STATE OF VERMONT
AGENCY OF HUMAN SERVICES
Department of Vermont Health Access (DVHA)

AHS Bulletin No: 12-05

Secretary of State's ID Number: ##P-###

FROM: Mark Larson, Commissioner
Department of Vermont Health Access

DATE: 5/25/12

SUBJECT: State Fiscal Year 2013 Expedited Cost Sharing Changes

CHANGES ADOPTED EFFECTIVE: 07/01/2012

TYPE OF RULE CHANGE

X **Adopted Rule Changes - Expedited**

Final Proposed Rule Change

Proposed Rule Change

RULE REFERENCE(S):

5441 5555 5650 7101

These expedited rule changes are being implemented as directed by (H.781) Act 162 of the 2011-2012 Legislative Session, An Act Making Appropriations for the Support of Government.

Sec. E.307 33 V.S.A. § 2073 is amended to read:
§ 2073. VPHARM ASSISTANCE PROGRAM
(d)(1) An individual shall contribute a co-payment of $1.00 for prescriptions where the cost-sharing amount required by Medicare Part D is less than $30.00, and a co-payment of $2.00 for prescriptions where the cost-sharing amount required by Medicare Part D is $30.00 or more. A pharmacy may not refuse to dispense a prescription to an individual who does not provide the co-payment.

Sec. E.307.1 33 V.S.A. § 2074(c) is amended to read:
(c) Benefits under VermontRx shall be subject to payment of a premium and co-payment amounts by the recipient in accordance with the provisions of this section.

(4) A recipient shall contribute a co-payment of $1.00 for prescriptions costing less than $30.00, and a co-payment of $2.00 for prescriptions costing $30.00 or more. A pharmacy may not refuse to dispense a prescription to an individual who does not provide the co-payment.

Sec. E.307.2 VHAP AND MEDICAID CO-PAYS
(a) The following co-payments for individuals enrolled in the VHAP and Medicaid programs are hereby authorized and set by the general assembly, pursuant to 33 V.S.A. § 1901(b), and may be promulgated in rules by the secretary of human services or designee, in accordance with 33 V.S.A. § 1901(a)(1), and are effective upon adoption of rules pursuant to Sec. E.307.10 of this act:

(1) co-payments that apply to prescriptions and durable medical equipment/supplies: enrolled individuals shall contribute a co-payment of not more than $1.00 for prescriptions or durable medical equipment/supplies costing less than $30.00, a co-payment of $2.00 for prescriptions or durable medical equipment/supplies costing $30.00 or more but less than $50.00, and a
co-payment of $3.00 for prescriptions or durable medical equipment/supplies costing $50.00 or more;
(2) co-payments that apply to hospital outpatient services: not more than $3.00 per hospital visit;
(3) co-payments that apply to hospital emergency room services: for individuals enrolled in VHAP, $25.00 per hospital visit;
(4) co-payments that apply to hospital inpatient stays: for individuals enrolled in Medicaid, the $75.00 co-payment for inpatient hospital stays is eliminated.

The intent of these changes is to ensure that individuals continue to have affordable access to coverage and bring copayment obligations into alignment across eligibility groups.

The specific rule changes are as follows: elimination of the Medicaid $75.00 inpatient admission co-pay; implementation of a $3.00 co-pay for the VHAP waiver expansion population for outpatient hospital services (thus aligning copayment requirements with copayment requirements for individuals enrolled in traditional Medicaid eligibility groups); implementation of a $3.00 co-pay for the VHAP waiver expansion population for prescriptions costing $50.00 or more (thus aligning copayment requirements with copayment requirements for individuals enrolled in traditional Medicaid eligibility groups); and implementation of nominal co-pay requirements for Durable Medical Equipment (DME) and medical supplies for both traditional Medicaid and VHAP, this change also clarifies language in the VPharm and VScript programs per statute further defining $1.00 co-payment as being applied to prescriptions costing $29.99 or less than $30.00.

Sec. E.307.10 EXPEDITED RULES
(a) Notwithstanding any contrary provision in 3 V.S.A. chapter 25, and in order to implement Sec. E.307.2(a) (VHAP and Medicaid co-pays) of this act, the agency of human services may adopt expedited rules in accordance with this section. Expedited rules under this section shall have the full force and effect of rules adopted under 3 V.S.A. chapter 25.
(b) Notwithstanding 3 V.S.A. chapter 25 and Sec. F4 of No. 146 of the Acts of the 2009 Adj. Sess. (2010), the agency shall:
(1) Adopt the expedited rule without prefiling or filing in proposed or final proposed form, and adopt the expedited rule after whatever notice and hearing that the agency finds to be practicable under the circumstances. The agency shall make reasonable efforts to ensure that expedited rules are known to persons who may be affected by them. These efforts may occur prior to passage of this act and also shall occur on adoption of the rules by the agency.
(2) File expedited rules adopted under this section with the secretary of state and with the legislative committee on administrative rules. The legislative committee on administrative rules shall distribute copies of expedited rules to the appropriate standing committees.
(3) Ensure that expedited rules adopted under this section shall include as much of the information required for the filing of a proposed rule as is practicable under the circumstances.
(c) On a majority vote of the entire committee, the committee may object under this subsection if an expedited rule is:
(1) beyond the authority of the agency;
(2) contrary to the intent of the legislature; or
(3) arbitrary.
(d) When objection is made under subsection (c) of this section, on majority vote of the entire committee, the committee may file the objection in certified form with the secretary of state. The objection shall contain a concise statement of the committee's reasons for its action. The secretary shall affix to each objection a certification of its filing and as soon as practicable transmit a copy to the agency. After a committee objection is filed with the secretary under this subsection, to the extent that the objection covers a rule or portion of a rule, the burden of proof thereafter shall be on the agency in any action for judicial review or for enforcement of the

rule to establish that the part objected to is within the authority delegated to the agency, is consistent with the intent of the legislature, and is not arbitrary. If the agency fails to meet its
burden of proof, the court shall declare the whole or portion of the rule objected to invalid. The failure of the committee to object to a rule is not an implied legislative authorization of its substantive or procedural lawfulness.

Specific Changes to Rule Sections Since the Last Filing

Section	**Description of Change**
5441	Second paragraph, delete: *$29.99 or*, and add: *than $30.00*
5555	First paragraph, delete: *$29.99 or*, and add: *than $30.00*
5650	Second paragraph, delete: *$29.99 or*, and add: *than $30.00*
7101.2 (C)	First paragraph, delete: *ANFC related… age 21 and older and SSI related Medicaid beneficiaries*; delete: *18*, and, add: *21*; delete: *…enrolled in a managed health care plan*; first bullet, delete: *$75.00 for the first day of an inpatient hospital stay in a hospital*; second paragraph, delete: *Medicaid beneficiaries age 21 and older enrolled in a managed health care plan are subject to the following copayment requirements, unless exempt under 4161 (B):*; third bullet, add: *and durable medical equipment/supplies*; third bullet, first item, add: parenthesis to *original or refill*, and add: *or durable medical equipment/supplies*, delete: $29.99, and add: $30.00; third bullet, second item, add: parenthesis to *original or refill*, and add: *or durable medical equipment/supplies*; third bullet, third item, add: parenthesis to *original or refill*, and add: *or durable medical equipment/supplies*.
7101.3 (E)	First paragraph, delete: *ANFC related… age 21 and older and SSI related Medicaid beneficiaries*; delete: *18*, and, add: *21*; delete: *…enrolled in a PCCM*; first bullet, delete: *$75.00 for the first day of an inpatient hospital stay in a hospital*; second paragraph, delete: *Medicaid beneficiaries age 21 and older enrolled in a managed health care plan are subject to the following copayment requirements, unless exempt under 4161 (B):*; third bullet, add: *and durable medical equipment/supplies*; third bullet, first item, add: parenthesis to *original or refill*, and add: *or durable medical equipment/supplies*, delete: $29.99, and add: $30.00; third bullet, second item, add: parenthesis to *original or refill*, and add: *or durable medical equipment/supplies*; third bullet, third item, add: parenthesis to *original or refill*, and add: *or durable medical equipment/supplies*.

Responses to Public Comments

A public hearing is to be held on Monday, June 4, 2012 from 10:00 a.m. to 12:00 p.m. at the Department of Vermont Health Access (DVHA) Conference Room, 289 Hurricane Lane Williston, Vermont.

Written Comments may be submitted no later than 12:00 p.m. on Monday, June 4, 2012 to Greg Needle, DVHA, 312 Hurricane Lane, Suite 201, Williston, Vermont 05495, via email: greg.needle@state.vt.us, or by Fax: (802)-879-8224.

