the member to select another PCP within ten (10) business days of the postmark date of termination of a PCP notice to members. The notice shall include information on options for selection a new PCP. The Contractor's written policies and procedures for PCP selection shall be approved by DVHA.

Additionally, if a provider associated with the ACO decides to terminate their care or treatment of a Medicaid member, the ACO will, within fifteen (15) calendar days of termination, notify DVHA of the member's name, unique ID number (UID) and the cause for the termination of the relationship (this will not be required when a member loses eligibility).

#### 4.2.2 Special Healthcare Needs Populations

The Contractor shall have plans for provision of care for the special healthcare needs populations and for provision of medically necessary, specialty care through direct access to specialists. Under this contract, the definition and reference for children with special health care needs is the one adopted by the Maternal and Child Health Bureau (MCHB) and published by the American Academy of Pediatrics (AAP):

"Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

In accordance with 42 CFR 438.208(c)(2), which specifies allowable staff, the Contractor shall have a *health care professional* assess the member through a detailed health assessment if a health screening identifies the member as potentially having a special health care need. CMS has identified the following populations as meeting the statutory definition of "special healthcare populations" pursuant to 42 CFR 438.208:

- Adults in the Community Rehabilitation Services program,
- Children in the Enhanced Family Treatment program,
- People with traumatic brain injuries,
- Children in the high-tech needs program,
- Individuals with developmental disabilities, and
- People receiving Home and Community Based Services.

The Contractor shall offer continued coordinated care services to any special health care needs members transferring into the Contractor's membership.

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#### 4.2.3 Member Termination from the ACO

The Contractor may neither terminate attribution in its ACO nor encourage a member to leave its ACO because of a member's health care needs or a change in a member's health care status. A member's health care utilization patterns may not serve as the basis for disenrollment from the ACO.

The Contractor shall notify DVHA in the manner outlined in the ACO Operations Manual within ten (10) calendar days of the date it becomes aware of the death of one of its members, giving the member's full name, address, Social Security Number, member identification number and date of death. The Contractor will have no authority to pursue recovery against the estate of a deceased Medicaid member.

In the event of the death of an ACO attributed member, the ACO shall receive fifty percent (50%) of the usual capitation payment for any member who dies on or before the 15<sup>th</sup> calendar day of the month. The recoupment of any capitation payments made to the Contractor due to the death of an ACO attributed member will occur during the year-end reconciliation process.

#### 4.3 Member-Contractor Communications

##### 4.3.1 Member Services Helpline

The State shall continue to maintain a statewide toll-free telephone helpline staffed with trained personnel knowledgeable about the Vermont Medicaid program as well as basic information about the ACO's programs. The State's Member Services Helpline is intended to be equipped to handle a variety of basic, first tier member inquiries, including the ability to address member questions, concerns, complaints and requests for PCP changes.

The Contractor shall be responsible for its own Member Services Helpline to handle questions from its members that require the specific expertise and authority by the Contractor to resolve. Staff assigned to this function must be available to provide sufficient "live voice" access to members during, at a minimum, the hours between 8 a.m. and 6 p.m. Eastern, Monday through Friday. The Contractor shall provide an after-hours voice message system that informs callers of the Contractor's business hours and offers an opportunity to leave a message after business hours. Calls received in the voice message system shall be returned within one (1) business day. During hours of operation, the Contractor must be able to receive transfers from DVHA's Member Services Helpline, AHS staff and members who wish to directly call the ACO.

The Contractor's helpline may be closed on all holidays observed by the State government. Call center closures, limited staffing or early closures shall not burden a member's access to care.

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The Contractor's helpline shall offer language translation services for members whose primary language is not English and shall provide Telecommunications Device for the Deaf (TDD) services for hearing impaired members.

The Contractor's Helpline staff shall be trained to ensure that member questions and concerns are resolved as expeditiously as possible. The Contractor shall maintain a system for tracking and reporting the number and type of members' calls and inquiries it receives during business hours and non-business hours. The Contractor shall monitor its member services helpline service and report its telephone service level performance to DVHA in the timeframes and specifications described in the ACO Reporting Manual.

Upon a member's joining the ACO, the Contractor shall inform the member about the State's Member Services Helpline as well as the Contractor's Helpline.

The Contractor must meet the following performance standards related to the responsiveness of staffed telephone lines:

- During open hours, seventy-five percent of all incoming calls that opt to talk to a live operator are answered by a live operator within 25 seconds of leaving the contractor's Interactive Voice Response (IVR) system;
- Lost call abandonment rate after the call exits the IVR shall not exceed five percent.
- 98% of calls are answered by a live agent within four minutes.

#### 4.3.2 Electronic Communications

The Contractor shall provide an opportunity for members to submit questions or concerns electronically, via e-mail and through the member website.

The Contractor shall respond to questions and concerns submitted by members electronically within twenty-four (24) hours. If the Contractor is unable to answer or resolve the member's question or concern within twenty-four (24) hours, the Contractor shall notify the member that additional time will be required and identify when a response will be provided. A final response shall be provided within three (3) business days.

The Contractor shall maintain the capability to report on e-mail communications received and responded to, such as total volume and response times. The Contractor shall be prepared to provide this information to DVHA upon request.

The Contractor shall collect information regarding the member's preferred mode of receipt of Contractor-generated communications and send materials in the selected format. Options may include the ability to receive paper communications via mail or electronic communications through email or a secure web portal when confidential information is to be transmitted. When a member notifies the Contractor of selection to receive communications electronically, that choice shall

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be confirmed through US mail with instructions on how to change the selection if desired. When applicable, the Contractor shall comply with a member's preferred mode of communication.

#### 4.4 Member Information, Outreach and Education

The Contractor shall take reasonable measures to ensure that materials sent to the member are in the member's preferred language. The Contractor shall inform members that information is available upon request in alternative formats and how to obtain them. DVHA defines alternative formats as Braille, large font letters, audiotape, prevalent languages and verbal explanation of written materials. To the extent possible, written materials shall not exceed a sixth grade reading level.

The Contractor shall inform the members that, upon the member's request, the Contractor will provide information on the structure and operation of the Contractor and, in accordance with 42 CFR 438.6(h), will provide information on the Contractor's provider incentive plans.

The Contractor shall be responsible for developing and maintaining member education programs designed to provide the members with clear, concise and accurate information about the Contractor's program and the Contractor's network.

The State encourages the Contractor to incorporate community advocates, support agencies, health departments, other governmental agencies and public health associations in its outreach and member education programs. The State encourages the Contractor to develop community partnerships with these types of organizations, in particular with community mental health centers, local health offices and prenatal clinics in order to promote health and wellness within its membership.

The Contractor shall have in place policies and procedures to ensure that materials distributed to members are accurate in content, accurate in translation relevant to language or alternate formats and do not defraud, mislead or confuse the member. The Contractor shall provide information requested by the State for use in member education, upon request.

##### 4.4.1 New Member Materials

The Contractor has the option to provide to its DVHA members a Welcome Packet to introduce them to the ACO. If the Contractor chooses this option, the Welcome Packet is subject to review by DVHA to ensure consistency with other member materials sent out by DVHA. The Welcome Packet may include, but not be limited to, a new member letter, explanation of where to find information about the Contractor's provider network, information about completing a health needs screening and any unique features of the ACO.

The Contractor is required to give DVHA members the option to opt out of data sharing, that is, for DVHA to send the Contractor claims information about the

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member. A notice must be sent to attributed members outlining the procedures that the member may follow should they wish to change their claims data sharing preferences (either to opt in or opt out of data sharing).

#### 4.4.2 Member Website

The Contractor shall provide and maintain a website for members to access information pertaining to the Contractor's services. The website shall be in a DVHA-approved format (compliant with Section 508 of the US Rehabilitation Act) to ensure compliance with existing accessibility guidelines. The website shall be live and meet the requirements of this section on the effective date of the Contract. DVHA must approve the Contractor's website information. The website shall be accurate and current, culturally appropriate, and written for understanding at a sixth grade reading level. The Contractor shall inform members that information is available upon request in alternative formats and how to obtain alternative formats. To minimize download and wait times, the website shall avoid techniques or tools that require significant memory or disk resources or require special intervention by the user to install plug-ins or additional software. The Contractor shall allow users print access to the information. Such website information shall include, at minimum, the following:

- The Contractor's searchable provider network identifying each provider's specialty, service location(s), hours of operation, phone numbers, public transportation access and other demographic information. The Contractor must update the on-line provider network information every thirty (30) days, as needed, at a minimum;
- The Contractor's contact information for member inquiries, grievances and appeals;
- The Contractor's member services phone number, TDD number, hours of operation and after-hours access numbers;
- The member's rights and responsibilities, as enumerated in 42 CFR 438.100, which relates to enrollee rights;
- A description of the Contractor's disease management programs and care management services;
- Contractor-distributed literature regarding all health or wellness promotion programs that are offered by the Contractor;
- The Health Insurance Portability and Accountability Act (HIPAA) privacy statement;
- The executive summary of Contractor's Annual Quality Management and Improvement Program Plan Summary Report; and
- Links to DVHA's website for general Medicaid information.

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#### 4.4.3 Preventive Care Information

The Contractor is responsible for educating members regarding the importance of using preventive care services in accordance with preventive care standards.

#### 4.4.4 Cost and Quality Information

Making cost and quality information available to members increases transparency and has the potential to reduce costs and improve quality. The Contractor shall make cost and quality information available to members in order to facilitate more responsible use of health care services and inform health care decision-making. Example cost information includes average cost of common services, urgent versus emergent care costs, etc.

Provider quality information shall also be made available to members. The Contractor shall capture quality information about its network providers, and must make this information available to members. In making the information available to members, the Contractor shall identify any limitations of the data. The Contractor shall also refer members to quality information compiled by credible external entities.

#### 4.5 Member and Potential Member Communications Review and Approval

Member and potential member communications developed by the Contractor shall be approved by DVHA. The Contractor must develop and include a Contractor-designated inventory control number on all member marketing, education, training, outreach and other member materials with a date issued or date revised clearly marked. The purpose of this inventory control number is to facilitate DVHA's review and approval of member materials and document its receipt and approval of original and revised documents.

The Contractor shall not refer to or use DVHA or other state agency names or logos in its member and potential member communications without prior written approval. Any approval given for the DVHA or other state agency name or logo is specific to the use requested, and shall not be interpreted as blanket approval.

#### 4.6 Member-Provider Communications

The Contractor shall comply with 42 CFR 438.102, which relates to member-provider communications. The Contractor must not prohibit or otherwise restrict a health care professional, acting within his or her lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient regarding the following:

- The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered, regardless of whether benefits for such care are provided under Medicaid or CHIP;

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- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; and
- The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

#### 4.7 Member Rights

The Contractor shall guarantee the following rights protected under 42 CFR 438.100 to its members:

- The right to receive information in accordance with 42 CFR 438.10, which relates to informational materials;
- The right to be treated with respect and with due consideration for his or her dignity and privacy;
- The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;
- The right to participate in decisions regarding his or her health care, including the right to refuse treatment;
- The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion;
- The right to request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in the HIPAA Privacy Rule set forth in 45 CFR parts 160 and 164, subparts A and E, which address security and privacy of individually identifiable health information; and
- The right to be furnished health care services in accordance with 42 CFR 438.206 through 438.210, which relate to service availability, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.

The Contractor shall also comply with other applicable state and federal laws regarding member rights, as set forth in 42 CFR 438.100(d).

The Contractor shall have written policies in place regarding the protected member rights listed above. The Contractor shall have a plan in place to ensure that its staff and network providers take member rights into account when furnishing services to the

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Contractor's members. Members shall be free to exercise protected member rights, and the Contractor shall not discriminate against a member that chooses to exercise his or her rights.

#### **4.8 Interpretation Services**

In accordance with 42 CFR 438.10(c)(4), the Contractor shall arrange for interpretation services to its members free of charge for services it provides, including, but not limited to the member services helpline described in Section 4.3.1. The Contractor shall notify its members of the availability of these services and how to obtain them.

The requirement to provide interpretation applies to all non-English languages. Interpretation services shall include sign language interpretation services for the deaf.

Additionally, the Contractor shall ensure that its provider network arranges for interpretation services to members seeking healthcare-related services in a provider's service location. This includes ensuring that providers who have twenty-four (24) hour access to healthcare-related services in their service locations or via telephone (e.g., hospital emergency departments, PCPs) shall provide members with twenty-four (24) hour oral interpreter services, either through interpreters or telephone services. For example, the Contractor shall ensure that network providers provide TDD services for hearing impaired members, oral interpreters, and signers.

