# MEDICAID COMPREHENSIVE QUALITY STRATEGY

**STATE OF VERMONT**
**AGENCY OF HUMAN SERVICES**

*Produced by*
*AHS Performance Accountability Committee (PAC)*
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HCBS Transition Plan Preface

## Overview

On January 10, 2014, the Centers for Medicare and Medicaid Services (CMS) issued final regulations regarding home and community-based settings (HCBS), with additional guidance and information posted on March 18, 2014. The rule supports enhanced quality in HCBS programs, outlines person-centered planning practices, and reflects CMS' intent to ensure that individuals receiving services and supports under 1915(c), 1915(k), and 1915(i) Medicaid authorities have full access to the benefits of community living and are able to receive services in the most integrated setting.

CMS is asking Vermont to provide assurances that the State's Managed Long Term Services and Supports (MLTSS) in the Choices for Care Program are in compliance with certain aspects of the HCBS rule - specifically, those related to the *setting requirement* and *person centered approaches* for service planning. Two specific STC's from the Global Commitment to Health 1115 demonstration waiver are summarized below:

- person centered planning (i.e., the process, the service plan, and the review of the service plan) will be in compliance with the characteristics set out in 42 CFR 431.301 (c)(1)-(3) (STC #29)

- Compliance with the characteristics of home and community based settings in accordance with 42 CFR 441.301 (c)(4) for Choices for Care Services (e.g., those not found in the Vermont State Plan) (STC #32)

## Background

In all Vermont programs, consumers have equal access to an array of traditional state plan services, including Private Non-Medical Institution Services (PNMI), inpatient, skilled nursing and other rehabilitative therapies and service options. The final service package is based on consumer choice, individualized planning, medical necessity (including level of care determinations) and medical appropriateness; thus individual plans may include institutional (Nursing Facility and PNMI), home-based and other rehabilitative based services as part of their person centered planning process.

The State's goal in adopting a consolidated waiver was to streamline regulatory structures, decrease unnecessary administrative burden and ensure support and alignment of its current payment reform and health care efforts focusing on the comprehensive integrated of long term, primary and acute care. The State requested that any new STC requirements be focused on value-based purchasing, quality oversight and the shared state and federal goals of integrated MLTSS care as part of health care reform.

Regardless of the setting beneficiaries choose, Vermont's values are in alignment with the Federal HCBS rules and Managed Long Term Services and Support Guidance. As such, at its discretion and over time, the State's Comprehensive Quality strategy will also review the rules and guidance supporting all Special Health Need Populations served under the Demonstration and services provided in Private Non-Medical Institutions and other community residential options authorized under the State Plan and the Global Commitment Demonstration.

Choices For Care Programs in Vermont Impacted by Federal Rule

The vast majority of Choices for Care services are provided to Global Commitment to Health waiver participants in their homes. However persons may also choose adult family care (a community based shared living arrangement) or institutional settings (e.g., skilled nursing facility, private non-medical institutions). Table 1 below shows the service array available to Choices for Care participants and their coverage authority.

Table 1: Choices for Care Program Benefits

| **42 CFR 440.180 HCBS Service** | **Choices for Care Benefit** | **Coverage Authorization (State Plan or GC)** |
|---|---|---|
| Case Management | Case Management | GC |
| Home Maker | Home Maker - Moderate Needs Group only | GC |
| Personal Care | Personal Care | GC |
| Adult Day Rehabilitation | Adult Day | State Plan -Day Health Rehabilitation |
| Habilitation | Assisted Living Residences | State Plan - Private Non-Medical Institution (Assistive Community Care) |
| | Enhanced Residential Care – Level III | State Plan - Private Non-Medical Institution (Assistive Community Care) |
| | Adult Family Care | GC |
| | Nursing Facility Care | State Plan– Nursing Facility |
| Respite | Respite Care (in home or foster home) | GC |
| Other Cost Effective Alternatives to institutional care | Companion Care | GC |
| | Assistive Devises and Home Modifications | GC |
| | Personal Emergency Response System | GC |

Table 2 illustrates the specific Choices for Care benefits that will be examined in the first phase of the Comprehensive Quality Strategy.

| **Phase 1 of Comprehensive Quality Strategy (Choices for Care)** | | |
|---|---|---|
| Choices for Care SETTINGS | Person Centered Planning 42 CFR 431.301(c) (1)-(3) | HCBS Settings 42 CFR 441.301(c)(4) |
| | | |
| Home Based | ✓ | |
| Adult Family Care | ✓ | ✓ (e.g., HCBS Transition Plan) |
| Enhanced Residential Care (PNMI) | ✓ | ✓(e.g., State's MLTSS CQS) |
| Nursing Facility | ✓ | |

Comprehensive Quality Strategy Transition Plan Elements

Vermont's Global Commitment to Health Comprehensive Quality Strategy (CQS) is intended to serve as a blueprint for Vermont and its contracted health plan in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. In doing so, it describes specifications for quality assessment and performance improvement activities that the Agency of Human Services (AHS) will implement to ensure the delivery of quality health care. In addition, the CQS identifies the framework and strategy for achieving and maintaining compliance with the federal HCBS requirements for Choices for Care HCBS programs. Specifically, the CQS contains the following Transition Plan elements:

a. A detailed description of the state's assessment of compliance with the home and community-based settings requirements for adult family care. Please see attached document for an update on progress to date. The assessment process is expected to be completed by December 31, 2015. Depending on the outcome of the initial assessment - the state may choose to conduct site specific evaluations.

b. A detailed description of the remedial actions the state will require to assure full compliance with the home and community-based settings requirements for adult family care settings, including timelines, milestones and monitoring process. It is anticipated that all settings will be fully compliant by March 17, 2019.

c. A description of the public input process, with a summary of public comments. Vermont is committed to ensuring that our statewide Comprehensive Quality Strategy (CQS) is reviewed publicly and that public input is incorporated into the final strategy. The CQS is subject to public input, as required at 42 CFR 441.301(6)(B)(iii) and 42 CFR 441.710(3)(iii). Prior to submission of the CQS, the state will:

    - Allow a minimum of a 30-day public comment period on the Draft CQS
    - Consider public comments and modify the Draft CQS accordingly
    - Submit evidence of public comment and our response to comments

The CQS and all related documents can be found here http://dvha.vermont.gov/administration/draft-versions-of-state-plan-changes

Assessment of HCBS Setting Requirements for Other GC Programs

As described above – the state is engaged in an assessment of compliance with the home and community-based settings requirements for adult family care settings. The Choices for Care assessment process is expected to be completed by October 1, 2015. The monitoring of the compliance the new HCBS rules will be an ongoing process that will be incorporated into existing quality assessment and performance improvement processes. Based on considerable stakeholder interest, Vermont is taking this opportunity to further assess programs/settings for GC Demonstration populations who are designated by the State as persons with Special Health Care needs under 42 CFR 438. Once the assessment process is completed for Choices for Care participants – the following Special Health Need populations will also be considered:

- Developmental Services (DS)
- Traumatic Brain Injury (TBI)
- Children with a Severe Emotional Disturbance (SED)
- Community Rehabilitation and Treatment (CRT)

The state will apply the same process, including key elements described above, as they conduct this assessment. The CQS will be updated to capture the outcomes of this work. Table 3 below outlines Vermont's phased approach to implementing the new HCBS rules identified in their waiver STCs.

Table 3: Global Commitment to Health Specialized Program Assessment and Quality Phases

| | GC Specialized Program Self-Assessment and Quality Phases | | | | |
|---|---|---|---|---|---|
| | Choices for Care | Developmental Services | Traumatic Brain Injury | Community Rehabilitation and Treatment | Children's Mental Health (Mental Illness under 22) |
| Quality Strategy Timeline | | | | | |
| Phase 1: Due 12/31/15 | ✓ | | | | |
| Phase 2: Due 12/31/16 | ✓ | ✓ | ✓ | | |
| Phase 3: Due 12/31/17 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Phase 4: Due 12/31/18 | ✓ | ✓ | ✓ | ✓ | ✓ |

<u>Phase 1: Initiation</u>

- This phase begins with the Global Commitment (GC) Comprehensive Quality Strategy (CQS). The CQS serves as a blueprint or road map for Vermont and its contracted health plan in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. The critical elements of the CQS are: performance measures, performance improvement projects, and compliance with federal and state regulations including Medicaid Managed Care & the Special Terms and Conditions. During this phase, AHS will establish a framework that sets the stage for the subsequent three phases. Specific milestones include: introduction of monitoring and oversight methodology and the development of a plan for assessment of CFC HCBS and in particular Adult Family Care settings. Additional tasks include the following:
    a) A self-assessment of CFC adherence to state and federal standards of care to include:
        i. Assessment of existing initiatives designed to improve the delivery of CFC, including performance measures or Performance Improvement Projects (PIPs) directed to this population.
        ii. Examination of processes to identify any potential corrective action steps toward improving the CFC system.
    b) Person-Centered Planning and Integrated Care Settings*
    c) Comprehensive and Integrated Service packages
    d) Qualification of Providers
    e) Participant Protections

*Vermont's rules and statutes currently require person-centered planning for all populations. The quality and monitoring of these requirements are being addressed by the CQS.

Phase 2: CFC Implementation & Additional Discussion

- During this phase control processes are implemented for all CFC adult family care settings; project management infrastructure necessary to support the consistent, successful application of monitoring and oversight techniques by the MCE is created, a self-assessment tool is identified, and MCE staff are trained and mentored. In addition, the development of a work plan and the modification of DVHA/DAIL IGA and DVHA/DAIL Quality Plan will take place. Some other specific milestones include the following: modes of communication with stakeholders are established, corrective action plan template and reporting tools are developed and monitoring and oversight is initiated. At the same time that CFC AFC setting implementation is taking place, state staff will assess programs/settings for GC Demonstration populations who are designated by the State as persons with Special Health Care needs under 42 CFR 438 (i.e., Developmental Services and Traumatic Brain Injury). The state will apply the same process and key elements as those used for CFC adult family care settings (including stakeholder involvement) as they conduct these assessments. Phase 2 will be completed by December 31, 2016.

Phase 3: Additional Implementation

- This phase broadens the scope of the activities described in phase two to include the assessment of additional GC Demonstration populations who are designated by the State as persons with Special Health Care needs under 42 CFR 438 (i.e., children's mental health and community rehabilitation and treatment). Phase 3 will be completed by December 31, 2017. Activities in phase three may be expanded beyond DAIL. In this case, processes and structures to support cross-departmental decision-making will need to be identified. All monitoring/oversight tools will be shared among AHS departments.

Phase 4: Maintenance

- The purpose of the Maintenance phase is to ensure long-term continuity by establishing all measures identified above as a core elements and essential monitoring functions within the MCE. Starting with year 4, it is expected that the necessary structures and processes will be in place to support ongoing monitoring and oversight activities. Phase four will be completed by December 31, 2018. Full compliance for all GC populations included in this phased approach is expected to take place by the end of 2019.

This approach will allow the state to use lessons learned in early phases to be incorporated in later phases and ensures that a solid foundation of quality assurance and improvement is in place that aligns with Vermont's statutes, policies and values related to home and community delivery systems.

# I. INTRODUCTION

The Comprehensive Quality Strategy (CQS) is intended to serve as a blueprint or road map for Vermont and its contracted health plan in assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. In doing so, it sets forth specifications for quality assessment and performance improvement activities that the Agency of Human Services (AHS) will implement to ensure the delivery of quality health care. The Centers for Medicare and Medicaid Services (CMS) published its final rule related to Home and Community Based Services (HCBS) for Medicaid-funded long term services and supports provided in residential and non-residential home and community-based settings. The final rule took effect March 17, 2014. The CQS identifies the framework and strategy for achieving and maintaining compliance with the federal HCBS requirements for Choices for Care HCBS programs. Rather than developing a transition plan – Vermont has opted to have the CQS demonstrate the state's compliance with the HCBS requirements and should suffice as the Statewide Transition Plan.

Managed Care Goals, Objectives and Overview

**Medicaid Managed Care in Vermont**

For more than two decades, the state of Vermont has been a national leader in making affordable health care coverage available to low-income children and adults, and providing innovative system reforms to support enrollee choice and improved outcomes. Vermont was among the first states to expand coverage for children and pregnant women, accomplished in 1989 through the implementation of the state-funded Dr. Dynasaur program, which later in 1992 became part of the state-federal Medicaid program. When the federal government introduced the State Children's Health Insurance Program (SCHIP) in 1997, Vermont extended coverage to uninsured and under-insured children living in households with incomes below 300% of the Federal Poverty Level (FPL). In 1995, Vermont implemented a Section 1115(a) Demonstration, the Vermont Health Access Plan (VHAP). The primary goal was to expand access to comprehensive health care coverage through enrollment in managed care for uninsured adults with household incomes below 150% (later raised to 185% of the FPL for parents and caretaker relatives with dependent children in the home). VHAP also included a prescription drug benefit for low-income Medicare beneficiaries who did not otherwise qualify for Medicaid. Both Demonstration populations paid a modest premium on a sliding scale based on household income. The VHAP waiver also included a provision recognizing a public managed care framework for the provision of services to persons who have a serious and persistent mental illness, through Vermont's Community Rehabilitation and Treatment program. While making progress in addressing the coverage needs of the uninsured through Dr. Dynasaur and VHAP, by 2004 it became apparent that Vermont's achievements were being jeopardized by the ever-escalating cost and complexity of the Medicaid program. Recognizing that it could not spend its way out of projected deficits, Vermont worked in partnership with CMS to develop two new innovative 1115 demonstration waiver programs, Global Commitment to Health (GC) and Choices for Care (CFC). Both demonstrations have enabled the State to preserve and expand the affordable coverage gains made in the prior decade; provide program flexibility to more effectively deliver and manage public resources; and improve the health care system for all Vermonters. The Global Commitment to Health Section 1115(a) demonstration was initiated in October 1, 2005 and is designed

to use a multi-disciplinary approach including the basic principles of public health, the fundamentals of effective administration of a Medicaid managed care delivery system, public-private partnership, and program flexibility. The Global Commitment (GC) to Health Section 1115(a) Demonstration continued VHAP and also was designed to provide flexibility with regard to the financing and delivery of health care to promote access, improve quality and control program costs. An amendment to the Global Commitment (GC) to Health Demonstration approved by CMS on October 31, 2007, allowed Vermont to implement the Catamount Health Premium Assistance Program for individuals with incomes up to 200% of the Federal Poverty Level (FPL) who enroll in a corresponding Catamount Health Plan. Created by state statute and implemented in October 2007, the Catamount Health Plan is a commercial health insurance product, initially offered by both Blue Cross Blue Shield of Vermont and MVP Health Care, which provided comprehensive, quality health coverage for uninsured Vermonters at a reasonable cost regardless of income. CMS approved a second amendment on December 23, 2009 that expanded federal participation for the Catamount Health Premium Assistance Program up to 300% of the FPL. Additionally, this amendment allowed for the inclusion of Vermont's supplemental pharmaceutical assistance programs in the GC Demonstration. Renewed on January 1, 2011, the current GC Demonstration has subsequently been amended twice; once on December 13, 2011 to include authority for a children's palliative care program, and most recently on June 27, 2012, to update co-pay obligations. On October 2, 2013, CMS extended the Global Commitment to Health demonstration for three years. Effective January 1, 2014, the state expanded coverage under its approved state plan to the new adult group authorized by the Affordable Care Act. The demonstration project was amended to affect the new adult group and to and terminate the VHAP, CHAP, and ESI demonstration programs, as these programs were no longer necessary. The VHAP-Pharmacy, VScript, and VScript Expanded programs were also terminated effective January 1, 2014, because of the availability of pharmacy and other benefits in the Marketplace. Effective January 1, 2014, Vermont was authorized to provide hospice services to adults concurrently with curative therapy. Also effective January 1, 2014, Designated State Health Program (DSHP) funding was made available to support state programs subsidizing the purchase of insurance in the Marketplace for individuals whose income is above 133 percent of the federal poverty level (FPL) and up to and including 300 percent FPL. Vermont received transitional coverage DSHP authority through April 30, 2014 to assist the state in transitioning individuals in the former Expansion Populations to the appropriate coverage vehicle. As of January 30, 2015, Vermont is amending the Global Commitment to Health demonstration to include the Choices for Care section 1115 demonstration. Specifically, Vermont expects to demonstrate its ability to achieve universal access to health care, cost containment, and improved quality of care.

**Medicaid Managed Care Program Goals**

The State's goal in adopting a consolidated waiver is to streamline regulatory structures, decrease unnecessary administrative burden and ensure support and alignment of its current payment reform and health care efforts focusing on the comprehensive integrated of long term, primary and acute care. The State requested that any new STC requirements be focused on value-based purchasing, quality oversight and the shared state and federal goals of integrated MLTSS care as part of health care reform. The Global Commitment to Health (GC) 1115 Demonstration waiver was designed to test the hypothesis that greater Medicaid program and resource flexibility and the lessening of federal regulatory restrictions governing the operation of Vermont's Medicaid program would permit the State to better meet the needs of Vermont's publicly insured and uninsured populations for the same or a lower cost.

The state's goal in implementing the demonstration is to improve the health status of all

Vermonters by:

· Increasing access to affordable and high quality health care;
· Improving access to primary care;
· Improving the health care delivery for individuals with chronic care needs;
· Containing health care costs; and
· Allowing beneficiaries a choice in long-term services and supports and providing an array of home and community-based alternatives recognized to be more cost-effective than institutional based supports.

The goals align with Institute for Healthcare Improvement's Triple Aim but are more specific in identifying pathways for the state to achieve its goals.

**Elements**

The Quality Strategy includes, at a minimum, information relating to the following issues:

- DVHA's sub-contract and IGA provisions that incorporate the standards specified in 42 CFR Subpart D
- Procedures that
  - assess and improve the quality and appropriateness of care and services furnished to all Medicaid enrollees through sub-contracts and IGAs especially to individuals with special health care needs
  - Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee at the time of enrollment.
  - Document how AHS will regularly monitor and evaluate the use of national performance measures and levels that may be identified and developed by CMS in consultation with AHS and other relevant stakeholders.
- Procedures that document how AHS will regularly monitor and evaluate the arrangement for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered.
- Procedures that document how AHS will regularly monitor and evaluate the use of intermediate sanctions.
- Procedures that document how AHS will regularly monitor and evaluate the information system regarding its ability to support initial and ongoing operations and review of the Quality Strategy.
- Procedures that document how AHS will regularly monitor and evaluate compliance with AHS standards for access to care, structure and operations, and quality measurement and improvement.

