Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Vermont Focused Program Integrity Review

Final Report

March 2020

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Executive Summary

The Centers for Medicare & Medicaid Services (CMS) is committed to performing program integrity reviews with states in order to identify risks and vulnerabilities to the Medicaid program and assist states with strengthening program integrity operations. The significance/value of performing onsite program integrity reviews include: (1) assess the effectiveness of the state's PI efforts, including compliance with certain Federal statutory and regulatory requirements, (2) identify risks and vulnerabilities to the Medicaid program and assist states to strengthen PI operations, (3) help inform CMS in developing future guidance to states and (4) help prepare states with the tools to improve PI operations and performance.

The CMS conducted a focused review of Vermont to determine the extent of program integrity oversight of the managed care program at the state level, and to assess the program integrity activities performed by selected managed care entities (MCEs) or in this case Prepaid Inpatient Health Plan (PIHP), under contract with the Agency of Human Services (AHS) which is Vermont's Medicaid State Agency. Additional key stakeholders in the Vermont healthcare delivery model are the Department of Vermont Health Access (DVHA) and OneCare Vermont an Accountable Care Organization (ACO). Vermont has a unique healthcare delivery model that will be described further in the report.

During the week of September 9, 2019, the CMS review team visited AHS. The CMS team conducted interviews with officials from AHS, DVHA and OneCare staff.

Summary of Recommendations

The CMS review team identified a total of nine recommendations based upon the completed focused review modules and supporting documentation, as well as discussions and/or interviews with key stakeholders. The recommendations were in the following areas: State Healthcare Delivery System, State Oversight of Managed Care Program Integrity Activities, MCE Investigations of Fraud, Waste, and Abuse, Overpayment Recoveries, Audit Activity, Return on Investment, Payment Suspensions, and Terminated Providers and Adverse Action Reporting. The recommendations will be detailed further in the next section of the report.

Overview of Vermont's Medicaid Program

- The AHS is the single state agency responsible for overseeing the managed care-like Medicaid delivery system in Vermont.
- Vermont has CMS approval to operate a Section 1115 Demonstration called Vermont Global Commitment to Health that uses a managed care-like model that complies with federal regulations at 42 CFR 438 that would apply to non-risk PIHPs, including beneficiary rights and protections.
- The AHS entered into an intergovernmental agreement with DVHA to administer the managed care-like Medicaid model for Vermont enrollees.
- The AHS has assigned all PI functions to DVHA.
- The DVHA PI unit has 13 staff members and is responsible for the overall program integrity operations for Vermont's Medicaid program.

- The DVHA sub-contracts with Accountable Care Organization (ACO), OneCare Vermont for a portion of its Medicaid population, and has not sub-delegated program integrity (PI) responsibilities.
  Both DVHA and OneCare have a compliance officer and compliance program.
- DXC Technologies Inc. (DXC) is contracted as Vermont's Medicaid Fiscal Agent and is responsible for the operation of its MMIS system.
- In FFY 2018 Vermont's Medicaid expenditures exceeded $1.6 billion. The Federal Medical Assistance Percentage matching rate was 53.47 percent.

Overview of Managed Care in Vermont

- In FFY 2018 Vermont had approximately 169,871 thousand Medicaid beneficiaries. Approximately 100 percent of the Medicaid population was enrolled in the PIHP.
- Vermont's managed care program accounts for the majority of the Medicaid expenditures in Vermont.
- During the onsite review AHS, DVHA, and OneCare Vermont were interviewed. Table 1 and Table 2 below provide enrollment/SIU and expenditure data for DVHA.

Table 1.

	Department of Vermont Health Access
Beneficiary enrollment total	Medicaid 169,871 Active Medicaid enrolled (9/15/2018 FFY 18)
Provider enrollment total	Vermont has a total of 19,817 active participating providers
Year originally contracted	2006 Contract
Size and composition of SIU	DVHA's PI Unit has 13 FTE's
National/local plan	Local

Table 2.