#### **4.9 Cultural Competency**

In accordance with 42 CFR 438.206, the Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

#### **4.10 Advance Directives**

The Contractor shall comply with the requirements of 42 CFR 422.128, which relates to advance directives, for maintaining written policies and procedures for advance directives. The Contractor should adhere to Vermont State Law and the DVHA Provider Manual that addresses advance directives, which is excerpted below.

Hospitals, nursing homes, home health agencies, hospices and prepaid health care organizations are required to provide certain patients with information about their right to formulate advance directives and maintain written policies and procedures with respect to advance directives. They are also required to document in patients' files whether or not an advance directive is in effect, provide education for staff and the community on issues concerning advance directives, and ensure compliance with State law on advanced directives at their facilities. Providers are responsible to guard the confidentiality of member information in a matter consistent with the confidentiality requirements in 45 CFR parts 160 and 164 and as required by state law.

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#### 4.11 Member Grievances and Appeals

DVHA shall maintain its own internal Grievance and Appeals processes for grievances and appeals not directly related to the ACO. The Contractor, however, shall serve as the first line to intake grievances and appeals that are specific to actions taken by the Contractor related to its DVHA members. The Contractor shall establish written policies and procedures, subject to review and approval by DVHA, governing the resolution of grievances and appeals.

The Contractor's Grievance and Appeals procedures shall comport with DVHA's policies on member grievances and appeals as stated in the DVHA Member Handbook. The Contractor shall be responsible for addressing the following situations whenever a member is attributed to the ACO:

- A member expresses dissatisfaction (a grievance) with the ACO, an ACO policy or a provider affiliated with the ACO; or
- A member wishes to appeal a decision or action taken by the ACO (in accordance with the definitions provided in 42 CFR 438, Subpart F).

In cases where there is disagreement between the ACO and DVHA about which entity should handle a particular grievance or appeal, DVHA will make the final determination.

##### 4.11.1 State Fair Hearing Process

In accordance with 42 CFR 438.408, the State maintains a fair hearing process which allows members the opportunity to appeal the Contractor's decisions to the State.

If there is a reduction or termination in covered services in amount, duration or scope, then Medicaid recipients must have access to grievances, appeals and a state fair hearing process. In situations where an attributed ACO member has exhausted the Contractor's grievance and appeals process and is still dissatisfied, the member may request a DVHA fair hearing within ninety (90) calendar days from the date of the Contractor's decision. Although DVHA staff will coordinate the fair hearing process, the Contractor shall be responsible for providing all requested information made by DVHA related to the member appeal in the timeframe requested by the State. The Contractor shall assist DVHA, as needed and requested by DVHA, in support of the fair hearing process including, but not limited to, attending the fair hearing.

The Contractor shall include the DVHA fair hearing process as part of the written internal process for resolution of appeals.

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4.11.2 Continuation of Benefits Pending Appeal

In certain member appeals, the Contractor will be required to continue the member's benefits pending the appeal, in accordance with 42 CFR 438.420. As a subdelegated entity of DVHA, the Contractor shall develop a policy to adhere to the requirements as described in 42 CFR 438.420.

4.11.3 Member Notice of Grievance, Appeal and Fair Hearing Procedures

The Contractor shall follow and communicate, when necessary, information listed in the DVHA General Provider Agreement related to member grievance, appeal and State fair hearing procedures and timeframes to providers and subcontractors at the time they enter a contract with the Contractor.

4.11.4 Recordkeeping Requirements of Grievances and Appeals

For purposes of quality review, the Contractor shall accurately maintain records for grievances and appeals that contain, at minimum, the following information:

- A general description of the reason for the appeal or grievance;
- The date the appeal or grievance was received;
- The date the appeal or grievance was reviewed;
- The resolution of the appeal or grievance;
- The date of the resolution of the appeal or grievance;
- The dates and details of all correspondence/communication between the Contractor and the member related to the grievance or appeal; and
- The name and UID number of the member for whom the appeal or grievance was filed.

The Contractor shall provide such record(s) of grievances and appeals upon request by DVHA.

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#### **5.0 Provider Network and Services**

##### **5.1 Network Development**

The Contractor shall develop and maintain a provider network in compliance with the terms of this section and 42 CFR 438.206. The Contractor shall develop a network to meet the health care needs of its attributed population. The Contractor shall develop a comprehensive network prior to the effective date of the Contract. The Contractor shall be required during the readiness review process to demonstrate network adequacy through the submission of Geo Access reports in the manner and timeframe required by DVHA.

The Contractor shall ensure that its provider network:

- Provides adequate numbers of facilities, physicians, ancillary providers, service locations and personnel for the provision of high-quality covered services for its members;
- Is geographically accessible; and
- Is supported by written provider agreements

The Contractor shall also ensure that all of its contracted providers can respond to the cultural and linguistic needs of its attributed members. The network shall be able to meet the unique needs of its members, particularly those with special health care needs. The Contractor will be required to participate in any state efforts to promote the delivery of covered services in a culturally competent manner.

The Contractor shall ensure that all of its network providers are enrolled as Medicaid providers and follow all Vermont Medicaid provider enrollment criteria. In some cases, DVHA members attributed to the Contractor may receive covered services outside of the Contractor's provider network. The Contractor shall encourage providers outside of its network to enroll with both the Contractor and Vermont Medicaid.

The Contractor must monitor medical care standards to evaluate access to care and quality of services provided to members, evaluate providers regarding their practice patterns, and have a mechanism in place to address Quality of Care concerns.

##### **5.2 Network Composition Requirements**

DVHA will regularly and routinely monitor the Contractor's network access, availability and adequacy. DVHA may require corrective action if the Contractor fails to maintain a provider network commensurate with the number of attributed DVHA members.

At the beginning of its Contract with the State, the Contractor shall submit regular network access reports as directed by DVHA. The Contractor shall submit network access reports on an annual basis or at any time there is a significant change to the provider network e.g., the Contractor no longer meets the network access standards). The Contractor shall comply with the policies and procedures for network access reports

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set forth in ACO Reporting Manual. DVHA shall have the right to expand or revise the network requirements as it deems appropriate.

In accordance with 42 CFR 438.12, the Contractor shall not discriminate any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision. This does not require the Contractor to contract with providers beyond the number necessary to serve all of its members' needs. The Contractor is not precluded from establishing any measure designed to maintain quality and control costs consistent with the Contractor's responsibilities.

The Contractor shall ensure that its network of providers adheres to requirements in the DVHA General Provider Agreement to offer hours of operation to DVHA members that are no less than the hours of operation offered to commercial members. The Contractor shall also make covered services available twenty four (24)-hours-a-day, seven (7)-days-a-week, when medically necessary. In meeting these requirements, the Contractor shall:

- Establish mechanisms to ensure compliance by providers;
- Monitor providers regularly to determine compliance; and
- Take corrective action if there is a failure to comply.

#### 5.2.1 Acute Care Hospital Facilities

The Contractor shall provide a sufficient number and geographic distribution of acute care hospital facilities to serve the expected number of DVHA members. DVHA has set a goal for the Contractor that allows DVHA members to access hospital services within thirty (30) minutes in urban areas and sixty (60) minutes in rural areas. Exceptions shall be justified and documented to the State on the basis of community standards for accessing care.

#### 5.2.2 Primary Care Provider (PCP) Network Requirements

DVHA has set a goal for the Contractor that allows DVHA members access to PCPs within thirty (30) minutes of the member's residence, unless the attributed member has specifically selected a PCP that is outside of the 30 minute range. Providers that may serve as PCPs include

- Family practitioners
- General practitioners
- Pediatricians
- Certified family practitioners
- Internal medicine physicians
- Geriatric medicine physicians

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- Preventive medicine physicians
- Gynecologists
- Endocrinologists (if primarily engaged in internal medicine)
- Osteopathic medicine providers
- Naturopaths
- Nurse practitioners

The Contractor shall have a mechanism in place to track its PCP's accepted Medicaid panel size. DVHA shall monitor the Contractor's PCP network to evaluate its member-to-PCP ratio.

The Contractor shall have a mechanism in place to ensure that contracted PCPs provide or arrange for coverage of services twenty four (24)-hours-a day, seven (7)-days-a-week and that PCPs have a mechanism in place to offer members direct contact with their PCP, or the PCP's qualified clinical staff person, through a toll-free telephone number twenty four (24)-hours-a-day, seven (7)-days-a-week. Each PCP shall be available to see DVHA members at least three (3) days per week for a minimum of twenty (20) hours per week. The Contractor shall also assess the PCP's non-Medicaid practice to ensure that the PCP's Medicaid population is receiving accessible services on an equal basis with the PCP's non-Medicaid population.

The Contractor shall ensure that the PCPs serving as the ongoing source of the member's care provide "live voice" coverage after normal business hours. After-hour coverage for the PCP may include an answering service or a shared-call system with other medical providers.

#### 5.2.3 Specialist and Ancillary Provider Network Requirements

The Contractor shall provide and maintain a comprehensive network of provider specialists and ancillary providers.

A physician contracted as a PCP with one ACO may contract as a specialist with other ACOs.

DVHA has set a goal for the Contractor to develop and maintain a comprehensive network of specialty providers listed below. For providers identified with an asterisk (\*), the Contractor's goal is, at a minimum, two providers for each specialty type within sixty (60) minutes of the member's residence. For providers identified with two asterisks (\*\*), the Contractor's goal is, at a minimum, one specialty provider within ninety (90) minutes of the member's residence.

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<b>Specialties</b>	
<ul style="list-style-type: none"> <li>› Anesthesiologists*</li> <li>› Cardiologists*</li> <li>› Cardiothoracic surgeons**</li> <li>› Chiropractors**</li> <li>› Dermatologists**</li> <li>› Durable medical equipment providers*</li> <li>› Endocrinologists*</li> <li>› Gastroenterologists*</li> <li>› General surgeons*</li> <li>› Hematologists*</li> <li>› Home health care providers*</li> <li>› Infectious disease specialists**</li> <li>› Interventional radiologists**</li> <li>› Nephrologists*</li> <li>› Neurologists*</li> <li>› Neurosurgeons**</li> <li>› Non-hospital based anesthesiologist (e.g., pain medicine)**</li> </ul>	<ul style="list-style-type: none"> <li>› OB-GYNs*</li> <li>› Occupational therapists*</li> <li>› Oncologists*</li> <li>› Ophthalmologists*</li> <li>› Orthopedic surgeons*</li> <li>› Orthopedists*</li> <li>› Otolaryngologists*</li> <li>› Pathologists**</li> <li>› Physical therapists*</li> <li>› Psychiatrists*</li> <li>› Pulmonologists*</li> <li>› Radiation oncologists**</li> <li>› Rheumatologists**</li> <li>› Speech therapists*</li> <li>› Urologists*</li> </ul>

5.2.4 Non-psychiatrist Mental Health and Substance Abuse Providers

The Contractor shall establish a network of mental health providers, addressing both mental health and addiction, as set forth below.

The following list represents mental health providers that shall be available in the Contractor’s network:

- Psychologists;
- Licensed Clinical Social Workers;
- Psychiatric Nurse Practitioners;
- Licensed Marital and Family Therapists;
- Licensed Mental Health Counselors;
- Licensed Alcohol and Drug Counselors;
- Board Certified Behavior Analysts; and
- Board Certified Assistant Behavior Analysts.

DVHA has set a goal for that Contractor that in urban areas, the Contractor shall provide at least one (1) mental health provider within thirty (30) minutes from the member’s home. In rural areas, the Contractor’s goal is to provide at least one (1) mental health provider within forty-five (45) minutes from the member’s home. The Contractor must provide assertive outreach to members in rural areas where mental health services may be less available than in more urban areas. The Contractor also shall monitor utilization in rural and urban areas to assure equality of service access and availability.

All covered mental health services shall be delivered only by licensed providers within their scope of practice.

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The Contractor is expected to coordinate with all county-based Designated Agencies (DAs), Special Service Agencies (SSAs) and Parent-Child Centers (PCCs). If all DAs, SSAs, and PCCs are not included in the provider network, the Contractor shall demonstrate that this does not hinder coordination of care or create an access issue. The Contractor shall, at a minimum, establish referral agreements and liaisons with DAs, SSAs, and PCCs.

#### 5.2.5 Mid Level Providers

Mid Level providers are health care professionals who are licensed to practice medicine and, as defined by state law, under the supervision of a physician. Mid Level providers can perform some of the services that physicians provide, such as physical exams, preventive health care and education.

The Contractor is encouraged to implement initiatives to encourage providers to use Mid Level Providers as authorized under State law.

