MEDICAID COMPREHENSIVE QUALITY STRATEGY

STATE OF VERMONT
AGENCY OF HUMAN SERVICES

Produced by
Members of the
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TABLE OF CONTENTS

HCBS Transition Plan Preface

Orientation

On October 24, 2016, the Center for Medicare and Medicaid Services (CMS) approved Vermont's request to continue the Global Commitment to Health (GC) 1115 waiver. As per the waiver's Special Terms and Conditions (STCs), Vermont shall expand on the managed care quality strategy requirements at 42 CFR 438.340 and adopt and implement a comprehensive, dynamic, and holistic continuous quality improvement strategy that integrates all aspects of quality improvement programs, processes, and requirements across the state's Medicaid program. This document is known as the Comprehensive Quality Strategy (CQS). Vermont's GC 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. CMS also requires states to submit a State Transition Plan (STP) that documents how they will comply with the new HCBS rules at 42 CFR 441. Rather than developing a separate state 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. Thus, the CQS identifies the framework and strategy for achieving and maintaining compliance with the Medicaid Managed Care regulations found at 42 CFR 438 as well as the new federal HCBS requirements at 42 CFR 441 for all applicable Vermont HCBS programs.

While much of the Comprehensive Quality Strategy (CQS) outlines how Vermont plans to assess and improve the quality of care that Medicaid Managed Care beneficiaries receive, the following three sections of the CQS respond specifically to the requirements of a home and community-based settings transition plan:

- HCBS Transition Plan Preface (pp. 3-15)
- The fourth part of Section III: State Standards (pp. 59-63)
- Appendix A-E VT HCBS Program Systemic Assessments and Work Plans (links on pp. 80 - 84)

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.

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. 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. Based on considerable stakeholder interest, Vermont is taking this opportunity to assess programs/settings for GC Demonstration populations that are designated by the State as persons with Special Health Care needs under 42 CFR 438. An overview of the programs and their settings can be found below.

Choices For Care Program (CFC)

Persons may become eligible for participation in the Choices for Care (CFC) Long-Term Care program by meeting Medicaid Long-Term Care eligibility rules, 1915(c) institutional eligibility rules, GC Demonstration population rules, and by also meeting clinical criteria for High, Highest, or Moderate Needs services. Persons designated as High or Highest Needs must meet nursing facility level of care, and persons with Moderate Needs are at risk for nursing home level of care. Persons with Moderate Needs are eligible for a limited benefit package to assist them in remaining in their home. Ninety-eight percent of CFC consumers meet Medicaid Aged, Blind, or Disabled (ABD) eligibility rules and are in the High or Highest Needs Group (i.e., meeting a nursing facility level of care).

In the CFC program consumers have equal access to an array of traditional State Plan services, including Private Non-Medical Institution Services (PNMI), inpatient, skilled nursing, home–based, and other rehabilitative 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, home-based, and other rehabilitative-based services as part of their person-centered planning process.

Most Choices for Care services are provided to participants in their homes. However, persons may also choose to reside in one of the following out-of-home setting types:

- *Adult Family Care (AFC)* – A 24-hour, home-based, shared living arrangement providing care for no more than two persons unrelated to the provider. Adult Family Care homes must meet DAIL safety and accessibility standards prior to participant placement, with inspections every three years. Each AFC home maintains a contract with a Host Agency responsible for quality oversight and case management services on behalf of the participant. An Adult Family Care Coordinator from the host agency assists the home provider and participants in creating a person-centered care plan and live-in agreement. Home providers do not serve as case managers or guardians for persons in their care.

- *Enhanced Residential Care (ERC)* – Residential Care Homes in Vermont are licensed to provide room, board, and personal care to three or more residents unrelated to the provider. CFC ERC services involve a daily package of services provided to individuals residing in an approved, Vermont Licensed Level III Residential Care Home (RCH) or Assisted Living Residence (ALR). All CFC ERC providers must also be enrolled as Medicaid Assistive Community Care Service (ACCS) providers and receive a Medicaid payment for Assistive Community Care Services (i.e., private non-medical institution), as well as an enhanced residential care payment for services to CFC participants. Prior to participation in the CFC ERC program, providers must request a variance of licensing standards that restrict residential admissions to persons who do not meet

Nursing Facility level of care. In addition to these residential arrangements, CFC participants who are residing in their own homes or in an Adult Family Care setting may also receive Day Health Rehabilitation from a State-Certified Adult Day Service provider. Day Health Rehabilitation is a State Plan service and is defined below.

- Day Health Rehabilitation: Services provided at a Day Health Rehabilitation Center are health assessment and screening, health monitoring and education, nursing, personal care, physical therapy, occupational therapy, speech therapy, social work, and nutrition counseling/services.

Due to the nature of Vermont's Medicaid State Plan, the GC STCs, and Medicaid Managed Care rules, expenditures for the full continuum of service (home based, shared living, enhanced residential, and nursing facility care), commensurate with participant needs and choice, are allowable under Vermont's Section 1115 Demonstration.

Respite Care is a flexible option that is available only to persons who are in home or community settings (i.e. in their own home or in Adult Family Care). Respite may be provided in any setting that the participant chooses. Respite settings may include the persons own home, a Residential Care Home, an Adult Family Care Home, an Adult Day Program or a Nursing Facility. CFC limits the total amount of respite that a beneficiary can receive to 720 hours or 30 days per year. It can be used in hourly increments or 24-hour increments in a residential care home. Variances are allowed.

Companion Care is also an option available only to persons who are in home or community settings (i.e. in their own home or in Adult Family Care). Companion care is provided in the home setting.

In addition to Choices for Care specific program policies, the settings policies and regulations that govern Adult Day, Adult Family Care, Residential Care Home and Nursing Facilities also extend to the Respite services that may be provided in those settings.

Developmental Disabilities Services (DDS)

DDS supports are meant to maximize independence while protecting the health, wellness, and safety of consumers who are considered part of a vulnerable/special health needs population under the Global Commitment to Health Medicaid Managed Care model. Services to children under 21 are expected to focus on developmental growth and assistance with skill building whenever possible. DDS programs for persons over the age of 21 are meant to provide long-term services and supports, and enrollment is frequently expected to be life-long in nature.

The DDS program includes services and supports provided by private non-profit developmental disabilities services providers throughout the state to assist individuals who have a developmental disability to live and work in their communities. Services include service coordination, community supports, employment supports, respite, clinical services, crisis services, home supports, and transportation. Respite allocation is based on a person-centered needs assessment and limited to 30 days. The State's only public institution providing developmental disability services, Brandon Training School, was closed in 1993. The last sheltered workshop was closed in 2002. All program services are provided in the community. Individual support plans and associated services are highly individualized and based on person-centered planning, consumer choice and allowable services as defined in the DDS State System of Care Plan.

Home Supports include services, supports, and supervision provided to individuals in and around their residences up to twenty-four hours a day, seven days a week (24/7). An array of services is provided to individuals, as appropriate, in accordance with an individual planning process that results in an Individual Support Agreement (ISA). The services include the provision of assistance and resources to improve and maintain opportunities and experiences for individuals to be as independent as possible in their home and community. Services include support for individuals to acquire and retain life skills and for maintaining health and safety. Support for home modifications required for accessibility for an individual with a physical disability may be included in Home Supports. Home Supports does not include costs for room and board. Below are the types of residential arrangement available in the DDS program.

- *Supervised Living* - These arrangements include regularly scheduled or intermittent hourly supports provided to an individual who lives in his or her home or that of a family member. Supports are provided on a less-than-full-time (not 24/7) schedule.

- *Shared Living* – These arrangements provide individualized support for one or two adults and/or children in the home of a contracted home provider. Home providers typically have 24-hour, seven-day-a-week responsibility for the individuals who live with them. No more than two individuals may live in or receive respite in the same home. All shared living arrangements must meet DDS safety and accessibility standards prior to participant placement. Home providers are considered independent contractors with a Host Agency responsible for quality oversight and case management services on behalf of the participant. Home providers do not serve as case managers or guardians for persons in their care.

- *Staffed Living* These arrangements provide individualized support for one or two adults and/or children in a home setting. Home settings are staffed on a full-time basis by paid providers. No more than two individuals may live in or receive respite in the same setting. All staffed living arrangements must meet DDS safety and accessibility standards prior to participant placement.

- *Group Living* - These arrangements require the setting to be licensed by the Division of Licensing and Protection. For recipients who are under the age of eighteen, the setting must be licensed by DCF as a Residential Child Care Facility or Foster Home. Group Living arrangements include supports provided in a home setting for three to six people that are staffed full time by paid providers. The Vermont State System of Care Plan does not allow funds to be used to increase the availability of settings that provide residential supports to more than four persons over the age of 18 without approval of the Commissioner; no setting may serve more than six adults. Currently, there are no group settings for children that exceed two participants.

- ICF/DD - An Intermediate Care Facility for people with Developmental Disabilities is a highly structured residential setting for up to six people. ICF/DD settings provide needed intensive medical and therapeutic services.

Traumatic Brain Injury (TBI)

This program diverts and/or returns Vermonters, with a moderate to severe traumatic brain injury, from hospitals and other out-of-state facilities to a community-based or less restrictive residential setting. The goals of the program are intended to support individuals to achieve their optimum independence at home

and help them return to work**.** Vermont's TBI program contains two components: A recovery oriented and rehabilitative program and a long-term support program. A determining factor for acceptance into the TBI includes a person's potential for rehabilitation and recovery. The primary goal of the program is considered short term in nature. Overtime, it is expected that the services and supports necessary will decrease culminating with graduation from the program. Persons who reach their maximum potential in the rehabilitation program, that are subsequently identified as needing long term services and supports, are considered for transfer into the Choices for Care program. However, if a person does not meet the criteria necessary to receive their long-term services and supports from the Choices for Care program, TBI program enrollment is not terminated, the person may be assessed for continuation in the TBI long term care program as openings are available. In State Fiscal Year 2015, the TBI program served 82 individuals, of that group, approximately 27 persons were receiving long term services and support through the TBI program. Currently only 3 people receiving long term service and supports are residing in Residential Facilities and those persons are in the process of transitioning to the Choices for Care Program.

The TBI program includes services and supports provided by private non-profit agencies that specialize in TBI recovery and support throughout the state. Providers must be approved by the TBI program and adhere to certain training, service planning and documentation requirements. All program services are provided in the community. Individual support plans and associated services are highly individualized and based on a variety of functional assessments, the person's medical profile and individual consumer choice about where to receive services.

In most cases, rehabilitative services are provided in the persons own home or family home, however, when this is not possible residential care and supervised living options are available to consumers. All residential settings (3 or more persons) are licensed as Level III or Level IV Residential Care Homes. For persons who receive 1:1 support in supervised living arrangements, the home provider must be working with a host Agency authorized to provide TBI services.

TBI recovery plans may include twenty-four hours a day, seven days a week (24/7) support. An array of services is provided to individuals, as appropriate, in accordance with an individual planning process that results in a Plan of Care. TBI services does not have a specific respite limit and will be provided to the caregiver based on need, as identified in the TBI Service Plan. Respite is used in 24-hour increments. There is a requirement that the caregiver receive 2 days per month of respite which is 24 days per year. Prior authorization by the TBI Program Manager or their designee is required for utilization of respite service. The plan of care is reviewed and approved by TBI Program staff prior to implementation. Services include support for individuals to recover and retain life skills and for maintaining independence, community living, health and safety. For individuals who are not able to return home following their brain injury, residential supports may include the following types of community living and residential arrangements are available.

- *Supervised Living* – These arrangements provide support for persons who require less than 24/7 care and/or supervision during their recovery. Support may be in the persons own home, or in a shared or staffed living situation.

- *Shared Living* – These arrangements provide support to individuals in the home of a contracted home provider. Home providers typically have 24-hour, seven-day-a-week responsibility for the individuals who live with them. Home providers are expected to work closely with the care manager, life skills aid and rehabilitation team to assure care is aligned with rehabilitation goals

and objectives. All supervised living arrangements must meet TBI safety and accessibility standards prior to participant placement. Home providers are considered independent contractors with a Host Agency responsible for quality oversight and case management services on behalf of the participant. Home providers do not serve as case managers or guardians for persons in their care.

- *Staffed Living* - These arrangements provide individualized support for one or two persons in a home setting. Home settings are staffed on a full-time basis by paid providers. All staffed living arrangements must meet safety and accessibility standards prior to participant placement.

- *Residential Facilities* - These arrangements require the setting to be licensed by the Division of Licensing and Protection as a Level III or IV Residential Care Home and also approved by the TBI program to accept participants needing recovery or long-term support.

Community Rehabilitation and Treatment (CRT)

The Department of Mental Health (DMH) and its provider system have a strong dedication to serving persons in their home, community, school, and work settings. The CRT program operates using best practices in psychiatric treatment. Those practices promote rehabilitative and recovery services in the individual's own home. However, when this is not possible, residential recovery options are available to persons experiencing a severe and persistent mental illness. These residential treatment programs are licensed as Therapeutic Community Residences or as Level III Residential Care Homes and may also be enrolled as Assistive Community Care Private Non-Medical Institution (PNMI) providers under the Medicaid State Plan. Housing and Home Supports provide services, supports and supervision to individuals in and around their residences up to 24 hours a day and include:

- *Supervised/Assisted Living* Consists of regularly scheduled or intermittent (hourly) supports provided to an individual who lives in his or her home or that of a family member. These settings are neither provider-owned nor provider-controlled.