MCEs	**FFY 16**	**FFY 17**	**FFY 18**
Department of Vermont Health Access	$1,679,425,056	$1,600,236,799	$1,595,969,592

Results of the Review

The CMS review team identified areas of concern within the state's managed care-like program integrity oversight, thereby creating a risk to the Medicaid program. The CMS will work closely with the state to ensure that all the identified issues are satisfactorily resolved as soon as possible. These issues and CMS recommendations for improvement are described in detail in this report.

State Healthcare Delivery System

The state of Vermont operates as a state-wide, public, non-risk PIHP under the Global Commitment to Health Section 1115 Demonstration authority. Vermont's program utilizes a managed care-like model to operate and has entered into an Intergovernmental Agreement (IGA) with the Department of Vermont Health Access (DVHA), and various Intergovernmental Partners that include; Department of Mental Health (DMH), Department of Disabilities, Aging, and Independent Living (DAIL), Vermont Department of Health (VDH), Department for Children and Families (DCF) and Agency of Education (AOE) that administer the Medicaid managed care-liked model for all enrollees. Specifically, all individuals receiving Medicaid benefits within the state receive services through this managed care-like service delivery model.

In addition to the demonstration, the state has also implemented the Vermont All-Payer Accountable Care Organizational Model agreement (All-Payer Model). The Vermont All-Payer Accountable Care Organization (ACO) Model is the CMS test of an alternative payment model in which the most significant payers throughout the entire state – Medicare, Medicaid, and commercial health care payers – incentivize health care value and quality, with a focus on health outcomes, under the same payment structure for the majority of providers throughout the state's care delivery system and transform health care for the entire state and its population.[1]

The DVHA serves as the state's only MCE, in this case, PIHP and is not a traditional managed care program in the sense of a risk-based capitation program with private contractors. In accordance with the Section 1115 demonstration special terms and conditions (STC) # 24- The managed care-like model shall be subject to 42 CFR 438 requirements as a non-risk PIHP and AHS shall be subject to 42 CFR 438 requirements as the state and DVHA shall be subject to 42 CFR 438 requirements as a non-risk PIHP.[2] The DVHA sub-contracts with Accountable Care Organization (ACO), OneCare Vermont for a portion of its Medicaid population, but has not sub-delegated program integrity (PI) responsibilities. The DVHA also has sub-agreements with state entities in mental health services, developmental disability services, and specialized children and family services that provide specialty care for Global Commitment enrollees.

Additionally, under the Section 1115 demonstration STC #33 - All program integrity requirements in federal statute and regulations that are required of the state in its oversight of a non-risk PIHP shall be the direct responsibility of AHS and may not be delegated to DVHA. Therefore, AHS must maintain authority, accountability, and oversight of the program, to include oversight of DVHA and any other contracted entities. Based upon the documentation and discussions with key staff during the onsite review it appears that AHS is not in compliance with the requirement of maintaining direct responsibility for oversight of program integrity efforts as the single state agency. It appears that AHS has delegated PI responsibilities to DVHA.

Recommendation #1:

[1] https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model

[2] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-ca.pdf.

The state should ensure compliance with the requirements pursuant to 42 CFR 438, subpart H related to oversight of the program integrity functions that are the sole responsibility of the state and should not be delegated to DVHA.

State Oversight of Managed Care Program Integrity Activities

The CMS review team identified a lack of robust program integrity contract language that allows the state to maintain the necessary program integrity controls and oversight capabilities while maintaining the flexibility to govern its managed care program effectively. The CMS recognizes that AHS through its IGA with DVHA delegated all PI function. However, the current contract with OneCare of Vermont has no outlined program integrity requirements. The state should consider enhancing/improving the program integrity contract language.

Some of the program integrity issues that AHS might consider requiring in its ACO contracts include, but are not limited to the following: 1) Disposition of provider complaints and allegations of provider fraud, waste, and abuse; 2) Review and tracking of suspected provider fraud referrals to DVHA; 3) Development and implementation of written policies and procedures on payment suspensions in accordance with 42 CFR 455.23 and/or 42 CFR 438.608(a)(8); 4) Specific language around program integrity recoupments or overpayment recoveries after all appeal rights are exhausted; 5) Collaborating and conducting joint audits and initiating routine onsite provider visits during an investigation/audit; 6) Verifying Medicaid services with beneficiaries; 7) Tracking suspected provider fraud referrals; and 8) Disposition of provider adverse actions to include exclusions and terminations.