State Medicaid programs are required to make nurse practitioner services available to Medicaid recipients in accordance with 42 CFR 441.22. The Contractor shall permit members to use the services of nurse practitioners out-of-network if no nurse practitioner is available in the Contractor's network.

#### 5.2.6 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

DVHA strongly encourages the Contractor to contract with all willing Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) that meet all of the Contractor's requirements regarding the ability of these providers to provide quality services.

#### 5.2.7 School-based Services for Individualized Education Programs

DVHA strongly encourages the Contractor to develop relationships with providers of school-based services for children to ensure comprehensive multidisciplinary evaluation exists between the PCP and the school.

#### 5.2.8 Urgent Care Clinics

DVHA strongly encourages the Contractor to affiliate or contract with non-traditional urgent care clinics, including retail clinics.

#### 5.2.9 Other Providers

DVHA strongly encourages the Contractor to contract with other providers that deliver services covered in the capitation payment such as dialysis treatment centers, transplant centers, and transgender facilities.

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#### **5.3 Provider Contracting**

The Contractor shall be responsible for assuring that its network providers are enrolled with Vermont Medicaid. DVHA will continue to enroll and revalidate providers using the Provider Screening and Enrollment requirements in 42 CFR Subpart E. DVHA's enrollment criteria are outlined at <http://www.vtmedicaid.com/Enrollment/enrollmentIndex.html#>.

DVHA shall immediately disenroll any ACO provider if the provider becomes ineligible to participate in the Medicaid program for any reason. DVHA shall notify the Contractor at the time of disenrollment.

The Contractor shall immediately inform the DVHA Program Integrity Unit via a written communication should it disenroll, terminate or deny provider enrollment or credentialing for "program integrity" reasons (i.e., the detection and investigation of fraud and abuse).

The Contractor shall report the addition or disenrollment of any ACO-contracted provider on a monthly basis and indicate each provider's enrollment or termination effective date with the Contractor. Refer to Section 10.0 in this Scope of Work for more details on this process.

When a PCP disenrolls from the ACO, the Contractor shall be responsible for assisting members assigned to that PCP in selecting a new PCP within the Contractor's network. Refer to Section 4.2.1 in this Scope of Work for more detail on this process.

In accordance with 42 CFR 438.10(f), the Contractor shall make a good faith effort to provide written notice of a provider's disenrollment to any member that has received primary care services from that provider or otherwise sees the provider on a regular basis. Such notice shall be provided within fifteen (15) calendar days of the Contractor's receipt or issuance of the provider termination notice. If a PCP disenrolls from the ACO, but remains a Medicaid provider, the Contractor shall assure that the PCP provides continuity of care for his/her Medicaid members for a minimum of thirty (30) calendar days or until care is transitioned to another PCP.

#### **5.4 Provider Agreements**

The Contractor must have a process in place to review and authorize all network provider contracts. The network provider contracts must not be in conflict with any aspect of the DVHA General Provider Agreement.

Contractor must submit a model or sample contract of each type of provider agreement to DVHA for review and approval at least sixty (60) calendar days prior to the Contractor's use of the agreement.

To allow sufficient processing time for the enrollment of the PCP and to ensure attributed lives to the Contractor with an effective date of January 1, 2017, the Contractor shall

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submit the complete list of providers who may be eligible to have attributed members to DVHA by December 1, 2016.

The Contractor shall include in all of its provider agreements provisions to ensure continuation of benefits. The Contractor shall identify and incorporate the applicable terms of its Contract with the State. Under the terms of the provider services agreement, the provider shall agree that the applicable terms and conditions set out in the Contract, any incorporated documents and all applicable state and federal laws, as amended, govern the duties and responsibilities of the provider with regard to the provision of services to members. The provider agreements shall meet the following requirements:

- Describe a written provider claim dispute resolution process;
- Require each provider to maintain a current Vermont Medicaid provider agreement and to be duly licensed in accordance with the appropriate state licensing board and remain in good standing with said board;
- Require providers to adhere to DVHA timely filing requirements for claims submissions.
- Include a termination clause stipulating that the Contractor shall terminate its contractual relationship with the provider as soon as the Contractor has knowledge that the provider's license or Vermont Medicaid provider agreement has terminated.
- Obligate the terminating provider to submit all claims or encounters for services rendered to the Contractor's members to DVHA's fiscal agent while serving as the Contractor's network provider.
- Not obligate the provider to participate under exclusivity agreements that prohibit the provider from contracting with other state contractors.
- Provide a copy of a member's medical record at no charge upon request by the member, and facilitate the transfer of the member's medical record to another provider at the member's request.

#### 5.5 Provider Credentialing

The Contractor shall have written credentialing and re-credentialing policies and procedures and maintain a credentialing and re-credentialing process for all contracted providers that meets the National Committee for Quality Assurance (NCQA) guidelines.

#### 5.6 Medical Records

The Contractor shall assure that its records and those of its participating providers document all medical services that the member receives in accordance with state and federal law. The provider's medical record shall include, at a minimum:

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- The identity of the individual to whom service was rendered;
- The identity of the provider rendering the service;
- The identity and position of the provider employee rendering the service, if applicable;
- The date on which the service was rendered;
- The diagnosis of the medical condition of the individual to whom service was rendered;
- A detailed statement describing services rendered;
- The location at which services were rendered;
- Written evidence of physician involvement and personal patient evaluation will be required to document the acute medical needs; and
- A current plan of treatment and progress notes, as to the medical necessity and effectiveness of treatment, must be attached to the prior authorization request and available for audit purposes.

The Contractor's providers shall maintain members' medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Medical records shall be legible, complete, signed and dated and maintained as per the DVHA General Provider Agreement.

Confidentiality of, and access to, medical records shall be provided in accordance with the standards mandated in the Health Insurance Portability and Accountability Act (HIPAA) and all other state and federal requirements, including, but not limited to, 42 CFR Part 2.

The Contractor's providers shall permit the Contractor and representatives of DVHA to review members' medical records for the purposes of monitoring the provider's compliance with the medical record standards, capturing information for clinical studies, monitoring quality or any other reason. The failure of Contractor and/or its participating providers to keep and maintain detailed and accurate medical records as required in this section may result in Contractor and/or its participating providers repaying DVHA or Contractor for amounts paid corresponding to the services rendered for which accurate and detailed medical records are not provided in a timely manner.

#### 5.7 Provider Education and Outreach

The Contractor shall provide ongoing education about the ACO program as well as Contractor-specific policies and procedures to its provider network. In addition to developing its own provider education and outreach materials, the Contractor shall coordinate with DVHA-sponsored provider outreach activities upon request.

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The Contractor shall educate its contracted providers, including mental health providers, regarding provider requirements and responsibilities, the Contractor's prior authorization policies and procedures, clinical protocols, member's rights and responsibilities, claims submission process, claims dispute resolution process, program integrity, identifying potential fraud and abuse, pay-for-outcome programs and any other information relevant to improving the services provided to the Contractor's members.

#### 5.7.1 Provider Communications Review and Approval

Provider communication materials specific to this contract shall be pre-approved by DVHA. The Contractor shall develop and include a Contractor-designated inventory control number on all provider communications, including letters, forms, bulletins and promotional, educational, training, informational or other outreach materials, with a date issued or date revised clearly marked.

The Contractor shall submit all provider communication materials designed for distribution to, or use by, contracted providers to DVHA for review and approval at least thirty (30) calendar days prior to distribution. The Contractor must receive approval from DVHA prior to distribution or use of materials. DVHA's decision regarding any communication materials is final. The Contractor shall include the State program logo(s) in their provider communication materials upon DVHA request.

The Contractor shall not refer to or use DVHA or other state agency names or logos in its provider communications without prior written approval by DVHA. Any approval given for the DVHA, or other state agency name or logo is specific to the use requested, and shall not be interpreted as blanket approval.

#### 5.7.2 Provider Policy and Procedures Manual

The Contractor may provide and maintain a Provider Policies and Procedures Manual specific to Contractor operations provided that this manual is not in conflict with the information provided in the DVHA Provider Manual, found at: <http://www.vtmedicaid.com/Downloads/manuals/New%20Consolidated%20Manual/VTMedicaidProviderManual.pdf>

If the Contractor develops an ACO Provider Policies and Procedures Manual, it shall be available both electronically and in hard copy (upon request) to all network providers, without cost, when they are initially enrolled, when there are any changes in policies and procedures, and upon a provider's request.

#### 5.8 Contractor Outreach with Providers

The Contractor shall have in place policies and procedures to maintain frequent communications and provide information to its provider network. The Contractor shall give providers at least thirty (30) calendar days advance notice of material changes that may affect the providers' procedures such as changes in subcontractors, claims

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submission procedures or prior authorization policies. The Contractor shall post a notice of the changes on its website to inform both network and out-of-network providers and make payment policies available to non-contracted providers upon request.

In accordance with 42 CFR 438.102, the Contractor shall not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member. Contractor shall communicate this clearly to all providers.

#### 5.8.1 Provider Website

The Contractor shall maintain a provider website that contains information about its Medicaid line of business. The Contractor may choose to develop a separate provider website or incorporate it into the home page of the member website described in Section 4.4.2.

To minimize download and wait times, the website shall avoid techniques or tools that require significant memory or disk resources or require special intervention on the user side to install plug-ins or additional software. The Contractor shall allow users print access to the information. The provider website may have secured information available to network providers but shall, at a minimum, have the following information available to all providers:

- Contractor's contact information;
- DVHA's Provider Policy and Procedure Manual and any ACO Provider Policy and Procedure Manual and associated forms;
- Contractor's clinical guidelines;
- Contractor's provider communication materials, organized online in a user-friendly, searchable format by communication type and topic;
- Provider payment dispute resolution procedures;
- Prior authorization procedures designed by the Contractor if they are different from DVHA's, including a complete list of services which require prior authorization;
- Appeal procedures;
- The Health Insurance Portability and Accountability Act (HIPAA) privacy statement;
- The executive summary of Contractor's Annual Quality Management and Improvement Program Plan Summary Report; and
- Links to DVHA's website for general Medicaid information.

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#### 5.8.2 Provider Services Helpline

In addition to the Provider Service Helpline provided by DVHA's fiscal agent, the Contractor shall maintain a toll-free telephone helpline for all providers with questions, concerns or complaints that are specific to ACO operations. The Contractor shall staff the Provider Services Helpline with personnel trained to accurately address provider issues from 8:00 am to 5:00 pm Eastern, Monday through Friday, at minimum. The Contractor shall provide a voice message system that informs callers of the Contractor's business hours and offers an opportunity to leave a message after business hours.

The ACO Provider Services Helpline may be closed on all holidays observed by the State government.

The Contractor shall maintain a system for tracking and reporting the number and type of provider calls and inquiries. The Contractor must monitor its Provider Services Helpline and report its telephone service performance to DVHA each quarter as described in the ACO Reporting Manual.

#### 5.8.3 State Fiscal Agent Workshops and Seminars

The State fiscal agent sponsors workshops and seminars for all Vermont Medicaid providers. The Contractor shall participate in the workshops and attend the provider seminars. A Contractor representative shall be available to make formal presentations and respond to questions during the scheduled time(s) as requested by DVHA. The Contractor is also encouraged to set up an information booth with a representative available during the provider seminars.

#### 5.9 Payment for Health Care-Acquired Conditions and Provider-Preventable Conditions

The Contractor shall develop policies and procedures to prohibit the payment of charges for certain hospital acquired conditions and "never events." These policies and procedures and any changes thereto shall be approved by DVHA prior to execution of the contract.

The Contractor shall require that as a condition of payment, all providers agree to comply with the reporting requirements in 42 CFR 447.26(d).

#### 5.10 Member Payment Liability

The Contractor and its subcontractors shall ensure that members are not held liable for any of the following:

- Covered services provided to the member which the Contractor is responsible for which the Contractor does not pay the provider; or

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- The Contractor's debts or subcontractor's debts, in the event of the entity's insolvency.

The Contractor shall ensure that its providers do not balance bill its members, i.e., charge the member for covered services above the amount paid to the provider by the Contractor. If the Contractor is aware that an out-of-network, non-Medicaid provider, such as an out-of-state emergency services provider, is balance billing a member, the Contractor shall instruct the provider to stop billing the member. The Contractor shall also contact the member to help resolve issues related to the billing.

Vermont Medicaid providers are prohibited from charging a member, or the family of the member, for any amount not paid as billed for a covered Medicaid service.

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### 6.0 Utilization Management

#### 6.1 Utilization Management Program

The Contractor has the option to operate and maintain a utilization management program for the services for which it is responsible for managing and delivering in this contract. DVHA will continue to run its own utilization management program for services delivered to DVHA members attributed to the ACO that are not covered in the capitation payment to the Contractor.