**Medicaid Managed Care Program Objectives**

The objectives reflect the state's priorities and areas of concern for the population covered by the Managed Care Entity (MCE) contract. Results of prior program experience, performance measurement, External Quality Review Organization (EQRO), and other quality related reporting activities will help to identify the quality strategy objectives.

Table 4: Quality Strategy Objectives:

| Focus Area | Objective | Time Frame | Targets |
|---|---|---|---|
| | | | |
| Diabetes | AHS will demonstrate a 5% improvement in the HgA1c testing and LDL screening of Medicaid managed care beneficiaries with diabetes over the next two years. | 1/2015-12/2017 | 68.3% & 48.5% |
| Asthma | AHS will demonstrate a 5% improvement in the use of appropriate medications for people with asthma over the next two years. | 1/2015-12/2017 | 86.5% |
| Prenatal care | AHS will demonstrate a 5% improvement in the rate of pregnant women receiving prenatal care over the next two years. | 1/2015-12/2017 | TBD* |
| Annual dental visits | AHS will demonstrate a 5% improvement in enrollee access to dental visits over the next two years. | 1/2015-12/2017 | 71.1% |
| Prevention | AHS will demonstrate a 5% improvement in enrollee breast cancer screening over the next two years. | 1/2015-12/2017 | 40.0% |
| Prevention | AHS will demonstrate a 5% improvement in enrollee chlamydia screening in women over the next two years. | 1/2015-12/2017 | 53.1% |
| Prevention | AHS will demonstrate a 5% improvement in controlling enrollee high blood pressure over the next two years. | 1/2015-12/2017 | TBD* |
| Behavioral Health | AHS will demonstrate a 5% improvement in antidepressant medication management (acute and continuation phase) over the next two years. | 1/2015-12/2017 | 66.5% & 46.3% |
| Behavioral Health | AHS will demonstrate a 5% improvement in follow-up after hospitalization for mental illness (7 day and 30 day) over the next two years. | 1/2015-12/2017 | 43.7% & 64.9% |
| Behavioral Health | AHS will demonstrate a 5% improvement in Initiation and engagement of alcohol and other drug dependence treatment over the next two years. | 1/2015-12/2017 | 36.0% & 14.3% |
| Access to Care | AHS will demonstrate a 5% improvement in adult enrollee access to preventive/ambulatory health services over the next two years. | 1/2015-12/2017 | 91.7% |
| Access to Care | AHS will demonstrate a 5% improvement in children and adolescents' access to primary care practitioners over the next two years. | 1/2015-12/2017 | TBD* |
| Access to Care | AHS will demonstrate a 5% improvement in the rate of children (First 15 months and 3rd-6th years) receiving 6 or more well child visits over the next two years. | 1/2015-12/2017 | 79.8% & 75.1% |
| Access to Care | AHS will demonstrate a 5% improvement in the rate of adolescents receiving well care visits over the next two years. | 1/2015-12/2017 | 49.3% |
| Consumer Satisfaction | AHS will demonstrate a 5% improvement in consumers rating of satisfaction with health plan over the next two years. | 1/2015-12/2017 | TBD* |

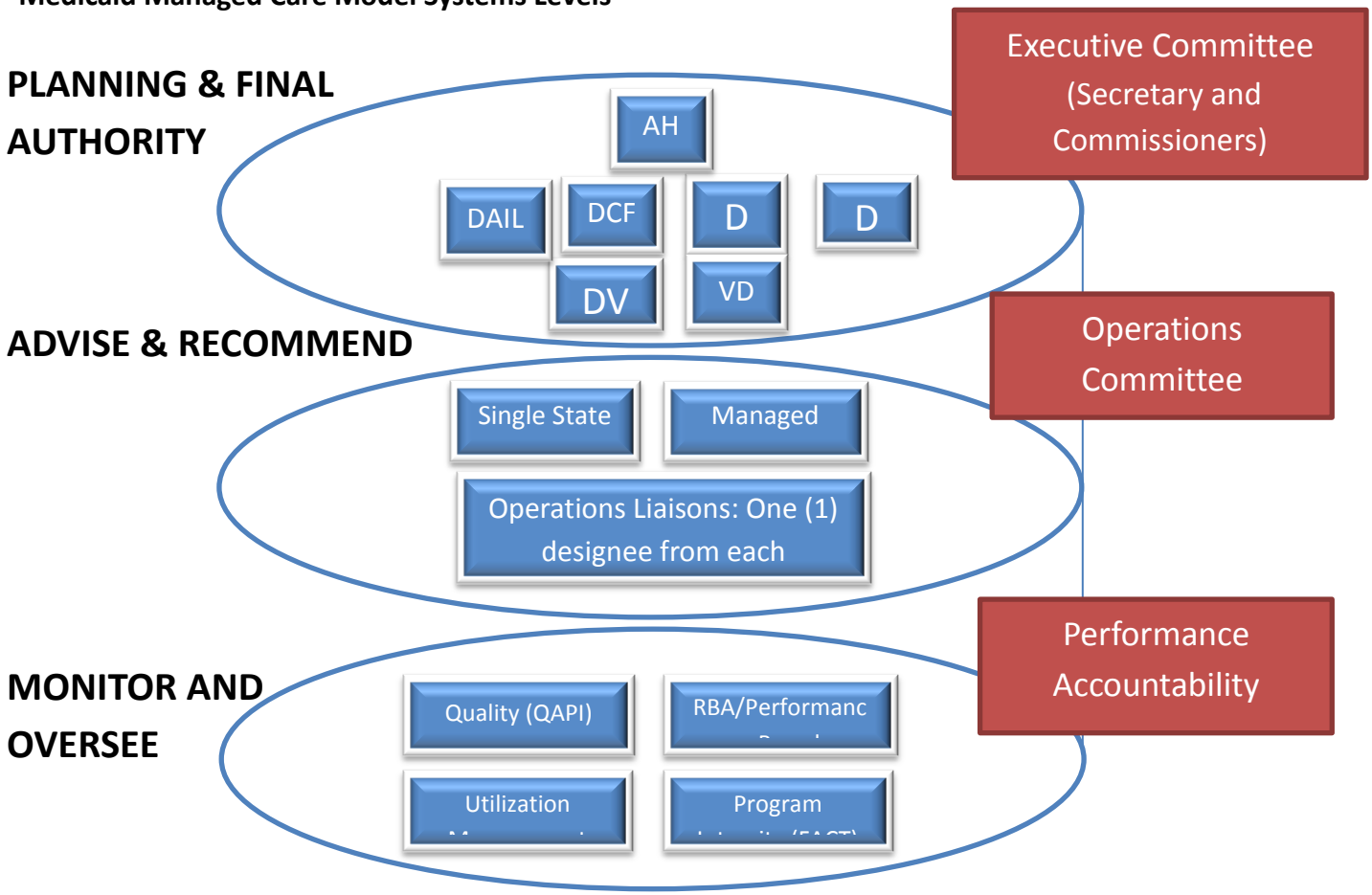
* Targets to be identified by the waiver measures work group by December 31, 2015.

**Overview of the Quality Management Structure**

According to the GC's Special Terms and Conditions (STCs), Vermont operates its managed care model in accordance with federal managed care regulations, found at 42 CFR 438. The Agency of Human Services (AHS), as Vermont's Single State Medicaid Agency, is responsible for oversight of the managed care model. The Department of Vermont Health Access (DVHA) operates the Medicaid program as if it were a Managed Care Organization in accordance with federal managed care regulations. Program requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. CMS reviews and approves the IGA annually to ensure compliance with Medicaid Managed Care requirements. DVHA also has sub-agreements with the other State entities that provide specialty care for GC enrollees (e.g., mental health services, developmental disability services, and specialized child and family services). As such, since the inception of the GC Demonstration, DVHA has modified operations to meet Medicaid managed care requirements. This includes requirements related to network adequacy, access to care, beneficiary information, grievances, quality assurance and quality improvement. Per the External Quality Review Organization's findings, DVHA has achieved exemplary compliance rates in meeting Medicaid managed care requirements. Additionally, in its role as the designated unit responsible for operation of the traditional Medicaid program (including long term care, SCHIP and DSH), DVHA is responsible for meeting requirements defined in federal regulations at 42 CFR 455 for those services excluded from the GC Demonstration. Each state Medicaid agency contracting with a MCE is required to develop and implement a written strategy for assessing and improving the quality of managed care services. The strategy must comply with the provisions issued in the Code of Federal Regulations (CFR). Under the current waiver structure, AHS pays DVHA a per member per month (PMPM) estimate using prospectively derived actuarial rates for the waiver year. This capitation payment reflects the monthly need for federal funds based on estimated GC expenditures. On a quarterly basis, AHS reconciles the federal claims from the underlying GC expenditures on the CMS-64 filing. As such, Vermont's payment mechanisms function similarly to those used by state Medicaid agencies that contract with traditional managed care organizations to manage some or all of the Medicaid benefits. It is believed that the use of a managed care system will allow Vermont to purchase the best value health care for Medicaid beneficiaries, improve access to services for underserved and vulnerable beneficiary populations, and protect them from substandard care.

The need for AHS-wide cross-departmental teams has been identified for three core areas. These include Executive, Operations, and Performance Accountability. Each team is facilitated by an AHS senior staff member and/or senior managers from departments and divisions impacted by Global Commitment. These teams are responsible for ensuring that necessary changes in internal operations occur related to the DVHA/MCE work plan, IGA commitments and other relevant state and federal regulations. The AHS Performance Accountability Committee (PAC) is charged with the development, integration, and maintenance of a Comprehensive Quality Strategy (CQS), generating AHS -wide quality standards for access to care, structure and operations, and quality measurement and improvement that comply with Title 42 of the Code of Federal Regulations sections 438.206 – 438.236. Additionally, this group will make recommendations to the Secretary's Office regarding the overall AHS direction related to quality and outcome measurement. The CQS supports the authority and responsibility of AHS for the development and implementation of effective management of the Quality Strategy.

**Medicaid Managed Care Model Systems Levels**




**Executive Committee**

*Purpose:* The primary purpose of the Agency of Human Services (AHS) Medicaid Managed Care Model Executive Committee is to establish and convey a clear vision and strategy for the system that is understood by all stakeholders and communicated within every organizational unit.

*Standing Committee Membership:* The Executive Committee shall be composed of the AHS Secretary and all AHS Department Commissioners.

*Chair:* The Committee chair shall be the AHS Secretary.

*Process:* The Committee shall meet as often as necessary to carry out its governance responsibilities, but a minimum of three (3) times a year. The Committee shall formally respond to the Operations Committee regarding all recommendations submitted by the Operations Committee.

*Responsibilities:* The Committee holds final authority on all matters relating to the Global Commitment to Health waiver (including investments) and all new initiatives that impact health care reform and funded by Medicaid. The Committee shall develop rules for decision making (by-laws) and set formal procedures (e.g., Roberts Rules of Order or Joint Consensus).

**Operations Committee**

*Purpose:* The primary purpose of the Agency of Human Services (AHS) Medicaid Managed Care Model Operations Committee is to ensure that policies and policy changes are aligned with the health

care reform vision and strategies and are in compliance with the Agency's agreement with CMS under the Special Terms and Conditions (STC) of the Global Commitment to Health waiver.

*Standing Committee Membership:* The Committee shall be composed of at least three (3) standing members from AHS and three (3) members from the Department of Vermont Health Access (DVHA).

*Expanded Committee Membership:* The Commissioner from each AHS department shall appoint an O*perations Liaison* to the Committee who is a senior policy and program leader.

*Chair:* The Secretary of the Agency of Human Services shall appoint an Operations Committee chair who will report the Operations Committee's recommendations to the Executive Committee.

*Process:* The Committee shall meet as often as necessary to carry out its governance responsibilities, but a minimum of three (3) times a year. Following each meeting, the Committee chair shall provide a report to the Executive Committee. Reports shall include the following elements: an overview of actions since the last Operations Committee report; a broad overview of current projects, including the status of goals and whether timelines are being met, and; any recommendations for future plans.

*Responsibilities:* The Committee is responsible for advising and providing recommendations to the Executive Committee. It connects the Agency's work to its vision and strategy by addressing the needs of stakeholders. The Committee shall develop rules for decision making and set formal procedures. Examples of Operations Committee work include but are not limited to the following: assistance with waiver renewals; recommendations on quality improvement initiatives and/or compliance issues; IGA renewals, and; reviewing new strategies, policies and procedures intended to enhance the effectiveness of AHS's interactions with physicians, hospitals and other provider community constituents.

**Performance Accountability Committee**

*Purpose:* The primary purpose of the Agency of Human Services (AHS) Medicaid Managed Care Model Performance Accountability Committee is to oversee and monitor the operations of the Managed Care model, ensuring its practices are aligned with the health care reform vision and strategies and are in compliance with the Agency's agreement with CMS under the Special Terms and Conditions (STC) of the Global Commitment to Health waiver.

*Standing Committee Membership:* The Committee shall be composed of DVHA and AHS management and program staff who are responsible for ensuring that quality and value of care for the beneficiary population meet or exceed the Agency's vision and values and align with the strategic plan and the Global Commitment to Health STCs.

*Expanded Committee:* The Commissioner from each AHS department shall appoint ad hoc Committee members who are policy and program leaders to address specific needs and complete specific tasks or projects. These ad hoc members will remain on the Committee for the duration of their assignments.

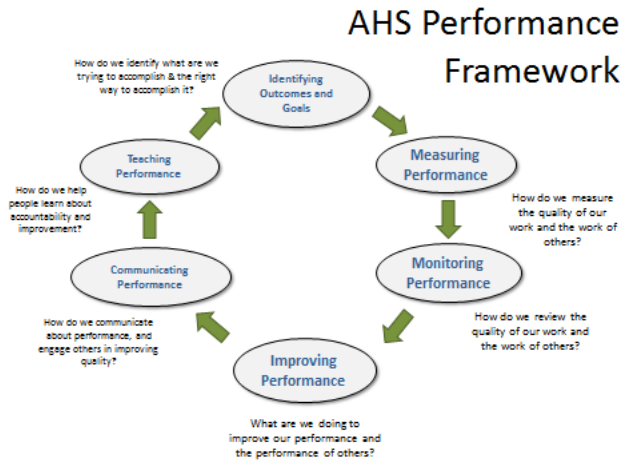
*Chair:* The Operations Committee chair shall appoint a Performance Accountability chair who will report the Committee's recommendations to the Operations Committee.

*Process:* The Committee shall meet as often as necessary to carry out its responsibilities under this plan, but a minimum of six (6) times a year. Following each meeting, the Committee chair shall provide a report to the Operations Committee. Reports shall include the following elements: an overview of actions since the last Performance Accountability Committee report; a broad overview of current projects, including the status of goals and whether timelines are being met, and; any recommendations for future plans.

*Responsibilities:* The Committee is responsible for advising and providing recommendations to the Operations Committee. It is responsible for monitoring quality and compliance for the Managed Care model. The Committee shall develop rules for decision making and set formal procedures. Examples of work include but are not limited to the following: reviewing results of EQRO audits and providing recommendations for continuous improvement; developing and monitoring utilization management, quality improvement, program integrity, and compliance plans, and; oversight of existing programs.

**AHS Performance Framework**

The AHS Performance Framework identifies the key/critical components of an AHS quality/performance management system. The development of the system was guided by - and intentionally incorporates - many of the principles associated with Results Based Accountability (RBA) to ensure synergy with the State's roll-out.




The Agency of Human Services Performance Framework outlines the key components of our continuous improvement strategy to improve outcomes for the people we serve. Each component in the Performance Framework encompasses a range of strategies, practices, processes, and activities happening within each Department and across the Agency. The AHS Performance Framework enables us to better understand and strengthen our mechanism for remaining accountable for improving conditions of well-being for the Vermonters we serve.

The Framework is based on the understanding that in order to pursue our mission and accomplish our goals, we must actively and continually measure our performance, monitor our progress, and improve our strategies based on what we've learned - from employee evaluations and professional development, the success of our biggest programs, to the effectiveness of our administration. In order to embed continuous improvement as a practice into the Agency culture, we must also communicate about our progress, and help teach others about accountability and how we can work together to improve conditions of well-being in Vermont.

**State and Provider Responsibilities**

The Single State Agency, AHS, retains ultimate authority and accountability for public managed care responsibilities and adherence to the CQS, including monitoring and evaluation of the public managed care model's compliance with requirements specific to the MLTSS assurances identified in STC 1(a)(vii)(2) - as well as the health and welfare of enrollees.

1. <u>Development & Review of Quality Strategy</u>

The State of Vermont will use a process to develop, review and revise its CQS that includes internal meetings with key decision makers and external meetings with stakeholders (i.e. beneficiaries, advocacy groups and providers). The Performance Accountability Committee (PAC) was designed to build

strategic partnerships among department stakeholders, obtain input, and build consensus on the state's quality assessment and improvement activities as well as increase their understanding of the requirements of the CFR and State. The PAC will review the effectiveness of this strategy on an annual basis. The CQS will use both qualitative and quantitative methods to collect data designed to assess the impact of the Quality Strategy. AHS will assess the Quality Strategy objectives using HEDIS results, CAHPS and other consumer survey results, and the EQRO Technical Report Strengths and Opportunities for Improvement section. AHS considers a change in reporting to be significant enough for stakeholder review when the numbers, types, or timeframes of reporting are revised. AHS will report strategy updates to CMS at least annually.

**Public Engagement**

Vermont is committed to ensuring that our statewide Comprehensive Quality Strategy (CQS) is reviewed publicly and that public input is incorporated into the final strategy. The CQS is subject to public input, as required at 42 CFR 441.301(6)(B)(iii) and 42 CFR 441.710(3)(iii). The State will solicit and obtain the input of beneficiaries, the Medicaid and Exchange Advisory Board (MEAB), and other stakeholders in its development. Prior to submission of the CQS, the state will:

–Allow a minimum of a 30-day public comment period on the Draft CQS

–Consider public comments and modify the Draft CQS accordingly

–Submit evidence of public comment and our response to comments

Public meeting notices will be advertised in local newspapers and on posted on state websites. In addition, public meeting notices will be distributed to beneficiary and provider stakeholder groups and organizations. Information on the AHS website will include a summary of the new federal rule, the CQS, and provided the mailing address and e-mail address for submission of public responses, comments and input to the CQS. A summary of the comments received and the state's response to these comments will be shared with CMS. The state's final CQS including revisions based on the receipt of public comments will be posted on the AHS website concurrent with submission to CMS.