Additionally, since AHS is responsible for oversight of the managed care-like model acting as a non-risk PIHP, the state is subjected to the requirements of 42CFR 438, ensuring compliance with state, federal statutes, regulations, special terms and conditions, waiver and expenditure authority. During the PI review, it was determined that AHS was not in compliance with 42 CFR 438.10 (c) (3), which requires the state to have a website that provided content that directly links to its PIHP website.

Recommendation#2:

The state should ensure compliance with the web site requirements described in 42 CFR 438.10 (c).

The state reported that the oversight of the managed care system in Vermont is a collaborative effort between AHS and DVHA. Both AHS and DVHA share the programmatic and contractual oversight of the managed care program, while DVHA has oversight of the program integrity activities related to fraud, waste, and abuse. Under the Section 1115 demonstration waiver, DVHA functions as the managed care entity and has entered into an IGA with AHS. Through this IGA, AHS has outlined written policies and procedures for how it will coordinate oversight of various functions and which departments are responsible for each of the specific activities.

As stated previously, AHS as the single state agency is not permitted to delegate any program integrity functions in federal statute and regulations that are required to be performed by the state. During the interview, it was determined that AHS lacked oversight of DVHA's PI

processes and has delegated a lot of AHS oversight responsibilities to DVHA. The AHS does not have a formal, documented process for comprehensive oversight of DVHA. The AHS advised the review team that they conduct a yearly Federal Clinical Laboratory Improvements Amendments (CLIA) audit of DVHA, but no other compliance reviews. The CMS recognizes that AHS may utilize ad hoc processes that they may consider effective that are not memorialized in policy or process. However, AHS could benefit from a more formal process that helps ensure that they are not delegating their oversight responsibilities to DVHA, which would be non-compliant with the current Section 1115 demonstration STCs.

Recommendation#3:

The state should consider developing a formal, documented process for comprehensive program integrity oversight of DVHA to ensure compliance with 42 CFR 438.66 State monitoring requirements.

The AHS require plans to have administrative and management arrangements or procedures, including a mandatory compliance plan, which is designed to guard against fraud, waste, and abuse. The MCEs must also have written internal controls designed to detect and report known or suspected fraud, waste, and abuse activities. Compliance plans are reviewed by the compliance committee annually. The compliance committee which is led by DVHA is comprised of representatives from all Medicaid departments including AHS. There is no policy or procedure that outlines how the compliance plan should be submitted and to whom.

When asked how often compliance plans are submitted to AHS, DVHA, and OneCare each provided different responses that were inconsistent. OneCare stated they have never submitted a compliance plan to AHS, and they only submit to DVHA. OneCare's last submission of a compliance plan was February 2018. The DVHA indicated that they submit their compliance plan annually, but not directly to AHS, instead, they submit it to the compliance committee. The AHS was unable to provide an internal process for annually reviewing the MCE compliance plans.

Recommendation#4:

The state should consider developing a policy and procedure for the annual submission, review and approval of MCE compliance plans by AHS.

Provider Screening and Enrollment

The AHS has delegated enrollment responsibilities to DVHA and has identified high risk and moderate risk providers under 42 CFR 455.450. High risk and moderate risk providers are subject to enhanced screening that may include onsite visits, FBI background checks, and FBI fingerprinting. The MCEs are required to screen and enroll providers based on the identified, categorical risk levels designated by AHS. The AHS does not conduct onsite visits. The DVHA does credentialing and enrolling of providers, under 42 CFR 438.602 (b) and 42 CFR 455.436, however, the review team could not determine if DVHA was ensuring that OneCare complied with the database requirements of 42 CFR 455.436. Specifically, the review team was advised

by OneCare that all required federal database checks are conducted by their employer, The University of Vermont Medical Center (UVMC). According to OneCare, UVMC has policies and procedures that require all prospective employees and contractors to be screened prior to engaging their services by: (1) requiring each prospective employee and contractor to disclose whether such individual or entity is an Ineligible Person, and (2) screening the employee or contractor against, the System for Award Management (SAM) List of Parties Excluded from Federal Programs, the Department of Health and Human Services' Office of Inspector General's (OIG) List of Excluded Individuals/Entities, and the New York State Office of the Medicaid Inspector General (OMIG) Restricted, Terminated or Excluded Individuals or Entities List. Currently, OneCare does not have a process to track, nor do they verify that these federal database checks are conducted by UVMC. Moreover, neither DVHA nor OneCare could provide documentation that these database checks are being conducted by UVMC as required by federal regulations.