- *Group Living* consists of group living arrangements for three or more people, owned and/or staffed full-time by employees of a provider agency. These recovery-oriented arrangements can be short-term or long-term residential arrangements that may or may not include rental subsidies. In the CRT system of care, group living arrangements include all residential programs (long-term residential, transitional residential, or otherwise) that are funded through the CRT program.

- *Intensive Residential Treatment* consists of group arrangements for three or more people, staffed full-time by employees of a provider agency. These arrangements are designed to be recovery oriented and not considered long-term permanent living options.

On a limited basis, the CRT program supports highly individualized Wraparound packages to divert or reduce the need for continued hospitalization; these plans may include placements in shared or staffed settings described below. It is estimated that 30 to 40 persons per year may require this level of support. Enhanced funding is requested and prior-approved on a person-by-person basis:

- *Shared Living Home Providers* are individualized shared-living arrangements for adults, offered within a home provider's home. Home providers are contracted workers and are not considered staff of the host agency in their role as contracted provider.
- *Staffed Living* consists of residential living arrangements for one or two people, staffed full-time by employees of a provider agency.

Enhanced Family Treatment (EFT)

The Department of Mental Health (DMH) and its provider system have a strong dedication to serving children, youth and their family in their home, community and school. Home and community-based services are provided agencies designated by DMH to support in home service packages, however there are times when an out-of-home placement is necessary in order to achieve specific skill development and provide more intensive treatment options. When an out-of-home placement is necessary, they are expected to be short term or intermittent in nature. Placements are approved for up to six months to provide intensive treatment and providers are expected to work in conjunction with the child family to address identified. DMH expects that families will be supported to remain together whenever possible. The family is the cornerstone of treatment; they are not only involved in developing the treatment plan, but are active participants in the treatment and evaluation of services. Active family involvement helps to ensure that treatment services are individualized to the family's needs, are culturally sensitive and appropriate, and support a focus on the family's strengths, resources, and natural supports.

The Enhanced Family Treatment program diverts and/or returns children from psychiatric or intensive residential placement. Services are based on best practice in EPSDT and Wraparound care and are designed to support children in living in a family home with an intensive package of treatment services and supports commensurate with clinical assessments. The major difference between the EFT and other treatment plans is the ability to provide out-of-home community-based therapeutic care. These included:

- *Therapeutic Foster/Respite Care or Shared Parenting*– These arrangements provide individualized support for children in the home of a contracted foster home provider. Foster home arrangements may include 24-hour, seven-day-a-week services or a shared parenting arrangement whereby children live part time in the foster home and part time with their family as members learn new skills and positive coping strategies for family living. DMH authorizes respite to occur with a specified periodicity over the duration of the 6-mo waiver period. EFT plans of care and budgets are reviewed every 6 months, including respite services which involves, but is not limited to, the use of initial clinical assessment data, clinical documentation, and plan of care information. Home providers are expected to work closely with the case manager, family and treatment team to assure care is aligned with family integration goals and the child's treatment plan objectives. Home providers are considered independent contractors with a Host Agency responsible for quality oversight and case management services on behalf of the child. Home providers do not serve as case managers or guardians for children in their care.

- *Transitional Living* - These arrangements are targeted to children and adolescents transitioning to home from psychiatric or intensive residential treatment and adolescents transitioning to adulthood. These settings are required to be licensed by the Department of Children and Families

as a Residential Treatment Facility. Each community setting serves no more than 4 children or youth.

The EFT program includes services and supports provided by private non-profit agencies that specialize in intensive treatment for children who are experiencing severe emotional disturbance and their families. Providers must be approved by DMH program and adhere to certain training, service planning and documentation requirements. All program services are provided in the community. Individual treatment plans and associated services are highly individualized and based on a variety of functional assessments, the child and family's clinical profile, values and cultural preferences and choice about where to receive services.

Palliative Care Program

Medicaid enrolled individuals under the age of 21 living with a serious life-limiting or life-threatening illness or condition are served in Vermont's Palliative Care Program. No equivalent program currently exists in Vermont for Medicaid enrolled individuals over 21 years of age. Palliative Care Program services are delivered using home health agencies and thus default to where they provide services. As a result, the program does not provide services in settings other than an individual's private home or the home of a family member. Vermont presumes that individuals living in their own private home or the home of a family member complies with the HCBS Settings Rule.

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 as well as all Special Health Need Populations served under the Demonstration. Specifically, the CQS contains the following Transition Plan elements:

a. *Systemic Assessments*: These documents assess the existing Vermont regulations and standards related to HCBS delivery to determine if they meet the federal HCBS final rule requirements. One assessment is included for each special health need population. Items are scored as alignment, partial alignment, silent, or non-compliant. All items that do not receive a score of alignment are subject to remediation or corrective action plans and included on the associated Work Plan. Please see **Appendixes A-E** of this strategy for links to individual program Systemic Assessments.

b. *Work (Remediation) Plans*: These documents expand upon the Systemic Assessment by identifying subsequent action steps including timelines, milestones and monitoring process, for the Vermont regulations and standards that did not receive a score of alignment. The action step must resolve the identified issue and bring the Vermont regulation and/or standard into alignment with the federal HCBS final rule. One work plan is included for each special health need population. Please see **Appendixes A-E** of this strategy for links to individual program Work Plans.

c. A description of the *Public Input Process*. Vermont is committed to ensuring that all element of our statewide Comprehensive Quality Strategy (CQS) are reviewed publicly and that public input is incorporated into the final version of the 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 CQS
- Consider public comments and modify the 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/global-commitment-to-health/comprehensive-quality-strategy

Approach

Vermont is taking a phased approach to HCBS setting rule implementation. 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. 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 Implementation Phases				
	Choices for Care	Developmental Services	Traumatic Brain Injury	Community Rehabilitation and Treatment	Enhanced Family Treatment (Mental Illness under 22)
Quality Strategy Timeline					
Phase 1: Due 12/31/15	✓				
Phase 2: Due 12/31/18	✓	✓	✓		
Phase 3: Due 12/31/19	✓	✓	✓	✓	✓
Phase 4: Due 12/31/22	✓	✓	✓	✓	✓

The paragraphs that follow identify the major tasks associated with each phase.

Phase 1: CFC Initiation

This phase begins with updating 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 new HCBS settings rules, and the Special Terms and Conditions of the waiver. During this phase, AHS will establish a framework that sets the stage for the subsequent three phases. Specific milestones in phase one include: conducting a systemic assessment for the Choices for Care program, using the results of the systemic assessment to develop a work plan that identifies remedial action steps, developing an overall remediation strategy, establishing a heightened scrutiny plan and process, drafting a relocation plan and process, proposing a plan for ongoing monitoring, as well as educating stakeholders and consumers re: the process. A link to the CFC **systemic assessments** and **work plans** can be found in Appendix A of this document.

Phase 2: DS, TBI, CRT, and EFT Initiation

This phase broadens the scope of the activities described in phase one to include additional GC Demonstration populations that are designated by the State as persons with Special Health Care needs under 42 CFR 438. During this phase, systemic assessments and work plans (aka remediation plans) are developed for those beneficiaries receiving Developmental Disabilities Services (DS), Traumatic Brain Injury services, Community Rehabilitation Treatment (CRT), and Enhanced Family Treatment (EFT) services. Like the process described above for CFC, the State will determine if there are deficiencies and the best mechanism for remediation and quality improvement. Phase two activities will follow the same process (including stakeholder involvement) and produce documents that contain the same key elements as those generated for the CFC program described in Phase 1 above. Links to the DS, TBI, CRT, and EFT **systemic assessments** and **work plans** can be found in Appendix B-E of this document. Also during this time, the state will begin to implement remediation activities identified in the CFC work plan that was developed in the previous phase. Timelines for the activities will depend on the nature of the corrective action. Changes in legislative rules or statute may take three to twelve (or more) months depending on the committee agenda and nature of the change requested. Changes involving program policies can typically be instituted in one to three months depending on their complexity and the level of stakeholder review required. During this phase, the state also plans to develop survey instruments and protocols to conduct comprehensive site-specific assessments of all HCBS settings to assess the extent to which HCBS settings comply with, are contradictory to or are silent on the requirements under the new HCBS rules. The assessment tool initially identified is a provider self-assessment survey. Copies of provider surveys can be found here: http://dvha.vermont.gov/global-commitment-to-health/hcbs-surveys

In addition, the state will develop a plan to validate the results of the provider-specific self-assessment. At this time, the state plans to validate the results using a mixed-methods approach – using consumer survey as well as data from related oversight and monitoring activities that use a variety of desk and on-site review methodologies and tools. Copies of the consumer surveys can be found here: http://dvha.vermont.gov/global-commitment-to-health/hcbs-surveys

Finally, during this stage, the state will review and modify (as necessary) their overall remediation strategy, heightened scrutiny plan and process, relocation plan and process, and plan for ongoing monitoring. As with phase 1 above, the state will continue to educate and involve stakeholders and consumers in the process.

Phase 3: Initiation and Provider Self-Assessment and Validation

During this time, the state will continue to implement and finalize remediation activities identified in the CFC work plan and begin to implement remediation activities identified in the DS, TBI, CRT, and EFT work plans. As with CFC, timelines for the activities will depend on the nature of the corrective action. Also during this phase, the state also plans to implement the survey instruments and protocols necessary to conduct a comprehensive site-specific assessment of all HCBS settings (i.e., provider assessments and validation activities). In addition, the state plans to draft remediation strategies and corresponding timelines that will resolve issues that the site-specific settings assessment process and subsequent validation strategies identify. Validation activities will be completed by 6/17/19. On or before 7/17/19, a chart will be created showing the number of sites falling into categories of compliance (a) fully compliant with the settings criteria, (b) could come into full compliance with modifications, (c) cannot comply with the federal settings criteria, or (d) are presumptively institutional in nature. Based on the results, remediation will need to be developed for any services, settings, or policies that are determined to not meet the federal HCBS requirements. Please see separate **remediation strategies** section below for more detail. Finally, during this stage, the state will continue to review and modify as necessary their overall remediation strategy, heightened scrutiny plan and process, relocation plan and process, and plan for ongoing monitoring. As with the above phases, the state will continue to educate and involve stakeholders and consumers in the process.

Phase 4: Maintenance

The purpose of the Maintenance phase is to ensure long-term continuity by establishing all activities identified above as a core element and essential monitoring functions within Vermont's Medicaid managed care-like entity. During this phase, the state will finalize items on all Corrective Action Plans that were generated because of the systemic assessment, site-specific settings assessment, or validation activities, and also begin routine monitoring of compliance with the requirements of the new rules for providers for whom no Corrective Action Plan is in effect. Starting with Phase 4, it is expected that the necessary structures and processes will be in place to support ongoing monitoring and oversight activities. 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. More detail can be found in the **ongoing monitoring** section below. The CQS will be updated to capture the outcomes of this work. Full compliance for all GC populations included in this phased approach is expected to take place by March 17. 2022.

Systemic Assessments and Remediation (2/6/17 and 3/17/18)

Systemic Assessments review the existing Vermont regulations and standards related to HCBS delivery to determine if they meet the federal HCBS final rule requirements. Items are scored as alignment, partial alignment, silent, or non-compliant. All items that do not receive a score of alignment are subject to remediation or corrective action plans and included on the associated Work Plan. All programmatic Systemic Assessments were completed on or before 2/6/17. *Work or Remediation Plans* expand upon the System Assessments by identifying subsequent action steps for the Vermont regulations and standards that did not receive a score of alignment. Following the detailed systemic review of each program, the State will determine if there are deficiencies and the best mechanism for remediation and quality improvement. The action step must resolve the identified issue and bring the Vermont regulation and/or standard into alignment with the federal HCBS final rule.

Final timelines will depend on the nature of the corrective action. Changes in legislative rules or statute may take three to twelve (or more) months depending on the committee agenda and nature of the change requested. Changes involving program policies can typically be instituted in one to three months depending on their complexity and the level of stakeholder review required. Systemic Assessment-related Remediation for all programs was completed on or before 3/17/18. Target effective date of new rules and regulations identified through the assessment is on or before 12/31/18.

Site Specific Settings Assessment (6/17/19) and Remediation (3/17/22)

The state plans to develop survey instruments and protocols as well as complete comprehensive site-specific assessments of all HCBS settings to assess the extent to which HCBS settings comply with, are contradictory to or are silent on the requirements under the new HCBS rules. Providers will complete a self-assessment survey instrument to assess their level of compliance with the new rules. To increase the response rate, a process will be created to follow-up with providers failing to meet requested response timeframes. Site Specific Settings Assessment target end date is 6/17/19. Based on the results of the survey and the Validation activities described in Phase 3 above, an authorized representative of each provider will attest in writing whether they believe that their organization's rules and policies are either fully compliant with the new rules or that remediation is necessary. Providers that indicate that remediation is necessary will be required to submit a Corrective Action Plan to the State within 30 days of submission of the provider self-assessment. The State will work with providers, through a corrective action process, to improve the quality of care and the setting characteristics to align with State and federal HCBS standards. During this time, participants will have the choice of continuing to receive services from the provider while the provider implements corrective action to bring the setting into compliance or transition to a new provider. Please see separate **relocation plan and process** section below for more detail. For programs that the State identifies as needing heightened scrutiny, an on-site assessment by State staff will be conducted. Please see following **heightened scrutiny plan and process** section for more detail.