## II. ASSESSMENT

1. Quality and Appropriateness of Care

Vermont assesses the quality and appropriateness of care delivered to Medicaid managed care enrollees through: State Internal monitoring, Quality Indicators monitoring; PIPs, Compliance with federal and state regulations, and EQRO activities, including the EQRO Annual Report. Demonstrating success and identifying challenges in meeting objectives of managed care are based on data that reflects: health plan quality performance, access to covered services, extent and impact of care management, use of person-centered care planning, and enrollee satisfaction with care. Measures used in this approach include but are not limited to The National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) and consumer satisfaction surveys including the Consumer Assessment Health Care Provider Systems (CAHPS) survey.

**Definition of special health care needs**.

The MCE is required to establish and maintain policies and procedures to identify and coordinate health care services for members with special health care needs. Participants in the following programs are identified by the state as having special health care needs:

- Developmental Services, Traumatic Brain Injury, Choices for Care MLTSS program (DAIL)
- Community Rehabilitation and Treatment (CRT) and Children with a Severe Emotional Disturbance (DMH)

For each enrollee that the managed care entity confirms as having special health care needs, the individual is assigned a care coordinator. In addition to facilitating the development of a multidisciplinary service plan, the care coordinator is also responsible for coordinating service among providers, monitoring the treatment plan, and providing periodic reassessments. The MCE defines individuals with special health care needs and is able to identify such enrollees through information contained in Health Risk Assessments; special application for service (e.g., DS, CMH, TBI, etc.), claims data review, or any other available data source.

2. National Performance Measures

Vermont AHS requires DVHA to report performance measures. A number of the measures are part of the CMS core performance measures for children and adult in Medicaid and CHIP.

### Population Specific Metrics

This section includes information on population specific metrics for each population covered by the Medicaid program, including children, pregnant women, non-disabled adults (including parents), individuals receiving home and community services (HCBS), and individuals receiving long term services and supports (Choices for Care).

Table 5: Population Specific Measures

| POPULATION | MEASURES | TARGET | BENCHMARK |
|---|---|---|---|
| | | | |
| Children | Adolescent Well-Care Visits (AWC) | 49.3% | 47.0% |
| | Children and Adolescents' Access to Primary Care Practitioners (CAP) | TBD | TBD |
| | Well-Child Visits in the First 15 Months of Life (W15) | 79.8% | 76.0% |
| | Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34) | 75.1% | 71.5% |
| | Annual Dental Visit (ADV) | 71.1% | 67.7% |
| | | | |
| Pregnant Women | Prenatal and Postpartum Car (PPC) | TBD | TBD |
| | | | |
| Adults | Breast Cancer Screening (BCS) | 40.0% | 38.1% |
| | Chlamydia Screening in Women (CHL) | 53.1% | 50.6% |
| | Comprehensive Diabetes Care (CDC) HbA1c Testing & LDL-C screening | 68.3% & 48.5% | 65.1% & 46.2% |
| | Use of Appropriate Medications for People With Asthma (ASM) | 86.5% | 82.4% |
| | Controlling High Blood Pressure (CBP) | TBD | TBD |
| | Adults' Access to Preventive/Ambulatory Health Services (AAP) | 91.7% | 87.3% |
| | | | |
| Mental Illness | Follow-Up After Hospitalization for Mental Illness (FUH) 7 and 30 days | 43.7% & 64.9% | 41.6% & 61.8% |
| | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) | 36.0% & 14.3% | 34.3% & 13.6% |
| | Antidepressant Medication Management (AMM) Acute and Continuation Phase | 36.0% & 14.3% | 63.3% & 44.1% |
| Choices for Care (CFC) | TBD* | TBD* | TBD* |
| Developmental Disability Services (DS) | TBD* | TBD* | TBD* |
| Traumatic Brain Injury (TBI) | TBD* | TBD* | TBD* |
| Community Rehabilitation and Treatment (CRT) | TBD* | TBD* | TBD* |

* LTSS measures, targets, and benchmarks (where applicable) will be identified by the waiver measures work group by December 31, 2015.

Metrics are measured at the following levels of aggregation: the state Medicaid agency, specific health care program (such as Choices for Care), and potentially at each direct health services provider. The state will work with CMS to further define metrics, as appropriate, for collection. This section also

includes the specific methodology for determining benchmark and target performance on these metrics. Measures include, but are not limited to:

1. HCBS performance measures in the areas of: level of care determinations, person-centered service planning process, outcome of person-centered goals, health and welfare, outcomes, quality of life, effectives process, community integration, and assuring there are qualified providers and appropriate HCBS settings.

The metrics are aligned with the Medicaid and CHIP adult and child core measures, and also align with other existing Medicare and Medicaid federal measure sets where possible and appropriate. In addition, the metrics go beyond HEDIS and CAHPS data, and reflect cost of care.

3. Monitoring, Compliance, and Evaluation

The Agency of Human Services (AHS) uses two main sources of information to determine compliance with CMS requirements: 1) document review and 2) interviews with MCE personnel.

*Document Review*

AHS will monitor MCE compliance with standards using desk audits and an on-site review process. Typically, an onsite visit will begin with a review of documents. Prior to the onsite visit, the MCE will receive a list of documents needed for review. This will be accompanied by instructions on how to organize and prepare the documents for the reviewers. These instructions will request that documents remain available to reviewers for the duration of the onsite visit. Reviewers might request the MCE to provide an orientation to the organization of their documents. Also prior to the onsite visit, reviewers might request reports on previous reviews and subsequent MCE corrective actions in order to identify areas on which the reviewers might need to focus the current monitoring.

During document review, reviewers begin the assessment of compliance with regulatory provisions, and issues that will be pursued during interviews. MCE staff does not need to be present during this onsite activity, but should be available if reviewers have questions or difficulty locating a particular document or item of information.

During the review of documentation, reviewers will conduct the following:

- Take notes that will assist in making determinations about compliance with the regulatory provisions;
- Identify topics or issues that need clarification or follow-up during interviews;
- Identify items of information that were not available or located in documents to provide the MCE an opportunity to respond; and
- Identify specific document content for discussion at an interview to provide the MCE an opportunity to prepare participants with copies or to identify additional participants that may be necessary for the discussion.

*Interviews*

While document review is an important part of determining compliance, understanding the document content and performance of procedures outline in the documents typically can only be determined by talking with MCE personnel. Therefore, interaction with MCE staff is required to obtain a complete

picture of the degree of compliance with requirements. Interviews provide clarification. They can reveal the extent to which what is documented is actually implemented. Interviews also provide an opportunity to explore any issues that were not fully addressed in documents, and also provide a better understanding of MCE performance.

*Internal Monitoring*

Onsite visits are an effective method for performing monitoring activities such as document review and interviews. Early contact and communication with the MCE is necessary to plan an efficient and effective survey and therefore is a crucial step in arranging and conducting an onsite evaluation. A communication plan and expectations should be outlined and followed to the extent possible. Prior to receiving an onsite visit, the MCE should be provided with information such as: the scope of the evaluation to be performed, how the evaluation will be conducted, lists of documents that need to be available, instructions for the organization and presentation of documents, completion of any forms or other data gathering instruments, expected interview participants, administrative arrangements, and other expectations or responsibilities.

**Home and Community Based Service (HCBS)**

Special focus is placed on long term care services and supports (CFC) populations and addresses the following:

1. A self-assessment of CFC adherence to state and federal standards of care to include:
    i. Assessment of existing initiatives designed to improve the delivery of CFC, including performance measures or Performance Improvement Projects (PIPs) directed to this population.
    ii. Examination of processes to identify any potential corrective action steps toward improving the CFC system.
2. Person-Centered Planning and Integrated Care Settings
3. Comprehensive and Integrated Service packages
4. Qualifications of Providers
5. Participant Protections

The MCE must determine whether services in these settings meet the community standards set forth in the rules. Initial and ongoing compliance with standards will include, but not be limited, to the following methods: licensing reviews, provider qualification reviews, site visits, survey of individuals in receipt of HCBS, provider self-assessment, or a sample of settings. If necessary, CMS will allow Vermont up to four years to phase in these changes. All such services will be in compliance with CMS requirements before March 2019.

4. <u>External Quality Review</u> (EQR)

The Vermont Agency of Human Services (AHS) meets this requirement by contracting with Health Services Advisory Group, Inc. (HSAG), an EQRO, beginning in contract year (CY) 2007–2008 to conduct the three Centers for Medicare & Medicaid Services (CMS) required activities (i.e., validation of performance measures, validation of performance improvement projects, review of compliance with standards) and to prepare the EQR annual technical report bringing together the results from the activities it conducted. The current contract with HSAG is due to expire on February 14, 2016.

*External Oversight*

In addition to the internal oversight activities described above, the MCE is required to participate in the annual external independent review of quality outcomes, timeliness of, and access to services covered under this strategy. AHS will contract with an External Quality Review Organization (EQRO) to conduct activities outlined in Subpart E of 42 CFR 438. The EQRO is used to review MCE compliance with AHS specified standards for quality program operations, validation of AHS-required performance measures, and validation of AHS required performance-improvement projects. The external review may include but not be limited to all of any of the following: medical record review, performance improvement projects and studies, surveys, calculation and audit of quality and utilization indicators, administrative data analysis and review of individual cases. The EQRO will submit a technical report to AHS which will be used to guide quality assessment and improvement efforts. The EQRO report will:

- Assess the MCE's strengths and weaknesses with respect to quality, timeliness and access to health care services
- Provide recommendations for improving quality of programs/services and care furnished by the MCE
- Evaluate the implementation and effectiveness of the Quality Strategy

## III. STATE STANDARDS

### 1. Access Standards

This section includes a discussion of the standards that the state has established in the MCE contract for access to care, as required by 42 C.F.R. Part 438, subpart D (i.e., *availability of services*, *assurances of adequate capacity and services*, *coordination and continuity of care*, and *coverage and authorization of services*). These standards relate to the overall goals and objectives listed in the quality strategy's introduction (see Section I above). This section also provides a summary description of the contract provisions.

| Regulatory Reference | DESCRIPTION |
|---|---|
| §438.206 | Availability of Services |
| §438.206(b)(1) | Maintains and monitors a network of appropriate providers |
| §438.206(b)(2) | Female enrollees have direct access to a women's health specialist |
| §438.206(b)(3) | Provides for a second opinion from a qualified health care professional |
| §438.206(b)(4) | Adequately and timely coverage of services not available in network |
| §438.206(b)(5) | Out-of-network providers coordinate with the MCE or PIHP with respect to payment |
| §438.206(b)(6) | Credential all providers as required by §438.214 |
| §438.206(c)(1)(i) | Providers meet state standards for timely access to care and services |
| §438.206(c)(1)(ii) | Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service |
| §438.206(c)(1)(iii) | Services included in the contract are available 24 hours a day, 7 days a week |
| §438.206(c)(1) | Mechanisms/monitoring to ensure compliance by providers |
| §438.206(c)(2) | Culturally competent services to all enrollees |
| § 438.207 | Assurances of Adequate Capacity and Services |
| §438.207(a) | Assurances and documentation of capacity to serve expected enrollment |
| §438.207(b)(1) | Offer an appropriate range of preventive, primary care, and specialty services |
| §438.207(b)(2) | Maintain network sufficient in number, mix, and geographic distribution |
| § 438.208 | **Coordination and Continuity of Care** |
| §438.208(b)(1) | Each enrollee has an ongoing source of primary care appropriate to his or her needs |
| §438.208(b)(2) | All services that the enrollee receives are coordinated with the services the enrollee receives from any other MCE/PIHP |
| §438.208(b)(3) | Share with other MCEs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services |
| §438.208(b)(4) | Protect enrollee privacy when coordinating care |
| §438.208(c)(1) | State **mechanisms to identify** persons with special health care needs |
| §438.208(c)(1) | State mechanisms to identify persons with special health care needs |
| §438.208(c)(2) | **Mechanisms to assess** enrollees with special health care needs by appropriate health care professionals |
| §438.208(c)(3) | If applicable, **treatment plans developed** by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; approved in a timely manner; and in accord with applicable state |

| | |
|---|---|
| | standards |
| §438.208(c)(4) | Direct access to specialists for enrollees with special health care needs |
| § 438.210 | Coverage and **Authorization of Services** |
| §438.210(a)(1) | Identify, define, and specify the amount, duration, and scope of each service |
| §438.210(a)(2) | Services are furnished in an amount, duration, and scope that is no less than the those furnished to beneficiaries under fee-for-service Medicaid |
| §438.210(a)(3)(i) | Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished |
| §438.210(a)(3)(ii) | No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition |
| §438.210(a)(3)(iii) | Each MCE/PIHP may place appropriate limits on a service, such as medical necessity |
| §438.210(a)(4) | Specify what constitutes "medically necessary services" |
| §438.210(b)(1) | Each MCE/PIHP and its subcontractors must have **written policies and procedures for authorization** of services |
| §438.210(b)(2) | Each MCE/PIHP must have **mechanisms to ensure consistent application of review criteria** for authorization decisions |
| §438.210(b)(3) | Any decision to deny or reduce services is made by an appropriate health care professional |
| §438.210(c) | Each MCE/PIHP must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested |
| §438.210(d) | Provide for the authorization decisions and notices as set forth in §438.210(d) |
| §438.210(e) | Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services |

42 CFR 438.206 Availability of services

These standards ensure that services covered under the Medicaid Plan are available and accessible to enrollees.

**MCE requirements**

Maintain a Network of Appropriate Providers

Through its contracts with Medicaid providers and subcontracted Departments, the MCE must ensure that a network of appropriate providers is maintained to furnish adequate access to all covered Global Commitment to Health services. In establishing and maintaining this network, the MCE must consider the following:

- Anticipated enrollment in the *Global Commitment to Health Waiver*;
- Expected utilization of services, taking into consideration the characteristics and health care needs of the population served;
- That services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
- Number and types of providers required to furnish the contracted services;
- Number of providers who are not accepting new patients; and
- Geographic location of providers and *Global Commitment to Health Waiver* enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees, and whether the location(s) provide physical access for enrollees with disabilities.

**AHS monitoring activities**

AHS has implemented programs and processes to monitor and assure that members' access to care is not restricted. AHS will conduct a thorough analysis of providers to ensure that the MCE is able to provide access to health care services as required. AHS will review the MCE Provider and geographic access data to determine compliance with this standard. The Provider Capacity data will contain information on the number and type of providers, anticipated enrollment, and actual and expected health care utilization. In addition to identifying the number of providers available by specialty and type, this data will also contain the number of PCPs and mental health practitioners accepting new Medicaid patients, as well as, those not accepting new Medicaid patients. Geographic access data will contain the geographic distribution of each primary, specialty, and behavioral health care provider. Focus of the review will be on access to services (e.g., calculated distance for members to travel from their primary residence to PCPs, specialists, hospitals, etc., 24-hour availability of services, scheduling and wait times, types of transportation that members ordinarily use for each service area, number of providers with physical access for members with disabilities for each service area, and selection and assignment of primary care provider). By monitoring this data, AHS will ensure that there are sufficient numbers and types of health care resources available to Medicaid enrollees. In addition to the above, AHS will conduct the following activities:

* Review provider directory no less than biennially (including volume of non-Medicaid individuals served
* Review the MCE's provider contracts and contracting and non-contracting provider selection criteria
* Review results of MCE provider and/or enrollee survey re: geographic accessibility and physical accessibility of care

<u>Provides Beneficiaries with Direct Access to a Women's Health Specialist:</u>

**MCE requirements**

The MCE must provide female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.

**AHS Monitoring Activities**

AHS will ensure that the MCE stipulates direct access to a women's health specialist by conducting the following activities:

* Review new enrollee materials or enrollee handbook
* Review provider directory no less than biennially (identifying women's health specialist)

*Cultural Considerations*

**MCE requirements**

The MCE shall participate in AHS efforts to promote the delivery of services in a culturally competent manner to all *Global Commitment to Health Waiver* enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The MCE shall comply fully with AHS policies for providing assistance to persons with Limited English Proficiency. The MCE shall develop appropriate methods of communicating with its enrollees who do not speak English as a first language, as well as, enrollees who are

visually and hearing impaired, and accommodating enrollees with physical disabilities and different learning styles and capabilities. Enrollee materials, including the enrollee handbook, shall be made available in all prevalent non-English languages. A prevalent non-English language shall mean any language spoken as a first language by five percent or more of the total statewide Global Commitment to Health Waiver enrollment.

The MCE shall ensure in-person or telephonic interpreter services are available to any enrollee who requests them, regardless of the prevalence of the enrollee's language within the overall program. AHS contracts with in-person and telephonic interpreter vendors, as well as, written translation vendors on behalf of DVHA and other departments under the AHS umbrella. The MCE will use these vendors as necessary and will bear the cost of their services, as well as the costs associated with making American Sign Language (ASL) interpreters and Braille materials available to hearing- and vision-impaired enrollees.

DVHA shall include information in the enrollee handbook on the availability of oral interpreter services, translated written materials, and materials in alternative formats. The Global Commitment to Health enrollee handbook shall also include information on how to access such services.

**AHS Monitoring Activities**

AHS will assess the cultural, ethnic, racial and linguistic needs of Medicaid beneficiaries and make recommendations to the MCE to adjust the availability of practitioners within its network, if necessary. AHS will review IGAs to ensure that they stipulate culturally and linguistically appropriate care to members. AHS will also review new member materials, the enrollee handbook, and provider contracts to ensure compliance with this standard.

<u>Provides for a Second Opinion from a Qualified Health Professional</u>

The MCE must provide for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one, at no cost to the enrollee.

**(4)** If the network is unable to provide necessary medical services, covered under the contract, to a particular enrollee, the MCE must adequately and timely cover these services out of network for the enrollee for as long as the MCE is unable to provide them.

**(5)** Requires out-of-network providers to coordinate with the MCE with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.

Global Commitment to Health enrollees served through the public insurance programs shall have the right to obtain a second opinion from a qualified health care professional, within the network of enrolled Medicaid providers. If needed, the MCE will arrange for the enrollee to obtain a second opinion by enrolling a qualified provider in the program, at no cost to the enrollee.

**AHS Monitoring Activities**

AHS will review IGAs to ensure that they provide for a second opinion from a qualified health professional. In addition, AHS shall conduct the following activities:

* Review provider agreements
* Review new member materials and enrollee handbooks

Provides Services Not Available In-Network:

If the network is unable to provide necessary services covered under the MCE contract to a particular beneficiary, DVHA must adequately and timely cover these services out-of-network for the beneficiary, for as long as the MCE is unable to provide the coverage.

