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RE: Responses to Public Comments for the following Health Care Administrative Rules:

- 7101 Medicaid Benefit Delivery
- 4.102 Emergency Services
- 6.100 Medicaid Cost Sharing

A summary of comments received and the Agency of Human Services' responses to those comments is included below. Comments were received from Vermont Legal Aid, Inc. and the Vermont Medical Society.

Proposed rule 7101, Medicaid Benefit Delivery

1) **Removal of Sections**

Comment: Commenters mentioned concern with removal of sections regarding services requiring referrals, Quality Management/Quality Improvement, and provisions of network adequacy.

Response: The Medicaid Benefit Delivery rule is being amended primarily to remove Grievances and Appeals, Emergency Services, and Cost Sharing language. Sections being removed outside of this list are due to practices that are no longer in place (e.g. referrals) or are not appropriate to be included in administrative rules (e.g. located elsewhere such as the provider manual or addressed in federal regulation). A full revision to this rule will occur at a later date.

2) **Definitions:**

Comment: The definition for "utilization review" at § 7101.3(a)(11) references several terms whose definitions have been removed from § 7101.3(a), specifically "ambulatory review," "prior authorization" or "prospective review," "case management," and "discharge planning." This section keeps the definitions for "second opinion," "certification," "concurrent review," and "retrospective review," however. This section should include the definitions for all techniques listed under the "utilization review" definition.

Response: The rule has been amended to remove "Techniques may include ambulatory review, prior authorization, second opinion, certification, concurrent review, case management, discharge planning or retrospective review" from the definition of "Utilization review".

3) **Other**

Comment: Comments were received suggesting revisions for sections 7101.3(e)(2) Waiting times for appointments, 7101.3(e)(3) Standards for the assessment of provider capacity to provide timely access to healthcare services, and 7101.3(f) Confidential information.

Response: As previously mentioned, the amendments made to this rule are to remove sections of the rule. Sections of the rule that remain and any revisions will be addressed in future HCAR rule filings.

Comment: § 7101.3 (g) Disclosure of information - The proposed rule keeps the requirement that "DVHA shall supply to each beneficiary . . . the following information . . . in handbook form." However it removes the entire list of information (twenty items) that will be included in the member handbook. It is unclear what will be in the handbook. The content that must be included in the member handbook is listed in 42 C.F.R. § 438.10 (g). The federal regulation should be cited in the Vermont rule, if AHS decides not to include details in this rule. The handbook should be an explanation of how Medicaid works and should include specifics such as an overview of coverage, cost-sharing, prior authorizations, appeals, network adequacy, and the exception process. It is critical for beneficiaries to have this information in one place.

Response: The rule has been amended to restore the handbook requirements list to the rule.

Proposed Rule 4.102, Emergency Services

Comment: It is unclear to VMS if 7101.3 (L), regarding care being provided outside Vermont, if necessary, by enrolling the provider, is affected by the proposal or proposed to be retained elsewhere in HCAR. VMS suggests retaining this section to give clarity to providers and patients seeing to understand coverage.

Response: Information for enrolling out of state providers is located in the Provider Manual.

Proposed Rule 6.100, Cost Sharing

Comment: A sentence should be added to §6.100.2 that specifically says that there are no copayments required with DME. We have seen significant provider confusion around DME billing.

Response: The proposed rule at §6.100.2 lists the copayment requirements for Vermont Medicaid. DME is not one of the services subject to a copayment. The Vermont legislature repealed the requirement for DME copayments in 2014 (Act 50 sec.E.307.2). Provider payments for DME are not reduced by the copay amount. The rule will not be revised, it is not practical to list all of the services that are not subject to cost sharing.

Comment: The revised rule at § 6.100.2(a)(1) removes the co-payment exception for dual eligible beneficiaries. This should be added back into the rule: "A beneficiary covered by Medicare has no co-payment requirement for outpatient services." Removing the exception impacts the beneficiaries who generally have the least money and the most medical needs. If you do not restore this exception, please explain the basis for deleting it.

Response: Beneficiaries who are dually eligible for Medicare and Medicaid are required to pay a copayment when Medicaid is the primary payer for hospital outpatient services. Therefore, the statement will not be included in the new rule. A copayment is not charged when Medicaid is the secondary payer.

Comment: Current cost sharing rules sections 7101.3 (E) and 7101.2 (C) cross reference exceptions to copayments found under 4161 (B). 6.100 as proposed does not contain this cross reference and it is unclear from our review if all crossed referenced exceptions are now

incorporated fully into 6.100. VMS wants to ensure that other crossed referenced exceptions are included rather than require providers to be familiar with other sections of rule that are not cross referenced or incorporated.

Response: The Agency of Human Service is adopting Cost Sharing rule 6.100 as a new rule to consolidate the copayment requirements and exceptions into one rule and eliminate the need for cross references. As existing rules are adopted under the body of HCAR, redundant sections will be repealed.

Comment: 4161(C)(3) lists additional exceptions to those found in the proposed new rule such as emergency hospital services, federally qualified health centers and services provided by other licensed providers and it is unclear from our brief review if such exceptions will be retained. If so, they should be incorporated or cross referenced. VMS strongly suggests all applicable exceptions be listed in one location for ease of reference and compliance for providers.

Response: The rule cited as 4161(C)(3) is no longer in effect and the specific exemptions listed in the comment are not in current rule. Section 6.100.3 of the proposed rule includes the specific exemptions and options that Vermont Medicaid applies to copayments. To assure that mandatory exemptions can be found in one location the final proposed rule has been amended to incorporate the mandatory federal exemptions by reference.