Any Corrective Action Plans and other remediation strategies must be fully implemented by March 17, 2022 so that the entire service delivery system will be compliant with the new rules. The state will incorporate results of settings analysis into a draft version of the CQS/STP and release it for public comment on or before 8/17/19. A final version of the document will be submitted to CMS on or before 10/17/19.

Heightened Scrutiny Plan and Process (10/17/19)

During the systemic assessment process of any of the phases listed above, the State might identify settings that are presumed to have the qualities of an institution. Identification of settings that overcome the presumption will be submitted for heightened scrutiny. The State does not anticipate removing beneficiary choice in settings. In these Specialized Programs, the Section 1115 Demonstration provides an equal entitlement to institutional and community-based services commensurate with a recipient's clinical profile and allowable program services. In addition, many of these specialized services are also available as traditional State Plan or EPSDT services.

The state's process for heightened scrutiny, reviewing settings presumed to be non-HCB and determining if they warrant CMS' heightened scrutiny review, will be part of the onsite review process. Settings and issues will be initially identified through the desk review of member and provider survey responses on or before 7/17/19. Specifically, responses that note a setting is on the grounds of or adjacent to a public institution or appear to be isolating in nature (based upon responses to the community access and integration service category) will be targeted for heightened scrutiny review. The state's process will be consistent with the CMS heightened scrutiny process. Information and evidence will be gathered on settings requiring heightened scrutiny on or before 8/17/19. The state will submit a request, with sufficient evidence, to CMS for heightened scrutiny review on or before 10/17/19 of all settings presumed to be non-HCB (i.e. settings that are institutional or isolating in nature), but that the state believes are appropriate settings for HCBS and that have the qualities of HCB settings. A list of settings requiring heightened scrutiny along with their information and evidence will be incorporated into the final version of the CQS/STP and released for public comment.

Ongoing Monitoring

The Global Commitment Demonstration and State statute allows the Department of Vermont Health Access (DVHA) to function as a Public Managed Care Entity. The Agency of Human Services (AHS) in its role as the Single State Agency is responsible for ensuring that all public managed care functions are clear and properly executed. To effectively and efficiently operate the program DVHA partners with other State Agencies to operate the program using Medicaid Managed Care Rules. In the case of Choices for Care, Developmental Services, and Traumatic Brain Injury, all operational oversight is provided by the Department of Disabilities Aging and Independent Living (DAIL). Thus DAIL, through the DVHA/DAIL partnership and State statute is the entity responsible for on-going monitoring of compliance. In the case of Community Rehabilitation and Treatment and Enhanced Family Treatment, all operational oversight is provided by the Department of Mental Health (DMH). Thus DMH, through the DVHA/DMH partnership and State statute is the entity responsible for on-going monitoring of compliance.

The state will monitor progress on Corrective Action Plans and will also begin routine monitoring of compliance with the requirements of the new rules during the Transition period for providers for whom no Corrective Action Plan is in effect. Monitoring of compliance with the HCBS Final Rule will occur long after the March 17, 2022, federal implementation date. On an ongoing basis, the state will ensure effective monitoring of provider settings to support continued compliance with all applicable HCB settings requirements. The Vermont MCE will have primary operational responsibility for monitoring, with oversight from AHS and an External Quality Review Organization. MCE staff will monitor member experience and compliance with HCB settings requirements by modifying its current monitoring/oversight tools to include the new HCBS requirements. If the MCE identifies a compliance issue during a review, the provider will be notified of the issue and remediation measures will be taken, including but not limited to the development of a CAP, to address the issue. The provider will submit periodic updates to the MCE on the status of implementation. AHS and an External Quality Review Organization will be responsible for overseeing the MCE and will ensure that they adhere to all applicable CMS guidance.

Relocation Plan and Process (Notification Completed 3/17/21 and Relocation Completed 3/17/22)

The state has no plans to remove any of the current services from the system and is committed to supporting the needs and preferences of individuals within the requirements of the HCBS final

regulations. If a provider is found deficient in any area, the State will work with them, through a corrective action process, to improve the quality of care and the setting characteristics to align with State and federal HCBS standards. During this time, participants will have the choice of continuing to receive services from the provider while the provider implements corrective action to bring the setting into compliance or transition to a new provider. In the event of a transition, the state will work with the individual and his/her family/caregiver and provider (existing and new), etc. to develop a smooth transition process that will ensure continuity of care and protect the health and welfare of the individual throughout the process. Through the person-centered planning process, the state will ensure that members make an informed choice from alternative settings that comply with the HCB settings requirements and will provide the necessary supports. Should the State determine that a setting cannot or will not meet required standards; a review of the individualized plan of care for each Specialized Program enrollee living in that setting would occur. Planning would include a discussion of needs and preferences with each participant. The State would notify the member, guardians, case managers, facility support staff, and any other identified responsible parties on or before 3/17/21 that the setting is not in compliance with HCBS settings requirements, not willing to remediate, has been identified for removal from the HCBS System, and that relocation is required. The person and their team would locate another suitable setting within the community. Transition planning and notice would occur based on the individual's clinical needs. In communities where no other options exist, the State may, at its discretion, seek qualified providers through procurement or other designation processes. Beneficiary relocation across all providers will be completed by 3/17/22.

Vermont Global Commitment to Health Comprehensive Quality Strategy

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 all applicable Vermont 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.

Global Commitment to Health Overview

The Vermont Global Commitment to Health Medicaid Section 1115(a) Demonstration was originally approved on September 27, 2005, and implemented on October 1, 2005. The Global Commitment to Health Section 1115(a) Demonstration is designed to use a multi-disciplinary approach to comprehensive Medicaid reform, 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.

As of January 1, 2017, Vermont and CMS extended the Global Commitment to Health Demonstration to further promote delivery system and payment reform to meet the goals of the State working with the Center for Medicaid and CHIP Services, and the Center for Medicare and Medicaid Innovation (CMMI). Consistent with Medicare's payment reform efforts the Demonstrations allow for alignment across public payers. Specifically, Vermont expects to demonstrate its ability to achieve universal access to health care, cost containment, and improved quality of care.

Since 2005, the Global Commitment to Health Demonstration has reduced Vermont's uninsured rate from 11.4 percent in 2005 to approximately 2.7 percent in 2015 through expansion of eligibility and other Accountable Care Act reforms. The Demonstration has also enabled Vermont to address and eliminate bias toward institutional care and offer cost-effective, community-based services. For example, the proportion of Choices for Care participants served in the community has passed fifty percent and continues to increase. In addition, Vermont no longer has a waiting list for individuals in the Highest and High Need Groups under the Choices for Care component of the Demonstration.

Due to the expansion of eligibility under the Vermont State Plan, pursuant to the Affordable Care Act, expansion of eligibility is no longer the primary focus of the Demonstration. However, the Demonstration continues to promote delivery system reform and cost-effective community-based

services as an alternative to institutional care. The State's goal in implementing the Demonstration is to improve the health status of all Vermonters by:

- Promoting delivery system reform through value-based payment models and alignment across public payers;
- Increasing access to affordable and high-quality health care by assisting lower-income individuals who can qualify for private insurance through the Marketplace;
- Improving access to primary care;
- Improving the health care delivery for individuals with chronic care needs; and
- Allowing beneficiaries a choice in long-term services and supports and providing an array of home and community-based (HCBS) alternatives recognized to be more cost-effective than institutional based supports.

The State employs four major elements in achieving the above goals:

1. ***Program Flexibility***: Vermont has the flexibility to invest in certain specified alternative services and programs designed to achieve the Demonstration's objectives (including the Marketplace subsidy program).

2. ***Managed Care Delivery System***: Under the Demonstration the Agency for Human Services (AHS) executes an annual agreement with the Department of Vermont Health Access (DVHA), which delivers services through a managed care-like model, subject to the requirements that would be applicable to a non-risk pre-paid inpatient health plan (PIHP) as defined by the Special Terms and Conditions (STCs).

3. ***Removal of Institutional Bias***: Under the Demonstration, Vermont provides a choice of settings for delivery of services and supports to older adults, people with serious and persistent mental illness, people with physical disabilities, people with developmental disabilities, and people with traumatic brain injuries who meet program eligibility and level of care requirements.

4. ***Delivery System Reform***: Under the Demonstration, Vermont supports systemic delivery reform efforts using the payment flexibility provided through the Demonstration to create alignment across public and private payers.

The initial Global Commitment to Health and Choices for Care Demonstrations were approved in September of 2005 and became effective October 1, 2005. The Global Commitment to Health Demonstration was extended for three years, effective January 1, 2011, and again for three (3) years, effective October 2, 2013. The Choices for Care Demonstration was extended for five (5) years effective October 1, 2010, and became part of the Global Commitment to Health Demonstration in January 2015. The following amendments have been made to the Global Commitment to Health Demonstration:

- 2007: A component of the Catamount Health program was added, enabling the State to provide a

premium subsidy to Vermonters who had been without health insurance coverage for a year or more, have income at or below 200 percent of the FPL, and who do not have access to cost-effective employer-sponsored insurance, as determined by the state.

- 2009: The State extended Catamount Health coverage to Vermonters at or below 300 percent of the FPL.

- 2011: The State included a palliative care program for children who are at or below 300 percent of the FPL and have been diagnosed with life limiting illness that would preclude them from reaching adulthood. This program allows children to receive curative and palliative care services such as expressive therapy, care coordination, family training and respite for caregivers.

- 2012: CMS provided authority for the State to eliminate the $75 inpatient admission co-pay and to implement nominal co-payments for the Vermont Health Access Plan (VHAP) as articulated in the Medicaid state plan.

- 2013: CMS approved the extension of the Global Commitment to Health Demonstration which included sun-setting the authorities for most of the Expansion Populations, including Catamount Health coverage, because these populations would be eligible for Marketplace coverage beginning January 1, 2014. The extension also added the New Adult Group under the State Plan to the population affected by the Demonstration effective January 1, 2014. Finally, the extension also included premium subsidies for individuals enrolled in a qualified health plan whose income is at or below 300 percent of the FPL.

- 2015: In January 2015, the Global Commitment to Health Demonstration was amended to include authority for the former Choices for Care Demonstration. In addition, the State received Section 1115 authority to provide full Medicaid State Plan benefits to pregnant women who are determined presumptively eligible.

Demonstration Goals

The State's high-level goal for all health reforms is to create an integrated health system able to achieve the Institute of Medicine's "Triple Aim" goals of improving patient experience of care, improving the health of populations, and reducing per-capita cost.[1] This is supported in the Global Commitment to Health Demonstration through supporting innovative delivery system reforms, including Medicaid Accountable Care Organizations (ACO) and the development of progressive in-home and community based services and supports that are cost-effective and support persons who have long-term care service and support needs, complex medical, mental health and/or substance use disorder treatment needs. Overarching Demonstration goals are described below:

- ***To increase access to care***: All enrollees must have access to comprehensive care, including financial, geographic, physical, and communicative access. This means having health insurance, appropriate providers, timely access to services, culturally sensitive services, and the opportunity for second opinions as needed.

[1] Crossing the Quality Chasm: A New Health System for the 21st Century. Washington DC: National Academy Press, Institute of Medicine; 2001.

- ***To contain health care cost***: Cost-effectiveness takes into consideration all costs associated with providing programs, services, and interventions. It is measurable at the category-of-service, individual enrollee, aid category, and aggregate program levels.

- ***To improve the quality of care***: Quality refers to the degree to which programs/services and activities increase the likelihood of desired outcomes. The six domains necessary for assuring quality health care identified by the Institute of Medicine (IOM, 2001) are:
    - *Effectiveness*: Effective health care provides evidence-based services to all who can benefit, refraining from providing services that are not of benefit.
    - *Efficiency*: Efficient health care focuses on avoiding waste, including waste of equipment, supplies, ideas, and energy.
    - *Equity*: Equal health care provides care without variation in quality due to gender, ethnicity, geographic location, or socioeconomic status.
    - *Patient Centeredness*: Patient-centered care emphasizes a partnership between provider and consumer.
    - *Safety*: Safe health care avoids injuries to consumers from care that is intended to help.
    - *Timeliness*: Timely health care involves obtaining needed care and minimizing unnecessary delays in receiving care.

- ***To eliminate institutional bias:*** By allowing specialized program participants choices in where they receive long-term services and supports and by offering a cost-effective array of in-home and community services for older adults, people with serious and persistent mental illness, people with developmental disabilities and people with traumatic brain injuries who meet program eligibility and level of care requirements.