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To get more information about the Administrative Procedures Act and the Rules applicable to state rule making go to the website of the Department of the Vermont Secretary of State at: http://vermont-

archives.org/aparules/index.htm or call Louise Corliss at 828-2863. [General information, not specific rule content information]

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For information on upcoming hearing before the Legislative Committee on Administrative rules go to the website of the Vermont Legislature at: http://www.leg.state.vt.us/schedules/schedule2.cfm or call 828-5760.

5441 Cost-Sharing (01/15/2010, 09-17)

A beneficiary shall contribute the following base cost-sharing amounts, which shall be indexed to the increases established under 42 C. F. R. § 423.104(d)(5)(iv) and then rounded to the nearest dollar amount:

VPharm Premiums

% FPL	Monthly Premium, per Beneficiary
> 150%	$17.00
> 150% but < 175%	$23.00
> 175% but < 225%	$50.00

In addition, a beneficiary shall contribute a co-payment of $1.00 for prescriptions where the cost-sharing amount required by Medicare Part D is less than $30.00, and a co-payment of $2.00 for prescriptions where the cost-sharing amount required by Medicare Part D is $30.00 or more.

A pharmacy may not refuse to dispense a prescription to a beneficiary who does not provide the co-payment.

5555 Co-Payments (01/15/2010, 09-17)

A beneficiary shall contribute a co-payment of $1.00 for prescriptions costing less than $30.00, and a co-payment of $2.00 for prescriptions costing $30.00 or more.

A pharmacy may not refuse to dispense a prescription to a beneficiary who does not provide the co-payment.

5650 Cost Sharing Requirements (01/15/2010, 09-17)

All VScript beneficiaries must pay monthly premiums as specified in 4160 through 4162 to be enrolled in a VScript coverage group.

The following premium amounts apply to VScript.

VScript Premiums

VScript Group Income	Coverage Group Monthly	Program Fee, Per Beneficiary
> 150% < 175% FPL	VScript	$23.00
> 175% < 225% FPL	VScript Expanded	$50.00

In addition, a beneficiary shall contribute a co-payment of $1.00 for prescriptions costing less than $30.00, and a co-payment of $2.00 for prescriptions costing $30.00 or more.

A pharmacy may not refuse to dispense a prescription to a beneficiary who does not provide the co-payment.

7101 Medicaid Benefit Delivery

Eligible beneficiaries receive covered services through either the fee-for-service or a managed health care delivery system. Most beneficiaries are required to receive covered services through a managed health care delivery system. The following beneficiaries are exempt from managed health care enrollment and will receive covered services through the fee-for-service delivery system:

A. home and community-based waiver beneficiaries;

B. beneficiaries living in long-term care facilities, including ICF/MRs;

C. beneficiaries who are receiving hospice care when they are found eligible for Medicaid; D children under age 21 enrolled in the high-tech home care program;

E. beneficiaries who have private health insurance that includes both hospital and physician services or beneficiaries who have Medicare (parts A and/or B);

F. beneficiaries who meet a spend-down who are not enrolled in a VHAP managed health care plan; and

G. beneficiaries whose requirement to enroll in a managed health care delivery system is anticipated to last for three or fewer months based on known changes, such as imminent Medicare eligibility.

If the beneficiary is not exempt under subsections A-G above, he or she will be required to receive covered services through a managed health care delivery system.

Choice Options for Beneficiaries Subiect to the Managed Health Care Delivery System Requirement

Options 1 through 4 below apply to beneficiaries who belong to a category of beneficiaries to whom one or more commercial managed care plans have a contractual obligation to offer plan enrollment.

Option 1 - When the beneficiary belongs to a category of beneficiaries for whom two or more commercial managed care plans have a contractual obligation to offer plan enrollment and the beneficiary resides in a geographic area in which two or more commercial managed care plans have the capacity to accept new plan enrollees, the beneficiary's choice is enrollment in one of the two or more commercial managed care plans available.

NOTE

The standards the department uses to determine the geographic area that a managed health care plan serves are defined in the Medicaid Procedures Manual at P-2443; these standards are in accordance with federal standards for access to care and the Department of Banking, Insurance, Securities and Health Care Administrations Rule 10.

Option 2 - When the beneficiary belongs to a category of beneficiaries for whom one or more commercial managed care plans have a contractual obligation to offer plan enrollment, the beneficiary resides in a geographic area in which only one commercial managed care plan has the capacity to accept new plan enrollees, and the beneficiary's city or town of residence is served by two or more PCCM providers who are available, ac'cessible, and appropriate, the beneficiary's choice is between enrollment in the one commercial managed care plan available or enrollment in the PCCM program. This option is subject to approval by the Centers for Medicare and Medicaid Services.

Option 3 - When the beneficiary belongs to a category of beneficiaries for whom one or more commercial managed care plans have a contractual obligation to offer plan enrollment and all commercial managed care plans lack the capacity to accept new plan enrollees, and the beneficiary's city or town of residence is served by two or more PCCM providers who are available, accessible, and appropriate, the beneficiary's choice is to enroll in the PCCM program. This option is subject to approval by the Centers for Medicare and Medicaid Services.

Option 4 - When the beneficiary belongs to a category of beneficiaries for whom one or more commercial managed care plans have a contractual obligation to offer plan enrollment and all commercial managed care plans lack the capacity to accept new plan enrollees, and the beneficiary's city or town of residence is served by only one PCCM provider who is available, accessible, and appropriate, the beneficiary's choice is to select the PCCM program or choose to receive services through the fee-for-service system. This option is subject to approval by the Centers for Medicare and Medicaid Services.

Options 5 and 6 below apply to beneficiaries who belong to a category of beneficiaries for whom enrollment in a commercial managed care plan is not available due to absence of a plan that has a contractual obligation to offer plan enrollment to this category of beneficiaries.

Option 5 - When the beneficiary's city or town of residence is served by two or more PCCM providers who are available, accessible, and appropriate, the beneficiary's choice is to enroll in the PCCM program. This option is subject to approval by the Centers for Medicare and Medicaid Services.

Option 6 - When the beneficiary's city or town of residence is served by only one PCCM provider who is available, accessible, and appropriate, the beneficiary's choice is to enroll in the PCCM program or choose to receive services through the fee-for-service system. This option is subject to approval by the Centers for Medicare and Medicaid Services.

When none of the above options applies, the beneficiary receives Medicaid-covered services through the fee for service system.

A benefit counselor will assist beneficiaries in making an informed choice among available managed health care delivery system options. When enrollment in a managed care delivery system is not mandatory, a benefits counselor will assist beneficiaries in making an informed choice between enrolling in a managed health care delivery system or remaining in the fee-for-service system.

7101.1 Fee for Service

Payment is made using a fee-for-service reimbursement system for:

- services furnished to beneficiaries not required to enroll in managed health care plans who are ineligible for voluntary enrollment,
- services furnished to beneficiaries who are eligible for voluntary enrollment and have chosen not to enroll,
- certain wrap-around and other services not included in the contracts with managed health care plans, and
- services furnished to beneficiaries during retroactive periods of eligibility or prior to enrollment in managed health care plans.

This process includes the following steps the department, the eligible Medicaid beneficiary and the medical care provider must take for the provider to receive payment for services given to the beneficiary.

The department must:

- give each Medicaid eligible person an identification document showing that the person has been found eligible for Medicaid,
- accept and process all provider claims itself or through its administrative agent, and notify providers of decisions on claims and pay approved claims.

The beneficiary must:

- tell the provider he or she wants the provider's services charged to Medicaid,
- advise the provider if he or she has private health insurance coverage in addition to Medicaid,
- accept liability for any applicable co-payment (see Obligation of Receipts), and
- show the provider his or her identification document if it has been issued.

The provider must:

- verify that the individual is still eligible for Medicaid on the date the service is provided,
- bill any other liable third parties prior to billing Medicaid,
- accept the Medicaid payment rate as payment in full and bill the beneficiary only for any applicable co-payments once Medicaid has been accepted as a source of payment,
- give a Medicaid covered service (see rules 7200 - 7600), and
- file a claim with the department or its agent, including all necessary information about the service and the identifying information from the beneficiary's identification document.

Rules and time limits for these steps are given in rules 4160-4164, 7105-7108, and 7201-7203.

7101.2 Managed Health Care Plan

Under a managed health care plan, a per-person payment for a defined array of services is made to the plan each month for each enrolled member.