**AHS Monitoring Activities**

AHS will review IGAs to ensure that they provide for services that are not available. In addition, AHS will conduct the following activities:

* Review the MCE's new member materials, enrollee handbooks, and other enrollee information materials

Coordination of Payment with Out-of-Network Providers:
N/A

Demonstrates Providers are Credentialed:

The MCE must demonstrate that its providers are credentialed

The MCE shall ensure that all providers participating in the *Global Commitment to Health Waiver* meet the credentialing requirements established by AHS for the Medicaid program. At a minimum, the MCE shall ensure that all *Global Commitment to Health Waiver* providers are licensed and/or certified where required, and are acting within the scope of that license and/or certification, or Federal authority, including Federal Clinical Laboratory Improvements Amendments (CLIA) requirements. Providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act are prohibited from participation in the *Global Commitment to Health Waiver*. Providers may not furnish services that are subject to the Certificate of Need law when a Certificate has not been issued. Each physician must have a unique identifier.

**AHS Monitoring Activities**

AHS ensures compliance with these standards through review of provider contracts and survey data. To provide further assurance of compliance, AHS may also crosscheck a sample of executed provider agreements with the National Practitioner Data Bank for sanctions or licensure limitations.

Timely Access to Services:

The MCE must comply with the requirements of this paragraph.

**(1)** ***Timely access.*** The MCE must--

- **(i)** Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services;
- **(ii)** Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.
- **(iii)** Makes services available 24 hours a day, 7 days a week when medically necessary.
- **(iv)** Establish mechanisms to ensure compliance.

**(v)** Monitor providers regularly to determine compliance.
**(vi)** Take corrective action if there is a failure to comply.

In addition to delivery system structure and organization, timeliness of services is central to provision of accessible care. The MCE must ensure that coverage is available to enrollees on a twenty-four hour per day, seven day per week basis. Coverage may be delegated to the subcontracted Departments, but the MCE must maintain procedures for monitoring coverage to ensure twenty-four hour availability.

The MCE shall ensure that travel time to services does not exceed the limits described below:

Primary Care – No more than 30 miles or 30 minutes for all enrollees from residence or place of business unless the usual and customary standard in an area is greater, due to an absence of providers. The MCE's network will include all Medicaid participating providers, which equates to nearly all providers in the State of Vermont. However, if the travel time standard is exceeded in an area which contains a non-participating provider, the MCE will work aggressively to bring that provider into the network.

Hospitals – Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater, mental health services where access to specialty care may require longer transport time, and for physical rehabilitative services where access is not to exceed 60 minutes.

General Optometry – Transport time will be the usual and customary, not to exceed one hour, except in areas where community standards will apply.

Lab and X-Ray – Transport time will be the usual and customary, not to exceed one hour, except in areas where community access standards will apply.

All Other Services – All services not specified above shall meet the usual and customary standards for the community.

The MCE shall require its providers to meet in-office waiting times for appointments do not exceed one hour, except in areas where a longer waiting time is usual and customary. Exceptions to the one-hour standards must be justified and documented to AHS on the basis of community standards.

Appointment availability shall meet the usual and customary standards for the community, and shall comply with the following:

- Urgent care: Within twenty-four hours;
- Non-urgent, non-emergent conditions: Within 14 days;
- Preventive Care: Within 90 days.

Network providers must offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

The MCE must establish mechanisms to ensure that network providers comply with the timely access requirements; monitor regularly to determine compliance; and take corrective action if there is a failure to comply.

**AHS Monitoring Activities**

AHS will review data regarding regular and routine care appointments, urgent care appointments, and after-hours care. AHS monitors this data to assure that there will be providers within the standards for distance and travel time. AHS will accomplish the above by conducting the following activities:

* Review survey data from enrollees/providers
* Review provider contracts, orientation, or enrollment documents
* Review new member materials, enrollee handbooks
* Review Grievance/Appeal data

42 CFR 438.207 Assurance of adequate capacity and services

**MCE Requirements**

The MCE shall update network capacity data biennially and at any time there has been a significant change in the MCE's operations that would affect adequate capacity or services, including changes in services, benefits, payments or enrollment of a new population.

**AHS Monitoring Activities**

AHS shall review variable definitions used by the MCE to provide network capacity data. This activity will assess whether or not the MCE offers an appropriate range of covered services adequate for the anticipated number of enrollees for the service and that the MCE maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

42 CFR 438.208 Coordination and continuity of care

**MCE Requirements**

The MCE must implement procedures to deliver primary care to and coordinate health care services for all MCE enrollees. These procedures must meet State requirements and must do the following:

**(1)** Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity designated as primarily responsible for coordinating the health care services furnished to the enrollee.

**(2)** Coordinate the services the MCE furnishes to the enrollee with the services the enrollee receives from any other MCE, PIHP, or PAHP.

**(3)** Share with other MCEs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment of the enrollee's needs to prevent duplication of those activities.

**(4)** Ensure that in the process of coordinating care, each enrollee's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

**(c)** ***Additional services for enrollees with special health care needs.***

**(1) Identification.** The State must implement mechanisms to identify persons with special health care needs to the MCE, as those persons are defined by the State. These identification mechanisms must—

**(i)** Must be specified in the State's quality improvement strategy in § 438.202; and

**(ii)** May use State staff, the State's enrollment broker, or the State's MCEs and PIHPs.

## 438.208 Coordination and continuity of care – *continued*

**(2) Assessment**. The MCE must implement mechanisms to assess each Medicaid enrollee identified by the State (through the mechanism specified in paragraph (c)(1) of this section) and identified to the MCE by the State as having special health care needs in order to identify any ongoing special

conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.

**(3) Treatment plans.** If the State requires MCE to produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be—

**(i)** Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;

**(ii)** Approved by the MCE in a timely manner, if this approval is required by the MCE; and

**(iii)** In accord with any applicable State quality assurance and utilization review standards.

**(4) Direct access to specialists.** For enrollees with special health care needs determined through an assessment by appropriate health care professionals (consistent with § 438.208(c)(2)) to need a course of treatment or regular care monitoring, the MCE must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

Modern health care delivery systems are multi-faceted and involve complex interactions between many providers. Such delivery systems require coordination across the continuum of care. This standard requires that the MCE implement procedures to deliver primary care to and coordinate health care services for all enrollees.

The MCE shall assist in the coordination of services provided through its network of Medicaid providers and its subcontracted Departments. The MCE shall require that each enrollee's record contains the name of his/her primary care provider.

The MCE shall maintain mechanisms to assess each enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals. When treatment plans are required, the treatment plan must be developed with the participation of the enrollees' primary care provider and enrollee, in consultation with any specialists caring for the enrollee. The treatment plan must be approved by the MCE in a timely manner, if approval is required. The treatment plan must conform to the State's quality assurance and utilization review standards.

If the contracted network is unable to provide necessary medical services covered under the contract to a particular enrollee, the MCE must adequately and timely cover these services out of network for the enrollee, for as long as the entity is unable to provide them.

*Primary care coordination*

The MCE must ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care delivered to the enrollee. All members shall select their PCP, but if the member does not select a PCP, the MCE must select one for the member and notify the member of the PCP's name, location, and office telephone number.

*Members with special health care needs*

The MCE is required to establish and maintain policies and procedures to identify and coordinate health care services for members with special health care needs. Participants in the following programs are identified by the state as having special health care needs:

- Developmental Services, Traumatic Brain Injury, Choices for Care MLTSS program (DAIL)
- Community Rehabilitation and Treatment (CRT) and Children with a Severe Emotional Disturbance (DMH)

For each enrollee that the managed care entity confirms as having special health care needs, the individual is assigned a care coordinator. In addition to facilitating the development of a multidisciplinary service plan, the care coordinator is also responsible for coordinating service among providers, monitoring the treatment plan, and providing periodic reassessments.

The MCE defines individuals with special health care needs and is able to identify such enrollees through information contained in Health Risk Assessments; special application for service (e.g., DS, CMH, TBI, etc.), claims data review, or any other available data source.

**AHS Monitoring Activities**

In accordance with 42 CFR 438.208, the MCE with its sub-contractors must implement procedures to deliver primary care and coordinate health care for all beneficiaries. AHS looks for three elements to determine if the MCE has a basic system in existence: (1) beneficiaries with special health care needs must receive case management services according to established criteria and must receive the appropriate care; (2) the MCE must have IGAs with other appropriate agencies or institutions to coordinate care; and (3) the MCE must monitor continuity of care across all services and treatment modalities. AHS will review the following documents to determine compliance with this standard:

* New member materials, enrollee handbooks
* Provider manuals and contracts
* Agreements between DVHA and its IGA partners

<u>42 CFR 438.210 Coverage and authorization of services</u>

**MCE Requirements**

*Coverage*

The Global Commitment to Health Waiver includes a comprehensive health care services benefit package. The covered services will include all services that AHS requires be made available through its public insurance programs to enrollees in the Global Commitment to Health Waiver including all State of Vermont title XIX plan services in the following categories:

- Acute health care services
- Preventive health services
- Behavioral health services, including substance abuse treatment
- Specialized mental health services for adults and children
- Developmental services
- Pharmacy services
- School-based services

The monthly capitation amount paid by AHS to DVHA, as the Public MCE, will include payment only for services covered under the Global commitment to Health Waiver.

*Authorization of Services*

For the processing of requests for initial and continuing authorizations of services, each contract must require--

**(1)** That the MCE and its subcontractors have in place, and follow, written policies and procedures.

**(2)** That the MCE --

**(i)** Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and

**(ii)** Consult with the requesting provider when appropriate.

**(3)** That any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

The term "service authorization request" means a Global Commitment to Health Waiver enrollee's request for the provision of a service, or a request by the enrollee's provider. DVHA and its IGA partners shall maintain and follow written policies and procedures for processing requests for initial and continuing authorization of medically necessary, covered services. The policies and procedures must conform to all applicable Federal and State regulations, including specifically 42 CFR 438.210(b).

DVHA may require pre-authorization for certain covered services including, but not limited to, inpatient hospital admissions, home and community based services, and certain pharmaceutical products. For inpatient admissions, specific review criteria for authorization decisions is identified and outlined in the Acute Care Management Program Descriptions policies and procedures manual. DVHA will ensure consistent application of review criteria for authorization decisions. Review Criteria shall be incorporated in the Utilization Management Plan.

For standard authorization decisions, the subcontracted Departments must reach a decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 14 calendar days from receipt of the request for service, with a possible extension of up to 14 additional calendar days if the enrollee or provider requests the extension; or the subcontracted Department justifies to DVHA a need for additional information and how the extension is in the enrollee's best interest.

For cases in which a provider indicates, or the subcontracted Department determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function, the subcontracted Department must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three working days after receipt of the request for service. The three days may be extended by up to 14 additional calendar days if the enrollee requests the extension, or if the subcontracted Department justifies to DVHA a need for additional information and how the extension is in the enrollee's interest.

Any case where a decision is not reached within the referenced timeframes constitutes a denial. Written notice must then be issued to the enrollee on the date that the timeframe for the authorization expires. Untimely service authorizations constitute a denial and are thus adverse actions.

Planned services will be identified by the authorized clinician working with the enrollee and under the direct supervision of a prescribing provider. Any decision to deny, reduce the range, or suspend covered services, or a

failure to approve a service that requires pre-authorization, will constitute grounds for noticing the enrollee. Any disagreement identified by the enrollee at any interval of evaluation, will also be subject to notice requirements.

Notices must meet language format requirements set in the above section.

Notice must be given within the timeframes set forth above, except that notice may be given on the date of action under the following circumstances:

- Signed written enrollee statement requesting service termination;
- Signed written enrollee statement requesting new service or range increase:
- An enrollee's admission to an institution where he or she is ineligible for further services;
- An enrollee's address is unknown and mail directed to him or her has no forwarding address;
- The enrollee's physician prescribes the change in the range of clinical need

DVHA or its IGA partner shall notify the requesting provider and issue written notices to enrollees for any decision to deny a service, or to authorize a service in an amount, scope or duration less than that requested and clinically prescribed in the service plan. Notices must explain the action DVHA or the IGA partner has taken or intends to take; the reasons for the action; the enrollee's right to a second opinion regarding the service decision, or at least, a clinical program director not involved in the service decision; the enrollee's right to file an appeal and procedures for doing so; circumstances under which an expedited resolution is available and how to request one; the enrollee's right at any time to request a Fair Hearing for covered services and how to request that covered services be extended; the enrollee's right to request external review by DVHA/AHS for covered services (as applicable to Medicaid eligibility) or alternate services; and the circumstances under which the enrollee may be required to pay the costs of those services pending the outcome of a Fair Hearing or external review by DVHA/AHS.

**AHS Monitoring Activities**

AHS will review MCE policies/procedures requiring licensed professionals to supervise all medical necessity decisions as well as written procedures specifying the type of personnel responsible for each level of UM decision making. In addition, AHS might also review written job descriptions with qualifications for practitioners who review denials of care based on medical necessity that requires: education, training or professional experience in medical or clinical practice and current license to practice without restriction. In addition, AHS shall conduct the following activities:

* Review DVHA/IGA Partner provider manuals
* Review grievance files or aggregate data related to payment/non-payment for services.
* Review the MCE's agreements with employees who perform utilization management activities.

2. Structure and Operations Standards

This section includes a discussion of the standards that the state has established in the MCE contract for structure and operations, as required by 42 C.F.R. Part 438, subpart D (i.e., *provider selection, enrollee information, confidentiality, enrollment and disenrollment, grievance systems,* and *sub contractual relationships and delegation*). These standards relate to the overall objectives listed in the quality strategy's introduction (see Section I above). This section also provides a summary description of the contract provisions.

| Regulatory Reference | DESCRIPTION |
|---|---|
| §438.214 | Provider Selection |
| §438.214(a) | Written policies and procedures for selection and retention of providers |
| §438.214(b)(1) | Uniform credentialing and recredentialing policy that each MCE/PIHP must follow |
| §438.214(b)(2) | Documented process for credentialing and recredentialing that each MCE/PIHP must follow |
| §438.214(c) | Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment |
| §438.214(d) | MCEs/PIHPs may not employ or contract with providers excluded from Federal health care programs |
| §438.218 | Enrollee Information |
| §438.218 | Incorporate the requirements of §438.10 |
| §438.224 | Confidentiality |
| §438.224 | Individually identifiable health information is disclosed in accordance with Federal privacy requirements |
| §438.226 | Enrollment and Disenrollment |
| §438.226 | Each MCE/PIHP complies with the enrollment and disenrollment requirements and limitations in §438.56 |
| §438.228 | **Grievance Systems** |
| §438.228(a) | Grievance system meets the requirements of Part 438, subpart F |
| §438.228(b) | If applicable, random state reviews of notice of action delegation to ensure notification of enrollees in a timely manner |
| §438.230 | **Subcontractual Relationships and Delegation** |
| §438.230(a) | Each MCE/PIHP must oversee and be accountable for any delegated functions and responsibilities |
| §438.230(b)(1) | Before any delegation, each MCE/PIHP must evaluate prospective subcontractor's ability to perform |
| §438.230(b)(2) | **Written agreement** that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate |
| §438.230(b)(3) | **Monitoring** of subcontractor performance on an ongoing basis |
| §438.230(b)(4) | **Corrective action** for identified deficiencies or areas for improvement |

42 CFR 438.214 Provider selection

**MCE Requirements**

In accordance with 42 CFR 438.214, the MCE must implement written policies and procedures for selection and retention of providers and that those policies and procedures include, at a minimum, a process contracting with providers who have signed contracts or participation agreements with the MCE, that these policies and procedures and they do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. In addition, the MCE may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act. Finally, the MCE must comply with the additional requirements established by the State listed below:

The MCE shall ensure that all providers participating in the *Global Commitment to Health Waiver* meet the requirements established by AHS for the Medicaid program. At a minimum, the MCE shall ensure that all *Global Commitment to Health Waiver* providers are licensed and/or certified where required, and are acting within the scope of that license and/or certification, or Federal authority, including Federal Clinical Laboratory Improvements Amendments (CLIA) requirements. Providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act are prohibited from participation in the *Global Commitment to Health Waiver*. Providers may not furnish services that are subject to the Certificate of Need law when a Certificate has not been issued. Each physician must have a unique identifier.

The MCE agrees to ensure that network providers do not intentionally discriminate against *Global Commitment to Health Waiver* enrollees in the acceptance of patients into provider panels, or intentionally segregate Global Commitment to Health enrollees in any way from other individuals receiving services.

The MCE shall not knowingly have a relationship with either of 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.
- An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

FFP is not available for amounts expended for providers excluded by Medicare, Medicaid, or SCHIP, except for emergency services.

**AHS Monitoring Activities**

AHS will review a sample of provider files and provider contract to determine the extent to which the standards are being implemented. In addition, AHS will review aggregate information and individual files of a sample of provider for whom the MCE has recently denied participation.

<u>42 CFR 438.218 Enrollee information</u>

**MCE Requirements**

The MCE shall be responsible for educating individuals at the time of their enrollment into the *Global Commitment to Health Waiver*. Education activities may be conducted via mail, by telephone and/or through face-to-face meetings. The MCE may employ the services of an enrollment broker to assist in outreach and education activities.

The MCE shall provide information and assist enrollees in understanding all facets pertinent to their enrollment, including the following:

- What services are covered and how to access them
- Restrictions on freedom-of-choice
- Cost sharing

- Role and responsibilities of the primary care provider (PCP)

- Importance of selecting and building a relationship with a PCP
- Information about how to access a list of PCPs in geographic proximity to the enrollee and the availability of a complete network roster
- Enrollee rights, including appeal and Fair Hearing rights (described in greater detail below); confidentiality rights; availability of the Office of Health Care Ombudsman; and enrollee-initiated dis-enrollment
- Enrollee responsibilities, including making, keeping, canceling appointments with PCPs and specialists; necessity of obtaining prior authorization (PA) for certain services and proper utilization of the emergency room (ER)

The MCE and AHS shall coordinate the development of the *Global Commitment to Health Waiver* enrollee handbook, which shall help enrollees and potential enrollees understand the requirements and benefits of the various programs available through the *Global Commitment to Health Waiver*. The MCE shall mail the enrollee handbook to all new enrollee households within 45 business days of determination of eligibility for the *Global Commitment to Health Waiver*. Enrollees may request and obtain an enrollee handbook at any time.