Elements

- The Quality Strategy includes, at a minimum, information relating to the following issues: The MCO and PIHP contract provisions that incorporate the standards of Part 438, subpart D;
- Procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs;
- Procedures that identify the race, ethnicity, and primary language spoken of each Medicaid enrollee;
- Procedures that regularly monitor and evaluate the MCO and PIHP compliance with the standards of Part 438, subpart D
- Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO and PIHP contract;
- For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this Part 438;
- An information system that supports initial and ongoing operation and review of the State's quality strategy; and
- Standards, at least as stringent as those in Part 438, subpart D, for access to care, structure and operations, and quality measurement and improvement.

Specialized Programs

Under the GC Demonstration, Vermont is authorized to provide an array of cost-effective in-home and community services. Providers of these services must meet designation, certification and/or additional licensing requirements to be approved by the State to serve the most vulnerable of Vermont's citizens. These specialized programs are designed to support a unique group of beneficiaries, each is outlined below.

- *Choices for Care*: long-term services and supports for persons with disabilities and older Vermonters. The Demonstration authorizes HCBS waiver-like and institutional services such as: nursing facility; enhanced residential care; personal care; homemaker services; companion care; case management; adult day services; and adult family care.

- *Developmental Disability Services*: provides long-term services and supports for persons with intellectual disabilities. The Demonstration authorizes HCBS waiver-like services, including service coordination, residential habilitation, day habilitation, supported employment, crisis services, clinical intervention, respite and self-directed care.

- *Traumatic Brain Injury Services*: provides recovery oriented and long-term services and supports for persons with a traumatic brain injury. The Demonstration authorizes HCBS waiver-like services including crisis/support services, psychological and counseling supports, case management, community supports, habilitation, respite care, supported employment, environmental and assistive technology and self-directed care.

- *Enhanced Family Treatment*: provides intensive in-home and community treatment services for children who are experiencing a severe emotional disturbance and their families. The Demonstration authorizes HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, respite, supported employment, crisis and community supports.

- *Community Rehabilitation and Treatment Program*: provides recovery oriented, in-home and community treatment services for adults who have a severe and persistent mental illness. The Demonstration authorizes HCBS waiver-like services including service coordination, flexible support, skilled therapy services, environmental safety devices, counseling, residential treatment, , supported employment, crisis and community supports.

  Through a special provision as a Designated State Health Program, Community Rehabilitation and Treatment benefits can be extended to individuals with severe and persistent mental illness with incomes between 133 and 150 percent of the federal poverty level, under the Demonstration.

Demonstration Hypotheses

The State has identified the following overarching hypotheses for the Demonstration.

- The Demonstration will result in improved access to care;
- The Demonstration will result in improved quality of care;
- Value-based payment models will promote access to care and appropriate use of resources;
- Improved access to preventive care will result in lower overall costs for the healthcare delivery system;
- Improved access to primary care will result in positive health outcomes;

- Enhanced care coordination will promote timely access to needed care;
- The Demonstration will result in enhanced community integration;
- The Demonstration will maintain or reduce spending in comparison to what would have been spent absent the Demonstration;

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 priority areas.

Table 4: Quality Strategy Priority Areas:

Priority Area	Objective w/Target	Time Frame
Access to Care	AHS will demonstrate a 5% improvement in Preventive care visits of Medicaid managed care beneficiaries over the next five years.	1/1/2017-12/31/2021
	AHS will demonstrate a 5% improvement in the rate of adolescents receiving well care visits over the next five years.	1/1/2017-12/31/2021
	AHS will demonstrate a 5% improvement in the rate of Well-Child Visits in the First 15 Months of Life over the next five years.	1/1/2017-12/31/2021
	AHS will demonstrate a 5% improvement in the rate of Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life over the next five years.	1/1/2017-12/31/2021
	AHS will demonstrate a 5% improvement in enrollee access to dental visits over the next five years.	1/1/2017-12/31/2021
	Percent of dental practices eligible for the incentive payment over the next five years.	1/1/2017-12/31/2021
	Number of dental providers in Vermont that accept Medicaid relative to the total Medicaid population over the next five years.	1/1/2017-12/31/2021
	AHS will demonstrate a 5% improvement in follow-up after hospitalization for mental illness (7 day and 30 day) over the next five years.	1/1/2017-12/31/2021
	AHS will demonstrate a 5% improvement in Children and Adolescents' Access to Primary Care Practitioners over the next five years.	1/1/2017-12/31/2021
	IFS grantees will demonstrate a 2% decrease in the average wait time (in days) between first call requesting services and first appointment offered over the next five years.	1/1/2017-12/31/2021
	AHS will demonstrate a 2% increase in referrals to Early Childhood and Family Mental Health Clinicians during the measurement period over the next five years.	1/1/2017-12/31/2021
	AHS will demonstrate a 2% increase in mid-level developmental assessments/evaluations completed during the measurement period over the next five years.	1/1/2017-12/31/2021
Prevention	AHS will demonstrate a 5% improvement in enrollee chlamydia screening in women over the next five years.	1/1/2017-12/31/2021
	AHS will demonstrate a 5% improvement in enrollee breast cancer screening over the next five years.	1/1/2017-12/31/2021
Chronic Conditions	Medication Management for People with Asthma over the next five years.	1/1/2017-12/31/2021

	AHS will demonstrate a 5% improvement in Initiation and engagement of alcohol and other drug dependence treatment over the next five years.	1/1/2017-12/31/2021
Health Outcomes	AHS will demonstrate a 5% improvement in controlling enrollee high blood pressure over the next five years.	1/1/2017-12/31/2021
Enhanced Care Coordination*	Blueprint (CHT) and VCCI measures TBD	1/1/2017-12/31/2021
	IFS grantees will demonstrate a 2% increase of children who have the CANS administered per the eligibility guidelines in the IFS Procedures Manual over the next five years.	1/1/2017-12/31/2021
	IFS grantees will demonstrate a 2% increase in the percent of clients that have a plan completed within 45 days of referral over the next five years.	1/1/2017-12/31/2021
	AHS will demonstrate a 2% increase in the percent of clients that have a One Plan completed within 45 days of referral over the next five years.	1/1/2017-12/31/2021

*****Objectives w/targets to be identified by the waiver measures work group by December 31, 2017.

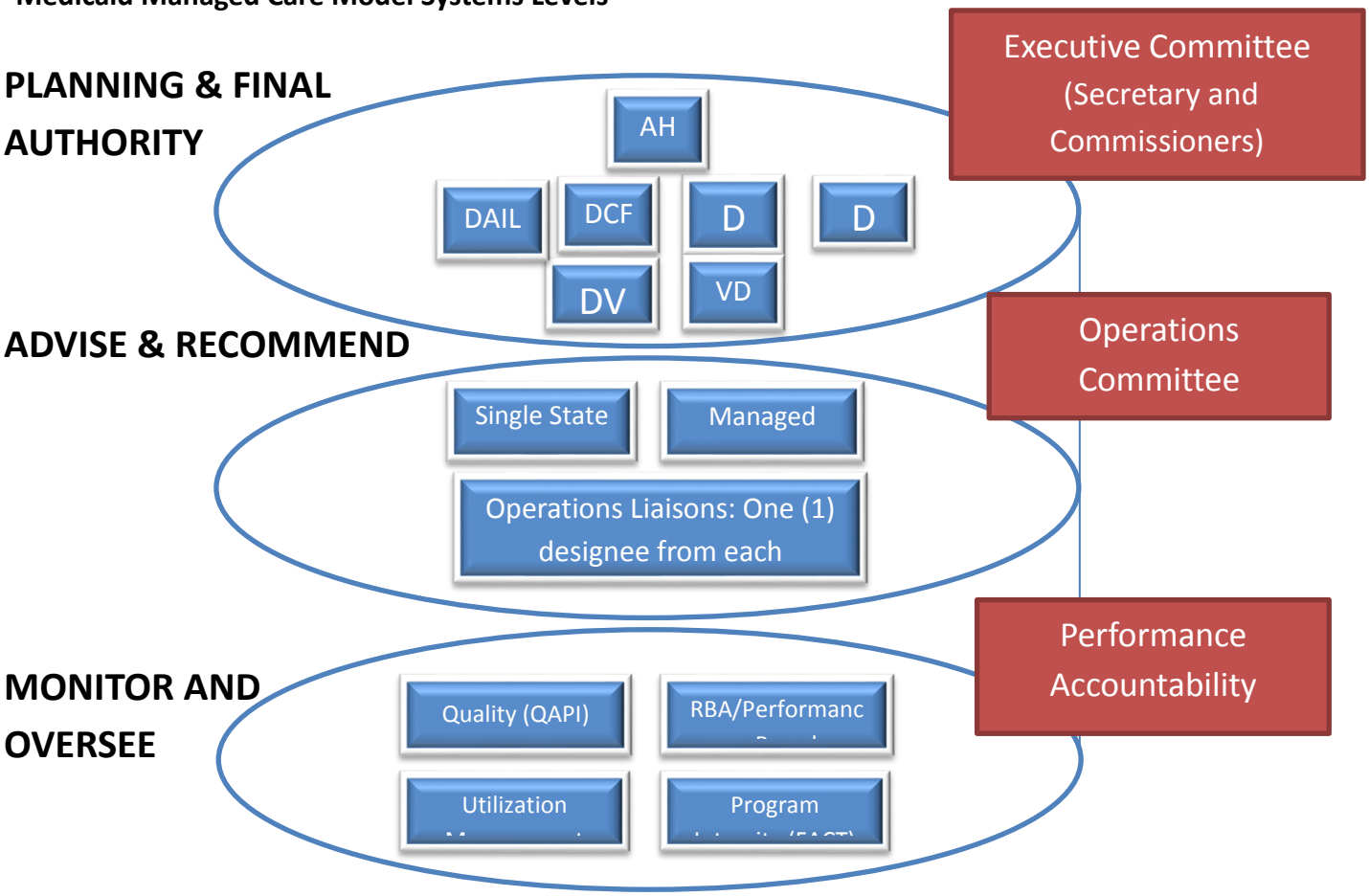
Overview of the Quality Management Structure

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.

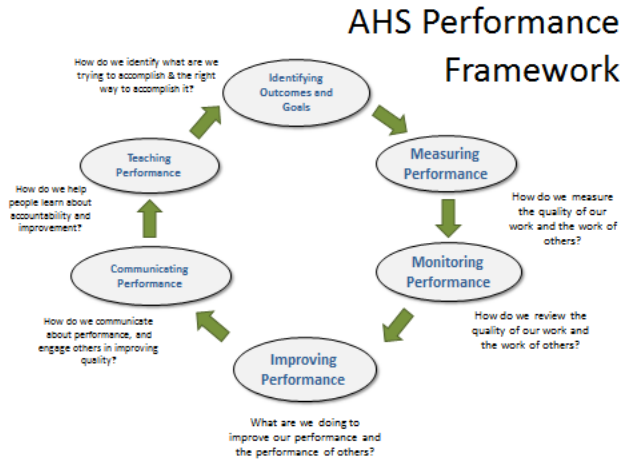
Chair: The Operations Committee chair shall appoint a Performance Accountability chair who will report the Committee's recommendations to the Operations Committee.

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.

Development, Evaluation, and Revision of Quality Strategy

The CQS includes all elements identified in 42 CFR §438.340(b)(1-11). The State of Vermont uses a process to develop, review and revise its CQS that includes internal meetings with key decision makers and external meetings with beneficiaries and other key stakeholders (e.g., advocacy groups, providers, etc.). The State makes the CQS available for public comment before submitting the strategy to CMS for review, including obtaining input from the Medical Care Advisory Committee, beneficiaries, and other stakeholders. The State submits a copy of the initial strategy for CMS comment and feedback prior to adopting it in final.

The State reviews and updates the quality strategy as needed, but no less than once every 3 years. This review includes an evaluation of the effectiveness of the quality strategy conducted within the previous

3 years. 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.

Updates to the quality strategy take into consideration the recommendations provided in the EQRO Annual Technical Report. Results of the review are available on the DVHA web site here. The State submits a copy of the revised strategy whenever significant changes, are made to the document, or whenever significant changes occur within the State's Medicaid program. AHS considers a change in reporting to be significant enough for stakeholder review when the numbers, types, or timeframes of reporting are revised.

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 438.340, 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 provide 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 and Enhanced Family Treatment (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, individuals with mental illness, non-disabled adults, 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	CY2016 RATE
Children	Adolescent Well-Care Visits (AWC)	49.2%	46.85%
	Children and Adolescents' Access to Primary Care Practitioners (CAP)	TBD	TBD
	Well-Child Visits in the First 15 Months of Life (W15) 6 or more visits	70.75%	67.38%
	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	76.23%	72.6%
	Annual Dental Visit (ADV) Total	68.11%	64.87%
Adults	Breast Cancer Screening (BCS)	56.93%	54.22%
	Chlamydia Screening in Women (CHL)	55.15%	52.52%
	Adults' Access to	79.57%	75.78%

	Preventive/Ambulatory Health Services (AAP) Total		
	Medication Management for People with Asthma (MMA) Total	74.68%	71.12%
Mental Illness	Follow-Up After Hospitalization for Mental Illness (FUH) 7 and 30 days	45.27% & 62.53%	43.11% & 59.55%
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	36.74% & 15.04%	34.99% & 14.32%
Choices for Care (CFC)	*Ambulatory Care*	TBD*	TBD*
Developmental Disability Services (DS)	*Ambulatory Care*	TBD*	TBD*
Traumatic Brain Injury (TBI)	*Ambulatory Care*	TBD*	TBD*
Community Rehabilitation and Treatment (CRT)	*Ambulatory Care*	TBD*	TBD*

* Targets and benchmarks (where applicable) will be identified by the waiver measures work group by December 31, 2017.