Upon enrollment, managed health care plans shall provide their members with handbooks that include information such as the following:

- what services are covered and how to access those services;
- the procedures for changing primary care providers;
- the procedures for obtaining specialty referrals;
- services that do not require a primary care provider referral;
- services that are covered as wrap-around benefits;
- appointment procedures and information on what to do in a medical emergency;
- information about member rights and responsibilities;

- information on how to register a complaint or file a formal grievance with the plan.

A. Managed Health Care Plan Services

Medicaid beneficiaries enrolled in managed health care plans are eligible for the same range of medically necessary services as those beneficiaries in the fee-for-service system.

1. Services Requiring Plan Referral

The following services as defined in the State Plan and by regulation are included in

the monthly payments made to the managed health care plans subject to negotiated contract provisions and must be accessed through the beneficiary's primary care provider (Medicaid regulatory citations are indicated where applicable):

- inpatient services (rule 7202);
- outpatient services in a general hospital or ambulatory surgical center (rule 7203);
- physician services (rules 7301-7310);
- medical and surgical services of a dentist (rule 7311);
- covered organ and tissue transplants, including expenses related to providing the organ or doing a donor search (rule 7305);
- home health care (rule 7401);
- hospice services by a Medicare-certified hospice provider (rule 7402);
- outpatient therapy services (home infusion therapies and occupational, physical, speech and nutrition therapy) (rules 7203, 7401);
- prenatal and maternity care (rules 7202, 7301);
- medical equipment and supplies (rules 7504, 7505);
- skilled nursing facility services for up to 30 days length of stay per episode (rule 7601);
- mental health and chemical dependency services (rule 7403.1);

  NOTE: If a participating managed health care plan has a contract with an institution for mental diseases, services are limited to 30 days per episode and 60 days per calendar year.

- podiatry services (rule 7308); Self-Referral Services

2. Self-Referral Services

The following services are also included in the monthly payments made to the health plans, but may be accessed by health plan enrollees from the plan's network providers without a referral from their primary care provider:

- unlimited visits per calendar year to a network gynecological health care provider for reproductive or gynecological care, as well as visits related to follow-up care for problems identified during such visits;
- one mental health and chemical dependency visit (plans may determine the number of visits beyond the initial visit that can be provided before authorization is required

from the plan's mental health and substance abuse intake coordinator, or primary care physician); and

- one routine eye examination every 24 months (rule 7316).

B. Wrap-Around Benefits

Medicaid beneficiaries enrolled in managed health care plans are eligible to receive additional services as defined in the State Plan and by regulation that are not included in the managed health care plan package. Some of these services do not require a referral from the beneficiary's primary care provider and are reimbursed on a fee-for-service basis. Examples of these services are:

- transportation services (rule 7408);
- dental care for children under age 21 (rule 7312) and limited dental services for adults up to the annual benefit maximum (rule 7313);
- eyeglasses for children under age 21 furnished through the department's sole source contractor (rule 7316);
- chiropractic services (rule 7304);
- family planning services (defined as those services that either prevent or delay pregnancy);
- personal care services (rule 7406); and
- prescription drugs and over-the-counter drugs prescribed by a physician for a specific disease or medical condition (rules 7502-7502.6).

C. Cost Sharing

Medicaid beneficiaries age 21 and older are subject to the following copayment requirements, unless exempt under rule 4161 (B):

- $3.00 per day per hospital for hospital outpatient services unless the beneficiary is also covered by Medicare. A beneficiary covered by Medicare has no co-payment requirement for outpatient services.
- $3.00 for each dental visit.
- Prescriptions and durable medical equipment/supplies:
  - $1.00 for each prescription (original or refill) or durable medical equipment/supplies having a usual and customary charge of less than $30.00;
  - $2.00 for each prescription (original or refill) or durable medical equipment/supplies having a usual and customary charge of $30.00 or more but less than $50.00;
  - $3.00 for each prescription (original or refill) or durable medical equipment/supplies having a usual and customary charge of $50.00 or more.

D. Enrollment

1. Choice of Managed Health Care Delivery System

   a. When beneficiaries are required to enroll in a managed health care plan (rule 7101 Option 1), a benefit counselor will assist beneficiaries in making an informed choice among available managed health care plan options. The benefits counselor will initiate a follow-up contact with an individual who has failed to notify the benefits counselor of his or her decision of a plan and will provide additional information if requested to do so. If no choice has been made within 30 days of being contacted, the benefits counselor will assign the individual to a managed care plan using a state-approved algorithm.

      i. All eligible members of a Medicaid group are expected to select the same managed health care plan, except when it creates a hardship or a different plan is indicated for medical reasons. The department reserves the right to determine, in these specific cases, when enrollment in a different managed health care plan is indicated.

      ii. Beneficiaries enrolled in managed health care plans will be required to select a primary care provider (PCP) from among the plan's network of providers. The benefits counselor will provide beneficiaries with information about each plan's provider network so that they may select a PCP at the time of enrollment or when contacted by the plan. A beneficiary who fails to select a PCP will have one assigned by the plan. Once assigned, individuals may make subsequent changes in their PCP every 30 days with fifteen days notice to the managed health care plan. An individual's stated preference is contingent upon the availability of the chosen PCP.

   b. When beneficiaries are required to enroll in a managed health care plan or the PCCM program (rule 7101 Options 2 and 3), a benefit counselor will assist beneficiaries in making an informed choice among available managed health care plans and the PCCM program. The benefits counselor will initiate a follow-up contact with an individual who has failed to notify the benefits counselor of his or her decision to enroll in a plan or the PCCM program and will provide additional information if requested to do so. If no choice has been made within 30 days of being contacted, the benefits counselor will assign the individual to a managed care plan or the PCCM program and a PCCM provider using a state-approved algorithm.

2. Change of Managed Health Care Plan

   Enrollees may change their choice of managed health care plan for any reason within 30 days of the effective date of coverage under a plan. Members may change plans once per year thereafter, and at other times for good cause. Good cause is limited to the following circumstances:

   - The individual notifies the department of a change in his or her place of residence and, as a result, is outside the service area of the plan.
   - The department has found that there is a rational and justifiable reason for determining that good cause exists, or, upon appeal, the Human Services Board finds good cause exists.

   Managed health care plan changes will become effective on the first day of the following month, if all required actions have been completed on or before the 15th day of the prior month. Otherwise, the change shall become effective the first of the second month after all required actions are completed.

At least 30 days prior to the anniversary date, enrollees will receive a notice of their opportunity to renew their enrollment with their current managed health care plan or to choose another plan. Information about the plan options and assistance available in making a selection will be included in the notice.

3. Disenrollment

In rare instances it may become necessary to pursue disenrollment of individuals who are intentionally unresponsive to basic managed care expectations. The following may be disenrolled:

- Individuals who pose a threat to plan employees or other members.
- Individuals who regularly fail to arrive for scheduled appointments without canceling, despite documented aggressive outreach efforts by the managed health care plan.
- Individuals who do not cooperate with treatment and have not made an affirmative decision to refuse treatment, despite documented aggressive outreach efforts by the plan.

Grounds for disenrollment does not include individuals who have cooperated with the plan in its effort to inform them fully of the treatment options and the consequences of their decisions regarding treatment and who have subsequently made an informed decision to refuse treatment.

Plan disenrollment requests must conform to criteria for disenrollment established by the department. Managed health care plans must notify the affected member, or his or her designated representative, in writing, of a plan-initiated request for disenrollment. Only the department may disenroll a member from a managed health care plan.

Individuals remain in the managed health care plan until the department decides to disenroll the individual. Individuals are notified of this decision in writing and of their right to request a fair hearing before the Human Services Board. Medicaid beneficiaries who are disenroIled, unless enrolled in another managed health care plan or the PCCM program immediately thereafter, will receive services through the traditional fee-for-service system.

4. New Enrollees

An individual not enrolled in a Medicaid managed health care plan who joins a Medicaid group will be enrolled in the head of household's managed health care plan. An individual already enrolled in a managed health care plan who joins another Medicaid group will remain in his or her current health plan until the next review. Subsequent changes in managed health care plan enrollment may be made in accordance with provisions under Change of Managed Health Care Plan.

E. Appeals of Managed Health Care Plan Decisions

Beneficiaries enrolled in managed health care plans have the right to appeal medical care decisions made by the managed health care plans based on medical/clinical necessity determinations. Although the medical director of the managed health care plan will make medical/clinical determinations, the department retains the authority to review and affirm or deny such determinations made by the managed care plans.