Additionally, the review team determined that AHS lacked the required uniform credentialing policy for DVHA according to 42 CFR 438.214. This deficiency was also identified in the 2018-2019 External Quality Review (EQR) Technical Report.

Recommendation#5:

The AHS should develop a policy and procedure to ensure compliance with provider selection requirements at 42 CFR 438.214.

MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCEs.

Vermont's IGA between AHS and DHVA delegated all program integrity responsibilities to DVHA and requires that the MCEs program integrity program include policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for suspected cases of fraud, waste, and abuse in the administration and delivery of services. According to 42 CFR 455.14, if the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a "preliminary" investigation to determine whether there is sufficient basis to warrant a full investigation. The AHS, DVHA, and Program Integrity Unit (PIU) has entered into a Memorandum of Understanding with the Medicaid Fraud and Residential Abuse Unit (MFRAU)[3], which allows DVHA's PIU to make referrals directly to the MFRAU.

Although AHS has entered into an IGA with DVHA for all PI functions, the review team was unable to determine whether there was direct oversight from AHS. Specifically, DVHA has policies and procedures in which they conduct PI operations and make referrals to MFRAU, but

[3] Medicaid Fraud & Residential Unit (MFRAU) is the name of the Medicaid Fraud Control Unit (MFCU) in Vermont.

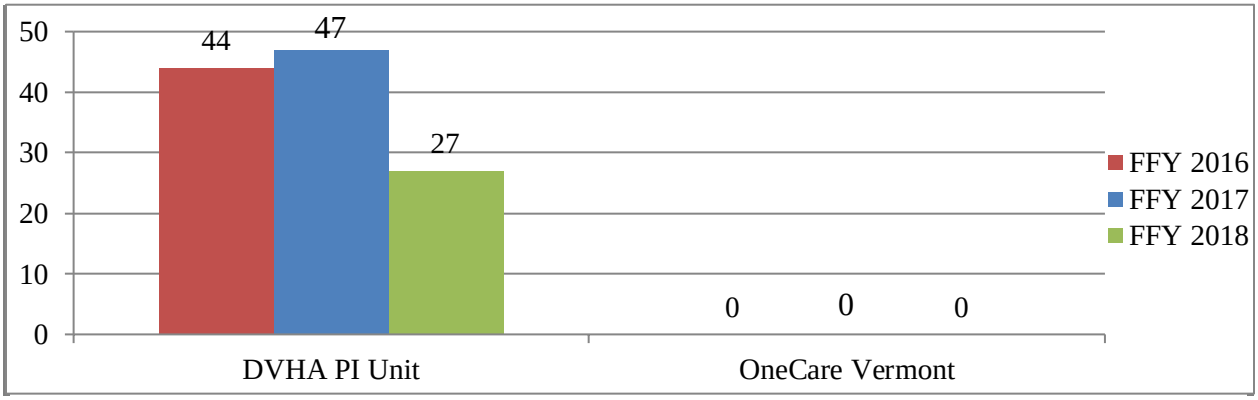
they do not have policies or procedures in place that require the notification of AHS related to referrals to MFRAU.

Recommendation #6:

The state should consider developing, compiling, implementing and updating as necessary, written policies and procedures addressing all program integrity functions as required by 42 CFR 455.13-21 and 438.608. This would also include a referral policy.

Table 3 below identifies the number of referrals that DVHA and OneCare made to the state in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals by the MCEs is low, compared to the size of the plan. The level of investigative activity by the MCEs has changed over time.

Table 3.