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 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. The state will work with CMS to further define metrics, as appropriate, for collection.

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. External Quality Review (EQR)

As per 42 CFR 438.350, the State contract with a qualified External Quality Review Organization (EQRO) to perform an annual external quality review of its PIHP entity. 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 State follows an open, competitive procurement process that is in accordance with State law and regulations when contracting with an EQRO. In addition, the State complies with 45 CFR part 75 as it applies to State procurement of Medicaid services during the EQRO contracting process.

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 determine compliance with the standards set forth in 42 CFR §438 subpart D and the quality assessment and performance improvement requirements described in §438.330, validate performance measures required in accordance with §438.330(b)(2) during the preceding 12 months , validate performance improvement projects required in accordance with §438.330(b)(1) that were underway during the preceding 12 months, and validate network adequacy during the preceding 12 months to comply with requirements set forth in §438.68. In addition, the EQRO provides technical guidance to the PIHP to assist them in conducting activities related to the mandatory activities that provide information for the EQR and the resulting EQR technical report. 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 State ensures that the EQR activities result in an annual detailed technical report that summarizes findings on access and quality of care, including:

(1) A description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the PIHP.

(2) For each EQR-related activity conducted in accordance with §438.358:
(i) Objectives;
(ii) Technical methods of data collection and analysis;
(iii) Description of data obtained, including validated performance measurement data for each activity conducted in accordance with §438.358(b)(1)(i) and (ii); and
(iv) Conclusions drawn from the data.
(3) An assessment of the PIHP's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
(4) Recommendations for improving the quality of health care services furnished by each PIHP including how the State can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
(5) Methodologically appropriate, comparative information about the PIHPs year over year performance.
(6) An assessment of the degree to which the PIHP has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

The State posts the most recent copy of the annual EQR technical report on the Web site required under §438.10(c)(3) by April 30th of each year and provides printed or electronic copies of the information specified in this report, upon request, to interested parties such as participating health care providers, enrollees and potential enrollees of the PIHP, beneficiary advocacy groups, and members of the general public. In addition, the State makes the information specified in the report available in alternative formats for persons with disabilities, when requested.

III. STATE STANDARDS

1. Access Standards

This section includes a discussion of the standards that the state has established in the DVHA 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	Brief Description
§438.68	**Network Adequacy**
§438.68(b)	Provider specific network adequacy standards and scope
§438.68(d)	Network adequacy exception request process
§438.68(e)	Publication of network adequacy standards
§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(b)(7)	Timely access to family planning providers
§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)(iv)	Mechanisms to ensure compliance by providers
§438.206(c)(1)(v)	Monitoring of network providers to ensure compliance
§438.206(c)(2)	Culturally competent services to all enrollees
§438.206(c)(3)	Physical access, reasonable accommodations and accessible equipment for enrollees with physical or mental disabilities
§ 438.207	**Assurances of Adequate Capacity and Services**
§438.207(a)	Assurances and documentation of capacity to serve expected enrollment
§438.207(b)	Documentation to demonstrate compliance with all §438.207 requirements
§438.207(b)(1)	Offer an appropriate range of preventive, primary care, specialty care and LTSS
§438.207(b)(2)	Maintain network sufficient in number, mix, and geographic distribution
§438.207(c)	Documentation annually and anytime there has been a significant change in operations that would affect capacity and services
§438.208	**Coordination and Continuity of Care**
§438.208(b)(1)	Each enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating services accessed by the enrollee
§438.208(b)(2)	Coordinate services the enrollee receives: between settings of care; with the services the enrollee receives from any other MCE/PIHP; with the services the enrollee receives from fee-for-service Medicaid; with the services the enrollee receives from community and social support providers
§438.208(b)(3)	Make best effort to conduct an initial screening of each enrollees needs within 90 days of the effective date of enrollment for all new enrollees

Regulatory Reference	Brief Description
§438.208(b)(4)	Share with other MCEs, PIHPs, and PAHPs serving the enrollee the results of its identification and assessment to prevent duplication of those activities
§438.208(b)(5)	Ensure maintenance and sharing of enrollee information in accordance with professional standards
§438.208(b)(6)	Privacy protections when coordinating care
§438.208(c)(1)	State mechanisms to identify persons who need LTSS or persons with special health care needs
§438.208(c)(2)	Mechanisms to assess enrollees with LTSS or special health care needs by appropriate health care and LTSS professionals
§438.208(c)(3)	LTSSS or special health care needs treatment/service plans developed by individuals meeting LTSS service coordination requirements and a person trained in person centered planning as defined in §441.301(c)(1) and (2) in consultation with the any providers caring for the enrollee and with enrollee participation ; approved in a timely manner; reviewed and revised at least annually 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)(4)	DVHA may place appropriate limits on a service, such as medical necessity
§438.210(a)(4)(i)	Limits based on criteria specified in the Medicaid State Plan
§438.210(a)(4)(ii)(A)	Ensure that services furnished can reasonably achieve their purpose
§438.210(a)(4)(ii)(B)	Ensure that services supporting persons with LTSS needs or on-going chronic conditions are reflective of enrollee need
§438.210(a)(4)(ii)(C)	Ensure that family planning services are provided in manner that enables the enrollee's freedom to choose the method of family planning to be used
$438.210(a)(5)	Specify what constitutes "medically necessary services" in a manner that is no more restrictive than the State Plan, statutes or regulations or other State policy and procedures
§438.210(b)(1)	DVHA and its subcontractors must have written policies and procedures for authorization of services
§438.210(b)(2)	DVHA must have mechanisms to ensure consistent application of review criteria for authorization decisions and authorize LTSS based in an enrollee's current needs and assessments and consistent with the person-centered service plan
§438.210(b)(3)	Any decision to deny or reduce services is made by an appropriate health care professional
§438.210(c)	DVHA 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

DVHA 42 CFR 438.68 Network Adequacy Requirements

These standards ensure that contract network is adequate to support services to enrollees in a timely and efficient manner. DVHA will maintain the following time, distance standards statewide for all services covered under the contract. Upon request, these standards will be made available at no cost to enrollees with disabilities in alternative formats or through the provision of auxiliary aids and services. Any DVHA requests for exceptions that have been approved by the State will be specified in the AHS/DVHA contract.

Travel time to services must not exceed the limits described below for all regions of the State:
Primary Care (Adult and Pediatric) – 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. DVHA's network will include all Medicaid participating providers, which equates to approximately 80% all providers in the State of Vermont. However, if the travel time standard is exceeded in an area which contains a non-participating provider, DVHA will work aggressively to bring that provider into the network.

OB/GYN -

Behavioral Health (mental health and substance use disorder; adult and pediatric) -

Specialist (Adult and Pediatric) -

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.

Pharmacy -

Pediatric Dental -

LTSS Providers (for provider types in which an enrollee must travel for services) -

Additionally, network adequacy standards, other than time and distance for LTSS providers that travel to the enrollee to deliver services include:

- At least one certified Home Health Agency serving Choices for Care program particpants in each region;
- At least one Designated or Specialized Service Agency (DA/SSA) per region serving persons with developmental disabilities
- At least one certified provider of Traumatic Brain Injury Services per region

In establishing and maintaining this network, DVHA 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 available to enrollees, and whether the location(s) provide physical access for enrollees with disabilities;
- The ability of network providers to communicate in with Limited English Proficiency enrollees in their preferred language;
- The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications and accessible equipment for enrollees with physical and mental disabilities;
- The availability of triage lines or screening systems as well as tele-medicine, e-visits and/or other innovative technological solutions.

AHS Monitoring Activities: The 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 DVHA is able to provide access to health care services as required. AHS will review DVHA 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 and LTSS 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
- Review DVHA provider contracts and contracting and non-contracting provider selection criteria
- Review results of DVHA provider and/or enrollee survey re: geographic accessibility and physical accessibility of care

AHS will review data regarding regular and routine care appointments. 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

DVHA 42 CFR 438.206 Availability of Services Requirements

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

Maintain a Network of Appropriate Providers
Consistent with the scope of its contracted services and 42 CFR 438.68 above, DVHA will maintain and monitor a network of appropriate providers, supported by written agreements, that is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities

AHS monitoring activities: AHS will review DVHA 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 and LTSS 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
- Review DVHA provider contracts and contracting and non-contracting provider selection criteria
- Review results of DVHA provider and/or enrollee survey re: geographic accessibility and physical accessibility of care

Provide Beneficiaries with Direct Access to a Women's Health Specialist
DVHA 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 DVHA 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)

Provide for a Second Opinion from a Network Provider
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, DVHA 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

Provide for Services Not Available from a Network Provider
If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, DVHA must adequately and timely cover these services out of network for the enrollee, for as long as the DVHA provider network is unable to provide them.

> **AHS Monitoring Activities:** AHS will review IGAs to ensure that they provide for services that are not available. In addition, AHS will review DVHA's new member materials, enrollee handbooks, and other enrollee information materials

Out-of-Network Providers
DVHA will ensure that payment to out-of-network providers and cost to the enrollee is no greater than it would be if the services were furnished within the network.

> **AHS Monitoring Activities:** AHS will review DVHA's new member materials, enrollee handbooks, and other enrollee information materials to ensure that enrollee cost is no greater than it would be if the services were furnished within the network.

Demonstrate Providers Are Credentialed
DVHA 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, DVHA 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.

Family Planning Providers
DVHA will ensure network providers include family planning providers sufficient ensure timely access to services for enrollees.

> **AHS Monitoring Activities:** AHS will review data regarding access to care and network adequacy to assure that sufficient family planning providers are available. AHS may also:
> - Review survey data from enrollees/providers
> - Review provider contracts, orientation, or enrollment documents
> - Review new member materials, enrollee handbooks
> - Review Grievance and Appeal data

Timely Access to Services
In addition to delivery system structure and organization, timeliness of services is central to provision of accessible care. DVHA 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 DVHA must maintain procedures for monitoring coverage to ensure twenty-four-hour availability as medically necessary.

DVHA 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.

DVHA 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 providers ensure timely access to services. 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

Access and Cultural Considerations

DVHA 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, disabilities and regardless of gender, sexual orientation or gender identity.

AHS Monitoring Activities: AHS will assess the cultural, ethnic, racial and linguistic needs of Medicaid beneficiaries and make recommendations to DVHA 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.

Physical Accessibility and Reasonable Accommodations

DVHA must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

AHS Monitoring Activities: AHS will review provider agreements, enrollee materials and IGAs to ensure that they stipulate accessibility and reasonable accommodation standards.

DVHA 42 CFR 438.207 Assurance of Adequate Capacity and Services Requirements

Documentation submitted by DVHA will demonstrate they offer an appropriate range of preventive, primary care, specialty services, and LTSS that is adequate for the anticipated number of enrollees statewide. DVHA will maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees

DVHA shall update network capacity data annually and at any time there has been a significant change in the DVHA operations that would affect adequate capacity or services, including changes in services, benefits, geographic service areas, payments or enrollment of a new population.

> **AHS Monitoring Activities:** AHS shall review variable definitions used by DVHA to provide network capacity data. This activity will assess whether or not DVHA offers an appropriate range of covered services adequate for the anticipated number of enrollees for the service and that DVHA 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.

DVHA 42 CFR 438.208 Coordination and Continuity of Care Requirements

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 DVHA and its IGA partners implement procedures to deliver coordinated health care services and supports for all enrollees.

DVHA and its IGA Partners will implement policies and procedures to deliver and coordinate services for all enrollees. These procedures must meet the following requirements:

(1) Ensure that each enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the enrollee. The enrollee must be provided information on how to contact their designated person or entity;

(2) Coordinate the services furnished to the enrollee:

- Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; and
- With the services the enrollee receives from community and social support providers.

(3) Provide best efforts to conduct an initial screening of each enrollee's needs, within 90 days of the effective date of enrollment for all new enrollees, including subsequent attempts if the initial attempt to contact the enrollee is unsuccessful;

(4) Share with AHS and/or other entities serving the enrollee the results of any identification and assessment of that enrollee's needs to prevent duplication of those activities;

(5) Ensure that each provider furnishing services to enrollees maintains and shares, as appropriate, an enrollee health record in accordance with professional standards; and

(6) 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.