Bidders should specify in their response if they intend to exercise this option and, if so, how. If a Contractor chooses to implement a utilization management program, it must adhere to the specifications listed in this Section 6 of the Scope of Work.

Any limitations on the services covered under this contract as specified in the Medicaid Covered Services Rules or in the State Plan must be adhered to. For the comprehensive list of limitations, refer to the Medicaid Covered Services Rules at <http://humanservices.vermont.gov/on-line-rules/dvha>. However, the Contractor may place appropriate limits on coverage on the basis of medical necessity or utilization control criteria. Exception to these limits can be allowed by the Contractor if doing so produces the same or better outcome while maintaining payment neutrality of state funds. The Contractor should adhere to Medicaid Covered Services Rule 7103 for medical necessity when implementing utilization control criteria. The Contractor is prohibited from arbitrarily denying or reducing the amount, duration or scope of the services covered under this contract solely due to diagnosis, type of illness or condition.

##### 6.1.1 Clinical Guidelines

The Contractor shall establish and maintain medical management clinical criteria and practice guidelines in accordance with state and federal rules and regulations. Clinical criteria must be based on valid and reliable clinical evidence or consensus among clinical professionals and consider the needs of the Contractor's attributed members. The Contractor shall use a nationally recognized set of guidelines, including but not limited to McKesson Health Solutions' InterQual or Milliman Care Guidelines. If the Contractor chooses to utilize separate guidelines for physical health and mental health services, the Contractor shall demonstrate that the guidelines are evidence-based and nationally recognized and that use of separate guidelines would have no negative impact on members, and would not otherwise violate the Contractor's requirements under 8 VSA§4089b.

##### 6.1.2 Practice Guidelines

The Contractor shall utilize practice guidelines that have been established by DVHA. The full list of guidelines is available at <http://dvha.vermont.gov/providers/clinical-coverage-guidelines>. The Contractor may adopt additional guidelines subject to the review and approval by DVHA.

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Pursuant to 42 CFR 438.210(b), relating to authorization of services, the Contractor shall consult with contracting health care professionals in developing practice guidelines. The Contractor shall, at a minimum, review and update the guidelines biannually, distribute the guidelines to providers and make the guidelines available to members upon request.

#### 6.1.3 Utilization Management Staffing

The Contractor shall have mechanisms in place to ensure consistent application of review criteria for authorization decisions as well as the manner in which requesting providers are consulted. The Contractor shall have sufficient staff with clinical expertise and training to interpret and apply the utilization management criteria and practice guidelines to providers' requests for health care or service authorizations for the Contractor's members. Utilization management staff shall receive ongoing, and at a minimum annual, training regarding interpretation and application of the utilization management guidelines. The Contractor shall provide a written training plan, which shall include dates and subject matter, as well as training materials, upon request by DVHA. The Contractor will conduct inter-rater reliability testing of its staff approving or denying authorization requests at least annually for each area of specialty the staff is responsible for, e.g. acute level of care, outpatient rehabilitation and chiropractic procedures, therapies, DME, etc. The Contractor will have in place an enhanced educational plan for any staff member that does not meet minimum passing requirements, of no less than 80%, in this testing process.

For emergency medical services, the Contractor shall conduct a prudent layperson review to determine whether an emergency medical condition, as defined in Medicaid Covered Services Rule 7101, exists. Rule 7101 states that

“Emergency medical condition” means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possess an average knowledge of health and medicine, to result in:

- a. placing the member's physical or mental health in serious jeopardy; or
- b. serious impairment to bodily functions; or
- c. serious dysfunction of any bodily organ or part.”

Licensed clinical professionals who have the appropriate clinical expertise in the treatment of a member's condition or disease are the only personnel allowed to make decisions to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested when the reason for denial or limitation is lack of medical necessity. Likewise, licensed clinical professionals should review approvals based on medical necessity.

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Administrative staff may deny an authorization request due to lack of timely filing of the request or lack of documentation requested by the Contractor that is needed to reach a determination on the request.

The Contractor shall not provide incentives to utilization management staff or to providers for denying, limiting or discontinuing medically necessary services. DVHA may audit Contractor denials, appeals and authorization requests. If the Contractor delegates some or all of its prior authorization function to subcontractors, the Contractor shall conduct, at a minimum, annual audits and ongoing monitoring to ensure the subcontractor's performance complies with the Contract, the Contractor's policies and procedures, and state and federal law.

#### 6.1.4 Utilization Management Policies and Procedures

The Contractor's utilization management program shall have policies and procedures that meet all NCQA standards. Additionally, the Contractor's policies and procedures shall comply with requirements in 42 CFR 438.206 related to second opinions and women's health and 438.208 related to members with special health care needs direct access to a specialist.

The Contractor's utilization management program shall have policies and procedures that include appropriate timeframes for:

- Completing initial requests for prior authorization of services;
- Completing initial determinations of medical necessity;
- Completing provider and member appeals and expedited appeals for prior authorization of service requests or determinations of medical necessity, per state law;
- Notifying providers and members in writing of the Contractor's decisions on initial prior authorization requests and determinations of medical necessity; and
- Notifying providers and members of the Contractor's decisions on appeals and expedited appeals of prior authorization requests and determinations of medical necessity.

The Contractor shall have the ability to set its own authorization criteria; however, at minimum, the Contractor must adhere to DVHA's current requirements where prior authorization is mandated. The current DVHA requirements are listed at <http://dvha.vermont.gov/for-providers/clinical-coverage-guidelines>.

Contractor's utilization management program shall have policies and procedures and systems in place to assist utilization management staff in:

- Identifying instances of over- and under-utilization of emergency room services and other health care services,

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- Identifying aberrant provider practice patterns (especially related to emergency room, inpatient services, transportation, drug utilization, preventive care and screening exams),
- Ensuring active participation of a utilization review committee,
- Evaluate efficiency and appropriateness of service delivery,
- Incorporating subcontractor's performance data (if any function is subcontracted), and
- Facilitating program management and long-term quality of care and identifying critical quality of care issues.

The Contractor's utilization management program shall not be limited to traditional utilization management activities, such as prior authorization. The Contractor shall maintain a utilization management program that integrates with other functional units as appropriate and supports the Quality Management/Assurance and Improvement Program as described in Section 8 of the Scope of Work.

The Contractor's utilization management program shall refer members to care coordination and disease management, care management and case management, as set forth in Section 7 of the Scope of Work. The Contractor's utilization management program shall also encourage and educate members on health literacy and informed, responsible medical decision making.

The Contractor shall identify areas of high and low utilization and key reasons for the utilization patterns. The Contractor shall identify those members that have over- or under-utilization and perform the necessary outreach and screening to assure the member's services are coordinated and that the member is aware of and participating in the appropriate disease management, care management or complex case management services.

In order to monitor potential under- or over-utilization of mental health services, DVHA may require Contractors to provide separate utilization reports for mental health services.

The Contractor shall report its medical necessity determination decisions to DVHA in a standard report that will be part of the ACO Reporting Manual. The State reserves the right to standardize certain parts of the prior authorization reporting process, such as requiring the Contractor to adopt and apply the same definitions that DVHA uses regarding approved, pended, denied, and suspended authorization requests. When adopted, these standards shall be set forth in the ACO Reporting Manual.

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#### 6.1.5 Authorization Determination Timeframes

If the Contractor chooses to employ its own authorization requirements beyond those used by DVHA, then the Contractor shall adhere to the authorization determination deadlines set forth in Vermont Medicaid Rule, 7102.4 and Interpretive memo from 06/01/2008. The Contractor shall notify members of standard authorization decisions as expeditiously as required by the member's health condition, not to exceed three (3) calendar days after the request for services and the receipt of all necessary information. . An extension of up to fourteen (14) calendar days is permitted if the member or provider requests an extension or if the Contractor justifies to DVHA a need for more information and explains how the extension is in the member's best interest. The Contractor will be required to provide its justification to DVHA upon request for approval. Extensions require written notice to the member and shall include the reason for the extension and the member's right to file a grievance.

For situations in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires. The Contractor shall notify members as well as providers who requested the services in writing of decisions to terminate, suspend or reduce previously authorized covered services, at least eleven (11) calendar days before the date of action.

#### 6.1.6 Record Keeping

The Contractor shall track all prior authorization requests in their information system. All notes in the Contractor's prior authorization tracking system shall be signed by clinical staff and include the appropriate suffix (e.g., RN, MD, etc.). For all prior authorization requests, the Contractor shall provide a prior authorization number to the requesting provider and maintain a record of the following information, at a minimum, in the Contractor's information system: (i) name and title of requesting provider, (ii) mode of request (e.g., phone, fax, web-based), (iii) date and time of request (iv) clinical synopsis, which shall include timeframe of illness or condition, diagnosis and treatment plan, and (v) prior authorization request number.

Specifically for all denials of prior authorization requests, the Contractor shall also maintain a record of the clinical guideline(s) or other rationale supporting the denial (e.g., insufficient documentation).

The Contractor shall submit the data elements for authorization approvals, as well as other information requested by DVHA, in a file format specified by DVHA on a daily basis to DVHA's fiscal agent. The fiscal agent will use this authorization information to adjudicate claims submitted by ACO-affiliated providers for

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services where DVHA requires prior authorization. Refer to Section 10 in the Scope of Work for further details.

#### 6.1.7 Notices of Authorization Decisions

The Contractor shall provide a written notice to the member and provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested. The notice shall meet the requirements of 42 CFR 438.404, "Notice of Action." The notice to members shall be provided at a sixth grade reading level. The notice shall be given within the timeframes described in 42 CFR 438.404(c).

The notification letters used by the Contractor shall be approved by DVHA prior to use and clearly explain the following:

- The action the Contractor or its subcontractor has taken or intends to take;
- The reasons for the action;
- The clinical criteria and/or specific State rule that supports the action;
- The member's or the provider's right to file an appeal with the Contractor and the process for doing so;
- The procedure to request a State fair hearing following exhaustion of the Contractor's appeal process;
- Circumstances under which expedited resolution is available and how to request it; and
- The member's right to have benefits continue pending the resolution of the appeal, how to request continued benefits and the circumstances under which the member may have to pay the costs of these services.

#### 6.2 Utilization Management Committee

The Contractor must have a utilization management committee directed by the Contractor's Medical Director. The DVHA Medical Director must be an invited member of the committee. Additionally, the Utilization Management Committee must utilize a multidisciplinary group of providers that will include independent providers that will participate, at minimum, in the review and approval of new practice guidelines or updates to existing practice guidelines.

The committee shall be responsible for:

- Monitoring providers' requests for rendering health care services to its members;
- Monitoring the medical necessity of health care services provided to its members;
- Reviewing the effectiveness of the utilization review process and making changes to the process as needed;

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- Writing policies and procedures for utilization management that conform to industry standards including methods, timelines and individuals responsible for completing each task; and
- Confirming the Contractor has an effective mechanism in place for an ACO provider or Contractor representative to respond within one hour to all emergency room providers twenty four (24)-hours-a-day, seven (7)-days-a-week after ACO members' initial emergency room screening.

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#### **7.0 Care Management**

The Contractor's primary function in support of its DVHA members is to integrate and enhance the coordination and management of care of members.

The Contractor shall develop policies and procedures regarding physical and mental health coordination. Further, the Contractor should be prepared to monitor and evaluate the effectiveness of its policies and procedures and develop and implement mechanisms to improve coordination and continuity of care based on monitoring outcomes.

The Vermont Chronic Care Initiative (VCCI) program at DVHA will remain actively involved in complex case management for the population of non-ACO attributed Medicaid members who meet the pre-defined eligibility requirements of the program. At the initiation of this contract, it is anticipated that some members currently receiving complex case management through the DVHA VCCI program will attribute to the ACO and be care managed by the ACO. DVHA will provide the list of these members to the ACO. The Contractor must begin active engagement with these members immediately upon notice of attribution.

At the time that members attribute to the ACO, DVHA members may already be receiving case management from another entity such as a Designated Agency. As such, the Contractor will work with the member and the other entity (if it is a participating or an aligned entity with which protected health information is allowed to be shared) to determine where and how the member should receive case management services across organizations.

Sections 7.1 and 7.2 below articulate DVHA's vision for care management under an ACO model. DVHA suggests that Bidders use this as a frame of reference when articulating its solution to care management. If a Bidder recommends an alternative strategy to DVHA's vision for care management, the Bidder should be prepared to offer a rationale on why an alternative approach will yield more effective results in the Triple Aim of improving the experience of care of DVHA's members, improving the health of DVHA's members, and reducing per member costs among DVHA's members attributed to the ACO.