Beneficiaries first must seek remedy of a medical care decision through the managed health care plan's formal grievance process. The managed health care plan may take up to 15 days to seek resolution of a complaint related to medical care and must address issues in fewer

INTERPRETIVE MEMO

[X] Medicaid Covered Services Rule Interpretation

[ ] Medicaid Covered Services Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed-either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 71 0 **1.3**

Date of this Memo **05/0112008 Page 1 of 1**

This Memo: [X] is New **[ ] Replaces one dated**

QUESTION: Has there been a change in what practitioners may be considered primary care providers (PCP)?

ANSWER: Yes. Act 88 of the Vermont Legislature authorized the OVHA to provide coverage for medically necessary health care services within the Medicaid benefit package provided by a Naturopathic Physician (N.D.). N.D.s must be licensed in Vermont and provide treatment within the scope of their practice as described in chapter **81** of Title 26 of the Vermont Statutes Annotated. N.D.s having either local admitting hospital privileges or a formal arrangement with a physician who have local hospital admitting privileges and arrange 24 hour-a-day / seven days-a-week coverage for their patients may enroll as PCP's with Vermont Medicaid. N.D.s looking to enroll as PCPs should contact EDS and review the Vermont Medicaid Provider Manual for more information.

N.D.s who do not meet the above conditions to become a PCP for Vermont Medicaid are considered specialists. Services from an N.D. as a specialist require a PCP referral.

than 15 days if warranted by the patient's condition. Plans may take up to 30 days to seek resolution of a complaint not related to medical care. The decision of the managed health care plan shall be in writing and shall be sent to the beneficiary and to the department.

If a beneficiary disagrees with the decision resulting from the managed health care plan's grievance process, he or she may request a fair hearing.

A managed health care plan must provide a service if it is determined medically/clinically necessary by the department

7101.3 Primary Care Case Management (PCCM)

The primary care case management (PCCM) program is a managed health care service delivery system that requires a beneficiary to choose a primary care provider (PCP) and to access specified medical care through this provider. The primary care provider (PCP) will provide and coordinate medical care for the beneficiary through direct service delivery or by making appropriate referrals to other providers for necessary services.

Payments are made to providers using the fee-for-service reimbursement method.

For beneficiaries enrolled in the PCCM program specialty services require referral, unless the service is designated as a self-referral service. See rule 710 1.3(D).

A. Definitions

1. “Adverse determination” means a determination by the OVHA that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the OVHA's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced or terminated.

2. “Ambulatory review” means utilization review of health care services performed or provided in an outpatient setting.

3. “Case management” means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

4. “Certification” means a determination by the OVHA or its designated utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the OVHA's requirements for medical necessity, appropriateness, health care setting, level and intensity of care and effectiveness.

5. “Clinical peer” means a health care provider who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically provides or manages the medical condition, procedure or treatment under review.

6. “Clinical review criteria” means the written screening procedures, decision abstracts, clinical protocols, practice guidelines and utilization management and review guidelines used by the OVHA to determine the necessity and appropriateness of health care services.

7. “Director” means the Director of the Office of Vermont Health Access.

8. “Concurrent review” means utilization review conducted during a beneficiary's hospital stay or course of treatment.

9. "Confidentiality code" means the confidentiality requirements applicable to the OVHA under state and federal law.

10. "Credentialing verification" means the process of obtaining and verifying information about a health care provider sufficient to determine if the provider can be enrolled as a participating provider in the Medicaid program.

11. "OYHA" means the Office of Yermont Health Access.

12. "Discharge planning" means the formal process for determining, before discharge from a health care facility, the coordination and management of the care that a beneficiary will receive following the discharge.

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

    a. placing the member's physical or mental health in serious jeopardy; or

    b. serious impairment to bodily functions; or

    c. serious dysfunction of any bodily organ or part.

14. "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

15. "Grievance" means a written or oral complaint submitted by or on behalf of a beneficiary regarding the:

    a. availability, delivery or quality of health care services; or

    b. claims payment, handling or reimbursement for health care services.

16. "Gynecological health care services" means preventive and routine reproductive health and gynecological care, including annual screening, counseling, and treatment of gynecological disorders and diseases in accordance with the most current published recommendations of the American College of Obstetricians and Gynecologists.

17. "Gynecological health care provider" means a health care provider or health care facility that is primarily engaged in providing gynecological health care services.

18. "Health care provider" or "provider" means a person, partnership or corporation, other than a facility or institution, licensed or certified or authorized by law to provide professional health care service to an individual during that individual's medical care treatment or confinement.

19. "Health care facility" means all facilities and institutions, whether public or private, proprietary or nonprofit, that offer diagnosis, treatment, inpatient or ambulatory care to two or more unrelated persons. The term shall not apply to any facility operated by religious groups relying solely on spiritual means through prayer or healing, but includes all facilities and institutions included in 18 V. S. A. §9432(10).

20. "Health care services" or "services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

21. "Medical Director" means a health care provider who is board-certified or board-eligible in his or her field of specialty and who is charged by the OVHA with responsibility for overseeing all clinical activities of the PCCM program, or his or her designee.

22. "Medically-necessary care" is defined at rule 7103.

23. "Network" means all providers participating in Medicaid who have also agreed to act as the primary care provider (PCP) for one or more beneficiary.

24. "Peer review committee" means a committee as defined in 26 V. S. A. §1441, and for purposes of this rule includes any committee established by the OVHA pursuant to 18 V. S. A. §9414(c)(1) and 10.202(G)(1) of this rule.

25. "Person" means a natural person, partnership, unincorporated association, corporation, limited liability company, municipality, the state of Vermont or a department, agency or subdivision of the state, or other legal entity.

26. "Primary care provider" is defined at rule 7101.3(B).

27. "Primary care services" include services provided by providers specifically trained for and skilled in first-contact and continuing care for persons with undiagnosed signs, symptoms or health concerns, not limited by problem origin (biological, behavioral or social), organ system or diagnosis. Primary care services include health promotion, disease prevention, health maintenance, counseling, patient education, case management, and the diagnosis and treatment of acute and chronic illnesses in a variety of health care settings.

28. "Prospective review" or "prior authorization" means utilization review conducted before an admission or a course of treatment. (See also rule 7102.)

29. "Quality assurance program" means a set of procedures and activities designed to safeguard or improve the quality of medical care by assessing the quality of care or service, usually against a set of established standards, and taking action to improve it.

30. "Quality improvement" means the effort to improve the level of performance of and outcomes of treatment delivered to beneficiaries. Opportunities to improve care and service are found primarily by continual examination of, and continual feedback and education about how services are provided.

31. "Quality of care" means the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes, decrease the probability of undesired health outcomes, and are consistent with current professional knowledge.

32. "Referral" means that a PCP has authorized that a beneficiary should have one or more appointments with a health care provider for consultation, diagnosis, or treatment of a medical condition, to be covered as a benefit.

33. "Retrospective review" means utilization review of medical necessity that is conducted after services have been provided to a beneficiary, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

34. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the proposed service.

35. "Secondary verification" means verification of a health professionals credentials based on evidence obtained by means other than direct contact with the issuing source of the credential *(e.g.,* copies of certificates provided by the applying health professional).

36. "Stabilized" means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result or occur before a beneficiary can be transferred.

37. "Urgently-needed care" or "urgent care" means those health care services that are necessary to treat a condition or illness of an individual that if not treated within twenty-four (24) hours presents a serious risk of harm.

38. "Utilization management" means the set of organizational functions and related policies, procedures, criteria, standards, protocols and measures used by the department to ensure that it is appropriately managing access to and the quality and cost of health care services provided to its beneficiaries.

39. "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prior authorization, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

40. "Utilization review guidelines" mean the normative standards for resource utilization for various clinical conditions and medical services that are used by the OVHA in deciding whether to approve or deny health care services.

41. "Utilization review organization" means an entity that conducts utilization review, other than the OVHA performing a review for its own beneficiaries.

B. Primary Care Provider (PCP)

Under this system a payment is made to the primary care provider (PCP) each month for case management services provided to each beneficiary enrolled with the PCP. Family practitioners, general internists, pediatricians, or doctors of general medicine, that are enrolled with Vermont Medicaid may become a PCP in the PCCM program. Specialists may become a PCP only under the conditions described below. The PCP selected by a beneficiary shall coordinate needed medical services. PCPs will be responsible for providing beneficiaries with referrals to specialists when in their judgement it is considered medically necessary; for coordinating all ancillary, outpatient and inpatient services; and for preventing the duplication of services.