The enrollee handbook must be specific to the *Global Commitment to Health Waiver* and be written in language that is clear and easily understood by an elementary-level reader. The enrollee handbook must include a comprehensive description of the *Global Commitment to Health Waiver*, including a description of covered benefits, how to access services in urgent and emergent situations, how to access services in other situations (including family planning services and providers not participating in the Vermont Medicaid program), complaint and grievance procedures, appeal procedures (for eligibility determinations or service denials), enrollee disenrollment rights, and advance directives.

With respect to information on grievance, appeal and Fair Hearing procedures and timeframes, the *Global Commitment to Health Waiver* enrollee handbook must include the following information:

- Right to a State of Vermont Fair Hearing, method for obtaining a hearing, timeframe for filing a request, timeframes for resolution of the Fair Hearing, and rules that govern representation at the hearing;
- Right to file grievances and appeals;
- Requirements and timeframes for filing a grievance or appeal;
- Availability of assistance in the filing process;
- Toll-free numbers that the enrollee can use to obtain assistance in filing a grievance or an appeal;
- The fact that, when requested by the enrollee, benefits will continue if the enrollee files an appeal or a request for a State of Vermont Fair Hearing within the timeframes specified for filing; and that the enrollee may be required to pay the cost of any services furnished while the appeal is pending if the denial is upheld;
- Any appeal rights that the State of Vermont makes available to providers to challenge the failure of the MCE to cover a service;
- Information about Advance Directives and the service providers' obligation to honor the terms of such directives;

The following additional information must be included in the enrollee handbook:

- Information on specialty referrals;
- Information on accessing emergent and urgent care (including post-stabilization services and after-hours

care);
- Information on enrollee disenrollment;
- Information on enrollee right to change providers;
- Information on restrictions to freedom of choice among network providers;
- Information on enrollee rights and protections, as specified in 42 CFR 438.100 and IGA Section 2.15;
- Information on enrollee cost sharing; and
- Additional information that is available upon request, including information on the structure of the *Global Commitment to Health Waiver* and any physician incentive plans.

The MCE shall notify its enrollees in writing of any change that AHS defines as significant to the information in the *Global Commitment to Health Waiver* enrollee handbook at least 30 business days before the intended effective date of the change.

**AHS Monitoring Activities**

AHS will review Enrollee Handbook annually, as well as, welcome packet and any updates as needed.

*Confidentiality*

The MCE agrees that all information, records, and data collected with the agreement shall be protected from unauthorized disclosures. In accordance with section 1902(a)(7) of the Social Security Act, the MCE agrees to provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan. In addition, the MCE agrees to guard the confidentiality of recipient information, in a manner consistent with the confidentiality requirements in 45 CFR parts 160 and 164. Access to recipient identifying information shall be limited by the MCE to persons or agencies which require the information in order to perform their duties in accordance with the agreement, including AHS, the United States DHHS, and other individuals or entities as may be required by the State of Vermont.

Any other party may be granted access to confidential information only after complying with the requirements of State and Federal laws and regulations, including 42 CFR 431, Subpart F pertaining to such access. AHS shall have absolute authority to determine if and when any other party shall have access to this confidential information. Nothing herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals.

Nothing in this section shall be construed to limit or deny access by enrollees or their duly authorized representatives to medical records or information compiled regarding their case, or coverage, treatment or other relevant determinations regarding their care, as mandated by State and/or Federal laws and regulations.

**AHS Monitoring Activities**

AHS will review provider contracts and partner IGAs for policies and procedures regarding the use and disclosure of any individually identifiable health information.

42 CFR 438.226 Enrollment and disenrollment

**MCE Requirements**

The MCE must comply with the enrollment and disenrollment requirements and limitations set forth in 438.56 including; disenrollment requested by the MCE, disenrollment requested by the enrollee, procedures for disenrollment, and timeframes for disenrollment determinations.
The MCE shall ensure that individuals who lose eligibility are disenrolled from the *Global Commitment to Health Waiver*. Loss of eligibility may occur due to:

- Death;
- Movement out of State of Vermont;
- Incarceration;
- No longer meeting the eligibility requirements for medical assistance under the *Global Commitment to Health Waiver*; and
- The enrollee's request to have his/her eligibility terminated and to be disenrolled from the program

The MCE shall compare, on a daily and no less than monthly basis, the active Global Commitment to Health enrollee list with the ESD's Medicaid/VHAP eligibility list to confirm Medicaid/VHAP status for all Global Commitment to Health enrollees. DVHA shall not receive a capitation payment for any individual who is not eligible under the *Global Commitment to Health Waiver*.

The MCE shall not disenroll any individual except those who have lost eligibility as specified under 2.2.4 of the AHS/DVHA IGA. This prohibition specifically precludes disenrollment on the basis of an adverse change in the enrollee's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

**AHS Monitoring Activities**

AHS will review ESD policies and procedures pertaining to enrollment. Upon request, information on dis-enrollments (by reason code) shall be available to AHS for audit purposes.

42 CFR 438.228 Grievance System

**MCE Requirements**

The MCE must have a grievance system that meets the requirements of CFR 438 Subpart F. DVHA and its IGA partners shall adhere to uniform Grievance and Appeals rules and policies. AHS shall be responsible for ensuring grievance and appeals rules, policies and practices comply with the federal statutes and regulations, including provisions applicable to MCE operations. For purposes of the Grievance and Appeals process, Designated Agencies and Specialized Services Agencies are contracted agents of the MCE. Therefore, any decisions these entities make that fall under the definition of "action" as defined at 42 CFR 438.400 are subject to the MCE's appeal process. The MCEs must maintain records of grievances and appeals. Grievance is defined as an expression of dissatisfaction about any matter other than an "action." An appeal is defined as a request for review of an "action."

Action is defined to include:

- Denial or limited authorization of a requested service, including the type or level of service;
- Reduction, suspension, or termination of a previously authorized service;

- Denial, in whole or in part, of payment for a service;
- Failure to provide services in a timely manner, as defined by the State;
- Failure of an MCE to act within the timeframes; or
- Denial of a Medicaid enrollee's request to obtain services outside the network:
  - from any other provider (in terms of training, experience, and specialization) not available within the network
  - from a provider not part of the network who is the main source of a service to the recipient - provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within 60 days.
  - Because the only plan or provider available does not provide the service because of moral or religious objections.
  - Because the recipient's provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the network.
  - The State determines that other circumstances warrant out-of-network treatment.

**AHS Monitoring Activities**

The Agency of Human Services (AHS) shall engage in various activities to ensure the following two requirements are met:

- the Managed Care Organization (MCE) has in effect a grievance system that meets the requirements of 42 CFR Part 438 Subpart F, and
- the MCE operations related to the processing of grievances and appeals are monitored as specified in 42 CFR 438.66.

First, AHS shall require that the MCE submit on a quarterly basis a Grievance and Appeal Activity Report. This report shall contain aggregate information regarding the number, type, origin, notification and resolution time, and decision of each activity; a list of all grievances that have not been resolved to the satisfaction of the enrollee; the nature of grievances requiring expedited review and the decisions; and any trends relating to a particular provider or service. If the report reveals "undesirable trends" relating to a particular provider or service, the MCE must conduct an in-depth review, report the findings to AHS, and take corrective action. Second, Grievance and Appeal Activity Reports shall be presented quarterly to the Agency Quality Assurance and Performance Improvement (QAPI) Committee for identification of patterns or trends that might emerge and to identify areas on which to focus improvement efforts. Finally, AHS or its designee shall annually review a random sample of all grievance and appeal files to ensure that they comply with all applicable AHS standards identified in the Quality Strategy as well as all Federal standards contained in 42 CFR Part 438 Subpart F and 42 CFR 438.210(c). Standards include but are not limited to the following:

- Notice of action
- Resolution and notification
- Expedited resolution of appeals
- Information about the grievance system to providers and subcontractors
- Continuation of benefits
- Effectuation of reversed appeal resolutions

42 CFR 438.230 Subcontractual relationships and delegation

**MCE Requirements**

The MCE may subcontract with other State Departments under the AHS umbrella to provide certain covered *Global Commitment to Health Waiver* services that are relevant to the programs they administer, including the Department for Disabilities, Aging and Independent Living (DAIL), Department of Health (VDH), Department of Education (DOE), Department of Mental Health (DMH), and the Department for Children and Families (DCF) – (collectively referred to as the Departments). Prior to subcontracting with any other entity, DVHA shall evaluate each Department's ability to perform the activities covered under the proposed contract.

In addition to services available through the subcontracted Departments, enrollees may access certain health and mental health services from licensed Medicaid-enrolled providers.

Licensed and enrolled Medicaid providers must:

- Meet the requirements set forth in 42 CFR 431.107;
- Meet DVHA's established enrollment requirements;
- Be willing to coordinate care with DVHA or its designee, including sharing clinical information (with appropriate enrollee consent); and
- Accept DVHA's fee schedule.

Unless authorized by State or federal statute or regulation, the MCE and the subcontracted Departments shall be prohibited from discriminating with respect to the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State of Vermont law, solely on the basis of that license or certification. This provision does not prohibit the MCE and the subcontracted Departments from limiting network participation based on quality, cost or other reasonable business purposes as permitted under federal laws and regulations. If a provider is denied enrollment in the Medicaid program the MCE must provide written notice of its reason(s) for denying enrollment.

All contracts and subcontracts for services pertinent to the *Global Commitment to Health Waiver* must be in writing and must provide that AHS and the United States Department of Health and Human Services (DHHS) may:

- Evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed; and
- Inspect and audit any financial records of such contractor/subcontractor.

Written contracts must specify the activities and reporting responsibilities of the contractor or subcontractor and provide for revoking delegation or imposing other sanctions if the contractor or subcontractor's performance is inadequate.

No subcontract terminates the responsibility of AHS and the MCE to ensure that all activities under this IGA are carried out. In the event of non-compliance, AHS (as the Single State Agency) will determine the appropriate course of action to ensure compliance. The MCE agrees to make available to AHS and CMS all subcontracts between the MCE and the Departments.

The MCE shall maintain evaluation tools, reports, improvement plans, and reported service data profiles used in the service plan and utilization review monitoring activity. At the direction of AHS, the MCE shall also

conduct ongoing monitoring of the Departmental subcontractors through the review of required reports and data submissions.

**AHS Monitoring Activities**

AHS will perform the following activities to ensure compliance with the aforementioned standard:
* Review sample of MCE contracts or written agreements with entities performing the delegated activities
* Review results of the most recent review of the delegated activity

3. Measurement and Improvement Standards

This section includes a discussion of the standards that the state has established in the MCE contract for measurement and improvement, as required by 42 C.F.R. Part 438, subpart D (i.e., *practice guidelines*, *quality assessment and performance improvement program*, and *health information systems*). All Performance Improvement Project (PIP) topics, tied to specific goals, are included in the CQS. These standards relate to the overall objectives listed in the quality strategy's introduction (see Section I above). This section also provides a summary description of the contract provisions.

| Regulatory Reference | DESCRIPTION |
|---|---|
| § 438.236 | Practice Guidelines |
| §438.236(b) | Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate. |
| §438.236(c) | Dissemination of practice guidelines to all providers, and upon request, to enrollees |
| § 438.240 | **Quality Assessment and Performance Improvement Program** |
| §438.240(a) | Each MCE and PIHP must have an ongoing quality assessment and performance improvement program |
| §438.240(b)(1) & §438.240(d) | Each MCE and PIHP must **conduct PIPs** and measure and report to the state its performance<br><br>List out PIPs in the quality strategy |
| §438.240(b)(2) & §438.240(c) | Each MCE and PIHP must **measure and report performance measurement data** as specified by the state<br><br>List out performance measures in the quality strategy |
| §438.240(b)(3) | Each MCE and PIHP must have **mechanisms to detect both underutilization and overutilization of services** |
| §438.240(b)(4) | Each MCE and PIHP must have **mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs** |
| §438.240(e) | Annual review by the state of each quality assessment and performance improvement program<br><br>If the state requires that an MCE or PIHP have in effect **a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program**, indicate this in the quality strategy. |
| § 438.242 | Health Information Systems |

| | |
|---|---|
| §438.242(a) | Each MCE and PIHP must maintain a health information system that can collect, analyze, integrate, and report data and provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility |
| §438.242(b)(1) | Each MCE and PIHP must collect data on enrollee and provider characteristics and on services furnished to enrollees |
| §438.242(b)(2) | Each MCE and PIHP must ensure data received is accurate and complete |

42 CFR 438.236 Practice guidelines

**MCE Requirements**

*Practice Guidelines*

The MCE shall adopt program guidelines that are based on valid clinical evidence, or based on the consensus of health care professionals, consideration of the needs of enrollees, and consultation with health care professionals who participate in the Global Commitment to Health Waiver and other program stakeholders. Program guidelines shall be reviewed and updated periodically as appropriate. The MCE shall disseminate the guidelines to its subcontracted Departments and shall require the Departments to disseminate the guidelines among all their designated providers.

**AHS Monitoring Activities**

The MCE must provide evidence that they have adopted clinical practice guidelines for the treatment of at least two acute or chronic health conditions. AHS shall review the following:
* Practice guidelines
* Provider manuals, enrollee handbook, newsletters, bulletins or other forms of communication for evidence of use of practice guidelines

42 CFR 438.240 Quality Assessment and Performance Improvement Program

**MCE Requirements**

The MCE shall maintain a comprehensive Quality Plan for the Global Commitment to Health Waiver that details the plans, tasks, initiatives, and staff responsible for improving quality and meeting the requirements and beneficiary services incorporated under the MCE contract. All IGA partners must also develop and maintain an internal Quality Plan. In addition to complying with contractual terms related to specific CQI activities, processes and reporting, the MCE must have procedures that: (1) assess the quality and appropriateness of care and services furnished to all Medicaid beneficiaries and to individuals with special health care needs; (2) detect the over-utilization and under-utilization of health care services; (3) regularly monitor and evaluate compliance with the standards for MCEs, and (4) comply with any national performance measures and levels that may be identified and developed by the Center for Medicare and Medicaid Services (CMS) in consultation with AHS and other relevant stakeholders. The Quality Management Plan shall conform to all applicable Federal and State regulations. The Quality Management Plan shall be available to AHS upon request.

The MCE is required to report Performance Measures including results from Consumer Satisfaction Feedback Activities to AHS to assess the quality and appropriateness of care and services furnished to all Medicaid

beneficiaries and to individuals with special health care needs. Performance Measures will be required in the following focus areas:

- Childhood and Adolescent Immunization
- Chronic Conditions – Asthma and Diabetes
- Prenatal Care
- Children's Health – Well-Child Visits
- Oral Health – Annual Dental Visits
- Behavioral Health
- Consumer Satisfaction

The MCE will report Performance Measurement data to AHS on a quarterly basis. The MCE is required to track and trend this data to watch for any patterns. A corrective action report will be required after 3 quarters of a negative trend. The MCE might include plans for a Performance Improvement Projects when the agreed upon indicators is below the performance rate previously defined. Possible Performance measures could include:

- HEDIS clinical measure
- HEDIS-like clinical measure
- CAHPS composite, rating result or question
- Non-CAHPS composite, rating result or question in an area of service identified as relevant to the MCE's enrollees.

The MCE must also conduct performance improvement projects that are designed to achieve, through ongoing measurement and intervention, significant improvement, sustained over time, in clinical and non-clinical care and services that are expected to have a favorable effect on health outcomes and member satisfaction. The performance improvement projects should focus on clinical and non-clinical areas, and involve the following:

- Measurement of performance using objective quality indicators;
- Implementation of system interventions to achieve improvements in quality;
- Evaluation of the effectiveness of the interventions;
- Planning and initiation of activities for increasing or sustaining improvement; and
- Reporting of the status and results of each project to AHS as requested in a timely manner.

Each year the MCE must select one focus area in which to conduct a quality improvement project. These projects may take several years to complete but must demonstrate sustained improvement as required in the CMS protocol. Proposed projects will be submitted to AHS for review and approval assuring the project meets the following criteria:

- Evaluates the quality (i.e., effectiveness, efficiency, equity, patient-centeredness, safety, and timeliness) of programs/services and care
- Has a favorable effect on the structure, process, or outcome of programs/services and/or care
- Uses indicators of quality that are objective performance measures (i.e., use of measures and metrics),
- Increases or sustains the improvements obtained.

The CMS or AHS may specify performance measures and topics for performance improvement projects.

The MCE shall also develop and maintain a comprehensive Utilization Management Plan to identify potential over- and under-utilization of services. The Utilization Management Plan must conform to all applicable Federal and State regulations. The MCE shall not structure compensation for any entity that conducts utilization management services in such a way to provide incentives for the denial, limitation or discontinuation of medically necessary services to any enrollee.

**AHS Monitoring Activities**

AHS will annually review the MCE's Quality Plan, including practitioner availability and accessibility, clinical practice guidelines, continuity and coordination of care, clinical and non-clinical performance measures, and performance improvement activities. Review of the quality program includes use of preventive health guidelines and disease management programs, care coordination or case management programs to enrollees and practitioners. Other standards reviewed include: utilization management, information systems, medical record documentation standards and confidentiality policies and procedures.

AHS will monitor results of performance measures (including feedback from enrollees) and other methodologies to monitor services provided to Vermont Medicaid members annually. In addition to consumer satisfaction surveys, AHS will also monitor member perceptions of accessibility and adequacy of services through the use of anecdotal information, grievance and appeals data, and enrollment information. Audits of the performance measures are followed by corrective action plans when appropriate. DVHA and its sub-contracts are also required to report the status and results of each performance improvement project in an annual report and upon request of AHS. In addition to the above, AHS will perform the following activities:

* Review data gathered as a result of compliance monitoring activities
*Conduct compliance monitoring of QAPI Standards
*Review data for evidence that claims are evaluated to assess the degree of over-and under-utilization

<u>42 CFR 438.242 Health Information Systems</u>

**MCE Requirements**

In accordance with 42 CFR 438.242, the MCE shall maintain a management information system that collects, analyzes, integrates and reports data. The system must provide information on areas including, but not limited to, service utilization, grievances, appeals and disenrollments for reasons other than loss of Medicaid eligibility. The system must collect data on enrollee and provider characteristics. The MCE management information system must have the capabilities to collect, maintain, and report encounter data in accordance with the Global Commitment to Health Waiver's Terms and Conditions. All collected data must be available to AHS and the CMS upon request.