Members with LTSS or Special Health Care Needs

DVHA 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 LTSS or special health care needs:

- Developmental Disability Services (DDS), Traumatic Brain Injury (TBI), Choices for Care (CFC) programs within DAIL
- Community Rehabilitation and Treatment (CRT) and Enhanced Family Treatment services for children with a Severe Emotional Disturbance (EFT) programs within DMH

DVHA and its IGA partners will assure that identification, assessment and care coordination services for enrollees with special health care needs or who need LTSS as defined by AHS are implemented. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements defined by AHS as appropriate. The treatment or service plan must be:

- Developed by an individual meeting LTSS service coordination requirements with enrollee participation, and in consultation with any providers caring for the enrollee;
- Developed by a person trained in person-centered planning using a person-centered process and plan as defined in 42 CFR §441.301(c)(1) and (2);
- Approved in a timely manner;
- In accordance with any applicable AHS quality assurance and utilization review standards; and
- Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the enrollee's circumstances or needs change significantly, or at the request of the enrollee per 42 CFR §441.301(c)(3).

For enrollees with special health care needs who are determined through the assessment above to need a course of treatment or regular care monitoring, DVHA and its IGA partners must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.

For each enrollee that DVHA and/or its IGA partners confirm as having special health care needs, the individual will be 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.

DVHA and its IGA partners will identify such enrollees through information contained in Health Risk Assessments; special application for services (e.g., DDS, EFT, TBI, etc.); claims data review; or review of any other available data source.

AHS Monitoring Activities: In accordance with 42 CFR 438.208, DVHA with its sub-contractors must implement procedures to deliver and coordinate health care for all beneficiaries. AHS looks for the following elements to determine if DVHA has a basic system in existence: (1) beneficiaries must be assigned to Primary Care Medical Home, Advanced Primary Care Practice, Specialized Health Home, Accountable Care Organization or otherwise have a person or entity identified for coordination of services (2) persons with special health care or LTSS needs must receive case management services according to established State criteria and must receive the appropriate care; (3) DVHA must have IGAs with other appropriate agencies or institutions to coordinate care; and (4) DVHA and its IGA partners 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

DVHA 42 CFR 438.210 Coverage and Authorization of Services 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
- LTSS

The monthly capitation limit established by AHS for DVHA, operating a managed care-like model, will include anticipated payment only for services specified in the Special Terms and Conditions under the Global commitment to Health Medicaid Demonstration.

Services will be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid. DVHA will ensure that services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

DVHA may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

Authorization of Services

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 that policies and procedures will:

- Have mechanisms to ensure consistent application of review criteria for authorization decisions;
- Consult with the requesting provider for medical services when appropriate;
- Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan; and
- Ensure 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 an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

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 72 hours after receipt of the request for service. The 72 hours may be extended by up to 14 additional calendar days if the enrollee requests the extension, or if DVHA justifies to the State 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.

Service Limitation and Medical Necessity

DVHA may place appropriate limits on a service on the basis of criteria applied under the State plan, such as medical necessity; or for the purpose of utilization control, provided that:

- The services furnished can reasonably achieve their purpose, as required above;
- The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and
- Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with 42 CFR § 441.20

DVHA determinations of ''medically necessary services'' must be no more restrictive than that used in the State Medicaid program, including quantitative and nonquantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures. DVHA and its IGA partners are responsible for covering services that address the:

- Prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability;
- Ability for an enrollee to achieve age-appropriate growth and development;
- Ability for an enrollee to attain, maintain, or regain functional capacity;
- Opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person centered goals, and live and work in the setting of their choice.

Covered Outpatient Drug Decisions

All outpatient covered drug authorization decisions provide notice as described in Section 1927(d)(5)(A) of the Act.

Compensation for Utilization Management Activities

DVHA 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. DVHA 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 review DVHA 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 DVHA 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	Brief 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 DVHA must follow
§438.214(b)(2)	Documented process for credentialing and recredentialing that DVHA 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)	DVHA may not employ or contract with providers excluded from Federal health care programs
§438.10	**Enrollee Information**
§438.10 (c)(1)	Provide all enrollee information in a manner and format that is easily understood and readily accessible
§438.10 (c)(2)	Utilize the beneficiary support system as described in §438.71
§438.10 (c)(4-7)	Use definitions consistent with the State for managed care terminology and provide information consistent with all requirements in §438.10
§438.10 (d)(1-6)	Ensure oral interpretation and written materials are available in prevalent non-English languages and alternative formats; provide required enrollee notifications
§438.10(f)	Notice of termination of a contracted provider
§438.10(g)	Provide enrollee handbook meeting all requirements of §438.10(g)
§438.10(h)	Provide a provider directory consistent with all requirements in §438.10(h)
§438.10(i)	Provide a prescription coverage information and formulary information consistent with §438.10(i)
§438.224	**Confidentiality**
§438.224	Individually identifiable health information is disclosed in accordance with Federal privacy requirements
§438.56	Enrollment and Disenrollment
§438.56	DVHA 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	**Sub-contractual Relationships and Delegation**
§438.230(b)(1)	DVHA must oversee and be accountable for any delegated functions and responsibilities
§438.230(c)	Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or specify other remedies if the subcontractor's performance is inadequate; agreements will meet all requirements in §438.230

DVHA 42 CFR 438.214 Provider Selection Requirements

In accordance with 42 CFR 438.214, DVHA 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 DVHA, 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. DVHA will follow the State's uniform credentialing and re-credentialing policies for acute, primary, behavioral, substance use disorders and LTSS providers. In addition, DVHA 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, DVHA must comply with the additional requirements established by the State listed below:

DVHA 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, DVHA 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.

DVHA 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.

DVHA 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 DVHA has recently denied participation.

DVHA 42 CFR 438.10 Enrollee information Requirements

DVHA 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. DVHA may employ the services of an enrollment broker to assist in outreach and education activities.

DVHA shall provide information and assist enrollees in understanding all facets pertinent to their enrollment. All informational material will adopt uniform AHS definitions for identified managed care terms and include 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 other beneficiary supports available under 42 CFR 438.71
- 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)

DVHA 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*. DVHA 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 including the Long-term Care Ombudsman and/or other advocates designated by the State to assist participants;
- 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 DVHA to cover a service; and
- 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) including what constitutes an emergency medical condition, that prior authorization is not required for emergency services and that the enrollee has the right use any hospital or other setting for emergency 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 ;
- Information on enrollee cost sharing;
- Additional information that is available upon request, including information on the structure of the *Global Commitment to Health Waiver* and any physician incentive plans; and Toll-free and TTY/TDY numbers for member services and any DVHA unit providing services directly to enrollees.

DVHA 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.

DVHA will provide to enrollees a provider directory for physicians, including specialists, hospitals, pharmacies, behavioral health providers and LTSS providers which will include the following information:

- The provider's name as well as any group affiliation.
- Street address(es).
- Telephone number(s).
- Web site URL, as appropriate.
- Specialty, as appropriate.
- Whether the provider will accept new enrollees.
- The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.
- Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

The provider directory will be available in paper format upon request and must be updated at least monthly; electronic provider directories must be updated no later than 30 calendar days after DVHA receives updated provider information. Electronic provider directories must be made available on DVHA's web site in a machine-readable file and format.

DVHA will provider formulary information and will ensure that the following information about its formulary is available on their web site in a machine-readable file and format and provide;

- Which medications are covered (both generic and name brand); and
- Identify which tier each medication is on.

Accessibility of Enrollee Materials

DVHA will ensure that any information provided to enrollees electronically is:

- In a readily accessible format,
- Placed in a location on the Web site that is prominent and readily accessible,
- In an electronic form, which can be electronically retained and printed,
- consistent with the content and language requirements of 42 CFR 438.10; and
- The enrollee is informed that the information is available in paper form without charge upon request and provided upon request within 5 business days.

All written materials for potential enrollees and enrollees must:

- Use easily understood language and format;
- Use a font size no smaller than 12 point;
- Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency; and
- Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point.

DVHA shall comply fully with AHS policies for providing assistance to persons with Limited English Proficiency. DVHA 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.

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

DVHA 42 CFR 438.224 Confidentiality Requirements

DVHA 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, DVHA 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, DVHA 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 DVHA 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.

DVHA 42 CFR 438.56 Enrollment and Disenrollment Requirements

DVHA must comply with the enrollment and disenrollment requirements and limitations set forth in 438.56 including; disenrollment requested by DVHA, disenrollment requested by the enrollee, procedures for disenrollment, and timeframes for disenrollment determinations.

DVHA 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

DVHA 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/Global Commitment status for all Global Commitment to Health enrollees.

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

DVHA 42 CFR 438.228 Grievance System Requirements

DVHA 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 DVHA operations. For purposes of the Grievance and Appeals process, Designated Agencies and Specialized Services Agencies are contracted agents of DVHA and/or its IGA partners Therefore, any decisions these entities make that fall under the definition of "adverse benefit determination" as defined at 42 CFR 438.400 are subject to DVHA appeal process. DVHA must maintain records of grievances and appeals. Grievance is defined as an expression of dissatisfaction about any matter other than an "adverse benefit determination." An appeal is defined as a request for review of an "adverse benefit determination." Adverse Benefit Determination 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 DVHA or the Departments 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:

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

First, AHS shall require that the DVHA 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, DVHA 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

DVHA 42 CFR 438.230 Subcontractual Relationships and Delegation Requirements

A subcontractor means any individual or entity that has a contract with DVHA that relates directly or indirectly to the performance of DVHA operations. A network provider is not a subcontractor by virtue of the DVHA provider agreement. DVHA may subcontract with entities within or outside of State government to provide services under the Demonstration. Contracts with outside entities will follow all necessary State and federal procurement rules and approvals. Inter-Governmental Agreements (IGAs) with other Departments in state government will be used to provide certain covered *Global Commitment to Health Demonstration* services that are relevant to the programs they administer. These other Departments are collectively referred to as "IGA partners" which include the Department for Disabilities, Aging and Independent Living (DAIL), Department of Health (VDH), Agency of Education (AOE), the Department for Children and Families (DCF) and the Department of Mental Health (DMH).

IGA partners are required to adhere to 42 CFR 438 as if they were operating as sub-contractors of a non-risk PIHP. IGA agreements do not diminish the role of state agencies in performing governmental functions as assigned by the AHS or as established under State law. Any activities delegated to a subcontractor or IGA partner will be specified in a written agreement. Written agreements must provide:

- The activities and reporting responsibilities of the contractor or subcontractor;
- That AHS, CMS, the HHS Inspector General, the Comptroller General or their designees have the right to audit, evaluate and inspect any books records, contracts, computer or other electronic systems of the subcontractor or of the sub-contractor's contractor, that pertain to any aspect of services and activities performed or determination of amounts payable under the contract;
- The subcontractor will make available for purposes of audit or inspection its premises, physical facilities, equipment, books, records or contracts related to Medicaid enrollees;
- The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later;
- For revocation of delegation or specify other remedies where AHS or DVHA determines that the subcontractor has not performed satisfactorily.

DVHA will submit sub-contractor ownership and control disclosures to AHS pursuant to 42 CFR 438.602 (c) for all sub-contract agreements with entities that are outside of State government.

No subcontract terminates the responsibility of AHS and DVHA to ensure that all activities as defined in the Medicaid Demonstration Special Terms and Conditions 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. DVHA agrees to make available to AHS and CMS all subcontracts between the DVHA and the Departments. DVHA and the Departments 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, DVHA may 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 DVHA 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 DVHA 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	Brief 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
§438.236(d)	Ensure that the application of the guidelines for utilization management, enrollee education, coverage of services and other others are consistent with such guidelines
§ 438.330	**Quality Assessment and Performance Improvement Program**
§438.330(a)	DVHA must have an ongoing quality assessment and performance improvement program
§438.330(b)(1) & §438.330(d)	DVHA must conduct PIPs and measure and report to the state its performance
§438.330(b)(2) & §438.330(c)	DVHA must measure and report performance measurement data as specified by the state
§438.330(b)(3)	DVHA must have mechanisms to detect both underutilization and overutilization of services
§438.330(b)(4)	DVHA must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs
§438.330(b)(5)	DVHA must have mechanisms to assess the quality and appropriateness of care furnished to enrollees using LTSS, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee care plan; and participate with the State to prevent, detect and remediate critical incidents that, at a minimum meet §441.302(b) for HCBS programs
§438.330(e)	Annual review by the state of DVHA's process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program
§ 438.242	**Health Information Systems**
§438.242(a)	DVHA 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)	Ensure that the claims processing and retrieval systems are able to collect data elements necessary to meet requirements of 1903(r)(1)(F) of the SSA
§438.242(b)(2)	DVHA must collect data on enrollee and provider characteristics and on services furnished to enrollees as specified by the State, including but not limited to race, ethnicity, and primary language spoken of each Medicaid enrollee
§438.242(b)(3)	DVHA must ensure data received is accurate and complete
§438.242(c)	DVHA will collect enrollee encounter data sufficient to identify the provider who delivers any item or service to enrollees on a frequency and level of detailed specified by the State

DVHA 42 CFR 438.236 Practice Guideline Requirements

Practice Guidelines

DVHA and the Departments 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. DVHA 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: DVHA and the Departments 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

DVHA 42 CFR 438.330 Quality Assessment and Performance Improvement Program Requirements

DVHA 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 AHS/DVHA 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, DVHA must have procedures that:

- Assess the quality and appropriateness of care and services furnished to all Medicaid beneficiaries and to individuals with special health care needs;
- Detect the over-utilization and under-utilization of health care services;
- Regularly monitor and evaluate compliance with managed care standards; ,
- 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; and
- Assess the quality and appropriateness of care furnished to enrollees using long-term services and supports, including:
    - Assessment of care between care settings;
    - A comparison of services and supports received with those set forth in the enrollee's treatment/service plan; and
    - Participation in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per §§ 441.302 and 441.730(a) that are based, at a minimum, on the requirements on the State for home and community-based waiver programs per § 441.302(h)

The Quality Management Plan shall conform to all applicable Federal and State regulations. The Quality Management Plan shall be available to AHS upon request.