If a beneficiary has either a life-threatening condition or disease, or a degenerative or disabling condition or disease, that requires specialized medical care over a prolonged period of time, a specialist with expertise in treating the condition or disease may act as the beneficiary's PCP. If a specialist agrees to act as the PCP, the specialist shall provide and coordinate medical care for the beneficiary through direct service delivery or by making appropriate referrals to other providers for necessary services. The OVHA Medical Director must review and approve of such arrangements before a specialist may become the PCP. Ifthe request is denied by OVHA, the beneficiary has the right to appeal OVHA's decision and to request a fair hearing.

C. Services Requiring a PCP's Referral

The following services must be accessed through the beneficiary's PCP and are subject to the OVHA's prior authorization requirements. Services requiring prior authorization are found in the Provider Manual. (Medicaid regulatory citations are indicated where applicable):

- Inpatient service (rule 7202);

- outpatient services in a general hospital or ambulatory surgical center (rule 7203);
- physician services (rules 7301-7310);
- specialty medical and surgical services of a dentist (rule 7311);
- covered organ and tissue transplants, including expenses related to providing the organ or doing a donor search (rule 7305);
- home health care (rule 7401);
- hospice services by a Medicare-certified hospice provider (rule 7402);
- outpatient therapy services (home infusion therapies and occupational, physical, speech and nutrition therapy) (rules 7203, 7401);
- medical equipment and supplies (rules 7504, 7505);
- skilled nursing facility services (rule 7601);
- podiatry services (rule 7308);

D. Self-Referral Services

The following services may be accessed by beneficiaries without a referral from their primary care provider (PCP):

- unlimited visits per calendar year to a PCCM gynecological health care provider for reproductive or gynecological care, as well as visits related to follow-up care for problems identified during such visits;
- mental health and chemical dependency visits up to benefits of $500 per year. Thereafter, providers must request prior authorization from the department for additional services;
- mental health and chemical dependency services provided by a community mental health center;
- Community Rehabilitation and Treatment Services (CRT);
- one routine eye examination every 24 months (rule 7316) and eyeglasses for children under age 21 furnished through the department's sole source contractor (rule 7316);
- transportation services (rue 7408);
- emergency services (rule 7102.3);
- dental care for children under age 21 (rule 7312) and limited dental services for adults up to an annual benefit maximum (rule 7313);
- chiropractic services (rule 7304);
- maternity/prenatal (rules 7202, 7301);
- family planning services (defined as those services that either prevent or delay pregnancy); and
- personal care services (rule 7406).

E. Cost Sharing

Medicaid beneficiaries age 21 and older are subject to the following co-payment requirements, unless exempt under rules 4161(B):

- $3.00 per day per hospital for hospital outpatient services unless the individual is also covered by Medicare. An individual covered by Medicare has no co-payment requirement for outpatient services.
- $3.00 for each dental visit.
- Prescriptions and durable medical equipment/supplies:
  - $1.00 for each prescription (original or refill) or durable medical equipment/supplies having a usual and customary charge of less than $30.00;
  - $2.00 for each prescription (original or refill) or durable medical equipment/supplies having a usual and customary charge of $30.00 or more but less than $50.00;
  - $3.00 for each prescription (original or refill) or durable medical equipment/supplies having a usual and customary charge of $50.00 or more.

F. Enrollment

1. Choice of Primary Care Provider (PCP)

A benefits counselor will assist beneficiaries in making an informed decision among the choices described in rule 7101, Options 5 and 6.

The benefits counselor will initiate a follow-up contact with an individual who has failed to notify the benefits counselor of his or her decision and will provide additional information if requested to do so. If two or more PCCM PCPs are available and no choice has been made within 30 days of being contacted, the benefits counselor will assign the individual to a PCP using a state-approved algorithm.

2. Change of Primary Care Provider (PCP)

Enrollees may change their primary care provider (PCP) for any reason every 30 days. Primary care provider changes will become effective on the first day of the following month, if all required actions have been completed by the fifteenth of the prior month. Otherwise, the change shall become effective the first of the second month after all required actions are completed.

If a beneficiary has to change PCP as a result of his or her PCP restricting or terminating participation in the PCCM program, the OVHA will assist the beneficiary in selecting another PCP in order to assure continuity of care.

3. Disenrollment

The OVHA has sole authority for disenrolling beneficiaries from the PCCM program. The OVHA may disenroll beneficiaries from the PCCM program for any of the following reasons:

- The beneficiary loses Medicaid eligibility;
- The beneficiary fails to pay required premiums;
- The beneficiary is placed in a nursing facility or ICF-MR for more than thirty (30)

days, enrolls in any other state waiver program, enrolls in the department's “High Tech Home Care” program, or enrolls in Medicare or other comprehensive health insurance plan;

- The beneficiary's change of residence places him or her outside the area where choice of PCCM provider is available, and the beneficiary chooses not to continue enrollment in the PCCM program;
- The OVHA has found that there is a rational and justifiable reason for determining that good cause exists, or upon appeal, the Human Services Board finds good cause exists, as the result of a formal request for disenrollment filed by the beneficiary;
- The OVHA has found that there is a rational and justifiable reason for determining that good cause for disenrollment or transfer to another PCCM provider exists, as the result of a formal request for disenrollment filed with the department by the beneficiary's PCP;
- The OVHA has found that there is a rational and justifiable reason for determining that good cause exists, or, upon appeal, the Human Services Board finds good cause exists; or
- The beneficiary poses a threat to PCCM providers, staff or other beneficiaries.
- The beneficiary regularly fails to arrive for scheduled appointments without canceling, despite documented aggressive outreach efforts by his or her PCP; and
- The beneficiary does not cooperate with treatment and has not made an affirmative decision to refuse treatment, despite documented aggressive outreach efforts by their PCP.

Grounds for disenrollment do not include beneficiaries who have cooperated with their PCP in his/her effort to inform them fully of the treatment options and the consequences of their decisions regarding treatment and who have subsequently made an informed decision to refuse treatment.

The beneficiary will remain enrolled in the PCCM program until the OVHA decides to disenroll or continue the enrollment of the beneficiary. Each beneficiary will be notified of the OVHA's decision in writing and of his/her right to request a fair hearing before the Human Services Board. Beneficiary disenrollments will become effective on an end-of-month basis, but not fewer than five (5) days after the OVHA has made a determination that the beneficiary will be disenrolled.

Individuals who are disenrolled, unless enrolled in a managed health care plan immediately thereafter, will receive services through the fee-for-service system.

4. Conversion of Managed Care Plan Enrollees to the PCCM program

If a beneficiary's delivery system is changed from a commercial managed care plan to the PCCM program, the beneficiary will be assigned to his or her existing PCP. Thereafter, the beneficiary may change his or her PCP according to the provisions of rule 7101.3 F.2.

If the managed care plan members PCP does not participate as a PCP in the PCCM program, the beneficiary will receive covered benefits in the fee-for-service system. The beneficiary's subsequent enrollment in the PCCM program will be deferred for at least six months beyond the date of disenrollment from the managed care plan. The OVHA will make every effort to enroll the beneficiary's provider in the PCCM program prior to the expiration of the enrollment deferral period.

G. Quality Assurance and Utilization Review

1. The OVHA shall ensure that health care services provided to its beneficiaries are consistent with prevailing professionally-recognized standards of medical practice. To that end, the OVHA shall establish and implement procedures ensuring the availability of, accessibility to and continuity of care for each beneficiary consistent with the beneficiary's clinical condition, including procedures for the identification, evaluation, resolution and follow-up of potential and actual problems in their administration and delivery of health care services.

2. The OVHA shall develop and maintain an internal quality assurance program that monitors and evaluates the full range of its health care services across all institutional and non-institutional settings. The quality assurance program shall be fully described in writing and provided to all administrative and clinical staff of the OVHA, and made available to all providers upon request. A summary of the program shall be provided to anyone upon request.

3. The OVHA's quality assurance and utilization management program shall ensure that in making decisions to approve or deny care, it uses not only utilization review standards and guidelines but also clinical case data, information and practice guidelines so as to balance the clinical decision-making process with its cost-containment measures.

4. The OVHA shall have in place the administrative structures, policies, and procedures necessary to support operations that meet the requirements and criteria contained in these rules.

5. The OVHA shall clearly define the organizational relationships and responsibilities for quality assurance functions and assign them to appropriately qualified individuals.

6. The OVHA shall establish effective procedures to develop, compile, and evaluate the statistical and other information necessary to support an effective quality assurance and utilization management program.