The MCE must also maintain claims history data for all Global Commitment to Health Waiver enrollees through contractual arrangements with its Fiscal Agent. IGA partners shall submit encounter reports for all services rendered to Global Commitment to Health Waiver enrollees, when service-specific claims for such services are not processed through the MMIS. Reporting shall be in accordance with the CMS Special Terms and Conditions of the 1115 Medicaid Waiver Demonstration. The MCE must make such claims and encounter data available to AHS and CMS upon request.

Encounter data submitted to DVHA and IGA partners will be edited by DVHA and IGA partners for accuracy, timeliness, correctness, and completeness. Any encounter data failing edits will be deleted. Any encounter data

denied will be returned to the provider for review and possible resubmission. Encounter data must represent services provided to Global Commitment to Health Waiver enrollees only. The MCE must have a process to ensure that services were actually provided. In addition to the automated process described above, the MCE will at least biennially perform medical/case record reviews for the purposes of comparing submitted claims and encounter data to the medical record to assess correctness, completeness and to review for omissions in encounters or claims.

While there is currently an information system that supports initial and ongoing operation and review of the Quality Strategy, AHS in collaboration with the MCE and its IGA partners is currently developing a data ware house that will be able to provide encounter (i.e., aggregated, unduplicated service counts provided across service categories, provider types, and treatment facilities). This evolving Health Information Technology will impact the future monitoring of QAPI activities.

**AHS Monitoring Activities**

AHS shall have access to the claims and encounter data as reported by DVHA or its IGA partner. AHS will monitor MCE encounter and claims data procedures in order to ensure compliance with this standard. Monitoring includes the following activities:

* Review procedures used by the MCE to ensure the reliability of the data obtained from the providers and contained in it MIS
* Review reports produced by the MIS to support utilization management, grievance processes, enrollment services, and its QAPI program
* Review provider contracts to determine the extent to which expectations for data collection and reporting are outlined

4. HCBS Standards

On January 10, 2014, the Centers for Medicare and Medicaid Services (CMS) issued final regulations regarding home and community-based settings (HCBS), with additional guidance and information posted on March 18, 2014. The rule supports enhanced quality in HCBS programs, outlines person-centered planning practices, and reflects CMS' intent to ensure that individuals receiving services and supports under 1915(c), 1915(k), and 1915(i) Medicaid authorities have full access to the benefits of community living and are able to receive services in the most integrated setting. CMS is asking Vermont to provide assurances that the State's Managed Long Term Services and Supports (MLTSS) in the Choices for Care Program are in compliance with certain aspects of the HCBS rule - specifically, those related to the *setting requirement* and *person centered approaches* for service planning. Two specific STC's from the Global Commitment to Health 1115 demonstration waiver are summarized below:

- person centered planning (i.e., the process, the service plan, and the review of the service plan) will be in compliance with the characteristics set out in 42 CFR 431.301 (c)(1)-(3) (STC #29)

- Compliance with the characteristics of home and community based settings in accordance with 42 CFR 441.301 (c)(4) for Choices for Care Services (e.g., those not found in the Vermont State Plan) (STC #32)

This section includes a discussion of the new HCBS standards that identified in the State's waiver STCs.

Choices For Care Programs in Vermont Impacted by Federal Rule

The vast majority of Choices for Care services are provided to Global Commitment to Health waiver participants in their homes. However persons may also choose adult family care (a community based shared living arrangement) or institutional settings (e.g., skilled nursing facility, private non-medical institutions). Table 3 below shows the service array available to Choices for Care participants and their coverage authority.

Table 6: Choices for Care Program Benefits

| 42 CFR 440.180 HCBS Service | Choices for Care Benefit | Coverage Authorization (State Plan or GC) |
|---|---|---|
| Case Management | Case Management | GC |
| Home Maker | Home Maker - Moderate Needs Group only | GC |
| Personal Care | Personal Care | GC |
| Adult Day Rehabilitation | Adult Day | State Plan -Day Health Rehabilitation |
| Habilitation | Assisted Living Residences | State Plan - Private Non-Medical Institution (Assistive Community Care) |
| | Enhanced Residential Care – Level III | State Plan - Private Non-Medical Institution (Assistive Community Care) |
| | Adult Family Care | GC |
| | Nursing Facility Care | State Plan– Nursing Facility |
| Respite | Respite Care (in home or foster home) | GC |
| Other Cost Effective Alternatives to institutional care | Companion Care | GC |
| | Assistive Devises and Home Modifications | GC |
| | Personal Emergency Response System | GC |

In all Vermont programs, consumers have equal access to an array of traditional state plan services, including Private Non-Medical Institution Services (PNMI), inpatient, skilled nursing and other rehabilitative therapies and service options. The final service package is based on consumer choice, individualized planning, medical necessity (including level of care determinations) and medical appropriateness; thus individual plans may include institutional (Nursing Facility and PNMI), home-based and other rehabilitative based services as part of their person centered planning process. Table 2 illustrates the specific Choices for Care benefits that will be examined in the first phase of the Comprehensive Quality Strategy.

Table 7: Phase 1 of the Comprehensive Quality Strategy

| Phase 1 of Comprehensive Quality Strategy (Choices for Care) | | |
|---|---|---|
| Choices for Care SETTINGS | Person Centered Planning 42 CFR 431.301(c) (1)-(3) | HCBS Settings 42 CFR 441.301(c)(4) |
| | | |
| Home Based | ✓ | |
| Adult Family Care | ✓ | ✓ (e.g., HCBS Transition Plan) |
| Enhanced Residential Care (PNMI) | ✓ | ✓(e.g., State's MLTSS CQS) |
| Nursing Facility | ✓ | |

Settings that are NOT Home and Community Based

The following settings are not considered Home and Community-based:

–Nursing facilities
–Psychiatric institutions ("IMDs")
–Intermediate Care Facilities for Individuals with Intellectual Disability
–Hospitals
–Any other setting having the qualities of an institution

Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

HCBS provided to a member in his or her own home are assumed to meet the requirements of the new rule.

Assessment of HCBS Setting Requirements for Other GC Programs

As described above – the state is engaged in an assessment of compliance with the home and community-based settings requirements for adult family care settings. The Choices for Care assessment process is expected to be completed by October 1, 2015. The monitoring of the compliance the new HCBS rules will be an ongoing process that will be incorporated into existing quality assessment and performance improvement processes. Based on considerable stakeholder interest, Vermont is taking this opportunity to further assess programs/settings for GC Demonstration populations who are designated by the State as persons with Special Health Care needs under 42 CFR 438. Once the assessment process is completed for Choices for Care participants – the following Special Health Need populations will also be considered:

- Developmental Services (DS)
- Traumatic Brain Injury (TBI)
- Children with a Severe Emotional Disturbance (SED)
- Community Rehabilitation and Treatment (CRT)

The state will apply the same process, including key elements described above, as they conduct this assessment. The CQS will be updated to capture the outcomes of this work. Table 3 below outlines Vermont's phased approach to implementing the new HCBS rules identified in their waiver STCs.

Table 8: Global Commitment to Health Specialized Program Self-Assessment and Quality Phases

| | GC Specialized Program Self-Assessment and Quality Phases | | | | |
|---|---|---|---|---|---|
| | Choices for Care | Developmental Services | Traumatic Brain Injury | Community Rehabilitation and Treatment | Children's Mental Health (Mental Illness under 22) |
| Quality Strategy Timeline | | | | | |
| Phase 1: Due 12/31/15 | ✓ | | | | |
| Phase 2: Due 12/31/16 | ✓ | ✓ | ✓ | ✓ | |
| Phase 3: Due 12/31/17 | ✓ | ✓ | ✓ | ✓ | ✓ |
| Phase 4: Due 12/31/18 | ✓ | ✓ | ✓ | ✓ | ✓ |

Vermont is taking a phased implementation approach to addressing Special Terms and Conditions related to person centered planning and home and community based settings.. The goals of our multi-year approach to quality assurance and improvement are to:

- Ensure that new oversight processes do not create increase administrative burden or redirect resources from funds available to provide direct care services to enrollees;
- Ensure that clients are in settings of their own choosing regardless of their type
- Minimize any potential disruption in care
- Use lessons learned in early phases of quality assurance to inform future activities

Starting with the review and approval of the modified Comprehensive Quality Strategy (CQS), the MCE will begin to establish a new monitoring and oversight approach for beneficiaries receiving all HCBS services. Full implementation of the quality plan (e.g., metrics for all programs and populations) is expected to take place by the end of 2019.

Detail regarding the various phases is as follows:

- <u>Phase 1: Initiation</u>
    - This phase begins with the Global Commitment (GC) Comprehensive Quality Strategy (CQS). The CQS serves as a blueprint or road map for Vermont and its contracted health plan in

assessing the quality of care that beneficiaries receive, as well as for setting forth measurable goals and targets for improvement. The critical elements of the CQS are: performance measures, performance improvement projects, and compliance with federal and state regulations including Medicaid Managed Care & the Special Terms and Conditions. During this phase, AHS will establish a framework that sets the stage for the subsequent three phases. Specific milestones include: introduction of monitoring and oversight methodology and the development of a plan for assessment of CFC HCBS and in particular Adult Family Care settings. Additional tasks include the following:

f) A self-assessment of CFC adherence to state and federal standards of care to include:
   iii. Assessment of existing initiatives designed to improve the delivery of CFC, including performance measures or Performance Improvement Projects (PIPs) directed to this population.
   iv. Examination of processes to identify any potential corrective action steps toward improving the CFC system.

g) Person-Centered Planning and Integrated Care Settings*

h) Comprehensive and Integrated Service packages

i) Qualification of Providers

j) Participant Protections

*Vermont's rules and statutes currently require person-centered planning for all populations. The quality and monitoring of these requirements are being addressed by the CQS.

- <u>Phase 2: CFC Implementation & Additional Discussion</u>

  - During this phase control processes are implemented for all CFC adult family care settings; project management infrastructure necessary to support the consistent, successful application of monitoring and oversight techniques by the MCE is created, a self-assessment tool is identified, and MCE staff are trained and mentored. In addition, the development of a work plan and the modification of DVHA/DAIL IGA and DVHA/DAIL Quality Plan will take place. Some other specific milestones include the following: modes of communication with stakeholders are established, corrective action plan template and reporting tools are developed and monitoring and oversight is initiated. At the same time that CFC AFC setting implementation is taking place, state staff will assess programs/settings for GC Demonstration populations who are designated by the State as persons with Special Health Care needs under 42 CFR 438 (i.e., Developmental Services and Traumatic Brain Injury). The state will apply the same process and key elements as those used for CFC adult family care settings (including stakeholder involvement) as they conduct these assessments. Phase 2 will be completed by December 31, 2016.

- <u>Phase 3: Additional Implementation</u>

  - This phase broadens the scope of the activities described in phase two to include the assessment of additional GC Demonstration populations who are designated by the State as persons with Special Health Care needs under 42 CFR 438 (i.e., children's mental health and community rehabilitation and treatment). Phase 3 will be completed by December 31, 2017. Activities in phase three may be expanded beyond DAIL. In this case, processes and structures to support

cross-departmental decision-making will need to be identified. All monitoring/oversight tools will be shared among AHS departments.

- Phase 4: Maintenance

  - The purpose of the Maintenance phase is to ensure long-term continuity by establishing all measures identified above as a core elements and essential monitoring functions within the MCE. Starting with year 4, it is expected that the necessary structures and processes will be in place to support ongoing monitoring and oversight activities. Phase four will be completed by December 31, 2018. Full compliance for all GC populations included in this phased approach is expected to take place by the end of 2019.

This approach will allow the state to use lessons learned in early phases to be incorporated in later phases and ensures that a solid foundation of quality assurance and improvement is in place that aligns with Vermont's statutes, policies and values related to home and community delivery systems.

Choices for Care (CFC) Home and community-based settings must have all of the following qualities, based on the needs of the individual as indicated in their person-centered service plan:

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. *42 CFR 441.301(c)(4)(i)/441.710(a)(1)(i)/441.530(a)(1)(i)*

- The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. *42 CFR 441.301(c)(4)(ii)/ 441.710(a)(1)(ii)/441.530(a)(1)(ii)*
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint. *42 CFR 441.301(c)(4)(iii)/ 441.710(a)(1)(iii)/441.530(a)(1)(iii)*

- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact. *42 CFR 441.301(c)(4)(iv)/ 441.710(a)(1)(iv)/441.530(a)(1)(iv)*

- Facilitates individual choice regarding services and supports, and who provides them. *42 CFR 441.301(c)(4)(v) 441.710(a)(1)(v)/441.530(a)(1)(v)*

Table 9: HCBS Regulations – Examples of Acceptable Practice.

| REGULATORY REQUIREMENT | EXAMPLES OF ACCEPTABLE PRACTICE |
|---|---|
| Opportunities to seek employment and work in competitive integrated settings | Individual works in an integrated setting or, if the individual would like to work, there is activity that ensures the option is pursued. |
| Engage in community life | Individual regularly accesses community as chooses (shops, attends religious services, schedules appointments, lunch with family and friends)<br>Individual has access to public transportation, accessible transportation for appointments and shopping; training to use public transportation. Where public transportation is limited, other resources are provided.<br>Individual participates regularly in meaningful non-work activities in integrated community settings for the period of time desired by the individual |
| Control personal resources | Individual has checking or savings account or other means to control own funds; access to own funds. |
| Receive services in the community | Individual can choose from whom they receive services and supports. |
| Privacy | Individual can make private telephone calls/text/email at the individual's preference and convenience.<br>Health information is kept private.<br>Assistance provided in private, as appropriate, when needed. |
| Dignity and respect | Individual is assisted with grooming as desired; assisted with dressing in their own clothes appropriate to the time of day, weather and preferences.<br>Staff communicates with individuals in dignified manner.<br>Informal (written and oral) communication conducted in a language that the individual understands. |
| Freedom from coercion | Individuals are free from coercion: e.g., able to file complaints, discuss concerns; able to make personal decisions such as hairstyle and hair color |
| Freedom from restraint | Individual has unrestricted access in the setting: no barriers to exit and entrance; physical accessibility. |
| Initiative, autonomy and independence | Individual is free to come and go at will (no curfew or other requirement for a scheduled return to the setting)<br>The setting is an environment that supports individual comfort, independence and preferences (*e.g.*, kitchen with cooking facilities, dining area, laundry, and comfortable seating in shared areas). |
| | |

| REGULATORY REQUIREMENT | EXAMPLES OF ACCEPTABLE PRACTICE |
|---|---|
| Daily activities | Individual chooses and controls a schedule that meets his/her wishes in accordance with a person-centered plan.<br>Participates in unscheduled and scheduled community activities in the same manner as individuals not receiving Medicaid HCBS services. The individual chooses when and what to eat.<br>The individual chooses and controls a schedule that meets his/her wishes in accordance with a person-centered plan. |
| Physical environment | The individual has his/her own bedroom or shares a room with a roommate of choice. |
| With whom to interact | The individual chooses with whom to eat or to eat alone.<br>Visitors are not restricted. |
| Choice of services | Staff ask individual about needs and preferences. Individuals are aware of how to make a service request. Requests for services and supports are accommodated as opposed to ignored or denied. Choice is facilitated in a manner that leaves the individual feeling empowered to make decisions. |
| Choice of providers | The individual chooses from whom they receive services and supports. Individual knows of other providers who render the services s/he receives. Individual knows how and to whom to make a request for a new provider. |

Adapted from CMS, *Exploratory Questions to Assist States in Assessment of Residential Settings* accessible at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Exploratory-questions-re-settings-characteristics.pdf.

Provider-owned or controlled residential settings must also comply with some additional requirements. Standards that apply to provider-owned or controlled residential settings include the following:

- Responsibilities and rights of tenant, Legally enforceable agreement
- Privacy in sleeping or living unit
- Lockable doors, staff have keys only as needed
- Freedom to furnish and decorate
- Choice of roommates for shared rooms
- Control own schedule and activities and access to food at any time
- Able to have visitors at any time
- Physically accessible

Under Certain Conditions a Residential Provider can Modify Some of These Additional Requirements. Additional requirements may be changed only when a member's Person Centered Plan describes:

(*1*) Identify a specific and individualized assessed need.
(*2*) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
(*3*) Document less intrusive methods of meeting the need that have been tried but did not work.
(*4*) Include a clear description of the condition that is directly proportionate to the specific assessed need.
(*5*) Include regular collection and review of data to measure the ongoing effectiveness of the modification.
(*6*) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
(*7*) Include the informed consent of the individual.
(*8*) Include an assurance that interventions and supports will cause no harm to the individual.

*The requirement that a setting is physically accessible may not be modified.

**MCE Monitoring Activities**

The MCE must determine whether services in these settings meet the community standards set forth in the rules. Initial and ongoing compliance with standards will include, but not be limited, to the following methods: licensing reviews, provider qualification reviews, site visits, survey of individuals in receipt of HCBS, provider self-assessment, or a sample of settings. If necessary, CMS will allow Vermont up to four years to phase in these changes. All such services will be in compliance with CMS requirements before March 2019.

## IV. IMPROVEMENT & INTERVENTIONS

This section describes how the state will attempt to improve the quality of care delivered by the MCE through interventions including, but not limited to the following: Cross-state agency collaborative; Grants; and Disease management programs.

*Improvement*

AHS will assess whether or not the objectives identified in the Introduction have been met by comparing results of performance measures over time. Based on the results of the assessment activities, AHS will attempt to improve the quality of care provided by the MCE. Examples of interventions that might be applied include but are not limited to the following:

- Cross-agency collaborative/initiatives
- Performance improvement projects
- Changes in benefits for program participants
- Information system or electronic health record initiatives
- Implementing optional EQRO activities

In the CQS, AHS will describe the process it intends to follow to embark on quality improvement. As results from the assessment activities are produced, AHS will be able to more clearly define steps to quality improvement. Interventions for improvement of quality activities are varied and based on the ongoing review and analyses of results from each monitoring activity by the State and EQRO. As results from assessment activities are produced, it is likely that AHS will be able to further and more clearly define interventions for quality improvement as well as progress towards objectives. The State's EQRO report will include an assessment of MCE's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries, recommendations for improving the quality of health care services furnished by each MCE, and an assessment of the degree to which each MCE has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year. This information will be used to inform any needed quality improvement activities, sanctions, or other program changes. Additionally, the EQRO report will be used to inform the State of any needed oversight or regulatory support to improve managed care health care delivery.