DVHA and the Departments are 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; and
- For LTSS enrollees: quality of life; rebalancing of community care and institution care; and community integration.

DVHA will report Performance Measurement data to AHS on a quarterly basis. DVHA 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. DVHA 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.

DVHA 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 the access to and quality of care;
- 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, no less than annually, to AHS as requested in a timely manner.

Each year DVHA 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.

AHS Monitoring Activities: AHS will annually review the DVHA 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

DVHA 42 CFR 438.242 Health Information Systems Requirements

In accordance with 42 CFR 438.242, DVHA 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 including but not limited to race, ethnicity, and primary language spoken of each Medicaid enrollee. DVHA 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.

DVHA 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. DVHA 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 and be collected and maintained in a manner sufficient to identify the provider who delivers any item(s) or service(s) to enrollees. DVHA must have

a process to ensure that services were actually provided. In addition to the automated process described above, DVHA 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 DVHA 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 DVHA encounter and claims data procedures in order to ensure compliance with this standard. Monitoring includes the following activities:

- Review procedures used by DVHA 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.

Based on considerable stakeholder interest, Vermont is taking this opportunity to assess programs/settings for GC Demonstration populations that are designated by the State as persons with Special Health Care needs under 42 CFR 438. In addition to 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)

All home and community-based settings associated with the aforementioned populations 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) 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. 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. Health information is kept private. 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. Staff communicates with individuals in dignified manner. 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) 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. 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. 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. 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.
Settings Option*	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.

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.

*During public comment, it was brought to the state's attention that this CMS table was incomplete. Rather than contacting the owner or removing the table from the document, the state added the suggested missing requirement and its corresponding CFR language.

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. Intermediate Sanctions

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.

Electronic Health Record Incentive Program (EHRIP)

The Vermont EHRIP is an integral part of the HIE/HIT program, establishing electronic health records as a source of clinical data for transmission to the HIE. It began in 2011 and to date, has awarded over $47 million dollars in incentive payments to approximately one thousand eligible providers and hospitals enrolled in the program. Vermont's EHRIP program is designed to support providers' adoption of certified electronic health record technology to improve the quality, safety and efficiency of patient health care.

The Electronic Health Record Incentive Program (EHRIP) is designed to support providers during the period of transition in health information technology. The vision is that electronic health record use will improve the quality, efficacy, and efficiency of patient health care.

Health Information Technology (HIT) and Health Information Exchange (HIE) Activities

The HIE/HIT program in Vermont is organizationally housed in the Department of Vermont Health Access (DVHA); the Vermont Medicaid Enterprise. The Vermont Health Information Exchange (VHIE) is a Medicity platform with enhanced local capabilities operated exclusively (by statute) by Vermont Information Technology Leaders (VITL). Working closely with the VHCIP program and partnering with other departments within the Vermont Agency of Human Services, the HIE/HIT program provides facilitation, HITECH funding and technical support for meaningful use as well as health data and infrastructure needs across the health care landscape in Vermont. Through health data accessibility, the VHIE aims to enhance care coordination, health care data analytics, and population health management.

The Health Data Exchange Network takes responsibility for the management, exchange and access to clinical and human services data throughout the clinical provider community, the Vermont Agency of Human Services and their affiliated entities. The program vision is to ensure the wellbeing of all Vermonters by ensuring that health and human services data is available at the right time, in the right place, and in the right way to support continuous improvements in individual health, health care outcomes, and health care cost.

Vermont Health & Human Services Enterprise Platform (HSEP)

The Human Services Enterprise Platform (HSEP) is a shared suite of modern technology tools positioned to satisfy a significant portion of AHS' software needs including transactions, analysis, and infrastructure. Today these needs are supported by over 200 different, detached, disconnected software packages. Leveraging one system, over many, represents material savings for the State, and allows for rapid response to ever-changing regulatory, policy, and programmatic demands. Components of note in the HSEP include a rules engine, an Electronic Service Bus (ESB), and an anticipated Master Data Management (MDM) solution, including enterprise Master Person Index

(eMPI), a Provider Directory, and a consent management solution. This architecture was deployed first to establish the Health Insurance Exchange, MAGI Medicaid, and Dr. Dynasaur. The Vermont Health & Human Services Enterprise Platform unifies four Vermont health care reform programs with the vision of providing infrastructure, services, and functional components that each program can share.

The Health and Human Services Enterprise (HSE)

The Health and Human Services Enterprise (HSE) is a portfolio of programs (Vermont Health Connect, Integrated Eligibility, Medicaid Management Information System, HIE/HIT) that rely upon a Services Oriented Architecture (SOA). The HSE is a multi-year, multi-phased portfolio of programs whose goals are, in furtherance of the mission of the Agency of Human Services (AHS), to reshape and enhance internal business processes, improve public/private sector partnerships, optimize utilization of information, and modernize the IT environment within which AHS delivers benefits, care and services to beneficiaries in the State of Vermont. The HSE was expressly established by the Secretary of AHS to realize the "Agency of One" vision through a focus on integrating services, improving systems and the sharing of applicable data in a timely and effective manner (while comporting with relevant privacy requirements) to ensure:

- Vermonters receive the services critical to their success and can identify additional supports that will help them prosper;
- Vermonters will benefit from cross-departmental referrals and awareness – that there exists "no wrong door" for Vermonters seeking access to care and benefits;
- Policy and Public Health efforts have necessary data for program analysis and program service coordination.

The Agency of Human Services' (AHS) Health & Human Services Enterprise (HSE) is Vermont's approach to transform legacy systems into an environment of coordinated and integrated service delivery. The Health & Human Services Enterprise Platform (HSEP) is fundamental to and supports Vermont's concept of the HSE which encompasses the Vermont Health Connect (VHC) insurance exchange, Integrated Eligibility & Enrollment (IE&E), Medicaid Management Information System (MMIS), and HIT/HIE.

Vermont Health Connect

Vermont launched a federally required health benefits exchange, Vermont Health Connect (VHC), on October 1, 2013. VHC allows individuals and small businesses to compare and purchase qualified private health insurance plans, access federal and state tax credits, determine eligibility, and enroll individuals in public health insurance plans. Vermont Health Connect (VHC), currently uses the HSEP's basic Health Insurance Exchange and Eligibility & Enrollment services and capabilities for access to Qualified Health Plans, MAGI Medicaid and Dr. Dynosaur.

Integrated Eligibility and Enrollment

Integrated Eligibility and Enrollment (IE&E) is a technical solution that is being developed to determine Vermonters' eligibility and to enroll them in a multitude of assistance services sponsored by the Agency of Human Services, rather than have disparate processes for these services. IE&E will leverage already developed elements in Vermont Health Connect. It will add capabilities to the HSEP allowing for automation and standardization of the health & human services case management and

program administration systems (screening, application, eligibility determination and enrollment). This represents the integration of the Agency's remaining health programs and economic services into one system.

Medicaid Management Information System

The Medicaid Management Information System (MMIS) Program is a collective initiative under the Health & Human Services Enterprise. The new MMIS Program is being developed to align with new Federal and State regulations stemming from the Federal Affordable Care Act and Vermont Act 48 of 2011, as well as be compliant with the CMS Seven Standards and Conditions. The MMIS Program is a claims processing system that will streamline billing, payment, and other Medicaid operational components.

There are two key projects under the MMIS umbrella that are currently underway.

i. The **Pharmacy Benefit Management (PBM)** program represents clinical, operational, and business services that allow Vermont to meet the challenge of increasing pharmaceutical costs for consumers with a real solution. Vermont's PBM program is aimed at both reducing and controlling costs of drugs and providing the State with high quality, local pharmaceutical expertise. In FY2016, the PBM generated $15.3 million in savings thanks to improved operational efficiency.

ii. **Care Management** is a set of activities intended to improve clinical patient care and reduce the need for services by helping patients and caregivers more effectively manage health conditions and issues impacting health and well-being. **The Enterprise Care Management System** supports not only AHS care management staff but also hundreds of Vermont provider organizations engaged in direct care services. The Enterprise Care Management system offers some of the highest levels of sophistication in forecasting & analytics, and vastly improves Vermont's ability to utilize data to improve population-wide outcomes. The system will unite and integrate the Agency's related care management programs in a way that was never possible before.

These combined responsibilities provide Vermont with a powerful engine for delivery system change, as well as creating a focused perspective for managing the comprehensive IT and other systems changes being led by DVHA in support of that system change. Many of these delivery system changes affect the Agency of Human Services along with many private and community organizations. In support of Vermont's aggressive payment and delivery reform goals, the State has identified the following IT initiatives:

- Implement technological solutions, including data warehouses and point-of-care tools, in support of Vermont's All-Payer Model Agreement and Medicaid 1115 Global Commitment to Health waiver;
- Build out of the statewide HIE network to provide connectivity for clinical and financial data transfer;
- Implement core components of SOA infrastructure to support the Agency of Human Services and its partners;
- Re-procure the Medicaid Management Information System (MMIS) in a modular approach as a more comprehensive and integrated enterprise solution;
- Provide statewide outreach to and support for EHR adoption, implementation, upgrade and meaningful use;
- Continue technical support for the statewide expansion of the Blueprint for Health patient-centered

medical home, 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;

- Develop and implement technology in support of population health including Vermont's Immunization Registry, Prescription Management System, and other public health reporting functions through the HIE;
- Develop and implement an upgrade to AHS' eligibility and enrollment systems, Integrated Eligibility (IE), which will include integration with the state Health Insurance Exchange; and
- Expand or replace AHS' CSME (Central Source for Measurement and Evaluation), which is the Agency- wide data warehouse to support Medicaid and other Agency program operations, reporting, evaluation, and planning.

V. DELIVERY SYSTEM REFORMS

Health care in Vermont – as well as in the country as a whole – is in the midst of a major transformation. In Vermont, health care reform efforts touch virtually all sectors of health and health services. The Vermont Medicaid program has historically paid for services for Medicaid beneficiaries on a FFS basis. Increasingly, Vermont's Medicaid program has been expanding its use of service delivery and payment systems, as an alternative to traditional FFS. In addition, the current 1115 Medicaid Waiver, Global Commitment to Health, promotes delivery system and payment reform by allowing Vermont Medicaid to enter into ACO arrangements that align in design with that of other health care payers in support of the Vermont All-Payer ACO Model.

Payment Models

Dental Supplemental Payment Program

The Dental Supplemental Payment Program was created to recognize and reward dentists serving high volumes of Medicaid beneficiaries and to improve access to dental care. The incentive program methodology was developed by Vermont Medicaid in conjunction with the Vermont State Dental Society and approved by the State Legislature's Health Access Oversight Committee at their September 19, 2006 meeting. The SFY '08 appropriation provided for the funds for the incentive payment. An incentive pool for improving access to dental care for Medicaid enrollees was incorporated into the State's base Medicaid appropriation such that payments are made every six months to the dental practices that meet criteria for serving Vermont Medicaid beneficiaries. Dental practices that receive cost-based reimbursement (like Federally Qualified Health Centers) are ineligible for the program. Dental practices that receive $50,000 or more semi-annually in Medicaid paid claims are eligible for incentive payments. The Vermont Medicaid dental benefit is capped at $510 per year, meaning that providers who meet the incentive payment threshold are by necessity treating more Medicaid beneficiaries.

The total incentive pool is capped at $292,836 annually; distributions of $146,418 are made twice a year. Historically, 31-48 dental practices have qualified for semi-annual incentive payments. Most recently payments were made to 46 practices.

This payment arrangement is expected to advance the following goal/objective of the CQS:

- Access to Care/Improve Enrollees Access to Dental Visits

The Dental Incentive Program is included in the GC Evaluation Design. Quarterly and annual Monitoring and Evaluation data is used to assess the degree to which the payment arrangement is achieving its goal/objective.

Blueprint

The Blueprint for Health is a state-led, multi-payer program dedicated to achieving well-coordinated and seamless health services, with an emphasis on prevention and wellness. As such, the Blueprint employs several different approaches to incentivizing delivery system reform and increased quality and performance through payment reform.

Advanced Primary Care Practice/Patient Centered Medical Home

The foundation of the Blueprint model is a Multi-payer Advanced Primary Care Practice (MAPCP) program. Participation is optional for providers, but mandatory for Vermont's commercial payers (with the exception of self-insured plans) and Medicaid. Current participating payers in the Blueprint for Health include Medicaid, Medicare, Blue Cross Blue Shield of Vermont, MPV and CIGNA. The Blueprint PCMH pay for performance model uses a Per-Patient-Per-Month approach (PPPM) to incentivize primary care practices to become recognized as an official National Committee for Quality Assurance's Physician Practice Connections-Patient Centered Medical Home (NCQA PCC-PCMH) and to participate in local Community Collaboratives (CC) oriented towards improving population health and local care coordination activities for their region.