7. The OVHA's quality assurance program shall include, but not be limited to, the following components:

   a. A designated committee that is responsible for the OVHA's quality assurance activities. The committee shall include, but not be limited to, at least one beneficiary in the PCCM program and participating providers.

   b. Accountability of the designated committee to the Director of the OVHA through the Medical Director.

   c. Participation in the quality assurance program by the appropriate providers, support staff and beneficiaries. At a minimum, this shall include all PCPs, unless good cause is shown why they should not participate. The OVHA shall establish programs to periodically train such providers, support staff and members to participate meaningfully in the quality assurance program.

   d. Supervision of the quality assurance program by the Medical Director of the OVHA, who shall be a physician licensed in Vermont.

   e. Regularly-scheduled meetings of the designated committee.

f. Minutes or records of the meetings of the designated committee that describe, in detail, the committee's actions, including the problems discussed, recommendations made and any other pertinent information.

H. Quality Management and Improvement

1. The OVHA shall establish an internal system capable of identifying opportunities to improve care. This system shall be structured to identify practices that result in improved health care outcomes, identify problematic utilization patterns, identify those providers that may be responsible for either exemplary or problematic patterns, and foster an environment of continuous quality improvement.

2. The Medical Director shall have primary responsibility for the quality assessment and quality improvement activities required of, and carried out by or on behalf of, the OVHA. The Medical Director shall approve the written quality assessment and quality improvement programs and shall periodically review and revise the program documents and act to ensure their ongoing appropriateness.

3. The OVHA shall use the findings generated by the system to work, on a continuing basis, with network providers and other staff to improve the health care delivered to its beneficiaries.

4. The OVHA shall develop and maintain an organizational program for designing, measuring, assessing and improving the processes and outcomes of health care as identified in its quality improvement program, which shall be under the direction of its Medical Director. The organizational program shall include:

a. A written statement of the objectives, lines of authority and accountability, evaluation tools, including data collection responsibilities, performance improvement activities and an annual effectiveness review of the quality improvement program.

b. An annual written quality improvement plan that describes how the OVHA intends to:

i. analyze both processes and outcomes of care, including focused review of individual cases as appropriate, to discern the causes of variation;

ii. identify the targeted diagnoses and treatments to be reviewed by the quality improvement program each year. In determining which diagnoses and treatments to target for review, the OVHA shall consider practices and diagnoses that affect a substantial number of its beneficiaries or that could place beneficiaries at serious risk. This section shall not be construed to require the OVHA to review every disease, illness and condition that may affect a beneficiary;

iii. use a range of appropriate methods to analyze quality, including:

(A) collecting and analyzing information on over-utilization and under-utilization of services, high-volume and high-risk services, and the continuity and coordination of care for acute and chronically-ill populations;

(B) evaluating courses of treatment and outcomes of health care, including health status measures, consistent with reference data bases such as

current medical research, knowledge, standards and practice guidelines; and

(C) collecting and analyzing information specific to a beneficiary or provider or providers, gathered from multiple sources such as utilization management, claims processing, and documentation of both the satisfaction and grievances of beneficiaries;

(D) compare program findings with past performance, as appropriate, and with internal goals and external standards, where available, adopted by the department;

iv. measure the performance of network providers and conduct peer review activities, such as:

(A) identifying practices that do not meet the OVHA's standards;

(B) taking appropriate action to correct deficiencies;

(C) monitoring providers to determine where they have implemented corrective action; and

(D) taking appropriate action when a provider has not implemented corrective action;

v. use treatment protocols and practice parameters developed with the appropriate clinical input and using the evaluations described in paragraphs (i) and (ii) of this subsection (b), or use acquired treatment protocols developed with appropriate clinical input, and give its providers sufficient information about the protocols to enable them to meet the standards established in the protocols;

vi. evaluate access to care for beneficiaries according to standards established in rule 7101.3, including the travel and waiting time standards;

vii. describe the OVHA's strategy for integrating public health and Agency of Human Services goals with the health services offered to beneficiaries, including a description of the OVHA's good faith efforts to initiate or maintain communication with other AHS departments to develop coordinated services for designated populations;

viii. use preventive health services, such as:

(A) adopting practice guidelines specific to preventive health services that are based on reasonable medical evidence;

(B) establishing effective procedures for informing beneficiaries on a continual basis about health promotion and preventive health services available to them; and

(C) assessing its performance in the use of preventive health services;

ix. implement improvement strategies related to program findings;

x. evaluate periodically, but not less than annually, the effectiveness of the strategies implemented in paragraph (ix) of this subsection (b);

xi. ensure that the PCCM providers and beneficiaries have the opportunity

to participate in developing, implementing and evaluating the quality improvement system; and

xii. provide beneficiaries the opportunity to comment on the quality improvement process.

I. Utilization Review and Management

1. The OVHA shall be responsible for monitoring all utilization review activities carried out by it or on its behalf and for ensuring that all requirements of this rule and other applicable laws and rules are met.

2. The OVHA will meet the standards established by 18 VSA §9414.

3. The OVHA shall implement a written utilization review program that describes all review activities, both delegated and non-delegated, for services provided to its beneficiaries. The program document shall describe the following:

a. procedures to evaluate whether the requested service is a covered service. In the case of new technology or new application of existing technology, the OVHA has a mechanism to evaluate its inclusion among covered services based on reviews of information from appropriate bodies, using professionals in the process;

b. procedures to evaluate the clinical necessity, appropriateness, efficacy or efficiency of health services;

c. the practice guidelines, data sources and utilization review guidelines used in utilization review decision-making;

d. the process by which individual clinical case data, assessments and information are prospectively, concurrently and retrospectively used together with clinical review criteria and utilization review guidelines in making decisions to approve or deny requested health care services;

e. the criteria used to reach utilization review decisions when individual clinical assessments and utilization review guidelines conflict;

f. the process for conducting reviews of adverse determinations;

g. mechanisms to ensure the consistent application of review criteria decisions that, within the scope of coverage limits, are compatible with the unique needs of each individual patient and each presenting situation;

h. the data collection processes and analytical methods used in assessing the utilization of health care services by its beneficiaries;

1. provisions for ensuring the confidentiality of clinical and proprietary information;

J. the organizational structure (for example, utilization review committee, quality assurance committee, or other committee) that periodically assesses utilization review activities and reports to the OVHA Director; and

k.

functionally responsible for the day-to-day management of the utilization review function.

the staff position

4. The OVHA's utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to ensure their ongoing efficacy. The OVHA may develop its own clinical review criteria, or it may purchase clinical review criteria from qualified vendors. These criteria shall be periodically reviewed and updated by the OVHA with the involvement of practicing physicians and other health care providers within the PCCM network. The OVHA shall give relevant clinical review criteria to its network providers, and shall make them available to members upon request.

5. The OVHA shall have a registered nurse or physician immediately available by telephone to render utilization review determinations to its providers outside of normal business hours, when such decisions are required to be rendered outside of normal business hours. . If urgent care is required outside of normal business hours, the request for authorization must be made on the next business day.

6. With regard to utilization review determinations, the OVHA shall ensure that:

   a. individual clinical case assessments, data and practice guidelines for the relevant clinical conditions are given equal or greater weight than utilization review guidelines in making decisions to approve or deny care, with the former taking precedence over the latter when there is a conflict between the two;

   b. all determinations to deny or limit an admission, service, procedure or extension of stay are rendered by the director with the advice of the medical director. Such determinations shall be made in accordance with clinical and medical necessity criteria established in rules 7102 and 7103 and relevant clinical practice guidelines;

   c. it does not retroactively deny reimbursement for a covered service provided to a beneficiary by a provider who relied upon the written or oral authorization of the OVHA or its agents prior to providing the service to the beneficiary, or for a covered service provided to a beneficiary by his or her primary care provider or a specialist who relied upon the written or oral referral of the primary care provider, except in cases where there was material misrepresentation or fraud; and

   d. all authorizations are confirmed in writing within twenty-four hours of being given in a manner that specifies the services authorized, and are included as part of the beneficiary's records.

7. The OVHA shall issue utilization review decisions in a timely manner pursuant to the requirements of rule 7102.

   a. The OVHA shall obtain all information required to make a utilization review decision, including pertinent clinical information.

   b. The OVHA shall have a process to ensure that utilization reviewers apply clinical review criteria consistently.

8. The OVHA shall routinely assess the effectiveness and efficiency of its utilization review program.

9. The OVHA shall have a data system sufficient to support utilization review program activities and to generate management reports to enable it to effectively monitor and manage health care services provided to its beneficiaries.

10. If the OVHA delegates any utilization review activities to a utilization review organization, the OVHA shall maintain effective oversight of those activities, which shall include:

    a. written description of the utilization review organization's activities and responsibilities, including reporting requirements;

    b. evidence of formal approval of the utilization review organization program by the OVHA; and

    c. a process by which the OVHA evaluates the performance of the utilization review organization.