#### **7.1 Member Assessment**

##### **7.1.1 Initial Screening**

An initial screening is conducted within ninety (90) calendar days of contract initiation for each DVHA member who has not been seen by a primary care provider (PCP) within the previous 12 months to identify the member's immediate physical and/or mental health care needs. The initial screening will identify members who have complex or serious medical conditions as well as those who are receiving ongoing treatment. This screening must consider screening for conditions such as Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Diabetes, Coronary Artery Disease (CAD), Hypertension and Asthma. Additionally, the Contractor will identify those members who are due (or overdue) for their recommended Preventive

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Health Evaluations. The initial screening will also assist in determining if the member should be included in the Care Management Program.

The Contractor's initial screening tool(s) should be evidence-based, should align with other State screening tools, and will be subject to DVHA's review prior to use. The results of the screening may trigger supplemental questions or could require immediate triage and referral to a licensed health care professional per clinical protocols developed by the Contractor.

The initial screening may be administered in person, by phone, electronically through the Contractor's secure website, or by mail to assure the engagement of the largest number of members. The Contractor must provide information on the number of members screened in this process. The expectation is that 75% of the target population will have an initial screening completed within 120 days of attribution to the ACO.

#### **7.1.2 Comprehensive Health Assessment**

For individuals stratified into the medium or high risk care management levels, the Contractor will complete an evidence-based Comprehensive Health Assessment within 180 days of attribution to the ACO. The Comprehensive Health Assessment will be used to develop and implement a comprehensive care plan to meet the member's needs as well as personal health goals. The Contractor may utilize different Comprehensive Health Assessments for children, adolescents, and adults.

The completed comprehensive health assessment should be shared with the member's PCP and/or mental health providers with appropriate consents and permissions. The Contractor should develop a solution for storing the information collected from comprehensive health assessments in a standard electronic format and in a manner that can be shared with health professionals and DVHA. The expectation is that 50% of the target population will have a comprehensive health assessment completed within 180 days of attribution to the ACO.

#### **7.1.3 Screening and Assessment of Women of Child Bearing Years**

The Contractor shall implement methods to promptly identify members who are of child bearing years to assess pregnancy plans. DVHA strongly encourages that, in order to be consistent with other state assessment tools, the Contractor includes as part of this screening the State's one key question, "Would you like to become pregnant in the next year?" and, based on the member's response, a related follow up plan for risk prevention.

All identified pregnant women shall have a comprehensive health assessment completed. Any pregnancy risk assessment tools must include pregnancy risk factors such as prior history of pre-term labor, multiple births, use of alcohol or

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controlled substances, obesity, smoking, or other indicators which put both mother and infant at risk.

#### 7.1.4 Other Screenings

In addition to the Comprehensive Health Assessment, the Contractor should use other strategies to identify the risk and needs of its members. Other strategies may include, but are not limited to:

- Analyzing claims and medical records to assess diagnoses;
- Identifying gaps in care;
- Gathering any information from previous care plans, when available; and
- Reviewing information with the member to identify the member's care strengths, needs and available resources to enable person-centered planning. This will include family and caregiver input, as appropriate.

#### 7.2 Risk Stratification

The Johns Hopkins ACG System is suggested to be used to supplement the initial screening and other tools proposed by the Contractor to aid in the stratification of members into appropriate care management levels based on severity and risk scores. The predictive modeling tool will assign members to one of four Care Management Levels listed below:

- Low Risk – Members with low risk are assigned to “Healthy Member” Level of Care.
- Medium Risk – Members with medium risk are assigned to “Disease Management” Level of Care.
- High Risk – Members with high risk are assigned to “Care Coordination” Level of Care.
- Very High Risk – Members with very high risk are assigned to “Complex Case Management” Level of Care.

The requirements for members assigned to each Care Management level are described below:

##### 7.2.1 Low Risk

*Description:* Intended for members with no disease indicators and no risk identified.

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*Interventions:* Contractor is encouraged to develop interventions that support continued healthy behaviors.

#### 7.2.2 Medium Risk

*Description:* Intended for members with, or at risk for, a chronic condition such as CHF, COPD, Diabetes, CAD, Hypertension or Asthma.

*Interventions:* Contractor is encouraged to focus on interventions such as:

- Distribution of educational materials
- Preventive Care reminders
- Referrals to evidence-based self-management services to support sustainable changes via improved skill and confidence.
- In addition to all services listed above, pregnant women also receive the following interventions:
  - Pregnancy care health education materials
  - Tobacco cessation materials
  - Other services specific to their pregnancy risk factors

*Method of Communication:* US mail, electronic direct-to-consumer contacts, interactive voice recordings, and/or web-based education materials

*Frequency of Communications:* Minimally two times per year

*Qualifications of Staff:* Health coaching services may be provided by non-clinical staff as appropriate with escalation to licensed clinical staff as indicated by educational need, provider request and/or change in clinical status.

#### 7.2.3 High Risk

*Description:* Intended for members who need assistance with care coordination, making preventive care appointments, and accessing care to address the member's chronic health conditions and supporting adherence to treatment plan. This level may also include assistance with obtaining needed social services to address the member's ongoing health needs. Members who are at risk for an acute or catastrophic episode in the future may be prioritized for very high risk level of care management services (Complex Case Management).

*Interventions:* Contractor is encouraged to focus on interventions such as:

- All interventions described in 7.2.2 above
- Comprehensive health assessment
- Prioritized problem list and related goals regarding patient self-management

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- Coordination among service providers
- Assistance with appointments
- Education regarding the following:
  - Diagnosis
  - Prescribed treatment and importance of adherence to treatment
  - Use of medical home
  - Appropriate use of urgent and emergent care services
  - Self-management skills and plan specific to diagnosis

*Method of Communication:* Telephonic or in-person

*Frequency of Communication:* Four times per year

*Qualification of Staff:* Licensed staff with experience and training in care management and/or complex case management.

#### 7.2.4 Very High Risk

*Description:* Involves the active coordination of care and services with the member and among providers while navigating the extensive systems and resources required for the member. It includes the implementation of a complex case management plan directed at the member's chronic health conditions. Within the plan, targeted and achievable goals will be set by the Contractor with the active participation of the member. Goals may also be psychosocial in nature if they take priority for ensuring the improvement of the member's health condition. Goals must have defined milestones to document progress, clearly defined accountability and responsibility, and timely review with appropriate corrections as indicated. Members who are stratified as very high risk may exhibit one or more of these conditions:

- Multiple chronic conditions
- High service utilization patterns
- High and complex pharmacy utilization
- Cognitive involvement
- Psychosocial or socioeconomic indicators of health

*Interventions:* Contractor is encouraged to focus on interventions such as:

- All interventions described in 7.2.3 above
- Development of a comprehensive care plan directed at the member's chronic health condition (described in 7.3 below)
- Coordination and sharing of information on interventions and treatments among providers, particularly between physical health and mental health providers

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*Method of Communication:* Telephonic or in-person

*Frequency of Communication:* As condition requires, minimally monthly. Case managers should be able to engage in care conferences with the member's health care providers as necessary.

*Qualification of Staff:*

- The Contractor's staff performing complex case management must be licensed physician assistants, registered nurses, therapists, social workers, mental health providers, and/or licensed alcohol and drug counselors (LADCs).
- Complex case management staff must have the training, expertise and experience in providing case management and care coordination services for individuals with complex health needs, including individuals with mental health needs.
- The active member-to-staff ratio will not exceed 50:1.

### 7.3. Care Plan Development

For individuals participating in complex case management, the Contractor shall utilize a person-centered care plan development process which is evidence-based. The Contractor will use data from multiple sources in the development of each member's care plan including, at minimum, claims data, data collected through the predictive modeling tool, the initial health screening, the comprehensive health assessment, available medical records, bio-medical data, and consultations with the member's health care providers which should occur at least every other month.

Services called for in the care plan will be coordinated by the Contractor's care management staff, in consultation with any other care managers already assigned to a member by another entity.

Contractors should initiate mechanisms for members, their families and/or advocates, or others chosen by the member to be actively involved in the care plan development. The member or family should become knowledgeable about the care plan, such as an understanding of care plan goals and medication names, their uses and side effects. The care plan must reflect cultural considerations of the member including the Contractor's strategies to engage with members with limited English proficiency.

The Contractor's Medical Director shall be available to consult with the clinicians on the complex case management team as needed to develop the care plans for high risk cases and consult with the DVHA Medical Director as appropriate.

The care plan must be adjusted to meet individual needs and may include elements such as those listed below:

- Clinical history
- Diagnosis

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- Functional and/or cognitive status;
- Immediate service needs;
- Use of services not covered by the ACO;
- Accommodation needs;
- Barriers to care (e.g., language, transportation);
- Names of the member's health care providers;
- Local community resources;
- Family or other natural support resources;
- Clearly identified, member-centered, measurable long-term goals and objectives;
- Clearly identified, member-centered, measurable short-term goals and objectives;
- Goals and planned interventions and progress toward goal achievement including objective measures as biomedical data (e.g., HEDIS measures);
- Utilization statistics on hospitalizations, emergency services, primary care and specialty care;
- Self-management status/referral;
- Readiness for change and engagement level; and
- All contacts with the member, his/her providers and other service delivery entities.

The Contractor will develop a process for reviewing and updating the care plans with members on an as-needed basis, no less often than annually. In addition, the Contractor shall develop a protocol for re-evaluating members who have moved across the levels of management (disease, care and complex case management). The Contractor shall identify triggers which would immediately move the member to a more assistive level of service.

#### **7.4 Reporting Requirements**

The Contractor shall document the number of persons participating in care management by care management level and by condition of interest at intervals specified by DVHA.

The Contractor shall be prepared to report on the interventions utilized in each care management level and the success rate of these interventions.

The Contractor shall document case management contacts, interventions and outcomes in an electronic care management system. A monthly electronic file of key variables in the care plan of each DVHA attributed member as high risk shall be made available to the DVHA case management system via an electronic interface in a file format approved by DVHA to support a single continuous care plan in the event that a DVHA member transitions into or out of the ACO over the course of the contract. Refer to Section 10.4.9 in the Scope of Work for more details on this file exchange.

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#### **8.0 Quality Management**

##### **8.1 Quality Management Definitions**

The Contractor shall monitor, evaluate and take effective action to identify and address any needed improvements in the quality of care delivered to its attributed members by all providers, including specialists, in all types of settings, in accordance with the provisions set forth in the contract. The Contractor shall submit quality improvement data in a time and manner as set forth by DVHA including, but not limited to, data that meets HEDIS standards for reporting and measuring outcomes.

Additionally, the Contractor must submit information requested by DVHA to complete its annual Quality Strategy Plan. This will include the results of any performance improvement projects or quality improvement projects. For purposes of this Section 8,

- A “corrective action plan” shall mean a plan to remediate an identified program deficiency in response to an action or sanction by DVHA.
- A “quality improvement project” is a planned strategy for program improvement and is incorporated into the Contractor’s Quality Management and Improvement Program Work Plan.
- A “performance improvement project” shall mean a planned strategy for program improvement which adheres to CMS protocols for performance improvement projects.

##### **8.2 Quality Management and Improvement Program**

The Contractor’s Medical Director shall be responsible for the coordination and implementation of the Quality Management and Improvement Program. The program shall have objectives that are measurable and supported by consensus among the Contractor’s medical and quality improvement staff. Through the Quality Management and Improvement Program, the Contractor shall have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of health care services that are safe, effective, timely and member centered. As a key component of its Quality Management and Improvement Program, the Contractor may develop incentive programs for both providers and members, with the ultimate goal of encouraging appropriate utilization of health care resources and improving health outcomes of ACO members.

The Contractor shall meet the requirements of 42 CFR 438 subpart D on Quality Assessment and Performance Improvement including, but not limited to, the requirements listed below in developing its Quality Management and Improvement Program and the Quality Management and Improvement Program Work Plan. In doing so, it shall include (i) an assessment of quality and appropriateness of care provided to members with special needs, (ii) completion of performance improvement projects in a reasonable time so as to allow information about the success of performance

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improvement projects to be incorporated into subsequent quality improvement projects; and (iii) production of quality of care reports at least annually or as otherwise required by DVHA.