As illustrated above, AHS delegated all PI activities to DVHA. Currently, DVHA does not refer investigations to AHS or provide notifications of PI activities. The PI unit instead, referred cases where there was a credible allegation of fraud to MFRAU. Moreover, OneCare was not contractually required to conduct fraudulent investigations. This lack of notification of PI activities to AHS and the lack of investigatory efforts by OneCare were of particular concern to the review team. Specifically, OneCare's direct relationship with providers gives them a unique opportunity to identify and report fraudulent behaviors to DVHA, but due to a lack of contractual requirements, this information might not get shared.

According to PI staff, the decrease in referrals was due to the transitioning of healthcare services in Vermont from an FFS to an ACO model and may have contributed to this reduction in referrals. The PI unit is currently conducting outreach training to various entities throughout the state to further educate providers and beneficiaries about fraud, waste, and abuse. The PI unit believes these efforts will possibly increase awareness and referrals in the future. Also, they have made a Referral Form available across multiple state websites to allow easy reporting access for providers and beneficiaries to alert PI to any potential issue or concern.

Recommendation #7:

The state should ensure that a standard operating procedure (SOP) or a process exists between DVHA and AHS informing them of all relevant PI activities.

Overpayment Recoveries, Audit Activity, and Return on Investment

The table 4 below identifies the activities related to preliminary investigations, full investigations, total overpayments identified and total overpayments recovered.

Table 4.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2016	44	18	$4,478,238	$4,478,238
2017	47	16	$3,470,216	$3,470,216
2018	27	7	$3,285,274	$3,285,274

As previously mentioned, DVHA attributed the decrease in cases from FFY 2016-FFY 2018 to transitioning of healthcare services in Vermont from an FFS to an ACO model. Although fewer cases were identified during the timeframe, overpayments identified and recovered did not show a significant change in trend. This lack of change in identified overpayments and recoveries were attributed to the state implementing cost avoidance measures. Another factor in the overall reduction was the federal share of most of the settlements identified in FFY18 was taken out before sending Vermont their share of the recoveries. In the past, Program Integrity recorded all the settlements received in total, which included the federal share.

Overall, the amount of overpayments identified and recovered by the PIHP appears to be low for a Medicaid managed care –like program of Vermont's size. Although DHVA is required to return overpayments from their network providers to AHS, it is important that AHS obtain a clear accounting of any recoupments, since these dollars are factored into establishing annual rates. Without these adjustments, the rates paid may be inflated per member per month.

Encounter Data

The DHVA is engaged in a payment model with an ACO whereby, it pays a combination of monthly fixed prospective payments and fee-for-service to participating providers for a set of services for a cohort of the Medicaid population that is considered attributed to the ACO. The DVHA does not have traditional capitated providers. The DVHA functions as a managed care FFS program that does not rely on encounter data. However, encounter, claims, and cost data are available through the Medicaid Management Information System (MMIS). The DVHA has access to the databases to review for PI and audit review. The DVHA does utilize a capitated payment structure to pay its providers on a per member per month bases (PMPM). Encounter data is only used for rate-setting purposes. The AHS does have a process for reporting Medical Loss Ratio (MLR) standards.

Payment Suspensions

In Vermont, Medicaid MCEs are contractually required to suspend payments to providers at the state's request. The state confirmed that there is contract language within its IGA mirroring the payment suspension regulation at 42 CFR 455.23. The review team confirmed that there was no contractual language in OneCare's contract for them to mirror the payment suspension regulation at 42 CFR 455.23, however, there was contractual language in OneCare's contract related to affiliations with debarred or suspended individuals.

The regulation at 42 CFR 455.23(a) requires that when the State Medicaid Agency determines that there is a credible allegation of fraud, it must suspend all Medicaid payments to a provider unless the agency has good cause not to suspend payments or to suspend payment only in part. The AHS has delegated the suspension responsibilities to DVHA. The DVHA's Program Integrity's Medicaid Audit and Compliance Unit (MACU) is responsible for suspension related functions according to 42 CFR 455.23. The MACU Procedure Manual requires the plans to suspend provider payments for cases involving a potential MFRAU referral and credible allegations of fraud (CAF). Payment suspension must be reviewed and approved by the PI Director/Associate Director (AD) and DVHA's attorney prior to the case being referred or a payment suspension being pursued. If the PI Director/AD approves the proposal, a meeting is held with DVHA's attorney to discuss the case. The attorney will need to see the case record one week before the meeting and will have one week after the meeting to review and approve the PI's MFRAU/CAF recommendation. All cases where a payment suspension is deemed appropriate must have the recommendation reviewed and signed-off by the Commissioner and the Secretary of Human Services and if good cause exists and a payment suspension is not implemented, the Medicaid Payment Suspension Request form is not routed for the Commissioner and the Secretary of Human Services' signatures.