11. The OVHA shall coordinate the utilization review program with its other medical management activities, including quality improvement, data reporting, grievance procedures, and processes for assessing beneficiary satisfaction.

12. The OVHA shall provide beneficiaries and providers with access to its review staff by a toll-free number or collect-call telephone line.

13. When conducting utilization review, the OVHA shall collect only the information necessary to perform the function.

14. Compensation to persons providing utilization review services for the OVHA shall not contain incentives, direct or indirect, for those persons to limit access to medically-necessary care. Compensation to such persons may not be based, directly or indirectly, on the quantity or type of adverse determinations rendered.

J. Procedures for Utilization Review Decisions

1. The OVHA shall maintain written procedures for making utilization review decisions and for notifying beneficiaries, representatives of beneficiaries, and providers acting on behalf of beneficiaries of its decisions.

2. For initial and concurrent review determinations, the OVHA shall, within three (3) working days of obtaining all necessary information regarding the admission, procedure or service requiring a review determination, make the determination and notify the treating provider of the determination by telephone. Written confirmation of the determination will be sent to the provider within twenty-four (24) hours of the telephone notification.

    a. In the case of an adverse concurrent review determination, the beneficiary shall not be liable for any services provided before notification to the beneficiary of the adverse determination. Benefits will continue if a fair hearing is requested.

    b. The OVHA shall establish procedures to expedite initial and concurrent review determinations in cases involving urgently-needed care. In no event shall the OVHA take more than twenty-four (24) hours from the time the service is first requested to make an initial or concurrent review determination for such services.

3. The OVHA shall conduct retrospective review determinations consistent with federal requirements.

4. A written notification of an adverse determination shall include the principal reason or reasons for the determination and instructions on how to appeal the determination and how to request additional information. Within 90 days of PCCM program implementation, the OVHA will add to the written notification, the clinical rationale for the determination including an explanation of the clinical review criteria used to make the determination. The OVHA shall make the actual clinical review criteria available to the beneficiary upon request.

5. The OVHA shall act promptly and in good faith to obtain the information necessary to make utilization review decisions. For purposes of this section, “necessary information” includes the results of any face-to-face clinical evaluation or second opinion that may be required.

6. The OVHA shall have written procedures to address the failure or inability of a provider or a beneficiary to provide all necessary information for utilization review, which shall include a description of the information required for the review. Copies of the procedures are available to all network providers. In cases where the provider or beneficiary will not release the necessary information, the OVHA may deny certification. In no event shall the OVHA penalize a provider for failing to provide a beneficiary's medical records to the OVHA when the beneficiary has not authorized release of the records and the provider is not otherwise obligated by law or regulation to disclose the records.

K. Fair Hearings, Appeals and Grievances

1. Fair Hearings – Beneficiaries may appeal a denial, reduction or termination of benefits by requesting a fair hearing orally or in writing as specified in rule 4154. Beneficiaries must request a hearing within 90 days of the adverse action. The OVHA shall act on a fair hearing within the time frames specified in the Human Services Board rules found at P2127.

2. Expedited Appeal – Beneficiaries may request an expedited appeal orally or in writing of a denial, reduction or termination of urgent care or emergency services. The OVHA shall respond as expeditiously as the beneficiary's medical condition requires, but in no event more than three (3) days after receipt of the information necessary to resolve the appeal. This shall include any appeal related to whether or not the service in question constitutes emergency services or urgent care. Beneficiaries who are dissatisfied with the resolution of an expedited appeal may continue with the fair hearing process.

3. Grievance – Beneficiaries may file a grievance orally or in writing related to complaints about availability, delivery or quality of health care or about claims payment, handling or reimbursement for health care services. The OVHA shall respond to grievances within thirty (30) days after receipt of the information necessary to resolve the grievance. Grievances that relate to a denial, reduction or termination of benefits may be appealed to the Human Services Board.

4. Guidelines for Fair Hearings, Expedited Appeals and Grievances – Fair hearings shall be conducted pursuant to Human Services Board rules. Expedited appeals and grievances shall be conducted pursuant to the following guidelines:

   a. The person or persons reviewing the expedited appeal or grievance on behalf of the OVHA shall not have been involved with the adverse determination or other issue that is the subject of the hearing, appeal or grievance.

   b. The OVHA shall act promptly and in good faith to obtain the information necessary to resolve the appeal or grievance. For purposes of this section, “necessary

information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

c. The OVHA shall document its resolution in writing. The resolution shall contain:

- The names and titles of the person or persons reviewing the appeal or grievance on behalf of the OVHA;
- A statement of the reviewer's understanding of the beneficiary's appeal or grievance;
- The reviewer's decision in clear terms, including the basis or other rationale for the decision in sufficient detail for the beneficiary to understand the decision;
- A reference to the evidence or documentation used by the reviewer in making the decision, including clinical review criteria used to make a determination relating to medical care;
- In the case of expedited appeals a notification that the beneficiary may continue with the fair hearing process, if he or she is dissatisfied with the resolution of the expedited appeal.
- The number of the State Health Care Ombudsman.

d. The OVHA shall provide the beneficiary with all the information in its possession or control relevant to the appeal or grievance process and the subject of the appeal or grievance, including applicable policies or procedures and (to the extent applicable) copies of all necessary and relevant medical records. The OVHA will not charge the beneficiary for copies of any records or other documents necessary to resolve the appeal or grievance.

e. For fair hearings and expedited appeals related to medical care, the OVHA shall provide any covered service that had been denied or restricted for which a reversal has been made by its reviewers or by the Human Services Board.

f. If fair hearing or expedited appeal relates to a concurrent review determination for emergency services or urgent care, the service shall be continued without liability to the beneficiary until the OVHA has notified the beneficiary of its final resolution, consistent with fair hearing rules.

5. Appeals Register - The OVHA shall maintain written records documenting all fair hearings, expedited appeals and grievances received during a calendar year (the appeals register). The OVHA shall retain the register compiled for a calendar year for three years. Each register shall contain, at a minimum, the following information:

- The identity of the beneficiary who filed the fair hearing, expedited appeal or grievance, using a unique identification number assigned consistently to that beneficiary;
- A general description of the reason for the fair hearing, expedited appeal or grievance;
- The date the request was received by the OVHA;
- The date of each review and hearing (if any);

- In the case of an expedited appeal, whether the appeal was resolved or went to fair hearing;
- The number of days it took to gather the information necessary to resolve issue and the resolution of the fair hearing, expedited appeal or grievance.

6. Information - The OVHA shall share the information collected by it in its fair hearing, expedited appeal and grievance processes with the persons responsible for its quality assurance, quality improvement and utilization review and management programs.

7. Procedures - The OVHA will maintain procedures by which persons who are unable to file written appeals may notify the department of a grievance or an appeal. The OVHA shall be responsible for documenting such grievances and providing copies to the beneficiaries for their use, or the use of their representatives.

L. Emergency Services

1. Beneficiaries have access to emergency services twenty-four (24) hours per day, seven (7) days per week, while the beneficiary is within the United States at the time such services are needed.

2. The OVHA shall cover emergency services necessary to screen and stabilize a beneficiary and does not require prior authorization of such services.

3. The OVHA will cover urgently-needed care whether the beneficiary is inside or outside of Vermont. Payment for such services will be made by enrolling the provider, if otherwise eligible, in the Vermont Medicaid program.

4. Any provider providing services under this section shall furnish to the beneficiary's primary care provider all relevant and necessary medical information for the beneficiary's ongoing care.

M. Medical Records

1. Medical Records Practices. The OVHA shall work with its PCCM providers to establish, maintain and use a patient record system that will facilitate the documentation and retrieval of statistically-meaningful clinical information, as follows:

   a. Clinical records should be maintained in a manner that is current, detailed and organized and that permits effective beneficiary care and quality review. Records may be written or electronic.

2. Maintenance of Health Care Information; Confidentiality Procedures. The OVHA shall comply with the confidentiality procedures in 33 VSA § 111, AHS rule 96.1 and applicable federal law.

N. Provider Agreement

1. The OVHA will not include any provision in the PCCM addendum to the provider agreement that prohibits the health care provider ITom disclosing to beneficiaries or potential beneficiaries information about the agreement or the beneficiaries' benefit plan that may affect their health or any decision regarding their health.

2. The OVHA shall not prohibit a PCCM PCP ITom, or penalize a PCCM PCP for, discussing treatment options with beneficiaries regardless of the OVHA's position on the treatment options, or advocating on behalf of beneficiaries within the utilization review or appeals processes established by the OVHA, nor shall it penalize a provider because

the provider in good faith reports to state or federal authorities any act or practice by the OVHA that jeopardizes patient health or welfare.