The Contractor's Quality Management and Improvement Program shall:

- Include developing and maintaining an annual Quality Management and Improvement Program Work Plan which sets goals, establishes specific objectives based upon priorities identified, identifies the strategies and activities to undertake, monitors results, and assesses progress toward the goals.
- Have in effect mechanisms to detect both underutilization and overutilization of services and the ability to report these findings to DVHA as required. The activities the Contractor takes to address underutilization and overutilization must be documented and outcomes must be reported to DVHA.
- Have written policies and procedures for quality improvement. Policies and procedures must include methods, timelines and individuals responsible for completing each task.
- Incorporate an internal system for monitoring services, including data collection and management for clinical studies, internal quality improvement activities, assessment of certain target populations and other quality improvement activities requested by DVHA.
- Use Healthcare Effectiveness Data and Information Set (HEDIS) rate data, Consumer Assessment of Health Plans (CAHPS) survey data, and data from other similar sources to periodically and regularly assess the quality and appropriateness of care provided to members.
- Collect measurement indicator data related to areas of clinical priority and quality of care. DVHA reserves the right to identify areas of clinical priority and indicators of care.
- Report any national performance measures developed by CMS in the future at the request of DVHA.
- Have procedures for collecting and assuring accuracy, validity and reliability of performance outcome rates that are consistent with protocols developed in the public or private sector.
- Report the incentives offered and the results of any physician incentive program, if one has been put in place.
- Report the incentives offered and the results of any member incentive program, if one has been put in place.

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- Participate in other quality improvement activities, including, but not limited to, External Quality Reviews, to be determined by DVHA.

#### 8.3 Quality Management and Improvement Committee

The Contractor shall establish an internal Quality Management and Improvement Committee to develop, approve, monitor and evaluate the Quality Management and Improvement Program and Work Plan. The Contractor's Medical Director shall be an active participant in the Contractor's Quality Management and Improvement Committee. The committee shall be representative of management staff, Contractor departments, community partners, advocates, members and subcontractors, as appropriate and shall include the DVHA Medical Director or designee. Subcontractors providing direct services to members shall be represented on the committee.

The Contractor shall have a structure in place (e.g., other committees, sub-committees, work groups, task forces) that is incorporated into, and formally supports, the Contractor's Quality Management and Improvement Committee and Quality Management and Improvement Program Work Plan. All functional units in the Contractor's organizational structure shall integrate their performance measures, operational activities and outcome assessments with the Contractor's internal quality management and improvement committee to support the Contractor's quality management and improvement goals and objectives.

The Contractor shall have appropriate personnel attend and participate in regularly scheduled DVHA Quality Committee meetings.

#### 8.4 Quality Management and Improvement Program Work Plan Requirements

The Contractor's Quality Management and Improvement Committee, in collaboration with the Contractor's Medical Director, shall develop an annual Quality Management and Improvement Program Work Plan. The plan shall identify the Contractor's quality management goals and objectives and include a timeline of activities and assessments of progress towards meeting the goals.

The Contractor shall submit its Quality Management and Improvement Program Work Plan to DVHA during the readiness review and annually thereafter. The Contractor shall provide progress reports to DVHA on no less than a quarterly basis. The Contractor must be prepared to periodically, as determined by DVHA, report on its quality management activities to DVHA's Quality Committee.

The Contractor shall prepare the annual Quality Management and Improvement Program Work Plan using standardized reporting templates provided by DVHA. The ACO Reporting Manual will contain more information regarding this template.

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#### 8.5 HEDIS and CAHPS

In the initial year of the contract, the Contractor is not required to contract with a certified HEDIS Auditor or a certified CAHPS survey to tabulate the results of outcome measures pertaining to the DVHA members attributed to the ACO. Instead, the Contractor will work in close collaboration with DVHA and its contracted HEDIS Auditor and CAHPS survey firm in the sampling of DVHA members both attributed and not attributed to the ACO.

For the tabulation of HEDIS measures, the Contractor will be responsible at the request of DVHA to conduct chart reviews in the field on hybrid HEDIS measures among ACO-affiliated providers representing its proportion of all DVHA members in the denominator of specified HEDIS measures. DVHA staff will conduct the remaining chart reviews to represent the non-attributed members that it manages.

In contract years after the first year of the contract, DVHA reserves the right to request that the ACO contract directly with a certified HEDIS auditor or conduct a CAHPS survey to collect information annually on DVHA members attributed to the ACO.

#### 8.6 External Quality Review

Pursuant to federal regulation, DVHA is subject to external quality reviews. The Contractor shall provide all information required for this review in the timeframe and format requested by the External Quality Review Organization. The Contractor shall cooperate with and participate in all external quality review activities, as requested. The Contractor's Quality Management and Improvement Program should incorporate and address findings from these external quality reviews.

#### 8.7 Incentive Programs

##### 8.7.1 Pay for Outcomes Program

DVHA shall require the Contractor to participate in a pay for outcomes program that focuses on rewarding the Contractor's efforts to improve quality and outcomes for its attributed members. DVHA shall provide, at minimum, financial performance incentives to Contractors based on performance targets in priority areas established by the State. The Contractor performance targets are set forth in Attachment D.

DVHA has the right to revise measures on an annual basis and will notify the Contractor of changes to pay for outcome measures.

For any payments made by DVHA to the Contractor in the pay for outcomes program, at minimum, fifty (50%) of the rewards must be passed on to ACO network providers. The Contractor will develop a methodology to distribute the rewards to providers. The methodology must be approved by DVHA before any monies may be distributed.

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#### 8.7.2 Provider Incentive Programs

In addition to the pay for outcomes program in Section 8.7.1, the Contractor may establish other incentives for its providers. The Contractor will determine its own methodology for incentivizing providers. The Contractor must obtain DVHA approval prior to implementing its provider incentive program and before making any changes thereto. The State encourages creativity in designing pay for performance programs. However, the Contractor shall be cognizant and comply with federal regulations regarding physician incentive plans as stated in 42 CFR 538.8(h).

The Contractor will make no specific payment directly or indirectly to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual member.

#### 8.7.3 Member Incentive Programs

The Contractor may establish member incentive programs to encourage appropriate utilization of health services and healthy behaviors. Member incentives may be financial or non-financial. The Contractor will determine its own methodology for providing incentives to members. The Contractor must obtain DVHA approval prior to implementing its member incentive program and before making any changes thereto.

DVHA encourages creativity in designing pay for performance programs. However, the Contractor may not offer gifts or incentives greater than \$10.00 for each incentive and not to exceed \$50.00 total per year per individual in order to be in conformance with federal regulations. In any member incentive program, the incentives shall be tied to appropriate utilization of health services and/or health-promoting behavior.

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#### **9.0 Performance Reporting**

##### **9.1 ACO Reporting Manual**

The State places great emphasis on the delivery of quality health care to Medicaid members. Performance monitoring and data analysis are critical components in assessing how well the Contractor is maintaining and improving the quality of care delivered. DVHA uses various performance targets, industry standards, national benchmarks and program-specific standards to review and monitor the Contractor's performance and clinical outcomes. The Contractor shall submit performance data specific to the Medicaid ACO program unless otherwise specified by DVHA. DVHA reserves the right to publish the evaluation of the ACO's performance and/or recognize the Contractor when it exceeds performance indicators.

The Contractor shall comply with all reporting requirements set forth in this Section as well as the ACO Reporting Manual. As referenced in Section 2.16 of the Scope of Work, the ACO Reporting Manual will contain a catalog of the reports that will be required to be submitted by the Contractor to DVHA and the periodicity schedule of each report submission. For every report, DVHA will provide both a report template (most of which will be developed in Microsoft Excel) and instructions for how to complete each report. It is anticipated that some reports will be submitted monthly, some quarterly, some semi-annually, and others annually. DVHA may change the frequency of reports and may require additional reports. DVHA shall provide at least thirty (30) calendar days' notice to the Contractor before changing reporting requirements. DVHA may request ad hoc reports at any time.

The Contractor shall submit the requested data completely and accurately within the requested or required timeframes and in the formats identified by DVHA. Throughout the initial implementation, some specific reporting, identified by DVHA, will occur more frequently (e.g., member helpline statistics on a weekly basis); until Contractor demonstrates that its performance is consistent and meets the State's requirements and standards. The State reserves the right to require the Contractor to work with and submit data to third-party data warehouses or analytic vendors.

The Contractor shall have policies, procedures and mechanisms in place to ensure that the financial and non-financial performance data submitted to DVHA is accurate. The Contractor shall submit its performance data and reports under the signatures of either its Chief Financial Officer or Chief Executive Officer certifying the accuracy, truthfulness and completeness of the Contractor's data. The ACO Reporting Manual will include the reporting requirements that are highlighted below.

DVHA reserves the right to audit the Contractor's self-reported data and change reporting requirements at any time with reasonable notice. DVHA may require corrective actions and will assess liquidated damages, as specified, in Attachment E, for Contractor non-compliance with these and other subsequent reporting requirements and performance standards.

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At the date of release of this RFP, the ACO Reporting Manual is still under development. A listing of anticipated reports and metrics that DVHA will collect is shown below. Bidders should be aware that this list is not exhaustive and should not be considered to be all of the reporting requirements to DVHA in this Contract.

#### 9.1.1 Financial Reports

Financial Reports assist DVHA in monitoring the Contractor's financial trends to assess its stability and continued ability to offer health care services to its members. If the Contractor does not meet the financial reporting requirements, DVHA shall notify the Contractor of the non-compliance and designate a period of time, not less than ten (10) calendar days, during which the Contractor shall provide a written response to the notification. Examples of Financial Reports to be submitted by the Contractor include, but are not limited to,:

- Financial Stability Indicators;
- Reimbursement for FQHC and RHC Services;
- Physician Incentive Plan Disclosure; and
- Medical Loss Ratio.

#### 9.1.2 Member Service Reports

Member Service Reports identify the methods the Contractor uses to communicate to members about preventive health care and program services and monitor member satisfaction. Examples of Member Service Reports to be submitted by the Contractor include, but are not limited to,:

- Member Helpline Performance Report;
- Member Grievances Report;
- Member Website Utilization Report; and
- Marketing and Outreach Report.

DVHA shall have the right to require more frequent Member Service reporting, especially at the beginning of the Contract and during implementation of program changes as necessary to ensure satisfactory levels of member service throughout the Contract term.

#### 9.1.3 Network Development Reports

Network Development Reports assist DVHA in monitoring the Contractor's network composition by specialty and geographic location in order to assess member access and network capacity. The Contractor shall identify from its current DVHA member profile gaps in network services and the corrective actions that the Contractor is taking to resolve any potential problems relating to network access and capacity. Examples of Network Development Reports to be submitted by the Contractor include, but are not limited to,:

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- Network Geographic Access Assessment, including PCPs and Specialists;
- Twenty four (24)-Hour Availability Audit; and
- Provider Directory.

DVHA shall have the right to require more frequent Network Geographic Access Assessment reporting at the beginning of the Contract and during implementation of program changes as necessary to ensure satisfactory network access until the Contractor demonstrates that the network access standards have been met.

#### 9.1.4 Provider Service Reports

Provider Service Reports assist DVHA in monitoring the methods the Contractor uses to communicate to providers about clinical, technical and quality management and improvement issues relating to the program. Examples of Provider Service Reports to be submitted by the Contractor include, but are not limited to,:

- Provider Helpline Performance Report; and
- Formal Provider Payment Disputes;

#### 9.1.5 Quality Management Reports

Quality Management Reports document the methods and processes the Contractor uses to identify program and clinical improvements that enhance the appropriate access, level of care, quality and utilization of program services by its members and providers. These reports assist DVHA in monitoring the Contractor's quality management and improvement activities. Examples of Quality Management Reports to be submitted by the Contractor include, but are not limited to,:

- Quality Management and Improvement Program Work Plan;
- Quality Management Committee Meeting Minutes;
- Quality Improvement Program Statistical Analysis;
- Return on Investment of Provider Incentive Programs; and
- Return on Investment of Member Incentive Programs.

#### 9.1.6 Utilization Reports

Utilization Reports assist DVHA in monitoring the Contractor's utilization trends to assess its stability and continued ability to offer health care services to its members. Examples of Utilization Reports to be submitted by the Contractor include, but are not limited to,:

- Prior Authorization Report; and
- HEDIS-like utilization metrics using claims data only

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#### 9.1.7 Care Management Reports

Care Management Reports assist DVHA in monitoring the number and stratification of DVHA's ACO members in care management levels by condition of interest. Examples of Care Management Reports to be submitted by the Contractor include, but are not limited to,:

- Initial Health Screenings Report;
- Comprehensive Health Screenings Report; and
- Reports by Level of Care Management: low, medium, high and very high

#### 9.1.8 Payment Reports

Payment Reports assist DVHA in monitoring the Contractor's payment processing activities to ensure timely and accurate payments to providers. Examples of reports to be submitted by the Contractor include, but are not limited to,:

- Payment Aging Summary;
- Most Frequent Payment Denial Reasons; and
- Completion Reports for Submissions on the ACO Decision Response File (refer to Section 10.4.5)

#### 9.1.9 CMS Reporting

The Contractor shall provide DVHA with data requested by the Centers for Medicare and Medicaid Services (CMS) to meet the reporting obligations described in the CMS Special Terms and Conditions (STCs) for the State's Global Commitment waiver or State Innovation Model (SIM) grant reporting. CMS often requests additional data and reports in advance of DVHA's monthly conference calls with CMS. In preparation for these calls, DVHA will ask the Contractor for data requested by CMS. The Contractor shall submit this data in the timeframe specified by DVHA.