1. <u>Intermediate Sanctions</u>

The premise behind the CQS is one of continuous quality improvement. AHS strongly believes in working with the MCE in a proactive manner to improve the quality of care received by VT Medicaid recipients. However, should the need arise; part of AHS's quality management process is the existence of sanctions and conditions for contract termination that may be imposed should the continuous quality improvement process not be effective. The sanctions of MCE plan meet the federal requirements of 42 CFR 438 Subpart I, as well as State requirements for sanctions and termination. AHS will have the right to impose penalties and sanctions, arrange for temporary management, as specified below, or immediately terminate MCE contract under conditions specified below.

2. Health Information Technology

This section details how the state's information system supports initial and ongoing operation and review of the state's quality strategy. In addition, it describes any innovative health information technology (HIT) initiatives that will support the objectives of the state's quality strategy and ensure the state is progressing toward its stated goals.

Vermont has new programs that have been or will soon be initiated, many of which require the expanded utilization of HIT and HIE to succeed. These programs address care delivery, cost control, and payment models that in general give consideration to the continuum of care and care providers involved in an episode of care for an individual. Significantly, Medicaid is at the center of, and is driving, many of these changes. The Agency of Human Services (AHS) –includes the Blueprint for Health and other programs that are engaged in health care delivery and payment reforms across the State. So in a very real sense, Medicaid is at the heart of state health reform initiatives. However, it is critical to note that this transformed system is designed to support an infrastructure for all Vermonters, not only those who happen to be on public programs at a given moment in time.

There are many other major efforts underway in Vermont, each with some aspect of HIT or HIE, but ALL of which share the need for timely accurate information, and they also overlap with each other to varying extents. The major project areas include the Health Benefit Exchange (HBE), or Vermont Health Connect (VHC), which began operation on October 1, 2013; Medicaid Management Information Systems (MMIS) work which includes a system replacement as well as a MITA (Medicaid Information Technology Architecture) Self-Assessment; an Integrated Eligibility (IE) solution; and the expansion of Health Services Enterprise (HSE) architecture. In addition, Vermont's Blueprint for Health (VBH) program continues to expand as the flagship for healthcare delivery reform in Vermont. As the VBH expands to incorporate more providers into the program it also expands in the types of medical conditions and associated clinical data that need to be accumulated into Vermont's clinical data registry (CDR). Also, a "Hub and Spoke" model for addressing opiate substance abuse and any associated mental health issues is underway. In addition, a State Innovation Model (SIM) grant is underway to test three different payment models, requiring the infrastructure of HIT and HIE to support the specific goals of this grant. The SIM grant proposal includes incorporating the full continuum of providers, including those beyond primary and specialty care, into the payment reform models. These providers include Vermont's designated agencies (DAs) who deliver behavioral health (BH), mental health (MH) and substance abuse (SA) services; home health services (HH), and long term support services (LTSS) which includes long term and post –acute care providers (LTPAC).

Specifically, Vermont is undertaking a robust combination of health reform, HIT, and IT initiatives:

- build out of the statewide HIE network to provide connectivity for clinical and financial data transfer, not just for Eligible Providers and Eligible Hospitals, but for all Medicaid providers – including Home Health, Mental Health/Behavioral Health/Substance Abuse Providers, and Long Term Care – to ensure comprehensive clinical messaging and electronic claims processing across the continuum of care;
- implementation of core components of SOA infrastructure to support the Agency of Human Services and its partners. This is referred to as the Health Services Enterprise (HSE) architecture;
- re-procurement of the Medicaid Management Information System (MMIS) as a more comprehensive and integrated solution;

- statewide outreach to and support for EHR adoption, implementation, upgrade and meaningful use, including close collaboration of Medicaid and the ONC-funded Regional Extension Center (REC);
- development and implementation of the MAPIR (Medical Assistance Provider Incentive Repository) provider portal in collaboration with other states to support Eligible Provider/Eligible Hospital enrollment, attestation, and audit trail connecting the CMS National Registration & Attestation System (NLR) and state MMIS;
- statewide expansion of the Blueprint for Health medical home / community health team / multi-insurer payment reform model that includes the build out of a statewide clinical data registry, decision support, and clinical messaging system integrated with HIE and EHR systems to support both Meaningful Use and implementation and evaluation of delivery system reforms;
- development, implementation, testing, and production environment roll-out for Immunization Registry and other public health reporting functions through the HIE;
- investigation and future deployment of a unified patient portal solution through the HIE;
- Integrated Eligibility (IE) for modernization and upgrade of the Agency's eligibility and enrollment systems, including development of capacity for those systems to support a state Health Insurance Exchange (HIX) as envisioned by the Affordable Care Act;
- expansion or replacement of CSME (Central Source for Measurement and Evaluation), the Agency wide data warehouse to support Medicaid and other Agency program operations, reporting, evaluation, and planning;
- integration of Children's and Family services across categorical programs and departments to ensure a child- and family-centered focus to improve communication, reduce bureaucratic overlap and confusion, and eliminate program and resource redundancies; and
- development of broad based, system level payment reform pilot strategies (such as Accountable Care Organizations) to expand delivery system payment reforms to the full continuum of care.

Vermont's vision is to operate a system of care and services where fragmentation is a "Never Event." Just as performing a surgical procedure on the wrong limb should never happen, a hospital discharge or other transition event that leads to an inappropriate readmission should never happen in a high functioning, high quality system. One of the leading causes of fragmentation of care and lack of coordination is poor or incomplete communication. HIT and HIE, when effectively deployed and utilized, provide the means for comprehensive communication of information across the continuum of care, services, and providers. As progress is made with HIT and HIE, and with adding more types of provider organizations to the ranks of participating providers (as challenging as that will be), the role of information emerges as the key to achieving the outcomes of the Triple Aim: a better experience of care for the individual, improved population health, and reductions in the cost of health care.

All of this fits under the framework of Vermont's unique Global Commitment to Health 1115 waiver and its public entity Managed Care Organization model which provides additional opportunity for leveraging of resources. Such expansive change might be impossible to achieve in a larger state in the timeframe contemplated by Vermont, but both the state's scale and the work done on health reform and development of many of the initiatives listed above over the preceding seven years make Vermont an ideal laboratory for change.

## V. DELIVERY SYSTEM REFORMS

"Managed Long-Term Services and Supports" refers to the delivery of LTSS (including both home and community based services (HCBS) and institutional-based services) through capitated Medicaid managed care programs. Home and community-based services (HCBS) are services made available to support individuals living at home or in a community based setting; these may include home health care, durable medical equipment, assistive technology, chore services, nursing care, transportation, adult day care, in-home meal services, and more. With waiver consolidation, Vermont is using MLTSS as a strategy for expanding home- and community-based services, promoting community inclusion, ensuring quality and increasing efficiency. MLTSS offers States a broad and flexible set of program design options. The design and implementation of the CQS is transparent and appropriately tailored to address the needs of the MLTSS population. Providing more integrated care - and coordinating acute care with long term services and supports hold the promise of delivering better care at lower costs.

**Payment Reform involving Medicaid**

SIM/VHCIP - Vermont was awarded $45 million under the SIM program over a four-year period. Under the SIM grant, Vermont's payers (Medicaid and Commercial) will test three existing Medicare models: the Shared Savings Accountable Care Organization, Bundled Payments and Pay-for-Performance. Grants funds will be used to accomplish three major project aims:

- Improve care;
- Improve population health; and
- Reduce health care costs.

Hub & Spoke The Agency of Human Services (AHS) is collaborating with community providers to create a coordinated, systemic response to the complex issues of opiate and other addictions in Vermont. A *Hub* is a specialty treatment center responsible for coordinating the care of individuals with complex addictions and co-occurring substance abuse and mental health conditions across the health and substance abuse treatment systems of care. A *Hub* is designed to do the following:

- ♦ Provide comprehensive assessments and treatment protocols.
- ♦ Provide methadone treatment and supports.
- ♦ For clinically complex clients, initiate buprenorphine treatment and provide care for initial stabilization period.
- ♦ Coordinate referral to ongoing care.
- ♦ Provide specialty addictions consultation and support to ongoing care.
- ♦ Provide ongoing coordination of care for clinically complex clients.

A *Spoke* is the ongoing care system comprised of a prescribing physician and collaborating health and addictions professionals who monitor adherence to treatment, coordinate access to recovery supports, and provide counseling, contingency management, and case management services. *Spokes* can be:

- ♦ Blueprint Advanced Practice Medical Homes
- ♦ Outpatient substance abuse treatment providers
- ♦ Primary care providers
- ♦ Federally Qualified Health Centers
- ♦ Independent psychiatrists

Blueprint for Health - Vermont's Blueprint for Health (Blueprint) provides statewide expansion of Advanced Primary Care Practices (APCP), also known as Patient Centered Medical Homes (PCMH), supported by Blueprint Community Health Teams (CHTs) comprised of nurse coordinators, clinician case managers, social workers and other professionals who extend the capacity of primary care practices to provide multidisciplinary care and support.

## VI. CONCLUSIONS & OPPORTUNITIES

Achievements since the initial quality strategy was developed include:

- Implementation and engagement of the External Quality Review Organization;
- Selection and reporting of HEDIS, and select child core set and adult core set measures
- Selection of performance goals and implementation of a performance accountability framework;
- Maturation of the PIPs with technical assistance from the EQRO;

As described in Section III. Improvement, the MCE performance regarding PIPs and many performance measures has improved over time. Health Services Advisory Group, Inc. has noted that the Agency has significantly enhanced the overall monitoring of compliance review activities. The Agency will continue to work with its partners to move the MCEs to higher quality in clinical and administrative practices.

**Global Commitment to Health Evaluation Highlights**

1. Global Commitment's ability to increase Medicaid beneficiary access to primary care

Global Commitment has succeeded at increasing access to care for Vermont Medicaid beneficiaries over the years of the waiver as measured in the following areas:

- *Average Enrollment:* Between 2008 and 2014, average annual enrollment grew by approximately 5, 000 individuals; for an overall increase of 32.3%.

- *Number of Uninsured:* The uninsured rate in Vermont decreased from 7.6% in 2009 to 6.8% in 2012, well below the national rate of 15.7% in 2011 (most recent U.S. Census data available).

- *HEDIS Measures:* Global Commitment improved in standing relative to HEDIS access to care measures and as related to scores achieved by accredited Medicaid HMO's as reported in the NCQA 2014 report: State of Health Care Quality.

  - Global Commitment was significantly higher than the accredited Medicaid HMO average (14.4%) for Well Child Visits in the First 15 months of Life.
  - Global Commitment continues to achieve high performance for Child and Adolescent access to primary care physician (PCP) with scores ranging from 91.7% to 98.3% across the childhood years. All score were above the associated Medicaid HMO averages
  - Global Commitment also achieves high scores related to Adult Access to Preventive and Ambulatory Care, 84.1% to 93% across the adult years.

- *Beneficiary Satisfaction*: According to the CAHPS 2014 Medicaid Adult Survey, 86% of respondents answered that they "always/usually" got the care they needed and 83% reported "always/usually" receiving that needed care quickly. Overall, CAHPS survey results for these measures have remained steady over the past few years. A further break down of that composite data shows that 81% of respondents answered that they received an appointment for a check-up or routine care as soon as they needed. Similarly, 81% of those surveyed said they "always/usually" got an appointment to see a specialist as soon as they needed.

2. Extent to which Global Commitment has enhanced the quality of care for Medicaid beneficiaries

Global Commitment has succeeded at enhancing the quality of care for Vermont Medicaid beneficiaries as measured in the following areas:

- The Vermont Chronic Care Initiative has made improvements in health outcomes for Vermont's highest risk Medicaid beneficiaries. Inpatient hospital utilization among the Top 5% was reduced from Program Year 5 (PY5) to Program Year 6 (PY6) by 37%, declining from 476 visits per 1,000 members in SFY 2012 to 301 visits per 1,000 members in 2013.
- Readmission rates for Vermont Chronic Care Initiative members in the Top 5% dropped from PY5 to PY6 by 34%, from 77 readmissions per 1,000 members in SFY 2012 to 51 per 1,000 members in SFY 2013.

- Emergency room utilization for Vermont Chronic Care Initiative members was 17% lower among the Top 5% from PY5 to PY6, decreasing from 1,461 visits per 1,000 members in SFY 2012 to 1,215 visits per 1,000 members in 2013.

- Vermont's Medicaid program had above-average performance (greater than the national HEDIS 75th percentile) in 2014 for the following HEDIS measures that also relate to quality of care:
  - ✓ Antidepressant Medication Management—Effective Acute Phase Treatment;
  - ✓ Antidepressant Medication Management—Effective Continuation Phase Treatment;
  - ✓ Use of Appropriate Medications for People with Asthma (total);
  - ✓ Well-Child Visits in the First 15 Months of Life—Six or More Visits; Children's and
  - ✓ Children and Adolescents' Access to Primary Care Practitioners (all indicators);
  - ✓ Adults' Access to Preventive/Ambulatory Health Services; and
  - ✓ Annual Dental Visits measure, which involve distinct provider specialties.

3. Global Commitment's ability to contain (by maintaining or reducing) Medicaid spending in comparison to what would have been spent absent the waiver

Global Commitment has contained spending relative to the absence of the Demonstration over the years of the waiver. The cost-effectiveness of the Demonstration can be summarized as follows:

**Choices for Care Evaluation Highlights**

1. Choices for Care's ability to increase Medicaid beneficiary access to primary care

Choices for Care has succeeded at increasing access to care for Vermont Medicaid beneficiaries over the years of the waiver as measured in the following areas:

- CFC increased in its ability to serve participants in the community. Data demonstrated that more participants are being served in HCBS settings: 49% of CFC participants are served in nursing facilities and 51% are served in HCBS settings.
- In addition to increasing percentages of Highest and High Needs Group participants living in home and community settings, there were no waiting lists for High Needs Group participants.
- There were decreases in the number of applicants waiting for eligibility and financial determination.
- CFC participants expressed satisfaction regarding access to the types and amount of supports they need and want.

2. Extent to which Choices for Care has enhanced the quality of care for Medicaid beneficiaries

Choices for Care has succeeded at enhancing the quality of care for Vermont Medicaid beneficiaries as measured in the following areas:

- CFC maintained positive gains in terms of quality, satisfaction, staff courtesy, and choice.
- CFC maintained good ratings of sense of choice and control. Ratings continued to be high for someone to listen, someone to count on in an emergency and safety.
- There were improved ratings for social life satisfaction and achievement of personal goals.
- Self-rated health remained steady.

3. Choices for Care's ability to contain (by maintaining or reducing) Medicaid spending in comparison to what would have been spent absent the waiver

Choices for Care has contained spending relative to the absence of the Demonstration over the years of the waiver. The cost-effectiveness of the Demonstration can be summarized as follows:

- CFC remained budget neutral. The Long Term Care portion of the Choices for Care budget was under budget by $7,733,594 thru the end of SFY13.

Since 2007, the Vermont Agency of Human Services (AHS) has contracted with Health Services Advisory Group, Inc. (HSAG), an External Quality Review Organization (EQRO), to review the performance of DVHA in the three CMS required activities (i.e., Compliance with Medicaid Managed Care Regulations, Validation of Performance Improvement Projects, and Validation of Performance Measures), and to prepare the EQR annual technical report which consolidates the results from the activities it conducted. Over the past five years, HSAG reports observing tremendous growth, maturity, and substantively improved performance results across all three activities. Vermont's Medicaid Managed Care Model has achieved the following scores relative to the three mandatory areas of EQR:

- Average Overall Percentage of Compliance Score of 93.8%;
- Average Performance Improvement Validation scores for Evaluation Elements Met of 98.4%, Critical Elements Met of 100%, and an Overall Validation Status of Met for each year - indicating high confidence in the reported results; and
- Performance Measures Validation finding of 100% Fully Compliant and a determination that the measures were valid and accurate for reporting for each year.

In addition, with each successive EQRO contract year, HSAG has found that DVHA has increasingly followed up on HSAG's prior year recommendations and has initiated numerous additional improvement initiatives. For example, they found that Vermont's Medicaid Managed Care Model regularly conducts self-assessments and, as applicable, makes changes to its internal organizational structure and key positions to more effectively align staff skills, competencies, and strengths with the work required and unique challenges associated with each operating unit within the organization.

HSAG also said that DVHA's continuous quality improvement focus and activities, and steady improvements over the five years have been substantive and have led to demonstrated performance improvements, notable strengths, and commendable and impressive outcomes across multiple areas and performance indicators.

Finally, HSAG has concluded that DVHA has demonstrated incremental and substantive growth and maturity which has led to its current role and functioning as a strong, goal-oriented, innovative, continuously improving Medicaid managed care organization model.
This growth is also evidenced in evaluation efforts as reflected by the 2012 CAHPS survey data on "Overall Rating of Health Plan": the percentage of beneficiaries that rated the health plan 8 out of 10 or higher improved from 68.1% in 2009 to 81.3% in 2012.

Examples of DVHA's success in enhancing the quality of care for beneficiaries during the GC Demonstration include the following data:

- DVHA had above-average performance (greater than the national HEDIS 75th percentile) in 2012 for the following HEDIS measures that also relate to quality of care:

    - ✓ Antidepressant Medication Management—Effective Acute Phase Treatment;
    - ✓ Antidepressant Medication Management—Effective Continuation Phase Treatment;
    - ✓ Well-Child Visits in the First 15 Months of Life—Six or More Visits; Children's and
    - ✓ Adolescents' Access to Primary Care Practitioners (all indicators); and
    - ✓ Annual Dental Visits measure, which involve distinct provider specialties.

Vermont's Medicaid Managed Care Model's most recent Performance Improvement Project (PIP), Increasing Adherence to Evidence-Based Pharmacy Guidelines for Members Diagnosed with Congestive Heart Failure, received a score of 96% for all applicable evaluation elements, a score of 100% for critical evaluation elements and an overall validation status of Met indicating a finding of high confidence in the reported baseline and re-measurement results.

Drafting the CQS has allowed AHS to think strategically about quality data and management intervention activities. The CQS can guide monitoring and intervention activities for MCE and other AHS programs. The CQS will regularly guide reviewers and recommend corrective action/follow-up; additionally, it will guide AHS Senior Leadership, which will be an important step to ensuring the implementation of quality activities. AHS continues to promote and support ongoing efforts of transparency and sharing. There has also been significant improvement in the collaboration between AHS and DVHA and the other AHS Departments, as well as between other programs on quality activities. The plan to institute formal quality strategies on a regular basis will strengthen these collaborations and assure a forum for dialogue, review of interim results, follow-up of corrective action, sharing of best practices, and identification of systems changes. After the implementation of this CQS, the AHS reserves the right to make modifications after the data has been collected and deemed as necessary.