This payment arrangement is expected to advance the following goal/objective of the CQS:

- Access to Care/Improving the Rate of Adolescents Receiving Well Care Visits
- Health Outcomes/Controlling Enrollee High Blood Pressure

The Blueprint PCMH pay for performance model is included in the GC Evaluation Design. Quarterly and annual Monitoring and Evaluation data is used to assess the degree to which the payment arrangement is achieving its goal/objective.

Community Health Teams

CHTs are multidisciplinary teams that partner with Patient Centered Medical Homes (PCMHs), the hospital, and existing health and social service organizations. CHTs supplement services available in PCMHs and link patients to the social and economic services that make healthy living possible for all Vermonters. CHT services include: population/panel management and outreach, individual care coordination, brief counseling and referral to more intensive mental health care as needed, substance abuse treatment support, and condition-specific wellness education. CHTs are flexible in terms of staffing, design, scheduling and site of operation, resulting in a cost-effective, core community resource which minimizes barriers and provides the individualized support that patients need in their efforts to live as fully and productively as possible. CHT services are available to all patients with no eligibility requirements, prior authorizations, referrals or co-pays.

Key stakeholders in each health service area (HSA) must agree upon and identify at least one administrative entity accountable for leading implementation and ongoing operations of the MAPCP model in their HSA. Lead administrative entities receive multi-insurer payments, including Medicare and Medicaid, to support hiring of local Community Health Teams (CHTs).

The number of core CHT members hired in each geographic service area is scaled up or down, depending on the size of the population served by participating Primary Care Practices.

This payment arrangement is expected to advance the following goal/objective of the CQS:

- Enhanced Care Coordination/TBD

The Blueprint CHT payment model is included in the GC Evaluation Design. Quarterly and annual Monitoring and Evaluation data is used to assess the degree to which the payment arrangement is achieving its goal/objective.

Women's Health Initiative

The Women's Health Initiative (WHI) extends the Vermont Blueprint for Health to obstetrics, gynecology, family planning and nurse midwifery practices. Because many women receive substantial preventive care services in these practices, there is an opportunity to increase access to services to improve health outcomes for women and children, as well the potential to reduce unintended pregnancies.

WHI practices shall receive three (3) Blueprint-specific forms of payment from WHI-participating insurers or payers, to support the provision of high-quality women's health primary care and well-coordinated preventive women's health services for women ages 15 – 44.

Practices who choose to participate in the Women's Health Initiative agree to implement and maintain the WHI strategies, which include the following:

- Stock LARC;
- Screen for Mental Health, Substance Abuse, and Inter-Partner Violence;
- Provide Family Planning Counseling;
- Offer Same Day LARC Insertion;
- Develop Referral Networks for Women's Health Services;
- Develop Referral Networks for Primary Care; and
- Screening for Social Determinants of Health

WHI strategies were identified to address the risks for unintended pregnancy and to improve the health of women and their children. The strategies focus on improving health and reducing health risk, enhancing family planning services, addressing barriers to accessing long acting reversible contraception (LARC), and further enhancing the integration of health services.

This payment arrangement is expected to advance the following goal/objective of the CQS:

- Prevention/Improvement in Enrollee Chlamydia Screening in Women
- Access to Care/Improvement in Preventive Care Visits

The WHI payment model is included in the GC Evaluation Design. Quarterly and annual Monitoring and Evaluation data is used to assess the degree to which the payment arrangement is achieving its goal/objective.

Global Commitment to Health Wavier

The Agency of Human Services (AHS), as Vermont's Single State Medicaid Agency, is responsible for oversight of the Global Commitment to Health 1115 research and demonstration waiver. While not a formal Managed Care Organization, the Department of Vermont Health Access (DVHA) operates the Vermont Medicaid program using a managed care-like model in accordance with federal Medicaid managed care regulations. Program requirements and responsibilities are delineated in an inter-governmental agreement (IGA) between AHS and DVHA. DVHA also has sub-agreements with the other State entities that provide specialty care for Global Commitment (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 and its IGA partners have modified operations to meet Medicaid managed care requirements, including requirements related to network adequacy, access to care, beneficiary information, grievances, quality assurance, and quality improvement. Overall implementation of the waiver is guided by the goals, measures and monitoring activities outlined in the AHS Comprehensive Quality Strategy (CQS).

DVHA Next Generation Accountable Care Organization (ACO)

The Agency of Human Services has implemented the Vermont Medicaid Next Generation Model Accountable Care Organization (ACO) Program. This program is a one-year program with four optional one-year extensions. The program is an agreement between Medicaid and provider organizations (under an umbrella ACO) that aims to hold providers accountable for patient quality of care and costs. By providing a prospective, all-inclusive, population-based capitation payment to the ACO for a set of defined health services, the program seeks to improve the efficiency and quality of care delivery to the program's assigned Medicaid beneficiaries, and provide the opportunity for an ACO to perform their own utilization and care management activities.

The Medicaid Next Generation Model ACO Program is an evolution of Vermont's current Medicaid ACO program, the Vermont Medicaid Shared Savings Program (VMSSP), which began in 2014 and just completed its third and final performance year in 2016. Because the VMSSP offered an upside-only risk arrangement (in which ACOs are not responsible for shared losses), the Next Generation Model ACO program's shared financial risk requirement goes further than the VMSSP to hold providers accountable for patient outcomes and costs. It should be noted that although the Vermont Next Generation Model ACO is structured similarly to the Medicare Next Generation ACO Model, it has been modified to address the needs of the Medicaid population in Vermont.

This payment arrangement is expected to advance the following goal/objective of the CQS:

- Access to Care/Improvement in the Rate of Adolescents Receiving Well-Care Visits
- Chronic Conditions/Improvement in the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Health Outcomes/Improvement in Controlling Enrollee High Blood Pressure

The VMNG ACO payment model is included in the GC Evaluation Design. Quarterly and annual Monitoring and Evaluation data is used to assess the degree to which the payment arrangement is achieving its goal/objective.

Integrating Family Services (IFS)

The Integrating Family Services (IFS) bundled payment model supports Medicaid services for pregnant women and children birth through age 21 across service domains, including: mental and behavioral health, developmental disabilities, and substance use. Services reach across the continuum of prevention, diagnosis, and treatment.

The bundled rate allows providers to bill once a month for Medicaid services after a single unit of service. That single payment supports services regardless of how frequently or intensively services occurred in a month for an individual. The bundled rate further supports IFS delivery of service in the most natural setting for the child and family, including in the home, and allows the provider to focus on the plan of care and supporting individuals in meeting goals.

Services include the following Medicaid State Plan and Demonstration services:

Section 1115 Demonstration Services: specialized mental health services for children under 22 with a severe emotional disturbance; specialized developmental disability services for individuals under 18.

State Plan Services: mental health clinic services, targeted case management, specialized rehabilitation services (early childhood development and mental health), intensive family-based services, extended nursing visits for pregnant and post-partum women.

This payment arrangement is expected to advance the following goal/objective of the CQS:

- Access to Care/Decrease in the Average Wait Time Between First Call Requesting Services and First Appointment Offered
- Enhanced Care Coordination/Increase of Children who have the CANS Administered Per the Eligibility Guidelines in the IFS Procedures Manual
- Enhanced Care Coordination /Increase in the Percent of Clients That Have a Plan Completed Within 45 Days of Referral

The IFS payment model is included in the GC Evaluation Design. Quarterly and annual Monitoring and Evaluation data is used to assess the degree to which the payment arrangement is achieving its goal/objective.

Children's Integrated Services (CIS)

Children's Integrated Services (CIS) provides health promotion, prevention and early intervention services to pregnant and post-partum women, infants, and children birth to age six. CIS services are provided in the home, and all individuals accessing CIS services are assigned one care coordinator, regardless of how many service needs an individual may have. The care coordinator is responsible for the plan of care, providing services and care coordination for other services and is the one point of contact for the individual and service providers in the plan of care. CIS is currently in the process of fully implementing evidence-based home visiting models across nursing and family support throughout Vermont. The models are for nurses, the Maternal Early Childhood Sustained Home visiting model and for social workers, Parents As Teachers (PAT). These models are approved by the Maternal, Infant and Early Childhood Home Visiting Program at the Federal Office of Health and Human Services.

In addition to streamlining program requirements and administration for early childhood services, this delivery system reform model combines Medicaid funding for covered services to create a single case rate within each region. This case rate allows providers to bill once a month for services regardless of how many home visits occurred in a month for an individual. The case rate requires care coordination and management across providers which provides a client-centered experience for individuals and families and is expected to improve health outcomes as a result.

This payment arrangement is expected to advance the following goal/objective of the CQS:

- Access to Care/Increase in Referrals to Early Childhood and Family Mental Health Clinicians
- Access to Care/Increase in Mid-Level Developmental Assessments/Evaluations Completed
- Enhanced Care Coordination /Increase in the Percent of Clients That Have a One Plan Completed Within 45 Days of Referral

The CIS payment model is included in the GC Evaluation Design. Quarterly and annual Monitoring and Evaluation data is used to assess the degree to which the payment arrangement is achieving its goal/objective.

Investments

Under the public managed care model, the Demonstration provides the State with flexibility to invest in the delivery system using two types of investments. The first are health care innovations that:

a. Reduce the rate of uninsured and/or underinsured in Vermont;
b. Increase the access to quality health care by uninsured, underinsured, and Medicaid beneficiaries;
c. Provide public health approaches and other innovative programs to improve the health outcomes, health status and quality of life for uninsured, underinsured and Medicaid-eligible individuals in Vermont; and
d. Encourage the formation and maintenance of public-private partnerships in health care, including initiatives to support and improve the health care delivery system and promote transformation to value-based and integrated models of care.

The second type of investment is specifically related to delivery reform projects. CMS has provided the State with one-time spending authority to support Accountable Care Organizations and Medicaid community providers in delivery system reform through activities such as, but not limited to:

- Infrastructure improvement;
- Quality and heath improvement information development and dissemination;
- Community related population health projects;
- Socio-economic risk assessment and mitigation; and
- Provider integration to build integration across physical health, mental health substance use disorder treatment and long-term services and supports.

Investment awards are expected to give preference to activities that promote collaboration, build capacity across the care continuum, consider social determinates of health, and promote an integrated health care system consistent with the framework set forth in the Vermont All-Payer Model Agreement (described below) and the Global Commitment Demonstration. Specifically, the State would like to encourage ACO-based provider led reform that features (a) collaboration between providers, (b) reimbursement models that move away from Fee-For-Service payment, and (c) rigorous quality measurement that aligns with the APM quality framework.

In late November of 2017 two new investments were approved by CMS in the ACO delivery system reform category. Investments are scheduled to begin in 2018 and include administrative and infrastructure support for:

- OneCare Vermont ACO Quality Health Management Measurement Improvement investment. This project is designed to assist the ACO in providing technical assistance to network providers in setting

quality improvement targets and using a suite of new and enhanced information dissemination tools and reports; and

- OneCare Vermont ACO Advanced Community Care Coordination investment. This project is designed to support an integrated care delivery system that is person-centered, efficient and equitable through the implementation of a community-based care coordination model.

Investments are expected to advance the goals/objectives of the CQS and are included in the GC Evaluation Design. Quarterly and annual Monitoring and Evaluation data is used to assess the degree to which the investment is achieving its goal/objective.

All Payer Model

The All-Payer Model agreement between the State and the Federal government was approved by the Green Mountain Care Board on October 26, 2016 and signed by the Governor and the Secretary of Human Services on October 27, 2016. The agreement includes a target for a sustainable rate of growth for health care spending in Vermont across Medicaid, Medicare, and commercial payers, and builds on past programs like Vermont's Medicaid and commercial Shared Savings Programs. As currently implemented, this model focuses on a set of health care services roughly equivalent to Medicare Parts A and B (hospital and physician services). The agreement includes quality targets and performance measurement requirements and requires Vermont payers to offer aligned value-based ACO payment models comparable to Medicare's Next Generation ACO program (which may include shared savings/risk arrangements, capitation payments or global budgets). The State must provide a plan in 2019 for integrating any institutional long-term services and supports in the total cost of care in the next Medicare Demonstration period.

The All-Payer Model (APM) Agreement and Global Commitment Medicaid Demonstration are complementary frameworks that support Vermont's health care reform efforts. Each agreement provides federal support to further Vermont's strategic goal of creating an integrated health care system, including increased alignment across payers and providers.

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

Choices for Care Systemic Assessment and Work Plan

Appendix B

Developmental Services Systemic Assessment and Work Plan

Appendix C

Traumatic Brain Injury Systemic Assessment and Work Plan

Appendix D

Community Rehabilitation and Treatment Systemic Assessment and Work Plan

Appendix E

Enhanced Family Treatment Systemic Assessment and Work Plan