#### 9.1.10 Other Reporting

DVHA shall have the right to require additional reports to address program-related issues that are not anticipated at the time of the RFP release but are determined by DVHA to be necessary for program monitoring.

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#### 10.0 Information Systems

##### 10.1 Definitions

The following terms are used to describe the Contractor's and DVHA's activities in this engagement as it relates to information systems.

*ACO-Affiliated Provider, or ACO-Contracted Provider* – A Provider enrolled with Vermont Medicaid, and with whom an ACO has a contractual relationship, regarding the services within the scope of the ACO contract with DVHA.

*Fee for Service (FFS) Claim* – A claim that is paid directly to Providers, due to one or more of the following situations: a) the service provided is not within the scope of ACO covered services; b) the member is not attributed to the ACO; and/or c) the Provider is not affiliated with the ACO.

*Zero-Paid Claim* – A claim submitted to DVHA by an ACO-affiliated provider, which is paid zero dollars with an Explanation of Benefits (EOB) code indicating that the member and services are covered by the ACO. ACO-Affiliated Providers are reimbursed for ACO-covered members and ACO-covered services by the ACO.

*WHPP Claim Amount* – Would Have Paid Provider (WHPP) amount is the calculated amount for an adjudicated zero-paid claim that the DVHA would have paid if it were a FFS claim. The DVHA Medicaid Management Information System (MMIS) utilizes the same pricing rules to calculate both the paid amount on FFS claim payments and WHPP claim amounts. The WHPP claim amounts for zero-paid claims are reported to the ACO as part of the Medicaid Decision File for informational purposes. The WHPP amount is not included in Remittance files to providers.

*Medicaid Provider Remittance Advice Files* – Providers will continue to receive Remittance Advices (in paper format or as 835 X12 files), containing final dispositions for all claims submitted to Vermont Medicaid (both FFS paid claims and zero-paid claims). The RAs will include an Explanation of Benefits (EOB) code to indicate those claims that have been zero paid and that have been reported to the ACO.

*HPE* – Hewlett Packard Enterprises, the fiscal agent contracted by DVHA to perform the information system functions that are the responsibility of DVHA related to this contract.

*Third Party Liability (TPL)* – TPL refers to the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan. By law, all other available third party resources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services that are available under the Medicaid state plan.

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*Coordination of Benefits (COB)* – COB refers to the activities involved in determining Medicaid benefits when a DVHA member has coverage through an individual, entity, insurance, or program that is liable to pay for health care services. Individuals eligible for Medicaid assign their rights to third party payments to the State Medicaid Agency. Examples of third parties which may be liable to pay for services: Group health plans, Self-insured plans, Managed care organizations, Pharmacy benefit managers, Medicare, Court-ordered health coverage, Settlements from a liability insurer, Workers' compensation, Long-term care insurance, Other state or Federal coverage programs (unless specifically excluded by law).

#### 10.2 Summary of Contractor Information System Responsibilities

The Contractor shall have an Information System (IS) sufficient to support the Medicaid ACO program requirements, and the Contractor shall be prepared to submit all required data and reports accurately and completely in the format specified by DVHA. The Contractor shall maintain an IS with capabilities to perform the data receipt, transmission, integration, management, assessment and system analysis tasks described in this Scope of Work.

In the event the State's technical requirements require amendment during the term of the Contract, the State will work with the Contractor in establishing the new technical requirements. The Contractor shall be capable of adapting to any new technical requirements established by the State, and the State may require the Contractor to agree in writing to the new requirements. Contractor-initiated changes to the requirements shall require DVHA approval. The Contractor is required to pay for new technical requirements for its own systems.

The Contractor shall develop processes for developing, testing, and promoting system changes and maintenance. The Contractor shall notify DVHA prior to the installation or implementation of major software or hardware changes, upgrades, modifications or replacements that may impact mission critical business processes, such as file exchanges with the State's fiscal agent, service authorization management, provider payment data management, case management files, and any other processing affecting the Contractor's capability to interface with the State or the State's contractors.

The Contractor shall have written policies and procedures sufficient to manage the Medicaid ACO program. These policies and procedures will ensure accurate and valid provider payment detail data and will reflect that services delivered to members and payments made to providers are made in compliance with State and Federal regulations and in accordance with this Contract. These policies shall address the submission of provider payment data from any subcapitated providers or subcontractors. DVHA shall monitor the Contractor's performance utilizing a random sample audit of all program documentation and payments. DVHA will review the Contractor's compliance with its internal policies and procedures to ensure the accuracy and timeliness of the payments to providers and services provided to members. The Contractor is required to comply with the requirements of the review and audit and to provide all requested documentation. DVHA shall require the Contractor to submit a corrective action plan and will require

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non-compliance remedies for the Contractor's failure to comply with payment accuracy reporting standards.

The Contractor will provide DVHA with a project plan for all system changes or system upgrades associated with this contract. The project plan will include but is not limited to: project timeline, costs, milestones, deliverables, testing processes and protocols, criteria for a go-no go decision, contingency plan and mitigation strategies. The Contractor will provide the project plan to DVHA allowing for a 30 day review. The Contractor will proceed with the plan changes upon written acceptance and approval of the plan.

The Contractor shall have a plan for creating, accessing, storing and transmitting health information data in a manner that is compliant with HIPAA standards for electronic exchange, privacy and security requirements (45 CFR 162 and 164), which address security and privacy of individually identifiable health information.

The Contractor must be ready to begin systems testing with the State's fiscal agent, in the format specified by DVHA, by October 15, 2016.

The Contractor shall attend in person any meetings hosted by DVHA or its fiscal agent in relation to the development of and the ongoing remediation of any issues that arise from the data exchange process. Notwithstanding any scheduled meetings where these issues may be addressed, the Contractor shall report any problems with data submissions to the designated DVHA Contract Compliance Manager.

#### 10.3 Security and Privacy Practices

The Contractor's IS shall meet the requirements as specified by DVHA. The Contractor's electronic mail encryption software for HIPAA security purposes must be compatible with DVHA's and with DVHA's fiscal agent email software.

The Contractor's IS plans for privacy and security shall include, but not be limited to:

- Administrative procedures and safeguards (45 CFR 164.308);
- Physical safeguards (45 CFR 164.310); and
- Technical safeguards (45 CFR 164.312).

The Contractor shall make all data available to DVHA and, upon request, to CMS. In accordance with 42 CFR 438, subpart H, which relates to certifications and program integrity, the Contractor shall submit all data, under the signatures of either its Chief Financial Officer or Chief Executive Officer certifying the accuracy, truthfulness and completeness of the Contractor's data. Software and services provided to or purchased by the State shall be compatible with the principles and goals contained in the electronic and information accessibility standards adopted under Section 508 of the Federal Rehabilitation Act of 1973 (29 USC 794d). Any deviation from these architecture requirements shall be approved in writing by DVHA in advance. The Contractor shall comply with all DVHA Application Security Policies. Any deviation from DVHA policies shall be approved in writing.

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#### 10.3.1 Disaster Recovery Plan

Information system contingency planning shall be developed in accordance with the requirements of this Section and with 45 CFR 164.308, which relates to administrative safeguards. Contingency plans shall include: Data Backup plans, Disaster Recovery plans and Emergency Mode of Operation plans. Application and Data Criticality analysis and Testing and Revisions procedures shall also be addressed within the Contractor's contingency plan documents. The Contractor is responsible for executing all activities needed to recover and restore operation of information systems, data and software at an existing or alternative location under emergency conditions within twenty-four (24) hours of identification of a disaster. The Contractor shall protect against hardware, software and human error. The Contractor must maintain appropriate checkpoint and restart capabilities and other features necessary to ensure reliability and recovery, including telecommunications reliability, file back-ups and disaster recovery. The Contractor shall maintain full and complete back-up copies of data and software, and shall back up and store its data in an off-site location.

For purposes of this Scope of Work, "disaster" means an occurrence of any kind that adversely affects, in whole or in part, the error-free and continuous operation of the Contractor's or its subcontracting entities' IS or affects the performance, functionality, efficiency, accessibility, reliability or security of the system. The Contractor shall take the steps necessary to fully recover the data or system from the effects of a disaster and to reasonably minimize the recovery period. DVHA and the Contractor will jointly determine when unscheduled system downtime will be elevated to a "disaster" status. Disasters may include, but is not limited to, natural disasters, human error, computer virus or malfunctioning hardware or electrical supply.

The Contractor shall notify DVHA, at minimum, within four (4) hours of discovery of a disaster or other disruptions in its normal business operations. Such notification shall include a detailed explanation of the impact of the disaster, particularly related to mission critical business processes, such as processing affecting the Contractor's capability to interface with the State or the State's contractors. Depending on the anticipated length of disruption, DVHA, in its discretion, may require the Contractor to provide DVHA a detailed plan for resuming operations. In the event of a catastrophic or natural disaster, the Contractor shall resume normal business functions at the earliest possible time, not to exceed thirty (30) calendar days. In the event of other disasters or system unavailability caused by the failure of systems and technologies within the Contractor's span of control (including, but not limited to, system failures caused by criminal acts, human error, malfunctioning equipment or electrical supply), the Contractor shall resume normal business functioning at the earliest possible time, not to exceed ten (10) calendar days.

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DVHA will review the Contractor's Disaster Recovery Plan during the Readiness Review process and may review it at any time after contract initiation upon request.

### 10.4 Data File Exchanges

This Contractor will be responsible for the receipt and delivery of file exchanges with the State's fiscal agent. The Contractor must accept and submit data files in electronic format, currently via secure file transfer protocol ("SFTP") or as directed by DVHA. DVHA shall have the right to amend the data transfer process during the Contract term.

The Contractor's information systems must utilize the State's unique identification number (UID) to properly identify each member.

The list of data file exchanges is summarized below; however, this list may change in number and/or periodicity at any time during the course of the contract based on the needs of the State.

File Name	Inbound to DVHA/ Outbound from DVHA	Anticipated Periodicity
ACO Affiliated Provider File	Inbound	Monthly
Medicaid Member Attribution File	Outbound	Monthly
Medicaid ACO Remittance File	Outbound	Monthly
Medicaid Decision File	Outbound	Weekly
ACO Decision Response File	Inbound	Weekly
ACO Non Claims Payments File	Inbound	Weekly
Medicaid FFS Payments File	Outbound	Weekly
ACO Service Authorization File	Inbound	Daily
ACO Case Management File	Inbound	Monthly

#### Medicaid-ACO File Exchange Definitions, Requirements and Uses

*The first word in the file name indicates who is responsible for generating the file, while the rest of the name is descriptive about the file content. The organizations involved in file exchange are noted in parentheses.*

##### 10.4.1 ACO Affiliated Provider File

(ACO to HPE) This file contains the current list of Vermont Medicaid enrolled providers who are affiliated with the ACO, including a method of identifying changes. The Contractor shall submit provider roster updates to the State's fiscal agent in an agreed upon format and process. The Contractor shall keep provider enrollment and disenrollment information up-to-date.

##### 10.4.2 Medicaid Member Attribution File

(DVHA to HPE for initial attribution, HPE to ACO ongoing) This file contains information including the list of members currently attributed to the ACO. The

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HPE MMIS system will store and maintain the member attribution status, including the history of changes to member status that may impact per member per month (PMPM) payments (such as death, Medicaid eligibility, or third party primary coverage). The effective date of any retrospective change will also be reported.

#### 10.4.3 Medicaid ACO Remittance File

(HPE to ACO) This file contains the details of Per Member Per Month (PMPM) payments made by DVHA to the ACO.

The Contractor shall be responsible for reconciling capitation payments against the Medicaid Member Attribution File and identify any errors or omissions to the State's fiscal agent within ten (10) business days of receipt of the Medicaid ACO Remittance File.

#### 10.4.4 Medicaid Decision File

(HPE to ACO) This file contains information related to claims submitted by ACO-affiliated providers for ACO-covered services for all attributed members to the ACO. The Medicaid Decision File contains DVHA's disposition of the claim status which may be paid (zero-paid claims) or denied (with denial reason).