Appendix A: Summary of Public Comment

Vermont is committed to ensuring that our statewide Comprehensive Quality Strategy (CQS) is reviewed publicly and that public input is incorporated into the final version. Public meeting notices were advertised in the *Burlington Free Press* and posted on multiple state websites. In addition to the *Burlington Free Press* – the notice was sent to Agency of Human Services District Offices, the Medicaid and Exchange Advisory Board, Disability Aging and Independent Living Advisory Board, and the Developmental Services State Program Standing Committee. In addition, the public hearing date was published in the Agency of Administration Department of Libraries public meeting calendar. A formal public hearing was held on Thursday, August 20, 2015 from 12pm-2pm at 208 Hurricane Lane in Williston Vermont. Public input received included:

- Oral comment by four (4) public hearing attendees
- Written comment received during the 30 day public comment period by three (3) organizations

The public meeting recording was transcribed by a state contractor. After reviewing the transcript and the other written comment documents received, the state identified the comments in the table below. In an attempt to thoroughly capture stakeholder feedback - the state chose to break apart some commenter's statements into multiple comments. Also, to enhance readability, the state created headers for similar comments. Please note that comments are not further sorted by individual or organization – so multiple comments under the same header might (and in many cases do) belong to the same individual or organization. All public comment reference documents will be submitted to CMS in their entirety along with the CQS.

## Public Comment Received on VT Global Commitment to Health Comprehensive Quality Strategy & State Responses

Outreach & Stakeholder Involvement

| Public Comment | State Response |
|---|---|
| According to CMS, there are two steps in the state transition plan process. First, a state must assess what they are doing now and compare that to what is required in the new rules. We are expecting to be involved in the assessment; in other words, nothing about us without us | The CQS requires the AHS/DVHA to provide a detailed description of the state's assessment of compliance with the home and community-based settings requirements for services not authorized under the Medicaid State Plan (e.g., adult family care). The assessment process is expected to be completed by December 31, 2015. Stakeholder feedback is an essential element of this process and will be included prior to completion. |
| We thank you for this opportunity to comment on the transition plan, but CMS said that public must be able to comment on both the assessment and the transition plan. | Please see response above |
| As disability rights organizations -- or as a disability rights organization for people with developmental disabilities, we would like the opportunity to work with the Department to assess our system and finalize Vermont's HCBS transition plan. | Based on considerable stakeholder interest, Vermont is taking this opportunity to further assess programs/settings for GC Demonstration populations who are designated by the State as persons with Special Health Care needs under 42 CFR 438. Once the assessment process is completed for Choices for Care participants – the following Special Health Need populations will also be considered:<br><br>• Developmental Services (DS)<br>• Traumatic Brain Injury (TBI)<br>• Children with a Severe Emotional Disturbance (SED)<br>• Community Rehabilitation and Treatment (CRT)<br><br>The state will apply the same process and key elements as those used for CFC adult family care settings (including stakeholder involvement) as they conduct these assessments. |
| So if the message had been heard to involve people with disabilities, I personally think it now needs to be put into action. | Please see response above. |
| Particularly with regard to true community settings, but it's felt like there's this huge national process out here and we are -- we haven't been part of it. | Please see response above. |
| As someone who always sticks my nose into things, I would have appreciated the opportunity to stick my nose in earlier, to -- have an earlier involvement in the | Thank you for your feedback. |

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| formulation of this process. | |
| I guess anytime that, you know, a state has to do an assessment of where things are and where they need to go, always involve people with disabilities in that. | Thank you for your feedback. |
| We appreciate that AHS has made efforts to get stakeholder input on the CQS. However, the process has been insufficient. | Thank you for your feedback. |
| With regard to engaging stakeholders in the development of the CQS, AHS appears to have met the letter but not the spirit of the new HCBS Rule. | Thank you for your feedback. |

## Scope of the CQS

| Public Comment | State Response |
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| Taken together (and also noting the titular description of "Phase III" as "if required") these statements leave the strong impression that Vermont views the HCBS rules found at 42 CFR§441.301(c)(1-3), 42 CFR §441.301(c)(4) and 42 CFR §441.301(c)(6) as applying only to the Choices for Care program and not to Developmental Services, TBI or CRT Home and Community-Based services. | The CQS requires the AHS/DVHA to provide a detailed description of the state's assessment of compliance with the home and community-based settings requirements for Choices for Care services not authorized under the Medicaid State Plan (e.g., adult family care). Based on considerable stakeholder interest, Vermont is taking this opportunity to further assess programs/settings for GC Demonstration populations who are designated by the State as persons with Special Health Care needs under 42 CFR 438. |

## Public Comment & Implementation Timelines

| Public Comment | State Response |
|---|---|
| AHS's own timeline is unrealistic in terms of providing CMS with a reasonable summary of public comments and agency response as required under 42 CFR § 441.301(c)6. | Vermont is committed to ensuring that our statewide CQS is reviewed publicly and that public input is incorporated into the final strategy. A summary of public comments and agency response will be made available on September 8, 2015. |
| Other than the fact that all service populations will be incorporated into the CQS by December 31, 2019, there is no specific timeline presented for phases 2, 3, and 4. | The CQS has been modified to indicate that Phase 1 will be completed by December 31, 2015 – with each subsequent phase lasting one year. |
| VHCA would like to see a more specific timeline for the four-phase approach to implementation, and earlier engagement of ERC providers. | The CQS has been modified to indicate that Phase 1 will be completed by December 31, 2015 – with each subsequent phase lasting one year. It is the state's expectation that stakeholders will be invited to participate in all phases of CQS review and in identifying areas for further action. This will include multiple opportunities for ERC and other providers to engage the state with |

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| | concerns, comments and suggestions. |

Person Centered Planning

<table>
<tr><th>Public Comment</th><th>State Response</th></tr>
<tr><td>Throughout your plan, you repeatedly state that plans for developmental services are to be announced. We are most concerned about assessing and planning for how Vermont will implement HCBS setting requirements, person-centered planning requirements, and conflict-free case management requirements.</td><td>Table 2 below illustrates the specific Choices for Care benefits that will be examined in the first phase of the Comprehensive Quality Strategy.<br><br>Table 2: Phase 1 of the Comprehensive Quality Strategy
<table>
<tr><th colspan="3">Phase 1 of Comprehensive Quality Strategy (Choices for Care)</th></tr>
<tr><th>Choices for Care SETTINGS</th><th>Person Centered Planning 42 CFR 431.301(c) (1)-(3)</th><th>HCBS Settings 42 CFR 441.301(c)(4)</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Home Based</td><td>✓</td><td></td></tr>
<tr><td>Adult Family Care</td><td>✓</td><td>✓ (e.g., HCBS Transition Plan)</td></tr>
<tr><td>Enhanced Residential Care (PNMI)</td><td>✓</td><td>✓(e.g., State’s MLTSS CQS)</td></tr>
<tr><td>Nursing Facility</td><td>✓</td><td></td></tr>
</table>
To aid in clarity – this table has been added to the draft CQS.</td></tr>
<tr><td>I’m concerned about how to implement the person-centered planning requirements and especially without conflict involved in that as well as the conflict-free case management.</td><td>Please see response above.</td></tr>
<tr><td>In addition, the CQS states that “CMS will allow Vermont up to four years to phase in these changes.” The person-centered planning provisions of the HCBS rules at 42 CFR§441.301(c)(1), (2) and (3) became effective on March 17, 2014 and do not allow for a phase in or transition period. As such, Vermont should currently be in compliance with the HCBS person- centered planning provisions as to all HCBS populations.</td><td>The Global Commitment to Health 1115 demonstration waiver STC’s state the following re: the person-centered planning provisions of the HCBS rule:<br><br>➢ person centered planning (i.e., the process, the service plan, and the review of the service plan) will be in compliance with the characteristics set out in 42 CFR 431.301 (c)(1)-(3) (STC #29)<br><br>Vermont’s rules and statutes currently require person-centered planning for all populations. The quality and monitoring of these requirements are being</td></tr>
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| | addressed by the CQS. |
| The CQS should include information on the extent of Vermont's compliance with the person-centered planning rule and describe specific steps it will take to come into compliance where necessary.<br>At a minimum, the CQS should describe how Vermont will ensure compliance with the following aspects of person- centered planning:<br><br>1) Providers of HCBS for the individual, or those who have an interest in the individual or are employed by a provider of HCBS for the individual do not provide case management or develop the individual's person-centered plan. 42 CFR §441.301(c)(1)(vi);<br>2) The setting in which the individual resides is chosen by the individual. 42 CFR<br>§441.301(c)(2)(i); and<br>3) Natural unpaid supports are provided voluntarily to the individual in lieu of … HCBS waiver services and supports. 42 CFR §441.301(c)(2)(v). | Please see response above. |

Applicability of new HCBS rule to Vermont

| Public Comment | State Response |
|---|---|
| Vermont is required to comply with the Home and Community Based Service (HCBS) regulations found at 42 CFR §441.301(c)(1), (2) and (3) pertaining to Person-Centered Planning, 42 CFR§441.301(c)(4) and (5) pertaining to Home and Community Based Settings, and 42 CFR §441.301(c)(6) pertaining to a Transition Plan for coming into compliance with Home and Community Based Settings requirements. | The CQS requires the AHS/DVHA to provide a detailed description of the state's assessment of compliance with the home and community-based settings requirements for Choices for Care services not authorized under the Medicaid State Plan (e.g., adult family care). Based on considerable stakeholder interest, Vermont is taking this opportunity to further assess programs/settings for GC Demonstration populations who are designated by the State as persons with Special Health Care needs under 42 CFR 438. |
| Although Vermont's waiver is a section 1115(a) demonstration waiver, the state is expected to meet or transition to the new HCBS requirements "in accordance with the timelines articulated in the rule. | The CQS has been modified to indicate that Phase 1 will be completed by December 31, 2015 – with each subsequent phase lasting one year. |
| CMS has explicitly determined that Vermont must operate its 1115 waiver, as to ***all*** HCBS services, in compliance with the amended regulations (emphasis added). | The CQS requires the AHS/DVHA to provide a detailed description of the state's assessment of compliance with the home and community-based settings requirements for Choices for Care services not authorized under the Medicaid State Plan (e.g., adult family care). Based on considerable stakeholder interest, Vermont is taking this opportunity to further assess programs/settings for GC |

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| | Demonstration populations who are designated by the State as persons with Special Health Care needs under 42 CFR 438. |
| The CQS Home and Community Based Services (HCBS) (page 15) states "Special focus is placed on long term care services and supports (CFC) populations and addresses the following…" Again, there is no reference to other Home and Community Based Service populations covered by the HCBS rules such as Developmental Services, Traumatic Brain Injury and CRT service recipients. The CQS should provide detailed information on adherence to state and federal standards of care, person-centered planning and integrated care settings, comprehensive and integrated service packages, qualification of providers, and participant protections for these HCBS populations, not just Choices for Care recipients. | Please see response above. |
| Additionally, the CQS states "The AHS/DVHA must determine whether services in these settings meet the community standards set forth in the rules." It is unclear what "settings" are being referred to; the HCBS rules apply to all settings in which HCBS are provided and to the settings where individuals receiving those services live. | Please see response above. |
| The introductory sentence (III.d. HCBS Standards page 40) is confusing in that it implies that some HCBS are not covered by the new rules. The services covered by the rule are defined at 42 CFR §441.180. "'Home or community-based services' means services, not otherwise furnished under the State's Medicaid plan, that are furnished under a [1915(c) waiver]." As noted above, although Vermont's is an 1115(a) demonstration waiver, CMS has determined that the HCBS requirements apply. The introductory sentence should be revised by deleting the word "certain." | Please see response above. |

General Comments

| Public Comment | State Response |
|---|---|
| At page 40, last sentence, the CQS states that "HCBS provided to a member in his or her own home are assumed to meet the requirements of the new rule." Please provide the source or reference for this assertion. | The regulations allow states to presume the enrollee's private home or the relative's home in which the enrollee resides meet the requirements of HCB settings – this statement can be found in a response from CMS found here http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/q-and-a-hcb-settings.pdf |

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| At page 41 the third full paragraph appears to contain a syntactical error in the sentence "The Special Terms and Conditions of the Global Commitment Waiver require the Choices for Care Program HCBS assure…" | Thank you for your feedback. Edits were made to the draft CQS to correct the error in the sentence. |
| The third sentence of the fourth full paragraph on page 40 states "Based on considerable stakeholder interest, AHS plans to engage stakeholders in conversations about the Vermont rules and policies that govern other Global Commitment programs to discuss where person-centered planning and home and community based standards identified above [42 CFR §441.301(c)(1-3) and 42 CFR §441.301(c)(4)] should also be reviewed and monitored." This sentence is confusing at best. | Thank you for your feedback. Edits were made to the draft CQS to enhance clarity. |
| The CQS fails to demonstrate the state's compliance with the HCBS requirements and does not suffice as the Statewide Transition Plan required by 42 CFR §441.301(c)(6). | The CQS identifies the framework and strategy for achieving and maintaining compliance with the federal HCBS requirements for Choices for Care HCBS programs. Specifically, the CQS contains the following Transition Plan elements:<br><br>d. A detailed description of the state's assessment of compliance with the home and community-based settings requirements for adult family care. Please see attached document for an update on progress to date. The assessment process is expected to be completed by December 31, 2015. Depending on the outcome of the initial assessment - the state may choose to conduct site specific evaluations.<br><br>e. A detailed description of the remedial actions the state will require to assure full compliance with the home and community-based settings requirements for adult family care settings, including timelines, milestones and monitoring process. It is anticipated that all settings will be fully compliant by March 17, 2019.<br><br>f. A description of the public input process, with a summary of public comments. Vermont is committed to ensuring that our statewide Comprehensive Quality Strategy (CQS) is reviewed publicly and that public input is incorporated into the final strategy. The CQS is subject to public input, as required at 42 CFR 441.301(6)(B)(iii) and 42 CFR 441.710(3)(iii).<br><br>The CQS is subject to CMS review and approval. |

Assessment and Self-Assessment

<table>
<tr><th>Public Comment</th><th>State Response</th></tr>
<tr><td>VHCA is concerned about how ERC providers, including those geographically located in the vicinity of a nursing facility, will be assessed by the State.</td><td>The CQS has been modified to indicate that Phase 1 will be completed by December 31, 2015 – with each subsequent phase lasting one year. The state will include stakeholder engagement opportunities in each phase of its assessment. This will include multiple opportunities for ERC and other providers to engage the state with concerns, comments and suggestions. Table 3 below outlines Vermont's phased approach to implementing the new HCBS rules identified in their waiver STCs.<br><br>Table 3: Global Commitment to Health Specialized Program Assessment and Quality Phases
<table>
<tr><td></td><td colspan="5">GC Specialized Program Assessment and Quality Phases</td></tr>
<tr><td></td><td>Choices for Care</td><td>Developmental Services</td><td>Traumatic Brain Injury</td><td>Community Rehabilitation and Treatment</td><td>Children with a Severe Emotional Disturbance</td></tr>
<tr><td>Quality Strategy Timeline</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Phase 1: Due 12/31/15</td><td>✓</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Phase 2: Due 12/31/16</td><td>✓</td><td>✓</td><td>✓</td><td></td><td></td></tr>
<tr><td>Phase 3: Due 12/31/17</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td></tr>
<tr><td>Phase 4: Due 12/31/18</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td><td>✓</td></tr>
</table></td></tr>
<tr><td>Did you complete an assessment?</td><td>The CQS requires the AHS/DVHA to provide a detailed description of the</td></tr>
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| | |
|---|---|
| | state's assessment of compliance with the home and community-based settings requirements for Choices for Care services not authorized under the Medicaid State Plan (e.g., adult family care). The assessment process is expected to be completed by December 31, 2015. |
| VHCA believes that early engagement of ERC providers is critical to ensure we retain an adequate provider network to meet the needs of Vermonters. | Please see response above. |
| Also, the STCs clarify that the state must include in its CQS a "self-assessment of MLTSS adherence to state and federal standards of care…" | Please see response above. |

Performance Measures

| Public Comment | State Response |
|---|---|
| Metrics, benchmarks, and targets are unspecified for all long term services and supports nor does the CQS lay out a process by which AHS will select appropriate metrics and set improvement targets. | The CQS has been edited to include the process by which AHS will select appropriate metrics and set improvement targets. |
| No measures are provided for populations receiving Home and Community Based Services, specifically; individuals enrolled in Choices for Care, or receiving Developmental Disability, Traumatic Brain Injury or Community Rehabilitation and Treatment (CRT) HCBS. | Please see response above. |
| HCBS performance measures in the areas of level of care determinations, planning process, outcome of person-centered goals, health and welfare, outcomes, quality of life, effective process, community integration and assuring there are qualified providers and appropriate HCBS settings | Please see response above. |

Improvement Strategies

| Public Comment | State Response |
|---|---|
| The CQS includes a table listing a number of best practices that are consistent with the regulatory requirements under the HCBS Rule. However, the table is not linked to any specific strategy that AHS intends to deploy in reviewing service quality. | Vermont assesses the quality and appropriateness of care delivered to Medicaid managed care enrollees through: State Internal monitoring, Quality Indicators monitoring; Performance Improvement Projects (PIP), Compliance with federal and state regulations, and External Quality Review Organization (EQRO) activities, including the EQRO Annual Report. |

Monitoring of CQS

| Public Comment | State Response |
|---|---|
| The CQR does not describe what role, if any, an EQRO might play in assessing quality metrics in MLTSS for HCBS, including evaluating compliance with the HCBS rule. We would like to take this opportunity to urge the Department to include external review and to make this an explicit part of the CQS as it applies to DS, TBI, and CRT. | AHS will contract with an External Quality Review Organization (EQRO) to conduct activities outlined in Subpart E of 42 CFR 438. The EQRO is used to review MCE compliance with AHS specified standards for quality program operations, validation of AHS-required performance measures, and validation of AHS required performance-improvement projects. The EQRO will submit a technical report to AHS which will be used to guide quality assessment and improvement efforts. The EQRO report will: assess the MCE's strengths and weaknesses with respect to quality, timeliness and access to health care services; provide recommendations for improving quality of programs/services and care furnished by AHS/DVHA; and evaluate the implementation and effectiveness of the Quality Strategy |