3. The PCCM agreement shall contain provisions clearly stating the requirements and responsibilities of the PCCM program and participating providers with respect to administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or state requirements. The agreement must allow the provider to participate in the OVHA's quality assurance program, dispute resolution process, and utilization management program.

4. No PCCM agreement shall contain a provision offering an inducement to a provider to forego providing medically-necessary services to a beneficiary.

5. Each PCCM agreement shall contain provisions to ensure the availability and confidentiality of the health records necessary to monitor and evaluate the quality of care, and to conduct medical and other health care evaluations and audits to determine, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to beneficiaries. Each provider agreement shall include provisions requiring the provider to make health records available as required by law to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of beneficiaries, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

6. The PCCM provider agreement shall describe a mechanism for informing each provider participating in its PCCM program on an ongoing and current basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on the services.

O. Network Adequacy

1. The OVHA will not require any beneficiary to be assigned to the PCCM program unless covered health care services, including referrals to participating specialty physicians, are accessible to members on a timely basis, as follows. The OVHA will make a good faith effort to attract sufficient numbers and types of providers to ensure that all covered health care services will be provided without unreasonable delay.

   a. Travel time standards. Travel times for PCCM beneficiaries, under normal conditions from their residence or place of business, generally should not exceed the following:

      - thirty (30) minutes to a network primary care provider;
      - thirty (30) minutes to an outpatient facility for mental health or chemical dependency services;
      - sixty (60) minutes for laboratory, x-ray, pharmacy, general optometry, inpatient psychiatric, MRI and inpatient medical rehabilitation services;
      - ninety (90) minutes for cardiac catheterization laboratory, kidney transplantation, major trauma treatment, neonatal intensive care, and open-heart surgery services; and

- reasonable accessibility for other specialty hospital services, including major burn care, organ transplantation (other than kidneys), and specialty pediatric care.

b. Waiting time standards. Waiting times for appointments should generally not exceed the following:

- immediate access to emergency care;
- twenty-four (24) hours for urgent care;
- two (2) weeks for the initial treatment of non-emergency or non-urgent care, with prompt follow-up care as necessary, including referrals for specialty services;
- ninety (90) days for preventive care (including routine physical examinations); and
- thirty (30) days for routine laboratory, x-ray, general optometry, and all other routine services.

c. The OVHA shall develop and implement written standards or guidelines that address the assessment of provider capacity to provide timely access to health care services.

2. The OVHA will not require any beneficiary to be assigned to the

The OVHA shall, either directly or through contracts or other arrangements, provide the services of primary care providers sufficient to respond to initial and basic care needs of members. The OVHA shall inform its primary care providers of their responsibility to provide referrals and any specific procedures that must be followed in providing referrals.

3. The OVHA shall permit its beneficiaries to make at least two visits per calendar year to a network gynecological health care provider for reproductive or gynecological care, as well as visits relating to follow-up care for problems identified during such visits, without a referral from the beneficiary's primary care providers. All such visits shall be subject to the utilization review procedures used by the department. A gynecological health care provider providing services under this section shall furnish to the beneficiary's primary care provider all relevant and necessary medical information for ongoing care.

4. The PCPs shall ensure the coordination and continuity of care for their patients. For purposes of this section, “coordination and continuity of care” mean that a beneficiary's health care services are managed by the PCP in a manner that facilitates the treatment of a condition, illness or other medical condition, including all primary care services and any necessary referrals. The OVHA shall establish guidelines for referrals to both participating and non-participating physicians and other providers.

5. The OVHA shall permit certain new members to continue to use their previous providers, so long as those providers agree to abide by the OVHA's payment rates, quality-of-care standards and protocols, and to provide the necessary clinical information to the plan, as follows:

- new beneficiaries with life-threatening, disabling or degenerative conditions shall be allowed to continue to see their providers for sixty (60) days from the date of enrollment or until accepted by a new provider within the PCCM program, whichever is shorter; and

- women in their second or third trimester of pregnancy shall be allowed to continue to obtain care from their previous provider until the completion of postpartum care.

6. The OVHA shall establish policies and procedures to ensure the orderly transfer of those beneficiaries whose providers' agreement has expired or been terminated, whether with or without cause, to other health care providers in the PCCM network.

7. The OVHA shall establish policies and procedures through which a beneficiary with a condition that requires ongoing care from a specialist may obtain a standing referral to a participating specialist, subject to the utilization review procedures. For purposes of this provision, “standing referral” means a referral for ongoing care to be provided by a participating specialist that authorizes a series of visits with the specialist for either a specific time period or a limited number of visits, and which is provided according to a treatment plan developed by the beneficiary's primary care provider, the specialist, the beneficiary and the OVHA.

8. The OVHA shall ensure that beneficiaries may obtain a referral to a health care provider outside of Vermont when a health care provider with appropriate training and experience is not available within Vermont who can meet the particular health care needs of the beneficiary, subject to the utilization review procedures of the OVHA. The beneficiary shall not be responsible for any additional costs incurred by the OVHA under this paragraph other than any applicable cost-sharing.

P. Confidential Information

The OVHA shall take the appropriate steps necessary to ensure that information gathered by it in its quality assurance activities shall be confidential and privileged.

Q. Disclosure of Information

The OVHA shall supply to each beneficiary upon enrollment and upon major revision thereafter the following information. The information shall be in handbook form and in twelve-point type, and shall be in plain language. This requirement may be satisfied by giving a copy of the handbook to each household, rather than to each individual beneficiary. The OVHA shall make available to any beneficiary, upon request, a listing by specialty of the name, telephone number and address of all health care providers and health care facilities enrolled in PCCM and Medicaid (including, in the case of physicians, information as to board certification). This list shall be updated (by addendum or otherwise) at least once every six months, and shall indicate which primary care providers are accepting new patients. In addition, the handbook shall include:

1. Coverage provisions, including covered health care services and items, benefit maximums, benefit limitations, exclusions from coverage (including procedures deemed experimental or investigational by the OVHA), restrictions on referral or treatment options, requirements for prior authorization or utilization review, the use of formularies, and any other limitations on the services covered.

2. A description of the rule 7104 procedure for coverage of prescription drugs from manufacturers that do not participate in the federal rebate program. In addition to the criteria contained in rule 7104, the OVHA shall also consider the following criteria in making rule 7104 determinations for prescription drugs. The currently covered drug:

   - has not been effective in treating the patient's medical condition; or
   - causes or is reasonably expected to cause adverse or harmful reactions in the beneficiary.

3. If prior authorization or utilization review is required before obtaining treatment or services, the process a beneficiary must use to obtain that authorization or review, including any time lines that apply.
4. The financial inducements offered to any Medicaid provider or health care facility for the reduction or limitation of health care services. Nothing in this paragraph shall be construed to require disclosure of individual contracts or the specific details of any financial arrangement between the OVHA and a health care provider.
5. The beneficiary's responsibility for payment of premiums, coinsurance, co-payments, deductibles and any other charges, annual limits on a beneficiary's financial responsibility, caps on payments for covered services, and the beneficiary's financial responsibility for non-covered procedures, treatments or services.
6. The beneficiary's financial responsibility for payment when services are provided by a health care provider who is not part of the PCCM network or by any provider after an adverse determination by the OVHA.
7. The criteria used by the OVHA for selecting and credentialing the health care providers it enrolls.
8. The grievance and appeals procedures used to resolve disputes between a beneficiary and the OVHA.
9. A summary of its quality assessment and quality improvement programs.
10. The utilization review procedures of the organization, including the credentials and training of utilization review personnel.
11. The procedure for obtaining emergency services, including any requirements for prior authorization and payment for services rendered outside of Vermont.
12. All necessary mailing addresses and telephone numbers to be used by beneficiaries seeking information or authorization.
13. The process for selecting primary care providers and for obtaining access to other providers in the PCCM network, including any restrictions on the use of network specialists.
14. The procedure for changing primary and specialty care providers within PCCM, including any restrictions on changing providers.
15. How beneficiaries can obtain standing referrals to Medicaid participating specialists, or use specialists or specialized facilities to provide and coordinate their primary and specialty care.
16. The waiting time and travel time standards established in this rule.
17. Whether the health care providers are prohibited from participating in other managed care plans or from performing services for persons who are not members of the PCCM program.
18. Opportunities for beneficiary participation in the development of OVHA policies and in the OVHA's quality assurance and quality improvement activities.
19. The consumer information and services, including the toll-free number for the OVHA Ombudsman.

20. A list of all information available to the beneficiary upon request.