DVHA's fiscal agent will continue to receive all claims from Vermont Medicaid providers. All claims will continue to be processed through DVHA's edits and audits.

Upon initiation of this contract, DVHA's fiscal agent will identify all claims that need to be passed to the Contractor for payment that meets the criteria for:

- An attributed member to the ACO;
- A contracted provider with the ACO; and
- A service that is included in the capitation payment to the ACO.

When claims meet all of these criteria, DVHA's fiscal agent will assign a paid or denied status to the claim which represents the disposition of the claim under fee-for-service pricing logic. When the claim status is paid, the fiscal agent will assign a payment of \$0 to the claim. Claims identified as the responsibility of the ACO will be provided to the ACO Contractor on an agreed upon schedule. The ACO will then be responsible for any additional review of the claims and payment to ACO contracted providers for services rendered.

The Contractor shall review data provided by DVHA's fiscal agent and either deny or make payments to providers within fourteen (14) calendar days of receipt.

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#### 10.4.5 ACO Decision Response File

(ACO to HPE) This file contains the ACO paid amount to ACO-affiliated providers, for claims previously reported to the ACO in Medicaid Decision Files.

The Contractor shall demonstrate and maintain the capability to pay providers for services rendered to the Contractor's members, in compliance with HIPAA, including National Provider Identification (NPI). The Contractor shall maintain detailed records of remittances to providers. The Contractor must include the Internal Control Number (ICN) created by the State's fiscal agent to identify to its providers the ACO's payment assigned to each claim originally submitted by the provider to the State's fiscal agent. DVHA retains the option to review and approve the format of the remittance advice sent to the ACO's providers that relates to payments for Medicaid covered services.

The Contractor shall submit provider payment data to DVHA's fiscal agent for every service rendered to a member for which the Contractor either paid or denied reimbursement. These provider payments will include detail originally submitted by the fiscal agent to the Contractor as well as Contractor-specific variables such as an identification of payment transaction type (i.e., original, void, replacement, recoupment, duplicate, adjustment), ACO payment status, and ACO paid amount. As provided in 42 CFR 447.46(c) (2), the Contractor may, by mutual agreement, establish an alternative payment schedule with in-network providers.

DVHA requires that its providers submit claims in accordance with the DVHA Provider Manual. The Contractor may not impose a stricter timeline on its contracted providers. The Contractor shall have written policies and procedures detailing the documentation and resolution of provider payment disputes, regulations, including HIPAA regulations related to the confidentiality and submission requirements for protected health information (PHI). The Contractor shall ensure that all communication with providers is efficient, informative, relevant and documented.

The Contractor shall submit one hundred percent (100%) of processed provider payments (paid or denied) to DVHA's fiscal agent within thirty (30) calendar days of processing. If the Contractor fails to comply with provider payment data submission requirements, DVHA shall require the Contractor to submit a corrective action plan to address the issues and liquidated damages may be assessed if the corrective action plan is not successful.

DVHA will reconcile the Medicaid Decision File data sent outbound to the Contractor against the ACO Decision Response File data inbound from the Contractor to assess compliance with payment and contractual requirements.

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DVHA shall have the right to audit all payments. The Contractor must comply with all the requirements of an audit and must provide all requested documentation.

DVHA must pre-approve the Contractor's delegation of any payment processing functions to a sub-contractor, and the Contractor must notify DVHA and secure DVHA's approval of any change to sub-contracting arrangements for payment processing.

#### 10.4.6 ACO Non Claims Response File

(ACO to HPE) This file contains payments the ACO has made to their affiliated providers which were not reported at a claim level in ACO Decision Response Files.

#### 10.4.7 Medicaid FFS Payments File

(HPE to ACO) This file contains paid claims data for all attributed members to the ACO paid by DVHA on a fee-for-service basis: a) for Medicaid services not included in the ACO capitated payment but provided to ACO members; or b) for ACO capitated services provided to ACO members by non-ACO providers.

#### 10.4.8 ACO Service Authorization File

(ACO to HPE) This file contains services requiring authorization that have been approved by the ACO for ACO attributed members. The fiscal agent will use this authorization information to adjudicate claims submitted by ACO-affiliated providers for services where DVHA requires prior authorization.

This file is to be transferred to DVHA's fiscal agent on a nightly basis in a specified file format. Information contained in the file will be specified by DVHA.

On an as requested basis, DVHA may request from the ACO the authorization requests that have been denied by the ACO for ACO attributed members. It is anticipated that the file format for denied authorizations will be in the same format as the file for approved authorizations.

#### 10.4.9 ACO Case Management File

(ACO to HPE) This file contains data elements related to ACO attributed members who have been case managed by the ACO. Elements of the file that will be transmitted are anticipated to include the member UID, diagnoses, start and end date receiving case management, the reason for case management, the level of case management, elements in the case management/treatment plan, the

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member's compliance with the case management/treatment plan, and evaluation of whether the case management was successful.

#### 10.5 Third Party Liability (TPL) Issues

Upon initiation of the contract, Vermont Medicaid members who have third party coverage of any kind will not be attributed to the Contractor. If the Contractor becomes aware that one of its DVHA members obtains third party coverage or is enrolled with another insurer, the Contractor is responsible for reporting this information to DVHA's fiscal agent within five (5) calendar days.

When the Contractor has identified members who have newly discovered health insurance, members who have changed coverage, or members who have casualty insurance coverage, the Contractor will provide the State and its fiscal agent the following information:

- Member name/UID number/Social Security number
- Carrier name/address/phone number/contact person
- Policyholder name/address/Social Security number/relationship to member
- Policy number/Group Number/effective date/coverage type

When a DVHA member who is attributed to the Contractor obtains third party insurance coverage, the capitation payments prospectively will cease and any capitation payments made previously that were determined to be inappropriate after the fact will be recouped by DVHA in a year-end reconciliation. Additional specifications related to the recoupment of payments from third party insurance ("chasing payments") and how this activity interplays with the year-end reconciliation will be detailed in the ACO Operations Manual and will be made available to the Contractor prior to the readiness review process.

#### 10.6 Year End Reconciliation Process

DVHA will complete a year end reconciliation process on or about 180 days after the end of each 12-month contract performance period to reconcile any payments owed from or to the Contractor over the course of the previous 12-month period. The files described in Section 10.4 will serve as the primary basis for this reconciliation. However, on an as needed basis, DVHA may request from the Contractor additional files to exchange with DVHA's fiscal agent to support this year end reconciliation. The Contractor will be obligated to provide these files as requested.

There may be situations where, due to new knowledge of retrospective TPL, items that would normally be accounted for in the year end reconciliation will not be accounted for because they become known more than 180 days after the end of the 12-month contract period. In this situation, the retrospective TPL adjustment items will be accounted for in the next year's reconciliation process.

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10.7 Health Information Technology and Data Sharing

The use of Health Information Technology (HIT) has the potential to improve the quality and efficiency of health care delivery. The Contractor shall cooperate and participate in the development and implementation of current and future DVHA- or State-sponsored HIT initiatives. Contractors must complete and participate in data sharing agreements with any health information technology entity required by DVHA.

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#### **11.0 Program Integrity**

11.1 The Contractor shall comply with three important provisions of Program Integrity (PI). As more fully set out below, the contractor shall comply with (1) the provider contracting requirements found in Sections 5.3 of this Request for Proposal, (2) the requirements for a Program Integrity Plan; and (3) the requirement for ongoing monitoring of the Contractor's provider network.

##### 11.1.1 Provider Contracting

Under Section 5.3 of this RFP, the contractor must ensure that each provider in its network has been enrolled in the Vermont Medicaid Program. The contractor must also assure that its network providers have entered into and keep current a Medicaid provider agreement.

Because Vermont Medicaid will perform Medicaid required screening and enrollment for ACO network providers, the Contractor need not incur this cost.

##### 11.1.2 Program Integrity Plan

Pursuant to 42 CFR 438.608, which sets program integrity requirements, the Contractor must have an administrative procedure that includes a mandatory compliance plan that describes in detail the manner in which it will detect fraud and abuse. The Program Integrity Plan shall serve as the Contractor's compliance plan. The Program Integrity Plan shall incorporate the collaboration with the DVHA PI Unit's fraud, waste and abuse efforts and shall be submitted annually and more frequently if required by the DVHA PI Unit. The Program Integrity Plan and/or updates to the Program Integrity Plan shall be submitted through the reporting process to DVHA, who shall forward to the DVHA PI Unit, ten (10) business days prior to scheduled meetings discussing the Plan. The Plan shall include provisions enabling the efficient identification, investigation, and resolution of waste, fraud and abuse issues of vendors, subcontractors and the Contractor itself. Although provider fraud, waste and abuse will be investigated by the DVHA PI Unit, the contractor should have mechanisms to report identified or alleged instances. The Program Integrity Plan shall also include:

- Written policies, procedures and standards of conduct that articulate the organization's commitment to comply with all applicable state and federal standards.
- The designation of a Compliance Officer and a Compliance Committee.
- The type and frequency of training and education for the Compliance Officer and the organization's employees who will be provided to detect fraud. Training must be annual at a minimum and address the False Claims Act, Federal and Vermont laws and requirements governing Medicaid reimbursement and the utilization of services. In particular, this shall include changes in rules and other federal and state laws governing Medicaid provider participation and payment as directed by

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CMS and DVHA. Education regarding the False Claims Act of staff of the contractor must be provided to DVHA in its Program Integrity Plan.

- A risk assessment of the Contractor's compliance plan and contractual requirements with providers and subcontractors, as well as other programmatic policies shall be submitted on an 'as needed' basis and updated after program integrity-related actions, including financial-related actions (such as overpayment, repayment and fines), are taken. The Contractor shall inform the DVHA PI Unit of such actions in its audit plan. The assessment shall also include a listing of the Contractor's top three (3) vulnerable areas and shall outline action plans mitigating such risks.
- An organizational chart and communication plan highlighting lines of communication between the Compliance Officer and the organization's employees.
- Provision for internal monitoring and auditing.
- A description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including but not limited to:
  - A list of provisions in the subcontractor and provider contracts that ensure the integrity of provider credentials.
  - A list of provisions for the confidential reporting of PI Plan violations to the Compliance Officer or designated person.
  - A list of provisions for the adherence to ACO related regulations and applicable waivers granted under the Affordable Care Act, Stark Law, Anti-kickback statute, civil money penalty law (CMP), Gainsharing CMP, and incentives.
- Provisions ensuring that the identities of individuals reporting violations of the Contractor are protected and that there is no retaliation against such persons.
- Specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance PI Plan violations.
- Requirements regarding the reporting of any confirmed or suspected provider fraud and abuse under state or federal law to the DVHA PI Unit and pursuant to section 11.1.3.
- Provisions for prompt response to detected offenses, and for development of corrective action initiatives.

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- Compliance and Program integrity-related goals, objectives and planned activities for the upcoming year

#### 11.1.3 Ongoing Monitoring of the Contractor's Provider Network

The Contractor shall have adequate staffing and resources to monitor provider and sub-contractor contracts to ensure compliance.

The contractor will work collaboratively with the DVHA PI Unit and will develop and implement any necessary corrective action plans required of the Contractor. The Contractor shall further require their contracted providers or subcontractors to comply with any requested corrective action plans as a result of fraud and abuse activities identified by either the Contractor or the DVHA PI Unit.

The Contractor shall cooperate with all appropriate state and federal agencies, including the Medicaid Fraud and Residential Abuse Unit (MFRAU) and the DVHA PI Unit, in investigating fraud and abuse.

The Contractor shall promptly refer all incidents of suspected fraud, waste and abuse to the DVHA PI Unit.

On a quarterly basis, and as otherwise directed by the DVHA PI Unit, the Contractor shall submit a detailed Report to DVHA which outlines the Contractor's compliance and program integrity-related activities, as well as identifies the Contractor's progress in meeting program integrity-related goals and objectives.

The contractor agrees that the DVHA Program Integrity Unit is responsible for overseeing the integrity of all Medicaid Payment, including the underutilization of services or the over reporting of services such as split billing, unbundling of services or other billing methods that would cause ACO capitation to increase artificially.

The contractor agrees that the DVHA PI Unit may conduct oversight reviews of the Contractor's Compliance or Program Integrity related activities to determine the effectiveness of Contractor's operations. Such audit activities may include conducting interviews of relevant staff, reviewing all documentation and systems used for such activities, and reviewing any performance metrics. The DVHA PI Unit may issue a corrective action or performance improvement plan and outline timelines for improvement measures.