The review team could not determine AHS's level of oversight in DVHA's suspension process since they appear to have delegated all the state's responsibility and authority to DVHA for suspending providers when a credible allegation of fraud has been identified. Ultimately, DVHA is responsible for determining whether a payment suspension is in the best interest of Vermont's Medicaid program, not AHS. OneCare did not suspend any providers during the last three FFYs and is not contractually required to do so.

In the last three FFYs DVHA had ten suspected MCE provider fraud referrals accepted by the MFRAU for criminal investigation. A payment suspension was imposed on five providers in the last three FFYs. According to DVHA staff there has not been a suspension since 2017.

Recommendation #8:

The state should consider amending IGA and OneCare contract language to clearly delineate the policies and procedures related to the regulations at 42 CFR 455.23.

Terminated Providers and Adverse Action Reporting

Table 5.

The table 5 below identifies the activities related to provider terminations (both for cause and not for cause) and provider disenrollment.

MCEs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated For Cause in Last 3 Completed FFYs	
Department of Vermont Health Access	2016 2017 2018	2140 0823 1998	2016 2017 2018	4 1 3

Overall, the number of providers terminated for-cause by DVHA appears to be low, compared to the number of providers enrolled with the MCEs and compared to the number of providers dis-enrolled or terminated for any reason. There were only eight providers terminated for-cause within the last three FFYs. Additionally, OneCare advised that in its role as a contractor the termination of providers is not a part of their agreement with DVHA, however, if a provider is terminated for cause by DVHA, OneCare stated they would remove the provider from the monthly provider roster. The current ACO contract does not address provider terminations nor does it address the process that OneCare would remove the provider from the monthly roster it submits to DVHA.

Additionally, the IGA between AHS and DVHA does not contain language that addresses for-cause adverse action provider terminations. The CMS guidance indicates for-cause adverse action terminations may include, but is not limited to, termination for reasons based upon fraud, integrity, or quality. Section 6501 of the Affordable Care Act mandates that state Medicaid agencies effectively terminate providers that have been terminated for cause. The DVHA advised the onsite team that provider terminations based on violations of fraud, integrity, and quality are considered for-cause terminations. The CMS acknowledges that this may be an expectation of the MCEs, but the AHS's IGA and OneCare contract does not support this assertion and does not specify that terminations due to fraud, integrity, or quality are considered for-cause. The DVHA must identify and report for-cause terminations so that AHS can take the appropriate actions to safeguard the Medicaid program. The AHS only submitted information on one of the three terminated providers to the DEX system in 2018.

Recommendation #9:

The AHS should consider the following: **1)** Amend the IGA with DVHA and contract with OneCare to include such provisions; **2**) Implement policies and/or contract language to address clear reporting of for-cause terminations; and **3**) Require prompt reporting requirements regarding for-cause terminations that should be adopted by all Vermont plans. Accordingly, additional education is warranted to ensure provider for-cause terminations are identified, reported, and handled appropriately.

Status of Corrective Action Plan from Year 2015 Review

Vermont's last CMS program integrity review was in August 2015, and the report for that review was issued in October 2016. The report contained seven recommendations. The CMS completed a desk review of the corrective action plan in June 2018. The desk review indicated that the findings from the 2015 review have all been satisfied by the state.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Vermont to consider utilizing:

- Continue to take advantage of courses and training at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to Vermont are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the Regional Information Sharing Systems (RISS) as a tool to identify effective program integrity practices.
- Access the Medicaid Provider Enrollment Compendium (MPEC) for information related to Medicaid Provider Enrollment requirements https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf.
- Access the Toolkits to Address Frequent Findings: Payment Suspension Toolkit website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf.

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

CMS looks forward to working with Vermont to build an effective and strengthened program integrity function.